

Public Meeting of the Board of Directors

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

Agenda

		LEAD	TIME
1	Apologies for absence (verbal)	MM	9.30m
2	Sharing Stories - The Actual Experience of Living with Cerebral Palsy (Being Disabled) and Mental Health Issues (verbal)		9.35am
3	Declarations of interests and any declarations of conflicts of interest in any agenda item (enclosure)	MM	10.05am
4	Minutes of the meeting held on 30 July 2026 (enclosure)	MM	-
5	Matters arising (verbal)	MM	-
6	Actions outstanding from the public meetings of the Board of Directors (enclosure)	MM	-

Use of resource

7	Chief Executive's report (enclosure)	SM	10.15am
8	Report from the Chair of the Finance and Performance Committee for the meeting held on 22 September 2026 (to follow)	KW	10.30am
9	Report from the Chief Financial Officer (enclosure)	DH	10.35am
10	Report of the Chief Operating Officer (enclosure)	JFA	10.45am
	10.1 Winter Plan and Board Assurance Statement (enclosure)	JFA	-

Break

10.55am

Patient centred care

11	Report from the Chair of the Quality Committee for the meeting held on 10 September 2026 (enclosure)	FH	11.10am
12	Report from the Director of Nursing and Professions (enclosure)	NS	11.15am
	12.1 Safer Staffing Annual Report & Establishment Review Reports (enclosure)	NS	11.25am
	12.2 Safer Staffing Report (enclosure)	NS	-
13	Guardian of Safe Working Hours Q1 Update (enclosure)	CH	11.35am

Workforce

14	Report from the Chair of the Workforce Committee for the meeting held on 6 August 2026 (enclosure)	ZBS	11.45am
15	Equality Annual Report including WRES, WDES and Gender Pay Gap (enclosure)	DS	11.50am
16	Equality Diversity & Inclusion EDS Standards (enclosure)	DS	12pm

Governance

17	Report from the Chair of the Mental Health Legislation Committee for the meeting held on 4 August 2026 (enclosure)	KK	12.15pm
	17.1 Mental Health Legislation Committee Terms of Reference (enclosure)	KK	-
18	Use of Trust Seal (verbal)	MM	-
19	Any other business (verbal)	MM	12.20pm

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

Declaration of Interests for members of the Board of Directors

Name	Directorships, including Non-executive Directorships, held in other organisations (with the exception of those of dormant companies).	Ownership, or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services.	Any substantial or influential connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.	Any other commercial or other interests you wish to declare. This should include political or ministerial appointments (where this is information 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.

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 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
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.

Name	Directorships, including Non-executive Directorships, held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services.	Any substantial or influential connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.	Any other commercial or other interests you wish to declare. This should include political or ministerial appointments (where this 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
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.

Name	Directorships, including Non-executive Directorships, held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services.	Any substantial or influential connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.	Any other commercial or other interests you wish to declare. This should include political or ministerial appointments (where this 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
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 30 July 2026 at 09:30am

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

Board Members

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)

Apologies

✓

✓

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
Mr Mark Dodd	Deputy Chief Operating Officer (deputising for Chief Operating Officer)
Dr Wendy Neil	Consultant Psychiatrist & Responsible Officer (for minute 26/085)
Mrs Tracey Needham	Head of People Engagement (for minute 26/096)

Three members of the public attended the meeting, including one governor.

Action

26/079

Mrs McRae opened the public meeting at 09:30 and welcomed everyone.

Apologies for absence (agenda item 1)

Apologies were received from Ms Kaneez Khan, Non-Executive Director and Mrs Joanna Forster Adams, Chief Operating Officer. Mr Mark Dodd attended as Deputy Chief Operating Officer. The meeting was quorate.

26/080	Declaration of interests for directors and any declared conflicts of interest in respect of the agenda items (agenda item 2) 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.
26/081	Minutes of the previous meeting held on 28 May 2026 (agenda item 3) The minutes of the meeting held on 28 May 2026 were received and agreed as an accurate record.
26/082	Matters arising (agenda item 4) There were no matters arising.
26/083	Actions outstanding from the public meeting of the Board of Directors (agenda item 5) 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 the update on operational priorities which included in the papers, therefore the action was closed. The Board received the cumulative action log, agreed to close the actions that had been completed and noted the updates provided for ongoing actions.
26/084	Report from the Chief Executive (agenda item 6) Dr Munro presented the Chief Executive's report, taking the content as read. She highlighted the recommendation for the Trust to adopt the Lord Mann report recommendations, noting that all Trusts had received letters from a legal firm noting concern with adopting the included definition, however as it did not affect any policies and procedures for dealing with discriminatory

behaviour this was not a concern. The Board provided support to adopt the recommendations.

She noted that the Trust had still not received the Well Led report from the CQC but had been informed this should be received by 13 August 2026. The Trust had written to the CQC CEO, Regional Chief Nurse and Director for Mental Health, to set out the experiences with inspections and final factual inaccuracies, however no response had been received so this would be pursued as it would be helpful to continue to have an open dialogue. She noted her visit to Ward 5 which had shown much to be proud of, including MDT working and improvements in the use of the ward environment in readiness to move to Parkside Lodge.

She noted that the Board to Board meeting would provide further detail on the alignment with Leed Community Healthcare NHS Trust (LCH) but noted the engagement that had taken place regarding the new organisation's name which had been agreed as Leeds Partnership NHS Foundation Trust (LPFT). NHS England (NHSE) had supported the new name, and this would be used following the formal approval of the merge next year.

No direct communication had been received from the newly appointed Secretary of State for Health and Social Care, but this was expected in due course. The publication of the Quality Strategy was acknowledged and that this would support the work with the new organisation.

She also highlighted the Reasons to be Proud section within her report of individuals, services and teams.

Mrs McRae noted the awaited Well Led review report but thanked the Executive Team for their hard work in relation to this alongside the ongoing Trust priorities and focus. She thanked Dr Munro for the report.

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

26/085

Annual Responsible Officer and Medical Revalidation Report (agenda item 7)

Dr Neil presented the report, taking the content as read. She reminded the Board that the paper was to provide assurance regarding compliance with the required regulations and the level of support provided to medical colleagues. She noted that the previous update provided to the Board had included the impact on the role of the Responsible Officer and teams due to the increase in doctors and thanked the Board for their support to secure additional funding

which had provided real benefit for the service and the doctors within the Trust.

She noted that doctor appraisals had been completed on time and to a high quality, and had all been approved by the General Medical Council as appropriate. She acknowledged the work that had taken place to support this position and the appraisers who carried out this role.

In relation to managing concerns regarding doctors, training had been undertaken with NHSE, and the Trust therefore had a cohort of highly trained senior doctors to support and lead investigations if required. She acknowledged the need to maintain high standards throughout the integration work with LCH, and work was underway to consider how to align whilst continuing business as usual.

She updated the Board on the support that had been put in place for neurodivergent doctors following an initiative that started in September 2025. The work had been led by neurodivergent doctors with a training and education package to all doctors and support available for access including the development of StaffNet pages to provide information. The work had been shared regionally showcasing the work within the Trust, along with the peer group established to support doctors together with a package for support and mentoring.

She concluded by noting that the paper contained the areas of focus for the next year. Since completing the paper, the final priority for last year had been completed, meaning all 22 had been achieved.

Dr Hosker commented that there was clear assurance provided that robust processes were in place for regulatory delivery. He acknowledged the potential risks around integration but noted the good position that could be connected across the organisations.

Mrs Mellor noted the achievements including the appraisal position and queried if the neurodiversity support had been widely publicised to share the work. Dr Neil noted that it had been intentional not to share it widely as it had been specifically focused on doctors as it was acknowledged that doctors were disproportionately likely to have a neurodivergent diagnosis or symptoms, specifically psychiatrists and GPs. She noted that the next step was to link into the organisation to understand how this could be shared across other professional groups.

Mrs McRae thanked Dr Neil for the report.

The Board **received** the Annual Responsible Officer and Medical Revalidation Report and **noted** the content.

26/086 Report from the Chair of the Finance and Performance Committee for the meeting held on 27 July 2026 (agenda item 8)

Miss Wilburn presented the Chair's report from the Finance and Performance Committee meeting taking it as read. She highlighted the update provided on the Trust's current financial position which was slightly ahead of plan with the support of non-recurrent benefits which were not insignificant. There had been discussion regarding deconstructing the block contract and any associated risks which would continue to be monitored. She noted the update regarding workforce efficiency progress, including agency use being below trajectory with a slight increase in overtime figures.

The Committee received an update from the Information Governance Group with a focus on inappropriate access to patient records, and it was agreed that this would be reviewed in more depth at a future Committee meeting including the link to national guidance.

Mr Wright commented that the medical agency position was positive and contributing well to the Trust's financial position.

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.

26/087 Report from the Chief Financial Officer (agenda item 9)

Mrs Hanwell presented the report, taking the content as read. She noted the year to date position was ahead of plan due to technical flex linked to pressure from Out of Area Placements (OAP) earlier in the year, but she was confident that OAPs would improve over the coming months. Linked to the Full Business Case for the integration, she noted the work undertaken on understanding the underlying position as this needed to be declared monthly as part of the National Oversight Framework and Northeast region oversight processes. She was confident in the revised underlying position based on the improvements to be made regarding OAPs.

In relation to deconstructing the block, Mrs Hanwell noted the review exercise underway, with submissions due in August / early September 2026. There was a £40 million gap based on the review to date and activity and productivity

would be crucial. Certain areas had been noted to have a reduction in activity, but there was a need to understand the nuances and impact of this. There was a need to get to a legitimate outcome based process which was a serious issue for all Mental Health and community providers, and work would continue and any changes would be managed in a staged way to reduce any associated risks. She noted that Finance and Performance Committee would be kept updated as the full parameters were not currently known. Mrs Burns Shore commented that there was the potential for the changes to lead to a reduced desire to transform services which was the opposite of the future aspiration. Mrs Hanwell acknowledged that it was complex for mental health as it was a more standard costing process for acute Trusts, and whilst this was recognised nationally there was still a focus to move in that direction.

In relation to costing, Mr Wright commented that the Trust did not position well on benchmarking and included in that was the input of data and the clinical model that lay behind it. He noted that Finance and Performance Committee had noted that other organisations featured highly in benchmarking and given their proximity geographically it would be worth investigating their processes and any learning. Mrs Hanwell responded that there was a Directors of Finance group in place, and that provided an opportunity to discuss that point. She noted that there may be a level of under recording of activity so further discussion would take place on this across Trusts, including clinical engagement. Mrs Mellor added that it would be important to link with LCH to consider any integration elements and develop a shared approach.

Mrs McRae thanked Mrs Hanwell for the update provided.

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

26/088

Operational Priorities Update Report – Q1 (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 requested that the Board disregard the appendix as it contained draft priorities and a number had now been combined to reflect the work underway and a reduction down to 8 priorities. She noted that the PFI priority had been deliberately excluded as the work was commercially sensitive.

She noted the alerts in the report were regarding finances as the position was behind on budget efficiency, bank and overtime costs, and the others were linked to the flow programme which would be discussed in private Board.

Mrs McRae thanked Mrs Hanwell for the update provided.

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

26/089 Data Security & Protection Toolkit (agenda item 10)

Dr Hosker presented the report, taking the content as read, noting it had been presented to Finance and Performance Committee. He noted the assurance provided through the internal audit report with two minor issues identified which would be addressed, and the positive position for the Trust overall.

Prof Healey commented that it was a technical report but with accessible information. She referred to the discussion at Audit Committee as to whether the internal audit report included enough detail about access to medical records given the high-profile nature of the issue, and whether a separate report was needed for assurance purposes. Miss Wilburn responded that the point had been discussed in Finance and Performance Committee in detail, and the Committee had asked for more detail on the points raised, as noted in the Chair's report, and this would be followed up. Dr Hosker added that there was a minor recommendation in the audit report about access to records, and the Trust was not passive in its position and did undertake active random audits that reviewed access to records and who had accessed them and why. Mrs Mellor noted that access to records was not just a technical issue and therefore may require more focus at Board. Mrs McRae reiterated that the work would be undertaken to review this through the Finance and Performance Committee who would then be able to consider if there were issues for the Board to follow up on including behavioural elements of access to records. Dr Munro noted that the profile of access issues had raised due to national media coverage and incidents, and the Trust had already commenced work last year due to an increase in incidents, therefore she was reassured that the internal audit report noted work that was already underway.

Mrs McRae thanked Dr Hosker for the update provided.

The Board **received** the Data Security & Protection Toolkit and **noted** the content.

26/090 Report of the Chief Operating Officer (agenda item 12)

Mr Dodd presented the report, taking the paper as read. He highlighted the ongoing issues with length of stay and Emergency Department waits, and that these areas were part of Trust priorities and work was underway to address them.

He noted that there were currently no older people OAPs which was positive, but flow within older people's services remained a challenge and would be part of the areas of focus for the flow programme so improvements were anticipated.

He noted the discussion at Finance and Performance Committee regarding PICU seclusion damage resulting in it being taken out of use, however it was now back in operation. He updated that the Connect inpatient service was out of business continuity and had a plan in place for recovery and progress was being made. The Red Kite View business continuity process was also noted to have reached a conclusion, and the service was fully operational.

Miss Wilburn commented that the Finance and Performance Committee had focused in detail on OAPs, flow and length of stay and the ongoing recommendations, and agreed to pass the discussion back to Executive Directors about how they were being taken forward.

Mrs McRae commented that it was positive to hear the impact of the work that had been underway and involvement of staff within this. She thanked Mr Dodd for the update.

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

26/091

Report from the Chair of the Quality Committee for the meetings held on 11 June and 9 July 2026 (agenda item 13)

Dr Healey presented the Chair's Report from the Quality Committee meetings, taking them as read. She highlighted the health equity strategic plan which provided overall assurance to the Committee but is also a part of other Committees' focus too, and work was ongoing across the organisation to progress this. The Committee received the annual complaints & PALs report which now focused less on the process for responses and more on learning and actions taken, which was positive, and a further update would be provided to the Committee in 6 months.

She noted that there was a discussion regarding restrictive practice that acknowledged an increase in numbers can happen due to a small number of patients, however the overall trend was positive looking year on year.

She noted the Committee's interest in assurance regarding complexity of service provision, considering collaborative working and variations in approaches, and that the assurance regarding sub-contracts with quality metrics in place was a great step forward.

She added that there was work underway to strengthen assurance regarding medical devices, with a focus on safety of medical devices and wider practice, which was positive.

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.

26/092

Report from the Medical Director (agenda item 14)

Dr Hosker presented the report taking it as read by the Board. He noted that medical agency spend continued to improve, and risk areas were linked to a group of community agency doctors as ideally a substantive medical group was required for the flow programme work, however the agency staff were long term so did provide a level of continuity.

He informed the Board that digital was now within his portfolio therefore that section of the report would continue to get more detailed and he highlighted the joint EPR project continued, and workshops had been undertaken with LCH. He provided assurance that this would continue to be an area of focus.

In relation to Mental Health legislation, following previous Board discussion on the impending changes, he confirmed that a workshop had taken place to focus on the impact and planning required to implement the changes.

Mrs Mellor commended the report and noted the detail regarding the Andrew Sims Centre and the potential to generate growth. Dr Hosker commented that the historic idea for the centre to generate income had been hugely impacted by the pandemic due to a shift in online learning and online courses provided by Royal Colleges. The Centre was trying to recover from that position and consider sustainability and growth options, including event management. In relation to research he noted that it was challenging to compete with other research areas but there was an appetite to generate income where possible, and a continued intention to focus on this and consider opportunities provided through the integration process.

In relation to a query from Mrs Mellor regarding the deanery risks noted in the paper, Dr Hosker noted that it was for awareness at the moment as it was likely to have an impact on the delivery of training over the next 12 months, but there was a need for further detail to fully understand this, and it was not a critical risk at the current time.

Mrs Burns Shore noted the progress in pharmacy was positive given the previous position, and the inclusion of KPIs would support the measuring and monitoring of progress.

Mrs McRae noted that there had been a recent appointment to a Deaf CMAHS post recently, but it did not appear in the paper as a vacancy filled, and Dr Hosker noted that this was due to it being a succession position rather than ongoing vacancy. Mrs McRae thanked Dr Hosker for the report.

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

26/093 Guardian of Safe Working Hours Annual Report and Q4 Update (agenda item 15)

Dr Hosker presented the report taking it at read by the Board. He noted it was the annual report to provide an overview to the Board. He referenced the increase in incidents which would continue to be monitored, and that the sense from the Guardian was that this would be managed and wasn't a longer term cause for concern.

Mrs McRae thanked Dr Hosker for the report.

The Board of Directors **received** the Guardian of Safe Working Hours Annual Report and Q4 Update and **noted** the content.

26/094 Report from the Chair of the Workforce Committee for the meeting held on 18 June 2026 (agenda item 16)

Mrs Burns Shore presented the report taking it at read by the Board. She highlighted the robust discussion regarding the sickness absence report, and that the Committee had requested a comprehensive review of all initiatives taken with a focus on the outcomes to consider next steps. It was noted that a neighbouring Trust had a different approach to the application of the policy on sickness absence which would need to be reviewed regarding adoption, and a discussion for the Executive Management Team to consider moving forward. It was acknowledged that it was noted within the Chief Operating Officer report that sickness absence was also being reviewed at operational level.

She referenced the excellent paper received on learning environments for nurses and doctors which gave an overwhelmingly positive position.

The Board acknowledged that understanding different approaches to sickness management would be helpful. 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.

26/095

Report from the Director of People and Organisational Development
(agenda item 17)

Mr Skinner presented the report taking it as read by the Board. He highlighted the sickness absence position for June 2026 was 6.8% in month and reminded the Board that this was included in the National Oversight Framework (NOF). He noted the introduction of an oversight group which would focus on areas with higher sickness rates to understand the detail. Application of the policy was key, and the Trust focus was on well-being, therefore a review of the policy regarding formal management processes would be undertaken. He added that there was a lack of return-to-work interviews undertaken despite early intervention from management being beneficial, so this needed to increase.

He informed the Board that NHSE had launched two pieces of work relating to staff standards and the Management and Leadership Framework. The standards would be part of the NOF ratings and included tackling racism and line management and were mandated areas, whereas the People Promises and Plan were not mandated by NHSE. The detail behind the approach was awaited. The Management and Leadership Framework was a more robust competency framework for line managers, which included all managers undertaking a 360 self-assessment by Q4, therefore work was in place to plan this as systems were not yet in place nationally. He added that work underway by the Trust would support this to be undertaken.

Mrs Hanwell queried the definition of managers within the framework, and Mr Skinner acknowledged that this had not been provided nationally so Trusts were awaiting clarification. Dr Munro asked if there had been any further discussion around a regulatory body for managers as previously discussed, and Mr Skinner confirmed that there had not been any further detail provided.

Mrs Burns Shore queried the process for the 360 reviews, and Mr Skinner responded that there was a framework in place as part of the leadership academy but as this would be abolished it was unclear how this would be progressed at the current time.

Prof Healey noted that the NOF metrics had changed and it may be unlikely there was a robust data source for them, therefore there was a risk with the

presentation of data and the overall position. Mrs McRae commented that there were issues with several metrics so hopefully these would get refined.

Mrs McRae thanked Mr Skinner for the report

The Board of Directors **received** and **noted** the Report from the Director of People and Organisational Development.

26/096

2025 NHS Staff Survey Trust-level Action Plan (agenda item 17.1)

Mrs Needham presented the report taking it as read by the Board. She noted that it was the first time that a Trustwide action plan had been developed as it was now a mandated process.

She informed the Board that a deep dive into all free text comments had been done for the first time, and had identified themes such as workforce capacity, wellbeing, development and recognition, and leadership and management, however there were also high score areas which should be acknowledged. The action plan was based on realistic deliverables over the next 12 months balanced with work taking place across the organisation as there was a need to demonstrate improvements through the next staff survey. The action plan was therefore designed to deliver meaningful change through existing projects and would be monitored through the People and OD governance structure and through to Workforce Committee. There was a request for Board direction on timescales for updates to review progress.

Mrs Burns Shore commented that the measures looked sensible, however communication to staff regarding the overall position in some areas and managing misinformation that may be part of the results was important. Mrs Needham noted that this would be picked up at local level following the review of the free text comments to ensure correct information was provided. She added that once the plan had been approved there would be Trustwide communication regarding Board approval which would be helpful.

Dr Munro thanked Mrs Needham and the team for the work undertaken to support the process and commented it was reassuring to see familiarity with the areas of work already underway linked to the identified themes. Mrs Needham noted that the team were working on a plan to consider engagement approaches to improve update with completion of the staff survey.

Miss Wilburn commented that the action plan showed areas known about which aligned to discussions held within Board and Committees, and it provided an opportunity to build on the Trust's ability to target any linked areas to the NOF. Mrs Needham added that there was a need to understand the

current position for the organisation in relation to the new staff standards, and this was being reviewed currently, as triangulation on all measures and action plans would provide more opportunities for improvement.

Mrs Burns Shore noted that the action plan would be reviewed quarterly at the Workforce Committee, and the Board noted bi-annual updates would be acceptable for Board updates on progress.

The Board thanked Mrs Needham and the team for the work that had been undertaken to achieve this position. Mrs McRae thanked Mrs Needham for the report

The Board of Directors **received** and **noted** the content of the 2025 NHS Staff Survey Trust-level Action Plan.

26/097

Report from the Chair of the Audit Committee for the meeting held on 14 July 2026 (agenda item 18)

Mr Wright presented the report taking it as read by the Board. He highlighted the three Internal Audit reports that were presented to the Committee on organisational governance, minimising self-harm and medicines management.

In relation to the organisational governance report, he noted the split opinion result which identified good process for ward to board governance, but instances where there was a lack of evidence to support reporting of this. The process was not evidenced to their satisfaction, but the Committee were assured work was underway to address this. The minimising self-harm report had shown good management responses that provided a good level of assurance with the approach.

He noted that although there were a group of limited assurance reports, they were from 2025/26 and were incorporated in the Significant Assurance Head of Internal Audit opinion report already issued for the year to March 2026. The remarks made by the Head of Internal Audit at the Committee noted that Executive Directors supported discussions and ensured robust responses that were tracked, which was a credit to the organisation, and this had supported significant assurance for the Head of Internal Audit opinion.

He commented that internal audit colleagues had noted that there had been instances where services could have investigated and acted on some issues before internal audit work was undertaken which may save additional recommendations being reported, and he therefore suggested that in those cases it would present the Trust in a better light if we undertook some actions before an internal audit took place.

The Committee had received the annual and Q1 Health and Safety Report and whilst content with much of the report, there were inconsistent numbers of incidents when compared with other reports, therefore work continued to review this and Mr Wright was confident that this would be resolved for future reports.

He noted the review of the risk management report where good progress was noted, and it now included more than clinical risks which was positive. He queried whether the report should be authored from a corporate perspective, rather than clinical governance, to emphasise the point that support the focus on risk is present in all parts of the organisation not just clinical areas.

Mrs McRae queried if internal audit was used to make improvements happen, however Mr Wright commented that the Trust was highly regarded for using audit to support areas with known issues which was positive, the feedback was that where a problem is identified the Trust should attempt to resolve it prior to the audit as it may make the recommendation process easier. Dr Munro noted that sometimes internal audit provided a more comprehensive set of recommendation and actions to support improvements, and it was also used once changes have been made to sense check them, so it was important to balance the approach for the rationale for using audit. Miss Sanderson noted that the self-harm audit was an example that provided quick wins from the recommendations and acknowledged that the policy was not fully implemented at the time of the audit taking place. Prof Healey commented that there was an unwritten set of criteria for use of internal audit, and perhaps consideration of what the overall approach was may provide a more consistent approach for use, however Mrs McRae noted that there may always be a grey area that was subjective. Mrs Hanwell added that within the scope of audit there was an opportunity to consider whether all areas were suitable for review at the current time, and it did allow for the removal of certain areas, and the Trust had a good history of deferring audits when they were not appropriate.

Mrs McRae thanked Mr Wright for the report

The Board of Directors **received** and **noted** the Report from the Chair of the Audit Committee.

26/098

Board Assurance Framework (agenda item 19)

Dr Munro presented the report, taking it as read by the Board. She noted the Board Assurance Framework (BAF) had been refreshed following the discussions at the Board Development workshop and the changes agreed. It

was presented to the Board for final approval, and the content within the Committee report triangulated the review undertaken.

Mrs Hanwell noted the BAF comparison exercise presented in the Audit Committee which identified a variation in risk appetite compared to LCH for residual risk, and that this presented an opportunity for Board discussion as part of the integration programme and development of the BAF for the new organisation. Mr Wright added that the benchmarking suggested that the Trust set unrealistic target risk scores which led to the Trust consistently failing to meet the target. We should therefore consider being less onerous in the target risk scores we set ourselves.

The Board of Directors **received** the Board Assurance Framework and **approved** the content.

26/099 Scheme of Delegation (agenda item 20)

Dr Munro presented the report, taking it as read by the Board, noting the minor amends set out within paper which required Board approval.

The Board of Directors **received** and **approved** the Scheme of Delegation.

26/100 Use of Trust Seal (agenda item 21)

The Board **noted** that the Trust Seal had not been used since the last Board meeting.

26/101 Any other business (agenda item 22)

There were no additional items of business raised.

26/102 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 11:15 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.

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
	There are no open actions for the Board of Directors			

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
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	<u>COMPLETE</u> It was noted that this was included in the operational priorities for July 2026.
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) 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.	Clare Edwards	Management action	<u>COMPLETE</u> This has been added to the Board Strategic Session forward plan for October 2026.
Actions from Committees for the Board of Directors				
	None			



Leeds and York Partnership
NHS Foundation Trust

Meeting of the Board of Directors

Paper title:	Chief Executives Report
Date of meeting:	24 September 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	Demand for services	✓
SR8	Health inequalities	✓
SR9	System change	✓

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

24 September 2026

Chief Executive's report

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

Our services and our people

Service Visit to Asket Croft and Asket House

It was a pleasure to meet with staff and service users at our community-based rehabilitation facilities at 'The Askets'. There are stable and committed leadership teams in place and the team managers shared the ongoing work they are doing to support staff and improve services. There has been a stronger focus on reducing sickness absence and recent success in recruiting newly qualified nurses and occupational therapists.

The team highlighted some of the changes that have been made within the environments following the CQC inspection early this year and were preparing for peer review visits to evaluate and support ongoing improvements.

The patients I met with at both units were all consistent in their high praise for the support, interventions and relationships fostered with staff and specific mention was made for the nursing staff and occupational therapy staff. It was also great to hear about the strengthening of links not community-based activities/opportunities and greater in reach for the community rehabilitation team. Staff were curious about the impact the merger with LCH will have on them and we talked about opportunities for staff development which works both ways to support patients with rehabilitation and recovery.

National Oversight Framework

The results for **Quarter 1 2026/27** have now been finalised and are expected to be published shortly.

We have been informed we are in segment **3 and** this is an improvement since Quarter 4 2025/26 when we were in segment 4 - and where we predicted we would be.

Our average metric score is **2.53** (lower the score the higher performing in range between 1 and 4) and our ranking in the national league table for non-acute NHS providers is **44/58** compared to Quarter 4 2025/26 ranking position 48/61 representing an improvement in position.

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

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

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

- Submission of our checkpoint report to NHSE on the 4th of September.
- Formal endorsement from NHSE for the new Trust name post-merger.
- Conclusion of the phase one 'Best of Both' staff engagement events to inform our culture diagnostic.
- Workshops planned to begin phase two to develop our values and behaviours framework for the new trust.
- Recruitment to the new Trust board got underway starting with the new Trust Chair Helen Thomson.
- Letters to all local MPS to update on our plans and request an opportunity to meet in person.
- Working ongoing developing a new Trust Strategy
- Work ongoing and on track on full business case, patient benefit cases, and post transaction implementation plan.

2. SYSTEM UPDATE

National Update

Since the last board meeting there has been significant changes in political leadership and personnel. We now have a new secretary of state for health and social care – Yvette Cooper. We have had an initial

CEO meeting with the SoS in which she shared her observations of the progress and challenges in health and social care. She also talked about areas of personal focus which centred on the importance of national standards delivered locally, working in partnership and with citizens and communities. Key service areas of interest include maternity service improvements and children and young people's mental health.

West Yorkshire ICB Updates

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

Leeds Place Updates

- Timescales for delegation of commissioning functions from the ICB to place based partnerships has now been revised to April 2028 reflecting the significant work involved.
- Tim Ryley has now taken up post as our Director of Leeds Provider Partnership working for the partners in the city to support us develop our arrangements to take on delegated functions from the ICB. Tim will work closely with the Director of Integration once they have been appointed.
- Caroline Baria – Director for Adult Services in Leeds City Council has announced she is retiring. Recruitment will get underway this month for a replacement.

3. Reasons to be Proud

This section is shorter than usual as our September's huddle was scheduled for later in the month to accommodate the annual members meeting and Trust celebration event. On that note a huge thanks to everyone who helped make the day a success and videos from the day will be shared over the next few weeks.

East, North-East Community Learning Disability Team



Through a period of significant change, colleagues have pulled together to support one another, adapt to new challenges and continue delivering high-quality, person-centred care.

- Demonstrated resilience and teamwork while managing multiple staffing changes across the service.
- Maintained continuity of care and created a welcoming, supportive environment for both existing and new team members.

"Our team motto is 'we bridge each other's gaps', and this has been very evident throughout this period of change." Nominator Selina Armstrong

Judges comment - "A great example of coming together. Continuity of care and perseverance were clear throughout."



This month's Research Hero is Dr Dan Romeu, who played a key role in a pilot study exploring the use of the CAARMS assessment for people with Autism Spectrum Disorder.

During his placement with the service, Dan led the ethical approval process, secured funding, and supported the study from start to finish. His dedication helped the project progress successfully and reach the dissemination stage.

Dan has since presented the research at a Leeds-wide conference and is lead author on the study paper, with further findings due to be shared at the LYPFT R&D Forum in October 2026.

"It has been a pleasure and a privilege to be part of this project. I am incredibly grateful to the LADS team and everyone who supported us throughout the study."

Dr Sara Munro
Chief Executive Officer
16 September 2026

Meeting of the Board of Directors

Paper title:	Report of the Chief Financial Officer
Date of meeting:	24 September
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	Demand for services	
SR8	Health inequalities	
SR9	System change	

Executive summary

At month 5 we are reporting a £28k surplus against a balanced plan. There are a number of significant pressures within the position. The efficiency programmes have been developed. Recurrent budget efficiency has now started to deliver but there still remains a significant under-delivery year to date. Capital expenditure is progressing in line with plan

Another Deconstructing the Block exercise has been completed with resulting in a £21.1m gap against a £163.4m contract which represents 12.9% of the contract value. The remaining gap can be reconciled through the unwinding of the deflator, the early stages of the currency implementation and the assumptions made to calculate the national averages. Poor data quality underpins the exercise and represents a significant risk to providers.

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

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

Recommendation

The Board is asked to:

- Note the Trust revenue and capital positions for 2026/27 at month 5.
- Note the results of the Deconstructing the Block exercise

Meeting of the Board of Directors

24 September 2026

Chief Finance Officers Finance Report

1 Introduction

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

2 Revenue Position

At the end of August we are reporting a £28k surplus against a balanced plan as shown below.

Income & Expenditure Plan Position	Plan Annual £'000	Month 5		
		Plan YTD £'000	Actual YTD £'000	Variance YTD £'000
Income:				
Patient Care Income	249,522	104,914	105,003	89
Other Income	28,165	12,857	13,562	705
Total Income	277,687	117,771	118,565	794
Expenditure:				
Pay Expenditure	(201,533)	(84,411)	(84,961)	(550)
Non Pay Expenditure	(71,172)	(31,286)	(31,457)	(171)
Total Expenditure	(272,705)	(115,697)	(116,418)	(721)
Surplus/ (Deficit)	4,982	2,074	2,147	73
Adjustments for NHSE Reporting	(4,982)	(2,074)	(2,119)	(45)
Adjusted Position	0	0	28	28

It should be noted that the overall positive position against plan is supported by a significant number of one-off non-recurrent mitigations:

- Technical flexibilities totalling c.£2.1m year to date.

- Slippage on the opening of the new Perinatal non-recurrent benefit of £0.8m YTD
- Interest Receivable is £0.4m above planned levels but expected to reduce when interest rates reduce
- Additional income above planned levels of £0.7m

Excluding the technical flexibilities in the position the actual monthly net run rate position is shown below:

Month	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Surplus / (Deficit)	{1,126}	{640}	{359}	{255}	{168}

Whilst still an underlying deficit position at month 5 (August), the above table demonstrates a month on month improving run rate position, mainly reflecting reductions in out of area placements, bank expenditure and 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 directly links to achievement of run rate efficiencies.

Within the position the significant expenditure pressures remain as :-

- Pay Expenditure - substantive pay and bank combined £1.1m higher than plan with agency spend £0.5m under plan.
- Non-Pay expenditure - Out of Area placements expenditure across Working Age Adult (WAA), Older People and Complex Rehabilitation £2.6m over plan collectively, with £1.9m attributable to WAA.

Overall, the position is balanced due to the mitigations noted above.

3 Efficiency Programme 2026/27

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.

3.1 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 5:

Schemes	Recurrent / Non- Recurrent	YTD Plan (£000)	YTD Actual (£000)	YTD Variance (£000)
NR Income	Non-Recurrent	417	402	(15)
Technical Flexibility	Non-Recurrent	0	350	350
Agency Reduction	Recurrent	255	741	486
Bank Reduction	Recurrent	144	0	(144)
MARS Scheme	Recurrent	600	600	0
Community Transformation	Recurrent	833	292	(542)
Job Planning	Recurrent	63	0	(63)
Contract in-housing Overhead	Recurrent	146	0	(146)
Digitalisation Project	Recurrent	208	0	(208)
Fragile Services	Recurrent	208	0	(208)
Procurement/ Non-Pay inflation	Recurrent	417	417	0
Pay / Vacancies	Recurrent	941	820	(121)
Additional Income	Recurrent	0	613	613
		4,231	4,234	3
	Recurrent	3,814	3,482	(332)
	Non-Recurrent	417	752	335
	Total	4,231	4,234	3

The Trust is broadly on plan at M5 largely due to realising the full year impact of MARS efficiency (agreed in 25/26), additional income over the amount anticipated in plan and a higher than anticipated reduction in agency expenditure at this stage of the year. The shortfall on recurrent scheme delivery is under review and mainly due to timing of delivery.

3.2 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 (EQIA) panel was held on 31st July 2026 where the first tranche of efficiency schemes were reviewed. There were £1.7m of schemes agreed to be progressed and £1.2m of which have been transacted in month 5, with the remaining £0.5m to be transacted when the additional funding to which they relate is received by the Trust.

The second EQIA panel will be held at the end of September.

Scheme or Service / Department	Target £000	Transacted £000	Variance £000
Community Transformation	2,000	0	2,000
Job Planning	150	0	150
Contract in-housing	350	0	350
Procurement/ Non-Pay inflation	1,000	0	1,000
Additional Income	500	0	500
Adult Acute Services	1,514	0	1,514
Care Services Others	360	387	-27
Children + Young People	258	0	258
Forensic Services	86	43	43
LD Services	1,892	0	1,892
Liaison + Perinatal Services	1,173	134	1,039
Older Peoples Services	1,163	0	1,163
Regional + Specialist Services	900	0	900
Chief Financial Officer	335	327	8
Chief Nurse	353	100	253
Chief Operating Officer	28	0	28
Medical	959	0	959
People and OD Directorate	580	181	399
Total	13,600	1,170	12,430

After transacting £1.2m in month, £12.4m or 91% is remaining to be transacted, the vast majority of this is still yet to be identified.

It has been agreed at the Extended Executive Management Team meeting that there will be a shift in approach to the delivery of recurrent budget CIP. There needs to be more aggregation and alignment across services, rather than specific individual budget holders. This is in line with the programme work underway for the Community First programme which takes a more pathway approach and covers multiple budget/service areas. We are refining the approach and methodology which will include independent/peer review and utilise multiple sources of data to inform the work and reassign targets in care services areas.

The corporate savings are being delivered through holding of vacancies. There is high degree of confidence that the recurrent budget savings will be achieved linked to the integration work.

4 Provider Collaboratives

The Trust is part of four Provider Collaboratives (PC) in West Yorkshire, each having their own risk and gain share arrangement in place. At M5 the only PC currently forecasting a deficit in year is the Adult Secure PC hosted by South West Yorkshire Partnership NHS FT. Overall there is a likelihood that the PCs will end the year in surplus. Each PC will make decisions on a reinvestment approach, whilst continuing to hold contingency for risk. It is highly likely that the Children and Young Peoples PC will be able to make some recurrent investment and is currently reviewing options, including the establishment of day services similar to those developed in Humber at Mill Lodge.

The Trust is also part of two PCs in Humber and North Yorkshire (Adult Secure and Children and Young People). Volatility on high cost and unpredictable of Exceptional Packages of Care does persist, but there is still a likelihood of a surplus.

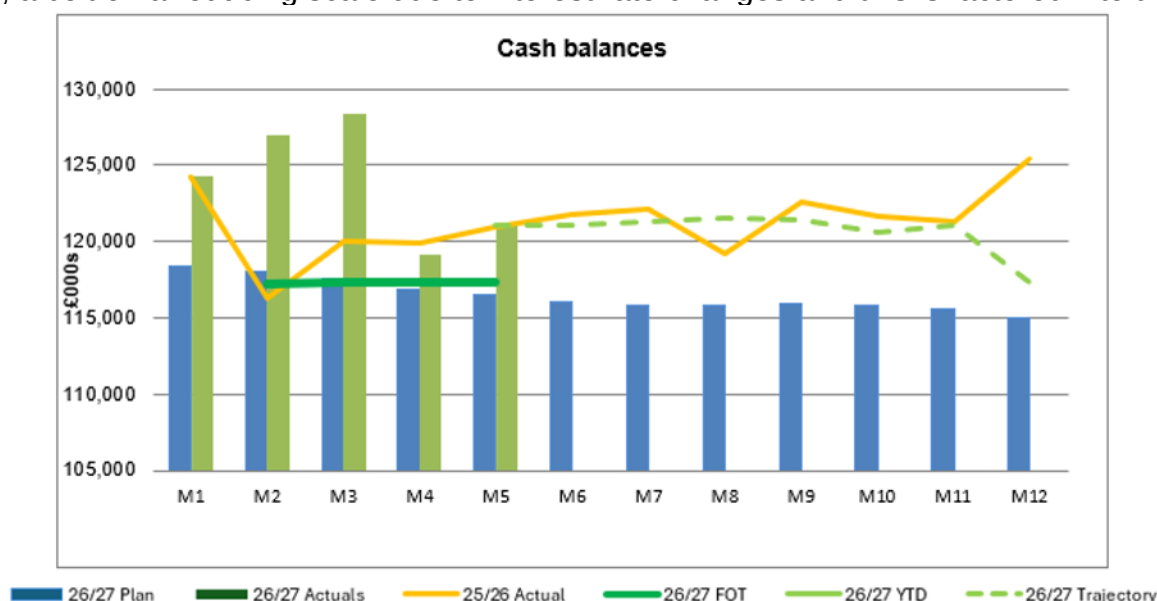
5 Capital Position

Cumulative Capital expenditure at M5 is £1.5m against a plan of £1.5m. 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. In addition, the plan assumed Public Dividend Capital (PDC) of £3.2m in year; of which £2.5m is related to the new Electronic Patient Record scheme and is now more likely to be required in future years. The current climate means that there is a degree of uncertainty in respect of PDC planned in year. Conversely, PDC is likely to be available for other/specific purposes, and the Trust will endeavour to maximise any opportunities that arise.

6 Cash position

At the end of August, the Trust has a cash balance of £121.1m. 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.



7 Better Payments Practice Code

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

The key targets are:

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

Below is the Trust performance against each target:

30 Days Summary			
Category	BPPC Paid Period	% Number Passed	% Value Passed
Non NHS	AUG-26	95.9%	99.2%
Non NHS	Year to date	95.0%	98.5%
NHS	AUG-26	88.6%	95.9%
NHS	Year to date	93.2%	89.3%
Total	AUG-26	95.6%	98.9%
Total	Year to date	94.9%	97.6%

By value YTD we are at 97.6% which is very impressive however by number of invoices we are 0.1% below target. After a positive start this percentage dropped in June and July but since a rapid task and finish group to resolve the delay was stood up we have improved the percentage and aim to be back to 95% or above in September.

There was a drop in the proportion of NHS invoices paid with in 30 days during August, 88.6% compared to 98.7% in July. This is due to invoices getting stuck in staff members workflows whilst on holiday. Ways of reducing this have been discussed and include regular reviews of invoices that are in staff's workflow.

8 Deconstructing the Block (DTB)

The 10 year health plan highlights the need to move away from block contracts and develop flexible, transparent and appropriate contracting arrangements to support service transformation and improved patient care (i.e neighbourhood mental health). The first deconstructing the blocks (DTB) exercise ran between July-September 2025. Due to many concerns regarding the variability and inconsistency in the data produced, it was decided nationally not to implement any changes to pricing and payment for Mental Health and community services in the 2026/27 planning round.

The intention is for 2026/27 DTB exercise to influence the NHS payment scheme for 2027/28. This exercise ran from July 2026 with the Trust submission to the ICB in early September. ICBs will

collate results from all providers for the systems and send to NHSE 17 September. The contract value used for the exercise is the opening 2026/27 offer, this is then compared with activity from the 2025/26 national cost collection costed at an adjusted national average price. One of the main adjustments to the price was that prices applied in the exercise have been deflated for an estimated productivity change between 2019/20 and 2024/25. This assumes that prices and costs would have been less if productivity would have continued at a rate based on Office of National Statistics (ONS) estimates of public healthcare productivity. In the NHS generally productivity over this period has reduced not increased. The deflator amount equated to a 14.6% reduction in price.

All providers have completed the exercise in a consistent way. There are “allowable” exclusions where certain items in the block contract can be excluded where no activity is generated. The biggest examples of this for LYPFT is the out of area placements and other pass-through subcontracts. Once Trust activity for 2025/26 was multiplied by the nationally adjusted prices, and after exclusions, a £21.1 gap was identified, meaning our calculated value of payments was lower than the actual block contract income of £163.4m. This represents 12.9% of the contract value. This remaining gap is broadly explicable/ reconcilable through the unwinding of the deflator, and the assumptions made to calculate the national averages, due to the early stages of implementation of national price currencies. Alongside this data quality and data capture is a known significant risk across providers and this underpins the exercise. LYPFT is not an outlier in having a significant gap in the results from the exercise.

A detailed analysis of the Trusts return has been shared with the Finance and Performance Committee and approved for submission. It remains unclear what the next steps are nationally and how the results from this exercise will be used to inform policy and pricing for 2027/28 onwards.

9 Conclusion

At month 5 we are reporting a £28k surplus against a balanced plan. There are a number of significant pressures within the position. The efficiency programmes have been developed. Recurrent budget efficiency has now started to deliver but there still remains a significant under-delivery year to date. Capital expenditure is progressing in line with plan.

10 Recommendation

The Board is asked to:

- Note the Trust revenue and capital positions for 2026/27 at month 5.
- Note the results of the Deconstructing the Block exercise

Appendix A – Capital Position

Leeds and York Partnership NHS Foundation Trust				
CAPITAL PROGRAMME - at 31 August 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	240	58	182
Security review	200			
Sub-Total	1,000	240	58	182
IT/Telecomms Operational				
IT Network Infrastructure	200	75	(13)	88
Server/Storage	30			
PC replacement EUL	250	120	(13)	120
Sub-Total	480	195	(13)	208
Estates Strategic Developments				
Lifecycle contribution	100	40	54	(14)
Red Kite View	100		50	(50)
Mill lodge, York	100	25		
Clifton House, York	100			
Sustainability & Green Plan	300	40	1	39
Wellbeing	50	25		
PFI schemes	1,944	662	1,230	(568)
Decarbonisation strategy	300			
PFI demise/estate	300		60	(60)
Sub-Total	3,294	792	1,395	(653)
IT Strategic Developments				
Asset Management	60			
Anti-virus & Encryption	50			
Back up software	60			
Cyber security	50	25		
Integration System	50			
Voice recognition	140			
Remote working, access and agile	100			
IT strategic developments	100			
Smartphones	60	25		25
Sub-Total	670	50	0	25
NOF Capital Freedom				
Estates Infrastructure	0	200		200
IT Infrastructure	0			0
Sub-Total	0	200	0	200
Disposals				
ICS	0	0		0
Sub-Total	0	0	0	0
Total ICS Operational Capital	5,444	1,477	1,439	(37)
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	60	50	10
Sub-Total	150	60	53	7
Disposals				
Lease - vehicles			(8)	8
Sub-Total			(8)	8
Total IFRS16 Leased Assets	150	60	45	15
Total Capital Spend	8,837	1,537	1,485	(23)
Capital Funding Source:				
ICS Operational Capital	5,444	1,277	1,439	(162)
Public Dividend Capital (PDC)	3,243	0	0	0
IFRS16 Leased Assets	150	60	45	15
Total	8,837	1,337	1,485	(148)

Meeting of the Board of Directors

Paper title:	Report of the Chief Operating Officer
Date of meeting:	24 September 2026
Presented by: (name and title)	Joanna Forster Adams, Chief Operating Officer
Prepared by: (name and title)	Members of the Care Services' Senior Operational Leadership Team

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

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	✓
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	✓
SR6	Digital technologies	
SR7	Demand for services	✓
SR8	Health inequalities	✓
SR9	System change	

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

24 September 2026

Report of the Chief Operating Officer

1. INTRODUCTION

This report sets out the key management, development, and delivery issues across 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, out of area placements and long lengths of stay
- Older people’s long lengths of stay
- Emergency Department (ED) waits for mental health assessment
- Reliance and use of additional temporary staff
- Mother and Baby inpatient unit – ongoing business continuity/suspension of admissions.

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)

The Trust has worked in partnership with VOT Health triangulating frontline observation, staff interviews and data analytics to undertake a diagnostic and identify high impact service user flow improvement interventions. This was actioned due to continuing challenges relating to patient flow, ongoing increased lengths of stay and sustained reliance on Out of Area Placements. We have been working with NHS England Regional colleagues who have supported our approach to the work but will continue to closely monitor our position and improvements.

Thematic headlines from the analytic diagnostic includes:

- CRISS, and crisis services external to LYPFT, are not functioning optimally as an admission alternative and is not consistently and actively facilitating early discharge

- Admissions continue to be insufficiently purposeful despite significant work over the last 18 months to improve this
- Challenges in access to PICU
- Activity in our Community Mental Health Teams is less proactive and responsive than needed to ensure that a deterioration in mental health can be effectively treated/supported.

To progress this work, the Trust has introduced dedicated Senior Operational and Clinical Programme Leads to oversee and deliver on a Pathways and Flow Programme, Community First, with the following high-level objectives:

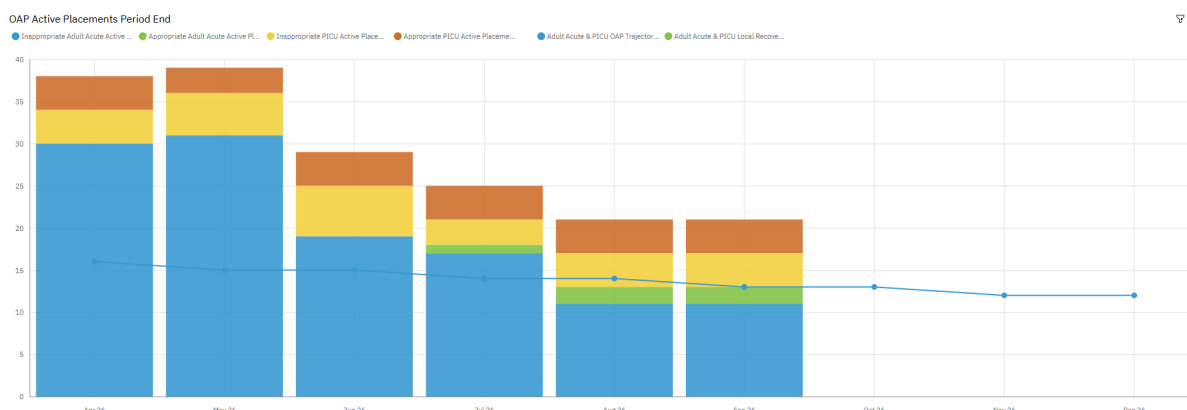
- Zero inappropriate Out of Area Placements by March 2027
- Reducing length of stay to the NOF score 2 (domain 3 – experience of care) in Adult Acute, PICU and Older Adult Services by March 2027.

The programme includes oversight for the review and delivery of all dedicated pathway and flow related workstreams (e.g. Neighbourhood Health, Mental Health ED) along with the monitoring of the GIRFT action plan implementation and delivery. A refreshed and refocused governance structure based on the provider collaborative model and principles, with key oversight and drive of quality, safety, performance and delivery has been established.

At the end of August, whilst Adult Acute and PICU services remained under sustained flow pressure, we have seen a reduction in the number of service users in Out of Area Placements. However, we remain off trajectory, see Graph 1. The Out of Area position has been further impacted by the temporary closure of two bedrooms (Ward 1 and Ward 5 at the Becklin Centre) in early July. This was as a result of damage to doors and frames where there has been a 9-week lead time to order replacement equipment and undertake repairs.

To reduce the risk of future delays, options are being considered with estates for maintaining contingency stock or access to compliant temporary replacement door sets, including associated frames and anti-barricade systems.

Graph 1



We aim to admit service users as close to Leeds as possible with most being placed in facilities in Yorkshire or the Northeast of the country, see Image 1. Distances from Leeds are shown in Table 1.

Image 1



Table 1

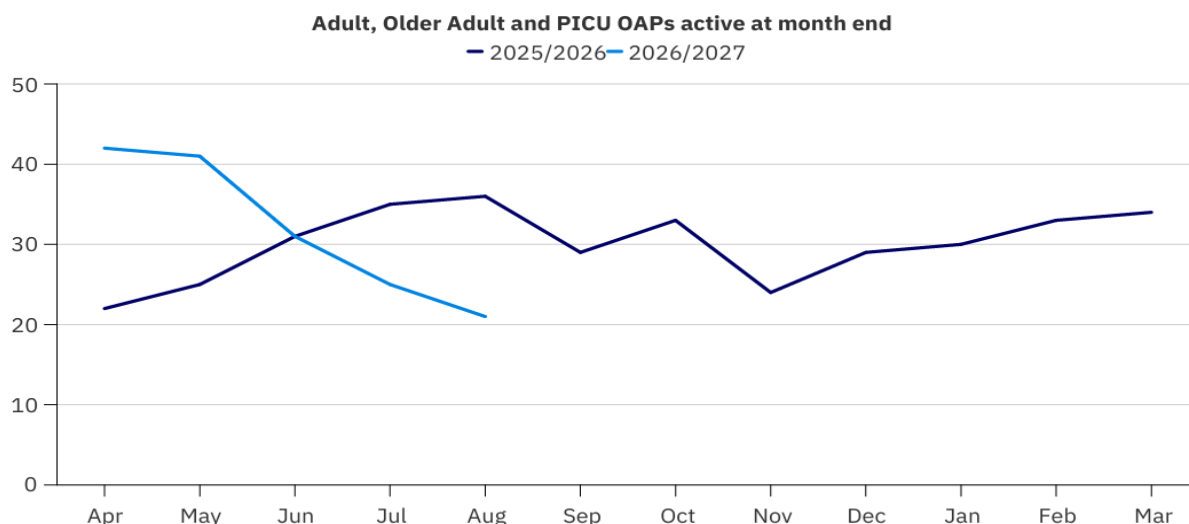
Placement Type	Placement Location	Number of Service Users	Distance from home
PICU	THE PRIORY HOSPITAL MIDDLETON ST GEORGE	x3	47-50 miles
	CYGNET HOSPITAL WIKE	X1	13 miles
	WATERLOO MANOR HOSPITAL	x4 (appropriate placements)	4-9 miles
Acute	THE PRIORY HOSPITAL MIDDLETON ST GEORGE	x 7 (includes 2 appropriate placements)	46-52 miles
	CYGNET HOSPITAL BIERLEY	x1	7 miles
	CYGNET VICTORIA HOUSE	x1	51 miles
	CYGNET HOSPITAL WYKE	x3	9-12 miles

There has been a significant reduction in reliance on Adult Acute, and PICU OAPs during 2026/27 compared with 2025/26. OAPs reduced from 42 in April to 21 in August, representing a 50% reduction over the period. This has been accompanied by a corresponding reduction in OAP bed days of approximately 36%, indicating both fewer patients requiring out of area care and a reduction in the overall time spent in external placements.

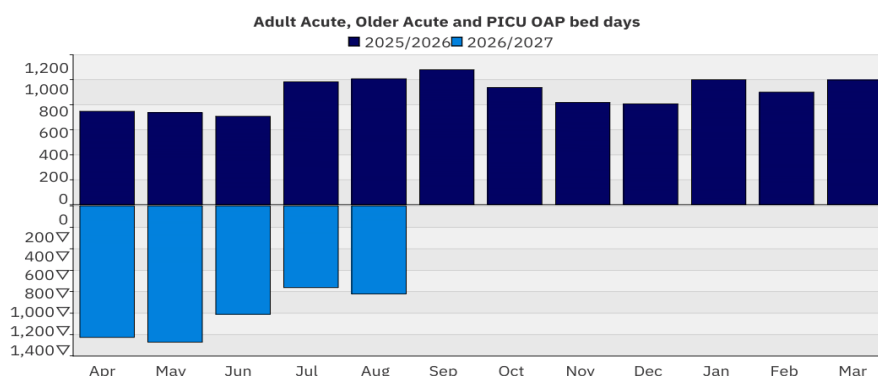
This improvement reflects the continued focus on patient flow, maximising the use of local bed capacity and reducing delays across inpatient pathways. The reduction in both placements and associated bed days suggests that our capacity is being utilised more effectively, enabling more patients to access care closer to home and reducing dependency on external providers.

Although further improvement is required to achieve the planned trajectory, the sustained downward trend demonstrates positive progress and provides assurance that the measures implemented to reduce out of area placements are having a measurable impact (See Graphs 2 and 3)

Graph 2



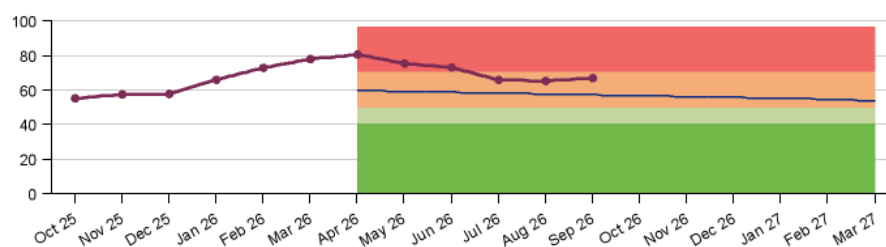
Graph 3



Reducing length of stay (LoS) remains a core component of the Community First Programme, as well as a key requirement within the National Oversight Framework (NOF). We remain in segment 3, recovering slightly from June when we were in segment 4, see Graph 4. We have a trajectory set to recover to a position of being segment 2 by the end of this financial year.

Graph 4

Adult Acute and PICU LoS on Discharge Rolling 3 Months Avg



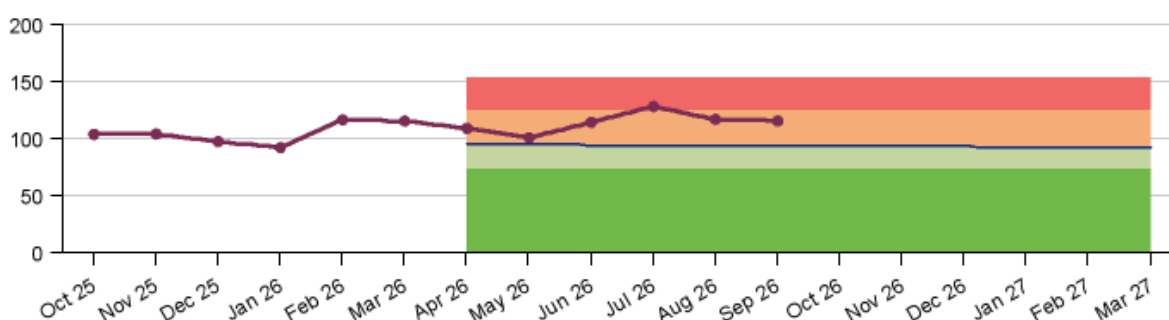
2.1.2 Older People's Length of Stay

Our Older People's Services continue to face challenges with capacity and flow into our inpatient service. We continue to see high inpatient demand and constrained flow that is impacting bed availability. Despite this, we have been able to eliminate all out of area placements through repatriation to our community services.

The most significant issue is the length of stay (see Graph 5) and clinically ready for discharge (see Graph 6). The average length of stay measure is now part of the new NHSE National Oversight Framework (NOF), which shows the service within segment 3 for this measure. We have set a trajectory for recovery to achieve segment 2 by the end of the financial year. The length of stay is impacted by long waits for onward placements, mostly within care home settings, resulting in the high number of service users deemed clinically ready for discharge. We have seen this number increase since May 2026. We are actively working with colleagues across Adult Social Care to source suitable placements.

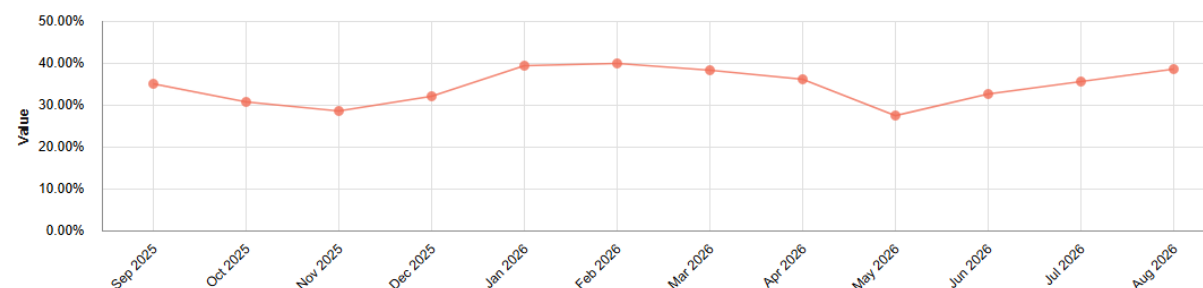
Graph 5

Older Adult LoS on Discharge Rolling 3 Months Avg



Graph 6

Inpatient OPS



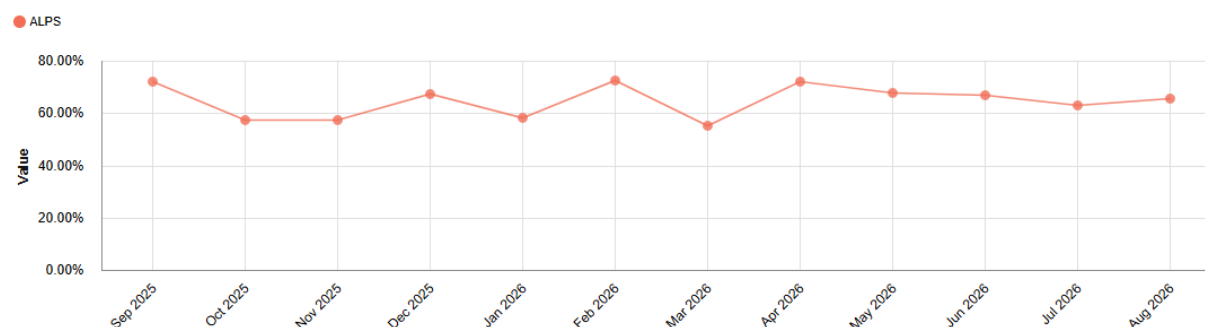
2.1.3 Emergency Department (ED) waits for mental health assessment

Achieving the one-hour target for all Acute Liaison Psychiatry Service (ALPS) referrals continues to be a challenge to the service. This is due to several ongoing factors including staffing availability, timing and volume of referrals which continues to affect our responsiveness (see Graph 7).

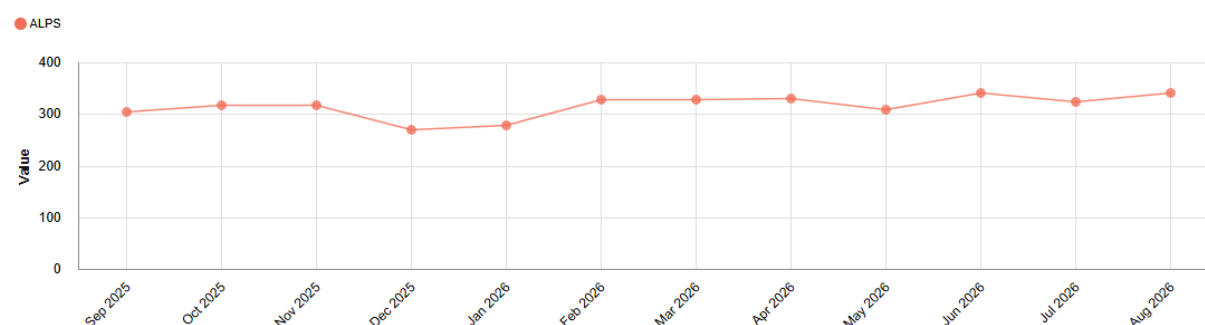
The number of referrals in each month has remained consistent, above 300 per month, since March of this year, see Graph 8. The flow of referrals remains challenging as it can be difficult to predict when referrals are made. More detailed analysis of referrals hasn't

identified patterns or trends that we can respond to improve our responsiveness on a sustained basis. However, we continue to test our recently established triage function which is welcomed by colleagues in LTHT.

Graph 7



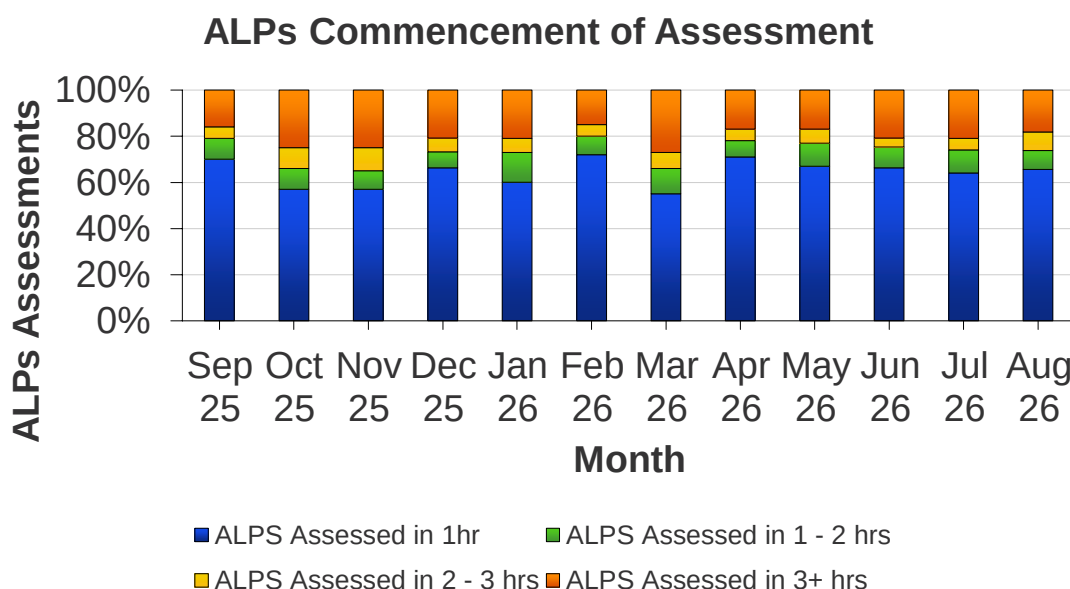
Graph 8



Where we have been unable to meet the 1-hour target time to assessment, we have seen over 80% of service users within 3 hours of referral throughout May, see Graph 9. However, this means that almost 20% 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. We are also progressing plans for the development of a Mental Health Emergency Department.

Graph 9



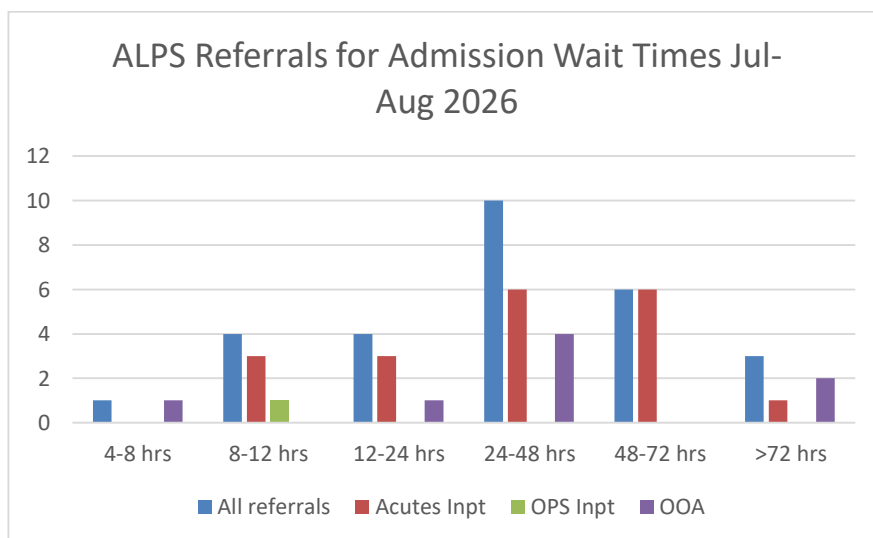
Whilst this target remains challenging, early indications are that in September the response times have improved due to a more assertive approach from the team, earlier in the assessment process, using the learning from the triage pilot and accreditation process. This will be kept under review, and further updates will be provided to the Board in the next report.

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 10. During July and August, we saw 23 service users waiting for admission more than 12 hours, the same number as May and June. There has been a marginal increase in the number waiting over 24 hours. Whilst most admissions have been to our Acute inpatient beds, we have also seen a slight increase to out of area units from the Emergency Department.

Delays continue to be attributed to delays in Mental Health Act assessments, with their completion impacted by the availability of beds within the Trust. We also continue to have a number of service users from outside of Leeds waiting for beds in the ED. Due to capacity in other Trusts we have also seen these service users waiting in excess of 24hrs for repatriation to their own area.

Graph 10



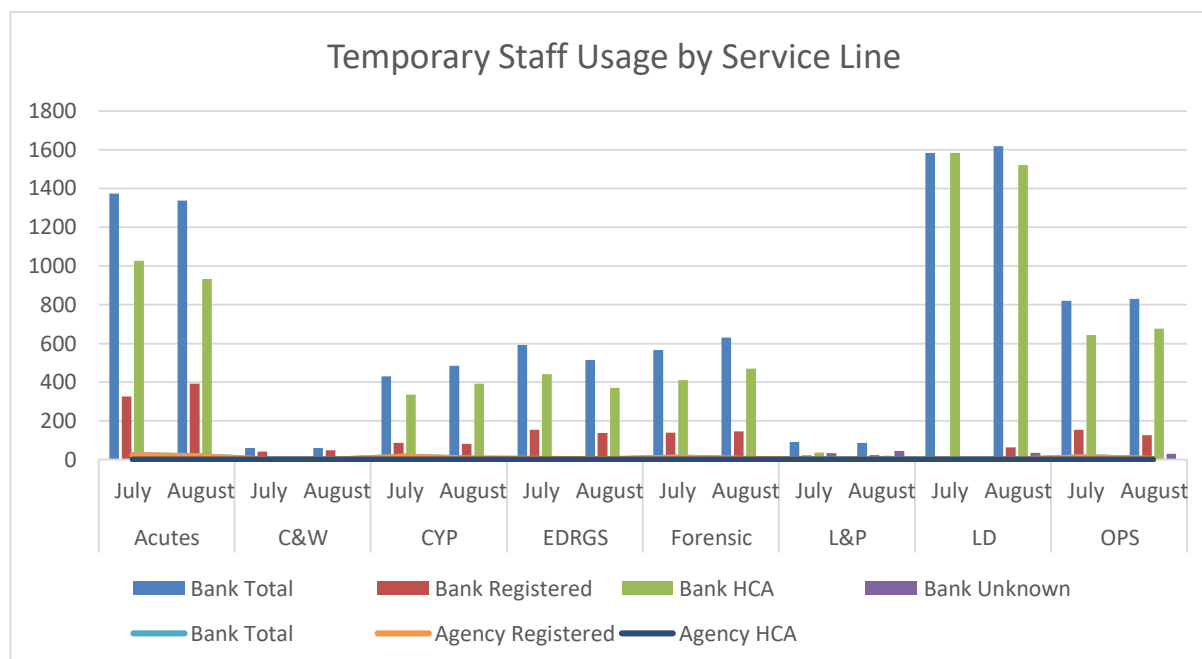
As part of the work to address mental health waits in ED, we have submitted a summary document to support the business case for funding for the capital bid with LTHT for an assessment unit specifically for those needing mental health care. The clinical model for the new unit is being developed in partnership with LTHT, and the intention of the integrated model is:

- **Unlocking Mental Health Capacity:** Medically fit patients, or those requiring only basic physical monitoring, receive specialist, time-rich psychiatric care away from acute hospital pressures. They are no longer subjected to the noise and intense clinical urgency of an acute trauma centre, which routinely exacerbates psychiatric distress.
- **Unlocking Acute Physical Capacity for Vulnerable Cohorts:** By absorbing mental health demand, the IPAU actively vacates physical capacity within the main ED. This freed capacity can be utilised as lower-stimulus medical environments for individuals with complex background factors (e.g., severe autism, profound learning disabilities, or advanced dementia) who are presenting with physical medical emergencies.
- **Reducing Onward Referral for Psychiatric Admissions:** By moving from assessment only to assessment and intervention, alongside the ability to provide a 'time rich' intervention we anticipate there will be few referrals of patient for psychiatric beds.

2.1.4 Temporary Staff Use

We continue to rely on the use of temporary staffing to ensure safe delivery of care to service users. The highest use is across our Specialist Supported Living (where we have high levels of vacancies), Adult Acute inpatients and Older Adult inpatient services. This is being monitored through the Bank Use Group and the Workforce Efficiencies Programme and is reported to the Finance and Performance Committee regularly to track progress. Graph 11 shows the number of shifts cover by temporary staffing type, the majority of which have been bank Healthcare Assistant (HCA) staff.

Graph 11

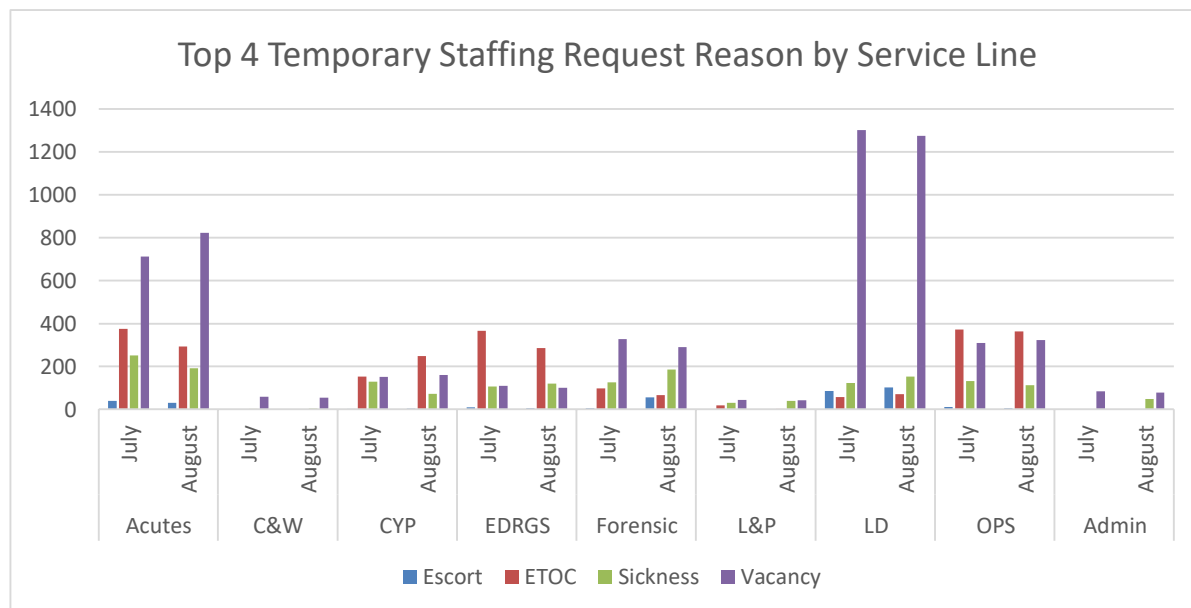


The reasons for use of temporary additional staff are shown in, Graph 12. We have HCA vacancies across Care Services which have been difficult to recruit to and a recruitment programme led by the Recruitment Team is in place to address this.

We see high temporary staff use to cover Enhanced Therapeutic Observations and Care (ETOC) where service users require higher levels of care, particularly in our inpatient settings. In our Acute Adult and Older Adult wards, the use of additional staff over and above establishments results in a year-to-date overspend of approximately £800k.

We are actively managing services to ensure they use their staffing establishments effectively, whilst maintaining service user safety. This is monitored through the Safer Staffing Group, the Bank Use Group and the Workforce Efficiencies Programme. To reduce the use of temporary staffing, effective roster management is crucial, but we have variability within teams and services. We are finalising enhanced management arrangements to rapidly improve where wards and departments persistently do not meet the standard necessary for effective roster management.

Graph 12



2.1.5 Mother and Baby Unit (MBU) ongoing Business Continuity incident

Significant structural work is required as part of the planned expansion of the Perinatal inpatient service. In late July, in the areas adjacent to the Unit, noise and vibration levels were found to be having a detrimental impact on patients and babies on the Unit. We immediately took steps to mitigate for this and moved into EPRR arrangements to oversee and manage the risks. This means that we have paused admissions until the work is complete which is currently on schedule for week commencing 21 September. At the time of writing this report, a total of 7 service users were being treated outside of Leeds.

We have robustly implemented actions and continue to monitor the progress of mothers, babies and families who are temporarily in out of area placements. Our MBU clinicians and broader team, together with colleagues from the Provider Collaborative Commissioning Hub have worked incredibly hard to maintain the care and treatment of patients either remaining in the Mount Unit or who are in other placements.

Our Estates team are overseeing the progress of works and actively working with health and safety colleagues to ensure that we can operate safely.

2.2 ADVISE

2.2.1 Crisis and Intensive Support referrals seen within 4 hours

Over recent months, work has been undertaken to strengthen monitoring and oversight of compliance with the 24-hour crisis response. This has improved our ability to identify emerging risks and support timely intervention.

Historically, the ability to monitor compliance consistently was constrained by limited performance visibility. Through close collaboration with the Informatics team, reporting has

been enhanced to provide a more reliable understanding of performance across crisis services.

Enhanced reporting arrangements now provide greater visibility of service activity, demand, and compliance rates, enabling teams to identify trends, pressures and areas requiring intervention at an earlier stage.

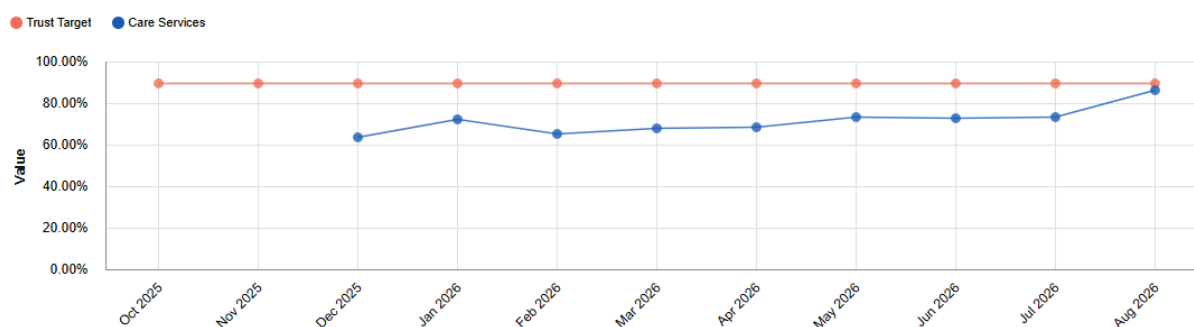
Leadership oversight has also been strengthened through daily performance reviews. These reviews support the timely identification and escalation of risks, maintain focus on compliance with the service standard and reinforce accountability across teams.

Improved reporting enables a better understanding of variation in performance across services and supports the identification of recurring themes where additional support, supervision or improvement activity may be required. This allows targeted actions to address barriers to compliance and support sustained improvement.

Collectively, these developments have strengthened governance arrangements and organisational oversight of crisis response performance. The Trust is now better placed to monitor compliance, respond to emerging challenges and support timely access to crisis services. Continued focus on data quality, operational oversight and targeted improvement activity will support delivery of the 24-hour crisis response.

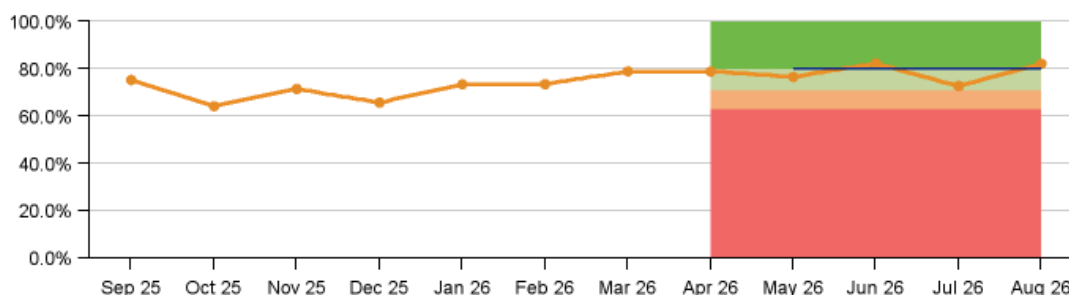
The 24-hour response standard is now a measure through National Oversight Framework as referenced in section 2.2.2. Overall performance across the past 6 months has remained reasonably consistent with some minor fluctuations between segment 1 and 2, see Graph 14. Services are working to maintain a constant position within segment 1.

Graph 13



Graph 14

CRISS and OPS Intensive Services Urgent Referrals Seen Within 24 Hours (%)



2.2.2 NHS Oversight Framework (NOF) measures in Care Services

Care Services has the oversight responsibility for 5 NOF measures as part of the new NHSE requirements. These are:

- Adult Acute and PICU LoS on Discharge Rolling 3 Months Average
- Older Adult LoS on Discharge Rolling 3 Months Average
- 3 Day Follow Up
- CRISS and OPS Intensive Services Urgent Referrals Seen Within 24 Hours
- 14 Day Readmission Rate.

These are monitored through the Care Service Finance and Performance Meeting which will then report into the NOF Executive Oversight Group, led by the Chief Operating Officer, where all NOF measures will be monitored across the Trust.

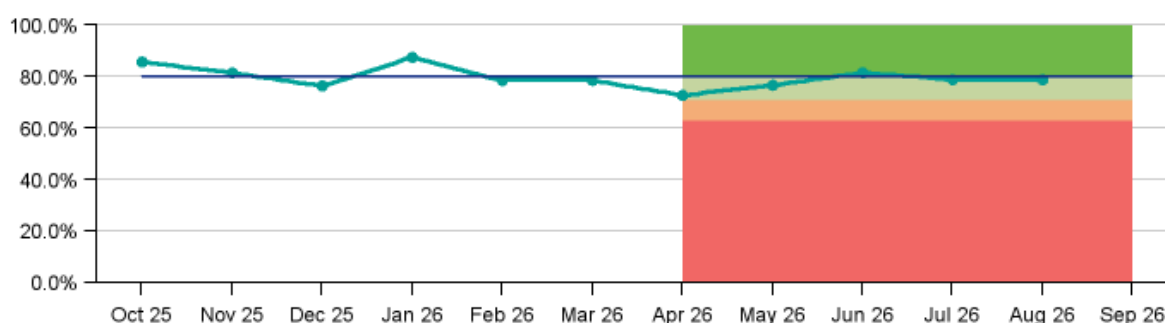
The Acute Adult & PICU, Older Adult LoS and CRISS and OPS Intensive Services Urgent Referrals Seen Within 24 Hours metrics are referenced earlier in the report.

2.2.2.1 Three-day Follow Up

We consistently maintain performance of around 80% across all areas, see Graph 15. Informatics has reconfigured this measure to sit within the Community Services data, previously this was sat against inpatient services. We have identified data quality issues which are being resolved but further steps are being taken to ensure this key patient safety measure improves.

Graph 15

① 3 Day Follow Up (HCP Commissioned Services) (%)



2.2.2.2 14 Day Readmission Rate

The data report for this measure has not yet been produced. This is because our Informatics team have been unable to produce a report based on the logic that underpins this measure. They are working to develop the measure that produces the data in line with NHSE requirements.

However, we submit readmission data to the Mental Health Minimum Data Set (MHMDS), the local replication of the NOF metric for the year to date is below in Table 2. This is a full replication including the rolling 3-month period and aligned to the MHSDS reporting cut off

dates, produced whilst we are waiting for the NOF measure to be produced. This would indicate that we are in segment 1 of the NOF for quarter 1 and so far into quarter 2. (This is unvalidated due to the limited information we have on NOF Quarter 1 scores at the time of producing this report).

Table 2

3 Month Rolling End	Actual (Readmission Rate %)	Numerator (Readmissions within 14 days)	Denominator (Eligible Discharges)
31 Aug 26	4.0%	8	199
31 Jul 26	3.5%	7	198
30 Jun 26	1.2%	2	165
31 May 26	2.1%	4	187
30 Apr 26	4.1%	8	196

Through the introduction of proactive weekly reviews of all adult acute and PICU admissions over the previous 7 days, we are now in a position where we review all readmissions. Although there is evidence of good practice, we have identified themes that have contributed to readmissions including poor communication around discharge planning and a lack of proactive community and crisis service engagement. Readmissions, including the themes identified, are to be addressed as a part of the Community First Programme and the workstreams that are included across the Community First Collaborative.

It is imperative that in-patient, crisis, and community services work together through MDT processes to ensure service users have recovery focused and successful discharge from inpatient to community. The Community First Collaborative will be instrumental in focusing the improvement work whereby community services take a lead role in the care of service users regardless of the setting they are in.

2.2.3 Assertive Outreach Team (AOT) Business Continuity

Due to temporary but significant workforce shortfall resulting from long-term sickness absence, short-term sickness, maternity leave, authorised leave and vacancies, business continuity arrangements were triggered on the 9 July 2026. The staffing deficit was affecting the team's ability to fully deliver the standard of care they require to a highly complex and high-risk service user group.

The service completed a business risk impact assessment to ensure priority pathways remained open, prioritising with people on caseload the type of intervention and frequency of contacts. The service continued to accept new referrals and were planning to manage these through a waiting list, providing referrers with support in managing these service users. However, this mitigation was not required.

The service met with the ICB and NHSE during the early stages of business continuity arrangements and were able to provide the assurance that the service would be maintained to ensure they met the needs of the service user group.

We returned to normal business on the 3 September 2026.

2.2.5 Specialised Supported Living (SSL) Property Damage

On the 27 July 2026, our SSL service at Sledmere Lane suffered significant damage to the roof after a tree was blown over. No service users or staff were injured and whilst the damage was extensive, it was in an area of the property that could be taken out of use for a period. The property is the responsibility of a private landlord and the service liaised with them to get the necessary repairs completed.

All the trees have now been removed, including other trees that were deemed high risk of collapse. Builders are carrying out assessments of the structural needs of a repair to the roof, which will be significant, and the centre area of the house is still not deemed safe for anyone to use. As such, contingency plans are still in place to navigate the affected areas whilst the building work is undertaken.

The team was supported by our Estates colleagues, and the incident was managed extremely well. The Head of Operations and the EPRR Lead will jointly lead a debrief session in September as the incident raised a number of issues regarding the response responsibilities from the Landlord, Adult Social Care and LYPFT. Also, we need to consider what would have needed to happen should the property have sustained more damage that made the whole of it unsafe to occupy.

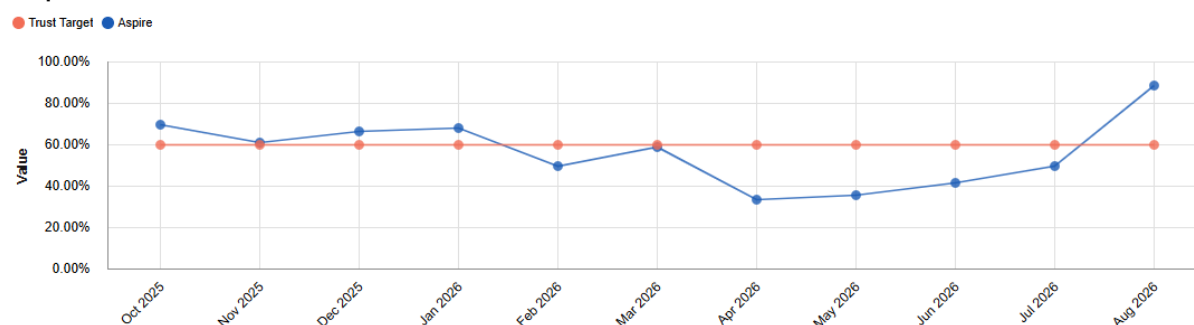
2.2 ASSURE

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

In March, there was a sharp deterioration against this key access target with marginal gradual improvements over the following 4 months, see Graph 16. A marked improvement through August resulted in performance at 89%. This is due to improved triage, assessment, and MDT processes. Additionally, actions included in the interim recovery plan, developed to support improvement ahead of in-sourcing of the service in October, are on track and contributing to the increase in access performance.

Whilst Care Coordinator caseloads remain higher than ideal, there has been a reduction in the total caseload by 45 since May 2026. Referrals have increased over the same period. This indicates that the service changes that have been implemented to more effectively manage the referral handling processes are starting to become embedded.

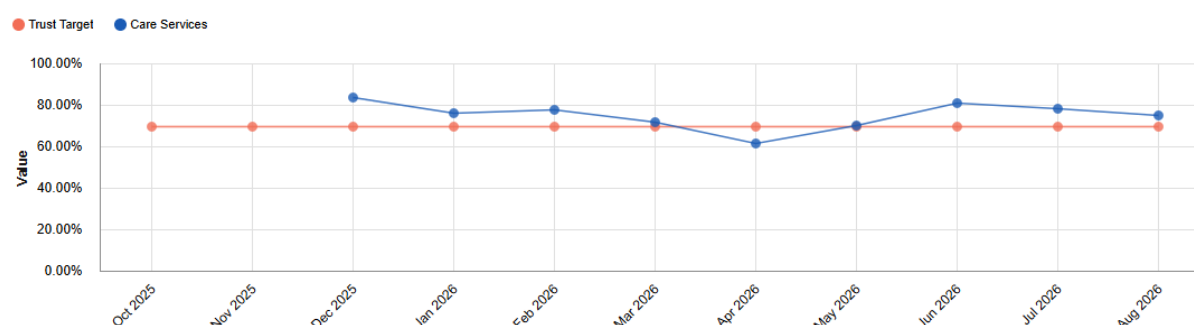
Graph 16



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

Performance against the 8-week KPI has been maintained since May, see Graph 17, following the implementation of the actions identified by the breach analysis. It is expected these improvements to recording processes and pathway coding will ensure a sustained recovery, albeit with some variation across the months.

Graph 17



3 SERVICE DEVELOPMENTS

3.1 National Gambling Service

In April 2025 a new statutory levy on gambling operators came into effect to support system-wide improvements in the research, prevention and treatment of gambling-related harms across the UK. 50% of the levy is allocated to NHS England as the treatment commissioner. During 2026/27 funding should pass to current NHS providers, via the ICB, in order to expand the current pathway to meet current demand. From April 2027 there will be further funding and further changes to the commissioning model.

The NGS has submitted a proposal for use of the additional funding during 2026/27. The proposal is designed to meet current need and to expand provision across the North of England. The proposal has been through LYPFT governance processes (CSDDG and FPG) and discussions with the two lead ICB's (Greater Manchester and West Yorkshire) are on-going.

Once approval is received via the ICBs, the Implementation Plan can commence. This will include recruitment to 20 plus posts across the geography, expansion of space at existing

sites, communications activities and development of outreach model. An Implementation Manager has been identified from LYPFT and will commence at the end of September to support the implementation process.

4 EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE (EPRR)

4.1 Incidents and Disruptions

4.1.1 Heatwave Preparedness and Response

We continued our Heatwave Preparedness and where triggered, have activated our response plan over the course of the summer. This will be a key area of scrutiny as part of the annual assessment process given the anticipated increase in adverse weather events for the coming year.

4.1.2 Burst Water Main – St Mary’s Hospital

On Friday 21 August a burst water main was discovered on St Mary’s Hospital site. A cast iron pipe servicing Trust premises Willow, Holly, Linden and Poplar were affected; however, Red Kite View and Woodlands Square were not affected. Services to affected buildings were suspended until 24 August with alternative arrangements put in place. The affected pipe was then replaced on 21 August. Estates and Facilities consider the pipe to the affected premises will need complete replacement and are looking at options to facilitate this in the medium term.

4.1.3 Industrial Action

Resident doctors in England accepted a government offer on pay and jobs in June 2026, ending a long-running dispute. However, Consultants in England voted in favour of industrial action in a ballot that closed on 6 July 2026, with 76% voting in favour out of a 51.5% turnout. Consultants now have a 12-month mandate. SAS Doctors (Specialty, Associate Specialist, and Specialist) doctors also voted in favour (90%), but their ballot missed the legal 50% turnout threshold at 43%.

We have commenced planning to respond to industrial action by Consultant Medical staff. If industrial action is announced, we will activate our coordination arrangements led by the Chief Operating Officer.

4.1.4 Demonstrations

The EPRR Team continues to monitor the situation as regards demonstrations that have been taking place in several parts of the Leeds district on a weekly basis since July. Demonstrations and counter demonstrations regarding the housing of refugees at a hotel in Seacroft have taken place with Trust staff informed beforehand, so they are able to take safety precautions if they are visiting the area. Communications have also been issued to staff to ensure they are aware of any disruption caused by 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. 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.

As we head into the winter period, we are planning our focus on key areas of access and responsiveness for service users to be sustained and improved. We are supported by system colleagues and partners and arrangements are being finalised for how we best work together over the winter period to provide a responsive service to our service users and the public.

6 RECOMMENDATION

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

Joanna Forster Adams
Chief Operating Officer
September 2026

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

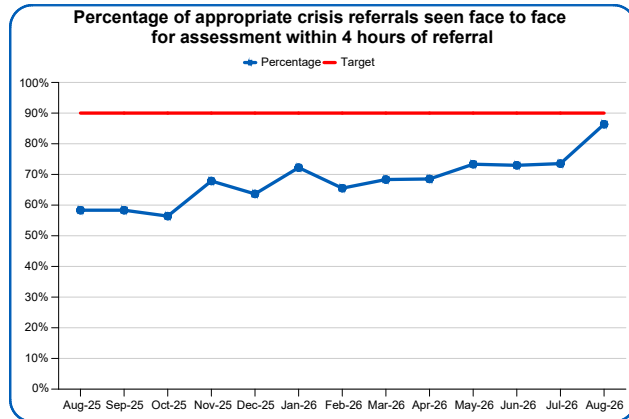
Service Performance - Chief Operating Officer

Services: Access & Responsiveness: Our response in a crisis Monthly	Target	Jun 2026	Jul 2026	Aug 2026
Percentage of ALPS referrals responded to within 1 hour	-	66.7%	64.0%	65.4%
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%	73.0%	73.5%	86.4%
Percentage of service users who stayed on CRISS caseload for less than 6 weeks	70.0%	93.4%	92.4%	93.8%
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support	50.0%	37.2%	52.8%	26.4%
Percentage of CRISS caseload where source of referral was acute inpatients	-	3.8%	3.0%	3.2%
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services	Target	Jun 2026	Jul 2026	Aug 2026
Gender Identity Service: Number on waiting list	-	7,193	7,223	7,011
Deaf CAMHS: average wait from referral to first face to face (inc. telemedicine) contact in days	-	261.83	346.67	252.33
Community LD: Percentage of referrals seen within 4 weeks of receipt of referral	75.0%	85.4%	83.9%	83.3%
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	Jun 2026	Jul 2026	Aug 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	-	99.4%	98.4%	94.1%
Crisis Assessment Unit (CAU) length of stay at discharge	-	41.40	25.00	29.25
Liaison In-Reach: attempted assessment within 24 hours	90.0%	80.0%	73.2%	69.7%
Becklin Ward 1 (Female) bed occupancy	-	101.5%	100.2%	99.2%
Becklin Ward 3 (Male) bed occupancy	-	100.8%	100.6%	99.1%
Becklin Ward 4 (Male) bed occupancy	-	99.2%	101.8%	102.5%
Becklin Ward 5 (Female) bed occupancy	-	102.2%	98.0%	99.1%
Newsam Ward 4 (Male) bed occupancy	-	101.1%	99.4%	98.8%
Older adult (total) bed occupancy	-	99.7%	97.1%	96.5%
The Mount Ward 1 (Male Dementia) bed occupancy	-	96.7%	86.2%	82.3%
The Mount Ward 2 (Female Dementia) bed occupancy	-	99.0%	99.8%	95.5%
The Mount Ward 3 (Male) bed occupancy	-	101.3%	99.0%	100.3%
The Mount Ward 4 (Female) bed occupancy	-	100.6%	100.6%	102.9%
Percentage of Occupied Bed Days Clinically Ready for Discharge	-	32.8%	35.6%	38.7%

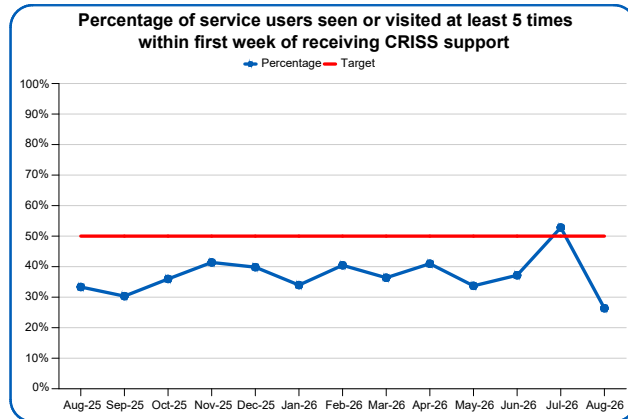
Service Performance - Chief Operating Officer

Services: Our acute patient journey	Target	Jun 2026	Jul 2026	Aug 2026
Out of Area Trajectory Active Placements at Month End	14	27	20	16
Total: Number of out of area placements beginning in month	-	14	8	10
Total: Total number of bed days out of area (new and existing placements from previous months)	-	898	624	650
Acute: Active Placements at Month End	-	19	17	11
Acute: Number of out of area placements beginning in month	-	9	7	6
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	709	479	515
PICU: Active Placements at Month End	-	6	3	5
PICU: Number of out of area placements beginning in month	-	5	1	3
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	129	124	130
Older people: Active Placements at Month End	-	2	0	0
Older people: Number of out of area placements beginning in month	-	0	0	1
Older people: Total number of bed days out of area (new & existing placements from previous months)	-	60	21	5
Cardiometabolic (physical health) assessments completed: Inpatients (quarterly)	80.0%	82.4%	-	-
Services: Our Community Care	Target	Jun 2026	Jul 2026	Aug 2026
Percentage of inpatients followed up within 3 days of discharge (Trust Level monthly local tracking)	80.0%	80.3%	78.5%	77.5%
Percentage of inpatients followed up within 3 days of discharge (HCP commissioned services only)	80.0%	81.5%	78.8%	77.3%
Number of service users in community mental health team care (caseload)	-	3,751	3,715	3,751
Percentage of referrals to memory services seen within 8 weeks (quarter to date)	70.0%	71.5%	78.1%	76.9%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50.0%	59.7%	52.6%	55.4%
Early intervention in psychosis (EIP) or at risk mental state (ARMS): Percentage starting treatment within 2 weeks	60.0%	41.7%	50.0%	88.9%
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	Jun 2026	Jul 2026	Aug 2026
Percentage of service users with NHS Number recorded	-	99.8%	99.8%	99.8%
Percentage of service users with ethnicity recorded	-	79.6%	79.4%	78.9%
Percentage of service users with sexual orientation recorded	-	40.4%	39.2%	38.0%
Services: Clinical Record Keeping - DQMI	Target	Mar 2026	Apr 2026	
DQMI (MHSDS) % Quality %	-	93.3%	93.4%	-

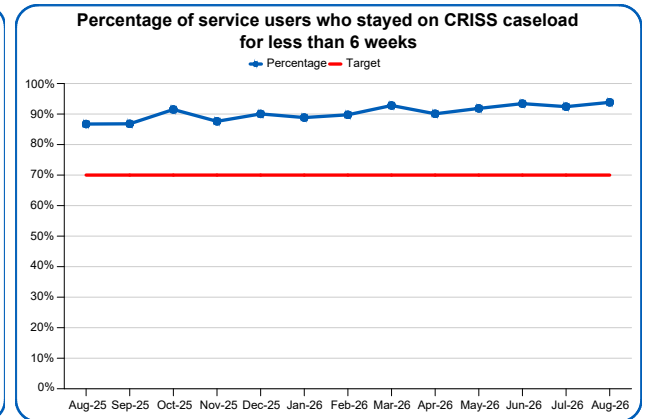
Services: Access & Responsiveness: Our Response in a crisis



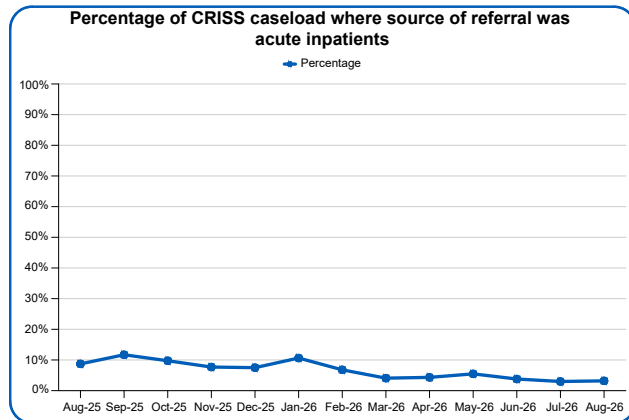
Contractual Target 90%: August **86.4%**



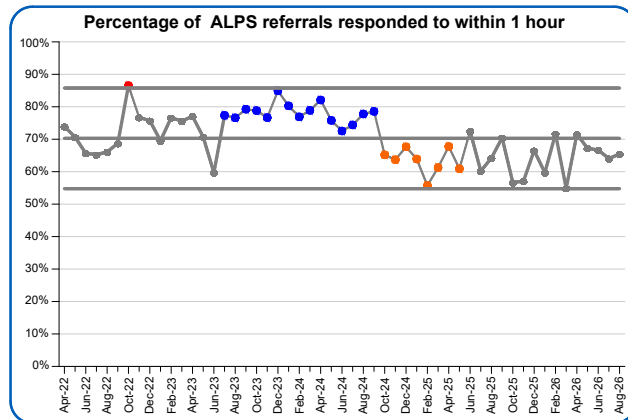
Contractual Target 50%: August **26.4%**



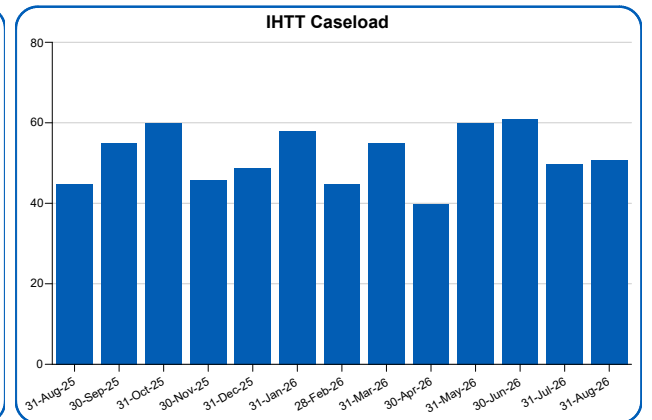
Contractual Target 70%: August **93.8%**



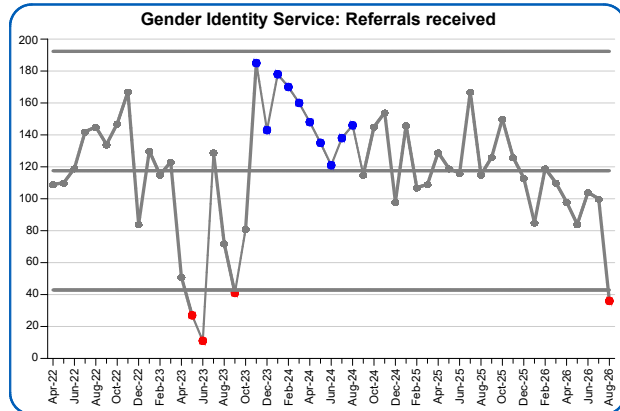
Contractual Target tba: August **3.2%**



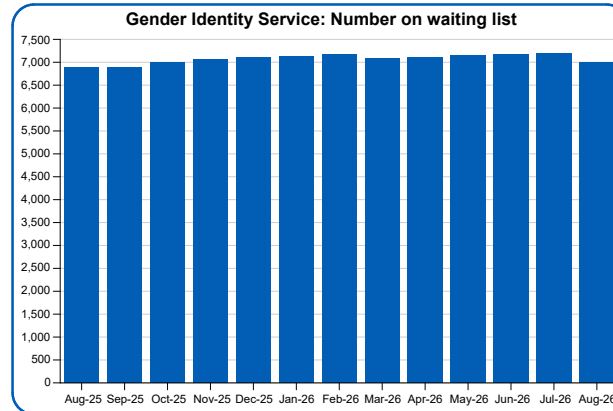
Contractual Target : August **65.4%**



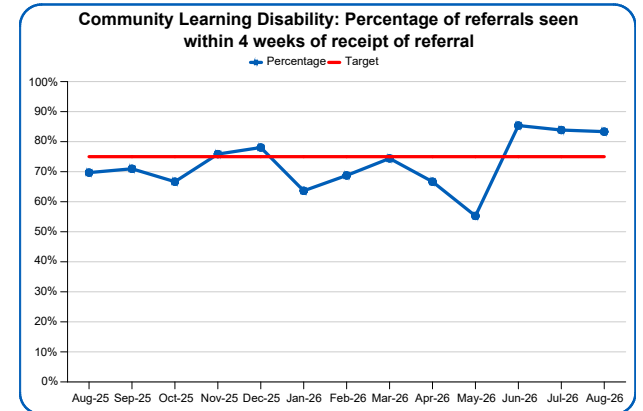
Caseload: August **51**



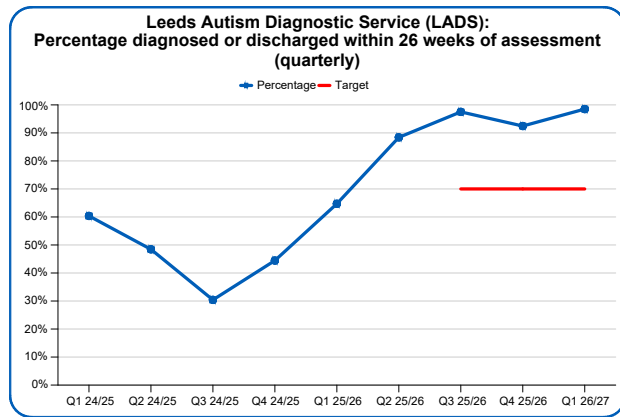
Total referrals: August 36



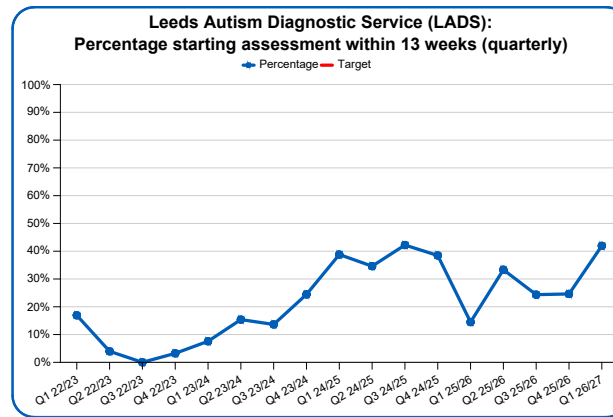
Number on waiting list: August 7,011



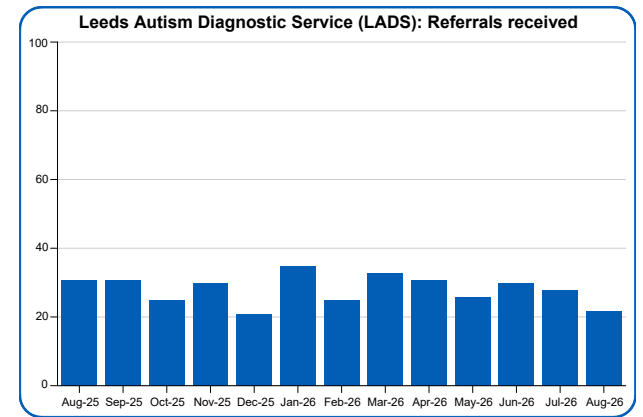
Contractual Target 75%: August 83.3%



Contractual Target 70%: Q4 98.5%



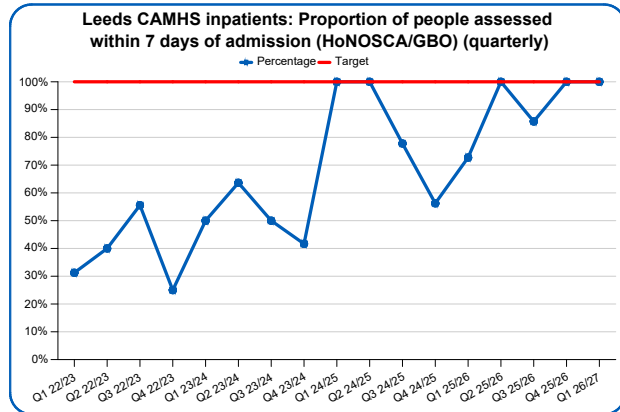
Contractual Target : Q4 41.9%



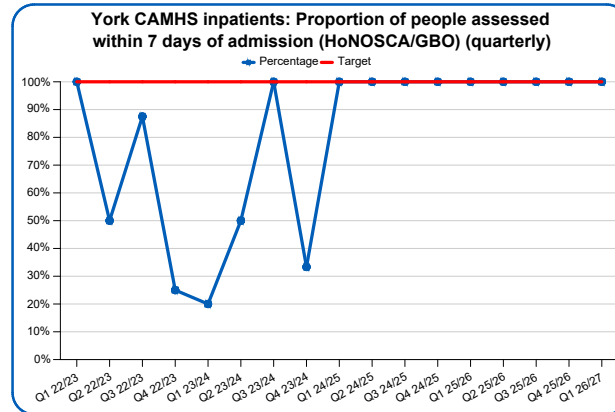
Local measure: August 22

SPC Chart Key

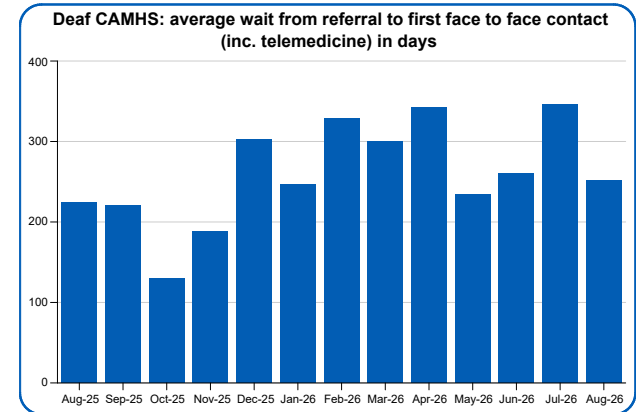




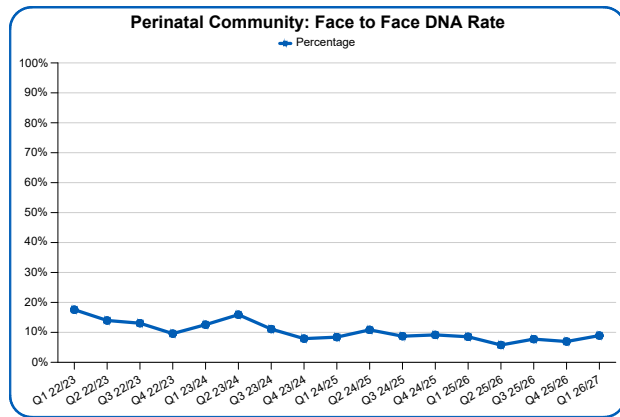
Contractual Target 100%: Q1 100.0%



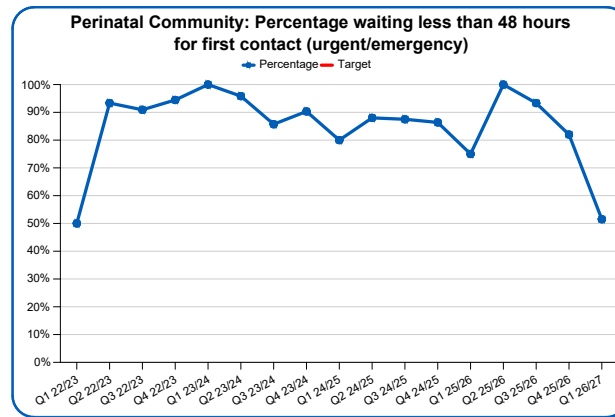
Contractual Target 100%: Q1 100.0%



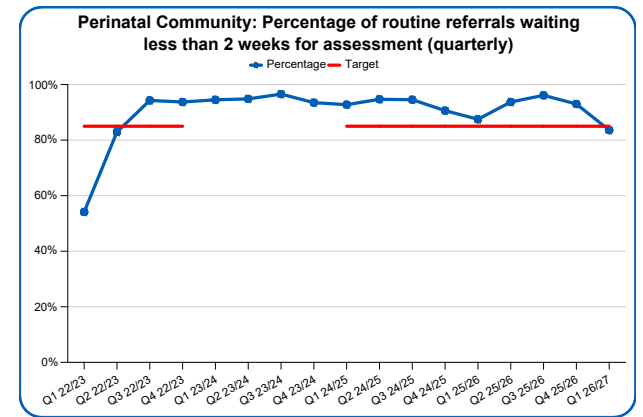
Local measure: August 252



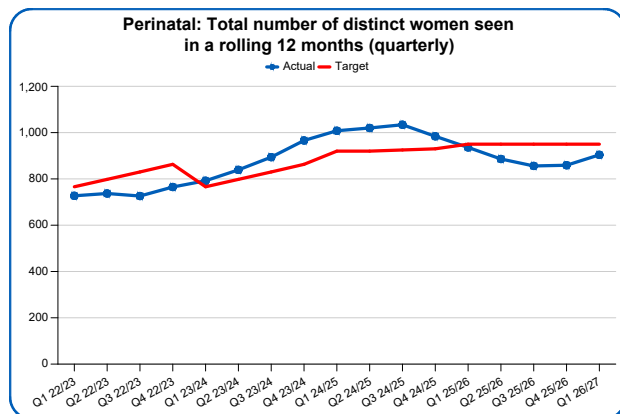
Contractual measure: Q1 8.9%



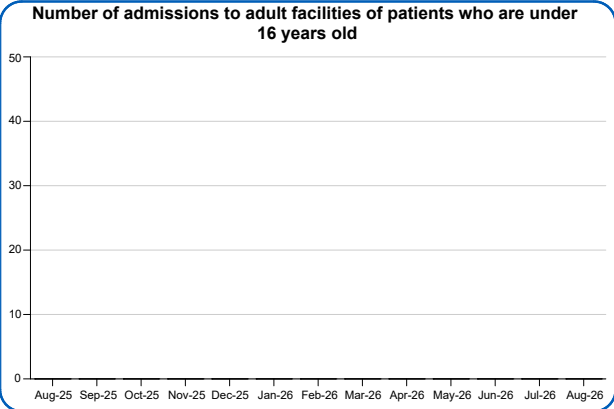
Contractual Target tba: Q1 51.5%



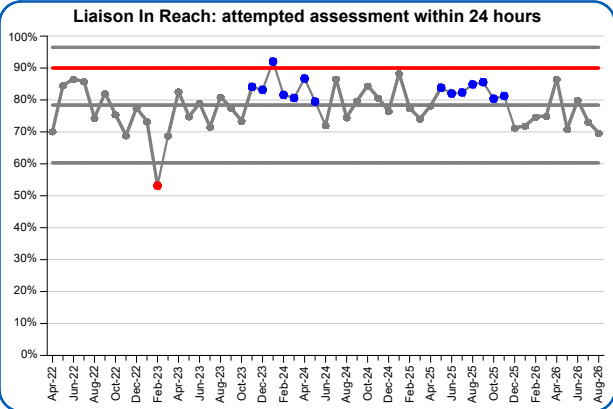
Contractual Target 85%: Q1 83.6%



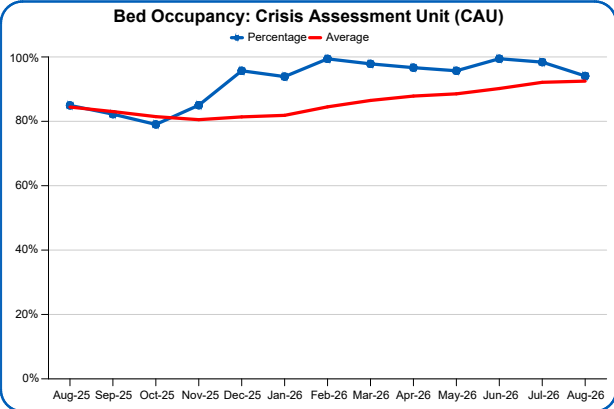
Local measure 950: Q1 904



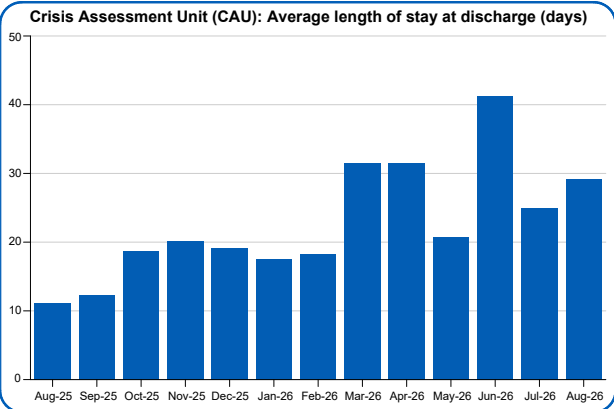
National (NOF) No target 0: August 0



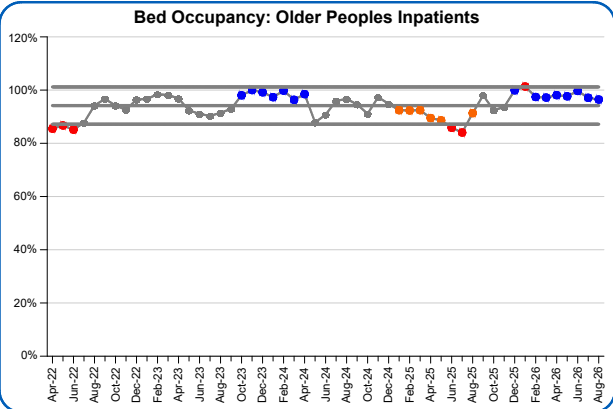
Contractual Target 90%: August 69.7%



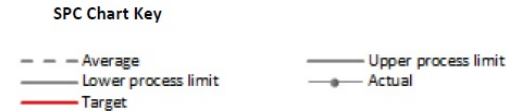
Local measure: August 94.1%



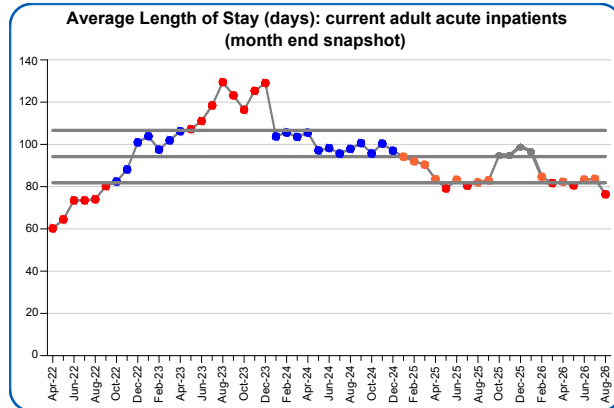
Local measure: August 29 days



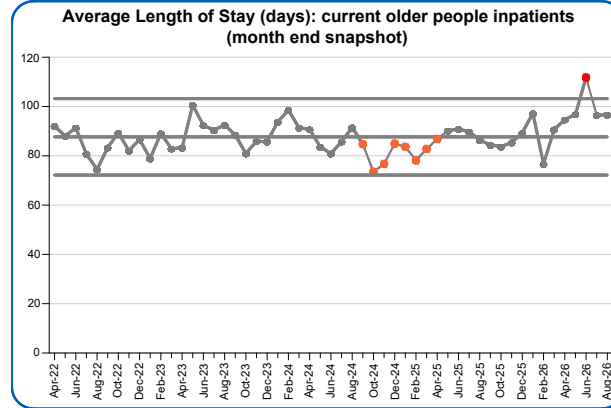
Local measure and target : August 96.5%



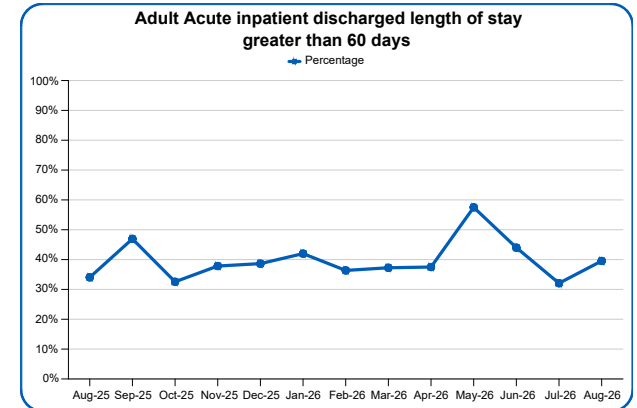
Services: Our acute patient journey (continued)



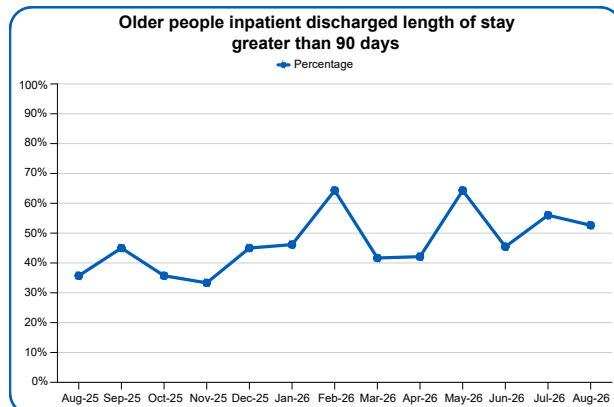
Local tracking measure: August 76 days



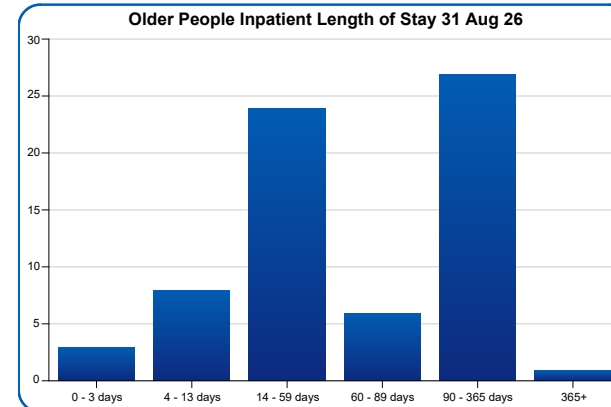
Local tracking measure: August 97 days



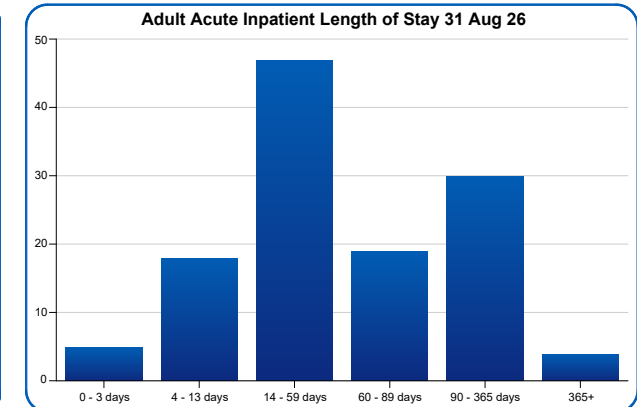
National (LTP): August 39.5%



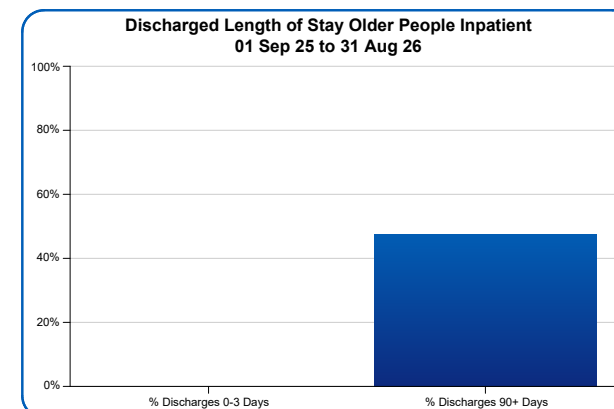
National (LTP): August 52.6%



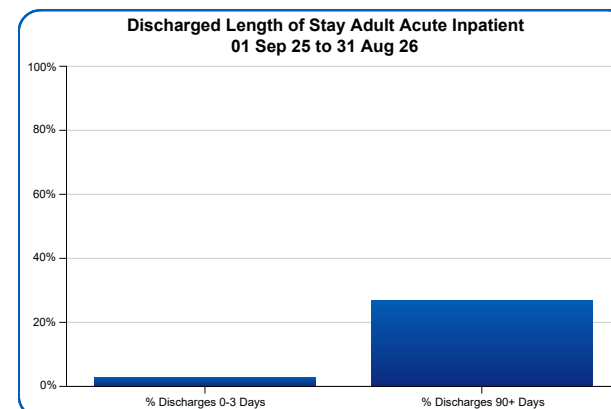
Local activity: 28 people with LOS 90+ days



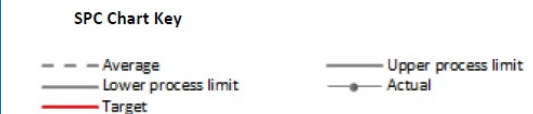
Local activity: 34 people with LOS 90+ days



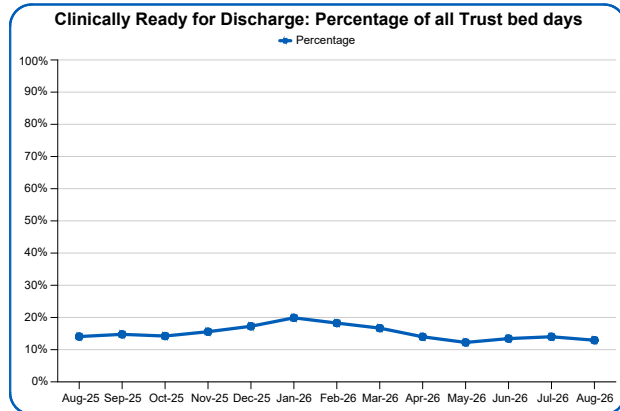
Local activity: % discharged LOS 90+ days = 47.7%



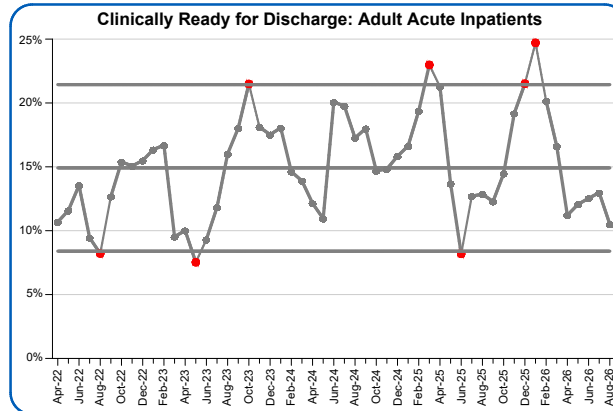
Local activity: % discharged LOS 90+ days = 27.1%



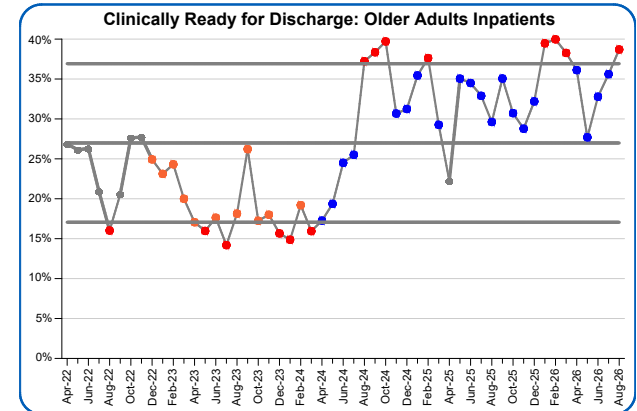
Services: Our acute patient journey (continued)



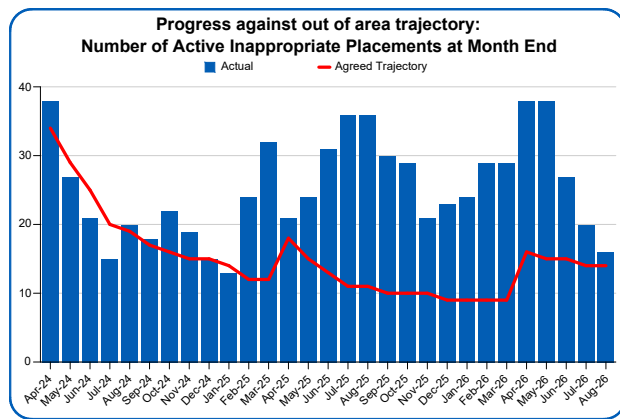
Local tracking measure: August 12.9%



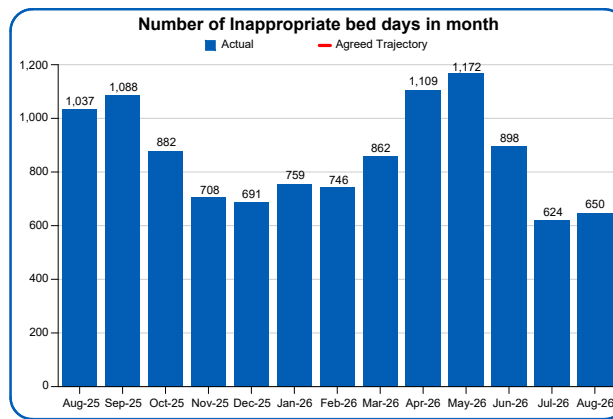
Local tracking measure: August 10.5%



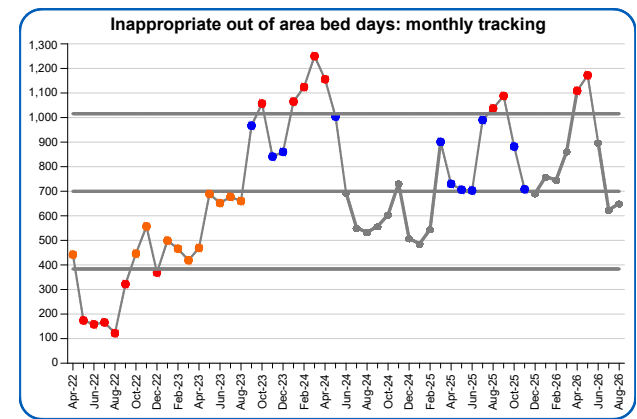
Local tracking measure: August 38.7%



Nationally agreed trajectory (August: 14): August 16 active placements



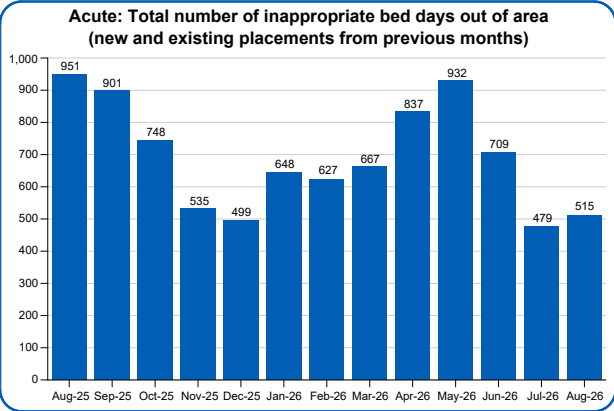
Local tracking measure: August 650 bed days



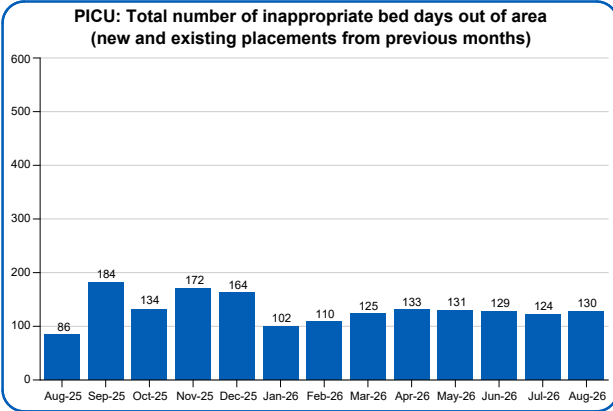
Local tracking measure: August 650 bed days

SPC Chart Key

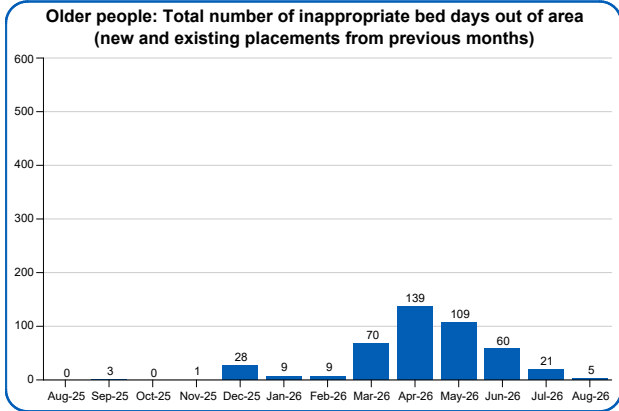
- Average
- Upper process limit
- Lower process limit
- Actual
- Target



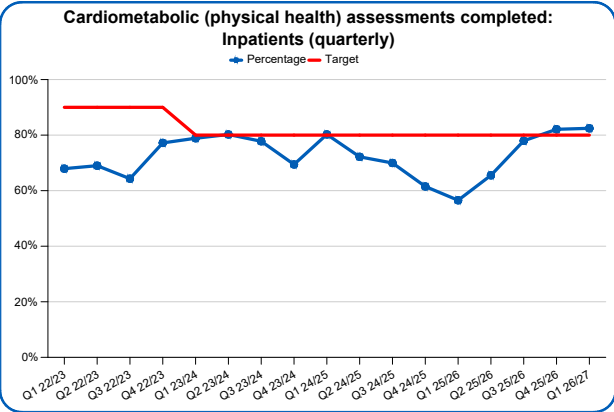
Nationally agreed trajectory (): August 515 days



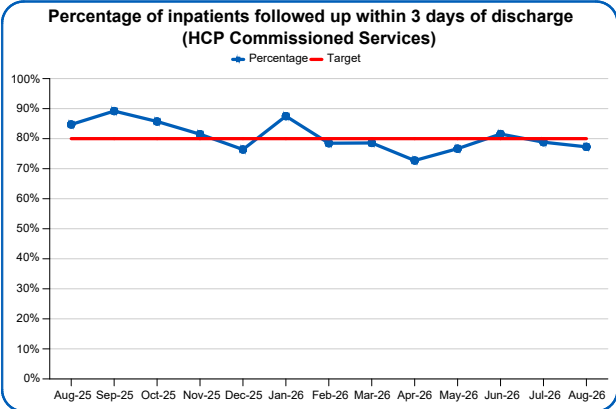
Nationally agreed trajectory (): August 130 days



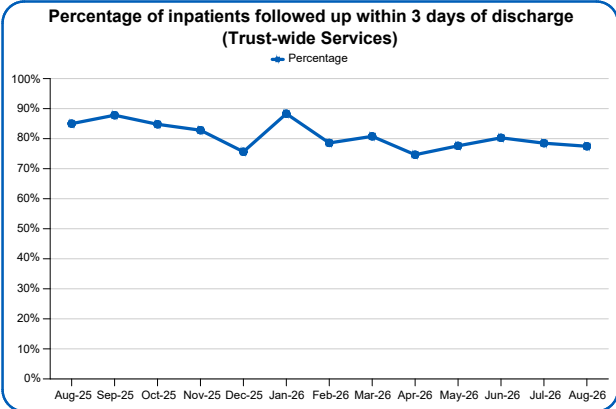
Local measure : August 5 days



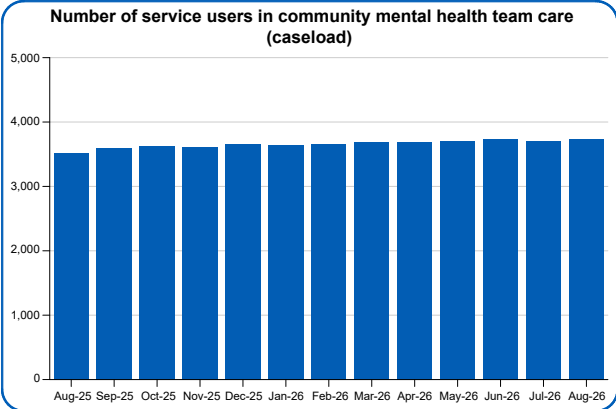
Contractual target 80%: Q1 82.4%



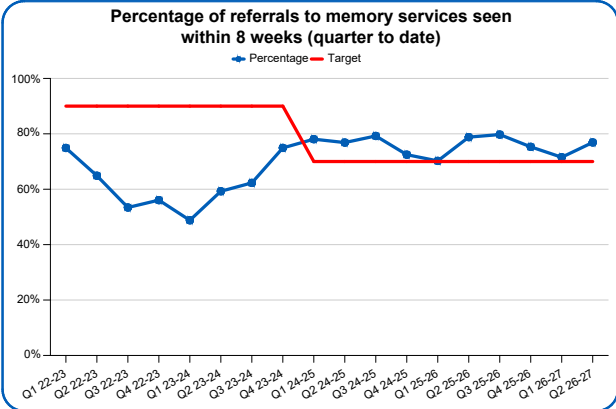
Contractual target 80%: August 77.3%



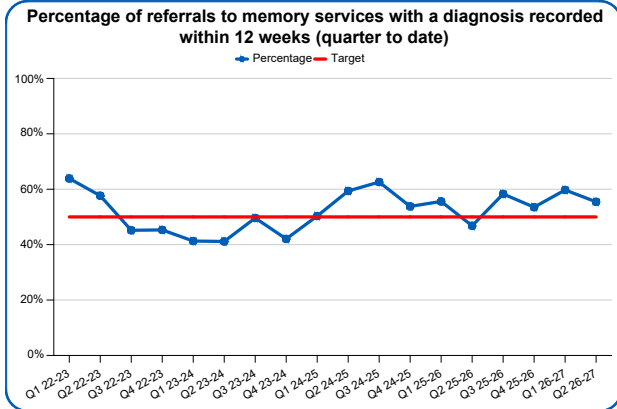
Local Tracking Measure 80%: August 77.5%



Local measure : August 3,751



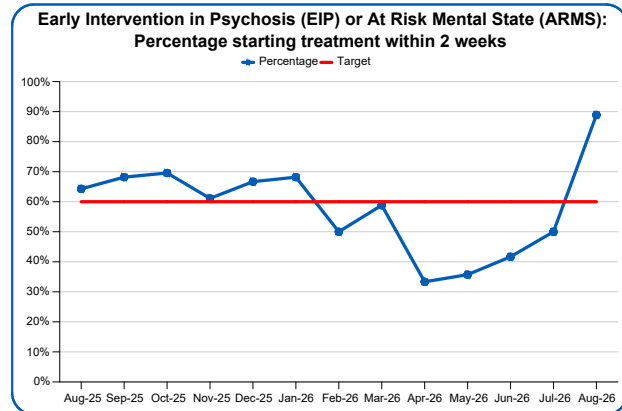
Contractual target 70%: Q2 26-27 76.9%



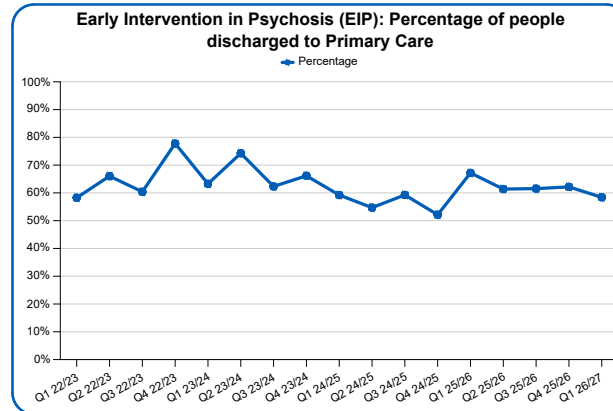
Contractual target 50%: Q2 26-27 55.4%

SPC Chart Key

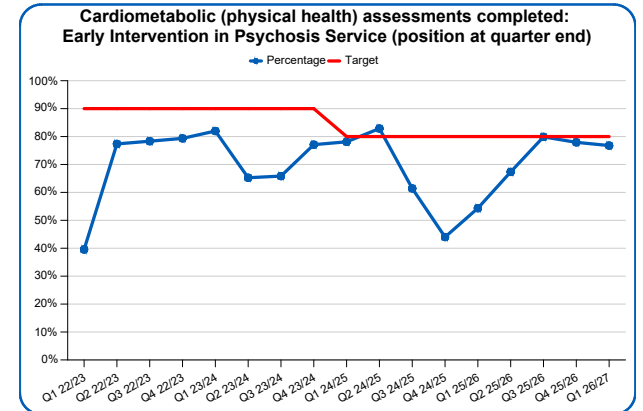
- Average
- Lower process limit
- Upper process limit
- Target
- Actual



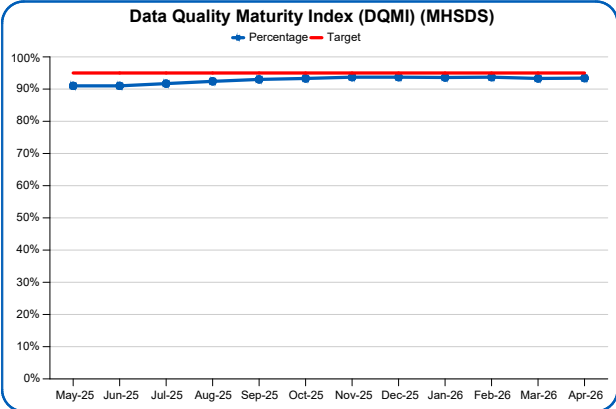
Contractual target 60%: August **88.9%**



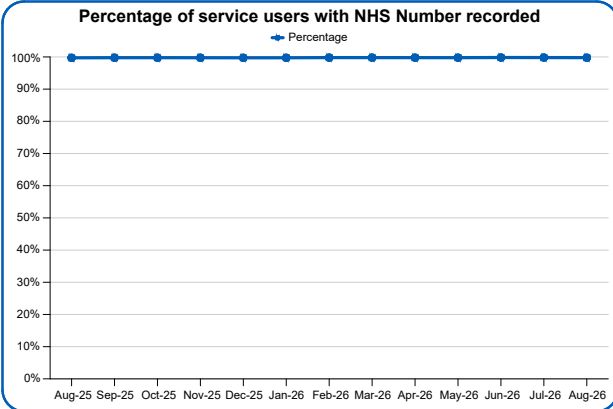
Contractual target tbc: Q1 **58.4%**



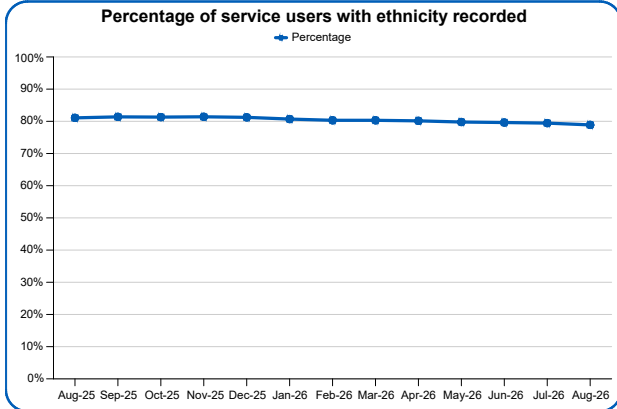
Contractual target 80%: Q1 **76.8%**



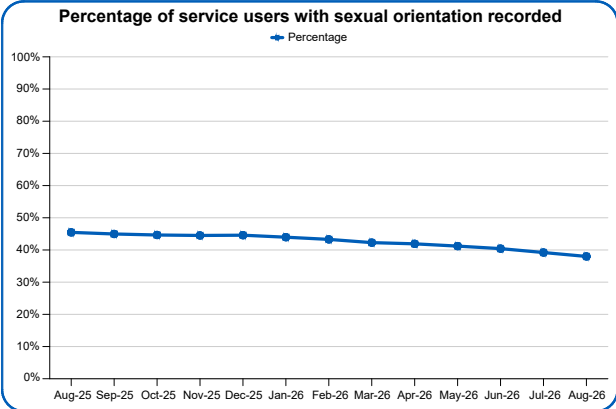
CQUIN / NHSOF Target 95%: April **93.4%**



Local measure: August **99.8%**



Local measure: August **78.9%**



Local measure: August **38.0%**

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.

Meeting of the Board of Directors

Paper title:	Winter Resilience and Operating Plan 2026/27 and Board Assurance Statement
Date of meeting:	24 September 2026
Presented by: (name and title)	Joanna Forster Adams, Chief Operating Officer
Prepared by: (name and title)	Mark Dodd, Deputy Chief Operating Officer for Adult Mental Health and Learning Disabilities

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	Demand for services	✓
SR8	Health inequalities	✓
SR9	System change	

Executive summary

The purpose of the Winter Resilience and Operating Plan is to set out the approach the Trust will take to maintaining service provision and minimising disruption during the winter of 2026/27.

In addition to the production and submission of the Plan, there is a requirement that the Trust provides a Board Assurance Statement to ensure the Board has had oversight of the Plan and that all considerations have been met in its development. The Board Assurance Statement and related documentation have been attached to facilitate the Board's considerations.

The Board is asked to note that whilst the overall assessment rating is "5 – Full Assurance" there are two sections (Capacity and Community, and UEC Flow) where the ratings are "4 – Substantial Assurance" and "3 – Partial Assurance" respectively. This is due to questions within those sections being not applicable to mental health trusts and the answer having to be "no".

Once the Board is assured the content of the Plan meets the requirements, it needs to agree the Board Assurance Statement can be signed (on its behalf) by the Chair and Chief Executive prior to the Plan and Statement being submitted to NHS England before the deadline.

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

No

Recommendation

The Board is asked to:

- Receive and review the Winter Plan Resilience & Operating Plan and Board Assurance Statement
- Be assured that the content of the Plan meets the requirements as set out in the Statement
- Agree that the Board Assurance Statement can be signed on its behalf signature of the Chair and Chief Executive, prior to submission NHS England.

Winter Resilience and Operating Plan

2026/27

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1. INTRODUCTION

The purpose of the Winter Resilience and Operating Plan is to set out the approach that Leeds and York Partnership NHS Foundation Trust (the Trust) will take to maintaining service provision and minimising disruption during the winter of 2026/27.

During winter 2026/27, Systems will be expected to maximise opportunities to continue to support the NHS recovery programme whilst also ensuring continued application of the UK Infection Prevention and Control guidance to prevent and control the spread of infection, and to respond to additional demands and pressures as they arise.

It is recognised that Winter Plans will need to be integrated and developed in partnership across each System, but also iteratively and be able to adapt to competing demands. Now, more than ever we know that effective resilience will only be achieved during the winter period through effective system and partnership-working with our NHS, Social Care, Third Sector / VCSE partners, with the public, with the people that use our services, and with our staff.

An Equality and Health Inequalities Impact Assessment (EHIA) was undertaken when developing this plan to determine its impact on people at risk of health inequalities, see appendix A. The initial screening indicates that a more detailed assessment was not required.

The Plan details the Trust's Operating Objectives for the winter period, the arrangements in place to effectively manage clinical and operational delivery of services, and the actions that will be taken to mitigate anticipated risks during this period. This includes:

- Operating Principles
- Maintaining capacity and flow
- Responding to surge and demand
- The identification of risks to critical services
- Maintaining the wellbeing of our staff and service users
- Links to the EPRR structure and wider system incident response.

1.1 Operating principles

In line with national guidance and developed System plans, we have several operating principles and objectives that underpin our Winter Plan, which builds on learning from previous years. Our operating principles and aims are to:

- Minimise disruption to service users, carers and our staff
- Maintain access, responsiveness, and flow through services, in partnership where this is required, ensuring emergency access / urgent care is sustained throughout
- Maintain and protect safe, high-quality service delivery
- Maintain all elements of service delivery in accordance with our agreed and current operating models wherever possible
- Continue to deliver all services for as long as is practicable in times of increased escalation, and any suspended or restrictions to services being recovered as soon as is possible

- Continue to develop and implement sustainable and effective services that can respond to 'on the day' demands of the population
- Seek to actively identify and address health inequalities across our services and the specific challenges faced by minority groups
- Ensure proactive leadership and management arrangements are in place that allow us to continue to adapt and respond as things change
- Use robust on-call arrangements to provide leadership and management outside of normal working hours
- Support our staff to prepare for and respond to the pressures and challenges we face through winter, actively promote and support staff's physical and mental wellbeing to ensure enhanced and ongoing resilience, including access to flu vaccinations
- Work as a proactive system partner, ensuring clear integrated plans and governance structures are in place for early escalation and mitigation of emerging / unexpected / external pressures
- Ensure that our contingency plans and emergency measures are evaluated to understand the impact they will have and mitigate risks wherever possible.

2. MAINTAINING FLOW AND MEETING DEMAND

2.1 Acute Capacity and Flow

Our acute mental health service has again continued to face considerable challenges throughout the year, including sustained high demand, constrained bed capacity, and increasingly complex discharge pathways. In light of this, a new programme of work entitled the Community First Collaborative, has been commissioned. Building on the long diagnostic carried out by VOT Health and building on the previous work of the Inpatient Quality Transformation Programme, and incorporating the neighbourhood health, GIRFT, Emergency Department and Crisis workstreams, the Community First Collaborative's mission is to:

Achieve Zero Out of Area bed use by March 2027 and reduce Length of Stay to the NOF score 2 (domain 3 – experience of care) in adult acute and PICU and older adult services, or lower, through whole-pathway redesign, strengthened operational control, evidence-based improvement and sustainable cultural change.

The two objectives of this work are:

- Outcome 1: Zero Working Age Adult Out of Area bed use by March 2027
- Outcome 2: Length of Stay at, or better than, the NOF score 2 (domain 3 – experience of care) in adult acute, PICU and older adult services.

The approach to achieve this will be via a collaborative, involving care services from the Community & Wellbeing, Adult Acute and the Liaison Service Lines. Alongside the two key objectives, the collaborative will additionally seek to deliver:

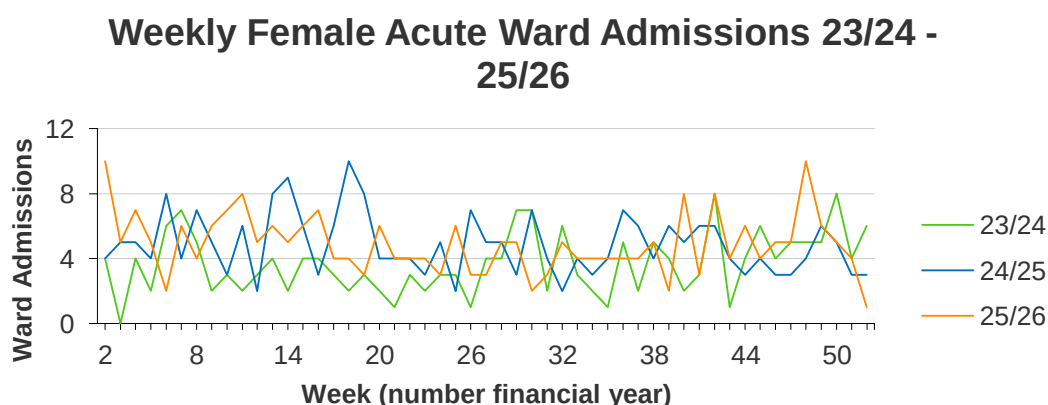
- Improved patient and carer experience.

- A shift towards community and prevention
- Reduced expenditure on out of area placements
- Improved patient flow
- Reduced external scrutiny
- Sustainable improvements embedded into business-as-usual arrangements.

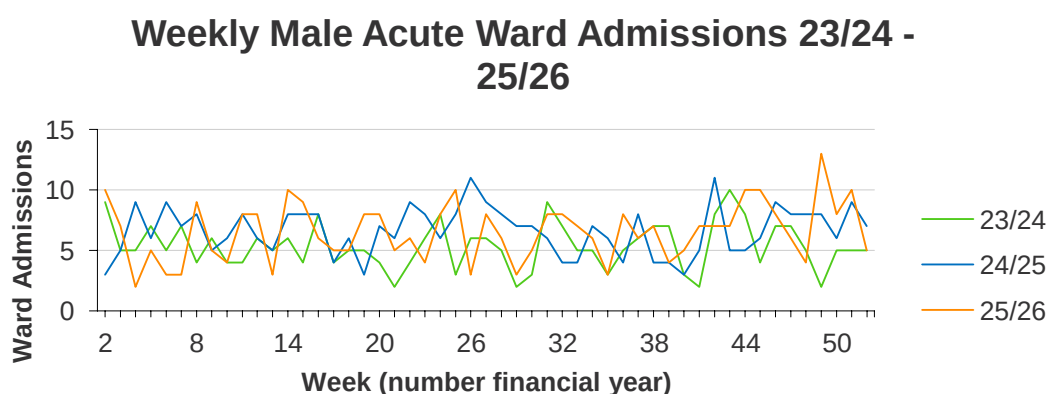
Work on establishing the collaborative and all workstreams is to be achieved by September, all in time for winter. The alignment of improvements with compassionate, values-driven care to create a more responsive and resilient system that better meets the needs of service users, carers, and staff remains at the centre of the programme, as does the focus on supporting safer admissions, more timely discharges, and a more therapeutic inpatient experience for sustained improvement across future winter periods.

Last winter we saw a reduction in female admissions compared to previous years, and yet an increase for the male population over the same period (see Graphs 1 and 2). There is no indication there are seasonal trends that can be attributed to this or planned for. However, where we enter the holiday period, in order to be responsive to any surge in demand, services will develop and implement occupancy reduction plans.

Graph 1



Graph 2

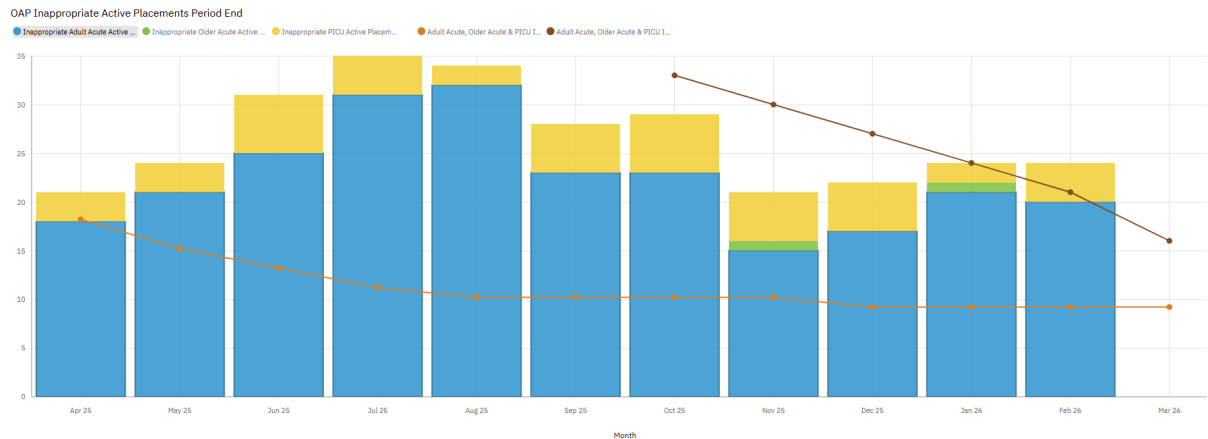


2.2 Working Age Adult (WAA) Out of Area trajectory

During 2025/26 the Inpatient Flow Programme struggled to make significant progress in reducing the number of Out of Area (OOA) placements. However, as we were coming out

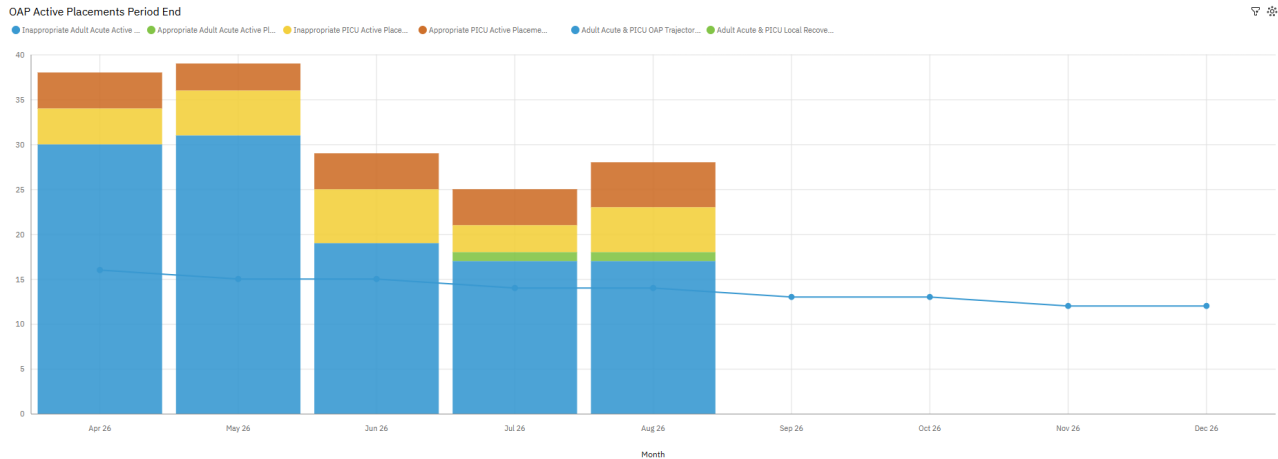
of winter last year, we again saw a surge in demand for inpatient admissions resulting in an increase in OOA placements (see Graph 3). This pressure is largely driven by consistent demand for admissions, alongside delays in discharging patients who are clinically ready. A key contributing factor to these delays is the limited availability of appropriate accommodation, particularly supported housing, which prolongs inpatient stays and reduces the availability of beds for new admissions. This is an issue that has been highlighted at a Leeds system level.

Graph 3



As we can see from Graph 4, we have been unable to achieve our planned trajectory to reduce OOA placements at this stage in 2026/27. We have changed our approach to managing a programme of work with dedicated Clinical and Operational Leadership with a real focus on admission avoidance and early discharge, with community services being integral to this work.

Graph 4



The Adult Acute Service now benefits from an integrated Capacity and Flow Team that brings together a range of multidisciplinary functions to support timely patient flow and effective discharge planning. The team includes 7-day bed management and discharge coordination functions, alongside dedicated housing officers from Leeds City Council and the third-sector Accommodation Gateway service. In addition, 2 social workers employed by Adult Social Care are embedded within the team, enabling a collaborative approach to addressing housing, social care, and discharge barriers. This integrated model supports early identification and resolution

of issues that may impact patient flow, aiming to reduce delays and improve patient outcomes.

2.3 Emergency Department (ED) waits for mental health assessment:

Throughout the winter of 2025/26 we continued to face challenges in the ability to transfer service users to mental health beds, which resulted in some long delays for admissions including those in the Emergency Department (ED) within LTHT. The need to reduce the length of waiting time for people who require admission to mental health inpatient treatment, was a priority area of work through 2025/26 and is an imperative as part of the planning requirements for winter 2026/27. The programme aimed to address this is broadly divided into three key areas:

- **Reducing Mental Health ED Attendances and Delays Project Oversight Group:**

This group was formed in 2025 to collaborate across care services, enhancing systems, processes, and communication. It consisted of several workstreams focused on data analysis, NHS England ED action cards, communication, and internal processes. Initial work included a process mapping exercise to thoroughly understand current escalation procedures and identify opportunities for efficiency.

Actions from the above oversight group in 2026 will continue to provide focus through winter 2026/27 to support the delivery of services through this period. These included:

- o **Front Door Mental Health Triage Pilot.** Although walk-in presentations are low, the presence of mental health nursing staff at the point of triage appears to support earlier assessment and signposting. A full evaluation is underway; however, initial findings suggest there may be value in adapting the model of patients conveyed by YAS, who represent a significantly larger proportion of Emergency Department attendances involving mental health needs.
- o **Ambient Voice Technology Pilot.** 6-month pilot commenced 1 June 2026. ALPS using “Heidi” ambient voice recording technology to automate transcription of assessments. Mid-point review suggests, there are still challenges as staff, and the technology, continue to learn and adapt, however, reduced administrative time is demonstrated.
- **Regular improvement meetings with Leeds Teaching Hospitals Trust (LTHT) colleagues:** We have regular meetings with colleagues from LTHT to address challenges in meeting demand and maintaining flow through Emergency Departments. This group includes Business Intelligence colleagues who are working to develop a shared data set to ensure consistency and provide reliable oversight of activity. The group has developed a shared escalation and action plan to minimise delays and improve communication. As work has evolved, this group is also leading on planning for the new mental health space in the emergency department.
- **Urgent Care Mental Health Emergency Department.** NHS England capital funding to develop a safe, therapeutic and lower-stimulation environment for individuals presenting with mental health needs who do not require immediate assessment or treatment within the main ED. Design completion is expected mid-

September, with the clinical model likely to operate through a shared care approach, delivering assessment and brief interventions within agreed inclusion/exclusion criteria. Located within the ED, the facility is intended to improve patient experience, maintain patient and staff safety, reduce ED congestion and improve flow.

- **Leadership of Acute Liaison Psychiatry Service (ALPS):** The leadership team for the ALPS has focused on improving their response times, achieving some progress while recognising the need for further improvements.

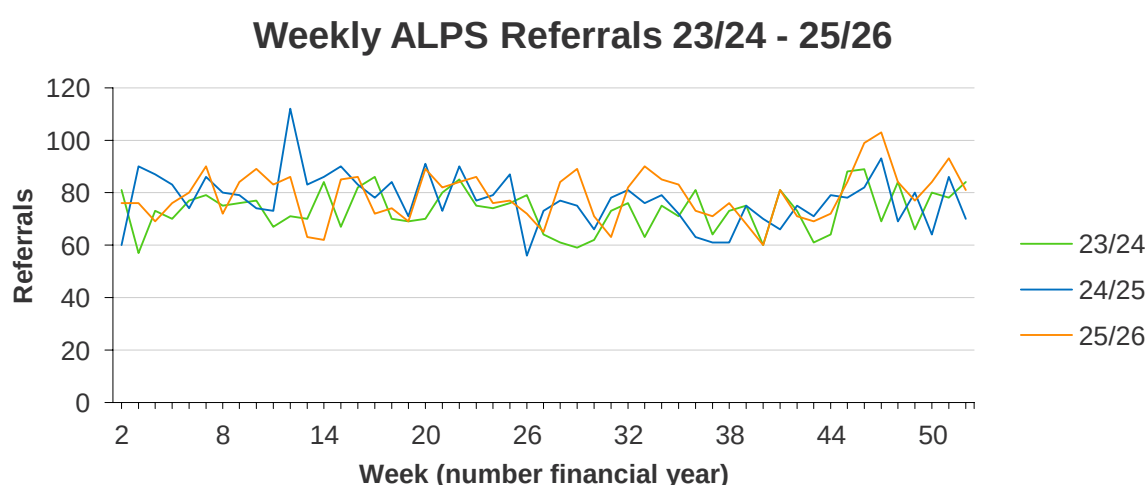
On average ALPS has seen an increase in the rate of activity each year, but it does not follow a clear seasonal pattern (see Graph 5). Data for the year 2025/26 has shown an increase in referrals over the winter period compared to the same period in previous years (see Graph 6).

In the previous years' plan we have reported an increase in the time from arrival to the ED and the referral to ALPS during the winter months. For 2025/26, due to issues regarding data sharing across LTHT and LYPFT we have been unable to obtain this data. We know that overall, ED attendances have increased over this period, and we can assume that the delays in referrals to the ALPS team are because of this increased activity and subsequent delays in triaging service users. The ALPS team is exploring how this might be improved on, including the potential use of a mental health triage system.

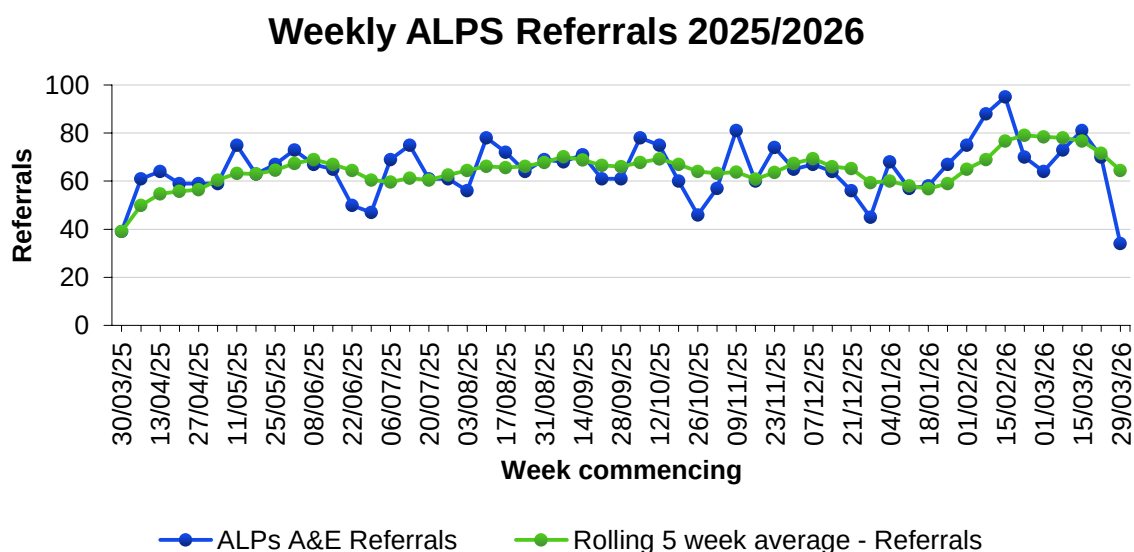
We will ensure that service users who have been identified as those who frequently use urgent care services and are considered high risk, have robust crisis / relapse plans in place to ensure we are responsive to their needs ahead of winter to reduce the demand on our ED services.

We did see an increased delay in the response time for assessment by the team over the past winter (see Graph 7), which is partly a result of vacancies and sickness absence. The team is in the process of recruiting to vacant posts and is expected to be fully staff ahead of this winter.

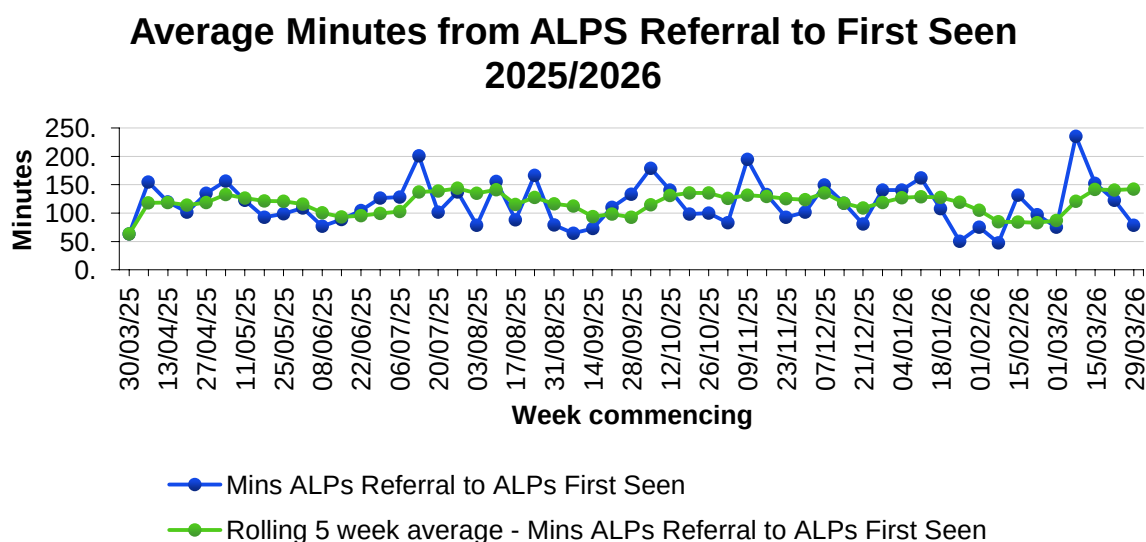
Graph 5



Graph 6



Graph 7



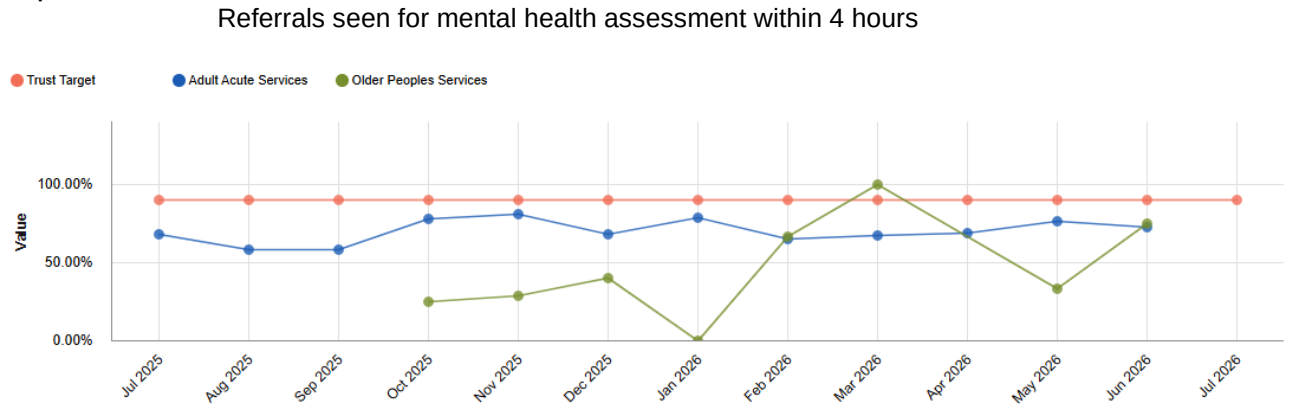
2.4 Crisis Resolution and Intensive Support Service (CRISS) and OPS Intensive Home Treatment Team (IHTT)

CRISS and IHTT provide a rapid response to service users who are experiencing an acute crisis in the community and is an alternative to hospital admission. These services are vital to reducing the demand for the inpatient service, to maintain capacity for those who require an inpatient stay at the point of need.

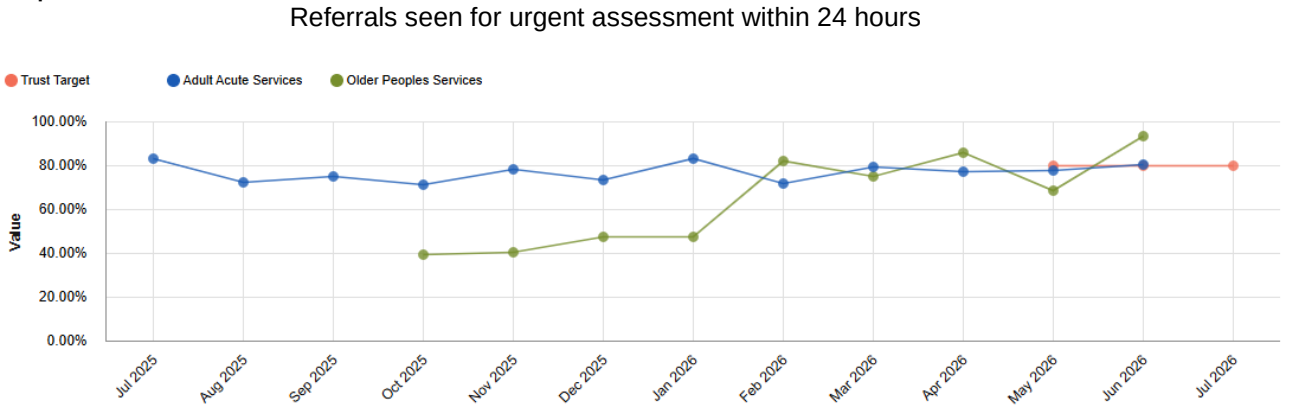
These services have different response times based on the priority of the response required, 4 hours and 24 hours. The service has struggled to meet the Key Performance Indicators (KPI) of 90% compliance against the targets throughout the past year since the service change as a result of staffing issues including sickness and vacancies (see

Graphs 8 and 9). There is a plan in place to support improvement against the KPIs, and we anticipate a significant improvement as we head towards winter. Team Managers are reporting to the Senior Leadership team on a weekly basis to monitor progress and identify actions that can be taken to improve response times, which includes moving the resource across the three areas. The service is actively recruiting staff to vacancies, and we expect all posts to be filled by the start of winter.

Graph 8

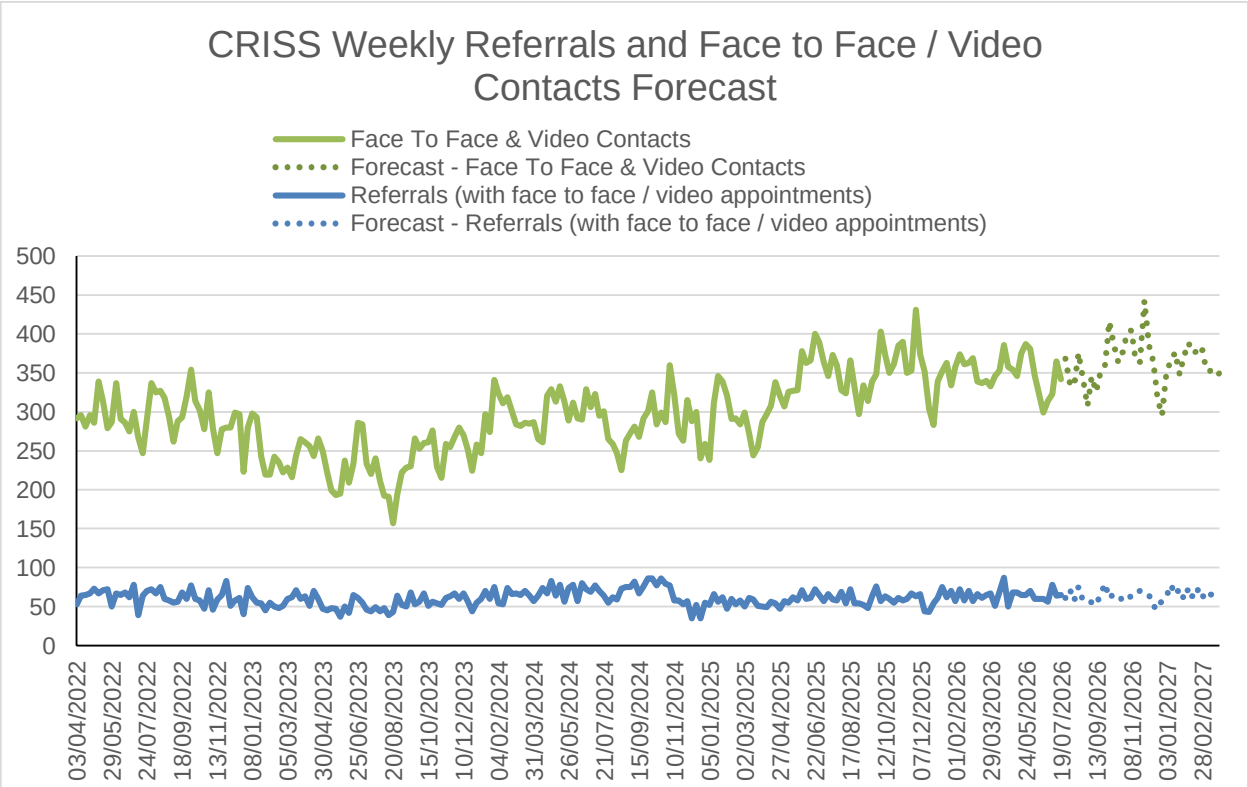


Graph 9



We have seen a consistent rate of referrals to this service over the past 3 years with a slight decrease early in the winter of 2024 (see Graph 10). We anticipate this to continue through to mid-2026/27. However, we have seen a return to the number of contacts for those service users under the care of CRISS to early 2022 levels following a reduction in late 2022/23 and mid-2023/24. We anticipate the number of contacts increasing over this next winter to mid-2026/27.

Graph 10



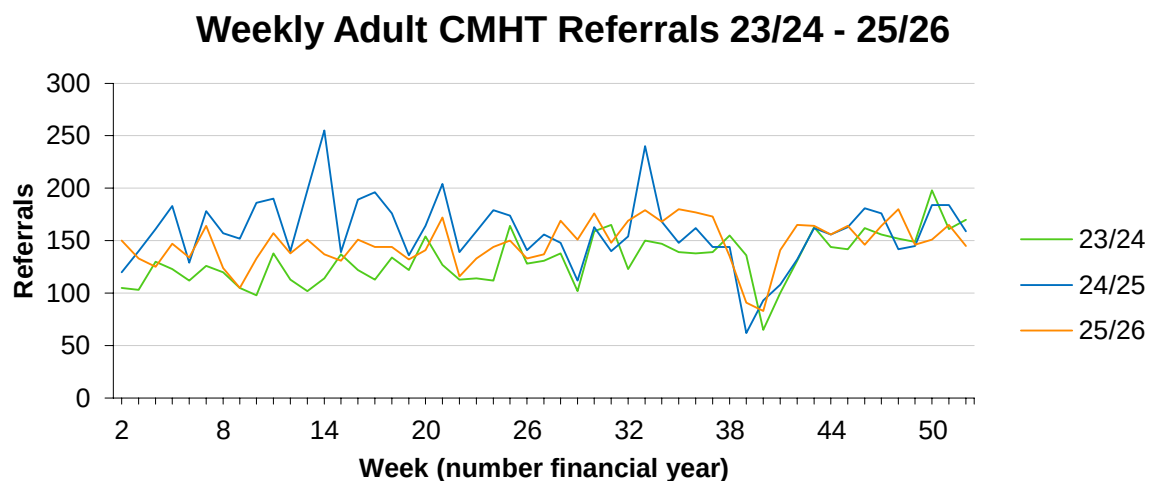
The service will continue to monitor levels of activity to ensure it is able to make improvements against its performance targets so we are responsive and alleviate any pressure that may result in other parts of the system.

2.5 Community Services

We will also ensure that our community-based services maintain the level of service that meets the needs of those we care for throughout the winter period, particularly over the holiday season. We do not expect any service to close during this period, and by taking this approach, we do not expect an increase in attendances to the Emergency Department or an increase in referrals to our crisis services because of service users being unable to access their usual support networks.

Whilst we have seen an increase in referrals to our Adult Community Mental Health Teams over the past year compared to previous years (see Graph 11), we expect to see a reduction in referrals in the early weeks of winter with a steady return to normal levels as winter ends.

Graph 11

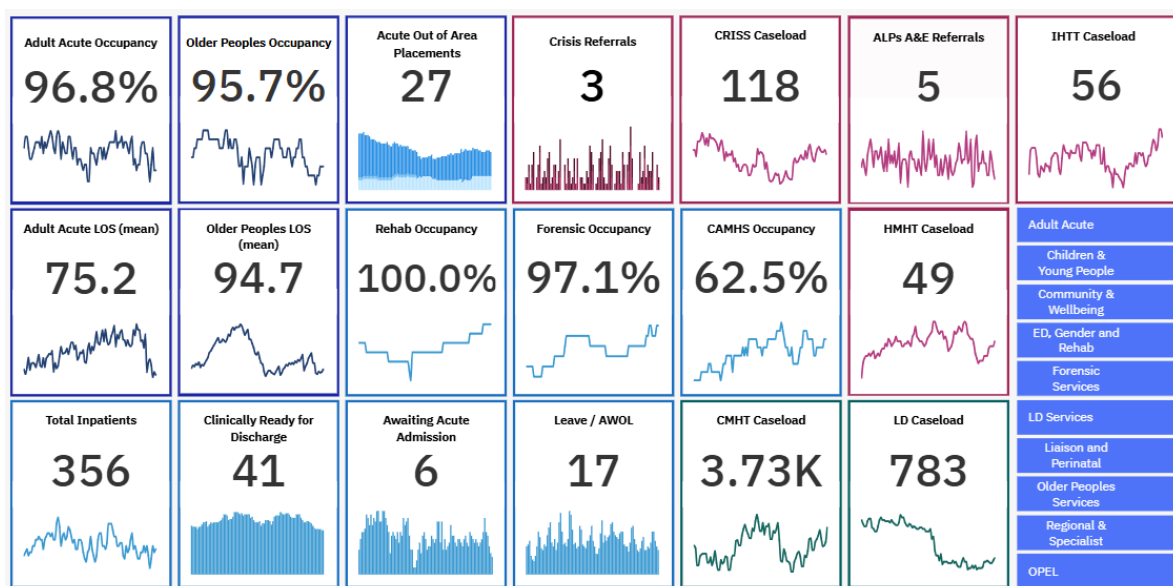


2.6 Responding to surge and demand

The analysis of data relating to activity throughout the year for the past three years shows that we do not generally experience surges in demand as a result of winter. We do though, experience increased demand and surges at various points throughout the year, but these are not identifiable as seasonal trends and have not been significant enough to require additional resources being allocated in these areas.

Should any increased surge and demand warrant additional resources being mobilised to support a particular area, we will use the service prioritisation system to identify the suitable resources to deploy. This will be coordinated and managed through the Trust's Strategic Coordination Group (SCG) which will be stood up ahead of winter to manage all winter pressures. These real time pressures are monitored through the Trust's Operational Dashboard (see example at Diagram 1) and the Operational Pressures Escalation Levels (OPEL) framework. We will also use the Mental Health Action Cards to support decision making, (see Appendix E).

Diagram 1



* Taken from ECHO 26/08/2026

2.6.1 Service Prioritisation

We have an established and agreed process of service prioritisation as part of our EPRR business continuity approach. This identifies which services are an essential priority and required to always be maintained at full capacity and will influence our decisions around the use / deployment of resources.

Three levels of priority have been agreed as below:

Priority 1 Services	These key services are essential priority and are required to be maintained at full capacity. Normal staffing numbers and skill mix will be maintained. This includes 24/7 inpatient services, supported living houses, urgent access / crisis services and key support services which include Switchboard, Estates and Digital.
Priority 2 Services	These services need to be maintained but may safely be delivered at a reduced capacity or alternate skill mix. This will be informed by an assessment of service user needs, risk and vulnerability using our agreed clinical RAG rating process. Services may therefore be reduced or consolidated, and some staff redeployed into priority 1 services.
Priority 3 services	These services could be reduced to a minimum level of delivery or could be stepped down entirely. Most staff are therefore likely to be redeployed into priority 1 services (or into priority 2 services as part of a revised skill-mix to release other staff to priority 1 services).

Priority 1 services have been identified as our inpatient wards (excluding respite services) and services that people use to access mental health services in a crisis (CRISS & Section 136, ALPS, Hospital In-reach, Liaison Service, Learning Disability Intensive Support Team, and Older Peoples Intensive Home Treatment Team (crisis and home treatment)). These services also have a high level of reliance on some support services. A full list of services and their priority can be found at Appendix B.

2.6.2 Key risks and mitigations

As part of our winter planning, we have set out the key mitigating actions and monitoring processes for each of our identified key risks as follows:

Identified Risk	Mitigation	Monitoring
High levels of staff unavailability as a result of illness / absence	• Daily monitoring and forecasting of staffing situation and absence • Robust planning, E-Rostering and use of temporary staff as necessary • Increase in responsive workforce capacity • Identification of corporate / support staff able to support delivery • Deployment and redeployment process and plans in place • Group established to oversee deployment and staffing • Workforce governance structures in place.	• Weekly service heat maps reviewed at the Operational Huddle • Escalation through the Strategic Coordination Group (SCG).

Identified Risk	Mitigation	Monitoring
Changes to national response to flu/ Covid-19 pandemic requiring further rapid change to service delivery	- Incident Management and IPC arrangements in place and tested; able to resume at pace - Strengthened operational structures in place and well established - Evidence of service ability to respond quickly and flexibly.	- Service changes overseen and monitored via CSDDG and EWCG - Decision logs maintained to record rationale and objective of change.
Significant delays in dementia pathway resulting in high levels of people Clinically Ready for Discharge (CRfD) and bed pressures	- Identified priority with Leeds winter plans - Use of winter monies to focus on potential solutions - Partnership planning and delivery with social care.	- Performance and activity reports (CRfD and bed occupancy) - Weekly meetings with social care and commissioners - Daily capacity and demand reports.
Significant increase in pressure on the acute sector (ED attendances, occupancy and bed pressures)	- Increased capacity in ALPS / Liaison service - Partnership approach with LTHT and system escalation and governance arrangements - ED avoidance assessment area in operation.	- Daily capacity / demand report - Performance reporting framework – metrics relating to ED and LTHT mental health activity.
Severe weather resulting in disruption to services (staffing, access, estates risks such as power outages)	- Business Continuity and Deployment & Redeployment plans in place, supported by strengthened operational management structures - Structures in place to support rapid response - Estates business continuity plans and on-call arrangements - Mutual aid.	- Escalation to EWCG - Estates, IT and procurement reports via EWCG.
Reduced engagement of staff as a result of ongoing pressures and repeated changes	- Health and Wellbeing and staff support interventions, leadership packs and oversight group - Mental Health and Wellbeing hub - Enhanced and regular comms and engagement forums (including CEO open sessions) - Local team / service line communication structures, briefings and virtual staff meetings - Individualised Wellbeing risk assessments and managerial relationships.	- Health and Wellbeing governance structures and Workforce committee - HR metrics - Evaluation reports - Staff survey.
Increased pressure on access services and reduced community capacity resulting in increased admission and Out of Area placements and disruption to pathways	- Increased capacity in clinical triage, CRISS and crisis house - CAU remodelled to provide short term assessment with CRISS - Daily capacity reviews and regular partnership meetings - Assertive monitoring of Out of Area placements (case manager).	- Daily monitoring and reporting (OPEL) - Weekly capacity system meeting with partners.

The risks identified above have been captured in the Strategic Coordination Group's risk register and will be monitored via that group with risk being a standing agenda item.

3. WINTER MANAGEMENT ARRANGEMENTS

3.1 Current Service Provision and Prioritisation

Services have continued to adapt their method of delivery over the past couple of years, with our services now operating a hybrid model of face-to-face and virtual clinical activity. Service leaders have supported this by developing detailed updated working instructions so that staff have clarity to support their work. Where services have identified issues in relation to backlog and / or waiting lists, work has been undertaken to plan to address these issues, supported where possible by detailed activity plans.

We continue to experience operational pressures across services, especially in terms of increased demand, recovering backlogs of treatment and care, and ongoing constraints in how we can deliver care. This occurs in the context of significant wider system pressures, which are already evident as we move into winter.

We are anticipating further Industrial Action (IA) by Consultants this year leading into winter, although there are currently no indications of this. The BMA has balloted its members to obtain a mandate for IA for 12 months from July 2026, which would enable them to strike at any time until July 2027. We have established a Strategic Coordination Group (SCG) to plan for and manage any IA to coordinate and maintain services during this period.

Our workforce availability, wellbeing and resilience is key in maintaining our ambition for minimal disruption to service delivery throughout the winter, therefore this is where much of our effort and support will be focused. We now have well established contingency arrangements and measures to maintain staffing availability and to maintain delivery of our access, crisis and inpatient priority services.

These pressures will be managed through the Heads of Service with an escalation route to the SCG during normal working hours. Outside of these hours we have a robust on-call system with three tiers of escalation including a Duty Manager, CSM on call (Tactical) and Director (Strategic) who will then report any issues into the SCG on the next working day.

3.2 Activity and Performance Management

During 2026, services have continued to receive and review activity data, with increasing access to performance dashboards. We have re-established more regular formalised governance arrangements relating to performance and activity via our Care Services Delivery and Development Group (CSDDG), led by the Chief Operating Officer and through the development of the Care Services Finance and Performance Group led by the Deputy Director of Operations. We have also maintained our 'heat map' approach for all service lines which is reviewed regularly via a weekly Operational Huddle which highlights areas of particular concern or challenge to maintaining service delivery and business continuity.

We will continue to maintain and improve our response times to referrals into our services as normal throughout winter. This may be impacted by any changes to our

service delivery because of the response required to support our priority services as part of the Business Continuity approach to maintaining services. Where this is the case, the services impacted will continue to deliver a reduced service and develop recovery plans to demonstrate how they will recover to the position prior to any changes being made following a further EHIA. This will be monitored through our Care Services Finance and Performance Group which is reported to the Board as part of the Chief Operating Officer's report on a bi-monthly basis. Our activity and performance will continue to be monitored through a monthly submission to ICB Commissioners and completion of mandated NHS England returns for specialised commissioned services.

3.3 Service Line Assurance Report

As part of our Winter Plan, each service line is required to complete and provide an assurance template that confirms the service line has adequate confidence in their processes and planning in relation to:

- **Staffing** (planning, cover arrangements and disruption mitigation)
- **Surge and Capacity** (service response to manage surge and increased demand)
- **Severe winter weather** (ability to operate within significant periods of adverse weather)
- **Outbreaks** (ability to manage Covid-19 and flu outbreaks).

This detailed assurance (with plans for additional actions and assurance as required) forms part of our comprehensive winter / emergency planning approach and ensures effective oversight and support for our services.

The report template is attached at Appendix C.

3.4 System-level winter arrangements

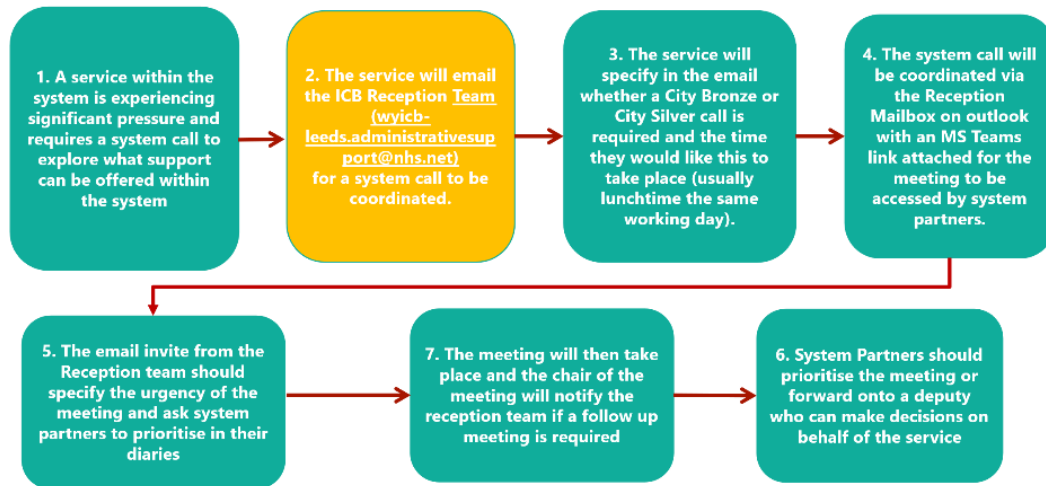
To support the oversight and management of risks we continue to use the Operational Pressures Escalation Level (OPEL) framework. This OPEL framework will continue to be integral to the monitoring and management of the risks resulting throughout winter 2026/27. The West Yorkshire System Coordination Centre (SCC) continues to monitor performance and responsiveness to ensure we support patient access. The SCC is a central co-ordination service to providers of care across the ICB footprint, with the aim to support patient access to the safest and best quality of care possible.

The Leeds health and care system will continue to maintain a system OPEL that reflects the wider system pressure and supports system leaders to balance risks. There is an established governance structure in place to manage these pressures over winter and there is a clear process for escalating system calls as detailed in Diagram 2 below. Further work is required, and is ongoing, to clarify the future audit, governance, decision ownership and chairing arrangements for system escalation to improve the effectiveness of the system working approach.

Diagram 2

Requests for City call (Bronze, Silver, Gold)

Flowchart of process



During September, the Leeds system will be standing up the Active System Leadership Resilience Group to respond to winter pressures across the system. The focus for LYPFT within this group will be:

- Increasing capacity within our CRISS service to ensure timely access to mental health services in a crisis
- Reducing the number of service users waiting in Emergency Departments over 24 hours for a mental health bed
- Ensuring smooth transition from points of access into mental health crisis services
- Increasing capacity of third sector crisis support services, promoting access alternatives to Emergency Departments
- Ensuring an effective end-to-end process review for people with complex dementia (both within the Mount and within LTHT) aiming to reduce the number of people in beds with complex dementia who no longer require a hospital bed
- Promoting and embedding implementation of pathways for younger people with mental health and housing needs, who no longer require a hospital admission.

4 WINTER STAFFING

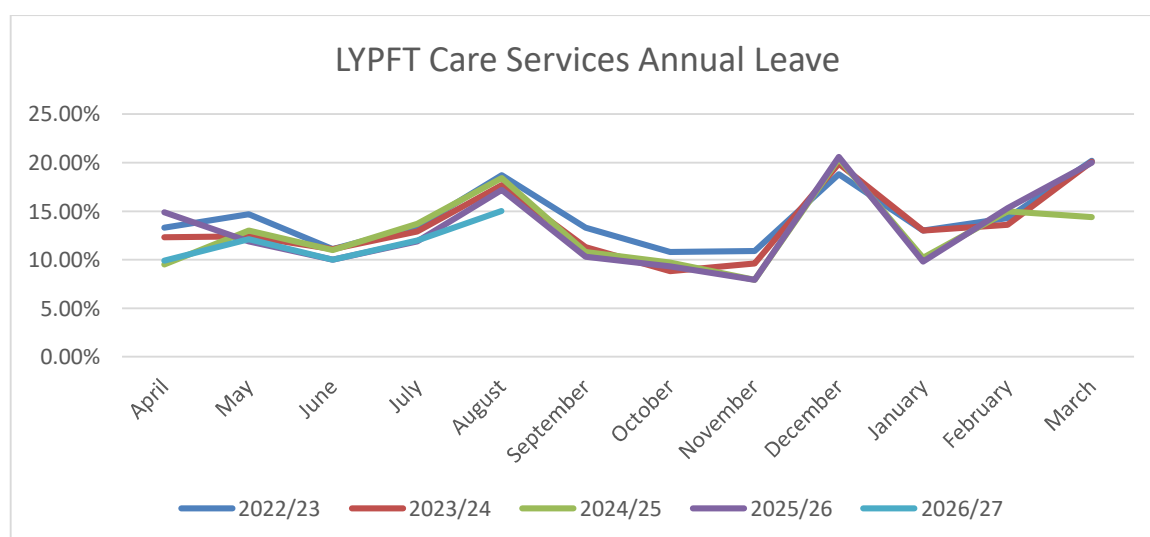
Having sufficient experienced staff on duty is a major asset in mitigating disruption, and a key potential risk to delivery throughout the winter period. Staffing pressures have, however, remained constant (at varying degrees) throughout 2025/26. Service lines monitor their staffing arrangements and any capacity issues that need addressing are escalated on a regular basis so they can be addressed in a timely fashion.

Winter staffing rotas are not done in advance through the whole winter. However, all teams are frequently reviewing rosters and planning in line with our electronic roster guidelines which ensure rosters are managed effectively and any shortfall can be identified and mitigations put in place.

We continue to see in-year variation regarding the taking of annual leave. These have tended to be through the height of summer, over the Christmas period and the end of the financial year. We know that increased rates of leave create pressure for the remaining workforce and reduces the responsiveness. At this stage of the year, we are seeing the usual trend in use of annual leave albeit at a reduced level (see Graph 12). We will continue to monitor this and put plans in place to start planning for the periods where we see increased use.

To maintain effective working, we operate with an optimal annual leave rate of between 11% and 17% throughout the year. We will take a proactive approach to try to maintain annual leave within these parameters and will ensure our priority services are fully staffed and operational to meet any increased demand. We will also ensure we have sufficient resilience in our system particularly our crisis, home treatment and liaison psychiatry services.

Graph 12



4.1 Maintaining Safe Staffing

Having sufficient experienced staff on duty is key to mitigating disruption to delivery throughout the winter period.

The Trust has a robustly developed approach to the deployment and redeployment of staff to maintain minimum safe staffing levels, particularly within the agreed priority services. This was revised following a period of review and feedback from staff, as well as a formal evaluation of effectiveness and impact. Our current Deployment & Redeployment process can be found at Appendix D.

Operational staffing arrangements, staffing pressures and the forecast staffing position across care services are reviewed within each of the service line management meetings, reporting to the CSDDG and linking closely to the Trust's governance structures relating to workforce planning, recruitment and retention.

Staffing pressures have, however, remained constant (at varying degrees) throughout 2026. This is due to periods of increased unavailability of staff, high rates of vacancies

and some sustained levels of demand for additional staff in priority services because of service user presentation and acuity. These are now predominantly dealt with through 'internal' deployment of staff within the service line (for example, practice development staff or senior clinical staff working directly within the clinical settings), cancelling non-essential activities, or through the 'day-to-day' deployment of staff from one area to another (as set out in the Trust's Staffing Escalation Protocol).

Services will enact their business continuity plans and associated OPEL actions where the triggering staffing levels identified in their Business Continuity Plan are reached, or where levels of activity and demand create pressures that result in an increasing OPEL position. If a business continuity incident is declared, the appropriate ICB will be informed as per EPRR guidance. This would also include reviewing the CSM on-call arrangements with a view to Heads of Operations moving to 7-day working.

These will include:

- Escalation internally and externally with partners (via system Silver)
- 'Internal' redeployment of staff across service lines to meet priority service needs
- Deployment of clinically qualified senior staff into direct clinical roles
- Cancelling of non-priority activities, study leave and 'ad-hoc' annual leave.



- Facilitate early discharge (utilising CRISS / IHTT for increased home support)
- Use of non-designated ward / bed space (such as de-escalation areas or additional bed capacity) to create capacity.



- Review of clinical activity across all service lines with reduction to release capacity and maintain priority and essential services
- Use of volunteers from other services who have identified a willingness to be redeployed to priority services when required
- Use of administrative / corporate support staff within care services.



- Consider step-down of services in non-priority category (supported by impact and risk assessments and mitigation)
- Implement formal redeployment processes across care services and corporate support services to maintain minimum staffing and the delivery of priority services.

4.2 Focus on Workforce

The NHS People Plan clearly sets out the national aims and objectives in relation to our workforce moving forward, with a key focus on four areas:

- **Looking after our people** – with quality health and wellbeing support for everyone
- **Belonging in the NHS** – with a particular focus on tackling inequalities and the discrimination that some staff face

- **New ways of working and delivering care** – making effective use of the full range of our people's skills and experience
- **Growing for the future** – how we recruit and keep our people, and welcome back colleagues who want to return.

These areas have influenced and been reflected in our ways of working over the last four years and are reflected within our 2025/26 Winter Plan. Our Trust People Plan which was first published in 2021, has been recently reviewed and updated for 2024-27, following extensive staff engagement. This outlines the objectives and action plans aligned with the national People Plan, ensuring that over the next three years we can be confident that we are focusing our efforts in areas that will make the greatest impact.

Workforce is identified as the key risk to every aspect of our system and local winter plans. In relation to the Winter Plan, there is a specific focus on two key areas: staff health and wellbeing; and different ways of working to most effectively deploy staff to meet service user need and maintain the continuity of our priority services. Our plans very much reflect the most recent national NHS guidance and advice in relation to preparation for winter 2025/26 and demand surge, which focuses on:

- Provision of health and wellbeing support
- Focus on flu vaccination
- Effective forward planning of deployment and rosters, with a key focus on roster scrutiny and approving annual leave within headroom limits to prevent the predictable seasonal trends and reliance on bank staff
- Recruitment and retention initiatives to grow, develop and upskill the workforce, inclusive of the new centralised Health Support Worker recruitment campaign with the target of a 50% vacancy reduction by the end of 2026/27
- Promotion of resilience and increased flexible working arrangements.

4.3 Staff well-being

The wellbeing of our staff is our priority, and the objectives set out in Our People Plan ensures staff are being supported to feel safe, healthy and well both physically and psychologically. The People Group oversees our approach to staff wellbeing, and we report bi-monthly to our Wellbeing Guardian (who is one of our non-executive directors) at the Workforce Committee.

In addition to the annual Performance Development Review (PDR) for individuals, the now mandatory Wellbeing Assessments should be undertaken as a minimum each year. Wellbeing Assessments are further supported by the Wellbeing Agreement which is completed by staff (supported by HR) who are seeking further health and wellbeing support because of a change in their health and wellbeing and / or the diagnosis of a disability, a long-term condition or illness. It can also be used following a change to a pre-existing condition.

The health and wellbeing offer to staff is regularly communicated through a monthly wellbeing focus in the Trustwide newsletter and through our Staffnet pages. This provision includes rapid access to services such as stress, anxiety and burnout therapy, counselling, physiotherapy, cognitive behaviour therapy (CBT) and our occupational

health service. Other support is offered for menopause, men's health, and financial wellbeing.

The Health and Wellbeing Team is available to support any teams or service that are under pressure through programmes such as our Critical Incident Staff Support Pathway (CRiSSP) and Health and Wellbeing Champion network.

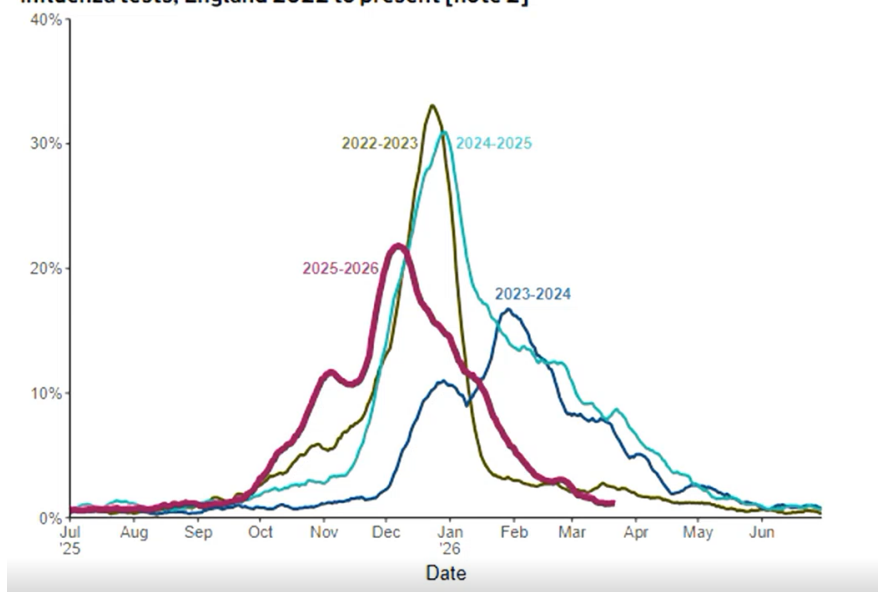
In addition, we play an active role in the Leeds One Workforce Programme (a set of continuing collaborative projects relating to workforce support and development) and the Thrive @ Work programme supports employees working in a health and care organisation in Leeds with support services, including Musculoskeletal (MSK) support, support with career choices and transition and Leeds Recovery College.

5 SUPPORTING THE HEALTH OF OUR PEOPLE AND PATIENTS OVER WINTER

The winter of 2025/26 saw a reduction in the cases of flu nationally, with the appearance of the virus occurring earlier than was expected, peaking at a lower level and lasting a shorter period of time compared to previous years. See Graph 13. The Deputy Director for Healthcare Public Health for NHSE across the NE & Yorkshire, presenting at the NE and Yorkshire Urgent and Emergency Care (UEC) winter planning webinar on the 28 July 2026, indicated that we are expecting a similar pattern during the winter of 2026/27.

Graph 13

Figure 4. Rolling 7-day positivity of tests positive for influenza among all reported influenza tests, England 2022 to present [note 2]



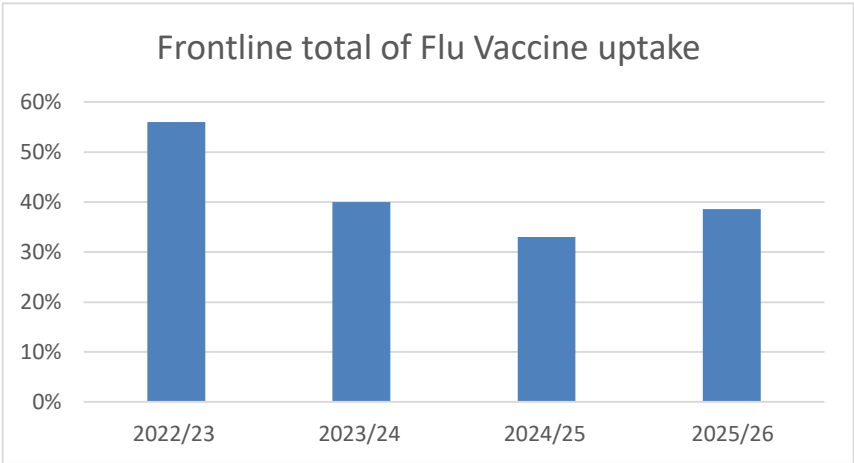
*Produced by the Deputy Director for Healthcare Public Health for NHSE across the NE & Yorkshire region.

5.1 Previous seasonal vaccination campaign uptake

Over the past three years we had seen a decline in the uptake of flu vaccines by eligible staff (see Graph 14). The reasons for this are unclear; however, one reason could be because of vaccine fatigue. During the past winter we had seen an increase in the uptake by frontline staff achieving near 39%, an increase of 6%, meeting the standard of improving by at least 5% on the previous year. There is a national emphasis to increase

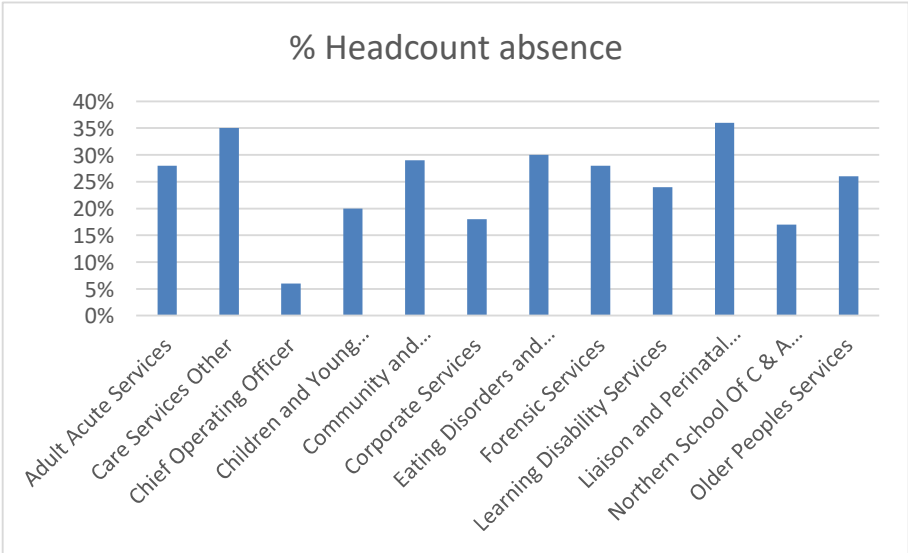
the rates of vaccine uptake again this year. This year NHSE has set a target of 60-65% uptake of the flu vaccine for frontline healthcare workers. Section 5.2 below sets out the Trust’s strategy for the vaccination programme for winter 2025/26.

Graph 14



During the winter period we see an increase in staff absence rates, particularly cold / flu type absences. During the winter of 2025/26, from 1 November to 28 February, there were a total of 818 staff, 25% of the Trust workforce, absent due to cold / flu related illnesses. This resulted in 3714 working days being lost to the Trust. The absence rates vary across all service areas as detailed in Graph 15 below. Based on the previous year’s absence rates we anticipate this will be the trend through this next winter. It is, though, unclear if the absence rate is linked to the low uptake in vaccinations.

Graph 15



5.2 Autumn / winter 2026-27 Vaccination Plan

We started planning for this year’s vaccination programme in June 2026, and it will commence on the 1 October for eligible cohorts. The Infection Prevention and Control Team (IPC Team) will start conducting ad-hoc drop-in visits onto inpatient wards. The aim will be to offer the vaccine at the earliest opportunity to all staff and to service users who have had the vaccine prescribed following a medical assessment.

The NHSE has circulated the eligible cohort for the upcoming autumn Covid-19 vaccination campaign, and we will only be offering the vaccine to eligible service users until 31 January 2027. Health and social care workers are not included in the eligibility criteria for Covid-19. Co-administration of the flu and Covid-19 vaccines will be offered to service users.

Vaccination will be offered in England in autumn 2026 to:

- Adults aged 75 years and over
- Residents in a care home for older adults
- Individuals aged 6 months and over who are immunosuppressed, as defined in tables 3 and 4 of the COVID-19 chapter of the UK Health Security Agency (UKHSA) Green Book on immunisation against infectious disease.

To maximise uptake and visibility, the focus will be more on drop-in vaccination visits onto inpatient areas and less on static clinics.

The campaign plan will include:

- Drop-in sessions from October daily to inpatient wards offering flu vaccine to staff. Covid-19 vaccine will be on offer to eligible service users only (this will be communicated to clinical teams to ensure cooperation and to ensure service users are assessed for vaccine eligibility ahead of the sessions).
- Registered Nurses within the Corporate Services will be supporting the vaccination campaign, conducting drop-in inpatient ward and community sites vaccination sessions.
- One static clinic split into two, across different sites each working day. For example, 8.30 am till 12 noon at the St Marys Hospital site then 1.30 pm till 4 pm at the Becklin Centre. The drop-in sessions will be publicised via an all-staff Trustwide Communications email on a weekly basis.
- Registered Nurses and Registered Nursing Associates in inpatient areas who are peer to peer vaccinators offering the flu vaccine to staff working in that area.
- The IPC Team will facilitate vaccination clinics within Leeds from October till December. From January till the end of March, the IPC Team will carry out walk-around visits onto wards to offer the vaccine to those who have not been vaccinated. This will include obtaining signed consent forms from staff who have had the vaccine elsewhere and those who choose to opt out. This is to ensure we can evidence a 100% offer to all frontline staff.
- Registered staff on the wards will vaccinate service users with the flu vaccine as soon as possible to ensure early protection.
- The IPC Lead Nurse / Vaccination Campaign Lead will record monthly frontline vaccination uptake figures on ImmForm, the UKSHA data collection system. A report of uptake figures will also be shared at the IPC Committee and with the Nursing and Professions Directorate.

The IPC Team will ensure records of staff and service user vaccine uptake is recorded on RAVS (Record a Vaccine Service).

5.2.1 Publicising the campaign

The campaign will be simple, visible, promoting engagement and vaccine confidence. We're framing vaccination as: "Stay strong, get vaccinated. Get yourself vaccinated to protect yourself, colleagues, and patients from serious illness". We've conducted photo shoots in clinical areas, which have been well received, to develop our visual concepts. Posters will be printed featuring colleagues across the Trust under this theme, to be displayed across key Trust locations and inpatient wards.

We will also be celebrating uptake across wards in order to create positive peer pressure to drive participation and sharing their "why I got jabbed" stories. Managers are being supported to emphasise the role of vaccination in keeping wards staffed and safe over winter, addressing key areas of concern including myths and misinformation.

We will be promoting a clear timetable of dates and locations for Trust wide drop-in clinics. We're also regularly reminding staff to complete the "Flu Form", to give consent or, state if they've received their vaccine elsewhere. However, if staff would rather not have the vaccine, they need to complete the form and state "rather not / excluded". This will ensure we can evidence we have offered the vaccine to 100% of staff Trustwide to keep our data accurate.

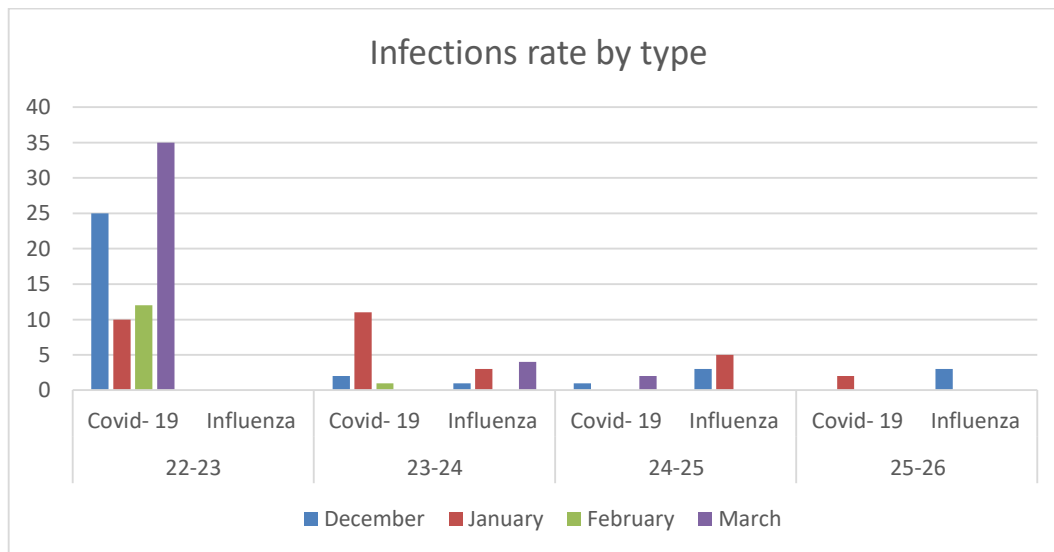
5.3 Fit Testing

NHS England is mandating that 'Fit Testing' has taken place for all relevant staff groups. The IPC Team will offer Fit Testing in clinical areas at the request of the Team Managers. In addition, all eligible staff will be provided with Fit Testing during any relevant mandatory training sessions. Team managers will be asked to provide the IPC Team with a list of exempt staff who cannot be Fit Tested due to health or other reasons. Records of staff completing Fit Testing will be held on ESR.

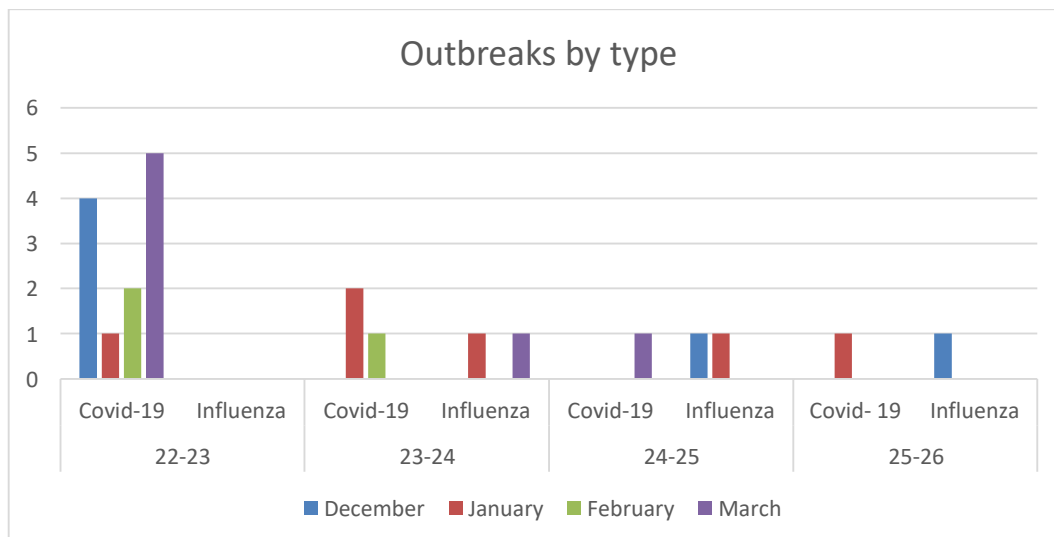
5.4 Outbreak Management

We have seen the rates of respiratory related infections in our service user population reduce over the winter months for the past four years (see Graph 16). We have also seen a reduction in the number of outbreaks reported (see Graph 17). In addition to this we have seen the average duration of outbreaks reducing from 12 days for the 2022/23 period to 10 days for subsequent periods with the average period dropping to 4 days in 2025/26.

Graph 16



Graph 17



We will continue to follow the previous year's approach to outbreak management as follows:

- During working hours, the IPC Team will stand up outbreak management meetings where an outbreak has been identified of any causative organism
- Once the IPC Team has been notified of two or more service users presenting with symptoms, IPC response time should be within 2 hours Monday to Friday 8 am till 4 pm
- An outbreak meeting will be held which will inform clinicians on the ward of the standard infection precautions they should implement to safeguard others
- From 8 am till 5 pm Monday to Friday, the IPC Team will provide a telephone advisory service and respond to staff / service queries
- The Outbreak and Countermeasures Plan sets out the Trust response to an outbreak on Trust premises and in the community.

Outside of normal working hours, as an interim measure until the next working day, the Duty Manager and the On Call CSM will close the affected ward to admissions, visiting, transfers and discharges to hospital and nursing and residential care unless a local interagency protocol has been agreed. A full handover must be provided to the IPC Team at the earliest opportunity by email to infectioncontrol.lypft@nhs.net. This plan can be accessed via Staffnet.

6. ADDRESSING HEALTH INEQUALITIES

Adverse cold weather can put people already experiencing health inequalities at greater risk of ill-health and even death, primarily because it increases the probability of complications from existing disease, and of injury due to falls.

There are a number of ways we can support the people we care for to reduce the risks associated with exposure to adverse cold weather including:

- Knowing who is at risk
- Being alerted to increased cardiovascular, respiratory and other complications from cold exposure
- Adapting individual care plans to respond to adverse cold weather
- Promoting vaccination for those eligible to reduce risks from Covid-19 and flu
- Having action plans in place tailored to the local context
- Signposting people to sources of support for housing, energy bills and other needs as appropriate, including specific support for those on low incomes.

We know fuel poverty is a long-standing health issue: the impact of cold housing on health and the stresses brought on by living in fuel poverty have been recognised for decades by researchers, medical professionals and policy makers alike. Fuel poverty is a longstanding council priority and aligns strongly with the Leeds Best City aim of tackling poverty and reducing inequalities.

Any increase in fuel poverty is concerning, but this issue has recently been amplified due to increases to energy bills and a rise in the cost of living more generally. Councils have launched schemes to help residents cut energy bills and homeowners, renters, and landlords of properties without gas central heating can now get energy saving green measures installed free of charge or at a significant discount, thanks to a new Council scheme.

Below are some resources available to service users and staff to help deal with the winter pressures people may experience:

There are many organisations that offer free, impartial and confidential help and advice with all types of debt including rent arrears, council tax and utilities. Many also offer help with other money problems such as benefit issues and budgeting and can be found here: <https://www.leeds.gov.uk/leedsmic/energy-fuel-and-food/energy-utility-and-household-bills>

Staff working with people experiencing fuel or poverty emergency or crisis, can apply for support with food, energy and essential household items through the Councils Local Welfare Support Scheme. The Leeds City Council one can be found here: <https://www.leeds.gov.uk/benefits/local-welfare-support-scheme> , City of York Council

can be found here: <https://www.york.gov.uk/news/article/1526/new-energy-efficiency-grants-for-homes-not-heated-by-mains-gas> .

Staff can also access [Supporting vulnerable people before and during cold weather: healthcare professionals - GOV.UK \(www.gov.uk\)](#) with [action cards](#)

7 EPRR RESPONSE

7.1 Winter Coordination

7.1.1 Strategic Coordination Group

To manage winter pressures, risks and any resultant disruption we will convene the Strategic Coordination Group. This executive-led group comprises a multi-disciplinary team of senior staff and has the remit to mitigate the risk of disruption from a wide range of factors ranging from weather to capacity, demand, and flow to infectious outbreaks. The group is supported by a Tactical Coordination Group charged with minimising environmental and weather-related impacts on Trust services.

The Strategic Coordination Group will convene on the 21 September 2026 and will run until the end of March 2027 with an assessment on the appropriateness of standing down the group to be made in late March 2027. The group reports to the Trust's Executive Management Team.

7.1.2 Tactical Coordination Group

The Tactical Coordination Group will operate from 24 September 2026 to coordinate all work to mitigate potential winter disruptions. The membership of the group includes:

- EPRR staff
- Estates and Facilities
- Operational Management
- Communications
- Physical Health
- Membership from Mitie and NHS Property Services.

Its role covers adverse weather response, power outage mitigation, disruption to other utilities and response to disruptive snow regarding site access. The group will report to the Trust's executive-led Strategic Coordination Group.

7.2 Adverse weather

The Trust has an Adverse Weather Plan that has been developed to manage adverse weather conditions over the winter period. The plan contains full details of the Trust's risk assessment, impact assessment and mitigation around disruption from adverse weather.

The Trust's EPRR team is registered to receive alerts regarding adverse weather from the Met Office, and flooding information and risks from the Environment Agency.

The Adverse Weather plan describes the process for communications with staff and when all-user e-mail notifications will take place so that services can consult their

business continuity actions in preparation for potential bad weather, for example, going to standby with flood defences at a site at high risk of flooding. Requests for these alerts are to be made via the Trust's Communications Team:

- In hours: A request to be made by phone to the duty communications officer's central number: 0113 85 55989.
- Out of hours: If the Director on call (Strategic Commander) declares a critical or major incident out of office hours, they can request out of hours communications support by calling 07534 907491.

For significant threats, amber or red warnings, the Trust would invoke organisational business continuity arrangements aimed at utilising resources to maintain critical clinical and organisational activities.

Incident coordination would also be an option that would be considered for managing widescale disruption and has been used in previous winters to manage disruptive snow events. Incident coordination would follow the principles set out in the Trust's Emergency Incident Response Plan.

7.3 Other winter risks

7.3.1 Power disruption

Winter brings with it increased risks to power distribution based on both the impact of storms and supply sided shortages first experienced in winter 2022/23 with a risk to gas and oil supplies caused by the Ukraine conflict and UK gas storage limitations.

Many of the same factors exist in winter 2026/27 as in previous years, hence the Trust will carry out work to boost resilience around potential outages. As part of this:

- The Trust will implement a series of black start tests, simulating a power cut, testing the back-up generators and their control system's ability to detect the outage and then activate and power the building
- Emergency lighting equipment will be checked to ensure it is in place and is still effective. This includes checking ward stocks of torches and LED safety lights issued to services across the Trust
- Communication equipment checking will be requested for all in patient areas; these are ward business continuity mobile phones.

7.3.2 Maintaining access to Trust sites.

The Trust's sites are covered by three providers of facilities services: Trust owned and leased sites provided by Trust Estates staff; Leeds PFI sites provided by Mitie; and York sites provided by NHS Property Services. All three providers have in place advance warning arrangements via met office alerting, supplemented by EPRR issuing warnings.

On receipt of a snow or ice warning the providers will mobilise snow clearing and gritting resources to maintain access to sites including an out of hours response.

8. Conclusion

As discussed throughout this plan, we continue to see pressure across our services, particularly our acute inpatient and liaison services, throughout the year. Whilst we have plans in place to work to improve the position, we expect this to continue into winter and beyond.

Winter brings the added pressures from across the wider system, nowhere more so than in our Acute Hospital provider, which results in added challenges to the delivery of mental health services. Working with the Integrated Care Board and other healthcare provider partners, including the VCSE, we will ensure that disruption is kept to a minimum for the people we provide services for.

Joanna Forster Adams
Chief Operating Officer

Contributions by:

Mark Dodd: Deputy COO for AMH & LD
Cath Hill: Head of Operational Governance
Sam Grundy: Head of EPRR
Gugu Ncube-Mpofu: Lead Infection Prevention and Control Nurse Specialist
Eve Townsley: Head of Operations for Liaison and Perinatal Services
Ian Burgess: Senior Information Manager
Sophie Valinakis: Head of Health Equity
Laura McDonagh: Head of Operations for Acute Services
Warren Duffy: Deputy Director of Estates & Facilities
Holly Tetley: Associate Director of Employment

GLOSSARY

Term	Explanation
Business Continuity	The capability of the organisation to continue delivery of products or services at acceptable predefined levels following a disruptive incident.
Business continuity incident	An event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, to below acceptable pre-defined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.
Command and control (and communication)	Often referred to as C ³ . The exercise of vested authority through means of communications and the management of available assets and capabilities, in order to achieve defined objectives.
Critical incident	A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions.
EPRR	This refers to Emergency Preparedness, Resilience and Response - this term covers all aspects of responding to emergency incidents and disruptive events in the NHS.
Mitigation	Measures taken to reduce an undesired consequence.
Mutual aid agreement	Pre-arranged understanding between two or more entities to render assistance to each other.
OPEL	Operating Pressures Escalatory Limits - this is the NHS England Framework governing how health providers reflect their position regarding capacity, demand and flow and the necessary actions to take to try to alleviate these pressures.
SiTRep	Situation Report - a teleconference or report detailing the current situation affecting a service, department or site. This is used as a basis to formulate action to manage the incident or problem.

Appendix A:

	Initial EHIA Screening Questions:	Yes or No
1	Are you reviewing a policy, procedure or are your services due for review or introducing new changes?	No
2	Are you establishing a new policy, procedure, or developing a new service?	No
3	Could the policy / service change or the way in which it is carried out have a negative impact on people with a particular protected characteristic? For example, does it put a particular group at a disadvantage on the grounds of age, disability, sex, ethnicity, gender reassignment, marriage and civil partnership, pregnancy and maternity, religion or belief, and sexual orientation equality?	No
4	Could the policy / service change or the way in which it is carried out have a negative impact on relations between different groups?	No
5	Is the negative impact, if any, unavoidable? Could it be considered to be unlawful discrimination? Can it be justified by the aims and importance of the policy/service? Are there other ways in which the Trust's aims can be achieved without causing a negative impact on some diverse groups?	No
6	Could taking particular measures, reduce the negative impact?	No
7	Is further research or consultation necessary? Would this research be proportionate to the importance of the policy/service/function? Is it likely to lead to a different outcome?	No

Appendix B: Service Priority Categorisation

Priority Services	
• CRISS • Older Peoples IHTT • LD Intensive Support Team • ALPS & LTHT Liaison In-reach • Section 136 suite	All crisis / urgent access services.
• Acute Wards & PICU • CAU • Mount wards • Asket Wards • CYP inpatient wards (Mill Lodge & Red Kite View) • Mother & Baby Unit • YCED (Ward 6) • Complex Rehab (Ward 5) • Forensic Wards • 2&3 Woodlands Square • Supported Living	Inpatient services and Supported Living Houses – maintain 24/7. Some reduction in full MDT availability in some teams, which will be managed by cross cover or redeployment (depending on requirements). Minimum staffing requirements being reviewed and confirmed in partnership with nursing directorate.
• NICPM	Maintain as a priority ward.
Maintain but can reduce / redeploy some staff	
• CMHTs • CLDTs • Assertive Outreach • Community R&R • CONNECT community team • Community Forensic Team • Community Perinatal • Deaf CAMHS • Physical Health Team • Care Homes Team • Recovery College (telephone & online support) • Forward Leeds (Addictions) • PD Network • LADS & ADHD • Gender service • Gambling service • Chronic Fatigue & Liaison Outpatients • Psychosexual medicine • Offender PD services • OpCourage Enhanced Pathway Team • OpCourage Core Pathway Team	These services can all operate currently on a reduced number of staff but have a requirement to maintain some access and an active caseload, including direct contact (including some face-to-face contact) with some service users. All service users have been RAG rated, and this informs us of the required capacity and skill mix for the team Some staff are therefore available for redeployment from these teams.
Could step down	
• LD Involvement Team • PD Pathway Development Service • MH Primary Care	These services can be closed to new referrals and stopped down, with only emergency contact cover in place Priority cases would come via crisis or liaison where necessary.

Essential Support Services

These support services have been identified as being critical to the ongoing delivery of care services:

1. Information Technology - provision of:
 - a. Care Director
 - b. EPMA
 - c. E-mail system.
 - d. Shared folders and wide area network
 - e. Access to NHS spine apps and Leeds Care Record
 - f. Big Hand
2. Pharmacy – provision of medication, advice and support to clinicians
3. Estates – provision of:
 - a. Hard and soft FM at owned and leased sites
 - b. Soft FM at NHS PS Sites
 - c. Liaison with Landlords, NHS PS and the SPV/ Mitie
4. Workforce Systems
 - a. E roster
 - b. ESR
 - c. Bank systems
5. Procurement – provision of:
 - a. Clinical consumables
 - b. Bill payments for medical equipment
 - c. Consumables, food, drink etc for inpatients
6. IPC- advice and response to outbreaks, pandemics, and advice in a HAZMAT/CBRN incident
7. Switchboard – Maintaining telephone communications across the Trust.

Appendix C

Winter Planning Assurance 2025-26

Introduction

The questions below are focussed on the key resilience principles that need management consideration. After brief, a brief narrative can you RAG rate your assessed level of preparedness.

1. **Staffing** – do you have effective plans in place to mitigate disruption caused by reduced workforce, annual leave, and the Christmas holiday period?

RAG assurance rating	Choose an item.

2. **Surge and capacity** – have you assessed the effectiveness of your plans to manage surge and increased capacity during the winter? For services that interface with other providers have you assessed likely impact on work from these providers facing surge?

RAG assurance rating	Choose an item.

3. **Severe winter weather** – assessment of the services ability to continue to operate faced with significant periods of snow/ ice

RAG assurance rating	Choose an item.

4. **Outbreaks** –what is your assessment of your services ability to manage outbreaks in teams and on wards

RAG assurance rating	Choose an item.

5. Risks to escalate

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Appendix D

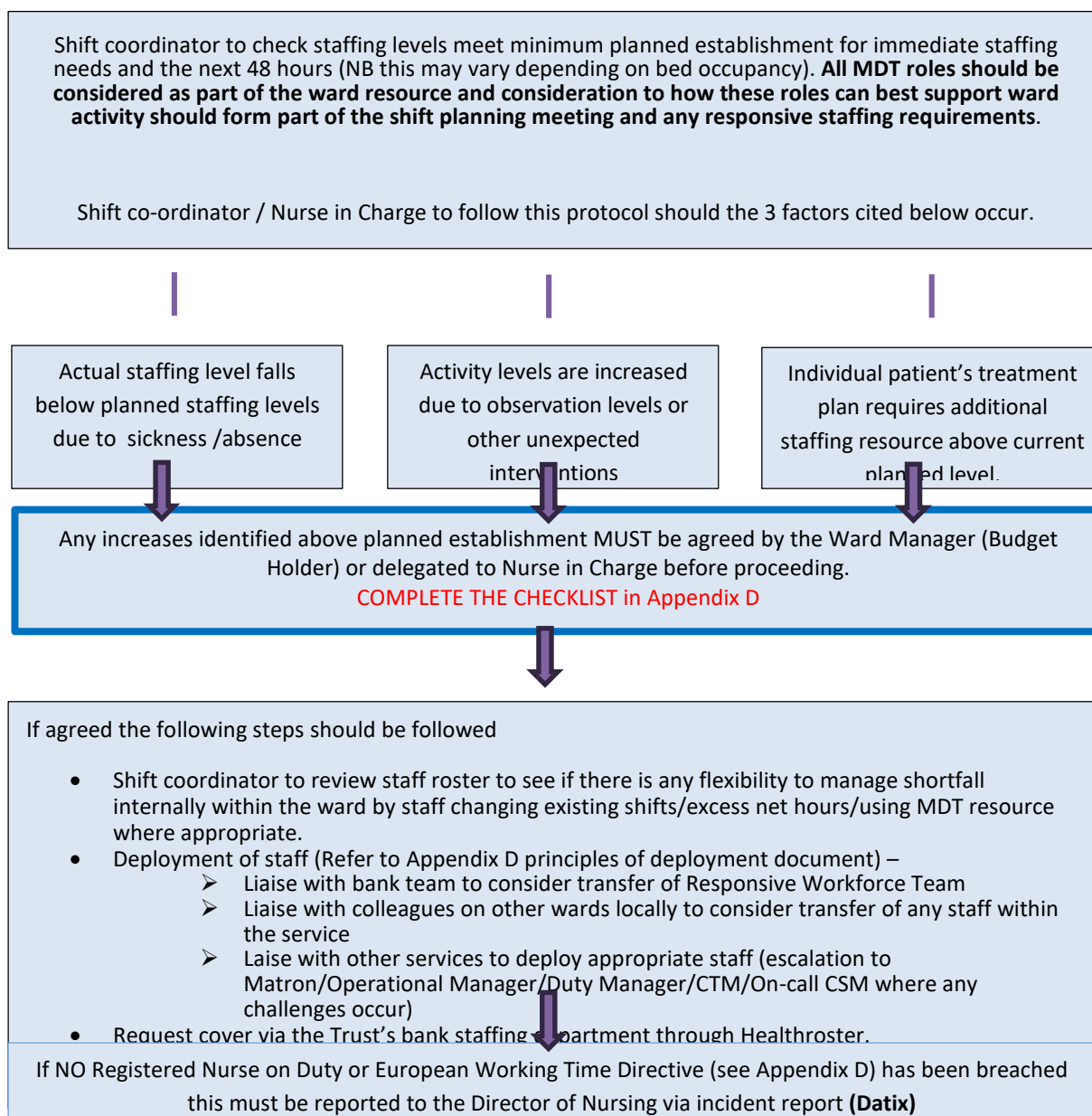
STAFFING ESCALATION AND DEPLOYMENT PROTOCOL

The purpose of this document is to provide guidance on the daily management of the ward ensuring the optimal staffing levels are met which meet the patients' needs as determined by risk and level of acuity and dependency.

When planned staffing levels are insufficient to meet current patient need, the following principles within the flowchart should be applied. This will enable clinical areas to identify and deploy resources to maintain safety where necessary.

Effective escalation of staffing shortfalls supports timely interventions to resolve issues to ensure a safe environment is maintained for the patient in addition to the health, safety and wellbeing of the staff members on duty.

This protocol should be applied in situations where the staffing level is insufficient within an inpatient ward/unit and applied alongside 'principles of deployment'.





All changes to the rostered staff via the deployment to other areas must be made on the Health Roster by the Shift Coordinator/Nurse in Charge or Duty Manager.

Appendix D/1

Checklist for Safer Staffing

NAME OF WARD or SERVICE:	
DATE:	
SHIFT:	

1. Potential staffing shortage identified on unit - reason identified as:

Vacancy	Sickness absence	Special Leave	Study Leave	Maternity Leave	Annual Leave	High activity	Other

2. Has consideration been given to all members of the MDT and how they can support ward operation/delivering patient care?)
3. Can the rota be arranged more effectively to provide the necessary staffing?
4. What would be the consequence of not covering the shift/additional duty? (Risk Assessment) Can this be managed?
5. What will additional staff be required to do? Identify particular grade/s, qualifications, skills or experience.
6. Does the full shift need to be covered or if not, what hours specifically need cover?
7. Requests to cover overtime to be agreed - follow HR-0032 Overtime Procedure. This must be adhered to HR-0032

CONSIDERED ALL OPTIONS	YES / NO
Explore how the MDT on duty can support ward operation/delivering care whilst maintaining profession specific commitments	
Consider changes to the rota/effective rostering/shift swaps	
Has agreement for an additional duty from WM/CTM or delegated Nurse been sought (Name and Role)	
Consider deployment of RWT	
Consider deployment within own service/site	
Consider deployment within other services	
Request bank cover via healthroster	
Request cover agency via healthroster	
Utilise overtime (overtime procedure check list must be completed)	
Have any changes been made on Healthroster	

Name	Designation
Signature	Date

Appendix D/2

Principles of Deployment

Deployment to an area outside of a staff member's service, the CTM / Operational Manager or Matron (Duty Manager out of hours) ideally should identify and move staff (substantive or bank) who have previously expressed a willingness.

In the circumstances this is a reasonable management instruction and should the person object, an individual conversation should also take place with the CTM or Matron/Operational Manager to explore the concerns, offer support/guidance and confirm that there are no legitimate/reasonable reasons why the member of staff cannot be deployed to the ward/service (such as ill health or specific personal circumstances), and that they have the necessary skills / training to undertake the role. Information & reassurance should be provided in relation to any unique procedure within the specialty and plans on how this will be managed. Any refusal to be moved that is considered unreasonable should be recorded & reported to the relevant Head of Operations.

Principles:

1. All services should have information about their service and an induction process (both Bank and Substantive) which will include induction to the environment and be familiar with the fire safety evacuation procedure and other elements of safety pertinent to that area at the beginning of the shift
2. The Duty Manager role is a responsive mechanism to support services where there are staff shortages or other issues that require manager oversight. They are not a proactive mechanism to support teams with their staffing issues in advance of these issues.
3. Staff with medical considerations that would prevent them from being redeployed into specific services should have an active (3 months) OH referral in place, which clearly states what restrictions are in place and a compliant wellbeing assessment.
4. All staff should be made aware of the nature of critical responses to staffing pressures from a service user-centric position and explanation provided of the real risk to service user care.
5. All Duty Managers and Redeployed staff will be supported by the Trust in undertaking risk assessments, deployment decisions and decisions whilst deployed into services.

Operational:

1. Ensure that rosters are created, approved and published in good time (8 weeks in advance is best practice) to create opportunity for Substantive and Temporary Staff to provide cover for vacant duties in advance of working.
2. Service Rostering – Reviewing the current shift by shift allocation module at a more service level approach including a cluster system that means the wards look at service before redeploying from outside. This would help in 3 ways:
 - a. Ensuring that peoples skills are matched to services.
 - b. Ensures that people are working within services they are familiar with.
 - c. Ensures that all colleagues are sighted on the tiered approach which should provide assurance of minimal moves out of clusters.

3. Each service ensures it has taken all the necessary steps to cover shifts within the team, service and service line structures during normal working hours. No escalation should be made to the Duty Manager during this time. Escalation to the Duty Manager should only occur as the end of the normal day as a means by which to flag any ongoing issues identified during the day with an identified plan by the service that intends to resolve the issue.
4. Where redeployment of Healthcare staff is required, the Responsive Workforce Team (RWT) should be considered in advance of approaching ward based staff. The RWT roster is accessible to all managers under Healthroster.
5. Where the RWT cannot provide cover, the following should be considered before redeployment action:
 - a. Does the Staff Member have:
 - i. Medical Exemption - Under a current OH referral?
 - ii. Skills exemption - In that they are not of the appropriate registration or do not have the appropriate training to provide adequate and safe care e.g. RNLD moving to Mental Health Unit. A brief assessment of staffs skill set should be undertaken as part of the deployment considerations.
 - iii. Experiential exemption – Are they a preceptee or have they been Involved in a recent incident or performance issue that would prohibit them from moving.
 - iv. European Working Time Directive (EWTD): Consider whether moving an individual or requesting them to stay beyond the end of their normal hours would breach the EWTD or impact on any caring responsibilities they may have outside of work. (Warnings of breaches will be visible on the roster when allocating duties).
6. Where services required longer-term support, consideration will be given to moving staff into short-term block bookings/placements to avoid concurrent requests.
7. Services should capture all movements to improve data integrity and inform decision making/reduce commitment of both rostering and management teams on safer staffing follow ups.

Appendix D/3

Working Time Directive

The UK's Working Time Regulations 1998 lay down the minimum conditions relating to weekly working time, rest entitlements and annual leave in the UK, although UK employees can opt in and out of the provisions relating to the minimum 48-hour working week

LYPFT's policy and guidance to WTD  [HR-0046.pdf](#) has been written in question and answer format for simplicity. If you cannot find the answer to a question, please contact your manager or the Human Resources Department who will be pleased to help you.

Meeting of the Board of Directors

Paper title:	Chair's Report from the Quality Committee meeting on 10 September 2026
Date of meeting:	24 September 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	Demand for services	
SR8	Health inequalities	
SR9	System change	

Committee details:	
Name of Committee:	Quality Committee
Date of Committee:	10 September 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 BAF, paying particular attention to Strategic Risk 1 (SR1) and SR2. Overall, it was assured that SR1 and SR2 were being adequately controlled.	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9
The committee received a report which provided an update on progress made against the Quality Strategic Plan and an update on the scope and timeline for developing a Trust-wide quality dashboard for use by the Board and its committees. It noted that the first prototype of the quality dashboard would be available in December 2026 for the Board and its committees and agreed that it was assured on the progress and activities in relation to the Quality Strategic Plan.	SR2
The committee received a report which provided an overview of falls reported across the Trust between April 2025 and March 2026, including analysis of trends, learning from incidents resulting in harm, and progress against key improvement initiatives. It was	SR1 SR5 SR6 SR7

assured that falls reported in the Trust were being considered in a robust and governed way and that data was being used to drive improvement work.	
The committee received a report which provided an overview of quality and safety arrangements for adult acute and psychiatric intensive care unit (PICU) out-of-area (OOA) placements between 1 April 2026 and 31 June 2026. It was informed of a new programme of work which would look at how the Trust could systematise the collection of incident data and provide assurance that OOA placements were meeting expected quality standards. An update on this work will be provided in November 2026.	SR1 SR4
The committee reviewed the National Confidential Inquiry into Suicide, Homicide and Safety in Mental Health (NCISH) Trust Safety Scorecard for 2026 which provided key indicators and benchmarking data designed to support quality improvement. It requested that more recent data on deaths be provided so it could understand the current numbers for overall and inpatient cohorts. The committee noted the 100% completion by the Trust of NCISH questionnaires for the second consecutive year, compared to a national rate of 90%, and agreed this was excellent practice that should be commended.	SR1
The committee reviewed a presentation which provided the highlights of the Complex Psychosis Pathway's Annual Quality Report, focusing on how the service had scored itself against the STEEEP dimensions. It acknowledged the major changes faced by the service, noting that the Trust's rehabilitation and assertive outreach provision had been consolidated into a single complex psychosis pathway. Overall, the committee was assured that the service had robust systems in place to identify and understand its quality issues, drive improvement, and maintain a clear awareness of its 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 service's strengths, weaknesses, challenges, and blind spots, and how these were being managed.	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9
The committee reviewed a presentation which provided the highlights of the Gender Identity Service's Annual Quality Report, focusing on how the service had scored itself against the STEEEP dimensions. It noted the achievements of the service, which included significant improvement work, progress made against the Levy action plan and the positive feedback received on its use of ambient voice technology. It also discussed challenges faced by the service which included the implementation of the Levy reforms and action plan while managing long waits, an unsuitable estate, limited outcome data and uncertainty about future prescribing responsibilities. Overall, the committee was assured that the service had robust systems in place to identify and understand its quality issues, drive improvement, and maintain a clear awareness of its strengths and weaknesses. The committee was also assured that the Executive Team had a strong understanding of the service's strengths, weaknesses, challenges, and blind spots, and how these were being managed.	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9

The committee received the Research and Development Annual Report alongside a supplementary report which provided information on the arrangements to ensure patient safety in clinical trials. It was assured by the information provided. It welcomed the positive stories within the report and suggested that these could be shared across the Trust.	SR1 SR2
The committee reviewed a presentation which provided the highlights of the CONNECT Service's Annual Quality Report, focusing on how the service had scored itself against the STEEEP dimensions. It acknowledged that the service was managing presentations involving avoidant restrictive food intake disorder (ARFID), neurodiversity and other coexisting needs for which traditional single-condition evidence was limited. It recognised there were tensions associated with the CONNECT service redesign and noted that the Executive Team was aware of this and providing support where needed. Overall, the committee was assured that the service had robust systems in place to identify and understand its quality issues, drive improvement, and maintain a clear awareness of its strengths and weaknesses. The committee was also assured that the Executive Team had a strong understanding of the service's strengths, weaknesses, challenges, and blind spots, and how these were being managed.	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9

REFER - Items to be referred to other

Issue	Relates to BAF Risk
The committee agreed to refer the broader issue of staff being unable to attend training due to capacity and service pressures to the Workforce Committee.	SR1 SR3

Recommendation

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

Meeting of the Board of Directors

Paper title:	Director of Nursing and Professions Quarterly Report
Date of meeting:	24 September 2026
Presented by: (name and title)	Nichola Sanderson. Director of Nursing and Professions
Prepared by: (name and title)	Nichola Sanderson, Director of Nursing and Professions Marie-Clare Trevett, Deputy Director for Allied Health Professions and Social Workers Alison Quarry, Deputy Director of Nursing Sarah Abel, Deputy Director of Psychological Professions

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

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	✓
SR3	Culture and environment for the wellbeing of staff	
SR4	Financial sustainability	
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Demand for services	
SR8	Health inequalities	
SR9	System change	

Executive summary

This paper provides an update and overview of key programmes of work and progress within the Nursing and Professions Directorate, which centers around the continued ambition to provide safe, effective, high-

quality care to all who are involved in Leeds and York Partnership NHS Foundation Trust, the wider West Yorkshire ICB, and in support of national improvement projects.

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

No.

Recommendation

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

Meeting of the Board of Directors

Sept 2026

Director of Nursing and Professions Quarterly Report

This paper provides an update and overview of key programmes of work and progress within the Nursing and Professions Directorate, which centres around the continued ambition to provide safe, effective, high-quality care to all who are involved in Leeds and York Partnership NHS Foundation Trust, the wider West Yorkshire ICB, and in support of national improvement projects.

ASSURE

Band 5 Nursing Job Evaluation Review

In February 2026, the Secretary of State announced an employer led review of all Band 5 nursing roles as part of the Government's commitment to delivering a fairer deal for nurses. This builds on the NHS Staff Council agreement reached in June 2025, and the publication of national nursing and midwifery profiles.

All NHS organisations were required to submit a Band 5 Nursing Job Evaluation Delivery Plan to their NHS Region by 31 July 2026. The delivery plan supports regional and national assurance processes, sets out organisational milestones and the identification of implementation risks. Organisations are expected to complete all reviews and implement any resulting outcomes by October 2028.

The Trust has established robust governance arrangements to oversee this programme of work. A multidisciplinary Joint Working Group, co-chaired by the Deputy Director of Nursing and a Human Resources Business Partner, has been established and includes representation from Nursing and Professions, the People and Organisational Development Directorate, and Trade Union colleagues. The group is providing oversight of planning and implementation, and ensuring the progress against the national requirements is on track.

The Trust has submitted all baseline information mandated by NHS England. This included details of Band 5 nursing job descriptions currently in use, the date of their most recent review, and other relevant workforce information. To support the review process, a comprehensive exercise to verify the job descriptions currently applicable to nursing staff across the organisation is underway. This provides a clear baseline from which the review programme can proceed.

The next phase of the work will involve a structured gap analysis to assess the extent to which current job descriptions accurately reflect the duties, responsibilities, and requirements of contemporary nursing roles. Work will take place with nursing staff through established supervision arrangements or small-group engagement sessions, where preferred, to confirm the accuracy and relevance of existing job descriptions and identify any areas requiring amendment. This process will provide assurance that job

descriptions are current, consistent, and aligned to service requirements before formal evaluation activity commences.

Appropriate governance and project management arrangements are in place, all required baseline information has been submitted to NHS England, and the Trust remains on track to meet the national milestones associated with the Band 5 Nursing Job Evaluation Review programme.

Care Quality Commission (CQC) Update

During the reporting period, the CQC has now published their three Core Service Assessment Reports following their assessment in February and March 2026. They are:

- 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.
- Long stay or Rehabilitation Mental Health Wards for Working Age Adults - This service has maintained the requires improvement rating overall. Following the assessment the service was issued with a warning notice to ensure immediate improvements were made in specific areas.

The reports are available to read in full on the CQC's website and identify areas where improvements are required as well as examples of good practice and positive feedback from patients, carers and staff. We have requested the CQC review several findings, as we consider information provided during the inspection was not reflected in the published report. We have provided more evidence to support this in line with the usual review processes.

The CQC highlighted positive team cultures, strong multidisciplinary team working, evidence of learning from incidents and quality improvement activity and caring and compassionate staff.

Areas for improvement identified by the CQC included:

- Strengthening governance, oversight and assurance arrangements
- Improving compliance with mandatory training compliance, particularly fire safety
- Strengthening the quality and oversight of documentation including care planning and risk assessments
- Addressing environmental concerns relating to the estate, in particular on Ward 5, Newsam
- Physical health monitoring and documentation
- Effectiveness of audits and governance systems in identifying and addressing concerns

In response to the CQC assessment findings, the Trust has been focusing on improvement activity which has been overseen by the Trust's CQC Steering Group, with several actions already completed. Core services have developed local actions plans to address the areas for improvement and will be submitted to the CQC, providing assurance of the work that has been undertaken. Additionally, Trust wide actions have been commenced to address those Trust wide improvements identified by the CQC.

Improvement Activity following CQC Assessment

Leadership teams have taken prompt and proactive action to address the areas for improvement identified by the CQC. Targeted improvement plans have been developed across all assessed services, with progress subject to ongoing oversight through established governance arrangements.

Within **Older People's Services**, weekly audits of physical health observations and enhanced therapeutic observations have been introduced to strengthen assurance and oversight. Arrangements for the cleaning and maintenance of clinical equipment have been reinforced, and a recovery plan has been implemented to improve compliance with mandatory training requirements, supported by additional targeted training sessions.

Within **Acute Services**, processes for monitoring both the completion and quality of care plans have been strengthened to ensure greater consistency and oversight. Immediate action was taken to address the environmental risks identified during the assessment, including the installation of observation mirrors and modifications to identified doors. Expectations relating to infection prevention and control standards have been reaffirmed with clinical teams, and quality assurance processes for physical health assessments and monitoring have been enhanced to provide greater confidence in the delivery of safe and effective care.

Within **Rehabilitation Services**, immediate remedial works were undertaken to address environmental concerns identified by the CQC, including repairs to sinks, toilets and light fittings. Governance arrangements relating to estates management and safeguarding have been strengthened, and compliance with mandatory fire safety training has improved significantly.

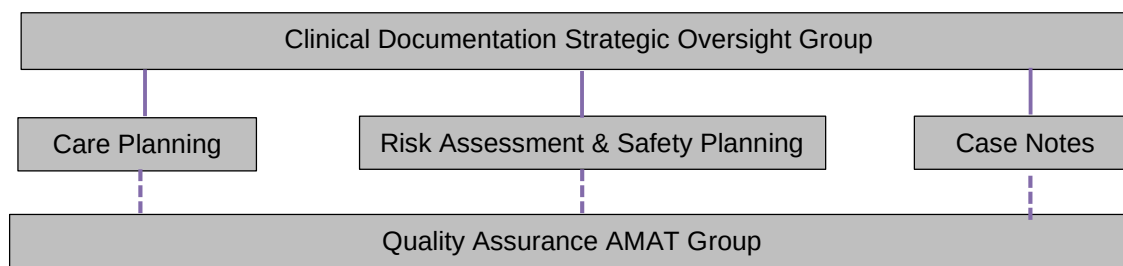
On 29 July 2026 at a Rapid Quality Review Meeting attended by representatives from the Integrated Care Board (ICB) and NHS England. The Trust provided assurance regarding the actions taken within Rehabilitation Services in response to the CQC assessment, outlining the progress made against the identified improvement actions and the arrangements in place to sustain these improvements.

To ensure wider learning from the CQC assessment is implemented across the organisation, Trust wide actions are underway to improve the quality of documentation, care planning and risk assessments with the establishment of a Clinical Documentation Strategic Oversight Group. Additionally, the Trust is standardising its quality checks and assurance mechanisms to ensure consistency across services and to strengthen oversight.

Improving the Quality and Consistency of Care Planning, Risk Assessment and Clinical Documentation

A learning event was held through the Unified Clinical Governance Group in May 2026 to review organisational intelligence relating to the quality of care planning and clinical documentation. This included learning from patient safety incidents, CQC feedback, a baseline case note review, and a systems based analysis of identified gaps and barriers.

Following the event, it was agreed that focused working groups would be established to drive improvement in these areas. The following structure was agreed:



The Trust has a well-established Risk Assessment and Safety Planning Project Group, which successfully led the move away from stratified risk assessment in line with national guidance. The group developed and implemented the Risk Assessment and Management Plan (RAMP) across the Trust and is now focused on strengthening and embedding a consistent approach to safety planning.

In addition, two new working groups have been established, focusing on care planning and case note quality. Both groups have held their initial meetings and seek to ensure there is good multidisciplinary representation and a range of services present.

The purpose of these groups is to define clear standards and expectations, identify tools, resources and learning opportunities to support frontline staff, and promote best practice in care planning and documentation. As well as identifying what works well, they will also explore barriers to producing high quality clinical records and implement targeted improvements. This work includes consideration of digital innovation and the potential safe and effective use of AI to support clinical practice.

These groups will work closely with the Audit Management and Tracking (AMAT) workstream, which is developing the quality assurance module within the system. This collaboration will help ensure that robust processes are in place to provide ongoing oversight, assurance and monitoring of documentation quality across clinical services.

Each working group will report into the Clinical Documentation Strategic Oversight Group, chaired by the Deputy Director for Psychological Professions, which is due to commence in September 2026.

Enhanced Therapeutic Observations and Care (ETOC) Programme Update

Significant progress continues to be made in embedding Enhanced Therapeutic Observations and Care (ETOC) programme across LYPFT, supported by strong multidisciplinary leadership and robust governance arrangements.

Key achievements include the development of improved data collection and reporting processes, strengthening the Trust's ability to monitor observation activity, workforce deployment and associated outcomes. ETOC data is now routinely collected through Health Roster, Datix and Care Director systems, alongside quarterly submissions to NHS England. The Trust has consistently achieved a Green RAG rating for these submissions, providing assurance regarding data quality and compliance.

The Trust continues to make a significant contribution to the national ETOC agenda. Work undertaken on our Psychiatric Intensive Care Unit (PICU), has been recognised through the publication of a national paper highlighting the role of Occupational Therapy within ETOC delivery. The work demonstrated the benefits of adopting a multidisciplinary approach to therapeutic observations, with reported improvements in collaborative working, patient engagement and overall care experience.

Building on this success, a further research paper is currently being developed following the collection and analysis of service user feedback. In parallel, the Trust is supporting Occupational Therapy student placements, linked to the ETOC programme in partnership with the Practice Learning Team, helping to develop future workforce capability, embed therapeutic approaches to observation practice and reiterate the value of the skills and competency required to deliver ETOC.

A pilot across inpatient services is currently testing enhanced monitoring of observation hours delivered by substantive and bank staff. This work is supporting improvements in data accuracy, governance and future service planning, with findings informing the next phase of implementation.

Improving service user and staff experience remains a central focus. Feedback gathered through Peer Support Workers and multidisciplinary teams is informing ongoing reviews of ETOC training, policy and practice to ensure observations are therapeutic, person centred and recovery focused. Collaboration with the Culture of Care Programme, Prevention and Management of Violence and Aggression (PMVA) Leads and the Critical Incident Staff Support Pathway (CRISSP) Team has further strengthened consideration of both patient experience and staff wellbeing, including risks associated with prolonged observation duties.

Violence Prevention and Reduction (VPR) Standard - Progress Update

The Trust has completed benchmarking against NHS England's revised Violence Prevention and Reduction (VPR) Standards (Version 2, December 2024) and established a comprehensive improvement programme to strengthen violence prevention, staff safety and organisational learning. A dedicated Violence Prevention and Reduction Steering Group now provides strategic oversight, with reporting through Trust governance structures to ensure alignment with priorities relating to staff wellbeing, patient safety and quality improvement.

The review identified strengths in leadership, governance, staff engagement and training, alongside opportunities to strengthen data quality, assurance, organisational learning and evaluation. In response, the Trust has developed a joint approach with Leeds Community Healthcare (LCH), including plans for a shared strategy, aligned policies and a common improvement framework.

Key developments include:

- Enhanced governance and reporting arrangements through the VPR Steering Group.

- Development of improved Datix (Trust incident reporting system) and ECHO (intelligence and insight portal) reporting to strengthen oversight of violence and aggression trends, organisational learning and quality improvement opportunities.
- Establishment of a staff engagement workstream, including staff surveys, listening events and improved access to support following incidents.
- Joint work with Leeds Community Healthcare to strengthen health, safety and security arrangements, including environmental risk assessments, security reviews and personal safety initiatives.
- Introduction of a formal review process for serious staff related incidents, enabling greater organisational learning, assurance and sharing of good practice.

A comprehensive VPR Improvement Plan will be implemented by October 2026, with progress monitored through measures relating to incidents of violence and aggression, staff and patient experience, training compliance, post-incident support and evidence of service improvements.

Work has also commenced on a joint review of the Trust's Violence Prevention and Reduction Strategy and Policy ahead of renewal in 2027. This will support the development of a consistent, integrated approach across both organisations and ensure continued alignment with national VPR standards.

Reinstatement of Payments to Lived Experience Partners

Following legal advice, received payments to lived experience partners were paused to enable the development of a process to ensure they received the appropriate level of employment rights. Significant work has been progressed to develop and implement a solution that enables lived experience partners participating in Level C involvement opportunities to be paid as 'workers'. Level C activities are those where the lived experience partner is actively involved in decision making and co-production. Level C opportunities recommenced on 27 July 2026, supported by a robust communications plan to ensure that all staff members and lived experience partners have been made aware of the changes and associated payment arrangements. The new payment process will be trialled for a 6 month period at which point it will be reviewed and any recommended improvements made.

Growth in Supporting Clinical Psychology Doctorate Trainees and Associated Tariff Income

During 2025-26, Leeds and York Partnership NHS Foundation Trust hosted 33 Clinical Psychology Doctorate Trainees, an increase from 29 the previous year. The Trust continued to provide a diverse range of placements across community, inpatient and specialist services, responding successfully to increasing placement demand while maintaining high quality learning opportunities. As a result, associated income from NHS England to support clinical psychology placement co-ordination and practice learning activity (Tariff) increased to £99,000 per annum.

Leeds and York Partnership NHS Foundation Trust also hosted 7x Year in Industry Interns, providing valuable experience across a range of psychological services and clinical settings. Feedback from Interns was highly positive, with learners reporting increased confidence, enhanced understanding of psychological professions and greater insight into NHS careers. For 2026-27, placement capacity has

increased to 8 internship opportunities.

Despite ongoing financial pressures and increasing demand for placements, Leeds and York Partnership NHS Foundation Trust remains committed to developing the future psychological professions workforce through high quality learning experiences, strong university partnerships and continued expansion of placement opportunities.

Evaluation of Equality and Diversity Across Assistant Psychologist Recruitment

An evaluation of equality and diversity across Assistant Psychologist recruitment found no clear evidence of systemic bias is observed at a descriptive level of recruitment. Overall, recruitment is highly competitive, with most applicants exiting at the shortlisting stage. Outcomes are broadly equitable across demographic groups, with no clear systemic bias identified. However, variability between smaller groups and reliance on shortlisting decisions highlight the importance of ongoing monitoring and review.

Successful Assistant Psychologist applicants reflect a reasonably diverse cross-section of the overall applicant pool, particularly in relation to ethnicity, though representation varies across demographic characteristics:

- **Gender:**
Successful candidates are predominantly female, mirroring the wider applicant pool, with no meaningful difference in selection rates between genders. This suggests outcomes are equitable despite gender imbalance in applications.
- **Ethnicity:**
Successful applicants come from a range of ethnic backgrounds, indicating diversity in outcomes as well as applications. While selection rates vary between groups, there is no consistent evidence that any single ethnic group is systematically advantaged or disadvantaged. Some variation appears linked to small subgroup sizes rather than structural inequality.
- **Disability:**
Most successful applicants report no disability, reflecting application patterns. However, selection rates for disabled and non-disabled applicants are broadly comparable, suggesting no clear disparity in outcomes based on disability status.
- **Sexual Orientation:**
Successful applicants include individuals from a range of sexual orientation groups. As with other characteristics, selection rates are broadly similar, although interpretation is limited by smaller numbers in some categories and non-disclosure.

Psychological Professions Titles Compliance Assurance

Following the issue of a draft for “Guidance on NHS requirements for use of Psychological Professions titles”, in March 2026, the Board can be assured the workforce is compliant. Leeds Community Healthcare Trust, alongside Leeds and York Partnership NHS Foundation Trust responsible professionals, Clinical and Operational Leads have been sighted on the requirements. The dissemination of these requirements and processes for service level checks has been completed, with the appropriate structures already being embedded within Leeds and York Partnership NHS Foundation Trust. The draft has been approved with no subsequent changes. These guidelines were accompanied

by a new “Supervision and CPD requirements for the Psychological Professions” document issued by Psychological Professions Network and was disseminated at the same time, as a parallel requirement.

ADVISE

White Ribbon Campaign: World Cup Awareness Activity

The Safeguarding Team used the increased public attention associated with the World Cup to raise awareness of domestic abuse and reinforce the Trust's commitment to the White Ribbon Campaign and the prevention of violence against women and girls. Evidence highlights a significant increase in domestic abuse reporting during major football tournaments. Safeguarding staff undertook engagement visits across clinical areas, encouraging staff to sign the White Ribbon Promise and participate in discussions regarding the recognition, impact and prevention of domestic abuse.

Staff engagement was positive and demonstrated a strong willingness to develop their understanding of safeguarding responsibilities and the role they can play in challenging violence against women and girls. The campaign provided an effective opportunity to increase awareness, promote professional curiosity and strengthen safeguarding culture across the organisation.

SEND Inspection

The Leeds Area SEND Inspection identified significant and systemic weaknesses across the Leeds Local Area Partnership, comprising Leeds City Council and West Yorkshire Integrated Care Board (ICB). Whilst inspectors recognised examples of strong frontline practice and committed staff across health, education, and social care services, they concluded that system leadership, governance arrangements, Education, Health and Care Plan (EHCP) processes, neurodevelopmental pathways, and transition arrangements have not developed sufficiently to meet increasing levels of demand.

As a consequence, the local area has been directed to produce a Priority Action Plan and will be subject to a monitoring inspection within approximately 18 months, followed by a full reinspection within approximately three years.

For Leeds and York Partnership NHS Foundation Trust, the inspection findings are particularly relevant to services involved in mental health, neurodevelopmental assessment and support, learning disability provision, therapy services, and transition pathways between children's and adult services.

The most significant implications for the Trust relate to:

- The quality and timeliness of health contributions to EHCPs.
- Neurodevelopmental assessment waiting times.
- Transition arrangements for young people moving into adult services.
- Multi-agency governance, data sharing, performance oversight and assurance.
- Strengthening the Trust's contribution to the wider SEND improvement programme.

Preceptorship and Graduate Recruitment

The Trust continues to strengthen its nursing workforce through a combination of internal career development opportunities and external recruitment pathways.

Nine colleagues are currently being supported through the Registered Nurse Degree Apprenticeship and Transfer to Nursing programmes. Subject to successful completion of their studies and professional registration requirements, all are expected to progress into Registered Nurse roles within the Trust by the end of the year.

In addition, 57 nursing students from the three Leeds Universities are anticipated to qualify between September 2026 and January 2027. Recruitment has been undertaken through a competitive interview process, supported by the Practice Learning and Development Team (PLDT). Support has included university based interview preparation sessions, mock interviews, and coaching conversations with Legacy Mentors to help students prepare for employment.

To date, 22 candidates have successfully completed the interview process and accepted offers of employment, with a further 6 candidates awaiting interview. Subject to successful completion of the recruitment process, a total of 28 newly qualified nurses are expected to join the Trust during the autumn and winter period.

Start dates are yet to be confirmed as students continue to complete their academic programmes and fulfil the requirements for professional registration. If all appointments progress as planned, the Trust can expect up to 37 new Registered Nurses to join the workforce through apprenticeship, transfer and graduate recruitment routes during 2026/27.

Seasonal Flu Vaccination Campaign 2026/27

The Infection Prevention and Control (IPC) Team is currently developing the 2026/27 Seasonal Flu Vaccination Campaign. The national campaign commences on 1 October 2026, with eligible cohorts able to receive vaccination from September onwards. All Trust staff will be eligible to receive the seasonal flu vaccine. Service users will be offered the seasonal flu vaccine where appropriate, while COVID-19 vaccination will be available only to those who meet the Joint Committee on Vaccination and Immunisation (JCVI) eligibility criteria.

The Trust has set an ambitious target of achieving 60-65% flu vaccine uptake amongst frontline Healthcare Workers. This represents a significant increase from the Trust's 2025/26 uptake rate of 38% and reflects the importance of workforce vaccination following the early circulation of influenza observed during the previous winter season. A particular focus this year will be on encouraging staff to be vaccinated as early as possible to maximise protection ahead of peak seasonal demand.

For NHS Trusts and Foundation Trusts, the 2026/27 NHS Oversight Framework (NOF) includes a workforce vaccination measure focused on frontline Healthcare Worker flu vaccine uptake. This metric is intended to assess how effectively organisations protect patients and staff from seasonal influenza and reduce winter pressures. The measure is used as an indicator of:

- Patient safety
- Infection prevention and control
- Workforce resilience
- Organisational leadership and culture in relation to vaccination uptake

Work is currently underway to understand the detailed methodology that will be used to assess and score organisations. While the Trust will be benchmarked against peer organisations, the final technical guidance is yet to be formally published. Based on the latest available information, there is no nationally prescribed uptake target. Instead, organisations will be scored relative to each other, with all organisations assigned a score between 1.00 and 4.00 according to their ranked uptake performance. Scores are allocated based on absolute vaccination uptake percentages, with higher-performing organisations receiving higher scores.

Given the scale of improvement required to achieve the Trust's aspirational target, a revised approach to the vaccination campaign is being implemented. The campaign will be led by the Director of Nursing, supported by a team of senior leaders who will work alongside the Trust's peer-to-peer vaccinators. This leadership-led approach aims to increase visibility of the campaign and reinforce the importance of vaccination in supporting patient safety, workforce wellbeing and organisational resilience.

The increased accessibility to flu vaccination introduced in previous years will be maintained. Workforce drop-in clinics will commence from 1 October 2026, enhanced by outreach activity across both inpatient and community settings.

From October onwards, the Director of Nursing and senior colleagues will undertake regular walkarounds across Inpatient Services and Community sites, working alongside the Trust's 66 peer-to-peer vaccinators. These vaccinators will play a key role in delivering and promoting the vaccination programme, ensuring staff across inpatient and community services have convenient access to vaccination and information about its benefits.

Trauma Informed Care and Practice

To strengthen the Trust's delivery of person centred, compassionate care, there is a recognised need to establish a Trust wide Trauma Informed Care and Practice Strategy with a supporting framework.

The first phase will involve a comprehensive review of current provision to identify existing trauma informed initiatives, areas of good practice, and opportunities for further development across the organisation. This scoping exercise will also include engagement with NHS partners, Voluntary, Community and Social Enterprise (VCSE) organisations, alongside people with lived experience to understand best practice and inform the Trust's approach and allow for co-production.

Following the completion of the scoping phase, a multidisciplinary Task and Finish Group will be established to co-produce the strategy and framework. The group will develop a clear implementation plan, identifying priorities, responsibilities, workforce development requirements, and measures of success.

The strategy and framework will progress through the Trust's governance processes for review, scrutiny

and approval. Once approved, a phased implementation programme will support embedding trauma informed principles across services, supported by ongoing monitoring, evaluation and assurance arrangements. This will ensure the approach remains effective, sustainable, and aligned with organisational priorities.

ALERT

Learning From the Southport Inquiry

In response to safeguarding learning emerging from the Southport Inquiry, the Leeds and York Partnership NHS Foundation Trust Safeguarding Team has developed a new e-learning package to strengthen staff knowledge and confidence in recognising, assessing, and responding to emerging risks. The package focuses on the early identification of vulnerability and risk, effective information sharing, professional curiosity and challenge, multi-agency working, and the application of Prevent and MAPPA processes where appropriate. A key element of the training is to reinforce the learning that individuals may present a significant risk of serious harm in the absence of a clear ideological motivation. The package highlights the importance of recognising concerning behaviours associated with fixation, grievance, obsessional interests, violence risk, online influences, and other indicators of vulnerability, ensuring staff understand that a Prevent referral or wider multi-agency risk management response may be appropriate even where no specific extremist ideology has been identified.

The learning resource has been developed internally by the Safeguarding Team and will be assigned to staff undertaking Level 2 and Level 3 safeguarding training. This will support a consistent Trust wide approach to the identification, escalation, and management of safeguarding concerns, promoting earlier intervention and more effective partnership working to reduce the risk of harm.

ReSPECT

The use of ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) continues at the Mount and the Learning Disability Services are preparing teams to start its use. There is a further delay to the introduction of read/write access to ReSPECT on Leeds Care Record and the earliest this will now be available is November. Consequently, further roll out be paused until access is available, due to the known risk accessing an individual's current ReSPECT form. This is mitigated at the Mount by support from Leeds Teaching Hospital Trust Geriatricians. Learning Disabilities Services will not commence use until access is available to them, but they will prepare teams and service users and carers in the meantime for its future use.

Nichola Sanderson
Director of Nursing & Professions
Sept 2026

Meeting of the Board of Directors

Paper title:	Annual Safe Staffing Review Paper Safer Staffing Annual Establishment Review
Date of meeting:	September 2026
Presented by: (name and title)	Nichola Sanderson, Director of Nursing & Professions
Prepared by: (name and title)	Alison Quarry, Deputy Director of Nursing Miriam Blackburn, Head of Nursing Jennifer Connelly, Professional Lead Nurse Adele Sowden, E-Rostering Team Manager

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

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	✓
SR6	Digital technologies	
SR7	Demand for services	
SR8	Health inequalities	
SR9	System change	

Executive summary

The purpose of the Safer Staffing Annual report is to inform the Trust Board and the public of the latest position in relation to staffing in LYPFT inpatient wards and the wider workforce plan to provide assurance that the standards required to deliver safe and effective care are being met. The report draws on the above requirements and contains a high-level overview of data and analysis providing the Board with information on the position of all staffing on wards against safer staffing levels for the 12-month period of the 1st of May

2025 – 30th April 2026.

The Annual Safer Staffing Establishment Review was conducted across all 28 inpatient wards at LYPFT, in line with National Quality Board (NQB) guidance. The review aimed to assess whether current staffing levels are sufficient to deliver safe and effective care, using a triangulated approach: combining data from the Mental Health Optimal Staffing Tool (MHOST), quality indicators, and professional judgement.

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.

No

Recommendation

The Board is asked to:

- Note the findings of the 2026 Annual Safe Staffing Review Paper and Safer Staffing Establishment Review.
- Be assured that arrangements are in place to monitor, support and mitigate any impact of reduced staffing levels or skill mix in relation to patient safety.
- Agree the recommended establishment changes and associated funding arrangements.
- Agree the position to be reported to the Board of Directors.
- Note that annual reviews and six-month assurance reviews will continue in line with National Quality Board standards.

Meeting of the Board of Directors

24 September 2026

Annual Safe Staffing Review Paper

(Data period 1st May 2025 – 30th April 2026)

1 Executive summary

This annual safer staffing report provides assurance on the staffing position across Leeds and York Partnership NHS Foundation Trust's 28 mental health and learning disability inpatient wards during the period 1 May 2025 to 30 April 2026. The report reviews workforce capacity, staffing compliance, recruitment and retention activity, temporary staffing usage, workforce wellbeing, and quality indicators to assess whether safe and effective care continues to be delivered.

Overall, the Trust has maintained arrangements to support safe staffing despite ongoing workforce challenges. During the reporting period seven shifts occurred without a Registered Nurse physically present on the ward, all of which were managed through established escalation processes and reviewed through governance arrangements.

Significant progress has been made in reducing Registered Nurse vacancies, with vacancy rates improving to 10% for Band 5 nurses and 11% for Band 6 nurses by April 2026. Recruitment of Allied Health Professionals also remains strong. However, Healthcare Support Worker vacancies continue to present a significant challenge, increasing to almost 22% by the end of the reporting period. In response, a dedicated Healthcare Support Worker Recruitment and Retention Programme has been established to improve recruitment, retention, induction, career development and workforce redesign.

The Trust continues to rely on temporary staffing to support service delivery, although progress has been made in reducing agency usage, particularly amongst Registered Nurses and Healthcare Support Workers. Bank staffing remains a critical component of workforce resilience, while redeployment processes continue to be used to safely manage staffing pressures across inpatient services

Workforce wellbeing remains a priority. Sickness absence remained above the Trust target throughout the year, although a range of support initiatives, including the Critical Incident Staff Support Pathway (CriSSP), wellbeing interventions and professional support programmes, continue to provide assistance to staff and teams.

Quality indicators demonstrate a mixed picture. There has been a reduction in incidents of violence and aggression, while falls have increased and remain a key area of focus. Compliance with compulsory training remained above target and appraisal performance remained consistently high. Patient feedback continues to be positive, with 69% of respondents rating their care as good or very good. Several quality improvement programmes, including Enhanced Therapeutic Observation and Care (ETOC) and Culture of Care, are supporting improvements in patient experience, workforce deployment and care quality.

The Board of Directors are asked to be assured that there are appropriate systems and controls are in place to monitor staffing levels, manage workforce risks and maintain patient safety. While notable progress has been made in Registered Nurse recruitment and reducing agency reliance, continued focus is required to address Healthcare Support Worker vacancies and sustain a resilient workforce capable of meeting future service demand. The Trust Board of Directors is asked to note the report and be assured that effective arrangements are in place to monitor, mitigate and respond to staffing risks across inpatient services.

2 Introduction

Leeds and York Partnership NHS Foundation Trust (LYPFT) provides inpatient care across 28 Mental Health and Learning Disability Wards. Ensuring that NHS organisations have the right staff, with the right skills in place, has been a key Trust Board requirement since the NHS National Quality Board (NQB) issued guidance in 2016.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18, ensures that providers deploy enough suitably qualified, competent, and experienced staff to enable them to meet all regulatory requirements described in this part of the act. This identifies that staff must receive the support, training, professional development, supervision, and appraisals necessary for them to carry out their role and responsibilities.

The purpose of this report is to inform the Trust Board and the public of the latest position in relation to staffing in LYPFT inpatient wards and the wider workforce plan to provide assurance that the standards required to deliver safe and effective care are being met.

The report draws on the above requirements and contains a high-level overview of data and analysis providing the Board with information on the position of all staffing on wards against safer staffing levels for the 12 month period of the 1st May 2025 – 30th April 2026.

The flow chart below supports providers of NHS services with the delivery of the right staff, with the right skills, in the right place at the right time (National Quality Board 2016) and has been used to provide a framework for the illustration of safer staffing:

Triangulated approach to staffing decisions



3 The Mental Health Optimal Staffing Tool (MHOST)

The Mental Health Optimal Staffing Tool (MHOST) was developed with the support of Health Education England in response to the absence of a published, evidence-based workforce tool suitable for use in mental health hospitals. It has been created in collaboration with clinical leaders and workforce professionals across Mental Health Trusts and has undergone rigorous testing and validation. The tool is free of charge to all NHS Trusts in England and LYPFT started to test its use in 2019 when we became licensed to use it.

The MHOST outlines how changes in a patient's clinical condition may influence the number of nursing staff needed to deliver appropriate care. It uses a set of care level indicators on a scale of 1-5 which measure the dependency/acuity of patients in different settings (see appendix 1). These are routinely being used by Ward Leads at LYPFT to record patient acuity and dependency.

Once the data has been recorded, the toolkit incorporates the skill mix (derived from the budgeted establishment) and the financial headroom (22%) applicable to the ward and then issues a recommended Nursing and Healthcare Support Worker staffing level per ward measured as Care Hours Per Patient Day (CHPPD) and Full-Time Equivalents (FTE).

Training on the use of MHOST was delivered by NHSE (NHS England) with leaders from across 26 of our inpatient wards (the tool does not support the use in Learning Disabilities Inpatients) who have met the required competency level for the use of the tool and in turn ensuring its validity and reliability.

All attendees of the training carried out an inter-rater reliability assessment to provide assurance that the required standard had been met to appropriately assess the levels of care required by patients as defined by the tool.

Following the training delivered by NHSE, additional in-house training has taken place to meet capacity needs. This has been necessary due to changes in ward leadership over time. In house training has allowed teams to ensure that there are adequate numbers of staff trained in data collection for the MHOST.

MHOST data collection is collected in March and September each year as two data collection periods are required to inform establishment reviews within services. Application of this evidence based tool provides some quality assurance to this process. This data cannot be used in isolation and should always be triangulated with professional judgement and quality indicators.

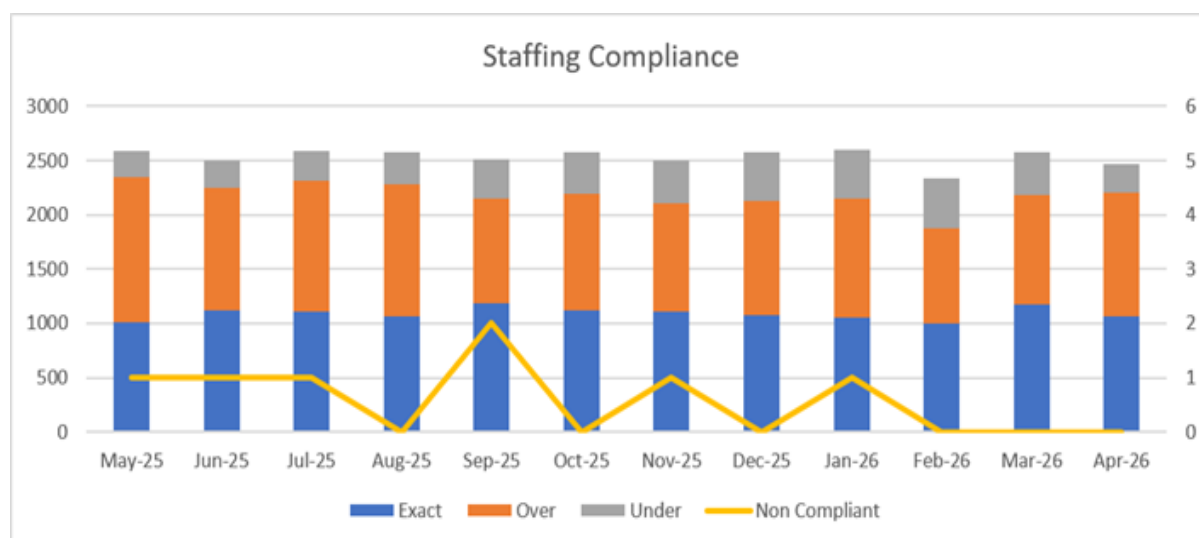
Establishment Reviews

An assessment of the current workforce establishment based on acuity and dependency and informed by an evidence based tool (MHOST) must be reported to the Trust Board and reviewed annually, in accordance with the NQB (2016) and NHS Improvements Developing Workforce Safeguards (2018).

Establishment reviews were conducted across all 28 wards in LYPFT between February and May 2026, and a report setting out recommendations based on these findings is due to be finalised and presented to the Board of Directors.

A new Safe Staffing Policy is currently being developed to support the establishment review process and wider safer staffing agenda within the Trust. The policy will also consolidate outcomes from a range of previous workstreams aimed at improving the quality and efficiency of staffing on our wards, including effective escalation for staffing increases, and the cultural shift required from services to facilitate safe, high-quality staffing through effective use of the Multidisciplinary Team (MDT).

4 Review of Staffing Activity from 1 May 2025 – 30 April 2026 – 28 Mental Health and Learning Disability Wards



The staffing compliance data above tells us whether the wards met the planned numbers of staffing during a shift. However, the planned staffing numbers do not necessarily reflect the staffing need on any given duty as this may fluctuate dependent upon the current patient group. Planned numbers are based on the

whole-time equivalent (WTE) number of staffing posts (establishment) the inpatient wards are funded to deliver care and treatment.

During this period, a total of 30,413 shifts were required to ensure safer staffing in inpatient areas. This was a 70 shift increase from the previous 12 months.

- 26177 of the required shifts met/exceeded planned staffing numbers. A decrease of 996 on the previous 12 month reporting period.
- 4229 of the required shifts did not meet planned staffing numbers. The previous 12 month reporting period had a rate of 3169.
- 7 of the shifts did not have a Registered Nurse on duty. The previous 12 month reporting period had a compliance rate of 1.

The data demonstrates that there was a decrease in the number of shifts that met or exceeded the planned staffing numbers and an increase in the number of shifts that did not meet the planned staffing numbers. In some cases, there may be shifts where they did not meet the planned staffing for that duty and this will not have impacted on care provided or workload for staff members, for example if there were a sizeable proportion of the service users on leave. Also, the implementation of the staffing escalation protocol, supports consideration of how wider members of the MDT support patient care in the event of Nursing and Health Support Worker shifts being below the planned hours, this supports maintaining high quality care whilst not requesting additional Nurses or Health Support Workers to cover vacant shifts.

The number of shifts that did not have a Nurse on duty increased over the reporting period and this is covered in more detail in section 5 of this paper.

Fill Rate Monthly Indicator (Unify) Data

The fill rate monthly indicator data is a further data set to consider alongside measures of quality and safety. The monthly returns which are illustrated in Appendix 2 demonstrate the average % fill rate of Registered Nurses and unregistered staff for both day shift and night shifts against the planned establishment.

It is of note that by itself this data does not reflect the total amount of care provided on a ward nor does it demonstrate whether care is safe and effective. The data does not include roles which work across more than one ward and roles that sit outside of a rota such as Ward Managers, Practice Development, and the wider MDT. It does include both substantive and temporary staff. It should therefore be considered alongside other quality and safety metrics.

Where Registered Nurse fill rate falls below 100% which can be accounted for through vacancies, sickness and other leave, an adjustment to the skill mix is frequently made by the backfilling of Registered Nurse duties with Health Support Workers. This can be seen in the fill rate data whereby the unregistered duties reflect above 100% fill rate accounting for the deficit in Registered Nurses.

During the data period several of the inpatient services can be seen to far exceed the unregistered fill rate and therefore exceed the planned establishment. This occurs when additional duties have been filled due to increased activity in the clinical area.

Observation and engagement of our service users is one of the key clinical interventions in our inpatient services and is utilised to maintain safety and support recovery. Enhanced observations may require additional staffing above the planned establishment, for example, a service user may require 1 or 2 staff to remain with the service user to support their care and treatment plan. Enhanced observations account for a large proportion of the additional duties and may also include interventions such as physical care needs, falls prevention, escorts and facilitating leave.

The Trust is engaged in the Enhanced Therapeutic Observation and Care Programme (ETOC). The aim of the NHS ETOC programme is to strengthen MDT involvement and improve the quality of therapeutic observations, and on the ward, this is supported by using the MDT to bring together different professional perspectives to understand risks, patterns, and engagement. This shared approach reduces the need for additional staffing by distributing observation responsibilities and decision making across the team, while also improving the consistency and quality of observations, communication, and care planning.

5 Exception Reports – No Registered Nurse on Duty

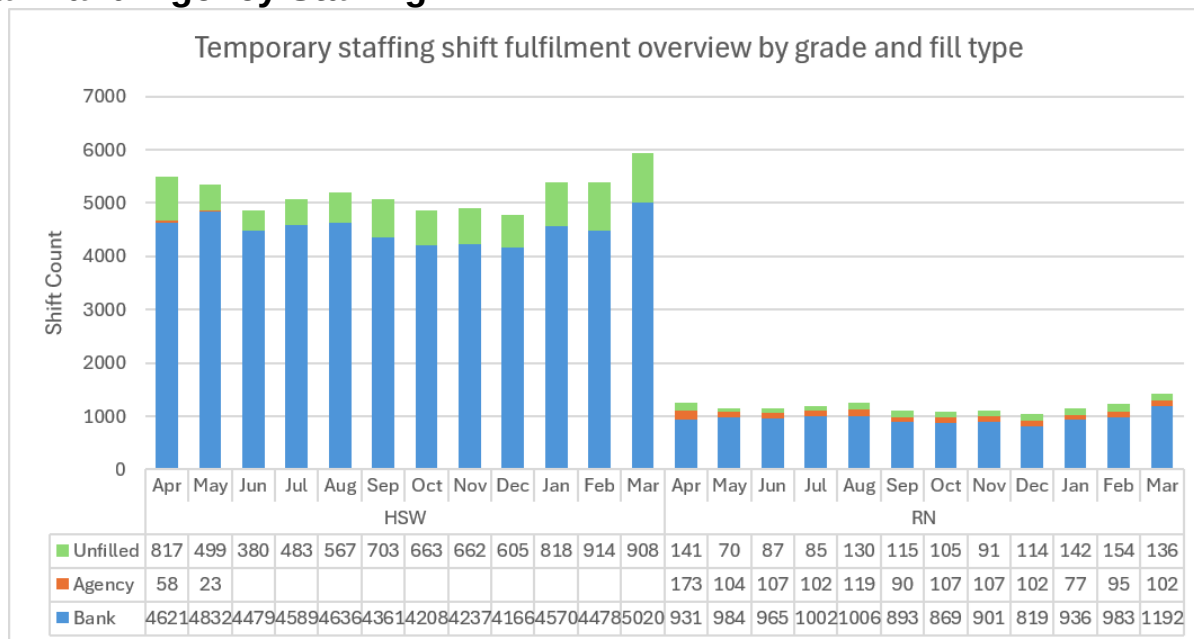
The Health and Social Care Act 2008 ensures that providers deploy enough suitably qualified, competent, and experienced staff to enable them to meet all regulatory requirements described in this part of the act. To meet the potential care and treatment needs within any of the LYPFT Inpatient Wards, we aim to maintain at least one Registered Nurse on duty who can take charge and carry out duties under the Mental Health Act. Where unexpected absences occur such as sickness absence and in turn the local minimum standards would not be achieved, the Safe Staffing Escalation Procedure is enacted. This allows for several actions to be carried out such as the use of temporary staffing, overtime, and deployment from other inpatient wards.

During the reporting period, the requirement for one Registered Nurse on duty on each shift was not met on seven occasions.

On five occasions, there was no Registered Nurse on 2 or 3 Woodland Square. On each occasion, a Nurse Associate was able to act as Shift Coordinator and administer medication which falls within their scope of practice with oversight from a Registered Nurse working on the other ward at Woodland Square. The specialist nature of this service proves challenging to identify unplanned cover or deploy a Registered Nurse from other areas of the Trust with the appropriate skills and competencies. Nursing Associates, who were on duty, administered medication which is within scope of their practice and co-ordinated the shift with support provided by the Registered Nurse from the neighbouring ward within the service.

A further two instances occurred, one at Red Kite View PICU and one on Ward 2 Newsam Centre, Womens Service Leeds Forensics. This was due to unexpected sickness. On Red Kite View, a Nursing Associate was supported by a Nurse from the adjoining ward after the Registered Nurse from PICU needed to leave at 10pm. At the Newsam Centre, a Nurse from an adjoining ward administered medication and supported the duty. In these instances learning was escalated to the Safer Staffing Steering Group for consideration.

6 Bank and Agency Staffing



The above chart looks at the period of 1 April 2025 - 31 March 2026, slightly different to the reporting period of 1 May 2025 – 30 April 2026.

The above chart demonstrates the significant contribution Bank and Agency temporary staffing make to care delivery to mitigate unavailability and additional duties above planned establishment where demand has fluctuated. The graph above, counts the actual number of shifts worked by headcount, which is different from the staffing compliance chart and shows the number of shifts that had the right number of staff. This graph also shows the number of shifts requested that were not filled.

A combined total of 78,433 shifts were requested during this period.

- 14,136 Registered Nurse shifts were requested. These were filled by Bank Registered Nurses (81.2%, 11,481) and Agency Registered Nurses (9.1%, 1285).
- 9.7% (1370) of shifts requested for Registered Nurses remained unfilled. This has reduced since previous reporting periods.
- 64,297 Health Support Worker shifts were requested. These were filled by Bank Health Support Workers (87.4%, 56,197) and Agency Health Support Workers (0.1%, 81). After May 2025, there have been no shifts worked by Agency Health Support Workers.
- 12.5% (8,019) of shifts requested for Health Support Workers remained unfilled. A small increase on the previous reporting period.

During the reporting period, the overall fill rate for requested shifts was 88%. There was an increase in unfilled Health Support Worker duties since the previous reporting period but a decrease in unfilled duties for Registered Nurses. This may be due to a range of reasons including seasonal variation as this report

incorporates a full year's data and previous reports covered 6 month periods, a reduction in Registered Nurse vacancies and an increase in Health Support Worker vacancies.

There has been a significant change in the number of shifts covered by Agency Health Support Workers due to the Trust no longer supporting the use of agencies for these shifts. The percentage of Agency Registered Nurses also reduced from 36.2% of requested shifts being filled in the previous reporting period to 9.1% for this past 12 month period.

Good workforce planning includes access to a temporary workforce to manage vacancies and other unavailability and to have nursing staff available to be responsive to service user's needs. This enables flex in staffing capacity as demand fluctuates. The high number of vacant shifts which have been reliant on bank and agency to fill has exceeded this resource for both registered and unregistered staff as demonstrated above. This has been impacted by the high number of Health Support Worker vacancies, and that Health Support Worker shifts are often used to backfill Registered Nurse vacancies or sickness. When the proportion of temporary staff becomes too great, this can potentially impact on the quality of care provided as temporary staff are less likely to know the service and service users well, and therefore less able to effectively meet the needs of service users.

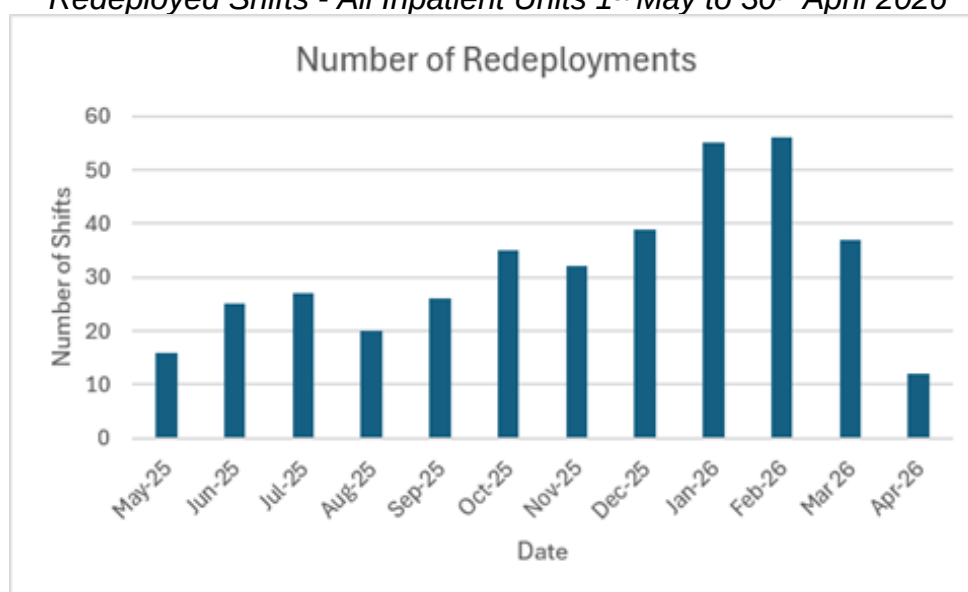
To mitigate the potential impact on the quality of care, a number of these shifts have been carried out by substantive staff working additional duties or bank staff/agency staff who work regularly in a preferred clinical area and therefore are familiar with both the patient group and service. In turn, this offers continuity of care and any potential negative impact on the quality of care provided.

5.1 The Responsive Workforce Team

The Responsive Workforce team has been gradually transitioned into substantive roles over the past few years, with just one member remaining who is currently being prepared for a substantive post.

5.2 Deployment of Staffing

Redeployed Shifts - All Inpatient Units 1st May to 30th April 2026

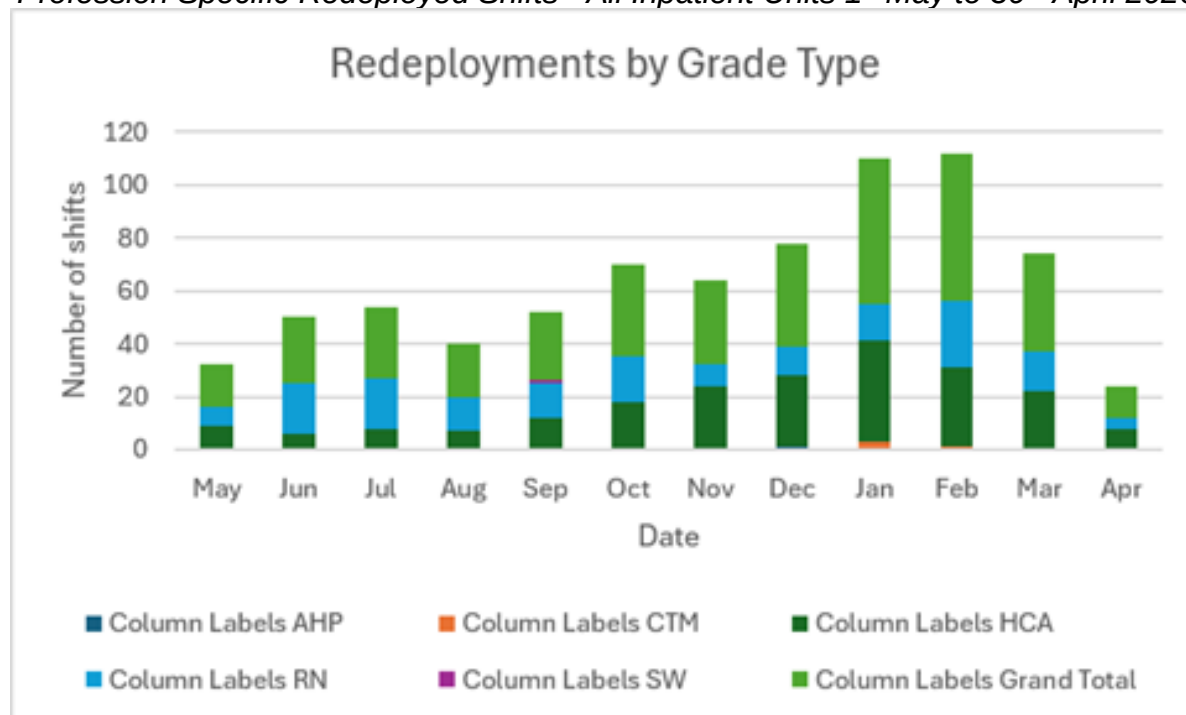


The above graph illustrates a total of 380 redeployments of staff who were required to be deployed from their home ward to other clinical areas across the 12 month data period to support the safe staffing of our inpatient areas. The highest number of staff redeployments occurred in January and February 2026 due to increased levels of sickness during these months 8.9% in January and 8.6% in February, this may have contributed to the rise in redeployments.

This data needs to be approached with some level of caution due to the reliance on manual adjustment of the rota to capture the deployments which is known to be less accurate for the deployment of Health Support Workers, particularly when this is within their own service area.

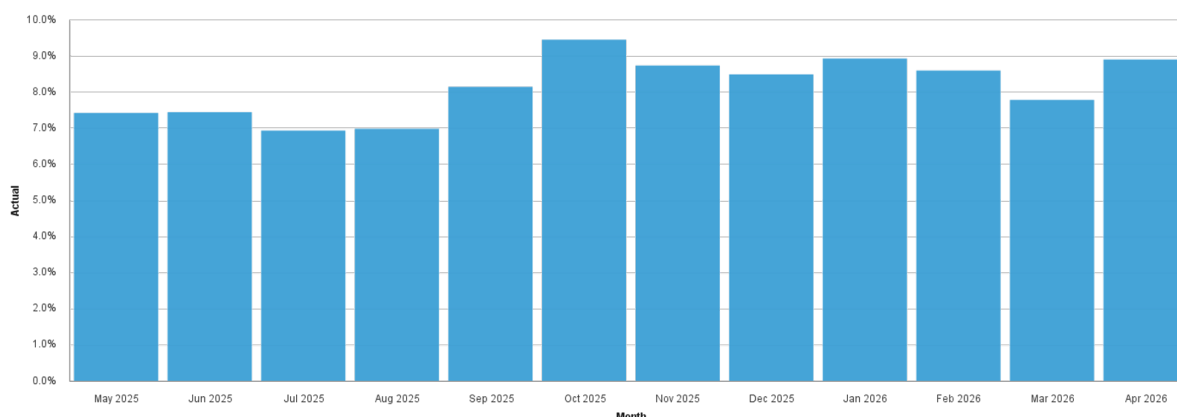
The below graph illustrates profession specific redeployment with the highest number of redeployments during the data collection period being Healthcare Support Workers (n=209) followed by Registered Nurses (n=165). The other professional groups were low occurrences with Clinical Team Manager being redeployed a total of four times and Allied Health Professionals (AHP) and Social Workers both occurring on one occasion.

Profession Specific Redeployed Shifts - All Inpatient Units 1st May to 30th April 2026



7 Inpatient Sickness Absence Unavailability - 28 Mental Health and Learning Disability Wards.

The following chart demonstrates the sickness absence rates across the data period 1st May 2025 – 30th April 2026 aggregated across all inpatient areas.



The Trusts target for sickness absence according to our Informatics and Performance system (Echo) is 5% indicating that the rate is higher when combining all the wards.

Compliance has remained consistently above the Trust wide target of 5%, with the lowest recorded at 6.9% in July 2025 and the highest at 9.5 % in October 2025.

The Trust has made considerable progress in supporting colleagues with health and wellbeing needs. Workforce pressures are known to be a contributory factor impacting on wellbeing and attributing to increased sickness absence rates.

The introduction of a Critical Incident Staff Support Pathway (CrISSP) which commenced in January 2022 has been instrumental in supporting colleagues and teams through responding to all critical incidents that are recorded as high-level harm or through the direct request from Team Managers/Leaders. Together with trained facilitators across the organisation, the initiative has supported over fourteen hundred colleagues requiring such support. The following table illustrates the number of sessions facilitated and the number of staff supported between 1 May 2025 to 30 April 2026.

Number of sessions	Number of staff supported
84	319

To further support the full CrISSP pathway and ensure local teams are provided with more immediate wellbeing support following an incident, joint Team Leader and Peer Practitioner Training continues to be rolled out Trust wide.

The following table illustrates the number of training sessions delivered and the number of staff attending the sessions from 1 May 2025 to 30 April 2026.

Number of training sessions	Number of staff attending the training session
5	45

The People Wellbeing Lead also provides Wellbeing Buddying support offering a wellbeing drop in, for an agreed time limited period, to clinical areas who may be experiencing a challenging time to provide an emotional check in and ensure they are aware of the wellbeing offer in the organisation.

The support received was described as highly beneficial, increasing awareness of strategies to promote both individual and team well-being. The sessions also validated experiences and allow staff to voice concerns openly. Importantly, they encouraged reflection on the positive impact of care provided, even in challenging circumstances, reinforcing the value of listening and meaningful engagement with service users.

8 Vacancies – 28 Mental Health and Learning Disability Wards

Vacancy management identifies how the organisation effectively manages its vacancies and workforce size.

The table on the next page breaks down the funding allocated to Band 3, Band 5, and Band 6 posts by headcount. It also identifies how many staff were in post and the vacancy factor by month.

All Inpatients

	Nurse Band 6											
Period	May 25	June 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
Funded	120.4	120.4	121.4	121.4	120.2	120.2	120.2	120.2	120.2	120.2	120.2	122.78
In-post	103.01	103.85	100.85	105.05	106.21	107.17	107.97	109.97	107.97	107.97	108.97	109.27
Vacancy	-17.39	-16.55	-20.55	-16.35	13.99	-13.03	-12.23	-10.23	-12.23	-12.23	-11.23	-13.51
Percentage	-14.44	-13.75	-16.93	-13.47	-11.64	-10.84	10.17	-8.51	-10.71	-10.71	-9.34	-11

	Nurse Band 5											
Period	May 25	June 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
Funded	242.65	242.65	241.97	241.97	235.68	235.68	235.68	235.68	235.68	235.68	235.68	236.38
In-post	194.24	192.12	193.12	191.88	195.11	197.11	201.91	208.82	211.78	215.38	214.34	211.74
Vacancy	-48.41	-50.53	-48.85	-50.09	-40.57	-38.57	-33.77	-26.86	-23.9	-20.3	-21.34	-24.64
Percentage	-19.95	-20.82	-20.19	-20.7	-17.21	-16.37	-14.33	-11.4	-10.14	-8.61	-9.05	-10.42

	Healthcare Asst Band 3											
Period	May 25	June 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
Funded	396.51	396.51	408.53	407.53	407.38	407.38	407.38	407.38	407.38	407.38	407.38	418.1
In-post	335.93	337.61	334.81	336.96	338.36	336.27	331.47	324.17	324.49	321.08	321.25	326.25
Vacancy	-60.58	-58.9	-73.72	-70.57	-69.02	-71.11	-75.91	83.21	-82.89	-86.3	-86.13	-91.85
Percentage	-15.28	-14.85	-18.05	-17.32	-16.94	-17.46	-18.63	-20.43	-20.35	-21.18	-21.14	-21.97

There has been a reduction in both Band 5 and 6 Registered Nurse vacancies with a vacancy rate of 10% (25.64 WTE) for Band 5 and 11% (13.51 WTE) for Band 6 in April 2026. The table above shows that the vacancy rates for both Band 5 and 6 Registered Nurse has fallen as the last 12 months have progressed.

Over the last 12 months, Health Support Worker vacancies have increased with vacancy rates ranging from 14.85% (58.9 WTE) to 21.97% (91.85 WTE) in March 2026. This has been due to a combination of factors which includes long-standing vacancies which have proven challenging to recruit, high turnover rates within inpatient services and a recent uplift in Band 3 roles within both Working Age Adult Acutes and York Forensic Service. Due to the number of Health Support Worker vacancies, a Health Support Worker Recruitment and Retention Group has been commenced within the organisation with a focus on recruitment, retention and workforce redesign, with the aim of reducing the number of vacancies.

8.1 Recruitment and Pipeline Data - 28 Mental Health and Learning Disability Wards

Recruitment and Pipeline Data

Nursing and AHP recruitment activity across inpatients wards 1 May 2025 – 30 April 2026.

Role	No of vacancy adverts	Advertised WTE	Appointed WTE	Fill Rate of Vacant WTE (%)	Change in appointed WTE vacancies since last report
Band 5 Nursing (Non-Preceptee)	21	61.0	25.0	41	3.0 decrease
Band 6 Nursing	68	84.9	44.0	52	7.0 decrease
Band 5 Practitioners/ AHP Roles	6	9.0	8.0	89	9.0 decrease
Band 6 Practitioners/ AHP Roles	17	22.0	18.0	82	No change
Healthcare Support Worker	57	154.2	53.0	33	11.0 decrease
Total	169	331.1	148	297	30 decrease

Preceptees 2025

Role	Applied	Placed	Change from 2024
Local	48	46	2 decreases
Out of Area	0	0	0
Total	48	46	2 decrease

The preceptee data relates to third-year graduates from 2025. During the reporting period, there was a reduction of 11 graduating students compared with the previous year, alongside a decrease in the number of preceptee vacancies across all Trust services. Consequently, for the second consecutive year, the Out of Area Preceptee Programme was not implemented. Due to the reduced number of available vacancies,

the two unsuccessful graduates were not offered their first-choice service and subsequently chose not to take up employment within the Trust.

During the reporting period, there were 145.9 WTE vacancies for Band 5 and 6 Nursing roles. The overall fill rate for the period was 47%, suggesting there remain opportunities to strengthen recruitment. This should be considered alongside the recognised shortage of qualified Band 5 and 6 Nurses across the NHS.

Allied Health Professionals (AHP) Band 5 and 6 there were 31.0 WTE vacancies. The overall fill rate of vacancies for the profession was an impressive 84% showing strong recruitment and talent availability.

For Band 3 Healthcare Support Workers, the reporting period showed a low vacancy fill rate of 34% (a decrease of 25%), alongside an increase in vacancies of 45.2 WTE. This indicates that these roles continue to be difficult to recruit to, with a notable rise in turnover of Healthcare Support Workers across inpatient settings.

Overall, for the reporting period the recruitment activity has seen:

- 6908 applications (increase YOY 167)
- 908 applicants interviewed (increase YOY 90)
- 161 conditional offers (decrease YOY 71)
- 148 new colleagues starting (decrease YOY 4).

Service Level Agreements (SLA's) are being maintained with time to hire (conditional to unconditional) currently at 22.5 days (no change YOY) which sits well below the SLA of 27 days.

8.2 Graduate Recruitment

Across the three Leeds Universities, 57 nursing graduates are expected between September 2026 and January 2027. Of these, 42 applied within the first round of recruitment, with 16 successfully interviewed and offered posts.

The Practice Learning and Development Team (PLDT) has supported graduates across all professions with interview preparation sessions delivered at universities, alongside mock interviews and coaching conversations with Legacy Mentors. This offer remains ongoing to ensure graduates are well prepared for interviews and more confident in presenting their skills and experience.

8.3 Preceptees

A review of the Preceptorship delivery model was undertaken in response to feedback regarding engagement, venue suitability, and financial sustainability. The agreed approach for 2025 to 2026 introduced a revised six session rolling programme using a split cohort model, where smaller groups attend workshop sessions on alternate months alongside self-directed learning. This model has now been implemented and early feedback from both preceptees and facilitators has been positive, with improved engagement and a more effective learning environment, while also supporting safer staffing and a more cost-effective approach to delivery.

On the multiprofessional Preceptorship register, there are currently 62 Registered Nurses, 11 Nursing Associates and 13 Allied Health Professionals which includes 4 Rotational Occupational Therapists with another one due to start once all recruitment checks are completed. This reflects strong engagement with the Preceptorship programme across the workforce. The Practice Learning and Development Team

continues to provide structured Preceptorship support through workshops, awareness sessions and forums, as well as individual support as required, to enable Preceptees to build confidence and develop within their roles while promoting safe and effective clinical practice. Preceptorship awareness sessions are open to staff who support Preceptees, including Preceptors and Managers. Pre-preceptorship resources are available on the Learners Hub, a Futures NHS Platform for pre-registration learners and Preceptees.

8.4 Health Care Support Worker Programme

A Healthcare Support Worker workstream was established following a paper presented to the Safer Staffing Steering Group, which highlighted vacancies in Healthcare Support Worker roles and the need for targeted recruitment and retention initiatives. Three subgroups sit within the overarching structure: a retention group, alongside recruitment and workforce redesign groups. These feed into a central Task and Finish Group, which in turn reports to the Safer Staffing Steering Group meeting.

The primary aim of the workstream is to reduce Healthcare Support Worker vacancies and improve retention by strengthening support for staff through effective induction, supervision, and professional development. The group will meet monthly over a four month period to deliver agreed outputs, with a focus on implementing practical, actionable strategies and ensuring clear communication of role expectations.

The workstream will also consider workforce redesign, including whether vacancies can be utilised to better support the roles and responsibilities typically undertaken by Healthcare Support Workers. This may involve the development of new roles or the optimisation of the fidelity of existing roles within the workforce.

8.5 Apprenticeship Strategy / Central Backfill

During the 2025/26 financial year, a total of 139 apprenticeships commenced. Of these, 29 were in clinical roles. This included 15 Nursing Associate apprentices who commenced across service lines (13 in April 2026 and 2 in February 2026). The 2 Student Nursing Associates (SNAs) who started in February 2026 have their backfill funded through service line budgets.

In addition, 11 Registered Nurse degree apprenticeships (Transfer to Nursing) have commenced (6 in February 2026 and 5 in October 2025), supporting services including Learning Disabilities, Perinatal, Community and Wellbeing, CAMHS, Adult CMHT, Inpatient Operations, and Nursing and Quality. 10 of these posts receive backfill support from a centralised budget equivalent to 0.2 WTE of their salary, with the remaining post being supported by the relevant service. Further clinical starts included an Occupational Therapist and Physiotherapist both commenced in September 2025 and a Dietitian who commenced in May 2025.

In September 2025, the Enhanced Clinical Practitioner apprenticeship was supported for the first time, with 1 Occupational Therapist from Rehabilitation Services commencing. This apprenticeship does not require backfill and is more closely aligned with CPD rather than a defined post at completion. Plans to expand this provision across Allied Health Professionals roles are currently under consideration.

For clinical support roles, 23 apprenticeships were initiated in adult care related standards. These are mainly used as entry-level routes and pathways to professional accreditation, including Level 2 to Level 5 adult care roles and a Peer Support Worker role. The remaining apprenticeships focused on developing colleagues' skills in digital and data capabilities, as well as leadership and management.

8.6 Legacy Mentors

Leeds and York Partnership Foundation Trust Legacy Mentors have developed a programme of support for staff in the organisation since the role's inception in August 2023. Initially, the primary focus was towards post-preceptorship and early career professionals. However, in response to need, the service expanded to include colleagues from all areas of practice and professional backgrounds; being mindful of generational and cultural behaviours and acting in a timely way to offer bespoke support. The starting point is a request for help and/or support either directly from the mentee, their line manager, or another colleague and consists of an initial conversation to clarify the issues that require support, and individuals are usually seen within two weeks if their off duty allows. Timeliness of support is prioritised by the Legacy Mentors, and the service is delivered without operating a waiting list in an identified safe space in the individual's area of work.

The offer is unique as it transcends the traditional hierarchical boundaries by reiterating the basic principles of care delivery – respect, care, compassion, honesty, diligence, commitment, and professionalism. Legacy Mentors are already seeing a shift in thinking, practice, and culture by applying these principles in their mentoring work. The experience and organisational memory of the Legacy Mentors to positively influence the current and future workforce is critical to successful recruitment and retention strategies going forward across all grades of staff.

From inception to 31 December 2025, the Legacy Mentors have returned the following number of contacts:

- Legacy Mentors have seen 75 colleagues (by headcount) across this period.
- Most of the contacts have occurred face to face, with a smaller number of meetings taking place on teams where required.
- The number of contacts by interventions is 222.
- The number of active cases currently sits at 29.
- The number of closed cases is 87.

Awareness sessions have also been delivered to large groups (<80 attendees) of Preceptees, Students, Health Support Workers, as well as other colleagues. The overall retention rate from contacts with the Legacy Mentors is 95%; with a 100% satisfaction rate across all contacts.

8.7 Talent Development and Retention

Talent Development

Personal Development Review (PDR) compliance remains high, currently standing at 84%. This process includes a development and career conversation and is supported by a skills workshop delivered as part of the 360 Managers programme. In response to lower satisfaction levels of appraisals reported in the staff survey, this year we will be focusing on the purpose of the process and what makes a good PDR conversation. The impact will be measured through the 2026 staff survey responses.

The successful Career Development programme continues to run with sessions available on Career Planning, Application Forms and Interview Skills. Research has been undertaken to review the career development experiences of colleagues with protected characteristics in response to Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data, reporting poorer career support experiences and outcomes for these groups. This work has informed several career development actions to be undertaken in the year ahead.

Retention

Exit Interview data continues to inform organisational retention plans. This year, this data was supplemented with New Starter Questionnaires which were sent to new colleagues at 4 and 18 months in post from April 2025 to Dec 2025. Ninety-two responses were gathered offering insight into colleagues' early experiences, the consistency of local induction practices, and the factors influencing engagement and retention. Overall, the majority of respondents reported positive early experiences, however, a significant minority reported gaps in induction quality, clarity of expectations, access to IT systems, and consistency of managerial contact. These issues appear to stem from local practice differences rather than systemic barriers.

Thematic analysis of free text responses reveals 5 core themes shaping new starter experience: the quality and structure of induction, timely IT access, visible and consistent managerial presence, team culture and leadership behaviours, and clarity and fairness around development and progression. Findings will be cross referenced with the People Plan objectives and existing programmes of work to ensure issues are addressed and processes improved.

The Trust Launched its 'Let's Get Flexible' campaign in May 2025, which included a new Flexible Working Procedure, application process, managers workshop and a communications campaign which included a number of case studies from individuals and managers. A Team Rostering pilot was established at Ward 4, Newsam Centre and work continues to trial different approaches to support Managers and teams to ensure they can balance individual needs with those of the service, service users and their colleagues. Three hundred flexible working requests have been received to date and the Flexible Working People Promise was the only promise to see an increase in this year's staff survey results.

9 Quality Indicators

The Safer Staffing Steering Group have been working together to identify a series of quality indicators which can be used to triangulate workforce information recommended in the guidance produced by the CNO of England and the National Quality Board¹ in which to support the review of safer staffing levels. More specific guidance for mental health wards has also been developed which has also been used to support the work².

The data details a range of metrics across each inpatient service relevant to aspects of patient safety, clinical effectiveness and in turn patient experience. This is being used to support clinical service establishment reviews alongside care hours per patient day (CHPPD) and MHOST data, to understand how staff capacity may affect the quality of care.

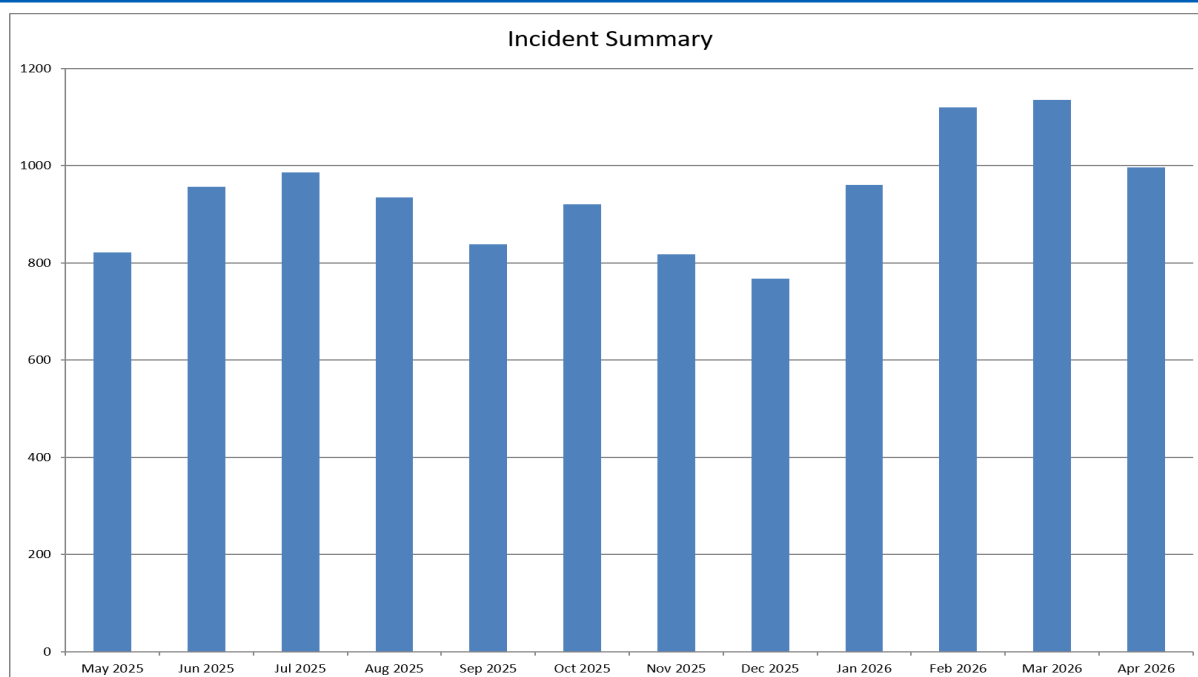
9.1 Incident Data - 28 Mental Health and Learning Disability Wards

Total number of Incidents

The graph below details the total number of incidents reported for the period 1 May 2025 to 30 April 2026. The number of incidents experienced and reported is impacted by many variables however, there is a wealth of evidence which suggests a relationship between the number of Registered Nurses and patient safety, with evidence suggesting nursing workforce and staffing levels and clinical patient outcomes are correlated.

¹ <https://www.england.nhs.uk/wp-content/uploads/2013/04/ngb-guidance.pdf>

² https://www.england.nhs.uk/wp-content/uploads/2022/03/Safer_staffing_mental_health.pdf

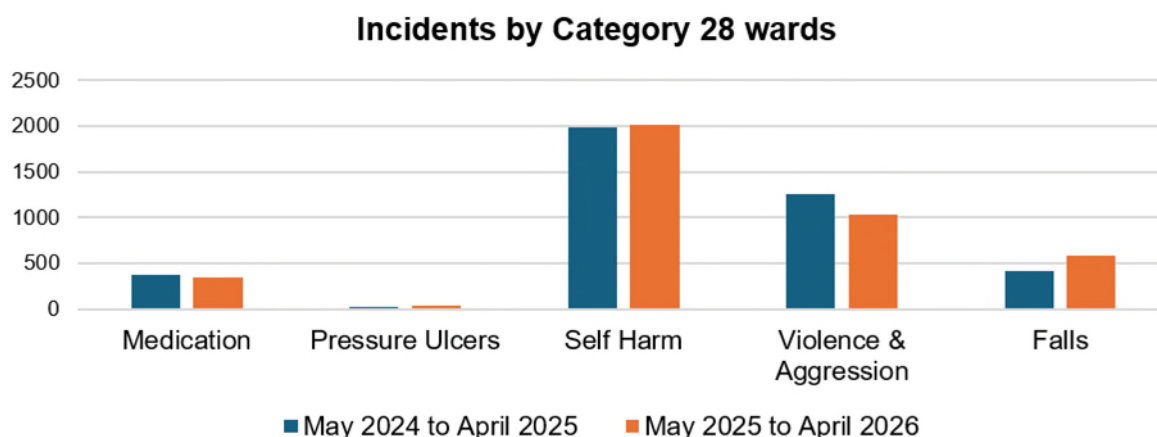


Total Number of incidents by category

The graph below details incidents by category for the period 1 May 2025 to 30 April 2026 compared to the previous 12 month period. In relation to patient safety incidents, medication errors and pressure ulcers (including both those present on admission and those acquired during admission) have remained relatively stable.

There has been a reduction in incidents of violence and aggression, decreasing from 1,262 during the period May 2024 to April 2025 to 1,040 in the period May 2025 to April 2026.

However, there has been a slight increase in falls, rising from 414 between May 2024 and April 2025 to 590 between May 2025 and April 2026.



The above information is taken from the "Inpatient Patient Safety Incidents" dashboard on ECHO on 5/6/2026.

Violence and Aggression

The Positive and Safe Working Group provides leadership and oversight in many quality improvements initiatives that are impacting directly on our inpatient activity. Care planning meetings, reflective forums, post incident reviews, and post incident debriefs are becoming valuable in staff sharing concerns, problem

solving to reduce recurrence of incidents that may result in violence and aggression that in turn may require the use of restrictive practice. Several wards have adopted safety huddles to address issues around conflict behaviour such as violence and aggression, self-harm, and/or absconding; proactively identifying situations that may require restrictive interventions and seeking alternative collaborative solutions to avoid escalation. As a Trust, we are working to implement the Violence Prevention and Reduction Standards to create safer environments by identifying risks early, supporting staff and patients, and applying evidence-based approaches to reduce harm.

The Trust is currently reviewing the training available to staff in relation to self-harm to support staff with the best available evidence in line with NICE Guidance and strengthen the current training offer. The Trusts Suicide Prevention Environmental Survey Action Group continues to run regularly with a focus on potential risks of self-harm within the built environment and consider any changes required to support patient safety. Self-harm incidents are reported on the Trusts Datix system and these are investigated as appropriate, learning identified and improvements made to clinical processes as required.

Falls and Pressure Ulcers

The Falls and Pressure Ulcer Improvement Forum (FAPU) meet monthly, and reviews all falls of moderate or severe harm reported on Datix to identify individual or thematic learning and good practice across care services. PSIRF learning responses are commissioned where needed. The group has recently commenced a quality improvement initiative, focussing on falls prevention in the Older People's Service (OPS). This work is led by a Practice Development Nurse in OPS. The aim is to improve information provided on Datix reports, to enable teams to effectively identify contributory factors and put prevention measures in place. The project is supported by the Continuous Improvement Team and will report on completion to FAPU in the autumn.

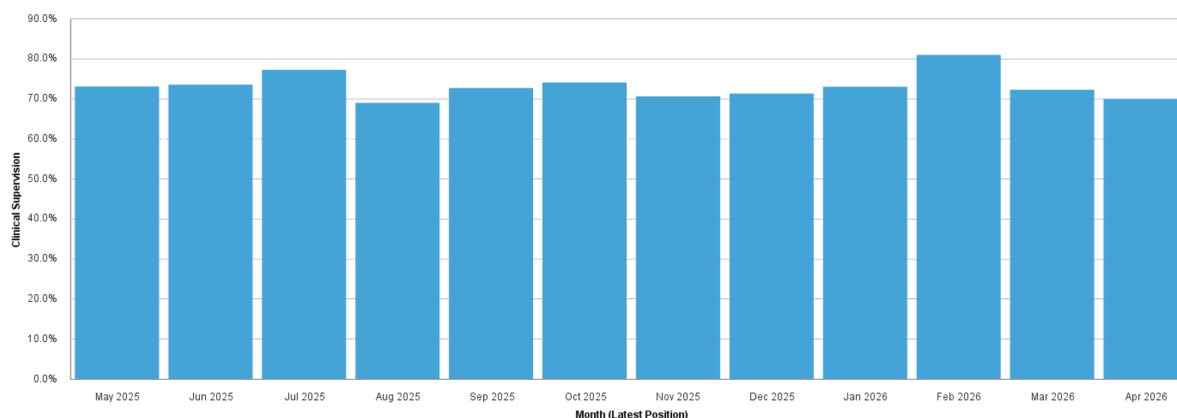
Medicines

Medication errors and themes are discussed within Medicines Safety Committee which is attended by representatives from a range of services. Key messages are taken from the learning and disseminated via Trustwide Communications and via the Unified Clinical Governance Group. In addition, a number of clinical services have local Medicines Management Groups to discuss medication incidents and share good practice.

Following recent learning in relation to medication administration errors, a Medication Competency Framework has been developed, added to Learn, and rolled out across the Trust for all Registered Nurses and Nursing Associates. The impact of this training will be evaluated, and the content reviewed over the next 12 months.

9.2 Clinical Supervision - 28 Mental Health and Learning Disability Wards

The below graph shows the inpatient services compliance with clinical supervision. The compliance target for the Trust is 85%. During the reporting period the lowest recorded at 68.9% in August 2025 and the highest at 80.9% in February 2026.

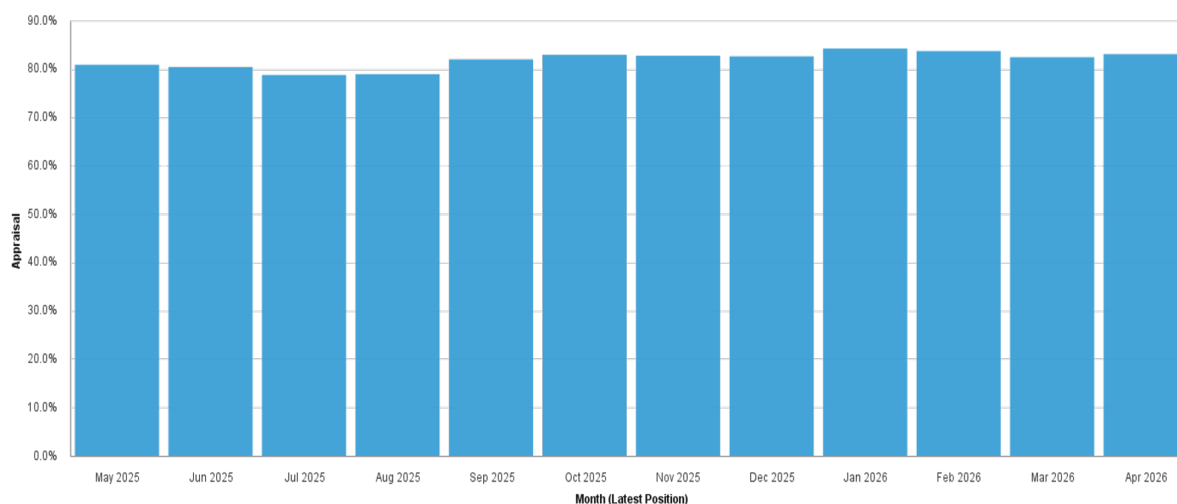


Effective clinical supervision supports both staff well-being and improves the quality of care delivered to service users. Leeds and York Partnership Foundation Trust has invested in the training of Professional Nurse Advocates across the organisation, a national programme which was launched in response to the pandemic to aid recovery for our workforce. The programme provides the skills to facilitate Clinical Restorative Supervision (CRS) to colleagues and teams in nursing and beyond. Clinical Restorative Supervision Groups continue to be offered across a range of services within the organisation.

9.3 Appraisal - 28 Mental Health and Learning Disability Wards

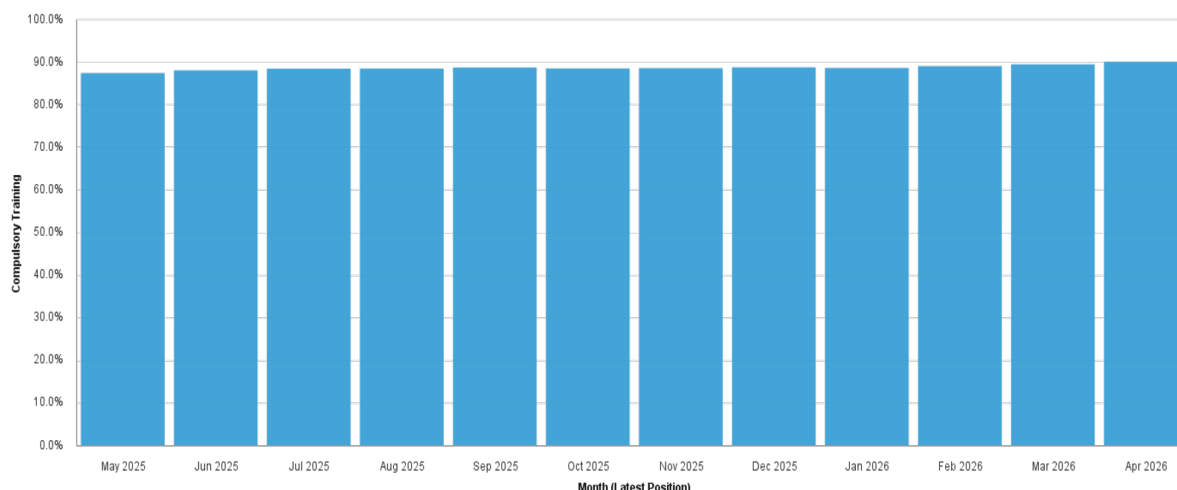
Ensuring that our workforce have regular performance reviews has a positive impact on our services. This is because there is a proven link between our colleagues being clear about what is expected of them, having regular feedback on their performance, and agreeing to development needs and how this impacts the services we provide.

The below graph shows the inpatient services compliance with appraisals. The Trust target for compliance is 85%. During the reporting period the lowest recorded was 78.9% in August 2025 and the highest at 84.2% in January 2026.



9.4 Compulsory Training - 28 Mental Health and Learning Disability Wards

The below graph shows the inpatient services compliance with compulsory training.

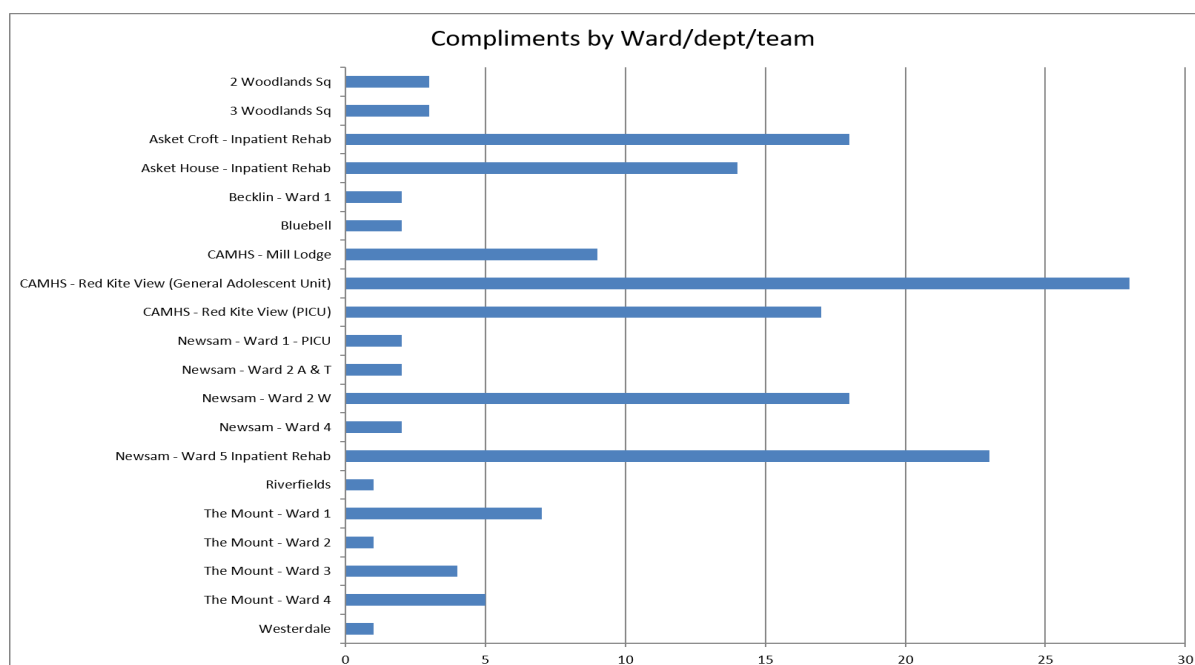


Compulsory training is required to adequately protect service users, our colleagues, visitors, and the public by enabling safe practice by a competent workforce.

The Trust compliance with compulsory training has been consistently above the target of 85% which is consistent with and supports the delivery of safe care.

9.5 Compliments - 28 Mental Health and Learning Disability Wards

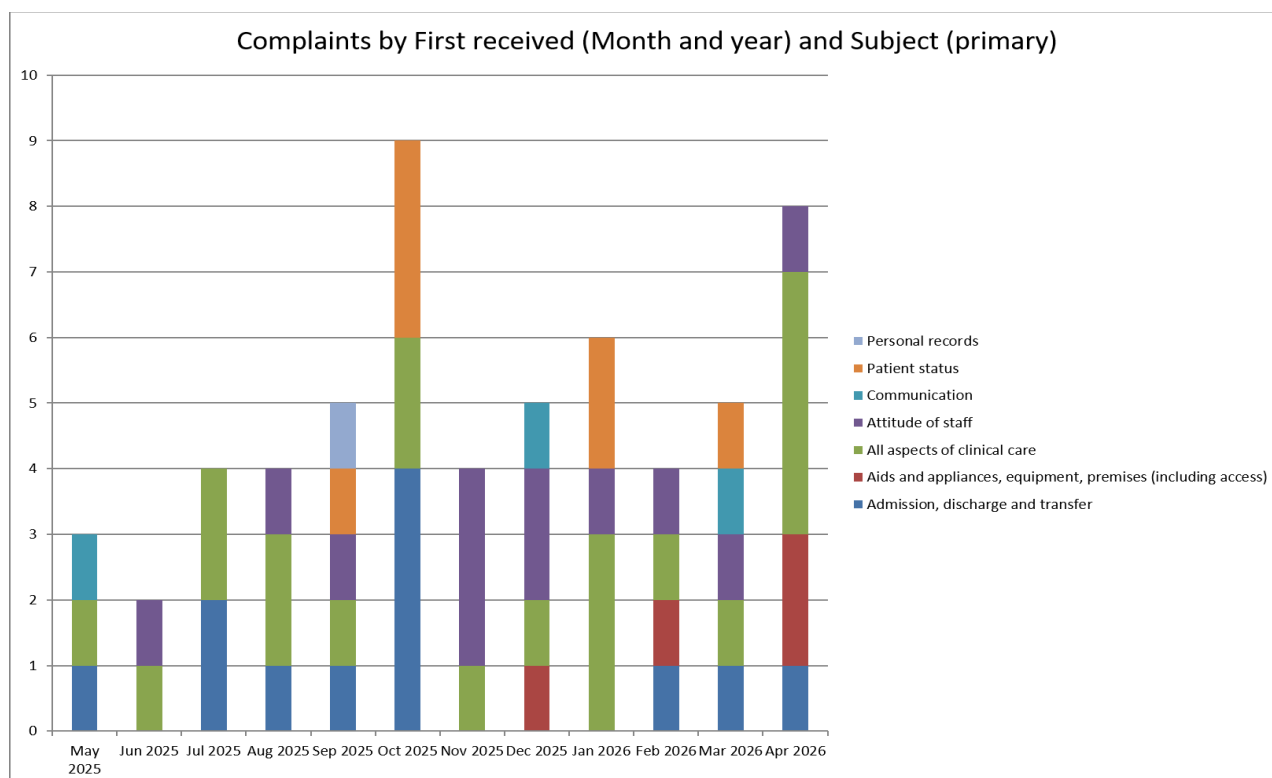
The data below shows the number of compliments received during the collection period. A total of 162 compliments were recorded, with 20 wards included in this report receiving at least one compliment. The highest numbers being received at Red Kite View GAU, Ward 5 Newsam Centre and Asket Croft.



Complaints – 28 Mental Health and Learning Disability Wards

Below shows the number of complaints for inpatient services over the data collection period from when

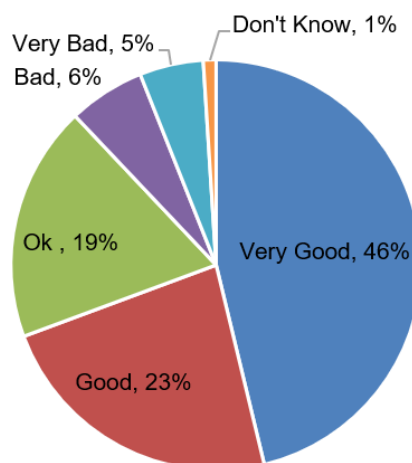
they were first received, and their primary category. There was a total of 59 complaints across inpatient services from 1 May 2025 to 30 April 2026, the largest proportion of these complaints related to aspects of clinical care (n=20) and staff attitude (n=11).



9.7 Have Your Say - 28 Mental Health and Learning Disability Wards

Have Your Say feedback is an important indicator for the quality of care being provided as it gives us direct feedback from the people we provide care to. Across the inpatient wards who have received Have Your Say feedback, the largest proportion of service users who provided feedback described their care as either 'very good' or 'good' (69%). 19% of service users described the care they received as 'ok' and 11% described their care as either 'bad' or 'very bad'.

The below chart shows the reported experience of service users for all inpatient services from 1 May 2025 to 30 April 2026.



9.8 Culture of Care

Over the past two years, pilot wards have participated in the National Culture of Care pilot, an NHS England initiative launched in 2024. The programme sets out twelve standards designed to strengthen the delivery of safe, compassionate, and equitable mental health and learning disability inpatient services. It places a strong emphasis on staff well-being, patient safety, and trauma / autism informed practice, ensuring that lived experience meaningfully shapes therapeutic environments.

The pilot with NHS England concluded on 31 March 2026, with the expectation that all organisations would independently implement a culture of care within their inpatient services, without ongoing input from NHS England. A Trustwide launch event in February 2026 brought together leaders, frontline colleagues and people with lived experience to celebrate progress and outline the next phase of rollout.

Introductory workshops across inpatient areas have been introduced to strengthen engagement. These sessions help staff and service users understand the programme's purpose, relevance and practical application, equipping teams to embed Culture of Care principles within everyday practice. These workshops have been delivered in both Leeds and York Forensics and are currently being offered within Working Age Adult Acutes. It is anticipated that the workshops will be delivered across all inpatient wards until November 2026.

The Lived Experience Lead for the Culture of Care continues to play a pivotal role in embedding this approach across services. This includes contributing to events and workshops, enhancing training such as PMVA through the inclusion of lived experience perspectives, and developing the newly established Lived Experience Professionals Group to support peer workers within inpatient settings.

10.0 Summary

This paper outlines the shared local and national workforce challenges facing our inpatient services, as well as the sustained and proactive efforts required to ensure that service users receive the highest standard of care despite ongoing pressures linked to long standing workforce supply issues. It is widely recognised that having the right number of suitably qualified, competent and experienced staff is essential to delivering high quality care.

This paper provides the high-level data to demonstrate the position in relation to staffing Leeds and York Partnership Foundation Trust inpatient wards and the wider workforce plan to provide assurance that the standards required to deliver safe and effective care are being met. Progress has been noted in vacancy rates for Registered Nurses and Allied Health Professionals; however, challenges remain around recruitment and retention for Health Support Workers. A workstream has commenced to explore opportunities for workforce redesign alongside recruitment and retention initiatives for Health Support Workers.

It is important to acknowledge that despite the vacancies within the Trust, the delivery of care through the multidisciplinary team and the professional specific roles is not captured in the planned staffing establishment and should be considered when reviewing the data. The wider multidisciplinary team brings increased skills and supports the quality of care delivered.

Quality indicators as set out in the NQB have also illustrated an increase in the number of falls incidents however there was a reduction in violence and aggression, two of the areas focused on for the report.

Clinical supervision, compulsory training and appraisal rates have also remained high, which are likely in turn to influence staff experience.

Patient experience data continues to suggest most service users report a good experience relating to their care and treatment.

The paper highlights quality improvement initiatives currently underway, such as ETOC and Culture of Care, which aim to enhance the experience of care alongside the effective use of the existing workforce. It emphasises the importance placed on understanding the service user experience, gathering feedback, and using this meaningfully to inform and implement improvements.

11 Recommendations

The Board of Directors are asked to:

- Note the content of the 12 monthly report and the progress in relation to key work streams.
- Be assured that arrangements are in place to monitor, support and mitigate any impact of reduced staffing levels or skill mix in relation to patient safety.

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June 2026

Appendix 1: Care Level Indicators taken from The Shelford Group (2019) Mental Health Optimal Staffing Tool MHOST: Implementation Guidance for Mental Health Inpatient Wards.

Adult Acute Mental Health Wards

Acuity and Dependency Level	Descriptor
Level 1 Low Dependency	Self-caring and able to do most daily living activities of unaided. Patient has capacity to engage with therapeutic interventions. Patient is at predischARGE state. Risks can be managed by community services.
Level 2 Medium Dependency	More dependent on ward staff for his/her mental, social or physical health needs. Patient has capacity to engage with therapeutic interventions. May be potential barriers preventing a safe and timely discharge.
Level 3 Medium/High Dependency	Heavily reliant on Ward Team for his / her care. Presents as medium- to high-risk or fluctuating risk. Has high-level mental, social or physical health needs. Low or inconsistent engagement with therapeutic interventions. There may be potential barriers preventing a safe and timely discharge.
Level 4 High Dependency	Dependant on Ward Team for his/ her care. Requires high engagement and intervention. Major mental, social or physical health needs. Presents as high-level risk to self-and/or others. Minimal engagement with therapeutic interventions.
Level 5 Highest Dependency	Requires one to one care. Major mental, social or physical health needs. Is a significant risk to self-and/or other people. Leave from the ward isn't allowed other than planned hospital appointments with escort. May be awaiting step up to PICU or low-secure environment.

Child and Adolescent Mental Health Wards

Acuity and Dependency Level	Descriptor
Level 1 Low Dependency	Self-caring and able to do most daily living activities unaided. Core therapeutic interventions are provided. Able to access education services unaided. Can leave the ward without supervision (supported by parents or social services). Proactively engaging with staff to manage risks. Concordant with treatment and care plan. Minor/stable mental illness symptoms, not affecting functioning. Unlikely to self-harm or harm others.
Level 2 Medium Dependency	Self-caring and able to do some daily living activities unaided. Increased staff support required when accessing core therapeutic interventions, education and community services. Able to access education services unaided. Can leave the ward without supervision (supported by parents or social service staff). Proactively engaging with staff to manage risks. Concordant with treatment and care plan. Minor/stable mental illness symptoms, which do not affect functioning. Unlikely to self-harm or harm others.
Level 3 Medium/High Dependency	Requires support from staff to meet personal care needs. Requires support when accessing therapeutic interventions, education and community activities. Proactively engaging with staff to manage risks. Not fully concordant with treatment and care plan. Minor/stable mental illness symptoms, not affecting functioning, but which needs staff intervention. Engagement with staff/ward

	routine is inconsistent, requiring frequent intervention. Moderate mental illness symptoms having definite impact on ability to function. Moderate risk to self and others.
Level 4 High Dependency	Requires direct intervention from staff when attending to personal care needs. Needs one-to-one support from staff when accessing therapeutic interventions, education and community services. Not concordant with treatment and care plan, requiring staff intervention. Social and family issues require staff intervention. Limited engagement with staff. Moderate to high mental-illness symptoms, which significantly influence functioning. Self-harm and risk to others is moderate to high.
Level 5 Highest Dependency	Requires direct input and staff intervention for personal care. Requires constant one-to-one care at all times. Non-concordant with treatment and care plan, requiring constant staff intervention. Engagement with staff/ward routine is inconsistent requiring ongoing intervention. Significant mental illness symptoms having severe effect on functioning. High risk to self and others. For transfer to higher-security care.

Eating Disorder Wards

Acuity and Dependency Level	Descriptor
Level 1 Low Dependency	Diet specific – Patient is completing all diet in a step-down unit or dining room. Manifests only reduced eating disorder behaviours. Selects portions correctly with little assistance. Challenges self with food. Few compensatory and safety behaviours such as purging, laxative misuse or excessive exercise. Can go on independent snacks and meals. Some preoccupation with food, weight and shape. Physical health – Physical observations are recorded at least monthly. Blood investigations are generally within range. Weighed weekly and is restoring or maintaining weight. Accepts medications. Mental health – Concordant with care plan. General observation. Patient has leave periods. Patient reports improving wellbeing. Preparing for discharge. Fully engaging in ward activities, willing to engage in recovery focussed sessions. Engages with therapeutic plan and occupations independently or in a group. Can retain information and attention span is much improved. Mental health is stable; patient is functioning well. No self-harm or harm to others.
Level 2 Medium Dependency	Diet specific – Patient is completing all meals in a step-down unit or dining room. Manifests reduced eating disorder behaviours. Selects portions correctly and with little assistance. Can go on independent meals and snacks off site. Reduced compensatory and safety behaviours such as purging, laxative misuse or excessive exercise. Some preoccupation with food, weight and shape. Physical health – Physical observations are recorded up to once daily. Physical observations and bloods taken are generally within range. Weighed weekly and is maintaining or restoring weight. Accepts medication. Mental health – Concordant with care plan, General observation. Mental health continues to fluctuate. Anxiety levels around mealtimes may be present. Remains on post mealtime observations. Engaging in therapeutic plan, which may include social eating and meal preparation with some concerns or areas that require support. Engaging in meaningful leisure-based OT groups,

	may attend but not fully engage in recovery-based sessions. No self-harm or harm to others.
Level 3 Medium/High Dependency	Diet specific – Not always managing to eat meals and snacks but usually accepts oral nutritional supplements. Some compensatory eating disordered behaviours may be present, such as purging, laxative misuse and or excessive exercise. Not suitable for a step-down unit. There may be some eating disordered behaviours at the table, such as breaking up or secreting food. May find it difficult or avoids making food choices. Physical health – Physical observations are monitored once daily and are stable. Bloods taken weekly and generally within range. Engaging, but struggling to restore weight. Accepts medication. Mental health – Intermittently, concordant with care plan, Likely to be on intermittent observations. Mental health fluctuates. Reduced concentration, attention span and recall. High anorexic cognitions around, weight, size and shape. Post meal observations. Some engagement in meaningful ward-based activities either alone or in a group, but unable to concentrate for extended periods. May have some concerns that require further intervention. No self-harm or harm to others.
Level 4 High Dependency	Diet specific – Not always managing diet, always or usually refuses oral nutritional supplements. Naso-gastric tube maybe in situ. Manifests compensatory eating disorder behaviours such as purging, laxative misuse and excessive exercise. Eating disordered behaviours likely to be present at the table, e.g. breaking up food, secretion. Patient likely to avoid making menu choices. Risks re-feeding syndrome. Physical health – Physical observations recorded at least once daily, and readings fluctuate. Bloods taken more frequently than weekly. Difficulty restoring weight most weeks. Wheelchair may be required off the ward. Restrictions around bathroom use. May require more intense physical interventions. Mostly concordant with medications. Mental health – non-concordant with care plan, Higher observations and can have escorted leave off the ward with staff if physical observations are stable. May experience intense anorexic cognitions around weight, shape and size. May engage in ward-based leisure activities with encouragement and support. Difficulties in finding occupations in which to engage independently due to poor concentration, motivation, or high-risk level. On post-meal observations.
Level 5 Highest Dependency	Patient requiring one-to-one care or constant supervision to maintain safety, welfare and care.

Older Age Mental Health Wards

Acuity and Dependency Level	Descriptor
Level 1 Low Dependency	Personal care can be managed by one staff, or patient is independent. Has cognitive impairment, but not at risk. Mental state is stable/ predictable. General, hourly observations required. Vital signs are monitored twice daily. Medically stable, requires rehabilitation only. No significant care-package

	changes required. Ready for discharge. Supportive family able to cope at home. Patient can contribute to care and care planning.
Level 2 Medium Dependency	Patient is on general, hourly observations. Personal care can be managed by one staff. Early warning score trigger point reached, requiring escalation. Normal observation and therapeutic interventions. Mental state fluctuates. Care needs require regular re-evaluation. Increased multi-disciplinary team input. Patient has significant co-morbidity, e.g. an infection. Patient and family are participating in care/care planning.
Level 3 Medium/High Dependency	Has significant mental and physical health problems, which fluctuate. Has co-morbidities, but physical health is stable. At risk, but safety can be maintained with moderately skilled interventions. Daily living activities are managed by two staff and rarely requires one-to-one care. Multiagency discharge, where there has been a change in circumstance/care or package, which is the ward-based nurse's/therapist's responsibility. Increased psychological/emotional and education support required by patient and/or family carers. Patient requires direct supervision and medication to ensure compliance, or has a complex drug regimen, including prolonged preparatory/administration/post-administration care.
Level 4 High Dependency	Has significant on-going care needs, which can be met by two staff. Intermittent observations or one-to-one for part of the day. Significant co-morbidities with fluctuating physical health needs. At risk – has an unpredictable mental state or is likely to harm self or others. Skilled intervention required to maintain safety. Family/carers require increased psychological, educational and emotional support.
Level 5 Highest Dependency	Patient requiring one-to-one care or constant supervision to maintain safety and care.

Perinatal (Mother and Baby) Wards

Acuity and Dependency Level	Descriptor
Level 1 Low Dependency	Pre-discharge - Mother fully looks after her baby. Uses home leave appropriately. Engages in activities. Mother-baby interaction is safe and consistent. Attachment is good. Risk level is low. Baby requires no support from staff and is 'general observation' only.
Level 2 Medium Dependency	Mother cares for baby with minimum staff-support i.e. verbal prompts only. Mum is self-caring. Requires accompanied home leave. Mum needs only prompt to engage in activities. Mother and baby interaction shows some attachment, but not consistent or safe. Risk is stable. Agreed care plan in place. Baby needs little support from staff i.e. mother requires verbal prompting and reassurance.
Level 3 Medium/High Dependency	One-to-one observations part of the day. High risk, mother is unpredictable and volatile. Requires supervision when handling her baby and needs help with baby care: bathing, feeding, changing nappies. Needs prompting with self-care. If home leave is allowed, then escort is required. Not engaging in activities. Baby requires planned interventions at specific times. Has a nursery-nurse care plan.

Level 4 High Dependency	One-to-one observations, most of the day. Constant supervision required when engaging with baby. Intermittent support when self-caring; requires verbal and physical prompting. Not engaging in activities. Home leave is not allowed. Mental health seriously impedes mum's ability to care for her baby. May neglect and possibly harm her baby. Behaviour is chaotic. Mother and baby may need transferring to an adult MH unit or PICU.
Level 5 Highest Dependency	Constant supervision and support when undertaking self-care activities. Not engaging in activities. Less or no ability to communicate needs. Mental health severely affects ability to care for her baby. Harm to herself and baby - high risk. Disruptive behaviour that affects the whole ward. Mother and baby may require transfer to adult MH unit or PICU.

Psychiatric Intensive Care

Acuity and Dependency Level	Descriptor
Level 1 Low Dependency	Self-caring – able to do self-care activities unaided. Core therapeutic interventions are provided. Non-PICU patient awaiting discharge or transfer.
Level 2 Medium Dependency	More dependent on ward staff for his/her personal care needs. Requires more than base-level core interventions. Ready for transfer/discharge.
Level 3 Medium/High Dependency	Heavily reliant on ward team for his/her safety and care.
Level 4 High Dependency	Fully dependent on ward team for his/her safety and care. Requires high engagement and frequent interventions. Additional support needed to meet personal care needs.
Level 5 Highest Dependency	Has harmed or may harm self or others. In a de-escalation/extra care area. Secluded patients. Increased support required to meet personal care needs. Possible transfer to a forensic service unit. Complex discharge process.

Forensic Low Secure/ Rehabilitation Wards

Acuity and Dependency Level	Descriptor
Level 1 Low Dependency	Settled, stable and assessed. Engages with treatment and care plan. At pre-discharge phase. Demonstrates insight. Risks are understood and fully engages with management plan. No significant physical, mental or social issues. Observation requirements are 30 minutes to one hourly. Manifests ad-hoc, unpredictable behaviour.
Level 2 Medium Dependency	Some, ad-hoc unpredictable behaviour. Short-term but significant physical, mental and social problems. Active rehabilitation programme in place. Lacking family support, or family needs significant help at home. Risks are known but patient isn't fully engaging with risk-management plan. Requires thirty-minute observations.

Level 3 Medium/High Dependency	Manifests predictable behaviours that require extra observations, otherwise routine observations are 15 to 30 minutes. Has potential to harm self-and/or others. Complex discharge process is likely.
Level 4 High Dependency	Newly admitted or patient is being re-integrated after seclusion. Manifests serious aggression and likely to self-harm or harm others. Complex discharge process is likely. 1-1 observation required intermittently.
Level 5 Highest Dependency	Imminent destructive behaviour to self and/or others. If opportunity arises, then patient may wander or abscond. Manifests major physical, mental and social problems. Does not engage with his/her risk management plan. Constant 1-1 observation required.

APPENDIX 2

The below information shows where wards have worked above or below their baseline establishment.

For example, if a ward has 70% Registered Nurse fill rate it means that there have been 30% unfilled Registered Nurse duties. In this case, we would expect to see a Health Support Worker fill rate of 130% where the Registered Nurse deficit has been back filled by Health Support Workers. If a ward is working on its baseline establishment, the Registered Nurse fill rate and Health Support Worker fill rate will add up to 200%. However, if the two figures add up to over 200%, this means that the ward has worked above its establishment. This may be due to observation, acuity, escorts or a similar reason.

Two months of this data has been included below.

Safer Staffing: Inpatient Services March 2026

Fill rate indicator return

Staffing: Nursing, Care Staff and AHPs

Ward name	Cumulative count	Care Hours Per Patient Day (CHPPD)							Day				Night				Allied Health	
		Registred	Non-registred	Registred	Non-registred	Registred	Non-registred	Overall	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill
WardName	PatientCount	CHPPD_R	CHPPD_N	CHPPD_R	CHPPD_N	CHPPD_R	CHPPD_N	CHPPD_O	AvgFR_RNI	AvgFR_NRI	AvgFR_RNI	AvgFR_NRI	AvgFR_RNI	AvgFR_NRI	AvgFR_RNI	AvgFR_NRI	AvgFR_RAI	AvgFR_NRI
2 WOODLAND SQUARE	110	9.2	7.8	1.2	0.0	0.0	0.0	18.2	87%	243%	100%	-	110%	100%	100%	-	-	-
3 WOODLAND SQUARE	115	8.0	14.7	0.8	0.9	0.0	0.0	24.4	76%	161%	100%	100%	100%	126%	-	100%	-	-
ASKET CROFT	581	1.4	2.5	0.0	0.0	0.5	0.0	4.4	83%	93%	-	-	100%	102%	-	-	100%	-
ASKET HOUSE	470	1.6	1.7	0.0	0.0	0.6	0.0	3.9	102%	60%	-	-	100%	100%	-	-	100%	-
BECKLIN CAU	182	3.9	14.8	0.5	0.0	0.0	0.0	19.2	101%	94%	100%	-	101%	138%	-	-	-	-
BECKLIN WARD 1	726	2.2	3.9	0.2	0.0	0.3	0.1	6.8	88%	207%	100%	-	83%	219%	100%	-	100%	100%
BECKLIN WARD 3	673	2.2	3.4	0.5	0.1	0.4	0.2	6.9	72%	154%	100%	100%	97%	115%	100%	100%	100%	100%
BECKLIN WARD 4	719	2.7	3.3	0.3	0.1	0.2	0.2	6.7	113%	183%	100%	100%	92%	226%	100%	100%	100%	100%
BECKLIN WARD 5	685	2.7	5.7	0.0	0.0	0.4	0.1	8.9	104%	168%	-	-	99%	175%	-	-	100%	100%
MOTHER AND BABY AT THE MOUNT	161	9.6	6.8	0.5	0.0	0.0	0.0	16.9	107%	96%	100%	-	87%	81%	-	-	-	-
NEWSAM WARD 1 PICU	368	4.4	7.9	0.0	0.6	0.7	0.3	13.9	94%	109%	-	100%	95%	124%	-	100%	100%	100%
NEWSAM WARD 2 FORENSIC	363	3.1	10.7	0.0	0.1	0.2	0.4	14.4	103%	141%	-	100%	101%	203%	-	-	100%	100%
NEWSAM WARD 2 WOMENS SERVICES	248	4.6	9.1	1.0	0.0	0.6	0.4	15.6	101%	91%	100%	-	100%	104%	100%	-	100%	100%
NEWSAM WARD 3	404	3.0	4.6	0.0	0.1	0.0	0.0	7.7	107%	84%	-	100%	130%	98%	-	-	-	-
NEWSAM WARD 4	651	2.8	3.4	0.0	0.0	0.2	0.2	6.6	106%	100%	-	-	100%	110%	-	-	100%	100%
NEWSAM WARD 5	1494	0.9	1.2	0.1	0.0	0.5	0.1	2.9	93%	104%	100%	-	92%	114%	100%	-	100%	100%
NEWSAM WARD 6 EDU	574	3.2	9.1	0.3	0.0	1.0	0.2	13.8	165%	1117%	100%	-	102%	381%	-	-	100%	100%
NICPM LGI	412	3.2	2.7	0.0	0.0	0.5	0.0	6.4	103%	108%	-	-	77%	145%	-	-	100%	-
RED KITE VIEW GAU	240	7.3	14.8	0.4	0.0	0.0	0.0	22.5	96%	89%	100%	-	95%	140%	100%	-	-	-
RED KITE VIEW PICU	146	12.0	22.5	0.0	0.0	0.0	0.1	34.6	97%	82%	-	-	100%	123%	-	-	-	100%
THE MOUNT WARD 1 NEW (MALE)	361	4.4	12.3	0.3	0.0	0.0	0.0	17.0	125%	113%	100%	-	94%	228%	-	-	-	-
THE MOUNT WARD 2 NEW (FEMALE)	470	3.5	9.5	0.4	0.2	0.0	0.0	13.6	91%	122%	100%	100%	100%	223%	100%	-	-	-
THE MOUNT WARD 3A	614	2.4	2.9	0.3	0.1	0.0	0.0	5.8	89%	93%	100%	100%	100%	119%	100%	-	-	-
THE MOUNT WARD 4A	664	2.4	4.6	0.2	0.0	0.0	0.0	7.1	94%	133%	100%	-	100%	204%	100%	-	-	-
YORK - BLUEBELL	274	4.2	8.0	0.0	0.0	0.1	0.0	12.4	108%	85%	-	-	110%	96%	-	-	100%	100%
YORK - MILL LODGE	219	7.1	8.4	1.0	0.0	2.4	0.7	19.6	85%	89%	100%	-	79%	144%	100%	-	100%	100%
YORK - RIVERFIELDS	256	4.6	6.1	0.0	0.0	0.6	0.5	11.7	106%	113%	-	-	101%	113%	-	-	100%	100%
YORK - WESTERDALE	341	3.7	6.5	0.0	0.5	0.3	0.4	11.4	130%	93%	-	-	103%	106%	-	100%	100%	100%

Safer Staffing: Inpatient Services April 2026

Fill rate indicator return

Staffing: Nursing, Care Staff and AHPs

Ward name	Cumulative count	Care Hours Per Patient Day (CHPPD)							Day				Night				Allied Health	
		Registred	Non-registred	Registred	Non-registred	Registred	Non-registred	Overall	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill
WardName	PatientCount	CHPPD_R	CHPPD_N	CHPPD_R	CHPPD_N	CHPPD_R	CHPPD_N	CHPPD_O	AvgFR_RNI	AvgFR_NRI	AvgFR_RNI	AvgFR_NRI	AvgFR_RNI	AvgFR_NRI	AvgFR_RNI	AvgFR_NRI	AvgFR_RAI	AvgFR_NRI
2 WOODLAND SQUARE	98	9.8	8.9	1.0	0.0	0.0	0.0	19.6	87%	196%	100%	-	100%	100%	-	-	-	-
3 WOODLAND SQUARE	102	8.5	18.3	1.5	0.0	0.0	0.0	28.3	72%	189%	100%	-	100%	128%	100%	-	-	-
ASKET CROFT	594	1.5	2.4	0.0	0.0	0.7	0.1	4.6	91%	99%	-	-	100%	102%	-	-	100%	100%
ASKET HOUSE	480	1.5	1.6	0.0	0.0	0.6	0.0	3.7	103%	104%	-	-	103%	107%	-	-	100%	-
BECKLIN CAU	174	4.0	14.9	0.5	0.0	0.0	0.0	19.4	101%	93%	100%	-	101%	136%	-	-	100%	-
BECKLIN WARD 1	690	2.2	4.0	0.4	0.0	0.3	0.2	7.1	84%	255%	100%	-	82%	214%	100%	-	100%	100%
BECKLIN WARD 3	657	2.4	3.9	0.4	0.1	0.3	0.2	7.3	82%	171%	100%	-	100%	131%	100%	100%	100%	100%
BECKLIN WARD 4	666	2.8	3.2	0.3	0.2	0.3	0.1	7.0	116%	183%	100%	100%	97%	244%	100%	100%	100%	100%
BECKLIN WARD 5	674	2.6	4.6	0.0	0.0	0.4	0.0	7.7	101%	142%	100%	-	100%	139%	-	-	100%	-
MOTHER AND BABY AT THE MOUNT	150	10.8	8.3	0.5	0.0	0.0	0.0	19.6	121%	88%	100%	-	92%	100%	100%	-	-	-
NEWSAM WARD 1 PICU	343	4.4	8.0	0.0	0.6	0.7	0.1	13.9	83%	105%	-	100%	97%	115%	-	100%	100%	100%
NEWSAM WARD 2 FORENSIC	330	3.2	11.0	0.0	0.0	0.4	0.3	14.8	105%	151%	-	-	100%	175%	-	-	100%	100%
NEWSAM WARD 2 WOMENS SERVICES	244	4.4	9.2	0.6	0.0	0.5	0.5	15.1	98%	92%	100%	-	100%	105%	100%	-	100%	100%
NEWSAM WARD 3	392	2.8	4.9	0.0	0.2	0.1	0.0	7.8	97%	93%	-	100%	118%	100%	-	100%	100%	-
NEWSAM WARD 4	636	2.8	4.3	0.2	0.0	0.3	0.2	7.9	108%	143%	100%	-	100%	153%	100%	-	100%	100%
NEWSAM WARD 5	1455	0.9	1.3	0.1	0.0	0.6	0.1	3.0	93%	112%	100%	-	91%	125%	100%	-	100%	100%
NEWSAM WARD 6 EDU	698	2.3	6.9	0.1	0.0	0.8	0.1	10.2	130%	1058%	100%	-	104%	335%	-	-	100%	100%
NICPM LGI	436	3.1	2.4	0.0	0.0	0.8	0.0	6.3	117%	104%	-	-	80%	143%	-	-	100%	-
RED KITE VIEW GAU	195	8.4	19.6	1.2	0.0	0.0	0.0	29.1	90%	112%	100%	100%	94%	158%	100%	-	-	-
RED KITE VIEW PICU	153	10.3	20.5	0.0	0.0	0.0	0.0	30.8	79%	93%	-	-	100%	104%	-	-	-	-
THE MOUNT WARD 1 NEW (MALE)	422	3.8	11.0	0.4	0.0	0.0	0.0	15.2	157%	140%	100%	-	100%	238%	100%	-	-	-
THE MOUNT WARD 2 NEW (FEMALE)	462	3.4	9.2	0.2	0.3	0.0	0.0	13.2	93%	123%	100%	100%	95%	205%	100%	-	-	-
THE MOUNT WARD 3A	541	2.7	3.1	0.4	0.1	0.0	0.0	6.4	91%	96%	100%	100%	100%	107%	100%	-	-	-
THE MOUNT WARD 4A	635	2.4	4.2	0.2	0.0	0.0	0.0	6.8	96%	132%	100%	-	100%	159%	100%	-	-	-
YORK - BLUEBELL	270	3.8	8.5	0.4	0.0	0.3	0.0	13.0	95%	102%	100%	-	107%	101%	-	-	100%	-
YORK - MILL LODGE	166	8.3	10.1	1.7	0.0	3.2	0.9	24.1	76%	96%	100%	-	86%	137%	100%	-	100%	100%
YORK - RIVERFIELDS	269	4.8	8.7	0.0	0.0	0.4	0.6	14.5	138%	189%	-	-	100%	177%	-	-	100%	100%
YORK - WESTERDALE	330	4.0	6.4	0.0	0.0	0.4	0.4	11.2	138%	81%	-	-	100%	101%	-	-	100%	100%

Meeting of the Board of Directors

September 2026

Safer Staffing Annual Establishment Review Paper

1.0 Executive Summary

This paper presents the findings of the 2026 Safer Staffing Annual Establishment Review across Leeds and York Partnership NHS Foundation Trust's 28 inpatient wards. The review was undertaken in accordance with National Quality Board guidance and Care Quality Commission expectations, using a triangulated methodology that combined Mental Health Optimal Staffing Tool (MHOST) data, quality and workforce indicators, benchmarking information and professional judgement. The purpose of the review was to determine whether current staffing establishments remain sufficient to provide safe, effective and therapeutic care across inpatient services.

Overall, the review provides assurance that the majority of inpatient wards have staffing establishments that remain appropriate to meet patient need. Most services demonstrated alignment between workforce deployment, patient acuity and quality indicators, and therefore require no substantive establishment changes at this time. However, the review also identified a small number of areas where patient complexity, dependency and service demands have increased and where wards are routinely operating above their funded establishments, resulting in an ongoing reliance on temporary staffing or locally agreed staffing uplifts to maintain safe care.

A key theme emerging from the review is the increasing complexity of inpatient populations. This is particularly evident within Rehabilitation, Older People's and Acute Services, where staff described rising demands associated with physical healthcare, frailty, personal care, enhanced observations and therapeutic engagement. Across these services, staffing pressures are not solely driven by occupancy but by the intensity of nursing and support required to meet patients' physical, psychological and relational care needs. While MHOST recommendations generally aligned with service experience, professional judgement remained essential in understanding local service factors, ward environments and emerging risks.

The review identified a limited number of services where substantive establishment changes are recommended. These recommendations are intended to address recurrent staffing gaps, improve workforce resilience and reduce reliance on temporary staffing arrangements that have become embedded within service delivery.

Summary of Establishment Review Outcomes

Ward/Service	Outcome	Key Action
Asket House	Current establishment satisfactory	Routine review only
Asket Croft	Increase staffing establishment recommended	Additional Registered Nurse provision required
Becklin Wards 1 & 5	Current establishment satisfactory	Evaluate impact of previous uplift
Becklin Wards 3 & 4 / Newsam Ward 4	Current establishment satisfactory Increase Ward 4 Newsam budget to align with other acute inpatient wards.	Budget alignment.
Crisis Assessment Unit (CAU)	Increase staffing establishment recommended	Additional night-time Health Support Worker provision
Forensic Wards Leeds	Current establishment satisfactory	Resolve roster and budget alignment
Forensic Wards York	Current establishment satisfactory	Resolve roster and budget alignment
Mill Lodge	Current establishment satisfactory	Routine review only
Mother and Baby Unit	Current establishment satisfactory	Routine review only
NICPM	Current establishment satisfactory	Routine review only
PICU Newsam Centre	Current establishment satisfactory	Routine review only
Red Kite View PICU	Increase staffing establishment recommended	Further consideration through Provider Collaborative
Red Kite View GAU	Current establishment satisfactory	Routine review only
The Mount Ward 1	Shift pattern review recommended	Skill mix redesign
The Mount Ward 2	Shift pattern review recommended	Skill mix redesign
The Mount Ward 3	Current establishment satisfactory	Routine review only
The Mount Ward 4	Increase staffing establishment recommended	Additional health support worker required
Ward 5 Newsam Centre	Current establishment satisfactory	Routine review only
Woodlands 3	Increase staffing establishment recommended	Budget and establishment alignment required
Yorkshire Centre for Eating Disorders	Further service model work required	Review again in six months

The recommended establishment increases focus on five specific areas. At Asket Croft, additional registered nursing capacity is required to strengthen therapeutic interventions, improve care planning and provide greater nursing leadership. At the Crisis Assessment Unit, the review supports formal funding of an additional night Health Support Worker role that is already being deployed operationally to maintain safety and manage demand. At The Mount Ward 4, the evidence demonstrated sustained reliance on temporary staffing to meet increasing patient dependency and physical health needs, supporting a recommendation for additional support worker capacity. 3 Woodlands Square requires its funded

establishment to be aligned with the staffing model already required to operate safely, while Newsam, Ward 4 requires investment to support therapeutic activity and ensure consistency with other acute wards.

The total recurrent investment associated with these recommendations is approximately £531,000 per annum.

In addition to establishment growth, the review identified opportunities to improve staffing models through redesign. For the Mount, Wards 1 and 2, the evidence supported changes to skill mix and deployment rather than an increase in overall numbers. These changes would strengthen registered nurse leadership during daytime hours, increase support overnight when demand is highest and remove twilight shifts that are frequently difficult to fill. Importantly, these recommendations can be achieved at a small cost saving while better reflecting patient needs.

The review also highlighted the ongoing challenge of temporary staffing usage. A number of wards continue to rely on bank and agency staffing to fill substantive vacancies and respond to fluctuating demand. While temporary staffing provides necessary flexibility, a sustained dependence can reduce continuity of care, impact team cohesion and limit opportunities to build therapeutic relationships. The proposed uplifts largely reflect staffing levels that services are already routinely deploying through temporary workforce expenditure and would therefore provide greater stability and consistency for patients and staff.

Alongside establishment reviews, the Trust has implemented a number of workforce initiatives aimed at reducing staffing pressures, including a centralised Healthcare Support Worker recruitment model, targeted recruitment and retention workstreams, and development of local recruitment pathways through education providers. The Trust is also continuing to embed the Enhanced Therapeutic Observations and Care (ETOC) programme, which seeks to improve oversight, standardise practice and reduce reliance on enhanced observation arrangements that can significantly impact workforce demand.

The review concludes that current staffing establishments are appropriate across the majority of inpatient services. However, there is a robust evidence base for targeted establishment growth in a small number of wards where funded establishments no longer fully reflect patient need or operational demand. The recommended changes are expected to improve patient safety, quality of care, therapeutic engagement, workforce resilience and continuity of care while reducing dependence on temporary staffing. Subject to approval, outcome measures will be developed to evaluate the impact of these investments on quality indicators, workforce metrics and patient experience.

It is acknowledged that no additional recurrent funding will be available over and above existing budgets. Consequently, services seeking establishment growth will be required to demonstrate how the costs can be met through increased CIP delivery, efficiency savings, service redesign, or the repurposing of existing resources, ensuring that workforce developments remain financially sustainable.

2.0 Introduction

Leeds and York Partnership NHS Foundation Trust (LYPFT) annual establishment review has been conducted in line with national regulatory requirements. Demonstrating sufficient staffing is one of the fundamental quality and safety standards required to comply with the Care Quality Commission (CQC) regulation. The purpose of this report is to inform the Trust Board of the findings from the annual establishment reviews and any subsequent recommendations relating to the planned establishments reviews in Leeds and York Partnership NHS Foundation Trust inpatient areas to enable safe and effective care to be delivered.

3.0 Background and Context

The establishment review process complies with the requirements set within the [National Quality Board report \(NOB 2016\)](#). The NOB document supports NHS providers to deliver the right staff, with the right skills in the right place, at the right time. It outlines the expectations for nursing and midwifery staffing through the use of a triangulated approach to staffing decisions based on patient's needs, acuity, and risk, using evidence-based tools and the use of professional judgement.

Triangulated approach to staffing decisions



In January 2018, the NOB published an [improvement resource](#) that makes specific reference to how these expectations are adopted within mental health services. The guidance acknowledges that staffing reviews need to consider other inpatient roles that support nursing staff to provide good care; this has been considered in this review.

Leeds and York Partnership NHS Foundation Trust have adopted use of the [Mental Health Optimal Staffing Tool \(MHOST\)](#) as its evidence based mental health workforce tool. The MHOST was created with the support of Health Education England. It has been developed alongside clinical leaders and workforce

staff in Mental Health Trusts and rigorously assessed and validated.

4.0 Establishment Review Process

Prior to any establishment review taking place within the organisation, data collection from a range of sources is required. The process included data collection from a variety of sources which was reviewed and scrutinised at an establishment review outcome meeting attended by senior leaders from across the Trust. The process was applied to all wards across the organisation.

4.1 Purpose

Each review focused on identifying whether the current planned (budgeted) establishments across our inpatient wards remained appropriate to deliver safe and effective care through the application of the triangulated approach including the use of MHOST data, quality indicators and professional judgement.

4.2 Scope

Leeds and York Partnership NHS Foundation Trust provides inpatient care across 28 Mental Health and Learning Disability Wards. Establishment reviews were carried out on all inpatient areas.

4.3 MHOST Use and Data Collection

The data collectors for each ward were either Band 6 or 7 Registered Nurse's (RNs) or Allied Health Professionals (AHP's) and were kept to a minimum (2-3 colleagues) to ensure consistency. Each ward carried out inter-rater reliability.

The first MHOST data collection period was completed in September 2023 with a further data collection completed every 6 months. Each year, two MHOST data collection periods provide the data to support evidence-based workforce planning. Two sets of data collection of 28 days are required as a minimum before the data should be considered as part of the staffing establishment planning.

4.4 Quality Indicator and Workforce Metrics

Examples of what can be considered as a quality indicator are listed within the NQB guidance. Services were asked to consider any quality indicators that may be particularly important to their service. This data was then taken from the Trusts ECHO system for the previous 12 months. This information was gathered by either Professional Lead Nurses, Head of Nursing, or the individual service.

Examples of quality indicators include but were not limited to:

- Incidents including serious incidents
- Staff metrics including sickness, stress, or mental health related sickness
- Clinical supervision, appraisal, and compulsory training compliance
- Length of stay
- Complaints
- Service user feedback

In addition, benchmarking data was used. This included inpatient wards across Leeds and York Partnership NHS Foundation Trust and also other mental health organisations inpatient areas of a similar function i.e. female acute inpatient.

The data described above was reviewed collectively and considered based on the professional judgement of those in the room throughout the meeting. Professional judgement can be described as the use of accumulated knowledge and experience in order to make an informed decision. A professional judgement framework was referred to in order to support discussions.

The outcome of the review of data and discussion led to recommendations for each clinical area.

5.0 Results

It was found that many wards were routinely utilising excess staffing above that of their agreed baseline establishments. It was acknowledged that this does not automatically lead to the need for an increase in establishment and in some clinical areas the review of clinical practice was required before further consideration of any increase to staffing is recommended. The process and analysis via the MHOST tool suggests that additional staffing is however required in some areas based on the triangulated approach.

5.1 Summary of Key Points from Establishment Reviews

Ward	Outcome	Actions
Asket House	Current establishment satisfactory	Review in line with routine establishment review.
Asket Croft	Recommendation to increase staffing establishment	
Becklin Wards 1 & 5	Current Establishment Satisfactory	The staffing uplift agreed through last year's establishment review was not in post at the point of review. The impact of this uplift will need to be evaluated once fully embedded. Consideration will be given, via the clinical model review, to the introduction of a substantive Band 7 Clinical Leadership role within the acute admission wards through skill mixing/repurposing of establishment.
Becklin Wards 3 & 4, Newsam Ward 4	Current Establishment Satisfactory Ward 4 Newsam budget to be uplifted to align to the remaining Acute Ward Budgets.	The staffing uplift agreed through last year's establishment review was not in post at the point of review. The impact of this uplift will need to be evaluated once fully embedded. Consideration will be given, via the clinical model review, to the introduction of a substantive Band 7 Clinical Leadership role within the acute admission

		wards through skill mixing/repurposing of establishment.
Crisis Assessment Unit (CAU).	Recommendation to increase staffing establishment	
Forensic Wards Leeds (provider collaborative)	Current Establishment Satisfactory	There was a misalignment between the roster and budget. A meeting was subsequently required with the Service Operational Managers, Finance, and People Analytics to resolve.
Forensic Wards York (provider collaborative)	Current Establishment Satisfactory	There was a misalignment between the roster and budget. A meeting was subsequently required with the Service Operational Managers, Finance, and People Analytics to resolve.
Mill Lodge (Provider Collaborative)	Current Establishment Satisfactory	Review in line with routine establishment review.
Mother and Baby Unit	Current Establishment Satisfactory	Review in line with routine establishment review.
National Inpatient Centre for Psychological Medicine (NICPM)	Current Establishment Satisfactory	Review in line with routine establishment review.
PICU Newsam Centre	Current Establishment Satisfactory	Review in line with routine establishment review.
Red Kite View PICU (provider collaborative)	Recommendation to increase staffing establishment	To provide summary information to the Provider Collaborative for review.
Red Kite View GAU (provider collaborative)	Current Establishment Satisfactory	Review in line with routine establishment review.
The Mount Ward 1	Recommendation to adjust shift patterns.	
The Mount Ward 2	Recommendation to adjust shift patterns.	
The Mount Ward 3	Current Establishment Satisfactory	Review in line with routine establishment review.
The Mount Ward 4	Recommendation to increase staffing establishment	
Ward 5 Newsam Centre	Current Establishment Satisfactory	Review in line with routine establishment review.
Woodlands 2 & 3	Recommendation to increase staffing establishment in Woodlands 3	A misalignment between the roster establishment and the budgeted establishment was identified and has been resolved through the establishment review process.

Yorkshire Centre for Eating Disorders (YCED) (provider collaborative)	Further improvement and model design work required. No change at present.	Current work being undertaken within the service in relation to the use of enhanced therapeutic observation and care, the clinical model and visits to other eating disorder units. To review establishment in six months.
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5.2 Areas with Recommendations to Increase Leeds and York Partnership NHS Foundation Trust Staffing Establishment

The evidence reviewed demonstrated that a small number of LYPFT's inpatient wards are under resourced resulting in a reliance on increasing the safer staffing workforce each duty based on clinical need. Temporary workforce is predominantly used to fill these duties.

The staffing establishment review has enabled evidence based recommendations to be made to increase the staffing establishment in some clinical areas. However, there are areas where no increase in the establishment has been recommended and there continues to be significant use of temporary staffing. This can be for a number of reasons including vacancies within the substantive workforce, sickness and increased staffing due to patient need which may fluctuate over time.

To support areas where there is increased use of temporary staffing, there is focused work taking place on the recruitment of Health Support Workers which had led to a change in the recruitment process. There are three workstreams focused on the Health Support Worker workforce which looks at recruitment, retention and workforce redesign. Together these workstreams aim to reduce the number of Health Support Worker vacancies in the Trust which in turn will reduce the number of temporary staff being used.

The new monthly centralised recruitment approach is now underway. It is anticipated that this initiative will result in a minimum of 8 new Healthcare Support Worker (HSW) recruits joining the organisation each month. However, as the programme remains in its early stages, further evaluation and analysis will be required over the next 3-6 months to fully assess its impact and effectiveness.

In addition, work is underway with local colleges to develop recruitment pathways for 16 graduates from healthcare related programmes, further expanding and strengthening the pool of potential applicants which should increase the number of recruits further.

It has been agreed that a further 10 Health Support Worker vacancies will be recruited to with our Preceptee Registered Nurses which will benefit both the reduction in Health Support Worker vacancies and in turn a reduction in Bank staffing alongside supporting our new nurses to be allocated a Registered Nurse role. These posts will be converted back when a substantive Registered Nurse post becomes available.

The Trust remains engaged in the Enhanced Therapeutic Observations of Care (ETOC) Programme. The programme is a national initiative addressing the rise in observation and engagement practices across inpatient wards, which are now recognised as restrictive practice. Leeds and York Partnership NHS Foundation Trust wards show elevated staffing due to Enhanced Therapeutic Observations and Care (ETOC) demands.

The programme aims to:

- Standardise training and competencies for all staff, including temporary workers.
- Improve oversight, data collection, and reflective practice.
- Ensure registered professionals lead complex Enhanced Therapeutic Observations and Care (ETOC) interventions.
- Reduce reliance on temporary staff by refining care delivery models.

The Trust has made substantial progress in advancing the programme, with enhanced oversight of Enhanced Therapeutic Observations and Care (ETOC) provision and commencing the development of training programmes for staff. Enhanced Therapeutic Observations and Care (ETOC) leads have supported services with higher levels of ETOC utilisation to strengthen delivery approaches and optimise multidisciplinary team involvement in supporting people requiring enhanced levels of engagement and observation. Further work with clinical and operational leaders will focus on embedding Enhanced Therapeutic Observations and Care (ETOC) principles into routine practice and identifying opportunities to reduce reliance on temporary staffing through sustainable workforce solutions.

Targeted improvement work has commenced in clinical areas with the highest utilisation of Enhanced Therapeutic Observations and Care (ETOC), beginning with Connect Ward 6. This is being delivered through a collective leadership approach, supported by a dedicated improvement action plan. Performance trajectories and outcome measures are currently being developed to monitor progress, evaluate impact, and drive sustained improvement.

It is anticipated that, collectively, the two workstreams noted above will contribute to reducing staffing pressures and enhance the quality of care provided. Ongoing monitoring will include an assessment of temporary staffing usage to determine whether these changes lead to a reduction in reliance on our temporary workforce.

5.3 Recommendations From the Establishment Review Process

The following information sets out the current evidence using the MHOST data, quality indicators and benchmarking data outlining and leading to, the recommended outcomes.

Asket Croft

Asket Croft is a community based rehabilitation unit. It is part of the Trusts Level 1 rehabilitation service under the Complex Psychosis Pathway, alongside Asket House. The aim of the service is to enable people to define, build and live a meaningful, independent and satisfying life.

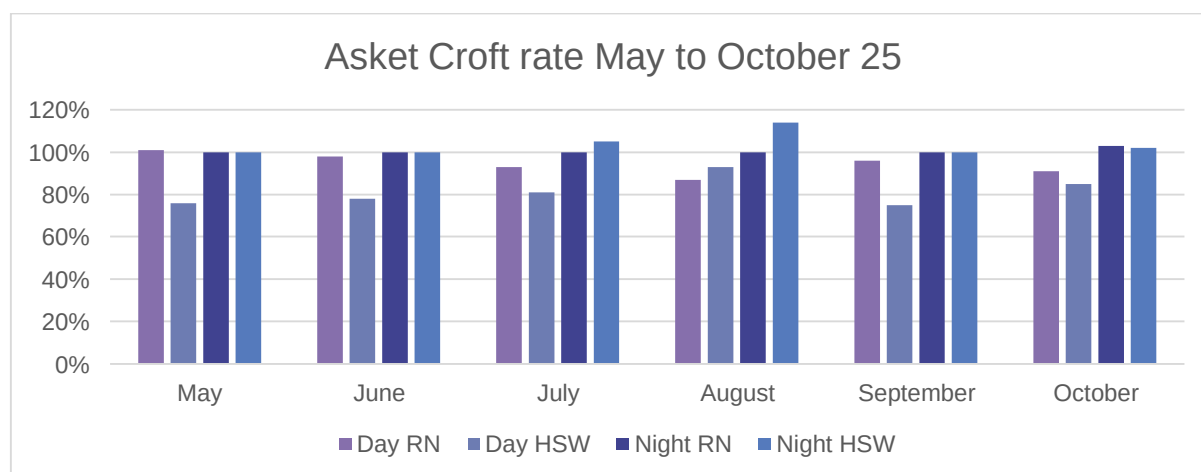
Asket Croft is a 20 bedded mixed gender community inpatient unit that provides a supportive setting for service users in the early stages of their recovery who have a higher level of need compared to the adjacent unit, Asket House.

Below is the current WTE, the MHOST recommendations described within the establishment review and the actual worked for November and December 2025.

Ward	Total Budget WTE (excluding headroom 22%)	MHOST WTE Recommendation	Total worked including bank/agency 2-month trend Sept-Oct 2025
Asket Croft	15.3	14.9	13.94

Although the budget, MHOST recommendation, and total worked during September to October 2025 are closely aligned, it is important to note that this does not take into account the experience of the staff team in delivering quality rehabilitation within the environment. The team describe challenges, particularly in the nursing workforce in delivering specific interventions. This is a particular challenge in the morning where much of a Registered Nurses time is taken up with medication rounds and shift coordination. This can significantly reduce the time available to nurses to spend therapeutic time with those individuals they are allocated to and support their recovery. The afternoons can see increased activity particularly with rehab interventions

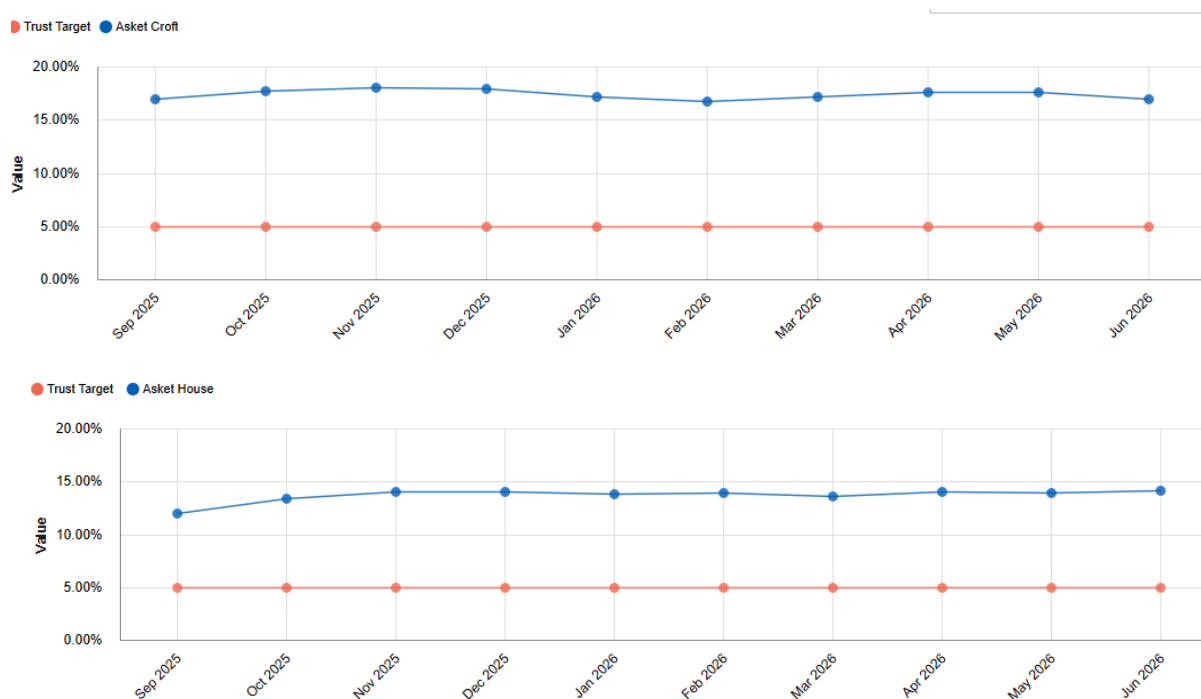
The below graph details the fill rate between May and October 2025 for Asket Croft:



Both units at Asket House and Asket Croft have significant amounts of flexible working and sickness levels are high. This is often due to a history of redeployments into the clinical area for staff with long term health conditions. This subsequently can impact on staffing availability due to sickness and challenges with managing rosters to meet the agreed flexible working arrangements. The leadership team within the service are being supported by HR colleagues in relation to sickness management processes and reviews of flexible working agreements in line with trust procedures.

Below are the sickness levels for Asket House and Asket Croft over the last 12 months which have been

consistently above the Trust target.



The current staffing establishment that Asket Croft currently work on is:

- Early Shift
1 Registered Nurse and 2 Health Support Workers
- Late Shift
1 Registered Nurse and 2 Health Support Workers
- Night shift
1 Registered Nurse and 2 Health Support Workers

In addition, Asket Croft has the following:

- 1 Band 6 Occupational Therapist
- 2 Band 5 Occupational Therapist
- 0.2 Psychologist
- 1 Administrator
- Medical staff

They also have a number of roles split cross the Complex Psychosis Pathway including:

- Dietician
- Healthy Living Advisor
- Band 7 Occupational Therapist
- Social Worker due to commence in post

The unit also uses a Registered Nurse on a 9-5 shift when there are MDT days on Tuesdays and Wednesdays. The Occupational Therapists also work within the establishment at times within the week, whilst having some time supernumerary to focus on specific interventions.

The below table details the overspend in staffing to meet the clinical demand. There have been significant absences within the service which have impacted on bank spend.

2025-2026 Financial Position			Variance from budget £			
Ward	Funded WTE	Annual Pay Budget	Substantive	Agency	Bank	Total
Asket Croft	20.15	£946,077	£41,944	£4,329	£131,062	£93,448

Recommendation

It is recommended that Asket Croft increases its Registered Nurse provision during the day taking them to:

- Early Shift
2 Registered Nurses and 2 Health Support Workers
- Late Shift
2 Registered Nurses and 2 Health Support Workers
- Night Shift
1 Registered Nurse and 2 Health Support Workers

This increase will support the service users and the team with the quality of care being delivered. It will increase Registered Nurse provision to support service users with nursing specific interventions, providing supervision to others and supporting the teams to work more effectively, providing more time for the development of care plans, robust documentation and managing increasing complexity within the service. It is anticipated that increased nursing intervention, alongside the wider MDT, will support the recovery of service users and aid in their progression in the rehab pathway, impacting on patient experience and length of stay.

Asket Croft provides more intensive support than Asket House and require increased intervention and support from the staff team and therefore increased resource.

The below considers the WTE and cost change required to increase the staffing establishment without including any of the shifts worked by OTs in the baseline establishment

Ward Type	Ward Name	Divided by Hours	
		WTE Change	Cost Change
Rehabilitation	Asket Croft	3.0	£157,419

Benchmarking Data

The benchmarking information is in relation to those counted within the baseline establishment and does not consider additional roles.

Ward type	Bed numbers	Early	Late	Nights (12 hours)
Rehabilitation	18	6	6	4
Rehabilitation	14	4	4	2
Rehabilitation	23 across 5 Bungalows	5 (2 Registered Nurse, 3 Health Support Workers)	5 (2 Registered Nurse, 3 Health Support Workers)	4 (2 Registered Nurse, 2 Health Support Workers)

The benchmarking data indicates that from a Nursing and Health Support Worker perspective, similar settings, some with a lower bed base, have a higher baseline establishment compared to Asket Croft.

The Mount - Ward 1 & 2

Ward 1 and Ward 2, The Mount are Female and Male Dementia Wards for service users with a clear diagnosis of dementia of any age and have BPSD (Behaviours and Psychological Symptoms of Dementia). Ward 1 is 14 bedded Male Dementia Ward and Ward 2 is a 15 bedded Female Dementia Ward.

The current staffing establishment for each ward is below:

- Early/Late Shift
2 Registered Nurses and 5 Health Support Workers
- 9-5
1 Registered Nurse
- Twilight
1 Registered Nurse and 1 Health Support Worker
- Night Shift
2 Registered Nurses and 3 Health Support Workers

The ward also has:

- Activity Coordinators
- Medical Team
- Ward Manager
- Occupational Therapy
- Psychologist.

The team also have input from wider MDT members such as Physio, Dieticians, Speech and Language Therapy, a Geriatrician and Healthy Living Service.

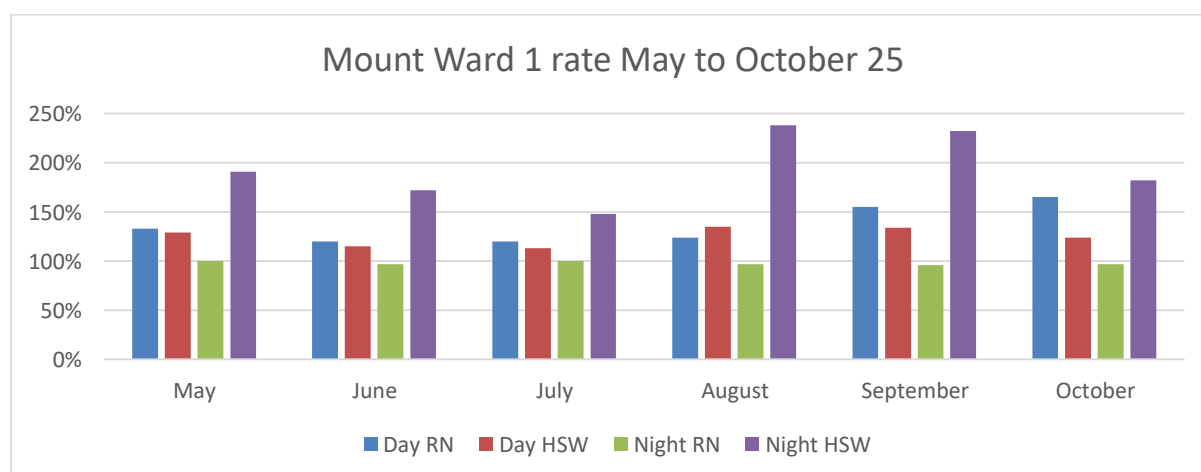
Below is the current WTE, the MHOST recommendations described within the establishment review and the actual worked for September and October 2025.

Ward	Total Budget WTE (excluding headroom 22%)	MHOST WTE Recommendation	Total worked including bank/agency 2 month trend Sept-Oct 2025
Ward 1	29	25.6	51.2
Ward 2	30.5	26.6	47.4

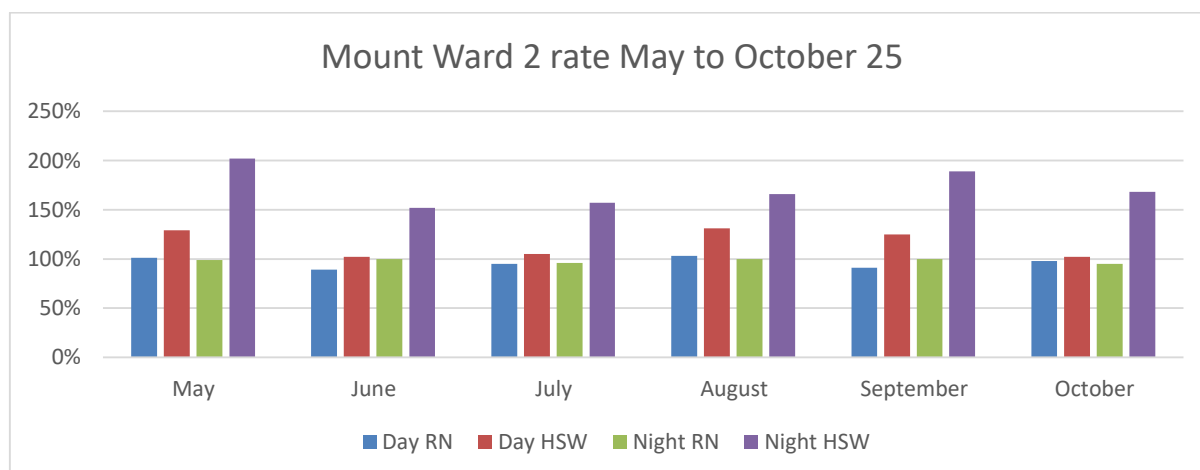
On both wards, the shifts worked compared to the budgeted establishment is significantly higher, with the wards seeing an overspend and reliance on the use of temporary staffing to meet the needs of the patients on the ward. The teams describe increased frailty within the population since covid, increasing physical health needs and monitoring within the service. This impacts on activity on the ward in delivering personal care and also off the ward, supporting patients to appointments and to the Acute Trust for assessment and admission where required for example after a fall or deterioration in physical health.

Ward 1 had 23% additional duties and Ward 2 had 17%. Some of these additional duties may be in relation to adjusted skill mix, particularly on Ward 2 where there was a 21.8% Registered Nurse vacancy rate that may be covered by Health Support Workers, however, it also suggests that teams are working over the baseline establishment, with the fill rate graphs below supporting this.

The below graph details the fill rate between May and October 2025 for Ward 1:



The below graph details the fill rate between May and October 2025 for Ward 2:



Both fill rates indicate that night shifts for Health Support Workers are consistently staffed above the baseline establishment on both wards.

The team describe increased leadership and management responsibilities within the wards due to high numbers of staff. This includes supporting supervision, appraisal and absence for compulsory training. They also describe that night shifts can often be very busy due to the nature of a dementia ward and the support required to patients overnight. This is reflected within the use of increased staffing above the establishment being particularly evident at night.

The team indicated that they currently have twilight shifts built into the rosters and that these can often be unfilled and therefore feel that that distribution of staff as well as skill mix should be considered.

The below table details the overspend in staffing to meet the clinical demand, all wards are underspent on substantive pay due to vacancies within the service.

2025 - 2026 Financial Position			Variance from budget £			
Ward	Funded WTE	Annual Pay Budget	Substantive	Agency	Bank	Total
Ward 1	47.65	£2,059,557	-£456,820	£81,430	£795,888	£420,498
Ward 2	47.66	£2,040,510	-£598,609	£141,897	£966,688	£509,976

Recommendation

It is recommended that:

- Day Shift
3 Registered Nurses and 4 Health Support Workers
- Twilight
Remove
- Night Shift
2 Registered Nurses and 4 Health Support Workers

The increase in Registered Nurses during the day would support the shifts with nursing specific duties such as medicines administration, shift coordination and leadership. Due to the number of staff employed on the two wards, the availability of registered staff to provide leadership and support to the team is essential in the delivery of safe, high quality care. This would include providing supervision, supporting with appraisals and increasing availability of Registered Nurses to support physical health interventions and personal care.

The below table details the cost associated with the recommended changes in the staffing establishment.

Ward Type	Ward Name	WTE Change	Cost Change
Dementia	Ward 1	-0.79	-£16,159
Dementia	Ward 2	-0.79	-£13,316

Due to the removal of the two twilight shifts on each ward, the skill mix change and addition of 1 Health Support Worker at night sees a cost saving for both wards. The changes will require a Quality Impact Assessment prior to changes taking place.

Benchmarking Data

Ward Type	Early/Late Shift	Alternate Shifts	Night Shift
Mixed Dementia (12 Beds)	2 Registered Nurses and 7 Health Support Workers		2 Registered Nurses and 6 Health Support Workers
Male Dementia (16 Beds)	1 Registered Nurse and 7 Health Support Workers		1 Registered Nurse and 6 Health Support Workers
Mixed Dementia and Functional Ward (16 Beds)	2 Registered Nurses 2 Health Support Workers 1 Registered Nurse (Monday + Thursday) 1 band 6 Registered Nurse (Monday, Tuesday, Thursday)	1 Registered Nurse (Twilight 16.40-23.00)	1 Registered Nurse and 2 Health Support Workers
Mixed Dementia and Functional Ward (16 Beds)	2 Registered Nurses and 2 Health Support Workers	1 Activity Worker 9-5 Monday to Thursday and 1 Registered Nurse Monday to Friday	1 Registered Nurse and 3 Health Support Workers.

Those wards above that are solely dementia wards, work on higher numbers of staff at night than Wards 1 and 2 with a similar or lower bed base supporting the recommendation to increase the budgeted establishment overnight,

The Mount - Ward 4

Ward 4 at the Mount is a 21 bedded Female Functional Older Adult Inpatient Ward. The ward cares for

people with a range of mental health conditions, with the majority being over the age of 65 however, at times may have younger people dependent upon need. This ward has one more bed than the other functional ward for older people at the Mount.

The current staffing establishment is:

- Early shift
2 Registered Nurses and 4 Health Support Workers/Nursing Associates/Associate Practitioners.
- 9-5
1 Registered Nurse Monday to Friday.
- Late shift
2 Registered Nurses and 3 Health Support Workers/Nursing Associates/Associate Practitioners.
- Night shift
2 Registered Nurses and 2 Health Support Workers/Nursing Associates/Associate Practitioners.

The ward has a 9-5 Registered Nurse on duty from Monday to Friday to support with MDT reviews.

The ward also has a wide MDT including:

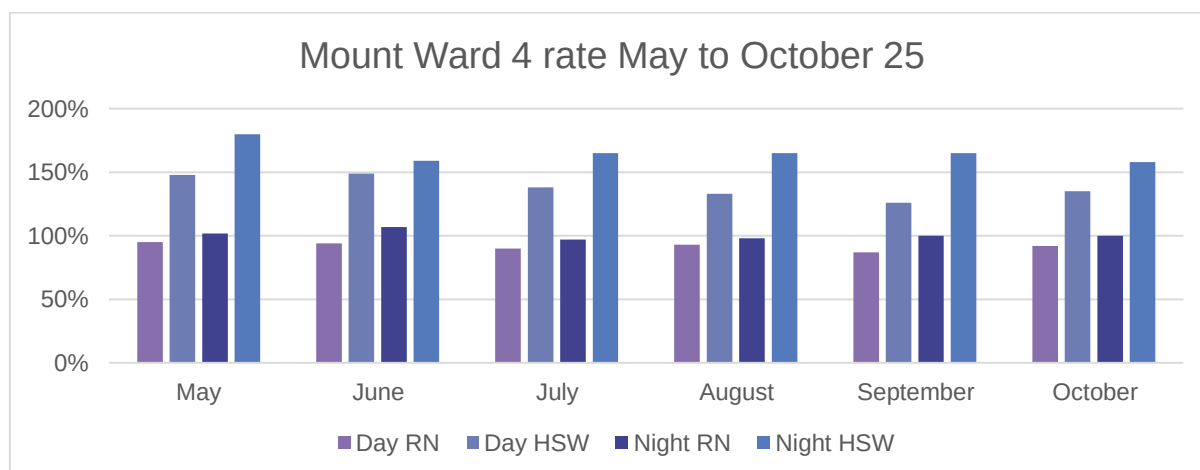
- 1 Ward Manager
- Band 6 Occupational Therapist.
- Band 5 Occupational Therapists.
- Activity Coordinators.
- Medical team.

The team also has support from wider MDT members, the Healthy Living Services and a Geriatrician.

Below is the current WTE, the MHOST recommendations described within the establishment review and the actual worked for November and December 2025.

Ward	Total Budget WTE (excluding headroom 22%)	MHOST WTE Recommendation	Total worked including bank/agency 2-month trend Nov- Dec 2025
Ward 4	22.9	29	36.31

The service described a challenging winter period across The Mount which saw a particular increase in staffing during this time. However, the below graph details the fill rate between May and October 2025 for Ward 4 which indicates that there has been use of increased numbers of Health Support Workers that has been sustained over a period of time both during the day and at night.



Shifts covered by bank or agency during the data period for the establishment review was 36.8% with 15.4% being additional duties showing the increase in demand above the establishment. The wards MHOST indicated a requirement of 12.5 Registered Nurses and 16.5 Health Support Workers which is higher than the current budgeted establishment without headroom of 10.8 Registered Nurses and 13.4 Health Support Workers. The clinical team felt that the MHOST outcomes aligned with the reality of working on the ward.

The below table details the overspend in staffing to meet the clinical demand, all wards are underspent on substantive pay due to vacancies within the service. There was a total overspend of £218,058,

2025 - 2026 Financial Position			Variance from budget £			
Ward	Funded WTE	Annual Pay Budget	Substantive	Agency	Bank	Total
Ward 4 Mount	35.88	£1,579,225	£463,935	£82,367	£599,626	£218,058

The ward has seen supervision rates below the Trust target and describe prioritising patient care which can make it challenging to maintain clinical supervision rates. The team describe significant time being required supporting patients to attend both planned medical appointments and also support them with care required at the acute Trust that may be unplanned and in response to an incident such as a fall or a deterioration in physical state. Environmental factors also impacted on staff time such as being on the top floor and time being taken to support patients to fresh air and ensuring staff are available in the ward environment where there are challenges with line of sight.

The team describe that requirements for increased staffing are more often associated with higher patient dependency levels than with clinical presentation, with patients requiring additional support for personal care, physical health monitoring, and related interventions.

Benchmarking Data

The below benchmarking information relates to two mixed functional and organic older peoples ward with 16 beds, 5 less than Ward 4.

Ward Type	Early/Late Shift	Alternate Shifts	Night Shift
Mixed Dementia and Functional Ward.	2 Registered Nurses 2 Health Support Workers 1 Registered Nurse (Monday + Thursday) 1 band 6 Registered Nurse (Monday, Tuesday, Thursday)	1 Registered Nurse (Twilight 16.40-23.00)	1 Registered Nurse and 2 Health Support Workers
Mixed Dementia and Functional Ward	2 Registered Nurses and 2 Health Support Workers	1 Activity Worker 9-5 Monday to Thursday and 1 Registered Nurse Monday to Friday	1 Registered Nurse and 3 Health Support Workers.

Recommendation

Based on the MHOST outcomes, the quality data and the professional judgement described within the establishment review, it is recommended that the baseline establishment is increased by one per shift. It was discussed that this would be for a Health Support Worker or Nursing Associate to support with the personal care of patients throughout the day and non nurse specific duties. The recommended establishment for the ward is as follows:

- Early shift
2 Registered Nurses and 5 Health Support Workers/Nursing Associates/Associate Practitioners.
- 9-5
1 Registered Nurse Monday to Friday.
- Late shift
2 Registered Nurses and 4 Health Support Workers/Nursing Associates/Associate Practitioners.
- Night shift
2 Registered Nurses and 3 Health Support Workers/Nursing Associates/Associate Practitioners.

The uplift would reduce reliance on temporary staffing which have been used consistently over a period of time to meet the needs of the ward population. Introducing increased numbers of substantive staff will support continuity of care for those within the environment alongside relational security.

The below table details the cost associated with the recommended uplift in staffing establishment.

Ward Type	Ward Name	WTE Change	Cost Change (Health Support Worker)	Cost Change (Nursing Associate)
Older Peoples Functional	Ward 4	6.04	£256,368	£278,870

Crisis Assessment Unit

Crisis Assessment Unit (CAU) is a six-bed inpatient unit that originally comprised of 3 male and 3 female beds, accepting admissions for adults experiencing acute and complex mental health crises. It provides short-term admission in a safe and therapeutic environment to support further assessment for up to 72 hours. Since July 2025, the service has been operating as a 6 bed Female Acute Admission Ward.

The roster and budget for the Crisis Assessment Unit, Street Triage and Section 136 Suite are managed on a combined basis. As a result of these integrated roster and budget arrangements, it is difficult to identify the specific budget allocation for the Crisis Assessment Unit separately. The effective delivery of the service is dependent on a whole service approach, with staff working across all three areas to ensure safe, high-quality care is maintained. This collaborative model also facilitates appropriate rest breaks for staff, supporting their wellbeing and helping to sustain the provision of effective care and treatment.

Section 136 Suite is a health based place of safety where individuals detained by the police under the Mental Health Act can be safely assessed and supported during a mental health crisis. In addition, the service covers the street triage which provides expert advice to emergency services such as police and carries out assessments in the community when indicated alongside supporting in the decision making for section 136 assessments.

The current staffing establishment allocated for the service is:

- Early/Late shift
3 Registered Nurses and 4 Health Support Workers
- Night shift
3 Registered Nurses and 4 Health Support Workers (Budgeted for 3 Registered Nurse and 3 Health Support Workers)

The Crisis Assessment Unit has recently increased night staffing by one Health Support Worker to support safer staffing levels, provide adequate staffing for PMVA incidents and enable staff to take appropriate rest breaks. However, this additional resource has not yet been reflected within the budget allocation.

The current staffing establishment allocated for CAU is:

- Early/Late shift
1 Registered Nurse and 1 Health Support Worker
- Night shift
1 Registered Nurse and 2 Health Support Workers (Budgeted for 1 Registered Nurse and 1 Health Support Worker)

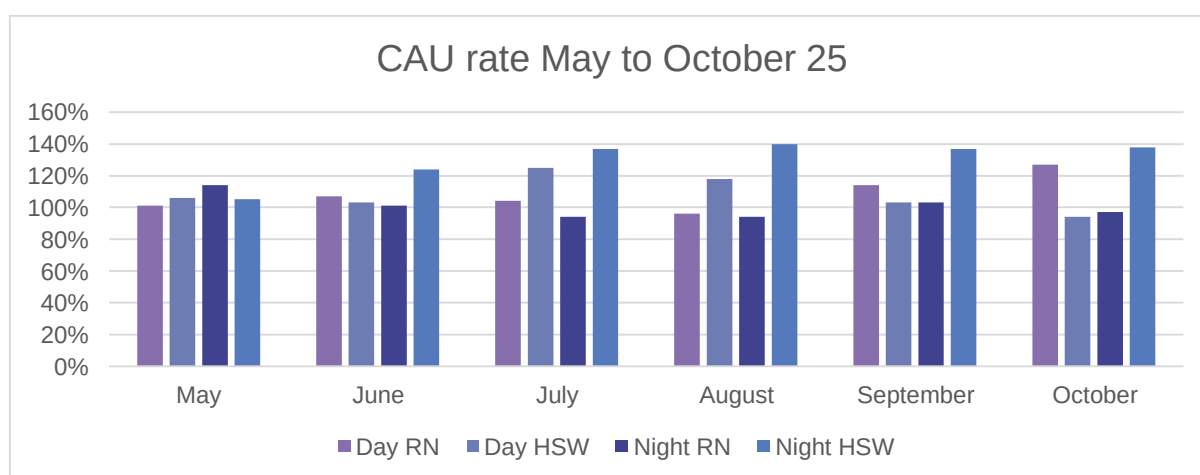
In addition, CAU has the following

- 1 Ward Administrator
- 1 Band 3 Activity Coordinator tends to work the core hours Monday to Friday 9am-5pm, this role which was funded from the Health Support Worker vacancies.

The MHOST data suggests a reduction in staffing; however, it is important to note that the analysis does not consider the alignment of the Crisis Assessment Unit with the Section 136 Suite, nor the nursing hours required to meet assessed need, particularly when flex beds are in use. In addition, the MHOST recommendation does not provide sufficient safer staffing figures to meet PMVA requirements, highlighting the need for the application of professional judgement. The budgeted establishment and total worked is closely aligned.

Ward	Total Budget WTE RN & HSW (excluding headroom 22%)	MHOST WTE Recommendation (CAU only)	Total worked including bank/agency 2-month trend Sept-Oct 2025
CAU, Section 136, Street Triage	27.8	12.6	28.8

The below graph details the fill rate between May and October 2025 highlights that CAU is working over the budgeted establishment for Health Support Workers.

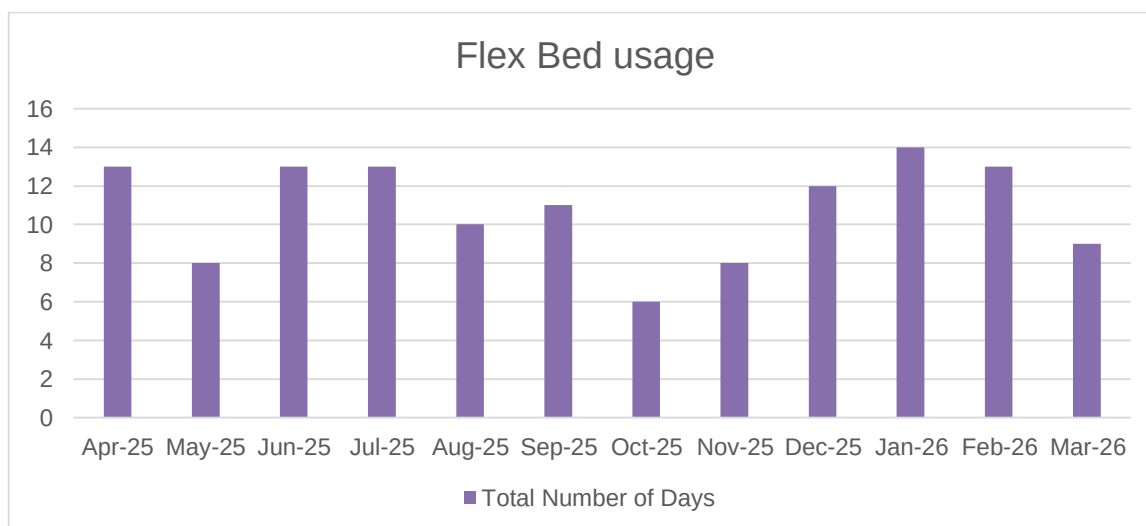


The below table details the overspend in staffing to meet the clinical demand, the service is underspent on substantive pay due to vacancies within the service. The vacancy rate in the Crisis Assessment Unit for Registered Nurses was 6.4% and 30.4% for Health Support Workers in January 2026. However, this vacancy rate is predicted to reduce in the future with the recruitment of preceptee nurses and centralised health support worker recruitment.

2025 - 2026 Financial Position			Variance from budget £			
Ward	Funded WTE (All Roles)	Annual Pay Budget	Substantive	Agency	Bank	Total
CAU, Section 136, Street Triage	39.72	£2,065,403	£413,640	£46,683	£323,828	£43,129

The use of flex beds within a Section 136 Suite refers to the temporary use of an additional bed to manage periods of increased demand, enabling safe assessment and care of individuals detained under the Mental

Health Act while maintaining flexibility within the service. The below table details the number the usage of flex bed within the past 12 months. The occupancy rate of flex beds usage ranges from 6 to 14 days each month with an overall average of 9.75 days.



The current staffing establishment allocated for the Section 136 Suite is:

- Early/Late shift
1 Registered Nurse and 2 Health Support Workers
- Night shift
1 Registered Nurse and 1 Health Support Workers

This staffing resource will provide the staffing establishment required to deliver care and treatment to service users occupying flex beds, as well as those brought to the unit by the police for assessment under Section 136.

The service operates as a fluid model, with all three areas working collaboratively to provide mutual support during periods of increased activity and demand. However, rising demand within the flex beds and other areas of the service can place additional pressure on staffing resources, resulting in operational challenges.

Benchmarking Data

Unfortunately, comparable benchmarking data was not available, as the service operates a unique model that brings together three distinct service areas, each with different roles and responsibilities, within a single service line.

Recommendation

It is recommended that the Crisis Assessment Unit increases its by 1 Health Support Worker on the night shift. Thus, increasing the total safer staffing numbers taking them to:

- Early/Late Shift
1 Registered Nurse and 1 Health Support Worker
- Night Shift
1 Registered Nurse and 2 Health Support Workers

An increase to the establishment will reduce the reliance on temporary staff; substantive staff will provide both consistency and relational security which in turn will positively impact on the quality of care delivered. Research highlights that incidents such as aggression occurred more when there were fewer staff members in the milieu, there was an absence of regular staff, or when patients were unfamiliar with the staff. The highest proportion of patient safety incidents which occur in the Crisis Assessment Unit are incidences of violence and aggression.

Increasing the staffing establishment within the Crisis Assessment Unit will provide greater workforce resilience and enhance the service's ability to respond effectively to fluctuations in demand, while also supporting safer staffing requirements for the management of PMVA incidents. The ward faces additional challenges relating to its environmental layout, which limits visibility from the nurses' station and necessitates the continuous presence of a staff member within the day area and wider ward environment to maintain patient observation and safety.

This increase in staffing capacity will help ensure the delivery of safe and effective care, maintain appropriate staffing levels across the service, and enable staff to take adequate rest breaks. The ward has been operating with these clinical staffing levels; however, the finance budget has not been updated to reflect this requirement. The table below outlines the costs associated with this staffing uplift.

Ward Type	Ward Name	WTE Change	Cost Change
Working Age Adult Acute	CAU	1.61	£47,470
	Total	1.61	£47,470

Newsam - Ward 4

Ward 4, Newsam Centre is a twenty-one bedded ward. The shift patterns include long days (12 hours) and a combination of early and late shifts (7.5 hours) with most staff working long days. The data reflects moderate vacancy issues across both Registered Nurse (16.1%) and Health Support Worker (17.6%) grade types in Newsam 4 which is being managed through Bank.

As the service has one fewer bed than the other adult acute admission wards, it has not historically been allocated an Occupational Therapy Assistant budget, unlike those wards. This impacts the provision of structured activities on the unit. Evidence indicates that meaningful activities can have a positive effect on service user experience and contribute to a reduction in incidents.

The current staffing establishment is:

- Early/Late shift
3 Registered Nurses and 3 Health Support Workers
- Night shift

2 Registered Nurses and 3 Health Support Workers

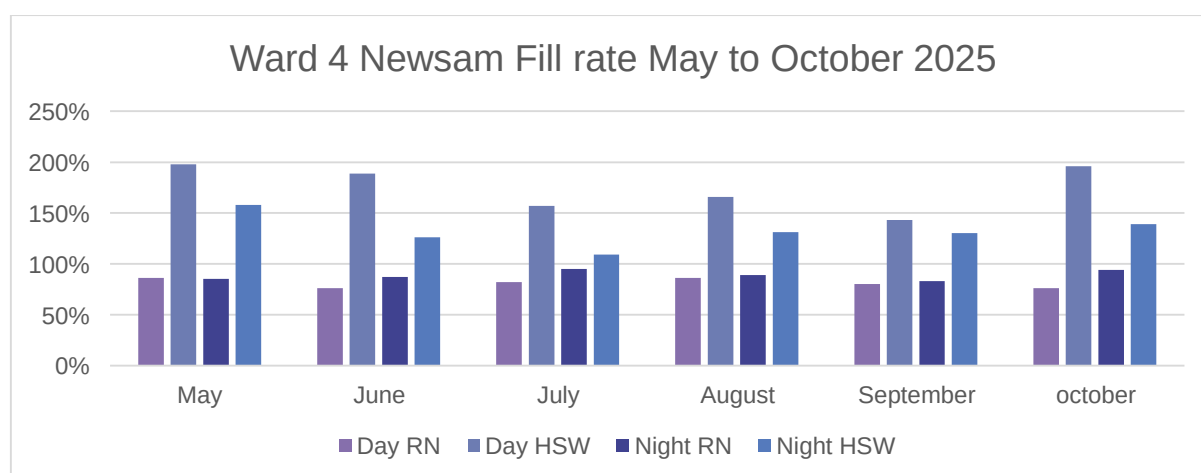
In addition, ward 4 Newsam has the following

- 1 Ward Manager
- 1 Ward Administrator
- 0.5 Band 6 Occupational Therapist
- 1 Band 5 Occupational Therapist
- 2 Nursing Associates
- 1 Peer Support worker
- 0.25 Practice Development (2 WTW across the service)

The MHOST data suggests the budgeted staffing establishment for ward 4 Newsam is correct, with it almost perfectly aligning with the MHOST data. The total worked is lower which reflects the vacancy rate and various types of leave within the workforce during the data collection period.

Ward	Total Budget WTE RN and HSW (excluding headroom 22%)	MHOST WTE Recommendation	Total worked including bank/agency (2 months trend)
Ward 4 Newsam	27.06	27.6	19.91

The below graph details the fill rate between May and October 2025 highlighting that Ward 4, Newsam Centre is working under the budgeted establishment for Registered Nurse and over the budgeted establishment for Health Support Workers. There were several Registered Nurse vacancies and staff redeployments within the ward during the data collection period, which impacted on this position.



The below table details the overspend in staffing to meet the clinical demand, Ward 4 Newsam is underspent on substantive pay due to vacancies within the service.

2025 - 2026 Financial Position			Variance from budget £			
Ward	Funded WTE (All Roles)	Annual Pay Budget	Substantive	Agency	Bank	Total
Ward 4 Newsam	33.79	£1,517,063	-£376,976	£56,343	£287,058	-£33,575

Benchmarking Data

The information below outlines the staffing establishment for a comparable unit with a similar bed capacity, service model, and patient case mix and presentation profile.

Ward type	Bed numbers	Early	Late	Nights (12 hours)
Bradford	20	3 Registered Nurses & 4 Health Support Workers	3 Registered Nurses & 4 Health Support Workers	2 Registered Nurses & 3 Health Support Workers

Other Roles Bradford

- 1 Psychologist Band 8a attached to each ward
- 1 Psychology Assistant attached to each ward
- 1 Band 6 Occupational Therapist
- 1 Band 5 Occupational Therapist
- 1 Band 3 Occupational Therapy Assistant
- 1 Band 7 Physio and 1 Band 5 across all adult inpatients

Some wards have incorporated a Band 7 Clinical Lead role within their staffing establishment.

Recommendation

It is recommended that funding for one Occupational Therapy Assistant post is incorporated into the budget. This will align the ward with other wards across the service and promote consistency in staffing provision. This financial uplift will bring the ward in line with the staffing levels and budget allocation of the other acute admission wards.

In addition, the post will support the equitable delivery of structured therapeutic activities for service users, enhancing engagement and improving the overall service user experience. Increased access to meaningful activities may also help to reduce boredom and the associated risks of disengagement and challenging behaviours.

Ward Type	Ward Name	WTE Change	Cost Change
Working Age Adult Acute Admission	Ward 4 Newsam	1.00	£34,798
	Total	1.00	£34,798

3 Woodlands Square

Leeds and York partnership Trust have two Learning Disability Specialist Health Planned Care (Respite) Services. People who use this service require specialist health respite care on a regular basis. 3 Woodland Square provides respite for people who have a learning disability, behaviours that challenge, autism and/or

a mental health need. Referrals to the service are managed through Adult Social Care alongside funding if additional staffing is required for increased level of nursing support such as 1-1 care.

3 Woodlands Square is a 4 bedded respite unit supporting individuals with behaviours that challenge. On occasion, a fifth bed may be opened in response to clinical need and crisis admissions, in line with requests from the ICB. The unit is divided into two areas: a male and a female section. The Registered Nurse works across both areas, while Health Support Workers are allocated between the two sections to provide appropriate cover.

The MHOST tool is not evidence based for use within Learning Disability Services and, as such, cannot be appropriately applied in this setting. This creates a significant limitation for 3 Woodlands Square, as it is unable to utilise MHOST data to inform its establishment review or to evidence safer staffing requirements. Consequently, the ward is placed at a disadvantage when seeking to justify its staffing levels, as it lacks a recognised and comparable dataset to support clinical need, patient presentations and workforce planning decisions.

The establishment review process found that the finance budget and staffing establishment are not aligned. The budget has not been updated since 2017 to reflect the ward's current clinical requirements. The ward requires four staff members on every clinical shift to meet safer staffing standards, including the provision of PMVA cover. Both wards are standalone units and require an adequate safer staffing response to support PMVA interventions and manage other medical emergencies safely and effectively.

The current staffing establishment is:

- Early/Late Shift
1 Registered Nurse and 3 Health Support Workers (Budgeted for 1 Registered Nurse and 2 Health Support Workers)
1 Registered Nurse 9-5pm
- Night shift
1 Registered Nurse and 2 Health Support Workers
- Numbers are adjusted for any 1-1s which is funded by Adult Social Care

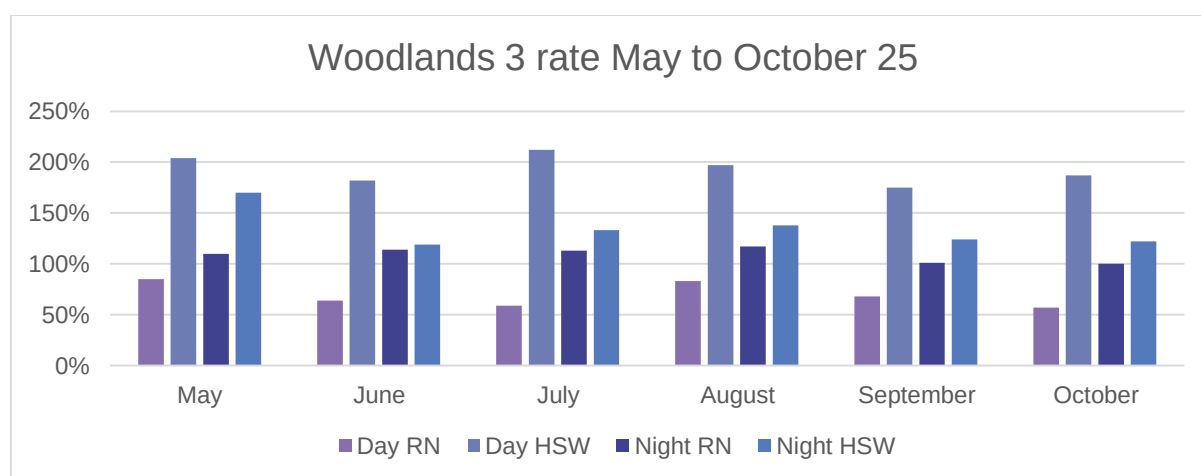
In addition, 3 Woodlands Square has the following

- 0.5 Ward Manager
- Nursing Associate
- 0.25 LD Physician
- 0.5 Activity Lead

The total hours worked detailed below were lower than the budgeted establishment, largely due to the vacant post, which represented an approximate vacancy rate of 14% at the time of reporting. Unavailability metrics indicate a high level of sickness absence, much of which was covered through Bank staff. In addition, several members of staff were on maternity leave during the reporting period, which also affected the overall staffing position.

Ward	Total Budget WTE RN & HSW (excluding headroom 22%)	MHOST WTE Recommendation	Total worked including bank/agency (2-month trend)
Woodlands 2 & 3 (amalgamated budget)	23.42	N/A	17.73

The below graph details the fill rate between May and October 2025 highlights that 3 Woodlands Square is working over the budgeted establishment for Health Support Workers.



The below table details the overspend in staffing to meet the clinical demand, 3 Woodlands Square is underspent on substantive pay due to vacancies within the service.

2025 - 2026 Financial Position			Variance from budget £			
Ward	Funded WTE (All Roles)	Annual Pay Budget	Substantive	Agency	Bank	Total
Woodlands 2 & 3 (amalgamated budget)	35.80	£1,687,988	£-261,790	£28,282	£304,686	£71,178

Benchmarking Data

The information below outlines the staffing establishment for a unit with a slightly higher bed capacity, a comparable service model, and a similar patient case mix and presentation profile.

Ward type	Bed numbers	Early	Late	Nights (12 hours)
Osborne Court Adults	5	1 Registered Nurse & 3 Health Support Worker	1 Registered Nurse & 3 Health Support Worker	0 Registered Nurse & 2 Health Support Worker

Recommendation

It is recommended that 3 Woodlands Square increase their establishment by 1 Band 3 Practitioners on the late shift. Thus, increasing the total safer staffing numbers taking them to:

- Early
2 Registered Nurses and 2 Health Support Workers
- Late Shift
1 Registered Nurse and 3 Health Support Workers
- Night Shift
1 Registered Nurse and 2 Health Support Workers

The ward has been operating with these clinical staffing levels; however, the finance budget has not been updated to reflect this requirement. The table below outlines the costs associated with this staffing uplift.

Ward Type	Ward Name	WTE Change	Cost Change
Learning Disability Service	Woodlands 3	1.71	£75,000
	Total	1.71	£75,000

Wards Delivered by the Provider Collaborative

Business cases to the relevant Provider Collaborative are being developed reflecting the recommendations detailed in this report for clinical areas funded by the Provider Collaborative, this applies to recommendations for Red Kite View.

Further work to review the clinical models for YCED alongside targeted work in relation to ETOC were agreed before further decisions are made due to potential changes to the service specifications and the clinical model and pathway. The use of the temporary workforce will continue to provide flexibility should this be necessary as work progresses.

6.0 Summary

Annual establishment reviews ensure staffing levels remain appropriate to deliver safe and effective care. Between February and April 2026, all 28 inpatient wards completed a review using a triangulated approach incorporating MHOST data, quality indicators and professional judgement.

The review found that while most wards were operating within agreed establishments, some were routinely staffing above baseline levels, and MHOST data identified areas where further staffing enhancements are required. As a result, establishment uplifts are recommended in a number of areas to better reflect current service need and operational demand. The remainder of wards have been reviewed and the staffing establishment concluded as either appropriate or further work required until the significant programmes of work progress and the impact understood. Flexibility of the use temporary staffing could still be applied should this be necessary.

The proposed uplift, costing approximately £531,373, is expected to reduce reliance on temporary staffing, improve workforce stability, strengthen continuity of care and support better patient outcomes and staff

experience. An impact assessment will be undertaken to evaluate improvements in quality indicators and reductions in bank and agency usage.

Without additional substantive staffing, services may continue to face challenges in maintaining workforce stability, therapeutic engagement and service resilience. While the Trust remains supportive of staffing growth where there is a clear quality and safety benefit, any establishment increases will need to be funded through efficiency savings, service redesign, increased CIP delivery or the repurposing of existing resources, as no additional recurrent funding is available.

Sign off and Governance

The establishment review has been shared through the appropriate governance forums within Leeds and York Partnership NHS Foundation Trust including the Executive Management Team Forum.

An assurance statement from the Director of Nursing is enclosed (Appendix 1)

The Board are asked to:

- Note and be assured by the content of the paper
- Support the recommendations as outlined in the paper

Appendix 1

Statement of assurance

I, Nichola Sanderson, as the Executive Director of Nursing and Professions can confirm that the nursing staffing establishment review for 2025/2026 has been completed in accordance with the National Quality Board (NQB) and the Developing Workforce Safeguards framework.

The review has incorporated

- Evidence based workforce planning tools
- Professional clinical judgement
- Analysis of patient acuity, dependency and outcomes
- Engagement with Finance, HR, and Clinical and Operational Leadership
- Consideration of current and projected service demands

Based on the findings and triangulated data, I am satisfied that the proposed staffing establishments are:

- Safe and appropriate to meet patient care needs
- Financially and regulatory sustainable
- Aligned with regulatory expectations and quality standards

I therefore formally sign off this review and recommend its submission to the Trust Board for assurance and approval.

Signed



Nichola Sanderson
Director of Nursing & Professions

Meeting of the Board of Directors

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

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

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Demand for services	
SR8	Health inequalities	
SR9	System change	

Executive summary

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

The paper contains a high-level overview of data and analysis to provide the Board of Directors and the public with information on the position of Leeds and York Partnership Trust wards staffing against safer staffing levels between 1st May and 31st July 2026.

This report states that there were no clinical shifts without a registered nurse on duty during the reporting period.

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.

No

Recommendation

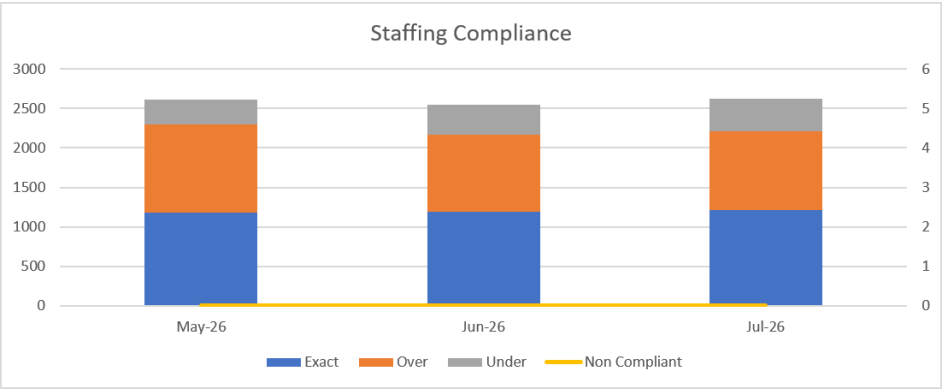
The Board is asked to:

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

Meeting of the Board of Directors

24 September 2026

Safer Staffing: Inpatient Services – May, June, July 2026



	Number of Shifts		
	May	June	July
Exact	1177	1193	1215
Over Compliance	1118	976	991
Under Compliance	314	376	415
Non-Compliant	0	0	0

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

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

Narrative on Data Extracts Regarding LYPFT Staffing Levels on x28 Wards during July 2026: This is the whole time equivalent (WTE) number of staffing posts the inpatient wards are funded for to deliver planned level of care and interventions within their speciality by shift.

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

Exact or Over Compliant Shifts: Compliance data indicates that the number of shifts staffed exactly as planned between May 2026 and July 2026 has remained relatively stable. In both June 2026 and July 2026, there was a decrease in the number of Registered Nurse and Health Support Worker duties staffed above the planned establishment. Where wards are operating above their baseline staffing levels, this is often in response to the need for enhanced observations to ensure safe and effective care delivery.

Under Compliant Shifts: Compliance data indicates that the number of shifts worked under the planned establishment between May 2026 and July 2026 has increased month on month, though remain lower than in January and February this year. Those shifts that are under compliant may be due to a range of reasons. In some instances, it may not be operationally necessary to allocate staff to all vacant duties; particularly if there are vacant beds or service users are on leave. Additionally, the multidisciplinary team may provide sufficient support to maintain safe and effective care delivery. At times, shifts may be intentionally left unfilled, with teams adhering to the staffing escalation and deployment protocol during these periods. Further work is required to capture these changes on Healthroster to ensure the need is reflected accurately.

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

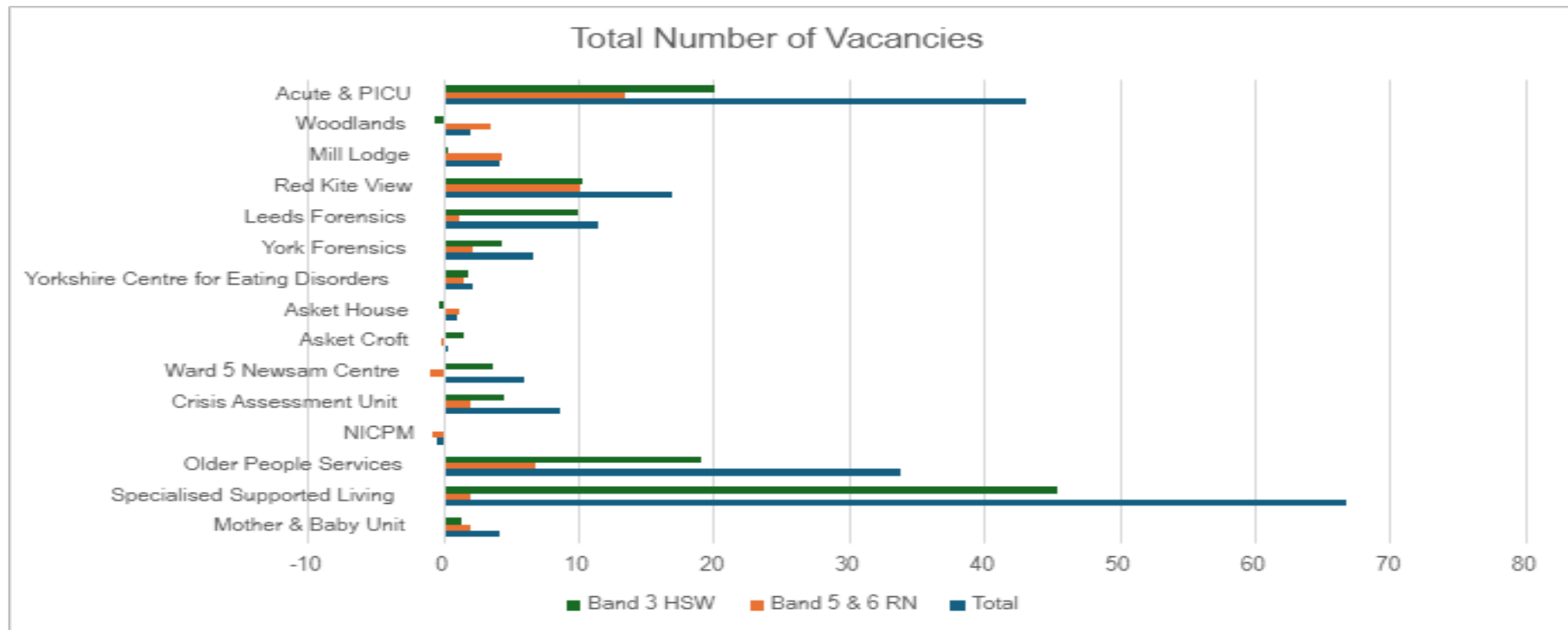
Non-Compliant Shifts: This metric represents the number of shifts where no Registered Nurses were on duty. This was not breached in May, June or July 2026

Vacancies

The below chart indicates the total number of vacancies across each service as reported on ECHO in July 2026. The vacancies are across the multidisciplinary teams and not solely related to Registered Nurses and Health Support Workers, which are roles traditionally viewed in the safer staffing figures. Alongside this are the Registered Nurse and Band 3 Health Support Worker vacancies taken from the finance data for July 2026.

Although Registered Nurses and Health Support Workers are those reported in the safer staffing figures. It is important to recognise the range of roles within the multidisciplinary teams for providing safe and effective care in our ward establishments which is not accurately captured in the unify data (Appendix A). The highest total number of vacancies are currently in the Specialised Supported Living Service, Acute and PICU

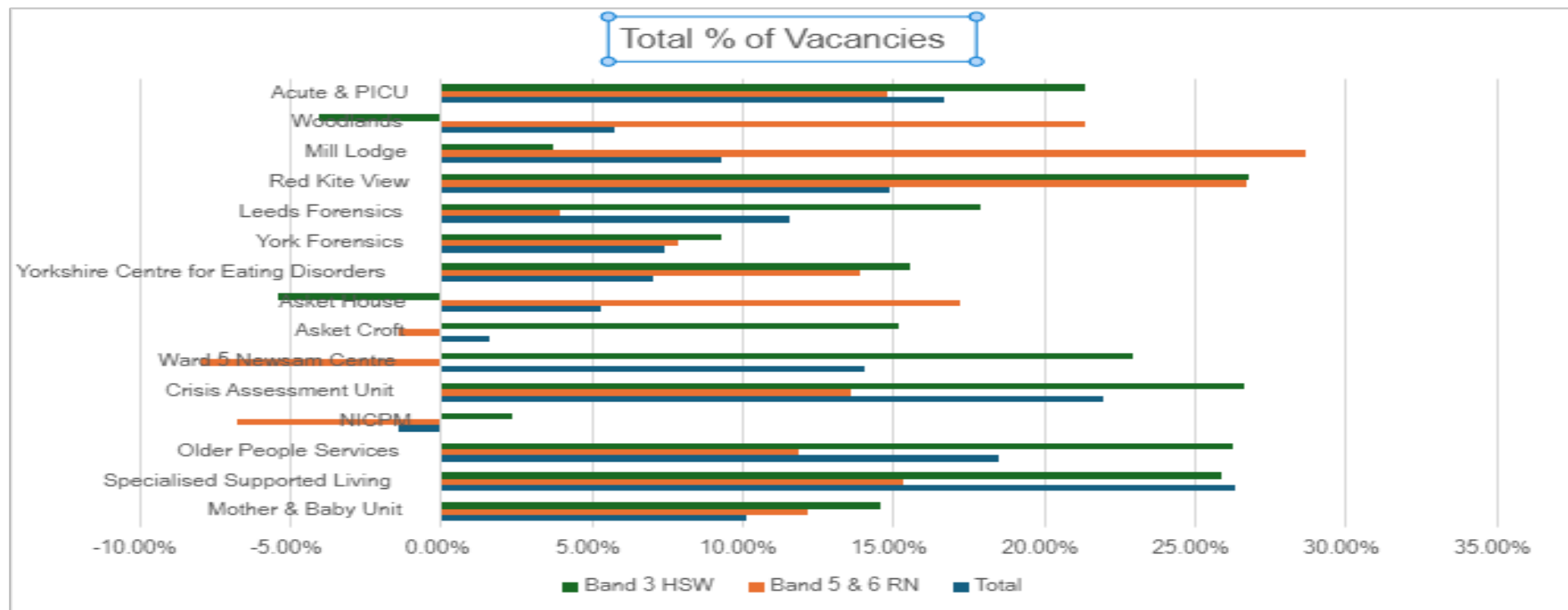
and Older People's Service. The highest numbers of Registered Nurse vacancies are currently within Acute and PICU, Red Kite View and Older People's Service.



The below chart indicates the total % of vacancies across each service as reported on ECHO in July 2026. This applies to multidisciplinary teams as a whole and is not limited to Registered Nurses and Health Support Workers, who have traditionally been the focus of safer staffing data. The highest percentage of vacancies are within the Specialised Supported Living Service, Crisis Assessment Unit and Older People's

Service. The chart also includes the % vacancies for Registered Nurses and Band 3 Health Support Workers for each service taken from the finance data for July 2026.

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



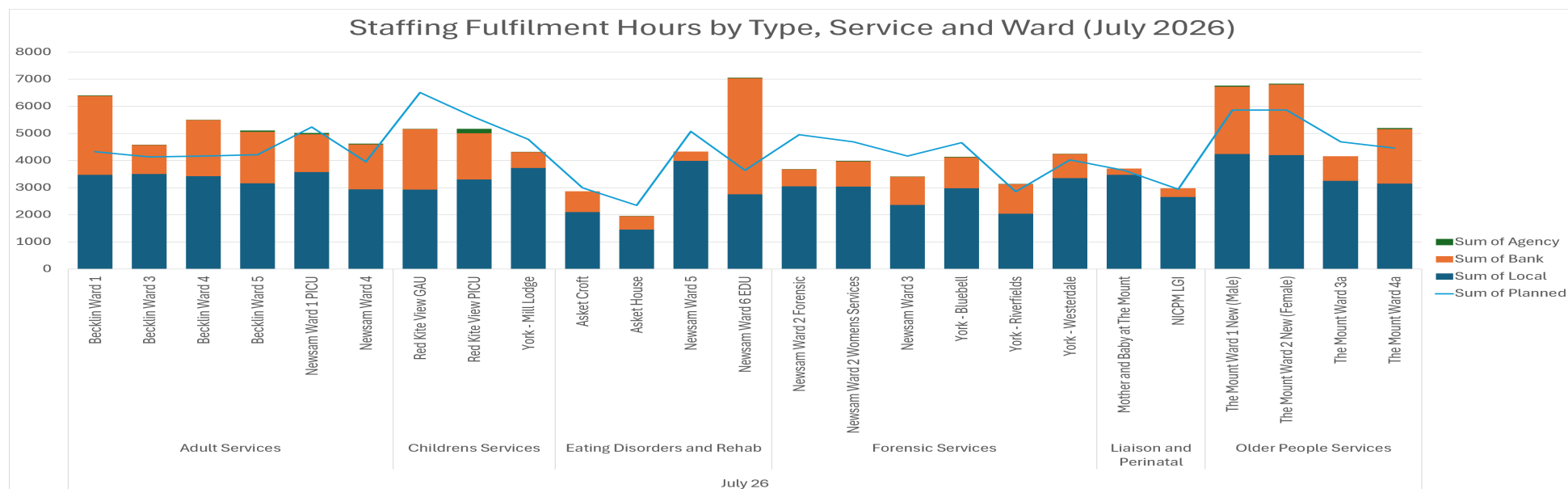
Ongoing recruitment initiatives are currently in progress, aimed at addressing existing workforce gaps. The recent uplift in Health Support Workers in Acute Inpatient and PICU, Crisis Assessment Unit and York Forensic Service has created additional vacancies. There is currently a recruitment campaign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

vacancies. Outputs from this group includes the creation of a minimum standards document for Health Support Workers covering key areas such as induction, supervision and professional development. In addition, there is a proposal to explore the reintroduction of an induction programme specifically for Healthcare Support Workers, with the aim of enhancing the quality of care delivered through the development of confidence and skills, while also supporting the retention of the Healthcare Support Worker workforce.

The Registered Nurse vacancy position will be supported by the intake of preceptees due to begin employment in September 2026. A proportion of current Registered Nurse vacancies have been intentionally held open by services until these preceptees commence, alongside a cohort of individuals who will complete their training and subsequently register as Registered Nurses through the Nurse Apprenticeship Programme. The proposal to convert 10 Health Support Worker vacancies into Registered Nurse posts to support the recruitment of preceptee nurses is progressing. This initiative will both provide employment opportunities for newly qualified nurses who might otherwise remain without posts and help to reduce Health Support Worker vacancies, which have historically been difficult to recruit to. Additional Registered Nurse vacancies have also arisen through natural turnover, as Band 5 nurses progress into Band 6 roles.

Temporary Staffing Use

The table below shows the total number of inpatient clinical hours completed in July 2026 and the proportion of hours during the reporting period that were covered by bank or agency staff. Usage patterns in the data indicate that certain areas relied more heavily on bank staff which include YCED, Ward 1 Becklin Centre and Wards 1, 2 and 4 Mount. There has recently been an establishment review which has recommended an increase in the baseline establishment for Ward 1, 2 and 4 at the Mount which should see a reduction in temporary staff use. Targeted work is underway within YCED to support the team with the current temporary staff usage.



Enhanced Therapeutic Observation and Care

The Trust remains engaged in the national Enhanced Therapeutic Observation of Care Programme (ETOC).

The Enhanced Therapeutic Observation of Care Programme continues to be one of the main reasons for additional staff being required in inpatient areas above the establishment, alongside existing vacancies.

The Enhanced Therapeutic Observation of Care Programme staffing dashboard shared through the Safer Staffing Steering Group meeting provides improved oversight of observation related activity. Current data shows that enhanced observations account for an average of 37% of bank staff usage. The dashboard enables services to review patterns, discuss pressures, and identify opportunities for improvement.

Usage trends continue to highlight higher reliance on bank staffing within YCED, the Dementia Wards at The Mount, the Female Acute Inpatient Wards and Red Kite View, with over 20% of the Enhanced Therapeutic Observation of Care Programme being used to manage violence and aggression across our inpatient areas.

There is a pilot under way capturing bank versus substantive hours and who is delivering within eyesight and above to support with workforce review and deployment as part of the reducing bank working group

The Enhanced Therapeutic Observation of Care Programme Steering Group continues to progress a range of improvement actions as part of the national programme, with updates and learning shared through safer staffing governance routes

Safer Staffing Steering Group

The Trust's Safer Staffing Steering Group continues to meet monthly, with a focus on evaluating the safety and quality of staffing across inpatient services, identifying improvement workstreams through ongoing learning, and oversight of the staffing establishment review process. The Trust establishment reviews have been completed and recommendations presented to the Executive Management Team in August 2026. Ward teams are completing the next round of MHOST data collection throughout September 2026.

Summary

Ongoing recruitment initiatives are currently in progress, aimed at addressing existing workforce gaps. The recruitment campaign to support teams with the recruitment of Health Support Workers continues with a recent move to centralised recruitment. A working group continues to meet regularly to carry out a targeted programme of work to address the rise in Health Support Worker vacancies.

The Registered Nurse vacancy position will be supported by the intake of preceptees due to begin employment in September 2026. A proportion of current Registered Nurse vacancies will be intentionally held open by services until these preceptees commence, alongside a cohort of individuals who will complete their training and subsequently register as Registered Nurses through the nurse apprenticeship programme. There is also a proposal to convert ten Health Support Worker vacancies into Registered Nurse posts to support the recruitment of preceptee nurses.

In both June 2026 and July 2026, there was a decrease in the number of Registered Nurse and Health Support Worker duties staffed above the planned establishment compared to May. Under compliance shifts increased month on month from May, though remained lower than in January and February this year. Under compliant shifts may be due to a variety of factors, including situations where the multidisciplinary team is able to provide sufficient support to ensure safe and effective care.

Recommendations

The Board is asked to:

- Discuss and note the content of the report.

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

Alison Quarry, Deputy Director of Nursing
Miriam Blackburn, Head of Nursing
Jennifer Connelly, Professional Lead Nurse
September 2026

APPENDIX A

Safer Staffing: Inpatient Services May 2026

Fill rate indicator return

Staffing: Nursing, Care Staff and AHPs

	Cumul	Care Hours Per Patient Day (CHPPD)								Day				Night				Allied Health	
Ward name	ative count	Registe red	Non- registe	Registe red	Non- registe	Registe red	Non- registe	Overall	Averag e fill	Averag e fill	Averag e fill	Averag e fill	Averag e fill	Averag e fill	Averag e fill	Averag e fill	Averag e fill	Averag e fill	
WardName	PatientCo	CHPPD_R	CHPPD_N	CHPPD_R	CHPPD_N	CHPPD_R	CHPPD_N	CHPPD_O	AvgFR_RN	AvgFR_NRI	AvgFR_RN	AvgFR_NRI	AvgFR_RN	AvgFR_NRI	AvgFR_RN	AvgFR_NRI	AvgFR_RAI	AvgFR_NRI	
2 WOODLAND SQUARE	115	9.1	7.7	0.2	0.0	0.0	0.0	17.0	99%	143%	100%	-	100%	103%	-	-	-	-	
3 WOODLAND SQUARE	104	8.1	17.5	2.1	0.0	0.0	0.0	27.8	68%	206%	100%	-	100%	133%	100%	-	-	-	
ASKET CROFT	511	1.6	2.6	0.0	0.0	0.8	0.2	5.3	88%	81%	-	-	100%	103%	-	-	100%	100%	
ASKET HOUSE	480	1.5	1.5	0.0	0.0	0.8	0.0	3.8	102%	99%	-	-	100%	100%	-	-	100%	-	
BECKLIN CAU	179	3.6	15.0	0.5	0.0	0.0	0.0	19.1	89%	98%	100%	-	101%	139%	-	-	-	-	
BECKLIN WARD 1	670	2.5	5.0	0.2	0.0	0.4	0.1	8.3	97%	268%	100%	-	88%	260%	100%	-	100%	100%	
BECKLIN WARD 3	665	2.3	3.1	0.5	0.2	0.5	0.2	6.8	81%	152%	100%	100%	92%	108%	100%	100%	100%	100%	
BECKLIN WARD 4	655	2.3	3.9	0.5	0.0	0.2	0.1	7.0	81%	265%	100%	-	92%	250%	100%	-	100%	100%	
BECKLIN WARD 5	644	2.7	3.7	0.2	0.2	0.5	0.1	7.3	97%	119%	100%	100%	97%	114%	-	100%	100%	100%	
MOTHER AND BABY AT THE MOUNT	164	10.1	6.8	0.7	0.0	0.0	0.0	17.5	123%	76%	100%	-	97%	175%	100%	-	-	-	
NEWSAM WARD 1 PICU	343	4.6	7.7	0.0	0.7	0.6	0.0	13.7	89%	110%	-	100%	100%	105%	-	100%	100%	-	
NEWSAM WARD 2 FORENSIC	330	3.1	7.0	0.0	0.2	0.5	0.0	10.8	97%	95%	-	100%	100%	100%	-	-	100%	-	
NEWSAM WARD 2 WOMENS SERVICES	263	3.8	11.6	0.3	0.0	0.5	0.5	16.7	91%	123%	100%	-	100%	139%	-	-	100%	100%	
NEWSAM WARD 3	420	2.5	4.6	0.0	0.1	0.7	0.0	7.8	94%	87%	-	100%	100%	100%	-	100%	100%	-	
NEWSAM WARD 4	637	2.7	3.7	0.1	0.1	0.3	0.2	7.2	99%	139%	100%	100%	100%	113%	100%	100%	100%	100%	
NEWSAM WARD 5	1398	1.0	1.4	0.1	0.0	0.5	0.2	3.2	99%	113%	100%	-	96%	137%	100%	-	100%	100%	
NEWSAM WARD 6 EDU	810	1.9	5.5	0.1	0.0	0.6	0.2	8.4	125%	1138%	100%	-	97%	290%	-	-	100%	100%	
NICPM LGI	418	3.2	2.5	0.0	0.0	0.8	0.0	6.5	98%	122%	-	-	92%	117%	-	-	100%	-	
RED KITE VIEW GAU	238	6.1	11.5	1.0	0.2	0.0	0.0	18.9	76%	82%	100%	100%	93%	111%	100%	-	-	-	
RED KITE VIEW PICU	74	25.0	42.7	0.0	0.7	0.0	0.0	68.5	105%	81%	-	100%	110%	130%	-	-	-	-	
THE MOUNT WARD 1 NEW (MALE)	406	3.8	10.2	0.3	0.0	0.0	0.0	14.3	98%	108%	100%	-	98%	197%	100%	-	-	-	
THE MOUNT WARD 2 NEW (FEMALE)	475	3.4	9.5	0.3	0.1	0.0	0.0	13.3	78%	124%	100%	100%	99%	219%	100%	-	-	-	
THE MOUNT WARD 3A	608	2.4	2.7	0.5	0.1	0.0	0.0	5.7	87%	98%	100%	100%	102%	114%	100%	-	-	-	
THE MOUNT WARD 4A	634	2.4	4.2	0.0	0.0	0.0	0.0	6.5	93%	122%	100%	-	102%	159%	100%	-	-	-	
YORK - BLUEBELL	278	3.9	10.0	0.0	0.0	0.4	0.0	14.3	108%	104%	-	-	100%	131%	-	-	100%	-	
YORK - MILL LODGE	194	7.0	9.3	0.8	0.2	2.8	0.5	20.6	101%	99%	100%	100%	59%	138%	100%	-	100%	100%	
YORK - RIVERFIELDS	300	3.9	5.3	0.0	0.0	0.3	0.3	9.7	111%	106%	-	-	101%	122%	-	-	100%	100%	
YORK - WESTERDALE	323	3.8	9.9	0.0	0.0	0.4	0.4	14.5	125%	105%	-	-	101%	155%	-	-	100%	100%	

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Safer Staffing: Inpatient Services June 2026

Fill rate indicator return

Staffing: Nursing, Care Staff and AHPs

Ward name	Cumulative count	Care Hours Per Patient Day (CHPPD)								Day				Night				Allied Health	
		Registered	Non-registered	Registered	Non-registered	Registered	Non-registered	Overall		Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill
WardName	PatientCount	CHPPD_R	CHPPD_N	CHPPD_R	CHPPD_N	CHPPD_R	CHPPD_N	CHPPD_O		AvgFR_RN	AvgFR_NRI	AvgFR_RN	AvgFR_NRI	AvgFR_RN	AvgFR_NRI	AvgFR_RN	AvgFR_NRI	AvgFR_RAI	AvgFR_NRI
2 WOODLAND SQUARE	115	9.1	7.7	0.2	0.0	0.0	0.0	17.0		99%	143%	100%	-	100%	103%	-	-	-	-
3 WOODLAND SQUARE	104	8.1	17.5	2.1	0.0	0.0	0.0	27.8		68%	206%	100%	-	100%	133%	100%	-	-	-
ASKET CROFT	511	1.6	2.6	0.0	0.0	0.8	0.2	5.3		88%	81%	-	-	100%	103%	-	-	100%	100%
ASKET HOUSE	480	1.5	1.5	0.0	0.0	0.8	0.0	3.8		102%	99%	-	-	100%	100%	-	-	100%	-
BECKLIN CAU	179	3.6	15.0	0.5	0.0	0.0	0.0	19.1		89%	98%	100%	-	101%	139%	-	-	-	-
BECKLIN WARD 1	670	2.5	5.0	0.2	0.0	0.4	0.1	8.3		97%	268%	100%	-	88%	260%	100%	-	100%	100%
BECKLIN WARD 3	665	2.3	3.1	0.5	0.2	0.5	0.2	6.8		81%	152%	100%	100%	92%	108%	100%	100%	100%	100%
BECKLIN WARD 4	655	2.3	3.9	0.5	0.0	0.2	0.1	7.0		81%	265%	100%	-	92%	250%	100%	-	100%	100%
BECKLIN WARD 5	644	2.7	3.7	0.2	0.2	0.5	0.1	7.3		97%	119%	100%	100%	97%	114%	-	100%	100%	100%
MOTHER AND BABY AT THE MOUNT	164	10.1	6.8	0.7	0.0	0.0	0.0	17.5		123%	76%	100%	-	97%	175%	100%	-	-	-
NEWSAM WARD 1 PICU	343	4.6	7.7	0.0	0.7	0.6	0.0	13.7		89%	110%	-	100%	100%	105%	-	100%	100%	-
NEWSAM WARD 2 FORENSIC	330	3.1	7.0	0.0	0.2	0.5	0.0	10.8		97%	95%	-	100%	100%	100%	-	-	100%	-
NEWSAM WARD 2 WOMENS SERVICES	263	3.8	11.6	0.3	0.0	0.5	0.5	16.7		91%	123%	100%	-	100%	139%	-	-	100%	100%
NEWSAM WARD 3	420	2.5	4.6	0.0	0.1	0.7	0.0	7.8		94%	87%	-	100%	100%	100%	-	100%	100%	-
NEWSAM WARD 4	637	2.7	3.7	0.1	0.1	0.3	0.2	7.2		99%	139%	100%	100%	100%	113%	100%	100%	100%	100%
NEWSAM WARD 5	1398	1.0	1.4	0.1	0.0	0.5	0.2	3.2		99%	113%	100%	-	96%	137%	100%	-	100%	100%
NEWSAM WARD 6 EDU	810	1.9	5.5	0.1	0.0	0.6	0.2	8.4		125%	1138%	100%	-	97%	290%	-	-	100%	100%
NICPM LGI	418	3.2	2.5	0.0	0.0	0.8	0.0	6.5		98%	122%	-	-	92%	117%	-	-	100%	-
RED KITE VIEW GAU	238	6.1	11.5	1.0	0.2	0.0	0.0	18.9		76%	82%	100%	100%	93%	111%	100%	-	-	-
RED KITE VIEW PICU	74	25.0	42.7	0.0	0.7	0.0	0.0	68.5		105%	81%	-	100%	110%	130%	-	-	-	-
THE MOUNT WARD 1 NEW (MALE)	406	3.8	10.2	0.3	0.0	0.0	0.0	14.3		98%	108%	100%	-	98%	197%	100%	-	-	-
THE MOUNT WARD 2 NEW (FEMALE)	475	3.4	9.5	0.3	0.1	0.0	0.0	13.3		78%	124%	100%	100%	99%	219%	100%	-	-	-
THE MOUNT WARD 3A	608	2.4	2.7	0.5	0.1	0.0	0.0	5.7		87%	98%	100%	100%	102%	114%	100%	-	-	-
THE MOUNT WARD 4A	634	2.4	4.2	0.0	0.0	0.0	0.0	6.5		93%	122%	100%	-	102%	159%	100%	-	-	-
YORK - BLUEBELL	278	3.9	10.0	0.0	0.0	0.4	0.0	14.3		108%	104%	-	-	100%	131%	-	-	100%	-
YORK - MILL LODGE	194	7.0	9.3	0.8	0.2	2.8	0.5	20.6		101%	99%	100%	100%	59%	138%	100%	-	100%	100%
YORK - RIVERFIELDS	300	3.9	5.3	0.0	0.0	0.3	0.3	9.7		111%	106%	-	-	101%	122%	-	-	100%	100%
YORK - WESTERDALE	323	3.8	9.9	0.0	0.0	0.4	0.4	14.5		125%	105%	-	-	101%	155%	-	-	100%	100%

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

Safer Staffing: Inpatient Services July 2026

Fill rate indicator return

Staffing: Nursing, Care Staff and AHPs

Ward name	Cumulative count	Care Hours Per Patient Day (CHPPD)							Day				Night				Allied Health	
		Registered	Non-registered	Registered	Non-registered	Registered	Non-registered	Overall	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill
WardName	PatientCount	CHPPD_R	CHPPD_N	CHPPD_R	CHPPD_N	CHPPD_R	CHPPD_N	CHPPD_O	AvgFR_RNI	AvgFR_NRI	AvgFR_RNI	AvgFR_NRI	AvgFR_RNI	AvgFR_NRI	AvgFR_RNI	AvgFR_NRI	AvgFR_RAI	AvgFR_NRI
2 WOODLAND SQUARE	120	8.5	8.9	0.3	0.0	0.0	0.0	17.7	91%	185%	100%	-	100%	113%	-	-	-	-
3 WOODLAND SQUARE	115	8.2	15.3	1.6	0.0	0.0	0.0	25.1	78%	182%	100%	-	100%	125%	100%	-	-	-
ASKET CROFT	554	1.6	2.5	0.0	0.0	0.6	0.3	5.0	87%	88%	100%	-	100%	102%	-	-	100%	100%
ASKET HOUSE	495	1.6	1.5	0.0	0.0	0.6	0.0	3.7	102%	97%	-	-	101%	100%	-	-	100%	-
BECKLIN CAU	183	3.7	15.0	0.6	0.0	0.0	0.0	19.3	89%	99%	100%	-	100%	135%	-	-	-	-
BECKLIN WARD 1	663	2.8	5.8	0.2	0.0	0.4	0.2	9.4	107%	321%	100%	-	93%	287%	100%	-	100%	100%
BECKLIN WARD 3	686	2.1	3.2	0.6	0.0	0.3	0.2	6.5	76%	142%	100%	-	84%	115%	100%	-	100%	100%
BECKLIN WARD 4	694	2.4	4.2	0.5	0.0	0.3	0.1	7.5	87%	360%	100%	-	96%	250%	100%	-	100%	100%
BECKLIN WARD 5	632	2.9	4.2	0.2	0.2	0.4	0.2	8.0	97%	121%	100%	100%	101%	125%	-	-	100%	100%
MOTHER AND BABY AT THE MOUNT	122	14.1	8.1	0.4	0.0	0.0	0.0	22.7	119%	60%	100%	-	102%	150%	-	-	-	-
NEWSAM WARD 1 PICU	338	4.6	8.5	0.0	0.7	0.9	0.0	14.8	80%	113%	-	100%	95%	112%	-	100%	100%	-
NEWSAM WARD 2 FORENSIC	372	3.0	6.4	0.0	0.1	0.5	0.0	9.9	99%	97%	-	100%	110%	102%	-	-	100%	-
NEWSAM WARD 2 WOMENS SERVICES	284	4.0	9.2	0.1	0.0	0.3	0.5	14.0	96%	98%	100%	-	111%	110%	-	-	100%	100%
NEWSAM WARD 3	434	2.6	4.6	0.0	0.1	0.5	0.0	7.9	99%	93%	-	100%	113%	98%	-	100%	100%	-
NEWSAM WARD 4	647	2.6	3.5	0.0	0.1	0.4	0.3	6.9	105%	113%	-	100%	89%	112%	100%	100%	100%	100%
NEWSAM WARD 5	1419	1.0	1.3	0.1	0.0	0.3	0.2	3.0	98%	106%	100%	-	94%	112%	100%	-	100%	100%
NEWSAM WARD 6 EDU	848	1.9	5.3	0.2	0.0	0.5	0.2	8.1	138%	932%	100%	-	96%	314%	-	-	100%	100%
NICPM LGI	428	3.1	2.7	0.0	0.0	0.9	0.0	6.7	93%	141%	-	-	90%	119%	-	-	100%	-
RED KITE VIEW GAU	305	5.2	9.9	0.7	0.2	0.0	0.0	16.0	83%	87%	100%	100%	97%	116%	100%	-	-	-
RED KITE VIEW PICU	122	14.8	26.5	0.0	0.7	0.0	0.0	42.0	97%	84%	-	100%	105%	120%	-	-	-	-
THE MOUNT WARD 1 NEW (MALE)	374	4.1	11.5	0.2	0.1	0.0	0.0	16.0	87%	101%	100%	100%	102%	215%	-	-	-	-
THE MOUNT WARD 2 NEW (FEMALE)	466	3.5	8.9	0.4	0.2	0.0	0.0	13.0	80%	117%	100%	100%	90%	202%	100%	-	-	-
THE MOUNT WARD 3A	614	2.4	2.9	0.5	0.1	0.0	0.0	5.9	84%	99%	100%	100%	100%	116%	100%	-	-	-
THE MOUNT WARD 4A	655	2.4	4.3	0.1	0.0	0.0	0.0	6.8	98%	135%	100%	-	99%	167%	-	-	-	-
YORK - BLUEBELL	294	3.7	10.0	0.0	0.0	0.4	0.0	14.1	102%	115%	-	-	120%	128%	-	-	100%	-
YORK - MILL LODGE	183	8.2	8.6	1.2	0.3	3.7	0.7	22.8	92%	78%	100%	100%	73%	132%	100%	-	100%	100%
YORK - RIVERFIELDS	288	4.1	6.1	0.0	0.0	0.0	0.6	10.9	112%	116%	100%	-	100%	131%	-	-	-	100%
YORK - WESTERDALE	341	3.2	8.6	0.0	0.0	0.3	0.4	12.5	104%	91%	-	-	100%	134%	100%	-	100%	100%

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

Meeting of the Board of Directors

Paper title:	Guardian of Safe Working Quarterly Report: Quarter 1: 1 st April 2026 to 30 th June 2026
Date of meeting:	24 September 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	Demand for services	
SR8	Health inequalities	
SR9	System change	

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 3 exception reports received during the reporting period, with no breaches leading to a GOSWH fine and no 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

24 September 2026

Guardian of Safe Working Hours Report: Quarter 1: 1st April 2026 to 30th June 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 01.04.2026 to 30.06.2026.

2 Quarter 1 Overview

Vacancies		There are a total of 45 Core Training posts and 2 NIHR posts. There are a total of 35 Higher Training posts. All schemes are full.					
Rota Gaps		April 2026		May 2026		June 2026	
		PRS	Middle Tier	PRS	Middle Tier	PRS	Middle Tier
	Gaps	7	15	21	17	20	9
	Internal Cover	6	15	16	17	14	9
	Agency cover	0	0	0	0	0	0
	Unfilled	1	0	5	0	6	0
Fill Rate		86%	100%	76%	100%	70%	100%
Reasons for Rota Gaps		Sickness (7)	Sickness (1) Vacant (3) Off rota (3) Left trust (7) LTFT (1)	Sickness (9) Vacant (1) LTFT (3) Parental (3) Off rota (1) Left trust (4)	Vacant (4) Off rota (3) Left trust (8) LTFT (2)	Sickness (6) LTFT (3) Parental (1) Vacant (4) Left trust (5) Special leave (1)	Sickness (1) Vacant (2) Off rota (2) Left trust (4)
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, 1 st tier) is covered by FY2 and CT doctors. The middle tier rota (2 nd / middle tier) is covered by Higher Trainee doctors and continues to have a high fill rate.					

		It is noted that there has been a spike in resident doctor sickness during these months.		
		Red Kite View Middle Tier Rota. There are two established higher training posts. 1 is vacant.		
		April 2026	May 2026	June 2026
	Gaps	28	27	23
	Bank locum shifts	28	27	23
	LYPFT vacant shifts	1 (covered by bank)	0	0
	Fill rate	100%	100%	100%
	Reason	Sickness (1)		
Exception reports (ER)		There were 3 exception reports submitted during the reporting period - 2 related to lost educational opportunities. In both these cases the resident doctor was moved from OC2 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 the inability to take contractual breaks On review this was not upheld as non-contracted work was undertaken during this period. This was flagged to the DME and DPME Ops Lead to provide feedback on workload. Of note there were three additional ERs submitted in error relating to on-calls at LTHT. These have not been considered in the above numbers. It is noted that the number of ERs received in this reporting period is below average in contrast to the previous reporting periods which had seen a trend of higher than average numbers. 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 Q1 reporting period took place on 14 th 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 is 17th September
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 board reports will include results of a detriment survey sent out quarterly to resident doctors. The detriment survey during this reporting period identified no reported detriment among respondents; however the response rate was low at 5%, which limits the strength of this finding. The low response rate may indicate that detriment is not a significant concern for resident doctors within the Trust, although continued monitoring and engagement through RDF will be important to ensure any emerging concerns are identified.
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	As part of trust integration with Leeds Community Healthcare Trust exploratory work will take place to consider options for CAMHS higher trainee on call rota and this work will be supported by the RDF.

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

Meeting of the Board of Directors

Paper title:	Chair's Report from the Workforce Committee meeting on 6 August 2026
Date of meeting:	24 September 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	Demand for services	
SR8	Health inequalities	
SR9	System change	

Committee details:	
Name of Committee:	Workforce Committee – Part A
Date of Committee:	6 August 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
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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
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The Committee received a review of the interventions implemented during the previous 12 months to reduce sickness absence and an assessment of the organisational processes that may contribute to prolonged absence. In summary, the Committee identified the following issues to monitor at future meetings. The first was around sickness absence which related to conflict or concerns at work and ensuring timely responses to and investigations of grievances or concerns. The second was around timely referrals to Occupational Health (OH) and ensuring that referrals were dealt with in a timely manner to minimise waiting times for a first appointment. The third was around returning to work, ensuring effective and appropriate interventions while the staff member was on sick, acknowledging that this may need to be an independent member of staff and not the manager, and timely and rigorous return to work conversations.

The Committee noted that an Absence Performance Oversight Group had been established to provide robust accountability and challenge and heard that the Wellbeing and Attendance Policy had been separated into two policies to provide clearer guidance for managers.

SR3

The Committee received an update on health and safety and noted the declining usage rates of the lone working system and discussed what further action should be taken. The Committee also noted that health and safety audits had identified challenges with First Aid provision and heard about the work to ensure this training was fit for purpose, with an update to come back to the next Committee meeting. The Committee also discussed the discrepancies in the violence and aggression data being reported to different committees, and emphasised the importance of presenting consistent, reconcilable data, noting that an improved system for recording incidents should support this.

SR3

The Committee received an update on Medical Appraisal and Revalidation data and sought further detail on the doctors deferred during the reporting period and requested further assurance on the appraisals that were awaiting review and sign off. The Committee also received an update on the work to improve compliance with Clinical Risk training for medical staff, currently at 68%, including opportunities to make the training more relevant and accessible, with an update on progress to be brought to the October meeting.

SR3

The Committee discussed the issue of some mandatory training not always being relevant to all staff roles. It was suggested that the content and applicability of all mandatory training should be considered as part of the transition arrangements for the new merged organisation with progress to be monitored by the Committee.	SR3
The Committee received an update on the Trust's progress against the Workforce Race Equality Standard and Workforce Disability Equality Standard for the period 2025/26. The Committee discussed where results had seen unfavourable changes and received assurance on the actions being taken to address the issues. The Committee highlighted the positive increase in the percentage of staff saying their employer had made reasonable adjustment(s) to enable them to carry out their work, noting the positive impact of the work to review and improve the workplace adjustments process at the Trust. The Committee also highlighted the progress reflected in the 2025/26 Gender Pay Gap report.	SR3
ASSURE – specific areas of assurance received warranting mention to Board	
Issue	Relates to BAF Risk
The Committee reviewed the Board Assurance Framework so that it could be mindful of its responsibility to assure that SR3 was being adequately controlled through the course of the meeting. The Committee was assured that SR3 was being adequately controlled; considered whether it was receiving assurance on any gaps through the reports it was already receiving; and agreed that it did not require any further assurance on the way in which SR3 was being managed.	SR3
The Committee received an update on the self-assessment against the Violence Prevention and Reduction Standard, welcomed the introduction of the key performance and quality indicators, and acknowledged the good level of assurance received.	SR3
The Committee received the update on the Trust-wide NHS Staff Survey Action Plan, developed in response to new national requirements for a Board-owned plan, noting that it had been approved at the Board of Directors' meeting on 30 July 2026.	SR3
The Committee received assurance on recruitment to the OH Service which was expected to reduce waiting times. The Committee requested a trajectory of improvement for OH waiting times to show when waits were expected to reach a reasonable threshold.	SR3
REFER - Items to be referred to other Committees	
Issue	Relates to BAF Risk
No items to refer.	

Recommendation

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

Meeting of the Board of Directors

Paper title:	Equality, Diversity and Inclusion Report WRES/WDES and GPG update
Date of meeting:	17 September 2026
Presented by: (name and title)	Darren Skinner – Director of People and Organisational Development
Prepared by: (name and title)	Zaidah Ahmed Head of EDI

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	Demand for services	
SR8	Health inequalities	✓
SR9	System change	

Executive summary

This paper provides a summary update on the Trust's progress against the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) for the period 2025/26. The paper includes details of progress against current priority areas and actions. It also summarises the gender pay gap report 2025/26, which as required, has been reported on the Trust's website.

Although there is no legal obligation to report on the comparable staff survey data for LGBTQ+ this is included in this report for completion along with proposed actions to address the issues raised by LGBTQ+ staff.

The WRES and WDES are national standards that aim to respond to lack of progress in race and disability equality in the NHS. The data identifies areas that aim to address equality gaps and improve the workplace experience for our substantive ethnically diverse and disabilities/LTHCs (long term health conditions) colleagues.

The WRES comprises of nine metrics with only four showing a favourable change (*two of these – metric 2 – recruitment, are only a slightly positive difference - metric 8 still worse than the sector average despite a slight improvement and metric 2 still highlights a marked disparity between ethnicities*). This is similar to last year when also four metrics showed a favourable change. Due to changes in the wording in the staff survey question around percentage of staff believing the organisation provides equal opportunities during 2025, there is no comparison data available for this relating to metric 7 in this reporting period.

The areas of unfavourable change are as follows:

- The likelihood of ethnically diverse staff entering the formal disciplinary process has increased from a likelihood of 2.37 to 2.72.
- The percentage of ethnically diverse staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months has significantly increased to 36.0% from 30.7% last year and is worse than the sector average.
- The percentage of ethnically diverse staff experiencing harassment, bullying or abuse from staff in last 12 months has increased to 20.9% and is again, worse than the sector average.
- The percentage difference between the organisation's Board voting membership and its overall

Workforce (BME representation) continues to show an under-representation. Although the number of ethnically diverse staff on the board remains the same there has been a year-on-year increase in workforce ethnicity representation, which is positive.

The WDES is comprised of ten metrics (*of which some are split into a number of sub-metrics e.g. metric 4a-d and 9 and 9a*), four of these show a favourable change, **seven** highlight unfavourable changes and for one metric there is no comparison data due to changes in the wording of the question during 2025, as indicated in the WRES section above.

The areas where there have been unfavourable change are as follows:

- There has been a slight decrease in disability representation and status in the workforce when compared to the previous year, a decline of -0.69% to 11.31%
- Metric 4b; percentage of disabled staff experiencing harassment, bullying or abuse from managers in the last 12 months, this has increased to 9.6%
- Metric 4c; percentage of disabled staff experiencing harassment, bullying or abuse from colleagues in the last 12 months, an increase of 3.3% to now 20.9%
- Metric 4d; percentage of disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it, this is significantly unfavourable with a decline of -7.7% of reporting to now 58.4% and worse than the sector average of 61.7%
- Metric 6; percentage of disabled staff who felt pressure from their manager to come to work, despite not feeling well enough to perform their duties has increased to 16.4%
- Metric 9a; a decreased staff engagement score of 6.60 which is worse than the sector average of 6.64
- The percentage difference between the organisation's Board voting membership and its overall disabled workforce shows an under-representation at 5%.

The Trust's GPG reporting data shows a positive year on year reduction in the median gender pay gap figure.

On average women within the Trust now earn £1.00 for every £1 that men earn when comparing median hourly pay. In 2020/2021 women earned 95p for every £1 that men earned when comparing median hourly pay. This shows a 5.3% reduction in the median GPG.

For the previous 2 years the median bonus gender pay gap has been zero, indicating parity in terms of the award distribution to both women and men. It should be noted that during that reporting period an equal distribution award round was in operation which influenced the median GPG figure. For 2024/25, women's median bonus pay was 54.36% higher than men's – this means they earned £1.54 for every £1 that men earn when comparing median bonus pay.

The mean bonus data identifies that women's average bonus pay was 32.92% higher than men's. Across our workforce a total of 0.3% of women and 1.2% of men received bonus pay.

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

The recommendations and actions within the paper are likely to have a positive impact on several protected groups identified under the Equality Act 2010, particularly race, disability and sex, with additional consideration given to sexual orientation. The proposed actions aim to address identified inequalities in recruitment, disciplinary processes, staff experience, bullying and harassment, representation, staff engagement and career progression. These actions should help to reduce disparities experienced by ethnically diverse and disabled staff and promote greater equality of opportunity.

Recommendation

The Board is asked to:

- Note the 2026 WRES and WDES results.
- Receive assurance that the WRES and WDES data was submitted in May 2026 in line with submission requirements and that actions will be published on the Trust website by October 2026 to meet statutory reporting requirements.
- Note the Gender Pay Gap (GPG) figures for 2025-26 and to receive assurance that the GPG data was submitted in line with reporting requirements.
- Note the inclusion LGBTQ+ data which provides a more comprehensive overview of the experiences of staff with protected characteristics
- Support the proposed actions to address the issues raised in the data.

Meeting of the Board of Directors

Equality, Diversity and Inclusion Report 17th September 2026

1. Executive Summary

This paper provides a summary update on the Trust's progress against the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) for the period 2025/26. The paper includes details of progress against current priority areas and actions. It also summarises the gender pay gap report 2025/26, which as required, has been reported on the Trust's website.

Although there is no legal obligation to report on the comparable staff survey data for LGBTQ+ this is included in this report for completion along with proposed actions to address the issues raised by LGBTQ+ staff.

The WRES and WDES are national standards that aim to respond to lack of progress in race and disability equality in the NHS. The data identifies areas that aim to address equality gaps and improve the workplace experience for our substantive ethnically diverse and disabilities/LTHCs (long term health conditions) colleagues.

The WRES comprises of nine metrics with only four showing a favourable change (*two of these – metric 2 – recruitment, are only a slightly positive difference - metric 8 still worse than the sector average despite a slight improvement and metric 2 still highlights a marked disparity between ethnicities*). This is similar to last year when also four metrics showed a favourable change. Due to changes in the wording in the staff survey question around percentage of staff believing the organisation provides equal opportunities during 2025, there is no comparison data available for this relating to metric 7 in this reporting period.

The areas of unfavourable change are as follows:

- The likelihood of ethnically diverse staff entering the formal disciplinary process has increased from a likelihood of 2.37 to 2.72.
- The percentage of ethnically diverse staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months has significantly increased to 36.0% from 30.7% last year and is worse than the sector average.

- The percentage of ethnically diverse staff experiencing harassment, bullying or abuse from staff in last 12 months has increased to 20.9% and is again, worse than the sector average.
- The percentage difference between the organisation's Board voting membership and its overall

workforce (BME representation) continues to show an under-representation. Although the number of ethnically diverse staff on the board remains the same there has been a year-on-year increase in workforce ethnicity representation, which is positive.

The WDES is comprised of ten metrics (*of which some are split into a number of sub-metrics e.g. metric 4a-d and 9 and 9a*), four of these show a favourable change, **seven** highlight unfavourable changes and for one metric there is no comparison data due to changes in the wording of the question during 2025, as indicated in the WRES section above.

The areas where there have been unfavourable change are as follows:

- There has been a slight decrease in disability representation and status in the workforce when compared to the previous year, a decline of -0.69% to 11.31%
- Metric 4b; percentage of disabled staff experiencing harassment, bullying or abuse from managers in the last 12 months, this has increased to 9.6%
- Metric 4c; percentage of disabled staff experiencing harassment, bullying or abuse from colleagues in the last 12 months, an increase of 3.3% to now 20.9%
- Metric 4d; percentage of disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it, this is significantly unfavourable with a decline of -7.7% of reporting to now 58.4% and worse than the sector average of 61.7%
- Metric 6; percentage of disabled staff who felt pressure from their manager to come to work, despite not feeling well enough to perform their duties has increased to 16.4%
- Metric 9a; a decreased staff engagement score of 6.60 which is worse than the sector average of 6.64
- The percentage difference between the organisation's Board voting membership and its overall disabled workforce shows an under-representation at 5%.

The Trust's GPG reporting data shows a positive year on year reduction in the median gender pay gap figure. On average women within the Trust now earn £1.00 for every £1 that men earn when comparing median hourly pay. In 2020/2021 women earned 95p for every £1 that men earned when comparing median hourly pay. This shows a 5.3% reduction in the median GPG.

For the previous 2 years the median bonus gender pay gap has been zero, indicating parity in terms of the award distribution to both women and men. It should be noted that during that reporting period an equal distribution award round was in operation which influenced the median GPG figure. For 2024/25, women's median bonus pay was 54.36% higher than men's – this means they earned £1.54 for every £1 that men earn when comparing median bonus pay.

The mean bonus data identifies that women's average bonus pay was 32.92% higher than men's. Across our workforce a total of 0.3% of women and 1.2% of men received bonus pay.

LGBTQ+ Although there is currently no national benchmark available for sexual orientation or gender identity, analysis of relevant staff survey indicators are included for completeness in terms of this EDI update.

There are three areas where results are unfavourable for LGBTQ+ staff when compared to heterosexual staff.

- There is a difference of 10.2% in the percentage of LGBO staff experiencing at least one incident of harassment, bullying or abuse from patients, relatives or the public when compared to heterosexual staff.
- Reporting incidents of harassment, bullying or abuse by LGBO staff has decreased in 2025 by -2.3% 57.4% and there is a -6.5% difference between LGBO staff reporting compared to heterosexual staff.
- There is a difference of 7.5% between the percentage of LGBO staff who felt the pressure to come to work despite not feeling well enough at 59.9% compared to heterosexual staff at 52.4%.

For **transgender** staff, six areas show **significantly unfavourable** results in terms of year-on-year decline or when compared with cisgender staff.

- The last column in Table 14 below (*Diff 2025*) highlights five areas in which there are significant percentage differences in the experience of transgender compared to cisgender colleagues in the domains listed.
- There has been a 6.7% increase in the percentage of transgender staff experiencing harassment, bullying or abuse from managers.
- During 2025, 26.7% of transgender staff experienced harassment, bullying or abuse from other colleagues, an increase of 12.4% when compared to the previous year.
- Only 37.5% of transgender staff believe the organisation provides equal opportunities for career progression/promotion compared to 60.2% of cisgender staff.
- There has been a 12.5% increase in 2025 in the percentage of transgender staff who have felt pressure from their manager to come to work despite not feeling well enough to perform duties at 62.5% .
- There has been a 13.3% decline in the percentage of transgender of staff satisfied with the extent to which their organisation values their work to 43.8%.

2. WRES and WDES Performance Overview

2.1 WRES

The WRES is comprised of nine metric areas and a summary overview is provided below along with the Trust's Workforce Race Equality Data.

Metric 1

Percentage of staff in Agenda for Change pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

2026 data highlights that 26.16% of our workforce (excluding bank) are from an ethnically diverse background. This is an increase of 1.16% when compared with 2025 data and is above the current 2021 Census figures for Leeds which identify that 21% of the population are from an ethnically diverse background.

Although this is a positive representation of ethnically diverse staff working in the Trust when

compared to the census and an increase from the previous year, there continues to be under-representation at senior and Board levels, with the highest proliferation of ethnically diverse staff at bands 2-6 for both clinical and non-clinical roles. There is clearly further work required to ensure the Board is reflective of the workforce and this will need to be addressed through the recruitment process as and when board appointments arise.

“Relative Likelihood” WRES Metrics Two, Three and Four

The following three metrics indicate the likelihood of ethnically diverse (BME) candidates being appointed from shortlisting, staff entering a formal disciplinary process and staff accessing non mandatory training.

A figure of 1.0 suggests an equal position, however it is worth noting that the calculation of this data can be affected by small numbers.

Table 1

WRES Metric	Metric Description	2025 Score	2026 score
2	<i>Relative likelihood of white staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts.</i>	2.90	2.30

Table 1 highlights that there has been a slightly favourable change, with a decrease of 0.6 in the likelihood of white staff being appointed from shortlisting compared to ethnically diverse staff. For the 2026 figure, this states white staff are 2.30 times more likely to be appointed from shortlisting compared to ethnically diverse staff. However, this figure is still significantly above the ratio required to achieve parity between both white and ethnically diverse racial groups at around 1.00.

There was a 28% increase during this reporting period in the number of ethnically diverse people who were shortlisted to interview at 1634, compared to 1164 in the 2025 reporting period. Potential reasons for this may include values-based recruitment which was implemented to address disparities in the workforce and values-based questioning is utilised at interviews.

In 2025/26, there were a total of 495 appointments (excluding bank) where ethnicity was known. Of this 39.3% were from an ethnically diverse background and 60.7% were white.

Targeted recruitment interventions include the Disability Confident charter which includes actions around recruitment, the guaranteed interview scheme, outreach work undertaken with local community organisations e.g. Hamara healthy living centre (third sector organisation supporting South Asian and culturally diverse communities in South Leeds), attending Scope’s Inclusive Recruitment fair to promote LYPFT to skilled disabled jobseekers, Lighthouse Futures Reverse Jobs Fair, sharing vacancies with Workplace Leeds, Career Transition Partnership (Veterans) and Leeds City College.

Table 2

WRES Metric	Metric Description	2025 Score	2026 score
3	<i>Relative likelihood of BME staff entering the formal disciplinary process compared to White staff.</i>	2.37	2.72

There has been an unfavourable change in the likelihood of ethnically diverse staff entering the formal disciplinary process compared to white staff for 2026, resulting in ethnically diverse staff being 2.72 times more likely to. During 2025/26, there were a total of 32 individuals who entered the formal disciplinary process, 50% of these (16) were from ethnically diverse backgrounds. There has been an increase in the overall number of people who entered formal disciplinary processes during this period by 146% when compared to the 2024/25 figure of a total of 13 people, seven of which were from ethnically diverse backgrounds.

During 2025/26 there has been a refresh in the Trust's Disciplinary policy to provide clearer thresholds for formal and informal action and aims to embed a Just and Learning Culture approach. Development of the new Resolving Concerns policy and procedure will support further in providing a framework to enable concerns to be addressed and resolved earlier with a reduced necessity for formal escalation.

Table 3

WRES Metric	Metric Description	2025 Score	2026 score
4	<i>Relative likelihood of white staff accessing non-mandatory training or CPD</i>	0.75	0.93

The figures in Table 3 highlight that ethnically diverse staff are more likely to access non-mandatory training or CPD. These are positive scores for the past two years highlighting there is more equity in access to training and development and how these are promoted. Career development listening sessions were undertaken with staff networks during the first quarter of 2026 with resulting in actions aimed at outlining organisational commitment and clarity in signposting of available development opportunities, clarity on supporting structures – career development programmes, coaching and promotions and an ongoing communications campaign to promote development offers with the use of good practice and case studies.

Metrics 5 to 8 Staff Survey Responses

Two of the four national staff survey WRES metric results highlight an unfavourable change, as illustrated in Table 4 below.

Table 4

WRES Staff Survey Metrics	2022	2023	2024	2025	Year on Year Change		Against Sector Average	
% Staff- All Ethnic Groups								
% experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	35.8%	33.7%	30.7%	36.0%	5.3%	Significantly Unfavourable	33.8%	Worse
% experiencing harassment, bullying or abuse from staff in the last 12 months	22.5%	17.1%	17.8%	20.7%	2.9%	Unfavourable	20.2%	Worse
% believing that the organisation provides equal opportunities for career progression or promotion	Note: Due to changes in the question wording in 2025, previous years' results for WRES indicator 7 (Q15) are not reported			52.2%			51.6%	Better
% experiencing discrimination at work from manager/team leader or other colleagues in the last 12 months	11.8%	10.2%	13.2%	12.9%	-0.3%	Favourable	12.7%	Worse

There has been a significant increase in the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months and in addition to this, an increase in these behaviours experienced from other staff. Both measures are worse than the sector

average.

There is a slightly positive change to the percentage of staff experiencing these behaviours from line managers/team leaders or other colleagues, but the figure is still worse when compared against the sector average.

Changes to the wording of the question relating to indicator 7 (percentage believing the organisation provides equal opportunities for career progression) means that we are unable to provide a direct comparison to the previous year's data, however the figure for 2026 is slightly better than the sector average.

Table 5

WRES Metric	Metric Description	2025 Score	2026 score
9	<i>Percentage difference between the organisation's Board voting membership and its overall workforce (BME representation).</i>	-26%	-26%

Table 5 compares the difference between the Board voting membership and our overall ethnically diverse workforce. The ethnicity representation in our workforce has increased year on year, however this is not reflective within the Board and shows a disparity. The recruitment of a more diverse board is something that will need to be considered as Board members step down.

2.2 WDES

The WDES is comprised of ten metric areas.

Metric 1

This metric looks at the percentage of staff in Agenda for Change pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

The 2026 data shows that 11.31% of our workforce (excluding bank) have a disability or long-term health condition. This is a decrease of 0.69% when compared to 2025. For almost 8.0% of our workforce in 2026, disability or long term health condition status is not declared or is unknown.

“Relative Likelihood” WDES Metrics Two and Three

Table 6

WDES Metric	Metric Description	2025 Score	2026 score
2	<i>Relative likelihood of non-Disabled staff being appointed from shortlisting compared to that of</i>	1.1	0.87

	<i>Disabled staff being appointed from shortlisting across all posts.</i>		
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The ratio in Table 6 for 2026 illustrates that for the financial year 2025-26, disabled staff were more likely to be appointed from shortlisting compared to non-disabled staff.

In 2025-26 there were a total of 478 appointments where Disability status was known. Of this total 14% were Disabled, which is slightly above the disability representation of our overall workforce at 11.31%.

Table 7

WDES Metric	Metric Description	2025 Score	2026 score
3	<i>Relative likelihood of Disabled staff entering the formal capability process compared to non-Disabled staff.</i>	0	0

This metric is based on data from a two-year rolling average (2024/25 and 2025/26). During this period there were no disabled and three non-disabled staff entering the formal capability process on the grounds of performance.

Metrics 4 to 9a Staff Survey Responses

Six out of the nine staff survey WDES metric areas show an unfavourable change, as detailed in Table 8 below.

There has been a significant unfavourable change in the following two areas:-

The percentage of staff with disabilities saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it has decreased to 58.4% when compared with the previous year at 66.1% and is worse than the sector average of 61.7%.

The percentage of staff with disabilities satisfied with the extent to which their organisation values their work has decreased to 39.0% currently from 45.7% in the previous reporting year, and is worse than the sector average of 42.5%.

The area of significant improvement has been in:

The percentage of staff saying their employer has made reasonable adjustment(s) to enable them to carry out their work, which has increased by 7.1% from the previous year to 88.0% currently, which is also better than the sector average of 79.1%.

During 2025-26, there has been significant work undertaken to review and improve the workplace (reasonable) adjustments process in the Trust, with the development of a new procedure and staffnet support, due to be launched in summer 2026. Awareness of reasonable adjustments has been increasing during this time due to stakeholder involvement and responsibilities and discussions with the Trust's disability/LTHCs network - DaWN.

Another area of favourable change is metric 4a – the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months, which has slightly decreased by -1.0% to 25.7%.

Data will be shared with teams and services to inform their staff and to gather member views in

relation to potential improvement actions and areas of planning at team level to inform staff survey intention plans and discussions have taken place with the DaWN staff network to share these findings.

Table 8

WDES Staff Survey Metrics									
% Staff with a Long-Term Condition (LTC) or illness	2022	2023	2024	2025	Year on Year Change		Against Average	Sector	
% experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	30.9%	25.7%	26.7%	25.7%	-1.0%	Favourable	27.2%	Better	
% experiencing harassment, bullying or abuse from managers in the last 12 months	9.6%	8.7%	7.9%	9.6%	1.7%	Unfavourable	11.6%	Better	
% experiencing harassment, bullying or abuse from colleagues in the last 12 months	19.7%	17.2%	17.6%	20.9%	3.3%	Unfavourable	18.9%	Worse	
% saying the last time that they experienced harassment bullying or abuse at work,	59.4%	59.2%	66.6%	58.4%	-7.7%	Significantly Unfavourable	61.7%	Worse	

they or a colleague reported it								
% believing that the organisation provides equal opportunities for career progression or promotion	Note: Due to changes in the question wording in 2025, previous years' results for WRES indicator 7 (Q15) are not reported				50.8%		55.13%	Worse
% who felt pressure from their manager to come to work when not feeling well enough to work	16.2%	14.9%	15.9%	16.3%	0.4%	Unfavourable	18.3%	Better
% satisfied with the extent to which their organisation values their work	49.9%	47.4%	45.7%	39.0%	-6.7%	Significantly Unfavourable	42.5%	Worse
% saying their employer has made reasonable adjustments to enable them to carry out their work	83.5%	86.5%	80.9%	88.0%	7.0%	Significantly Favourable	79.1%	Better
WDES 9a - Staff Engagement score (0-10).	6.81	6.90	6.69	6.60	-0.09	Unfavourable	6.64	Worse

Table 9

WRES Metric	Metric Description	2025 Score	2026 Score
10	<i>Percentage difference between the organisation's Board voting membership and its overall workforce (Disabled representation).</i>	6.14%	5%

The metric in Table 9 compares the difference between the Board voting membership and our overall Disabled workforce. The data identifies that our voting Board membership is under representative of our Disabled workforce at 11.31%.

3. Gender Pay Gap

The Trust's GPG reporting data shows a positive year on year reduction in the median gender pay gap figure. On average women within the Trust now earn £1.00 for every £1 that men earn when comparing median hourly pay. In 2020/2021 women earned 95p for every £1 that men earned when comparing median hourly pay. This shows a 5.3% reduction in the median GPG.

The GPG includes a bonus pay calculation which is based on the NHS Clinical Excellence Awards (CEA) payments awarded to medical consultants within the Trust.

For the previous 2 years the median bonus gender pay gap has been zero, indicating parity in terms of the award distribution to both women and men. It should be noted that during that reporting period an equal distribution award round was in operation which influenced the median GPG figure. For 2024/25, women's median bonus pay was 54.36% higher than men's – this means they earned £1.54 for every £1 that men earn when comparing median bonus pay.

The mean bonus data identifies that women's average bonus pay was 32.92% higher than men's. Across our workforce a total of 0.3% of women and 1.2% of men received bonus pay.

There continue to be several historic CEA awards which are recurrently paid each year. The gender distribution of bonus pay and the historic CEA awards has influenced this increase due to a small number of female medical consultants who have been in receipt of an award over a long period of time compared with a larger number of male medical consultants whose length of service is much shorter and therefore they have only been in receipt of an award for the past couple of years.

The Equality Act 2017 Regulations require all organisations that employ more than 250 staff to publish their gender pay gap (GPG) information annually.

Data for the 2024/2025 GPG reporting period has been submitted to NHSE in line with reporting requirements. A summary of the results for Leeds and York Partnership Foundation Trust can be found on the Government's gender pay gap web pages.

The GPG differs from equal pay in the following way. Equal pay deals with pay differences between women and men who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a woman or man. The gender pay gap shows the differences in the average pay gap between women and men. Organisations are required to publish both the mean and median GPG pay figure.

Table 10 – Gender Pay Gap averages from 2017/18 to 2024/25.

Reporting period	2017 – 18	2019 – 20	2020 – 21	2021 – 22	2022 – 23	2023 – 24	2024 – 25
Publication date	2019	2021	2022	2023	2024	2025	2026
Average Gender Pay Gap- MEAN	11.5%	11.4%	10.9%	10.3%	10.5%	8.1%	7.2%
Average Gender Pay Gap- MEDIAN	4.4%	5.9%	5.3%	3.1%	2.3%	0.7%	-0.1%

Mean Gender Pay

The latest mean (average) gender pay figure again indicates a positive decrease of 0.9% when compared to 2023/2024 reporting period. When comparing the data detailed in Table 1, it shows a 4.3% reduction in the mean GPG over the seven-year data period.

It should be noted that although utilising mean averages are useful, that very high or low hourly pay figures can substantially influence and distort the overall figure as detailed in the section below.

Median Gender Pay

Our latest data indicates a substantial positive year on year reduction in the median gender pay gap figure as detailed in Table 1 above. On average women within our Trust now earn £1 for every £1 that men earn when comparing median hourly pay (rounded to -0.1%).

Gender Pay Quartile Profile

Table 11 - percentage of females in each pay quartile.

The lower quartile represents the lowest salaries in the Trust and the upper quartile represents the highest salaries.



The gender representation in LYPFT is approximately 74% female / 26% male. The above infographic suggests that the lower middle and upper pay quartiles represent the Trust averages where the lower and upper middle quartiles have a slightly higher male representation.

Bonus Gender Pay Gap

Table 12– the mean and median bonus pay linked to clinical excellence awards.

Reporting period	2017 – 18	2019 – 20	2020 – 21	2021 – 22	2022 – 23	2023 – 24	2024 – 25
Publication date	2019	2021	2022	2023	2024	2025	2026
Average Bonus Gender Pay Gap- MEAN	5.5%	33.0%	20.3%	15.7%	16.8%	-18.4%	-32.9%
Average Bonus Gender Pay Gap- MEDIAN	60.2%	66.0%	37.5%	36.8%	0%	0%	-54.4%

The bonus pay gap calculation is based on the NHS Clinical Excellence Awards (CEA) payments awarded to medical consultants within the Trust.

It should be noted that local CEA payments ceased in 2023/24, and historical awards only will continue to be paid.

Median Bonus Gender Pay Gap

The median gender bonus pay gap is -54.4%, which indicates a favourable female distribution. This is representative of the cumulative CEA payments for our longer serving female consultants.

Mean Bonus Gender Pay Gap

The latest mean bonus data identifies that women's average bonus pay was 32.9% higher than men's. This can be explained by the fact that there is a small number of female medical consultants who have been in receipt of a CEA payment for a number of years compared with a larger pool of male medical consultants, whose length of service is much shorter.

Across our workforce a total of 0.3% of women and 1.2% of men are in receipt of a CEA payment.

4. LGBTQ+

The data in Table 13 highlights that there are three areas where results are unfavourable for LGBO staff compared with heterosexual staff:

- There is a difference of 10.2% in the percentage of LGBO staff experiencing at least one incident of harassment, bullying or abuse from patients, relatives or the public when compared to heterosexual staff.
- Reporting incidents of harassment, bullying or abuse by LGBO staff has decreased in 2025 by -2.3% 57.4% and there is a -6.5% difference between LGBO staff reporting compared to heterosexual staff.
- There is a difference of 7.5% between the percentage of LGBO staff who felt the pressure to come to work despite not feeling well enough at 59.9% compared to heterosexual staff at 52.4%.

Table 13 – Staff Survey Question

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

Table 14 – Gender Identity

Six areas in the table below highlight that transgender staff have **poorer** experiences in the Trust compared to cisgender staff. There has been a **significant decline** year on year in five areas outlined in the table.

- The last column in Table 14 below (*Diff 2025*) highlights five areas in which there are significant percentage differences in the experience of transgender compared to cisgender colleagues in the domains listed.
- There has been a 6.7% increase in the percentage of transgender staff experiencing harassment, bullying or abuse from managers.
- During 2025, 26.7% of transgender staff experienced harassment, bullying or abuse from other

colleagues, an increase of 12.4% when compared to the previous year.

- Only 37.5% of transgender staff believe the organisation provides equal opportunities for career progression/promotion compared to 60.2% of cisgender staff.
- There has been a 12.5% increase in 2025 in the percentage of transgender staff who have felt pressure from their manager to come to work despite not feeling well enough to perform duties at 62.5% .
- There has been a 13.3% decline in the percentage of transgender of staff satisfied with the extent to which their organisation values their work to 43.8%.

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

5. Next Steps and Proposed Actions

5.1 WRES, WDES & LGBTQ+ Actions

Overall the data from the WRES, WDES as well as the data for LGBTQ+ staff highlights significant

areas for improvement if the Trust is to improve the experience of our ethnically diverse workforce and staff with disabilities/long term health conditions.

Achievements since September 2025:

- **Established** a Strategic EDI Group, chaired by the Chief People Officer, to provide clear leadership for the Trust's EDI agenda, set strategic direction, and oversee the delivery of agreed actions. The group has met regularly since its inaugural meeting in September 2025.
- **Developed** a new Resolving Concerns Policy and Procedure to replace the previous grievance and bullying and harassment processes. This new approach has supported earlier resolution of workplace concerns, reduced unnecessary escalation into formal procedures, and strengthened the Trust's response to bullying and harassment complaints.
- **Delivered** a comprehensive communication plan to raise awareness of the extensive support available for staff with disabilities and long-term health conditions. Information has also been embedded within the new starter process and wellbeing conversations to improve accessibility and awareness.
- **Implemented** a new workplace adjustment process, supported by clear guidance for managers, to ensure staff receive appropriate workplace adjustments in a timely and consistent manner.
- **Completed** a listening exercise with the Trust's staff networks to better understand how the organisation can support the career development of staff with disabilities and long-term health conditions, ethnically diverse staff, and LGBTQ+ colleagues. Feedback has informed ongoing improvements to the Trust's EDI priorities.
- **Reviewed and enhanced** recruitment and selection training to strengthen unconscious bias awareness and reinforce the importance of diverse and representative recruitment panels across the Trust.
- **Evaluated** the Cultural Competence Training pilot and **developed an implementation plan** to roll out the programme more widely across the Trust, with an initial focus on identified hotspot areas.

As part of the integration, we are mapping out the EDI agenda with LCH. Once this work is complete, we will be in a stronger position to identify the key actions and priorities moving forward.

6. Governance and Assurance

The Trust's WRES and WDES data was submitted in line with reporting requirements i.e. by 31 May 2026 and the data and revised action plan will be published in October 2026 on the Trust's website as per national reporting requirements.

The data and action plans will be shared with staff networks, who have played a key role in contributing to our improvement actions, as well as the Equality, Diversity and Inclusion Strategic Group, the People and Culture Committee, senior leadership teams, trade union representatives, and other relevant governance groups involved in delivering the actions. This will ensure that the

findings inform planning, decision-making, and the ongoing implementation of improvement initiatives.

Work is now underway to develop a reporting framework on the ethnicity pay gap in line with national

requirements and further information about this will be provided to the Board when we are clear about the expectations and reporting requirements.

Further work will be undertaken of the staff survey data in the areas mentioned above to drill down further and explore issues at a more granular level so that hotspot areas can be identified and targeted action and interventions are provided.

7. Recommendations

The board is asked to:

- Note the 2026 WRES and WDES results.
- Receive assurance that the WRES and WDES data was submitted in May 2026 in line with submission requirements and that actions will be published on the Trust website by October 2026 to meet statutory reporting requirements.
- Note the Gender Pay Gap (GPG) figures for 2025-26 and to receive assurance that the GPG data was submitted in line with reporting requirements.
- Note the inclusion LGBTQ+ data which provides a more comprehensive overview of the experiences of staff with protected characteristics
- Support the proposed actions to address the issues raised in the data.

Name of author Zaidah Ahmed

Title Head of EDI

Date paper written 20/8/26

Meeting of the Board of Directors

Paper title:	Equality Diversity & Inclusion EDS Standards
Date of meeting:	24 September 2026
Presented by: (name and title)	Darren Skinner – Director of People and Organisational Development
Prepared by: (name and title)	Zaidah Ahmed Head of EDI

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	Demand for services	
SR8	Health inequalities	✓
SR9	System change	

Executive summary

The EDS is an accountability improvement tool for all NHS organisations in England to review and develop their services, workforces and leadership. It is driven by evidence and insights. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities. It is driven by data, evidence, engagement and insight.

The EDS is commissioned by NHS England with support from the NHS Equality and Diversity Council (EDC), and comprises of eleven measured outcomes split into three core Domains, which are:

- 1) Commissioned or provided services
- 2) Workforce health and well-being
- 3) Inclusive leadership

The EDS outcomes are evaluated, scored, and rated using available evidence and insight. The ratings are used to provide assurance or point to the need for improvement. The EDS is also designed to encourage the collection and use of better evidence and insight across the range of protected characteristics described in the Equality Act 2010. This will help us as an NHS organisation to meet our public sector equality duty (PSED) and to set our equality objectives.

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

The EDS specifically considers the impact of NHS services, workforce health and wellbeing, and inclusive leadership on people with protected characteristics under the Equality Act 2010. Therefore, the recommendations in this paper have relevance to the requirements of the protected groups and support the Trust's Public Sector Equality Duty (PSED) and equality objectives.

Recommendation

The Board is asked to receive and note the contents of this report.

Meeting of the Board of Directors

Thursday 24 September 2026

Equality Delivery System (EDS)

1. Executive Summary

The EDS is an accountability improvement tool for all NHS organisations in England to review and develop their services, workforces and leadership. It is driven by evidence and insights. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities. It is driven by data, evidence, engagement and insight.

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The public sector's equality duty is to eliminate discrimination, harassment, and victimization; advance equality of opportunity and promote good relations between different protected groups.

We must consider:

- Age
- Disability
- Gender reassignment
- Carers
- Race
- Religion or belief
- Sexual orientation
- Sex
- Pregnancy and maternity (and paternity)

Inclusion health groups: people who are socially excluded and experience multiple risk factors for poor health such as poverty, violence, and complex trauma. This can include people who experience homelessness, drug and alcohol dependence, Gypsy, Roma and Traveler communities, sex workers, victims of modern slavery, refugees, asylum-seekers, and undocumented migrants.

This year (2025/26) we choose to carry out in depth equality assessments on each of the three very different services supported by inclusion officers:

- CONNECT Eating Disorder Service

- Crisis Service (East)
- Community Mental Health Team (East)

Each service followed the full EDS assessment and has a subsequent EDS Action Plan that will be supported and delivered via the services Clinical Improvement Forums.

Adhering to the NHSE EDS guidance, we have provided the full EDS (2025/26) report using the highest of the three services assessed, which this year is CONNECT Eating Disorders Service.

Partnership approach: We worked collaboratively with West Yorks ICB, NHS providers, Healthwatch and Forum Central to peer review each other's EDS assessments. We held collaborative spaces where we shared our initial findings and discussed system wide improvements we could make, we collated shared objectives and formed actions plans based on this work.

Details of our evidence and performance on each outcome are detailed in the appended reports.

- Appendix one – Completed EDS template with supporting evidence and action plan 2026/27,
- Appendix two - The Trust's WRES and WDES report,
- Appendix three - The Trust's Freedom to Speak Up Annual Report.

4 NHSE EDS Scoring Framework

Undeveloped activity – organisations score out of 0 for each outcome	Those who score under 8 , adding all outcome scores in all domains, are rated Undeveloped
Developing activity – organisations score out of 1 for each outcome	Those who score between 8 and 21 , adding all outcome scores in all domains, are rated Developing
Achieving activity – organisations score out of 2 for each outcome	Those who score between 22 and 32 , adding all outcome scores in all domains, are rated Achieving
Excelling activity – organisations score out of 3 for each outcome	Those who score 33 , adding all outcome scores in all domains, are rated Excelling

5 LYPFT 2025/26 Scoring Outcome

LYPFT 2025/26 final score outcome for each domain and an overall rating is as follows:

1	Commissioned or provided services.	Score of 9 out of a possible 12	rated as achieving
2	Workforce health and wellbeing	Score of 6 out of a possible 12	rated as developing
3	Inclusive Leadership	Score 3 out of a possible 9	rated as developing
LYPFT total		18 out of a possible 33	rated as developing

6 Key issues, significant risks, and mitigations

This year we have continued to take a robust and pragmatic approach to the EDS process to ensure that the process is properly embedded across the Trust with a focus on continuous improvement and practical actions to address staff and service experience.

Integral to the EDS process is to address any disparities between the protected groups under the Equality Act 2010. Although some satisfactory progress has been made in implementing the EDS action plan, there are still a number of areas that need further work and it is proposed to make the areas outlined below key priorities for 2026.

7 Agreed EDS Improvement Actions

Domain One: CONNECT Community Adult Eating Disorder Service

- **Treatment delays** (reduce wait times)

Increase psychological capacity by hiring two new full-time equivalent therapists within the next 12 months to reduce the average waiting time from referral to treatment and achieve the NHSE standard of '90% of service users receiving treatment within four weeks.

- **Tracking referrals** (monitoring delays)

Fully implement reliable recording method for referral-to-treatment times within 6 months, ensuring 100% of all new referrals are recorded using this system to provide accurate monthly demographic reporting on waiting times.

- **Information leaflets in alternative languages** (accessibility)

Identify the top ten most prevalent languages spoken by our service users using recent demographic data, translate core information leaflets into these ten languages within six months, and ensure they are readily available in all service locations and online by the start of quarter 3 (2026/27).

- **Cultural competence** (training and awareness)

Within the next 12 months, achieve 90% staff attendance of 'Cultural Competence and Humility' training. Participating staff will measurably increase their cultural competency and demonstrate the application of skills in managing culturally diverse patient needs, specifically through effective communication (clarifying preferences), adopting a patient-centred approach that incorporates individual cultural preferences, and engaging in self-reflection to identify and challenge implicit biases, as measured by post-training reflections and quality improvement standard.

- **Recording compliments and complaints** (capturing feedback)

Establish a standardised system for recording and capturing all compliments and complaints received across all contact points (email, cards, verbal, written feedback forms) by the end of Q1 and include a summary of this data in the quarterly performance reports starting from Q2.

Domain Two: EDS Improvement Actions

- Ensure access to information about the protected characteristics of staff using Health and Wellbeing services.
- Review and co-produce a basic monitoring form as an effective way to record who is accessing the main Health and Wellbeing services, and that staff are given support and resources to ensure that they feel confident in collecting staff data.
- Develop and implement an improvement plan to address Health Inequalities within the workforce - NHS England EDI Improvement Plan High Action 4.
- FTSUG, Staff Side and HRBP's and other key stakeholders collaborate on triangulating relevant bullying, harassment, abuse, discrimination data.

Domain Three EDS Improvement Actions

- Implement a talent management programme to help improve diversity and inclusivity within the Trust's senior leadership team and Trust board.

8 Responsibilities for delivery and governance

Overall responsibility for the EDS lies with the Board. The newly established Strategic EDI Steering Group has oversight of the EDS and Trust's EDI strategy.

The responsibility for the improvement plan for Domain 1 is with the leadership and management of those Services and progress is overseen by the Clinical Services Development and Delivery Group.

For Domains 2 and 3 responsibility sits with the People and Organisational Development Directorate and regular updates on progress will be provided to the Strategic EDI Steering Group and the Workforce Committee.

The results of the EDS review and the resulting action plan should feed into service-based plans and corporate and strategic objectives. They should also contribute to longer-term equality objectives. Integral to EDS is the insights and meaningful engagement of staff networks and staff side representation.

It is important that the Trust uses the EDS as the core of its equality work and a contributory to strategies to address health inequalities.

9 Conclusion

The implementation of the EDS is mandatory as per the NHS contract and the framework was developed to support NHS organisations and commissioners to meet the requirements set out in the Equality Act 2010 and public sector duty (PSGD).

The template below focuses on outcomes associated with domain 1, 2 and 3 and provides evidence and insight against all areas. The scores form the basis for the EDS improvement action plan, and the EDS template will be published on the Trust's website by the 28 February 2026.

As noted above, the report scoring has been Peer Reviewed by representatives from the West Yorkshire ICB, Leeds Teaching Hospitals and Leeds Community Healthcare NHS Trust on 1st December 2025.

5 Recommendation

It is recommended that the Board note the evidence and insights detailed in the attached EDS report template and to support the delivery of the action plan in 2026/27.

Board should note that the evidence and action plan must be published on the Trust's website by 28 February 2026.

Appendix One:

LYPFT Completed NHS Equality Delivery System (EDS) template with supporting evidence and insights

Name of Organisation		Leeds and York NHS Partnership Foundation Trust CONNECT Community Adult Eating Disorder Service	
Organisation Board Sponsor/Lead		Joanna Forster Adams (Chief Operating Officer) Darren Skinner (Director of People and Organisational Development)	
Name of Integrated Care System		West Yorks ICB	
EDS Lead	Sophie Valinakis (Head of Health Equity) Zaidah Ahmed (Head of EDI)	At what level has this been completed?	
EDS engagement date(s)	22 nd Sept 25 (Equity Leads across ICB) 1 st Dec 25 (EDI Leads across ICB)	Individual organisation	Leeds and York NHS Partnership Foundation Trust
		Partnership* (two or more organisations)	Leeds and York NHS Partnership Foundation Trust Leeds Community Hospital Leeds Teaching Hospital Trust Healthwatch Forum Central
		Integrated Care System-wide*	West Yorks Integrated Care Board
Date completed	29.12.25	Month and year published	28.02.26
Date authorised	tbc	Revision date	tbc

EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly

Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance to scores are below

Undeveloped activity – organisations score out of 0 for each outcome	Those who score under 8 , adding all outcome scores in all domains, are rated Undeveloped
Developing activity – organisations score out of 1 for each outcome	Those who score between 8 and 21 , adding all outcome scores in all domains, are rated Developing
Achieving activity – organisations score out of 2 for each outcome	Those who score between 22 and 32 , adding all outcome scores in all domains, are rated Achieving
Excelling activity – organisations score out of 3 for each outcome	Those who score 33 , adding all outcome scores in all domains, are rated Excelling

Appendix One: EDS Assessment & Action Plan

Domain 1: Commissioned or provided services

Domain One	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	- Referral to the service done by GP or health professionals and consent checked. - Letter of appointment sent with information about service and what will happen next. - Referral-response times are monitored against national standard. - Assessment Waiting Times: The average time from referral to assessment is 15 weeks, which is a significant delay. The goal of commencing treatment within 3 weeks of assessment is not being met. - Treatment Delays: The average waiting time from referral to treatment is now 16 weeks, up from a previous 10-12 weeks. This is due to staff shortages, specifically maternity leave and sick leave. - National Benchmark: The service has internally adopted a 4-week target from referral to treatment, which is more ambitious than the national benchmark of 90% of patients commencing treatment within 18 weeks. However, the service is currently struggling to meet even this internal target. - The service offers First episode and Rapid Early intervention for eating disorders (FREED) for adults with less than 3 years duration of illness and aged 18-25 with a suspected diagnosis of moderate / severe Anorexia Nervosa i.e. core psychopathology and BMI <17kg/m². Also, for those diagnosed with mild / moderate Bulimia nervosa (core psychopathology and weekly bingeing and purging) with less than 3 years duration of illness and aged 18-25. - Lack of Capacity: delays are primarily attributed to insufficient psychological capacity within the team. - Open Access: CONNECT operates an open access pathway that offers support to people who do not meet the service criteria and want to access specialist eating disorders advice. The 'Hub' is a weekly session open to anyone with an eating disorder including carers and family. Translator can be booked for non -English speakers if required.	1	CONNECT Community Adult Eating Disorder Service

Continued... Domain 1: Commissioned or provided services	Continued... 1A: Patients (service users) have required levels of access to the service	- Training: CONNECT delivers eating disorders specific interventions training is offered to all the staff to share good practice, knowledge and research. - Dieticians provide information on portion sizes & dietary plans to improve care. - University training: CONNECT delivers eating disorders training to student nurses and OT students on eating disorders, presentation and treatment. - Training to other professions: CONNECT has delivered training to Prison staff, other health professionals, and General Practitioners. CONNECT also offer Medical Emergency in Eating Disorders (MEED) Training to other professionals - Inclusion and Engagement with Communities / VSCE. Inclusion coordinator has actively been involved in doing outreach work with culturally diverse communities, listening to their voices and understanding the barriers to accessing service. Inclusion worker involved in educating and empowering culturally diverse communities to feel able to access the service and staff to be more inclusive in their approach. - Patient Information: eating disorders information leaflets available for patients and staff. These are currently in English only. Work is needed to make them available in different formats and alternative languages. - Language and communication – communication needs are captured at referral. Interpreters including British Sign Language (BSL) are available via the Trust interpreter and translation booking system. - Social media: Instagram used to educate & inform about eating disorders inc. live recordings on nutrition, addressing challenging times e.g. Christmas, Diwali, Ramadan. - Accessibility – CONNECT Eating Disorders base has accessible ground-floor facilities; flexible locations, including home visits, or other suitable locations, based on service user preference and risk to support individual needs. - Data collection across the service, particularly regarding the recording of ethnicity and sexual orientation in Care Director, requires improvement. - Pregnant women are prioritised access to the service. - Exclusion Criteria: CONNECT does not accept referrals for individuals who have a current history of psychosis or any other psychiatric or physical health disorder which requires treatment before their eating disorder can be addressed. CONNECT requires a period of three months of abstinence following the misuse of/dependency on illicit substances and/or alcohol. There is an exclusion criterion which leave out a lot of other eating disorders like ARFID, Binge disorders.		CONNECT Community Adult Eating Disorder Service
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Continued... Domain 1: Commissioned or provided services	1B: Individual patients (service users) health needs are met	- Service user preferences, such as preferred gender of worker, pronouns, name and venue are all considered from receiving the referral. - Welcome pack available is available, however we identified this will be made into alternative languages and formats. - Adaptable and patient centred care: the service is adaptable and tailored to meet service users' unique needs where possible. This has been feedback from service users, for example, staff are trained to be competent in skills to provide care as the patient's complexity intensifies. Staff are trained in diabetic care to allow better quality care for patients in the Type 1 Diabetes and Disordered Eating (T1DE) Pathway. - Religion: where there are further individual needs relating to religion, the views and wishes of the family are taken into consideration e.g. consideration during Ramadan when providing care to a patient from Muslim families. Care plans facilitate cultural and spiritual needs. - Facilities: prayer rooms available at base near outpatient clinic rooms. - Care plans are completed on admission and reviewed regularly. Care plans are culturally inclusive considering dietary needs, religious needs, sensory, spiritual needs, Collaborative care plans done with service users and when consent given carers involved. - Dieticians tailor-make dietary plans to suit cultural needs. - Evidence of care: documenting of care provided on Care Director with clear care plans and safety management for high-risk patients. - Appointment reminders are done via texts, calls or emails if preferred. - Equipment: every staff member has weighing scales, and equipment is available on clinic sites to ensure care needs on weight monitoring are met. - Evidence based treatment: CONNECT offer treatment evidence based and in accordance with NICE Guidelines such as Cognitive Behavioural Therapy Eating Disorder Focused (CBT-ED), Cognitive Behavioural Therapy (CBT), The Maudsley Model of Treatment for Adults with Anorexia (MANTRA) and psychological therapy. - CONNECT staff are trained in Care, Treatment Reviews (CTRs) and Dynamic support registers (DSR) and Care (Education). The service now has a good understanding of the CTR and DSR process and the importance of these processes for effectively supporting people with learning disabilities or autism.	2	CONNECT Community Adult Eating Disorder Service
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Continued... Domain 1: Commissioned or provided services	Continued... 1B: Individual patients (service users) health needs are met	- Treating Eating Disorders LD/Neurodivergence Pathway has been co-produced with involvement of service users from the beginning, and their voices were listened to. (Treatment of Eating disorders in Autistic people = 'TEA'). - Collaborating with other healthcare services e.g. Gastro- wards for Medical Emergency in Eating Disorders (MEED) patients, Community Mental Health Team, MEED Huddles are done weekly to prioritise patient care and safety. Diabetes team, Leeds Autism Diagnosis Service, Perinatal service etc to facilitate coordination of care for patients. - Sex/Gender: where there may be characteristics such as sexual orientation or gender reassignment, the service has ready-made space to acknowledge these individualities. Service users' preference of worker considered when making allocations. CONNECT work collaboratively with Gender Identity services. - Information: the service offers accessible information for our patients. CONNECT offers reasonable adjustments such as interpreters where required. Visual communication aids are available. - Collaborative care: CONNECT has a strong commitment to involving patients in their care plans. Staff accurately reflect this engagement by completing the relevant section in Care Director showing collaboration and using service user voices. - Treatment reviews and CPA: are done collaboratively with service users and helps to ensure that treatment is meeting service user needs. - Disability: wheelchair access is available and face to face appointments offered for service users with hearing difficulties. - Carers are offered support on a 1:1 basis and in a group setting. Carers lead in post. - Evaluation/Audit: auditing care is done to evaluate the quality, accuracy and completeness to ensure that all patients receive safe quality care.		CONNECT Community Adult Eating Disorder Service
	1C: When patients (service users) use the service, they are free from harm	- Datix - incidents, near misses, and feedback (including safeguarding) are recorded via Datix. - Training: all staff trained on incident recording and use of Datix to ensure all incidents are captured. Staff have all completed Risk Assessment Management Plan training. Mandatory training including Safeguarding. All staff are up to date with mandatory training including Oliver McGowan. - Incident Data: CONNECT recorded seven incidents during the period. These incidents included self-harm, information governance breaches (confidentiality), and one death.	3	CONNECT Community Adult Eating Disorder Service

Continued... Domain 1: Commissioned or provided services	1C: When patients (service users) use the service, they are free from harm	- Investigation of Death: reported death involved a service user who was not actively under the care of CONNECT at the time but had contact with the service within the six months prior. - Safety Outcome: A fact-finding investigation was initiated in response to the incidents. Of the seven incidents, 90% were categorised as causing low or no harm, indicating the community service is safe. - CIF (Clinical Improvement Forum) meetings review incidents and themes. CTMs (Clinical Team Managers) have access to dashboards. - Thematic reviews and learning from serious Incidents and AARs (After Actions Reviews) are shared with the team in clinical improvement forums and clinical governance meetings. - PSIRF (Patient Safety Incident Response Framework) has been adopted are used post-incident to support learning. - Safety planning is standard across the team, using RAMP (Risk Assessment and Management Plan) and MDTs (Multi-disciplinary Team meetings), recent audit completed. - Safeguarding supervision is available to all staff via team meeting and on 1:1 basis. - Supervision: all staff members use regular clinical and management supervision to improve clinical practice.		CONNECT Community Adult Eating Disorder Service
	1D: Patients (service users) report positive experiences of the service	Feedback- gathered via Have Your Say, PALS (Patient Advice and Liaison Service), Datix and Service User Involvement Group & Carer Support Group. CONNECT uses patient experience data and feedback to influence the wider system and build interventions. Feedback also gathered during clinical interventions. All care is person-centred and holistic health needs are assessed. Collaborative working: CONNECT has been actively working with the local Voluntary Community Social Enterprises, engaging with culturally diverse communities in the West Yorkshire region and finding out more about barriers to accessing services and how these can be reduced. The service has been actively raising awareness and listening to feedback ensuring all patient voices are heard for example recent engagement work with Hamara women's group. Service User involvement group meets once a month. It includes those who used the service within the last 12 months. This group brings people with lived experience	3	CONNECT Community Adult Eating Disorder Service

Continued... Domain 1: Commissioned or provided services	Continued... 1D: Patients (service users) report positive experiences of the service	together to share their views and provide valuable feedback to help develop and improve the service. Carer Support Group meets once a month via zoom. Carers are specifically for parents and carers of a loved one who has been referred to the service. Carer feedback captured through Carers Support Group and from individual feedback. Feedback volume remains limited, with only a few Have Your Say responses received between January and March 2025. CONNECT is working on capturing all forms of feedback given. Key Feedback Themes - Compassionate, Supportive, Individualised Care: - Feedback highlights the warmth, empathy, and compassion of staff. Clinicians are described as "approachable, kind, and supportive." - Service users felt "really supportive, reassuring, and non-judgmental." - Dieticians were praised for providing personalised care and clear nutritional guidance. - Empowerment and Autonomy: - Service users valued being given responsibility for their recovery with CONNECTs guidance. - Feedback included feeling "heard and understood," which helped them "explain things I've never said out loud before." - The service helped users "understand myself more and what I've been struggling with and gave me answers." Clinicians are approachable, kind, and supportive. - "Everyone has been extremely easy to talk to and have made me feel relaxed and cared for." - Feedback referred to the importance of clear communication and autonomy. Service users value being given responsibility for their recovery, with CONNECTs guidance. - "Told me directly how things were... whilst ultimately giving me the freedom to make the decisions for myself." - "Very clear and individual nutrition plan based on my personal circumstances." - "I felt really heard and understood. It helped me explain things I've never said out loud before."		CONNECT Community Adult Eating Disorder Service
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<i>Continued... Domain 1: Commissioned or provided services</i>	Continued... 1D: Patients (service users) report positive experiences of the service	- "He helped me understand myself more and what I've been struggling with and gave me answers." - Group Support: feedback from group therapy treatment indicates that group therapies are beneficial for building Connection, normalising experiences, and providing emotional support. - You say, we did: CONNECT is good at giving feedback on what they have done following feedback. This is done via Instagram, service user group and carers group.		CONNECT Community Adult Eating Disorder Service
Domain 1: Commissioned or provided services overall rating			9	

Domain Two	Outcome	Evidence	Rating	Owner
Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Comprehensive Occupational and wellbeing offer in place for all staff including bank staff. EDI data is now provided via the Occupational Health Service and will be discussed and reviewed at the Strategic EDI Steering Group A range of information is available to staff to support the self-management of listed health conditions including mental health, MSK and reasonable adjustments e.g., Thrive and counselling support. Support and advice on managing obesity in line with NICE guidance. Wide range of menopause support in place. All health and wellbeing information is updated and developed on a regular basis.	2	POD

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	LYPFT Values and Behaviours in place and discussed at induction and integrated into leadership offer and PDR Pilot of and roll out Cultural Competence and Humility Training across LYPFT undertaken and learning being used to develop further training as part of the Trust's 360 Manager programme. Developing a positive workplace culture workshop developed and being rolled out to teams as appropriate. Violence Reduction Group in place. WRES and WDES plans in place to support a year-on-year reduction in bullying and harassment Action plan to support the full implementation of PCREF in place. FTSUG, Staff Side and HRBP's and other key stakeholders collaborate on triangulating relevant workforce data and co-producing appropriate interventions.	1	
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	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	FTSU service embedded in the Trust for over 5 years and promoted via: • A FTSUG or FTSUAs attend the monthly Trust Induction so that new starters to the Trust are aware of the service. • Intranet page available to all staff that includes the Raising Concerns policy and FTSU communications plan. • Visibility on site via posters, attendance at team meetings and visits. The team wear a Green Lanyard to be recognisable. • Regular use of communications methods - Trust Wide communications newsletter and blogs. • Regular issuing of evaluation forms to gain feedback from colleagues and managers on how to improve our communications. • FTSUG reporting (6 monthly) at the Public Board meeting. • Signposting staff to Trust Health and Wellbeing Resources and supporting to identify and signpost any further support/advice that colleagues may need on their concerns. • FTSU service promotes the Speak Up, Listen Up and Follow Up Training modules for all staff across the Trust on iLearn • Managers and colleagues are requested to promote the FTSU service within their teams as an ongoing action. • FTSU Guardian and 5 FTSU Ambassadors from diverse backgrounds already in place • The team have been on refresher training including cultural inclusion, sexual safety, preventing radicalisation, EDI and human rights and learning disabilities and autism	2	POD
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		• Current ambassadors have renewed their support to continue as an ambassador with agreed protected time from line managers • The FTSUG continues to have a presence a staff network meeting • Concerns from all protected characteristics within the Trust are collated and this data is shared and discussed with the Head of EDI and Director of People HR Support & Intervention • Confidential Advice and Guidance: HR provides a safe and confidential space for staff to raise concerns outside of their direct management line. They offer advice on both informal and formal routes to address bullying, harassment, or abuse. • Formal Processes: Staff can access the grievance & B&H procedure/policy, which outlines clear steps for raising and investigating concerns. • Mediation Services: Where appropriate, HR can facilitate mediation to support resolution and rebuild working relationships. • Collaborative Working: HR work closely with staff-side representatives, the Freedom to Speak Up Guardian, and staff networks to ensure staff feel supported and heard. These partnerships help us triangulate concerns and ensure appropriate action is taken. • Staff can contact HR directly via the HR Advice Line or email, or be referred through staff-side, wellbeing services, or the Freedom to Speak Up Guardian.		
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		- Managers are also encouraged to signpost staff to HR when concerns are raised informally, particularly if the staff member is uncomfortable approaching their line manager. - The Trust's B&H policy has been reviewed to ensure that it is in line with the national NHS work on Resolving Concerns, to ensure our approach is consistent, inclusive, and accessible.		
	2D: Staff recommend the organisation as a place to work and receive treatment	Targeted work in place to improve Exit interview completion rates for staff with protected characteristics. Exit interview feedback is reviewed and action plans developed in response to feedback. People plan in place with a focus on improving staff experience at work.	1	POD
		Teams, services and POD with key stakeholders including staff networks and staff side review NHS staff survey data to help understand the reasons why staff are not recommending LYPFT as a place to work or receive care. Service / directorate and Trust wide action plans in place to address feedback from staff.		

Domain	Outcome	Evidence	Rating	Owner
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Leading the way in mental health, learning disability and neurodiversity care

integrity

simplicity

caring

Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Trust's 360 Manager and the new national leadership and management framework include the recommendations of the Messenger Review so that all leaders and managers are aware of their EDI role. Review of EDI development needs of the board and managers across the Trust undertaken and interventions to address these needs are being developed. EDI discussed at board meetings as part of the COO's report. Strategic EDI Steering Group in place – reporting to the Trust's workforce committee. Trust's equality objectives have been updated and published with clear actions to meet the objectives. Talent programme for deputy directors completed (Shadow Board Programme). Listening Events held with staff networks to support the scoping of a Talent Programme aimed at addressing inequalities and lack of progression for underrepresented staff.	1	POD
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks	Strategic EDI Steering Group in place with a focus on assurance and governance in respect of the EDS, the NHS EDI Improvement Plan 6 High Impact actions and EDI objectives. Workforce Board report includes EDI data in relation to all of the protected characteristics.	1	POD/ Ops

	and how they will be mitigated and managed	Chief Operating Officer's report includes as a standing item work underway to improve the key EDI and Health Inequalities KPI's		
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Each Board member and VSM (Band 8C+) to have formalised SMART EDI objectives relating to workforce and or tackling Health inequalities, with an annual submission for accountability purposes. Board members to receive the necessary support to help them to demonstrate how data and lived experience have been utilised to improve organisational culture. Board meetings always start with a Service User story followed by a discussion reflecting on lessons learning / best practice. Health Inequalities improvement plan is in place to support senior leaders to support tackling health inequalities and creating a truly inclusive LYPFT.	1	POD/Ops

EDS Organisation Rating (overall rating):

1	Commissioned or provided services.	Score of 9 out of a possible 12	rated as achieving
2	Workforce health and wellbeing	Score of 6 out of a possible 12	rated as developing
3	Inclusive Leadership	Score 3 out of a possible 9	rated as developing
LYPFT total		18 out of a possible 33	rated as developing

Organisation name: Leeds and York NHS Partnership Foundation Trust

- Those who score **under 8**, adding all outcome scores in all domains, are rated **Undeveloped**
- Those who score **between 8 and 21**, adding all outcome scores in all domains, are rated **Developing**
- Those who score **between 22 and 32**, adding all outcome scores in all domains, are rated **Achieving**
- Those who score **33**, adding all outcome scores in all domains, are rated **Excelling**

EDS Action Plan				
EDS Lead			Year(s) active	
Sophie Valinakis (Head of Health Equity) Zaidah Ahmed (Head of EDI)			2026/27	
EDS Sponsor			Authorisation date	
Joanna Forster Adams (Chief Operating Officer) Darren Skinner (Director of People and Organisational Development)			28/02/26	
Domain One	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Service information leaflets in alternative languages to improve accessibility for those speaking alternative languages to English.	Identify the top ten most prevalent languages spoken by our service users using recent demographic data, translate core information leaflets into these ten languages within six months, and ensure they are readily available in all service locations and online by the start of quarter 3 (2026/27).	Start of Q3 (2026/27)

	1B: Individual patients (service users) health needs are met	Reduce treatment delays and waiting times to access services.	Increase psychological capacity by hiring two new full-time equivalent therapists within the next 12 months to reduce the average waiting time from referral to treatment and achieve the NHSE standard of '90% of service users receiving treatment within four weeks.	End of Q4 (2026/27)
		Improving recording of referrals and monitoring delays	Fully implement reliable recording method for referral-to-treatment times within 6 months, ensuring 100% of all new referrals are recorded using this system to provide accurate monthly demographic reporting on waiting times.	Start of Q3 (2026/27)
	1C: When patients (service users) use the service, they are free from harm	Increase Cultural Competency and Cultural Humility Training and awareness	90% staff attendance of 'Cultural Competence and Humility' training. Participating staff will measurably increase their cultural competency and demonstrate the application of skills in managing culturally diverse patient needs, specifically through effective communication (clarifying preferences), adopting a patient-centred approach that incorporates individual cultural preferences, and engaging in self-reflection to identify and challenge implicit biases, as measured by post-training reflections and quality improvement standard.	End of Q4 (2026/27)
	1D: Patients (service users) report positive experiences of the service	Recording compliments and complaints (capturing feedback)	Establish a standardised system for recording and capturing all compliments and complaints received across all contact points (email, cards, verbal, written feedback forms) by the end of Q1 and include a summary of this data in the quarterly performance reports starting from Q2.	End of Q2 (2026/27)

Domain Two	Outcome	Objective	Action	Completion date
Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Increase the monitoring of staff health with protected characteristics.	<i>EDI data is now provided via the Occupational Health Service and will be discussed and reviewed at the Strategic EDI Steering Group</i>	Completed.
		Increase information available for the self-management of listed conditions.	<i>A range of information is available to staff to support the self-management of listed health conditions. This is updated and developed on a regular basis.</i>	Completed
		Address health inequalities within the workforce	Develop and implement an improvement plan to address Health Inequalities within the workforce - NHS England EDI Improvement Plan High Action Plan	July 2026

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occurs	Promote and proactively discuss LYPFT Values and Behaviours at Team meetings.	Completed and On-going.
			Pilot of and roll out Cultural Competence and Humility Training across LYPFT.	Completed.
			Reflect on the evaluation of the above pilot and agree how best to embed this training within the Trust's development offer.	July 2026
			Re-convene the work of the Violence Reduction Group	Completed
			Implement WRES and WDES plans to reduce B&H year on year.	On-going work October 2026
			Review and refresh the anti-racism statement.	Sept 2026
			Implement the PCREF.	Completed
			FTSUG, Staff Side and HRBP's and other key stakeholders collaborate on triangulating relevant workforce data and co-producing appropriate interventions.	On-going

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Improve the support available for staff outside of their line management structure around bullying, harassment, abuse and violence from any source.	Promote the Freedom to Speak up Guardian service across LYPFT.	Completed and on-going
			Increase the number and diversity of Freedom to Speak Up Ambassadors across LYPFT.	Completed
			Review, Promote and Support the use of an Equality and Diversity monitoring form for LYPFT and external support services.	Completed
			Review and implement a communication and engagement plan to promote services that support staff experiencing bullying, harassment, verbal and physical abuse across LYPFT.	Completed
	2D: Staff recommend the organisation as a place to work and receive treatment	Increase quality of exit interview data available	In collaboration with People and OD Directorate improve Exit interview completion rates for staff with protected characteristics.	Completed and action plans in place to address issues highlighted.
		Review and deep dive into the NHS staff survey data to help understand the reasons why staff are not recommending LYPFT as a place to work or receive care.	In collaboration with POD stakeholders and staff networks to deep dive into relevant workforce and patient service data to co-produce key actions to address why staff are not recommending the Trust as a place to work or receive treatment.	Sept 2026

Domain 3	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Meeting LYPFT Legal and Contractual EDI and Health Inequalities obligations – Beyond Compliance	EDI as recommended by the Messenger Review must be embedded and mainstreamed as the responsibility of all regardless of role, and especially leaders and managers from front line to board.	Completed as an integral part of the NHS Leadership and Management Framework.
			Review the EDI development needs of the board and managers across the Trust and develop appropriate interventions to address these needs.	Completed – board development sessions planned for 2025/26
			Update the Trust's Equality Objectives to ensure compliance with the specific equality duties under the Equality Act.	Completed
			Implement a talent management program to help improve the diversity and inclusivity on the Trust board and Senior Leadership Teams.	Sept 2026
			Re-start EDI Strategy Group focusing on receiving assurance on the NHS EDI Improvement Plan 6 High Impact actions and EDI objectives.	Completed

			Develop the Workforce Board report to include EDI data in relation to all of the protected characteristics. Scope and implement a participatory EDI Board Development session	Completed EDI sessions planned as part of the board development programme planned for the new board.
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Improve the quality of health inequalities and equality impact assessments in business cases.	To provide equality and health inequality impact assessment training and support for managers and leaders across LYPFT. To review and recommend Equality and Health Inequalities are standing items and discussed in Board and Committee meetings to improve the key EDI and Health Inequalities KPI's.	From April 2026 Completed. This is covered as part of the Chief Operating Officers board report.
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	To ensure robust approach to tackling health inequalities at senior level. Ensure accountability of senior leaders to support tackling health inequalities and creating a truly inclusive LYPFT.	In collaboration with Health Equity Team implement – NHS Confederation Leadership Framework for Health Inequalities - https://www.nhsconfed.org/articles/leadership-framework-health-inequalities-improvement . Each Board member and VSM (Band 8C+) to have formalised SMART EDI objectives relating to workforce and or tackling Health inequalities, with an annual submission for accountability purposes.	On-going work Completed

			The EDI Team to offer support to Care / Services wanting to develop a SMART EDI objective as part of their Intention Plans. Board members to receive the necessary support to help them to demonstrate how data and lived experience have been utilised to improve organisational culture. Board members to receive support to help with reviewing relevant data to establish EDI areas of concern and prioritise actions.	April 2026 Completed Board meetings always start with a Service User story followed by a discussion reflecting on lessons learning / best practice. Completed
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Appendix 2 – WRES/WDES

Appendix 3 – Freedom to Speak Up Board Paper

Meeting of the Board of Directors

Paper title:	Chair's Report from the Mental Health Legislation Committee meeting on 4 August 2026
Date of meeting:	24 September 2026
Presented by: (name and title)	Kaneez Khan, Non-executive Director and Chair of the Mental Health Legislation Committee
Prepared by: (name and title)	Kieran Betts, Corporate Governance Officer

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

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	
SR5	Adequate working and care environments	✓
SR6	Digital technologies	✓
SR7	Demand for services	✓
SR8	Health inequalities	✓
SR9	System change	✓

Committee details:	
Name of Committee:	Mental Health Legislation Committee
Date of Committee:	4 August 2026
Chaired by:	Kaneez Khan, Non-executive Director

ALERT – areas which the committee wishes to escalate as potential areas of non-compliance, that need addressing urgently, or that it is felt Board should be sighted on

Issue	Relates to BAF Risk
No issues to which the Board needs to be alerted.	N/A

ADVISE – any new areas of monitoring or existing monitoring where an update has been provided to the committee and there are new developments

Issue	Relates to BAF Risk
The Committee agreed that three separate actions relating to delays to Mental Health Act assessments being systematically recorded, the frequency and reasons for lapsed first medical recommendations, and the absence of routine recording of inpatient bed delays reflected a common underlying issue concerning pressures on inpatient bed availability and the recording of associated data. The Committee therefore agreed to consolidate these actions into a single action for Ms Sanderson to establish whether data relating to inpatient bed waits is collected, where such information is held, and the level of detail available, and to report her findings back to the Committee.	SR1, SR5, and SR7
The Committee heard that issues with car parking availability for Mental Health Act Managers (MHAMs) continued at specific sites, such as The Mount, which was impacting MHAMs attending face-to-face hearings. The Committee noted that the Trust had commissioned a specialist car parking consultancy to undertake feasibility assessments across the Trust estate. It also noted that Seacroft Hospital was independently undertaking a comprehensive review of its car parking arrangements.	SR1, SR5, and SR7
The Committee received feedback from the MHAMs Forum and noted that a number of IT and compliance with information governance issues had been raised, including security and accessibility considerations associated with using personal devices for work purposes such as accessing and downloading patient records, and the inconsistent availability of Trust IT support. The Committee noted that these matters had been raised with Mr Oliver Wyatt, Head of Mental Health Legislation for progression and agreed monitor progress of these issues.	SR1 and SR6

ASSURE – specific areas of assurance received warranting mention to Board

Issue	Relates to BAF Risk
The Committee considered issues escalated from the Mental Health Legislation Operational Steering Group, including the implementation of the Right Care, Right Person	SR1, SR7, SR8 and SR9.

approach, developments to missing persons procedures, and partnership working with West Yorkshire Police. The Committee noted the updates provided.	
The Committee received feedback from the MHAMs Forum and noted that issues had been raised by the MHAMs regarding the quality of reports submitted for Barring Order hearings. The Committee noted that Dr Dissanayaka would provide refresher training for RCs and MHAMs to clarify the purpose of Barring Order hearings, together with the relevant statutory criteria and evidential requirements.	SR1 and SR7
The Committee received the Mental Health Legislation (MHL) Activity Report for Q1 2026-27 and was assured that the plans in place were sufficient to ensure ongoing compliance with all MHL. The Committee agreed that the revised content and format of the report made it much easier to understand and highlight areas requiring further scrutiny. It agreed that the content and format of the report should remain unchanged for a period, aside from a small amendment identified at the meeting to label the contents of patient demographic data more clearly.	SR1, SR7 and SR8
The Committee considered the implications for deprivation of liberty assessments arising from the Attorney General for Northern Ireland Supreme Court judgment. The Committee was assured that the MHL Team was working closely with clinical teams, neighbouring Trusts and the Adult Social Care Deprivation of Liberty Safeguards Team to ensure that Trust practices reflected the significant changes to the legal framework relating to deprivation of liberty, while continuing to protect and uphold the rights of service users. The Committee agreed that benchmarking work would be undertaken following the publication of national guidance to provide assurance that the Trust's interpretation and implementation of the judgment remained aligned with emerging practice across the sector.	SR1 and SR7
The Committee received the MHL Audit Review Update which summarised the audits conducted by the MHL Team in the year to provide assurance regarding compliance with legislation, national guidance, and Trust policies and procedures. The Committee was assured by the breadth of audit activity undertaken by the MHL Team in the year to monitor and support ongoing compliance.	SR1, SR3, SR5, SR6, and SR7
The Committee reviewed and approved the proposed amendments to its Terms of Reference. It noted that the revisions increased the number of Non-executive Director (NED) members on the Committee to three and amended the quorum requirements so that a minimum of three members must be present for a meeting to be quorate, including at least one Executive Director member and one NED member. The Committee further noted that the revised Terms of Reference would be submitted to the Board of Directors at its September 2026 meeting for formal ratification.	N/A
The Committee received and considered the outcomes of the Committee Effectiveness Review, which was completed by nine Committee members and regular attendees. It noted the positive assurance provided through the review process and agreed that no	N/A

changes were required to either the Committee's Terms of Reference or its working practices as a result of the findings.	
REFER - Items to be referred to other Committees	
Issue	Relates to BAF Risk
No issues to which require to be referred to other Committees.	N/A

Recommendation

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

Meeting of the Board of Directors

Paper title:	Review of the Terms of Reference of the Mental Health Legislation Committee
Date of meeting:	24 September 2026
Presented by: (name and title)	Kaneez Khan, Non-executive Director and Chair of the Mental Health Legislation Committee
Prepared by: (name and title)	Kieran Betts, Corporate Governance Officer

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

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

Executive summary

The Board is asked to note that at its meetings held on 12 May 2026 and 4 August 2026, the Mental Health Legislation Committee agreed the following amendments to its Terms of Reference (ToR):

- Increase the number of Non-executive Director members from two to three.
- Amend the quorum requirements so that the minimum number of members required for a meeting to be quorate is three, including at least one Non-executive Director and one Executive Director,

- rather than requiring specified Executive Directors to be in attendance.
- Update the deputies identified in Appendix 1a – Schedule of Deputies.

The Board is also asked to note that all proposed amendments are highlighted in red in the attached version of the ToR. The changes reflect revisions to the Committee's membership and quorum arrangements, bringing them into line with those of other Board Committees. It is anticipated that these changes will improve the likelihood of meetings being quorate in future. The amendments have also been reviewed and approved by the Medical Director in advance of this meeting.

The Board is asked to review and ratify the proposed amendments to the Mental Health Legislation Committee's Terms of Reference.

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

No.

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

Recommendation

The Board is asked to review and ratify the proposed amendments to the Mental Health Legislation Committee's Terms of Reference.

Mental Health Legislation Committee

Terms of reference

(Approved by the Mental Health Legislation Committee on 4 August 2026
Ratified by the Board of Directors on TBC)

1 Name of Committee

The name of this Committee is the Mental Health Legislation Committee

2 Composition of the Committee

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

Members: full rights

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

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

In attendance: in an advisory capacity

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

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

2.1 Governor Observers

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

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

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

2.2 Associate Non-executive Directors

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

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

3 Quoracy

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

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

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

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

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

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

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

4 Meetings of the Committee

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

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

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

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

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

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

5 Authority

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

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

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

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

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

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

6 Role of the Committee

6.1 Purpose of the Committee

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

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

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

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

6.3 Duties of the Committee

The Mental Health Legislation Committee had the following duties:

Mental Health Legislation

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

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

Mental Health Act Managers' Forum

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

Performance and Regulatory Compliance

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

Training, Clinical Development, and Guidance

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

Assurance

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

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

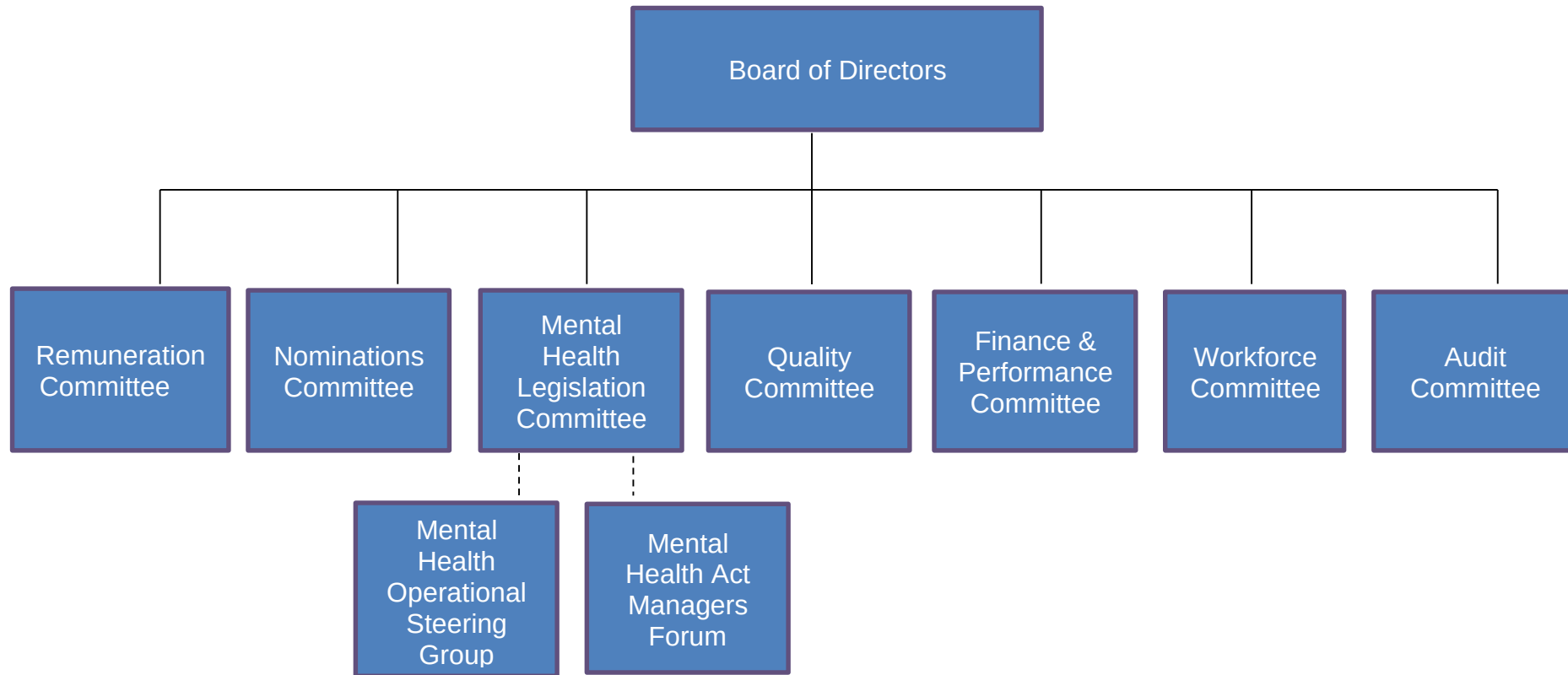
Service User and Carer Involvement

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

Internal Audit

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

7 Relationship with other Groups and Committees



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

8 Duties of the Chairperson

The Chair of the Committee shall be responsible for:

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

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

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

9 Review of the Terms of Reference and Effectiveness

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

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

Schedule of deputies

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

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

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

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