Leeds and York Partnership
NHS Foundation Trust

Public Meeting of the Board of Directors

will be held at 9.30am on Thursday 30 July 2026
Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR

Agenda

		LEAD	TIME
1	**Apologies for absence** (verbal)	MM	9.30am
2	**Declarations of interests and any declarations of conflicts of interest in any agenda item** (enclosure)	MM	-
3	**Minutes of the meeting held on 28 May 2026** (enclosure)	MM	-
4	**Matters arising** (verbal)	MM	-
5	**Actions outstanding from the public meetings of the Board of Directors** (enclosure)	MM	-
	Use of resource		
6	**Chief Executive's report** (enclosure)	SM	9.35am
7	**Annual Responsible Officer and Medical Revalidation Report** (enclosure)	WN	9.50am
8	**Report from the Chair of the Finance and Performance Committee for the meeting held on 27 July 2026** (to follow)	KW	10.10am
9	**Report from the Chief Financial Officer** (enclosure)	DH	10.15am
10	**Operational Priorities Update Report – Q1** (enclosure)	DH	10.25am
11	**Data Security & Protection Toolkit** (enclosure)	CH	10.35am
12	**Report of the Chief Operating Officer** (enclosure)	MD	10.45am
	Break		10.55am

Patient centred care			
13	**Report from the Chair of the Quality Committee for the meetings held on 11 June and 9 July 2026** (enclosure)	**FH**	**11.05am**
14	**Report from the Medical Director** (enclosure)	**CH**	**11.10am**
15	**Guardian of Safe Working Hours Annual Report and Q4 Update** (enclosure)	**LS**	**11.20am**
Workforce			
16	**Report from the Chair of the Workforce Committee for the meeting held on 18 June 2026** (enclosure)	**ZBS**	**11.35am**
17	**Report from the Director of People and Organisational Development** (enclosure)	**DS**	**11.45am**
	17.1 2025 NHS Staff Survey Trust-level Action Plan (enclosure)	**TN**	**11.55am**
Governance			
18	**Report from the Chair of the Audit Committee for the meeting held on 14 July 2026** (enclosure)	**MW**	**12.05pm**
19	**Board Assurance Framework** (enclosure)	**SM**	**12.15pm**
20	**Scheme of Delegation** (enclosure)	**SM**	**12.20pm**
21	**Use of Trust Seal** (verbal)	**MM**	**-**
22	**Any other business** (verbal)	**MM**	**12.25pm**

The next meeting of the Board will be held on Thursday 24 September 2026 at 9.30am
Inspire@2 room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR

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
Nichola Sanderson Director of Nursing and Professions	None.	None.	None.	None.	None.	None.	None.	None.

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Darren Skinner Director of People and Organisational Development	**Director** Skinner Consulting Ltd. **Director** Kenilworth Court Block D RTM Company Ltd.	None.	None.	None.	None.	None.	None.	None.

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NON-EXECUTIVE DIRECTORS								
Merran McRae Chair	**Director** Finnbo Ltd	None.	None.	None.	None.	None.	**Deputy Lieutenant** West Yorkshire Lieutenancy **Trustee** Yorkshire Sculpture Park	**Director** Finnbo Ltd
Zoe Burns-Shore Non-executive Director	**Executive Director for Customer Delivery** Money and Pensions Service	None.	None.	None.	None.	None.	None.	None.
Frances Healey Non-executive Director	None.	None.	None	**Trustee** The National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	None.	None.	**Visiting Professor** University of Leeds **Advisory Role and Peer Reviewer** Research studies and potential research studies related to patient safety	None.
Kaneez Khan Non-executive Director	**Director** Primrose Consultancy Yorkshire **Director** Leeds Faith Forum	None.	None.	None.	None.	None.	None.	None.
Lynne Mellor Non-executive Director	**Director** The Human Digital Collaborative Ltd.	None.	None.	None.	None.	None.	None.	None.

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

Public Board of Directors

Thursday 28 May 2026 at 09:30am

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

Board Members		**Apologies**
Mrs M McRae	Chair of the Trust	
Mrs Z Burns Shore	Non-Executive Director (Senior Independent Director)	
Mrs J Forster Adams	Chief Operating Officer	
Mrs D Hanwell	Chief Financial Officer and Deputy Chief Executive	
Professor F Healey	Non-Executive Director	
Dr C Hosker	Medical Director	
Ms K Khan MBE	Non-Executive Director	✓
Mrs Lynne Mellor	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
Miss Rose Cooper	Deputy Head of Corporate Governance
Ms Sally Higgins	Specialist Addictions Practitioner (for minute 26/050)
Ms Maria Preston	Clinical Team Manager (for minute 26/050)
Mr Jonathan Mitchell	Clinical Lead (for minute 26/050)
Ms Amanda Naylor	Service Manager (for minute 26/050)
Mrs Shereen Robinson	Freedom to Speak Up Guardian (for minute 26/069)

Three governors attended the meeting.

		Action
	Mrs McRae opened the public meeting at 09:30 and welcomed everyone.	
26/049	**Apologies for absence** (agenda item 1)	
	Apologies were received from Ms Kaneez Khan, Non-Executive Director. The meeting was quorate.	

26/050 **Sharing stories – A Hidden Team in a Hidden World** (agenda item 2)

Mrs McRae welcomed Ms Sally Higgins, Specialist Addictions Practitioner (Sex Worker Outreach Team), Ms Maria Preston, Clinical Team Manager, Mr Jonathan Mitchell, Clinical Lead and Ms Amanda Naylor, Service Manager.

Ms Higgins and Ms Preston provided the Board with a presentation regarding the Mental Health role that had been developed specifically working with sex workers to support them to access services. They introduced the Board to Forward Leeds which was a partnership organisation with Addiction Plus being the Trust element, which was primarily a drug treatment service but also provided specialised mental health support. Ms Preston gave an overview of partnerships within the system linked into the service, including the requirement for people to be a verified rough sleeper to get partnership support. They had identified that there was a gap within the service provision regarding sex workers, as most women experienced hidden homelessness, therefore were excluded from accessing services despite a clear need for specialist mental health support. The Sex Worker Outreach Team (SWOT) was launched in 2024 and provided support with complex needs, complex trauma, and unmet physical and mental health needs.

Ms Higgins provided an overview of her role noting she took internal clients from the SWOT team to provide them with mental health support. Her clients were predominantly women who she met around twice a week in person with the aim to work with them for a year to get them into structured treatment. She also undertook specialist psycho-social interventions, one off interventions, and had an advocacy role as well as providing onward referrals. She informed the Board that she also provided support to staff within the SWOT team as they had challenging roles due to the nature of the service, and provided opportunity for debriefs and case consultation. She had developed a well-being guide for staff to provide and promote support opportunities. She noted that the Street Outreach multidisciplinary team had been hugely helpful in providing wider support too.

The aim of the role was to remove barriers to services, allow clients to access services in a format that suited them and make trusted referrals to support onward access into services. She noted that many of the women had no previous history of accessing mental health services, therefore the ability to assess and advocate for them supported them to access secondary mental health services. The service also focused on making other services aware of the client group and how to access them, sometimes bypassing the usual routes.

They informed the Board that they had recently presented a poster at a conference, and showed the Board a video of the content, and an article that had been published about the service.

They provided an overview of the future for the role and the ongoing work to make the role permanent through demonstrating the impact on the service and outcomes, with an opportunity to develop the role further to meet wider needs of the clients.

Mrs McRae thanked the team and acknowledged that they were the voice of the service users and how positive it was to hear about the work they undertook. Mrs Burns Shore noted that the work showed a deep understanding of the needs of the client group and the removal of barriers to services was exceptional.

Miss Wilburn commented it was incredible to see the support for this vulnerable group of people and noted that the challenge was the stigmatisation of the group. Ms Higgins responded that there was a lot of misunderstanding of sex workers, people knew they were there and in the managed area, but negative views came from not knowing the detail and understanding the clients and the issues they faced. She added that there was an on street based police team who were supportive and helpful for the women, but part of the advocacy role was to try and reduce negative views. They were a visible population but were hidden to services with no representation or support from services, and no other role like it could be identified across the NHS.

Mr Skinner commended Ms Higgins on the staff wellbeing element of the service, and queried as a single handed practitioner, what was the resilience in team. Ms Preston noted that they were able to manage this amongst the team as they had built relationships within wider services and they would continue to work with others to develop the service further.

Prof Healey commented that the kindness shown to the client group was inspiring and that there may be an opportunity to use research support to demonstrate the value of the role and outcomes. She asked if there was flexibility in mainstream services regarding their service offer to meet needs of the client group. Ms Preston responded that if people could engage with mainstream services they would not end up in their situation, therefore there needed to be a bridge between the role and wider services as it was hard to transition people into other services.

Dr Munro thanked the team noting they should be incredibly proud of the service, and that sharing knowledge and details around this client group was so helpful. She added it was positive that there was a case being built for a permanent role as it would support the women to continue to access services and the opportunity for others to then access through word of mouth.

Mrs McRae reiterated thanks on behalf of the Board to all involved in the presentation and service.

	The Board of Directors **thanked** everyone for attending the meeting and sharing the work of the team.
26/051	**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.
26/052	**Minutes of the previous meeting held on 26 March 2026** (agenda item 4)
	The minutes of the meeting held on 26 March 2026 were **received** and **agreed** as an accurate record.
26/053	**Matters arising** (agenda item 5)
	There were no matters arising.
26/054	**Actions outstanding from the public meeting of the Board of Directors** (agenda item 6) Mrs McRae presented the action log which showed those actions previously agreed by the Board in relation to the public meetings, those that were completed and those that were still ongoing. It was noted that for action 37 regarding the working group for measures for priorities, an update would be provided at the meeting in July 2026. Action 43 was noted as completed as Hill Dickinson had provided the information required to confirm the quoracy arrangements for the Council of Governors were appropriate.
	The Board **received** the cumulative action log, **agreed** to close the actions that had been completed and **noted** the updates provided for ongoing actions.

26/055 **Report from the Chief Executive** (agenda item 7)

Dr Munro presented the Chief Executive's report, taking the content as read. She highlighted the ongoing wait for the CQC inspection report, however in the past week the Trust had received draft reports for older adults and acute inpatient services, and they were going through accuracy checks. The initial feedback from CQC regarding the Well Led inspection was noted and it was unlikely that the Trust would receive a draft report soon.

The SEND inspection was noted with the service provision predominantly in Leeds Community Healthcare NHS Trust (LCH), and the draft report was out for accuracy checks, with the City Council and ICB leading on the collation of the response.

She noted that Trusts had been advised the new National Oversight Framework (NOF) would be published but it had been delayed due to a change in the Secretary of State. In the meantime, a call had been held with the CEO of NHS England to confirm that operational priorities continued.

She noted the session Board members had undertaken as the start of the cultural change programme for the integration programme, and that the feedback from NHS England regarding the Strategic Outline Case was still awaited.

There was an event scheduled for 3 July 2026 for the Leeds Provider Partnership work to share the plans for the shadow Joint Committee and responding to the changes of the ICB.

She highlighted the Reasons to be Proud section, including the apprenticeship programme which was going from strength to strength, the chaplaincy service events and the teams and individuals of the month.

Mrs McRae queried if there were further details regarding the Joint Committee details, and Dr Munro responded that in the future there would be a requirement to agree representation of Chairs and Non-Executive Directors before full delegated authority was agreed, however it was being worked through currently therefore a smaller group was in place currently to review the requirements of the group for decision making arrangements and devolved responsibility.

Mrs McRae thanked Dr Munro for the report.

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

26/056	**Report from the Chair of the Finance and Performance Committee for the meetings held on 28 April and 26 May 2026** (agenda item 8) Miss Wilburn presented the Chair's reports from the Finance and Performance Committee meetings taking them as read. She focused on the meeting in May 2026, noting that there were no areas to alert the Board to. She advised that the Committee had received the month one position, which was a balanced plan but due to significant non-recurrent benefits. It was noted that if the Out of Area Placement (OAP) position remained the same for the year then there would be no further non-recurrent options, therefore it needed to be rectified. She highlighted that overtime and agency rates were performing better than the previous year but remained an area of focus alongside bank use. The Committee had discussed the metrics that may be used to understand the detail. She noted that, in relation to length of stay data, the metric within the NoF currently only showed those patients discharged therefore discussion had taken place regarding other metrics that may help to understand the position more given the impact on patient flow and OAPs. Mrs McRae queried the data reviewed at Workforce Committee regarding bank usage, and Mrs Burns Short confirmed the Committees were not duplicating the discussions as they looked at different elements of bank use, however a more consolidated discussion may be helpful to link it all together. It was agreed that bank usage, and a triangulated update from all Committees and work programmes, would be on the agenda for a Board Strategic Session. Mrs McRae thanked Miss Wilburn for the report. The Board of Directors **received** the Chair's report from the Finance and Performance Committee and **noted** the matters reported on.	**CE**
26/057	**Report from the Chief Financial Officer** (agenda item 9) Mrs Hanwell presented the report, taking the content as read. She noted that the first section provided detail of the 2025/26 outturn position and that the Trust delivered the financial position. However, there were two areas not achieved which were OAPs and bank usage so they would be the focus for 2026/27. She noted that the budget Cost Improvement Programmes (CIP) had been rolled into 2026/27 too. She highlighted that in 2026/27 serious interventions had been put in place to manage the OAPs position, and whilst the position was over plan, last year had ended in a higher than anticipated position. She noted that this had	

impacted on the month one position, along with bank expenditure, and there was a need to consider mitigations through the year and focus on recurrent efficiency targets to make budget and run rates more aligned.

Mr Wright acknowledged the month one position, however the move from budget base to run rate base was complicated, but he was pleased to see that the report showed a more unitary way of measuring the position would be a good focus. Dr Munro noted that the regional position for North East, Yorkshire and Humber was £40m adverse to plan, and there had been a 6.6% workforce growth which would influence the line of interrogation. Mrs Hanwell added that workforce growth and recurrent CIP efficiencies would be the focus for all organisations and there would be no financial mitigation for the upcoming industrial action which would increase the pressure.

Mrs McRae thanked Mrs Hanwell for the update provided.

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

26/058 **Operational Priorities Update Report – Q4** (agenda item 10)

Mrs Hanwell presented the report, taking the content as read, and noting it had been discussed in detail at Finance and Performance Committee. She highlighted the challenge regarding language and expectations of the priorities in the Committee discussion, therefore a correlation of milestones and headline priorities would be considered for the setting of the priorities for 2026/27. She noted that several priorities were multi-year and complex so would be carried over, and the first report would be presented to the Board of Directors in July 2026. She also noted the query at Finance and Performance Committee regarding the alert status of the priorities so consideration would be given to how this was described and communicated moving forward. Miss Wilburn added that the discussion had been about whether the progress update reflected the position fully, and that there was a balance between achieving milestones and the stretch needed to fully address the issue. The challenge was around setting milestones to deliver stretch for 2026/27, which Mrs Hanwell confirmed would be reflected in the Q1 update report.

Prof Healey queried the priorities from last year that were not on the 2026/27 plan but had only completed the first stage of work, and still felt important, therefore was there a gap on where they were being held and embedded. Mrs Hanwell referred to the discussion regarding the quality dashboard when reviewing he 2026/27 priorities, and whilst she was confident it was being embedded, she appreciated that there was a visibility issue. This had been the challenge from the Executive Directors too therefore it was being reviewed. Mrs McRae acknowledged that some areas would become

business as usual, but there was a concern that there would be some drift if areas were not a priority. Dr Munro confirmed that this had been acknowledged and was the reason a review was to take place.

Mr Wright commented that the focus needed to be on milestones and ensuring that they demonstrated effective outcomes delivered therefore these would be reviewed when presented in Q1. Mrs Mellor added that understanding the critical path of the milestones would be helpful. Mrs Hanwell responded these points would be addressed in the July report to Board, which would be reviewed by the Executive Management Team (EMT) ahead of presenting to the Board.

Mrs McRae thanked Mrs Hanwell for the update provided.

The Board **received** the Operational Priorities report and **noted** the content.

26/059 **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 provided an update regarding the company that had been commissioned to undertake diagnostic work to eliminate the OAP position, who had presented to EMT that week and the proposed use of data analytics to identify areas of improvement was helpful and would form the basis of the Board Strategic Session in June 2026.

She noted that the report included actions taken to provide assurance on performance positions, and that length of stay data for Committees would be considered along with appropriate reporting into Board.

She highlighted the positive position regarding the Eating Disorder and the Enhanced Therapeutic Observations of Care.

Mrs McRae queried the procurement of a block contract for PICU beds and the impact this had on cost. Mrs Forster Adams responded that it provided appropriate quality of care but did not meet financial requirements.

Mr Wright referred to the point regarding length of stay data which was a key area of focus for the Trust, and that the statistics received at Committee and Board level were limited therefore wider analysis was needed, including potential benchmarking data to understand comparisons to other Trusts. There was a need for need for clearer understanding around the interpretation of service users being ‘ready for discharge’ and the wider issue regarding the structure of service position and the connection to length of stay. Prof Healey referenced the discussion at Quality Committee regarding the change in clinical model required in the Older Adults service, and Dr Hosker responded

that he agreed with the points raised and the benchmarking approach, and that culture around interfacing services needed to be an area of focus along with preventing people being admitted to hospital. He noted that there may be an increase in length of stay whilst the improvements were made. In relation to the changes to clinical models, he commented that there needed to be radical change in how services were provided, and a plan to focus on culture around how people worked. Miss Sanderson noted that there was a need to acknowledge that it was multi-faceted and the high-level feedback from the CQC regarding care planning and documentation and the impact on length of stay. There was work to do around understanding the grip and oversight of care delivered to improve this. Mrs McRae noted that the next Board Strategic day focused on flow and OAP therefore would provide an opportunity for longer debate. Mrs Hanwell added that model hospital data was available to show benchmarking and the Trust was an outlier, but there was a debate about front end admission avoidance, and this would be discussed in the strategic session.

Mrs Burns Shore queried the reduction in staff within the Connect service, and Miss Sanderson responded that it was linked to the risks from the patient group being different to other inpatient areas therefore it was not possible to 'lift and shift' the approach due to the presenting needs of service users.

Mrs Mellor noted it was a clear report and referenced the discussion at Finance and Performance Committee regarding the percentage of patients in crisis and management of team reviews. She also commented on how the Estate Strategy and PFI approach could support service delivery. Mrs Forster Adams recognised the work taking place at a city level regarding the crisis service transformation and the Trust was committed to partnership working to consider the offer. She noted that information would be considered as to how to support people as an alternative to hospital admission and there would need to be an increase in responsiveness within services and more proactive approaches to deliver this. Mrs Hanwell added that some of the Trust buildings did not naturally lend themselves to the service ambition, but this would need to be considered in terms of how this was approached and the ability to utilise the estate and freedoms to act financially.

Mrs McRae thanked Mrs Forster Adams for the update.

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

26/060 **EPRR Annual Report** (agenda item 11.1)

Mrs Forster Adams noted that all three EPRR documents required Board review and approval as per governance processes.

	The Finance and Performance Committee had reviewed the annual report in April 2026 and since then slight amendments had been made due to partnership working with Leeds Community Healthcare NHS Trust (LCH). The report articulated the areas of focus for the year, and she noted that the process was tried and tested and good progress had been made. Prof Healey noted it was a good assurance report for the Board and noted that Mental Health Trusts had a different role within public emergences, which included a decontamination role which was a nationally prescribed approach. Mrs Forster Adams noted that there was a need for the Trust to increase familiarity with this role to ensure awareness throughout the Trust about the role. Mrs Burns Shore queried if business continuity was used to get an increased response to needing support, and Mrs Forster Admas responded it provided a discipline and framework to allow progress to be made in some areas which was a good position.
	The Board **received** the EPPR Annual Report and **approved** the content.
26/061	**EPRR & Business Continuity Policy** (agenda item 11.2)
	The Board **received** the EPPR & Business Continuity Policy and **approved** the content.
26/062	**EPRR Board Assurance Statement** (agenda item 11.3) Mr Wright noted the internal audit regarding EPRR had provided significant assurance which was helpful to note in the context of the Board approving the statement.
	The Board **received** the EPPR Board Assurance Statement and **approved** the content.
26/063	**Report from the Chair of the Quality Committee for the meetings held on 9 April and 14 May 2026** (agenda item 12) Dr Healey presented the Chair's Report from the Quality Committee meetings, taking them as read. She noted that the Annual Service Reports were a good summary of the services position before Non-Executive

	Directors and Governors attended learning visits, therefore they would be shared ahead of service visits for background reading. She noted the approval of the Quality Account which would be presented to the Extraordinary Board meeting in June 2026. The Committee reviewed the staff survey results linking to quality of care to patients, and received an update on outcome measures and the change regarding portal feedback which would need to be aligned to the NHS app. She also noted the Committee had received the CQC preliminary letters and reports, and noted the learning for ongoing assurance papers through the Committee. In relation to OAPs, the Committee would continue to review the quality element of the placements. Mrs McRae referred to the lived experience and coproduction discussion at the April meeting and queried the clarity for services on how to engage and access tools to use for involvement. Miss Sanderson commented that there was an opportunity to review approaches as part of the remuneration review of service users. Mrs McRae thanked Dr Healey for the reports.
	The Board of Directors **received** the Chair's reports from the Quality Committee and **noted** the matters reported on.
26/064	**Quality Committee Terms of Reference** (agenda item 12.1)
	The Board of Directors **noted** and **approved** the Quality Committee Terms of Reference.
26/065	**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 that the Service User Network was nominated for the awards within West Yorkshire due to the work they undertake which was positive to note. She referenced the internal audit regarding service user remuneration for involvement and noted that the payment policy would be reviewed as the findings noted that the service users would be entitled for employment which would impact on benefits. Work had therefore paused to understand how to ensure the Trust were looking after service users and lived experience partners, and that they were not negatively impacted through the remuneration process. She noted that the preferred outcome would go to the

Extended EMT meeting in June for approval, and it would provide opportunity to engage with service users and services regarding options for co-production.

She assured the Board regarding the introduction of the risk assessment tool and the positive impact this had had due to its successful implementation, and it would be used through the Culture of Care work to share learning more widely outside of the organisation.

She informed the Board that the flu vaccine campaign ended in March 2026 and the uptake number was lower than was desired as the Trust did not achieve the 5% national increase. The Datix Project Board was noted to be in place with LCH as part of the integration programme and would include engagement with users of the system to build a system that was useful and meaningful moving forward.

She alerted the Board to the previous decision not to use telecare and to focus on clinical engagement as this was the preferred option. The Trust would continue to work on the initial feedback from the CQC in relation to inspections and factual accuracy checks for the reports received to date. Mrs McRae queried if the telecare issue was only noted through the national alert, and Miss Sanderson confirmed that as the devices were not used across all services the issue with them not being updated was not a concern for the Trust.

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

26/066 **Safer Staffing Report** (agenda item 13.1)

Miss Sanderson presented the report taking it at read by the Board. She noted that there were no episodes of shifts without a registered nurse and the vacancies for Healthcare Support Workers remained a high proportion of the reason for bank use. She noted that the registered nurse vacancies should be filled through the preceptorship programme, however there would be some preceptees who would not be offered a post due to the number of vacancies, but the Trust would continue to work with them to consider options.

She highlighted that last year saw a reduction in the use of bank staff however the target of reducing use by 10% did not flow into the financial position, but this was due to the acuity of those service users that the bank shifts were used for. Mrs Hanwell added that the distinction between reducing bank spend and the utilisation of bank was important to note.

Mr Wright referenced the public question to Board a few months ago regarding students and the roles offered at the end of the course and the current position. Miss Sanderson noted that the individual involved had extended their training in which time the offer had been changed, however they continued their placements currently. She noted that the options had been considered to ensure they were as fair as possible in the allocation of roles. Mr Wright commented that as there was no growth in workforce the messaging to those in training needed to be balanced and realistic. Dr Munro noted that the national workforce strategy was delayed but expected at some point, and the NHS 10 year plan noted that the workforce would be lower at the end of the 10 years due to use of technology and other initiatives. However, the match for supply and demand of workforce had always been challenging and historically newly qualified staff had been able to choose roles, and grade drift had also occurred to improve recruitment, therefore a consistent approach was needed. Mr Skinner confirmed that engagement too place to showcase roles to students to support employment opportunities.

Mrs McRae thanked Miss Sanderson for the report.

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

26/067 **Violence Prevention Reduction Self-Assessment Standard** (agenda item 14)

Miss Sanderson presented the report taking it at read by the Board. She noted that the version 2 standards were introduced in 2024 and a Task and Finish Group had been put in place to map the Trust position against the domains. She highlighted work had not progressed as would have been expected therefore rigour around the governance processes and escalation needed to be improved and would be the focus for the next 6 months. The Task and Finish Group would lead on this and work would be done in July to provide assurance on the delivery of the standards.

Prof Healey noted the work that had been done to understand the split between patients and staff affected by violence and aggression, and that this could now be done, therefore it would be possible to track improvements for both groups. She also noted the self-harm prevention audit led by Health and Safety, however clinical involvement in this was important therefore this needed to be reviewed by Quality Committee too. Miss Sanderson responded that the work would be overseen by the Nursing and Professions Council and through to Quality Committee.

The Board endorsed the plan and the continuation of the workstream. Mrs McRae thanked Miss Sanderson for the report.

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

26/068 **Leeds Gender Identity Service's Response to the Levy Report** (agenda item 15)

Dr Hosker presented the report taking it at read by the Board. He reminded the Board that the Levy Report was a national report for all gender clinics and it had produced local reports which identified some areas for improvement within the service. Services were asked to produce improvement plans, and the paper addressed the key lines of enquiry and whether they were applicable to the service, and the intended response. The overall approach would link to the National Board and oversight plan.

Prof Healey queried the ongoing oversight for the report and work required, and Dr Hosker responded that most of the work linked into the national improvement plan and oversight sat there along with Trust links into the national oversight lead who met regularly with him and Dr Munro. Mrs McRae commented that the report noted the sponsorship needed by Board for improvement work and queried what the ask was. Dr Hosker responded that the national expectation was for work to go through Boards, but the Trust preference would be for updates via the Medical Director directorate reports. The National Board meeting would take place in June and would outline expectations and requirements which would then be considered. The Board agreed for the updates to be a subset of the Medical Director directorate report, but any additional actions or escalations to alert the Board to needed to be highlighted. Dr Munro added that Dr Hosker was the designated Board member lead for the work, and there was a need to be mindful of the scrutiny the services were under and how this was managed nationally alongside the political context.

Mrs Hanwell noted the link to national concerns regarding service provision and that the report suggested a push for funding, and Dr Hosker commented that this would need further discussion across the Executive Directors.

Miss Wilburn reflected on the Gender Service team feedback to Board previously, and that it was unclear on the impact of the recommendations on the service and how helpful they were. Dr Hosker noted that there was a need to consider how to implement the recommendations within the financial constraints, however some recommendations were helpful for wider consideration of service delivery.

Mrs McRae highlighted that the main recommendation for Board was to be assured that the service was engaged with the national approach, and that

Board would be sighted on any material escalations. She also noted the point regarding administrative resource shortfall, which the Board acknowledged but noted that the service needed to review how to address that. Mrs Forster Adams noted that the cover paper specifically highlighted administrative resource issues, but she was not clear on the detail despite it being highlighted for Board attention as there were no administrative vacancies and additional resource had put in. Dr Hosker acknowledged that AI would take some of the administrative burden away, but there was a need to review in entirety and discuss further. Mrs McRae noted that the Board acknowledged that a wider EMT discussion would take place with escalation and updates to be provided via the Medical Director directorate report. She thanked Dr Hosker for the report.

The Board of Directors **received** the Leeds Gender Identity Service's Response to the Levy Report and **noted** the content.

26/069 **Freedom to Speak Up Guardian Report** (agenda item 16)

Mrs Robinson presented the report taking it at read by the Board. She highlighted key points including the increase in activity with 76 concerns which, whilst welcomed as part of the speak up culture, did reflect the national climate and ongoing workforce pressures. Most concerns related to people or culture issues and had all been followed up. Inappropriate behaviours was a high theme nationally, so the Trust was in line with the national trend and not an outlier.

She noted the targeted interventions that had taken place as part of the collective concerns raised as these had increased, and Organisational Development support and service actions plans had been put in place to address them. The administrative review work had led to colleagues feeling more pressure linked to different ways of working and how this was communicated and discussed with staff. Mrs Robinson noted she was mindful of the need to triangulate the concerns with other data, such as staff survey results, to identify key areas of focus.

She highlighted that five more ambassadors had been recruited, which had been a Board focus, and would mean increased visibility and local support. She thanked communications colleagues who had supported the campaign.

She noted the ask to update the Board on training, and although it had doubled there was still a low uptake, therefore she was working with colleagues to increase uptake. It had been included in the 360 manager training and induction, and was being publicised widely.

She noted the actions for the next six months which included triangulating concerns with the staff survey results to understand the increase in contacts, reducing the time for actions to be taken following concerns being raised whilst acknowledging the complexity of concerns, and continuing to work with staff networks and Equality, Diversity and Inclusion colleagues regarding discrimination and inappropriate behaviours.

Mrs Robinson shared stories of successful outcomes for learning and improvement, including improvements in experiences for preceptees.

Mrs Burns Shore noted that, in her role as Senior Independent Director, she had met with Mrs Robinson and identified that three quarters of contacts could go straight to line managers, so work was being done to understand why this was not being addressed at that level.

Mrs Mellor commented that through the integration programme work with there was an opportunity for triangulation of data and a need to include the Guardian role within the cultural change programme, as it would be vital to understand how to support staff. Mrs Robinson noted that the Guardians were meeting regularly and were working together to consider how to streamline processes, including culture and opportunities for learning.

In relation to the administrative staff concerns, Mrs Forster Adams commented that in care services they were being asked to work very differently, and this would impact on how clinical colleagues worked, therefore there was a need to think about how they were supported through the changes as they were significant. It was acknowledged that managing change and communicating this with staff was key.

Mr Wright asked if queries had been raised regarding the integration with LCH and job security. Mrs Robinson noted she had seen some raised and had signposted colleagues back to the communication that had been circulated and line managers. Some colleagues wanted to know the detail, but it was not available yet, so she was mindful of the uncertainty of change, but it was more about perception currently so there was a need to provide reassurance.

Mrs McRae noted the Board responsibilities for the Freedom to Speak Up Guardian role, and expressed thanks to Mr Cleveland in his role and Senior Independent Director, and Mrs Burns Shore for now taking this on.

She thanked Mrs Robinson for the report.

The Board of Directors **received** and **noted** the report from the Freedom to Speak Up Guardian.

26/070	**Report from the Chair of the Workforce Committee for the meeting held on 16 April 2026** (agenda item 17) Mrs Burns Shore presented the report taking it at read by the Board noting the discussions had covered many points. She highlighted the low levels of mandatory training for medical staff and that a further update would be provided at the next meeting, although this was balanced with an improvement in the job planning position. There was a continued focus on sickness with further review to take place. Dr Hosker noted that there was a need to understand the detail behind the consultant training position as 59% of doctors had done all of their training. Mrs McRae commented that there was a need to understand whether it was a reporting issue, and where there was potential for a quality issue. Mr Wright noted the positive progress with job planning but queried the assurance on the quality of the job plans that were submitted. Dr Hosker responded that there had been an internal audit on job plans and this would be the next area of focus with updates provided through Workforce Committee. He noted that the use of the digital system would make the review of quality easier. Mrs McRae thanked Mrs Burns Shore for the report. The Board of Directors **received** and **noted** the Report from the Chair of the Workforce Committee.
26/071	**Report from the Chair of the Mental Health Legislation Committee for the meeting held on 12 May 2026** (agenda item 18) Miss Wilburn presented the report taking it as read by the Board. She noted that there were no areas for alert and highlighted the discussion regarding the S135 processes which the Committee would monitor. The Committee were also reviewing defective detentions which were related to documentation issues not inappropriate detentions, and this would continue to be monitored. She noted the issue raised on behalf of the Mental Health Act Managers regarding parking issues for the managers when attending hearings in person, and that the concerns were noted and would be discussed through appropriate governance routes. Mrs McRae queried the issue escalated to EMT regarding systematic data collection issues, and Dr Munro responded that this would be reviewed and considered as appropriate. Mrs McRae thanked Miss Wilburn for the report

	The Board of Directors **received** and **noted** the Report from the Chair of the Mental Health Legislation Committee.
26/072	**Report from the Chair of the Audit Committee for the meeting held on 14 April 2026** (agenda item 18) Mr Wright presented the report taking it as read by the Board and acknowledging the attendance of governors at the Committee meeting. He noted that the Extraordinary Audit Committee in June would include the accounts and external audit report approval, and to date no issues had been referred through to the Committee. He informed the Board that the external auditors, KPMG, had been chosen by the national audit office to provide more detail around the work that they had undertaken which had led to the need for additional information to be submitted. It was noted that this would also come at a financial cost to the Trust. He thanked all Committee Chairs for their support in the agreement of the internal audit plan for 2026/27. He noted that the last three audit reports had achieved significant assurance which was a positive position for the Head of Internal Audit opinion report. Mrs McRae thanked Mr Wright for the report
	The Board of Directors **received** and **noted** the Report from the Chair of the Audit Committee.
26/073	**Annual Declarations of Interest incl. NED Independence** (agenda item 20) Mrs McRae presented the report, taking it as read by the Board. She thanked all Board members for contributing and completing the relevant documentation.
	The Board of Directors **received** the Annual Declarations of Interest and **noted** the content.
26/074	**Fit and Proper Person Annual Declaration** (agenda item 21)

	Mrs McRae presented the report, taking it as read by the Board. All Board members were noted as compliant, and she thanked all members for completing the required elements to achieve this.
	The Board of Directors **received** and **noted** the Fit and Proper Person Annual Declaration.
26/075	**Self-certification against condition CoS7 of Provider Licence** (agenda item 22) Dr Munro presented the report, taking it as read by the Board, noting that it demonstrated the Board to self-certification of resources.
	The Board of Directors **received** and **noted** the self-certification against condition CoS7 of Provider Licence.

26/076	**Use of Trust Seal** (agenda item 23)
	
	Mrs McRae informed the Board that the Trust seal had been used on the following occasions:
	
	- 139 – The Mount: Deed of Indemnity, notice of assignment PA/lease, HOLD HARMLESS letter and Trust Certificate
	  o signed by Mrs Merran McRae, Chair, Dr Sara Munro, Chief Executive, Mrs Dawn Hanwell, Chief Financial Officer, and Mrs Clare Edwards, Associate Director of Corporate Governance (13 May 2025)
	- 140 – The Mount: Deed of Variation, Novation, Collateral Warranties
	  o signed by Mrs Merran McRae, Chair, and Mrs Clare Edwards, Associate Director of Corporate Governance (21 May 2025)

	The Board **noted** that the use of the Trust Seal.
26/077	**Any other business** (agenda item 24)
	There were no additional items of business raised.
26/078	**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 12:30 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.

NHS
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
37	**Organisational Priorities Q2 Update Report** (minute 25/144 - agenda item 10 – November 2025) Dr Healey queried whether there was an opportunity for the update to be presented to see specific measures within the report including trajectories for performance as this would show the full picture of milestones and impact. Mrs Hanwell agreed to review and amend the report as appropriate to deliver this.	**Dawn Hanwell**	July 2026	**UPDATE** It was noted that a working group had been established and an update would be provided at the July 2026 Board meeting.
44	**Report from the Chair of the Finance and Performance Committee for the meetings held on 28 April and 26 May 2026** (minute 26/056 - agenda item 8 – May 2026)	**Clare Edwards**	Management action	**NEW** **COMPLETE** This has been added to the Board Strategic Session forward plan for October 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
	It was agreed that bank usage, and a triangulated update from all Committees and work programmes, would be on the agenda for a Board Strategic Session.			

Leeds and York Partnership NHS Foundation Trust

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
43	**Approval of a change to the Constitution** (minute 26/045 - agenda item 19 – March 2026) Mr Wright queried the alignment to other Foundation Trust constitutions and Mrs McRae noted that the Corporate Governance Team would be able to review this.	**Corporate Governance Team**	May 2026	**COMPLETE** Hill Dickinson confirmed as part of the review of the Constitution, that the quoracy arrangements were a common stipulation for foundation Trusts, and was a reasonable approach to take.
Actions from Committees for the Board of Directors				
	None			

Agenda item
6

Meeting of the Board of Directors

Paper title:	Chief Executives Report
Date of meeting:	30 July 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

30 July 2026

Chief Executive's report

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

Our services and our people

Trust Response to Lord Mann report

On 4 June Lord Mann published his review into tackling racism and antisemitism within the NHS with recommendations to support making services safe for all patients, communities and colleagues. On the same day NHS England wrote to all NHS Trusts with a set of actions we must take in response. This review comes at a time of increased political and civil unrest which has emboldened displays of racist behaviour - and which we know have affected colleagues and service users across the communities we serve. Any form of racism, be it antisemitism, islamophobia or any other form, is something we are committed to eradicating. But we know we have a way to go. In the last year, we've seen significant increases in staff experiencing abuse from patients and the public, and from each other. As a Trust we have more staff reporting discrimination at work than similar NHS trusts. There needs to be a firmer response to this.

The Trust Board were able to give this matter serious and lengthy consideration at a workshop in June, which included reflection on the work that has already started and how we can build on existing commitments. We have sent out a response to all staff giving more detail on the recommendations and next steps. As a starting point and to set the tone, all members of the Trust Board will set objectives around reducing discrimination and racism and will undertake new anti-racism training when it becomes available. That is one of the recommendations of Lord Mann's review.

We have also committed to join NHSE in signing up to the **NHS Race and Health Observatory Seven Anti-Racism Principles.** These were developed to help healthcare organisations transition from passive pledges to tangible, workplace actions. These principles are designed to dismantle structural, institutional, and interpersonal racism to improve patient safety, strengthen leadership, and protect staff. The seven principles are:

1. Demonstrate leadership by naming racism - explicitly and consistently.
2. Understand and acknowledge – how structural, institutional, and interpersonal racism deeply impact healthcare access and health outcomes.
3. Meaningfully involve racially minoritised individuals and communities.
4. Collect and publish data.
5. Identify racial bias – by continuously auditing and check clinical tools, medical devices, and operational processes for hidden biases.
6. Apply a race critical lens – applying scrutiny to how our work may affect minority groups.
7. Evaluate and reflect - anti-racism work requires ongoing reflection rather than treating diversity goals as a one-time checklist.

These principles have been used in the work led by our Health Equity team and have now been formally adopted by the Trust Board.

We have also agreed to adopt **the new government definition of anti-Muslim hostility** and I expect to see it appear or be referenced in the development of relevant policies or guidance on acceptable behaviours in the workplace going forward.

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

It is also the prejudicial stereotyping of Muslims, or people perceived to be Muslim including because of their ethnic or racial backgrounds or their appearance, and treating them as a collective group defined by fixed and negative characteristics, with the intention of encouraging hatred against them, irrespective of

their actual opinions, beliefs or actions as individuals.

It is engaging in unlawful discrimination where the relevant conduct – including the creation or use of practices and biases within institutions – is intended to disadvantage Muslims in public and economic life.

CQC inspection Outcomes

The CQC have now published the inspection reports for three of our core services

- **Adult acute wards and our Psychiatric Intensive Care Unit (PICU)** – the overall rating for this service has moved from good to requires improvement,
- **Wards for older people with serious mental illness** – the overall rating for this service has moved from good to requires improvement, and
- **Long stay or rehabilitation mental health wards for working age adults** – which following inspection was issued with a warning notice to ensure immediate improvements were made in specific areas. This service has maintained the requires improvement rating overall.

The reports identify areas where improvement is required alongside examples of good practice and positive patient feedback. Following this, significant improvement work has been undertaken and evidence of the actions taken were shared with the CQC as part of the Factual Accuracy process. Examples include:

- Strengthening governance and assurance arrangements including safeguarding, environmental safety and fire safety.
- Enhancing safeguarding oversight and monitoring.
- Improving care planning and clinical record keeping processes with establishment of Trust-wide improvement group.
- Addressing environmental and estates concerns within Ward 5 Newsam.
- Improving compliance with mandatory training requirements.
- Strengthening audit and quality assurance processes.

The finalised action plans will be shared through the CQC Steering Group and with Quality Committee

prior to submission to the CQC. Services will be expected to have oversight of their action plans through their governance structure with oversight from CQC Steering Group. Evidence will be collated to demonstrate completion of actions plans and the Trusts internal peer review process will be utilised to ensure improvements and embedded and sustained. We will be requesting a review of the services ratings which may involve reinspection at the earliest opportunity.

Service Visits

In recent weeks I have visited adult secure services at Clifton house and children and young people's services at Mill lodge. The visits were arranged to discuss the proposed consultation on the new trust name which doesn't include York recognising this would be a loss for these services. It was a good opportunity to visit the wards and meet a wide range of staff and service users. With the senior team we talked about the ways in which all the 'specialist' and regional services could come together to ensure we design in the right leadership and culture, so they are all consistently well led, connected and valued within the new organisation. I saw some great practice examples at Clifton house related to the culture of care programme on managing section 17 leave and tackling hate crime which has since been shared with other services.

During a visit to ward 5 rehabilitation ward at the Newsam centre I was also able to meet with some patients and a range of staff. The board is aware there has been significant progress over many months on co-production, service improvements and environmental upgrades. I did discuss with the leadership team the CQC reports which were draft at that stage and the improvements made since the visit in March. We talked about the valuable feedback on the care and compassion of staff and patient feedback which was all positive and testament to the leadership and culture in the service.

1. ALIGNMENT WITH LEEDS COMMUNITY HEALTHCARE NHS TRUST

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

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

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

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

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

Leeds Partnership NHS Foundation Trust (LPFT)

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

- It reflects the wider partnership model and service delivery that exist into our regional and specialist services so signals we are not solely Leeds based.
- It represents the way we work now and the way we want to continue to develop in the future as working in partnership with others is critical for the services we provide.

- This approach is being raised in the best of both culture engagement work and in the workshop on future strategy as to what we want to be known for and the culture within the organisation.
- It is an important marker to distinguish us from acute trusts.

As the list for consultation was agreed in advance with NHSE/DHSC we do not require any further approvals at this stage but have sought endorsement from NHSE regional director. We are now socialising the new name internally and externally including formally updating local MPs.

Key Dates ahead are:

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

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

2. SYSTEM UPDATE

Leeds Place Provider Partnership

On 3 July approximately 100 leaders from across Leeds health and care organisations came together to explore system dynamics that enable or hinder effective partnership working. The event formed part of the ongoing development of the Leeds Provider Partnership (LPP) and focused on understanding why barriers to collaboration persist, despite widespread commitment to integrated working. The event was designed to support a system-wide conversation about how Leeds can strengthen collaboration in the context of:

• Team Leeds and Leeds Ambitions

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

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

Key Messages from Participants

Feedback from all discussion groups pointed to four interconnected themes:

***Trust and Relationships*:** Collaboration depends on trust, relationships and psychological safety. Participants felt these should be recognised as core components of system productivity rather than additional activity.

***Shared Purpose and Collective Accountability*:** Participants called for a stronger focus on population outcomes, shared success measures and collective decision-making rather than organisational priorities.

***Leadership and Culture*:** Leaders have a critical role in modelling collaborative behaviours, supporting innovation and creating environments where staff feel empowered to work across boundaries.

***Conditions for Collaboration*:** Participants highlighted the need to remove barriers, clarify risk and accountability, and create the practical conditions that enable collaborative working at scale.

What this means for the partnership

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

• How Team Leeds ambitions can be translated into meaningful change for frontline teams.
• How capacity and headspace can be created for collaboration and innovation.
• How leaders will model collaborative behaviours and hold themselves accountable.
• How progress will be measured.

• How challenge, transparency and community influence can be strengthened.

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

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

West Yorkshire Integrated Care Board

Interviews have taken place for the appointment of a substantive CEO for the ICB. At the time of writing the successful candidate has not been announced.

The management of change process is continuing with place-based integrator roles to be appointed to in early August.

Regional Updates

Sam Allen has been appointed as the regional director for NHSE in the North East Yorkshire and Humber region following the departure of Fiona Edwards earlier this month. Sam is a very experienced provider and ICB CEO and will continue to be the CEO for the North East North Cumbria ICB. Sam has already put in place direct engagement opportunities with CEOs to agree ways of working and opportunities for closer working going forward.

Chairs and CEOs attended a regional event with Sam and Bill McCarthy the regional chair on the 17th of July and outputs from this will be shared verbally at the board meeting.

Quality strategy for NHS-funded care in England

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

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

The strategy focuses on:

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

Why this matters now

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

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

Priorities for this strategy

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

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

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

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

- clarifying who is responsible and accountable for quality at every level of the healthcare system
- setting clear priorities to improve the quality of care while adopting a transparent, co-ordinated and value-based approach
- strengthening leadership and management capability to create the right culture and conditions for improvement
- listening to and working with people and communities on what matters to them
- using data to manage quality, inform decisions and support accountability at all levels
- increasing transparency**,** making the NHS the world's leading healthcare system for public access to information on care quality
- developing and embedding technology to underpin quality management and improvement

- aligning incentives and rewards with accessible, high-quality and productive care
- promoting research and innovation to support continuous improvement in clinical care and how the NHS operates
- creating a more co-ordinated and improvement-focused approach to regulation

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

A shared responsibility

This strategy asks every member of staff, both clinical and non-clinical, to see quality improvement as their responsibility, not someone else's. It also asks the system to be honest about where care is falling short and what it will take to put things right.

The prize is significant: fewer avoidable deaths, longer healthier lives and care that people can trust. Working together, we can create a system that delivers high-quality care everywhere and for everyone. It is recommended that the Quality committee undertake an initial review ahead of a session at a joint board with LCH later in the year so we can plan ahead for the quality strategy for the new organisation.

3. REASONS TO BE PROUD

Thank you to all our colleagues who took part in **Leeds Pride** March on Sunday 19th July 2026 and joining up with colleagues from Leeds Community Healthcare.

QED Recognition for Ward 6, Newsam

Ward 6 at the Newsam Centre has been awarded the Quality Network for Eating Disorders (QED) Certificate for Most Engaged Service for the 2025–2026 review cycle, recognising the team's commitment to quality improvement and excellent patient care.

The award highlights Ward 6's strong involvement in the QED programme and dedication to delivering safe, compassionate and person-centred care. During the review cycle, two team members participated in four peer reviews, sharing learning and best practice with services across the country.

Beth Gripton, Clinical Lead for Ward 6, said: "This award is a fantastic achievement and reflects the passion, dedication and commitment of the entire Ward 6 team. I am incredibly proud of everyone involved and the difference they make to patients and their families every day."

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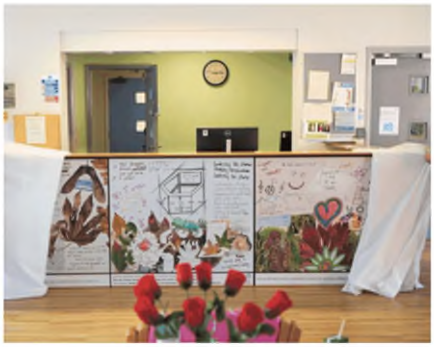
Seeking Truth: Labels. Identity. Repair

Service users from Asket House and Asket Croft celebrated the unveiling of three striking art panels created through workshops led by Leeds-based artist Sai Murray.

The project was initiated by Dr Anjula Gupta, Consultant Clinical Psychologist, as part of an Improving Population Health Fellowship exploring social justice practice in mental health services.

Using poetry, drawing and collage, over five weeks they explored themes of identity, discrimination, heritage, culture and repair, creating powerful artworks that reflect their experiences and hopes for the future.

"This project shows how creativity can help people reflect on their experiences, connect with others and share their stories in meaningful ways."



Leeds and York Partnership NHS Foundation Trust 48

Celebrating Success: EMERGE Carers Awarded BIGSPD Poster Prize

EMERGE Carers is celebrating a fantastic achievement after winning the Perspectives from Practice poster prize at the BIGSPD conference.

- Submitted a poster showcasing the EMERGE Carers Booklet and its co-production journey.
- Developed alongside carer consultants Alice and Lorna to support carers of people with complex emotional needs.
- Recognised for bringing together lived experience and professional expertise to create a resource shaped by carers, for carers.

A well-deserved achievement for everyone involved in the project.

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West and South CLDT

Team of the Month

The West and South CLDT has been recognised as Team of the Month for providing exceptional, compassionate support to a person with a learning disability and dementia, their family and care team during a difficult time.

"They looked after [my brother], the staff team caring for him and also provided significant support to us as a family."

They were praised for delivering this care quietly, diligently and compassionately, and for consistently providing person-centred support of the highest standard.

Lauren Bolton, Staff Nurse

Individual of the Month

Lauren has been recognised for consistently going above and beyond for service users, colleagues and student nurses.

From supporting people to be fully involved in their care to championing learning and development across the ward, Lauren's commitment makes a real difference every day.

She is a valued team member whose compassion, leadership and positive influence are highly regarded by those around her.

"Lauren is committed to improving the patient experience and values whole team learning. Well regarded by the team."

Philip Okoh

Sara's Spotlight Award

Congratulations to Philip receiving a Sara's Spotlight Award in recognition of the exceptional care, compassion and reassurance he provided to a service user and their family during an incredibly difficult time.

Philip was praised by a service user's family for his kindness, compassion and support during their loved one's final hours.

His dedication, professionalism and communication demonstrated the very best of our Trust values.

"Sometimes nursing is about simply being there for others and holding someone's hand. Philip was there for this gentleman, and he was there for this family."
– Scott Walker, Matron

Dr Sara Munro

Chief Executive Officer
21 July 2026

Agenda item
7

Meeting of the Board of Directors

Paper title:	Responsible Officer Annual Report 1 April 2025 – 31 March 2026
Date of meeting:	30 July 2026
Presented by: (name and title)	Dr Wendy Neil, Responsible Officer
Prepared by: (name and title)	Dr Wendy Neil, Responsible Officer

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

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

Executive summary

This report has been produced using the template provided by NHS England, setting out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The report is in 4 parts:

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

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:

- read and agree that this report provides assurance that the key requirements for compliance with regulations and key national guidance required of LYPFT as a designated body are met

The Chair is asked to:

- sign the statement of compliance on p26 to enable the completed report to be submitted to NHSE

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

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

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

Section 1 Qualitative/narrative

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

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of: Leeds and York Partnership NHS Foundation Trust can confirm that:

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

Y/N	Yes
Action from last year:	Maintain the current Responsible Officer arrangements
Comments:	Leeds and York Partnership Foundation Trust (LYPFT) and Leeds Community Healthcare (LCH) are to integrate into a new, single organisation in Q1 2027/28. An extensive programme of work is planned for the forthcoming year to

	enable this and will include a review of the Responsible Officer arrangements for the new organisation.
Action for next year:	Work with Responsible Officer of LCH to review and agree the Responsible Officer arrangements for the new organisation.

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

Y/N	Yes
Action from last year:	To gain approval for, and implement, changes and enhancements to the team structure within the Medical Directorate to ensure there is sufficient capacity for the Responsible Officer to carry out the responsibilities of the role
Comments:	The business case submitted for 4xadditional PAs was approved and enabled the team to be enhanced and restructured in Q4 2025/26 to better reflect its roles and responsibilities. This included the development of (and appointment to) a new role of Director of Medical Professional Standards (Complaints and Concerns lead) to work alongside the current Directors of Medical Professional Standards (consultant lead), (SAS doctor lead) and (strategic lead).
Action for next year:	To review and evaluate the effectiveness of the new team structure.

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

Y/N	Yes
Action from last year:	Maintain
Comments:	Information about doctors on GMC Connect is regularly cross-referenced with data held by the People and Development Team to check that all medical practitioners are connected to the correct designated body. This information is used to generate a ‘Starters and Leavers’ report which is reviewed at each meeting of the ‘Good Medical Practice Assurance Group’ (overseen by the RO). Additional checks are made around the

	time of Resident Doctor rotations to ensure the doctor's prescribed connection is correct
Action for next year:	Maintain

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

Y/N	Yes
Action from last year:	To disseminate and embed into practice the updated Medical Appraisal procedure once ratified.
Comments:	The updated Medical Appraisal procedure was ratified on 28/10/2025 and has been added to L2P resources.
Action for next year	Noting the forthcoming integration with LCH, the appraisal team will work with their equivalents in LCH to review the pre-existing policies and procedures and collectively develop and ratify a shared policy for Medical Appraisal and Revalidation.

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

Y/N	Yes
Action from last year:	Maintain
Comments:	The Trust's next peer review is due in Q3 2027/28. Noting the likely changes as a result of the forthcoming integration with LCH, consideration will be given to deferring this for 12 months to enable the new structures and processes to become embedded.
Action for next year:	Maintain

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another

organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	To review the impact and outputs of the new Medical In-Post Review Framework
Comments:	Trust employed locum and short-term placement doctors working in LYPFT continue to be managed the same as substantive doctors. They receive a tailored local induction and are supported in CPD, appraisal, revalidation and governance. The new system of Medical In-Post Reviews of doctors providing clinical sessions to LYPFT but who have a prescribed connection to another organisation have been conducted routinely for the past 12 months. Anecdotal feedback has been positive. No governance issues have been identified, and the doctors have been encouraged to use the outputs of the reviews as supporting information for their own appraisal.
Action for next year	To undertake a formal review of the Medical In-Post Review Framework, the outputs of which will be discussed and actioned via GMPAG

1B – Appraisal

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

Y/N	Yes
Action from last year:	To continue to oversee the provision of a Casenote audit, review the results and develop action plans as appropriate.
Comments:	Casenote audit is now embedded as one of the Trust's priority audits with the recommendation that doctors complete this once every 5 years. The 3rd annual Casenote audit was completed in Q3 2025/26 and a total of 104 doctors have submitted data since the audit's inception. The

	results have been reviewed by GMPAG and will be shared with the doctors at the SMC meeting of 21/04/26. The new Director of Medical Professional Standards (Complaints and Concerns lead) began in post in Q4 2025/26. Their role will include working with colleagues to develop and improve standards for the investigation and management of complaints about doctors and ensure appropriate support is provided to doctors during this process where necessary.
Action for next year:	To continue to oversee the provision of a casenote audit, review and feedback the results and develop action plans as appropriate To undertake a review of the investigation and management of complaints about doctors.

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

Y/N	Yes
Action from last year:	To embed a process within the Medical Directorate to access DATIX and provide doctors with meaningful data for their supporting information
Comments:	The Medical Directorate now has access to the Trust's DATIX system to obtain incident reports that can be used as supporting information for doctors' appraisals and thus support reflective practice.
Action for next year:	To continue to monitor the use and effectiveness of access to DATIX and review the process over the coming year to ensure it provides meaningful information for clinicians.

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

Y/N	Yes
Action from last year:	To disseminate and embed into practice the updated Medical Appraisal procedure once ratified.
Comments:	The Medical Appraisal procedure was ratified on 28/10/25and has been added to L2P resources and disseminated to doctors in the Trust.

Action for next year:	Noting the forthcoming integration with LCH, the appraisal team will work with their equivalents in LCH to review the pre-existing policies and procedures and collectively develop and ratify a shared policy for Medical Appraisal and Revalidation.

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

Y/N	Yes
Action from last year:	To continue to review and develop appraiser teaching and training materials to ensure this is relevant to local and national standards. To continue to monitor the number of medical appraisers and complete further rounds of recruitment as required.
Comments:	The programme of training and ongoing support for appraisers which was updated in 2024/25 and is well established, as is the appraiser's annual assurance review when the appraiser's performance and development needs are discussed. A round of appraiser recruitment was undertaken in Q3 2025/26 resulting in 5 new appraisers being recruited and subsequently trained. The Trust currently has 29 trained appraisers (20 consultants and 9 SAS doctors). A further round of recruitment has been scheduled for Q2 2026/27 to support the appraisal needs of the increasing number of doctors with a prescribed connection with LYPFT.
Action for next year:	For the Director of Medical Professional Standards (Strategic Lead) and colleagues to work with their equivalents in LCH to share data about the number and training needs of the appraisers in each organisation and develop an action plan to address any gaps.

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

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Y/N	Yes
Action from last year:	To continue to obtain feedback from Appraiser Development Forums (ADFs) and annual Appraiser Assurance reviews to inform topics for future appraiser training. To encourage appraiser participation at regional network events. RO to take on the role of chair of the regional Mental Health Appraisal Lead network and develop a programme of education and development for group members.
Comments:	The structure of the new appraiser training has been modified to incorporate a face-to-face ADF with existing appraisers. This has enabled shared learning and reflection and has received positive feedback from all delegates. The RO is now chair of regional Mental Health Appraisal Lead Network. The next meeting will take place on 13/05/26, its focus being a workshop led by the Director of Medical Professional Standards (SAS lead) on 'Supporting Neurodiverse Doctors during appraisal'. The event is open to all appraisers and is fully subscribed.
Action for next year:	Update new appraiser training to incorporate RCPsych changes to CPD requirements. To review the structure and content of the ADF meetings to ensure they remain relevant for appraisers. To deliver and evaluate a workshop on 'Supporting Neurodiverse Doctors during appraisal' at the forthcoming regional Mental Health Appraisal Lead Network meeting.

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

Y/N	Yes
Action from last year:	To embed the process of quality-assuring Medical Education-related work undertaken by doctors and include this in the supporting information for discussion and reflection at appraisal.
Comments:	All doctors with additional specific roles in Medical Education have an annual review to quality assure their work and

	identify any training and development needs (mirroring the Medical In-Post reviews). This is overseen by the Director of Medical Education. It is then used as part of a doctor's supporting information to enable their completion of the robust medical education section within appraisal. Data regarding the quality of the appraisal continues to be reviewed as part of the appraiser's annual Assurance Review meeting.
Action for next year:	For the Medical Education In-Post review to be monitored in conjunction with the Director of Medical Education and any changes/updates to be actioned as appropriate. To review the collective outputs of the Appraiser Assurance reviews, share at GMPAG, and action any changes as appropriate.

1C – Recommendations to the GMC

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

Y/N	Yes
Action from last year:	Maintain
Comments:	GMPAG meets bi-monthly to review the progress of doctors under notice for revalidation. Recommendations about the fitness to practice of those doctors are considered at that meeting and, when recommendations are agreed, they are submitted to the GMC within the required timescales. If/when delays occurred there is a mechanism in place to record and review this and for the matter to be discussed with the doctor to ensure transparency. In 2025/26 all recommendations about the fitness to practice of doctors were made to the GMC within the expected timescales with no exceptions.
Action for next year:	Continue

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

Y/N	Yes
Action from last year:	Maintain
Comments:	GMPAG proactively reviews the cases of those doctors under notice for revalidation. If any issues are identified which it is felt may possibly result in deferral or non-engagement then the doctor would be contacted after the meeting to explore the issues further and offer appropriate support. This, and any subsequent contacts, are documented and shared with the doctor for their information, reflection and action. As a result of this approach there were 0 deferrals or cases of non-engagement in 2025/26. When a revalidation recommendation is made to the GMC the doctor is informed of this in writing by the RO on the following working day the recommendation was made.
Action for next year:	Continue

1D – Medical governance

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

Y/N	Yes
Action from last year:	Maintain
Comments:	The agenda for the Trust's 'Senior Medical Council' has been reviewed and now incorporates as standing items inputs from the Medical Director, the Deputy Medical Director for Medical Staffing, Medical Leadership and Mental Health Legislation and the Deputy Medical Director for Clinical Leadership, Research and Improvement.

Action for next year:	To review and update the Medical Line Manager job description to include the requirement for the postholder (or their nominated deputy) to attend local clinical governance meetings.

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

Y/N	Yes
Action from last year:	To review the impact and outputs of the new Medical In-Post Review Framework for doctors working in LYPFT but who have a prescribed connection elsewhere
Comments:	A review of the new Medical In-Post Review Framework has been started however due to time constraints and conflicting priorities this work has not yet been completed. The results are tabled for discussion at the GMPAG meeting of 05/05/26 following which an action plan will be developed. GMPAG has as a standing agenda item updates on doctors in difficulty and doctors at risk, this includes doctors about whom concerns have been raised. If the outcome of an investigation into a doctor's conduct or performance includes an action plan then the doctor's details remain on the GMPAG agenda until the RO has confirmed that all actions have been signed off as satisfactorily completed.
Action for next year:	To complete a review of the impact and outputs of the new Medical In-Post Review Framework for doctors working in LYPFT but who have a prescribed connection elsewhere and develop an action plan as appropriate.

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

Y/N	Yes
Action from last year:	Maintain
Comments:	The Medical Directorate Administrator continues to collate and upload onto L2P Trust governance information for all doctors in preparation for their scheduled medical appraisal.

Action for next year:	Maintain

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

Y/N	Yes
Action from last year:	To deliver and evaluate Case Investigator Training
Comments:	Case investigator training was delivered in Q1 2025/26. The feedback was excellent in all domains. Suggestions for improvement included increasing the number of interactive sessions in d1 and providing copies of relevant Trust policies in advance of the training. This will be incorporated into future training sessions. LYPFT now has a full complement of doctors who are trained as Case Investigators (n=25). The new Director of Medical Professional Standards (Complaints and Concerns lead) began in post in Q4 2025/26.
Action for next year:	For the RO and Director of Medical Professional Standards (Complaints and Concerns lead) to work with their equivalents in LCH to review the pre-existing policies and procedures and collectively develop and ratify a shared responding to concerns policy. For the Director of Medical Professional Standards (Complaints and Concerns lead) to undertake Case Manager training.

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

Y/N	Yes
Action from last year:	To continue to work with the Medical Workforce Race Equality Standard (MWRES) lead to ensure the Trust responds fairly and appropriately when concerns are raised about doctors. To undertake an annual Equality Impact Assessment (EIA) in conjunction with the MWRES lead to review compliance against MWRES indicators regarding investigations into concerns regarding doctors.
Comments:	The 2025/26 EIA noted that there were 10 doctors about whom a concern was recorded that year. This is similar to previous years. The gender and ethnicity of those doctors was broadly proportionate to the medical workforce within the Trust. Data about doctors about whom concerns have been raised are reported to the Trust Board as part of the Medical Director's report.
Action for next year:	To continue to work with the Medical Workforce Race Equality Standard (MWRES) lead to ensure the Trust responds fairly and appropriately when concerns are raised about doctors. To continue to undertake an annual Equality Impact Assessment (EIA) to review numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	Maintain
Comments:	MPIT forms continue to be requested as standard once notification has been received of a doctor's recruitment to a role within LYPFT. These are reviewed by the RO.

	The RO continues to have regular meetings with the ELA and other ROs to enable benchmarking of practice. The GMPAG has as a standard agenda item relating to doctors in difficulty and doctors at risk. This includes a sub-section for doctors connected elsewhere who also work in LYPFT. If concerns are raised then the RO is responsible for liaising with appropriate individuals and the doctor is informed of any actions taken. This occurred on 3 occasions in 2025/26.
Action for next year:	Maintain

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes
Action from last year:	To complete evaluation of the role of the Cultural Inclusion Ambassadors (CIAs) in the Responding to Concerns Advisory Groups (RtCAGs) and develop an action plan depending on findings
Comments:	Evaluation of the role of the CIAs was undertaken in Q2-3 2025/26. It revealed that the initial challenges with the use of CIAs in RtCAGs had been effectively managed as the role had become embedded, with all CIAs feeding back that they felt that they had a positive impact on the RtCAG process and that they were satisfied with the role overall. Areas for future development including improving timeliness of documentation sharing and providing feedback to CIAs re their performance following RtCAGs have now been implemented.
Action for next year:	To review the pastoral support provided to doctors about whom concerns have been raised and design and implement a process for overseeing this.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	Maintain
Comments:	The RO is a regular attender at regional RO meetings and chairs the regional Mental Health Appraiser Lead network when national reviews and policies are discussed on a regular basis. These are then shared internally at GMPAG and learning incorporated as appropriate. Examples in the past year include reviews of the Trust's Managing Concerns about Medical Colleagues policy following the publication of the High Court judgment in the case of Dr MN v NHS Foundation Trust L (July 2025), and review of the Trust's governance arrangements for locum doctors following the publication of the Aubrey report (November 2025). The Trust has an established clinical governance framework, with all Services working to a structured work plan including domains for continuous learning, innovation and applying the best knowledge
Action for next year:	To undertake a review of the Trust's clinical governance and clinical leadership and explore opportunities to strengthen opportunities for doctors in relation to governance from the wider system.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	RO to continue to input into PPA Service Reference Group and incorporate relevant learning into LYPFT ways of working.
Comments:	The RO has remained a member of the PPA Service Reference Group which has included reviews of the programmes of support offered by PPA to Trusts. Internally the reviewed pay progression process for doctors has provided an opportunity for checking compliance with job planning, appraisal and mandatory training of doctors.

	In response to requests from Medical Line Managers a bespoke teaching session has been provided on managing complaints about doctors to ensure this is in accordance with Trust and national standards. A 'Medical leadership' day is also planned for Q1 2026-27 to help strengthen leadership and management in the Trust.
Action for next year:	To deliver and evaluate the 'Medical Leadership Day'

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	To continue to undertake annual audits of pre-employment background checks for doctors
Comments:	The 2025/26 pre-employment check audits conducted for substantive doctors and agency locums revealed 100% compliance in all domains. This is a reflection of the proactive management of pre-employment checks which is now embedded as usual practice. In addition an audit was undertaken of Trust practice re locum doctors against the recommendations of the Aubrey report. The audit provided assurance that local systems were in keeping with the key recommendations of the report. An action plan is being developed to address the areas of relative weakness (specifically: reviewing and renewing of locum contracts, verification and monitoring of GMC register, mandatory training)
Action for next year:	To compete actions following review of Trust practice against recommendations of the Aubrey report

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	To work with colleagues in the Trust to implement the ambitions of the 'People Plan'.
Comments:	The Trust's People Plan and associated People Ambitions are centred on four key priorities: looking after our people, fostering a sense of belonging in the NHS, developing new ways of working and delivering care, and growing for the future. The Medical Directorate is working collaboratively with the People and Organisational Development Team to align the plan with the needs of the medical workforce.
Action for next year:	To work to optimise the alignment between the People Plan and the medical workforce to support workforce gaps and development needs.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	Maintain
Comments:	A programme has been developed during Q3-4 2025/26 to improve the awareness of neurodiversity within the medical workforce and enhance the support for neurodivergent doctors. This is being delivered during Q4 2025/26 and Q1 2026/27. Mandatory training for all doctors continues to include the requirement to undertake regular diversity and inclusion training. Compliance with this is currently 98%.

Action for next year:	To evaluate the outputs and impact of the work undertaken to improve the support for neurodivergent doctors.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	To continue to pursue opportunities for doctors to contribute to work within the organisation to embody the Trust values
Comments:	The agenda for the Trust's 'Senior Medical Council' has been reviewed and now incorporates as standing items inputs from the Medical Director, the Deputy Medical Director for Medical Staffing, Medical Leadership and Mental Health Legislation and the Deputy Medical Director for Clinical Leadership, Research and Improvement. A 'Medical Leadership' day is planned for Q1 2026-27 to help strengthen leadership and management in the Trust.
Action for next year:	To deliver and evaluate the 'Medical Leadership Day'

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	To continue to work with colleagues in the complaints team to ensure complaints about doctors are managed fairly and appropriately.
Comments:	The successful recruitment of a Director of Medical Professional Standards (Complaints and Concerns Lead) in Q4 2025/26 will further strengthen the associated processes and develop closer working relationships with colleagues in the complaints team to ensure concerns are managed effectively.

Action for next year:	To review the impact of the appointment of the Director of Medical Professional Standards (Complaints and Concerns lead) on the management of complaints about doctors.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Yes
Action from last year:	To continue to undertake an annual Equality Impact Assessment (EIA) in conjunction with the MWRES lead and reflect on the findings
Comments:	Results from the 2025/26 EIA were reviewed by the GMPAG. It confirmed that there were 10 doctors about whom a concern was recorded in 2025/26. This is similar to previous years. The gender and ethnicity of those doctors was broadly proportionate to the medical workforce within the Trust. A 'Fair Experience for All' checklist was completed for all investigated cases and revealed no evidence that PMQ or any other protected characteristics had contributed to the concerns raised or the outcome for the doctor following the investigation.
Action for next year:	To continue to review data regarding doctors involved in concerns and disciplinary processes to identify trends and ensure that processes remain fair, transparent, and compliant with the principles set out in the Equality Act 2010.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	RO to take on the role of chair of the Regional Network meetings and develop a programme of education and development for group members.

Comments:	The RO, Directors of Medical Professional Standards and the Head of Medical Development and Operations continue to regularly attend regional and mental health-specific network meetings and feedback relevant information to GMPAG. The RO is now chair of the Regional Network meeting.
Action for next year:	Maintain

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	151
Total number of appraisals completed	144
Total number of appraisals approved missed	7
Total number of unapproved missed	0
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	8
Total number of late recommendations	0
Total number of positive recommendations	8
Total number of deferrals made	0
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	39
Total number of trained case managers	4
Total number of concerns received by the Responsible Officer[2]	10
Total number of concerns processes completed	10
Longest duration of concerns process of those open on 31 March (working days)	0
Median duration of concerns processes closed (working days)[3]	45
Total number of doctors excluded/suspended during the period	0

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of doctors referred to GMC	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	N/A
Total number of new doctors joining the organisation	42
Total number of new employment checks completed before commencement of employment	42
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	N/A

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
21 of the 22 actions identified in the 2025/26 report have been completed and LYPFT remains compliant with the Medical Profession (Responsible Officers) (Amendment) Regulations 2023.
Actions still outstanding
To undertake a review of the impact and outputs of the new Medical In-Post Review Framework for doctors working in LYPFT but who have a prescribed connection elsewhere.
Current issues
Nil
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Work with Responsible Officer of LCH to review and agree the Responsible Officer arrangements for the new organisation.

Review and evaluate the effectiveness of the new team structure.

Noting the forthcoming integration with LCH, the appraisal team will work with their equivalents in LCH to review the pre-existing policies and procedures and collectively develop and ratify a shared policy for Medical Appraisal and Revalidation.

Undertake a formal review of the Medical In-Post Review Framework, the outputs of which will be discussed and actioned via GMPAG.

Continue to oversee the provision of a casenote audit, review and feedback the results and develop action plans as appropriate.

Undertake a review of the investigation and management of complaints about doctors.

Continue to monitor the use and effectiveness of access to DATIX and review the process over the coming year to ensure it provides meaningful information for clinicians.

For the Director of Medical Professional Standards (Strategic Lead) and colleagues to work with their equivalents in LCH to share data about the number and training needs of the appraisers in each organisation and develop an action plan to address any gaps.

Update new appraiser training to incorporate RCPsych changes to CPD requirements.

To review the structure and content of the ADF meetings to ensure they remain relevant for appraisers.

Deliver and evaluate a workshop on ‘Supporting Neurodiverse Doctors during appraisal’ at the forthcoming regional Mental Health Appraisal Lead Network meeting.

For the Medical Education In-Post review to be monitored in conjunction with the Director of Medical Education and any changes/updates to be actioned as appropriate.

Review the collective outputs of the Appraiser Assurance reviews, share at GMPAG, and action any changes as appropriate.

Review and update the Medical Line Manager job description to include the requirement for the postholder (or their nominated deputy) to attend local clinical governance meetings.

Complete a review of the impact and outputs of the new Medical In-Post Review Framework for doctors working in LYPFT but who have a prescribed connection elsewhere and develop an action plan as appropriate.

For the RO and Director of Medical Professional Standards (Complaints and Concerns lead) to work with their equivalents in LCH to review the pre-existing policies and procedures and collectively develop and ratify a shared responding to concerns policy.

For the Director of Medical Professional Standards (Complaints and Concerns lead) to undertake Case Manager training.

Continue to work with the Medical Workforce Race Equality Standard (MWRES) lead to ensure the Trust responds fairly and appropriately when concerns are raised about doctors.

Continue to undertake an annual Equality Impact Assessment (EIA) to review numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Review the pastoral support provided to doctors about whom concerns have been raised and design and implement a process for overseeing this.

Undertake a review of the Trust's clinical governance and clinical leadership and explore opportunities to strengthen opportunities for doctors in relation to governance from the wider system.

Deliver and evaluate the 'Medical Leadership Day'.

Compete actions following review of Trust practice against recommendations of the Aubrey report.

Work to optimise the alignment between the People Plan and the medical workforce to support workforce gaps and development needs.

Evaluate the outputs and impact of the work undertaken to improve the support for neurodivergent doctors.

Review the impact of the appointment of the Director of Medical Professional Standards (Complaints and Concerns lead) on the management of complaints about doctors.

Continue to review data regarding doctors involved in concerns and disciplinary processes to identify trends and ensure that processes remain fair, transparent, and compliant with the principles set out in the Equality Act 2010.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

The number of doctors with a prescribed connection to LYPFT has increased for the past 5 consecutive years (from 112 in 2020/21 to 155 in 2025/26) as a result of expansion of the medical workforce in reconfigured services and a reduced reliance on agency doctors. In addition, there has been a 4-fold increase in the number of doctors working into LYPFT who have their prescribed connection elsewhere (e.g. doctors who provide clinical sessions into LYPFT as part of a Service Level Agreement).

In Q3 2025/26 the business case for a 4PA increase in funding for the Medical Professional Standards Team was approved for a period of 2 years. This, together with the team's ongoing proactive oversight of the systems and processes supporting doctors, has ensured that the Trust has remained compliant with the statutory Medical Profession (Responsible Officers) (Amendment) Regulations 2023.

In 2025/26 there were 0 unapproved missed appraisals and 100% of the recommendations for revalidation made to the GMC were positive and submitted on time.

For those doctors working into LYPFT who have their prescribed connection elsewhere Medical In-Post reviews are now being conducted on a regular basis. These provide assurance to LYPFT of the doctors' ongoing fitness to undertake the role and assurance to the doctor's RO of the scope of their work in LYPFT in accordance with NHSE recommendations. A formal evaluation of this process, started in 2025/26, has been identified as a priority for completion in the forthcoming year.

Another priority for the forthcoming year will be our further engagement with our counterparts in LCH to share best practice and work together to develop policies and procedures in readiness for the integration of our organisations in Q1 2027/28.

Pending and following the integration we will continue to provide the best support we can for our doctors. When concerns are raised about a doctor these will continue to be managed in accordance with the Trust policy and, following further training delivered in Q1 2025/26, we now have a full complement of doctors who are trained as Case Investigators (n=25). With the appointment to the new post of Director of Medical Professional Standards (Complaints and Concerns Lead) we have begun work to review and further strengthen the pastoral support provided to doctors subject for formal and informal complaints and concerns investigations. This will be completed and the impact evaluated in 2026/27.

Within the Trust and Regionally a separate, but equally important, piece of work for 2026/27 will be the delivery and evaluation of a programme of work developed by the RO and members of the Medical Directorate team to improve awareness of neurodiversity within the medical workforce and enhance the support for neurodivergent doctors. The team will also continue in 2026/27 to be actively involved

in regional and national networks and reference groups, pursuing opportunities for shared learning and development for the benefit of all.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Leeds and York Partnership NHS Foundation Trust

Name:	Merran McRae
Role:	Chair
Signed:	
Date:	

Name of the person completing this form:	Dr Wendy Neil
Email address:	Wendyneil@nhs.net

Agenda item
9

Meeting of the Board of Directors

Paper title:	CFO Finance Report
Date of meeting:	30 July 2026
Presented by: (name and title)	Dawn Hanwell – Chief Finance 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

At month 3 we are reporting a £42k surplus against a balanced plan. There are a number of significant pressures within the position. The underlying run-rate in the month is in deficit but reducing month on month offset by non-recurrent flexibilities.

The efficiency programmes have been developed. Recurrent budget efficiency has been agreed to be devolved to divisions and departments to manage, to ensure alignment within overall available resources rather than the efficiency being held centrally. Capital expenditure is progressing and ahead of plan.

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 the Trust revenue and capital positions for 2026/27 at month 3.
- Note the risk of the Deconstructing the Block exercise
- Note the Q4 NOF score and new Financial metrics

Meeting of the Board of Directors

30 July 2026

CFO Finance Report

1 Introduction

This report provides an overview of the financial position as at the end of June 2026, and other relevant updates

2 Revenue Position

At the end of June we are reporting a small £42k surplus against a balanced plan as shown below.

		Month 3		
Income & Expenditure Plan Position	**Plan Annual £'000**	**Plan YTD £'000**	**Actual YTD £'000**	**Variance YTD £'000**
Income:				
Patient Care Income	249,522	63,203	63,334	131
Other Income	28,165	6,979	7,302	323
Total Income	**277,687**	**70,182**	**70,636**	**454**
Expenditure:				
Pay Expenditure	(201,533)	(50,724)	(51,116)	(392)
Non Pay Expenditure	(71,172)	(18,215)	(18,214)	1
Total Expenditure	**(272,705)**	**(68,939)**	**(69,331)**	**(392)**
Surplus/ (Deficit)	**4,982**	**1,243**	**1,306**	**63**
Adjustments for NHSE Reporting	**(4,982)**	**(1,243)**	**(1,264)**	**(21)**
Adjusted Position	**0**	**0**	**42**	**42**

It should be noted that the overall positive position against plan includes some one-off technical flexibilities of c£2m year to date. Excluding these flexibilities the actual monthly position is shown below:

	April (£000)	May (£000)	June (£000)
Surplus / (Deficit)	(1,126)	(640)	(359)

Thie month on month figures do demonstrate an improving run rate position, mainly reflecting reductions in out of area placements, bank expenditure and also an increase in training income. It remains key that the month on month run-rate continues to improve as the year progresses to reduce this over reliance on non-recurrent benefits. This links to achievement of run rate efficiencies.

Within the position there are number of significant variances: -

- Other Income - Interest receivable and commercial income £0.3m better than plan, this is a volatile position and anticipated to reduce.
- Pay Expenditure - substantive pay and bank combined £0.8m higher than plan with agency spend £0.4m under plan.
- Non-Pay expenditure - Out of Area placements expenditure across Working Age Adult (WAA), Older People and Complex Rehabilitation £1.8m over plan collectively, with £1.2m attributable to WAA. This overspend is offset by a number of underspending areas such as premises spend and non-clinical supply spend.

3 Recurrent Underlying Financial Position

As part of monthly financial monitoring and the new regulatory oversight noted in section 6 below Trusts now must report on their underlying financial position as well as the in year and forecast outturn position. An assessment of the recurrent underlying financial position was conducted as for 26/27 based on the forecast exit run rate form 25/26. This was submitted in February as part of the financial plan. The reported underlying recurrent position at that point was a deficit of £4.3m .

Bridging item	£000	Category
25/26 Forecast	2,682	Starting Point
Non-Recurrent Flex up to M5	1,510	Non-Recurrent
CREST SDf Funding	1,826	Non-Recurrent
PFI Funding	900	Non-Recurrent
Interest Receivable	5,131	Non-Recurrent
Perinatal Ward Expenditure	1,500	Known Change
Adult Acute OAPs	-3,500	Assumption
Interest Receivable	-3,750	Assumption
Bank Expenditure	-2,000	Assumption
	4,299	**1.6% of recurrent income**

We have refreshed and recalculated the latest forecast recurrent underlying position at month 3. The table below show the updated position and assumptions, which has been reported in our month 3 financial returns. This shows an improved position and underlying deficit of £1.3m.

Bridging item	£000	Category
26/27 M3 Forecast	1,947	Starting Point
Technical Flex up to M3	2,452	Non-Recurrent
Interest Receivable	5,000	Non-Recurrent
Perinatal Ward Expenditure	1,500	Known Change
Adult Acute OAPs	-5,200	Assumption £2m
Rehab OAPS	-1,000	Back to £3.5m budget
Interest Receivable	-2,000	Assumption £2m per year
50% of bank reduction	1,400	Recruitment
Bank Expenditure	-2,800	Assumption £14.6m
	1,299	**0.48% of recurrent income**

The key main assumptions that underpin the improved position are expected recurrent reductions in OAPs expenditure to maximum budgeted amounts and reduction in bank usage in line with the bank capped target spend (offset by 50% recruitment to substantive staff).

The £1.3m recurrent underlying deficit is 0.48% of recurrent income which should be deemed as a small underlying deficit for regulatory purposes. This position will be kept under review and should improve further as the alignment of run rate and budget is managed over the coming period.

4 Efficiency Programme 2026/27

Similar to 2025/26 the efficiency programme is split into the run-rate efficiency based on the financial plan submitted to NHSE and monitored monthly via reporting to NHSE, and the internal efficiency programme linked to budgets to ensure overall budgetary balance. The latter is what services and departments are monitored against, as our financial management is budgetary based. We aim to reduce the gap between the two forms of efficiency monitoring and align run rate expenditure and budgets over the next financial year as part of the integration planning.

4.1 Run-rate Efficiency Programme 2026/27

The Trust efficiency programme for 2026/27 is to deliver in year run-rate savings of £11.4m. This is the target based on the financial plan submitted to NHS England, which reflects run rate movements year on year (not recurrent internal budget).

Below is a breakdown of the schemes to achieve the £11.4m target and the performance against each scheme in month 3:

Schemes	Recurrent / Non-Recurrent	YTD Plan (£000)	YTD Actual (£000)	YTD Variance (£000)
Agency Reduction	Recurrent	102	494	392
Bank Reduction	Recurrent	57	0	(57)
MARS Scheme	Recurrent	600	600	0
Technical Flexibility	Non-Recurrent	0	350	350
Community Tranformation	Recurrent	500	175	(325)
Job Planning	Recurrent	38	0	(38)
Contract in-housing Overhead	Recurrent	88	0	(88)
Digitalisation Project	Recurrent	125	0	(125)
Fragile Services	Recurrent	125	0	(125)
Procurement/ Non-Pay inflation	Recurrent	250	250	0
NR Income	Non-Recurrent	250	250	0
Pay / Vacancies	Recurrent	565	352	(213)
Additional Income	Recurrent	0	368	368
		2,699	**2,839**	**140**

We are £140k ahead of plan at M3 largely due to realising the full MARS efficiency that was enacted at the end of the previous financial year, additional income over the amount anticipated in plan and a higher than anticipated reduction in agency expenditure.

4.2 Internal Budget Efficiency Programme 2026/27

To ensure that internal budgets are balanced there is a requirement to achieve a £13.6m recurrent budget efficiency. This has been devolved to services and departments to ensure it is visible and management teams know their resource envelope they must provide their service within. The first Equality, Quality Impact Assessment panel will be held on 31st July 2026 where the first tranche of efficiency schemes will be reviewed.

5 Deconstructing the Block Contracts

The 10 Year Health Plan set out an aim, as part of the overall financial reset, to deconstruct current block contracts and re-establish the link between payment and activity levels and total contract values. An exercise was completed in 2025/26 however the results for mental health and community services were not sufficiently robust to be implemented in the 2026/27 planning round (they were implemented on Acute contracts)

NHSE undertook further work with the HFMA to understand the issues affecting data quality more deeply and to work with the sector to improve the robustness of the analysis.
This work has been completed with input from several providers and commissioners.
A second exercise is now underway during this summer to compare current contract values with payment based on national prices x activity for each core mental health and community contracts.
There will be two aligned collections: one covering core ICB-commissioned services and a separate

collection covering delegated specialised mental health services which include Provider Collaboratives.

Templates to undertake this work have been sent out with initial discussions happening at a system level as Commissioners will need to agree with all Provider submissions. Data quality is absolutely crucial in this work as there are national costs per groups of activity based on the 2024/25 National Cost Collection results. This is a critically important piece of work as the results will inform the 2027/28 planning round and payment scheme. Potentially there is a significant risk that if the trust activity x national prices do not equal our contract values our income will be reduced in 2027/28, subject to parameters and rules yet to be determined.

6 North East & Yorkshire (NEY) NHSE Approach to Financial Delivery

Under the new ways of working and enhanced performance and oversight role of NHSE regions, our regional team at NEY have developed a Risk stratification tool to identify the levels of financial risk at organisational level to help determine the potential support and intervention required. This is separate from the National oversight Framework and is specifically targeted at financial delivery risks. As a region NEY is one of the most financially challenged in the country ending 25/26 with an aggregate deficit of £378.6m, which was 145.3m off plan. Underlying positions in the 26/27 planning round have deteriorated further.

NEY region aims to support Boards in the delivery of financial plans, improve transparency on actions being taken with all leaders in the region and ensure appropriate / proportionate assurance reporting mechanisms. The expectation is that an integrated approach is taken to support, improvement and oversight, with support and interventions to be co-produced with CEOs and NHSE wherever possible. The risk stratification categorises trusts into one of 4 categories and this determines the level of intervention/support. This is illustrated below:-

Fig 1 – Risk Stratification

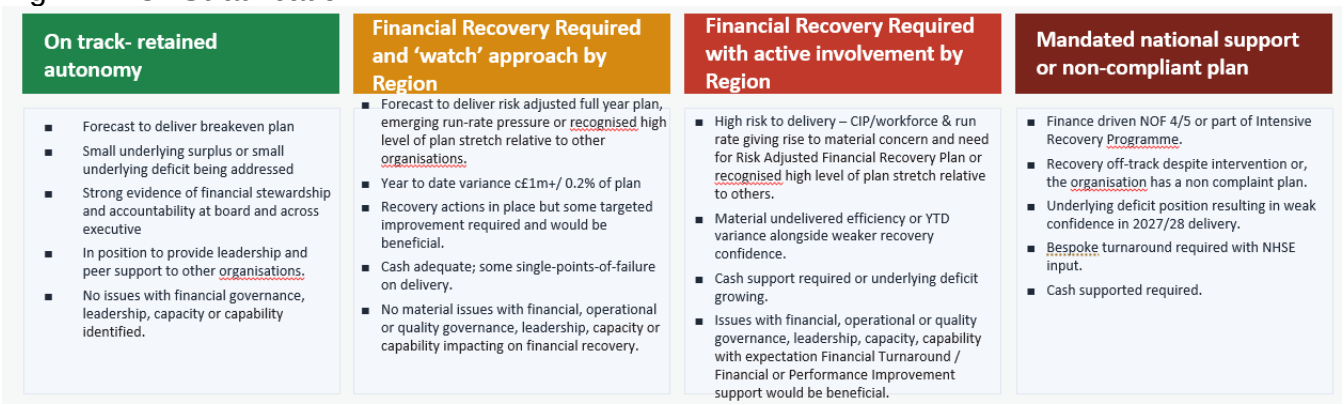
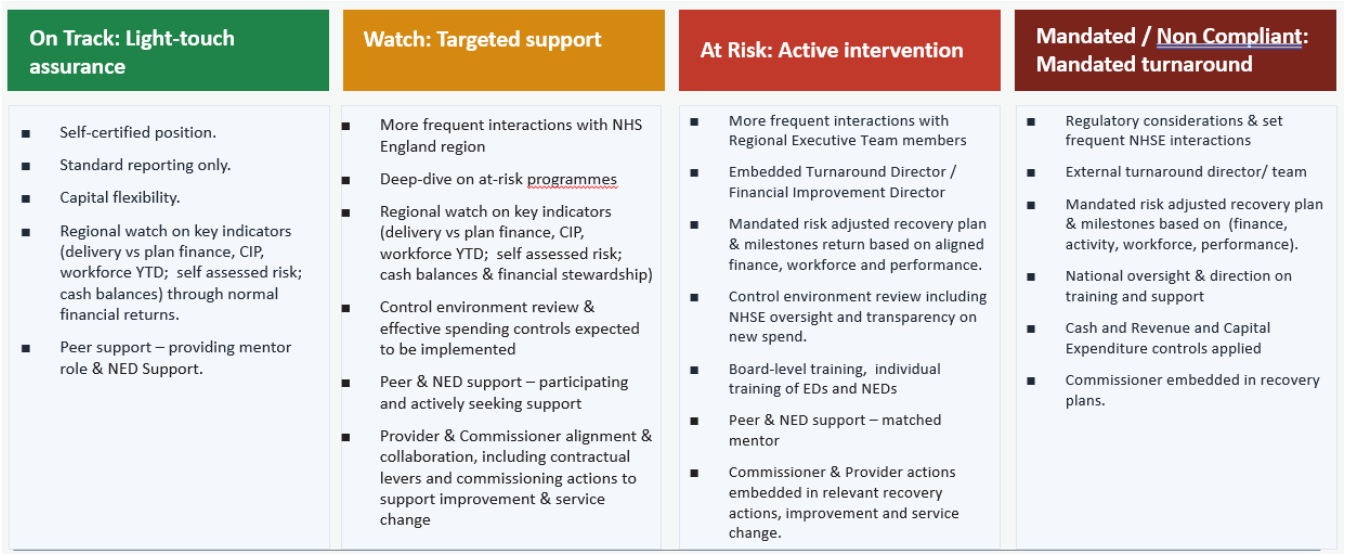


Fig 2 - Support and Interventions



On Track: Light-touch assurance	Watch: Targeted support	At Risk: Active intervention	Mandated / Non Compliant: Mandated turnaround
■ Self-certified position. ■ Standard reporting only. ■ Capital flexibility. ■ Regional watch on key indicators (delivery vs plan finance, CIP, workforce YTD; self assessed risk; cash balances) through normal financial returns. ■ Peer support – providing mentor role & NED Support.	■ More frequent interactions with NHS England region ■ Deep-dive on at-risk programmes ■ Regional watch on key indicators (delivery vs plan finance, CIP, workforce YTD; self assessed risk; cash balances & financial stewardship) ■ Control environment review & effective spending controls expected to be implemented ■ Peer & NED support – participating and actively seeking support ■ Provider & Commissioner alignment & collaboration, including contractual levers and commissioning actions to support improvement & service change	■ More frequent interactions with Regional Executive Team members ■ Embedded Turnaround Director / Financial Improvement Director ■ Mandated risk adjusted recovery plan & milestones return based on aligned finance, workforce and performance. ■ Control environment review including NHSE oversight and transparency on new spend. ■ Board-level training, individual training of EDs and NEDs ■ Peer & NED support – matched mentor ■ Commissioner & Provider actions embedded in relevant recovery actions, improvement and service change.	■ Regulatory considerations & set frequent NHSE interactions ■ External turnaround director/ team ■ Mandated risk adjusted recovery plan & milestones based on (finance, activity, workforce, performance). ■ National oversight & direction on training and support ■ Cash and Revenue and Capital Expenditure controls applied ■ Commissioner embedded in recovery plans.

It has been confirmed that at quarter 1 the Trust is in GREEN 'On Track' category and therefore be in receipt of limited intervention from the Regional NHSE team.

7 Capital Position

Capital expenditure at M3 is £1.2m against a plan of £0.75m. The variance is due to the phasing of spend in the plan on our PFI schemes. The capital forecast out-turn remains in line with planned allocations. The capital position is detailed in Appendix A.

The Trust has an operational capital envelope of £5.6m in 2026/27 and assumed Public Dividend Capital (PDC) of £3.6m in year. The current climate means that there is no guarantee that all PDC will be obtained in year. Conversely, PDC is likely to be available for other/specific purposes, and the Trust will endeavour to maximise any opportunities that arise.

8 Cash position

At the end of June, the Trust has a cash balance of £128.4m. This is higher than plan due to the out-turn cash position for prior year being £6m ahead of plan (mainly linked to deferred income) and this position has continued into 2026/27. Our overall liquidity (a test of our ability to pay outgoings without further new income) remains high with cover for 89 days operating expenditure. NHS organisations are expected to operate with a minimum 4/5 days, so we remain in a very positive position. Our cash balances provide the ongoing interest receivable benefit to our revenue position, albeit on a reducing scale due to interest rate changes and this is factored into the plan.

9 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 Non NHS	Current YTD Number	Current YTD £	Current month JUN-26 Number	Current month JUN-26 £
Total bills paid in the year	3,202	32,971,349	1,118	11,076,356
Total bills paid within target	3,009	32,096,136	1,044	10,549,646
Percentage of bills paid within target	94.0%	97.3%	93.4%	95.2%

By value YTD we are at 97% which is very impressive however by number of invoices, after a positive start we have reduced to 94% YTD. To recover this position a rapid task and finish group have been stood up to resolve the delay in processing invoices.

10 National Oversight Framework (NOF)

Changes have been made to the overall National Oversight Framework (NOF) metrics and scoring for 26/27. The relevant domain for finance is the Productivity and Value for Money domain which is subject to some additional metrics. As previously, the overall scoring methodology includes an override relating to organisational financial performance. The override means any organisation in deficit or in receipt of deficit support will be limited to an organisational delivery score of no greater than 3.

The last reported overall finance domain score was segment is a 2. This reduced from a 1 due to the updated relative cost difference. The National Cost Collection Index of 111 drives a segmentation score for relative cost difference of 3.14. The below metrics make up the Trusts domain score.

	Raw measure	Raw score derived	Score	Overall Score
Planned surplus / deficit as a proportion of turnover	0.00%	1.00		
YTD surplus / deficit	0.34%	1.00		
Aggregated finance score			1.00	
Relative cost difference	111	3.14	3.14	
DOMAIN SCORE - Productivity & value for money				**2**

The updated framework for 26/27 is expected to include 2 additional metrics within the Productivity and Vale for Money domain as shown:

Innovation	% of clinical trials set up within 90 days
	Data Quality Maturity Index

The inclusion of these additional metrics which have limited absolute financial relevance but hold 50% of the weighting for the overall metric score, could impact the domain rating in 26/27.

It is also anticipated that there will be an additional metric in the Workforce domain that will calculate how far Trusts are over or under the Bank and Agency expenditure caps. This will form part of the 6 metrics in that domain.

Once the metrics included in the 2026/27 NOF have been agreed and it is fully understood how they are to be scored, an update will be brought to the committee.

11 Conclusion

At month 3 we are reporting a £42k surplus against a balanced plan. There are a number of significant pressures within the position. The underlying run-rate in the month is in deficit but reducing month on month offset by non-recurrent flexibilities.

The efficiency programmes have been developed. Recurrent budget efficiency has been agreed to be devolved to divisions and departments to manage, to ensure alignment within overall available resources rather than the efficiency being held centrally. Capital expenditure is progressing and ahead of plan.

10 Recommendation

The Board is asked to:

- Note the Trust revenue and capital positions for 2026/27 at month 3.
- Note the risk of the Deconstructing the Block exercise
- Note the Q4 NOF score and new Financial metrics

Appendix A – Capital Position

Leeds and York Partnership NHS Foundation Trust

CAPITAL PROGRAMME - at 30 June 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	800	120	9	111
Security review	200			
Sub-Total	**1,000**	**120**	**9**	**111**
IT/Telecomms Operational				
IT Network Infrastructure	200	25	12	13
Server/Storage	30			
PC replacement EUL	250	60	(1)	61
Sub-Total	**480**	**85**	**11**	**74**
Estates Strategic Developments				
Lifecycle contribution	100	20		20
Red Kite View	100		37	(37)
Mill lodge, York	100			
Clifton House, York	100			
Sustainibility & Green Plan	300	20		20
Wellbeing	50			
PFI schemes	1,944	462	1,039	(577)
Decarbonisation strategy	300			
PFI demise/estate	300		71	(71)
Sub-Total	**3,294**	**502**	**1,147**	**(645)**
IT Strategic Developments				
Asset Management	60			
Anti-virus & Encryption	50			
Back up software	60			
Cyber security	50			
Integration System	50			
Voice recognition	140			
Remote working, access and agile	100			
IT strategic developments	100			
Smartphones	60	15		15
Sub-Total	**670**	**15**	**0**	**15**
Total ICS Operational Capital	**5,444**	**722**	**1,166**	**(444)**
PDC Funded Schemes				
EPR developments	2,500			
Estates Safety Fund	743			
Total PDC Funded Schemes	**3,243**			
IFRS16 Leased Assets				
Leased buildings			3	(3)
Leased vehicles	150	30	24	6
Sub-Total	**150**	**30**	**26**	**4**
Disposals				
Lease - vehicles			(4)	4
Sub-Total			**(4)**	**4**
Total IFRS16 Leased Assets	**150**	**30**	**23**	**7**
Total Capital Spend	**8,837**	**752**	**1,189**	**(437)**

Agenda item
10

Meeting of the Board of Directors

Paper title:	2026 – 2027 Organisational Priorities Quarter 1 Progress Report
Date of meeting:	30 July 2026
Presented by: (name and title)	Dawn Hanwell, Chief Financial Officer
Prepared by: (name and title)	Amanda Burgess, Head of the Programme Management Office

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

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

Executive summary

This is our first report providing a summary of the Trust's progress against our 2026 – 2027 organisational priorities. This report sets out how we are initiating our 8 priorities each with an identified lead executive. Our quarterly report is in place to demonstrate the progress made against each priority specifically, identify where a priority may require attention or further action to ensure its intended outcomes are achieved.

Each slide provides a summary of a priority and details how we are delivering against each of the high-

level milestones. We have adopted the 'alert, advise, assure' approach to provide the key messages on whether the defined milestones are being met, alert where matters require escalation or give assurance that a priority is on track.

In total we have 56 high-level milestones for delivery. At the end of quarter one we have:

- 5 milestones marked as 'alert'
- 1 milestone marked as 'advise'
- 50 milestones marked as 'assure'

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

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

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

Recommendation

The Board of Directors is asked to:

- Consider our position against our 2026/27 organisational priorities at the end of quarter 1.
- Be assured as to the systems and processes in place for monitoring and supporting the delivery of each priorities high-level milestones and underpinning tasks.

Leeds and York Partnership
NHS Foundation Trust

2026 – 2027 Organisational Priorities Report

Quarter 1 Progress Report

Overview and key messages

This is the first progress report for 2026 – 2027 and provides a summary of the Trust's progress against our 8 organisational priorities.

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

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

At the end of quarter 1 2026 – 2027 the following priorities are reporting as red (alert):

- **Delivery of our Patient & Flow Programme:** this is our performance against the out of area placement and 1 hour A&E assessment targets. Extensive work is underway to reshape how we govern this programme of work and informed by a recent external report revisit the scope, aims and measurable objectives.

The following priorities are reporting as amber (advise):

- **Efficiency and Productivity Programme:** this is our performance against the bank and overtime workforce and budget savings targets. We have our first Equality and Quality Impact Assessment Panel scheduled to take place in July, whereby the first tranche of 2026/27 recurrent budget savings will be considered. Those that are successfully approved by the panel will be transacted in quarter 2.

We have begun the year on track to deliver the following priorities (assure):

- Delivering a transformed children and young people service for Leeds
- Opening an 18-bed level 2 high intensity inpatient facility for men
- Opening an additional 6 beds within our perinatal inpatient service for the population of Yorkshire and Humber
- Implementing the recommendations from the Levy Report
- Becoming an integrated provider of community and mental health services
- Enabling the strategic shift from analogue to digital

2026 – 2027 organisational priorities quarter 1 progress summary

Organisational priority goals	Priority	Link	Lead	Exc Owner	Scheme Status	RAG Rating	Start	End	Alert	Advise	Assure
How we are operating efficiently	Delivery of our Efficiency and Productivity Programme	Link	Jonathan Saxton	Dawn Hanwell	Live	Amber	Apr-26	Mar-27	3	0	2
How we are improving the quality of our care services	Delivering our Patient and Flow Programme	Link	Josef Faulkner & Ben Alderson	Joanna Forster Adams	Live	Red	Aug-24	Jan-27	2	0	0
	Delivering a transformed Children and Young People service for Leeds	Link	Tim Richardson	Joanna Forster Adams	Live	Green	Jan-26	Dec-27	0	1	6
How we are improving the quality of our care services	Open an 18 bed level 2 high intensity inpatient facility for men	Link	Ric Carroll & Warren Duffy	Joanna Forster Adams & Dawn Hanwell	Live	Green	Sep-24	Apr-27	0	0	10
	Open an additional six beds within our perinatal inpatient service for the population of Yorkshire and Humber in 2026/27	Link	Eve Townsley & Warren Duffy	Joanna Forster Adams & Dawn Hanwell	Live	Green	Apr-26	Feb-27	0	0	3
	Implement the recommendations from the Levy Report (Adult Gender Dysphoria Clinics)	Link	Ric Carroll	Chris Hosker	Live	Green	Apr-26	Mar-27	0	0	3
How we are running our organisational effectively	Become an integrated provider of community and mental health services (LCH/LYPFT)	Link	Dawn Hanwell	Dawn Hanwell	Live	Green	Mar-26	Jun-27	0	0	3
	Enabling the strategic shift from analogue to digital	Link	Ian Hogan	Chris Hosker	Live	Green	Jan-26	Mar-27	0	0	23

Delivery of our Efficiency & Productivity Programme

Our performance at the end of quarter 1

Target	Full Year	YTD Plan	YTD Actual	Status
Run Rate Efficiency	11,429	2,699	2,839	✔
Recurrent Budget	13,600	3,399	0	●
Achieve a 10% reduction in bank usage	14,591	4,194	4,285	●
Reduce overtime expenditure	220	70	73	●
Eliminate agency spending	3,504	1,102	711	✔

Alert, Advise, Assure

Alert:

We reviewed our efficiency and productivity programme for 2026/27 and continuing with exec-led governance/oversight for the workforce efficiency targets. Despite the measures put in place to reduce bank expenditure by 10% and overtime these still continue to be challenging targets, and we begin the year above the set trajectories.

Our first equality and quality impact assessment panel for 2026/27 is set to take place on 31st July 2026, where we will consider the proposed recurrent budget efficiency savings for approval/rejection.

Assure:

We begin the financial year ahead of trajectory for both run-rate efficiency and agency expenditure.

Delivery of our Patient & Flow Programme: overview

Alert, Advise, Assure

Alert:

Earlier this year the Trust commissioned independent specialists VOT Health to complete a phase 1 diagnostic across the acute working age pathway. The diagnostic has identified a set of high impact changes providing realistic, solution-focused objectives spanning acute inpatient, crisis and community services. These objectives are in alignment with, and complementary to the priority developments already underway. To achieve this, we have chosen to reorganise our critical Care Services priorities under the auspices of one programme. The first step of the reorganisation is to take a new approach to how the programme is governed.

Our proposed approach to governance is one that is inspired from that of the provider collaborative model, where a whole pathway approach is taken, with deliverable and measurable outcomes, a significant focus on quality, safety and assurance along with value for money. Strong partnerships underpin provider collaboratives, with a shared strategic vision, objectives and collaboration at their core, with evidence-based focus on reducing reliance on inpatient care.

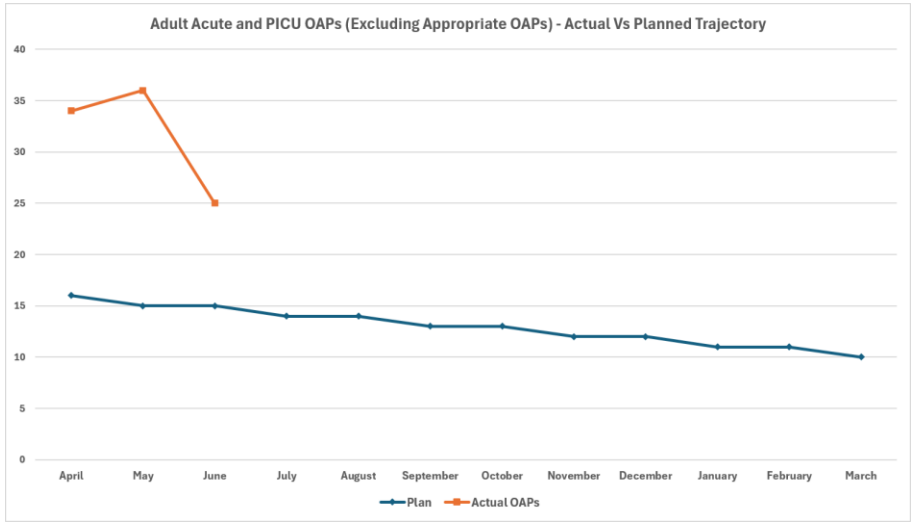
To achieve the required outcome of zero out of area admissions by March 2027 and a significant reduction in length of stay, it is vital to develop collaboration across care services. A 'Care Services' Collaborative is to be established that will oversee the delivery of this critical programme of work which incorporates:

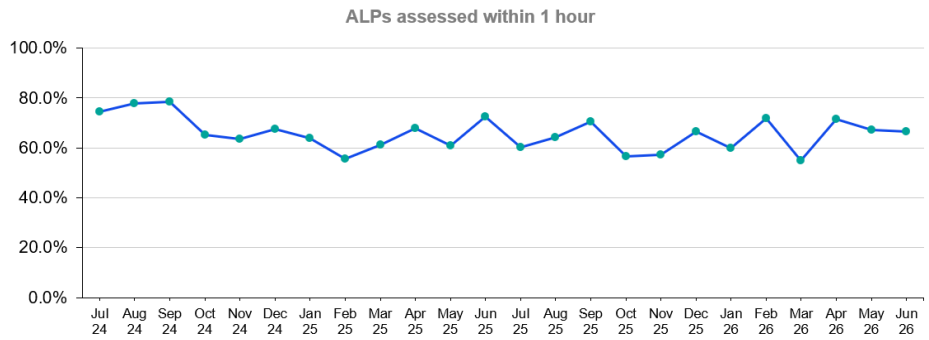
- Strengthening our purposeful admission work across all adult acute inpatient wards
- Reviewing our crisis pathway
- Optimising community services with integrated models of care, treatment and aligned with Neighbourhood Health

Wrapping around the programme will include monitoring service performance (including financial) against local and national measures alongside monitoring, oversight and assurance of the quality and safety of both service delivery and improvements. It is the intent in early quarter two to have fully established governance, approved Programme Initiation Document with clearly defined measurable objectives and a refreshed timeline.

Delivery of our Patient & Flow Programme: performance

Our performance at the end of quarter 1





Alert, Advise, Assure

Alert:

Out of area placement trajectory: At the end of quarter one we have 25 adult acute and PICU inappropriate out of area placements. The number of placement have continued to decline during July however, we still remain above the set trajectory. The revised governance, objectives and operational and clinical leadership enacted will reshape the programme during July.

ALPs assessed within 1 hour: The project initiated back in April 2025 was centred around trialling and testing key service changes, with the objective of ensuring we see all service users (across the age range) that attend A&E within 1 hour, and reducing the time spent in A&E for mental health presentations. This has included implementing administration systems and processes, understanding the times of the day we see the biggest demand, inform how we manage capacity within the service and, piloting having a member of the ALPs team at the point of ED triage. All these initiatives are to be evaluated to determine the impact on the target position.

Delivering a transformed children and young people service for Leeds programme

Our performance at the end of quarter 1

	Objective or Milestone	Start	Finish	Actual Progress	Status
Establish West Yorkshire Children and Young People's Transformation Partnership Governance Structure to drive overarching Transformation aspirations (fewer CYP in inpatient beds, shorter lengths of stay, treatment closer to home)	Develop a PID documenting the aim/objectives for the Provider Collaborative in 2026/27	Apr-26	Oct-26	90%	✔
	Establish the PC governance structure that creates the right conditions to review data, identify and understand variance, develop clinical models, provide commissioning support and challenge, and direct, evaluate and drive systemwide transformation.	Apr-26	Oct-26	85%	✔
At place develop alternatives to hospital Day Provision, Intensive Support and Consultation and Advice functions.	Scope the requirements and develop a case for change to pilot a Day Provision offer within Leeds	Jan-26	Nov-26	50%	✔
	Commence day service provision pilot at Red Kite View (12-month pilot)	Jan-27	Dec-27	40%	✔
	Scope the requirements and develop a case for change to pilot an Intensive Support Service within Leeds	Jan-26	Nov-26	40%	✔
	Commence Intensive Support Service pilot (12-month pilot)	Jan-27	Dec-27	40%	✔
	Enhance Consultation and Advice function	Jan-26	Nov-26	10%	ⓘ

Alert, Advise, Assure

Advise:

We have initiated a key programme of work both as a children and young people (CYP) provider collaborative partner and internally to improve the overall offer for young people presenting with mental health needs across the CYP mental health system. The governance structure for the programme has been agreed by both the West Yorkshire Mental Health, Learning Disability and Autism and Provider Collaborative Boards. The Project Initiation Document setting out the aims and objectives for the Provider Collaborative has been developed and awaiting approval. The aim and objectives for the programme are aligned with national and regional evidence to:

- Develop the day care provision for CYP
- Develop the crisis offer for CYP
- Develop outreach services for CYP

Although initial discussions have taken place there has been a delay in progressing the consultation and advice function. We have a Project Manager joining the team in August who will be instrumental in taking this work forward and we believe that the timescales set are realistic and achievable.

Open an 18-bed level 2 high intensity facility for men

Our performance at the end of quarter 1

Objective or Milestone	Start	Finish	Actual Progress	Status
Management of Change, Organisational Development & Recruitment	Sep-24	Nov-26	39%	✔
Service Set Up	Sep-24	Nov-26	45%	✔
RIBA Stage 5 & 6	Nov-24	Nov-26	38%	✔
Procurement of FF&E	Jun-26	Oct-26	1%	✔
Transfer Planning	Jul-26	Nov-26	0%	✔
Service Transfer	Aug-26	Dec-26	0%	✔
Staff Familiarisation	Oct-26	Nov-26	11%	✔
Operational testing & equipping	Oct-26	Nov-26	0%	✔
H&S, Environmental Standards & Readiness Assessment	Oct-26	Nov-26	0%	✔
Post Move Monitoring First 100 Days	Dec-26	Apr-27	0%	✔

Alert, Advise, Assure

Assure:

We are well underway with the programme of work to adapt our services to the new NHS guidelines which include moving our Complex Rehabilitation Inpatient Service, currently located in Ward 5 at the Newsam Centre in Seacroft, to a redesigned and refurbished facility at Parkside Lodge in Armley.

Recruitment to the expanded team is underway and service specific operating procedures are in the process of being reviewed and updated, in readiness for the opening in early December.

Open an additional six beds within our perinatal inpatient service for the population of Yorkshire and Humber

Our performance at the end of quarter 1

Objective or Milestone	Start	Finish	Actual Progress	Status
Workforce mobilisation	Oct-24	Jan-27	41%	✔
Perinatal Scheme	Jun-26	Oct-26	11%	✔
Readiness Assessment & Phased Start	Nov-26	Feb-27	0%	✔

Alert, Advise, Assure

Assure:

We are well underway with the work that will enable the provision of an additional six mother and baby unit beds for the Yorkshire and Humber as part of the Perinatal Provider Collaborative. The service will be co-located alongside our existing specialist eight bed perinatal inpatient ward at The Mount.

Recruitment to the expanded team is underway and service specific operating procedures are in the process of being approved in readiness for the opening from November.

Delivery of our integration transformation programme

Our performance at the end of quarter 1

Objective or Milestone	Start	Finish	Actual Progress	Status
Business Case	Apr-26	Oct-26	45%	✔
Stage 1:Transition - Q3	Apr-26	Dec-26	27%	✔
Stage 2: Shadow - Day1 -Q4	Mar-26	Jun-27	6%	✔

Alert, Advise, Assure

Assure:

Work is underway to recalibrate the overall Programme Plan, including categorising and aligning all activity with the programme governance framework, creating a staged/timed plan that will take the programme to go-live and post 100 days.

The programme stages/timed phases provide a framework for identifying and managing the critical delivery tasks/milestones that must be completed. Alongside the critical 'must do' categories that are a way of defining/managing the work to be delivered.

At this end of quarter one stage, we are 'on track' to deliver:

- Business case phase
- Stage 1 (transition phase): Legal and regulatory aspects of the Corporate Governance and Transition Communications workstreams
- Strategic Outline Case has been fully delivered.

Implement the recommendations from the Levy Report (Adult Gender Dysphoria Clinics)

Our performance at the end of quarter 1

Objective or Milestone		Start	Finish	Actual Progress	Status
Changes to referral pathway	Prepare for the implementation of referral pathway changes, including patient communications.	Apr-26	Dec-26	30%	✔
Optimise improvement targets	Implement a revised 6-month target to see 30 new and complete second assessments for service users	Apr-26	Jan-27	25%	✔
New prescribing arrangements	Plan and agree the prescribing monitoring process for the first 12 months of treatment in readiness for NHSE guidance release	Apr-26	Mar-27	15%	✔

Alert, Advise, Assure

Assure:

Following the publication of the Levy review on 18 December 2025, the gender service in Leeds is embarking on a comprehensive transformation of its adult gender care pathway. This will involve significant changes to its service model, governance, and operational practices. This transformation will be tracked and encompasses the following elements:

- Adopting a shorter clinical pathway
- New hormone prescribing responsibilities
- Engagement with National structures
- Addressing performance gaps, improving clinical productivity and standardising processes
- Managing surgical waiting lists

We are currently on track to deliver this programme of work.

Enabling the strategic shift from analogue to digital: AVT

Our performance at the end of quarter 1

Programme	Objective or Milestone	Start	Finish	Actual Progress	Status
Ambient Voice Technology (AVT)	Anatham Pilot	Jan-26	Oct-26	65%	✔
	Heidi Pilots	Apr-26	Oct-26	50%	✔
	Expression of interest submitted to front line productivity	Feb-26	Oct-26	90%	✔
	Pilot Evaluation	Nov-26	Dec-26	0%	✔
	Big Hand Replacement	Dec-26	Dec-26	0%	✔
	Initiate Trust Wide Deployment	Feb-27	Mar-27	0%	✔

Alert, Advise, Assure

Assure:

Ambient Voice Technology (AVT): At the end of quarter one we are underway with the piloting of both Heidi and Anatham AVT tools. In addition, Intelligent Recap software has been deployed and is in use. All pilots will be subject to an evaluation process to commence from November 2026.

The evaluation process is vital in understanding the AVT tool(s) of choice that will enable the retirement of Big Hand software.

Enabling the strategic shift from analogue to digital: NHS App

Our performance at the end of quarter 1

Programme	Objective or Milestone	Start	Finish	Actual Progress	Status
NHS APP	Appointment Management approach identified	Jul-26	Sep-26	0%	✔
	Define service user Appointment communication requirements	Jul-26	Sep-26	0%	✔
	CareDirector development and configuration	Jul-26	Sep-26	0%	✔
	Patient Portal development and configuration	Mar-26	Oct-26	60%	✔
	Standardised letters, forms, questionnaires established	Jul-26	Nov-26	0%	✔
	Appointment Management piloted/evaluated through Patient Portal with supporting SOP	Nov-26	Dec-26	0%	✔
	Trust Onboards to MH Wayfinder Programme	Jan-27	Feb-27	0%	✔
	Appointment bookings through NHS App	Mar-27	Mar-27	0%	✔
	Manage direct service user communication i.e. appointment letters, general correspondence through the NHS App	Mar-27	Mar-27	0%	✔
	Appointment questionnaires through NHS App	Mar-27	Mar-27	0%	✔

Alert, Advise, Assure

Assure:

NHS App: At the end of quarter one work is underway with the supplier Netcall to develop/configure the Patient Portal. The next step will be to identify the right approach for appointment management and handling direct service user communication.

Enabling the strategic shift from analogue to digital: new EPR

Our performance at the end of quarter 1

Programme	Objective or Milestone	Start	Finish	Actual Progress	Status
Procurement and Implementation of a new EPR	LCH Specification Review and Stakeholder Engagement	Mar-26	Jul-26	75%	✔
	Specification and ITT update (LYPFT & LCH)	Mar-26	Jul-26	75%	✔
	Pre-Tender Notification & Review	Jul-26	Aug-26	0%	✔
	Specification and ITT Finalisation and Approval	Aug-26	Sep-26	0%	✔
	Tender Publication	Sep-26	Oct-26	0%	✔
	Tender Evaluation	Nov-26	Dec-26	0%	✔
	Full Business Case Approval	Jan-27	Jan-27	0%	✔

Alert, Advise, Assure

Assure:

Procurement and implementation of a new EPR: The future EPR stakeholder sessions within the Trust have concluded, with the intent to run the same sessions with Leeds Community Healthcare NHS Trust workforce throughout July and August. The outcome of the stakeholder sessions will inform our outcome-based specification. The pre-tender notification and review documentation will conclude at the end of August 2026, in readiness for the tender publication in September/October 2026.

Agenda item
11

Meeting of the Board of Directors

Paper title:	Data Security and Protection Toolkit
Date of meeting:	30 July 2026
Presented by: (name and title)	Dr Chris Hosker, Medical Director
Prepared by: (name and title)	Carl Starbuck, Head of Information Governance / Data Protection 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.	✓

Executive summary

Presenting the final scoring of this year's NHS Digital Data Security & Protection Toolkit return. This is the 8th return against the DSP Toolkit and the 2nd against the Cyber Assessment Framework (CAF) aligned Toolkit. For this reporting year, NHS-E decided to leave the attainment levels per Outcome as they were from last year to allow for embedding of the changes, but added 2 new data collections.

Internal Audit carried out an appraisal of a subset of Outcomes aligned to the national Audit Framework mandated by NHS Digital.

Final audit opinion was that 'Standards Met' had been achieved, and only 2 minor points of improvement were noted. Final audit outcome is:-

- Overall risk determined for the 12 outcomes included in our testing sample:- **LOW**
- Overall confidence level of Independent Assessment:- **HIGH**

On the basis of the Audit, the Trust has returned a 'Standards Met' result on the Toolkit, with an Action Plan drafted to cover the points agreed with the Auditors which will be tracked by the IG Group, reported monthly.

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 of Directors is asked to:

- Accept the assurance provided by this report, noting that this is already our final position.
- Accept that the Action Plan will be tracked to completion by IGG in the months ahead.

Meeting of the Board of Directors

30 July 2026

Data Security and Protection Toolkit

Executive summary

Presenting the final scoring of this year's NHS Digital Data Security & Protection Toolkit return. This is the 8th return against the DSP Toolkit and the 2nd against the Cyber Assessment Framework (CAF) aligned Toolkit. For this reporting year, NHS-E decided to leave the attainment levels per Outcome as they were from last year to allow for embedding of the changes, but added 2 new data collections.

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Data Security & Protection Toolkit v8 – 2025-2026

The DSP Toolkit v8 consists of 47 Outcomes broken down into the following 5 domains:-

A - Managing risk (7)
B - Protecting against cyber attack and data breaches (20)
C - Detecting cyber security events (7)
D - Minimising the impact of incidents (5)
E - Using and sharing information appropriately (8)

Figures in brackets denote the number of Outcomes per domain.

Each of the 47 Outcomes breaks down into multiple evidential requirements, with each Outcome having 3 possible results:-

- Not Achieved
- Partially Achieved
- Fully Achieved

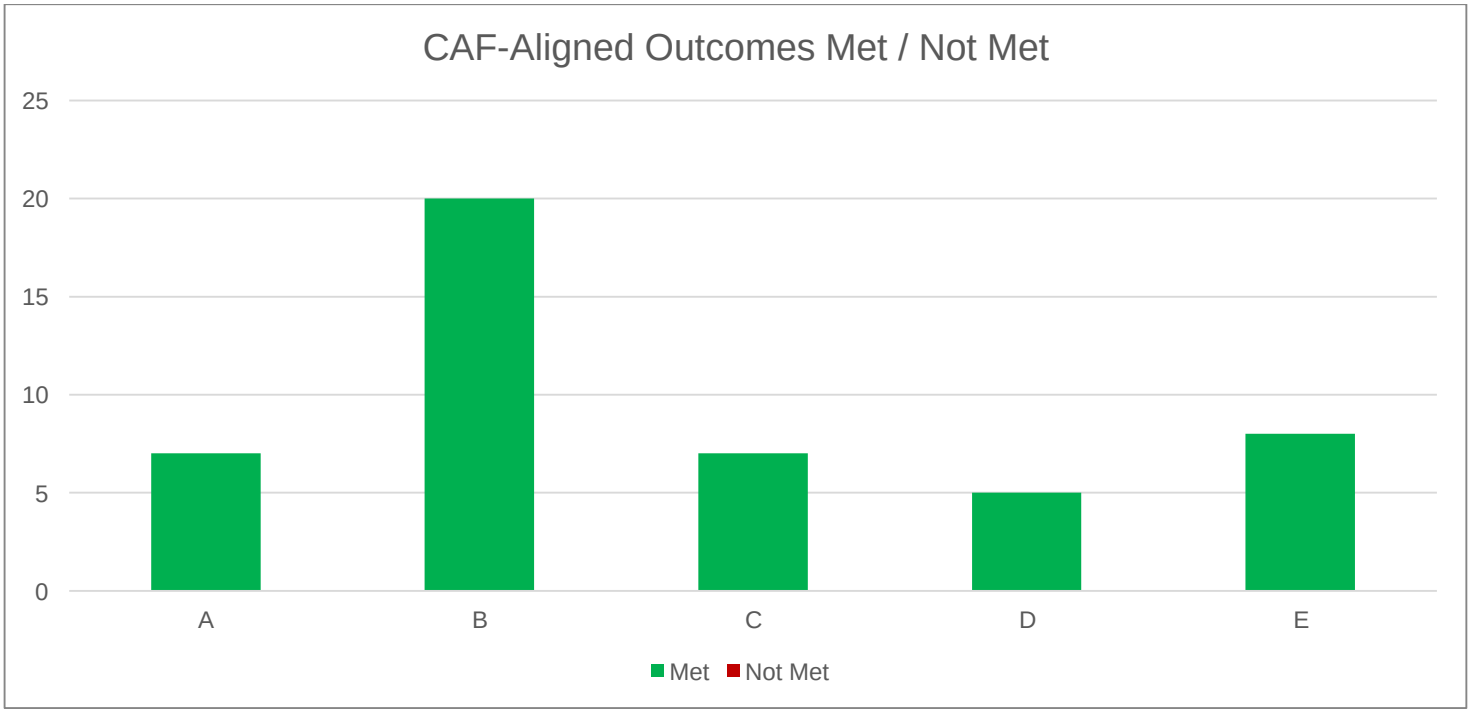
Some Outcomes are simplified to just Not Achieved / Fully Achieved.

The original vision for the CAF-aligned Toolkit was to build and strengthen the Outcomes each year over a 5-year planning horizon, such that the Outcomes expected to be Not Achieved or Partially Achieved in the first year are gradually raised to Partially or Fully Achieved, ultimately strengthening the assurance requirement with all Outcomes to be Fully Achieved in year 5. However to allow the new CAF-aligned Toolkit to embed, NHS England paused the intent to strengthen the required attainment in year 2, so all Outcomes had the same attainment target in 2025-2026, although 2 new data collections were mandated:-

- A register of Information Assets relevant to essential business functions, and
- A register of essential systems not compliant with the mandate for Multi-Factor Authentication.

Each of the Outcomes was passed to an appropriate subject matter expert to assemble an evidence base against each Outcome and then document our compliance on the DSP Toolkit website. All evidence items must be complete to mark the Outcome as Partially or Fully Achieved.

At the close of the Toolkit in June, and based on the Audit report, the Trust stated that all Outcomes had met target, with the reporting graphically represented per domain as follows:-



A - Managing risk
B - Protecting against cyber attack and data breaches
C - Detecting cyber security events

D - Minimising the impact of incidents
E - Using and sharing information appropriately

Internal Audit's report was initially presented to the Information Governance Group (21st May 2026), however an error was identified in the report, and a new draft was presented which was agreed and made final in June. The final report is attached as Appendix A, which shows the recommendations arising out of the Audit, and the management response to these recommendations**.**

A 'Standards Met' outcome was achieved, and as the June IG Group was quorate to approve the action, the Toolkit has been finalised and published. Only 2 Outcomes were identified with low-priority points of improvement, and these have been written up as an action plan which will be tracked monthly at IGG, with both actions allocated to responsible officers and with an agreed deadline for completion.

Conclusion

This concludes the presentation of the Data Security and Protection Toolkit outcome report for 2025 / 2026.

Recommendation

The Board of Directors is asked to:

- Accept the assurance provided by this report, noting that this is already our final position.
- Accept that the Action Plan will be tracked to completion by IGG in the months ahead.

APPENDIX A – Internal Audit DSPT Report 2025-2026*
**Note: Incorrectly dated 2026/2027*

Carl Starbuck
Head of Information Governance / Data Protection Officer
23/06/2026

LYPFT 01 2026/27 Data Security and Protection Toolkit

Leeds and York Partnership NHS Trust

Final Audit Report

10th June 2026

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:

Contents

Final Report Distribution

Executive sign-off
Dawn Hanwell, Chief Financial Officer & Deputy Chief Executive

Distribution
Carl Starbuck, Head of Information Governance and Data Protection Officer
Andy Gleadall, Head of Network Operations
Hergy Galsinh, Head of Cyber Security
Ian Hogan, Chief Digital Information Officer

Committee
Audit Committee

:

Section 1: Introduction

Why security and governance of information issues in the Health and Social Care sector require attention from independent assessors

Data and information are critical business assets that are fundamental to the continued delivery and operation of health and care services across the UK. The Health and Social Care sector must have confidence in the confidentiality, integrity and availability of their information assets and must ensure that any personal data collected, stored and processed by public bodies are aligned to specific legal and regulatory requirements.

The need to demonstrate an ability to defend against, block and withstand cyber-attacks and data breaches has been amplified by the introduction of the Network and Information Systems (NIS) Regulations and the UK General Data Protection Regulation (GDPR). As such, it is essential that Health and Social Care sector organisations that are impacted by those regulations take proactive measures to defend themselves from cyber-attacks and data breaches and evidence their ability to do so in line with regulatory and legal requirements.

The Cyber Assessment Framework (CAF) aligned Data Security and Protection Toolkit (DSPT) is one of several mechanisms in place to support Health and Social Care organisations in their ongoing journey to manage cyber security and information governance risk.

The CAF-aligned DSPT allows organisations that have access to NHS patient data and systems to measure their performance against the five objectives of the CAF-aligned DSPT, providing valuable insight into the technical and operational security and governance of information control environment and relative strengths and weaknesses of those controls. Another mechanism is to independently assess the security and governance of information control environments of Health and Social Care organisations. Independent assessment providers help to strengthen the trust placed on the CAF-aligned DSPT submissions by Health and Social Care organisations' boards, Department of Health and Social Care and NHS England by assessing the effectiveness of the organisation's security and governance of information controls. This approach ensures that the controls in place are effective in securing patient data throughout the organisation's estate, including staff handling of data and safe storage on the organisation's systems.

The role independent assessment providers play in helping to strengthen the reliance placed on the CAF-aligned DSPT submissions by Health and Social Care Organisations' boards, Department of Health and Social Care and NHS England is summarised in the National Data Guardian report, 'Review of Data Security, Consent and Opt-Outs and the Care Quality Commission report, Safe data, safe care'. Both reports include the following recommendation: 'Arrangements for internal data security audit and external validation should be reviewed and strengthened to a level similar to those assuring financial integrity and accountability' (NDG 6, CQC 6 Table of recommendations). Therefore, it is essential that independent assessment providers, including internal auditors, focus on the assessment of the effectiveness of health and social organisations' security and governance of information controls, as opposed to simply focusing on the veracity of their CAF-aligned DSPT submissions.

Reporting period: 1 July 2025 to 30 June 2026.

:

Scope and Objectives

This independent assessment provides the following:

1. An assessment of the overall risk associated with Leeds and York Partnership NHS Foundation Trust (LYPFT) security and governance of information control environment. For example, the level of risk associated with weak or failing controls and security and governance of information objectives not being achieved;
2. An assessment as to the veracity of LYPFT's self-assessment / DSPT submission and the Independent Assessor's level of confidence that the submission aligns to their assessment of the risk and controls. The objective of this independent assessment from an LYPFT perspective is to understand and help address security and governance of information risk and identify opportunities for improvement; whilst also satisfying the annual requirement for an independent assessment of the DSPT submission.

Scope of the review

The scope of the review included consideration of processes supporting the DSPT self-assessment process, including:

- The process for compiling and reviewing the toolkit (including approval within the governance structure); and
- The availability of evidence supporting in-scope outcomes and validation of that evidence by the DSPT Coordinator.

Our approach

Our work involves the following activities:

- Meetings with key staff involved in the process
- Walkthroughs of key processes relevant to the completion of the DSPT
- Desktop review of documentation supporting the DSPT
- Sample testing where appropriate.

In cases where we note controls do not exist, we have raised this as a finding.

Out of Scope

- Our work is limited to assessment of the evidence to support the 12 outcomes required to be assessed for this review; therefore, the review will not provide assurance that the entire DSPT return is accurate and complete.
- Our work will not include detailed testing of information technology (IT) systems and will not cover the submission of the DSPT.
- Further limitations of the scope identified during our work will be included within the final report.

Section 2: Executive Summary

CAF-aligned DSPT Independent Assessment Report Outputs

Our review followed the CAF-aligned DSPT Independent Assessment Framework and Guidance published by NHS England. We have reviewed 12 outcomes across the five objectives in the Cyber Assessment Framework. NHS England has mandated a set of outcomes to be audited for 2025/2026. Organisations are required to select a further 3 outcomes to be audited which should be approved by the organisation's Board. The scope of the audit has been approved by the organisation and the independent assessor.

We produced this report as an output of this review. As a result of our evidence assessment and interviews with key stakeholders, we have identified 2 findings in total. All findings and associated management actions have been discussed and accepted by the Chief Financial Officer and Deputy Chief Executive on behalf of the Trust.

Overall Risk Assurance Rating

Overall risk determined for the 12 outcomes included in our testing sample across all five CAF objectives	**Low**
This is a measurement of how many outcomes have been assessed as not meeting the minimum standard as prescribed by NHS England. Basis – Number of outcomes rated as not meeting minimum achievement levels for each rating Very high = More than 4 High = Between 2 and 4 outcomes Moderate = No more than 1 Low = All met Very low = All met and at least 1 exceeded	
Overall confidence level of Independent Assessment	**High**
This is a measurement of whether the evidence provided by the Trust meets their own self-assessment of outcome achievement levels. Level of deviation between self and independent assessment High level of deviation = Low confidence Medium level of deviation = Medium Low level or no deviation = High	

Overall Risk Assurance Rating

The table below summarises our independent assessment of each outcome in our testing sample. The overall risk rating has been derived from an evaluation of the impact and likelihood of each in-scope outcome, from which we have assigned a point scoring to derive an overall assessment conclusion based on NHS England guidance.

Objective	Outcome	Minimum achievement level set by NHSE (as per the profile set for 25/26)	Trust assessed achievement level	IA assessed achievement level	High	Medium	Low	Minimum Level Met	Minimum achievement level met?
A	**A1.a**	Achieved	Achieved	Achieved	-	-	-	A#1 – A#4	Yes
B	**B1.a**	Partially Achieved	Partially Achieved	Partially Achieved	-	-	-	PA#1- PA#7	Yes
	B4.a	Partially Achieved	Partially Achieved	Partially Achieved	-	-	-	PA#1 – PA#4	Yes
	B5.a	Partially Achieved	Partially Achieved	Partially Achieved	-	-	-	PA#1 = PA#2	Yes
	B5.c	Achieved	Achieved	Achieved	-	-	-	A#1 – A#2	Yes
C	**C1.b**	Partially Achieved	Partially Achieved	Partially Achieved	-	-	PA#3	PA#1 – PA#4	Yes
D	**D2.a**	Achieved	Achieved	Achieved	-	-	-	A#1 – A#3	Yes
E	**E2.a**	Achieved	Achieved	Achieved	-	-	-	A#1 – A#3	Yes
	E2.c	Achieved	Achieved	Achieved	-	-	-	A#1 – A#3	Yes
A	**A1.c**	Achieved	Achieved	Achieved	-	-	-	A#1 – A#5	Yes
B	**B2.d**	Partially Achieved	Partially Achieved	Partially Achieved	-	-	PA#2	PA#1 – PA#5	Yes
D	**D1.c**	Achieved	Achieved	Achieved	-	-	-	A#1 – A#4	Yes

We have determined overall risk rating of the organisation's data security and protection control environment, for the in-scope assessments as **Low.** Our assessment is based on NHS England guidance. The NHS England definitions in Appendix A were used for aiding the decision of calculating the overall risk assessment for LYPFT

Areas of good practice

- ✓ Clear senior accountability for information governance and cyber security risks is established through defined executive roles and governance structures.
- ✓ A comprehensive Joiners, Movers and Leavers (JML) process is in place and applied across all staff groups, supporting effective lifecycle management of user access.
- ✓ Role based and least privilege access controls are implemented, with appropriate separation between standard and privileged access.
- ✓ User access changes linked to role changes, and leavers are consistently managed through formal processes, reducing the risk of inappropriate access retention.
- ✓ System access to key platforms is logged and retained, supporting auditability and investigation of access activity.
- ✓ Access related issues are logged, prioritised and resolved through a defined service management process with appropriate service levels.
- ✓ Cyber incident response arrangements are supported by a formally documented and maintained Cyber Incident Response Plan.
- ✓ Cyber incident response exercises are informed by credible threat intelligence and realistic attack scenarios relevant to the organisation's risk profile.
- ✓ Exercises are planned, documented, and subject to senior review and validation through an established testing schedule.
- ✓ Lessons learned from cyber exercises are clearly documented, assigned owners, and tracked through postexercise action plans.
- ✓ Cyber exercises test the full incident lifecycle, including detection, escalation, recovery and post incident review, with appropriate consideration of essential clinical services.

Summary of key findings	
Identity & Access Management	**3.1** No completed or retained evidence of periodic access reviews was available at the time of audit. Risk: Without documented evidence of periodic access reviews, there is a reduced level of assurance that user access continues to align with current roles and responsibilities over time.
Securing logs	**3.2** The Trust should progress the planned implementation of a SIEM solution to enhance monitoring and auditability of access to security log data, including improved visibility over log viewing activity, to further strengthen assurance for future reviews. Risk: There is a reduced level of assurance over the completeness and consistency of monitoring access to security log data, including visibility of log viewing activity, which may limit the Trust's ability to evidence effective oversight in this area.

Section 3: Findings and Agreed Actions

Finding 1: Identity & Access Management	Low Risk
For B2.d PA#2, we noted that a defined process exists (JML, annual account audit), however**:** no completed or retained evidence of periodic access reviews was available at the time of audit. As per the CAF requirements of Indicator of Good Practice B2.d, organisations should periodically review user access rights and revoke access that is no longer required to ensure continued alignment with roles and responsibilities. While a defined process for periodic access reviews exists, no completed or retained evidence of such reviews was available at the time of audit, limiting assurance over its operation in practice.	

Root Cause
The root cause of this finding has been categorised as; Policy and Procedural. While a policy-level requirement exists for periodic access reviews through the Joiners, Movers and Leavers process and the annual audit requirement, arrangements to consistently document, retain, and evidence completion of these reviews were not fully embedded in practice at the time of audit.

Risk
In the absence of completed and retained evidence of periodic access reviews, there is an increased risk that user access may not remain appropriate to current roles, leading to unauthorised or excessive access to systems and information.

Unique ID	Agreed Action	Expected Evidence of Implementation	
6521	A process review will be organised to ensure consistency in retaining documentation, and related evidence of completion with periodic reviews made available.	TBC	
Expected Impact		**Responsible Officer**	**Target Date**
To increase security posture and periodic reviews maintained in alignment with periodic reviews. Process arrangements will be put into practice to minimise the risk of unauthorised access to systems and information and revoke access where necessary in alignment to roles and responsibilities.		Head of Network Operations	31/03/27

Finding 2: Securing logs	Low Risk
For C1.b, PA#3, we noted that controls exist for restricting and protecting logs. However, monitoring of read-only log viewing is partial, with reliance on admin-level monitoring pending SIEM implementation, which are required as per the national guidance for the following indicator of good practice: As per the CAF requirements of Indicator of Good Practice C1.b, Organisations should protect security logs from unauthorised access and ensure that access to logs is appropriately monitored and auditable. While controls were in place to restrict and protect access to log data, monitoring of read-only log viewing was partial and relied on administrator-level oversight pending the implementation of a SIEM solution, limiting assurance that all access to security logs can be comprehensively monitored.	

Root cause
The root cause of this finding has been categorised as; Policy and Procedural. While controls were in place to restrict and protect security logs, monitoring of read-only log viewing was partial and relied primarily on administrator-level oversight pending the implementation of a SIEM solution, limiting assurance over comprehensive monitoring of log access activity.

Risk
There is a reduced level of assurance over the completeness and consistency of monitoring access to security log data, including visibility of log viewing activity, which may limit the Trust's ability to evidence effective oversight in this area.

Unique ID	Agreed Action
6522	To evaluate the decision around the outcome of national funding applied for (expected Summer 26). If successful, relevant processes to procure the SIEM solution and integrate with the existing system will be planned during the calendar year.

How the action will be evidenced/evidence of implementation	Responsible Officer	Target Date
The solution provides an effective SIEM product which allows seamless integration with our existing security product suite. However, this subject to funding. Once implemented, relevant controls will be planned to protect access to log data and monitoring of read-only viewing. Once implemented, further information will be provided. If unsuccessful, a review will be conducted to assess what alternative options are available once a decision is made.	Head of Cyber Security	31/03/27

Appendix A: Understanding your report ratings

How to determine the indicator of good practice achievement level

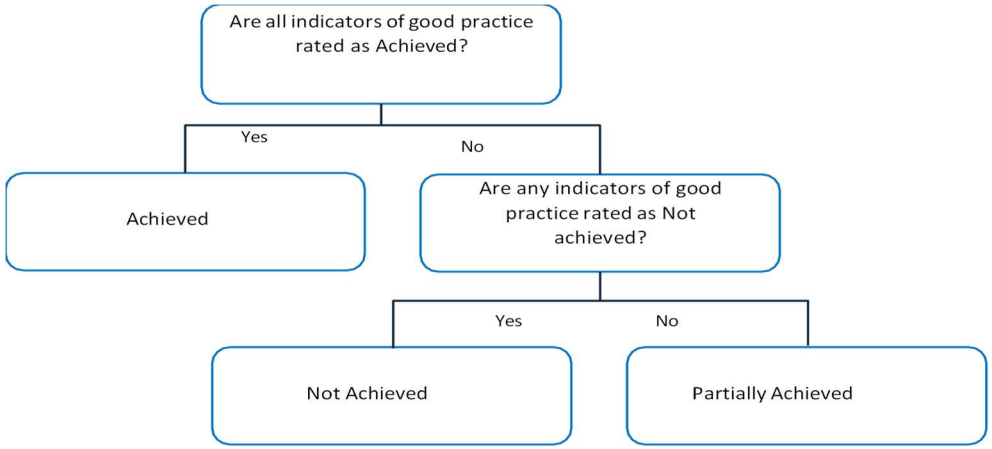
The CAF-aligned DSPT Independent Assessor must assess the achievement level for each in-scope DSPT indicator of good practice assessed as part of their DSPT review. The Independent Assessor leverages knowledge and subject matter expertise alongside observations made during the assessment to evaluate each indicator of good practice against the Not Achieved, Partially Achieved or Achieved statements of the Cyber Assessment Framework. These statements are used to assign an achievement level to each indicator of good practice.
This achievement level reflects the maturity of the organisation in being able to meet the expected outcomes through implementation of controls and processes.

How to determine the outcome level achievement level

The DSPT Independent Assessor must then follow the CAF requirements to assign an achievement level at the outcome level. The CAF states that an outcome will be rated as Achieved if every underlying indicator of good practice is rated as Achieved. An outcome with be rated as Not Achieved if one or more underlying indicator of good practice is rated as Not Achieved. Finally, an outcome will be rated as Partially Achieved if no indicator of good practice is rated as Not Achieved, but not all indicators of good practice are rated as Achieved.

How to determine the overall risk rating for the organisation

The DSPT Independent Assessor then uses the table below to assign an overall risk rating to the organisation.



Overall Risk Rating across all tested outcomes	
Very High	More than four outcomes are rated as not meeting minimum achievement levels required and/or the organisation cannot comply with mandatory policy requirements.
High	Between two and four outcomes are rated as not meeting minimum achievement levels required.
Moderate	No more than one outcome is rated as not meeting minimum achievement levels required.
Low	All minimum achievement levels have been met.
Very Low	All minimum achievement levels have been met and achievement levels have been exceeded for at least one outcome.

Overall Confidence and Risk Levels

The confidence-level in the veracity of the LYPFT DSPT self-assessment submission has been determined by comparing our assessment findings against the self-assessment made by the LYPFT. The following NHS England definitions were used for aiding the decision of applying a confidence-level.

Level of deviation between self and independent assessment	Confidence level
High level of deviation - the organisation's self-assessment against the Toolkit differs significantly from the Independent Assessment. For example, the organisation has declared as "Standards Met" (meeting the expected achievement levels across all outcomes) but the independent assessment has found multiple outcomes as not meeting minimum levels of achievement.	**Low**
Medium level of deviation - the organisation's self-assessment against the Toolkit differs somewhat from the Independent Assessment. For example, the Independent Assessor has exercised professional judgement in comparing the self-assessment to their independent assessment and there is a non-trivial deviation or discord between the two.	**Medium**
Low level or no deviation - the organisation's self-assessment against the Toolkit does not differ / deviates only minimally from the Independent Assessment.	**High**

Appendix B: Summary of work undertaken, and risks reviewed – Mandatory outcomes

Below we set out our assessment of the organisations' current scores for the CAF outcomes reviewed under the scope of this assessment.
We have based our assessment on the requirements set out within the NHS England Independent Assurance Framework, and indicated whether not, in our opinion, Leeds and York Partnership Foundation Trust have met the in-scope outcomes.

Achieved	Understated	Overstated	Agree but insufficient
From the evidence available we are able to agree with the organisations self-assessment as a reasonable assessment of current performance	From the evidence provided it is our assessment that the organisation is performing at a level higher than recorded.	From the evidence available we are not able to agree he self-assessment as a reasonable assessment of current performance	From the evidence provided it is our opinion the organisation has been accurate with its self-assessment, but it has not currently completed the mandatory outcomes as required by NHSE.

Req. #	Description	IGP#	Trust Assessment	Internal Audit Assessment	Comment	Overall Assessment
A1.a	You have effective organisational information assurance management led at board level and articulated clearly in corresponding policies.	A#1	**Achieved**	Agree	We reviewed the Trust's corporate records management policy to confirm that a formally documented policy exists, is current, and has been approved through an appropriate governance route. Evidence reviewed included: IG-0007 Corporate Records Management Guidance (Version 4.1, effective October 2024), which states the Trust's approach to the management of corporate (non-clinical) records, including the creation, maintenance, tracking and disposal of records across their lifecycle. The policy content was reviewed to confirm explicit alignment with: the NHS Records Management Code of Practice (2023), and relevant data protection legislation (UK GDPR and Data Protection Act 2018). The document header and supporting information were reviewed to confirm version control, document ownership, and approval via the Information Governance Group, evidencing formal organisational approval. Explicit examples of testing undertaken: Verified that a single, Trust-wide records management policy is in place and accessible. Checked that the policy scope covers records	Agree

					management responsibilities at an organisational level (rather than informal or local guidance). Confirmed that the policy explicitly references relevant national records management guidance, demonstrating alignment with external standards. Confirmed that the policy has been formally approved and is subject to periodic review. Our testing confirmed that the organisation has an established and formally approved Information Governance framework in place. This is set out principally within the Information Governance Policy (IG-0001), which defines strategic ownership (including SIRO and Caldicott Guardian roles), governance arrangements, and the overarching approach to managing personal and special category data. The framework is supported by a suite of aligned policies, including the Data Protection Policy (IG-0010) and the Confidentiality Code of Conduct (IG-0003), which together provide a clear organisational position on information governance, confidentiality, and compliance with UK GDPR and relevant NHS requirements. Based on the testing performed, we confirm that a documented and approved organisational records management policy are in place.	
		A#2	**Achieved**	Agree	We examined the Trust's corporate records management policy to confirm that it has been subject to formal review and approval, evidencing organisational ownership and accountability. Evidence reviewed included: IG-0007 Corporate Records Management Guidance (Version 4.1, effective October 2024), including the document header and supporting information confirming version control, document ownership and approval arrangements . Historic and current versions of IG-0007, which demonstrate that the policy has been approved via the Information Governance Group and is subject to periodic review, providing assurance of formal governance oversight . Testing undertaken: Verified that the records management policy includes a document reference number, version number and effective date, evidencing formal document control. Confirmed that the policy identifies an approving	

					committee/group with Trust-wide remit (Information Governance Group). Confirmed that the policy is maintained as a controlled corporate document and is periodically reviewed rather than ad-hoc or informal guidance. We confirmed that the Trust's records management policy has been formally approved through an appropriate governance structure and is subject to version control and review. Testing also confirmed that the Information Governance framework is underpinned by comprehensive records management policies covering the full lifecycle of records. This includes the Digital Health Records Policy (EDM-0002), which sets out requirements for the creation, maintenance, access, tracking, and disposal of health records, and the Medical Records Destruction Procedure (EDM-0003), which defines formal destruction and approval processes aligned to the NHS Records Management Code of Practice. Operational procedures supporting records digitisation and control (EDM-0001) were also reviewed. In addition, related policies covering data quality (IG-0006), subject access (IG-0008), and secure handling and transmission of information (IG-0009 – Safe Haven Guidance) were reviewed to confirm the breadth and consistency of records management controls across the organisation.	
		A#3	**Achieved**	Agree	We reviewed the Trust's corporate records management policy to confirm that it explicitly aligns with, and signposts to, appropriate national records management guidance and relevant data protection legislation. Evidence reviewed included: IG-0007 Corporate Records Management Guidance (Version 4.1, effective October 2024), with particular focus on the policy background, references and supporting documentation sections. Internal references within the policy to the NHS Records Management Code of Practice (2023) and applicable data protection legislation, including the UK General Data Protection Regulation (GDPR) and Data Protection Act 2018.	

					Testing undertaken: Checked that the policy explicitly references current national records management guidance rather than relying solely on local practice. Confirmed that the policy signposts users to the NHS Records Management Code of Practice (2023) as the primary external standard. Confirmed that relevant legislative frameworks governing records management and personal data handling are referenced within the policy. Additional testing also confirmed that core Information Governance, data protection, confidentiality, and records management policies are formally approved through established governance routes, including the Information Governance Group, Digital Steering Group, and Policy and Procedure Group, as appropriate. Policies clearly identify named owners and responsible roles, and include defined review cycles to support ongoing oversight and currency. The presence of consistent approval and governance arrangements across the wider policy suite provides assurance that the Information Governance framework is organisation-wide rather than isolated to individual policy documents. We confirm the Trust's records management policy is aligned with relevant national guidance and legislative requirements.	
		A#4	**Achieved**	Agree	We reviewed the Trust's corporate records management policy to confirm that it is maintained under formal document control arrangements and is accessible as an approved organisational policy. Evidence reviewed included: IG-0007 Corporate Records Management Guidance (Version 4.1, effective October 2024), including the document control information within the policy header and supporting sections, which demontrates version control, effective date and document ownership. Testing undertaken: Confirrmed the policy includes a unique document reference number, version number and effective date, demonstrating controlled document management. Confirmed that the policy is designated as corporate guidance intended for Trust-wide application, rather than local or informal reference.	

					Verified that the policy is subject to periodic review and update, indicating that it is actively maintained rather than static or obsolete. In addition to the core Information Governance and Records Management policies, related policies covering data quality, access, subject access, safe handling and IT controls were also reviewed to confirm the breadth and consistency of the organisational framework We also tested to confirm that the Information Governance framework is supported by a range of complementary policies that reinforce its implementation in practice. This includes IT-related policies governing system use, access control, and information security, as well as policies addressing national requirements such as the National Data Opt-Out. Our review of these supporting documents provided further assurance to confirm that Information Governance arrangements are properly embedded in a wider organisational environment, rather than solely as high-level policy statements. We confirm that the Trust's records management policy is maintained as a controlled corporate document and is accessible for organisational use.	

Req. #	Description	IGP#	Trust Assessment	Internal Audit Assessment	Comment	Overall Assessment
B1.a	You have developed and continue to improve a set of information assurance and resilience policies, processes and procedures that manage and mitigate the risk of adverse impact on your essential function(s).	PA#1	**Partially Achieved**	Agree	Our testing confirmed that the organisation has established and formally approved policies and procedures in place that collectively address information governance, confidentiality, data protection, records management, and data quality requirements. Key policies reviewed included the Information Governance Policy (IG-0001), Data Protection Policy (IG-0010), Confidentiality Code of Conduct (IG-0003), and supporting records management documentation such as the Digital Health Records Policy (EDM-0002) and Medical Records Destruction Procedure (EDM-0003). These documents set out the organisation's	Agree

					requirements for the lawful, secure, and appropriate handling of personal and special category data and demonstrate alignment with UK GDPR, the Data Protection Act 2018, National Data Guardian principles, and the NHS Records Management Code of Practice (2023). The breadth and clarity of policy coverage provide assurance that required information governance arrangements are formally defined at an organisational level rather than relying on informal or localised practice.	
		PA#2	**Partially Achieved**	Agree	Our testing confirmed that the organisation's policy framework provides comprehensive coverage across the full information and records lifecycle. This includes procedures governing record creation, access, maintenance, retention, scanning, and destruction, supported by operational documentation such as the Scanning Preparation Centre Operating Procedures (EDM-0001). In addition, policies addressing data quality (IG-0006), subject access rights (IG-0008), safe handling and transmission of information (IG-0009 – Safe Haven Guidance), and national requirements such as the National Data Opt-Out were reviewed to assess the completeness of the framework. Our review confirmed that policies are not limited to high-level statements but are supported by detailed procedural documentation as necessary, which provides consistent direction across digital and physical records. The bredth of documentation provides assurance that the organisation's arrangements extend beyond a minimum compliance goal and are sufficiently comprehensive to support day-to-day practice.	
		PA#3	**Partially Achieved**	Agree	Our testing of the evidence provided confirmed that policies within scope are subject to defined governance, ownership, and review arrangements. Core policies identify named owners and responsible roles, including the Senior Information Risk Owner and Caldicott Guardian, and are approved through established governance routes such as the Information Governance Group, Digital Steering Group, and Policy and Procedure Group, as appropriate. We found review cycles are clearly stated, which support continued oversight and periodic refresh of documentation, ensuring these are quickly compliant,	

					should there be a change in legislation, guidance, or organisational practice. The consistent application of ownership, approval, and review controls across the wider policy structure provides assurance that information governance arrangements are embedded within the organisation's governance framework and are not reliant on isolated or could become legacy documentation.	

Req. #	Description	IGP#	Trust Assessment	Internal Audit Assessment	Comment	Overall Assessment
B4.a	You design security into the network and information systems that support the operation of your essential function(s). You minimise their attack surface and ensure that the operation of your essential function(s) should not be impacted by the exploitation of any single vulnerability.	PA#1	**Partially Achieved**	Agree	We reviewed the network architecture documentation and topology diagrams to confirm that the Trust's network and information systems have been designed using structured, enterprise-grade approaches consistent with professional practice. This included review of on-premise, DMZ, SD-WAN and Azure network topologies referenced within SMH Topology.pdf, BKC Topology.pdf, B4.a_Azure Network Topology.pdf. The presence of layered network design, segmentation, high-availability configurations and consistent architecture across sites demonstrates that systems have been designed and maintained by individuals with appropriate technical expertise, which is relevant to ensuring security controls are built in at design stage rather than retrospectively.	Agree
		PA#2	**Partially Achieved**	Agree	We examined the firewall security rules and boundary configurations, governing internet-facing and 'demilitarized zone' (DMZ) traffic to assess the strength of perimeter defences. This included review of pre- and post-rules for internet-facing firewalls and DMZ security policies: B4.a_Internet_Facing_Sec_Policies_Pre_Rules.pdf, B4.a_Internet_Facing_Sec_Policies_Post_Rules.pdf, B4.a_DMZ_Sec_Policies_Post_Rules.pdf, which we found to contain relevant evidence of high-availability firewall deployment. The rules demonstrate 'default-deny' positions, geographic and threat-based blocking and controlled access between zones. This provided assurance that external interfaces are	

					protected by robust and proportionate boundary defences.	
		PA#3	**Partially Achieved**	Agree	We reviewed SD-WAN flow views, connectivity dashboards, and supporting architecture diagrams to assess whether data flows between the Trust network and external interfaces are designed to be clear and monitorable. The evidence supplied by the Trust was reviewed and included SD-WAN site flow visualisations and redundancy views: SDWAN_Site_Flows.jpg, SDWAN_Redundancy_Resiliency.jpg, SDWAN_Redundancy_Resiliency_VPNs.jpg, which is supported by network topology documentation. These demonstrate defined ingress and egress paths, identifiable source and destination flows, and centralised visibility of traffic, which is needed for the effective monitoring and anomaly detection at network boundaries.	
		PA#4	**Partially Achieved**	Agree	We reviewed the Trust's documented network disaster recovery arrangements to assess whether recovery has been designed to be straightforward and achievable. Detailed within ICT_401 – Network Services Disaster Recovery Plan is evidence of high-availability firewalls, redundant circuits, SD-WAN failover and multiple data centre locations which align with many aspects of a full N+1 strategy. The documentation sets out clear recovery phases, prioritisation of services, and defined responsibilities, demonstrating that network and information systems are architected to support timely recovery following incidents, which is directly relevant to resilience and continuity requirements under this assertion.	
		PA#5	**Partially Achieved**	Agree	We examined firewall rules, DMZ controls, and monitoring arrangements to assess how external inputs to network and information systems are validated and monitored. Our review of the firewall rulebases and DMZ security configurations (B4.a_Internet_Facing_Sec_Policies_Post_Rules.pdf , B4.a_DMZ_Sec_Policies_Post_Rules.pdf) confirms the use of application-aware rules, threat-based	

					controls, and restrictive inbound and outbound access. Where full content validation at the boundary may not be technically feasible, centralised logging and monitoring arrangements provide compensating controls, demonstrating that inputs are either validated at the boundary or subject to additional monitoring, in line with the assertion.	

Req. #	Description	IGP#	Trust Assessment	Internal Audit Assessment	Comment	Overall Assessment
B5.a	You are prepared to restore the operation of your essential function(s) following adverse impact.	PA#1	**Partially Achieved**	Agree	Our audit testing was undertaken to assess if the Trust has identified the systems, networks, and underlying technologies required to support and restore its essential functions, and whether dependencies between those components are understood and documented. Testing included a review of the Trust's essential function of scoping documentation, system and infrastructure dependency mapping, and supporting disaster recovery plans for infrastructure and network services. Key documentation reviewed included the RGD Essential Function Template, which identifies essential functions alongside supporting information systems, infrastructure components, and suppliers, including an assessment of whether failure could result in cascading impact across services. This was supported by the Essential Function Interdependencies documentation, which provides a structured mapping of critical systems and shared infrastructure supporting the delivery of essential services. In addition, detailed technical documentation was reviewed, including the Infrastructure Services Disaster Recovery Plan (ICT-131) and the Network Services Disaster Recovery Plan (ICT-200). These documents identify core infrastructure components (such as data centres, domain controllers, identity services, network connectivity, security controls, backup platforms, and cloud services), their hosting locations, and the dependencies between infrastructure layers, network services, and clinical and operational systems. The DSPT B5.a evidence	Agree

					template was also reviewed to confirm how these documents are referenced and described within the Trust's DSPT submission. Conclusion Based on the evidence reviewed, the organisation demonstrates that it has identified the key networks, information systems, and underlying technologies required to support the restoration of its essential functions. The relationship between foundational components (such as power, connectivity, identity, and core infrastructure) and dependent clinical and corporate systems is documented across multiple artefacts. Interdependencies are described at both service and technical levels, providing assurance that system relationships and potential cascading impacts are understood. This demonstrates that system identification and dependency awareness are in place and documented. RGD Essential Function Template (Excel) – clearly identifies essential functions, supporting systems, suppliers, and whether failures could cascade. Essential Function Interdependencies (PDF) – provides a system-level and service-level dependency map showing shared infrastructure and cross-service reliance. ICT_131 – Infrastructure Services DR Plan – documents: Core infrastructure components (DCs, PAM, TPM, backups, data centres) Dependencies between systems, networks, and sites Backup and restoration arrangements ICT_200 – Network Services DR Plan – details: WAN, LAN, SD-WAN, firewalls, voice, and network security Interdependencies between network components and essential services DSPT B5.a Evidence Template – explicitly states system identification and interdependency understanding, with referenced source documents.	

		PA#2	**Partially Achieved**	Agree	Our testing was undertaken to assess if the organisation has clearly defined and documented the order in which systems and services must be restored following disruption, taking account of technical and operational dependencies. Our testing focused on reviewing disaster recovery documentation, Trust-wide incident and business continuity arrangements, and the narrative provided within the DSPT B5.a evidence template. Evidence reviewed The Infrastructure Services Disaster Recovery Plan (ICT-131) was reviewed to confirm how recovery activities are structured and sequenced across response, resumption, and restoration phases. This document describes the restoration of core enabling services, including data centres, identity services, privileged access management, and backup and recovery platforms, which underpin wider system recovery. The Network Services Disaster Recovery Plan (ICT-200) was reviewed to assess how the recovery of network services is prioritised. The plan defines recovery sequencing that begins with connectivity and security components (such as WAN, LAN, and firewalls), followed by dependent services including remote access, cloud connectivity, and application services. Trust-wide documentation, including the Emergency (Incident Response) Plan (EP-0004) and the Business Continuity and EPRR Policy (EP-0005), was also reviewed to confirm how technical recovery actions align with organisational escalation, coordination, and service restoration processes. The DSPT B5.a evidence template references these documents and describes a tiered recovery approach informed by business impact assessments and system dependencies. Conclusion The evidence reviewed demonstrates that the organisation has defined and documented recovery priorities and sequencing systems supporting essential functions. Recovery order is described across technical disaster recovery plans and aligned to Trust-wide incident and business continuity arrangements. While recovery actions remain context-dependent, the documented approach shows a clear understanding of which systems must	

					be restored first to enable effective service recovery. This evidence provides assurance that recovery order is understood and formally documented. Evidence overview: ICT_131 (Infrastructure DR Plan): Clearly defines phased recovery (response, resumption, restoration) Specifies foundational services (power, DCs, identity, storage) that must precede system recovery ICT_200 (Network DR Plan): Explicit recovery sequencing (WAN - LAN - security - Azure - applications) Service-specific recovery ordering EP-0004 (Emergency / Incident Response Plan) and EP-0005 (BC & EPRR Policy): Provide Trust-wide escalation, coordination, and recovery governance B5.a Evidence Template: Explicitly references DRPs, BC plans, and tiered recovery approaches Includes narrative on recovery prioritisation based on BIAs and dependencies	

Req. #	Description	IGP#	Trust Assessment	Internal Audit Assessment	Comment	Overall Assessment
B5.c	You hold accessible and secured current backups of data and information needed to recover operation of your essential function(s).	A#1	**Achieved**	Agree	We tested to assess if the Trust has implemented comprehensive, centrally managed backup arrangements that ensure data required to support essential functions is secured and accessible from secondary locations in the event of an extreme incident. Our testing focused on reviewing the design and configuration of the enterprise backup solution, the location and security of backup data, and evidence of operational use and governance of backup controls. Testing included a review of the DSPT B5.c Evidence Template, which describes the Trust's hybrid backup architecture and references supporting technical evidence, including system	Agree

					reports and configuration screenshots. The Infrastructure Services Backup Plan (ICT-130) was reviewed to confirm the design, scope, and governance of backup and recovery arrangements. This document sets out a centrally managed backup service delivered through the Rubrik platform, operating across both on-premise and cloud-based infrastructure, with defined restoration procedures in place for major incidents and extreme events. Configuration evidence was reviewed via Rubrik SLA Domain information, including screenshots showing centrally defined SLA policies applying automated backup schedules, retention periods, and replication settings across multiple system types and environments. Operational evidence of secure, secondary-site backup storage was reviewed through documentation describing replication of backup data from on-premise Rubrik appliances to the Trust's Azure-hosted Rubrik Security Cloud environment, providing geographic and architectural separation. Access controls, encryption, and role-based access management for the backup environment are described within ICT-130 and supporting evidence. Examples supporting the conclusion SLA Domain configuration evidence demonstrates that backup policies are defined centrally and automatically applied across systems supporting essential functions, reducing reliance on manual configuration, and supporting consistency of coverage. The hybrid architecture described within ICT-130 shows that backup data is stored both locally and replicated to a secondary, cloud-hosted environment, ensuring backups remain accessible in the event of loss of the primary data center. The backup service is managed through a single enterprise portal, with access restricted via RBAC and supporting encryption in transit and at rest, demonstrating that backup data is both secured and centrally accessible under controlled conditions. The integration of backup and recovery arrangements into Trust-wide incident and disaster recovery planning further demonstrates that backups are intended for use during extreme events and not	

					solely for routine operational recovery. The evidence reviewed demonstrates that the Trust has implemented comprehensive, automated, and centrally managed backup arrangements, with backup data secured and replicated to secondary locations to support recovery from extreme events. Backup policies are applied consistently across systems supporting essential functions, and the security, accessibility, and governance of backup data are clearly defined. Backups are managed centrally through Rubrik, with policy-based automation across workloads. A hybrid architecture is in place, comprising: On-premise Rubrik appliances; and Replicated cloud-based storage (Azure / Rubrik Security Cloud). The SLA Domains screenshot shows defined, centrally managed SLA policies covering: Daily, hourly, weekly, and monthly backup frequencies; Replication and retention settings; and Multiple workloads and system types. Backup data is secured, with encryption in transit and at rest, and access restricted via RBAC. The Infrastructure Backup Plan (ICT-130) explicitly describes recovery capability in the event of a major or extreme incident.	
		A#2	**Achieved**	Agree	We tested the supplied evidence to confirm if backups of data and information required to support essential functions are being consistently performed, routinely tested, formally documented, and subject to ongoing review. Testing focused on reviewing backup coverage, operational restore activity, documentation governing backup and recovery arrangements, and evidence of monitoring and oversight of backup performance. We reviewed: The DSPT B5.c Evidence Template was reviewed to understand how the Trust describes its backup arrangements and the supporting evidence used to substantiate the assertion.	

					The Infrastructure Services Backup Plan (ICT-130) was reviewed to confirm that backup schedules, restoration procedures, roles, responsibilities, and governance arrangements are formally documented and maintained under version control. Operational evidence was reviewed through multiple Rubrik reports, including the Compliance Report and Protection Status reporting, which demonstrate that systems supporting essential functions are routinely backed up in line with defined SLA policies and that backup success is actively monitored. Evidence of routine testing and recovery capability was reviewed through recovery task reports and a worked recovery example, showing successful restoration activity, validation by technical staff, confirmation by end users, and closure through the IT service management process. Examples supporting the conclusion Protection Status and Compliance reporting demonstrate that backups are routinely executed and monitored, with systems supporting essential functions showing current successful backups under defined SLA domains. Recovery task reporting provides evidence of successful restore activity carried out over the past year, demonstrating that backups are not only created but are practically recoverable. A detailed recovery example shows an end-to-end restoration process, including incident logging, assessment, execution of recovery, verification of restored data, and formal closure, providing assurance that backup testing is embedded into operational practice. ICT-130 documents the formal backup and restoration arrangements, including schedules, recovery procedures, and review expectations, supporting consistency and organisational oversight of backup controls. The Rubrik platform provides centralised reporting and monitoring, supporting routine review of backup success, retention, and compliance against defined policies. The evidence reviewed demonstrates that backups of data required to recover essential functions are routinely performed, tested through real recovery activity, formally documented, and actively	

					monitored. Backup and restoration arrangements are embedded within operational processes and supported by centralised reporting and governance. The evidence demonstrates: Comprehensive backup coverage exists for systems supporting essential functions, evidenced through: Protection Status reports; Compliance reports; and SLA configuration data. Regular backup execution is occurring, with recent successful backups shown across multiple object types. Backup testing is evidenced through: Recovery task reports showing successful restore activity over the past 12 months; and A worked end-to-end restoration example showing initiation, recovery, validation, and closure. Backup arrangements, schedules, roles, and responsibilities are formally documented within ICT-130. Backup activity, success/failure, retention, and compliance are actively monitored through Rubrik reporting.	

Req. #	Description	IGP#	Trust Assessment	Internal Audit Assessment	Comment	Overall Assessment
C1.b	You hold log data securely and grant appropriate access only to accounts with business need. No system or user should ever need to modify or delete master copies of log data within an agreed retention period, after which it should be deleted.	PA#1	**Partially Achieved**	Agree	We reviewed role-based access controls within the Trust's logging and monitoring platforms to confirm that access to log data is restricted to authorised personnel only. This included review of user and role assignments within Palo Alto Panorama (Fig 1 – User Access.png), and the supporting narrative in DSPT Evidence 2026 – C1b. The evidence supplied shows that access to security logs is limited to named users within Network, Infrastructure, and Cyber Security roles, with permissions aligned to business need and the principle of least privilege, which is relevant to preventing unauthorised access to sensitive log data.	Agree

					The screenshot (Fig 1 – User Access.png) shows named user accounts, defined roles and role-based access controls within Palo Alto Panorama. Access is clearly limited to administrators and authorised technical roles, aligning with the "business need" principle. The written narrative in DSPT Evidence 2026 - C1b explicitly describes: Role-based permissions Least-privilege access JML processes for reviewing access	
		PA#2	**Partially Achieved**	Agree	We tested to confirm whether authorised users and systems are able to access log data in a controlled and appropriate manner to support operational and investigative activity. The evidence supplied and reviewed included the Trust's description of access arrangements for automated systems (e.g. Panorama, Microsoft Defender for Endpoint, Tanium) and human users via predefined roles, as set out in DSPT Evidence 2026 – C1b.docx, supported by the Panorama user role configuration (Fig 1 – User Access.png). This confirms that access is sufficient to allow logs to be queried and analysed, while restricting 'write' or administrative permissions where not required, which is relevant to maintaining both usability and security of log data. The narrative confirms that: Automated systems (e.g. Panorama, MDE, Tanium) have defined access. Human users access logs via predefined roles. Read/write permissions are restricted, with most access read-only. This is supported visually by distinct administrator roles and accounts shown in Fig 1.	
		PA#3	**Partially Achieved**	Overstated	We reviewed the Trust's arrangements for monitoring access to log data to determine whether actions such as deletion, modification or large-scale export are auditable and subject to oversight. Evidence from DSPT Evidence 2026 – C1b.docx confirms that administrative actions within logging platforms (e.g. Palo Alto Panorama) are logged and reviewed, and that alerts are in place for suspicious	

					activity such as unauthorised privilege escalation or abnormal log access patterns. While monitoring all read-only log viewing is not currently comprehensive, the controls in place provide partial visibility over access to log data, which is relevant to detecting misuse or inappropriate handling of security logs. Monitoring of administrative actions (delete, modify, export). Alerts for suspicious behavior (e.g. large-scale copying, privilege escalation). However, the narrative explicitly acknowledges a limitation: Not all read-only log viewing is currently monitored. A SIEM solution is planned to strengthen coverage.	

Req. #	Description	IGP#	Trust Assessment	Internal Audit Assessment	Comment	Overall Assessment
D2.a	When an incident or near miss occurs, steps must be taken to understand its root causes and ensure appropriate remediating action is taken.	A#1	**Achieved**	Agree	Our testing was to assess if the Trust routinely undertakes root cause analysis following information governance, cyber, or related incidents and 'near misses', and whether their prescribed actions are embedded within normal incident management and governance arrangements. We reviewed D2.a Evidence Template; we reviewed this to understand how incidents are reported, escalated, analysed, and governed through DATIX and supporting Information Governance (IG) structures. Our testing considered the role of DATIX in incident capture, escalation mechanisms, and the governance forums through which incidents and lessons learned are reviewed. When an incident report is submitted, DATIX automatically flags the incident to the Head of Information Governance, ensuring contemporaneous visibility of incidents as they occur rather than retrospective awareness. This establishes a clear audit trail showing when the incident was reported and when it entered formal review, supporting timely root cause analysis from the outset. Evidence seen confirms that all relevant incidents	Agree

					are reported via DATIX, which has automatic flaggging of incidents, which are communicated to the Head of Information Governance as they are logged. Incidents are reviewed as they occur, with ICT-specific or cyber incidents discussed at weekly Senior Management Team meetings, and broader oversight provided through monthly Information Governance Group meetings with SIRO and Caldicott Guardian involvement. Monthly incident reports and twice-yearly thematic reviews are produced to identify trends, share learning, and support preventative action. Examples reviewed: When an information governance, cyber, or related incident or near miss occurs, it is reported by staff through the Trust's DATIX system. Each DATIX submission creates a date-stamped incident record at the point of reporting, capturing fields including Incident Date, Date Reported, severity, incident category, description, and immediate action taken, as described in the D2.a evidence template. Following submission, DATIX records are reviewed and developed through date-stamped investigation stages, including manager review, identification of contributory factors, investigation progress, findings, and actions taken. These records form the basis of monthly Information Governance Group reporting, providing a regular, time-bound cycle of review with SIRO and Caldicott Guardian oversight, as evidenced in the standing agenda items and reporting arrangements described within the D2.a template. In addition, twice-yearly thematic reports via DATIX are presented to Trust-wide governance forums to review trends and lessons learned over defined reporting periods. The Head of Information Governance also retains a rolling 12-month log of incident-related correspondence and advice, providing longitudinal evidence of learning and action over time rather than isolated incident review. The evidence shows that root cause analysis is conducted routinely as part of the Trust's incident	

					management and lessons-learned processes, with structured escalation and governance oversight ensuring learning is captured and reviewed.	
		A#2	**Achieved**	Agree	Our testing confirmed that information governance incidents are reported via DATIX and are reviewed as a standing agenda item (5.3 – DATIX IG Incident Review) at the Information Governance Group (IGG). IG Group minutes from February, March, and April 2026 demonstrate that incident summaries are routinely presented to the Group, including near misses, non-breach, non-reportable, and potentially reportable incidents, with commentary on severity, investigation status, and any requirement for escalation. Supporting IG Incident Reports presented to IGG show that incidents are categorised, reviewed for severity, and assessed to determine whether they are systemic or attributable to individual error, with follow-up actions identified where further investigation or decision-making is required. (IG Group Meeting Minutes.March 2026) In addition, a Quality Improvement for Information Governance report presented to the Trustwide Clinical Governance Group provides aggregated analysis of IG incidents and near misses across reporting periods, including identification of themes, trend analysis, and confirmation of whether systemic issues are emerging, with learning and oversight escalated to an appropriate senior forum. (5.3 - IG Incident Report) The evidence demonstrates that information relating to governance incidents and near misses is subject to structured and recurring review through established governance arrangements. Incidents are categorised, monitored, and reviewed to assess severity, trends, and the presence (or absence) of systemic causes, with appropriate escalation and learning routes in place.	
		A#3	**Achieved**	Agree	We tested to confirm that those responsible for analysing incidents have access to complete and relevant incidents and near miss information to support effective root cause analysis. D2.a Evidence Template confirms that DATIX is the central incident reporting system for all incident types, which ensures consistent and complete	

					reporting. DATIX records include incident severity, description, contributory factors, immediate actions taken, investigation progress, findings, and action plans, all of which are available to managers and the Head of Information Governance. DATIX incidents are automatically flagged to the Head of Information Governance on submission, with direct hyperlinks provided to full incident records. A rolling 12-month log of related correspondence and advice is retained to support continuity of analysis and learning. We confirmed that DATIX is the single system used for recording all incidents and near miss data, including information governance and cyber-related incidents. Each DATIX record captures a comprehensive, structured dataset, including: Incident date and severity Incident category and description Immediate actions taken Manager's review and investigation findings Contributory factors Actions taken and action plans This information is available in full to managers responsible for investigating incidents and to the Head of Information Governance, who are automatically alerted upon submission of an incident. The presence of defined investigation and action-tracking fields within DATIX enables those analysing incidents to access all relevant information needed to perform root cause analysis, without reliance on parallel systems or informal records. Testing also confirmed that DATIX incidents are automatically flagged to the Head of Information Governance at the point of submission, ensuring timely availability of incident data for review and guidance. In addition, a rolling 12-month log of incident-related email correspondence and advice is retained by the Head of Information Governance, providing supplementary context to support ongoing analysis, learning, and follow-up across incidents. This retained correspondence supports continuity of analysis where incidents require additional clarification, guidance, or escalation, and allows	

					historical data to be referenced during thematic reviews. That incident data required for RCA is centrally captured, consistently structured, and directly accessible to those undertaking analysis. Cyber-specific alerts received via the national CareCERT platform are similarly triaged, actioned, and tracked, with evidence confirming defined roles, response times, and oversight of the process. For cyber-related incidents and near misses originating from national intelligence, the Trust receives alerts via the NHS CareCERT platform. These alerts are issued with date and time stamps and are routed to defined cyber, IG, and senior roles within the organisation. The CareCERT platform provides visibility of alert status, response activity, and resolution, ensuring that cyber-related near-miss data is also available to those responsible for analysis. From the CareCERT platform screenshot provided (Fig A), there is a clear example: Alert ID: CC-4711 Alert name: Microsoft Releases Out-of-Band Security Update for Windows Server Update Service (WSUS) Issued: 27 October 2025 at 11:17 AM Status: Not applicable This provides explicit evidence that: Cyber alerts originating from national intelligence are received by the Trust; and Alerts are time- and date-stamped at source within the national CareCERT platform. This is further supported by IG Group and Trustwide Clinical Governance reporting, which demonstrates that incident trends and conclusions are used to inform organisational learning and oversight. Our analyis of the evidence supplied shows that complete and relevant incident and near miss data is made available to those responsible for analysis, through centrally managed reporting systems and automated escalation mechanisms.	

Req. #	Description	IGP#	Trust Assessment	Internal Audit Assessment	Comment	Overall Assessment
E2.a	You appropriately assess and manage information rights requests such as subject access, rectification and objections.	A#1	**Achieved**	Agree	We tested the supplied evidence to confirm whether the Trust has defined, documented, and approved processes in place to enable individuals to exercise their data subject rights, including Subject Access Requests (SARs) and related information rights, in line with the UK GDPR and Data Protection Act (2018). Testing included review of the Medical Records Access Request Procedure (IG-0008), which sets out the process for service users and their representatives to submit and exercise data subject rights in relation to health records, including receipt of requests, identity verification, statutory timescales, redaction controls, and disclosure methods. The Subject Access Request (Employee Records) Procedure (HR-0053) was reviewed to confirm equivalent arrangements for current and former employees, including submission routes, HR ownership, logging, identity checks, and compliance with the one-calendar-month statutory timescale. The Freedom of Information Act Procedure (IG-0005) was reviewed to confirm that FOI requests are clearly distinguished from SARs and routed through an appropriate and separate process, reducing the risk of misclassification of personal data requests. Public-facing information published on the Trust website was also reviewed to confirm that individuals are clearly signposted on how to exercise their information rights and submit requests. The evidence demonstrates that the Trust has clear, documented, and approved processes in place to support the exercise of data subject rights for service users, employees, and other individuals. These processes are aligned with statutory requirements and are accessible via both internal documentation and external-facing guidance.	Agree

		A#2	**Achieved**	Agree	We tested the supplied evidence and statement to assess whether data subject rights requests are consistently logged, tracked through to completion, and subject to monitoring and oversight to ensure statutory timescales are met. The evidence confirms that SARs relating to employee records are logged by the Human Resources team and tracked via a dedicated SAR tracker spreadsheet, capturing key information such as date of request, progress, and completion status, with monitoring through to response. For health records, the Medical Records Access Request Procedure specifies the use of an Access Request tracker spreadsheet that records case reference numbers, dates, identity checks, progress, and performance against statutory timescales. The procedure explicitly states that performance data from this tracker is reported to the Information Governance Group. The Freedom of Information Act Procedure confirms that FOI requests are logged using unique reference numbers and tracked through an Excel workbook, with monthly performance reporting to the Information Governance Group, including workload volumes and compliance with statutory deadlines. From our analysis, we can confirm that the Trust has established logging and tracking mechanisms for requests and related information rights, supported by defined monitoring arrangements and governance reporting. These controls provide assurance that requests are managed and monitored in line with statutory requirements.	
		A#3	**Achieved**	Agree	We tested to ascertain whether the Trust's handling of data subject rights requests includes appropriate safeguards, lawful decision-making, secure disclosure methods, and defined escalation routes. From the evidence supplied we note: The Medical Records Access Request Procedure details requirements for identity verification, application of the Serious Harm Test by an Appropriate Healthcare Professional, and redaction of third-party information where a duty of confidence	

					applies. Secure disclosure methods are defined, including recorded delivery and secure electronic transmission only where agreed. The Employee SAR Procedure sets out equivalent safeguards for staff records, including identity checks, third-party redaction, secure disclosure arrangements, and escalation routes to the Data Protection Officer and the Information Commissioner's Office where required. The FOI Procedure further confirms consistent application of lawful exemptions, documentation of decision-making, complaint handling, and ICO escalation routes, reinforcing organisational consistency in the handling of information rights requests. In conclusion, the supplied evidence demonstrated that data subject rights requests are processed lawfully, securely, and consistently, with appropriate technical, procedural, and governance safeguards in place. Clear escalation and complaint routes further support compliance with statutory and regulatory requirements.	

Req. #	Description	IGP#	Trust Assessment	Internal Audit Assessment	Comment	Overall Assessment
E2.c	A robust policy and system is in place to ensure opt-outs are correctly applied to the information being used and shared by your organisation.	A#1	**Achieved**	Agree	Our testing has confirmed that the Trust has formally adopted the National Data Opt-Out within its approved local governance framework. IG-0003 – Confidentiality Code of Conduct includes Appendix F: National Data Opt-Out Policy. This explicitly states the Trust's obligation to comply with national data opt-out requirements and to assess uses or disclosures of confidential patient information against national policy. The document is approved by the Information Governance Group and ratified through formal Trust processes, demonstrating organisational commitment to compliance. IG-0003 – Confidentiality Code of Conduct (Appendix F: National Data Opt-Out Policy) explicitly	Agree

					states that, as an NHS provider, the Trust is required to enact the National Data Opt-Out and will continue to apply it as a matter of policy. The appendix confirms the Trust's obligation to review uses or disclosures of confidential patient information against national opt-out rules, aligning local practice to the national framework. The policy makes clear that National Data Opt-Out requirements are not optional, and that compliance is embedded within Trust confidentiality and data protection arrangements.	
		A#2	**Achieved**	Agree	Testing identified that IG-0003 Appendix F sets out clear operational arrangements for applying the National Data Opt-Out in practice. The policy confirms that opt-out choices are received from national systems, held within back-office processes, and applied to datasets produced for purposes beyond individual care, such that records of individuals who have opted out are excluded where appropriate. The policy also confirms that opt-out preferences are not recorded in core clinical systems, ensuring patient care is not adversely impacted while preferences are respected. Appendix F sets out how the Trust receives and consumes opt-out choices from the national 'MESH' service and holds them within back-office systems, demonstrating that opt-outs are technically and operationally implemented and not merely acknowledged. The policy explicitly states that datasets drawn for secondary uses are produced minus those who have opted out, which demonstrated that opt-outs are applied prior to disclosure or secondary use. It is clearly stated that opt-out choices are not recorded in core clinical systems, ensuring that patient care is unaffected while choices are still operationally respected.	
		A#3	**Achieved**	Agree	Our review of the supplied evidence confirmed that the Trust's arrangements support patient awareness and informed choice. IG-0003 Appendix F requires staff to signpost service users to appropriate national resources where queries about the National Data Opt-Out are raised.	

					This is supported by publicly available Trust information explaining how patient information is used and how opt-out choices can be exercised, demonstrating transparency and alignment between internal policy and external communications. Appendix F confirms that, when asked, staff are expected to guide service users to appropriate national resources explaining the National Data Opt-Out and how to register a choice. National opt-out information and registration routes are referenced, and this is reinforced by public-facing Trust information made available via the Trust website (E2c Evidence URL). This demonstrates consistency between internal policy, staff expectations, and external transparency provided to patients.	

Appendix C: Summary of work undertaken and risks reviewed – Additional outcomes

Req. #	Description	IGP#	Trust Assessment	Internal Audit Assessment	Comment	Overall Assessment
A1.c	You have senior-level accountability for the security and governance of information, systems and networks, and delegate decision-making authority appropriately and effectively. Risks to information, systems and networks related to the operation of your essential function(s) are considered in the context of other organisational risks.	A#1	**Achieved**	Agree	We reviewed governance arrangements to assess whether senior management has visibility of key decisions relating to information and cyber security risks. Evidence confirms that accountability for information risk is assigned to the SIRO, with operational responsibility supported by the CDIO and oversight from the Caldicott Guardian. These roles are represented on key governance forums, including the Information Governance Group and the Digital Steering Group. Information and informatics risks are recorded on the DATIX risk management system, reviewed monthly at the Information Governance Group, and escalated through established committees where required. Regular reporting to the Board of Directors is described, providing senior management and Board-level visibility of key risk decisions.	Agree.
		A#2	**Achieved**	Agree	We reviewed arrangements supporting decision-makers in making effective and timely information risk decisions. Evidence shows that the CDIO chairs regular DDaT senior leadership and Extended SMT meetings, where portfolio risks and issues are discussed and managed through a departmental Risk & Issues Log. Risks requiring organisational-level oversight are escalated to the corporate DATIX risk register and reviewed through the Information Governance Group, with reporting to the SIRO and Caldicott Guardian. This demonstrates that risk decision-makers understand and operate within the Trust's established risk management framework.	
		A#3	**Achieved**	Agree	We assessed whether risk decision-making is appropriately delegated and escalated to individuals with suitable authority, knowledge, and skills. The evidence supplied identifies defined subject matter experts across information governance, cyber security,	

					network operations, and end-user computing who support the identification and management of risks. Risks are managed through these roles and progressed via established governance structures, with escalation to senior forums where required. This demonstrates that responsibility for managing and escalating risks is delegated appropriately within the organisation.	
		A#4	**Achieved**	Agree	We reviewed arrangements for the ongoing review of information and cyber security risk decisions. Evidence confirms that review frequency is aligned to risk severity, likelihood, and volatility. The DATIX risk register and DDaT Risk & Issues logs support the scheduling of reviews, re-scoring, and recording of updates, with outcomes discussed at the appropriate governance forums. This provides assurance that risk management decisions are regularly reviewed to ensure they remain relevant and valid.	
		A#5	**Achieved**	Agree	We assessed whether risk decisions are coordinated across different departments. From analysis of the evidence provided, we noted that it shows cross-representation through shared membership of the DDaT SMT, Information Governance Group, Digital Steering Group, and Board reporting structures. Operational DDaT management attend multiple forums, enabling cross-departmental discussion and alignment of risks, including those shared between Network / Cyber Security and End User Compute teams. We conclude that information and cyber security risk decisions are joined-up across departmental boundaries.	

Req. #	Description	IGP#	Trust Assessment	Internal Audit Assessment	Comment	Overall Assessment
B2.d	You closely manage and maintain identity and access control for users, devices and systems accessing the network	PA#1	**Partially Achieved**	Agree	We reviewed the Trust's processes for verifying users and assigning access to systems supporting essential functions. The supplied evidence illustrates how user access is	Agree

	and information systems supporting your essential function(s).				provisioned through formal Joiners, Movers and Leavers (JML) processes, with access requests initiated by managers and actioned by the Service Desk using approved request forms. Access is assigned on a role-based basis, with standard user accounts separated from privileged or administrative access. Screenshots of Active Directory user objects and privileged access arrangements demonstrate that elevated permissions are restricted to designated individuals and that a least-privilege access model is applied. B2.d submission describes least-privilege model and role-based access. Screenshots show: Active Directory user objects located in appropriate OUs. Privileged access controls (separate privileged/admin context). JML procedure (ICT001): Access requests via formal forms (FRM001 / FRM002). Line manager initiation + Service Desk provisioning. Explicit separation between standard and elevated access. Evidence supports that users are verified, authorised, and issued minimum required access.	
		PA#2	**Partially Achieved**	Overstated	We assessed the arrangements for reviewing user access and removing access that is no longer required. The JML procedure defines periodic access reviews, including an annual account audit across different staff groups and systems, and links access revocation to leaver and role-change processes. The evidence supplied demonstrated that adaquate processes are in place to identify and remove access when roles change or employment ends. However, while the procedure mandates regular reviews, no completed access review outputs or signed review records were provided as part of the evidence set. ICT001 includes: Annual Account Audit (JML016) requirement.	

					Periodic checks across staff groups and core systems. Descriptive statement in B2.d template refers to regular access reviews. Process exists for identifying and removing access via JML and leaver workflows. No specific completed access review output (e.g. signed access review, extract, or dated sample). Annual audit is defined, but execution evidence isn't shown.	
		PA#3	**Partially Achieved**	Agree	We reviewed the operation of JML controls to confirm that access is reviewed when users change role or leave the organisation. We would cite the ICT001 Joiners, Movers and Leavers procedure, which prescribes detailed processes for joiners, movers and leavers across all staff groups, including substantive, bank, agency, students and third-party users. Screenshots of Joiners, Movers and Leavers forms and system pages demonstrate that role changes and leavers are formally processed and trigger the review, amendment or removal of system access. This provides assurance that access is appropriately reviewed throughout the employee lifecycle. ICT001 JML procedure is very detailed and comprehensive, covering: Joiners, movers, leavers Substantive, bank, agency, students, partners Screenshots show: Joiners / Movers / Leavers system pages (SW1 / SW2 / SW3). JML splash / workflow pages. Clear rules for: Role change reviews Same-day disabling for leavers Removal of system and data access	
		PA#4	**Partially Achieved**	Agree	We assessed whether user, device and system access to systems supporting essential functions is logged and monitored. Our evidence included screenshots of Windows Security Event Logs showing successful logon activity, demonstrating that access events are timestamped and attributable to specific systems and accounts.	

					The evidence confirms that access logging is in place and logs are available to support monitoring, investigation and audit activity. The documentation also confirms that access logs are not routinely cross-correlated with other datasets, which is consistent with the partially achieved self-assessment. Windows Security Event Log screenshot (Event ID 4624): Successful logon Timestamped Source system identified Narrative states: Logs are retained and available Not routinely cross-correlated with HR or other datasets This explicitly matches the PA#4 wording (“logged and monitored but not compared”).	
		PA#5	**Partially Achieved**	Agree	We reviewed access-related issues raised by staff and how they are managed and resolved by the IT Service Team. Evidence includes screenshots from the IT service management system showing access requests being logged, categorised, prioritised and managed against defined service levels. The examples supplied, demonstrate that access issues, including those relating to clinical systems, are assigned an impact and urgency and are resolved within defined response and resolution timeframes, with managerial involvement where approval is required. This provides assurance that access issues are resolved without undue delay. Cherwell ticket screenshot: Logged access issue (EPMA) Priority, impact, urgency recorded SLA dates visible (respond / resolve). Service Desk workflow clearly demonstrated. JML process requires manager involvement for approvals. Evidence shows that access issues are: logged,	

					prioritised, tracked against SLAs, and resolved via a defined process.	

Req. #	Description	IGP#	Trust Assessment	Internal Audit Assessment	Comment	Overall Assessment
D1.c	Your organisation carries out exercises to test response plans, using past incidents that affected your (and other) organisation, and scenarios that draw on threat intelligence and your risk assessment.	A#1	**Achieved**	Agree	We reviewed evidence of cyber incident response exercises to assess whether scenarios are informed by threat intelligence and real-world experience. The Trust has undertaken exercises based on credible cyber threats, including malware, phishing and insider-style attacks, informed by external threat intelligence sources and national exercise frameworks. Scenario documentation demonstrates that exercises are designed to reflect plausible attack vectors and risks relevant to the organisation's operating environment. Scenarios are explicitly demonstrated by: Threat intelligence feeds (TISP) NCSC / DHSC "Exercise in a Box" Immersive Labs scenarios The "Truth for All" exercise is clearly: A malware / ransomware-style incident Expanded to test insider threat, phishing, lateral movement, and impact on clinical services The evidence explicitly references learning from real-world breaches (e.g. credential misuse, exploitation of unpatched vulnerabilities).	Agree
		A#2	**Achieved**	Agree	We reviewed documentation supporting the planning, review and validation of cyber incident response exercises. The evidence supplied to us confirms that exercises are formally documented, with scenarios, outcomes, and reviews recorded. Completed exercises are reviewed and validated by senior cyber and digital leads, and validation is recorded through the testing schedule and associated governance arrangements. Exercises are: Documented through formal scenario packs (slides)	

					Supported by After-Action Reports Reviewed and validated via: Testing schedule Head of Cyber Security / CDIO sign-off Fig B and Fig D clearly demonstrate: Review output Validation outcomes Follow-up actions	
		A#3	**Achieved**	Agree	We assessed whether exercises are conducted on a routine basis and whether learning is used to refine response arrangements. Evidence demonstrates that cyber incident response exercises are delivered as part of a planned programme, with After Action Reports produced following each exercise. Any identified lessons learned are documented, assigned owners, and tracked through a post-exercise action plan, with updates made to response documentation and processes where required. Multiple exercises conducted (not a single event) Explicit After-Action Reports produced Lessons learned are: Clearly articulated Assigned owners Given target completion dates Evidence shows: Planned updates to the Cyber Incident Response Plan Changes to roles (e.g. loggist) Improvements to logging, escalation clarity, and stakeholder communication	
		A#4	**Achieved**	Agree	We tested to confirm all relevant stages of the incident response lifecycle for essential functions. Our evidence demonstrates that exercises are structured to test detection, analysis, containment, escalation, recovery and post-incident activities, including the impact on clinical services and business continuity arrangements. Scenarios progress through escalating stages to test decision-making, restoration activities and post-incident review, providing assurance that the full response cycle is exercised.	

					The “Truth for All” exercise explicitly and progressively tests: Detection & Analysis (initial alert, threat intelligence, log analysis) Containment & Eradication (isolation, lateral movement, malware spread) Recovery & Restoration (backup restoration, dependency on clinical services, extended BCP operation) Post-Incident Activity (pentesting, remediation, communications, governance questions) The scenario deliberately escalates to: Risk to life Clinical service disruption Regulatory reporting obligations Board-level scrutiny	

Appendix D: Audit Brief

Internal Audit Brief – Data Security and Protection Toolkit – 18 March 2026

Audit objective	This independent assessment will provide the following: • An assessment of the overall risk associated with the organisation's security and governance of information control environment. For example, the level of risk associated with weak or failing controls and security and governance of information objectives not being achieved. • An assessment as to the veracity of organisation's self-assessment / DSPT submission and the Independent Assessor's level of confidence that the submission aligns to their assessment of the risk and controls. The objective of this independent assessment from the organisation's perspective is to understand and help address security and governance of information risk and identify opportunities for improvement; whilst also satisfying the annual requirement for an independent assessment of the DSPT submission.
Audit Background and Scope	Data and information are critical business assets and ensuring their confidentiality, integrity and availability are fundamental to the continued delivery and operation of health and care services across the UK. Leeds and York Partnership NHS Foundation Trust must have confidence in the confidentiality, integrity and availability of their information assets and must ensure that any personal data collected, stored and processed by public bodies are aligned to specific legal and regulatory requirements to support the delivery of high-quality care to patients. The Data Security and Protection Toolkit (DSPT) is an annual return (requiring submission on 30 June 2026) and is NHS England's (NHSE) tool for ensuring organisations which have access to NHS patient data and systems measure their performance against security standards aligned to the NCSC Cyber Assessment Framework (CAF). The expectations for security and governance of information controls under CAF-aligned DSPT profile are designed to be comparable level to the previous DSPT, providing additional control testing only in areas where NHS England considers a higher standard to be a necessary obligation such as threat management. The review will be conducted in accordance with the national DSP audit framework, Strengthening Assurance, as updated for 2025-26. The prescribed sample of assertions for audit is published on the NHS England website at

https://www.dsptoolkit.nhs.uk/News/auditnews

The Reporting period is 01 July 2025 to 30 June 2026.

The new CAF-aligned DSP has five objective areas and a total of 47 outcomes. These will be assessed over a multi-year period. Each year, a selection of outcomes from across the 5 objectives will be tested. In 2025/2026 NHSE has mandated a common core set of 9 outcomes to be assessed for all organisations that undertake the CAF-aligned DSPT. In addition, organisations will need to select at least 3 further outcomes locally based on assessed risk.

Scope of the review

The scope of the review will include consideration of processes and evidence that support the DSPT self-assessment process, including:

- The process for compiling and reviewing the toolkit (including approval within the governance structure); and
- The availability of evidence supporting in-scope outcomes and validation of that evidence by the DSPT Coordinator.

Out of scope

- Our work is limited to assessment of the evidence to support the outcomes required to be assessed for this review (as detailed below) therefore, the review will not provide assurance that the entire DSPT return is accurate and complete.
- Our work will not include detailed testing of IT systems and will not cover the submission of the DSPT to NSHE.
- Further limitations of scope identified during our work will be included within the final report.

Potential Key Risks and Counter Fraud Risks associated with the area	The audit will address risks in relation to the following mandatory outcomes prescribed for the 2025-26 audit: A1.a Board direction B1.a Policy, process and procedure development B4.a Secure by design B5.a Resilience preparation B5.c Backups C1.b Securing logs D2.a Incident root cause analysis E2.a Managing data subject rights under UK GDPR E2.c National data opt-out policy The audit will also address risks in relation to the	**Methodology**	Audit fieldwork will consist of: • Obtaining access to the organisation's DSP Toolkit self-assessment • Reviewing the mandatory evidence texts that will be assessed for the organisation • Requesting and reviewing the documentation provided in relation to in-scope evidence texts • Interviewing the stakeholders who are responsible for each of the in-scope self-assessment responses

	following locally selected outcomes: A1.c Decision Making and Approval B2.d Identity and Access Management D1.c Testing & Exercising		• Walkthroughs of key processes relevant to the completion of the DSPT • Desktop review of documentation supporting the DSPT; and sample testing where appropriate. • Using professional judgement and knowledge of the organisation, reviewing the operation of key technical controls using the DSP Toolkit Independent Assessment Framework. In cases where we note controls do not exist, we will raise this as a finding
Client Contacts	Carl Starbuck, Head of Information Governance and Data Protection Officer Andy Gleadall, Head of Network Operations Hergy Galsinh, Head of Cyber Security Ian Hogan, Chief Digital Information Officer	**Internal Audit Contacts**	Helen Higgs, Managing Director and Head of Internal Audit Helen.Higgs2@nhs.net Jonathan Hodgson, Assistant Director and Audit Manager jonathan.hodgson@nhs.net Bryony Harris, Senior Auditor bryony.harris2@nhs.net
Executive Sign Off	Dawn Hanwell, Chief Financial Officer & Deputy Chief Executive	**Committee Reporting**	Audit Committee: July 2026
Timing	Start date of fieldwork End date of fieldwork Draft report date Management responses Final report date	07/04/2026 15/05/2026 22/05/2026 29/05/2026 12/06/2026	

Data Protection: Access to and use of personal data, as required for this audit, will be managed in accordance with the Internal Audit Charter and Data Protection legislation.

Agenda item
12

Meeting of the Board of Directors

Paper title:	**Report of the Chief Operating Officer**
Date of meeting:	30 July 2026
Presented by: (name and title)	Mark Dodd, Deputy Director of Operations
Prepared by: (name and title)	Members of the Care Services' Senior Operational Leadership Team

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

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

Executive summary

This report highlights key service delivery and development issues and provides a summary of performance against established standards. It also outlines 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. It has also been presented and discussed in the Finance and Performance Committee.

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

No

Recommendation

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

MEETING OF THE BOARD OF DIRECTORS

30 July 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 that we are managing.

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 2.1 below). However, as a very high-level summary the most concerning issues include:

- Acute Flow and Out of Area Placements and Long Lengths of Stay
- Older People's Out of Area Placements
- Emergency Department (ED) waits for mental health assessment
- Crisis and Intensive Support Referrals seen within 4 hours.

In addition to the items detailed in the sections below, the Board is advised of the establishment of an overarching Pathway and Flow Programme. A single programme with the aim of reducing the need for hospital admission, stopping out of area placements and significantly reducing service user inpatient lengths of stay.

This programme will build on the work undertaken over the past two years around capacity and flow; progress the learning and insights from the VOT Health diagnostic report; and sit alongside the Quality Development Programme which has the aim of ensuring there are robust clinical and operational processes allowing us to consistently deliver high-quality care across the Acute Service Line.

Governance and reporting arrangements are being put in place and further updates will be reported to the Board.

2 SERVICE DELIVERY AND KEY PERFORMANCE ESCALATIONS

2.1 ALERT

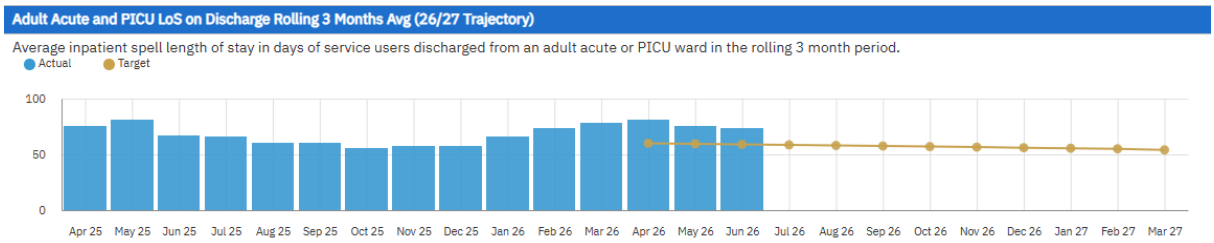
This section sets out the key areas of concern for care services that have been identified through our governance arrangements. These updates relate to the areas where services face most challenge and where risks are highest.

2.1.1 Acute flow and Out of Area Placements (OAPs)

2.1.1.1 Current position

Reducing length of stay (LoS) remains a core component of the Inpatient Quality Transformation Programme, as well as a key requirement within the National Oversight Framework (NOF) and medium-term planning. However, current performance has deteriorated over the past three months against the agreed trajectory, as illustrated in Graph 1.

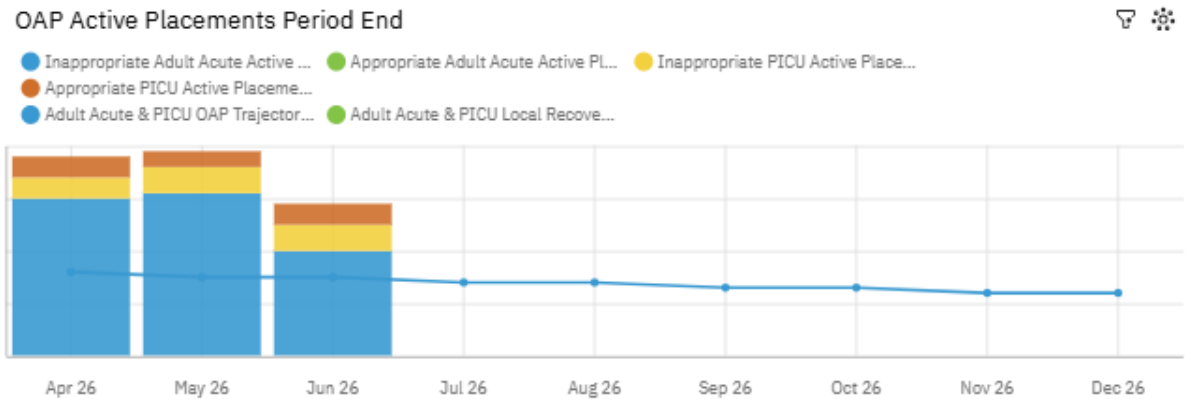
Graph 1



The rolling three-month average LoS on discharge remains above plan and is not demonstrating the expected downward trajectory, indicating that underlying flow constraints persist despite stable throughput.

At the end of May, Acute and PICU services remained under sustained flow pressure, with out of area placements above plan and trajectory, see Graph 2. This reflects underlying constraints within the inpatient system rather than short-term variation in demand or throughput.

Graph 2



Whilst these service users receive inpatient care in services located outside of Leeds, we aim to keep them as close to home as possible, with most of them being placed in facilities in Yorkshire or the Northeast of the country, as seen in Image 1. Unfortunately, due to the demand for mental health placements nationally, we have had to place some service users further afield with five in the East of the country. 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 appropriately or inappropriately placed.

Image 1

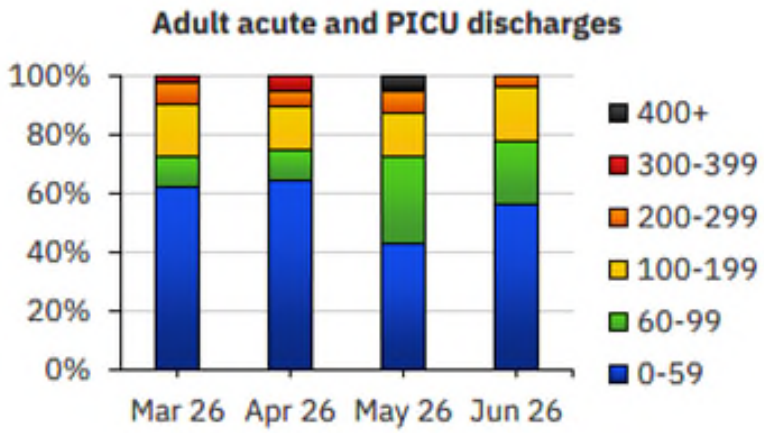
Table 1

Placement Type	Placement Location	Number of Service Users	Distance from home
PICU	THE PRIORY HOSPITAL MIDDLETON ST GEORGE	x3	46-49 miles
	WATERLOO MANOR HOSPITAL	x6 (4 appropriate and 2 Inappropriate)	4-9 miles
Acute	THE PRIORY HOSPITAL MIDDLETON ST GEORGE	x10	47-53 miles
	ELLINGHAM FARM	x2	136-146 miles
	CYGNET HOSPITAL BIERLEY	x1	26 miles
	CYGNET VICTORIA HOUSE	x1	51 miles
	CYGNET HOSPITAL WYKE	x6	9-12 miles
Older Peoples Services	THE PRIORY HOSPITAL MIDDLETON ST GEORGE	x2	48-50 miles

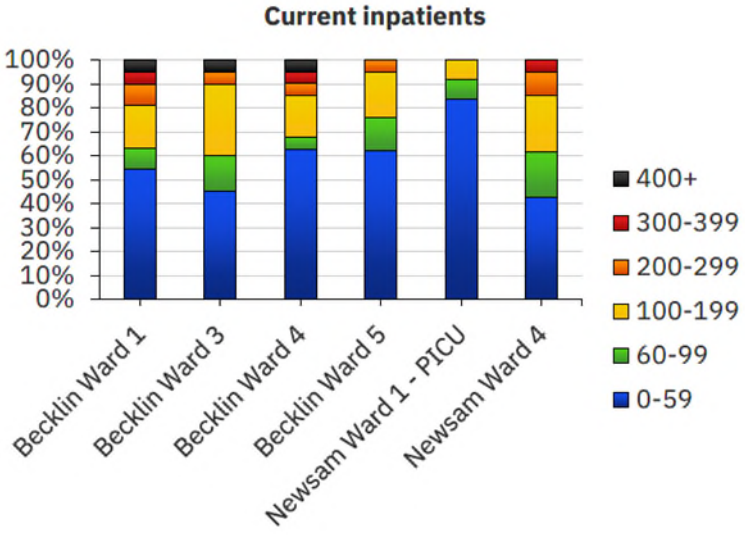
Over the past three months (March to May), Adult Acute and PICU services have maintained consistent levels of flow, with 130 discharges broadly aligned to the current inpatient position of 122 patients.

While over half of discharges during this period (57%) occurred within 0 to 59 days (see Graph 3) this pattern is also reflected in the current inpatient cohort, where 53% of patients remain within the same length of stay range (Graph 4). This indicates that although short-stay pathways are functioning, overall flow has plateaued and is insufficient to offset pressures elsewhere in the system.

Graph 3



Graph 4



This plateau in flow is directly contributing to the sustained reliance on out of area placements. Despite stable discharge performance, capacity is not being released at the pace required to meet demand. As a result, out of area placements continue to be utilised as a mitigating measure when local bed availability is constrained.

The primary driver of this position is a small but high-impact long-stay cohort:

- 14 patients (11% of the cohort) have a LoS greater than 200 days
- Patients exceed 400 days, including one approaching 1,000 days
- A further 23 patients fall within the 100 to199-day range, representing a clear risk of progression into long-stay status.

Although relatively small in number, these patients occupy a disproportionate number of beds, restricting capacity and limiting the ability of the service to improve flow. This creates

a blockage at the end of the pathway, meaning that effective short-stay throughput does not translate into overall system movement.

In addition, the cohort of patients within the 100 to 199-day range represents a risk to future flow and the out of area position.

2.1.1.2 Length of stay by gender

Analysis of discharges over the March to May period shows some variation in length of stay by gender, although this should be interpreted with caution given the influence of small numbers in the longest stay categories.

Male patients accounted for most discharges (61%), with an average length of stay of 72.8 days, while female patients accounted for 50 discharges (38%), with a higher average length of stay of 92.1 days. There was one non-binary patient discharged, with a length of stay of 350 days, reflecting a single case within the long-stay cohort.

While average LoS is higher for female patients, this is largely driven by activity within Becklin Ward 5, a female ward, which recorded both the highest LoS and the highest discharge activity over the period. The ward also discharged patients within the longest stay categories, including 300 to 399 and 400+ days, significantly influencing the overall average.

It is important to note that length of stay is measured at the point of discharge. The higher LoS observed reflects the discharge of a small number of long-stay patients during the period, which inflates the reported average. As these patients have now left the system, the current female inpatient position shows some improvement.

In addition, male and female pathways operate with different bed capacities (65 male beds; 50 female beds), which limits direct comparison. The smaller female bed base increases the impact of individual long-stay cases.

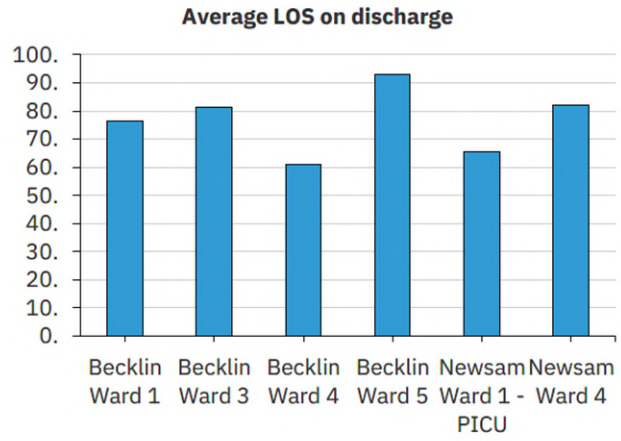
Overall, the observed variation reflects the distribution of long-stay patients and structural capacity differences, rather than a consistent difference in pathway performance.

2.1.1.3 Ward-level variation

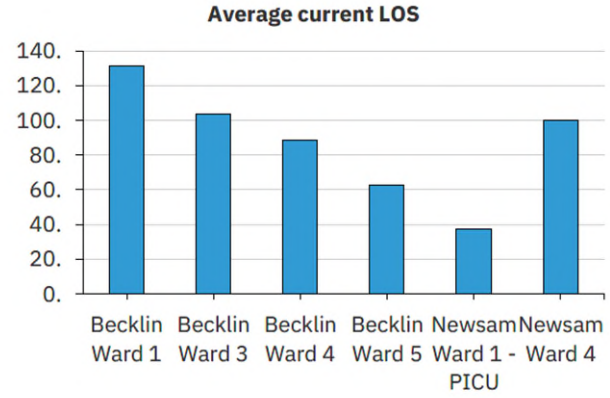
There is clear and important variation in length of stay across wards, reflecting differences in both current pressure and underlying flow challenges as shown in Graphs 5 and 6:

- Becklin Ward 1 is currently experiencing the greatest pressure, with the highest average LoS (124.7 days), driven by a concentration of long-stay patients, including one approaching 1,000 days
- Becklin Ward 3 presents both current and emerging risk, with a notable cohort in the 100 to 199-day range alongside one patient exceeding 400 days
- Becklin Ward 4 has an established but smaller long-stay cohort, with patients in both 300 to 399 and 400+ day ranges
- Becklin Ward 5 recorded both the highest LoS and discharge activity over March to May; current data indicates improving flow, with a reduction in LoS
- Newsam Ward 4 shows moderate long-stay pressure contributing to a sustained, though less acute, impact on flow
- Newsam Ward 1 (PICU) continues to operate effectively, with consistently lower LoS and minimal long-stay accumulation.

Graph 5



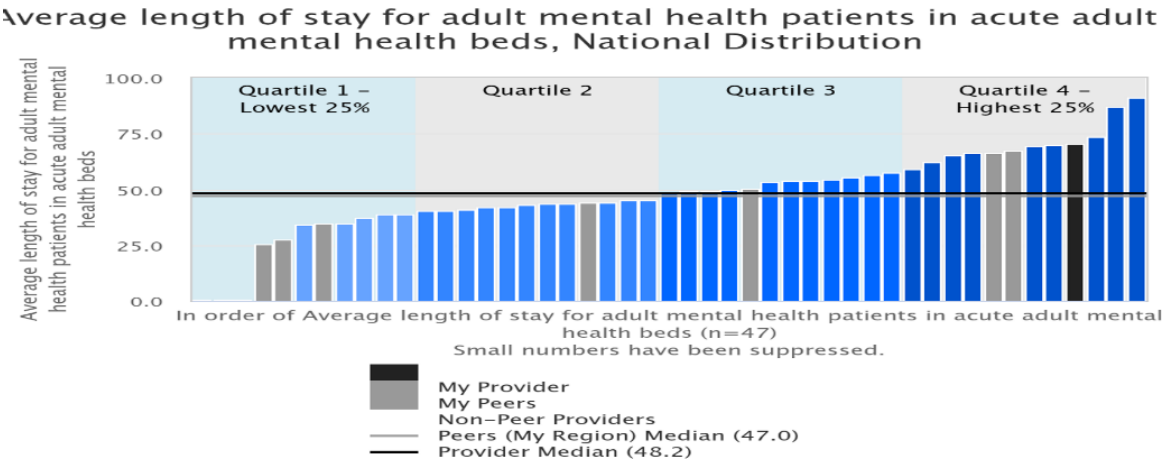
Graph 6



2.1.1.4 Benchmarking

Benchmarking from The Model Hospital confirms that the Trust sits within the highest national quartile for length of stay, significantly above both national and regional medians (approximately 47–48 days), see Graph 7. This places the service among the highest LoS providers.

Graph 7



2.1.1.5 Key actions to date

To improve flow, increase internal capacity, and reduce reliance on out of area placements, the following actions are being prioritised:

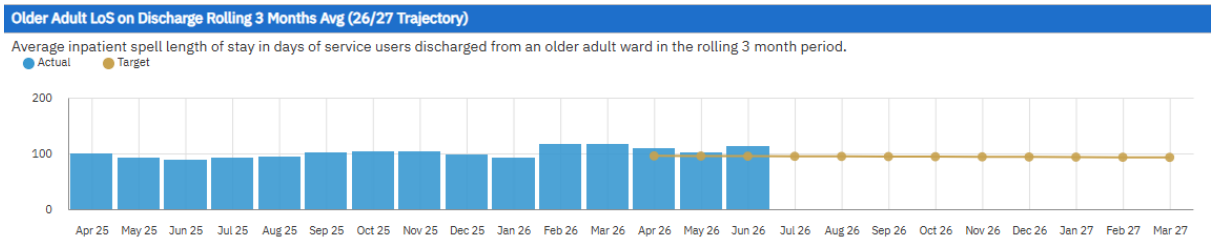
- Targeted management of the long-stay cohort with fortnightly senior clinical and operational reviews for patients with a length of stay >90 days
- Timely escalation of barriers to discharge, including system partner dependencies, through established governance routes
- Increased focus on the 100 to199-day cohort to prevent transition into long-stay status
- Enhanced partnership working with Adult Community Services and housing providers
- Recent appointment of a dedicated social worker to support progression, discharge planning, and delays in Care Act assessments.

2.1.2 Older people's out of area position

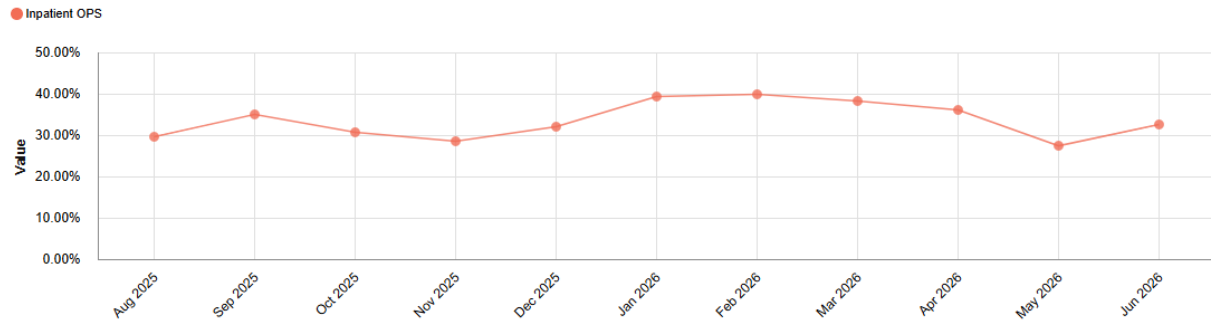
Our Older People's Services continue to operate under sustained system pressure, with high inpatient demand and constrained flow significantly impacting bed availability. While out of area placements have reduced to two, the service remains highly vulnerable to further admissions out of area due to ongoing capacity pressures.

Length of stay and clinically ready for discharge levels remain elevated, reflecting delays in patient flow, see Graphs 8 and 9; however, the average length of stay metric has been impacted by the recent safe discharge of several long-stay patients.

Graph 8



Graph 9



Maintaining patient safety remains the primary priority; however, there is a continued focus on maximising operational efficiency and flow. A matron-led flow improvement project,

supported by internal programme resource, is driving targeted actions including strengthened discharge planning, reduction in unwarranted variation, and improved in-hospital processes alongside enhanced system partnership working. Collectively, these actions aim to stabilise capacity and improve throughput.

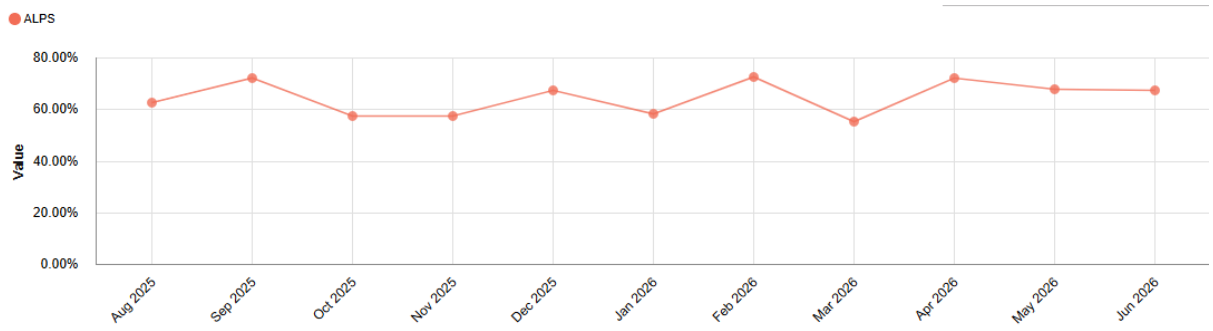
2.1.3 Emergency Department (ED) waits for mental health assessment

Achieving the one-hour target for all Acute Liaison Psychiatry Service (ALPS) referrals remains a challenge due to several factors including staffing constraints, the timing and volume of referrals. During April, we had seen an improvement in response times, with 72% of service users being seen within 1 hour. This has decreased to 68% for May and June, see Graph 10.

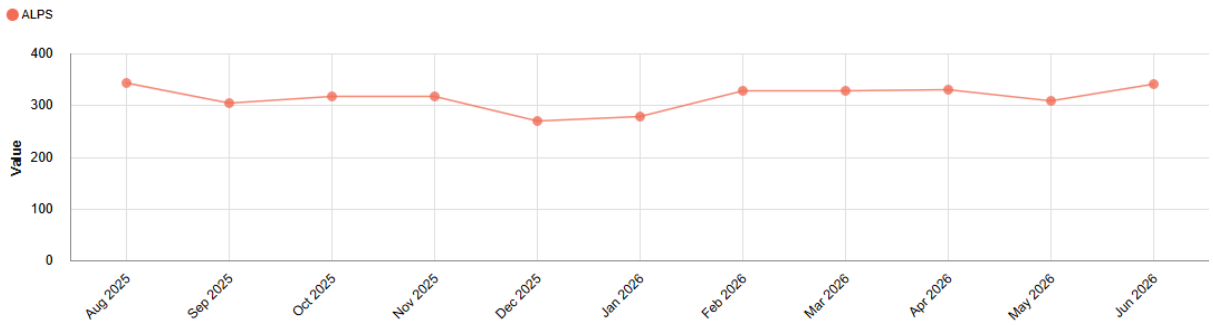
The number of referrals in each month has remained above 300 for the past year, except for December and January this past winter, see Graph 11. The flow of referrals remains challenging as it can be difficult to predict when referrals are made. More detailed analysis of referrals hasn't identified patterns or trends that we can respond to. This unfortunately can lead to delays which can be difficult to mitigate.

One reason for reduced response rates in the past has been staff sickness; however, we have seen this improve during April and May, to 2.40%, well below the Trust's target of 5%.

Graph 10



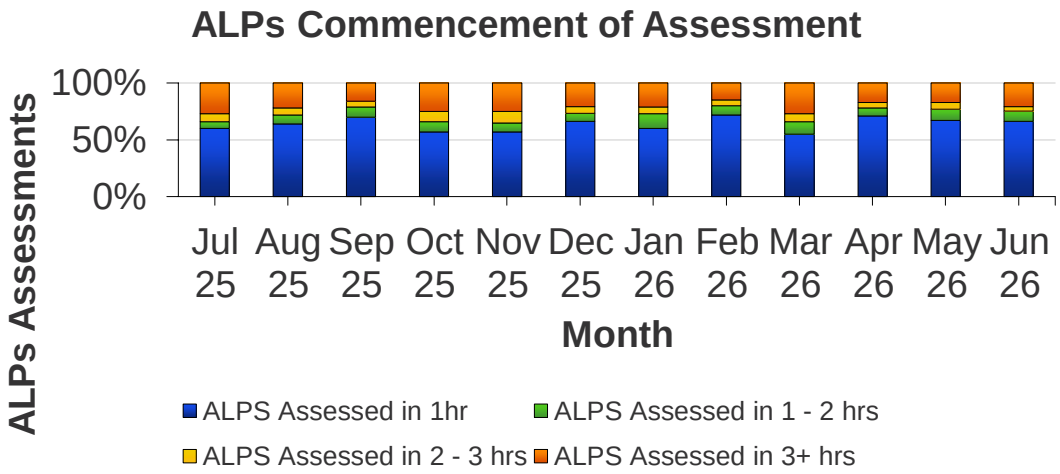
Graph 11



Where we have been unable to meet the 1-hour target time to assessment, we have seen approximately 83% of service uses within 3 hours of referral throughout May, see Graph 12. However, this means that approximately 17% 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 to avoid any delays.

Graph 12



The Acute Liaison Psychiatry Service (ALPS) has started a pilot of the Heidi AI platform, with the aim of releasing clinical time and improving service efficiency. The team also continues to pilot the triage role at the St James's University Hospital site, with a formal evaluation scheduled for July, once the pilot concludes at the end of June. Further work is also being undertaken, supported by the Nursing Directorate, to review the current staffing establishment, alongside activity data and identify opportunities for improvement.

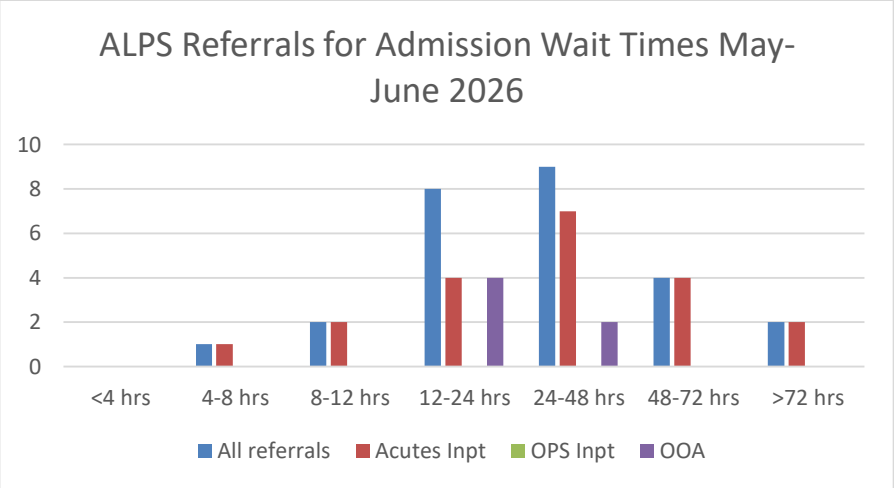
We have submitted a joint capital bid, with LTHT to develop a space where service users being assessed can be accommodated in a safer, more therapeutic environment. We are actively involved in the programme of works to develop this area and we are leading work to develop an effective clinical model. This work will be monitored through the ED workstream as part of the overarching Pathway and Flow Programme.

2.1.3.1 Emergency Department (ED) waits for admission

We continue to see several service users waiting within the ED for more than 12 hours following assessment for admission, see Graph 13. During May and June, we saw 23 service users waiting for admission more than 12 hours, with the majority waiting over 24 hours. Most admissions have been to our Acute inpatient beds, with only 6 being admitted out of area. Those with the longest delays, over 48 hours, were admitted to wards in Leeds.

Delays continue to be attributed to delays in Mental Health Act assessments, with their completion is impacted by the availability of beds within the Trust. Ways in which we are addressing the length of time people have to wait in the ED is being picked up and progress monitored through the capacity and flow work and the wider Pathway and Flow Programme.

Graph 13



2.1.4 Crisis and Intensive Support referrals seen within 4 hours

We have seen a slight improvement across all Crisis and Intensive Support referrals seen within 4 hours through May, achieving 74%, dropping to 67% in June, see Graph 14.

The performance for Crisis and Intensive Support referrals against their KPI, which had improved in May to 76%, has reduced to 66% in June for individuals seen within 4 hours, see Graph 15. There remains some variation across localities, with performance at 83.33% in the East, 66.67% in the South, and 71.43% in the West, indicating inconsistent delivery and targeted improvement required, particularly in the South.

The 24-hour response standards overall performance across the same period was 77.68%, with a more mixed locality picture: South performing strongly at 95.83%, compared to East at 71.88% and West at 73.21%. This variation highlights differences in operational delivery and capacity alignment across the service.

Operational Managers continue to maintain a strong focus on improving response times through enhanced oversight, strengthened referral processes, and improved workforce deployment. Breaches within the 4-hour standard were limited and largely associated with service user preference, engagement challenges, with no safety concerns identified.

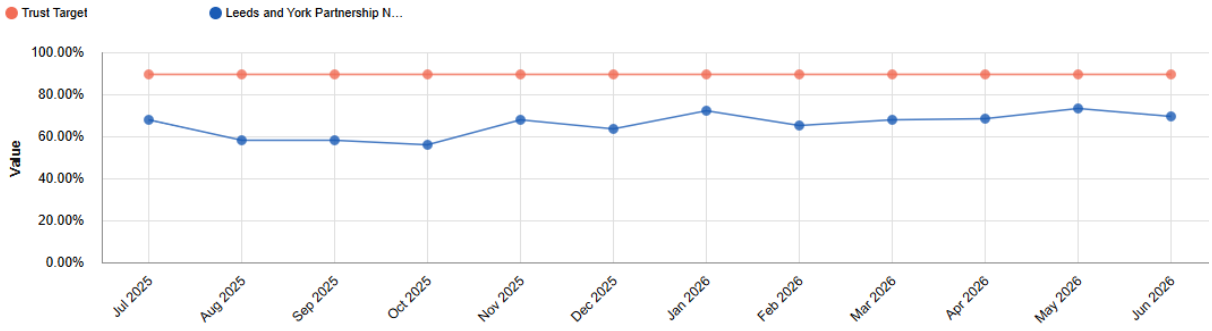
A clear improvement trajectory remains in place, with actions focused on:

- Strengthening data quality and referral accuracy
- Improving consistency of response across localities
- Enhancing early allocation, coordination, and workforce alignment to demand.

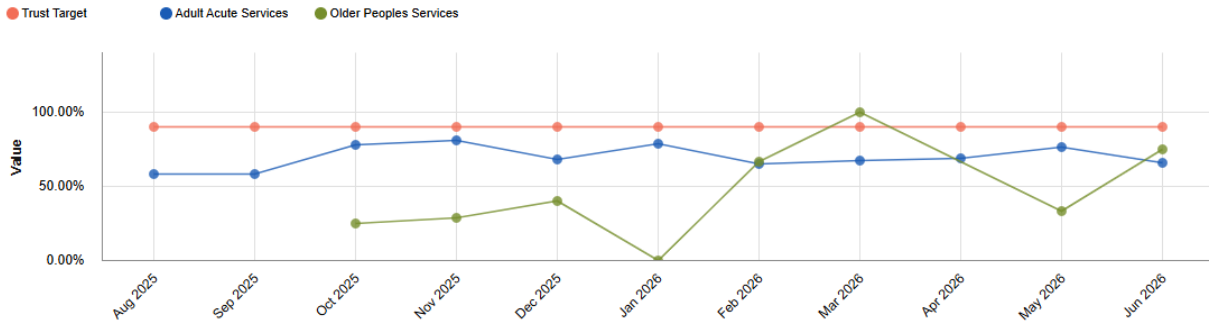
Within our Older peoples Services, both the Intensive Care Home Treatment Team (ICHTT) and the Intensive Home Treatment Team (IHTT) are measured against the same 4-hour performance standard. ICHTT's referral profile largely involves patients already residing in care home settings, meaning fewer cases are assessed as requiring an immediate 4-hour response. IHTT recorded a small number of 4-hour priority referrals (May: 3, June: 5), however there were a number of minor breaches (May: 2, June: 2), with service users being

seen between 4 and 8 hours, with no identified patient safety concerns. This resulted in performance of 33% in May, improving to 75% in June. This variation reflects the low number of applicable referrals and differing service contexts, rather than any underlying quality or safety concerns.

Graph 14



Graph 15



2.2 ADVISE

2.2.1 NHS Oversight Framework (NOF) measures in Care Services

NHS England (NHSE) has produced additional NOF measures for 2026/27 which are currently being worked through by our Informatics Team to develop these into our dashboards. In reviewing the NOF measures NHSE has discontinued the reporting on two of the measures relating to the Children and Young People's Service, therefore these have been removed from this report. As the new measures are produced via our reporting mechanisms, they will be added to future COO reports.

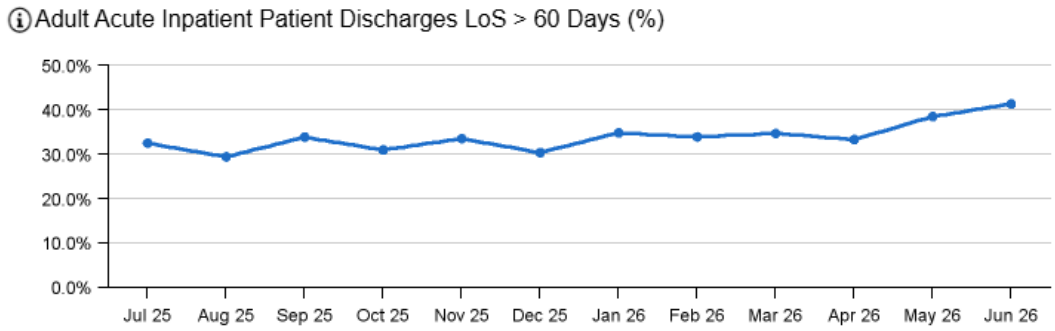
We continue to monitor performance against the NOF measures relating to Care Services through our Care Service Finance and Performance Group with an Executive Oversight Group being established where all NOF measures for the Trust will be reported on by colleagues who have responsibility for individual measures.

2.2.1.1 Percentage of adult inpatients discharged with a LoS exceeding 60 days

The proportion of adult acute inpatient discharges with a length of stay greater than 60 days has remained consistently high over the past 12 months, this has increased through May

and June to 40%, see Graph 16. Whilst there is some month-to-month variation, there has been no sustained downward trend, indicating that long lengths of stay remain a persistent system challenge.

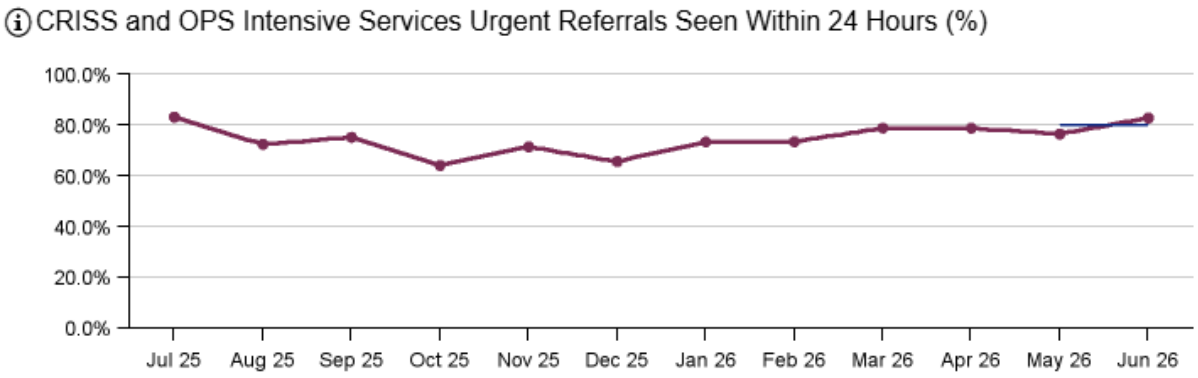
Graph 16



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

We have seen a sustained improvement since the last COO Report, see Graph 17; however, we continue to have areas that struggle to maintain a consistent level of performance. This remains a priority area of focus for those services involved.

Graph 17

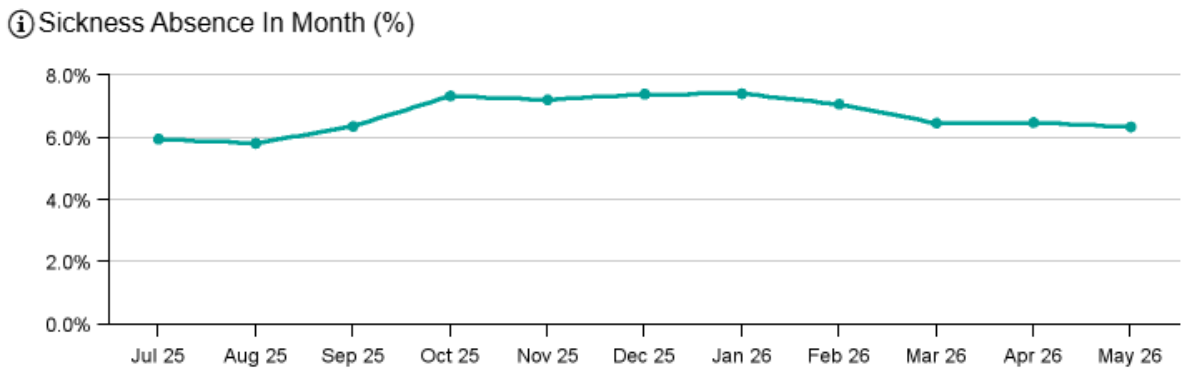


2.2.1.3 Sickness absence rate

The sickness absence rate for the Trust remains a high priority, with the aim of achieving 5%. Our overall Trust absence rate has been maintained through May at 6.3%, see Graph 18. Care Services sickness absence rate remains at a higher level at 7.7%. We have been unable to reduce this rate, despite efforts of managers and HR colleagues.

This deterioration has contributed to the change in the Trust's segmentation rating to segment 4, resulting in an intervention from NHSE. This now requires a more focused approach to attendance management that includes a bi-weekly meeting being established by the Executive Director of People and Workforce where performance against this measure will be closely monitored.

Graph 18



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

As reported in the Board report in March, we saw a decline in this Key Performance Indicator in February. We then saw an improvement in March but through April we have seen a significant deterioration with a slight recovery in May, see Graph 19.

Aspire implemented a revised triage, assessment, and MDT process in July 2025, designed to be as streamlined as possible whilst maintaining appropriate clinical assurance.

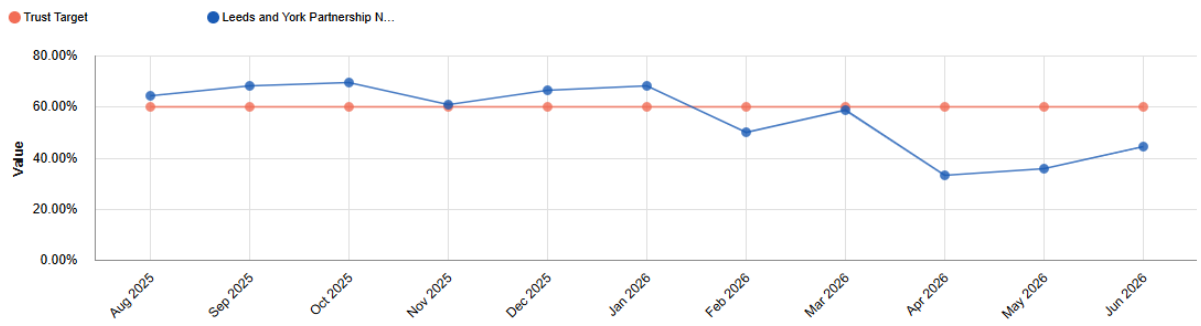
Care Coordinator caseloads remain high, which continues to present challenges in timely allocation of referrals, particularly when balancing service demand with the need to minimise staff burnout and sickness absence. This is further compounded by the ongoing changes relating to future service contracting arrangements.

Positively, referral numbers reduced to more typical levels in April and May (approximately 40 per month), which is expected to support improvements in performance over the coming months.

Aspire meets quarterly with the Community and Wellbeing Service Line to review contractual performance, with RTT delivery remaining a key focus of these discussions. An interim recovery plan is being developed to support improvement ahead of the contract termination date. It is anticipated that performance will recover to the required standard by August 2026, positioning the service strongly ahead of transition to LYPFT delivery.

We also continue to maintain oversight of the process for contract transfer with Aspire through a weekly Contracts Task and Finish Group and a monthly Quality Oversight meeting which includes the senior leadership of Aspire, to ensure the contract transfer is being managed effectively, whilst maintaining the required level in the service delivery quality.

Graph 19

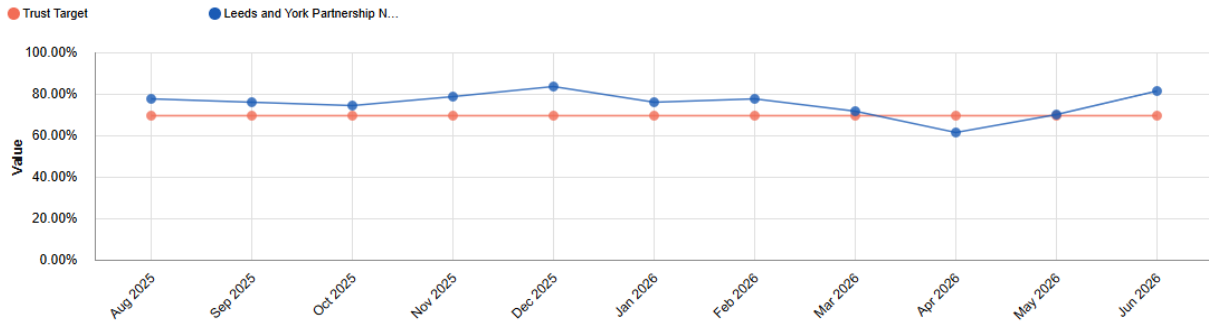


2.2.3 Memory Assessment Service (MAS) 8-week key performance indicator (KPI)

Performance against the 8-week KPI has improved significantly through May into June, see Graph 20, following the implementation of the actions identified through the breach analysis. The review confirmed that the primary issue related to pathway recording and data capture, particularly where patients were initially assessed within CMHT services before onward referral to MAS, rather than operational or clinical performance.

Improvements to recording processes and pathway coding have resulted in what is expected to be a sustained recovery, with current performance at 82%.

Graph 20



2.3.1 PICU seclusion room damage

The repair works to the PICU seclusion room, reported in the May Board report, were fully completed. The work included the replacement of the three damaged doors, alongside remedial works to door frames and surrounding areas to ensure the environment is safe, secure, and fit for purpose.

However, on 27 June 2026, the PICU seclusion room sustained further significant damage, rendering the room unavailable for use again. A full assessment of the damage has now been completed, with repairs being required to the sink, toilet, associated pipework and wall coverings. Minor damage was also identified to two internal door frames.

Good progress has been made with the repairs; however, due to dependency on contractor and supplier timescales, a definitive completion date cannot yet be confirmed.

To mitigate operational impact, and as previously reported, PICU and the Forensic Services have an established agreement which allows PICU service users to access the Forensic Service seclusion room when it is not in use. This arrangement remains in place throughout the period the PICU seclusion room is unavailable and ensures continued access to seclusion facilities where clinically required.

2.3 ASSURE

2.3.2 CONNECT Inpatient Business Continuity

Following the cessation of inpatient business continuity on 14 April 2026, commissioners increased the quality surveillance level from 'routine' to 'focused' on 2 June 2026.

Commissioners required assurance regarding progression of a revised service model and a response was submitted to commissioners on 12 June 2026, which included:

- A business continuity recovery plan which commenced 20 May 2026, addressing an increase in the number of patients awaiting allocation to a lead professional (keyworker). This has an 8-week recovery trajectory (to complete 15 July 2026). Progress was reviewed at the June Local Operational Governance Meeting, where the community service was confirmed to be ahead of the planned recovery trajectory
- A business continuity debriefing was arranged for 23 June 2026. Led by the Head of EPRR, this included commissioners and senior operations and clinical staff within the inpatient and community service
- A revised timeline for completion of the revised service model, with a business case expected by 15 September 2026
- An action plan to introduce recommendations made by the Nursing and Professions Directorate in May 2026 to optimise the deployment of staff, align the ward's observation practices and staff rostering with Trust policy and standard operating expectations.

2.3.3 Red Kite View – CYPMH Inpatient Service

The Board is advised that the refurbished PICU ward was reoccupied on 2 June, with the business continuity incident being formally stood down at the strategic co-ordination group on 8 June. However, it was agreed by the group that the section 136 suite would remain closed and discussions with colleagues in LCH about the future provision of the service are ongoing.

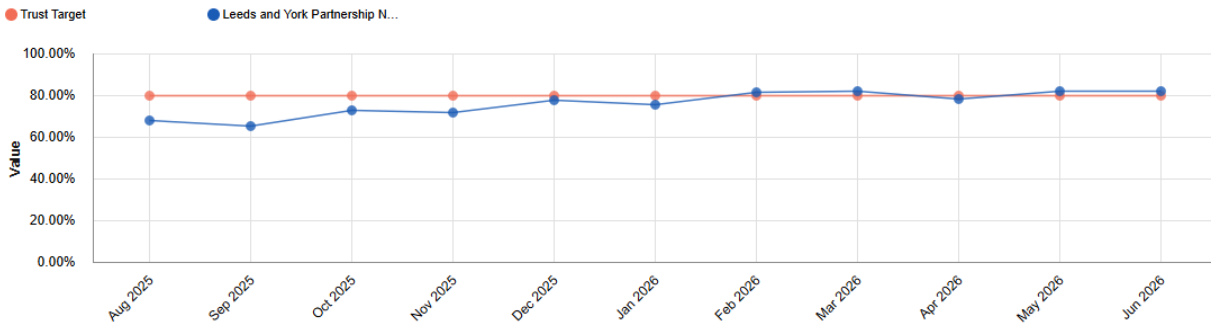
The Emergency Planning Response and Resilience (EPRR) Team is leading on a planned debrief, which will aim to capture learning from the business continuity incident and re-occupancy. This will take place during July with a cross section of staff expected to contribute.

2.3.4 Physical Health Assessment on inpatient wards

We continue to see a sustained improvement in the completion rate for Cardiometabolic assessments across our inpatient services over this past year. Across Care Services we are reporting achieving 82% completion against the target of 80%, see Graph 21. We continue to have variation across the different services, and this is monitored both at a

service level and through the Care Services Finance and Performance management arrangements.

Graph 21



3 SERVICE DEVELOPMENTS

3.1 Rough Sleepers Service

The rough sleepers service is continuing to develop alongside the My Gaff Leeds (MGL) service and integrate the delivery teams where possible. To support this work, the ICB has issued a specification to the rough sleepers' service which will be used as the template for the clinical delivery team in MGL. This should be ratified within Quarter 2 of 2026/27.

3.2 National Deaf CAMHS Investment

The additional funding from NHS England (NHSE) for this service was expected to be made available at the beginning of July. These additional funds will be available following a change to the national inpatient provision and our Finance Team is working with NHS England to agree when these funds will be made available.

In order to effectively allocate these funds, the service has developed a workforce plan. There is expected to be a significant uplift in staffing across all three sites, which will be based on clinical need for those areas. We expect that, in the longer term, this will have a positive impact on flow and capacity for those who use the service.

3.3 Volunteers Service

Engagement is underway with Leeds Community Healthcare Trust (LCH) to expand volunteers' placements to include LCH services. Services are collaborating to develop a case for expansion, as LCH does not have an existing volunteer's function. A proposal is being developed for the local Governance Forum in June 2026.

4 EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE (EPRR)

4. 1 Incidents and Disruptions

4.1.1 Heatwave Preparedness

The Trust continues its heatwave preparedness work with the Heatwave Tactical Group sitting fortnightly. A site visit to the Mount was made on 23 April by the Estates Team and the Head of EPRR to understand the challenges faced by patients and staff in the Older People's Service to explore solutions. Actions will be monitored by the Heatwave Tactical Group. In response to a heatwave between 22 and 25 June Business Continuity Plans were activated, and equipment was distributed to mitigate the heat in patient areas.

4.1.2 Industrial Action

On 29 June Resident Doctors in England voted to accept the government's pay and jobs offer and call off any planned industrial action. British Medical Association (BMA) members voted in favour of accepting the deal by a majority of 53%. The turnout on the vote was 57%. Therefore, we have stepped down any planning arrangement we had in place for Resident Doctors' potential strikes.

However, on 7 July, 76% of consultant members of the BMA said they would be prepared to take industrial action, on a turnout of just under 52%. This provides a mandate lasting 12 months. Consultants last took industrial action in 2023.

A ballot of specialist, associate specialist and specialty (SAS) doctors also showed that a majority (90%) were willing to strike, but the 43% turnout was under the 50% threshold needed to give a legal mandate to take industrial action.

The Trust held a scoping meeting for consultant industrial action on 13 July with a further meeting set for 17 August. If 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, considering any concurrent incidents.

4.1.3 Demonstrations

The EPRR Team continues to monitor the situation regarding demonstrations that have been taking place in several parts of the Leeds district on a weekly basis since July. Demonstrations and counter demonstrations in the Seacroft area 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 ongoing demonstrations in central Leeds relating to the situation in the Middle East.

5 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
July 2026

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

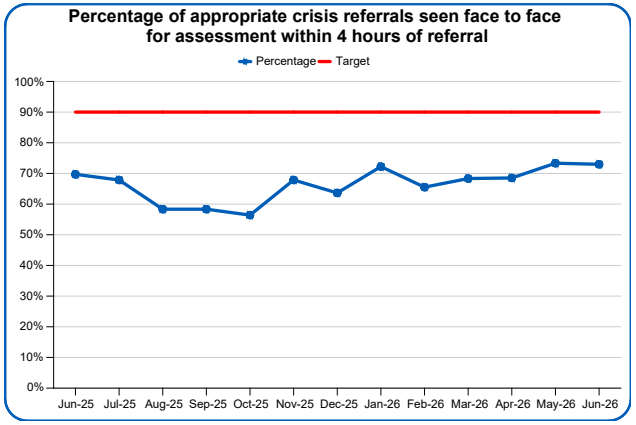
Service Performance - Chief Operating Officer

Services: Access & Responsiveness: Our response in a crisis Monthly	Target	Apr 2026	May 2026	Jun 2026
Percentage of ALPS referrals responded to within 1 hour	-	71.5%	67.2%	66.7%
Number of S136 detentions over 24 hours	-	0	0	0
Percentage of appropriate crisis referrals seen face to face for assessment within 4 hours of referral	90.0%	68.5%	73.3%	73.0%
Percentage of service users who stayed on CRISS caseload for less than 6 weeks	70.0%	90.1%	91.8%	93.4%
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support	50.0%	41.0%	33.7%	37.2%
Percentage of CRISS caseload where source of referral was acute inpatients	-	4.3%	5.5%	3.8%
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services	**Target**	**Apr 2026**	**May 2026**	**Jun 2026**
Gender Identity Service: Number on waiting list	-	7,128	7,167	7,193
Deaf CAMHS: average wait from referral to first face to face (inc. telemedicine) contact in days	-	343.20	235.25	261.83
Community LD: Percentage of referrals seen within 4 weeks of receipt of referral	75.0%	66.7%	55.3%	85.4%
Leeds Autism Diagnostic Service (LADS): Assessment to Diagnostic Decision within 26 Weeks (quarterly)	70.0%	-	-	98.5%
Leeds Autism Diagnostic Service (LADS): Percentage starting assessment within 13 weeks (quarterly)	-	-	-	41.9%
CAMHS inpatients: Proportion of people assessed within 7 days of admission (HoNOSCA / GBO) (quarterly)	100.0%	-	-	100.0%
Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency) (quarterly)	-	-	-	51.5%
Perinatal Community: Percentage of routine referrals waiting less than 2 weeks for assessment (quarterly)	85.0%	-	-	83.6%
Perinatal Community: Total number of distinct women seen in rolling 12 months (quarterly)	950	-	-	904
Perinatal Community: Face to Face DNA Rate (quarterly)	-	-	-	8.9%
Services: Our acute patient journey	**Target**	**Apr 2026**	**May 2026**	**Jun 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	-	96.7%	95.7%	99.4%
Crisis Assessment Unit (CAU) length of stay at discharge	-	31.60	20.86	41.40
Liaison In-Reach: attempted assessment within 24 hours	90.0%	86.6%	70.9%	80.0%
Becklin Ward 1 (Female) bed occupancy	-	104.5%	100.7%	101.5%
Becklin Ward 3 (Male) bed occupancy	-	99.5%	99.9%	100.8%
Becklin Ward 4 (Male) bed occupancy	-	100.9%	101.8%	99.2%
Becklin Ward 5 (Female) bed occupancy	-	102.1%	101.7%	102.2%
Newsam Ward 4 (Male) bed occupancy	-	101.0%	99.5%	101.1%
Older adult (total) bed occupancy	-	98.1%	97.7%	99.7%
The Mount Ward 1 (Male Dementia) bed occupancy	-	100.5%	95.2%	96.7%
The Mount Ward 2 (Female Dementia) bed occupancy	-	102.7%	103.8%	99.0%
The Mount Ward 3 (Male) bed occupancy	-	90.2%	92.3%	101.3%
The Mount Ward 4 (Female) bed occupancy	-	100.8%	100.0%	100.6%
Percentage of Occupied Bed Days Clinically Ready for Discharge	-	36.1%	27.7%	32.8%

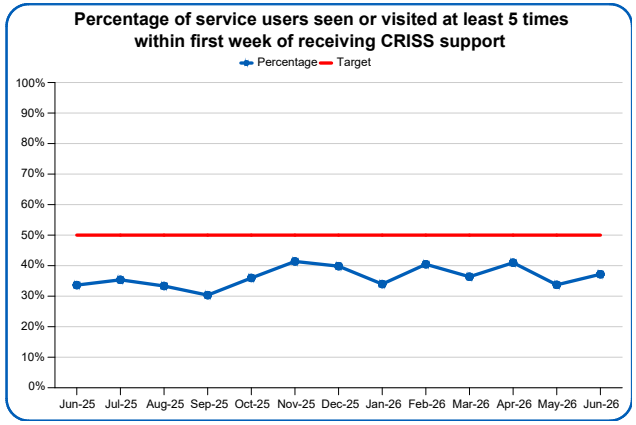
Service Performance - Chief Operating Officer

Services: Our acute patient journey	Target	Apr 2026	May 2026	Jun 2026
Out of Area Trajectory Active Placements at Month End	15	38	38	27
Total: Number of out of area placements beginning in month	-	21	16	14
Total: Total number of bed days out of area (new and existing placements from previous months)	-	1,109	1,172	898
Acute: Active Placements at Month End	-	30	31	19
Acute: Number of out of area placements beginning in month	-	18	11	9
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	837	932	709
PICU: Active Placements at Month End	-	4	5	6
PICU: Number of out of area placements beginning in month	-	1	4	5
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	133	131	129
Older people: Active Placements at Month End	-	4	2	2
Older people: Number of out of area placements beginning in month	-	2	1	0
Older people: Total number of bed days out of area (new & existing placements from previous months)	-	139	109	60
Cardiometabolic (physical health) assessments completed: Inpatients (quarterly)	80.0%	-	-	82.4%
Services: Our Community Care	**Target**	**Apr 2026**	**May 2026**	**Jun 2026**
Percentage of inpatients followed up within 3 days of discharge (Trust Level monthly local tracking)	80.0%	74.6%	77.6%	80.3%
Percentage of inpatients followed up within 3 days of discharge (HCP commissioned services only)	80.0%	72.7%	76.7%	81.5%
Number of service users in community mental health team care (caseload)	-	3,699	3,712	3,751
Percentage of referrals to memory services seen within 8 weeks (quarter to date)	70.0%	61.6%	66.0%	71.5%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50.0%	53.7%	60.0%	59.7%
Early intervention in psychosis (EIP) or at risk mental state (ARMS): Percentage starting treatment within 2 weeks	60.0%	33.3%	35.7%	41.7%
Early intervention in psychosis (EIP) : Percentage of people discharged to primary care (quarterly)	-	-	-	58.4%
Cardiometabolic (physical health) assessments completed: Early Intervention in Psychosis Service (quarterly)	80.0%	-	-	76.8%
Services: Clinical Record Keeping	**Target**	**Apr 2026**	**May 2026**	**Jun 2026**
Percentage of service users with NHS Number recorded	-	99.8%	99.8%	99.8%
Percentage of service users with ethnicity recorded	-	80.1%	79.8%	79.6%
Percentage of service users with sexual orientation recorded	-	41.9%	41.2%	40.4%
Services: Clinical Record Keeping - DQMI	**Target**	**Jan 2026**	**Feb 2026**	**Mar 2026**
DQMI (MHSDS) % Quality %	95.0%	93.6%	93.7%	93.3%

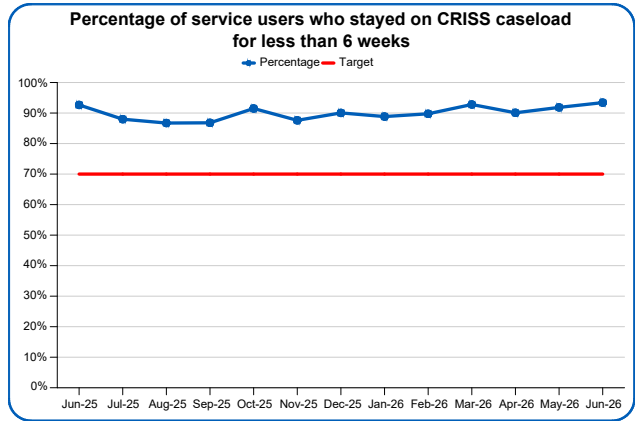
Services: Access & Responsiveness: Our Response in a crisis



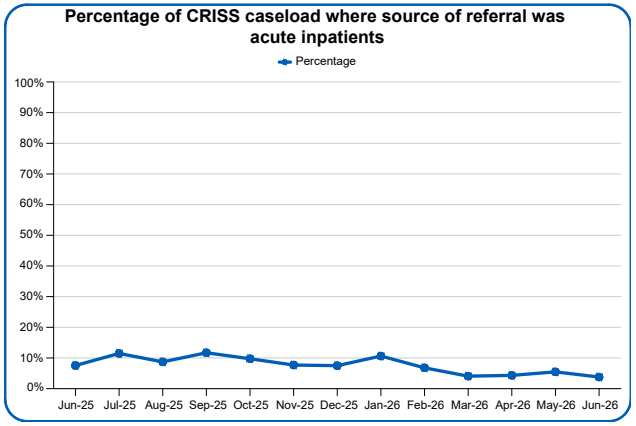
Contactual Target 90%: June 73.0%



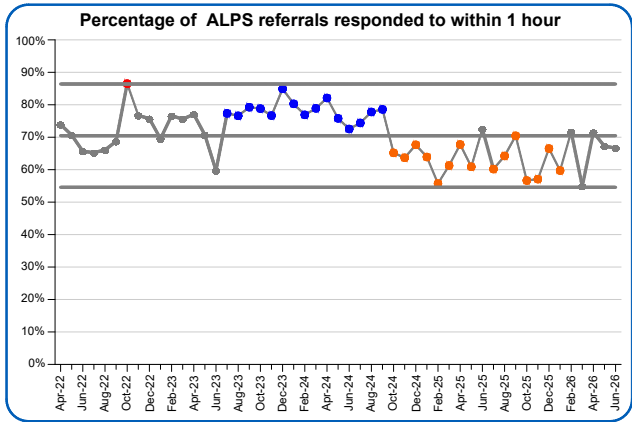
Contractual Target 50%: June 37.2%



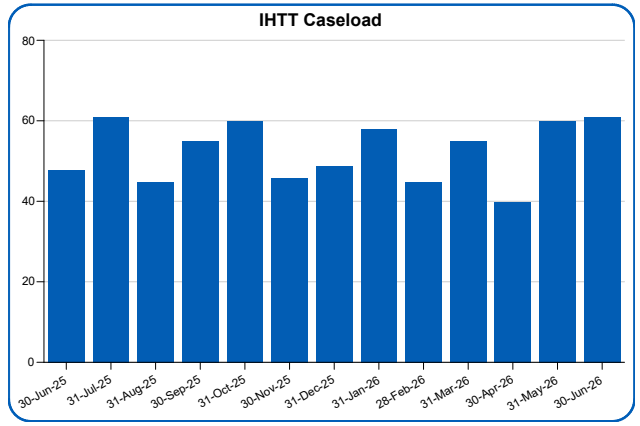
Contractual Target 70%: June 93.4%



Contractual Target tba: June 3.8%

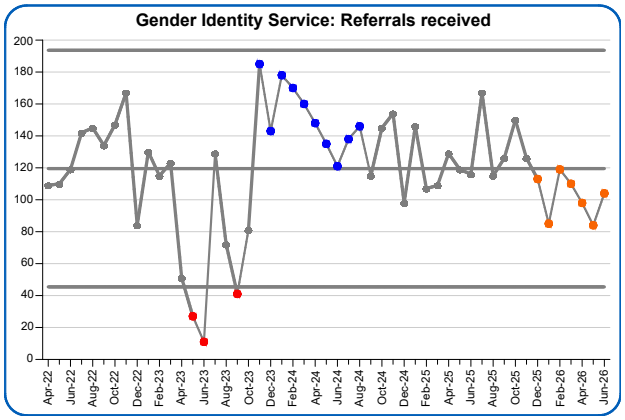


Contractual Target : June 66.7%

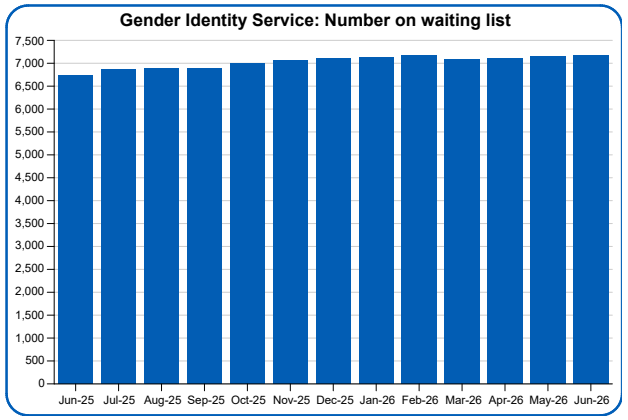


Caseload: June 61

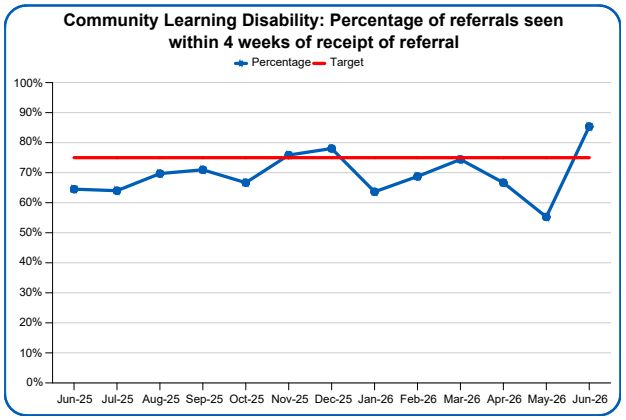
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services



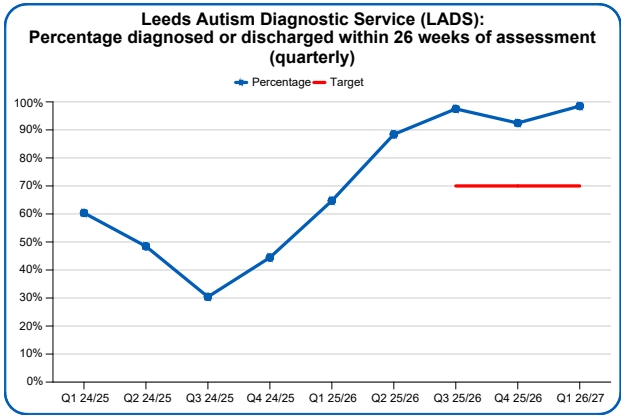
Total referrals: June 104



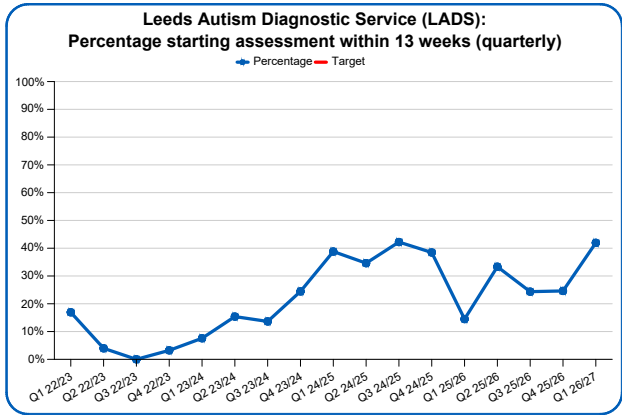
Number on waiting list: June 7,193



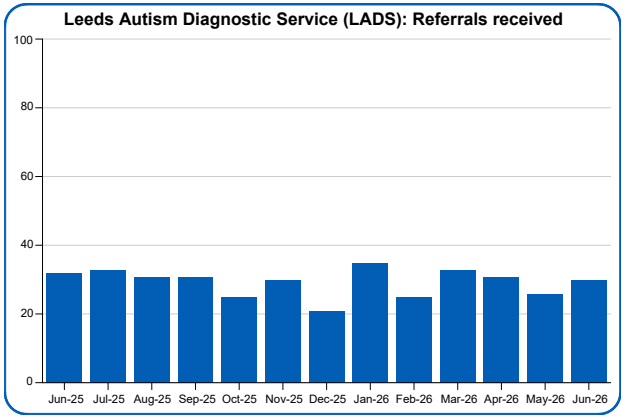
Contractual Target 75%: June 85.4%



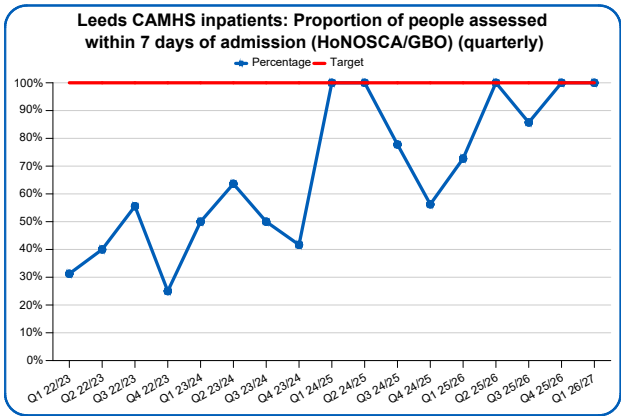
Contractual Target 70%: Q4 98.5%



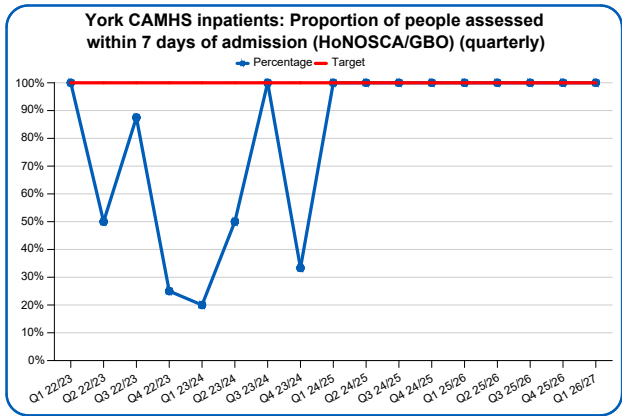
Contractual Target : Q4 41.9%



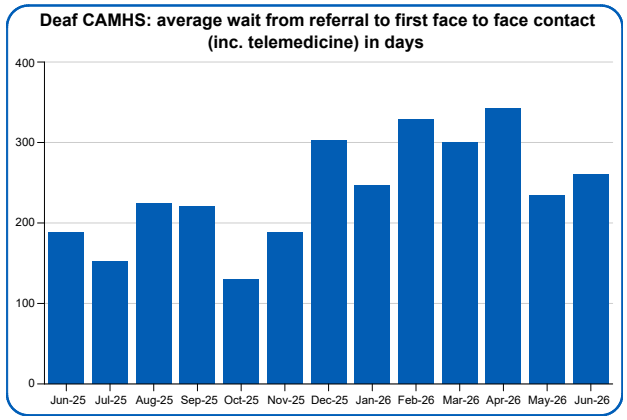
Local measure: June 30



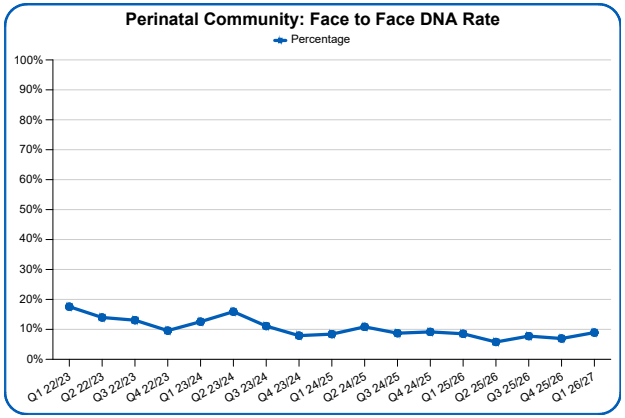
Contractual Target 100%: Q1 100.0%



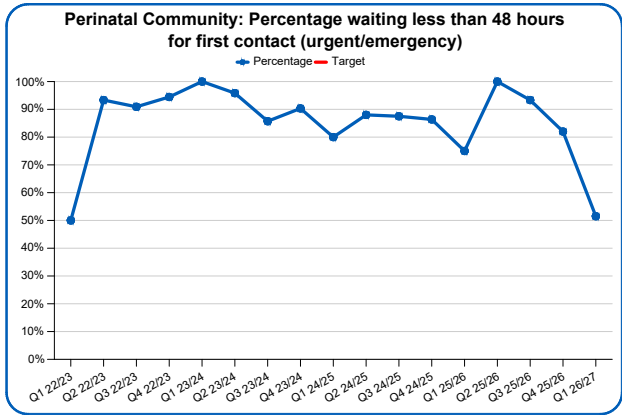
Contractual Target 100%: Q1 100.0%



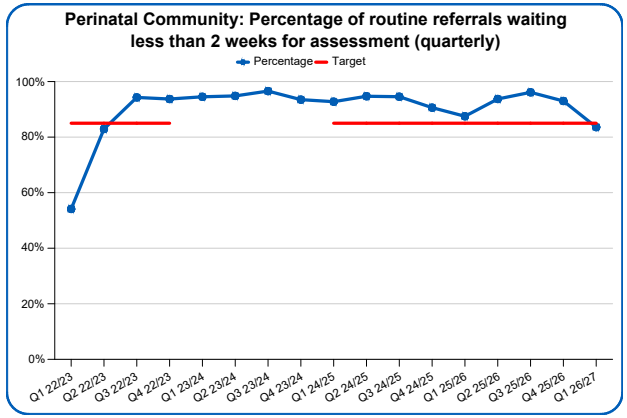
Local measure: June 262



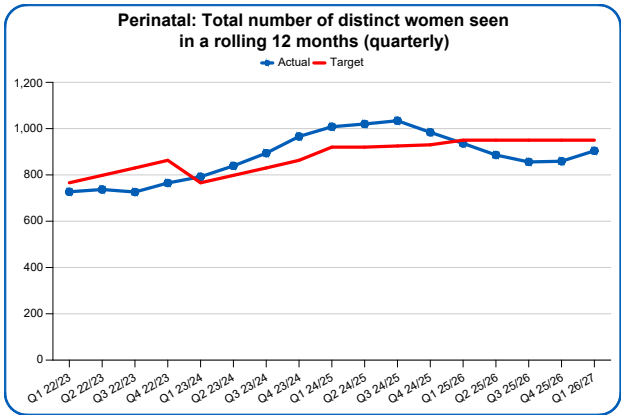
Contractual measure: Q1 8.9%



Contractual Target tba: Q1 51.5%

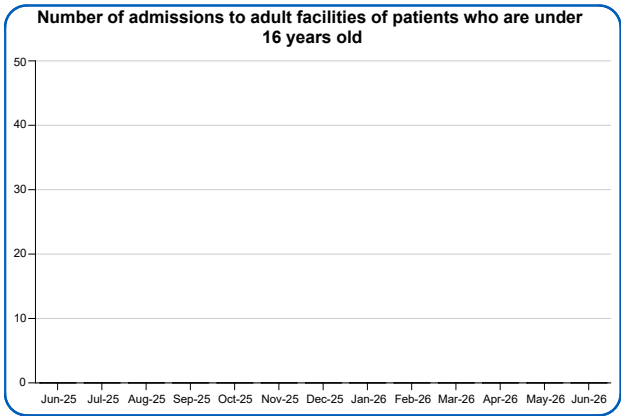


Contractual Target 85%: Q1 83.6%

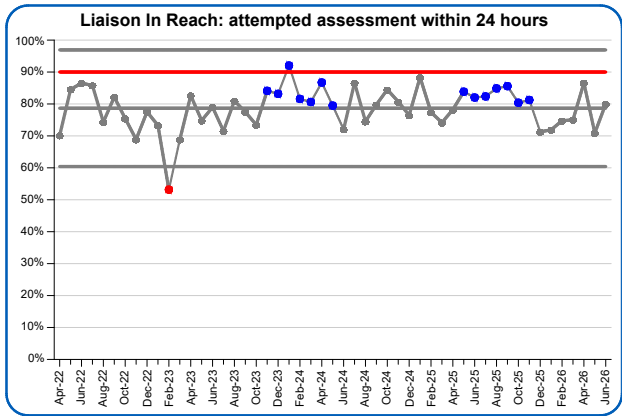


Local measure 950: Q1 904

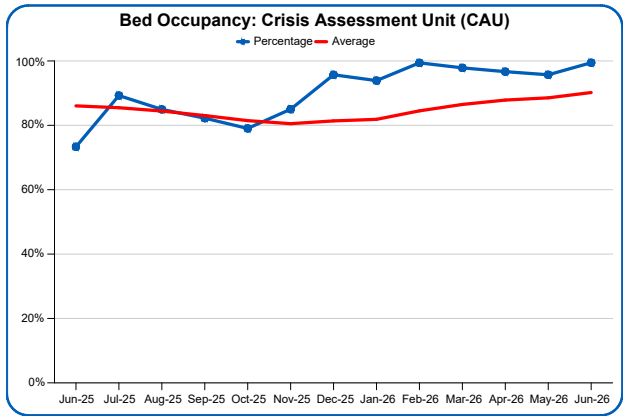
Services: Our acute patient journey



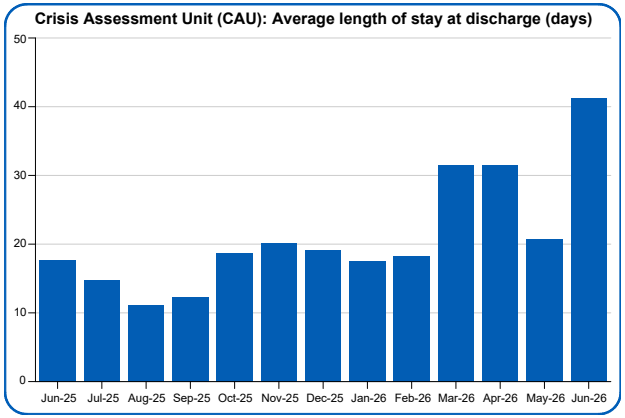
National (NOF) No target 0: June 0



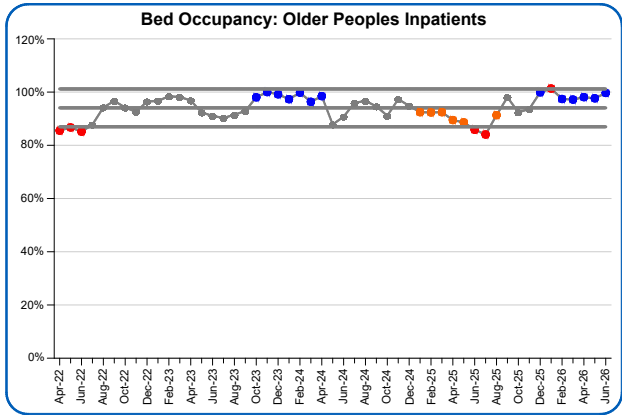
Contractual Target 90%: June 80.0%



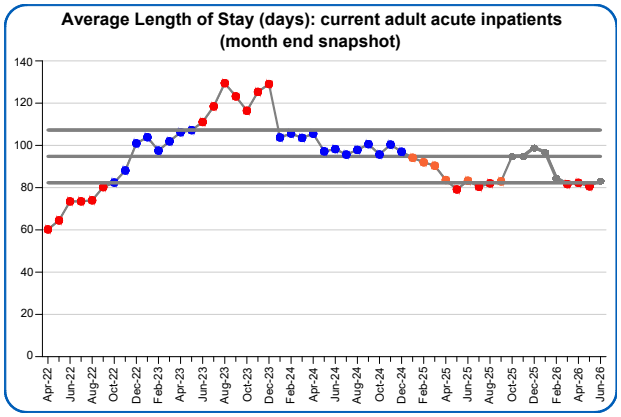
Local measure: June 99.4%



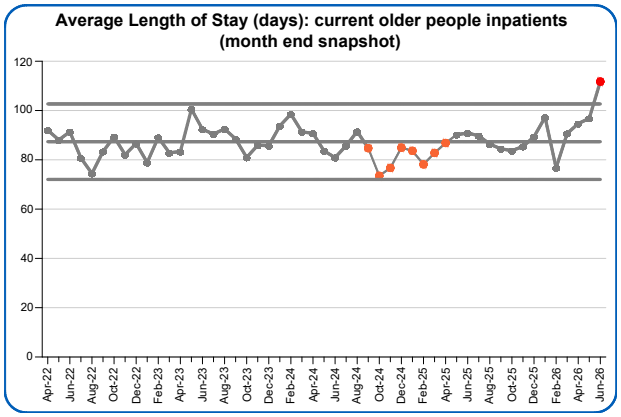
Local measure: June 41 days



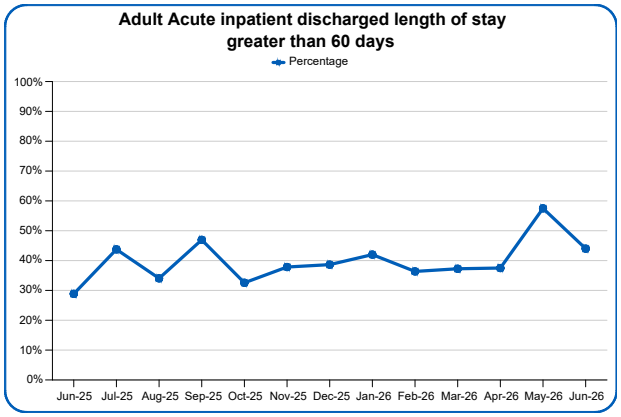
Local measure and target : June 99.7%



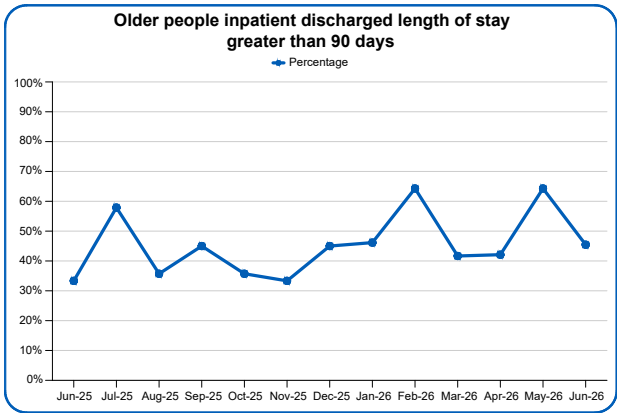
Local tracking measure: June 83 days



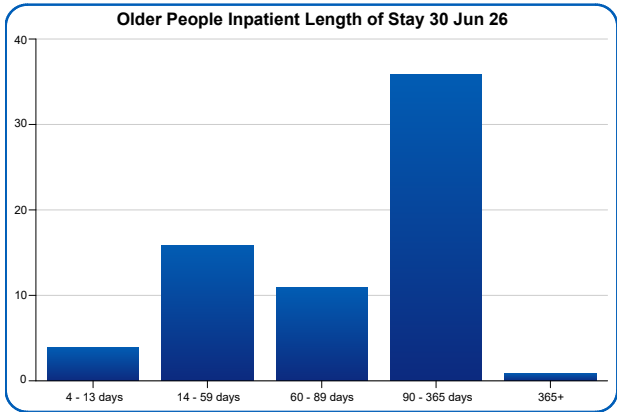
Local tracking measure: June 112 days



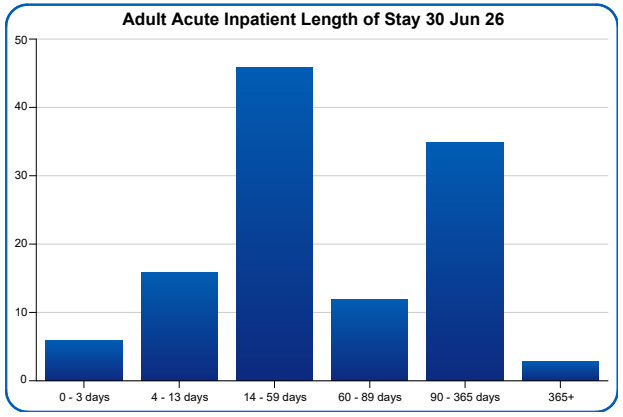
National (LTP): June 44.0%



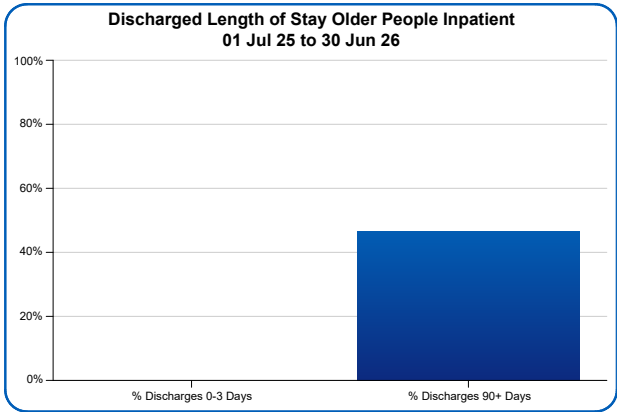
National (LTP): June 45.5%



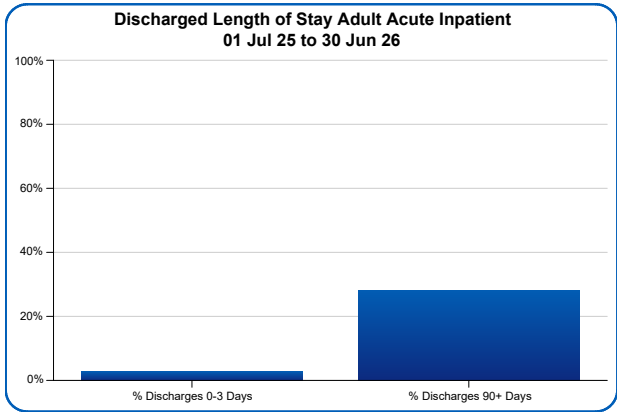
Local activity: 37 people with LOS 90+ days



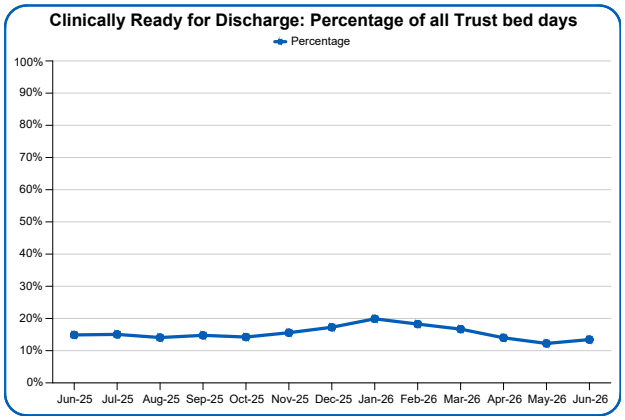
Local activity: 38 people with LOS 90+ days



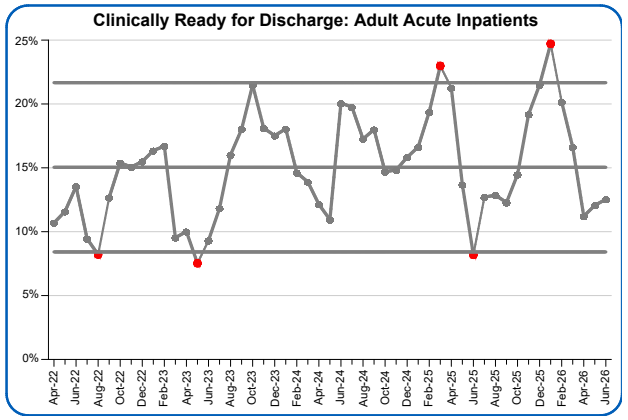
Local activity: % discharged LOS 90+ days = 46.8%



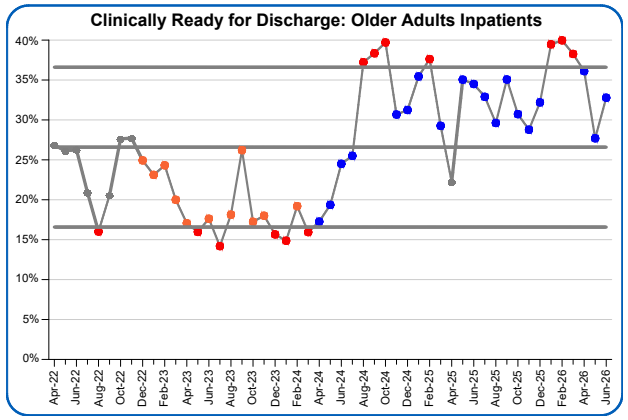
Local activity: % discharged LOS 90+ days = 28.4%



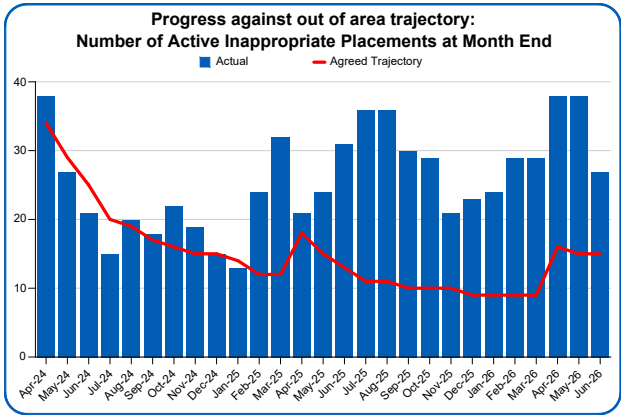
Local tracking measure: June 13.4%



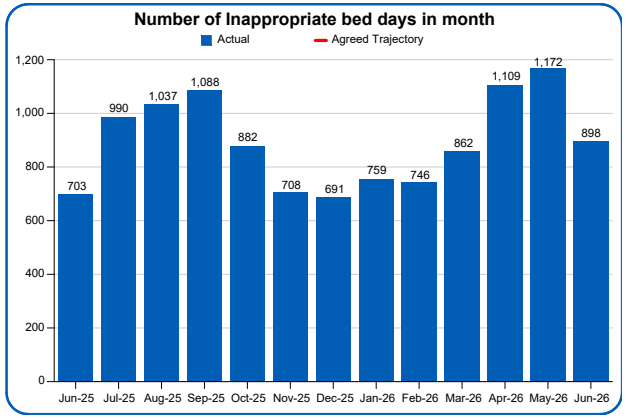
Local tracking measure: June 12.5%



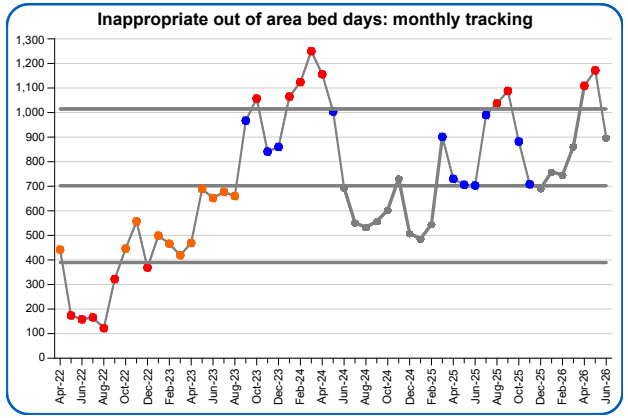
Local tracking measure: June 32.8%



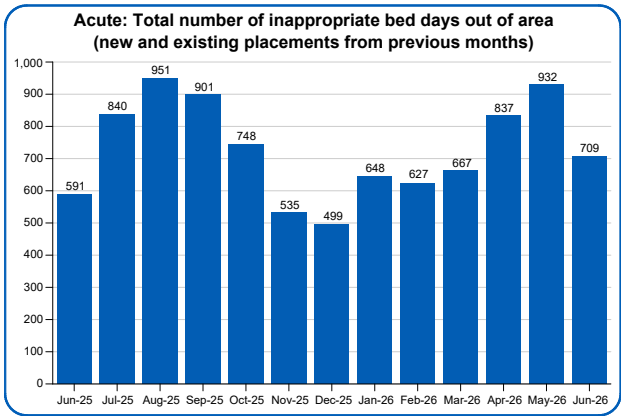
Nationally agreed trajectory (June: 15): June 27 active placements



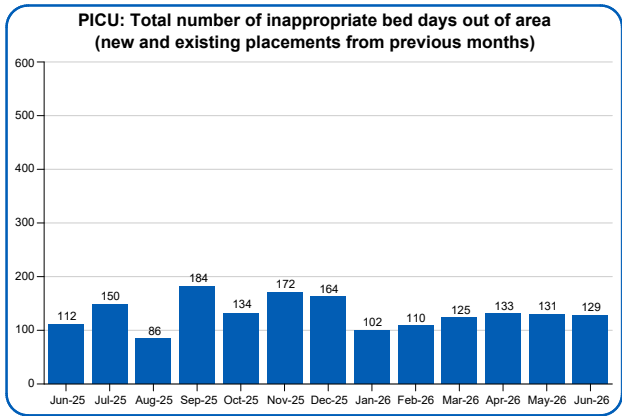
Local tracking measure: June 898 bed days



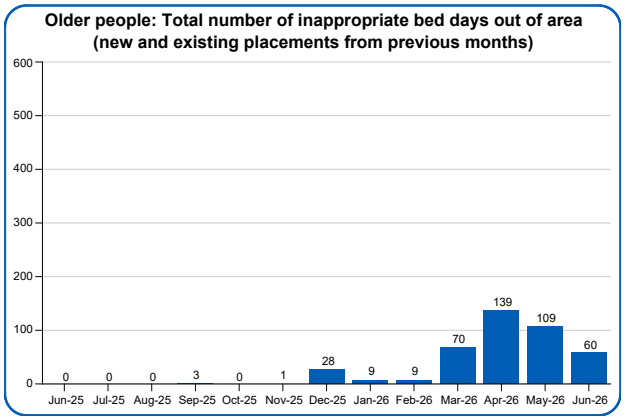
Local tracking measure: June 898 bed days



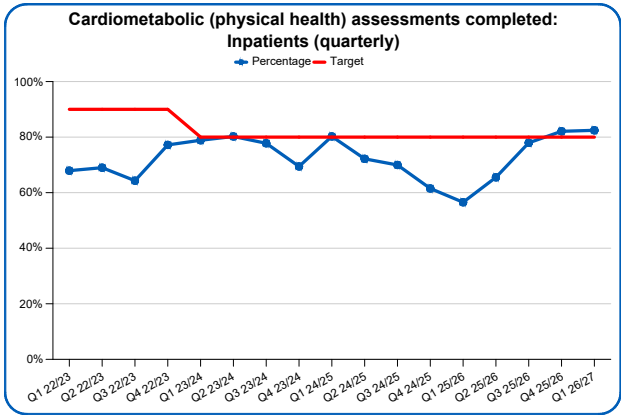
Nationally agreed trajectory (): June 709 days



Nationally agreed trajectory (): June 129 days

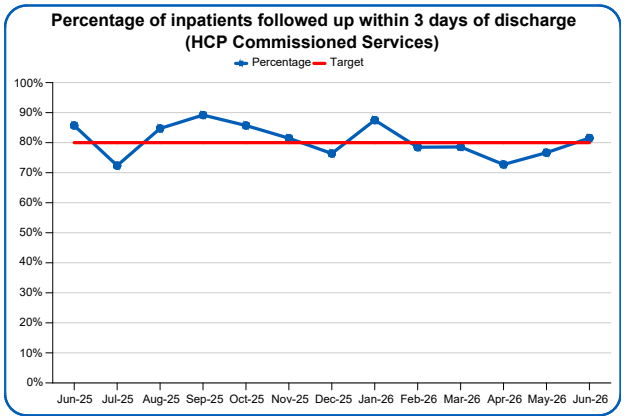


Local measure : June 60 days

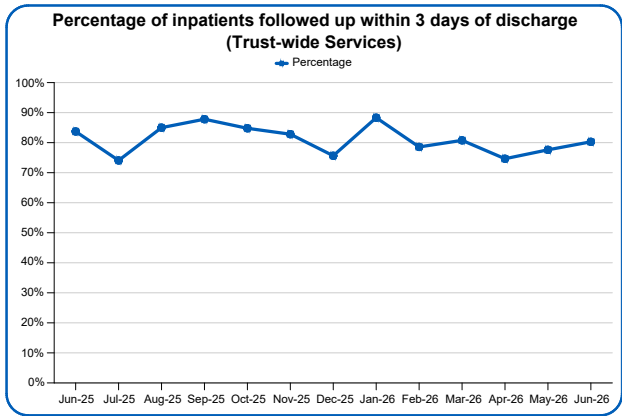


Contractual target 80%: Q1 82.4%

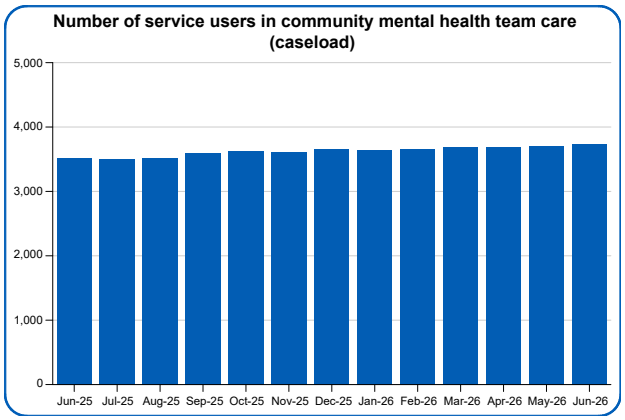
Services: Our community care



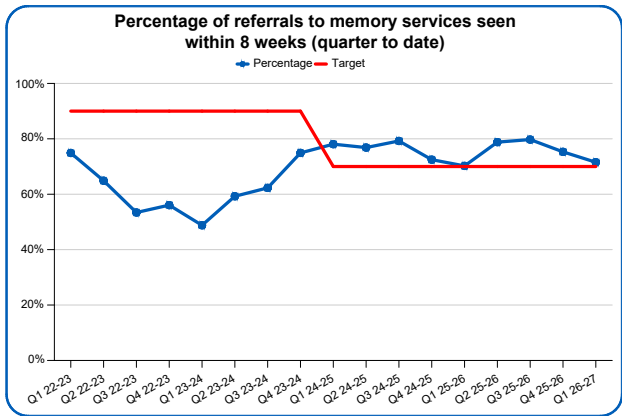
Contractual target 80%: June 81.5%



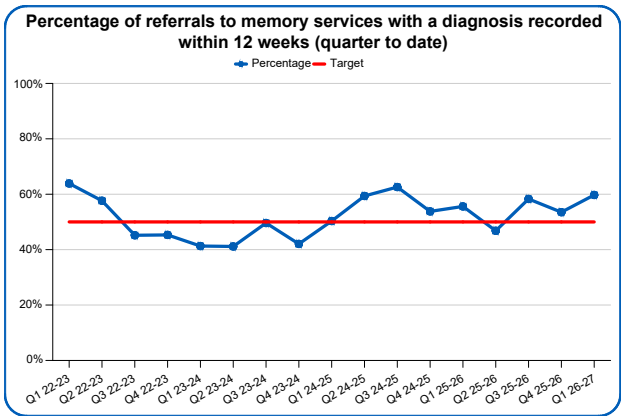
Local Tracking Measure 80%: June 80.3%



Local measure : June 3,751

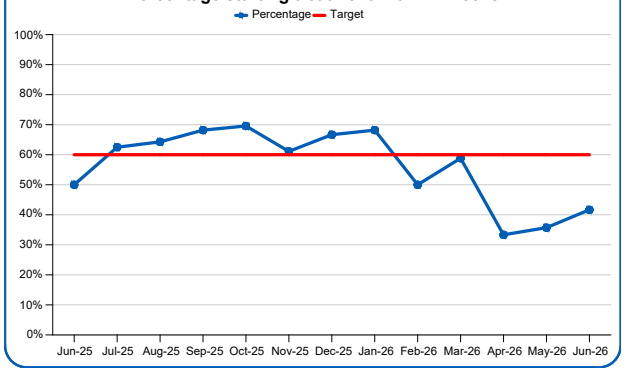


Contractual target 70%: Q1 26-27 71.5%



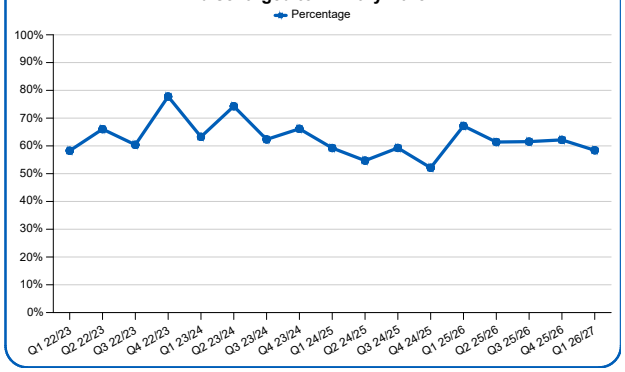
Contractual target 50%: Q1 26-27 59.7%

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



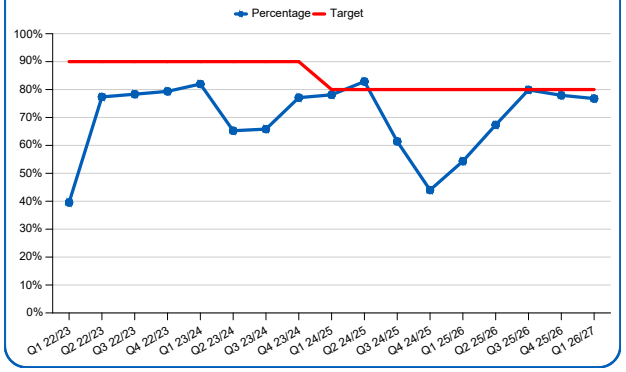
Contractual target 60%: June 41.7%

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



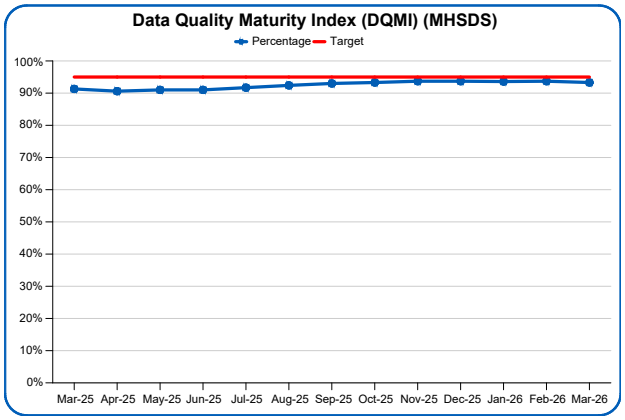
Contractual target tbc: Q1 58.4%

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

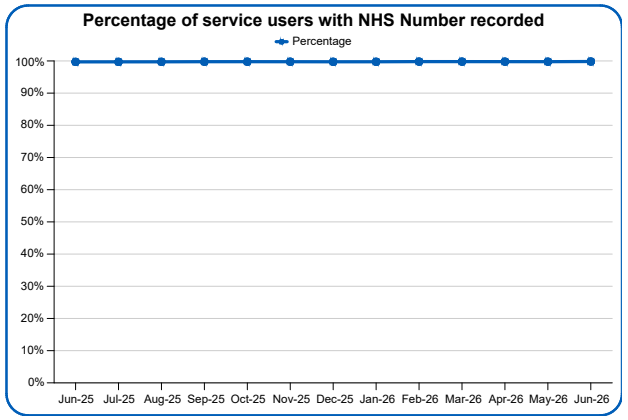


Contractual target 80%: Q1 76.8%

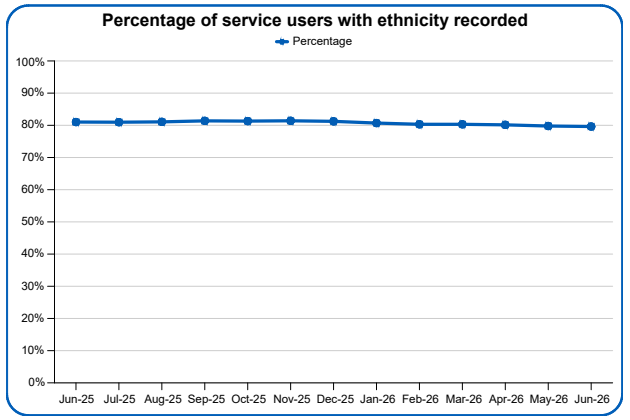
Services: Clinical Record Keeping



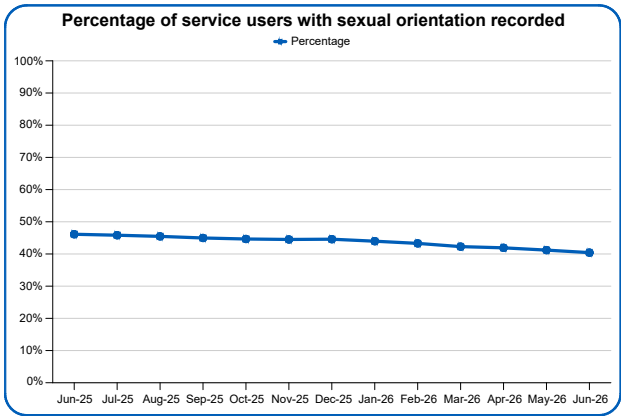
CQUIN / NHSOF Target 95%: March 93.3%



Local measure: June 99.8%



Local measure: June 79.6%



Local measure: June 40.4%

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
13

Meeting of the Board of Directors

Paper title:	Chair's Report from the Quality Committee meeting on 11 June 2026
Date of meeting:	30 July 2026
Presented by: (name and title)	Prof. Frances Healey, Non-executive Director and Chair of the Quality Committee
Prepared by: (name and title)	Kerry McMann, Head of Corporate Governance

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

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

Committee details:	
Name of Committee:	Quality Committee
Date of Committee:	11 June 2026
Chaired by:	Prof. 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
The committee received a report which provided an update on the work being undertaken in relation to the Improving Health Equity Strategic Plan 2025-2029. It was assured that the ambitions within the Improving Health Equity Strategic Plan were being progressed via the agreed programme delivery plans and the governance arrangements in place to support this work.	SR1 SR2 SR3 SR4 SR5 SR6 SR7
The committee discussed a report which provided an overview of Patient Advice and Liaison Service (PALS) contacts, formal complaints, and compliments received by the Trust between 1 April 2025 and 31 March 2026. It approved the report for publication. It acknowledged improvements in timeliness and process but highlighted the need for better thematic analysis and cross-cutting organisational learning. It was agreed that an interim report would be submitted in six months' time to provide assurance on the Trust's work to identify cross-cutting themes, organisational learning and any issues that require organisational action (formal action).	SR1 SR7

The committee received the Restrictive Interventions Annual Report which provided an overview of the restrictive interventions used across the Trust between 1 April 2025 and 31 March 2026, summarised current activity, outlined areas for improvement, and described progress in embedding personalised and trauma-informed approaches to care. It was pleased to see a sustained significant reduction in physical restraint across a number of services, noting that a number of organisational initiatives had contributed to this, including the national culture of care work, the integration of safety huddles and the appointment and embedding of a lived experience role within the Prevention and Management of Violence and Aggression Team.	SR1 SR7
The committee discussed the 2025 Community Mental Health Services Survey results. It agreed to highlight the positive survey results to the Communications Team, ensuring that good news is shared internally and externally.	SR1 SR7
The committee reviewed two presentations which provided the highlights of the Children and Young People's Mental Health Service's (Red Kite View) and the Older People's Service Line's Annual Quality Reports, focusing on how the services had scored themselves against the Learning, Culture and Leadership Framework and the STEEEP dimensions. The committee acknowledged the cultural and operational turnaround at Red Kite View, with improved incident management and leadership focus extending beyond inpatient wards. It was pleased to hear that the Older People's Service Line had strong leadership and was committed to implementing the Quality Strategic Plan. Overall, the committee was assured that the services had robust systems in place to identify and understand their quality issues, drive improvement, and maintain a clear awareness of their strengths and weaknesses in relation to learning, culture, and leadership. The committee was also assured that the Executive Team had a strong understanding of the services strengths, weaknesses, challenges, and blind spots, and how these were being managed.	SR1 SR2 SR3 SR4 SR5 SR6 SR7
The committee discussed a report which summarised the findings from the Getting It Right First Time (GIRFT) Mental Health Urgent & Emergency Care visit on 12 February 2026. It noted that the report detailed 13 recommendations to address cross-boundary challenges, including Emergency Department (ED) environments, front-door triage, statutory assessment delays, and acute inpatient flow. It acknowledged that the recommendations aligned with existing Trust priorities on inpatient flow.	SR1 SR5 SR6 SR7

REFER - Items to be referred to other	
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
13

Meeting of the Board of Directors

Paper title:	Chair's Report from the Quality Committee meeting on 9 July 2026
Date of meeting:	30 July 2026
Presented by: (name and title)	Prof. 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:	9 July 2026
Chaired by:	Prof. 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 the Board Assurance Framework (BAF), paying particular attention to strategic risk one (SR1) and SR2. It was suggested that the wording on SR2 should be amended from 'quality, safety and outcomes' to 'quality including safety and outcomes', acknowledging that safety was integral to quality. Overall, it was assured that SR1 and SR2 were being adequately controlled.	SR1 SR2
The committee received the Annual Report of Infection Prevention and Control (IPC), Medical Devices and Antimicrobial Stewardship for 2025/26 and the IPC BAF. It discussed the flu vaccination campaign for 2026/27, recognising the impact of flu on sickness absence across the Trust and suggested that the Executive Management Team should consider the Trust's approach for the 2026/27 campaign. The committee noted the achievements for the team during the year, which included: • A reduction in airborne transmission related outbreaks compared to the previous year. • Zero methicillin-resistant Staphylococcus aureus (MRSA) assigned bacteraemia cases during the year. • Zero assigned Clostridioides difficile case during the year. • Zero assigned Escherichia coli (E. Coli) gram negative bacillus bacteraemia case during the year.	SR1 SR5

• 94% of all staff members with a substantive post being up to date with statutory and mandatory Infection Prevention and Control training for level 1 and level 2. • 38% of front-line staff vaccinated against influenza, which is a five percentage point increase on last year's uptake of 33%. The committee noted that a separate annual report on medical devices, covering policies, training, cleaning and maintenance, availability and reported incident trends would be provided for a future meeting.	
The committee received the Safeguarding Team's Annual Report for 2025/26. It was pleased to hear that the Trust had successfully achieved White Ribbon UK re-accreditation and that mandatory safeguarding training figures had consistently reached the expected compliance rate throughout 2025/26. It supported the proposal for a Trustwide Safeguarding Strategy to be developed and implemented. The committee agreed that it was assured on the activity of the Safeguarding Team and thanked the team for its work during 2025/26.	SR1 SR7
The committee reviewed and discussed the results of the committee effectiveness questionnaire. Overall, the committee agreed that it remained effective and acknowledged that, although further developments were not required at the present time, it would continuously seek to improve its effectiveness.	SR1 SR2
The committee received a paper which had been provided in response to an action relating to the oversight of quality metrics in relation to clinical sub-contracts. It noted that previously there had been no consistent framework for monitoring the quality and performance of sub-contracted services. It was assured that, following a comprehensive review of all current subcontracts, strengthened quality metrics and clearer escalation routes had been established, with standardised monitoring processes developed aligned with the Provider Selection Regime.	SR1 SR7

REFER - Items to be referred to other	
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
14

Meeting of the Board of Directors

PAPER TITLE:	Medical Director's Report
DATE OF MEETING:	30 July 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)		x
SO1	We deliver great care that is high quality and improves lives.	x
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)		x
SR1	Quality including safety assurance processes	x
SR2	Delivery of the Quality Strategic Plan	x
SR3	Culture and environment for the wellbeing of staff	x
SR4	Financial sustainability	x
SR5	Adequate working and care environments	x
SR6	Digital technologies	x
SR7	Plan and deliver services that meet the health needs of the population we serve.	x

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

30th July 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

The Medical Directorate continues to deliver a broad and ambitious programme of work across workforce development, clinical leadership, education, digital transformation, quality improvement, medicines safety, research, and mental health legislation, while simultaneously preparing for organisational integration with Leeds Community Healthcare (LCH). Across all areas there remains a strong focus on maintaining safe, high-quality care, supporting our workforce, improving productivity, and strengthening organisational resilience during a period of significant change.

A major strategic development during the reporting period has been the publication of the new Quality Strategy for NHS-funded services. I had the opportunity to hear first-hand from Professor Frankie Swords, National Medical Director**,** about the intentions and ambitions of this strategy at the recent Regional Medical Directors' Roadshow in York**.** The strategy places renewed emphasis on quality as a shared organisational endeavour and provides an important opportunity to align emerging national priorities with our existing quality improvement, clinical leadership, governance and patient safety programmes. Initial work is already underway within the Improvement and Knowledge Service to assess areas of alignment, opportunity and learning for the Trust.

Workforce sustainability remains a key priority, with continued progress in reducing medical vacancies through substantive consultant recruitment, development of SAS and Specialist Grade career pathways, successful appointment of trust doctors, and the retention of higher trainees into substantive consultant posts. These initiatives are supporting a gradual reduction in agency reliance while maintaining safe clinical services. Job planning compliance remains strong at 97%.

Medical Education and the Andrew Sims Centre continue to perform strongly despite capacity pressures. Significant achievements include excellent trainee support, high levels of mandatory training compliance,

positive feedback from the University of Leeds, continued leadership development opportunities, and the expansion of educational partnerships that may create future opportunities for both service development and income generation.

The Directorate continues to play a central role in preparing for the future integrated organisation with LCH. Key programmes include the development of a shared Electronic Patient Record, implementation of a Trust-wide electronic prescribing strategy, and expansion of Ambient Voice Technology, which is already demonstrating benefits in reducing administrative burden and improving clinical productivity.

Alongside this, work continues to strengthen clinical leadership, quality improvement, medicines safety and governance arrangements. Notable developments include progress in the Pharmacy "Getting to Good" programme, the continued development of quality and performance dashboards, and the establishment of workstreams to support clinical leadership development and organisational readiness during the integration period.

Research activity remains strong, with successful study recruitment, the launch of the Trust's first commercial trial, and growing collaboration with regional partners. At the same time, the Mental Health Legislation team is leading preparations for implementation of the Mental Health Act 2025, responding to significant legal developments relating to deprivation of liberty, and progressing implementation of the Thalamos electronic Mental Health Act system.

Overall, the Directorate continues to deliver substantial programmes of work that support the Trust's strategic objectives while responding to national policy developments, workforce challenges, digital transformation and organisational integration. The breadth of activity outlined in this report demonstrates a continued focus on quality, safety, innovation and workforce development across all areas of responsibility.

3. CORE DIRECTORATE FUNCTIONS

3.1 Personnel and structure changes:

Medical Professional Development Centre /Andrew Sims Centre (ASC)/Medical Education:

The Head of Medical Development and Operations has embedded regular meetings with LCH to map the operational functions required to support the medical workforce. The LCH medical operations postholder has resigned, but closer working relationships have ensured that the existing administrative teams at LCH are appropriately supported and that a sustainable administrative management structure had been established to maintain service continuity while promoting a positive team culture, staff health, and wellbeing.

The administrative teams within the Medical Directorate continue to operate at full capacity, with workload pressures being closely monitored. Regular supervision continues for all team members, with a strong emphasis on staff wellbeing, resilience, and the early identification and mitigation of burnout risks.

3.2 MEDICAL PROFESSIONAL LEADERSHIP

Medical staffing levels – vacancies, recruitment

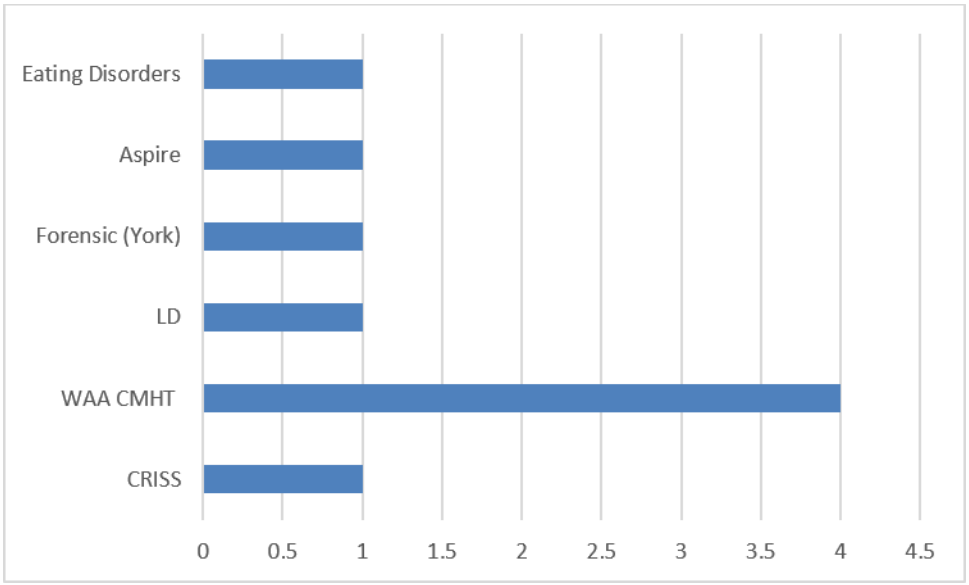
Following the last report:

- 1 substantive consultant has been successfully appointed in York forensic services,
- 1 substantive consultant has been offered a post in South CMHT and
- 1 Specialty Doctor in CAMHs has been successful with their application to become a Specialist Grade doctor.

There are currently a total of 10 agency doctors (1 Specialty Doctor and 9 consultants). This is a reduction of 1 agency doctor in Q1.

A) Consultant vacancies

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



The recruitment and mitigation plan for each of the services is listed below and all vacancies have dates scheduled at AAC panels. Running alongside the substantive posts there are also adverts for Trust locum consultants, which further supports the work of reducing agency costs. A Specialist Grade post has been advertised, rather than a consultant post in Community Rehab Team (CRT) due to a request from the existing Consultant who has requested to reduce their current sessions. Regular discussion take place with the leadership teams within services where the vacancies remain to review possibilities for alternatives to consultant recruitment. A recent example of this has been ward 1 Becklin Centre who have recruited a MPAC to a post that was previously a consultant psychiatrist.

Post	Reason for agency cover	Specific Workforce Planning to Recruit to Vacancy
Ward 1 Becklin	Resignation	The substantive consultant unexpectedly resigned and there is currently an agency locum covering. The AAC for the substantive post was scheduled to take place in April but there were no applicants. The service has now filled the consultant psychiatrist gap with a nurse consultant MPAC who will commence in post in September 26.
Eating Disorders	Long term vacancy after retirement.	Following the service review a consultant post at 0.8WTE is about to be advertised with high confidence in recruitment. The agency Consultant will continue in the meantime.
Forensic (York)	Resignation	There is a higher trainee who is acting up into this post and has been successful in obtaining the substantive post. They will commence in August 2026.
LD (ENE)	Retirement	Agency in place for 3 days currently. Advert now out for 0.9 post. Agency Consultant will remain in the meantime.
CRISS/CAU	Vacancy due to internal move	Post remains vacant. Requires Responsible Clinician status – alternatives have been considered. Agency remains in post.
Aspire	Vacancy due to sickness and planned internal move	Post being advertised and agency locum in place for 3 days currently. At AAC in May 2 applicants were not appointable.

WAA CMHT Vacancies

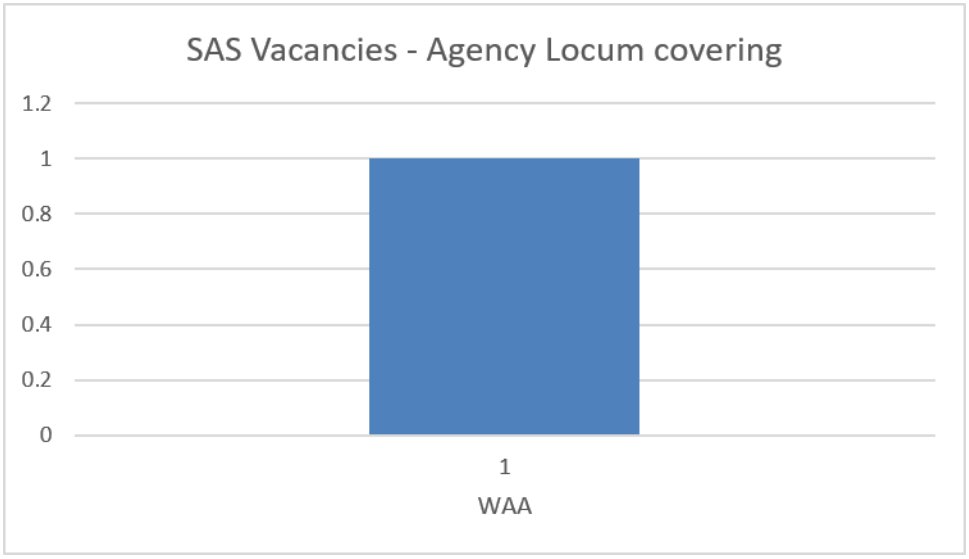
The information below shows the number of vacancies currently in WAA CMHT in comparison to the number of agency locums that are in post covering these vacancies. Since Q4 3 substantive consultants have been appointed 1 consultant in South CMHT and 2 consultants in ENE. As above, all posts are being advertised each month.

CURRENT VACANCIES	AGENCIES LOCUMS COVERING VACANCIES
West CMHT Team B West Leeds PCN 1.5 (2 posts) Team D Woodsley area PCN 1.0 Team F Armley PCN 0.6 TOTAL – 3.1 WTE	 2 x F/T locum consultants 1 x F/T locum SD
South CMHT	

Team C Hunslet/Middleton PCN 0.6 Team E LS25/26 PCN 0.5 Total – 1.1 WTE	1 x F/T locum consultant (1 x substantive consultant has been appointed and will commence in August 2026) There will be no vacancies then in South CMHT
ENE CMHT Team B Central PCN 0.5 Team C York Road PCN 0.5 Total – 1.0 WTE	1 X F/T Locum Consultant
Total vacancies: 5.2 WTE	Covered by 5 F/T agency doctors (4 Consultants and 1 SD)

B) **SAS doctors**

There is currently 1 agency SAS doctor CMHT.



Recruitment has taken place for the following areas: Ward 5 Becklin, South CMHT, OPS and CRISS and there is one vacancy remaining that is out to advert in OPS.

Trust Doctors

Following a successful round of recruitment, three trust doctors have been appointed to fill resident doctor level service gaps and will commence in post in August.

New Work

A medical line manger time out/training update session took place in March and covered several topics including wellbeing and attendance and the complaints process.

The Medical Directorate are currently working with Retinue to embed a Direct Engagement model - the 'go live' date is scheduled for 20th July and once fully live this would effectively reduce our agency doctor position to zero. However, there are some concerns that working with this model could potentially impact service provision should any of the current agency locums choose not to move over to be directly engaged. This has been highlighted and escalated. Some agency doctors have indicated they will not move to the direct engagement model.

Specialist Grade Doctors
Workstreams allowing SAS Drs to progress in their career contribute to alternatives to consultant recruitment. These improve LYPFT's offer to the SAS workforce, increasing chances of retention in and recruitment to LYPFT.

Funding has been secured for a specialist grade post in CRT, - the role will provide backfill for a service gap as the current postholder requires a change in job plan and clinical sessions. The post is currently out to advert.

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
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, in Quarter 3 we reported that a higher trainee in south CMHT had expressed an interest in applying for a consultant post, this doctor has now successfully obtained a substantive consultant post in the Trust and will commence in August following completion of training. In addition to this and following discussions, a higher trainee is currently acting up in Forensics and has also successfully obtained a substantive post with LYPFT and will commence in August. These are examples of the joined-up work that is taking place between medical education and the medical directorate to reduce the need for agency locums.

Job planning status update

Job Plan Compliance
The current overall completed compliance is 97%. 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.

(a) Consultants

Service	Number of Signed off Job Plans	Job plan due
Adult Acute Services	6	0
Adult Acute Services (CRISS)	3	0
CAMHS (inc Deaf CAMHs)	7	0
Community (WAA)	20	2*
Eating Disorders	2	1*

Forensic	4	0
LD	2	0
Liaison	13	1*
OPS	16	0
Perinatal	8	0
Public Health	1	0
Regional & Specialist	6	0
Rehab	3	0
Grand Total	89	4

Job plan due: *one doctor on maternity leave *; one doctor is currently on a career break*; two are late, for which reminders have been sent.

(b) SAS

Service	Signed off job plan	Job plan due
Adult Acute Services	6	0
Adult Acute Services (CRISS)	4	0
CAMHS (inc Deaf CAMHS)	3	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	1*
Rehab	3	0
Grand Total	52	1

Job plan due: *The doctor whose job plan is due has been on long term sick.

(c) Specialist Grade

Service	**Signed Off Job Plan**	**Job Plan Due**
CAMHS	1	0
Community WAA	0	1

Job plan due: The doctor only commenced in post in May and has 3 months to complete.

Job Planning Policy

The Job Planning policy written collectively with the Deputy Medical Director, HR Business Partner and Head of Medical Development and Operations has now been approved via the Trust Governance process.

3.3 Specialty Doctor and Associate Specialist (SAS) Advocate update

Dr Abhi Inglis has stepped down from the SAS Advocate role following their successful appointment as SAS Tutor. Recruitment to the vacant SAS Advocate post is currently underway.

3.4 Medical Continuing Professional Development (CPD) and the Andrew Sims Centre

The Andrew Sims Centre (ASC) continue to develop professional business relationships by collectively working with colleagues at LYPFT Trusts internal departments by co-organising events. ASC are currently working with colleagues to arrange the annual AGM. Additionally, ASC continues to build external relationships with Hospital Trusts and is currently working with Nottinghamshire Healthcare NHS Trust to arrange an event. The Head of Medical Development and Operations has been approached by the Clinical Lecturer in Psychological Medicine at the Leeds Institute of Health Sciences, University of Leeds, regarding a proposal for ASC to develop and deliver a new course commencing in Autumn 2027. Initial discussions have been positive, and a detailed proposal is currently being scoped to determine the staffing requirements, resource implications, and implementation plan. Subject to approval, this initiative represents an exciting opportunity to expand ASC's portfolio, strengthen its partnership with the University of Leeds, and generate a significant additional income stream for the organisation.

In Q4 the centre ran several courses including Section 12 Refresher Course and the SAS away day. There is currently a total of 12 events scheduled to take place before the end of December.

The centre continues to support the administration of medical study leave for Consultant and SAS Doctors, working closely with the Director of CPD. As of August 2026, ASC will no longer oversee the Red Kite View middle tier rota this will move to colleagues in the Medical Education Centre.

ASC continues to be closely monitored in relation to workforce capacity and its future operating model. The Band 4 postholder has verbally resigned, and arrangements are currently being finalised regarding their leaving date. The Band 6 is due to return from maternity leave in Q2. The Deputy Head of Medical Development and Operations is overseeing the management of ASC until her return. There has been a period of sickness and the centre has been in business continuity and reliant on resources from outside of ASC. Members of the Medical Directorate team and Medical Education team have provided input in addition to carrying out their own day to day roles working at full capacity.

3.5 Medical Education

There are lots of positives to report on this quarter; the MELM (Medical Education Leadership and Management Team) structure continues to work well. Dr Laura Shaw has replaced Dr Becky Asquith as Core Trainee Tutor and Guardian of Safe Working Hours and commenced the post with effect from 1st March 2026. Dr Matthew Murray replaces Dr Xinya (JinJin) Guo as Core Trainee Medical Education Tutor from August 2026 and will be working alongside Dr Grace Gibson who remains in post to oversee the Undergraduate Medical Education teaching programme.

Dr George Crowther, Consultant Psychiatrist with LYPFT in Liaison Psychiatry, was successful in his application for Champion of Supported Return to Training (SuppoRTT) - Academic/Research within the deanery, he will commence this post with effect from 1st August 2026.

Following highly competitive interviews for a higher trainee to be Trust sponsored to attend the Royal College of Psychiatrists Leadership and Management Fellow Scheme, Dr Ben Rutt has been successful. The programme aims to accelerate leadership and management development through the national teaching programme and with a local apprenticeship model in a leadership project mentored by a medical leader. Dr Rutt will be our LYPFT Mental Health Innovation Fellow mentored by Dr Tom Lane, Consultant Psychiatrist

LYPFT and Psychiatry ICU manager at the University of Leeds (UoL). The project will be to design, develop, and implement basic mental health communication and examination skills workshops for year 2 undergraduate medical students placed in LYPFT. This work aligns with the UoL Curriculum Redefined MBChB course programme commencing in Year 1 2026 academic year and provides the pedagogical changes LYPFT needs to deliver on our contract with the UoL for the 2027 academic year.

FY3 recruitment has recently proved a success; the intention of the posts, besides filling gaps in the service is to give doctors taking a break from training the opportunity to take up a post in Psychiatry before they decide what specialty they want to train in. 4 out of 6 current FY3 doctors have been offered training posts in Psychiatry and GP, commencing in August 2026. The Trust now has zero costs for agency spend at core training/Trust doctor level.

The Trusts current compliance rate for mandatory training for resident doctors is now 98%, the highest it has been in recent years.

The Medical Education team achieved the deadline for issuing out of hours rotas in line with the code of practice and some rotas were issued almost two weeks before the deadline date. The Medical Education team also took over responsibility from the Andrew Sims Centre to plan the Red Kite View middle tier rota. In addition to this, the team had the added pressure of planning the June out of hours rota cover for industrial action (despite this being cancelled at the 11th hour) and were still able to maintain business as usual and get rotas out ahead of schedule. This is a real testament to the teams' hard work, commitment, and efforts.

The University of Leeds have provided multiple evidence of outstanding feedback from this academic year medical student placements. A taster includes:

- Having a Firm Lead was a really good idea and it was nice to have small group teaching. FOCAS was a great way to have observed consultation skills and receive really personalised feedback.
- Great weekly teaching at Leeds/York. Intro week was well organised. Felt well supported.
- Really good teaching on placement at Leeds, biweekly sessions and loved we got to rotate around community and ward-based care.
- This was probably the most structured placement I have had. There was excellent teaching throughout and the resources provided were very useful. I particularly enjoyed the variety of settings we were exposed to, including acute adult psychiatry, older adult psychiatry, and the Mother and Baby Unit. I felt I learned a huge amount during this placement and developed a much better understanding of Psychiatry as a whole.
- The placement team were supportive and responsive when concerns were raised. In particular, Dr Musabbir, Deputy DUGME, worked hard to modify my timetable and implement adjustments to support me throughout the rotation.

The GMC NTS 2026 survey has now been closed, although the full results have not yet been received, confirmation from the deanery has been received that the Trust has not experienced any patient safety concerns or undermining comments about LYPFT.

All outstanding actions following the implementation of the 10-Point Plan have now been implemented. Meal provisions are being monitored for quality, usage, and wastage. The resident doctor peer leads are very

satisfied with LYPFTs dedication to continuing to improve the working lives of resident doctors. Since implementation of the 10-Point Plan it has been identified that resident doctors working at Mill Lodge and Clifton House have been completing ILS and Breakaway training for both Trusts. This was reviewed by both LYPFT and TEWV Medical Education teams and a change was implemented so these are now only completed once but marked as compliant for both Trusts.

Before the challenges, as both an exciting opportunity, yet challenging additional workload, is the working towards a single medical education team in the new organisation for April 2027.

Other challenges are:

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. Postgraduate Medical Education was hoping it could be TUPE'd to a Yorkshire and Humber Trust under a Lead Employer contract, however it has now been confirmed that they will sit within DHSC. The redundancy programme is currently underway with several colleagues' requesting voluntary redundancy and currently going through a process to agree settlement figures. This is a worrying time for the deanery as it will lose a lot of its knowledgeable and experienced colleagues.

4. RESPONSIBLE OFFICER

The annual Responsible Officer report has been submitted as a separate paper.

5. CLINICAL LEADERSHIP AND QUALITY OF CARE

There has been a pause on the formal clinical leadership review in light of the upcoming integration. A separate clinical leadership task group has been agreed to involve LYPFT and LCH to scope current structures and core requirements in advance of a review across the whole post integration once the service structure is clear. In the short term the focus is on stability and clarity of leadership to ensure patient safety and quality of care during the transition phase.

There have been some changes within the clinical leadership group. Jo Ramsden has been successful in being appointed as National lead for interventions in the Offender Personality Pathway and will be sconded for two years to that role. There is an ongoing processes to appoint interim clinical leads in Emerge and also in the Complex Psychosis Pathway where Ashley Fallon is on longer term leave. Kerry Hinsby has been appointed as the interim clinical lead in Forensic. Ben Alderson is moving to take on the Clinical Leadership of the new Pathway and Flow Programme. A process is in place to backfill his role in the Older Peoples service.

The clinical leadership development programme has continued, key milestones are:

- Clinical Lead Action Learning Sets now self-sustaining as peer supervision forum with consistent attendance (8--12 participants per session). The first "self-led" Action Learning Set too place this quarter with positive feedback from attendees in relation to success and usefulness.
- Using the outcomes of the previously completed Learning Needs Assessment, a Clinical Leadership submission was made as part of the Trust Training Needs Analysis work.

- Clinical Leadership Journal Club sessions have taken place monthly over the last quarter which have explored topics such as, the impact of “real team” and “co-acting group membership” within health care and theories, challenges and practical insights when navigating health care leadership. The journal club provides a forum for those in Clinical Lead roles to explore and discuss the application of Clinical Leadership research and evidence base to self, services, clinical lead community and leading for quality.
- The Clinical Leads Working Group which is focussed on establishing and strengthening the interface between clinical leadership and Trust governance structures is established and meeting monthly.
- Work has commenced in scoping out and designing Clinical Leadership Development activities that are focused on the outputs of Quality (STEEEP). The initial focus is on Clinically Leading for excellent, high-quality, person-centred care. A scoping process is under way using the person-centred elements of 2025 / 26 quality reports to identify themes. Information gained will be used to design Clinical Lead Development Day sessions. A meeting has is being arranged with Alison Quarry to ensure that the work is aligned with other Trust workstreams.

Work has continued on the shared understanding of quality and development of a Quality Dashboard. Agreement was made with EEMT to focus initially on ensuring that each service user has a risk assessment, care plan, and outcomes measures in place in a data management system that connects daily management, monthly clinical governance and yearly Annual Service Quality Reports.

6. MEDICINES SAFETY

The Pharmacy Service continues to work through their ‘Getting to Good’ (G2G) recovery plan and the senior management team are on course to complete their Affina Team Journey by the end of the calendar year with the next tier of managers starting their journey in the Autumn.

A comparative review of Workforce Metrics done in March 2026 indicates the G2G work is starting to impact.

Vacancies and staff turnover rates now back within normal limits with the headcount increased from 58 staff (51.79wte) to 69 staff (63.2wte). Staff turnover rates have reduced from 15.96% to 11.37%, in April 2024 the staff turnover was 24.56%.

Sickness absence levels were 9.13% in Apr25 (20% in Feb25) and have reduced to 6.37%, similar to Trust as a whole, as are the reasons for sickness absence.

Appraisals & Compulsory Training have also improved with appraisal rates increasing from 66.67% to 78% and compulsory training now at 93%. Staff wellbeing reviews are currently at 85%.

The recent Staff Survey also showed positive results with an increase in all people promise scores with ‘we are compassionate and inclusive’ seeing the highest change from 5.58 percent to 7.01%. The survey completion rate also improved being up by 24.4% from 27.1% (N=16) to 51.5% (N=34).

This year’s Intention plan is to further increase completion rates and improve scores by completing the G2G plan.

An online inhouse Snapshot Staff Survey was done in March, specifically focussing on the impact of the key G2G workstreams. Thirty-two pharmacy staff completed the survey, the majority felt that Line Management and Communication were improving, scoring 4.06/ 3.41 out of 5 respectively. Just under half felt Training was also improving, scoring 3.22 out of 5 and a quarter of staff felt Task Clarity and Role Clarity were improving, both scoring just under 3.

The Pharmacy Service are in the process of finalising a new Business Continuity Plan and have recently signed an updated SLA with LTHT (for medicines procurement and medicines information services, the CMM dispensary stock management and labelling system and out-of-hours medicines supply).

Medicines Governance recovery work also continues. Reviews of medicines-related policies and procedurs are back on track with oversight at the MOG and the review of related documents is progressing with the 'Framework to Support the Delegation of Specific Medicines Related Tasks to 'Medicines Aware' Staff ('2nd Checker')' being completed in Apr26.

New Guidance for the 'Management of FP10 Prescriptions (Clinicians and Services)' was approved in Feb26 and a framework to support the reporting and management of CD Stock Balance Discrepancies in clinical areas is due to be approved in Aug26.

All outstanding minor actions from previous Internal Audits of Medicines Management) were completed May26.

The recent internal audit of Medicines Assurance Processes, focusing on the Controlled Drug (CD) and Medicines Management Assurance (MMA) checks undertaken within clinical areas concluded that there was 'Limited assurance'. There were recommendations to strengthen the reporting of MMA and CD checks into service line governance meetings (and the MOG), particularly regarding action/s to address non-compliance. Further recommendations including moving to an e-system and the need to update the Medicines Safety Committee ToRs (since done). Work has started with a target completion date of April 27 which correlates to the existing work plan.

#The December 2025 upgrade to Version 13 of MedChart EPMA introduced a community prescribing function. However, the cost of the supplier (Delandus) developing Clozapine prescribing functionality within the system is prohibitive meaning approximately 380 paper prescriptions will need to remain on an Access database until a new EPMA system is procured or an alternative solution is identified.

7. CLINICAL INFORMATION MANAGEMENT

Executive Summary:

Significant progress continues across the Trust's digital transformation portfolio, with major programmes advancing to support safer, more efficient and more integrated care. Key areas of focus include procurement of a replacement Electronic Patient Record (EPR), implementation of Electronic Prescribing and Medicines Administration (EPMA), staged roll out of Ambient Voice Technology (AVT), replacement of the Datix incident management system, improvements to pathology ordering and communications, and development of digital infrastructure to support CONNECT services.

The most significant challenge remains identification of capital funding to support EPR procurement and implementation. While an application to the national Frontline Productivity Fund was deemed outside the scope of that programme, NHS England colleagues have identified alternative funding routes which are currently being explored.

Overall, programme delivery remains on track, with strong confidence ratings across all major projects and governance arrangements now established.

Key Achievements:
Electronic Patient Record (EPR)

Work continues towards procurement of a replacement EPR across Leeds and York Partnership NHS Foundation Trust and Leeds Community Healthcare NHS Trust, creating an opportunity to establish a shared digital platform across the future merged organisation.

Achievements to date include:

- Completion of stakeholder engagement across LYPFT clinical, operational, executive and digital teams.
- Completion of pre-market engagement with six potential suppliers.
- Development of an initial high-level specification informed by stakeholder and supplier engagement.
- Commencement of Leeds Community Healthcare stakeholder engagement and specification development.
- Ongoing collaboration with procurement partners to develop a multi-lot procurement approach.

Electronic Prescribing and Medicines Administration (EPMA)

Progress continues towards a Trust-wide EPMA strategy, including:

- Establishment of programme governance through the EPMA Steering Group.
- Development of a draft EPMA Vision and Strategy.
- Preparations for deployment within Willow View.
- Initial work to support future integration with CONNECT electronic prescribing services.
- Review of user roles, access controls and training arrangements.

Datix DCIQ

The programme to replace the existing Datix platform is progressing well:

- Governance arrangements established.
- System environment creation is underway.
- Discovery workshops planned to define future-state requirements and implementation priorities.

Ambient Voice Technology (AVT) – Heidi Pilot

The Trust's pilot of Ambient Voice Technology (AVT) using Heidi has now progressed to the evaluation phase, with work underway to gather data regarding safety, effectiveness and impact on clinical practice.

Initial feedback from participating clinicians has been positive. Staff report that Heidi is safe and appropriate for use within their clinical settings and that it has reduced the amount of time spent on clinical administration, allowing greater focus on direct patient care. The pilot is now being expanded through a staged rollout to additional services, including the ALPS, LADS and ADHD teams.

The pilot deliberately selected two services where implementation challenges were anticipated. One service was chosen because the patient population was considered more likely to have concerns regarding the use of AI-supported technology, particularly around confidentiality and trust. A second service was selected because workforce pressures and operational demands were expected to create barriers to adoption of new technology. This approach has enabled the Trust to develop and refine different implementation methodologies tailored to specific service and population needs, generating valuable learning for future deployments.

The programme team is currently developing a publication describing the implementation approach, lessons learned and factors influencing successful adoption across different clinical settings. This will support future AVT deployments both within the Trust and potentially across the wider NHS.

A challenge was encountered during the reporting period following a Heidi software update which temporarily affected user access to the application. For a period of five days, staff were required to access Heidi through the web-based application rather than the desktop application. This triggered the programme's "Amber" threshold within the agreed stop-go criteria. In response, Heidi was formally requested to provide a detailed incident report, including root cause analysis, lessons learned and the mitigations that will be implemented to reduce the likelihood and impact of similar incidents in the future.

Digital Integration and Connectivity

Work is progressing to improve interoperability and digital support across services:

- Investigation of pathology ordering and communication issues with regional pathology providers.
- Development of digital requirements for CONNECT services.
- Progress towards defining the CONNECT service model and associated digital solutions.
- Initial options appraisal work underway to identify appropriate future systems.

Risks and Challenges
EPR Funding

The principal programme risk remains securing sufficient capital funding for EPR procurement and implementation.

Although the Trust's Frontline Productivity Fund application was unsuccessful, alternative funding opportunities are being explored with NHS England. In parallel, a review is underway to identify a minimum viable implementation approach that could be delivered within a constrained financial envelope.

Resource Capacity

Successful delivery of the EPR programme will require specialist programme management and business change capability. Discussions continue regarding potential partnership arrangements and shared resources to mitigate this risk.

Next Steps

Over the next quarter, the Digital Programme will focus on:

- Completing Leeds Community Healthcare stakeholder engagement.
- Finalising and approving the joint EPR specification and Invitation to Tender documentation.
- Progressing EPR funding discussions with NHS England.
- Finalising the EPMA Vision and Strategy.
- Commencing Datix DCIQ discovery workshops.
- Compile pilot data and begin the staged rollout of AVT
- Developing options appraisals for CONNECT digital solutions.
- Continuing work with regional pathology providers to improve order communications processes.

Assurance

- Governance arrangements are established across all major digital programmes.
- Delivery confidence remains high across the portfolio.
- Key milestones for EPR procurement preparation have been achieved.
- Work is progressing to support digital integration across the future merged organisation.
- Funding options and delivery models are actively being developed to manage emerging financial risks.
- Evidence is emerging that AVT can reduce administrative burden for clinicians in LYPFT.
- Learning from the AVT pilot is informing future Trust-wide deployment planning.

The most significant issue requiring ongoing executive oversight is the identification and confirmation of funding arrangements for the EPR programme.

8. RESEARCH AND DEVELOPMENT

During the reporting period 5 studies opened, and 105 participants were recruited from 8 service areas. 30 studies are currently open or in follow up. 0/1 study recruited their first participant within 90 days of regulatory approval This is a new metric that forms part of the NHS Operating Framework.

In 26/27 we received NIHR Regional Research Delivery Network (RRDN) strategic funding to deliver our successful research ready schools programme across additional RRDN regions, the first training sessions have been delivered to Southwest Central and Northeast North Cumbria RRDNs.

The Easy ECG study is comparing the effectiveness of a 6-lead mobile ECG machine with a traditional 12-lead. This study is funded by Alivecor and sponsor by LYPFT. There are now 9 out of 10 studies sites set up nationally. As of today (14/7/26) there are 174 recruits for this study nationally.

On the 26th May we successfully opened our first commercial trial. MINDSET2, sponsored by Bristol Myers Squibb, which aims to test KarXT + KarX-EC for the treatment of cognitive impairment associated with mild

to moderate Alzheimer's disease. We are working in partnership with LTHT clinical research facility and other support services to maintain safe and effective delivery of the trial. This trial has received a lot of early interest from service users, with the first consent visit planned for the 29th July. The opening of MINDSET forms part of a wider Leeds Research Collaboration where key partners from across the city have developed an approach to build on joint feasibility and capacity building for future research in Leeds. This activity is in collaboration with LCH/LTHT/YAS/GP's.

The Trust's service user and carer research involvement group celebrates its 20th anniversary this year and received a Spotlight award from Sara Munro at an event on 13th May.

The Research Department is working with LCH to determine day 1 critical activities for the merger. Ensuring a smooth transition as well as compliance with statutory, regulatory and contractual obligations.

Susanna Wright (OT) applied and was successful in being awarded a NIHR Internship. These internships provide funded backfill to staff to support them to think about research.

REGISTER Research Forum - Research

9. IMPROVEMENT AND KNOWLEDGE SERVICE

The Improvement and Knowledge Service is currently supporting 69 active clinical audit and improvement projects across Trust services. Alongside this, the team continues to contribute to key organisational priorities, including the Clinical Inpatient Model Review, the Inpatient Quality Transformation Programme, Optimising Community Services and the Culture of Care programme.

Demand remains high across all three service areas. The Improvement Team has seen a continued increase in requests for Learning, Culture and Leadership assessments, with four currently underway. Clinical Effectiveness and Library and Knowledge Services remain at full capacity, requiring careful prioritisation to protect support for Trust priorities and direct patient care.

Development of the Clinical Audit and NICE Guidance modules within AMaT remains a significant area of focus. The Clinical Audit module is expected to go live in September 2026, followed by the NICE Guidance module in October. NICE compliance monitoring continues, with two guidelines currently undergoing baseline assessment and one requiring an action plan.

The service has agreed its improvement priorities for 2026/27, including developing a joint improvement training programme with LCH colleagues, creating standard tools and templates, and improving access to self-directed and facilitated improvement support through refreshed Staffnet pages.

Attention is being applied to the newly published national quality strategy for NHS funded care, to determine the points of synergy and difference as compared with our own quality strategic plan and the local implications and opportunities.

10. MENTAL HEALTH LEGISLATION COMPLIANCE

Mental Health Act 2025

The Mental Health Act 2025, which amends and modernises the Mental Health Act 1983, received Royal Ascent on 18 December 2025. The majority of the provisions are not yet in force and are scheduled to be implemented over the next ten years. We have already started planning for the amendments as they will have a significant impact on clinicians' workloads and responsibilities. The MHL Team, supported by a solicitor, presented the amendments to the Board on 30 April 2026 with a focus on the impact for clinicians and the Trust. We held a strategy day with senior clinicians on 17 July 2026 to focus on the impact of the amendments which has informed our planning and ensured we are gearing towards being ready for the changes when they are implemented.

Supreme Court Landmark Judgement – Deprivation of Liberty

On 2 June 2026, the Supreme Court delivered a landmark judgment in a challenge brought by the Attorney General for Northern Ireland concerning what constitutes a 'deprivation of liberty'.
The judgment significantly narrows the scope for a deprivation of liberty and in so doing overturns the previously accepted '*acid test*', established by the Supreme Court in the *Cheshire West* case in 2014.
As a result of the judgment, there is no longer a single and universally applicable test for determining where a deprivation of liberty arises. Instead, decisions will require a multifactorial assessment of a person's individual specific circumstances. This judgement will have a significant impact for clinicians and service users, and we are supporting clinical teams with individual cases where DoLS applications would have previously been made while we await guidance from the Department of Health.

Thalamos eMHA

Following the acquisition of the Thalamos eMHA application we are working closely with the project lead and Thalamos to implement the system in a structured and planned way. We have completed process mapping and a time and motion study within the MHL team and, with the support of the Medical Directorate, are commencing our work with clinicians who will be using the system.

CQC Second Opinion Appointed Doctors (SOAD)

Our pilot of SOAD days continues to be very successful. After consultation with CQC we have been arranging days where SOAD's can speak to multiple clinicians and patients in one day to assist in reducing the delays in authorising consent to treatment provisions. The MHL team arrange and coordinate appointments to ensure that delays are kept to a minimum and clinical time is saved. We have received very positive feedback from the SOAD team and have been asked to speak to a number of other trusts about adopting our systems and processes.

11. CONCLUSION

This 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

30 July 2026

Agenda item
15

Meeting of the Board of Directors

Paper title:	Guardian of Safe Working Quarterly Report: Quarter 4: 1st Jan 2026 to 31st March 2026
Date of meeting:	30th July 2026
Presented by: (name and title)	Dr Chris Hosker, Medical Director
Prepared by: (name and title)	Dr Laura Shaw, Guardian of Safe Working Hours

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 12 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 14th May 2026 with opportunity for feedback from Core and Higher Trainee representatives, as well as continued review of ERs and rota gaps.
- Exception Reporting reforms were implemented in February 2026 and have been successfully embedded. 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? **Yes**

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

This is detailed within the strategic risks, specifically strategic risks 1, 7 and 8.

Recommendation

The Board of Directors are asked:

- 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

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

Meeting of the Board of Directors

30 July 2026

GUARDIAN OF SAFE WORKING HOURS ANNUAL REPORT

April 2025 to March 2026

Executive Summary

On 1st February 2017 Leeds and York Partnership Foundation Trust (LYPFT) transitioned all doctors in training on to the 2016 Junior Doctor Contract. At this time, Dr Cashman was appointed as Guardian of Safe Working Hours (GOSWH), succeeded by Dr Alderson on 1st December 2019, Dr Asquith on 1st June 2023 and latterly Dr Shaw on 2nd March 2026.

There is a Trust strategic workforce plan in place to address recruitment and retention of staff. Both the Guardian of Safe Working Hours and the Medical Education Department (MEC) continue to work with our doctors in training and their clinical and educational supervisors to ensure patient safety and effective training.

Exception reporting is both welcomed and encouraged by the GOSWH and MEC, to ensure any deviation from the contract terms and conditions is understood and actioned accordingly. There has been a total of 199 exception reports since the contract was implemented in February 2017. 37 of these are within the reference period of this report. There have been no reports raising concerns regarding patient safety in this period. There have been no breaches incurring fines in this reporting period.

1. Introduction

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 Resident doctors contract 2016 and in accordance with Resident Doctors terms and conditions of service (TCS).
The report is for the period from 1st April 2025 to 31st March 2026.
It covers:

- staff vacancies and locum usage
- exception reports
- work schedule reviews

Background

The LYPFT Guardian of Safe Working Hours (GOSWH) was appointed in November 2016 and is responsible for ensuring compliance with the terms and conditions of the Resident Doctor Contract 2016. This is done through working with both the employed doctors and the organisation, with concerns raised both informally and formally through the mechanism of Exception Reporting, and also via a quarterly Resident Doctor Forum (RDF) for which the GOSWH is chair. Details of exception reports for 2025-2026, as well as RDF feedback, are addressed later in this report

The current head count of all doctors in training working in LYPFT is 117. A summary table is included in appendix A. This total includes core trainees, higher trainees, foundation year doctors, and GP trainees. Less than full time trainees (LTFT) can be allocated to Trusts on a supernumerary basis i.e., additional to the agreed training scheme posts, which accounts for higher numbers of trainees than posts. It should also be noted that where there are vacant training places the Trust recruits junior grade doctors on temporary contracts. With the implementation of the 2016 contract these posts are called Trust doctors, and sometimes referred to as 'FY3s', but are not doctors in a training programme. These doctors are also employed under the resident doctors 2016 contract, as agreed with the Local Negotiating Committee.

LYPFT forms part of the Leeds and Wakefield Psychiatry core training scheme and acts as lead employer for trainees within LYPFT and Leeds Community Health Trust (LCH). Historically LYPFT also acted as lead employer for trainees being hosted within the scheme at South West Yorkshire Partnerships Foundation Trust (SWYPFT), however since August 2020 in SWYPFT now acts as lead employer for the trainees being posted within their organisation.

There are 45 established core training and 2 NIHR whole time equivalent posts funded via the medical tariff for Doctors in Training placed within LYPFT and LCR. In addition to these posts, there are 5 trust doctors ('FY3s') in service-funded posts to support service provision.

LYPFT is also the employer of psychiatry Higher Trainees (HT) allocated to the 34 established posts within the Trust across general adult psychiatry, psychotherapy, old age psychiatry, intellectual disability, and CAMHS. 2 CAMHS posts are based in York, with trainees allocated to these posts participating in the York locality rota, but continuing to be employed by LYPFT.

Rotas for on call work within LYPFT and LCH core training are coordinated through LYPFT. This includes a Psychiatry Resident Shift (PRS) rota, staffed by the CT's and FY2s. 4 doctors are resident on call on evenings and weekend days, with 3 further doctors working night shifts. There is also a non-resident middle tier on call rota which is staffed by the HTs, with two doctors working per 24 hour shift.

Leeds Teaching Hospitals Trust (LTHT) is the lead employer for the Foundation Training Scheme and holds responsibility for contractual requirements including exception reporting for these doctors. LYPFT is currently hosting 21 Foundation Trainees, including two FY1 Academic Clinical Fellows and six FY2s who participate in the LYPFT PRS rota. There is joint working between LYPFT and other local GOSWHs when required.

Vacancies and Rota Gaps

Current Vacancies

In the absence of a trainee being allocated to a post, individual services are responsible for addressing gaps in daytime cover using a risk assessment approach. The options available to meet service needs are establishing specialty doctors posts, or booking of an agency locum if the need is short term and / or recruitment to specialty doctor post is unsuccessful. The CT vacancy at the end of March 2026 is zero as the vacant posts have been filled through the appointment of 'FT3' trust doctors. Such appointments have been funded through service budgets.

Rota Gaps

In 2025/26 there have been a total of 453 rota gaps, 240 on the PRS rota (16% of all shifts) and 213 on the middle tier rota (29% of all shifts). The monthly breakdown of rota gaps has been provided in each of the quarterly reports and are included, along with reasons for gaps, in appendices B and C. Usual reasons for gaps include sickness, compassionate or other statutory leave, coming off the rota or leaving the trust, and gaps related to vacant posts or LTFT working.

159 shifts on the PRS rota were covered by internal locums. This equates to 66%
of rota gaps which represents a decline from the year of 2024/2025 reporting period whereby 71.3% of rota gaps were covered internally, and a further decline from 91.7% in 2023/2024. A total of 81 (34%) vacant PRS shifts were unfilled. All vacant middle tier shifts were filled with internal locum cover. There has been no use of agency locums on either the PRS or middle tier rota.

Cover for Rota Gaps

The medical education teams approach to providing cover for rota gaps is, in the first instance, to agree internal cover by doctors already working on the rota. This is known as an internal locum shift.

If the gap is still not covered, there are a number of doctors who have worked on the LYPFT rotas or are working in a medical post within the Trust that does not include an on-call commitment, who are approached. These would also be known as internal locum shifts.

If the shift remains uncovered, then the rota may be authorised to run on reduced staffing by the Director of Postgraduate Medical Education – Operational Lead. In this scenario the medical education team communicates this to the doctors of all grades on the rota, on-call senior manager and switchboard for the date affected to make them aware of the reduced cover. Doctors on the on-call rotas are informed of the possible need to 'act down' if there was a staffing crisis. The Director of Postgraduate Medical Education – Operational Lead has now ensured that in situation where a shift cannot be filled the doctors who are working that shift are remunerated with an equal proportion of the internal locum fee that would have been spent were the shift to be filled.

There has been no use of external locums to cover rota gaps. It is recognised that such doctors are not often familiar with the trust or IT systems which limits effectiveness in providing out of hours cover. It is felt

that utilising internal locum cover or running on an reduced rota or with acting down arrangements is most acceptable for patient safety. External locum cover would be considered if required in extenuating circumstances. There has been no use of external locum cover in this reporting period.

Exception Reports

There have been 37 Exception Reports (ERs) in this reporting period. These are detailed in the quarterly reports and are provided in Appendix D. There have been no immediate safety concerns raised. There have been no ERs which have identified breaches for which issuing of a fine has been warranted as per the T+Cs.

The ER's in this reporting period have mostly been related to difference in educational opportunities or difference in hours worked. Further detail as follows:

- Quarter 1: 7 exception reports received.

    - One ER related to the delay in a (middle tier) resident doctor getting their rest due to completion of a MHA assessment, with delay contributed by lengthy wait for trust taxi. This has been fed back to the Medical Directorate and no further action required at this time.
    - Three ERs related to loss of educational opportunity through being unable to join ALPS due to acuity of work on the PRS rota. MEC continue to liaise with doctors when this occurs and whereby there have been 2+ missed opportunities, alternative arrangements to regain the learning experience where possible are made.
    - One ER related to loss of educational opportunity to attend psychotherapy supervision due to clinical commitments. This was escalated to the DME who has liaised with the Clinical Supervisor.
    - Two ERs related to claims for additional time worked at the end of a normal working day, due to the need to attend to an urgent physical health assessment. Both were settled with TOIL.

    Quarter 2: 3 Exception Reports received
    - 1 related to loss of educational opportunity during core placement whilst dealing with a medical emergency. No further action was required.
    - 2 related to loss of educational opportunities due to being called back from ALPS to support the PRS rota. Further opportunities were made available to the affected doctor and therefore no further action required.

    Quarter 3: 15 Exception reports received
    - 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.

- Quarter 4: 12 Exception reports received

  - 5 related to lost educational opportunities.
    3 were due to resident doctors being moved from NOC2 shifts in which resident doctors gain experience of ALPS or MHA assessments to cover rota gaps. Medical education were able to offer subsequent shifts to ensure resident doctors gained this experience and no further action was necessary.
    One related to IT access which was satisfactorily resolved.
    One related to a resident doctor missing teaching due to clinical acuity and an alternative opportunity could not be provided. This was subsequently escalated to the clinical lead of the service and will be monitored for the emergence of any patterns.
  - 6 related to additional hours worked.
    2 of these were due to medical emergencies occurring close to the end of the resident doctor's shift.
    2 were related to clinical workload, and led to a discussion between resident doctor and clinical supervisor to develop a plan regarding timing of clinical work.
    2 did not provide additional details.
    All of these related to core placement and all were less than 2 hours. All resident doctors requested payment rather than TOIL.
    One ER related to inadequate supervision during core placement. This was subsequently escalated to the clinical lead of the service and will be monitored for the emergence of any patterns.

Under the 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training, Guardians of Safe Working are required to monitor and report on any instances of actual or perceived detriment associated with exception reporting. As such future board reports will include results of a detriment survey sent out quarterly to resident doctors commencing from Quarter 1 2026-2027.

Work Schedules

A work schedule is a document that sets out the intended learning outcomes, mapped to the educational curriculum, the scheduled duties of the doctor, time for appropriate non-clinical activities, and the number and distribution of hours for which the doctor is contracted. Work scheduling allows both educational planning necessary for training programmes, as well as the ability to plan and deliver clinical services.

A generic work schedule issued by the employer forms the basis for a personalised work schedule, which is prepared by both the doctors in training and their clinical supervisors at the beginning of each placement. MEC communicate with the doctors to ensure these are understood and completed. Where forms are not returned by the deadline, then a reminder is sent from MEC and if this does not result in a return, then MEC inform the GOSWH who contacts the trainee and their clinical supervisor to support where needed.

Where there are exception reports raised, or following request from the doctor or employer, a work schedule review can take place. This is a formal process by which changes to the work schedule may be suggested and / or agreed. No work schedule reviews have been completed in this reporting period.

I would note that whilst LYPFT do not hold responsibility for issuing of work schedules for Foundation Year doctors employed by LTHT, MEC have begun collecting evidence of 'timetables' being completed with the clinical supervisor so that we can be satisfied that doctors working within our trust are provided with the required information to support work scheduling with their lead-employer.

During this reporting period detailed rotas have been provided no later than 6 weeks before the rota commences. As part of the reforms from February 2026 future board reports will include 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).

Fines

There have been no Exception Reports which have identified breaches resulting in a financial penalty for the Trust. The total fine fund as of the end of this reporting period is £262.15 and sits within a GOSWH cost centre. Spending from such funds will be agreed via the RDF.

Resident Doctors Forum

The RDF has met on four occasions in 2025/2026. RDF was chaired by Dr Asquith for three occasions and most recently Dr Shaw.

In addition to discussing rota gaps and exception reports as detailed above, resident doctors have used the forum to offer feedback via the resident doctor forums, the Resident Doctor Committee (RDC) and Higher Trainee Committee (HTC)

In 2025/2026 some of the key matters discussed included:

- Update of the 'Opt Out' forms completed by the resident doctors to voluntarily opt out of the European Working Time Directive, to explicitly state that locum work cannot be undertaken during contractually mandated rest periods.
- Unfilled rota gaps on the PRS rota. Discussion that the addition of the third resident doctor on night shifts was to support emergency experience for the doctors and so even with a rota gap of one

doctor on days or nights there is still sufficient resident doctor cover to not pose a patient safety concern.

- Delays in notification of rotations for Higher Trainees being announced by the Deanery. Agreed that if rotations have not been released by the Deanery 12 weeks in advance MEC will release this information to trainees directly. Advised leave requests are difficult to coordinate but MEC will support and accommodate rota swaps when required.
- Planning of Resident Doctor Industrial Action
- Proposed changes to Exception Reporting processes and subsequent development and implementation of processes to support contractual reforms coming into place in February 2026.
- Discussions were held about the 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 for improving the working lives of resident doctors remains a standing agenda item and progress discussed.
- Plans for the roll out of a detriment survey to resident doctors from Q1 2026-2027.

Issues Arising

Engaging Resident Doctors

The GOSWH has continued to attend induction to introduce the role to new starters in LYPFT. RDF has not been postponed or cancelled over this reporting period. All but one RDF meetings have had representation from both CT and HT grades, one had HT representation only. RDF has been held on Microsoft Teams throughout this reporting period in-line with the requests from the Resident Doctors to continue with use of this platform rather than a face to face meeting. The GOSWH continues to highlight that informal discussions are welcomed whereby there may be uncertainty as to whether Exception Reporting is indicated, or for any other reason, and relevant contact details are provided at induction time to new starters, and re-circulated to existing resident doctors. The GOSWH and MEC continually support a culture of reporting variance from the work schedule or T+Cs.

Recruitment

National recruitment in Core Psychiatry Training continues to improve. This is reflected locally in our CT recruitment.

LYPFT have a number of strategies in place aimed at increasing recruitment targeted at both medical students and Foundation Trainees. These include the ongoing engagement with undergraduate teaching through the University of Leeds and increased visibility throughout the Foundation Training Programme teaching sessions.

The Trust have a named Foundation Year tutor to enhance trainees experience within the speciality, as well as a designated teaching programme for the FYs placed within the Trust.

The CTs are also encouraged to participate in the medical student teaching programme by having protected time to deliver this to students from years 2 – 4. This provides a valuable experience for both CTs and medical students, and allows an opportunity for informal discussions also about the psychiatry training pathway. A notable strength of the core trainee programme is the support given to trainees in relation to passing membership exams through the Core Trainee Psychiatry Course held at Leeds University, with protected time to attend this throughout the training years. Of note from September 2026 this course will be run by Sheffield Health Partnership following an agreement with NHS England to deliver the psychiatric training course (PTC).

Summary

On 4 February 2026, revisions to the Resident Doctor Terms and Conditions of Service introduced significant changes to the exception reporting process. The reforms were intended to simplify reporting arrangements, strengthen independent oversight of safe working, and encourage timely identification and resolution of issues relating to working hours, rest, training opportunities and service pressures. A key change was the enhancement of confidentiality within the exception reporting process. Educational and Clinical supervisors no longer have automatic access to individual exception reports, helping to ensure that doctors can raise concerns about safe working without concern of detriment associated with this. Responsibility for reviewing and managing exception reports now sits with the appropriate clinical and administrative leads, with reports relating to additional hours being reviewed and actioned by the medical directorate while educational exception reports are considered by the Director of Medical Education. There is escalation to the Guardian of Safe Working Hours where required.

The Trust has successfully embedded these revised arrangements within its existing governance processes. Robust exception reporting systems were already well established locally, and the contractual changes have been incorporated with minimal disruption. Resident doctors continue to be encouraged to submit exception reports whenever their actual working patterns differ from their agreed work schedules, and reports are reviewed promptly through established governance pathways. Regular oversight by the Guardian of Safe Working Hours enables recurring themes to be identified and addressed, providing assurance that concerns relating to safe working, training opportunities and service pressures are managed effectively. Overall, the exception reporting system continues to support a culture of openness, continuous improvement and safe patient care.

Whilst LYPFT receives relatively few ER's comparative to other local and national trusts, these numbers are increasing. This likely represents both the awareness of the resident doctors to the T+Cs of their contract and the attentiveness to working to these, as well as the culture of encouraging and accepting exception reporting that has promoted by the GOSW and MEC. Given the reforms came into effect for Quarter 4 of this reporting period it is yet to see if this leads to an increase in Exception Reports.

Rota gaps continue to be a challenging issue. There are many reasons for rota gaps and MEC have worked extremely hard to minimise impact of rota gaps, with all filled gaps being covered by the internal locum pool of doctors and no reliance on external locums.

Given that there have been no patient safety concerns from ER it is clear that the rota patterns enable the resident doctors to work according to their contract in order to deliver safe patient care.

Recommendations

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 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 Laura Shaw
GMC 6158782
Guardian of Safe Working Hours

Appendix A

Grade of Dr	WTE posts within LYPFT	Current numbers* (inc LTFT)
CT Psychiatry	47 + 2 NIHR	50 (inc 2 NIHR)
HT Psychiatry	36	33
GP Trainee	5 (*Includes 2 Innovative GP - does not cover on-calls 50:50 split between GP & LYPFT)	6 (inc 2 GP ITP)
FY Dr	20 FY1 2 FY1 ACF 6 FY2	20 FY1 2 FY1 ACF 6 FY2
Total	**118**	**117**

*Whilst the schemes have been full, current numbers are lower than WTE posts due to trainees more recently leaving the scheme

Appendix B

Quarter 1 2025/2026

Rota Gaps		April		May		June	
		CT	HT	CT	HT	CT	HT
	Gaps	16	27	26	24	27	24
	Internal Cover	12	27	18	24	21	24
	Agency cover	0	0	0	0	0	0
	Unfilled	4	0	8	0	6	0
Fill Rate		75%	100%	70%	100%	78%	100%

Quarter 2 2025/2026

Rota Gaps		July		August		September	
		CT	HT	CT	HT	CT	HT
	Gaps	29	22	22	13	24	10
	Internal Cover	17	22	11	13	19	10
	Agency cover	0	0	0	0	0	0
	Unfilled	12	0	11	0	5	0
Fill Rate		59%	100%	50%	100%	79%	100%

Quarter 3 2025/2026

Rota Gaps		October		November		December	
		CT	HT	CT	HT	CT	HT
	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%

Quarter 4 2025/2026

Rota Gaps		January 2025		February 2025		March 2025	
		PRS	Middle Tier	PRS	Middle Tier	PRS	Middle Tier
	Gaps	22	14	2	18	16	15
	Internal Cover	9	14	2	18	5	15
	Agency cover	0	0	0	0	0	0
	Unfilled	13	0	0	0	11	0
Fill Rate		41%	100%	100%	100%	31%	100%

Appendix C

Reasons for rota gaps. Number of gaps per reason:

	PRS Rota	Middle Tier (HT) Rota
April- June 2024	Sickness – 18 LTFT – 8 Vacant – 25 Off rota – 7 Special leave – 4 Left trust – 7	Left trust – 13 Off rota – 19 LTFT – 8 Sickness – 5 Vacant – 21 Special leave - 1
July - September 2024	Sickness – 18 LTFT – 21 Vacant – 14 Off rota – 7 Left trust – 14 Special leave - 1	Left trust – 3 Vacant – 20 LTFT – 5 Sickness -1 Off rota - 16
October – December 2024	Sickness – 15 LTFT – 9 Off rota – 10 Special absence – 3 Vacant shift - 6 Left trust 13	Sickness – 7 Vacant – 20 Off rota – 8 LTFT – 7 Maternity/paternity - 4
January – March 2025	Sickness – 15 LTFT – 10 Off rota – 10 Special absence – 3 Left trust - 2	Sickness – 2 Vacant – 13 Left trust – 14 LTFT – 5 Off rota - 12 Special leave - 1

Appendix D

Exception Reports (ER) 25/26	
Reference period of report	01/04/25 - 31/03/26
Total number of exception reports received	37
Number relating to immediate patient safety issues	0
Number relating to hours of working	20
Number relating to pattern of work	1
Number relating to educational opportunities	15
Number relating to service support available to the doctor	1

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	2
Total number of overtime payments	6
Not specified TOIL/Payment (12)	
Total number of work schedule reviews	0
Total number of reports resulting in no action	17
Total number of organisation changes	0
Compensation	0
Unresolved	0
Total number of resolutions	**37**
Total resolved exceptions	**37**

Meeting of the Board of Directors

30 July 2026

Guardian of Safe Working Hours Report: Quarter 4: 1st Jan 2026 to 31st March 2026

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 01.01.2026 to 31.03.2026.

2 Quarter 4 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		Jan 2026		Feb 2026		March 2025	
		PRS	Middle Tier	PRS	Middle Tier	PRS	Middle Tier
	Gaps	22	14	2	18	16	15
	Internal Cover	9	14	2	18	5	15
	Agency cover	0	0	0	0	0	0
	Unfilled	13	0	0	0	11	0
Fill Rate		41%	100%	100%	100%	31%	100%
Reasons for Rota Gaps		Sickness (7) LTFT (5) Off rota (5) Left trust (2) Special absence (3)	Vacant (6) Off rota (5) Special leave (1) LTFT (2)	LTFT (1) Off rota (1)	Sickness (2) Vacant (5) Off rota (3) Left trust (6) LTFT (2)	Sickness (8) LTFT (4) Off rota (4)	Vacant (2) Off rota (4) Left trust (8) LTFT (1)
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. The middle tier rota (2nd / middle tier) is covered by Higher Trainee doctors and continues to have a high fill rate.					

	It is noted that there was a spike in resident doctor sickness in January and March and additionally there were more vacant night shifts during these months. These can be more difficult to fill due to a need for rest prior to and following the shift which makes the use of internal locum doctors less accessible due to day time clinical commitments.
Exception reports (ER)	There were 12 exception reports in total during the reporting period. - 5 related to lost educational opportunities. 3 were due to resident doctors being moved from NOC2 shifts in which resident doctors gain experience of ALPS or MHA assessments to cover rota gaps. Medical education were able to offer subsequent shifts to ensure resident doctors gained this experience and no further action was necessary. One related to IT access which was satisfactorily resolved. One related to a resident doctor missing teaching due to clinical acuity and an alternative opportunity could not be provided. This was subsequently escalated to the clinical lead of the service and will be monitored for the emergence of any patterns. - 6 related to additional hours worked. 2 of these were due to medical emergencies occurring close to the end of the resident doctor's shift. 2 were related to clinical workload, and led to a discussion between resident doctor and clinical supervisor to develop a plan regarding timing of clinical work. 2 did not provide additional details. All of these related to core placement and all were less than 2 hours. All resident doctors requested payment rather than TOIL. One ER related to inadequate supervision during core placement. This was subsequently escalated to the clinical lead of the service and will be monitored for the emergence of any patterns. Of note there were two additional ERs submitted in error relating to on calls at LTHT, one of which was withdrawn. These have not been considered in the above numbers. It is noted that the number of ERs received in this and the previous reporting period are higher than usual. This may be reflective of the increased awareness of resident doctors about contractual 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. There have been no information breaches (fines levied whereby confidential information is shared outside of processes detailed within the T&Cs). There have been no 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 T&Cs state that immediate safety concerns be immediately escalated (orally) to the to the clinician responsible for the service in which the risk is 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. Detailed rotas were issued no later than 6 weeks before the rotation commences. Future board reports will include information regarding issue of generic work schedules.
Resident Doctor Forum (RDF)	The meeting held during the Q4 reporting period took place on 14th May 2026 held late due to allow newly appointed Guardian of Safe Working Hours to establish role and arrange suitable meeting date. - The 10 point plan to improve resident doctors working lives was discussed with an update from the Medical Education Department confirming two outstanding items have been covered. Food provisions at Becklin Centre have been provided and out of hours parking pays having been provided and signage has been implemented. - Proposed changes to Exception Reporting processes were discussed and changes have been embedded. Future detriment surveys were discussed. - The next RDF date to be confirmed.
Detriment	Under the 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training, Guardians of Safe Working are required to monitor and report on any instances of actual or perceived detriment associated with exception reporting. As such future board reports will include results of a detriment survey sent out quarterly to resident doctors commencing from Quarter 1 2026-2027.
Payroll	No payroll issues reported in this reporting period. 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.
Additional Updates	Rebecca Asquith 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 and was replaced by Laura Shaw who was appointed and commenced the post in March 2026.

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 GOSWH attendance at induction for new starters, we continue to support the position that doctors are encouraged to work according to the T&Cs for their own safe practice and the safe care of patients. In this quarter there have been no Exception Reports identifying immediate safety concerns. There is ongoing work around Exception Reporting reforms and the 10 point plan detailed above.

4 Recommendations

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 T&Cs 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 Laura Shaw
GMC 6158782
Guardian of Safe Working Hours

Agenda item
16

Meeting of the Board of Directors

Paper title:	Chair's Report from the Workforce Committee meeting on 18 June 2026
Date of meeting:	30 July 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:	18 June 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 received detailed analysis of long-term sickness absence, noting mental health as the primary factor and discussed what interventions were in place to address performance. It was agreed that a comprehensive list of all interventions and activity that was currently happening and had taken place over the last 12 months to reduce sickness absence was brought to a future meeting including trajectories for improvement. The Committee also agreed to review the timeliness of processes that impact long-term sickness and agreed that assurance would come back to a future meeting on the actions being taken to address low compliance with sickness absence policies, such as the requirement for managers to undertake return-to-work interviews. The Committee also noted the Trust's position with sickness absence relative to other regional mental health organisations and agreed that the Executive Directors should review the Trust's Wellbeing and Attendance Procedure and consider the implications for any potential changes to this. It was agreed that the outcome of this review would be presented to the Board of Directors for discussion and support.	SR3
The Committee received an update on the work to ensure the Trust provides high quality learning environments for all learners across the organisation and noted the consistently positive feedback. The Committee discussed the upcoming merger with Leeds Community Healthcare (LCH) NHS Trust, noting the challenges regarding adequate teaching space and the need to integrate non-mental health students in future provision. The Committee asked for an update on the 10 Point Plan to improve the working conditions for Resident Doctors to come back to a future meeting, noting the important link to resolving industrial action in the BMA.	SR3 & SR5
The Committee noted the update on the proposed change to unfair dismissal eligibility, with the qualifying period expected to reduce from two years to six months by early 2027 which may lead to a significant increase in claims and associated organisational costs. The Committee asked that an update was brought to a future meeting on what actions were being taken in response to this and how the potential impacts would be managed.	SR3

The Committee noted the need to address disparities in duties and training between substantive and bank Band 3 staff in some services and heard that work was being undertaken within the POD directorate to explore this further and identify training requirements, with an update to be brought to a future meeting.	SR3
The Committee received an update on Medical Compulsory Training Data and noted low compliance with Clinical Risk mandatory training. The Committee heard that course availability and scheduling conflicts were the main barriers to compliance, and efforts were underway to resolve these process issues. It was agreed that an update on Clinical Risk training compliance for all staff groups would be provided at a future meeting.	SR3
ASSURE – specific areas of assurance received warranting mention to Board	
Issue	**Relates to BAF Risk**
The Committee reviewed the amended Board Assurance Framework, specifically Strategic Risk (SR) 3, and agreed that it was satisfied with the content. 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 noted good compliance rates with medical job planning and medical appraisals and revalidation.	SR3
The Committee received the Mandatory and Statutory Training Internal Audit Report, as referred by the Audit Committee, for information and assurance, noting that it had received an opinion of significant assurance.	SR3
REFER - Items to be referred to other Committees	
Issue	**Relates to BAF Risk**
It was agreed that the communications plan for the merger with LCH would go to the next Transition Committee for review to ensure appropriate messaging and assurances for staff.	SR3

Recommendation

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

Agenda item
17

Meeting of the Board of Directors

Paper title:	People Analytics Report
Date of meeting:	30 July 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.	✓
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 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? If yes please set out what action has been taken to address this in your paper.

No.

Recommendation

The Board is asked to receive and note the report.

Meeting of the Board of Directors

30 July 2026

People Analytics Report

1. 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.

2. 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.

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

- The Trust in month sickness absence rate for May is 6.38% This is an increase from 5.65% for the same period last year.

- The rolling 12-month sickness absence rate is 6.73% (May 26) and the Trust is 3rd highest absence in the region with the highest sickness rates based on the NHS Digital benchmarking data (March 26).

- 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 10.36%. This is primarily due to a recent MARS program in the Trust that predominantly affected staff in the admin and clerical staff group as well as a vacancy freeze that is currently in affect.

- Clinical Supervision compliance continues to fluctuate between 70-80% (currently 76%) with all but four clinical services within 10% of target. The clinical supervision module expiration is 8 weeks so compliance can significantly fluctuate day to day.

- Compliance has been stable over the 13-month period averaging 88%. In May 2026 91% of staff have in-date mandatory training, above the 85% target.

3. Recommendations

The Board is asked to receive and note the report.

Andrew McNichol
Head of People Analytics
July 2026

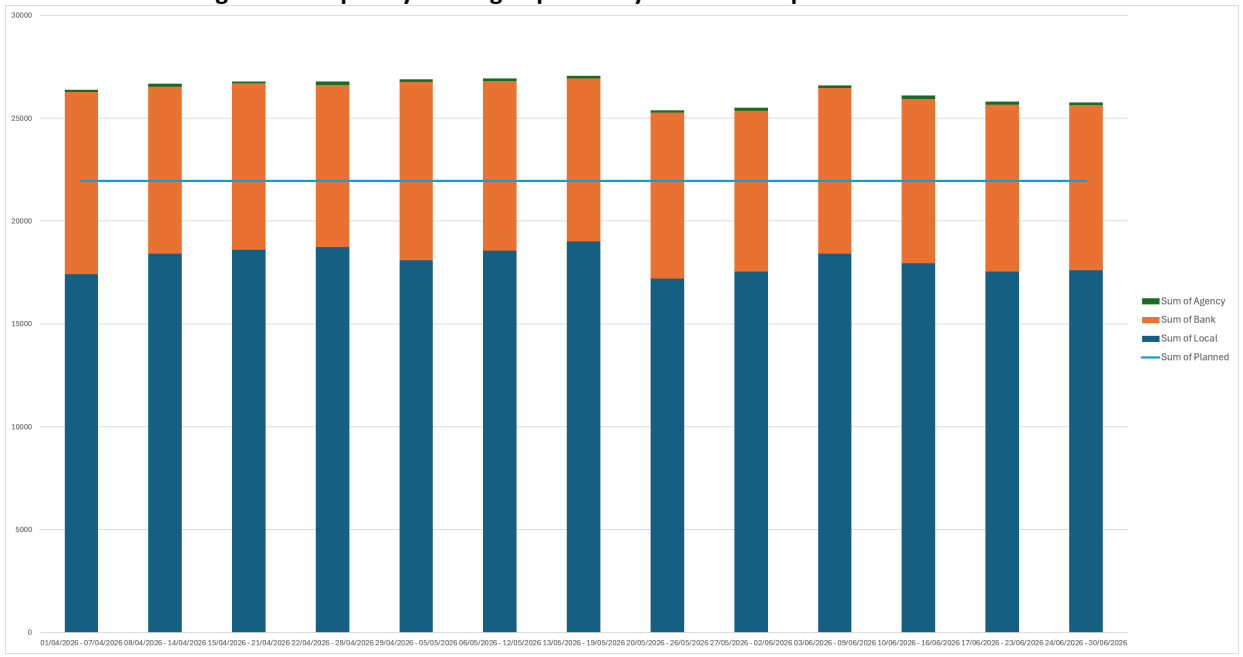
1.1 - Our People

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

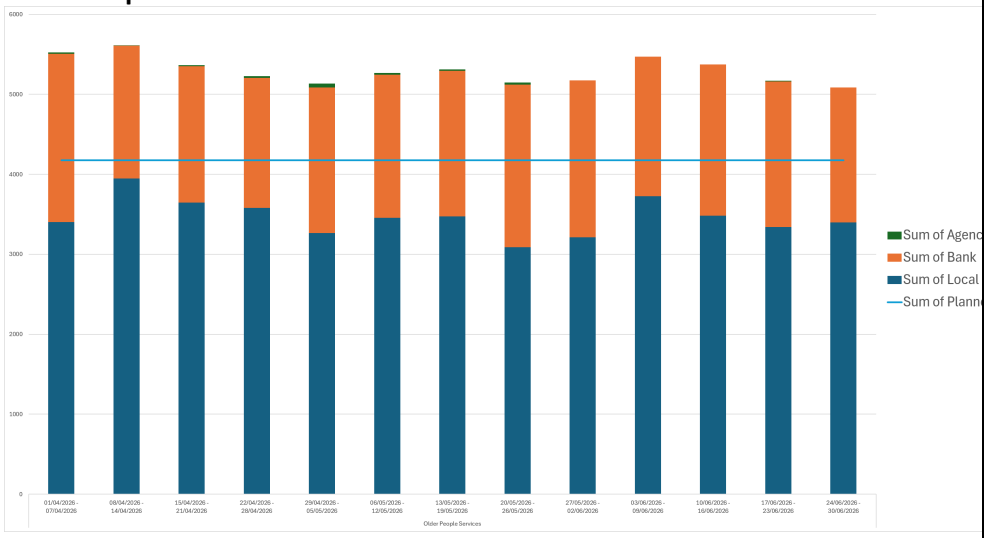
The chart below represents the Staffing fulfilment distribution for all inpatient services for April-June 26 by Week/ Service (Blue – Substantive, Orange – Bank, Green – Agency). The scale is deliberately set to demonstrate the overall usage and temporary staffing dependency across the Inpatient Services.



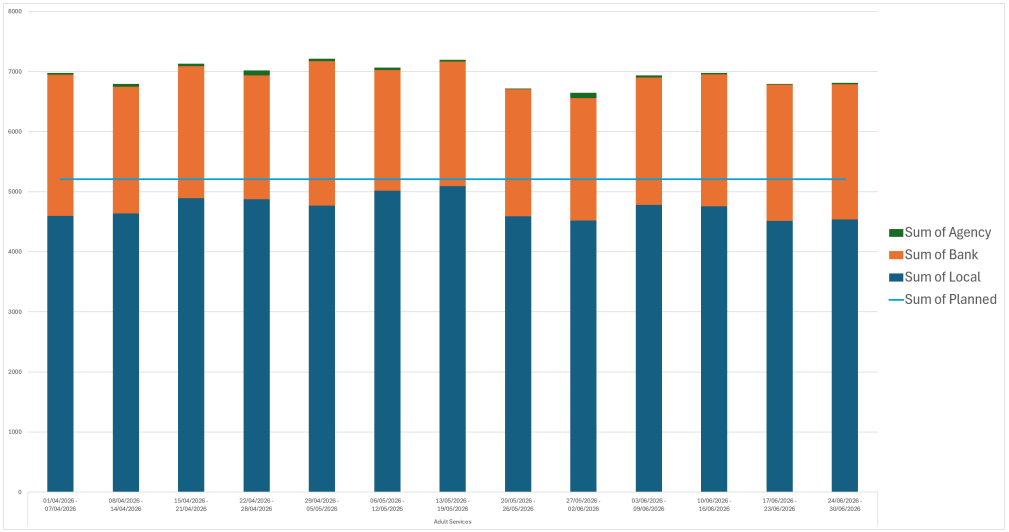
The planned hours represented by the blue line is the RN and HCA requirement for the ward and the bar columns represent the combined RN and HCA hours per 24 day.

The chart demonstrates the demand over and above the established budget that is being requested to support the additional staffing requirements.

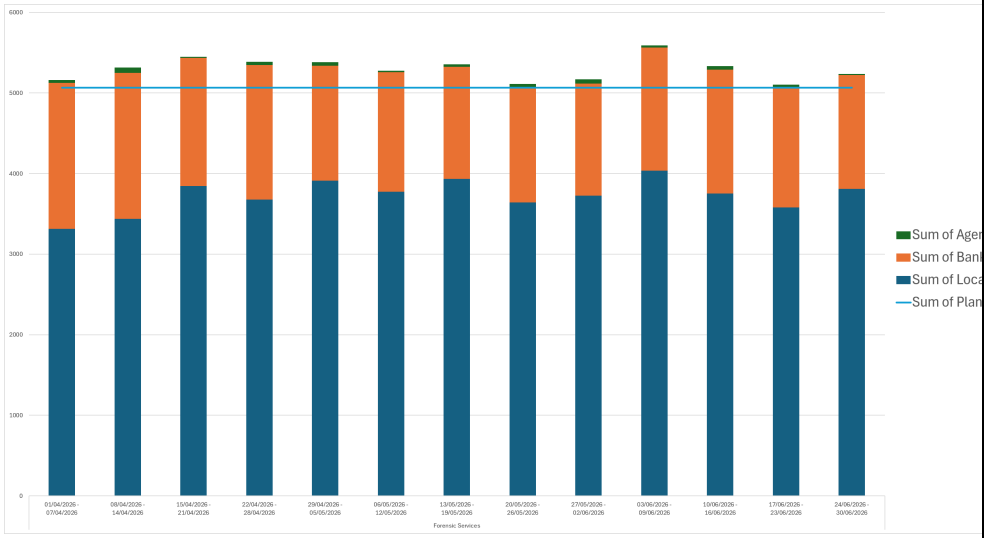
Older Peoples Services



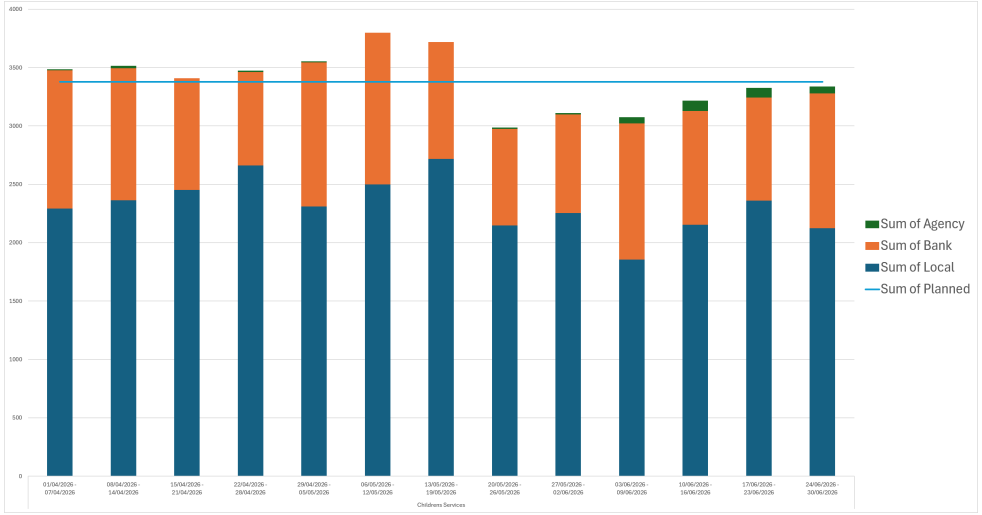
Adult Services



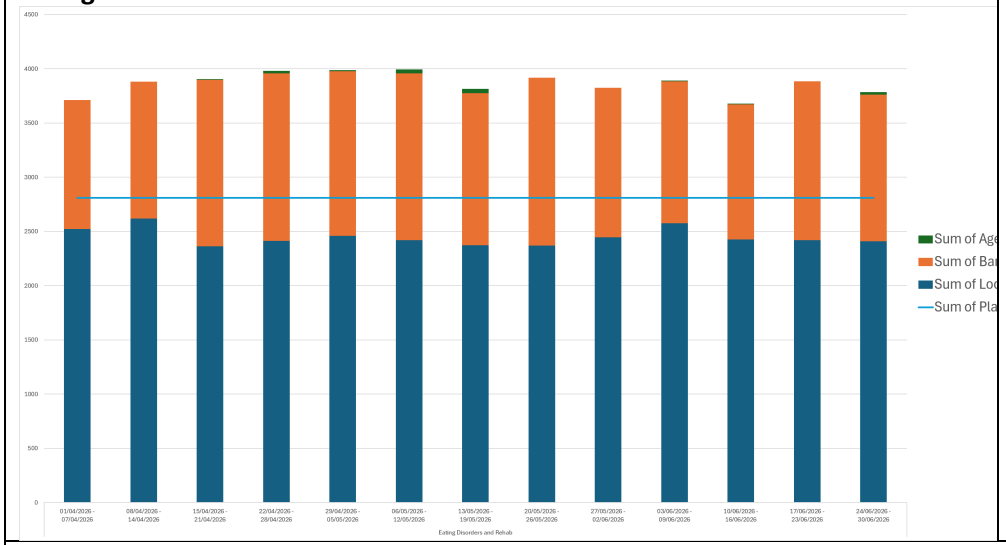
Forensic Services



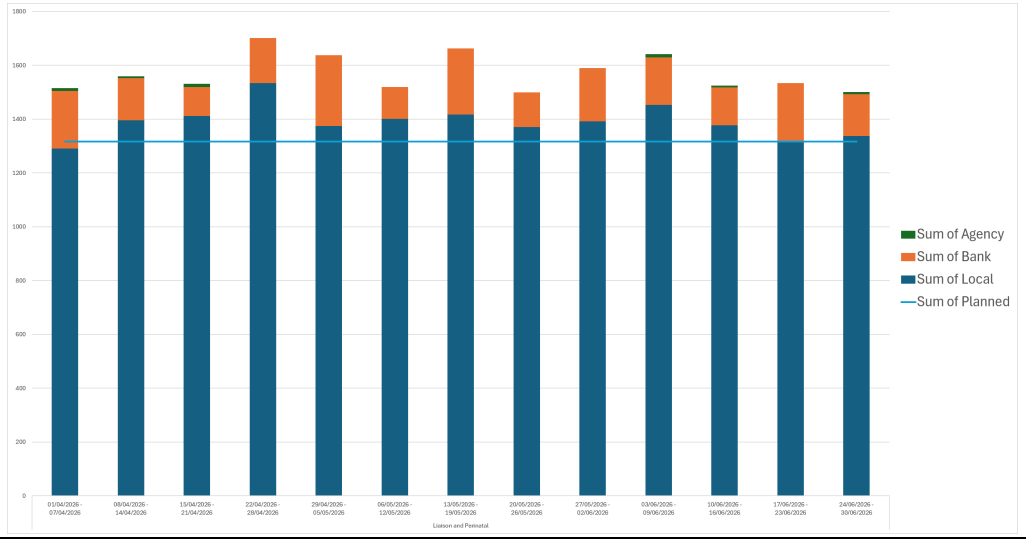
Childrens Services



Eating Disorders and Rehabilitation



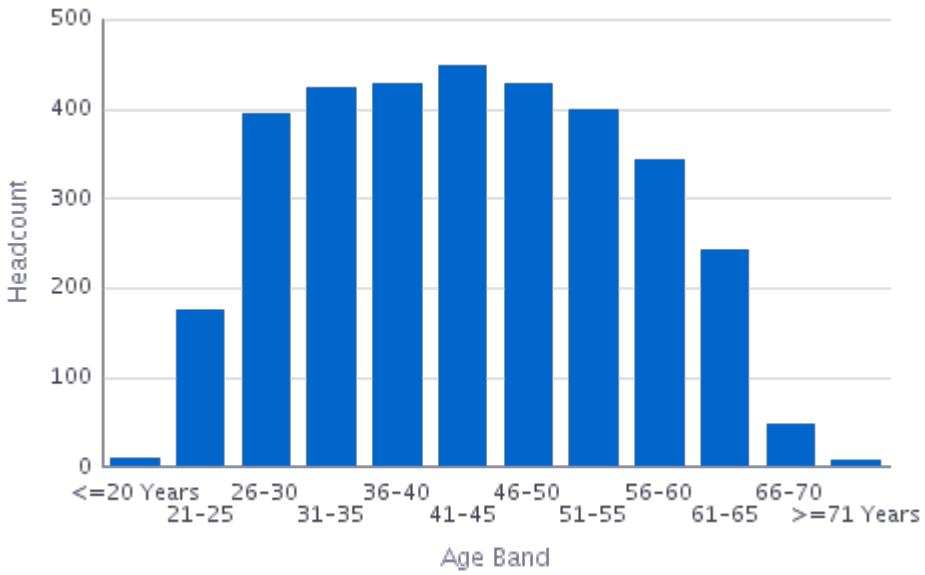
Liaison and Perinatal



1.2 Our People Profile

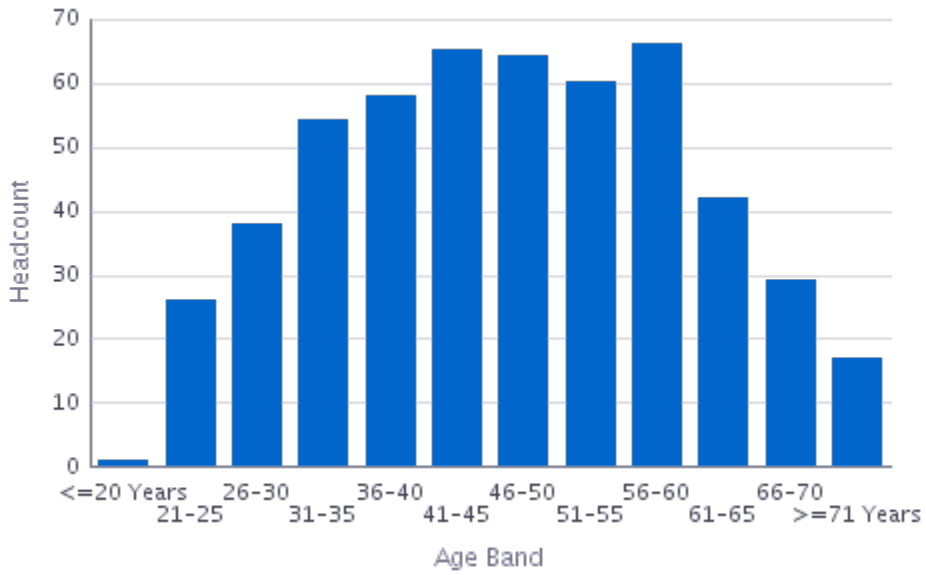
Our People – Substantive

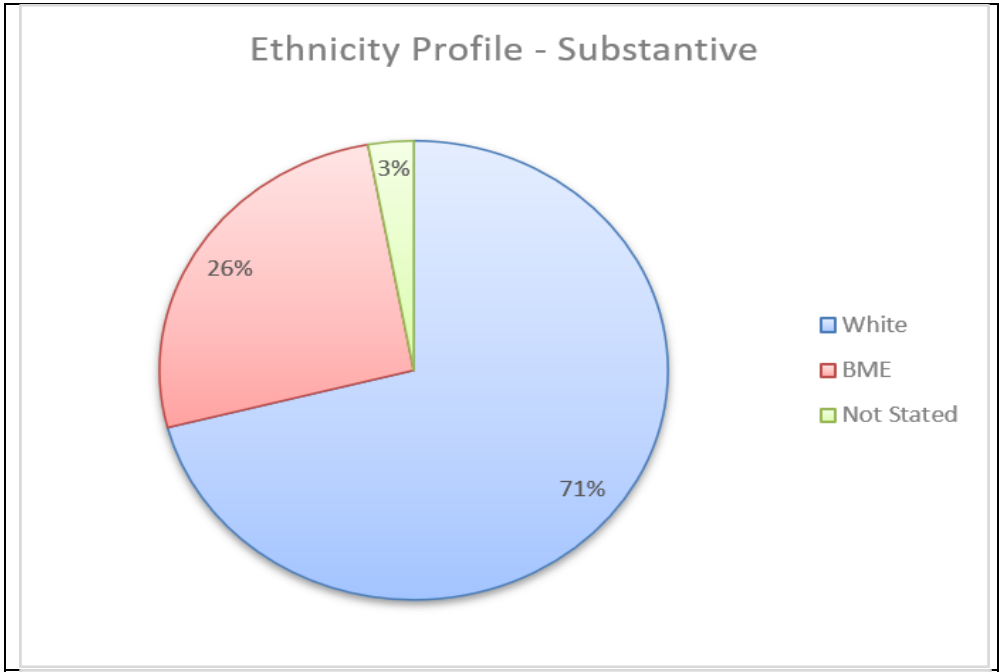
Percentage by Age Band

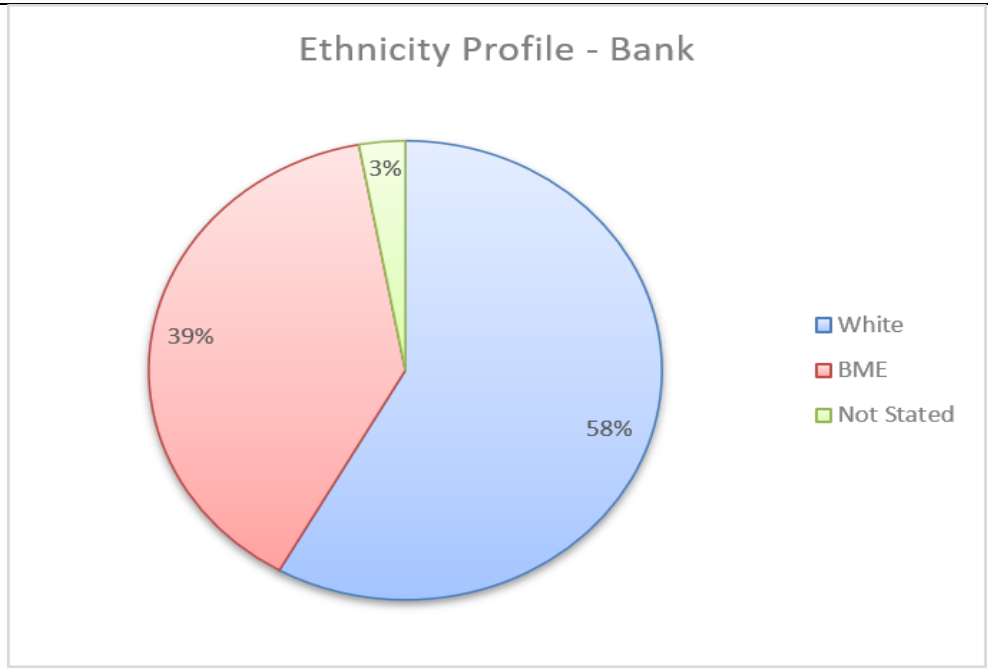


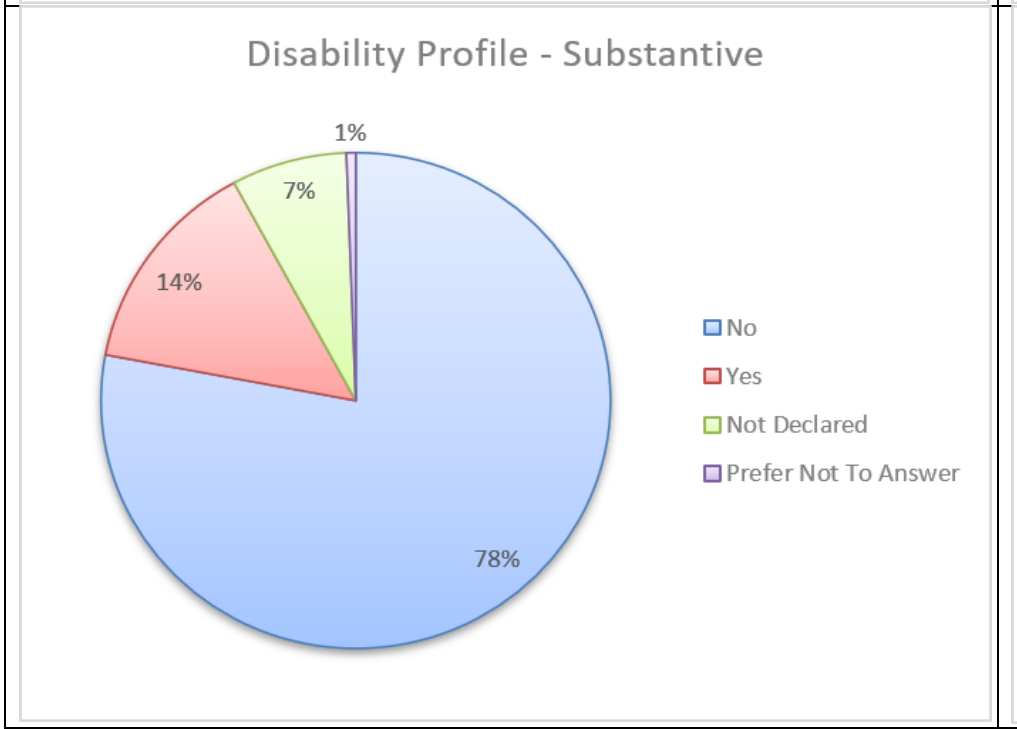
Our People - Bank

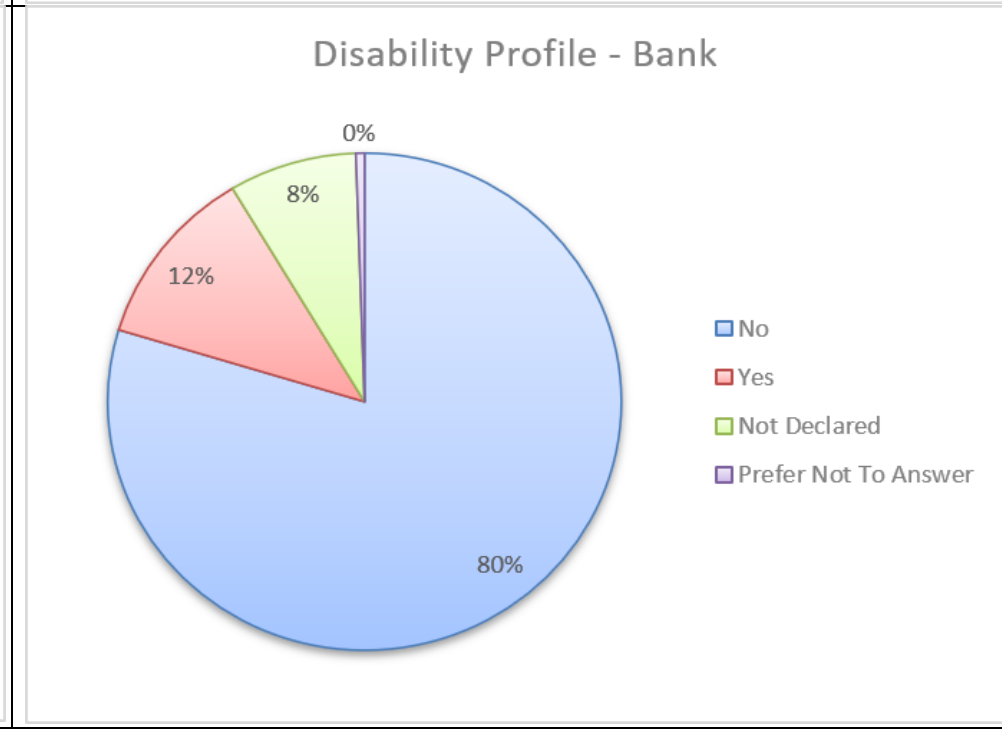
Percentage by Age Band

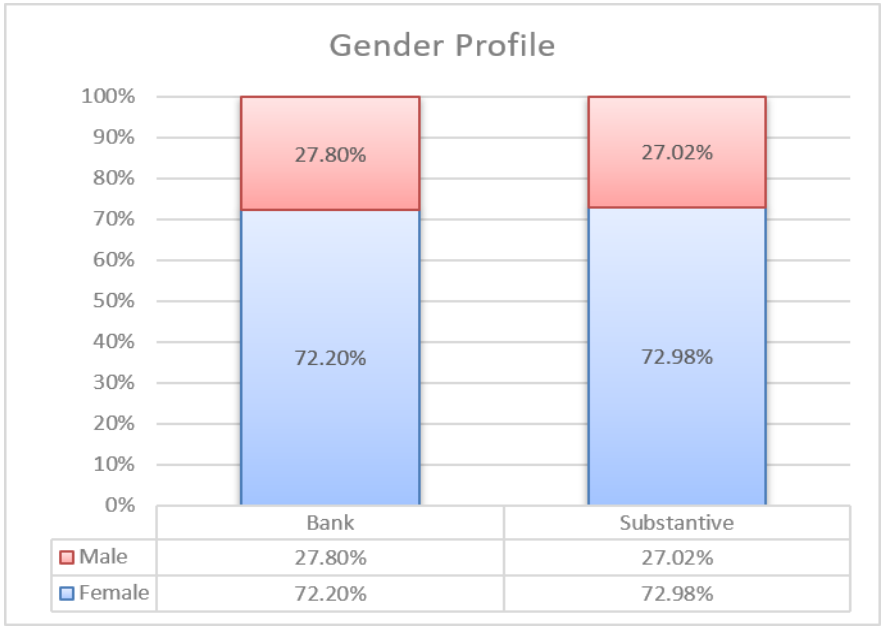


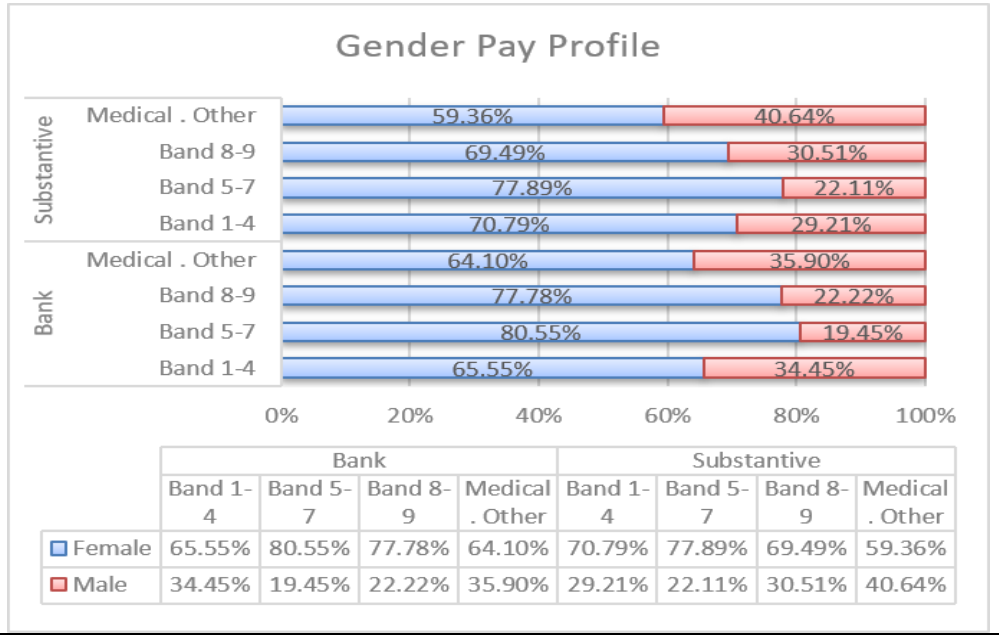

Ethnicity Profile - Substantive
3%
26%
71%
White
BME
Not Stated


Ethnicity Profile - Bank
3%
39%
58%
White
BME
Not Stated

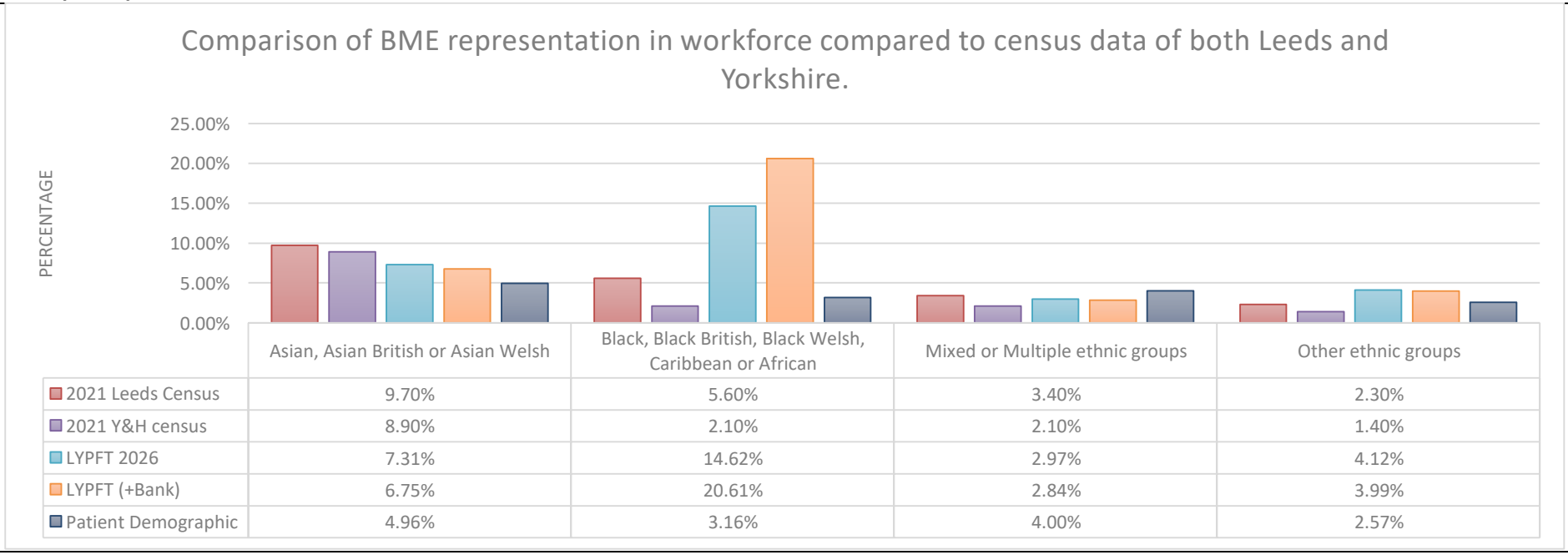

Disability Profile - Substantive
1%
7%
14%
78%
No
Yes
Not Declared
Prefer Not To Answer

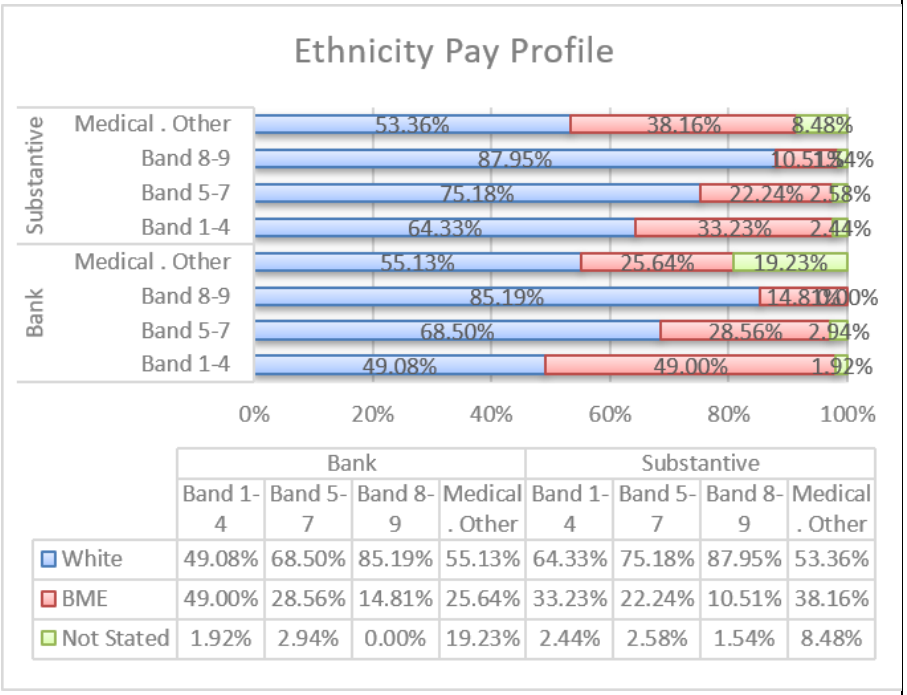

Disability Profile - Bank
0%
8%
12%
80%
No
Yes
Not Declared
Prefer Not To Answer





1.3 Our People Representation





	Bank				Substantive			
	Band 1-4	Band 5-7	Band 8-9	Medical . Other	Band 1-4	Band 5-7	Band 8-9	Medical . Other
White	49.08%	68.50%	85.19%	55.13%	64.33%	75.18%	87.95%	53.36%
BME	49.00%	28.56%	14.81%	25.64%	33.23%	22.24%	10.51%	38.16%
Not Stated	1.92%	2.94%	0.00%	19.23%	2.44%	2.58%	1.54%	8.48%

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 3% 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.

Our people ambitions
Belonging in the NHS

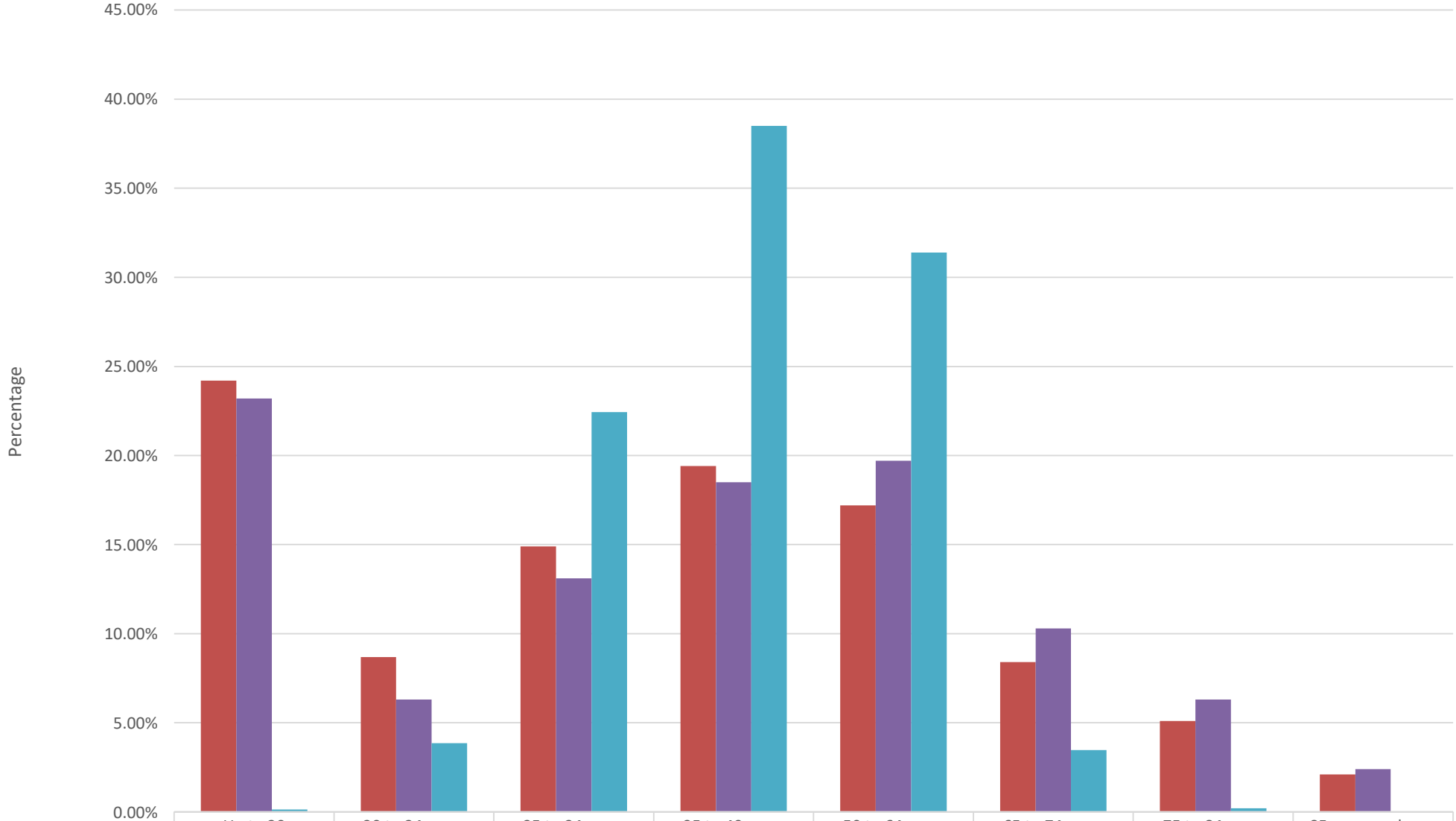
Commitment: Improve the experience of those people with a protected characteristic as identified by the Equality Act.

People Plan Objectives for 2026-27:

- Develop and embed a Culture Oversight and Delivery Group that provides clear governance for culture-related work across the organisation. Lead the delivery of a new collaborative support offer for services requiring the greatest support. Oversee progress across the full schedule of cultural development activity.

- Continued development, coordination and delivery of the EDS, WRES, WDRES and Gender Pay Gap action plans, ensuring alignment with organisational priorities and measurable progress against agreed actions.

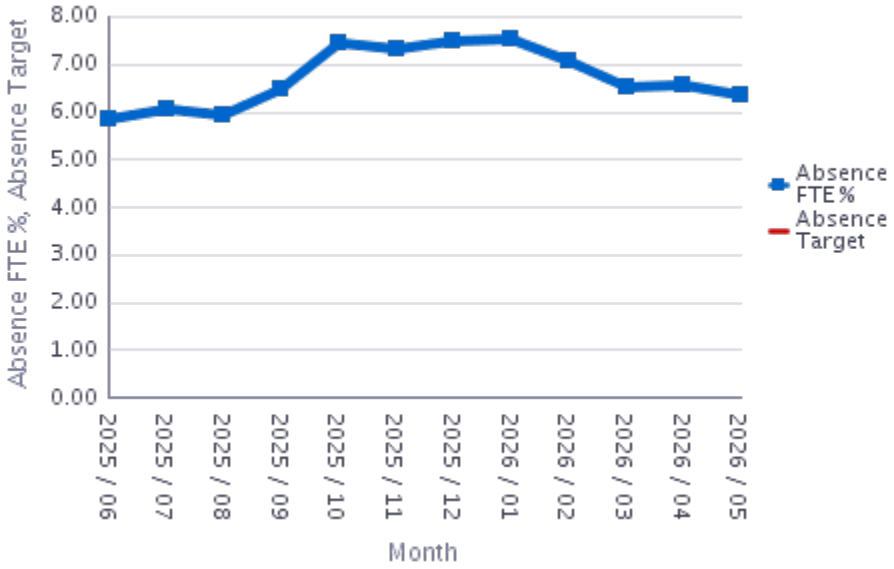
Comparison of Age representation in workforce compared to census data of both Leeds and Yorkshire.



	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 May26	0.13%	3.85%	22.45%	38.51%	31.39%	3.47%	0.21%	0%

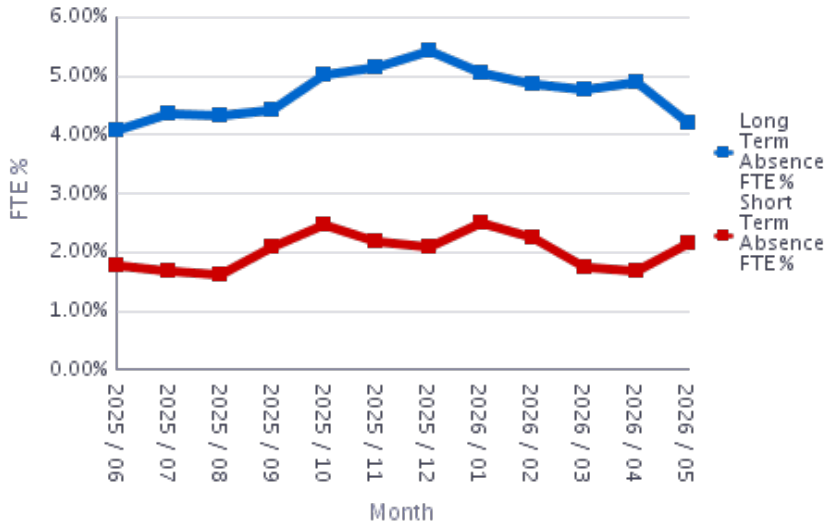
1.4 Our People – Absence

Absence FTE %	Absence Days	Absence FTE	Available FTE
6.73%	83,863	74,859.20	1,112,522.76



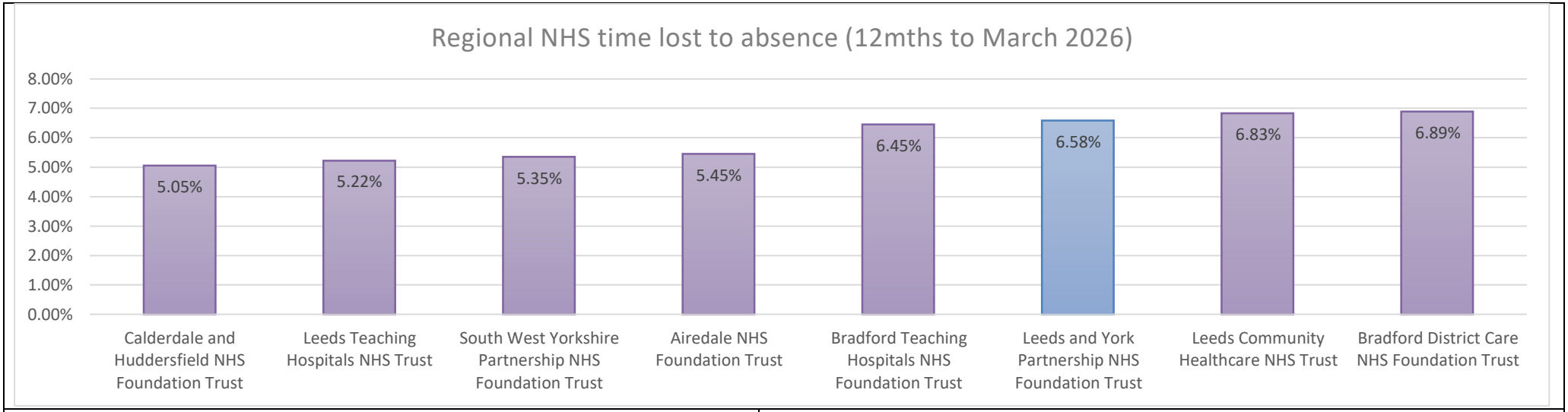
Org L4	Employee Count	Absence Occurrences	Absence FTE %
173 Adult Acute Services	478	1,089	9.08%
173 Care Services Other	45	56	4.45%
173 Chief Operating Officer	18	13	3.41%
173 Children and Young People's Services	238	486	7.58%
173 Community and Wellbeing Services	404	562	6.52%
173 Corporate Services	879	860	3.68%
173 Eating Disorders and Rehabilitation and Gender Services	375	704	8.33%
173 Forensic Services	291	615	8.47%
173 Learning Disability Services	408	728	8.22%
173 Liaison and Perinatal Services	335	633	7.01%
173 Older Peoples Services	416	846	7.12%
173 West Yorkshire Staff Mental Health and Wellbeing Hub	5	2	0.41%
Grand Total	**3943**	**6,595**	**6.73%**

Absence Long-Short Term



Absence by length

Absence Band (Days)	# Absence Occurrences
0-1	1,870
2	1,268
3	657
4	438
5	362
6	204
7	211
8-14	437
15-21	218
22-27	111
28 Days-6 Months	736
6 Months-12 Months	75
> 12 Months	8



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.

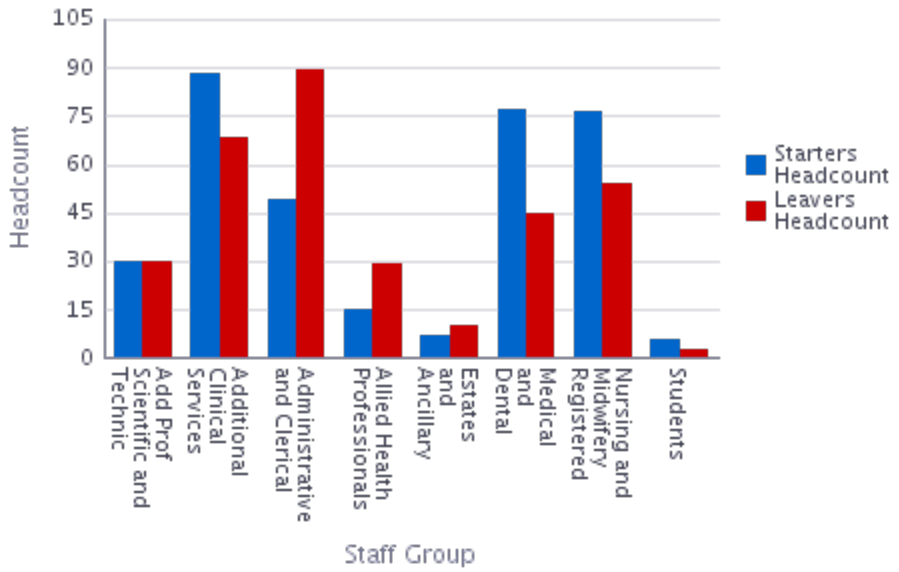
- **Ensure compliance with Sexual Safety charter assurance framework.**
- **Build on existing attendance improvement plans and develop a more universal approach to include both preventative measures and robust plans for monitoring and managing sickness absence.**
- **Ensure we are compliant with the new requirement in Employment Rights Act 2025 for a mandatory Menopause Action Plan in place to foster a more inclusive and supportive work environment by April 2027.**

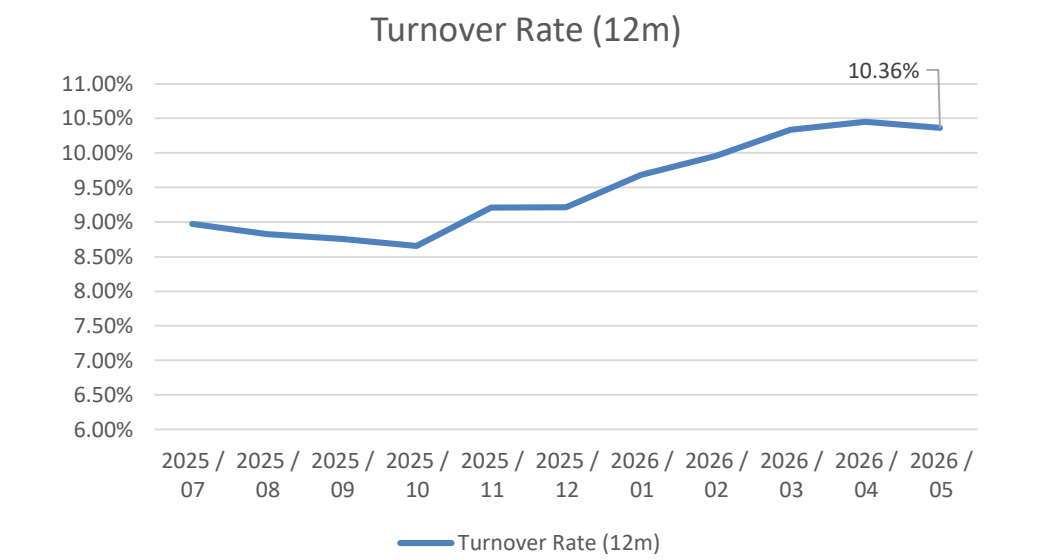
Key Points

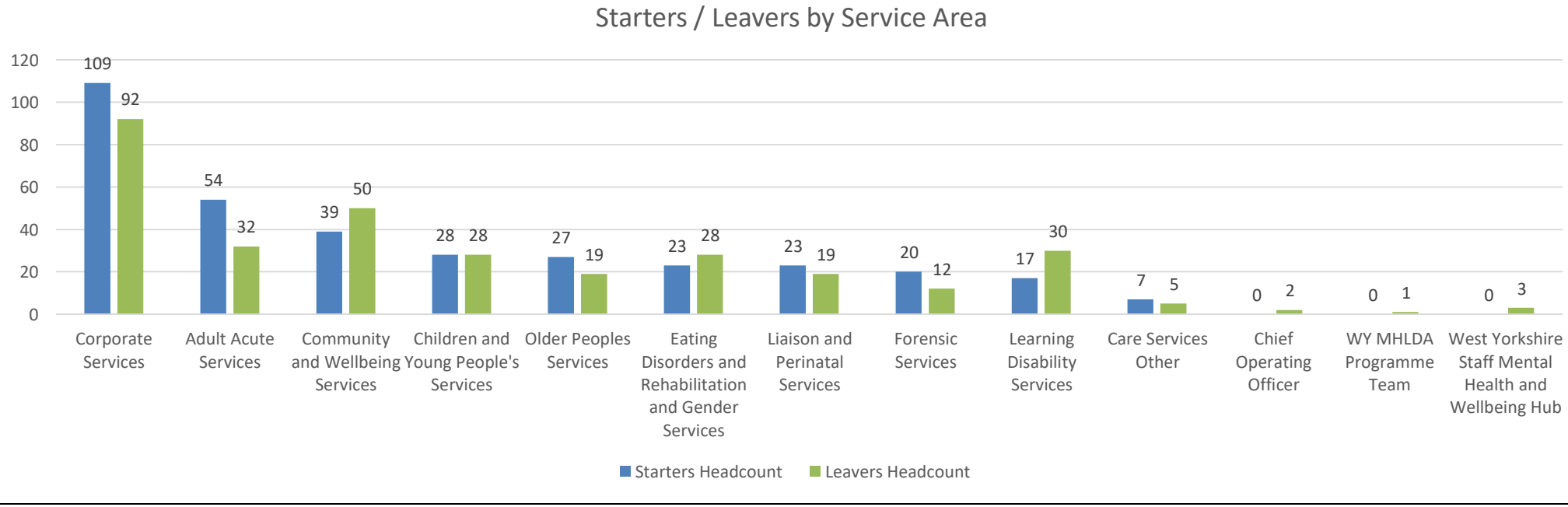
- The Trust in month sickness absence rate for May is 6.38**%** This is an increase from 5.65% for the same period last year.
- The rolling **12-month** sickness absence rate is 6.73% (May 26) and the Trust is 3rd highest absence in the region with the highest sickness rates based on the NHS Digital benchmarking data (March 26).
- 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	692	979	33,564	40.0
S12 Other musculoskeletal problems	286	370	9,102	10.9
S13 Cold, Cough, Flu - Influenza	1412	1,961	8,829	10.5
S25 Gastrointestinal problems	811	1,073	5,985	7.1
S28 Injury, fracture	151	162	3,527	4.2

1.5 Our People – Retention







Leaver Destination

Destination On Leaving	Leavers
Abroad - EU Country	1
Abroad - Non EU Country	10
Death in Service	3
Education Sector	7
Education or Training	14
General Practice	1
NHS Organisation	66
No Employment	88
Other Private Sector	25
Other Public Sector	10
Prison Service	2
Private Health Care	13
Self Employed	3
Social Services	1
Unknown	82
Grand Total	**326**

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	5
Dismissal	9
End of Fixed Term Contract	50
Has Not Worked	1
Mutually Agreed Resignation	21
Pregnancy	1
Redundancy - Compulsory	2
Redundancy - Voluntary	9
Retirement - Ill Health	4
Retirement	24
Voluntary Resignation	200
Grand Total	**326**

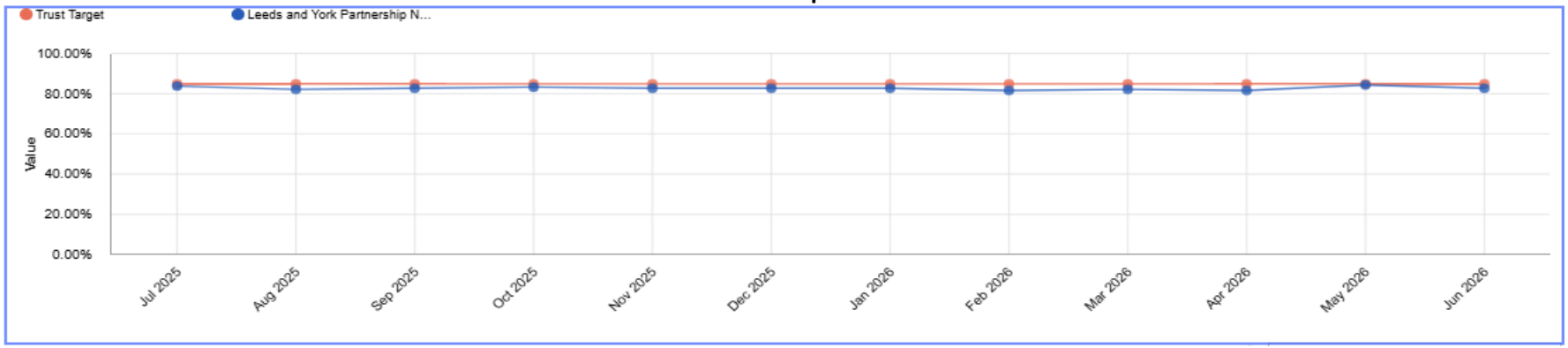
Our people ambitions
Growing for the future

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

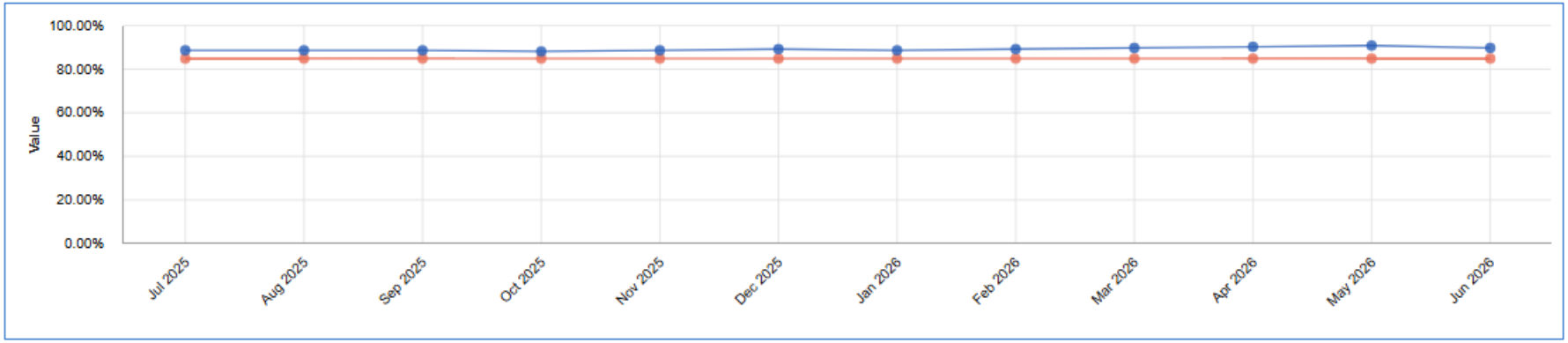
- **Support the Trust to reduce the growing HSW vacancy position through a variety of resourcing solutions.**
- **Support the Trust to deliver on the 2026-2029 planning submission in relation to strategic resourcing / workforce redesign including the development of a matrix to identify the Trusts fragile services.**
- **Continue to monitor the evolution of the Employment Rights Act and ensure that People Policies and Processes are updated accordingly.**
- **Culture Dashboard development.**

1.6 Our People – Learning and Development

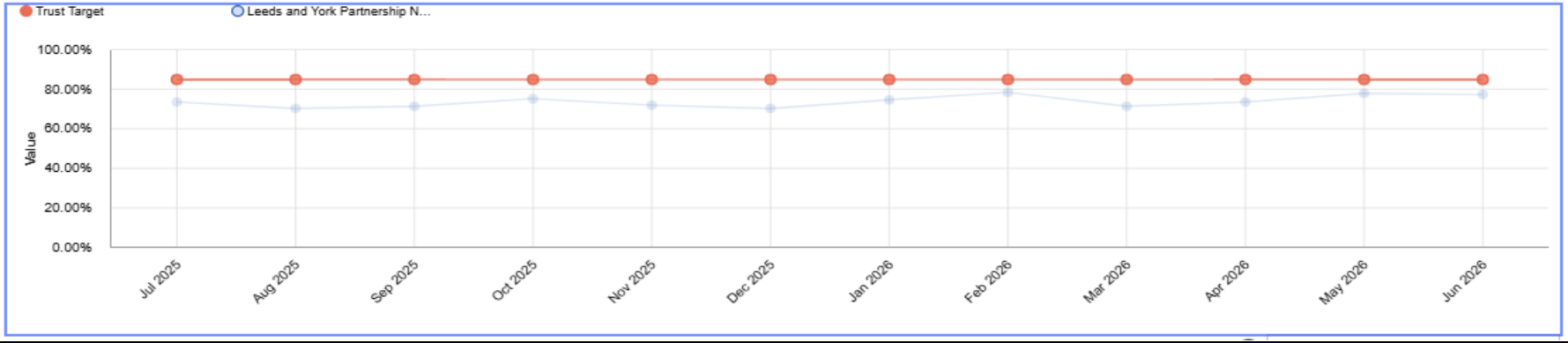
Performance Development Reviews



Compulsory Training



Clinical Supervision



Care Service	Requirement	Number compliant	Number non-compliant	Total Headcount	Compliance status
Adult Acute Services	Annual Appraisal	246	63	309	80%
Care Services Other	Annual Appraisal	26	4	30	87%
Chief Operating Officer	Annual Appraisal	14	2	16	88%
Children and Young People's Services	Annual Appraisal	128	16	144	89%
Community and Wellbeing Services	Annual Appraisal	218	55	273	80%
Corporate Services	Annual Appraisal	516	91	607	85%
Eating Disorders and Rehabilitation and Gender Services	Annual Appraisal	233	27	260	90%
Forensic Services	Annual Appraisal	202	31	233	87%
Learning Disability Services	Annual Appraisal	241	73	314	77%
Liaison and Perinatal Services	Annual Appraisal	197	53	250	79%
Older Peoples Services	Annual Appraisal	269	53	322	84%
Trust Board - Executive Directors	Annual Appraisal	5	1	6	83%
Trust Board - Non Executive Directors	Annual Appraisal	0	6	6	0%

Care Service	Requirement	Number compliant	Number non-compliant	Total Headcount	Compliance status
Adult Acute Services	Clinical Supervision	215	80	295	73%
Care Services Other	Clinical Supervision	15	4	19	79%
Chief Operating Officer	Clinical Supervision	1		1	100%
Children and Young People's Services	Clinical Supervision	112	32	144	78%
Community and Wellbeing Services	Clinical Supervision	141	65	206	68%
Corporate Services	Clinical Supervision	2	1	3	67%
Eating Disorders and Rehabilitation and Gender Services	Clinical Supervision	162	58	220	74%
Forensic Services	Clinical Supervision	176	41	217	81%
Learning Disability Services	Clinical Supervision	91	13	104	88%
Liaison and Perinatal Services	Clinical Supervision	165	43	208	79%
Older Peoples Services	Clinical Supervision	200	73	273	73%

Our people ambitions
New ways of working and delivering care

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

- **Provide people and culture leadership and support to enable the transition to one NHS provider across mental health and community services.**
- **Develop a robust digital Learning Needs Analysis (LNA) and associated training plan for the Trust, linked ot the Digital Strategy this aims to ensure the workforce is equipped with the relevant digital skills to demonstrate tangible productivity gains.**
- **Consider the new Workforce Solution and impact on current People systems once timelines and activity is established.**

Key Points

PDR

- PDR compliance has remained within tolerance of target 85% for 25 consecutive months. In May 26 compliance is 83%.

Clinical Supervision

- Clinical Supervision compliance continues to fluctuate between 70-80% (currently 76%) 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 May 2026 91% 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
17.1

Meeting of the Board of Directors

Paper title:	2025 NHS Staff Survey Trust-level Action Plan
Date of meeting:	30 July 2026
Presented by: (name and title)	Darren Skinner, Director of People and Organisational Development
Prepared by: (name and title)	Tracey Needham, Head of People Engagement Sarah Turner, People Engagement Lead

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 presents the 2025 NHS Staff Survey findings and seeks Board approval of the Trust-level action plan required under national guidance.

Results show continuing strengths in flexible working, reasonable adjustments, meaningful work and staff feeling trusted, but declining experience in morale, wellbeing, engagement, feeling valued and speaking up. Free-text feedback reinforces concerns about workforce capacity, burnout, leadership visibility, communication, career development and retention.

Three Trust-wide priorities are proposed: workforce capacity and burnout; leadership and culture; and career development and retention. The action plan uses existing and aligned workstreams to remain deliverable within current capacity and integration pressures, with Board oversight of delivery, impact and assurance during 2026/27.

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 approve the proposed Trust-wide priority areas and action plan, take assurance on the governance and delivery arrangements, and note the national requirement for a Board-owned, in-year response to the 2025 NHS Staff Survey findings.

- **Decision:** Approve the three Trust-wide priority areas requiring focused improvement: workforce capacity and burnout; leadership and culture; and career development and retention.
- **Decision:** Approve the Trust-level Action Plan attached at Appendix 1 as the Board-owned response to the 2025 NHS Staff Survey findings.
- **Assurance:** Take assurance that governance, monitoring and reporting arrangements are in place to oversee delivery, impact and escalation throughout 2026/27.
- **Information:** Note that the plan consolidates existing and aligned workstreams to remain deliverable within current capacity, workload pressures and the LYPFT/LCH integration context

Meeting of the Board of Directors

30 July 2026

2025 NHS Staff Survey Trust-level Action Plan

1. Executive Summary

This paper summarises the key findings from the NHS Staff Survey 2025 and seeks Board approval for the Trust-wide priority areas and action plan required under national guidance.

The 2025 staff survey indicates areas of reduced staff experience across several NHS People Promise themes, most notably morale, wellbeing and engagement. At the same time, the Trust continues to perform strongly in areas such as flexible working, reasonable adjustments, and staff feeling trusted to do their job.

Both quantitative data and free-text feedback present a consistent picture of increasing workforce pressure, rising burnout and a decline in how valued and heard staff feel. Three priority areas requiring focused improvement have been identified: workforce capacity and burnout, leadership and culture, and career development and retention.

Delivering measurable improvement in these areas is now a requirement under the NHS Standard Contract and Medium-Term Planning Framework, which mandate clear, Board-owned, in-year action plans.

The proposed action plan focuses on existing and developing workstreams so it remains deliverable within current capacity, workload pressures and the integration context while demonstrating measurable progress within 12 months.

2. Context and Requirements

The NHS Standard Contract and Medium-Term Planning Framework require the Trust to review survey results, analyse free-text feedback, identify the three most significant areas requiring focused improvement, implement targeted in-year actions and publish outcomes.

This moves the Trust beyond localised intention planning towards a clearer Trust-wide action plan with Board accountability and oversight.

3. Key Findings

Response rates declined to 45% for substantive staff and 17.6% for bank staff, but the overall trends remain clear. Strengths include high levels of staff feeling trusted to do their job, strong appraisal completion, meaningful work, flexible working and reasonable adjustments.

Key experience metrics have declined: fewer staff feel the Trust supports their health and wellbeing, reported burnout has increased to 25.6%, fewer staff feel valued (46.6%), and confidence in speaking up has reduced.

Equality indicators also show areas of concern, with worsening reports of harassment in WRES data and a decline in engagement and feeling valued among disabled staff reflected in WDES measures.

4. Qualitative Insights

Free-text analysis reinforces the quantitative findings, with 68.9% of comments coded as negative. Feedback shows a contrast between positive local team experiences and more challenging organisational-level experiences, particularly around leadership visibility, communication and decision-making.

Appendix 1 provides representative staff comments that illustrate the staff experience behind the survey findings. These comments highlight both the strengths to maintain and the areas requiring focused improvement, providing a clear evidence base for the proposed Trust-wide action plan.

5. Priority Areas Requiring Focused Improvement

The three priority areas requiring focused improvement are:

- workforce capacity and burnout
- reflecting vacancies, recruitment controls and increasing workload;
- leadership and culture, particularly senior visibility, communication and responsiveness; and career development and retention, including progression, meaningful development and the quality of appraisal conversations.

Together, these themes point to systemic pressures affecting staff experience, retention and organisational culture. The proposed action plan responds to the underlying issues identified through staff feedback, using immediate wellbeing and support interventions alongside longer-term culture and organisational development work for the future integrated organisation.

6. Proposed Action Plan

The Trust-wide action plan at Appendix 2 focuses on the three priority areas requiring focused improvement identified through the NHS Staff Survey 2025 and free-text analysis.

The action plan consolidates current and emerging activity rather than creating a separate programme of work. It draws on activity that is already underway or aligned to existing workstreams, ensuring deliverability within current workload, capacity and the integration context between Leeds and York Partnership NHS Foundation Trust (LYPFT) and Leeds Community Healthcare NHS Trust (LCH).

Workforce Capacity, Wellbeing and Burnout
To address workforce pressures and burnout, the Trust will use a Digital Learning Needs Analysis to identify where digital tools and artificial intelligence can improve productivity, reduce administrative burden and increase time for patient care. A targeted 12-month pilot will also strengthen support for colleagues experiencing stress, anxiety, depression or other mental health-related absence through earlier Occupational Health referral, wellbeing assessment, manager support and monitoring.

Leadership and Culture
To strengthen leadership and culture, engagement activity across LYPFT and LCH will support co-creation of a shared Vision, Values and Behaviours for the newly integrated organisation. This provides an opportunity to respond directly to staff feedback and shape the culture, leadership expectations and employee experience of the future organisation. A Trust-wide culture development mapping exercise will also improve oversight, alignment and assurance of cultural improvement activity.

Development and Recognition
To improve development and recognition, the Trust will reset the quality and consistency of Personal Development Reviews, strengthening career conversations, objective setting and regular development discussions. This will be supported by manager development, clearer guidance, quality monitoring and implementation of Career Development Listening Project recommendations, including a central Career Development Hub, expanded coaching, mentoring, apprenticeships and targeted actions to improve equity of access for under-represented groups.

Cross-workstream Delivery, Monitoring and Impact
Across all workstreams, key milestones have been established and will be monitored through regular reporting to provide assurance regarding implementation, delivery and impact. Delivery will be supported through aligned service-level Intention Plans, ensuring a clear line of sight between local improvement actions and Trust-wide priorities. Progress and impact will be measured through outcome indicators including reductions in the duration of S10 sickness absence, improvements in Staff Survey scores relating to wellbeing, feeling valued, appraisal quality and career development, increased uptake of career development opportunities, and evidence of staff involvement in shaping the future organisation.

7. Governance and Assurance

Delivery of the action plan will require clear Board-level ownership and oversight, with progress monitored through established governance structures and supported by the Culture, Oversight and Delivery Group. Regular reporting will track implementation, impact and variation across services, providing assurance that actions are aligned, reducing duplication and delivering meaningful and sustained improvement.

Service-level Intention Plan governance is also being strengthened through consistent local review, monitoring and escalation where barriers to progress are identified.

Addressing these themes will support improvements in staff wellbeing, engagement, retention and

attendance, with wider benefits for quality of care, organisational performance and successful integration.

8. Conclusion

The NSS25 findings show that the Trust retains important strengths in team culture and flexibility, while workforce pressure and inconsistent leadership experience continue to affect wellbeing, engagement and retention. The proposed action plan provides a focused, deliverable response through existing and aligned workstreams.

9. Recommendations

https://nhs-my.sharepoint.com/personal/traceyneedham_nhs_net/Documents/Attachments/undefinedThe Board of Directors is asked to:

- Approve the three priority areas requiring focused improvement identified through the survey analysis.
- Approve the Trust-level Action Plan attached at Appendix 2.
- Agree the proposed governance and oversight arrangements to monitor delivery and impact throughout 2026/27.
- Note that the action plan uses existing and aligned workstreams to remain deliverable within current capacity and the integration context.

Sarah Turner / Tracey Needham
People Engagement Lead / Head of People Engagement
03 July 2026

Appendices
Appendix 1 – Representative free-text comments
Appendix 2 – Trust-wide action plan

Appendix 1 – Representative free-text comments

In total we had 212 free text comments

Sentiment	Volume	%
Negative	146	68.9%
Mixed	33	15.6%
Positive	27	12.7%
Neutral	6	2.8%

Top 3 areas of satisfaction

Engagement, morale and motivation

"I am lucky. I really enjoy my job."
"I enjoy working for this organisation."
"I am proud to work for LYPFT who strive to achieve very high standards of patient and staff care."
"…employee friendly organisation with opportunities to grow and provide meaningful contribution towards the mental health sector."

Leadership and local team culture

"Great supportive managers and a supportive team who all respect and care for each other."
"I have the best ward manager."
"My manager's support and confidence in me has really helped me to settle in."
"I am impressed by the openness and inclusiveness shown by the leadership group."

Flexible working and work–life balance

"Allow working from home and flexible hours whenever possible… contributes strongly to job satisfaction."
"The ability to integrate work and home life is really important, especially for those with caring responsibilities."

Top 3 areas of dissatisfaction

Workforce capacity pressures, burnout and reduced care quality

"We are working on minimal staffing… It is at a dangerously low level."
"We are unable to provide a truly person-centred service… It is making me reconsider my future in the organisation."

"The pressure to meet savings targets is leaving teams stretched thin and the added strain is becoming increasingly difficult to manage… we risk seeing a continued rise in burnout and staff turnover."
"Putting more work onto other colleagues as a result of recruitment constraints surely goes against this Trust's values."
"I feel like patient care, the safety of our patients and their wellbeing is bottom of the priority. The only thing that appears to be a priority is the budget and the lack of resources we have to create a safe, caring, therapeutic environment."

Leadership and culture: senior visibility, communication and inconsistent experience
"The next levels of leadership are not always visible and there are minimal opportunities for them to be able to be involved in things that happen within the team. When something is raised as a concern to higher leadership, it is known that they take this concern forward, but feedback is not always given to know how the outcome affects practice."
"There is a significant lack of organisation and lack of clear objectives in middle and senior management... Timeframes lapse, and are often just accepted and not met... improvements are not made properly and focus on reactivity or quick fixes rather than sustainable change... people sometimes look overwhelmed with workload."
"Poor communication, slow to act on issues raised… overly concerned with tick boxes rather than people."
"There is still a culture of protecting the organisation's reputation rather than embracing transparency… leaders of the organisation higher up. I feel disconnected from their decision-making and culture."
"Executive Management Team have a toxic culture which does filter down to other teams, make colleagues feel frustrated, worried and sometimes upset."

Career development, progression and retention
"The biggest issue I experience in this workplace is development and career development opportunities."
"Ability to progress within my current role is non-existent."
"It would be good to have career progression… at the moment everything is locked and no money within the Trust."
"Managers… are appointed without appropriate training… affecting junior staff and contributing to staff turnover."
"I feel frustrated by the lack of opportunities for career progression and feel really undervalued in my service."

People Promise Element	2025 Staff Survey scores	Development areas	Focus	Steps to take	Outcomes	Measures	Lead areas	Timescales	Current status	Update notes
We are safe and healthy	There has been a 5.8% decrease in the proportion of staff who feel the Trust takes positive action to support health and wellbeing, falling to 63.9%. Unfavourable increase of 5.1% of staff reporting burnout due to work, rising to 25.6%.	Financially Driven Workforce Capacity Pressures Burnout: financial constraint, workforce capacity, and burnout, with colleagues describing recruitment freezes and prolonged vacancies leading to unsafe staffing levels, increased workloads, and reduced quality of care.	**Buronout:** Reducing workload pressure and admin burden	Implement a Digital Learning Needs Analysis (LNA) to identify where AI and digital tools can improve productivity and efficiency and reduce administrative burden.	Reduced perceived admin burden; increased human capacity; improved staff experience.	Reduction in identified administrative burden in pilot areas. Improved staff feedback regarding efficiency and productivity. Increased utilisation of agreed digital tools.	Strategic Resourcing / Digital	Start date: April 2026 Delivery date: March 27	In Progress	
We are safe and healthy	There has been a 5.8% decrease in the proportion of staff who feel the Trust takes positive action to support health and wellbeing, falling to 63.9%. Unfavourable increase of 5.1% of staff reporting burnout due to work, rising to 25.6%.	Financially Driven Workforce Capacity Pressures Burnout: financial constraint, workforce capacity, and burnout, with colleagues describing recruitment freezes and prolonged vacancies leading to unsafe staffing levels, increased workloads, and reduced quality of care.	**Burnout:** Targeted support and early intervention for colleagues, experienceing Anxiety/Stress/Depression/Other Psychiatric Illnesses (S10 absence)	12 month S10 absence Pilot - Implement a Day 1 referral process to Occupational Health for all S10-related absences. Introduce daily S10 absence notification to OH to enable early intervention. Ensure timely contact (within 5 working days) and offer an initial wellbeing assessment. Provide early advice, support, and action planning involving both employee and manager. Strengthen manager responsibilities for prompt follow-up, action plans, and review meetings. Improve timeliness of absence reporting to support effective early intervention.	Earlier access to support for colleagues experiencing stress-related absence. Increased early intervention, reducing escalation of mental health issues. Improved return-to-work outcomes and reduced duration of absence. More consistent application of the S10 pathway across services. Enhanced manager engagement and accountability in supporting staff wellbeing. Better data capture and system responsiveness, enabling more effective monitoring and evaluation.	Improved timeliness of wellbeing interventions. Reduction in average duration of S10 absence. Increased proportion of staff supported through agreed wellbeing plans. Reduction in repeat S10 absence episodes	Health & Wellbeing / Human Resources / Occupational Health / People Analytics	Start date: March 2026 Delivery date: March 2027	In Progress	Review point every 3 months, most recent review May 2026
We are compassionate and inclusive	Compassionate culture (sub-score) 7.16 (down -0.08), Compassionate leadership (sub score) 7.53 (down -0.05). Confidence in speaking up has reduced, with 66.0% of staff (-4.3%) reporting that they feel safe to raise concerns of any kind.	Leadership & Culture (Senior Leadership) Inconsistency of leadership experience across services, potentially missing key compassionate leadership behaviours (psychological safety, listening, fairness, inclusion)	**Leadership and Culture:** Co-creating a shared vision, values and behaviours that embed compassionate leadership and define how we work together as one organisation.	Comprehensive engagement with colleagues across both organisations will capture perspectives on the 'Best of Both' and inform the development of a shared Vision, Values and Behaviours for the new Trust, ready for Day One on 1 April 2027. This work, detailed within the Transform Programme Plan, will include a cultural diagnostic across both Trusts, identification of 'Best of Both' strengths, development of a shared vision and emerging cultural identity, and the establishment of a leadership expectations framework.	New Vision, Values and Behaviours co-created and recognised by colleagues within the new organisation.	Number and diversity of staff participating. Staff report feeling involved in shaping the future organisation. Vision, Values and Behaviours adopted within organisational processes.	OD / Engagement / Co-create	Start date: May 2026 Delivery date: April 2027	In Progress	
We are compassionate and inclusive	Compassionate culture (sub-score) 7.16 (down -0.08), Compassionate leadership (sub score) 7.53 (down -0.05). Confidence in speaking up has reduced, with 66.0% of staff (-4.3%) reporting that they feel safe to raise concerns of any kind.	Leadership & Culture (Senior Leadership) Inconsistency of leadership experience across services, potentially missing key compassionate leadership behaviours (psychological safety, listening, fairness, inclusion)	**Leadership and Culture**: Improving culture development activity oversight	Culture development mapping activity to capture the initiatives within the Trust that impact our culture and support decision making. This will then enable a gap analysis to identify core focus for cultural development needs as we build towards a new organisation.	The Trust will be able to clearly articulate what initiatives are in place to support regulatory and good practice requests with a live reference document. Guided cross-cutting priorities for cultural development	Single organisational view of culture activity. Improved governance and oversight. Clearer alignment between culture initiatives and organisational priorities.	OD / EDI / Health Equity / FTSU / Engagement / Health & Wellbeing	Start date: February 2026 Delivery date: April 2027	In Progress	Map/document produced. Meeting held early July to analyse gaps and agree collective priorities across culture teams and programmes. Actions to be discussed at Culture Oversight Delivery Group late July.
We are always learning / We are recognised and rewarded	Fewer colleagues feel that the Trust values their work, with a decrease of 5.8%, bringing score to 46.6%. This is echoed by only 28.08% of staff saying their PDR left them feeling that the Trust values their work. 52.37% of staff feel there are opportunities for them to develop in their career (-3.27%)	Career Development, Progression & Retention Development time is deprioritised, PDRs high completion rate, but quality drops and becomes "tick-box", feeling less valued, recognised, and invested in	**Development and Recognition**: Improving appraisal and development experience	Reset the quality and consistency of PDRs using Workforce Committee recommendations. Launch a communication campaign focused on the purpose of PDRs, meaningful career and development conversations, objective setting and regular review through supervision and 1:1s. Increase engagement with 360 Manager training, share best practice case studies, introduce manager guidance and monitor both compliance and quality measures.	Improved quality and consistency of PDRs; more meaningful career and development conversations; greater clarity of objectives; increased staff satisfaction with appraisal; improved perceptions of being valued and supported to develop.	PDR purpose' communications campaign launched, Increase in attendance at PDR and Career Conversation workshops. Improvement in Staff Survey questions relating to appraisal quality and feeling valued.	Talent Development / OD	Start date: September 2026 Delivery date: Ongoing	Not Started	Background work is in progress
We are always learning / We are recognised and rewarded	Fewer colleagues feel that the Trust values their work, with a decrease of 5.8%, bringing score to 46.6%. This is echoed by only 28.08% of staff saying their PDR left them feeling that the Trust values their work. 52.37% of staff feel there are opportunities for them to develop in their career (-3.27%)	Career Development, Progression & Retention Development time is deprioritised, PDRs high completion rate, but quality drops and becomes "tick-box", feeling less valued, recognised, and invested in	**Development and Recognition:** Career development offer	Implement the Career Development Listening Project recommendations. Promote the LYPFT Career Development Framework, develop a central Career Development Hub on Staffnet providing clear information on career pathways, coaching, mentoring, apprenticeships, shadowing, projects, secondments and learning opportunities. Expand the Career Development Programme, strengthen manager capability for career conversations, promote career stories and role models, to improve confidence and equity of access to development opportunities.	Improved awareness and access to career development opportunities; fairer and more consistent experiences across staff groups; increased confidence and career ownership; improved perceptions of career progression, particularly for under-represented and non-clinical colleagues; stronger organisational learning culture and retention.	Utilisation of Career Development Hub resources. Increased participation in career development activities. Increased take-up of mentoring and coaching. Improvement in Staff Survey score: "There are opportunities for me to develop my career in this organisation." Improved awareness of development opportunities across staff groups.	Talent Development / EDI / OD /	Start date: October 2026 Delivery date: Ongoing	Not Started	Background work is in progress

Agenda item
18

Meeting of the Board of Directors

Paper title:	Chair's Report from the Audit Committee meeting on 14 July 2026
Date of meeting:	30 July 2026
Presented by: (name and title)	Martin Wright, Non-executive Director and Chair of the Audit 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:	Audit Committee
Date of Committee:	14 July 2026
Chaired by:	Martin Wright, Non-executive Director

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

ADVISE – any new areas of monitoring or existing monitoring where an update has been provided to the committee and there are new developments	
Issue	**Relates to BAF Risk**
The 'Organisational Governance: 'Ward to Board' Escalation and Assurance Flow' internal audit report was received with a split assurance opinion, with the governance framework element receiving significant assurance and the system operation element receiving limited assurance. The committee was assured on the actions being taken to address the issues identified in the report.	SR3
The 'Minimising Self-harm and Suicide' internal audit report was received with an overall opinion of limited assurance. The committee was assured on the actions being taken to address the issues identified in the report.	SR2
The 'Medicines Management' internal audit report was recevied with an overall opinion of limited assurance. The committee was assured on the actions being taken to address the issues identified in the report.	SR2

ASSURE – specific areas of assurance received warranting mention to Board	
Issue	**Relates to BAF Risk**
The committee received the Risk Management Annual Report for 2025/26 which outlined the Trust's risk management governance arrangements, including the roles and responsibilities of the Director of Nursing and Professions, the Executive Risk Management Group, and the Patient Safety Team in regard to overseeing risk registers, managing risk, and escalation processes. It agreed that the report demonstrated continued improvement within the risk management systems and processes.	SR2
The committee noted that the 'Performance Delivery' internal audit report had been finalised with an opinion of significant assurance.	SR5

The committee received and noted the contents of the Outstanding Audit Actions Report. It was assured that there were no overdue actions as of 1 July 2026.	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9
The committee received the Tender and Quotation Exception Report covering 1 April 2026 to 30 June 2026. It noted that one quotation wavier had been approved during the period.	SR4
The committee received the Local Counter Fraud Annual Report for 2025/26 and the Local Counter Fraud Progress Report and was assured by the information provided.	SR4
The committee approved the Draft Local Counter Fraud Annual Work Plan for 2026/27.	SR4
The committee received the Sponsorship, Hospitality, and Gift Registers and noted their contents.	SR4
The committee received the Health and Safety Quarterly update for quarter one of 2026/27 and the Health and Safety Annual Report for 2025/26. It noted the ongoing proactive approach to safety within the Trust and agreed that it was assured by the information provided, subject to further work agreed with the team to reconcile the number of incidents reported.	SR1 SR5

REFER - Items to be referred to other Committees

Issue	**Relates to BAF Risk**
It was agreed that the ‘Minimising Self-harm and Suicide’ internal audit report would be referred to the Quality Committee for information and assurance.	SR2
It was agreed that the ‘Medicines Management’ internal audit report would be referred to the Quality Committee for information and assurance.	SR2
It was agreed that the ‘Performance Delivery’ internal audit report would be referred to the Finance and Performance Committee for information and assurance.	SR6

Recommendation

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

Agenda item
19

Meeting of the Board of Directors

Paper title:	Board Assurance Framework
Date of meeting:	30 July 2026
Presented by: (name and title)	Dr Sara Munro, Chief Executive
Prepared by: (name and title)	Clare Edwards, Associate Director of Corporate Governance

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

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

Executive summary

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

Following the review of the Board Assurance Framework at the Board Strategic Discussion Day in April

2026, this has now been updated to reflect the agreed amendments. This includes:

- Wording of all strategic risks
- Additional system risk (SR9)
- SR7 has now been split into two separate risks, SR7 & SR8, to reflect health inequalities and demand for services.

Each Committee has reviewed the strategic risks to consider: if they are assured that these are being adequately controlled; whether they are receiving assurance on any gaps through the reports are already being received; and whether the Committees required any further assurance on the way in which the risks are being managed.

ERMG undertook a final review of the content of the BAF on Wednesday 15 July 2026 and confirmed the content was appropriate and accurate.

The Board of Directors is asked to formally approve the Board Assurance Framework for 2026/27.

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

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

This is detailed within the strategic risks, specifically strategic risks 1, 7 and 8.

Recommendation

The Board is asked to:

- Receive the BAF and to be assured of the review that has been undertaken to ensure that this accurately reflects the position for 2026/27, including risk scoring and mitigating actions.

Meeting of the Board of Directors

30 July 2026

Board Assurance Framework

1 Executive Summary

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

Board Assurance Framework

2.1 Strategic Objectives

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

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

2.2 The BAF

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

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

2.3 Risk Management

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

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

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

2.4 Structure of the BAF Risk Report

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

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

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

2.5 Strategic Risk Detail Updates

Following the review of the Board Assurance Framework at the Board Strategic Discussion Day in April 2026, this has now been updated to reflect the agreed amendments. This includes:

- Wording of all strategic risks
- Additional system risk (SR9)
- SR7 has now been split into two separate risks, SR7 & SR8, to reflect health inequalities and demand for services.

Each Committee has reviewed the strategic risks to consider: if they are assured that these are being adequately controlled; whether they are receiving assurance on any gaps through the reports are already being received; and whether the Committees required any further assurance on the way in which the risks are being managed.

The Board of Directors is asked to approve the content of the BAF for 2026/27.

BAF Dashboard

	Risk Title	Oversight Committee	Lead Executive	Strategic Objectives			Initial risk score	Previous Risk Score				Change	Target risk score	Risk Appetite	Target date
				1	2	3		Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27				
SR1	Quality including Safety Assurance Processes	QC	DoN&P	✓			4	12	12	12	12	⟷	4	M	30 Apr 27
SR2	Delivery of the Quality Strategic Plan	QC	MD	✓			9	12	12	12	12	⟷	6	C	31 Mar 28
SR3	Culture and environment for the wellbeing of staff	WC	DoP&OD		✓		12	16	12	12	12	⟷	9	C	30 Apr 27
SR4	Financial sustainability	F&PC	DoF			✓	8	12	12	15	12	↓	4	C	31 Mar 27
SR5	Adequate working and care environments	F&PC	DoF			✓	8	12	12	12	12	⟷	4	O	31 Mar 28
SR6	Digital Technologies	F&PC	MD			✓	12	12	12	12	12	⟷	4	O	31 Mar 27
SR7	Demand for Services	F&PC	COO	✓			12	-	-	-	12	⟷	6	S	31 Dec 27
SR8	Health Inequalities	F&PC	COO	✓			12	-	-	-	12	⟷	6	S	31 Dec 27
SR9	System Change	Board	CEO	✓		✓	12	-	-	-	8	⟷	3	S	30 Apr 27

Strategic Risk 1

BAF Risk SR1	If there is a breakdown of quality and / or regulatory assurance processes, there is a risk the Trust cannot maintain standards of safe practice and compliance with regulatory requirements.		
Strategic Objective:	1. Through our care services: We deliver great care that is high quality and improves lives		
Accountable Director	Executive Director of Nursing and Professions	**Initial Risk Score**	4 (L2xC2)
		Current Risk Score	12 (L3x4C)
Oversight Committee	Quality Committee	**Target Risk Score**	9 (L3xC3)
Risk Appetite	Minimal	**Target Date:**	30 April 2027

Controls in place

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

NB: Controls and actions within SR2 should be considered in conjunction with those noted within SR1 due to interdependencies

Details of Assurance

Assurance Rating:	**Partial**

Management / Service Level	**Review Process / Oversight**	**Independent (external / internal audit)**
- Escalation processes - Tier three clinical governance meetings supported by TOR and clinical governance framework. - Escalation mechanism in place from ward to board - Weekly LIMM meeting to review incidents (graded 3 and above) and deaths - Monthly Trust Incident Review Group with a focus on SI reports and overdue actions	- Clinical Governance Framework - Patient Safety Oversight Report - 6-monthly Learning from Deaths report to Quality Committee - PSII reports reviewed and signed off at Trust Incident Review Group - Quarterly safer staffing report to Board	- Peer reviews: ICS level - Provider collaborative and ICB quality visit - Audit Yorkshire – internal audit programme & reports - Healthwatch external visit - 2019 CQC inspection report, overall rating good - CQC MHA reviews - Low assurance - complaints / claims - Significant assurance – sexual safety audit

- Bi-monthly CQC oversight group with overview of peer reviews - Monthly safer staffing group with oversight of staffing levels and annual establishment review - Monthly positive safety group with overview of incidents of restraint - Monthly CLIP report shared with services giving an overview of incidents, complaints, PALS - E-rostering system in place - Monthly working group with overview of the implementation of the RAMP - Monthly suicide prevention environment group - Monthly sexual safety group meeting - Monthly falls and pressure ulcer group to review falls and pressure ulcer incidents (graded 3 and above) - Monthly safeguarding report shared with services giving overview of safeguarding training compliance and safeguarding referrals. - Monitoring of organisational change requirements for Mental Health Act compliance	- Reducing restrictive practice report to Quality Committee - Sexual safety report to Quality Committee - Evaluation of the implementation of the RAMP to be reported through Quality Committee - Suicide prevention environment group summary supported to clinical environment group and escalated to ESG. - Nursing and Professions highlight report to quality committee - Falls and pressure ulcer group report to quality committee - Peer review reports shared via clinical governance structures - Monthly Executive risk management to review and discuss 15+ risk - Annual quality accounts - Annual Clinical Supervision Training report to Nursing and Professions' Council.	- Limited assurance – integrated governance and risk management framework - Significant assurance – Patient safety incident response framework

Gaps in assurance / controls:	- Development of suicide prevention plan and self-harm strategy - Development of Clinical Governance dashboard - Development of safer staffing SOP - End of life care - Complaints process - Development of physical health training - Development of Mental Health Act amendments strategy

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress
Establishment of end of life care steering group to develop clinical practice standards	Deputy Director for AHP's, Social Workers	30 September 2026	Steering and implementation group overseeing the change from DNACPR to ReSPECT. In place. A pilot at the Mount commenced in February, no concerns/risk highlighted. Training and communication roll out underway. There is a delay in the citywide project to provide read write access to ReSPECT on Leeds Care Record, but there is mitigation in place at the Mount to manage access. Access is due to be available in Q2 26 therefore the wider roll out in the trust will take place to coincide with this. Completion of this work and closure of this risk is delayed until this is resolved.

Development of a suicide prevention plan and Self-Harm Strategy	Head of Nursing	31 Aug 2026	Previous plans and current guidance being reviewed and PID being developed with support from Project Manager to guide strategy development and action plans. External review of plans underway from Yorkshire Audit. Engagement with citywide work ongoing to inform local plan Working with neighbouring trusts to develop training
Review of Clinical Governance framework to support and improve consistency with how clinical governance operates across the organisation.	Head of Clinical Governance	1 June 2026	Clinical Governance improvement plan in place. Meeting held with Deputy Medical Director to review current Clinical Governance framework and strengthen to ensure services are discussion the correct actions and understand how to access data.
Culture of Care Standards Transformation Programmes	Professional Lead for Nursing	31 December 2026	The national two-year Culture of Care pilot concluded on 31st March 2026. NHSE has ended their support, and the Trust has now launched the next phase of the programme to roll out the programme across the remaining wards with support form CI Team and the Lived Experience Worker. Evaluation of the programme to data has been developed with positive impact, Introductory workshops across inpatient areas have been introduced to strengthen engagement and programme roll out expected to be achieved in 6-9 months.
Development of clinical governance dashboard in conjunction with the quality improvement team to support Tier 3 Clinical governance meetings.	Head of Clinical Governance	31 May 2026	Work in conjunction with quality improvement team to develop range of indicators that will inform services on the quality of care being delivered within services. To link with wider work on quality dashboard and annual service reports.
Development of a safer staffing SOP	Deputy Director of Nursing	31 June 2026	A SOP will be developed to support a standardised and consistent approach across inpatient services for the annual safer staffing establishment reviews with the staffing escalation procedure forming part of the document.
Complaints process and procedure	Head of Patient Experience, Complaints and legal services	31 May 2026	Full review and development of the Trust's Complaints Procedure and the Complaints Investigator Pack is complete. The revised and amalgamated PALS and Complaints procedure will be presented to Nursing & Professions Council 01/04/2026 for approval, followed by Policies & Procedures Group later this month. Strengthened governance arrangements for complaints have been agreed, developed in partnership with Clinical Leads and Heads of Operations. This includes improved oversight, clearer accountability, and enhanced systems for sharing learning and monitoring actions across services.

			Review of complaints KPIs has been completed, including investigation timescales and performance thresholds – detailed in the procedure. The team are now making changes to the Datix system to ensure this data is collated and monitored and will update the tracker accordingly. Revised escalation processes have also been implemented to support timely completion of complaint responses and reduce delays.
Development of a strategic response and working group to respond to organisational readiness for MHA amendments	Oliver Wyatt, Head of Legislation	31 May 2027	Working group agreed and arranged to commence in July 2026

Contributory risks at level 12 or above				
1359	**Complaints processes -** Timescales for completion of complaint responses exceeding what is deemed a reasonable expectation.	Head of Patient Experience, Complaints and Inquest	Trust wide clinical governance	12 (L4xC3)
1331	**Equipment risk -** The majority of equipment risks are now managed, however a final agreement about how to comply with the national patient safety alert for bed rails is expected be agreed through appropriate governance in April 26. This is turn should lead to a reduction in risk score.	Deputy Director for AHP's, Social Workers	Trust wide clinical governance	16 (L4xC4)
1286	**Clinical Governance -** There is a risk that the inconsistencies in how clinical governance is applied and operating across all clinical services, does not provide us with the organisational assurance around the quality of care being delivered to our services users and carers.	Head of Clinical Governance	Trust wide clinical governance	12 (L3xC3)
1361	**Trust physical health training and support -** Concern regarding the quality and consistency of the current inhouse physical health training delivered to staff across the trust	Professional Lead for Allied Health Professionals	4 in 1 meeting	12 (L4xC3)
1330	**Capacity within the patient safety team -** Due to staffing vacancies within the patient safety team, there is a risk that: Processes in relation to patient safety are not followed in a timely manner, i.e. allocation of learning responses, compassionate engagement with families Delays in completion of learning responses, with increased timescales to complete AAR, PSII Investigators/reviewers are not offered support to complete learning responses, including Patient Safety Incident Investigations (PSII's) Training relating to patient safety is not available.	Head of Clinical Governance	Trust wide clinical governance	12 (L4xC3)
1024	**Clinical Risk Assessment -** Findings from patient safety incident reviews have identified issues with the completion of risk assessments within the organisation. This includes the quality of information within the assessments, how meaningful these are to staff and patients and issues with completion in line with Trust guidance.	Director of Nursing and Professions	Risk assessment group	12 (L4xC3)
1416	**MHA Amendments** - there is a risk that the organisation has not commenced its readiness work and strategic approach to respond to the MHA amendments.	Head of MH Legislation	MH Legislation Steering Group	`12 (L4xC3)

Strategic Risk 2

BAF Risk SR2	If the Trust is unable to effectively embed the Quality Strategic Plan, there is a risk that the organisation will not develop the leadership, culture, insight, improvement capability and learning systems required to continuously improve quality, including safety and outcomes, for the people who use our services.		
Strategic Objective:	1. Through our care services: We deliver great care that is high quality and improves lives		
Accountable Director	Medical Director	**Initial Risk Score**	9 (L3xC3)
		Current Risk Score	12 (L4xC3)
Oversight Committee	Quality Committee	**Target Risk Score**	6 (L2xC3)
Risk Appetite	Cautious	**Target Date:**	31 March 2028

Controls in place

Leadership, culture and improvement conditions

- Learning Culture and Leadership (LCL) Framework
- Collective and relational leadership programmes
- Clinical leadership development programme
- Safe Effective Reliable Care Framework

Quality insight and measurement

- STEEEP framework and quality dashboard development
- Annual Service Quality Reports
- Quality and culture measurement development
- Clinical governance reporting structures

Improvement and learning infrastructure

- Trust improvement methodology
- Quality Improvement and Knowledge (QuIK) governance process
- Clinical audit and NICE governance arrangements
- Knowledge mobilisation and QI Bookcase development

Organisational governance and oversight

- Trustwide Clinical Governance structure
- Unified Clinical Governance Group
- Quality Committee oversight
- Executive Risk Management Group

Cross-organisational learning and integration

- QuESt development work

▪ Boundary spanning and partnership working activity

NB: Controls and actions within SR1 should be considered in conjunction with those noted within SR2 due to interdependencies

Details of Assurance		
Assurance Rating:	**Partial**	
Management / Service Level	**Review Process / Oversight**	**Independent (external / internal audit)**

- Quality Improvement and Knowledge (QuIK) reporting and oversight process - Standardised QSP workstream reporting framework (delivery, impact, risks and learning) - Annual Service Quality Reports - Service-level improvement and governance structures - Learning Culture and Leadership (LCL) framework implementation - Clinical leadership development and peer learning activity - STEEEP quality dashboard pilot and metric development - Patient safety investigation and organisational learning processes - Improvement methodology, coaching and apprenticeship support - Quality improvement project reporting and escalation processes	- Quality Committee oversight of Quality Strategic Plan delivery and associated risks - Board assurance through Quality and Performance reporting and Board governance processes - Executive Risk Management Group review of strategic risk profile and mitigating actions - Quality Improvement and Knowledge (QuIK) programme oversight and workstream review - Trustwide Clinical Governance Group oversight of quality governance and improvement alignment - Review of Annual Service Quality Reports and emerging STEEEP quality metrics - Medical Director and Deputy Medical Director oversight of quality governance and improvement priorities - Monitoring of organisational quality insight, leadership and improvement capability development through QSP reporting structures	- Internal Audit reviews relating to quality governance, risk management and organisational effectiveness - Audit Yorkshire internal audit programme and associated recommendations - CQC Well-Led evidence and external regulatory review processes - External benchmarking and collaborative learning through IHI Healthcare Improvement Alliance Europe and wider system partnerships - Evaluation activity linked to leadership and cultural development programmes - External challenge and feedback through governance, integration and partnership workstreams where applicable

Gaps in assurance / controls:	- Variation in improvement maturity and capability across services - Inconsistent use and integration of quality, culture and operational data - Limited organisational capacity and protected time for improvement activity - Early-stage maturity of integrated quality dashboard and measurement systems - Fragmentation between improvement, audit, research, informatics and operational learning systems - Limited ability to consistently evidence impact and outcomes from improvement activity - Risk of organisational change and integration reducing focus or delivery capacity

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress
Develop an organisational improvement capability and maturity approach to support more consistent improvement practice across services.	Deputy Director of Improvement	March 2027	Initial alignment work underway, including review of governance interfaces and reporting structures in progress.
Develop a more integrated organisational quality insight approach through the continued development of STEEEP	Deputy Director of Improvement	March 2027	Initial STEEEP pilot activity completed within Acute Care Services. Further work planned to strengthen consistency of quality metrics and support ward-to-board visibility.
Strengthen clinical, collective and relational leadership capability to support continuous improvement and organisational learning.	Deputy Medical Director / Director for Collaborative Working / Head of Organisational Development (OD) and Culture	March 2027	Clinical leadership development activity established, including Action Learning Sets, induction support and peer learning forums. Evaluation and alignment work continuing across wider leadership programmes.

Clarify and develop the role of QuESt in supporting organisational learning, evidence mobilisation and coordination across improvement-related functions.	Deputy Medical Director/ Head of Research / Deputy Director of Improvement	December 2026	Review of remit and governance underway, including exploration of stronger alignment between improvement, research, knowledge services, informatics and clinical effectiveness functions.
Develop approaches that support quality improvement and organisational learning across organisational and system boundaries, including Trust integration activity.	Director for Collaborative Working	March 2027	Early scoping work underway through boundary spanning and leadership workstreams to support alignment and shared learning across organisations.
Strengthen evaluation and assurance arrangements across QSP workstreams to better evidence organisational impact, learning and outcomes.	Deputy Medical Director/ Deputy Director of Improvement	December 2026	Standardised QuIK reporting framework introduced to support more consistent reporting of delivery, impact, risk and organisational learning across workstreams.
Contributory risks at level 12 or above			
None			

Strategic Risk 3

BAF Risk SR3	If the Trust fails to deliver an inclusive culture and environment, then this may impact on the ability to recruit, retain and attend to the wellbeing of staff to enable them to be their best and deliver quality services now and in the future.		
Strategic Objective:	2. For our people: We provide a rewarding and supporting place to work		
Accountable Director	Director of People and Organisational Development	**Initial Risk Score**	12 (L3xC4)
		Current Risk Score	12 (L3xC4)
Oversight Committee	Workforce Committee	**Target Risk Score**	9 (L3xC3)
Risk Appetite	Cautious	**Target Date:**	30 April 2027

Controls in place

- Trust People Plan
- Widening Participation Plan
- Apprenticeship Strategy
- Leadership and Management Programme
- Leadership Academy programmes
- Collective Leadership Programme
- Exit Interview process
- Performance Reporting Compliance
- Performance Reporting Compliance
- Health and Safety Committee
- People and Culture Trust Integration Plan
- WRES AND WDES Annual Action Plans

Details of Assurance

Assurance Rating:	**Partial**

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

Gaps in assurance / controls:	- Demographic challenges - Economic and environmental factors - National workforce supply issues

	- Health of the population nationally i.e. long term conditions increasing - Capacity of employees inc. manager, to undertake training and development

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress
Establishment of a Workplace Adjustments Task Group to develop and implement a process which supports employees with workplace adjustments to enable them to remain in work. Supporting those with long term conditions and disabilities.	Deputy Director of People and OD	30 June 2026	Policy to be ratified by Trust Policies and Procedures Group June 2026.
Nursing and Midwifery Job Profile Reviews (National Job Evaluation Programme)	Deputy Director of People and OD	30 September 2026	HR Business Partner Lead working with Deputy Director of Nursing to undertake baseline assessment to inform workplan required. Group to be established in January 2026 with various stakeholders including Staff Side. NHSE Reporting commenced in October 2025 (quarterly).
Ensure we are compliant with new requirement to have a Menopause Action Plan	Head of Wellbeing	30 September 2026	Monthly peer support network established Recording of menopause absence since Oct 25. Working towards Henpicked Accreditation A library of resources launched Oct for individuals, line managers and allies. Awareness campaign running Jan – August.
An evidence based Health and Wellbeing Strategy in place	Head of Wellbeing	31 December 2026	Diagnostic against NHS Health and Wellbeing Framework complete. Following the diagnostic tool being presented to Workforce Committee in February a twelve month action plan will be developed and delivered through the Wellbeing & Attendance Group. This was discussed at Wellbeing & Attendance Group 26 Feb and further work on proposed actions needs developing and will be further discussed at the next meeting April.
Strategy to Reduce Healthcare Support Worker Vacancies	Head of Strategic Resourcing and Talent	31 March 2027	Trustwide HCSW Vacancy Reduction Governance Group Established (inc. 3 Sub Groups – Recruitment, Retention and Workforce Redesign). Piloting centralised HCSW Assessments Centres Oversight by the Monthly Workforce Efficiencies Group

Contributory risks at level 12 or above

Ref	Description	Lead / Responsible Director	Oversight Group	Score
1360	The HR Operations team has experienced a reduction in capacity following the departure of two HR Administrators. These roles have not been backfilled, resulting in a significant gap in administrative support. The remaining team members, including HR Advisors and HR Managers,	Deputy Director People and OD	POD SLT	**12 (L3xC4)**

	are now required to absorb the additional workload, which includes routine administrative tasks, case tracking, correspondence, and data management. This shift in responsibilities is placing considerable strain on the team, diverting focus from strategic and advisory functions to operational and transactional duties. The increased workload risks delays in service delivery, reduced responsiveness to managers and staff, and potential errors in HR processes due to time pressures and lack of dedicated administrative oversight. **Risk Update (March 2026):** A number of mitigating actions have now progressed which are expected to have a positive impact on capacity and workflow management over the next quarter: Case Management System: • A case management system has been purchased, with development work due to begin in April 2026. Once implemented, this will support improved tracking, reporting, and workload oversight. It is anticipated to deliver efficiency gains and reduce manual administrative burden. • Band 4 HR Officer Request Submitted: A staffing request has been submitted to recruit to the vacant Band 4 HR Officer post. If approved and successfully recruited to, this will provide additional operational capacity and reduce pressure across the team. These actions will help to strengthen controls; however, their impact will depend on successful implementation and recruitment. The underlying risk relating to capacity and increasing case complexity remains until these mitigations are fully embedded.			

Strategic Risk 4

BAF Risk SR4	If the Trust has a lack of financial sustainability, this may result in the destabilisation of the organisation and an inability to meet our objectives.		
Strategic Objective:	3. Using our resources wisely: We deliver effective and sustainable services		
Accountable Director	Chief Financial Officer	**Initial Risk Score**	8 (L2xC4)
		Current Risk Score	12 (L3xC4)
Oversight Committee	Finance & Performance Committee	**Target Risk Score**	4 (L2xC2)
Risk Appetite	Cautious	**Target Date:**	31 March 2027

Controls in place

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

Details of Assurance

Assurance Rating: **Partial**

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

Gaps in assurance / controls:

- No agreed plan for the 2026/27 recurrent budget £13.6m CIP
- SSL contract deficit

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress
Confirmed schemes detailing how the Trust will achieve the 2026/27 recurrent budget £13.6m CIP	Deputy Director of Finance	31 March 2027	Targets have currently been given to services and departments, schemes are being worked up

Contributory risks at level 12 or above

Ref	Description	Lead / Responsible Director	Oversight Group	Score
651	Failure to achieve ongoing recurrent budget CIP requirements and demonstrate efficient and effective care will lead to a deterioration in the financial position.	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	16 (L4xC4)
949	Changes to the capital funding regime may impact on the ability to secure sufficient capital (CDEL) allocations to deliver our long-term capital planning objectives, including reprovision of PFI. Capital resources are allocated to each ICS to help address ICS priorities, there is a risk that LYPFT capital requests may not be prioritised in the context of the other ICS priorities. The operational methodology used for allocating capital resources between organisations may not benefit LYPFT and be lower than historic planned levels. The Health & Social Care bill introduced a requirement to manage within capital allocations, however there is a risk that other system partners do not.	Deputy Director of Finance / Chief Financial Officer	Financial Planning Group	12 (L3xC4)
1148	Out of Area Placement expenditure increasing threatening the financial sustainability of the Trust	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	16 (L4xC4)
869	Reliance on non-patient income e.g. Commercial & Interest Receivable	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	12 (L4xC3)
649	The impact of financial risk share agreements linked to Provider Collaboratives	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	12 (L3xC4)
1325	Risk that the EPR system cost substantially more than the current EPT system when it is renewed	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	12 (L3xC4)
1326	Financial cost and impact of exiting the PFI	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	12 (L3xC4)

Strategic Risk 5

BAF Risk SR5	If the Trust is unable to provide adequate working and care environments, then it may be unable to deliver safe and effective services.		
Strategic Objective:	3. We deliver effective and sustainable services		
Accountable Director	Chief Financial Officer	**Initial Risk Score**	8 (L2xC4)
		Current Risk Score	12 (L3xC4)
Oversight Committee	Finance & Performance Committee	**Target Risk Score**	4 (L2xC2)
Risk Appetite	Open	**Target Date:**	31 March 2028

Controls in place

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

Details of Assurance

Assurance Rating:	**Partial**

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

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

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress

Extreme heating feasibility studies to be undertaken and costed and taken to CEG for discussion.	Deputy Director of Estates and Facilities	31 October 2026	Some works have progressed but deferred to October 2026 due to information that is now available on the PFI sites in relation to liability.
Health and Safety Audits to be completed on all the Trusts owned, leased and PFI Estate, on a periodic basis.	Head of Health and Safety	31 October 2026	This is a rolling programme to satisfy HSE requirements and to assure ourselves of our environment safety. - 2024/25 schedules complete. - 2025/26 underway. - 2025/26 complete – to be re-reviewed during next year
Security Risk Assessments to be conducted on all the Trusts owned, leased and PFI Estate and to be completed on a periodic basis.	Trust Security Manager	31 December 2026	All buildings will be risk assessed across both physical and infrastructure security by the Trusts Security Team in accordance with the agreed schedule. This is a rolling programme; 2024 Risk Assessments are complete 2025 Risk Assessments are complete following appointment of new Security Manager 2026 next assessments are scheduled
PFI Joint Steering Group	Deputy Chief Executive / Chief Financial Officer Deputy Director of Estates and Facilities	August 2028	Quarterly meetings are maintained, and extraordinary meetings take please where required. Overseen by Exec level directors at respective organisations. Clear agenda with specific focus on business as usual, strategic projects and PFI Demise. This group now has oversight of PFI demise.
PFI LYPFT Concession Group	Deputy Chief Executive / Chief Financial Officer Deputy Director of Estates and Facilities	August 2028	Regular meeting are in place meeting every 2-3 months with a master overarching programme. Formal updates and reports provided for assurance or to seek appropriate support. The workplans are supported by legal reviews and under guidance from the NISTA (formally known as IPA)
PFI Joint Demise Group	Deputy Chief Executive / Chief Financial Officer Deputy Director of Estates and Facilities	August 2028	Established in May 2024 under formal remit set out in Terms of References – a joint working group operationally managing crucial elements of the PFI Demise and reporting into the PFI Joint Steering Group, key features include; - Leases Expiry - Condition Survey - Documentation / Operating Manuals - Formal reporting and monitoring is provided to the Joint Steering Group as well as a Joint Demise Action Plan.

PFI LYPFT Monthly Contract / Performance Monitoring Meetings	Deputy Director of Estates and Facilities	August 2028	Monthly meetings continue to progress with all parties including Mitie FM. Reports are provided to the PFI JSG and will be reviewed for effectiveness ahead of the PFI Demise and to ensure 'Business as Usual' assurance is provided in alignment to the Demise Plans.
Green Steering Group	Deputy Director of Estates and Facilities	31 October 2026	Heat decarbonisation plans have been produced to help inform route to net zero and capital requirement – detailed feasibilities required to identify deliverability element. Green Steering Group continue to meet, Net Zero risk remains as a 12 but will be reviewed over the next few months to ensure it is suitably scored.
Fire Safety Group – effectiveness reporting to oversight groups	Deputy Director of Estates and Facilities	31 August 2026	Continue to priorities at Health and Safety Group / Audit Committee / Fire Safety Group. Score of 15 to be wholistically reviewed in summer of 2026.

Contributory risks at level 12 or above

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

Strategic Risk 6

BAF Risk SR6	If the Trust has insecure, inadequate and poorly utilised digital technologies, then there is a risk the quality and continuity of services and regulatory conformity is compromised, and there may be a failure to identify and take opportunities for future innovation and transformation.		
Strategic Objective:	3. We deliver effective and sustainable services		
Accountable Director	Medical Director	**Initial Risk Score**	12 (L3xC4)
		Current Risk Score	12 (L3xC4)
Oversight Committee	Finance & Performance Committee	**Target Risk Score**	4 (L2xC2)
Risk Appetite	Open	**Target Date:**	31 March 2027

Controls in place

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

Details of Assurance

Assurance Rating:	**Partial**

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

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

Mitigating actions underway for controls and assurance:

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

			being reviewed. Engagement planned to understand barriers across nonclinical areas. EPR Programme will also support this action as we evolve and mature through the programme startup
Continued Engagement with Digital Leeds and ICB regarding support around digital literacy.	Chief Digital Information Officer	31 March 2027 (ongoing process)	Discussions taken place across the ICS and city footprint via CIO and digital leadership groups and meetings. Engaged in discussions regarding support and sharing of knowledge and understanding however direct influence over shared ideas is small and programme being owned/delivered by the local Authority. West Yorks CIO digital Council reconvened and sharing regional digital intent and ICB support. Work to drive a Leeds specific view continues, with regular engagement across LYPFT and LCH beginning to explore opportunities associated with the planned merger as well as meetings with LTHT CIO. West Yorkshire Mental Health CIO's network continues to meet, share and discuss potential for collaboration across the system on digital literacy.
Deliver cyber communications plan with target on delivering messages and examples of phishing relating to key annual milestones, religious festivals, significant holidays, return to school etc.	Head of Cyber and Networks	31 March 2027 (ongoing process)	Comms completed and delivered against a number of themes, including broader awareness session to further support the most recent internal Phishing exercise. Continual process and subject matters continue to evolve and flex with need. A new schedule of themes is being developed with the intent to share a single message across LYPFT and LCH. Phishing exercises continues and targeted communications and training identified for those staff members who fall for the Trust led phishing campaigns
Clinical and Care Service Engagement and involvement throughout EPR scoping, specification and procurement cycle to support views on functional requirements to support future uptake and adoption of a new EPR	Chief Digital Information Officer	30 November 2026 (ongoing process throughout EPR Procurement)	LYPFT stakeholder events to finalise high level specification complete. Work underway to expand agreed high level functional specification to cover aspects of LCH care provision that are outside the traditional mental health delivery spec, sexual health services and 0-19 servies. Procurement now focused on delivering a single EPR for the future integrated organisation. Additional soft market engagement undertaken to expand review of functionality and inclusion of LCH digital colleagues ahead of more focused pre0market engagement.

Delivery of EPR functional requirements outside of CareDirector to support emerging need to support clinical pathways and mitigate potential areas of clinical risk and patient safety.	Chief Digital Information Officer	31 December 2026 (ongoing process until EPR replacement)	Enhanced Therapeutic and Observations Care (ETOC) functionality delivered to support care services. Work underway with care services to understand additional observation requirements. Further work to begin to review opportunities, impact and requirements associated to merger and the requirement of a single EPR procurement Review of complementary systems to support areas of development that CareDirector cannot deliver against continues in line with integration and interoperability requirements to ensure ability to review and report on all data. OpenEHR environment created. ARCHETYPES under review to support application development for recording of observations
Usability reviews and NHS APP integration a fixed requirement for patient portal procurement and deployment	Chief Digital Information Officer	31 March 2027 (ongoing process)	NHS App integration dependent upon appointment management through portal, conversations ongoing with national team regarding questionnaire-based app integration. The appointment management module needs to be further investigated and may require operational changes in how CareDirector is used. Meetings are underway with the supplier and the national WayFinder programme regarding integration with the NHSApp Engagement and service review beginning to determine requirements and delivery of appointment management for ADHD services. This is a direct patient portal review and NHS App integration, whilst being discussed and reviewed, will follow.

Contributory risks at level 12 or above

Ref	Description	Lead / Responsible Director	Oversight Group	Score
105	The danger of a cyber-attack to the Trust's ICT infrastructure through malicious hacking or system virus infection.	Chief Digital Information Officer / Chief Financial Officer	Digital Steering Group	12 (L3xC4)
1223	Advanced will not continue to make the same levels of investment in the growth of CareDirector v6. Going forward Advanced have committed to continue to maintain and support CareDirector v6 for the duration of customers current contract term, but the roadmap will be adjusted to only focus on essential maintenance activities and key legislative/security work.	Chief Digital Information Officer / Chief Financial Officer	Digital Steering Group	16 (L4xC4)

Strategic Risk 7

BAF Risk SR7	If the Trust fails to respond to changes in population growth and presentation, and changing delivery models such as Neighbourhood Health, then there is a risk of potential harm to patients due to long waits, an inability to strengthen equity of access, additional pressure on staff, financial consequences and poor performance as measured through the National Oversight Framework.		
Strategic Objective:	1. Through our care services: We deliver great care that is high quality and improves lives		
Accountable Director	Chief Operating Officer	**Initial Risk Score**	12 (L3xC4)
		Current Risk Score	12 (L3xC4)
Oversight Committee	Finance & Performance Committee	**Target Risk Score**	6 (L2xC3)
Risk Appetite	Seek	**Target Date:**	31 December 2027

Controls in place

- Care service governance structure and framework in place to monitor and plan service delivery and development and report ward-to-board and board-to-ward
- Care Services Strategic Plan
- Operational planning and prioritisation process
- Trust's People Plan
- Quality Strategic Plan
- Working in partnership with the ICB in relation to marginalised communities
- Contribution to and delivery of the Leeds Health and Wellbeing Strategy 2023 to 2030
- Member of the Leeds Health and Care Partnership
- Partnership with other NHS organisations and community groups across our service delivery areas
- Improving Health Equity Strategic Plan 2025/26 and related action plan
- Care Services Priorities Leadership Collective governance reporting arrangements
- Community Mental Health Transformation Programme
- Community Mental Health Redesign Programme including the design with partners of the Neighbourhood model project work
- Reducing Mental Health ED Attendances and Delays Programme
- Inpatient Quality Transformation Programme
- Programme of work to reduce Length of Stay
- Utilisation of population health information in the planning and design of services
- EHIA tool
- Out of Area Placement programme to ensure people are appropriately placed according to their need
- Care Services Finance and Performance governance and reporting arrangements in place
- Agreed reporting metrics at Service Line and Directorate-wide level
- COO report including reporting on performance, priorities and service delivery
- Waiting List Management Process in place
- Business Continuity Management System in place
- Business Continuity Plans

Details of Assurance

Assurance Rating:	**Partial**	
Management / Service Level	**Review Process / Oversight**	**Independent (external / internal audit)**
- Chief Operating Officer governance structure and reporting framework	- Assurance reports, discussion and actions relating to governance groups including:	- Audit Yorkshire – internal audit programme & reports

- Care Services Strategic Plan implementation programme - Annual planning, monitoring and delivery framework - Business planning process - Update on delivery of the Trust's people Plan - Update on delivery of the Quality Strategic Plan - Waiting times monitoring process - Protected characteristics monitoring - Workforce monitoring reports - Reduction in restrictive practice workstream - Capacity and flow programme - EPRR monitoring compliance with Business Continuity management system - Care Services Finance and Performance governance and reporting arrangements - Care Services Priorities governance and reporting arrangements	o Board of Directors o Finance & Performance Committee o Mental Health Legislation Committee o Workforce Committee o Quality Committee o Executive Risk Management Group o Care Services Development and Delivery Group o Care Services Finance and Performance Group o Care Services Priorities Leadership Collective o ICB MH Population Board o Improving Health Equity Strategic Plan 2025/26 to Quality Committee o IHE Year One action plan to Quality Committee - Chief Operating Officer reports to Board and F&P - Annual Service Quality Reports - CSDDG Annual Report	o Business Continuity (significant assurance) August 2023 o Business Planning (significant assurance) May 2024 o Waiting List Management (significant assurance) June 2024 o Health Equity (significant assurance) February 2026 o Performance Delivery (significant assurance) June 2026 - Contract meetings and monitoring - Provider Collaborative Framework - Community Mental Health Transformation Partnership Board

Gaps in assurance / controls:	- Compliance with Business Continuity Management System - Update of the Care Services Strategic Plan to take account of changes in the way to Trust operates and new NHSE guidance - Further strengthening of the reporting on and monitoring of the NOF metrics

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress
Compliance with the Business Continuity Management system	EPRR Lead	31 May 2027	Work is ongoing to ensure all relevant services have a business continuity plan and that these are regularly reviewed within relevant governance groups and evidence of this is provided to the EPRR Team. It is anticipated that all Care Services Teams will have a business continuity plan by the end of October 2025. All Corporate Services Teams will have a plan by May 2026 (Corporate Business Plans support the delivery of Care Services).
Care Services Strategic Plan appendices to be updated by service lines	Chief Operating Officer	31 October 2026	The review of the strategic plan is underway in line with the 10-year plan and the new planning framework and guidance. It is anticipated that the CSSP will be completed in 2026.
Further strengthening of the reporting on and monitoring of the NOF metrics	Deputy Director for Operations	31 July 2026	Review the metrics and how these are monitored within the Care Services governance and reporting structure – review dashboards reported at Service Line and CS Finance and Performance Group,

Contributory risks at level 12 or above

Ref	Description	Lead / Responsible Director	Oversight Group	Score
92	The current level of demand for the gender service is greater than planned level of activity, resulting in a lengthy waiting list for assessment and treatment. In addition, due to the child and adolescent service closure, there are further increasing numbers of transfers from the child and adolescent services which is impacting upon waiting times to access the service for all. This presents a potential risk to service user mental and physical health, due to the inability to access care in a timely way.	Operational Manager for the Gender Service	Care Services Delivery and Development Group	12 (L4xC3)
997	Delays in Mental Health Act assessments (relating to access to beds and access to S12 approved medical staff or AMHPs) may result in delayed admission to hospital when required and risk to service users.	Head of Mental Health Legislation	Mental Health Legislation Operational Steering Group	12 (L3xC4)
1101	West Yorkshire GPs are declining Connect blood requests for physical health monitoring under instruction from the West Yorks LMC that states eating disorder blood monitoring is not mandatory for GPs. Connect are not commissioned to provide phlebotomy services and do not have access to the necessary systems for requesting and monitoring bloods. This presents a potential risk to service user physical health, due to the inability to access care in a timely way.	CTM	Care Service Delivery and Development Group	12 (L3xC4)
1212	Delayed service user transfer from LTHT to LYPFT inpatients. This has resulted in service users requiring mental health admission remaining in medical beds in LTHT for significant periods of time. There is a potential risk to service users due to not receiving timely and skilled mental health interventions. Additionally, there is a risk to other patients in LTHT and to staff.	CTM	Capacity and Flow Group	12 (L3xC4)
1213	Increased risk of Leeds Service Users being inappropriate sent out of area for care and treatment because of reduced flow across our inpatient services.	Head of Operations	Capacity and Flow Group	16 (L4xC4)
1260	The risk of new and emerging pandemics, as shown by COVID19, could have a devastating impact on society and a direct impact on how the Trust continues to provide services.	EPRR Lead	EPRRG	12 (L3xC4)
1270	ADHD waiting list of 4,700 plus patients for diagnostic assessment, 100 minimum patients added to list each month, waiting time for new non-urgent assessments of 10 years minimum, likely far longer. This presents a potential risk to service user mental health, due to the inability to access care in a timely way.	Operational Manager	Care Service Delivery and Development Group	12 (L4xC3)
1271	Patient waiting times for ADHD medication initiation presents a risk to patients due to a delay in medication commencing.	Operational Manager	Care Service Delivery and Development Group	12 (L4xC3)
1289	Physical health team are experiencing caseload and capacity issues and are unable to provide the level of service to meet service user need.	CTM	Care Service Delivery and Development Group	12 (L4xC3)
1343	Increase in violent incidents within the S136 suite increasing risk of harm to service users and staff, risk that the current control of closing a bed risk increased attendances to the LTHT A&E department	Head of Operations	Care Service Delivery and Development Group	12 (L4xC3)
1404	There is currently a significant wait for access to speech and language therapy input for the Learning Disability Service, with 60+ service users waiting for input that are deemed high need based on initial screening. Currently the wait time is 33 weeks for high priority cases. The majority of the referrals rated as high are for dysphagia which holds a significant risk if not assessed and appropriate advice given.	Clinical Lead	Care Service Delivery and Development Group	15 (L3xC5)

1412	Long waits for the ME/CFS Service. The potential impact on patient care, treatment and experience. Risk of deterioration in patient presentation/condition due to backlog. Risk related to referrers- due to length of time on duty desk, referrers are not aware if a referral has been accepted or not along with not receiving early information regarding sign posting to other services/offering guidance where needed.	Operational Manager	Care Service Delivery and Development Group	12 (L4xC3)

Strategic Risk 8

BAF Risk SR8	If the Trust fails to address the inequalities built into its own systems and processes, there is a risk that we are inadvertently delivering unfair access or care and exacerbating inequalities in health outcomes within some cohorts of the population.		
Strategic Objective:	1. Through our care services: We deliver great care that is high quality and improves lives		
Accountable Director	Chief Operating Officer	**Initial Risk Score**	12 (L3xC4)
		Current Risk Score	12 (L3xC4)
Oversight Committee	Finance & Performance Committee	**Target Risk Score**	6 (L2xC3)
Risk Appetite	Seek	**Target Date:**	31 December 2027

Controls in place

- Care service governance structure and framework in place to monitor and plan service delivery and development and report ward-to-board and board-to-ward
- Improving Health Equity governance arrangements in place
- Care Services Strategic Plan
- Annual operational planning and prioritisation process
- Quality Strategic Plan
- Contribution to and delivery of the Leeds Health and Wellbeing Strategy 2023 to 2030
- Member of the Leeds Health and Care Partnership
- Working in partnership with the ICB in relation to marginalised communities
- Partnership with other NHS organisations and community groups across our service delivery areas
- Work to look at inequalities in relation Restrictive Practices and their reduction
- Community Mental Health Transformation Programme
- Utilisation of population health information in the planning and design of services
- EHIA tool
- Improving Health Equity Strategic Plan 2025-2029 and implementation plan
- PCREF Action Plan 2024-2027
- 'Must do' work on EDS, PCREF and Equality Act duties
- Care Services Finance and Performance Meeting and agreed reporting metrics
- Improving Health Equity Steering Group
- Equality & Health Inequality Impact Assessment Process
- Improving Health Equity Strategic Plan 2025/26
- IHE Year One action plan

Details of Assurance

Assurance Rating:	**Partial**	
Management / Service Level	**Review Process / Oversight**	**Independent (external / internal audit)**
- Chief Operating Officer governance structure and reporting framework - Care Services Strategic Plan implementation programme - Annual planning, monitoring and delivery framework - Business planning process - Update on delivery of the Quality Strategic Plan	- Assurance reports, discussion and actions relating to governance groups including: o Board of Directors o Finance & Performance Committee o Mental Health Legislation Committee o Workforce Committee o Quality Committee	- Audit Yorkshire – internal audit programme & reports o Health Equity (significant assurance) February 2026 - Contract meetings and monitoring - Provider Collaborative Framework - Community Mental Health Transformation Partnership Board

- Waiting times monitoring process - Protected characteristics monitoring - Reduction in restrictive practice workstream - Monitoring of the ethnic mix of detained patients and those who access our service - Capacity and flow programme - Equality & Health Inequality Impact Assessment Process - Annual delivery of the Equality Delivery System and subsequent Action plans	o Executive Risk Management Group o Care Services Development and Delivery Group o Care Services Finance and Performance Group o Improving Health Equity Steering Group o ICB MH Population Board o Improving Health Equity Strategic Plan 2025/26 to Quality Committee o IHE Year One action plan to Quality Committee o Patient Carer Race Equality (PCREF) Working Group o Synegi Core Group on Racial Equity o EDI Strategic Group. - Chief Operating Officer reports - Annual Service Quality Reports - CSDDG Annual Report - WREN / DAWN / Rainbow Group	- Leeds and Yorks, Health Inequality Oversight Group (HIOG) - Leeds City Council Health and Wellbeing Scrutiny Committee - NHSE National PCREF Oversight Group - DHSC National Advanced Choice Documents Implementation Group

Gaps in assurance / controls:	- Health Equity indicators and metrics - Health Equity training - Review and map ill health prevention to identify areas where health equity can be strengthened - Support services to develop IHE goals and plans - Develop a record of equity focused quality improvement projects and initiatives

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress
Agree an initial health equity indicators and metrics.	Head of Health Equity	31 July 2026	The annual report includes Health Inequalities metrics as stipulated under the NHS England statement on Health Inequalities. The Health Equity Data Group last met May 2026. BI Team currently adding the Health Equity Index measures onto the Improving Health Equity Data Dashboard. This will be a rolling 4 quarters Health Equity report by ethnicity, deprivation, detention rates and restrictive practices.
Commission and support delivery of the Advancing Mental Health Equity collaborative training for LYPFT.	Head of Health Equity	31 July 2026	Business case completed but put on pause. The new Culture Oversight and Delivery Group will commence in June and will have responsibility to review the culture development work.
Review and map ill health prevention to identify areas where health equity can be strengthened .	Higher Trainee (ST5) in Old Age Psychiatry	31 October 2026	Work is underway to map out all the work that is required to ensure all elements of the physical health pathway are understood and working optimally and will seek to reduce variation. This will then be implemented with a Trust physical health strategy.
Provide direction and guidance for services as they develop their IHE goals and plans.	Director of Public Health / Head of Health Equity	31 September 2026	HE Fellowships completed to drive improvement across our services and help teams to consider equity priorities and how we measure equity. Data Working Group established and will enable stakeholders to explore the linkage of the Quality and Equity Dashboards. Continued work to focus on our mandatory reporting alongside key metrics created on a bi-annual report

			to be created using partnership data and published externally to aid consistency and partnership working particularly on Patient Carer Race Equality Framework (PCREF).
Record in one location the full range of equity focused quality improvement projects and initiatives at the Trust.	Head of OD and Culture / OD Team	31 July 2026	The Organisational Development (OD) team has produced an overview of the culture development work we have within the Trust. The new Culture Oversight and Delivery Group will commence in June and will have responsibility to review the culture development work. New development requests will come to this group for a decision and will go up to the People Group for approval. We can also use this mapping work as part of the People and Culture transition workstream when sharing our work with Leeds Community Healthcare.

Contributory risks at level 12 or above

Ref	Description	Lead / Responsible Director	Oversight Group	Score
	There are no contributory risks for Health Equity rated 12+			

Strategic Risk 9

BAF Risk SR9	If the Trust cannot adequately engage in, influence and adapt to the significant changes that are taking place within NHSE/DHSC, the West Yorkshire ICB and the Trust Integration programme with LYPFT, then there is a risk that the Trust is unable to deliver on its medium-term plan		
Strategic Objective:	1. Through our care services: We deliver great care that is high quality and improves lives **3.** Using our resources wisely: We deliver effective and sustainable services		
Accountable Director	Chief Executive	**Initial Risk Score**	8 (L2xC4)
		Current Risk Score	8 (L2xC4)
Oversight Committee	Board of Directors	**Target Risk Score**	3 (L1xC3)
Risk Appetite	Seek	**Target Date:**	1 April 2027

Controls in place

- Trust strategy and priorities that consider multiple complex changes, including Trust integration
- Developed and sustained system partnerships
- Ability to adapt and collaborate
- Care Services Strategic Plan
- Annual operational planning and prioritisation process
- Trust's People Plan
- Quality Strategic Plan
- Working in partnership with the ICB
- Partnership with other NHS organisations
- Engagement in Leeds Provider Partnership Joint Committee (Shadow Form for 2026/27)
- Engagement in Leeds Committee of the West Yorkshire ICB

Details of Assurance

Assurance Rating:	**Partial**

Management / Service Level	**Review Process / Oversight**	**Independent (external / internal audit)**
- Annual planning, monitoring and delivery framework - Business planning process - Transition Steering Group - Trust Integration Programme	- Assurance reports, discussion and actions relating to governance groups including: o Board of Directors o Finance & Performance Committee o Mental Health Legislation Committee o Workforce Committee o Quality Committee o ICB MH Population Board - Assurance reports to Transition Committee from Transition Steering Group - AAA reports from Transition Committee to the Board of Directors	- Audit Yorkshire – internal audit programme & reports - Contract meetings and monitoring - Provider Collaborative Framework - Partnership Leadership Team Meetings - Leeds Provider Partnership Joint Committee - Leeds Committee of the West Yorkshire ICB

Gaps in assurance / controls:	- Significant degree of change in the system (health and care environment)

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress

Approval of the Strategic Outline Case by NHS England for the Trust integration with Leeds Community Healthcare NHS Trust	Chief Executive	3 June 2026	COMPLETE – rating of Amber provided for the integration programme following review of the Strategic Outline Case
Trust Board of Directors approval of the Leeds Provider Partnership Joint Committee: - Terms of Reference - Collaboration Agreement	Chief Executive / Associate Director of Corporate Governance	25 June 2026	COMPLETE - documents circulated for discussion within Private Board of Directors meeting and approved
Submission of the Full Business Case to NHS England for the integration with Leeds Community Healthcare NHS Trust	Chief Executive	30 September 2026	Work underway with Deloitte to deliver the Full Business Case, including Patient Benefit Case and opportunities for integration This is to include the response to the recommendations from the rating for the Strategic Outline Case from NHS England.
Delivery of the Trust Integration Programme for the transaction process to be successfully and safely delivered on Day One	Chief Financial Officer	1 April 2027	Trust Integration Programme in place, with two launch workshops completed and workstream programme plans in place

Contributory risks at level 12 or above

Ref	Description	Lead / Responsible Director	Oversight Group	Score
Please refer to Transition Programme Risk Register for further detail				

Risk Appetite	Strategic Risk

Minimal	**SR1: Quality including Safety Assurance Processes** Delivering high quality services and care is core to the organisation's aims, objectives and ambition, however the Trust will avoid risk which compromises the delivery of high quality and safe services, and jeopardises compliance with our statutory duties for quality and safety or meeting our regulatory compliance requirements. It recognised that ultra-safe for one patient group could be risky for another patient group and that the avoidance of risk would never allow for improvements to be made. The importance of counter balancing risks at patient level and Trust level is acknowledged.
Cautious	**SR2: Delivery of the Quality Strategic Plan** The Trust has a cautious risk appetite for the delivery of the Strategic plan and will consider new opportunities to deliver solutions to support the achievement of the key areas within the Plan. This includes a Patient Portal and Quality and Culture Dashboard, utilising technology to support the delivery of this, whilst considering any associated risks. The Trust has a cautious risk appetite for the development and embedding of the Quality Strategic Plan and recognises that strengthening organisational capability for continuous improvement requires ongoing learning, collaboration, innovation and organisational change. The Trust is willing to support new approaches that strengthen leadership, culture, quality insight, improvement capability and organisational learning, including the use of digital and data-enabled solutions, while remaining cautious where changes may adversely impact the quality, safety or experience of care.
Cautious	**SR3: Culture and environment for the wellbeing of staff** The Trust has a cautious risk appetite to providing a rewarding and supportive place to train and work and recruiting and retaining the best staff. The Trust acknowledges the need to support staff through change management and innovative changes to our care delivery models therefore is open to risks associated with the implementation of new models of working, however will avoid risk compromising patient or staff safety.
Cautious	**SR4: Financial sustainability** Our appetite for financial risk is cautious. We continually aim to deliver our services within the budgets set out in our financial plans and will consider accepting risks that may result in limited financial impacts or losses on the basis that there may be opportunities elsewhere within the Trust. We will ensure that all such financial responses deliver optimal value for money.
Open	**SR5: Adequate working and care environments** The Trust is open to delivering our vision to make the best use of our most modern and fit for purpose estate, in line with our Estates Strategy. This includes offering the most appropriate therapeutic environment for our service users, and ensuring efficiency and effectiveness of use for our workforce to deliver care.
Open	**SR6: Digital technologies** The Trust is open to ensuring secure and adequate digital technologies being utilised across the organisation. It recognises the importance of making the best use of data to inform and increase our understanding of our population to provide insight into the best way to provide care. The long-term Digital Plan aims to use innovative technology and intelligence to enable safer, inclusive and more effective care. We will avoid risks that increase our exposure to cyber-fraud or incidents
Seek	**SR7: Demand for Services** The Trust would actively seek opportunities to respond to the changing needs of the population, and consider service model requirements to address this. It is actively considering and changing delivery models to support approaches such

	as Neighbourhood Health. Whilst the Trust acknowledges the risk of patient harm, it would seek opportunities to improve performance and any impact on the financial position, as it is for the Patient Flow Programme.
Seek	**SR8: Health Inequalities** The Trust has an open risk appetite for collaboration with people and communities to ensure their experience influences equitable approaches, acknowledging that people who need help for their mental health, people with learning disabilities and those with neurodiversity conditions endure inequalities which affect their health and lives. We are committed to co-designing, co-producing and co-delivering proactive and integrated care and support through our care services.
Seek	**SR9: System Change** The Trust is progressing the integration programme with Leeds Community Healthcare NHS Trust, and seeking opportunity to align and deliver services to better suit the population of Leeds, and wider, through this process, both operationally and financially. The Trust is actively engaged in the wider system working with the Leeds Provider Partnership, and across West Yorkshire and Yorkshire and Humber, to understand the opportunity to align to the future plans of the NHS and consider the implications for the services offered by the Trust.

3 Conclusion

The BAF demonstrates the key strategic risks for the organisation, and the controls and assurance have been updated to reflect the levels of assurance, with actions detailed on further work to be taken.

The document will be updated as per established governance and oversight processes, with links to the identified oversight committees.

4 Recommendation

The Board is asked to:

- Receive the BAF and to be assured of the review that has been undertaken to ensure that this accurately reflects the position for 2026/27, including risk scoring and mitigating actions.

Clare Edwards
Associate Director for Corporate Governance & Board Secretary
14 July 2026

Agenda item
20

Meeting of the Board of Directors

Paper title:	Approval of changes to the Reservation of Powers to the Board of Directors and Council of Governors and Schedule of Decisions/Duties Delegated by the Board of Directors (known as The Scheme of Delegation)
Date of meeting:	30 July 2026
Presented by: (name and title)	Dr Sara Munro, Chief Executive Officer
Prepared by: (name and title)	Kerry McMann, Head of Corporate Governance

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

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

Executive summary

The Board is required to approve changes to the document '*Reservation of Powers to the Board of Directors and Council of Governors and Schedule of Decisions/Duties Delegated by the Board of Directors'* (known as The Scheme of Delegation).

The Scheme of Delegation has been reviewed by the Head of Corporate Governance on behalf of the Board. The Head of EPRR, Assistant Director of Finance and Mental Health Legislation Team Leader have also reviewed their relevant sections.

The proposed changes are set out below for consideration and approval. The changes are also highlighted within the document.

- Section two (portfolios of executive directors) – directorate functions updated to reflect the lists that were approved at the Extended Executive Management Team meeting on 15 April 2026.
- Section three (reservation of powers to the Board of Directors) – amendment to 6.1 to reflect the Board's responsibilities in relation to approving the EPRR and Business Continuity Policy.
- Section nine – name of organisation updated from Community Links to Inspire North.
- Section ten – committee responsibilities amended so they reflect what is outlined in the relevant terms of reference.
- Throughout the document – references to NHS Improvement updated.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? If yes please set out what action has been taken to address this in your paper.

No.

Recommendation

The Board is asked to review and approve the proposed changes to the Scheme of Delegation.

Leeds and York Partnership
NHS Foundation Trust

Reservation of Powers to the Board of Directors and Council of Governors

and

Schedule of Decisions/Duties Delegated by the Board of Directors

Responsible: Chief Executive
Prepared by: Head of Corporate Governance
Ratified by: Board of Directors
Date: July 2026
Next review: July 2028

CONTENTS

SECTION 1 – INTRODUCTION

NHS England's Code of Governance for NHS Provider Trusts (October 2022) requires there to be a formal document setting out the Reservation of Powers to the Board of Directors and a Schedule of Decisions/Duties Delegated by the Board of Directors.

The purpose of this document is to define those powers specifically reserved to the Board of Directors, while at the same time detailing those delegated to the appropriate level. However, the Board of Directors remains accountable for all of its functions, including those delegated to the Chair of the Trust, individual directors or officers in the Trust, and will establish ways in which it will receive information about the exercise of those delegated functions to enable it to maintain a monitoring role.

All matters which are not reserved for the Board of Directors or delegated to its committees shall be exercised by the Chief Executive. In turn, the Chief Executive will delegate as he/she sees fit to members of the Executive Management Team. All powers delegated by the Chief Executive can be reassumed by him/her should the need arise.

It should be noted (in accordance with the provisions of the emergency Powers Section of Annex 8 paragraph 4.2 of the Constitution that in an emergency the powers that the Board of Directors has retained to itself may be exercised by the Chief Executive and the Chair of the Trust after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and the Chair of the Trust shall be reported to the next formal meeting of the Board of Directors for approval.

This document also includes a schedule of Reservation of Powers to the Council of Governors which is set out in Section 4; and these include those matters for which it has responsibility set out in the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

ABBREVIATIONS USED IN SECTIONS OF THIS DOCUMENT:

- BoD = Board of Directors
- Code of G = Code of Governance
- CoG = Council of Governors
- Const = Constitution
- FP = Financial Procedures
- MHA = Mental Health Act
- SFIs = Standing Financial Instructions
- SO = Standing Orders

SECTION 2 – PORTFOLIOS OF EXECUTIVE DIRECTORS

All the powers of the Trust that have not been retained by the Trust Board or delegated to a committee will be exercised on behalf of the Board by the Chief Executive. They will in turn delegate some of these duties to the executive directors. Below if a high-level list of the duties that fall into each of the portfolios of the executive directors (greater detail of individual responsibilities is set out in directors' job descriptions).

	Directorate functions
Chief Financial Officer and Deputy Chief Executive	• Financial leadership, standards and governance with expert professional advice to the Board of Directors and the Council of Governors • Financial performance delivery • Contracting • Estates and facilities including security management • Commercial activities including the North of England Commercial Procurement Collaborative (NoE CPC). • Supplies and procurement • Internal audit and counter fraud • Health and safety • ~~Informatics and Information Management and Technology~~ • Capital development • Management of the Programme Management Office which oversees the delivery of the Trust's strategic programmes
Director of Nursing and Professions / Director of Infection and prevention and control (DIPC)	• Nursing, social work and AHP leadership, standards, governance and revalidation with expert professional advice to the Board of Directors and Council of Governors • Quality review and assurance • Professional leadership and strategies • Clinical governance • Safer staffing and practice placement facilitation, new professional roles • Risk management including oversight of risk registers and Datix reporting • Serious incident reporting and learning from incidents • Safeguarding children and adults • Infection prevention and control • Physical health • Patient experience and carer involvement • Smoking cessation • Complaints/PALs and claims • CQC compliance • Chaplaincy
Medical Director	• Medical leadership, standards and governance, including revalidation with expert professional advice to the Board of Directors and Council of Governors • Medical education and training (undergraduate and postgraduate)

	Directorate functions
	• Research and development • Improvement & knowledge • Medicines management • Caldicott guardian • Mortality review • Quality review • Compliance with NICE / national clinical standards • Andrew Sims Centre and events management • Accountable for clinical leadership (clinical directors / clinical leads) • Clinical quality supported by others • Mental Health Legislation • Informatics and Information Management and Technology
Chief Operating Officer	• Management and leadership across Care Services • Service Delivery • Resource deployment • Care services financial management • Accountable Emergency Officer with responsibility for Emergency Preparedness, Response and Resilience • Clinical Services Strategic Plan and delivery of service developments • Performance management and delivery of performance standards • Partnership development • Service Integration • Service transformation and development • Quality delivery • Executive lead for health equity • Oversight of performance using National Oversight Framework • Leadership of provider collaboratives • Delivery of services within the West Yorkshire, Humber and North Yorkshire and Regional provider collaborative and partnership arrangements
Director of People and Organisational Development	• Organisational development and ~~HR~~ people function, leadership standards and governance with expert professional advice to the Board of Directors and Council of Governors • Workforce planning and workforce information/systems • Strategic resourcing • Employment practice • Recruitment • Learning and development, including compulsory training • Temporary Workforce, including clinical and non-clinical staff bank • Workforce Equality, Diversity and Inclusion • Employee Engagement, reward and recognition • Employee health and wellbeing, including Occupational Health services • Partnership Working • Workforce data and analytics 10 Year Workforce Plan

SECTION 3 - RESERVATION OF POWERS TO THE BOARD OF DIRECTORS

The Board of Directors must determine those matters on which decision are reserved unto itself. These reserved matters are set out below:

MATTERS RESERVED TO THE BOARD OF DIRECTORS	
General Enabling Provision The Board of Directors shall exercise all powers of the Trust as set out in the NHS Act 2006 (as amended by the Health and Social Care Act 2012), subject to any restrictions by its license, or as delegated in accordance with this Scheme. The Board at a full session may determine any matter it wishes in within its statutory powers.	
1. Regulations and Control	
1.1	Approve the Reservation of Powers to the Board of Directors and Council of Governors, Schedule of Decisions/Duties Delegated by the Board of Directors (BoD SO 4.5).
1.2	Approve the Standing Financial Instructions which set out the responsibilities of individuals (BoD SO 2.5)
1.3	Approve the Standing Orders for the Board of Directors as set out in the Constitution (BoD SO 15.1).
1.4	Suspend Standing Orders pertaining to the Board of Directors BoD SO 3.10).
1.5	Approve variations or amendments to the Constitution (including the Standing Orders) in conjunction with the Council of Governors (Const 44.1.2).
1.6	At the next formal meeting of the Board of Directors ratify any urgent decisions taken by the Chair of the Trust and Chief Executive (BoD SO 4.2)

MATTERS RESERVED TO THE BOARD OF DIRECTORS	
1.7	At any point during discussions at a Board of Directors' meeting require and receive the declaration of interests of any member of the Board of Directors that may conflict with those of the Trust; and determining the extent to which that Board member may remain involved with the matter under consideration (BoD SO 6.6).
1.8	Approval of the format for the Declaration of Interests' form (BoD SO 7.2).
1.9	Determine the independence of the non-executive directors. (Code of G. A.3.1)
1.10	Regularly review and at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services as per the Provider Licence. (SFIs para 7.1)
1.11	Establish and disband the sub-committees that are directly accountable to the Board of Directors (BoD SO 5.1.1)
1.12	Receive reports from its sub-committees including those that the Trust is required to establish and take appropriate action.
1.13	Confirm the recommendations of the Trust's sub-committees where they do not have the power to make such a decision. (Where sub-committees made a decision which is within their delegated power this will be regarded as having been made by the Board of Directors)
1.14	Ratify the terms of reference and reporting arrangements of all sub-committees that are formally established by the Board of Directors (BoD SO 4.3).
1.15	At its next formal meeting receive a report of the application of the Trust seal since the last report to the Board of Directors (BoD SO 11.3.1).
1.16	Ratify, or otherwise, instances of non-compliance with the Board of Directors' Standing Orders and the justification for such non-compliance (BoD SO 4.7)
1.17	Ratify a memorandum of understanding between the Chair of the Trust and the Chief Executive setting out a division of responsibilities, review any modifications to that memorandum (BoD SO 2.6)

MATTERS RESERVED TO THE BOARD OF DIRECTORS	
1.18	Approve the wording of any statement of the Board of Directors pertaining to a dispute between the Council of Governors and the Board of Directors (BoD SO 10.3).
1.19	Decide on whether the Trust will insure through the risk pooling schemes administered by the NHS Resolution (SFIs para 20.2)
1.20	Make any arrangements it considers appropriate to the provision of indemnity insurance or similar arrangements for the benefit of the Trust or directors to meet all or any liability which are properly the liability of the Trust recognising the Public Benefit Corporation status (BoD SO 2.13.2) (SFIs para 20.4)
1.21	Approve any recording by members of the public of any public Board of Directors' meeting (BoD SO 3.2.5).
1.22	Resolve to exclude members of the public from any meeting or part of a meeting (BoD SO 3.1.2)
1.23	Determine that certain matters appear on each agenda of the Board of Directors' meeting (BoD SO 3.4.1)
1.24	Provide permission that governors, directors, officers or any employee or representative of the Trust in attendance at a private meeting or private part of a meeting of the Board of Directors may disclose the contents of the papers or any discussion (BoD SO 3 1.9)
1.25	Send a copy of the agenda of the meeting of the Board of Directors to the Council of Governors (BoD SO 3.4.3)
1.26	Send a copy of the minutes of the public Board of Directors' meeting to the Council of Governors (BoD SO 3.9.5)
1.27	Determine the times and places for the meetings of the Board of Directors (BoD SO 3.2)
1.28	Approval of the Trust's banking arrangements. (SFIs para 5.1.2)
1.29	Approve arrangements relating to the discharge of the Trust's responsibilities as a Corporate Trustee for funds held on Trust
1.30	Approve arrangements relating to the discharge of the Trust's responsibilities as Bailee for patient's monies

MATTERS RESERVED TO THE BOARD OF DIRECTORS	
1.31	Grant delegated authority to the Chair or other directors to carry out actions on its behalf
2. Appointments / Dismissal / Terms and Conditions	
2.1	Ratify any changes to the overall number of non-executive directors and executive directors (BoD SO 2.8).
2.2	Appoint one of the independent non-executive directors as the Senior Independent Director (BoD SO 2.10.4).
2.3	Advise a partner organisation of concerns regarding any individual that an organisation may appoint to the Council of Governors (i.e. an appointed governor) (Const para 11.5).
2.4	Approve the appointment of any advisor to assist or advise the Council of Governors. (Const para 11.6)
2.5	Appoint, discipline and dismiss the Trust Secretary (BoD SO 2.11)
2.6	Consider and approve proposals presented by the Chief Executive for setting remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee. (SFIs 9.1.4)
2.7	Approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service etc for employees. (SFIs para 9.3.2)
2.8	Approve the directors' Code of Conduct
3. Strategy, Business Plans, Budgets and Statutory returns	
3.1	Define and set the aim, goals and strategic objectives of the Trust (i.e. the Trust Strategy).

MATTERS RESERVED TO THE BOARD OF DIRECTORS	
3.2	Approve any supporting (underpinning) strategies (Clinical Services, Estates, IT, Quality, and People Plan). Note: for clarity the approval of all other strategies are delegated to the Executive Management Team to be approved.
3.3	Approve the capital programme (FP 4.3).
3.4	Approve any outline and final business cases for capital investments of £1m or more (or a linked series of projects for which the combined value would exceed £1m).
3.5	Approve any long-term borrowing and ensure this is consistent with the plans outlined in the annual plan (SFIs para 11.2.3)
3.6	Ratify proposals for acquisition, disposal or change of use of land and/or buildings of £1m or more (or a linked series of acquisitions, disposals or change of use of land for which the combined value would exceed £1m)
3.7	Approve any new PFI contract and / or significant changes to PFI contracts (for avoidance of doubt this would include any refinancing agreements).
3.8	Approve proposals in individual cases for the write-off of losses or making of special payments of £500k or more and all those of a novel or contentious nature. (SFIs para 14.2.8)
3.9	Approve the introduction or discontinuance of any significant activity or operation in relation to the Trust. An activity or operation shall be regarded as significant where it is of a novel or contentious nature, or if it has a gross annual income in excess of £1m per annum.
3.10	Approve the introduction or discontinuation of any significant activity or operation relating to the areas of responsibility for those Committees in Common established by the Board, where this has gross annual income or cost to the Trust in excess of £500k per annum.
3.11	Approve the level of non-pay expenditure on an annual basis (SFIs para 10.1.1)
3.12	Approve orders for items of expenditure in respect of service directorate and corporate budgets where the value is for £1m or more. (FP 4.1)
3.13	Approve the Care Quality Commission Registration Declaration.

MATTERS RESERVED TO THE BOARD OF DIRECTORS	
3.14	Approve the Trust's Quality Report.
3.15	Approve any monitoring returns prior to submission to NHS England, ensuring these are submitted at such frequency as is required (SFIs para 3.5.1)
3.16	Approve the Trust's forward plan prior to submission to NHS England, ensuring that it has regard to the views of the Council of Governors
3.17	Receipt and adoption of the Trust's Annual Report and Annual Accounts.
3.18	Where applicable receive recommendations from the evaluation team on matters regarding in-house services that are subject to competitive tendering. (SFIs para 8.9.4)
3.19	Receive reports from the Chief Financial Officer on financial performance against budget and plans.
4. Audit	
4.1	Approve the annual Letter of Representation to the external auditors.
4.2	Receive from the External Auditor any Public Interest Report. (SFIs para 2.4.7)
5. Monitoring	
5.1	Receive such reports as the Board sees fit from sub-committees in respect of their exercise of delegated powers, including an annual report of activities undertaken by the sub-committees
5.2	Continuous appraisal of the affairs of the Trust by means of reports to the Board, in whatever format the Board determines
5.3	Receive performance reports against agreed internal, local, contractual and national targets and standards

MATTERS RESERVED TO THE BOARD OF DIRECTORS	
5.4	Receive and approve key reports as required including reports to and from ~~NHS Improvement~~ NHS England in regard to compliance
6. Emergency Preparedness Resilience and Response	
6.1	Receive and ratify EP-0005 –~~Business Continuity and EPRR Policy and Business Continuity Management System Procedure~~ EPRR and Business Continuity Policy
6.2	Receive and approve the EPRR Annual Report
6.3	Receive and confirm the EPRR assurance declaration annually

SECTION 4 - RESERVATION OF POWERS TO THE COUNCIL OF GOVERNORS

MATTERS RESERVED TO THE COUNCIL OF GOVERNORS	
1.1	Approve changes to the Trust's Constitution in conjunction with the Board of Directors (Const para 44.1)
1.2	Appoint and/or disband the committees that are directly accountable to the Council of Governors and approve their Terms of Reference. (CoG SO 6.1)
1.3	Receive the annual report and accounts and any related auditors' reports. (Const para 41) (SFIs para 4.1.3)
1.4	Appoint or remove the Chair of the Trust and other non-executive directors and decide their remuneration, allowances and other terms and conditions. (Const para 24.1) (SFIs para 9.1.5)
1.5	Approve the appointment of the Chief Executive. (Const para 27.2)
1.6	Appoint the Deputy Chair of the Trust. (Const para 26)
1.7	Appoint or remove the Trust's external auditors. (Const para 37.2) (SFIs para 2.4.2)
1.8	Hold the non-executives, individually and collectively, to account for the performance of the Board (Const para 15.1.1).
1.9	Receive from the External Auditor any Public Interest Report. (SFIs para 2.4.7)
1.10	Require one or more of the directors to attend a meeting to obtain information about the Trust's performance, or information about how the directors have performed their duties in order to determine if there is a need to vote on issues concerning that performance. (CoG SO 4.1.9.2)
1.11	Resolve to exclude members of the public from any formal meeting or any part of a meeting of the Council of Governors (CoG SO 4.1.2)
1.12	Determine times and places of Council of Governors' meetings having regard for the accommodation of the public at those meetings (CoG SO 4.1.7 and 4.1.8)

MATTERS RESERVED TO THE COUNCIL OF GOVERNORS	
1.13	Give permission for governors, directors or officers to disclose the content of a paper or discussion taken in a private meeting of the Council of Governors (CoG SO 4.2.2)
1.14	Determine that certain matters should appear on each Council of Governors' agenda (CoG SO 4.6.1)
1.15	Approve by majority vote the implementation of any proposals to increase by 5% or more the proportion of total income in any financial year derived from non-NHS activities. (Const para 40.7)
1.16	Approve by majority vote entering into a significant transaction (a significant transaction is defined in the Constitution). (Const para 46.1)
1.17	Approve by majority vote an application to NHS England (one of our regulators) for a merger with or the acquisition of another foundation trust or NHS trust. (Const para 45)
1.18	Approve by majority vote an application to ~~NHS Improvement~~ NHS England for the separation and dissolution of the foundation trust. (Const para 45)
1.19	Determine whether the provision of activities other than the provision of goods and services for the purpose of health services in England will to any significant extent interfere with the fulfillment of the Trust's principal purpose (Const para 40.6.1)
1.20	Be consulted on the appointment of the Senior Independent Director. (BoD SO 2.10.4)
1.21	Agree a clear process for the appointment of the Chair of the Trust and the other non-executive directors. (Code of G C.1.4)
1.22	Agree a process for the evaluation or appraisal of the Chair of the Trust and the other non-executives, including the outcomes of the evaluation of the Chair of the Trust and the non-executive directors. (Code of G D.2)
1.23	Receive a report on the outcome of the evaluation or appraisal of the Chair of the Trust or the other non-executive directors, particularly where this is linked to a re-appointment process. (ToR for CoG)

MATTERS RESERVED TO THE COUNCIL OF GOVERNORS	
1.24	Represent the interests of the members of the Trust as a whole and the interests of the public. (Const para 15.1.2)
1.25	At the next formal meeting of the Council of Governors approve any urgent decisions taken by the Chair of the Trust on behalf of the Council of Governors. (CoG SO 5.1)
1.26	Suspend the Standing Orders pertaining to the Council of Governors. (CoG SO 4.13.1)
1.27	Approve the wording of any statement of the Council of Governors pertaining to a dispute between the Council of Governors and the Board of Directors. (CoG SO 10.3)
1.28	Inform NHS England that in the Council of Governors' opinion the Board of Directors has not responded constructively to concerns of the Council of Governors. (CoG SO 10.9)
1.29	Nominate the Lead Governor.
1.30	Approve any recording of a public Council of Governors' meeting by any member/s of the public. (CoG SO 4.1.5)
1.31	Agree the remit of any individual to whom the Council of Governors has delegated responsibility to that individual. (CoG SO 5.3)
1.32	Appoint or disband a sub-committee of the Council of Governors. Agree the Terms of Reference of any such sub-committee and agree the membership and determine the chair of the sub-committee (CoG SO 6.5)
1.33	Authorise the delegation of any powers of a sub-committee to any other committee (CoG SO 6.4)
1.34	Receive any report of non-compliance with Council of Governors Standing Orders at a formal meeting and determine action or ratification (CoG SO 11.1)

SECTION 5 – SCHEDULE OF DECISIONS/DUTIES DELEGATED BY THE COUNCIL OF GOVERNORS AS SET OUT IN ANNEX 7 OF THE CONSTITUTION (The Standing Orders of the Council of Governors)

STANDING ORDER REF	DELEGATED TO	DECISION / DUTY DELEGATED AS SET OUT IN THE STANDING ORDERS OF THE COUNCIL OF GOVERNORS
1.1	CHAIR OF THE TRUST	Final authority in the interpretation of Annex 7 of the Constitution (Council of Governors' Standing Orders) in respect of the Council of Governors.
3.3	CHAIR OF THE TRUST	Has responsibility for the leadership of the Council of Governors.
3.2 and 3.4	CHAIR OF THE TRUST	Has responsibility for chairing the Council of Governors' meetings.
4.1.4	CHAIR OF THE TRUST	May exclude any member of the public from a meeting of the Council of Governors if they are interfering with or preventing the proper or reasonable conduct of that meeting.
4.1.6 & 4.1.10	CHAIR OF THE TRUST	Invite members of the public to ask questions or otherwise participate in a meeting of the Council of Governors.
4.3.1	CHAIR OF THE TRUST	In exceptional circumstances call a meeting of the Council of Governors at any time.
4.3.3	CHAIR OF THE TRUST	Chair any meeting of the Council called by governors
4.3.3	TRUST SECRETARY	Attend any meeting of the Council called by governors
4.4.1	CHAIR OF THE TRUST OR AUTHORISED OFFICER	Sign a notice of business to be conducted at public meetings of the Council of Governors.

STANDING ORDER REF	DELEGATED TO	DECISION / DUTY DELEGATED AS SET OUT IN THE STANDING ORDERS OF THE COUNCIL OF GOVERNORS
4.4.1	CHAIR OF THE TRUST	Agree any agenda papers that are to follow the main agenda and papers going out
4.4.3	CHAIR OF THE TRUST	Waive notice of a meeting of the Council of Governors.
4.4.4	GOVERNORS	Those governors calling a meeting in default of the chair shall sign a notice of business to be transacted at that meeting.
4.5.2	GOVERNORS	Send apologies to the Trust Secretary should they not be able to attend a formal Council meeting
4.6.2	CHAIR OF THE TRUST	Decide if an agenda item received less than 12 days before a meeting will be included on the agenda
4.6.3	CHAIR	Decide those items that are to be on the agenda of the Council of Governors
4.7.1	DEPUTY CHAIR OF THE TRUST	In the absence of, incapacity of, or exclusion of the Chair of the Trust, chair the meetings of the Council of Governors.
4.8.1	CHAIR OF THE TRUST	Include on the agenda all notice of motions received
4.8.2	CHAIR OF THE TRUST	Give a final ruling for requests to permit emergency motions
4.7.3	GOVERNOR	In the absence of, incapacity of, or exclusion of the Chair of the Trust and the Deputy Chair of the Trust, chair the meetings of the Council of Governors.
4.9.1	CHAIR OF THE TRUST	Give a final ruling in questions of order, relevancy and regularity of matters pertaining to governors' statements
4.10.1	CHAIR OF THE TRUST	Have a second or casting vote.

STANDING ORDER REF	DELEGATED TO	DECISION / DUTY DELEGATED AS SET OUT IN THE STANDING ORDERS OF THE COUNCIL OF GOVERNORS
4.11.1	CHAIR OF THE TRUST	Sign the minutes of the meetings of the Council of Governors.
4.11.2	CHAIR OF THE TRUST	To agree where it is appropriate for discussions to take place in respect of the minutes of the meeting
4.13.5	AUDIT COMMITTEE	Review every decision to suspend Standing Orders of the Council of Governors.
5.1	CHAIR OF THE TRUST AND FIVE ELECTED GOVERNORS	The powers which the Council of Governors has retained to itself within these Standing Orders may in emergency be exercised by the Chair of the Trust after having consulted at least five elected Governors.
7.1 and 7.4	GOVERNORS	Declare relevant and material interests
7.7	GOVERNORS	Inform the Trust Secretary within 7 days of becoming aware of a relevant or material interest
8.1 & 8.2	TRUST SECRETARY	Establish and maintain a Register of Interests for Governors.
10.2	CHAIR OF THE TRUST	Endeavour to resolve any dispute between the Council of Governors and the Board of Directors through discussion in the initial stages.
10.3	CHAIR OF THE TRUST	Ensure a draft Dispute Statement is included on the next agenda of the formal meeting of either the Board of Directors or the Council of Governors for approval.
10.4	CHAIR OF THE TRUST	Ensure the approved Dispute Statement is included on the next agenda of the formal meeting of either the Board of Directors or the Council of Governors as appropriate. That meeting shall agree the precise wording of a Response to Disputes Statement.
10.5	CHAIR OF THE TRUST	Communicate the outcome of any Dispute Statement to the other party and deliver the written Response to Disputes Statement.
10.6	CHAIR OF THE TRUST	Communicate to the other party where there is no prospect of full or partial resolution and advise accordingly.

STANDING ORDER REF	DELEGATED TO	DECISION / DUTY DELEGATED AS SET OUT IN THE STANDING ORDERS OF THE COUNCIL OF GOVERNORS
11.2	ALL GOVERNORS AND STAFF	Duty to disclose any non-compliance with Annex 7 of the Constitution in respect of the Council of Governors.
13.2	ALL GOVERNORS	Disclose to the Board Secretary any relationship with a candidate who is applying for any staff appointment within the Trust, when the candidate makes the application. (For clarity "relationship" shall be defined as spouse or co-habiting partner, or close family member).

SECTION 6 – SCHEDULE OF DECISIONS/DUTIES DELEGATED BY THE BOARD OF DIRECTORS AS PER ANNEX 8 OF THE CONSTITUTION (the Standing Orders of the Board of Directors)

STANDING ORDER REF	DELEGATED TO	DECISION/ DUTY DELEGATED AS SET OUT IN THE STANDING ORDERS OF THE BOARD OF DIRECTORS
1.1	CHAIR OF THE TRUST	Final authority in the interpretation of Annex 8 of the Constitution (Standing Orders for the Board of Directors).
1.1	CHIEF EXECUTIVE OR TRUST SECRETARY	Advise the Chair on the interpretation of the Standing Order for the Board of Directors.
2.4.3	CHIEF EXECUTIVE	Overall performance of the executive functions of the Trust.
2.4.4	CHIEF FINANCIAL OFFICER	Provision of financial advice and for the supervision of financial control and accounting systems.
2.4.4	CHIEF EXECUTIVE AND CHIEF FINANCIAL OFFICER	Ensuring the discharge of obligations under relevant Financial Directions.
2.4.6	CHAIR OF THE TRUST	Operation of the Board of Directors and will chair all Board meetings when present.
2.4.7	CHAIR OF THE TRUST	Have responsibility for the induction of the non-executive directors, their portfolios of interests and assignments and their performance.
2.4.8	CHAIR OF THE TRUST AND CHIEF EXECUTIVE	Ensure the Board of Directors discusses key and appropriate issues.

STANDING ORDER REF	DELEGATED TO	DECISION/ DUTY DELEGATED AS SET OUT IN THE STANDING ORDERS OF THE BOARD OF DIRECTORS
2.4.9	CHAIR OF THE TRUST	Leadership of the Board of Directors, ensuring the Board of Directors and Council of Governors work effectively together.
2.10	CHAIR OF THE TRUST AND THE NON-EXECUTIVE DIRECTORS	Appoint the Chief Executive.
2.10	COMMITTEE OF CHAIR OF THE TRUST, NON-EXECUTIVE DIRECTORS AND CHIEF EXECUTIVE	Appoint members of the Executive Team.
3.2.1	CHAIR OF THE TRUST	Call meetings of the Board of Directors
3.1.4	CHAIR OF THE TRUST	Exclude any member of the public from a public Board of Directors' meeting if they are interfering with or preventing the proper or reasonable conduct of the meeting.
3.1.6	CHAIR OF THE TRUST	Decide whether any question from a member of the public will be put to the Board of Directors at a public meeting.
3.3.1	CHAIR OF THE TRUST OR AUTHORISED OFFICER	Sign a notice of business to be conducted at public meetings of the Board of Directors.

STANDING ORDER REF	DELEGATED TO	DECISION/ DUTY DELEGATED AS SET OUT IN THE STANDING ORDERS OF THE BOARD OF DIRECTORS
3.3.1	CHAIR OF THE TRUST	Agree that papers may be sent out late as "to follow".
3.5.1	CHAIR OF THE TRUST	Chair all Board of Directors' meetings.
3.5.2	DEPUTY CHAIR OF THE TRUST	Carry out the role of the Chair of the Board of Directors in the absence of the Chair.
3.5.3	NON-EXECUTIVE DIRECTOR	Chair the Board of Directors' meeting in the absence of both the Chair of the Trust and the Deputy Chair of the Trust.
3.6.1	CHAIR OF THE TRUST	Include on the agenda all notices of motion received.
3.6.2	CHAIR OF THE TRUST	Give final ruling to requests to permit emergency motions.
3.7.1	CHAIR OF THE TRUST	Give final ruling in questions of order, relevancy and regularity of matters pertaining to directors' statements.
3.8.1	CHAIR OF THE TRUST	Have a second or casting vote
3.9.1	CHAIR OF THE TRUST	Sign the minutes of the meeting of the Board of Directors.
3.10.5	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board of Directors)

STANDING ORDER REF	DELEGATED TO	DECISION/ DUTY DELEGATED AS SET OUT IN THE STANDING ORDERS OF THE BOARD OF DIRECTORS
4.2	CHAIR OF THE TRUST AND CHIEF EXECUTIVE AND TWO NON-EXECUTIVE DIRECTORS	The powers which the Board of Directors has retained to itself within these Standing Orders may in emergency be exercised by the Chair of the Trust and Chief Executive after having consulted at least two non-executive directors.
4.4	CHIEF EXECUTIVE	Carry out any function that is not reserved to the Board of Directors or delegated to an executive committee or Board committee.
4.5	CHIEF EXECUTIVE	The Chief Executive shall prepare a Schedule of Decision/Duties Delegated by the Board of Directors and Council of Governors identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
4.7	ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
6.1 & 6.4	ALL DIRECTORS	Declare relevant and material interests and any pecuniary interest in any contract, proposed contract or other matter under discussion by the Board of Directors.
7.1	TRUST SECRETARY	Establish and maintain Registers of Interests in line with the Trust's Declaration of Interest Policy, and the Bribery Act 2010.
7.2	TRUST SECRETARY	Keep the Register of Interests up to date adding new information as received.
9.1	ALL STAFF	Comply with national guidance on standards of business conduct for NHS staff.
9.9	ALL DIRECTORS INCLUDING THE CHAIR OF THE TRUST	Disclose any relationship between themselves and a candidate for staff appointment in line with the Trust's Anti-Bribery Policy and the Bribery Act 2010. (CE or nominated director to report the disclosure to the Board of Directors.) (For clarity "relationship" shall be defined as spouse or co-habiting partner, or close family member).
10.2	CHAIR OF THE TRUST	Endeavour to resolve any dispute between the Board of Directors and the Council of Governors through discussion in the initial stages.

STANDING ORDER REF	DELEGATED TO	DECISION/ DUTY DELEGATED AS SET OUT IN THE STANDING ORDERS OF THE BOARD OF DIRECTORS
10.4	CHAIR OF THE TRUST	Ensure any Dispute Statement is included on the next agenda of the formal meeting of either the Board of Directors or the Council of Governors as appropriate.
10.5 &10.6	CHAIR OF THE TRUST	Communicate the outcome of any Dispute Statement to the other party and advise if there is no prospect of full or partial resolution.
11.1.1	CHIEF EXECUTIVE OR NOMINATED OFFICER	Keep the seal in a safe place and maintain a register of sealing.
11.2.1	CHAIR OF THE TRUST AND TRUST BOARD SECRETARY	The Board of Directors has delegated the witnessing of the application of the seal to the Chair of the Trust or in their absence the Deputy Chair and the Trust Board Secretary or in their absence their nominated officer.
11.2.2	CHIEF FINANCIAL OFFICER AND CHIEF EXECUTIVE	Approve any building, engineering, property or capital document prior to sealing.
12.1	CHIEF EXECUTIVE/ EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.
12.2	CHIEF EXECUTIVE	The Board of Directors may authorise the Chief Executive, to sign on behalf of the Trust any agreement or other document not required to be executed as a deed, the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which the Board of Directors has delegated appropriate authority.
13.1	CHIEF EXECUTIVE	Ensure all existing and new Directors and officers are notified of and understand their responsibility within the Standing Orders, Standing Financial Instructions, Reservation of Powers and Schedule of Decision/Duties delegated to the Board of Directors.

SECTION 7 – SCHEDULE OF DECISIONS/DUTIES DELEGATED BY THE NHS FOUNDATION TRUST ACCOUNTING OFFICER MEMORANDUM (Taken from the NHS Foundation Trust Accounting Officers' Memorandum August 2015) Note: the use of the term Monitor in the context of this section refers to the statutory body 'Monitor' the duties of which have been subsumed into the role of NHS England.

PARA REF	DELEGATED TO	DECISION/ DUTY DELEGATED AS SET OUT IN THE ACCOUNTING OFFICERS MEMORANDUM
3	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Duty to prepare the accounts in accordance with the NHS Act 2006. Duty to personally sign the accounts. Witness before the Committee of Public Accounts to deal with questions arising from the accounts or from any report made to Parliament by the Comptroller and Auditor General under the National Audit Act 1983.
5	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Responsible to Parliament for resources under his/her control.
7	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Responsible for the overall organisation, management and staffing of the NHS foundation trust and for its procedures in financial and other matters. The accounting officer must ensure that: a) there is a high standard of financial management in the NHS foundation trust as a whole b) the NHS foundation trust delivers efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation c) financial considerations are fully taken into account in decisions by the NHS foundation trust.

PARA REF	DELEGATED TO	DECISION/ DUTY DELEGATED AS SET OUT IN THE ACCOUNTING OFFICERS MEMORANDUM
9	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Required to: a) personally sign the accounts and, in doing, so accept personal responsibility for ensuring their proper form and content as prescribed by Monitor in accordance with the Act b) comply with the financial requirements of the NHS provider licence c) ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts (so that they disclose with reasonably accuracy, at any time, the financial position of the NHS foundation trust) d) ensure that the resources for which you are responsible as accounting officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official e) ensure that assets for which you are responsible such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate f) ensure that any protected property (or interest in) is not disposed of without the consent of Monitor g) ensure that conflicts of interest are avoided, whether in the proceedings of the board of directors, or council of governors or in the actions or advice of the NHS foundation trust's staff, including yourself h) ensure that, in the consideration of policy proposals relating to the expenditure for which you are responsible as accounting officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the board of directors.

PARA REF	DELEGATED TO	DECISION/ DUTY DELEGATED AS SET OUT IN THE ACCOUNTING OFFICERS MEMORANDUM
10	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure that effective management systems appropriate for the achievement of the Trust's objectives, including financial monitoring and control systems, have been put in place. Ensure that managers at all levels: a) have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives b) are assigned well-defined responsibilities for making the best use of resources (both those consumed by their own commands and any made available to organisations or individuals outside the NHS foundation trust), including a critical scrutiny of output and value for money c) have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.
11	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure that their arrangements for delegation promote good management and that they are supported by the necessary staff with an appropriate balance of skills.
12	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Responsibility to see that appropriate advice is tendered to the Board of Directors and the Council of Governors on all matters of financial propriety and regularity, and more broadly, as to all considerations of prudent and economical administration, efficiency and effectiveness. Determine how and on what terms such advice should be tendered, and whether in a particular case to make reference to their own duty, as Accounting Officer, to justify to the Public Accounts Committee, transactions for which they are accountable.
13	BOARD OF DIRECTORS	Act in accordance with the requirements of propriety or regularity.
13	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Make written objections to proposals by the Board of Directors, Council of Governors or Chair which he considers to infringe the requirement to act with the requirements of propriety or regularity. If the Board of Directors, Council of Governors or Chair decides to proceed, seek a written instruction to take the action in question, and inform Monitor of the position (if possible, before the decision is implemented).

PARA REF	DELEGATED TO	DECISION/ DUTY DELEGATED AS SET OUT IN THE ACCOUNTING OFFICERS MEMORANDUM
14 and 15	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	If a course of action is contemplated which raises an issue relating to his wider responsibilities for economy, efficiency and effectiveness, draw the relevant factors to the attention of the Board of Directors or Council of Governors and advise them in whatever way he deems appropriate. If his decision is overruled, and the proposal is one which he would not feel able to defend to the Public Accounts Committee as representing value for money, seek a written instruction before proceeding. Inform Monitor of such an instruction, if possible, before the decision is implemented. If there is no time to submit advice in writing due to extreme urgency, ensure that if the advice is overruled, both the advice and the instructions are recorded in writing immediately afterwards.
16	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Appear before the Public Account Committee from time to time to give evidence on the reports arising from examinations undertaken by the Comptroller and Auditor General, and answer questions concerning expenditure and receipts for which he/she is Accounting Officer.
17	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Furnish the Public Accounts Committee with explanations of any weaknesses in the matters covered in paragraphs 8-15 of the NHS Foundation Trust Accounting Officer Memorandum, to which his/her attention has been drawn by the Comptroller and Auditor General or about which they may wish to question to Accounting Officer.
19	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure that he/she is adequately and accurately briefed on matters which are likely to arise at any hearing of the Public Accounts Committee.
21	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure that he/she is generally available for consultation, and that in any temporary period of unavailability, there will be a senior officer in the Foundation Trust who can act on his behalf if required.
22	BOARD OF DIRECTORS	Where it becomes clear that the Accounting Officer is so incapacitated that he/she will be unable to discharge his/her responsibilities over a period of four weeks or more, appoint an acting Accounting Officer (usually the Finance Director), until his/her return.
23	ACTING ACCOUNTING OFFICER	Sign accounts where the Accounting Officer is unable to sign in time for printing.

SECTION 8 - SCHEDULE OF DECISION/DUTIES DELEGATED BY THE BOARD OF DIRECTORS (AS PER THE STANDING FINANCIAL INSTRUCTIONS)

Standing Financial Instructions (SFIs) has within it details of duties that have been delegated to executive directors and other officers within the Trust. (As per the version dated March 2023). Please note that the duties reserved to the Board of Directors as set out in the SFIs are detailed in Section 3 of this document.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
1.1.5	CHIEF FINANCIAL OFFICER	Provide advice on matters regarding the interpretation or application of SFIs.
1.1.7	CHIEF FINANCIAL OFFICER	Receive notice of non-compliance with the SFIs from staff and members of the Board of Directors as soon as it is reasonably practicable.
1.3.5	CHIEF FINANCIAL OFFICER	Is required to: (a) implement the Foundation Trust's financial policies and co-coordinate any necessary amendments to the policies where appropriate (b) maintain an effective system of internal financial control (c) ensure that accurate financial records of financial transactions are regularly kept up to date and disclose the financial position of the Trust when required and within a reasonable time scale (d) (i) provide financial advice to the Board of Directors, Council of Governors and employees (ii) advise on the design, implementation and supervision of systems of internal financial control (iii) prepare and maintain the Trust Accounts, certificates, estimates records and reports.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
1.3.7	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	To ensure any contractor or their employees are aware of their duties within the SFIs.
1.3.8	CHIEF FINANCIAL OFFICER	Ensure that the manner by which the Board of Directors and employees carry out their financial function are of a satisfactory standard.
2.1.1	BOARD OF DIRECTORS	Establish the Audit Committee consisting of at least three non-executives in accordance with the Constitution, with clearly defined terms of reference.
2.1.3	CHIEF FINANCIAL OFFICER	Ensure an adequate Internal Audit service is provided.
2.1.3	AUDIT COMMITTEE	Monitor arrangements and be involved in the selection process when / if an Internal Audit service provider is changed.
2.2.1	CHIEF FINANCIAL OFFICER	Is required to: (a) ensure there are arrangements to review, evaluate and report on the effectiveness of internal control (b) ensure that the Internal Audit service is adequate and meets mandatory audit standards (c) provide advice on what stage to involve the police in cases of misappropriation of funds and other financial irregularities not involving fraud or corruption (d) ensure that the Annual Internal Audit Report is prepared for the consideration of the Audit Committee (e) ensure that at least every three years an internal audit plan a strategy plan for the forthcoming three years is submitted to the Audit Committee for consideration; and that an Internal Audit Annual Plan for the coming year is submitted to the Audit Committee for consideration.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
2.3.2	STAFF	Where matters concerning Trust property or suspected irregularity in the exercise of any function of a pecuniary nature the Chief Financial Officer must be notified and must comply with the relevant financial procedures.
2.3.4	CHIEF FINANCIAL OFFICER	He / she must agree the reporting system for Internal Audit with the Internal Audit representative and the Audit Committee. The agreement should be in writing and comply with the guidance on reporting contained in the Internal Audit Standards. The CFO must also review the reporting system at least every three years.
2.3.5	CHIEF FINANCIAL OFFICER	Identify a formal review process to monitor the extent to which staff comply with audit recommendations and report any failure to implement the recommendations within a reasonable timescale to the Audit Committee.
2.5.1	CHIEF FINANCIAL OFFICER AND CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Monitor and ensure compliance with all relevant laws, codes and contractual obligations governing the conduct of countering fraud and corruption.
2.5.3	CHIEF FINANCIAL OFFICER	Receive reports from the Local Counter Fraud Specialist and work with the staff from NHS Counter Fraud Authority in accordance with the NHS Anti-crime Manual.
2.5.3	LOCAL COUNTER FRAUD SPECIALIST	Provide a report to the audit Committee at least annually.
2.6.2	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Overall responsibility for controlling and coordinating security.
3.1.1	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Compile and submit to the Board a Business Plan that takes into account financial targets and forecast limits of available resources.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
3.1.2	CHIEF FINANCIAL OFFICER	Prepare and submit budgets for approval by the Board prior to the start of the financial year.
3.1.3	CHIEF FINANCIAL OFFICER	Monitor and review financial performance against the budget and business plan. Report the findings of the above review to the Board and Finance and Performance Committee, with any significant variances being reported to the Board of Directors as soon as possible.
3.1.4	BUDGET HOLDERS	Provide the Chief Financial Officer with information as required to enable budgets to be compiled.
3.1.6	CHIEF FINANCIAL OFFICER	Ensure that budget holders are adequately trained on an ongoing basis.
3.2.1	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Delegate the management of a budget to permit the performance of a defined range of activities.
3.3.1	CHIEF FINANCIAL OFFICER	Devise and maintain systems of budgetary control.
3.3.2 (c)	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Other than those staff provided for within the available resources and manpower establishments, the appointment of any permanent staff over and above this shall be approved by the Chief Executive.
3.3.3	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure the best possible use of resources, both manpower and finances and for delivering value for money at all times.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
3.3.4	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Identify and implement cost improvement plans and revenue generation initiatives in accordance with the requirements of the Annual Business Plan.
4.1.2	CHIEF FINANCIAL OFFICER	Ensure that the Foundation Trust prepares, each financial year, annual accounts in accordance with the Treasury and NHS England requirements.
4.1.4	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure the Trust sends copies of the annual accounts and any report of the External Auditor on them to NHS England and once it has so done, lay a copy of those documents before Parliament
4.1.5	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Responsible for complying with the requirements relating to the form, preparation and presentation of the accounts
4.2.1	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure the Trust prepares annual reports in accordance with the accounting policies and guidance given by ~~NHS Improvement~~ NHS England and sends these to ~~NHS Improvement~~ NHS England
5.1.1	CHIEF FINANCIAL OFFICER	Manage the Foundation Trust's banking arrangements and advise on the provision of banking services and operation of accounts.
5.2.1	CHIEF FINANCIAL OFFICER	Is responsible for: (a) commercial bank accounts and Government Banking Service (GBS) accounts; (b) establish separate bank accounts for the Foundation Trust's non-exchequer funds; (c) ensure payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made; (d) reporting to the Board of Directors all arrangements made with the Foundation Trust's bankers for accounts to be overdrawn when utilising a working capital facility.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
5.3.1	CHIEF FINANCIAL OFFICER	Prepare detailed instructions on the operation of bank and GBS accounts.
5.3.2	CHIEF FINANCIAL OFFICER	Advise the Trust's bankers in writing of the conditions under which each account will be operated.
5.3.3	CHIEF FINANCIAL OFFICER	Approve security procedures for any cheques issued without a hand-written signature e.g. lithographed.
5.4.1	CHIEF FINANCIAL OFFICER	Review the commercial banking arrangements of the Foundation Trust at regular intervals to ensure they reflect best practice.
6.1.1	CHIEF FINANCIAL OFFICER	Design, maintain and ensure compliance with systems for the proper recording, invoicing, collection and coding of all monies due.
6.1.3	CHIEF FINANCIAL OFFICER	Responsible for the prompt banking of all monies received.
6.2.1	CHIEF FINANCIAL OFFICER	Approve and regularly review the level of all fees and charges (other than those determined by the Department of Health or by Statute).
6.2.2	ALL STAFF	Inform the Chief Financial Officer promptly of money due arising from transactions which they initiate / deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.
6.3.1	CHIEF FINANCIAL OFFICER	Ensure appropriate recovery of all outstanding debts, including formal follow up procedure for all debtor accounts and ensure overpayments are detected and prevented where possible and recovery initiated.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
6.4.1	CHIEF FINANCIAL OFFICER	Is required to approve the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable, order and securely control stationery stocks, and provide adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines.
6.4.3	CHIEF FINANCIAL OFFICER	Approve any exceptional arrangements for disbursements to be made from any cash received.
6.4.5	CHIEF FINANCIAL OFFICER	Receive a report of any loss or significant trends of any loss or shortfall of cash, cheques or other negotiable instruments.
7.2	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure the Foundation Trust enters into suitable legally binding contracts (LBC) with commissioners for the provision of NHS services.
7.3	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure that the Foundation Trust works with all partner agencies involved in both the delivery and the commissioning of the service required.
7.6	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Set out and agree a written partnership agreement with other partner organisations as identified in the Regulations for section 75 partnership arrangements and demonstrate that the aim of any such agreement is to improve services for users by raising standards and improving the quality and responsiveness of services.
8.3.1	CHIEF FINANCIAL OFFICER	Approve procurement procedures where goods are not processed through NHS supply chain.
8.3.3	CHIEF FINANCIAL OFFICER	Where tender processes have been waived in respect of the provision of legal advice or services the Chief Financial Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
8.3.3	CHIEF FINANCIAL OFFICER	Report to the Auditors where the Head of Procurement has approved an extension to an existing contract rather than carrying out a competitive exercise.
8.3.5	CHIEF FINANCIAL OFFICER	Where it is decided that competitive tendering is not applicable and should be waived, the reasons should be documented in an appropriate record and he/she is required to report it to the Audit Committee in a formal meeting.
8.3.8	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Receive a report on those goods or services procured which were originally estimated to be below the limits for tender / quotation as set in the Standing Financial Instruction which subsequently are found to have a value above those limits.
8.4.3 (i)	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Approve the awarding of any contract where this may appear not to be strictly competitive
8.4.3 (ii)	CHIEF FINANCIAL OFFICER / CHIEF EXECUTIVE	Where only one tender is sought and/or received, the Chief Financial Officer along with the Chief Executive, as far practicable, shall ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.
8.4.4	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Consider if any tenders received after the due time and date, but prior to opening of other tenders should be included in the tendering process.
8.4.5 (iii)	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Authorise the acceptance of tenders which will commit expenditure in excess of that which is allocated by the Trust.
8.4.7	CHIEF FINANCIAL OFFICER	Make or instigate any enquiries deemed appropriate concerning the financial standing and financial suitability of approved contractors.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
8.4.11	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER) / CHIEF FINANCIAL OFFICER	One of either the Chief Executive of Chief Financial Officer shall approve any quotation which commits expenses in excess of that allocated.
8.5.1	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER) / CHIEF FINANCIAL OFFICER	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
8.9.1	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure that best value for money can be demonstrated for all services provided on an in-house basis and may also determine from time to time that in-house services should be market tested by competitive tendering.
9.2.2	CHIEF FINANCIAL OFFICER	Have authority to vary or amend funded establishments.
9.4.1	CHIEF FINANCIAL OFFICER	In respect of processing the payroll the CFO is required to: specify timetables for submission of properly authorised time records and other notifications; ensure the final determination of pay and allowances (including verification that the rates of pay and relevant conditions of service) are in accordance with current agreements; make payment on agreed dates; and agree method of payment.
9.4.2	CHIEF FINANCIAL OFFICER	Ensure there is a contract with the payroll provider which sets out in detail how payroll payments will be administered.
9.4.4	CHIEF FINANCIAL OFFICER	Ensure that the chosen method for arranging the payroll service is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
10.1.1	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Determine the level of delegation for non-pay expenditure to budget managers.
10.1.2	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Required to set out the list of managers who are authorised to place requisitions for the supply of goods and services which should be updated and reviewed on an on-going basis and annually by the Finance/Supplies Department, the maximum level of each requisition and the system for authorisation above that level.
10.1.3	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
10.2.1/ 10.2.2	CHIEF FINANCIAL OFFICER OR CHIEF EXECUTIVE	Provide advice when appropriate to the requisitioner (person issuing the purchase order) in respect of an item to be supplied where the advice of the Head of Procurement is not considered to be acceptable to the requisitioner.
10.2.2	CHIEF FINANCIAL OFFICER	Responsible for the prompt payment of accounts and claims in accordance with the Better Payment Practice Code.
10.2.4	CHIEF FINANCIAL OFFICER	For prepayments outside of normal commercial arrangements the Chief Financial Officer is to be satisfied with the proposed arrangements before contractual arrangements proceed.
10.2.5	CHIEF FINANCIAL OFFICER	Approve the official orders form.
10.2.6 (a)	CHIEF FINANCIAL OFFICER	Receive notice of all contracts (except as otherwise provided for in the Schedule of Decision/Duties Delegated by the Board of Directors), including leases, tenancy agreements and other commitments which may result in a liability in advance of any commitment being made.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
10.2.6 (e)	CHIEF FINANCIAL OFFICER	Authorise a requisition / order for an item or items for which there is no budget provision.
10.2.6 (j)	CHIEF FINANCIAL OFFICER	Maintain a list of employees and officers authorise to certify invoices.
10.2.6 (l)	CHIEF FINANCIAL OFFICER	Determine the format of the petty cash records
10.2.7	CHIEF FINANCIAL OFFICER	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the relevant guidance, e.g. ESTATECODE.
10.2.8	CHIEF FINANCIAL OFFICER	Determine the procedures for payments to local authorities and voluntary organisations under Section 75 arrangements.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
11.2.2	CHIEF FINANCIAL OFFICER	Advise the Board of Directors of any utilization of a working capital facility at the next appropriate Board meeting.
11.3.3	CHIEF FINANCIAL OFFICER	Provide advice to the Finance and Performance Committee on investments and report periodically to the Finance and Performance Committee concerning the performance of investments held.
11.3.4	CHIEF FINANCIAL OFFICER	Prepare detailed procedural instructions on investment operations on the records to be maintained.
12.1	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Is responsible for: ensuring that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans; the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.
12.2 (a)	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	For every major capital expenditure proposal the Chief Executive will ensure (in accordance with the limits outlined in the scheme of delegation) that a business case is produced.
12.2 (b)	CHIEF FINANCIAL OFFICER	Certify professionally to the costs and revenue consequences detailed in the business case.
12.3	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Where capital scheme contracts stipulate stage payments, issue procedures for their management incorporating recommendations of ESTATECODE and other relevant guidance.
12.4	CHIEF FINANCIAL OFFICER	On an annual basis the Chief Financial Officer should assess the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.
12.5	CHIEF FINANCIAL OFFICER	Issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
12.6	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	For the capital programme the Chief Executive will issue to the manager responsible for any scheme: specific authority to commit expenditure; authority to proceed to tender; and approval to accept a successful tender.
12.6	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Issue a scheme of delegation for capital investment management in accordance with NHS England guidance and the Foundation Trust's Standing Orders.
12.7	CHIEF FINANCIAL OFFICER	Issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.
12.8	CHIEF FINANCIAL OFFICER	Agree any finance or operating lease entered into.
12.9.1	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Maintain the registers of assets, taking account of the advice of the Chief Financial Officer concerning the form of any register and the method of updating and arranging for a physical check of assets against the asset register to be conducted once a year.
12.9.5	CHIEF FINANCIAL OFFICER	Approve procedures for reconciling balances on non-current assets accounts in ledgers against balances on non-current asset registers.
12.9.7	CHIEF FINANCIAL OFFICER	Calculate and pay capital charges as specified.
12.11.1	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Has overall control for non-current assets
12.11.1	CHIEF FINANCIAL OFFICER	Advise the Chief Executive on the overall control of non-current assets.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
12.11.2	CHIEF FINANCIAL OFFICER	Approve the asset control procedures (including non-current assets, cash, cheques and negotiable instruments, and also including donated assets).
12.11.3	CHIEF FINANCIAL OFFICER	Receive notification of all significant discrepancies revealed by the verification of physical assets to non-current asset register.
13.2.3	CHIEF FINANCIAL OFFICER	Set out procedures and systems to regulate the stores including records for receipt of goods, issues from and returns to stores, and losses.
13.2.4	CHIEF FINANCIAL OFFICER	Agree the stocktaking arrangements and, if a physical checking of the stock is required, determine the extent to which this would be done.
13.2.5	CHIEF FINANCIAL OFFICER	Approve alternative arrangements where it is found that a complete system of stores control is not justified.
12.2.6	CHIEF FINANCIAL OFFICER	Approval of a system for the review of slow moving and obsolete items and those for condemnation, disposal and replacement of unserviceable items
13.2.6	CHIEF FINANCIAL OFFICER	Receive a report from the designated manager/pharmaceutical officer on any evidence of significant overstocking and of any negligence or malpractice.
13.3	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	For goods supplied via the central warehouses, identify those authorised to requisition and accept goods from the store.
13.3	CHIEF FINANCIAL OFFICER	Receive copies of delivery notes once goods received have been checked against this.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
13.4	CHIEF FINANCIAL OFFICER	Approve all transfers and returns recorded on a system or form.
14.1.1	CHIEF FINANCIAL OFFICER	Prepare detailed procedures for the disposal of assets, including condemnations, and ensure that these are notified to staff.
14.1.1	CHIEF FINANCIAL OFFICER	Responsible for the approval of material disposals.
14.1.3 (b)	CHIEF FINANCIAL OFFICER	Approve the form to be used in respect of converting, destroying or disposing of unserviceable items.
14.1.4	CHIEF FINANCIAL OFFICER	Receive a report from the Condemning Officer of any evidence of negligence and take the appropriate action
14.2.1	CHIEF FINANCIAL OFFICER	Prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.
14.2.2	CHIEF FINANCIAL OFFICER	Report suspected criminal acts immediately to the police such a theft or arson. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, he/she must inform the relevant LCFS.
14.2.2	CHIEF FINANCIAL OFFICER	Liaise appropriately with the Local Counter Fraud Specialist, NHS Counter Fraud Authority and the External Auditor regarding all frauds.
14.2.3	CHIEF FINANCIAL OFFICER	For any losses caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer must immediately notify the Board of Directors; the External Auditor; and the NHS Counter Fraud Authority.
14.2.5	CHIEF FINANCIAL OFFICER	Take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
14.2.6	CHIEF FINANCIAL OFFICER	For any loss, he/she should consider whether any insurance claim can be made.
14.2.7	CHIEF FINANCIAL OFFICER	Maintain a Losses and Special Payments Register in which write-off action is recorded.
15.1.1	CHIEF FINANCIAL OFFICER	Responsible for the accuracy and security of the computerised financial data of the Foundation Trust and in conjunction with Information and Knowledge Services Department.
15.1.2	CHIEF FINANCIAL OFFICER	Ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation.
15.1.3	CHIEF FINANCIAL OFFICER	Publish and maintain a FOI Publication Scheme.
15.3	CHIEF FINANCIAL OFFICER	Ensure that contracts for computer services for financial applications with another health organisation or any other agency clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. Periodically seek assurances that adequate controls are in operation where personal data is processed on the Trust's behalf by another organisation.
16.3	CHIEF FINANCIAL OFFICER	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping and disposal of patients' property.
16.4	CHIEF FINANCIAL OFFICER	Determine the form to be used to record patients' property
16.5	CHIEF FINANCIAL OFFICER	The opening and operation of separate accounts for patients' monies as may be required by Department of Health guidelines.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
17.1.3	CHIEF FINANCIAL OFFICER	Ensure that each charitable fund which the Trust is responsible for is managed appropriately with regard to its purpose and to its requirements.
17.4.1	CHIEF FINANCIAL OFFICER	Ensure that regular reports are made to the Board of Trustees with regard to the receipt of funds, investments and expenditure.
17.4.2	CHIEF FINANCIAL OFFICER	Prepare and submit annual accounts for the charitable funds in the required manner and within agreed timescales.
17.4.3	CHIEF FINANCIAL OFFICER	Prepare an annual trustees' report and the required returns to the Charity Commission for adoption by the Charitable Funds Committee.
17.5.2	CHIEF FINANCIAL OFFICER	Maintain all financial records for charitable funds to enable the production of reports and to the satisfaction of internal audit and the financial auditor.
17.5.3	CHIEF FINANCIAL OFFICER	Determine the basis on which the distribution of investment income to the charitable funds and the recovery of administration costs will be performed.
17.5.4	CHIEF FINANCIAL OFFICER	For the charitable funds ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year and liaise with the financial auditor and provide them with all necessary information, as required by the current legislation governing the administration of charities.
18	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER) VIA THE CHIEF FINANCIAL OFFICER	Ensure that all staff are made aware of the Trust's policy on acceptance of gifts and other benefits in kind by staff.
19.2	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Maintain archives for all documents required to be retained under the direction contained in Department of Health guidance; Records Management Code of Practice.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
19.5	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Have authority to destroy records held in accordance with latest Department of Health guidance "Records Management Code of Practice"
20.1	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure that the Foundation Trust has a risk management programme, in accordance with the current assurance framework requirements.
20.3	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed. Ensure documented procedures also cover the management of claims and payments.
20.5.3	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Manage clinical negligence clams and inform the Board of Directors of any major developments on claims related issues.

SECTION 9 – SCHEDULE OF DECISIONS/DUTIES DELEGATED BY THE POWERS OF THE MENTAL HEALTH ACT 1983 OR ANY OF ITS SUBSEQUENT AMENDMENTS

FUNCTIONS WHICH CANNOT BE DELEGATED TO OFFICERS OF THE TRUST

FUNCTION	STATUTORY REFERENCE	CODE OF PRACTICE REFERENCE	AUTHORISED PERSON/COMMITTEE
Review of patients' detention or Community Treatment Order	MHA S20(3) MHA S20A(5)	Chapter 38	Non-executive Directors and the committee of Mental Health Act Managers (MHAM)
Exercise of hospital managers' power to discharge unrestricted detained patients and patients subject to a Community Treatment Order	MHA S23(2)(a)	Chapter 38	Non-executive Directors and the committee of Mental Health Act Managers (MHAM)

FUNCTIONS WHICH CAN BE DELEGATED TO OFFICERS OF THE TRUST

FUNCTION	STATUTORY REFERENCE	CODE OF PRACTICE REFERENCE	AUTHORISED PERSONS
Formal receipt of statutory admission documents for detained patients	MHA S11(2) Regulation 4*	Chapter 35	Professional in charge of a ward/unit or deputy Mental Health Legislation Officer Mental Health Law Adviser Mental Health Legislation Team Leader Head of Mental Health Legislation

FUNCTION	STATUTORY REFERENCE	CODE OF PRACTICE REFERENCE	AUTHORISED PERSONS
Receipt of statutory documents in respect of section 5(2)	MHA S5(2) Regulation 4(1)(g)*	Chapter 18 paragraph 18.6	Professional in charge of a ward/unit or deputy Mental Health Legislation Officer Mental Health Law Adviser Mental Health Legislation Team Leader Head of Mental Health Legislation
Receipt of record for purposes of section 5(4)	MHA S5(4) Regulation 4(1)(h)*	Chapter 18 Paragraph 18.26	Professional in charge of a ward/unit or deputy Mental Health Legislation Officer Mental Health Law Adviser Mental Health Legislation Team Leader Head of Mental Health Legislation
Receipt of discharge notice/order by the patient's nearest relative	MHA S25(1) Regulation 25(1)*	Chapter 32 paragraphs 32.21, 32.22 & 32.24	Professional in clinical team Mental Health Legislation Officer Mental Health Law Adviser Mental Health Legislation Team Leader Head of Mental Health Legislation
Receipt of report barring discharge by nearest relative			Mental Health Legislation Officer Mental Health Law Adviser Mental Health Legislation Team Leader Head of Mental Health Legislation

FUNCTION	STATUTORY REFERENCE	CODE OF PRACTICE REFERENCE	AUTHORISED PERSONS
Scrutiny of statutory forms	MHA S15 Regulation 4(3)*	Chapter 35	Administrative scrutiny: Mental Health Legislation Officer Mental Health Law Adviser Mental Health Legislation Team Leader Head of Mental Health Legislation Medical scrutiny: Consultant Psychiatrist (section 12 approved)
Rectification of documentation	MHA S15 Regulation 4(3)*	Chapter 35	Mental Health Legislation Officer Mental Health Law Adviser Mental Health Legislation Team Leader Head of Mental Health Legislation
Recording of admission	Regulations 4 and 6*	Chapter 35	Professional in Charge of a ward/unit or deputy Mental Health Legislation Officer Mental Health Law Adviser Mental Health Legislation Team Leader Head of Mental Health Legislation

FUNCTION	STATUTORY REFERENCE	CODE OF PRACTICE REFERENCE	AUTHORISED PERSONS
Authorisation of the transfer of patients	MHA S19 Regulation 7*	Chapter 37 paragraphs 37.16 – 37.27	Decision to transfer is made by the Responsible Clinician Documentation is completed by: Professional in charge of a ward/unit or deputy Mental Health Legislation Officer Mental Health Law Adviser Mental Health Legislation Team Leader Head of Mental Health Legislation
Formal receipt of renewal and extension documentation on behalf of the hospital managers	MHA S20(3)(b) MHA S20A(5) Regulation 13*	Chapter 32	Mental Health Legislation Officer Mental Health Law Adviser Mental Health Legislation Team Leader Head of Mental Health Legislation
Provision of information to patients and their nearest relatives	MHA S130d, 132, 132A & 133 Regulation 26*	Chapter 4 paragraphs 6.15 and 12.6	Multidisciplinary team Mental Health Legislation Officer Mental Health Law Adviser Mental Health Legislation Team Leader Head of Mental Health Legislation As prescribed in Trust s.132 protocol
Submission of statement of authority to the Tribunal	Tribunal Rule 32**	Chapter 12 paragraph 12.11	Mental Health Legislation Officer Mental Health Law Adviser Mental Health Legislation Team Leader Head of Mental Health Legislation

FUNCTION	STATUTORY REFERENCE	CODE OF PRACTICE REFERENCE	AUTHORISED PERSONS
Referral of cases to the Tribunal	MHA S68 Tribunal Rule 32**	Chapters 12 and 39 paragraphs 12.10 and 37.39	Mental Health Legislation Officer Mental Health Law Adviser Mental Health Legislation Team Leader Head of Mental Health Legislation
Referral of cases to the Secretary of State	MHA S67	Chapter 37 paragraphs 37.44 – 37.46	Mental Health Legislation Officer Mental Health Law Adviser Mental Health Legislation Team Leader Head of Mental Health Legislation
Return of patients who are absent without leave (AWOL)	MHA S18	Chapter 28 Paragraph 28.4, 28.8	Any member of staff of the Trust or staff contracted to the Trust from Aspire, ~~Community Links~~ Inspire North, Touchstone and North Point. Any other person authorised by the Hospital Managers (for written authorisation purposes, the Schedule of Decisions directs that this function can be exercised by a service manager, the patient's responsible clinician or anyone delegated by the service manager or responsible clinician).

*The Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008 (SI2008/1184)
**Health, Education and Social Care Chamber of the First-tier Tribunal

References
Mental Health Act 1983 Mental Health Act 1983 Code of Practice 2015
The Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008 (SI 2008/1184)

Tribunal Procedure (First Tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 (SI 2008/2699)
Reference Guide to the Mental Health Act 1983, Department of Health 2015

SECTION 10 – SCHEDULE OF RESPONSIBILITIES DELEGATED TO THE SUB-COMMITTEES OF THE BOARD OF DIRECTORS

The table below sets out the responsibilities that have been delegated to the sub-committees of the Board of Directors (including Committee in Common). Further details of the individual duties can be found in their respective Terms of Reference.

NAME OF COMMITTEE	DELEGATED RESPONSIBILITY OF THE COMMITTEE
Audit Committee	The purpose of the Audit Committee is to provide the Board of Directors with assurance that: • Clinical, financial reporting, compliance, risk management, health and safety and internal control principles and standards are being appropriately applied and are effective, reliable and robust • An effective governance framework is in place for monitoring and continually improving the quality of health care provided to service users to enable the Trust's strategic objectives to be achieved.
Quality Committee	The Quality Committee has responsibility for providing assurance to the Board of Directors on the effectiveness of the: • Trust's quality ~~and~~, including patient safety, systems and processes • Quality ~~and~~, including patient safety, of the services provided by the Trust • Control and management of quality ~~and~~, including patient safety, related risks within the Trust.
Finance and Performance Committee	The principle purpose of Finance and Performance Committee is to provide the Board with Assurance on: • Financial governance and performance; • Contractual performance • Strategic matters in relation to procurement, estates, information technology and information management; • Financial and clinical service performance including clinical actively and key performance indicators.

NAME OF COMMITTEE	DELEGATED RESPONSIBILITY OF THE COMMITTEE
Mental Health Legislation Committee	The MHL Committee provides assurance to the Board regarding compliance with all aspects of the Mental Health Act 1983 and subsequent amendments and on compliance with all aspects of mental health legislation including, but not limited to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards / Liberty Protection Safeguards.
Workforce Committee	The purpose of the committee is to provide the Board with assurance in relation to: • 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. • A positive working environment for staff which promotes an open culture that helps staff do their job to the best of their ability.
Nominations Committee	The purpose of the Nominations Committee is to regularly review the structure, size and composition of the Board of Directors and make recommendations for changes where appropriate. In particular, the committee should evaluate the balance of skills, knowledge and experience on the Board of Directors. It shall also have a role in ensuring appropriate succession plans are in place for members of the executive team. In relation to the appointment of executive and non-executive directors the committee shall prepare a description of the role and capabilities required for appointment of both executive and non-executive directors, including the Chair of the Trust.
Remuneration Committee	The purpose of the Remuneration Committee is to provide the Board of Directors with assurance that executive directors are rewarded appropriately for their contribution; ~~that~~ to agree appropriate contractual arrangements and levels of remuneration ~~are in place~~; and to be assured of the performance of individual executive directors against their agreed objectives, and that plans are in place to address any areas of development.
West Yorkshire Mental Health Services Collaborative Committees in Common	With our mental health partners in West Yorkshire (Bradford District Care Foundation Trust, Leeds Community Healthcare NHS Trust, and South West Yorkshire Partnership Foundation Trust) the Committees in Common will progress working together to improve acute and specialist mental health services for local communities, as part of the wider West Yorkshire & Harrogate Health and Care Partnership. It will work together as the lead organisations to deliver ~~the Mental Health Five Year Forward View~~ the agreed programmes of work, and to undertake commissioning/lead provider responsibilities on behalf of West Yorkshire Integrated Care Board for local people in West Yorkshire, build on what's good and working well already across the region, sharing best practice and designing new service models together.

It should be noted that strategies that sit beneath the five supporting strategies are presented to Board sub-committees (Workforce Committee, Quality Committee, Finance and Performance Committee and Mental Health Legislation Committee) so they are sighted on the detail, but are not presented for approval.

It has also been agreed by the Board that the following NED Champion roles will be carried out through the Board sub-committee structure:

NED champion role	NED / Sub-committee to oversee the NED Champion role
Maternity board safety champion	• Named champion to be the chair of the Quality Committee. • Requirements of the role to be discharged through the Quality Committee. Note - while LYPFT does not provide maternity services, it was agreed by the Board in January 2021 that the Quality Committee would carry out the NED Champion role for the Perinatal Service.
Wellbeing guardian	• Named champion to be the chair of the Workforce Committee. • Requirements of the role to be discharged through the Workforce Committee.
Freedom to speak up	• Named champion to be the Senior Independent Director. • Requirements of the role to be discharged through the Board of Directors.
Doctors disciplinary	• Named champion to be the chair of the Workforce Committee. • Requirements of the role to be discharged through the Workforce Committee.
Hip fracture, falls and dementia	• Requirements of the role to be discharged through the Quality Committee.
Learning from deaths	• Requirements of the role to be discharged through the Quality Committee.
Safety and risk	• Requirements of the role to be discharged through the Audit Committee.

NED champion role	NED / Sub-committee to oversee the NED Champion role
Health and safety	• Requirements of the role to be discharged through the Audit Committee.
Children and young people	• Requirements of the role to be discharged through the Quality Committee.
Resuscitation	• Requirements of the role to be discharged through the Quality Committee.
Cybersecurity	• Requirements of the role to be discharged through the Finance and Performance Committee.
Emergency preparedness	• Requirements of the role to be discharged through the Finance and Performance Committee.
Safeguarding	• Requirements of the role to be discharged through the Quality Committee.
Procurement	• Requirements of the role to be discharged through the Finance and Performance Committee.
Security management – violence and aggression	• Requirements of the role to be discharged through the Workforce Committee.
Palliative and of Life Care Champion	• Requirements of the role to be discharged through the Quality Committee.
Patient Experience	• Named champion to be Kaneez Khan.
Sustainability	• Named champion to be Katy Wilburn.

SECTION 11 – SCHEDULE OF RESPONSIBILITIES DELEGATED TO THE ACCOUNTABLE EMERGENCY OFFICER (AEO) (as set out in the NHS Commissioning Board's (NHS England's) The role of 'Accountable Emergency Officers' for Emergency Preparedness, Resilience and Response (EPRR))

Following the Health and Social Care Act 2012, organisations must have an appointed Accountable Emergency Officer (AEO) who is a Board-level director who is responsible for EPRR in their organisation; this person should be supported by a non-executive director (the Chair of the Finance and Performance Committee). The Accountable Emergency Officer has the appropriate authority, resources and budget to direct the EPRR portfolio and is responsible for:

a. Ensuring that the organisation is compliant with the EPRR requirements as set out in the civil contingencies act (2004); the NHS planning framework and the NHS standard contract as applicable;
b. Ensuring that the organisation is properly prepared and resourced for dealing with a major incident or civil contingency event;
c. Ensuring their organisation, and any providers they commission, have robust business continuity planning arrangements in place which reflect standards set out in the Framework for Health Services Resilience (PAs 2015) and ISO 22301;
d. Ensuring the organisation has a robust surge capacity plan that provides an integrated organisational response and that it has been tested with other providers and parties in the local community(ies) served.
e. Ensuring that the organisation complies with any requirements of NHS England, or agents thereof, in respect of the monitoring of compliance.
f. Providing NHS England, or agents thereof, with such information as it may require for the purpose of discharging its functions; and
g. Ensuring that the organisation is appropriately represented at any governance meetings, sub-groups or working groups of the local health resilience partnership (LHRP) or local resilience forum (LRF).

In this Trust the role of Accountable Emergency Officer has been delegated to the Chief Operating Officer by the Chief Executive. The day-to-day management of an incident will be carried out through the EPRR Lead under the management of the Accountable Emergency Officer.