

DRAFT MINUTES OF THE PUBLIC BOARD MEETING

Thursday 30 July 2026

Boardroom (034), Ground Floor, Trust HQ, SJUH

Present:	Antony Kildare	Trust Chair
	Mike Baker	Non-Executive Director
	Mark Burton	Non-Executive Director
	Jo Bray	Director of Corporate Affairs
	Brendan Brown	Chief Executive Officer
	Suzanne Dunkley	Chief People Officer (from agenda item 8.1)
	Jenny Ehrhardt	Chief Finance Officer
	Elizabeth Garthwaite	Chief Medical Officer
	Beverley Geary	Chief Nurse
	Angela Graves	Non-Executive Director
	Andrew Greenwood	Non-Executive Director (via MST) (exited at agenda item 8.3)
	Mike Harvey	Director of Transformation
	Tim Hiles	Chief Operating Officer
	Paul Jones	Chief Digital and Information Officer (via MST) (exited at agenda item 10.1)
	Jo Koroma	Associate Non-Executive Director
	Simon Le Clerc	Non-Executive Director
	Craige Richardson	Director of Estates and Facilities
	Ricky Singh	Associate Non-Executive Director
	Amanda Stainton	Associate Non-Executive Director
	Laura Stroud	Associate Non-Executive Director
	Gillian Taylor	Non-Executive Director
	Jane Westmoreland	Director of Communications
In attendance:	Vickie Hewitt	Trust Board Administrator
Presenting:	Miguelle Domalaon	Resourcing Project Intern (for agenda item 9.1)
	Richard Horner	Head of Resourcing (for agenda item 9.1)
	Chris Kelly	Associate Director of Estates, Compliance and Risk (for agenda item 13.2)
	Roger Mumby	Programme Manager, Internal Review Office (for agenda item 8.5)
	Becky Musgrave	Head of Midwifery (for agenda item 8.3(ii), 9.5(ii) and 10.2).
	Lucy Oswald	Apprenticeship and Employability Co-Ordinator (for agenda item 9.1)
	Alan Sheppard	Freedom to Speak Up Lead (for agenda item 11.3)
Apologies:	None	

Agenda Item		ACTION
	Standing Items	
1	Welcome, Introductions and Apologies for Absence	
	No apologies for absence were received. It was noted that Suzanne Dunkley would be joining the meeting late owing to the need to respond to an ongoing Trade Union dispute with further detail to be provided in the Chief Executive update at agenda item 7. Antony Kildare welcomed members to the meeting, and it was noted that Andrew Greenwood, Non-Executive Director (NED) had joined the meeting via MS Teams (MST) owing to a prior commitment associated with his substantive role. It was further noted that Paul Jones, Chief Digital Information Officer (CDIO) had joined the meeting via MST following prior agreement with the Chief Executive.	
2	Declarations of Interest	
	Antony Kildare reported a new declaration, informing that his brother had been appointed as a NED to the Information Commissioners Office (ICO). This had been registered on the Trust's Declare System and was shared with the Board for information. There were no further declarations of interest relating to the agenda, and the meeting was confirmed to be correct.	
3	Draft Minutes of the Last Meeting	
	The draft minutes of the last meeting held 28 May 2026 were agreed to be a correct record.	
4	Matters Arising	
	Prior to the meeting two questions were submitted from members of the Public which were read out by the Director of Corporate Affairs. The first related to a follow up to a query raised in January 2026 regarding endometriosis services in Leeds. A further response was requested in regard to the recruitment and capacity timelines, actions taken to reduce wait times for follow-ups, clinical safety and managing future demand. Elizabeth Garthwaite provided a verbal update to the Board and reported that the endometriosis service had been reviewed via the Scrutiny Committee the previous week. It was noted that the demand for endometriosis services had increased significantly, with referrals raising by approximately 78%. She provided further detail regarding patient numbers on active pathways, and whilst acknowledging the lengthy waiting times in some areas, assurance was given that work was actively underway to reduce these. It was noted that the increase in referrals reflected previously unidentified demand and that associated pressures had also impacted GP services. She advised that the Trust was not a designated specialist admissions centre and did not have the funding framework required to deliver complex care. These concerns had been escalated with commissioners. She advised that the Trust was utilising available capacity and deploying specialist resources appropriately, whilst also expanding robotic surgery and	

	ultrasound capacity to support early intervention and treatment. She updated on the expansion of the Patient Initiated Follow-Up (PIFU) strategy, with 25% of patients now managed through this approach. She reported that discussions were ongoing with NHSE regarding the regional endometriosis service offer and would keep the Board updated on developments as required. The second question had been received from 'SEEN in Health' in relation to toilet facilities in Martin Wing. Craige Richardson reported that the Board had not been aware of this particular area however an onsite visit had taken place that week, and he confirmed that the staff toilet facilities in Martin Wing would be reviewed as part of the Trust's ongoing assessment of its estate. This would inform required improvement actions and agreed timescales ensuring compliance with regulators. On completion of the works the Trust's Head of Health and Safety would revisit the area and confirm that the location was compliant with regulations for mixed sex facilities. A direct response would be provided to SEEN in Health via email. Post-meeting note: A health and safety inspection undertaken on 28 July 2026 identified a number of required improvements to the toilet facilities. The associated Action Plan was shared with SEEN in Health and the Director of Estates and Facilities. At the time of reporting, timescales for completion had not been agreed due to the requirement to procure contractors; however, assurance was provided that an update would be submitted to SEEN in Health once the timescales had been established.	
5	Review of Action Tracker	
	The action tracker was reviewed and progress noted.	
6	Chair's Report	
	The report provided detail on the activity of the Trust Chair since the previous meeting. Antony Kildare noted the detail within the report and in addition provided a verbal update following his attendance at the WYAAT Committee in Common (CiC); Bill McCarthy, Chair, North and East, NHSE had presented an update on the state of works for the NHS following the appointment of the new Secretary of State for Health and Social Care and new Prime Minister. He shared insight to the update received which had included the impact of devolution and neighbourhood models on acute Trust's and had explored the new role of ICBs in the commissioning space. He referenced the pilot change in schedule of the Board meetings with the Public meeting held in the morning and welcomed feedback from Board members on the effectiveness of this. The Board received and noted the update.	
7	Chief Executive's Report	
	The report provided an update on the activities of the Chief Executive since the last Board meeting and sought ratification of the consultant appointments made under delegated authority.	

The Board noted that a Trade Union protest was taking place outside the meeting venue to coincide with the Board meeting. Brendan Brown provided a verbal update, advising that the protest involved staff in Theatre Assistant roles and related to concerns regarding Agenda for Change banding. The Board was informed that the Chief People Officer was engaged in discussions with the Trade Union representative.

Drawing attention to the detail within the report he noted the changes in national leadership including a new Prime Minister, Secretary of State for Health and Social Care, and NHSE Regional Director.

He noted that the report framed a number of areas that would be explored further throughout the Board meeting agenda. He referenced the recent publications of the Amos Review Report, Ockenden Review into Nottingham University NHS Hospital Trust, and Fuller Reviews which had informed a 10-point plan for the NHS and noting the reports had been shared with the Board at agenda item 10.1(i) with increased scrutiny provided by the Perinatal Improvement Assurance Committee (PIAC). He reiterated the Trust's commitment to learning and improving and noted the additional assurance that would be provided to the Board on the Trust's progress.

Laura Stroud recognised that the learning arising from these publications was applicable to other areas across the Trust in addition to Maternity and explored how learning was shared, and the Board could be assured of the embedding of recommendations. Brendan Brown confirmed that each of the report's findings were being reviewed in detail and actions would be incorporated into existing improvement plans where appropriate. Assurance to the Board would be provided through a number of means including through the Executive Team and Committee Chairs' reports. He emphasised the need to prioritise meaningful action and implementation of learning, rather than generating additional action plans.

Ricky Singh reflected on the potential for significant changes to the NHS following the changes in leadership at the Centre and explored how the Trust ensured that it stayed the course and absorbed the impact of outside changes on frontline colleagues. Brendan Brown shared his reflections and noted the role of the Board Assurance Framework (BAF) in supporting the Board to navigate through areas of concern. He reflected that the Board's focus should remain on the quality and value of services provided to patients and referenced the Leeds Way Values and the Board's role in setting out clear expectations to support colleagues, with the Executive Team absorbing or triaging information from external sources.

Simon Le Clerc explored how the Trust would measure progress which prompted wider discussion and noted the role of the Integrated Accountability Framework (IAF) and Integrated Accountability Meetings (IAM) to support this process. It was confirmed that the IAF incorporated and triangulated various KPI's including key performance metrics and patient experience.

Antony Kildare shared that the latest WYAAT CiC had explored how Board's navigated through the volume of Central directives focussed on managing the

	current situation, as well as fulfilling its duty on strategic direction which would be an area of ongoing focus. The Board received the update and confirmed its ratification of the consultant appointments as listed within the report.	
	Governance Risk and Regulatory	
8.1(i)	Blue Box – Corporate Risk Register	
	The latest Corporate Risk register (CRR) was provided in the Blue Box for information and was received and noted.	
8.1(ii)	Board Assurance Framework	
	An updated BAF was presented for Board approval following updates to align the strategic risks with the updated strategic ambition and updated Leeds Way Values. Mike Harvey updated against the approval being sought for the refreshed BAF and explained that this was the first step of the refresh process. He explained that further revisions were taking place, which would report to the Board in September 2026 and would include additional narrative on the effectiveness of mitigations as well as incorporating feedback from the NED Team as raised during the Board Timeout. He reflected that the Trust continued to operate in a highly challenged environment and expanded on the role of the BAF in providing a clear line of sight to strategic goals and noting that progress had been made across several areas. Suzanne Dunkley joined the meeting There was a wider discussion by the Board which recognised the BAF as a live risk document and changes were expected to be made to it throughout the year aligned to a regular review process. Further detail was requested on the KPI's cited within the report and it was confirmed these would be included within the report to the September Board and was awaiting the conclusion of ongoing work with the Executive and NED Teams. Andrew Greenwood shared that he had engaged with Mike Harvey and the Director of Quality to explore the BAF's alignment to the Trust's strategic ambition and ensure that controls were supportive of the achievement of this. Mark Burton reflected on the cultural element underpinning the BAF and in ensuring CSUs were understanding of the risk journey to support effective escalation. He referenced the findings of the CQC Well-led inspection and the importance for the Board to foster a culture in which staff felt supported to speak up. The Board approved the updated BAF and noted the further review and improvements that would be recommended for adoption at the next meeting.	
8.2	Board and Committee Assurance of Risk	
	The report had been shared following review by the Finance and Performance (F&P) Committee and requested that the Board, and specifically Committee Chairs, consider the proposals within the report and the assurance received of risk reporting within Committees.	

	The Board received the report and further consideration would be given by Committee Chairs with recommendations to be explored within their respective Committees.	
8.3	CQC Inspection Improvement Plans	
	Brendan Brown noted the increased regulatory scrutiny on the organisation and commented on the impact on colleagues and the role of the Executive Team in supporting Leaders. He noted the additional detail on progress that would be provided across the next agenda items.	
8.3(i)	Well-led Improvement Update	
	The report provided an update on progress against the Trust's Well-led Improvement Plan. Jo Bray noted the detail within the report and drew attention to the action plan within the report's appendices. She explained that the majority of actions had now been closed with work moving to ensuring they were embedded and sustainable. She referenced the Well-led Board Development Assessment supported by NHS Alliance (NHSA) which was testing some of these processes, with feedback anticipated to be reported in September which would support the identification of any areas of weakness and could inform resets in some areas. There was a wider discussion by the Board which reflected on the importance of getting the basics right and to be delivering these consistently before expanding aspirations to achieve an outstanding rating. Suzanne Dunkley commented on the traction made following the refresh of the Trust values and in setting clear expectations for staff. She confirmed that creating the right culture was a priority however this needed to be in a phased approach to ensure it was sustained. Following a query from Mark Burton, Brendan Brown provided insight to the regulatory accountability that the Trust was held to via the Integrated Quality Improvement Group (IQIG) meetings Chaired by NHSE Regional Director. The Board received the report and noted the progress made which would be further validated following receipt of the NHSA Well-led review.	
8.3(ii)	Perinatal Improvement Update	
	The report provided an update on progress against the Perinatal Improvement Plan (PIP) Beverley Geary drew attention to the detail within the report and referenced the recent national publications related to Maternity Care (included at agenda item 10.1(i) and cited within the Chief Executive Update). She reported that in response to the findings of these publications, a fundamental review of the PIP was taking place and being supported by NHSE and the Internal Review Team. An updated plan would be presented at the next Board meeting which would reflect any additional recommendations from recent national publications. She reported that the Director of Midwifery post was out for advert and expanded on the need to attract the right person for LTHT, with an external candidate able to provide a pair of fresh eyes to the service. Further detail on the recruitment process would be provided via the PIAC.	

	Gillian Taylor noted there was a backlog in the movement of some actions and explored the rationale for this. Beverley Geary expanded on the need for the action to be embedded and evidenced prior to closure. Tim Hiles explored how assurance was received that actions were having the desired impact and making a difference which prompted wider discussion. The need for actions to deliver a sustained change in outcome was recognised and where an action was not delivering, for teams to have the confidence to challenge whether the right action was being taken. The discussion noted the role of the PIAC in seeking assurance of the progress and delivery of planned actions, and in the Board retaining oversight of this position. The Board received the report and noted the further review of the PIP which was taking place and would be included in the report to the next meeting.	
8.4	Mortuary Oversight and Post-Death Care; Board Assurance Statement	
	The report provided the Board with a summary of the assurance in response to NHS England's (NHSE) letter of 26 June 2026 on mortuary oversight and post death care, issued following the Nottingham University Hospitals NHS Trust (NUHNT) Maternity Review, the Human Tissue Authority's (HTA) report into NUHNT, and the recommendations of the Fuller Inquiry. Elizabeth Garthwaite highlighted the detail within the report and reported that a self-assessment had been completed against the Fuller Inquiry recommendations; of the 20 recommendations applicable to the Trust, 11 were assessed as fully compliant, seven as partially compliant and two as non-compliant. She noted the inclusion of the detailed assessment at Appendix 1 with areas of non-compliance predominantly related to the estate. A Care of the Deceased Improvement Plan had been developed in response to areas of non or partial compliance with a weekly Task and Finish Group in place to oversee progress. She noted that the HTA visit to LTHT earlier in the year had also identified some recommendations for the estate which would be incorporated into the action plan. The risk relating to the estate had also been escalated for consideration on the Corporate Risk Register (CRR). She reported that a further self-assessment was required against the NHS Premises Assurance Model (PAM) for submission in September 2026 and work was already underway to complete this. She drew attention to the Board Assurance Statement at Appendix 2 which was seeking Board approval prior to submission to NHSE. The statement confirmed that roles and responsibilities for post-death care were clear and tested; that time-limited action plans were in place to address gaps against the Fuller recommendations; that safeguarding oversight had been reviewed against the updated Safeguarding Accountability and Assurance Framework; that effective governance structures were in place for mortuary services; and that an agreed timeline was in place for the PAM self-assessment. Gillian Taylor noted that the Internal Auditors had conducted a review of the mortuary services the previous year which had provided further independent assurance. She updated that she had attended a Leadership Walkround to the	

	service and had the opportunity to engage directly with members of the Mortuary Team. She was mindful that the recommendations within the Fuller Report went beyond the assessment within the Internal Audit report which prompted wider discussion. Craige Richardson expanded on the capital investment in security for the mortuary services which included CCTV on all entry points and access control on doors. He explained that the Fuller Review also recommended access control to exit the department and to consider the removal of electrical devices from visitors. He reported that there was a routine audit of those with access to the department and he had recently met with the mortuary lead to gain assurance on the staff interaction of challenge to access areas of the estate. Brendan Brown commented further on the importance of the Board assurance on the care of people within its mortuaries. He noted that the Executive Team was conducting unannounced visits to the area to test assurances and confirmed that these were also taking place out of hours. Following a query from Mark Burton, Elizabeth Garthwaite confirmed that there was an operational improvement plan in place to respond to the areas of non-compliance identified which she would retain Executive oversight of. The Board confirmed it had received assurance regarding the Trust's compliance with the Fuller Inquiry recommendations and noting the improvement plan in place to address identified gaps, confirmed its approval of the Board Assurance Statement which would be submitted to NHSE following the meeting.	
8.5	Leeds Independent Review into Maternity and Neonatal Services <i>In attendance: Roger Mumby, Programme Manager, Internal Review Office</i> Roger Mumby provided a verbal update on the latest progress against the Leeds Maternity and Neonatal Independent Review. He reported that preparations for the Leeds Maternity and Neonatal Review were progressing well. Additional appointments had been made to the Internal Review Team including Programme Manager, HR/staff support lead, Communications Manager, Data Analyst, and a Midwife who would provide direct support to the case review process. He reported that the Programme Director and Team were regularly meeting with representatives from DHSC and NHSE to establish the arrangements for supporting the review, including the transfer of case records (Open Book), training in the use of the IT system procured by NHSE and relevant information sharing agreements. He reported that families would have 28 days to respond to the opt-out letters from the Open Book exercise before case reviews commenced at the end of September 2026. He advised that the draft Terms of Reference (ToR) for the Leeds Review were in the final stages of development following review by staff and clinicians at DHSC and NHS England, by the Independent Chair and her Team, and by families. These were presented by the Chair of the Independent Review to families at an introductory meeting held at Leeds Town Hall on 18 July 2026.	

He confirmed that staff continued to be updated on progress through the perinatal briefing meetings. 'Staff Voices' meetings were being scheduled to take place towards the end of the year and would continue throughout the course of the review. He confirmed that a clearer timetable on the Staff Voices meetings would be communicated once dates had been confirmed.

He noted that the Review process was due to take approximately 30 months from the end of September 2026 through to the end of March 2029, with the final report anticipated by September 2029.

He noted the publication of the Independent Review of Maternity Services at NUHNT final report (24 June 2026) and Independent Investigation into Maternity and Neonatal Services in England final report (30 June 2026) (both of which were provided to the Board in the Blue Box as supporting information to agenda item 10.1). He informed that the reports had been reviewed with Executives at the Improvement Steering Group, with senior leaders on 1 July 2026 and at the PIAC on 9 July 2026.

In response to both reports NHSE had published a 10-point plan on 30 June 2026 to be implemented in the first 100 days. Further detail had been reviewed via the PIAC with the actions summarised below:

1. Commence roll out of Martha's Rule across all maternity and neonatal services in 2026/27.
2. Implement a monthly cycle of collecting and analysing real-time patient outcomes and experience data.
3. Establish clear joint accountability at board level for maternity and neonatal services, with Medical Directors and Chief Nurses holding shared responsibility for oversight, performance, and improvement.
4. 'Amos into action' staff listening exercise to be launched by NHSE.
5. National rollout of the Perinatal Equity and Anti-discrimination Programme, which will be available to all Trust's by the end of 2026.
6. Review staffing to ensure 24/7 availability and responsiveness across key workforce groups.
7. Review the safety and quality of homebirth services.
8. Review how Trust's respond to patient safety incidents, complaints, and concerns within maternity and neonatal services, with openness, humanity, and candour.
9. Deliver safe and effective triage in maternity services.
10. Post death care – respond to the board assurance statement by 31 July and to the Human Tissue Authority requirement to review and assure completeness of incident records over the past 10 years. [cross-reference to the approval received at agenda item 8.4].

He reported that the Executive Team was working with CSU leaders to identify the support required to help teams to implement this plan, and that actions were being reviewed and incorporated into the Perinatal Improvement Plan with progress to be reported to PIAC.

Antony Kildare informed that an open invitation had been extended to Donna Ockenden, Chair of the Independent Review to meet with the Board in

	anticipation of the Nottingham Review publication however a suitable date had not yet been identified. The Board received and noted the update. It was confirmed that this item would remain a standing agenda item to facilitate a verbal update on the latest progress of the review. Roger Mumby exited the meeting	
9.1	Staff Story	
	<i>In attendance: Miguelle Domalaon, Resourcing Project Intern, Richard Horner, Head of Resourcing and Lucy Oswald, Apprenticeship and Employability Co-Ordinator</i> The Board received a verbal update on the David Forbes Nixon Project Search. Lucy Oswald provided an overview of the supported employment programme, which aimed to support young people with learning disabilities and/or autism transition into paid employment through a year-long supported internship. Participants were hosted within employing organisations, to enable them to gain workplace experience, receive job coaching and develop employability skills. She noted that the Trust hosted its first cohort in 2021. Since then, the programme has supported 37 candidates, with 10 securing employment within the Trust and others progressing into employment with external organisations. Four individuals from the inaugural cohort remained employed by the Trust. Miguelle Domalaon shared her experience as a candidate of the programme and her internship within the Resourcing Team. She spoke positively about the opportunities provided and the support and mentorship she had received from colleagues. Richard Horner shared his experience as Miguelle's line manager and highlighted the positive contribution Miguelle had made to the Resourcing Team, including supporting the development of an accessibility tool for the Trust. He advised that Miguelle had subsequently secured a substantive role within the Trust through a fair and open recruitment process. The Board welcomed the update, commended the positive impact of the programme on participants and the organisation, and received assurance from the experiences and outcomes presented. Miguelle Domalaon, Richard Horner, and Lucy Oswald exited the meeting	
8.6	Code of Conduct and Nolan Principles	
	The report invited all Board Directors to pledge their support to the Trust's Code of Conduct. The Code of Conduct for the Board of Directors at LTHT adhered to the Nolan Principles, the values set out in The Leeds Way and underpinned the capable, compassionate, and inclusive leaders with exemplary behaviours as defined by the CQC Well-led guidance.	

	The Board noted the detail within the report and confirmed their commitment to the Code of Conduct, Nolan Principles and Leeds Way values.	
8.7	Blue Box – Senior Independent Director Assurance of Chair’s Appraisal	
	The report set the assurance of the process that underpinned the Senior Independent Directors appraisal of the Chair based on 360 feedback and delivery against objectives agreed in early September 2025 and was presented for information.	
8.8	Health and Safety Policy	
	The Health and Safety (H&S) Policy was presented for Board approval following review and endorsement by the Policies and Procedures Group. There had been minimal changes with the majority of revisions made around terminology. The content of the policy had also been reviewed and supported by the H&S Group. The Board received the policy and confirmed its approval of the H&S Policy.	
8.9	Risk Management Policy	
	The Risk Management Policy was presented for Board approval following review and endorsement by the Policies and Procedures Group. There had been minimal changes with the majority of revisions made around terminology. The content of the policy had also been reviewed and supported by the Risk Management Committee. The Board received the policy and confirmed its approval of the Risk Management Policy.	
8.10	Audit Committee Chairs Summary Report	
	The report provided a summary of the key highlights from the Audit Committee meeting held 24 June 2026 and sought to alert, advise, and provide assurance to the Board on the key areas discussed. Gillian Taylor highlighted the focus of the meeting on reviewing and endorsing the year-end processes including the Annual Accounts, Annual Governance Statement, Annual Report and Quality Account which were subsequently approved by the Board on 25 June 2026, and the Annual Accounts were submitted to NHS England on 26 June 2026. In addition, she informed that an Extra-Ordinary Committee meeting had been held that morning to receive an update on progress against the Business Continuity Plan Compliance (as alerted to the Board in May 2026) and assurance on the actions taken in response to the Internal Audit review of Employment Checks. The Board received the report and noted the assurance received via the Audit Committee.	
8.11	Blue Box – Insurance for Directors	
	The report set out the insurance arrangement for directors and was provided for information.	
8.12	Board Forward Workplan 2026/27	
	The 2026/27 Board Workplan was presented for endorsement following a review exercise that had been conducted. It was noted that flexibility would be retained to respond to new and emerging areas that required Board oversight. The Board confirmed its endorsement of the workplan.	

	Quality of Care	
9.2	Integrated Quality Performance Report	
	The Integrated Quality and Performance Report (IQPR) was presented for information and contained the latest position on a number of key metrics against performance, people, quality, and finance. Tim Hiles reported that performance against Ambulance Handover Times continued to remain strong and was positive of the ownership of the standard by internal teams, For June the average handover for the Trust was 14.52 minutes against a trajectory of 20.54. He referenced the strategic decision to transfer the risk of patients waiting in ambulances into the ED rather than ambulances queuing. He reported that performance against the Emergency Care Standard (ECS) for June was 76.9% against an external trajectory of 80.3%. The Trust had ranked 29 of 118 Trust's in peer comparisons and he explained that ECS performance remained challenging nationally, with pressures reflected across peer organisation. Antony Kildare noted his attendance at the recent WYAAT CiC and all Trust's had shared they were experiencing unprecedented pressures for this time of year. Tim Hiles continued that the Referral to Treatment (RTT) standard was performing against trajectory and there was a focus on ensuring 18ww RTT delivery throughout the year. He referenced the recent deep dive to the Finance & Performance (F&P) Committee on performance of this standard which had provided detail to the challenges in achieving waiting lists, and current constraints to activity plans. The deep dive had provided assurance on actions being taken in response with recognition of the balance of resources across elective and non-elective care. He highlighted that the Cancer Waiting Times had seen significant improvements against the 28-day and 31-day standards with the Trust performing at or above the target. He reported that the Trust had achieved sustained improvements against the 62-day standard however the backlog continued to impact progress. There were 140 patients waiting over 62-days for treatment, and of these 23 patients had been waiting over 104 days. He reported that there had been a temporary deterioration within the Diagnostic's standard which was due to constrained capacity within the ultrasound service. There was an active recovery plan in place and there was confidence in the recovery over the next six months. Elizabeth Garthwaite drew attention to the mortality indicators and reported that both the Standard Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Rate (HSMR) continued to be within the expected range. She expanded on the underpinning investigation and quality processes with assurance provided via the QAC. She reported there had been four Never Events within the year-to-date and explained that the Patient Safety Incident Response Framework (PSIRF) was a key driver in responding to incidents and sharing learning. She reported that there was a new Director of Quality in post who was working to ensure robust	

quality process was in place and to further embed learning from incidents. The QAC continued to seek assurance on learning from incidents and how this was shared across the organisation to reduce repeatable incidents.

Beverley Geary referenced the maternity metrics within the report and informed there had been two stillbirths during the reporting period which had been reviewed through the Perinatal Mortality Review Tool (PMRT) process. She noted the further detail that would be provided within the Perinatal Update at agenda item 10.2.

Suzanne Dunkley drew attention to the People Metrics from page 17 and explained these aligned with KPIs within the IAF. She reported there had been new NHS Staff Standards published nationally which would be embedded into existing People processes within the Trust.

She reported sickness absence at 5.26% and explained the People Improvement Framework was supporting CSUs and Corporate Functions to achieve further reductions and was also supporting targeted interventions to some specific CSUs. Following a query from Laura Stroud she confirmed the triangulation of people and quality metrics and there was a correlation within pressured areas. She expanded on the process of the IAF in supporting the identification of at risk areas which would then inform and prompt further action.

She reported that the Trust had exceeded Agency usage within the current period which was due to the response of some particular pressures and included staffing support within Children and Mental Health services, and security. Bank spend had also increased above trajectory and she advised that work was taking place to ensure a sustainable Whole Time Equivalent (WTE) position. The vacancy rate for the Trust as a total was 5.38% however this varied across individual CSUs.

Following a query from Simon Le Clerc, she explained that the Trust did not currently have a voluntary redundancy programme.

Jenny Ehrhardt updated on the income and expenditure position and informed that the Trust was reporting a year-to-date deficit of £14m which was £3.1m adverse to the NHSE plan. The biggest drivers of the year to date deficit were costs associated with the resident doctors' industrial action, medical pay award funding shortfall and under delivery of the waste reduction programme. She updated on the targeted support provided to CSUs to support them in the achievement of their financial plans.

She reported that the region had implemented an additional oversight framework with further detail provided to the F&P Committee.

She reported there had been a change in the approach to capital spend within the Trust aligned to risk and prioritisation. Further detail had been shared with the F&P Committee and a copy of the report would be shared with Board members for information.

Following a query from Ricky Singh, Jenny Ehrhardt expanded on the process with CSU to identify waste reduction programmes throughout the year.

	The Board received and noted the report.	
9.3	Quality Assurance Committee (QAC) Chairs Summary Report	
	The report provided a summary of the key areas of discussion from the QAC meeting held 18 June 2026 and sought to alert, advise, and provide assurance to the Board against the areas discussed. Laura Stroud noted the alert regarding the potential breach of the HTA licence had been escalated to the Board on 25 June 2026 and a further update would be provided to the private Board meeting on progress. She clarified that there had been no clinical or patient harm with the breach relating to governance processes. She reported that the QAC had sought assurance on the rollout of Martha's Rule which was promoted across Adult and Children's areas. There was an active Team in place to respond to calls and a review had taken place of the theme of concerns which had evidenced that 75% had not met the escalation criteria for Martha's Rule and had been referred back to the local areas for resolution. She noted the Committee's review and endorsement of the Quality Account which had subsequently been signed off by the Board on 25 June 2026. She highlighted the assurance received by the Committee on the actions taken to ensure safer staffing, noting the further detail that would be provided to the Board at agenda item 9.5. She also noted the Committee's review of the Complaints Annual Report which would be received by the Board at agenda item 9.4. She noted that the Committee had received a large volume of annual reports at its June meeting and was in the process of reviewing the regulatory statutory requirements for reporting, with a view to streamline the volume received by the Committee and utilise its sub-committee structure where appropriate. The Board received the report and noted the assurances received by the QAC. Andrew Greenwood exited the meeting	
9.4	Complaints Annual Report	
	The 2025-26 Complaints and Patient Advice Liaison Service (PALS) Annual Report was provided to the Board. Beverley Geary reported that the Trust continued to experience significant and sustained pressure across complaints and PALS services. She noted that performance against local timeliness targets was below the 80% standard that had been agreed however the Trust was compliant against national timeline standards. She reported that there had been increasing complexity of questions within complaints spanning over multi-CSUs and specialities and noted that Women's and Children had seen the most significant increase. She advised of work	

taking place to address the root cause of recurring themes and updated on the increased promotion of early resolution meetings.

She reported that the Trust had undertaken a complaints survey and drew attention to the findings within table four of the report. She explained this was an opt in process and therefore limited responses had been received. A recurring theme had been on the need to ensure clear and consistent communication throughout the complaint's response process. She confirmed there was a policy in place however application was variable across CSUs and work was taking place to rectify this.

She drew attention to the key themes and learning from complaints with the most reported themes (around 80%) related to communication, treatment, staff interaction and administration, access, and patient flow.

She referenced the CQC's Regulation 16 breach in September 2025 and reported that the improvement action plan in response had been completed however not yet fully embedded. A Complaints Management Group had been established to oversee progress and ensure actions were embedded.

She highlighted the areas of priority within the current year which included an increase in visible leadership and contact, a refresh of the internal complaints response progress to remove unnecessary bureaucratic barriers and to restore complaint response performance to internal standards. An AI Tool was being piloted to ensure that complaints responses were responding to all questions raised within the original complaint.

Antony Kildare recognised the understanding of the challenge and the planned progress towards improvement. He questioned what further support the Board could provide and Beverley Geary was positive of the oversight and discussion through the QAC. She was mindful that due to the increase in volume of complaints the Team had not made the desired progress and therefore the review and refresh approach had been supportive. Laura Stroud commented on the customer service expertise around the Board which could support this process, commenting on the need to take different action versus more of the same.

Elizabeth Garthwaite reflected on the ownership of early intervention within the complaints process and the clarity for staff on where this was provided. She updated that work was taking place with the Medical Team to support this and equip Teams with the skills to provide early responses in the right way without acting defensively.

Brendan Brown further explored the increase in complaints, and there was recognition of the increased negative media attention and the multiple routes for individuals to raise complaints. There was a wider discussion on how success in this area could be measured with examples including a reduction in the volume of reopened complaints. The discussion noted the importance of focusing on the management of complaints and addressing root causes versus the overall volume. The actions on early intervention were supported and the impact of an apology recognised. The Board questioned if there was a way to

	measure this and Beverley Geary explained that this could be triangulated with the PALS data and how many concerns escalated to become a complaint. The Board received the report and was assured of the actions being taken to address the complaints backlog and enable a sustained process moving forward. The additional assurance and oversight by the QAC was noted.	
9.5	Nursing and Midwifery Safer Staffing	
	The report provided detail on the latest position against safer staffing metrics and sought to provide assurance that the Trust was fully compliant with national safer staffing regulations, policy, and speciality guidance. The Board noted the review and assurance by the QAC and received the report noting the assurance provided on the Trust's compliance with safer staffing regulations.	
9.5(i)	Perinatal Staffing	
	<i>In attendance: Becky Musgrave, Head of Midwifery</i> The report provided detail to key findings, risks, and actions regarding the Perinatal Workforce for the period December 2025 to May 2026. Becky Musgrave presented the Maternity and Neonatal Safe Staffing report, drawing attention to the detailed position set out within the paper. She reported a positive recruitment response across midwifery, with current vacancy gaps expected to reduce as newly appointed staff commenced during Quarter 3 and Quarter 4. In the interim, mitigating measures, including the use of Bank and Agency staff were being taken to maintain safe staffing levels until the recruitment pipeline was fully realised. She reported that staffing had impacted delays within the induction of labour pathway, which remained the key driver of maternity red flags. She advised that one-to-one care during labour had largely been maintained, with limited red flags reported. Where pressures had arisen, incidents had been mitigated through staff redeployment and service management actions. She noted that neonatal nursing and medical staffing had remained compliant with British Association of Perinatal Medicine (BAPM) standards throughout the reporting period, despite capacity pressures and the management of service outbreaks. She reported that the maternity budgeted establishment had been aligned to the 2024 Birthrate Plus recommendations and updated that a further Birthrate Plus assessment was scheduled to be completed before the end of 2026/27. She further reported that an obstetric workforce review had identified a requirement for consultant and resident workforce expansion. An initial business case had been approved, with funding secured for 2026/27, and further review planned during 2027. She drew the Board's attention to the key risks identified, noting that Midwifery sickness absence remained a concern at approximately 6%, with stress and anxiety continuing to be the predominant reasons for absence. Following wider	

	discussion, the Board noted the vulnerability of small specialist Teams, including fetal medicine and fetal assessment services, where high levels of staff unavailability could result in service disruption. Becky Musgrave noted that the homebirth provision remained vulnerable to workforce availability, with a significant proportion of planned homebirth services having been suspended during the reporting period due to insufficient staffing capacity. She reported that Neonatal services had experienced significant operational pressures during the period, including the management of Serratia and MRSA outbreaks, source isolation pressures, OPEL escalation, and a business continuity incident which necessitated the temporary closure of the SJUH Neonatal unit. She requested the Board note that an external regulatory risk remained due to the continued relevance of the CQC Section 29A Warning Notice relating to midwifery staffing. Antony Kildare reflected on the vulnerability in areas of the service and questioned the impact on staff with further detail provided by the Chief Nurse and Chief Medical Officer. There was a wider discussion which recognised the importance of informing and engaging Teams on the actions being taken to support them. The role of Leadership Walkrounds and increased visibility of Leadership Teams was noted and the Board was assured of the proactive action being taken. It was noted that staff were able to engage directly with the Board Maternity Safety Champions and confirmed that this feedback was shared at the PIAC. The Board received the report and was assured of the actions and mitigations in place to address the identified risks. It noted that the Section 29A Warning Notice would remain in place until the CQC reassessed the area.	
9.6	Leadership Walkround Programme	
	This report provided an update on the Leadership Walkround Programme and shared the key themes arising from the visits which had been conducted during Q1, noting this was a new style report in response to the feedback with the CQC Well-led review. Beverley Geary drew attention to the detail within the report and informed that 12 Leadership Walkrounds had been undertaken during Q1, including the Maternity Safety Champion Walkrounds. Key themes were identified against Quality of Care and Patient Experience, Culture, Leadership and Colleague Engagement, Continuous Improvement and Learning, Increasing Demand and Capacity Pressures, Digital Infrastructure, Clinical Environment and Estates, Workforce Sustainability and Staff Wellbeing, and System Working and Patient Flow with further detail provided within the report. No immediate or systemic patient safety concerns requiring Board intervention were identified; however recurring themes would continue to be monitored through the Leadership Walkround Programme and existing governance arrangements. A copy of the current programme was provided within the report's appendices noting that dates had been redacted.	

	The Board welcomed the additional out of hours visits being offered and the NED Team confirmed their availability to support more of these. There was recognition of the different hospital environment at different types of the day and in the Board's ability to observe services outside of peak operating times. The Board received the report and confirmed its assurance that the programme provided effective oversight of the quality and safety of care through direct engagement with patients, staff, and clinical services, with findings triangulated with existing quality governance and assurance processes	Beverly Geary
9.7	Blue Box – HCAI Annual Report	
	The 2025-26 Healthcare Acquired Infections (HCAI) Annual Report was provided in the Blue Box for information, and the assurance received by the QAC was noted.	
9.8	Blue Box – Q3 Mortality review (Learning from Deaths)	
	The Q3 Learning from Death report was provided in the Blue Box for information, and the assurance received by the QAC was noted.	
10.1	Perinatal Improvement Assurance Committee (PIAC) Chairs Summary Report	
	The report provided a summary of the key areas of discussion from the PIAC meeting held 9 July 2026 and sought to alert, advise, and provide assurance to the Board against the areas discussed. Simon Le Clerc drew attention to the detail within the report and noted the update on the Perinatal Improvement Plan (PIP) that had been provided to the Board at agenda item 8.3. He noted the assurance received by the Committee of the review of the Fuller Inquiry and Nottingham Report with relevant actions being incorporated into existing improvement plans. He drew the Board's attention to the continued delay in the implementation of the digital patient monitoring solution intended to support compliance with national maternity triage standards. Following a request from the Trust Chair, Paul Jones provided further detail and explained the Trust was awaiting a response on timelines from the system supplier. It was agreed that Brendan Brown would write to the supplier's Senior Team to stress the importance of the update and request an urgent reply on timescales for implementation. There was a wider discussion which noted the assurance received by the Committee on the workaround process however recognition that this was reliant on manual input and was resource heavy. Simon Le Clerc noted that the Committee had also raised concern on the volume of red flags raised in relation to the delay in the induction of labour pathways which were predominantly a result of staffing pressures. Improvement actions were underway however these would not be embedded until later in the year with assurance being sought on the mitigations in place. The Committee noted the additional recruitment taking place to support substantial staffing. He highlighted the positive feedback received on the Maternity Voices Partnership (MVP) and noted a recommendation to increase the MVP resource within the Trust.	Brendan Brown

	He updated of the establishment of the Perinatal Improvement Assurance Group (PIAG) within the Committee's sub-structure to provide additional oversight of the related improvement plans and enable the PIAC to fulfil its assurance function. The Board received the report and noted the assurance received by the PIAC. Paul Jones exited the meeting	
10.1(i)	Blue Box – Independent Review of Maternity Services	
	The following reports were shared with the Board for information noting the scrutiny and assurance provided via the PIAC: • Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust (24 June 2026) • Independent Investigation into Maternity and Neonatal Services in England (30 June 2026) • NHSE letter– post-death care and mortuary oversight (26 June 2026) • NHSE letter– 10 Point Plan (100 days) (30 June 2026)	
10.2	Perinatal Assurance Report	
	The report provided oversight of the quality and safety of the perinatal services aligned with the national NHSE Perinatal Quality Oversight Model (PQOM) for the reporting period May and June 2026. Becky Musgrave highlighted the detail within the report and assurance provided that the Perinatal Service continued to maintain robust oversight through the PQOM. No special cause variation had been identified within the core clinical outcome metrics during the reporting period, and she noted the ongoing monitoring against established governance mechanisms, including incident reviews, PMRT reviews, Maternity Newborn Safety Investigation referrals, Safety Champion intelligence, patient feedback, training compliance, and national improvement requirements. She requested that the Board note there were no immediate safety concerns identified through Safety Champion walkarounds or Freedom to Speak Up processes. Two referrals had been made to the MNSI during the reporting period, with the Trust awaiting the formal outcome of these. The Board's attention was drawn to the ongoing risk relating to workforce capacity and resilience, and she reported that recruitment activity across nursing and midwifery had progressed positively with current vacancies appointed to. She reported however that the majority of candidates would not commence in post until Q3 due to registration requirements and therefore the service remained reliant on Bank and Agency staff until substantive staffing levels improved. She reported that whilst Bank shifts continued to be released, not all shifts were being filled, requiring specialist, non-clinical and management midwives to be redeployed into clinical areas. She advised that although this mitigated immediate clinical staffing risks, it reduced capacity for specialist portfolio work, quality improvement activity, governance processes, and leadership oversight.	

	She highlighted that overall mandatory training compliance remained strong with the exception of PROMPT training compliance for Maternity Support Workers, which currently stood at 89% against a target of 90% with recovery plans in place. <u>Post-meeting Note:</u> <i>A further 10 Maternity Support Workers attended PROMPT training on 6 July, increasing compliance to 92%. The updated data was not available in time to be reported at the meeting; however, confirmed that, as of 7 July 2026 (formal MIS mid-point review), the Trust had achieved the required threshold of at least 90% and was compliant with all elements of Safety Action B training.</i> She updated on the operational pressures within the service and reported there had been an increase in red flags associated with delays in the induction of labour pathway. A rapid improvement programme had identified several mitigating actions, including dedicated induction of labour midwifery support, enhanced digital bed-state visibility, standardised cross-site communication arrangements, and pathway flow improvements. She reported that the Trust continued to perform strongly against national standards however informed of risk relating to fetal assessment service capacity, sustainability of smoking cessation services, compliance with reduced fetal movement scanning standards and implementation of uterine artery Doppler screening. Plans were progressing to redesign fetal assessment services to provide seven-day coverage and increased capacity, subject to workforce planning and relevant approvals. She informed that positive progress was being made against Year 8 of the Maternity Incentive Scheme (MIS), with leads identified and evidence mapping underway. She noted a specific compliance risk relating to external obstetric and neonatal attendance at PMRT reviews and heard that options were being explored to secure appropriate specialty representation. She updated on patient experience and health inequalities, reporting that Friends and Family Test feedback remained positive overall, with satisfaction rates exceeding 90% across antenatal and intrapartum pathways and neonatal services reporting 100% positive feedback. However, postnatal feedback had reduced to 87.5%, with common themes relating to staffing levels, responsiveness to pain relief needs, communication, and discharge processes. Elizabeth Garthwaite commented further in the reduction in the Trust's ability to support homebirths as a consequence of staffing. The health inequities aspect within the MOSS data was explored further with a higher portion of signals from deprivation groups. Assurance was received on the investigation process in place. The Board noted the assurance provided regarding the safety and quality of perinatal services, whilst recognising the continuing risks associated with workforce capacity pending commencement of newly recruited staff.	
	People and Culture	
11.1	People Committee Chairs Summary Report	

	The report provided a summary of the key areas of discussion from the People Committee meeting held 11 June 2026 and sought to alert, advise, and provide assurance to the Board against the areas discussed. Amanda Stainton noted the detail within the report and drew the Board's attention to the alert regarding concerns at the disproportionate representation of Black and Minority Ethnic (BME) colleagues within conduct cases during 2025/26. BME colleagues accounted for 44.9% of conduct cases, which was a significant increase from 31.5% in 2024/25, and exceeded the 31% of BME colleagues within the Trust workforce. She reported that further work was underway to understand contributing factors and identify underlying themes which would be reported to the next meeting. The Committee was positive of the impact of the new People Improvement Framework which was strengthening workforce oversight, accountability, and CSU engagement with people metrics. She noted the Committee's review of the Job Evaluation Annual Report and assurance received regarding the effectiveness of the Trust's Job Evaluation arrangements. The Committee had noted significant improvements in process efficiency, audit compliance and turnaround times and she highlighted the inclusion of full report at agenda item 11.6. The Board received the report and noted the alert and assurance received by the People Committee.	
11.2	Inclusion and Belonging Engagement Update	
	The report provided an update on continued progress against the Trust-wide Inclusion and Belonging (I&B) Action Plan. Suzanne Dunkley updated on the ongoing work to embed the refreshed Leeds Way Values of: Kind, Open & Honest, Responsible, and One Team which included the development of behavioural definitions for each. She highlighted the Senior Leaders Conference held 22 July 2026 and the engagement with leaders on the supporting behaviours to demonstrate these values. She referenced the recent publication of the national Lord Mann Review and confirmed that the Trust had completed a self-assessment process with the engagement from staff networks and recommendations aligning to the I&B action plan. She noted the raising profile of I&B champions and referenced the Freedom to Speak Up (FtSU) that would be provided at agenda item 11.3. The Board received the report and noted the progress made against the I&B actions.	
11.3	Freedom to Speak Up Annual Report	
	<i>In attendance, Alan Sheppard, Freedom to Speak Up (FtSU) Guardian</i> The report provided an annual update on the FtSU process and activity. Alan Sheppard drew attention to the detail within the report and highlighted the various routes available to staff to contact or raise a concern with the FtSU	

	Team. He reported that there had been 259 cases raised in 2025/26 compared to 260 the previous year. Across the reporting period, the majority of concerns raised related to inappropriate attitudes and behaviours, with 105 cases categorised under that theme, highlighting the importance of promoting behaviours and professional practice across the organisation. Appendix 2 provided a breakdown of all concerns categorised by CSU during the reporting period 1 April 2025 to 31 March 2026. He updated on the focused work to ensure psychological safety and the utilisation of the FtSU Champion Network to engage with staff. He reported that some of the concerns raised through the FtSU process would be better escalated through existing HR processes and work was taking place to align information and ensure clear routes of escalation for staff. He highlighted the results of the latest Staff Survey in relation to raising concern indicators which aligned to the national position however highlighted the need for additional engagement with staff. In response, targeted promotion and communication activity would be delivered in areas where awareness and confidence appeared lower, ensuring colleagues understood how to access FtSU services and what support was available Following a query from Mark Burton, Alan Sheppard provided further detail to the Champion Network across the Trust and the diversity within this. He reported that there were currently 140 staff members in Champion roles spread across CSUs. All CSUs, with the exception of one, had a lead Champion who would collate feedback from discussions and escalate themes and required actions. He informed there was more work to do to ensure FtSU Champion representation within Corporate Functions. Suzanne Dunkley commented on the further triangulation that would take place through the People Committee to align HR concerns with FtSU data and in support of the wider Speaking Up agenda. Ricky Singh questioned the increase in the volume of concerns raised as anonymous and Alan Sheppard explained this was due to the increased promotion and use of the online portal which enabled staff to choose anonymity. He confirmed this had been anticipated and was mirrored across other organisations. The Board received the report and was assured of the process and activity in place to support the FtSU agenda. Alan Sheppard exited the meeting	
11.4	Freedom to Speak Up Executive Assurance	
	The report supported the FtSU Annual Report received at agenda item 11.3 and sought to provide assurance on the Trust's recognition of the data, utilised to inform the identification and progression of improvement action. This included continued progression of the nationally mandated bi-annual speaking up self-assessment (completed and reported to Board in May 2025), and of several additional improvement actions underway for 2026.	

	Suzanne Dunkley reported on the assurance received by the Executive Team on the effectiveness of the FtSU process and was positive of the engagement of the FtSU Guardian and escalations via the FtSU Champion network. She reported that the National Guardian's Office had been stood down (with oversight transferred to NHSE) and there were two significant areas of activity for the Trust to incorporate within its existing arrangements which included the response to detriment, and harassment complaints. She confirmed that work was taking place to ensure these areas were embedded within existing processes and escalated. The Board received the report and noted the assurance received by the Executive Team.	
11.5	Blue Box – Leeds Health and Care Academy Annual Report	
	The 2025-26 Leeds Health and Care Academy Annual Report was provided in the Blue Box for information.	
11.6	Blue Box – Job Evaluation Annual Report	
	The 2025-26 Job Evaluation Annual Report was provided in the Blue Box for information noting the assurance received via the People Committee.	
	Access and Delivery of Services	
	<i>No items to report.</i>	
	Strategy, Leadership and Planning	
13.1	Winter Plan	
	The report provided a high-level assessment of the Trust's 2025/26 winter response, and included a summary of the principal lessons learned, and the priorities required to improve resilience ahead of winter 2026/27. Tim Hiles provided oversight of the multi-source process in place to review the effectiveness and implementation of the previous year's winter plan. He noted the detail within the report and summarised that overall, the plan was assessed as resilient and effective however there had been some specific challenges relating to corridor care which had impacted on patient experience. He reported that the QAC was receiving increased oversight of the corridor care position following the mandate from NHSE to eradicate the use of corridor care by 2029. The influenza peak had also arrived earlier than national and local forecasts had predicted and he reported that planning for the coming winter would incorporate learning from this. He advised that there was an active review of the trigger points within the decision-making tools to ensure these were aligned to a defined point to trigger the implementation of actions. He reported that a health inequalities impact assessment had been completed and reviewed which had found that the Trust had a higher-than-average deprivation group who attend the Emergency Department (ED). He explained that in order to maintain equity at the point of attendance, prioritisation was based on clinical urgency. Gillian Taylor shared her experience from a Leadership Walkround of J31 (one of the winter wards) and the feedback from staff of the limited access to support	

	functions such as physiotherapy within surge areas. Tim Hiles confirmed that this was being considered within the planning cycle and expanded on the role of the decision management tool which would include community partners within the coming year with a view to balance risk across the city whilst equalising the impact. The Board received the report and confirmed its assurance of the multi-source review process and identification of learning opportunities. It noted the report findings and confirmed its support to earlier planning, improved escalation, and decision-making frameworks, and strengthened system-wide alignment. It was noted that the 2026/27 LTHT winter plan would be reviewed by the F&P, and Quality Assurance Committees in August 2026 prior to seeking Board approval in September 2026.	
13.2	Sustainability Annual Report	
	<i>In attendance: Chris Kelly, Associate Director of Estates, Compliance and Risk</i> The 2025/26 Sustainability Annual Report was presented to the Board and updated on the Trust's progress towards achieving its net zero targets and the goal of becoming one of the greenest Trusts in the UK. The 2025-28 Green Plan, supporting this ambition, was included within the report's appendices. Craige Richardson set context to the Trust's ambition and highlighted the two key targets for the NHS: • For the emissions, the NHS control directly (the NHS Carbon Footprint), reach net zero by 2040, with an 80% reduction from our baseline year by 2032. • For the emissions, the NHS can influence (the NHS Carbon Footprint Plus), reach net zero by 2045, with an 80% reduction from our baseline year by 2039. He expanded on the role of the Green Plan in supporting this ambition and was positive of the progress made to date. He noted that environmental sustainability was one of the quality statements within the CQC Well-led Framework and the Trust had assessed well against this domain in the latest CQC Well-led review. Chris Kelly guided the Board through the key highlights of the report noting the key changes to the national carbon monitoring reporting which set the baseline year as 2019/20. In the 2025-26 financial year, the Trust recorded a total of 55,717 tCO₂e emissions, representative of a 40% reduction with a 2019/20 carbon baseline and was evidence of the success of emissions reduction works. Progress had been supported by a combination of decarbonisation projects and the continuous progress of carbon reduction measures outlined in the Green Plan He was mindful of the financial cost and investment to support the Trust to achieve net zero and decarbonise the estate and explained there were a number of national capital funds that the Trust was able to bid for to support this.	

	The Board received the report and was positive of the achievements to date and confirming its ongoing support for the long-term ambition to achieve its net zero targets. Chris Kelly exited the meeting	
13.3	Leeds Place Joint Committee in Common	
	The report provided an update on the development of the Leeds Provider Partnership Joint Committee arrangements and presented the Terms of Reference (ToR) and Collaboration Agreement for review and approval. The report followed the previous update to Board in May, which described the establishment and early progress of the Leeds Provider Partnership Shadow Joint Committee. Mike Harvey noted the documents seeking approval cited within the report's appendices and noted that approval at this stage did not create any immediate contractual obligations, transfer liabilities, establish pooled budgets, or delegate functions to the Joint Committee. Further work was required during the shadow period to determine the service scope, priority areas, delegations, financial framework, and future operating model for the partnership The Board received the report and approved the ToR and Collaboration Agreement for the Leeds Provider Partnership Joint Committee.	
13.4	Blue Box – Remuneration Committee	
	A summary of the Remuneration Committee meeting held 21 May 2026 was provided in the Blue Box for information and was received and noted.	
	Financial Performance and Oversight	
14.1	Finance & Performance Committee Chairs Summary Report	
	The report provided a summary of the key areas of discussion from the F&P Committee meetings held 27 May and 24 June 2026 and sought to alert, advise, and provide assurance to the Board against the areas discussed. Mark Burton drew attention to the alert section of the report and noted the Committee's consideration of its utilisation of the corporate risk governance documents as per the report provided to the Board at agenda item 8.2. He noted the alert related to the volume of No Criteria to Reside (NCtR) patients had been escalated to the Board at its Timeout on 25 June 2026. He highlighted the additional detail within the Advice and Assurance sections and reminded of the Committee's rotational focus on finance and performance items which was working effectively and allowing the Committee to dive deeper into each subject. In addition, he provided a verbal update of the key areas of discussion from the F&P Committee meeting held the previous day which had held a financial focus with the opportunity to raise any areas of escalating performance or variance. The Committee had received an update and assurance on the new risk-based process to prioritisation of the capital programme. It was agreed that a copy of the report would be shared with the Board for information. The month three position had been reviewed in detail, and it was noted that pay-expenditure	

	remained above plan, primarily due to the underfunding of the medical and dental pay award and increased bank costs above plan, Children's Mental Health Services agency usage and an increase in security costs. The Committee was updated of the revised NHSE Regional oversight of the financial position with the new approach providing a risk stratification of organisations within the context of performance and safety aligned to levels of support and intervention. Each trust was assigned a category; on track (light-touch assurance), watch (targeted support), at risk (active intervention) or mandated/non-compliant (mandated turnaround). The Region had confirmed that LTHT were in the 'watch' category at the end of month three and the Committee had explored the rationale for this and actions required to improve. Further detail would be shared with the Board during the Q2 Fundamental Financial Review. The Board received the report and noted the alert and assurance received by the F&P Committee.	
	Productivity and Value for Money	
15	<i>No items to report.</i>	
	Standing Concluding Items	
16	Risk	
	There were no items arising from the meeting for escalation to the Corporate Risk Register, or which impacted the risk tolerance levels as defined within the Risk Appetite Framework.	
	Legal Advice	
	There were no items arising from the meeting that warranted the consideration of legal advice.	
	Regulators	
	Noting the ongoing assurance received against the Well-led and Perinatal Improvement Plans, there were no further items for escalation to the Trust regulators.	
	Communications	
	Jane Westmoreland updated that the Trust had launched a TikTok account with a view to engage with a younger and wider audience. It was noted that there was specific communications support being provided to perinatal services as raised during the meeting.	
17	Meeting Effectiveness	
	It was noted that, owing to the volume and complexity of business considered, the meeting had concluded later than scheduled. Further comments on the meeting effectiveness were welcomed, and the Board was positive of the pilot in holding the Public Board meeting in the morning.	
18	Any Other Business	
	Laura Stroud commented on the recent heat wave weather alerts and explored if the Board should be seeking additional oversight of the actions required across the Trust. This would be considered by the Executive Team and a recommendation reported via the Action Tracker to the next Board meeting.	Execs