

Public Board

24 September 2026

Provider Capability Assessment

Presented for:	Information, Discussion and Approval
Presented by:	Brendan Brown, Chief Executive
Author:	Jo Bray, Director of Corporate Affairs, and Executive Team
Previous Committees:	N/A Submission October 2025 – annual process

Freedom of Information Act (FOIA) Exemption	☒ YES (restricted from the FOIA) ☐ NO (available to the public under the FOIA)
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Link to Strategic Objective	Applicable to all objectives
Link to Provider Capability Assessment	Governance, risk and regulatory
Link to CQC Well-led Statement	Governance, Management and Sustainability
Regulatory Impact	Considers all regulatory impact

Risk Appetite Framework				
Level 1 Risk	(✓)	Level 2 Risks	(Risk Appetite Scale)	Impact
Workforce Risk				
Operational Risk				
Clinical Risk				
Financial Risk				
External Risk		Legal & Governance Risk - We will operate the Trust in compliance with the Law and UK Corporate Governance Code, where applicable.	Averse	Operating out of tolerance
External Risk		Regulatory Risk – We will comply with or exceed all regulations, retain its CQC registration and always operate within the law.	Averse	Operating out of tolerance

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Key points	
The Board are asked to review the draft of the self-assessment for approval and submission to NHS England Regional Team.	Discussion & Approval
The Trust will remain red rated by the Regional Team due to the breaches within our Provider Licence.	

1. Summary

NHS England (NHSE) in August 2026 issued, for the second time to all acute providers, the criteria for the Board to self-assess against the 'Provider Capability Assessment'. This requires submission to NHSE North East Regional Team by 2 October 2026.

Full document [NHS England » Assessing provider capability: guidance for NHS trust boards](#)

2. Background

The Provider Capability Assessment will be used by region and 'sit' alongside the quarterly National Oversight Framework (NOF) segmentation rating for performance reporting.

Appendix 1 sets out the suggested draft of the self-assessment seeking Board approval.

2.1 Process

As part of its approach to oversight, NHSE will assess NHS Trusts 'capability, using this alongside providers' NOF segments to judge what actions or support are appropriate at each organisation. As a key element of this, NHS Boards will be asked to assess themselves against across the six domains of The Insightful Provider Board, namely:

- strategy, leadership and planning
- quality of Care
- people and culture
- access and delivery of services
- productivity and value for money
- financial performance and oversight.

The purpose of this is to focus Trust Boards' attention on a set of key expectations related to their core functions, as well as encourage an open culture of 'no surprises' between trusts and oversight Teams.

The guidance document is designed to help Boards make this self-assessment, set out the process and what organisations can expect along the way. Boards should use it to support a RAG rated self-assessment (Green/Amber-Green/Amber-Red/Red) against each of the domains, taking account of the 18 supporting capability statements. Boards should consider:

- 1) The extent to which the provider is meeting each capability statement, based on the returns template
- 2) The evidence underpinning their view, logging this in the return to the region as well as the issues preventing a 'green' return and actions underway to address.
- 3) What, given the above, the overall rating should be in each of the six areas.

2.2 NHSE Guidance on Assessment

2.2.1 Inability to make a positive self-assessment

The Board may not be able to make a positive self-assessment either because it considers the risks in a specific area are too great or its organisation is already manifestly failing in a

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specific area (for example, delivering on access targets). In these situations – and in line with the ‘no surprises’ ethos – in the self-assessment template Boards should provide:

- the reasons why a positive self-assessment cannot be made against specific criteria and the extent to which these have been outside the trust’s control to address (for example, industrial action, system-wide factors)
- how long the reasons have persisted
- a summary of any mitigating actions the Trust has taken or is taking
- if not already shared with oversight teams, a high-level description of Trust plans to address the issue, how long this is likely to take and KPIs or other information the trust will use to assess progress

Oversight Teams will use this information to form their view of the overall capability of the trust and tailor their oversight relationship with it.

2.2.2 The NHS provider trust capability rating

Regional oversight Teams will review the Trust’s submitted self-assessment and consider the statements and evidence. Using a range of considerations, including the historical track record of the Trust, its recent regulatory history and any relevant third-party information, the oversight team will decide the Trust’s capability rating and share this with it, including the rationale for the rating.

The table below sets out a high-level overview of the details from Appendix B, the RAG-rating approach to derive the rating – guidance for providers.

Rating - in either a specific domain or overall	Indicative characteristics
Green <i>High confidence in management</i>	• Strong track-record across management team • No concerns with board’s grip, • No reputational issues, system partner or other third-party concerns
Amber-green <i>Some minor issues that should be addressed</i>	• No material concerns, but some areas may require a watching brief and as yet are not affecting quality of care, delivery of core services, finance or the wider reputation of the NHS, or • Trust in ‘probation’ – no concerns but trust capability recovering from previous concerns before final assurance.
Amber-red <i>Material issue needs addressing or failure to address major issues over time</i>	• Serious governance/capability issues in at least one domain or capability statement and/or • Trust recovering from red-rating below, with serious issues still present but evidence of improvement and grip
Red <i>Significant and persistent concerns</i>	• Serious issues in multiple domains and/or • Serious ongoing issues in a single domain that management has been unable to address sufficiently over time • Trust in breach of governance licence condition or likely to be.

3. Proposal

The Board is fully aware of the Trusts current engagement with regulators, their recommendations for improvement and formal notice of breaches, as stated within Appendix 1.

Below is the high-level summary of the self-assessment against each of the six criteria as defined in the Capability Assessment.

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Leeds Teaching Hospitals NHS Trust is self-assessing against the overall Provider Capability Assessment with a red rating, in keeping with the submission last year. Noting a CQC inspection would be required to rate the Trust differently to remove the breaches with the Provider Licence.

Strategy, Leadership Planning	Red	Breaches within the Provider Licence
Quality of Care	Red	Breaches within the Provider Licence
People & Culture	Amber-Green	
Access & Delivery of Service	Amber-Green	
Productivity & Value for Money	Amber-Green	
Financial Performance & Oversight	Amber-Green	

4. Financial Implications

N/A.

5. Risk

The Trust has an averse risk appetite with regard to Legal & Governance risk and Regulatory risk set by the Board, more work is required to move back towards the tolerance defined by the Board.

6. Communication and Involvement

There will be Trust wide communication on the improvement work and the rating against the Provider Capability Assessment, as NHSE will publish this alongside the quarterly NOF reports.

7. Equality Analysis

The Trust strives to adhere to equality and diversity practices.

8. Improving Health Equalities

The Trust is committed to Improving Health Equity meaning reducing the unfair and avoidable differences in health some groups experience, the work of our Board and Committees underpins this commitment.

9. Publication Under Freedom of Information Act

This paper is currently the draft self-assessment that is to be discussed and approved by the Board. Should this be subjected to any changes following the discussion a final version would be updated and release in the public domain, if requested.

10. Recommendation

The Board are asked to receive the draft self-assessment and consider if this is a current snapshot summary of the Trust's assessment against the defined criteria of the Provider Capability Assessment which currently red rates the Trust. The overall red rating as defined by the criteria, a result of breaches with the Provider Licence.

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11.Supporting Information

Appendix A – The self-assessment against the required template for the Provider Capability Assessment

Appendix B – Using a RAG-rating approach to derive the rating – guidance for providers

Jo Bray

Director of Corporate Affairs

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Provider Capability Assessment (Leeds Teaching Hospitals NHS Trust as at 15 September 2026)

Provider capability self-assessment template 2026

Provider name:	Leeds Teaching Hospitals NHS Trust
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Providers should use the form and the supporting annex to rate themselves across each domain and, following Chair and CEO sign-off, submit to england.neyoversightregulation@nhs.net by **5pm Friday 2 October 2026**.

I. Strategy, leadership and planning

Capability statements	Proposed domain rating
	Red
	<i>Trust to insert commentary here. To include the board's views and evidence supporting its proposed rating, taking account of</i> <i>o the domain's capability statements</i> <i>o governance arrangements to oversee this area and their effectiveness to date</i> <i>o any areas where the board has identified concerns and/or development needs and actions planned or in place to address these.</i> <i>any relevant developments since the 2025 exercise.</i>
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners	<i>Do plans reflect and leverage the trust's distinct strengths and position in its local healthcare economy?</i> <i>• Are plans for transformation aligned to wider system strategy and responsive to key strategic priorities agreed at system level?</i> <i>• Can the board recognise when change is required and to adapt arrangements as the organisation evolves?</i> <i>• Does the board understand the key risks to delivering the strategy and ensures these are appropriately assessed and mitigated?</i> LTHT has approved its Organisational Strategy for 2026–2029. The strategy establishes four priorities, aligned to it's overall purpose to deliver excellent, safe and effective healthcare for every patient, every time. The four priorities are People, Improvement and

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Innovation, Partnerships and Outcomes. It reflects the Trust's role as a major provider of local, regional and specialist services and places greater emphasis on population health, reducing inequalities, integrated care, prevention and delivery through partnership.

The strategy is being translated into supporting clinical, operational, workforce, improvement, digital and partnership arrangements. Partnerships is now a distinct strategic priority, with governance established to oversee delivery and to connect Trust decision-making with Leeds and West Yorkshire priorities. The Trust's plans recognise its distinct strengths, including specialist clinical expertise, research and innovation, education, digital capability and its scale within the Leeds and West Yorkshire health economy. These strengths are being applied to system priorities through WYAAT collaboration, the Leeds Provider Partnership, neighbourhood health, integrated pathway redesign and work with academic and public-sector partners.

The Board recognises that delivery requires the strategy to be translated into measurable plans with clear ownership, milestones and outcomes. Current work to refresh the Board Assurance Framework, align clinical and operational strategy and develop partnership delivery arrangements is intended to strengthen this line of sight. Further work is required to ensure that emerging system priorities, particularly neighbourhood health and future provider partnership arrangements, have agreed resources and clear accountability for delivery.

The Board is assured that the Trust is developing a coherent strategic framework aligned to national and system priorities, while recognising that the principal focus for 2026/27 is embedding the strategy through measurable delivery plans, effective risk management and clearer system accountability.

The Trust continues to play a leading role in shaping and delivering digital strategy across Leeds, reflecting its position as a major teaching hospital and provider of both local and regional specialist services. The Leeds Care Record remains a key shared digital asset across the city, supporting integrated working between acute, primary, community, mental health, social care and third-sector partners, with further development aligned to Leeds-wide transformation priorities.

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	The Trust's digital priorities are increasingly focused on strengthening the digital foundations required to support both its own strategy and wider system transformation. This includes addressing significant legacy and technical debt within the core clinical systems estate, while developing a longer-term approach with national colleagues to address the wider strategic direction to support Neighbourhood care with a consistent patient record solution. Plans are developed in the context of Leeds, West Yorkshire and national priorities, with active engagement in programmes including the Federated Data Platform and emerging national clinical and digital initiatives such as the Single Patient Record. The Trust has demonstrated its ability to adapt its digital approach as national policy, technology and organisational requirements evolve, while maintaining a clear focus on interoperability and shared care across organisational boundaries. The Board recognises that delivery of this ambition is dependent upon sustained investment in digital capability and infrastructure. The principal strategic risk remains the need to address accumulated technical debt and replace ageing systems whilst simultaneously supporting transformation, productivity and increasing national and system expectations.
2. If in breach of licence: The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE	<i>Is the trust currently complying with the conditions of its licence?</i> <i>• Is the trust complying and regulatory instruments – for example, discretionary requirements and statutory undertakings and is there a board-level plan to return to compliance?</i> <i>• Is it co-operating with the requirements of any national performance improvement or recovery programmes?</i> The Trust is in breach of its provider licence which was set out in a letter received 17 October 2025 regarding regulations relating to Complaints, Good Governance and Staffing. Trust mapped progress against enforcement letter actions, set out improvement plans and has attended NHSE IQG monthly meetings to provide assurance of actions and progress to delivering and sustaining improvements. The Trust requires re-inspection by the CQC (with compliant rating) for the enforcement notices to be removed.

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3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan.	<i>Are all board positions filled and/or are there plans in place to address any vacancies?</i> <i>What proportion of board members are in interim/acting roles?</i> <i>• Is an appropriate board succession plan in place?</i> <i>• Are there clear objectives, accountabilities and responsibilities for all areas of operations including quality, delivering access standards, operational planning and finance?</i> The Chief Executive is currently seconded with arrangements defined by Fiona Edwards. The Trust is currently out to advert via an open competition for a permanent CE. The Chief Medical Officer is currently an internal secondment fulfilled by the Deputy CMO. Plans are being developed for a timeline for recruitment. The Trust is currently recruiting for a Non-Executive Director (who will be the Deputy Chair) as part of the succession plan for the departure of the current deputy in January 2027. The person specification aims to further build diversity of the Board. From Oct 2025 to the current time, the focus has been on stabilising the Board with permanent Executive positions (three in year) and embedding new Board members. We are now in a position to develop a Board succession plan during Q3. In response to the CQC Well-led findings published September 2025, the Board has defined a development programme, that has commenced during the year, this includes the NHSE commissioned Digital Board Programme facilitated by NHS Alliance. All Board members have participated in appraisals from either the Chair of Chief Executive, with objects defined. All Board members have carried out appraisals with clearly defined objectives.
4. The trust is working effectively and collaboratively with its system partners and	<i>Is the trust contributing to and benefiting from its provider collaborative?</i> <i>• Can the board evidence that it is working effectively with the wider system, not just focused on the organisation itself – for example, in terms of sharing resources and</i>

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provider collaborative for the overall good of the system(s) and population served	<i>supporting wider service reconfiguration and left shifts to community care where appropriate and agreed?</i> • <i>Do the trust's operating and financial plans align with those of its commissioning ICB or ICBs, in particular regarding activity and capital expenditure?</i> As outlined in Q1, the Trust has made Partnerships one of the four priorities within its 2026–2029 Organisational Strategy. As a result, LTHT has established an internal Partnerships Steering Group and Partnerships Delivery Group, providing stronger internal oversight of system commitments, delivery, risk and escalation. These arrangements bring together executive, clinical, operational, financial and enabling functions and are intended to provide a clearer line of sight between Trust priorities, system programmes and Board assurance. LTHT remains an active participant in Leeds and West Yorkshire partnership arrangements, including being a key stakeholder in the Leeds Provider Partnership, Leeds place-based governance and the West Yorkshire Association of Acute Trusts. The Leeds Provider Partnership (LPP) is operating in shadow form during 2026/27, with governance and programme infrastructure established and work progressing on future joint decision-making, contracting and financial arrangements. LTHT is actively contributing to the development of these arrangements and is using its own governance processes to assess the implications for quality, finance, workforce, activity and organisational accountability. The Trust is making a tangible contribution to system transformation. Current work includes proactive and reactive neighbourhood health workstreams which include intermediate care redesign, neighbourhood health developments in frailty, diabetes and multiple long-term condition pathways, virtual wards, peri-operative care, community-based comprehensive geriatric assessment, and work to strengthen the primary and secondary care interface. LTHT has aligned with system priorities of frailty, multiple long-term conditions and paediatrics as priority areas for further pathway redesign and is undertaking a stocktake of current provision to identify opportunities for scaling effective models across the city. The Board recognises that system arrangements remain in development and immediate benefits are unlikely to be realised in the short term. LTHT recognise that further clarity is required on the scope and operating model of the LPP, decision-making authority, named system SROs, financial flows, resource commitments and accountability for delivery. LTHT
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	is supporting the shadow arrangements and the development of future models, while seeking assurance that any movement of services or resources is supported by clear evidence, appropriate governance and demonstrable benefits for patients and the wider system. LTHT have allocated active PMO resource allocated to system facing roles helping to progress the LPP's development. The Trusts financial plans are linked to and consistent with WY ICB and Leeds Place within the system. The Trust fully engages in the NHSE and ICB planning process, sharing financial plans (including WRP and capital) within Leeds Place and WY ICB. This process includes shared understanding of the underlying financial position and the bridge from the prior year outturn to the new year plan. This information is consistent with the annual plan that is approved by the Trust Board. Specifically in relation to Capital, the Trust is part of the system Capital Working Group and, despite the changes to reduce the system element of capital approval, supports the system to deliver on the regional and national funding allocations. Overall, the Board is assured that LTHT has strong and mature relationships with system partners, has strengthened its internal partnership governance and is actively supporting shared transformation priorities. The principal development need is now to translate emerging system structures and positive relationships into a smaller number of clearly owned, resourced and measurable delivery programmes.
5. The trust has an effective cyber security strategy and uses digital technology to support organisational improvement	<i>Is there sufficient digital literacy at board level and is digital a core element of discussions regarding planning, delivery, assurance and risk?</i> • <i>Is cyber risk included on Board Assurance Frameworks and/or corporate risk registers?</i> • <i>Can the board articulate how digital is an enabler across the organisation's operations – quality, productivity, access and safety – and supports the governance and culture of the organisation</i> • <i>Are the trust's digital plans linked to and consistent with those of local and national partners as necessary?</i> The Trust has strong digital leadership and governance, with digital, data and cyber routinely considered at Board and Executive level as core enablers of quality, safety, productivity, access and organisational improvement. The Chief Digital and Information Officer is an Executive Director and Board member, and there is good Board-level

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understanding of both the opportunities presented by digital transformation and the risks associated with the Trust's existing technology estate.

Cyber security is treated as an organisational risk rather than solely a technical issue. Cyber risk is reflected through the Trust's corporate risk and assurance arrangements, with regular Executive and Board-level oversight. The Trust has an established cyber security programme and continues to strengthen preventative, detection, response and recovery capabilities.

Digital is increasingly integral to the Trust's approach to service transformation and productivity. The Trust has significant strengths, including its internally developed PPM+ electronic patient record, the Leeds Care Record, established data and analytics capabilities, and a growing portfolio of digital and AI-enabled innovation. Digital considerations are embedded within major clinical and operational transformation programmes rather than being treated as a separate technology agenda.

The Trust's digital strategy and investment priorities are aligned with local and national direction. We work closely with partners across Leeds and West Yorkshire and engage actively with national programmes, including the Federated Data Platform and emerging national digital and clinical initiatives. This enables the Trust both to contribute to national developments and to adopt capabilities where they support local priorities.

However, the Board is also clear about the material constraints within which the digital strategy is being delivered. Current digital expenditure is approximately 1.5% of Trust revenue, which is low relative to the scale, complexity and digital ambition of a major teaching hospital. Historic underinvestment has resulted in significant technical debt and a large, complex application and infrastructure estate. A number of important clinical and corporate systems require replacement or substantial modernisation, while legacy infrastructure continues to create resilience, cyber and operational risks.

The Trust has therefore adopted a risk-based approach to digital investment, balancing immediate resilience and cyber priorities with the need to modernise core clinical systems and exploit digital technology to improve productivity and patient care. Additional investment

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	is being directed towards digital, but closing the historic gap will require sustained investment over a number of years. Overall, the Trust considers digital leadership, literacy and governance to be a strength. The principal challenge is not recognition of the importance of digital or the ability of the Board to articulate its role, but ensuring that the level and pace of investment are sufficient to address accumulated technical debt while simultaneously delivering the digital transformation increasingly required to support safe, productive and sustainable healthcare.
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II. Quality of care

Capability statements	Proposed domain rating
	Red
	<i>Trust to insert commentary here. To include the board's views and evidence supporting its proposed rating, taking account of</i> <i>o the domain's capability statements</i> <i>o governance arrangements to oversee this area and their effectiveness to date</i> <i>o any areas where the board has identified concerns and/or development needs and actions planned or in place to address these.</i> <i>any relevant developments since the 2025 exercise.</i>
6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents,	<i>The trust can demonstrate and assure itself that internal procedures:</i> <i>• ensure required standards are achieved (internal and external)</i> <i>• investigate and develop strategies to address substandard performance</i> <i>• plan and manage continuous improvement</i> <i>• identify, share and ensure delivery of best practice</i> <i>• identify and manage risks to quality of care</i> The Trust has systems and processes in place to monitor and improve the quality of healthcare it provides. Which includes the management of patient safety, risk and clinical

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patterns of complaints and any further metrics it chooses to adopt).	effectiveness. However, following regulatory inspections, diagnostics and peer review the Trust are working on improvements plans within clinical services and trust wide in order to comply with breaches in CQC regulation. This will include reviewing ward to Board governance and oversight of the patient safety and quality of services, escalation and oversight of risks and processes for shared learning. The Patient Safety and Quality Strategy, aligned to the NHS Patient Safety Strategy sets out the Trust aims aligned to insight, involvement and improvement. Progress against this strategy is reported every six months to QAC and as a blue box to Board. CSU level reporting and the Trust Quality Account has also been aligned to the strategy. The Governance structures in place, reporting to Board enable proactive surveillance of quality and safety, clear strategies for the investigation and management of substandard performance and monitoring impact of quality improvement initiatives. Best practice is shared via a variety of routes from ward to board which reciprocates in enabling the proactive and pre-emptive identification of risks. The Trust is in breach of its Provider Licence (Complaints, Good Governance and Staffing) and has been held to account for oversight of improvement plans by NHSE Regional Team via monthly IQIG meetings. Moving forward from October, the Regional Team have revised the Terms of Reference, membership and frequency of these meetings to become QIG meetings for oversight and assurance. The Trust has been proactive in the creation of a new additional senior role, Associate Director of Compliance.
7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of	<i>There is board-level engagement on improving quality of care across the organisation</i> <i>• Board considers both quantitative and qualitative information, and directors regularly visit points of care to get views of staff and patients</i> <i>• Board assesses whether resources are being channelled effectively to provide care and whether packages of care can be better provided in the community</i> <i>• Board looks at learning and insight from quality issues elsewhere in the NHS and can in good faith assure that its trust's internal governance arrangements are robust</i>

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healthcare provided to its patients	• <i>Board is satisfied that current staff training and appraisals regarding patient safety and quality foster a culture of continuous improvement</i> The Trust has implemented PSIRF and members of the Board have received Board level patient safety training delivered by Trust Patient Safety Specialists. The Quality Assurance Committee, Chaired by a Non-Executive Director, with two further NED members, has delegated authority to lead on behalf of the Board of Directors the acquisition and scrutiny of assurances concerning (i) patient safety, clinical effectiveness and patient experience; (ii) the effectiveness of the quality governance framework including compliance with Fundamental Standards of Care; and (iii) learning and quality improvement. Since the implementation of the Trust Patient Safety and Quality Strategy 2024 – 2027, which is aligned to the NHS Patient Safety Strategy, the Committee has sought to ensure its triangulation of data, information and reports align to the strategies improvement areas of insight, involvement and improvement. The Board is fully appraised of compliance with current staff training and appraisals regarding patient safety and quality foster a culture of continuous improvement. Processes are in place to ensure accurate training needs analyses enable the delivery of appropriate training to all staff groups.
8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	<i>Does the board triangulate qualitative and quantitative information, including comparative benchmarks, to assure itself that it has a comprehensive picture of patient experience?</i> • <i>Does the board consider variation in experience for those with protected characteristics and patterns of actual and expected access from the trust's communities?</i> • <i>Is the board satisfied that it receives timely information on quality that is focused on the right matters?</i> • <i>Does the board consider volume and patterns of patient feedback, such as the Friends and Family Test or other real time measures, and explore whether staff effectively respond to this?</i> • <i>How does the organisation involve service users in quality assessment and improvement and how is this reflected in governance?</i>

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	• <i>Is the board satisfied it is equipped with the right skills and experience to oversee all elements of quality and address any concerns?</i> • <i>Is the board satisfied that the trust has a clear system to both receive complaints from patients and escalate serious and/or re-occurring complaints to the relevant executive decisionmakers?</i> • <i>Where there are follow-up actions resulting from CQC inspections, is the trust addressing these and can the board articulate how care will improve as a result?</i> Patient experience oversight and triangulation: Patient experience is monitored through a combination of qualitative and quantitative intelligence including patient stories, staff stories, complaints, PALS, Friends and Family Test (FFT) feedback, national patient surveys, patient safety information, executive walk-round feedback and comparative national benchmarking. Patient and staff stories are embedded within Board governance arrangements. Patient stories are presented at four of six Trust Board meetings each year, with staff stories presented at the remaining meetings. QAC and F&P Committee meetings also commence with a patient story, ensuring Board and Committee discussions remain focused on what matters most to patients, carers and communities. Results from the National Inpatient, Maternity, Urgent and Emergency Care, Adult Inpatient and Children and Young People's Surveys provide comparative national benchmarking and are reported through governance structures, including PEEG. FFT feedback is collated monthly and reported through Trust-wide dashboards. Trends, response rates and areas of concern are monitored, with six-monthly assurance reports presented to PEEG and actions reported back by Clinical Service Units (CSUs). Direct engagement with patients and communities. Executive and Non-Executive Director leadership walk-rounds provide opportunities to engage directly with patients, carers, service users and frontline staff, allowing Board members to hear experiences first-hand and validate information received through formal reporting routes.
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	The Trust fulfils its statutory duty to involve patients and the public through the Patient Reference Group, which meets four to six times per year and provides feedback on strategic initiatives that informs Board decision-making. Similar arrangements operate within Children's Services. Trust-wide listening events commissioned by the Board provide additional qualitative insight into patient and public experience and help develop a comprehensive understanding of patient experience across services. Patient Partners are embedded within Clinical Service Units and governance forums, including attendance at PEEG meetings and clinical quality review visits, ensuring the patient voice is represented in improvement and patient safety work. Health equity, inclusion and protected characteristics: Health equity is embedded throughout quality governance, patient experience and improvement work and is not treated as a standalone programme. All Trust Board reports include dedicated sections on Equality Analysis and Improving Health Equity, ensuring potential impacts on different communities and groups at risk of health inequalities are routinely considered. Equality and Health Inequality Impact Assessments are used to inform service design, quality improvement and patient involvement activity, including consideration of protected characteristics and CORE20PLUS5 priorities. Public Health colleagues, including Public Health Consultants, contribute to major programmes of work to ensure a health inequalities perspective is considered across cross-cutting themes and quality improvement initiatives. Equality, Diversity and Inclusion (EDI) considerations run throughout all workstreams and governance arrangements. Complaints, feedback and learning: Twice-yearly Board reports on Complaints and PALS include trend analysis, thematic review and progress against improvement plans. Annual reports are received through QAC and
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	PEEG, supported by six-monthly updates against the 2024-2026 Complaints and PALS Action Plans. Monthly performance and risk metrics relating to complaints and patient experience are reviewed through Corporate Operations governance arrangements. Complaints training is being strengthened to support personalised, restorative and inclusive responses, ensuring services are responsive to people from the global majority and those who may experience barriers accessing healthcare. The Complaints Policy has been reviewed and updated, with revised complaint response processes supporting personalised responses, openness, restorative approaches and compliance with the Duty of Candour. Internal Audit completed a review of complaints management in June 2025, providing positive assurance that complaints procedures and policies were being appropriately followed. Escalation, governance and Board assurance: Weekly Quality Meetings attended by the Chief Nurse and Chief Medical Officer provide early identification and escalation of quality, safety, complaints and patient experience concerns. Quality, safety and patient experience issues can be escalated through all Board Committees, ensuring significant risks, trends and concerns receive appropriate Executive and Board oversight. The Quality Assurance Committee provides detailed scrutiny on behalf of the Board regarding patient safety, clinical effectiveness, patient experience and the effectiveness of the Trust's quality governance framework. External reviews commissioned by Executive teams are reported through governance structures and findings are escalated to the Board where appropriate. Continuous improvement and CQC actions
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	The Trust is implementing actions to address regulatory breaches identified through the Trust-wide CQC Well-Led inspection, including improving the timeliness and effectiveness of complaints management and strengthening mandatory training compliance. Work is underway to strengthen Trust-wide listening and learning processes in response to findings from the CQC Maternity and Neonatal inspections. The Trust recognises further opportunities to strengthen the reporting of health inequalities, protected characteristics and variation in patient experience to provide enhanced Board assurance and oversight.
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III. People and culture

Capability statements	Proposed domain rating
	Amber-Green
	<i>Trust to insert commentary here. To include the board's views and evidence supporting its proposed rating, taking account of</i> <i>o the domain's capability statements</i> <i>o governance arrangements to oversee this area and their effectiveness to date</i> <i>o any areas where the board has identified concerns and/or development needs and actions planned or in place to address these.</i> <i>any relevant developments since the 2025 exercise.</i>
9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and	<i>Does the board look at all relevant staff (including trainee) information to monitor the experience of working at the trust and identify areas for improvement?</i> <i>• Does the board engage in staff forums to consider how quality of care can be improved and any cultural/staff experience issues addressed?</i> <i>• Are staff surveys and other information (such as the NHS Staff Standards) routinely reported to the board and issues discussed? Are agreed actions followed up?</i>

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improve staff experience	• <i>Does the board monitor the diversity of staff across the organisation to ensure it is representative of its local population?</i> Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience. The Board receives regular assurance on workforce experience through NHS Staff Survey results, Pulse Survey findings, Freedom to Speak Up reporting, Employment Relations reporting, Inclusion and Belonging reporting, workforce performance metrics and the Performance Improvement Framework. This information is used to identify workforce hotspots, understand variation in staff experience and monitor delivery of improvement actions. Workforce experience and culture are informed through staff side partnership arrangements, formal colleague networks, local colleague engagement activity and LTHT 'Live'. Feedback from these routes has informed actions relating to refreshed LTHT Values and Behaviours, speaking-up arrangements, responses to poor behaviour and targeted workforce improvement activity. Staff survey results are routinely reported through Board and the People Committee governance arrangements. Delivery of agreed actions is monitored through the Trust's High Impact Action Plan and CSU action plans. As at July 2026, 80% of CSUs had a staff survey action plan, 69% of High Impact Action Plan actions were complete and a further 25% were in progress, demonstrating active follow-up of issues identified through colleague feedback. The Board and People Committee also receive assurance through Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Equality Delivery System (EDS) and pay-gap reporting, supported by oversight of the Inclusion and Belonging Improvement Plan. These arrangements provide Board level oversight of workforce experience, engagement, equality, diversity and inclusion, enabling workforce disparities and inclusion priorities to be identified and monitored through established governance arrangements.
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10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels	<i>Does the trust regularly review skills at all levels across the organisation?</i> <i>• Does the board see and, if necessary, act on levels of compliance with mandatory training or where issues have been</i> <i>• Have all staff completed relevant training (as relevant to their roles e.g. safety, clinical, cybersecurity/information governance, counter fraud, safeguarding etc) and does the board see a log of avoidable staff-initiated events?</i> Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels. The Board receives regular assurance on workforce capability through workforce planning, workforce development and organisational development arrangements reviewed through Board and People Committee governance processes. Board assurance includes apprenticeship programmes, graduate development routes, leadership development activity, workforce planning initiatives and career development arrangements that support workforce capability and workforce sustainability. The Board routinely reviews workforce performance through the Integrated Quality Performance Report. In June 2026, Mandatory Training Compliance was 90.88% against a target of 85% and Local Induction Compliance was 91.40% against a target of 85%, providing assurance that mandatory training compliance is monitored, benchmarked and subject to governance oversight. Mandatory training reporting provides organisational assurance that compliance is monitored and maintained above target. Workforce development, education and career development initiatives provide additional assurance regarding workforce capability and future workforce sustainability. Further assurance development is required in relation to role specific training compliance, organisation wide skills assurance and reporting of avoidable colleague initiated events and associated learning.
11. Staff can express concerns in an open	<i>Does the board engage effectively with information received via Freedom To Speak Up (FTSU) channels, using it to improve quality of care and staff experience?</i> <i>• Are all complaints treated as serious and do complex complaints receive senior oversight and attention, including executive level intervention when required?</i>

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and constructive environment	• <i>Is there a clear and streamlined FTSU process for staff and are FTSU concerns visibly addressed, providing assurance to any others with similar concerns?</i> • <i>Is there a safe reporting culture throughout the organisation? How does the board know?</i> • <i>Is the trust an outlier on staff surveys across peers?</i> Staff can express concerns in an open and constructive environment. During the year we have introduced a weekly live stream meeting available to all staff called LTHT Live. This provides weekly access to Executives with an update and question and answers session. In addition, the CEO has a direct communication line. A new Weekly Executive Meeting (WEB) has been established with the representation of the senior leadership of the Trust in addition to the existing monthly Senior Leaders Meeting. Freedom to Speak Up arrangements are supported by a Guardian with access to the Chair, Chief Executive and Board members. The Trust has an established policy statement that provides colleagues with a formal route to raise concerns. At Board level, there is a lead Non-Executive Director and Executive Director lead for Freedom to Speak Up arrangements. The Board receives regular assurance through Freedom to Speak Up (FTSU) reporting, Inclusion and Belonging reporting, Employment Relations reporting, Staff Survey intelligence and CSU Speaking Up maturity assessments. Oversight is supported by an established FTSU Steering Group, Champion network, FTSU portal, detriment processes and a CSU Speaking Up maturity framework, providing multiple routes for concerns to be raised, reviewed and acted upon. Senior oversight of complex workforce concerns is supported through weekly HR process reviews, complex case reviews, lessons learned exercises and escalation arrangements within employee relations processes. These mechanisms support organisational learning and escalation where concerns are identified. The Board triangulates FTSU intelligence with Staff Survey results, Inclusion and Belonging reporting, Employment Relations reporting and workforce performance metrics to monitor organisational culture and psychological safety. FTSU themes and workforce culture
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	intelligence are used to inform improvement activity relating to staff experience, behaviours and local workforce issues, supporting the Trust's wider quality improvement objectives. Board reporting identified that LTHT's Staff Survey People Promise results were broadly aligned with the national position rather than outperforming national averages as previously. LTHT is therefore not currently reported as a significant positive or negative outlier when compared with national peers. The evidence demonstrates established reporting mechanisms, governance arrangements and improvement processes. Ongoing assurance will focus on demonstrating the impact of FTSU activity through evidence of concern resolution, action completion, organisational learning, colleague confidence to speak up and improvements to colleague experience and quality of care.
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IV. Access and delivery of services

Capability statements	Proposed domain rating
	Amber-Green
	<i>Trust to insert commentary here. To include the board's views and evidence supporting its proposed rating, taking account of</i> <i>o the domain's capability statements</i> <i>o governance arrangements to oversee this area and their effectiveness to date</i> <i>o any areas where the board has identified concerns and/or development needs and actions planned or in place to address these.</i> <i>any relevant developments since the 2025 exercise.</i>
12.Plans are in place to improve performance against the relevant access and waiting times standards	<i>Is the trust meeting those national standards in the NHS planning guidance that are relevant to it? If not, is the trust taking all possible steps towards meeting them, involving system partners as necessary?</i> <i>Where waiting time standards are not being met or will not be met in the financial year, is the board aware of the factors behind this?</i> <i>Is there a plan to deliver improvement?</i>

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	The Board maintains oversight of performance against national access standards through the Finance and Performance Committee, Integrated Accountability Meetings (IAMs) and routine executive review. Performance improvement remains a key organisational priority and is reflected within the Trust's multi-year planning framework, with trajectories agreed through the annual planning process. The Trust is not forecast to achieve all constitutional standards in 2026/27, particularly RTT and 62-day cancer performance. The Board has a clear understanding of the factors affecting delivery, including demand growth, workforce constraints, urgent care pressures and capacity limitations, and these are regularly reviewed through established governance arrangements. Improvement plans are in place across a number of key pathways, including elective recovery, cancer, diagnostics and urgent care. Progress and delivery risks are monitored through the Integrated Accountability Framework, which provides structured oversight, challenge and support where performance is off trajectory. The Board recognises the areas where further improvement is required and continues to monitor performance, delivery risks and the effectiveness of actions being taken to improve access and reduce waiting times for patients.
13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients	• <i>Can the board track and minimise any unwarranted variations in access to and delivery of services across the trust's patients/population and plans to address any variation are in place?</i> We have joint Public Health posts in place. The standard template for all Board and Committee reports seeks consideration to health inequalities. Reporting on inequalities is available to teams via a PLICS report that includes measures of deprivation and other indicators. To improve Board reporting, the Trust has developed an IQPR report which tracks equity across our services. Development of the governance and reporting structures will provide oversight and improved reporting to Board.

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	There is growing organisational understanding of Trust services having oversight of variation across constitutional standards quarterly and this information will be available to CSUs to support the patient pathway. Work to understand equity whilst waiting continues with the development of a risk stratification tool which will be applied to the waiting list which will provide teams to support patients to access care earlier. In addition, DNA tracking is provided via the DNA measures report in place of the DNA analyser.
14. Appropriate population health targets have been agreed with the ICB	<i>Is there a clear link between specific population health measures and the internal operations of the trust?</i> • <i>Do teams across the trust understand how their work is improving the wider health and wellbeing of people across the system?</i> LTHT has aligned its neighbourhood health and transformation priorities to the Leeds system population health agenda, having active workstreams to develop collaborative care pathways for patients with frailty, multiple long-term conditions, and those recovering from strokes, as well as a specific focus on Paediatric pathways. The overarching 2026 –2029 objective for this work is to reduce health inequalities and improve outcomes for Leeds' citizens who experience the poorest health. The Trust recognises the direct relationship between population health measures and demand on hospital services, including variations associated with deprivation, ethnicity, language, inclusion health groups and the long-term impact of industrial and socioeconomic factors across our population. There is growing organisational understanding of how Trust services can contribute to improving population health recognised through the establishment of our internal Partnerships governance structure. This strategic programme of work is anticipated to disseminate system priorities and agree delivery plans against these. As a result, clinical and operational teams are increasingly using population health intelligence to inform service design, outreach activity and pathways of care, such as the proactive care curiosity tool supported by the ICB. We have commenced a CSU-led programme of service review and transformation to meet the delivery requirements of our strategic objectives, which is being led by our partnerships team.

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V. Productivity and value for money

Capability statements	Proposed domain rating
	Amber-Green
	<i>Trust to insert commentary here. To include the board's views and evidence supporting its proposed rating, taking account of</i> <i>o the domain's capability statements</i> <i>o governance arrangements to oversee this area and their effectiveness to date</i> <i>o any areas where the board has identified concerns and/or development needs and actions planned or in place to address these.</i> <i>any relevant developments since the 2025 exercise.</i>
15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	• <i>Does the board use all available and relevant benchmarking data, as updated from time to time by NHS England, to:</i> <i>o review its performance against peers</i> <i>o identify and understand any unwarranted variations</i> <i>o put programmes in place to reduce unwarranted negative variation?</i> • <i>Is there a track record of delivery of planned productivity improvements?</i> The Board receives regular productivity and efficiency reporting through the Finance & Performance Committee, including benchmarking against peer organisations and national standards. This is used to identify unwarranted variation and target improvement actions through dedicated productivity programmes and operational governance arrangements. Comprehensive improvement plans are in place across outpatient productivity, theatre productivity and length of stay. These include initiatives to increase clinic utilisation, reduce unnecessary follow ups, improve theatre scheduling and utilisation, reduce cancellations, and support earlier discharge and improved patient flow. There is a clear track record of delivery. In 2026/27 the Trust delivered an additional 1,663 first outpatient appointments compared to the previous year, improved clinic utilisation, reduced

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	DNAs, increased theatre productivity and utilisation, and reduced overall length of stay by 0.7 days. NHS England has also recognised Leeds as an exemplar system for admission avoidance. Final published data for 2025/26 was received in July 2026 and will be the subject of a paper and discussion in Finance & Performance Committee in September 2026. This data shows an overall static productivity compared to 2024/25, resulting from growth in activity being offset by cost growth. However, compared to peers within the Region the Trust has accelerated activity growth more quickly than others, although this has also resulted in cost growth hence the flat productivity change. This paper also includes operational details on the delivery of productivity improvements in Theatres, on Length of Stay and in Outpatients to improve our utilisation of our capacity which will ultimately impact on the level of activity and thus the implied productivity. The Trust continues to seek to reduce our costs through our Waste Reduction programme, which at £95m is higher in 2026/27 than 2025/26. CSUs are expected to review the relevant Model Hospital and other benchmarking data for their services, although a central approach to this is being worked up to support these reviews.
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VI. Financial performance and oversight

Capability statements	Proposed domain rating
	Amber-Green
	<i>Trust to insert commentary here. To include the board's views and evidence supporting its proposed rating, taking account of</i> <i>o the domain's capability statements</i> <i>o governance arrangements to oversee this area and their effectiveness to date</i> <i>o any areas where the board has identified concerns and/or development needs and actions planned or in place to address these.</i> <i>any relevant developments since the 2025 exercise.</i>
16. The trust has a robust financial governance	<i>• Does the trust have a work programme of sufficient breadth and depth for internal audit in relation to financial systems and processes, and to ensure the reliability of performance data?</i>

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framework and appropriate contract management arrangements	• <i>Have there been any contract disputes over the past 12 months and, if so, have these been addressed?</i> • <i>[Potentially more appropriate for acute trusts] Are the trust's staffing and financial systems aligned and show a consistent story regarding operational costs and activity carried out?</i> • <i>Has the trust had to rely on more agency/bank staff than planned?</i> The Trust has an agreed Internal Audit plan approved and overseen by the Audit Committee. Financial systems and processes reviews are assessed by both internal audit and external audit, which includes a Value for Money assessment completed as part of the external audit. Action plans are developed to address any recommendations. The Trust annual Internal audit plan is developed through the auditor's approach to the Risk Universe, discussions with Executives and overall review by Audit Committee and Trust Board. Any areas for consideration which were not addressed in previous years due to capacity are also considered for prioritisation in future years. Data quality audits are included in the plan, although there is a recognised need to broaden the scope of this element of the plan. There have been no commissioner contract disputes over the last 12 months. Where there have been disputes with suppliers these have been managed per the relevant contract and resolved. The Trust's financial and workforce systems are aligned, with a better planning process for 26/27 than in previous years. Information from the activity and income systems are shared across the Trust on a monthly basis to ensure that operational teams are aware of the scale of activity being undertaken. The Trust is improving its triangulation of job planning processes with activity delivery. As at August 2026 reporting, the Trust has spent more on Bank & Agency staffing than had been planned. The Trust has utilised agency and bank staffing above planned levels during 2026/27, with August 2026 performance of 103 FTE agency staffing against a ceiling of 132 FTE and 715 FTE bank staffing against a ceiling of 729 FTE.
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	The Board maintains regular oversight of temporary staffing through the Integrated Quality Performance Report, People Committee and Turnaround Executive. Temporary staffing utilisation, expenditure and workforce plan delivery are routinely reviewed, supported by joint workforce action planning between HR, Finance and Clinical Service Units. A programme of improvement is in place to reduce reliance on temporary staffing whilst maintaining safe staffing levels. This includes strengthened vacancy controls, a Trust wide absence improvement programme, workforce establishment reviews, the Medical and Dental Optimisation Programme and a phased programme to centralise all Trust staff banks within the People Function to strengthen governance, improve deployment and reduce variation in temporary workforce management. Whilst temporary staffing usage remains above plan, robust governance arrangements are in place and delivery of improvement actions is subject to routine Board oversight. The Trust also continues to perform comparatively well against peers, with bank expenditure in the lowest national quartile and agency expenditure in the second lowest quartile as a proportion of total pay costs.
17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes	• <i>Does the board stress-test the impact of financial efficiency plans on resources available to underpin quality of care?</i> • <i>Are there sufficient safeguards in place to monitor the impact of financial efficiency plans on, for example, quality of care, access and staff wellbeing?</i> • <i>Does the board track performance against planned surplus/deficit and where performance is lagging it understands the underlying drivers?</i> During the end 2025, the Trust invited PwC to review our grip and control on our financial performance. With a further peer review planned during autumn 2026. An initial quality impact assessment is completed on all Waste Reduction Programmes, with a full QIA required for schemes that have an impact on any of the five CQC quality domains. The QIA is signed off by a senior medical or nursing colleague within the relevant CSU. The PMO keeps a log of all QIAs undertaken and an audit is performed twice per year, led by a Deputy Chief Nurse and a Medical Director (Ops) to provide assurance on the process and grading.

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	This process has oversight by the Chief Nurse. The Trust has recently appointed a new Director of Quality within the Chief Nurse's team and the QIA process will be the subject of a review to ensure it continues to meet the needs of the Trust and our patients. Regarding tracking performance against planned surplus/deficit and understanding the underlying drivers where performance is off track, the financial performance of the Trust is assessed at various meetings and through different lenses. It is reviewed as part of the WD1 reporting meetings, which is followed by a briefing from the Director of Finance to key Board members, the Executive Team and ICB and regional colleagues. The WD1 meetings review the monthly financial position at Trust level across NHSE category level against the best case of the fundamental review, the previous month, and run-rates for the last 12 months. The monthly position is also reviewed at individual CSU level by NHSE category against the forecast. The consolidated results are reported to the Turnaround Executive meeting, Finance & Performance Committee and Board, with mitigating actions discussed and agreed as necessary. The Finance & Performance Committee report includes appendices with detailed income, expenditure and variance information, including CSU performance. The Trust has implemented a new Integrated Accountability Framework, within which Finance is a key pillar. Meetings are held on a monthly basis for CSUs covering all aspects of quality, performance and finance, with feedback and escalation to Executives as necessary. A Fundamental Review of the financial position and forecast year end position is considered by the Board on a quarterly basis, which includes drives for variances to the plan, risk ranges for the forecast outturn (best, likely and worst case) which are agreed and reported to WY ICB and NHSE through the PFR. This process also identifies financial mitigations required, which are monitored through Finance & Performance Committee.
18. The trust engages with its system partners on the optimal use of NHS	• <i>Is the board contributing to system-wide discussions on allocation of resources?</i> • <i>Does the trust's financial plan align with those of its partner organisations and the joint forward plan for the system?</i> • <i>Would system partners agree the trust is doing all it can to balance its local/organisational priorities with system priorities for the overall benefit of the wider population and the local NHS?</i>

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resources and supports the overall system in delivering its planned financial outturn	Yes, the CEO and Executive Directors contribute to and in some cases lead their professional working groups in both the Leeds Place and across the ICB, and more widely in some cases. Any of these arenas could impact on resource allocations, although this is clearly the focus for the CFO groups. Whilst the NOF and performance regime for 2026/27 and beyond encourages more individual Trust working, LTHT recognises the dependencies across the system levels and thus works to support and influence for the benefit of our patients and population. The Trust financial plans align with the ICB and Specialised Commissioning in particular, with transparency where approaches differ for example in relation to the anticipated level of UEC demand in the contract with the ICB. The Trust tends to be seen as the "provider of last resort" and so offers mutual aid across a broad range of services, both clinical and non-clinical. Additional work is currently being undertaken internally to ensure that LTHT does not suffer financially from this approach which is for the benefit of patients. The Trust understands its scale and its role in supporting the system to deliver the plan and puts appropriate challenge into the system and system partners on allocation of resources and setting/delivery of plans. In 2026/27 the Trust was the only Acute Provider to set a balanced plan without access to DSF and indeed supported a neighbouring Trust to set a compliant plan through capital support. Whilst delivery of this plan is extremely stretching, the Trust remains committed to delivering and is in discussion with many system colleagues to support that delivery both operationally and financially.
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Signed on behalf of the Board of Directors

Chair: _____

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Signature: _____ Date: _____

Signed on behalf of the Board of Directors

Chief Executive: _____

Signature: _____ Date: _____

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Appendix B: Using a RAG-rating approach to derive the rating – guidance for providers

The table below sets out the approach providers should take to assess themselves across the six domains. Providers should set out, in their return template, a commentary covering the rationale behind each domain's rating, the evidence referenced in their return and improvements made since the last submission in 2025.

Note that regions will take their own views of capability across the board and will not have the level of detail that providers have – while the evidence here supports the rating it should not be considered automatic or algorithmic in every instance, rather it sets a general benchmark around different levels of capability taking account of the statements.

Leadership and strategy	
<i>Overarching expectation: the trust's board is working well as a unit to oversee the provider and has effective relationships with system partners and stakeholders. The board demonstrates the skills to oversee the delivery of safe, sustainable services, plans effectively and receives the right information to oversee performance and plan delivery as well as monitoring internal and external risk factors.</i>	
Capability statements	Indicative evidence
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners	<i>The following are indicative aspects of each level of capability but should not be seen as exhaustive</i> Green • Strategy is coherent, measurable, aligned with provider's objectives and system priorities. • If in breach: all undertakings being delivered; regulatory confidence restored and trust on track to compliance • Board has requisite range of skills; development plans active; succession plans in place; no vacancies > 3 months; no interims > 6 months. • Strong collaboration with local partners; joint planning; shared outcomes delivered.
2. If in breach: The trust is meeting and will continue to meet any requirements placed on it by ongoing	

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enforcement action from NHSE 3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan. 4. The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served 5. The trust has an effective cyber security strategy and uses digital technology to support improvement	- Regular board reporting on cybersecurity matters, cyber built into Board Assurance Frameworks; digital strategy embedded. Amber-Green - Strategy mostly aligned with the provider's objectives but lacks depth or consistent delivery. If in breach: On track to compliance with credible plans; minor slippage only. - Skills mostly adequate; some gaps recognised and being addressed. - Good relationships with system partners but inconsistent joint delivery. - Cybersecurity is mostly well-managed, but some areas lack maturity or consistency. - Concerns from independent board governance reviews or CQC well-led findings in past 6 months that are in hand Amber-Red - Strategy unclear, outdated, or inconsistently applied. If in breach: Behind trajectory on return to compliance; repeated slippage; weak assurance. - Significant capability gaps at board level; weak development; over-reliance on individuals. - CQC well-led 'requires improvement' - Patchy collaboration; strained relationships; siloed behaviour. - Outdated systems; weak cyber assurance; limited digital use. Red - No credible strategy; board direction fragmented. If in breach: persistent non-compliance; enforcement actions escalating; board grip absent. - Board lacks a number of core skills; no development; unsafe capability. - CQC well-led 'Inadequate' - Board isolated; system relationships dysfunctional.
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	No credible cyber strategy; repeated material incidents.
Quality oversight	
<i>Overarching expectation: the trust's board is set up for effective oversight of the quality of care it provides, monitoring safety, patient experience and using insights from third parties as appropriate. This is evidenced by robust information going to boards, a track record of high-quality care and an open, curious and enquiring approach on quality issues from executives and non-executives alike.</i>	
Capability statements	Indicative evidence
6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt). 7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving	<i>The following are indicative aspects of each level of capability but should not be seen as exhaustive</i> Green - Guidance is used effectively to drive improvements in quality of care. - Established quality governance arrangements in place; confidence in early warning systems; systems of triangulation identify issues before they become critical - Patient experience embedded in discussions around quality; concerns reach board quickly. Amber-Green - Mostly compliant with guidance and it is generally used to improve care; - Some gaps in the effectiveness of quality oversight e.g. escalation approaches or learning from close calls. Triangulation is used in places. - Systems in place to monitor patient experience but aren't always used consistently to escalate. Amber-Red - Guidance applied inconsistently

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the quality of healthcare provided to its patients 8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	- Board tends to be reactive to quality issues and actions to address issues are not consistently effective. - Limited insight into patient experience; slow escalation; weak or non-existent triangulation. Red - No regard for guidance; blind spots in safety and complaints. - Quality governance failing; evidence from third parties that serious risks are unmanaged. - No reliable patient experience monitoring.
People and culture	
<i>Overarching expectation: the board has an accurate, evidence-based view of the trust's culture and improves the organisation as a place to work. This is evidenced by: staff input being collected, valued and used in board decisions; staff being able to speak up where they have concerns; and staff have access to training and other opportunities to carry out their roles as well as possible.</i>	
Capability statements	Indicative evidence
9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience	<i>The following are indicative aspects of each level of capability but should not be seen as exhaustive</i> Green: Evidence that staff feedback drives improvement; strong culture indicated by high scores in staff survey, and Staff Standards measures.

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10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels 11. Staff can express concerns in an open and constructive environment	• Workforce plans credible; training embedded across the organisation; safe staffing levels in place and reviewed regularly. • Strong speaking-up culture. Amber-Green • Feedback collected but not consistently acted on. • Staff skills are mostly adequate but there may be gaps/insufficient depth in key areas. • Generally open culture; some pockets of concern in specific areas of the staff survey. Amber-Red • Feedback intermittently collected or when reported is out of date; limited impact on care or management actions. • Persistent gaps in skill levels in key areas; weak/ineffective training; • Evidence that staff groups indicate fear of speaking up; insufficient insights at board level. • Persistently lowest quartile in NHS staff survey Red • Persistent lowest 10% in NHS staff survey • Staff feedback ignored; culture deteriorating. • Unsafe staffing; no development in staff. • Evidence of a toxic culture; concerns suppressed.
Access and delivery of services	
<i>Overarching expectation: the board understands the drivers of delivery of core national access standards and uses this to optimise the trust's performance. The Board has extracted the maximum reasonable performance</i>	

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<i>from the resources, workforce and authority available to it, and does all it can to mitigate the impact of external factors.</i>	
Capability statements	Indicative evidence
12. Plans are in place to improve performance against the relevant access and waiting times standards 13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients 14. Appropriate population health targets have been agreed with the ICB	<i>The following are indicative aspects of each level of capability but should not be seen as exhaustive</i> Green • Generally delivering on trajectory vs plans. • Clear knowledge/awareness of access and care levels across local geography and demographics in order to identify and address inequalities; can demonstrate measurable improvement. • Targets aligned with system partners; joint delivery plans in place where necessary (e.g. with provider collaborative partners). Amber-Green • Plans credible but inconsistent delivery. • Inequalities in access/care identified; actions underway but not yet fully addressing issues. • Targets aligned with system partners; joint delivery plans in place as necessary (e.g. provider collaborative) but not fully implemented or delivering desired outcomes. Amber-Red • Under-delivery or deterioration in performance but board cannot demonstrate a credible plan to address it; • Underperforming local peers with no evidence of mitigating factors • Known variation in the quality of and access to services but little or no evidence of addressing them.

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	- Limited engagement across system partners to deliver access standards. Red - Behind trajectory on multiple access measures with no credible plan to address. - No insights into inequalities by demographic. - No engagement with rest of system
Productivity and value for money	
<i>Overarching expectation: the board understands how workforce, estate, asset utilisation, activity and provision of care interact at the trust to drive productivity. This is evidenced by a track record of improvements in productivity that are delivered within the wider context of quality of care and patient experience.</i>	
Capability statement	Indicative evidence
15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	<i>The following are indicative aspects of each level of capability but should not be seen as exhaustive</i> Green - Board understands drivers of productivity and can use them to improve use of resources; provider in top 25% vs peers - Productivity improvements are discussed in the context of quality of care, patient experience and staff wellbeing Amber-green - Board has good insights and credible plans but has not fully extracted efficiencies - Performance vs peers flat/declining <12 months Amber-red

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	• Board is aware of poor productivity and associated symptoms but has been unable to address them • Declining productivity vs peers >12 months Red • Board cannot explain the drivers behind poor productivity, quantify the upside or deliver improvement • Persistent bottom quartile in benchmarks vs peers
Financial performance and oversight	
<i>Overarching expectation: the trust's board demonstrates a good financial understanding and literacy, leads the forecasting and risk management process and has a track record of overseeing the delivery of financial plans and efficiencies and offers strong challenge and insight. There is effective triangulation of workforce, activity and finance in both forward planning and in-year oversight.</i>	
Capability statements	Indicative evidence
16. The trust has a robust financial governance framework and appropriate contract management arrangements 17. Financial risk is managed effectively, and financial considerations (for	<i>The following are indicative aspects of each level of capability but should not be seen as exhaustive:</i> Green • Track record of delivering financial plans 'without surprises'; cost improvement programmes are generally delivered • Executives and Non-Executives understand the drivers of the trust's financial position and the board links finance discussions to quality of care, operational demand and workforce

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example, efficiency programmes) do not adversely affect patient care and outcomes 18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	- Financial risks are reviewed regularly at board level; - Strong links between trust and system planning functions; supports system outturn. Impact of external factors outside the board's control are minimised Amber-Green - Occasionally off-plan, but generally returns to plan over time and by year-end - Cost improvement programs are delivered, but below forecast - Minimal reliance on one-off mitigations to hit plans Amber-Red - Understands headline numbers but struggles to explain or control how underlying drivers affect financial performance. - Unplanned reliance on agency/bank staff - Has recurring forecasting inaccuracies and missing planned performance – may rely on one-off mitigations to ameliorate under-performance - Shows weak linkage between workforce, activity levels, quality of care and financial performance. Red - Persistent plan under-delivery, with frequent unexpected in-year deterioration in performance vs plan, and little confidence in forecasts. Consistently misses savings targets. - Unplanned reliance on agency/bank staff - Board cannot clearly articulate factors behind the organisation's financial position; weak board-level financial governance, poor scrutiny of financial information and the factors behind performance
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	• Track record of reliance on external support, regulatory intervention or year-end bailouts; little connection with system partners on financial planning and investment
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