Agenda Item 8.2 Appendix A

Leeds Teaching Hospitals NHS Trust Improvement Plan				Date initiated	01/10/2025
				Date of Update	10/11/2026
Accountability		**Responsibility**			
Lead	**Oversight/governance structure**	**Lead**	**Oversight Group**		
Trust Board Trust Chair	Trust Board	Company Secretary Director of Quality Deputy Chief Nurses Deputy Directors of HR Head of Quality Governance FTSU Guardian Patient Safety Incident Response Manager Patient Safety and Quality Manager(s) Deputy Chief Medical Officer (Governance) Trust Risk Manager Associate Director of Communications	Trust Board (Public, Workshop or Timeout) Quality Assurance Committee (QAC) Workforce Committee Risk Management Committee (RMC) Patient Experience and Engagement Group (PEEG) Quality and Safety Assurance Group (QSAG) Learning, Training and Education Group (LETG)		
Chief Executive Officer Chief Medical Officer Chief Nurse (temporary) Interim Chief Operating Officer Interim Chief People Officer Director of Finance Director of Estates and Facilities Chief Digital and Information Officer	Executive Management Team				

Aim	Objective Ref	Objective	Expected outcome	Assurance Mechanism	Executive Lead	Oversight Committee
The Trust will deliver actions to achieve compliance with CQC Regulation 16 receiving and acting on complaints in relation to timely response and improve the effectiveness of responses.	1	Improve the Trust responsiveness to complaints.	Timeliness of complaint response achieving the locally set target of 80% Increase in local resolution of PALS and complaints.	Outcome report of root and branch review. Patient Experience Improvement Plan to address findings of review. Delivery of the action plan report through to QAC regularly and flow to Board	Chief Nurse	QAC
	2	Improve the effectiveness of complaint responses.	Self-assessed complaints maturity level Reduction on the number of complaints referred to PHSO	Completed PHSO maturity assessment presented at PEEG and reported through to QAC and flow to Board.	Chief Nurse	QAC
The Trust will deliver actions to achieve compliance with CQC Regulation 17 good governance and provider licence conditions NHS2(2), (4), (5 B,C,E,F) and (6).	3	Ensure the Trust have effective governance systems and processes to assess, monitor and improve the quality and safety of the services.	A reviewed and strengthened governance process which has effective management of the quality and safety of services.	Updated Executive Director portfolios with clear lines of accountability and alignment of operational management oversight. CSU governance systems and process effectiveness and barriers outcome report and supporting actions.	Chief Medical Officer Chief Nurse Chief Operating Officer	QAC
	4	Complete a review of the Trust corporate governance, from CSU Tri team to Board, systems to meet the requirements of regulation 17 and provider licence conditions NHS2(2), (4), (5 B,C,E,F) and (6).	An effective governance system which creates value and achieves Trust goals by establishing clear structures, roles, and processes for decision-making, accountability, risk management, and reporting.	Completed Provider Capability Assessment and rating from NHSE. 2026/27 corporate calendar and revised Committee ToRs Outcome report of review of Trust governance reporting structure.	Chief Executive and EMT	Trust Board
	5	Ensure the Trust have effective systems and processes to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.	A reviewed and strengthened risk management processes, escalation and oversight.	Overview at Risk Management Committee of workshop held with senior leaders. Refreshed Risk Register and Corporate Risk Register seen through regular presentation at RMC.	Chief Medical Officer	RMC
	6	Complete a review of the CSU governance systems to meet the requirements of regulation 17 and provider licence conditions NHS2(2), (4), (5 B,C,E,F) and (6).	An effective governance system which creates value and achieves Trust goals by establishing clear structures, roles, and processes for decision-making, accountability, risk management, and reporting.	Updated CSU QAG and CSU Speciality Forum terms of references. Outcome report of Group membership and methods of sharing feedback from groups presented at Quality and Safety Assurance Group	Chief Medical Officer Chief Nurse Chief Operating Officer	QAC
	7	Ensure the Trust has consistent and effective systems to ensure incidents are consistently reported, investigated appropriately and with lessons shared within and across services to prevent recurrence.	Consistent number of incidents reported across the Trust A revised Patient Safety incident Response Plan and supporting Learning Response toolkit that is aligned to national guidance.	Outcome report of Group membership and methods of sharing feedback from groups presented at Quality and Safety Assurance Group.	Chief Medical Officer Chief Nurse	QAC
The Trust will deliver actions to achieve compliance with CQC Regulation 18 staffing in relation to mandatory training compliance.	8	Improve the Trust mandatory training compliance with all modules that fall below the Trust standard.	Enhanced oversight through Workforce Metrics included compliance by training requirements. Increased compliance with resuscitation training.	Workforce Metrics report to Workforce Committee and supporting actions and minutes. Outcome of review of delivery of resuscitation training.	Chief People Officer	Workforce Committee

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Aim	Objective Ref		Expected outcome	Assurance Mechanism	Executive Lead	Oversight Committee
The Trust will complete targeted actions to improve Trust wide compliance with CQC Quality Statement - shared direction and culture and NHS and provider licence conditions NHS2 (6a).	9	Assess and re-set the culture and direction of the organisation ensuring the focus remains on the providing the best care and treatment for patients.	Increase in staff satisfaction scores. Final report of Trust current psychological safety and supporting action plan.	Communication plan of reset culture and resources for leaders. Schedule of engagement with staff regarding re-set	Chief Medical Officer Chief Nurse Chief Operating Officer	Trust Board
The Trust will complete targeted actions to improve Trust wide compliance with CQC Quality Statement capable, compassionate and inclusive leaders	10	Ensure the Trust cultural re-set and the desire to be a listening and learning organisation is widely understood and role modelled by the Board, its committees and by enhancing the current methods of developing and empowering employees within leadership roles.	Defined culture and ambition of the organisation shared within regular communications. Positive improvement within workforce metrics and staff survey results.	Defined Executive Portfolios with clear lines of accountability and responsibility. Report to Learning, Education and Training Group on cultural reset and recommendations. Teams Connect Plan engagement plan. 2026/27 Executive Leadership visit programme. Report on Senior Leader GEMBA Thursdays	Chief People Officer Chief Medical Officer Chief Nurse Chief Operating Officer	Workforce Committee
The Trust will complete targeted actions to improve Trust wide compliance with CQC Quality Statement Freedom to Speak Up and Listen Up culture	11	Continue to build on the established FTSU system and culture ensuring staff are aware of the process and action to take if they feel they suffer detriment from speaking up.	Increase in FTSU contacts demonstrating a developing positive reporting culture. Lead Champions in each CSU and Corporate Directorate	Regular communications. FTSU 6 monthly report to Board. Lead Champion Toolkit. Improved score in the FTSU self-assessment for 2025/26	Chief People Officer	Workforce Committee
The Trust will complete targeted actions to improve Trust wide compliance with CQC Quality Statement workforce equality, diversity and inclusion.	12	Review the EDI profile of the Trust ensuring opportunities for development and progression are equitable and inclusive.	External EDI Report commissioned by Senior Independent Director (SID), Well-led and MSSP report into Maternity EDI Improved score within Staff Survey EDI metrics	Align the three external reports EDI action plan SID updates to region	Chief People Officer	Workforce Committee Trust Board

Status	
NS	
O	On track
Off	Off track
C	Complete
E&A	Evidenced and assured (closure report submitted)
R	At risk
CL	Closed

1. To achieve compliance with Regulation 16 review the current system of complaint management from receipt through to final response to improve the timeliness of complaints

Ref	Improvement action description	Improvement action owner	Target date for implementation	Date Implemented	Status	Method of assurance	Responsibility for monitoring/ oversight	Planned review date
1.1	Complete a root and branch review of the current patient experience service and function (PALS and Complaints) to understand current position and develop actions focused on tools and training to support early resolution.	Deputy Chief Nurse	31/12/2025	31/12/2025	E&A	Outcome report of root and branch review. Patient Experience Improvement Plan to address findings.	PEEG →QAC	31/03/2026
1.2	Develop a Patient Experience improvement plan to address findings of the review in 1.1	Deputy Chief Nurse	28/02/2026	01/04/2026	E&A	Actions tracked through PEEG Delivery of the action plan report through to QAC regularly	PEEG →QAC	31/03/2026
1.3	Delivery Patient Experience improvement plan (1.2)	Deputy Chief Nurse	01/04/2027		O			

2. To achieve compliance with Regulation 16 review the effectiveness of complaints response in relation to the number of complaints escalated to the Parliamentary and Health Service Ombudsman (PHSO).

Ref	Improvement action description	Improvement action owner	Target date for implementation	Date Implemented	Status	Method of assurance	Responsibility for monitoring/ oversight	Planned review date
2.1	Complete NHS Complaint Standards organisational assessment tool in order to understand the Trust maturity level and present the findings at PEEG.	Deputy Chief Nurse	31/12/2025	01/04/2026	E&A	Completed maturity assessment presented at PEEG	PEEG →QAC	28/02/2026
2.2	After completion of the assessment incorporate the key actions into the improvement plan in 1.2.	Deputy Chief Nurse	31/01/2026	01/04/2026	E&A	Actions arising from the completed maturity assessment incorporated in the Patient Experience Improvement Plan	PEEG →QAC	31/03/2026
2.3	Review the current capacity within the patient experience team to determine whether this is sufficient to deliver the identified short, medium and longer term goals.	Deputy Chief Nurse	31/12/2025	01/04/2026	E&A	Paper to NMALT to propose options. If agreed relevant documentation submitted to TERG.	NMALT TERG	28/02/2026

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3. To achieve compliance with Regulation 17 ensure the Trust have effective governance systems and processes to assess, monitor and improve the quality and safety of the services.								
Ref	**Improvement action description**	**Improvement action owner**	**Target date for implementation**	**Date Implemented**	**Status**	**Method of assurance**	**Responsibility for monitoring/ oversight**	**Planned review date**
3.1	Complete a review of the Executive Director portfolios including lines of accountability to each job descriptions to identify and address any gaps and ensure alignment of operational management oversight. This review will examine the reporting processes and structures to and from CSUs, to and from individual or collective Executives for accountability of operational management and review the assurances to Committees and the Board.	Director of Corporate Affairs	31/01/2026	02/03/2026	**E&A**	Minutes from Board Workshop	Board Workshop	30/04/2026
3.2	To host a dedicated session at senior leaders to engage corporate leaders and CSU tri teams to discuss the current governance systems and processes, escalation practices, and barriers within our existing structure,	Chief Operating Officer	31/01/2026 Amended 26.03.2026 – new target date 31/05/2026	30/06/2026	**E&A**	Senior Leaders slides Written outcome report and supporting actions.	EMT→Board	31/03/2026
3.3	Using insight from 3.1 and 3.2 review the current resource to deliver governance across LTHT (Corporate and CSU level).	Chief Operating Officer Director of Quality	31/03/2026 Amended on 05/05/2026 – new target date 31/06/2026	30/06/2026	**E&A**	Options appraisal of current governance support benchmarked against other Trusts and a review of required resource.	EMT→Board	30/06/2026
3.4	Review the current Trust governance reporting structure (CSU Tri Team to Group/Committee and Board) responsible for the assessment, monitoring and oversight of quality and safety of services.	Director of Quality	31/03/2026	01/06/2026	**C**	Outcome report to EMT and Board Workshop	EMT→Board	30/06/2026

4. Complete a review of the Trust corporate governance systems to meet the requirements of regulation 17 and provider licence conditions NHS2(2), (4), (5 B,C,E,F) and (6).								
Ref	**Improvement action description**	**Improvement action owner**	**Target date for implementation**	**Date Implemented**	**Status**	**Method of assurance**	**Responsibility for monitoring/ oversight**	**Planned review date**
4.1	Complete the Provider Capability Assessment and submit to NHS England. Regional oversight teams will review the trust's submitted self-assessment and consider the statements and evidence and agree the trust's capability rating and share this and the rationale for the rating. This will be reviewed at the mid-year review meeting by NHSE Chair, CEO and Exec Directors, who will define the requirement of further submissions required by the Trust. This will be re self-assessed during Q4 ahead of the external Well-led review in Q1	Director of Corporate Affairs	24/10/2025 30/06/2026	24/10/2026	**E&A**	Completed self-assessment	Board Workshop	28/02/2026 30/09/2026
4.2	Reset the corporate calendar of the Board, aligned to the requirements of key governance publications required by regulators. Review where assurances will be carried out at Board and Committees and revise the terms of reference and work programmes for all Committees. *(aligned to 9.2)*	Director of Corporate Affairs	30/04/2026	02/02/2026	**E&A**	Corporate Calendar 2026/27 Revised terms of references and work plans	Trust Board	31/07/2026
4.3	Refresh the Board development programme to aligned to the Trusts re-set of culture as listening and learning organisation. Focusing on curiosity, just culture, psychological safety.	Director of Corporate Affairs	30/04/2026	01/04/2026	**E&A**	Refreshed Board Development Porgramme shared and approved at Board Workshop.	Trust Board	31/07/2026
4.4	Reset the annual review of committee effectiveness questionnaire to seek feedback on improvements made as a result of regulatory feedback so we can understand and embed changes.	Director of Corporate Affairs	30/04/2026	28/05/2026	**CL**	Annual report of Committee Effectiveness	Trust Board	30/06/2026

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			Amended on 05/05/2026 – new target date 01/07/2026					
4.5	During November Trust Chair to complete mid-year reviews with all NEDs to re-set objectives. Appraisals will be carried out during Q1 2026/27 which will monitor progress of delivery of objectives and re-set.	Chair	01/07/2026	20/07/2026	**E&A**	Documented mid-year reviews and annual appraisals	Chair	31/03/2026
4.6	Conduct a facilitated session to commence Board development and reflect on Board culture and behaviours and moving forward with new members.	Chief People Officer Director of Corporate Affairs	24/10/2025	24/10/2025	**E&A**	Board Timeout Slides and attendance.	Board Workshop	
4.7	With the stability to the Board appointments during the autumn and the focus of work to progress action plans, the Board will commission an external well-led review to be undertaken in Q1 2026/27 to measure progress and support development as a Board.(commission during November/December)	Director of Corporate Affairs	30/06/2026	30/6/2026	**E&A**	Final Independent report presented	Board Workshop	30/09/2026

5. To achieve compliance with Regulation 17 ensure the Trust have effective systems and processes to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.

Ref	Improvement action description	Improvement action owner	Target date for implementation	Date Implemented	Status	Method of assurance	Responsibility for monitoring/ oversight	Planned review date
5.1	Deliver a workshop with Senior Leaders on the Trust systems and process to log, review and report on CSU/Directorate level risks.	Director of Quality	31/03/2026 New target date 31/05/2026	31/05/2026	**C**	Slides and recording of presentation	RMC	30/04/2026
5.2	Complete a review by CSU/Corporate department of the current risk register, controls and mitigation to ensure it is reflective of the current risk appetite and management.	Trust Risk Manager	31/03/2026	30/06/2026	**C**	Risk register presented at RMC	RMC	30/06/2026
5.3	(1) Complete a review of the Corporate Risk Register, considering method of day-to-day management and accessibility, to ensure controls and risk mitigation is reflective of the current risk appetite and management. (2) Make Corporate Risk Register available to CSUs to cross reference	Trust Risk Manager	31/03/2026	05/05/2026	**C**	CRR	RMC Board	30/06/2026
5.4	Develop a 'back to basics' recording and managing risks guide/video resource for all staff to increase the understanding of management of risk and methods of escalation.	Patient Safety Incident Response Manager	31/03/2026	05/05/2026	**E&A**	Risk related resources produced and available on the intranet	RMC	30/06/2026

6. Complete a review of the Trust Clinical Service Unit governance systems to meet the requirements of regulation 17 and provider licence conditions NHS2(2), (4), (5 B,C,E,F) and (6).

Ref	Improvement action description	Improvement action owner	Target date for implementation	Date Implemented	Status	Method of assurance	Responsibility for monitoring/ oversight	Planned review date
6.1	Review the CSU Quality Assurance Group framework to ensure that it is reflective of the current process of regular reporting and escalation.	Head of Quality Governance	31/1/2027		**O**	Updated CSU QAG and CSU Speciality Forum terms of references.	QAC	31/03/2026
6.2	Review the membership of the Groups receiving regular reporting and escalation to ensure they are representative to manage quality, performance and finance.	Head of Quality Governance Director of Operations	31/05/2026 New target date 01/09/2026	01/06/2026	**C**	Outcome report of Group membership and methods of sharing feedback from groups presented at Quality and Safety Assurance Group.	QAC	31/03/2026
6.3	Review how key messages and oversight is shared from corporate level Groups and Committees back to CSU level in order to share knowledge, risks and learning points.	Head of Quality Governance	31/05/2026 New target date 01/11/2026	1/112026	**C**			

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6.4	Review CSU membership or representation at Corporate meetings to support shared learning with CSU peers.	Head of Quality Governance Director of Operations	31/05/2026		**CL**			

7. To achieve compliance with Regulation 17 ensure the Trust has consistent and effective systems to ensure incidents are consistently reported, investigated appropriately and with lessons shared within and across services to prevent recurrence.								
Ref	**Improvement action description**	**Improvement action owner**	**Target date for implementation**	**Date Implemented**	**Status**	**Method of assurance**	**Responsibility for monitoring/ oversight**	**Planned review date**
7.1	Patient Safety Specialists to undertake the PSIRF maturity self-assessment and share this matrix with WYATT Trusts to enable benchmarking and discussion through the WYATT shared learning Group	Head of Quality Governance	31/03/2026 Target date changed to 30/06/2026	20/07/2026	**C**	Completed self assessment. WYATT shared Learning minutes	QAC	31/03/2026
7.2	Review the current incident reporting form to improve the reporting process to include the removal of unnecessary fields, multicoding of CSUs that need to report multiple incidents for a care episode (Women's) and reinstate the ability to report incidents anonymously.	Patient Safety Incident Response Manager Patient Safety and Quality Manager(s)	28/02/2026	01/07/2026	**C**	Patient Safety Incident report	QSAG QAC	31/03/2026
7.3	Develop a 'back to basics' incident reporting guide/video resource for all staff to increase the understanding of reporting, the process after reporting and how learning is shared	Patient Safety Incident Response Manager Patient Safety and Quality Manager(s)	01/04/2026	01/07/2026	**C**	Completed guide shared Trust wide and on the Intranet	QAC	31/05/2026
7.4	Develop a 'back to basics' guide/video resource for incident handlers and senior leaders with patient safety oversight to ensure incident review, action, closure and shared learning is completed and consistent.	Patient Safety Incident Response Manager Patient Safety and Quality Manager(s)	30/04/2026 Amended on 21/04/2026 – new target date 01/08/2026	1/8/2026	C	Completed guide shared Trust wide and on the Intranet	QAC	31/07/2026
7.5	Develop a programme, with suitable resource, to implement the Trust Learning Response Toolkit. This will include development of learning tools, training for Lead Investigators and development of action learning sets.	Patient Safety Incident Response Manager Patient Safety and Quality Manager(s)	31/03/2027		**O**	Developed Learning Response toolkit in operation Staff conducting incident reviews trained to use the learning response toolkit or appropriate elements within it.	QAC→Board	30/06/2027
7.6	Using insight, improvement and involvement create the Trust Patient Safety Incident Response Plan for 2027-2029	Director of Quality	31/03/2027		**O**	Overview of development of the plan shared through QAC. Completed PSIRP endorsed by QAC and Board and approved by ICB.	QAC→Board	30/06/2027
7.7	Review the Trust core training day for lead investigators to ensure it is aligned to PSIRF, just culture and includes interactive sessions on how to complete an investigation.	Patient Safety Incident Response Manager Patient Safety and Quality Manager(s)	31/03/2026	04/03/2026	**C**	Outcome of review and updated training.	QAC	30/04/2026
7.8	Review and update the Incident Management Procedure to ensure it is reflective of PSIRF, Just Culture and the improved processes of reporting.	Patient Safety Incident Response Manager Trust Risk Manager	31/01/2026	04/03/2026	**C**	Updated Incident Management Procedure	QAC	30/04/2026
7.9	Review and update the Duty of Candour learning tool and template letters to reflect best practice and include family engagement.	Head of Quality Governance	31/03/2026	31/32026	**C**	Updated resource available on the intranet	QAC	30/04/2026
7.10	Conduct a Rapid Process Improvement Week to examine the systems and process of how we share and use the learning for improvement from Never Events.	KPO Professional Lead	31/01/2027		**O**	Report out of RPIW	QAC	30/06/2026
7.11	Expediate the use of Viva Engage, currently in trial, to provide an accessible and interactive space to share patient safety messages and learning, both internal and NHS wide, with all staff.	Chief Digital information Officer Director of Quality	31/12/2025 Amended 26.03.2026 –	01/07/2026	**C**	Viva engage patient safety page live and operational	QAC	31/03/2026

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		Director of Communications	new target date 31/05/2026					
7.12	Publish the Patient Safety Learning Cascades via Patient Safety learning channels, formal reporting to Quality Assurance Committee and where appropriate through Trust communications.	Head of Quality Governance	31/12/2025	31/12/2025	C	Learning cascades shared following finalisation of each PSII. Learning cascade outcome report which includes how each CSU have considered the learning, shared Trust wide.	QAC	31/03/2026
7.13	Develop and implement a Patient Safety and Quality Communications plan using different methods of communication.	Head of Quality Governance Director of Communications	03/01/2026	03/03/2026	C	Increased communications related to patient safety and quality and specifically learning from patient safety events.	QAC	31/03/2026

8. To achieve compliance with Regulation 18 improve the Trust mandatory training compliance with all modules that fall below the Trust standard.

Ref	Improvement action description	Improvement action owner	Target date for implementation	Date Implemented	Status	Method of assurance	Responsibility for monitoring/ oversight	Planned review date
8.1	Expand the workforce metrics slide presented at Workforce Committee to include compliance by subject of mandatory training to enable oversight and appropriate challenge of areas of low compliance.	Deputy Director Human Resources	31/03/2026	01/05/2026	E&A	Updated Workforce Metrics Workforce Committee Minutes	Workforce Committee	31/03/2026
8.2	Complete a deep dive of mandatory training compliance by subject, staff group and by CSU to identify priority areas for improvement and report the findings and subsequent improvement actions to Workforce Committee.	Deputy Director Human Resources Deputy Chief Medical Officer	31/03/2026	01/05/2026	E&A	Mandatory training deep dive Workforce Committee Minutes Workforce Committee Chairs report to inform Board	Workforce Committee	30/06/2026
8.3	In line with the Core Skills Training Framework undertake mapping of learning outcomes and content for paediatric and newborn resuscitation training.	Deputy Chief Medical Officer – Workforce Deputy Director Human Resources	31/03/2026	01/05/2026	E&A	Completed Framework for Resuscitation approved by Chief Medical Officer	Workforce Committee	31/01/2026
8.4	Following completion of 8.3 apply the changes to the training requirements, including new competency names via ESR.	Deputy Director Human Resources Deputy Chief Medical Officer	31/03/2026	01/05/2026	E&A	Updated ESR	Workforce Committee	31/03/2026
8.5	Update all training records within ESR to reflect the new competency names.	Deputy Director Human Resources Deputy Chief Medical Officer	31/03/2026	01/05/2026	E&A	Update ESR (note this will include a risk assessment and sign off that on transfer the start date will all be that date but that the expiry date will be correct)	Workforce Committee	31/03/2026
8.6	Review of current training compliance across all resuscitation categories and develop a plan a medium and long term plan to improve compliance.	Deputy Chief Medical Officer – Workforce Deputy Director Human Resources Deputy Chief Medical Officer	31/03/2026	01/05/2026	E&A	Report to Learning, Education and Training Group on review outcome and recommendations.	Workforce Committee	31/03/2026

9. Complete targeted actions to asses and reset the Trust shared direction and culture

Ref	Improvement action description	Improvement action owner	Target date for implementation	Date Implemented	Status	Method of assurance	Responsibility for monitoring/ oversight	Planned review date
9.1	Develop a revised communications plan, led by the Chief Executive and Executive Directors building on the LTHT Live and revised Senior Leaders already enacted on commencement of new CEO. Ensure the plan is multi-factored, fosters a culture of psychological safety and its effectiveness is evaluated at regular intervals.	Director of Communications	31/12/2025	28/05/2026	C	Sources of communication. Audit of staff view of revised methods.	CEO EMT	31/03/2026

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9.2	Assess and re-set the culture and direction of the organisation, including reviewing the current multilayered vision, as being a listening and learning organisation, ensuring the focus remains on the providing the best care and treatment for patients.	Chief People Officer	01/04/2026	28/05/2026	C	Defined culture and direction Schedule of engagement with staff regarding re-set Increase in staff satisfaction scores.	Trust Board	31/03/2026
9.3	Develop a supporting toolkit of resources for leaders within the organisation to enable sharing, role modelling and communication of the Trust shared direction and culture.	Director of Communications	01/04/2026	28/05/2026	C	Resource toolkit	EMT	31/05/2026
9.4	Commission an external psychological safety benchmark survey exploring whether employees feel comfortable speaking up, taking risks, and making mistakes without fear of negative consequences.	Chief Medical Officer	04/01/2026	04/01/2026	C	Final report of Trust current psychological safety and supporting action plan. Final evaluation of Trust psychological safety	EMT	30/06/2026
9.5	Complete the survey and based on the results of 9.3 develop an improvement plan to address areas of risk, opportunities for improvement and shared learning.	Deputy Chief Medical Officer – workforce	31/01/2027		O	Report on survey results – improvement plan	Trust Board	
9.6	Repeat the benchmarking survey in 9.3 to evaluate the impact.	Deputy Chief Medical Officer – workforce	01/04/2027		O	Report on survey results – improvement plan	Trust Board	

10. Complete targeted actions to improve Trust wide capable, compassionate and inclusive leaders								
Ref	**Improvement action description**	**Improvement action owner**	**Target date for implementation**	**Date Implemented**	**Status**	**Method of assurance**	**Responsibility for monitoring/ oversight**	**Planned review date**
10.1	Review all Executive Directors Senior Leadership team to ensure there is a dedicated Deputy in their absence.	Executive Management team	01/06/2026	30/04/2026	C	Clear structure of accountability visible to all staff	EMT	31/03/2026
10.2	Develop a targeted plan of inclusive team building focusing on nurturing a culture of kindness, collaboration, cohesion and civility utilising the Trust Teams Connect programme.	Deputy Chief Medical Officer – Workforce	31/03/2026		CL	Developed Teams Connect plan with targeted sessions.	Workforce	30/06/2026
10.3	Revise the Board Leadership Visit Schedule for 2026/27 to include visits in and out of hours to increase visibility of the Board.	Deputy Chief Nurse	01/04/2026	26/03/2026	C	Report – leadership visit schedule 2026/27.	QAC	TBC
10.4	Develop a process of weekly gemba walks ‘Gemba Thursday’ where senior leaders commit to visit a clinical or non-clinical area, as a minimum once a month.	Deputy Chief Nurse Head of Quality Governance	01/04/2026	30/04/2026	C	Report setting our purpose and process for the visits presented to Quality and Safety Assurance Group for approval. Outcome report presented to QSAG and flowing to QAC.	QAC	31/07/2026
10.5	Ensure the Trust cultural re-set and the desire to be a listening and learning organisation is widely understood by enhancing the current methods of developing and empowering employees within leadership roles.	Executive Management team	30/04/2027		CL	Defined culture and ambition of the organisation shared within regular communications. Positive improvement within workforce metrics and staff survey results.	Trust Board	31/07/2026
10.6	Commence a Trust Wide people engagement programme to all leaders to articulate the ambition within the inclusion and belonging development plan.	Chief People Officer Chief operating Officer	30/04/2027		CL	Report to Learning, Education and Training Group on cultural reset and recommendations.	Workforce	TBC

11. Build upon the Freedom to Speak Up and Listen Up culture								
Ref	**Improvement action description**	**Improvement action owner**	**Target date for implementation**	**Date Implemented**	**Status**	**Method of assurance**	**Responsibility for monitoring/ oversight**	**Planned review date**
11.1	Review the resources required to deliver the FTSU Guardian role, including the contracted hours of the FTSU Guardian by analysing workload, benchmarking against comparable organisations, and consulting key stakeholders.	Freedom to Speak Up Guardian	31/03/2026	05/01/2026	E&A	Completed review of FTSU resource	Workforce Committee	31/03/2025
11.2	Implement the CSU lead champion in all CSUs and within all Corporate Directorates to resolve any issues at local level where possible.	FTSU Guardian	30/04/2026	30/4/2026	C	Lead champion model included within Guardian reports to Board	Trust Board	Trust Board
11.3	Develop a supporting toolkit of resources for the Lead Champion role which includes terms of engagement that all CSU/Corporate Directorate leads must adhere to.	FTSU Guardian	28/02/2026 Target date changed on 06/03/2026 – new target date 01/04/2026	1/4/2026	C	Lead Champion Resources MOU for CSU/Corporate Teams and Lead Champions	Workforce Committee Trust Board	Trust Board

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			Target date changed on 06/05/2026 – new target date 31/05/2026					
11.4	Review the representation of the FTSU Steering Group to ensure there is a voice for all staff groups engaged in shaping, promoting and self-assessment of the Trust FTSU model.	FTSU Guardian	28/02/2026 New target date 01/03/2026	1/3/2026	**C**	Annual FTSU Guardian report	Workforce Committee	TBC
11.5	Review the 2024/25 FTSU annual report: A summary of speaking up to Freedom to Speak Up Guardians and implement actions to address the call to action for leaders, line managers and the organisation.	FTSU Guardian FTSU Steering Group	30/04/2026	05/01/2026	**E&A**	Annual FTSU Guardian report	Workforce Committee	TBC
11.6	Develop a 12-month communication plan of FTSU promotion, sharing of staff experience of speaking up, the role of a Champion and the Trust stance on detriment.	FTSU Guardian	30/04/2026 Target date changed on 06/05/2026 – new target date set 31/05/2026	07/08/2026	**C**	Annual FTSU Guardian report	Workforce Committee	TBC
11.7	Review the 2024/25 FTSP Guardians Office Self-assessment to consider areas where improved compliance is required and action that will be taken to enhance these areas.	FTSU Steering Group	30/04/2026	05/01/2026	**E&A**	Annual FTSU Guardian report	Workforce Committee	TBC

12. Complete targeted actions to improve workforce equality, diversity and inclusion								
Ref	**Improvement action description**	**Improvement action owner**	**Target date for implementation**	**Date Implemented**	**Status**	**Method of assurance**	**Responsibility for monitoring/ oversight**	**Planned review date**
12.1	Conduct a desktop review of the Trust approach to equality and inclusion, based on 15 key questions/areas agreed with NHS England in response to concerns raised to both NHSE and the Care Quality Commission (CQC) prior to the CQC Well-led inspection.	Director of Corporate Affairs	30/06/2025	30/6/2025	**E&A**	Draft report presented at Board Workshop	Board time-out	01/10/2025
12.2	Host a detailed discussion with the report author at the first day of the Board Timeout session focussing on the review outcomes and recommendations factoring in the Well-led and MSSP reviews into the overall discussion	Director of Corporate Affairs	23/10/2025	23/10/2025	**E&A**	Board Workshop Agenda Supporting papers Board Workshop minutes	Board time-out	31/01/2026
12.3	Develop an EDI action plan in order to address the findings and recommendations within all external reviews of the Trust EDI.	Associate Director HR	27/11/2025	Initial plan developed in Nov 2025, ongoing	**E&A**	Final EDI action plan	Workforce Committee	31/01/2026
12.4	Build the findings from the MSSP EDI diagnostic into the EDI action plan.	Associate Director HR	27/11/2025	Initial plan developed in Nov 2025, ongoing	**E&A**	Final EDI action plan	Workforce Committee	31/01/2026
12.5	Publish the enei report and full supporting action plan (aligning the three aspects of the external reviews) and the MSSP EDI report.	Director of Corporate Affairs	27/11/2025	27/11/2025	**E&A**	Board papers on LTHT website	Workforce Committee	31/01/2026
12.6	Report assurance of the progress of the actions to the Strategic EDI Group reporting clear assurance of progress (or escalation of issues) to the Workforce Committee.	Deputy Director of HR	31/03/2026	31/3/2026	**E&A**	Strategic EDI Group papers Workforce Committee papers	Workforce Committee	30/06/2026

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12.7	Provide an update to the Board of progress against the action plan and agree frequency of future reporting to Board.	Deputy Director of HR	31/03/2026	31/3/2026	**E&A**	Board papers on LTHT website	Workforce Committee	30/06/2026
12.8	Provide an update to region regarding the progress and assurance actions the action plan.	Chief People Officer /Senior Independent Director	30/11/2025 31/03/2026	31/3/2026	**E&A**	Report to region.	Trust Board	30/06/2026
12.9	Review the diversity of senior leaders and the Board and benchmark against similar sized NHS Trusts.	Deputy Director of HR	31/03/2026	31/3/2026	**E&A**	Report to Workforce Committee Any recommendations added to the EDI action plan	Workforce Committee	30/06/2026
12.10	Compare how the Trust benchmarks against other NHS Trusts related to reported instances of discrimination, harassment and bullying or abuse in staff that do not identify as white British.	Deputy Director of HR	01/04/2026	1/4/2026	**E&A**	Report to Workforce Committee Any recommendations added to the EDI action plan	Workforce Committee	30/06/2026

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