Public Meeting of the Board of Directors

will be held at 9.30am on Thursday 29 January 2026
Cheer Room, The Studio, Riverside West, Whitehall Road, Leeds LS1 4AW

Agenda

		LEAD	TIME
1	**Apologies for absence** (verbal)	MM	9.30am
2	**Sharing stories – Forensics** (verbal)		9.35am
3	**Declarations of interests and any declarations of conflicts of interest in any agenda item** (enclosure)	MM	-
4	**Minutes of the meeting held on 27 November 2025** (enclosure)	MM	-
5	**Matters arising** (verbal)	MM	-
6	**Actions outstanding from the public meetings of the Board of Directors** (enclosure)	MM	10.05am
Use of resource			
7	**Chief Executive's report** (enclosure)	SM	10.10am
8	**Report from the Chair of the Finance and Performance Committee for the meeting held on 27 January 2026** (to follow)	CHe	10.30am
9	**Report from the Chief Financial Officer** (enclosure)	DH	10.35am
10	**Organisational Priorities Q3 Update Report** (enclosure)	DH	10.45am
11	**Report of the Chief Operating Officer** (enclosure)	JFA	10.55am
	Break		11.05am

Patient centred care			
12	**Report from the Chair of the Quality Committee for the meetings held on 11 December 2025 and 15 January 2026** (enclosure)	**FH**	**11.20am**
	12.1 Quality Committee Terms of Reference (enclosure)	**FH**	**-**
13	**Report from the Director of Nursing and Professions** (enclosure)	**NS**	**11.25am**
	13.1 Safer Staffing Report (enclosure)	**NS**	**11.35am**
Workforce			
14	**Report from the Chair of the Workforce Committee for the meeting held on 4 December 2025** (enclosure)	**ZBS**	**11.45am**
Governance			
15	**Report from the Chair of the Audit Committee for the meeting held on 20 January 2026** (enclosure)	**MW**	**11.50am**
	15.1 Audit Committee Terms of Reference (enclosure)	**MW**	**-**
16	**Mental Health Legislation Committee Terms of Reference** (enclosure)	**KK**	**12pm**
17	**Board Assurance Framework** (enclosure)	**SM**	**12.05pm**
18	**Approval of the appointment of the Senior Independent Director** (enclosure)	**MM**	**12.10pm**
19	**Use of Trust Seal** (verbal)	**MM**	**-**
20	**Any other business** (verbal)	**MM**	**12.15pm**

The next meeting of the Board will be held on Thursday 26 March 2026 at 9.30am
Inspire@2 room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR

AGENDA ITEM

3

Declaration of Interests for members of the Board of Directors

Name	Directorships, including Non-executive Directorships, held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services.	Any substantial or influential connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.	Any other commercial or other interests you wish to declare. This should include political or ministerial appointments (where this is information is already in the public domain – this does not include personal or private information such as membership of political parties or voting preferences)	Declarations made in respect of spouse or co-habiting partner
EXECUTIVE DIRECTORS								
Sara Munro Chief Executive	**Interim Chief Executive Officer** Leeds Community Healthcare NHS Trust	None.	None.	**Trustee** Workforce Development Trust	None.	None.	None.	None.
Dawn Hanwell Chief Financial Officer and Deputy Chief Executive	None.	None.	None.	**Class B Director** Community Ventures (Leeds) Ltd	None.	None.	None.	None.
Chris Hosker Medical Director	**Director** Trusted Opinion Ltd.	None.	**Director** Lilac Tree Clinic Ltd.	None.	**Director** Lilac Tree Clinic Ltd.	None.	None.	Partner: **Director** Trusted Opinion Ltd.
Joanna Forster Adams Chief Operating Office	None.	None.	None.	None.	None.	None.	None.	Partner: **Director of Public Health** Middlesbrough Council and Redcar and Cleveland Borough Council Partner: **Chair** The Junction Charity
Nichola Sanderson Director of Nursing and Professions	None.	None.	None.	None.	None.	None.	None.	None.

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Darren Skinner Director of People and Organisational Development	**Director** Skinner Consulting Ltd.	None.	None.	None.	None.	None.	None.	None.

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NON-EXECUTIVE DIRECTORS								
Merran McRae Chair	**Director** Finnbo Ltd	None.	None.	**Trustee** Yorkshire Sculpture Park	None.	None.	**Deputy Lieutenant** West Yorkshire Lieutenancy	Partner: **Director** Finnbo Ltd
Zoe Burns-Shore Non-executive Director	**Executive Director for Customer Delivery** Money and Pensions Service	None.	None	None	None.	None	None.	None
Frances Healey Non-executive Director	None	None.	None	**Trustee** The National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	None	None	**Visiting Professor** University of Leeds **Advisory Role and Peer Reviewer** Research studies and potential research studies related to patient safety	None
Cleveland Henry Non-executive Director	**Director** 63 Argyle Road Ltd.	None	None	**Chair of the Board of Trustees** Community Foundations for Leeds **Director** Leeds Digital Ball Community Interest Company	None	None	**Interim Chief Operating Officer** Optum UK	Partner: **Lead Cancer Nurse** Leeds Teaching Hospitals NHS Trust

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Kaneez Khan Non-executive Director	**Director** Primrose Consultancy Yorkshire	None	None	None	None	None.	None	None
Katy Wilburn Non-executive Director	**Non-executive Director and Chair of Customer Committee** Thirteen Group	None.	None.	None.	None.	None.	**Principal Consultant (Governance and Regulation)** Altair Consultancy and Advisory Services Ltd.	None.
Martin Wright Non-executive Director	None.	None.	None.	**Trustee** Roger's Almshouses (Harrogate) .	None.	None.	None.	Partner: **Trustee** Roger's Almshouses (Harrogate)

Declarations pertaining to directors being a Fit and Proper Person under the CQC Regulation 5 and meeting all the criteria in the Provider Licence and the Trust's Constitution to be and continue to be a director

Each director has been checked in accordance with the criteria for fit and proper persons and have completed the necessary self-declaration forms to show that they do not fit within any definition of an "unfit person" as set out in the provider licence, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008 or the Trust's constitution; that they meet all the criteria for being a fit and proper person as defined in the Social Care Act 2008 (Regulated Activities) Regulations 2008; and that there are no other grounds under which I would be ineligible to continue in post.

		Executive Directors						Non-executive Directors						
		SM	**NS**	**DH**	**CHos**	**JFA**	**DS**	**MM**	**ZB-S**	**KK**	**FH**	**CHe**	**MW**	**KW**
a)	Are they a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) have not been discharged?	No	No	No	No	No	No	No	No	No	No	No	No	No
b)	Are they a person who has made a composition or arrangement with, or granted a trust deed for, any creditors and not been discharged in respect of it?	No	No	No	No	No	No	No	No	No	No	No	No	No
c)	Are they a person who within the preceding five years has been convicted of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) being imposed on you?	No	No	No	No	No	No	No	No	No	No	No	No	No
d)	Are they subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986?	No	No	No	No	No	No	No	No	No	No	No	No	No

e)	Do they meet all the criteria for being a fit and proper person as defined in the Social Care Act 2008 (Regulated Activities) Regulations 2008.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Public Board of Directors

Thursday 27 November 2025 at 09:30am

in Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR

Board Members **Apologies**

Mrs M McRae	Chair of the Trust
Mrs Z Burns Shore	Non-Executive Director
Mrs J Forster Adams	Chief Operating Officer
Mrs D Hanwell	Chief Financial Officer and Deputy Chief Executive
Mr C Henry	Non-Executive Director (Senior Independent Director)
Dr F Healey	Non-Executive Director
Dr C Hosker	Medical Director
Ms K Khan MBE	Non-Executive Director
Dr S Munro	Chief Executive
Mr D Skinner	Director of People and Organisational Development
Miss N Sanderson	Director of Nursing and Professions
Miss K Wilburn	Non-Executive Director
Mr M Wright	Non-Executive Director (Deputy Chair of the Trust)

All members of the Board have full voting rights.

In attendance

Mrs Clare Edwards	Associate Director of Corporate Governance / Trust Board Secretary
Mr Kieran Betts	Corporate Governance Assistant
Ms Gail Galvin	Clinical Lead for Acute Services (for minute 25/132)
Ms Tina Mistry	Senior Psychologist (for minute 25/132)
Ms Fiona Lowis	Consultant Psychologist (for minute 25/132)
Ms Jess Plowman	Service User (for minute 25/132)
Mrs Shereen Robinson	Freedom to Speak Up Guardian (for minute 25/155)

Five members of the public attended the meeting, including two governors.

		Action
	Mrs McRae opened the public meeting at 09:30 and welcomed everyone.	
25/131	**Apologies for absence** (agenda item 1)	
	There were no apologies for absence. The meeting was quorate.	

25/132 **Sharing stories – Adult Acute** (agenda item 2)

Mrs McRae welcomed Ms Gail Galvin, Clinical Lead for Acute Services, Ms Tina Mistry, Senior Psychologist, Ms Fiona Lowis, Consultant Psychologist, and Ms Jess Plowman, Service User for the Adult Acute Services Sharing Stories.

Ms Galvin introduced the team, noting that the focus of the presentation would be on the inpatient pathway. Ms Plowman provided a background to her family life and experiences, noting that she had a decline in her mental health following the death of her patents, with a history of sections. Prior to one of her admissions, she had waited for two and half weeks for an inpatient bed whilst in deep psychosis, which led to challenges for her children and family. She did not recall her first week in hospital, but taking her medications had improved her presenting behaviour and she found that being heard and listened to was very important for her recovery; whilst she was on Ward 5 she felt her voice was heard and it was her shortest admission because she was listened to. When she was made aware that her consultant had previously looked after her mother, she gained trust in her and the care she was provided with.

She praised the staff support she received, and the relationships built with the Health Care Assistants. She noted that medication was provided in a caring, compassionate and supportive manner which supported her to take her medication whilst trust was built up. The psychology support was very helpful, and the strategies put in place continued to help her and her family.

She commented that the night staff were usually bank or agency, and she did not find that they listened or engaged as much as day staff, and more permanent staff on night would support the bank staff to be able to deliver more personalised care. She noted the importance of compassion from staff, and that a change of food menu would be beneficial to service users as it could be challenging to order food that service users wanted to eat.

Mrs McRae commented that the courage and commitment shown by Ms Plowman was incredible and to share her story in front of the Board was helpful to service improvement opportunities. Miss Sanderson added that Ms Plowman's journey through health care demonstrated how hard she had worked to get to her current position with positive outcomes.

Dr Healey offered her thanks to Ms Plowman for sharing her story and acknowledged the importance of providing care close to home, however she asked whether support was provided for her children and family. Ms Plowman confirmed that support was offered to her husband and her children's school were supportive, and wider family input had helped.

Mrs Forster Adams noted her thanks for sharing the story, and that it was

	important to hear concerns. In relation to the delay for admission, work was underway to try and reduce that happening but there was a need to consider the support offered whilst service users were waiting at home, and she offered her apologies for Miss Plowman's experience. She also noted the importance of connecting and having relationships with staff and asked the team how they responded to service user experiences. Ms Galvin responded that 'Have your Say' was a tool for feedback and themes were similar, therefore there was a focus on workforce and keeping staff within the ward team to provide continuity. She added that there were many workstreams in place to address lived experience feedback. Dr Munro offered her thanks to Miss Plowman and the team and acknowledged that there was a need to reduce bank and agency use, however nighttime was a vulnerable time as the wider multi-disciplinary team were not there and there were no family visits or activities, therefore there was a need to consider roster management and skill mix. The Board requested that Miss Sanderson, Mrs Forster Adams and Mr Skinner understand the current position for the night rostering and staff allocation process and consider requirements for the future planning of rostering. Ms Khan thanked Ms Plowman for her bravery in sharing her story and noted that the allocation of night staff had been a frequent discussion, so it was helpful to hear her experiences. Mrs McRae reiterated her thanks to Ms Plowman and the team for the presentation, noting it was important to hear positive and negative feedback, and that Ms Plowman's honesty had been very important. The Board of Directors **thanked** everyone for attending the meeting and sharing the engagement work within the Adult Acute Service.	**NS / JFA / DS**
25/133	**Declaration of interests for directors and any declared conflicts of interest in respect of the agenda items** (agenda item 3) Dr Healey noted that, whilst not a direct conflict of interest, she had been involved in the court case referred to in Miss Sanderson's report as a witness on behalf of NHS England. This was noted for information only. The Board of Directors **noted** that there were no changes to the declarations of interests, and no conflicts in respect of any of the agenda items.	

25/134	**Minutes of the previous meeting held on 25 September 2025** (agenda item 4)
	The minutes of the meeting held on 25 September 2025 were **received** and **agreed** as an accurate record.
25/135	**Matters arising** (agenda item 5)
	The Board of Directors **noted** that there were no matters arising.
25/136	**Question received from a member of the public** (agenda item 5.1) Mrs McRae noted that a question had been received asking for clarification on conditional offers of jobs after completing the nursing course as it was stated throughout the programme but now did not appear clear. Miss Sanderson responded noting that in 2019 there was a clear offer that if students fulfilled the criteria, then an offer would be made at the end of training which was important as there was a need to support the student workforce through their training and career. Over the last 12 months work had been undertaken to review the offer as there was not currently the rate of vacancies in relation to preceptorship and student nurse places. She acknowledged it was important to offer appropriate placements at the end of training therefore work was taking place, with communication to students, that there was a move to preferential interviews rather than a direct job offer. The arrangements were not yet finalised, and there was a need to work with the university to ensure a consistent message was given. She added that a significant amount of support would be available in preparation for the interview process. She confirmed that work was underway with details being finalised, and the overall timelines would be clear by the beginning of January 2026. Mrs McRae noted that historically vacancies had been an issue, but this had been addressed which impacted on student placements, however the Trust recognised the investment by both parties and there was a balance needed between keeping dedicated students and available vacancies. Miss Sanderson acknowledged the work undertaken by students and would keep communication open to ensure that they were kept up to date with progress.
	The Board of Directors **noted** the response to the question raised.

25/137	**Actions outstanding from the public meeting of the Board of Directors** (agenda item 6) Mrs McRae presented the action log which showed those actions previously agreed by the Board in relation to the public meetings, those that were completed and those that were still outstanding. For action 34 regarding the Safer Staffing Establishment Review, Miss Sanderson noted that this was on track for a progress report to be provided at the end of the financial year. In relation to action 35 regarding the missing ethnicity data, Mrs Forster Adams updated that this was being reviewed through performance meetings, and an update would be given to the Finance and Performance Committee in January 2026. The Board **received** the cumulative action log, **agreed** to close the actions that had been completed and **noted** the updates provided for ongoing actions.
25/138	**Report from the Chief Executive** (agenda item 7) Dr Munro presented the Chief Executive's report, taking the content as read. She noted key points including the recent service visits undertaken, which included the Specialist Supported Living Service who recently presented to the Board, and she noted it was positive to see the work undertaken on enhanced care packages to access services in the local community and the consultancy work underway to support other services and complex cases. In relation to industrial action, she offered her thanks to all involved and noted that there had been no cancelled activity which was reassuring for patient care, however there was uncertainty on whether there would be any future action. Dr Munro and Dr Hosker had attended a resident doctors meeting in the Trust which was a positive meeting with good engagement. There was a need to balance local relationships and the national dispute with action taken by the Trust for resolution where possible. She confirmed that there was no need for an additional reporting route to the Board as there was as established process for escalation through the Medical Director report to the Board. She updated that the staff engagement sessions were well underway following positive evaluation from the previous round.

In relation to the medium term plan, Dr Munro informed the Board that further guidance had been received, and the detail would be covered in the Chief Financial Officer's report, however a first draft would be presented to the Extraordinary Board of Directors in December 2025 for approval. A five year submission would be needed in early February 2026, however it was acknowledged that the timescales would be challenging with additional technical guidance also expected.

She updated that the Boards of both LYPFT and Leeds Community Healthcare NHS Trust (LCH) had made the decision to develop a Strategic Outline Case for the development of the new organisation incorporating both existing Trusts. The Strategic Outline Case was now underway with timescales to be agreed with NHS England for approval, and legal support would be put in place.

Dr Munro highlighted the Reasons to be Proud, noting the excellent online and in person Remembrance Service, which was a credit to all involved.

Mr Wright commented that there were three processes that would run in parallel, all of which were interlinked, which were the integration with LCH, the development of a Joint Committee for providers, and the ICB changes. Due to this there was a risk that the governance may be confusing in relation to priorities and processes, therefore he asked for assurance regarding how it would be manged. Dr Munro provided reassurance that this was acknowledged, and the Provider Partnership Review Report set out the direction of travel over the next 12-18 months regarding the Joint Committee and delegated functions. The Committee would function in shadow form ahead of the ICB changes and would consider the impact of changes in the ICB and Place based arrangements. She referenced the plans for regional structure change within NHS England, including Chair recruitment, and that the timing for the due diligence for the Strategic Outline Care would need to align to national approval processes being made at the appropriate time.

Discussion took place regarding the importance of engagement work with staff through the process, and Dr Munro noted that the engagement sessions were focusing on the individual services to make the information relevant with an opportunity for further discussion.

Mrs McRae noted that, in terms of alignment with LCH, staff seemed to agree with the proposal from the recent discussions that had taken place and it was important to focus on the golden thread of finance and equality of service provision, and need to ensure that this remained in place throughout the process. The Board acknowledged that need to ensure stability for staff in services and that different groups of staff would have different concerns, therefore would need these to be addressed. Dr Hosker confirmed that communication had been undertaken with staff already and there had not been concerns raised to date, as they understood the benefit to services.

Ms Khan queried whether the ICB redundancies costs would require Trust support, and Dr Munro confirmed that the Trust cash position would not be used to cover any of the gap, and ICBs would need to plan how to close the financial gap over the coming financial year. She acknowledged it was a complex situation regarding the voluntary redundancy process and there was no degree of predictability at the current time.

Mrs McRae thanked Dr Munro for the report.

The Board **received** the report from the Chief Executive and **noted** the content.

25/139 **Provider Partnership Review Report** (agenda item 7.1)

Dr Munro presented the paper noting that the same report was being presented to all members of the Partner Boards and Executive Committee of Leeds City Council to share the recommendations. She confirmed that the programme of work was already underway, and both Mrs Hanwell and Mrs Forster Adams were involved for the Trust with a review to take place of additional individuals potentially needed to support the different workstreams.

She highlighted that formal governance would require Board approval as the proposed Joint Committee would operate as a subcommittee of the Board, which would need to include representation from Chairs and Non-Executive Directors. It was expected that elements of ICB governance at Place level would cease to ensure there was no duplication as Board oversight would be in place through the amended structure.

She highlighted that the report made recommendations regarding joint appointments, however this would be determined through the merge process via the Strategic Outline Case, and the recommendations would be reviewed as part of the process.

Mr Wright queried the process for securing professional expertise, and Dr Munro responded that there was a need for professional and legal support, however this would be discussed in the private Board of Directors meeting as there was a need to ensure that updates were provided to both Trust Boards at the same time.

Mrs McRae welcomed the GP provider collaboration to support the alignment of services and thanked Dr Munro for the report.

	The Board **received** the Provider Partnership Review Report and **noted** the content.
25/140	**Provider Capability Self-Assessment Return** (agenda item 7.2) Dr Munro presented the papers that were submitted to NHS England in relation to the Trust's return. They were presented to the Board for completeness as whilst they had been approved at the private Extraordinary Board of Directors meeting, there was an expectation from NHS England to present them at a public Board meeting. No feedback had been received at the current time; however, the returns would be considered alongside the segmentation work with the NHS England regional team developed a consistent methodology for review. Mrs McRae thanked Dr Munro for the report.
	The Board **received** the Provider Capability Self-Assessment Return and **noted** the content.
25/141	**Report from the Chair of the Finance and Performance Committee for the meetings held on 28 October and 25 November 2025** (agenda item 8) Miss Wilburn presented the Chair's reports from the Finance and Performance Committee meeting taking them as read. She focused on the report from the meeting in November 2025 noting that the Committee had received the finance report for month 7 and assurance regarding the medium-term planning process, with the significant elements being brought to Board in due course. She highlighted the detailed discussion that took place regarding the future reporting for the financial position, as there was a current focus on the variance against the budget, but also a need to look at the run rate, therefore the next meeting would review the position in a different format to consider the reporting option to take forward. The Committee had received the bank usage report which was helpful in terms of workforce with the report giving reassurance that less hours were used in bank shifts compared to previous years. However, it was noted as bank shifts were used for higher cost shifts at evening and weekends the reduction in hours was not resulting in a reduction in the cost. She noted that the Committee discussed the 104 week wait position and the individual case detail provided reassurance regarding the process and impact. The information governance report that was presented regarding

	access to patient records by staff provided reassurance on the process and action taken in relation to these incidents. Mr Wright emphasised the reduction in month 7 of bank costs of £200,000 in one month and that this would continue to be reviewed. Mr Henry added that the trajectory for the use of bank staff due to holidays taken in the latter part of the year would see an increase in usage so needed to be considered as a potential future challenge. Mrs McRae commented that the balance of bank and permanent staff on night shifts and the quality of care provided on these shifts linked to the action agreed earlier in the meeting. Mrs McRae thanked Committee members and Miss Wilburn for the report.
	The Board of Directors **received** the Chair's report from the Finance and Performance Committee and **noted** the matters reported on.
25/142	**Finance and Performance Committee Terms of Reference** (agenda item 8.1)
	The Board of Directors **noted** and **approved** the Finance and Performance Committee Terms of Reference.
25/143	**Report from the Chief Financial Officer** (agenda item 9) Mrs Hanwell presented her Chief Financial Officer's report, noting the discussion at Finance and Performance Committee therefore taking it as read. She reminded the Board of the break-even plan and that there was confidence the stretch would be achieved. She confirmed that the Trust would not be asked for money towards the ICB costs at a system level, and whilst the system position was tight it would be linked to system changes and future considerations within the planning guidance. In relation to the capital expenditure, she noted that the upgrades at the Mount and Parkside Lodge were significantly behind however this continued to be expedited to recover progress. For the medium-term planning process, the role of the Board and individual organisational accountability regarding deliverability and credibility of plans linked to the provider capability self-assessment that had taken place, therefore a read across had been done of the submission to ensure consistency. She noted the 2 year revenue plan would be done in December 2025, however testing of the three year allocation remained ongoing therefore some areas would not be confirmed for the draft plan.

	She noted in relation to the MARS scheme that the outlay would be paid back within 12 months which was a positive position. Mrs McRae queried the timeline for the unidentified CIP costs and Mrs Hanwell noted that further exploration of these was underway. Mrs McRae thanked Mrs Hanwell for the report.	
	The Board **received** the Chief Financial Officer's report and **noted** the content.	
25/144	**Organisational Priorities Q2 Update Report** (agenda item 10) Mrs Hanwell presented the update report, taking it as read, noting the collective responsibility across all Executive Directors for the schemes. Miss Wilburn queried if there was a disconnect between the progress shown in the report and Chief Operating Officer report in relation to significant operational challenges as there were variations in the detail provided and a need to sense check the outcomes of the projects were still needed to address operational challenges. Mrs Hanwell responded that the milestones to be achieved may not provide immediate outcomes, however she was confident that, through the oversight process, programmes and milestones were delivering but the expectation of impact and outcomes may take longer. Dr Munro added that when the position was reviewed at the Extended Executive Management Team meetings there was consideration of the milestones and any changes in the implementation of certain programmes, therefore this was part of the review that took place ahead of presentation to the Board. Mrs Forster Adams noted that the inpatient flow programme work was on track and the changing inpatient model was longer term work, therefore the Chief Operating Officer report provided more operational detail rather than contradictory information. Dr Healey queried whether there was an opportunity for the update to be presented to see specific measures within the report including trajectories for performance as this would show the full picture of milestones and impact. Mrs Hanwell agreed to review and amend the report as appropriate to deliver this. Mrs McRae thanked Mrs Hanwell for the report.	**DH**
	The Board **received** the Organisational Priorities Q2 Update Report and **noted** the content.	

25/145 **Report of the Chief Operating Officer** (agenda item 11)

Mrs Forster Adams presented her report, noting the depth of the discussion at Finance and Performance Committee. She highlighted thanks to all those working in services for delivering high quality care whilst additional work was ongoing in terms of improvement and transformation.

She informed the Board that there were concurrent incidents being managed through the EPRR framework which included the industrial action as referenced by Dr Munro, and the issues at Red Kite View which would be covered in the private Board meeting. Admissions to Red Kite View were currently on a case by case basis due to the estate decamp and investigative work which was a dynamic situation under constant review.

She noted that no activity had been cancelled because of industrial action which was a positive position and thanked medical directorate colleagues for the work undertaken to support this to be delivered.

There was an improved position for Out of Area Placements and she acknowledged that it was challenging clinically and operationally to deliver on this however the right programme of work was in place. The closure of Oasis House had had a significant impact however it had reopened which had supported the Out of Area Placement position.

She noted that operationally there was oversight of service users awaiting admission from Emergency Departments (ED), and that there was a need to admit them more quickly, however there were also service users in the community awaiting admission therefore there was a need to ensure a focus on both areas. She acknowledged the response times in ED were not where they needed to be in October 2025, but action had been taken including work with acute providers to understand the detail.

She referenced the discussion at Finance and Performance Committee regarding community access times and, whilst the Trust benchmarked well at a national level, part of the work for Community Transformation was to ensure swift access to assessment. This would be reported back through Finance and Performance Committee and the Board.

Mrs Burns Shore noted that discussions had taken place at Board previously regarding the Trust's outlier position for out of area placements and conscious choices had been made. Mrs Forster Adams acknowledged this and added that the decision had been taken to continue with placements as close to home as possible rather than increase ward size or use independent sector beds. In other organisations with a broader geographical spread, there was a use of inpatient capacity flexibly. She noted that a formal letter had been received from the regional Medical Director and, following a meeting, it had been concluded that there was no additional input required and the input from

the Royal College of Psychiatry would continue. It was important to note that the Trust was an outlier, and a conscious decision had been made regarding process for pout of area placement management, but this was under active review. Mrs McRae noted that the recent provision was still out of area but closer to home, and Mrs Forster Adams commented that there was an opportunity for negotiation with NHS England as to whether this could be classed as in area, and there may be an opportunity for PICU placements more locally which was also being reviewed.

Mr Wright referenced the work with colleagues outside of the NHS to improve the discharge pathway and that it would be interesting to understand how this could be facilitated and improved to improve the patient pathway. Mrs Forster Adams noted that work had been undertaken with colleagues at an operational level and was now being formalised with input into the workstream regarding accommodation and housing which was beneficial.

Mrs McRae thanked Mrs Forster Adams for her report.

The Board **received** the Chief Operating Officer report and discussed the content.

25/146 **Emergency Preparedness, Resilience and Response (EPRR) Core Standards Assurance Report** (agenda item 11.1)

Mrs Forster Adams took the document as read and noted thanks to the EPRR team for producing it. It provided an assessment against the EPRR Core Standards, and she reported that the Trust had maintained compliance at 74%, which whilst technically non-compliant, had been retained despite periods of absence within the team. The position had been reviewed at the Finance and Performance Committee with assurance provided in relation to progress made with the Data Protection Security Toolkit position. There were some outstanding issues nearing conclusions and she added that the Hazmat standards for Mental Health organisations were heavily dependent on external support, so discussions remained ongoing.

Mrs McRae commented it was positive that the position was maintained however queried if the Trust would always be non-compliant. Mrs Forster Adams responded that it was possible to move into partial compliance if tasks were completed such as lockdown, and there were opportunities to work across the sector to strengthen the position. The Trust benchmarked well in the sector but Bradford District Care NHS Foundation Trust had achieved partial compliance so there was a need to review any learning for that position. She added that the Hazmat issue applied to many organisations across Yorkshire as the arrangements with Yorkshire Ambulance Service remained ongoing.

Mr Henry noted that the consequences of non-compliance were discussed at Finance and Performance Committee and that the cyber security threat was an area of focus. Mrs Forster Adams noted that there was a requirement to meet the standards and be prepared for emergencies, and the fact the Trust had multiple incidents underway showed the ability to respond. The Trust would continue to improve compliance and the position and focus on collaborative working. Mr Wright added that the integration process with LCH may bring positive opportunities for the team.

The Board approved the Emergency Preparedness, Resilience and Response Assurance Report.

Mrs McRae thanked Mrs Forster Adams and the EPRR team for the report.

The Board **received** and **approved** the Emergency Preparedness, Resilience and Response Core Standards Assurance Report.

25/147 **Report from the Chair of the Quality Committee for the meetings held on 9 October and 13 November 2025** (agenda item 12)

Dr Healey presented the Chair's Report from the Quality Committee meetings held on 9 October and 13 November 2025, taking them as read. She highlighted that, in relation to sexual safety, there had been an agreement with the Workforce Committee to bring the topic under the oversight of the Quality Committee, and this would be formally reflected in the Committee Terms of Reference.

In relation to the Domestic Abuse, Stalking and Honour-based Violence (DASH) position she noted that consistency was important and assurance was provided on work underway to understand the position. She noted that the quality dashboard would mainly be for measures at service level and that there was work underway for reporting into the Quality Committee and Board with Trust level metrics which would be monitored for performance.

Excellent assurance had been provided in relation to the self-harm assessment process and risk; however, the Committee asked for a strategy to collate the work and the timeframe for this to be completed.

In relation to Learning from Deaths, the Committee had seen progress in the approach to reporting and assurance on the processes in place for reviewing deaths and any learning because of these.

Mrs McRae thanked Dr Healey for the reports.

The Board of Directors **received** the Chair's reports from the Quality Committee and **noted** the matters reported on.

25/148 **Report from the Director of Nursing and Professions** (agenda item 13)

Miss Sanderson presented the report taking it at read by the Board. She highlighted the submission of the self-assessment for the level 2 Triangle of Care and confirmed that there was more rigour in the process to cross reference and assess the position alongside peers and ensure consistency across the ratings provided. She also noted the accreditation received from the Royal College of Psychiatry for the Trust patient safety incident process which was an extremely positive position.

She confirmed that work continued to progress with the national Enhanced Therapeutic Observation and Care Programme (ETOC), with dedicated teams in place to lead it. There would be a focus on how service users were cared for through the multi-disciplinary team approach and interventions available for the least restrictive way of working which would influence practice at a local level.

She referenced the recent legal judgment affecting another Trust and individual ward manager, and the wider learning regarding assurance processes in place for suicide prevention and environmental surveys, including the ability to risk assess individual support for service users rather than blanket decisions being made.

She noted that the flu campaign had started well with good uptake, which was comparable to last year, however uptake had started to reduce. She remained confident that the Trust would achieve the required 5% increase by the end of the campaign.

She noted the recent retirement from clinical practice of Sharon Prince, Deputy Director for Psychological Professions, who had moved to a role to lead the work with Synergi, and thanked her for all her contributions over her time with the Trust.

She informed the Board that the CQC visited Mill Lodge and Red Kite View CAMHS in October and had provided initial feedback with the final report expected in the New Year.

Mrs McRae queried if there was a correlation with staff absence due to flu and vaccine rates. Miss Sanderson responded that there were not many outbreaks of flu and low rates of staff sickness due to it.

Mrs McRae thanked Miss Sanderson for the report.

The Board of Directors **received** the Report from the Director of Nursing and Professions and **noted** the content.

25/149 **Safer Staffing Report** (agenda item 13.1)

Miss Sanderson presented the report taking it as read by the Board. She noted that in August and September 2025 there had been a mix of shifts over and above establishments however a high proportion were consistent with establishment levels. In September 2025 there had been two shifts with no registered nurse at night which were both related to sickness, and plans were in place to ensure risks were mitigated including support from other wards for medication administration.

She highlighted that vacancies remained high across York forensic adult acute services however this should reduce following the appointment of the student cohort.

She noted that significant work had been undertaken in relation to enhanced and therapeutic observation which would continue. There was a continued focus on the multi-disciplinary team approach to care across inpatient units which moved away from specific roles to a broadened shared responsibility and accountability, which was also supporting and impacting on a reduction in bank staff usage.

The Board of Directors **received** the Safer Staffing Report and **noted** the content.

25/150 **Violence Prevention Reduction Self-Assessment Standard** (agenda item 13.2)

Miss Sanderson presented the report noting that there had been a decision to include assessment for both patients and staff in the update. Structured escalation and governance process were in place that aligned to the organisational priorities. There were four identified areas for work with a lead identified for each, and work would continue with updates through to the Quality Committee.

Mr Henry commented that the benchmarking information did not provide dates on when improvements would be undertaken, and Miss Sanderson responded that the supporting workstreams were newly implemented so this would be worked through and dates identified.

Dr Healey noted that violence and aggression was reviewed by multiple Committees and would be an area for discussion at a future Non-Executive Director discussion to consider a dedicated oversight Committee. Mrs McRae noted that this would be discussed at the meeting arranged for 18 December 2025.

The Board of Directors **received** and **noted** the content of the Violence Prevention Reduction Self-Assessment Standard.

25/151 **Report from the Medical Director** (agenda item 14)

Dr Hosker presented the report taking it as read by the Board, noting the national context including industrial action by resident doctors which had been the thirteenth episode. He expressed his thanks to the operational teams for their response and noted that action was likely to continue and intensify.

In relation to job planning he noted that the data included compliance and performance, with work focusing on the quality of job plans and objectives created. For the wider medical workforce work continued to actively recruit; in 2023 there were 22 agency consultants, and the current position was 9 agency consultants with a much lower medical agency spend as a result.

He noted that the previous report the Board received regarding professional standards and revalidation outlined the stretch therefore there was a need to consider funding for the work required.

Dr Julie Hankin had been appointed as Deputy Medical Director for leadership and would bring a wealth of experience which would be of great benefit.

In relation to digital innovation, he highlighted the focus on AI opportunities to support clinical care and the trial of two systems. Dr Munro commented that she had seen a demonstration of ambient AI which was quick in populating fields in the clinical system and creating a letter which had the potential for a positive impact. Dr Health commented that there was a need to balance efficiency and effectiveness on the impact for care provided through AI and benefit for patients. Dr Hosker added that there were opportunities for benefits through AI which were being explored.

Dr Munro informed the Board that the Teaching Trust status process had been paused at the current time.

Mrs McRae thanked Dr Hosker for the report.

	The Board of Directors **received** and **noted** the content of the report from the Medical Director.
25/152	**Guardian of Safe-working Hours Q2 Report** (agenda item 14.1) Dr Hosker presented the report taking it as read by the Board, noting the standard format for the quarterly update. He confirmed that all exceptions had been managed in house with no escalations for the Board.
	The Board of Directors **received** and **noted** the content of the Guardian of Safe Working Hours Q2 Report.
25/153	**Report from the Chair of the Workforce Committee for the meeting held on 27 October 2025** (agenda item 15) Mrs Burns Shore presented the report, taking it as read by the Board, noting the detail covered in previous discussions. She highlighted the review of the PDR process as the staff survey results showed low value in relation to PDR. A short evaluation had been put on the platform to understand colleague's thoughts, and it demonstrated that an engaged manager led to a positive improvement, therefore the focus was on improving the culture of PDRs around an ongoing conversation rather than only an annual discussion. There was no expectation for immediate progress but there was a lot of work underway to address this. She noted that despite efforts regarding sickness levels the position was not moving, therefore at the next Committee meeting there would be a deep dive into the activity underway and consideration of any alternative options that may improve the position. Mr Wright commented that it would be helpful to understand the split between short and long term sickness and Mrs Burns Shore confirmed that this would be included in the review.
	The Board of Directors **received** the Report from the Chair of the Workforce Committee and **noted** the content.
25/154	**Report from the Director of People and OD** (agenda item 16) Mr Skinner presented the report taking it as read and highlighted several key points. He noted that sickness absence in month had hit 7.39% which was a

significant increase on last year, with the ongoing rolling sickness absence being 6.03%. Over 70% of absence was in the top 5 reasons, however there was an inability to differentiate between home and work stress and anxiety related absence, and there was a need to understand the detail around the cold and flu category and any vaccination link.

The Trust had recently commissioned a series of webinars around resilience as the data indicated a significant number of the younger workforce were absent due to stress and anxiety. The webinars would commence in early December 2025, and the impact would be evaluated.

He noted that the PDR position was good, but there was a challenge to maintain a consistent level of recording for clinical supervision. The Trust compulsory training aligned to the core skills training framework however there was a disconnect with NHS England's reduction in compulsory training, therefore the Trust approach was to address priority training.

Mr Wright queried the definition of absence occurrence, and Mr Skinner responded that occurrence was one period so could be one day or five days. Mr Wright questioned the 90 long term occurrences in corporate services, and it was agreed that Mr Skinner would review the detail to understand the figure and provide the detail to the Board. **DS**

Dr Munro noted the national work regarding changes to the workforce following the 10 Year Plan and queried whether any changes were anticipated. Mr Skinner responded that there was no explicit detail currently and it was likely that the 10 Year Workforce Plan would provide the detail. The management and leadership development framework was being rolled out along with other initiatives for consideration.

He noted that there would be a need for a future discussion regarding the Accessible Information Standards for papers published on the Trust website and the content needed for reports to Board to present the detail in a more accessible way.

Mr Henry queried whether there was a risk to the organisation due to the profile of staff between 50 and 64 years old, and Mr Skinner responded that it was part of workforce planning but was challenging as retirement could not be predicted.

Discussion took place regarding reasonable adjustments, specifically for neurodiversity, and it was noted that work was ongoing to understand reasonable adjustments across the Trust as a whole and the associated increase in employment tribunals.

Dr Healey commented there may be opportunities for considering support for the future workforce to support a reduction for absence, and it was noted that this would be included in the sickness absence deep dive.

Mrs McRae thanked Mr Skinner for the report.

The Board **received** the Report from the Director of People and OD and **noted** the content.

25/155 **Report from the Freedom to Speak Up Guardian** (agenda item 17)

Mrs Robinson presented the report taking it as read by the Board. She noted that there had been an increase in concerns this year and they were more complex requiring more contacts with staff and managers to ensure resolution.

She highlighted themes from the concerns such as work based practices, including working hours and sickness, which whilst raised by an individual impacted on the whole team, and bullying concerns between line manager and colleagues, which again impacted on the wider team. There were also themes relating to patient safety issues such as violence and aggression and lone working, therefore she had linked with the Deputy Director of Nursing and service leads to triangulate data from Datix to support action planning.

She noted that concerns had been raised regarding discrimination and protected characteristics, and that the community unrest issues had impacted on staff experiences.

She highlighted the work undertaken via Speak Up Week, and the Board session regarding the reflection tool which had since been completed. There had also been a focus on improving training uptake with all staff to complete level 1 training, and she was working with the training team to make this mandatory training.

In terms of actions for improvement, there would be a focus on measuring the impact of speak up activity and the use of the cultural dashboard and staff survey results to triangulate results. She also noted that the online reporting tool was now available for online anonymous reporting. There was work in place to increase the number of ambassadors which may lead to an increase in workload but there would be a review of working arrangements to meet the needs of the service. She informed the Board that she was now involved in exit interviews to improve feedback and actions that could be taken by line managers.

Mrs McRae noted that it was helpful to see the impact of Board discussions and actions taken to address the points that had been raised. She thanked Mrs Robinson for the report.

The Board **received** the Report from the Freedom to Speak Up Guardian and **noted** the content.

25/156 **Report from the Chair of the Mental Health Legislation Committee for the meeting held on 4 November 2025** (agenda item 18)

Miss Wilburn presented the Chair's report, taking it as read, and noted there were no areas of escalation for the Board. She highlighted that the Terms of Reference had been reviewed and would be presented to the Board in January 2026.

The Committee had received feedback from the Mental Health Act Managers regarding the section extension process which was positive feedback and worked well so would be kept under review through the Committee.

A thematic review of the detention of black adult males had been provided by Dr Hosker which provided detail on numbers and in depth studies into their journey through the services. The recommendations linked to greater deprivation of liberties which would be reviewed in more detail.

Mrs McRae thanked Miss Wilburn for the report.

The Board **received** and **noted** the content of the Report from the Chair of the Mental Health Legislation Committee.

25/157 **Report from the Chair of the Audit Committee for the meeting held on 21 October 2025** (agenda item 19)

Mr Wright presented the Chair's report, taking it as read, and highlighted Audit Yorkshire had advised of a data analytics tool which may be useful for e-rostering, especially given discussions at the meeting, and there may be opportunities for consideration of its use elsewhere. He noted that the Terms of Reference had been reviewed and would be presented to the Board of Directors in January 2026.

In relation to internal audits, he noted that Audit Yorkshire were introducing root cause analysis in their reports to look for themes across audit reports to further understand findings, and this was being trialled for their overarching report at year end. He added that the extension of action target dates for

	recommendations following internal audit had been raised by Audit Yorkshire as an area of focus, therefore the Committee was supportive of the Executive Risk Management Group recommendation for extensions to be granted through Executive Director approval. The Committee received the Health and Safety Report and, whilst there was still work to do regarding definitions, progress was being made for the Q3 report. The objectives for the Committee had been considered to include the use of AI to provide additional context to reports, the support reduction in the pack size, and the assurance provided within reports to be clearly highlighted. Dr Munro questioned the benefit of the root cause analysis approach by Audit Yorkshire and noted she would discuss this in her next meeting with them to understand the impact and rationale for this. Mrs McRae thanked Mr Wright for the report.
	The Board **received** and **noted** the content of the Report from the Chair of the Audit Committee.
25/158	**Board Assurance Framework** (agenda item 20) Dr Munro presented the updated Board Assurance Framework noting the updates and thanked Mrs Edwards and the Committees for the updates. She highlighted that the risk appetite amendments had been fully supported by the Executive Risk Maangment Group.
	The Board **received** the Board Assurance Framework and **noted** the content.
25/159	**Future Meeting Dates and Work Schedule** (agenda item 21)
	The Board **noted** the future meeting dates and work schedule.
25/160	**Use of Trust Seal** (agenda item 22)

	The Board **noted** that the Trust Seal had not been used since the previous meeting.
25/161	**Any other business** (agenda item 23)
	There were no additional items of business raised.
25/162	**Resolution to move to a private meeting of the Board of Directors** At the conclusion of business, the Chair closed the public meeting of the Board of Directors at 12:50 and thanked members of the Board and members of the public for attending. The Chair then resolved that members of the public would be excluded from the meeting having regard to the confidential nature of the business transacted, publicity on which would be prejudicial to the public interest.

Leeds and York Partnership NHS Foundation Trust

Cumulative Actions Report for the Public Board of Directors' Meeting

AGENDA ITEM

6

Open Actions

Log number	Action (including the title of the paper that generated the action)	Person who will complete the action	Meeting to be brought back to / date to be completed by	Update report – comments
34	**Safer Staffing Establishment Review** (minute 25/122 - agenda item 12.2 – September 2025) It was agreed that Miss Sanderson would provide a progress report at the end of the financial year which would be a combined report to consider the full pathway for the areas, not just staffing.	**Nichola Sanderson**	March 2026	**UPDATE** Miss Sanderson noted that this was on track for a progress report to be provided at the end of the financial year.
35	**Report from the Chair of the Mental Health Legislation Committee for the meeting held on 5 September 2025** (minute 25/126 - agenda item 16 – September 2025) Mrs Forster Adams noted the missing ethnicity data for approximately 6% of service users was a key	**Joanna Forster Adams**	January 2026	**UPDATE** An update will be provided to the Finance and Performance Committee in January 2026.

Log number	Action (including the title of the paper that generated the action)	Person who will complete the action	Meeting to be brought back to / date to be completed by	Update report – comments
	performance metric to support the Trust ambition to address health inequalities therefore it would be reviewed in the performance meetings and reported through to the Finance and Performance Committee.			
36	**Sharing stories – Adult Acute** (minute 25/132 - agenda item 2 – November 2025) The Board requested that Miss Sanderson, Mrs Forster Adams and Mr Skinner understand the current position for the night rostering and staff allocation process and consider requirements for the future planning of rostering.	**Nichola Sanderson, Joanna Forster Adams, Darren Skinner**	January 2026	**NEW**
37	**Organisational Priorities Q2 Update Report** (minute 25/144 - agenda item 10 – November 2025) Dr Healey queried whether there was an opportunity for the update to be presented to see specific measures within the report including trajectories for performance as this would show the full picture of milestones and impact. Mrs Hanwell agreed to review and amend the report as appropriate to deliver this.	**Dawn Hanwell**	January 2026	**NEW**
38	**Report from the Director of People and OD** (minute 25/154 - agenda item 16 – November 2025)	**Darren Skinner**	January 2026	**NEW**

Log number	Action (including the title of the paper that generated the action)	Person who will complete the action	Meeting to be brought back to / date to be completed by	Update report – comments
	The 90 long term occurrences in corporate services were queried and it was agreed that Mr Skinner would review the detail to understand the circumstances of this figure and provide the detail to the Board.			

Closed Actions

Log number	Action (Including the title of the paper that generated the action)	Person who will complete the action	Meeting to be brought back to / date to be completed by	Update report - comments
33	**Specialist Supported Living Peer Review Update** (minute 25/120 - agenda item 12 – September 2025) Miss Sanderson agreed that she would include a specific section in her Director of Nursing and Professions report to include the feedback and information from peer reviews moving forward as it was acknowledged that this would be helpful to inform the internal audit programme or share good practice	**Nichola Sanderson**	Management action	**COMPLETE** This is now in place
Actions from Committees for the Board of Directors				
	None			

Agenda item
7

Meeting of the Board of Directors

Paper title:	Chief Executives Report
Date of meeting:	29 January 2026
Presented by: (name and title)	Dr Sara Munro, Chief Executive Officer (CEO)
Prepared by: (name and title)	Dr Sara Munro, Chief Executive Officer (CEO)

This paper supports the Trust's strategic objective/s (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	✓
SO3	We use our resources to deliver effective and sustainable services.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	✓
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	✓
SR6	Digital technologies	✓
SR7	Plan and deliver services that meet the health needs of the population we serve.	✓

Executive summary

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

Recommendation

The Board is asked to note the content of the report

Meeting of the Board of Directors

29 January 2026

Chief Executive's report

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

Our services and our people

Service Pressures

The board is aware that resident doctors rejected the latest offer on terms and conditions from the government and went ahead with industrial action from the 17th to the 22nd of December 2025. This posed a significant risk of disruption for our services but as a result of outstanding planning and cross departmental teamwork we did not have any impact on patient safety and core service delivery. The BMA is currently balloting members on future industrial action.

As noted in the report from the chief operating officer we continued to manage and respond to significant demand on services which has impacted on our patient flow and the ongoing need to utilise out of area inpatient care for service users. High levels of patient need and staff sickness combined meant we did not see the typical easing of demand for inpatient beds over the festive period.

Staff Engagement

We have concluded the second round of executive engagement events with our services which covered updates on delivery of trust priorities and future direction of travel for the Trust in Leeds and with Leeds Community Healthcare NHS Trust. As with the first-round initial feedback is these sessions are well received. Further evaluation is underway and this will be considered alongside our staff survey results and evaluation of our collective leadership programme to determine our approach for 2026/27. We have received the initial results from the annual staff survey which are for internal use only until published in

March 2026. The board can be assured that work is already underway on reviewing the data and working with teams and departments on areas for improvement and areas for shared learning.

Medium Term Planning

All Trusts and ICBs are required to submit 5-year strategic plans in February 2026. The trust board met in December to approve our draft submission to NHSE which was done on time. Since then, we have been asked to submit additional information demonstrating board review and sign off and chairs and CEOs are meeting with the regional team and ICB CEO/Chair to discuss our plans further. Feedback from this meeting will be shared verbally at the board meeting and there is a separate paper to board seeking comments on our final plan before submission which is due on the 12th February 2026.

ALIGNMENT WITH LEEDS COMMUNTIY HEALTHCARE NHS TRUST

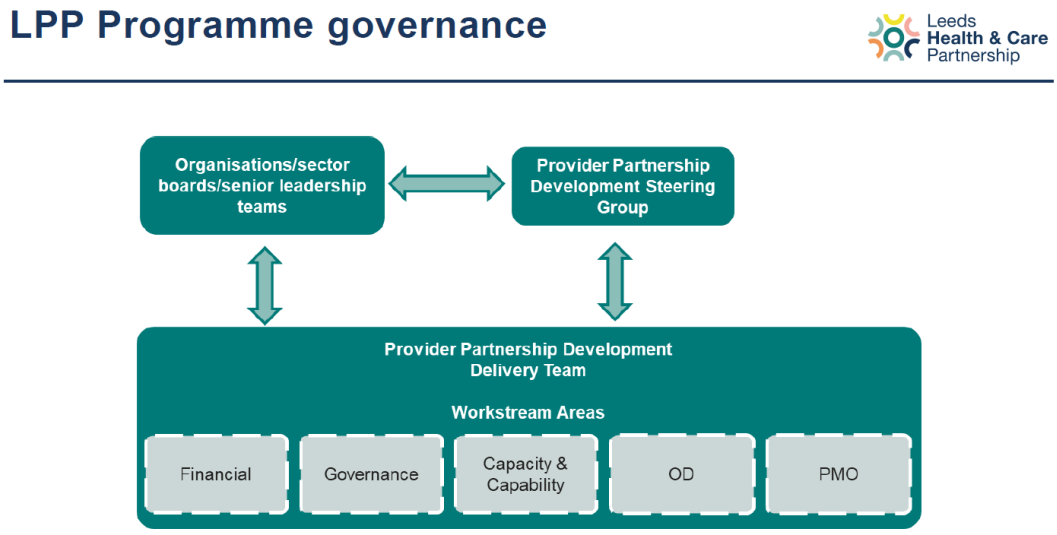
Both trust boards formally agreed in November to develop a strategic outline case to explore the benefits and costs of merging our two organisations to create a new integrated provider of physical and mental health services. Since then, we have

- Put in place the core leadership team to manage the transition between the organisations and NHSE.
- Secured the support of Deloittes to progress the strategic outline case with the aim to share a draft late January 2026 for comments. Submission to NHSE regional team is planned for late February.
- Held a joint board meeting on the 7th January 2026 which covered information and insights on the clinical service portfolio across both organisations and the project plan for development of the SOC and then full business case. Feedback from the session was positive and we are planning a further board to board in March.
- Held several staff engagement sessions to brief colleagues across both Trusts on the proposals and seek initial feedback that will inform the detailed planning and future engagement.
- An initial meeting has been held to set up a working group called a ‘Transition Committee’ which will work on behalf of both boards to oversee the detailed transition plan. Further information included terms of reference for the transition committee will be shared with both boards on the proposed next steps.

LEEDS SYSTEM UPDATE

The Leeds Provider Partnership

Following the Leeds place review that concluded in 2025 we are continuing the work with statutory partners, primary and the VCSE to improve the way we lead and manage health and care services across the city. We shared our proposals in a check and challenge session with the ICB leadership team in December 2025 and received positive and constructive feedback. There is further work to do on understanding, negotiating and agreeing the future relationship and level of delegation of ICB functions to the place-based provider partnership over the next 6-9 months. The ICB is keen to support place partnerships to be ready to operate in shadow form during 2026 and to formally delegate to a host place provider from April 2027 those functions agreed to be held at place on behalf of the ICB. The key strands of work in Leeds are captured in the following diagram.



West Yorkshire Integrated Care Board (ICB) Changes

Since the last board meeting the West Yorkshire ICB has now concluded the first round of a voluntary redundancy scheme. This was mandated nationally to support future organisational change to the operating model of ICBs, which included a significant reduction in funding and headcount. Feedback is that there has been a high number of applications for redundancy in this phase and following the review and approvals process the ICB have finalised the proposed structures for the organisation which have gone out for formal consultation. Pending the outcomes of that the appointment for senior roles in the ICB

are scheduled to commence in April 2026. The aim is to conclude the redundancy process for all staff by October 2026.

There are some areas of function/activity which the ICB is asking for provider trusts to host on their behalf. As this is still in the early stages of negotiations we will update in the private board on the latest position. We have also agreed commitment of funding for the MHLDA collaborative team (hosted by the Trust) for the next 12 months which will be discussed at the committee in common meeting later this month.

At the start of the new year the CEO for the ICB Rob Webster wrote to partners to inform us that he is standing down from his position this year. The timescales for this are to be confirmed once the new permanent chair for the ICB has been appointed. Interviews for the chair have now taken place, and we will update the board once we have been informed of the outcome of the recruitment process.

Reasons to be proud

We finished off 2025 with a festive all staff huddle highlighting the achievements and reasons to be proud from the year with special thanks from our Trust Chaplain, Director of nursing and reminders of the wellbeing offers, and reward and recognition approaches form our staff engagement team. If you didn't see it first time round it can be watched via staff net.

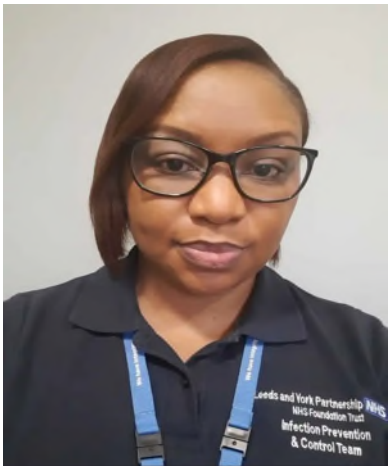
A look back at LYPFT in 2025

- Celebrated our staff, services and Teams achievements with monthly awards, Spotlight Platform and the Annual general Meeting.
- Strengthened inclusion, safety, and compassion and delivered our first Equality, Diversity and Inclusion listening events
- Progressed several of our Trust priorities including neighbourhood health, community pathway integration
- Advanced inpatient flow and culture of care
- Supported our staff and services, with the Shine and Thrive roadshow, and Wellbeing Champions.
- Teams came together to improve our sites for each other and our service users.

Decorate Your Ward or Office

Celebrating Infection Prevention and Control Success

Great news from our IPC Team led by Gugu Ncube!



- Zero reportable infections for the third year running
- Covid-19 outbreaks reduced by 52 percent compared to last year
- E-learning flexibility boosted engagement - Training compliance at 90 percent!
- IPC Link Champions improving communication and outbreak response
- Strong partnership with Pharmacy for antimicrobial stewardship
- Looking ahead - Continued focus on safe care and infection control excellence.

December Team of the Month - Complex Dementia Wraparound Team

The Complex Dementia Wraparound Team from the Older People's Service has been named Team of the Month. Despite facing the challenge of being decommissioned, the team has shown exceptional resilience, mutual support, and dedication to each other during a time of uncertainty.

- The team is being decommissioned in November 2025 but has remained united and supportive.
- Their Clinical Team Manager ensured clear communication and guidance on next steps.
- Team members have supported each other emotionally, maintaining respect and care throughout.
- Judges praised the team for perseverance and strong evidence of mutual support during change.

"Clear care and perseverance demonstrated by a team going through a hard time. Credit to them all and to the team leaders." — Judges' comments

January Team of the Month - CRISS East

Celebrating Crisis Resolution Intensive Support Service (CRISS) East for their unity, resilience, and commitment to person-centred care.

- Put service users at the heart of care
- Adapted to growing service demands
- Created an inclusive, supportive culture
- Streamlined processes for efficiency

Excellent examples of a team coming together through a challenging time."

Individual of the Month – December – Paula Caliskan

Paula is a truly caring and dedicated nurse who always goes the extra mile for both patients and

colleagues. Her passion and integrity shine through in everything she does.

- Always ready to help and support others
- Speaks up for what's right and advocates for patients
- Flexible and willing to adapt when needed
- Builds trust through honesty and openness
- Known for her kindness and "mother hen" approach

"Paula consistently demonstrates compassion and integrity, making her a trusted and invaluable member of the team.." — Judges' comments

Individual of the Month – January – Charlotte Kelly

Recognising Charlotte Kelly for her outstanding professionalism and leadership during a challenging shift.

- Adapted quickly to changing patient plans
- Maintained calm and clear communication
- Prioritised patient safety and team support
- Set an example of empathy and integrity

"Seeing her in action made me reflect how fortunate I am to have such a passionate individual in my staff group." - Nominator

Research & Development - Karen Lloyd Student Nurse Newsam Ward 4

Karen Lloyd, a student nurse on Newsam Ward 4, has gone above and beyond to champion research in her clinical placement, making a real difference to the Vision Quest study.

- Welcomed the research team and made time to engage
- Helped identify suitable service users with respect and care

- Built trust so participants felt comfortable joining the study
- Played a key role in hitting local recruitment targets
- Passionate about sharing research opportunities with colleagues

“I’ve loved being part of research—it’s shown me how nurses can make a real impact beyond day-to-day care.“ – Karen Lloyd

A Spotlight on Spotlight

At Leeds and York Partnership NHS Foundation Trust, our recognition platform Spotlight has become a brilliant part of how we celebrate colleagues and say “thank you” for the incredible work happening across our services.

Here’s what the last two years look like:

✨ 4,923 unique colleagues have received an e-card

✨ 495 nominations submitted

✨ £9,263.49 earned in cashback rewards

✨ 30,568 e-cards sent since launch

✨ Becklin Ward 5 take the top spot with an amazing 1,092 e-cards sent

✨ 140 LYPFT trees planted through collected rewards

But it’s not just the numbers that matter, it’s what they represent: kindness, appreciation, and a culture that celebrates each other.

Spotlight on the Shine & Thrive Summer Roadshow

This year, our Shine and Thrive summer roadshow helped amplify awareness of Spotlight across the

Trust. Running from July to September, the People Engagement and Wellbeing teams brought interactive stalls, gratitude walls, wellbeing resources, freebies, and prize draws to sites across LYPFT, all with a focus on appreciation, connection, and supporting colleague wellbeing.

The roadshow highlighted the power of recognition and encouraged even more colleagues to get involved in celebrating each other.

A word from our Chief Executive, Dr Sara Munro

“I love Spotlight and thoroughly enjoyed sending plenty of cards and messages of appreciation over the Christmas period. What’s fantastic is that so many more of us are using it year on year. We just know that it means a lot to get that token of appreciation come through. If you’ve never used it, have a look, it’s a simple way to show colleagues and teams the recognition they deserve.”

Dr Sara Munro

Chief Executive Officer
21 January 2026

Agenda item
9

Meeting of the Board of Directors

Paper title:	CFO Finance Paper
Date of meeting:	29 January 2026
Presented by: (name and title)	Dawn Hanwell, Chief Financial Officer, and Deputy Chief Executive
Prepared by: (name and title)	Jonathan Saxton, Deputy Director of Finance

This paper supports the Trust's strategic objective/s (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	
SO2	We provide a rewarding and supportive place to work.	
SO3	We use our resources to deliver effective and sustainable services.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

Executive summary

The Trusts income and expenditure position is broadly as anticipated at month 9, with a £551k surplus, and working towards a forecast outturn of £900k as agreed at system level. However, the deteriorating run-rate of the Trust is a note of concern. The year to date position is substantially supported by one off non-recurrent means and based on the latest forecast, if the run-rate of the Trust does not reduce in the final quarter of the financial year, further non-recurrent mitigation will be required to deliver the agreed position.

The Trust maintains an overall robust financial position our cash position remains strong with a cash balance of £122.6m, and liquidity is strong with cover for 93 operating expenditure days. Our overall cumulative better payment practice code (BPPC) performance remained strong, achieving 89.2% of bills paid within target by number (93.7% by value).

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? **No**

If yes, please set out what action has been taken to address this in your paper.

Recommendation

The Board is asked to:

- Review and consider the Trust revenue and capital positions for 2025/26.

MEETING OF THE BOARD OF DIRECTORS

29 JANUARY 2026

CHIEF FINANCIAL OFFICER REPORT

1 Introduction

This report provides an overview of the reported financial position at the end of month 9, 2025/26 financial year.

2 Income and Expenditure Performance 2025/26

The table below summarises the position reported to NHSE. This is a £551k surplus against the Trust break-even plan.

		Month 9		
Income & Expenditure Plan Position	Plan Annual £'000	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000
Income:				
Patient Care Income	235,819	183,663	184,316	653
Other Income	37,634	24,966	24,864	(101)
Total Income	**273,453**	**208,628**	**209,180**	**552**
Expenditure:				
Pay Expenditure	(200,366)	(150,827)	(148,665)	2,162
Non Pay Expenditure	(68,406)	(54,212)	(56,599)	(2,387)
Total Expenditure	**(268,772)**	**(205,039)**	**(205,264)**	**(225)**
Surplus/ (Deficit)	4,681	3,589	3,916	327
Adjustments for NHSE Reporting	**(4,681)**	**(3,589)**	**(3,365)**	**224**
Adjusted Position	0	0	551	551

The Trust is in a favourable position year to date and on trajectory to achieve the stretch target of a £900k surplus position. However, in month the run-rate of the Trust deteriorated resulting in an increased use of non-recurrent mitigations. The decline in the run-rate was due to:

- Increased activity in Adult Acute out of area beds
  - Activity increased in month, particularly in more expensive PICU beds
  - Year to date spend is £4.6m over plan at M9.
  - Expenditure is now £7.4m year to date against a full year plan of £3.5m

- Delayed discharges in Complex Rehab out of area beds
  - This has resulted in a £0.3m overspend against plan due to a reducing trajectory
- Increased bank expenditure;
  - Increased in month due to sickness and annual leave
  - Bank expenditure is now £0.9m over plan year to date
- Increased agency usage
  - Increased in month due to usage of Medical agency in Community Services
  - Agency is £1.7m under plan year to date
  - Due to the increase in medical agency the favourable variance is now reducing
- Reduction in Interest Receivable
  - Due to the reduction in interest rates in December, Interest Receivable has reduced
  - It remains above plan year to date, however the favourable variance will now reduce

The non-recurrent mitigations used to mitigate the year to date position have increased to £6.1m;

- Interest receivable that is £0.8m over planned levels,
- £2.5m of technical flexibilities have been released into the position
- Unutilised/unplanned additional one-off income £0.5m (PFI and MHIS)
- Slippage on the Perinatal development £1.3m year to date
- Unitary charge underspend £0.8m (related to Parkside Lodge and Little Woodhouse Hall)

If the run-rate does not reduce in the remaining quarter of the financial year, achieving the £900k surplus at year end will become challenging.

3 Efficiency Programme

The CIP programme is overseen by the Financial Planning Group where opportunities to increase the run-rate CIP and recurrent budget CIP are explored and progress against each target is monitored.

3.1 Run Rate efficiency

The efficiency programme target is to deliver in year run-rate savings of £18.5m. This is based on our system plan, which reflects run rate movements year on year (not recurrent internal budget).

Schemes	Recurrent / Non-Recurrent	Risk	YTD Plan (£000)	YTD Actual (£000)	YTD Variance (£000)	Annual Plan (£000)	Forecast (£000)	Variance (£000)
Interest Receivable	Non-Recurrent	Low	0	964	964	0	1,219	1,219
Technical Flexibility	Non-Recurrent	Low	2,063	2,477	414	1,993	2,999	1,006
CPC Gainshare	Recurrent	Low	378	375	(3)	504	500	(4)
Reducing Agency 30%	Recurrent	Low	1,500	3,270	1,770	2,600	4,410	1,810
Reducing Bank 10%	Recurrent	Medium	894	97	(797)	1,550	121	(1,429)
OAPs Improvement	Recurrent	High	2,862	0	(2,862)	4,101	0	(4,101)
Non-Pay Savings	Recurrent	Low	747	329	(418)	996	479	(517)
Unidentified	Recurrent	Medium	2,250	0	(2,250)	3,000	0	(3,000)
Overtime Reduction	Recurrent	Low	0	383	383	0	527	527
Additional Income agreed	Recurrent	Low	0	443	443	0	591	591
Non-recurrent Income	Non-Recurrent	Low	0	1,282	1,282	0	1,642	1,642
Reducing Pay (Recurrent)	Recurrent	Low	0	1,073	1,073	0	1,521	1,521
Interest Receivable	Recurrent	Low	2,817	2,817	0	3,756	3,756	0
Reducing Pay (Non-Recurrent)	Non-Recurrent	Low	0	0	0	0	0	0
			13,511	**13,511**	**(0)**	**18,500**	**17,765**	**(735)**
	Recurrent		11,448	8,788	(2,660)	16,507	11,905	(4,602)
	Non-Recurrent		2,063	4,723	2,660	1,993	5,860	3,867
			13,511	**13,511**	**(0)**	**18,500**	**17,765**	**(735)**

Year to date overall the run-rate reductions are on plan having achieved the target of £13.5m year to date (YTD). However notably the scale of non-recurrent delivery (35% YTD), attributable mainly to the non-recurrent benefits highlighted above are supporting this position. The non-recurrent schemes cannot be relied upon at the same scale in future years.

The full year estimate of current schemes are £17.8m against the £18.5m target, an additional £0.7m being required in the remaining 3 months of the year. To continue to reduce this gap, work continues in the Workforce & Agency Project Board.

Appendix D details the Trust run-rate by month for Care Services and Corporate Services for 2024/25 and 2025/26.

3.2 Budget efficiency

The Trusts recurrent internal budgets identified a recurrent £14.5m budget saving programme (recurrent CIP). This is based on allocated budgets not run rate profiles. It is a target figure to balance budgets. assuming every service and department is operating from their opening base budget position, not what is being spent (run rate).

Two Quality Impact Assessment (QIA) panels have been held year to date where several schemes have been agreed to be progressed. In month an additional £0.5m CIP, as a result of the MARS CIP, has been transacted resulting in £7.7m of schemes being transacted in total this financial year, as seen below.

	Target	Transacted	Remaining	Percentage Transacted
CFO	2,000	1,653	347	83%
POD	650	34	616	5%
Nursing	600	293	307	49%
Care Services	9,700	3,554	6,146	37%
Medical	850	31	819	4%
CEO	200	133	67	67%
COO	50	50	0	100%
MARS	0	516	-516	100%
Reserves	450	1,465	-1,015	325%
	14,500	**7,729**	**6,771**	**53%**

47% or £6.7m of recurrent Budget CIP is still to be identified. The main schemes in scope still to be identified relate to programmes of work in care services. The challenge and opportunities for corporate departments will also require more scoping across a wider collaborative approach. Non recurrently vacancies in corporate departments are mitigating recurrent delivery.

4 Forecast

A revised forecast has again been completed in month. Due to the deteriorating monthly run-rate the gap between the forecast against the required £0.9m surplus has increased and this is despite the Trust being informed that non-recurrent income of £0.6m will be received to offset against the additional costs of strike action earlier in the year.

The main assumptions within this forecast are:

- Adult Acute OAPs total £9.5m, a £6m overspend on budget.
- SSL overspend of £0.3m
- Adult Acute (£2.9m), Older People (£0.3m), and CYP Wards (£0.3m) continue to overspend
- Interest rate remains at its current level until the end of the financial year, this is £5.0m against a £3.8m budget.
- Expenditure of £5.4m in Agency, reduced from £8.4m in 24/25
- Expenditure of £17m in Bank, increased from £15m in 24/25
- All other variances remain broadly as is
- Non recurrent flexibility over and above year to date of c£1m

Based on the assumptions above, the Trust achieving a forecast £0.9m surplus as agreed is becoming more challenging. To achieve this stretch based on the M9 forecast, the Trust is reliant on further non-recurrent mitigations, this will not impact services.

5 Capital Expenditure

The capital position is detailed in Appendix A. Cumulative year to date capital expenditure is £5.75m at M9 against a plan of £12.7m. The year-to-date position reflects significant in year slippage on the two significant construction schemes at Parkside Lodge (the refurbishment to move ward 5 complex rehab from Newsam Centre) and the Mount (additional perinatal beds). Both schemes have been impacted by several delays including the complexity of agreeing deeds of variation with Equitix, the owners of these sites. All efforts are being made to accelerate the delivery of these schemes but there are still some timing risks against the plans, which are being closely managed.

6 Cash Position

As discussed previously, there is increased emphasis and scrutiny on organisational cash balances, due to the guidance on dealing with cash shortages at a system level. The cash balance of the Trust remains consistently above £100m linked to our strategic investment needs. Year to date this is above our planned expectation, due to the capital investment slippage, and higher than anticipated opening balances.

The Trust remains in a strong cash position £122.6m as at the end of December. Our overall liquidity (a test of our ability to pay outgoings without further new income) remains high with cover for 93 days operating expenditure. This means the Trust would be able to pay all it's day to day running costs for 93 days with no new income. A minimum of 4/5 days liquidity is expected to be maintained for an NHS organisation. We are a positive outlier in this regard, but for recognised reasons.

7 Better Payments Practice Code

The Better Payment Practice Code is a national standard that NHS organisations are expected to follow to ensure prompt payment of supplier invoices, supporting good financial management and protecting the cash flow of suppliers, particularly Small or Medium sized Entities. NHS trusts report their BPPC performance each month and year-to-date.

The key targets are:

- Pay at least 95% of invoices within 30 days (from receipt of a valid invoice)
- Pay 95% of invoices by number AND by value

Below is the Trust performance against each target:

Better payment practice code All	Current YTD Number	Current YTD £'000	Current month DEC-25 Number	Current month DEC-25 £'000
Total bills paid in the year	10,743	114,028	1,296	11,559
Total bills paid within target	9,585	106,880	1,165	11,284
Percentage of bills paid within target	89.2%	93.7%	89.9%	97.6%

The Trust achieved the in month target by value but year to date is 93.7%, this is an improving figure. In terms of the target by number of invoices, the Trust is 89.2% year to date, again this is improving month on month and work is still on going to reach target by the end of the financial year.

8 System Financial Position

At the point of writing this report the West Yorkshire System position had not been finalised.

9 Conclusion

The Trusts income and expenditure position is broadly as anticipated at month 9, with a £551k surplus, and working towards a forecast outturn of £900k as agreed at system level. However, the deteriorating run-rate of the Trust is a note of concern. The year to date position is substantially supported by one off non-recurrent means and based on the latest forecast, if the run-rate of the Trust does not reduce in the

final quarter of the financial year, further non-recurrent mitigation will be required to deliver the agreed position.

The Trust maintains an overall robust financial position our cash position remains strong with a cash balance of £122.6m, and liquidity is strong with cover for 93 operating expenditure days. Our overall cumulative better payment practice code (BPPC) performance remained strong, achieving 89.2% of bills paid within target by number (93.7% by value).

10 Recommendation

The board is asked to:

- Review and consider the Trust revenue and capital positions for 2025/26.

Appendix A – Capital Plan

CAPITAL PROGRAMME - at 31 December 2025	Year to Date			
	Annual Plan £'000	YTD Plan £'000	Actual Spend £'000	YTD Variance £'000
ICS Operational Capital				
Estates Operational				
Health & Safety /Fire/Accessibility/ Backlog	750	270	130	140
Security review	150	70		70
Sub-Total	**900**	**340**	**130**	**210**
IT/Telecomms Operational				
IT Network Infrastructure	250	100	440	(340)
Server/Storage	30	15		15
PC replacement EUL	360	150	342	(192)
Cyber security	170	50		50
Sub-Total	**810**	**315**	**782**	**(467)**
Estates Strategic Developments				
Lifecycle contribution	100	50	284	(234)
St Marys House, North Wing Therapy room	0	0		0
Aire Court	350	75		75
Sustainibility & Green Plan	250	100	97	3
Completion of Minor Schemes	228	228	115	113
Woodlands Generator	50	50		50
The Mount Perinatal	5,000	5,000	2,481	2,519
Accoustics- improvement	150	150		150
Security - critical system replacement	300	200		200
Newsam Sensory room	0	0	26	(26)
Mansafe	0	0		0
Clifton House	0	0	148	(148)
Sub-Total	**6,428**	**5,853**	**3,150**	**2,703**
IT Strategic Developments				
Data Centre and adjustments (ICB)	2,036	0		0
Sub-Total	**2,036**	**0**	**0**	**0**
Disposals				
ICS	0	0	(11)	11
Sub-Total	**0**	**0**	**(11)**	**11**
Total ICS Operational Capital	**10,174**	**6,508**	**4,052**	**2,456**
PDC Funded Schemes				
EPR developments	2,500	0		0
Complex Rehab	5,600	5,600	1,262	4,338
St Marys House, North/South Wing/Estate Strategy	375	350	237	113
Water main upgrade (lead) SMH/SMHosp	115	115		115
Total PDC Funded Schemes	**8,590**	**6,065**	**1,499**	**4,566**
IFRS16 Leased Assets				
Leased Buildings	0	0	15	(15)
Lease Cars	150	120	261	(141)
Sub-Total	**150**	**120**	**277**	**(157)**
Disposals				
Leased	0	0	(80)	80
Sub-Total	**0**	**0**	**(80)**	**80**
Total IFRS16 Leased Assets	**150**	**120**	**196**	**(76)**
Total Capital Spend	**18,914**	**12,693**	**5,747**	**6,946**

Agenda item
10

Meeting of the Board of Directors

Paper title:	Organisational Priorities Quarter 3 Progress Report 2025 – 2026
Date of meeting:	29 January 2026
Presented by: (name and title)	Dawn Hanwell, Chief Financial Officer
Prepared by: (name and title)	Amanda Burgess, Head of the Programme Management Office

This paper supports the Trust's strategic objective/s (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	✓
SO3	We use our resources to deliver effective and sustainable services.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	✓
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	✓
SR6	Digital technologies	✓
SR7	Plan and deliver services that meet the health needs of the population we serve.	✓

Executive summary

This report provides a summary of the Trust's progress against our 2025 – 2026 organisational priorities. This is the third report of 2025 – 2026 setting out how we are initiating our 15 priorities each with an identified lead executive. Our quarterly report is in place to demonstrate the progress made on each priority specifically, identify where a priority may require attention or further action to ensure its intended outcomes are achieved.

Each slide provides a summary of a priority and details how we are delivering against each of the high-level milestones. We have adopted the 'alert, advise, assure' approach to provide the key messages on whether the defined milestones are being met, alert where matters require escalation or give assurance that a priority is on track.

In total we have 113 high-level milestones for delivery. At the end of quarter three we have:

- 6 milestones are marked as 'alert'
- 15 milestones are marked as 'advise'
- 92 milestones are marked as 'assure'

All our organisational priorities are governed through the executive-led portfolio specific governance groups to ensure monthly oversight and monitoring is achieved. Any escalations are reporting through to the monthly Extended Executive Management Team meetings.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? **State below, No.**

If yes, please set out what action has been taken to address this in your paper.

Recommendation

The Board of Directors is asked to:

- Consider our position against our 2025/26 organisational priorities at the end of quarter 3.
- Be assured as to the systems and processes in place for monitoring and supporting the delivery of each priorities high-level milestones and underpinning tasks.

Leeds and York Partnership
NHS Foundation Trust

2025 – 2026 Organisational Priorities Report

Quarter 3 Progress Report

Overview and key messages

This is the third progress report for 2025 – 2026 and provides a summary of the Trust's progress against our 15 organisational priorities.

The reporting format demonstrates at a high level how we are progressing against the key milestones for each priority. Using the 'alert, advise, assure' approach to provide clarity on where we might be going off track, what measures we are putting in place to ensure we deliver the priority and where we are making good progress.

We govern and have oversight of the progress we are making against our priorities through the monthly Extended Executive Management Team meetings. On a quarterly basis assurance is provided through the Finance & Performance Committee and Board of Directors meetings.

At the end of quarter 3 2025 – 2026 the following priorities are reporting as red (alert):

- **People Plan metrics:** this is our performance against the BAME staff entering a disciplinary process.
- **Workforce efficiencies:** this is our performance against the target for reducing bank expenditure by 10%.
- **ReSPECT:** although good progress has been made it has taken longer than anticipated to resolve the issue of our clinical workforce being able to have read/update access to the ReSPECT documentation on the Leeds Care Record (LCR).
- **Delivering an expanded perinatal inpatient service:** although good progress has been made, it is taking longer than anticipated to collect the demographic demand data from all community partners. This is something we will continue to work through as a provider collaborative.

The following priorities are reporting as amber (advise):

- **Efficiency and Productivity Programme:** this is our performance against our budget and run-rate savings targets.
- **People Plan metrics:** this is our performance against sickness absence, stress and anxiety, MSK and compliance with clinical supervision.
- **Inpatient Quality Transformation Programme:** this is our performance against the out of area placement trajectory and the help we have sought from NHS England GIRFT programme and Royal College of Psychiatry to review our adult acute clinical model.
- **Redesigned community mental health service:** although significant progress has been made, we are slightly behind with developing the business case for our future eating disorders model.
- **Clinical outcome measures:** although good progress has been made, we have decided to shift the focus of the project slightly to determine the specific service outcome measures utilised and how they are used.
- **CYP transformation:** although good progress has been made, we have taken more time to engage with key stakeholders on the revised governance structure and the tasks to review place-based pathways. This will conclude during quarter four.
- **Future facilities management model:** although good progress has been made, it is our intention to take the final business case through governance during quarter four.

2025 – 2026 organisational priorities quarter 3 progress summary

Priority Area	Link	Lead	Exc Owner	Scheme status	Alert	Advise	Assure
Delivery of our Efficiency and Productivity Programme (total efficiency programme)	Link	J. Saxton	D. Hanwell	Live		1	1
Delivery of our workforce efficiency programme	Link	J. Saxton	D. Skinner	Live	1		2
Delivery of our Inpatient Quality Transformation Programme	Link	L. McDonagh	J. Forster Adams	Live			3
Reducing mental health ED attendances and delays Project	Link	E. Townsley	J. Forster Adams	Live			4
Delivering a Redesigned Community Mental Health Service Programme	Link	R. Carroll	J. Forster Adams	Live		1	1
CYPMH Transformation Programme (inc redesign of Tier 3.5/4 models of care)	Link	T. Richardson	J. Forster Adams	Live		4	2
Delivering an expanded perinatal inpatient service and provider collaborative	Link	R. Mumby	C. Hosker	Live	1	2	21
Implementation of ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) to replace the DNARCPR (Do Not Attempt Cardiopulmonary Resuscitation) document across the organisation	Link	M.C. Trevett	C. Hosker	Live	2		7
Delivering Improving Health Equity strategic priorities	Link	S. Valinakis	J. Forster Adams	Live			3
Create clinical outcome reporting systems enabling the implementation of outcome measures across all our care services	Link	E. Joubert, I. Hogan	C. Hosker	Live		2	7
Development and implementation of Quality dashboards for revision in selective services	Link	R. Wylde,	C. Hosker, D.Skinner	Live			16
Development and implementation of Culture dashboards	Link	T. Needham A. McNichol	D.Skinner	Live			6
Develop and agree our future FM model across our PFI sites	Link	W. Duffy	D. Hanwell	Live		1	3
Conclude the EPR procurement process and develop/ratify the business case for the preferred EPR. In parallel explore and develop options for adding to the existing EPR platform.	Link	I. Hogan	D. Hanwell	Live			3
Delivery of key People Plan priority metrics	Link	H. Tetley, A. McNichol	D. Skinner	Live	2	4	13

Delivery of our Efficiency & Productivity Programme

Our performance at the end of quarter 3

Savings Type	Annual Target	YTD Target	YTD Actual	Status
Budget	£14,500,000	£10,875,000	£5,512,506	ⓘ
Run Rate	£18,500,000	£13,511,000	£13,510,691	✔

Alert, Advise, Assure

Advise:

We have reviewed our efficiency and productivity programme for 2025/26. Against the budget saving target, we are behind plan. To date we have transacted 50% of our budget efficiency target.

At the end of quarter 3, we are achieving our year-to-date run-rate savings target, though this is non-recurrently.

Delivery of our Workforce Efficiency Programme

Our performance at the end of quarter 3

Savings Type	Type	YTD Target	YTD Actual	Status
Efficiency Workstream - Overtime Reduction	Run-Rate	£386,225	£247,209	✔
Reducing Agency Spend	Run-Rate	£700,000	£2,009,128	✔
Reduce Bank Expenditure	Run-Rate	£417,000	£0	●

Alert, Advise, Assure

Alert:

We have reviewed our Workforce Efficiency Programme for 2025/26 and continuing with the exec-led governance in place. Reducing bank expenditure by 10% is an important priority with greater controls put in place for how we approve the booking and filling of additional shifts. During quarter four we are launching a new protocol for booking annual leave.

NB. Please note that negative performance is shown as zero.

Assure:

At the end of quarter three we are making good progress and below target with both the reducing agency spend by 30% and overtime expenditure.

Reducing mental health ED attendances and delays project

Our performance at the end of quarter 3

Objective or Milestone	Start	Finish	Progress	Status
Baseline Audit of activity against the ED Action Cards	May-25	Jun-26	100%	✔
Project Set-up and Governance	Jun-25	Jul-25	100%	✔
Full Review of ALPS System, processes, reporting and partnership working	Jun-25	Jun-26	54%	✔

Alert, Advise, Assure

Assure: We have established a project to develop, implement and monitor the progress we are making across three workstreams. During quarter 3 we have completed a baseline audit of the Emergency Department Action Cards and initiating the improvements we are piloting over the winter, including: enhancing administration support, piloting a triage role and shared escalation arrangements with our acute trust partners.

All activities will be tracked against the two National Oversight Framework metrics.

In addition, aligned with the Urgent and Emergency Care Plan 2025-2026 we are working with our partners at LTHT to explore the feasibility of creating a mental health facility on the acute Trust site.

Delivery of our Inpatient Quality Transformation Programme

Our performance at the end of quarter 3

Objective or Milestone	Start	Finish	Progress	Status
Improving Flow Programme	Aug-24	Mar-26	87%	✔
Culture of Care	Feb-25	Mar-26	75%	✔
Adult Acute Care Pathway	Apr-25	Mar-27	34%	✔

Alert, Advise, Assure

Advise:

Adult Acute Care Pathway: The acute clinical model review is progressing through the diagnostic phase with process mapping completed for all acute wards, with our workforce actively engaging in the facilitated sessions. The case for change will be considered by the Care Services Leadership Collective in January 2026. In tandem we have sought assistance from NHS England GIRFT programme and Royal College of Psychiatry to review our adult acute clinical model and help us in testing the scenarios described in the case for change.

Improving Flow: Our out of area trajectory remains off plan and continues to be actively monitored. Work is ongoing to address long lengths of stay and those who are clinically ready for discharge.

Assure:

Culture of Care (CoC): Our CoC programme is progressing towards its scheduled completion in March 2026 with several key developments underway. A new lived experience member of staff has been recruited to support focus groups with service users and staff. Additionally training plans for Culture of Care and coproduction are being developed. The pilot wards have implemented PDSA cycles and change ideas supported by the Quality Improvement Team.

Delivering a Redesigned Community Mental Health Service Programme

Our performance at the end of quarter 3

Objective or Milestone	Start	Finish	Progress	Status
Implementation of the complex psychosis Pathway Project Group	Apr-25	Mar-26	95%	✔
Optimising LYPFT community services with integrated models of care and treatment	Jun-25	Nov-26	32%	ⓘ
Delivering a transformed West Yorkshire Eating Disorder Service	Jan-00	Apr-26	22%	ⓘ

Alert, Advise, Assure

Advise:

WY eating disorders service: The business case has been delayed for the revised eating disorder model, given the further time required to complete the workforce modelling. It is now anticipated that the business case will be taken through our governance arrangements in March 2026.

Community services: The case for change proposing a revised service model was presented at the Care Services Leadership Collective meeting in November 2025. Extensive modelling work is underway to determine how the workforce will be shaped around three core pathways. The business case will bring Leeds place community services into one service line and likely include a proposal to trial a Neighbourhood Community Mental Health Centre model, ideally aligned and combined with neighbourhood physical health developments. Owing to the time required to conclude the modelling, it is likely that the timescales for taking the final business case through governance will need to be reconsidered at the January Care Services Leadership Collective.

Assure:

Complex psychosis pathway: The Complex Psychosis Pathway mobilised on 5th January 2026. The mobilisation followed an extensive readiness assessment process to determine if it was safe to go-live.

Children and young people transformation programme

Our performance at the end of quarter 3

Objective or Milestone	Start	Finish	Progress	Status
Revise PC Board governance structure including ensuring the PC Development Session includes all nominated place-based leads	Oct-24	Oct-25	70%	ⓘ
Working with place-based providers develop a Standard Operating Procedure that meets the PC aim	Jun-25	Mar-26	100%	✔
Develop a PID documenting the aim/objectives for the PC in 2025/26	Sep-25	Mar-26	90%	ⓘ
Working with place-based providers develop a Standard Operating Procedure that meets the PC aim	Jun-25	Mar-26	45%	ⓘ
Understanding, identify and address the variation in each place-based pathways	Apr-25	Mar-26	65%	ⓘ
Scoping what an inpatient outreach team, day provision and crisis offer might look like linked with each place-based pathway	Jan-26	Mar-26	30%	✔

Alert, Advise, Assure

Advise: We have initiated a key programme of work both as a children and young people (CYP) provider collaborative partner and internally to improve the overall offer for young people presenting with mental health need across the CYP mental health system. A workshop event took place with the provider collaborative on 24th October 2025, whereby agreement was given in principle for the revised structure. The proposed structure is to be presented at the West Yorkshire Mental Health, Learning Disability and Autism Programme Board during quarter 4.

Given the need to take the structure through governance, the tasks to develop place-based pathways and Standard Operating Procedure have been revised from October 2025 to March 2026.

Assure: Overall, we are on track with the tasks we have set ourselves for delivery. We have endorsement from the Chief Executive's across each place that the provider collaborative should lead on the transformation of CYP with the workshop being the first step in the transformation process.

Delivering an expanded perinatal inpatient service and provider collaborative

Our performance at the end of quarter 3

Objective or Milestone	Start	Finish	Progress	Status
Perinatal Programme - Ward Build Programme	Oct-25	Jun-26	0%	✔
Phased Start	Jun-26	Sep-26	0%	✔
Organise workshop for stakeholders	May-25	May-25	100%	✔
Collate and write report on outputs from workshop with recommendations and present at CRG/Assurance Board	Jun-25	Jun-25	100%	✔
Agree and priorotise recommendations	Jul-25	Aug-25	100%	✔
Form working groups / develop project initiation docs for sign off	Sep-25	Sep-25	100%	✔
Stand up working group to analysise current pathway and agree on local additions	May-25	May-25	100%	✔
Document and agree pathway with wider collaborative groups with local protecols added	Jun-25	Aug-25	100%	✔
Organise and deliver a session with other PNPC to deepen understanding of existing inclusion/exclusion criteria	Jul-25	Mar-26	20%	ⓘ
Work closely with Referral Management Service to develop collective understanding of agreed pathway	Jun-25	Feb-26	100%	✔
Design information/education sessions in relation to pathway	Aug-25	Nov-25	100%	✔
Develop TOR and seek opinion from CRG	Sep-25	Mar-26	50%	ⓘ
Set up working group	May-25	May-25	100%	✔
Develop Project Brief/action plan for sign off	Jul-25	Jul-25	100%	✔
Set up working group through Co-Production Group	Jun-25	Jul-25	100%	✔
Develop project brief/action plan for sign off	Jul-25	Aug-25	100%	✔
Link community workforce with MBU so induction/expereince/insight into MBU operations can be can be gained by community staff	Sep-25	Apr-26	10%	✔
Collect data from community partners for WTE/demand/activity	Apr-25	Mar-26	50%	✔
Analysis of demograhics at place level across the system	Jul-25	Feb-26	100%	✔
Analysis of demographic demand at community level	Aug-25	Oct-25	0%	●
Analysis of demograhic demand at MBU level	Oct-25	Nov-25	100%	✔
Propose targeted interventions to address inequities	Dec-25	Jan-26	100%	✔
Twice yearly healthcare inequality session at CRG	Apr-25	Mar-26	75%	✔
Agree and disemminate post go live evaluation of PC in first year (in addition to RC survey)	Jan-26	Feb-26	20%	✔

Alert, Advise, Assure

Alert: The Perinatal Provider Collaborative (PC) was formally initiated during 2024/25. Largely the work is on track, however it is taking longer than anticipated to collect the demographic demand data from all community partners. This is something we will continue to work through as a provider collaborative.

Advise: We are behind with formulating working groups to consider how we will ensure consistent bed access, utilisation and overall criteria. We had anticipated that this would be underway by October 2025 however we intend to have the groups underway by the end of March 2026.

Furthermore, due to the delayed release of the reviewed National Service Specification, it has not been possible to refine the inclusion and exclusion criteria for the service. We have revised the timescales for this task from September 2025 to the end of March 2026.

Implementation of ReSPECT across the organisation

Our performance at the end of quarter 3

Objective or Milestone	Start	Finish	Progress	Status
Implementation Group set up and first meeting was the 5th June 2025. Terms of Reference have been circulated in draft for comment.	Mar-25	Jun-25	100%	✔
Liaise with LTHT digital team regarding read/write access for consultants, nurse consultants and higher trainees to ensure that they can write and update the ReSPECT document on the LCR.	Jul-25	Jul-25	100%	✔
LYPFT to register interest in the citywide digital document plan through Leeds Care Record	Jun-25	Jun-25	100%	✔
Liaise with LTHT digital team regarding read/write access for consultants, nurse consultants and higher trainees to ensure that they can write and update the ReSPECT document on the LCR.	Jul-25	Jul-25	40%	●
Training to use the Leeds Care Record.	Jul-25	Dec-25	10%	●
Training analysis	Jun-25	Dec-25	100%	✔
Once the training analysis is completed Level1,2 & 3 to be rolled out	Jan-26	Jun-26	100%	✔
A pilot at The Mount, OPS inpatients will start in 12 months, June 2026. The Mount currently use ReSPECT and DNARCPR, the pilot will remove the DNAR form in its entirety and the ReSPECT form will replace this.	Jun-26	May-27	0%	✔
Implementation across all adult inpatient and LD inpatient wards.	Dec-26	Jun-28	90%	✔

Alert, Advise, Assure

Alert: Work is taking longer than anticipated with our partners within the LTHT Digital Team to ensure our clinical workforce can be able to read/update the ReSPECT document on the Leeds Care Record (LCR) and receive the necessary training. Further updates are expected to be known during quarter four.

Assure: At the end of quarter three we are largely on track with this programme of work and for some elements ahead of schedule. During quarter three training has begun across all three levels.

The ReSPECT pilot will take place within older adult inpatients from 1 June 2026 and will last 12 months.

Delivering Improving Health Equity Strategic Priorities

Our performance at the end of quarter 3

Objective or Milestone	Start	Finish	Progress	Status
Increased coordination of LYPFTs existing programmes, projects and initiatives focused on improving equity to amplify the impact and efficiency of existing initiatives.	Apr-25	Mar-26	80%	✔
Ensure we are meeting our statutory obligations relating to equity, maximising opportunities to broaden this work and embed within the broader strategic plan. This includes Equality Act, Public Sector Equity Duty, EDS 22, PCREF and the Health Inequalities Duties under Health and Care Act.	Apr-25	Mar-26	80%	✔
Strengthen our foundations: a focus on our patient, carer, staff and community engagement.	Apr-25	Mar-26	80%	✔

Alert, Advise, Assure

Assure:

During quarter three our External Auditors conducted an audit of our compliance with the Health Equity Plan. The overall rating of 'significant assurance' was given, demonstrating LYPFT are effectively addressing the Health Equity agenda.

We have a new PCREF Partnership Group and PCREF Advanced Choice Documents Group established. Both groups are fundamental to our engagement and collaborative working with the community.

Furthermore, during quarter three the new Trust Equality Impact Assessment Policy and Template has been completed and a trial begun. The final version is currently going through governance for ratification during quarter four.

Create clinical outcome reporting systems enabling the implementation of outcome measures across all our care services

Our performance at the end of quarter 3

Objective or Milestone	Start	Finish	Progress	Status
Establish ePROMs (electronic Patient Reported Outcome Measures) Project governance arrangements, including the development of a PID and Project Timeline	Jun-25	Aug-25	100%	✔
Develop understanding of the use of ePROMs across all service areas	Jun-25	Oct-25	80%	ⓘ
Pilot and evaluate ePROMs questionnaires through Patient Portal Questionnaire/Survey Module for the Gambling Service	Oct-25	Dec-25	100%	✔
Pilot and evaluate ePROMs questionnaires and deployment approach through Patient Portal Questionnaire/Survey Module within two CMHT services	Jan-26	Mar-26	0%	ⓘ
Deploy ePROMS across all in-scope services across the Trust. Deployment phased by readiness/infrastructure	Apr-26	Dec-26	0%	✔
Design, build and test the Patient Portal	Jan-25	Oct-25	100%	✔
Expression of interest submitted to integrate the Patient Portal with the NHS App	Jun-25	Jun-25	100%	✔
Compliance, testing and training for Patient Portal including the creation and approval of the Digital Clinical Safety Case and training materials for all staff using Patient Portal	Jul-25	Nov-25	100%	✔
Onboard with the NHS App MH Wayfinder Programme in readiness for the Trust endorsing the use of the Patient Portal Appointments Module	Jul-26	Mar-26	50%	✔

Alert, Advise, Assure

Advise: At the end of quarter 3 we have taken the decision to shift the focus of the project slightly to determine the specific service outcome measures utilised and how they are used. The intent is for the Digital Team to work with each service to operationalise access to the digital delivery of the measures. To date the first pilot and evaluation has been completed, with positive results that the concept is working. Three further services will be identified during January to follow the same process as the pilot phase.

Assure: We are now working towards the enablement of patient reported outcome measures through the NHS App Wayfinder project. This is now being progressed with NHS England and the supplier. The delivery timescales have been amended from December 2025 to March 2026. Digital appointments is a priority within the medium-term planning guidance and the NHS 10 Year Plan. Further consideration will need to be given as to how we standardise our appointment management processes across services prior to digital enablement.

Development and implementation of the Culture dashboard

Our performance at the end of quarter 3

Objective or Milestone	Start	Finish	Progress	Status
Establish a project mandate and identify project team members and SRO including publishing a Project Initiation Document outlining the scope, governance and deliverables of the project.	Apr-25	Jun-25	100%	✔
Build a proof of concept Civility and Respect Dashboard as phase 1 utilising stakeholder input to validate and refine dashboard design.	Jul-25	Sep-25	100%	✔
Consolidate learning: Review all feedback and develop plans for a final prototype.	Oct-25	Nov-25	100%	✔
Service-wide integration: Finalise dashboard prototype and ensure it supports aligned reporting across teams, services, and board.	Dec-25	Feb-26	70%	✔
Embed governance structures: Establish clear feedback loops and reporting pathways to support a culture of learning and safety.	Mar-26	May-26	0%	✔
Plan for full rollout: Agree next steps for full implementation.	May-26	May-26	0%	✔

Alert, Advise, Assure

Assure:

We are making good progress with the development of the culture dashboard with the intent to have a prototype in place by February 2026. Full rollout will take place in the first quarter of 2026/27.

Development and implementation of Quality dashboard for revision in selective services

Our performance at the end of quarter 3

Objective or Milestone	Start	Finish	Progress	Status
Engage clinical leaders: Hold workshops with Clinical Team Managers and professional leads to introduce STEEEP and daily management systems	Apr-25	Jun-25	100%	✔
Baseline understanding: Assess current knowledge and define local meaning for each STEEEP domain (starting with Safe).	Apr-25	Jun-25	100%	✔
Develop draft metrics: Identify potential KPIs and discuss how they would provide assurance at team, service, and board levels.	Apr-25	Jun-25	100%	✔
Data infrastructure review: Document existing metric availability and explore future measurement needs (involving Informatics/BI as needed).	Apr-25	Jun-25	100%	✔
Introduce to teams: Begin phased rollout of STEEEP and daily management system to teams, starting with Safe.	Jul-25	Sep-25	100%	✔
Initiate testing: Agree on initial trial metrics and processes, including reporting structures for clinical governance	Jul-25	Sep-25	100%	✔
Refine dashboard design: Use insights from team and leadership workshops to inform dashboard and data alignment development.	Jul-25	Sep-25	100%	✔
Engage wider stakeholders: Conduct discovery conversations with other clinical leads to shape future service-wide plans	Jul-25	Sep-25	100%	✔
Trial review and adaptation: Collect feedback on the Safe trial, agree improvements, and plan the next cycle (e.g., Effective)	Oct-25	Dec-25	100%	✔
Expand implementation: Launch second phase of team trials incorporating adjusted metrics and processes	Oct-25	Dec-25	100%	✔
Strengthen governance links: Advance the alignment of metrics across team, service line, and beyond for better visibility and assurance	Oct-25	Dec-25	100%	✔
Continue dashboard iteration: Develop or enhance dashboards based on evolving requirements and feedback	Oct-25	Dec-25	100%	✔
Consolidate learning: Use findings from Safe and Effective trials to develop an action plan for rolling out all six STEEEP domains.	Jan-26	Mar-26	20%	✔
Service-wide integration: Finalise dashboard prototype and ensure it supports aligned reporting across teams, services, and board.	Jan-26	Mar-26	20%	✔
Embed governance structures: Establish clear feedback loops and reporting pathways to support a culture of learning and safety.	Jan-26	Mar-26	20%	✔
Plan for full rollout: Agree next steps for full implementation.	Jan-26	Mar-26	0%	✔

Alert, Advise, Assure

Assure:

During quarter three we have made excellent progress to complete several key milestones. The focus on the priority has shifted from developing domain specific metrics to developing a reporting structure and culture that will allow all metrics to be reviewed in a timely and productive manner.

During quarter four it is our intent to strengthen the governance links across teams/services aligned with the developed metrics. Alongside this, services are continuing to develop their knowledge of our clinical information system CareDirector and reporting tool Echo to enable the effective use of data.

Develop and agree our future facilities management model across our PFI sites

Our performance at the end of quarter 3

Objective or Milestone	Start	Finish	Progress	Status
Facilities management long list of delivery model options considered through PFI programme governance	Jul-25	Jul-25	100%	✔
Meeting with NHS England to consider the Trust's preferred option(s) for soft/hard facilities management	Jul-25	Aug-25	100%	✔
Facilities management short list of delivery model options with a preferred option considered through PFI programme governance	Sep-25	Sep-25	100%	✔
Development and approval of an Outline Business Case for facilities management considered through PFI programme governance and ratified by the Board of Directors	Sep-25	Mar-26	50%	ⓘ

Alert, Advise, Assure

Advise: During quarter three our future facilities management delivery options were considered through our Trust governance. The business case for our future facilities management provision will be presented to the Board of Directors in March 2026.

Assure: Overall, we have made good progress with this priority. Allowing sufficient time to fully analyse the data and engage with key stakeholders to inform our future strategy for facilities management.

Conclude the EPR procurement process and develop/ratify the business case for the preferred EPR. In parallel explore and develop options for adding to the existing EPR platform

Our performance at the end of quarter 3

Objective or Milestone	Start	Finish	Progress	Status
Options and OBC Development	Mar-25	Jul-25	100%	✔
OBC Approval	Jul-25	Jul-25	100%	✔
Procurement Preparation	Sep-25	May-26	50%	✔
Final Procurement pre approval	Jun-26	Jun-26	0%	✔
Procurement	Jul-26	Dec-26	0%	✔

Alert, Advise, Assure

Assure:

At the end of quarter three we are on track with the key milestones we have set ourselves for delivery by December 2026. The stakeholder sessions have concluded, and the final specification has been drafted. Work is now underway on the pre-market engagement documentation for potential vendors.

Delivery of our People Plan metrics

Our performance at the end of quarter 3

KPI	YTD Target	YTD Actual	Suggested RAG	RAG (Select Red, Amber, Green)					Status
				Q1	Q2	Q3	Q4	Latest	
People Promise 4 theme score -We are safe and healthy.	6.00%	6.50%	Green	Green	Green	Green		Green	✔
Improve staff sickness levels (0.2% reduction year-on-year to 4%)	5.00%	6.31%	Amber	Amber	Amber	Amber		Amber	ⓘ
Stress and Anxiety	30.00%	39.00%	Amber	Amber	Amber	Amber		Amber	ⓘ
MSK	10.00%	14.40%	Amber	Amber	Amber	Amber		Amber	ⓘ
Compulsory Training	85.00%	89.00%	Green	Green	Green	Green		Green	✔
Wellbeing Assessments	85.00%	71.00%	Green	Green	Green	Green		Green	✔
People Promise 3 theme score - We each have a voice that counts	7.10%	7.00%	Green	Green	Green	Green		Green	✔
Performance Development Review (PDR) Compliance	85.00%	82.00%	Green	Green	Green	Green		Green	✔
Percentage of BAME Colleagues entering Disciplinary Process (WRES)*	1.25%	2.37%	Red	Red	Red	Red		Red	●
Bullying and Harassment (>70%)	70.00%	66.20%	Green	Green	Green	Green		Green	✔
Percentage of Disabled Staff (staff survey) sharing disability status in ESR	18.00%	11.02%	Amber	Green	Green	Green		Green	✔
Staff Survey Increase the number of staff reporting positive opportunities for flexible working (75% 2 year progressive Target)	75.00%	73.00%	Green	Green	Green	Green		Green	✔
Clinical Supervision	85.00%	69.00%	Green	Amber	Amber	Amber		Amber	ⓘ
Vacancies	5.00%	10.60%	Red	Red	Red	Red		Red	●
Turnover (8-10%)	10.00%	9.20%	Green	Green	Green	Green		Green	✔
Apprenticeships	80.00%	97.00%	Green	Green	Green	Green		Green	✔
Decrease the Internal Bank workforce	536	542	Green	Green	Green	Green		Green	✔
Monthly Fill Rates - RN	80.00%	92.00%	Green	Green	Green	Green		Green	✔
Monthly Fill Rates - HCA	80.00%	86.00%	Green	Green	Green	Green		Green	✔

Alert, Advise, Assure

Alert:

WRES: Although we have seen a reduction in the number of staff entering formal disciplinary processes to such a degree that the WRES metric now reflects a distorted position when viewed in isolation. In 2023/24 we had 25 cases of which 13 colleagues were from an ethnically diverse background. We have seen a positive decrease in case numbers with 13 in total and of those 7 colleagues were from an ethnically diverse background for 2024/25. The Trust has a clear WRES action plan to do more to address this continued disparity.

Advise:

Sickness: At the end of December our sickness rate is at 6.31%. We are however continuing to see an increase in absence related to stress, anxiety and MSK. Absence reasons are being scrutinised as part of the wider workforce efficiency measures.

Clinical supervision: At the end of quarter 3 we are behind the target for clinical supervision.

Assure:

Overall, at the end of quarter 3 we continue to make good progress with our metrics.

Agenda item
11

Meeting of the Board of Directors

Paper title:	**Report of the Chief Operating Officer**
Date of meeting:	29 January 2026
Presented by: (name and title)	Joanna Forster Adams, Chief Operating Officer
Prepared by: (name and title)	Members of the Care Services' Senior Operational Leadership Team

This paper supports the Trust's strategic objective/s (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	✓
SO3	We use our resources to deliver effective and sustainable services.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	✓
SR3	Culture and environment for the wellbeing of staff	
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	✓
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	✓

Executive summary

This report highlights key service delivery issues and provides a summary of performance against established standards. It also outlines some of our key service developments; our EPRR response to incidents over the period of the report; and summaries some of our work to address health inequalities. It is set in the context of people working to make immediate improvements where our performance is not where we need it to be, and a significant amount of work is ongoing to implement transformational sustainable improvements to meet the needs of the population.

The report is derived from work with operational, clinical and quality colleagues, where information and intelligence is used alongside experience, to establish where we should prioritise our efforts for improvement (and recovery where necessary). Our established arrangements for operational and clinical governance enable us to highlight key areas for the attention of the Board. It has also been presented and discussed in the Finance and Performance Committee.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? **State below, 'Yes' or 'No'.**

No

Recommendation

The Board of Directors is asked to be assured of the work being undertaken to deliver our care services and to manage the range of challenges and issues outlined in this report.

MEETING OF THE BOARD OF DIRECTORS

29 January 2026

Report of the Chief Operating Officer

1 INTRODUCTION

This report highlights key service delivery issues and provides a summary of performance against established standards. It is set in the context of people working to make immediate improvements where our performance is not where we need it to be, and a significant amount of work is ongoing to implement transformational sustainable improvements to meet the needs of the population. Care Services transformation programmes are reported in the quarterly Trust Priorities Report, but progress remains positive.

We have been working with partners through the winter and festive period to sustain access and responsiveness improvements and to successfully navigated a period of industrial action mid-December with no planned activity being cancelled as a result.

There are no new issues reported, but areas of alert include:

- Red Kite View Inpatient Service reduced capacity
- Performance issues:
    - Acute Flow and Out of Area Placements
    - Long Lengths of Stay
    - Physical Health Assessment on In-Patient wards and in Aspire
    - Emergency Department (ED) waits for mental health assessment
    - Crisis and Intensive Support Referrals seen within 4hrs.

2 SERVICE DELIVERY AND KEY PERFORMANCE ESCALATIONS

2.1 ALERT

This section sets out the key areas of concern for care services that have been identified through our governance arrangements. These updates relate to the areas where services face most challenge and where risks are highest.

2.1.1 Red Kite View – CYPMH inpatient service

Red Kite View services continue to work in business continuity as a result of the previously reported water ingress and resultant damp. This primarily affects the PICU and High Dependency Area (HDA) of Red Kite View, which is the Children and Young Peoples' Mental Health Service inpatient unit on the St Mary's Hospital site in Armley. Whilst we continue to provide both PICU and General Assessment and Treatment services, we have temporarily ceased access to the S136 facility but keep this under active review.

We have been operating under these conditions since mid-October due to the significant damp issue and resultant environmental works and investigations required.

Strategic and tactical coordination groups continue to coordinate the assessment and implementation of actions to return the areas back to normal use as soon as possible. Due to the technical requirements of investigations and surveys, there have been delays in remedial works commencing. However, an independent surveyor has now completed an assessment of the whole building with the report having been made available the first week of January. The remedial work is due to commence in the week of the 26 January 2026 to return the ward to its original state, and works are expected to complete within 9 to 12 weeks.

2.1.2 Acute flow and Out of Area Placements (OAPs)

2.1.2.1 Current position

Recovery of acute flow continues at a slow pace, with Out of Area Placements (OAPs) numbers remaining broadly stable. Despite this, there is a gradual reduction in overall bed days. In November, there was a notable decrease in new placements, with 4 classed as inappropriate and 2 as appropriate, compared to October's figures of 13 inappropriate and 3 appropriate placements. However, this improvement was not sustained, as December saw a rebound to 13 inappropriate and 3 appropriate placements.

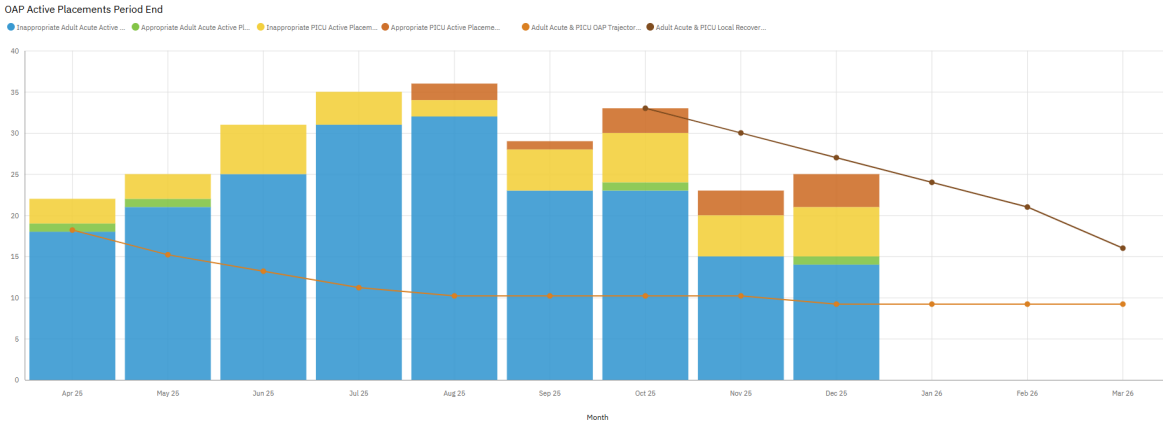
The increase in appropriate placements during both October and December is primarily attributable to a rise in referrals to PICU, with those presenting with sexually disinhibited behaviours requiring admission to single-sex environments to ensure patient safety. This trend highlights the complexity of managing patient risk profiles within acute services and highlights the importance of maintaining access to single sex PICU provision for those who require it.

At the end of December 2025, there were a total of:

- 15 inappropriate Acute OAPs
- 6 inappropriate PICU placements
- 5 appropriate PICU placements.

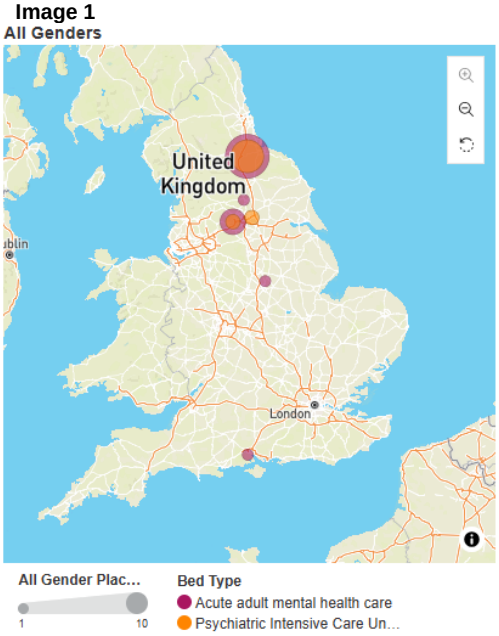
Our planned trajectory and performance are as shown in Graph 1 below:

Graph 1



All patients received inpatient care in services located outside of Leeds, but we continue to place them mainly in Yorkshire or the Northeast of the country, with the furthest placement south of Leeds being in Bournemouth as shown in Image 1 below. (This was an appropriate placement at the time of admission due to the location of the service user).

Image 1

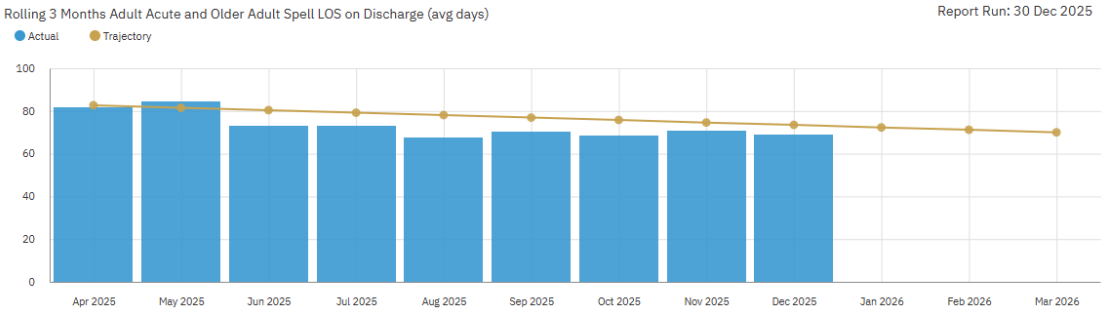


2.1.2.2 Lengths of stay (Acute Services)

Reducing length of stay (LoS) remains a core component of the Inpatient Quality Transformation Programme, and current performance is aligned with the agreed trajectory. However, further improvements are required to meet NHS England's Operational Planning requirements, as this is a key priority within the National Oversight Framework (NOF). A review of the clinical and operational model for our acute inpatient wards is currently underway, the Case for Change is on track to be presented to the Care Service Priorities Collaborative in January.

Our performance against the trajectory is:

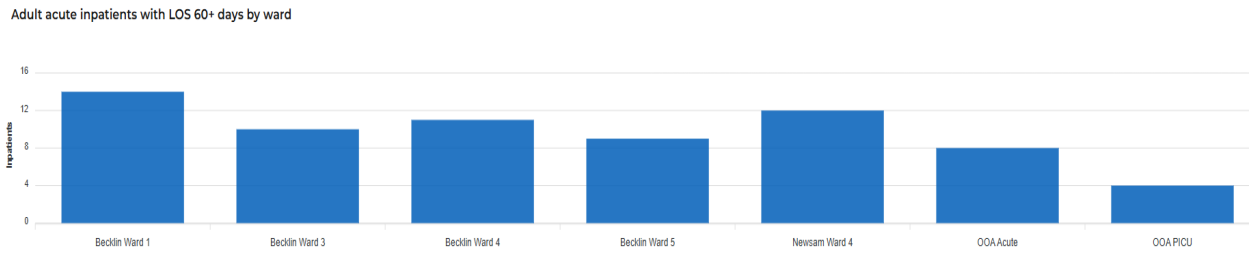
Graph 2



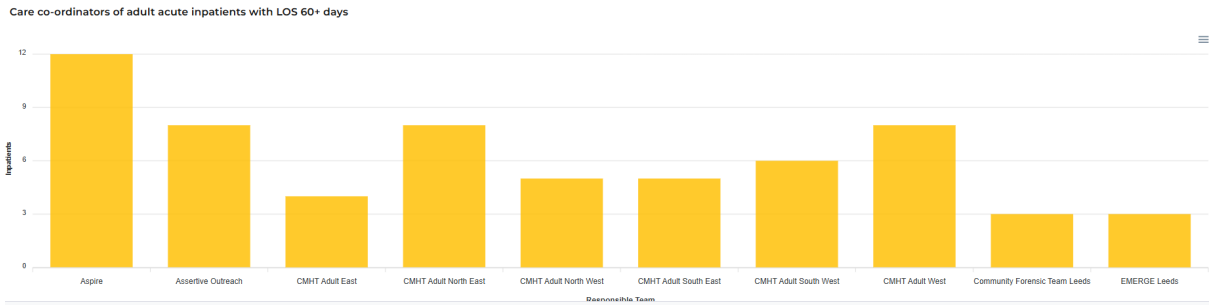
	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Actual	81.7	84.5	73.1	73.1	67.7	70.1	68.5	71.0	68.7			
Trajectory	82.7	81.5	80.4	79.2	78.1	76.9	75.8	74.6	73.5	72.3	71.2	70

Sustained progress in reducing length of stay is critical to meeting our agreed trajectory and improving overall system flow. To achieve this, we are working collaboratively with adult social care, housing, and third-sector partners to ensure timely discharge for patients who are clinically ready. Addressing complex discharge barriers remains a key priority, with 50% of individuals in acute beds currently having a LoS exceeding 60 days. We are closely monitoring this through multi-agency discharge meetings, focusing on strengthening collaboration with Community Teams to improve planning and expedite discharge in the most clinically effective way and timeframe. Additionally, we anticipate improvement with the opening of a new care home provider in early January, which is expected to enable the discharge of several service users who have been inpatients for over 60 days, significantly contributing to LoS reduction and improved capacity within acute services.

Graph 3



Graph 4



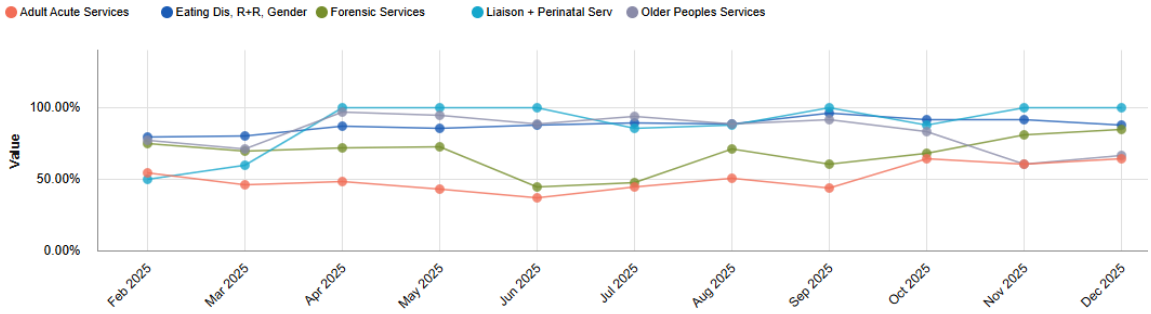
Key Actions:

- Continue multi-agency discharge meetings with a focus on complex cases and community team engagement
- Support the transition of long-stay patients (>60 days) to the new care home provider opening in January
- Use real-time data and dashboards to track LoS and escalate delays promptly
- Strengthen links with social care, housing, and third-sector partners to remove systemic barriers.

2.1.3 Physical health assessment on in-patient wards and in Aspire

Currently the Perinatal, Rehabilitation and Forensic Services are achieving the target of 80% completion, with some in-month variation. The Forensic Service has made significant improvements to recover their position over the past two months and has plans in place to maintain this, see graph 5 below.

Graph 5

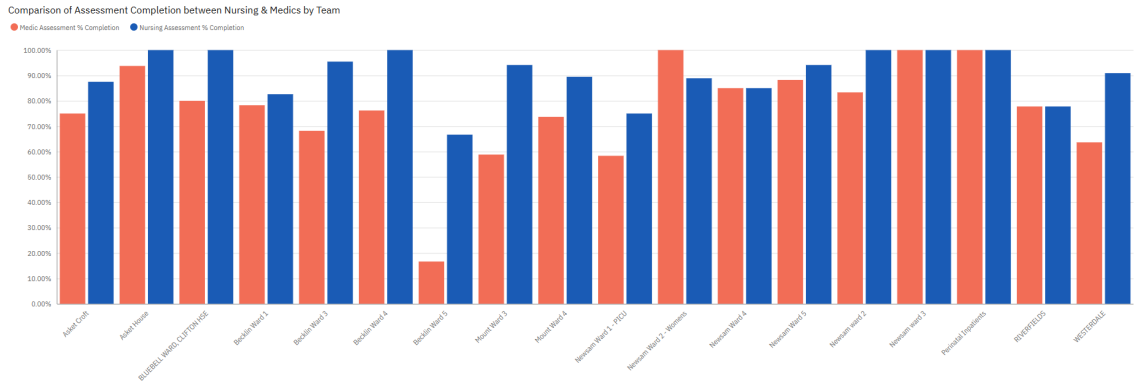


The Acute Service overall position has deteriorated over the past two months and continues to struggle to recover the 80% target. Four of the 6 clinical areas are close to achieving the 80% target; however, the remaining two areas are significantly off target. This has been picked up by the Leadership team as a priority area of work and is being monitored closely through the monthly Care Services Finance and Performance meeting.

We have also seen a significant deterioration in our Older Peoples' service at the Mount. The service had been consistent for several months in its achievement of the target. We have looked at the reasons for this and have found that the Nursing components of cardiometabolic assessments are consistently completed and recorded. The main challenge remains the medical element, where gaps relate primarily to recording rather than assessments not being undertaken. Compliance has been affected at times by medical staff changes and periods of industrial action. However, actions have been implemented to improve consistency, including allocation of monitoring responsibility by Clinical Team Managers and consultant-led plans to strengthen medical completion rates. At the time of writing this report, all assessments on Ward 3 had been completed. On Ward 4, two new admissions were pending completion, and one patient had declined assessment. Ongoing monitoring is in place, and performance is expected to move towards meeting the target consistently.

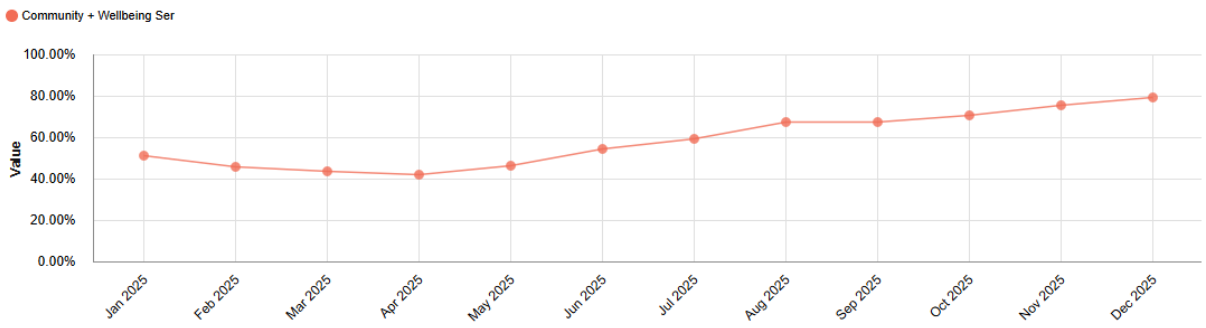
Overall, we have seen an improvement against the variation we had previously seen across the Medical and Nursing assessments, see graph 6, with still some areas for development identified.

Graph 6



The improvement plan agreed with colleagues in Aspire (Inspire North) who we commission to deliver Early Intervention in Psychosis Services, has seen the service achieve the 80% compliance target since September 2024, see graph 7. Work is ongoing with the service to maintain this position and is testament to the hard work focusing on this aspect of care.

Graph 7

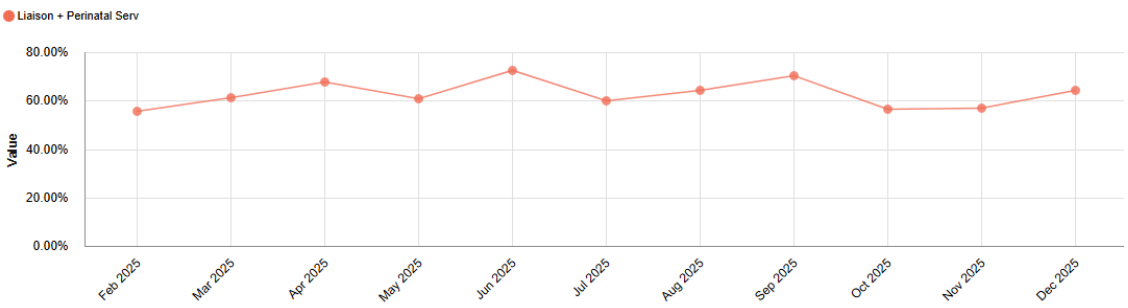


2.1.4 Emergency Department (ED) waits for mental health assessment

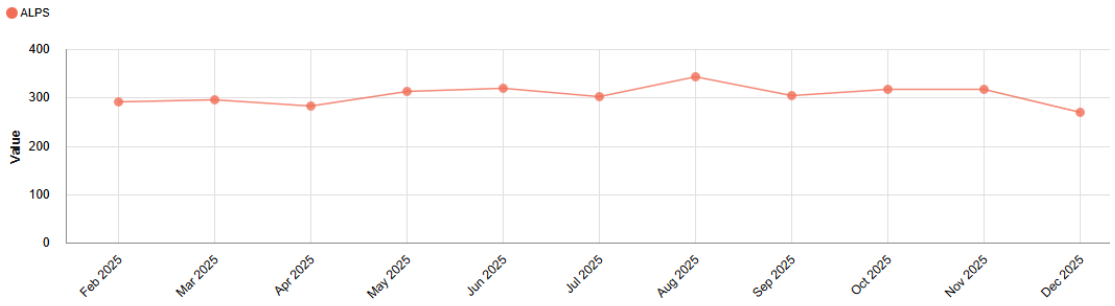
As previously reported, we have seen a continued decline in the 1-hour response time by our Acute Liaison Psychiatry Service (ALPS) through November with a slight recovery in December, see graph 8, and we continued to receive a slight increase in number of referrals in November, see graph 9. This is a key priority for us to ensure that people requiring mental health treatment are detected and start this in a timely manner.

Whilst we saw an improvement following the implementation of an action plan in May 2025, we have been unable to maintain performance against the target, the reasons for this remain unclear and are set against a context of moving into a facility in LTHT significantly closer to ED in preparation for winter. The service is looking at different ways of working which might help achieve the target, including the introduction of a triage function to screen referrals on arrival at the ED. This pilot will focus on 'walk ins' initially to identify people who need our service at St James's Hospital. This will better inform the response to those service users to avoid the time they have to wait for assessment and signpost them early to appropriate services. This pilot will continue throughout January, with the findings being reported back through CSDDG in March 2026.

Graph 8

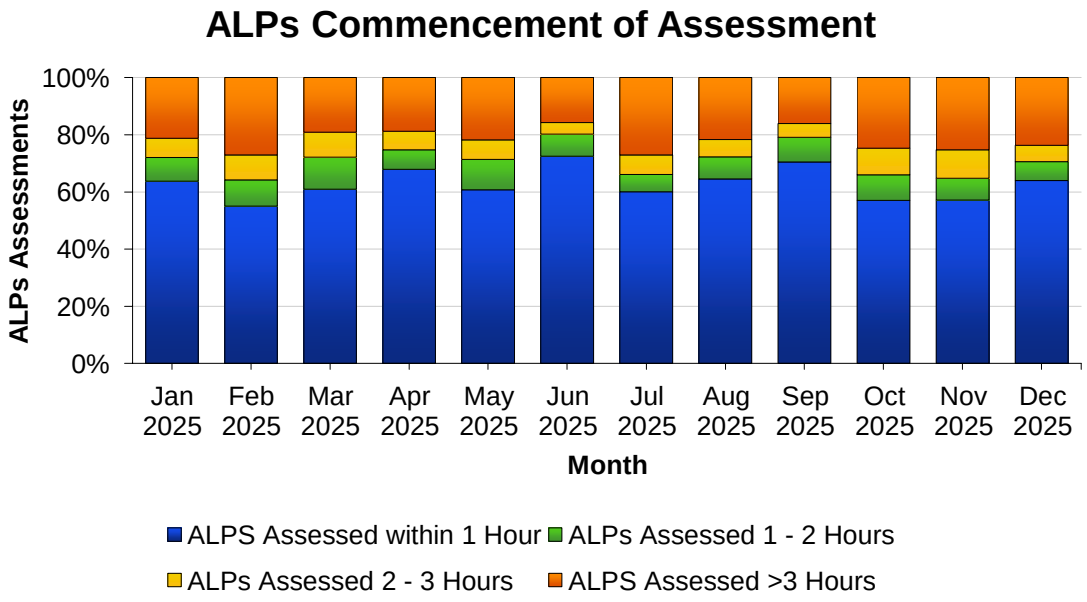


Graph 9



Graph 10 below shows where we have been unable to meet the 1-hour target time to assessment. It also shows we have seen approximately 75% of service uses within 3 hours of referral throughout November and December. However, this means that approximately 25% of all referrals have waited more than 3 hours. We continue to see a number of service users being referred to ALPS before they are deemed medically fit, which means the assessment cannot be undertaken until such time as the service user is fit enough to be seen. The service has worked with our Informatics team to develop an ALPS ED dashboard that shows 'live' referrals referred to ALPS with their waiting time. The dashboard will continue to be refined overtime to ensure the data presented is accurate and meets the needs of the service.

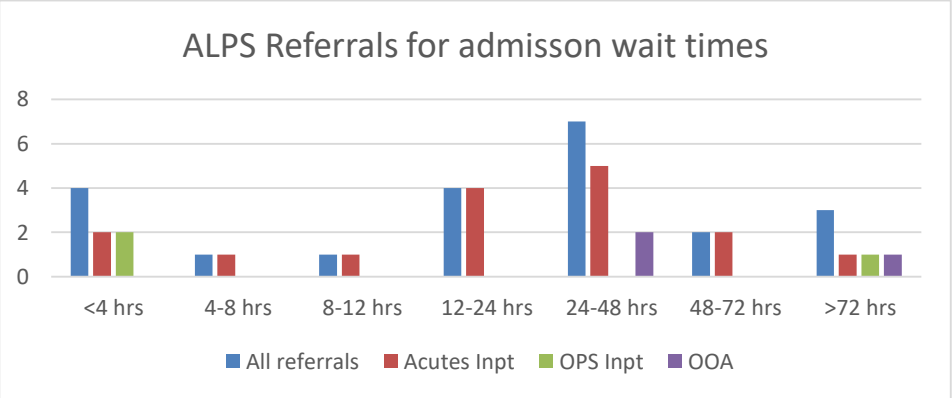
Graph 10



Reducing the length of time that people requiring Mental Health admission wait in ED remains a high priority for the Trust, particularly as we continue through winter. The work programme remains on track and is making considerable progress. We have continued to have service users waiting over 12 hours for admission within the LTHT Emergency

Department (ED) through November and December, see graph 11. We have seen fewer referrals to out of area placements compared to numbers previously reported, with a higher proportion being admitted to LYPFT inpatient services, and delays being as a result of Mental Health Act assessments and the availability of beds within the Trust.

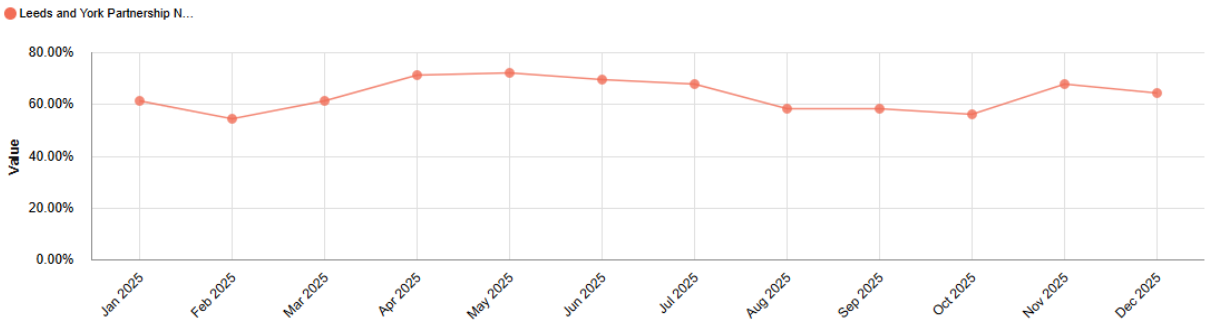
Graph 11



2.1.5 Crisis and Intensive Support referrals seen within 4 hours

Since October 2025, we have been reporting our 4-hour Crisis response with the inclusion of our Intensive Care Homes Team (ICHT) and our Intensive Home Treatment Team (IHTT) within our Older Peoples services, see graph 12. We continue to struggle to achieve the performance target of 90% across all our Crisis services, currently at 65% (CRISS at 70% and ICHT/IHTT at 40%). We are still in the process of implementing the 4-hour very urgent standard to our ICHT and IHTT teams which has not been a standard they have used previously. Our Informatics Team is working with senior leaders across all our Crisis services to understand what factors are contributing to poor performance and what steps can be taken to improve this.

Graph 12



2.2 ADVISE

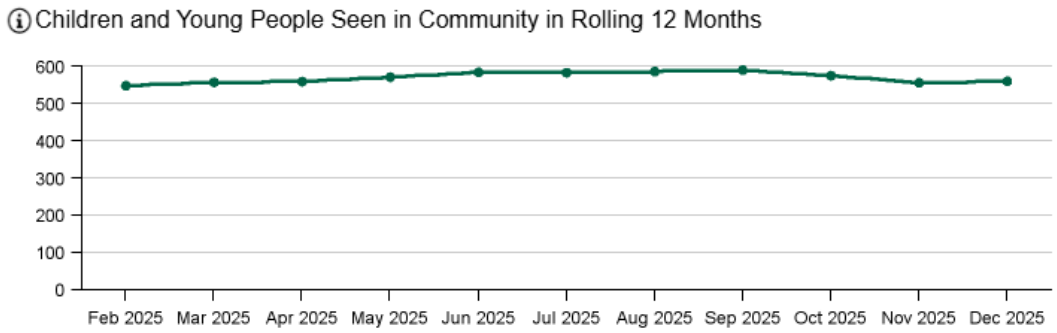
2.2.1 NHS Oversight Framework (NOF) measures in Care Services

We continue to monitor the performance against the NOF measures on the Care Services Dashboard through our Care Service Delivery and Development Group and our Care Services Finance and Performance Meeting.

2.2.1.1 Children and young people seen in the community in a rolling 12 months

We have seen a steady increase in access to the service over the summer period with a slight decrease through October to normal rates of referral, which has continued through November, levelling out in December, see graph 13, but continues to be higher than the beginning of the year.

Graph 13

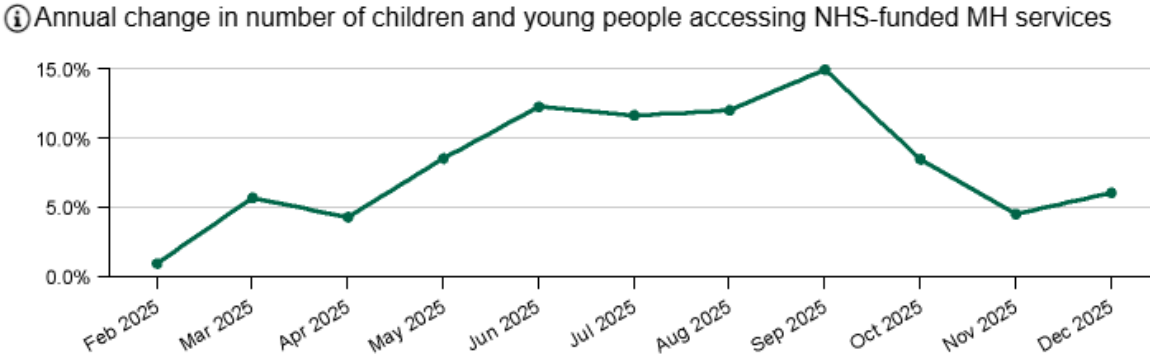


	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Actual	549	558	560	572	585	584	587	591	576	557	561

2.2.1.2 Annual change in the number of children and young people accessing NHS funded services

Whilst we have seen an increase over this calendar year, see graph 14. we continued to see a decrease from October through November, with a slight increase into December. The National Deaf Child and Adolescent Mental Health Service usually sees a variation across the school year.

Graph 14

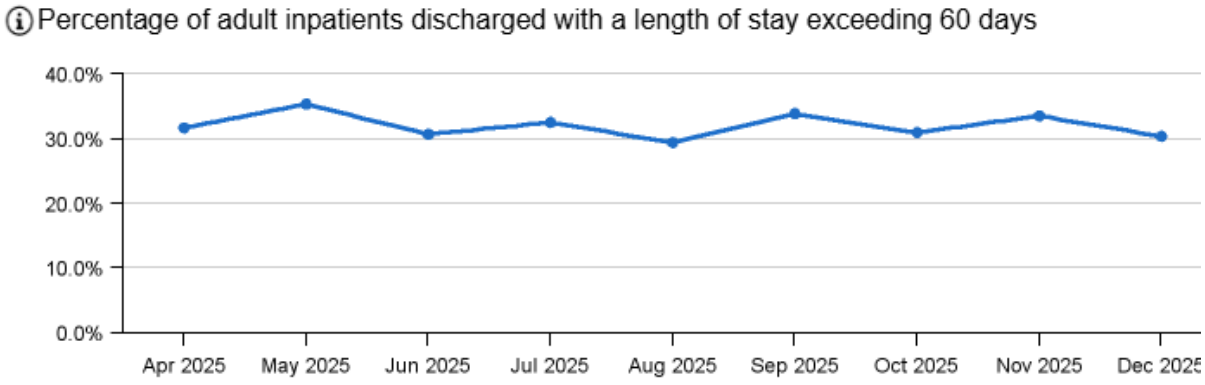


	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Actual	0.9%	5.7%	4.3%	8.5%	12.3%	11.7%	12.0%	15.0%	8.5%	4.5%	6.0%
Numerator	5	30	23	45	64	61	63	77	45	24	32
Denominator	544	528	537	527	521	523	524	514	531	533	529

2.2.1.3 Percentage of adult inpatients discharged with a length of stay exceeding 60 days

This metric saw a slight increase in November and decrease to below 30% in December, see graph 15. This remains an area of focus within the Inpatient Quality Transformation Programme with clinical teams still being required to review these cases to determine what course of action is required to facilitate discharge.

Graph 15

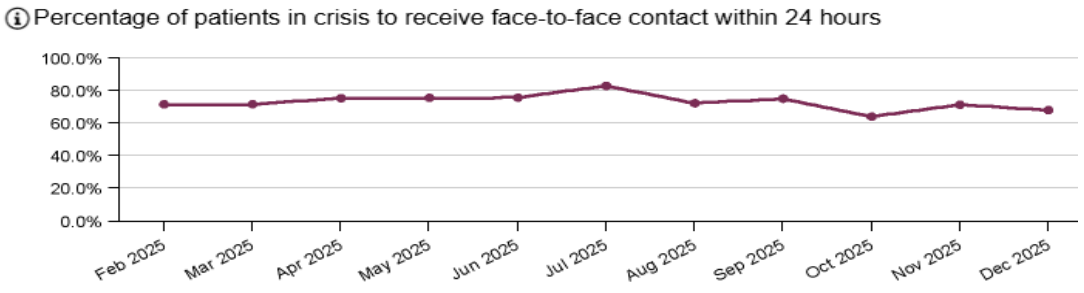


	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Actual	31.7%	35.4%	30.7%	32.5%	29.4%	33.9%	31.0%	33.6%	30.4%
Numerator	52	58	51	55	53	60	53	51	45
Denominator	164	164	166	169	180	177	171	152	148

2.2.1.4 Percentage of patients in crisis to receive face-to-face contact within 24 hours

We saw a slight improvement through November in this metric, with another decline in December, see graph 16. We continue to see challenges in achieving this target in both our CRISS and IHTT services. Whilst we have seen some improvement in some areas, we have been unable to maintain the level of performance consistently across all areas. This remains a priority area of focus for those services involved.

Graph 16

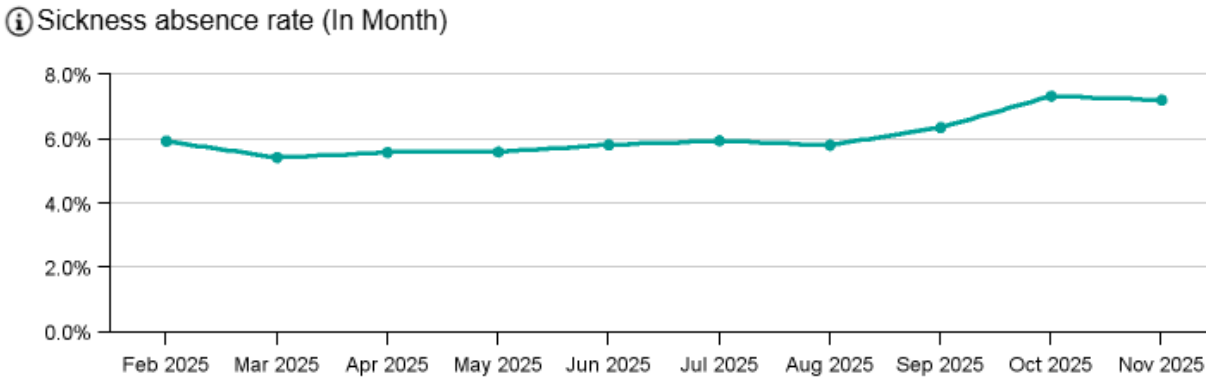


	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Actual	71.8%	71.8%	75.6%	75.8%	75.9%	83.2%	72.5%	75.3%	64.2%	71.5%	68.2%
Numerator	56	56	68	72	63	94	79	70	95	103	90
Denominator	78	78	90	95	83	113	109	93	148	144	132

2.2.1.5 Sickness absence rate

The sickness absence rate for the Trust remains a high priority, with the aim of achieving 5%. We have seen our overall sickness absence rate peak at 7.3% through November, see graph 17. We continue to review and monitor this through our operational governance arrangements and will report direct to the Care Services Finance and Performance Group.

Graph 17



	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025
Actual	5.9%	5.4%	5.6%	5.6%	5.8%	5.9%	5.8%	6.4%	7.3%	7.2%
Numerator	5.1K	5.2K	5.2K	5.3K	5.4K	5.7K	5.6K	5.9K	7K	6.7K
Denominator	86.4K	95.4K	92.2K	95K	92.1K	95.4K	96.2K	93.3K	95.5K	92.4K

2.2.2 Waiting times

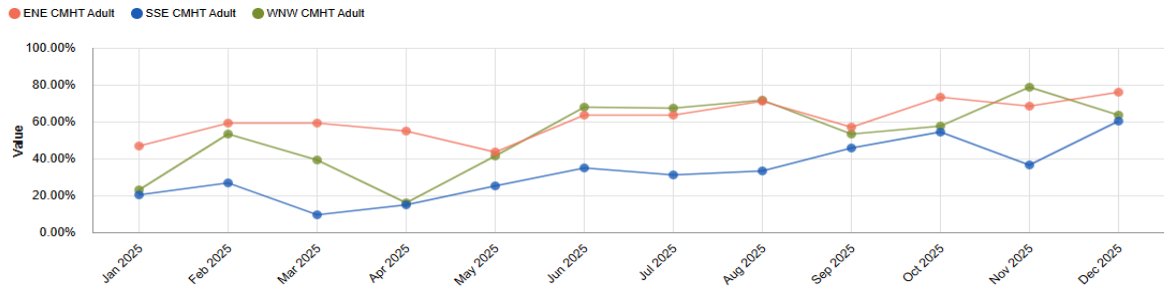
2.2.2.1 104+ week waits

At the time of writing there has been no service users who have breached this waiting time other than the one previously reported on. Our Informatics Team continue to maintain oversight of our long waits, and the Deputy Director has agreed they will alert services at 72 weeks to ensure that actions can be taken to avoid any breaches. Team Managers are actively encouraged to use the ‘Waiting 1st Direct Contact’ dashboard on CareDirector to monitor waiting times. This metric is being monitored as a standing agenda item at the Care Services Finance and Performance Meeting.

2.2.2.2 Average wait from referral

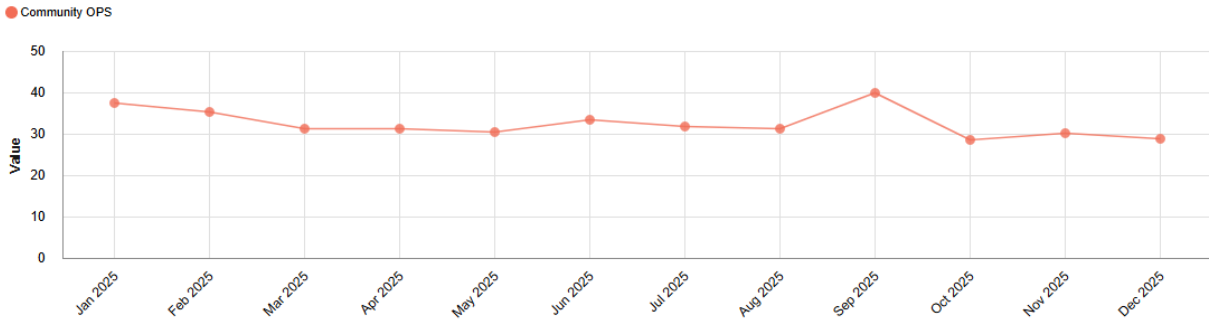
We continue to see variation across the months in the percentage of service users seen within 4 weeks of referral within our Community Mental Health Teams. Overall, we have seen a significant improvement since the beginning of the year, see graph 18.

Graph 18



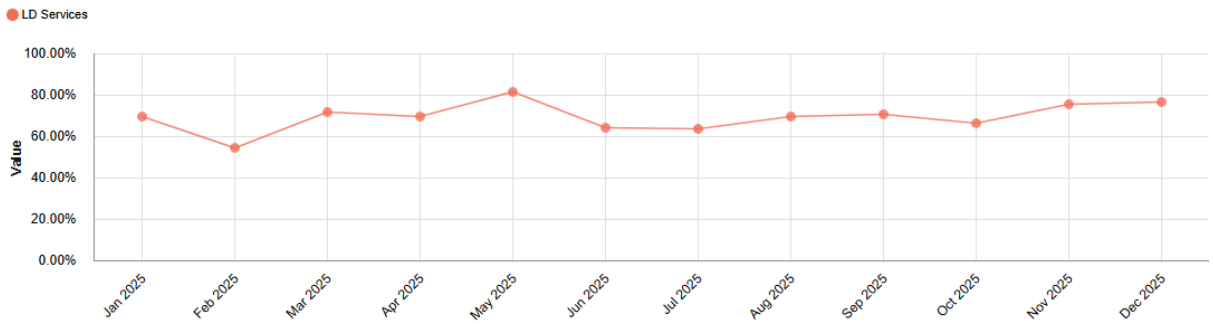
Our Older Peoples' Service Community Teams have recovered to a position of undertaking the first face-to-face contact within 30 days during October which has been sustained through November and December, see graph 19.

Graph 19



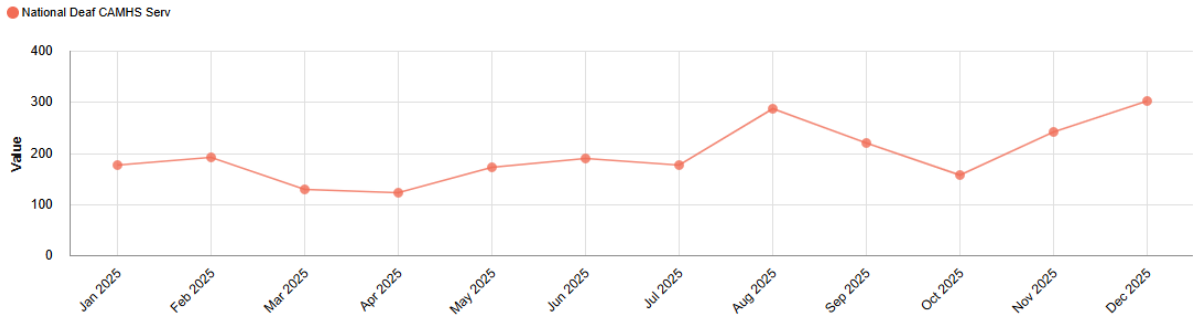
Our Learning Disability Services has recovered to meet the 75% standard of referrals seen for assessment within 4 weeks during November and December, see graph 20, with the LD Assessment and Referral Team (ART) achieving 85% referrals seen within 4 weeks in December.

Graph 20



Whilst we saw an improvement from a position of service users waiting an average of 300 days throughout September and October, since then we have seen a significant decline, see graph 21. The service continues to struggle with sickness absence and undertaking non-commissioned activity, both of which are being addressed through the management structures.

Graph 21



2.3 ASSURE

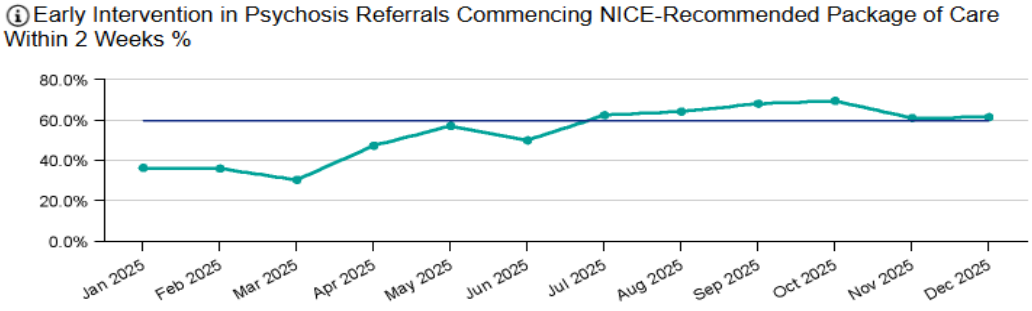
2.3.1 Enteral Feed and Oral Nutrition Support (ONS) Supply

There remains a risk of the lack of availability and supply of feeds for enteral feeding particularly within our Learning Disability Services, but these have reduced by changes in our working arrangements and the addition of temporary Dietician resource. As a result in the reduction of risk, the Tactical Group that monitored and assessed the risk, recommended to move from a position of business continuity to one of business as usual at the Strategic Group on the 8 December 2025. As a result, the Tactical Group was stood down. Whilst some backlog of work remains, it is hoped this can be dealt with as supply disruption begins to occur less frequently. Nutricia have reduced their reporting since they believe they are stabilising production. In practice, there are still issues but the situation is improving.

2.3.2 Aspire- Early Intervention in Psychosis Services two-week referral to commencing treatment

Aspire continues to maintain improvements against the treatment commencement target. Whilst we saw a slight decline in November, it did not drop below the 60% target and has remained over 60% through December, see graph 22.

Graph 22



	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Actual	36.4%	36.0%	30.4%	47.4%	57.1%	50.0%	62.5%	64.3%	68.2%	69.6%	61.1%	61.5%
Numerator	8	9	7	9	8	10	15	9	15	16	11	8
Denominator	22	25	23	19	14	20	24	14	22	23	18	13

2.3.3 Regional and Specialist Service Line changes

Commencing in January 2026, changes will be made to the Head of Operations reporting for the services that are within the Regional and Specialist Service Line. This is because the Head of Operations for this service line will be resigning their position under the Mutually Agreed resignation Scheme (MARS), with a leaving date of the 28 February 2026. All the Heads of Operations have been involved in the decision around service realignment and several of them have agreed to add some of these services to their service lines. This is an interim position and whilst the operational reporting structure will change, we do not anticipate any changes in the functions and service delivery of any of the services involved.

2.3.4 Rehabilitation Services

The workforce consultation for the Complex Psychosis Pathway was completed in November 2025. Mobilisation and implementation work is progressing to plan, with the go-live date scheduled for 5 January 2026. A go-live readiness testing session with all senior clinical and operations staff was successfully completed on the 27 November. Work is progressing to plan for the following processes:

- Triage and assessment
- Inpatient care pathway/community pathway
- Community in-reach standards
- Flow across the pathway
- Out of area referral process
- Acute admission avoidance (relapse prevention beds)
- Capacity and flow governance.

3. WINTER PREPAREDNESS

We continue to build on our experience of the planning and preparation for winter with a clear set of operating principles as set out in our Winter Plan. This year we are seeing increased scrutiny on mental health services this winter with a focus on reducing the number of service users waiting in EDs for over 12 hours. We have completed much of our pre-winter planning and have commenced our coordination arrangements. We have not identified any areas that we anticipate will be problematic over this period but will continue to maintain good oversight and will be prepared to respond to any pressures as needed.

Our Winter Coordination arrangements have been established through the Strategic Coordination Group (SCG) and Tactical Coordination Group (TCG), with these running until March 2026. The Deputy Director of Operations and EPRR Lead will maintain links across the Leeds and West Yorkshire systems to ensure we maintain our service delivery and support our system partners. We have well established links with our partners to be able to achieve this.

4. SERVICE DEVELOPMENTS

4.1 Refresh of the Care Services Strategic Plan

The refresh of the Care Services Strategic Plan commenced at the beginning of December, at a timeout with operational, clinical and professional leads along with subject matter experts. The outputs are based on the NHS 10 Year Plan, Healthy Leeds Plan, national and local policies and importantly population health data.

The outputs have been incorporated into the key headlines used to form the content of the 5-year narrative plan to be submitted in response to the Strategic Commissioning Framework.

Over the coming period a revision of the care services strategic plan will incorporate these objectives and work to identify key priorities for all service lines, to ensure they address population health need and health inequalities.

4.2 Healthwatch Review of NHS 111 "When Crisis Calls"

Healthwatch has undertaken a review of the NHS 111 Mental Health Crisis Support Line, to understand people's views and experiences since its introduction. Over 350 people from Leeds who have experienced a mental health crisis provided their input into the report.

The key findings are as follows:

- 57% of people who did not use NHS111 for support during their crisis did not know this was an option
- 3 in 5 people didn't find the support offered by NHS 111 helpful in managing their mental health crisis
- People's experiences of call handlers on the phoneline were inconsistent. Positive experiences involved call handlers listening well and offering clear next steps. Others described not having clear next steps or support in place to manage their crisis, being passed between services with no follow-up, or having call handlers without knowledge of local services or their mental health needs. Negative experiences left callers feeling as though they were dismissed or unheard
- Some people calling on someone's behalf, such as a carer or family member, struggled to get support for the person they were calling for, leaving them to manage the situation alone and negatively affecting their own mental health (this has already been addressed)
- Feedback from autistic people, and people from culturally diverse communities suggests that NHS 111's mental health support is not always accessible or appropriate for them
- While 69% of people were okay with the automated voice menu, others asked for it to be simplified.

Based on these findings, Healthwatch made several recommendations which have been presented at the Leeds Mental Health Partnership Board, the Crisis Transformation Board, the West Yorkshire ICB Programme Team and the Commissioning Group. The findings and recommendations have been taken into consideration by the West Yorkshire ICB and the provider of the NHS111 Mental Health Crisis Line, who are working to implement the recommendations.

Whilst LYPFT does not have a contractual relationship with the NHS111 Mental Health Crisis Line provider, we recognise the importance of maintaining a good working relationship to ensure the smooth transition of service users between services. The report commended LYPFT Crisis Services for the work they have done to date with the NHS 111 provider, to train and develop staff and improve communication between the teams.

4.3 ADHD waiting times

The Executive Management Team reviewed the position of ADHD service provision following a temporary pause on non-urgent referrals which has been in place for 14 months. Following this review, it was agreed that the service remains closed to all but urgent referrals, internal referrals and to young people transitioning from the Children and Young People's Service.

Over the past 12 months a number of waiting list management measures have been taken in partnership with the GP Confederation in Leeds and the Leeds Place ICB. These have included:

- Contacting all patients on the waiting list for diagnostic assessment to outline options for assessment, advice and support. The Trust's website now includes frequently asked questions, support options and guidance.
- Leeds GP Confederation established a Neurodevelopment Support Service, that initially focused on LYPFT waiters from lower IMD groups. The support that was offered included signposting to other services and re-routing referrals to an alternative provider if appropriate. 546 patients were managed through this process.
- Of the 546 patients contacted between January and April, 83 patients (15.2%) remained under LYPFT.
- Additional contact has been made with people who were identified as being out of area, plus people who did not respond to numerous contacts, and where appropriate have been removed from the waiting list.

These actions led to a reduction of approximately 1,400 patients who were awaiting assessment from October 2024.

In order to improve access for people, a West Yorkshire ICB led procurement exercise concluded in August 2025 which successfully identified an initial 6 accredited alternative providers to undertake ADHD assessments. This is in addition to the LYPFT provision for people meeting the urgent/complex criteria.

A process to transfer people with the longest waits from LYPFT has commenced. There has been a temporary hiatus in the process as some aspects required further clarification. It is the ICBs intention this will continue until the waiting lists are equalised across West Yorkshire, the timings of which are not yet understood fully as this depends on the capacity within the alternative providers. This process is under continual review by the West Yorkshire ICB Commissioning Forum. The ICB will add additional suitably qualified providers to the framework to increase capacity every 6 months.

Since the implementation of the new arrangements in Leeds and West Yorkshire the number of referrals to LYPFT has decreased to an average of 15-20 per month. As a result of the changes, we are now receiving 15-20 appropriate referrals per month that we are in a position to respond to in a timely way.

As part of the West Yorkshire Neurodiversity program, the proposal is to develop the type of community hub provided by the Leeds GP Confederation across all of West Yorkshire and review the criteria and thresholds for secondary care services. As such, EMT supported the proposal to continue operating in the way the service has done since the closure of the waiting list in October 2024.

5 EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE

5.1 NRS Healthcare liquidation

The company NRS Healthcare (also known as Nottingham Rehab Ltd) went into liquidation on 1 August 2025. This company provided equipment to NHS providers and local authorities across the country.

A tactical group was formed to gather information, assess any risks to our services and identify options and contingencies. This group included representatives from all services and the Procurement Team and has now been stood down. The Trust's Procurement Team has identified and provided services with guidance which lists alternative suppliers and where they may be used. This covers equipment supply and ongoing servicing of existing equipment. A specific contact within the Procurement Team has been identified who will deal with any other supply issues including the ongoing servicing of equipment.

5.2 Industrial action

The Trust planned for, and responded to, industrial action by members of the BMA between 07:00 on Friday 14 November until 07:00 on Wednesday 19 November and also 07:00 on Wednesday 17 December until 07:00 on Monday 22 December.

Currently the BMA have two separate mandates for strike action. The first is a six-month strike mandate for resident doctors in England, which began in July 2025 and will last until January 2026. This mandate allows for industrial action, primarily driven by a pay dispute with the government. The BMA intend to ballot to extend this mandate well into 2026.

The second mandate covers newly qualified doctors in their first year of practice in England. The ballot of first-year resident doctors saw 97% (or 3,950) vote for strike action over unemployment and training place shortages on a 67% turnout. The periods of industrial action in November and December was taken following both mandates.

The Trust activated strategic and tactical coordinating meetings to gather intelligence, assess risks and ensure plans were in place to respond to the strikes, taking into account any concurrent incidents. There was no requirement to escalate any issues during either period of industrial action.

5.3 Demonstrations

The EPRR Team continues to monitor the situation regarding demonstrations that have been taking place in several parts of the Leeds district on a weekly basis since July. Demonstrations and counter demonstrations regarding the housing of refugees at hotels in Oulton and Seacroft have taken place with Trust staff informed beforehand, so they are able to take safety precautions if they are visiting the area. Communications have also been issued to staff to ensure they are aware of any disruption caused by weekly Gaza related demonstrations in central Leeds.
The impact of these demonstrations is significant with many staff, service users and families deeply affected. The EPRR team play a role in alerting staff to the practical effects and reach of the activity, but our EDI Team, Wellbeing Team and managers across the organisation are offering support to people directly or indirectly affected.

5.4 Aspire Leeds business continuity incident

A short business continuity incident was declared on 18 November following a break in at the Aspire premises in Armley. This affected the EIP service that is commissioned by LYPFT for delivery by Aspire. The team was unable to deliver clinical interventions directly from the building until 21 November. Service users continued to receive the service either virtually or in the community. A tactical group was formed to provide oversight of the incident response. The incident was stood down on 21 November when normal service was resumed following repairs to the building.

6 REPORT FROM THE HEAD OF HEALTH EQUITY

In partnership with the EDI team in or Workforce Directorate, we have been evaluating progress and working on the EDS accountability improvement tool for all NHS organisations in England. A full report will be shared with members of the Quality Committee and Workforce Committee in February which will be followed by a report to Trust Board in line with the EDS requirements.

7 SUMMARY AND RECOMMENDATION

We continue to manage and lead a response to a range of challenges in the delivery of consistent and sustainable high-quality care for all people needing our support through a whole system approach. The report highlights the most significant service delivery and development challenges we face but importantly sets out where service delivery has stabilised or where improvements have been made in Care Services.

The Board is asked to be assured of the work being undertaken to deliver our Care Services and to manage the range of challenges and issues outlined in this report.

Joanna Forster Adams
Chief Operating Officer
January 2026

Contributions from members of the Care Services' Senior Operational Leadership Team

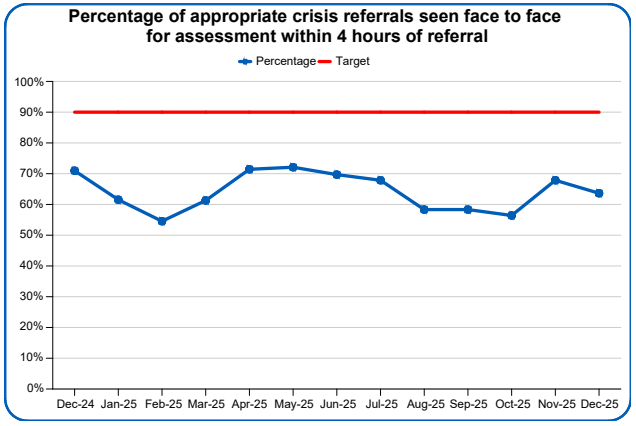
Service Performance - Chief Operating Officer

Services: Access & Responsiveness: Our response in a crisis Monthly	Target	Oct 2025	Nov 2025	Dec 2025
Percentage of ALPS referrals responded to within 1 hour	-	56.7%	57.1%	66.5%
Number of S136 detentions over 24 hours	-	0	0	1
Percentage of appropriate crisis referrals seen face to face for assessment within 4 hours of referral	90.0%	56.4%	67.9%	63.6%
Percentage of service users who stayed on CRISS caseload for less than 6 weeks	70.0%	91.5%	87.6%	90.0%
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support	50.0%	36.0%	41.4%	39.8%
Percentage of CRISS caseload where source of referral was acute inpatients	-	9.7%	7.7%	7.5%
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services	**Target**	**Oct 2025**	**Nov 2025**	**Dec 2025**
Gender Identity Service: Number on waiting list	-	7,016	7,072	7,134
Deaf CAMHS: average wait from referral to first face to face (inc. telemedicine) contact in days	-	130.73	189.48	303.33
Community LD: Percentage of referrals seen within 4 weeks of receipt of referral	75.0%	66.7%	75.9%	78.0%
Leeds Autism Diagnostic Service (LADS): Assessment to Diagnostic Decision within 26 Weeks (quarterly)	70.0%	-	-	97.5%
Leeds Autism Diagnostic Service (LADS): Percentage starting assessment within 13 weeks (quarterly)	-	-	-	24.4%
CAMHS inpatients: Proportion of people assessed within 7 days of admission (HoNOSCA / GBO) (quarterly)	100.0%	-	-	92.9%
Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency) (quarterly)	-	-	-	93.3%
Perinatal Community: Percentage of routine referrals waiting less than 2 weeks for assessment (quarterly)	85.0%	-	-	96.1%
Perinatal Community: Total number of distinct women seen in rolling 12 months (quarterly)	950	-	-	856
Perinatal Community: Face to Face DNA Rate (quarterly)	-	-	-	7.7%
Services: Our acute patient journey	**Target**	**Oct 2025**	**Nov 2025**	**Dec 2025**
Number of admissions to adult facilities of patients who are under 16 years old	0	0	0	0
Crisis Assessment Unit (CAU) bed occupancy	-	79.0%	85.0%	95.7%
Crisis Assessment Unit (CAU) length of stay at discharge	-	18.75	20.25	19.22
Liaison In-Reach: attempted assessment within 24 hours	90.0%	80.4%	81.2%	71.3%
Becklin Ward 1 (Female)	-	102.3%	101.1%	105.4%
Becklin Ward 3 (Male)	-	98.4%	96.5%	100.9%
Becklin Ward 4 (Male)	-	99.7%	101.7%	103.5%
Becklin Ward 5 (Female)	-	99.7%	100.3%	103.1%
Newsam Ward 4 (Male)	-	99.2%	98.3%	100.2%
Older adult (total)	-	92.4%	93.7%	99.9%
The Mount Ward 1 (Male Dementia)	-	97.7%	100.5%	97.7%
The Mount Ward 2 (Female Dementia)	-	85.6%	85.8%	102.4%
The Mount Ward 3 (Male)	-	86.9%	88.8%	98.1%
The Mount Ward 4 (Female)	-	98.9%	99.4%	101.4%
Percentage of Occupied Bed Days Clinically Ready for Discharge	-	30.7%	28.8%	32.2%

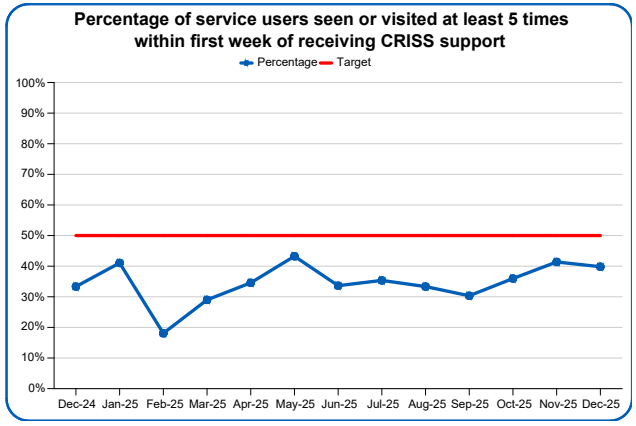
Service Performance - Chief Operating Officer

Services: Our acute patient journey	Target	Oct 2025	Nov 2025	Dec 2025
Out of Area Trajectory Active Placements at Month End	9	29	21	23
Total: Number of out of area placements beginning in month	-	13	5	16
Total: Total number of bed days out of area (new and existing placements from previous months)	-	882	708	691
Acute: Active Placements at Month End	-	23	15	17
Acute: Number of out of area placements beginning in month	-	9	3	11
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	748	535	499
PICU: Active Placements at Month End	-	6	5	6
PICU: Number of out of area placements beginning in month	-	4	1	4
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	134	172	164
Older people: Active Placements at Month End	-	0	1	0
Older people: Number of out of area placements beginning in month	-	0	1	1
Older people: Total number of bed days out of area (new & existing placements from previous months)	-	0	1	28
Cardiometabolic (physical health) assessments completed: Inpatients (quarterly)	80.0%	-	-	77.9%
Services: Our Community Care	**Target**	**Oct 2025**	**Nov 2025**	**Dec 2025**
Percentage of inpatients followed up within 3 days of discharge (Trust Level monthly local tracking)	80.0%	84.8%	82.8%	75.6%
Percentage of inpatients followed up within 3 days of discharge (HCP commissioned services only)	80.0%	85.7%	81.5%	76.4%
Number of service users in community mental health team care (caseload)	-	3,636	3,621	3,661
Percentage of referrals to memory services seen within 8 weeks (quarter to date)	70.0%	74.8%	76.5%	79.7%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50.0%	61.0%	57.5%	58.3%
Early intervention in psychosis (EIP) or at risk mental state (ARMS): Percentage starting treatment within 2 weeks	60.0%	69.6%	61.1%	66.7%
Early intervention in psychosis (EIP) : Percentage of people discharged to primary care (quarterly)	-	-	-	61.5%
Cardiometabolic (physical health) assessments completed: Early Intervention in Psychosis Service (quarterly)	80.0%	-	-	79.9%
Services: Clinical Record Keeping	**Target**	**Oct 2025**	**Nov 2025**	**Dec 2025**
Percentage of service users with NHS Number recorded	-	99.8%	99.8%	99.7%
Percentage of service users with ethnicity recorded	-	81.3%	81.4%	81.2%
Percentage of service users with sexual orientation recorded	-	44.7%	44.5%	44.6%
Services: Clinical Record Keeping - DQMI	**Target**	**Jul 2025**	**Aug 2025**	**Sep 2025**
DQMI (MHSDS) % Quality %	95.0%	91.7%	92.4%	93.0%

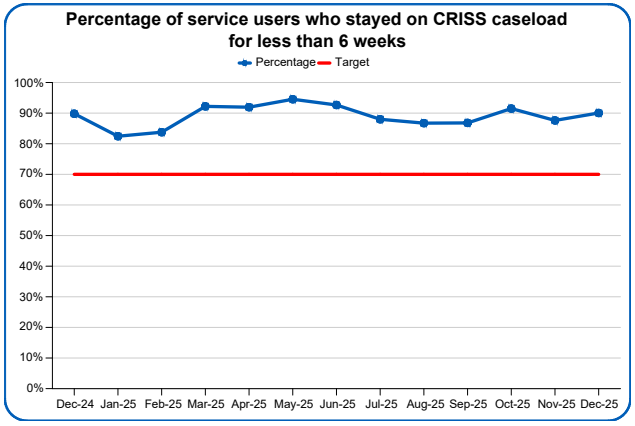
Services: Access & Responsiveness: Our Response in a crisis



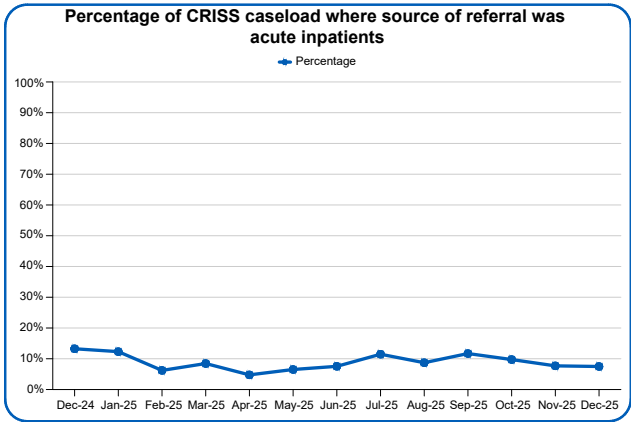
Contactual Target 90%: December 63.6%



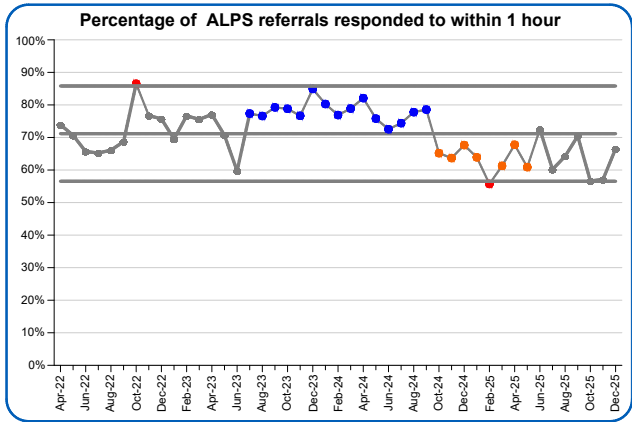
Contractual Target 50%: December 39.8%



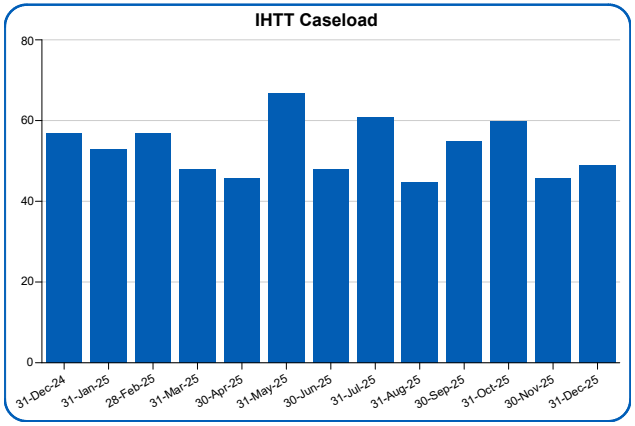
Contractual Target 70%: December 90.0%



Contractual Target tba: December 7.5%

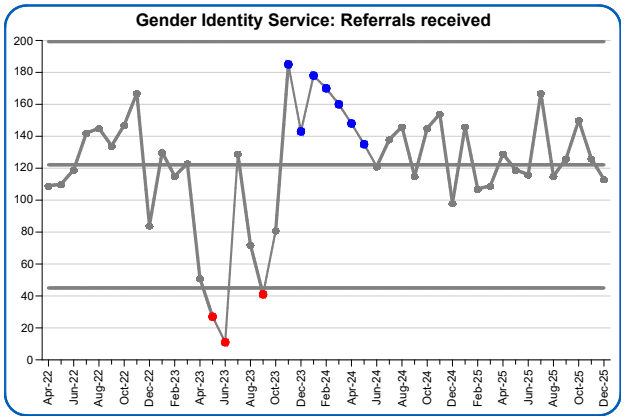


Contractual Target : December 66.5%

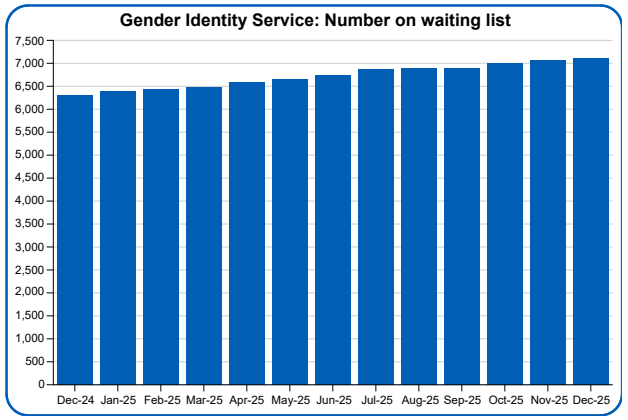


Caseload: December 49

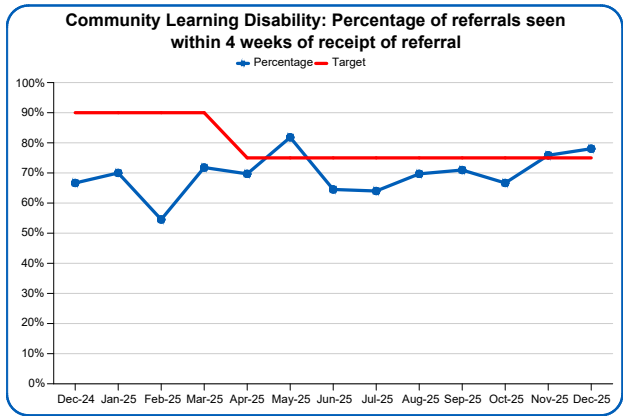
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services



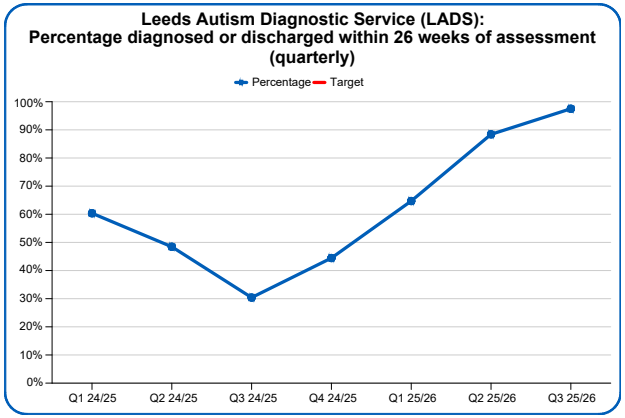
Total referrals: December 113



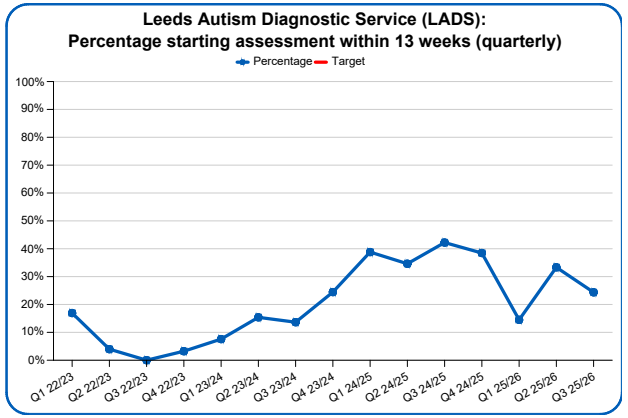
Number on waiting list: December 7,134



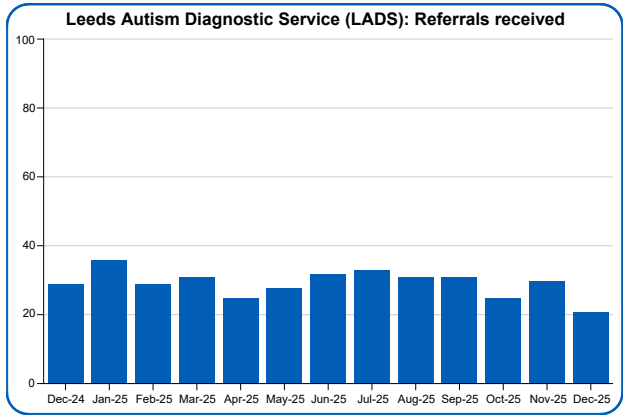
Contractual Target 75%: December 78.0%



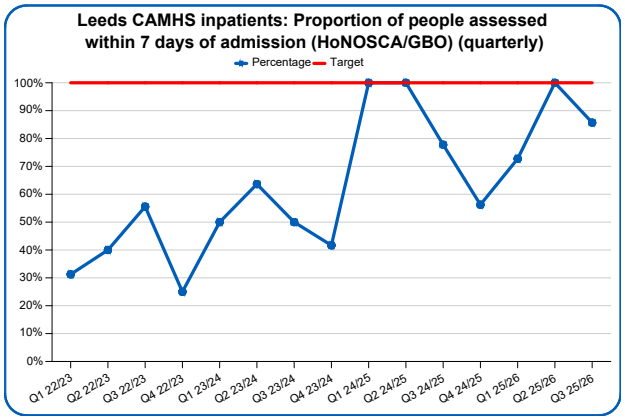
Contractual Target 70%: Q3 97.5%



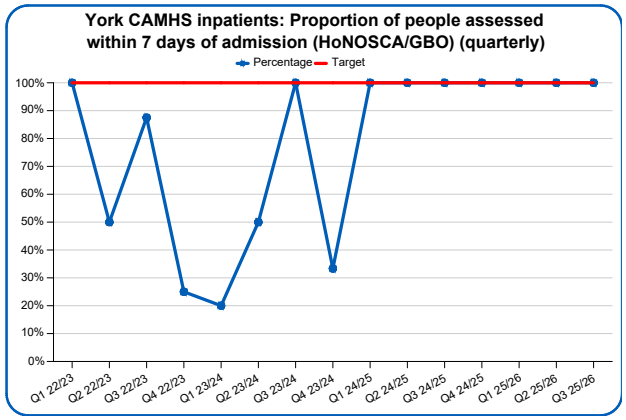
Contractual Target : Q3 24.4%



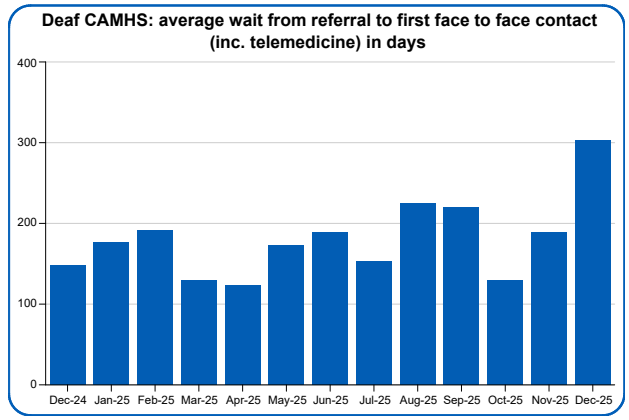
Local measure: December 21



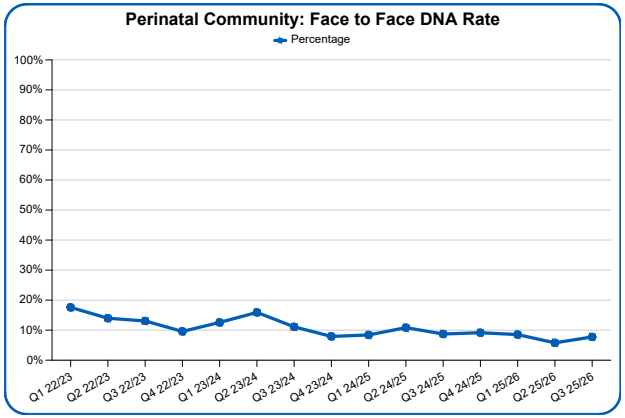
Contractual Target 100%: Q3 85.7%



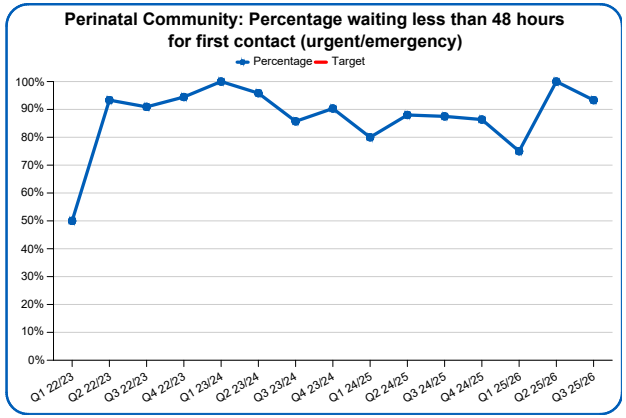
Contractual Target 100%: Q3 100.0%



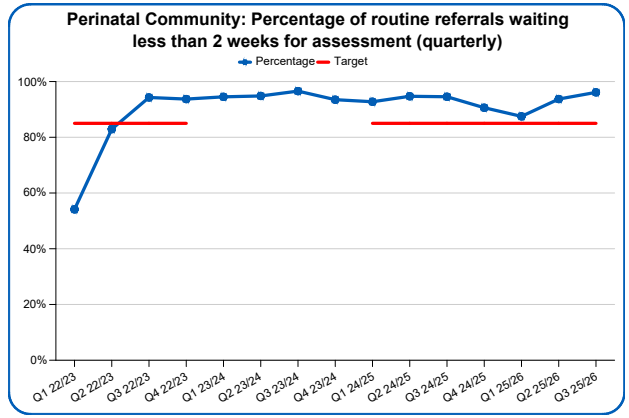
Local measure: December 303



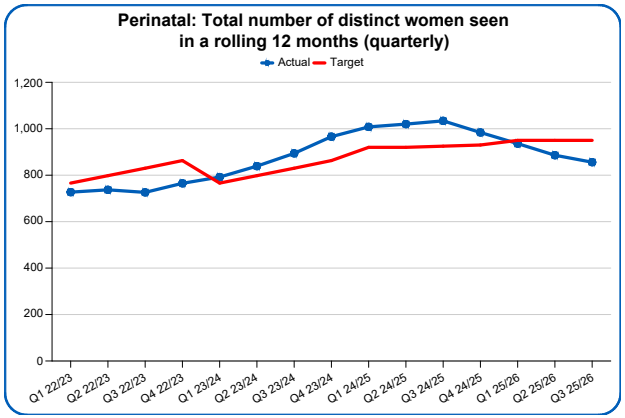
Contractual measure: Q3 7.7%



Contractual Target tba: Q3 93.3%

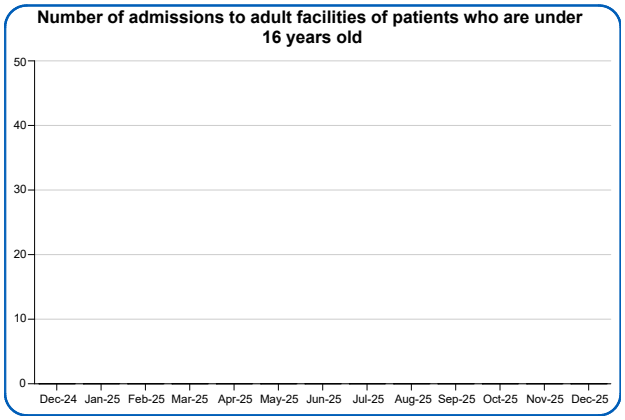


Contractual Target 85%: Q3 96.1%

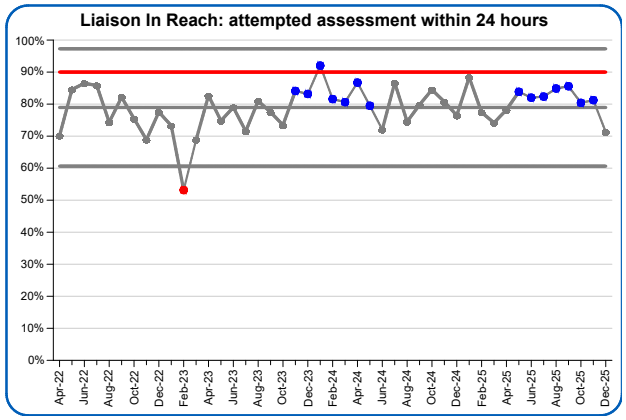


Local measure 950: Q3 856

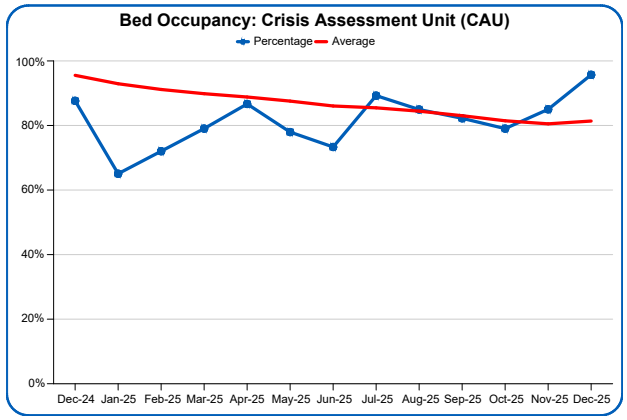
Services: Our acute patient journey



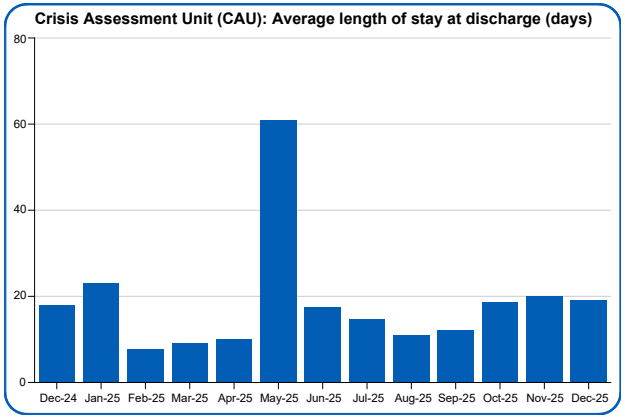
National (NOF) No target 0: December 0



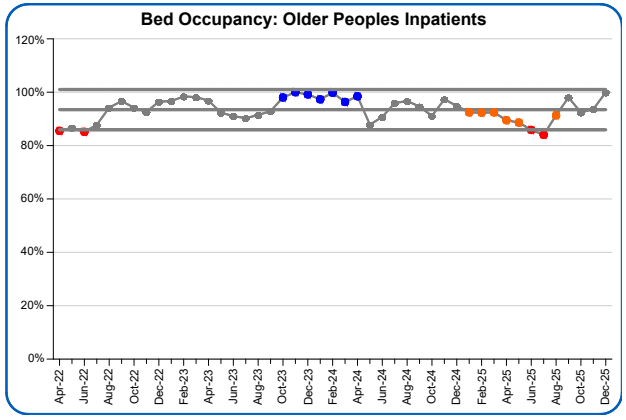
Contractual Target 90%: December 71.3%



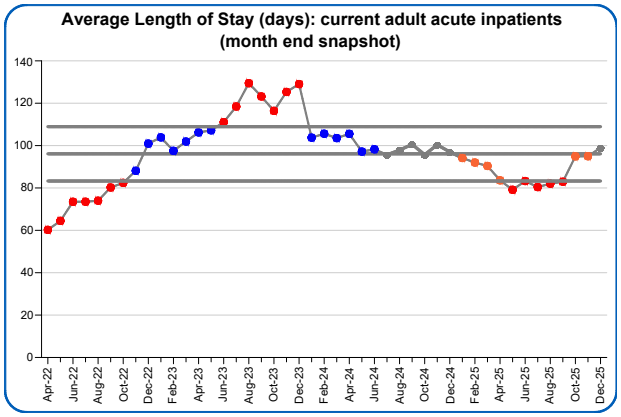
Local measure: December 95.7%



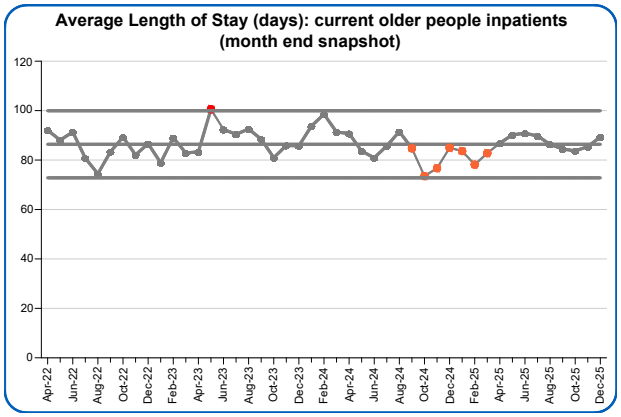
Local measure: December 19 days



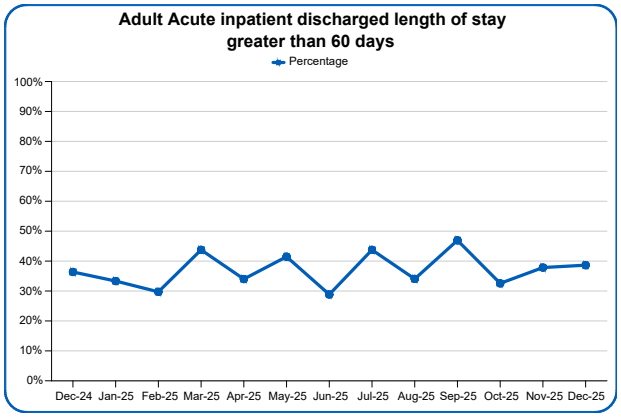
Local measure and target : December 99.9%



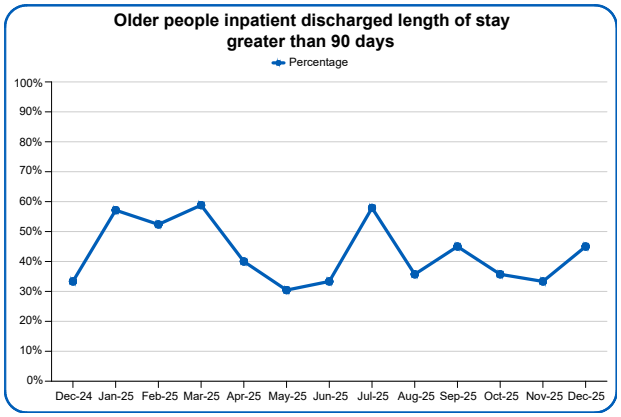
Local tracking measure: December 99 days



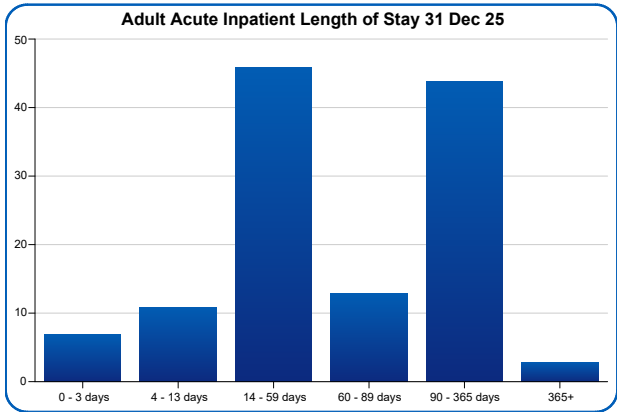
Local tracking measure: December 89 days



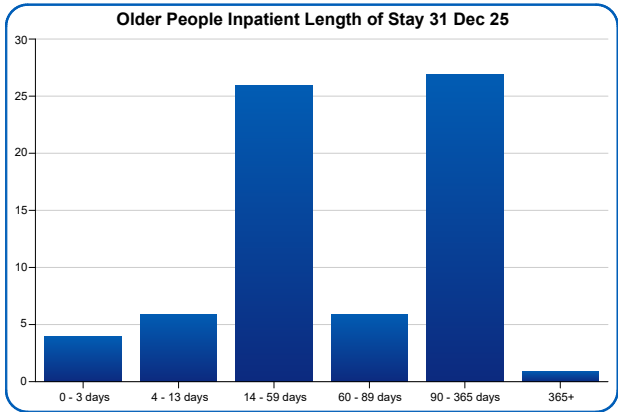
National (LTP): December 38.6%



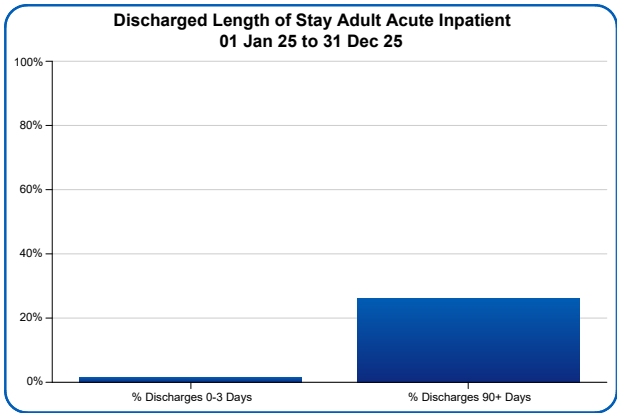
National (LTP): December 45.0%



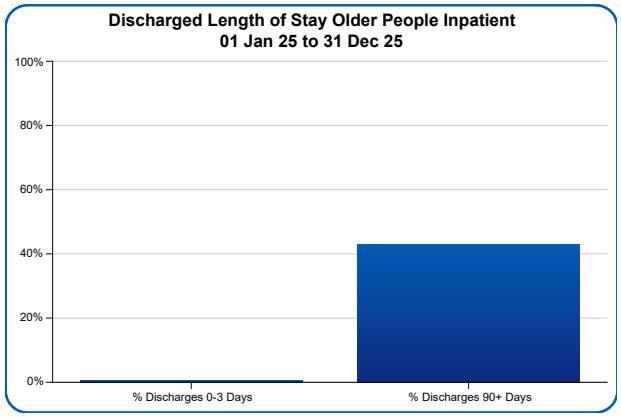
Local activity: 47 people with LOS 90+ days



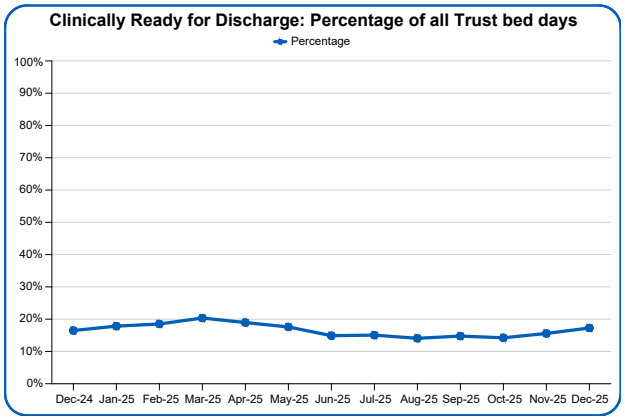
Local activity: 28 people with LOS 90+ days



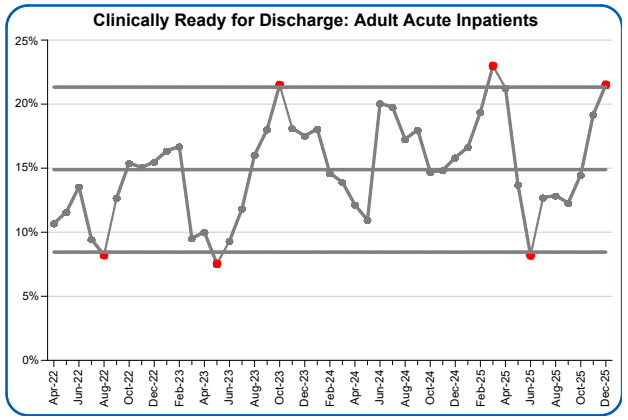
Local activity: % discharged LOS 90+ days = 26.5%



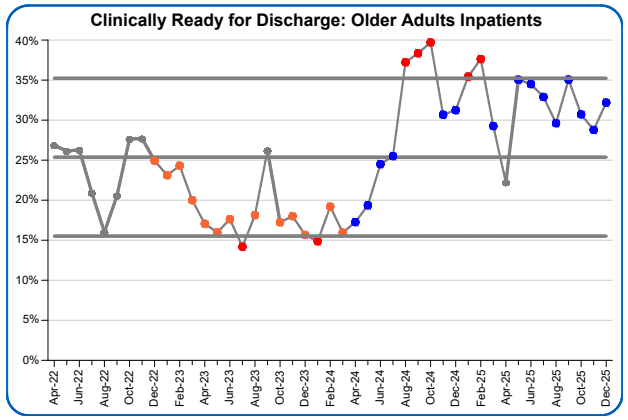
Local activity: % discharged LOS 90+ days = 43.4%



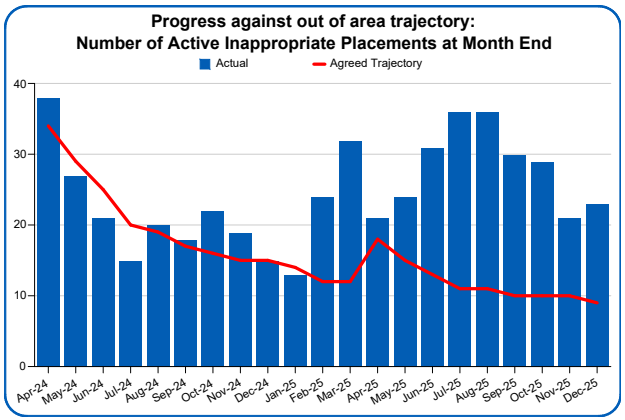
Local tracking measure: December 17.3%



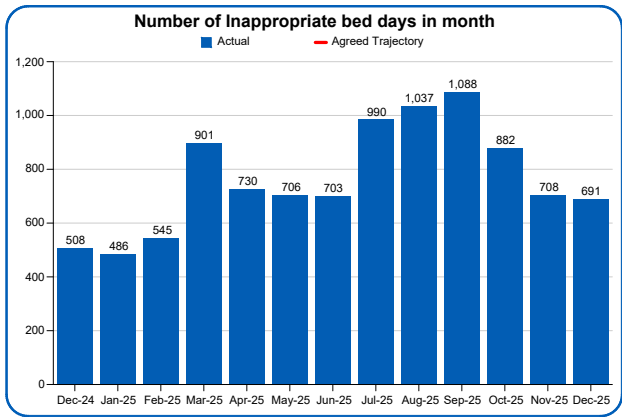
Local tracking measure: December 21.5%



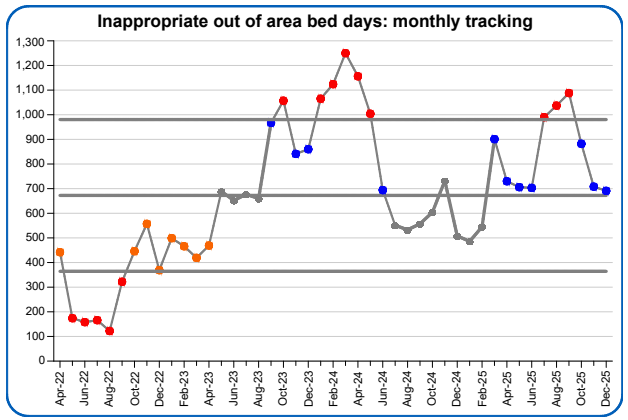
Local tracking measure: December 32.2%



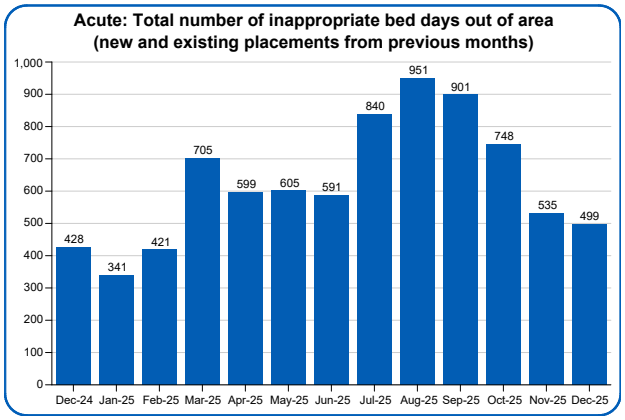
Nationally agreed trajectory (December: 9): December 23 active placements



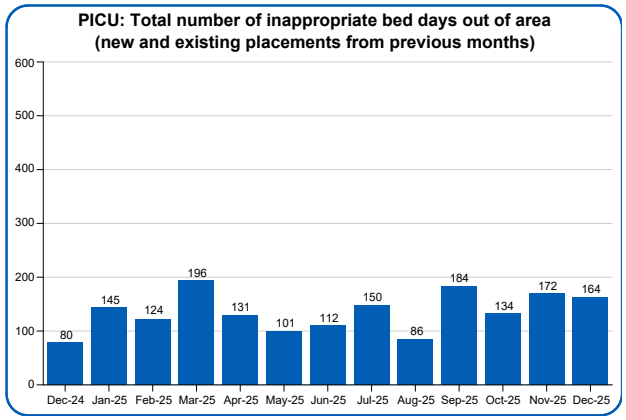
Local tracking measure: December 691 bed days



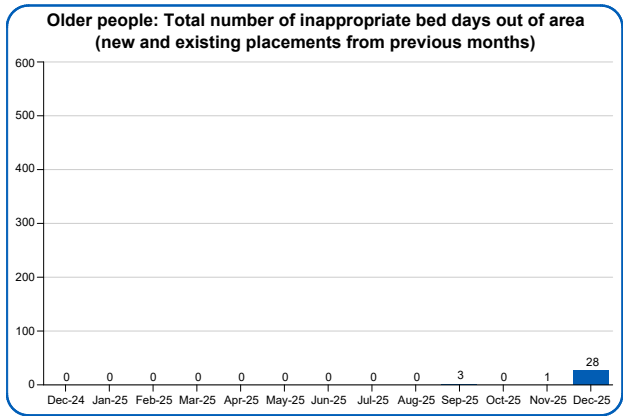
Local tracking measure: December 691 bed days



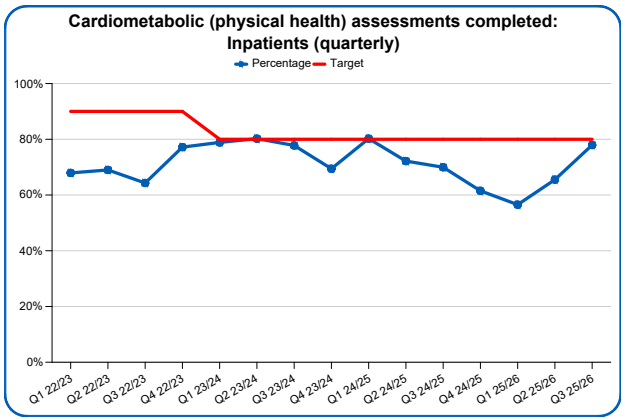
Nationally agreed trajectory (): December 499 days



Nationally agreed trajectory (): December 164 days

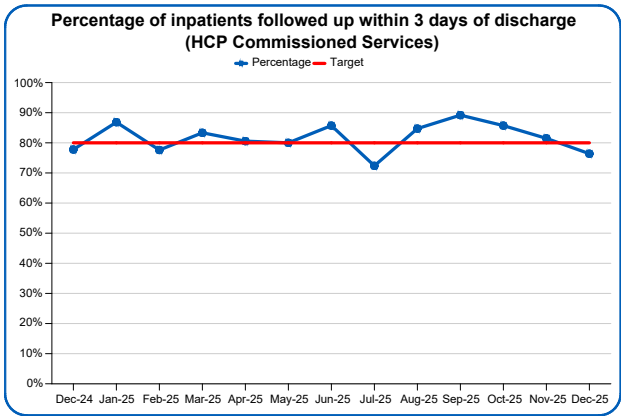


Local measure : December 28 days

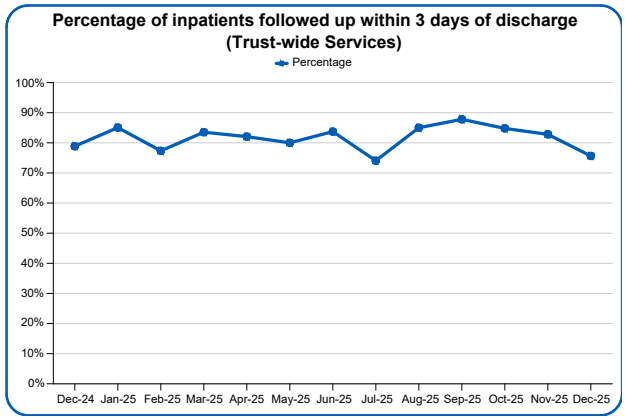


Contractual target 80%: Q3 77.9%

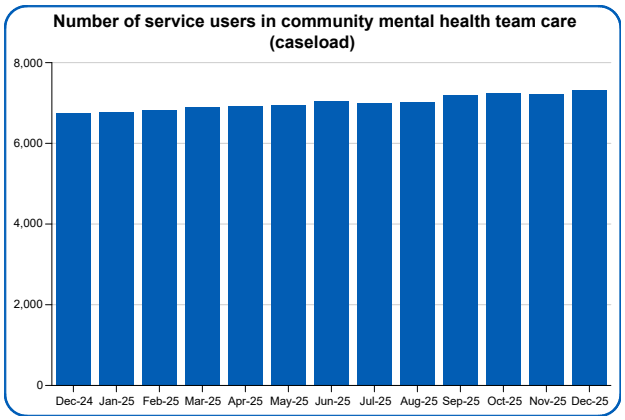
Services: Our community care



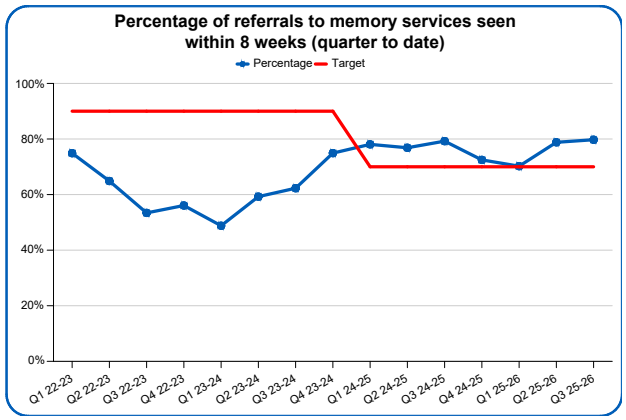
Contractual target 80%: December 76.4%



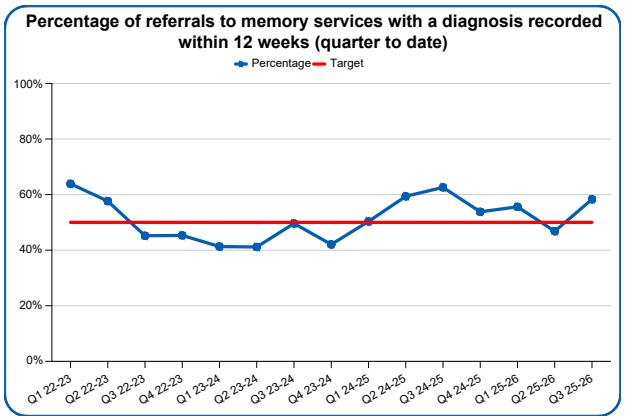
Local Tracking Measure 80%: December 75.6%



Local measure : December 3,378

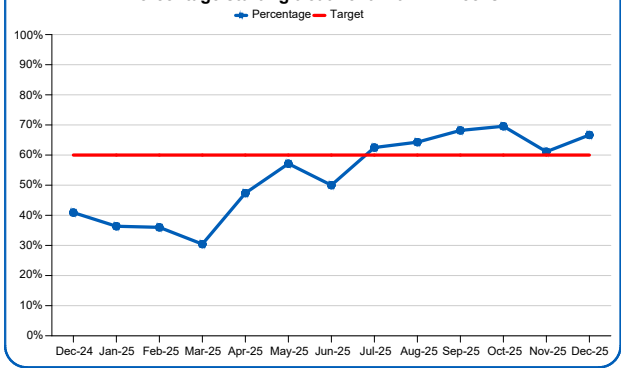


Contractual target 70%: Q3 25-26 79.7%



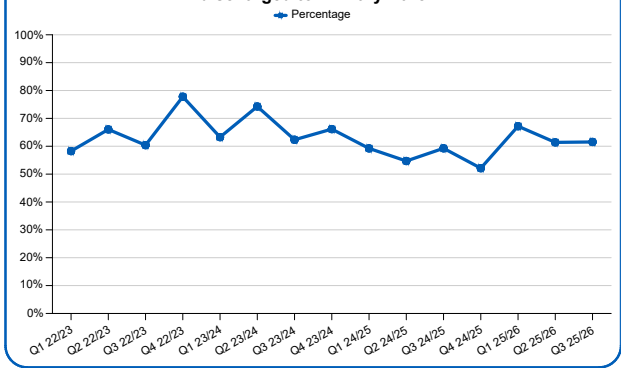
Contractual target 50%: Q3 25-26 58.3%

Early Intervention in Psychosis (EIP) or At Risk Mental State (ARMS): Percentage starting treatment within 2 weeks



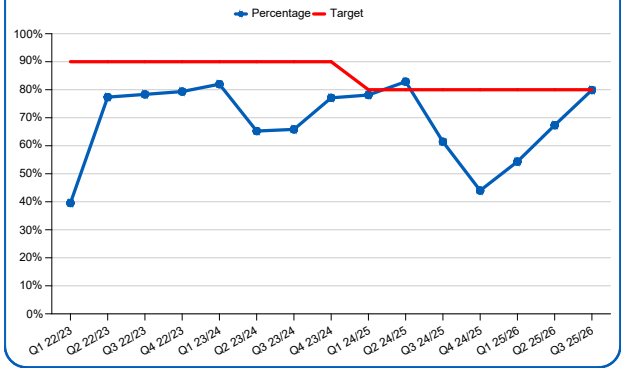
Contractual target 60%: December 66.7%

Early Intervention in Psychosis (EIP): Percentage of people discharged to Primary Care



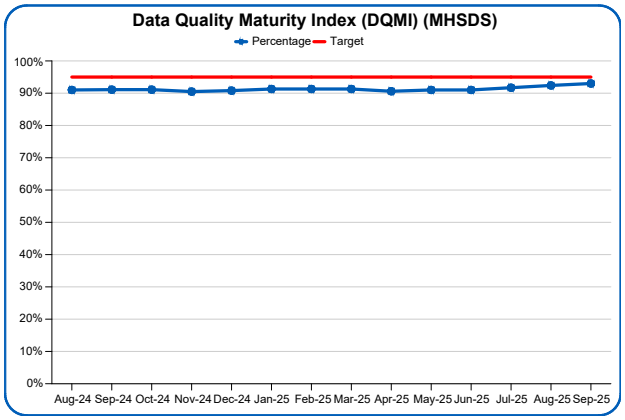
Contractual target tbc: Q3 61.5%

Cardiometabolic (physical health) assessments completed: Early Intervention in Psychosis Service (position at quarter end)

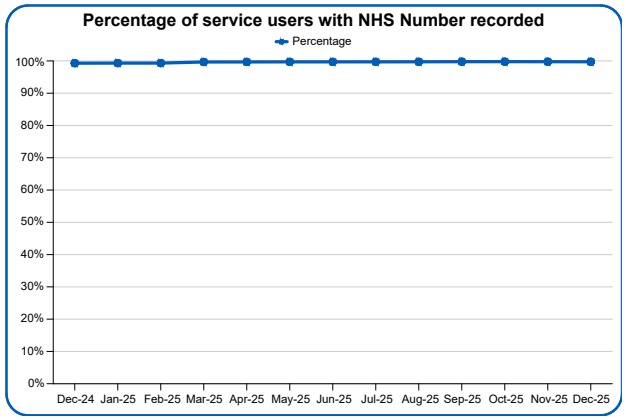


Contractual target 80%: Q3 79.9%

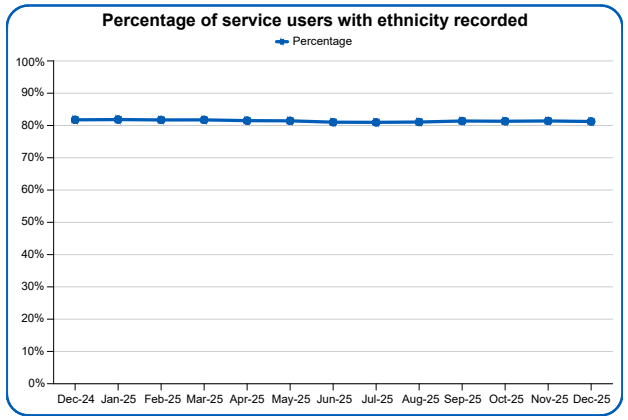
Services: Clinical Record Keeping



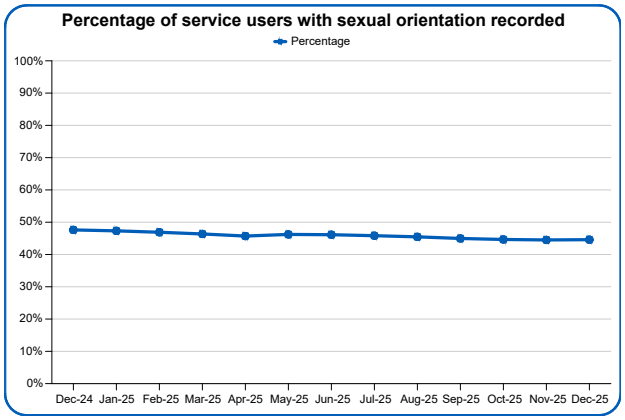
CQUIN / NHSOF Target 95%: September 93.0%



Local measure: December 99.7%



Local measure: December 81.2%



Local measure: December 44.6%

Glossary

Services: Access & Responsiveness: Our response in a crisis	
Percentage of appropriate crisis referrals seen face to face for assessment within 4 hours of referral	Of all the referrals receiving a face-to-face assessment following referral to the crisis service, the proportion that were assessed within 4-hours of referral.
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support	Of all the referrals discharged from Crisis Resolution or Intensive Support Service (CRISS) that were open for at least 7-days, the proportion that had at least 5 successful face-to-face contacts during the first 7-days of service involvement.
Percentage of service users who stayed on CRISS caseload for less than 6 weeks	Of all the referrals discharged from Crisis Resolution or Intensive Support Service (CRISS), the proportion that had a length of referral of 6-weeks or less at the time of discharge.
Percentage of CRISS caseload where source of referral was acute inpatients	Of all the referrals open to the Intensive Support Service (ISS) at the end of the period, the proportion that were an inpatient at the time of referral.
Percentage of ALPS referrals responded to within 1 hour	Of all the referrals from Accident & Emergency, to the Acute Liaison Psychiatry Service (ALPS) that were assessed, the proportion that were assessed within 1-hour.
IHTT Caseload	Number of service users allocated to a named member of staff in the Intensive Home Treatment Team at the end of the period (waiting list allocations are excluded).
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services	
Gender Identity Service: Number on waiting list	The number of referrals open at the end of the period where the service user was waiting for an assessment
Deaf CAMHS: average wait from referral to first face to face (inc. telemedicine) contact in days	For all the referrals in Deaf Child and Adolescent Mental Health Services (CAMHS) receiving their first face-to-face or video contact during the period, the average number of days between referral and the first contact.
Community LD: Percentage of referrals seen within 4 weeks of receipt of referral	Of all the referrals to a Community Learning Disability Team that received their first attended, direct contact in the period, the proportion where the contact took place within 28-days of referral.
Leeds Autism Diagnostic Service (LADS): Percentage starting assessment within 13 weeks (quarterly)	Of all the Leeds Autism Diagnostic Service (LADS) referrals receiving their first direct, attended assessment taking place face-to-face or by video, with an 'Autism Assessment' intervention recorded as part of the contact in the period, the proportion where the assessment took place within 91-days of referral.
CAMHS inpatients: Proportion of people assessed within 7 days of admission (HoNOSCA / GBO) (quarterly)	Of all the admissions to a Child and Adolescent Mental Health Services (CAMHS) ward that received either a Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) or Goal Based Outcomes (GBO) assessment, the proportion where either assessment took place within 7-days of admission.
Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency) (quarterly)	Of all the referrals to the Perinatal Community service with an 'Emergency' or 'Urgent' referral priority that received a first direct, attended contact in the period, the proportion where the contact took place within 48-hours of referral.
Perinatal Community: Percentage of routine referrals waiting less than 2 weeks for assessment (quarterly)	Of all the referrals to the Perinatal Community service with a 'Routine' referral priority that received a first direct, attended face-to-face or video contact in the period, the proportion where the contact took place within 14-days of referral.
Perinatal Community: Total number of distinct women seen in rolling 12 months (quarterly)	The total number of women with a direct, attended, face-to-face or video contact, during the 12-months ending in the period; women seen multiple times are counted once.
Perinatal Community: Face to Face DNA Rate (quarterly)	Of all the face-to-face, attended and did not attend (DNA), contacts with the Perinatal Community Team in the period, the proportion of face-to-face contacts that the service user did not attend.
Services: Our acute patient journey	
Number of admissions to adult facilities of patients who are under 16 years old	Number of admissions to inpatient services, excluding Child and Adolescent Mental Health Services (CAMHS), where the service user was aged under 16 on the day of admission.
Crisis Assessment Unit (CAU) bed occupancy	Of the total number of available beds on the ward and the number of days each bed was available, the proportion of those days where a bed was occupied. For example, on a 10-bed ward in the month of April where no beds were unavailable due to maintenance/repairs, etc., there are 300 available bed days. Where there were service users in beds for 150 of

	those days, this would result in 50% occupancy.
Crisis Assessment Unit (CAU) length of stay at discharge	For all the discharges from the Crisis Assessment Unit in the period, the average number of days each service user stayed on the ward.
Liaison In-Reach: attempted assessment within 24 hours	Of all the service users assessed by Hospital Mental Health Inreach following referral from Leeds Teaching Hospitals Trust (LTHT), the proportion that were assessed within 24-hours of referral.
Bed Occupancy rates for individual wards (multiple measures)	Of the total number of beds available in the period on the ward, the proportion where a service user was occupying the bed, including any leave days.
Percentage of Occupied Bed Days Clinically Ready for Discharge	Of the total number of occupied bed days in the period, the proportion where the service user was ready for discharge from inpatient care.
Out of Area Trajectory Active Placements at Month End (multiple measures)	The total number of out of area placements active at the end of the period, where the placement was not the result of patient choice e.g. where a staff member needed inpatient care.
Total: Number of out of area placements beginning in month (multiple measures)	The total number of all out of area placements that begin during the period.
Total: Total number of bed days out of area (new and existing placements from previous months) (multiple measures)	The total number of occupied bed days that take place as part of an out of area placement during the period, regardless of whether the placement started during or before the period.
Cardiometabolic (physical health) assessments completed: Inpatients (quarterly)	Of the number of service user on a ward at the end of the period, the proportion with all elements of the cardiometabolic assessment completed within the same admission, and during the previous 12-months.
Services: Our Community Care	
Percentage of inpatients followed up within 3 days of discharge (Trust Level monthly local tracking)	Of all discharges from Trust inpatient services, the proportion where the service user received a direct, attended, face-to-face, video or telephone contact within 3-days of discharge (excluding day of discharge).
Percentage of inpatients followed up within 3 days of discharge (HCP commissioned services only)	Of all discharges from Trust Leeds Healthcare Partnership (HCP) commissioned inpatient services, the proportion where the service user received a direct, attended, face-to-face, video or telephone contact within 3-days of discharge (excluding day of discharge).
Number of service users in community mental health team care (caseload)	Number of service users allocated to a named member of staff in an Adult or Older People's community team at the end of the period (waiting list allocations are excluded).
Percentage of referrals to memory services seen within 8 weeks (quarter to date)	Of the number of service users referred to the Memory Assessment Service (MAS) from an external source that do not have a prior Dementia diagnosis, that receive a first direct, attended face-to-face or video contact, the proportion that receive the first contact within 8-weeks of referral.
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	Of all the referrals where the service user receives a Dementia diagnosis in the period, the proportion where the diagnosis was given within 12-weeks of referral.
Early intervention in psychosis (EIP) or at risk mental state (ARMS): Percentage starting treatment within 2 weeks	Of the referrals where a care coordinator allocation starts in the period, or the first direct, attended, face-to-face, video or telephone contact in the referral took place in the period, the proportion where the latest of these two events, took place within 14-days of referral.
Early intervention in psychosis (EIP) : Percentage of people discharged to primary care (quarterly)	Of all the referrals discharged from the Early Intervention in Psychosis service in the period, the proportion where the service user was referred back to Primary Care.
Cardiometabolic (physical health) assessments completed: Early Intervention in Psychosis Service (quarterly)	Of the total number of referrals open to the Early Intervention in Psychosis (EIP) service with a care coordinator allocation active at the end of the period, the proportion with all elements of the cardiometabolic assessment completed during the previous 12-months.
Services: Clinical Record Keeping	
Percentage of service users with NHS Number recorded	Of all the referrals open during the period, the proportion where the service user's NHS number is recorded on their CareDirector record.
Percentage of service users with ethnicity recorded	Of all the referrals open during the period, the proportion where the service user's ethnicity is recorded on their CareDirector record. Where a service user declines to provide an answer, this is counted as complete; however, any ethnicity recorded as 'Unknown' is not counted as complete.
Percentage of service users with sexual orientation recorded	Of all the referrals open during the period, the proportion where the service user's sexual orientation is recorded on their CareDirector record. Where a service user declines to provide an answer or their sexual orientation is recorded as

	'Unknown', this is counted as incomplete.
Services: Clinical Record Keeping - DQMI	
DQMI (MHSDS) % Quality %	The Data Quality Maturity Index (DQMI), is a weighted score based on the completeness and quality of several fields in the Trust's Mental Health Services Dataset (MHSDS) submissions to NHS Digital. The score is derived by NHS Digital from the MHSDS submission and published on their website 3-4 months later.

Agenda item
12

Meeting of the Board of Directors

Paper title:	Chair's Report from the Quality Committee meeting on 11 December 2025
Date of meeting:	29 January 2026
Presented by: (name and title)	Dr Frances Healey, Non-executive Director and Chair of the Quality Committee
Prepared by: (name and title)	Kerry McMann, Head of Corporate Governance

This paper supports the Trust's strategic objective/s (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	
SO3	We use our resources to deliver effective and sustainable services.	✓

This paper relates to the Trust's strategic risk/s (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	✓
SR3	Culture and environment for the wellbeing of staff	
SR4	Financial sustainability	
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

Committee details:	
Name of Committee:	Quality Committee
Date of Committee:	11 December 2025
Chaired by:	Dr Frances Healey, Non-executive Director

ALERT – areas which the committee wishes to escalate as potential areas of non-compliance, that need addressing urgently, or that it is felt Board should be sighted on	
Issue	**Relates to BAF Risk**
No issues to report.	Not applicable

ADVISE – any new areas of monitoring or existing monitoring where an update has been provided to the committee and there are new developments	
Issue	**Relates to BAF Risk**
No issues to report.	Not applicable

ASSURE – specific areas of assurance received warranting mention to Board	
Issue	**Relates to BAF Risk**
The committee reviewed two presentations which provided the highlights of the Gambling Service's and the Leeds Autism Diagnostic Service's Annual Quality Report, focusing on how the services had scored themselves against the Learning, Culture and Leadership (LCL) Framework and the STEEEP dimensions of quality to enable the conditions for high quality care to flourish. Overall, the committee was assured that the services had good systems in place for understanding their quality issues and to drive improvements, and good knowledge of their strengths and weaknesses in relation to learning, culture and leadership. The committee was also assured that the Executive Team had a clear understanding of the services' strengths, weaknesses, challenges and blind spots and how issues were being managed.	SR1 SR2 SR3 SR4 SR5 SR6 SR7
The committee reviewed the Board Assurance Framework and was assured that SR1 and SR2 were being adequately controlled.	SR1 SR2
The committee received and discussed a report which provided an overview of activity relating to the Care Quality Commission (CQC) in 2024/25.	SR1
The committee received a report which provided an update on the plans for the development of the 2025/26 Quality Account.	SR1

REFER - Items to be referred to other Committees	
Issue	**Relates to BAF Risk**
No issues to report.	Not applicable

Recommendation

The Board of Directors is asked to note the update provided.

Agenda item
TBC

Meeting of the Board of Directors

Paper title:	Chair's Report from the Quality Committee meeting on 15 January 2026
Date of meeting:	29 January 2026
Presented by: (name and title)	Dr Frances Healey, Non-executive Director and Chair of the Quality Committee
Prepared by: (name and title)	Kerry McMann, Head of Corporate Governance

This paper supports the Trust's strategic objective/s (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	
SO3	We use our resources to deliver effective and sustainable services.	✓

This paper relates to the Trust's strategic risk/s (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	✓
SR3	Culture and environment for the wellbeing of staff	
SR4	Financial sustainability	
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

Committee details:	
Name of Committee:	Quality Committee
Date of Committee:	15 January 2026
Chaired by:	Dr Frances Healey, Non-executive Director

ALERT – areas which the committee wishes to escalate as potential areas of non-compliance, that need addressing urgently, or that it is felt Board should be sighted on	
Issue	**Relates to BAF Risk**
No issues to report.	Not applicable

ADVISE – any new areas of monitoring or existing monitoring where an update has been provided to the committee and there are new developments	
Issue	**Relates to BAF Risk**
No issues to report.	Not applicable

ASSURE – specific areas of assurance received warranting mention to Board	
Issue	**Relates to BAF Risk**
The committee reviewed an extract from the Board Assurance Framework which detailed strategic risks one and two so that it could be mindful of its responsibilities to assure that these risks were being adequately controlled throughout the course of the meeting.	SR1 SR2 SR3 SR4 SR5 SR6 SR7
The committee received a presentation which provided the highlights of the Working Age Adults Community Mental Health Team's Annual Quality Report, focusing on how the service had scored itself against the Learning, Culture and Leadership Framework and the STEEEP dimensions of quality to enable the conditions for high quality care to flourish. Overall, the committee was assured that the service had good systems in place for understanding its quality issues and to drive improvements, and good knowledge of its strengths and weaknesses in relation to learning, culture and leadership. The committee was also assured that the Executive Team had a clear understanding of the service's strengths, weaknesses, challenges and blind spots and how issues were being managed.	SR1 SR2 SR3 SR4 SR5 SR6 SR7

The committee received the Annual Report on Resuscitation which provided a comprehensive update on all aspects of resuscitation in the Trust and covered the period from December 2024 to December 2025. It noted that there had been 50 incident reports of patients becoming physically unwell in the reporting period and no inpatient cardiac arrests in the organisation during this time. It discussed training compliance and noted that a plan was in place for the Trust to train in-house instructors for infant emergency life support to reduce reliance on external providers.	SR1

REFER - Items to be referred to other Committees	
Issue	**Relates to BAF Risk**
No issues to report.	Not applicable

Recommendation

The Board of Directors is asked to note the update provided.

Agenda item
TBC

Meeting of the Board of Directors

Paper title:	Terms of Reference for the Quality Committee
Date of meeting:	29 January 2026
Presented by: (name and title)	Dr Frances Healey, Non-executive Director and Chair of the Quality Committee
Prepared by: (name and title)	Kerry McMann, Head of Corporate Governance

This paper supports the Trust's strategic objective/s (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	
SO3	We use our resources to deliver effective and sustainable services.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	✓
SR3	Culture and environment for the wellbeing of staff	
SR4	Financial sustainability	
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

Executive summary

The Quality Committee reviewed and approved its terms of reference on 9 October 2025. A further change was then approved on 11 December 2025. The following amendments were made (all amendments highlighted in yellow in the attached document):

- Page two – governance groups updated and note added to reflect that the Director of People and OD's attendance at meetings is dependent on the agenda items being discussed.

- Page three – amendment to clarify that governor observers are offered an opportunity after the

meeting to raise any points of clarification, rather than at the end of the meeting.

- Page six – Updates to titles of documents and frameworks.
- Page seven – sentence added to reflect that the committee has agreed to lead assurance on sexual safety for staff and patients.
- Page nine – job title updated

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? State 'Yes' or 'No'.

No.

Recommendation

The Board is asked to:

- Review the changes made and ratify the revised Terms of Reference.

Quality Committee

Terms of reference

**(Approved by the committee on 11 December 2025
To be ratified by Board of Directors on 29 January 2026)**

1 Name of group / committee

The name of this committee is the Quality Committee.

2 Composition of the group / committee

The members of the committee and those who are required to attend are shown below together with their role in the operation of the committee.

Members: full rights

Title	Role in the group / committee
Non-executive Director	Chair of the meeting. Non-executive directors provide constructive challenge and strategic guidance, and lead in holding the executive to account. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of clinical and other information, and make sure that clinical quality controls, and systems of risk management and governance, are robust and implemented (Code of Governance for NHS Provider Trusts, NHS England 2022)
Non-executive Director	Deputy chair of the meeting. Non-executive directors provide constructive challenge and strategic guidance, and lead in holding the

	executive to account. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of clinical and other information, and make sure that clinical quality controls, and systems of risk management and governance, are robust and implemented. (Code of Governance for NHS Provider Trusts, NHS England 2022)
Director of Nursing and Professions and Director of Infection Prevention and Control	Executive director lead for quality. Chair of the: ~~Patient Experience Group~~ Lived Experience Strategic Group; Trustwide Safeguarding Committee; Professions and Nursing Council; and Infection Prevention Control, Physical Health, Medical Devices and Anti-Microbial Meeting. Assurance and escalation provider to the Quality Committee.
Chief Operating Officer	Executive director with responsibility for oversight and delivery and development of Care Services. Assurance and escalation provider to the Quality Committee.
Medical Director	Joint executive lead for quality. Medical input and Chair of the Trustwide Clinical Governance Group. Assurance and escalation provider to the Quality Committee.
Director of People and Organisational Development	Staff training and development issues related to quality. Assurance and escalation provider to the Quality Committee. Attendance at meetings will be dependent on the agenda items being discussed.
Chief Financial Officer	Executive lead for financial resources including Cost Improvement Programmes. Assurance and escalation provider to the Quality Committee. Attendance at meetings will be dependent on the agenda items being discussed.

While specified board members will be regular members of the Quality Committee any other board member can attend the meeting on an ad-hoc basis if they wish and will be recognised as a member for that particular meeting and if necessary will count towards the quoracy.

2.1 Attendees

The Quality Committee may also invite other members of Trust staff to attend to provide advice and support for specific items when these are discussed in the committee's meetings.

These could include, but are not exhaustive to, the following individuals:

- Associate Director for Corporate Governance
- Deputy Director of Nursing
- Clinical Directors
- Head of Nursing and Patient Experience
- Professional and Clinical Leads

2.2 Governor Observers

The role of the governor at Board sub-committee meetings is to observe the work of the committee, rather than to be part of its work as they are not part of the formal membership of the committee. The governor observes Board sub-committee meetings in order to get a better understanding of the work of the Trust and to observe non-executive directors appropriately challenging the executive directors for the operational performance of the Trust.

At the meeting the governor observer will be required to declare any interest they may have in respect of any of the items to be discussed (even-though they are not formally part for the discussion). Governors will receive an information pack prior to the meeting. This will consist of the agenda, the minutes of the previous meeting and summaries of the business to be discussed. Governor observers will be invited to the meeting by the Corporate Governance Team. The chair of the meeting should ensure that there is an opportunity for governor observers to raise any points of clarification ~~at the end of~~ after the meeting.

2.3 Associate Non-executive Directors

Associate Non-executive Directors (ANEDs) will be invited to attend Board Sub-committee meetings as part of their induction. They will be in attendance at the meeting, in the capacity of observer only, unless invited to contribute by the Chair in circumstances that support the ANEDs development and understanding. This is so the accountability of the substantive members of the committee is maintained.

ANEDs will be invited to meetings by the Corporate Governance Team and will be sent copies of the meeting papers.

3 Quoracy

Number: The minimum number of members for a meeting to be quorate is three. This should comprise at least one non-executive director and one executive director. Attendees do not count towards this number. If the chair is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by the deputy chair.

Non-quorate meeting: Non-quorate meetings may go forward unless the chair decides otherwise. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

Alternate chair: In the absence of the Chair the alternate chair of the meeting will be another non-executive director.

Deputies: Where appropriate, members may nominate deputies to represent them at a meeting. Deputies do not count towards the calculation of whether the meeting is quorate except if the deputy is representing the member under formal "acting up" arrangements. In this case the deputy will be deemed a full member of the committee. It may also be appropriate for attendees to nominate a deputy to attend in their absence. A schedule of deputies can be found in section 10.

4 Meetings of the committee

Meetings may be held face-to-face or remotely as is considered appropriate. Remote meetings may involve the use of the telephone and / or electronic conference facilities.

Frequency: The Quality Committee will meet monthly to transact its normal business.

Urgent meeting: Any committee member may, through the chair, request an urgent meeting. The chair will normally agree to call an urgent meeting to discuss the specific matter unless the opportunity exists to discuss this in a more expedient manner (for example at a Board meeting).

Administrative support: The Corporate Governance Team will provide secretariat support to the committee.

Minutes: Draft minutes will be sent to the chair for review and approval within seven working days of the meeting.

Papers: Papers for the meeting will be distributed electronically by the Corporate Governance Team five working days prior to the meeting. Papers received after this date will only be included if decided upon by the chair.

5 Authority

Establishment: The Quality Committee is a sub-committee of the Board of Directors and has been formally established by the Board of Directors.

Powers: The Quality Committee is constituted as a standing committee of the Trust Board of Directors. The committee is authorised by the Board to investigate and seek assurance on any activity within its terms of reference.

In consultation with the Board of Directors, the committee is able to access independent professional advice and secure the attendance of persons outside the Trust with relevant experience and expertise if it considers this necessary.

Cessation: The Quality Committee is a standing committee in that its responsibilities and purpose are not time limited. It will continue to meet in accordance with these terms of reference until the Trust Board determines otherwise.

6 Role of the committee

6.1 Purpose of the committee

The Quality Committee has responsibility for providing assurance to the Board of Directors on the effectiveness of the:

- Trust's quality, including patient safety, systems and processes
- Quality, including patient safety, of the services provided by the Trust
- control and management of quality, including patient safety, related risks within the Trust.

The quality committee is committed to improving governance on a continuing basis through evaluation and review.

6.2 Guiding principles for members (and attendees) when carrying out the duties of the group / committee

In carrying out their duties members of the committee and any attendees of the committee must ensure that they act in accordance with the values of the Trust, which are:

- we have integrity
- we are caring
- we keep it simple.

6.3 Duties of the group / committee

The Quality Committee is seeking assurance that:

- systems and processes are effective

- quality, including patient safety, of services that the Trust provides is good and continuously improving
- quality of the experience of people using our service is good and continuously improving.

It carries out its duties to provide assurance to the Board of Directors. In addition to this, it is authorised to seek information that will allow it carry out its purpose. It will:

- Seek assurance on systems and processes to ensure monitoring and assessment of the quality, including patient safety, and improvements in services

- Seek assurance on the mechanisms to involve service users, carers, the public and partner organisations in improving services

- Seek assurance on the systems for identifying, reporting, mitigating and managing quality, including patient safety, related risks including the monitoring of incidents, investigations and deaths; and complaints, claims, and compliments

- Review the Board Assurance Framework to seek assurance on behalf of the Board that those strategic risks where it has been listed as an assurance receiver, are being effectively controlled; that the risk score (which has been determined by the executive team) is at the right level; and that any gaps are being addressed appropriately. It may also inform any deep-dive which it may wish to undertake into any area on which is requires further assurance.

- Seek assurance on compliance against the Care Quality Commission's registration and notification requirements and action plans in response to CQC inspection.

- Monitor, scrutinise and provide assurance to the Board of Directors on the Trust's compliance with national standards, including the Care Quality Commission's Fundamental Standards, and the quality elements relating to NHS England's ~~System~~ NHS Oversight Framework, the quality elements within the NHS Standard contract, NICE guidance and CQUIN schemes.

- Seek assurance on the quality impact assessments for key strategic programs of work

- Receive assurance on the work carried out and reported to the Trustwide Clinical Governance Group, including: Quality Plan; Quality Account ~~Report~~; Infection Prevention and Control; Safeguarding; Research and Development; Clinical Audit and NICE; Continuous Improvements; and measuring outcomes across Trust services

- Receive assurance on activity within operational services that contributes to the understanding and improvement of quality, including patient safety, within the Trust.

- Review the draft Internal Audit Annual work plan so it can be assured on the sufficiency of the work the Auditors will carry out in respect of clinical matters. Assurance on this

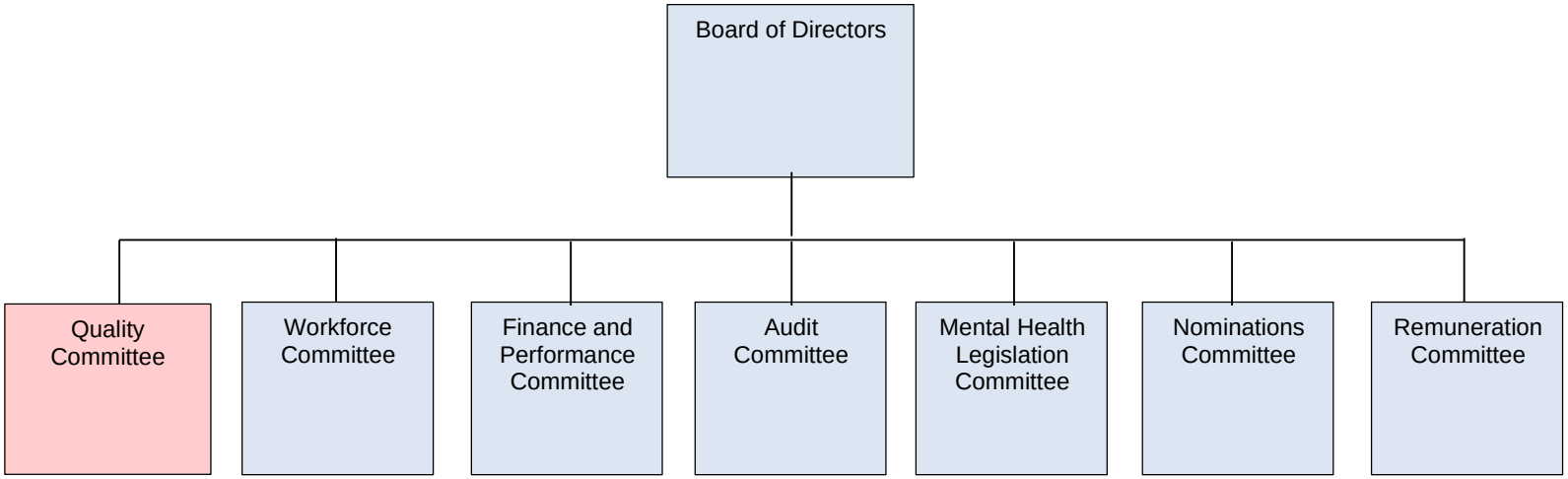
sufficiency (or comments on any matters that should be included) will be provided to the Audit Committee to allow it to approve the overall plan.

- Have oversight of relevant data and specific initiatives in relation to the Equality and Inclusion Agenda as requested by the Board of Directors, recognising the importance of inclusion and accessibility in delivering quality services.
- Carry out the duties of the Maternity Board Safety Champion, with the chair of the committee being the named champion.
- Carry out the role of Hip Fracture, Falls and Dementia Champion
- Carry out the role of Learning from Deaths Champion
- Carry out the role of Children and Young People Champion
- Carry out the role of Resuscitation Champion
- Carry out the role of Safeguarding Champion
- Carry out the role of Palliative and of Life Care Champion

Although the committee's general remit is quality of care for patients, some issues affecting patients and staff are best managed with joint assurance, and the committee has currently agreed to lead assurance on sexual safety for staff and patients

An assurance and escalation report will be made to the Board of Directors by the Chair of the committee.

7 Relationship with other groups and committees



The Quality Committee does not have any sub-committees. It is linked to the Trustwide Clinical Governance Group as an assurance receiver. The Quality Committee provides a route of escalation for this group to the Board of Directors. Although this does not preclude any other group being asked to provide assurance. The committee has a duty to work with other Board sub-committees to ensure matters are not duplicated.

8 Duties of the chairperson

The Chair of the committee shall be responsible for:

- agreeing the agenda with the Director of Nursing~~, Quality~~ and Professions and the Medical Director
- directing the conduct of the meeting ensuring it operates in accordance with the Trust's values
- giving direction to the Committee Secretariat
- ensuring all members have an opportunity to contribute to the discussion
- ensuring the agenda is balanced and discussions are productive, and when they are not productive they are efficiently brought to a conclusion
- deciding when a matter requires escalation to the Board of Directors
- checking the minutes
- ensuring key information is presented to the Board of Directors in respect of the work of the committee
- ensuring that governor observers are offered an opportunity at the end of the meeting to raise any points of clarification.

In the event of there being a dispute between any 'groups' in the hierarchy (in the case of this Board sub-committee, this would be between the Board and the Quality Committee and, in recognition of the nature of matrix working between the work of all Board sub-committees, the Quality Committee and any other Board sub-committee) it will be for the chairs of those groups to ensure there is an agreed process for resolution; that the dispute is reported back to the 'groups' concerned; and that when a resolution is proposed regarding the outcome this is also reported back to the 'groups' concerned for agreement.

The chair of the Quality Committee will also be the named Maternity Board Safety Champion, with the requirements of the role to be discharged through the committee.

9 Review of the terms of reference and effectiveness

The terms of reference shall be reviewed by the committee at least annually and then presented to the Board of Directors for ratification. This will also occur throughout the year if a change has been made to them.

In addition to this the chair must ensure the committee carries out an annual assessment of how effectively it is carrying out its duties and make a report to the Board of Directors including any recommendations for improvement.

Appendix 1a

Schedule of deputies

Full member (by job title)	Deputy (by job title)
NED Chair	Second NED
NED member	None
Director of Nursing and Professions / Director of Infection Prevention and Control	Deputy Director of Nursing
Chief Operating Officer	Deputy Director of Operations
Director of People and Organisational Development	Associate Director
Medical Director	Clinical Director

Agenda item
13

Meeting of the Board of Directors

Paper title:	Director of Nursing and Professions Quarterly Report
Date of meeting:	29 January 2026
Presented by: (name and title)	Nichola Sanderson. Director of Nursing and Professions
Prepared by: (name and title)	Nichola Sanderson Director of Nursing and Professions

This paper supports the Trust's strategic objective/s (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	√
SO2	We provide a rewarding and supportive place to work.	
SO3	We use our resources to deliver effective and sustainable services.	√

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	√
SR2	Delivery of the Quality Strategic Plan	√
SR3	Culture and environment for the wellbeing of staff	
SR4	Financial sustainability	
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	√

Executive summary

This paper provides an update and overview of key programmes of work and progress with the Nursing and Professions Directorate which centre around the continued ambition to provide safe, effective, high-quality care to all who are involved in LYPFT and the wider ICS.

The paper provides assurance with regards to the Culture of Care programme and describes how the Culture of Care and the Lived Experience role is supporting the development of inpatient culture that is inclusive and committed to quality improvement. The Enhanced Therapeutic Observation and Care

(ETOC) programme of work continues to deliver changes to enhance patient care by focusing on a person-centred approach, improved safety and efficient resource management.

The flu campaign has to date achieved a 5% target increase of frontline staff vaccinated against flu, which is positive. Significant work has been completed in relation to inpatient meals, and this is rightly celebrated. The Trust received confirmation that we have retained the 2-star Triangle of Care accreditation.

A recent internal audit showed low assurance in relation to our complaints and claims processes. The work to address this is underway and described in the report.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?
No.

Recommendation

The Board is asked to be assured of the work in progress within the Nursing and Professions Directorate and how this improves patient care and safety alongside improving the skills and knowledge of the nursing and allied health professionals working across LYPFT.

Meeting of the Board of Directors

December 2025

Director of Nursing and Professions Quarterly Report

This paper provides an update and overview of key programmes of work and progress within the Nursing and Professions Directorate, which centers around the continued ambition to provide safe, effective, high-quality care to all who are involved in LYPFT and the wider ICS.

Assure

Culture of Care Update

LYPFT actively engaged in the Culture of Care programme, a national quality transformation initiative led by NHS England for mental health inpatient services. The programme is designed to strengthen the culture within inpatient mental health, learning disability, and autism wards, ensuring that they provide safe, therapeutic, and equitable environments for patients, while also fostering rewarding and supportive workplaces for staff. Established as a two-year pilot across selected wards, the programme is scheduled to conclude in March 2026, with preparations already underway for a phased implementation across inpatient services thereafter.

The Culture of Care Lived Experience role is now a central component of the organisation's Culture of Care implementation plan. The Culture of Care Lived Experience Lead has been fully introduced to all participating wards and is providing leadership on key components of the programme, with the longer-term objective of ensuring that the Culture of Care approach is embedded across all inpatient areas. This role offers critical insight from individuals with direct experience of inpatient services, thereby enhancing programme delivery and strengthening engagement across participating wards.

Through both direct ward involvement and strategic contributions, it will support the development of an inpatient culture that is inclusive and committed to continuous quality improvement. Key responsibilities include strengthening training programmes, such as PMVA, by integrating lived experience into their design and delivery, and embedding the Culture of Care principles throughout. The role is working in close collaboration with the existing Peer Support Workers and other lived experience roles within inpatient services. This includes establishing dedicated service-user focus groups to create a consistent and accessible mechanism for gathering feedback from individuals on the wards participating in the Culture of Care pilot. The aim is to ensure that service-user perspectives are captured routinely and meaningfully, supporting continuous improvement at ward level.

Enhanced Therapeutic Observation and Care

The NHS is caring for more patients with complex needs who require Enhanced Therapeutic Observations and Care (ETOC). The NHS must ensure the workforce is effectively engaged, trained and deployed to provide innovative, patient centred solutions that promote therapeutic and safe care. In August 2024, NHS England launched the ETOC programme, which supports Trusts to make local, clinically led, and patient centred approaches that improve their care provision.

Co-designed with clinical leaders, frontline staff and wider stakeholders, four main pillars have been identified to support systems to provide quality patient care. These four pillars inform the programme strategy:

- Effective leadership and oversight – including governance, data, local assurance, clinical policy making.
- Effective person-centred and safe therapeutic care – including identifying the need for ETOC, monitoring and stepdown.
- Effective education and training – ensuring that that staff are trained in reviewing, providing and overseeing ETOC.
- Effective workforce planning and deployment – planning for levels of ETOC, ensuring that ETOC is considered during safe staffing establishment setting processes.

Services are sharing that the demand for enhanced therapeutic observations and enhanced care has been increasing across the organisation, evidenced through LYPFT seeing a rise in temporary staffing costs associated with acuity and observations. In July 2025, LYPFT joined the NHSE ETOC collaborative programme.

The initial focus within LYPFT was engaging services with the work and establishing a steering group and a governance structure. The ETOC steering group was set up in August 2025, and it feeds into the Trusts safer staffing and positive and safe workstreams. It also provides updates to Quality Committee.

Data insights enhance patient care by enabling a person-centred approach, improved safety, and efficient resource management. Within the steering group it was recognised that as an organisation, our data regarding observations wasn't clear or easily accessible.

Being able to measure the ETOC metrics will mean that services will understand their workforce deployment, ETOC demand and quality and safety incidences that occur when patients are under a restrictive intervention such as ETOC. This means that by capturing the ETOC data there is an opportunity for robust oversight into the delivery of ETOC resulting in an ability to track progress and act where required.

So far changes have been made to:

- Healthroster

  The categories for additional/bank duties where reviewed as it was felt the categories didn't reflect reasons for requesting additional staff outside of sickness/vacancies, therefore ETOC was added as a category with reasons such as risk to self, risk to others and physical health included in reasons. What this has allowed is on increased oversight and awareness of bank shifts requested and reasons when related to observation in ward areas. This supports services to think about workforce deployment and service need, such as valuable data to support establishment reviews, identify any themes and inform training.

  The aim is for a monthly report to be shared through the Trust Safer Staffing Group.

- Datix

Changes have been made to our Datix system meaning that recording incidents on observations and the different levels are now mandatory. A staff category section has now also been added to capture incidents affecting staff when on observations as previously, observations were only recorded on Datix for incidents affecting patients. Dashboards have been set up so this information can be reviewed by ward managers and above. This supports staff wellbeing being factored into the work.

- Care Director

LYPFT use Care Director as our EPR system and until now recording of observations has been on paper records with an observation care plan and signing sheets for recording of observations. A form has now been created on Care Director to record the observation level. The patients care plan is used to describe the interventions and care required. This is currently being piloted across 6 inpatient wards.

Due to the move to the form on Care Director, observation levels can then be viewed on a dashboard allowing local and service oversight. A further Trust dashboard will be developed allowing increased oversight of observations across the organisation.

Next steps

- Review training package as currently it is an i-learn package. The aspiration is to create face to face training, linking the work with other programs such as Culture of Care and ensure that ETOC is factored into all training delivered (where applicable).
- Review pilot of recording of observations with the intention to roll out Trust wide. A review of the pilot is due to take place in January 2026.
- Review workforce deployment and cultures as part of safer staffing work and establishment reviews.

Advise

Vaccination Campaign
The below are the vaccine uptake figures collated at the end of week 13 into the campaign. The Trust has achieved the 5% target increase of frontline staff vaccinated against flu from what was recorded at the end of 2024/25 vaccine campaign at 33%. LYPFT is currently at 38.3%. In December 2024 frontline staff flu vaccine uptake was 31%.

Staff Uptake
- Frontline staff flu vaccine - 956 = 38.3%.
- Trust wide overall flu vaccine – 1122 = 28.5%

Service User uptake
- Flu vaccine - 71 inpatients
- Covid-19 vaccine – 30 inpatients

Introduction of a recruitment process for graduating students

In 2017 LYPFT introduced a recruitment process for graduating students, providing they each met set criteria. The process was conditional based and not guaranteed. The aim was to reduce recruitment delays and build on our relationship with all the universities and promote LYPFT as a first choice of employer for the students graduating. It was at a time when Band 5 vacancies were more prolific nationally and we recognised that several Leeds students did not continue in Leeds post-graduation and we wanted to improve this.

This approach was successful in significantly increasing the number of Leeds based students that were recruited and over time reducing the number of Band 5 vacancies. This was to such an extent that in 2024 we over recruited to Band 5 vacancies and in 2025 there were challenges in identifying suitable positions for new graduates.

Therefore, a Task and Finish Group convened over the summer months to review workforce data and therefore determine the actions required in relation to recruitment and retention across LYPFT. This work recognised the reduction in Band 5 vacancies across the Trust. During the September 2025 meeting, the group concluded that the existing approach to graduate recruitment would not fully meet the needs of students or the Trust for 2026.

The key reasons for this were:

Limited scope of the career conversation approach – Managers reported the process was not related to the specific clinical areas and prevented them from forming an accurate view of candidates' clinical judgment and skills.

Feedback on interview experience – Recruiting managers highlighted that Leeds graduates often lack formal interview experience at Band 5 level. This creates challenges later when these nurses apply for Band 6 posts, as they have had limited exposure to structured interview processes.

Financial position of the NHS – In previous years, we were able to over recruit Band 5 positions because we anticipated that the number of vacancies would exceed the number of graduates, this year the number of graduates is greater than the predicted number of vacancies.

Safer staffing – consideration is to be given for the number of preceptees and new starters in clinical teams to ensure safe staffing levels and appropriate staff development, this will ensure that the number of preceptees match with the capacity of those providing preceptorship, to support role modelling and the right level of support.

The Task and Finish Group have designed a new process which the students are actively being informed about and supported to engage in. The aim remains to support as many local students into LYPFT positions as possible, and support will be available to students from the Practice Learning Development Team throughout.

In summary the process is now: -

- Students will be invited to a clinical service information event and to be able to ask questions

about the service before deciding where to apply.

- They will need to complete a standard application form for roles they interested in, up to a maximum of 3 positions. These vacancies will only be available to Leeds cohorts during this process and will only be opened more widely following the completion of this process.
- Students will be guaranteed an interview for the vacancies they apply for (up to the maximum of 3). These will be competitive interviews.
- The standard recruitment process will then apply, including all pre-employment checks and successful entry onto the NMC register.

Update on letter received from a student nurse regarding guaranteed recruitment on graduation
The Director of Nursing and Professions has completed a written response to the student nurse who raised several concerns with regards to RMN recruitment at LYPFT following graduation. The student raised several questions, and the Director of Nursing provided a robust written response, with an offer of a career conversation and ongoing support. The student has stated he is satisfied with the response.

CQC CAMHS visit and subsequent report
The CQC report following the CAMHS visit is due at the end of January 2026. The Nursing Directorate board report will provide an update for the next quarter.

Inpatient Mealtimes
Dr Susan Guthrie, Principal Speech and Language Therapist has successfully published a paper in the Mental Health Nursing Journal**.** https://onlinelibrary.wiley.com/doi/10.1111/inm.70212 The paper describes the findings of patients' perspective on inpatient mealtimes, insights on swallowing, mental wellbeing and recovery. 13 patients took part in the study aged between 20 and 60 years across a range of inpatient services at LYPFT. Strong emotions associated with mealtimes were shared by the participants. With experience of mealtimes being largely negative, including increased stress and anxiety compared to home mealtimes. The queuing system presented emotional challenges, with increased frustration at not receiving the food ordered, as well as the food being unappealing. Sharing of mealtimes was highlighted, with participants describing care for others by offering food or drink as an important part of maintaining relationships. Others felt the closed dining room environment on the ward as perceived to exacerbate relationships issues between patients. The study highlighted both the positive and negative aspects of mealtimes and how these can influence mental wellbeing for adults with mental illness. Lack of choice and autonomy are not well recognised and are currently overlooked in mental health recovery.

In addition to the publication of the paper. the accessible summary (video) has had great interest over the last few months also. This research has been disseminated at several conferences and interest groups to a range of healthcare professionals. Dr Guthrie's thesis has had 300+ views. The next step is to complete and submit a paper summarising staff and Speech and Language Therapist perspectives, and a write up of our quality improvement project.

Recordings of clinical session procedure for all professional groups C-0094
This procedure is now live. It relates to the audio or video recordings of any clinical interaction (or clinical supervision) by a clinician. These types of recordings are most often made to support training or accreditation requirements. It stipulates the consent and information governance processes required in order that the data is stored, shared with relevant partners using the correct method and deleted safely. Information sharing agreements must be in place.

The key messages are:

1. The key issues addressed by this procedure relate to recording therapy sessions for training, clinical supervision and professional accreditation purposes.
2. This procedure applies to all recordings in the organisation whether interaction was face to face or virtual.
3. This procedure applies to all members of staff who record sessions for the above purposes. It forms part of the Trust's overall approach to information.
4. Security and Information Governance. It is informed by and related to several key policies such as email use, cloud and MS Office 365, video platform therapy, information security, information governance and data retention. Further information on recording service users on Teams can be found on Staffnet.

Clinical supervision training

This training continues to be offered inhouse, and facilitated by core professions including psychological professionals, nurses, and a range of staff from the AHP group. An evaluation report this year has prompted a refresh of the content in line with feedback and indicates that attendance is higher from some service areas. The Trust will continue to promote the training. There has been recent recruitment of more facilitators (who offer around a half day a month each) that will allow more slots and teams can request a dedicated date. In addition, as there is a high non-attendance/cancellation rate the team will over book for a period to review if this increase capacity and attendance.

Racial Equity Community of Practice Group

The facilitation of this group has now been handed over to Alex Perry, Consultant Clinical Psychologist and Lynn Chibage, Clinical Engagement and Inclusion Coordinator. It has now moved online and continues to meet once a month.

Triangle of Care Accreditation

In December 2025, we received confirmation from the Carers Trust that we had successfully retained the 2-star Triangle of Care (TOC) accreditation for the period 2025–2026. This achievement reflects the Trust's ongoing commitment to embedding a 'think carer' ethos across all services.

The Carers Trust commended us for maintaining accreditation and for demonstrating progress in the following areas:

- Governance and accountability.
- Carer involvement in care planning.
- Staff training on carer engagement.
- Confidentiality and information sharing.
- Partnerships with local carer support organisations.

The Carers Trust highlighted opportunities for improvement, such as strengthening our data collection, enhancing carer information provision across teams and ensuring consistent carer involvement in discharge planning and self-assessments.

The Director of Nursing and Professions supports an ambitious TOC Strategic Plan to be introduced in 2026, overseen by the Patient and Carer Experience Team. Key objectives include increasing clinical

leads' accountability for achieving the six Triangle of Care standards, embedding Triangle of Care principles into everyday clinical practice, and driving measurable improvements in carer engagement and experience.

Alert

Progression Following Claims & Complaints Audit
An internal audit completed in November 2025 showed low assurance for the Trust's current approach to managing claims and complaints. The audit highlighted weaknesses in the systems used to define and monitor claims and complaints performance and compliance metrics, as well as the absence of formal processes for triangulating and reviewing claims and complaints data to support organisational learning and effective risk identification. Whilst the audit outcome was low assurance, Audit Yorkshire acknowledged the developments planned by the team to strengthen these processes. The Clinical Governance Team has committed to delivering a revised Claims Procedure by the end of January 2026 and a revised Complaints Procedure by the end of March 2026.

Since the audit, significant improvements have been implemented. The Complaints Consent Form has been updated to include identity verification for individuals providing consent, ensuring appropriate access to and sharing of confidential information during investigations. Clinical engagement has been strengthened by adding Clinical Leads to the initial distribution list upon receipt of complaints and ensuring that final responses are shared with them, accompanied by a request to disseminate learning through established Tier 3 governance structures. The Investigator Pack has undergone a comprehensive review and update. Pilot testing commenced on 23 December 2025 to ensure usability and effectiveness in supporting robust investigations. Feedback from participants in the pilot will be used to inform any further refinements.

Stakeholder engagement has been a key focus for the complaints process improvement work. A process design session was held with clinical and operational colleagues, including RACI mapping, and individual meetings have been arranged with service lines unable to attend. Questionnaires have been circulated to service users, carers, and staff to gather feedback on both the complaints and claims processes through multiple forums, including Trust-wide communications, clinical governance routes, and the service user/carer involvement database. As of 5 January 2026, 15 service user/carer and 32 staff responses have been received. The questionnaires will close on 7 January 2026 to allow responses to be reviewed and considered as part of the procedure. In addition, the Trust's Complaints Procedure is being revised to ensure full compliance with the Local Authority Social Services and NHS Complaints (England) Regulations 2009, while the Claims Procedure has been updated to meet NHS Resolution expectations, including compliance with reporting guidelines, pre-action protocols, and statutory requirements. The revised Claims Procedure has been circulated for comment.

To strengthen organisational learning, a new Oversight and Improvement Group, chaired by the Head of Nursing has been established. This group will review complaints, claims, and incident data, triangulate themes and trends, commission task-and-finish groups, and monitor the impact of improvement actions.

These changes represent a significant step towards improving governance, compliance, and learning across the Trust in respect of complaints and claims.

Independent Investigation – Mr P

In June 2022, Mr P violently assaulted Ms B. Police investigations indicated that Mr P and Ms B were in a relationship, although the precise nature of this relationship remains unclear. In May 2023, Mr P was convicted of the murder of Ms B and received a custodial sentence with a minimum term of 29 years.

In January 2023 NHS England commissioned an Independent Mental Health Homicide Review (IMHHR), undertaken by Psychological Approaches, to review the psychiatric care and treatment provided to Mr P. The review examined involvement from the following LYPFT services:

- Community Mental Health Team (CMHT)
- Adult Liaison Psychiatry Service (ALPS)
- Intensive Support Service (ISS)
- Crisis Service
- Crisis Assessment Unit
- Inpatient Centre
- Street Triage

The full investigation report has been shared with all relevant stakeholders in order to progress the recommendations. An Executive Summary was published on 14 January 2026 and is available via the following link:
https://www.england.nhs.uk/north-east-yorkshire/wp-content/uploads/sites/49/2026/01/Mr-P_Exec_summary_Publication.pdf.

Nichola Sanderson
Director of Nursing & Professions
January 2026

Agenda item
13.1

Meeting of the Board of Directors

Paper title:	LYPFT 2 Month Safer Staffing Review Report
Date of meeting:	29 January 2026
Presented by: (name and title)	Nichola Sanderson, Director of Nursing
Prepared by: (name and title)	Alison Quarry, Deputy Director of Nursing Miriam Blackburn, Head of Nursing Jennifer Connelly, Professional Lead Nurse Adele Sowden, E-Rostering Team Manager

This paper supports the Trust's strategic objective/s (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	✓
SO3	We use our resources to deliver effective and sustainable services.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

Executive summary

This paper draws on the NHS National Quality Board (2016) reporting requirements to ensure that nursing and care staffing, capacity and capability is enabled to deliver high quality care and the best possible outcomes for patients whilst balancing quality and financial objectives and acknowledging the ongoing pressures experienced in relation to staffing and resource.

The paper contains a high-level overview of data and analysis to provide the Board of Directors and the public with information on the position of Leeds and York Partnership Trust wards staffing against safer staffing levels between 1st October to 28th November 2025.

This report states that one clinical shift during the period in question were without a registered nurse and sets out the measures implemented to maintain patient safety.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? **State below, 'Yes' or 'No'.**

NO

If yes, please set out what action has been taken to address this in your paper.

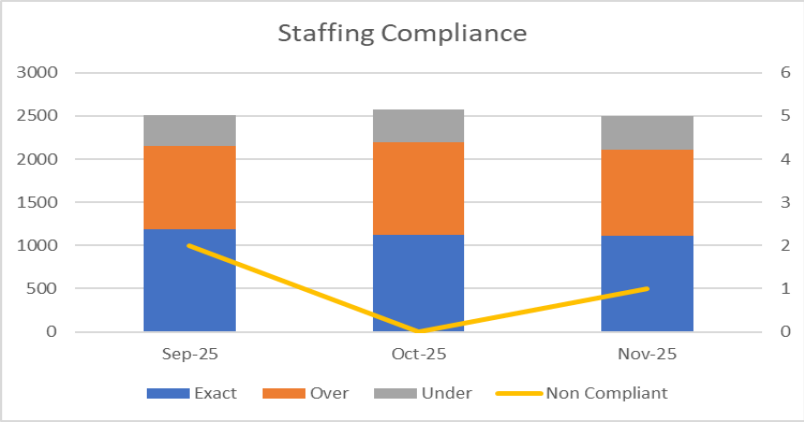
Recommendation

The Board is asked to:

- Note the content of the report.
- Be assured that arrangements are in place to monitor, support and mitigate any impact of reduced staffing levels or skill mix in relation to patient safety.

Safer Staffing: Inpatient Services – October 2025 to November 2025

	Number of Shifts		
	Sept	**Oct**	**Nov**
Exact	1188	1120	1111
Over Compliance	963	1072	995
Under Compliance	362	387	398
Non-Compliant	2	0	1



Risks: Registered Nursing vacancies continue to be a major theme across the focussed areas highlighted by the Unify data (Appendix A).

Mitigating Factors: Reduced Registered Nurse fill rates are being partially mitigated in many of our units by increasing Healthcare Support Worker (HSW) duties through Bank and Agency staffing to reach minimum staffing numbers. Ongoing improvements to the recruitment strategy and a multi-professional approach to a review of establishments, continues to be progressed. An annual establishment review using an evidenced-based approach is embedded in process.

Narrative on Data Extracts Regarding LYPFT Staffing Levels on x28 Wards during November 2025: This is the whole time equivalent (WTE) number of staffing posts the inpatient wards are funded for to deliver planned level of care and interventions within their speciality by shift.

Staffing compliance: This tells us whether the wards met the planned numbers of staffing during a shift. The planned staffing numbers do not necessarily reflect the actual staffing need on any given duty as this may fluctuate dependent on current patient group and need.

Exact or Over Compliant shifts: Compliance data shows a slight decrease in the number of shifts that were staffed precisely as planned between October and November 2025. In November, there was a reduction in the number of Registered Nurse and Health Support Worker duties staffed above the planned establishment. Where wards are operating above their baseline staffing levels, this is often in response to the need for enhanced observations to ensure safe and effective care delivery.

Under Compliant Shifts: There was an increase in the number of shifts worked under the planned establishment in October and again in November 2025. This is reflective of the previous safer staffing report where increases were also noted. Those shifts that are under compliant may be due to a range of reasons. In some instances, it may not be operationally necessary to allocate staff to all vacant duties; particularly if there are vacant beds or service users are on leave. Additionally, the multidisciplinary team may provide sufficient support to maintain safe and effective care delivery. At times, shifts may be intentionally left unfilled, with teams adhering to the staffing escalation and deployment protocol during these periods. Further work is required to capture these changes on Healthroster to ensure the need is reflected accurately.

These figures, albeit a relatively small difference, support positively the current trust priorities work to reduce the temporary workforce expenditure.

*(Note this differs from the unify report in Appendix A which shows the total hours over the month rather than on a shift-by-shift basis).

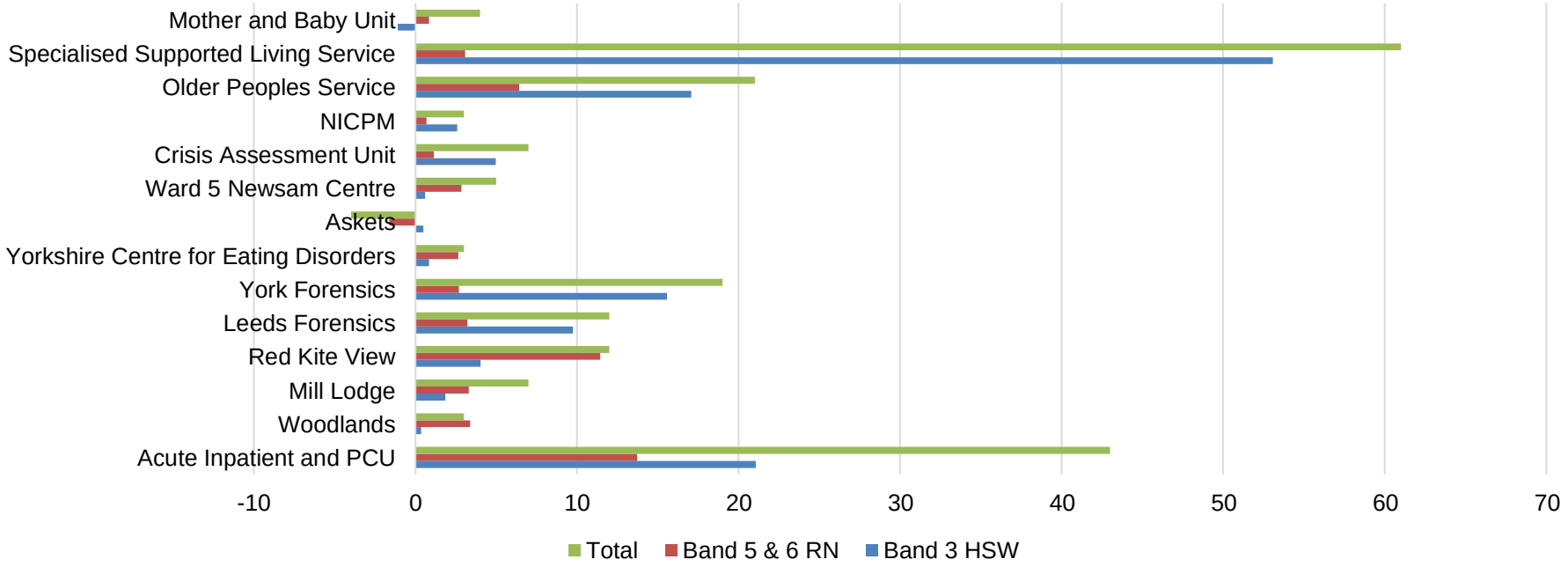
Non-Compliant Shifts: This metric represents the number of shifts where no Registered Nurse was on duty. This occurred once in November 2025 due to unexpected sickness absence. On the 5th November 2025 the Registered Nurse at 2 Woodland Square was absent from the day duty due to illness. The Band 4 Nursing Associate on 2 Woodlands Square was supported by the Registered Nurse from 3 Woodland Square. The ward manager who is also a Registered Nurse, who would ordinarily assume responsibility for cover, was unavailable due to annual leave.

The specialist nature of this service proves difficult to identify unplanned cover or deploy a Registered Nurse from other areas of the Trust with the appropriate skills and competencies. The Nursing Associate, who was on duty, administered medication which is within scope of their practice and co-ordinated the shift with support provided by the Registered Nurse from the neighbouring ward within the service at 3 Woodland Square.

Vacancies

The below chart indicates the total number of vacancies across each service as reported on ECHO in November 2025. The vacancies are across the multidisciplinary teams and not solely related to Registered Nurses and Health Support Workers, which are roles traditionally viewed in the safer staffing figures. Alongside this are the Registered Nurse and Band 3 Health Support Worker vacancies taken from the finance data for November.

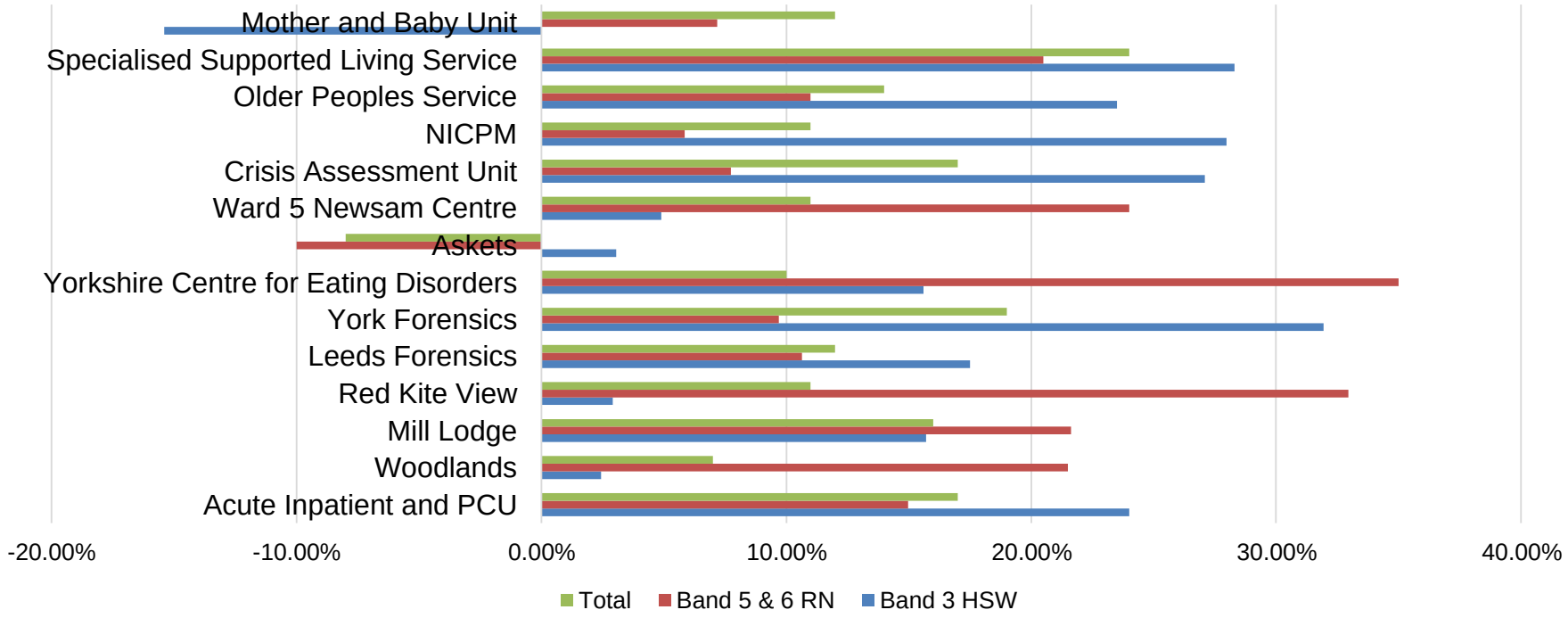
Although Registered Nurses and Health Support Workers are those reported in the safer staffing figures, it is important to recognise the range of roles within the multidisciplinary teams for providing safe and effective care in our ward establishments which is not accurately captured in the unify data (Appendix A). The highest number of vacancies remain within the Older People's Service, Acute Inpatient and PICU and the Specialised Supported Living Service as highlighted in the previous report albeit the vacancies have reduced on both the Acute Inpatient and PICU and Older Peoples Service.



The below chart indicates the total % of vacancies across each service as reported on ECHO in November 2025. This applies to multidisciplinary teams as a whole and is not limited to Registered Nurses and Health Support Workers, who have traditionally been the focus of safer staffing data. The highest percentage of vacancies remain within the York Forensic Services and the Specialised Supported Living Service as was noted in the previous two monthly report. The chart also includes the % vacancies for Registered Nurses and Band 3 Healthcare Support Workers for each service taken from the finance data for November 2025.

Ongoing recruitment initiatives are currently in progress, aimed at addressing existing workforce gaps. These efforts are complemented by the scheduled onboarding of Registered Nurse Preceptees, some of those who have been successfully recruited have taken up positions in October. The recent uplift in Health Care Support Workers in Acute Inpatients and PICU has created additional vacancies. There is currently a recruitment campaign to support teams with the recruitment of Healthcare Support Workers. An evaluation of these recruitment initiatives has been discussed through the safer staffing governance. The evaluation concluded that adopting a webinar first approach showed promise as an effective recruitment method, enhancing engagement and improving candidates' understanding prior to submitting applications. Although the conversion rate had demonstrated some improvement this was lower than anticipated. The Recruitment and Resourcing Service intends to deliver a further Health Support Worker Recruitment Webinar and appointment campaign in January 2026, incorporating the improvements identified through the evaluation.

The table below indicates that a number of wards are currently over-recruited. This position arises from a combination of factors, notably the backfilling of posts to cover maternity and other long-term absence, together with planned recruitment aligned to forthcoming service expansion in the Mother and Baby unit.


Mother and Baby Unit
Specialised Supported Living Service
Older Peoples Service
NICPM
Crisis Assessment Unit
Ward 5 Newsam Centre
Askets
Yorkshire Centre for Eating Disorders
York Forensics
Leeds Forensics
Red Kite View
Mill Lodge
Woodlands
Acute Inpatient and PCU
-20.00%
-10.00%
0.00%
10.00%
20.00%
30.00%
40.00%
Total
Band 5 & 6 RN
Band 3 HSW

Safer Staffing Group

The Trust's Safer Staffing Steering Group continues to meet on a monthly basis, with a focus on evaluating the safety and quality of staffing across inpatient services, identifying improvement workstreams through ongoing learning, and the oversight the staffing establishment review process. The six-monthly MHOST data collection was carried out during September 2025. The data has since been analysed, and the annual establishment reviews are now in progress across all inpatient areas, with completion expected by February 2026.

Several workstreams commissioned through the Safer Staffing Steering Group have now concluded, and following consultation at a Service User Network (SUN) Spotlight event, which focussed on an approach to move away from the concept of care being delivered by Registered Nurses and Health Support Workers towards a more integrated multidisciplinary team (MDT) approach to the delivery of care. The next step is to hold discussions within the Safer Staffing Steering Group about embedding this approach into practice.

The Trust has recently engaged in the national Enhanced Therapeutic Observation and Care Programme (ETOC). The programme supports Trusts to make local, clinically led, and patient centred approaches that improve care provision. ETOC is one of the main reasons for additional staff being required on inpatient areas above the establishment. Within LYPFT, an ETOC Steering Group has commenced and has progressed changes to the Trusts e-rostering system, making changes to the 'reason' options for booking additional staff. The group has also commenced a pilot of electronic observation care plans which have historically been paper based. The group continues to work through a range of improvements as part of the programme which includes a review of the Trusts training. Regular updates on programme will be shared through the Safer Staffing Group.

Summary

A sustained reduction in overall vacancies across inpatient areas is expected over the coming months, with some improvements already noted, driven by recent recruitment campaigns and the onboarding of newly qualified Preceptee Nurses. The recent uplift in Health Care Support Workers in Acute Inpatients and PICU has generated further Band 3 vacancies, the new Trustwide initiative to recruit Health Care Support Workers established will address this need alongside other local initiatives.

There has been a reduction in the number of Registered Nurse and Health Support Worker duties staffed above the planned establishment. A combination of factors such as application of the staffing escalation tool and more effective integration of our multi-disciplinary teams will have supported this reduction. The delivery of care through the multidisciplinary team and the professional specific roles which is not captured in the planned staffing establishment should be considered when reviewing the data.

Recommendations:

The Board is asked to:

- Discuss and note the content of the report.
- Be assured of the arrangements in place to monitor, support and mitigate the impact of reduced staffing levels and skill mix in relation to quality and safety in inpatient setting.

APPENDIX A

Safer Staffing: Inpatient Services October 25

Fill rate indicator return
Staffing: Nursing, Care Staff and AHPs

Ward name	Cumulative count	Care Hours Per Patient Day (CHPPD)							Day				Night				Allied Health	
		Registered	Non-registered	Registered	Non-registered	Registered	Non-registered	Overall	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill
WardName	PatientCo	CHPPD_RI	CHPPD_NI	CHPPD_RI	CHPPD_NI	CHPPD_RA	CHPPD_NI	CHPPD_O	AvgFR_RN	AvgFR_NR	AvgFR_RN	AvgFR_NR	AvgFR_RN	AvgFR_NR	AvgFR_RN	AvgFR_NR	AvgFR_RA	AvgFR_NR
2 WOODLAND SQUARE	113	9.3	7.6	1.4	0.0	0.0	0.0	18.3	93%	184%	100%	-	100%	107%	100%	-	-	-
3 WOODLAND SQUARE	91	8.7	20.3	1.7	0.0	0.0	0.0	30.7	57%	187%	100%	-	100%	122%	100%	-	-	-
ASKET CROFT	564	1.6	2.5	0.0	0.0	0.8	0.0	4.9	91%	85%	-	-	103%	102%	-	-	100%	-
ASKET HOUSE	465	2.0	1.4	0.0	0.0	0.8	0.0	4.2	137%	44%	-	-	117%	97%	-	-	100%	-
BECKLIN CAU	147	5.3	18.5	0.0	0.4	0.0	0.0	24.2	127%	94%	-	100%	97%	138%	-	-	-	-
BECKLIN WARD 1	666	2.2	4.6	0.5	0.0	0.3	0.0	7.6	86%	275%	100%	-	82%	243%	100%	-	100%	-
BECKLIN WARD 3	671	2.2	3.7	0.0	0.4	0.3	0.3	6.8	70%	324%	100%	100%	96%	168%	100%	100%	100%	100%
BECKLIN WARD 4	680	2.5	3.7	0.3	0.0	0.2	0.1	6.9	95%	224%	100%	-	96%	205%	100%	-	100%	100%
BECKLIN WARD 5	680	2.7	7.1	0.1	0.0	0.2	0.1	10.2	103%	365%	100%	-	98%	360%	-	-	100%	100%
MOTHER AND BABY AT THE MOUNT	222	6.4	5.6	0.0	0.0	0.0	0.0	11.9	100%	83%	-	-	84%	123%	-	-	-	-
NEWSAM WARD 1 PICU	372	4.1	7.8	0.0	0.5	0.7	0.1	13.2	86%	107%	-	100%	92%	117%	-	100%	100%	100%
NEWSAM WARD 2 FORENSIC	360	3.0	11.8	0.0	0.2	0.1	0.0	15.0	101%	101%	-	100%	104%	120%	-	100%	100%	-
NEWSAM WARD 2 WOMENS SERVICES	341	3.5	9.3	0.2	0.0	0.0	0.5	13.5	113%	127%	100%	-	124%	137%	-	-	-	100%
NEWSAM WARD 3	400	3.2	4.9	0.0	0.1	0.0	0.0	8.2	102%	97%	-	-	139%	106%	-	100%	-	-
NEWSAM WARD 4	646	2.4	3.1	0.2	0.0	0.4	0.2	6.3	76%	196%	100%	-	94%	139%	100%	-	100%	100%
NEWSAM WARD 5	968	1.3	2.1	0.2	0.0	0.9	0.3	4.8	97%	76%	100%	-	73%	91%	100%	-	100%	100%
NEWSAM WARD 6 EDU	782	1.6	5.3	0.2	0.0	0.5	0.1	7.7	106%	881%	100%	-	58%	259%	-	-	100%	100%
NICPM LGI	346	4.2	2.8	0.0	0.0	1.0	0.0	8.0	115%	90%	-	-	85%	132%	-	-	100%	-
RED KITE VIEW GAU	294	5.6	10.2	0.7	0.0	0.0	0.0	16.5	90%	83%	100%	-	91%	115%	100%	-	-	-
RED KITE VIEW PICU	141	11.6	21.7	1.0	0.0	0.0	0.0	34.2	125%	88%	100%	-	95%	102%	100%	-	-	-
THE MOUNT WARD 1 NEW (MALE)	424	3.5	9.3	0.0	0.0	0.0	0.0	12.8	165%	124%	-	-	97%	182%	-	-	-	-
THE MOUNT WARD 2 NEW (FEMALE)	398	4.0	9.1	0.0	0.2	0.0	0.0	13.4	98%	102%	100%	100%	95%	168%	-	100%	-	-
THE MOUNT WARD 3A	539	2.7	3.7	0.0	0.2	0.0	0.0	6.6	83%	100%	100%	100%	100%	104%	-	100%	-	-
THE MOUNT WARD 4A	644	2.4	4.0	0.4	0.0	0.0	0.0	6.9	92%	135%	100%	-	100%	158%	100%	-	-	-
YORK - BLUEBELL	310	3.6	8.3	0.0	0.0	0.5	0.3	12.7	113%	99%	100%	-	107%	113%	-	-	100%	100%
YORK - MILL LODGE	233	7.1	9.0	0.5	0.0	1.5	1.6	19.5	87%	100%	100%	-	86%	151%	-	-	100%	100%
YORK - RIVERFIELDS	277	3.9	6.3	0.0	0.0	0.6	0.6	11.5	97%	152%	-	-	103%	100%	-	-	100%	100%
YORK - WESTERDALE	310	3.5	8.6	0.0	0.5	0.3	0.6	13.5	103%	135%	-	100%	100%	100%	-	-	100%	100%

*** Allied health professionals refers only to Occupational therapists that are included in the ward establishment**

Safer Staffing: Inpatient Services November 25

Ward name	Cumulative count	Care Hours Per Patient Day (CHPPD)							Day				Night				Allied Health	
		Registered	Non-registered	Registered	Non-registered	Registered	Non-registered	Overall	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill
WardName	PatientCo	CHPPD_RI	CHPPD_NI	CHPPD_RI	CHPPD_NI	CHPPD_R/	CHPPD_NI	CHPPD_O	AvgFR_RNI	AvgFR_NRI	AvgFR_RN/	AvgFR_NRI	AvgFR_RNI	AvgFR_NRI	AvgFR_RN/	AvgFR_NRI	AvgFR_RAI	AvgFR_NR/
2 WOODLAND SQUARE	103	9.2	8.4	1.4	0.0	0.0	0.0	19.0	85%	245%	100%	-	100%	110%	-	-	-	-
3 WOODLAND SQUARE	100	8.4	18.3	1.3	0.0	0.0	0.0	28.0	67%	197%	100%	-	100%	122%	100%	-	-	-
ASKET CROFT	536	1.5	2.6	0.0	0.0	0.8	0.0	4.9	91%	85%	-	-	100%	102%	-	-	100%	-
ASKET HOUSE	471	1.8	1.8	0.0	0.0	0.6	0.0	4.2	125%	67%	-	-	100%	114%	-	-	100%	-
BECKLIN CAU	153	4.6	18.1	0.3	0.1	0.0	0.0	23.1	109%	100%	100%	100%	113%	143%	-	-	-	-
BECKLIN WARD 1	637	2.4	6.9	0.4	0.0	0.3	0.0	10.1	91%	462%	100%	-	78%	388%	100%	-	100%	-
BECKLIN WARD 3	637	2.3	3.1	0.0	0.3	0.2	0.2	6.2	70%	186%	100%	100%	100%	119%	-	100%	100%	100%
BECKLIN WARD 4	671	2.6	2.5	0.2	0.0	0.3	0.1	5.7	103%	125%	100%	-	92%	144%	100%	-	100%	100%
BECKLIN WARD 5	662	2.7	7.0	0.1	0.0	0.3	0.1	10.2	105%	307%	100%	-	99%	366%	100%	-	100%	100%
MOTHER AND BABY AT THE MOUNT	226	6.5	5.4	0.4	0.0	0.0	0.0	12.2	103%	93%	100%	-	88%	118%	100%	-	-	-
NEWSAM WARD 1 PICU	360	4.2	8.2	0.0	0.6	0.8	0.4	14.2	85%	109%	-	100%	90%	133%	-	100%	100%	100%
NEWSAM WARD 2 FORENSIC	360	2.9	10.6	0.0	0.0	0.4	0.0	13.9	97%	109%	-	100%	101%	115%	-	-	100%	-
NEWSAM WARD 2 WOMENS SERVICES	289	3.9	10.8	0.4	0.0	0.0	0.1	15.3	106%	132%	100%	-	108%	144%	-	-	-	100%
NEWSAM WARD 3	384	2.7	5.2	0.0	0.1	0.3	0.0	8.3	92%	100%	-	-	117%	103%	-	100%	100%	-
NEWSAM WARD 4	619	2.4	2.8	0.2	0.0	0.4	0.2	6.0	83%	171%	100%	-	82%	132%	100%	-	100%	100%
NEWSAM WARD 5	902	1.4	2.0	0.3	0.0	0.9	0.3	4.9	94%	80%	100%	-	85%	80%	100%	-	100%	100%
NEWSAM WARD 6 EDU	704	1.7	6.0	0.2	0.0	0.6	0.2	8.7	99%	1163%	100%	-	66%	254%	-	-	100%	100%
NICPM LGI	326	4.2	3.1	0.0	0.0	1.0	0.0	8.4	117%	102%	-	-	86%	133%	-	-	100%	-
RED KITE VIEW GAU	270	6.0	11.2	0.8	0.0	0.0	0.0	18.0	99%	88%	100%	-	85%	122%	100%	-	-	-
RED KITE VIEW PICU	99	15.9	26.5	0.7	0.0	0.0	0.0	43.1	83%	72%	100%	-	93%	110%	100%	-	-	-
THE MOUNT WARD 1 NEW (MALE)	422	3.9	8.5	0.2	0.0	0.0	0.0	12.6	143%	105%	100%	-	97%	195%	100%	-	-	-
THE MOUNT WARD 2 NEW (FEMALE)	386	4.3	11.2	0.2	0.1	0.0	0.0	15.8	101%	130%	100%	100%	102%	213%	-	-	-	-
THE MOUNT WARD 3A	533	2.7	4.0	0.0	0.2	0.0	0.0	6.9	90%	108%	-	100%	99%	131%	100%	-	-	-
THE MOUNT WARD 4A	626	2.5	3.4	0.5	0.0	0.0	0.0	6.4	99%	112%	100%	-	100%	139%	100%	-	-	-
YORK - BLUEBELL	300	3.8	7.2	0.0	0.0	0.3	0.2	11.5	118%	78%	-	-	100%	101%	-	-	100%	100%
YORK - MILL LODGE	208	7.5	8.7	1.2	0.0	1.9	1.2	20.5	89%	99%	100%	-	77%	145%	100%	-	100%	100%
YORK - RIVERFIELDS	252	4.9	5.7	0.0	0.0	0.5	0.6	11.6	120%	108%	-	-	104%	97%	-	-	100%	100%
YORK - WESTERDALE	300	3.9	8.6	0.0	0.1	0.4	0.4	13.4	125%	121%	-	100%	107%	106%	-	-	100%	100%

*** Allied health professionals refers only to Occupational therapists that are included in the ward establishment**

Agenda item
14

Meeting of the Board of Directors

Paper title:	Chair's Report from the Workforce Committee meeting on 4 December 2025
Date of meeting:	29 January 2026
Presented by: (name and title)	Zoe Burns-Shore, Non-executive Director and Chair of the Workforce Committee
Prepared by: (name and title)	Rose Cooper, Deputy Head of Corporate Governance

This paper supports the Trust's strategic objective/s (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	
SO2	We provide a rewarding and supportive place to work.	✓
SO3	We use our resources to deliver effective and sustainable services.	

This paper relates to the Trust's strategic risk/s (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

Committee details:	
Name of Committee:	Workforce Committee – Part A
Date of Committee:	4 December 2025
Chaired by:	Zoe Burns-Shore, Non-executive Director

ALERT – areas which the committee wishes to escalate as potential areas of non-compliance, that need addressing urgently, or that it is felt Board should be sighted on	
Issue	**Relates to BAF Risk**
No issues to report.	

ADVISE – any new areas of monitoring or existing monitoring where an update has been provided to the committee and there are new developments	
Issue	**Relates to BAF Risk**
The Committee noted the increase in the number and complexity of concerns being raised to the Freedom to Speak Up Guardian (FTSUG) as outlined in the People and Organisational Development Governance Group Chair's Report and was mindful of how this would be resourced if numbers continued to increase. It was agreed that the Trust's FTSUG would be sent an open invitation to attend the Workforce Committee going forward to give them the opportunity to be part of the discussion at each meeting.	SR1
The Committee heard about plans to develop a clear process for supporting workplace adjustments to mitigate the organisational risk. The Committee noted that this was an issue which was reflected in the Staff Survey results and noted the increase in employment tribunal claims linked to disability discrimination. It was agreed that an update on the workplace adjustments process would be scheduled for the next Committee meeting in February 2026 to provide further assurance on this matter.	SR3
The Committee heard that the Trust was well positioned in terms of compulsory training alignment to the Core Skills Training Framework (CSTF); however, NHS England was introducing a new outcomes-driven competency framework which would require organisations to undertake further work in readiness for the rollout in April 2027.	SR3

ASSURE – specific areas of assurance received warranting mention to Board	
Issue	**Relates to BAF Risk**
The Committee reviewed the Board Assurance Framework so that it could be mindful of its responsibility to assure that SR3 was being adequately controlled through the course of the meeting. The Committee was assured that SR3 was being adequately controlled; considered whether it was receiving assurance on any gaps through the reports it was already receiving; and agreed that it did not require any further assurance on the way in which SR3 was being managed.	SR3

The Committee received an update on the Leeds Recovery College staff wellbeing programme. The Committee praised the holistic approach to supporting staff wellbeing and noted the benefits of this programme for building resilience and reducing sickness absence linked to stress and anxiety and highlighted the importance of this programme continuing. The Committee was also pleased to note the successful adaptation of the Wellness Recovery Action Plan (WRAP) course for staff from Global Majority backgrounds. The Committee noted the high demand for courses which were often oversubscribed.	SR3
The Committee received the report on the actions being taken by the organisation to support care leavers into employment at the Trust, in response to a request from the Council of Governors. The Committee was pleased with the approach being taken and fully supported the proposal to include care leaver candidates within the Guaranteed Interview Scheme. It was noted that this outcome would be reported to the next Council of Governors' meeting in February 2026.	SR3
The Committee received a report which summarised the Trust's reward and recognition activities, including engagement with the Spotlight platform and the Shine and Thrive Summer Roadshow. The Committee praised the People Engagement Team for their time and hard work in developing high impact and cost-effective schemes that maintain recognition and foster a culture of appreciation.	SR3
The Committee received a benchmarking paper on suicide prevention and postvention for staff and was assured that the Trust's provision was largely in line with the benchmarks.	SR3

REFER - Items to be referred to other Committees	
Issue	**Relates to BAF Risk**
No items to be referred.	

Recommendation

The Board of Directors is asked to note the update provided.

Agenda item
15

Meeting of the Board of Directors

Paper title:	Chair's Report from the Audit Committee meeting on 20 January 2026
Date of meeting:	29 January 2026
Presented by: (name and title)	Martin Wright, Non-executive Director and Chair of the Audit Committee
Prepared by: (name and title)	Kieran Betts, Corporate Governance Officer

This paper supports the Trust's strategic objective/s (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	✓
SO3	We use our resources to deliver effective and sustainable services.	✓

This paper relates to the Trust's strategic risk/s (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	✓
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	✓

Committee details:	
Name of Committee:	Audit Committee
Date of Committee:	20 January 2026
Chaired by:	Martin Wright, Non-executive Director

ALERT – areas which the committee wishes to escalate as potential areas of non-compliance, that need addressing urgently, or that it is felt Board should be sighted on	
Issue	**Relates to BAF Risk**
No issues to which the Board needs to be alerted.	N/A

ADVISE – any new areas of monitoring or existing monitoring where an update has been provided to the committee and there are new developments	
Issue	**Relates to BAF Risk**
The "Claims and Complaints Management" internal audit report was received with an opinion of low assurance. The Committee was assured by the actions being taken to address the issues identified in the report and was reassured that all actions remained on track for completion within the agreed timelines. It also noted that this remained a key area of importance for the Trust and emphasised the need for the updated Complaints Management Procedure, the new oversight group, and other planned improvements to be fully embedded across the Trust. It agreed that this item should be referred to the Quality Committee for further assurance on the improvements in this area.	SR1, SR3, SR4, SR5, and SR7
The "Delivering Financial Efficiencies" internal audit report was received with a split assurance opinion with the 'Governance' elements receiving an overall opinion of significant assurance, and the 'Outturn' receiving an overall opinion of limited assurance. The Committee noted that the findings of the audit were not surprising to the Trust and was reassured that the Trust remained committed to delivering a viable Cost Improvement Programme (CIP). It was additionally reassured that the findings of the audit supported the idea that the Trust had good governance arrangements in this area and noted that the Trust had consistently delivered on its previous financial targets.	SR4
The Committee agreed that the planned "Data Quality: Clinical Quality Dashboard" internal audit should be postponed and included instead on the 2026/27 internal audit plan due to delays in the development of the new Clinical Quality Dashboard. It agreed that the freed capacity within the 2025/26 audit plan would be used for an audit of the Annual Service Quality Reports.	SR1

ASSURE – specific areas of assurance received warranting mention to Board	
Issue	**Relates to BAF Risk**
The Committee was assured that good progress had been made on the delivery of the 2025-26 internal audit plan, with 83% of the plan completed to date and the remainder	SR1, SR3, SR4, SR5,

on track to be completed by the end of the financial year. It noted that it had received the following internal audit reports since its last meeting on 21 October 2025: • Health Equity – Significant assurance • Retention and Wellbeing – Significant assurance • Salary Overpayments Benchmarking – Benchmarking only The Committee agreed that the Health Equity report should be referred to the Quality Committee asking it to consider whether the planned actions with 2027 completion dates were appropriately timed. It also agreed that the Retention and Wellbeing report should be referred to the Workforce Committee, suggesting that the Committee might focus on addressing the issues regarding data noted in the report. The Committee was assured with the findings of the Salary Overpayments benchmarking report, noting that this was a particular area of strength for the Trust, which performed in the top quartile across the majority of the benchmarks measured.	SR6 and SR7
The Committee received the findings of Audit Yorkshire's independent validation of completed audit recommendations, which found that of the 38 closed recommendations assessed, four lacked sufficient evidence to support closure. The Committee noted that these actions had been reopened.	N/A
The Committee received and noted the contents of the Outstanding Audit Actions Report. It noted that there were no overdue actions and 23 actions within a revised target date as of 20 January 2026. It was additionally reassured that no audit actions would be deferred due to the ongoing planned acquisition of Leeds Community Healthcare NHS Trust, but that there was scope for actions to be superseded by new actions where it was deemed appropriate.	SR1
The Committee received and noted the contents of the Local Counter Fraud Progress Report. It noted the ongoing work of the Counter Fraud team to streamline NHS Counter Fraud Authority's 124 fraud risk descriptors to 44 risks which still met all governance requirements. The Committee noted that because of this work, the Trust may only achieve partial compliance with Component 3 of the Counter Fraud Functional Standards in 2025/26, but that this would recover to full compliance by 2026/27. It also noted that, while there were no current fraud investigations, four payroll-to-payroll data matches had been identified and would be subject to further investigation.	SR4
The Committee received and noted the Q3 2025–26 Health and Safety (H&S) Quarterly Update and was reassured that no H&S enforcement actions were taken against the Trust during the reporting period. It noted that future quarterly reports received would focus on environmental H&S factors, with clinical and workforce H&S issues instead reported to the Quality Committee and Workforce Committee respectively. The Committee stressed the need for clear data source references, particularly where subsets of data were used. It also confirmed that the Annual Health and Safety Report received by the Committee would remain a comprehensive, overarching report to ensure full oversight while avoiding duplication with other reports, such as the Quality Account.	SR3 and SR5

The Committee received the External Audit Risks and Early Reflections for 2025–26 and was reassured that the identified risks were consistent with those from previous years. It noted the updated Trust materiality of £5.52m (for individual errors) and £6.5m (for the financial statements as a whole), calculated using the Trust's 2025/26 total revenue forecast, along with the planned external audit timeline and the agreed total audit fees.	SR4
The Committee noted and was assured that there were no tender waivers nor quotation waiver reports for the period of 1 October 2025 – 31 December 2025. It noted that there had been one instance in the period where the lowest-value tender was not accepted due to higher technical expertise demonstrated by an alternative bidder relating to capital work at North Wing, St Mary's House.	SR4

REFER - Items to be referred to other Committees	
Issue	**Relates to BAF Risk**
It was agreed that the findings of the Claims and Complaints Management internal audit report would be referred to the Quality Committee for additional consideration of where assurance needs to be strengthened.	SR1, SR3, SR4, SR5, and SR7
It was agreed that the Health Equity internal audit report would be referred to the Quality Committee, with a focus on the Committee determining the appropriateness of the implementation timeframes for certain audit recommendations.	SR1 and SR7
It was agreed that the Retention and Wellbeing internal audit report would be referred to the Workforce Committee, with a focus on obtaining the data needed to support the report's finding that the Trust's processes were effective in this area.	SR3, SR4, and SR5
It was agreed that issues regarding the compliance rates with Health and Safety training identified in Appendix 5 of the Q3 2025–26 Health and Safety (H&S) Quarterly Update would be referred to the Workforce Committee.	SR3 and SR5

Recommendation

The Board of Directors is asked to note the update provided.

Agenda item
15.1

Meeting of the Board of Directors

Paper title:	Terms of Reference for the Audit Committee
Date of meeting:	29 January 2026
Presented by: (name and title)	Martin Wright, Non-executive Director and Chair of the Audit Committee
Prepared by: (name and title)	Kieran Betts, Corporate Governance Officer

This paper supports the Trust's strategic objective/s (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	
SO3	We use our resources to deliver effective and sustainable services.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	✓
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

Executive summary

The Audit Committee reviewed and approved its Terms of Reference on 21 October 2025. The following substantive amendments were made (as highlighted in red in the attached document).

- Section 6.3 – Quality Account (page 6) – Updated all references from "Quality Report" to "Quality Account" to reflect updated regulations.

- Section 6.3 – Internal Audit (page 8) - Updated section on Internal Audit to note that the Internal Audit function needs to meet the “Global Internal Audit Standards”, as opposed to “Public Sector Internal Audit Standards” to accurately reflect a change in the standards used.
- Section 6.3 – Counter Fraud (page 8) – Updated the section on Counter Fraud in two ways:
    1. To reflect that the role and responsibilities of counter fraud are based on Government functional standard 013 and the NHS Counter Fraud’s Authority’s interpretation of these standards (“The NHS Requirements”). Previously the section noted that these responsibilities were governed by “Section 47 of the Base Model Contract between Foundation Trusts and PCTs and Schedule 13 of this contract…” but this information is no longer relevant.
    2. Updated the items in the counter fraud section on which the Committee is to be assured to reflect the updated guidance issued in the March 2024 Healthcare Financial Management Association NHS audit committee handbook.

In addition, several minor changes were made to the Terms of Reference which are not highlighted in red, including:

- Standardising the capitalisation of proper nouns throughout the document (e.g. Chair of the Committee” rather than “chair of the committee”).
- Standardising how “Associate Non-executive Directors” are referred to in the document.
- Amending the governance structure diagram on page 9 so that the Audit Committee is correctly highlighted in this diagram, rather than the Workforce Committee.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? State ‘Yes’ or ‘No’.

No.

Recommendation

The Board is asked to:

- Review the changes made and ratify the revised Terms of Reference.

Audit Committee

Terms of reference

**(Approved by the Audit Committee on 21 October 2025
To be ratified by the Board of Directors)**

1 Name of Committee

The name of this Committee is the Audit Committee.

2 Composition of the Committee

The members of the Committee and those who are required to attend are shown below together with their role in the operation of the Committee.

Members

Title	Role in the Committee
Non-executive Director (Chair of the Committee)	Committee Chair and responsible for evaluating the assurance given and identifying if further consideration / action is needed. Non-executive Directors provide constructive challenge and strategic guidance, and lead in holding the executive to account. In particular, Non-executive Directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of clinical and other information, and make sure that clinical quality controls, and systems of risk management and governance, are robust and implemented. (Code of Governance for NHS Provider Trusts, NHS England 2022)
2 Non-executive Directors	Responsible for evaluating the assurance given and identifying if further consideration / action is needed.

	Non-executive Directors provide constructive challenge and strategic guidance, and lead in holding the executive to account. In particular, Non-executive Directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of clinical and other information, and make sure that clinical quality controls, and systems of risk management and governance, are robust and implemented. (Code of Governance for NHS Provider Trusts, NHS England 2022)

While specified Non-executive Directors will be regular members of the Audit Committee, any other Non-executive Director can attend the meeting on an ad-hoc basis if they wish and will be recognised as a member for that particular meeting and if necessary will count towards the quoracy.

Attendees

Title	Role in the Committee	Attendance guide
Chief Financial Officer	Key responsibilities regarding audit and reporting	Every meeting
Internal Audit representation	Independent assurance providers	Every meeting
External Audit representation	Independent assurance providers	Every meeting
Local Counter Fraud representation	Independent assurance providers	Dependant on the agenda
Associate Director for Corporate Governance	Committee support and advice	Every meeting

The Chair of the Audit Committee shall be seen as independent and therefore must not Chair any other governance committee either of the Board of Directors or wider within the Trust.

Executive Directors and other members of staff may attend by invitation in order to present or support the presentation of agenda items / papers to the Committee. Executive Directors will be invited to attend a meeting where a low assurance and/or limited assurance report has been issued by Internal Audit and is on the agenda to be discussed.

The Chair of the Trust and the Chief Executive will be invited to attend the Audit Committee once per year.

2.1 Governor Observers

The role of the Governor at Board Sub-committee meetings is to observe the work of the Committee, rather than to be part of its work as they are not part of the formal membership of the Committee. The Governor observes Board Sub-committee meetings in order to get a better understanding of the work of the Trust and to observe Non-executive Directors appropriately challenging the Executive Directors for the operational performance of the Trust.

At the meeting the Governor observer will be required to declare any interest they may have in respect of any of the items to be discussed (even-though they are not formally part for the discussion). Governors will receive an information pack prior to the meeting. This will consist of the agenda, the minutes of the previous meeting and summaries of the business to be discussed. Governor observers will be invited to the meeting by the Corporate Governance Team. The Chair of the meeting should ensure that there is an opportunity for Governor observers to raise any points of clarification at the end of the meeting.

2.2 Associate Non-executive Directors

Associate Non-executive Directors (ANEDs) will be invited to attend Board Sub-committee meetings as part of their induction. They will attend the meeting in the capacity of observer only, unless invited to contribute by the Chair in circumstances that support the ANEDs development and understanding. This is so the accountability of the substantive members of the Committee is maintained.

ANEDs will be invited to meetings by the Corporate Governance Team and will be sent copies of the meeting papers.

3 Quoracy

Number: The minimum number of members for a meeting to be quorate is two. Attendees do not count towards this number.

Deputies: Non-executive Directors do not have deputies. Non-core Non-executive Directors may be asked to attend if there is a risk to the meeting not being quorate.

Attendees should nominate a deputy to attend in their absence. A schedule of deputies, attached at appendix 1, this should be reviewed at least annually to ensure adequate cover exists.

Non-quorate meeting: Non-quorate meetings may go forward unless the Chair decides otherwise. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

Alternate Chair: If the Chair of the Audit Committee is not available the meeting shall be chaired by one of the other Non-executive Directors.

4 Meetings of the Committee

Meetings may be held face-to-face or remotely as is considered appropriate. Remote meetings may involve the use of the telephone and / or electronic conference facilities.

Frequency: The Audit Committee will normally meet as required but will in any case meet no fewer than four times per year.

Urgent meeting: Any of the Committee members may, in writing to the Chair, request an urgent meeting. The Chair will normally agree to call an urgent meeting to discuss the specific matter unless the opportunity exists to discuss the matter in a more expedient manner (for example at a Board meeting).

Minutes: Draft minutes will be sent to the Chair for review and approval within seven working days of the meeting.

Papers: Papers for the meeting will be distributed electronically by the Corporate Governance Team five working days prior to the meeting. Papers received after this date will only be included if decided upon by the Chair.

Private Sessions of the Committee

At least once a year the Committee will meet privately with representatives from internal audit and external audit.

At the discretion of the Chair of the Committee, it may also choose to meet privately with the Chief Financial Officer and any other key senior officer in the Trust as may be required.

Members of the Committee will also meet together in private at a frequency determined by the Chair.

5 Authority

Establishment: In accordance with the NHS Act 2006 and the Code of Governance the Board of Directors is required to establish an Audit Committee as one of its Sub-committees.

Powers: The Committee is a Non-executive Committee of the Board of Directors and has no executive powers. The Committee is authorised by the Board of Directors to seek assurance on any activity. It is authorised to seek any information or reports it requires from any employee, function, group, or committee; and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board of Directors to obtain outside legal or other independent

professional advice and to secure the attendance of persons outside the Trust with relevant experience and expertise if it considers this necessary.

Cessation: The Audit Committee is a standing Committee in that its responsibilities and purpose are not time limited. While the functions of the Audit Committee are required by statute the exact format may be changed as a result of its annual review of its effectiveness.

In addition, the Trust should periodically review its governance structure for continuing effectiveness and as a result of such a review the Board may seek to alter the format or the number of Non-executive Director core members of the Audit Committee.

6 Role of the Committee

6.1 Purpose of the Committee

The purpose of the Audit Committee is to provide the Board of Directors with assurance that:

- Clinical, financial reporting, compliance, risk management, and internal control principles and standards are being appropriately applied and are effective, reliable, and robust
- An effective governance framework is in place for monitoring and continually improving the quality of health care provided to service users to enable the Trust's strategic objectives to be achieved.

Objective	How the Committee will meet this objective
We deliver great care that is high quality and improves lives	The Audit Committee has a core responsibility to scrutinise the Trust's governance arrangements to determine that these are operating effectively and that the Trust is able to provide high quality care through these arrangements.
We use our resources to deliver effective sustainable care	The Audit Committee exercises scrutiny of the annual financial reporting of the organisation; on-going financial health; and controls designed to deliver efficiency, effectiveness, and economy for all Trust functions

6.2 Guiding principles for members (and attendees) when carrying out the duties of the Committee

In carrying out their duties, members of the Committee and any attendees of the Committee must ensure that they act in accordance with the values of the Trust, which are:

- We have integrity
- We are caring
- We keep it simple.

6.3 Duties of the Committee

Notwithstanding any area of business on which the Committee wishes to receive assurance the following shall be those items on which the Committee shall receive assurance:

Board Assurance Framework

- Be assured that the organisation has in place an effective Board Assurance Framework
- Be presented with the Board Assurance Framework and receive assurance that this presents the up-to-date position in respect of controls, assurances and that gaps are being addressed, and be assured as to the completeness of the information included in the Framework
- Use the Board Assurance Framework to inform the Committee's forward work plan, in particular focussing on those gaps that pose a major risk to the organisation.

Quality Account

- Be assured in respect of the process for delivering the Quality Account with the submission of a paper which explains how the Quality Account has been populated.

Risk Management

- Receive assurance as to the Risk Management Process (including structures processes and responsibilities for managing key risks), including the process for capturing and reviewing high and extreme risks
- Carry out the duties of Safety and Risk Champion.

Health and Safety

- Receive an annual report and regular update reports on health and safety management within the Trust
- Have oversight quarterly of the progress against the Health and Safety action plan
- Carry out the duties of the Health and Safety Champion.

Compliance and Disclosure Statements

- Be assured of the action taken by officers who have operated outside of the tender and quotation procedures

- Be presented with notification of any waivers of the Standing Financial Instructions and Standing Orders (for the Board of Directors and Board of Governors) and be assured of their appropriateness.

Annual Accounts and Annual Report

- Be presented with and review the main items / contentious items in the Annual Accounts, taking advice from the Chief Accounting Officer and the External Auditors as to accuracy, prior to advising the Board if the Accounts can be adopted
- Be presented with the ISA260 Report on the Annual Accounts and be assured as to the findings and the management actions agreed, also be assured that either there were no (or otherwise) significant findings
- Be presented with a periodic report setting out the progress against the recommendations made in the ISA 260 reports (pertaining to the last set of annual accounts) and be assured as to progress against recommendations / action plans.

Annual Governance Statement and Head of Internal Audit Opinion

- Be presented with the draft Annual Governance Statement and have an opportunity to input to the content
- Be presented with the final version of the Annual Governance Statement and be assured that it provides an accurate picture of the processes of internal control within the organisation
- Be presented with the Head of Internal Audit Opinion and be assured that this is an accurate assessment of the Trust and also be assured that the opinion is in accordance with the Annual Governance Statement.

Registers

- Be presented with the Losses and Special Payments Report to be assured as to the appropriateness of payments made and that control weaknesses have been addressed
- Be presented with the Sponsorship Register to be assured that it is complete, and that sponsorship received by the organisation / individuals is appropriate and has been applied for according to the procedure
- Be presented with the Hospitality Register to be assured that it is complete, and that hospitality received by individuals is appropriate, proportionate, and unable to be considered an inducement and has been recorded according to the procedure
- Be presented with the register of Management Consultants to be assured that it is complete and that consultants have been appointed appropriately, and according to the procedure.

Internal Audit

- The Committee shall ensure there is an effective Internal Audit function established by management that meets mandatory Global Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

    - Consideration of the provision of the Internal Audit service, the cost of the audit function and (where the service is provided in-house) any questions of resignation and dismissal
    - Review and approval of the Internal Audit strategy, operational plan, and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation
    - Consideration of the major findings of Internal Audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources
    - Ensuring that the Internal Audit function is adequately resourced and has appropriate standing with the organisation.

External Audit

- The Committee shall review the work and findings of the External Auditor. In addition to this the Committee will:

    - Make recommendations to the Council of Governors as to the appointment, reappointment, termination of appointment and fees of the External Auditor, and if the Council of Governors rejects the Audit Committee's recommendations, it will prepare an appropriate statement for the Board of Directors to be included in the Trust's Annual Report
    - Review the audit program of work and fees and discuss with the External Auditor, before audit work commences, the nature and scope thereof
    - Review External Audit reports together with the management response, and the annual governance report (or equivalent)
    - Consider whether it is appropriate and beneficial to the Trust for the External Auditor to undertake investigative and advisory work for the Trust.

Counter Fraud

- Every NHS organisation is required by the NHS standard contract to have a counter fraud function. The counter fraud function's role and responsibilities are based on the "Government functional standard 013: counter fraud (counter fraud standard)" and its

interpretation for the NHS, “the NHS requirements”, which are defined and supported by the NHS Counter Fraud Authority (NHSCFA).

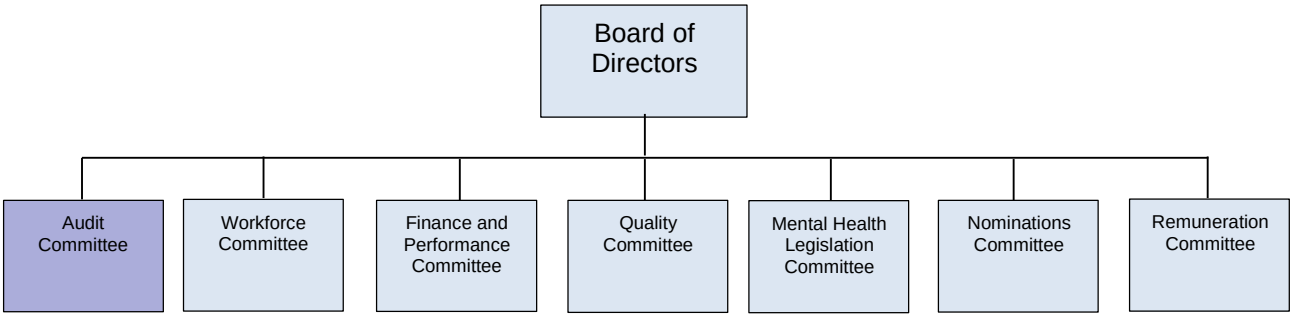
- The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery, and corruption that meet the NHSCFA’s standards and shall review the outcomes of work in these areas.
- With regards to the Local Counter Fraud Specialist it will:
    - Review, approve, and monitor counter fraud work plans
    - Receive regular updates on counter fraud activity
    - Monitor the implementation of action plans
    - Discuss NHSCFA quality assessment reports
    - Receive a copy of the counter fraud functional standard return for awareness and to be reassured that the submission is consistent with the counter fraud progress updates presented to the Committee throughout the year

7 Relationship with other groups and committees

The Audit Committee is the primary governance committee providing an overarching governance role, having a direct relationship with other Board Sub-committees.

The Board Sub-committees will provide one of the main sources of assurance to the Audit Committee. However, this assurance will be validated by the work of, and reports from other sources of assurance including, but not exclusively, Internal Audit, External Audit, and Counter Fraud Services.

The following is a diagram setting out the governance structure in respect of assurance.



The Committee has a duty to work with other Board Sub-committees to ensure matters are not duplicated.

8 Duties of the Chairperson

The Chair of the Committee shall be responsible for:

- Agreeing the agenda
- Directing the meeting ensuring it operates in accordance with the Trust's values
- Giving direction to the minute taker
- Ensuring everyone at the meeting has a reasonable chance to contribute to the discussion
- Ensuring discussions are productive, and when they are not productive they are efficiently brought to a conclusion
- Deciding when it is beneficial to vote on a motion or decision
- Checking the minutes
- Ensuring sufficient information is presented to the Board in respect of the work of the Committee
- Ensuring the Chair's report is submitted to the Board as soon as possible.
- Ensuring that governor observers are offered an opportunity at the end of the meeting to raise any points of clarification.

In the event of there being a dispute between any 'groups' in the hierarchy (in the case of this Board sub-committee, this would be between the Board and the Audit Committee and, in recognition of the nature of matrix working between the work of all Board sub-committees, the Audit Committee and any other Board sub-committee) it will be for the Chairs of those groups to ensure there is an agreed process for resolution; that the dispute is reported back to the 'groups' concerned; and that when a resolution is proposed the outcome is also reported back to the 'groups' concerned for agreement.

9 Review of the Terms of Reference and effectiveness

The Terms of Reference shall be reviewed by the Committee at least annually and then presented to the Board of Directors for ratification, where there has been a change.

In addition to this the Chair must ensure the Committee carries out an annual assessment of how effectively it is carrying out its duties and make a report to the Board of Directors including any recommendations for improvement, along with any remedial action to address weaknesses. The Chair will also be responsible for ensuring that the actions to address any areas of weakness are completed.

Appendix 1a

Schedule of deputies

It may not be necessary or appropriate for all members (or attendees) to have a deputy attend in their absence. If this is the case please state below "no deputy required".

Full member (by job title)	**Deputy (by job title)**
Non-executive Director (Chair of the Committee).	Either one of the Non-executive Directors.

Attendee (by job title)	**Deputy (by job title)**
Chief Financial Officer	Deputy Director of Finance
Associate Director for Corporate Governance	Head of Corporate Governance

Agenda item
16

Meeting of the Board of Directors

Paper title:	Terms of Reference for the Mental Health Legislation Committee
Date of meeting:	29 January 2026
Presented by: (name and title)	Kaneez Khan, Non-executive Director and Chair of the Mental Health Legislation Committee
Prepared by: (name and title)	Kieran Betts, Corporate Governance Officer

This paper supports the Trust's strategic objective/s (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	
SO3	We use our resources to deliver effective and sustainable services.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	✓
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

Executive summary

The Mental Health Legislation Committee reviewed and approved its Terms of Reference on 4 November 2025. The following minor changes were approved to be made to the Terms of Reference:

- Updating the format of the document so that it is presented in the new Trustwide ToR template.
- Standardising the capitalisation of proper nouns throughout the document (e.g. Chair of the Committee" rather than "chair of the committee").
- Standardising how "Associate Non-executive Directors" are referred to in the document.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? State 'Yes' or 'No'.

No.

Recommendation

The Board is asked to:

- Review the changes made and ratify the revised Terms of Reference.

Mental Health Legislation Committee

Terms of reference

**(Approved by the Mental Health Legislation Committee on 4 November 2025
To be ratified by the Board of Directors)**

1 Name of Committee

The name of this Committee is the Mental Health Legislation Committee

2 Composition of the Committee

The members of the Committee and those who are required to attend are shown below together with their role in the operation of the Committee

Members: full rights

Title	Role in the Committee
Non-executive Director	Committee Chair and responsible for evaluating the assurance given and identifying if further consideration / action is needed. Non-executive Directors provide constructive challenge and strategic guidance, and lead in holding the executive to account. In particular, Non-executive Directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of clinical and other information, and make sure that clinical quality controls, and systems of risk management and governance, are robust and implemented. (Code of Governance for NHS Provider Trusts, NHS England 2022)
Non-executive Director	Deputy Chair and responsible for evaluating the assurance given and identifying if further consideration / action is needed. Non-executive Directors provide constructive challenge and strategic guidance, and lead in holding the executive to account. In particular, Non-executive Directors should scrutinise the performance of the executive management in meeting agreed

	goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of clinical and other information, and make sure that clinical quality controls, and systems of risk management and governance, are robust and implemented. (Code of Governance for NHS Provider Trusts, NHS England 2022)
Medical Director	Executive Director with MHL Knowledge
Director of Nursing and Professions	Executive Director with links to CQC

In attendance: in an advisory capacity

Title	Role in the group / committee	Attendance guide
Associate Medical Director for Mental Health Legislation	Advisory and technical expertise	Every meeting
Head of Service (Adult Social Care, Leeds)	Linkage to Local Authority	Every meeting
Head of Mental Health Legislation	Advisory and technical expertise	Every meeting
Deputy Chair of Mental Health Act Managers Forum	MHAM's perspective, experience, and concerns	Every meeting
Chair of the MHL Operational Steering Group	Linkage to Services, Chair of the MHL Operational Steering Group	Every Meeting
Associate Director for Corporate Governance	Linkage to Board and other sub-committees	As required

In addition to anyone listed above as a member, at the discretion of the Chair of the Committee the Mental Health Legislation Committee may also request individuals to attend on an ad-hoc basis to provide advice and support for specific items from its work plan when these are discussed in the meetings.

2.1 Governor Observers

The role of the governor at Board Sub-committee meetings is to observe the work of the Committee,

rather than to be part of its work as they are not part of the formal membership of the Committee. The Governor observes Board Sub-committee meetings in order to get a better understanding of the work of the Trust and to observe Non-executive Directors appropriately challenging the Executive Directors for the operational performance of the Trust.

At the meeting the Governor observer will be required to declare any interest they may have in respect of any of the items to be discussed (even-though they are not formally part for the discussion). Governors will receive an information pack prior to the meeting. This will consist of the agenda, the minutes of the previous meeting and summaries of the business to be discussed. Governor observers will be invited to the meeting by the Corporate Governance Team. The Chair of the meeting should ensure that there is an opportunity for Governor observers to raise any points of clarification at the end of the meeting.

2.2 Associate Non-executive Directors

Associate Non-executive Directors (ANEDs) will be invited to attend Board Sub-committee meetings as part of their induction. They will attend the meeting in the capacity of observer only, unless invited to contribute (in exceptional circumstances) by the Chair. This is so the accountability of the substantive members of the Committee is maintained.

ANEDs will be invited to meetings by the Corporate Governance Team and will be sent copies of the meeting papers

3 Quoracy

Number: The minimum number of members for a meeting to be quorate is three and must include one Non-executive Director and the Medical Director. Attendees do not count towards quoracy. If the chair is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by the Deputy Chair.

Deputies: Where appropriate members may nominate deputies to represent them at a meeting. Deputies do not count towards the calculation of whether the meeting is quorate except if the deputy is representing the member under formal “acting up” arrangements. In this case the deputy will be deemed a full member of the committee.

It may also be appropriate for attendees to nominate a deputy to attend in their absence.

A schedule of deputies, attached at appendix 1, should be reviewed at least annually to ensure adequate cover exists.

Non-quorate meeting: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

Alternate Chair: The unique character of Board Sub-committees is that they are Non-executive

Director chaired. The Mental Health Legislation Committee has two Non-executive Director members hence the role of the Chair will automatically fall to the other Non-executive Director if the chair is unable to attend.

4 Meetings of the Committee

Meetings may be held face-to-face or remotely as is considered appropriate. Remote meetings may involve the use of the telephone and / or electronic conference facilities.

Frequency: The Mental Health Legislation Committee will normally meet every three months or as agreed by the Committee.

Urgent meeting: Any Committee member may request an urgent meeting. The Chair will normally agree to call an urgent meeting to discuss the specific matter unless the opportunity exists to discuss the matter in a more expedient manner.

Administrative support: The Corporate Governance Team will provide secretariat support to the committee.

Minutes: Draft minutes will be sent to the Chair for review and approval within seven working dates of the meeting.

Papers: Papers for the meeting will be distributed electronically by the Corporate Governance Team five working days prior to the meeting. Papers received after this date will only be included if decided upon by the chair.

5 Authority

Establishment: The Mental Health Legislation Committee is a sub-committee of the Board of Directors and has been formally established by the Board of Directors.

Powers: The MHL Committee's powers are detailed in the Trust's Scheme of Delegation. The Mental Health Legislation Committee has delegated authority to oversee the management and administration of the Mental Health Act 1983, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards / Liberty Protection Safeguards. The Committee is authorised by the Board to investigate and seek assurance on any activity within its terms of reference. The Committee is authorised by the Board to approve the appointment, re-appointment and make decisions in respect of remuneration to the Trusts Mental Health Act Managers. The Board will be cited on any decisions taken in respect of Mental Health Act Managers via the Chair's report. The delegated powers will be reviewed by the Board at a minimum of three yearly intervals. In consultation with the Board of Directors, the committee is able to access independent professional advice and secure the attendance of persons outside the Trust with relevant experience and expertise if it considers this necessary

Cessation: The MHL Committee is a standing committee in that its responsibilities and purpose are not time limited. However, the Committee has a responsibility to review its effectiveness annually

and on the basis of this review and if agreed by a majority of members the Chair of the committee may seek Board authority to end the Mental Health Legislation Committee's operation.

In addition, the Trust should periodically review its governance structure for continuing effectiveness and as a result of such a review the Board may seek the winding up of the Mental Health Legislation Committee.

This Committee was implemented as a part of the 2013 governance review.

6 Role of the Committee

6.1 Purpose of the Committee

Objective	How the group / committee will meet this objective
Governance and compliance	The MHL Committee provides assurance to the Board regarding compliance with all aspects of the Mental Health Act 1983 and subsequent amendments and on compliance with all aspects of mental health legislation including, but not limited to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards / Liberty Protection Safeguards.

6.2 Guiding principles for members (and attendees) when carrying out the duties of the Committee

In carrying out their duties, members of the Committee and any attendees of the group / committee must ensure that they act in accordance with the values of the Trust, which are:

- We have integrity
- We are caring
- We keep it simple.

6.3 Duties of the Committee

The Mental Health Legislation Committee had the following duties:

Mental Health Legislation

- The Committee will monitor and review the adequacy of the Trust's processes for administering the Mental Health Act 1983 and subsequent amendments and on compliance with all aspects of mental health legislation including the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards / Liberty Protection Safeguards.

- Formally submit an annual report on its activities and findings to the Board of Directors.
- Consider and make recommendations on other issues and concerns in order to ensure compliance with the relevant mental health legislation and to promote best practice by adherence to the codes of practice.
- Review the findings of other relevant reports functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

Mental Health Act Managers' Forum

- The Mental Health Legislation Committee will ensure that the Mental Health Act Managers' Forum us supported to share experience, promote shared learning and raise concerns, where appropriate both amongst themselves and, with the Trust Board and management.
- The Mental Health Legislation Committee will act as arbiter of any disputes in the work of Mental Health Act Managers arising either through the Mental Health Act Managers' Forum or from individuals

Performance and Regulatory Compliance

- Will receive assurance from the Mental Health Legislation Operational Steering Group regarding the flow of Mental Health Act inspection reports and related Provider Action Statements.
- Will receive assurance from the Mental Health Act Managers' Forum regarding training, learning, and development.
- To provide relevant assurance to the Board as to evidence of compliance with the Care Quality Commission registration and commissioning requirements related to the Mental Health Act.

Training, Clinical Development, and Guidance

- To monitor and recommend action to ensure there are adequate staff members/skill mix trained in the application of mental health legislation and there is sufficient training provided to maintain the required competency levels within clinical teams.
- To oversee the development and implementation of good clinical practice guidelines and effective administrative procedures in regard to the Mental Health Act and Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards / Liberty Protection Safeguards and advise on any other matters pertinent to the Mental Capacity Act within the Trust.

Assurance

- To ensure adequate quality control arrangements are in place to enable:
    - An Annual Mental Health Act report

  - Continuous monitoring arrangements
  - The agreed board reporting process
- To ensure there is an agreed programme of clinical audit and mechanisms for following up actions arising.
- Receive the Board Assurance Framework and ensure that sufficient assurance is being received by the Committee in respect of those strategic risks where it is listed as an assurance receiver.
- Receive the quarterly documentation audit to be assured of the findings, how these will be addressed, and progress with actions.

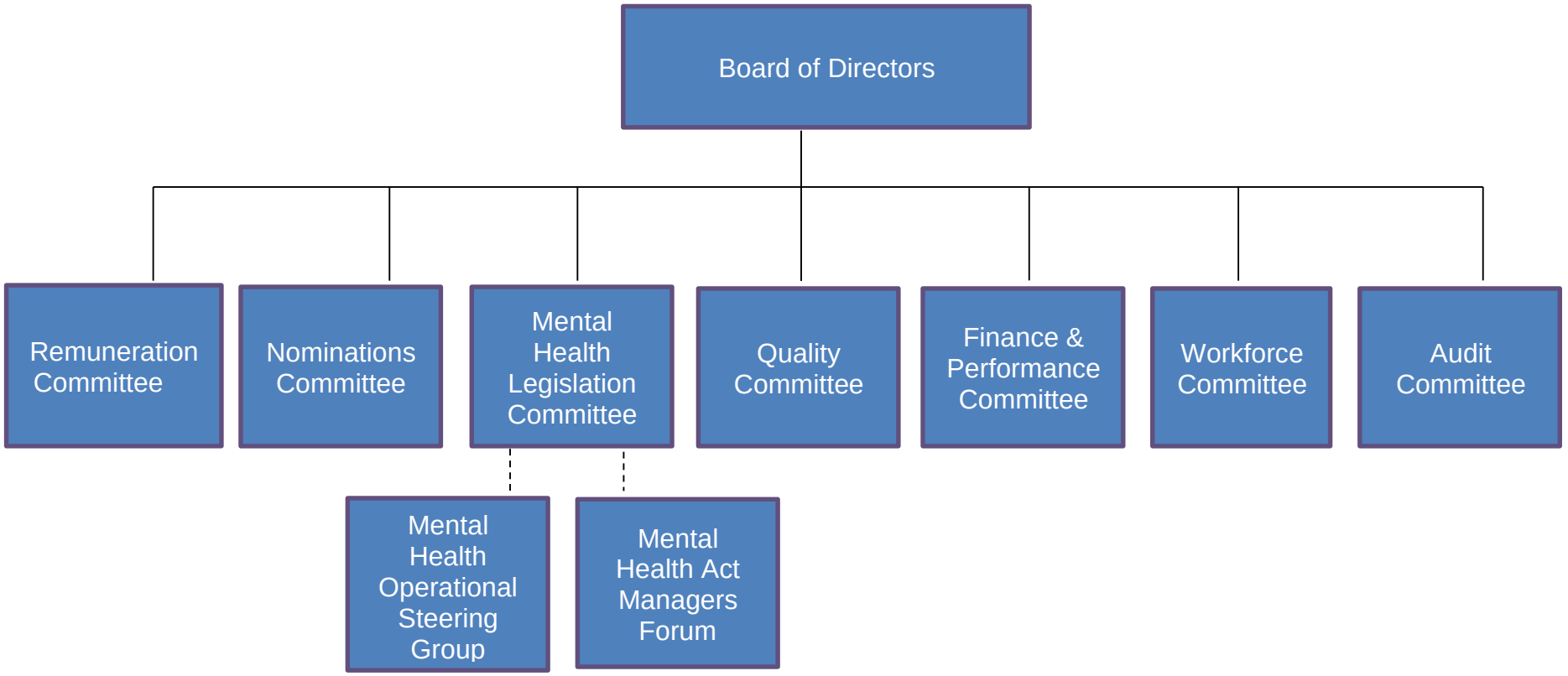
Service User and Carer Involvement

- To ensure that there is a mechanism for service users, carers, and other groups with an interest to contribute to discussions and agreement on proper use of the relevant legislation, with particular regard to the experience of compulsory detention and its therapeutic impact.
- Consider any feedback received from service user surveys.

Internal Audit

The Committee will review the draft Internal Audit Annual work plan so it can be assured on the sufficiency of the work the Auditors will carry out in respect of matters pertaining to the duties of the Committee. Assurance on the plan's sufficiency (or comments on any matters that should be included) will be provided to the Audit Committee to allow it to approve the overall plan.

7 Relationship with other Groups and Committees



The Committee has a duty to work with other Board Sub-committees to ensure matters are not duplicated.

8 Duties of the Chairperson

The Chair of the Committee shall be responsible for:

- Agreeing the agenda
- Directing the meeting ensuring it operates in accordance with the Trust's values
- Giving direction to the minute taker
- Ensuring everyone at the meeting has a reasonable chance to contribute to the discussion
- Ensuring discussions are productive, and when they are not productive, they are efficiently brought to a conclusion
- Deciding when it is beneficial to vote on a motion or decision
- Checking the minutes
- Ensuring sufficient information is presented to the Trust Board of Directors in respect of the work of the committee.
- Ensuring that Governor observers are offered an opportunity at the end of the meeting to raise any points of clarification.

It will be the responsibility of the Chair of the Committee to ensure that it (or any group that reports to it) carries out an assessment of effectiveness annually, and ensure the outcome is reported to the Trust Board along with any remedial action to address weaknesses. The Chair will also be responsible for ensuring that the actions to address any areas of weakness are completed.

In the event of there being a dispute between any 'groups' in the hierarchy (in the case of this Board Sub-committee, this would be between the Board and the Mental Health Legislation Committee and, in recognition of the nature of matrix working between the work of all Board Sub-committees, the Mental Health Legislation Committee and any other Board Sub-committee) it will be for the chairs of those groups to ensure there is an agreed process for resolution; that the dispute is reported back to the 'groups' concerned; and that when a resolution is proposed the outcome this is also reported back to the 'groups' concerned for agreement.

9 Review of the Terms of Reference and Effectiveness

The Terms of Reference shall be reviewed by the Committee at least annually and be presented to the Board of Directors for ratification, where there has been a change.

In addition to this the Chair must ensure the Committee carries out an annual assessment of how effectively it is carrying out its duties and make a report to the Board of Directors including any recommendations for improvement.

Appendix 1a

Schedule of deputies

It may not be necessary or appropriate for all members (or attendees) to have a deputy attend in their absence.

If this is the case please state below “no deputy required”.

Full member (by job title)	**Deputy (by job title)**
Non-executive Director (Chair)	Non-executive Director
Non-executive Director	None
Medical Director	Executive Director (ideally with knowledge and experience of MHL)
Director of Nursing and Professions	Deputy Director of Nursing

Attendee (by job title)	**Deputy (by job title)**
Associate Medical Director for Mental Health Legislation	No deputy available to attend this Committee
Head of Service (Adult Social Care, Leeds)	Service Delivery Manager
Associate Director for Corporate Governance	Head of Corporate Governance
Head of Mental Health Legislation	Mental Health Legislation Team Leader / Law Advisor
MHA managers’ nominated individual	Another MHA Manager
Chair of the Mental Health Legislation Operational Steering Group	Deputy Chair of the Mental Health Legislation Operational Steering Group

Agenda item
17

Meeting of the Board of Directors

Paper title:	Board Assurance Framework
Date of meeting:	29 January 2026
Presented by: (name and title)	Dr Sara Munro, Chief Executive
Prepared by: (name and title)	Clare Edwards, Associate Director of Corporate Governance

This paper supports the Trust's strategic objective/s (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	✓
SO3	We use our resources to deliver effective and sustainable services.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	✓
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	✓
SR6	Digital technologies	✓
SR7	Plan and deliver services that meet the health needs of the population we serve.	✓

Executive summary

It is a requirement for all Trust Boards to ensure there is an effective process in place to identify, understand, address, and monitor risks. This includes the requirement to have a Board Assurance Framework that sets out the risks to the strategic plan by bringing together in a single place all the relevant information on the risks to the Board being able to deliver the organisation's objectives.

The updated position, including the amended risk appetite scores were reviewed at the Executive Risk

Management Group meeting on Wednesday 14 January 2026. It was agreed that the content was appropriate, with a recommendation for Board approval.

There were no other key points for escalation to the Board of Directors within this update.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? **Yes**

If yes, please set out what action has been taken to address this in your paper.

This is detailed within the strategic risks, specifically strategic risks 1 and 7.

Recommendation

The Board is asked to:

- Receive the BAF and to be assured of the review that has been undertaken to ensure that this accurately reflects the position as of January 2026, including risk scoring and mitigating actions.

Meeting of the Board of Directors

29 January 2026

Board Assurance Framework

1 Executive Summary

It is a requirement for all Trust Boards to ensure there is an effective process in place to identify, understand, address, and monitor risks. This includes the requirement to have a Board Assurance Framework that sets out the risks to the strategic plan by bringing together in a single place all the relevant information on the risks to the Board being able to deliver the organisation's objectives.

Board Assurance Framework

2.1 Strategic Objectives

This Board Assurance Framework is informed by Trust strategy and the related strategic objectives. These are:

1. Through our Care Services: we deliver great care that is high quality and improves lives.
2. For our People: we provide a rewarding and supportive place to work.
3. Using our resources wisely: we deliver effective and sustainable services.

2.2 The BAF

Overall responsibility for the BAF sits with the Chief Executive and this is administered by the Associate Director for Corporate Governance who has a co-ordinating role in respect of the information, and for ensuring the document moves through its governance pathway effectively and provides check and challenge to the content.

This BAF sets out the principal risks and how they could impact on the strategic goals.

2.3 Risk Management

The Board Assurance Framework has seven strategic risks. Each strategic risk has an assigned lead Executive Director who has oversight of the detail within the risk ensure identified actions are appropriate and have correct timeframes.

Board Committees review the BAF at their meetings to ensure that the risks remain appropriate and that there is assurance that they are appropriately managed.

The Executive Risk Management Group has oversight of all Trust risks, with specific focus on the strategic risks and risks rated 15 or above. There is a clear escalation route to the Executive Management Team and the Trust Board for any identified risk or action required.

2.4 Structure of the BAF Risk Report

This report helps to focus the Executive and Board of Directors on the principal risks to achieving the Trust's strategic goals and in-year objectives and to seek assurance that adequate controls and actions are in place to manage the risks appropriately.

The BAF is structured and mapped against the three strategic objectives.

Each of the risk scores identifies how the score has been calculated with likelihood and consequence ratings. This is shown as '*LX x CX'* in the main body of the BAF.

2.5 Strategic Risk Detail Updates

There are no key updates or areas of escalation for the Board of Directors to be aware of. All amends and updates have been made as appropriate with no material impact on the current risk ratings.

BAF Dashboard

Risk ref	Risk Title	Oversight Committee	Lead Executive	Strategic Objectives			Initial risk score	Previous Risk Score				Change	Target risk score	Risk Appetite	Target date
				1	2	3		Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27				
SR1	Quality including Safety Assurance Processes	QC	DoN&P	✓			4	12	12	12	12	⟷	4	M	30 Apr 26
SR2	Delivery of the Quality Strategic Plan	QC	MD	✓			9	12	12	12	12	⟷	6	C	31 Mar 28
SR3	Culture and environment for the wellbeing of staff	WC	DoP&OD		✓		12	16	12	12	12	⟷	6	C	30 Apr 26
SR4	Financial sustainability	F&PC	DoF			✓	8	12	12	15	15	⟷	4	C	31 Mar 26
SR5	Adequate working and care environments	F&PC	DoF			✓	8	12	12	12	12	⟷	4	O	31 Mar 28
SR6	Digital technologies	F&PC	DoF			✓	12	12	12	12	12	⟷	4	O	31 Dec 25
SR7	Plan & deliver services for health needs of the population	F&PC	COO	✓			12	12	12	12	12	⟷	6	S	31 Dec 27

Strategic Risk 1

BAF Risk SR1 Risk 636	If there is a breakdown of quality including safety assurance processes, we risk not being able to maintain standards of safe practice, meeting population health needs and compliance with regulatory requirements.		
Strategic Objective:	1. Through our care services: We deliver great care that is high quality and improves lives		
Accountable Director	Executive Director of Nursing and Professions	**Initial Risk Score**	4 (L2xC2)
		Current Risk Score	12 (L3x4C)
Oversight Committee	Quality Committee	**Target Risk Score**	4 (L2xC2)
Risk Appetite	Minimal	**Target Date:**	30 April 2026

Controls in place

- Clinical governance structures in place at all tiers of the organisation to embed clinical governance.
- Process in place to review and learn from death supported by Learning from death policy and Learning from Incidents and Mortality
- Peer review process in place with oversight from CQC steering group
- Annual process in place for reporting on the controls in place in relation to risk to compliance incorporating the Annual Governance Statement Compliance
- Process for managing patient safety events supported by PSIRF policy and plan
- Structures and processes in place for staff to raise concerns and escalate issues supported by Whistle Blowing Procedure and Freedom to Speak Up Guardian
- Processes in place to seek and receive patient and carer feedback
- Risk management processes and policies in place to support the identification, management and reporting of incidents and risks
- Safer staffing group and establishment process
- Trust wide working group to implement the Risk Assessment and Management Plan (RAMP)
- Suicide prevention environment survey
- Culture of care programme
- Implementation of Sexual safety standards
- Systems (with supporting policies) in place relating to Safeguarding, physical health, Infection Prevention Control.
- Clinical Supervision training offer in place to support clinical practice.

Details of Assurance

Assurance Rating:	**Partial**

Management / Service Level	**Review Process / Oversight**	**Independent (external / internal audit)**
- Escalation processes - Teir three clinical governance meetings supported by TOR and clinical governance framework. - Escalation mechanism in place from ward to board - Weekly LIMM meeting to review incidents (graded 3 and above) and deaths - Monthly Trust Incident Review Group with a focus on SI reports and overdue actions - Bi-monthly CQC oversight group with overview of peer reviews - Monthly safer staffing group with oversight of staffing levels and annual establishment review	- Clinical Governance Framework - Quarterly combined report reviewed by Quality Committee (currently paused while undergoing review) - 6-monthly Learning from Deaths report to Quality Committee - SI/PSII reports reviewed and signed off at Trust Incident Review Group - Quarterly safer staffing report to Quality Committee - Quarterly reducing restrictive practice report to Quality Committee	- Peer reviews: ICS level - Provider collaborative and ICB quality visit - Audit Yorkshire – internal audit programme & reports - Healthwatch external visit - 2019 CQC inspection report, overall rating good - CQC MHA reviews - Low assurance - complaints / claims - Significant assurance – sexual safety audit - Limited assurance – integrated governance and risk management framework - Significant assurance – Patient safety incident response framework

- Monthly positive safety group with overview of incidents of restraint - Monthly CLIP report shared with services giving an overview of incidents, complaints, PALS - E-rostering system in place - Monthly working group with overview of the implementation of the RAMP - Monthly suicide prevention environment group - Monthly sexual safety group meeting - Monthly falls and pressure ulcer group to review falls and pressure ulcer incidents (graded 3 and above) - Monthly safeguarding report shared with services giving overview of safeguarding training compliance and safeguarding referrals.	- Quarterly sexual safety report to Quality Committee - Evaluation of the implementation of the RAMP to be reported through Quality Committee - Suicide prevention environment group summary supported to clinical environment group and escalated to ESG. - Nursing and Professions highlight report to quality committee - Falls and pressure ulcer group report to quality committee - Peer review reports shared via clinical governance structures - Monthly Executive risk management to review and discuss 15+ risk - Annual quality accounts - Annual Clinical Supervision Training report to Nursing and Professions' Council.	

Gaps in assurance / controls:	- Development of suicide prevention plan and self-harm strategy - Development of Clinical Governance dashboard - Development of safer staffing SOP - End of life care - Complaints process

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress
Establishment of end of life care steering group to develop clinical practice standards	Deputy Director for AHP's, Social Workers	31 March 2026	Stakeholder and implementation group dates set which will have oversight of the risk until ReSPECT is implemented.
Development of a suicide prevention plan and Self-Harm Strategy	Head of Nursing	31 May 2026	Previous plans and current guidance being reviewed and PID being developed with support from Project Manager to guide strategy development and action plans. Engagement with citywide work ongoing to inform local plan Working with neighbouring trusts to develop training
Culture of Care Standards Transformation Programmes	Professional Lead for Nursing	31 March 2026	Lauch event attended in May 2024. QI and coaching for pilot sites to commenced in September 2024. Pilot sites currently implementing change ideas and collecting assurance data. Pilot sites due to come to an end in March 2026 and then a plan to roll out following this date.
Development of clinical governance dashboard in conjunction with the quality improvement team to support Tier 3 Clinical governance meetings.	Head of Clinical Governance	31 March 2026	Work in conjunction with quality improvement team to develop range of indicators that will inform services on the quality of care being delivered within services. To link with wider work on quality dashboard and annual service reports.

Development of a safer staffing SOP	Deputy Director of Nursing	31 March 2026	A SOP will be developed to support a standardised and consistent approach across inpatient services for the annual safer staffing establishment reviews with the staffing escalation procedure forming part of the document.
Complaints process and procedure	Head of Patient Experience, Complaints and legal services	31 May 2026	Review of current complaints processes, including update of complaints procedure and complaints investigator pack underway. Working with Clinical Leads to strengthen governance arrangements in relation to complaints, including the sharing of learning and actions. Review of KPI's in relation to complaints including timescale for complaint investigations. Reviewing escalation process to support timely completion of complaint response.

Contributory risks at level 12 or above

973	**ReSPECT and DNACPR documentation -** There are no agreed, trust wide, clinical practice standards in place that ensure consistency in regards to the access and storage of DNA CPR and ReSPECT documentation within inpatient areas.	Deputy Director for AHP's, Social Workers	ReSPECT stakeholder group/4 in 1 meeting	15 (L3xC5)
1359	**Complaints processes -** Timescales for completion of complaint responses exceeding what is deemed a reasonable expectation.	Head of Patient Experience, Complaints and Inquest	Trust wide clinical governance	12 (L4xC3)
1331	**Equipment risk -** There are a number of risks related to the provision of equipment that supports care delivery and activities of daily living. These include changes to telecare, timely procurement and transport of beds, wheelchairs and bariatric items. General maintenance of the equipment, the skills of Occupational Therapists to prescribe equipment and meeting the required standards for bed levers/sticks/rails. In addition to the above NRS a major equipment provider has gone into liquidation so their services will no longer be available.	Deputy Director for AHP's, Social Workers	Trust wide clinical governance	16 (L4xC4)
1286	**Clinical Governance -** There is a risk that the inconsistencies in how clinical governance is applied and operating across all clinical services, does not provide us with the organisational assurance around the quality of care being delivered to our services users and carers.	Head of Clinical Governance	Trust wide clinical governance	12 (L3xC3)
1361	**Trust physical health training and support -** Concern regarding the quality and consistency of the current inhouse physical health training delivered to staff across the trust.	Professional Lead for Allied Health Professionals	4 in 1 meeting	12 (L4xC3)
1330	**Capacity within the patient safety team -** Due to staffing vacancies within the patient safety team, there is a risk that: Processes in relation to patient safety are not followed in a timely manner, i.e. allocation of learning responses, compassionate engagement with families Delays in completion of learning responses, with increased timescales to complete AAR, PSII Investigators/reviewers are not offered support to complete learning responses, including Patient Safety Incident Investigations (PSII's) Training relating to patient safety is not available.	Head of Clinical Governance	Trust wide clinical governance	12 (L4xC3)
1024	**Clinical Risk Assessment -** Findings from patient safety incident reviews have identified issues with the completion of risk assessments within the organisation. This includes the quality of information within the assessments, how meaningful these are to staff and patients and issues with completion in line with Trust guidance.	Director of Nursing and Professions	Risk assessment group	12 (L4xC3)

Strategic Risk 2

BAF Risk SR2 Risk 829	There is a risk that we fail to make the improvements outlined in the Quality Strategic Plan and that this has an impact on how we understand and act on the care of those who use our services.		
Strategic Objective:	1. Through our care services: We deliver great care that is high quality and improves lives		
Accountable Director	Medical Director	**Initial Risk Score**	9 (L3xC3)
		Current Risk Score	12 (L4xC3)
Oversight Committee	Quality Committee	**Target Risk Score**	6 (L2xC3)
Risk Appetite	Cautious	**Target Date:**	31 March 2028

Controls in place

- Quality Strategic Plan
- Safe Effective Reliable Care Framework
- LYPFT LCL Framework
- Improvement Methodology
- STEEEP Framework
- Trustwide Clinical Governance structure
- Learning from Deaths process
- GAAP framework

Details of Assurance

Assurance Rating:	**Partial**

Management / Service Level	**Review Process / Oversight**	**Independent (external / internal audit)**
- Escalation processes - Unified Clinical Governance Group - Clinical Governance toolkit - Patient safety investigation framework and process - Annual Service Quality Reports - Quality Improvement and Knowledge Meeting - CLIP report	- Quality Strategic Plan - Clinical Governance Framework - Board of Directors minutes - Medical Director reports - Trustwide Clinical Governance Group - Assurance reports incl. Quality & Performance report to Committee / CoG - Clinical Governance Group minutes - Quality Committee minutes - STEEEP Framework - Quality Report - Improvement methodology - Freedom to Speak Up Guardian reporting - Executive Risk Management Group	- Internal Audit reports - CQC preparation evidence - Audit Yorkshire – internal audit programme & reports

Gaps in assurance / controls:	- Multi-disciplinary support and service leadership group - Development of culture of innovation and improvement - Data access and availability

Mitigating actions underway for controls and assurance:			
Action	**Lead**	**Target Date**	**Progress**
Development of collective leadership	Director for Collaborative Working	Complete	Complete
Building improvement capacity and capability programme.	Deputy Director of Improvement	31 March 2026	Improvement Apprenticeships are making a positive contribution to building organisational improvement capability and capacity. As part of National Apprenticeship Week in February, a programme of activity will promote the Improvement Apprenticeship offer, supporting the longer-term ambition to embed an Improvement Apprentice within each service line.
Creation of an integrated quality and culture dashboard	Deputy Director of Improvement	31 December 2026	The Aligning STEEEP metrics, removing unwarranted variation and preparing for the next steps to develop quality dashboards paper is due to be presented at the QuIK meeting on the 27th Jan 2026. It will be discussed in order to get to a firm action plan for the year 26/27. In summary the paper describes work to bring quality measures together across services using the STEEEP framework, so that quality can be understood in a clear and joined-up way from ward to board. It builds on the Annual Service Quality Reports and conversations with clinical, operational and corporate leaders to understand how quality data is currently used, where it works well, and where there is variation or gaps. The aim is to support better decision-making by linking quality with finance, performance and people information, while keeping services involved and avoiding a one-size-fits-all approach to measurement. It reviews progress and challenges across all STEEEP areas, including safety, timeliness, effectiveness, efficiency, equity and person-centred care, and highlights where further development is needed, particularly around dashboards, use of data in day-to-day management, and joined-up governance.
The prioritisation of the setup, configuration and digital enablement of the Patient Portal solution to support eProms but also to include other functionalities.	Chief Digital Information Officer	Complete	Digital enablement now complete and capabilities available. Outcome measure forms have been configured, reviewed and tested and the pilot within gambling services has been successfully integrated into service delivery. System configuration is now complete – email and SMS delivery mechanisms for patient outcome questionnaires configured. Data quality issues required additional checks and measures to

			ensure correct data uploaded to Patient Hub to enable outcome measures questionnaires to be sent to patients – required unanticipated system development to accommodate nuances of Mental Health service provision. Clinical lead reached out to services to identify next services for deployment.
Identifying all proms used across the organisation; establishing where proms are not used; supporting teams with effective use of proms; imbedding proms in clinical practice; interfacing with Patient Portal and EPR teams to ensure digital delivery and access to analysed results.	Clinical Director	31 March 2027	The pilot has been completed with good results – an evaluation report has been shared with the QUICK group and will be presented there during the next meeting. The next phase of the project will focus on getting three more services using digital eProms. The project will continue on a phased approach. There was a change in focus of this project following a meeting with Chris Hosker and Julie Hankin towards the end of 2025. This means that services will use eProms already embedded in those services with the focus being on digitising those and improving the processes of them doing so. Where services don't have proms in place, they will be supported to identify such measured and implement them, considering no real resource available to do so.
Contributory risks at level 12 or above			
None			

Strategic Risk 3

BAF Risk SR3 Risk 1109	There is a risk that we fail to deliver a culture and environment that recruits, retains, and attends to the wellbeing of staff to enable them to be their best and deliver quality services now and in the future.		
Strategic Objective:	2. For our people: We provide a rewarding and supporting place to work		
Accountable Director	Director of People and Organisational Development	**Initial Risk Score**	12 (L3xC4)
		Current Risk Score	12 (L3xC4)
Oversight Committee	Workforce Committee	**Target Risk Score**	6 (L2xC3)
Risk Appetite	Cautious	**Target Date:**	30 April 2026

Controls in place

- Trust People Plan
- Widening Participation Plan
- Apprenticeship Strategy
- Leadership and Management Programme
- Leadership Academy programmes
- Collective Leadership Programme
- Exit Interview process
- Performance Reporting Compliance

Details of Assurance

Assurance Rating:	**Partial**

Management / Service Level	**Review Process / Oversight**	**Independent (external / internal audit)**
- People & OD structure - PDR Process / Career Conversation Toolkit - Annual mandatory Wellbeing Assessment - In-house bank workforce - Temporary staffing register - Bank Staff Survey / Awards - Workforce and Efficiency Group - Reducing Bank Group - Safer Staffing Group	- Board of Directors minutes - Work force Committee minutes - People Plan dashboard - Monitoring via JNCC & JLNC - Monitoring of training and development - Director of People and OD reports - Executive Risk Management Group - OD & Resourcing Group	- Health Education England review - Workforce alliance framework - Audit Yorkshire – internal audit programme & reports

Gaps in assurance / controls:	- Demographic challenges - National workforce supply issues - Capacity of employees inc. manager, to undertake training and development

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress
Further upskilling for managers on workforce planning and how to develop new roles / skill mixing to support services and fill vacancies.	Head of Strategic Resourcing and Talent	31 March 2026	Introduction of the Workforce Planning Standard Operating Procedure (SOP). Career development programme in place alongside the apprenticeship strategy to help upskill individuals.

			Planned increase of nurse apprenticeship programmes. Identification of new roles and opportunities for skill mixing. Align the training provision with the national NHS Management and Leadership, identifying gaps in development.
Development of a Culture Dashboard which provides a temperature check of the Trust culture providing areas of excellence, areas of improvement and areas of concern.	Head of People Analytics, Head of Engagement	31 March 2026	Task Group established with Informatics expertise to develop a proof of concept. Discussions and updates provided to the Civility & Respect Task Group. Engagement with various stakeholders on the concept of a culture dashboard including content and requirements.
Establishment of a Workplace Adjustments Task Group to develop and implement a process which supports employees with workplace adjustments to enable them to remain in work. Supporting those with long term conditions and disabilities.	Deputy Director of People and OD	31 March 2026	Task Group started in Summer 2025. Centralising budget oversight now confirmed Developing Procedure and Guidelines for employees and managers.
Nursing and Midwifery Job Profile Reviews (National Job Evaluation Programme)	Deputy Director of People and OD	30 September 2026	HR Business Partner Lead working with Deputy Director of Nursing to undertake baseline assessment to inform workplan required. Group to be established in January 2026 with various stakeholders including Staff Side. NHSE Reporting commenced in October 2025 (quarterly).
Establish a task and finish group on Sexual Misconduct to ensure compliance against the NHS England Sexual Safety Charter Assurance Framework	Head of Wellbeing	Complete	Task and Finish group started in August 2025. Anonymous reporting mechanism now in place Draft risk assessment and sexual misconduct policy currently going through governance. Sexual misconduct elearning module is now available for all staff on Learn. Compliance return to NHS England planned for early Feb 26 A long term action plan will be agreed once policy is in place.
Ensure we are compliant with new requirement to have a Menopause Action Plan	Head of Wellbeing	30 September 2026	Monthly peer support network established Recording of menopause absence since Oct 25. Working towards Henpicked Accreditation A library of resources launched Oct for individuals, line managers and allies. Awareness campaign running Jan – August.
An evidence based Health and Wellbeing Strategy in place	Head of Wellbeing	March 2026	A strategic review of the diagnostic tool is being presented to Workforce Committee Feb 26, a twelve month action plan will be developed and delivered through the Wellbeing & Attendance Group.

Contributory risks at level 12 or above

Ref	Description	Lead / Responsible Director	Oversight Group	Score

1360	The HR Operations team has experienced a reduction in capacity following the departure of two HR Administrators. These roles have not been backfilled, resulting in a significant gap in administrative support. The remaining team members, including HR Advisors and HR Managers, are now required to absorb the additional workload, which includes routine administrative tasks, case tracking, correspondence, and data management. This shift in responsibilities is placing considerable strain on the team, diverting focus from strategic and advisory functions to operational and transactional duties. The increased workload risks delays in service delivery, reduced responsiveness to managers and staff, and potential errors in HR processes due to time pressures and lack of dedicated administrative oversight.	Deputy Director People and OD	POD SLT	**12 (L3xC4)**

Strategic Risk 4

BAF Risk SR4 Risk 619	There is a risk that a lack of financial sustainability results in the destabilisation of the organisation and an inability to meet our objectives.		
Strategic Objective:	3. Using our resources wisely: We deliver effective and sustainable services		
Accountable Director	Chief Financial Officer	**Initial Risk Score**	8 (L2xC4)
		Current Risk Score	15 (L3xC5)
Oversight Committee	Finance & Performance Committee	**Target Risk Score**	4 (L2xC2)
Risk Appetite	Cautious	**Target Date:**	31 March 2026

Controls in place

- Efficiency & Productivity Programme including Cost Improvement Programme
- Revenue & Capital Plan
- Standing Financial Instructions
- Organisational plans
- Tender and procurement policy / programme
- Out of Area Placement programme
- System partners working arrangements
- Financial modelling and forward forecasting
- External Audit

Details of Assurance

Assurance Rating: **Partial**

Management / Service Level	Review Process / Oversight	Independent (external / internal audit)
- Chief Financial Officer governance framework / structure - Efficiency Groups – Workforce & Agency Project Board / Inpatient Flow Group / Procurement Steering Group - Finance training - Finance skills development - Fraud awareness courses - Budget holder training	- Board of Directors minutes - Finance & Performance Committee minutes - Provider Collaborative reports - Finance & Provider Collaborative meetings - Financial Planning Group - Tender review process - Executive Risk Management Group	- Provider Collaborative Framework – signed risk and gain shares - Leeds Strategic Finance Executive Group - Audit Yorkshire incl. Head of Internal Audit Opinion - Annual Accounts - Capital Planning Forum - Audit Yorkshire – internal audit programme & reports - NHS England – performance metrics - PWC West Yorkshire Financial Improvement Support Audit

Gaps in assurance / controls:

- No agreed plan for the recurrent budget £14.5m CIP
- SSL contact deficit

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress
Confirmed schemes detailing how the Trust will achieve the £14.5m recurrent budget CIP	Deputy Director of Finance	31 March 2026	Targets have currently been given to services and departments, schemes are being worked up

Contributory risks at level 12 or above				
Ref	Description	Lead / Responsible Director	Oversight Group	Score
651	Failure to achieve ongoing recurrent budget CIP requirements and demonstrate efficient and effective care will lead to a deterioration in the financial position.	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	16 (L4xC4)
731	A continuation of agency spend at current levels could negatively impact the Trust in achieving its financial plan and hinder the system to meet it's overall system agency cap	Deputy Director of Finance / Chief Financial Officer	Financial Planning Group	12 (L3xC4)
949	Changes to the capital funding regime may impact on the ability to secure sufficient capital (CDEL) allocations to deliver our long-term capital planning objectives, including reprovision of PFI. Capital resources are allocated to each ICS to help address ICS priorities, there is a risk that LYPFT capital requests may not be prioritised in the context of the other ICS priorities. The operational methodology used for allocating capital resources between organisations may not benefit LYPFT and be lower than historic planned levels. The Health & Social Care bill introduced a requirement to manage within capital allocations, however there is a risk that other system partners do not.	Deputy Director of Finance / Chief Financial Officer	Financial Planning Group	12 (L3xC4)
1147	Failure to re-negotiation of the SSL contract to ensure that is financially viable	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	16 (L4xC4)
1148	Out of Area Placement expenditure increasing threatening the financial sustainability of the Trust	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	16 (L4xC4)
1149	Impact of the growing gap between tariff uplift and Trust inflationary pressures	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	15 (L5xC3)
869	Reliance on non-patient income e.g. Commercial & Interest Receivable	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	16 (L4xC4)
649	The impact of financial risk share agreements linked to Provider Collaboratives	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	12 (L3xC4)
1323	Failure to achieve the Trust expenditure run-rate reduction required to meet the Financial plan for the year	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	16 (L4xC4)
1325	Risk that the EPR system cost substantially more than the current EPT system when it is renewed	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	12 (L3xC4)
1326	Financial cost and impact of exiting the PFI	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	12 (L3xC4)

Strategic Risk 5

BAF Risk SR5 Risk 615	Due to an inability to provide adequate working and care environments we risk being unable to deliver safe and effective services.		
Strategic Objective:	3. We deliver effective and sustainable services		
Accountable Director	Chief Financial Officer	**Initial Risk Score**	8 (L2xC4)
		Current Risk Score	12 (L3xC4)
Oversight Committee	Finance & Performance Committee	**Target Risk Score**	4 (L2xC2)
Risk Appetite	Open	**Target Date:**	31 March 2028

Controls in place

- Security Management Policy
- Health and Safety Policy
- Technical Policies (Water, Asbestos, Fire Safety)
- Sustainability Plan (LYPFT Green Plan)
- Strategic Estates Plan
- Capital Project Planning and delivery
- PFI Governance Framework and overarching programme management to support work plans
- 2025 Commissioned 6 Facet Survey
- Compliance, Risk, Assurance, Governance group established locally
- Statutory Returns to NHSE (Premises Assurance Model, Patient Led Assessment of Care Environment, Estates Return Information Collection)

Details of Assurance

Assurance Rating:	**Partial**	
Management / Service Level	**Review Process / Oversight**	**Independent (external / internal audit)**
- Chief Financial Officer governance framework / structure - Operational site meetings - Escalation processes - Risk assessments - Compliance, Risk, Assurance and Governance Groups for Estates & Facilities	- Finance & Performance Committee minutes - Estates Steering Group minutes - Clinical Environment Group minutes - Environment audit programme - PFI demise governance process - Chief Financial Officer reports - PFI BAU and operational contract management - Executive Risk Management Group	- Audit Yorkshire – internal audit programme & reports - Independent Authorising Engineer / Independent Advisor Audits as per the requirements of Premises assurance Model (PAM) - Patient Led Assessment of the care environment (PLACE) - Estates Return Information Collection (ERIC)

Gaps in assurance / controls:	- Limited capital finance availability to address backlog maintenance (below condition B) - Limited capital finance availability to fully support the care services aspirations - Staffing pressures in relation to capacity, recruitment and retention, staffing competence etc short against required standards (HTM, HBN, National Standards Cleaning / Catering) - Management and current ownership provision of our estate as a large proportion is managed and invested in by others i.e PFI and NHSPS.

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress

Extreme heating feasibility studies to be undertaken and costed and taken to CEG for discussion.	Deputy Director of Estates and Facilities	31 March 2026	Deferred to March 2026 due to pressures of prioritising Green Plan / Decarbonisation Feasibilities. Update paper to Green Steering Group too.
Implementation of on-site staff safety alarm system using Capital Allocation via ESG, to address the issues in relation to the alarms. Supplemented with door lock adaptations and local SOPs.	Deputy Director of Estates and Facilities	Complete	
Health and Safety Audits to be completed on all the Trusts owned, leased and PFI Estate, on a periodic basis.	Head of Health and Safety	31 March 2026	This is a rolling programme to satisfy HSE requirements and to assure ourselves of our environment safety. - 2024/25 schedules complete. - 2025/26 underway.
Security Risk Assessments to be conducted on all the Trusts owned, leased and PFI Estate and to be completed on a periodic basis.	Trust Security Manager	31 December 2026	All buildings will be risk assessed across both physical and infrastructure security by the Trusts Security Team in accordance with the agreed schedule. This is a rolling programme; 2024 Risk Assessments are complete 2025 Risk Assessments are complete following appointment of new Security Manager 2026 next assessments are scheduled
PFI Joint Steering Group	Deputy Chief Executive / Chief Financial Officer Deputy Director of Estates and Facilities	August 2028	Quarterly meetings are maintained, and extraordinary meetings take please where required. Overseen by Exec level directors at respective organisations. Clear agenda with specific focus on business as usual, strategic projects and PFI Demise. This group now has oversight of PFI demise.
PFI LYPFT Concession Group	Deputy Chief Executive / Chief Financial Officer Deputy Director of Estates and Facilities	August 2028	Regular meeting are in place meeting every 2-3 months with a master overarching programme. Formal updates and reports provided for assurance or to seek appropriate support. The workplans are supported by legal reviews and under guidance from the NISTA (formally known as IPA)
PFI Joint Demise Group	Deputy Chief Executive / Chief Financial Officer Deputy Director of Estates and Facilities	August 2028	Established in May 2024 under formal remit set out in Terms of References – a joint working group operationally managing crucial elements of the PFI Demise and reporting into the PFI Joint Steering Group, key features include; - Leases Expiry - Condition Survey - Documentation / Operating Manuals -

			Formal reporting and monitoring is provided to the Joint Steering Group as well as a Joint Demise Action Plan.
PFI LYPFT Monthly Contract / Performance Monitoring Meetings	Deputy Director of Estates and Facilities	August 2028	Monthly meetings continue to progress with all parties including Mitie FM. Reports are provided to the PFI JSG and will be reviewed for effectiveness ahead of the PFI Demise and to ensure 'Business as Usual' assurance is provided in alignment to the Demise Plans.
Green Steering Group	Deputy Director of Estates and Facilities	31 March 2026	• Updated 2025 Green Plan has prompted the review of the previously known Sustainability Steering Group. The Group / ToRs, Membership and Action plan has been refreshed as the approach will now be organisationally wide oppose to be being delivered from just Estates and Facilities – there are 9 workstreams in alignment with Greener NHS. (The above is complete) Heat decarbonisation plans have been produced to help inform route to net zero and capital requirement – detailed feasibilities required to identify deliverability element.
Fire Safety Group – effectiveness reporting to oversight groups	Deputy Director of Estates and Facilities	31 March 2026	Ensure that fire safety is more overtly discussed and reported where appropriate. Updates regularly go to HSC but details of recent risk items need to be polarized to alert / assure accordingly. Within Q4, relevant groups and committees to be informed of main issues and priorities.

Contributory risks at level 12 or above

Ref	Description	Lead / Responsible Director	Oversight Group	Score
1008	The Trust is unable to meet the NHS Carbon Neutral requirements by 2040 and to implement a sustainable culture within the organisation	Deputy Director of Estates and Facilities / Chief Financial Officer	Estates Steering Group	12 (L3xC4)
1332	Fire Safety - failure to comply with fire safety policy and protocols	Deputy Director of Estates & Facilities / Chief Financial Officer	Health and Safety Committee / Audit Committee	15 (L5xC3)

Strategic Risk 6

BAF Risk SR6 Risk 635	As a result of insecure, inadequate and poorly utilised digital technologies there is a risk the quality and continuity of services is compromised.		
Strategic Objective:	3. We deliver effective and sustainable services		
Accountable Director	Chief Financial Officer	**Initial Risk Score**	12 (L3xC4)
		Current Risk Score	12 (L3xC4)
Oversight Committee	Finance & Performance Committee	**Target Risk Score**	4 (L2xC2)
Risk Appetite	Open	**Target Date:**	31 December 2025

Controls in place

- Digital Strategy
- Cyber Security Policy
- IT Policy
- Data security and protection toolkit
- ICT infrastructure

Details of Assurance

Assurance Rating:	**Partial**

Management / Service Level	**Review Process / Oversight**	**Independent (external / internal audit)**
- Chief Financial Officer governance framework / structure - Procurement processes incl. requisition approval - Junior Buyer / procurement team training - Category Codes (E Class) - Over £5k approval process - Digital Change Leads - ICT infrastructure - Phishing Exercise - Board level training	- Board of Directors minutes - Finance & Performance Committee minutes - Digital Steering Group minutes - Procurement & ICT meeting minutes / action log - Information Governance Group - Cyber monitoring system - CareCerts process - Chief Financial Officer reports - Executive Risk Management Group	- Audit Yorkshire – internal audit programme & reports - NHS Digital - National Cyber Operations Centre portal (returns process) - Penetration Testing - Phishing Exercise

Gaps in assurance / controls:	- Culture, staff ability and aptitude - Cyber attack awareness

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress
Work with staff through Digital Change Team to understand the barriers to using technology and provide the necessary help and support.	Chief Digital Information Officer	31 December 2026 (ongoing process)	This is a continual process through our journey to deliver effective and efficient digital solutions and forms part of a continual improvement cycle. Engagement through the digital change team continues to better understand barriers and to look at solutioning responses. Major review of CareDirector forms completed and workflows are currently

			being reviewed. Engagement planned to understand barriers across nonclinical areas. EPR Programme will also support this action as we evolve and mature through the programme startup
Continued Engagement with Digital Leeds and ICB regarding support around digital literacy.	Chief Digital Information Officer	31 March 2026 (ongoing process)	Discussions taken place across the ICS and city footprint via CIO and digital leadership groups and meetings. Engaged in discussions regarding support and sharing of knowledge and understanding however direct influence over shared ideas is small and programme being owned/delivered by the local Authority. Delay on further engagement due to changes across the system and impact of delivering ICB blueprint. Work to drive a Leeds specific view continues, with regular engagement across LYPFT and LCH beginning to explore opportunities associated with the planned merger. West Yorkshire Mental CIO's network continues to meet, share and discuss potential for collaboration across the system on digital literacy.
Deliver cyber communications plan with target on delivering messages and examples of phishing relating to key annual milestones, religious festivals, significant holidays, return to school etc.	Head of Cyber and Networks	31 March 2026 (ongoing process)	Schedule of themes determined. Comms completed and delivered against a number of themes, including broader awareness session to further support the most recent internal Phishing exercise. Continual process and subject matters continue to evolve and flex with need.
Clinical and Care Service Engagement and involvement throughout EPR scoping, specification and procurement cycle to support views on functional requirements to support future uptake and adoption of a new EPR	Chief Digital Information Officer	30 November 2026 (ongoing process throughout EPR Procurement)	Outline Business Case developed approved by EPR programme board, Finance & Performance Committee and Trust Board. Reformed digital steering group accountable for delivery A number of stakeholder events have taken place to support and finalise high level specification. Further work to begin to review opportunities, impact and requirements associated to merger and the requirement of a single EPR procurement.
Delivery of EPR functional requirements outside of CareDirector to support emerging need to support clinical pathways and mitigate potential areas of clinical risk and patient safety.	Chief Digital Information Officer	31 December 2026 (ongoing process until EPR replacement)	Enhanced Therapeutic and Observations Care (ETOC) functionality delivered to support care services. Work underway with care services to understand additional observation requirements.

			Further work to begin to review opportunities, impact and requirements associated to merger and the requirement of a single EPR procurement Review of complementary systems to support areas of development that CareDirector cannot deliver against continues in line with integration and interoperability requirements to ensure ability to review and report on all data. OpenEHR environment created. ARCHETYPES under review to support application development for recording of observations
Usability reviews and NHS APP integration a fixed requirement for patient portal procurement and deployment	Chief Digital Information Officer	31 March 2026 (ongoing process)	NHS App integration dependent upon appointment management through portal, conversations ongoing with national team regarding questionnaire-based app integration. The appointment management module needs to be further investigated and may require operational changes in how CareDirector is used. Meetings are underway with the supplier and the national WayFinder programme regarding integration with the NHSApp

Contributory risks at level 12 or above

Ref	Description	Lead / Responsible Director	Oversight Group	Score
105	The danger of a cyber-attack to the Trust's ICT infrastructure through malicious hacking or system virus infection.	Chief Digital Information Officer / Chief Financial Officer	Digital Steering Group	12 (L3xC4)
1223	Advanced will not continue to make the same levels of investment in the growth of CareDirector v6. Going forward Advanced have committed to continue to maintain and support CareDirector v6 for the duration of customers current contract term, but the roadmap will be adjusted to only focus on essential maintenance activities and key legislative/security work.	Chief Digital Information Officer / Chief Financial Officer	Digital Steering Group	16 (L4xC4)

Strategic Risk 7

BAF Risk SR7 Risk 1111	There is a risk we fail to understand, plan and deliver services that meet the health needs of the population we serve.		
Strategic Objective:	1. Through our care services: We deliver great care that is high quality and improves lives		
Accountable Director	Chief Operating Officer	**Initial Risk Score**	12 (L3xC4)
		Current Risk Score	12 (L3xC4)
Oversight Committee	Finance & Performance Committee	**Target Risk Score**	6 (L2xC3)
Risk Appetite	Seek	**Target Date:**	31 December 2027

Controls in place

- Care service governance structure and framework in place to monitor and plan service delivery and development and report ward-to-board and board-to-ward
- Care Services Strategic Plan
- Annual operational planning and prioritisation process
- Trust's People Plan
- Quality Strategic Plan
- Working in partnership with the ICB in relation to marginalised communities
- Partnership with other NHS organisations and community groups across our service delivery areas
- Work to look at inequalities in relation Restrictive Practices and their reduction
- Community Mental Health Transformation Programme
- Utilisation of population health information in the planning and design of services
- EHIA tool
- Out of Area Placement programme to ensure people are appropriately placed according to their need
- Business Continuity Plans
- Improving Health Equity Strategic Plan 2025-2029 and implementation plan
- PCREF Action Plan 2024-2027
- 'Must do' work on EDS, PCREF and Equality Act duties
- Care Services Performance Meeting and agreed reporting metrics
- Waiting List Management Process in place
- Business Continuity Management System in place
- Improving Health Equity Steering Group

Details of Assurance

Assurance Rating:	**Partial**

Management / Service Level	**Review Process / Oversight**	**Independent (external / internal audit)**
- Chief Operating Officer governance structure and reporting framework - Care Services Strategic Plan implementation programme - Annual planning, monitoring and delivery framework - Business planning process - Update on delivery of the Trust's people Plan - Update on delivery of the Quality Strategic Plan	- Assurance reports, discussion and actions relating to governance groups including: o Board of Directors o Finance & Performance Committee o Mental Health Legislation Committee o Workforce Committee o Quality Committee o Executive Risk Management Group	- Audit Yorkshire – internal audit programme & reports - Contract meetings and monitoring - Provider Collaborative Framework - Community Mental Health Transformation Partnership Board

- Waiting times monitoring process - Protected characteristics monitoring - Workforce monitoring reports - Reduction in restrictive practice workstream - Monitoring of the ethnic mix of detained patients and those who access our service - Capacity and flow programme EPRR monitoring compliance with Business Continuity management system	o Care Services Development and Delivery Group o Care Services Performance Group o ICB MH Population Board - Chief Operating Officer reports - Annual Service Quality Reports - CSDDG Annual Report - WREN / DAWN Group	

Gaps in assurance / controls:	- Health Inequalities Strategy Implementation Plan - Compliance with Business Continuity Management System - Equality Impact Assessment Process

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress
Development of an Equality & Health Inequality Impact Assessment Process	Head of Health Equity	31 January 2026	New EHIA Policy, guidance and templates in development which will enable the Trust to proactively and positively consider how we can help improve health equity and actively work to tackle known inequalities. This is further enabling us to support and evidence the responsibility of LYPFT to reduce inequalities in access, experience and outcomes.
Compliance with the Business Continuity Management system	EPRR Lead	31 May 2027	Work is ongoing to ensure all relevant services have a business continuity plan and that these are regularly reviewed within relevant governance groups and evidence of this is provided to the EPRR Team. It is anticipated that all Care Services Teams will have a business continuity plan by the end of October 2025. All Corporate Services Teams will have a plan by May 2026 (Corporate Business Plans support the delivery of Care Services).
Care Services Strategic Plan appendices to be updated by service lines	Deputy Director for Service Development	28 February 2026	The review of the strategic plan is now underway in line with the 10-year plan and the new planning framework and guidance. It is anticipated that the CSSP will be completed in the New Year

Contributory risks at level 12 or above

Ref	Description	Lead / Responsible Director	Oversight Group	Score
92	The current level of demand for the gender service is greater than planned level of activity, resulting in a lengthy waiting list for assessment and treatment. In addition, due to the child and adolescent service closure, there are further increasing numbers of transfers from the child and adolescent services which is impacting upon waiting times to access the service for all. This presents a potential risk to service user mental and physical health, due to the inability to access care in a timely way.	Operational Manager for the Gender Service	Care Services Delivery and Development Group	12 (L4xC3)
1101	West Yorkshire GPs are declining Connect blood requests for physical health monitoring under instruction from the West Yorks LMC that states eating disorder blood monitoring is not mandatory	CTM	Care Service Delivery and Development Group	12 (L3xC4)

	for GPs. Connect are not commissioned to provide phlebotomy services and do not have access to the necessary systems for requesting and monitoring bloods. This presents a potential risk to service user physical health, due to the inability to access care in a timely way.			
1212	Delayed service user transfer from LTHT to LYPFT inpatients. This has resulted in service users requiring mental health admission remaining in medical beds in LTHT for significant periods of time. There is a potential risk to service users due to not receiving timely and skilled mental health interventions. Additionally, there is a risk to other patients in LTHT and to staff.	CTM	Capacity and Flow Group	12 (L3xC4)
1213	Increased risk of Leeds Service Users being inappropriate sent out of area for care and treatment because of reduced flow across our inpatient services.	Head of Operations	Capacity and Flow Group	16 (L4xC4)
1260	The risk of new and emerging pandemics, as shown by COVID19, could have a devastating impact on society and a direct impact on how the Trust continues to provide services.	EPRR Lead	EPRRG	12 (L3xC4)
1263	A supplier of a service that has been identified as critical to one of the Trust main service provision obligations or a key supporting service goes into administration or entirely closes, creating a service provision risk.	EPRR Lead	EPRRG	12 (L3xC4)
1270	ADHD waiting list of 4,700 plus patients for diagnostic assessment, 100 minimum patients added to list each month, waiting time for new non-urgent assessments of 10 years minimum, likely far longer. This presents a potential risk to service user mental health, due to the inability to access care in a timely way.	Operational Manager	Care Service Delivery and Development Group	12 (L4xC3)
1271	Patient waiting times for ADHD medication initiation presents a risk to patients due to a delay in medication commencing.	Operational Manager	Care Service Delivery and Development Group	12 (L4xC3)
1289	Physical health team are experiencing caseload and capacity issues and are unable to provide the level of service to meet service user need.	CTM	Care Service Delivery and Development Group	12 (L4xC3)
1305	Gap in the provision of Psychological services to acute wards within the Newsam Centre. Post will not be filled until June 2026 due to maternity leave	Head of Operations	Care Service Delivery and Development Group	12 (L4xC3)
1313	Gap in dietetic provision to working adult acute inpatients due to promotion of a dietician leaving a gap in the rota	Operational Manager	Care Service Delivery and Development Group	12 (L4xC3)
1343	Increase in violent incidents within the S136 suite increasing risk of harm to service users and staff, risk that the current control of closing a bed risk increased attendances to the LTHT A&E department	Head of Operations	Care Service Delivery and Development Group	12 (L4xC3)

Risk Appetite	Strategic Risk
Minimal	**SR1: Quality including Safety Assurance Processes** Delivering high quality services and care is core to the organisation's aims, objectives and ambition, however the Trust will avoid risk which compromises the delivery of high quality and safe services, and jeopardises compliance with our statutory duties for quality and safety or meeting our regulatory compliance requirements. It recognised that ultra-safe for one patient group could be risky for another patient group and that the avoidance of risk would never allow for improvements to be made. The importance of counter balancing risks at patient level and Trust level is acknowledged.
Cautious	**SR2: Delivery of the Quality Strategic Plan** The Trust has a cautious risk appetite for the delivery of the Strategic plan and will consider new opportunities to deliver solutions to support the achievement of the key areas within the Plan. This includes a Patient Portal and Quality and Culture Dashboard, utilising technology to support the delivery of this, whilst considering any associated risks.
Cautious	**SR3: Culture and environment for the wellbeing of staff** The Trust has a cautious risk appetite to providing a rewarding and supportive place to train and work and recruiting and retaining the best staff. The Trust acknowledges the need to support staff through change management and innovative changes to our care delivery models therefore is open to risks associated with the implementation of new models of working, however will avoid risk compromising patient or staff safety.
Cautious	**SR4: Financial sustainability** Our appetite for financial risk is cautious. We continually aim to deliver our services within the budgets set out in our financial plans and will consider accepting risks that may result in limited financial impacts or losses on the basis that there may be opportunities elsewhere within the Trust. We will ensure that all such financial responses deliver optimal value for money.
Open	**SR5: Adequate working and care environments** The Trust is open to delivering our vision to make the best use of our most modern and fit for purpose estate, in line with our Estates Strategy. This includes offering the most appropriate therapeutic environment for our service users, and ensuring efficiency and effectiveness of use for our workforce to deliver care.
Open	**SR6: Digital technologies** The Trust is open to ensuring secure and adequate digital technologies being utilised across the organisation. It recognises the importance of making the best use of data to inform and increase our understanding of our population to provide insight into the best way to provide care. The long-term Digital Plan aims to use innovative technology and intelligence to enable safer, inclusive and more effective care. We will avoid risks that increase our exposure to cyber-fraud or incidents
Seek	**SR7: Plan & deliver services for health needs of the population** The Trust has an open risk appetite for collaboration with people and communities to ensure their experience influences equitable approaches, acknowledging that people who need help for their mental health, people with learning disabilities and those with neurodiversity conditions endure inequalities which affect their health and lives. We are committed to co-designing, co-producing and co-delivering proactive and integrated care and support through our care services.

3 Conclusion

The BAF demonstrates the key strategic risks for the organisation, and the controls and assurance have been updated to reflect the levels of assurance, with actions detailed on further work to be taken.

The document will be updated as per established governance and oversight processes, with links to the identified oversight committees.

4 Recommendation

The Board is asked to:

- Receive the BAF and to be assured of the review that has been undertaken to ensure that this accurately reflects the position as of January 2026, including risk scoring and mitigating actions.

Clare Edwards
Associate Director for Corporate Governance & Board Secretary
20 January 2026

Agenda item
18

Meeting of the Board of Directors

Paper title:	Approval of the appointment of the Senior Independent Director (SID) and approval of the SID role description
Date of meeting:	29 January 2026
Presented by: (name and title)	Merran McRae – Chair of the Trust
Prepared by: (name and title)	Kerry McMann – Head of Corporate Governance

This paper supports the Trust's strategic objective/s (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	✓
SO3	We use our resources to deliver effective and sustainable services.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	✓
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	✓
SR6	Digital technologies	✓
SR7	Plan and deliver services that meet the health needs of the population we serve.	✓

Executive summary

Approval of the appointment of the Senior Independent Director

The Board will be aware that it is required to appoint a Senior Independent Director (SID) as per the Code of Governance and the Constitution.

Since 2022 Cleveland Henry has carried out the role of the SID, but as he comes to the end of his final term of office on the 31 March 2026 the Board is required to identify another of the independent non-

executive directors who shall be appointed to this role with effect from 1 April 2026.

The Chair of the Trust has approached Zoe Burns-Shore to take on this role, and she has agreed to do this (subject to this being approved by the Board of Directors). In accordance with the previously agreed role description this appointment is for 2 years but with the option for this to be extended, again requiring the approval of the Board of Directors.

The Board is asked to approve the appointment of Zoe Burns-Shore as the SID with effect from 1 April 2026 for a period of 2 years. This is a Board appointment but one which requires the support of the Council of Governors. This appointment will be presented to the governors for their support at the next Council meeting on the 26 February 2026.

Approval of the role description for the Senior Independent Director

A copy of the SID role description is attached. The role description has been reviewed and the following minor changes have been made:

- Role description has been reformatted into the Trust's branded template
- Job titles have been updated
- Titles of guidance documents have been updated
- Committee names have been updated

All changes are highlighted within the document. The Board of Directors is asked to approve the changes made to the role description.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? State 'Yes' or 'No'.

No.

Recommendation

The Board of Directors is asked to:

- Approve the appointment of Zoe Burns-Shore as the SID with effect from 1 April 2026 for a period of 2 years
- Approve the changes made to the role description for the SID

ROLE DESCRIPTION

TITLE	**Senior Independent Director (SID)**
REPORTS TO	**The SID seeks to be independent in all matters and does not have one route of reporting; this will depend on the nature of the matter**
ACCOUNTABLE TO	**Board of Directors**

1. JOB SUMMARY

The Senior Independent Director (SID) will be a non-executive director (NED) with all the general duties of a NED in common with other NEDs, but with the enhanced duties of the SID as set out in section 4 below (the SID appointment will not attract any extra remuneration).

In summary the SID will be available to directors, governors or members if they have concerns which have not or cannot be resolved through normal contact with the Chair of the Trust, the Chief Executive, or the Trust Board Secretary (~~Head of~~ Associate Director for Corporate Governance), or where such contact is considered to be inappropriate.

2. CRITERIA FOR ELIGIBILITY

The SID is to be a NED who is appointed by the Board of Directors and who is considered to fulfil the criteria of 'independent' as set out ~~by Monitor in the NHS Foundation Trust Code of Governance~~ in NHS England's Code of Governance for NHS Provider Trusts.

The Chair of the Trust is not eligible to be the SID. The Deputy Chair, whilst eligible to be the SID, cannot carry out this role when acting as Chair of the Trust, due to the need to be independent of the Chair role. The Senior Independent Director does not have to be the chair of the Audit ~~and Assurance~~ Committee.

The Board of Directors will review the appointment normally every two years, and may re-appoint the incumbent SID or choose another person from amongst the independent non-executive directors as it sees fit. For clarity the appointment period for the SID will normally be two years unless there are operational reasons as to why the Board may wish to vary the term of appointment.

3. WORKING RELATIONSHIPS

The SID will be appointed by the Board of Directors. The Board of Directors should consult the Council of Governors in respect of the individual who is to be appointed.

The SID will have the normal working relationships of a NED, however with specific reference to the role of the SID the main working relationships will be with:

- Governors
- Members
- Directors (including NEDs)
- The Board of Directors
- The Council of Governors
- Chair of the Trust
- ~~Head of~~ Associate Director for Corporate Governance (acting as Trust Board Secretary)

4. PRINCIPLE DUTIES AND AREAS OF RESPONSIBILITY

In addition to the general duties of a NED, the SID will have the following specific duties:

- Be available to directors (executive and non-executive) if they have concerns about the performance of the Board or the welfare of the Trust, which contact through the normal channels of Chair of the Trust, the Chief Executive, or the Trust Board Secretary (~~Head of~~ Associate Director for Corporate Governance) has failed to resolve or for which such contact is inappropriate
- Be available to governors and members if they have concerns about: the performance of the Board of Directors; the Trust's compliance with the terms of its licence or the welfare of the Trust; where contact through the normal channels of Chair of the Trust, the Chief Executive, or the Trust Board Secretary ~~Head of~~ Associate Director for Corporate Governance), has failed to resolve or for which such contact is inappropriate
- Help resolve any disagreements that may arise between the Council of Governors and Board of Directors, in accordance with any procedures agreed by the Trust and set out in the Constitution
- Maintain sufficient dialogue with governors (including regularly attending Council of Governors' meetings) in order to develop a balanced understanding of their issues and concerns
- When appropriate ensure that the issues and concerns of members and governors are communicated to the other non-executive directors and, as necessary, the Board as a whole

- Carry out the annual appraisal of the Chair of the Trust and make a report to the Appointments and Remuneration Committee and the Council of Governors on the outcome

- Meet with the non-executive directors, in the absence of the Chair of the Trust, at least annually to discuss his/her performance as part of the annual appraisal process (or for any other reason which may require the NEDs to meet without the Chair of the Trust)

- Chair the Nominations Committee and the Appointments and Remuneration Committee when matters concerning the incumbent Chair of the Trust are being considered

- Support the Chair of the Trust in leading the Board of Directors, acting as a sounding board and source of advice for the chair.

5. TIME COMMITMENT

The Senior Independent Director should ensure they will have sufficient time to meet the rigours of the role and the additional responsibilities.

6. APPROVAL

This role description is subject to approval by the Board of Directors at its meeting on 29 January 2026.

Any subsequent changes to the role description will be agreed by the Board of Directors.