Leeds and York Partnership
NHS Foundation Trust

Public Meeting of the Board of Directors

will be held at 9.30am on Thursday 26 March 2026 Mind Room, The Studio, Riverside West, Whitehall Road, Leeds, LS14AW

Agenda

		LEAD	TIME
1	**Apologies for absence** (verbal)	**MM**	**9.30am**
2	**Sharing stories – Regional Eating Disorder, Rehabilitation and Gender Services** (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 29 January 2026** (enclosure)	**MM**	-
5	**Matters arising** (verbal)	**MM**	-
	5.1 Update from CQC inspections (enclosed)	**NS**	-
6	**Actions outstanding from the public meetings of the Board of Directors** (enclosure)	**MM**	-
	6.1 Action 34 - Inpatient Staffing Establishment Review and Workforce Programme Updates	**NS**	
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 24 March 2026** (to follow)	**KW**	**10.25am**
9	**Report from the Chief Financial Officer** (enclosure)	**DH**	**10.30am**
10	**Report of the Chief Operating Officer** (enclosure)	**JFA**	**10.40am**
	Break		**10.50am**

Patient centred care			
11	**Report from the Chair of the Quality Committee for the meetings held on 12 February and 12 March 2026** (enclosure)	**FH**	**11am**
12	**Report from the Medical Director** (enclosure)	**CHo**	**11.05am**
13	**Guardian of Safe Working Hours Quarter 3 Report** (enclosure)	**CHo**	**11.15am**
Workforce			
14	**Report from the Chair of the Workforce Committee for the meeting held on 19 February 2026** (enclosure)	**ZBS**	**11.20am**
	14.1 Workforce Committee Terms of Reference (enclosure)	**ZBS**	**-**
15	**Safer Staffing Report** (enclosure)	**NS**	**11.25am**
16	**Report from the Director of People and Organisational Development** (to follow)	**DS**	**11.35am**
17	**Staff Survey Results** (enclosure)	**DS**	**11.40am**
Governance			
18	**Report from the Chair of the Mental Health Legislation Committee for the meeting held on 10 February 2026** (enclosure)	**KK**	**12pm**
19	**Approval of a change to the Constitution** (enclosure)	**MM**	**12.05pm**
20	**Use of Trust Seal** (verbal)	**MM**	**-**
21	**Any other business**	**MM**	**12.10pm**

The next meeting of the Board will be held on Thursday 28 May 2026 at 9.30am
Inspire@2 room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR

Declaration of Interests for members of the Board of Directors

Name	Directorships, including Non-executive Directorships, held in other organisations (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.	None.	None.	None.	None.	None.
Dawn Hanwell Chief Financial Officer and Deputy Chief Executive	None.	None.	None.	None.	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 Foundation *A charity which works to empower children, young people and their families to embrace life with confidence, facing life's challenges in a positive way.*

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Nichola Sanderson Director of Nursing and Professions	None.	None.	None.	None.	None.	None.	None.	None.
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 *Management consultancy*	None.	None.	None.	None.	None.	**Deputy Lieutenant** West Yorkshire Lieutenancy **Trustee** Yorkshire Sculpture Park	**Director** Finnbo Ltd *Management consultancy*
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.

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Cleveland Henry Non-executive Director	**Director** 63 Argyle Road Ltd. *Property Management Company.*	None.	None.	**Chair of the Board of Trustees** Community Foundation for Leeds *Supports thousands of charities and voluntary groups across the city, addressing inequalities and working together to help create opportunities for those that need help the most.*	None.	None.	**Director of Group Delivery & Deployment** EMIS Group (Digital Health sector) *Provider of healthcare software, information technology and related services in the UK.*	Partner: **Lead Cancer Nurse** Leeds Teaching Hospitals NHS Trust
Kaneez Khan Non-executive Director	**Director** Primrose Consultancy Yorkshire *Management Consultancy firm* **Director** Leeds Faith Forum	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.

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Martin Wright Non-executive Director	None.	None.	None.	**Trustee** Roger's Almshouses (Harrogate) *A charity providing sheltered housing, retirement housing, supported housing for older people.*	None.	None.	None.	Partner: **Trustee** Roger's Almshouses (Harrogate) *A charity providing sheltered housing, retirement housing, supported housing for older people.*

Annual Declaration of Non-executive Director Independence

The Code of Governance for NHS Provider Trusts requires the Board to determine to what extent non-executive directors are independent in character and judgement and whether there are relationships or circumstances which are likely to affect or could appear to affect their judgement.

Name	Has been an employee of the Trust within the last two years.	Has, or has had within the last two years, a material business relationship with the Trust directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the Trust.	Has received or receives additional remuneration from the Trust apart from a director's fee, participates in the Trust performance-related pay scheme, or is a member of the Trust's pension scheme.	Has close family ties with any of the Trust's advisers, directors or senior employees.	Holds cross-directorships or has significant links with other directors through involvement in other companies or bodies.	Has served on the Board for more than six years from the date of their first appointment.	Any other reason you wish to declare. This should include any 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)
Merran McRae Chair	No	No	No	No	No	No	None.
Zoe Burns-Shore Non-executive Chair	No	No	No	No	No	No	None.
Frances Healey Non-executive Director	No	No	No	No	No	No.	None.
Cleveland Henry Non-executive Director	No	No	No	No	No	No.	None.
Kaneez Khan Non-executive Director	No	No	No	No	No	No.	None.
Katy Wilburn Non-executive Director	No	No	No	No	No	No	None.

Name	Has been an employee of the Trust within the last two years.	Has, or has had within the last two years, a material business relationship with the Trust directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the Trust.	Has received or receives additional remuneration from the Trust apart from a director's fee, participates in the Trust performance-related pay scheme, or is a member of the Trust's pension scheme.	Has close family ties with any of the Trust's advisers, directors or senior employees.	Holds cross-directorships or has significant links with other directors through involvement in other companies or bodies.	Has served on the Board for more than six years from the date of their first appointment.	Any other reason you wish to declare. This should include any 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)
Martin Wright Non-executive Director	No	No	No	No	No	Yes, Martin was first appointed on 20 January 2018. In May 2023 the Council of Governors agreed to extend Martin's term of office by a further three years to 19 January 2027, at which point Martin will have served nine years on the Board since the date of his first appointment. This decision was in line with the Code of Governance for NHS Provider Trusts, which states Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the board of directors.	None.

Public Board of Directors

Thursday 29 January 2026 at 09:30am

in Cheer Room, The Studio, Riverside West, Whitehall Road, Leeds LS1 4AW

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)	
Professor 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
Dr Hayley Lyon	Consultant Clinical Psychologist, Leeds Low Secure Service (for minute 26/002)
Ms Aishia Williams	Matron, Leeds Forensic Inpatient Service (for minute 26/002)
Mr Ferenc Ebozue	Service User (for minute 26/002)

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

		Action
	Mr Wright opened the public meeting at 09:30 and welcomed everyone.	
26/001	**Apologies for absence** (agenda item 1)	
	Apologies were received from Mrs Merran McRae, Chair, and Mrs Dawn Hanwell, Chief Financial Officer. Mr Wright, Deputy Chair, chaired the meeting in the absence of Mrs McRae. The meeting was quorate.	

26/002 **Sharing stories – Forensics** (agenda item 2)

Mr Wright welcomed Dr Hayley Lyon, Consultant Clinical Psychologist, Leeds Low Secure Service, Ms Aishia Williams Matron, Leeds Forensic Inpatient Service, and Mr Ferenc Ebozue, Service User, acknowledging the importance of starting with a service user story. Mr Ebozue shared his experiences with the Board, noting that he had spent 3 years and 5 months in hospital, therefore it was difficult to pick individual stories to share so he was sharing his wider thoughts with opportunity for discussions. He commented that mental health was a great leveller in life and as a patient in Forensic Services there was a difference with acute care as admission into the Forensic Service was not necessarily because you were more unwell, but due to unlawful acts whilst mentally unwell, which was an added layer of oversight that was not easy to break free from.

He noted that an absolute discharge from Forensic Services was challenging, with lifelong monitoring usually in place, and the core mission of the service should be to give service users the best possible life given the restrictions. Staff and facilities were key to this, and he noted a few key points:

- Staffing crisis was a patient crisis: one reduced staff member on shift impacts on the ability of service users to move around
- Staff wellbeing was important with the need for more realistic guidelines of staff working conditions, as treating staff with empathy allowed them to support service users
- Need for a reduction in waste
- Need for increased investment in psychology: they are often the only person who sees service users as human rather than a risk, and provide an essential safeguard
- Prioritise ongoing psychological intervention to also address institutional trauma caused by long term hospitalisation which was important for quality of life
- Rational requests from patients should be listened to: they have no power to challenge so important to respond as they feel silenced if not
- Celebrating staff is important as service users never forget staff who put in time and effort with them
- Logic of facilities was often flawed, for example medium secure facility had desk and shelving but this was not available in low secure which may lead to a lack of motivation for service users
- Small indignities add up to leave people not feeling like a valued member of society

He felt that his experiences were representative of broader observations and reflected everyday reality for people in the broader forensic estate. He commented that it was a flawed system which, whilst not a criticism, was an opportunity for change, many of which were practical elements that would make a difference to those who would not be able to leave the system.

	He explained that psychology was a lifeline in locked wards and finding common ground could be difficult, so it helped social interaction. Admission to forensics was a traumatic experience and there was a lack of understanding for what it was like for service users as an indefinite admission was challenging to manage and deal with for future life. Mr Wright thanked Mr Ebozue for his story and the points made and asked if the document he referred to could be shared across the Board which was agreed. Mrs Burns Shore noted the importance of the ongoing trauma element, so that was important to consider along with the small indignities which were easier to fix. Prof Healey noted it was a powerful story, and it would be helpful for Mr Ebozue to share his experiences more widely to help the wider system. Mr Ebozue responded that he had limited interaction with services currently which was positive but discussing it brought an emotional component to deal with at times. Dr Hosker commented that Forensic Services had been challenged at times but had moved forward, and the solvable issues were important to consider as there was an opportunity to help others. Ms Khan thanked Mr Ebozue for sharing his experiences and the depth and breadth covered in aspects of care. Mr Wright reiterated his thanks to all for attending	**CE**
	The Board of Directors **thanked** everyone for attending the meeting and sharing the engagement work within the Forensics Service.	
26/003	**Declaration of interests for directors and any declared conflicts of interest in respect of the agenda items** (agenda item 3)	
	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.	
26/004	**Minutes of the previous meeting held on 27 November 2025** (agenda item 4)	
	The minutes of the meeting held on 27 November 2025 were **received** and **agreed** as an accurate record.	

26/005	**Matters arising** (agenda item 5) The Board of Directors **noted** that there were no matters arising.	
26/006	**Actions outstanding from the public meeting of the Board of Directors** (agenda item 6) Mr Wright 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. In relation to the ethnicity data action, Mrs Forster Adams confirmed that this had been completed and shared with the Finance and Performance Committee. It was agreed that the action log update for the Committee would be shared with the Board for completeness. The night rostering action was reviewed at the Finance and Performance Committee and was part of the wider rostering work. It would continue to be reviewed through the Committee, and escalations and updates would be provided to Board as required. The action was closed. The action in relation to the operational priorities' trajectories was to be reviewed by a small working group to agree appropriate trajectories. It was agreed that this would remain ongoing at the current time. Mr Skinner confirmed that the action related to long term sickness within corporate services remained ongoing as further detail was awaited. The Board **received** the cumulative action log, **agreed** to close the actions that had been completed and **noted** the updates provided for ongoing actions.	**JFA / CE**
26/007	**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 that Industrial Action had concluded and been well managed, and the current ballot would conclude at end of January 2026. The second round of executive led engagement events had concluded and feedback was being evaluated currently. She noted that the medium term plan would be covered at the private Board meeting, and that there had been a request for submission of Board minutes noting the discussions which had been fulfilled. She informed the Board of	

the joint meeting with NHS England regional team and ICB Chair with Leeds Community Healthcare NHS Trust (LCH) and LYPFT to discuss the high level strategic points. Feedback from the regional team was to focus on trajectories for Out of Area Placements and Length of Stay performance, and that they were satisfied with the responses provided including interaction with Getting it Right First Time (GIRFT) and external validation.

In relation to the alignment with LCH, a Board to Board meeting had been held in January 2026, and comments were due from both Boards in relation to the Strategic Outline Case which will be tabled for approval at the Extraordinary Board meeting in February 2026.

She noted that the ICB voluntary redundancy scheme would conclude in February 2026 therefore the final position was unknown at the current time, however there was a risk across all organisations and West Yorkshire as the impact was unclear, especially in relation to loss of expertise. She noted that the ICB core Executive Team was expected to be appointed in May 2026, with final date for implementation following a Management of Change process being October 2026. The CEO was stepping down, and the Chair replacement was not known, therefore the immediate impact was a risk with unknown implications.

She referenced the Reasons to be Proud and team achievements which were important to acknowledge, and noted that Amy Pratt had been appointed as Lead Governor.

She informed the Board that the Trust had received notification that the CQC would undertake a Well Led inspection on 14 to 16 April 2026 in line with the new approach, and before then would carry out unannounced inspections of core services. The Trust would commence planning for this and the Board Strategic Development Session on 10 March 2026 would review the position.

Mr Wright thanked Dr Munro for the report.

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

26/008 **Report from the Chair of the Finance and Performance Committee for the meeting held on 27 January 2026** (agenda item 8)

Mr Henry presented the Chair's report from the Finance and Performance Committee meeting taking it as read. He noted the detailed discussions that had taken place including the financial performance at month 9, the deterioration in the run rate, the reduced position with the Cost Improvement Programme and the capital programme position.

He highlighted the discussion regarding the expenditure across bank and agency staff, including the positive trajectory throughout the year with some increases due to staff absences. The Committee reviewed and discussed the organisational priorities and focused on delays in completion of some areas and the assurance provided to address this. The Committee also reviewed the Board Assurance Framework and were satisfied with the controls in place. He noted the positive update from the procurement team and the Green Plan review which was noted to be progressing well.

Mr Wright thanked Committee members and Mr Henry for the report.

The Board of Directors **received** the Chair's report from the Finance and Performance Committee and **noted** the matters reported on.

26/009 **Report from the Chief Financial Officer** (agenda item 9)

In absence of Mrs Hanwell, Dr Munro presented the report taking it as read by the Board. The month 9 position remained positive, and she highlighted the detail on the trajectory for the rest of the financial year and future years, acknowledging the challenges with the Cost Improvement Programme and run rate, however she noted positive work to date and confidence in the forecast.

Mrs Burns Shore acknowledged the importance of non-recurrent support that was offered for the financial position and queried whether this would cease in due course. Mr Henry commented that the Finance and Performance Committee had reviewed the plan for future years, the expectation and prediction on modelling for the interest rates, and the impact of this. He added that the finance team had been realistic but cautious on the elements that could be risks around this, acknowledging that there were several unknowns at the current time. Mr Wright commented that the challenge was to achieve balance at the end of the financial year, and there would be discussion in the private Board meeting regarding projections.

Dr Munro commented that the medium term plan would be covered in the private Board meeting as there were significant shifts to manage and the Trust did not want to be reliant on non-recurrent support however the Trust was not in the territory that others were for support. The aspiration of the 10 year plan was for all Trusts to use Foundation Trust status to generate surplus and reduce the need for support.

Miss Wilburn raised that the Trust was achieving the financial plan but not by means that were optimal and using non-recurrent funds, therefore there were risks that remained for addressing in future. Mr Henry acknowledged that this would be the hardest year, but the Finance and Performance Committee were

assured by the quality of financial management and projections presented.

Mrs Forster Adams noted that the run rate deterioration was linked to the Out of Area Placement position which had been noted at the Committee. This was impacted by delayed discharge in complex rehabilitation, but this was expected to recover by year end.

Mr Wright thanked Dr Munro and Mr Henry for the updates provided.

The Board **received** the Chief Financial Officer's report and **noted** the content.

26/010 **Organisational Priorities Q3 Update Report** (agenda item 10)

Dr Munro presented the update report, taking it as read, noting the collective responsibility across all Executive Directors for the schemes. She added that detailed assurance for the priorities sat within other reports to Committees or Board.

In relation to the People Plan metrics and the alert regarding disciplinary process, she noted that this was due to the metric process as disciplinaries had halved in number, which was a significant improvement, but due to the overall shrinking number it looked like deterioration. She noted that the final building arrangements were being expedited for the Perinatal Service, but all enabling work had taken place, and the area was freed up to make the changes once the legal position was agreed.

Prof Healey queried if there was any more that could be done to address any digital interoperability issues in relation to the Respect form, and Dr Hosker responded that it was in hand and whilst the paper process led to potential duplication, by the summer there should be the ability to edit the document on the care record therefore progress was being made.

Mr Wright noted that, as discussed at Finance and Performance Committee, the report was put together in individual sections by managers keen to demonstrate progress therefore there may be a need for oversight of updates before the report is published. Dr Munro responded that this linked back to the working group action from the action log, and they would be able to consider how to demonstrate progress with the work done and align this to the outcome needed. Mr Wright thanked Dr Munro for the report.

The Board **received** the Organisational Priorities Q3 Update Report and **noted** the content.

26/011 **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 key points including that the work on site at Red Kite View had started with an 11 week programme of work which would ensure progress was made. She noted that the team had managed the service extremely well during this time.

She informed the Board that the seasonal variation with flow had not been seen as expected, and work was underway to understand any immediate actions needed as this provided an extra layer of oversight for learning and escalation. She added that consultant medics had been involved which provided insight into short and long term action needed. This impacted on the financial plan and performance, therefore the Board should expect to receive a business case for use of PICU to support this.

A case for change had been received from acute services with further work to be done on it with support from Royal College of Psychiatrists and GIRFT colleagues.

She confirmed that Physical Health assessments had seen a general improvement, and performance deterioration within older adults had been addressed quickly and would be resolved.

In relation to waiting times in Emergency Departments, she informed the Board that through a programme of work the acute liaison service had introduced a triage process that was being trialled and was producing an immediate positive impact. She noted that it was not yet possible to confirm the National Oversight Framework indicators yet, however length of stay for adults and older adults would remain areas of focus.

She alerted the Board to a delay in progress with the refresh of the Care Services Strategic Plan and an update would be provided at the next Board meeting and Council of Governors.

Ms Khan commented it was positive to see that Out of Area Placements were closer to home than in the previous position, which would have a positive impact on service users and families. Mrs Forster Adams acknowledged this and noted that further work was needed to understand what was reasonable in terms of closer to home.

Mr Wright referenced the increasing number of service users in the community setting, and the impact on service delivery due to this which was important to acknowledge. Prof Healey thanked Mrs Forster Adams for the helpful report and commented that it may be helpful to have a wider strategic discussion to understand wider issues within inpatient care that could be done

	outside of a hospital ward setting, linked to the Mental Health Act and future changes. Mrs Forster Adams responded that this linked to work with acute colleagues about the consideration of the future model of care and how this would be delivered. Dr Hosker added that the transformation group was working on this to consider these wider issues and he offered reassurance that discussions were taking place. Mrs Forster Adams confirmed that the work was being reported through the Care Cervices priority groups, through to the Quality Committee and Board. It was agreed that the implications of the amendments to the Mental Health Act would be discussed at a future Board Strategic Discussion session. Mrs Forster Adams noted that discussions regarding Neighbourhood Health had commenced and would be referenced in more detail in her next report to the Board. Mr Wright thanked Mrs Forster Adams for her report.	**CE**
	The Board **received** the Chief Operating Officer report and discussed the content.	
26/012	**Report from the Chair of the Quality Committee for the meetings held on 11 December 2025 and 15 January 2026** (agenda item 12) Dr Healey presented the Chair's Report from the Quality Committee meetings held on 11 December 2025 and 15 January 2026, taking them as read. She confirmed that whilst there were differences in how Chair reports were approached, all assurance was provided to the Committee as needed through relevant reports. She highlighted that the Committee had received the annual report on resuscitation, which had evolved over the past year and was presented to the Committee to provide assurance on the position. It was a collaborative report across functions and was a good example of many services and leads contributing to deliver the report. She provided reassurance to the Board that the service reports were reviewed and questioned by the Committee to determine that the self-assessment process was accurate, and it demonstrated that the Executive Directors knew the strengths of services and where additional support was needed. Dr Munro commented that the process would be helpful for the CQC inspection that would take place, and routine annual reporting was useful to be able to demonstrate assurance. Mr Wright 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.	

26/013 **Quality Committee Terms of Reference** (agenda item 12.1)

Dr Healey noted that the changes were mostly technical, however there was one amendment to note regarding the entirety of sexual safety reporting through to Quality Committee instead of Workforce Committee.

The Board of Directors **noted** and **approved** the Quality Committee Terms of Reference.

26/014 **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 enhanced therapeutic observation work, which continued to progress positively. She noted that it was now possible to enter in Care Director the detail of the observation plan for service users which was beneficial. The vaccination campaign had achieved the national target, but uptake had been below the aim for the flu vaccine.

Following on from the student nurse job discussion at the Board meeting in November 2025, she updated that the previous offer was a job for all student nurses trained at the Trust, however adjustments had been made to the process and student nurses ready for qualification were now asked to apply for up to 3 vacancies. This gave the opportunity for job interview experience and allowed Care Services to consider areas of expertise and interest; therefore, she was confident it would allow for a better appointment process for student nurses and services.

In relation to clinical supervision training, she updated that more facilitators had been recruited based on the findings of evaluation, and content was being refreshed for the training. She informed the Board that the Trust had maintained accreditation for the Triangle of Care, and it was important to note that a Trust could not be considered for a three star triangle of care accreditation unless it was a combined community Trust, therefore this was an area to aspire to over the next 18 months.

She noted the recent internal audit regarding claims and complaints which received low assurance and confirmed that work had already been undertaken to make improvements which had already had a positive impact. Work had been done to engage service users, families and carers to understand how to improve the process, whilst also aligning policies to those of NHS England expectations.

Mrs Burns Shore noted the positive messages within the report and queried whether bank staff were disproportionately undertaking the enhanced

observations as previously reported. Miss Sanderson responded that work undertaken identified that was not the case and reminded the Board that substantive staff regularly picked up bank shifts so may be those undertaking the observations.

In relation to the complaints audit findings, Mrs Burns Shore asked if performance data was being triangulated with other relevant data. Miss Sanderson responded that the complaints data gave false assurance as it included a smaller number of metrics, therefore the data reviewed would be widened to include more than just national targets and would include the overall position. Prof Healey added that the 60-day completion rate would be an important metric, but with the acknowledgement that reasonable timescales would be agreed with complainants where necessary. Dr Munro noted that there had already been a significant improvement in recent weeks with response rates, and it had been maintained that a conversation was had following receipt of the complaint with the lead investigator, with an opportunity to meet ahead of getting the written response as these were important elements of the process. Complex complaints involving staff who had left the Trust remained a challenge but was being worked through.

Dr Munro noted that the team involved in the culture of care work had presented at the Committees in Common and the feedback was excellent regarding the focus on lived experience, and it was acknowledged by others as important to support lived experience colleagues therefore this should be shared widely across all wards to support improvements in all areas.

Miss Wilburn noted that, in relation to enhanced therapeutic observations, the discussion at Finance and Performance Committee regarding bank usage indicated that the volume was declining but the cost was increasing as they were used at evenings and weekends. She felt it was important to not duplicate reporting but to ensure that it was understood in expenditure reporting. Miss Sanderson noted that the team were working on how to align systems to be able to collate data in that way and provide more detail regarding observations needed and bank shifts requested. It was agreed that Miss Sanderson would provide assurance and more detail on bank staff usage for shifts and the percentage used for enhanced observations in her next Safer Staffing report. Mr Wright thanked Miss Sanderson for the report. **NS**

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

26/015 **Safer Staffing Report** (agenda item 13.1)

Miss Sanderson presented the report taking it as read by the Board. She noted that the numbers of registered nurses above establishment were

starting to reduce and the implementation of the staffing establishment tool supported this. In relation to breaches of shifts with no registered nurse, she confirmed that this was reported, however explained that such was the speciality of the registered nurses that it wasn't possible to move them around services to address this therefore short term sickness led to risks which was mitigated through associate nursing roles.

She confirmed that vacancies remained as per previous months in specific areas, and this was starting to reduce due to newly qualified preceptees commencing in roles across wards and services. There was a continued focus on embedding a multi-disciplinary team focus on working within services and away from specific roles for specific professions.

Mr Wright thanked Miss Sanderson for the report

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

26/016 **Report from the Chair of the Workforce Committee for the meeting held on 4 December 2025** (agenda item 14)

Mrs Burns Shore presented the report, taking it as read by the Board, noting previous discussions regarding an increase in Freedom to Speak Up contacts, therefore Mrs Shereen Robinson, Freedom to Speak Up Guardian, had been invited to attend the Committee at any point ahead of Board for escalations and support.

She noted that the process for reasonable adjustments was to be reviewed at the next Committee meeting to ensure progress was being made to reduce time delays. Mr Skinner noted it was a complex issue including procurement and Access to Work and the timelines did not always match up and recommendations were not always possible, therefore there was a need to review the process, and he was confident that the right colleagues were looking at solutions.

Mrs Burns Shore noted that compulsory training for the coming year and the work entailed would also be reviewed by the Committee. In relation to the Council of Governors query regarding support for care leavers being included as a protected characteristic, she was confident that work was taking place already as if it was a protected characteristic.

Mr Henry noted several Freedom to Speak Up ambassadors had stepped down so there would be a need to review this over the coming months. Dr Munro acknowledged this and noted that there had been an increase in the working hours of Mrs Robinson to support this which would be reviewed on

	an ongoing basis to support the service through the merger process for staff engagement. Mr Wright thanked Mrs Burns Shore for the report
	The Board of Directors **received** the Report from the Chair of the Workforce Committee and **noted** the content.
26/017	**Report from the Chair of the Audit Committee for the meeting held on 20 January 2026** (agenda item 15) Mr Wright presented the Chair's report, taking it as read, and noted that there were no specific areas for escalation. He highlighted that the complaints and claims internal audit had been reviewed and whilst it was a low assurance report the management response was detailed and clearly addressed the issues. The delivering financial efficiencies (CIP) internal audit had received a split opinion, with processes for delivering the CIP being good, however the issue was that they had not all been achieved. He added that the deferred internal audit regarding the quality dashboard would be added to the programme in the next year.
	The Board **received** and **noted** the content of the Report from the Chair of the Audit Committee.
26/018	**Audit Committee Terms of Reference** (agenda item 15.1)
	The Board of Directors **noted** and **approved** the Audit Committee Terms of Reference.
26/019	**Mental Health Legislation Committee Terms of Reference** (agenda item 16)
	The Board of Directors **noted** and **approved** the Mental Health Legislation Committee Terms of Reference.
26/020	**Board Assurance Framework** (agenda item 17) Dr Munro presented the Board Assurance Framework noting that it had been updated and there were no significant areas to note. She highlighted the

	discussion at the Executive Risk Management Group in January 2026 regarding the target risk scores and whether they were achievable and confirmed that this would be reviewed in Q1 of 2026/27, including a full review at the Board Strategic Development Session in April 2026 to consider the strategic risks for the coming year. Mrs Edwards agreed to add this to the agenda for the session.	**CE**
	Mr Wright noted that at a recent meeting of Chairs of Audit Committees there had been a discussion on the distinction between issues and risks, with the Board Assurance Framework meant to identify risks but often issues were included instead, therefore this was worthy of consideration when reviewed. Prof Healey added that the reality of complex NHS organisations was that there were known problems and a need to acknowledge that the risk framework did not always support that to be realised. Mr Henry noted that in relation to Strategic Risk 6 and the Digital Plan, the outline business case for EPR replacement, and the Digital Plan refresh would need to acknowledge the significant impact of the merger from a digital perspective. Dr Munro confirmed that this had already flagged in the Due Diligence process.	
	Ms Khan noted the fire safety risk that had been added to Strategic Risk 5 and Prof Healey noted that it had been discussed at the Audit Committee and assurance provided that it was high risk with mitigation in place to reduce implications. Dr Munnro added that it had been reviewed at the Executive Risk Management Group and subsequent communication had provided assurance that the right steps were being taken.	
	The Board **received** the Board Assurance Framework and **noted** the content.	
26/021	**Approval of the appointment of the Senior Independent Director** (agenda item 18)	
	Mr Wright presented the paper regarding the updated role description and proposal for Mrs Burns Shore to take on the role after the departure of Mr Henry. Mr Wright noted that the role description did not reference the Freedom to Speak Up role, however it was acknowledged that they did not have to be the same role. Prof Healey noted that there was an opportunity to review roles through the merge process and reduce any duplication across roles.	
	Mrs Burns Shore confirmed she was happy to take on the Freedom to Speak Up role at the same time. Handover would take place over the coming weeks, and she would formally commence in the roles on 1 April 2026.	

	The Board **approved** the Senior Independent Director proposal.
26/022	**Use of Trust Seal** (agenda item 19)
	The Board **noted** that the Trust Seal had not been used since the previous meeting.
26/023	**Any other business** (agenda item 20)
	There were no additional items of business raised.
26/024	**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 12:00 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.

Agenda item
5.1

Meeting of the Board of Directors

Paper title:	Care Quality Commission Update
Date of meeting:	26 March 26
Presented by: (name and title)	Nichola Sanderson, Director of Nursing and Professions
Prepared by: (name and title)	Abby Boden, Head of Clinical Governance Miriam Blackburn, Head of Nursing Tracey North, Clinical Governance and Regulations Support 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 provides an overview of the Care Quality Commission inspection findings following their core service assessments and describes some of the actions been taken by the Trust to address the areas for improvement.

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'.**

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

Recommendation

The board is asked to note to findings from the CQC core service assessments and be assured of the actions taken to date.

Meeting of the Board of Directors

March 2026

Care Quality Commission Update

Executive Summary

This paper provides an overview of the Care Quality Commission inspection findings following their core service assessments and describes some of the actions been taken by the Trust to address the areas for improvement.

Introduction

On 28 January 2026, Leeds and York Partnership NHS Trust received a letter from the Care Quality Commission (CQC) outlining their intent to undertake a well-led assessment of the Trust in April 2026.

This is the first time the Trust has been assessed under the CQC's single Assessment Framework, using the Well-Led Quality Statements whereby evidence will be collated against the following eight quality statements:

1. Shared direction and culture
2. Capable, compassionate, and inclusive leaders
3. Freedom to speak up
4. Workforce equality, diversity and inclusion
5. Governance, management and sustainability
6. Partnerships and communities
7. Learning, improvement and innovation
8. Environmental sustainability

As part of the well-led assessment, CQC notified the Trust they would be undertaking unannounced assessment of core services in advance of the well-led assessment. To date, the CQC have carried out the following unannounced core service assessments:

10 March – 12 March 2026

- Rehabilitation Inpatient Services, Asket House, Asket Croft and Ward 5 Newsam

3 February –5 February 2026

- Acute Inpatient Services, Becklin Centre wards 1, 3, 4 and 5. Newsam Centre wards 1 and 4
- Older People's Inpatient Service,

28 – 29 October 2025

- Mill Lodge
- Red Kite View, General Assessment Unit and PICU

During the core service assessment, inspectors spent time speaking to a range of staff, patients and carers, reviewing the clinical environment, observing multidisciplinary team (MDT) meetings, reviewing clinical records, policies and procedures and undertaking medication checks. Subsequent data requests were received following the assessments which the CQC will use to triangulate evidence they have collated during the onsite assessment. Verbal high-level feedback was provided at the end of each assessment period, followed by initial written feedback letters outlining areas of good practice and areas for improvement which can be found within the appendix.

Actions taken to date

To address the areas for improvement identified by the CQC, the following actions have been taken to date:

Care Plans and Risk Assessments: Quality and Standard of Documentation
Ongoing work and actions taken to date: • Trust Lead for Care Planning to be identified and oversight group to be agreed. • Governance of care planning work to be agreed through Tier 3 Clinical Governance/Unified Clinical Governance group • Audit and Quality Standards to be developed and aligned to CPA Procedure (to be replaced by Personalised Care Framework), STEEEP Framework and Quality Dashboards. • Procurement and implementation of a Quality Improvement and Audit System to manage clinical governance. • The Trusts Care Planning training piloted at RKV to be rolled out and made available on the Learn system and accessible to all staff by end of Q1.
Medication Management
Ongoing work and actions taken to date: • Governance and oversight to be agreed through the Medicines Safety Committee for Medicines Management Assurance checks to include accountability for the completion and escalation. • Exploration of extending the implementing an electronic temperature monitoring system across care services which is currently in situ in the Pharmacy Department
Physical health Assessments
Actions taken to date:

- Immediate review undertaken to establish the barriers to completing the Physical Health form.
- Training/sharing of information on the process for Physical Health documentation was completed with medical colleagues in the Acute Inpatient Service.
- An interim daily oversight process was established for completion of physical health checks and related documentation.
- Governance and oversight to be agreed through Tier 3 Clinical Governance for the completion and escalation where physical health checks and documentation is not completed.

Estates, Environment and Maintenance

Ongoing work and actions taken to date:

- The Acute Inpatient Service Suicide Prevention Environment Risk Assessments have been updated to reflect the blind spots identified and current mitigations.
- Mirrors have been procured and will be fitted in Acute Inpatient Wards on delivery.
- Blind spots have been raised and discussed through the Suicide Prevention Environment and other relevant groups (Positive and Safe, Violence Reduction) to understand the risk assessment and develop recommendations for wider consideration across all inpatient services.
- The Suicide Prevention Environmental Survey and Risk Assessment Procedure will be updated to reference blind spots and ensure these are considered as part of future ward level assessments. Where there are individual patient safety concerns in relation to blind spots in the environment, these risks are mitigated through effective risk assessment, engagement and observation.
- Immediate action taken to remove Service User from bedroom affected by mold. Estates and Facilities commenced immediate treatment of mold.
- Monthly facilities and estate walkaround have been implemented as well as monthly audit.

Training Compliance

Actions taken to date:

- Service Line oversight and process implemented to ensure staff are booked on to the relevant training course.
- Immediate review of training availability has taken place where compliance has been below Trust target, such as fire safety, and training plans and trajectory developed.
- Systems are in place in clinical areas to ensure there are staff on each shift with the appropriate skills and competencies.

In addition to the above, a summary of learning from the CQC core service assessment will be discussed at the Trusts Unified Clinical Governance Group in March 2025, with the findings shared with the Clinical Leaders across the Trust. Action planning meetings are also scheduled with the core services leadership team to develop local action plans.

In conclusion, this paper is provided to the Board for information and assurance on the actions that have been taken following the recent CQC activity.

Abby Boden
Head of Clinical Governance
March 26

Appendices

Initial Feedback letter for wards for acute wards for adults of working age and psychiatric intensive care units

By email

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

Our reference: AP19978

Dr. Sara Munro
Chief Executive
Leeds and York Partnership NHS Foundation Trust

06/02/2026

CQC Reference Number: AP17250

Provider account Number: RGD

Dear Sara Munro

Re: CQC inspection of wards for acute wards for adults of working age and psychiatric intensive care units

I am writing to provide written confirmation of the verbal feedback of the preliminary findings as highlighted during our inspection and explained to you and your colleagues at the feedback meeting.

Name of provider:
RGD

Location(s) inspected:
The Becklin Centre: wards 1,3,4 and 5
The Newsam Centre: wards 1 and 4

ASG/s inspected (if applicable) and date(s) of inspection:
Acute wards for adults of working age and psychiatric intensive care units: 3, 4 and 5 February 2026

CQC inspection lead:
Nick Kurth

Representatives of provider attending feedback meeting:
Abby Boden, Gail Galvin, Laura McDonagh, Paula Garrigan, Fred Besa
Initial feedback:

Positive findings:

- We observed a range of activities taking place. Feedback from staff and patient about activities was generally positive.
- We observed some positive interactions between staff and patients
- Staff we spoke with were passionate about their roles and the care they provided.
- We saw that safety huddles enabled staff to proactively manage risk.
- There were opportunities for development and progression within the service and wider trust.

Areas for improvement:

- We found that care plans were generic in content and lacked evidence of patient involvement. Some patients fed back they had not been offered copies of their care plan.
- Seclusion care plans were also generic, and seclusion records often did not provide a narrative to confirm why seclusion was still needed or whether it was appropriate to end seclusion.
- We found missing entries to confirm whether fridge and room temperature checks had taken place.
- In some records staff had not documented a rationale for why patients had been administered PRN medicine.
- We saw that staff across the wards were not always bare below the elbows. This included staff wearing watches, synthetic nails, rings, and bracelets.
- On the psychiatric intensive care unit, we found delays in staff completing physical health observations.
- There were some blind spots on wards which were not documented on the environmental risk assessments.

This letter does not replace the draft report that we will send to you but simply confirms our verbal feedback. It will also enable you to start to consider any action you may need to take, rather than waiting for the draft inspection report.

We will send you a draft inspection report to check its factual accuracy once we have completed our due processes.

I am also sending a copy of this letter to NHS England via email.

Could I take this opportunity to thank you once again for facilitating the inspection, and for the co-operation of you and your staff.

If you have any questions, please contact me through our National Customer Service Centre by telephone on 03000 616161, or you can write to the CQC address at the top of this letter.

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause a delay if you are not able to give it to us.

Yours sincerely

Gemma Berry

Deputy Director

Initial Feedback letter for wards for older people with mental health problems

CareQuality Commission

By email

Our reference: AP19978

Dr. Sara Munro
Chief Executive
Leeds and York Partnership NHS Foundation Trust

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

CQC Reference Number: AP17195

Provider account Number: RGD

Dear Sara Munro

Re: CQC inspection of wards for older people with mental health problems.

I am writing to provide written confirmation of the verbal feedback of the preliminary findings as highlighted during our inspection and explained to you and your colleagues at the feedback meeting.

Name of provider:
RGD

Location(s) inspected:

The Mount, Wards 1 2 3 and 4

ASG/s inspected (if applicable) and date(s) of inspection:
Wards for older people with mental health problems, 03 04 05 February 2026

CQC inspection lead:
Rob Buchanan

Representatives of provider attending feedback meeting:
Gary Poxton, Scott Walker and Ben Alderson

Initial feedback:

Positive findings:

- All ward areas were clean and well maintained. There were some helpful and interesting displays around the wards and there appeared to be a range of spaces to carry out activities
- Spoke to a lot of patients and carers and the feedback from that was almost all positive, particularly about the support that they received from staff on the wards
- Care records, including care plans, risk assessments and MHA paperwork was in good order and demonstrated that good care and treatment was being delivered.
- The majority of staff said they were happy with the support they received from their managers. Managers had a good understanding of their work.
- Senior managers demonstrating a clear vision for driving improvements and what their plans were for the future, for example through culture of care work and a number of QI projects. This vision was shared by ward staff.

Areas for improvement:

- MDT meetings didn't appear to be particularly engaging and lacked patient or family and carer involvement, or feedback from patients, families or carers.
- Staff were inconsistently documenting observations; there were a number of gaps. Unsigned and undated entries, and some of the entries gave limited information, including lots of repeat entries.
- Some staff did not consistently understand what ligature cutters/hook knives were or where they were located if they were needed. It is noted that the trust had taken immediate action to address this issue.
- We weren't assured that medical equipment was deep cleaned on a regular basis as there was no system for recording or monitoring this work.
- Staff told us and our experience demonstrated that the electronic systems were intermittently slow.

This letter does not replace the draft report that we will send to you but simply confirms our verbal feedback. It will also enable you to start to consider any action you may need to take, rather than waiting for the draft inspection report.

We will send you a draft inspection report to check its factual accuracy once we have completed our due

processes.

I am also sending a copy of this letter to NHS England, via email.

Could I take this opportunity to thank you once again for facilitating the inspection, and for the co-operation of you and your staff.

If you have any questions, please contact me through our National Customer Service Centre by telephone on 03000 616161, or you can write to the CQC address at the top of this letter.

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause a delay if you are not able to give it to us.

Yours sincerely

Gemma Berry

Deputy Director

Initial Feedback letter for Long stay or rehabilitation mental health wards for working age adults

12/03/2026

CQC Reference Number: AP19978

Dear Dr. Sara Munro

Re: CQC inspection of: Long stay or rehabilitation mental health wards for working age adults

Following your feedback meeting with Kirsty McKennell on Wednesday 10 March 2026. I thought it would be helpful to give you written feedback as highlighted at the inspection and given to your colleague Jeanette Lawson at the feedback meeting.

This letter does not replace the draft report we will send to you but simply confirms what we fed back on Wednesday 10 March 2026 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board

meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board.

An overview of our feedback

The feedback to you was:

Positive:

- The staff team in the main told us they enjoyed their job, felt well supported and were able to voice concerns and be listened to.
- The wards were clean.
- Patients told us they were happy on the wards and felt safe and well looked after.
- Both wards were mixed sex, and this was managed well with displays around sexual safety on display. There was a separate female lounge and bathroom as well as en suite bedrooms for all patients.
- On the whole the environment wasn't overly restrictive, doors were unlocked and patients had keys for their own bedrooms.
- Lots of patients were on the self-medication pathway at various stages or working towards this.
- There was good evidence of discharge planning for patients, and this showed patient involvement clearly.
- There was good evidence of multidisciplinary team working with strong links with the wider rehab network (community rehab team, assertive outreach teams, independent rehab providers in the locality and oversight was maintained of out of area patients)
- We observed two patients' MDT meetings on Asket Croft and found these to be holistic, and patient centred with patients given the option of leading fully or partially.
- There was a wide range of activities reported to be on offer by patients, and these were reviewed regularly for effectiveness and attendance.
- The rehab model on Newsam Ward 5 was now fully established and staff had embraced recent changes working hard together as a team to ensure the best outcomes for patients.

Areas for improvement:

- We found it difficult to evidence that care plans had been updated regularly and were not assured this was happening regularly.
- On Asket House and Asket Croft we found several care plans that were not updated and staff acknowledged that this may have been the case prior to us reviewing records. This was due to high staff sickness, particularly on Asket Croft and recent serious incidents impacting on staff availability to complete paperwork.
- On Newsam ward 5, we were able to see a clear audit trail for when patients risk assessments were updated on the records system by using the audit button which showed monthly updates and the date this took place. However, this was not the case for care plans where we found the oversight of this was held by the Advanced Nurse Practitioner on the ward who carried out monthly record audits. The ANP was able to show us emails from staff when they had told him they updated care plans, but emails were not available for all care plans each month and this was not a reliable system to audit the dates that care plans were updated. As the records system only indicated the date of last update and all the care plans have been updated on the ward on the evening of 10 March 2026, we were then unable to see previous dates.

- We found examples on the records system, where dates of care plan reviews were available and showed monthly updates, but we were told this was not the norm, as this meant closing the care plan each time it was updated and opening a new one. It was unclear why this system was used to evidence updates for risk assessments but was not used in the same way for care plans.
- We found the care plan for one patient with a significant leg wound on Asket Croft did not show evidence on the records system of being updated since August 2025. Although we were assured this was being managed correctly and tissue viability nurses were involved, we were not able to reliably see that the care plan had been updated since August 2025. We also noted patients IS and GK on Newsam Ward 5, had gaps between updates of up to 6 months.
- One patient DG on Asket House had a risk of AWOL and no care plan in place for this – we fed this back to the team on site at the end of day 1.
- We found that some patients had thorough safety plans whilst others were either not present or lacked detail.
- Some areas of Asket House and Asket Croft were tired, with chipped paint on walls in need of painting.
- Training in some areas was low, we await the data request for training compliance for figures in full, but food safety, fire safety, low level PMVA and ILS were noted to be showing as red on the ward manager views.
- Supervision compliance on Asket House was also noted to be low, we were however, aware a recent serious incident and high sickness levels had impacted on staff availability to complete supervision.
- The multi faith room on Asket House was locked and was on the blanket restriction register. It had been on since August 2024 due to issues with the doors (unable to remain open awaiting magnetic release), the last review of this blanket restriction was in November 2025, the room remained locked during our visit.
- Although medicines were generally well managed and patients on Asket House in particular were self medicating or on the pathway to do so, we found that several care plans noted incorrect information. For example, stating the patient was on stage one when they were now on stage two.
- At our last inspection we noted in the “should do” section that the trust should ensure that staff at Asket House and Asket Croft completed high-level physical intervention training including promoting safe and therapeutic services and breakaway skills. We found on this inspection that only low-level training was being provided for the staff and that not all staff were up to date with this training. The staff explained a full review of this has taken place and the rationale for choosing low level, we will request this via the data request process to review.
- Liquid medications in the clinic room on Asket House and Ward 5 were found to be opened and did not have a date of opening on the bottle. In addition, several items were out of date in all three clinic rooms and in one case on Asket Croft, in the emergency trolley/bag. The bag was sealed and checks had noted all contents were in date, but when opened there was an IV needle that had expired in January 2026. We were not assured that clinical audits were effective due to the number of items we found to be out of date. The following items were found to be out of date and highlighted to staff during the checks:
- **Asket House**
    - Expired specimen bottles expired April 2024
    - Expired dressings (October 2023 and Jan 2026) - expired syringes Feb 2026
- **Newsam Ward 5**
    - Expired nutritional supplement Fresubin (7 out of date since Jan 2026)

- There was no free access to fresh air for patients on Ward 5, this was because the ward was on first floor and the garden was accessed via an external fire escape staircase which was locked at all times due to risks in the garden and the lack of staff oversight in this area, there was therefore no free access to fresh air for patients who did not have section 17 leave to go off the ward
- On Newsam Ward 5 the environment was in a poor condition. We joined the monthly walk around with the inpatient operations manager and the facilities manager. We saw several issues including black mould in one patient bedroom that had been highlighted at the previous walkaround and escalated but not yet completed. In addition to this we found:
    - One patient had no running water in his bedroom sink, this had been reported the previous month, so had been an issue for at least 4 weeks and not resolved.
    - There were several lights that were not working in patient bedrooms.
    - Two toilets had constantly flowing water and one toilet was significantly blocked with soiled toilet paper to the brim of the toilet.
    - Two patient bedrooms had graffiti on the walls.
    - There was paint missing from walls in bedrooms, staining to walls, signs of leaks on ceilings in two rooms (kitchen and one patient bedroom)
    - One patient's bedroom sink had what staff believed was dried vomit which was blocking the sink.
- Care plans, although detailed and evidenced patient input, did not always reflect the patient's voice. We saw care plans containing phrases such as "you said you will do" rather than indicating exactly what the patient had said, even if this was to refuse to engage.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to NHS England as per our usual processes. You may choose to share our feedback with the integrated care board.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC, Citygate
Gallowgate, Newcastle upon Tyne, NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand.
It may cause delay if you are not able to give it to us.

Yours sincerely

Kirsty McKennell
Inspector

Agenda item
6.1

Meeting of the Board of Directors

Paper title:	Inpatient Staffing Establishment Review and Workforce Programme Updates
Date of meeting:	26 March 2026
Presented by: (name and title)	Nichola Sanderson, Director of Nursing & Professions
Prepared by: (name and title)	Alison Quarry, Deputy Director of Nursing

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 in relation to action 34 of the Board of Directors action log regarding the comprehensive inpatient staffing establishment review.

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 are asked to note the content of the paper and be assured by the plans in place to develop an agreed staffing model for the Acute Inpatient Service.

Meeting of the Board of Directors

26 March 2026

Inpatient Staffing Establishment Review and Workforce Programme Updates

1 Executive summary

A comprehensive inpatient staffing establishment review was completed in September 2024 across all 26 mental health inpatient wards. The review confirmed the need for targeted staffing uplifts in a small number of areas, informed by MHOST data, quality indicators, and professional judgement. An interim uplift of one Band 3 Health Support Worker per duty was approved for five acute wards, with a full workforce model deferred pending wider programme outputs. The paper notes, “the progress around Health Support Worker recruitment has not progressed as expected,” resulting in continued high vacancy levels.

Several Trust-wide programmes expected to influence future staffing requirements are progressing at varying pace. Key developments include:

- Health Support Worker Recruitment & Retention: A new large-scale recruitment campaign delivered limited conversion, prompting the creation of a dedicated programme focusing on recruitment, retention, development, and workforce redesign.
- MHOST Review: Early findings indicate current safer staffing levels are aligned with the existing care model, though MHOST does not fully account for modern multidisciplinary skill mix. Further modelling is required.
- Inpatient Quality Transformation Programme (IQTP): The case for change has been completed, highlighting significant pathway issues and the need for a remodelled workforce plan. Some areas of the transformation work are paused pending external review.
- Royal College of Psychiatrists Invited Review: Commencing April 2026, this review will provide independent scrutiny of pathways, clinical model, and workforce configuration, offering recommendations to inform the final workforce model.
- Enhanced Therapeutic Observation & Care (ETOC): Implementation of electronic observation recording has strengthened data quality and oversight. Further work is required before ETOC can be integrated into safe staffing models.

Overall, progress across the programmes are at varied stages. While important infrastructure improvements, such as electronic ETOC recording have been achieved, delays in recruitment and the early stage of clinical model redesign means that a finalised workforce model cannot yet be confirmed. The Royal College review is expected to provide essential diagnostic insight to support this work.

In the interim, the Trust remains focused on maintaining safe care through the agreed Band 3 uplift, strengthened oversight of safer staffing, and targeted action around the Health Support Worker workforce. The combined outputs of the establishment review, IQTP, and Royal College review will enable development of a sustainable, evidence-based workforce model aligned to clinical need, quality ambitions, and financial constraints.

2 Introduction

A comprehensive staffing establishment review was undertaken in September 2024 across the 26 mental health inpatient wards within Leeds and York Partnership NHS Foundation Trust (LYPFT). The review enabled evidence-based recommendations to be made regarding the required staffing uplift in a small number of clinical areas. Recommendations were informed by multiple data sources, including the Mental Health Optimal Staffing Tool (MHOST), quality indicators, and professional judgement.

At the time of the review, several significant Trust-wide workstreams were either underway or in early development, with anticipated impact on staffing requirements and workforce deployment. An options paper was therefore presented to consider how the Trust could continue to deliver safe and effective care while accounting for the anticipated outcomes of these programmes. It was agreed that an interim position would be adopted rather than implementing the full uplift in totality.

Agreed Actions

- Add one Band 3 per duty to Wards 1, 3, 4, 5 (Becklin Centre) and Ward 4 (Newsam Centre).
- Reassess staffing requirements post-programme(s) implementation (for all clinical areas)
- Launch a large-scale Health Support Worker recruitment campaign, including existing vacancies.

This paper provides an update on the key workstreams including the Inpatient Quality Transformation Programme and those programmes that were expected to influence staffing requirements and outlines the Trust's current position around an agreed staffing model for the Acute Inpatient Service.

2.0 Acute Inpatient Service Band 3 uplift

An uplift of an additional 1 x Band 3 per duty was agreed and the service identified that increasing the Health Support Worker resource in the interim would be most beneficial to support safer staffing numbers particularly due to the high levels of enhanced care and support around physical health care that were being delivered across the 5 wards.

The progress around Health Support Worker recruitment has not progressed as expected with a lower than anticipated success rate at service level and trust level recruitment campaigns and has consequently resulted in further vacancies being added to the already high numbers in existence.

2.1 Health Support Worker Recruitment Campaign Workstream

A targeted and new approach to the Health Support Worker recruitment campaign was piloted following approval at the Safer Staffing Steering Group meeting in September 2025 which aimed to recruit large

scale numbers through a more efficient means. This was developed in response to a decreasing number of successful appointments following recruitment initiatives.

Although the campaign delivered several positive outcomes, the conversion rate was insufficient to impactfully reduce vacancy levels. As a result, a dedicated programme of work has been established, led by the Deputy Director of Nursing and the Strategic Workforce Lead, to address Health Support Worker recruitment and retention more systematically and with a greater focus across 3 workstreams: recruitment, retention and continuous development and workforce redesign. The 3 workstreams will have dedicated leadership and oversight and will feed into the oversight programme to track and review progress.

3.0 Programme of Works

To support the development of a coherent, evidence-based workforce model for the Acute Inpatient Service, one that aligns clinical need, quality ambitions, and financial sustainability, it is essential to bring together several interconnected programmes of work. Only once these workstreams are synthesised can a clear and deliverable workforce model be finalised. Following the establishment review, it became clear that this step was essential to developing a successful workforce model. As a result, the anticipated timeframes were extended to allow this approach to be fully implemented and to maximise its effectiveness.

The remainder of this paper provides an update on the progress of the Acute Inpatient Service workforce model workstreams. It outlines how each programme of work has influenced the overall timeline and highlights the dependencies that must be resolved before a definitive workforce model can be progressed for Acute Inpatient Services.

3.1 Invited Review by the Royal College of Psychiatry

An invited review to LYPFT's approach of 'Assessment of Flow Efficiency' and 'Model of Care', by the Royal College of Psychiatry has been commissioned and is expected to commence in April 2026. The invited review offers a bespoke approach to allow services the ability to better understand the complexity of their concern under various lenses with a menu of workstreams which include Governance, Clinical Service Review and Clinical Model Review.

The **clinical model review will specifically** evaluate whether the current clinical model e.g. ward configuration, staffing, pathways, multidisciplinary working reflects current best practice and national standards. The outputs of the review will include, key findings, areas of good practice and recommendations for improvement.

3.2 MHOST

The 2025/26 annual establishment review is currently in progress across all 26 inpatient wards facilitated by the Professional Leads for Nursing. Using MHOST data, the review has been fully completed for the five inpatient wards required under the National Quality Board (NQB) Safer Staffing framework.

Findings indicate that current safer staffing levels are appropriately aligned with the needs of the existing care model and are sufficient to support the delivery of safe care. However, the MHOST tool

is primarily designed around traditional clinical roles, such as Registered Nurses and Healthcare Support Workers. As a result, it does not fully account for the broader skill mix or evolving workforce models used in modern mental health care.

To ensure a more comprehensive and future focused approach, the MHOST analysis should be supplemented with robust workforce modelling that incorporates quality, best practice, and the full multidisciplinary contribution to patient care. This will be identified through the ongoing work as part of the Inpatient Quality Transformation Programme.

3.2 Inpatient Quality Transformation Programme (IQTP)

The Inpatient Quality Transformation Programme (IQTP) is a national NHS England initiative designed to improve the quality, safety, and culture of care across Mental Health, Learning Disability, and Autism inpatient services. It builds on the NHS Long Term Plan and addresses longstanding challenges such as variation in care quality, outdated clinical models, and the need for more person-centred, trauma-informed practice.

A key aim, and as one of our Care Service Trust Priorities is to transform the adult acute inpatient clinical model to support timely, sustainable care pathways aligned with national best practice. A review of the IPF Programme shows that while work has commenced, it remains in early stages and has not yet led to significant pathway or practice change. In 2025/26 the leadership team have worked to address the ongoing capacity related pressure, at the same time as undertaking work to set out a case for change. The case for change was delivered in February 2026, which outlines the significant pathway issues that require improvement to provide a comprehensive, right sized acute inpatient service.

A central component of this work is the development of a remodelled workforce plan that right-sizes teams, aligns with the establishment review, and supports financial sustainability.

Early findings of the workforce modelling have recognised the richness and breadth or roles and/or skills across the MDT within the service. Further work is however needed to understand how these roles are utilised to maximise the impact, particularly around the quality of care we deliver while maintaining safer staffing numbers without the need to increase resource. There is early indication that an emphasis on clinical leadership, a need for increased therapeutic activity to be delivered and more specific to the male wards, an emphasis on harm reduction is required.

A workforce redesign workshop is schedule for Adult Acute and PICU services in Q1 26/27 which will include exploring opportunities for role redesign, repurposing vacancies, and introducing new roles (testing the early indictors), all within the financial envelope for the service line. The Band 3 Health Support Worker roles will be revisited due to the challenges in recruiting to these roles and the indication that other roles may be as equally valuable. The output will include a preferred workforce model, an assessment of how the current workforce aligns to it, and a learning needs analysis to support upskilling.

Although it is recognised that the Royal College review will inevitably introduce delays to some elements of the ongoing programme and its anticipated outputs, the added rigour and scrutiny provided by the review is expected to deliver greater long-term benefit.

The transformational work will be developed following further diagnostic and improvement analysis by the Royal College of Psychiatrists in collaboration with senior LYPFT leaders.

3.3 Enhanced Therapeutic Observation and Care (ETOC) Programme

LYPFT continues to participate in the national ETOC programme, which promotes clinically led, patient-centred approaches to therapeutic observations. The four pillars of the programme include: **Leadership and oversight**: governance, data quality, assurance, **Person-Centred and Safe Care**, **Education and Training**: Ensuring staff competency, **Workforce Planning and Deployment**: Integrating ETOC into safe staffing models

The LYPFT ETOC programme has benefited from dedicated leadership, with an ETOC Steering Group established in September 2025 to provide governance, strategic oversight, and alignment with the Safer Staffing and Positive & Safe workstreams. Initial priorities centred on engaging inpatient services and improving the quality, consistency, and accessibility of observation data to support effective oversight and continuous improvement. Early analysis highlighted that existing observation data was variable and not easily retrievable, limiting the Trust's ability to understand demand and associated workforce implications. To address this, a new electronic observation recording form has been developed within Care Director, replacing the previous paper-based system. The form was piloted across 10 inpatient wards from December 2025 and will now be rolled out Trust-wide from March 2026. Moving to electronic recording will significantly enhance visibility of observation levels through improved dashboards, enabling more robust oversight of ETOC demand, workforce deployment, training requirements, and emerging quality and safety themes.

The next phase of the programme will focus on clinical areas with consistently high levels of ETOC. This will involve exploring local culture and practice, identifying any gaps in staff competency or confidence, and considering how alternative therapeutic interventions may support safe and effective care while reducing reliance on enhanced observations. It is anticipated that the programme will not be able to move to the fourth pillar **Workforce Planning and Deployment** and integrating ETOC into safe staffing models until this phase is completed.

A particular emphasis will be placed on the Acute Inpatient Service as part of the forthcoming programme activity.

3 Conclusion

The inpatient establishment review has provided a robust foundation for understanding current staffing requirements across the Acute Inpatient Service, while also highlighting the wider system changes needed to deliver a sustainable and modernised clinical model. Progress across the associated workforce and quality improvement programmes has been mixed, with notable advancements, such as the implementation of electronic ETOC recording contrasted by ongoing challenges in Health Support Worker recruitment and the early stage of the IQTP related redesign work.

The forthcoming Royal College of Psychiatrists Review represents a pivotal opportunity to strengthen the Trust's diagnostic understanding of its inpatient pathways, clinical model, and workforce configuration. Although the temporary pause in some areas of transformational workforce planning aligned to the new clinical model will delay the development of a finalised staffing model, the

independent scrutiny and recommendations are expected to significantly enhance the quality, credibility, and long-term impact of the programme.

In the interim, the Trust remains committed to maintaining safe and effective care through the agreed Band 3 uplift, continued monitoring of safer staffing data, and targeted work to stabilise Health Support Worker recruitment and retention. The outputs of the Royal College Review, combined with the ongoing establishment review and IQTP activity, will enable the development of a coherent, evidence-based workforce model for the Acute Inpatient Service that aligns clinical need, quality ambitions, and financial sustainability

4 Recommendation

The Board are asked to note the content of the paper and be assured by the plans in place to develop an agreed staffing model for the Acute Inpatient Service.

Alison Quarry
Deputy Director of Nursing
16th March 2026

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	**COMPLETE** This is on the agenda for the March meeting.
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	**Dawn Hanwell**	March 2026	**UPDATE** It was noted that a working group would be established to consider this work and updates would be provided at the next Board meeting.

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
	milestones and impact. Mrs Hanwell agreed to review and amend the report as appropriate to deliver this.			
38	**Report from the Director of People and OD** (minute 25/154 - agenda item 16 – November 2025) 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.	**Darren Skinner**	January 2026	**COMPLETE** This has been circulated to Board members. Any further detail required can be requested through the Workforce Committee.
39	**Actions outstanding from the public meeting of the Board of Directors** (minute 26/006 - agenda item 6 – January 2026) In relation to the ethnicity data action (action 35), Mrs Forster Adams confirmed that this had been completed and shared with the Finance and Performance Committee. It was agreed that the action log for the Committee would be shared with the Board for completeness.	**Joanna Forster Adams / Clare Edwards**	Management action	**NEW** **COMPLETE** The update provided to the Finance and Performance Committee was shared with the Board.
40	**Report of the Chief Operating Officer** (minute 26/011 - agenda item 11 – January 2026) It was agreed that the implications of the amendments to the Mental Health Act would be	**Clare Edwards**	Management action	**NEW** **COMPLETE** The is on the forward plan for the session in April 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
	discussed at a future Board Strategic Discussion session.			
41	**Report from the Director of Nursing and Professions** (minute 26/014 - agenda item 13 – January 2026) It was agreed that Miss Sanderson would provide assurance and more detail on bank staff usage for shifts and the percentage used for enhanced observations in her next Safer Staffing report.	**Nichola Sanderson**	March 2026	**NEW** **COMPLETE** This has been included within the Safer Staffing Report.
42	**Board Assurance Framework** (minute 26/020 - agenda item 17 – January 2026) Dr Munro confirmed the BAF would be reviewed in Q1 of 2026/27, including a full review at the Board Strategic Development Session in April 2026 to consider the strategic risks for the coming year. Mrs Edwards agreed to add this to the agenda for the session.	**Clare Edwards**	Management action	**NEW** **COMPLETE** This has been added to the agenda for the Board Strategic Development Session in April 2026.

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
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 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.	**Joanna Forster Adams**	January 2026	**COMPLETE** An update was provided to the Finance and Performance Committee in January 2026, and this was shared with the Board for completeness.
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	**COMPLETE** This was reviewed at the Finance and Performance Committee and was part of the wider rostering work.
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:	26 March 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

26 March 2026

Chief Executive's Report

1 Executive summary

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

2 Our Services and Our People

Service Visits

At the end of January, I spent some time at the Mount visiting older adult services and the perinatal mental health service. It was evident that in older adult services there has been significant work undertaken across inpatient and community services. There is a stable and cohesive leadership team which is having a demonstrable impact on the service with improved recruitment and retention, improved pathways and focus on clinical effectiveness. As with all services there continues to be challenges with capacity and demand and the leadership team are looking longer term at service models and integration as part of the community transformation programme.

The Mother and Baby Unit expansion remains under development due to complexities with the PFI contract however in the meantime the service itself is on with recruitment and planning for the new delivery model once the additional beds are operational. The leadership ship shared with me changes they have made in the service pathway since taking on lead provider for the region with a dedicated triage function which brings together senior clinicians and decision makers across inpatient and community teams.

Consistent across both services was the focus on improvement, transformation and working in partnership and despite the day to day challenges a genuine sense of optimism and positivity instilled from the senior leadership team. Inevitably the merger with the community trust featured in our discussions with the services already identifying the benefits this can bring for them and what

they can offer in return.

CQC Inspections

At the last board meeting we reported that the CQC will be carrying out a full well-led inspection of the Trust on the 14th of April – our first since 2019. In line with the inspection framework, we have since had unannounced service level inspections – to our working age adult inpatient services (Becklin and Newsam Centre), older adult inpatient services (The Mount) and rehabilitation services (The Askets and Ward 5 Newsam). Initial verbal feedback was provided on the day with a follow up summary which we have responded to along with all data requests which will now be triangulated alongside the observational data before draft reports are received in 1-2 months' time.

We have also responded to all data requests for the well-led inspection which has been very well managed thanks to great teamwork. There may be further unannounced inspections of core services between now and the well-led inspection.

Mary Seacole Graduates Celebration Event

Earlier this month we hosted the celebration event for colleagues who have graduated from the Mary Seacole leadership development programme. We have been running this programme in collaboration with South West Yorkshire NHS Foundation Trust and Bradford District Care Trust for many years. This year Leeds Community Healthcare have also signed up to the programme. It was great to meet with a diverse range of colleagues who are committed to and passionate about their leadership role in the NHS and there are added benefits for participants from this being a multi organisation collaboration.

Medium Term Planning

We submitted our medium-term plan and associated detailed financial, performance and workforce trajectories to NHSE by the 12th February 2026. The regional team at NHSE have reviewed all submissions with the relevant ICB and now written to us to confirm our plan is classed as compliant. Some Trusts are being asked to review and revise their plans by NHSE.

We have been advised that the National Oversight Framework metrics will be changed for 26/27 to

align with the national priorities for NHS Trusts set out in our medium-term plans, the proposals are going to NHSE National Board in March for sign off. Board oversight and capability to deliver will continue to be an area of assurance for NHSE.

3 Alignment with Leeds Community Healthcare NHS Trust

Both boards formally approved our strategic outline case to merge the Trust with Leeds Community Healthcare Trust. The case set out our preferred option of acquisition of LCH by LYPFT which provides the simplest route and retains our Foundation trust status for the new organisation.

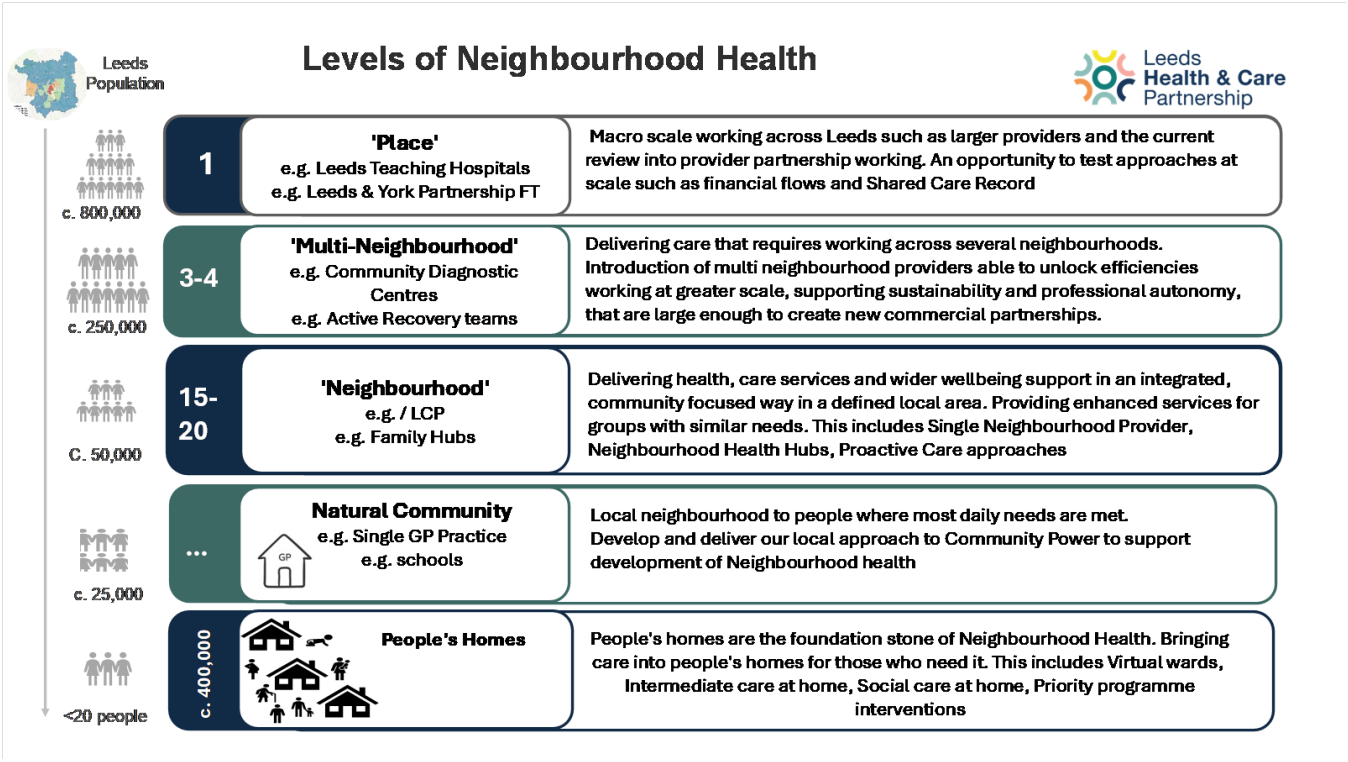
Following board approval, we submitted our strategic case to NHSE regional team on the 12th February. This is now being subject to review, and we have in place fortnightly meetings to discuss progress. At our initial meeting no risks queries or issues were identified, and we were told the national transaction team may also have capacity to review earlier than previously indicated. Our concern of course is to maintain momentum with the overall transition programme and more detail is included in the update paper to the private board.

We have sent out internal updates to staff and external updates to stakeholders. We have had no queries from external stakeholders. We have also briefed the council of governors and overview and scrutiny committee of our strategic plans and rationale.

4 System Update

Neighbourhood Health in Leeds

Nationally the publication of a specification for neighbourhood health care models has been delayed. However, within the city we are continuing with the development of our models. The Health and Wellbeing board held a workshop exploring the current proposals with the aim to have a draft for sign off in May on how we will implement neighbourhood health – from the broadest sense of prevention and wider health and wellbeing in every community through to the health and social care offer for when people have greater needs for support, intervention and recovery.

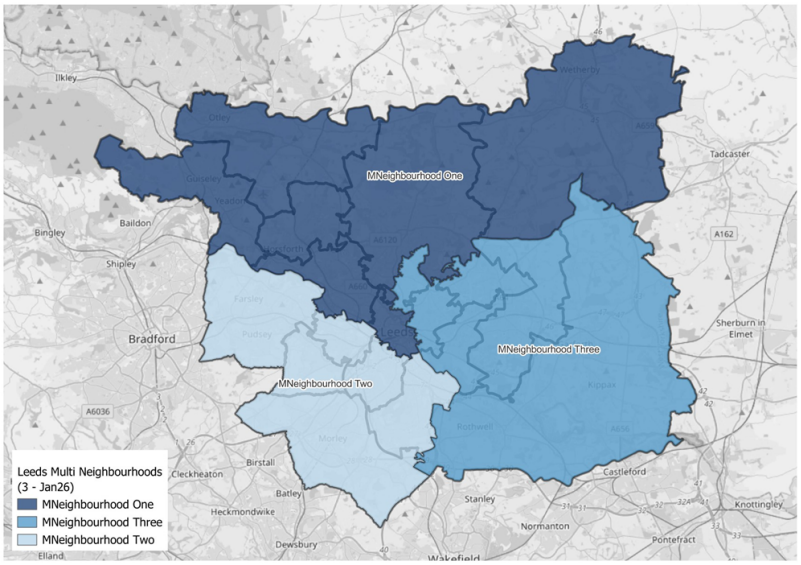


Neighbourhood footprints are matched to our primary care networks in the city and at the Partnership Leadership Team (PLT) this month we were asked to approve the footprints that will determine the multi neighbourhood level – the point at which we will 'cluster' services that are too niche, specialist or small to be delivered at every neighbourhood level. The following principles were discussed and PLT agreed to 3 multi neighbourhood footprints.

- *Starting point is single neighbourhood footprints then group single neighbourhoods together*
- *Some single neighbourhoods already group together with shared workforce or geography – we have treated them as a single unit or building block*
- *Every option works well for some areas but creates challenges for others*
- *Many of the challenges across sectors are created at single neighbourhood level but may be amplified in some multi-neighbourhood options*
- *The multi-neighbourhood/multi-specialist delivery model is only just being developed – we will get things wrong, may need to adjust, but we do need some footprints to start testing things.*
- *Most planned health and care should be delivered at a single neighbourhood or community level and we have taken a portfolio approach to developing the detail.*

Preferred Option: 3 Multi -Neighbourhoods

Leeds Health & Care Partnership

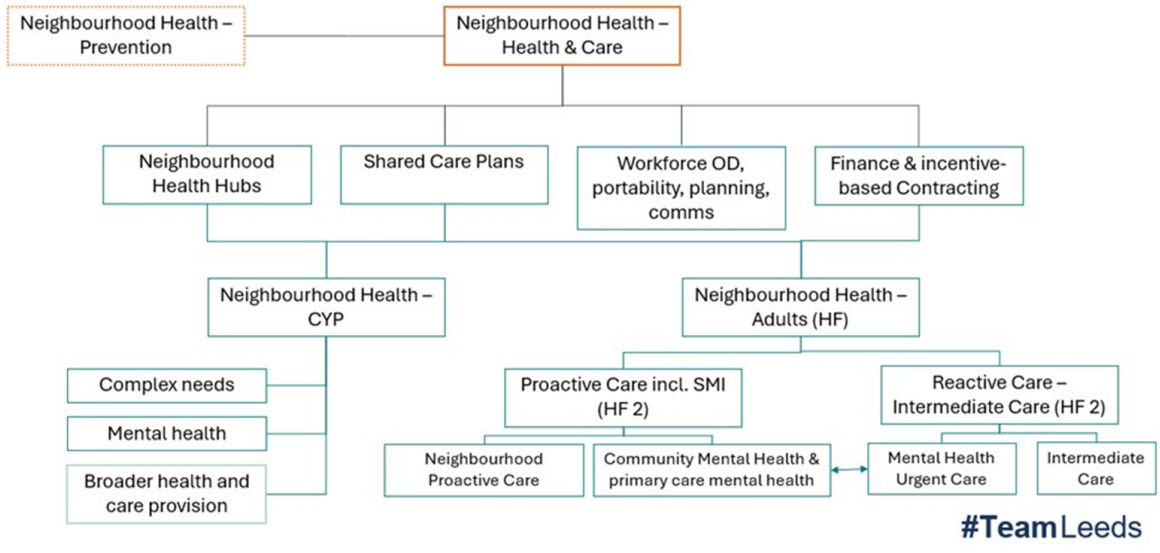


Multi Neighbourhood	Primary Care Network Definition
MN One Total Population = 357,021 (38%)	Otley, Yeadon, Woodsley, Holt Park, Central North, Wetherby and LSMP and The Light
MN Two Total Population = 289,309 (32%)	West Leeds, Armley, Bramley, Wortley & Middleton, Middleton & Hunslet, Morley and Beeston
MN Three Total Population = 297,319 (31%)	LS25/26, Seacroft, Cross Gates, York Rd, Chapeltown and Burmantofts, Harehills & Richmond Hill

January 2026

Proposed LHCP Portfolio Structure for 26/27:

Leeds Health & Care Partnership



The Leeds Provider Partnership

Each place within West Yorkshire is developing its own Place Provider Partnership (PPP). All places have been working with local partners to design their PPP and will shortly be working through membership of each PPP.

The ambition is that PPPs will have the ability to direct the resources across the partnership, to address the identified population health needs of local communities. This will result in making sure we can deliver smarter use of resources: targeted support where it's needed most, reducing duplication and delivering greater value for money.

In the ICB future operating model, at West Yorkshire level, the ICB strategic commissioning function will set an understanding of population need, based on qualitative and quantitative information. This will set a strategy, which in turn is translated into contractual form. Place Integrator Teams, working with emerging PPPs will develop integrated services locally to respond to the strategy, outcomes and contracts set by the ICB strategic commissioning function. When PPPs are mature, integrator teams will then move into the host PPP. PPPs will be a formal partnership of providers at Place level. They will have joint responsibility for planning and delivery across health, care and VCSE sector. Membership will reflect the breadth of local expertise including NHS providers, general practice, social care, public health, VSCE and citizen voice and this will be specific to each place. In terms of governance and decision making, it is proposed that a Joint Committee will operate in shadow form, alongside existing NHS West Yorkshire ICB Place Committees in 2026-27. This is a transitional year, from April 2026.

For the Leeds Place Provider partnership, we are working through our proposed memorandum of understating and terms of reference for our joint committee. Due to the timing of the ICB consultation and need for greater clarity on the place-based integrator function we have decided to extend this phase. Therefore, we are now aiming to have an agreed MoU, terms of reference and membership to set up a shadow joint committee from May – subject to Trust board approval/sign up.

The Joint Committee in the transitional period will 'build the decisions' about how to deliver: local priorities, service models, resource allocation. It will then recommend these to the existing Place committee. The Place Committee then 'takes the decision' during the transitional period We are working on the assumption that the Joint Committee will be fully operational in all five Places as we mobilise formal contracting arrangements by April 2027.

Leeds GP Confed CEO Update

Following the announcement from Jim Barwick that he is retiring in May 2026 the GP confederation have now recruited a new CEO. I was on the final interview panel and colleagues were involved in the stakeholder process. At the time of writing, I cannot confirm who the successful candidate is due to pre-employment checks being underway.

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 and completed a formal consultation on the new structures for the ICB in line with the national blueprint published in 2025. Feedback on the consultation was provided directly by organisations, the collaborative and the Leeds place provider partnership. A key theme in the feedback was the need for greater clarity on how the new structure would work with providers and with place-based partnerships given the significant reduction in capacity.

Final structures will be shared with staff on Monday 23 March, with the appointments to posts process starting immediately after. The majority of the appointments process is expected to complete in June 2026, with movement to the new model by 1 July. The transitional period will be difficult and disrupted by these changes; the ICB are ensuring business continuity processes are in place. Place Accountable Officers will continue to speak with partners to capture feedback at high level relating to key elements of the consultation and proposed structures.

Transitional arrangements are being enacted to current operating arrangements as some teams and functions will see much bigger resource gaps following voluntary redundancy. These changes are to ensure delivery of the core business of the ICB and continue to support transitional arrangements as some areas of work and responsibilities transfer to Place Provider Partnerships.
Following Rob Webster's announcement in January that he will be stepping down as ICB Chief Executive, Acting Chair, Professor Nadira Mirza, has confirmed that Rob will leave the organisation on 15 April 2026.

Jonathan Webb, the ICB's Director of Finance, has agreed to be Interim Chief Executive for the period between Rob leaving and a substantive Chief Executive starting in post. Ian Holmes will

continue in his role as Deputy Chief Executive during this period.

NHSE will also begin their consultation with regional staff shortly on changes to the regional structures.

4 Reasons to be Proud

Music Workshops Transforming Lives

A 10-week music programme is helping people across Assertive Outreach and Rehab Services express themselves and build confidence.

“Music gives people a safe way to be themselves.”

- Supports emotional wellbeing through singing, drumming and songwriting.
- Builds confidence, connection and new skills.
- Real stories of impact: improved memory, reduced cravings, emotional expression through rap, and practising English.

Outstanding Patient Experiences at St Mary’s House

Two recent 5-star reviews highlight the exceptional, compassionate and life-changing care provided across the Memory Clinic and ENE Older People’s Services at St Mary’s House.

- **Memory Clinic Review — Dr Madelaine and Yolisa**
  “The whole experience… from diagnosis with Dr Madelaine to follow-up with Yolisa has been exceptional.”
- **ENE Older People’s Services Review — Dr Jake Taylor**
  “Dr Jake Taylor’s care and treatment rebuilt my life… I felt a new life had come back to me.”

Crisis Assessment Unit / Police Pathways

The Crisis Assessment Unit (CAU) and Police Pathways team are being recognised for their exceptional integrity, flexibility and commitment during a period of significant change.

Adapted seamlessly to a merged pathway, working across CAU, the 136 Suite and Street Triage in any one shift.

- 'Flexed' the CAU to safely support acute admissions, helping keep service users close to home and reducing out-of-area placements.
- Continued to provide compassionate, high-quality care despite sustained operational pressures and uncertainty.
- Maintained an average length of stay of just 13 days, significantly lower than acute wards, even while supporting increased demand.

"The team consistently put service users first, no matter the challenge."

Jenna Hakiki, Senior Mental Health Practitioner

Jenna has been recognised for her exceptional compassion, dedication and impact in supporting veterans through OpCourage.

- Consistently treats veterans with dignity, respect and a genuine approach that encourages engagement.
- Works tirelessly to ensure care plans are understood and recovery goals are developed collaboratively.
- Tailors support to the diverse needs within the veteran community, helping build trust and confidence.
- Recently received powerful, heartfelt praise from an Afghan Warm Welcome service user for her life-changing support.

"Jenna's support helped me find hope and move forward."

Dr Sara Munro
Chief Executive Officer
16 March 2026

Agenda item

Meeting of the Board of Directors

Paper title:	CFO Finance Paper
Date of meeting:	27th March 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 at the end of February is ahead of trajectory to achieve a forecast outturn of £900k surplus, as agreed at system level. However, the year to date position has been, and continues to be substantially supported by one off non-recurrent means. Based on the latest forecast, we fully anticipate to achieve the £900k agreed surplus at year end, but again will be reliant on non-recurrent means.

The Trust maintains an overall robust financial position our cash position remains strong with a cash balance of £121.3m, and liquidity is strong with cover for 87 operating expenditure days. Our overall cumulative better payment practice code (BPPC) performance remained strong, achieving 94.1% of bills by value paid within target, by number (90.0% by number).

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

26 March 2026

Chief Finance Officer's Report

1 Introduction

This report provides an overview of the reported financial position at the end of month 11, 2025/26 financial year.

2 Revenue Position

The table below summarises the position reported to NHSE. This is a £917k surplus against the Trust break-even plan.

		Month 11		
Income & Expenditure Plan Position	Plan Annual £'000	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000
Income:				
Patient Care Income	235,819	223,965	225,607	1,642
Other Income	37,634	30,185	31,156	972
Total Income	**273,453**	**254,150**	**256,764**	**2,614**
Expenditure:				
Pay Expenditure	(200,366)	(183,906)	(181,306)	2,599
Non Pay Expenditure	(68,406)	(65,923)	(70,441)	(4,518)
Total Expenditure	**(268,772)**	**(249,829)**	**(251,748)**	**(1,919)**
Surplus/ (Deficit)	4,681	4,321	5,016	695
Adjustments for NHSE Reporting	**(4,681)**	**(4,321)**	**(4,099)**	**222**
Adjusted Position	0	0	917	917

The Trusts income and expenditure position at the end of February is ahead of trajectory to achieve a forecast outturn of £900k surplus, as agreed at system level. However, the year to date position has been, and continues to be substantially supported by one off non-recurrent means;

- Interest receivable that is £1.1m over planned levels,
- £2.8m of technical flexibilities have been released into the position
- Unutilised/unplanned additional one-off income £0.6m (PFI and MHIS)
- Slippage on the Perinatal development £1.5m year to date
- Unitary charge underspend £1.0m (related to Parkside Lodge and Little Woodhouse Hall)

The significant pressures in the year to date position remain:

- Bank expenditure - £1.2m adverse to plan, in the main due to ward overspends in Adult Acute and Older Peoples services. This is reduced in the pay expenditure line by significant vacancies equating to a £2.5m favourable variance and Agency expenditure, that has a £2.1m favourable variance to plan
- Out of Area bed expenditure in Adult Acute services has now increased to a £7.1m adverse variance to plan and £0.6m in Complex Rehab services.

2 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.

2.1 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	1,085	1,085	0	1,152	1,152
Technical Flexibility	Non-Recurrent	Low	2,080	2,777	697	1,993	2,927	934
CPC Gainshare	Recurrent	Low	462	458	(4)	504	504	0
Reducing Agency 30%	Recurrent	Low	2,200	4,361	2,161	2,600	4,811	2,211
Reducing Bank 10%	Recurrent	Medium	1,312	113	(1,199)	1,550	121	(1,429)
OAPs Improvement	Recurrent	High	3,658	0	(3,658)	4,101	0	(4,101)
Non-Pay Savings	Recurrent	Low	913	512	(401)	996	559	(437)
Unidentified	Recurrent	Medium	2,750	0	(2,750)	3,000	0	(3,000)
Overtime Reduction	Recurrent	Low	0	469	469	0	509	509
Additional Income agreed	Recurrent	Low	0	542	542	0	591	591
Non-recurrent Income	Non-Recurrent	Low	0	1,530	1,530	0	1,652	1,652
Reducing Pay (Recurrent)	Recurrent	Low	0	1,527	1,527	0	1,678	1,678
Interest Receivable	Recurrent	Low	3,443	3,443	0	3,756	3,756	0
Reducing Pay (Non-Recurrent)	Non-Recurrent	Low	0	0	0	0	0	0
			16,818	**16,818**	**(0)**	**18,500**	**18,260**	**(240)**
	Recurrent		14,738	11,426	(3,312)	16,507	12,529	(3,978)
	Non-Recurrent		2,080	5,392	3,312	1,993	5,731	3,738
			16,818	**16,818**	**(0)**	**18,500**	**18,260**	**(240)**

Year to date overall the run-rate reductions are on plan having achieved the target of £16.8m year to date (YTD). However notably the scale of non-recurrent delivery (32% 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 £18.3m against the £18.5m target, an additional £0.2m being required in the remaining month of the year.

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

2.2 Recurrent Budget Efficiency Programme

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. Year to date £7.7m of schemes have been 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.

3 Forecast

A revised forecast has again been completed in month. Based on this and the year to date position we fully anticipate achieving the £900k agreed surplus at year end.

The main assumptions within this forecast are:

- Adult Acute OAPs total £10.0m, a £6.5m overspend on budget.
- SSL overspend of £0.1m
- Complex Rehab OAPs overspend £800k
- 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 £18.5m in Bank, increased from £15m in 24/25
- All other variances remain broadly as is

4 Capital Expenditure

The capital position is detailed in Appendix A. Cumulative year to date capital expenditure is £10.3m at M11 against a plan of £15.5m. 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. The Parkside Lodge deed of variation is expected to be signed off by all parties in advance of the Finance and Performance Committee meeting, with the Mount deed following soon. Notwithstanding the deed of variation process, all efforts are being made to accelerate the delivery of these schemes, however, there remains some timing risks against the plans, which are being closely managed, to maximise the capital opportunities in year.

Providers plan for capital expenditure at 105% of capital allocations, with an acknowledgement that they must operate within the allocation (100%) in year. To facilitate this, LYPFT's 2025/26 capital plan includes £2m (phased in M12) on behalf of all providers within the ICS. In addition, Public Dividend Capital (PDC) of £2.5m was assumed in 2025-26 plans for the new Electronic Patient Record system, which will also now be delivered in future years.

5 Cash position

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 £121.3m 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 87 days operating expenditure. This means the Trust would be able to pay all it's day to day running costs for 87 days with no new income. A minimum of 4/5 days liquidity is expected to be maintained for an NHS organisation. We remain a strongly positive outlier in this regard, but for recognised reasons.

6 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 FEB-26 Number	Current month FEB-26 £'000
Total bills paid in the year	12,852	135,930	1,091	12,454
Total bills paid within target	11,566	127,894	1,026	11,728
Percentage of bills paid within target	90.0%	94.1%	94.0%	94.2%

The Trust paid 94.2% of invoices in 30 days in month by value but year to date is 94.1%. In terms of the target by number of invoices, the Trust is 90.0% year to date, 94% in month. Work is still on going to reach target by the end of the financial year.

7 Operational Plan

Following full operational plan submission on 12th February 2026 the North East Yorkshire (NEY) NHS England Region has completed its assurance activities including, targeted interventions with those organisations with ongoing gaps to compliance and risks with credibility of plans. LYPFT has not been one of the targeted Trusts. The feedback we have received to date from NEY Region has been positive, and they have noted both the integration with Leeds Community Healthcare NHS Trust and our Private Finance Initiative (PFI) estate proposals.

As the regional teams move towards the acceptance of all provider plans for delivery from 1st April, providers are given a final opportunity to make any further improvements and/or update any data quality corrections. We have used this as an opportunity to further review our submission and have made the decision that no improvements/corrections need to be made to the submission we made on 12th February 2026.

8 Conclusion

The Trusts income and expenditure position at the end of February is ahead of trajectory to achieve a forecast outturn of £900k surplus, as agreed at system level. However, the year to date position has been, and continues to be substantially supported by one off non-recurrent means. Based on the latest forecast, we fully anticipate to achieve the £900k agreed surplus at year end, but again will be reliant on non-recurrent means.

The Trust maintains an overall robust financial position our cash position remains strong with a cash balance of £121.3m, and liquidity is strong with cover for 87 operating expenditure days. Our overall cumulative better payment practice code (BPPC) performance remained strong, achieving 94.1% of bills by value paid within target, by number (90.0% by number).

9 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 28 February 2026	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	520	663	(143)
Security review	150	150		150
Sub-Total	**900**	**670**	**663**	**7**
IT/Telecomms Operational				
IT Network Infrastructure	250	250	440	(190)
Server/Storage	30	30		30
PC replacement EUL	360	330	341	(11)
Cyber security	170	170	46	124
Sub-Total	**810**	**780**	**827**	**(47)**
Estates Strategic Developments				
Lifecycle contribution	100	75	288	(213)
St Marys House, North Wing Therapy room	0	0		0
Aire Court	350	250		250
Sustainibility & Green Plan	250	250	238	12
Completion of Minor Schemes	228	228	137	91
Woodlands Generator	50	50		50
The Mount Perinatal	5,000	5,000	3,645	1,355
Accoustics- improvement	150	150	2	148
Security - critical system replacement	300	300	26	274
Newsam Sensory room	0	0	26	(26)
Mansafe	0	0	4	(4)
Clifton House	0	0	201	(201)
Sub-Total	**6,428**	**6,303**	**4,566**	**1,737**
IT Strategic Developments				
Data Centre and adjustments (ICB)	2,036	0		0
UPS Refresh	0	0		0
EUC Refresh	0	0	81	(81)
Wireless	0	0		0
Appcheck	0	0	180	(180)
Sub-Total	**2,036**	**0**	**261**	**(261)**
Disposals				
ICS	0	0	(11)	11
Sub-Total	**0**	**0**	**(11)**	**11**
Total ICS Operational Capital	**10,174**	**7,753**	**6,306**	**1,447**
PDC Funded Schemes				
EPR developments	2,500	1,500		1,500
Complex Rehab	5,600	5,600	3,264	2,336
St Marys House, North/South Wing/Estate Strategy	375	375	440	(65)
Water main upgrade (lead) SMH/SMHosp	50	50		50
Solar - North Wing & South Wing	0	0	42	(42)
Total PDC Funded Schemes	**8,525**	**7,525**	**3,747**	**3,778**
IFRS16 Leased Assets				
Leased Buildings	0	0	15	(15)
Lease Cars	150	150	274	(124)
Sub-Total	**150**	**150**	**289**	**(139)**
Disposals				
Leased	0	0	(86)	86
Sub-Total	**0**	**0**	**(86)**	**86**
Total IFRS16 Leased Assets	**150**	**150**	**203**	**(53)**
Total Capital Spend	**18,849**	**15,428**	**10,256**	**5,172**

Agenda item
10

Meeting of the Board of Directors

Paper title:	Chief Operating Officer's Report
Date of meeting:	26 March 2026
Presented by: (name and title)	Joanna Forster Adams, Chief Operating Officer
Prepared by: (name and title)	Members of Care Services' Senior 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; and our EPRR response to incidents over the period of the report. 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, and this report has been presented at the Finance and Performance Committee prior to sharing with Trust Board.

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

Recommendation

The Trust Board is asked to consider the content of this report on behalf of the Board and highlight any concerns, further intelligence or additional assurance required.

MEETING OF THE BOARD OF DIRECTORS

26 March 2026

Report of the Chief Operating Officer

1 INTRODUCTION

This report sets out the key management, development, and delivery issues across LYPFT Care Services. It aims to summarise and highlight the most significant service delivery issues we are facing.

Primarily, the main areas of concern are set out in the "Alert" section of the Service Delivery and Key Performance section of this report (Section 2 below). However, as a very high-level summary the most concerning issues include:

- Red Kite View inpatient service
- Acute flow and out of area placements and long lengths of stay
- Physical health assessment on inpatient wards and in Aspire
- Emergency Department (ED) waits for mental health assessment
- Crisis and Intensive Support Referrals seen within 4 hours.

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 Care Quality Commission

Through February and March, a series of service level inspections have taken place as part of our planned CQC Well Led assessment process. Information will be shared in more detail by the Director of Nursing and Professions.

2.1.2 Red Kite View – Children and Young People's Mental Health (CYPMH) inpatient service

The Psychiatric Intensive Care Unit (PICU) continues to operate in business continuity; however, remedial works have commenced and are expected to conclude by the end of April 2026. We continue to provide general acute and intensive care services for young people and work closely with colleagues across West Yorkshire to enable access for young people requiring admission. During the programme of works, the Section 136 suite remains closed due to accessibility issues and safety concerns relating to the construction work. Colleagues in Leeds Community Healthcare Trust (LCH) have been regular attendees at tactical meetings and have not reported any specific issues in relation to the closure of the suite.

2.1.3 Acute Flow and Out of Area Placements (OAPs)

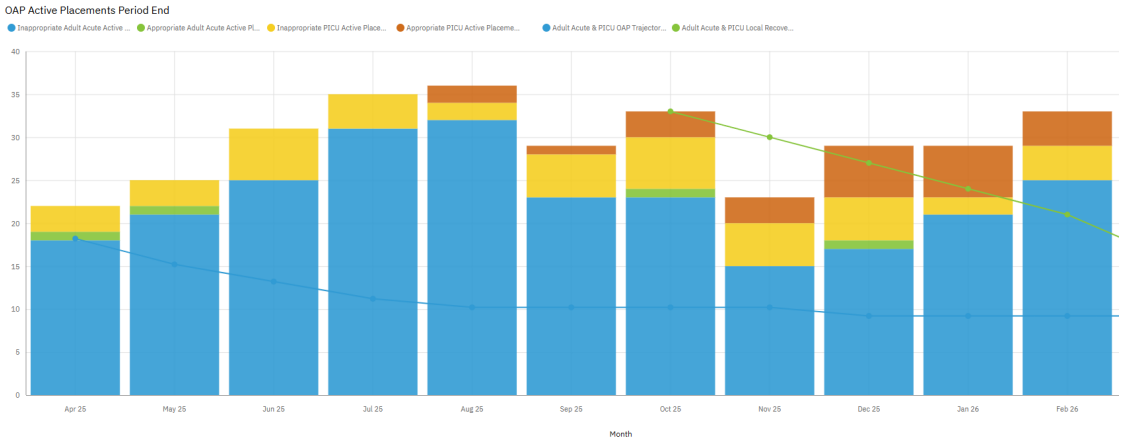
2.1.3.1 Current Position

Despite focused efforts across the system, the out of area recovery trajectory has not been achieved. January saw 16 new acute placements and two new PICU placements commenced. By the month end there were 21 acute and two PICU patients inappropriately placed, with a further six PICU placements deemed appropriate due to clinical need. This position has been driven by sustained clinical acuity, particularly amongst patients requiring single-sex PICU environments, as well as wider pressures affecting flow across the system.

Of the six appropriate PICU placements, three are female patients placed at Waterloo Manor in Leeds, which is a local PICU provision.

Our planned trajectory and performance are as shown in Graph 1.

Graph 1



Most service users in inpatient provision outside of Leeds are in Yorkshire or the north-east of the country, as seen in Image 1 below. We have one female service user placed in Norfolk, which was due to it being the closest bed available to Leeds. We have analysed the distance of these placements from individuals' home addresses, and this data can be seen in Table 1. This data includes all service users whether they are inappropriately or appropriately placed.

Image 1

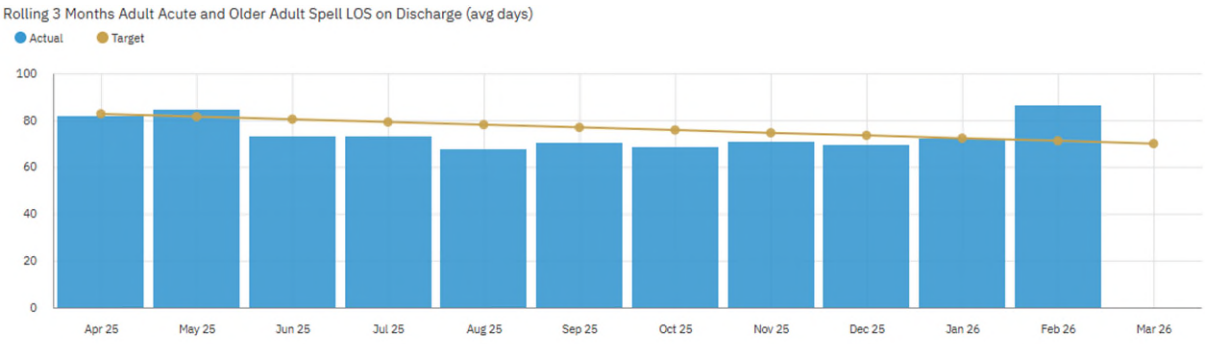
Table 1

Placement Type	Placement Location	Number of Service Users	Distance from home
PICU	CYGNET HOSPITAL WYKE	1	7 miles
	THE PRIORY HOSPITAL MIDDLETON ST GEORGE	3	46-54 miles
	WATERLOO MANOR HOSPITAL	3	5-9 miles
Acute	CYGNET HOSPITAL HARROGATE	2	13 miles
	CYGNET HOSPITAL WYKE	4	10-20 miles
	CYGNET VICTORIA HOUSE	2	44-50 miles
	PRIORY HOSPITAL ELLINGHAM FARM	1	136 miles
	THE PRIORY HOSPITAL MIDDLETON ST GEORGE	14	46-54 miles

2.1.3.2 Lengths of Stay (adult acute mental health)

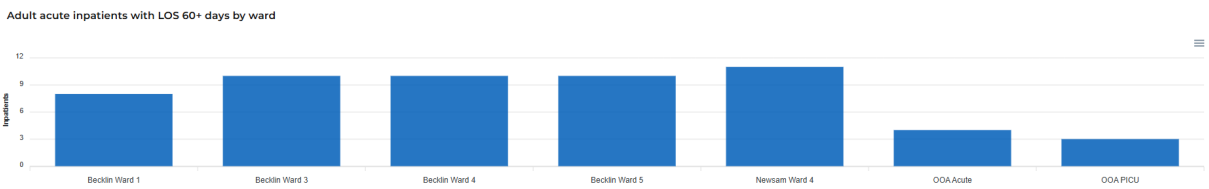
Discharges through January were steady, averaging 13 per week. However, this remains below the required 18 discharges per week across adult acute and PICU services, and this shortfall contributed to an increase in delayed bed days during the month, see Graphs 2-4. Reducing length of stay (LoS) remains a core component of the Inpatient Quality Transformation Programme, and current performance continues to align with the agreed trajectory. Nevertheless, further improvement is necessary to meet NHS England's Operational Planning requirements, as LoS is a key priority within the National Oversight Framework (NOF).

Graph 2

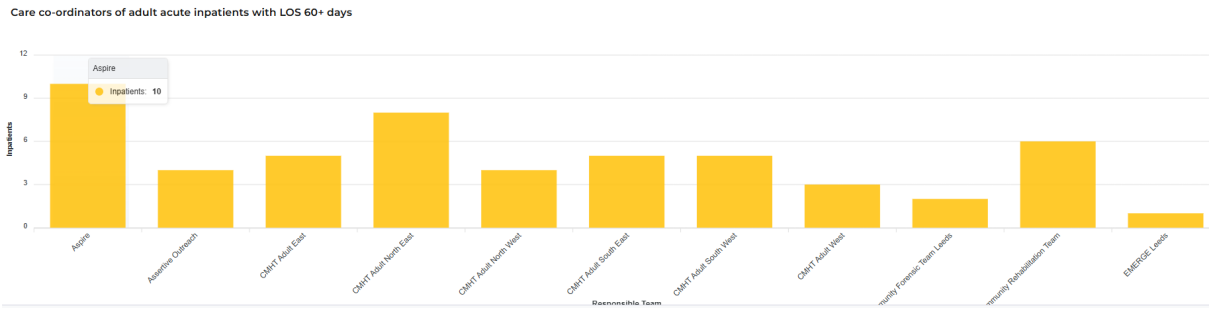


	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Actual	81.7	84.5	73.1	73.1	67.7	70.1	68.5	71.0	69.5	72.3	86.4	
Target	82.7	81.5	80.4	79.2	78.1	76.9	75.8	74.6	73.5	72.3	71.2	70

Graph 3



Graph 4



A review of the clinical and operational model for acute inpatient wards is ongoing. Whilst the case for change was presented to the Care Services' Priorities Leadership Collective in January, further work is required to fully develop and refine this case, ensuring it provides the necessary evidence, options, and implementation detail to support decision-making and drive the next phase of transformation. We will be supported by the Royal College of Psychiatrists to conclude the clinical model for acute inpatient services, and this will inform our future pathways, trajectories on length of stay, and resources required to operate the model of care.

We continue to work collaboratively with Adult Social Care, housing services, and third-sector partners to support timely discharge for all patients who are clinically ready. Addressing voids in community placements remains critical to improving flow, and a dedicated task and finish group has now been established to drive this work forward. This work will be overseen by the Improving Flow Workstream, ensuring clear governance, accountability, and alignment with wider system priorities.

2.1.3.3 Enhanced arrangements during January

In January, during a sustained period of OPEL 4 escalation, the Trust convened a series of strategic command meetings to address capacity and flow pressures. Chaired by the Medical Director, these meetings provided focused clinical and operational oversight and supported the expediting of discharges across our acute wards.

A lack of available step-down placements continues to be a significant challenge, limiting our ability to progress timely discharges and contributing to extended lengths of stay across acute services. Supported accommodation in the community also continues to experience notable bottlenecks, further constraining discharge options for patients who are clinically ready. We are working closely with Adult Social Care (ASC) to develop and secure supported accommodation pathways, recognising this as a critical component in improving discharge planning and strengthening overall system flow.

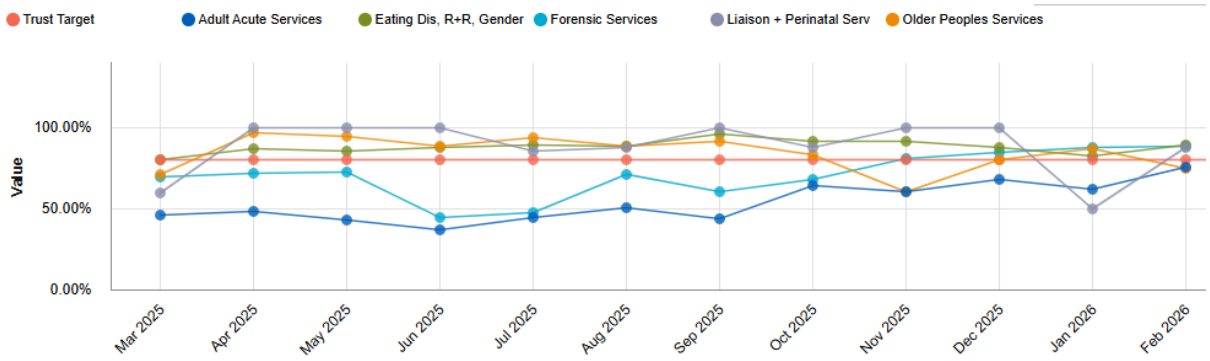
Additionally, we are now beginning to realise the benefits of the two Housing Officer posts, which are providing focused support on resolving accommodation-related delays and helping to progress complex discharges more efficiently.

2.1.4 Physical health assessment on inpatient wards and in Aspire

We have seen a significant improvement in the completion rate for cardiometabolic assessments across our inpatient services. Care Services are reporting achieving 82% completion against the target of 80%. Graph 5 shows the completion rate of each of the reporting services. Perinatal Services saw a significant decline in January, the reasons are

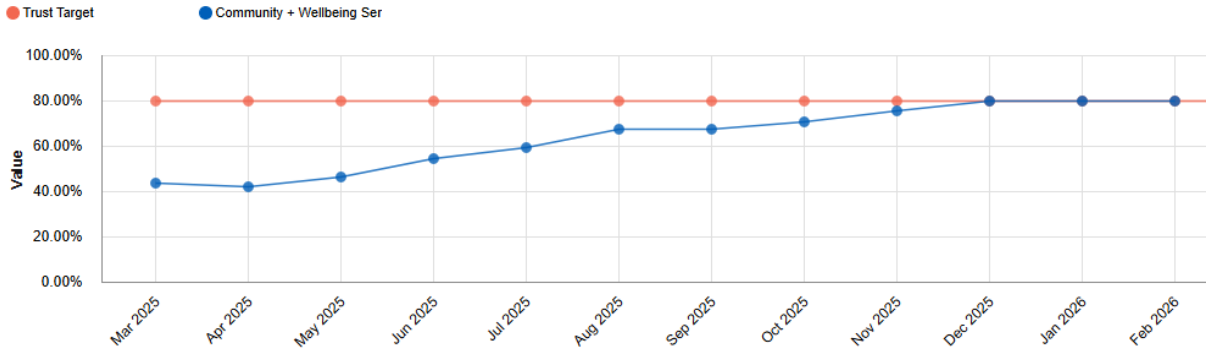
unclear, however they have been able to recover within the following month. A trend of improvement also continues in Adult Acute Services although current performance is at 72%. Actions are in place to achieve the target which are overseen by the Care Services Finance and Performance Group.

Graph 5



The improvement plan agreed with colleagues in Aspire (Inspire North) our Early Intervention in Psychosis Services, has continued to sustain the 80% compliance target, see Graph 6. This has been achieved by having dedicated staff to provide this intervention.

Graph 6



2.1.5 Emergency Department (ED) waits for mental health assessment

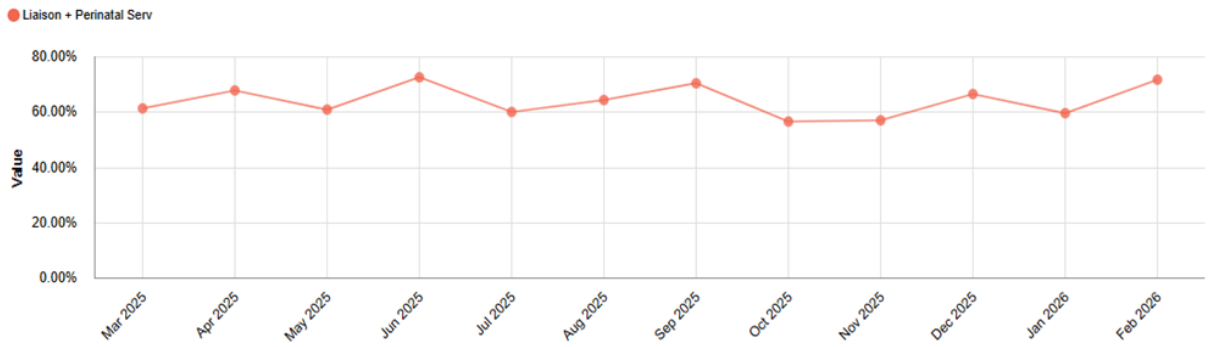
Work continues through the Reducing Mental Health ED Attendances and Delays Programme which maintains oversight of all activity across the EDs within the Leeds Teaching Hospitals Trust.

We have seen a slight deterioration in the response times in January; however, this has since recovered in February achieving 72% of referrals being seen in 1-hour, see Graph 7. We have seen unprecedented levels of activity in the Leeds system during this winter period with higher rates of referrals; however, this has slightly reduced through the early part of this calendar year, see Graph 8.

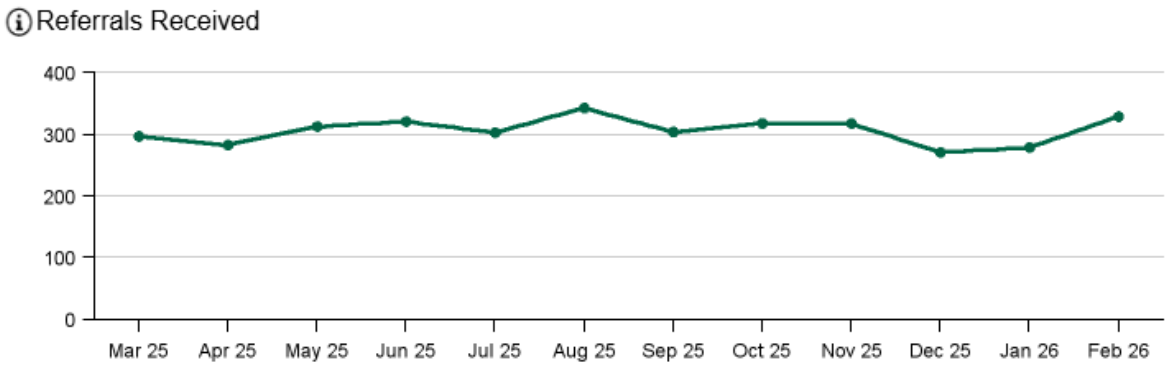
More detailed analysis of referrals has identified that 22% of ALPS referrals are from the LGI and that some delays are due to staff being based at SJUH and having to travel across sites. We have also identified the peak times that most referrals are made from SJUH. These are generally 10-12am, 3-5pm, 7-8pm and 2am. We are considering future service plans for referral management being based on what we have determined, and this would include adapting shift establishments to enhance night staffing, more single clinician assessments,

admin delegation, AI use, and the Triage Nurse pilot. We are also awaiting feedback from the GIRFT session, held on the 12 February, as to any additional actions we can consider in regard to bringing about improvements.

Graph 7

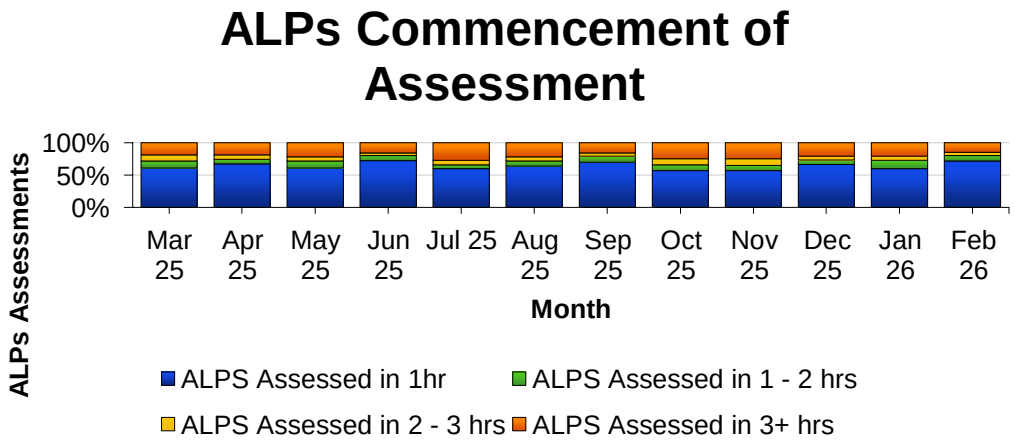


Graph 8



Where we have been unable to meet the 1-hour target time to assessment, we have seen approximately 85% of service uses within 3 hours of referral throughout January and February, see Graph 9. This means that approximately 15% of all referrals have waited more than 3 hours. We continue to work with colleagues in LTHT to ensure service users are referred to ALPS when they are medically fit, in order to avoid any delays.

Graph 9



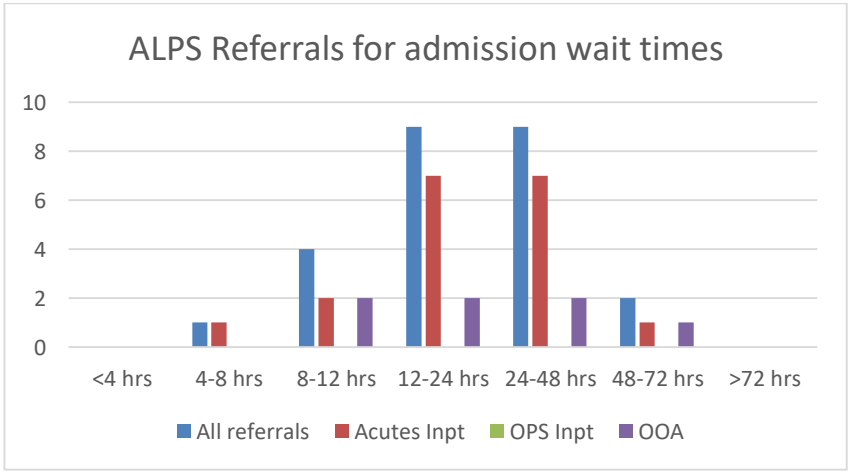
The triage role pilot, developed as part of the Reducing Mental Health ED Attendances and Delays programme, continues to operate on a small scale. The original intention was for Liaison colleagues to attend LTHT business meetings to raise awareness amongst frontline staff about the pilot and its potential to improve access and reduce unnecessary referrals. However, this has not been feasible over the past six weeks due to sustained operational pressures within LTHT, during which the Trust has remained in Silver Command and, on several occasions, declared Business Continuity incidents in response to high activity levels. This engagement will be revisited once winter pressures have eased.

Evaluation to date is limited due to the small numbers of people triaged at this stage. We anticipate there have been some initial implementation challenges, particularly in ensuring ALPS staff consistently complete the required triage documentation to accurately capture activity; this continues to be addressed.

Alongside this work, the programme has also included a Yorkshire Ambulance Service (YAS) audit undertaken by ALPS clinicians to quantify the number of individuals conveyed to ED with a primary mental health need and no accompanying medical requirement. Further analysis is planned; however, early indications suggest that footfall at the SJUH site is lower than previously anticipated. As such, efforts may be more effectively focused on strengthening collaborative working with YAS and Street Triage colleagues.

We have seen an increase in the time service users have had to wait in the ED for admission to a mental health bed, see Graph 10. We have seen more service users waiting for between 8 and 48 hours compared to previous reporting, with an increase in a number being admitted to out of area placements. However, compared to previous reporting periods we have had no one waiting for more than 72hrs. Delays continue to be as a result of Mental Health Act assessments and the availability of beds within the Trust.

Graph 10

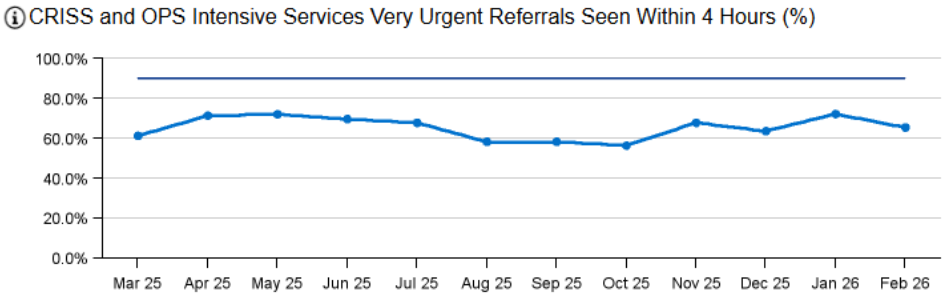


2.1.6 Crisis and Intensive Support Referrals seen within 4-hours

Whilst we continue to struggle to achieve the performance target of 90% across all our Crisis Services, currently at 65% (CRISS at 79% and ICHT/IHTT at 67%), we have seen some improvement, see Graph 11. This continues to be an area of challenge within our CRISS Teams. Most service users were seen within 12 hours of referral. The longest waits over 12 hours were 18 and 36 hours, this was because we were either unable to contact the service

users or they did not want to be seen at the suggested time. The Operational Managers continue to work with the teams to improve their response times.

Graph 11



2.2 ADVISE

2.2.1 CONNECT inpatient business continuity

The use of enhanced observations on The Yorkshire Centre for Eating Disorders (Ward 6 Newsam Centre) has risen due to an increase in self-harm behaviours and the number of service users requiring Naso-gastric feeding. In addition, the number of detained patients is higher than usual (8 rather than typically 4). The rise in enhanced observations has increased temporary staffing and at times there have been 14 staff rostered per shift, which leads to concerns regarding the safe management of such a large shift team.

The increase in self-harm can be attributed to an increase in service users presenting with complex emotional needs in addition to an eating disorder. These service users require a different clinical approach and staff require a different skill-set and supervision arrangements. The shift in presentation has increased stress for staff and there has been a reduction in bank staff accepting shifts on the ward. This has then led to unfilled shifts and there has been an increase in sickness absence among the established staff team. The service has responded with increased staffing from the CONNECT Community Team and, from the 29 January 2026, the service declared formal business continuity. As a result, the Operations Manager has worked with senior clinical staff to develop a recovery plan, including increased frequency of observation levels and earlier discharges, where appropriate. This has impacted on the pathways for service users receiving care in the community, but this has been managed ensuring those most in need are supported as a priority, as well as the service responding to service users who are being discharged from hospital settings.

2.2.2 Deaf CAMHS Access

An increase in the average waiting time for access to our Deaf CAMHS service was noted in February. This is accounted for by unexpected absence which has now recovered such that we expect to recover in the immediate future.

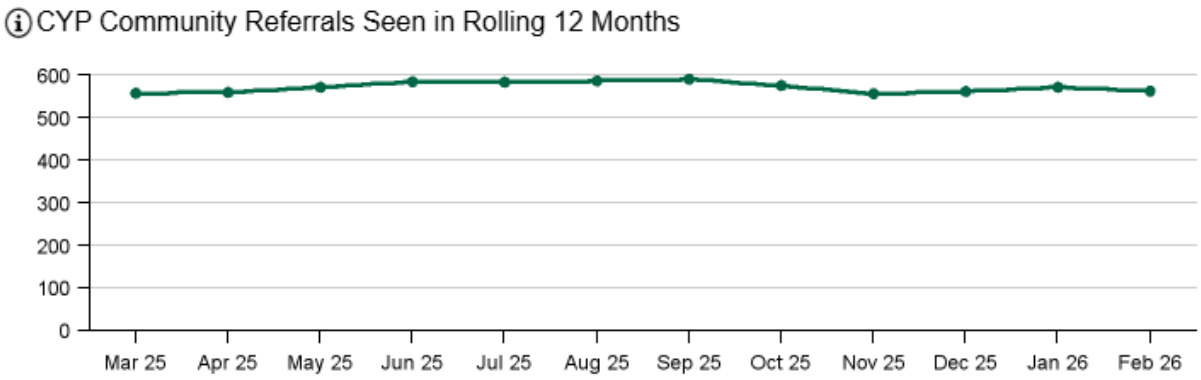
2.2.3 NHS Oversight Framework (NOF) Measures in Care Services

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 Group.

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

We have seen steady rates of referral since November, see Graph 12, to similar numbers as the beginning of the year. Consequently the 12-month rolling average across Deaf CAMHS and CYPMH Liaison has not risen significantly.

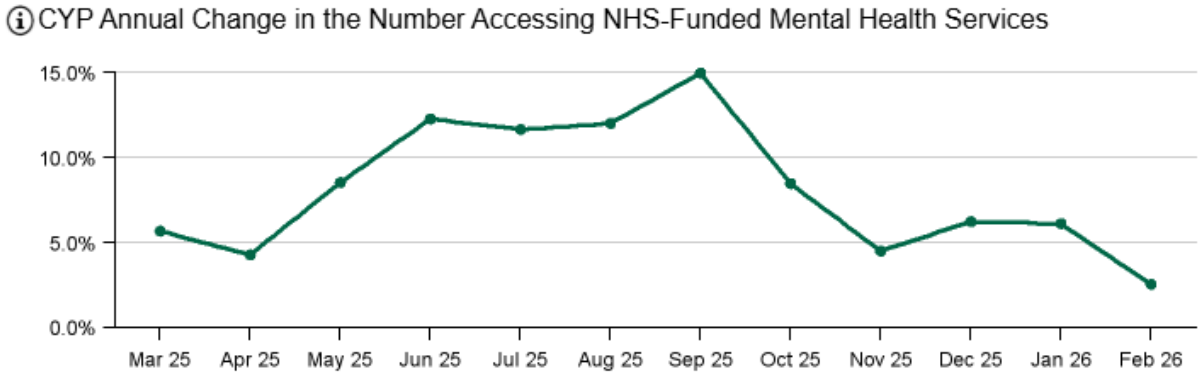
Graph 12



2.2.3.2 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 13. We continued to see a decrease in the number of new referrals into the services from October to February which is unusual for us. We continue to work with the national team, and local referrers, to ensure that all young people who would benefit from our support can easily access the service.

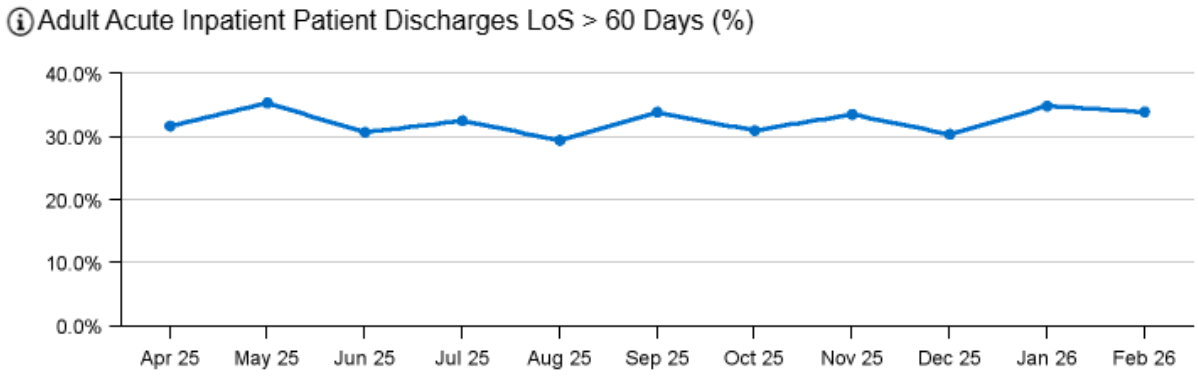
Graph 13



2.2.3.3 Percentage of adult inpatients discharged with a length of stay (LoS) exceeding 60 days

This metric has seen a slight increase since the last report, see Graph 14. 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.

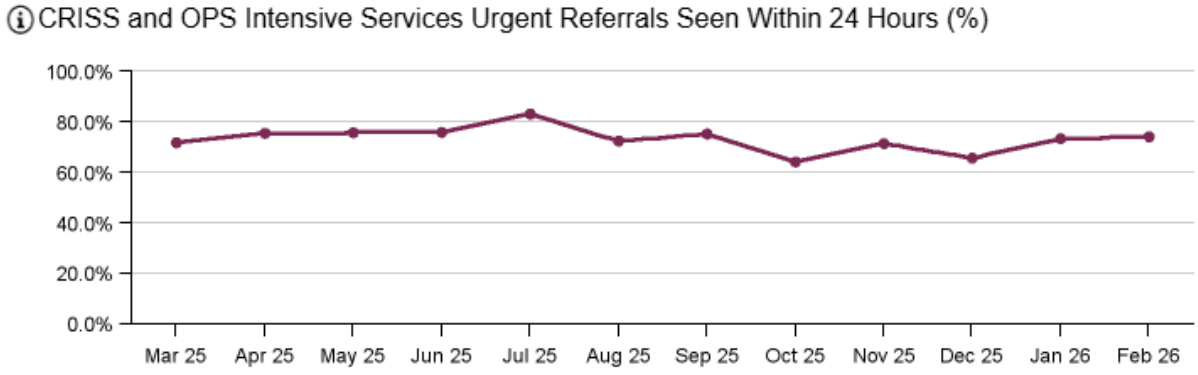
Graph 14



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

We have seen an improvement since December, see Graph 15. 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 continue to struggle to maintain the level of performance consistently across all areas. This remains a priority area of focus for those services involved.

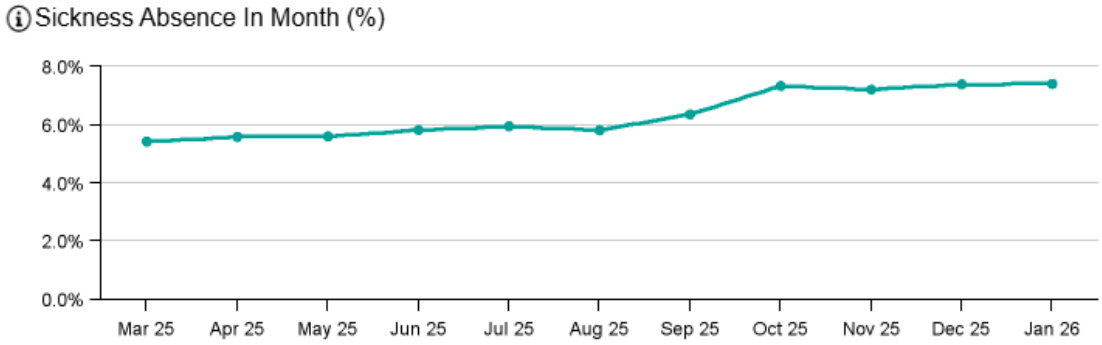
Graph 15



2.2.3.5 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 and remain consistent at this level, see Graph 16. We continue to review and monitor this through our operational governance arrangements and report performance to our Care Services Finance and Performance Group.

Graph 16



2.2.4 Waiting times in CMHT's

Whilst waiting times for accessing support from Community Mental Health Teams has improved, 30% of service users are still waiting more than 4 weeks for an assessment. Historically there hasn't been an NHS waiting time standard for CMHTs and services have not been established to operate to this. NHSE began publishing 4-week waiting time data in September 2024 and the Trust began to monitor this in April 2025. There has not been confirmation from NHSE that a waiting time standard will be set; however, we anticipate that this will be the case due to the publishing of data.

The service has begun process mapping of the referral receipt to assessment process and will be adopting a lean methodology to ensure that a revised process enables the new standard to be achieved. Engagement sessions have been held with clinical and administrative staff, supported by written guidance, to ensure CareDirector recording is correct and that the clock start / stop for waiting time is accurate. Existing monitoring arrangements within the service line will provide assurance that the revised process is effective. This includes:

- STEEEP framework metrics in governance meetings
- Individual caseload management
- GATE assessment audits and reviews.

Besides improvements to the process, waiting times compliance is usually impacted by variation in referral rates and unplanned changes in staff capacity. Management of assessment clinic capacity is underpinned by historical referral rates and absorbs seasonal variations. The service has a robust continuity process for responding to unplanned changes in staffing, often due to sickness absence, which prioritises service users at greatest risk and mobilises staffing resource flexibly between teams.

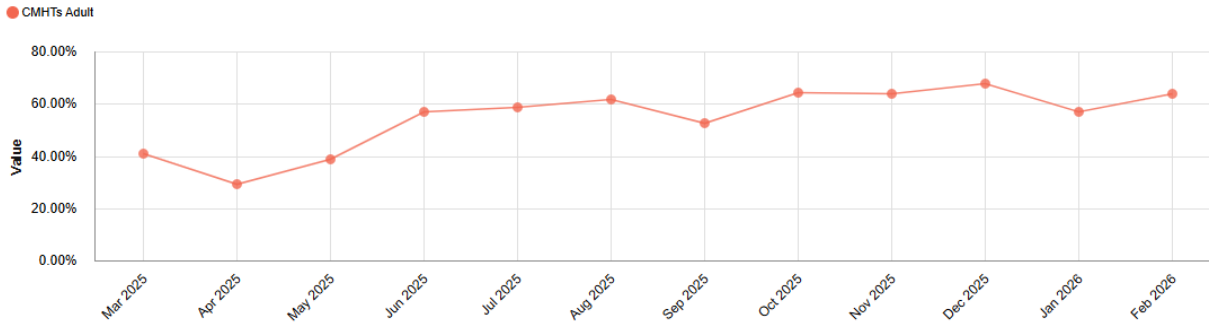
The CMHT waiting list Standard Operating Procedure (SOP) includes a waiting well element to provide support to service users whilst they are waiting post assessment. For cases that are awaiting their first appointment the duty desk seeks to prioritise cases based on length of time waiting. As an interim the SOP will be reviewed to determine if additional support is required for those individuals whose first contact is delayed.

The longer-term future model of community mental health services includes the development of Neighbourhood Community Mental Health Centres. This will locate a centre in those

neighbourhoods with the highest levels of mental ill health, so the community has access to immediate 'walk-in' assessment and support, entirely removing the need for referral.

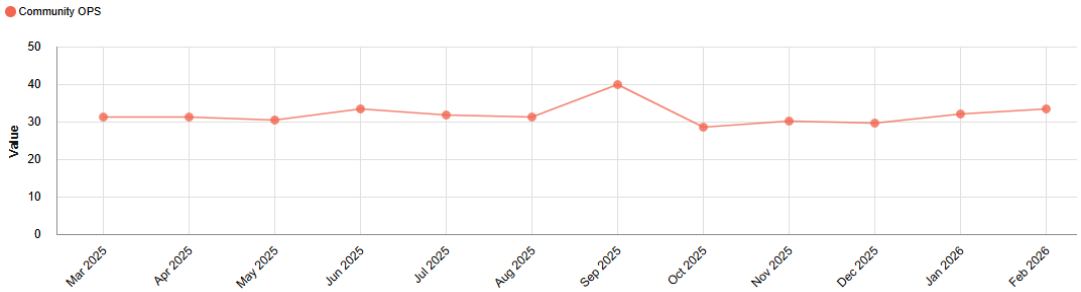
We have seen an improvement in the percentage of service users seen within 4 weeks of referral within our CMHTs through February, see Graph 17.

Graph 17



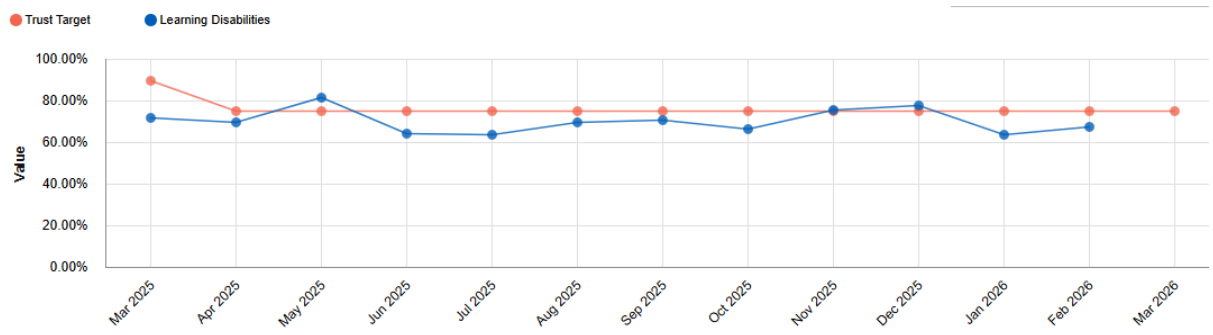
Our Older Peoples' Service Community Teams had recovered to a position of undertaking the first face-to-face contact within 30 days since October, which has deteriorated slightly through January and February, see Graph 18.

Graph 18



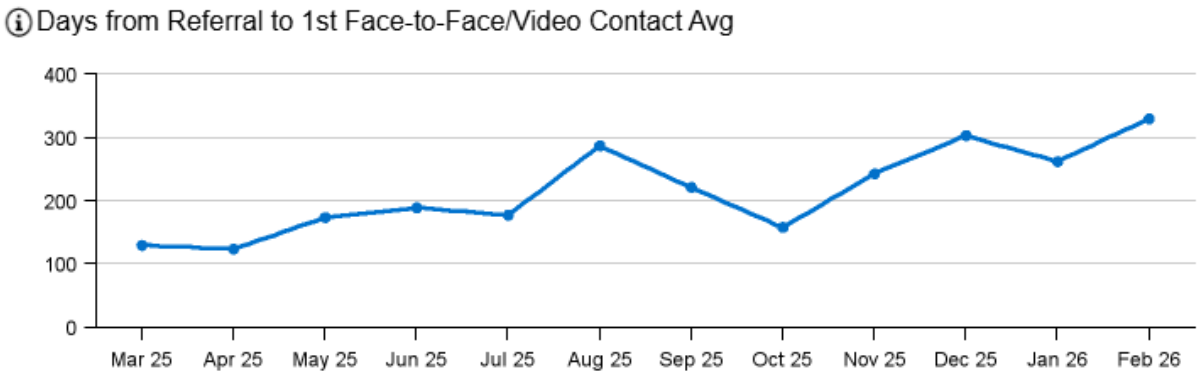
Our Learning Disability Services had recovered to meet the 75% standard of referrals seen for assessment within 4 weeks during November and December; however, this has since deteriorated through January and February, see Graph 19, with the Learning Disability Assessment and Referral Team (ART) dropping to 70% against the target with the Community Learning Disability Team CLDT continuing to maintain 64%. This situation has been reviewed by the Head of Operations and Clinical Lead for LD and have shared in detail the short-term issues that led to the deterioration, which was primarily unplanned staff absences. They have also identified how these issues have been addressed.

Graph 19



We had seen a deterioration in the response rate through the early part of winter with a slight improvement in January. This has further deteriorated in February, see Graph 20. The service continues to struggle with sickness absence which is being addressed through the management structures. The full team assessment process took place which has produced some suggestions to improve the wait times once implemented.

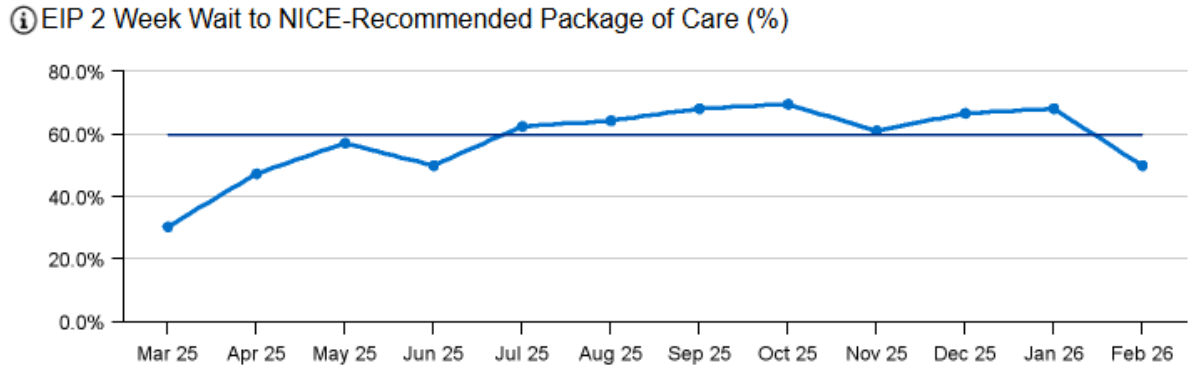
Graph 20



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

Aspire had continued to maintain improvements against the treatment commencement target. Whilst we have seen the achievement remaining over 60% since July 2025, we have seen a decline in February, see Graph 21. The service leadership team will continue to monitor and aim to recover to maintain the position over 60%.

Graph 21



2.3 ASSURE

2.3.1 Rehabilitation Services

The Complex Psychosis Pathway Service went live as planned on 5 January and a single point of access for referrals went live on 19 January. To date there have been no significant issues to report, with the main focus being on ensuring the Community Rehabilitation Team (CRT) operates well as a single team (combining CREST and Recovery Centre), building their caseload during quarter 4. There has been a significant increase in referrals for Level 2 inpatient rehabilitation being triaged, mainly from acute inpatient mental health and for the majority of referrals the service is not appropriate. We aim to reduce this as we proactively

identify patients within acute services rather than wait for them to be referred. This work has been trialled over the last 6 months and can now be fully mobilised with the CRT in place.

3 SERVICE DEVELOPMENT

3.1 Public Health Framework Tender

The North of England Commercial Procurement Collaborative (NOE CPC) and the NHS London Procurement Partnership (LPP) invited providers to tender for admission to a Public Health Related Services Framework Agreement designed for use by Integrated Care Systems (ICSs), Integrated Care Boards (ICBs), NHS England, Local Authorities, Combined Authorities, NHS Trusts, Foundation Trusts and other relevant provider organisations, nationwide.

The Framework is divided into six lots, each covering a major domain of Public Health services.

Lot 1	Sexual Health Services
Lot 2	Drug, Alcohol and Addiction Services
Lot 3	Behavioural Changes and Prevention (weight management, physical inactivity, smoking cessation, Type 2 diabetes, and mental health and wellbeing screening)
Lot 4	Child Health Services
Lot 5	NHS Health Checks and Screening Services
Lot 6	Integrated Service Delivery Partnerships

LYPFT has submitted a bid for Lots 2 and 6 and if successful this will allow commissioners to call off providers on the framework to contract with them to deliver the services which they are qualified for. The decision was taken to limit the application to lots where the Trust has the relevant expertise and where they align with core business for us. Further updates will be shared once the outcome of the tender process is known.

3.2 Quality of Care Services sub-contracts

The recent review of care services sub-contracts has highlighted variation in contract monitoring across performance and quality measures. It has been agreed that as the new contracts commence a process to review the contract measures from a performance and quality perspective will be undertaken.

Overseen by the Trustwide Clinical Governance Group and the Quality Committee we are developing a framework of assurance around the quality of care provided via service sub-contracts. In order to address this the following actions have been agreed

- A risk relating to reduced assurance on service quality, non-compliance with required standards, and potential service or financial underperformance has been added to the risk register.

- The Deputy Director of Nursing and the Deputy Director of Service Development have reviewed the sub-contract management processes used within the provider

collaboratives through the commissioning hub. NHS England has commended this approach as best practice, and key elements are being incorporated into the Trust's refreshed sub-contracting framework.

- A strengthened process for reviewing quality metrics within each sub-contract is underway. This will cover both initiation and ongoing delivery, include clear escalation routes, and align with the STEEEP Framework.

- Guidance for service managers on commissioning and contract monitoring is currently in development. This will be supported by targeted development sessions for relevant staff to ensure consistent understanding and application.

- A bi-annual quality performance report will be produced for the Care Service Delivery and Development Group and the Trustwide Clinical Governance Group to provide improved oversight of sub-contract quality and performance.

- Annual assurance reports will be submitted to the Quality Committee to support Board-level scrutiny and assurance through annual service quality reports.

Future updates on progress will be taken through the Quality Committee.

3.3 Leeds Health & Care Partnerships Transformation Programmes

Neighbourhood Health aims to bring about radical change to the way health and care systems work together in Leeds, supporting the delivery of the city's ambitions and most specifically reducing health inequalities. The Neighbourhood Health framework operates across three tiers: Prevention, Proactive Care and Reactive Care, whilst also considering the wider determinants of health. The Leeds Health and Care Partnership has identified this as the priority programme for the coming year and has been looking to incorporate the appropriate elements of existing priority programmes into a revised structure to sit under the future provider partnership for Leeds.

The current priority programmes include the Community Mental Health Transformation Programme, the Home First programme, Cardiovascular Health, and the Children and Young Peoples Programme. Each of these has had identified dedicated resource to support the programmes. A small working group has been developing proposals that will be shared with the Leeds Partnership Leadership Team on 9 March. The proposals include mental health remaining a priority for the city as part of the Neighbourhood Health Programme.

4 WINTER PREPAREDNESS

As we approach the end of the winter period this year, it has been clear that our planning and preparation has served us well in managing what could be a difficult time for services. We have worked well with system partners, particularly where they have experienced sustained pressures because of winter.

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.

On seasonal influenza vaccination, as of 1 February 2026 we are at 38.4% of frontline staff vaccinated; the same time last year, we were at 33%.

5 EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE

5.1 Incidents and Disruptions

5.1.1 Adult Eating Disorders Service, inpatient and community teams Business Continuity Incident.

In January and February, high levels of acuity and enhanced therapeutic observation and care demand on the eating disorder inpatient unit increased safer staffing levels to 300% of the baseline / contracted staff levels leaving the ward unable to maintain safe staffing levels without intervention. Standard LYPFT escalation responses including the use of temporary bank staff, requests for support from other services and offering overtime were enacted but failed to address the staffing gaps.

In week commencing 19 January, an informal operational response was implemented involving the deployment of CONNECT eating disorder community staff into the inpatient unit on an ad-hoc basis. This assured safe staffing levels until 28 January with low impact on the community service. A situational review on 27 January identified a high inpatient staffing demand which was expected would continue for at least 2 weeks and this highlighted gaps in inpatient staffing levels for weeks commencing 2 February and 9 February. To mitigate these gaps, significant numbers of community staff from CONNECT and a small number from Link-ED were deployed into the inpatient unit with a moderate impact on CONNECT services and low impact on Link-ED. Therefore, a decision was taken to declare a business continuity incident on 28 January 2026. The West Yorkshire ICB was notified.

The business continuity response has stabilised staffing pressures on the inpatient unit, but the high acuity levels remain, and the service remains in a declared business continuity incident as of 24 February.

The redeployment of community staff in line with business continuity plans has mitigated the inpatient staffing gaps but placed pressure on community service delivery.

Community treatment waiting times are increasing and patients are receiving less intensive care than is usually provided. The service is unable to fully support West Yorkshire Acute Trust (WYAT) hospitals with lower risk eating disorder patients who are ready for discharge.

Risk management is focused on high-risk patients with non-high risk experiencing increased waiting times. Impacts on community service delivery:

- Increased access times
- Reduced appointment frequency
- Risk of patient deterioration
- Risk of patients being readmitted to WYAT beds
- Risk of out of area beds and cost implications.

SBARs (Situation, Background, Assessment, Recommendation reports) continue to be sent providing updates on the incident. Actions being taken by the Trust to stand down from the situation are as follows:

- The inpatient unit has stood down all therapy pathways and redirected resource towards activities which will reduce acuity and enhanced observations and subsequently reduce staffing demand
- Increased frequency of Enhanced Therapeutic Observation and Care levels reviews
- Expediting discharges where appropriate
- Monthly SBAR reporting to the ICB and Provider Collaborative
- Weekly business continuity review.

5.1.2 Industrial Action

Currently the BMA has a mandate for strike action until August 2026. The government has been in intensive and constructive discussions with the BMA since the start of the new year. At present no further strike dates have been announced.

If further strikes are announced the Trust will activate strategic and tactical coordinating meetings to gather intelligence, assess risks and ensure plans are in place to respond, taking into account any concurrent incidents. There was no requirement to escalate any issues during any previous period of industrial action.

5.1.3 Demonstrations

The EPRR Team continues to monitor the situation with regard to demonstrations that have been taking place in several parts of the Leeds district on a weekly basis since July 2025. 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.

6 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
March 2026

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

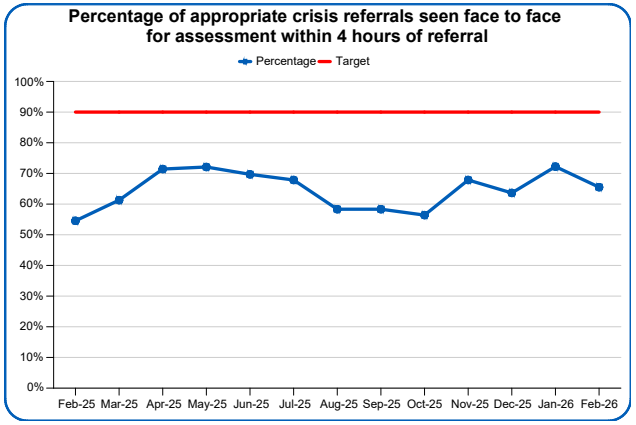
Service Performance - Chief Operating Officer

Services: Access & Responsiveness: Our response in a crisis Monthly	Target	Dec 2025	Jan 2026	Feb 2026
Percentage of ALPS referrals responded to within 1 hour	-	66.5%	59.7%	71.7%
Number of S136 detentions over 24 hours	-	1	1	0
Percentage of appropriate crisis referrals seen face to face for assessment within 4 hours of referral	90.0%	63.6%	72.2%	65.5%
Percentage of service users who stayed on CRISS caseload for less than 6 weeks	70.0%	90.0%	88.8%	89.8%
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support	50.0%	39.8%	34.0%	40.4%
Percentage of CRISS caseload where source of referral was acute inpatients	-	7.5%	10.6%	6.8%
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services	**Target**	**Dec 2025**	**Jan 2026**	**Feb 2026**
Gender Identity Service: Number on waiting list	-	7,134	7,150	7,186
Deaf CAMHS: average wait from referral to first face to face (inc. telemedicine) contact in days	-	303.33	247.42	329.79
Community LD: Percentage of referrals seen within 4 weeks of receipt of referral	75.0%	78.0%	63.6%	68.8%
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**	**Dec 2025**	**Jan 2026**	**Feb 2026**
Number of admissions to adult facilities of patients who are under 16 years old	0	0	0	0
Crisis Assessment Unit (CAU) bed occupancy	-	95.7%	93.9%	99.4%
Crisis Assessment Unit (CAU) length of stay at discharge	-	19.22	17.64	18.33
Liaison In-Reach: attempted assessment within 24 hours	90.0%	71.3%	71.9%	74.8%
Becklin Ward 1 (Female) bed occupancy	-	105.4%	106.6%	105.2%
Becklin Ward 3 (Male) bed occupancy	-	100.9%	104.0%	100.3%
Becklin Ward 4 (Male) bed occupancy	-	103.5%	104.3%	110.1%
Becklin Ward 5 (Female) bed occupancy	-	103.1%	103.2%	105.5%
Newsam Ward 4 (Male) bed occupancy	-	100.2%	100.5%	100.2%
Older adult (total) bed occupancy	-	99.9%	101.3%	97.4%
The Mount Ward 1 (Male Dementia) bed occupancy	-	97.7%	101.6%	91.6%
The Mount Ward 2 (Female Dementia) bed occupancy	-	102.4%	100.9%	100.5%
The Mount Ward 3 (Male) bed occupancy	-	98.1%	103.7%	100.2%
The Mount Ward 4 (Female) bed occupancy	-	101.4%	99.2%	96.4%
Percentage of Occupied Bed Days Clinically Ready for Discharge	-	32.2%	39.5%	40.0%

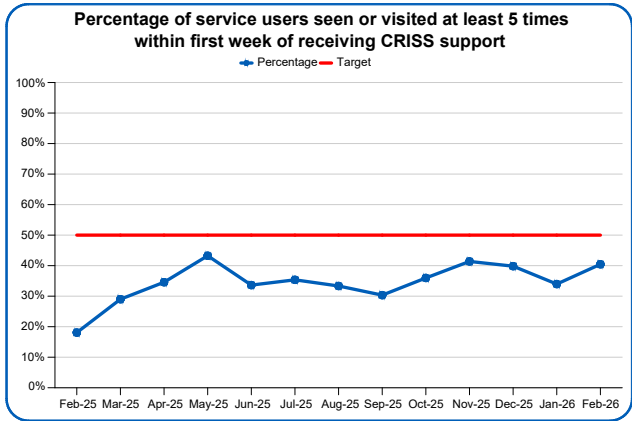
Service Performance - Chief Operating Officer

Services: Our acute patient journey	Target	Dec 2025	Jan 2026	Feb 2026
Out of Area Trajectory Active Placements at Month End	9	23	24	29
Total: Number of out of area placements beginning in month	-	16	18	17
Total: Total number of bed days out of area (new and existing placements from previous months)	-	691	759	746
Acute: Active Placements at Month End	-	17	21	25
Acute: Number of out of area placements beginning in month	-	11	16	13
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	499	648	627
PICU: Active Placements at Month End	-	6	2	4
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)	-	164	102	110
Older people: Active Placements at Month End	-	0	1	0
Older people: Number of out of area placements beginning in month	-	1	1	0
Older people: Total number of bed days out of area (new & existing placements from previous months)	-	28	9	9
Cardiometabolic (physical health) assessments completed: Inpatients (quarterly)	80.0%	77.9%	-	-
Services: Our Community Care	**Target**	**Dec 2025**	**Jan 2026**	**Feb 2026**
Percentage of inpatients followed up within 3 days of discharge (Trust Level monthly local tracking)	80.0%	75.6%	88.3%	78.6%
Percentage of inpatients followed up within 3 days of discharge (HCP commissioned services only)	80.0%	76.4%	87.5%	78.5%
Number of service users in community mental health team care (caseload)	-	3,661	3,655	3,670
Percentage of referrals to memory services seen within 8 weeks (quarter to date)	70.0%	79.7%	76.1%	77.2%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50.0%	58.3%	56.2%	53.2%
Early intervention in psychosis (EIP) or at risk mental state (ARMS): Percentage starting treatment within 2 weeks	60.0%	66.7%	68.2%	50.0%
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**	**Dec 2025**	**Jan 2026**	**Feb 2026**
Percentage of service users with NHS Number recorded	-	99.7%	99.7%	99.8%
Percentage of service users with ethnicity recorded	-	81.2%	80.7%	80.3%
Percentage of service users with sexual orientation recorded	-	44.6%	44.0%	43.3%
Services: Clinical Record Keeping - DQMI	**Target**	**Sep 2025**	**Oct 2025**	**Nov 2025**
DQMI (MHSDS) % Quality %	95.0%	93.0%	93.3%	93.7%

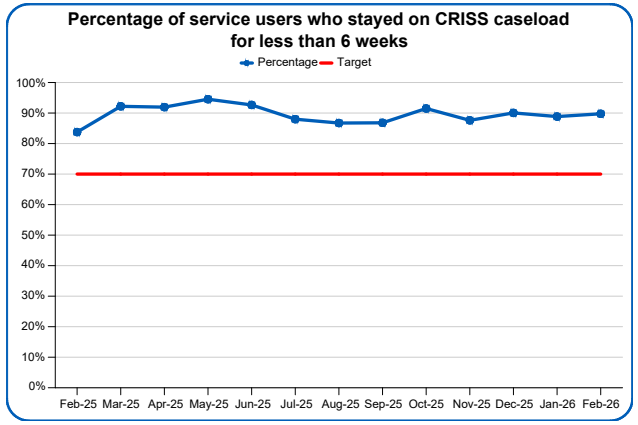
Services: Access & Responsiveness: Our Response in a crisis



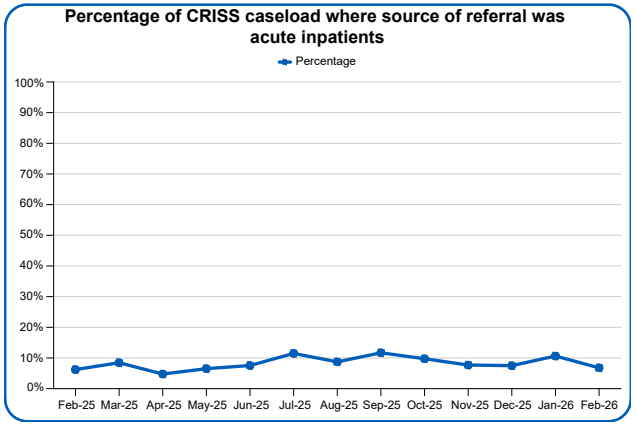
Contactual Target 90%: February 65.5%



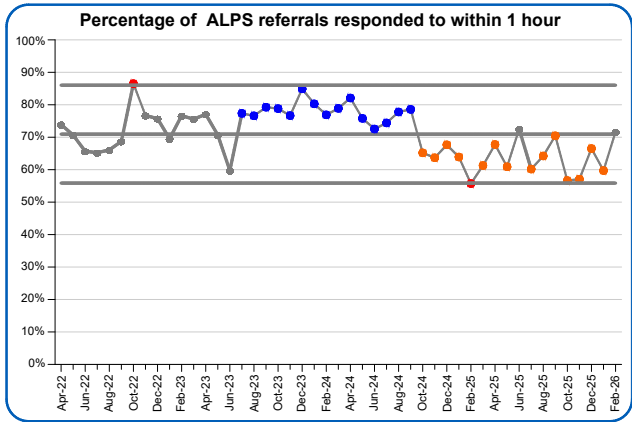
Contractual Target 50%: February 40.4%



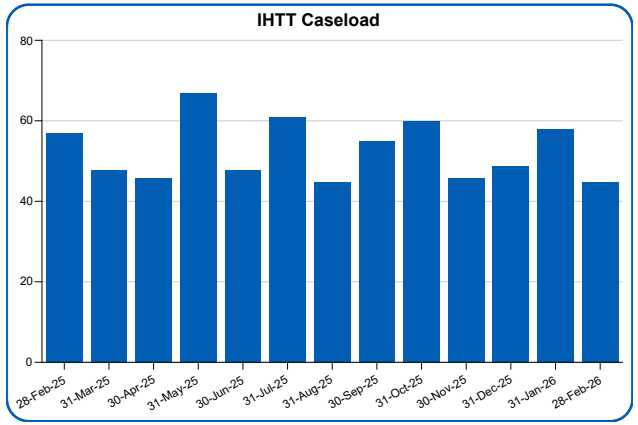
Contractual Target 70%: February 89.8%



Contractual Target tba: February 6.8%

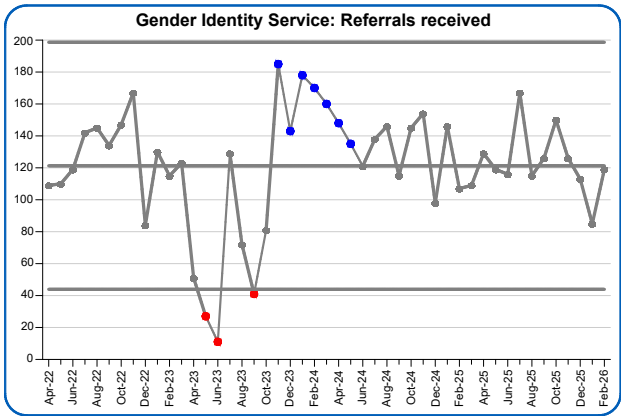


Contractual Target : February 71.7%

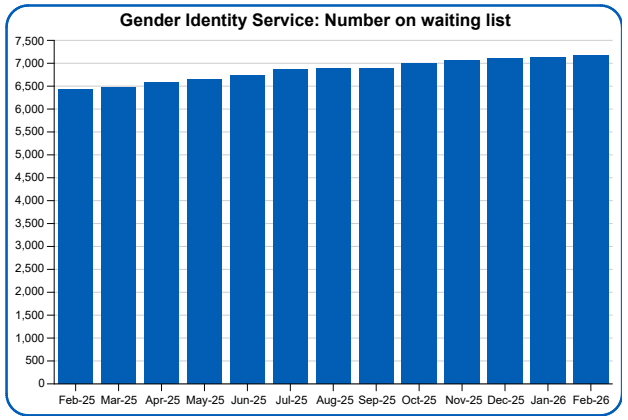


Caseload: February 45

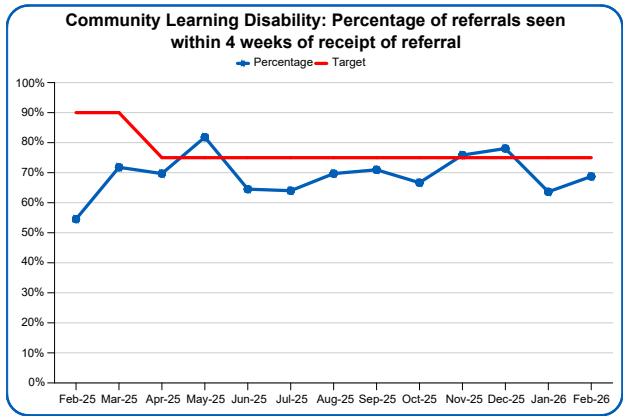
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services



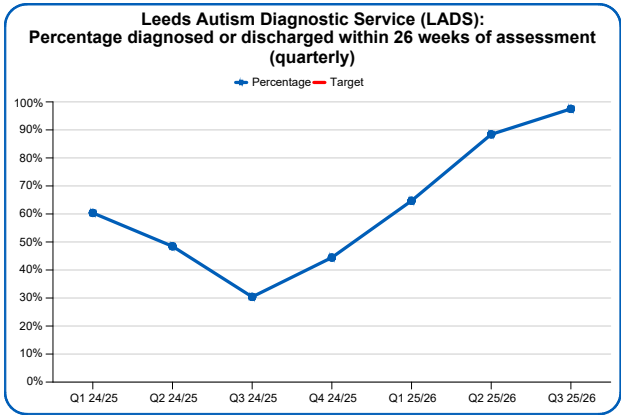
Total referrals: February 119



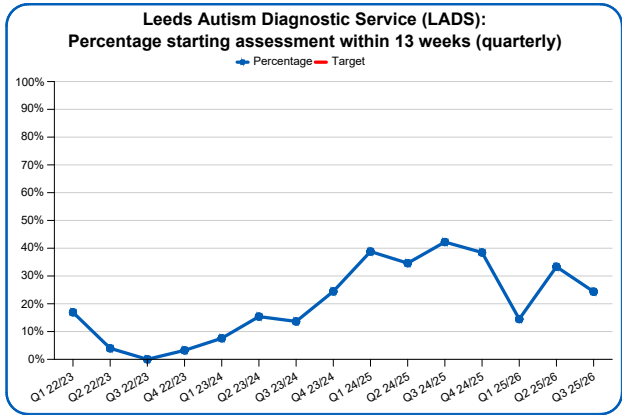
Number on waiting list: February 7,186



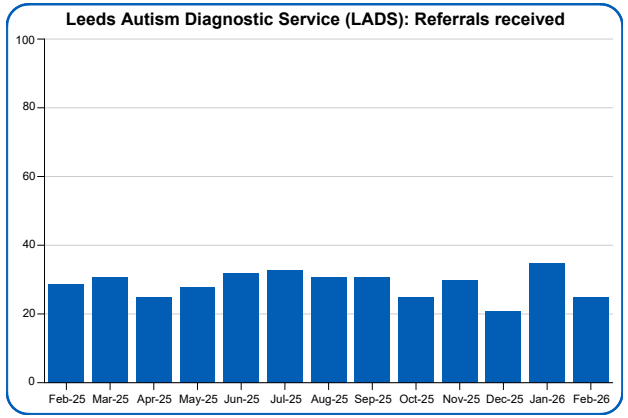
Contractual Target 75%: February 68.8%



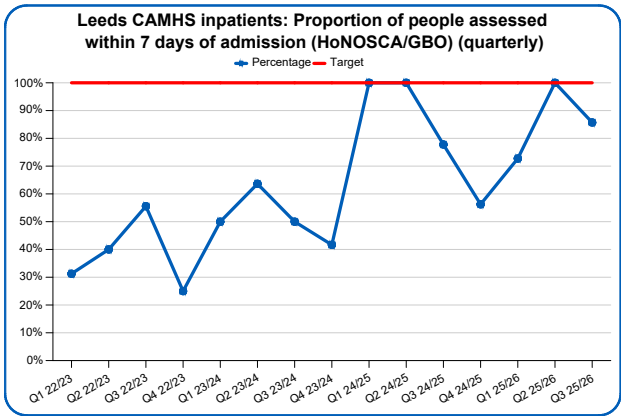
Contractual Target 70%: Q3 97.5%



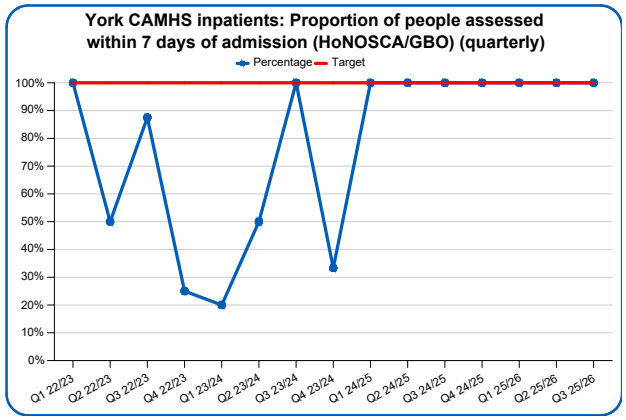
Contractual Target : Q3 24.4%



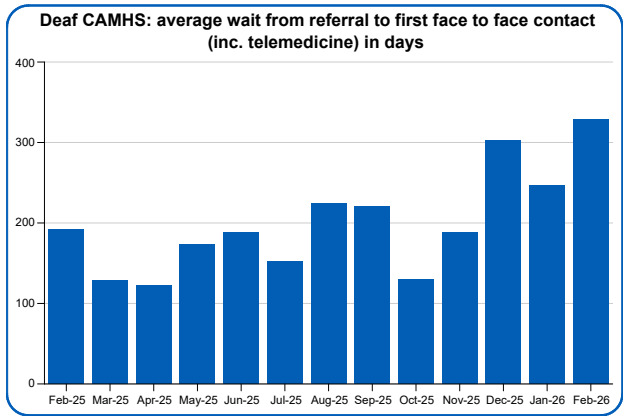
Local measure: February 25



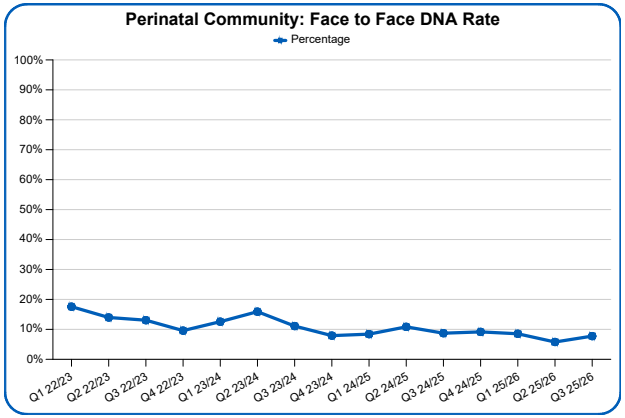
Contractual Target 100%: Q3 85.7%



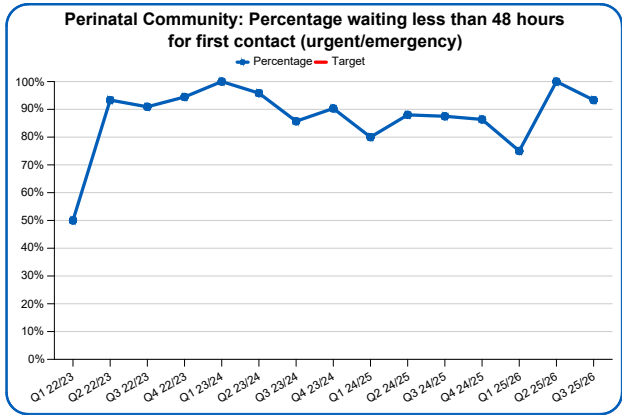
Contractual Target 100%: Q3 100.0%



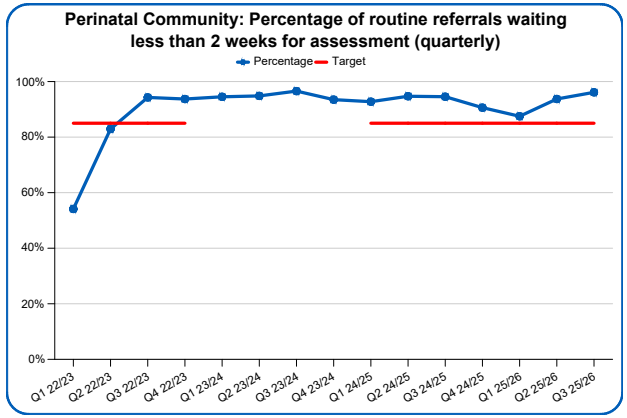
Local measure: February 330



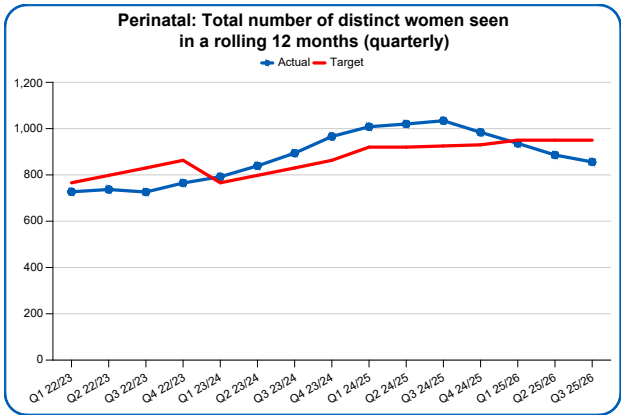
Contractual measure: Q3 7.7%



Contractual Target tba: Q3 93.3%

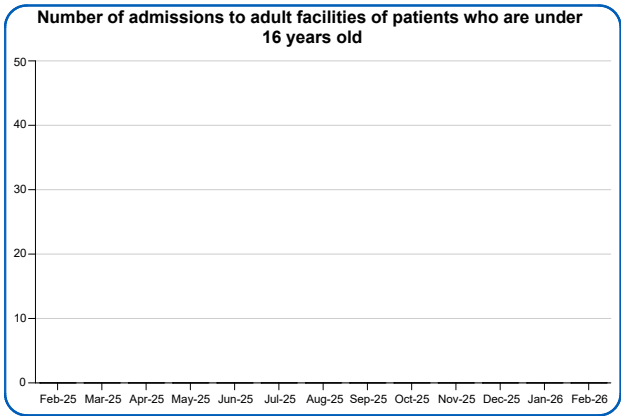


Contractual Target 85%: Q3 96.1%

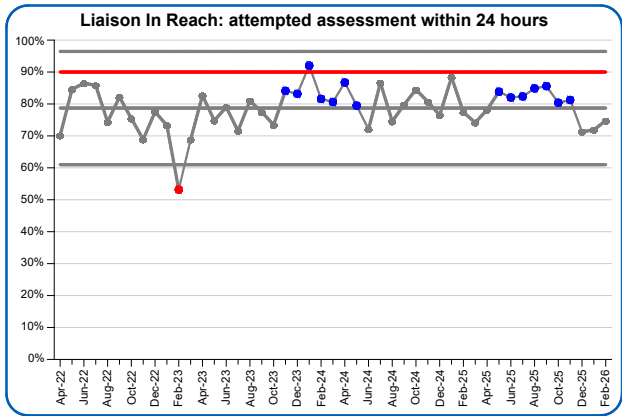


Local measure 950: Q3 856

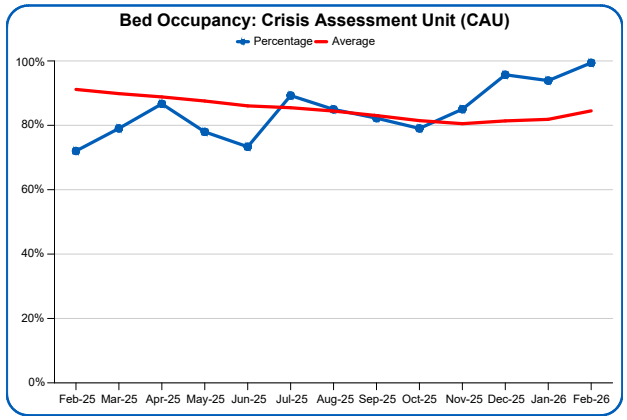
Services: Our acute patient journey



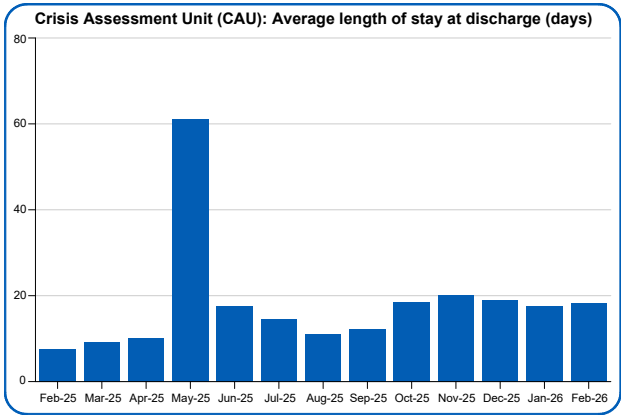
National (NOF) No target 0: February 0



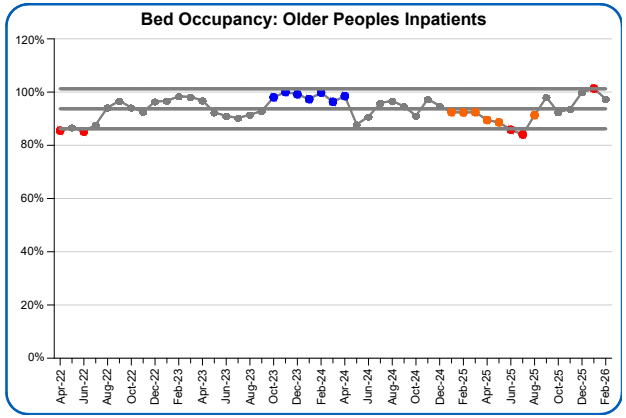
Contractual Target 90%: February 74.8%



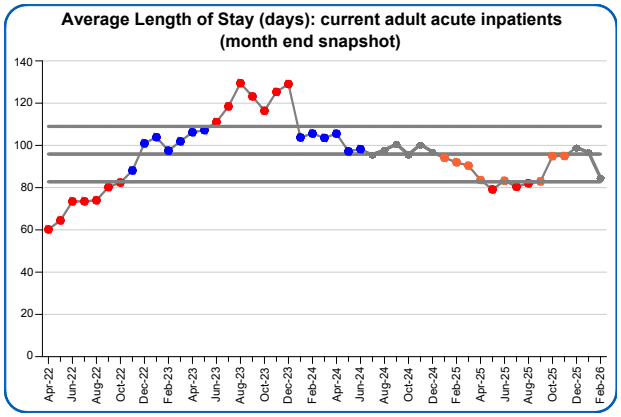
Local measure: February 99.4%



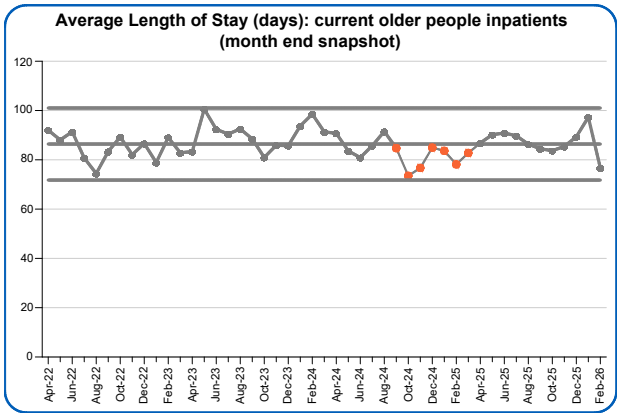
Local measure: February 18 days



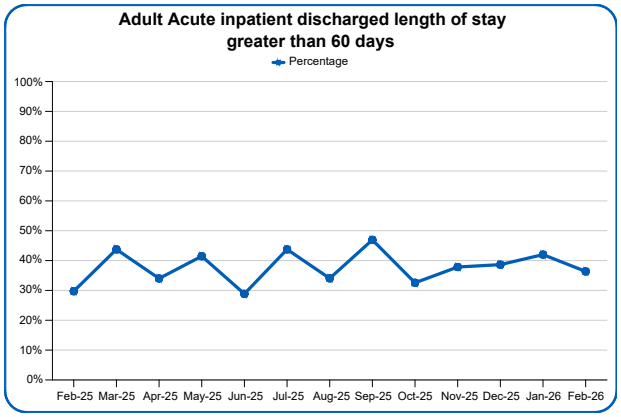
Local measure and target : February 97.4%



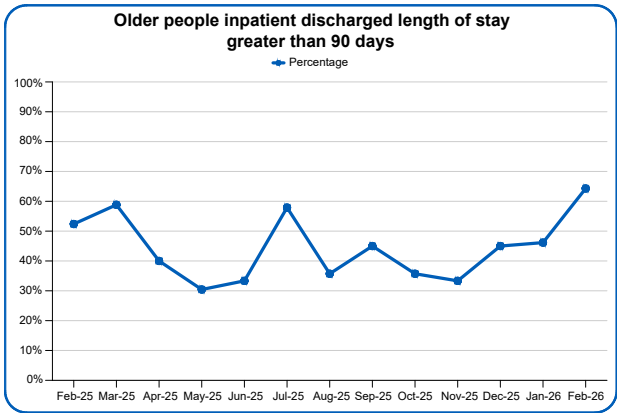
Local tracking measure: February 85 days



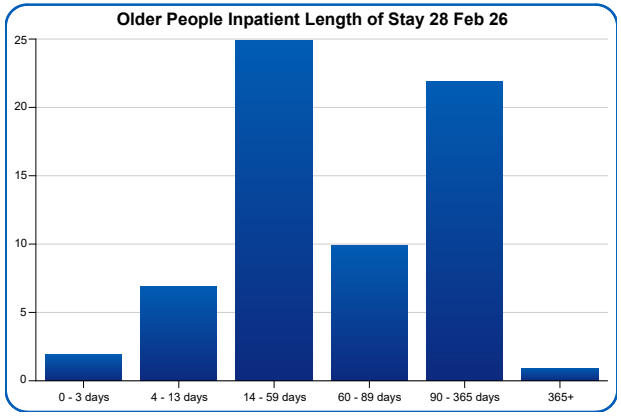
Local tracking measure: February 77 days



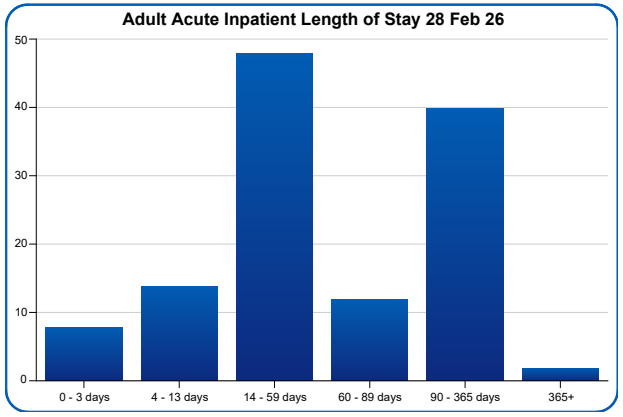
National (LTP): February 36.4%



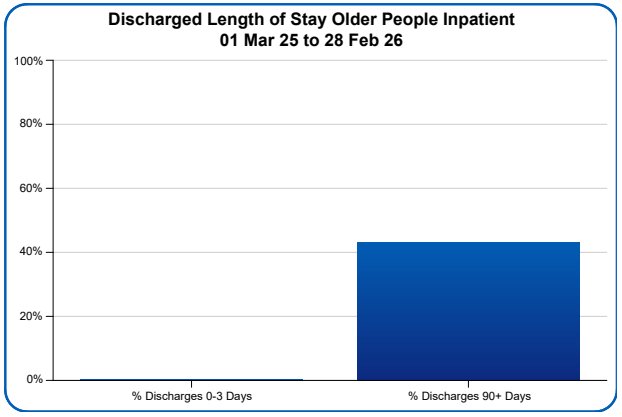
National (LTP): February 64.3%



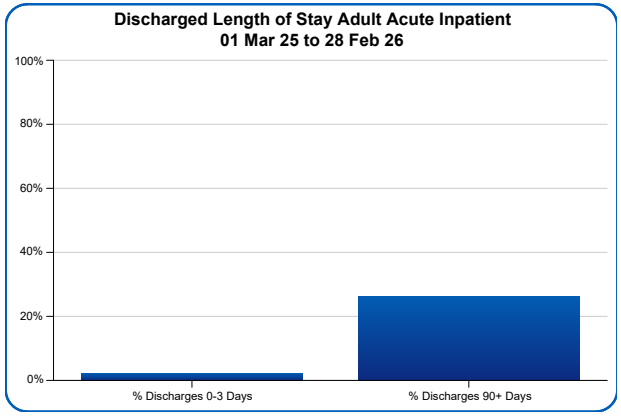
Local activity: 23 people with LOS 90+ days



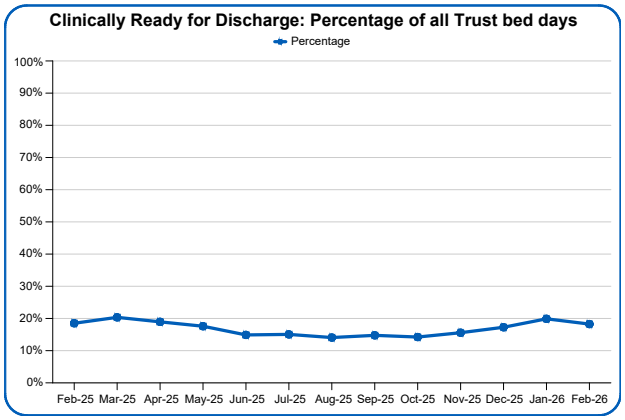
Local activity: 42 people with LOS 90+ days



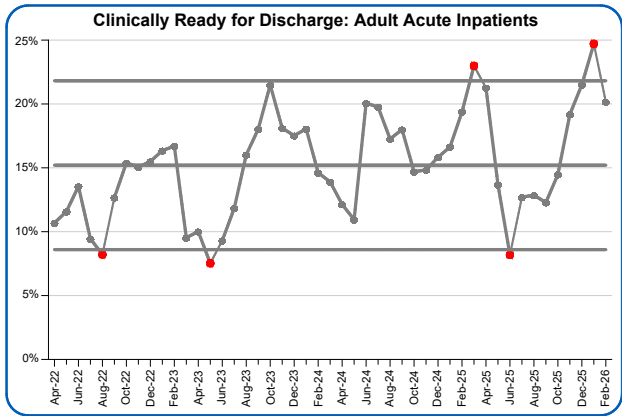
Local activity: % discharged LOS 90+ days = 43.5%



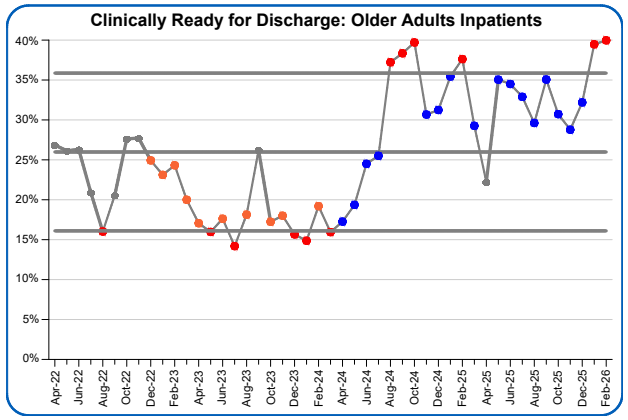
Local activity: % discharged LOS 90+ days = 26.6%



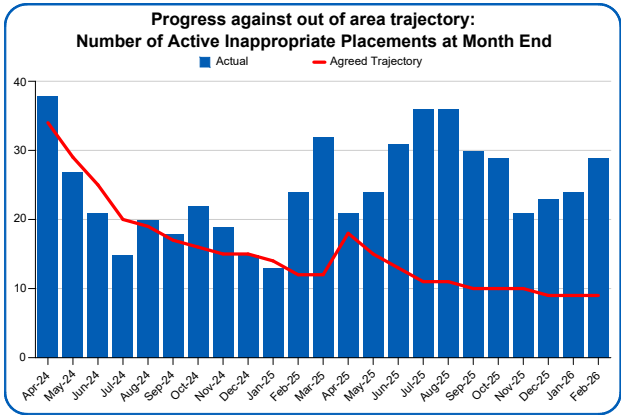
Local tracking measure: February 18.3%



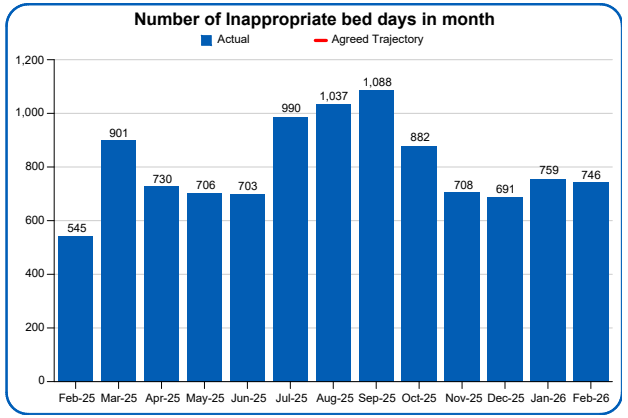
Local tracking measure: February 20.2%



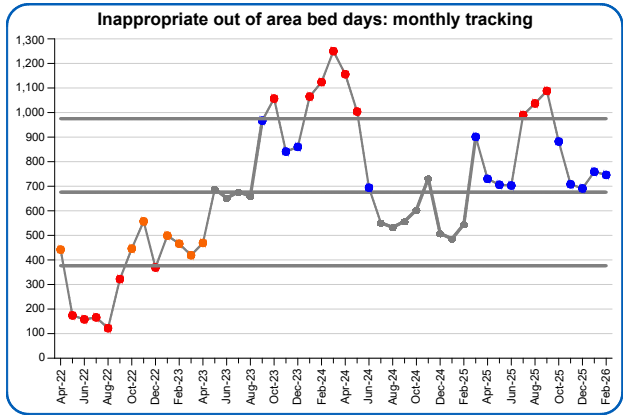
Local tracking measure: February 40.0%



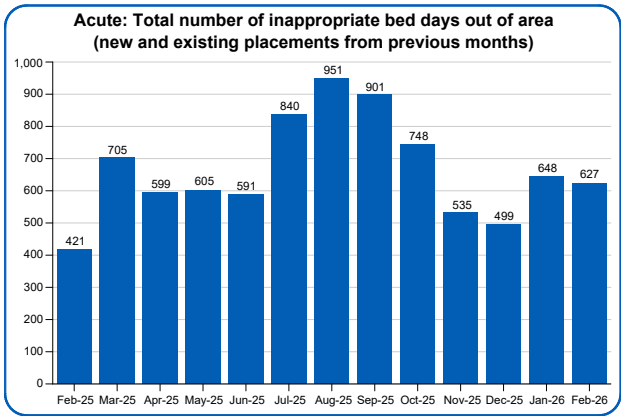
Nationally agreed trajectory (February: 9): February 29 active placements



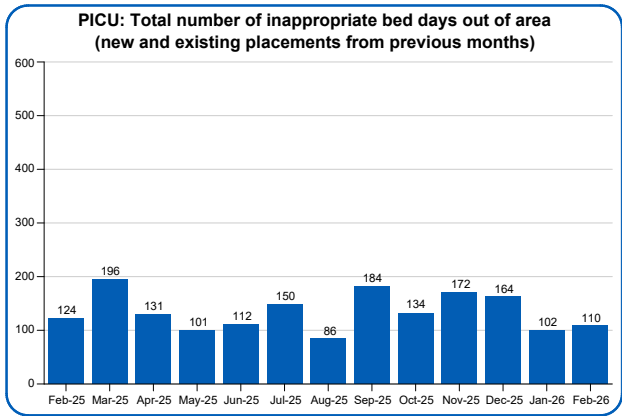
Local tracking measure: February 746 bed days



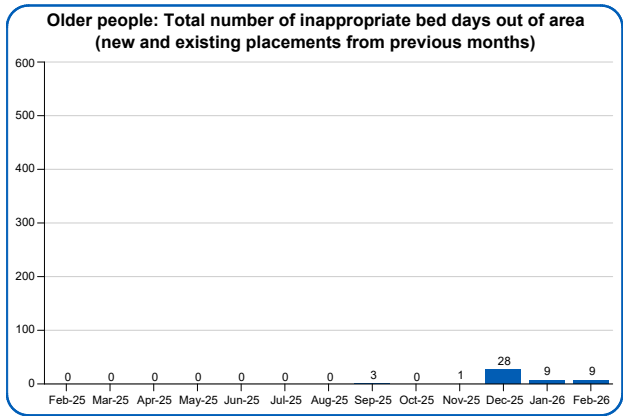
Local tracking measure: February 746 bed days



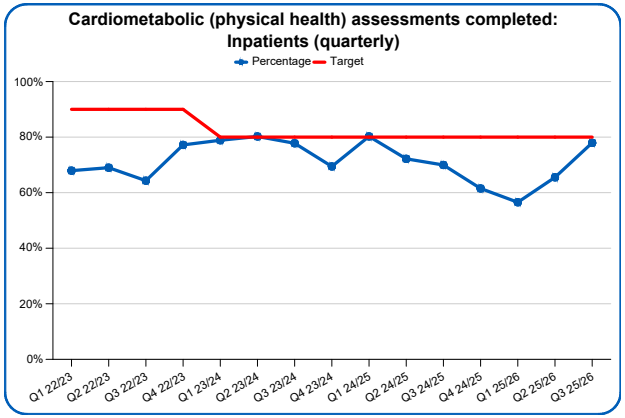
Nationally agreed trajectory (): February 627 days



Nationally agreed trajectory (): February 110 days

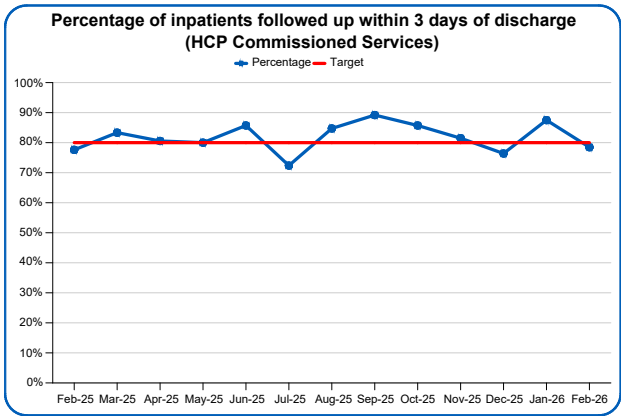


Local measure : February 9 days

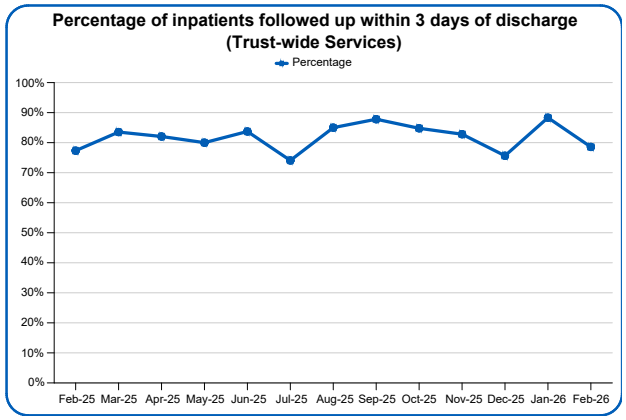


Contractual target 80%: Q3 77.9%

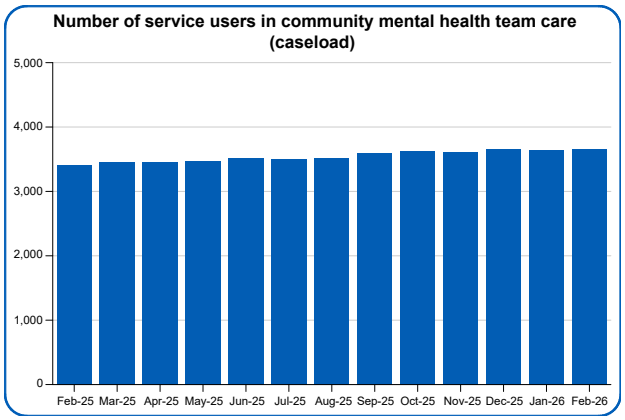
Services: Our community care



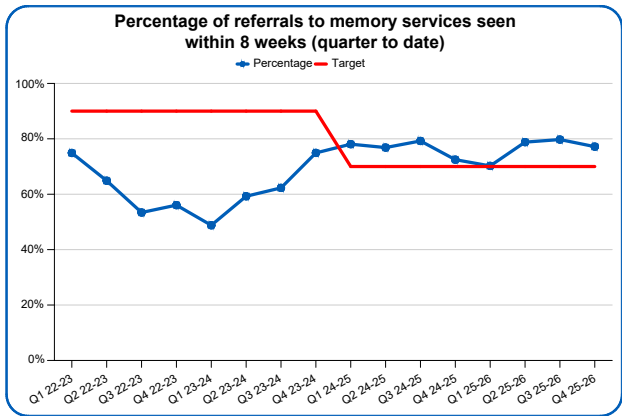
Contractual target 80%: February 78.5%



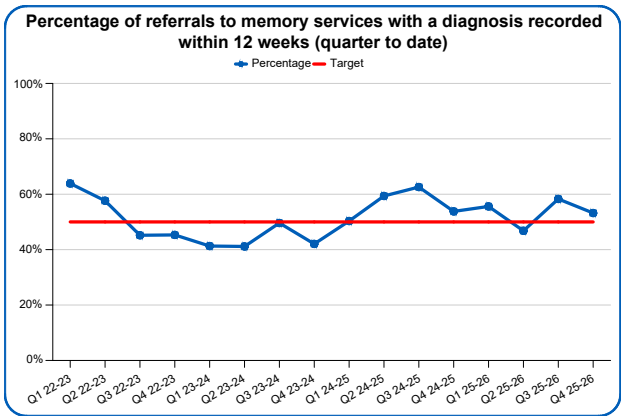
Local Tracking Measure 80%: February 78.6%



Local measure : February 3,670

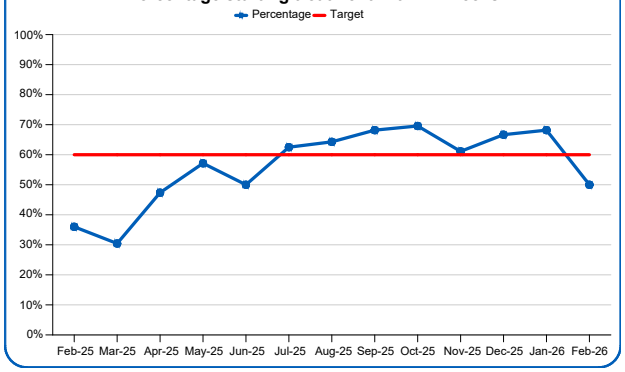


Contractual target 70%: Q4 25-26 77.2%



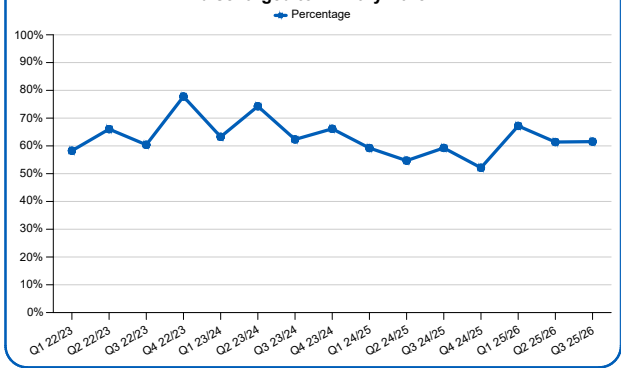
Contractual target 50%: Q4 25-26 53.2%

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



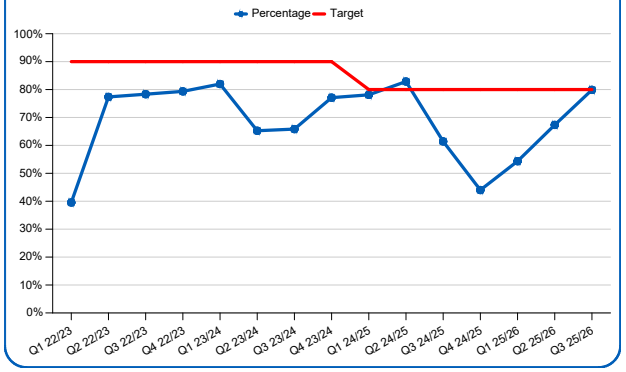
Contractual target 60%: February 50.0%

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



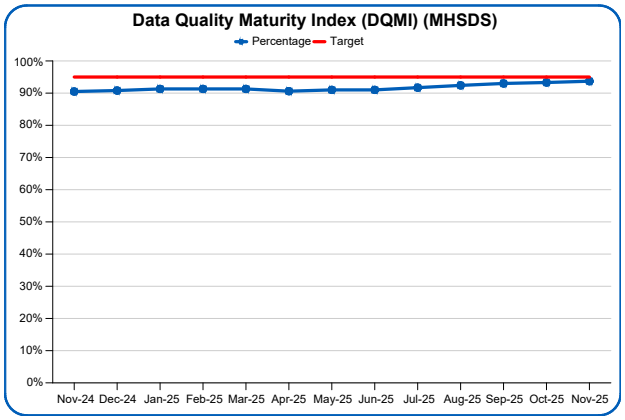
Contractual target tbc: Q3 61.5%

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

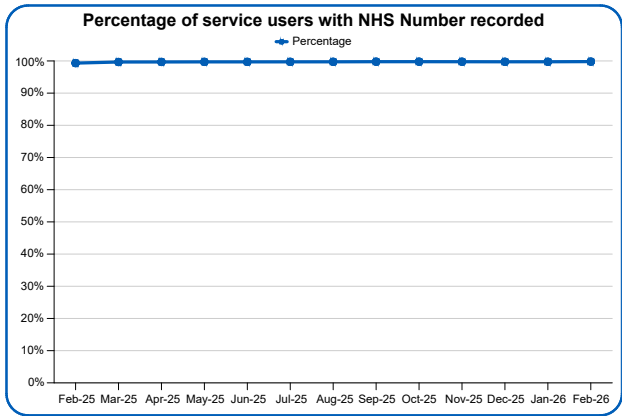


Contractual target 80%: Q3 79.9%

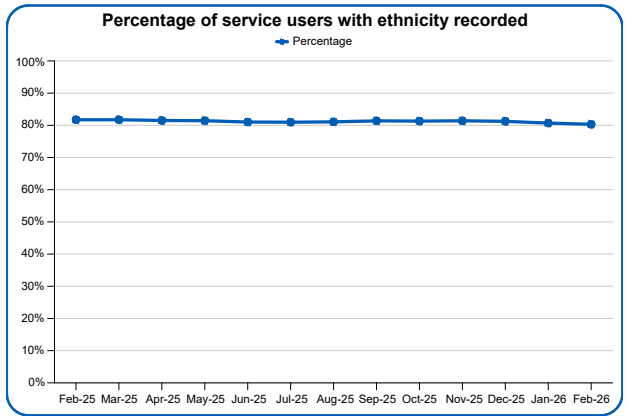
Services: Clinical Record Keeping



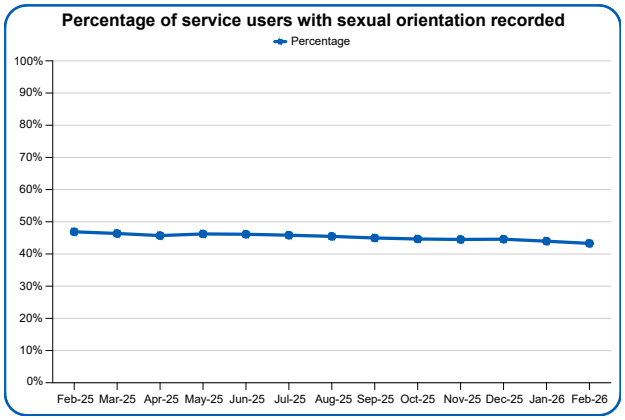
CQUIN / NHSOF Target 95%: November 93.7%



Local measure: February 99.8%



Local measure: February 80.3%



Local measure: February 43.3%

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
11

Meeting of the Board of Directors

Paper title:	Chair's Report from the Quality Committee meeting on 12 February 2026
Date of meeting:	26 March 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:	12 February 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**
The committee received a report which outlined key quality indicators for patients placed in out-of-area (OOA) acute and Psychiatric Intensive Care Unit (PICU) beds between 1 September 2025 and 31 December 2025. It welcomed the improvements that had been made to the report but agreed that it did not provide full assurance on quality and patient safety due to the gaps in quality data (e.g. routine reporting of all restrictive practice and incidents of self-harm). It had previously agreed the principle that the Trust should receive the same data as it recorded for patients receiving care within LYPFT services. It was agreed that the Trust should explore all possible routes for obtaining necessary data (formal action).	SR1 SR4

ASSURE – specific areas of assurance received warranting mention to Board	
Issue	**Relates to BAF Risk**
The committee reviewed and discussed the Board Assurance Framework, paying particular attention to strategic risk (SR) 1 and SR2. It agreed that it was assured that this is being adequately controlled and agreed that it would be mindful of its responsibilities to assure that these risks were being adequately controlled throughout the course of the meeting.	SR1 SR2
The committee received a paper which outlined the Trust's current position on the quality monitoring of clinical services commissioned from third-sector providers. It noted that a recent review of the 21 contracts the Trust held had identified gaps in the Trust's current approach to monitoring quality, assurance, and performance, noting that these included inconsistent quality metrics, variable monitoring practices, and limited reporting, creating a risk to the Trust's ability to demonstrate robust oversight. It was reassured that a programme of improvement was underway to strengthen governance and introduce a	SR1 SR7

more consistent and transparent framework. The committee agreed how assurance would be reported going forward and welcomed the progress made in this area.	
The committee reviewed the Equality Delivery System (EDS) Annual Report, noting that for 2025/26, in-depth equality assessments had been carried out for the Eating Disorder Service, the East Crisis Service and the East Community Mental Health Team with EDS action plans agreed. The committee discussed the information provided and praised the work undertaken in this area.	SR1 SR2 SR3 SR4 SR5 SR6 SR7
The committee received two presentations which provided the highlights of the Personality Disorder Service's and Addictions Plus Service's Annual Quality Reports, focusing on how the services had scored themselves 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 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

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
11

Meeting of the Board of Directors

Paper title:	Chair's Report from the Quality Committee meeting on 12 March 2026
Date of meeting:	26 March 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:	12 March 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 paper which set out the process for developing the Draft Internal Audit Plan for 2026/27 and the areas being considered for audit. It noted the audit topics identified for 2026/27 and was assured that the internal audit plan addressed the appropriate risk areas.	SR1 SR2 SR3 SR4 SR5 SR6 SR7
The committee received the Clinical Audit Priority Plan for 2026/27 and was assured on the priority topics.	SR2

The committee received a presentation which provided the highlights of the Learning Disability Service'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 a report which provided an update on the observation and engagement programme.	SR1
The committee received an update on the work undertaken to change the Trust's approach to clinical risk assessment. The committee acknowledged the complexities of this work and praised Ms Sanderson on the success of the roll out.	SR1
The committee received an update on the production of the 2025/26 Quality Account. It welcomed the work that had been undertaken to review the content to minimise duplication and remove information that did not add value.	SR1 SR2 SR3

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
12

Meeting of the Board of Directors

PAPER TITLE:	Medical Director's Report
DATE OF MEETING:	26th March 2026
PRESENTED BY: (name and title)	Dr Chris Hosker. Medical Director
PREPARED BY: (name and title)	Dr Chris Hosker. Medical Director & Directorate SLT

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 advise the Board of Directors of the status of the Medical Directorate and in doing so, provide assurance that it is functioning in a way that promotes the success of the Trust, its patients, its staff and the wider public, while also managing any current risks that are positioned as potential barriers to that success.

The paper's scope therefore covers the key functions that sit within the Medical Directorate and provides an update of key work within each one.

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 are asked to consider the information contained within this report on the key functions of the medical directorate and to be assured that the work being conducted is commensurate with the challenges being faced and in line with the wider Trust strategy

Meeting of the Board of Directors

26 March 2026

MEDICAL DIRECTOR'S REPORT

1. EXECUTIVE SUMMARY

The purpose of this report is to advise the Board of Directors of the status of the Medical Directorate and in doing so, provide assurance that it is functioning in a way that promotes the success of the Trust, its patients, its staff and the wider public, while also managing any current risks that are positioned as potential barriers to that success.

The paper's scope therefore covers the key functions that sit within the Medical Directorate and provides an update of key work within each one.

2. DIRECTORATE OVERVIEW

key developments across all core functions of the Directorate, include:

- **Medical Workforce and Professional Leadership** – recruitment to substantive posts, agency usage, developments within the SAS workforce, job planning performance, and emerging challenges around medical staffing capacity and wellbeing.
- **Medical Education and Professional Development** – progress under the Medical Education Leadership and Management model, improvements to induction and working conditions for resident doctors, and the impact of external system pressures on training and supervision.
- **Responsible Officer Functions** – assurance on appraisal and revalidation performance, outcomes of GMC investigations, and upcoming work to improve support for neurodiverse doctors and prepare for organisational alignment with Leeds Community Healthcare.
- **Clinical Leadership and Quality of Care** – the Trust-wide review of clinical leadership structures, progress against the Quality Strategy, and actions being taken in response to the Levy Review of Adult Gender Dysphoria Services.
- **Medicines Safety and Pharmacy Transformation** – the recovery and improvement programme ("*Getting to Good*"), workforce stabilisation, governance enhancements, and ongoing work to strengthen operational processes and medicines assurance.
- **Clinical Information Management** – update on digital innovation and the development of the business case for the Heidi AI clinical documentation tool, alongside broader considerations relating to the Trust's emerging AI strategy and digital governance.
- **Research, Improvement and Knowledge Services** – reporting on active research programmes, external collaborations, and the large portfolio of quality improvement and clinical audit activity supporting the organisation's safety and transformation priorities.
- **Mental Health Legislation Compliance** – summarising training performance, bespoke educational support to internal and external partners, and findings from recent audits related to CTO extension processes.

The Directorate continues to operate under sustained demand but is making clear progress in key areas. There are areas identified for continued investment, leadership attention and cross-organisational alignment. The report provides assurance that work is being directed towards the Trust's strategic objectives and that identified risks are being actively managed.

3. CORE DIRECTORATE FUNCTIONS

3.1 Personnel and structure changes:

The Andrew Sims Centre (ASC) continues to be closely monitored in relation to workforce capacity and its operating model. There has been good news that the Mental Health Law training courses (Section 12 approval and Approved Clinician Status) have been approved by the Northeast Approval Panel for delivery by ASC until 2027. These programmes remain the primary income stream for ASC. Although the calendar year began with lower than usual activity, the team has been proactive in securing events and courses that remain viable to deliver within current staffing constraints.

ASC maintains responsibility for managing the Red Kite View (RKV) out-of-hours on-call rotas. Given the reductions in staffing, contingency arrangements are in place to ensure this administrative function can be sustained, with additional support available from the Medical Directorate Administrators and Medical Education should any issues arise.

The Guardian of Safe Working (GoSW) reforms were implemented in February 2026. Due to potential conflicts of interest within Medical Education, this work has now transferred to, and is supported by, the Medical Directorate Administrators. During the first week of the new arrangements, three exception reports were escalated and managed collaboratively with the GoSW.

The Head of Medical Development and Operations has initiated discussions with LCH to map the operational functions required to support the medical workforce. This work includes a review of staffing levels and the capacity needed to deliver statutory and regulatory responsibilities.

Across all administrative functions in the Medical Directorate, the team are working at full capacity, and workload levels are being actively monitored. All team members continue to receive regular supervision, with a particular focus on wellbeing and burnout prevention.

3.2 MEDICAL PROFESSIONAL LEADERSHIP

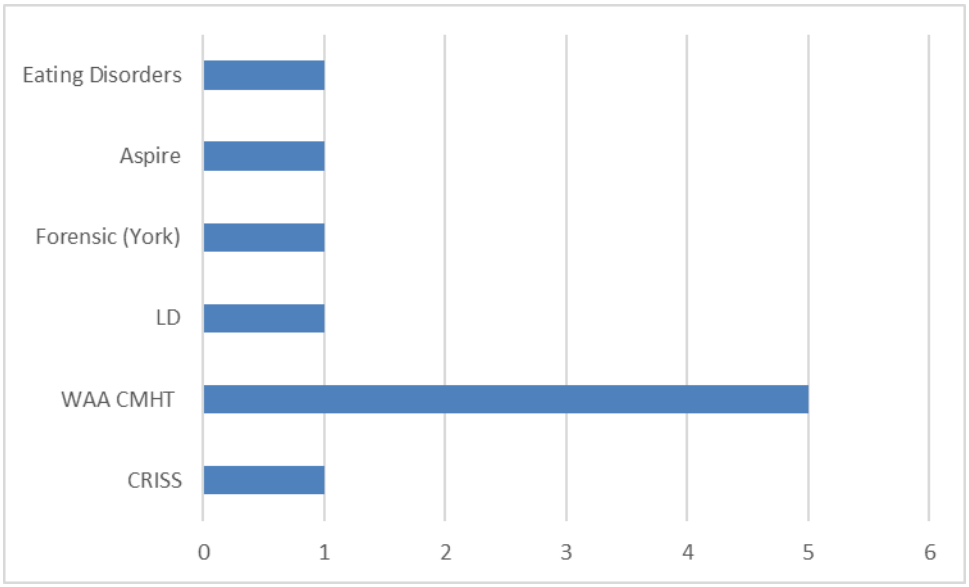
Medical staffing levels – vacancies and recruitment

We are pleased to report that following the last report submitted in November 2025, 1 substantive consultant has been successfully appointed to NICPM and 1 Specialist Grade doctor has been appointed to a substantive post in NE CMHT. A further consultant recruitment panel will be taking place on March 19th with the hope of a further substantive post being recruited to at Clifton (Forensic – York).

At Q3, there are a total of 11 agency doctors working at LYPFT (1 Specialty Doctor and 10 consultants). This compares to a total of 13 agency locum doctors in Q2.

Consultant vacancies

This table lists the clinical services where there are agency doctors filling vacancies.



All vacant posts have future dates scheduled at substantive appointment (AAC) panels. Running alongside the substantive posts there are also adverts for Trust locum consultant positions, providing the opportunity for potential candidates to apply for either, which supports the work of reducing agency costs. In ENE CMHT, a reconfiguration of two of the less than fulltime consultant patches have led to the creation of fulltime Specialist Grade (a recently introduced senior medical grade) post instead. This is being reviewed in other areas with a view to expanding this approach.

Post	Reason for agency cover	Specific Workforce Planning to Recruit to Vacancy
Ward 1 Becklin	Resignation	The substantive consultant has unexpectedly resigned, and the service are reviewing CVs for agency locums while considering alternative ways of covering.
CAMHs (Leeds RKV)	Resignation	This consultant post is not currently being advertised – the service has instead agreed an alternative medical workforce model using an additional SAS Dr in the interim.
Eating Disorders	Long term vacancy after retirement.	Service review is still ongoing and future medical workforce is unclear. Agency cover will continue in the meantime.
Forensic (York)	Resignation	Consultant recruitment panel March 19th 2026
LD (ENE)	Retirement	Agency in place for 3 days currently. Requires increased funding to be advertised as 10 PA post.
CRISS/CAU	Vacancy due to internal move	Post remains vacant. Requires RC – alternatives have been considered. Agency remains in post.

Aspire	Vacancy due to sickness and planned internal move	Post to be advertised. Agency locum in place for 3 days currently.
CMHT	Combination of resignations and expansion	Total vacancies: 7.2 WTE Covered by 5 agency consultants

SAS doctors

There is currently 1 agency SAS doctor CMHT.

Trust Doctors

3 X Trust Doctors (covering vacant resident doctor positions) have been appointed in Q3 and commenced on the 4th of February 2026.
There are no agency Trust doctors currently.

New Work

- Work with NOECPC is continuing through a benchmarking exercise to assess how LYPFT compares with other NHS organisations in terms of agency rates. All local Trusts have been contacted to provide details of their agency locum rates.
- A medical line manger time out/training update session has been arranged to take place in Q4.
- Work is currently taking place to embed a Direct Engagement model, the award has been made and the medical directorate will be working with the organisation awarded to implement.

Specialty Doctors (SDs)

Workstreams allowing SAS Drs to progress in their career contribute to creating alternative options to consultant recruitment and improve LYPFT's offer to the SAS workforce, increasing chances of retention in and recruitment.

A senior SAS Dr who applied to be an Autonomous Worker has been successful with their application

- Following the advertisement for a Specialist Grade in ENE WAA CMHT, this post has been offered, and the doctor commences in May 26. This post was created as an alternative to a consultant post.
- A senior SAS Dr has also applied for progression to Specialist Grade, and this application has been accepted as needed by the service due to having a long-term consultant vacancy.

The AC/Portfolio pathway is now up and running with 4 senior SDs working towards AC status or completion of the Portfolio route to enable application to consultant posts.

Higher trainees (HTs)

Discussions continue to take place between all eligible Higher Trainees (HTs) and the Deputy Medical Director who meets regularly and routinely with HTs rotating into the Trust to discuss

career opportunities, providing information about consultant opportunities available to them in LYPFT. A system with medical education is in place to ensure all eligible HTs are contacted. We also regularly provide HTs across Yorkshire and the Humber a monthly updated recruitment flyer highlighting all the Trust's consultant vacancies.

A recent example is the intended application following a discussion with the Higher trainee in South CMHT who has expressed an interest in applying for a consultant post in Q4, reducing the need for an agency locum.

Job planning status update

A) Job Plan Compliance

The current overall completed compliance is 94%. The tables below summarise compliance by grade broken down by service area. Reasons are also provided to add explanations for the doctors who have not yet started job plans.

Consultants:

Service	Number of Signed off Job Plans	Job plan due
Adult Acute Services	7	0
Adult Acute Services (CRISS)	3	0
CAMHS (inc Deaf CAMHs)	7	0
Community (WAA)	20	1*
Eating Disorders	2	1*
Forensic	4	1
LD	2	0
Liaison	11	0
OPS	16	1
Perinatal	8	1*
Public Health	1	0
Regional & Specialist	7	0
Rehab	3	0
Grand Total	91	6

Job plan due: *One doctor is on sick leave, *one doctor on maternity leave, *one has been completed but awaiting to be signed by the Consultant; two are late, for which reminders have been sent.

SAS:

Service	Signed off job plan	Job plan due
Adult Acute Services	6	0
Adult Acute Services (CRISS)	4	1
CAMHS (inc Deaf CAMHs)	4	0
Community (WAA)	8	0
Eating Disorders	2	0
Forensic	1	0
LD	3	0
Liaison	4	0
OPS	11	0
Perinatal	3	0
Public Health	0	0
Regional & Specialist	4	2
Rehab	3	0
Grand Total	53	3

Job plan due: For two doctors the line manager is on sick; this will be picked up by the DMD. The other doctor's job plan is late and a reminder has been sent.

Trust Doctors:

Service	Signed off job plan	Job plan due
Adult Acute Services	1	1
Adult Acute Services (CRISS)	1	0
CAMHS (inc Deaf CAMHs)	0	0
Community (WAA)	2	2
Eating Disorders	1	1
Forensic	1	0
LD	0	0
Liaison	0	0

OPS	0	0
Perinatal	0	0
Public Health	0	0
Regional & Specialist	0	0
Rehab	0	0
Grand Total	6	4

Job plan due: These four doctors are new into post and are due to have their first job plan within 3 months of their start date.

B) Job Planning Policy

The Job Plan policy has been developed and written collectively with the Deputy Medical Director, HRBP and Head of Medical Development and Operations and includes the appeals and mediation procedure. The first draft of the policy was presented to the Joint Local Negotiating Committee (JLNC) on 8th September 2025 where the British Medical Association (BMA) requested further time to review and comment on the policy. This has now been reviewed, updated by the Head of Medical Development and HRBP and was presented at JLNC in Q3 on March 3rd. Some additional final changes are being considered, and the policy will be completed and signed off by the end of April 2026.

c) Licence to Practice (L2P)

Licence to Practice (L2P) is the e-system which is used for job planning (the system is also used for medical appraisal). We are currently working with L2P to develop a supporting information resource section whereby all service objectives can be uploaded. In addition, we have implemented a standardised template of headings of a minimum of one personal, one service level and one Trust objective for all doctors to follow. This will provide assurance that the job planning objectives are aligned with Trust and service objectives.

3.3 Specialty Doctor and Associate Specialist (SAS) Advocate update

The role continues to predominantly involve linking in with colleagues to check on well-being of the SAS group within the workplace. This has increased in recent months due to new cohorts of SAS joining the trust and the introduction of the Portfolio and AC pathways. As before individual support and guidance has been provided as well as group discussions where appropriate. There has been a notable increase in colleagues feeling under pressure in recent months due to the current political climate and support and sign-posting has been offered where and when needed.

Working with the SAS tutor, we are keen to streamline the Trust Induction process for new SAS doctors by offering group meetings with both the SAS Advocate and the Tutor to address queries and concerns. However, this is difficult due to schedules and the varied start times of SAS

colleagues and, continues to be work in progress and will be discussed at the next SAS Committee (SASC).

Work has been taking place with the SASC to vary the format of the meetings to include teaching opportunities and external speakers. We are due to have topics such as Neurodiversity and ‘how best to approach the Portfolio pathway’ in upcoming meetings and are currently in the planning stages of the next well-being away day for our SAS cohort.

The SAS advocate is the lead in organisation of annual SAS wellbeing days, and we are putting together a programme based on feedback received from our SAS cohort. The hope is that these events encourage networking outside of the clinical environment.

The webpage set up on Staffnet has received good feedback and was used to promote SAS Week 2025 and share feedback provided by colleagues about our SAS cohort. Due to its success, it will now be the forum to share relevant course details and upcoming SASC meeting information.

There has been ongoing liaison with the LNC and national SAS advocate group to gain and share pertinent information relating to the SAS group both locally and nationally in terms of developmental opportunities, sharing good practice and employment issues. After discussion with the Yorkshire and Humber SAS tutors, it was agreed to centralise some of these developmental opportunities through HEE and a portion of the regional SAS developmental fund was used to do this. The topics were chosen based on regional training needs analysis results, which was conducted by me for SAS in our trust.

The SAS development group continues to meet regularly. The current lines of work include:

- Identifying areas in the trust where a Specialist Role would be beneficial. This continues to be a bone of contention due to financial limitations in certain sectors, but roles have been specified and allocated.
- Colleagues on the Portfolio Pathway and Approved Clinician pathways are progressing with their applications. We are due to meet with them in May to assess their progress and review what support is needed.
- Ensuring we are compliant with the BMA SAS Charter. We are now working towards SAS Excellence in Development Award (SEiD). The criteria have been released and will be reviewing our compliance with these in upcoming months before submitting our application. I am assisting the SAS Tutor with this.

3.4 Medical Education

Starting with the positives, the MELM (Medical Education Leadership and Management Team) structure continues to work well. Drs Kemi Okopi, Laura Shaw and Maya Patel have recently agreed to take on the role of Specialty Trainee Tutors which strengthens the Educational Supervision support available in higher training. Dr Robin Owen has stepped down as Specialty Trainee Tutor and Dr Becky Asquith has resigned from her Core Trainee Tutor and Guardian of Safe Working roles due to being offered a conflicting role within the Trust. Recruitment to replace Dr Asquith is currently underway.

Dr Tom Lane, Consultant Psychiatrist with LYPFT Rough Sleepers Team was successful in his application for a new University of Leeds and LYPFT collaboration of Clinical lecturer and honorary consultant psychiatrist. Tom will work closely with Dr Anne Cooper, DUGME and Dr Sharon Nightingale, DME to continue to quality assure high quality medical undergraduate mental health teaching in the new UoL Curriculum redefined. The new curriculum focuses on more community, and less acute hospital, experience in line with the NHS 10-year plan. Tom getting this post is real testament to the 'Cradle to Grave' model of medical education training in the Trust as he has held roles in medical education with us since core training.

Medical Education continues to work closely with Departments across the Trust to implement changes required under the 10-point plan for resident doctors. Arrangements are being made to reserve parking spaces for on-call doctors at the 3 inpatient sites and the kitchen facilities are being updated at Becklin Centre with an agreement that frozen microwaveable meals will be provided. Induction for resident doctors at Mill Lodge and Clifton House has been streamlined and a duplication of some parts of mandatory training has been removed from the mandatory training induction programme, which was due to these doctors being employed by LYPFT but covering on-calls for TEWV. The resident doctor peer leads are very satisfied with LYPFT dedication to continuing to improve the working lives of resident doctors.

Current challenges are:

In February 2026 resident doctors voted to continue strike action for another 6 months, no further details are known at this time.

The deanery continues to have significant staffing issues which is impacting the workload pressures internally for Medical Education and PLDT as there is reduced support compared to previously. The merge transition completion date with DHSC is currently set for April 2027.

Following the University of Leeds interface meeting that took place on 6th November 2025, it was confirmed by Dr George Crowther, LYPFT R&D, that more resident doctors are wanting to get involved in research and development opportunities which is encouraging to hear. Due to budget restraints within R&D they are finding it difficult to support the requests being made. The R&D team do have a few commercial projects on the horizon so hopefully this will bring in some vital funding and opportunities for resident doctors to get involved.

4. RESPONSIBLE OFFICER

Appraisal and revalidation

LYPFT currently has 148 doctors with a prescribed connection to LYPFT and 11 doctors working in the Trust with a prescribed connection elsewhere.

In the last quarter (Q3) 9 appraisals were undertaken and 2 recommendations for revalidation were submitted and approved by the GMC. There were 3 late appraisals, 2 due to sickness absence and 1 due to annual leave. There were 0 missed appraisals.

The recommendations from internal audit on the Trust's appraisal process (including medical appraisals) are on track to be completed by Q4. Medical appraisal compliance is reported into the Workforce Committee.

A business case was approved by the Trust's Financial Planning Group in November 2025 for funding of four Additional Programmed Activities (APAs) to support the expanding work of the Responsible Officer in overseeing Medical Professional Standards across the medical workforce, in accordance with the Medical Profession (Responsible Officers) (Amendment) Regulations 2013. This had led to the successful recruitment of a new Director of Medical Professional Standards – Complaints and Concerns Lead (Dr Becky Asquith), and a job share Director of Medical Professional Standards – SAS Lead (Dr Abhi Inglis). Both postholders are scheduled to commence in their roles on 1 March 2026.

Managing concerns about medical staff

Since the last report:

- One doctor who remained under GMC investigation from their previous employment has now left the Trust and relinquished their GMC licence to practice.
- The GMC investigation into a doctor who was previously employed by the Trust has concluded with the doctor being issued with a formal warning. The doctor is also subject to a further investigation by the GMC which remains ongoing. The RO continues to be in contact with the GMC regarding the case
- One agency doctor was referred by their previous employer to the GMC. The RO has provided requested information to the GMC, and the case is being reviewed by the GMC. The doctor's booking with the Trust has since ended and they are no longer working in the Trust.

Challenges and work planned for Q1

A working group set up by the RO and including representation from within the Medical Directorate and clinicians with lived experience of neurodiversity is due to roll out a programme of education and training events through Q1 and Q2 with the remit of improving understanding about, and support for, neurodiverse doctors. This will be backed by a dedicated Staffnet page, linking pre-existing LYPFT Health and Wellbeing resources with regional and national resources designed specifically for doctors. The impact of this work will be evaluated and shared in due course.

The alignment between LYPFT and LCH will provide both challenges and opportunities for all, and work will begin in Q1 to begin to understand the specific implications for the Medical Directorate and the RO with particular reference to medical appraisal, revalidation and professional standards.

External to LYPFT the RO and members of the Medical Directorate team will continue in 2026 to be actively involved in regional and national networks and reference groups, pursuing opportunities for shared learning and development for the benefit of all.

5. CLINICAL LEADERSHIP AND QUALITY OF CARE

Clinical leadership review

Following the appointment of Dr Julie Hankin as Deputy Medical Director for Clinical Leadership, Research and Improvement we have commenced a structured review of Clinical Lead and Clinical Director roles, examining scope, purpose, outcomes, and sustainability. This will include consideration of the upcoming merger with Leeds Community Trust and the requirements for clinical leadership in a newly constituted service.

A considerable amount of work has already been undertaken within the Trust focused on building a strong and coherent clinical leadership function. This review seeks to build on the 2020 work on Building Clinical leadership together, incorporating focus group work undertaken as part of the improvement plan and the ongoing work that the clinical directors and leads have undertaken since 2020. We also now have the ability to incorporate the latest NHS leadership frameworks to produce a simplified and value-adding clinical leadership function within the trust that can also look forward to the potential requirements of the new organisation.

However there remains considerable variation with regards to clinical director roles across services and there does not appear to be a clear, shared understanding of the roles and responsibilities. This makes it difficult to assess the impact of clinical leadership and leads to frustration on the ground which impedes continual improvement of services that we deliver. This review seeks to build on the work done on collective leadership within the Trust that but to add structural and operational clarity.

The agreed objectives of the work are

- Agreed role descriptors and competencies with a robust methodology for assessing the clinical leadership requirements for a specific service, with a focus on ensuring cost efficiency.
- Revised operational model, with clear leadership model embedded within it focusing on purpose, role and responsibilities/accountabilities
- Standardised contractual and remuneration model allowing for all professions
- Agreed procedures for recruitment
- Agreed performance management system
- Formalised development programme and pipeline
- Formalised support structures
- Agreed outcomes for measuring the impact of clinical leadership and linked dashboard development
- Integration of the revised NHS leadership framework

The review is due to report to EMT in June 2026 with a final options paper.

Quality strategy

Work is also being undertaken to review progress against the Quality strategy and bring this together into a clear plan reporting to the Quality Committee. To complement this an internal audit is being undertaken reviewing the adequacy and effectiveness of the Trust's arrangements for the governance, consistency and use of Annual Service Quality Reports to support service quality improvement.

Gender services
LYPFT has received the Leeds-specific findings from the Levy Review of Adult Gender Dysphoria Services. The report has been reviewed in detail by the leadership team, and a formal response has been submitted to NHS England addressing the factual accuracy of the content – there were some statements which were felt not to be accurate. This initial step has ensured that the information held about the Leeds Gender Identity Service is correct, balanced and reflective of current practice as seen by the Service itself.

The areas for improvement identified in the report have been acknowledged. Work is underway to draft a comprehensive action plan that will address each of the recommendations. This process is being led by the Clinical Director, who will coordinate engagement across clinical, operational and governance teams to ensure the areas for improvement highlighted in the report are considered and appropriately responded to. This action plan which will form part of a formal report to the Board, once approved by the Public Board, will then dictate the actions to be completed within agreed timeframes and regularly reported on, as appropriate.

6. MEDICINES SAFETY

Pharmacy Service Recovery: “Getting to Good” (G2G)

Following the Pharmacy Service exiting Business Continuity arrangements, a structured recovery programme titled “Getting to Good” (G2G) was established to support service stabilisation and improvement. The formal G2G programme commenced on 1 November 2025, following consultation with the full pharmacy team through a series of half-day engagement sessions held during summer 2025.

Progress and delivery of the recovery programme are monitored through six-weekly recovery oversight meetings involving the Project Sponsor (Chris Hosker), Human Resources (Michelle Mahoney), and Organisational Development (Julie Thornton).

In addition, the Pharmacy Improvement Group (PhIG) meets monthly to monitor progress, coordinate delivery across the workstreams, and provide updates to the wider pharmacy team. This group will also serve as the ongoing forum for wider service development and improvement initiatives involving the whole team.

The G2G programme is structured around six key workstreams, with the following progress achieved to date.

1. Line Management

Line manager roles, responsibilities, and required support were reviewed at a Line Managers’ Focus Group in December 2025. Several actions were agreed, including improvements relating to role clarity, induction, peer coaching, and escalation processes. These actions are scheduled for completion during March 2026.

All pharmacy line managers now have the LYPFT 360 Manager development programme assigned within their Learn profiles and induction plans. Completion of this training is monitored through the Pharmacy Workforce Meeting. Job descriptions and person specifications are currently being aligned to reflect these responsibilities.

A programme of bespoke HR-facilitated half-day workshops has also been introduced for pharmacy line managers covering key HR policies and procedures. The first session, focusing on wellbeing and attendance management, took place in December 2025 and was attended by over 80% of line managers, with remaining staff completing the training online. Further sessions covering performance management, grievance, and disciplinary procedures are scheduled between March and April 2026.

To support continuity of management oversight, a line management handover document was introduced in November 2025 to ensure robust handovers between managers. A pilot is currently underway to store these documents securely on the Learn platform.

Escalation routes within the service have also been clarified and are now reflected in the updated departmental structure published on StaffNet in December 2025, supported by a clear escalation flowchart.

2. Recruitment and Onboarding

Vacancy levels within the pharmacy workforce have reduced significantly, falling from 25% in October 2022 to 7.5% in February 2026.

An in-house Recruitment Tracker has been introduced to improve oversight of recruitment activity and is accessible to both the Pharmacy HR Business Partner and Finance Manager to support more timely recruitment processes.

A New Starter Onboarding Tracker has also been implemented to ensure that all required processes (including IT access, identification badges, and system permissions) are completed promptly.

Structured four-week induction programmes are now in place for new starters, supported by regular line management supervision. Work is underway to further develop a standardised induction framework, ensuring consistent onboarding aligned to individual roles and workplace requirements.

Staff turnover has reduced from 20% in February 2025 to 10% in December 2025. It should be noted that six pharmacy posts are fixed-term training roles of one to two years, resulting in an expected annual turnover of approximately three to four staff members. In addition, some staff leave to broaden their professional experience in other sectors. This movement is considered positive, as a number subsequently return to the Trust with enhanced skills and experience. A turnover rate of approximately 5–10% is therefore considered healthy within the service.

Regular line manager one-to-one meetings and exit interviews are used to identify any issues related to staff experience and to capture organisational learning.

3. Role Clarity

A review of job descriptions (JDs) across the pharmacy workforce is underway. Existing JDs have been mapped against current roles to identify any gaps or inconsistencies, and necessary updates are being made to ensure clarity of responsibilities across the service.

4. Task Clarity

A comprehensive review of Standard Operating Procedures (SOPs) is in progress. All in-house SOPs are expected to be fully updated by the end of March 2026.

Current SOPs are now centrally located on StaffNet, ensuring accessibility for all pharmacy staff. An electronic confirmation process is being developed to enable staff to confirm that new or updated SOPs have been read and understood.

SOPs are also being linked to relevant staff roles and incorporated within the new staff induction framework, ensuring clarity regarding task responsibilities.

5. Staff Training and Development

Leadership capacity for workforce development was strengthened in January 2025 following several years without a lead pharmacist for this area. In addition, the Lead Pharmacy Technician role was increased from 0.6 WTE to 1.0 WTE.

A Learning Needs Analysis (LNA) covering all pharmacy roles was completed in October 2025. As a result, Learn profiles have been updated to accurately reflect training requirements, with current compliance rates ranging from 89% to 100% across pharmacy sites.

A further Learning Needs Analysis is currently underway to identify core but non-mandatory training requirements. Ongoing professional development will be incorporated into individual appraisal and development plans.

Revised study leave guidance, including clarification of study leave allowances for commonly undertaken professional courses, is also nearing completion.

6. Communication

Monthly updates on G2G progress are shared with the pharmacy team following each Pharmacy Improvement Group meeting and through other relevant workstreams. The G2G Progress Tracker is also available on StaffNet for all pharmacy staff.

A revised departmental meeting structure has been introduced and is functioning well. Further work is ongoing to improve the flow of information between meetings and communication with the wider team.

Work is also underway to improve medicines supply communication processes. Current methods of requesting medicine supplies are being mapped ahead of future work with Quality Improvement colleagues. These processes represent a temporary workaround to address limitations in EPMA functionality and have been formally recorded on the clinical systems EPMA risk register.

Processes for managing Medicines Alerts, Recalls, and Safety Information have also been streamlined to improve recording, action tracking, and assurance reporting.

A review of team communication via Microsoft Teams was undertaken following a staff survey in December 2025. Subsequent workshops in January and February 2026 identified improvements, including the creation of a new whole-team channel, “Pharmacy Team Central”, with key information mirrored on physical noticeboards across sites.

Additional Service Improvement Work

Alongside the G2G programme, further work has been undertaken to strengthen pharmacy service delivery and medicines management across the organisation.

Dispensary Stock Management
Dispensary stock resets were completed at The Mount (June 2025) and the Becklin Centre (January 2026), alongside strengthened stock management processes.

Taxi Use for Medicines Transport
A review of medicines transport arrangements resulted in a 25% reduction in taxi expenditure in October 2025. Taxi use continues to be monitored through the Pharmacy Operations Meeting.

Clozapine Prescribing
The December 2025 upgrade to Version 13 of MedChart EPMA introduced a community prescribing function. A request has been submitted to the supplier (Delandus) to develop Clozapine prescribing functionality within the system. At present there is no confirmed timeline for implementation, which would enable the transfer of approximately 380 paper prescriptions currently held on an Access database.

Leadership Development
The senior pharmacy leadership team commenced the Affina Team Journey in January 2026. This structured leadership programme is designed to strengthen team effectiveness, collaboration, and leadership behaviours. Over the next two years, all pharmacy teams will participate in this programme.

Medicines Governance
Several medicines-related policies have recently been reviewed and updated, including:

- Medicines Code (December 2025)
- Self-Administration of Medication Policy (December 2025)
- Clozapine Policy (February 2026)

In addition, medicines-related tasks that may be undertaken by Nursing Associates have been reviewed and clearly defined (December 2025).

Internal Medicines Management Audits
Previously deferred minor actions relating to Controlled Drugs (CDs) and FP10 prescriptions have now been completed. The remaining three actions will be addressed following approval of updated in-house FP10 SOPs in March 2026.

A further internal audit of Medicines Assurance Processes is currently underway, focusing on the Controlled Drug (CD) and Medicines Management Assurance (MMA) checks undertaken within clinical areas. Findings from this audit will inform further improvement in pharmacy governance processes.

7. CLINICAL INFORMATION MANAGEMENT

We are commencing a pilot of Ambient Voice Technology (AVT) across two clinical services during March, with a number of additional services already expressing interest in participation. The selected solution, Heidi, has demonstrated positive outcomes in peer organisations, with reported efficiencies of approximately two hours of clinical time saved per clinician per week. In preparation for

deployment, a standard operating procedure (SOP) and detailed process mapping have been completed to support safe and consistent adoption. A hazard workshop has also been undertaken, providing assurance that robust safeguards are in place to mitigate known risks, including issues such as AI-generated hallucinations.

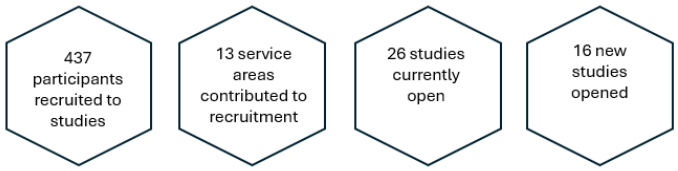
The patient portal is now live, representing a significant step forward in improving patient access and engagement. Work is underway to systematically gather and analyse usage data to inform iterative improvements and ensure the platform meets patient and service needs effectively. Early adoption metrics and feedback will be used to guide further development and optimisation over the coming months.

NHS England has collaborated with LYPFT and Leeds Community Healthcare NHS Trust to undertake research into clinician perspectives on our respective electronic patient record (EPR) systems. This work is expected to provide valuable insights to inform future procurement decisions and digital strategy. The final report is anticipated in late March and will be reviewed in detail to identify actionable recommendations.

Progress continues in identifying a suitable digital solution for ordering and viewing blood test, with particular focus on addressing the needs of CAMHS inpatient and ED services. In parallel, the Trust is exploring opportunities to streamline digital processes to enable a more responsive approach to clinician feedback and innovation. Engagement with NHS Innovation is underway to consider the development of a 'digital lab' model to support this ambition. Throughout all initiatives, patient safety remains paramount, with rigorous assessment and governance applied to the introduction of any new digital product or system.

8. RESEARCH AND DEVELOPMENT

In 25/26.....



Psychological Profession and AHP community of practice for research had a combined in-person event in December 2025. This brought together staff from across the organisation in those professions to talk about research. The session focussed on a year of reflection. It was a well-attended event with lots of positively in the room. The AHPs have gone on to create a yearbook highlighting evidence-lead practice they have delivered.

The latest version of our magazine Innovation has been published and the theme is Impact. 2265_Innovation56_FINAL.pdf

The R&D committee continue to monitor the finance risk identified and agreed to continue with the current plan in January's meeting.

We have opened Easy ECG a study we sponsor looking at mobile 6-lead ECG's for use in psychiatry. This is a multi-centre trial funded by AliveCor. The outputs will inform NICE of the use of the machines in psychiatry.

The COMIC team has published their work on experience of young people treated in inpatient unit for eating disorders. Eating Disorders Needing Inpatient Treatment (EDIP): Qualitative Interviews Exploring the Perspectives of Young People and Families - PubMed

9. IMPROVEMENT AND KNOWLEDGE SERVICE, and COLLABORATIVE WORKING

The Improvement & Knowledge Service continues to support delivery of Trust priorities, with sustained activity across quality improvement, clinical audit, and knowledge mobilisation. The service is currently supporting over 70 active improvement and audit projects most of which are aligned to Trust quality and safety priorities, while also contributing to major transformation programmes including the Clinical Inpatient Model Review and development of the Trust Quality Dashboard. Demand for support remains high, and all core teams are operating at or near full capacity.

Key Assurances
Improvement, audit, and knowledge activities remain closely aligned to Trust quality, safety, and transformation priorities, with over 70 active projects supporting services across the organisation.

Service Line	Clinical Audit	Improvement
Adult Acute	9	0
Children & Young People	2	2
Community & Wellbeing	1	1
Corporate & Other	13	3
Eating Disorders, R&R and Gender	1	3
Forensics	3	0
Learning Disabilities	2	2
Liaison & Perinatal	2	6
Older People Services	13	2
Regional & Specialist	9	0

Table: Number of projects by Service Line

Work continues to strengthen organisational improvement capability, including delivery of Learning, Culture and Leadership (LCL) maturity assessments and targeted training to build improvement skills across teams.

Progress is being made to improve organisational assurance through development of a Trust-wide Quality Dashboard and strengthening approaches to measurement and data use.

Strategic Risks / Challenges
All teams within the service are operating at full capacity, with increasing demand for support affecting responsiveness and requiring prioritisation aligned to Trust risk and strategic priorities.

Limited resilience exists in some specialist functions, including NICE guidance and clinical effectiveness support.

Collaborative Working
Key areas of collaborative activity include:

- Supporting the Trust leadership collective in relation to the transformation agenda.
- Completion of a summative report aligning organisational measures to STEEEP domains.
- Scoping work to review the Clinical Connections Project aligned to QSP Priority 5 (Working as a System).
- Partnership working to strengthen links between the Leadership Development and Quality Improvement platforms.

Sharing and Supporting Beyond Our Boundaries

The service continues to contribute nationally and internationally, including:

- Active participation in the Modern Productives programme with NHS Horizons, as members of both the Development and Guiding Groups.

- Sharing the Trust's improvement and quality journey with Manchester University NHS Foundation Trust's Improvement Team.

- Co-lead a session for the Michigan Value Collaborative, focusing on research and practical applications of Relational Coordination in healthcare.

- In partnership with South West London and St George's Mental Health NHS Trust ,co-designed and leading the delivery of a session titled "From Fragmentation to Shared Meaning: Building Trust, Collaboration and Knowledge in Complex Care Systems" at The International Forum on Quality and Safety in Healthcare.

10. MENTAL HEALTH LEGISLATION COMPLIANCE

We continue to work flexibly in delivering compulsory training in relation to MHA and MCA/DoLS. This includes delivering training at different times during the day and evenings to ensure as many staff as possible can access the training. Current compliance is:

Mental Capacity Act and DoLS Level 2	1276	213	1489	**86%**
Mental Health Act (Inpatient) Level 2	448	82	530	**85%**
Mental Health Legislation Awareness Level 1	1605	223	1828	**88%**

In addition to the compulsory training, we continue to offer bespoke sessions for teams and individuals in all aspects of mental health legislation. We have recently provided a number of training sessions for Carers Leeds to help increase their understanding of the Mental Capacity Act and DoLS.

In August 2025, a Mental Health Act Managers' panel identified a case where a CTO extension examination had been completed via video. This was deemed an isolated incident due to the patient's concurrent detention in an immigration facility. However, a further case identified in November 2025 involved a CTO extension examination conducted by telephone. The recurrence indicated a potential wider issue with compliance, prompting a full audit of all CTO extensions completed between January 2024 and November 2025. The aim of this audit was to provide assurance that examinations undertaken for CTO extension purposes during the review period complied with legal requirements.

During the audit, 13 CTO extension examinations were found to have been carried out remotely, which did does not meet the legal requirements and 8 patients required discharge from their CTO.

An action plan was developed which has been presented in both the Mental Health Legislation Operational Steering Group and Mental Health Legislation Committee.

To support clinicians and to free up clinical time, we are currently undertaking several pieces of work, including working with CQC to streamline the SOAD process and undertaking certain responsibilities in relation to obtaining warrants under s.135(2) MHA.

11. CONCLUSION

This extensive report provides an overview of the major pieces of work being conducted within the medical directorate and the areas of work that required ongoing focus and support.

12. RECOMMENDATION

The Board are asked to consider the information contained within this report on the key functions of the medical directorate and to be assured that the work being conducted is commensurate with the challenges being faced and in line with the wider Trust strategy

Dr Christian Hosker

Medical Director

26th March 2026

Agenda item
13

Meeting of the Board of Directors

Paper title:	Guardian of Safe Working Quarterly Report
Date of meeting:	Quarter 3: 1st October 2025 to 31st December 2025
Presented by: (name and title)	26 March 2026
Prepared by: (name and title)	Dr Chris Hosker, Medical Director

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 give assurance to the board that doctors in training are safely rostered and that their working hours are compliant with the terms and conditions of service (TCS) of the 2016 contract. Key points to note are:

- There have been 15 exception reports received during the reporting period, with no breaches leading to a GOSW fine and 0 immediate safety concerns recorded in this period.

- Resident Doctors Forum met on 10th October 2025 with opportunity for feedback from Core and Higher Trainee representatives, as well as continued review of ERs and rota gaps.
- Exception Reporting reforms are underway for implementation in February 2026. Work also continues with the 10 point plan to improve the lives of resident doctors.
-

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 of Directors are asked:

i. To agree that this report provides an assurance level for the systems in place to support the working arrangements of the 2016 Contract and TCS for the resident doctors working in the Trust and that they are meeting their objective of maintaining safe services

ii. To provide constructive challenge where improvement could be identified within this system.

Meeting of the Board of Directors

Thursday 30 January 2025

Guardian of Safe Working Hours Report

Quarter 3: 1st October 2025 to 31st December 2025

1 Executive summary

The purpose of this quarterly report is to give assurance to the board that doctors in training are safely rostered and that their working hours are compliant with the resident doctors terms and conditions of service (TCS). The report includes the data from 01.10.2025 to 31.12.2025.

2 Quarter 3 Overview

Vacancies		There are a total of 45 Core Training posts and 2 NIHR posts. There are a total of 35 Highter Training posts. All schemes are full.					
Rota Gaps		October 2025		November 2025		December 2025	
		PRS	Middle Tier	PRS	Middle Tier	PRS	Middle Tier
	Gaps	19	16	16	14	21	16
	Internal Cover	17	16	13	14	15	16
	Agency cover	0	0	0	0	0	0
	Unfilled	2	0	3	0	6	0
Fill Rate		89%	100%	81%	100%	71%	100%
Reasons for Rota Gaps		Sickness (5) Vacant (1) LTFT (2) Off rota (4) Left trust (5) Special absence (2)	Sickness (3) Vacant (5) Off rota (3) Maternity/paternity (2) LTFT (3)	Sickness (5) Vacant (4) LTFT (4) Left trust (3)	Sickness (2) Vacant (6) Off rota (3) Maternity/paternity (1) LTFT (2)	Sickness (5) Vacant (1) LTFT (3) Off rota (6) Left trust (5) Special absence (1)	Sickness (2) Vacant (9) Off rota (2) Maternity/paternity (1) LTFT (2)

Comments	Rota gaps arise for various reasons including sickness, gaps arising from Less Than Full Time working patterns, rota gaps, and other leave including parental leave or special leave. The Psychiatry Resident Rota (PRS, 1st tier) is covered by FY2 and CT doctors. Of the 11 PRS shifts that were uncovered, 2 of these were night shifts, 4 were evening shifts, and 5 were long day weekend shifts. The middle tier rota (2nd / middle tier) is covered by Higher Trainee doctors and continues to have a high fill rate.
Exception reports (ER)	There were 15 exception reports in total during the reporting period. - 3 related to lost educational opportunities. All 3 were due to parking issues at the Newsam Centre interrupting attendance at teaching. This has been escalated to the DME who is working with estates regarding parking in the context of the '10 point plan' - 12 related to additional hours worked. 1 of these was submitted in error by the resident doctor and required no further action. Circumstances contributing to the remaining situations included: Fewer doctors on site during new-starter inductions leading to increased work load; Medical staffing issues related to non-training grade doctors leading to increased work load for the resident doctor within the service. This has since been addressed by the service. The GOSWH has also contacted the Professional Lead to request the DME and GOSWH are informed whereby medical staffing issues could impact training experience so that support can be provided proactively; Increased work load in a core placement leading to discussions between the resident doctor and clinical supervisor to informally review work schedule to both of their satisfaction. No formal work schedule review has been required. It is noted that the number of ERs received in this reporting period is higher than usual. This may be reflective of the increased awareness of resident doctors about upcoming reforms and encouragement via the trust as well as external agencies (e.g BMA) to utilise this available mechanism to ensure safe working hours and appropriate action whereby there is deviation from the agreed work schedule. It is possible that with the ER reforms, there may be an increasing trend in ERs if there has been under-reporting thus far. The ERs received indicate resident doctors preference for payment rather than TOIL, which could lead to increased costs to services whereby doctors are working beyond their contracted hours. The GOSWH will continue to have oversight of ER trends and whereby patterns emerge, will continue to liaise with resident doctors to explore and address any issues.
Breaches and Fines	There have been no breaches in safe working hours or breaks.

	No fines were levied in this reporting period, nor in the 2025-2026 financial year thus far. The total fine fund as of the end of the 2024-2025 year is £262.15 and sits within a GOSW cost centre. Spending from such funds will be agreed via the RDF. Following ER reforms effective as of February 2026, in future Board Reports information will also be included on: Information Breaches (fines levied whereby confidential ER information is shared outside of processes detailed within the TCS) Access and Completion Breaches (fines levied whereby access issues to ER systems are not resolved within timescales)
Immediate Safety Concerns	None were raised in this reporting period. The TCS state that immediate safety concerns be immediately escalated (orally) to the to the clinician responsible for the service in which the risk if present (typically, the consultant on call) so that necessary support and remedy can be arranged, or advice given to complete an exception report.
Work Scheduling	No work schedule reviews have been required during this reporting period. With the reforms taking effect from February 2026, the GOSWH will include within future Board reports data on the provision of work schedules in accordance with the requirements of the Code of Practice (generic work schedules should be issued 8 weeks in advance, detailed rotas issued no later than 6 weeks before the rotation commences)
Resident Doctor Forum (RDF)	The meeting held during the Q3 reporting period took place on 10th October 2025 - Discussions were held about potential use of the fines money, with a plan for the resident doctor reps to take feedback via their respective forums. - The 10 point plan to improve resident doctors working lives was discussed with an update from the DME as to positive progress in this regard. - Proposed changes to Exception Reporting processes were discussed again in anticipation of reforms taking effect from February 2026. Guidance and updates via NHS Employers and Exception Reporting software provider (Allocate) was awaited at the time of the meeting, to be able to support implementation of the contractual changes. - The next RDF was scheduled for 30th January 2026.
Detriment	With the reforms taking effect from February 2026, the GOSWH will include within future Board reports results of a Detriment Survey. This will explore actual or perceived detriment experienced by doctors related to exception reporting.
Additional Updates	Work continued in Q3 around changes to the Exception Reporting processes, with v13 of the resident doctors TCS and exception reporting reforms being implemented as of February 2026. The GOSW, MEC, and the Medical Directorate continue to meet regularly to review processes in relation to these changes. A 10 point plan to improve resident doctors working lives was released in August 2025 and work has continued in this regard as per the Q2 report, led by the DME. The GOSWH will include in future Board reports details of any payroll issues experienced by resident doctors. Payroll at LTHT are following the national payroll

	improvement programme and reporting to NHSE. They will report twice yearly to the LYPFT Medical Education Manager who will feedback to the RDF. Rebecca Asquith has submitted her resignation as GOSWH due to being appointed to a new position within the trust that would pose a conflict of interest with the GOSWH role. Recruitment of a new GOSWH is underway.

3 Conclusion

Exception Reporting has now been in place within the Trust since 2016 with the first ER being made in 2017. We continue to work with resident doctors and both clinical and educational supervisors to ensure that we are developing a culture where ERs are positively received and used as a mechanism to effect change. Through MEC colleagues, the RDF, and GOSW attendance at induction for new starters, we continue to support the position that doctors are encouraged to work according to the TCS for their own safe practice and the safe care of patients. In this quarter there have been no Exception Reports identifying immediate safety concerns. Work continues around Exception Reporting reforms and the 10 point plan detailed above.

4 Recommendation

The Board of Directors are asked:

i. To agree that this reports provides an assurance level for the systems in place to support the working arrangements of the 2016 TCS for the resident doctors working in the Trust and that they are meeting their objective of maintaining safe services
ii. To provide constructive challenge where improvement could be identified within this system

Dr Rebecca Asquith
GMC 7151560
Guardian of Safe Working Hours

Agenda item
14

Meeting of the Board of Directors

Paper title:	Chair's Report from the Workforce Committee meeting on 19 February 2026
Date of meeting:	26 March 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:	19 February 2026
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 was informed that the Trust had applied to be an early implementer of the new Electronic Staff Record (ESR) replacement which, if accepted, would be done in conjunction with Leeds Community Healthcare NHS Trust (LCH). The Committee also heard that the People and Organisational Development Governance Group had begun to align its policies with those from LCH in preparation for the merger.	SR3
The Committee was informed that following a robust consultation process, Each Person would be the Trust's new Employee Assistance Programme provider from 1 April 2026. The Committee received reassurance that any ongoing counselling would not be disrupted, and a robust communications plan would be put in place for staff.	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 a report which set out the process for developing the Draft Internal Audit Operational Plan for 2026/27 and the areas being considered for audit. The Committee supported the plan and had no additional suggestions for areas to audit in 2026/27.	SR3
The Committee received an update on the current workstreams being undertaken by the Health and Safety Team, specifically regarding incidents reported via Datix that relate to staff safety, including general health and safety concerns as well as incidents involving violence and aggression. The Committee was pleased to note the progress with the roll	SR3

out of the Lone Working App and that 95% of managers had attended further training to improve their understanding of the system. The Committee discussed compliance with Health and Safety training and heard that a new arrangement was being established for training statistics to be reported to the Health and Safety Committee for additional oversight. The Committee highlighted the improved reporting which was clear on the role of the Workforce Committee regarding health and safety.	
The Committee received an update on the Workplace Adjustments Project and noted that the new process would launch in April 2026. The Committee highlighted the good progress being made and supported the continuation of the Workplace Adjustments Project as a key objective for the organisation.	SR3
The Committee received up to date figures for clinical supervision compliance which had increased to 75%. The Committee also heard that Wellbeing Assessment compliance had risen to 74% and performance was steadily recovering back to the 85% target following the move to an annual assessment requirement. The Committee was pleased to note the progress in both these areas.	SR3
The Committee received the Retention and Wellbeing Internal Audit Report which had been referred by the Audit Committee and was pleased to note the finding of significant assurance.	SR3
The Committee considered the results and comments received as part of its effectiveness review and noted that overall, the feedback was positive with all questions having received scores of ‘agree’ or ‘strongly agree’.	SR3
The Committee reviewed and approved its Terms of Reference (ToR) to ensure they represent the work that the Committee undertakes and agreed what further amendments were required. An updated version of the ToR will be presented to the March Board of Directors’ meeting for ratification.	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
14.1

Meeting of the Board of Directors

Paper title:	Terms of Reference for the Workforce Committee
Date of meeting:	26 March 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.	

Executive summary

The Workforce Committee reviewed and approved its Terms of Reference on the 19 February 2026, and the following amendments were made. All amendments are highlighted in yellow on the attached document:

- Page 3 – Removed the Associate Director for People Resourcing and Organisational Development as an attendee of the Committee.

- Page 3 – Updated the ‘Associate Director of Employment’ to ‘Deputy Director of People and OD’ and updated the description of their role in the Committee.
- Page 3 – listed the Head of People Analytics and Temporary Staffing as expected to attend every meeting due to the Workforce Performance Report being a standing item at each meeting.
- Page 3 – Added the Freedom to Speak Up Guardian as an attendee of the Committee.
- Page 7 – Added that the Committee has currently agreed to lead assurance on staff training under Duties of the Committee, as agreed between the Chair of the Workforce Committee and the Chair of the Quality Committee.
- Page 8 – Removed the People Experience Group from the list of POD Governance Groups.
- Page 10 – Updated the Schedule of Deputies in Appendix 1a to reflect that the Deputy Director of People and OD is the named deputy for the Director of People and Organisational Development.

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.

Workforce Committee

Terms of reference

(Approved by the Committee on 19 February 2026)

1 Name of committee

The name of this committee is the Workforce 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 (Chair of the Committee)	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	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 People and Organisational Development	Assurance on the OD and Workforce aspects of their portfolio in relation to the delivery of the strategic aims, goals and plans relating to staff and legal and statutory HR functions.
Director of Nursing and Professions	Assurance on the professional workforce aspects of the Nursing and Allied Health Professional, Psychology and Psychotherapy staff.
Medical Director	Assurance on the professional workforce aspects of the medical staff.
Chief Operating Officer	Executive Director with responsibility for oversight and delivery and development of Care Services. Assurance and escalation provider to the Workforce Committee.

While specified Board members will be regular members of the Workforce 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.

Non-executive directors are also welcome to observe Board sub-committee meetings that they are not a member of as part of their development.

In attendance: in an advisory capacity

The Committee may also invite other members of Trust staff and partners to attend to provide advice and support for specific items from its work plan when these are discussed at the Committee's meetings.

Title	Role in the committee	Attendance guide
Associate Director for Corporate Governance	Trust Board Secretary overseeing the information flows of the committees	Each meeting

Title	Role in the committee	Attendance guide
Deputy Director of People and OD	Provide information and assurance on the approach taken in leading the People and Organisational Development agenda, including the delivery of the Trust's People Plan strategy and measurable performance targets. Responsible and accountable for all aspects of Strategic Employee Relations and Change, Organisational Development, Workforce Wellbeing and Strategic Resourcing to the Trust. Deputising for the Director of People and OD as required	Each meeting
Head of People Analytics and Temporary Staffing	Provision of workforce information and undertaking of analytics as required	Each meeting
Head of Strategic Resourcing and Talent Development	Provide assurance on vacancies rates, the future direction of workforce skills and skills gaps	As Required
Head of Communications	Provide information and assurance on methods of communication	As Required
Head of Equality, Diversity and Inclusion	Provide information and assurance on the equality, diversity and inclusion agenda and plan	As Required
Head of Wellbeing	Provide information and assurance on the health and wellbeing across the Trust	As Required
Freedom to Speak Up Guardian	Provide a link to the Freedom to Speak Up work across the Trust	As Required

In addition to anyone listed above as a member, at the discretion of the Chair of the Committee the Workforce 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 a 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 of 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 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 and must include at least one non-executive director and one executive 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 second 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, attached at appendix 1a, 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: In the absence of the Chair the alternate chair of the meeting will be the second non-executive director.

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: Bi-monthly

Urgent meeting: Any member of the Committee 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 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 agreed by the chair.

5 Authority

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

Powers: The Workforce Committee is constituted as a standing committee of the Board of Directors. The Committee is authorised by the Board to 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 Workforce 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 purpose of the Committee is to provide the Board with assurance concerning all aspects of strategic workforce matters relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients and staff.

Its purpose is also to ensure there is a positive working environment for staff which promotes an open culture that helps staff do their job to the best of their ability.

Trust Strategic Objective	How the committee will meet this objective
We deliver care that is high quality and improves lives	Assurance on the delivery of the Trust's strategic workforce plan
We provide a rewarding and supportive place to work	Assurance on the delivery of the Trust's strategic workforce plan
We use our resources to deliver effective and sustainable services	Assurance on the delivery of the Trust's strategic workforce plan

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

On behalf of the Board of Directors the Committee will:

- Seek assurance on the progress made against the NHS People Plan.

- Seek assurance on the development and the delivery of the Trust's People Plan and have oversight of its key strategic themes which include: health and wellbeing; resourcing; equality and inclusion; engagement and retention; and leading together.

- Carry out the role of Wellbeing Guardian Champion and receive a Wellbeing Guardian Report at every meeting.

- Carry out the duties of the Designated Board Member when an investigation is undertaken regarding a doctor's practice in line with the Managing Concerns About Medical Colleagues (Maintaining High Professional Standards) Policy, with the Chair of the Committee being the Designated Board Member.

- Seek assurance on the development of the workforce to ensure the Trust has productive staff with the skills, competencies, and knowledge to provide safe and effective care.

- Be responsible for signing off any underpinning workforce strategies.

- Seek assurance that the Trust is meeting its legal and regulatory duties in relation to its employees.

- Have oversight of relevant workforce data and specific initiatives in relation to the Equality and Inclusion Agenda as requested by the Board of Directors, recognising that a significant element of the Trust's work to ensure equality and inclusion is with regard to the workforce.

- Seek assurance that the Trust is actively involved and where relevant influencing work taking place at a national, regional, and local level including the work carried out by the West Yorkshire and Harrogate Integrated Care System relating to workforce.

- Seek assurance on progress against the workforce metrics.

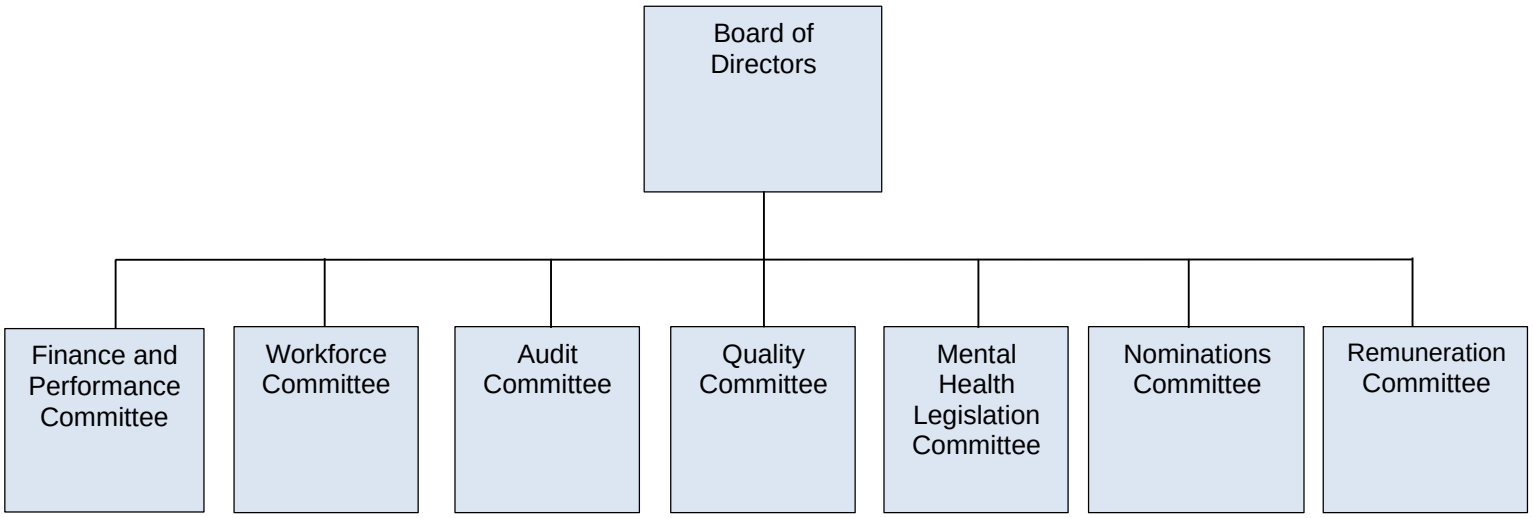
- Seek assurance around the risks delegated to it via the Board Assurance Framework. The Committee should determine if the appropriate level of risk has been identified, review the effectiveness of the controls in place relevant to the risks, review and challenge the strength of the assurances provided, identify any gaps in control or assurance and ensure that the risk lead identifies appropriate actions to address such gaps.

- Where necessary seek assurance into any area of work related to workforce and related matters on behalf of the Board.

- The Committee has currently agreed to lead assurance on staff training.

- The Committee will also 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 Workforce Committee does not have any sub-committees. It is linked to the People and Organisational Development (POD) Governance Group as an assurance receiver. The Workforce 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.

Reporting

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

Links with operational processes

The Workforce Committee receives a People and Organisational Development Governance Group Chair's Report at each meeting. This report summarises the recent activity of the People and Organisational Development (POD) Governance Group as well as highlight reports from each of the POD Governance Groups (People OD and Resourcing Group, People Employment Group ~~and People Experience Group~~).

8 Duties of the chairperson

The Chair of the Committee shall be responsible for:

- Agreeing the agenda and ensuring it is balanced
- 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 of Directors in respect of the work of the Committee
- Ensuring the Chair's report is submitted to the 'parent' committee as soon as possible
- 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 Workforce Committee to ensure that it (or any group / committee that reports to it) carries out an assessment of effectiveness annually, and ensure the outcome is reported to the Board of Directors 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 Workforce Committee and, in recognition of the nature of matrix working between the work of all Board sub-committees, the Workforce 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 Workforce Committee will also be the Designated Board Member when an investigation is undertaken regarding a doctor's practice in line with the Managing Concerns About Medical Colleagues (Maintaining High Professional Standards) Policy.

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)
NED Chair	Second NED on the Committee
Director of People and Organisational Development	Deputy Director of People and OD
Director of Nursing and Professions	Deputy Director of Nursing (as required)
Medical Director	Deputy Medical Director
Chief Operating Officer	Deputy Director (as required)

Agenda item
15

Meeting of the Board of Directors

Paper title:	LYPFT 2 Month Safer Staffing Review Report
Date of meeting:	26 March 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 December 2025 to 31st January 2026.

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?

NO

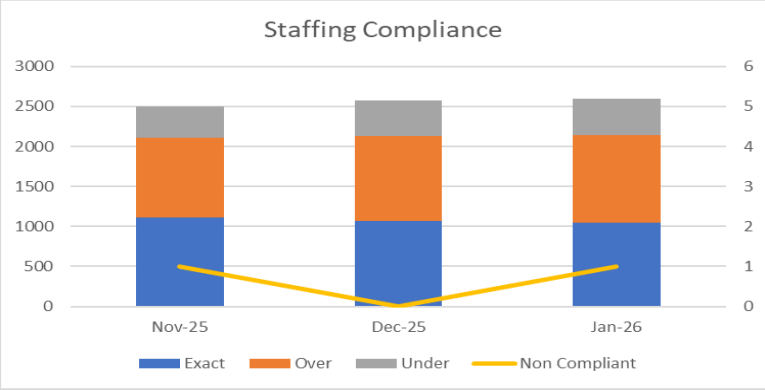
If yes, please set out what action has been taken to address this in your paper.

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 – December 2025 and January 2026



	Number of Shifts		
	Nov	**Dec**	**Jan**
Exact	1111	1073	1051
Over Compliance	995	1053	1093
Under Compliance	398	453	451
Non-Compliant	1	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.

Narrative on Data Extracts Regarding LYPFT Staffing Levels on x28 Wards during January 2026: 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 December 2025 and January 2026. In January 2026, there was an increase 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 December 2025 and January 2026 in comparison to the previous two months. 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.

*(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).

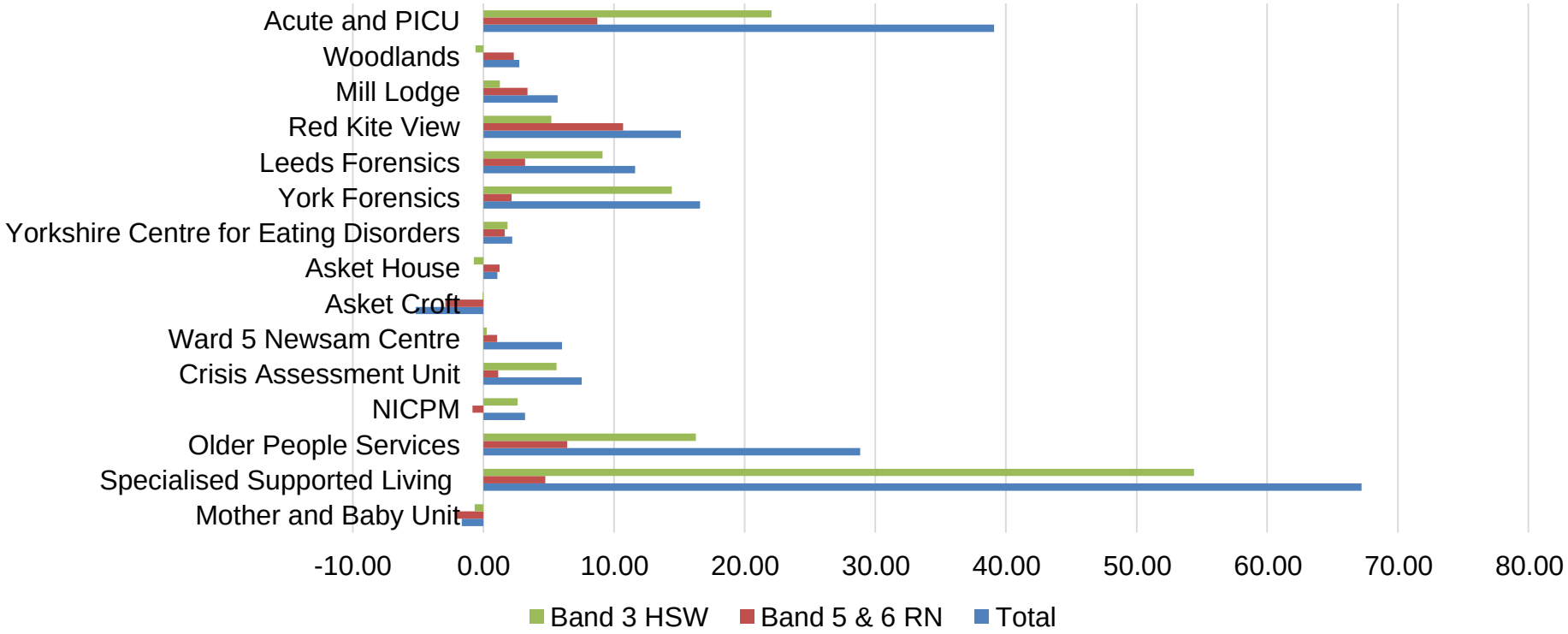
Non-Compliant Shifts: This metric represents the number of shifts where no Registered Nurses were on duty. There was one duty in January where this occurred. There was no Registered Nurses on 3 Woodland Square for the Early shift on the 18th of January 2026, the band 4 Nursing Associate was supported by the Registered Nurse from 2 Woodland Square. The ward manager who is also a Registered Nurse who would ordinarily assume responsibility for cover, was unavailable due to this being the weekend.

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 2 Woodland Square.

Vacancies

The below chart indicates the total number of vacancies across each service as reported on ECHO in January 2026. 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 January 2026.

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 total number of vacancies remain within the Older People's Service, Acute Inpatient and PICU and the Specialised Supported Living.

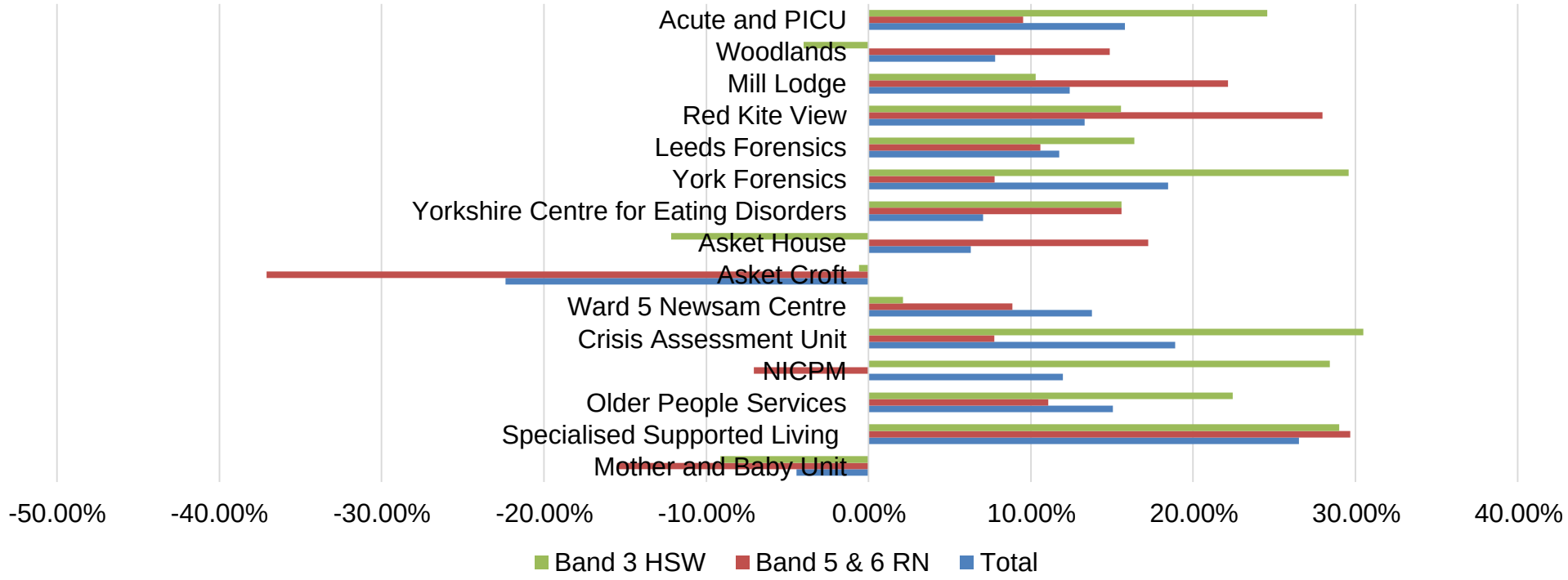


The below chart indicates the total % of vacancies across each service as reported on ECHO in January 2026. This applies to multidisciplinary teams as a whole and is not limited to Registered Nurses and Health Support Workers, who have traditionally been the focus of safer staffing data. The highest percentage of vacancies remain within the York Forensic Services and the Specialised

Supported Living Service as was noted in the previous 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 January 2026.

Ongoing recruitment initiatives are currently in progress, aimed at addressing existing workforce gaps. The recent uplift in Health Care Support Workers in Acute inpatient and PICU and York Forensic service has created additional vacancies. There is currently a recruitment campaign to support teams with the recruitment of Healthcare Support Workers. A working group has also been established to gain a full understanding of the recruitment challenges and to carry out a targeted programme of work to address the rise in Health Support Worker vacancies. The Registered Nurse vacancy position will be supported by the intake of preceptees due to begin employment in September 2026. A proportion of current Registered Nurse vacancies will be intentionally held open by services until these preceptees commence, alongside a cohort of individuals who will complete their training and subsequently register as Registered Nurses through the nurse apprenticeship programme.

The table below indicates that several 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.

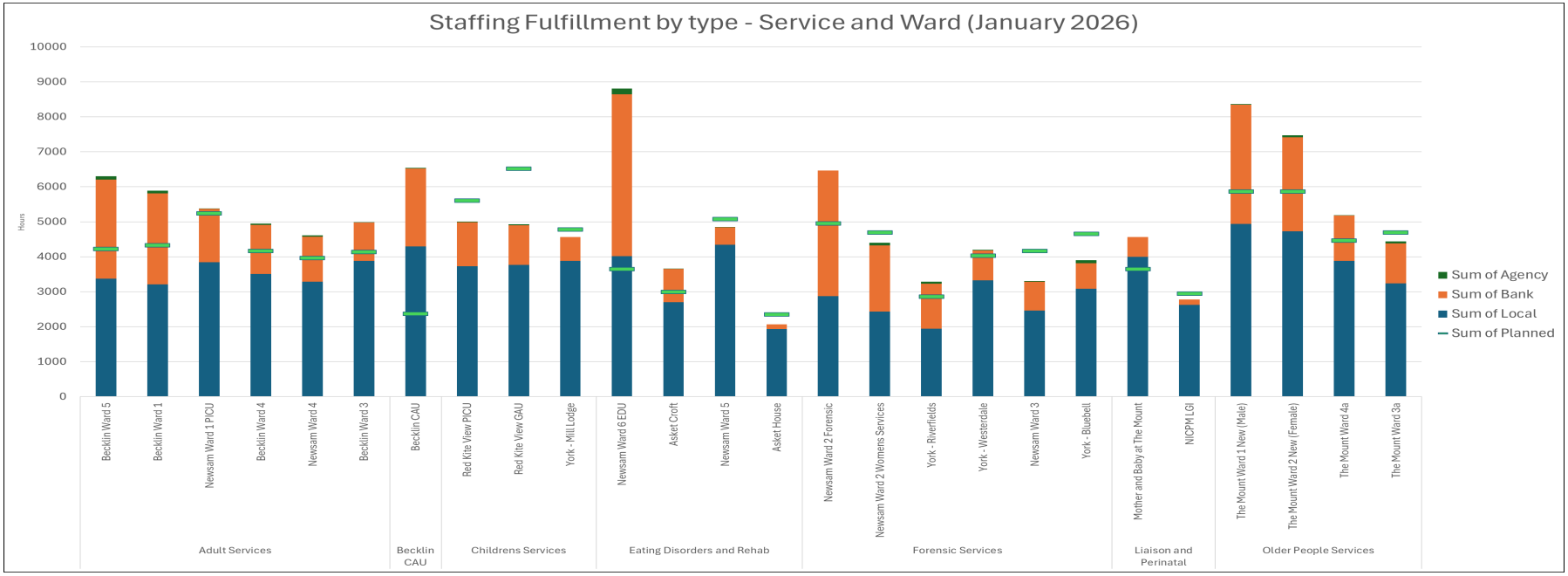


Safer Staffing Steering Group

The Trust's Safer Staffing Steering Group continues to meet monthly, 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 data from previous MHOST data collections has been analysed, and the annual establishment reviews are now in progress across all inpatient areas, with completion expected by the end of March 2026. Ward teams are due to commence the next 6-monthly MHOST data collection at the beginning of March 2026.

Temporary Staffing Use

The table below shows the total number of inpatient clinical hours completed in January 2026 and the proportion of hours during the reporting period that were covered by bank or agency staff. Usage patterns in the data indicate that certain areas relied more heavily on bank staff which include Newsam Ward 2 (Male), YCED and Ward 1 Mount.



Enhanced Therapeutic Observation of Care

The Trust has recently engaged in the national Enhanced Therapeutic Observation of 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, changes to this system include the reason options for booking additional staff. Review of the January 2026 data shows that 36% of additional bank duties were undertaken to facilitate enhanced therapeutic observations. Usage patterns in the data indicate that certain areas relied more heavily on bank staff to carry out observations in January 2026 which include YCED, Ward 1 Mount and the Female acute wards.

Following a successful pilot of electronic observation care plans, which were historically paper based, there is a plan to roll these out across inpatient wards from the beginning of March 2026, this will support a move away from paper-based observation care plans to a digital solution which strengthens oversight of enhanced observation levels within clinical areas. 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 the programme will be shared through the Safer Staffing Group.

Summary

Ongoing recruitment initiatives are currently in progress, aimed at addressing existing workforce gaps. The recent uplift in Health Care Support Workers in Acute inpatient and PICU and York Forensic service has created additional vacancies. There is currently a recruitment campaign to support teams with the recruitment of Healthcare Support Workers. A working group has also been established to gain a full understanding of the recruitment challenges and to carry out a targeted programme of work to address the rise in Health Support Worker vacancies.

The Registered Nurse vacancy position will be supported by the intake of preceptees due to begin employment in September 2026. A proportion of current Registered Nurse vacancies will be intentionally held open by services until these preceptees commence, alongside a cohort of individuals who will complete their training and subsequently register as Registered Nurses through the nurse apprenticeship programme.

There was an increase in the number of shifts worked under the planned establishment in December 2025 and January 2026 in comparison to the previous two months. Shifts recorded as under compliant may reflect a variety of factors, including situations where the multidisciplinary team is able to provide sufficient support to ensure safe and effective care. In such cases, this approach remains consistent with the staffing escalation and deployment protocol.

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 December 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_RNI	AvgFR_NRI	AvgFR_RNA	AvgFR_NRI	AvgFR_RNI	AvgFR_NRI	AvgFR_RNA	AvgFR_NRI	AvgFR_RAI	AvgFR_NRA
2 WOODLAND SQUARE	97	9.1	6.7	1.0	0.0	0.0	0.0	16.8	93%	155%	100%	-	100%	104%	-	-	-	-
3 WOODLAND SQUARE	112	7.8	15.1	1.4	0.0	0.0	0.0	24.4	69%	164%	100%	-	100%	116%	100%	-	-	-
ASKET CROFT	568	1.6	2.5	0.0	0.0	0.8	0.0	4.9	92%	79%	-	-	100%	100%	-	-	100%	-
ASKET HOUSE	494	1.7	1.7	0.0	0.0	0.7	0.0	4.1	124%	58%	-	-	100%	113%	-	-	100%	-
BECKLIN CAU	178	4.1	15.3	0.8	0.0	0.1	0.0	20.4	109%	98%	100%	-	101%	140%	100%	-	100%	-
BECKLIN WARD 1	699	2.3	4.0	0.3	0.0	0.3	0.0	6.8	91%	204%	100%	-	84%	214%	100%	-	100%	-
BECKLIN WARD 3	688	2.1	2.6	0.4	0.2	0.2	0.2	5.7	71%	112%	100%	100%	92%	88%	100%	100%	100%	100%
BECKLIN WARD 4	706	2.3	3.0	0.4	0.0	0.4	0.2	6.3	94%	178%	100%	-	78%	200%	100%	-	100%	100%
BECKLIN WARD 5	703	2.5	5.9	0.0	0.0	0.4	0.2	9.0	103%	269%	-	-	99%	276%	-	-	100%	100%
MOTHER AND BABY AT THE MOUNT	224	7.0	4.9	0.3	0.0	0.0	0.0	12.2	107%	82%	100%	-	98%	107%	100%	-	-	-
NEWSAM WARD 1 PICU	369	4.3	7.4	0.0	0.5	0.7	0.5	13.4	91%	102%	-	100%	85%	113%	-	100%	100%	100%
NEWSAM WARD 2 FORENSIC	372	3.0	12.1	0.0	0.0	0.3	0.2	15.6	98%	191%	-	100%	113%	201%	-	-	100%	100%
NEWSAM WARD 2 WOMENS SERVICES	300	3.9	11.0	0.3	0.0	0.0	0.5	15.6	106%	125%	100%	-	100%	151%	-	-	-	100%
NEWSAM WARD 3	434	2.5	4.6	0.0	0.2	0.0	0.0	7.2	95%	92%	-	-	100%	100%	-	100%	-	-
NEWSAM WARD 4	652	2.5	3.1	0.2	0.0	0.3	0.2	6.3	95%	165%	100%	-	87%	163%	100%	-	100%	100%
NEWSAM WARD 5	1034	1.2	1.9	0.3	0.0	0.7	0.3	4.3	96%	80%	100%	-	69%	88%	100%	-	100%	100%
NEWSAM WARD 6 EDU	840	1.7	4.0	0.2	0.0	0.5	0.2	6.6	126%	498%	100%	-	76%	207%	100%	-	100%	100%
NICPM LGI	252	5.1	3.6	0.0	0.0	1.3	0.0	10.0	99%	88%	-	-	77%	119%	-	-	100%	-
RED KITE VIEW GAU	296	5.1	11.9	0.5	0.0	0.0	0.0	17.6	78%	105%	100%	-	93%	123%	100%	-	-	-
RED KITE VIEW PICU	124	13.6	22.5	0.0	0.0	0.0	0.0	36.0	82%	70%	-	-	107%	116%	-	-	-	-
THE MOUNT WARD 1 NEW (MALE)	424	4.1	10.4	0.3	0.0	0.0	0.0	14.8	145%	142%	100%	-	103%	234%	100%	-	-	-
THE MOUNT WARD 2 NEW (FEMALE)	476	3.6	9.6	0.1	0.1	0.0	0.0	13.4	93%	134%	100%	100%	102%	209%	-	-	-	-
THE MOUNT WARD 3A	608	2.4	3.2	0.0	0.3	0.0	0.0	5.9	83%	100%	-	100%	100%	109%	-	100%	-	-
THE MOUNT WARD 4A	660	2.7	3.0	0.2	0.0	0.0	0.0	5.9	118%	94%	100%	-	97%	113%	100%	-	-	-
YORK - BLUEBELL	310	3.7	7.5	0.0	0.0	0.4	0.2	11.7	111%	82%	-	-	100%	105%	-	-	100%	100%
YORK - MILL LODGE	170	9.1	9.6	1.3	0.0	3.0	1.1	24.1	83%	97%	100%	-	82%	105%	100%	-	100%	100%
YORK - RIVERFIELDS	279	4.3	6.5	0.0	0.0	0.5	0.1	11.4	109%	135%	-	-	100%	124%	-	-	100%	100%
YORK - WESTERDALE	334	4.0	6.4	0.0	0.3	0.2	0.3	11.2	141%	83%	-	100%	100%	103%	-	-	100%	100%

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

Safer Staffing: Inpatient Services January 2026

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

Ward name	Cumulative count	Care Hours Per Patient Day (CHPPD)							Day				Night			
		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
2 WOODLAND SQUARE	100	10.5	7.9	1.7	0.0	0.0	0.0	20.1	95%	205%	100%	-	100%	110%	100%	-
3 WOODLAND SQUARE	118	6.9	16.5	0.8	0.0	0.0	0.0	24.2	62%	188%	100%	-	100%	121%	-	-
ASKET CROFT	561	1.6	3.6	0.0	0.0	0.0	0.0	5.2	95%	115%	-	-	100%	155%	-	-
ASKET HOUSE	461	1.7	1.7	0.0	0.0	0.0	0.0	3.5	108%	61%	-	-	100%	107%	-	-
BECKLIN CAU	169	4.2	17.3	0.5	0.0	0.0	0.0	21.9	96%	107%	100%	-	101%	144%	-	-
BECKLIN WARD 1	715	2.3	4.7	0.4	0.0	0.0	0.0	7.4	89%	282%	100%	-	95%	253%	100%	-
BECKLIN WARD 3	709	2.3	3.2	0.4	0.1	0.0	0.0	5.9	81%	143%	100%	100%	95%	115%	100%	-
BECKLIN WARD 4	711	2.5	3.0	0.2	0.0	0.0	0.0	5.7	98%	181%	100%	-	97%	157%	100%	-
BECKLIN WARD 5	704	2.6	5.0	0.0	0.0	0.0	0.0	7.6	103%	173%	-	-	104%	203%	-	-
MOTHER AND BABY AT THE MOUNT	204	7.1	7.2	0.5	0.0	0.0	0.0	14.8	100%	102%	100%	-	86%	117%	100%	-
NEWSAM WARD 1 PICU	368	4.8	7.3	0.0	0.3	0.0	0.0	12.4	100%	94%	-	100%	97%	118%	-	-
NEWSAM WARD 2 FORENSIC	372	2.9	12.4	0.0	0.1	0.0	0.0	15.4	99%	199%	-	100%	100%	220%	-	-
NEWSAM WARD 2 WOMENS SERVICES	260	4.1	11.1	0.2	0.0	0.0	0.0	15.4	99%	111%	100%	-	101%	130%	-	-
NEWSAM WARD 3	434	2.5	4.4	0.0	0.1	0.0	0.0	7.0	95%	91%	-	100%	110%	100%	-	-
NEWSAM WARD 4	654	2.5	3.1	0.3	0.0	0.0	0.0	5.9	96%	174%	100%	-	84%	169%	100%	-
NEWSAM WARD 5	1581	0.8	1.1	0.2	0.0	0.0	0.0	2.1	95%	83%	100%	-	84%	89%	100%	-
NEWSAM WARD 6 EDU	848	2.4	6.3	0.2	0.0	0.0	0.0	8.8	216%	835%	100%	-	86%	412%	100%	-
NICPM LGI	276	4.3	3.7	0.0	0.0	0.0	0.0	8.0	86%	102%	-	-	76%	131%	-	-
RED KITE VIEW GAU	282	5.2	9.9	0.5	0.0	0.0	0.0	15.5	74%	75%	100%	-	89%	106%	100%	-
RED KITE VIEW PICU	131	13.7	21.3	0.0	0.0	0.0	0.0	35.0	98%	70%	-	-	105%	103%	-	-
THE MOUNT WARD 1 NEW (MALE)	441	3.9	11.5	0.3	0.0	0.0	0.0	15.7	142%	132%	100%	-	102%	271%	100%	-
THE MOUNT WARD 2 NEW (FEMALE)	469	3.6	9.2	0.2	0.1	0.0	0.0	13.1	95%	124%	100%	100%	99%	190%	-	-
THE MOUNT WARD 3A	643	2.3	3.3	0.0	0.1	0.0	0.0	5.6	83%	102%	-	100%	100%	116%	-	-
THE MOUNT WARD 4A	646	2.5	3.2	0.2	0.0	0.0	0.0	5.9	102%	96%	100%	-	102%	120%	100%	-
YORK - BLUEBELL	310	3.7	7.4	0.0	0.0	0.0	0.0	11.2	121%	87%	-	-	100%	104%	-	-
YORK - MILL LODGE	153	9.8	10.9	2.0	0.0	0.0	0.0	22.7	92%	84%	100%	-	90%	136%	100%	-
YORK - RIVERFIELDS	279	4.2	6.2	0.0	0.0	0.0	0.0	10.4	106%	121%	-	-	101%	119%	-	-
YORK - WESTERDALE	341	4.2	6.4	0.0	0.2	0.0	0.0	10.9	151%	88%	-	100%	100%	100%	-	-

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

Agenda item
16

Meeting of the Board of Directors

Paper title:	Report from the Director of People and Organisational Development
Date of meeting:	26 March 2026
Presented by: (name and title)	Darren Skinner, Director of People and Organisational Development
Prepared by: (name and title)	Andrew McNichol, Head of People Analytics and Temporary Staffing

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.	X
SO3	We use our resources to deliver effective and sustainable services.	X

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 if to provide the board with an overview of the key workforce demographics linked to our people and highlight the plans in place to support performance in the context of the Trust People Plan.

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 receive and note the report.

Meeting of the Board of Directors

26 March 2026

Report from the Director of People and Organisational Development

The purpose of this report if to provide the board with an overview of the key workforce demographics linked to our people and highlight the plans in place to support performance in the context of the Trust People Plan.

Summary of key points:

- The staffing distribution across the organisation reflects a continued dependency on temporary staffing to meet the patient need. The Trust has been at net zero on agency healthcare support working since April 1st 2025 but Bank working still plays a significant role in meeting the demand across all services. Bank workers are being used to backfill vacancy, absence and acuity/activity but this demand for Bank has also reduced by 15% since April 2025.

- Staffing distribution charts reflect the service need being met in all services. Notably, the Eating Disorders services are seeing an increase in patient acuity over recent months which is largely being supported by the Bank Workforce and Children Services have reduced beds in Red Kite GAU which is affecting the normal planned hours requirement.

- The age and ethnicity profile of our workforce is broadly representative of the local population.

- The Trust in month sickness absence rate for February is 7.05% This is an increase from 5.95% for the same period last year.

- The rolling 12-month sickness absence rate is 6.48% (Feb 26) and the Trust is 4th highest absence in the region with the highest sickness rates based on the NHS Digital benchmarking data (Nov 25).

- The top five reasons for sickness absence over the last 12 months account for over 72% of all sickness within the Trust.

- Trust Turnover has increased in recent months from 8% to 9.3%. This is primarily due to a recent MARS program in the Trust that predominantly affect staff in the admin and clerical staff group.

- Clinical Supervision compliance continues to fluctuate between 70-80% With all but four services within 10% of target. The clinical supervision module expiration is 8 weeks so compliance can significantly fluctuate day to day.

- Compulsory Training compliance has been stable over the 13-month period averaging 86.6%. In July 2025 88.23% of staff have in-date mandatory training, above the 85% target.

Paper Author: Andrew McNichol (Head of People Analytics and Temporary Staffing)
Executive Sponsor : Darren Skinner (Director of People and Organisational Development

1.1 - Our People

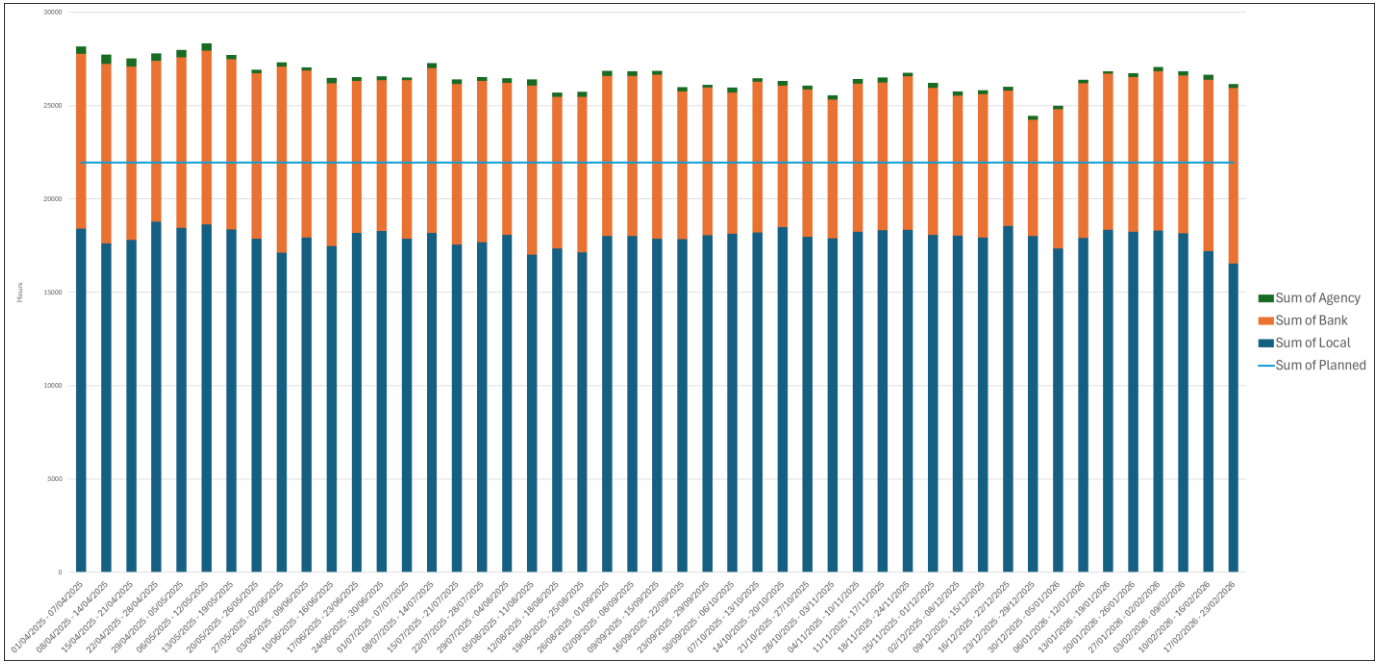
Our people ambitions
Growing for the future

Commitment: Deliver effective workforce planning processes which focus on recruitment and retention, new roles, skills mixing and future supply pathways to ensure a fit for purpose workforce for now and the future.

Resource Distribution and Staffing Fulfilment

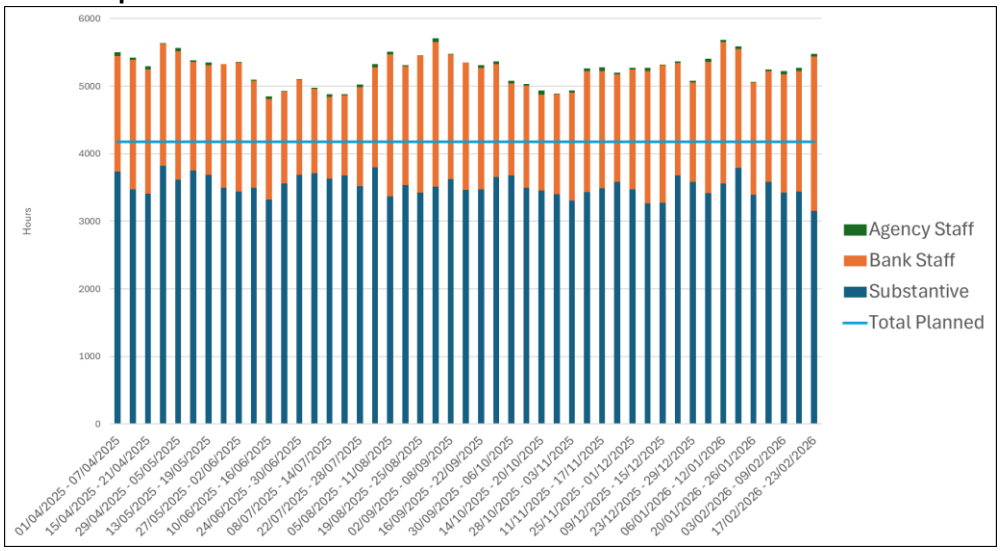
The chart below represents the Staffing fulfilment distribution for all inpatient services for April-Feb 26 by Week/ Service (Blue – Substantive, Orange – Bank, Green – Agency). The scale is deliberately set to demonstrate the overall usage and temporary staffing dependency across the Inpatient Services.

The planned hours represented by the blue line is the RN and HCA requirement for the ward and the bar columns represent the combined RN and HCA hours per 24 day.

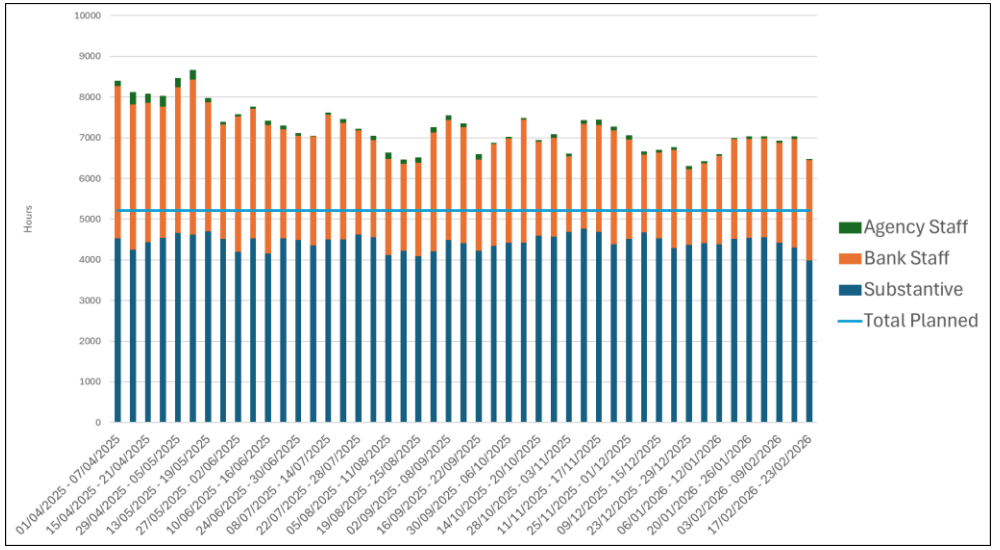


The chart demonstrates the demand over and above the established budget that is being requested to support the additional staffing requirements. An establishment review is currently underway across all services to review the planned hours by unit.

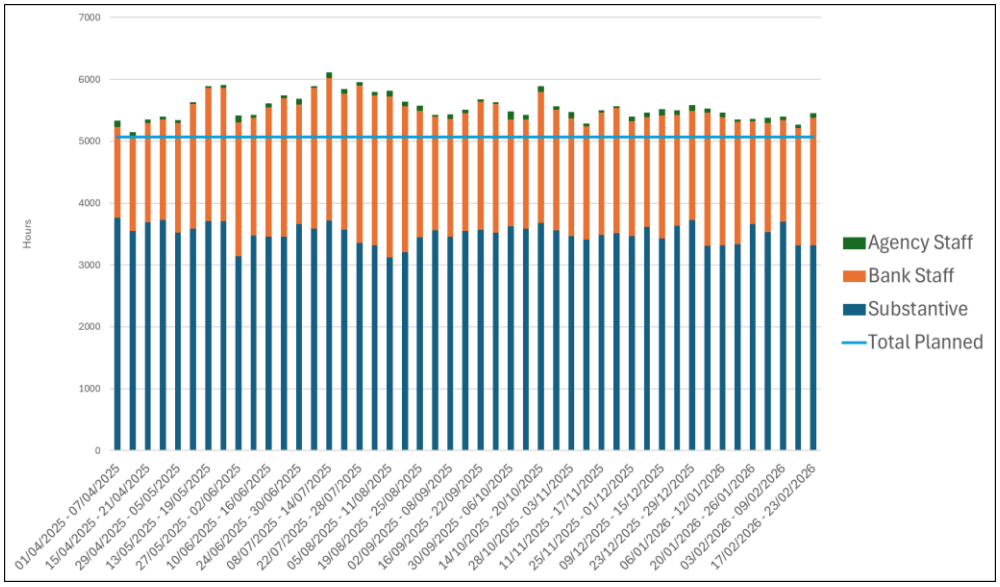
Older Peoples Services



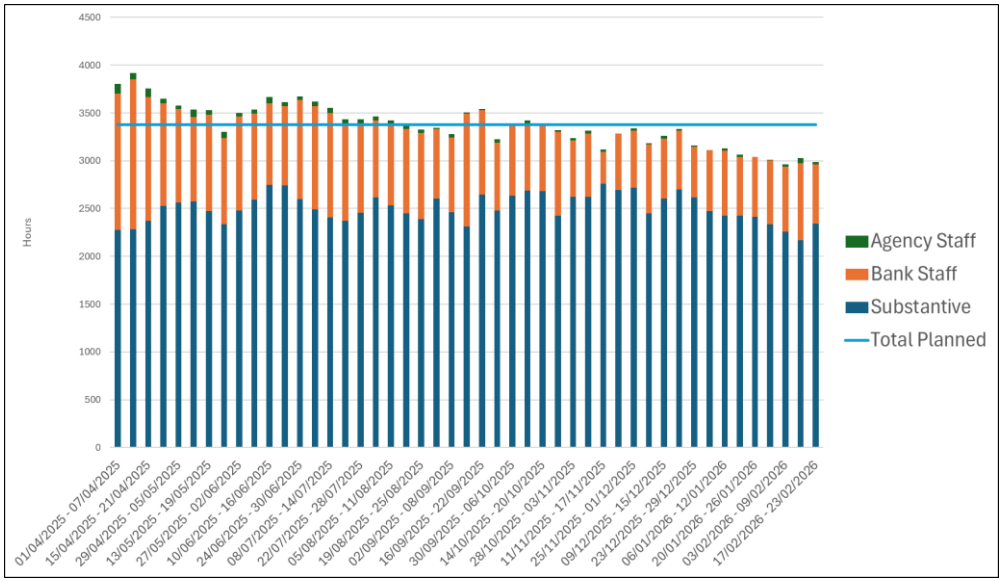
Adult Services



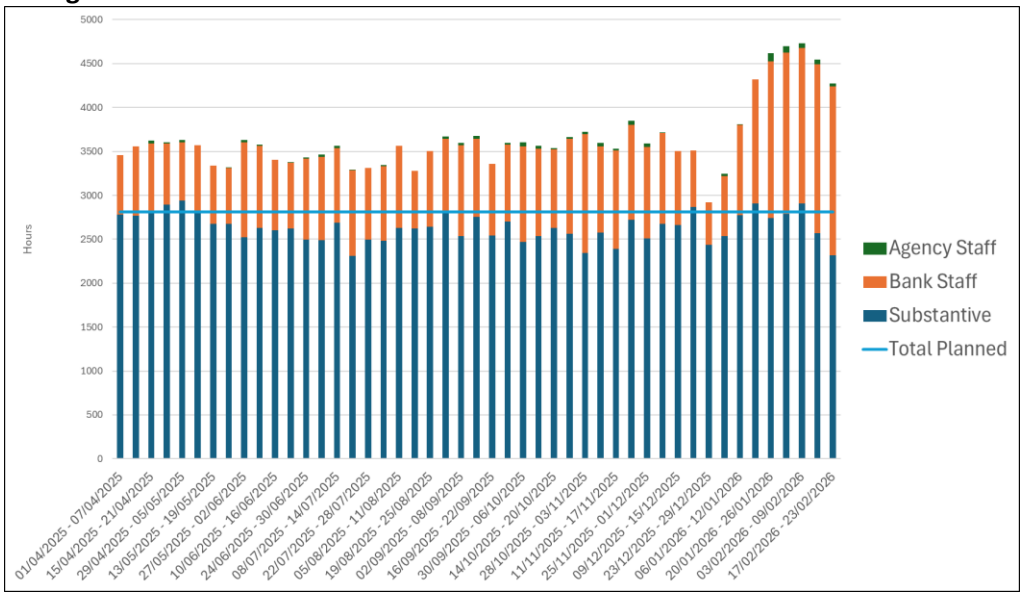
Forensic Services



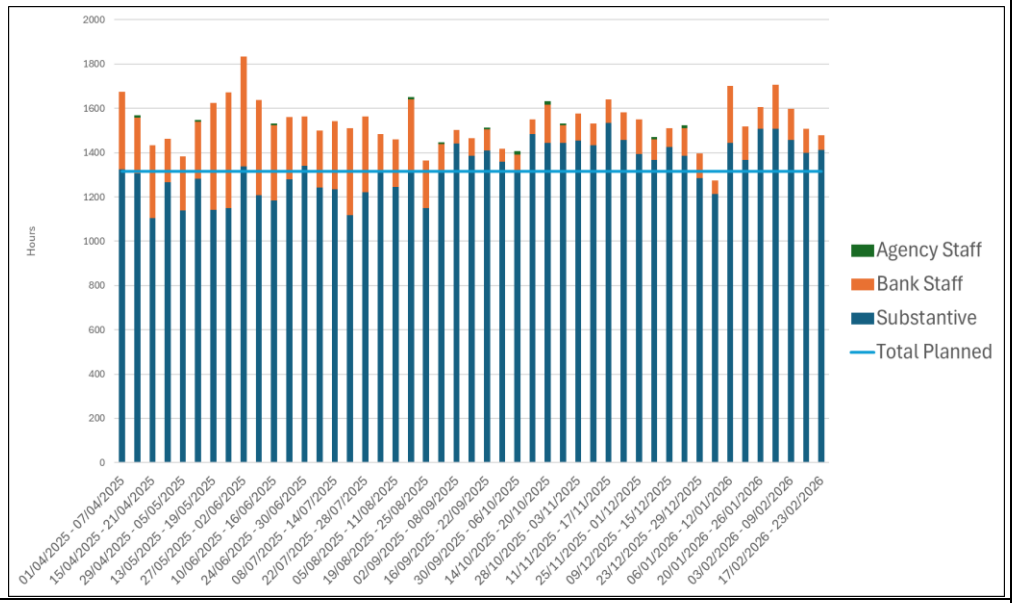
Childrens Services



Eating Disorders and Rehabilitation



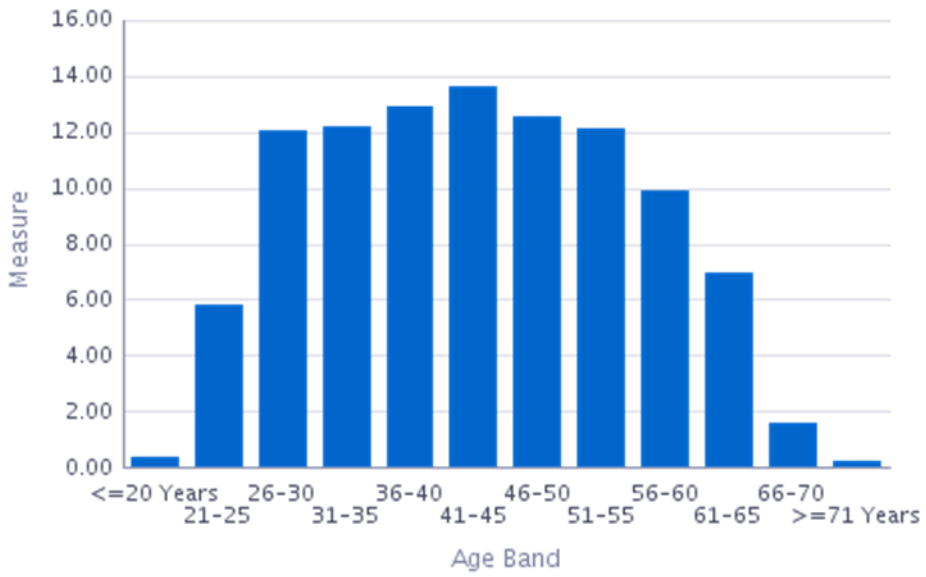
Liaison and Perinatal



1.2 Our People Profile

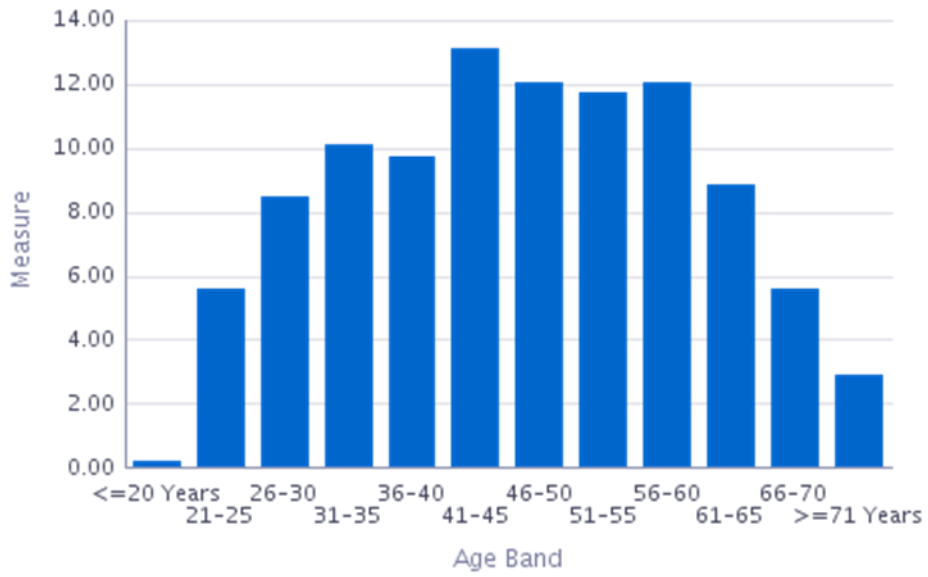
Our People – Substantive

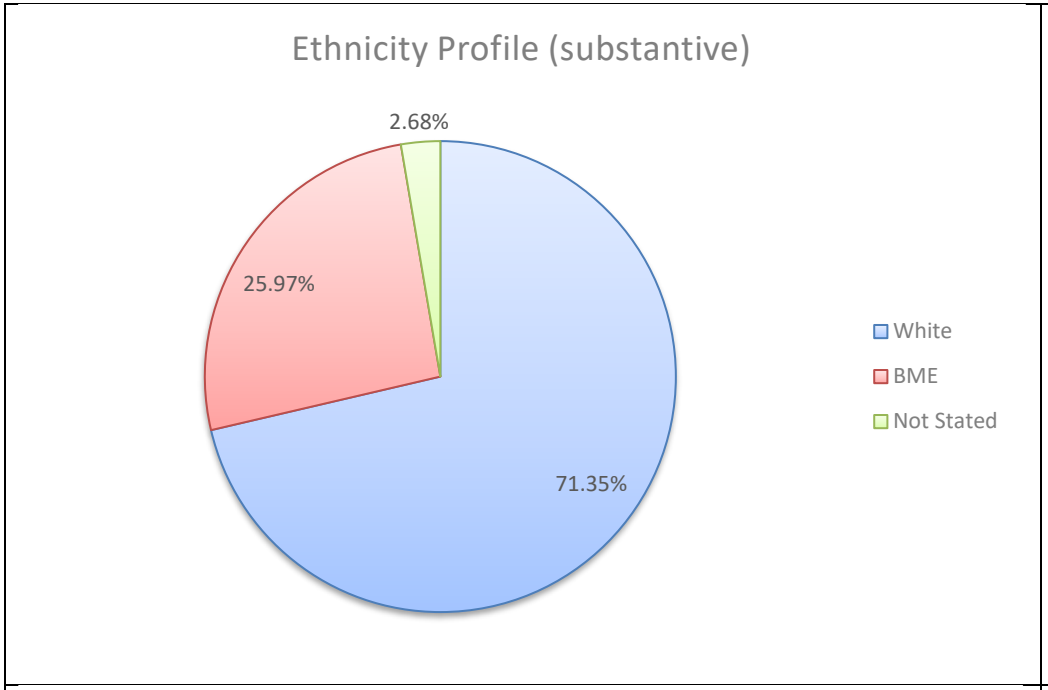
Percentage by Age Band

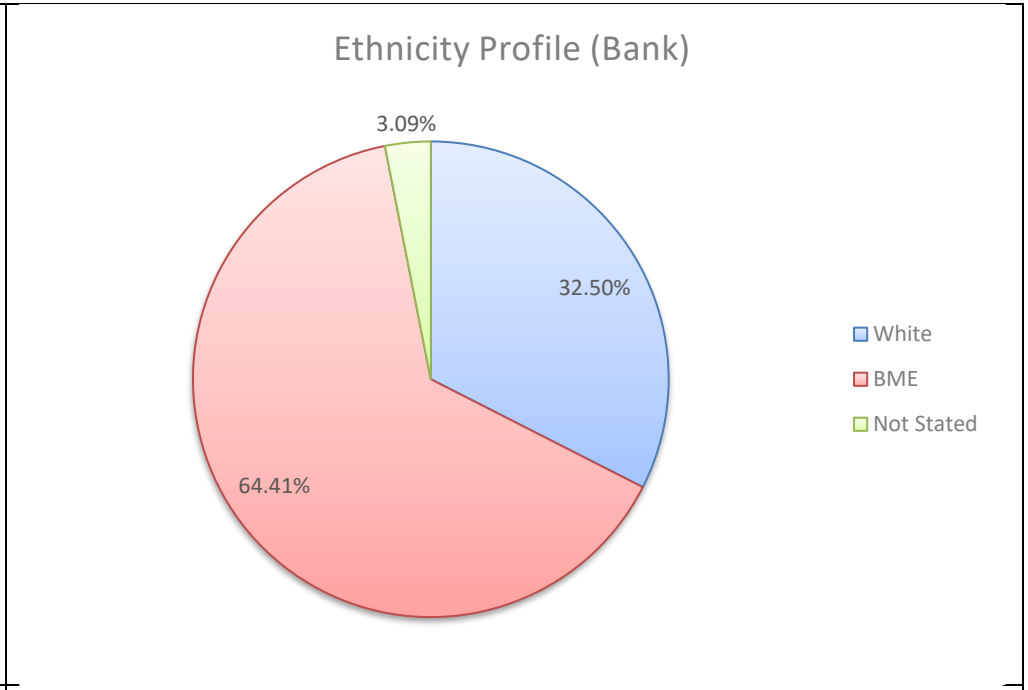


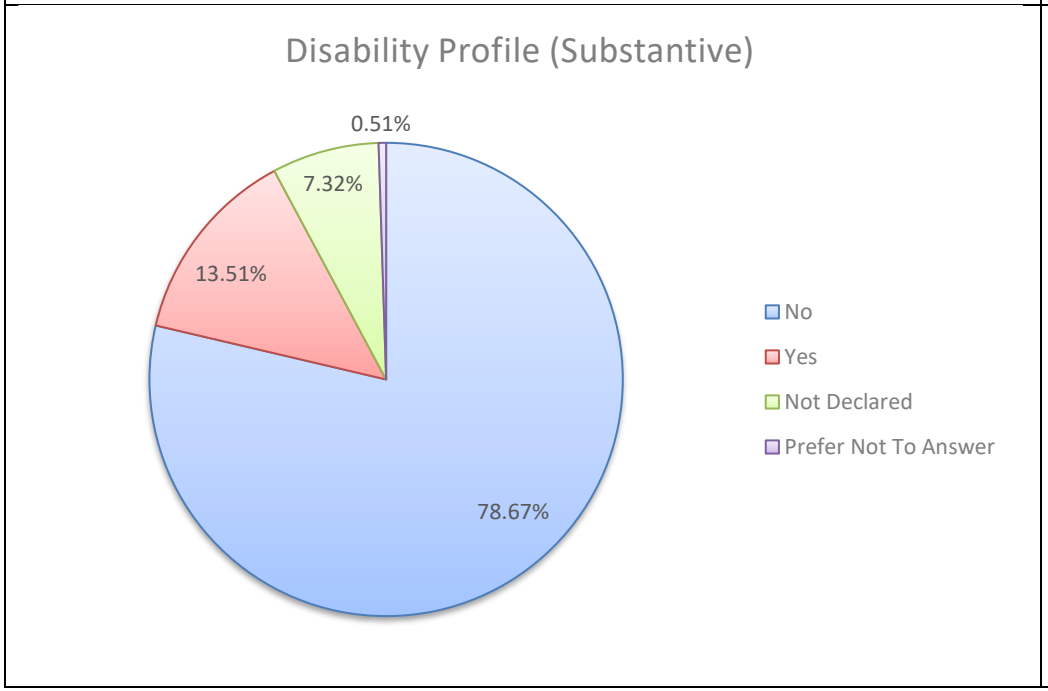
Our People - Bank

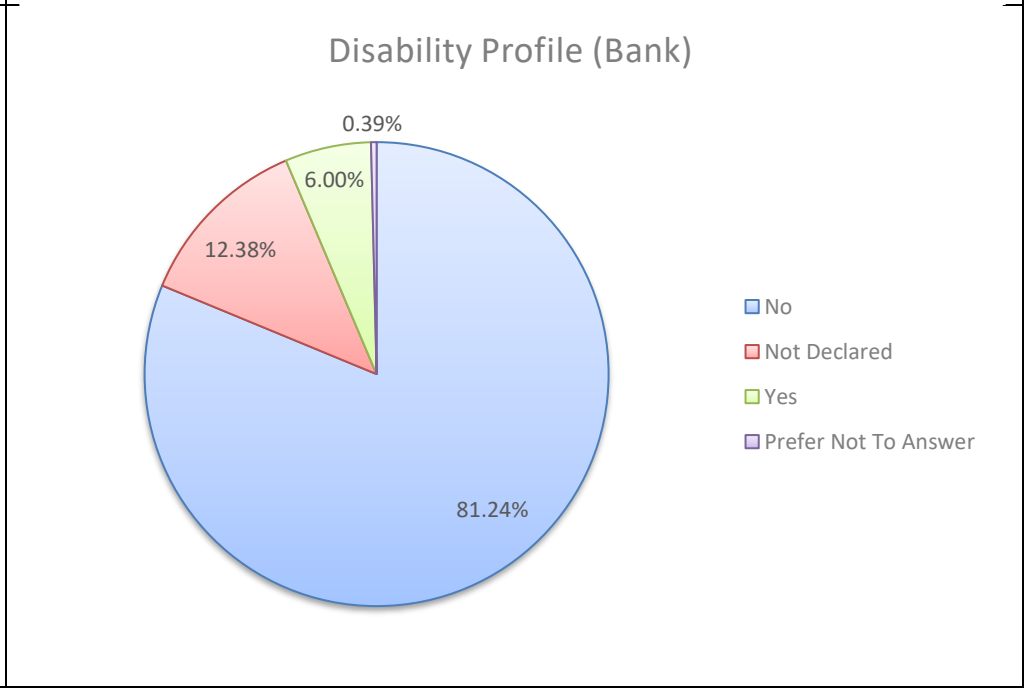
Percentage by Age Band

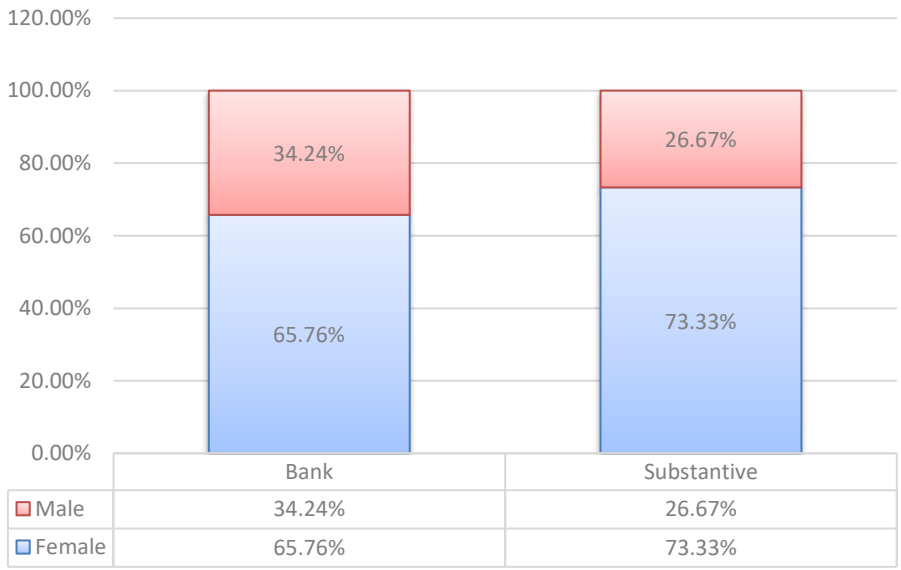



Ethnicity Profile (substantive)
2.68%
25.97%
71.35%
White
BME
Not Stated

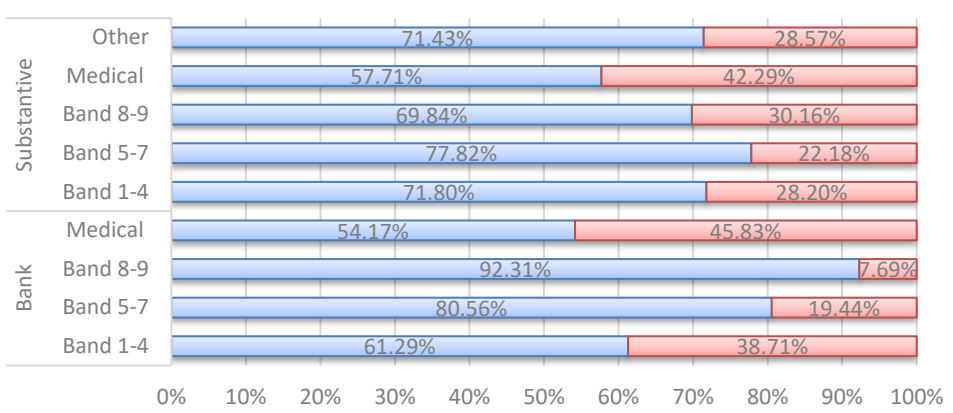

Ethnicity Profile (Bank)
3.09%
32.50%
64.41%
White
BME
Not Stated


Disability Profile (Substantive)
0.51%
7.32%
13.51%
78.67%
No
Yes
Not Declared
Prefer Not To Answer


Disability Profile (Bank)
0.39%
6.00%
12.38%
81.24%
No
Not Declared
Yes
Prefer Not To Answer

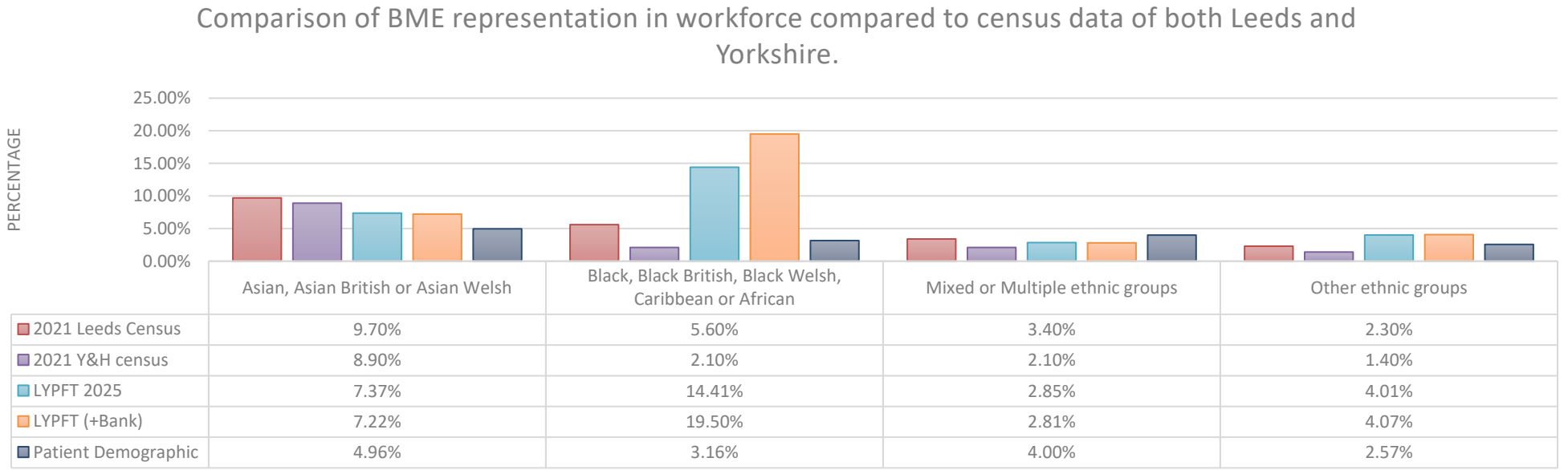


	Bank	Substantive
Male	34.24%	26.67%
Female	65.76%	73.33%

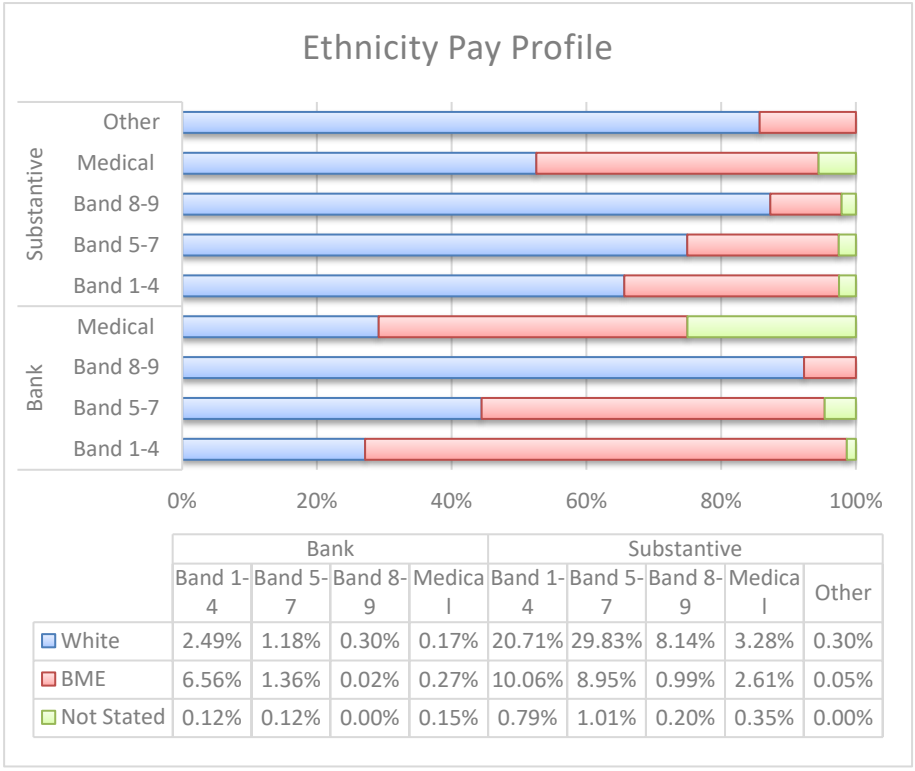


	Bank				Substantive				
	Band 1-4	Band 5-7	Band 8-9	Medical	Band 1-4	Band 5-7	Band 8-9	Medical	Other
Female	61.29%	80.56%	92.31%	54.17%	71.80%	77.82%	69.84%	57.71%	71.43%
Male	38.71%	19.44%	7.69%	45.83%	28.20%	22.18%	30.16%	42.29%	28.57%

1.3 Our People Representation



	Asian, Asian British or Asian Welsh	Black, Black British, Black Welsh, Caribbean or African	Mixed or Multiple ethnic groups	Other ethnic groups
2021 Leeds Census	9.70%	5.60%	3.40%	2.30%
2021 Y&H census	8.90%	2.10%	2.10%	1.40%
LYPFT 2025	7.37%	14.41%	2.85%	4.01%
LYPFT (+Bank)	7.22%	19.50%	2.81%	4.07%
Patient Demographic	4.96%	3.16%	4.00%	2.57%



	Bank				Substantive				
	Band 1-4	Band 5-7	Band 8-9	Medical	Band 1-4	Band 5-7	Band 8-9	Medical	Other
White	2.49%	1.18%	0.30%	0.17%	20.71%	29.83%	8.14%	3.28%	0.30%
BME	6.56%	1.36%	0.02%	0.27%	10.06%	8.95%	0.99%	2.61%	0.05%
Not Stated	0.12%	0.12%	0.00%	0.15%	0.79%	1.01%	0.20%	0.35%	0.00%

Key Points

- The age and ethnicity profile of our workforce is broadly representative of the local population even when considered against the patient ethnicity profile which reflects the impacts of health inequality of the broader Leeds and York census population.

Ethnicity:

- The Trust Bank has seen an increase of 6% in its representation of people from BME backgrounds from November 2024. This is in part due to the migration of agency workers onto the Trust bank as part of the workforce efficiency to reduce agency spend.

Pay:

- The proportion of staff from BME backgrounds in senior roles and pay bands reduces as the pay band increases. This is acknowledged in the Trust Workforce Race Equality Standard (WRES) reporting and actions are being considered for the Trust People Plan review in January 2026.

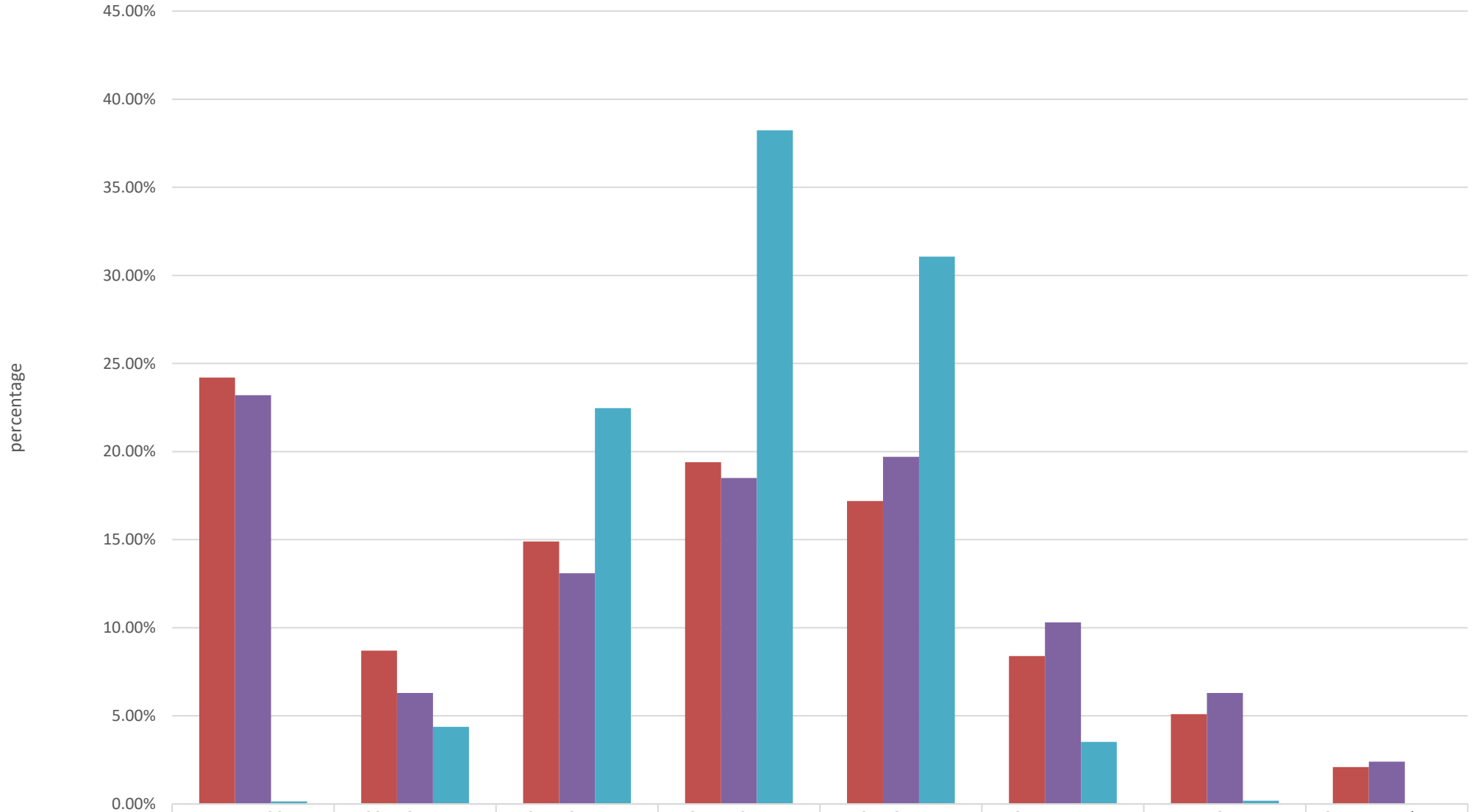
Our people ambitions
Belonging in the NHS

Commitment: Improve the experience of those people with a protected characteristic as identified by the Equality Act.

People Plan Objectives for 2025:

- **Embed the mediation support offer into business as usual processes by establishing a network of trained, supervised and effective mediators in-house, this will include the integration of early resolution training into the Manager 360 programme.**
- **Board members should demonstrate how organisational data and lived experience have been used to improve culture**
- **Evidence progress of implementation of the EDI NHS Improvement plan and by October 2025 implement plan to widen recruitment opportunities within local communities.**
- **Develop and implement an improvement plan to eliminate pay gaps. Implement "Mend the Gap" review for medical staff and effective flexible working options. Analyse data to understand pay gaps by protected characteristics and develop an improvement plan.**
- **Through upskilling and increased awareness, influence the culture to support eliminating the conditions in which bullying, discrimination, harassment and physical violence at work occur. Refer to the EDI Improvement plan for deliverables.**
- **Work in partnership with community organisations to implement and embed the improvement plan for health inequalities**
- **To grow the reciprocal mentoring programme to be part of EDI objectives and identify a number from each service line.**
- **Review and implement employment practices and support for our Neurodiversity colleagues and their managers.**

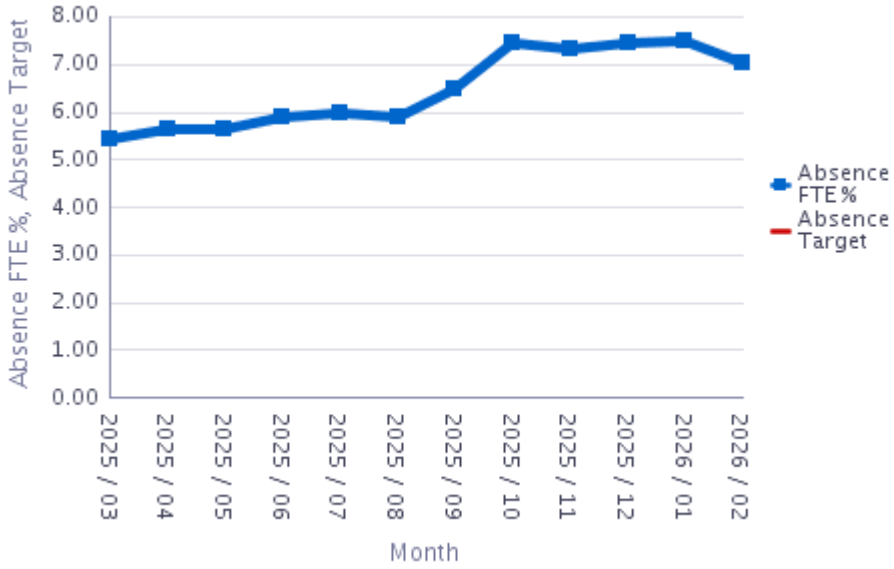
Comparison of Age representation in workforce compared to census data of both Leeds and Yorkshire.



	Up to 20	20 to 24 years	25 to 34 years	35 to 49 years	50 to 64 years	65 to 74 years	75 to 84 years	85 years and over
2021 Leeds Census	24.20%	8.70%	14.90%	19.40%	17.20%	8.40%	5.10%	2.10%
2021 Y&H Census	23.20%	6.30%	13.10%	18.50%	19.70%	10.30%	6.30%	2.40%
LYPFT Feb26	0.15%	4.37%	22.47%	38.24%	31.07%	3.52%	0.18%	0%

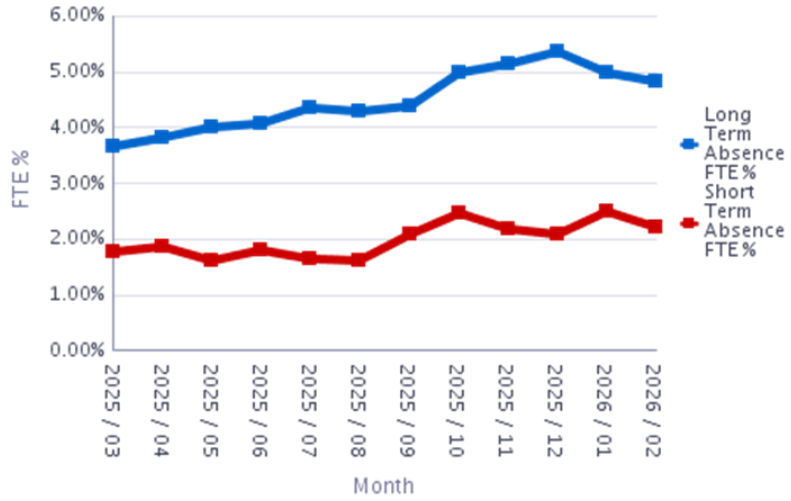
1.4 Our People – Absence

Absence FTE %	Absence Days	Absence FTE	Available FTE
6.48%	80,154	71,716.53	1,106,436.33



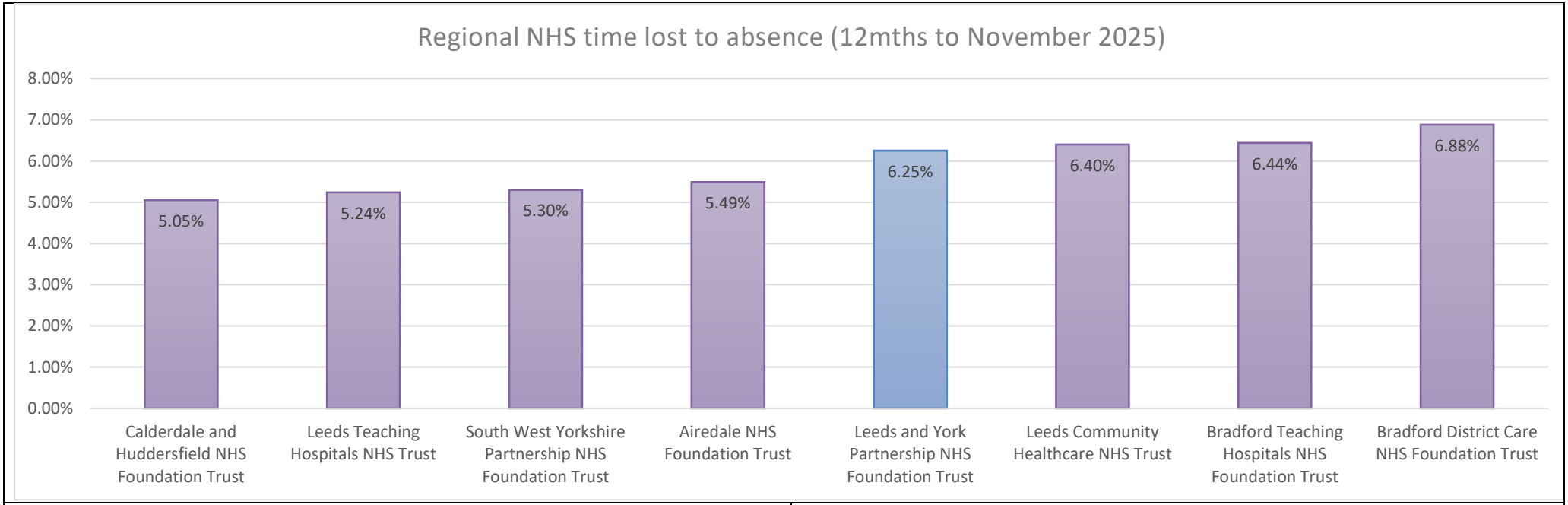
Service	Absence Occurrences	LT Absence Occurrences	ST Absence Occurrences
Adult Acute Services	1,075	112	963
Care Services Other	53	6	47
Chief Operating Officer	11	2	9
Children and Young People's Services	502	42	460
Community and Wellbeing Services	567	80	487
Corporate Services	875	87	788
Eating Disorders and Rehabilitation and Gender Services	725	89	636
Forensic Services	614	68	546
Learning Disability Services	727	98	629
Liaison and Perinatal Services	624	63	561
Older Peoples Services	841	89	752
West Yorkshire Staff Mental Health and Wellbeing Hub	2	0	2
Grand Total	**6,629**	**737**	**5892**

Absence Long-Short Term



Absence by length

Absence Band (Days)	# Absence Occurrences
0-1	1,899
2	1,280
3	676
4	442
5	370
6	197
7	208
8-14	442
15-21	217
22-27	132
28 Days-6 Months	692
6 Months-12 Months	66
> 12 Months	6



Our people ambitions
Looking after our people

Ensure our people have equal access to and use a full range of well-being support – physical, psychological, financial, and social.

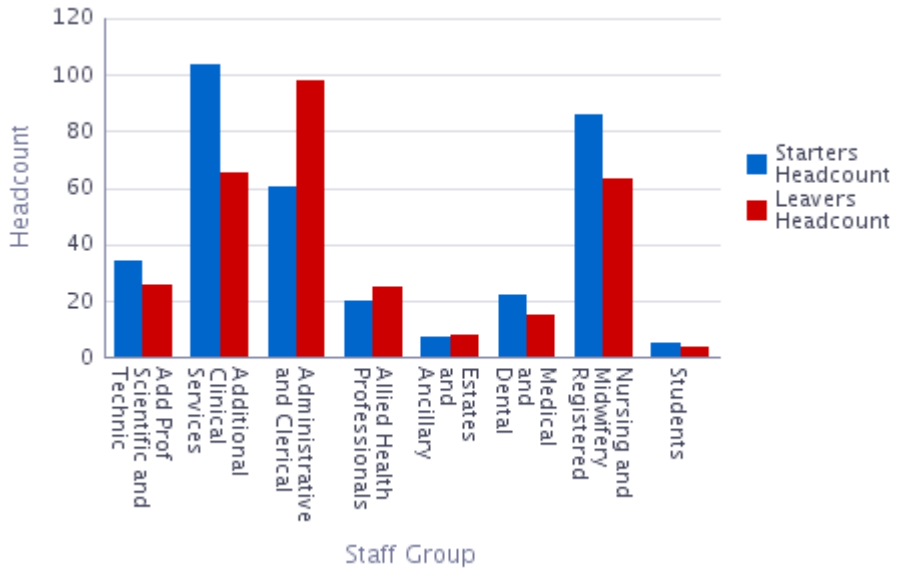
- **Put in place a Standard Operating Procedure for reasonable workplace adjustments which includes targets and waiting times this needs to have support from Procurement, Informatics and Finance.**
- **Review the Partnership Agreement with Occupational Health**
- **Achieve Menopause Accreditation and aspire to be a leading Trust for Menopause awareness and support Develop a Menopause Policy and grow and develop the support network**

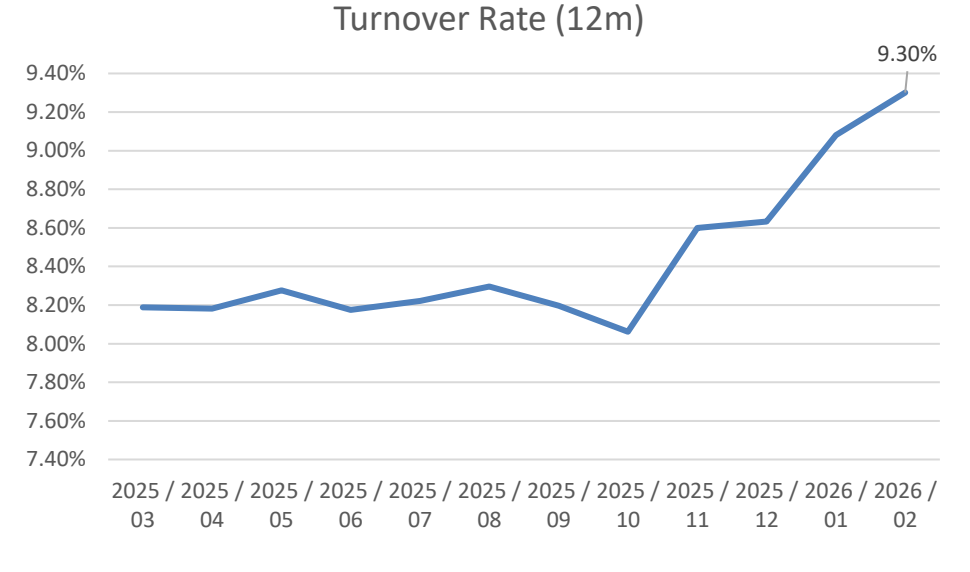
Key Points

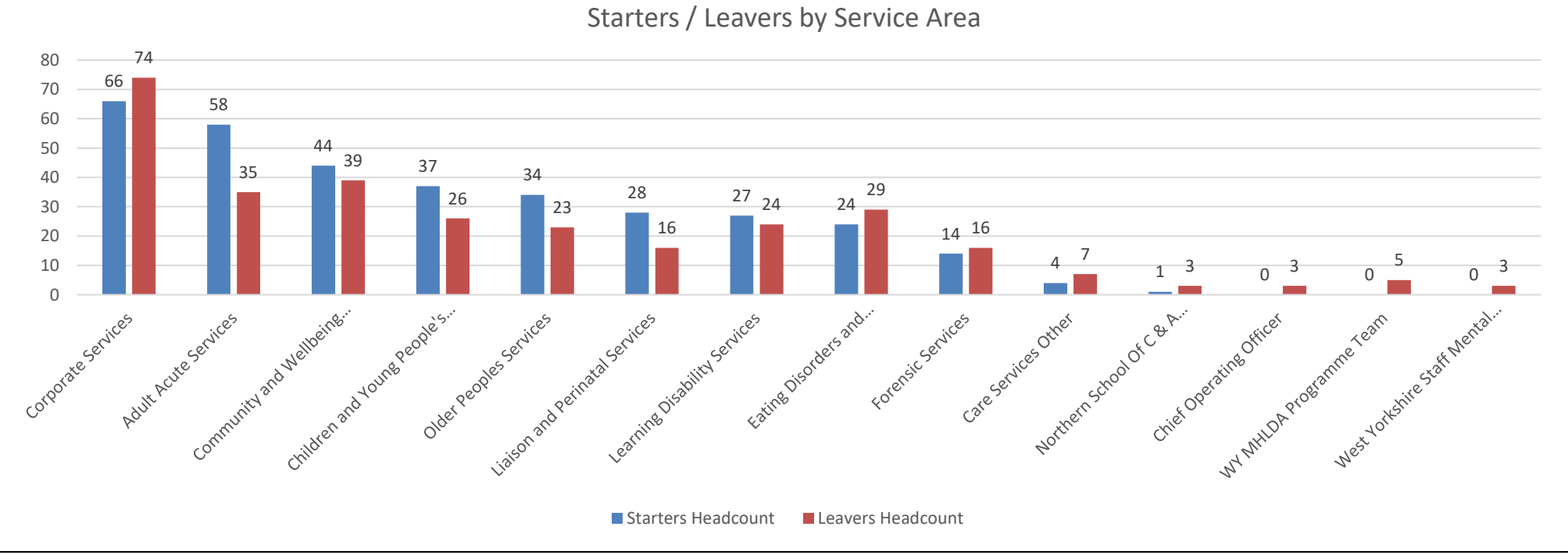
- The Trust in month sickness absence rate for February is 7.05**%** This is an increase from 5.95% for the same period last year.
- The rolling **12-month** sickness absence rate is 6.48% (Feb 26) and the Trust is 4th highest absence in the region with the highest sickness rates based on the NHS Digital benchmarking data (Nov 25).
- The **top five reasons** for sickness absence over the last 12 months account for over 72**% of all sickness** within the Trust.

Absence Reason	Headcount	Abs Occurrences	Abs Days	%
S10 Anxiety/stress/depression/other psychiatric illnesses	674	944	31,745	39.6
S13 Cold, Cough, Flu - Influenza	1408	1,971	8,800	11.0
S12 Other musculoskeletal problems	305	381	8,109	10.1
S25 Gastrointestinal problems	834	1,118	5,414	6.8
S28 Injury, fracture	156	168	3,857	4.8

1.5 Our People – Retention







Leaver Destination

Destination On Leaving	Leavers
Abroad - EU Country	1
Abroad - Non EU Country	10
Death in Service	2
Education Sector	8
Education or Training	9
General Practice	1
NHS Organisation	64
No Employment	89
Other Private Sector	27
Other Public Sector	15
Prison Service	1
Private Health Care	15
Self Employed	1
Social Services	1
Unknown	60
Grand Total	**304**

Leaver by Staff Group

Staff Group	Leavers
Add Prof Scientific and Technic	26
Additional Clinical Services	65
Administrative and Clerical	98
Allied Health Professionals	25
Estates and Ancillary	8
Medical and Dental	15
Nursing and Midwifery Registered	63
Students	4
Grand Total	**304**

Leaver by Reason

Leaving Reason	Leavers
Death in Service	3
Dismissal	11
Employee Transfer	5
Fixed Term Contract End	25
Mutually Agreed Resignation	21
Pregnancy	1
Redundancy - Compulsory	2
Redundancy - Voluntary	13
Retirement - Ill Health	2
Retirement Age	21
Voluntary Early Retirement - no Actuarial Reduction	1
Voluntary Resignation	199
Grand Total	**304**

Our people ambitions
Growing for the future

Develop and implement an innovative approach to talent development, embedding the right culture and improving retention through delivery of our retention strategy.

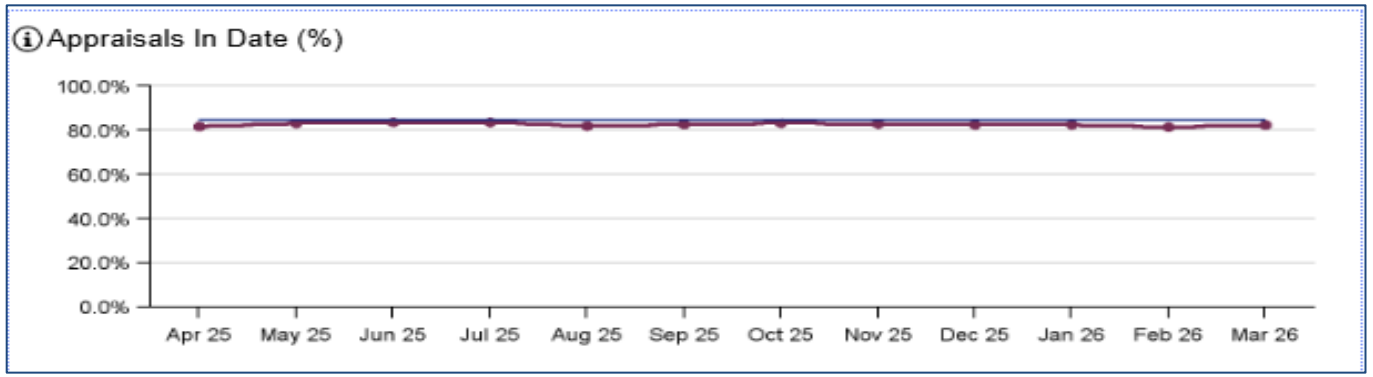
- **Pilot the new Succession Planning approach with EMT/SMT**
- **Launch the Stay Conversation approach.**

Increase the opportunities for flexible working across the Trust, including flexible retirement options.

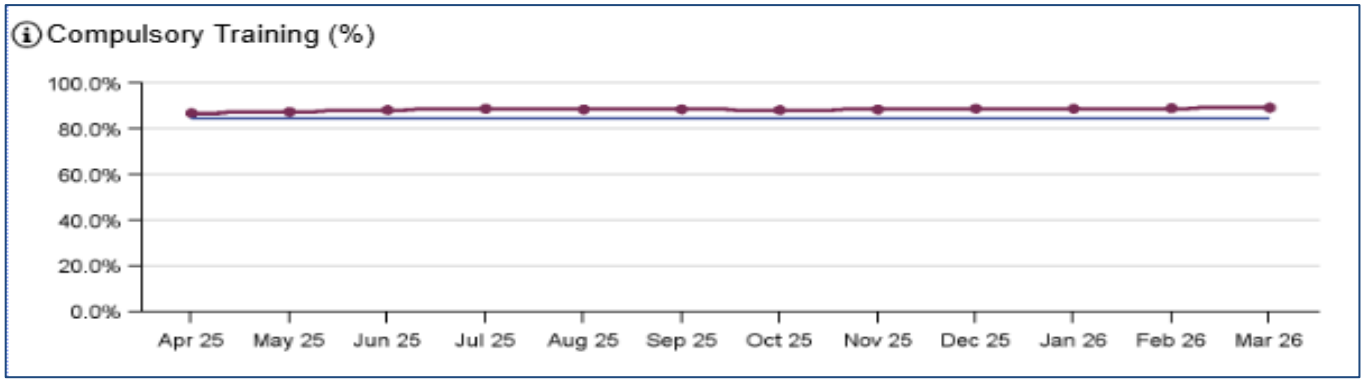
- **Deliver the flexible working priorities including the revised procedure, manager training and comms plan.**

1.6 Our People – Learning and Development

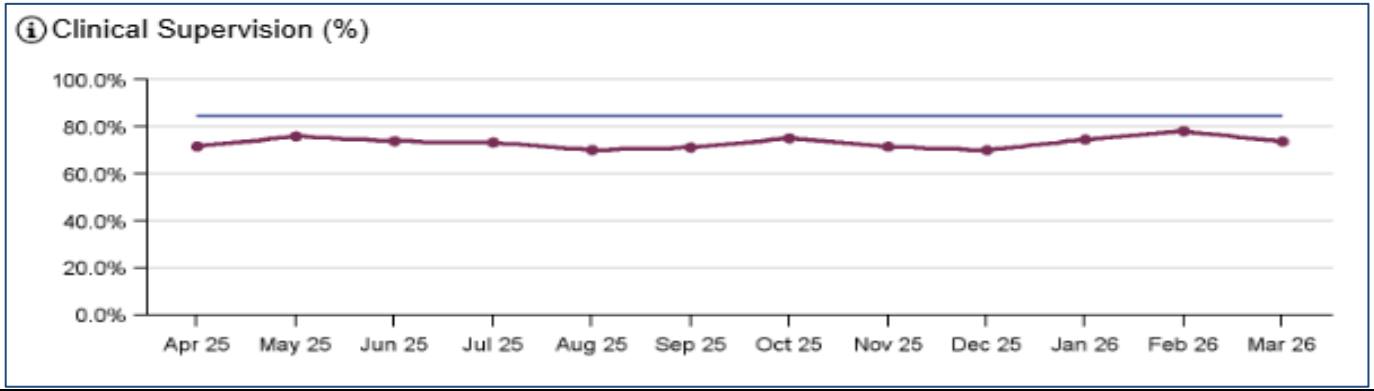
Performance Development Reviews



Compulsory Training



Clinical Supervision



Requirement	Service Line	Number compliant	Number non-compliant	Total Headcount	Compliance status
Annual Appraisal	Adult Acute Services	233	69	302	77%
Annual Appraisal	Care Services Other	21	8	29	72%
Annual Appraisal	Chief Operating Officer	14	2	16	88%
Annual Appraisal	Children and Young People's Services	137	10	147	93%
Annual Appraisal	Community and Wellbeing Services	219	57	276	79%
Annual Appraisal	Corporate Services	521	91	612	85%
Annual Appraisal	Disorders and Rehabilitation and Gender S	212	39	251	84%
Annual Appraisal	Forensic Services	198	34	232	85%
Annual Appraisal	Learning Disability Services	226	87	313	72%
Annual Appraisal	Liaison and Perinatal Services	205	35	240	85%
Annual Appraisal	Older Peoples Services	258	63	321	80%
Annual Appraisal	Trust Board - Executive Directors	6		6	100%
Annual Appraisal	Trust Board - Non Executive Directors	7		7	100%

Requirement	Service Line	Number compliant	Number non-compliant	Total Headcount	Compliance status
Clinical Supervision	Adult Acute Services	205	90	295	69%
Clinical Supervision	Care Services Other	9	7	16	56%
Clinical Supervision	Chief Operating Officer	1		1	100%
Clinical Supervision	Children and Young People's Services	119	25	144	83%
Clinical Supervision	Community and Wellbeing Services	133	78	211	63%
Clinical Supervision	Corporate Services	2		2	100%
Clinical Supervision	Disorders and Rehabilitation and Gender	173	52	225	77%
Clinical Supervision	Forensic Services	176	36	212	83%
Clinical Supervision	Learning Disability Services	86	22	108	80%
Clinical Supervision	Liaison and Perinatal Services	163	47	210	78%
Clinical Supervision	Older Peoples Services	209	74	283	74%
Grand Total		1276	431	1707	75%

Our people ambitions
New ways of working and delivering care

Provide accessible and intuitive software solutions to support People and OD initiatives.

- **Complete a tender exercise for a new employee relations case management system for HR.**
- **Assess the feasibility of AI applications in POD, conduct pilot programs in at least two areas, and implement AI solutions where efficiency gains exceed 20%.**
- **Implement a new SW form workflow**

Key Points

PDR

- PDR compliance has remained within tolerance of target 85% for 25 consecutive months.

Clinical Supervision

- Clinical Supervision compliance continues to fluctuate between 70-80% With all but four services within 10% of target. The clinical supervision module expiration is 8 weeks so compliance can significantly fluctuate day to day. Especially at year end with increased levels of annual leave.

Compulsory Training

- Compliance has been stable over the 13-month period averaging 88%. In February 89% of staff have in-date mandatory training, above the 85% target.

Definition of Staff Groups		
Add Prof Scientific and Technic	APS&T	All Qualified Technical Staff & Pharmacists – e.g. Optometrists, ODPs, General Technicians
Additional Clinical Services	ACS	All Unqualified Nursing Staff, Therapy Staff & Technical & Scientific Staff – e.g. Support Workers, Play Specialists, Physio Assistants
Administrative and Clerical	A&C	All Admin & Clerical Staff – e.g. Clerical staff, Managers, Senior Managers
Allied Health Professionals	AHP	All Qualified AHP Staff – e.g. Physios, Dieticians, Orthoptists
Estates and Ancillary	E&A	All Ancillary and Maintenance Staff – e.g. Domestics, Porters, Housekeepers, Joiners, Craftsman
Healthcare Scientists	HCS	All Scientific Staff – e.g. Biomedical Scientists, Scientists
Medical and Dental	M&D	All Medical Staff – e.g. Junior Doctors, Consultants
Nursing and Midwifery Registered	N&M	All Qualified Nursing Staff – e.g. Staff Nurse, Ward Manager, Health Visitors

Definition of Other Terms		
Black & Minority Ethnic groups	BME	Term used to refer to members of non-white communities in the UK
Full Time Equivalent	FTE	The unit used to show the equivalence to a full-time member of staff. Sometime referred to as Whole Time Equivalent (WTE). E.g. a nurse working 30 hours per week would have an FTE of 0.80

Key Performance Indicator	KPI	A type of measurement to evaluate success against a given target
Personal Development Review	PDR	Annual appraisal of staff performance and development

Agenda item
17

Meeting of the board of directors

Paper title:	2025 NHS Staff Survey and Bank Staff Survey Results
Date of meeting:	26 March 2026
Presented by: (name and title)	Darren Skinner, Director of People and OD
Prepared by: (name and title)	Tracey Needham Head of People Engagement

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 summarises the 2025 Staff Survey results for LYPFT. Substantive staff scores have fallen across most People Promise themes, with the largest drops in morale, wellbeing and engagement. Flexible working and reasonable adjustments remain strengths

Bank staff results appear more positive, but low response rates limit reliability. For Bank reports of harassment, bullying, abuse and discrimination from patients and the public have increased.

Equality analyses show persistent or widening gaps in feeling valued, team relationships, psychological safety and confidence to speak up.

New 2025 national requirements increase expectations on Boards for clear analysis and timely action planning, which the Trust can deliver through existing Intention Plans and governance routes.

This paper should be read alongside the accompanying video briefing, **Appendix 2 – NSS25 Results Briefing**, which provides a narrated walkthrough of the findings and key insights.

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 of Directors is asked to:

- Receive and note the high-level 2025 National Staff Survey results.
- Acknowledge the strengthened national expectations for survey reporting and action planning.
- Recognise the requirement for full analysis of free-text feedback and key areas of dissatisfaction.
- Agree and ensure timely, published action plans that demonstrate improvement aligned to the NHS People Promise.
- Take assurance from the plan to share results across services and governance groups to support improvement planning.

Meeting of the board of directors

26 March 2026

2025 NHS Staff Survey and Bank Staff Survey Results

1. Executive summary

This paper summarises the 2025 Staff Survey results for LYPFT. Substantive staff scores have fallen across most People Promise themes, with the largest drops in morale, wellbeing and engagement. Flexible working and reasonable adjustments remain strengths.

Bank staff results appear more positive, but low response rates limit reliability. For Bank reports of harassment, bullying, abuse and discrimination from patients and the public have increased.

Equality analyses show persistent or widening gaps in feeling valued, team relationships, psychological safety and confidence to speak up.

New 2025 national requirements increase expectations on Boards for clear analysis and timely action planning, which the Trust can deliver through existing Intention Plans and governance routes.

This paper should be read alongside the accompanying video briefing, **Appendix 2 – NSS25 Results Briefing**, which provides a narrated walkthrough of the findings and key insights.

2. Purpose and scope

This report provides the Board with a high-level summary of the 2025 survey results issued by the National Coordination Centre (NCC) for:

- Substantive Staff (weighted national data) and Bank Staff (unweighted data)

It highlights key trends, areas of strength, areas of concern, and implications for organisational action and assurance.

3. National Context and Board Accountability

3.1 NHS Standard Contract (September 2025)

The updated NHS Standard Contract requires providers to:

- Review and produce a written report for the Co-ordinating Commissioner on the results of each staff survey, including both the National Staff Survey and National Quarterly Pulse Surveys.
- Identify any actions reasonably required in response to survey findings.

- Implement those actions as soon as practicable.
- Publish the outcomes of, and actions taken in relation to, all staff surveys.

3.2 Medium Term Planning Framework

The Medium-Term Planning Framework reinforces these requirements and sets clear expectations that every NHS board will use the 2025/26 Staff Survey findings to:

- Undertake a full, detailed analysis of all free text comments.
- Identify, as a minimum, three areas where data indicates the greatest staff dissatisfaction.
- Complete a detailed analysis of where these issues are most prevalent within the organisation.
- Develop and implement detailed action plans to **address these issues within year** wherever possible.

3.3 Implications for the Trust and the Board

These national changes shift the Staff Survey from a diagnostic exercise to a core performance and assurance tool. Boards are now directly accountable for:

- Robust analysis of quantitative and qualitative staff feedback.
- Clear, evidence-based priorities for improvement.
- Assurance that actions are implemented and impact is monitored and reported transparently

This requires a more systematic and visible Trust-wide approach to analysis, action planning and reporting, with clear Board-level ownership and oversight.

4. Survey response rates

The 2025 LYPFT NHS Staff Survey for substantive (3,359) and bank staff (476) ran from 1 October to 28 November.

- 45% of Substantive Staff (1,504 responses); 4%▼ less than last year.
- 17.6% of Bank Staff (84 responses); 6.2%▼ less than last year.

5. 2025 NHS Staff Survey Results

5.1 People Promise Theme Overview (Substantive Staff)

Figure 1: 2025 NHS (Substantive) Staff Survey - People Promise themes compared to sector scores

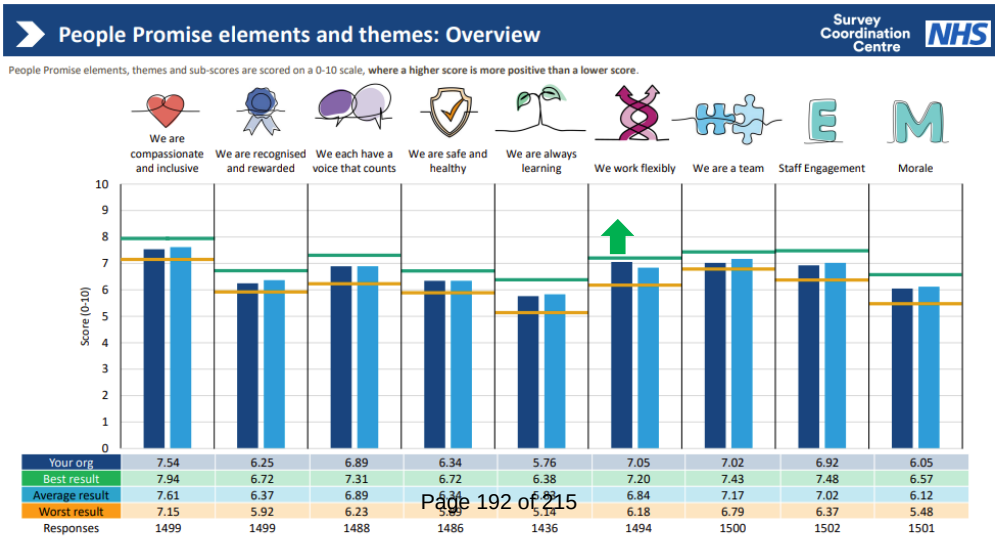


Figure 2: 2024 NHS (Substantive) Staff Survey - People Promise themes compared to previous year

Appendix B: Significance testing – 2024 vs 2025

Survey Coordination Centre NHS

Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2024 and 2025*. For more details, please see the Technical Guide.

People Promise elements	2024 score	2024 respondents	2025 score	2025 respondents	Statistically significant change?
We are compassionate and inclusive	7.57	1630	7.54	1499	Not significant
We are recognised and rewarded	6.35	1633	6.25	1499	Not significant
We each have a voice that counts	7.00	1615	6.89	1488	Not significant
We are safe and healthy	6.47	1620	6.34	1486	Significantly lower
We are always learning	5.77	1547	5.76	1436	Not significant
We work flexibly	7.04	1621	7.05	1494	Not significant
We are a team	7.06	1627	7.02	1500	Not significant
Themes					
Staff Engagement	7.02	1633	6.92	1502	Not significant
Morale	6.19	1634	6.05	1501	Significantly lower

Comparison with last year

- We work flexibly is the only theme with a slight increase (+0.01▲).
- The biggest positive movement is in We are always learning within Appraisals (+0.10▲).
- All other themes have declined since last year.
- The largest drops are Morale (-0.14▼) and We are safe and healthy (-0.13▼).
- Team working has fallen again to 7.02▼, down from 7.15 in 2022.
- Within Morale, Work pressure shows a significant decline (-0.22▼).

Comparison with sector

Table 1 shows LYPFT's performance against the sector over three years. Learning and Team Working have been below the sector average throughout, with declines in both areas accelerating.

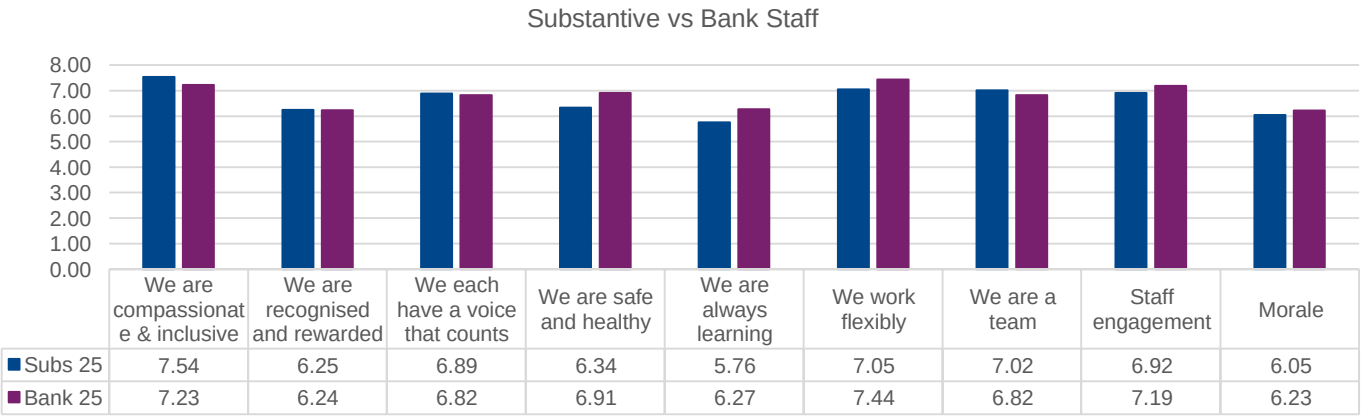
Table 1 Comparison against sector average

	2023	2024	2025
Above Sector Ave	▲ Flexible Working (+0.27) ▲ Safe & Healthy (+0.25) ▲ Morale (+0.09) ▲ Recognised & Rewarded (+0.07) ▲ Voice That Counts (+0.06) ▲ Staff Engagement (+0.01)	▲ Flexible Working (+0.21) ▲ Safe and Healthy (+0.07) ▲ Voice That Counts (+0.06)	▲ Flexible Working (+0.21)

Below Sector Ave	▼ Learning (-0.06) ▼ Team-working (-0.05)	▼ Learning (-0.17) ▼ Team-working (-0.09) ▼ Staff Engagement (-0.06) ▼ Compassionate & Inclusive (-0.04) ▼ Recognised & Rewarded (-0.01)	▼ Team-working (-0.15) ▼ Recognised & Rewarded (-0.12) ▼ Staff Engagement (-0.10) ▼ Learning (-0.07) ▼ Compassionate & Inclusive (-0.07) ▼ Morale (-0.05)
Same as Sector Ave	► Compassionate & Inclusive	► Morale	► Voice That Counts ► Safe and Healthy

5.2 People Promise Theme Overview (Bank versus Substantive Staff)

Figure 3: Substantive vs Bank Staff 2025 - People Promise theme results.



	We are compassionate & inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Morale
Subs 25	7.54	6.25	6.89	6.34	5.76	7.05	7.02	6.92	6.05
Bank 25	7.23	6.24	6.82	6.91	6.27	7.44	6.82	7.19	6.23

Bank staff (unweighted) showed improvements across all nine themes compared with substantive staff, with the biggest gain in Always Learning (+0.60). We Work Flexibly scored highest (7.44). Morale also improved (+0.13) but remains the lowest-scoring theme.

Bank staff outperform substantive staff across five People Promise elements:

- *Safe and healthy* (+0.57▲)
- *Always learning* (+0.51▲)
- *Work flexibly* (+0.39▲)
- *Staff engagement* (+0.27▲)
- *Morale* (+0.18▲)

- Significant differences for Bank Staff are in: Compassionate & Inclusive (-0.31▼) and Team-working (-0.20▼).

Although results show positive movement, the low response rate means they should be treated

cautiously. We do not yet have national bank staff reports or a release date, so sector comparisons aren't possible. National reports are expected in mid-April 2026.

6. National Staff Survey All Question Results

Please refer to Appendix 1 – 2025 National Staff Survey Data Sub and Bank to view the full set of results against all questions.

6.1 Well-Performing

Overall areas where the Trust is performing well

- Reporting violence: 90.5% of Substantive and 94.3% of Bank Staff reported the last incident.
- Feeling trusted: 89.9% of Substantive and 91.7% of Bank Staff feel trusted to do their job.
- Making a difference: 84.6% of Substantive and 92.3% of Bank Staff feel their role benefits service users.

Compared to last year, Substantive Staff report

▲ Reasonable adjustments: 88.3% (+7.4%).
▲ Appraisals/PDR: 88.9% (+5%).

Compared to last year, Bank Staff report

▲ Respect for individual differences: 83.1% (+15.9%).
▲ Time passes quickly at work: 64.6% (+15%).
▲ Able to get help and support: 70.7% (+14.4%).

6.2 Areas for Improvement

Overall areas where the Trust could look to improve

Compared to last year, Substantive Staff report

▼ Less action on Health & wellbeing: 63.9% (-5.8%, RED).
▼ More Burnout: 25.6% (+5.1%, RED).
▼ Feeling less valued for their work: 46.6% (-4.9%).
▼ Less confidence in speaking up: 66% (-4.3%) feel safe to raise any type of concern.
▼ In Engagement we see declines across Motivation, Involvement and Advocacy with only 60.6% (- 3.9%) would now recommend care to friends/family.
▼ In Morale we see declines across all sub themes; with 30% (+3.1%) often think about leaving.
▼ Feeling less valued through PDRs: 28.1% (-3.1%).

Compared to last year, Bank Staff report

▼ Increases in harassment and discrimination: 48.8% experienced harassment/bullying (+13%) and 33.7% experienced discrimination (+8.5%) from patients/public - both RED.
▼ Service User care is less of a top priority - at 80.5% (-8.7%, RED)
▼ Less access to nutritious food: 5.5% fewer staff feel able to eat nutritious, affordable food at work - RED.

6.3 Outliers compared to our benchmarking group

Our benchmarking group is Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts, comprising 48 organisations

Best in sector

- with (88.32%) for making reasonable adjustments, placing us top of our peer group.

Worst in sector

- for feeling respected by colleagues (71.53%)
- for team members understanding each other's roles (63.71%)
- for feeling a strong personal attachment to our teams (61.26%)

To watch – we score poorly

- for feeling valued within our teams (70.06%)
- for appraisals leaving staff feeling valued (28.08%)
- for motivation (6.78), an engagement sub-theme covering enthusiasm for work, looking forward to work, and time passing quickly at work

7. Equality and Inclusion Insights

7.1 Workforce Race Equality Standards (WRES) – Summary

- Worsening indicators for harassment.
- Career opportunities performing above sector average.
- Discrimination remains marginally worse than sector.

Figure 4: WRES Standard - Substantive Staff

Indicator	WRES Standard % Staff - ALL ETHNIC GROUPS	2021	2022	2023	2024	2025	YoY Ch		Sector Ave	Against Sector Ave
5	*% experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months*	*37.9%*	*35.8%*	*33.7%*	*30.7%*	*36.0%*	*5.3%*	*Significantly Unfavourable*	*33.8%*	*Worse than sector ave*
6	*% experiencing harassment, bullying or abuse from staff in the last 12 months*	*22.8%*	*22.5%*	*17.1%*	*17.8%*	*20.7%*	*2.9%*	*Unfavourable*	*20.2%*	*Worse than sector ave*
7	% believing that the organisation provides equal opportunities for career progression or promotion.	Note: Due to changes in the question wording in 2025, previous years' results for WRES indicator 7 (Q15) are not reported				52.2%			51.6%	*Better than sector ave*
8	*% experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months*	*13.8%*	*11.8%*	*10.2%*	*13.3%*	*12.9%*	*-0.3%*	*Favourable*	*12.7%*	*Worse than sector ave*

7.2 Workforce Disability Equality Standards (WDES) – Summary

The experience of staff with long-term conditions in 2025 presents a mixed organisational picture with both clear strengths and emerging cultural challenges:

- Strong performance on reasonable adjustments.
- Declining confidence in reporting bullying and harassment.
- Significant deterioration in feeling valued and engagement.

Figure 5: WDES Standard - Substantive Staff

Metric	WDES Standard % Staff with a Long-Term Condition (LTC) or illness	2021	2022	2023	2024	2025	YoY Ch		Sector Ave	Against Sector Ave
4a	*% experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months*	*31.2%*	*30.9%*	*25.7%*	*26.7%*	*25.7%*	*-1.0%*	*Favourable*	*27.2%*	*Better than sector ave*
4b	*% experiencing harassment, bullying or abuse from managers in the last 12 months*	*12.2%*	*9.6%*	*8.7%*	*7.9%*	*9.6%*	*1.7%*	*Unfavourable*	*11.6%*	*Better than sector ave*
4c	*% experiencing harassment, bullying or abuse from colleagues in the last 12 months*	*22.3%*	*19.7%*	*17.2%*	*17.6%*	*20.9%*	*3.3%*	*Unfavourable*	*18.9%*	*Worse than sector ave*
4d	% saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	66.9%	59.4%	61.2%	66.1%	58.4%	-7.7%	*Significantly Unfavourable*	61.7%	Worse than sector ave
5	% believing that the organisation provides equal opportunities for career progression or promotion.	Note: Due to changes in the question wording in 2025, previous years' results for WRES indicator 7 (Q15) are not reported				50.8%			52.2%	Worse than sector ave
6	*% who felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.*	*17.0%*	*16.2%*	*14.9%*	*15.9%*	*16.3%*	*0.4%*	*Unfavourable*	*18.3%*	Better than sector ave
7	% satisfied with the extent to which their organisation values their work	41.5%	49.9%	47.4%	45.7%	39.0%	-6.7%	*Significantly Unfavourable*	42.5%	Worse than sector ave
8	% saying employer has made reasonable adjustment(s) to enable them to carry out their work.	n/a	83.5%	86.5%	80.9%	88.0%	7.1%	Significantly Favourable	79.1%	Better than sector ave
9a	Staff engagement score (0-10)	6.76	6.81	6.90	6.69	6.60	-0.09	Unfavourable	6.64	Worse than sector ave

7.3 Sexual Orientation Equality Metrics; Lesbian Gay Bisexual Other+ (LGBO+) Summary

- The data is unweighted, and because this is not a national equality measure, sector comparisons aren't available.
- Higher levels of harassment and lower confidence in reporting.
- Persistent gaps in feeling valued and equal career opportunities.

Figure 6: Metrics for LGBO+ - Substantive Staff

LGBO+ (Lesbian, Gay, Bisexual, Other)	2024		2025		YoY 24/25	Diff 2025
Question	LGBO	Straight	LGBO	Straight	LGBO	LGBO vs SRT
% of staff who experienced at least one incident of harassment, bullying or abuse from: Patients / service users, their relatives or other members of the public.	25.8%	20.3%	30.6%	20.4%	4.8%	10.2%
% of staff who experienced at least one incident of harassment, bullying or abuse from: Managers.	4.9%	5.4%	5.1%	6.2%	0.2%	-1.1%
% of staff who experienced at least one incident of harassment, bullying or abuse from: Other colleagues.	18.8%	13.1%	14.1%	13.2%	-4.7%	0.9%
% of staff saying they, or a colleague, reported harassment, bullying or abuse.	59.7%	68.8%	57.4%	63.9%	-2.3%	-6.5%
% of staff who believe that their organisation provides equal opportunities for career progression / promotion.	54.4%	62.4%	59.5%	62.6%	5.1%	-3.1%
% of staff who have felt pressure from their manager to come to work despite not feeling well enough to perform duties.	61.7%	50.6%	59.9%	52.4%	-1.8%	7.5%
% of staff satisfied with the extent to which their organisation values their work.	47.5%	53.6%	46.2%	49.3%	-1.3%	-3.1%

7.4 Gender Identity Equality Metrics Summary

- This is the second year of comparable data for transgender staff. The data is unweighted, and because it is not a national equality measure, sector comparisons aren't available.
  Transgender staff report significantly poorer experiences across harassment, inclusion, career progression, wellbeing and feeling valued.

Figure 7: Metrics for Gender Identity – Substantive

Gender Identity Same as Birth - Yes/No (T- Transgender/C - Cisgender)	2024		2025		YoY 24/25	Diff 2025
Question	No - T	Yes - C	No - T	Yes - C	No - T	T vs C
% of staff who experienced at least one incident of harassment, bullying or abuse from: Patients / service users, their relatives or other members of the public.	35.7%	20.5%	33.3%	21.2%	-2.4%	12.1%
% of staff who experienced at least one incident of harassment, bullying or abuse from: Managers.	0.0%	5.3%	6.7%	6.0%	6.7%	0.7%
% of staff who experienced at least one incident of harassment, bullying or abuse from: Other colleagues.	14.3%	13.6%	26.7%	12.6%	12.4%	14.1%
% of staff saying they, or a colleague, reported harassment, bullying or abuse.	N/A	66.6%	N/A	62.4%	N/A	N/A
% of staff who believe that their organisation provides equal opportunities for career progression / promotion.	57.1%	61.4%	37.5%	60.2%	-19.6%	-22.7%
% of staff who have felt pressure from their manager to come to work despite not feeling well enough to perform duties.	50.0%	52.3%	62.5%	52.8%	12.5%	9.7%
% of staff satisfied with the extent to which their organisation values their work.	57.1%	52.2%	43.8%	49.4%	-13.3%	-5.6%

8. National Oversight Framework (NOF)

The NOF now uses three Staff Survey metrics; *raising concerns, engagement, and learning and development,* linking staff experience directly to national oversight. In 2025, most themes declined, with a couple below the benchmark average.

- *Raising Concerns*: declined (−0.17), reduced psychological safety and confidence to speak up
- *Engagement*: decreased (−0.10), mainly reduced by the Motivation sub theme (largest variance to benchmark average at −0.28, highlighted red in Figure 7).

Figure 8: National Oversight Framework (NOF) Metrics

	2024	2025	YoY	LYPFT Dif to Average	Average result 2025	Best result 2025	Note for NHS Oversight Framework (NOF)
PP3_2 Raising concerns (sub theme)	6.82	6.65	-0.17	0.01	6.64	7.26	Patient Safety domain, raising concerns
PP5_1 Development (sub theme)	6.68	6.57	-0.11	0.00	6.57	6.91	People & Workforce domain, learning
E Staff engagement	7.02	6.92	-0.10	-0.10	7.02	7.48	People & Workforce domain, Engagement
E_1 Motivation (sub theme)	6.89	6.78	-0.11	-0.28	7.06	7.35	People & Workforce domain, Engagement
E_2 Involvement (sub theme)	7.14	7.1	-0.04	0.07	7.03	7.33	People & Workforce domain, Engagement
E_3 Advocacy (sub theme)	7.02	6.9	-0.12	0.03	6.87	7.75	People & Workforce domain, Engagement

9. Volunteer Survey

The Volunteer Survey had a 41.7% response rate (53 of 127), up 11% from 2024. Results were mixed: seven measures improved and seven declined. The biggest improvement was a 7.42% rise in volunteers feeling valued, while the largest decline (-17.04%) related to how well the service responds to problems. Overall, volunteers feel appreciated but need stronger support when issues arise. These results have been shared with the Volunteer Team for action.

10. Intention Planning

Substantive results will be available to staff from 12 March 2026, with simplified outputs on ECHO.

Work is progressing across 70 Intention Plans, with timelines extended to ease pressure during ongoing strategic uncertainty. Services showing significant concern will be proactively escalated for targeted support. Initial findings have already been shared with Heads of Care Services.

Staffnet materials and Intention Plan guidance will be refreshed and aligned to the People Promise.

The refreshed People Plan is paused pending the Government's 10-Year NHS Workforce Plan but current priorities of leadership, wellbeing and inclusion remain in focus.

Relevant data is being shared through established governance routes (EDI Team, Quality Committee, Civility & Respect T&F Group, Wellbeing & Attendance Group, and Staff Networks) for coordinated action.

Bank Staff Survey findings will be shared with Bank Workforce Managers and progressed through the Bank Forum, supporting planning once national results are published in mid-April.

11. Conclusion

Substantive staff report worsening experiences across safety, wellbeing and engagement. Bank staff scores have improved, though should be treated cautiously. Volunteers feel more valued but need stronger support.

The strengthened national framework increases Board accountability for ensuring staff feedback leads to measurable improvement. The Trust's intention planning and governance structures provide a solid foundation, and work will continue through stronger engagement, clearer oversight and alignment with equality standards.

12. Recommendation

The Board of Directors is asked to:

- Receive and note the high-level 2025 National Staff Survey results.
- Acknowledge the strengthened national expectations for survey reporting and action planning.
- Recognise the requirement for full analysis of free-text feedback and key areas of dissatisfaction.
- Agree and ensure timely, published action plans that demonstrate improvement aligned to the NHS People Promise.
- Take assurance from the plan to share results across services and governance groups to support improvement planning.

Tracey Needham
Head of People Engagement
6 March 2026

Data Appendices

- Appendix 1 – 2025 National Staff Survey Data Sub and Bank
- Appendix 2 – NSS25 Results Briefing
- Appendix 3 – Slide deck NSS25 Results Briefing

Note: Total No. of RAG may no longer be represented visually in table due to Q changes

For percentage scores (%):
Unfavourable/favourable differences of 5% or more highlighted **red**/**green**. Unfavourable differences between 3% and 5% highlighted in **amber**.
For scale scores (0.0 to 10.0):
Unfavourable/favourable differences of 5.0 or more highlighted **red**/**green**. Unfavourable differences between 3.0 and 4.99 highlighted in **amber**

**LB = Measures where a lower score is better in italics and idenified with an asterisk (*).*
**1 Questions appear twice in reporting deck so RAG Colour Coded but not counted twice*

	Subs 2024	Subs 2025	Subs YoY	Bank 2024	Bank 2025	Bank YoY	Subs vs Bank 2025
	1	2	1	24	4	-20	Favourable vs Bank
	10	20	10	17	1	-16	Unfavourable vs Bank
	3	1	-2	5	39	34	
Number of respondents	1637	1504	-133	120	84	-36	n/a
Response Rate	49.5%	45.1%	-4.4%	23.8%	17.6%	-6.2%	n/a

National Staff Survey 2025
Leeds and York Partnership NHS Foundation Trust
Substantive staff is heat mapped against previous year using 'Weighted Data'
Bank staff 'Unweighted Data' is heat mapped against previous year using 'Unweighted Data'

			Substantive Staff - 2024 Weighted Data	Substantive Staff - 2025 Weighted Data	Substantive YoY Difference 2025 vs 2024	Bank Staff - 2024 Unweighted Data	Bank Staff - 2025 Unweighted Data	Bank YoY Difference 2024 vs 2025	Subs (weighted) versus Bank (unweighted) 2025
	Promise 1: We are compassionate and inclusive		**Subs 2024**	**Subs 2025**	**Subs YoY**	**Bank 2024**	**Bank 2025**	**Bank YoY**	**Subs vs Bank 2025**
	Sub	***Bank***	***Sub Score P1.1: Compassionate culture***	**2024**	**2025**	**YoY**	**2024**	**2025**	**YoY**	**2025**
	Q6a	Q8a	I feel that my role makes a difference to patients/service users. (Agree/Strongly Agree)	85.0%	84.6%	-0.4%	91.2%	92.3%	1.1%	-7.7%
NOF	Q25a	Q30a	Care of patients / service users is my organisation's top priority. (Agree/Strongly Agree)	79.5%	77.5%	-2.0%	89.2%	80.5%	-8.7%	-3.0%
	Q25b	Q30b	My organisation acts on concerns raised by patients/service users. (Agree/Strongly Agree)	75.5%	74.3%	-1.2%	77.3%	84.1%	6.8%	-9.8%
NOF	Q25c	Q30c	I would recommend my organisation as a place to work. (Agree/Strongly Agree)	67.0%	63.8%	-3.2%	78.3%	80.7%	2.4%	-16.9%
NOF	Q25d	Q30d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. (Agree/Strongly Agree)	64.5%	60.6%	-3.9%	70.0%	72.3%	2.3%	-11.7%
	Total Sub Score P1.1: Compassionate culture		**7.24**	**7.16**	**-0.08**	**7.67**	**7.74**	**0.07**	**-0.58**
	Sub	***Bank***	***Sub Score P1.2: Compassionate leadership***	**2024**	**2025**	**YoY**	**2024**	**2025**	**YoY**	**2025**
	Q9f	Q14f	My immediate manager…works together with me to come to an understanding of problems. (Agree/Strongly Agree)	77.9%	75.5%	-2.4%	54.7%	60.0%	5.3%	15.5%
	Q9g	Q14g	My immediate manager…is interested in listening to me when I describe challenges I face. (Agree/Strongly Agree)	79.7%	78.6%	-1.1%	55.6%	64.2%	8.6%	14.4%
	Q9h	Q14h	My immediate manager…cares about my concerns. (Agree/Strongly Agree)	78.6%	77.8%	-0.8%	57.4%	68.3%	10.9%	9.5%
	Q9i	Q14i	My immediate manager…takes effective action to help me with any problems I face. (Agree/Strongly Agree)	74.5%	73.7%	-0.8%	59.0%	66.7%	7.7%	7.0%
	Total Sub Score P1.2: Compassionate leadership		**7.58**	**7.53**	**-0.05**	**6.38**	**6.83**	**0.45**	**0.70**
	Sub	***Bank***	***Sub Score P1.3: Diversity and equality***	**2024**	**2025**	**YoY**	**2024**	**2025**	**YoY**	**2025**
	Q15	Q20	My organisations acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age. (Yes)	60.0%	57.7%	n/a	47.1%	51.2%	n/a	6.5%
**LB*	*Q16a*	*Q21a*	*In the last 12 months I have personally experienced discrimination at work from…patients/service users, their relatives or other members of the public. (Yes)*	*9.5%*	*8.5%*	*-1.1%*	*25.2%*	*33.7%*	*8.5%*	*-25.3%*

*LB	*Q16b*	*Q21b*	*In the last 12 months I have personally experienced discrimination at work from…manager/team leader or other colleagues. (Yes)*	*7.6%*	*6.7%*	*-0.9%*		*12.5%*	*8.8%*	*-3.8%*		*-2.1%*
	Q21	Q26	I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc). (Agree/Strongly Agree)	75.8%	72.8%	-3.1%		67.2%	83.1%	15.9%		-10.4%
	Total Sub Score P1.3: Diversity and equality			**8.51**	**8.53**	**0.02**		**7.39**	**7.55**	**0.16**		**0.98**
	Sub	***Bank***	***Sub Score P1.4: Inclusion***	**2024**	**2025**	**YoY**		**2024**	**2025**	**YoY**		**2025**
	Q7h	Q11f	I feel valued in my team. (Agree/Strongly Agree)	72.4%	70.1%	-2.3%		69.0%	68.7%	-0.3%		1.4%
	Q7i	Q11g	I feel a strong personal attachment to my team. (Agree/Strongly Agree)	61.0%	61.3%	0.3%		50.0%	55.4%	5.4%		5.8%
	Q8b	Q12b	The people I work with are understanding and kind to one another. (Agree/Strongly Agree)	76.0%	72.4%	-3.6%		61.5%	69.0%	7.5%		3.4%
	Q8c	Q12c	The people I work with are polite and treat each other with respect. (Agree/Strongly Agree)	76.8%	74.3%	-2.5%		63.2%	66.7%	3.5%		7.6%
	Total Sub Score P1.4: Inclusion			**6.97**	**6.93**	**-0.04**		**6.61**	**6.90**	**0.29**		**0.03**
	PROMISE 1: We are compassionate and inclusive Theme Score			**7.57**	**7.54**	**-0.03**		**7.01**	**7.23**	**0.22**		**0.31**
	Promise 2: We are recognised and rewarded			**Subs**	**Subs**	**Subs YoY**		**Bank**	**Bank**	**Bank YoY**		**Subs vs Bank**
	Sub	***Bank***	***We are recognised and rewarded***	**2024**	**2025**	**YoY**		**2024**	**2025**	**YoY**		**2025**
	Q4a	Q6a	I am satisfied with…the recognition I get for good work. (Statisfied/V.Satisfied)	62.1%	58.8%	-3.4%		56.7%	57.1%	0.4%		1.6%
	Q4b	Q6b	I am satisfied with…the extent to which the organisation values my work. (Statisfied/V.Satisfied)	51.4%	46.6%	-4.9%		48.7%	48.8%	0.1%		-2.3%
	Q4c	Q6c	I am satisfied with…my level of pay. (Statisfied/V.Satisfied)	37.8%	37.8%	0.0%		22.2%	32.5%	10.3%		5.2%
	Q8d	Q12d	The people I work with show appreciation to one another. (Agree/Strongly Agree)	70.2%	68.5%	-1.7%		60.7%	60.7%	0.0%		7.7%
	Q9e	Q14e	My immediate managers…values my work. (Agree/Strongly Agree)	79.0%	76.9%	-2.2%		62.9%	69.0%	6.1%		7.8%
	PROMISE 2: We are recognised and rewarded Theme Score			**6.34**	**6.25**	**-0.09**		**5.97**	**6.24**	**0.27**		**0.01**
	Promise 3: We each have a voice that counts			**Subs**	**Subs**	**Subs YoY**		**Bank**	**Bank**	**Bank YoY**		**Subs vs Bank**
	Sub	***Bank***	***Sub Score P3.1: Autonomy and control***	**2024**	**2025**	**YoY**		**2024**	**2025**	**YoY**		**2025**
	Q3a	Q5a	I always know what my work responsibilities are. (Agree/Strongly Agree)	82.6%	81.4%	-1.2%		84.6%	86.7%	2.1%		-5.3%
	Q3b	Q5b	I am trusted to do my job. (Agree/Strongly Agree)	90.2%	89.9%	-0.3%		87.3%	91.7%	4.4%		-1.8%
NOF	Q3c	Q5c	There are frequent opportunities for me to show initiative in my role. (Agree/Strongly Agree)	78.1%	77.9%	-0.2%		67.5%	76.5%	9.0%		1.4%
NOF	Q3d	Q5d	I am able to make suggestions to improve the work of my team/dept. (Agree/Strongly Agree)	77.6%	75.1%	-2.5%		62.2%	65.1%	2.9%		10.0%
	Q3e	Q5e	I am involved in deciding on changes introduced that affect my work area/team/dept. (Agree/Strongly Agree)	59.2%	56.6%	-2.6%		36.4%	34.9%	-1.5%		21.7%
NOF	Q3f	Q5f	I am able to make improvements happen in my area of work. (Agree/Strongly Agree)	61.7%	61.4%	-0.3%		41.4%	43.4%	2.0%		18.0%
	Q5b	Q7b	I have a choice in deciding how to do my work. (Often/Always)	63.9%	63.5%	-0.4%		37.6%	41.0%	3.4%		22.5%
	Total Sub Score P3.1: Autonomy and control			**7.19**	**7.14**	**-0.05**		**6.48**	**6.66**	**0.18**		**0.48**
	Sub	***Bank***	***Sub Score P3.2: Raising concerns***	**2024**	**2025**	**YoY**		**2024**	**2025**	**YoY**		**2025**
NOF	Q20a	Q25a	I would feel secure raising concerns about unsafe clinical practice. (Agree/Strongly Agree)	77.2%	73.5%	-3.7%		74.8%	72.3%	-2.5%		1.2%
NOF	Q20b	Q25b	I am confident that my organisation would address my concern. (Agree/Strongly Agree)	60.9%	59.1%	-1.8%		65.8%	69.9%	4.1%		-10.8%
NOF	Q25e	Q30e	I feel safe to speak up about anything that concerns me in this organisation. (Agree/Strongly Agree)	70.3%	66.0%	-4.3%		65.8%	68.7%	2.9%		-2.6%
NOF	Q25f	Q30f	If I spoke up about something that concerned me I am confident my organisation would address my concern. (Agree/Strongly Agree)	56.9%	54.1%	-2.8%		57.1%	62.7%	5.6%		-8.5%
	Total Sub Score P3.2: Raising concerns			**6.81**	**6.65**	**-0.16**		**6.90**	**6.97**	**0.07**		**-0.32**
	PROMISE 3: We each have a voice that counts Theme Score			**7.00**	**6.89**	**-0.11**		**6.68**	**6.82**	**0.14**		**0.07**
	Promise 4: We are safe and healthy			**Subs**	**Subs**	**Subs YoY**		**Bank**	**Bank**	**Bank YoY**		**Subs vs Bank**

	Sub	Bank	Sub Score P4:1 Health and safety climate	2024	2025	YoY	2024	2025	YoY	2025
	Q3g	Q5g	I am able to meet all the conflicting demands on my time at work. (Agree/Strongly Agree)	49.7%	46.2%	-3.5%	53.8%	63.4%	9.6%	-17.2%
	Q3h	Q5h	I have adequate materials, supplies and equipment to do my work. (Agree/Strongly Agree)	62.9%	59.7%	-3.2%	68.1%	70.4%	2.3%	-10.7%
	Q3i	Q5i	There are enough staff at this organisation for me to do my job properly. (Agree/Strongly Agree)	36.8%	35.2%	-1.7%	41.5%	42.2%	0.7%	-7.0%
	Q5a	Q7a	I never/rarely have unrealistic time pressures (Never/Rarely).	34.8%	35.1%	0.3%	43.7%	39.3%	-4.4%	-4.2%
	Q11a	Q16a	My organisation takes positive action on health and well-being. (Agree/Strongly Agree)	69.7%	63.9%	-5.8%	55.5%	63.4%	7.9%	0.5%
	Q13d	Q18d	The last time you experienced physical violence at work, did you or a colleague report it. (% Staff or Colleague who reported it and excludes DN/NA)	92.5%	90.5%	-2.1%	95.8%	94.3%	-1.5%	-3.8%
	Q14d	Q19d	The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it. (% Staff or Colleague who reported it and excludes DN/NA)	67.6%	63.5%	-4.1%	60.9%	71.4%	10.5%	-8.0%
	Total Sub Sc	***Total Sub score P4.1: Health and safety climate***		**6.02**	**5.81**	**-0.21**	**6.63**	**6.68**	**0.05**	**-0.87**

	Sub	Bank	Sub Score P4:2 Burnout	2024	2025	YoY	2024	2025	YoY	2025
*LB	Q12a	Q17a	How often, if at all, do you find your work emotionally exhausting? (Often/Always)	30.5%	33.8%	3.3%	19.3%	10.8%	-8.5%	22.9%
*LB	Q12b	Q17b	How often, if at all, do you feel burnt out because of your work? (Often/Always)	20.5%	25.6%	5.1%	13.3%	9.6%	-3.7%	15.9%
*LB	Q12c	Q17c	How often, if at all, does your work frustrate you? (Often/Always)	32.9%	34.5%	1.6%	14.2%	9.6%	-4.6%	24.9%
*LB	Q12d	Q17d	How often, if at all, are you exhausted at the thought of another day/shift at work? (Often/Always)	20.0%	24.8%	4.8%	13.3%	8.4%	-4.9%	16.4%
*LB	Q12e	Q17e	How often, if at all, do you feel worn out at the end of your working day/shift? (Often/Always)	33.6%	38.3%	4.7%	20.2%	14.5%	-5.7%	23.8%
*LB	Q12f	Q17f	How often, if at all, do you feel that every working hour is tiring for you? (Often/Always)	12.8%	16.2%	3.4%	9.2%	4.8%	-4.4%	11.3%
*LB	Q12g	Q17g	How often, if at all, do you not have enough energy for family and friends during leisure time? (Often/Always)	25.5%	27.6%	2.1%	20.0%	18.1%	-1.9%	9.6%
	Total Sub Score P4.2: Burnout			**5.37**	**5.19**	**-0.18**	**5.88**	**6.27**	**0.39**	**-1.08**

	Sub	Bank	Sub Score P4:3 Negative experiences	2024	2025	YoY	2024	2025	YoY	2025
*LB	Q11b	Q16b	Q11b In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? Examples may include back pain, neck or arm strains, and joint pain.? (Yes)	22.0%	31.9%	n/a	25.8%	20.5%	n/a	11.4%
*LB	Q11c	Q16c	During the last 12 months have you felt unwell as a result of work related stress? (Yes)	38.4%	39.3%	0.9%	29.2%	15.7%	-13.5%	23.7%
*LB	Q11d	Q16d	In the last three months have you ever come to work despite not feeling well enough to perform your duties? (Yes)	53.2%	54.8%	1.6%	27.5%	28.0%	0.5%	26.7%
*LB	Q13a	Q18a	In the last 12 months how many times have you personally experienced physical violence at work from…Patients / service users, their relatives or other members of the public (% staff saying they experienced at least one incident)	19.3%	17.0%	-2.3%	44.5%	46.4%	1.9%	-29.4%
*LB	Q13b	Q18b	In the last 12 months how many times have you personally experienced physical violence at work from…managers. (% staff saying they experienced at least one incident)	0.3%	0.2%	-0.2%	5.2%	3.7%	-1.5%	-3.5%
*LB	Q13c	Q18c	In the last 12 months how many times have you personally experienced physical violence at work from…other colleagues. (% staff saying they experienced at least one incident)	1.9%	1.1%	-0.8%	7.7%	7.4%	-0.3%	-6.3%
*LB	Q14a	Q19a	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...Patients / service users, their relatives or other members of the public. (% staff saying they experienced at least one incident)	23.2%	24.2%	1.0%	35.8%	48.8%	13.0%	-24.6%
*LB	Q14b	Q19b	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from…managers. (% staff saying they experienced at least one incident).	5.4%	6.6%	1.3%	6.7%	8.6%	1.9%	-2.0%

*LB	*Q14c*	*Q19c*	*In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from…other colleagues. (% staff saying they experienced at least one incident).*	*14.5%*	*14.1%*	*-0.4%*		*24.4%*	*24.4%*	*0.0%*	*-10.3%*
	Total Sub Score P4.3: Negative experiences			**8.04**	**8.03**	**-0.01**		**7.72**	**7.74**	**0.02**	**0.29**
	PROMISE 4: We are safe and healthy Theme Score			**6.47**	**6.34**	**-0.13**		**6.73**	**6.91**	**0.18**	**-0.57**
*LB	*Q17a*	*Q22a*	*In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? This may include offensive or inappropriate sexualised conversation (including jokes), touching or assault… From patients/service users, their relatives or other members of the public. (% staff saying they experienced at least one incident).*	*9.6%*	*11.0%*	*1.5%*		*15.1%*	14.3%	*-0.8%*	*-4.1%*
*LB	*Q17b*	*Q22b*	*In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? This may include offensive or inappropriate sexualised conversation (including jokes), touching or assault… From staff/colleagues. (% staff saying they experienced at least one incident).*	*3.8%*	*3.3%*	*-0.5%*		*7.7%*	8.5%	*0.8%*	*-4.4%*
	Q22	Q27	I can eat nutritious and affordable food while I am working. Please note, this could be food you buy or prepare yourself. (Often/Always).	57.5%	58.9%	1.4%		63.3%	57.8%	*-5.5%*	-4.4%
	Promise 5: We are always learning			**Subs**	**Subs**	**Subs YoY**		**Bank**	**Bank**	**Bank YoY**	**Subs vs Bank**
	Sub	***Bank***	***Sub Score P5.1: Development***	**2024**	**2025**	**YoY**		**2024**	**2025**	**YoY**	**2025**
NOF	Q24a	Q29a	This organisation offers me challenging work (Agree/Strongly Agree)	74.5%	73.5%	-0.9%		45.0%	50.0%	5.0%	23.5%
NOF	Q24b	Q29b	There are opportunities for me to develop my career in this organisation. (Agree/Strongly Agree)	55.4%	52.4%	-3.1%		41.2%	45.1%	3.9%	7.2%
NOF	Q24c	Q29c	I have opportunities to improve my knowledge and skills. (Agree/Strongly Agree)	75.2%	74.4%	-0.8%		56.8%	69.5%	12.7%	4.8%
NOF	Q24d	Q29d	I feel supported to develop my potential. (Agree/Strongly Agree)	63.4%	61.4%	-2.0%		39.2%	46.3%	7.1%	15.1%
NOF	Q24e	Q29e	I am able to access the right learning and development opportunities when I need to. (Agree/Strongly Agree)	65.5%	61.8%	-3.7%		51.7%	62.7%	11.0%	-0.9%
	Total Sub Score P5.1: Development			**6.67**	**6.57**	**-0.10**		**5.67**	**6.27**	**0.60**	**0.30**
	Q24f	Q29g	I am able to access clinical supervision opportunities when I need to	80.4%	79.3%	-1.1%		46.3%	55.1%	8.8%	24.2%
	Sub	***Bank***	***Sub Score P5.2: Appraisals***	**2024**	**2025**	**YoY**		**2024**	**2025**	**YoY**	**2025**
	Q23a	Q28	In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review. (Yes)	83.9%	88.9%	5.0%		23.5%	29.3%	5.8%	
	Q23b	na	It helped me to improve how I do my job. (Yes/definitely)	25.7%	24.7%	-1.1%					
	Q23c	na	It helped me agree clear objectives for my work. (Yes/definitely)	37.8%	36.7%	-1.1%					
	Q23d	na	It left me feeling that my work is valued by my organisation. (Yes/definitely)	31.2%	28.1%	-3.1%					
	Total Sub Score P5.2: Appraisals			**4.83**	**4.94**	**0.11**		**0.00**	**0.00**	**0.00**	**na**
	PROMISE 5: We are always learning Theme Score			**5.77**	**5.76**	**-0.01**		**5.67**	**6.27**	**0.60**	**na**
	Promise 6: We work flexibly			**Subs**	**Subs**	**Subs YoY**		**Bank**	**Bank**	**Bank YoY**	**Subs vs Bank**
	Sub	***Bank***	***Sub Score P6.1: Support for work-life balance***	**2024**	**2025**	**YoY**		**2024**	**2025**	**YoY**	**2025**
	Q6b	Q8b	My organisation is committed to helping me balance my work and home life. (Agree/Strongly Agree)	63.6%	63.8%	0.2%		61.7%	68.7%	7.0%	-4.9%
	Q6c	Q8c	I achieve a good balance between my work life and my home life. (Agree/Strongly Agree)	65.9%	64.8%	-1.1%		80.5%	84.3%	3.8%	-19.5%
	Q6d	na	I can approach my immediate manager to talk openly about flexible working. (Agree/Strongly Agree)	80.4%	81.4%	0.9%					

		Total Sub Score P6.1: Support for work-life balance	**6.97**	**6.98**	**0.01**		**7.01**	**7.44**	**0.43**		**-0.46**
	Sub	***Bank***	***Sub Score P6.2: Flexible working***	**2024**	**2025**	**YoY**		**2024**	**2025**	**YoY**		**2025**
	Q4d	na	I am satisfied with…the opportunities for flexible working patterns. (Satisfied/V.Satisfied)	72.7%	72.5%	-0.2%						
	Total Sub Score P6.2: Flexible working			**7.10**	**7.13**	**0.03**						**7.13**
	PROMISE 6: We work flexibly Theme Score			**7.04**	**7.05**	**0.01**		**7.01**	**7.44**	**0.43**		**-0.39**
	Promise 7: We are a team			**Subs**	**Subs**	**Subs YoY**		**Bank**	**Bank**	**Bank YoY**		**Subs vs Bank**
	Sub	***Bank***	***Sub Score P7.1: Team working***	**2024**	**2025**	**YoY**		**2024**	**2025**	**YoY**		**2025**
	Q7a	na	The team I work in has a set of shared objectives. (Agree/Strongly Agree)	74.1%	75.7%	1.6%						
	Q7b	na	The team I work in often meets to discuss the team's effectiveness. (Agree/Strongly Agree)	70.1%	68.1%	-2.0%						
	Q7c	Q11a	I receive the respect I deserve from my colleagues at work. (Agree/Strongly Agree)	73.5%	71.5%	-2.0%		69.5%	78.6%	9.1%		-7.0%
	Q7d	Q11b	Team members understand each other's roles. (Agree/Strongly Agree)	65.7%	63.7%	-2.0%		66.7%	76.2%	9.5%		-12.5%
	Q7e	Q11c	I enjoy working with the colleagues in my team. (Agree/Strongly Agree)	81.3%	79.1%	-2.2%		69.0%	73.5%	4.5%		5.6%
	Q7f	Q11d	My team has enough freedom in how to do its work. (Agree/Strongly Agree)	66.4%	63.2%	-3.2%		57.3%	56.6%	-0.7%		6.6%
	Q7g	Q11e	In my team disagreements are dealt with constructively. (Agree/Strongly Agree)	59.2%	58.2%	-1.1%		54.7%	55.4%	0.7%		2.7%
	Q8a	Q12a	Teams within this organisation work well together to achieve their objectives. (Agree/Strongly Agree)	51.5%	50.6%	-0.9%		61.5%	75.0%	13.5%		-24.5%
	Total Sub Score P7.1: Team working			**6.74**	**6.68**	**-0.06**		**6.74**	**6.96**	**0.22**		**-0.28**
	Sub	***Bank***	***Sub Score P7.2: Line management***	**2024**	**2025**	**YoY**		**2024**	**2025**	**YoY**		**2025**
	Q9a	Q14a	My immediate manager…encourages me at work. (Agree/Strongly Agree)	78.6%	77.1%	-1.5%		63.6%	69.9%	6.3%		7.2%
	Q9b	Q14b	My immediate manager…gives me clear feedback on my work. (Agree/Strongly Agree)	70.9%	70.5%	-0.4%		55.1%	58.5%	3.4%		11.9%
	Q9c	Q14c	My immediate manager…asks for my opinion before making decisions that affect my work. (Agree/Strongly Agree)	68.9%	68.6%	-0.3%		41.0%	47.6%	6.6%		21.0%
	Q9d	Q14d	My immediate manager…takes a positive interest in my health and well-being. (Agree/Strongly Agree)	79.5%	78.2%	-1.3%		57.9%	63.1%	5.2%		15.1%
	Total Sub Score P7.2: Line management			**7.38**	**7.35**	**-0.03**		**6.27**	**6.69**	**0.42**		**0.66**
	PROMISE 7: We are a team Theme Score			**7.06**	**7.02**	**-0.04**		**6.52**	**6.82**	**0.30**		**0.20**
	Measure: Staff Engagement			**Subs**	**Subs**	**Subs YoY**		**Bank**	**Bank**	**Bank YoY**		**Subs vs Bank**
	Sub	***Bank***	***Sub Score E.1: Motivation***	**2024**	**2025**	**YoY**		**2024**	**2025**	**YoY**		**2025**
NOF	Q2a	Q4a	I look forward to going to work. (Often/Always)	54.1%	51.7%	-2.4%		59.1%	65.4%	6.3%		-13.7%
NOF	Q2b	Q4b	I am enthusiastic about my job. (Often/Always)	69.0%	66.2%	-2.8%		65.5%	72.8%	7.3%		-6.6%
NOF	Q2c	Q4c	Time passes quickly when I am working. (Often/Always)	69.8%	68.2%	-1.7%		49.6%	64.6%	15.0%		3.5%
	Total Sub Score E1: Motivation			**6.89**	**6.78**	**-0.11**		**6.89**	**7.56**	**0.67**		**-0.78**
	Sub	***Bank***	***Sub Score E.2: Involvement***	**2024**	**2025**	**YoY**		**2024**	**2025**	**YoY**		**2025**
*1	Q3c	Q5c	There are frequent opportunities for me to show initiative in my role. (Agree/Strongly Agree)	78.1%	77.9%	-0.2%		67.5%	76.5%	9.0%		1.4%
*1	Q3d	Q5d	I am able to make suggestions to improve the work of my team/dept. (Bank 'Work we do') (Agree/Strongly Agree)	77.6%	75.1%	-2.5%		62.2%	65.1%	2.9%		10.0%
*1	Q3f	Q5f	I am able to make improvements happen in my area of work. (Agree/Strongly Agree)	61.7%	61.4%	-0.3%		41.4%	43.4%	2.0%		18.0%
	Total Sub Score E2: Involvement			**7.14**	**7.10**	**-0.04**		**6.31**	**6.47**	**0.16**		**0.63**
	Sub	***Bank***	***Sub Score E.3: Advocacy***	**2024**	**2025**	**YoY**		**2024**	**2025**	**YoY**		**2025**
*1	Q23a	Q30a	Care of patients/service users is my organisation's top priority. (Agree/Strongly Agree)	79.5%	77.5%	-2.0%		89.2%	80.5%	-8.7%		-3.0%

*1	Q23c	Q30c	I would recommend my organisation as a place to work. (Agree/Strongly Agree)	67.0%	63.8%	-3.2%		78.3%	80.7%	2.4%	-16.9%
*1	Q23d	Q30d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. (Agree/Strongly Agree)	64.5%	60.6%	-3.9%		70.0%	72.3%	2.3%	-11.7%
	Total Sub Score E3: Advocacy			**7.02**	**6.90**	**-0.12**		**7.51**	**7.57**	**0.06**	**-0.67**
	Staff Engagement: Engagement Theme Score			**7.01**	**6.92**	**-0.09**		**6.88**	**7.19**	**0.31**	**-0.27**
	Measure: Morale			**Subs**	**Subs**	**Subs YoY**		**Bank**	**Bank**	**Bank YoY**	**Subs vs Bank**
	Sub	***Bank***	***Sub Score M1: Thinking about leaving***	**2024**	**2025**	**YoY**		**2024**	**2025**	**YoY**	**2025**
*LB	*Q24a*	*na*	*I often think about leaving this organisation. (Agree/Strongly Agree)*	*27.0%*	*30.0%*	*3.1%*					*na*
*LB	*Q24b*	*na*	*I will probably look for a job at a new organisation in the next 12 mths. (Agree/Strongly Agree)*	*20.6%*	*22.9%*	*2.3%*					*na*
*LB	*Q24c*	*na*	*As soon as I can find another job, I will leave this organisation. (Agree/Strongly Agree)*	*13.6%*	*16.0%*	*2.5%*					*na*
	Total Sub Score M1: Thinking about leaving || Bank M1: Future Intentions			**6.25**	**6.10**	**-0.15**		**5.71**	**5.78**	**0.07**	**na**
	Sub	***Bank***	***Sub Score M2: Work pressure***	**2024**	**2025**	**YoY**		**2024**	**2025**	**YoY**	**2025**
*1	Q3g	Q5g	I am able to meet all the conflicting demands on my time at work. (Agree/Strongly Agree)	49.7%	46.2%	-3.5%		53.8%	63.4%	9.6%	-17.2%
*1	Q3h	Q5h	I have adequate materials, supplies and equipment to do my work. (Agree/Strongly Agree)	62.9%	59.7%	-3.2%		68.1%	70.4%	2.3%	-10.7%
*1	Q3i	Q5i	There are enough staff at this organisation for me to do my job properly. (Agree/Strongly Agree)	36.8%	35.2%	-1.7%		41.5%	42.2%	0.7%	-7.0%
	Total Sub Score M2: Work pressure			**5.64**	**5.41**	**-0.23**		**6.27**	**6.38**	**0.11**	**-0.97**
	Sub	***Bank***	***Sub Score M3: Stressors (HSE index)***	**2024**	**2025**	**YoY**		**2024**	**2025**	**YoY**	**2025**
*1	Q3a	Q5a	I always know what my work responsibilities are. (Agree/Strongly Agree)	82.6%	81.4%	-1.2%		84.6%	86.7%	2.1%	-5.3%
*1	Q3e	Q5e	I am involved in deciding on changes introduced that affect my work area/team/dept. (Agree/Strongly Agree)	59.2%	56.6%	-2.6%		36.4%	34.9%	-1.5%	21.7%
*1	Q5a	Q7a	I (never/rarely) have unrealistic time pressures. (never/rarely)	*34.8%*	35.1%	0.3%		43.7%	39.3%	-4.4%	-4.2%
*1	*Q5b*	*Q7b*	I have a choice in deciding how to do my work. (Often/Always)	63.9%	63.5%	-0.4%		37.6%	41.0%	3.4%	22.5%
*LB	*Q5c*	*Q7c*	*Relationships at work are (Never/Rarely) strained. (Never/Rarely)*	*52.1%*	*49.0%*	*-3.1%*		*47.0%*	*39.8%*	*-7.2%*	*9.2%*
*1	*Q7c*	*Q11a*	I receive the respect I deserve from my colleagues at work. (Agree/Strongly Agree)	73.5%	71.5%	-2.0%		69.5%	78.6%	9.1%	-7.0%
*1	*Q9a*	*Q14a*	My immediate manager…encourages me at work. (Agree/Strongly Agree)	78.6%	77.1%	-1.5%		63.6%	69.9%	6.3%	7.2%
	Total Sub Score M3: Stressors (HSE index)			**6.72**	**6.63**	**-0.09**		**6.35**	**6.47**	**0.12**	**0.16**
	Morale: Morale Theme Score			**6.20**	**6.05**	**-0.15**		**6.09**	**6.23**	**0.13**	**-0.18**
	Questions not included in People Promise themes			**2024**	**2025**	**YoY**		**2024**	**2025**	**YoY**	**2025**
	Q1	Q3	Do you have face-to-face, video or telephone contact with patients / service users as part of your job?	74.1%	73.1%	-1.1%		66.4%	72.6%	6.2%	0.5%
		Q1	Thinking about the bank work you do within this organisation, how often do you work in the same department or work area? By this we mean how often you work with the same people in the same part of the organisation (Often/Always)					79.9%	76.2%	-3.7%	
		Q9	I am able to decide the hours/shift pattern I want to work as a bank worker. (Often/Always).					82.1%	85.5%	3.4%	
*LB	*Q10b*	*na*	*On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?*	*24.7%*	*23.2%*	*-1.5%*					
*LB	*Q10c*	*na*	*On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?*	*49.4%*	*50.8%*	*1.4%*					

*LB	Q11e	Q16e	*Have you felt pressure from your 'manager' (Subs Q)/'organisation' (Bank Q - Yes Only) to come to work?*	*12.6%*	*14.8%*	*2.1%*		*42.4%*	*8.7%*	*-33.7%*		*6.1%*
*LB	Q16c.1	Q21C.1	*On what grounds have you experienced discrimination? – Age.*		*18.2%*	*n/a*			*0.0%*	*n/a*		*18.2%*
*LB	Q16c.2	Q21C.2	*On what grounds have you experienced discrimination? – Disability.*		*18.1%*	*n/a*			*0.0%*	*n/a*		*18.1%*
*LB	Q16c.3	Q21C.3	*On what grounds have you experienced discrimination? – Gender Reassignment*		1.5%	*n/a*			*0.0%*	*n/a*		*1.5%*
*LB	Q16c.4	Q21C.4	*On what grounds have you experienced discrimination? – Marriage & Civil Partnership*		0.0%	*n/a*			*0.0%*	*n/a*		*0.0%*
*LB	Q16c.5	Q21C.5	*On what grounds have you experienced discrimination? – Pregnancy & Maternity*		1.2%	*n/a*			*0.0%*	*n/a*		*1.2%*
*LB	Q16c.6	Q21C.6	*On what grounds have you experienced discrimination? – Race*		52.2%	*n/a*			*82.1%*	*n/a*		*-29.9%*
*LB	Q16c.7	Q21C.7	*On what grounds have you experienced discrimination? – Religion or Belief*		12.6%	*n/a*			*7.1%*	*n/a*		*5.5%*
*LB	Q16c.8	Q21C.8	*On what grounds have you experienced discrimination? – Sex*		19.3%	*n/a*			*7.1%*	*n/a*		*12.2%*
*LB	Q16c.9	Q21C.9	*On what grounds have you experienced discrimination? – Sexual Orientation*		7.9%	*n/a*			*0.0%*	*n/a*		*7.9%*
*LB	Q16c.10	Q21C.10	*On what grounds have you experienced discrimination? – Other*		16.9%	*n/a*			*14.3%*	*n/a*		*2.6%*
*LB	*Q18*	*Q23*	*In the last month, have you seen any errors, near misses, or incidents that could have hurt staff and / or patients / service users? (Yes)*	*30.8%*	*30.6%*	*-0.1%*		*27.6%*	*23.1%*	*-4.5%*		*7.5%*
	Q19a	Q24a	My organisation treats staff who are involved in an error, near miss or incident fairly.	*67.4%*	*64.2%*	*-3.2%*		*54.8%*	*58.5%*	*3.7%*		*5.7%*
	Q19b	Q24b	My organisation encourages us to report errors, near misses or incidents.	*88.4%*	*85.7%*	*-2.6%*		*79.5%*	*77.8%*	*-1.7%*		*8.0%*
	Q19c	Q24c	When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	*72.0%*	*70.2%*	*-1.8%*		*66.7%*	*72.4%*	*5.7%*		*-2.2%*
	Q19d	Q24d	We are given feedback about changes made in response to reported errors, near misses and incidents	63.6%	61.8%	-1.8%		52.4%	65.3%	12.9%		-3.6%
	Q26d.1		*If you are considering leaving your current job, what would be your most likely destination? - I would want to move to another job within this organisation.*	*14.5%*	*11.6%*	*-2.9%*						
	Q26d.2		*If you are considering leaving your current job, what would be your most likely destination? - I would want to move to another job in a different NHS Trust/organisation.*	*17.0%*	*15.9%*	*-1.1%*						
	Q26d.3		*If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job in healthcare, but outside the NHS.*	*3.4%*	*4.0%*	*0.6%*						
	Q26d.4		*If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job outside healthcare.*	*7.6%*	*8.1%*	*0.5%*						
*LB	*Q26d.5*		*If you are considering leaving your current job, what would be your most likely destination? - I would retire or take a career break.*	*7.9%*	*9.2%*	*1.3%*						
	Q26d.9		*If you are considering leaving your current job, what would be your most likely destination? - I am not considering leaving my current job.*	*49.6%*	*51.3%*	*1.7%*						
	Q31b	Q40b	Has your employer made reasonable adjustment(s) to enable you to carry out your work?	80.9%	*88.3%*	*7.4%*		*37.5%*	*50.0%*	12.5%		
	Bank Only Questions			**2024**	**2025**	**YoY**		**2024**	**2025**	**YoY**		**2025**
*1	na	Q29e	I am able to access the right learning and development opportunities when I need to. (Agree/Strongly Agree)					*51.7%*	*62.7%*	11.0%		
	na	Q29f	I can get the help and support I need if I have questions when I am at work. (Agree/Strongly Agree)					*56.3%*	*70.7%*	14.4%		

	na	Q32c	I feel supported by the bank team (such as receiving local and trust specific updates, hearing about new opportunities and general wellbeing support, etc.) (Agree/Strongly Agree)					61.3%	61.4%	*0.1%*		
	na	Q33	Which of the following best describes why you chose to work as a bank worker for the NHS? **HIGHEST SCORING QUESTION** - It offers flexible working arrangements / I am in control of the hours I work					62.5%	64.3%	*1.8%*		
	na	Q32a	It is easy to get hold of the bank team if I have a query. (Agree/Strongly agree)					69.2%	79.5%	*10.4%*		
	na	Q32b	When I contact the bank team with a query, I can quickly get the answers I need. (Agree/Strongly agree)					68.33%	67.47%	*-0.9%*		
*LB	na	*Q31a*	*In the next 12 months, I am planning/considering to Continuing to work on the bank at this organisation*					*75.8%*	78.6%	2.8%		
*LB	na	*Q31b*	*In the next 12 months, I am planning/considering to Continuing to do NHS bank work but not at this organisation*					*6.7%*	*7.1%*	0.4%		
	na	Q31c	In the next 12 months, I am planning/considering to Moving to a permanent contract at this organisation					28.3%	26.2%	-2.1%		
	na	*Q31d*	*In the next 12 months, I am planning/considering to Moving to a permanent contract at another NHS organisation*					*8.3%*	*10.7%*	2.4%		
*LB	na	*Q31e*	*In the next 12 months, I am planning/considering to Working in the NHS but paid by an external agency*					*0.8%*	*0.0%*	-0.8%		
	na	*Q31f*	*In the next 12 months, I am planning/considering to Moving to a job in healthcare, but outside the NHS*					*3.3%*	*1.2%*	-2.1%		
*LB	na	*Q31g*	*In the next 12 months, I am planning/considering to Moving to a job outside healthcare*					*2.5%*	*4.8%*	2.3%		
*LB	na	*Q31h*	*In the next 12 months, I am planning/considering to Taking a career break*					*1.7%*	0.0%	-1.7%		
*LB	na	*Q31i*	*In the next 12 months, I am planning/considering to Retiring*					*3.3%*	7.1%	3.8%		
*LB	na	*Q31j*	*In the next 12 months, I am planning/considering to Going into full time training or studying*					13.3%	8.3%	-5.0%		

Agenda item
18

Meeting of the Board of Directors

Paper title:	Chair's Report from the Mental Health Legislation Committee meeting on 10 February 2026
Date of meeting:	26 March 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.	✓

Committee details:	
Name of Committee:	Mental Health Legislation Committee
Date of Committee:	10 February 2026
Chaired by:	Kaneez Khan, 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 Committee considered issues escalated from the Mental Health Legislation Operational Steering Group regarding expired medical recommendations, which had resulted in delays in admitting service users to hospital. It noted the additional system pressures caused by the need to repeat Mental Health Act (MHA) assessments. The Committee reaffirmed that inpatient bed availability must not influence the completion of MHA assessments or applications and agreed that Approved Mental Health Professional processes would be reviewed to ensure adherence to this principle. It was further agreed that a review of existing data sources would be undertaken to determine whether delays in MHA assessments leading to lapsed medical recommendations were being systematically captured, and to better understand the frequency, impact, and underlying causes of such occurrences.	SR1, SR5, and SR7
The Committee received the Section 136 Monitoring Report for Q3 2025-26. It was assured that this report demonstrated a level of compliance with the three-hour target between a service user's admission and the start of their MHA assessment and was reassured that work was ongoing to improve this compliance further. It agreed that elements of this report would be incorporated into the Mental Health Legislation (MHL) Activity Report to ensure that the Committee could monitor developments in this area.	SR1 and SR7
The Committee received and discussed the Community Treatment Order (CTO) Extension Audit Report which found 17 cases of unlawful CTO extensions between January 2024 and November 2025 as there was no evidence that the extension examinations had been conducted in-person. The Committee noted that the affected patients had been discharged from the CTOs with duty of candour processes completed. It agreed that the following recommendations in the report should be implemented: • Introduction of a standardised process for recording CTO extension examinations. • Implementation of a mandatory Mental Health Legislation induction for all new and locum consultants, including CTO examination requirements. • Establishment of a quarterly sample audit of CTO extension documentation to monitor compliance with legislative and recording standards.	SR1, SR5 and SR7

ASSURE – specific areas of assurance received warranting mention to Board	
Issue	**Relates to BAF Risk**
The Committee formally endorsed the decisions made at the non-quorate Mental Health Legislation Committee meeting held on 4 November 2025.	N/A
The Committee received feedback from the Mental Health Act Managers (MHAMs) Forum. It noted that the ongoing “Paper Hearings” pilot continued to receive positive feedback from the MHAMs. The Committee noted that it was important for sufficient detail to be provided in the reports received for “Paper Hearings” to avoid unnecessary adjournments as there would be no opportunity for information to be added or clarified by Responsible Clinicians or Mental Health Nurses.	SR1, SR3, SR5, and SR7
The Committee received the Mental Health Legislation Activity Report for Q3 2025-26 and was assured that the plans in place were sufficient to ensure ongoing compliance with all Mental Health Legislation. The Committee discussed the two fundamentally defective detentions which had been recorded in the quarter and were reassured that the identification of these issues was demonstrative that internal checks and governance processes were working effectively. It noted that the scope of the MHL Activity Report had continually expanded over time and agreed to undertake a collective review of the current content of the report to identify areas which could be removed or streamlined to ensure an appropriate balance between comprehensive reporting, proportionality, and use of resource.	SR1, SR3, SR5, and SR7
The Committee was reassured on the process in place for using Section 136 Flex Beds as designated detention beds for acute patients in the event that there was insufficient inpatient capacity elsewhere. The Committee was reassured that although more service users had been detained to a flex bed using this process in recent months, that the average duration of detention in these beds had decreased.	SR1, SR5 and SR7
The Committee agreed that the Availability of Section 12 Approved Doctors report would be deferred to the May 2026 MHLC meeting as the Trust was awaiting data from the Adult Social Care Team in this area. It additionally noted that between October and December 2025 there were five escalations made to the Medical Director regarding the availability of a Section 12 appointed doctor as part of the approved process, one of which was stepped down.	SR1, SR5 and SR7
The Committee received a report which explored the current CTO data collected by the Trust. noted that the Trust’s CTO usage was slightly above the national average but aligned with comparable urban areas when demographic context was considered and discussed the continued overrepresentation of Black and minority ethnic males within the local CTO cohort. It was assured that current CTO practice appeared appropriate and concluded that a full deep dive would be disproportionate and unlikely to add value. The Committee agreed that a review would be undertaken to explore how existing CTO data	SR1, SR3, SR5, and SR7

could be presented in closer alignment with national statistics, and to consider future data collection needs relating to deprivation and area-based analysis to support effective monitoring going forward.	
The Committee noted and discussed the updated introduced by the Mental Health Act 2025 and the anticipated impact these changes would have on the Trust. It was assured that preparatory work was progressing where possible and that the MHL Team was being appropriately supported in the undertaking of this work. It was noted that an overview of the legislative changes and their substantive impact on the Trust would be presented to the Board of Directors at its Strategic Development meeting on 30 April 2026.	SR1, SR3, SR5, and SR7
The Committee reviewed the audit areas which had been identified in the Draft Strategic Internal Audit Report Plan for 2026-27 and confirmed that it was happy with the content of the plan as presented with no further areas to recommend for inclusion.	SR1, SR3, SR5, and SR7

REFER - Items to be referred to other Committees	
Issue	**Relates to BAF Risk**
The Committee agreed to feedback assurances to the Finance and Performance Committee who had raised issues with the reported 0% compliance rate for the three-hour target between a SU's admission and the commencement of their MHA assessment that: • the Trust was meeting the three-hour target in many instances; and • the MHL Committee would continue to monitor compliance with this target through the quarterly MHL Activity Report.	N/A

Recommendation

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

Agenda item
19

Meeting of the Board of Directors

Paper title:	Approval of a change to the Constitution
Date of meeting:	26 March 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

At the February 2026 Council of Governors meeting, the council approved an amendment to the Trust's constitution in relation to the quoracy rule for Council of Governors' meetings.

Under the current constitution, for Council meetings to be quorate at least one third of governors elected or appointed must be present, including a public governor, a carer governor, a service user governor, a staff governor and an appointed governor.

This requirement separated the service user and carer constituency into two constituencies, which does

not reflect the composition of the Council of Governors set out in the Trust's constitution (see table below). This has created challenges in meetings being quorate as there are only four seats for carer governors on the Council and there are often vacancies in those seats. For the last three meetings the Council has been dependent on a single carer governor being in attendance for the meetings to be quorate.

Extract from Annex 4 of the Trust's Constitution – Composition of Council of Governors

Elected Governors		
Constituency	**Area/ Class**	**Number of Governor Seats**
Public	Leeds	6
	York and North Yorkshire	1
	Rest of England and Wales	1
Service User and Carer	Service User Leeds	4
	Service User York and North Yorkshire	1
	Carer Leeds	3
	Carer York and North Yorkshire	1
	Service User and Carer Rest of United Kingdom	1
Staff	Clinical Staff Leeds and York & North Yorkshire	4
	Non-Clinical Staff Leeds and York & North Yorkshire	2
Appointed Governors		
Local Authority Governors		
City of York Council		1
Leeds City Council		1
Partner Organisation Governors		
Volition Leeds (mental health representative)		1
Volition Leeds (learning disability representative)		1
York Centre for Voluntary Services		1
Director for Children and Families Programme, West Yorkshire and Harrogate ICS		1

The Council of Governors agreed that the quoracy requirements should be updated to reflect the composition of the Council of Governors as set out in the Trust's constitution. It agreed to amend the Constitution (and therefore its Terms of Reference) to:

- At least one third of governors elected or appointed must be present, and must include a public governor, a service user or carer governor, a staff governor and an appointed governor.

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:

- consider and approve the proposed amendment to the Constitution
- Note that if agreed, this amendment would require retrospective approval by the membership at the Annual Members' Meeting in September 2026.