Overall rating: Requires Improvement

Our view of the service

Leeds Teaching Hospitals NHS Trust (LTHT) is an NHS acute Trust consisting of Leeds General Infirmary, St James's University Hospital, Leeds Children's Hospital, Chapel Allerton Hospital, Wharfedale Hospital, Seacroft Hospital and Leeds Dental Institute.

Services include acute medicine, urgent and emergency care, maternity services, acute frailty units, rehabilitation services, dental services and surgical services to a local population of approximately 800,000 people across the Leeds locality. As a tertiary care trust, it provides specialist services to the wider population outside of the Leeds area.

The trust employs around 22,000 people across the sites.

We last inspected whether the trust was well led or not in 2019. At that time, we rated them as Good.

Following concerns identified during a recent inspection of the trust's maternity and neonatal services, we wanted to assess how well led the trust was overall. At that time, we asked the trust to take urgent action and also, issued a section 29A Warning Notice.

Our assessment of Leeds Teaching Hospitals NHS Trust included an on-site visit on 17 to 19 June 2025. We also held focus groups with staff members and observed a board meeting.

We assessed all 8 of the quality statements in the well-led key question used when assessing an NHS trust in the single assessment framework.

Each quality statement assessed is awarded a score. Details on how we score can be found on our website: https://www.cqc.org.uk/about-us/how-we-do-our-job/ratings

You can find further information about how we carried out our assessments at: https://www.cqc.org.uk/about-us/how-we-do-our-job/what-we-do-inspection

We looked for evidence that there was an inclusive and positive culture of continuous learning and improvement that was based on meeting the needs of people who used services and wider communities. We checked that leaders proactively supported staff and collaborated with partners to deliver care that was safe, integrated, person-centred, sustainable reduced inequalities.

This is the first assessment for this service under our single assessment framework. We rated the well led key question as requires improvement.

Whilst we found examples of leaders who were inclusive, transparent and fostered a culture of transparency, learning and improvement this was not consistent in all areas. We found examples of leadership where significant improvement was required to support and enable the culture aspired to in the Leeds Way.

Organisational and governance structures had been in place for a long period with little review or refresh, for example the clinical service units (CSUs) had been in place for 13 years. Executives told us, that over the coming months there will be an opportunity with the new Board positions in place, to look at those structures, and to consider if there would be an alternative and more effective model.

There was a lack of consistency in escalation and reporting both from the CSUs and through executive mechanisms and associated board committees to the board. There appeared to be some confusion regarding roles, responsibilities and accountabilities between board committee level and the CSUs, which impacted the effectiveness of governance and oversight.

The trust placed a high degree of importance on partnerships and community working and took a pride in fostering research, innovation and partnership working.

Amongst most senior leaders there was a coherent consensus of where the trust was in terms of its strategic ambition and operational delivery and how it would need to improve to deliver consistently care that was safe, integrated, person-centred and sustainable.

At this inspection we found breaches of regulation in relation to Complaints, Good Governance and Staffing.

People's experience of this service

Patient and care surveys evidenced positive people's experience.

The trust's inpatient survey showed that LTHT scored 'about the same' as other trusts in each overall category and scored 'somewhat better than expected' for the category of kindness and compassion.

The trust's CQC national maternity survey showed that LTHT scored 'about the same' as other trusts in each overall category and the same was found within the national urgent and emergency care survey.

We looked at the most recent results of the Friends and Family Test. In June 2025, people rated their experience of services at the trust as 'Very good/good' in the following areas: Outpatients - 95.6%, Maternity - 95.1%, A&E - 82.8% and Inpatients & Day case - 95.1%. These results were based on 11,000 responses.

Shared direction and culture

Whilst there was a trust strategy, vision and values in place, we were told of concerns relating to a perceived or real culture related to the organisation's balance between the priorities of quality and finance, with a skew toward finance over quality. Evidence suggested this may have been affecting the escalation of concerns and business cases to improve services across the trust.

A trust strategy was in place with plans to refresh this from 2026 onwards. The trust strategy was underpinned by a framework and 3 'core strategies' of Operational, Clinical Services and Patient Safety and Quality with 10 'enabling strategies'.

The 2024 to 2026 strategy acknowledged that 2020 to 2023 had been challenging years and focussing on improvement was of key importance to achieve a vision of providing the highest quality specialist and integrated care. The strategic priorities to achieve the vision were:

- Develop integrated partnership services
- Support and develop our people
- Focus on care quality, effectiveness and patient experience
- Deliver continuous innovation and inclusive research
- Ensure financial stability

Underpinning the vision and strategic priorities were the organisations longstanding values which had been developed as 'the Leeds Way', which focussed on being Patient Centred, Fair, Collaborative, Accountable and Empowered.

There were 7 annual commitments to work toward for 2025/26 which included:

- Sustainability
- Compassion
- Team
- Resources
- Finance
- Quality
- Care

The 7 Commitments were refreshed every year and aligned with the trust's multi-year goals.

We heard reflections from leaders and staff that certain aspects of the strategy influenced negatively and disproportionately on the confidence to escalate matters or make decisions, especially with a financial impact. Consequently, we were told that at times, issues requiring additional finances to make a positive impact on patient experience or quality may not have been escalated or highlighted due to perceived financial priorities.

Some senior leaders were aware of this impact and told us that there was a risk that a heavily skewed focus on commercial aspects along with research and development, could detract from 'getting the basics right'.

Leaders aimed to have a positive, compassionate and listening culture which promoted trust and understanding between themselves and staff, however we found the implementation of this was inconsistent across the trust and at board level.

Before and during our inspection we received several detailed and in-depth accounts from staff, of bullying, harassment and detriment which had been experienced. Whilst this was a relatively small number of staff comparable to the size of the organisation, the accounts were powerful and provided evidence of pockets of practice and behaviours which did not align with the trust's values. This included all grades, designations and racial backgrounds of staff.

However, the most recent NHS staff survey results for the trust were better than average in all areas:

- The trust was better than average in response to the question, "In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from Managers or colleagues. The trust had an improving trend in scores in this area for the period of 2021 – 2024.
- The trust score for 'Compassionate Culture' was 7.24 against a national average of 7.05. In respect of 'Compassionate Leadership' the trust score was 7.07 against an average of 6.98. The trust's scores in these areas were consistent between 2021 and 2024.
- 62.34% of staff would recommend the trust as a good place to work, which was slightly better than the national average of 60.90%.

The trust's external strategy focused on active engagement and collaborative working with both local and wider stakeholder organisations. Senior leaders told us that there were plans to drive greater access at place level for healthcare so that health and care services could be delivered

closer to home to; improve outcomes, experience and avoid hospital admission, where possible.

Capable, compassionate and inclusive leaders

Most leaders had the experience, capacity, capability and integrity to ensure that the organisational vision could be delivered, that risks were managed appropriately and learning could be cascaded. However, we were told some key Board relationships were not as effective as they could be due to a sense of deference towards the chair by some members. This appeared to impact on what was escalated and shared openly, for example, there was limited transparency at board level, on the CQC enforcement action taken in relation to the maternity service.

There were 8 executives/director level posts:

- Chief Executive Officer
- Chief Operating Officer and Deputy Chief Executive Officer
- Chief Medical Officer
- Chief Nurse
- Director of Finance
- Director of HR and Organisational Development
- Director of Estates and Facilities
- Chief Digital Information Officer

The Chair of the trust had been in post since 2013 was leaving this role in Summer 2025. A new chair had been appointed and was due to start in August 2025. The trust board had 7 non-executive directors and 3 associate non-executive directors. Both non-executive directors and associate non-executive directors were experienced and could demonstrate necessary expertise.

There were two vacancies for non-executive directors which were being recruited to at the time of the inspection. Some board members acknowledged that greater diversity and better representation at board level would make the board more effective and also be representative of the communities served.

Leaders were aware of the need to further develop the effectiveness of their board and were exploring how this could be facilitated. The Trust had a shadow committee development programme in place that aimed to build confidence and understanding of assurance to the board committees. Historically, the trust had accessed the Leadership Academy's Shadow Board programme, with four current directors completing this programme.

Most leaders we spoke with were knowledgeable and open about the priorities and challenges across the trust and its impact on the quality of service. Some leaders were not as clear about how services could be improved and their role in identifying, supporting and driving improvement. Each director had their own leadership structure for their portfolio, however, it was not always clear who was accountable and responsible for its delivery.

For example, there were five Deputy Chief Nurses, but none were individually responsible for the full scope of the Chief Nurse's portfolio during their absence. As a result, there was no single designated Deputy Chief Nurse who could report comprehensively to the Chief Executive or other board members. This fragmented structure meant that updates had to be gathered from

multiple deputies, which could affect accountability and delay decision-making. This concern was shared with us during executive interviews.

The board lead for AHPS and midwifery was the chief nurse. However, there were notable gaps in senior leadership below this. For an organisation of this size, the absence, within the senior leadership structure of a dedicated role for Allied Health Professionals and a permanent Director of Midwifery (DoM) was significant.

Whilst a Deputy Chief Nurse did have oversight of the Adult Therapies CSU within their portfolio, this responsibility was shared across multiple CSUs and did not equate to a dedicated Director of Allied Health Professionals. The Trust had commissioned an external review of the Adult Therapies CSU, involving AHPs in the review

An interim DoM had been appointed on secondment, who also held the role of Deputy Chief Nurse.

We found that most, but not all leaders were visible to staff. In particular, staff commented positively on the visibility of the 5 deputy chief nurses. The executive and non-executive team undertook structured walkarounds of different hospital sites and departments. We were also informed that board meetings were rotated between sites to improve visibility and enable board members and executive leaders to be more accessible for staff.

Not all senior leaders completed site walkabouts at different times of the day. We were told there was a lack of senior leadership visibility at night with a consequent view that leaders may not have first-hand knowledge of any challenges that arose out of regular hours.

The trust's board had diverse skills, experience and lived experience of using services. For example, a non-executive director provided positive feedback on the care received for a family member who had recently been admitted to one of the trust's hospitals. This was shared at a board meeting we observed as part of our assessment.

The board was not working as cohesively as it should to be effective with feedback we received about the openness and the culture at board level being mixed. There was a consequent concern that sufficient and appropriate check and challenge could be lacking due to some exceptionally strong personalities within the board.

Most leaders were aware of the challenges created by varying cultures in some parts of the organisation and the changes that needed to happen to realign the trust to its strategic ambitions and values. Most leaders understood the impact that this had on both patient and staff experience and could articulate their intention to act and what the plans were to start to address this when the new chair was in post.

System partners could provide examples of working in partnership with the trust to improve services delivered to patients.

We reviewed a sample of 6 files for directors, which included 3 executive directors and 3 non-executive directors. Fit and proper persons checks were in place for directors, and these were in line with regulatory requirements. The trust had completed appropriate checks of board and executive directors' suitability for their roles in all of the files we reviewed. All had received an annual appraisal within the previous year.

Freedom to speak up

There was a freedom to speak up structure in place and the organisation had recognised the need to increase capacity, albeit this was only on a temporary basis. The freedom to speak up guardian was experienced in the role and had temporarily increased their working hours from three days per week to five, in response to increases in the volume of feedback. Leaders viewed this increase as a positive indication of a change in culture and a willingness and confidence amongst staff, in raising issues of concern.

There were 88 freedom to speak up champions across the trust supported by the guardian. A new online referral system had been introduced in November 2024 and there was dedicated administrative support for the freedom to speak up function.

The trust had a freedom to speak up policy which was in date and had been approved in December 2022. There was a designated executive lead and accountability for freedom to speak up sat with the board. The policy provided clear guidance and highlighted support available. The policy linked to national learning from the National Guardian's office, which provided materials to support learning around the subject.

The trust was developing a framework so that each of the 19 CSUs had a designated freedom to speak up lead. This was being rolled out with the intention that the lead would resolve any issues at local level where possible. There was escalation to the guardian if the issue could not be resolved. The lead would provide a monthly report and meet with the leadership team of the CSU to share feedback of the issues which was then reported back to the individual. This approach was not yet fully embedded; therefore, there was an inconsistent approach across the trust.

Freedom to speak up issues were reported to board on a bi-annual basis. The most recent report was provided by the guardian in May 2025. There had been an increase in the number of issues raised during the period of 1 April 2024 and 31 March 2025. In quarter 3 of 2024/25 there were 55 concerns raised and 103 in quarter 4. The board report provided an analysis of the themes and identified the CSUs where the concerns had been raised. Themes included a recent increase in patient safety concerns, incivility from managers and colleagues and an 'erosion' of the "Leeds Way" values. The trust had action plans in place to address the thematic concerns including the 'commitment to kindness and compassion for 25/26' being described as a 'welcome inclusion' to address the issues.

The NHS Staff Survey 2024 Benchmark Report identified 65.58% of respondents felt safe to speak up about anything that concerned them which was better than the national average of 60.29%. However, there was a slight downward trend in survey results for the trust in this area between 2020 - 2024 from 69.45% in 2020 to 65.58% in 2024.

There were 53.52% of respondents who said they were confident the organisation would address their concerns which was better than the national average of 48.23%. However, for the trust, there was a slight downward trend in survey results in this area from 54.59% in 2020 to 53.52% in 2024.

We received comments from a number of staff before, during and after our inspection who told us that they felt concerns were not listened to and told us they experienced detriment after doing so.

Workforce equality, diversity and inclusion

Senior leaders were aware of the lack of workforce diversity from Band 7 upwards and they and the non- executive directors recognised a lack of diversity at board level. This was alongside the need to ensure the workforce and the board was more representative of the communities served by the trust. This was a priority for them to act on with the incoming chair. We had contact with a number of staff before, during and after the inspection who told us they had been subjected to racist and bullying behaviours, which had a significant emotional impact on their wellbeing.

The trust had an Equality, Diversity and Inclusion Policy with its aim as 'valuing and embracing the diversity of its workforce and the communities it serves.' The goal of the policy was to 'create a work and patient environment that is fully inclusive and fair where staff could reach their full potential and patients receive the optimum level of care and treatment.'

The policy was in date and had been approved in September 2022. There were named executive leads for the policy. Accountability and reporting was to the Equality and Diversity Strategic Group and the Patient Experience sub-group. The policy provided guidance on the legal frameworks underpinning the equality and diversity strategy and NHS standards such as the NHS Workforce Race Equality Standard (WRES) and NHS Workforce Disability Equality Standard (WDES).

The NHS Workforce Race Equality Standard and NHS Workforce Disability Equality Standard were reported. There was an annual data submissions and review of the WRES and WDES action plan which was overseen and assured by the Workforce Committee.

The trust's most recent Workforce Race Equality data indicated the following:

- Minority ethnic staff accounted for around 20 – 30 % of the non-clinical workforce for Bands 1 – 3. For Bands 4 – 7 This dropped to between 10 to 20%. For band 8a - 8d there was a degree of fluctuation around the 10% point. Minority ethnic staff accounted for around 20% of Band 9 staff. There was no representation within the very senior manager grades.
- Minority ethnic staff accounted for around 20 – 40 % of the clinical workforce for bands 1 – 4. For Band 5 minority ethnic staff accounted for around 50% of the workforce but only accounted for 15% of the Band 6 -8d clinical staff. There was around 15% of the clinical workforce from minority ethnic backgrounds at Band 9 and around 5% for very senior managers.
- Minority ethnic staff accounted for around 30% of the medical and dental workforce at consultant grade, around 40% at non-consultant and trainee career grades and around 45% at 'Other' grades.

Broadly speaking, the trust WRES data followed the same trend as national NHS WRES data.

The 2024 NHS Staff Survey results in relation to minority ethnic staff at the trust were better than the national average for this cohort of staff.

The reported instances of discrimination, harassment and bullying or abuse was lower in comparison with national data. However, when compared with results for people who identified as white British the results were comparatively worse.

The percentage of staff from staff who were not white British who have experienced discrimination at work from a manager or colleague in the last 12 months was improving at the trust and had been since 2021.

Leaders acknowledged there was scope for further improvement to ensure greater representation and equality of experience for staff from minority ethnic groups.

Governance, management and sustainability

Governance

Whilst there were systems and processes established, they'd had limited review and were not operating effectively.

Organisational and governance structures had been in place for a long period with little review or refresh, for example the clinical service units (CSUs) had been in place for 13 years.

It was recognised, by executives, that over the coming months there would be an opportunity to look at those structures, and to consider if an alternative model may be more effective. In addition, there was a lack of consistency in escalation and reporting both from the CSU's and through executive mechanisms and associated board committees. There appeared to be some confusion regarding roles, responsibilities and accountabilities between board committee level and the CSU's, which may have impacted the effectiveness of governance and oversight.

Governance was supported by nine board committees with delegated authority, all of which were chaired by a non-executive director except risk management, which was a Board management committee chaired by the Chief Executive and attended by all executive directors:

- Audit Committee
- Infrastructure Committee
- Digital & Information Committee
- Finance & Performance Committee
- Research & Innovation Committee
- Quality Assurance Committee
- Remuneration Committee
- Workforce Committee
- Risk Management Committee

Each board committee was chaired by a non-executive director and included additional non-executive directors as members. The Finance and Performance Committee included the trust Chair as a member, which was unusual practice within a trust, and may have influenced the perceived bias towards financial management over quality. The governance structure lacked clear and consistent pathways for both board assurance and linking issues across different CSUs and committees to ensure effective oversight and action. We were told by several leaders this could also present a barrier to sharing the outcomes from lessons learned. However, each CSU had a Quality Assurance Group which then reported into both the Corporate Operations Weekly Meeting and the Quality and Safety Assurance Group. The latter reported/escalated matters to the Board Quality Assurance Committee.

The governance structure was based on 19 Clinical Service Units (CSU) across the trust. Each CSU was led by a triumvirate: a clinical director, head of nursing and a general manager. Oversight of CSUs was provided by various medical director of Operations, Deputy Chief Nurse, and a Director of Operations. These roles aligned with the broader organisational structure: Deputy Chief Nurses reported to the Chief Nurse, Directors of Operations to the Chief Operating

Officer, and Medical Directors of Operations, while part of the operational model, were professionally accountable to the Chief Medical Officer.

Some CSUs were grouped with similar units, forming part of an executive director's portfolio to support strategic alignment and operational coherence.

A ward and department accreditation programme was being developed to strengthen frontline leadership capabilities, enhance quality of care delivery, and improve patient experience outcomes. The launch of this has been delayed from July 2025 to September 2025.

The trust had systems in place to monitor compliance with mandatory training, supervision, and appraisal. Overall compliance with mandatory training was 85%. However, there was significant variation across individual modules. While some modules achieved 100% compliance, we were provided with evidence that one module, Paediatric Resuscitation Training Level 2 Medical, had a compliance rate as low as 52%. This inconsistency in training compliance could present a risk to staff preparedness and service quality, particularly in areas where low completion rates may affect the safe delivery of care.

The Audit Committee approved the 2025/26 Internal Audit Risk Assessment and Plan, which had been externally procured and recommended by the Executive Management Team via the lead responsible director.

The most recent audit of the trust was completed in June 2024. The audit opinion found no actual significant weaknesses identified across the areas of financial sustainability, governance and improving economy, efficiency and effectiveness.

There was an identified risk of significant weakness in relation to the area of financial sustainability, specifically how the Trust planned to bridge its funding gap and identify achievable savings. However, the Trust achieved a balanced financial position at the end of the 2024/25 financial year to confirm that the funding gap had been mitigated during the year.

The Board Assurance Framework (BAF), last updated in April 2025, was regularly presented at board meetings. It outlined strategic risks linked to corporate risks, with executive oversight. Each strategic risk included key controls, assurances, gaps, and required actions, and was mapped to Level 1 risks with corresponding risk appetites.

Information Management

The board and committees received reports at trust wide and CSU level, which demonstrated performance against key national and local metrics. For example, referral to treatment times (RTT) were contained within the papers of the Finance and Performance Committee.

The Trust had a Data Security Protection Toolkit for 2024. This is an annual self-assessment produced by NHS England. The audit provided assurance to the Audit Committee that all 108 mandatory and non-mandatory evidence items had been successfully completed.

The Quality Assurance Committee reviewed a wide range of data-based reports, including safe staffing, patient safety incidents, never events, and healthcare-acquired infections. It also considered essential metrics reports, which provided details about targets, performance trends, context, and improvement actions.

We found duplication of reports at some committees, for example safe staffing went to both Finance and Performance and Quality Assurance. We were told this was set out in the

committee agendas specifically to triangulate key metrics for example focusing on performance and quality and safety in the respective committees. Assurance reports would also be escalated to other committees to support triangulation, as recommended by committee chairs in the minutes of the meetings.

However, we identified areas where information management could be strengthened to improve service delivery. For instance, the trust had applied a 23% uplift in staffing establishment planning. However, we had conflicting views shared with us as to whether it only monitored sickness absence and did not account for other types of leave such as maternity, study, or special leave. However, trend data indicated that the uplift needed to be higher. This affected the robustness of the uplift figure. This lack of robust oversight has had left a gap in maternity staffing, in particular which resulted in a section 29A Warning Notice. The uplift has since been increased to 28% for maternity and critical care.

At board level, the trust had appointed a Senior Information Risk Owner, a Caldicott Guardian, and a Data Protection Officer. The Caldicott Guardian was well-informed about the challenges of managing data in a digitally evolving environment and expressed confidence in handling data protection, particularly in relation to research, innovation, and commercial partnerships.

Risk Management

The trust was taking action to review and improve the level of assurance regarding risk identification, mitigation and management.

There was a risk management policy which covered the trust's approach to risk, accountabilities, practical processes for calculating risk and this detailed the ways that recording and assurance were actioned.

The trust had a corporate risk register, which contained high level corporate risks over four specific areas. The trust grouped risks under categories such as Operational Risk, which included, for example, business continuity. Each group was assigned a risk appetite, with all risks on the corporate risk register designated as either minimal or cautious.

Each risk had a current score out of 25, alongside an initial score and a target score. All current scores contained on the risk register, fell within the significant risk range, indicating that key risks could remain unresolved. Risks were also assigned an executive lead, a responsible committee with a date of review.

The Risk Management Committee had oversight of risk across the trust and defined appetite levels for operational, clinical, and non-clinical risks. It also reviewed significant CSU-level risks. CSU attendance rotated.

This was partially mitigated through the attendance of all CSUs at Risk Management Committee on a 6 monthly basis to discuss their key risks and mitigating actions; this was in line with the Risk Management Committee annual work plan. CSUs were also invited to discuss emerging significant risks at Risk management Committee.

In addition, the CSUs reviewed their significant risks at their monthly Quality Assurance Group, where risks could be then escalated.

Partnerships and communities

Staff and leaders collaborated with external stakeholders and agencies. Leaders provided examples of how the trust worked in partnership with other organisations both within the local system, the region and nationally.

The trust had built strong relationships with local, regional and national system partnership organisations. There was a strong and longstanding partnership working with the other acute providers in the West Yorkshire locality, through the West Yorkshire Association of Acute Trusts (WYAAT). WYAAT is a provider collaborative bringing together six NHS trusts across West Yorkshire and Harrogate to deliver joined up acute hospital services. The aim of the association was to tackle variation in access and patient outcomes and to address challenges across the region. For example, the Yorkshire Imaging Collaborative (YIC), (the six NHS trust radiology departments across WYAAT) implemented transformational artificial intelligence and decision support tools which could help diagnose patients with life-threatening diseases more quickly.

The trust had a service level agreement with the local NHS Mental Health Trust with a protocol for joint working; this helped to ensure patient pathways were effective and monitored.

The Trust was working with partners on discharge schemes, to facilitate discharge home and into the community. From June 2024 to March 2025 an average of 55% to 61% of patients with no criteria to reside remained in hospital. This was slightly higher than the England average of 55% to 58% and was consistently higher than the ICB average of 49% to 52%. A patient who has no criteria to reside, is one who is ready to be discharged from hospital. The trust had a higher proportion of discharges delays due to capacity issues (51%) compared to the averages for England (35%), North-east and Yorkshire (28%) and ICB (35%), for patients with delayed discharge over 14 days. Over a third of the capacity delays (37%) were due to residential/care home care not yet being available. This was higher than the England average (25%), regional average (24%) and ICB average (26%).

As the ICB overall did not experience the same level of issues with discharging to care homes, this could suggest a local issue with care home capacity in the Leeds area or a lack of co-ordination between the hospital and home care providers to ensure patients could be discharged quickly.

The trust looked for ways to engage the community they served. For example, in March 2025 Leeds Children's Hospital were visited by pupils from a local primary school in where children acted as 'Hospital Inspectors'. In December 2024, the trust advertised for an additional 6 members of the public to become 'Patient Partners', making 17 in total. Their role being to join different project working groups and provide patient or carer voice, when new services are being developed or changed.

We spoke with healthcare partners such as Healthwatch Leeds who ensure people's voices are at the heart of shaping health and care services in the area. They told us the trust had a total commitment to partnership working and listening.

Work on addressing health inequalities was developing, including data driven analysis to understand and improve health outcomes for both patients and staff. This had culminated in the publication of a Health Equity & Public Health Strategy 2025-2028, in June 2025.

Partners also told us the trust had an active and lead role within the public health space, where it was part of the promotion of health equalities and initiatives, which supported marginalised groups and the wider population. For example, partners highlighted targeted work to address

disparities in prostate cancer outcomes among Black men, who were often diagnosed later in the care pathway. The trust implemented a focused approach involving direct engagement to better understand the barriers these men faced. This initiative led to significant improvements in both access to care and health outcomes for this group.

The trust had a designated Head of Nursing, who oversaw a safeguarding portfolio. Within this portfolio was the responsibilities for the following areas: learning disability, autism and the Mental Capacity Act. The trust had a designated team which could provide advice, guidance or training on areas around learning disability or autism, to enable staff to fully support service users.

Learning, improvement and innovation

Staff and leaders had some understanding about how to implement learning and make improvements happen. There had been positive improvement in the last 12 months regarding learning from complaints and deaths, however this continued to be work in progress. Cross organisational learning could be improved.

Whilst there were some systems and processes in place, these were not always operated effectively to assess, monitor and improve the quality and safety of the services provided. For example, low level incidents or instances of harm did not appear to be effectively collated, reviewed and learned from for the benefit of greater patient safety/experience. Escalation of learning from some never events was not disseminated effectively across the CSUs. Staff told us about the challenge the current governance structure could present when trying to share learning across CSUs. This created a lack of consistency in sharing learning which we saw in our review of incidents.

Concerns in services we inspected had not been effectively identified and mitigated resulting in the serving of a Warning Notice.

There was an embedded improvement methodology (the Leeds Improvement Method). Improvement programmes for finance and quality were in place (Kaizen and PMO), with a view to these working closer together in the future.

There was a system in place to learn from deaths, which was outlined in the Mortality Review Policy. A Mortality Review Group met bi-monthly to consider themes, trends and patterns so they could target activity where needed to learn from and prevent deaths. The work of the review group had resulted in some positive outcomes in some areas of the trust where engagement with this work and learning from deaths were not initially as strong

The Summary Hospital-level Mortality Indicator (SHMI) for the trust was as expected at 1.14. The sites of St James University Hospital SHMI was as expected, Leeds General Infirmary was higher than expected at 1.17; the executive leads were aware of this and had taken steps to try and analyse and understand this more clearly. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

We randomly sampled learning from death reports. We found that the trust had been compliant with national guidelines and the reviews were of an appropriate standard.

The trust used the national Patient Safety Incident Response Framework (PSIRF) and had been one of the early adopters of this. The PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The PSIRF Policy and Incident Investigation Procedure gave clear guidance about the criteria for what incidents require an investigation. The trust's Incident Reporting Procedure provided guidance of how to correctly grade incidents reported using an electronic system. We saw in most instances and where required, the trust carried out Patient Safety Learning Reviews (PSLR) and Patient Safety Incident Investigations (PSII).

We reviewed a random sample of 10 incident investigations related to patient care. The quality of these investigations and the resulting learning was variable. We found that not all cases clearly identified any reasons why the incident may have happened and the conclusions and recommendations for further action varied in clarity and effectiveness. In some cases, we reviewed, other system partners were involved in the care but were not always involved in the investigation and lessons learned were not always shared with them which created the potential for reoccurrence of incidents.

There was an annual report on incidents, coroners and claims for 2023-24 which was presented to the Quality assurance committee on 17 August 2024, however we could not determine whether the trust undertook theme or trend reviews of incidents nor what the outcomes were from the information they shared with us, before our inspection. This was a risk as the trust might miss learning and preventing further incidents.

The staff survey indicated some staff dissatisfaction with training including variation in experience and learning across different sites and specialties. However, the most recent NHS staff survey results for the trust were better than the average for the theme of 'We are always learning'. This was consistent across the last four years.

The staff survey was similarly consistent around 'Development' and 'Appraisals', with the annual trend for 'Appraisals' was improving. Information submitted by the trust, showed that compliance with staff appraisals was at 93%.

The trust monitored complaints and set a 80% local target for several response metrics. Most areas fell short of this target, except for responses within six months. Some CSUs struggled more than others and overall responsiveness was poor, aligning with patient feedback. We reviewed a sample of complaint responses and those we saw were well-structured, compassionate, and compliant with the trust's policy. However, compared to similar trusts, a higher number of complaints were escalated to the Parliamentary and Health Service Ombudsman (PHSO).

The trust had received several accreditations from external partners in the areas of: Anaesthesia Clinical Services Accreditation (ACSA), BSUG (British Society of Urogynaecology and UKAS (United Kingdom Accreditation Service) Haematological Malignancy Diagnostic Service. The trust was also working toward other such as the DCAP (Diabetes Care Accreditation Programme RCP).

The trust placed a high emphasis on research. Through April 2024 to March 2025, the Trust managed and delivered a diverse research portfolio, recruiting 22, 275 participants into 1,413

active research studies and 19,437 participants taking part in National Institute for Health and Care Research (NIHR) portfolio studies.

The trust had a 5-year Research & Innovation strategy and also held an annual research and innovation conference. The aim of this conference was to bring together clinicians, researchers and healthcare professionals from across the Trust and partner organisations to showcase the very latest ground-breaking research, innovation and advancements in patientcare within the NHS.

The Innovation Pop-Up was set up in 2021 and located at the Leeds General Infirmary where companies can connect and work collaboratively with the Trust's clinicians and innovation team, to be able to transform the latest advances in science, research, and technology into real world solutions.

Environmental sustainability – sustainable development

The Trust Strategy 2024-2026 outlined the ambition to become 'green trust'. There was a recognition as a large organisation, there was a need to significantly reduce environmental impact of the delivery of services to support the NHS's ambition to become a net-zero health service.

The trust aspired to become one of the greenest NHS Trusts in the UK. Their plans included improving sustainability throughout the organisation and the wider region.

The trust had a Green Plan which was published in 2022. The executive lead for the plan was the Director of Estates and Facilities, who was supported by a Head of Sustainability. The Green plan focussed on 9 core areas, which included among others: Sustainable care models, Medicines, Estates and facilities, Digital transformation and Travel and transport.

Within each core area there were details as to what had been achieved and the next steps from a strategic perspective. For example, with Travel and transport, the trust had launched a '1 day a week' campaign to encourage colleagues to pledge to reduce the frequency of driving to work and they had received Silver Level accreditation as a Cycle Friendly Employer.

The trust had made progress reducing environmental impact through the implementation of its Green Plan. For example, from the baseline year in 2013/14 up to the end of 2023/24, the Trust had reduced its NHS Carbon Footprint by 37% from 84,830 tonnes of carbon dioxide equivalent to 53,176 tonnes of carbon dioxide equivalent.

The trust had a target to achieve an 80% reduction in direct carbon emissions by 2032 and become carbon 'net zero' by 2040. The trust felt they were on a trajectory to deliver against this.

In addition to the Green Plan, the trust had produced an Estates Decarbonisation Strategy entitled "A Roadmap to Net Zero Carbon". Each of the five hospital sites had a roadmap detailing what interventions were needed to become carbon neutral. Examples of this carbon neutral drive included:

- Installation of air source heat pumps
- Installing photovoltaics (PV) for electrical generation
- Energy efficient LED lighting
- Replacing single glazed windows with low U value double glazing
- Installing draft proofing

- Repairing roofs and installing flat roof insulation

The trust had a specific estates risk register which included details of the risk, risk owner, risk score and controls in place.

The trust's Green Plan contained a section on medicines and how this impacted sustainability. Within this there was a focus on minimising the emissions from anaesthetic gases and overprescribing to ensure patients received the most effective treatment for their condition whilst minimising unnecessary medicines wastage and carbon impact.

The Green Plan was further supplemented by the West Yorkshire Health and Care Partnership Pharmacy and Medicines Optimisation Green Plan 2023 – 2026. This provided a focus on improving sustainability around four key areas: Respiratory, Anaesthesia, Overprescribing (Including Wasted Items) and Antimicrobials.

Environmental sustainability was seen to have an important role within the pharmacy team with one of the team strategies the focus on waste reduction and recycling and one of the teams 7 yearly commitments.

A Medicines Management and Pharmacy Services Green Group had been set up to steer sustainability projects and was an integral partner of the Trust Sustainability Group. There were examples of initiatives within the pharmacy team. Examples of this included, part pack returns, cardboard recycling, promotion of carbon literacy training, decommissioning of nitrous oxide gas use and reduction on aseptic consumables such as gloves and aprons. The team also supported regional sustainability initiatives and was part of the regional inhaler recycling scheme.