



**The Leeds
Teaching Hospitals**
NHS Trust

DRAFT MINUTES OF THE PUBLIC BOARD MEETING

Thursday 31 July 2025

Seminar Rooms 2 (099) and 3 (096), Gledhow Wing, SJUH

Present:	Linda Pollard	Trust Chair
	Amanda Stainton	Associate Non-Executive Director
	Clare Smith	Chief Operating Officer
	Chris Ellison	Deputy Director of Finance
	Chris Schofield	Non-Executive Director
	Craige Richardson	Director of Estates and Facilities
	Gillian Taylor	Non-Executive Director
	Jane Nixon	Non-Executive Director
	Joanne Koroma	Associate Non-Executive Director (exited at agenda item 12.6)
	Jo Bray	Company Secretary
	Laura Stroud	Non-Executive Director
	Magnus Harrison	Chief Medical Officer
	Mark Burton	Non-Executive Director
	Mike Baker	Non-Executive Director
	Phil Corrigan	Non-Executive Director
	Prof Phil Wood	Chief Executive
	Rabina Tindale	Chief Nurse
In Attendance:	Ai Lyn Tan	Medical Director, Research and Innovation (for agenda item 14.4(i))
	Chris Carvey	Deputy Director of HR
	John Speight	Deputy Chief Digital and Information Officer
	Jane Westmoreland	Associate Director of Communications
	Karen Ledgard	Head of Nursing, Outpatient Service (for agenda item 4)
	Karen Sykes	Head of Nursing for Safeguarding (for agenda item 12.1(iv) and 15.1)
	Kerrie Davies	NIHR/HEE ICA Clinical Lecturer (for agenda item 14.4(ii))
	Krystina Kozlowska	Head of Patient Experience (for agenda item 12.1(iii))
	Rukeya Miah	Director of Midwifery (for agenda item 10.1(i), via MST)
	Scott Johnston	National Maternity Improvement Advisor (for agenda item 10.2)
	Susanna Al-Samarrai	Regional Chief Obstetrician (for agenda item 10.2)
	Sudharsan Suriyakumar	Trust Board Administrator
	Wisdom Echefula	Governance Officer
Observing:	Esther Wakeman	Chief Executive, Leeds Hospitals Charity
	Antony Kildare	Trust Chair, Incoming

Ami-Rose Gardner Business Support Manager

Dawn Preston Complaints Manager, Patient Experience (joined at agenda item 11.1)

Joanne Bickers Senior Patient Carer and Public Involvement Officer (joined at agenda item 11.1)

Apologies: Jenny Ehrhardt Director of Finance
 Jenny Lewis Director of HR & Organisational Development
 Paul Jones Chief Digital and Information Officer
 Piru Sukumar University of Leeds, Future NED Development

Agenda Item		ACTION
1	Apologies for Absence	
	Apologies for absence were received from Jenny Ehrhardt, Director of Finance, Jenny Lewis, Director of HR and Organisational Development, Paul Jones, Chief Digital and Information Officer and Piru Sukumar, University of Leeds, Future NED Development.	
2	Welcome and Introductions	
	<p>The Trust Chair welcomed members of the Board to the meeting. The Chair welcomed staff and members of the public in attendance and reminded everyone that this was a meeting held in public, rather than a public meeting.</p> <p>She extended her thanks to Chris Schofield and Jane Nixon for their contributions, noting that their service with the Trust was coming to an end.</p>	
3	Declarations of Interest	
	<p>Prof Phil Wood declared his interest as a Trustee of NHS Providers.</p> <p>There were no other new declarations of interest, and the meeting was confirmed to be quorate.</p>	
4	Patient Story	
	<p><i>In attendance:</i> <i>Karen Ledgard, Head of Nursing, Outpatient Service</i></p> <p>Rabina Tindale introduced the patient story, which shared Felicia's experience of being diagnosed with dementia. Felicia's daughter Melinda spoke on her behalf and described her mother's experience of outpatient services, which was available to view via the following link: Patient Experience - Dementia Outpatients</p> <p>Melinda explained the difficulties she faced in securing an appointment for her mother and the challenges in finding someone in</p>	

<p>the hospital to listen to their concerns. She described how, eventually, an outpatient staff member and then a Business Manager engaged with her, offering understanding, reassurance and support, which made a significant difference to her and her mother. Melinda suggested that the Trust should consider allocating key staff to support patients, carers, or family members who call for advice, and that these staff should receive specific training to better meet the needs of patients with particular conditions.</p> <p>The lessons learned from Melinda and her mother's experience had led to a number of actions being implemented for both Clinical and non-Clinical Teams. These included the introduction of posters in all Outpatient departments, "Would you like to speak to someone about a concern or query?" to help patients raise issues with receptionists, Clinical staff, Directors or the Patient Advice and Liaison Service (PALS). The 'Know Who I Am?' document had also been introduced, developed with the LHTT Dementia Group and the Centre for Dementia Research at Leeds Beckett University. Dementia training opportunities were being increased for all staff. In addition, the development of a Complex Access Team was being considered to provide a consistent point of contact for patients and carers, ensuring patient needs were recorded. Switchboard processes had also been updated to redirect all outpatient clinical queries to Matrons.</p> <p>The Trust Chair thanked the Team for the patient story. Rabina Tindale spoke about the dementia-related changes that had been introduced and invited Karen Ledgard to provide further detail.</p> <p>Karen Ledgard noted that supporting families and ensuring good communication were vital, as issues could escalate if patients or carers were unable to reach the right person. She explained that the Referral Booking Team was exploring processes to provide earlier notification of additional needs, to better support patients. She also referred to ongoing work with Leeds Beckett University and highlighted the use of the ward-based 'Forget Me Not' system to flag additional needs, noting that this was not currently in place for Outpatients. She explained that within the five to ten minute window of an Outpatient appointment, staff needed to be able to identify and understand patient needs. A new document to help record these needs had been introduced in June. She acknowledged that training was a challenge, with current sessions providing only a basic level of understanding. She stressed the importance of offering more detailed training for Managers, which would be introduced.</p> <p>The Trust Chair reflected on her own personal experiences of carers attending appointments. Laura Stroud noted that this work was being reviewed through Quality Assurance Committee (QAC) and linked into the city-wide dementia strategy. She emphasised the impact of initiatives and the support of Estates and Facilities, and the contribution of Admiral Nurses, also noting the importance of reducing length of stay for patients with dementia.</p>

	<p>The Trust Chair noted that a letter of thanks would be written to the individual featured in the patient story video for their time and contribution.</p> <p>The Board received and noted the update.</p>	
5	Draft Minutes of the Last Meeting	
	The draft minutes of the last meeting held 29 May 2025 were confirmed to be a correct record.	
6	Matters Arising	
	<p>Prior to the meeting, several queries regarding the Trust's services were received from members of the public. The Trust Chair read aloud a question submitted by Peter Arnold:</p> <p><i>"How many hours per week, excluding her clinical duties, is the Lead Neonatal Clinician contracted to conduct her role as lead? Given the size and scope of this role, does the Executive Team believe this number of hours is sufficient to be effective and safe?"</i></p> <p>Responding Magnus Harrison explained that there were 19 Clinical Directors across the CSUs, not all of whom were medics. The Lead Neonatal Clinician had 8 hours per week allocated to the leadership role, with 17 Whole Time Equivalent (WTE) reporting into them. He provided clarification regarding the Lead Clinician role description, noting that the role encompassed subject matter expertise, job planning duties, governance, and leadership responsibilities, but excluded financial accountability, and was separate from clinical duties.</p> <p>Gillian Taylor enquired about the feedback to be provided to Peter Arnold, and Jo Bray explained that this would be recorded within the minutes.</p> <p>The Trust Chair confirmed that the Board had also received a number of further, interrelated questions regarding Maternity and Neonatal services, as well as oversight and accountability of these services. She emphasised that the Trust recognised the high level of public interest, and in order to ensure these questions were addressed fully and given proper time and consideration, the Trust would follow up directly with the families concerned. These response are included as Appendix 1 to the minutes, as each had received a written response from the new Chair, Antony Kildare.</p>	
7	Review of the Action Tracker	
	The action tracker was reviewed, and progress noted.	
8.1	Chair's Report	
	<p>The report provided an update on the actions and activity of the Trust Chair since the last Board meeting.</p> <p>The Trust Chair highlighted the details within her report. She noted that this was her final Chair's Report before retiring Leeds Teaching</p>	

	<p>Hospitals NHS Trust (LTHT) and expressed her thanks to colleagues across the Trust for their support and reflected on the achievements made over the past 13 years. She welcomed Antony Kildare (Trust's New Chair), confirming her confidence that the Trust would continue to be successful under his leadership.</p> <p>The Board received and noted the report.</p>	
9.1	Chief Executive's Report	
	<p>The report provided an update on the action and activities of the CEO since the last Board meeting.</p> <p>Prof Phil Wood drew attention to the key points within the report. He highlighted the publication of the final CQC inspection reports for Maternity and Neonatal services, which rated Maternity services at both LGI and St James's as 'inadequate' and Neonatal services as 'requires improvement'. He described this as very disappointing for staff and for the patients served.</p> <p>He welcomed colleagues from MSSP and confirmed induction into the programme. The Trust awaited the final well-led report. He also referred to NHS Resolution and the review of year six in conjunction with MSSP colleagues.</p> <p>Rukeya Miah joined the meeting.</p> <p>He added that the Maternity Teams had launched the nationally recognised Birmingham Symptom-specific Obstetric Triage System (BSOTS) in the Maternity Assessment Centres and Antenatal Day Units. This system supported safer, more efficient and consistent care for women and birthing people with urgent pregnancy concerns, helping to reduce delays and risks, and improving patient experience. He highlighted that this would be an important safety step in response to shortcomings identified. He also updated on the Tier 1 focus for elective care, which related to long waits for more specialised services, and confirmed LTHT remained in Segment 3 of the oversight framework. He drew attention to partnership work and provided feedback from the Research and Innovation Conference, which had focused on the Trust's commitments to "treating each other with compassion" and "moments that matter to our patients". Sustainability had been a key theme in June, with compassion the focus in July.</p> <p>The Trust Chair added a reflection on supporting and developing people. She referred to the RHS garden created for staff and patients' wellbeing, highlighting the addition of a special rose, with 50 new bushes dedicated to the Princess of Wales, alongside new seating.</p> <p>The Board received and noted the report.</p>	
10	Quality and Performance	
10.1(i)	Maternity & Neonates CQC and MSSP Reports and Action Update	

	<p>The report provided a summary of the Care Quality Commission (CQC) regulatory inspections of Maternity and Neonatal services and the NHS England (NHSE) Maternity Safety Support Programme (MSSP). It outlined the concerns raised, the actions being taken, and the steps underway to ensure the Trust continues to provide the highest quality care for families using these services.</p> <p>Rabina Tindale summarised the report. She confirmed that the CQC had conducted unannounced inspections of the Trust's Maternity services from 9-11 December 2024 and of Neonatal services from 14-16 January 2025, following concerns raised by families and whistleblowers. In January 2025, NHSE held a Rapid Quality Review meeting on Maternity services, with the Trust agreeing to take part in the enhanced MSSP. A diagnostic review visit took place in March 2025, and in July 2025 the Trust received both formal entry into the programme and the final MSSP diagnostic report.</p> <p>She noted that the Trust was also commissioning an independent external review of Neonatal mortality figures to provide greater understanding of the data. The terms of reference for this review were being agreed with NHSE. In addition, the Trust had taken part in the NHSE Peer Quality Review of Neonatal services. She updated on the immediate actions, noting that an overarching Maternity and Neonatal Action Plan had been developed to address all recommendations arising from CQC inspections, MSSP reviews, and other relevant external and internal reviews. In parallel, the Trust had established a Maternity and Neonatal Improvement Programme Board, chaired independently, to deliver sustainable improvement and transformational change. Recruitment to this Board and associated workstreams was ongoing, including the involvement of service users.</p> <p>She reported that the Trust received a letter on 27 January 2025 regarding possible urgent enforcement action under Section 31 of the Health and Social Care Act 2008. This related to the Neonatal service at SJUH, which was operating above its designation as a Special Care Baby Unit. While the service had previously agreed with Yorkshire and the Humber Neonatal Operational Delivery Network to provide additional less complex elements of intensive and high dependency care, the CQC raised concerns regarding equipment provision. The Trust immediately ceased these elements of care at SJUH. She highlighted that the recruitment of midwives had been a key priority. Since autumn 2024, 55 midwives had been appointed following Board approval of additional funding. The Trust remained 11 midwives short of the nationally recommended Birthrate Plus 2024 standard of 367, but active recruitment was continuing. A further 35 newly qualified midwives were due to start in autumn 2025. Actions were also being taken to address cultural concerns within Maternity services. These included increasing the number of Freedom to Speak Up Champions (FtSU), holding regular "Time to Talk" sessions, and monthly open meetings with the Chief Executive,</p>	
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<p>Chief Nurse and Director of Midwifery/Deputy Chief Nurse. Families were being engaged directly, with 20 service users contributing to the design of improvement work and joining the Improvement Board. Complaints processes were being reviewed with a trauma-informed approach, following a Board development session on this theme.</p> <p>Magnus Harrison explained the differences between levels of Neonatal care provided across the LGI and SJUH sites. He confirmed that, while agreements were in place with NHSE for the delivery of some additional elements of care at SJUH, the CQC had not recognised this commissioning arrangement. This had led to an impact on regional capacity and an increase in women being transferred out of Leeds for delivery. The data was being reviewed weekly (internally and by the CQC), and the Trust continued to engage with the CQC, Specialist Commissioners and Neonatal Operational Delivery Network, providing a monthly report to the CQC.</p> <p>Laura Stroud reflected that women's choice had been impacted as a result of regulatory action. Magnus Harrison confirmed that this was the case and acknowledged the impact on patients. Rabina Tindale, confirmed that she and Laura Stroud, in her capacity as Non-Executive Maternity Safety Champion, would continue to provide oversight. The Quality Assurance Committee (QAC) would remain the formal Board Committee for Maternity and Neonatal oversight, with the Improvement Board reporting into QAC. A stakeholder event was planned for September, with wide involvement including service users and community groups, ensuring diverse cultural perspectives were represented. Rukeya Miah emphasised the importance of embedding improvements in governance, reporting processes, human factors, and ward-to-Board visibility.</p> <p>Mike Baker welcomed the update and stressed the importance of ensuring improvements became embedded and sustainable. He highlighted the role of audit dashboards, which would link to ward accreditation processes from September, as a way of evidencing progress. Magnus Harrison observed that improvements would be reflected not only in patient outcomes but also in staff survey results and pulse checks, noting that staff engagement would be key to success. The Trust Chair acknowledged the significant investment being made in Maternity and Neonatal services. She stressed the need to maintain focus on the breadth of the Trust's other services, many of which also carried critical consequences for patients. She emphasised the importance of supporting staff, the benefits that new hospital developments would bring, and the challenge of delivering more with fewer resources.</p> <p>Rabina Tindale concluded by stressing the importance of restoring public confidence while supporting staff. The Trust Chair highlighted the need to ensure that the right questions were being asked to maintain public confidence in the NHS more broadly, noting that public trust was being eroded nationally.</p>
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	The Board received the report and was assured by the actions being taken to ensure that the Trust continued to provide the highest quality care for families using these services.	
10.1(ii)-(iv)	<u>BLUE BOX ITEM</u> – MSSP Report and CQC improvement actions	
	<p>The following items relating to MSSP and CQC improvement actions were provided in the blue box for information and was received and noted:</p> <ul style="list-style-type: none"> • 10.1(ii) – MSSP Entry Letter • 10.1(iii) – MSSP Report • 10.1(iv) – Report on Improvement actions to meet CQC Regulations 	
10.2	MSSP Diagnostic Overviews	
	<p><i>In attendance:</i> <i>Scott Johnston, National Maternity Improvement Advisor and</i> <i>Susanna Al-Samarrai, Regional Chief Obstetrician</i></p> <p>Scott Johnston explained the role of their Tin supporting organisations from a Maternity perspective. This support covered governance, workforce, culture, and wider improvement following the diagnostic visit, as outlined in the report. He confirmed the programme had moved from the diagnostic phase into the improvement phase. Scott Johnston highlighted areas of good practice, areas for improvement, and the actions required, noting progress across both sites (SJUH and LGI) and particularly strong performance in implementing the Saving Babies' Lives programme, with Leeds achieving some of the best results in the region. Susanna Al-Samarrai reflected on challenges raised by staff, particularly around leadership capacity to drive forward change. She emphasised that this was not unique to LTHT, but a common issue across organisations. She noted that financial constraints remained a major barrier, with staff voicing the view that appropriate investment could resolve a number of other challenges. She confirmed NHSE had no regulatory powers but acted in a supportive role, providing constructive challenge and acting as a sounding board for the Trust, its Executive Team, and the Non-Executive Maternity Safety Champion. She also noted that MIS reviews had commenced to provide the Board with assurance.</p> <p>In discussion, Mark Burton sought clarification on the level of engagement from the Trust, to which Scott Johnston responded that there had been good engagement across the organisation, with no barriers to access identified, although senior staff were naturally busier. Amanda Stainton asked about the biggest blockers to improvement, with Susanna Al-Samarrai confirming that finance and the need for a cultural shift were key factors. She explained that some staff held multiple roles, which could make delivery challenging, and that medical staff often took on additional leadership responsibilities. She stressed the importance of ensuring roles were purposeful and supported with the right tools. Mike Baker asked about the anticipated timescale for improvements, with Susanna Al-Samarrai</p>	

	<p>responding that meaningful change could be expected over 18 months to two years, supported by regular reset meetings with wider system partners, including the ICB. Gillian Taylor enquired about sustainability and preventing a reversion to old ways of working. Susanna Al-Samarrai explained that the transition from the MSSP would depend on staffing, finance, and cultural embedding, with specific exit criteria set nationally and regionally. Progress would be reported into the organisation, with issues escalated as required.</p> <p>The Trust Chair thanked Scott Johnston and Susanna Al-Samarrai for their update and contribution.</p> <p>The Board received and noted the update.</p>	
10.3(i)	CQC Well-led Updated	
	<p>The report provided an update on the Trust's position statement following the CQC well-led inspection and the initial feedback received.</p> <p>Magnus Harrison provided an overview of the report. He referred to the initial feedback via the letter at item 10.3(iii) received from the CQC, which was included in blue box, and informed that the draft inspection report was anticipated on 11 August, which the Trust would be required to carry out factual accuracy, with final publication to follow in due course.</p> <p>Prof Phil Wood commented that the report would be helpful for the Trust in reflecting on learning and identifying opportunities for improvement. He highlighted the importance of considering how services were delivered, and the Board's reflections of undertaking its role, alongside other ongoing improvement work.</p> <p>The Board received and noted the report.</p>	
10.3(ii)	BLUE BOX ITEM – CQC Letter – Feedback to Well-Led Review	
	The CQC feedback letter was provided in the blue box for information and was received and noted.	
10.4	External Review of Congenital Cardiac Services	
	<p>The report provided an update on the independent external review of Paediatric Congenital Cardiac services.</p> <p>Magnus Harrison highlighted the details within the report and informed that eight families had been included in the review. Seven of the reviews had been completed, and the parents of these children had been contacted by the Clinical Director for the Children's Hospital. A short summary of findings had been shared with families, and where concerns were identified, an apology was offered. All families had been given the opportunity to meet with the Clinical Team or Mr Andrew Parry (Paediatric Cardiac Surgeon, University Hospitals Bristol NHS Foundation Trust), to receive a more detailed account of the findings. The eighth case review was expected to be concluded within the next two months. Magnus Harrison noted that in November 2023, a group of Consultants, including Cardiologists,</p>	

	<p>had raised concerns regarding surgical outcomes. This was escalated to him, and a Surgeon's practice was restricted while an external review was commissioned. NHSE had been informed, and staff carrying out the initial review were unable to complete the work due to time constraints, a second external review was commissioned with regional and national involvement. One Surgeon had not been operating alone, but in view of Team dynamics, further steps were taken to cease their operating.</p> <p>He explained that actions were underway, including increasing PICU capacity over the winter months, progressing a programme for ECMO to address capacity constraints, and developing training links with University Hospitals Birmingham. The appointment of a new lead Consultant earlier in the summer had also helped stabilise the service. He confirmed that actions remained ongoing, with continued engagement with families. Five children remained under the Trust's care, four of whom had experienced complications due to the exceptional complexity of their cases.</p> <p>Jo Koroma raised a question about culture and the impact of new staff joining the Team. Magnus Harrison advised that he had met with the new Team member the previous week to begin OD planning for both services, and he would personally oversee this work to ensure a psychologically safe environment. He expressed an ambition to establish a training school for the specialty. Jo Koroma queried whether the Trust had thanked those who had raised concerns. Magnus Harrison confirmed that this had been done.</p> <p>Amanda Stainton questioned on how the progress would be measured. Magnus Harrison confirmed that outcomes were routinely monitored and reported nationally, and since the actions had been put in place, results had been positive. He stressed that the service had never been an outlier. He explained that the improvement plan would be managed by the CSU Tri-team with oversight from the Chief Operating Officer and Chief Nurse Teams, with direct reporting to the Chief Medical Officer, Quality Management Group (QMG), QAC and ultimately to the Board.</p> <p>The Board received the report and was assured by the actions being taken to deliver the recommendations from the review going forward.</p>	
10.5	IQPR	
	<p>The Integrated Quality Performance Report (IQPR) provided an overview of performance against the core key performance indicators; the report would be taken as read with attention drawn to any areas of variance or escalation with comments and queries welcomed (noting the scrutiny provided and assurance sought through the Board Committee structure against each of the metrics).</p> <p>Clare Smith highlighted the position in relation to operational performance. She noted that ambulance handover times had increased following reporting changes made in October 2023 which</p>	

	<p>added five to eight minutes to LTHT times, with LGI placed 36th nationally. Yorkshire Ambulance Service (YAS) remained an engaged and supportive partner and action plans were in place. Emergency Care Standards (ECS) delivery in June 2025 was 76.8%, above the national average of 72.9%, with LTHT ranked 34th out of 118 Trusts and the second highest nationally for attendances. Attendances across all sites increased by 2.1% compared to June 2024. RTT performance stood at 66.2%, ranking 23rd out of 118 Trusts. While progress had been made, performance remained beyond the Trust's planned trajectory and the Trust had been escalated to Tier 1 for Elective Care. Cancer performance against the 31-day target of 96% was achieved, with LTHT ranked 66th out of 118 Trusts, and supportive discussions had taken place with NHSE colleagues. Diagnostic waits continued to present challenges, particularly in Paediatric GA MRI due to theatre capacity and in Ultrasound due to staffing pressures. Medicare staff had commenced weekend working in June which was expected to improve performance from August. Additional capacity had been supported through a mobile MRI van and a new CT scanner at Seacroft, which became operational in April.</p> <p>Scott Johnston and Susanna Al-Samarrai exited the meeting.</p> <p>Magnus Harrison updated the Board on Mortality. He informed that mortality data was subject to a three-month lag and LGI remained an area of concern. The Mortality Improvement Group continued to review SHMI through statistical analysis, coding reviews and case note reviews. The Trust had strengthened its learning from deaths framework, using structured judgement reviews to identify learning and provide assurance on care quality. In relation to Never Events, seven were reported in 2024/25 and two in 2025/26 to date, namely an insulin overdose due to use of the wrong device and a retained surgical item in ENT theatres. All incidents were subject to Patient Safety Incident Investigation, and learning was shared through the WYAAT Shared Learning Group. Rabina Tindale reported on Maternity performance, noting LTHT's role as a tertiary centre and receipt of complex referrals. During June 2025 there were two stillbirths and three inborn Neonatal deaths. All cases continued to be reviewed through MDT processes using the Perinatal Mortality Review Tool, with learning reviewed through a health equity lens and used to inform service improvement.</p> <p>On workforce, Chris Carvey reported that in-month sickness absence rates remained within SPC limits but were higher than in Q1 2024/25. Coaching and training support for managers had been strengthened, and processes for Medical and Dental staff absence management were now fully embedded across all CSUs. CSU workforce plans incorporated retention actions aligned with NHS Staff Survey results and supported by the implementation of a Longevity Strategy to embed retention within business-as-usual.</p>	
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	<p>On finance, Chris Ellison confirmed that agency spend was above plan, particularly in Urgent Care, Women's Services and Radiology. Pathology agency usage remained high due to the LIMS implementation. The Workforce Plan Delivery Group continued to monitor required reductions, supported by deep dives into CSU-level agency spend. Bank spend in June 2025 was 3.46% of total staff costs, above the 2.71% target, driven in part by the J32 winter ward remaining open into May and bank reduction plans not yet delivering. Overtime spend had no target but continued to be monitored closely. Despite these pressures, LTHT was ranked joint third lowest nationally for combined agency and bank staffing spend, with reductions in variable pay supported through the Leeds Improvement Method daily management principles.</p> <p>The Board received and noted the report.</p>	
11	Risk	
11.1	Corporate Risk Register	
	<p>The report provided an overview of the current content of the Corporate Risk Register (CRR) and a summary of the associated discussions through the Risk Management Committee (RMC) from its meetings held 5 June 2025 and 3 July 2025.</p> <p>Prof Phil Wood summarised the details of the report and reminded the Board of the established process for risk review undertaken through the Risk Management Committee (RMC). The Trust had identified a range of significant risks currently being mitigated, the impact of which could directly affect the achievement of the Trust's strategic priorities and annual commitments, as well as meeting the requirements of the NHS Accountability Framework and CQC registration should mitigation plans prove ineffective. At the June 2025 meeting, the Committee was briefed on the potential emerging risk of industrial action following the ballot of resident doctors. This risk would continue to be monitored and overseen by the Corporate Operations Team in conjunction with HR. The Committee also acknowledged the ongoing risk related to regulatory oversight and conditions on the Trust's licence, noting that this had not changed, and the Trust continued to work collaboratively with the CQC and NHSE while the inspection cycle progressed. At the July meeting, the Committee considered an emerging risk relating to the Maternity Incentive Scheme (MIS), following receipt of a letter from NHS Resolution requesting that the Trust review its Year Six submission as part of the Maternity Safety Support Programme. The Trust had requested that NHSE undertake an independent review of the Year Six MIS submission to inform the Trust's response to NHS Resolution ahead of the deadline of 18 July 2025. This matter would be discussed further with the Director of Finance.</p> <p>The Board received and noted the report.</p> <p>Krystina Kozlowska, Dawn Preston and Joanne Bickers joined the meeting.</p>	

11.1(i)	BLUE BOX ITEM - Corporate Risk Register	
	The updated summary of Corporate Risk Register (July 2025) was provided in the Blue Box for information.	
11.2	Backlog Maintenance 2024/25	
	<p>The report provided an update on the Trust's estate Backlog Maintenance (BLM) position and liability, which represented the estimated cost of bringing the Trust's estate (premises and equipment) back to a minimum expected standard for healthcare (Condition B – sound, operationally safe and exhibiting only minor deterioration).</p> <p>Craige Richardson presented to the Board, noting that this work was subject to a mandatory annual independent survey undertaken through the ERIC system. The physical condition was assessed against 16 building and engineering elements, each broken down into sub-elements and graded on a sliding scale. The current position was reported as, physical condition BLM £243m and statutory compliance BLM £11m. In terms of impending liabilities, Years one to five physical condition was assessed at £98m and Years six to ten at £21m. The overall BLM liability was increasing, with the largest burden at LGI, followed by SJUH. While the proportion of BLM categorised as Critical Infrastructure Risk (CIR – high and significant rating) had reduced in recent years, the only reduction in overall BLM in the last decade occurred due to significant NHSE funding in 2019/20. Current investment was insufficient to keep pace with the deterioration of the estate, with around £60m per year required over the next five years to maintain the current level of liability. The Trust was targeting its limited Building and Engineering BLM capital (60% of annual B&E funding) towards CIR and high-risk items, guided by the Trust's Risk Appetite Framework. In 2025/26, £21m ring-fenced CIR investment had been secured from NHSE, and the Trust continued to advocate for New Hospital Programme investment at the LGI site.</p> <p>The Board discussed milestone targets for safely managing backlog liabilities and the associated risks to business continuity and patient safety, noting increasing concern given insufficient capital investment, delays to the Hospitals of the Future (HotF) programme, and the financial pressures of managing critical infrastructure and statutory risks on the LGI Clarendon Wing and Old Site for an extended period. Jo Koroma questioned whether the £5.7m of high-risk items would be funded this year. Craige Richardson confirmed that not all could be delivered this year but would be prioritised with the limited capital available, citing as an example £20m of fire safety work being addressed over four years. Jo Koroma requested that this information be presented in a five-year plan showing the trajectory of capital investment to address the risks, which would be taken forward through the Infrastructure Committee. Mike Baker commended the E&F Team for their work in maintaining the estate despite the constraints. He noted that delays to the New Hospital Programme</p>	<p>Craige Richardson</p>

	<p>had impacted progress on backlog reduction and stressed the need to consider radical funding options beyond NHSE allocations.</p> <p>Laura Stroud reflected on the importance of triangulating the capital limitations with patient experience and staff wellbeing, noting how critical these issues were to the working environment. In response, Craige Richardson outlined the assurance framework in place around six asset groups.</p> <p>The Trust Chair summarised the feedback that had been shared nationally, and Prof Phil Wood emphasised the need to consider the use of estates across the city as part of wider service delivery improvements. The Chair further referenced discussions at WYAAT and the ICB's estates review, which had prompted wider reflection on the Trust's surplus position and opportunities for reinvestment in capital. Clare Smith stressed the importance of addressing health inequalities and supporting harder-to-reach populations, drawing links to the data on projected health needs to 2031 and beyond, which had been discussed at the recent Board Timeout.</p> <p>The Board received and noted the report.</p>	
12	Assurance from Board Committees	
	Quality Assurance Committee	
12.1(i)	Chair's Summary Report	
	<p>The report provided an overview of significant areas of interest, highlighted the key risks discussed, key actions taken, and key actions agreed at the QAC at its meeting held 19 June 2025.</p> <p>Laura Stroud set context to the Committees role in reviewing the information it received through the lens of quality, safety and patient experience, and noted the patient story video, which shared Jeanette's experience. Members reflected on the Team's approach in embedding kindness into practice, describing this as powerful education. The Committee emphasised the importance of listening to both patients' families and staff as central to continued improvement, recognising the need to accept constructive criticism and model the values expected of a leading hospital. It was noted that kindness should remain at the heart of everything the Trust does, with a special thanks offered to the Team involved. Members reinforced the Committee's role in focusing on the experience of patients, families, and staff, alongside complaints handling and safeguarding.</p> <p>She highlighted that the Committee reviewed the final draft of the Quality Account 2024/25, which has been realigned to the Patient Safety and Quality Strategy improvement areas for 2025/26 under the themes of insight, involvement, and improvement. The Infection Prevention and Control (IPC) Annual Report and the Healthcare Acquired Infection (HCAI) report were also presented, providing assurance to the Board on progress against the IPC Board Assurance Framework, mapped to the ten criteria of the Health and Social Care Act 2008. Members received an overview of current</p>	

	<p>HCAI performance and benchmarking, as well as achievements in the Trust's management of the measles outbreak, antimicrobial stewardship, and water safety.</p> <p>She noted that the Safe Staffing Report was discussed and triangulated with the work of the Workforce Committee (WFC), supported by Amanda Stainton in her role as both QAC member and WFC Chair. The Committee also received the Children and Young People's Report, which provided an update on the Children's Hospital's compliance with the CQC framework, together with learning from the neonatal inspection. Members noted improvements in staffing levels following successful recruitment, alongside progress in mandatory training compliance.</p> <p>The Committee discussed LTHT's continued involvement in national dementia research with Leeds Beckett University, reviewed the formal report from Round Six of the National Audit of Dementia, and considered progress with the two-year pilot of the Transitions of Care Admiral Nurse service. Further updates were received on Perinatal Mortality Review Tool (PMRT) group activity and workforce challenges in Maternity and Neonatology, with assurances provided on the actions in place to mitigate risk and maintain safe and effective staffing. Members also reviewed the latest mortality metrics. The Committee discussed the Patient Harm Review, which would be brought back for further assurance at a future meeting. Progress was noted on complaints handling, and the Safeguarding Team was commended for their work and the assurance provided.</p> <p>The Board received the report and noted the assurances received by the QAC.</p> <p>Karen Sykes joined the meeting.</p>	
12.1(ii)	Q3 Report on Learning from Deaths	
	<p>The report provided an update on the appropriate processes in place to report on and review patient deaths and ensure that lessons are being learned and improvements outlined.</p> <p>Magnus Harrison introduced the report, noting that in Q3 2024/25, seven deaths had been escalated through the 'potential patient safety incident' reporting processes. The Summary Hospital-level Mortality Indicator (SHMI) remained 'above expected' for LGI, while continuing to be 'as expected' for SJUH. Other Trust sites did not have sufficient numbers of deaths to be included. At diagnosis group level, all ten SHMI indicators were reported as 'as expected' for this period, with continued oversight provided by the Mortality Improvement Group. He updated on the assurance received on the triangulation of information reviewed, including coronial referrals, Medical Examiner scrutiny of community deaths, and structured judgment reviews where concerns were identified. It was noted that childhood deaths, or those relating to patients with neurodivergence or autism, were reviewed through a separate process. The Dr Foster</p>	

	<p>model was also being used to identify expected patterns and outliers, with escalation processes in place.</p> <p>He noted that the Mortality Improvement Group continued to monitor Trust mortality indicators and undertake coding reviews to ensure quality and accuracy of the data, supported by the introduction of a new Structured Judgement Reviews (SJR) storage system to strengthen assurance. Looking ahead, specialty presentations in Q4 2024/25 will focus on mortality in patients with learning disability and autism, with ongoing collaboration between the Coding Team, Quality Governance Analyst, and specialties to monitor and review indicators and ensure accurate reporting.</p> <p>The Board received the report and noted the assurances in place for learning from deaths.</p>	
12.1(iii)	Annual Report on PALS & Complaints	
	<p><i>In attendance:</i> <i>Krystina Kozłowska, Head of Patient Experience</i></p> <p>The report provided the annual update summarising Trust activity and performance in relation to complaints and PALS during 2024/25.</p> <p>Krystina Kozłowska provided an overview of the details within the report, noting that the Trust received 676 complaints between 1 April 2024 and 31 March 2025, an increase of 93 (16%) from the 583 received in 2023/24. Of these, 363 (54%) related to a single Clinical Service Unit (CSU), 199 (29%) involved more than one CSU, and 114 (17%) involved external organisations. 15 out of 27 CSUs reported an increase in complaints compared with the previous year. Data quality had improved, with greater visibility of trends including a reduction in complaints relating to discrimination. The updated action plan for complaints had been informed by the findings of an excellent internal audit, which identified only three minor recommendations.</p> <p>The most significant rise in complaints was seen in the Women's CSU, which received 89 complaints, an increase of 34 (+61.8%) on the previous year. SIM and Radiology reported 81 complaints, an increase of 25 (+44.6%). These increases were noted to be consistent with national trends in Maternity and Neonatal services. The Trust continued to fall short of its timeliness target for complaint responses, with around 60% completed within the expected timeframe. The main themes remained consistent, with communication, particularly in relation to diagnosis continuing to feature most prominently, alongside concerns about medical staff. Staff interaction was highlighted as an area of particular concern, with a 20% increase reported. The Board discussed whether this was within normal variation and requested further review of civility data against control limits. Positive developments were also highlighted, including improved equality and diversity reporting. Complaints related to disability had fallen from 132 to 36, though the number related to race remained static, requiring further focus. She noted that</p>	

	<p>for the first time, PALS compliments had been included in the annual report, which was welcomed by members.</p> <p>Rabina Tindale acknowledged the considerable amount of work undertaken to manage complaints effectively. Phil Corrigan queried whether the significant rise in complaints within the Women's CSU was primarily due to communication issues. Krystina Kozłowska clarified that while communication was a recurring theme, Maternity services were overseeing the complaints and other factors contributed to the increase.</p> <p>Jo Koroma highlighted that staff interaction complaints had risen by 20%, noting that this did not appear to reflect normal variation. Clare Smith explained the use of upper and lower control limits and requested a further review of staff civility data. Rabina Tindale emphasised the Trust's ongoing commitments to embedding kindness and the "moments that matter" approach in staff interactions, and noted that this would continue to be monitored. Prof Phil Wood stressed that the rise in complaints should not be viewed negatively, and encouraged staff to continue speaking up. He highlighted the importance of triangulating complaints with other organisational data to target support effectively. Ownership and assurance of complaints should remain with the relevant CSUs, supported by the Complaints Team, and medical staff engagement was essential to improving service user experience.</p> <p>Krystina Kozłowska confirmed that the data was becoming more sophisticated, with analysis increasingly being used to inform improvement actions across the organisation.</p> <p>The Board received the report and was assured on the actions that are being taken to improve the experience and response to complaints and PALS.</p> <p>Krystina Kozłowska exited the meeting.</p>	
12.1(iv)	Annual Report on Learning Disabilities & Autism	
	<p>The report provided a summary of the key issues and activity in relation to Learning Disabilities and Autism during 2024/25.</p> <p>Karen Sykes noted the details within the annual report, emphasising the focus on addressing health inequalities for this group and the ongoing work to improve outcomes for patients. She outlined the quality improvements that had been implemented over the year, including the "Kids Super Saturday" initiative as an example of targeted support. She noted that the Team working in this area was small but had a clear strategy to define pathways for carers, enabling and empowering frontline staff to deliver care with appropriate reasonable adjustments in place. She added that while the national report had not yet been published, the Trust was proactively ensuring assurance and compliance with emerging standards.</p>	

	<p>The Board received the report and was assured of the actions in place for LTHT to meet the national standards for Learning Disabilities and Autism.</p> <p>Kerrie Davies joined the meeting.</p>	
12.1(iv)	BLUE BOX ITEM – Annual Report on LD&A	
	The annual report on Learning Disabilities and Autism was provided in the blue box for information and was received and noted.	
12.1(v)	Annual Report HCAI	
	<p>The report provided an update on the activities of the Trust's Infection Prevention and Control Team (IPCT) in relation to Health Care Associated Infection (HCAI) prevention and control during 2024–2025. It also provided assurance on progress against the IPC Board Assurance Framework (BAF), aligned to the ten criteria of the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections.</p> <p>Magnus Harrison summarised the report, highlighting the Trust's successful reduction in C. Difficile (CDI), MRSA, and MSSA infections over the year, achieved despite a national trajectory of increasing HCAs. LTHT's 15% reduction in CDI was recognised nationally and featured in a December 2024 National CDI webinar. Gram-negative infection rates, however, remained high compared with other NHS trusts. Key interventions included strengthening cohort ward guidance to prevent transmission, antimicrobial stewardship using the '#CARES' review tool, and hydrogen peroxide vapourisation (HPV) for environmental decontamination, with 2,500 instances conducted for effective cleaning. Water safety improvements and removal of hand wash basins were also undertaken, alongside PPE management.</p> <p>Laura Stroud noted the close monitoring of infection rates, emphasising the need to track progress against targets. Magnus Harrison noted on the teaching programme for approximately 100 resident doctors on safe cannula insertion and device monitoring was implemented to reduce device-related infections. Point prevalence audits and local campaigns on decolonisation were also completed within the AMS CSU.</p> <p>The Board received and noted the report.</p> <p>Moved to agenda item 12.2(i)</p>	
	Finance and Performance Committee	
12.2(i)	Chairs Summary Report	
	The report provided an overview of significant issues of interest, highlighted key risks discussed, key decisions taken, and key actions agreed at the Finance and Performance (F&P) Committee meetings held 28 May and 25 June 2025 and was received and noted.	
12.2(ii)	Verbal update of the meeting held 30 July 2025	
	Mark Burton provided a verbal summary of the key areas of note from the F&P Committee meeting held the previous day.	

	<p>He highlighted the patient story presented by the Neurosciences Department, noting the positive culture observed on the ward and the reflections it had prompted across Clinical Service Units (CSUs) regarding their own practices. He emphasised the Trust's annual commitment to "Moments that Matter," observing how such stories serve as exemplars across the organisation.</p> <p>From a financial perspective, he reported that, as of month three, the Trust was delivering against the Financial Framework Requirement (FFR) with a breakeven plan, consistent with previous years at the end of Q1. He anticipated a stronger position by month four. He noted that a deep dive into productivity and gaps would be undertaken at the September meeting.</p> <p>The Board received and noted the update.</p> <p>Moved to agenda item 12.6</p>	
	DIT Committee	
12.6	Chair's Report from Exo meeting 8th July	
	<p>The report provided an overview of significant issues of interest to the Board, highlights key risks discussed, key decisions taken, and key actions agreed at the Extra-Ordinary Digital Information and Technology (DIT) Committee meeting held 8 July 2025.</p> <p>Jo Koroma noted that this Ex-O meeting had been convened to address an action arising from the Committee meeting of 6 June 2025, specifically to provide assurance to the Board regarding the lessons learned from the Laboratory Information Management System (LIMS) Phase 2 Blood Sciences rollout in December 2024. She explained that the Emergency Preparedness post-response review, an internal confidential document produced routinely to support learning from incidents, had been leaked and reported in the Health Service Journal (HSJ) at the end of May. The Committee had reviewed the internal document and the rationale for its existence and recognised that it was not an assurance report for a Board Committee. For this reason, it was agreed that an additional assurance report would be presented to the Ex-O meeting prior to the July Board. By exception, a summary of the report was presented at the public Board meeting, as much of the content was already in the public domain. Lessons learned were categorised under people, process, and technology, and assurance was provided that these lessons had been successfully applied to the May 2025 go live, which proceeded smoothly.</p> <p>The Board received the report and noted the update.</p> <p>Jo Koroma exited the meeting.</p> <p>Moved to agenda item 12.1(vi)</p>	
12.1(vi)	Patient Safety & Quality Strategy	

	<p>The report provided an update against the first six months of the Patient Safety and Quality Strategy 2024-27.</p> <p>Magnus Harrison highlighted the key points within the report, noting that the strategic hierarchy had been refreshed to categorise the supporting strategies as either core or enabling, with the Patient Safety and Quality Strategy 2024 - 27 identified as a core strategy. The Trust had promoted a just culture that prioritised safety and encouraged learning from risk and safety events, avoiding inappropriate blame when things went wrong. He described how this approach had supported an environment of psychological safety within Teams, which in turn encouraged staff to raise concerns. He further explained on the thematic review of all patient safety events that had been conducted to develop the priorities in the Patient Safety Incident Response Plan (PSIRP). This review had considered incidents and complaints over the previous three financial years, clinical claims, Trust reports, national reporting, and all CQC enquiries from the same period, and had been aligned with the Trust's seven commitments.</p> <p>He noted that in February 2025, as part of the Patient Safety Roadmap, the Trust had focused on psychological safety and had created spaces for staff to discuss the concept of psychological safety and its impact on patient care. Patient Safety Specialists had supported improvements in safety culture by delivering civility training to teams across the organisation and had contributed to the implementation of Martha's Rule. In addition to the Trust Freedom to Speak Up (FtSU) Guardian, the Trust maintained a register of over 80 FtSU Champions across all CSUs and corporate services. 'Listen Up' training had been promoted to all staff in managerial roles to further support the Freedom to Speak Up Policy. The Guardian and Champions had regularly engaged with staff both Trust-wide and locally to advise on raising concerns.</p> <p>As part of NHSE's implementation of Martha's Rule, expressions of interest had been requested from adult and paediatric acute provider sites with an established 24/7 critical care outreach capability. The Trust had been successful and had secured two pilot sites: one adult and one paediatric.</p> <p>The Trust had continued to lead the WYAAT Patient Safety Shared Learning Group, a network established to discuss common challenges relating to quality and safety. The group had focused on sharing key learning points and themes arising from patient safety incident and Never Event investigations, reporting to the WYAAT Medical Directors and Chief Nurse Group.</p> <p>The Board received the report and was assured of the progress that had been made in delivering the priorities of the Patient Safety and Quality Strategy 2024-27.</p>	
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	Audit Committee	
12.3	Chairs Summary Report	
	<p>The report provided an overview of significant areas of interest, highlighted the key risks discussed, key actions taken, and key actions agreed by the Audit Committee at its meeting held 25 June 2025.</p> <p>Gillian Taylor provided an overall summary of the report. She noted that the Audit Committee recommended the approval of the accounts to the full Board on 26 June 2025, which were subsequently adopted. She highlighted that the Committee received the year-end report on Internal Audit activity and noted that there were no outstanding or overdue actions, representing a significant step change. She also reported the progress against the 2025/26 Internal Audit Plan.</p> <p>The Board received the report and noted the assurances received via the Audit Committee.</p>	
	Workforce Committee	
12.4(i)	Chairs Summary Report	
	<p>The report provided an overview of significant issues of interest, highlighted key risks discussed, key decisions taken, and key actions agreed at the Workforce Committee meeting held 17 July 2025.</p> <p>Amanda Stainton provided a high-level overview of the report and noted on the staff story, which featured a colleague working within Organisational Development and Culture as a Trainer. The colleague had described her career journey to date and outlined her participation in the Moving Forward Programme.</p> <p>She reflected on how the Committee discussed the opportunities available, particularly in relation to leadership development, noting the wide range of programmes in place and the value of the supporting documentation received. She explained the steps being taken to progress the red workstreams and drive improvement, which included the Year of Learning, increasing traction with the LET initiative, and continued engagement with senior leaders.</p> <p>The Board received the report and noted the assurances received via WFC.</p>	
	Research and Innovation Committee	
12.5	Chairs Report	
	<p>The report provided an overview of significant issues of interest, highlighted key risks discussed, key decisions taken, and key actions agreed at the R&I Committee meeting held 16 July 2025.</p> <p>Chris Schofield presented the report and highlighted the staff story presented, which focused on a nurse researcher who described the challenges of lacking a clear career pathway and funding support. He stressed that if the Trust wished to embed a culture of research across the organisation, it would need to address these issues seriously. Jane Nixon outlined the leading work of the Trust in</p>	

	<p>collaboration with the University of Leeds and noted that post-doctoral research was the next stage of development, but further work was required in reflecting this within pay banding structures. Magnus Harrison observed that the career pathway was not clearly defined, and this was particularly difficult for subject matter experts.</p> <p>Chris Schofield attention to a new risk relating to patients in research receiving either the wrong imaging scan or an excess number of scans. The risk score had increased from 12 to 16 since the last meeting and was now outside the Trust's Risk Appetite. Assurance was provided on the actions already implemented since these incidents were identified. However, it was noted that such occurrences were reportable to the CQC, with six instances recorded in the previous three months. Magnus Harrison agreed to address the escalation of the risk rating to 16, noting that RMC had reviewed this as a score of 12.</p> <p>The Board received the report and noted the assurance received via the R&I Committee.</p> <p>Ai Lyn Tan joined the meeting.</p>	
13	Strategy and Planning	
13.1	Partnership Update Report	
	<p>The report provided an update on the rapid changes and work progressing in the partnership space at present as well as some of the national and regional context that is shaping it.</p> <p>Prof Phil Wood highlighted the key points within the report and noted that a more detailed discussion had taken place during the Board workshop earlier in the day.</p> <p>The Board received and noted the report.</p>	
13.2	BLUE BOX ITEM – 10 Year Plan	
	The 10 Year Plan was provided in the blue box for information.	
14	Strategy and Planning	
14.1	Safer Staffing Review – Phase 1	
	<p>The report provided assurance that the Trust remained compliant with national safer staffing regulations, policy and speciality guidance and set out the actions and recommendations arising from the bi-annual establishment setting review. The report included detail on the:</p> <ul style="list-style-type: none"> • Safer Nursing Care Tool (SNCT) audit results for Nursing (Adult & Children inpatient areas and Emergency Departments) undertaken in January 2025. • Peer assessment against Care Hours Per Patient Day (CHPPD). • Overview of the Bi-annual establishment setting review for Nursing and Midwifery which took place between March and May 2025. 	

	<p>Rabina Tindale drew attention to the detail within the report. She explained that SNCT data had been collected across ten CSUs and 77 eligible wards and units. The Trust's funded nursing and midwifery establishment was 3,197.89 WTE, compared to an SNCT recommendation of 3,288.76 WTE, a variance of 90.87 WTE (2.76%), demonstrating close alignment between current staffing and SNCT recommendations.</p> <p>The ED SNCT audit provided reliable estimates of WTE staffing needs and patient acuity. Results showed that both Adult ED areas were staffed above the SNCT-recommended WTE levels. In Children's ED, however, the recommended WTE exceeded the funded establishment by 6.4 WTE.</p> <p>With regard to Maternity services, the Board noted the risk of a deficit of recruited midwives against the funded establishment due to high levels of maternity leave and long-term sickness absence. This had resulted in staffing shortages, with the potential to impact patient safety, staff health and wellbeing, and workforce resilience. As of April 2025, the service was funded to the recommended establishment of 367.45 WTE clinical midwives. In June 2025, the clinical midwifery vacancy was 16.41 WTE, with 1.8 WTE Band 6 midwives due to commence in post in July 2025. She further noted that the case mix calculation from the recent BR+ report recommended a ratio of 21 births per midwife, reflective of the increased complexity of care within the service. During the reporting period, the ratio had been consistently between 25 and 26 births per midwife. Assurance was provided of the processes in place to support bi-annual reviews.</p> <p>The Board received the report, noted the ongoing plans to provide safe staffing levels within nursing and midwifery across the Trust.</p>	
14.2	NMAHP Strategy – End of Year 1 Progress Report	
	<p>The report provided an update on the progress made during the first year of delivering the Nursing, Midwifery and Allied Health Professions (NMAHP) Strategy 2024-2028.</p> <p>Rabina Tindale highlighted the key details within the report. She noted that a key early initiative had been the rollout of the excellence in Leadership Programme, which supported ward and Team leaders at the start of their leadership journey. Designed to build confidence, strengthen leadership capability, and enhance team culture, the programme had successfully recruited 58 participants across two cohorts, including 44 current ward leaders. She further reported that LTHT had become the first NHS Trust nationally to co-develop and co-deliver the Professional Nurse Advocate (PNA) programme in partnership with a university provider, with 36 participants successfully completing the first cohort. The "Paper Picnic" initiative had been expanded into new departments including Theatres, Anaesthesia, and the Leeds Dental Institute, helping to reduce reliance on paper-based records and increase data accessibility.</p>	

	<p>She informed that a considerable amount of work had been undertaken over the past 12 months, including the revision of existing audits and the development of a new dashboard and associated processes. A full year accreditation schedule had been planned, starting with adult and children's inpatient wards, with the first six wards commencing their journey in September 2025, and maternity scheduled to come online in January 2026.</p> <p>The report also highlighted progress in human factors training, the promotion of a Just Culture, race and equality masterclasses, reductions in pressure ulcers, improvements in harm-free care, and the rollout of forthcoming pilot wards. Strategic priorities, including preceptorship, were also set out.</p> <p>Amanda Stainton commended the work of the Team and reflected on the visibility of leaders during leadership walk rounds.</p> <p>The Board received the report, noted the significant progress made during the first year of the NMAHP Strategy 2024–2028, and endorsed the continued delivery and scaling of priority programmes for 2025–26.</p>	
14.3	Sustainability Refresh Strategy – Green Plan 2025-28	
	<p>The NHS Green Plan 2025-28 was presented to the Board for approval. The Plan focused on sustainability and reducing the environmental impact of healthcare.</p> <p>Craige Richardson provided a detailed overview of the report, noting that this was the third edition of the Green Plan.</p> <p>The Board received the report and confirmed its approval of the LTHT revised Green Plan.</p>	
14.3(i)	BLUE BOX ITEM – The Green Plan	
	The Green Plan was provided in the blue box for information.	
14.4(i)	Research & Innovation Strategy Refresh 2025-2030	
	<p><i>In attendance: Ai Lyn Tan, Medical Director, Research and Innovation</i></p> <p>The 2025-2030 Research and Innovation (R&I) Strategy, "Tomorrow's Healthcare Today," was presented to the Board for approval.</p> <p>Magnus Harrison introduced the refreshed R&I Strategy 2025-30, and Ai Lyn Tan outlined the key themes within the report. Chris Schofield noted that the Strategy had been considered by the R&I Committee on two occasions and highlighted the ambition set out within the document. She emphasised the importance of continuing to support the development of research and innovation, which would be further progressed by the Executive Team.</p>	

	The Board received the report and approved the R&I Strategy 2025-2030, together with the associated Key Performance Indicators.	
14.4(ii)	Antimicrobial and Infectious Disease Research	
	<p><i>In attendance:</i> <i>Kerrie Davies, NIHR/ HEE ICA Clinical Director</i></p> <p>The R&I Committee had received this staff story at a recent Committee meeting, and this was brought to the Board to as one example of delivering research to bring to life the R&I strategy.</p> <p>Kerrie Davies presented to the Board on Antimicrobial Resistance (AMR) and infection. She emphasised that complications following surgery are common, and without robust diagnostics it was not possible to ensure antibiotics were only prescribed when necessary. Inappropriate prescribing contributed significantly to antimicrobial resistance. She highlighted that there were 245,000 cases of sepsis annually in the UK, with 48,000 deaths, and that the relative risk of death decreased by 46.6% if appropriate treatment was administered within one hour.</p> <p>She outlined her research focus on C. Difficile (CDI), noting that recurrent CDI alone costs the NHS approximately £124m annually. She explained her contributions to this field, including changing global diagnostics for CDI, improving treatment options, highlighting underdiagnosis, providing the most up-to-date epidemiology, and strengthening infection prevention practices.</p> <p>She expanded on these points with reference to her slides and expressed her thanks to the HCAI Research Group Team.</p> <p>The Board acknowledged the significant impact of research in healthcare and thanked Kerrie Davies for her presentation.</p> <p>Kerrie Davies exited the meeting.</p>	
15	Governance and Regulation	
15.1	Annual Report on Safeguarding	
	<p>The Safeguarding Annual Report was presented for assurance and provided information on the activities of the Trust Safeguarding Team and assurance that the Trust was meeting its statutory obligations and the required national standards with regard to safeguarding, and provided a summary of the key issues and activity in relation to Safeguarding Children, Adults, Prevent, Mental Health and Mental Capacity during 2024/25.</p> <p>Karen Sykes noted the detail within the annual report and highlighted that this had already been presented in QAC for assurance. She noted that it was a comprehensive report, reflecting the complexity of safeguarding activity within the Trust. She emphasised that the Team approached their work with a focus on quality improvement, underpinned by the principle that safeguarding is everybody's business. She highlighted several themes, including the need to</p>	

	<p>strengthen in-year reporting to provide greater clarity on impact, and the increasing complexity of safeguarding cases, particularly where the organisation continued to experience challenges in discharging patients safely. Staff were dealing with these issues daily, and the importance of psychological safety was recognised. The report also noted increases in self-neglect, modern slavery, and domestic abuse cases, although LTHT was not an outlier compared to national trends.</p> <p>Looking ahead, she expressed that the Team had a desire to become more research-active, to shift towards prevention rather than a solely reactive model, and to focus on training that was not only delivered but demonstrably impactful in changing practice. Safeguarding supervision was highlighted as a theme of the Well-Led review, with recognition that the team did not currently receive protected time for this. She thanked her Team for their dedication and commitment and acknowledged the Trust's continued support for safeguarding campaigns.</p> <p>The Board received and noted the report.</p> <p>Karen Sykes exited the meeting.</p>	
15.1(i)	BLUE BOX ITEM – Safeguarding Annual Report 2024/25	
	The Safeguarding Annual Report 2024/25 was provided in the blue box for information and was received and noted.	
15.2	Standing Orders Update	
	<p>The report sought Board approval of minor changes to the Terms of Reference (ToR) of Board Committees, as cited in the Standing Orders.</p> <p>Jo Bray highlighted the membership changes detailed within the report and requested Board approval.</p> <p>The Board received the report and approved the amendments to the Terms of Reference as set out.</p>	
15.3	Board of Directors Insurance, Annual Declaration	
	<p>The report set out the Trust's current insurance arrangements including cover for the organisation and for the Directors and Senior Officers.</p> <p>Jo Bray drew attention to the detail set out within the report and highlighted the arrangements in place for individual Directors and the cover provided they had acted honestly and in good faith.</p> <p>All Directors within the Board meeting provided their pledge to act in honestly and good faith.</p> <p>Post meeting note;:Director not in attendance have provided their confirmation outside the meeting, retaining an email audit trail.</p> <p>The Board received and noted the report.</p>	

15.4	BLUE BOX ITEM – Senior Independent Directors’ Report	
	The Senior Independent Directors’ report on the Appraisal of the Chair was provided in the blue box for information and was received and noted.	
16	Items for Information	
16.1	BLUE BOX ITEM - Forward Planner	
	The Board Forward Planner was provided in the Blue Box for information and was received and noted.	
17	Standing Agenda Items	
	Risk	
	There were no items arising from the meeting for escalation to the RMC for consideration on the CRR.	
	Legal Advice	
	There were no items arising from the meeting that warranted the consideration of legal advice.	
	Regulators - CQC or NHS England, ICB/Place issues	
	There were no items arising from the meeting for escalation to the Trust regulators.	
	Communications	
	No specific areas were highlighted as requiring additional communication.	
18	Review of Meeting and Effectiveness	
	Prof Phil Wood emphasised the importance of focusing on maternity and reflected on feedback from QAC. No further comments on the effectiveness of the meeting were raised.	
19	Any Other Business	
	No other business was discussed.	
20	Date of next meeting: Thursday, 25 September 2025.	

Appendix 1 Public Query and Response

Question 1: How are Leeds trust holding Julian, Phil and Linda accountable for allowing the decade long Leeds perinatal scandal to occur under their leadership?

Question 2: Phil and Linda - do you acknowledge that you are personally responsible for countless preventable baby deaths over the last decade?

Our response:

The Board recognises its collective responsibility for the overall performance of the Trust. We accept the significant concerns identified with our maternity and neonatal services, which we acknowledge have had a devastating impact on affected families.

As Chief Executive and Chair of the Trust, we want to reiterate our heartfelt sympathies and apologies to those families who have lost loved ones. We have sought to reassure you about the actions being taken to improve the services going forwards and wish to reinforce that through our offer to maintain an open dialogue with those families who wish to continue to engage with us.

Question 3: Will Philip Wood have the decency to admit that part of his decision to retire is to avoid the accountability that will be brought upon him and the hospital, in the near future, by an inevitable, government commissioned review into its maternity service?

Our response:

Professor Wood has said previously: “My intention was to retire in the next 12 to 18 months, but with the changes taking place within the NHS nationally, this feels like the right time for me to hand over to a new leader.

“I will be staying on until the end of this year as I am committed to making sure our robust maternity improvement plans, already developed with the CQC and NHS England, are fully embedded, and that we engage constructively with the Rapid National Investigation into Maternity and Neonatal services as it develops.

“Over the next five months, I will be working with our incoming Chair, our staff, the regulators and, most importantly, families who use our services, to ensure we are providing safe, compassionate care for everyone.”

Question 4: Does Philip Wood and the LTHT board publicly recognise how suspicious Philip Wood’s announced retirement looks when:

- There is a publicly emerging maternity safety scandal in Leeds, with failings in maternity care going back many years, including poor leadership.
- A government commissioned review of the maternity service in Leeds is inevitable and likely imminent and would bring significant scrutiny and pressure onto him (give his roles of CEO and, previously, CMO) and pressure onto hospital.
- The MSSP report and its 100 recommendations has been known to the hospital for three months now and released to the public in the last few days.
- It has just been announced the government are about to embark on setting up a regulation process for leaders in the NHS, in the same way as there is for doctors and nurses by the GMC and NMC, which would mean any leader who silences whistleblowers or behaves unacceptably, will be banned from returning to a health service position - holding managers to account for failings in leadership?

Our response:

Professor Wood has said previously: “My intention was to retire in the next 12 to 18 months, but with the changes taking place within the NHS nationally, this feels like the right time for me to hand over to a new leader.

“I will be staying on until the end of this year as I am committed to making sure our robust maternity improvement plans, already developed with the CQC and NHS England, are fully embedded, and that we engage constructively with the Rapid National Investigation into Maternity and Neonatal services as it develops.

“Over the next five months, I will be working with our incoming Chair, our staff, the

regulators and, most importantly, families who use our services, to ensure we are providing safe, compassionate care for everyone.”

The final MSSP report was received by the Trust in June and the timing of its publication was agreed with NHS England. Unlike many other Trusts, we have chosen to publish the report in full as we wished to be open and transparent.

We welcome the planned introduction of a regulation process for leaders in the NHS; this has been a proposal since November 2024 and legislation is due to be put before Parliament in 2026. This has had no bearing on the decision of the Chief Executive’s retirement.

Question 5: Would the board have like to publicly apologise, specifically for lying to the public, when regularly after each, media-outed, maternity safety incident; the Trust’s ‘right-to-reply’ would often say that lessons had been learnt from the case in question, despite the fact, that the CQC maternity inspection report in June reported that “none of the staff” they spoke with “were able to describe learning following recent incidents” and the CQC itself “were not provided with the necessary assurance that leaders had taken these incidents seriously and had investigated them as fully as would have been appropriate” and that “the service was in breach of the legal regulation relating to learning following incidents”?

Our response:

In healthcare the outcomes are sadly not always positive, and we know this can be incredibly distressing for families. When this happens, we thoroughly investigate the circumstances, always involving the family, to learn any lessons for the future.

The CQC reports and MSSP report both identified improvements we can make in terms of learning from incidents. We recognise we need to be better at listening to our staff, acting on their concerns and learning lessons, and we are sorry we have fallen short on this.

We do have processes in place to investigate incidents and share learning, but we clearly need to improve these to ensure learning is consistently shared. We are reviewing these processes as part of the Trust’s Maternity and Neonatal Improvement Programme and are committed to improve our systems.

Question 6: Does the board recognise how offensive and insensitive it is to bereaved and harmed families, who have been devastated by maternity failings, and who have been dismissed, lied to, gaslighted or unacceptably treated by the LTHT and its management, to be publicly praising Philip Wood for “outstanding leadership”? In light of this, does the board wish to retract that praise?

Our response:

The Board recognises that this has been a very sensitive and upsetting time for the families involved. We acknowledge that bereaved families may be upset by any praise for the Chief Executive.

However, Professor Phil Wood is retiring after 34 years’ service with the NHS and 23 of those at Leeds Teaching Hospitals. During this time, he has held roles as Consultant Immunologist, Clinical Director, Medical Director and Chief Medical Officer and made a positive impact in these roles.

During the latter period of Prof Wood’s career, he led the response to the COVID pandemic for the Trust and the roll out of vaccination programmes across West Yorkshire. His passion for research and innovation has helped Leeds become a leader in tailored healthcare, giving hope to patients with genetic conditions, and he has been instrumental in developing the plans for the Innovation Village at Leeds General Infirmary.

Question 7: Does the Trust admit, that it continues to persistently use deflective, obfuscating or minimising language or presentation of information in all of its communications that have any relation to maternity safety or maternity safety incidents - particularly when even as recently as last week - the landing page on the LTHT website for the uploaded MSSP report doesn't make it clear, to the public, that being invited onto the MSSP programme means "that concerns have been identified regarding the safety and quality" of maternity services (ie - it is of concern to the public) and when there are 4 listed (of 12 reported) examples of good practice, but only 3 listed recommendations (for improvement) of the 100 made by the MSSP report (for transparency even the summary report of 'areas of concerns' is 20 areas long). In any case, the 3 listed example recommendations are lesser or previously 'well-known' concerns instead of listing the incredibly concerning recommendations, such as, those regarding a "lack of a systematic maternity triaging process" and recommendations highlighting flaws in basic processes such as escalation, in response to reports of "de-escalation" of safety concerns (without resolution) or no clinical or midwifery on-call management staff, out of hours.

Our response:

As a Trust we have made a commitment to be fully open and transparent. We have been open about the findings of the CQC reports and included information on our website and social media to share with the public. We have shared information with families currently using our services. We believe we are the only NHS organisation to publish our MSSP report in full. This was published on our website and discussed in our Trust Board meeting with the aim to be open and transparent.

We are happy to discuss any other information you would wish to appear on the website.