Bundle Public Board Meeting 19 November 2026

0 Agenda
Final Agenda Public_Board_Meeting_19 November_2026

1 09:30 - Welcome, introductions and apologies:

2 Declarations of interest-Information from Declare

3 Youth Board

4 Questions from members of the public

5 Minutes of previous meeting action log and matters arising

5.a Minutes of the meetings held on: 17 September 2026
Item 5a Draft PUBLIC Board minutes 17 September 2026 v2 SM HT Approved

5.b Action log
Item 5b Public Board Action Log - 19 November 2026

5.c 09:55 - Patient Lived Experience: Community Discharge Assessment Team (CDAT)

6 10:25 - Interim Chief Executive's report
Item 6 Chief Executive's Report - November 2026

7 10:35 - Wildly Important Goals (WIGs)
Item 7i WIGs Update Paper Board Nov 2026
Item 7ii WIGs Mid Year Update 2026_27 Board

8 10:55 - Quality Committee Chair's Assurance Report: 10 November 2026
Item 8 Chair Assurance Report - Quality Committee November 2026 v3 HR HM AL

9 11:00 - Thirlwall Inquiry Report
Item 9 Thirlwall Board report Oct 2026 v3

10 11:10 - Business Committee Chair's Assurance Reports: 20 October 2026 and 17 November 2026 (tabled report)
Item 10i Chairs assurance report - Business Committee - 20 October 2026 v2LM

11 11:15 - Audit Committee Chair's Assurance Report: 6 October 2026
Item 11 Audit Committee Chair's Assurance Report October 2026 chair approved

12 11:20 - Integrated Performance Report (All Execs) -Sickness Absence Update (Jenny Allen)
Item 12i IPR Cover paper Performance Brief_BoardNov
Item 12ii IPR_Oct26
Item 12iii Trust Board Nov 2026 Sickness Absence cover report
Item 12iv NOF Sickness Absence update - Board Nov 2026

13 11:35 - People and Culture Committee Chair's Assurance Report: 7 October 2026
Item 13 PCC Chairs assurance report - PUBLIC Oct_26_Final

14 11:40 - Annual People Inclusion Report 2025/26

Item 14i Trust Board Annual People Inclusion Report 2025-26 FINAL 101126
Item 14ii Appendix A WRES performance 2019-2026 FINAL
Item 14iii Appendix B WDES Performance 2019- 2026 FINAL
Item 14iv Appendix C People Inclusion Improvement plan 2026 27 FINAL
Item 14v Appendix D Trust Board Equality Intentions FINAL
Item 14vi Appendix E LCH EDS22 Domain 2 and 3 assessment

15 11:50 - Significant Risks And Risk Assurance Report

Item 15 Board Significant Risk Report 191126

16 11:55 - Any Other Business. Questions On Blue Box Items And Close

17 Blue Box : Mortality Reports Quarter 2 – Presented to Quality Committee November 2026

Item 17i Blue Box Item Learning from Deaths Q2 2026_2027 report for QC (1)
Item 17ii Blue Box Item Learning from Deaths Q2 2026_2027 report for QC (2)
Item 17iii Blue Box Item Learning from Deaths Appendix 1 QC (1)

18 Blue Box: People Headlines and Strategy Update – Presented to People and Culture Committee October 2026

Item 18 Blue Box Item People Headlines - September 2026

19 Blue Box: Guardian For Safe Working Hours - Presented to People and Culture Committee October 2026

Item 19 Blue Box Item GoSWH- P&CC Committee report Final

20 Blue Box: Workplan

Item 20 Blue Box Item Trust Board Workplan Public v9 2026-2027 Nov 2026

21 Blue Box: Glossary

Item 21 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 19 November 2026
Time 9.30am -12 noon
Chair Helen Thomson DL, Acting Trust Chair

AGENDA			Paper
2026-27 1	9.30	**Welcome, Introductions and Apologies** *(Acting Trust Chair)*	**N**
2026-27 2		**Youth Board**	**N**
STANDING ITEMS			
2026-27 3	9.50	**Declarations Of Interest** *(Acting Trust Chair)*	**Y**
2026-27 4		**Questions From Members Of The Public**	**N**
2026-27 5		**Minutes Of Previous Meetings, Action Log And Matters Arising** *(Acting Trust Chair)*	
5a		Minutes of the meeting held on: • 17 September 2026 – **for approval**	**Y**
5b		Action Log	**Y**
5c	9.55	**Patient Lived Experience:** Community Discharge Assessment Team (CDAT)	**N**
STRATEGY AND PARTNERSHIPS			
2026-27 6	10.25	**Interim Chief Executive's Report** *(Dr Sara Munro)*	**Y**
2026-27 7	10.35	**Wildly Important Goals (WIGs)** *(Andrea Osborne)*	**Y**
BREAK – 10 minutes			
QUALITY AND SAFETY			
2026-27 8	10.55	**Quality Committee Chair's Assurance Report: 10 November 2026** *(Anne Cooper)*	**Y**
2026-27 9	11.00	**Thirlwall Inquiry Report** *(Sheila Sorby)*	**Y**
FINANCE, PERFORMANCE AND SUSTAINABILITY			
2026-27 10	11.10	**Business Committee Chair's Assurance Reports**: 20 October 2026 and 17 November 2026 (tabled report) *(Lynne Mellor)*	**Y**
2026-27 11	11.15	**Audit Committee Chair's Assurance Report:** 6 October 2026 *(Khalil Rehman)*	**Y**
2026-27 12	11.20	**Integrated Performance Report** *(All Execs)* - **Sickness Absence Update** *(Jenny Allen)*	**Y** **Y**
WORKFORCE			
2026-27 13	11.35	**People and Culture Committee Chair's Assurance Report: 7 October 2026** *(Rachel Booth)*	**Y**

2026-27 14	11.40	**Annual People Inclusion Report 2025/26** *(Jenny Allen)*	**Y**
GOVERNANCE AND WELL LED			
2026-27 15	11.50	**Significant Risks And Risk Assurance Report** *(Dr Sara Munro)*	**Y**
CLOSING BUSINESS			
2026-27 16	11.55	**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 16.

***Blue Box Items – To Note**		
2026-27 17	**Mortality Reports Quarter 2 – Presented to Quality Committee November 2026**	**Y**
2026-27 18	**People Headlines and Strategy Update – Presented to People and Culture Committee October 2026**	**Y**
2026-27 19	**Guardian For Safe Working Hours - Presented to People and Culture Committee October 2026**	**Y**
2026-27 20	**Workplan**	**Y**
2026-27 21	**Glossary**	**Y**

Minutes: Trust Board Meeting Held in Public
Date: 17 September 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
	Jenny Allen	Director of People
	Dr Ruth Burnett	Executive Medical Director
	Professor Ian Lewis (IL)	Associate Non-Executive Director
	Heather McClelland	Interim Executive Director of Nursing and AHPs
	Lynne Mellor (LM)	Associate Non-Executive Director - via virtual link
	Andrea Osborne	Executive Director of Finance and Resources
	Sam Prince	Executive Director of Operations
	Khalil Rehman (KR)	Non-Executive Director - via virtual link (Items 41-50)
In attendance:	Em Campbell	Health Inequalities Lead (Item 49)
	Helen Robinson	Company Secretary
	John Walsh	Freedom to Speak Up Guardian (Item 50)
Minutes:	Liz Thornton	Corporate Governance Officer
Apologies:	Anne Cooper (AC) Rachel Booth (RB) Alison Lowe OBE (AL)	Non-Executive Director Non-Executive Director Non-Executive Director

Item 2026-27 (41): Welcome introduction, apologies, and preliminary business

The Acting Trust Chair opened the Board meeting and welcomed members and attendees. She said that to ensure the Board remained quorate items which required approval would be taken out of agenda order.

Apologies: Apologies for absence were received from Non-Executive Director (AL), Non-Executive Director (RB) and Non-Executive Director (AC).

Item 2026-27 (42): 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 (43): Questions from members of the public

There were no questions from members of the public.

Item 2026-27 (44): Minutes of Previous Meetings, Action Log and Matters Arising

a) Minutes of the meeting held on 23 July 2026
The minutes were reviewed for accuracy and approved as a correct record of the meeting.

b) Action log
There was one actions on the log to review:
2026-27 (33): Business Committee Chair's Assurance Report 21 July 2026: the risk scores for environmental risks on the corporate risk register to be reviewed by the Risk Management Group (RMG): the Interim Chief Executive confirmed that the risks had been reviewed by the RMG and assurance had been received that effective action had been taken. **Action closed.**

There were no further actions or matters arising to address.

Item 2026-27 (45): Patient Lived Experience

The Board welcomed a patient who had received care from the Community Stroke Team. Also in attendance were Temba Ndirigu, Interim Clinical Lead, Specialist Business Unit and Laura Stubbs, Occupational Therapist from the Stroke Pathway Team.

Laura provided some information about the work of the Community Stroke Team and then the patient delivered a presentation about her journey through the care system after suffering a subarachnoid haemorrhage on 5 January 2026.

After spending almost nine weeks in hospital she was discharged into the care of Community Stroke Rehabilitation Team from 31 March until 10 July 2026. She explained that the Team had played a fundamental role in her recovery as a major source of support, providing understanding, hope, cognitive exercises and practical tasks for her to complete. Their formal support had now ended. She added that referral to a community neurological team and a future work-related rehabilitation pathway were paused until felt ready to move further forward.

The Interim Trust Chair invited questions from Board members.

The Executive Director of Operations asked how the patient felt about the transition from hospital care to the community team. She said that the transition from hospital to community services had felt disconnected, with a three-week delay before the first community appointment which had caused uncertainty and anxiety about the next steps.

It was suggested that an earlier introduction to the community team, for example whilst the patient was still an inpatient, would lead to clearer transition planning with an earlier sharing of knowledge. The Executive Director of Operations said that work was underway to try and improve the transition from hospital to community care.

Non-Executive Director (LM) noted that the patient's husband had become her main carer, and she wondered what help and support had been offered to him. The patient said that her husband was not always receptive to offers of help and taking support. The Board discussed signposting organisations such as Carers Leeds, and encouraging his attendance at the quarterly subarachnoid haemorrhage peer group, where partners could share their experiences.

The Interim Chief Executive said that she hoped the Trust's merger with LYPFT would offer more seamless access to talking therapy and psychiatric support to patients recovering from a stroke.

The Interim Trust Chair thanked the patient for attending the Board meeting and making such a powerful presentation about her recovery journey so far. She congratulated her on the excellent progress she had made in a relatively short period of time and wished her luck for the future which she hoped would result in her successfully returning to work.

Items taken out of agenda order

Item 2026-27 (46): Winter Plan 2026-27

The Executive Director of Operations presented the plan for assurance and approval. She explained that the plan set out board assurance statements for winter preparedness and had been tested

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through the city's executive-level leadership group. An equality-impact assessment had also been completed.

The Interim Trust Chair asked whether the detail about the communications with primary care and Primary Care Networks (PCNs) were explicit enough, to prevent primary-care teams referring patients acutely when community services could respond.

The Executive Director of Operations agreed to strengthen the narrative around the pathway links, but she was confident that the lines of communication were good.

Non-Executive Director (KR) asked how the organisation would manage workforce capacity during winter and whether severe winter pressures could have financial implications particularly given all the work which was required to support the integration with LYPFT.

The Executive Director of Operations provided assurance that the flow-management roles within the Trust would be protected from integration work, a winter funding pot was available, and business continuity plans would prioritise patients needing same-day care while allowing lower-risk work to be paused temporarily.

Non-Executive Director (LM) asked whether the current plan should be compared with LYPFT's plan ahead of next year's integrated winter plan.

The Executive Director of Operations said the organisations were already working as a single system where appropriate, including planning virtual wards, and would continue developing system responses beyond organisational boundaries.

Outcome: the Board

- Reviewed the assurance statements provided throughout the plan and approved it for submission to NHS England.

Item 2026-27 (47) Medical Director's Annual Report and Statement of Compliance

The Executive Medical Director presented the report which provided the Board with an update and overview regarding the Trust's responsibilities as an employer of Medical and Dental staff. The report was accompanied by the recommended template for the Statement of Compliance for 2025/26 which required sign off by the Board.

It was noted that the report and statement of compliance had been reviewed by the Quality Committee and recommended for approval.

Outcome: the Board

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

Items returned to agenda order

Item 2026-27 (48): Interim Chief Executive's Report

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

National Inclusion Week

During this week the Trust was reaffirming its commitment to creating an inclusive culture where all colleagues felt valued, respected and able to contribute fully. Inclusion remained central to the Trust's Strategy, supporting colleague wellbeing, equality of opportunity and the delivery of high-quality care.

National Oversight Framework

The results for Quarter 1 2026/27 had been finalised, and the Trust had been informed that it was in segment 3 as predicted. Detailed scores were being reviewed to identify those areas to prioritise for action and improvement.

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Farewell to West Yorkshire Police Custody

Later this month the Trust would formally hand over the police custody services for West Yorkshire to Mitie. This followed the Trust's decision not to retender for the service. The Board placed on record its thanks to all the staff who would move across and those who would remain and have been pivotal to leading the service and ensuring a safe transition over the past few months.

Progress on the creation of Leeds Partnership NHS Foundation Trust

Significant activity had taken place over the last six weeks including submission of the checkpoint report to NHS England (NHSE) on the 4 September 2026 and their formal endorsement of the new Trust name post-merger.

Ministerial visit to the Reginald Centre

Minister Diana Johnson who holds the portfolio for public health and patient safety including community healthcare, general practice, children's health and neighbourhood health had made a very successful visit to the Reginald Centre on 10 September 2026.

Outcome: The Board

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

Item 2026-27 (49): Health Equity Strategy

The Executive Medical Director presented the report which provided an update on the first year of the delivery of the Trust's 5-year tactical plan for equity and compliance with core equity requirements. It included early analysis of the potential equity benefits and risks in the Trust Integration Programme.

She reported progress in reducing equity gaps in waiting times and improving the completeness of ethnicity data, with valid ethnicity coding reported at approximately 97%, above the national benchmark. The Board noted that publishing and monitoring disparities had supported a fairer approach to waiting-list reduction. The health equity index was scheduled to become part of the IPR reporting from November, including analysis by ethnicity and deprivation.

Non-Executive Director (LM) suggested that the health equity report should be expanded to include information about the digital-inclusion work in the Trust.

Non-Executive Director (IL) asked how people with learning disabilities were being monitored. It was confirmed that learning disability and autism filters were included in business-intelligence reports, although small numbers and incomplete recording limited the interpretation to produce meaningful results.

The Board heard that a joint post with the equity team was supporting reasonable adjustments, noting that the electronic-record requirements to record them had been deferred until the end of March 2027.

Outcome: the Board

- Noted progress of the Health Equity Strategy.

Item taken out of agenda order

Item 2026-27 (50) Freedom to Speak Up Report

The Freedom to Speak Up Guardian (FTSUG) presented the six-monthly report which provided the Board with an update on the FTSU work undertaken in the Trust from 26 March 2026 to 17 September 2026.

He highlighted the key information:

- There had been seventy-nine concerns overall to the FTSUG and the Speaking Up Champions from Leeds Community Healthcare (LCH) staff.
- There had been a special focus on sexual safety work, organisational change and integration for the new organisation.

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The FTSUG reported that volumes remained at that high level, which was broadly consistent with wider NHS trends any contacts from members of the public were redirected and managed appropriately.

The FTSUG spoke about work with his counterpart at Leeds and York Partnership NHS Foundation Trust (LYPFT) to develop a FTSU operating model for the new organisation. The work would take best practice models from both organisations.

The Board discussed expanding the current network of Freedom to Speak Up champions and aligning it with LYPFT's ambassador network. The FTSUG said that he planned to attend the LYPFT ambassadors' meeting and invite his counterpart to the LCH champions' meeting, with a possible wider recruitment campaign and roadshow during organisational integration.

Outcome: the Board

- Noted the report.

Items returned to agenda order

Item 2026-27 (51) Quality Committee Chair's Assurance Report

51a) Assurance Report 8 September 2026

Associate Non-Executive Director (IL) presented the report from the meeting on 8 September 2026 on behalf of Non-Executive Director (AC) who had chaired the meeting. He highlighted the key issues in the report.

- There were no alerts to the Board.

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

Outcome: the Board

- Noted the Quality Committee Chair's Assurance Report.

51b) Patient Safety Update Report

The Interim Executive Director of Nursing and AHPs presented the report which evidenced improved incident handling and stronger oversight.

There was 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 was being identified through Rapid Review Meetings, enabling prompt implementation of improvements. No Never Events had been reported and there was a reduction in Patient Safety Incident Inspections commissioned

The Board noted a clearer separation of clinical and non-clinical data and assurance that overdue incidents would not recur in the new organisation.

Outcome: the Board

- Noted the findings of the update report.

Item 2026-27 (52): Business Committee Chair's Assurance Reports

Associate Non-Executive Director (LM) presented the report for the meeting on 15 September 2026. She highlighted some of the key issues in the report.

- There were no alerts to the Board.

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

Outcome: the Board

- Noted the Business Committee Chair's Assurance Report.

Item 2026-27 (53): Charitable Funds Chair's Assurance Report

The Acting Trust Chair presented the report on behalf of Non-Executive Director (AL) for a meeting on 8 September 2026. She highlighted the alert to the Board about 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 considered when determining the future approach to charitable funds within the new organisation.

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Outcome: the Board

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

Item 2026-27 (54): Integrated Performance Report (IPR)

54a) The Executive Director of Finance and Resources presented the report which provided an overview of performance across the Trust, measured across the six domains that aligned to the NHS Oversight Framework.

The Board noted that the Trust was forecasting a break-even position and had a healthy cash balance, while retaining flexibility to support integration, quality-and-value programmes, additional capacity and winter pressures. Temporary staffing costs were identified as a potential risk because operational flexibility would still be required during the next 12 to 18 months.

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

54b) Sickness Absence Update

The Director of People reported that sickness absence was tracking just below 7% and had declined gradually from its January peak. Approximately 70% of absence was long term, with nearly half of that linked to mental health, stress, anxiety and depression; higher absence rates were associated with areas experiencing substantial change.

Outcome: the Board:

- Received and noted the IPR report and the sickness absence update.

Item 2026-27 (55): Significant Risks and Risk Assurance Report

The Interim Chief Executive presented the update report which provided the Board with an overview of the Trust's material risks currently scoring 15 and above (extreme risks). This was based on information extracted from the Datix risk module on 25 August 2026.

One risk scored 15 (extreme) and 14 risks score 12 (high). The Board noted the narrative around this risk and the actions being taken to reduce the score.

Outcome: the Board

- Noted the changes to the significant risks since the last risk report was presented to the Board.

Item 2026-27 (56): Board Assurance Framework (BAF) 2026-27

The Interim Chief Executive presented the report which reported the output of the first quarterly review of the 2026/27 Board Assurance Framework.

Outcome: the Board

- Received the BAF, and was assured of the appropriateness of the updates, including risk scoring and mitigating actions.

Item 2026-27 (57) Board Members Service Visits

The Interim Chief Executive presented the report which provided 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.

During 2026/27, a programme of Learning Visits and Leadership Visits had been established, with visits undertaken across a range of clinical and corporate services. Feedback from visits was shared through the Trust's governance structures to support organisational learning and service improvement.

Outcome: the Board

- Noted the progress made in delivering the Board Service Visits Framework and the planned programme of future visits.

Item 2026-27 (58): Any Other Business, Questions On Blue Box Items, And Close

One matter was discussed:

The Interim Trust Chair asked about racism training for the Board.

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The Director of People said that a potential provider had been identified. The aim would be to deliver a joint session to both boards in the coming months.

Items in the Blue Box were noted.

No questions were raised.

The Acting Trust Chair closed the meeting at 12noon

Date and time of the next formal meeting

Thursday 19 November 2026 9.30am
Boardroom, Building 3, White Rose Office Park,
Millshaw Park Lane, Leeds, LS11 0DL.

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AGENDA ITEM 2026-27 (5b)

Leeds Community Healthcare NHS Trust
Trust Board Meeting (held in public) Action Log: 19 November 2026

Key		Key colour code
Total actions on action log	0	
Actions on log **completed** since last Board meeting on 17 September 2026 with a **proposal to close**		
Actions due for completion by 19 November 2026 – for update at the meeting		
Actions not due for completion before 19 November 2026		
Actions outstanding at 19 November 2026**: not having met agreed timescales and/or requirements**		

MEETING ON 17 SEPTEMBER 2026				
Agenda Item Number	**Action Agreed**	**Lead**	**Timescale/ Deadline**	**Status**
	NONE TO NOTE			

ACTIONS CLOSED AT MEETING ON 17 SEPTEMBER 2026				
MEETING ON 23 JULY 2027				
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 Action Closed**

Actions closed prior to 21 September are recorded separately

Agenda item:	2026-27 (6)
Title of report:	Interim Chief Executive's Report
Meeting:	Trust Board
Date:	19 November 2026

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

Purpose of the report:		
This report provides: An update to the Board on the Trust's activities since the last meeting and draws the Board's attention to any issues of significance or interest 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 Updates

Previously considered by:	Not applicable
Outcome of previous discussion/s:	Not applicable

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	✓

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: Equity and inclusion for patients and staff are key drivers for the Full Business Case and Patient Benefits Case, and have been fundamental to the creation of LPFT.	Workforce: (As previous)

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

List of Appendices:	None

Interim Chief Executive's Report

1 Executive Summary

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

2 Our Services and Our People

0-19 Service Update

We can confirm that the preferred bidder for the Leeds service has formally withdrawn from the procurement process. There were no other bidders apart from Leeds Community Healthcare NHS Trust.

Leeds City Council have formally notified us of this and we are awaiting next steps on how they wish to proceed. They have indicated they will await the outcome from the appeal we submitted to the Independent Patient Choice Panel as that will provide feedback on the original procurement process carried out.

Our preferred approach now is to work in partnership with Public Health colleagues to develop and agree the model for the next five years and continue to work positively together, building on the great progress the service has already been making.

The Executive Director of Operations has updated the staff within the 0-19 service and will continue to do so.

➢ 3 Progress on the creation of Leeds Partnership NHS Foundation Trust

Since the last public Board meeting, the plans for integration of the two Trusts have continued at pace, with support from NHS England. Key highlights include:

- NHS England checkpoint review was positive and support confirmed, with submission of the full business case by December 2026 and completion of the transaction achievable for 1 April 2027.
- Full business case, patient benefit cases and post transaction implementation plan have been submitted to both Boards for approval at Extraordinary Board meetings.
- Appointments have been made for the new Trust Board for Leeds Partnership NHS Foundation Trust and planning is underway to operate in shadow form in the last quarter of this financial year.
- The quality governance framework for the new Trust is being developed with support from Quality Matters Consultancy and will also incorporate the findings from the recent CQC inspection of Leeds and York Partnership NHS Foundation Trust.
- Finalising the first set of Key Performance Indicators (KPIs) for the new Trust integrated performance reporting.
- The development of the new vision and ambitions for the Trust is ongoing and will be subject to further engagement, including with external stakeholders over the next two months.
- The development of new values for the Trust has been progressing very well, utilising a 100 Voices engagement methodology. Further engagement with service users is planned so we can be clear in our commitment as to what the values mean for colleagues and for patients'/service users and carers. This will then inform the next phase of development of the framework for our leaders and managers to role model and lead on implementation.
- The Chair and I have meetings scheduled in the coming months with local MPs and the Mayor for West Yorkshire to brief them on our plans

- The next Board to Board in November 2026 will focus on the critical path to day one, post transaction planning and risk management.

4 System Update

National Update

The Secretary of State for Health and Social Care, Yvette Cooper, confirmed that NHS England will still be brought back into the Department of Health and Social Care (DHSC) on **1 April 2027**, subject to legislation passing Parliament. However, she has modified the delivery model to place greater emphasis on **devolution, local autonomy, social care integration and regional delivery**.

The key changes are:

- **Creation of an "NHS Group" inside DHSC**

  This NHS Group will:

  - Lead NHS operational delivery
  - Retain the role of NHS Chief Executive
  - Take on most of NHS England's national functions
  - Bring policy and operational teams together in one structure

  For NHS organisations, this means policy-making and operational performance management are expected to sit much closer together than they do now.

- **Regional NHS England teams will NOT move into DHSC**

  This is the biggest departure from earlier expectations. The seven regional NHS teams will instead sit within a **temporary Special Health Authority**, rather than becoming civil servants in DHSC. This is intended to keep regional teams close to the frontline and support a future devolved model. For trusts and Integrated Care Boards (ICBs), regional relationships will therefore remain more familiar than many had expected.

- **Greater emphasis on devolution**

  The Secretary of State has signalled that the future NHS should push power outwards, with the national centre:

  - Setting strategy
  - Defining minimum standards

- Holding organisations accountable
- Intervening where performance is poor

Rather than directing everything centrally, the model is intended to give local systems more flexibility in how they deliver outcomes.

- **Closer integration with social care**
  A recurring theme in the Secretary of State's statement was that NHS reform cannot be separated from social care reform. She linked the abolition of NHS England directly to ambitions around:
  - Community-based care
  - Prevention
  - NHS/social care integration
  - Future development of a national care service

- **New clinical and patient voice structures**
  - Establish the first **Clinical Council** to advise ministers on NHS clinical priorities
  - Appoint a **Patient Experience Director**
  - Retain and strengthen **Healthwatch**

➢ **West Yorkshire ICB and Partner Updates**

- A permanent Executive Director of Finance has been appointed by the West Yorkshire Integrated Care Board, Mike Woodhead, who is currently the Director of Finance at Bradford District Care NHS Foundation Trust.
- Brendan Brown has now been appointed permanently to the Chief Executive Officer (CEO) position at Leeds Teaching Hospitals NHS Trust (LTHT).
- Therese Patten has gone on secondment for 12 months from Bradford District Care NHS Foundation Trust (BDCFT) to North Lincolnshire and Goole NHS Foundation Trust as Interim CEO. Phil Hubbard is acting up as the CEO at BDCFT during this period.
- The Leeds Director of Integration has now been appointed - James Goodyear started in post in mid-November and is well known to Leeds

having worked as Director of Strategy at LTHT until 2023. Since that time he was Interim CEO of NHS Orkney.

- Interviews are now scheduled for the new Director for Adult and Health Services in Leeds City Council following the news that Caroline Baria is retiring in 2027.

5 Recommendations

The Board is recommended to:

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

Dr Sara Munro
Interim Chief Executive
11 November 2026

Agenda item:	2026-27 (7i)
Title of report:	Wildly Important Goals - Mid Year Update
Meeting:	Trust Board Held In Public
Date:	19 November 2026

Presented by:	Emma Tiernan, Associate Director of Business, Change and Development
Prepared by:	Andrea Osbourne, Executive Director of Finance & Resources

Purpose of the report:		
This report provides a mid-year update on progress against the Trust's 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.	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:
Neighbourhood Health - LCH continue to be at the heart of developing our Neighbourhood Health Model in Leeds underpinned by the alignment of LCH services and leadership teams more closely to neighbourhood footprints. **NOF update** - LCH has held in Segment 3 for Q1 of 26/27, with an overall metric score of 2.52 and a position of 43 out of 58 other non-acute trusts. **Q&V Programme** - As at August 2026, LCH is forecasting recurrent delivery of £8.1m against a planned target of £8.6m. There remains a high degree of

confidence to achieving the target in full as remaining plans continue to be developed.

Trust Integration Programme - Overarching programme plan in place and being implemented. Full Business Case, Post Implementation Transition Plan, Patient Benefit Cases all drafted and being refined. Governance reviewed and Transition Programme Board now in place and embedding. Programme is currently on track

Previously considered by:	People and Culture Committee, 7th October 2026 Business Committee, 20th October 2026 Quality Committee, 10th November 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

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: Our WIGs are designed to underpin our commitment to reduce health inequalities and increase inclusion. Any changes that are made to services as a result of the Quality and Value Programme are subject to an EQIA	Workforce: Human Factors metrics monitored throughout the Quality and Value Programme. Any changes that are made to services as a result of the Quality and Value Programme are subject to an EQIA

Recommendation(s)	Board is recommended to note the progress made to date.

List of Appendices:	None



Wildly Important Goals - Mid Year Update

Board

November 2026

Leeds Community Healthcare's Wildly Important Goals 2026/27

1 **Support rollout of the Neighbourhood Health Model across the Leeds system** including active participation in the National Neighbourhood Health Implementation Programme.



2 **Drive improvements in our National Oversight Framework position** through staff engagement, reducing waiting lists, minimising sickness absence, and boosting productivity.



3 **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.



4 **Oversee and implement the integration of LYPFT and LCH** to improve patient care delivery and optimise resources.



Senior Responsible Officers:
Sam Prince, Heather McClelland

Example projects:
- LCH involvement in the national neighbourhood health implementation.
- Leeds Provider Partnership development.
- Implementation of service transformations through the catalysts funding – including Active Recovery, Diabetes, Stroke.
- Services realigned to neighbourhoods.

What we expect to achieve:
- More joined up, seamless care for service users.
- A Joint Committee for Leeds that enables pooled budgets for more 'left shift' investment into community based care.
- The establishment of neighbourhood health hubs.

Senior Responsible Officers:
Sam Prince, Jenny Allen

Example projects:
- Access LCH – to improve experience for people waiting for our services.
- Productivity LCH – to embed a culture of improved productivity.
- Staff engagement and sickness improvement projects.

What we expect to achieve:
- Sickness better understood and managed to improve sickness absence rates.
- Improved staff survey results.
- NOF segmentation improved.

Senior Responsible Officers:
Andrea Osborne, Ruth Burnett

Example projects:
- Service redesigns.
- New service and leadership structure in place.
- Admin redesign consulted on and implemented.
- Information hub and digital letters fully rolled out.
- Tendered services mobilised or demobilised.

What we expect to achieve:
- Financial balance.
- Services transformed to be efficient and effective whilst mitigating any compromise of quality, safety, equity and effectiveness.

Senior Responsible Officers:
Sara Munro

Example projects:
The 7 workstreams that make up the Trust Integration programme:
- CEO Office and Corporate Governance (including Communications).
- Clinical and Quality.
- Digital Integration.
- Estates and Facilities.
- Finance and Contracting.
- Operations.
- People and Culture.

What we expect to achieve:
- New organisation, with new name and branding in place by 1 April 2027.
- New Board, committee structure, and exec team in place.
- Coproduced vision, values, and behaviours as the foundation of a new culture.
- Understanding of the service user and financial benefits and the next steps for achieving these.

Our Wildly Important Goals (WIGs) are the crucial high priority objectives that are the main focus for the organisation as part of our Medium Term Plan agreed with NHS England. Within each of the WIGs are a number of projects that contribute to the successful achievement and delivery of that WIG. This infographic helps outline the scope of each of our WIGs.

Wildly Important Goals 2026/27 - mid year progress update

At the halfway point of 2026/27, all four Wildly Important Goals are progressing well. Significant improvements have been achieved in neighbourhood health delivery, waiting list performance, service transformation and trust integration, with the majority of planned milestones on track and tangible benefits already being realised for patients and communities.

1 Neighbourhood Health

LCH at the heart of developing our Neighbourhood Health Model in Leeds.



Key achievements:

- Supporting **3,000 people** through proactive neighbourhood care, with ambition to reach **10,000** by year end.
- New **Community Care Beds** service delivery partnership consisting of LCH, Leeds City Council and Leeds GP Confed commenced on 1st July 2026.
- Additional community growth investment received to enhance models of care within Diabetes, Stroke, and Active Recovery. Mobilisation has started.
- New neighbourhood clinics referral process improving patient flow and access to care.

2 National Oversight Framework

Sustained improvements in access, productivity and performance.



Key achievements:

- LCH has held in Segment 3 for Q1 of 26/27, with an overall metric score of 2.52 and a position of 43 out of 58 other non-acute trusts.
- Waiting list performance continues to improve, with **82.2% of patients seen within 18 weeks**.
- Waiting list performance has remained above the 78% target throughout the year.
- Productivity dashboard has also been developed to help services better understand and respond to their relative costs and productivity metrics.

3 Quality and Value programme

Delivering transformation and sustainable improvement.



Key achievements:

- Forecasting delivery of **£8.1m recurrent savings**, equivalent to **94% of planned target of £8.6m**.
- 53% increase in CIVAS contacts following service redesign.
- Significant reductions in therapy waiting times, including a 37% reduction for routine physiotherapy patients and a 62% reduction for high-priority physiotherapy patients.
- Improved equity of access and reduced waiting lists across neighbourhood therapy services.

4 Trust Integration Programme

Integration programme on track for successful delivery.



Key achievements:

- Governance arrangements established, including Transition Programme Board.
- Procurement teams fully integrated and contract rationalisation underway.
- Chair designate appointed.
- More than **2,000 stakeholders** helped select the future organisation name: Leeds Partnership NHS Foundation Trust.
- More than **1,700 staff** engaged in shaping the future culture, vision and values.
- Process to get integration signed off with NHS England progressing well – this includes a full business case with financial modelling and patient benefit case studies.

1 Support rollout of the Neighbourhood Health Model across the Leeds system including active participation in the National Neighbourhood Health Implementation Programme.

1.1 Support rollout of Neighbourhood Health model across the Leeds System

LCH have been at the heart of developing our Neighbourhood Health Model in Leeds

Some highlights include:

- Working with all Primary Care Networks and Local Care Partnerships to deliver neighbourhood proactive care – currently supporting ~3000 people with an ambition to reach 10000 people by the end of the year

- Strengthening multidisciplinary working to support people living with frailty and long term conditions.
  - In October we are launching our 100-day challenge using a Test Learn Grow approach, working in collaboration to explore how we better support people most at risk of needing high cost, high intensity services.
  - In October we are testing a new multidisciplinary hub approach in collaboration with LTHT and primary care
  - Later in Q3 we will be launching a layered model for diabetes care in Inner South area which will develop the approach ahead of citywide rollout in 2027/28

- Aligned LCH services and leadership more closely to neighbourhood footprints and developing service models,

1 Support rollout of the Neighbourhood Health Model across the Leeds system including active participation in the National Neighbourhood Health Implementation Programme.

1.1 Support rollout of Neighbourhood Health model across the Leeds System

LCH have been at the heart of developing our Neighbourhood Health Model in Leeds

Further highlights include:

- Developing a business case for further investment in Active Recovery, our joint short-term home-based rehabilitation offer delivered in partnership with Leeds City Council. £1m investment being mobilised in 2026/27 to support additional 10 people/week and reduce bottlenecks
- Working with LTHT to deliver further investment and improvements in our integrated Stroke Transition to Home with launch planned for November 2026 to support an additional 5 people/week continue their recovery at home
- Working with partners to deliver a single joint citywide template for ReSPECT (Recommended Summary Plan for Emergency Care and Treatment). This will enable us to work together to support people and families particularly around palliative and end of life care and support needs.

- Leeds is part of the National Neighbourhood Health Implementation Programme (NNHIP), along with Bradford and Wakefield. This is supporting us to develop our practice in this area. The programme comes to an end in November 2026, but the work on Neighbourhood Health development will continue to be at the heart of our partnership approach in Leeds.

1.2 Business Units

Community Care Beds

- New contract and service delivery partnership consisting of LCH, Leeds City Council and Leeds GP Confed commenced on 1st July 2026.

Community Health & Wellbeing Pilot

- Pilot ended in March 2026
- Market Sounding exercise in progress for a limited trial whereby a Treatment of disease, disorder or injury (TDDI) provider will administer insulin for a specific cohort of patients.

Neighbourhood Clinics

- New referral process launched on 1st September has been positively received.
- Improves patient flow, reduces inappropriate appointments, eases the burden on referrers, and enhances data collection—helping to target resources where they're most needed and better understand demand.

Diabetes Neighbourhood Health Programme – Test Phase

- Business case approved for (LCH) to host system development of a tiered, integrated approach to diabetes care, testing this in Middleton & Hunslet and Beeston PCN areas; Programme Manager in post and mobilisation including recruitment is live.
- Creating the blueprint for a scalable Multi Neighbourhood Model.

Stroke Transition to Home

- PMO recruited/established; Successful recruitment to workforce model with significant number in post by end Sept. Await arrival of consultant therapist in November. Soft launch by end October in planning, subject to governance approvals.
- Improves care for people who may have an extended stay in hospital, enabling eligible stroke patients to leave hospital earlier, and receive intensive, specialist stroke rehabilitation at home thereby releasing acute capacity.

2. NOF

2 Drive improvements in our National Oversight Framework position through staff engagement, reducing waiting lists, minimising sickness absence, and boosting productivity.



Overall Progress

- LCH has held in Segment 3 for Q1 of 26/27, with an overall metric score of 2.52 and a position of 43 out of 58 other non-acute trusts.

Domain	Sub Domain	Measure	Score	Segment
Access to services	Elective care	% of cases waiting over 52 weeks for community care	2.9	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	3	3
		% 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	2.6	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	4.0	4
People	People and Culture	Sickness absence rate	3.9	4
		NHS staff survey engagement theme score	2.9	3
		National Education and Training Survey satisfaction rate	1.7	2
		NHS staff standards score	1.3	2
		Healthcare Worker Flu Vaccination Rate	1.9	2
	Workforce	Temporary staffing cost relative band	1	1

2. NOF

Access to Services – Waiting Lists

Performance continues to improve across services. Paediatric Neurodisability (PND) is now the only service contributing 52+ week waits to the Trust's NOF metric, with all remaining 52+ week waits expected to be cleared by the end of November 2026. Performance against the 18-week standard has remained above target throughout the year, with 83.7% of patients seen within 18 weeks at the end of September.

Finance, Productivity and Innovation

The work of the Productivity LCH Steering Group is now embedding well and is bringing attention to service performance in this area. A productivity dashboard has also been developed to help services better understand and respond to their relative costs and productivity metrics.

Sickness and Staff Engagement

The current score is based on the Quarter 4 sickness position due to reporting lags. Improving sickness absence remains a Trust priority, with robust monitoring and targeted improvement activity in place. Staff engagement performance will be updated following publication of the next NHS Staff Survey results.

3 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.



Year 3

3. Quality and Value Programme

Overall programme update

As at August 2026, the Trust is forecasting recurrent delivery of £8.1m against a planned target of £8.6m. There remains a high degree of confidence to achieving the target in full as remaining plans continue to be developed.

Service redesigns

- This year the service redesigns include:
  - ABU (Neighbourhood Team Core Offer, Proactive Care Community Matrons, Pharmacy Technicians, Palliative Care, Self Management)
  - CBU (CYPMHS, Fair Days Work across the whole Business Unit)
  - SBU (LemuRs, Leeds Community Pain Service, Dietetics, HHIT, Community Gynae, TB and legacy work from year 2 (LMWS, Podiatry, Cardiac, Respiratory, Diabetes, CNRS, MSK, SLT, TVS))

3 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.



Year 3

3. Quality and Value Programme

Notable Achievements

- A 53% increase in contacts within the CIVAS service following changes to operating hours.
- Significant reductions in therapy waiting times, including a 37% reduction for routine physiotherapy patients and a 62% reduction for high-priority physiotherapy patients.
- Improved equity of access and reduced waiting lists across neighbourhood therapy services.
- Increased clinical capacity through the cessation of low-value or duplicate activities, including oxygen review clinics, elective PCI assessments and face-to-face oximeter clinics.
- Improved targeting of palliative and end-of-life services towards patients with the greatest clinical need.

3. Quality and Value Programme

Corporate and admin redesigns (includes Ops Management)

- Corporate redesigns for year 2 include Procurement, QPD, Admin and Business Unit Leadership Redesign.
- Procurement & Leadership CIPs fully identified; Corporate Services gap stemming from QPD is being addressed through non-recurrent savings with future recurrent plans in development.
- Admin Redesign model costed and on track to deliver CIP.

Estates

- Good progress made (£290k achieved through avoidance of the cost of inflation) with remaining CIP in the process of being fully identified.

3 Quality and Value Programme

Business Development

Short-Term Community Beds:

The new service, a partnership between LCH, LCC and Leeds GP Confed, went live on 1st July 2026. Phase 2 post go live mobilisation is being managed through the Beds Leadership meeting attended by senior representatives from each partner organisation.

LMWS Talking Therapies & PCMH:

Talking Therapies & PCMH - LMWS Partnership, with LCH as lead, were successful in retaining both service elements. New contract commences 1/11/26.

Police Custody:

Current contracts expire 25th September 2026 (West Yorkshire) and 25th January 2027 (South Yorkshire and Hull & Humber). Demobilisation is underway to the new providers: Mitie for West Yorkshire and PHL for South Yorkshire and Hull & Humber.

4 Oversee and implement the integration of LYPFT and LCH to improve patient care delivery and optimise resources.



4. Trust Integration Programme

Programme update

- Overarching programme plan, full risk register, critical path with interdependencies in place and implementing
- Full Business Case, Post Implementation Transition Plan, Patient Benefit Cases drafted and being refined
- Governance reviewed and Transition Programme Board now in place and embedding
- Majority of tasks expected to be completed by this point in time have been completed and programme is currently on track

Finance, contracting and procurement

- LCH and LYPFT procurement teams fully integrated
- All contracts catalogued and being sense checked for efficiency opportunities and rationalisation – additional resource provided for this work
- One ledger to be in place for day one and Shared Business Services are supporting with the project plan for this

Digital systems

- Plans in place for day one arrangements. Mapping of all digital systems reaching conclusion
- Creation of a single risk management system (Datix) underway with additional resource provided to support

Due diligence

- Internal and external legal due diligence complete with all risks recorded and understood by leads and being mitigated through the programme plan. There are no risks of a material enough nature to delay the integration.

4 Oversee and implement the integration of LYPFT and LCH to improve patient care delivery and optimise resources.



4. Trust Integration Programme

Legal and regulatory

- Chair designate appointed, non exec director appointments underway – shadow Board to be in place by January 2027
- Exec structure consulted on and due to conclude towards end of year
- Statutory roles mapped and will be in place for day 1
- Board and committee structure drafted and terms of reference in development

Organisation name

- 2000 stakeholders took part in engagement – Leeds Partnership NHS Foundation Trust selected as preferred name

Organisational culture

- Co-create appointed as partner to lead multiyear cultural work
- Over 1700 staff engaged in diagnostic work - new vision, values, and leadership behaviours being developed using this feedback
- Organisational strategy also in development
- 100 voices staff engagement group established

Policies and procedures

- All policies and procedures catalogued and allocated to a workstream to review
- Priority policies for day 1 identified and will be reviewed by end of 2026

4 Oversee and implement the integration of LYPFT and LCH to improve patient care delivery and optimise resources.



4. Trust Integration Programme

Reporting and oversight

- Integrated performance report being prioritised for day 1
- KPI list for new organisation in development

Patient Benefit Transformation

- 3 x benefit cases have been developed with staff (CYPMHS, PCMH, Neighbourhood Health) and transformation work around these starting to mobilise
- Wider service integration opportunities being scoped

Corporate integrations

- Working group established to manage a consistent approach to corporate integrations
- Savings targets have been drafted as part of Full Business Case
- A schedule of corporate integration projects has been drafted for 2027/28
- Workforce data has been mapped and sense checked by workforce and finance subject matter experts

Clinical and Quality

- External partner appointed to support with review of clinical governance and effectiveness systems and processes
- Workstream fully established with 9 supporting subgroups

4 Oversee and implement the integration of LYPFT and LCH to improve patient care delivery and optimise resources.



4. Trust Integration Programme

Communications

- Staff communications mechanisms well embedded – monthly briefings, CEO-led events, FAQs, intranet site
- Joint AGM completed
- Plans for day one have been developed for intranet and website

Estates and Facilities

- Legal due diligence issues identified are being well managed
- External estates contract within LCH to be extended to 31st March 2027, after which the function will move to LPFT and affected staff will TUPE

Operations

- Joint EPRR and on call arrangements are well underway, with joint posts appointed to team
- New operating model will be to operate within the neighborhood geographic footprint agreed for Leeds, with LCH being an early adopter through the leadership review that is about to complete

People and Culture

- Significant additional resource provided to support the TUPE of 3000+ LCH staff to the new organisation
- Options for a single workforce system are being explored, being mindful that national constraints will hinder an integrated option for day 1
- Compulsory (stat/mand) training requirements mapped and understood for the new organisation

Committee Escalation and Assurance Report

Name of Committee:	Quality Committee	**Report to:**	Trust Board 19 November 2026
Date of Meeting:	10 November 2026	**Date of next meeting:**	12 January 2027

Introduction

The meeting was quorate. All items were discussed within the allocated timeframe, with constructive and healthy discussion throughout. A Service Spotlight on 'Redesign of ICAN Nurse Led Daytime Wetting Pathway - Behavioural Approach' was presented.

Alert	Action
• QC Workshop feedback – Committee noted feedback on SEND and Quality Metrics. Discussed the need for appropriate strategic oversight of children's services, particularly in the context of the Trust integration.	• Noted that a paper on children's services and SEND assurance arrangements would be presented to the Board.

Advise

- Current system pressures - Acute trusts were experiencing high numbers of people with no reason to reside, and pressures were expected to increase through November and early December. The ICB had withdrawn seven-day continuing healthcare cover. No significant delays in access to the LCH's own care. Delays were primarily associated with social care assessments and community provision, including patients in rehabilitation beds who were waiting for the relevant pathway.
- Quality Live Issues – The committee discussed the recent Adult Social Care CQC inspections at the South and Northwest Recovery Hubs and Adel Beck. Some common themes identified regarding the day-to-day management of patients, awaiting formal reports. Further information to be brought to the January meeting.
- Essential Clinical Skills - A gap was identified in central reporting of essential clinical skills, because records remain at service level while the future learning management system and ESR integration were still being developed. It was agreed to confirm that it would be recorded appropriately on the risk register and to consider whether interim controls were required while the integrated process was developed.
- Trust Integration Programme – It was reported that some actions cannot progress until milestones such as agreement of the new vision and values are complete. The committee agreed that its role remains oversight of the current organisation and that issues raised locally must be carried into the Transition Board without duplicating its work.
- Integrated Performance Report - The committee raised concerns about inconsistent data quality, unclear statistical presentation and limited ability to triangulate the integrated performance report. Members were asked to send specific examples of questionable or unclear data to the Interim Director of

Committee Escalation and Assurance Report

Nursing, AHP & Quality. These will be taken back to the relevant data leads before the February workshop, where the committee requested an explanation of data sources, controls and the basis for assurance.

- Quality & Value Report - The report outlined progress on quality, value and equality impact assessment programmes, while the committee requested stronger evidence that redesigns protected clinical complexity, included all patient groups, demonstrated outcomes and were not driven solely by cost reduction. It was agreed that future reporting would include concise updates supported by one or two case studies, including outcome evidence and examples of how challenges were identified and addressed.
- Leeds Short-Term Community Beds Partnership – Noted the partial assurance. It was identified that unclear accountability between the organisation and Leeds City Council had contributed to operational and assurance risks, requiring stronger governance arrangements and clearer responsibilities for frontline teams. It was agreed that learning from the review of partnership arrangements, governance processes and CQC findings would be incorporated into ongoing improvement plans and monitored through existing governance arrangements.
- Clinical Audit Programme - The Committee noted that overall audit compliance remained low at this stage of the year, consistent with previous years, but acknowledged the additional pressures associated with organisational change and the forthcoming merger. It was agreed to maintain focus on the completion of mandatory and priority clinical audits, with progress and compliance continuing to be monitored through existing governance and performance oversight arrangements.

Assurance

- Spotlight - Sharon Underwood and Angelina Bolton described the ICAN service redesign that replaced a delayed nurse-led daytime wetting pathway with a graduated support model, reducing a 129-child waiting list to under four weeks and increasing access to workshops and targeted one-to-one support. It was agreed that future reporting on the pathway should include outcome measures demonstrating the impact of the intervention on children and young people, alongside activity and access measures.
- Quality Strategy - The committee considered the paper more of an action-oriented quality plan than an ambitious strategy describing the intended future quality of services. Committee noted the importance of ensuring that transition arrangements maintain effective reporting, governance and oversight of patient care throughout the integration process.
- Wildly Important Goals – Mid Year update was noted on the progress against the Trust's 2026-27 Wildly Important Goals.
- NICE Guidance Compliance Update – It was noted that NG197 remained the only guideline outside the required timescale. It was agreed to continue work to evidence compliance with NG197 through existing training, governance and audit arrangements, aligned with the approach adopted by partner organisations.
- Learning from Deaths – Q2 Report – The Committee welcomed the progress made but discussed the need to strengthen the evidence of organisational learning arising from mortality reviews. It was noted that recurring learning themes continued to be identified and sought assurance that actions arising from reviews were leading to measurable improvements in practice and outcomes.

Committee Escalation and Assurance Report

- Managing Complexity - Members were assured that existing risk assessment processes remained in place and that staff continued to receive support in managing complex situations. It was agreed that the remaining work would be progressed as part of the policy development programme for the new organisation.
- Internal Audit Final Report - Equity & Quality Impact Assessment – Committee noted the report and the actions agreed and were satisfied that Phase 2 of the Audit was now underway.
- QAIG AAA – Noted the alerts from the August, September and October reports. It was advised to ensure future QAIG reporting clearly describes actions and mitigations in response to identified risks and trends, rather than reporting ongoing monitoring alone.
- Safeguarding AAA – Noted two alerts related to: Designated and Named Doctor role & SUDIC Doctor Cover (on the risk register) and IHNAs.
- IPC AAA – Noted two alerts and action taken.

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 scored 15 and 58 risks score 8-12 (high). Patient harm was the most common risk theme. It was agreed that the proposed risk escalation and reporting thresholds for the new organisation would be reviewed and reported back to the Committee.

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

The Committee provides the following levels of assurance to the Board on these strategic risks:	**Risk score (current)**	**Overall level of assurance provided that the strategic risk is being managed (or not)**	**Additional comments** **See above comments in report**
Risk 1 Failure to deliver high-quality, equitable care and continuous improvement: If the Trust fails to identify, deliver, and sustain high-quality care, promote learning, and drive continuous improvement in an equitable manner, there is an increased risk of unsafe or ineffective services. This may lead to preventable harm, poor patient outcomes, and a diminished patient experience.	16 (extreme)	Limited	The governance arrangements associated with the Leeds short-term Community Beds Partnership provided only partial assurance.
Risk 2 Failure to respond to increasing demand for services: If the Trust fails to respond to population growth and	12 (high)	Reasonable	

Committee Escalation and Assurance Report

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.			
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	Acknowledged continued work to strengthen equality, diversity and inclusion arrangements and the implementation of actions arising from the EQIA audit.

Author:	Rakhi Palliyath/Alison Lowe
Role:	Corporate Governance Officer/Committee Chair
Date:	10 November 2026

Agenda item:	2026-27 (9)
Title of report:	Thirlwall Report
Meeting:	Trust Board Meeting Held In Public
Date:	19 November 2026

Presented by:	Sheila Sorby, Deputy Director of Nursing and Quality, LCH
Prepared by:	Dr Ruth Burnett, Executive Medical Director Sheila Sorby, Deputy Director of Nursing and Quality, LCH Marie-Clare Trevett, Deputy Director for Allied Health Professions and Social Workers, LYPFT

Purpose of the report:		
The purpose of this report is to provide the Trust Boards (LCH and LYPFT) with an overview of the key findings of the Thirlwall Inquiry, assess the relevance of the recommendations to the Trusts, and provide assurance that appropriate systems and processes are in place to support patient safety, effective escalation of concerns, safeguarding, openness and organisational learning. The report seeks endorsement from the Boards of a proportionate review of Trust arrangements against the Inquiry's recommendations.	Approval	
	Discussion	X
	Assurance	X

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

Summary of Key Issues:

- The Thirlwall Inquiry identified significant failings in culture, leadership, safeguarding, governance and the management of concerns, with learning applicable across all NHS organisations.
- Both Trusts have established arrangements to support patient safety, safeguarding, Freedom to Speak Up, Duty of Candour and organisational learning, providing reasonable assurance that concerns can be raised and acted upon appropriately.
- Safeguarding has been identified as a key area for ongoing focus, particularly in relation to training, escalation pathways and preparedness for emerging national guidance.

- Opportunities have been identified to further strengthen governance, mortality oversight, leadership development and assurance regarding delivery of improvement actions, building on work already underway across both organisations.
- No concerns have been identified that mirror the circumstances of the Inquiry; however, a proportionate gap analysis is recommended to provide additional assurance, identify opportunities for improvement and ensure alignment with national expectations.

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)?	Patient care: Although this report focuses on the applicability of national recommendations rather than a specific equality analysis, health equity considerations are incorporated through existing mortality surveillance and mortality review arrangements. Available equality and demographic data are reviewed to identify potential variations in outcomes between patient groups, enabling any areas of inequity to be recognised, explored, and addressed through established governance processes.	Workforce: N/A

Recommendation(s)	The Board is recommended to: 1. Note the findings and recommendations arising from the Thirlwall Inquiry 2. Approve the completion of a gap analysis for both Trusts against the key themes and relevant recommendations of the Inquiry, including patient safety, safeguarding, Freedom to Speak Up, Duty of Candour, organisational culture and governance. 3. Support the development of an action plan to address any areas for improvement identified through the review, with clear executive ownership and delivery timescales, incorporating the Trust integration.

	4. Agree that progress against the action plan and implementation of learning is monitored through the Quality Committee, with periodic updates provided to the Board.

List of Appendices:	Appendix 1: Matrix of recommendations and required actions

Thirlwall report: Implications for LCH and LYPFT

1 Executive Summary

This report has been prepared to provide the Boards of Leeds Community Healthcare NHS Trust (LCH) and Leeds and York Partnership NHS Foundation Trust (LYPFT) with an overview of the findings of the Thirlwall Inquiry, consider the relevance of its recommendations to both organisations, and provide assurance regarding patient safety, safeguarding, governance, organisational culture and the effective escalation of concerns. The report also seeks Board endorsement for a proportionate review of Trust arrangements against the Inquiry's recommendations.

Although neither Trust provides neonatal inpatient services, the Inquiry's findings have significant relevance to all services. The Inquiry identified serious failings in organisational culture, leadership, safeguarding, governance and responsiveness to concerns, highlighting the risks associated with prioritising organisational reputation over patient safety and the consequences of failing to act on concerns raised by staff and families.

NHS England requires all Trust and ICB Boards to review the Inquiry findings at the next available public Board meeting and consider whether similar circumstances could occur within their own organisations, seeking assurance regarding the effectiveness of safeguarding, governance and speaking-up arrangements.

On reviewing the report against the current arrangements in both organisations it was found that both organisations have well-established arrangements to support patient safety and speaking up, including effective Freedom to Speak Up processes, positive reporting cultures, safeguarding governance structures and mechanisms for monitoring and learning from incidents, complaints and reviews. Staff survey results demonstrate that staff generally feel able to raise concerns.

The report identifies safeguarding as a key area of focus, reflecting the Inquiry's emphasis on safeguarding as a core patient safety function. Existing arrangements provide a strong foundation, including safeguarding policies, joint HR processes and specialist safeguarding involvement. However, further work is required to review training, strengthen awareness of escalation pathways and prepare for the implementation of forthcoming national guidance relating to deliberate harm by healthcare professionals.

Recent governance reviews and regulatory inspections across both Trusts have highlighted opportunities to strengthen quality governance and organisational assurance. While both Trusts have strong governance structures and established processes for monitoring improvement actions, further development is required to ensure consistent implementation, effective oversight and assurance that improvement actions deliver measurable and sustainable outcomes. A programme

of work is underway to strengthen action planning, governance arrangements and assurance processes across both organisations as part of the transition to Leeds Partnership NHS Foundation Trust (LPFT).

Overall, the report concludes that both Trusts can take reasonable assurance that effective arrangements are in place to support patient safety, safeguarding, Duty of Candour and Freedom to Speak Up. However, additional work is required to strengthen governance frameworks, safeguarding training, mortality oversight, leadership development and the monitoring of improvement actions.

Whilst the Trusts have not identified any concerns that mirror those considered by the Inquiry, there is value in undertaking a structured review of existing arrangements against the Inquiry's findings and emerging national guidance. Work is therefore underway to assess the strength of organisational safeguards relating to speaking up, workforce culture, safeguarding, incident escalation, clinical governance, patient safety, and Board assurance. This will enable the Trust to identify any opportunities for enhancement and ensure continued alignment with national expectations. Findings and any resulting actions will be incorporated into existing governance and assurance frameworks and reported to the Board through established mechanisms.

The Boards are therefore asked to approve a gap analysis against the Inquiry's recommendations and support the development and oversight of an action plan to address identified areas for improvement and ensure learning is embedded across the future organisation.

2.0 Summary of the Thirlwall Inquiry Report findings

The final version of the Thirlwall Inquiry Report, published on 15 September 2026, concluded that there had been a "complete failure" to protect babies on the neonatal unit at the Countess of Chester Hospital between 2015 and 2018 during the crimes of former nurse Lucy Letby.

Whilst community, mental health and learning disability Trusts do not generally provide neonatal inpatient services, the Inquiry identifies a number of fundamental themes that are relevant across all healthcare settings. These include organisational culture, safeguarding, leadership, governance, professional curiosity, incident escalation, freedom to speak up, and the quality of Board assurance. Consequently, the recommendations and learning arising from the Inquiry have been reviewed in the context of both Trusts.

The Inquiry found that concerns raised by clinicians were not acted upon with sufficient urgency, resulting in significant delays in recognising and responding to emerging patient safety risks. It highlighted a culture in which organisational reputation and external perception were, at times, prioritised over the effective investigation and escalation of concerns. The findings also underscored the risks associated with staff lacking confidence that concerns will be heard, appropriately scrutinised and acted upon, and the detrimental impact this can have on organisational transparency, learning and patient safety.

A further theme was the collective inability across the organisation to contemplate that deliberate harm could be occurring. This demonstrated the importance of fostering professional curiosity, constructive challenge and psychological safety, ensuring that staff at all levels feel empowered to question, escalate and challenge when concerns arise. The Inquiry also identified shortcomings in the use of

organisational intelligence, with warning signs from incidents, mortality data, complaints and other sources not being brought together to provide a comprehensive understanding of emerging risks.

The experiences of affected families highlighted the importance of openness, transparency and compassionate engagement when serious concerns arise. In parallel, the Inquiry identified significant weaknesses in governance, safeguarding and risk management processes, including failures to recognise when established escalation and investigative procedures should be applied. These findings reinforce the need for organisations to maintain robust mechanisms for identifying, triangulating and responding to intelligence from multiple sources, including patient safety events, complaints, safeguarding concerns, workforce indicators, Freedom to Speak Up activity and patient experience feedback.

Finally, the Inquiry highlighted a recurring national theme that recommendations arising from major reviews and inquiries are not always systematically monitored to ensure sustained implementation and impact. This presents an ongoing risk to healthcare organisations, as lessons identified may not consistently translate into lessons learned. Effective oversight, accountability and assurance processes therefore remain essential to ensure that improvement actions are implemented, embedded and regularly evaluated for effectiveness.

Collectively, the Inquiry serves as a reminder that the greatest risks to patients may arise not from the absence of governance structures, but from failures in organisational culture, leadership behaviours, escalation processes and the effective use of information to identify and respond to emerging concerns. The review undertaken by both Trusts has therefore considered not only the existence of relevant policies and frameworks, but also the extent to which these support a culture of openness, challenge, learning and patient-centred decision making.

➢ 3.0 Main body of the report

The Thirlwall Inquiry examined the circumstances surrounding serious and significant shortcomings in organisational culture, leadership, responsiveness to concerns, safeguarding processes and governance arrangements. NHS England emphasises that the failures represent both individual and systemic shortcomings.

These organisational lessons are highly relevant to both organisations, emphasising that a key component of providing safe and effective care is a culture where people can speak up and that appropriate action is taken to safeguard those in our care.

Neither Trust operates maternity or neonatal inpatient services and therefore the neonatal-specific operational requirements do not directly apply. However, it is important to note that babies are in the care of LYPFT in the Mother and Baby unit, and LCH provide a Sudden Unexpected Death in Infancy (SUDIC) provision for the city as well as paediatric services which are closely aligned to neonatal care.

3.1 Organisational Culture

The Inquiry highlights the importance of professional curiosity, psychological safety, effective challenge, escalation of concerns, listening to staff and families and acting promptly when risks are identified. A recurring theme of the Inquiry is the failure to act decisively on concerns raised by staff. The Board is asked to assure

themselves that staff feel empowered and supported to raise concerns without fear of detriment.

3.1.1 Freedom to speak up and staff survey

Both organisations have an established and effective freedom to speak up process, supported by whistleblowing processes. The freedom to speak up guardians are available to all staff and provide ongoing support to enable them to have their voice heard. They provide regular updates through governance processes, meeting with Executives / CEO and reporting to the Trust Board. A recent internal audit in LCH gave the Trust sufficient assurance in terms of the work of the guardian.

This is reflected in the latest staff survey results (table 1) which identifies that the majority of staff in both organisations feel able to speak out when they have concerns about unsafe clinical practice. It is to be noted this is higher than the national average. However, there is lower confidence about whether the organisation would address the concern, particularly in LYPFT. This would suggest that there needs to be greater emphasis on the actions taken or ensuring that feedback is given about the actions taken.

Table 1.

Staff Survey Question	LYPFT 2025 Score	LCH 2025 Score	2025 National Average
I would feel secure raising concerns about unsafe clinical practice.	73.46%	82.6%	71%
I am confident that my organisation would address my concern.	59.07%	70.0%	65%

Both organisations have a positive reporting culture, which was also reflected in the recent CQC inspection in LYPFT. This included taking the opportunity to learn from investigations. CQC findings did however identify that the visibility of the complaints process could be strengthened, and carers could be provided with more opportunities to provide feedback.

With the creation of Leeds Partnership Foundation Trust (LPFT) there is a clear commitment to continuing this culture of enquiry and safeguarding for our patients with a programme of cultural and engagement work including leadership development to enable that.

3.1.2 Leadership and Organisational development

The Inquiry reinforces the importance of visible and accountable leadership at all levels. Effective governance depends not only on clear processes but also on a culture in which professional challenge is welcomed and concerns are escalated without delay.

The Trust is committed to ensuring that leaders understand their responsibilities in relation to patient safety, duty of candour, safeguarding, and responding appropriately to concerns raised by colleagues, patients, families, and partners. Ongoing leadership development, organisational values work including in respect of the creation of a culture for LPFT, and governance oversight arrangements provide

a strong foundation for this, whilst recognising the need for continued vigilance and learning.

Both organisations are reviewing their leadership and management development offer against the NHS Leadership and Management Framework. LYPFT has completed a comprehensive mapping exercise, with a corresponding review currently underway within LCH following the recent leadership review process. This work is being progressed through the Trust Integration Programme's People and Culture Workstream to support a consistent, high-quality approach to leadership development, organisational culture and managerial capability across both Trusts. During 2027, this programme will support leaders and managers to understand, model and embed the new organisational Values and Behaviours, develop the capabilities required for the future organisation, and navigate organisational change and integration.

NHS England has also requested that trusts complete a leadership and management self-assessment to identify development needs and support managers in demonstrating competency against the Framework. Consideration is currently being given through the People and Culture Workstream as to whether this self-assessment will be undertaken during quarter 4 within existing organisations or aligned to implementation within the new organisation.

The Thirlwall Inquiry recommends amendments to the NHS Leadership and Management Code and Standards to strengthen and explicitly reflect the fundamental duty of all leaders and managers to prioritise patients, patient safety and quality of care. Once published, any revisions to the national framework will be reviewed and incorporated into the leadership and management development work outlined above, ensuring continued alignment with emerging national expectations and best practice.

3.1.3 Safeguarding

NHS England emphasises that safeguarding must be given appropriate prominence at Board level and that all staff and Board members must be compliant with safeguarding training requirements and understand escalation pathways. This should include how to identify individuals who are harming patients.

All service users and patients are vulnerable, due to the very nature of them being in receipt of care. However, for trusts delivering health visiting, school nursing, specialist children's services, community paediatrics, perinatal, children and young people’s mental health services and safeguarding services, this is particularly pertinent. One of the most significant aspects of the Thirlwall Inquiry is its recognition of safeguarding as a fundamental patient safety function rather than solely a response to abuse within families or communities. This reinforces the principle that safeguarding responsibilities extend to concerns regarding harm caused by professionals, healthcare environments and organisations themselves.

The findings align closely with established safeguarding principles and reinforce the importance of responding proportionately to allegations, concerns and patterns of risk involving healthcare professionals. The report identifies safeguarding as a critical patient safety function and emphasises that patient welfare must always take precedence over organisational reputation, professional hierarchies or concerns about challenging colleagues.

There are already several arrangements in place that support these principles, including:

- A Safeguarding Allegations Against Colleagues Policy. This is being reviewed as a priority for Day 1 of the new organisation, and with consideration of the Inquiry recommendations.
- Joint safeguarding and HR processes where concerns arise regarding individual conduct. Currently these are supported by the NHSE Being Fair tool.
- Allegation management training incorporated within management development programmes.
- Safeguarding specialist involvement in allegations against staff.
- Established governance structures for safeguarding and patient safety.

A review of the above is underway to ensure that the Inquiry recommendations are fully considered. This includes ensuring training for all staff on how to deal with concerns and suspicions about deliberate harm. It provides an opportunity to review awareness of escalation pathways, strengthen organisational learning and ensure that safeguarding, patient safety and workforce governance arrangements remain closely aligned. This will be appropriate to consider as part of a Board development plan.

3.3. Board Assurance, Governance and action planning

NHS England reminds organisations of the principles within the Insightful Provider Board Guide and emphasises the role of Boards in ensuring governance systems identify, escalate and respond appropriately to risk. It recommends that Trusts should consider whether current committee structures, quality reporting and risk management arrangements provide sufficient insight into emerging safety concerns. Importantly, the Inquiry highlights that assurance must extend beyond the completion of actions to understanding whether those actions have delivered the intended improvement and reduced risk.

3.3.1 Governance processes

The recent CQC inspection of LYPFT identified that governance systems in place did not always ensure high-quality service delivery and oversight. In response LYPFT and LCH commissioned Quality Matters consultancy to design and support the new quality governance arrangements for the integrated Trust. Phase one has been completed which consisted of a diagnostic and baseline assessment of governance arrangements. This scoping identified that LYPFT has strong governance structures, but the implementation is inconsistent and assurance processes are not yet sufficiently reliable. In addition, LCH had good reporting arrangements and local processes, but there is no clear organisation wide framework. These areas for improvement have informed the development of a new quality governance framework for LPFT with the fundamental purpose to support the identification of concerns and risk and drive improvements. In addition, the intention is to have quality and safety metrics for all services supported by clearly defined roles and responsibilities for staff at all levels and how they contribute to this quality governance.

3.3.2 Patient safety reporting processes

Both organisations have a defined process for tracking, monitoring and escalating improvement actions arising from patient safety incidents, complaints, safeguarding reviews, and other learning responses undertaken in line with the Patient Safety Incident Response Framework (PSIRF). All identified improvement actions are recorded on Datix, with a designated action lead and agreed completion timescale.

In LYPFT action owners receive automated prompts from the Datix system in respect of upcoming and overdue actions. On a monthly basis all ongoing actions on the Datix action module are included within monthly Incident Governance Reports, which are reviewed and monitored within local governance forums. Within these reports any risks and escalations relating to actions are outlined as requiring action by the service. Additionally, a monthly action monitoring report is shared with the Trust Incident Review Group (TIRG) in respect of ongoing and completed actions arising from learning responses agreed at TIRG. All patient safety incident investigations (PSIIs) are monitored through quality committee.

In LCH improvement action data is routinely extracted from Datix and reported through Business Unit Quality Reports, providing oversight of progress and assurance regarding implementation. These reports are reviewed through the Quality Assurance and Improvement Group (QAIG), a sub-group of the Quality Committee, where overdue actions are scrutinised, challenged and escalated as appropriate. Actions related to patient safety incident investigations are overseen by the clinical lead for the area. This process supports organisational learning, accountability and oversight of improvement activity across the Trust.

3.3.3 Action planning

In response to these broader system-wide lessons, work is underway within the LYPFT Nursing and Professions Directorate to strengthen the Trust's approach to action planning arising from incidents, reviews, audits and organisational learning, with implementation commencing within the Directorate and an intention to roll this out across the wider organisation, and onward into LPFT. The approach is shifting from a predominantly transactional model, where actions are considered complete once tasks have been undertaken, to an outcomes-focused methodology that evidence whether meaningful and sustainable improvement has been achieved. Equally LCH processes have been revised to ensure the Quality Leads quality assure the closure of PSII actions to ensure the response meets the action and there is evidence of completion.

Strengthening of this approach will ensure that action plans clearly articulate not only the actions required, but also the intended outcome, measures of success, methods for embedding learning, and the anticipated impact on patient care, carer experience and staff practice.

Robust programme management and action planning standards will be fundamental to this approach, providing clear accountability, appropriate risk prioritisation, realistic timescales and effective oversight. This will strengthen the Trust's ability to identify delayed or ineffective actions at an early stage and intervene promptly where progress or impact is not being achieved.

Quality improvement and organisational assurance will become the primary drivers of action planning. All significant action plans will include measures of effectiveness

and assurance mechanisms to determine whether the intended improvements have been realised and sustained over time. This will provide greater confidence that learning is translating into measurable improvements in quality, safety and experience, while also strengthening escalation processes where expected improvements are not being achieved.

The revised methodology is aligned with the ambitions of the NHS Quality Strategy and will support the development and delivery of the future Quality Strategy for Leeds Partnership NHS Foundation Trust (LPFT) as the organisations integrate. It strengthens the focus on understanding whether improvement interventions have delivered the intended outcomes, reduces the risk of actions being completed without meaningful change being achieved, and provides assurance that organisational learning is resulting in sustained improvements in patient safety, clinical effectiveness, patient and carer experience, and staff wellbeing.

Furthermore, this approach directly supports the key themes identified through the LYPFT recent CQC Well-Led review, demonstrating a strengthened focus on evidencing impact, improving the effectiveness of governance arrangements, embedding organisational learning and delivering continuous quality improvement, rather than simply monitoring the completion of actions. The approach therefore provides a stronger framework for Board assurance by enabling the organisation to understand whether learning has led to demonstrable and sustainable change.

To support implementation, the Trust is exploring the use of the Audit Management and Tracking (AMaT) system. AMaT is a digital governance, audit and quality improvement platform used across NHS organisations to manage audits, improvement programmes, inspection actions, risks and organisational learning within a single integrated system. The platform provides structured action planning, clear accountability, real-time progress monitoring and the ability to evidence whether actions have resulted in demonstrable improvement. A pilot will be undertaken within the Directorate to evaluate the system's ability to support enhanced governance, assurance and sustainable quality improvement before consideration of wider organisational adoption.

➢ 4. Impact

There are several specific recommendations contained within the Inquiry reporting operational, governance and workforce areas. A full matrix of the recommendations; associated relevance to both Trusts and Executive ownership is attached as Appendix 1. This summarises the assurances identified any actions identified.

This shows that both organisations demonstrate good processes related to freedom to speak up and patient safety. However recent inspections identify that greater attention is required to ensure that there are consistent and effective governance frameworks in place and more effective tracking of actions. It will also be vital to ensure that these processes remain robust and consistent in the transition to LPFT.

There are key developments required in safeguarding, including updating training and ensuring appropriate interface with workforce standards.

Other areas to address following the Inquiry’s recommendations for national updates are:

- Ensure that any changes in the process for sudden infant death services are implemented
- Updating and implementing the leadership and management framework
- Updating of staff contracts and other processes to reflect the soon to be developed deliberate harm protocol

5. Conclusion

The Thirlwall Inquiry is a powerful reminder that patient safety, safeguarding, professional curiosity and the willingness to challenge concerns must remain at the centre of organisational culture and governance.

Whilst neither Leeds Community Healthcare NHS Trust nor Leeds and York Partnership NHS Foundation Trust provides neonatal inpatient services, the Inquiry's findings are highly relevant to both organisations and reinforce the importance of effective speaking up arrangements, responsive leadership, robust safeguarding processes and governance systems that identify emerging risks and demonstrate the impact of improvement actions.

There is evidence of strong foundations across both Trusts, particularly in relation to Freedom to Speak Up, patient safety and safeguarding arrangements; however, recent inspections and governance reviews highlight opportunities to strengthen assurance, consistency and oversight. The proposed review and action plan will enable both organisations to assess compliance against the Inquiry's recommendations, address identified gaps, and ensure that, as the organisations transition to LPFT, patient safety and organisational learning remain paramount and are supported by effective governance, accountability and continuous improvement.

6 Recommendations

The Board is recommended to:

1. Note the findings and recommendations arising from the Thirlwall Inquiry

2. Approve the completion of a gap analysis for both Trusts against the key themes and relevant recommendations of the Inquiry, including patient safety, safeguarding, Freedom to Speak Up, Duty of Candour, organisational culture and governance.

3. Support the development of an action plan to address any areas for improvement identified through the review, with clear executive ownership and delivery timescales, incorporating the Trust integration.

4. Agree that progress against the action plan and implementation of learning is monitored through the Quality Committee, with periodic updates provided to the Board.

Sheila Sorby
Deputy Director of Nursing and Quality and DIPC

Marie-Clare Trevett

Deputy Director for Allied Health Professions and Social Workers

10 November 2026

Recommendations		Relevant to LCH	Relevant to LYPFT	Assurances	Actions	Action Lead	Exec lead/s	Timescale for completion
NHSE Recommendation (Letter)	Every Trust and ICB Board to review the Thirlwall report and to consider its findings at the next available public Board meeting: Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both Board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear.	Yes	Yes	Established and effective process of speaking up. Including the bi-annual board reports. sends a paper alongside HR before every board meeting covering formal and informal concerns and themes. A recent external audit gave the trust sufficient assurance in terms of the FTSUG work. Clinical and Workforce Concerns meetings with the directors to triangulate concerns and think through actions. The FTSUG attends and shares themes into the People and Culture Committee. Annual staff survey and pulse surveys include questions around speaking up culture.	Combined report being presented to both Trust Boards in November 2026 Interrogate Q3 staff pulse survey results regarding staff feeling able to speak up	Heather McClelland / Nichola Sanderson John Walsh & Shereen Robinson FTSU Guardians / Holly Tetley (Deputy Director of People & OD) and Catherine Hall (Associate Director People Solutions)	Ruth Burnett Heather McClelland Nichola Sanderson Christian Hosker	30 November 2026 31 Jan 2027

				Staff survey recorded high rates of confidence in feeling safe to raise any issues.				
Recommendation 1:	**CCTV and monitoring** All cots and incubators in all neonatal units should be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. The funding for this should be centrally managed and ring-fenced, to ensure consistency and implementation across all neonatal units at speed. By 31 March 2027, NHS England should set out a roadmap for how this will be implemented.	No	No					
Recommendation 2:	**Insulin** (i) Digital devices should be used to restrict access of insulin to authorised people and record access to insulin storage units. I acknowledge that steps are being taken to achieve this. By 31 March 2027, all neonatal units must meet the expected requirements for access control and storage of insulin set out in the NHS England Getting It Right First Time guide, GIRFT Neonatology: Guide to safe	No - neonatal units only	No - neonatal units only					

	insulin use. (ii) Until access to insulin requires the provision of biometric data, each Trust should install CCTV cameras focused on storage fridges, cupboards or units. The cameras should store recordings for at least 28 days. (iii) The GIRFT Laboratory Handling of Insulin Requests in the Investigation of Hypoglycaemia guidance for the testing and reporting of insulin and C-peptide results, issued in October 2025, must be made mandatory and of national application.							
Recommendation 3:	**Bereavement care** The National Bereavement Care Pathway for neonatal death should be implemented nationally and in all Trusts by 31 August 2027.	Yes, relevant to SUDIC	No, as no SUDIC service	LCH SUDIC team provide a specialised community based clinical team (Doctors and Nurses) to manage the official review process and supporting grieving families after the unexpected death of a child / young person from birth up to their 18th birthday	Undertake benchmarking against the nine standards, including assessment of the impact of the decommissioned bereavement keyworker role, and provide recommendations for service improvement.	SUDIC lead	Heather McClelland	31 Dec 2026

Recommendation 4:	**Safeguarding and contracts of employment** (i) All Trusts must provide safeguarding training to all staff (appropriate to their role and expertise) and Board members, including Non-Executive Directors. This training should include how to deal with concerns and suspicions about deliberate harm caused by staff. (ii) By March 2027, every existing contract of employment for work in an NHS hospital must be amended to include an obligation on the employee to follow all relevant safeguarding guidance, including the Suspicion of Deliberate Harm Protocol (at Recommendation 9), for dealing with concerns and suspicions about deliberate harm. Agency and bank staff contracts and all new contracts of employment must include the same obligation.	Yes	Yes	Mandatory training in Safeguarding Adults, Safeguarding Children, Mental Capacity and PREVENT across both organisations. Compliance figures monitored through Safeguarding Committee. Training for SUDIC team via Joint Agency Response SUDIC Training Annual SUDIC study day in Leeds LSCP offer	Review safeguarding training provision across both Trusts to all staff, managers, Board members and NEDs. To identify opportunities for standardisation and ensure training includes the recognition, escalation, and management of safeguarding concerns and suspicious circumstances. Review the interaction between the proposed protocol and the Trust's existing use of the NHS	Lynne Chambers / Janet Smith / Workforce Claire Gray-Sharpe / Claire Staveley	Heather McClelland Nichola Sanderson Jenny Allen	

					England Being Fair decision-making framework, to ensure clarity and consistency in application once the protocol is published. This should include consideration of alignment with the Trust's disciplinary and incident management policies. Amend all existing NHS employment contracts to include compliance with safeguarding guidance and the Suspicion of Deliberate Harm Protocol; ensure all new, agency and bank contracts include the			March 2027

					same requirement.			
Recommendation 5:	**Operating systems (interoperability)** NHS England must provide, by 31 March 2027, a clear and timed route to ensuring that computer systems are harmonised across the NHS by December 2028. Work on the development of a mandatory information standard with requirements for interoperability between systems should be taken forward and implemented as soon as possible. This should mean that data relating to babies and neonates in hospital may be entered on a single occasion, be reviewed in a timely manner and facilitate continuous monitoring.	No. NHSE action	No. NHSE action	Note there is local work being undertaken to improve information sharing between 0-19 service and midwifery services				
Recommendation 6:	**Monitoring deaths in hospitals** (i) By 31 March 2027, all hospital Trusts must have in place effective mechanisms for Board-level monitoring of all deaths of children and babies. (ii) By 31 March 2027, all hospital Trusts must have in place a clear and predetermined route to senior	Yes	Yes, specifically perinatal	Both Trusts have well embedded mortality review processes, which are subject to review as part of the Trust integration activity. Quarterly mortality report provided to Quality Committee / Trust	Undertake a review of the mortality processes jointly in LPFT to ensure robust and consistent processes on proportionate	Geraint Jones Abby Boden	Ruth Burnett Nichola Sanderson	

	management for the escalation of concerning data trends or patterns.			Board in LCH which incorporates both adults and children. LCH has Business Intelligence mortality dashboards for the Neighbourhoods which now include SPC data, which can be interrogated at service level. In Leeds there is a neonatal death overview panel (NDOP) and Children's death overview panel (CDOP). This is attended by Consultant in Public Health, LSCP rep, Community Paediatrician, Consultant obstetrician, Consultant from neonates and the LTHT public health midwife.	mortality surveillance and mortality review processes in the new Trust. With the upcoming implementation of Datix Cloud IQ (DCIQ) we will explore the use of the mortality module for an improved digital approach to Children's mortality recording.			
Recommendation 7:	**Data reporting** (i) All hospitals with a neonatal unit should name a 'lead reporter' with responsibility for inputting data regularly (at least weekly) and reviewing real-time data viewers on	No - neonatal units only	No - neonatal units only					

	neonatal and maternity units in the MBRRACE system. Whilst the lead reporter does not necessarily need to be a clinician, they must be trained to understand and interpret the available data and able to explain and discuss it with clinicians. (ii) Save where data requires immediate action, in which case a report should be made to the Medical Director and the Board immediately, the lead reporter should report to Trust Boards at least every six months and advise: (a) whether any alerts or a need for investigation have arisen (b) the investigation or action plan in place.							

Recommendation 8:	**Sudden Unexpected Death in Infancy and Childhood (SUDIC)** (i) NHS England must: (a) Immediately inform all Trusts with a neonatal unit that the SUDIC process applies to the sudden and unexpected deaths of babies who have never left hospital. (b) Direct all Trusts that they must, within seven days, draw this information to the attention of all relevant staff and the Board. (ii) DHSC must complete its review and revision of the SUDIC guidelines and ensure the revised guidelines are distributed to all Trusts by no later than 31 March 2027. The guidelines must include a clear statement that SUDIC applies to sudden and unexpected deaths of babies who have never left hospital. (iii) SUDIC forms must be redesigned and shortened to keep bureaucracy to a minimum. The focus should be on what it is essential to know.	Partial	No	N/A	Monitor the publication of the revised SUDIC guidelines and undertake a gap analysis on release to assess compliance of the LCH SUDIC service, identifying any required changes and recommendations for implementation.	SUDIC lead	Heather McClelland	31 March 2027 (dependent on national publication of revised guidelines)

Recommendation 9:	**Suspicion of Deliberate Harm Protocol and guidance** Protocol (i) By 31 March 2027, NHS England must produce and distribute a one-page protocol setting out the steps to be taken by managers when concerns or suspicions are raised that a healthcare professional may have deliberately harmed a patient. The Suspicion of Deliberate Harm Protocol must make explicit that: (a) It is irrelevant whether the person to whom the concerns have been expressed does or does not believe they are true, as is the fact that the person raising the concern is not sure. (b) Where concerns or suspicions of deliberate harm are being raised in good faith, they must be acted upon immediately. (c) Only in cases where the concerns are obviously irrational or malicious (which assessment must be recorded) will no further action be justified. (d)Pending investigation of a member of staff, action to protect patients by moving the person suspected of causing harm is likely to be the first step. (e) The moving of a person suspected of causing harm and the	Partial	Partial	LCH already adhere to the NHS England Being Fair tool (previously Just Culture Guide)- this decision making framework supports staff and evaluates individual conduct or fitness to practice when a patient safety response raises specific concerns about individuals who may be harming patients. This is cited within both the Trust disciplinary policy and incident management policy LYPFT use the just culture guide where there are concerns related to practice and patient safety. The safeguarding allegations against colleagues policy and the safeguarding and promoting the welfare of children policy is under review to embedded learning from the Thirlwell report	Monitor the publication of NHS England's suspected deliberate harm protocol and associated guidance, and assess the implications for community services to ensure relevant requirements are incorporated into Trust policies, processes, and practice (HR policies, safeguarding procedures, manager guidance, disciplinary processes and training). Train managers to respond appropriately to concerns,	Sheila Sorby / Alison Quarry / Janet Smith	Heather McClelland / Nichola Sanderson / Jenny Allen	31 March 2027 (dependent on national publication timescales)

	investigation into suspicions and concerns about a member of staff is a neutral act. (f) Safeguarding steps must be followed, as a result of which the police will become involved. <u>Guidance</u> (ii) Guidance of no more than two pages should accompany the protocol. It must set out the factors to be considered when assessing the nature of the concerns and suspicions. The reader should be directed to guard against their own biases, loyalties and prejudices. The guidance should explain what should be said and when to those who are or who may be involved with any investigation (such as patients, parents and staff). This must include that patient safety comes first, and investigation is required. The guidance should also explain that failure to follow the protocol will be a breach of contract by an employee, as well as a breach of the relevant code of conduct. <u>Implementation</u> (iii) Trusts must embed the Suspicion of Deliberate Harm Protocol and guidance within their hospital.				avoid bias, act immediately on concerns raised in good faith and prioritise patient safety following publication of the protocol by 31 March 2027			

Recommendation 10:	**Panel of experts** Serious consideration should be given by DHSC to the setting up of a panel of independent experts from all specialties to be called upon in situations where there are emerging concerns about an individual and harm to a patient or patients. A team from any specialty or combination of specialties would be drawn from the panel to conduct a swift, technical investigation into the concerns raised. This may most often be necessary where there are concerns that harm is being or has been caused inadvertently. The precise make-up of the panel should be determined by DHSC but could include, for example: (a) two doctors and two nurses from each clinical specialty (b) four senior managers (c) four pathologists including paediatric and perinatal pathologists (d) other experts as decided by DHSC. Where necessary, a small team (always including clinicians from the relevant specialty/specialties) would be drawn from the panel to carry out an independent investigation into clinical concerns. Such investigations should always	Partial	Partial	The Trusts have an established history of appropriately referring cases for independent review and investigation, including referrals to the Integrated Care Board (ICB), the Healthcare Safety Investigation Branch (HSSIB), and Domestic Homicide Review (DHR) processes where indicated. Learning from these reviews has informed organisational governance, oversight, and service improvement arrangements.	Ensure Clinical Governance teams maintain awareness of forthcoming Department of Health and Social Care (DHSC) guidance relating to independent inquiries, and review local processes to ensure requests for independent investigation are considered and initiated appropriately when circumstances meet the relevant criteria.	Claire Gray-Sharpe / Abby Boden	Heather McClelland / Nichola Sanderson	

	include safeguarding considerations (including contacting the police). In addition to reporting their findings to the Trust and DHSC, the experts would be available to be called as witnesses in any proceedings that may follow.							
Recommendation 11:	**Medical examiners** (i) The National Medical Examiner should, by 31 March 2027, prepare and distribute a one-page document setting out all the steps to be taken by a medical examiner when dealing with the death of a neonate. (ii) The revised SUDIC guidelines (see Recommendation 8 above) should be set out within the good practice guidelines for medical examiners, not merely signposted. (iii) Medical examiners should ask direct questions of the attending practitioner as to whether there is a	Partial	Partial	The Trusts actively engages with Medical Examiners and works collaboratively with the Medical Examiner service to support scrutiny of deaths, identification of learning, and appropriate escalation of concerns, contributing to organisational learning and quality improvement.	Ensure Children's Services and the SUDIC team maintain awareness of developments arising from the National Medical Examiner programme and review local processes accordingly,	Ensure perinatal services maintain awareness of developments arising from the National Medical Examiner programme and review local	Rachel Phillips	Ruth Burnett Christian Hosker

	concern that a child has been harmed or some other safeguarding concern. Where there may be such a concern, the medical examiner should ensure that there is a record made that day of the contact details of every doctor or nurse who attended to the baby during life. (iv) There should be a pool of neonatologists who can assist medical examiners with their work until such time as it is possible to appoint the appropriate number of regional neonatologist medical examiners. Ring-fenced funding should be provided for this purpose. (v) The medical examiner system should be reviewed again in 2027 by DHSC. The review should include the adequacy of funding for medical examiners and their support staff and offices. In particular, the question of whether the funding should be ring-fenced must be addressed. Thereafter, reviews should be as directed by DHSC and NHS England.				recognising that implementation may require engagement and discussions with bereaved families and other stakeholders.	processes accordingly, recognising that implementation may require engagement and discussions with bereaved families and other stakeholders.		

Recommendation 12:	**Paediatric and perinatal pathologists** DHSC and NHS England must ensure that, by June 2033, there are 37 doctors in training posts as paediatric and perinatal pathologists, in line with the workforce requirement set out by the Royal College of Pathologists in the November 2025 Paediatric and Perinatal Pathology Workforce Report. The incentive scheme should remain in place and funded until at least 37 doctors are in training posts as paediatric and perinatal pathologists.	No - action is for NHSE	No - action is for NHSE					

Recommendation 13:	**Accountability and regulation of managers** (i) DHSC and NHS England must develop and put in place a barring system for all managers (clinical and non-clinical) by September 2027. It should be reviewed in 2030 with a view to moving to a full statutory regulation system by September 2032. (ii) NHS England must require any Trust seeking approval for the movement of a senior manager to another Trust to demonstrate that: (a) The move is not proposed because of the manager's lack of capability or misconduct. (b) The manager meets the fit and proper person test. NHS England must not grant approval, and Trusts must not seek approval, unless they are able to demonstrate the matters at a. and b. above. (iii) In addition to the statutory duty for organisations, all managers must be subject to an individual duty of candour to all patients and colleagues. This should be included in the code of conduct and in the contract of employment for all managers. (iv) The NHS Leadership and Management Framework Code, a code of conduct for NHS managers	Partial	Partial	Both organisations have Fit and Proper Persons Test (FPPT) arrangements in place and undertake Disclosure and Barring Service (DBS) screening at the appropriate level for all staff on appointment. Enhanced DBS checks are completed for roles where required, in line with statutory and regulatory requirements.	Review and assess the relevance of the emerging Leadership and Management Framework Code of Conduct to Trust services, and identify any requirements for local implementation, policy alignment, or leadership development arrangements. Prepare for implementation of a national barring system for NHS managers and review recruitment, conduct and capability procedures to align with this.	HR / People Solutions)	Jenny Allen	31 Dec 2026 Statutory from 2032 Sept 2027

	published in July 2026, must be amended urgently to set out, at the beginning, the uncontroversial duty of every manager to put patients first. I suggest the following wording, with thanks to Mr Jarrold: 'I will make the care and safety of patients my first concern and act to protect them from risk.' What matters is that patients come first. (v) In the Leadership and Management Framework Standards, the competency 'delivering across healthcare' should be first (it is currently third). The first and fundamental competency under this heading is, rightly: "I put patients first and report safety concerns and incidents."				Strengthen recruitment and pre-employment checks for senior managers, including fit and proper person requirements and movement between organisations. Update manager contracts, codes of conduct, leadership frameworks and appraisal processes to include an individual Duty of Candour. Review leadership frameworks, OD programmes, appraisals and leadership			Sept 2027 ASAP

					development to ensure patient safety is the primary responsibility of all leaders and managers.			

Recommendation 14:	**Care Quality Commission (CQC)** (i) CQC should conduct without-notice inspections of hospital departments. Inspection teams should include at least two current practising experts in the relevant field (in this case paediatrics / neonatology). (ii) Inspectors should investigate what is happening in hospital departments and not accept what they are told at face value. Where processes are being inspected, questions must be asked to elicit the effectiveness of those processes. (iii)Training should make explicit that CQC is responsible for ensuring the safety of patients in hospitals and not just for checking there are processes in place which, if implemented, should ensure patient safety. Inspectors and team leaders must always approach an inspection of neonatal services not as a box-ticking exercise but as a way to determine that babies in hospital are safe.	No - action is for CQC	No - action is for CQC					
Recommendation 15:	**Assessment of the performance of CQC** There must be a rigorous and consistent review and assessment of the performance of CQC by the Health and Social Care Committee, initially once a year and, once the	No - action is for HSCC	No - action is for HSCC					

	committee is satisfied, once every three years, or such other frequency to be determined by the select committee.							
Recommendation 16:	**Parliamentary and Health Service Ombudsman** The functions of the National Guardian's Office should be taken over by the Parliamentary and Health Service Ombudsman in England. The Ombudsman's powers must be increased to include: (a) investigating complaints that whistleblowing in the NHS has not been dealt with adequately. (b) assisting whistleblowers by referring their concerns to the relevant NHS bodies and overseeing the response.	No - action is for PHSO	No - action is for PHSO					
Recommendation 17:	**Implementation of recommendations** A new responsibility for auditing the implementation of the recommendations of statutory inquiries into NHS bodies should be given to the National Audit Office. Funding for appropriate additional staffing should be made available so that it may begin its work by September 2027.	No - action is for NHSE/ NAO	No - action is for NHSE/NAO		Review Freedom to Speak Up arrangements and whistleblowing processes in anticipation of strengthened external oversight.		Jenny Allen	ASAP

Committee Escalation and Assurance Report

Name of Committee:	Business Committee	**Report to:**	Trust Board 19 November 2026
Date of Meeting:	20 October 2026	**Date of next meeting:**	17 November 2026

Introduction

The meeting was quorate. The Committee welcomed members of the Trust's Digital Innovations Team who delivered a service spotlight presentation on Digital Programme Management. The Committee received four business cases for approval. The Committee requested a future schedule of business cases and that the business cases followed the standard Trust template

Alert	Action
None at this meeting	.

Advise

- Quality & Value Programme update. A verbal update was provided on key issues discussed at the recent Quality and Value Board meeting which covered the Leadership Redesign Project, service demobilisations and progress on the possible roll out of E-community software in the Trust. The Committee requested that e-Community was presented as a Service Focus at the next meeting with assurance of a plan for going forward including 'stopping' the development if necessary.
- Four business Cases were presented:
  - Triage Business Case (Approved funding recruitment up to the delegated limit of £500k with a recommendation for approval of the remainder by the Trust Board)
  - Children's SLT Mainstream Service Business Case (Approved)
  - Akeso AR Business Case (Endorsed continued development)
  - Hunslet Health Centre Design and Delivery Business Case (Approved)
- Neighbourhood Health - the Committee heard that good progress continued. The report focussed on focussed on two AAA reports on the progress and improvements in proactive and reactive care. The Committee did discuss the need for benefits visibility noted that an evaluation report of the impact so far was due by mid-November and would be reported to the Committee in January 2027.
- Integrated Performance Report Waiting List Update – the Committee noted that positive performance improvements continued, Including the appointment of the PND Consultant.
- Health and Safety Report - the Committee received the six-monthly update report noting the alerts related to the nine RIDDOR reportable incidents

Committee Escalation and Assurance Report

- Finance report – the Committee received the Month 6 report - As at the end of September 2026 (Month 6), the Trust was reporting a year-to-date surplus of £0.496m against a planned break-even position and is forecasting a break-even outturn in line with plan.
- Corporate Benchmarking Report - the Committee received an update on the findings of the 2025/26 Corporate Benchmarking exercise, noting the identified areas for management review.

Assurance

- Wildly Important Goals (WIGs) – the Committee received and noted the six-monthly update report.
- Service Spotlight/focus - the Committee welcomed a presentation from the Trust's Digital Innovation Team about the implementation of the new Digital Project Management Methodology which had introduced a professional standardised project management approach which could be applied across the Trust.
- Internal Audit Report – Equality Impact Assessment - the Committee reviewed the report which was a substantial assurance opinion.The Health and Safety report was discussed and the Committee requested a short report prior to the next Committee to provide a an update on which actions are being addressed given priorities were unclear as actions were not RAG rated and a number of dates had slipped.
- Estates and Facilities Performance Management report (capital works, maintenance, NHS Premises Audit Model, Estates Return Information Collection) – the Committee received the quarterly update report noting the update on the decisions made by Leeds City Council about the redevelopment of Burmantofts Health Centre.
- Sustainability and Climate Adaptability Group AAA Report - the Committee noted the report, and suggested it should also be shared with SLT.

Risks Discussed and New Risks Identified

No new risks were identified.

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

Risk 2 Demand for Services: If we fail to respond to changes in population growth and presentation, and changing delivery models such as Neighbourhood Health, then the impact will be potential harm to patients due to long waits, inability to strengthen equity of access, additional pressure on staff, financial consequences and poor performance as measured through the National Oversight Framework.	12 (High)	Reasonable	Succession planning and the impact of demobilisation to be a key area of focus for the People and Culture Committee.

Committee Escalation and Assurance Report

Risk 4 Financial Sustainability: There is a risk that a lack of financial efficiency and sustainability results in the destabilisation of the organisation and an inability to meet our objectives	12 (High)	Reasonable	
Risk 5 Failure to maintain business continuity: If the Trust is unable to maintain business continuity in the event of significant disruption, in the short (less than one week) or longer term (above 1 week), then essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss.	12 (high)	Reasonable	
Risk 9 Infrastructure: If the Trust is unable to provide access to safe and fit for purpose digital and estate infrastructure then there is a risk that the quality and continuity of service provision will be compromised which may further impact achievement of all of the Trusts strategic goals and priorities.	12(High)	Reasonable .	Health and Safety Action Plan – further clarification requested regarding the level of risks associated with delays to the delivery of the objectives, and for this to be RAG rated.

Authors:	Liz Thornton/Helen Robinson/Lynne Mellor
Role:	Corporate Governance Officer/Company Secretary/Chair
Date:	21 October 2026

Committee Escalation and Assurance Report

Name of Committee:	Audit Committee	**Report to:**	Trust Board 19 November 2026
Date of Meeting:	6 October 2026	**Date of next meeting:**	1 December 2026

Introduction

Quorate meeting with a full agenda and good debate on key topics – good challenging conversations, particularly the request for changes to the Internal Audit Plan 2026/27, the SIRO Report and recognition of the Audit Committee's statutory responsibilities beyond 1 April 2027, particularly in relation to the approval of the Annual Accounts and the need to ensure that appropriate resources and governance arrangements remained in place to support these obligations.

Alert	Action
None	

Advise

- The Committee noted that there should be recognition of the Audit Committee's statutory responsibilities beyond 1 April 2027, particularly in relation to the approval of the Annual Report and Accounts and the need to ensure that appropriate resources and governance arrangements remained in place to support these obligations.
- Internal Audit Progress Report - one significant assurance final report had been issued, and one draft report had been issued since the last meeting. The Audit plan for 2026/27 was on track for completion by 31 March 2027.
- The final audit report on Equality Impact Assessments (Phase1) was discussed - the audit had adopted a two-phase approach, initially reviewing the design of the framework and governance arrangements before assessing operational implementation.
- A number of changes to the internal audit plan were discussed and either agreed or deferred for further discussion:
  - Learning from Deaths (Cancellation) - deferred for further discussion
  - Management of Medical Devices (Addition) – deferred for further discussion
  - Right to Work Checks (cancellation) – agreed
  - Clinical Supervision (addition) – agreed
- External Audit – it was reported that the National Audit Office had not yet completed the NHS Group Audit process for the previous financial year. Consequently, the audit certificate for the Trust could not yet be issued. The Committee requested assurance that the year-end financial reporting, audit readiness, governance arrangements and transition risks would be fully considered prior to the merger and reported to the Committee before the end of the financial year.
- The Committee received the quarterly SIRO report which included information about Information Governance training compliance within the Trust incidents reported to the Information Commissioner's Office (ICO). An additional report was requested which set out the process for investigating information governance breaches, current controls in place, and the arrangements for responding to any suspected inappropriate access to records.

Committee Escalation and Assurance Report

Assurance

- Three benchmarking Audit Reports were received and reviewed by the Committee – Waste Reduction and Cost Improvement Plans, Data Security and Protection Toolkit and Root Cause Analysis.
- An update on the number of open recommendations showed a continuing improvement, with additional executive management oversight leading to fewer being overdue.
- The Committee received the draft Charitable Funds Annual Accounts – noting that the accounts were still subject to independent examination by auditors.
- The Committee received the quarterly report on financial controls which included information about: Losses and Compensation Payments, Tender and Quotation Waivers, Procurement, Working Capital, including a quarterly update on receivables and payables held by the Trust over 90 days and External Audit Recommendations.
- The Local Counter Fraud Specialist provided an update, The Committee acknowledged the significant progress made by the organisation in strengthening its counter fraud arrangements and awareness activities.
- Board Assurance Framework - the Committee received the six-monthly Assurance Levels Report relating to the Board Assurance Framework (BAF).

Risks Discussed and New Risks Identified

None

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

The Committee provides the following levels of assurance to the Board on these strategic risks:	Risk score (current)	Overall level of assurance provided that the strategic risk is being managed (or not)	Additional comments
Risk 5 Failure to maintain business continuity	12 (high)	Reasonable	N/A

Author:	Liz Thornton/Khalil Rehman
Role:	Corporate Governance Officer/Committee Chair
Date:	18/10/2026

Agenda item:	2026-27 (12i)
Title of report:	Integrated Performance Report
Meeting:	Trust Board Meeting Held in Public
Date:	19 November 2026

Presented by:	Andrea Osbourne, Executive Director of Finance & Resources
Prepared by:	Victoria Douglas-McTurk, Assistant Director of Insight and Intelligence 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:

There are overall improvements in a number of areas of Trust performance and this is contributing to an improving overall NOF score. We are now achieving our overall sickness target following a long period of elevated sickness levels. This latter achievement is due to number of focussed interventions and efforts including support to managers and targeted interventions based on monitoring data. Unfortunately, due to the timing of the NHS Oversight framework this will not contribute to our segmentation until Q3 2026/27.

A long-standing CAS alert has been closed after many of months. We now have 0 CAS alerts outstanding.

In NHS Talking Therapies there are challenges on 2 fronts. Firstly; capacity and case complexity are driving higher than usual waiting times for screening and triage. Improvement groups and pilots have been put in place to address this. Secondly; a quirk of the PCMIS system is causing a lag between appointments happening and them being reported. This makes recent performance in relation to screening look positive when performance is deteriorating further.

Finally, audit activity is happening at lower levels than in comparison to previous years. An increase is anticipated later in the year; indeed, this increase forms the usual pattern, however a significant uptick is required to address the shortfall. There is also the risk that significant organisational change might disrupt the capacity and capability required to make that change

The Trust's performance in the NHS Oversight Framework overall is forecast to remain stable in Q2 2026/27, but our metric score is improving and getting closer to the score required for segment 2; 2.33.

Improvements in our Data Quality Maturity Index and percentage of patients in intermediate care beds without criteria to reside have been offset by higher segment scores for temporary (agency and bank) staffing.

The work being undertaken to deliver improvements is detailed in the individual sections of this report. Key areas for focus continue to be:

- Percentage of patients waiting over 52 weeks for community services
- Percentage of people discharged from community mental health services with a paired outcome recorded
- Percentage of total open children's and young persons mental health related waits that are over 104 weeks
- Relative difference in costs
- Sickness absence rate

Improvement in relative difference in costs is expected following publication of the National Cost Collection data for 25/26. This change will be included in the next report

Previously considered by:	
Outcome of previous discussion/s:	

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

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: We have introduced 3 new measures for assessing the equity of our care. These use the Health Equity Index (HEI) to assess variation. The HEI scores between 0 (no evidence of inequity) and 1 (extreme inequity). There is no "acceptable" level of inequity, and higher scores indicate that work is required to understand the drivers and the solutions. It show good levels of equity for our patients waiting less than 18 week waits for care. But highlights areas for improvement in our missed appointments and number of patients waiting more than 52 weeks for care. Improvement actions are planned via the Access LCH Steering Group.	Workforce:

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

October 2026

Reporting on: September & Q2 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

NHS Leeds Community Healthcare NHS Trust

Summary

There are overall improvements in a number of areas of Trust performance and this is contributing to an improving overall NOF score. We are now achieving our overall sickness target following a long period of elevated sickness levels. This latter achievement is due to number of focussed interventions and efforts including support to managers and targeted interventions based on monitoring data. Unfortunately, due to the timing of the NHS Oversight framework this will not contribute to our segmentation until Q3 2026/27.

A long-standing CAS alert has been closed after many of months. We now have 0 CAS alerts outstanding.

We have also introduced 3 new measures for assessing the equity of our care. These use the Health Equity Index (HEI) to assess variation. The HEI scores between 0 (no evidence of inequity) and 1 (extreme inequity). There is no "acceptable" level of inequity, and higher scores indicate that work is required to understand the drivers and the solutions. It show good levels of equity for our patients waiting less than 18 week waits for care. But highlights areas for improvement in our missed appointments and number of patients waiting more than 52 weeks for care. Improvement actions are planned via the Access LCH Steering Group.

In NHS Talking Therapies there are challenges on 2 fronts. Firstly; capacity and case complexity are driving higher than usual waiting times for screening and triage. Improvement groups and pilots have been put in place to address this. Secondly; a quirk of the PCMIS system is causing a lag between appointments happening and them being reported. This makes recent performance in relation to screening look positive when performance is deteriorating further.

Finally, audit activity is happening at lower levels than in comparison to previous years. An increase is anticipated later in the year; indeed, this increase forms the usual pattern, however a significant uptick is required to address the shortfall. There is also the risk that significant organisational change might disrupt the capacity and capability required to make that change.

Summary Performance

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

Top Highlights

Domain	KPI	Target	Actual	Performance	Assurance
Patient safety	CAS Alerts Outstanding**	0	0		
People & workforce	Total sickness absence rate (Monthly) (%)	<=6.5%	7%		
Improving health and reducing inequality	Missed appointments Health Equity Index (Ethnicity, IMD)		0.35		
Improving health and reducing inequality	Patients waiting more than 18 weeks Health Equity Index (Ethnicity, IMD)		0.18		
Improving health and reducing inequality	Patients waiting more than 52 weeks Health Equity Index (Ethnicity, IMD)		0.43		

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	78%		
Access to services	IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	>=75%	72%		
Effectiveness & experience of care	Priority 2 audits: number completed year to date versus number expected to be completed in 2021/22	100% by year end	6%		
Effectiveness & experience of care	Total number of audits completed in quarter	No Target	15		

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.

Leeds Community Healthcare NHS Trust

Summary

The Trust's performance in the NHS Oversight Framework overall is forecast to remain stable in Q2 2026/27, but our metric score is improving and getting closer to the score required for segment 2; 2.33.

Improvements in our Data Quality Maturity Index and percentage of patients in intermediate care beds without criteria to reside have been off set by higher segment scores for temporary (agency and bank) staffing.

The work being undertaken to deliver improvements is detailed in the individual sections of this report. Key areas for focus continue to be:

- Percentage of patients waiting over 52 weeks for community services
- Percentage of people discharged from community mental health services with a paired outcome recorded
- Percentage of total open children's and young persons mental health related waits that are over 104 weeks
- Relative difference in costs
- Sickness absence rate

Improvement in relative difference in costs is expected following publication of the National Cost Collection data for 25/26. This change will be included in the next report.

More detailed narrative on the other areas of interest is provided in the body of this report.

NHS Oversight Framework 2026/27		Q1				Q2 Forecast			
Domain	**Metric**	**Value**	**Score**	**Rank**	**Segment**	**Value**	**Score**	**Rank**	**Segment**
Overall			**2.52**	**43 of 58**	**3**		**2.44**		
Access to Services	Percentage of patients waiting less than 18 weeks for community care	81.39%	1	24	1	83.02%	1		1
	Percentage of patients waiting over 52 weeks for community services	1.74%	2.86	26	3	1.29%	2.86		3
	Percentage of people discharged from community mental health services with a paired outcome score recorded (all ages)		4		4		3		3
	Percentage of people discharged from community mental health services with a paired outcome score recorded (children and young people)	14.71%			3	21.0%			2
	Percentage of people discharged from community mental health services with a paired outcome score recorded (adult and older adult)	2.48%			4	2.25%			4
	Percentage of total open children's and young persons mental health related waits that are over 104 weeks	28.5%	3	29	3	28.5%	3	29	3
	Domain Summary		**2.72**		3				
Finance, productivity and innovation	Combined finance score		1		1		1		1
	Variance year-to-date to financial plan	0.26%	1	6	1	0.40%	1		1
	Planned surplus/deficit	0.00%	1	9	1	0.00%	1		1
	Relative difference in costs	118%	3.74	52	4	118%	3.74	52	4
	Data Quality Maturity Index score	29.5%	3.98	57	4	98.7%	1.08	6	1
	Percentage of clinical trials set up within 90 days	0%	4	38	4	50%	4		4
	Domain Summary		**3.18**		4		**2.46**		

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.

Leeds Community Healthcare NHS Trust

NHS Oversight Framework 2026/27		Q1				Q2 Forecast			
Patient Safety	NHS Staff survey – raising concerns sub-score	7.01	1.37	8	1	7.01	1.37	8	1
	Domain Summary		**1.37**		1		**1.37**		1
People	Healthcare Worker Flu Vaccination Rate	53%	1.90	12	2	53%	1.90	12	2
	NHS staff standards score	7.97	1.32	7	1	7.97	1.32	7	1
	NHS staff survey engagement theme sub-score	6.92	2.89	37	3	6.92	2.89	37	3
	National Education and Training Survey satisfaction rate	81.14%	1.72	28	2	81.14%	1.72	28	2
	Sickness absence rate	7.65%	3.94	58	4	6.69%	3.78	49	4
	Temporary staffing cost relative band score		1		1		4		4
	Temporary staffing agency		2		2		4		4
	Temporary staffing bank		1		1		3		3
	Domain Summary		**2.13**		2		**2.83**		
Experience of Care	NHS staff survey advocacy rate Score	6.95	2.42	28	2	6.95	2.42	28	2
	Percentage of intermediate care beds occupied by patients without criteria to reside	25.25%	2.64	23	3	25.22%	2.42		2
	Domain Summary		**2.53**		3		**2.42**		2

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 has fallen slightly but remains steady at 21549 at the end of Sept 2026. However, the number of patients waiting more than 52 weeks continues to decrease, falling to 509 at the end of Sept 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.

Paediatric Neuro Disability (PND) is now the only service with 52+ week waits contributing to the Trust's NOF score, with all remaining 52+ week waits expected to be cleared by the end of 2026. 18 Week Performance is currently sitting at 85.7% trust wide and 83.7% for NOF Reportable Services.

There has been a drop in performance in UCR this month following a pressured month in response. Validation has now taken place following data quality amendments resulting in slightly better performance.

NHS England data is also reporting that 28% of children and young people waiting for mental health services have waited more than 104 weeks, resulting in the Trust being placed in Segment 3 rather than the predicted Segment 1 for this measure. This is a data quality issue, and a Task and Finish Group is being established to investigate this position.

Domain Summary Performance

Data Quality : High Assurance Performance: On track

KPI	Reporting Month	Target	Actual	Performance	Assurance
Total Patients Waiting for Care - Trust Wide	Sep-26	No Target	21549	L	?
Number of patients currently waiting over 52 weeks - Trust Wide	Sep-26	0%	509	L	F
Total Patients Waiting for Care - Consultant-Led	Sep-26	No Target	1208	L	?
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	Sep-26	>=92%	42%	H	F
Number of patients waiting more than 52 Weeks (Consultant-Led)	Sep-26	0	195	L	F
Total Patients Waiting for Care - Community Sit Rep	Sep-26	0%	17751	L	?
Percentage of patients currently waiting under 18 weeks - Community Sit Rep	Sep-26	78%	86%	H	P
Number of patients currently waiting over 52 weeks - Community Sit Rep	Sep-26	0%	230	L	F
% Appointments missed, by service	Sep-26	No Target	4%		?
% of intermediate care beds occupied by patients without criteria to reside	Sep-26	No Target	18.60%		?
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	Sep-26	>=99%	100%	H	P
Community health services two-hour urgent response standard	Sep-26	>=70%	78%		?
Available virtual ward capacity per 100k head of population	Oct-26	No Target	7.8		?

Access to Services Domain (continued)

Accountable Exec: Sam Prince

KPI	Reporting Month	Target	Actual	Performance	Assurance
Number of CAMHS Eating Disorder patients breaching the 1-week standard for urgent care	Sep-26	No Target	0		
Number of Patients Accessing CAMHS	Sep-26	No Target	1204		
Percentage of Children over 5 currently waiting more than 18 weeks for a Neurodevelopmental Assessment	Sep-26	No Target	97%		
Percentage of Children currently waiting more than 18 weeks for a Neurodevelopmental Assessment	Aug-26	No Target	80%		
Percentage of NHS Talking Therapies patients completing a course of treatment and achieving reliable recovery	Sep-26	No Target	46%		F
% of people discharged from community mental health services with a paired outcome score recorded (children and young people)	Apr-26	No Target	15%		
% of people discharged from community mental health services with a paired outcome score recorded (adult and older adult)	Apr-26	No Target	2%		
% of total children and young people's mental health waits for help that are over 104 weeks	Apr-26	No Target	28%		
% of urgent/serious referrals to mental health crisis teams receiving their first face-to-face contact within 24 hours	Apr-26	No Target	0		
LMWS – Access Target; Local Measure (including PCMH)	Sep-26	24456 by year end	2624		
NHSTT - Number of courses of treatment	Sep-26	No Target	600		
NHSTT - Percentage of people receiving first screening appointment within 2 weeks of referral	Oct-26	No Target	78%	H	
NHSTT - Percentage of people referred should begin treatment within 18 weeks of referral	Oct-26	>=95%	98%		P
NHSTT - Percentage of people referred should begin treatment within 6 weeks of referral	Oct-26	>=75%	72%	L	P
Total Patients Waiting for Care - Dental	Sep-26	No Target	1116		
Percentage of patients currently waiting under 18 weeks - Dental	Sep-26	No Target	55%		
Number of patients currently waiting over 52 weeks - Dental	Sep-26	No Target	2		

*Please note the 2 patients showing as waiting over 52 weeks in Community Dental are a data validation error.

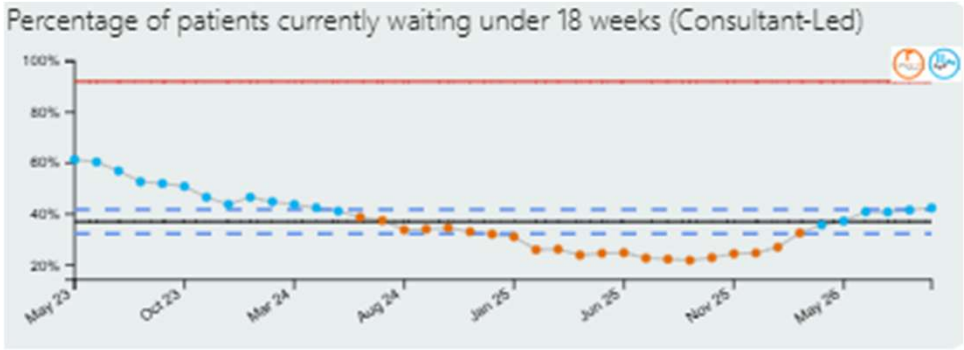
Consultant-led RTT Waiting Times

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

Target: 92% and 0 | Actual: 42% and 212 | 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 209 by the end of September.
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. The service has also made great progress in reducing 104+ week waits with only 2 remaining at the end of September.



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. Substantive recruitment into Paediatrician roles has now taken place and the service is continuing to reduce the longest waits.



When do we expect to see improvement

The service is anticipating 52+ week waits will be cleared by the end of 2026.

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% and 0 | Actual: 86% and 230 | SPC Variation: H L | SPC Assurance: ? F | Data Quality: **High Assurance**

What is the trend we see?

Following significant improvement during 2026, 85.7% of patients are currently seen within 18 weeks across the Trust, with performance remaining above the 78% target throughout the year. For NOF-reportable services, performance is slightly lower at 83.7% but remains comfortably above target, placing the Trust within Segment 1 for this metric. Across the Trust, five services are currently performing below the 78% standard: Community Paediatric Clinics, Child Development Centres, Children's Occupational Therapy, PND, and CYPMHS. Improvement plans are in place for each service, with progress monitored through Access LCH. Of the NOF-reportable services, only Children's Paediatric Clinics, Children's Occupational Therapy and PND remain below the 78% standard.





What is being done about it?

Paediatrician recruitment has now taken place in PND and recovery plans are well underway. In Occupational Therapy, newly appointed Band 5 staff are supporting reduction of the longest waits, while complex cases continue to require Band 6 expertise. The service is seeking to retain temporary Band 6 capacity for one day per week.

When do we expect to see improvement?

We expect 52 week waits to be cleared in PND by the end of 2026. Children's OT is unlikely to show significant improvement until additional band 6 resource is secured. CDC and CPC waits are predicted to continue to steadily fall.

What are the risks to delivery?

Any further impact on staffing or recruitment is likely to hinder recovery plans.

Criteria to Reside

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

Target: N/A | Actual: 18.7 | SPC Variation: | SPC Assurance: | Data Quality: Medium Assurance

What is the trend we see?

Broadly stable overall during the reporting period, with a changing cohort as people become ready for discharge and leave the service. Whilst the Trust is in NOF Segment 3 in Q1 and predicting to go to Segment 2 in Q2 there is then a risk of deterioration following the expansion of the service.



What is being done about it?

Social work tracker monitors pathways.
Daily Sitrep review has management and Registered Manager oversight.
Daily OT pro forma has clinical and therapy oversight.
Weekly leadership meetings review progress and actions.
Fortnightly partnership meetings and collaborative forums review cases, admissions and discharges.
The service is setting up peripheral stores and reviewing the equipment process, including funding approvals.

What are the risks to delivery?

Discharge delays reduce capacity for new admissions. We are seeking solutions to assessment and care-package delays, escalating unresolved barriers.

When do we expect to see improvement

The service is expecting ongoing steady improvement over time. The service is monitoring progress daily and are reviewing short-term assessment for care packages and active recovery to support timely discharge.

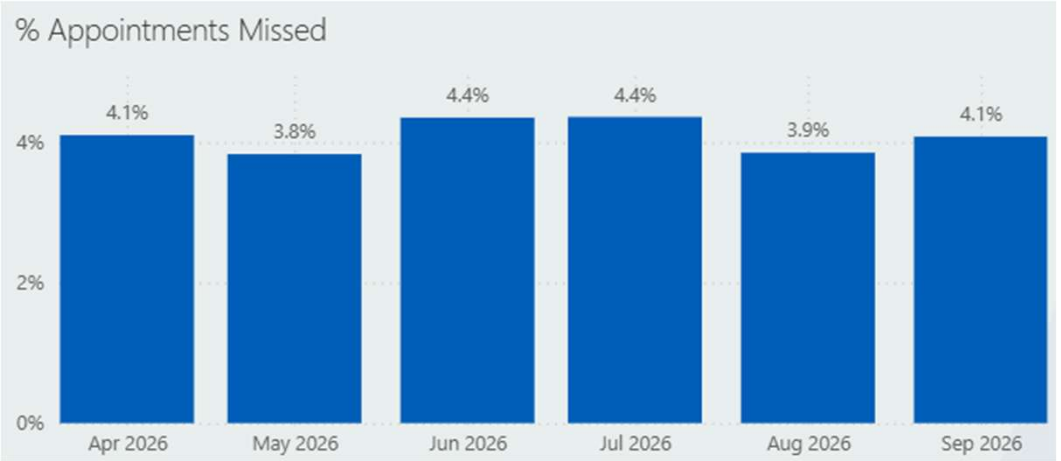
Missed Appointments

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

Target: No Target | Actual: 4.1% | Data Quality: Medium Assurance

What is the trend we see?

Missed appointment rates remain stable at 4.1%. While there is some variation between services, overall performance has remained steady.



What is being done about it?

Missed appointments are monitored through Access LCH and local service performance processes. Services have established approaches to improve attendance, including offering patient choice, flexible appointment options and alternative venues where appropriate.

The equity of missed appointments is now included as a separate measures please see page 32.

What are the risks to delivery?

N/A

When do we expect to see improvement

Given the current stable performance, no significant change is anticipated in the short term, although services will continue to implement measures to support attendance and reduce missed appointments where possible.

CYP Mental Health 104-week waits

Leeds Community Healthcare NHS Trust

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

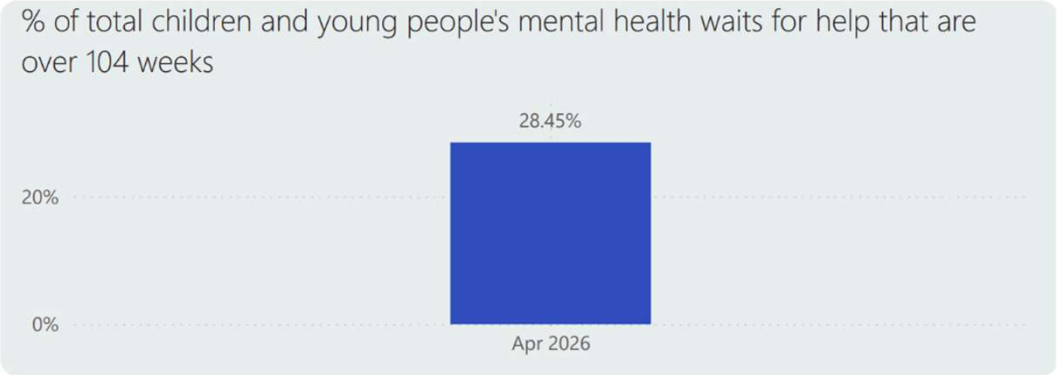
Target: 0 | Actual: 28.45% | Data Quality: **Low Assurance**

What is the trend we see?

This is a NOF metric, showing the last nationally reported position for the Trust. This measure is described as not including patients waiting for Neurodevelopmental Initial Assessments. Our internal data shows that the only patients waiting more than 104 weeks in the service are on our ND pathway. We anticipated that we would score 0%, but in fact scored 28.45%.

The 104-week wait indicator uses a national standard known as the Full Clock Stop Methodology, which requires an outcome measure to be recorded before a patient's clock can stop. Rates of recording outcome measures are low in the service, and this will be the focus of improvement work.

Patients who have both a referral for ND assessment and any other mental health referral open concurrently will also be included in the metric nationally.



What is being done about it?

BI have established a working group jointly with counterparts from LYPFT, as this metric impacts both Trusts in similar ways. Work will involve replicating national methodologies for calculating clock stops and referral spells, to better identify which patient records are being included in the KPI.

This will lead to improvement work alongside the service to correct recording within identified records.

What are the risks to delivery?

There is a risk that replicating the national methodology is not possible, as there are limitations to the guidance provided. These risks are being mitigated by working alongside NHSE analysis teams to check our assumptions and working.

There are some risks that some outcome measures can't be collected for historical patients.

When do we expect to see improvement

Improvement against the national standard is likely to take place within Q3 and Q4.

Patients Discharged from Mental Health Services with a Paired Outcome Measure

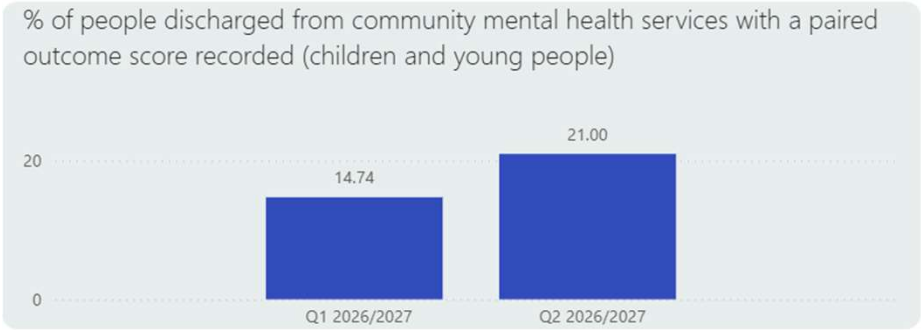
Domain: Access to Services | Accountable Exec: Sam Prince | Author: Samantha Steede

Target: No Target | Actual: 21% and 2.25% | Data Quality: **Low Assurance**

What is the trend we see?

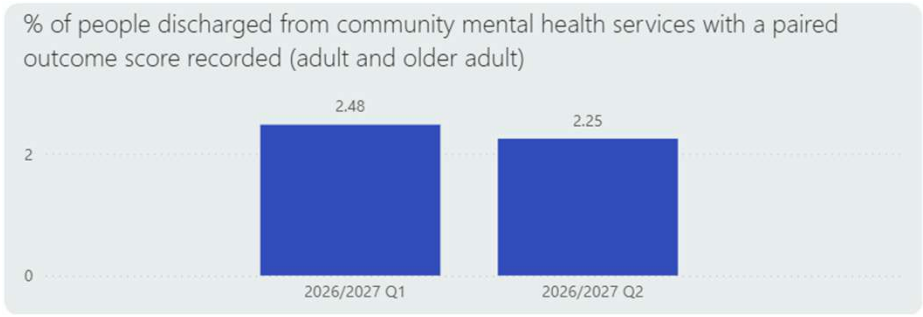
This is a NOF metric, showing the last nationally reported position for the Trust. This metric includes both our Children and Young People's Mental Health Service (CYPMHS) and our Primary Care Mental Health Service (PCMH). We are seeing an improvement in our CYP services, but PCMH is affected by a technical challenge.

For PCMH, the result relates to a technical challenge within NHS England to identify and capture our REQOL assessments.



What is being done about it?

The PCMH service send REQOL to their patients at referral and discharge. We have confirmed that REQOL is a valid measure for inclusion in the metric. We should therefore have a higher percentage of people with paired outcome scores, but this is not showing in the national data. A working group has been set up to examine the records that we would expect to count and aren't to pinpoint the cause of the discrepancy and take appropriate action.



When do we expect to see improvement

Within CYPMHS, performance has improved between Q1 and Q2, with a greater number of patients receiving paired outcome assessments. We believe that this will lead to the Trust moving from Segment 4 to Segment 3 for CYP in this metric, however final Sept figures are still to be published.

What are the risks to delivery?

If the action required to ensure that REQOL is counted correctly requires system configuration and/or a change in user practice improvement may take longer.

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**

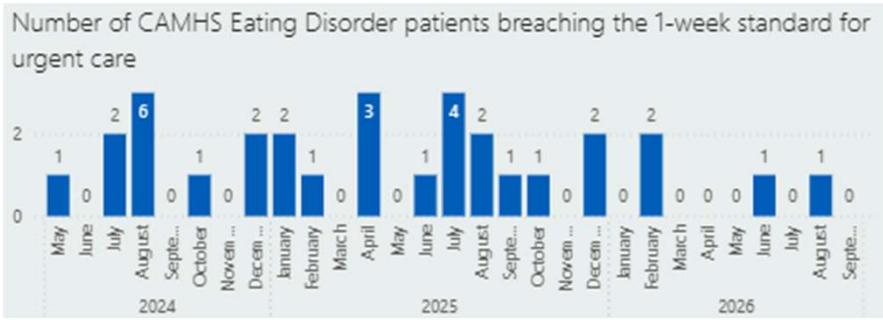
What is the trend we see?

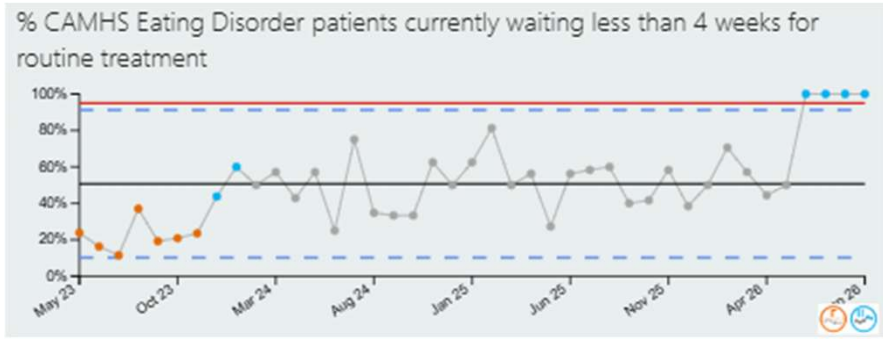
The service continues its trend of improved routine performance however one breach of the urgent 1-week standard was reported in the period (August).

However, this picture is not the same as national reporting where breaches are being reported. This is mostly due to a difference in how ED referrals are identified. Locally we allocate referrals to the ED service, but NHS England use the referral reason to identify ED referrals. This means NHS England are counting some referrals we are not.

There was also an issue with the incorrect SNOMED codes being reported into national data sets. The correct SNOMED codes are required to stop a wait. This issue has now been rectified.

We are assured that all ED referrals have been seen within the appropriate timeframes and are working on the data to ensure this reflects that.





What is being done about it?

Work is underway to update information appropriately and ensure that national methodologies reflect the true picture.

When do we expect to see improvement

We expect improvement in our locally reported measure to remain strong, however improvement against the national standard is likely to take until mid December 2026.

What are the risks to delivery?

There is a risk that replicating the National methodology is not possible, as there are limitations to the guidance provided. These risks are being mitigated by working alongside NHSE analysis teams to check our assumptions and working.

NHS Talking Therapies – 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

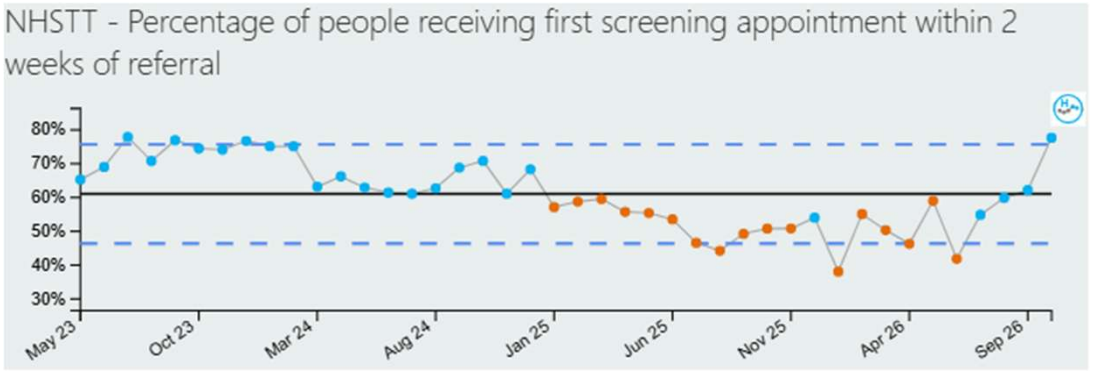
Target: No Target | Actual: 78% | SPC Variation: | SPC Assurance: N/A | Data Quality: Low Assurance

What is the trend we see?

Although the data presented here suggests strong improvement, the picture on the ground is actually deteriorating further.

This is due to a previously unidentified reporting lag, that is inherent in the way that PCMIS requires users to update patient records. There is no indication that teams are recording incorrectly.

However, it is likely that due to increasing pressure within the service, the length of the time delay is now stretching to 4 months.



What is being done about it?

BI Teams are working with the service to identify opportunities to report that avoid the visible lag in reporting times, and more accurately present performance in more real time ways.

What are the risks to delivery?

There is a risk that there are no alternative ways to report that avoid the time lag being visible in the data.

When do we expect to see improvement

We expect to develop a new measure during Q3

NHS Talking Therapies – 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: 72% | SPC Variation: | SPC Assurance: | Data Quality: Medium Assurance

What is the trend we see?

A statistically significant decline in the number of NHS TT patients seen within 6 weeks, with a significant decline in performance this financial year.

What is being done about it?

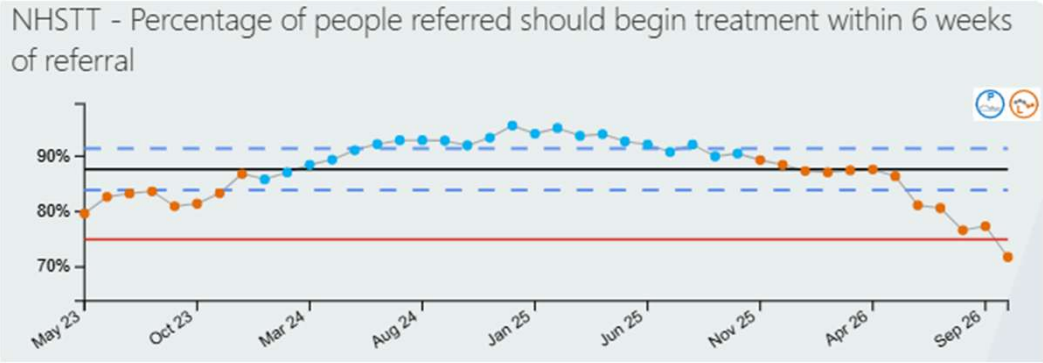
A screening improvement group has been established to identify and implement potential solutions. The rollout of Choose and Book across all screening activity is planned, although implementation timescales remain subject to change.

A pilot triage process is also being considered and is currently undergoing EQIA review. The pilot will require redeployment of existing resources and its impact on overall efficiency remains uncertain.

Neither initiative is expected to provide a rapid resolution. The underlying challenges are primarily driven by workforce capacity, increasing case complexity, and the management of risk and safeguarding issues that extend beyond the core scope of the service.

When do we expect to see improvement

It is anticipated that any material improvement is unlikely before the new financial year, with timelines of April or potentially October considered more realistic. In the interim, demand and waiting times are expected to continue to increase before the benefits of improvement actions are realised



What are the risks to delivery?

Delays in screening create a risk that some patients may not be identified as promptly as intended. However, the service is not commissioned to provide urgent care, and patients requiring treatment within six weeks, or at risk of significant deterioration, would be signposted to more appropriate services regardless of screening times.

Waiting times for treatment remain significantly longer than waiting times for screening, with overall delays driven primarily by treatment capacity rather than access to screening. While screening delays require ongoing attention, the greater risk relates to treatment waiting times and capacity constraints within the treatment pathway.

Finance & Productivity Domain Summary

Accountable Exec: Andrea Osborne

NHS Leeds Community Healthcare NHS Trust

Income & Expenditure: As at the end of September 2026, the Trust is reporting an adjusted year-to-date surplus of £0.496m against a planned break-even position. This represents an improvement of £0.186m compared with the year-to-date surplus of £0.310m reported at Month 5. The favourable variance is primarily driven by staffing vacancies across services and additional income generated from non-recurrent activities, including training programmes, research income, and the recovery of one-to-one nursing costs incurred year to date. From Month 7, staff recruited to support new business cases and waiting list initiatives are expected to commence in post, increasing expenditure during the second half of the year. As Business Units continue to fill vacant posts, and as current levels of non-recurrent income are not expected to be sustained for the remainder of the financial year, the Trust continues to forecast a break-even position at year-end, in line with its planned financial position.

Capital: After accounting for asset disposals of £0.556m, net capital expenditure totals £2.274m year to date compared to the planned £4.918m. This shortfall is due to delays in the renewal of a lease at Kippax with NHS Property Services and lower than planned remeasurement costs for the CHP leases. The Capital forecast spend is £8.141m, £0.477m 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 £58.424m, higher than the planned figure by £10.915m, partly due to £1.4m of PDC funding received for estates capital projects as well as due to proceeds on disposal. The cash operating days, which measure the Trust's ability to meet short-term liabilities, is 85 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 number and 97.8% by value of invoices.

Domain Summary Performance

Data Quality : High Assurance Performance: On track

Prior Year	Key Financial Indicators	YTD Plan	YTD Actuals	YTD Variance	Full Year Plan	Full Year Forecast	Full Year Variance
(951)	Adjusted (Surplus)/Deficit	-	(496)	**(496)**	-	-	**-**
49,922	Closing Cash Balance	47,509	58,424	**(10,915)**	49,387	49,987	**(600)**
10,221	Capital Expenditure (CDEL)	4,918	2,274	**(2,644)**	8,618	8,141	**(477)**
	Quality & Value Programme 26/27						
11,921	Recurrent Savings	3,050	1,179	**1,871**	6,100	4,229	**1,871**
2,079	Non Recurrent Savings	-	1,871	**(1,871)**	-	1,871	**(1,871)**
	Quality & Value Programme 25/26 - Legacy						
	Recurrent Savings	1,230	733	**497**	2,460	3,440	**(980)**
	Non Recurrent Savings		497	**(497)**	-	(980)	**980**
14,000	**Total Savings**	**4,280**	**4,280**	**-**	**8,560**	**8,560**	**-**
	Temporary Staffing						
2,329	Agency	617	865	**248**	1,233	1,656	**423**
5,564	Bank	2,400	2,834	**434**	4,801	5,535	**734**
7,893	**Total Temporary Staffing**	**3,017**	**3,699**	**682**	**6,034**	**7,191**	**1,157**
177,598	**Total Gross staff Costs**	**88,756**	**85,714**	**(3,042)**	**175,526**	**170,665**	**(4,861)**
4.4%	**Temp Staffing Costs as a % of gross staff costs**	**3.4%**	**4.3%**	**0.9%**	**3.4%**	**4.2%**	**0.8%**

Finance & Productivity Domain Summary

Accountable Exec: Andrea Osborne

Quality & Value Programme: As at the end of September 2026, the Trust has delivered £1.912m of recurrent savings against a year-to-date (YTD) target of £4.280m, which includes both the 2026/27 savings programme and legacy CIPs. This represents an improvement of £0.700m from M5. The resulting YTD recurrent savings shortfall has been fully mitigated through the delivery of non-recurrent savings. Several key programmes, including Adult Services staffing reviews, Procurement initiatives and Digital programmes, are expected to deliver significant benefits during the second half of the financial year. In-year recurrent delivery is forecast at £7.669m, with a full year effect of £8.560m meaning full delivery going into 2027/28.

Temporary Staffing: As at the end of September 2026, temporary staffing expenditure is £0.682m above plan year to date and represents 4.3% of gross staff costs, 0.9 percentage points higher than planned. A detailed stocktake and deep-dive review of the temporary staffing position has identified sustained cost pressures and resulted in a revision to the year-end forecast. Consequently, the forecast has moved from a break-even position to an adverse variance of £1.157m against plan. This reflects the use of temporary staffing to maintain safe service delivery and manage vacancies across Neighbourhood Teams, WYOI, Police Custody, 0-19 Services, LES, and hard-to-recruit medical posts within CAMHS and ICAN. Expenditure is expected to reduce as substantive recruitment progresses, with vacancies in Neighbourhood Teams being filled and the West Yorkshire Police Custody Service ceasing.

Data Quality Maturity Index (DQMI) – Overall Score

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

Target: 95% Actual: 98.5% SPC Variation: H SPC Assurance: F Data Quality: High Assurance

What is the trend we see?

In the last report low DQMI scores were reported. These were due to incomplete data in the mental health data set (MHDS) and inclusion of an annual return in the overall score. The data set expected the annual return to be submitted again in April and May, when it was not we scored 0% for those data sets hence the very low scores in those months. The annual return is now not included and the completeness of the MHDS has been improved. As a result, our overall score has significantly improved to 98.5% in July.

June's DQMI score will be used to calculate our Q2 26/27 NOF segment. Our score was 98.7%. This moves us out of segment 4 into segment 1.



What is being done about it?

Further changes to data sets have been approved. This includes increasing the frequency of two commissioning data sets and improving the alignment of our data sets with national guidance. These changes simplify how we process data for the national returns and should help to improve data completeness.

What are the risks to delivery?

Increasing the frequency of two commissioning data sets may decrease our overall score. Action will be taken to ensure that data completeness is at as high a level as possible before the frequency is increased.

When do we expect to see improvement

June 2026 has shown a significant improvement as expected.

Effectiveness & Experience of Care Domain Summary

Accountable Exec: Heather McClelland

NHS Leeds Community Healthcare NHS Trust

Summary

Service users reporting a 'very good' or 'good' experience remains stable this month at 94%. Implementation of standardised feedback will roll out in November, which should improve the quality of reporting.

The number of formal complaints is also consistent with previous months, and we are now able to monitor the number of early resolution concerns raised. A high proportion of all complaints raised are for one service (ICAN).

Compliance with NICE guidance is high, with no areas of significant concern and all except one guidance document either signed off as compliant or still within 2years implementation phase. A small number have been re-assessed following changes to the service and subsequently closed as compliant. The one guideline that is still outstanding is to be discussed at Quality Committee in November.

The Trust has completed 6/8 relevant national audits, with both the others impacted by data submission problems with the auditors. This is a long-standing issue that continues to be monitored.

The clinical audit programme across business units is showing lower than expected activity, although in line with previous years. There is a risk that activity over the last half of the year may be impacted by multiple major change programmes – implementation of neighbourhood model, leadership re-design and Trust integration. This will continue to be monitored.

Sub Domain Summary Performance

Data Quality : **Low Assurance**

Performance: Holding Steady

KPI	Reporting Month	Target	Actual	Performance	Assurance
Number of Compliments	Sep-26		50		
Total Number of Formal Complaints Received	Sep-26	No Target	11		
Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Community Care (FFT)	Sep-26	>=95%	94%		
Number of NICE guidelines with full compliance versus number of guidelines published in the year prior to last financial year applicable to LCH	Sep-26	100% by year end	96%		
Number of NICE guidelines with full compliance versus number of guidelines published last financial year applicable to LCH	Sep-26	No Target	77%		
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 in 2021/22	Sep-26	100% by year end	6%		
Total number of audits completed in quarter	Sep-26	No Target	15		
Hand Hygiene Compliance (Total number of unique audits/total number of staff)	Sep-26	No Target	47%		
Total Number of Hand Hygiene Audits Completed	Sep-26	No Target	1134		

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

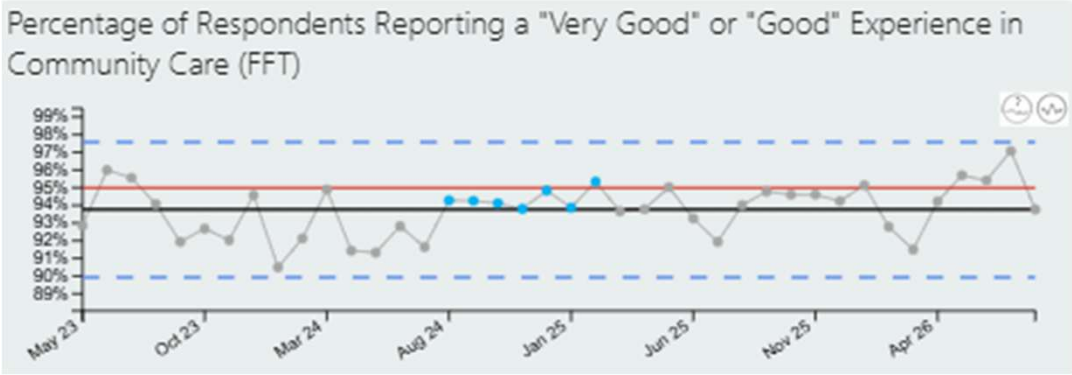
NHS Leeds Community Healthcare NHS Trust

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

Target: 95% | Actual: 94% | 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.



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 continues 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 for Trust wide roll out by 1 November 2026 with data quality improvement by end Quarter 3 2026/7.

What are the risks to delivery?

None currently identified

Total Number of Formal Complaints Received

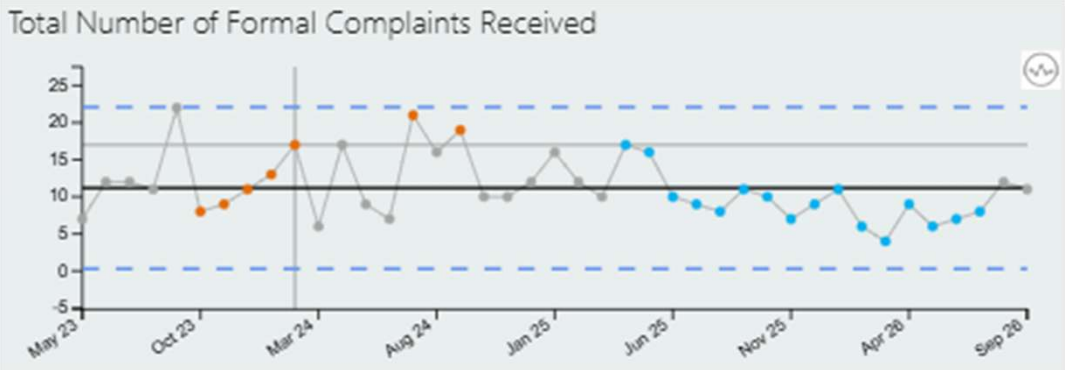
Domain: Effectiveness & Experience of Care | Accountable Exec: Heather McClelland | Author: Karen Otway

Target: N/A | Actual: 11 | SPC Variation: | SPC Assurance: N/A | Data Quality: Low Assurance

What is the trend we see?

There were 23 complaints in the reporting period (12 in Aug, 11 in Sep) in line with usual patterns.

Although not contained within the SPC chart Patient Experience received a further 28 PHSO complaints (8 Closer Look and 20 Early Resolution) which gives a total number of reported complaints in August as 40, compared to 32 in July 2026. This is an increase for the Trust. Interestingly 12 (30%) complaints were regarding ICAN services in August 2026.



What is being done about it?

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.

Current work is ongoing to map LCH and LYPFT complaints policies/processes to ensure all align.

The roll out the " Early Resolution First" process across the whole Trust will begin once the mapping with LYPFT is complete. This is anticipated to begin in Q4 2026/27.

When do we expect to see improvement?

By the end of Q4 2026/27.

What are the risks to delivery?

No new anticipated risks identified in month.

Number of Compliments

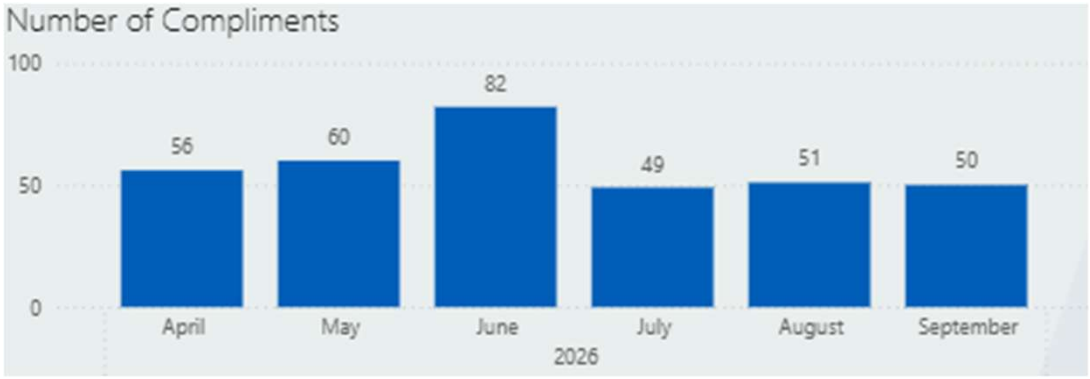
Domain: Effectiveness & Experience of Care | Accountable Exec: Heather McClelland | Author: Helen Rowland

Target: No Target | Actual: 50 | SPC Variation: N/A | SPC Assurance: N/A | Data Quality: High Assurance

What is the trend we see?

The number of compliments received in August and September remain around 50 per month. This is slightly below the beginning of the financial year (April 2026) and below the mean level for reporting, but is representative of the usual levels.

Following conversations with services there is no apparent reason for this reduction, but it is noted that in the first half of October 2026 compliments are higher .



What is being done about it?

Services continue to be encouraged to report compliments.

As previous described 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.

When do we expect to see improvement?

Within the next 12 month reporting period.

What are the risks to delivery?

No new anticipated risks identified in month.

Total Number of Audits Completed in a Quarter

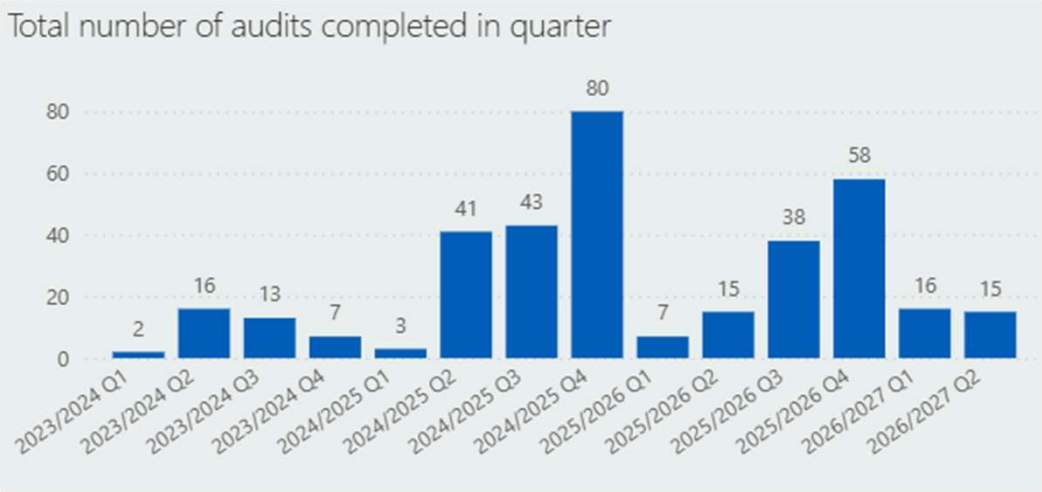
Leeds Community Healthcare NHS Trust

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

Target: No Target | Actual: 15 | SPC Variation: N/A | SPC Assurance: N/A | Data Quality: **High Assurance**

What is the trend we see?

Audit activity remains relatively low in the first half of 2026/27, with 16 audits completed in Quarter 1 and 15 in Quarter 2. This follows a pattern seen in previous years, where services typically undertake a greater proportion of planned audit activity during the second half of the financial year. Whilst this position is consistent with historical trends, continued monitoring will be required to ensure sufficient progress is made against the annual clinical audit programme.



What is being done about it?

The Clinical Effectiveness and Compliance Team continues to monitor delivery of the clinical audit programme through quarterly reporting and engagement with services. Services are supported to develop and maintain audit plans, with progress reviewed through established governance arrangements. Areas where audit activity is not progressing as expected are highlighted to operational and clinical leadership teams to support delivery. The revised reporting arrangements continue to provide improved visibility and oversight of audit activity across the Trust.

When do we expect to see improvement?

Based on previous years, an increase in audit completion is expected during Quarters 3 and 4 as services progress planned audit activity. Audit performance will continue to be monitored through quarterly reporting to ensure sufficient progress is being made against the annual programme.

What are the risks to delivery?

Whilst the current position is consistent with previous years, there is a risk that planned audit activity may not accelerate as expected during the second half of the year. Organisational changes, including leadership restructuring, may result in changes to service oversight, reduced organisational knowledge and competing priorities as leaders transition into new roles. In addition, work associated with organisational integration may impact capacity and focus for audit activity, increasing the risk that audits are delayed or not completed within planned timescales. Continued oversight will be required to maintain momentum and ensure delivery of the clinical audit programme.

Priority 2 Audits: Number Completed Year to Date Versus Number Expected To Be Completed

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

Target: No Target | Actual: 6% | SPC Variation: N/A | SPC Assurance: N/A | Data Quality: **High Assurance**

What is the trend we see?

Performance remains below previous years, with 6% of planned Priority 2 audits completed by Quarter 2. This compares unfavourably with the same period in recent years, where completion rates ranged from 10% to 35% by Quarter 2. Whilst audit activity has historically increased during the second half of the year, progress to date suggests delivery is slower than expected and will require a significant increase in activity to achieve the planned programme.



What is being done about it?

Delivery of the Priority 2 audit programme continues to be monitored through quarterly reporting and engagement with services. Progress is reviewed through governance arrangements, with operational and clinical leaders supported to identify barriers to delivery and maintain focus on completion of planned audits. Audit plans will continue to be monitored to ensure activity remains on track and any slippage is identified early.

When do we expect to see improvement

Based on previous years, an increase in audit activity is anticipated during Quarters 3 and 4. However, a greater rate of improvement than seen to date will be required if audit completion is to align with previous years and planned expectations for 2026/27.

What are the risks to delivery?

There is a risk that Priority 2 audits are not completed within planned timescales if delivery does not accelerate during the second half of the year. Leadership restructure may result in reduced organisational knowledge and oversight, with new leaders prioritising operational pressures whilst settling into posts. In addition, work associated with organisational integration may reduce capacity for audit activity and result in the clinical audit programme receiving less priority. If momentum is not maintained, there is a risk that planned assurance and improvement activity is delayed or not completed by year end.

NCAPOP Audits: Number Started YTD Versus Number Applicable to LCH

Leeds Community Healthcare NHS Trust

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

Target: No Target | Actual: 75% | SPC Variation: N/A | SPC Assurance: N/A | Data Quality: **High Assurance**

What is the trend we see?

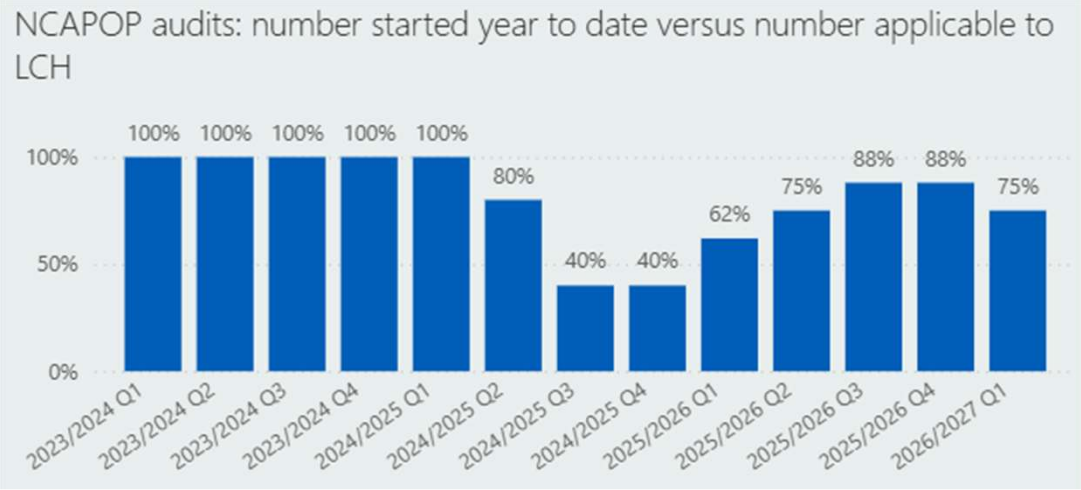
Six of the eight applicable NCAPOP audits have commenced, representing 75% of the programme year to date. This is lower than the position at the same point in some previous years; however, the two outstanding audits have not commenced due to ongoing national challenges associated with uploading community datasets. This issue is not specific to LCH and has been recognised by the relevant national audit programmes.

What is being done about it?

The Clinical Effectiveness and Compliance Team continues to work with services to support participation in national audits. The position of the two outstanding audits is being monitored through established governance arrangements, and liaison continues with national audit teams regarding the dataset upload issues. Further detail is provided within the Quality Committee six-monthly clinical audit report.

When do we expect to see improvement

Progress is expected once the national dataset upload issues have been resolved and participation can commence in the remaining applicable audits. In the meantime, the six audits currently in progress continue to be supported and monitored through routine governance processes.



What are the risks to delivery?

There is a risk that participation in the two outstanding audits may be delayed if the national issues relating to community dataset uploads remain unresolved. As these issues are external to the Trust and affect community providers more broadly, the risk to delivery is largely dependent on national resolution. Ongoing monitoring through governance arrangements will ensure any further implications are identified and escalated appropriately.

Number of NICE Guidelines with Full Compliance versus Number of Guidelines Published in the Year Prior to Last Financial Year Applicable to LCH

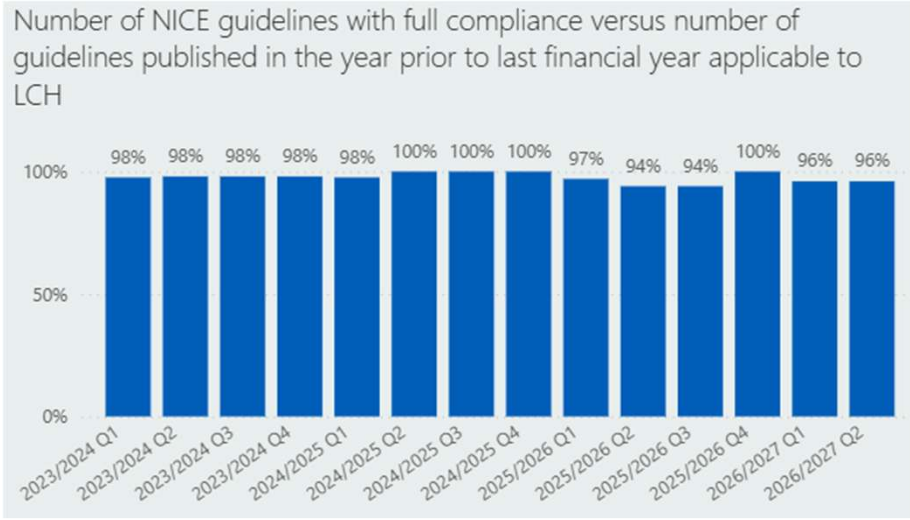
Leeds Community Healthcare NHS Trust

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

Target: No Target | Actual: 96% | SPC Variation: N/A | SPC Assurance: N/A | Data Quality: **High Assurance**

What is the trend we see?

Compliance with applicable NICE guidance remains high at 96%, consistent with performance seen in previous quarters and years. The measure has remained stable, generally achieving between 94% and 100% compliance, demonstrating sustained implementation of NICE guidance across the organisation. The current position provides assurance that applicable guidance is being reviewed and embedded within service delivery.



What is being done about it?

New and updated NICE guidance continues to be reviewed through established clinical effectiveness processes. Services are supported to complete assessments of applicability and compliance, with any actions required to achieve compliance monitored through local governance arrangements. Progress continues to be overseen by the Clinical Effectiveness and Compliance Team.

When do we expect to see improvement

The current level of performance is high and improvement opportunities are likely to be incremental. Compliance is expected to remain consistently above 90% as new NICE guidance is reviewed and implemented throughout the year.

What are the risks to delivery?

There are currently no significant risks identified to delivery. However, organisational changes, competing priorities and service capacity pressures may impact the timely review and implementation of newly published guidance. Ongoing oversight through established governance processes will help ensure compliance levels are maintained and any emerging risks are identified early.

Number of NICE Guidelines with Full Compliance Versus Number of Guidelines Published Last Financial Year Applicable to LCH

Leeds Community Healthcare NHS Trust

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

Target: No Target | Actual: 77% | SPC Variation: N/A | SPC Assurance: N/A | Data Quality: **High Assurance**

What is the trend we see?

Compliance has reduced to 77% in Quarter 2. However, this position has been influenced by the addition of four NICE guidance reviews associated with new pathway development within LeMURS. The inclusion of these reviews within the monitoring process demonstrates that NICE guidance is being actively considered as part of service development and pathway redesign. Whilst the measure has reduced, this reflects an increase in guidance under review rather than identified non-compliance.

What is being done about it?

NICE guidance associated with new pathway development is being reviewed through established clinical effectiveness processes. Services are supported to assess applicability and compliance, with any required actions monitored through local governance arrangements. The inclusion of guidance within the review process provides assurance that evidence-based practice is being considered during pathway development.

When do we expect to see improvement

Improvement is expected as the outstanding reviews are completed and compliance assessments are finalised. Progress will continue to be monitored through routine governance processes, with compliance levels expected to increase as pathway development work progresses.



What are the risks to delivery?

There are no significant concerns regarding compliance at this stage. However, delays in completing pathway development or associated NICE reviews may prolong the time taken to confirm full compliance. Organisational change and competing priorities could also impact the timely completion of reviews. Continued oversight will help ensure assessments are completed and actions progressed where required.

Hand Hygiene Compliance and Audits

Leeds Community Healthcare NHS Trust

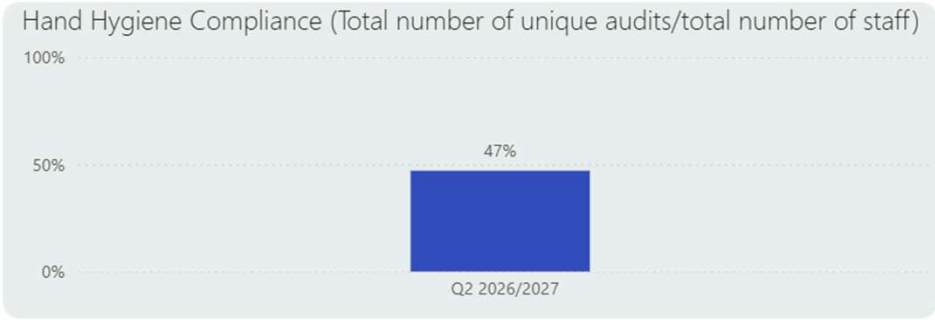
Domain: Patient Safety | Accountable Exec: Heather McClelland | Author: Rachael Ainley

Target: No Target | Actual: 47% and 1134 | Data Quality: **High Assurance**

What is the trend we see.

The data shows that in Q2 1134 hand hygiene audits were completed. This represents a completion rate of 47%. SBU achieved the highest submission rate at 50%, followed by ABU at 49% and CBU at 43%. The SBU and ABU submission rate was reduced from the previous quarter, whereas CBU increased their submission rate.

The audit is a quiz that each staff member is expected to complete each quarter. CBU's average score has improved significantly from 61% to 84%, whereas ABU have had a slight increase from 71% to 74% & SBU from 71% to 72%



What is being done about it?

The IPC team will explore potential reasons for the reduction in returns and work with colleagues within the BUs to provide appropriate support and encourage increased participation in future audit cycles.

From further analysis of the data the IPC team have identifies that staff members may be recording activity under other team names or service areas. Further investigation will be required to validate the data and determine the extent to which this may be influencing the reported scores.



When do we expect to see improvement.

Progress will continue to be monitored through the regular audit cycle, to ensure compliance levels remain satisfactory. Targeted work will continue in areas where compliance falls below the organisational standard.

What are the risks to delivery?

Competing demands for service delivery within teams experiencing other significant organisational changes. IPC will continue to review the hand hygiene audit process to ensure it remains effective and provides ongoing assurance of compliance with best practice. This will involve the team liaising closely with clinical team leads so that organisational changes can be reflected in the audit data.

Improving Health & Reducing Inequalities Domain Summary

Accountable Exec: Ruth Burnett

NHS Leeds Community Healthcare NHS Trust

Summary

In previous reports, odds ratios have been used to show the difference in average length of wait. This report now uses the Health Equity Index (HEI) to assess variation in data across population groups. This works by identifying the group with the best outcome and comparing average differences across groups. Statistical significance is embedded within the calculation so is more accurate in providing evidence of inequity. A score of 0 on the Health Equity Index indicates no evidence of inequity, a score of 1 indicates extreme inequity. Between 0 and 1 a higher score indicates greater inequity. There is no "acceptable" level of inequity, and higher scores indicate that further work is required to understand the drivers and the solutions. The Health Equity Index can be mapped over time, and the trend of the index (whether we are improving or getting worse) is important to note. Further background information and guidance on interpreting the HEI is available from lcht.healthequity@nhs.net

In this first report using the Health Equity Index, summary HEI scores have been provided for deprivation and ethnicity to show progress over time in addressing inequity across 3 measures:

- Patients waiting more than 18 weeks (HEI score trend over time 0.18)
- Patients waiting more than 52 weeks (HEI score trend over time 0.43)
- Missed appointments (HEI score trend over time 0.35)

From this we can see a reduction in inequity in the first 6 months of 2025-6 for waits over 18 weeks and 52 weeks, but inequity is consistently higher in longer waits over 52 weeks. There has been less improvement in inequity in missed appointments, which has a static HEI score of around 0.35.

Domain Summary Performance

Data Quality : **Medium Assurance**

Performance: **On Track**

KPI	Reporting Month	Target	Actual	Performance	Assurance
Percentage of open records with blank or null codes for ethnicity	Sep-26		1%		
Percentage of open records with residual ethnicity codes	Sep-26		2%		
Percentage of open records with a valid, non-residual ethnicity code	Sep-26		97%		
Missed appointments Health Equity Index (Ethnicity, IMD)	Sep-26		0.53		
Patients waiting more than 18 weeks Health Equity Index (Ethnicity, IMD)	Sep-26		0.25		
Patients waiting more than 52 weeks Health Equity Index (Ethnicity, IMD)	Sep-26		0.61		

Health Equity Index – 18 weeks and 52 weeks (Ethnicity, IMD)

Leeds Community Healthcare NHS Trust

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

Target: 0 (tbc) Actual: 0.18 & 0.43 SPC Variation: SPC Assurance: N/A Data Quality: High Assurance

What is the trend we see?

The HEI score for waiting times over 18 weeks is 0.18. This is positive score (0 being no inequality). For waiting times over 52 weeks, the HEI score is 0.43, indicating greater inequity in longer waits. In both 18 and 52 week waits, the inequality is arising particularly around differences in length of wait between ethnic groups.

What is being done about it?

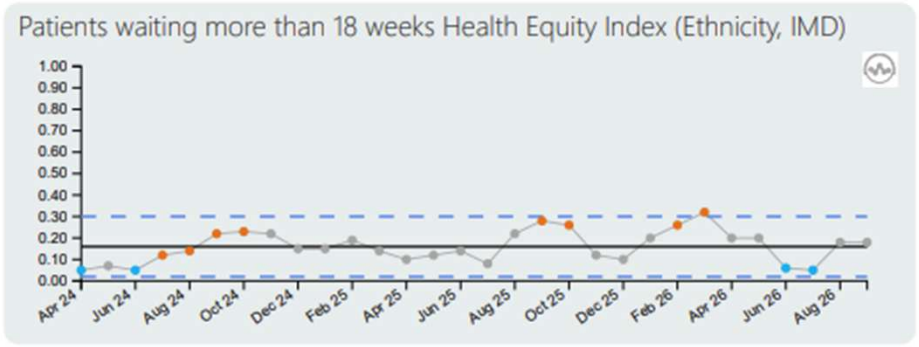
As the HEI score is calculated across multiple characteristics, further analysis is being undertaken to understand whether this inequity is being driven more in one demographic (deprivation or ethnicity) or service area.

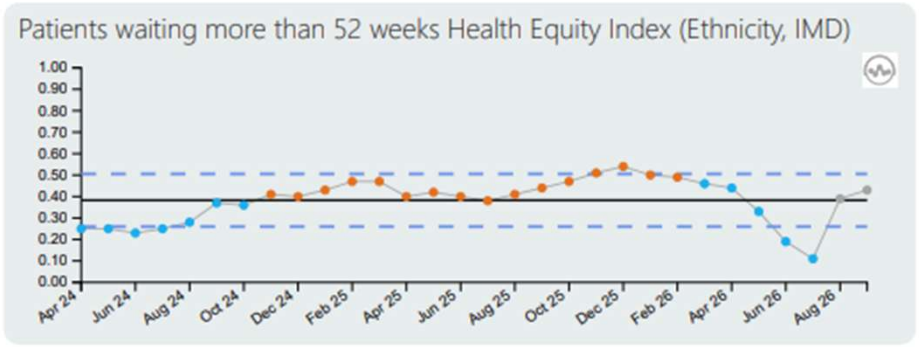
Improvement action will be targeted to those longest waits, where the HEI score shows greater inequity. This includes the roll-out of About Me to gather information about patient communication and other accessibility needs that can support engagement during waiting times, access when there is risk of deterioration and attendance at appointments. The November Access LCH meeting will include an update on the delivery of service improvement actions to reduce inequity in waiting times.

When do we expect to see improvement

About Me roll-out to new referrals continues from end October and recruitment to support completion of About Me for all existing referrals is underway. The availability of communication and other accessibility needs will increase immediately.

The timescale for implementing additional changes to reduce inequity in longest waits will depend on the findings of the review being undertaken in November. Smaller, individual actions are expected to start to have an impact by Q4, but the implementation of larger scale actions may be affected by other significant changes in the trust.





What are the risks to delivery?

Competing demands for service and admin leadership and in teams experiencing other significant changes risks capacity for implementing targeted improvements. These risks are mitigated by embedding equity considerations into the governance of these trust priorities (waiting times, productivity) and the equity team providing direct support to services where inequity is greatest.

Missed Appointments by Health Equity Index (Ethnicity, IMD)

Leeds Community Healthcare NHS Trust

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

Target: 0 (tbc) Actual: 0.35 SPC Variation: SPC Assurance: N/A Data Quality: High Assurance

What is the trend we see?

The HEI score for missed appointments in 0.35. This has been broadly static over the last 2 years, indicating that work to reduce missed appointments overall has not yet made an improvement to the inequity in missed appointments. The data shows inequality related to IMD is significant, with higher rates of missed appointments the lower the IMD.

What is being done about it?

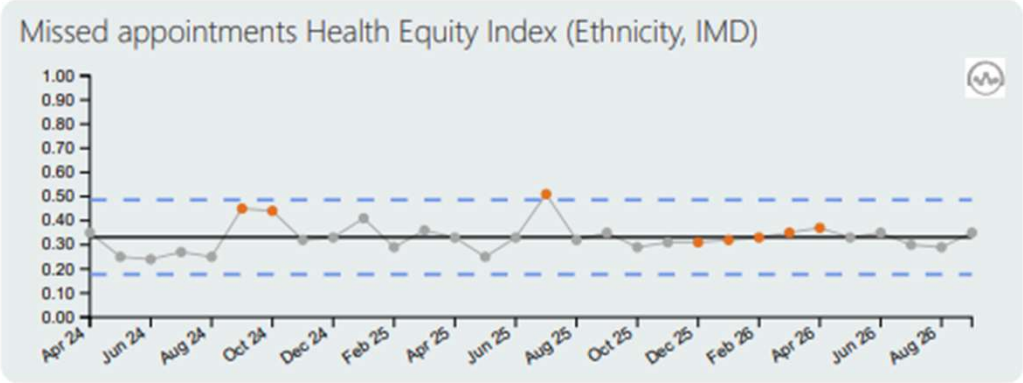
In addition to ongoing work through Access LCH to reduce inequity in waiting lists by supporting attendance at first appointments, we have now started a new programme of focussed work to:

- review missed appointment data to identify trends, outliers and differences between missed first and missed follow-up appointments
- engage with services, patients and community groups to find out what's already happening and what support is needed to make improvements
- use national and local evidence to develop a menu of change ideas that services can select from, as suits their patient cohort, the way they run their service etc
- provide more direct support to a small number of services to test improvements

Ongoing improvement work around access to interpreting and culturally appropriate care is also expected to contribute to improvements in access and experience for racialised communities, which may also contribute to a reduction in inequity in missed appointments.

When do we expect to see improvement

The timescale for implementing changes to reduce inequity in waiting times will depend on the review of data and results of engagement. Smaller, individual actions may start to have an impact in Q4, but the implementation of larger scale actions will continue into next year.



What are the risks to delivery?

Competing demands for service and admin leadership and in teams experiencing other significant changes risks capacity for implementing targeted improvements. These risks are mitigated by embedding equity considerations into the governance of these trust priorities (waiting times, productivity) and the equity team providing direct support to services where inequity is greatest.

Patient Safety Domain Summary

Accountable Exec: Heather McClelland

NHS Leeds Community Healthcare NHS Trust

Summary

Three Patient Safety Investigations were closed in the last month, with delays seen in completion of investigations within allocated timescales. This is due to a mixture of investigator dedicated time, delays in receiving information from partners and absence.

The number of PSII actions overdue is consistent with recent months. Work is ongoing with action owners to update and/or request an extension where further work is needed. The notification process for action owners has been updated to improve timeliness of response.

CAS alerts are now fully actioned or risks to the Trust documented on the Risk Register.

Compliance with statutory Duty of Candour is good, with further actions in place to reduce time between incident and rapid review, where DOC decisions are made.

Domain Summary Performance

Data Quality : **Medium Assurance**

Performance: **Off Track**

KPI	Reporting Month	Target	Actual	Performance	Assurance
Number of overdue PSII actions	Sep-26	No Target	17		
Number of Patient Safety Incident Investigations (PSII)	Sep-26	No Target	3		
Never Event Incidence**	Sep-26	0	0%		
CAS Alerts Outstanding**	Sep-26	0	0		
Compliance in Level 1 and 2 Patient Safety Training	Sep-26	TBC	91%		
Compliance with statutory Duty of Candour	Sep-26	TBC	1		
Attributed MRSA Bacteraemia - infection rate**	Aug-26	0	0		
Clostridium Difficule - infection rate**	Aug-26	3	0		
Percentage of teams who have completed a Medicines Code Assurance Check (MCAC) in the previous 24 months (rolling figure)	Aug-26	100% by year end	100%		

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?

Three Patient Safety Incident Investigations were concluded and approved by an Executive Director in August/September 2026. Whilst investigation activity has continued and cases have been progressed to completion; all three investigations exceeded their original planned completion timescales and 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 9 (Moderate). The changes as part of the leadership review may further impact upon investigator capacity and will be monitored via this risk.

The PSII extension process is now embedded to strengthen oversight and ensure delays are identified, escalated and approved before completion dates are exceeded.

Early learning and actions continue to be identified through Rapid Review Meetings to support timely patient safety improvements despite delays in report completion.

Recruitment to a Deputy Patient Safety Manager post to strengthen PSII oversight and overall team capacity has been successful and is in the process of onboarding however this has led to a gap in the Patient Safety Clinical Coordinator role which is now out to advert.

External training for Lead Investigators is being commissioned jointly with LYPFT to ensure all identified investigators have received the necessary training in line with the Patient Safety Incident Response Framework Standards to widen the pool of those who can be allocated a PSII, however the number awaiting this training is low. On review completed by the Patient Safety Manager LCH have enough Lead Investigators identified to meet the demand of allocation it is the time available to complete the PSII once allocated which is the ongoing issue.

When do we expect to see improvement

A review of Lead Investigator roles is needed and should be considered as part of the merger to understand whether sufficient time is built into existing roles of PSII Lead Investigators 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 and continue to take longer than six months which exceeds the timescale for completion of PSII outlined in the NHS England Guide to responding proportionately to patient safety incidents.

Number of Overdue PSII Actions

Leeds Community Healthcare NHS Trust

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

Target: No Target | Actual: 17 | Data Quality: High Assurance

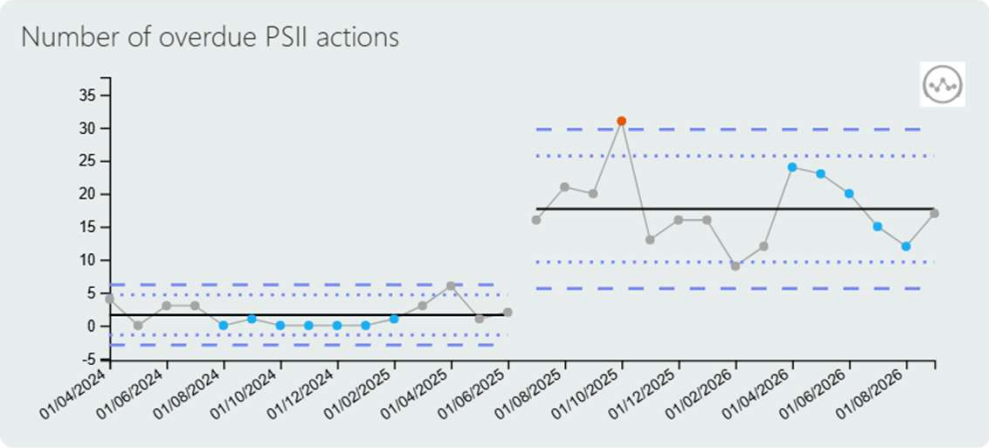
What is the trend we see?

There are currently 16 overdue PSII actions in the incident reporting system as one has been closed since the data was provided. This is an increase from the last report and the performance remains outside of the expected standard of zero overdue actions.

Overdue actions are distributed across business units with Corporate (8), Adult (3) and Specialist (5). Several actions are significantly overdue , with completion dates ranging from March 2025 to September 2026, indicating that some longstanding actions remain unresolved.

On review for this report the current position of the actions are:

- Seven an extension has been requested
- Five have been completed and are awaiting the evidence to be uploaded for assurance of completion
- Four the action owner/service are aware of the actions and are required to update and close/request extension



What is being done about it?

The Patient Safety Team continues to notify 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.

A review of the overdue actions for this report has identified that the process is being followed however not until the action becomes overdue indicating a reactive rather than proactive approach to PSII action management. A review of the extension document has identified that the use of the word "overdue" in the title is misleading so has been removed to avoid any confusion. The updated version has been shared with Clinical Leads and Quality Assurance Leads alongside a listing report for the overdue actions in this report.

When do we expect to see improvement

Improvement is expected over the next 3-4 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 Patient Safety Incident Investigation (PSII) and Patient Safety Learning Response (PSLR) actions process is not adhered to.

CAS Alerts Outstanding

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

Target: 0 | Actual: 0 | Data Quality: **High Assurance**

What is the trend we see

There are currently no outstanding CAS Alerts relating to Medical Devices.
Since the last QAIG meeting, the risk concerning bed rails, grab handles, and bed sticks has been resolved. The matter now sits more appropriately on the Risk Register, where the remaining actions are being progressed as deemed appropriate.



What is being done about it?

What are the risks to delivery?

When do we expect to see improvement

Workforce Total Sickness Absence rate (Monthly) (%)

Leeds Community Healthcare NHS Trust

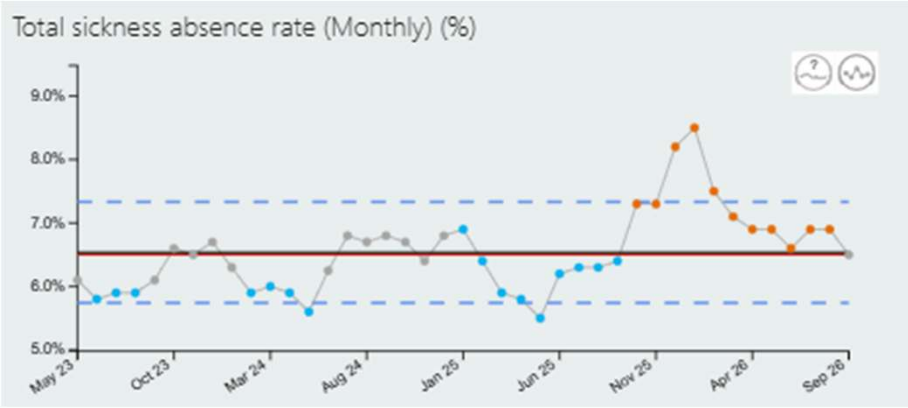
Domain: People & Workforce | Accountable Exec: Laura Smith and Jenny Allen | Author: Katie Wilson

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

What is the trend we see?

In the early months of 2026, the monthly sickness absence rate reached significantly above the target of 8.5%, severely breaching the established Upper Control Limit of 7.3% and signalling a critical disruption to workforce availability.

Following this peak, the data demonstrates a sustained and positive recovery trajectory through the spring and summer months. Sickness rates saw an initial sharp decline by April 2026 before entering a stable plateau around 6.9% mid-year; ultimately, by September 2026, the rate corrected itself entirely, dropping back down to align with the target of 6.5%.



What is being done about it?

Targeted Intervention: Monthly Compass meetings attended by the People Partners track absence trends to provide focused support to areas with high short- and long-term sickness rates, with tailored targeted intervention dependent on data trends. Close working with operational colleagues on these interventions.

Manager Support: Active initiatives like the "Managing Absence with Confidence" program delivered by People Partners remains well attended throughout the Trust and continues to receive positive engagement and feedback from attendees. People Partners closely aligned to services, meeting frequently with service managers to provide sickness workshops to track case work. Alongside the People Advisors who continue to attend formal absence meetings and progress cases in line with the Wellbeing at Work Policy and Toolkit.

Tracking Trends; Workforce data and reporting help pinpoint why and where sickness absences are high or have sudden spikes across services and underlying factors driving sickness .

When do we expect to see improvement

Based on historic data, previous years show that September usually represents the lowest rates before absences increase as we anticipate a seasonal rise in sickness starting in November.

Given the proactive management and early intervention steps designed to support managers through the transition period we anticipate this will prevent a repeat of the early 2026 sickness spike.

What are the risks to delivery?

Whilst sickness rates have decreased and continue to show a downward trend inline with target, there are concerns that the ongoing Leadership review and the organisational transfer to LYPFT could negatively impact sickness levels moving forward. Transitions of this scale naturally create uncertainty, which can increase staff stress and anxiety. Because absences are already affected by service pressures, workforce capacity, and management challenges, we must maintain an ongoing focus and provide targeted support to keep up this progress and prevent another spike in sickness during the changeover period. Work continues to proactively support managers and staff through organisational change.

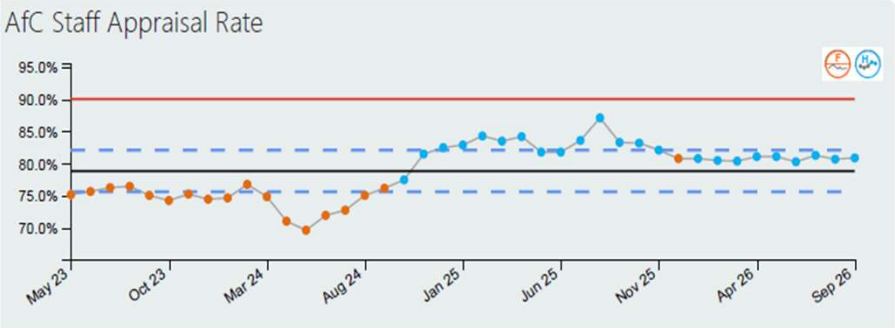
AfC Staff Appraisal Rate

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

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

What is the trend we see?

The anticipated post-summer increase in compliance has not been realised, with performance remaining broadly unchanged since August 2025. Despite this, compliance continues to outperform comparable periods in the previous two years, suggesting that earlier gains have been largely sustained. Actions are being reviewed to understand barriers to further improvement and support progress towards target levels.



What is being done about it?

There has been no significant change in approach since the previous update. Appraisal compliance continues to be monitored through Performance Panels, with support and challenge provided to services with lower levels of compliance. Although compliance remains above historical levels, performance has stabilised in recent months.

When do we expect to see improvement

Although appraisal compliance remains significantly higher than historical levels, progress has levelled off in recent months. Ongoing scrutiny through Performance Panels is helping to maintain performance, but it is not currently possible to confidently forecast further improvement

What are the risks to delivery?

Performance has plateaued
Appraisal compliance has remained broadly unchanged in recent months. Without additional interventions, further improvement may be difficult to achieve.

Competing organisational priorities
Operational pressures, workforce initiatives and wider transformation activity may limit capacity to focus on appraisal completion.

Managerial capacity and workload
Managers with large teams and competing demands may find it challenging to prioritise appraisals within expected timescales.

Staff Survey Results

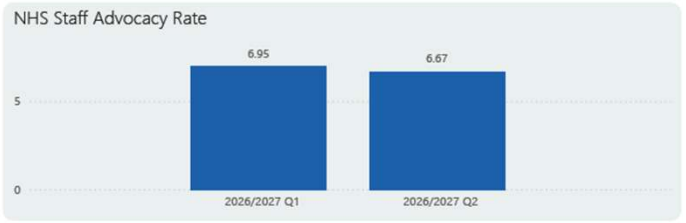
Domain: People & Workforce | Accountable Exec: Jenny Allen and Laura Smith | Author: Catherine Hall

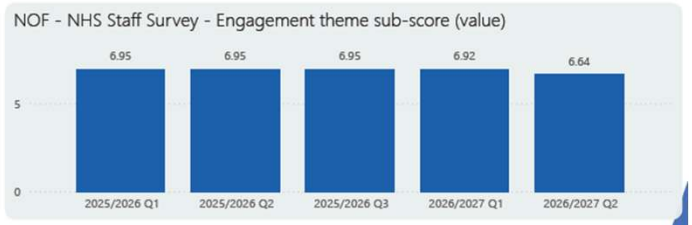
Target: No Target | Actual: 6.67 6.64 and 7.97 | Data Quality: **Medium Assurance**

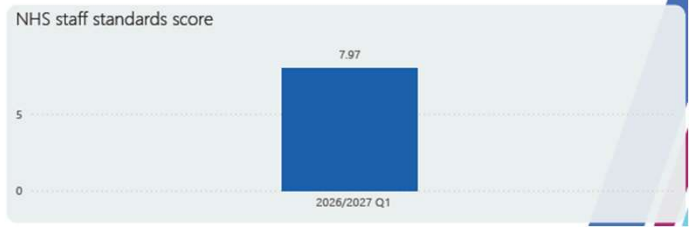
What is the trend we see?

The Staff Advocacy Rate and Engagement Theme Score have declined slightly in the most recent quarter, with the Engagement Score having been generally stable until this point. The Staff Standards Score was only introduced in July 2026, so there is insufficient data to determine a trend.

The organisation is currently undergoing significant change so a slight decline in these measures is not unexpected. Most of these indicators are drawn from the quarterly Pulse Survey which has a lower participation rate than the Annual Staff Survey and is therefore less reliable as a measure of overall colleague experience. The Annual Staff Survey, is currently underway with results due in January 2027 and will provide a more robust indicator of colleagues' experience at work.







What is being done about it?

We are currently three weeks into the Annual NHS Staff Survey with 29.3% of staff having participated, compared with 29.9% at the same point last year. The survey remains open for a further five weeks.

A range of actions are in place to encourage participation, including weekly updates to General Managers, executive messages at key points, Thursday newsletter bulletins, regular engagement with Staff Network Leads, campaign communications and targeted support for teams with lower response rates.

Earlier this year, managers across all teams and services developed intention plans, identifying areas of success and opportunities for improvement. Ahead of this year's survey launch, teams nominated for delivering the greatest improvements against their intention plans were recognised and celebrated across each business unit.

When do we expect to see improvement?

Given the scale of organisational change and the forthcoming merger, maintaining current Staff Survey and Engagement Theme Scores would represent a positive outcome. Many colleagues are experiencing uncertainty and increased workloads which can naturally impact engagement and staff experience measures.

As the organisation moves through the merger and colleagues settle into new teams, roles and ways of working we would expect to see Engagement Theme Scores to improve. By summer 2027, once the new organisation is more established and change has become embedded, we would anticipate seeing a strengthening of engagement and overall colleague experience.

What are the risks to delivery?

One key risk which could affect our ability to improve these scores would be increased disruption from organisational change being prolonged, delayed or affecting more staff.

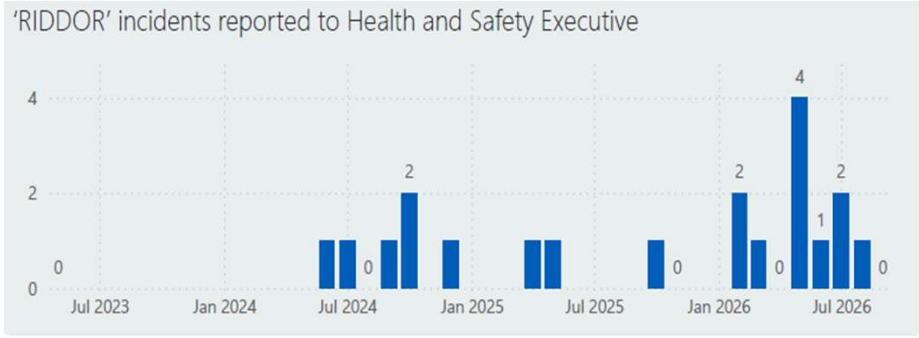
‘RIDDOR’ Incidents Reported to Health and Safety Executive

Leeds Community Healthcare NHS Trust

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

Target: 0 | Actual: 1, 0 | Data Quality: **Medium Assurance**

A staff member sustained a serious crush injury to their left ring finger while undertaking work duties within the Police Custody Suite. The staff member was travelling via the property store into the custody booking-in area when their finger became trapped between a frequently used internal door and the door frame as the door closed.



What is being done about it?

Immediate first aid was provided, followed by hospital treatment; however, due to the severity of the injury and subsequent necrosis, surgical amputation of the fingertip (distal phalanx) was required.

What are the risks to delivery?

Not applicable

When do we expect to see improvement

The investigation identified that the door closer had failed due to loss of oil pressure, causing the door to close with excessive speed and force. Following the incident, the defective door closer was replaced.

Digital Key Performance Indicators (KPIs) – Summary September 2026

NHS Leeds Community Healthcare NHS Trust

Summary

- This Digital KPI report is still in development as targets and measures are being 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 Subject Access (SAR) and Freedom of Information (FOI) are subject to further development. FOI performance is seeing a decrease in overdue responses, whereas SARs have seen a slight increase in overdue responses
- 100% of cyber alerts have been acknowledged within the NHSE 48-hour requirement and resolved within 14 days of acknowledgement.
- Patching performance remains positive
- Performance around incident detection and response times are impacted by the availability of internal resource.
- IT service desk performance has remained strong with respect to call volumes and time taken to answer and has remained in line with seasonal demand over the summer period, although there has been a rise in calls abandoned
- The spike in the response effort for P2 incidents during August was a "false positive" alert, triggered by a penetration test.

Domain	Metric	Jul-26			Aug-26			Sep-26			Comment
		Value	Target	RAG	Value	Target	RAG	Value	Target	RAG	
Cyber Alerts	Acknowledged within 48 hours	100%	100%	G	100%	100%	G	100%	100%	G	National Target
	Remediated within 14 days	100	100%	G	-	100%	G	-	100%	G	National Target
SIEM	Mean time to detect incidents P2	24secs	21 secs	A	55 secs	21 secs	A	34 secs	29 Secs	A	Local target calculated as average of last 3 months
	Mean time to detect incidents P3		46 secs	A	-	46 secs		-	46 secs		
	Mean time to resolve incidents P2	32 mins	< 4hrs	G	2 hrs	< 4hrs	G	1.5hrs	< 4hrs	G	Local target based on common SLA standard, P 2 resolved < 4 hours
	Mean Time to resolve incidents P3	-	<24 hrs		<24 hrs	-		-	<24 hrs		Local Target based on common SLA standard, P3 <24 hours
	Response Effort for Incidents P2	40 hrs	40 hrs	G	80 hrs	40 hrs	R	53 hrs	40 hrs	A	Local Target calculated as average of last three months
	Response Effort for incidents P3		7 hrs		-	-		-			Local Target
Service Desk	Calls Answered	89.30%	>=85%	G	90.80%	>=85%	G	89.30%	>=85%	G	ITIL Standard
	Average Answer Time	1.18 mins	2 mins	G	1.17 mins	2 mins	G	2.22 mins	2 mins	A	ITIL Standard
	Abandonment	10.70%	<= 5%	A	6.50%	<= 5%	A	13.40%	<= 5%	A	Local Standard
SAR Performance	Late – not within 1 calendar month										National Target
FOI Performance	Late > 20 working days										National target

Cyber Alerts

Leeds Community Healthcare NHS Trust

Domain: Digital | Accountable Exec: Andrea Osborne | Author: Richard Slough

Target: Respond 48hrs; Remediate 14days Actual: G | SPC Variation: N/A | SPC Assurance: N/A | Data Quality: High Assurance

What is the trend we see?

Between August and October 2026, six high-severity cybersecurity alerts were reviewed, covering vulnerabilities affecting Citrix NetScaler, SonicWall SMA1000, and Check Point appliances. The alerts related to active exploitation (cyber attackers are currently using vulnerabilities to target victims) , zero-day vulnerabilities (malicious actors are using previously unknown vulnerabilities to launch attacks before the vendor can release a fix) , and critical remote code execution (cyber-security vulnerability that allows an attacker to run malicious code or commands on a target device or network from a remote location without physical access). Following assessment, all alerts were determined to be not applicable to the organisation's environment, and no remediation actions were required.

DATE ISSUED	SOLUTION	DESCRIPTION	ALERT STATUS
17/08/2026	NetScaler	Active Exploitation of Citrix NetScaler AC and NetScaler gateway Vulnerability	Not Applicable
02/09/2026	Soniciwall	Exploitation of Zero-Day Vulnerabilities in SonicWall SMA1000 Series Appliances	Not Applicable
10/09/2026	NetScaler	Active Exploitation of Citrix NetScaler AC and NetScaler gateway Vulnerability	Not Applicable
22/09/2026	CheckPoint	Exploitation of Vulnerabilities affecting CheckPoint Appliances	Not Applicable
28/09/2026	NetScaler	Exploitation of Zero-Day Vulnerabilities affecting Cirix Netscaler	Not Applicable
09/10/2026	NetScaler	Critical Remote Code Execution Vulnerability in Citrix NetScaler	Not Applicable

What is being done about it?

Continuous monitoring remains in place to identify any changes in risk or applicability

When do we expect to see improvement?

The Trust routinely meets expected performance targets of responding to cyber alerts within 48 hours of notification and remediation within 14 days.

What are the risks to delivery?

The process relies on a small number of IT / Cyber staff to monitor and respond to High Severity Alerts; this dependency creates a risk in times of staff absence.

Mean Time to Detect Incidents

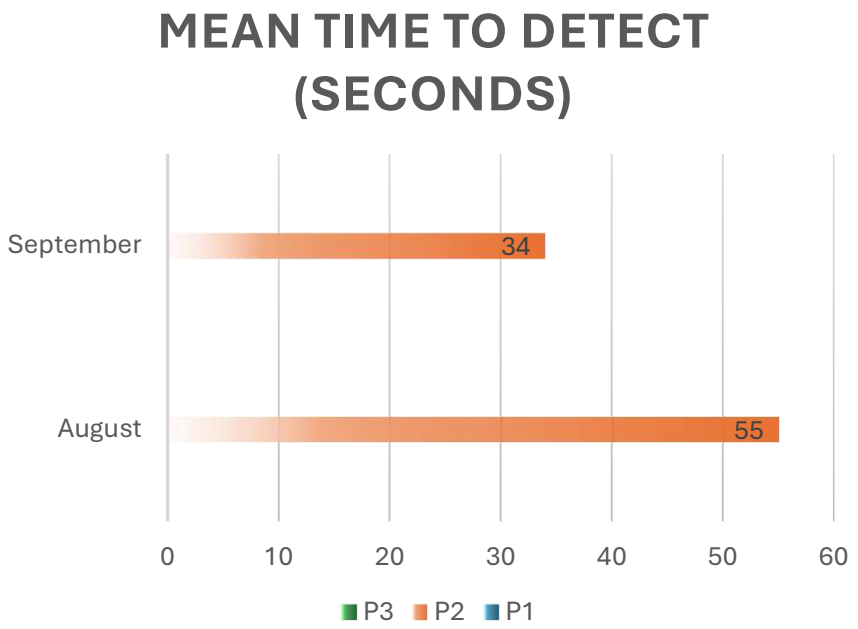
Leeds Community Healthcare NHS Trust

Domain: Digital | Accountable Exec: Andrea Osborne | Author: Richard Slough

Target: 21seconds (local target) | Actual: A | SPC Variation: N/A | SPC Assurance: N/A | Data Quality: High Assurance

What is the trend we see?

The three months to August have seen increases in detection times, rising from 11 to 55 seconds, followed by a fall in September, which is close to the target value of 29 seconds.



What is being done about it?

The detection time is being monitored

When do we expect to see improvement?

There is a continuous process of review.

What are the risks to delivery?

Whilst detections occur automatically through the SIEM, the analysis of the threat and response relies on manual intervention

Mean Time to Resolve Incidents

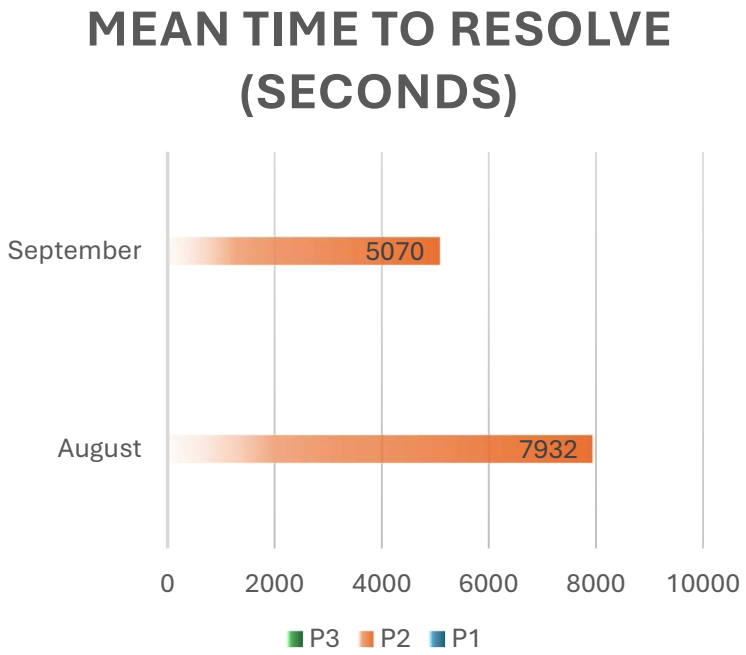
Leeds Community Healthcare NHS Trust

Domain: Digital | Accountable Exec: Andrea Osborne | Author: Richard Slough

Target: 4 hrs (local target) Actual: A | SPC Variation: N/A | SPC Assurance: N/A | Data Quality: **High Assurance**

What is the trend we see?

The increase in time to resolve issues in August was a consequence of a penetration test which caused and artificial increased in this measure to above the 2-hour resolution target, however performance recovered in September to fall to 84 mins.



What is being done about it?

The team continue to develop and refine processes for responding to alerts generated by the SIEM to ensure this occurs as rapidly as possible.

When do we expect to see improvement?

There is a continuous process of review and refinement of processes.

What are the risks to delivery?

The process relies on manual intervention which requires availability of limited resource.

Response Effort for Incidents

Leeds Community Healthcare NHS Trust

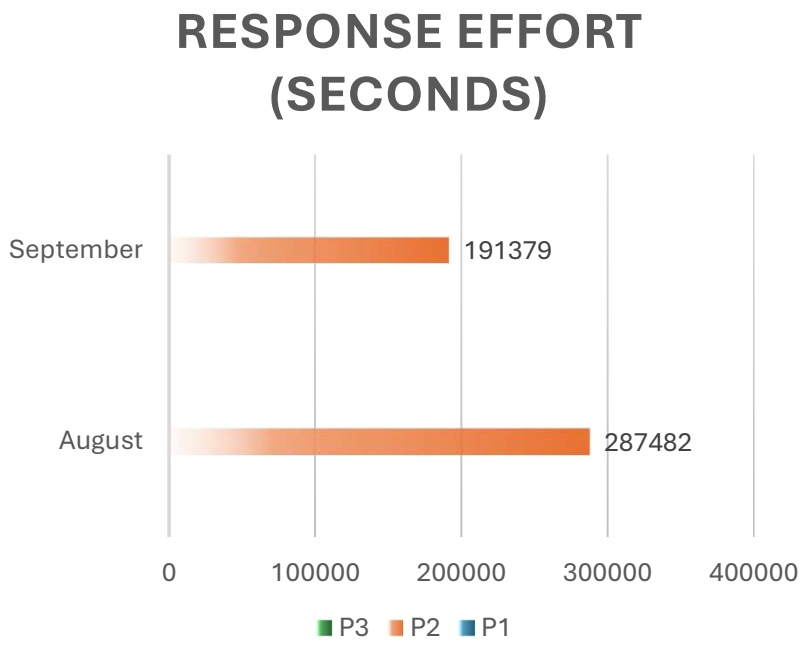
Domain: Digital | Accountable Exec: Andrea Osborne | Author: Richard Slough

Target: P1 21 sec, P2 <4hrs, P3 <24hrs | Actual: A | SPC Variation: N/A | SPC Assurance: N/A | Data Quality: High Assurance

What is the trend we see?

The response effort spike in August was affected by a planned penetration test which was expected.

Response effort will be affected by the nature and type of event which has occurred so a higher response effort may be proportional in relation to the type of event which has occurred.



What is being done about it?

The team continue to develop and refine processes for responding to alerts generated by the SIEM to ensure this occurs as rapidly as possible.

When do we expect to see improvement?

What are the risks to delivery?

The process relies on manual intervention which requires availability of limited resource

Service Desk Queue Performance

Leeds Community Healthcare NHS Trust

Domain: Digital | Accountable Exec: Andrea Osborne | Author: Richard Slough

Target: >=85% | Actual: G | SPC Variation: N/A | SPC Assurance: N/A | Data Quality: **High Assurance**

What is the trend we see?

Service Desk call volumes decreased to 1283 in August, due to the annual fall over the summer break, which is in line with seasonal trends. Performance was strongest in August, with a 93.5% call answer rate and 6.5% abandonment rate as staff returned from annual leave, the volumes and response times have moved back to more normal performance standards.

	July	August	September
Answer Rate	89.39	93.5%	86.6%
Abandonment	10.7%	6.5%%	13.4%
Speed of Answer	01:18	01:17	02.22
Call Volume	1628	1283	1759

What is being done about it?

Performance is within tolerance however, activities include:

- Encouraging staff to request support calls via HALO (Service desk system) to alleviate pressure on the 1st line IT support desk phone line.
- Standardise and introduce ITIL ways of working, to the IT Helpdesk team to improve efficiency
- Continued education and development for the 1st Line IT Helpdesk Manager

When do we expect to see improvement?

The improvement cycle is continuous.

What are the risks to delivery?

High staff turnover. Typically, helpdesk and roles are where people seeking a role in IT services may start their career but tend to move on as they gain experience.

Subject Access Request

Leeds Community Healthcare NHS Trust

Domain: Digital | Accountable Exec: Andrea Osborne | Author: Richard Slough

Target: Within 1 calendar month | Actual: 100%, 14 | SPC Variation: | SPC Assurance: N/A | Data Quality: Medium Assurance

What is the trend we see?

The number of open overdue Subject Access Requests (SAR) has increased over recent months after a sustained period around the mean.

What is being done about it?

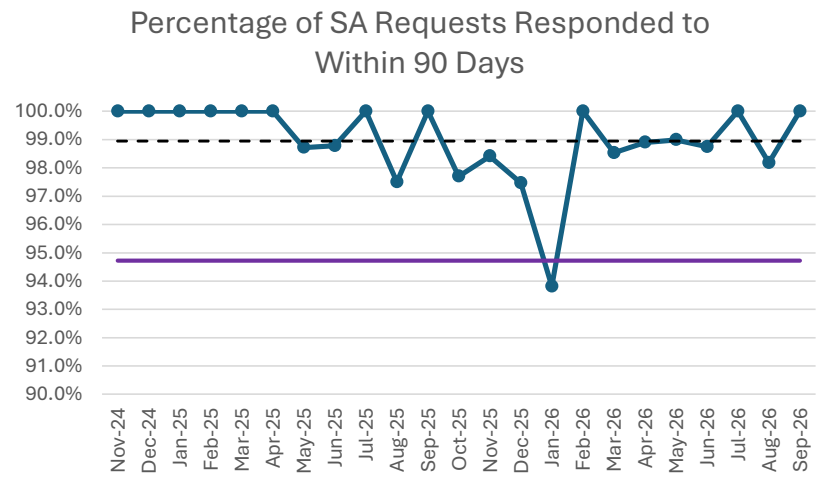
The Musculoskeletal service (who are recipient of a high proportion of SARs) have taken on extra staff over weekends to specifically deal with these requests.

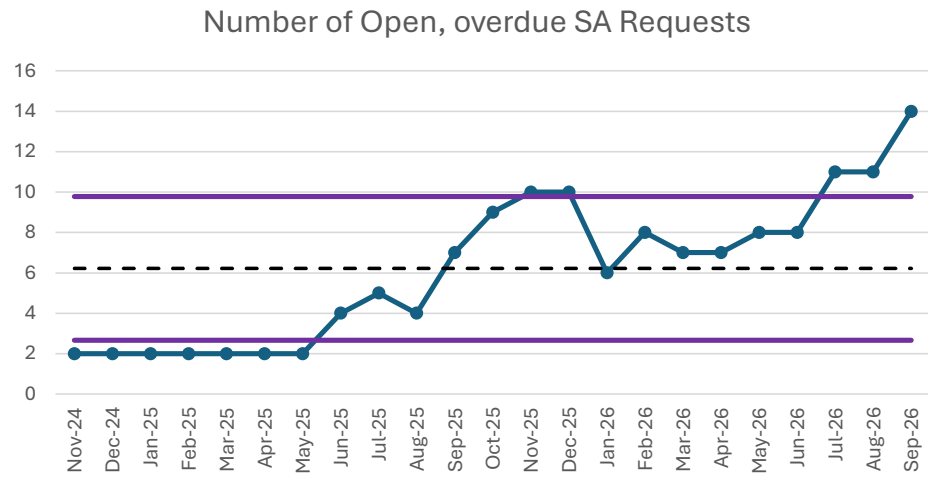
When do we expect to see improvement?

Improvements will be dependant upon the volume of SARs received in the next period. There is little seasonality to these requests, so a trend is hard to identify.

What are the risks to delivery?

Minimal- all requesters are made aware that requests may take the full permitted 3 months to process.





Freedom of Information Compliance

Leeds Community Healthcare NHS Trust

Domain: Digital | Accountable Exec: Andrea Osborne | Author: Richard Slough

Target: 95 % Within 20 working days | Actual: 83.3%, 74 | SPC Variation: H H | SPC Assurance: F N/A | Data Quality: **Medium Assurance**

What is the trend we see?

There is an overall upward trend in Freedom of Information (FOI) compliance, and the number of open and overdue FOI is decreasing, helping the Trust to correct the historic performance issues with requests not being provided within the statutory timescales and reducing the risk of compliant or Information Commissioner involvement.

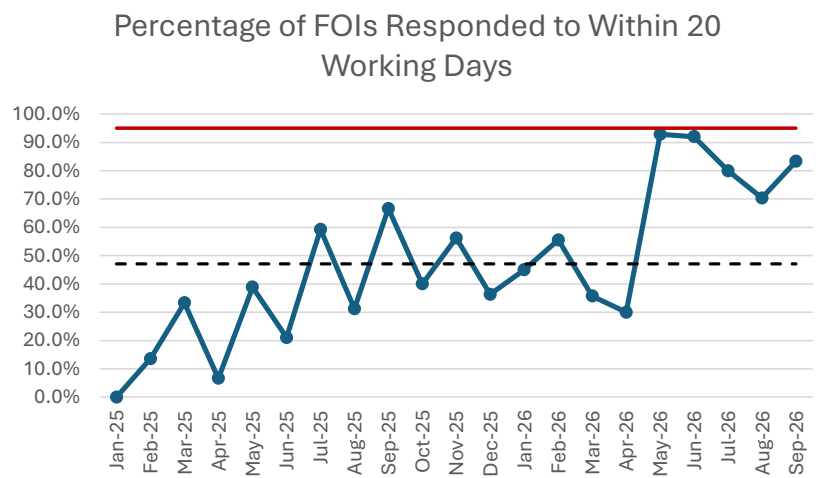
What is being done about it?

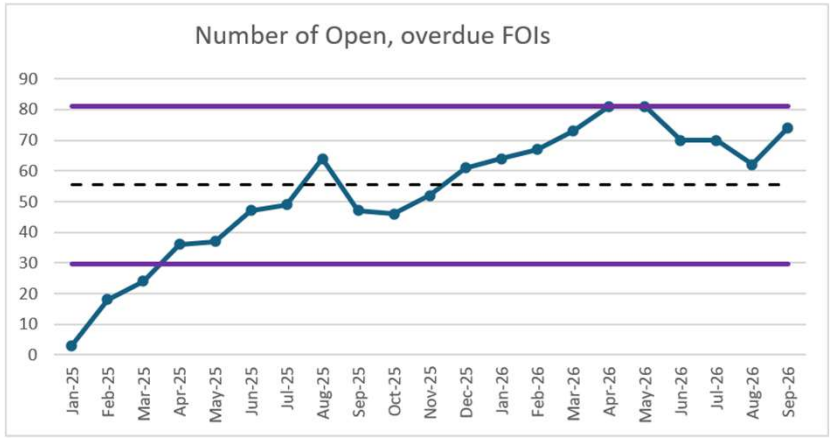
Services are being reminded of overdue FOI and lists of overdue request are sent to appropriate teams on a weekly basis to help manage the priority requests.

When do we expect to see improvement?

Some improvement is currently being seen however this remains resource intensive.

What are the risks to delivery?

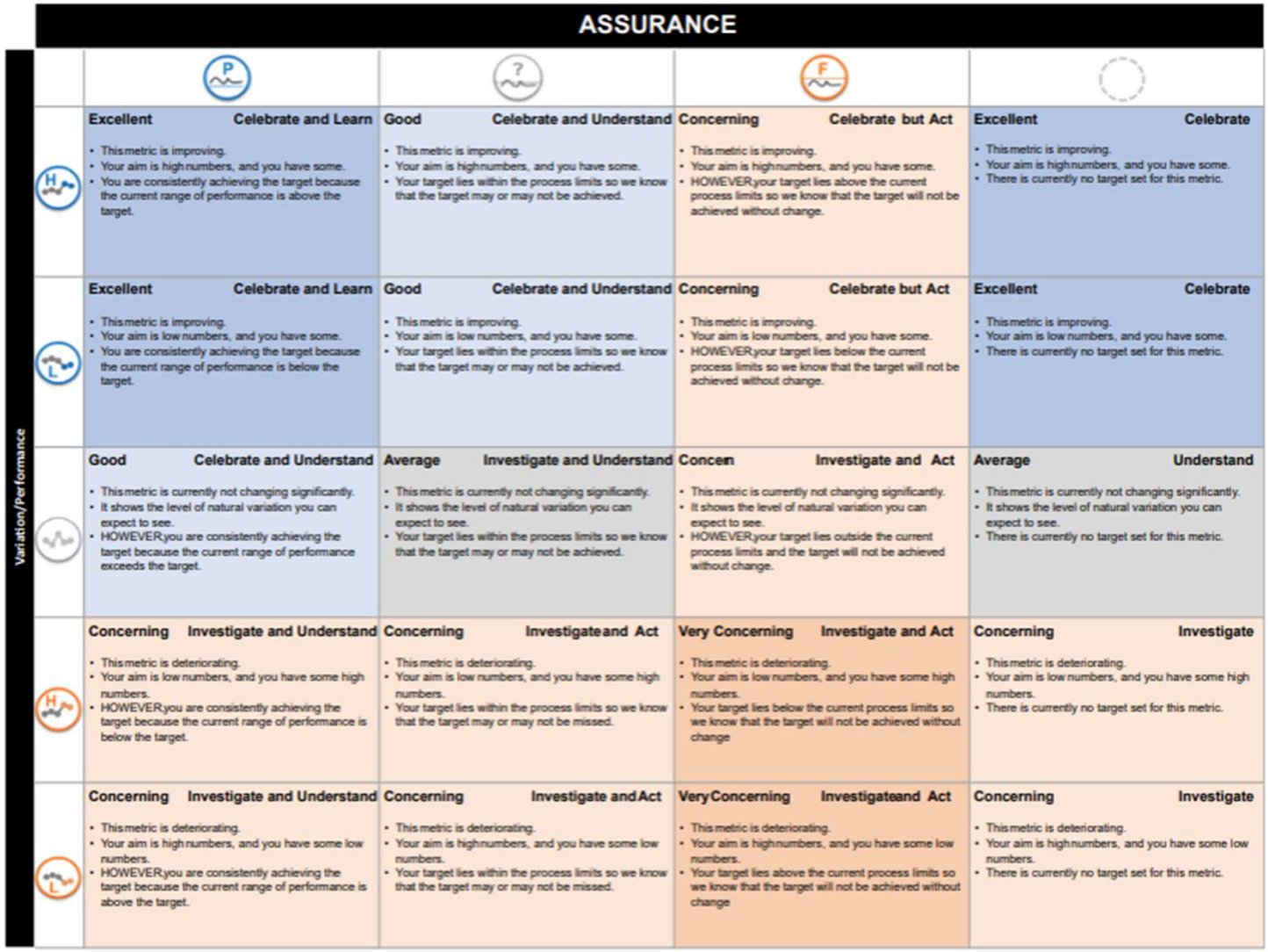




NHS Leeds Community Healthcare NHS Trust

	Variation/Performance Icons		
Icon	**Technical Description**	**What does this mean?**	**What should we do?**
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly** It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable** If the process limits are far apart, you may want to change something to reduce the variation in performance.
H	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?
L	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.	
H	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?
L	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.
F	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.
P	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction,** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.



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

Agenda item:	2026-27 (12iii)
Title of report:	NOF Update - Sickness Absence
Meeting:	Trust Board
Date:	19 November 2026

Presented by:	Jenny Allen – Chief People Officer
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 emerging focus on sustainable oversight, targeted improvement and prevention.	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:

- Overall sickness absence has reduced to 6.5% from 6.9% the previous month, although remains above the Trust target. The reduction is driven by improved long-term absence, whilst short-term sickness has increased, likely due to emerging seasonal pressures which are anticipated to continue as we move further into winter.
- The project has strengthened sickness management arrangements, manager capability, organisational health support and data reporting. Monthly collaborative 'Intervention Compass' meetings continue to provide oversight and support targeted interventions, informed by local service insight and intelligence.
- The next phase will focus on embedding sustainable business-as-usual arrangements, addressing outstanding areas for improvement and using emerging analysis and stakeholder engagement to agree future priorities, with continued emphasis on prevention and staff wellbeing.
- Additionally, the Trust is now fully engaged with an NHS regional sickness absence project which aims to focus on understanding further evidence around why staff sickness is high as well as what interventions are evidenced as having the most impact. The ability to learn from both the research as well as peer organisations is important in this context.

Previously considered by:	Summary of progress was previously considered by the Public Board on September 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 reduction in long-term absence and continued need for improvement against the Trust target. • Receive assurance on the established monitoring and oversight arrangements, including collaborative Intervention Compass reviews and targeted support for services. • Note the proposed forward focus on sustainable business-as-usual arrangements, addressing outstanding improvement areas and taking a collaborative, evidence-informed approach to agreeing future priorities.

List of Appendices:	N/A

Leeds Community Healthcare NHS Trust

NOF Update - Sickness Absence

Board Update

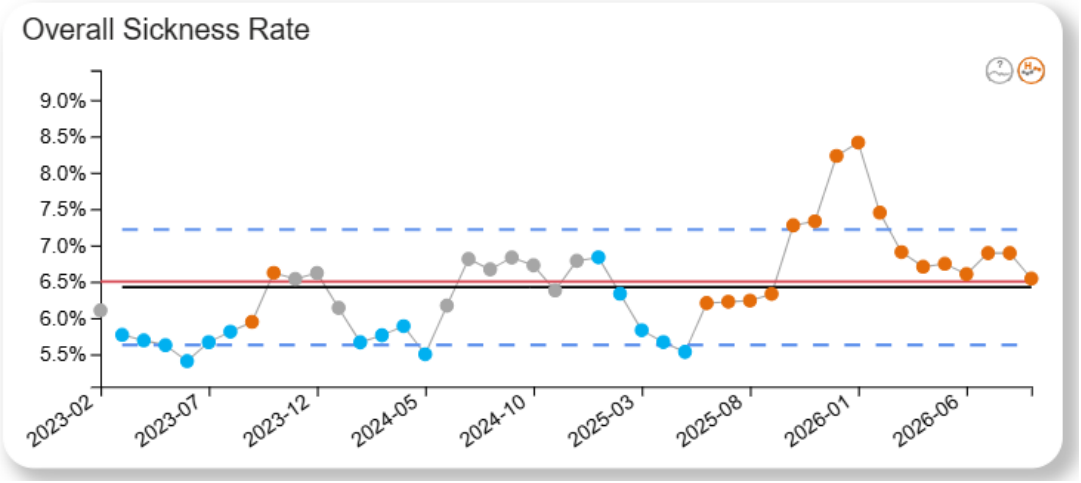
19th November 2026

Current Position

Leeds Community Healthcare NHS Trust

Where we are now

- Overall sickness absence was 6.5%, down 0.4 percentage points from the previous month (6.9%) and 0.7 percentage points above the Trust target of 5.8%. LCH remains in NOF Segment 4. Some monthly fluctuation is expected. The reduction is encouraging, although sickness absence remains above target and sustained improvement is still required.
- The reduction was driven by long-term sickness absence, which fell to 4.3% (-0.8 percentage points) and continues to account for approximately 66% of all sickness. Short-term absence increased to 2.2% (+0.4 percentage points), with increases in coughs, colds and flu suggesting emerging seasonal pressures.
- Variation remains across services and business units. ABU continues to report the highest sickness levels, while some services continue to experience sustained high absence requiring targeted attention.



Ongoing Oversight

- Monthly Intervention Compass meetings continue, bringing together the project team and People Partners to review sickness data alongside local service intelligence. These collaborative discussions help identify services requiring additional support, monitor interventions and maintain organisational oversight.
- The future operating arrangements for the ‘Support Compass’ are being reviewed to ensure this approach can be sustained and strengthened within existing business-as-usual processes.

Progress and Next Steps

Leeds Community Healthcare NHS Trust

Progress update

- In terms of manager capability and processes: Managing Absence with Confidence training is established as BAU, with strong engagement and positive evaluations. Changes to sickness panel processes have been introduced following the Task and Finish Group, although further review is needed to understand whether these have addressed the concerns raised by managers.
- Occupational Health contract monitoring and EAP promotion continue through existing arrangements. Work continues to understand and address ongoing concerns about Occupational Health provision, while organisational health diagnostic work continues in priority services. These are identified in an improved, data-driven way, informed by the 'Support Compass' framework and service level insight.
- The Unavailability Dashboard is live and clinical and operational leaders now all have access to their sickness dashboards.
- We have engaged operational leaders through the Operational and Clinical Forums to understand their experiences of managing sickness absence and identify areas where further improvement may be needed. Continued engagement with operational and clinical leaders will help inform priorities for the next phase of work.
- A workshop will take place to discuss benefits realisation and repositioning of remaining workstreams. The group will also discuss what next steps might look like including ongoing project priorities, re-evaluating project scope, and looking at sickness through different lenses.

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.
- Review the effectiveness of changes to sickness panel processes and identify what further action may be needed to improve Occupational Health provision.
- Agree priorities for the next phase of this programme of work, by using data analysis and service intelligence to inform a collaborative workshop with key stakeholders, to agree the next steps for continued improvement.
- Strengthen prevention and wellbeing support by taking a more proactive approach to understanding and responding to staff wellbeing needs, particularly during organisational change, working with services to identify where additional support may be beneficial.
- Participate fully in the regional project reviewing sickness absence and evidence around impactful interventions.

Committee Escalation and Assurance Report

Name of Committee:	People & Culture	**Report to:**	Private Trust Board 19 Nov 2026
Date of Meeting:	7th Oct 2026	**Date of next meeting:**	9th December 2026

Introduction

The meeting was supported by a clear agenda and a comprehensive set of papers, which enabled thorough and informed discussion and sufficient assurance in relation to the relevant strategic risks. There were positive and productive conversations around the 'Staff Story' and the Staffside update, which the Committee acknowledged were critical to understand culture and the lived experiences of people working at LCH.

Alert	Action
People KPIs and data -Sickness absence - workforce pressures and staff wellbeing were noted as specific areas of concern and the long term sickness absence remains high, requiring continued focus through the Committee. Challenges associated with supporting staff through the significant organisational changes currently being experienced across the Trust.	Undertake a deep dive review of sickness absence within the Adult Business Unit to enhance understanding of intervention effectiveness and support future learning.

Advise

- NOF People Measures – An update was provided on bank and agency usage. Bank and agency expenditure is running approximately 1% above the agreed NHS England plan. Agency use has reduced in recent months, and the appointment of a consultant paediatrician was expected to reduce reliance further.
- LCHT People Inclusion Improvement Plan 2025-2026- The report summarised the action taken and highlighted the progress made throughout the reporting period in delivering EDI improvement plan. It was highlighted that future reports should place greater emphasis on the lived experience of staff, supported by case studies and examples illustrating the impact of improvement work.
- Safe Staffing Report – Verbal update was provided. Future discussions should consider safe staffing alongside indicators such as sickness absence, vacancies, retention, bank and agency usage, and incidents to provide a fuller picture of workforce risk and service quality.

Assurance

- People Strategy and Headlines Update – The Committee noted several national workforce initiatives, including the Band 5 Nursing Review, Lord Mann Recommendations and NHS Staff Standards. Assurance was provided that these were being aligned with existing programmes, including the Inclusion Plan, to avoid duplication and address any gaps. It was advised that the NHS Staff Standards gap analysis and the associated Inclusion Plan would be presented to the Board at the next meeting.
- Leeds Health & Care Academy (LHCA) Annual Report 2025/26 - Kate O'Connell presented the Academy's annual report, explaining its city-wide partnership role, free learning provision, workforce innovation and proposed priorities for 2026–27.

Committee Escalation and Assurance Report

- Staffside Update – Amanda Thomson Melling, Staffside vice chair explained the role of staff side, its partnership with nine recognised unions and staff networks, its handling of the administration review and its planned involvement in creating the merged organisation.
- Trust Integration Programme – People & Culture elements - Committee noted progress across workforce systems, people policies, learning and development arrangements, and preparations for staff transfer to the new organisation. Also noted ongoing work to develop the culture, vision and values of the future organisation.
- Wildly Important Goals – The Committee noted the mid-year update.
- Professional Registration: Nursing and Allied Health Professionals – Report currently covered Nursing and AHP registrants only. Future reports to include other registered professions to provide a more comprehensive overview of professional registration across the Trust.
- Guardian of Safe Working Hours Report –Q1- The Guardian of Safe Working Hours reported no exception reports after the online system was introduced but identified low engagement with resident doctors' forums and insufficient monitoring data for CAMHS non-resident on-call work.

Risks Discussed and New Risks Identified

Noted an increase in the primary-care staffing risk to 16. Concerns about staff sickness and absence.

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

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

Committee Escalation and Assurance Report

absence, burnout, and workforce instability. This may result in reduced capacity and diminished quality of care.			absence, and the need to demonstrate the impact of ongoing improvement actions.

Author:	Rakhi Palliyath/Rachel Booth
Role:	Corporate Governance Officer/Committee Chair
Date:	14/10/26

Agenda item:	2026-27 (14i)
Title of report:	Annual People Inclusion Report 2025/26
Meeting:	Trust Board
Date:	19 November 2026

Presented by:	Jenny Allen, Director of People
Prepared by:	Rich Cooper, Senior People Consultant Richard Worlock, People Consultant Catherine Hall, Associate Director People Solutions

Purpose of the report:		
This report outlines progress and delivery against the NHS EDI Improvement Plan High Impact Actions, provides assurance on governance and performance, and seeks approval of the People Inclusion Improvement Plan 2026/27.	Approval	X
	Discussion	
	Assurance	

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

Summary of Key Issues:

Executive Summary

Good progress has been made during 2025/26 in delivering the NHS Equality, Diversity and Inclusion Improvement Plan and advancing the Trust's inclusion, belonging and workforce equality ambitions. Key achievements include the embedding of inclusive recruitment practices, improvements in workforce equality indicators, strengthened support for disabled staff and internationally recruited colleagues, implementation of the NHS Sexual Safety Charter, and increased Board accountability for inclusion.

Workforce representation has continued to improve, with increased representation of both ethnically diverse and disabled colleagues across a number of clinical and non-clinical workforce groups. Detailed WRES and WDES performance data are provided in Appendices A and B. These appendices demonstrate sustained improvements in workforce representation, staff experience and inclusion outcomes over time, including reductions in reported discrimination, bullying and harassment, alongside improved representation of disabled staff and colleagues from ethnically diverse backgrounds. Collectively, these trends provide evidence that the Trust's inclusion initiatives are having a positive impact.

However, workforce equality data, EDS assessments and pay gap analysis continue to identify areas where inequalities persist, particularly in relation to staff experience, career progression and workforce outcomes.

The findings from WRES, WDES, EDS, pay gap analysis, NHS Staff Standards assessments and Lord Mann Review recommendations have been mapped against the People Inclusion Improvement Plan, ensuring that identified gaps and improvement priorities are reflected within the Trust's programme of work for 2026/27.

Key priorities for the coming year include reducing workforce inequalities, improving workforce equality data quality and insight, implementing relevant NHS Staff Standards and Lord Mann Review actions, further embedding inclusive recruitment and talent management practices, and strengthening approaches to preventing discrimination, harassment, violence and inappropriate behaviour while promoting psychological safety, inclusion and belonging.

Progress will continue to be monitored through workforce equality indicators, workforce representation, recruitment and selection outcomes, employee relations data, pay gap reporting, staff experience measures and NHS Staff Standards metrics, supported by engagement with staff networks and wider co-production activity.

As the Trust prepares for the establishment of Leeds Partnership Foundation Trust from 1 April 2027, inclusion will remain a key strategic priority. The transition provides a significant opportunity to establish a shared culture built on inclusion, belonging and equity, supported by common values, behaviours and leadership expectations across the future organisation.

Level of Assurance: **Acceptable Assurance**. Effective governance arrangements and improvement programmes are in place, and progress has been demonstrated across a number of key areas. However, workforce equality data continues to identify persistent inequalities in staff experience and outcomes, requiring ongoing focus and targeted intervention to deliver sustained improvement.

Previously considered by:	People & Culture Committee, 07 Oct 2026
Outcome of previous discussion/s:	• Improved Executive Summary added assurance level for Board. • Strengthened narrative on progress and areas for development. • Added ‘Inclusion in Practice’ case studies. • Enhanced WRES and WDES analysis to demonstrate long-term improvements and ongoing challenges. • Strengthened section on future priorities, including opportunities arising from the transition to Leeds Partnership Foundation Trust. • Updated the EDI Improvement Plan to incorporate NHS Staff Standards and Lord Mann Review recommendations.

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

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: The report primarily focuses on workforce equality, diversity and inclusion. Activity relating to High Impact Action 4 supports wider organisational efforts to reduce inequalities through workforce wellbeing, inclusion and equitable access to support.	Workforce: The report provides analysis of workforce equality outcomes through the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Equality Delivery System (EDS), pay gap reporting and wider workforce metrics. The findings identify progress in workforce representation and inclusive recruitment, alongside ongoing inequalities in staff experience, career progression and workforce outcomes. These findings have informed the priorities within the People Inclusion Improvement Plan 2026/27.

Recommendation(s)	The Trust Board is asked to: • Receive assurance on progress against the NHS EDI Improvement Plan. • Approve the People Inclusion Improvement Plan 2026/27. • Note the key workforce inequalities identified through WRES, WDES, EDS and pay gap analysis. • Support continued oversight through Board assurance processes.

List of Appendices:	Appendix A-WRES Performance 2019-2026 Appendix B-WDES Performance 2019-2026 Appendix C-People Inclusion Improvement Plan 2026/27 Appendix D-Trust Board Equality Intentions Appendix E- NHS Equality Delivery System 2022

Annual People Inclusion Report 2025/26

Introduction

1.1 This report covers the period 1 November 2025 to 31 July 2026 and aligns with national reporting timelines for the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and other workforce equality reporting requirements. It summarises the progress made in delivering the NHS Equality, Diversity and Inclusion (EDI) Improvement Plan, highlighting actions taken to improve workforce equality, inclusion and staff experience, while demonstrating how the Trust continues to meet its obligations under the Public Sector Equality Duty (PSED) as set out in the Equality Act 2010.

1.2 During the reporting period, the Trust continued to strengthen the foundations required to support an inclusive workplace, including leadership accountability, inclusive recruitment, staff engagement and targeted support for underrepresented groups. The report demonstrates areas where measurable progress has been achieved, whilst also recognising that inequalities in workforce experience and outcomes remain and require continued focus.

1.3 The sections that follow provide an overview of the statutory, NHS and organisational frameworks that underpin the Trust's inclusion agenda, together with progress against key priorities and High Impact Actions. They also identify areas for further improvement and set out the priorities that will support implementation of the NHS Staff Standards, Lord Mann Recommendations and the development of the future organisation through integration with Leeds and York Partnership NHS Foundation Trust.

2. Background, Progress and Priorities 2026/27

2.1 The Trust's approach to equality, diversity, inclusion and belonging is informed by the Equality Act 2010, NHS EDI Improvement Plan, Workforce Equality Standards (WRES and WDES), Equality Delivery System (EDS), NHS Staff Standards and Lord Mann Review recommendations. These frameworks provide the basis for monitoring workforce inequalities, identifying priorities and driving continuous improvement. During 2025/26, preparations have also continued for the establishment of Leeds Partnership Foundation Trust, providing an opportunity to align and strengthen inclusion approaches across the future organisation.

2.2 Progress

Over recent years, the Trust has made significant progress in advancing equality, diversity, inclusion and belonging, supported by strong leadership commitment, targeted interventions and a focus on evidence-based improvement. This is reflected in improving workforce equality indicators, the embedding of inclusive recruitment practices, strengthened governance and delivery against a range of national standards and recommendations. During 2025/26, this progress has continued through initiatives designed to further embed inclusion across the

organisation and establish strong foundations for the future Leeds Partnership Foundation Trust.

Key achievements during the period:

- Board Inclusion Pledges and a Board Intention Plan established.
- People Inclusion Improvement Plan developed and implemented: A single strategic framework has been established to bring together the Trust's equality, diversity, inclusion and belonging priorities, providing a more coordinated approach to delivery, governance and assurance.
- Improved representation of underrepresented groups: The Trust has continued to increase the representation of both Black and Minority Ethnic (BME) and disabled colleagues across a number of clinical and non-clinical workforce groups. WRES and WDES data demonstrate improvements across several staff groups, including senior roles, providing evidence that actions to support inclusion, recruitment and career progression are having a positive impact. The Trust recognises that further improvement is required to ensure equitable representation and progression at the most senior levels. A full summary of performance is provided in Appendices A and B.
- Workforce equality indicators demonstrate a positive direction of travel: Improvements have been seen across a range of WRES and WDES measures relating to workforce representation, recruitment outcomes, career progression and staff experience. A full summary of performance against WRES and WDES indicators between 2019 and 2026 is provided in Appendices A and B.
- The BME Fair Recruitment Initiative is now fully embedded, supported by a recruitment dashboard that enables enhanced monitoring of recruitment outcomes by ethnicity and strengthens inclusive recruitment decision-making.
- Disability Pay Gap analysis completed, providing a clear evidence base and identified priorities for future improvement activity.
- NHS Sexual Safety Charter implemented, reinforcing the Trust's commitment to creating a safe working environment for all staff.
- NHS Pastoral Care Quality Award achieved, recognising the Trust's support for internationally recruited colleagues.
- Progress made against the ‘Too Hot to Handle’ recommendations, strengthening the Trust's approach to tackling bullying, harassment and discrimination.
- Adoption of the IHRA Working Definition of antisemitism in line with recommendations arising from the Lord Mann Review.
- The People Inclusion Improvement Plan has been updated to reflect NHS Staff Standards and Lord Mann Review recommendations, ensuring identified priorities are embedded within the Trust's EDIB programme and monitored through established governance arrangements.

2.3 Priorities 2026/27

The key priorities set out below represent a high-level summary of the actions contained within the People Inclusion Improvement Plan (Appendix C). Whilst

these priorities can be grouped into a small number of strategic themes, the underlying action plan brings together requirements from a range of national frameworks, statutory obligations, NHS Staff Standards, equality improvement programmes and reviews, including the Lord Mann Review. There is currently no single national framework that consolidates these requirements and, as a result, the Trust has brought together actions from multiple sources into a single improvement plan to provide a coherent and coordinated approach. This enables progress to be monitored through one overarching programme while maintaining alignment with national expectations, local priorities and the forthcoming transition to Leeds Partnership Foundation Trust.

The following priorities, which are reflected within the People Inclusion Improvement Plan (Appendix C), will guide the Trust's equality, diversity, inclusion and belonging agenda during 2026/27 and support preparations for the transition to Leeds Partnership Foundation Trust.

- Implement inclusive, values-based recruitment aligned to the new Trust values, alongside strengthened talent management and career development practices, to improve equity of opportunity across the workforce.
- Address workforce inequalities identified through WRES, WDES, pay gap analysis and staff experience data, with a focus on improving outcomes for underrepresented groups. Working with colleagues across Leeds Partnership Foundation Trust, the Trust will develop and implement targeted positive action interventions to improve representation, particularly within Bands 8a and above, and support equitable access to development, progression and leadership opportunities. Progress will be monitored through agreed equality metrics and KPIs within the new Trust's performance framework.
- Enhance workforce equality data, reporting and insight to strengthen accountability, measure impact and inform targeted interventions.
- Implement the NHS Staff Standards, including the Anti-Racism Improvement Standard and Violence Prevention and Reduction Standard, ensuring identified actions are embedded within the People Inclusion Improvement Plan.
- Deliver priority actions arising from the Lord Mann Review and continue to strengthen the Trust's approach to inclusion, belonging, safety and psychological wellbeing.
- Align equality, diversity, inclusion and belonging priorities, governance arrangements and delivery plans in preparation for the establishment of Leeds Partnership Foundation Trust.
- Use the transition to Leeds Partnership Foundation Trust as an opportunity to establish a shared culture built on inclusion, belonging and equity, underpinned by common values, behaviours and leadership expectations.
- Embed inclusive leadership through leadership development, management practice and organisational culture initiatives, ensuring inclusion is

understood, demonstrated and owned at every level of the future organisation.

3. Staff Engagement and Co-production

Achievement

3.1 Staff networks continue to play a vital role in shaping the Trust's inclusion agenda. During the reporting period, network members contributed to discussions on workforce equality, including WRES, WDES, NHS EDS2 and wider inclusion priorities, and helped develop the People Inclusion Improvement Plan 2026/27 (Appendix C). Their lived experience informed actions to improve inclusion, belonging, career progression and staff experience. The Trust also continued to provide organisational development support to strengthen networks' ability to influence change and represent the views of colleagues.

How do we know?

3.2 This is evidenced through:

- Regular engagement with staff networks and inclusion forums.
- Staff network involvement in the development of the People Inclusion Improvement Plan 2026/27.
- Feedback and insight gathered through WRES, WDES and EDS engagement activity.
- Contributions from staff network representatives to workforce equality discussions and improvement actions.
- Ongoing partnership working between staff networks, People Services and senior leaders to address emerging inclusion priorities.

What Next?

3.3 The Trust will continue to strengthen co-production and engagement with staff networks, ensuring that colleague voice remains central to the design, delivery and evaluation of inclusion initiatives.

3.4 As part of the transition to the Leeds Partnership Foundation Trust, opportunities will be explored to align staff network arrangements across both organisations, share learning and strengthen the contribution of lived experience to workforce equality, diversity and inclusion priorities.

3.5 This will support the development of a culture where all colleagues feel heard, valued and able to influence organisational change, whilst ensuring that future equality, diversity, inclusion and belonging priorities are shaped by the voices and lived experiences of colleagues.

Inclusion in Practice

Race Equality Network: Nine Years of Progress and Impact

What We Did

Established in October 2017, the Race Equality Network (REN) is Leeds Community Healthcare's longest-standing staff network. Created to support race equality and improve staff experience, the network has grown to over 180 members and provides peer support, advocacy and a strong staff voice across the Trust.

Over the past eight years, the network has helped shape key inclusion initiatives including Reverse Mentoring, Allyship, Fair Recruitment and leadership development. It has also championed career development opportunities and supported the development of accredited coaches from global majority backgrounds.

During 2025/26, the network worked with Trust leaders and colleagues to strengthen the Trust's response to discrimination from patients and members of the public. This included introducing zero-tolerance messaging, enhanced reporting and escalation processes, behavioural contracts for discriminatory behaviour, and refreshed awareness campaigns.

Impact

The network has played a significant role in strengthening inclusion, staff voice and organisational accountability. Its influence has contributed to improved support for staff experiencing discrimination, clearer reporting routes and increased visibility of race equality across the Trust.

The REN has also supported the introduction of faith-based staff fellowships, contributed to the development of the Staff Solidarity and Support Hub, and helped improve access to support, advice and guidance for colleagues and managers. The creation of the People Culture Committee has further strengthened the network's strategic influence through regular reporting and executive sponsorship.

Organisational Learning

The success of the Race Equality Network demonstrates the important role staff networks play in shaping culture, informing decision-making and improving staff experience. As Leeds Partnership Foundation Trust develops, work is underway to align with the Leeds and York Partnership Foundation Trust Workforce Race Equality Network, ensuring colleagues continue to have a strong voice and access to peer support, mentoring and career development opportunities within the new organisation.

4. Progress and Impact: People Inclusion Improvement Plan High Impact Actions

The sections below summarise the progress made against each High Impact Action (HIA), highlighting both the outcomes achieved and the areas where further improvement is required.

4.1 HIA 1: *Measurable EDI objectives for Chairs, Chief Executives and Board members.*

Achievement

The Trust has successfully embedded inclusion and equity within Board leadership responsibilities, strengthening Board oversight of workforce equality, staff experience and inclusion priorities.

All Board members have adopted a specific inclusion-related objective or pledge, strengthening personal accountability for improving workforce equality and inclusion outcomes (Appendix D).

How do we know?

This is evidenced through:

- Regular reporting to the Trust Board and People & Culture Committee.
- NHS Staff Survey results and Workforce Strategy reporting.
- Engagement with staff networks.
- Annual Board development sessions focused on equality, diversity and inclusion.
- Monitoring of individual Board commitments through the Board Intention Plan and associated assurance processes.

What Next

During 2026/27, the Board will continue to strengthen its oversight of inclusion and workforce equality through delivery of individual Board commitments, monitoring of workforce equality indicators and implementation of the People Inclusion Improvement Plan. As the organisation transitions to Leeds Partnership Foundation Trust, opportunities will be explored to develop a shared approach to Board leadership, accountability and inclusion across the future organisation.

Inclusion in Practice

Board Commitment to Inclusion and Reducing Inequalities in Experience

Following the annual Board development workshop in April 2026, which reviewed NHS Staff Survey, WRES and WDES findings, the Board considered areas of strength and concern in staff experience and reaffirmed its commitment to creating a more inclusive, equitable and supportive workplace.

What We Did

The Board agreed a series of commitments to strengthen inclusion and reduce inequalities in staff experience, including:

- Strengthening engagement with staff networks and listening directly to colleagues' experiences.
- Seeking feedback on culture, inclusion and belonging during service visits and engagement activity.
- Maintaining oversight of identified hotspot areas through the People and Culture Committee.
- Improving workforce data quality and transparency to support targeted action.
- Making personal commitments to support the Inclusion and Belonging agenda.

Impact

These commitments have strengthened Board visibility and accountability for inclusion and belonging, ensuring workforce equality, staff experience and organisational culture remain central to strategic decision-making.

Organisational Learning

The Board development workshop reinforced the importance of visible leadership, robust oversight and meaningful engagement in addressing inequalities in staff experience. The commitments agreed by Board members have strengthened accountability for inclusion and belonging and ensured workforce equality remains a key consideration in organisational decision-making.

Progress against these commitments will continue to be monitored through the People and Culture Committee, supported by regular review of workforce equality data, staff survey findings and inclusion improvement actions.

4.2 **HIA 2.** ***Overhaul recruitment processes and embed talent management processes.***

Achievement

The Trust has continued to strengthen inclusive recruitment through the BME Fair Recruitment process introduced in March 2024. Since implementation, representation of staff from ethnic minority backgrounds has increased across a number of workforce groups, particularly within non-clinical roles.

Notable improvements include:

- Band 4 increasing from 10.5% to 27.0%
- Band 5 increasing from 17.1% to 24.4%
- Band 6 increasing from 9.9% to 18.0%
- Band 7 increasing from 8.4% to 13.4%

These improvements are reflected within the Trust's WRES trajectory set out in Appendix A. Whilst these improvements cannot be attributed solely to the introduction of diverse recruitment panels, they provide encouraging evidence that the Trust's wider inclusive recruitment initiatives are contributing to a more representative workforce.

Increased representation across a number of workforce groups helps ensure the organisation is more reflective of the communities it serves and supports greater diversity within leadership and professional roles.

How do we know?

This is evidenced through:

- Sixteen colleagues have successfully completed BME Fair Recruitment panellist training, enabling trained BME representation to be embedded within all Band 7 and above recruitment processes and strengthening inclusive recruitment practice.
- Ongoing monitoring of workforce representation and recruitment outcomes through WRES reporting and workforce equality data.
- Inclusion mapping undertaken as part of the LCHT and LYPFT integration programme identified diverse recruitment panels and inclusive recruitment practices as key priorities for the future organisation.
- The recruitment process has been further strengthened through the introduction of a recruitment dashboard to monitor recruitment outcomes by ethnicity, improvements to recruitment advertising, and the development of inclusive recruitment guidance and onboarding resources for recruiting managers.

- Positive assurance that inclusive recruitment principles continue to be embedded within recruitment and selection processes, supporting efforts to reduce potential bias and promote fair and equitable recruitment outcomes.
- Continued partnership working through Leeds One Workforce initiatives to support access to employment and career opportunities for people from underrepresented communities

Inclusion in Practice

Strengthening Race Equality Through Recruitment Data

During preparation of the Trust's latest Workforce Race Equality Standard (WRES) submission, limitations were identified in the recruitment data available to measure the likelihood of appointment from shortlisting for candidates from different ethnic backgrounds.

Whilst the Trust was able to meet national reporting requirements, the available data did not provide sufficient insight into recruitment outcomes at each stage of the recruitment process or identify where inequalities may occur.

What We Did

As part of the Inclusive Recruitment Project, the Trust developed a recruitment dashboard designed to monitor recruitment outcomes by ethnicity across the full recruitment pathway, including:

- Application stage
- Shortlisting stage
- Interview stage
- Offer and appointment stage
- Service and team-level analysis

The dashboard is scheduled to go live before the end of 2026 and will provide significantly greater visibility of recruitment outcomes than is currently available through annual WRES reporting.

Impact

The new dashboard will enable the Trust to identify disproportionate outcomes more quickly, understand where barriers may exist within recruitment processes and take targeted action where inequalities are identified.

Organisational Learning

Recruitment equality data will be reported regularly through the People and Culture Committee, providing ongoing Board oversight of recruitment outcomes across different ethnic groups.

What Next

The transition to the new organisation provides an opportunity to establish a consistent and sustainable approach to inclusive recruitment. Priorities include increasing the pool of trained recruitment panellists, developing a shared panellist resource, and broadening representation across protected characteristics and lived experience.

Whilst representation has improved across a number of workforce groups and pay bands, disparities remain at more senior levels. Addressing these gaps will be important in supporting greater workforce equity and reducing ethnicity and disability pay gaps over time. This demonstrates the close relationship between the objectives of HIA 2 (Recruitment) and HIA 3 (Pay Gaps), with progression into senior roles representing a key factor in improving pay gap outcomes.

Building on the success of the BME Fair Recruitment Initiative, work will continue to strengthen recruitment data and reporting, further improve the inclusivity of recruitment materials and processes, and ensure employment opportunities are accessible to a diverse range of candidates.

In partnership with Leeds and York Partnership NHS Foundation Trust, a shared values-based and inclusive recruitment approach will be developed, aligned to the future Trust values, to promote equitable outcomes, reduce potential bias and support a diverse and representative workforce.

4.3 HIA 3: *Eliminate pay gaps with respect to race, disability, and gender.*

Disability Pay Gap

Understanding the Disability Pay Gap

The 2026 Disability Pay Gap analysis provides a clearer evidence base for identifying and addressing differences in pay and progression between disabled and non-disabled colleagues. The mean disability pay gap increased from **2.4% to 4.1%**, while the median increased from **0.1% to 2.2%**. Disabled colleagues remain broadly distributed across pay quartiles, although low disability declaration rates limit the Trust's ability to fully understand representation and the factors contributing to the gap.

How do we know?

- Annual Disability Pay Gap analysis identifies a widening mean and median pay gap.
- Pay quartile analysis provides insight into the distribution of disabled colleagues across the workforce.
- Workforce equality data has identified disability declaration as an area requiring further improvement.

What Next

The priority for 2026/27 is to move from identifying the gap to better understanding and addressing its causes. Further analysis will focus on representation and progression across pay bands, alongside action to improve disability declaration rates and strengthen the quality of workforce data. The Trust will continue working with the Leeds Health and Care Academy and Leeds health and care partners on disability inclusion, while merger planning will provide an opportunity to align approaches to inclusive recruitment, workplace adjustments and career development across the future organisation.

Ethnicity Pay Gap

Understanding the Ethnicity Pay Gap

The 2026 Ethnicity Pay Gap analysis shows that further improvement is required. The mean pay gap increased from **6.4% to 7.5%**, with the median increasing from **7.4% to 8.5%**. These findings reinforce the need for a continued focus on representation, career progression and equitable access to development and talent opportunities. WRES activity and inclusive recruitment work provide the mechanisms through which these inequalities can be better understood and addressed.

How do we know?

- Annual Ethnicity Pay Gap analysis demonstrates an increase in both the mean and median gap.
- WRES and workforce equality data provide supporting evidence on representation and workforce outcomes.
- Analysis continues to identify a reverse bonus pay gap, with BME colleagues receiving higher average payments under the former National Clinical Excellence Awards scheme.

What Next

Action will focus on improving progression opportunities for colleagues from ethnic minority backgrounds, increasing representation within senior pay bands and addressing barriers identified through WRES. This will be supported through inclusive recruitment, talent management, career development and succession planning, with opportunities to align approaches across the future organisation through the merger.

Gender Pay Gap

Understanding the Gender Pay Gap

The Trust has made measurable progress in reducing the Gender Pay Gap. In 2026, the mean gap reduced from **3.1% to 1.7%** and the median gap from **3.8% to 3.1%**, both favouring women. Women continue to be represented across all pay

quartiles, including the upper quartiles, demonstrating a comparatively equitable position and access to senior roles.

How do we know?

- Reduction in both the mean and median Gender Pay Gap.
- Women remain represented across all pay quartiles, including senior pay bands.
- Annual pay gap and workforce data provide ongoing oversight.

What Next

The Trust will seek to sustain this progress through continued monitoring of gender pay and workforce representation. Particular attention will be given to equitable access to development, career progression, talent management and leadership opportunities, alongside understanding differences in bonus payments. Merger planning will provide an opportunity to align talent, succession and leadership development approaches across the future organisation.

4.4 **HIA 4:** ***Health inequalities within the workforce.***

Achievement

The Trust has continued to strengthen its approach to workforce health and wellbeing, ensuring colleagues have access to a range of physical, mental and financial wellbeing support services. The offer includes wellbeing resources, peer support networks and targeted support during organisational change, with Board-level oversight provided through the Wellbeing Guardian.

Whilst the direct impact of individual wellbeing interventions can be difficult to measure, the Trust has established the foundations required to better understand health inequalities, monitor workforce wellbeing and target support where it is most needed. This provides a framework for identifying and addressing inequalities in workforce health and wellbeing, whilst improving equitable access to support, colleague experience and health outcomes.

How do we know?

Assurance is drawn from:

- EDS 2022 Domain 2 assessment and associated evidence.
- NHS Staff Survey indicators relating to health, wellbeing and staff experience.
- Sickness absence and wider workforce wellbeing data.
- Engagement and feedback from staff networks and colleagues.

- Uptake and feedback from health and wellbeing support, where available.
- Oversight through the Wellbeing Guardian and established governance arrangements.

Together, these sources enable the Trust to move beyond measuring the provision of wellbeing initiatives towards understanding whether support is reaching colleagues effectively and contributing to improved workforce experience and reduced inequalities.

Inclusion in Practice

Turning Staff Feedback into Action at Wharfedale Recovery Hub

Analysis of WRES data identified a disproportionate number of reports relating to abuse, harassment and discrimination experienced by staff at Wharfedale Recovery Hub. Feedback from global majority colleagues highlighted the impact these experiences were having on staff wellbeing, confidence and sense of safety at work, indicating the need for targeted support and intervention.

What We Did

- Staff engagement visits involving People Services, Staff Networks, Freedom to Speak Up Guardians, Health and Wellbeing Leads and senior leaders.
- Strengthened arrangements for managing abusive and discriminatory behaviour.
- Improved security incident reporting and patient handover processes.
- Promoted support available through staff networks, Freedom to Speak Up and wellbeing services.
- Offered Mary Seacole leadership development opportunities.
- Identified de-escalation training for all staff.

Impact

- Concerns raised by global majority Staff through WRES data were translated into practical action.
- Increased visibility of support available to staff, including health and wellbeing services.
- Strengthened relationships between colleagues, leaders and support networks.
- Improved arrangements to support the safety, wellbeing and psychological wellbeing of staff experiencing abuse, discrimination and security concerns.
- Workforce equality data was used to drive local improvement and enhance staff experience.

Organisational Learning

- Regular visits from Staff Network Chairs and inclusion leads.
- Development of local Inclusion Ambassadors.
- Ongoing monitoring through workforce equality data, staff feedback and local engagement activity.

What Next

During 2026/27, the Trust will strengthen its use of workforce, health and staff experience data to better understand inequalities in wellbeing outcomes and access to support. This will enable wellbeing interventions to be more effectively targeted, support equitable access to services, and provide clearer evidence of impact.

As part of the merger with LYPFT, opportunities will be explored to align wellbeing approaches across the future organisation, share effective practice and develop a consistent approach to workforce health and wellbeing. This will support the development of Leeds Partnership Foundation Trust as an inclusive workplace where staff wellbeing is considered alongside workforce equality, staff experience and organisational culture.

4.5 **HIA 5:** ***Comprehensive Induction and onboarding programme for International recruited staff***.

Achievement

The Trust's commitment to supporting internationally educated nurses and midwives has been externally recognised through achievement of the NHS Pastoral Care Quality Award, acknowledging best practice in pastoral support for internationally recruited colleagues. Dedicated support continues to be provided through the International Nurses and Midwives Pastoral Lead, ensuring both new and existing internationally recruited staff receive tailored guidance and support.

The Trust has also contributed to national learning through collaboration with the Queen's Nursing Institute, resulting in publication of the article "*Valuing Internationally Educated Nurses and Diversity in the Community Nursing Workforce"*.

How do we know?

This is evidenced through:

- Achievement of the NHS Pastoral Care Quality Award, recognising best practice in pastoral support for internationally recruited colleagues.
- Positive survey feedback demonstrating high levels of satisfaction and retention amongst internationally educated nurses and midwives.
- Dedicated support provided through the International Nurses and Midwives Pastoral Lead.
- Ongoing feedback gathered through pastoral support and engagement arrangements.

What Next

The Trust will continue to strengthen support for internationally educated colleagues, building on the success of the pastoral care model and learning from staff feedback. As part of the merger with LYPFT, opportunities will be explored to share best practice and develop a consistent approach to supporting internationally recruited staff across the future organisation. This will support workforce retention, inclusion and belonging, while ensuring both new and existing internationally recruited colleagues receive tailored guidance and support.

4.6 **HIA 6:** ***Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.***

Achievement

The Trust has strengthened its approach to tackling bullying, harassment, discrimination and violence by improving reporting routes, enhancing the management of concerns and increasing organisational capability to respond to discriminatory behaviour. These improvements have provided colleagues with clearer routes to raise concerns and access support.

Key developments during the period included:

- Implementation of recommendations arising from the Too Hot to Handle review, including subject matter experts and lived experience representation within investigations and hearings.
- Implementation of the NHS Sexual Safety Charter and associated mandatory training.
- Alignment with the NHS Staff Standards, including the EDI Staff Standard and Anti-Racism Standard, and identification of actions arising from the Lord Mann Review.
- Raising awareness of reporting routes, support services and initiatives such as the No Bystanders and Allyship campaigns to encourage a culture of speaking up and shared responsibility.
- Enhanced monitoring of discrimination, hate incidents and abuse through established governance arrangements.
- Partnership working with Leeds and York Partnership NHS Foundation Trust to develop a shared Violence Prevention and Reduction Strategy.

Collectively, these actions support the Trust's commitment to creating a safe, inclusive and respectful working environment where discrimination, bullying, harassment and abuse are actively challenged.

How do we know?

This is evidenced through:

- Ongoing monitoring of NHS Staff Survey indicators relating to bullying, harassment, discrimination and abuse.

- Enhanced reporting and oversight of discrimination, hate incidents, violence and aggression through established governance arrangements.
- Delivery of actions arising from the Too Hot to Handle review, including strengthened investigation and hearing processes.
- Implementation of the NHS Sexual Safety Charter and associated mandatory training.
- Monitoring of progress against NHS Staff Standards, Lord Mann Review recommendations and the Violence Prevention and Reduction Strategy.
- Feedback from staff networks, Freedom to Speak Up processes and workforce engagement activities.

Inclusion in Practice

Safe Spaces: Listening and Responding During Community Tension

During the summer of 2025, national and international events, alongside incidents within parts of Leeds, had a direct impact on some colleagues' experiences both inside and outside the workplace. A number of staff reported feeling unsafe whilst travelling to and from work, being approached by members of the public and, in some cases, experiencing abusive or discriminatory behaviour.

What We Did

In response, the Trust established a Safe Spaces Group, led in partnership with colleagues from across the organisation and strongly influenced by the Race Equality Staff Network.

Actions included:

- Establishing dedicated Safe Spaces drop-in sessions, both online and in person.
- Providing opportunities for colleagues to share experiences and concerns.
- Promoting wellbeing, inclusion and speaking-up support.
- Enhancing security briefings and safety communications.
- Introducing additional security measures in identified locations.
- Implementing individual workplace adjustments where required.
- Monitoring concerns through established governance and support arrangements.

Impact

The initiative provided colleagues with safe opportunities to discuss concerns, access support and influence organisational responses during a period of heightened anxiety and uncertainty.

It strengthened organisational visibility, improved access to support and reinforced the Trust's commitment to creating a workplace where colleagues feel safe, valued and able to raise concerns.

Organisational Learning

Safe Spaces arrangements are now established within the Trust and can be mobilised rapidly in response to future incidents or periods of heightened community tension. Learning from this work continues to inform the Trust's approach to staff wellbeing, inclusion and psychological safety.

What Next

During 2026/27, the Trust will implement priority actions arising from the NHS Staff Standards, Lord Mann Review and NHS Violence Prevention and Reduction Standard, with a particular focus on anti-racism, staff safety, speaking up, allyship and psychological safety. As work progresses towards the creation of Leeds Partnership Foundation Trust, a shared approach to violence prevention, staff safety and inclusion will be developed and embedded across the future organisation. Progress will be monitored through the People Inclusion Improvement Plan and established governance arrangements, supporting a safe, respectful and inclusive working environment for all colleagues.

5. NHS Staff Standards

5.1 During September and October 2026, the Trust completed baseline assessments against the NHS Staff Standards and undertook a gap analysis against the Lord Mann Recommendations on tackling racism and promoting inclusion within NHS organisations.

5.2 The assessments identified that many of the foundations required to support an inclusive workplace are already in place, including strengthened governance, leadership accountability, staff engagement, inclusive recruitment and targeted development interventions. However, they also highlighted areas where further work is required to translate these foundations into measurable improvements in staff experience and outcomes.

5.3 The findings reinforce a key theme of this report: whilst progress has been made, inequalities remain and continued action is required.

5.4 Priorities for 2026/27 include strengthening anti-racism, preventing and addressing bullying, harassment and discrimination, embedding inclusive leadership and management practices, supporting staff health and wellbeing, and ensuring clear accountability for equality, diversity and inclusion at all levels of the organisation.

5.5 In preparation for integration with Leeds and York Partnership NHS Foundation Trust, work in many of these areas is already being progressed collaboratively. Following the merger, priorities, delivery plans and governance arrangements will be aligned to support a consistent approach across the new organisation.

5.6 The table below summarises the Trust's current position against the NHS Staff Standards and the key actions identified for 2026/27. RAG ratings reflect the Trust's current level of alignment with each NHS Staff Standard. Green indicates the standard is largely met, with only routine development activity required. Amber indicates that the Trust has many of the necessary foundations in place but has identified a small number of priority gaps requiring further development to achieve full alignment with the standard. Where relevant, these actions have been incorporated into the People Inclusion Improvement Plan 2026/27 (Appendix C) and will be monitored through established governance processes.

Table 1: Assessment Against NHS Staff Standards

Standard	Current Position	RAG Status	Key Actions for 2026/27
Line Management	The Trust has established a range of leadership and management development interventions; however, further work is required to fully embed the expectations of the NHS Staff Standard across the organisation.	Amber	Embed the NHS Management and Leadership Framework. Implement the manager self-assessment process. Strengthen support and development for first-time managers
Health and Wellbeing	A range of wellbeing initiatives are in place; a more strategic and consistent approach is required.	Amber	Introduce routine health and wellbeing conversations. Develop a Health and Wellbeing Approach aligned to the NHS Health and Wellbeing Framework. Enhance manager capability to discuss wellbeing and reasonable adjustments confidently and consistently
Violence Prevention and Reduction	Improvement activity is being progressed through the Violence Prevention and Reduction Programme led by LYPFT	Amber	Continue implementation of actions through the Violence Prevention and Reduction Project Team. Monitor impact and assurance through existing governance arrangements.
Championing Sexual Safety	Key requirements are largely in place, with implementation activity underway.	Green	Complete rollout of mandatory Sexual Safety in the Workplace training. Provide specialist training for those

			undertaking investigations into sexual misconduct. Monitor compliance and effectiveness through governance processes.
Tackling Racism	Work has commenced to strengthen organisational capability and deliver key elements of the Anti-Racism Framework.	Amber	Appoint a Board-level Senior Responsible Officer (SRO) for anti-racism Introduce personal anti-racism objectives for all Board members. Develop an Anti-Racism Policy, supported by clear zero-tolerance messaging and anti-racism training for staff and managers. Strengthen reporting, accountability and assurance mechanisms relating to race equality.
Promoting Flexible Working	Further work is required to strengthen oversight and improve consistency of experience.	Amber	Improve collection and reporting of flexible working data. Develop and implement a Board-owned Flexible Working Action Plan. Monitor progress through the People and Culture Committee.

6. Delivering Lord Mann Recommendations

6.1 The Lord Mann Review highlighted the continuing need for NHS organisations to take proactive action to tackle racism, antisemitism and all forms of discrimination, strengthen leadership accountability, and ensure all staff feel safe, valued and supported at work.

6.2 Leeds Community Healthcare NHS Trust already has a strong foundation in this area through its Equality, Diversity and Inclusion (EDI) Improvement Plan, Workforce Race Equality Standard (WRES) action planning, staff networks, Freedom to Speak Up arrangements, and ongoing work to address bullying, harassment and discrimination. The recommendations arising from the Lord Mann Review provide an opportunity to build on this existing work, strengthen organisational accountability, and further embed anti-racist principles across the Trust.

6.3 To ensure a focused, proportionate and impactful response, the recommendations have been consolidated into three strategic priorities for 2026/27:

1. Leadership, Governance and Accountability

- Ensure anti-racism is a visible organisational priority, led from the top, with clear governance, accountability, oversight and assurance arrangements embedded across the Trust.
- Appoint a Board-level Senior Responsible Officer (SRO) for anti-racism.
- Introduce personal anti-racism objectives for all Board members to strengthen individual and collective accountability for delivery.
- Strengthen reporting, accountability and assurance mechanisms relating to race equality through existing governance structures.

2. Workforce Intelligence and WRES Improvement

- Use workforce data, staff experience measures and qualitative intelligence to identify inequalities, target interventions and drive measurable improvements in race equality.
- Continue to strengthen workforce data quality, transparency and reporting to support evidence-based decision-making and targeted action.

3. Education, Training and Capability Building

- Build the confidence and capability of staff, managers, leaders and investigators to recognise, challenge and respond effectively to racism, antisemitism and discrimination.
- Develop and implement an Anti-Racism Policy, supported by clear zero-tolerance messaging and appropriate anti-racism training for staff and managers.

6.4 Alongside these strategic priorities, the Trust will continue to deliver a range of established business-as-usual activities including policy development, staff engagement, support for staff affected by racism, promotion of reporting routes, staff

network involvement, and visible leadership commitment to a zero-tolerance approach to racism. This will ensure anti-racism remains embedded throughout the organisation rather than being delivered solely through standalone initiatives.

6.5 Progress will be monitored through the People and Culture Committee, supported by regular reporting on workforce metrics, staff experience measures, WRES indicators and delivery against agreed actions. The Board will receive regular assurance on progress, impact and areas requiring further attention.

6.6 By focusing on these three priorities, the Trust will strengthen leadership accountability, improve understanding of workforce inequalities, enhance organisational capability to respond to racism and discrimination, and support measurable improvements in staff experience and inclusion for all colleagues.

7. Next steps for 2026/27

7.1 The Trust has continued to make good progress in delivering the NHS EDI Improvement Plan High Impact Actions and has established strong foundations for advancing equality, diversity, inclusion and belonging across the organisation. As preparations continue for the establishment of Leeds Partnership Foundation Trust on 1 April 2027, a key priority will be to use this transition as an opportunity to strengthen and reset expectations around inclusion, leadership and organisational culture across the new Trust.

7.2 Looking ahead to the creation of Leeds Partnership Foundation Trust, the merger presents a unique opportunity to establish a shared culture built on inclusion, belonging and equity. Through the development of common values, behaviours and leadership standards, the new organisation can set clear expectations for how colleagues lead, work together and create psychologically safe environments. Embedding these principles through leadership development, management practice and organisational culture initiatives will be critical to ensuring inclusion is understood, demonstrated and owned at every level of the organisation.

7.3 During 2026/27, the Trust will focus on addressing the inequalities identified through workforce equality data, including differences in staff experience, career progression, workforce representation and pay. Improving workforce equality data quality and declaration rates will remain a priority, supporting a better understanding of workforce demographics and enabling more targeted interventions.

7.4 Priority actions will include strengthening inclusive recruitment and talent management, reducing ethnicity and disability pay gaps, improving staff safety and wellbeing, supporting career development opportunities for underrepresented groups, and tackling bullying, harassment and discrimination. This work will support implementation of the NHS Staff Standards, delivery of priority actions arising from the Lord Mann Review, and ongoing efforts to create an inclusive environment where all colleagues feel safe, valued, respected and able to thrive.

7.5 Progress against the High Impact Actions and the People Inclusion Improvement Plan will continue to be monitored through established governance arrangements,

including regular reporting to the People & Culture Committee and Trust Board. Workforce metrics, staff experience measures, pay gap analysis, WRES, WDES and EDS outcomes will continue to be used to assess impact, demonstrate progress and inform continuous improvement as the organisation transitions to Leeds Partnership Foundation Trust.

7.6 This paper provides Acceptable Assurance rather than Substantial Assurance because, whilst effective governance and improvement arrangements are in place and progress has been made across a number of priority areas, workforce equality data continues to highlight persistent inequalities in staff experience and outcomes. Further work is therefore required to demonstrate sustained improvement and measurable impact for colleagues from protected characteristic groups and to embed inclusion and belonging consistently across the future organisation.

8. Key Inclusion Risks and Mitigations

Whilst overall progress has been made against the Trust's inclusion priorities, a number of strategic risks remain which require continued oversight and monitoring through the Trust's governance arrangements.

8.1 **Workforce experience**
Some staff groups continue to report less positive experiences in relation to discrimination, bullying, harassment and inclusion.

Mitigation: Delivery of the People Inclusion Improvement Plan, targeted action informed by WRES, WDES and NHS Staff Survey findings, and continued support through Staff Networks, Safe Spaces and Freedom to Speak Up arrangements.

8.2 **Career progression and representation**
Differences in representation and progression opportunities remain across some workforce groups.

Mitigation: Inclusive recruitment processes, leadership development programmes, talent management initiatives and ongoing monitoring of workforce equality indicators.

8.3 **Pay gap inequalities**
Ethnicity and disability pay gaps have increased and require continued analysis and monitoring.

Mitigation: Further workforce analysis, targeted development interventions and regular review through People and Culture Committee governance arrangements.

8.4 **Data quality and declaration rates**
Incomplete declaration of protected characteristic data may limit the Trust's understanding of workforce inequalities and reduce the effectiveness of targeted interventions.

Mitigation: Ongoing campaigns to improve staff confidence in disclosure, enhanced communications regarding the use of workforce data and regular monitoring of data completeness.

8.5 **Organisational change**
The transition to a new provider organisation presents a risk that progress on inclusion could be disrupted if equality, diversity and inclusion considerations are not embedded throughout the transition process.

Mitigation: Embedding inclusion principles within organisational design, workforce transition planning, governance arrangements and staff engagement activity.

8.6 Overall, these risks are considered manageable and are subject to active mitigation. Continued Board oversight will be required to ensure that improvements in activity, governance and culture translate into sustained improvements in workforce experience and outcomes.

9. Conclusion

9.1 Overall, the Trust has made progress in advancing equality, diversity and inclusion during 2025/26, strengthening leadership accountability, inclusive recruitment practices, workforce equality monitoring and support for underrepresented groups. These developments have established strong foundations for improvement and have helped shape the priorities set out within the People Inclusion Improvement Plan 2026/27.

9.2 Whilst progress has been made, workforce equality data continues to highlight persistent inequalities in staff experience, career progression, representation and pay. Addressing these inequalities will remain a key priority during 2026/27 as the Trust focuses on delivering measurable improvements in workforce outcomes, implementing the NHS Staff Standards and Lord Mann Recommendations, and creating a culture where all colleagues feel safe, valued, respected and able to thrive. The key inequalities identified through WRES and WDES performance data, detailed in Appendices A and B, will directly inform the delivery of the People Inclusion Improvement Plan during 2026/27 and provide a framework for measuring future progress and impact.

9.3 The Trust is well positioned to build on the progress achieved to date and to support the development of an inclusive, equitable and welcoming culture within the Leeds Partnership Foundation Trust from April 2027.

10. Recommendations

The Trust Board is asked to:

- Receive assurance on progress against the NHS EDI Improvement Plan.
- Approve the People Inclusion Improvement Plan 2026/27.
- Note the key workforce inequalities identified through WRES, WDES, EDS and pay gap analysis.

- Support the implementation of the NHS Staff Standards and Lord Mann Recommendations.
- Support continued oversight through established Board assurance processes.

Leeds Community Healthcare NHS Trust

Workforce Race Equality Standard (WRES) Performance 2019-2026

	Metrics 1 to 4 & 9 is extracted from the workforce data held on ESR as at 31/3/25 and Metrics 5 to 8 is taken from the 2024 NHS staff survey.
WRES Indicator	**Metric description**
1	The percentage of staff in each of the AfC Bands1-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce

Clinical roles BME Representation.

	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	VSM
2026	0%	0%	22.4%	8.4%	19.6%	10.7%	10.6%	4.9%	16.7%	8.3%	25%	0%
2025	0%	0%	19.4%	8.9%	16.8%	10.7%	9.1%	4.8%	23.5%	0%	33.3%	0%
2024	0%	4.8%	19%	10.5%	17.1%	9.9%	8,4%	5%	22.2%	0%	33.3%	0%
2023	0%	11.1%	15%	11.4%	13.4%	9.9%	7.0%	7.2%	15.4%	6.7%	0%	0%
2022	0%	18.8%	14.6%	11.3%	10.5%	9.8%	5.2%	8.7%	13.3%	7.7%	0%	0%
2021	0%	28.6%	14.3%	7.4%	10.8%	8.7%	4.9%	4.9%	5.9%	8.3%	0%	0%
2020	50%	13.3%	14.2%	8.7%	10.8%	8.1%	3.2%	4.4%	0%	10%	0%	0%
2019	50%	7.7%	12.2%	7.9%	10.7%	7.3%	3.5%	3.9%	0%	0%	0%	0%

	Medical & Dental Consultant	Medical & Dental Non-Consultant Career Grade	Medical & Dental Trainee Grades	KQ00	MQ00	NQ00	WQ00	CQ00
2026	24.25 (8)	25% (3)	0%	50%(1)	0%	0%	16.7% (1)	0%
2025	22.6% (7)	27.3% (3)	9.1% (1)	50% (1)	0%	0%	14.3% (1)	0%
2024	25% (8)	25% (8)	0%	50% (1)	0%	0%	14.3% (1)	0%
2023	29.6% (8)	21.4% (3)	11.1.% (1)	50% (1)	0%	18.9% (7)	14.3% (1)	0%
2022	36.7% (11)	30.8% (4)	0%	0%	0%	6.7% (1)	14.3% (1)	0%
2021	36.4% (12)	33.3% (5)	0%	0%	0%	37.5% (3)	0%	0%
2020	31.3% (5)	14.3% (1)	0%	0%	0%	0%	0%	50% (1)
2019	43.8% (14)	35.3% (6)	0%	0%	0%	0%	0%	50% (1)

Non-Clinical roles BME Representation.

	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	VSM
2026	0%	20.9%	15%	27%	24.4%	18%	13.4%	8.6%	20%	9.1%	0%	0%
2025	0%	16.4%	15.6%	29.1%	21.2%	16.4%	10.8%	8.8%	5%	10%	0%	0%
2024	0%	15.9%	19%	10.5%	17.1%	9.9%	8.4%	5%	22.2%	0%	33.3%	0%
2023	0%	16.1%	17.5%	20.7%	19.8%	12.9%	14.1%	7.1%	4.3%	0%	0%	0%
2022	50%	22%	16%	19.3%	14.6%	15.7%	12.9%	5.5%	4.8%	0%	0%	0%
2021	40.9%	20.2%	15.7%	22.1%	14.4%	11.1%	14%	0%	7.1%	0%	0%	0%
2020	38.5%	20.3%	14.7%	20.3%	10.1%	11.1%	11.5%	0%	5.9%	0%	0%	0%
2019	38.5%	15.5%	15.5%	17.1%	10.9%	8.6%	9%	0%	5.9%	0%	0%	0%

WRES Indicator	Metric description	31.3.19 score	31.3.20 score	31.3.21 score	31.3.22 score	31.3.23 score	31.3.24 score	31.3.25 score	31.3.26 score
2	Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts.	0.16	0.35	0.84	0.24	0.96	0.6	0.5	A review of workforce equality data has been commissioned through the Inclusive Recruitment Project

WRES Indicator	Metric description	31.3.19 score	31.3.20 score	31.3.21 score	31.3.22 score	31.3.23 score	31.3.24 score	31.3.25 score	31.3.26 score
3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process.	0.16	0.35	0.84	0.24	0.96	0.6	0	No data available

WRES Indicator	Metric description	31.3.19 score	31.3.20 score	31.3.21 score	31.3.22 score	31.3.23 score	31.3.24 score	31.3.25 score	31.3.26 score
4	Relative likelihood of White staff accessing non mandatory training and CPD compared to BME staff.	1.3	1	1.1	0.8	1.5	1.7	1.7	0.9

WRES Indicator	Metric description	NHS Staff Survey **2018**	NHS Staff Survey **2019**	NHS Staff Survey **2020**	NHS Staff Survey **2021**	NHS Staff Survey **2022**	NHS Staff Survey **2023**	NHS Staff Survey **2024**	NHS Staff Survey **2025**
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months *White staff percentage in brackets.	22.4% (25.7%)	21% (26.5%)	21% (24%)	23.8% (26.4%)	16.3% (23.9%)	17.7% (18.8%)	17.6% (18%)	18% (18.1%)

WRES Indicator	Metric description	NHS Staff Survey **2018**	NHS Staff Survey **2019**	NHS Staff Survey **2020**	NHS Staff Survey **2021**	NHS Staff Survey **2022**	NHS Staff Survey **2023**	NHS Staff Survey **2024**	NHS Staff Survey **2025**
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months *White staff percentage in brackets	21.2% (16.7%)	24.1% (16.7%)	24.8% (16.4%)	19.3% (16%)	12.9% (12.8%)	15.2% (11.7%)	14% (12.1%)	14.3% (10.4%)

WRES Indicator	Metric description	NHS Staff Survey **2018**	NHS Staff Survey **2019**	NHS Staff Survey **2020**	NHS Staff Survey **2021**	NHS Staff Survey **2022**	NHS Staff Survey **2023**	NHS Staff Survey **2024**	NHS Staff Survey **2025**
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion. *White staff percentage in brackets.	41% (65.4%)	39.9% (64%)	40.5% (66.3%)	45.6% (65.9%)	49.8% (62.9%)	50.4% (66.7%)	50.5% (63.2%)	50.4% (60.2%)

WRES Indicator	Metric description	NHS Staff Survey 2018	NHS Staff Survey 2018	NHS Staff Survey 2018	NHS Staff Survey 2018	NHS Staff Survey 2018	NHS Staff Survey 2018	NHS Staff Survey 2018	NHS Staff Survey 2018
8	. Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team *White staff percentage in brackets.	16.9% (3.9%)	17.9% (4.3%)	15.3% (4.3%)	13.7% (4.3%)	12.1% (4.2%)	11.3% (2.7%)	7.6% (3.9%)	9.4% (3.8%)

WRES Indicator	Metric description	31.3.19 score	31.3.20 score	31.3.21 score	31.3.22 score	31.3.23 score	31.3.24 score	31.3.25 score	31.3.26 score
9	Percentage of BME Board membership	0	0	0	8.3%	8.3%	16.7%	0	0

WDES Metric 1

Metric description - Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (*including Executive Board members*) compared with the percentage of staff in the overall workforce.

Nonclinical		Disabled								Non-Disabled								Notknown & undeclared							
		2019	2020	2021	2022	2023	2024	2025	2026	2019	2020	2021	2022	2023	2024	2025	2026	2019	2020	2021	2022	2023	2024	2025	2026
Cluster 1	Bands 1-4	6%	7%	6%	6%	6%	6%	6%	8%	86%	85%	85%	85%	79%	73%	75%	69%	8%	8%	9%	9%	15%	21%	19%	23%
Cluster 2	Bands 5-7	5%	6%	5%	5%	6%	10%	12%	11%	85%	87%	89%	87%	87%	84%	83%	82%	9%	8%	6%	8%	7%	6%	5%	7%
Cluster 3	Bands 8a-8b	4%	3%	3%	7%	8%	6%	8%	10%	91%	89%	87%	92%	88%	88%	84%	80%	5%	8%	10%	1%	4%	6%	8%	10%
Cluster 4	Bands 8c - VSM	0%	0%	0%	0%	0%	0%	4%	7%	70%	63%	60%	87%	85%	81%	46%	54%	30%	38%	40%	13%	15%	19%	50%	39%

Clinical		Disabled								Non-Disabled								Not known/undeclared							
		2019	2020	2021	2022	2023	2024	2025	2026	2019	2020	2021	2022	2023	2024	2025	2026	2019	2020	2021	2022	2023	2024	2025	2026
Cluster 1	Bands 1-4	4%	4%	4%	5%	5%	5%	3%	5%	86%	85%	86%	84%	79%	77%	69%	80%	8%	8%	9%	11%	16%	18%	28%	15%
Cluster 2	Bands 5-7	4%	5%	5%	6%	6%	6%	7%	8%	86%	85%	82%	83%	80%	75%	74%	71%	10%	10%	13%	11%	14%	19%	19%	21%
Cluster 3	Bands 8a-8b	4%	4%	4%	2%	3%	6%	11%	19%	92%	85%	83%	85%	87%	80%	80%	72%	5%	11%	14%	13%	10%	14%	9%	9%
Cluster 4	Bands 8c - VSM	9%	8%	0%	0%	0%	0%	0%	0%	82%	75%	85%	88%	82%	85%	52%	42%	95	17%	15%	12%	18%	15%	48%	58%
Cluster 5	Medical & Dental consultants	0%	0%	0%	0%	0%	3%	3%	3%	79%	75%	67%	70%	59%	47%	48%	46%	21%	24%	33%	30%	41%	50%	51%	51%
Cluster 6	Medical & Dental non consultants	5%	13%	7%	8%	7%	8%	9%	0%	60%	62%	67%	62%	64%	75%	64%	67%	35%	25%	27%	30%	29%	17%	27%	33%
Cluster 7	Medical & Dental trainee consultants	0%	0%	0%	0%	0%	9%	3%	0%	0%	0%	0%	0%	22%	9%	32%	0%	100%	100%	100%	100%	78%	82%	65%	100%

WDES Metric 2

WDES Metric	Metric description	31.3.19 score	31.3.20 score	31.3.21 score	31.3.22 score	31.3.23 score	31.1.24 score	31.1.25 score	31.3.26 score
2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts. *(ESR data)*	1.9	2.5	1.2	1	0.4	1.6	1.4	A review of workforce equality data has been commissioned through the Inclusive Recruitment Project

A relative likelihood above 1 indicates that non-disabled applicants are more likely to be appointed from shortlisting compared to Disabled applicants: egg a likelihood ratio of 2 indicates non-disabled applicants are twice (2 times) as likely to be appointed from shortlisting as Disabled applicants. (ESR data 31.3.2024)

WDES Indicator 3

WDES Metric	Metric description	31.3.19 score	31.3.20 score	31.3.21 score	31.3.22 score	31.3.23 score	31.1.24 score	31.1.25 score	31.3.26 score
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process. *(ESR data)*	2	0	0	0	0	0	0	0

This metric based on data from a two-year rolling average of the current year and the previous year, and applies to capability on the grounds of performance only and not ill health (ESR data 31.3.2024)

WDES Metric 4 - Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse.

WDES Metric	Metric description	NHS Staff Survey 2018	NHS Staff Survey 2019	NHS Staff Survey 2020	NHS Staff Survey 2021	NHS Staff Survey 2022	NHS Staff Survey 2023	NHS Staff Survey 2024	NHS Staff Survey 2025
4a(i)	Staff experiencing harassment, bullying or abuse from the public in the last 12 months *(Nondisabled staff scores in brackets)*	34% (22%)	31% (24%)	34% (22%)	34% (24%)	14% (9%)	25% (16%)	23% (17%)	23% (16%)
4a(ii)	Staff who have experienced harassment, bullying or abuse from managers in the past 12 months *(Nondisabled staff scores in brackets*	11% (7%)	12% (5%)	15% (7%)	12% (7%)	9% (5%)	10% (3%)	7% (4%)	9% (4%)
4a (iii)	Staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months. *(Nondisabled staff scores in brackets)*	21% (11%)	19% (12%)	20% (11%)	20% (10%)	14% (9%)	14% (9%)	16% (8%)	14% (6%)
4a(iv)	Staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months. *(Nondisabled staff scores in brackets)*	56% (56%)	55% (57%)	60% (60%)	49% (53%)	58% (59%)	54% (60%)	61% (57%)	63% (69%)

WDES Metric 5

WDES Metric	Metric description	NHS Staff Survey 2018	NHS Staff Survey 2019	NHS Staff Survey 2020	NHS Staff Survey 2021	NHS Staff Survey 2022	NHS Staff Survey 2023	NHS Staff Survey 2024	NHS Staff Survey 2025
5	Percentage of Disabled staff compared to nondisabled staff believing that the Trust provides equal opportunities for career progression or promotion (*Nondisabled staff scores in brackets)*	59% (65%)	57% (64%)	56% (65%)	58% (65%)	54% (64%)	63% (65%)	63% (55%)	54.8% (59.9%)

WDES Metric 6

WDES Metric	Metric description	NHS Staff Survey 2018	NHS Staff Survey 2019	NHS Staff Survey 2020	NHS Staff Survey 2021	NHS Staff Survey 2022	NHS Staff Survey 2023	NHS Staff Survey 2024	NHS Staff Survey 2025
6	Percentage of Disabled staff compared to nondisabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties (presenteeism) *(Nondisabled staff scores in brackets)*	30% (20%)	22% (15%)	29% (17%)	26% (16%)	24% (13%)	19% (11%)	19% (14%)	24.1% (13.2%)

WDES Metric 7

WDES Metric	Metric description	NHS Staff Survey 2018	NHS Staff Survey 2019	NHS Staff Survey 2020	NHS Staff Survey 2021	NHS Staff Survey 2022	NHS Staff Survey 2023	NHS Staff Survey 2024	NHS Staff Survey 2025
7	Percentage of Disabled staff compared to nondisabled staff saying that they are satisfied with the extent to which the organisation values their work (Nondisabled staff scores in brackets)	44% (51%)	49% (60%)	50% (57%)	44% (53%)	45% (55%)	50% (57%)	54% (45%)	41.1% (54.3%)

WDES Metric 8

WDES Metric	Metric description	NHS Staff Survey 2018	NHS Staff Survey 2019	NHS Staff Survey 2020	NHS Staff Survey 2021	NHS Staff Survey 2022	NHS Staff Survey 2023	NHS Staff Survey 2024	NHS Staff Survey 2025
8	Percentage of staff with a long-lasting health condition or illness, saying that their employer has made adequate adjustment(s) to enable them to carry out their work	83%	79%	79%	81%	77.6%	78.4%	80.8%	80.5%

WDES Metric 9

WDES Indicator	Metric description	NHS Staff Survey 2019	NHS Staff Survey 2020	NHS Staff Survey 2021	NHS Staff Survey 2022	NHS Staff Survey 2023	NHS Staff Survey 2024	NHS Staff Survey 2025
9a	Staff engagement score (0-10)							
	The staff engagement score for Disabled staff, compared to nondisabled staff. (*Non-disabled staff score in brackets)*	6.8 (7.2)	6.8 (7.4)	6.8 (7.3)	6.6 (7.1)	6.7 (7.2)	6.9 (7.3)	6.6 (7.1)

NHS
Leeds Community Healthcare
NHS Trust

People Inclusion Improvement Plan 2026/7

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
	Organisational Priority: Equality Monitoring and Workforce Data.					
N/A	Reduce the proportion of staff recorded as "Unknown" or "Prefer Not to Say" on ESR across all protected characteristics, through targeted communication, data quality campaigns and routine verification of workforce records.	Continue to provide clear and accessible information ensuring that staff have easy access to information about the importance of equality declaration and how it contributes to creating an inclusive workplace. Achieve a minimum 5% improvement in declaration rates across all protected characteristics by March 2027. Measures of success: • Ethnicity unknown/prefer not to say: reduce	CPO Associate Director People Services & People Solutions	Monthly via IPR		Equality Act 2010 S149 WDES WRES EPGR DPGR Lord Mann Rec.

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
		from 16.3% to below 12% • Disability unknown/prefer not to say: reduce from 19.9% to below 15% • Religion or Belief: reduce from 29.3% to below 24% • Sexual Orientation: reduce from 21.5% to below 17%				
		Continue to regularly track and analyse equality declaration rates to identify any trends or patterns that may indicate areas for improvement. Use this data to inform targeted interventions and strategies to increase staff declaration.	CPO Associate Director of People Services	Monthly via IPR		Equality Act 2010 S149 WDES WRES EPGR DPGR Lord Mann Rec.
		Promote the ESR Equality Data self-service function through My LCH, staff onboarding and corporate induction to improve equality declaration rates and workforce data quality.	CPO Associate Directors of People Services & People Solutions	Monthly		Equality Act 2010 S149 WDES WRES EPGR DPGR Lord Mann Rec.

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
		Continue to provide the Workforce Equality Data dashboard and continued access for all LCH staff.	CPO Associate Director of People Services	In place		
High impact action 1: **Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.**						
1.0	Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable	The Trust Chair will embed personal accountability for EDI and anti-racism across the Board through measurable objectives for all Executive and Non-Executive Directors, with executive leadership provided by a Board-level SRO and regular Board oversight of delivery. Measures of success: • 100% of Executive Directors and Non-Executive Directors have at least one EDI objective and one	Chair CEO Board Secretary	19.11.26	Next Review 31.03.27	Equality Act 2010 S149 Lord Mann Rec

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
		anti-racism objective included within their appraisal. • Annual Board development session focused on inclusion, anti-racism and leadership accountability. • Quarterly Board oversight of progress against agreed EDI and anti-racism objectives. • Appoint the Chief Executive Officer (CEO) or Chief Operating Officer (COO) as the Board-level Senior Responsible Officer (SRO) for anti-racism and discrimination				
1.1	Board members should demonstrate how organisational data and lived experience have been used to improve culture	The Trust Board will continue to strengthen inclusive leadership and engagement by receiving patient and colleague	Chair Board Secretary	19.11.26 In place		Equality Act 2010 S149 WDES WRES EPGR

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
		stories at Board meetings, increasing Non-Executive Director visits to services and teams, and maintaining active Executive sponsorship of staff networks. Following recent Board appointments refresh Executive sponsorship arrangements for staff networks to ensure each network has an active Executive sponsor who can provide visible leadership, advocacy and support for network priorities.	CEO Board Secretary	19.11.26	01.04.26	DPGR GPGR LGBTQIA+ Lord Mann Rec EDS2022 Domain 3.1 & 3.2
1.2	NHS boards must review relevant data to establish EDI areas of concern and prioritise actions.	Trust Board will regularly review relevant Equality, Diversity and Inclusion (EDI) data to identify areas of inequity and concern, prioritise improvement actions, and provide oversight of progress against agreed improvement plans. Progress and key metrics will be reviewed quarterly	Chair CEO	19.11.26	Next Review 31.03.27	Reviewed Quarterly at P&CC

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
		by the People and Culture Committee, with escalation of significant risks and issues to the Trust Board as appropriate.	CPO re P&CC			
High impact action 2: **Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.**						
2.0	Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.	Implement a new mandatory Values-Based Inclusive Recruitment Course aligned to the Leeds Partnership NHS Foundation Trust (LPFT) values for all recruiting managers. The programme will include updates on inclusive recruitment practices, equitable selection processes, reducing bias in recruitment, and supporting fair and values-based hiring decisions. Measures of success: • Mandatory recruitment training is in place	CPO Associate Director of People Services and Solutions	19.11.26	31.07.27	EPGR DPGR GPGR WDES WRES EDS 2022 Domain 2.1

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
		for all recruiting managers. • Inclusive recruitment principles are embedded within recruitment processes.				
2.1	Reduce workforce inequalities identified through WRES, WDES, pay gap and staff experience data by implementing targeted positive action initiatives, in partnership with Leeds Partnership Foundation Trust, to improve representation in senior roles (Band 8a+). Monitor progress through agreed equality metrics and KPIs within the new Trust performance framework.	• Analyse workforce equality data to identify and prioritise key inequality gaps. • Implement targeted positive action programmes to improve representation and progression of underrepresented groups, particularly in Bands 8a and above. • Increase equitable access to development, leadership and career progression opportunities. • Monitor and report progress through	CPO Associate Director of People Solutions	19.11.26	31.07.27	EPGR DPGR GPGR WDES WRES EDS 2022 Domain 2.1

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
		agreed equality KPIs and the new Trust performance framework.				
2.2	Undertake quarterly monitoring of recruitment data and outcomes by protected characteristic, with actions implemented where disparities are identified	Measures of success: • Quarterly monitoring of recruitment outcomes by protected characteristic. • Recruitment disparities identified, reported and reviewed. • Action taken to address identified inequalities.	CPO Associate Director of People Operations and Solutions	19.11.26	31.03.27	EPGR DPGR GPGR WDES WRES EDS 2022 Domain 2.1
2.3	Work in partnership with the Disability, Neurodiversity and Long-Term Conditions, Pride and Race Equality Networks to inform recruitment and talent management strategies, ensuring the voices and experiences of under-represented groups shape actions to improve workforce diversity and inclusion	Measures of success: • Annual work plans are in place for each staff network. • Quarterly meetings are held between staff networks and Executive Sponsors. • Annual report demonstrating network impact on	CPO Associate Director People Solutions	19.11.26	Next Review 31.03.27	EPGR DPGR GPGR WDES WRES EDS 2022 Domain 2.2

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
		organisational decision making.				
2.4	Develop and oversee a Board-owned Flexible Working Action Plan informed by workforce data, ensuring equitable access to flexible working and contributing to improved retention, talent development and representation across all workforce groups.	Measures of success: • Board-owned Flexible Working Action Plan implemented and monitored. • Flexible working requests (formal and informal) are collected, monitored and reported by protected characteristic, staff group/profession, pay band and department. • Approval and rejection rates, and the types of flexible working requests, are routinely reviewed to identify and address disparities. • Flexible Working Champion	CPO Associate Director of People services Head of People Partnering	19.11.26	31.03.28	EPGR DPGR GPGR WDES WRES EDS 2022 Domain 2.1 NHS Staff Standards

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
		provides oversight and assurance on delivery of the Action Plan. • Reduced disparities in access to flexible working across workforce groups. • Improved flexible working and work-life balance indicators in the NHS Staff Survey.				
High impact action 3: **Develop and implement an improvement plan to eliminate pay gaps.**						
3.0	Increase the number of women in the Gender Pay Gap Reporting Quartile 4 (Highest)	Promote local, regional and national development, leadership and networking opportunities for women, supporting career progression, visibility and representation at all levels of the organisation. • Analyse representation of women in Bands 8a+.	CPO Associate Director People Services & Solutions	19.11.26	Next Review 31.03.27	EPGR DPGR GPGR WDES WRES EDS 2022 Domain 2

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
		• Monitor access to talent programmes and acting-up opportunities. • Promote mentoring and sponsorship schemes. • Review progression data annually.				
3.1	Increase the use of skill-based assessment tasks in recruitment *(DWP best practice*)	Increase the use of skills-based assessment tasks in recruitment and selection processes, drawing on DWP best practice to support fair and inclusive hiring, through quarterly communications and guidance to Recruiting Managers	CPO Associate Director of People Services	19.11.26	Next Review 31.03.27	EPGR DPGR GPGR WDES WRES EDS 2022 Domain 2.1
3.2	Ensure all LCH promotion, pay and reward processes are transparent for all.	Continue adhering to the Agenda for Change Job Evaluation Process and Job Evaluation Panel, and clear and transparent processes for non-Agenda for Change staff.	CPO Associate Director of People Services	19.11.26	Next Review 31.03.27	EPGR DPGR GPGR WDES WRES EDS 2022 Domain 2.

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
3.3	Promote and support flexible working opportunities for men in line with the Flexible Working Policy, helping to reduce gender stereotypes and support equitable career progression and work-life balance.	Promote the Trusts flexible working policy for men and women through quarterly promotion pieces & personal stories in My LCH and through People Partner networks	CPO Associate Director of People Services	19.11.26	Next Review 31.03.27	EPGR DPGR GPGR WDES WRES EDS 2022 Domain 2.4
		Work with People Partners and People Process to develop a robust process for capturing and reporting flexible working data through ESR, enabling regular monitoring and informed workforce planning.	CPO Associate Director of People Services	19.11.26	Next Review 31.03.27	GPGR EDS 2022 2.4
3.4	Increase the number of men who are taking Shared Parental Leave	Encourage the uptake of Shared Parental Leave to support a more equitable sharing of childcare responsibilities. Continue to work in partnership with the Men's Health Forum to raise awareness and increase uptake through targeted communications, quarterly promotion campaigns and staff stories shared via My LCH.	CPO Associate Director of People Services	19.11.26	Next Review 31.03.27	EDS 2022 Domain 2.4 GPGR

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
3.5	Reduce the Ethnicity Pay Gap	Undertake a detailed analysis of the Trust's Ethnicity Pay Gap data, aligned to the NHS Workforce Race Equality Standard (WRES) and EDI Improvement Plan, to identify the structural drivers of disparity, inform evidence-based interventions, and apply best practice from within the NHS and other sectors to advance race equity in pay, progression and workplace experience. • Analyse pay gap by band, occupation and directorate. • Barriers to progression and career development are identified and addressed • Develop a targeted race equality progression programme.	CPO Associate Director of People Services	19.11.26	Next Review 31.05.27	WRES EPGR Lord Mann Rec EDS 2022 Domain 2.1/3/4.

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
		• Produce annual action report.				
3.6	Reduces the Disability Pay Gap	Undertake a detailed analysis of the Trust's Disability Pay Gap data, aligned to the Workforce Disability Equality Standard (WDES), EDI Improvement Plan and the social model of disability, to identify and address barriers affecting disabled colleagues. Findings will inform targeted actions to improve equity in pay, progression, recruitment, retention, workplace experience and representation at senior level. Measures of success: • Annual Disability Pay Gap analysis completed and reported annually. • Improved disability data quality and declaration rates. • Recruitment, progression, retention and	CPO Associate Director of People Services	19.11.26	Next Review 31.05.27	Disability Confident EPGR WDES EDS 2022 Domain 2.1/3/4

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
		representation of disabled staff monitored and reviewed. • Barriers to workplace inclusion and career progression identified and addressed. • Targeted improvement plan implemented, monitored and benchmarked against WDES indicators and NHS best practice.				
	High impact action 4: **Develop and implement an improvement plan to address health inequalities within the workforce.**					
4.0	Develop and implement a Health and Wellbeing plan aligned to the NHS Health and Wellbeing Framework, using workforce data to identify and address health inequalities and improve wellbeing outcomes for all colleagues	Measures of success: • Health and Wellbeing Strategy developed and implemented. • Workforce health and wellbeing data routinely reviewed to identify inequalities.	CPO Associate Director of People Solutions	19.11.26	31.07.27	NHS Staff Standards

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
		• Targeted actions implemented to address identified health inequalities. • Improvement in NHS Staff Survey health and wellbeing indicators. • Reduction in disparities in health and wellbeing outcomes between protected characteristic groups				
4.1	Line managers should continue to have regular wellbeing conversations with their teams supported by national resources, including the health and wellbeing framework	Strengthen manager capability to support staff health, wellbeing and safety by ensuring completion of mandatory health and wellbeing competencies and embedding meaningful wellbeing conversations within routine management practice, aligned to the NHS People Promise and NHS Staff Standards.	CPO Associate Director of People Solutions	19.11.26	31.07.27	WDES WRES DPGR EPGR GPGR LGBTQIA+ EDS 2022 Domain 2.1/3/4 NHS Staff Standards

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
4.2	NHS organisations are encouraged to adapt NHS England's policy on menopause awareness as applicable to their local workforce. They should also adopt and implement the Supporting our NHS people through menopause: guidance for line managers and colleagues.	Continue to promote and maintain the Trust's status as a Menopause Friendly Employer by raising awareness of the support available, providing manager awareness sessions, and promoting access to individual support through the Occupational Health provider.	CPO Associate Director of People Solutions	19.11.26	In place Next Review 31.03.27	WDES WRES DPGR EPGR GPGR LGBTQIA+ NHS Staff Standards
4.3	Achieve reaccreditation of the Disability Confident Leaders Accreditation	Work with LYPFT to achieve and maintain Disability Confident Leader accreditation, including review and implementation of the current action plan and supporting evidence requirements. Measures of success: • Disability Confident Leader accreditation achieved and maintained.	CPO Associate Director of People Solutions	19.11.26	31.05.27	NHS Standard Contract WDES EDS2022 Domain 2.2/4 & 3.2/3 NHS Staff Standards

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
4.4	Improve the experience and wellbeing of disabled staff by strengthening manager capability to discuss reasonable adjustments, support disability disclosure and create inclusive workplace environments that reduce health inequalities.	Measures of success: • Increased disability declaration rates. • Increased manager confidence in supporting staff and implementing reasonable adjustments. • Improvement in WDES staff experience indicators.	CPO Associate Director of People Solutions	19.11.26	31.09.27	NHS Staff Standards
	High impact action 5: **Implement a comprehensive induction, onboarding, and development programme for internationally recruited staff.**					
5.0	Deliver the LCHT comprehensive induction, onboarding, and development programme for internationally recruited staff, as quired.	Continue to provide dedicated pastoral support to internationally recruited nurses through the Pastoral Support Officer, promoting wellbeing, inclusion, retention and a positive employment experience.	Director of Nursing Head of Clinical Education	31.12.26	In place	Equality Act 2010 S149 WRES EPGR EDS2022 Domain 2.

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
	High impact action 6: **Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.**					
6.0	Year on year improvement scores and reduction of disparity of experience between different protected characteristics.	Use staff experience and workforce data to identify and address disparities between protected characteristic groups, implementing targeted actions to reduce bullying, harassment and discrimination Measures of success: • Year-on-year improvement in NHS Staff Survey, WRES and WDES staff experience indicators. • Improvement in WRES Indicator • Reduction in disparities in staff experience between protected characteristic groups. • Formal hearings and investigations	CPO Associate Director of People Services & Solutions Head of People Partnering	19.11.26	31.05.27	Equality Act 2010 S149 WRES WDES

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
		include appropriately trained individuals with the expertise to identify and address discrimination, bias and inequitable treatment.				
6.1	Create a safe, secure, and supportive working environment for all LCHT staff by preventing and reducing incidents of violence, aggression, and abuse in the workplace	Work collaboratively with Leeds and York Partnership NHS Foundation Trust (LYPFT) to develop a Violence Prevention and Reduction (VPR) Strategy and supporting VPR Policy. This will include agreeing strategic priorities, developing a delivery plan and key performance indicators, securing senior leadership commitment, and establishing governance arrangements to oversee progress, manage risks and promote good practice. Measures of success: • Incidents of violence,	CPO Head of Facilities and Safety	19.11.26	31.05.27	NHS Violence Prevention and Reduction (VPR) Standard NHS Staff Standards NHS People Promise – We are Safe and Healthy Equality Act 2010 S149 Health and Safety at Work etc. Act 1974 WRES WDES EDS 2022 Domain 3 & 4 https://cms.nhsstaffsurveys.com/app/reports/2024/RY6-

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
		aggression and abuse monitored and reviewed quarterly. • Reduction in reported incidents over time. • Improved staff survey indicators relating to safety and experience. • Increased confidence in reporting and managing incidents. • Delivery of agreed Violence Prevention and Reduction a				benchmark-2024.pdf

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
6.2	Deliver actions arising from the Lord Mann Review and NHS Staff Standards through the Inclusion Improvement Plan, promoting a culture of belonging, respect and inclusion for all colleagues.	Implement actions arising from the NHS Staff Standards review and Lord Mann Review that have been incorporated into this Inclusion Improvement Plan, strengthening the prevention of discrimination, harassment and exclusion and promoting a culture of belonging and respect for all colleagues. Measures of success: • Improved NHS Staff Survey scores relating to inclusion, fairness and belonging. • Reduction in reported experiences of discrimination, bullying and harassment. • Reduced disparities in experience between protected	CEO Trust Board	19.11.26	30.11.26	Lord Mann Review Recommendations NHS Anti-Racism Framework NHS Staff Standards Equality Act 2010 S149 WRES EDS 2022 Domain 3.2, 3.3 and 4.1 NHS People Promise – We are Compassionate and Inclusive

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
6.3		characteristic groups. • Improvement in WRES and WDES staff experience indicators. • Progress evidenced through NHS Oversight Framework indicators and reporting requirements				

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
	Implement and promote the Trust's Anti-Racism Policy and anti-racism training programme, reinforcing a zero-tolerance approach to racism, discrimination and harassment and supporting a culture of dignity, respect and inclusion for all colleagues.	Measures of success: • Anti-Racism Policy developed and implemented. • Anti-racism training programme delivered and evaluated. • Improvement in NHS Staff Survey discrimination indicators. • Improvement in WRES Indicator 8. • Increased confidence to report and challenge racism and discrimination. • Reduction in reported experiences of racism and discrimination.	CPO Director of People Solutions	19.11.26	31.09.27	Lord Mann Review Recommendations NHS Anti-Racism Framework NHS Staff Standards

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
6.4	Embed the Sexual Safety in Healthcare Charter	Continue to strengthen arrangements for preventing, reporting and responding to sexual misconduct, ensuring a safe, respectful and inclusive working environment for all colleagues. Measures of success: • Board-level oversight of sexual safety arrangements maintained. • All colleagues complete mandatory sexual misconduct awareness training. • Specialist sexual misconduct investigation training completed by designated investigators. • A pool of appropriately trained investigators	CPO Head of Safeguarding Head of People Partnering	19.11.26	31.05.27	Lord Mann Review Recommendations NHS Anti-Racism Framework NHS Staff Standards Equality Act 2010 S149 WRES EDS 2022 Domain 3.2, 3.3 and 4.1 NHS People Promise – We are Compassionate and Inclusive

Ref	Measure *(NHSE require improvement no specific targets have been allocated)*	Action	Director Owner and Lead	Review Date	Delivery Date	Links & Notes
		• Policies and procedures remain aligned with the NHS Sexual Misconduct Policy Framework. • Staff confidence in, and awareness of, reporting processes maintained or improved.				

Appendix D: Trust Board Intentions

On 12 June 2026, the Board considered the outcomes of staff survey analysis and formally endorsed the identification of three priority areas of staff dissatisfaction. The Board recognised that these themes are already reflected within the Trust's existing improvement plans and People Promise priorities and noted their alignment with Board pledges and wider organisational development initiatives. The Board further supported the continued oversight of these areas through established governance and assurance processes, providing ongoing scrutiny of progress and impact.

The objectives are designed to address the underlying drivers of staff experience identified through the analysis, while building on areas of strength.

Theme	Objective	Rationale
Engagement	To strengthen staff engagement by improving how organisational change is communicated and experienced, and by increasing visible Board-level engagement with staff to ensure that staff voice informs decision-making.	Staff survey feedback indicates change, uncertainty and a perceived gap between staff voice and organisational decision-making as key drivers of experience. Analysis indicates that the issue is not change itself, but how it is experienced in practice, including clarity, communication and involvement. Board member pledges place emphasis on increased visibility, direct engagement (including with staff networks), and strengthening feedback loops. This objective reflects the need to support staff through ongoing organisational change, including the Trust's integration programme, while improving connection between staff experience and organisational decisions.
Wellbeing ('We are Safe and Healthy')	To ensure sustained Board-level visibility of workforce pressures by overseeing a range of workforce indicators and staff experience data and maintaining focused attention on areas where these pressures are having the greatest impact on staff wellbeing and service delivery.	Staffing, workload and capacity represent the most prominent and consistent area of dissatisfaction across staff feedback. Whilst workforce pressures are influenced by wider system factors, the analysis indicates that their impact on staff wellbeing remains significant.

Appendix D: Trust Board Intentions

		Workforce pressure is reflected through a combination of operational workforce indicators (including vacancy rates, sickness absence and turnover), service performance, and staff experience data such as survey results and feedback from service visits. This objective reflects the Board's role in maintaining visibility of these indicators collectively, ensuring that areas of greatest impact are identified and that workforce pressures are considered alongside service delivery and performance.
Inclusion	To strengthen an inclusive and equitable staff experience by ensuring that equality, diversity and inclusion are consistently considered in Board decision-making, informed by workforce data, and supported through engagement with staff networks.	Whilst not identified as a standalone area of dissatisfaction, issues relating to fairness, inclusion and psychological safety are evident across staff feedback, particularly in relation to voice, culture and experience of change. WRES/WDES reporting and Board discussion highlight the importance of understanding variation in staff experience across different staff groups. This includes using workforce data to identify differences in experience and outcomes, alongside insight from staff networks to understand lived experience. Board pledges emphasise engagement with staff networks, improving data visibility, and reinforcing inclusion as a core organisational priority. This objective ensures that inclusion is actively embedded within all areas of focus, rather than treated as a separate activity.

NHS Equality Delivery System 2022

Leeds Community Healthcare NHS Trust

Domain 2 (*Workforce health and well-being)* & Domain 3 (*Inclusive leadership*).

Leeds Community Healthcare NHS Trust

Domain	Outcome	Evidence	Owner	Proposed Improvement actions	Rating
Domain 2: ***Workforce health and well-being***	**2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions**	**Direct Psychological Support** Leeds Mental Wellbeing Service (LMWS) provides assessment and treatment for common mental health conditions, including stress, anxiety, depression, PTSD and panic. Support is available through individual, group and online sessions. All LCH staff can access the service regardless of GP registration and can self-refer online or by telephone. The Employee Assistance Programme, provided by Health Assured, offers free and confidential support to all LCH staff. This includes up to six counselling sessions, a 24/7 helpline, wellbeing resources and practical advice for personal and work-related challenges. Additional guidance is available from the Staff Wellbeing Clinical Psychologist for colleagues who are unsure which support service best meets their needs. NHS England Support Services NHS staff can access a range of free and confidential wellbeing support, including the 24/7 text service by texting SUPPORT to 85258. Additional support is available through the NHS self-check tool, which helps staff identify appropriate wellbeing services. Further information can be found via the NHS Website, Mental Health Services, and NHS support offers. For non-urgent medical advice call 111, and for emergencies call 999. Coaching is available to all staff through LCH's internal coaching network and the North East and Yorkshire Leadership Academy (NEYLA), supporting personal development, wellbeing and professional goals. Further information is available via the Trust coaching webpage. Bereavement Support	**People Director**	**Suggested Improvement Actions** • Develop a single **Leeds Partnership NHS Foundation Trust Workforce Wellbeing Strategy**, bringing together physical health, mental health and wellbeing support offers. • Review and harmonise staff wellbeing support across LCH and LYPFT to ensure equitable access for all colleagues following the merger. • Introduce a wellbeing dashboard to monitor uptake, access and outcomes across wellbeing services and staff groups. • Increase awareness and promotion of wellbeing services through targeted communications and manager briefings. • Implement targeted support for staff with long-term health conditions, including obesity, diabetes, asthma and COPD, alongside existing mental health provision. • Use NHS Staff Survey, sickness absence and occupational health data to identify health inequalities and target wellbeing interventions. • Evaluate the effectiveness of counselling, coaching and psychological support services through regular staff feedback and outcome measures. **Measures of Success** • Increased awareness and utilisation of wellbeing services. • Improvement in NHS Staff Survey wellbeing indicators. • Reduction in sickness absence related to mental health and stress. • Positive staff feedback on access to wellbeing support. • Harmonised wellbeing offer implemented across Leeds Partnership NHS Foundation Trust. • Annual reporting on wellbeing service uptake and outcomes by protected characteristic where possible.	**3 (ACHIEVING)**

Domain	Outcome	Evidence	Owner	Proposed Improvement actions	Rating
		Staff can access free bereavement support, signposting and resources through the Leeds Bereavement Forum (lbforum.org.uk) and Cruse Bereavement Support, which offers a national helpline and one-to-one grief support. Training and additional bereavement resources are also available. Baby Loss and Miscarriage Support Staff can access specialist support for baby loss, miscarriage and bereavement through local support groups, the Miscarriage Association, Petals Charity (free counselling for individuals and couples), and Child Bereavement UK, which provides confidential advice, information and support. Resources are also available through Baby Loss Awareness Week.			**3 (ACHIEVING)**
Domain 2: ***Workforce health and well-being***	**2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source** **2B: When at work,**	**Violence Prevention and Reduction Strategy** LCH is working with Leeds and York Partnership Foundation Trust to implement a Violence Prevention and Reduction Strategy, strengthening the prevention, reporting and management of violence and aggression towards staff through established governance arrangements. **#NotInADaysWork and Zero Tolerance** The Trust promotes a zero-tolerance approach to violence, abuse and aggression towards staff and patients, with incidents investigated and appropriate action taken where required. **#NoBystanders** The #NoBystanders campaign encourages staff to challenge inappropriate, discriminatory and abusive behaviour, helping to create a safe, respectful and inclusive workplace.	**People Director**	**Suggested Improvement Actions** • Implement the Violence Prevention and Reduction Strategy across Leeds Partnership NHS Foundation Trust and monitor impact through workforce and incident reporting data. • Embed the Staff Behaviour Framework across the new organisation to promote a culture of civility, inclusion and respect. • Complete benchmarking against the Mann recommendations and implement agreed actions to address workforce race inequalities. • Harmonise #NoBystanders, Cultural Conversations and anti-bullying initiatives across the new organisation. • Strengthen reporting and learning arrangements for incidents involving violence, abuse, harassment, bullying and discrimination. • Use NHS Staff Survey, WRES and incident reporting data to identify and address disproportionate experiences amongst protected groups.	**3 (ACHIEVING)**

Domain	Outcome	Evidence	Owner	Proposed Improvement actions	Rating
	staff are free from abuse, harassment, bullying and physical violence from any source	**Cultural Conversations** Cultural Conversations support cultural competence, inclusion and understanding across the workforce. All teams are expected to undertake at least two cultural conversations each year to reflect on learning and experiences relating to different cultures. **Impact** NHS Staff Survey results demonstrate improvements in staff experience, with reports of harassment, bullying and abuse from patients and the public reducing from **23.5% in 2022 to 18.6% in 2025**, and reports involving colleagues reducing from **10.0% to 8.6%** over the same period.		**Measures of Success** • Sustained reduction in reports of bullying, harassment and abuse in the NHS Staff Survey. • Improvement in WRES indicators relating to discrimination and harassment. • Increased staff confidence in reporting concerns and inappropriate behaviour. • Reduction in incidents of violence and aggression towards staff. • 100% of teams complete Cultural Conversations annually. • Positive staff feedback regarding organisational culture, civility and inclusion. • Violence Prevention and Reduction Strategy fully implemented across Leeds Partnership NHS Foundation Trust.	
Domain 2: ***Workforce health and well-being***	**2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source**	**Critical Incident Staff Support Pathway (CrISSP)** Provides peer-led 1:1 and group debrief support for staff following critical incidents, promoting wellbeing and psychological recovery. **Freedom to Speak Up Guardian** Supports a positive speaking-up culture where staff can raise concerns confidently and know that their views will be listened to and acted upon. **Employee Assistance Programme (EAP)** Provides free, confidential counselling and wellbeing support for all staff. **Leeds Mental Wellbeing Service (LMWS)** Offers workshops and resources, including Managing Worry sessions, to help staff build coping strategies and improve their mental wellbeing. **Staff Networks** Staff can access peer support and advocacy through the Race Equality Network, Disability, Neurodiversity and Long-Term Conditions Network, PRIDE Network, Men's Health Forum, and Health and Wellbeing Engagement Group.	**People Director**	**Suggested Improvement Actions** • Develop a harmonised staff wellbeing and support offer across Leeds Partnership NHS Foundation Trust. • Increase awareness and visibility of support services through targeted communications and manager briefings. • Evaluate the effectiveness and accessibility of support services through regular staff feedback and utilisation data. • Strengthen links between Staff Networks, Freedom to Speak Up, wellbeing services and the Staff Behaviour Framework. • Monitor access to support services by protected characteristic to identify and address inequalities in uptake and experience. **Measures of Success** • Increased awareness and utilisation of support services. • Improvement in NHS Staff Survey indicators relating to wellbeing, speaking up and support. • Positive staff feedback regarding access to confidential support. • Increased confidence in raising concerns through Freedom to Speak Up routes. • Evidence of equitable access to support services across staff groups.	**3 (ACHIEVING**

Domain	Outcome	Evidence	Owner	Proposed Improvement actions	Rating
Domain 3: ***Inclusive leadership***	**3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities**	**Both equality and health inequalities are standing agenda items and discussed in board and committee meetings.** The Health Equity and Workforce EDI Strategies are reported to Trust Board three times annually, with Workforce Strategy updates presented to the Business Committee every six months. **Board members and senior leaders meet staff networks at least 3 or more times a year. All staff networks have a senior sponsor.** The EDI Forum meets three times a year and includes staff network representatives, Staff Side representatives and senior leaders. **Board members hold services to account, allocate resources, and raise issues relating to equality and health inequalities on a regular basis.** Regular reporting is provided on BME representation, including Band 8a+ roles, and women in senior leadership, with health equity considerations incorporated into Board reporting and assurance processes. **Board members and senior leaders demonstrate commitment to health inequalities, equality, diversity, and inclusion** Leadership commitment is demonstrated through active Board sponsorship of EDI, participation in the BME Reverse Mentoring Programme, Board development sessions, and the inclusion of EDI objectives within Board and Executive appraisals.	**Medical and the People directorates**	**Suggested Improvement Actions** • Develop and implement a single **Leeds Partnership NHS Foundation Trust EDI and Health Equity Strategy**, aligned to the priorities of both organisations. • Establish Board-level **EDI Champion** and **Health Equity Champion** roles within the new organisation. • Review and harmonise Board, Executive and senior leader EDI objectives across Leeds Partnership NHS Foundation Trust. • Maintain and strengthen Executive sponsorship arrangements to ensure all staff networks continue to have active Board-level engagement post-merger. • Implement a joint inclusive leadership development programme focused on: ▪ Inclusive leadership ▪ Anti-racism ▪ Disability inclusion ▪ Health inequalities • Develop and deliver a merger transition engagement plan with staff networks and equality groups to support the development of an inclusive organisational culture. **Measures of Success** ▪ Single EDI and Health Equity Strategy approved and implemented. ▪ 100% of Board and Executive appraisals include EDI objectives. ▪ Board-level EDI and Health Equity Champions appointed. ▪ Staff network satisfaction with Board engagement maintained or improved. ▪ Increased representation of underrepresented groups in senior leadership roles. ▪ Improvement in WRES, WDES and NHS Staff Survey inclusion indicators. ▪ Positive staff feedback regarding inclusive leadership within Leeds Partnership NHS Foundation Trust.	**3 (ACHIEVING)**

Domain	Outcome	Evidence	Owner	Proposed Improvement actions	Rating
Domain 3: ***Inclusive leadership***	**3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed**	Equality and health inequalities are embedded within Board and Committee governance and decision-making processes. The Health Equity and Workforce EDI Strategies are reported to Trust Board three times annually, with Workforce Strategy updates provided to the Business Committee every six months. Equality and Equity Impact Assessments (EQIAs) are fully embedded and required for service developments, policy changes and significant organisational decisions. Governance and assurance are strengthened through a strategic equity risk within the Board Assurance Framework, with assurance monitored through Committees and reported regularly to the Board.	**Medical and the People directorates**	**Suggested Improvement Actions** • Develop and implement a harmonised governance framework for Leeds Partnership NHS Foundation Trust, ensuring equality, diversity, inclusion and health inequalities impacts are explicitly considered and reported within all Board and Committee decision-making processes. • Harmonise Equality and Equity Impact Assessment (EQIA) processes across both organisations. • Embed equality and health inequalities considerations within all Board and Committee reporting templates. • Maintain and strengthen the strategic equity risk within the Board Assurance Framework following the merger. • Undertake annual audits of Board and Committee papers to assess the quality and consistency of equality and health inequalities consideration. • Develop Board-level reporting on the impact of decisions on workforce equality, patient experience and health inequalities. **Measures of Success** • Harmonised governance framework approved and implemented. • 100% of Board and Committee papers include consideration of equality, diversity, inclusion and health inequalities impacts, risks and mitigations. • EQIA compliance maintained for all significant service, policy and organisational change proposals. • Annual audit demonstrates consistent consideration of equality and health inequalities within decision-making. • Strategic equity risk reviewed regularly through Board and Committee governance structures. • Evidence of Board decisions being informed by equality and health inequalities assessments.	**3 (ACHIEVING)**

Domain	Outcome	Evidence	Owner	Proposed Improvement actions	Rating
Domain 3: ***Inclusive leadership***	**3C: Board members, system and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients**	The NHS Staff Survey results are presented to the Trust Board in March of each year. The Trust Board reviews WDES, WRES, Gender Pay Gap and NHS EDI Improvement Plan HIA performance annually, with findings informing the LCH EDI Improvement Plan and associated action plans, which are developed through stakeholder engagement and approved by the Board. Regular reporting monitors BME representation, including Band 8a+ roles, and women in senior leadership, with improvements seen in BME representation over the past two years. PCREF has now been incorporated into the Trust's governance structure.	**Company Secretary** **Medical and the People directorates**	**Suggested Improvement Actions** • Develop a single **Leeds Partnership NHS Foundation Trust EDI Performance Framework**, incorporating WRES, WDES, Gender Pay Gap, PCREF and NHS Staff Survey indicators. • Establish baseline equality, diversity, inclusion and health equity metrics for the new organisation and agree annual improvement targets. • Complete benchmarking against the **Mann recommendations** and implement a measurable action plan through the EDI governance framework. • Embed the **Staff Behaviour Framework** across the new organisation and monitor progress through workforce metrics, Staff Survey results and governance reporting. • Develop a unified EDI dashboard for Board and Committee oversight, including workforce, leadership and patient equity indicators. • Monitor delivery of the PCREF action plan through established governance arrangements and Board reporting. **Measures of Success** • Annual improvement in WRES, WDES and NHS Staff Survey indicators. • Increased representation of underrepresented groups at Band 8a+ and senior leadership levels. • Reduction in workforce disparities identified through WRES, WDES and Staff Survey data. • Completion of Mann recommendation benchmarking and implementation of agreed actions. • Delivery and monitoring of Staff Behaviour Framework actions. • PCREF milestones achieved and reported through governance structures. • Quarterly EDI dashboard reviewed by Board and Committees, with action taken to address identified inequalities.	**3 (ACHIEVING)**

Agenda item:	2026-27 (15)
Title of report:	Significant Risks and Risk Assurance Report
Meeting:	Trust Board
Date:	19 November 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 2 November 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 (2 November 2026):

- There are 117 open risks on the risk register, 31 of which have been managed to the target level.
- One risk scores 15 (extreme) and 14 risks score 12 (high)
- There are 4 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:	Quality Committee 10 November 2026 Business Committee 17 November 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	✓

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: The report highlights risks that may affect timely access to safe, effective care, including capacity and demand pressures. Some transformation-related risks may also have implications for health inequalities and equitable access to services.	Workforce: The report identifies workforce risks, including staffing capacity, compliance and wellbeing, which may impact service delivery. The report provides a high-level overview of organisational risks and does not include detailed workforce demographic analysis.

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 (September 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 (September)
Total Open Risks	117	121
Risks Scoring 15 or above	1	1
New Risks	4	6
Closed Risks	8	6
Risk Score Increasing	2	2

Risk Score Decreasing	4	10

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**	**13**	**Cautious (4 – 6)**
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. As of 29 September 2026, 567 out of 1152 remain on the neurodevelopment triage waiting list. The work is on schedule to be completed by 30th October 2026. (update 30/9/26)				

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	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26
1383	Mind Mate Neurodevelopmental Referral Triage Waiting List	15	15	5	15	15	15	15	15	15	15	15	15
954	Diabetes Service waiting times	12	12	2	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	12	12	12	12
1307	Triage Hub clinical decision making due to the impact of managing capacity and demand	12	9	9	9	9	9	9	9	9	9	9	12
1336	The reporting of Health and Safety, Fire Safety, Security and Moving and Handling accidents and incidents	6	6		6	6	6	12	12	12	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	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	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26
1395	Decommissioning and disposing risk of non-concordance with the organisational process for medical devices.	9	9	9	9	9	9	12	12	12	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	12	16	12
1462	Occupational health support and compliance					12	12	12	12	12	12	12	12
1467	Clinical And Safeguarding Supervision Portal (CASSP) - Compliance Data					12	12	12	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	12	12	12
1494	Demand exceeds capacity in the Speech and Swallowing Team for patients with swallowing (dysphagia) needs.									12	12	12	12
1503	Inconsistent Clinical Assessment, Documentation, Incident Reporting and Safeguarding Management for Children and Young People within WYOI									12	12	12	12

3.3 Since the September report, there has been no overall change in the number of risks scoring 12, which remains at 14. However, one risk previously scored at 12 has reduced to 6, while another has increased from 9 to 12.

3.4 In the previous report, two 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, two additional risks have met the criteria for static classification, increasing the number of static risks scoring 12 or above to four.

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 117. Of these there are 51 clinical risks and 66 operational risks. This table shows how all these risks are currently graded in terms of consequence and likelihood and provides an overall picture of risk.

	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost Certain	Total
5 - Catastrophic	0	0	1	0	0	1
4 - Major	0	4	5	0	0	9
3 - Moderate	2	22	36	9	0	69
2 - Minor	0	13	16	4	0	33
1 - Negligible	1	2	1	1	0	5
Total	3	41	59	14	0	117

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, 28 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 21 January 2027.

[1] Risks: 1109, 1125, 1168,1169, 1196, 1285, 1307, 1319, 1353, 1356, 1357, 1365, 1366, 1369, 1374, 1392, 1393, 1395, 1414, 1419, 1437, 1439, 1453, 1470, 1478, 1485, 1501, 1503

[2] Risks: 1206, 1221, 1242, 1250, 1336, 1400, 1415, 1423, 1428, 1434, 1444, 1462, 1463, 1465, 1467, 1468, 1486. 1505

[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: 4 November 2026

Agenda item:	2026-27 (7c)
Title of report:	Learning from deaths
Meeting:	Quality Committee
Date:	10/11/2026

Presented by:	Geraint Jones, CCIO
Prepared by:	Geraint Jones, CCIO

Purpose of the report:		
To provide the Quality Committee with an overview of Learning from Deaths activity and mortality surveillance for Quarter 2 2026/27, including mortality review findings, themes identified from case reviews, child death review activity, and progress against the Learning from Deaths Trust integration programme.	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:

- In Q2 2026/27, 832 adult deaths were reported and 420 reviewed, including 90 Level 2 reviews; 19 progressed to structured review and four to Patient Safety Incident Investigation (PSII). One death was considered, at the time of reporting, more likely than not due to problems in care.
- Learning focused on deterioration and escalation, communication and handover, mental capacity, falls prevention and end-of-life care, alongside examples of compassionate, coordinated practice.
- Unexpected deaths and neighbourhood mortality patterns remain within control limits; over 80% of patients achieve their preferred place of death.
- Outstanding child death reviews, overdue inquest actions, and capacity-related delays require oversight. Data discrepancies, differing business unit reporting periods and year-to-date totals require reconciliation.
- Priorities are to align review processes and documentation with LYPFT, strengthen action tracking and progress delayed ReSPECT implementation.

Previously considered by:	

Outcome of previous discussion/s:	

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

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: No significant variation in mortality patterns	Workforce:

Recommendation(s)	• Note and consider the mortality and Learning from Deaths information presented for Quarter 2 2026/27. • Receive assurance regarding the ongoing development of mortality review processes and organisational learning arising from deaths.

List of Appendices:	1. Data pack 2. Adult and Specialist Business Unit Mortality Report 3. Children's Business Unit Mortality Report

Executive summary

This paper provides the Quality Committee with an overview of Leeds Community Healthcare NHS Trust's Learning from Deaths activity for Quarter 2 2026/27 (July–September 2026), including mortality surveillance, learning from reviews and investigations, child death review activity, and progress towards aligning processes with Leeds and York Partnership NHS Foundation Trust.

During the quarter, 832 adult deaths were reported and 420 received a review, including 90 Level 2 reviews. Nineteen deaths triggered a structured review and four triggered a Patient Safety Incident Investigation. At the time of reporting, one death was considered more likely than not due to problems in care. Surveillance identified no abnormal patterns in unexpected deaths or neighbourhood mortality, and the paper reports that over 80% of patients achieved their preferred place of death.

Learning highlights recognising and escalating deterioration, communication and handover, mental capacity assessments, falls prevention and end-of-life care.

Reviews also identified compassionate care, effective multidisciplinary working and support for patients and families. However, outstanding child death reviews, overdue inquest actions, capacity-related delays and delayed ReSPECT implementation require continued oversight. Inconsistent reporting periods and discrepancies in the data and year-to-date totals require reconciliation and limit the assurance available.

Priorities are to align review methodology, policy and documentation across both trusts; strengthen governance and action tracking; reconcile reporting data; and progress delayed improvement work. The Committee is asked to note and consider the findings, discuss the outstanding risks and delivery priorities, and receive assurance on the development of review processes and how learning is informing improvements in care.

1. Learning from Deaths

The paper provides an overview on mortality data recorded during quarter 2, financial year 2026/2027. All deaths of services users who have had contact with the Trust's services are reviewed by the clinical teams that meet the criteria as agreed within the Trust's Learning from Deaths policy in alignment with the national guidelines on learning from deaths (2017). In Q2, LCH was notified of 832 adult deaths, of which 67 were in scope for Level 2 Mortality review, with an additional 23 out of scope (expected) deaths reviewed. 19 have triggered a structured review. Four deaths triggered a PSII, of which one was considered at this time to have been more likely than not due to problems in care (table 1). All learning from deaths is fed back through the Mortality Review Group regardless of the level of review undertaken.

Financial Quarter	Q1: Apr–Jun 26	Q2: Jul – Sep 26	Q3: Oct – Dec 26	Q4: Jan – Mar 27	2026/27 YTD
Total Deaths	891	832			1723
Total Deaths reviewed	435	420			855
Deaths subject to Level 2 review "fact finding and initial learning"	82	90			172
Number progressed to Structured Case Review	5	19			26
Number of deaths investigated as a Patient Safety Incident Investigation	3	4			7
Number of deaths reported as "a death thought more likely than not due to problems in care"	3	1			4

Table 1. Mortality Reviews

If opportunity for further learning and improvement of Trust systems and processes are identified from the level 2 review, a structured review is commissioned for an independent senior clinician to review and present the case at the monthly Mortality

Case Review meeting. After action and PSSI investigations are commissioned as soon as identified regardless of the stage of mortality review.

In Q2, a total of 90 deaths were reviewed at level 2 and 19 are due to be presented at the Mortality Case Review Meeting following a structured independent review.

1.1 Learning themes

Mortality case reviews, inquests, and Patient Safety Incident Investigations (PSIIs) identified consistent learning across several areas of care. The main themes and examples of good practice are summarised below.

Recognition of deterioration, escalation, and timely response

Reviews emphasised the need to act on changes in a patient's condition, repeat observations when deterioration is identified and escalate promptly to registered clinicians. Critical information should be communicated directly to those delivering care. Learning also highlighted timely triage and response, supported by oversight of caseloads, work allocation and delayed visits.

Communication, handover, and care coordination

Communication and information sharing were recurrent themes. Learning highlighted effective handover and care coordination between teams, services, and care settings, including the transfer of information between organisations and electronic patient record systems. Timely, sensitive discussions with patients and families about deterioration, prognosis and care planning were also important.

Mental capacity and patient-centred decisions

Reviews highlighted earlier consideration and documentation of mental capacity assessments, more personalised care planning, and clear records of discussions when patients decline care or treatment. Learning emphasised balancing respect for individual autonomy with appropriate family involvement and information sharing.

Falls prevention and risk management.

Learning focused on completing and documenting falls risk assessments, monitoring and escalating concerns after a fall, reassessing risk as circumstances change and using safety equipment appropriately.

End-of-life care.

Reviews reinforced effective advance care planning, anticipatory medication, and symptom management, alongside clear communication with patients and families. DNACPR/ReSPECT and other care-planning decisions need to be clearly recorded and shared, with care coordinated across service and organisational boundaries.

Clinical practice and workforce learning

Wound swab management: a Trust Standard Operating Procedure has been developed to standardise collection, processing, review of results and subsequent action.

Pressure care: learning highlighted earlier use of pressure-relieving equipment and specialist referral.

Multidisciplinary working: reviews identified opportunities to strengthen joint working.

Workforce support: learning emphasised staff competence, supervision and confidence when responding to emergencies or deterioration.

1.2 Inquests and patient safety investigations

Between March and September 2026, 12 adult inquests concluded: three natural-cause conclusions, three narrative conclusions, two suicides, two drug-related deaths and two deaths by misadventure. No Regulation 28 Prevention of Future Death Reports were received.

Five PSIIs were declared under the Patient Safety Incident Response Framework criterion that death was more likely than not due to problems in care. Two were linked to an open inquest.

Of these five, four remained ongoing. One was subsequently de-logged after further review found that the PSII criteria had not been met.

In addition, three further PSIIs and one Independent Review remained in progress.

Five investigations had been completed, including two awaiting inquest hearings.

1.3 Good practice and positive assurance

Alongside areas for improvement, reviews identified good and compassionate practice. Examples included responsive palliative and community care, effective multidisciplinary and cross-service working, good communication and family support, timely equipment and care packages, and smooth transitions from acute to community services. In some cases, patients' wishes were respected, unnecessary hospital admission was avoided, and the preferred place of care or death was achieved.

Patients and families gave positive feedback about the quality and value of support from the Homeward Care Service. In one case, HM Coroner was reassured that learning had been identified and appropriate actions implemented; consequently, a Regulation 28 report was not required.

1.4 Overall learning and assurance

The combined findings highlight priorities in recognising and escalating deterioration, communication and handover, falls and risk management, mental capacity and patient-centred care, and end-of-life care. The review process also identifies and shares positive practice, providing assurance that learning from deaths is informing improvements in clinical care and service delivery.

2. Mortality Surveillance

SPC charts below detail the deaths reported over a two-year reporting period 2024-2026. There is a downward trend over the last two quarters that is in line with seasonal variation. However, overall, the number of deaths is currently lower than the previous year, this will continue to be monitored (figure 1a). Number of unexpected deaths remains within control limits. Deaths for the non-white population remain within control limits for each ethnicity, however, deaths in the white population mirror the overall reducing trend in deaths.

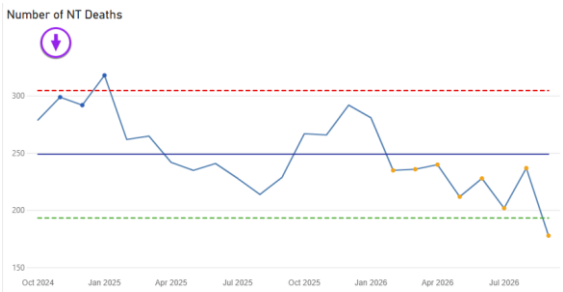


Figure 1a. total deaths

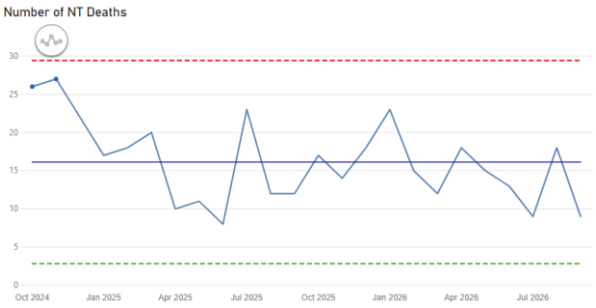


Figure 1b. Unexpected Deaths

Surveillance in mortality patterns continues at the neighbourhood level. With the Neighbourhood Health Model work is required to realign the data from the current model to the new model as boundaries evolve. Figures 2 a-d (appendix 1) show the variation in mortality rates for the neighbourhood teams. Analysis of the SPC charts for individual teams shows variation within control limits and no abnormal patterns emerging.

4.1. Equity

Deaths by neighbourhoods shows variation in line with known health inequalities, more deaths being reported in neighbourhoods with older populations and greater deprivations. Only IMD decile 7 shows a reducing trend aligned with the overall picture. With only age range 80-89 showing a matching reducing trend picture.

Despite the variation in deprivation and ethnicity across the neighbourhoods over 80% of patients achieve their Preferred Place of Death (PPD). There is a downward trend in achievement on the SPC charts (Figures 4a&b), however, this is in terms of actual numbers and aligned to drop in total number of deaths, not proportion of PPD achieved.

3. Learning from Deaths Improvement plan

A city-wide project to have ReSPECT forms on Leeds Care Record is in progress, however, the implementation has been further delayed until mid-Q3 due to concerns regarding change in process from primary care.

The Mortality Integration Group has now agreed a new review methodology and terminology, comprising Screening Review, Mortality Review and Structured

Judgement Review. The joint Mortality policy will be aligned to reflect the planned future state.

The detailed Mortality Review questions and associated documentation are currently being aligned across SystmOne, mortality trackers and the DCIQ upgrade. Neither Trust currently use the Datix mortality module, the upgrade to DCIQ is an opportunity to evaluate if it brings benefit. Plan for aligning questions across all platforms with pilots in services that currently do not use the SystmOne Mortality review surveys.

- Children's services (LCH)
- LMWS (LCH)
- Elderly Mental Health inpatients (LYPFT)

Work is underway to establish an integrated approach to learning from mortality reviews, incidents, and inquests. Governance arrangements, meeting membership, and action-tracking arrangements are also being reviewed to strengthen accountability and oversight.

Conclusion
Quarter 2 reporting demonstrates continued learning from deaths, with reviews identifying both opportunities to improve care and examples of compassionate, coordinated practice. Mortality surveillance has not identified abnormal patterns in unexpected deaths or neighbourhood trends, but outstanding reviews, data discrepancies and delays in improvement work remain areas requiring oversight. Aligning processes with LYPFT and strengthening action tracking will be important to support consistent reviews, reliable assurance, and demonstrable improvements in care.

Recommendation
Quality Committee is requested to:

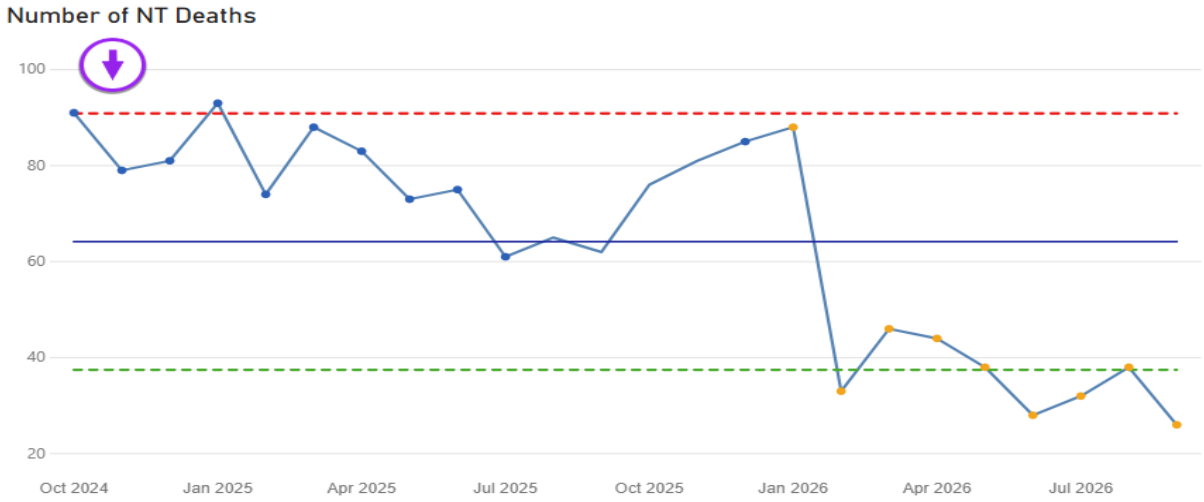
- Note and consider the mortality and Learning from Deaths information presented for Quarter 2 2026/27.
- Receive assurance regarding the ongoing development of mortality review processes and organisational learning arising from deaths. Appendix 1: Data Pack

Appendix 1: Data Pack
Table 2: Deaths by review category

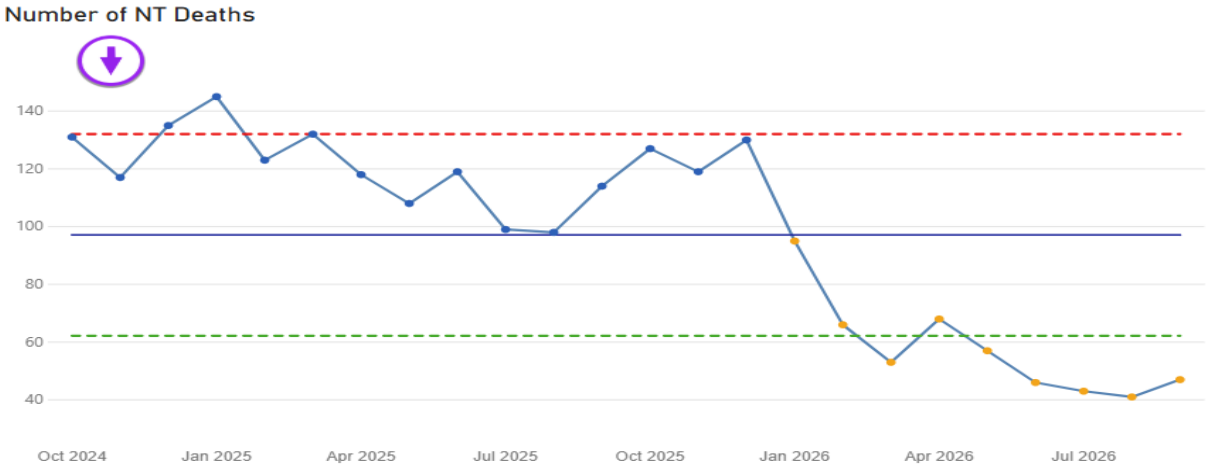
Financial Quarter	Q1 26	Q2 26	Q3 26	Q4 27	2026/27 YTD
CHILD Deaths — Expected	2	5			7
CHILD Deaths — Un-expected	3	5			8
ADULT Deaths — Expected	377	362			298
ADULT Deaths — Un-expected	58	58			39
ADULT Deaths — Inpatient / CCB	1	4			0
ADULT Deaths — LD/ASD	9	1			9
ADULT Deaths — LMWS	2	1			1
ADULT Deaths — Family concerns	0	0			0
ADULT Deaths — Coroner/MD requests	0	0			0
Total Deaths — ALL					

Figures 2a, b, c, surveillance

Neighbourhood Teams North



Neighbourhood teams South



Neighbourhood teams West

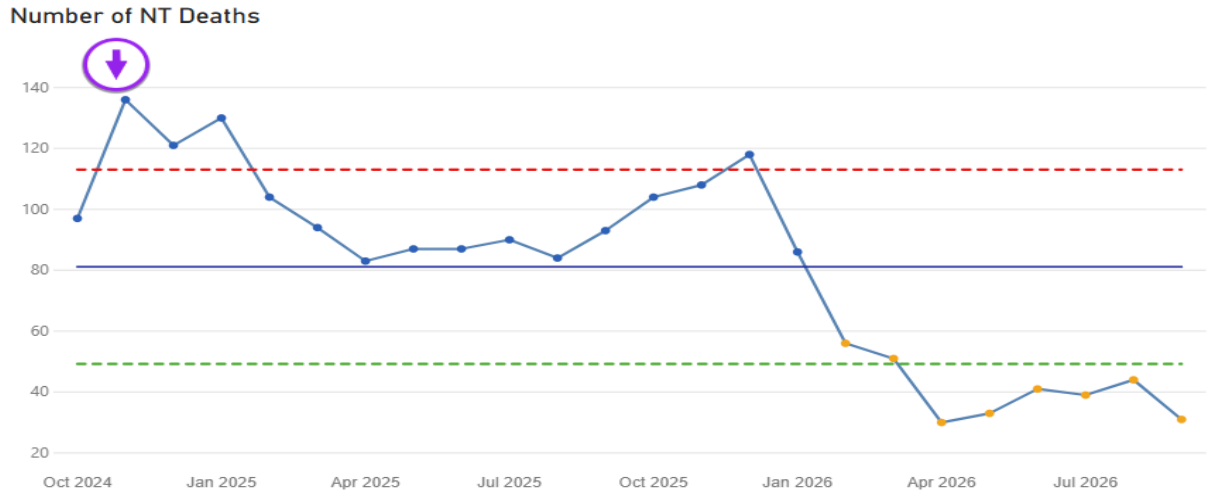


Figure 3a. IMD decile 7

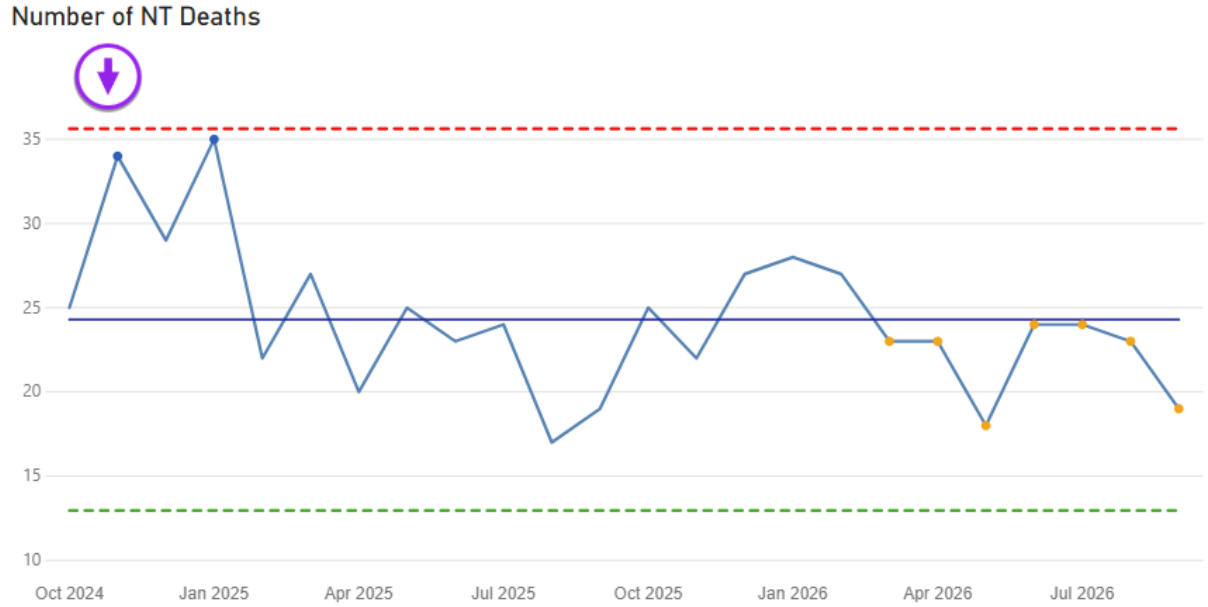


Figure 3b. Age 80-89

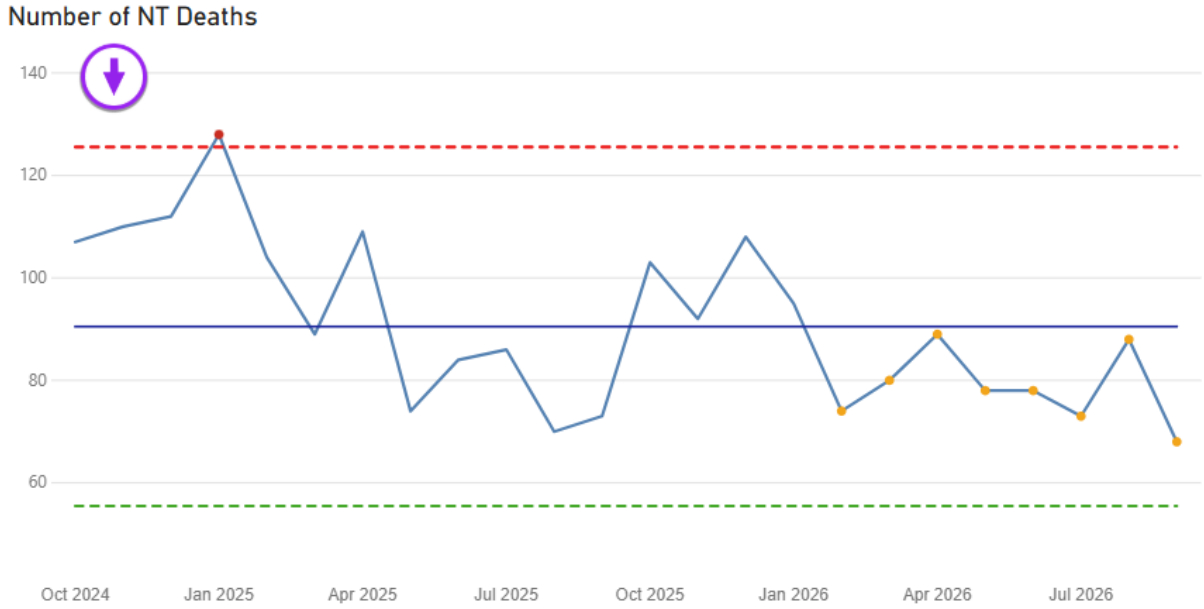


Figure 4a. Preferred place of death 1st Choice achieved.

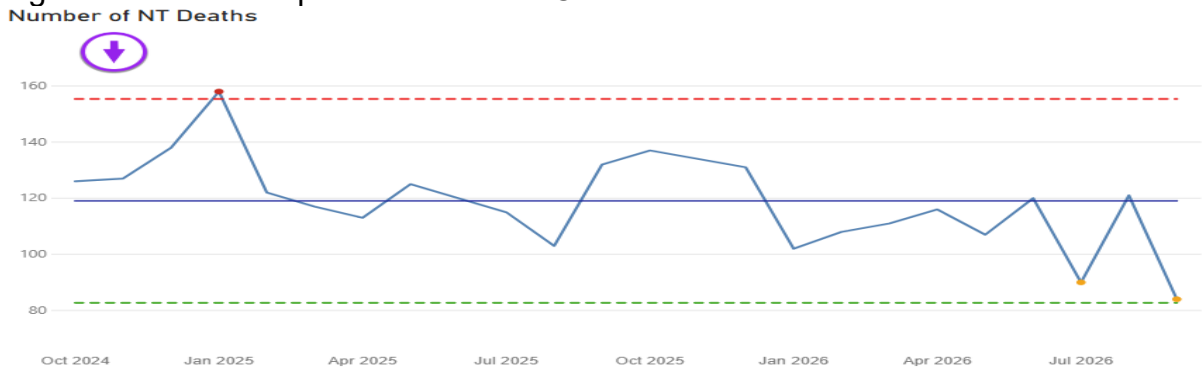
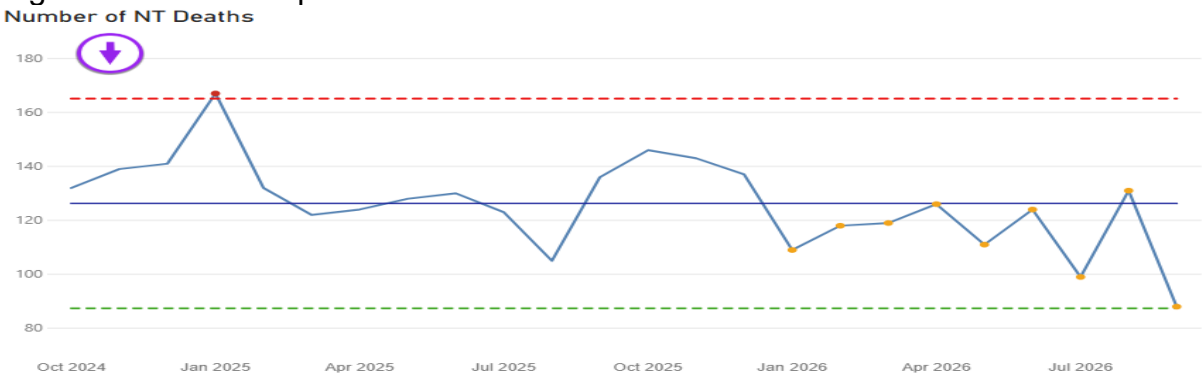


Figure 4b. Preferred place of death 2nd Choice achieved.



NHS
Leeds Community Healthcare
NHS Trust

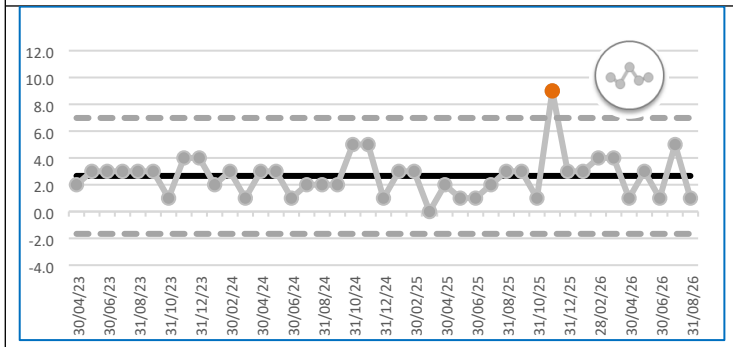
Escalation and Assurance Report

Group / Workstream:	Child Death Report	**Report to:**	Quality Assurance Improvement Group
Date of report:	20/08/2026	**Time period covered by report:**	May - Aug 2026
Report author:	Sarah Hemsley	**Role:**	Quality Lead - CBU

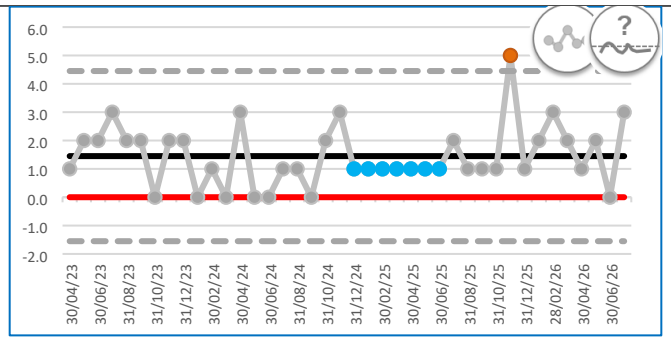
Introduction

This is the escalation and assurance report for child deaths between May and August 2026 (up to 20/08/2026). During this period there has been 10 reported deaths (5 SUDIC and 5 expected). All deaths have followed the child death rapid review process. None have required escalation to any further investigation.

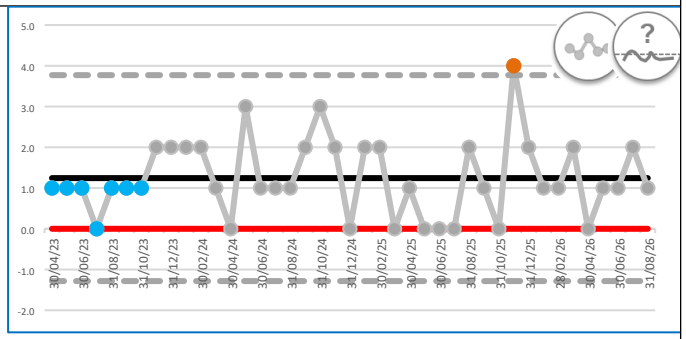
All Child Deaths



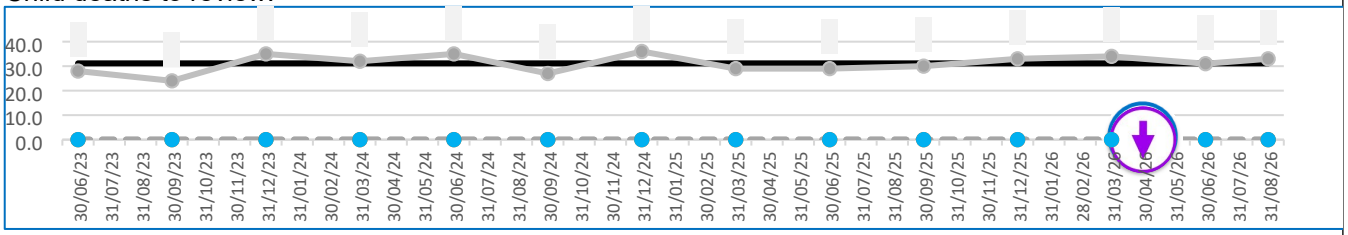
Unexpected (SUDIC) Child Deaths



Expected Child Deaths



Alert	Action
1. No escalations	

Advise	
1. The work to progress the movement from completion of the child death rapid review via a MS word form to using a questionnaire format via S1 has been limited due to service capacity, there is also now consideration of how these will be managed post April 2027 due to changes in the Datix merger.	To continue to progress this work. The DCIQ (Datix Cloud) project is considering the use of a mortality module on Datix
2. Child deaths to review. 	Eight cases are scheduled to be discussed in September 2026. This (pending further deaths) would reduce the number to 25 requiring reviews, with the oldest case dating back to November 2025 by the end of September 2026 For assurance, all deaths have followed the child death rapid review process, reviewed by Clinical Lead for CBU

Escalation and Assurance Report

There are currently thirty-three Leeds child deaths to review, this includes SUDICs (18) and expected (15), this is similar to previous reports (34). **Incident ID: 111390** is subject to a Patient Safety Incident Investigation, this was separately commissioned external investigation (LYPFT) and remains under review	and Quality Lead for CBU. None have required escalation to any further investigation.
Assurance	
1. The 0-19 PHINS are working with the neonatal team and midwives to develop a process for ensuring 0-19's are made aware of any babies likely to either need neonatal support at birth or may have additional needs	
2. Feedback from a recent case discussed at the child death meeting highlighted the importance of a consistence Consultant Paediatrician, with the family reporting the Paediatrician 'always had the child's back' this was in relation to balancing the child's quality vs quantity of life which was extremely important to the young person and his family.	
3. Clinical Lead for CBU continues to attend the CDOP meetings and there is no new learning.	
Risks Discussed and New Risks Identified	
None	

Recommendation: The Quality Assurance & Improvement Group is recommended to note the assurance levels provided against the strategic risks

Group / Workstream:	Adult Mortality	**Report to:**	Quality Assurance & Improvement Group
Date of report:	25/08/2026	**Time period covered by report:**	Q1 Apr 26- Jun 26
Report author:	Frankie Skirrow and Karen Otway. Temba Ndirigu, Kirsty Jones, Geraint Jones.	**Role:**	Quality Assurance Lead SBU Quality Assurance Lead ABU

Introduction

This is the AAA Mortality report for Q1. Data is based on Q1 Apr-Jun 26. All BI data has been reviewed 25/08/2026.

Alert		Action
1.	**PSII's declared in Q1 relating to deaths: (4) Apr 26-Jun 26** **Chapeltown NT: 113062:** LD death. 45 meeting planned 7/09/26 and within timescale. **LMWS PCMH: 113578:** TOR meeting held: Concerns in relation to MDT and decision that PCMH were most appropriate service. AAR completed with LYPFT. Then to decide if it meets criteria as a death though more likely than not due to problems in care. Pending decision. **Response services: 113427:** HTA completed and DOC. Pending decision re whether it meets PSII criteria. **Response services: 113618:** 45-day meeting planned 4/09/2026 and within timescale	For awareness, no actions required. All within timescale.
2.	**Inquest actions overdue: 2 (the previous 2 actions on last AAA report have been completed)**	Handlers are required to update. SOP's paused due to capacity with CET and is a risk on their risk reg ID: 1414.

Service	ID	Type	Team	Responsibility ('To')	Action Title/Recommendation	Due date
Quality and Professional Development (QPD)	15962	Inquest Action	Clinical Governance Team	Henderson, Ann Louise	Process to be implemented for the management of Standard Operating Procedures across the trust following learning identified linked to Inquest	25/04/2025
Quality and Professional Development (QPD)	16158	Inquest Action	Clinical Education	Beal, Hannah	LCHT should have a system where records of clinically essential training (completed/overdue/planned) for any member of staff is held.	17/01/2025

Advise

1.	**Ongoing PSII's in LMWS: 3 deaths:** Learning in relation to the DNA/Discharge/cancellations/referrals rejected processes and communication with other services have been identified but all three continue to be investigated and so final learning and actions will be shared once competed.

S1 Systems, processes & practices to keep people safe	*S4 Medicines management*	*S5 Track record on safety*	*S6 lessons learned & improvements made*	*E1 Standards, legislation & evidence-based practice*	*E2 Outcomes of care & treatment*	*E3 Staff skills, knowledge & experience*	*R4 Listening & responding to concerns & complaints*

2.	**Continuation of increased data relating to LD deaths.** Noted that there have been 9 LD deaths in Q4 25/26 and 9 in Q1 26/27. No current updates from LD lead. Likely due to enhancing awareness in NT's to report and review deaths with a learning disability, however to provide further assurance we will request a narrative from LD lead. Previously the LD lead had stated that we were not a national outlier and therefore seeing this increase may be positive in relation to increased awareness and reporting. Noted that although summary of data states 9 LD deaths, the BI data shows 14 and therefore some discrepancies. LD lead to explore this to determine. Update required from LD lead in relation to the regional meeting, noted in last AAA that this was going to be discussed.
3.	**Data** received from BI for expected and unexpected deaths for both business units does not match with data summary totals. Meeting needs to take place to review and further explore.
4.	**Theme** noted in Q1 in relation to delays in care during the period of the new triage and response NT processes. This demonstrates that change has an impact and that we need to consider the impact of the change to mitigate effectively. DoN aware and Chief Information Officer is writing a report for TLT. Plans in ABU to review the Response, out of hours and triage EQIA's considering this learning. Meeting planned 10/09/2026 and will action learning and associated risks accordingly.
5.	The mapping of mortality process with LYPFT continues. Demo planned early September to review jointly.
Assurance	
1.	**Data: Deaths for ABU and SBU** have remained within expected control limits, showing only common cause variation, particularly some seasonal variation which is consistent and no evidence of sustained deterioration or emerging concerns. Continued routine monitoring is recommended. The NT data reflects 21 data points below the mean and so when should control points be changed?
2.	**Deaths with Autism tab:** now added to BI data, but currently blank. LD lead to promote the new tab.
3.	**Ethnicity data:** To note that since 2022-end of Q4 25/26 preferred place of death for mixed/black/ black British was tracking at 80% but now in Q1 26/27 we are now achieving 100% PPD. This is a 20% increase. Also consistency of 82% of white British populations PPD.
4.	**Inquests:** Between 01/03/2026 and 01/07/2026 report from patient safety. 9 in LMWS (4 ABU NT): Patient Safety has reported that, during the reporting period, 60% of all inquests received relate to the Leeds Mental Wellbeing Service (LMWS). Based on the provisional causes of death recorded to date, it is anticipated that a number of these cases are likely to conclude with a finding of suicide. Out of these deaths, one required DOC and has had a joint After Action Review completed by LCH and LYPFT. Pending decision as to whether this meets a PSII based on nation criteria of a death thought more likely than not due to problems in care. All others did not require DOC. Provisional Cause of Death Total

	This trend is consistent with intelligence received from the Trust's external legal advisers, who have also reported a recent increase in the number of inquests involving similar circumstances nationally, therefore we are not an outlier. The position will continue to be monitored through established governance processes, with any emerging themes or learning identified and escalated as appropriate.
5.	**Update from previous AAA:** A system wide PSII was commenced in August 25: ID 108491: due to a concerning death involving Multisector; LTHT, LYPFT, LCH and GP in primary care. Immediate actions due to potential future risk identified, to amend the syringe driver policy and training are now complete. NICHE Health and Social Care Consulting have been awarded the contract to complete the multi sector investigation. 2 staff have been interviewed by NICHE and have received appropriate support and debrief.
Risks Discussed and New Risks Identified	

S1 Systems, processes & practices to keep people safe	*S4 Medicines management*	*S5 Track record on safety*	*S6 lessons learned & improvements made*	*E1 Standards, legislation & evidence-based practice*	*E2 Outcomes of care & treatment*	*E3 Staff skills, knowledge & experience*	*R4 Listening & responding to concerns & complaints*

Agenda item:	2026-27 Blue Box (18)
Title of report:	People Strategy and Headlines
Meeting:	Trust Board
Date:	19 November 2026

Presented by:	Jenny Allen, Director of People
Prepared by:	Jenny Allen, Director of People

Purpose of the report:		
This report provides: The Board with an update on progress against the LCH Strategic People Framework as well as continuing to sight the Board on the national NHS people agenda and LCH progress towards the delivery of key national priorities.	Approval	
	Discussion	X
	Assurance	X

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

Summary of Key Issues:

- This report is presented to each meeting of the LCH People & Culture Committee as a current snapshot of People & Culture headlines, priorities, and progress.
- This month's report focused on updating the Committee on progress against the LCH Strategic People Framework as well as setting out key areas in terms of the national NHS people agenda.
- It is important to note the alignment between the two with the national policy direction and expectations shaping our LCH people priorities.
- The report is coming to the Trust Board for information and following the P&C Committee discussion.

Previously considered by:	People and Culture Committee – 7th October 2026
Outcome of previous discussion/s:	Report noted and recommendations approved.

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

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: Please note the focus on staff inclusion within the paper and work on the Staff Survey WRES and WDES results.

Recommendation(s)	The Board is asked to: - Note progress against the four priorities within the LCH Strategic People Framework; - Take assurance that appropriate plans and governance arrangements are in place to respond to the national NHS People priorities outlined in the report; - Note the key risks and areas requiring continued oversight, particularly People Directorate capacity, integration-related organisational change and delivery of staff experience and inclusion improvement actions; and - Confirm whether the information presented provides Acceptable Assurance regarding delivery of the Strategic People Framework and the Trust's response to the national People agenda.

List of Appendices:	N/A

People Strategy Update & Headlines

1. Introduction:

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

It is important to note the alignment between the two with the national policy direction and expectations shaping our LCH people priorities. The report is now coming to the Trust Board for information and assurance.

2. Overall Assurance:

Overall, the assessment of the level of assurance against delivery of the Strategic People Framework and the national priorities covered by this report is identified as ***Acceptable***.

Progress continues across all four areas of the Strategic People Framework, with key developments including implementation of the People Services single front door, continued targeted organisational health interventions, development of the future leadership offer, and progression of People and Culture integration arrangements.

The Trust has also mobilised its response to the key national requirements highlighted in this report. Delivery plans and governance arrangements are in place for the Band 5 Nursing Job Evaluation programme; implementation of the NHS Staff Standards is being mapped into existing improvement plans; and the Lord Mann recommendations are being incorporated into the Trust's inclusion work.

No matters requiring escalation to Board are identified through this report at this stage. However, the Committee is asked to maintain oversight of delivery capacity within the People Directorate, the cumulative people implications of Trust Integration Programme as well as national programmes, and delivery of the improvement actions arising from staff experience, WRES and WDES data.

3. Progress Against the LCH Strategic People Framework:

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

- Leadership and Management;
- Transforming our People Services;
- Staff Experience;
- Transforming our Organisation.

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

3.1 Leadership and Management:

Within this domain and in the first 5 months of the framework's operation, several things are of note:

- Our LCH leadership offer is starting to dovetail much more with the requirements for the new organisation – Leeds Partnership Foundation Trust (LPFT) – with the work on draft values and behaviours intended to also shape leadership development for leaders at all levels from the organisation's inception.
- Further leadership training is also being prepared and following the implementation of the leadership review in LCH – this will utilise much of what is already on offer but provision will be intentional and structured to those leaders populating the new structure and aligned with LCH's move to replicate the new neighbourhood model in the city.
- Additionally, race training for the Board as well as senior leaders across LCH and LYPFT has been scoped and there is further exploration of the provision of this with a particular well known and credible provider.
- Health and well-being training for managers continues to be delivered and is evaluation well. Further areas of focus are being developed including in terms of softer skills and reasonable adjustments.
- Our Organisational Health approach continues to have an impact in teams facing challenges, including Police Custody, Wetherby YOI and Dental Services. Targeted interventions have also been extended to Wharfedale, Community Care Beds and Nights, informed by Staff Survey feedback and WRES analysis and where we work with leaders to enhance the culture and experience for staff.
- We continue to ensure all leadership development offers are promoted through our staff networks and to all network members. We also have a coaching network that is diverse and available to all staff including those with protected characteristics.

3.2 Transforming our People Services:

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

- In early October, a single front door access to people services within LCH was implemented – the technology being utilised is Halo, which the Trust is already licenced to use. It is anticipated that this digital front door will transform our service offer ensuring that routine queries are dealt with more efficiently coupled with additional manager support and self-service for staff and managers. Considerable work to prepare both staff within the People directorate as well as managers has taken place, as well as configuration on the system.

- Our People Partnering project continues with a key focus on case work deep dives and ensuring that we are partnering with key parts of the business on for example the targeted intervention work mentioned above. The role of People Partners in this work and as a key part of business unit teams is critical.
- We are in the first wave of Trusts working with the national team on the People Portal (formerly New Workforce Solution) which is effectively the replacement of ESR. With LYPFT we are now committed to being an early adopter in was one of the roll out and we continue to work closely with LYPFT colleagues to ensure alignment of systems and approach pending the People Portal adoption.
- In terms of the resourcing agenda there is continued focus on understanding both Bank and Agency usage across the Trust with a view to continuing to drive down this usage and cost – *please note the NOF update within the Board IPR agenda item*.
- Our roll out of people dashboards to enable managers to understand and make decisions based on their people data in real time continues with several additional dashboards now in use.

People Services Business as Usual Delivery:

People Directorate capacity remains an area of active management. Alongside the transformation programme, the Directorate is supporting two significant organisational change programmes, increasing volumes of employee relations activity, recruitment and core workforce systems. Employee relations case volumes have doubled in less than two years. Capacity and prioritisation are therefore being actively monitored by the People Senior Leadership Team, with any impact on delivery of statutory, regulatory or strategic priorities escalated through the appropriate governance route

3.3 Staff Experience:

Our work overall on staff engagement and experience continues with our staff engagement project closely aligned with our focus on staff absence and organisational health. *Further updates on staff sickness are included in the NOF information included within the Board pack.*

Additionally, and as referenced elsewhere in the pack, the people and culture transform elements of the Trust Integration Programme continues at pace with significant progress on our joint Best of Both cultural change programme.

In terms of inclusion and following good and constructive discussions with both this Committee in April as well as the Board at a Board workshop in May, several actions have been completed:

- The Board Intention Plan has been formulated with a clear commitment to zero tolerance in terms of discrimination against protected characteristics including race and disability.
- Work continues on areas highlighted under WRES and WDES Staff Survey data in terms of last years' scores.

- We continue to work with colleagues in other organisations to understand what more we could implement in terms of anti-racist practise, and we are building on our 'cultural conversations' work to improve both the awareness and competence of our leaders and managers.
- The Annual Inclusion Plan and report is on this month's Committee agenda in draft and incorporates the recommendations on inclusion from both the Lord Mann review as well as the Staff Standards work published in the summer. It has also now been considered by the Trust Board.
- As set out above, race training for the Boards of both LCH and LYPFT is being scoped and sourced for roll out in the next few months.

Finally this year's annual Staff Survey has now launched and as at the end of week 4 almost 30% of staff have completed the survey. Star teams in terms of intention plan delivery from last years' survey results have been invited and visited in recent weeks with goody bags and certificates recognising their hard work as a lead into this year's survey. The staff survey opened on Monday the 5th of October and closes after 8 weeks on Friday the 27th of November.

3.4 Transforming our Organisation:

Under this heading is the People and Culture workstream for the Trust Integration Programme (TIP).

In addition, it is worth noting that work on linking with LYPFT colleagues in respect of the provision of people services at scale and for the future is progressing at pace with detailed mapping of the work within each directorate in each organisation now complete. The two people directorates are working on a roadmap to day 1 of the new organisation and using the mapping work to lead into decisions about how work will be undertaken from day 1 onwards, with staff and manager experience at the heart of what we are trying to achieve. There is some overlap between this work, being in wave one of the People Portal implementation, and that of the People and Culture workstream so close connection between the two remains.

4. National NHS People Agenda:

4.1 Strategic Context:

The national People agenda is increasingly being shaped by implementation of the 10-Year Health Plan, the emerging 10 Year Workforce Plan and the requirement for integrated multi-year planning. The direction of travel is towards a workforce model capable of supporting the three strategic shifts of hospital to community, analogue to digital and sickness to prevention, alongside greater productivity, flexibility and workforce sustainability. NHS planning expectations increasingly require demonstrable alignment between workforce, activity, quality and finance.

4.2 Key National Policy and Programme Updates:

NHS Staff Standards:

The Department of Health and Social Care and NHS England published the new NHS Staff Standards on 6 July 2026, establishing nationally required minimum expectations for staff experience across secondary care, including community healthcare organisations. The standards are intended to reduce variation in employment experience and give staff experience greater parity with operational and financial performance.

The Standards cover six priority areas:

- Line management
- Health and wellbeing
- Violence prevention and reduction
- Championing sexual safety
- Tackling racism
- Promoting flexible working.

Importantly, these are minimum national employment standards rather than advisory good practice. They complement the NHS People Promise and implementation is mandatory, with performance reflected through the NOF and wider assurance arrangements, drawing on relevant NHS Staff Survey measures.

The Standards provide an opportunity to review existing People and Culture arrangements against the six requirements, identify any gaps and ensure that appropriate evidence, metrics and improvement actions are incorporated into existing workforce governance. The work on gaps is progressing well with action plans being drawn up vis a vis each standard and incorporated into the appropriate ongoing area of work e.g. Trust inclusion plan for tackling racism / Violence Prevention and Reduction plan for that area of the Staff Standards.

Nursing Workforce Reform – Band 5 Review:

- As previously reported to the Committee, this is a national programme to review all Band 5 nursing roles during 2026 and forms part of wider Agenda for Change reform agenda and specifically the agreement reached between the government and the RCN in terms of N&M pay;
- The aim is to ensure staff are appropriately banded for the work they undertake and that they are supported with career progression;
- To date in LCH we have undertaken a review of all N&M band 5 and band 6 job descriptions to assure ourselves that they are aligned with national profiles. Additionally, we have worked with operational colleagues and staff side partners to review how these JDs are used in practice on the ground and that staff are operating within the scope of their professional practice.
- Trusts were required to submit a Band 5 Nursing Job Evaluation Delivery Plan by 31 July 2026, demonstrating how all Band 5 nursing roles will be reviewed by October 2028.
- The Trust has developed and submitted the required delivery plan working alongside LYPFT colleagues and has commenced implementation in line with the national requirements.

- Progress against the plan will be monitored through this Committee and reported into Trust Board as required. This reflects NHS England's expectation that Boards maintain oversight of delivery, risks, partnership arrangements and the workforce and financial consequences of the review.
- To date work has centred around engagement and communications with Nursing staff as well as the RCN as well as understanding benchmarking and other similar types of Trusts' approach to this work.

Lord Mann Review:

The Lord Mann Review, published in June 2026, examined how the NHS identifies, reports and responds to antisemitism and other forms of racism. Its 36 recommendations have been accepted in full by Government and seek to strengthen accountability, improve reporting and investigation, and embed a more consistently anti-racist culture across the NHS.

For NHS employers, the principal expectations include:

- Stronger leadership and accountability, including visible Board-level ownership of tackling racism and antisemitism;
- Clearer and more consistent reporting, investigation and support arrangements for staff and patients experiencing racism or discrimination;
- Improved training and capability, including anti-racism, antisemitism and cultural competence
- Stronger use of workforce, Staff Survey and WRES data to identify inequalities and monitor improvement;
- effective action to protect staff from racism and abuse from colleagues, patients and the public, alongside creating a culture in which staff feel safe to speak up.

NHS England has accepted the recommendations relevant to it and is incorporating them into wider national arrangements, including the NHS Staff Standards and NHS Oversight Framework.

The Trust has reviewed the Lord Mann recommendations and is taking forward the requirements through its existing arrangements including the above-mentioned Annual Inclusion Plan and Report. Work is being aligned with related national requirements, including the NHS Staff Standards and existing WRES and staff experience improvement activity, to ensure a coordinated rather than standalone response.

4.3 Implications for LCH:

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

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

LCH will need to continue to balance delivery of immediate workforce pressures with readiness for significant structural and cultural reforms over the coming period alongside delivery of the People and Culture workstream of the Trust Integration Programme (TIP). As we move towards the creation of a new organisation it will be important that the foundational work in both LCH and LYPFT is utilised to create the right working conditions, environment, and staff experience in a merged Trust and the Best of Both engagement work recently completed and report on provides much of that.

To note LCH also continues to contribute to and to lead on behalf of the city of Leeds the workforce agenda as a key partner of the Leeds Health and Care Academy – *see update from Kate O'Connell, Director of the Academy within the agenda pack.*

5. Conclusion:

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

➢ 6. Recommendations:

The Board is asked to:

- Note progress against the priorities within the LCH Strategic People Framework;
- Take assurance that appropriate plans and governance arrangements are in place to respond to the national NHS People priorities outlined in the report;
- Note the key risks and areas requiring continued oversight, particularly People Directorate capacity, integration-related organisational change and delivery of staff experience and inclusion improvement actions; and
- Confirm whether the information presented provides Acceptable Assurance regarding delivery of the Strategic People Framework and the Trust's response to the national People agenda.

Jenny Allen

Director of People

Updated 9th November 2026

Agenda item:	2026-27 Blue Box Item (19)
Title of report:	Guardian of Safe Working Hours Report – Q1
Meeting:	Trust Board Meeting Held in Public
Date:	19 November 2026

Presented by:	Dr Baljit Karda Consultant Community Paediatrician and GoSWH
Prepared by:	Dr Baljit Karda Consultant Community Paediatrician and GoSWH

Purpose of the report:		
To provide assurance to the board that doctors and dentists in training within LCH NHS Trust are safely rostered and that their working hours are consistent with the Terms & Conditions of Service (TCS) for NHS Doctors and Dentists in Training (England) 2016.	Approval	
	Discussion	x
	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:

- To appoint a resident doctors' representative for the resident doctors' forum and an LNC resident doctors' representative
- To improve training experience for community paediatric resident doctors.
- Continue the implementation of the NHS England 10-point action plan.
- Improve resident doctors' attendance at the resident doctors' forum to gain insight into their experience and address if any concerns.

Previously considered by:	Guardian For Safe Working Hours - Quarterly 3 Report presented to People and Culture Committee 10th June 2026
Outcome of previous discussion/s:	NA

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

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: NA	Workforce: Demographic data relating to protected characteristics are not routinely collected within the exception reporting dataset and therefore demographic analysis is not available. The exception reporting process is accessible to all doctors, and no equity or inclusion concerns have been identified during this reporting period.

Recommendation(s)	**The Board is recommended to:** • Support the GoSWH to improve training experience for community paediatric resident doctors. • Note the low engagement of CAMHS resident doctors in the Resident Doctors Forum and support efforts to improve participation. • Note that the Resident Doctors' Representative posts remain vacant.

List of Appendices:	None

Guardian of Safe Working Hours report

- **1 Executive Summary**
- Key work continues to improve resident-doctor experience.
-

The Guardian continues to monitor those elements of the NHS England 10 Point Plan that relate to safe working hours, exception reporting, and rota management. The data for CAMHS NROC (non-resident on-call) monitoring was not available at the time of writing the report. Low engagement at the resident doctors' forum continues to limit our ability to gather meaningful insight into trainees' experiences. Support from CAMHS and the Medical Director is required to identify barriers to engagement and any additional support needed to ensure effective trainee oversight and feedback.

2 Main body of the report

The role of Guardian of Safe Working Hours (GOSWH) was introduced as part of the 2016 Resident Doctor's contract. The role of the GOSWH is to independently assure the confidence of Resident doctors that their concerns will be addressed and that improvements will be made in working hours and rotas.

Purpose of Guardian of Safe Working Hours report
To provide assurance that doctors and dentists in training within LCH NHS Trust are safely rostered and that their working hours are consistent with the Resident Doctors Contract 2016 Terms & Conditions of Service (TCS).

To report on any identified issues affecting trainee doctors and dentists in Leeds Community Healthcare NHS Trust, including morale, training and working hours.

3 Impact

This report has been informed by discussions with the Joint Negotiating Committee, HR business partner, BMA Industrial Relations Officer (IRO), and guidance received from NHS employers and Health Education England.

Quality

Exception reports
No exception reports were filed during this quarter.

Fines
No fines were levied by the GOSWH during this quarter

- **Resources**

Rota gaps and CAMHS ST rota
The CAMHS ST non-resident on-call rota consists of a 1:5 rota, and gaps on this rota are covered by locums, typically doctors who have worked on the rota in the past or doctors currently working for LCH who are willing to do extra shifts or consultant step-down arrangements where necessary. The current CAMHS ST on call rota is checked by senior CAMHS admin staff with experience in managing CAMHS consultant rota to double check the Locum shifts picked up by resident doctors. There are currently two rota gaps within the service: one arising from maternity leave and the other relating to reasonable workplace adjustments.

Rota Gaps (number of night shifts needing cover)		April 2026		May 2026		June 2026	
		CT	ST	CT	ST	CT	ST
	Gaps	n/a	26	n/a	25	n/a	25
	Internal Cover	n/a	5	n/a	7	n/a	14
	External cover	n/a	21	n/a	18	n/a	11
	Unfilled	n/a	0	n/a	0	n/a	0

Work is underway to collate information on CAMHS NROC (non-resident on-call) activity and monitoring. This will also be discussed with the new cohort of CAMHS trainees at the October Resident Doctors' Forum.

- **Risk and assurance**

The Resident Doctors' Representative position for both the Resident Doctors Forum (RDF) and Local Negotiating Committee (LNC) remains vacant. Requests for expressions of interest were made during resident doctor induction, and a further call will be made at the October RDF.

The Resident Doctors Forum was held virtually via MS Teams in July; however, no resident doctors or BMA Industrial Relations Officer (IRO) representatives attended. Resident doctors continue to be well supported by medical staffing and the People Partnering team.

NHSE 10 Point Plan to improve resident doctors' working lives

The Trust Medical Education team, working with the Medical Directorate, Director of Medical Education and GOSWH, is ensuring the Trust continues to deliver on the requirements in NHS England's 10-Point Plan, published in August 2025, to improve resident doctors' working lives. The last review was in Aug 2026.

Community paediatric Training issue: Community paediatric resident doctors continue to work their on-call shift in LTHT, and this has an impact on their community paediatrics training. GOSWH and the community paediatric college tutor will link in with the LTHT team (rota co-ordinator and college tutors) to ensure the training time is optimised. In the past, a few small changes have been made to the rota, which has given the resident doctors more time in the community. This can be improved further. GOSWH will link in with the team on a regular basis to explore long-term solutions to the issue.

- **Equity**

Demographic data relating to protected characteristics are not routinely collected within the exception reporting dataset and therefore demographic analysis is not available. The exception reporting process is accessible to all doctors, and no equity or inclusion concerns have been identified during this reporting period.

4 Next steps

GOSWH will continue to work collaboratively with key stakeholders across the trust to ensure effective and timely implementation of the 10-point plan.

GSWH will continue to work with Key people to improve community paediatric training at LCH.

GoSWH will continue to work with CAMHS to improve resident doctor attendance at the Resident Doctors Forum (RDF). Improving engagement will help identify and address any concerns, provide assurance that working hours are safe, and ensure that training opportunities and protected teaching time are maintained.

5 Recommendations

The Board is recommended to:

- Support GoSWH in its work to enhance community paediatric training opportunities.
- Note the low level of engagement from CAMHS resident doctors in the Resident Doctors Forum (RDF) and support efforts to improve attendance and engagement to better understand trainee experience, ensure safe working hours, and protect training opportunities.
- Note that the Resident Doctors' Representative posts for both the Resident Doctors Forum (RDF) and Local Negotiating Committee (LNC) remain vacant

Name of author: Dr Baljit Karda
Title/s: Guardian of Safe Working Hours, Leeds Community Healthcare Trust
Date paper written: 09/11/2026

Leeds Community Healthcare NHS Trust

Trust Board Workplan April 2026 -March 2027
Version: 8 8 November2026

Agenda Item 2026-27 (20)

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	25 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 TBC)	EDFR						X			
Estate Strategy	Six monthly (May/November)	EDFR		X				Deferred			
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		
Research and Development Strategy	Annual (March 2027)	EMD								X	
People Headlines and Strategy update	3 X per year (March, July and November)	DOP				X		X Blue Box		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						
Learning From Deaths - Mortality reports	Quarterly (May + annual report, July, ~~September~~ November and January)	EMD		X4 + Annual Report - Deferred		X Blue Box Q1		X Q2 Blue Box	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	X	
Charitable Funds Annual Report and Accounts Trustees Meeting only	Annual (January)	EDFR								X	
Charitable Funds Committee Chair's Assurance Report	Quarterly (July, Sept, Jan and March)	CS				X	X		X	X	
Charitable Funds 6 monthly Update Report (To go to Trustees meeting annually)	Six monthly (May and Nov)	EDN&AHPS		X							
Emergency Preparedness, Resilience & Response Statement of Compliance	Six monthly (July - Annual Report and January)	EDO				X Annual Report only			X		
Integrated Performance Report	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	Included in Intgrated Performance Report from November 2026 X			
Sustainability (Green) Plan	Six monthly (July, and January)	EDO				X Blue box			X (Blue Box)		
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-Blue Box		X	Resident doctors rep: Dr Salma Ehag to be invited - might need to check with Ruth
Medical Director's annual report	Annual (Septemper)	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 inlciuding 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 (March) -from 2027	CS								X	
Board Members Service Visits Report	3 x year (September, January, 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											
Thirlwall Enquiry Report	(November 2026)	EDN&AHPS						X			
Review/Revision of Standing Orders and Standing Financial Instructions	January 2027	EDFR						X			

GLOSSARY

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