Leeds and York Partnership
NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST
PUBLIC MEETING OF THE BOARD OF DIRECTORS
will be held at 9.30 am on Thursday 29 September 2022
Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR

A G E N D A

		LEAD
1	**Sharing stories - South CMHT digital project** (verbal)	
2	**Apologies for absence** (verbal)	**SP**
3	**Declarations of interests and any declarations of conflicts of interest in any agenda item** (enclosure)	**SP**
4	**Minutes of the meeting held on 28 July 2022** (enclosure)	**SP**
5	**Matters arising** (verbal)	
6	**Actions outstanding from the public meetings of the Board of Directors** (enclosure)	**SP**
7	**Chief Executive's report** (enclosure)	**SM**
8	**Report from the Chair of the Workforce Committee for the meeting held on 1 August 2022** (enclosure)	**HG**
9	**Report from the Chair of the Mental Health Legislation Committee for the meeting held on 9 August 2022** (enclosure)	**SW**
10	**Report from the chair of the Audit Committee for the meeting held on 16 August 2022** (enclosure)	**MW**
11	**Report from the Chair of the Quality Committee for the meeting held on 8 September 2022** (enclosure)	**JB**
12	**Report from the Chair of the Finance and Performance Committee for the meeting held on 27 September 2022** (enclosure / verbal)	**CHe**
13	**Report from the Chief Operating Officer** (enclosure)	**JFA**
14	**Chief Financial Officer's Report** (enclosure)	**DH**
15	**Safer staffing report** (enclosure)	**CW**
16	**Guardian of Safe-working Hours Quarterly Report** (enclosure)	**CHos**
17	**Care Services Strategic Plan** (enclosure)	**JFA**

18	**Workforce Race and Disability Equality Standards and Gender Pay Gap Progress Update 2022** (enclosure)	**DS**
19	**Health Education England / General Medical Council annual self-assessment report (SAR)** (enclosure)	**DS**
20	**EPRR Assurance Standards update** (verbal)	**JFA**
21	**Board Assurance Framework update** (enclosure)	**SM**
22	**West Yorkshire (WY) Integrated Care System (ICS) Mental Health, Learning Disability & Autism (MHLDA) Committee-in-Common Chair's report for meeting held on 27 July 2022** (enclosure)	**SP / SM**
23	**Use of Trust Seal** (verbal)	**SP**
24	**Any other business**	

The next meeting of the Board will held on Thursday 24 November 2022 at 9.30 am
Venue to be confirmed

AGENDA ITEM

3

Declaration of Interests for members of the Board of Directors

Name	Directorships, including Non-executive Directorships, held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services.	Any substantial or influential connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.	Any other commercial or other interests you wish to declare. This should include political or ministerial appointments (where this is information is already in the public domain – this does not include personal or private information such as membership of political parties or voting preferences)	Declarations made in respect of spouse or co-habiting partner
EXECUTIVE DIRECTORS								
Sara Munro Chief Executive	None.	None.	None.	**Trustee** Workforce Development Trust *Helping employers to cultivate their ultimate workforce through increasing productivity, improving learning supplies and helping to boost the skills of the UK's employees.*	None.	None.	None.	None.
Dawn Hanwell Chief Financial Officer and Deputy Chief Executive	None.	None.	None.	None.	None.	None.	None.	Partner: **Director** Whinmoor Marketing Ltd. *Marketing and advertising company to help with the growth of local, national and overseas markets.*
Chris Hosker Medical Director	None.	None.	None.	None.	None.	None.	None.	None.

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Cathy Woffendin Director of Nursing, Quality and Professions	None.	None.	None.	None.	None.	None.	None.	None.
Joanna Forster Adams Chief Operating Office	None.	None.	None.	None.	None.	None.	None.	Partner: **Director of Public Health** Middlesbrough Council and Redcar and Cleveland Borough Council Partner: **Chair** The Junction Charity *Works to empower children, young people and their families to embrace life with confidence, facing life's challenges in a positive way.*
Darren Skinner Interim Director of Human Resources	**Director** Skinner Consulting Ltd.	None.	None.	None.	None.	None.	None.	None.

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NON-EXECUTIVE DIRECTORS								
Susan Proctor Non-executive Director	**Director** SR Proctor Business Consulting Ltd *Independent company offering consultancy on specific projects relating to complex and strategic matters working with Boards and senior teams in health and faith sectors. Investigations into current and historical safeguarding matters.*	None.	None.	**Chair** Day One Charity *Holistic support for patients and families affected by major trauma.*	None.	None.	**Chair** Adult Safeguarding Board, North Yorkshire	None.
Helen Grantham Non-executive Director	**Director,** Entwyne Ltd *Provides HR and OD consultancy and services which include projects, advice, recruitment support*	**Sole owner,** Entwyne Ltd *Provides HR and OD consultancy and services which include projects, advice, recruitment support*	None	None	None	None	None	Partner: **Director** Per Call Ltd *Co-owner of the company that provides marketing and website services to self-employed builders, roofers, gardeners*

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Frances Healey Non-executive Director	None	None	None	None	None	None	**Patient Safety Consultant** National patient safety team at NHS England and NHS Improvement *Advisory roles and peer review for research studies and potential research studies related to patient safety*	None.
Cleveland Henry Non-executive Director	**Director** 63 Argyle Road Ltd. *Property Management Company.*	None	None	**Trustee** Community Foundations For Leeds *Supports thousands of charities and voluntary groups across the city, addressing inequalities and working together to help create opportunities for those that need help the most.*	None	None	**Group Delivery & Deployment Director** EMIS Group (Digital Health sector) *Provider of healthcare software, information technology and related services in the UK.*	Partner: **Lead Cancer Nurse** Leeds Teaching Hospitals NHS Trust

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Merran McRae Non-executive Director	**Director** Finnbo Ltd *Management consultancy*	None.	None.	**Trustee** Hollybank Trust *Provider of teaching, residential care and a range of therapies and enrichment activities for children, young people and adults with disabilities.* **Trustee** The Hepworth Gallery *Art Gallery* **Trustee** Yorkshire Sculpture Park *Independent charitable trust and registered museum.*	None. .	None. .	None.	Partner: **Director** Finnbo Ltd *Management consultancy*
Susan White Non-executive Director	**Non-executive Director** Spectrum Health Community Interest Company *A social enterprise which provides substance misuse, sexual health and prison health services across West Yorkshire and also the NE and NW of England.*	None.	None.	None.	None.	None.	None.	None.

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Martin Wright Non-executive Director	None.	None.	None.	**Trustee** Roger's Almshouses (Harrogate) *A charity providing sheltered housing, retirement housing, supported housing for older people.*	None.	None.	None.	None.

Declarations pertaining to directors being a Fit and Proper Person under the CQC Regulation 5 and meeting all the criteria in the Provider Licence and the Trust's Constitution to be and continue to be a director

Each director has been checked in accordance with the criteria for fit and proper persons and have completed the necessary self-declaration forms to show that they do not fit within any definition of an "unfit person" as set out in the provider licence, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008 or the Trust's constitution; that they meet all the criteria for being a fit and proper person as defined in the Social Care Act 2008 (Regulated Activities) Regulations 2008; and that there are no other grounds under which I would be ineligible to continue in post.

		Executive Directors						Non-executive Directors						
		SM	**CW**	**DH**	**CHos**	**JFA**	**DS**	**SP**	**CHe**	**HG**	**SW**	**FH**	**MM**	**MW**
a)	Are they a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) have not been discharged?	No	No	No	No	No	No	No	No	No	No	No	No	No
b)	Are they a person who has made a composition or arrangement with, or granted a trust deed for, any creditors and not been discharged in respect of it?	No	No	No	No	No	No	No	No	No	No	No	No	No
c)	Are they a person who within the preceding five years has been convicted of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) being imposed on you?	No	No	No	No	No	No	No	No	No	No	No	No	No
d)	Are they subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986?	No	No	No	No	No	No	No	No	No	No	No	No	No
e)	Do they meet all the criteria for being a fit and proper person as defined in the Social Care Act 2008 (Regulated Activities) Regulations 2008.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Minutes of the Public Meeting of the Board of Directors held on Thursday 28 July 2022 at 9:30 am. in Create@1, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR

Board Members		**Apologies**
Dr S Proctor	Chair of the Trust	
Prof J Baker	Non-executive Director	
Mrs J Forster Adams	Chief Operating Officer	
Miss H Grantham	Non-executive Director (Deputy Chair of the Trust)	✓
Mrs D Hanwell	Chief Financial Officer and Deputy Chief Executive	
Mr C Henry	Non-executive Director	✓
Dr C Hosker	Medical Director	
Miss M McRae	Non-executive Director	✓
Dr S Munro	Chief Executive	
Mr D Skinner	Interim Director for People and Organisational Development	
Mrs S White	Non-executive Director	
Mrs C Woffendin	Director of Nursing, Quality and Professions	
Mr M Wright	Non-executive Director (Senior Independent Director)	

All members of the Board have full voting rights

In attendance

Mrs C Hill	Associate Director for Corporate Governance / Trust Board Secretary
Mr K Betts	Governance Assistant
Dr F Healey	Associate Non-executive Director
Ms L Heffron	Engagement and OD Practitioner (minute 22/077)
Mrs K Khan MBE	Associate non-executive Director
Mr S Madathil	Temporary Staffing Manager (for minute 22/077)
Ms T Needham	Head of People Engagement (for minute 22/077)
Mrs R Pilling	Carer Coordinator, Patient and Carer Experience Team (for minute 22/067)
Mrs J Trafford	Service user (for minute 22/067)
Mr A Trafford	Service user (for minute 22/067)
Dr W Neil	Consultant Psychiatrist and Responsible Officer (for minute 22/073)

One member of the public observed the meeting

		Action
	Dr Proctor opened the public meeting at 09.30 am and welcomed everyone.	
22/067	**Sharing Stories** (agenda item 1) Mrs Pilling presented a film that had been co-produced with service users in support of the reset of Pharmacy services. Mrs Pilling explained the film had been produced for pharmacy staff to use for training purposes so they could better understand the experience of service users in relation to matters such as: receiving information about their medication; changes in dosage; and explanations about side effects. Mr and Mrs Trafford then explained their own experiences and why they decided to get involved with the project.	

Dr Hosker thanked those involved in the project and explained the difference the film had made to the pharmacy staff's understanding of service users' experience and suggested that it would be helpful for the film to be available to all professions, not just pharmacists.

Mrs White asked about Mr and Mrs Trafford's experience of receiving medication after discharge. Mrs Trafford explained that communication between organisations isn't always sufficient, and that service users can sometimes be left to sort out receiving further supplies of medication themselves. Dr Munro outlined the importance of ensuring there is continuity of receipt of medication to ensure any progress made in hospital isn't lost when service users move back into the community.

The Board then talked about information leaflets and the importance of recognising that not everyone finds narrative easy to read or understand and acknowledged the use of graphics can be helpful in these circumstances.

The Board **thanked** Mr and Mrs Trafford for attending the meeting to share their experiences and also thanked the team involved in the co-production of the film. The Board also acknowledged the importance of service users being involved in co-producing training films to be used by staff.

22/068 **Apologies for absence** (agenda item 2)

Apologies were received from Miss Helen Grantham, Non-executive Director; Mr Cleveland Henry, Non-executive Director; and Miss Merran McRae, Non-executive Director.

22/069 **Declaration of interests for directors and any declared conflicts of interest in respect of the agenda items** (agenda item 3)

It was noted there were no updates to directors' declared interests and no member of the Board declared a conflict in any agenda item.

22/070 **Minutes of the previous meeting held on 19 May 2022** (agenda item 4)

It was noted the minutes showed the wrong venue and should have recorded the meeting was held in the Hemmingway Room, St George's, 60 Great George St, Leeds LS1 3D. Mrs Hill agreed to correct this. **CHill**

Subject to the change in venue, the minutes of the meeting held on 19 May 2022 were **received** and **agreed** as an accurate record.

22/071 **Matters arising** (agenda item 5)

There were no matters arising.

22/072	**Actions outstanding from the public meetings of the Board of Directors** (agenda item 6) Dr Proctor presented the action log which showed those actions previously agreed by the Board in relation to the public meetings, those that had been completed and those that were still outstanding. Dr Munro advised the Board on the progress with the public inquiry into the handling of the COVID pandemic. She noted the chair of the Inquiry had set out the phasing of the various stages which Mrs Hill agreed to circulate to members of the Board.	**CHill**
	The Board **received** the cumulative action log and **noted** the content.	
22/073	**Annual Responsible Officer and Medical Revalidation report** (agenda item 16) Dr Neil presented the Annual Responsible Officer and Medical Revalidation report noting that this set out details of the work undertaken over the last 12 months adding that the report would be submitted to NHS England. Dr Neil outlined some of the details in the report. In response to a question about information relating to any concerns about individual locum or short-term placement doctors which the Trust provides to their employing bodies, Dr Neil confirmed that any such information would be provided on a pro-active basis. Dr Munro asked how the Trust benchmarked in relation to maintaining the standards of appraisals undertaken, particularly through the COVID period which had brought with it a number of challenges in carrying these out. Dr Neil explained that whilst there was no benchmarking information, she was part of a regional network of mental health responsible officers which had continued to meet through COVID where such matters were discussed, and that anecdotally the Trust was ahead of other organisations. Dr Hosker paid tribute to Dr Neil and the team in the way they had worked to oversee and maintain the high standards and number of appraisals carried out over the last two years. He added that whilst there were no concerns about the appraisal process there was still more work to do in relation to job planning. Mrs Hanwell asked about CareDirector and whether the situation had improved in obtaining information from the new patient information system. Dr Neil reported that the situation had improved with the information from CareDirector being more accessible and relevant than from the old system. Dr Proctor noted there had been no referrals to the General Medical Council (GMC) but sought assurance that people felt able to raise concerns should these arise. Dr Neil explained there were no concerns that had reached the threshold for reporting to the GMC but that concerns had been raised which had been dealt with internally. She also advised the Board that the raising concerns policy had been recently updated and this provided a framework to raise and investigate any concerns reported and to monitor trends. Dr Hosker	

added that the Guardian of Safe Working would receive any concerns raised by junior doctors.

The Board **received** the Annual Responsible Officer and Medical Revalidation report and **agreed** this could be signed off by the Chair of the Trust.

22/074 **Report from the Chief Executive** (agenda item 7)

Dr Munro presented her Chief Executive's report and drew attention to the key information it contained. In terms of service visits the Board noted there was a plan to hold the September Board meeting at Red Kite View and there would be an opportunity to visit the unit during the course of the day.

Mrs White asked about the Leeds Health and Care Hub and expressed concern this was another body the Trust would need to service which may have the potential to create further capacity issues. Dr Munro advised that she was aware of the potential for duplicating effort but that other groups with a workforce agenda were linked into this to ensure this was limited. However, it was also noted that increasing the number of groups within the region that were overseeing workforce matters could lead to things being missed if there was a lack of understanding as to what each group was responsible for. With regard to the ICB approach to recruitment, Dr Proctor asked for the slides produced by Sonya Robertshaw to be shared with members of the Board noting these detailed the mental health and learning disability workforce strategy for West Yorkshire. Mrs Hill agreed to circulate the link. **CHill**

Mr Skinner then spoke about recruitment processes for Red Kite View, noting the Trust had been asked to produce a national best practice case to set out and share its processes to recruit staff to the unit.

Dr Healey observed that the new Mental Health Act had an emphasis on what could be done in inpatient settings that could not be done elsewhere. She added that in order to ensure the act was implemented properly a review would need to be carried out to assess any changes required. Dr Munro noted there was also work to do to ensure the community model of care fits with the inpatient model and that ringfenced investment was available to support any changes needed.

The Board **received** a report from the Chief Executive and **noted** the content.

22/075 **Report from the Chair of the Quality Committee for the meetings held on 13 June and 11 July 2022** (agenda item 8)

The Board received the Chair's reports from the Quality Committee meetings that had taken place on 13 June and 11 July 2022. Attention was drawn in particular to:

- The Research and Development Strategy and the need to ensure sufficient funding to undertake and carry out research

- The safer staffing report and the assurance received in relation to the breaches.

With regard to funding for research, Dr Hosker advised that initial funding had been secured. However, with regard to subsequent academic posts he noted this would be subject to further discussions.

With regard to the Annual Quality Reviews, Dr Hosker noted these go to the Quality Committee for assurance, but don't go to the Board more widely. However, it was noted that Board sub-committee papers were provided to all NEDs and as such were available in the Quality Committee agenda packs. Dr Healey suggested there needed to be further consideration as to how these and other reports were used and how the Board sub-committees work together so information was shared across the committees. It was agreed that further consideration of how reports are used and circulated needed to take place. **FH / CHos / CW / CHill / KM**

Mrs Hill noted that in relation to Board and sub-committee papers, Teams was being used as a repository for these papers and that she and Miss McMann would look at ensuring information on how to access these was circulated again. **CHill / KM**

The Board **received** the reports from the Chair of the Quality Committee and **noted** the matters reported on.

22/076 **Report from the Chair of the Workforce Committee for the meeting held on 16 June 2022** (agenda item 9)

The Board received the Chair's report from the Workforce Committee meeting that had taken place on 16 June 2022. Attention was drawn in particular to:

- The progress with the development of a cultural dashboard which would set out this data in one place and highlight any hot spots.

The Board **received** the report from the Chair of the Workforce Committee and **noted** the matters reported on.

22/077 **Report from the Chair of the Finance and Performance Committee for the meetings held on 28 June and 25 July 2022** (agenda item 10)

The Board received the Chair's report from the Finance and Performance Committee meetings that had taken place on 28 June and 25 July 2022. Attention was drawn in particular to:

- Service performance, in particular performance for physical health checks
- The wait times for the Gender Identity service and the reset plans and waiting list management.

- Emergency Preparedness Resilience and Response annual report which detailed the huge amount of work that had been undertaken by the team to support the management of the pandemic.
- A discussion on cultural and behaviours in relation to the digital agenda. Mrs White noted the committee had identified this as an issue that cut across a number of Board sub-committees and suggested there was a need for the Board to look at this at one of its Strategic Discussion sessions. Dr Proctor asked that she and Mrs Hill look at where this can be added to the forward plan. **SP / CHill**
- The reduction of the agency cap and the impact this might have on the workforce given the difficulties there were in some areas to recruit staff. It was suggested that Mr Henry and Miss Grantham as chairs of the Finance and Performance Committee and the Workforce Committee should discuss which committee would receive assurances on this matter. **CHe / HG**

The Board **received** the report from the Chair of the Finance and Performance Committee and **noted** the matters reported on.

22/078 **Bank staffing survey** (agenda item 18)

Ms Needham presented the slides setting out the findings from the bank staff survey. She explained that she and Andrew McNichol had been working with the NHS England/Improvement Staff Engagement Team to promote the need for and develop a national bank survey. She added that for the coming year the survey would be voluntary for organisations with this being mandated in future years. She added that the questions would feed into the People Promise, but that some of the language used would be amended to ensure the questions were relevant for bank staff.

Ms Needham then outlined the main findings from the survey as set out on the slides, in particular the results around bank staff feeling they don't have a voice within the services and discrimination against bank staff by service users, noting these had been marked as areas for improvement.

Ms Needham then advised that a deep dive had been done into some of the responses and a specific area for concern was around violence, bullying and harassment. She explained this area was being linked into the work carried out by the Associate Director for People Experience on the prevention of violence and aggression.

Mr Madathil then outlined some of the actions being undertaken in relation to the findings from the survey including a listening session in August with bank staff to better understand their experience of violence, aggression, bullying and harassment. The Board expressed concern about the findings in regard to bullying and harassment and discussed this matter in some detail and the possible factors that could lead to situations where bullying and harassment, violence and aggression might take place. It also supported the work to look in more detail at the specifics of the responses within the survey to better understand what targeted work needs to take place.

The Board also sought to understand the conversion rate of bank staff being employed into substantive posts, and what the reasons were for not wanting to be employed substantively. Mr Madathil explained that to date 116 staff had converted with the bank often being seen as a progression to gaining a profession. He added that many of the barriers to converting had now been removed but a cohort of staff still wished to remain on the bank to maintain a flexible way of working.

Mr Skinner noted that a question had been asked about staff feeling the need to come into work when they were not well. He explained that during the COVID pandemic the Trust ensured that bank staff were paid whilst they were sick if this was when they had a booked shift. He added that whilst NHS England had asked organisations to revert back to pre-COVID sick-pay arrangements, the Trust had taken the decision to continue the arrangements until the end of September.

Dr Proctor asked for the slides to be made available to members of the Board. **CHill**
She also asked for details of the bank staff event on 16 August be circulated to members of the Board who were encouraged to attend. **CHill**

The Board **thanked** Ms Needham, Mr Madathil and Ms Heffron for attending the meeting to present the findings from the bank staff survey.

22/079 **Report from the Chief Operating Officer** (agenda item 11)

Mrs Forster Adams presented her Chief Operating Officer's report, noting this had been scrutinised by the Board sub-committees. She then drew attention to the key points in the report.

Mr Wright welcomed the report, including the use of the AAA (assure, advise, alert) format noting this assisted the Board in focusing on the key areas of information and data. He also observed that it was apparent from the report there was a huge amount of work ongoing both at a Trust and ICB level and asked if it might be better to focus on a few things rather than try and address everything at the same time. Mrs Forster Adams noted that this had been considered in the context of the first draft of the Care Services Strategic Plan. She added that service line leadership teams had also considered what it was important to focus on and they would be using their judgment on what was needed at a particular point in time.

Dr Proctor noted there had been a decline in the performance of Liaison Psychiatry where 65.7% of people had been seen within one hour of being referred, however, she added that this should be seen in the context of a very busy emergency department and whilst this performance was below target the team should be commended on achieving this level.

The Board **received** and **noted** the detail in the Chief Operating Officer's report.

22/080 **Chief Financial Officer's Report** (agenda item 12)

Mrs Hanwell presented her Financial Officer's Report noting that at month 3 the Trust was reporting an income and expenditure surplus of £763k compared with a plan of £251k. She noted the Trust was in a good financial position and expected to exceed its target overall. She explained the position was being kept under review to ensure money was spent appropriately without creating recurrent financial risk.

She added the main financial challenge in regard to expenditure was workforce noting the level of vacancies, explaining that not all vacancies were able to be filled.

Mrs Hanwell then reminded the Board that any forecast surplus must be seen in the context of the ICB financial regime and that through the year discussions would be undertaken at a system level and would take account of partner organisations' financial position.

Mrs Hanwell then drew attention to the reintroduction of the Single Oversight Framework noting that within this would be a target for agency spend. She explained that whilst the target was still to be announced it was expected to return to pre-COVID levels less 10% which would likely create a target less than the Trust's forecast spend. Mrs Hanwell added that whilst this might be a challenging target to meet it would provide a helpful point of negotiation which could be used when discussing with agency staff providers what their level of charges might be.

Mrs White thanked Mrs Hanwell for the report. She noted that the Finance and Performance Committee had agreed to receive information about the Trust's position for both agency spend and efficiency plans. She also noted the committee had welcomed a report setting out the service line under and overspend and this had proved useful in triangulating against the Chief Operating Officer's performance report.

Dr Healey asked about the funding of the national pay award. Mrs Hanwell explained this would be fully funded but the funding would be at the expense of some national development programmes.

Prof Baker asked whether there would be a system agency cap and what would happen if this was breached. Mrs Hanwell reported that whilst the Single Oversight Framework set out targets at different levels within the system, the agency cap was to be set at a Trust and not system level.

The Board also recognised that at the present time, whilst the cost of agency was an ongoing financial pressure, the other pressure would be the impact of the rising cost of energy. Mrs Hanwell acknowledged this but noted there would be no new money from the treasury for 2022/23 and any financial consequences would need to be managed in year.

The Board **received** the Chief Financial Officer's report and **noted** the content.

22/081	**Report from the Director of Nursing, Quality and Professions** (agenda item 13) Mrs Woffendin presented her Director of Nursing, Quality and Professions report. She drew attention to: the revised clinical governance arrangements; the new CQC strategy setting out changes to the way they regulate; and achieving stage 2 accreditation for Triangle of Care. With regard to the Triangle of Care, Mrs Woffendin explained the accreditation was for the work the Trust had achieved in working alongside carers to improve their experiences. She added this was an excellent achievement which demonstrated commitment in ensuring carers were at the forefront of this important area of work. With regard to the new way in which the CQC will regulate as set out in the report, it was noted that the example provided could be construed by the reader as the scores for this Trust. It was suggested the paper on the website was amended.	**CHill**
	The Board **received** the report from the Director of Nursing, Quality and Professions and **noted** the content.	
22/082	**Six-monthly safer staffing report** (agenda item 14) Mrs Woffendin presented the paper noting this contained a high-level overview of data and analysis for staffing of wards against safer staffing levels for the six-month period from 1 November 2021 to 30 April 2022, adding this period had presented a number of challenges. Mrs Woffendin added the report brings together data from the periods previously reported to the Board in the two-monthly reports and that that Board would have been advised of any breaches detailed in this report. Mrs Woffendin then outlined some of the key information in the report and drew attention to the work to grow and maintain the nursing and professions workforce. Dr Proctor asked for the next six-monthly report to include information about staff who had successfully attained promotions to band 7 and above.	**CW**
	Dr Proctor also asked about the apprenticeship levy and whether the Trust uses all the levy. Mr Skinner advised the Trust would use as much as it is able and then share any unused levy within the system. Dr Proctor asked about the relationship the Trust had with Bradford University in terms of student nurses. Mrs Woffendin explained the work to try and attract students from Bradford. Dr Proctor agreed to link in with the Dean of the university in relation to this matter.	**SP**

	The Board **received** the six-monthly safer staffing report and **noted** the content.	
22/083	**Medical Director's report** (agenda item 15) Dr Hosker presented his Medical Director's Report. He drew attention to the main points in the report including: the challenges around the recruitment and retention of doctors linked to the need to reduce spending on agency staff; the importance and progress made with international recruitment; the Mental Health Legislation Team and the training they had provided on the Depravation of Liberty new code of practice; the Research and Development Strategy and the work to re-brand the function and bring it closer to services; and the staffing problems in the Pharmacy Department and the work to look at skill-mixing and staffing in different ways. Dr Proctor noted the report indicated that the junior doctor's rotation dates would move to August from 2023 rather than October, noting the added pressure this creates for support services both in HR and medical education at a time when annual leave for staff is at its highest. Dr Proctor asked if this was something that should be raised by the Board at an ICB level. Dr Munro noted there was a relationship meeting with Health Education England where this could be raised in the first instance to understand what the route of escalation should be.	**SM**
	The Board **received** and **noted** the content of the Medical Director's Report	
22/084	**Director of People and Organisational Development report** (agenda item 17) Mr Skinner presented his Director of People and Organisational Development Report noting this was the first report to the Board. He outlined the work being carried out within the directorate. He drew particular attention to the Messenger Review and the work being carried out in relation to the recommendations from this review. Mr Skinner then provided an update on the Big Thank-you Event and the COVID Stars, noting that these had been very well received by staff and initiative had been supported by Staffside.	
	The Board **received** and **noted** the content of the Director of People and Organisational Development Report.	
22/085	**Emergency Preparedness Resilience and Response (EPRR) Annual Report** (agenda item 19) Mrs Forster Adams presented the EPRR Annual Report noting this covered the period up 31 March 2022. She paid tribute to the EPRR team and the	

	work they had overseen through a very difficult and busy period. The Board also extended its thanks to the team.
	The Board **received** and **approved** the EPRR Annual Report.
22/086	**Cyber security dashboard** (agenda item 20) Mrs Hanwell presented the cyber security dashboard, noting this had been received and discussed at the Finance and Performance Committee in some detail. She added the Trust was in a good position and was making progress with the implementation of the two-factor authentication log on for Trust staff.
	The Board **received** and **noted** the content of the cyber security dashboard.
22/087	**Use of the Trust seal** (agenda item 21)
	The Board **noted** the seal had not been used since the last meeting.
22/088	**Any other business** (agenda item 22) Dr Proctor noted this was the last meeting for Prof Baker. The Board thanked him for all the work he had done on the Board including providing his clinical insight and especially for the development of the work of the Quality Committee. The Board paid tribute to the difference he had made and his dedication to seeking assurance on the promotion of the delivery of quality services.
22/089	**Resolution to move to a private meeting of the Board of Directors** At the conclusion of business, the Chair closed the public meeting of the Board of Directors at 13:00 and thanked members of the Board and members of the public for attending. The Chair then resolved that members of the public would be excluded from the meeting having regard to the confidential nature of the business transacted, publicity on which would be prejudicial to the public interest.

Leeds and York Partnership NHS Foundation Trust

Cumulative Actions Report for the Public Board of Directors' Meeting

OPEN ACTIONS

AGENDA ITEM

6

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Report from the Chief Operating Officer (minute 21/089 – agenda item 12 – July 2021) Dr Munro noted that once the details of the national inquiry into COVID-19 were known there would be an update provided to the Board in relation to the Trust's readiness	**Sara Munro / Cath Hill**	Date to be confirmed	**ONGOING**
Report from the Chair of the Quality Committee for the meetings held on 13 June and 11 July 2022 (minute 22/075 - agenda item 8 – July 2022) **NEW -** Dr Healey suggested there needs to be further consideration as to how the Annual Quality Reviews and other reports are used and how the Board sub-committees work together and information is shared across the committees.	**Frances Healey / Chris Hosker / Cath Woffendin / Cath Hill / Kerry McMann**	Management action	**ONGOING** A meeting has taken place to look at the work of the Quality Committee, the format of the reports it wants to receive and the links to other Board sub-committees – another meeting has been scheduled

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Report from the Chair of the Finance and Performance Committee for the meetings held on 28 June and 25 July 2022 (minute 22/077 - agenda item 10 – July 2022) **NEW -** It was agreed that cultural and behavioural issues in relation to the digital agenda would be added to the Board Strategic Discussion session forward plan.	**Sue Proctor / Sara Munro / Cath Hill**	Management action	**ONGOING** The forward plan is being updated and this session will be incorporated into the forward plan
Report from the Chair of the Finance and Performance Committee for the meetings held on 28 June and 25 July 2022 (minute 22/077 - agenda item 10 – July 2022) **NEW -** In regard to the reduction of the agency cap and the impact this might have on the workforce given the difficulties there are in some areas to recruit staff. It was suggested that Mr Henry and Miss Grantham as chairs of the Finance and Performance Committee and the Workforce Committee should discuss which committee would receive assurances on this matter.	**Cleveland Henry / Helen Grantham**	Management action	**ONGOING** Helen Grantham and Cleveland Henry are to meet to discuss this and will advise the Board
Six-monthly safer staffing report (minute 22/082 - agenda item 14 – July 2022) **NEW -** In terms of attracting student nurses from Bradford University, Dr Proctor agreed to link in with the Dean of the university in relation to this matter.	**Sue Proctor**	Management action	**ONGOING** An email has been sent to the Dean of Bradford University and further discussions are awaited

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Approval of the final version of the Trust's Green Plan (minute 22/060 - agenda item 18 – May 2022) It was suggested that progress against the Plan would be monitored through the Finance and Performance Committee with an update to the Board. Mrs Hill agreed to clarify the reporting cycle and add this to the forward plan.	**Cath Hill**	Management action	**COMPLETED** It has been agreed that a report will come to the Board annually on the Trust's Green Plan with updates from the Finance and performance Committee every 6 months reported via the committee's chair's report
Approval of the final version of the Trust's Green Plan (minute 22/060 - agenda item 18 – May 2022) It was noted that currently, Mrs White was the NED champion for sustainability and a successor would need to be identified to carry on this role. Dr Proctor agreed to pick this up in the NED appraisals which were currently taking place.	**Sue Proctor**	Management action	**COMPLETED** The Chair of the Trust will be the champion with an opportunity for the new incoming chair considering how this should be taken forward in the future when they take up post
Actions outstanding from the public meetings of the Board of Directors (minute 22/072 - agenda item 6 – July 2022) **NEW -** Dr Munro advised the Board on the progress with the public inquiry into the handling of the COVID pandemic. She noted the chair of the Inquiry had set out the phasing of the various stages which Mrs Hill agreed to circulate to members of the Board.	**Cath Hill**	Management action	**COMPLETED**

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Report from the chair of the Finance and Performance Committee for the meeting held on 27 September 2021 (minute 21/109 – agenda item 11 – September 2021) A presentation on the emerging digital strategy, noting that the committee had suggested that this should be presented to the Board at a future Board strategic discussion session. Mrs Hill agreed to add this to the forward plan.	**Cath Hill** **(Dawn Hanwell)**	September Board of Directors' meeting	**COMPLETED** This is on the agenda for the September private Board meeting
Minutes of the previous meeting held on 19 May 2022 (minute – 22/070 - agenda item 4 – July 2022) **NEW -** It was noted that the minutes showed the wrong venue and should have recorded that the meeting was held in the Hemmingway Room, St George's, 60 Great George St, Leeds LS1 3D. Mrs Hill agreed to correct this.	**Cath Hill**	Management action	**COMPLETED**
Report from the Chief Executive (minute 22/074 - agenda item 7 - July 2022) **NEW -** Dr Proctor asked for the slides produced by Sonya Robertshaw be shared with members of the Board which detailed the mental health and learning disability workforce strategy for West Yorkshire. Mrs Hill agreed to circulate the link.	**Cath Hill**	Management action	**COMPLETED**

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Report from the Chair of the Quality Committee for the meetings held on 13 June and 11 July 2022 (minute 22/075 - agenda item 8 – July 2022) **NEW -** Mrs Hill noted that in relation to Board and sub-committee papers, Teams was being used as a repository for these papers and that she would look at ensuring information on how to access these was circulated again.	**Cath Hill / Kerry McMann**	Management action	**COMPLETED** Information on how to access the papers stored on Teams has been circulated
Bank staffing survey (minute 22/078 - agenda item 18 – July 2022) **NEW –** Dr Proctor asked for the slides to be circulated to members of the Board.	**Cath Hill**	Management action	**COMPLETED**
Bank staffing survey (minute 22/078 - agenda item 18 – July 2022) **NEW –** Dr Proctor asked for details of the bank staff event on the 16 August be circulated to members of the Board who were encouraged to attend.	**Cath Hill**	Management action	**COMPLETED**
Report from the Director of Nursing, Quality and Professions (minute 22/081 - agenda item 13 – July 2022) **NEW -** With regard to the new way in which the CQC will regulate, as set out in the report it was noted that the example provided could be construed as the scores for this Trust by the reader. It was suggested the paper on the website was amended.	**Cath Hill**	Management action	**COMPLETED**

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Medical Director's report (minute 22/083 - agenda item 15 – July 2022) **NEW -** It was noted that junior doctor rotation dates would move to August from 2023 rather than October and the added pressure this creates to support services in HR and medical education at the busiest annual leave time. Dr Munro noted there was a relationship meeting with Health Education England where this could be raised in the first instance to understand what the route of escalation should be.	**Sara Munro**	Management action	**COMPLETED** This matter was raised at the meeting with HEE who advised the decision cannot be reversed however, the Trust asked if in it could be involved and consulted with before changes are made
Safe Staffing Report (minute 22/015 – agenda item 14 – January 2022) Mrs Woffendin advised safe staffing levels in community teams would be included in the next 6-monthly report.	**Cathy Woffendin**	January 2023 Board of Directors' meeting	
Six-monthly safer staffing report (minute 22/082 - agenda item 14 – July 2022) **NEW -** Dr Proctor asked for the next six-monthly report to include information about staff who have successfully attained promotions to band 7 and above.	**Cathy Woffendin**	January 2023 Board of Directors' meeting	

NHS
Leeds and York Partnership
NHS Foundation Trust

CLOSED ACTIONS

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Report from the Chief Executive (minute 22/050 - agenda item 7 – May 2022) It was agreed the work around health inequalities would be added to the Board-to-Board agenda for the September meeting. Mrs Hill agreed to add this to the programme.	**Cath Hill**	Management action	**COMPLETED**
Report from the Chair of the Mental Health Legislation Committee for the meeting held on 3 May 2022 (minute 22/053 - agenda item 10 – May 2022) It was agreed that Liberty Protection Safeguards and concerns about case-law would be added to the Board development session on 9 June so the Board could be advised on the level of risk around this. Mrs Hill agreed to add this to the programme.	**Cath Hill**	Management action	**COMPLETED**
Report from the Chair of the Mental Health Legislation Committee for the meeting held on 3 May 2022 (minute 22/053 - agenda item 10 – May 2022) The Board agreed that Human Rights Act training for Board members would be added to the Board development programme.	**Chris Hosker / Oliver Wyatt**	Management action	**COMPLETED** This has been added to the programme for the 13 October 2022

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Approval of the changes to the Trust's Constitution (minute 22/061 - agenda item 19 – May 2022) The Board asked for there to be a communication plan put in place to ensure the change in age for members is communicated widely.	**Cath Hill**	Management action	**COMPLETED** The Corporate Governance Team have agreed a plan for communication of the change in eligibility to be a member which will be implemented over the coming weeks
Report from the Chief Operating Officer (minute 22/030 – agenda item 12 – March 2022) Mrs Forster Adams agreed to bring a report back to a private Board meeting that set out information around future plans for service provision within the most challenged services for the Board to consider.	**Joanna Forster Adams**	July and September Board of Directors' Board meeting	**COMPLETED** The draft Clinical Services Strategic Plan is on the agenda for the July private Board meeting
Chief Financial Officer's Report (minute 22/031 – agenda item 13 – March 2022) The Board agreed that Mrs Hanwell would look at the timing of sessions for the Board and the Council of Governors in regard to a workshop to look at the detail in the financial plan.	**Dawn Hanwell**	Dates to be confirmed	**COMPLETED** This has been scheduled for the Board-to-Board meeting in September 2022

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
7

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Executive's Report
DATE OF MEETING:	29th September 2022
PRESENTED BY: (name and title)	Dr Sara Munro – Chief Executive
PREPARED BY: (name and title)	Dr Sara Munro – Chief Executive

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	✓
SO3	We use our resources to deliver effective and sustainable services.	✓

EXECUTIVE SUMMARY

The purpose of this paper is to inform the Board of Directors on some of the activities of the Chief Executive which are undertaken to support the delivery of the Trusts strategic objectives and other important matters for the Board to be apprised of.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes please set out what action has been taken to address this in your paper
	No	

RECOMMENDATION

The Board is asked to note the content of the report.

MEETING OF THE BOARD OF DIRECTORS

29 September 2022

Chief Executive's Report

The purpose of this report is to update and inform the Board of key activities and issues from the Chief Executive.

1. Our Services and Our People

As this report covers a period of leave there is only one service visit to highlight which was to the Specialised Supportive living Service. It was great to see more of the diverse care and support the team provides ranging from supporting individuals who can live more independent lives and are active in their local communities through to individuals who require intense support for complex physical health care and challenging behaviour. As with previous visits the staff shone through in terms of true person-centred care and support. The leadership team have reinvigorated the work across the service on shared values and opportunities for learning which were hampered during covid. You will also see in the reasons to be proud section the service has been shortlisted for an award for positive practice for their co production work with service users.

Following the sad and sudden death of Her Majesty Queen Elizabeth II the leadership team quickly responded to ensure we had clear and robust arrangements in place for the national public holiday. This involved direct liaison with service users affected, additional planning to ensure safe staffing and standing up additional on call arrangements. I want to thank all those involved in the preparation and all those who continued to work through the public holiday. We held a special memorial service hosted by Father Sam Cowling Green which was very well attended. Key reflections of the service centred in public service and the importance of the Queen to our veteran's service and staff who have shared their own special thanks to the Crown.

You will note from fellow executive director reports our services continue to face significant demand and are responding to this as well as looking ahead to the implementation of the care service strategic plan which we will cover later in more detail. In addition, extensive planning is

already underway for the winter period, so we have safe and resilient services in place. A key strand of this is our vaccination programme both for Flu and Covid Boosters which has already commenced. The board should also note that we are due to roll out this year's staff survey.

There is as ever a lot going on and the Board is well sighted on the strategic priorities which are enabling us to focus longer term but cannot get in the way of the here and now issues. With that in mind we have held of the first of 2 workshops with senior leaders from all departments. The aim is to develop an integrated and collectively owned set of priorities that link our strategic plans through to our business planning at service level and importantly ensure we have the right level of engagement and culture to deliver. This is a new approach for us and is complex however engagement has been very positive and as an executive team we believe is the best way to enable us to deliver across all our departments over the coming years.

2. National Priorities from the Secretary of State

On the same day as our workshop referenced above the new Secretary of State announced their priorities for the NHS entitled 'Our plan for patients'. A link is enclosed to access the full government briefing. Key headlines are:

- Patients will be informed and empowered through better sharing of data and transparency of information on alternative pathways for their own care.
- Prevention: supporting health lives through screening, home based monitored and expanding mental health support in schools. Supporting people to remain or return to employment is also included.
- Primary care and meeting public expectations on access to GPs through access targets, technology and expanding the role of pharmacies.
- Improving performance and productivity across 4 key areas;
  Ambulances – expanding 111, reducing ambulance response times and handover delays, creating additional bed capacity for the winter.
  Backlogs – reducing elective waiting times with new targets set for the next 3 years, expanding community diagnostics, prioritising urgent treatment for conditions such as cancer, better use of data and digital to increase productivity and patient choice.
  Care – additional investment of £500 million for social care to support discharge from hospital and free up beds. Recruitment campaigns to expand the social care workforce.

Investment in IT to free care staff up. Delivering on the ‘cap and means test’ reforms by October 2023.

Doctors and Dentistry – freeing up GPs to deliver more direct care to their patients and changing the dental contract to encourage more dentists to take on NHS work and expansion of the wider dental workforce.

To support all these additional actions related to workforce are also described:

- incentivising staff retention and the return of retired staff, by creating additional pension flexibilities and correcting pension rules regarding inflation
- keeping the emergency registers of health professionals for 2 more years
- recruiting more skilled staff from overseas and making it easier for qualified health professionals to practice here
- recruiting more people to work in care, both from the UK and internationally
- supporting new models of care and new roles for frontline health professionals, including expanding the number of mental health practitioners in primary care and strengthening mental health support in schools
- supporting the NHS and social care to make the most of digital technology

The full report can be found through the following link.
https://www.gov.uk/government/publications/our-plan-for-patients/our-plan-for-patients

There is limited mention to mental health, learning disability and autism services in this the plan but we are clear as a Trust and as a sector that we continue to have a clear mandate to expand and deliver against the long-term plan priorities.

At the time of writing this report we are still awaiting publication of the new operating model for NHSE and the revised long term plan trajectories which have been delayed due to changes in the ministerial roles and the national period of mourning.

At a meeting of sector CEOs and the national mental health team in NHSE earlier this month we were assured the national commitment of increased growth to our sector over the next 2 years has not changed and are now discussing what the priorities should be post the long-term plan

trajectories. At a regional level we have a meeting planned for October with the regional mental health team in NHSE and mental health providers to discuss, debate and agree how best we work at place, ICS, region and national to ensure we don't have duplication and over burdensome assurance processes.

3. Our Partnerships

West Yorkshire Integrated Care System

During September the West Yorkshire ICB has held a Partnership meeting in public and a meeting of the Integrated Care Board in Public.

It is not possible to distil all the areas of discussion so I will list the key areas of focus;

- Insights from Healthwatch on citizen feedback across all health and care services in West Yorkshire
- Elective recovery plans
- Financial strategy and principles for how we work as a system
- Progress report on equality, inclusion and diversity.
- Children and Young People's health needs and priorities for the future.
- System performance covering urgent and emergency care including ambulance response times, cancer, elective, IAPT, dementia diagnosis rates, primary care access and key workforce data.
- Poverty and the impact of the additional cost of living crisis on our most vulnerable citizens.
- Capital priorities and risks for the system.
- Winter planning.

All documents can be accessed on the West Yorkshire Partnership website.

The Leeds Health and Care Partnership

The Leeds Health & Care Partnership continues to evolve. Whilst the introduction in statute of Integrated Care Systems and the Integrated Care Board has brought about some significant changes, in Leeds and West Yorkshire the partnerships were already highly developed and

continuing to evolve. The following areas were highlighted to the committee at its public board meeting that was held on the 22nd of September at New Wortley Community Centre.

- The three sub-committees of the Leeds Committee of the ICB have now all met at least once and membership of the committee itself is in place. The Sub-committees (Delivery and Inequalities, Finance and Best Value and Quality & People's Experience) are responsible for seeking assurance on behalf of the committee that in each area of the Triple-Aim of Outcomes, Experience and Finance the partnership is sustaining good care and financial balance and making progress in areas of improvement. Finance and Best Value will also have the task of reviewing major business cases and financial plans. All partner organisations are represented on each and each has an independent chair.

- Within the city we already have a range of Population and Care Boards alongside the Partnership Executive Group. Without increasing the number of meetings and where possible rationalising them we have over the last year been clarifying and strengthening the role of these with a particular emphasis on how they interact with each other (and local care partnerships) to prioritise and deliver improvements in care and outcomes for and with the population. Clinical and professional review of data and insights from the public is creating a strong person centred and population health focus to their work. This will continue to evolve. Leeds was selected as one of the national NHS England Place Based Partnership pilot sights for testing population health. This has enabled us to look with the support of external expertise at our leadership and Governance, our Financial Stewardship approach, and the use of data to empower change. All partner organisations have been involved. The national team saw Leeds as already having a strong population health management approach and at the same time there were areas where we needed to improve, around data and intelligence. The Partnership Executive Group reviewed the work and recommendations at its last meeting in early September.

- A small group of Chief Officers have been working together to produce a shared mandate/common narrative articulating the assets of the partnership, our priorities and key building blocks if we are to progress delivering our part of the Health & Wellbeing Strategy and Vision. This is currently going through its final review with a wider group of colleagues before sign-off at the start of October. We will be sharing with the Committee at that point. It pulls together much of what we have already been doing and the way we work. Its purpose

is to both provide a strong articulation of the Leeds Health & Care Partnership externally and provide a mandate and articulation to our own city leadership and colleagues. The city communication colleagues are developing the accompanying products and communication plans

4. Reasons to be Proud

Awards Nominations

There have been a significant number of teams and individuals nominated and now shortlisted for awards over the past couple of months and I hope I have managed to capture them all below

- **LYPFT Vaccination Team** : shortlisted for HSJ Patient Safety Award 2022: Improving Health Outcomes for Minority Ethnic Communities
- **Three specialist services :** nominated at Positive Practice in Mental Health Awards
  - Leeds Autism Diagnostic Service
  - Specialised Supported Living Service
  - Veterans High Intensity Service
- **Tara Mitchell** : finalist for Mental Health Social Worker of the Year at the Social Worker of the Year Awards 2022
- **Michael Muggridge** : shortlisted for the National Advisor award at the LGBT Health Awards 2022 for his work on the Health Inequalities Task Group
- **Red Kite View** : finalist for the Best Collaborative Arts Project at the Building Better Healthcare Awards 2022 and shortlisted in the Mental Health Innovation of the Year category at the HSJ Awards 2022
- **Communications Team** : shortlisted for Best Use of Digital Communications and Engagement at NHS Communicate Awards 2022 for Red Kite View staff recruitment campaign

Team of the Month – Julys Winner

Westerdale Ward – Clifton House

"On the 14th April, a patient physically assaulted staff and was placed in seclusion. Weeks later and whilst still in seclusion he assaulted a further staff member. A referral was submitted to medium secure care and for the past three months the processes of assessment, clinical discord between services and an arbitration process resulted in him remaining in seclusion.
"Supported by the wider Trust; PMVA team, restrictive practice, safeguarding, MHA Office to name a few, the team have maintained their compassionate care abilities despite the therapeutic relationship with the patient being significantly impacted.
"I am immensely proud of their integrity and dedication under such challenges and nominate them for this award". **- Nominator**

"This submission embodies the work of the Trust in supporting an individual to provide high quality care despite challenging circumstances.
"It shows how important strong teamwork is and the importance of supporting each other."
- Judges

Research Heroes

Research Heroes is a new initiative launched by our Research and Development Team (R&D)

- They are individuals or teams who are part of a hidden army of staff supporting research across the Trust and beyond
- We want to take the opportunity to celebrate their contribution and thank them for making a difference

September's Research Heroes are…
Jennifer Mcintosh, Professional Lead for AHPs, Dietitian
Hannah Curran, Specialist Dietitian
Jennifer and Hannah are conducting a Randomised Control Trial of Continuous Enteral Feeding vs Bolus Feeding for Adolescents with Anorexia Nervosa

Dr Sara Munro
Chief Executive
23rd September 2022

Chair's Report

AGENDA ITEM
8

Name of the meeting being reported on:	Workforce Committee
Date your meeting took place:	1 August 2022
Name of meeting reporting to:	Board of Directors – 29 September 2022

Key discussion points and matters to be escalated:

Issues to which the Board needs to be alerted:

- No issues to which the Board needs to be alerted.

Issues to advise the Board on:

- The Committee considered the workforce risk and agreed the following wording: *There is a risk that we fail to deliver a culture and environment that recruits, retains, and attends to the wellbeing of staff to enable them to be their best and deliver quality services now and in the future.*

- The Committee received the control improvement audit on the new workforce governance structure which provided an analysis of the current position and areas for development. The Committee welcomed the findings and noted the actions to be taken forward.

- The Committee was concerned to note that clinical supervision performance had dropped significantly since the figures were last reported in May 2022. The Committee also noted that appraisals performance showed little improvement at 65% but heard that the launch of the new appraisal platform had been brought forward to early September 2022 which should help to address this. The Committee continued to keep a focus on these two areas and requested that further updates were provided at the October meeting.

- The Committee received the People and Organisational Development Governance Group Chair's Report and noted that conversations were taking place with mental health collaborative partners about their approach to Covid-19 sick pay and isolation. The Committee understood that the Trust's current arrangements for Covid-19 sick pay would be continued until the end of September 2022 when they would be reviewed again. The Committee also received an update on the 2022/23 Pay award and noted that various eventualities were being planned for.

- The Committee received the Wellbeing Guardian Report and noted the positive impact of the wellbeing visits which allowed the team to get direct feedback on what could be done to further support managers and their staff. The Committee heard that staffing shortages was a key area causing stress for staff.

- The Committee agreed to align its strategic discussions to the four ambitions set out in the People Plan, providing an opportunity for 'deep dive' sessions into the following areas: Looking after our people; Belonging in the NHS; New ways of working and delivering care; and Growing for the future. The October session would focus on new ways of working and delivering care and would look at topics such as digital innovation, agile working, and the redesign of services.

Things on which the Board is to be assured:

- The Committee received a first draft of the high-level performance dashboard which was aligned to the four ambitions of the People Plan and noted the ongoing work to develop workforce performance reporting.

- The Committee received the 2022 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) results and progress against the actions ahead of the September Board of Directors' meeting. The Committee also received assurance that the WRES and WDES and Gender Pay Gap data for the reporting period would be submitted in August 2022 and actions would be published on the Trust's website by October 2022 to meet the statutory reporting requirements.

Items to be referred to other Board sub-committees:

- No items to be referred to other Board sub-committees.

Report completed by:	Helen Grantham August 2022

Chair's Report

AGENDA ITEM
9

Name of the meeting being reported on:	Mental Health Legislation Committee
Date your meeting took place:	Tuesday 9 August 2022
Name of meeting reporting to:	Board of Directors (29 September 2022)

Key discussion points and matters to be escalated:

Issues to which the Board needs to be alerted:

None.

Issues to advise the Board on:

- The Committee will be reviewing the content and presentation of the quarterly Mental Health Legislation Report with the aim of making this more meaningful and honing the focus on improving practice over time.

Things on which the Board is to be assured:

- The Committee received a comprehensive "peer review" analysis following the failings identified by CQC at Norfolk and Suffolk NHS Foundation Trust and were assured that with the exception of one area levels of awareness and robust plans are in place at our Trust.

- The Committee received a report on service users detained for long periods including those who are out of area and were assured that there are appropriate review mechanisms and governance frameworks in place for all service users detained under the MHA, particularly those that are detained for an extended period of time.

- A full range of comprehensive and widespread Human Rights training will be rolled out across the Trust starting with the Board in October with the aim of embedding Human Rights in the Trust's approach and training Human Rights practice leads who will champion this approach. This will provide good underpinning preparation for forthcoming legislative changes.

• Mandatory training levels for Mental Health Legislation remain sound at 85% overall and both mandatory and bespoke training is being delivered in a flexible way. • The Mental Health Legislation Operational Steering Group has made excellent progress in ensuring meaningful service user representation and involvement.	
Items to be referred to other Board sub-committees: None.	
Report completed by:	Sue White – 3 May 2022

Chair's Report

AGENDA ITEM
10

Name of the meeting being reported on:	Audit Committee
Date your meeting took place:	Tuesday 16 August 2022
Name of meeting reporting to:	Board of Directors (29 September 2022)

Key discussion points and matters to be escalated:

Issues to which the Board needs to be alerted:

A private meeting of Audit Committee members; Sharron Blackburn, Deputy Head of Internal Audit; and Emma Shippey, Senior Internal Auditor; took place prior to the main meeting commencing. The committee noted that from an internal audit perspective there were no matters of concern that needed to be brought to the committee's attention.

Subsequent to that meeting, Helen Higgs (Managing Director and Head of Internal Audit at Audit Yorkshire) set out a change to Audit Yorkshire's operating model which will see the appointment of a strategic lead for audit and assurance services. She advised that this would be Sharron Blackburn, who's role will be to improve the team's knowledge of the Trust at a more strategic level, placing them in a better position to help support the Trust to continuously improve. This will mean that in addition to regular one to one meetings, Sharron will aim to attend some key strategic meetings (Board, sub-committee, senior management meetings) as appropriate, and generally be more visible and available for support and advice.

Issues to advise the Board on:

- The committee received and reviewed the Internal Audit Progress Report. It noted the report provided information and assurance on seven internal audit reports where significant assurance had been given. The committee also noted there were two limited assurance reports in relation to "Service Users' Property and Money" and "Care Plans and Clinical Risk Assessments". The Committee agreed to defer consideration of these reports until its next meeting scheduled for 18 October 2022, as the Executive Directors with oversight of these areas were unavailable to attend the August meeting which had been convened at relatively short notice.

- The Committee received and agreed the Local Counter Fraud Annual Work Plan. It noted the plan was structured around the areas of strategic governance; inform and

involve; prevent and deter; and hold to account. The committee will receive updates on progress against the plan at each of its meetings.
Things on which the Board is to be assured: • The committee received and supported the Health and Safety Annual Report. The committee recommended this report is shared more widely with the Board and / or its sub-committees to better disseminate its contents across the governance structure. Discussions are ongoing to look at how this might be done without introducing undue duplication. • The committee received an update on outstanding audit actions and was assured these actions were being dealt with in an appropriate way with the Executive Risk Management Group being sited on these actions. • The committee reviewed the responses to the annual committee effectiveness questionnaire. The committee discussed the comments that had been provided and concluded it was working effectively, in accordance with its terms of reference and to best practice as set out in the HFMA Audit Committee Handbook. It also agreed there were no areas of concern to escalate to the Board or changes to make to the way in which it operates.
Items to be referred to other Board sub-committees: • The Audit Committee would like to take the opportunity to remind the chairs of other Board sub-committees they are able to recommend areas for consideration for inclusion on the internal audit workplan by requesting these through their Chair's Report (which are presented to the Board of Directors). This is to ensure other committees are linked into the internal audit assurance process and the plan is informed by any areas of emerging risk or potential gaps in assurance.

Report completed by:	Martin Wright, 21 September 2022.

AGENDA ITEM

11

Chair's Report

Name of the meeting being reported on:	Quality Committee
Date your meeting took place:	8 September 2022
Name of meeting reporting to:	Board of Directors – 29 September 2022

Key discussion points and matters to be escalated:

Issues to which the Board needs to be alerted

- No issues to which the Board needs to be alerted.

Issues to advise the Board on:

- No issues to advise the Board on.

Things on which the Board is to be assured

- The committee received the Little Woodhouse Hall Adolescent Inpatient Service Annual Quality Report. Whilst the report only encompassed the service before the site closed, discussion noted lessons could be learned from the development of the new service and the Red Kite View new build. The committee suggested the Trust reviewed systems to ensure the learning from developments like this informs future service takeovers, newly developed services, and new builds. It agreed to raise this for further discussion at the Board of Directors meeting on 29 September 2022.

- The committee reviewed the Medicines Optimisation Group Annual Report and was assured on the work of this group.

- The committee received a report which contained an independent qualitative review of the current work with outcome measures. It discussed the concerns and experiences relating to outcome measures listed in the report and suggested that members of staff could connect with their peers in acute trusts to resolve these concerns.

- The committee reviewed the Learning from Deaths Report which contained a summary of the learning from deaths for quarter one. It questioned how it could be assured that all previous learning and actions had been embedded across the Trust and was informed of plans to use the IHI's 90-day Learning Cycle to measure the impact of actions.

- The committee received an update on the management of Covid-19 across the Trust. It was assured that the Trust continued to follow all national IPC guidance and that the Director of IPC had daily oversight of all positive cases and outbreak management within the Trust.

Items to be referred to other Board sub-committees: • No items to be referred to other Board sub-committees.

Report completed by:	Dr Frances Healey, September 2022

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
13

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Report from the Chief Operating Officer
DATE OF MEETING:	29 September 2022
PRESENTED BY:	Joanna Forster Adams: Chief Operating Officer
PREPARED BY:	Joanna Forster Adams: Chief Operating Officer Mark Dodd: Deputy Director of Service Delivery Andrew Jackson: EPRR Lead Edward Nowell: Performance and Information Manager

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	
SO2	We provide a rewarding and supportive place to work.	
SO3	We use our resources to deliver effective and sustainable services.	

EXECUTIVE SUMMARY

The report sets out the key management, development, and delivery issues across LYPFT Care Services. It is a summary of activity and aims to provide information that is supported by detailed information reports, intelligence, and operational governance arrangements. On a scheduled basis this report sets out a range of updates including those that are regular or standard, periodic or "one off" together with escalations for information or alert.

This month the report includes:

- System pressures and recovery planning (update)
- Update on: Our EPRR position
- Key service delivery and performance issues
- Reset and Recovery
    - Revised Older Adult Inpatient Model (update on progress)
    - Focus on waiting list recovery (update).

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes please set out what action has been taken to address this in your paper

RECOMMENDATION

The Trust Board are asked to consider the content of this report and highlight any concerns or additional assurance required.

MEETING OF THE BOARD OF DIRECTORS
29 September 2022

Chief Operating Officer: Trust Board Report

1. Introduction

The report sets out the key management, development, and delivery issues across LYPFT Care Services. It is a summary of activity and aims to provide information that is supported by detailed information reports, intelligence, and operational governance arrangements. On a scheduled basis this report sets out a range of updates including those that are regular or standard, periodic or "one off" together with escalations for information or alert.

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    - Focus on waiting list recovery (update).

2. Health and Care System Pressures

2.1 System Flow Programme Update

As previously reported, we are actively working with health and care system partners as a matter of ongoing urgency to manage demand and support the population of Leeds to receive high quality, responsive, accessible, and timely healthcare.

We continue to work in partnership with our colleagues to improve the way in which we meet the needs of people with dementia within the acute hospital. In collaboration with Dementia UK, we have appointed two Admiral Nurses who will work into Leeds Teaching Hospital to support people with dementia, their families, and professionals to ensure the right place destination on discharge, preventing placement breakdown and proactively pre-empt crisis. Furthermore, we are aiming to establish a Mental Health Practitioner within the Leeds System, Transfer of Care Hub to provide expert mental health and dementia advice and support. We aim to have a practitioner in post by the end of October 2022.

Little work has progressed through the Frailty Population Health Management Board over the summer period. Lou Bergin (Clinical Lead) and Eve Townsley (Head of Operations for Older Adult Services) are due to present to the Frailty Board in late September with a focus on improving outcomes for people with Dementia. The content of the presentation has been developed through workshops with representatives of system partners, including clinicians. It will highlight the recommended areas of strategic focus for the city and we will present an update on outputs and agreed next steps in the coming months.

2.2 Health and Care System Pressures – Operational Response

We continue to have sustained challenges across our much of Care Services because of workforce availability (absence and increasing levels of vacancies), high levels of demand for access into services and ongoing recovery of Covid related backlogs.
This is well reported through our service delivery reports to Board with a clear focus on those areas which face challenges. Our Community and Wellbeing Service continues to be our most significant concern. In collaboration with the Governance Lead for the service, the Community and Wellbeing Service has developed a template to a Quality Impact Assessment to measure the impact current challenges have had on the service user population. This will be progressed as the Service meets in early October where they will set out a clear timeframe they intend to work to. This is currently being monitored through the Trust Wide Clinical Governance meeting on a regular basis.

Across the Health and Social Care system in Leeds we continue to operate in ‘Silver’ command. We continue to experience system pressures at various times, often linked with ongoing Covid infection rates. This approach enables us to respond immediately to these system pressures and take necessary action to support the wider system. More latterly the focus has been on the

forthcoming Winter Planning, to identify where we expect the pressures to be and how we might respond as an Organisation, Leeds System and wider into the ICB system.

Following the sad passing of Her Majesty Queen Elizabeth II, a public holiday was announced for the 19th of September. Services were quick to respond to this announcement and made the necessary changes to their service delivery on this day. Where appointments had to be cancelled as services were stood down, all service users were contacted to make them aware. It was agreed that all services that would not normally continue to run on Public Holidays were to be stood down unless it was felt to be too disruptive to their service user group. A few services that would have normally stood down agreed to continue a skeleton service, namely Forward Leeds and Perinatal Community to avoid any unnecessary disruption.

Through the Deployment and Staffing we were able to identify any staffing pressures that may arise due to the Public Holiday, particularly in the inpatient areas. We were quickly assured that there would be little or no impact on the running of services over this period. We also stood up an Incident Response Team meeting to ensure that we were taking all the necessary actions to minimise the disruption to our service delivery. This also enabled us to keep up to date with any instruction from NHSE. There were clear messages across the Trust following these meetings to ensure all staff were kept up to date with developments. This included support for staff who were working to enable them to watch the funeral if they wished whilst as work, whilst ensuring services were not disrupted.

3. Update on ongoing and recently de-escalated incidents

3.1 Pandemic

The Coronavirus pandemic is still being treated as a level 3 incident by NHS England. The Trust is required to provide daily situation reports covering covid cases, symptomatic cases, numbers of beds and instances of no right to reside. Weekly situation reports covering lateral flow stocks and lateral flow test results.

Predictions from the government's Scientific Pandemic Influenza Group on Modelling (SPI-M) are suggesting another wave of covid this winter coupled with a resurgence of influenza. Therefore, it is unlikely that any relaxation of incident levels will be made or if made will persist throughout the coming winter.

3.2 Heatwave

The Trust activated its heatwave plan twice during the summer in the face of unprecedented temperatures. September has brought milder temperatures and by mid-September the Met Office heatwave warning system stands down.

As mentioned in the last report to the Finance and Performance Committee the Trust purchased in the region of 80 cooling devices as well as around 50 fans to assist in keeping our buildings cool. The cooling devices will be collected by stores at the end of September for cleaning, electrical and mechanical testing, and safe storage at Roseville Road. The devices will then be redistributed from mid May 2023 in preparation for next year's summer.

In addition, we have commissioned an independent and expert review of safe and effective air-cooling devices across our Estate. This is expected to result in investment into key operating areas of the Trust in advance of May 2023.

3.3 Cyber attack

The cyber-attack (Ransome Ware) that affected one/Advanced on 4 August 2022 continues to cause massive disruption to affected providers. The attack impacted on the following applications: Adastra, Caresys, Odyssey, Carenotes, Crosscare, Staffplan and eFinancials. The trust was not directly affected by this attack although the impact on Carenotes system affected a significant number of Mental Health Trusts in the country.

System recovery has been advised a fix in weeks and backlog recovery of notes could run to many months. There have been impacts on patient care reported through the incident management arrangements.

Some salutary learning has already emerged from this incident:

- Advance was assessed as being compliant with NHS digital rules for providers on NHS IT systems.
- Providers plans and particularly planning assumptions for impact and duration of a cyber-attack were generally far too optimistic about speed of recovery and extent of the disruption.
- Assumptions that criminal gangs will not target the health sector whilst the pandemic is ongoing are now proven to be without substance.

The impact and scale of the attack brings with it the realisation that absolute protection for NHS systems is not possible and hence a focus on impact limitation, additional supporting strategies and planning for recovery are key tools. This is about business continuity and both care and corporate services clearly understanding the impact a cyber-attack will have on their ability to maintain critical parts of their services.

The Trust is planning a further cyber exercise this autumn looking at a worst-case scenario of a cyber-attack affecting Trust systems for a sustained period.

4. Ongoing EPRR work and priorities

4.1 Preparing for Delivery of the Principles of Health Command (PHC)Training

NHS England unveiled a new approach to EPPR training in June 2022. The new approach called the Principles of Health Command (PHC) training is based on a mandatory training package. The package is delivered to all staff whose roles are identified as meeting the specified training needs contained in the PHC training guide.

The Trust has always adopted a broad identification of staff needing this type of training, but consequences of the new training initiation are that significantly more staff will need training including groups never previously considered – medical staff, workforce staff and facilities staff.

The requirements are also that those delivering training for staff need to have a valid and formal training qualification – specified as level 3. Hence the Resilience lead and the EPRR Officer have successfully undertaking training and work to gain this qualification in August 2022.

4.2 Winter Planning

The Trust is currently developing its winter plan in response to NHS England directions. Guidance received on 12 August 2022 helps frame some of the objectives on this year's plan. For example:

- Planning around ticking an assumed new surge in covid variants and the seasonal influenza via vaccination programmes.
- Increasing capacity outside acute hospitals
- Ensuring timely discharge
- Provision of better support at home – adoption of virtual ward initiatives.

  This year's plan is going to be led by data in a more fundamental way than in some previous years**.** This is particularly true in terms of the two greatest challenges the Trust is likely to face this winter:
- Staffing disruption and low numbers – The workforce information team are being asked to prepare some long-term predications of staffing through until March 2023 based on three different scenarios.

- Capacity and surge – Informatics are being sked to model expected demand for beds through the coming winter to identify any pressure points and areas where advanced planning may be prudent.

  The plan will include EPRR considerations around severe wither weather and potential disruptions.

  We anticipate sharing of our arrangements for winter in October 2022 initially through our Finance and Performance Committee.

4.3 Exercise Arcadia

Exercise Arcadia was a multi-agency tabletop exercise held on 5th September 2022. The purpose was to assess the Northeast and Yorkshire Low and Medium secure decant plan that has been in development during 2022 was fit for purpose to go forward to be finalised and approved by signatory organisation.

The exercise was run via an MS Teams meeting attended by providers, commissioners and ICBs from across West, South and East Yorkshire / Humberside.

A debrief report will be prepared for later in 2022 but preliminary issues identified were about the complexity of a secure services mental health decant. The need to engage with regulators and the ministry of justice to ensure there is wider understanding of chosen relocation sites. Finally, the expectation that the loss of a single ward would potentially mean that the incident became a national level 3 incident as a solution may be needed at national level.

5. Service Delivery and Performance Key Escalations

5.1 Service Lines

We continue to have regular and established governance arrangements in place where we come together, on a weekly basis, to understand the issues in each service line and highlight any hotspots requiring additional support or specific focussed actions. More recently we have strengthened and re-established our arrangements for regular Quality and Performance Reviews – a collective leadership arrangement with intelligence and outputs routed through our Operational and Quality Governance arrangements. (Details of these are outlined in our Governance, Accountability and Assurance Framework – GAAP).

Some of our services continue to experience ongoing pressures particularly relating to capacity and demand, which has been impacted by the sustained workforce availability position:

Adult Community Mental Health Services –has continued to operate in business continuity since November 2021 with continued mitigations in place. The Leadership team has worked tirelessly under difficult circumstances to maintain a good level of service. We continue to see staff leaving the service, despite intensive leadership efforts and support, wellbeing support and retention schemes in place. The positive news is that we have also had small numbers of staff join. As the Executive Team are aware, some elements of the service have been consolidated across broader footprints of where it makes sense to do so to minimise the impact of challenges for our service users most in need. Some of this work has been supported with the help of staff from other parts of the Trust volunteering to undertake this work, particularly within the Depot, Clozaril and Physical Health Clinics. Particular thanks to staff from our Physical Health Team and soe in our specialist services.

The Leadership Team developed a proposal to request additional support form Care Services and the Nursing Directorate through temporary redeployment. This was supported by the Executive Team, and we have seen a positive response to the request which has enabled the CMHT to bolster its staffing position. To date we have identified 7.9wte staff to deploy into CMHT for a period of 6 months to provide additional support and stabilise the current position. This has been achieved through a mixture of staff volunteering and services identifying staff with appropriate skills who can be released with minimal impact on their home service. An incentive package was established for those temporarily deployed to ensure they did not face any financial difficulties because of the changes to their role.

The CMHT has also worked closely with Voluntary and third sector services in developing alternative roles to address the staffing shortages. We anticipate that with the addition of newly appointed Registered Nurses in September/October along with the above actions, CMHT will be sufficiently stabilised to enable a move out of business continuity by the end of 2022.

Older Adult inpatient services – continues to face staffing challenges within the in-patient area. The work on the proposal to undertake a service improvement plan and progress a reduction in the bed base has unfortunately been delayed. This has been due to significant system and staffing challenges which have been exacerbated by covid outbreaks, meaning the focus of the team has had to be on maintaining service delivery. We have also not been able to secure any additional capacity which is essential to lead to improvement work. We have now had the opportunity to revisit the proposal the Exec team supported in early July and the staffing predictions for autumn/winter. Further detailed can be found in Section 6.2 of this document.

Forensic services – workforce availability and level of vacancies remains a key challenge. The service has undertaken a safer staffing benchmarking exercise for Newsam Centre, considering staffing in comparative areas across West Yorkshire and Humber and Nort Yorkshire. A paper has been prepared which is currently going through the robust governance process to ensure careful consideration has been given to the proposal before being submitted through the West Yorkshire Adult Secure Provider Collaborative. The service is also undertaking a skill mix review at Clifton House to ensure we have appropriate staffing levels and skill mix which may assist with some of the recruitment challenges they have faced.

5.2 Key Service Delivery and Performance Issues

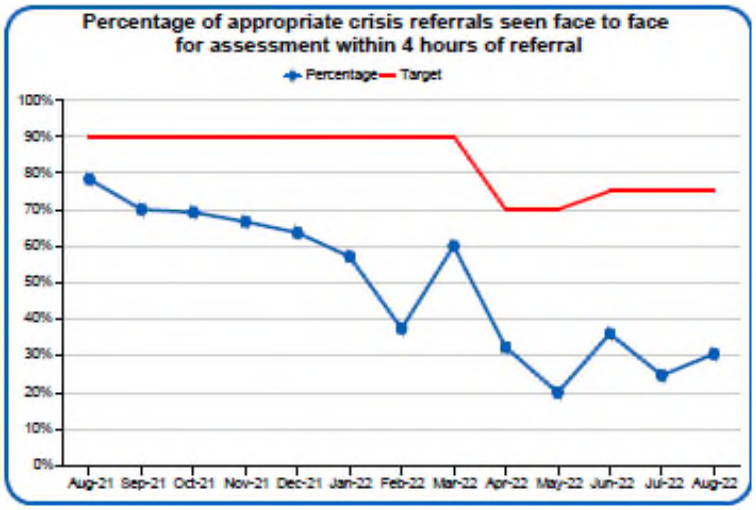
A comprehensive Service Delivery and Performance report is attached in Appendix A. There is significant detail included in this report, but issues of note include:

5.2.1 Alert

There are three key areas that the Board should be alerted to.

Crisis response face to face

In addition to staffing issues, which are resolving slowly, we have been able to determine that the two-step process from SPA triage to Crisis has contributed to the service being unable to achieve this standard. From mid-September, partly due to staffing shortages, Clinical Triage though SPA will cease, and staff will transfer into the Crisis Team. This will result in all calls being triaged by Crisis team staff and therefore reducing the delays in face-to-face assessments. We have found by analysing the data from the point the Crisis Team receives the referral, we have achieved a 65%-80% response rate. We anticipate that we will see a significant increase in the response from October 2022. We will keep this approach under close review to measure improvement and assess sustainability.



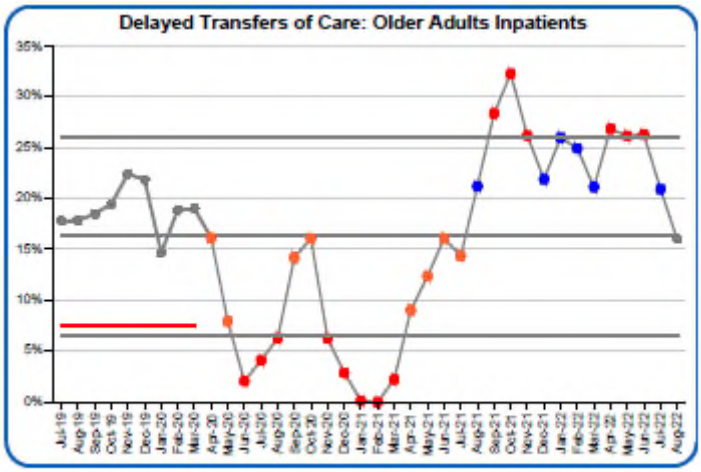
Contactual Target 75%: August 30.6%

Delayed Transfers of Care

In both our Older Adult and Adult inpatient services, we continue to experience significant delayed transfers of care, albeit that we have seen a slight improvement on the previous reporting period.

Our Older Adult Service is more adversely affected with a total of thirteen service users delayed across our four wards and one in an out of area placement. These delays are as a result of very limited access to care home (with or without nursing care) provision. These delays range from one to ten months. It is also worth noting here that the proposed opening of Dolphin Manor, expected late this calendar year, has now been delayed to building works required to the site, with a new expected date of opening being April 2023.

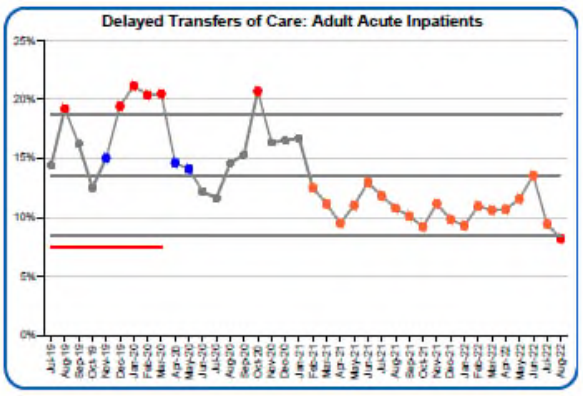
We have currently three service users in an OOA placement one of whom is delayed. We are monitoring these placements through our Care Navigator who is maintaining contact with the Wards and these cases are discussed regularly through the capacity calls. Each service user also has a Social Worker allocated to them to ensure that all actions are being taken to support their current care and identifying their ongoing care needs.



Local tracking measure: August 16.0%

In our Adult Acute inpatients, we have twelve service users experiencing delays. The reasons for these delays range from Ministry of Justice restrictions, housing, community packages of care and access to specialist placements. We have seen a continued positive improvement and stabilisation due to the work of a Housing Officer into the service. This excellent work continues although more recently we have seen a rise in service users with even more complex needs needing specific supported housing. We are working with colleagues in housing to understand where we can support this group of individuals into appropriately supported accommodation. Many of the service users delayed and awaiting supported accommodation have already been rejected from numerous placements due to their risk history. This increases the pressure and wait for those areas where service users will be accepted as a result have led to long waiting list for these places.

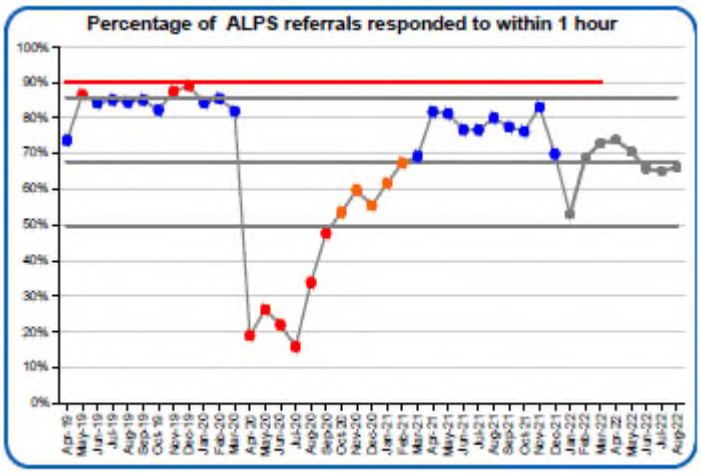
We had experienced delays in accessing Forensic inpatient services. This does continue to be an issue. However, we have seen the numbers decrease as the Forensic has been able to respond to delays as their service has started to stabilise. Thanks to the Leadership Team in Forensic Services for supporting this improvement.



Local tracking measure: August 8.2%

We continue to work proactively through our capacity calls daily and DToC meetings that occur twice a week. These meetings involve discharge coordinators, Adult Social Care and Accommodation Gateway workers.

Acute Liaison In reach response to A and E within 1 hour

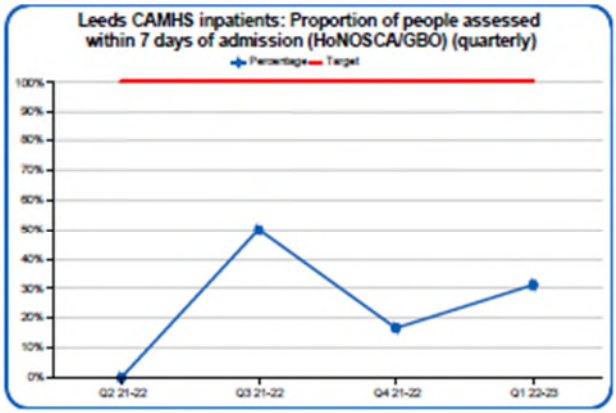


Contractual Target : August 66.1%

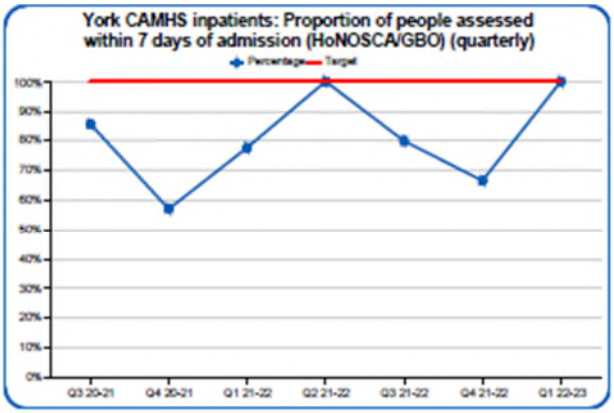
Within the Liaison In reach service, achievement of the 24-hour assessment target has seen a decline in performance with 74.3% of people being seen within 24-hour response time. Staffing challenges, including sickness and vacancies have impacted on capacity to respond. However, we are seeing signs of recovery in September with a reduction in team sickness. This will be a key area of focus for us in the coming weeks and months to ensure that we can maximise our response over the course of the winter period.

5.2.2 Advise

Proportion of CYPMH people assessed within 7 days



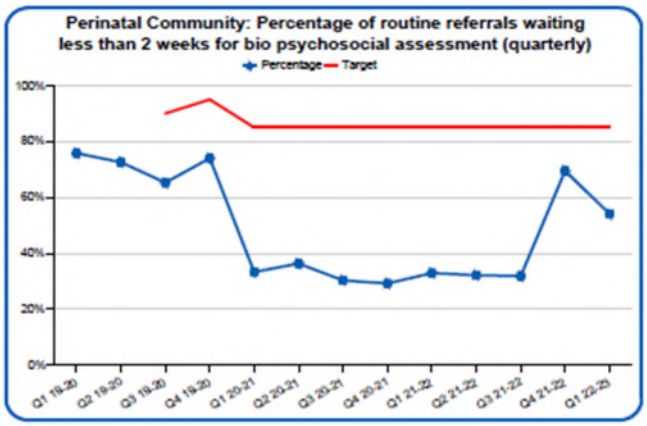
Contractual Target 100%: Q1 31.2%



Contractual Target 100%: Q1 100.0%

The percentage of people admitted to Children and Younger People's inpatient services, with both a Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and Goal Based Outcomes (GBO) assessment completed within 7 days of admission, fell below target in Quarter 1 as previously reported. A further update will be provided in the next COO report as this measure is reported on quarterly.

Perinatal



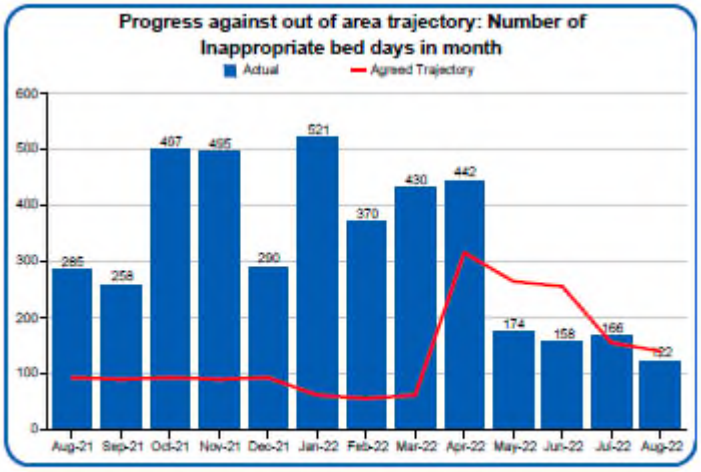
Contractual Target 85%: Q1 54.1%

In Perinatal Services the percentage of women waiting less than 2 weeks for first contact (routine) in Q1 was 54.1%, this is below the 85% target. This has been monitored throughout the summer by the Clinical Lead and Head of Operations and additional steps taken to ensure that the access and response standard is achieved. A further update will be provided in the next COO report as this measure is reported on quarterly.

5.2.3 Assure

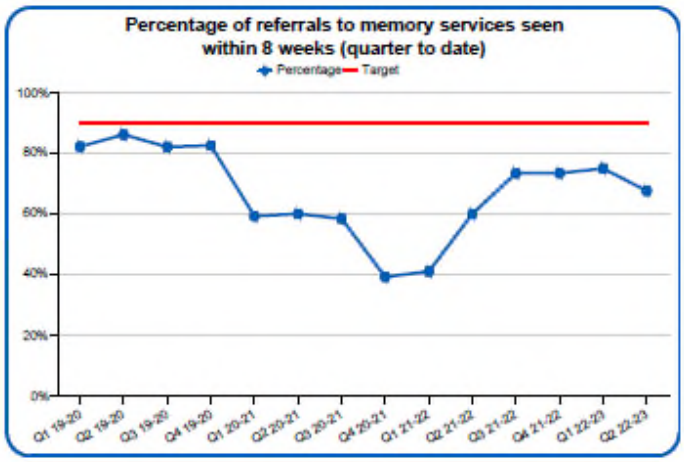
There are three areas to highlight for assurance. They include:

Adult Acute Services out of area placements continue to be at a level below the agreed trajectory. The ongoing work of the Capacity and Demand team together with clinicians and managers, continues to result in very few people being admitted out of area. We saw an slight increase in demand in July as a response to ward closures, due to Covid and high demand for beds.

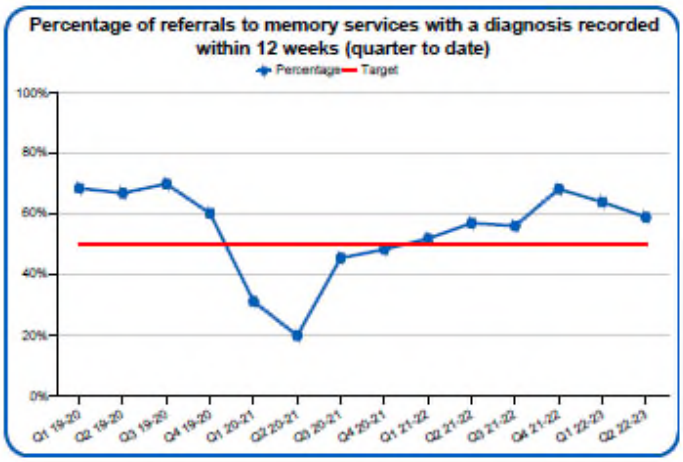


Nationally agreed trajectory (140): August 122 bed days

Memory Services



Contractual target 90%: Q2 22-23 67.5%



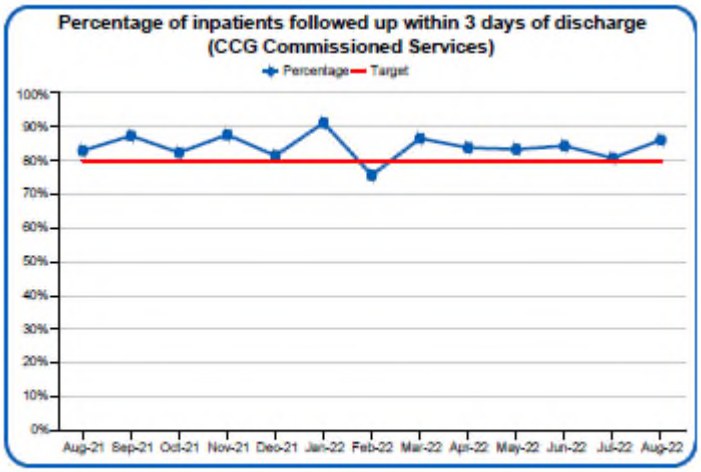
Contractual target 50%: Q2 22-23 58.9%

We have seen a continued increase in referrals to MAS and we have largely maintained our clinical contacts at a consistent level. We have also seen some recent improvements in relation to 15-day access target. There has been a reduction in the numbers of people seen within the agreed 8 weeks for an assessment which is partly due to staff unavailability, predominantly due to increased vacancies over this period. This has also had a negative impact on the 12-week diagnosis target.

We are continuing to work with the Continuous Improvement Team to evaluate the service in order to refine how we deliver the service and understand the local variation in service delivery. The team have identified some data quality issues in one locality that they are working on to improve which has also impacted on the performance data.

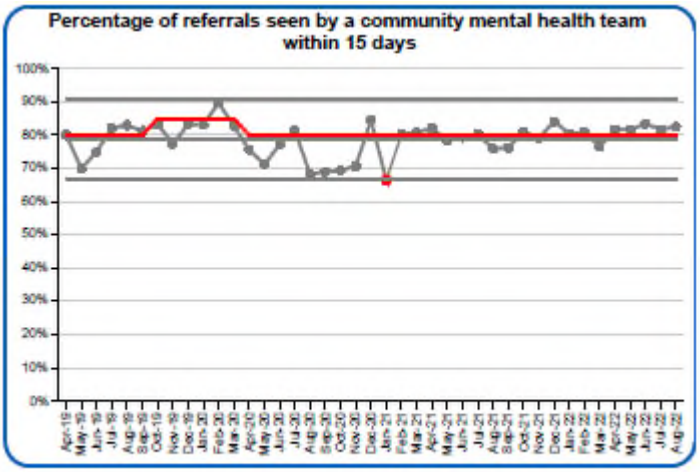
The service continues weekly monitoring of the CT Head scanning wait times continues and has demonstrated a largely improving picture. A further meeting with LTHT senior managers has been held to review the collective actions taken to date. All urgent CT and MRI scans are being undertaken within 3-4 weeks of referral, which is back in line with LTHT normal writing times. Routine scans at taking roughly 12 weeks from referral although we continue to see this improve. It is anticipated that by late October or early November the wait times will have reduced to 6 weeks for routine scans as per LTHT standard wait times.

People followed up within 72 hours of discharge is a key safety measure which we are consistently achieving. This is closely tracked and monitored to ensure that we support people in this transition time post discharge. We continue to maintain a position that meets the target set by the ICB.



Contractual target 80%: August 86.1%

Community Mental Health Services, continue to face staffing challenges as discussed previously, despite this we continue to achieve high levels of access and response within 15 days of referral.



Contractual target 80%: August 82.5%

6. Reset and Recovery of Care Services

6.1 Approach

We continue to implement our reset plans across all Care Services. As previously briefed these have developed into business plans/objectives and have influenced the content of the Care Services Strategic Plan. We have business plan priorities for each of our services which are already being used to support objective setting and importantly to aid discussions with staff in the appraisal process. Appended is an example of the posters developed to illustrate what we are working on in services during 2022/23. This example is for our Learning Disabilities Service line. A complete set will be available to members of the Finance and Performance Committee in October for information – but are now being used in Services. We have clear milestones that are being updated on a quarterly basis as part of our normal operating processes.

6.2 Update on Stabilisation of Older Adult Inpatient Services.

Our Older Adult inpatient services have been at the forefront of responding to Covid19 however, the longevity of the pandemic and prolonged recovery period has resulted in the service experience pressure in their workforce. We continue to require a high level of additional staff to meet the needs of service users whilst experiencing increased rates of sickness and vacancies. The leadership team developed a stabilisation plan aimed to improve care delivery and staff experience across our in-patient services.

The work on the proposal to undertake a service improvement plan and progress a reduction in the bed base has been slow due ongoing staffing challenges and recent Covid outbreaks. The identification of appropriate project leadership capacity has proved more challenging than initially

thought given our ongoing staffing pressures. We are exploring options to be able to expedite this given the importance of stabilising the service in preparation for winter. We continue to work on the project milestones that are being finalised in the PID and demonstrate the critical pathway and Quality Impact Assessment (QIA) which will be shared through our Clinical Governance processes.

As part of the stabilisation plan process, we have engaged staff from across all areas affected by the plan and sought their feedback which has been mixed. From an inpatient perspective, the consistent feedback is that staff are concerned about the proposed clinical model but are also frustrated with the current situation and are keen for an alternative to be enacted.
The service will continue to take steps to address the concerns set out in the plan and engage staff to ensure service improvements can be taken to progress this work.

6.3 Focus on Waiting List and Backlog Recovery

A detailed section on waiting list recovery is included in the appended Service Performance report. It includes a summary of baseline waiting times from year 2019/20 and the current waiting time from recent months. Each service area listed has produced a summary of the current position and action taken. In the context of backlog recovery, the following points are highlighted.

6.3.1 Alert

ADHD: The average time to first contact reduced in August but was still an average of 50 days above the 2019/20 baseline. In reality this reduction is artificial as it is due to service users moving out of area as up to 20% of those waiting were students. Waits are contributed to significant staff vacancies including 50% of the nursing establishment and the substantive Consultant Psychiatrist. More positively, the Consultant post has been covered by a locum which is working well at present, with the permanent post recruited to, with them due to start in November 2022.

With the aim of improving accessibility and the offer to people with ADHD, we continue to develop our work on capacity and flow engaging with Primary Care and system colleagues to start discussions on system redesign. As part of this work at a West Yorkshire ICS has commenced a ‘deep dive’ over the next 18 months.
Capacity and demand modelling is being refined and will be included in the November Public Board report.

Chronic Fatigue Service: The average time to first contact (assessment) has remained static despite an increase in referrals to the service. The service is fully recruited but sickness has impacted on capacity and availability of our therapists. We have reduced our group capacity to focus on 1-1 interventions and short-term posts have been advertised but we have been unsuccessful in attempts to cover long term sickness. We are exploring alternative solutions but at this point do not anticipate any significant improvement in waiting times.

LADS: The service continues to experience high rates of referrals which impact significantly on the waiting list. The monthly referrals have seen an increase of approximately 33% this year compared to a similar period in 2021/22. The service is reviewing the referral and assessment processes to improve flow and reduce the time it takes from referral to diagnosis.

6.3.2 Advise

CMHT OPS: We have seen a marginal increase in the average time to first contact within these services. This has been because of staffing vacancies and sickness, in addition to different practices across the localities. This variation in practice is being explored by the Senior Management Team to ensure a consistent approach to referrals. It is anticipated that this work, in addition to addressing the vacancies and sickness, will enable the service to be more responsive to referrals. The outputs from this work will be mapped to forecast trajectories and surveillance undertaken as part of our performance management governance arrangements.

CMHTs Adult: There has been a slight improvement on the average time to first contact within CMHTs over recent months, however the waiting list remains at a similar level. This is despite remaining in business continuity with high rates of vacancies. Significant work has been undertaken to re-model the service to mitigate against the impact of significant staff availability constraints. The service has been supported by other service lines to bolster their staffing compliment. This, together with ongoing recruitment and the support of the VCSE organisations is expected to see the service gradually recover from its current position later this calendar year.

Gender Services: The referral rate for the Gender service remains high at over 100 per month, with a significant increase in August. Strategically the demand for Gender Services continues to be a concern for LYPFT and other providers and this is being discussed at a national level through the MH Network.
Internally there has been an operational challenge delaying registration of referrals. The service is taking steps to recover this position over the next few months. The service has seen some slight

delays over the summer months due to sickness and vacancies, however they continue to implement the strategy developed because of the new investment from NHSE last year.

Leeds LD Community: The CLDT waiting has continued to reduce over the past 12-18 months to a more stable position. We have recently seen a spike in the waiting times because of staff vacancies and absence. There has also been an increased backlog for service users requiring further assessment of their complex needs such as IQ assessments to establish eligibility. We have also seen the level of complexity and acuity of referrals increase, which has increased alongside some system and process concerns which have led to a lack of flow and discharge and has collectively meant that the waiting list has not reduced to fully manageable levels.
We are confident that, with some recent recruitment alongside a psychiatry review and some other planned interventions that we will start to see a gradual reduction in the waiting list over the next quarter in LD services.

Liaison Out-Patients: There has been a further reduction in the average time to first contact over the reporting period. We have however, seen an increase in waiting lists which correlates with an increase in referrals to the service. The team are maximising all available capacity by mainly utilising the virtual platform, Attend Anywhere, to improve our accessibility, options for people and waiting times.

Memory Assessment Service: We have seen a steady increase in the waiting list over the past year and a slight reduction in our response rates. This is predominantly due to staffing vacancies and sickness within the service. There have also been some issues regarding the quality of the data in some of the localities which is being addressed by the service. The response rates have also been adversely affected by the wait for CT/MRI scanning, which has now all but been resolved with the provision of these tests resuming back to pre-pandemic response times.

6.3.3 Assure

Deaf CAMHS: The service has seen a significant improvement and recovery on the waiting time, half that of the baseline year. The waiting list is at its lowest for over three years. This has been because of work that has been undertaken to make changes to their reporting processes to ensure this reflects their current post pandemic practice. We do see seasonal variations, with peaks in referrals prior to and after the school summer holidays. The service is fully aware of the variations across the year and can respond to the changes in demand as they occur.

Gambling Services: Identified through our service recovery processes, additional resource has been committed to the service to complete front end assessments which have successfully and consistently reduced the waiting time since the start of Q1. There had been an increase in referrals during August which contributed to a slightly longer time to first contact during this period. The service has had 4 vacancies due to staff leaving and commencing maternity leave which has slightly impacted wait times during this period. We anticipate that we will continue to improve the wait times as the staffing position improves.

Veterans: The waiting list for Veterans (CTS) has remained consistent around 30 to 40 days. The increased waiting times have been because of a concentration of referrals within the north-east patch. We have flexed staff across the region as much as possible and have tried to recruit multiple times with limited success. We anticipate that we will be able to reduce our waiting list significantly by 2023 which has been agreed with our NHS England commissioners.

7. Summary

Care services continue to face significant workforce challenges across all areas. As a priority to partially address this in some of the worst affected areas, mainly our Adult CMHT, we have reluctantly taken the decision to temporarily deploy a small (but invaluable) number of additional staff from other areas. This will help us to continue to provide essential care. Other areas, Older Adult in-patient areas and Forensic services have made use of our Responsive Workforce Team and temporary contracts to bolster their staffing. All areas continue to take steps to recruit and retain staff with a small degree of success. We have recruited newly qualified Nurses from local universities as previous years, but we have seen a decline in these numbers this year. We have also engaged out VSCE partners to support the delivery of our services.

We continue to face several service delivery challenges post pandemic with services focussed on recovery from the Pandemic. Services now have better understanding of the backlogs and waits and have taken steps to address these, however these have been further impacted by the staffing challenges. In addition to this we are also facing the challenges that will result from the system pressures we experience as we move into the Winter period, along with the cost-of-living crisis.

Joanna Forster Adams
Chief Operating Officer

Andrew Jackson

EPRR Lead

Mark Dodd

Deputy Director of Service Delivery

September 2022.

Introduction

Key themes to consider this month: **Unless otherwise specified, all data is for August 2022**

Consistency and improvement:
We continue to have sustained challenges across our much of Care Services because of workforce availability (absence and increasing levels of vacancies), high levels of demand for access into services and ongoing recovery of Covid related backlogs.

We have mitigating and monitoring actions in place to minimise the impact on the safety and quality of care we deliver to the people who use our services. (An improved process evaluating the quality impact of ongoing workforce challenges is being developed as part of the Safer Staffing arrangements we have in place and will be reported thematically through the autumn and winter period).

One area of most concern currently, and has been for some time, is the Community and Wellbeing Service. Across the Health and Social Care system in Leeds we continue to operate in 'Silver' command. We continue to experience system pressures at various times, often linked with ongoing Covid infection rates. This approach enables us to respond immediately to these system pressures and take necessary action to support the wider system. More latterly the focus has been on the forthcoming Winter Planning, to identify where we expect the pressures to be and how we might respond as an Organisation, Leeds System and wider into the ICB system.

As a result of the continued challenges and pressure on services, performance is affected in some areas. Whilst some improvements against key performance indicators have been seen in some services, consistency, and improvement in other areas of the Trust is a fluctuating picture.

Areas where performance has been impacted/are below target are the percentage of appropriate crisis referrals seen face-to-face for assessment within 4 hours of referral, the percentage of service users seen at least 5 times in the first week of receiving Crisis Resolution and Intensive Support Service (CRISS) support, the percentage of assessments attempted by Liaison In-Reach within 24 hours, the percentage of referrals to Community Learning Disability Teams seen within 4 weeks and the percentage of referrals to the Memory Assessment Service (MAS) seen within 8 weeks.

However, there are some services where, despite significant challenges, access and response standards have been maintained. They include the percentage of referrals to the Early Intervention in Psychosis service seen within 2 weeks, the percentage of referrals to Community Mental Health Teams seen within 15 days, the percentage of referrals to MAS with a diagnosis recorded within 12 weeks and the percentage of inpatient discharges followed up within 3 days.

Work in Progress:
As part of the reset and recovery of Care Services work, services have been using some of the available national demand and capacity modelling tools. Services have started this work and it is providing good insight into the management of waiting lists, the resources required to bring them back to sustainable levels, the length of time it will take to reach a position of recovery to business as usual and has highlighted where more focus is needed on recording of information. A presentation with updates on this work was given to Heads of Operations, with an invitation to take up the offer of support in this area reiterated to services that have yet to participate.

Updates on action plans and progress against these, will be presented as part of the CQPR Appendix accompanying the Chief Operating Officer Report tabled at public board meetings. The August report is the second report to include this section, for which services have provided an update on their plans to address backlogs and address waiting times.

Service Performance - Chief Operating Officer

Services: Access & Responsiveness: Our response in a crisis	Target	Jun 2022	Jul 2022	Aug 2022
Percentage of crisis calls (via the single point of access) answered within 1 minute *	-	58.0%	54.6%	56.4%
Percentage of ALPS referrals responded to within 1 hour	-	65.7%	65.2%	66.1%
Percentage of S136 referrals assessed within 3 hours of arrival	-	26.7%	15.2%	10.7%
Number of S136 referrals assessed	-	45	46	56
Number of S136 detentions over 24 hours	0	1	4	3
Percentage of appropriate crisis referrals seen face to face for assessment within 4 hours of referral	75.0%	36.1%	24.7%	30.6%
Percentage of service users who stayed on CRISS caseload for less than 6 weeks	70.0%	87.1%	80.4%	88.0%
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support	50.0%	41.2%	42.7%	44.3%
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services	**Target**	**Jun 2022**	**Jul 2022**	**Aug 2022**
Gender Identity Service: Number on waiting list	-	3,626	3,666	3,718
Deaf CAMHS: average wait from referral to first face to face (inc. telemedicine) contact in days **	-	34.34	20.85	-
Community LD: Percentage of referrals seen within 4 weeks of receipt of referral	90.0%	78.9%	55.3%	75.6%
Leeds Autism Diagnostic Service (LADS): Percentage starting assessment within 13 weeks (quarterly)	-	16.9%	-	-
CAMHS inpatients: Proportion of people assessed within 7 days of admission (HoNOSCA / GBO) (quarterly)	100.0%	38.9%	-	-
Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency) (quarterly)	-	50.0%	-	-
Perinatal Community: Percentage of routine referrals waiting less than 2 weeks for bio psychosocial assessment (quarterly)	85.0%	54.1%	-	-
Perinatal Community: Total number of distinct women seen in rolling 12 months (quarterly)	766	727	-	-
Perinatal Community: Face to Face DNA Rate (quarterly)	-	17.6%	-	-
Services: Our acute patient journey	**Target**	**Jun 2022**	**Jul 2022**	**Aug 2022**
Number of admissions to adult facilities of patients who are under 16 years old	-	0	0	0
Crisis Assessment Unit (CAU) bed occupancy	-	88.9%	81.7%	88.7%
Crisis Assessment Unit (CAU) length of stay at discharge	-	10.38	10.33	7.18
Liaison In-Reach: attempted assessment within 24 hours	90.0%	86.5%	85.8%	74.3%
Bed Occupancy rates for (adult acute excluding PICU) inpatient services:	94.0% - 98.0%	98.2%	97.6%	97.5%
Becklin Ward 1 (Female)	-	97.0%	96.8%	98.2%
Becklin Ward 3 (Male)	-	98.6%	99.1%	99.3%
Becklin Ward 4 (Male)	-	96.5%	96.9%	96.9%
Becklin Ward 5 (Female)	-	101.8%	98.1%	94.4%
Newsam Ward 4 (Male)	-	96.8%	97.2%	98.8%
Older adult (total)	-	85.1%	87.8%	94.2%
The Mount Ward 1 (Male Dementia)	-	90.6%	96.0%	95.8%
The Mount Ward 2 (Female Dementia)	-	79.6%	80.4%	94.4%

Service Performance - Chief Operating Officer

Services: Our acute patient journey	Target	Jun 2022	Jul 2022	Aug 2022
The Mount Ward 3 (Male)	-	86.9%	89.2%	92.2%
The Mount Ward 4 (Female)	-	83.1%	85.2%	95.0%
Percentage of delayed transfers of care	-	12.3%	10.7%	9.6%
Total: Number of out of area placements beginning in month	-	2	3	1
Total: Total number of bed days out of area (new and existing placements from previous months)	140	158	166	122
Acute: Number of out of area placements beginning in month	-	0	0	0
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	11	42	15
PICU: Number of out of area placements beginning in month	-	2	2	1
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	87	34	14
Older people: Number of out of area placements beginning in month	-	0	1	0
Older people: Total number of bed days out of area (new & existing placements from previous months)	-	60	90	93
Cardiometabolic (physical health) assessments completed: Inpatients (quarterly)	90.0%	67.9%	-	-
Services: Our Community Care	**Target**	**Jun 2022**	**Jul 2022**	**Aug 2022**
Percentage of inpatients followed up within 3 days of discharge (Trust Level monthly local tracking)	80.0%	83.3%	81.5%	83.9%
Percentage of inpatients followed up within 3 days of discharge (CCG commissioned services only)	80.0%	84.3%	80.7%	86.1%
Number of service users in community mental health team care (caseload)	-	3,992	3,927	3,886
Percentage of referrals seen within 15 days by a community mental health team	80.0%	83.4%	81.7%	82.5%
Percentage of referrals to memory services seen within 8 weeks (quarter to date)	90.0%	74.9%	70.3%	67.5%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50.0%	63.9%	55.9%	58.9%
Early intervention in psychosis (EIP) or at risk mental state (ARMS): Percentage starting treatment within 2 weeks	60.0%	69.2%	93.3%	78.9%
Early intervention in psychosis (EIP) : Percentage of people discharged to primary care (quarterly)	-	58.3%	-	-
Cardiometabolic (physical health) assessments completed: Early Intervention in Psychosis Service (quarterly)	90.0%	39.5%	-	-
Services: Clinical Record Keeping	**Target**	**Jun 2022**	**Jul 2022**	**Aug 2022**
Percentage of service users with NHS Number recorded	-	99.1%	98.9%	98.9%
Percentage of service users with ethnicity recorded	-	75.3%	75.3%	74.9%
Percentage of service users with sexual orientation recorded	-	30.9%	31.1%	31.0%
DQMI (MHSDS) % Quality %	95.0%	88.1%	92.2%	91.4%

* SPA calls answered within 1 minute includes calls to the 0800 number only from April 2022.

** Reporting of the Deaf CAMHS time to first contact measure has recommenced as of April 2022 following work by the service to resolve some recording issues affecting this indicator.

Services: Reset and Recovery

	Baseline Time to First Contact (Q3 19/20)	Avg. Time to First Contact (Days)			Waiting List Month End		
		Jun 2022	Jul 2022	Aug 2022	Jun 2022	Jul 2022	Aug 2022
ADHD	271.8	395.4	455.2	319.1	2,136	2,246	2,371
Chronic Fatigue Service	116.7	138.0	140.0	139.8	171	175	181
CMHT OPS	37.1	36.0	42.6	26.9	132	114	140
CMHTs Adult	48.6	48.0	41.3	44.5	481	502	494
DEAF CAMHS	42.4	34.3	20.9		14	5	7
Gambling Services		63.2	45.1	57.3	123	119	123
Gender Services	182.4	936.8	678.4	600.1	2,904	2,981	2,969
LADS	83	139.5	164.6	151.5	338	352	380
Leeds LD Community	47.5	48.6	83.9	36.6	187	163	107
Liaison Out Patients	70.1	65.1	55.5	36.4	105	111	121
Memory Assessment Service	52.5	47.3	50.1	52.4	441	468	508
Perinatal Community	16	21.0	16.5	17.9	64	65	89
Veterans	36.9	101.6	87.6	94.6	38	41	36

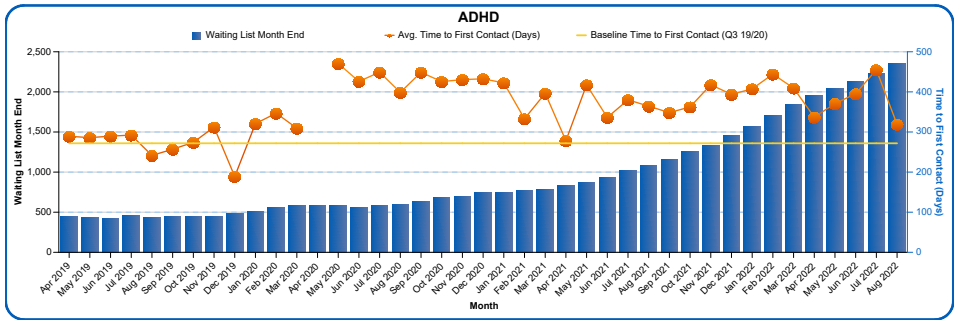
* The measure 'Baseline Time to First Contact (Q3 19/20)' relates to the average time (in days) from referral to first face to face contact only for referrals with a first contact between October and December 2020.

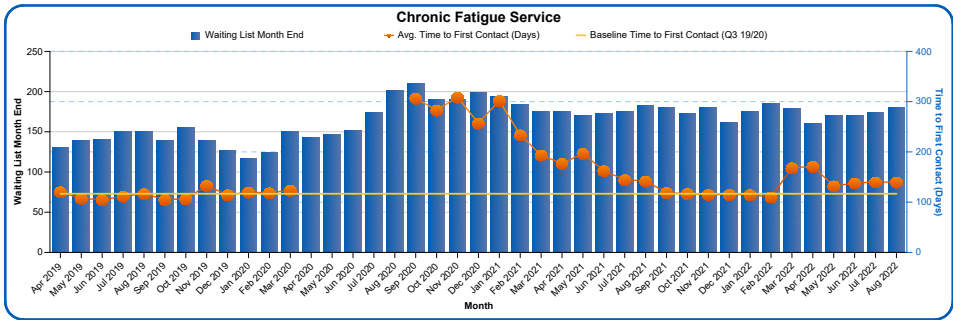
** The measure 'Avg. Time to First Contact (Days)' relates to the average time from referral to first face to face or telemedicine contact.

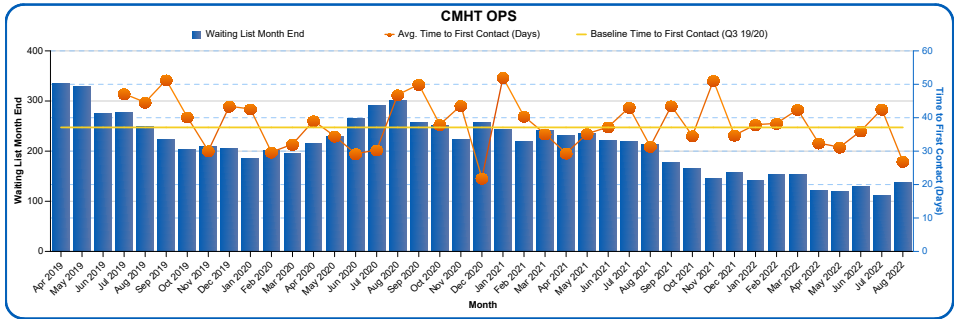
*** Where there is no data point for the measure 'Avg. Time to First Contact (Days)' this is because the service did not see any service users for a first contact in that month.

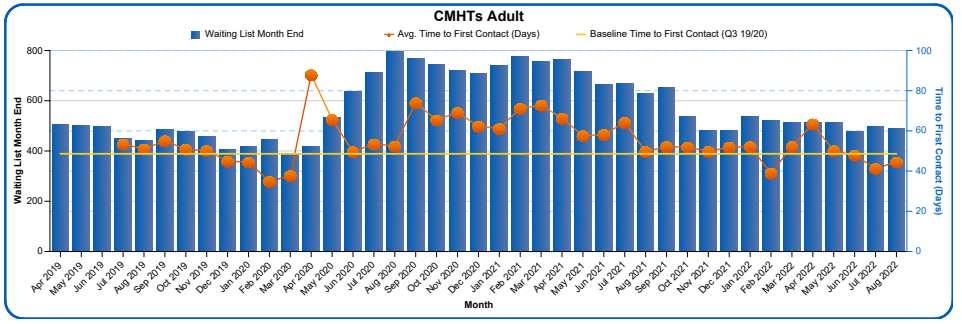
**** The baseline measure for the Gambling Service has been removed as this service was new in Q3 19/20 and therefore, the waiting time to be seen is not reflective of this service's time to first contact.

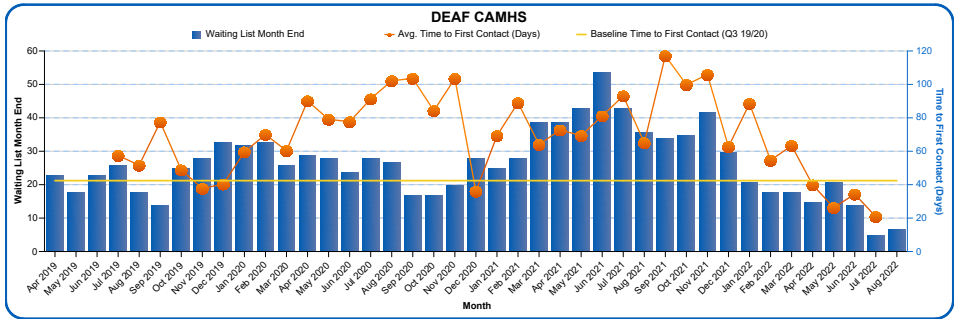
Services: Reset and Recovery (continued)

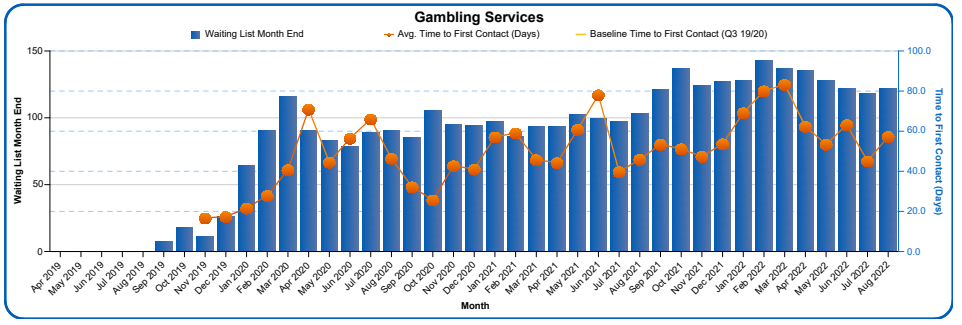


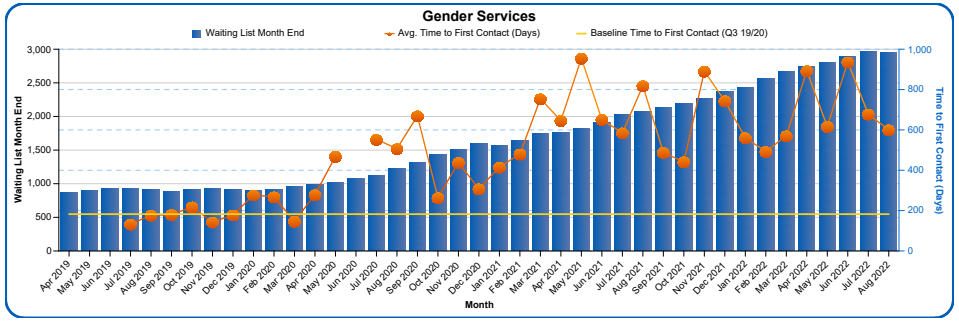


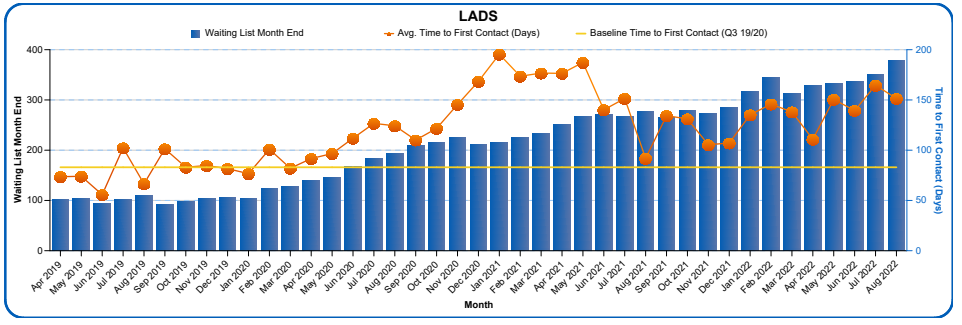












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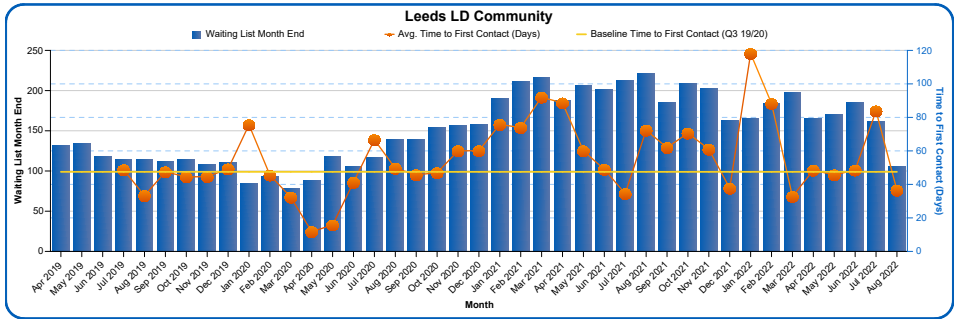
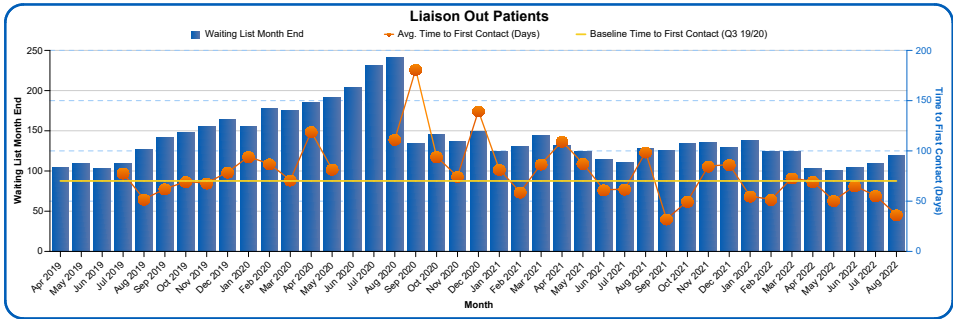
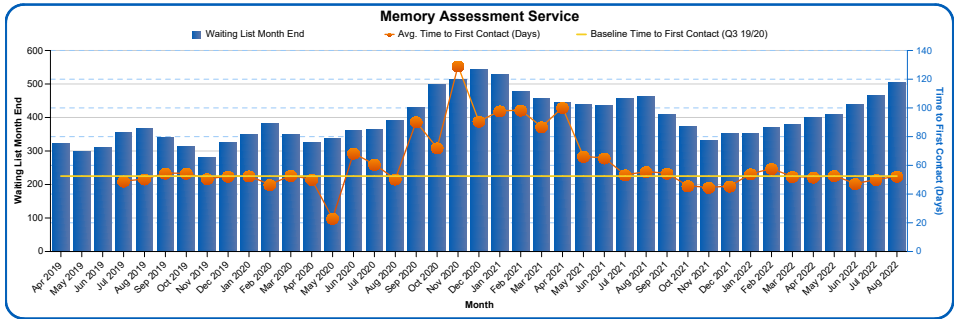
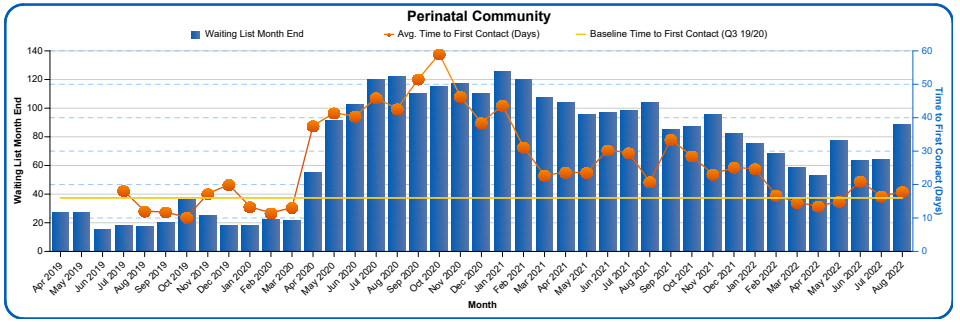
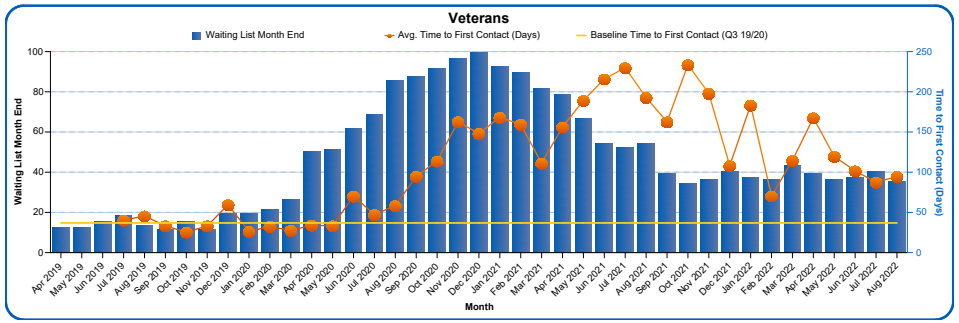
Services: Reset and Recovery (continued)











**** The baseline measure for the Gambling Service has been removed as this service was new in Q3 19/20 and therefore, the waiting time to be seen is not reflective of this service's time to first contact.

Services: Reset and Recovery

ADHD: The average time to first contact reduced in August but was still an average of 50 days above the 2019/20 baseline. In reality this reduction is artificial as it is due to service users moving out of area as up to 20% of those waiting were students. Waits are contributed to significant staff vacancies including 50% of the nursing establishment and the substantive Consultant Psychiatrist. More positively, the Consultant post has been covered by a locum which is working well at present, with the permanent post recruited to, with them due to start in November 2022.

With the aim of improving accessibility and the offer to people with ADHD, we continue to develop our work on capacity and flow engaging with Primary Care and system colleagues to start discussions on system redesign. As part of this work at a West Yorkshire ICS has commenced a 'deep dive' over the next 18 months. Capacity and demand modelling is being refined and will be included in the November Public Board report.

CFS: The average time to first contact (assessment) has remained static despite an increase in referrals to the service. The service is fully recruited but sickness has impacted on capacity and availability of our therapists. We have reduced our group capacity to focus on 1-1 interventions and short-term posts have been advertised but we have been unsuccessful in attempts to cover long term sickness. We are exploring alternative solutions but at this point do not anticipate any significant improvement in waiting times.

CMHT OPS: We have seen a marignal increase in the average time to first contact within these services. This has been because of staffing vacancies and sickness, in addition to different practices across the localities. This variation in practice is being explored by the Senior Management Team to ensure a consistent approach to referrals. It is anticipated that this work, in addition to addressing the vacancies and sickness, will enable the service to be more responsive to referrals. The outputs from this work will be mapped to forecast trajectories and surveillance undertaken as part of our performance management governance arrangements.

CMHTs Adult: There has been a slight improvement on the average time to first contact within CMHTs over recent months, however the waiting list remains at a similar level. This is despite remaining in business continuity with high rates of vacancies. Significant work has been undertaken to re-model the service to mitigate against the impact of significant staff availability constraints. The service has been supported by other service lines to bolster their staffing compliment. This, together with ongoing recruitment and the support of the VCSE organisations is expected to see the service gradually recover from its current position later this calendar year.

Deaf CAMHS: The service has seen a significant improvement and recovery on the waiting time, half that of the baseline year. The waiting list is at its lowest for over three years. This has been because of work that has been undertaken to make changes to their reporting processes to ensure this reflects their current post pandemic practice. We do see seasonal variations, with peaks in referrals prior to and after the school summer holidays. The service is fully aware of the variations across the year and can respond to the changes in demand as they occur.

Gambling Services: Identified through our service recovery processes, additional resource has been committed to the service to complete front end assessments which have successfully and consistently reduced the waiting time since the start of Q1. There had been an increase in referrals during August which contributed to a slightly longer time to first contact during this period. The service has had 4 vacancies due to staff leaving and commencing maternity leave which has slightly impacted wait times during this period. We anticipate that we will continue to improve the wait times as the staffing position improves.

Gender Services: The referral rate for the Gender service remains high at over 100 per month, with a significant increase in August. Strategically the demand for Gender Services continues to be a concern for LYPFT and other providers and this is being discussed at a national level through the MH Network.

Internally there has been an operational challenge delaying registration of referrals. The service is taking steps to recover this position over the next few months. The service has seen some slight delays over the summer months due to sickness and vacancies, however they continue to implement the strategy developed because of the new investment from NHSE last year.

LADS: The service continues to experience high rates of referrals which impact significantly on the waiting list. The monthly referrals have seen an increase of approximately 33% this year compared to a similar period in 2021/22. The service is reviewing the referral and assessment processes to improve flow and reduce the time it takes from referral to diagnosis.

LD Community: The CLDT waiting has continued to reduce over the past 12-18 months to a more stable position. We have recently seen a spike in the waiting times because of staff vacancies and absence. There has also been an increased backlog for service users requiring further assessment of their complex needs such as IQ assessments to establish eligibility. We have also seen the level of complexity and acuity of referrals increase, which has increased alongside some system and process concerns which have led to a lack of flow and discharge and has collectively meant that the waiting list has not reduced to fully manageable levels.

We are confident that, with some recent recruitment alongside a psychiatry review and some other planned interventions that we will start to see a gradual reduction in

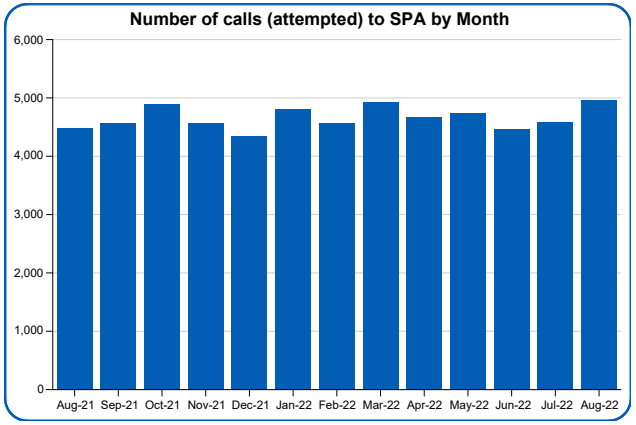
the waiting list over the next quarter in LD services.The CLDT plan for Management of the waiting list includes:

Liaison Outpatients: There has been a further reduction in the average time to first contact over the reporting period. We have however, seen an increase in waiting lists which correlates with an increase in referrals to the service. The team are maximising all available capacity by mainly utilising the virtual platform, Attend Anywhere, to improve our accessibility, options for people and waiting times.

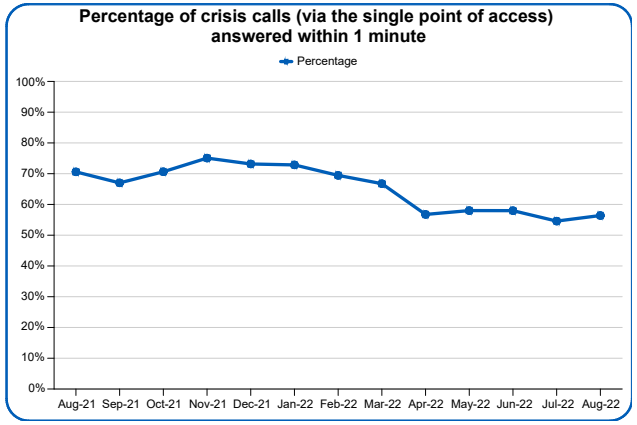
Memory Assessment: We have seen a steady increase in the waiting list over the past year and a slight reduction in our response rates. This is predominantly due to staffing vacancies and sickness within the service. There have also been some issues regarding the quality of the data in some of the localities which is being addressed by the service. The response rates have also been adversely affected by the wait for CT/MRI scanning, which has now all but been resolved with the provision of these tests resuming back to pre-pandemic response times.

Veterans: The waiting list for Veterans (CTS) has remained consistent around 30 to 40 days. The increased waiting times have been because of a concentration of referrals within the north-east patch. We have flexed staff across the region as much as possible and have tried to recruit multiple times with limited success. We anticipate that we will be able to reduce our waiting list significantly by 2023 which has been agreed with our NHS England commissioners.

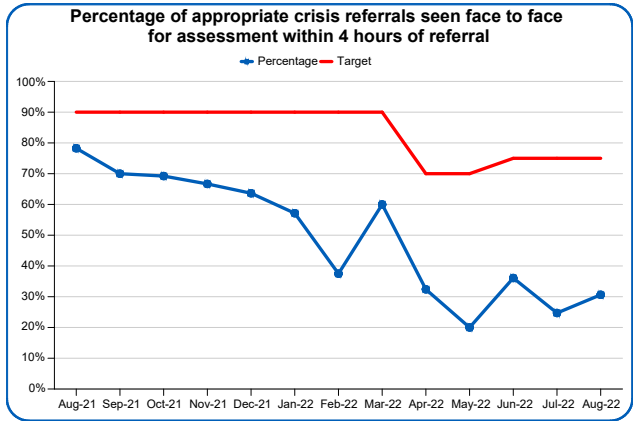
Services: Access & Responsiveness: Our Response in a crisis



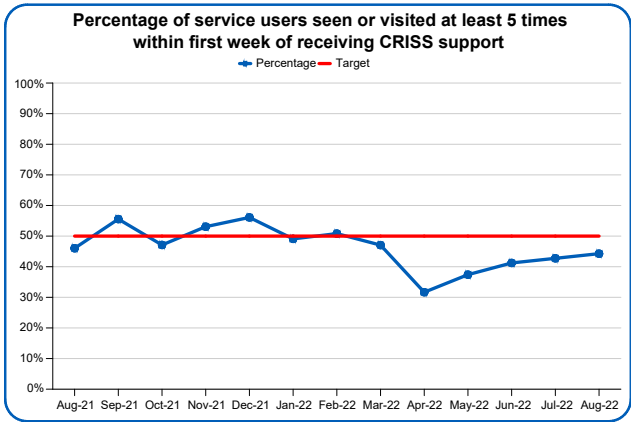
Number of calls : August 4,977



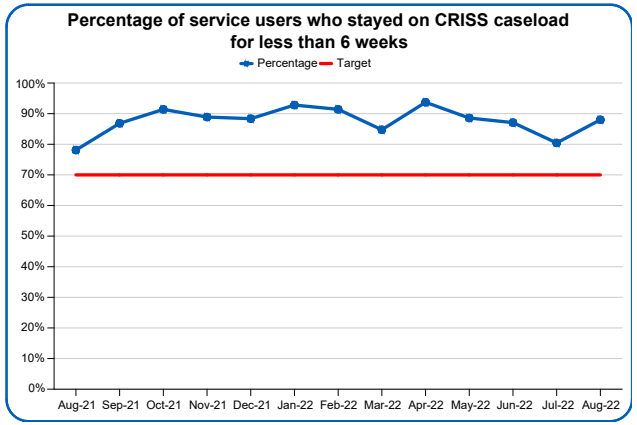
Local target - within 1 minute: August 56.4%



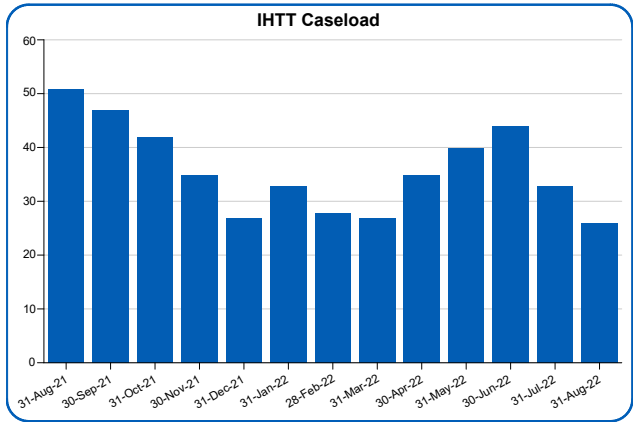
Contactual Target 75%: August 30.6%



Contractual Target 50%: August 44.3%

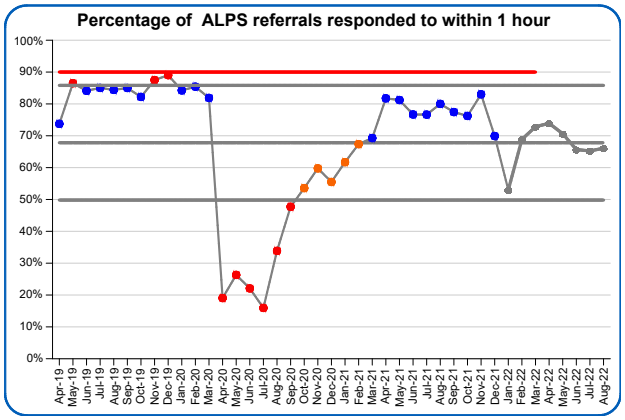


Contractual Target 70%: August 88.0%

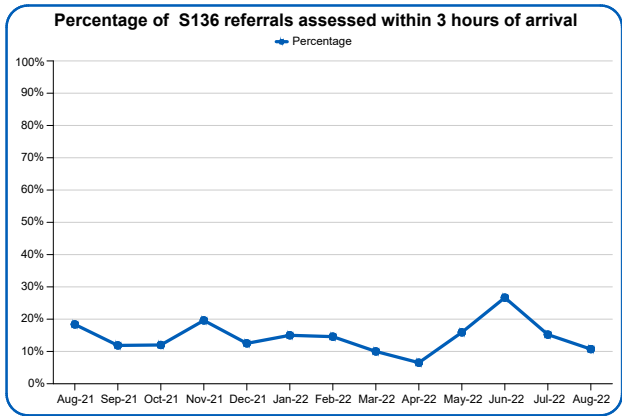


Caseload: August 26

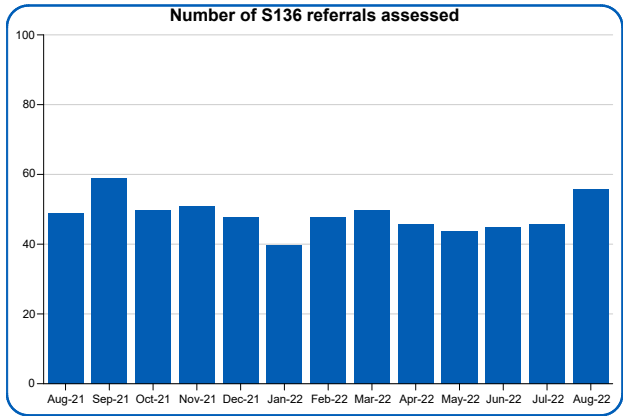
Services: Access & Responsiveness: Our Response in a crisis (continued)



Contractual Target : August 66.1%



Contractual Target : August 10.7%



Total referrals assessed: August 56

Services: Access & Responsiveness: Our Response in a crisis

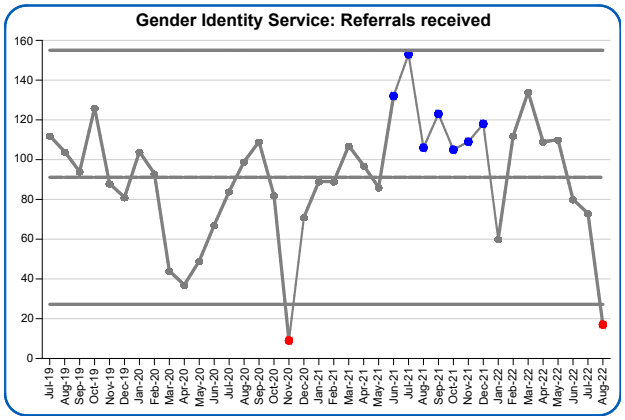
There has been a marginal improvement in the performance of the Acute Liaison Psychiatry Service with 66.1% of people seen within one hour of referral. We are focussed on making improvements of at least 10% heading into the winter period and will be setting out how best we achieve and maintain this in October.

Demand was higher this month and operational difficulties remain with the team not being permanently based within the Emergency Department. We have received confirmation that a Capital Bid to improving the experience of patients in mental health crisis who present to Leeds Urgent, and Emergency Care Services has been approved and we are working with acute colleagues on this scheme. We also continue to work with system partners to ensure we deploy the resources and expertise needed in the Acute hospital setting appropriately to enable swifter and better discharge of people with mental health issues.

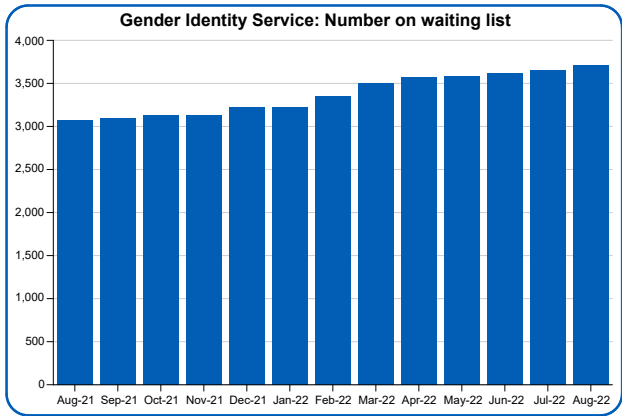
Performance against the Crisis assessment within 4-hour response has increased in August to 30.6% but remains well below the standard we work to. The service continues to report that in reality they are seeing considerably more people in Crisis on a face to face basis than those reported. Work has identified a process issue between Clinical Triage within SPA and the Crisis Assessment team. This is now being addressed and it is anticipated that this delay in the process will be resolved within the next two months at which point the service will a significant increase in the reported response rates. A recovery trajectory is being finalised and will be available to member of the Finance and Performance Group in October 2022/November 2022.

The percentage of service users seen at least 5 times during the first week of receiving Crisis Resolution and Intensive Support Service input, has improved slightly in August to 44.3% of service users receiving the required level of input. On initial engagement some people are found not to require intensive support and are transferred to Community Mental Health Teams (CMHT) and therefore do not require 5 contacts. Some service users referred on to CMHTs from the Intensive Support Service (ISS), do not require the intensity of ISS as an alternative to admission, for example, wrap around care over the weekend for Clozapine titration.

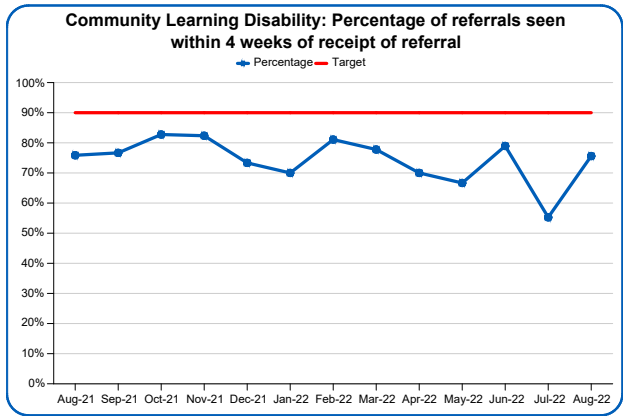
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services



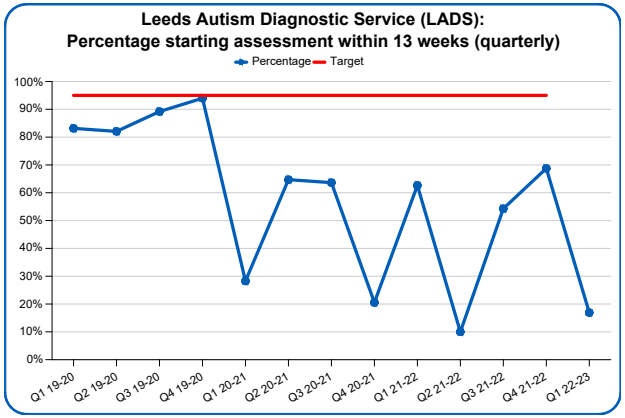
Total referrals: August 17



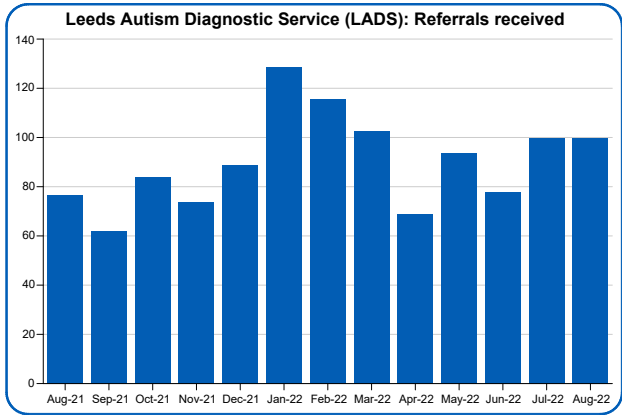
Number on waiting list: August 3,718



Contractual Target 90%: August 75.6%

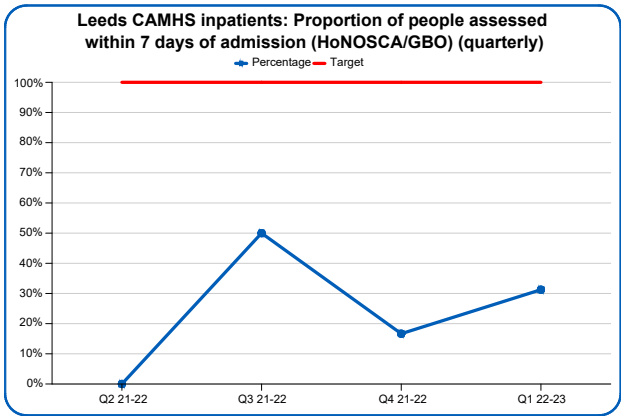


Contractual Target : Q1 16.9%

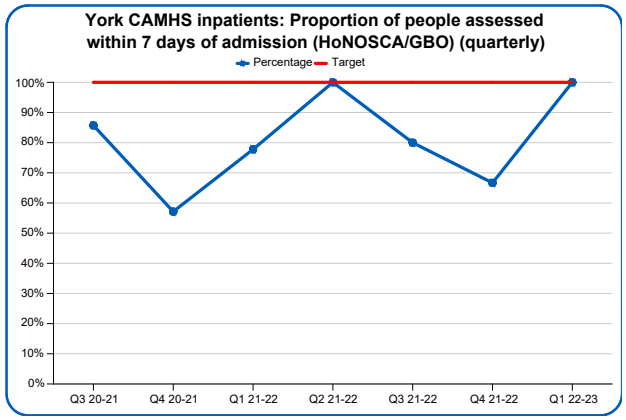


Local measure: August 100

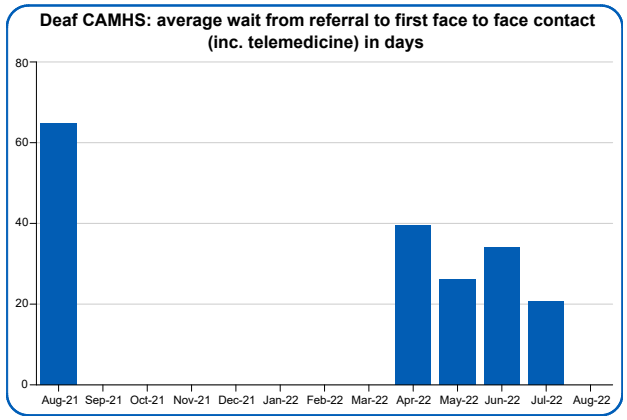
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services (continued)



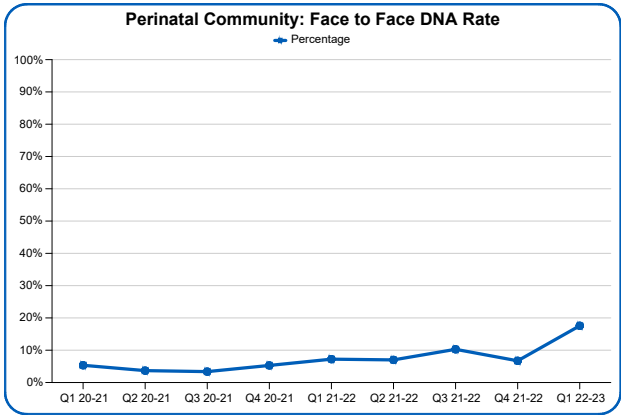
Contractual Target 100%: Q1 31.2%



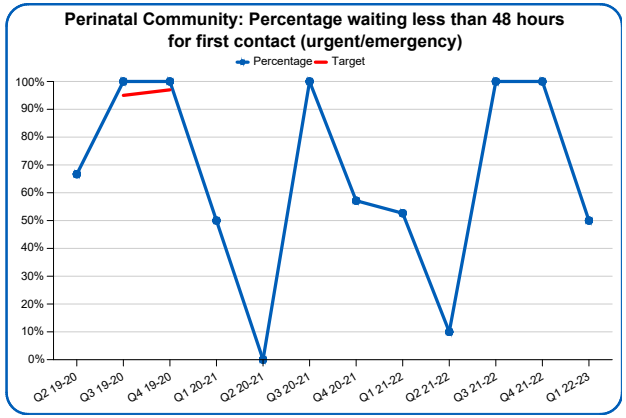
Contractual Target 100%: Q1 100.0%



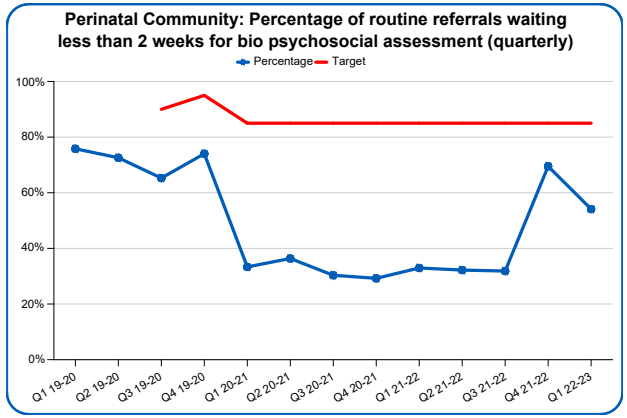
Local measure: August



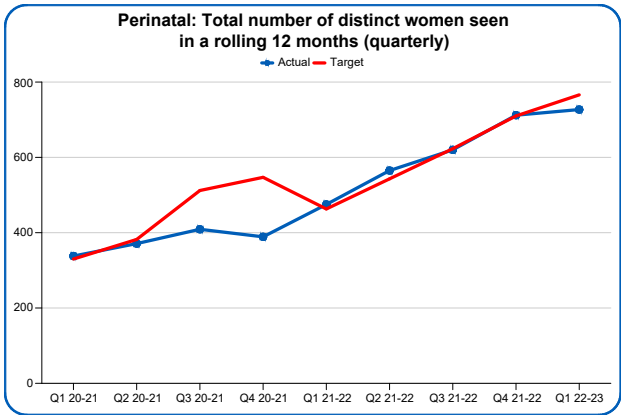
Contractual measure: Q1 17.6%



Contractual Target tba: Q1 50.0%



Contractual Target 85%: Q1 54.1%

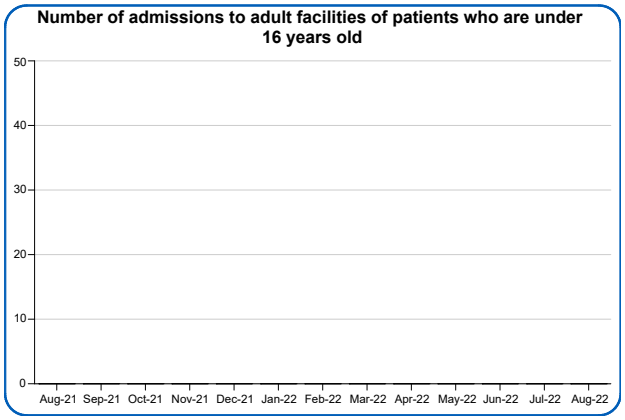


Local measure 766: Q1 727

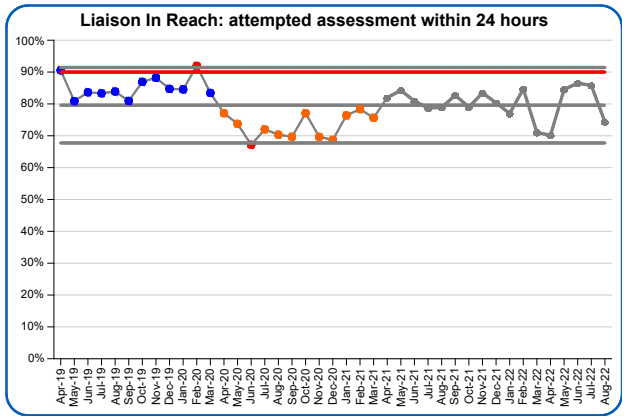
Services: Our Regional and Specialist Services

The percentage of referrals seen within 4 weeks of receipt of referral saw a significant dip down to 55 % in July due to some very particular and unexpected absences and pressures in the team. The compliance has recovered in August to a more usual 75% (although still short of the 90% target). Due to the small numbers involved this only equates to around 6 patients with good reasons for not meeting the target timescale, mostly related with delays in getting adequate information to determine eligibility. We have also had a recent meeting with the Leeds ICB about service specifications and a discussion took place about how relevant and meaningful this target is with a view to moving towards a more outcome focussed set of measures.

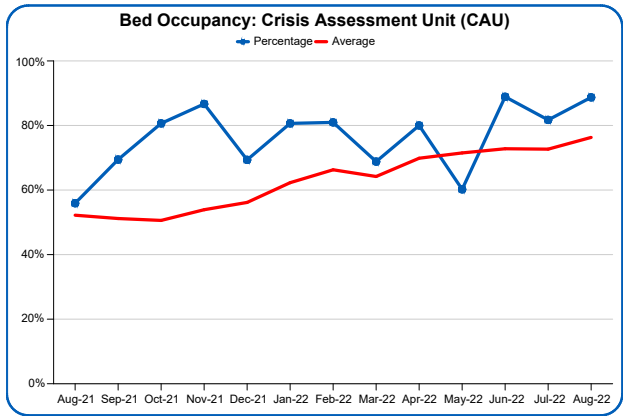
Services: Our acute patient journey



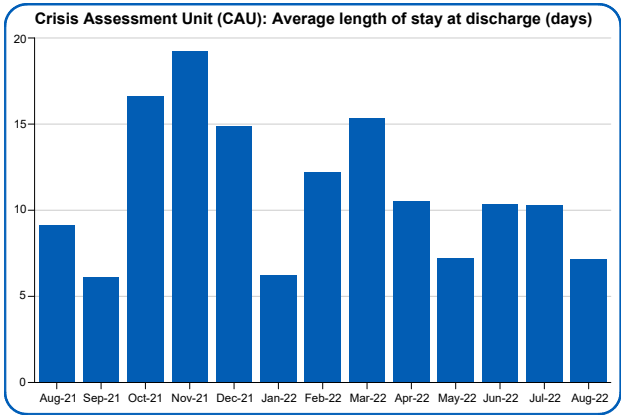
National (NOF) No target : August 0



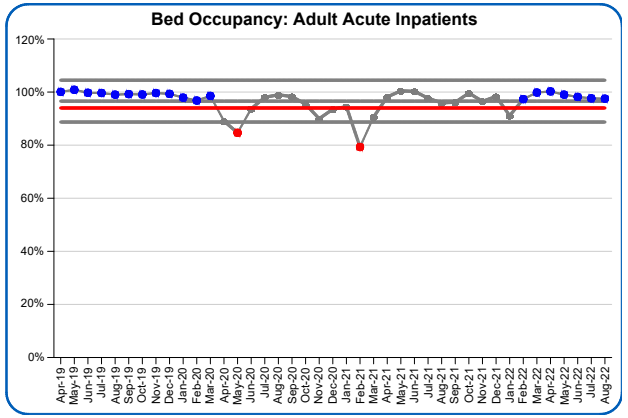
Contractual Target 90%: August 74.3%



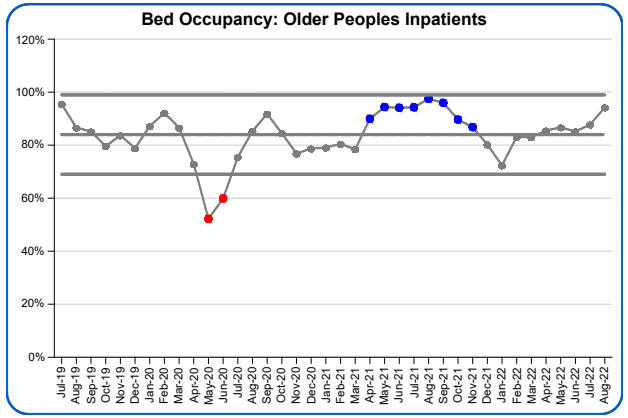
Local measure: August 88.7%



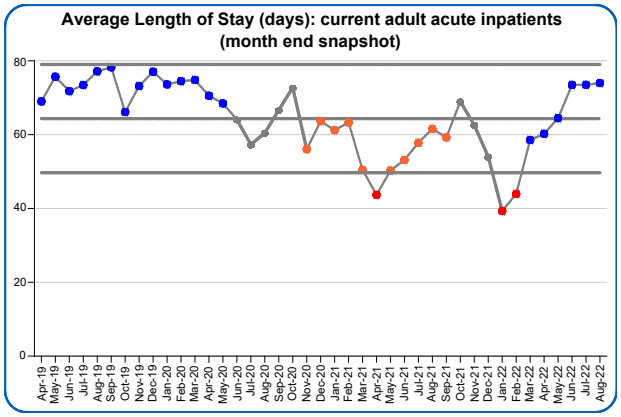
Local measure: August 7 days



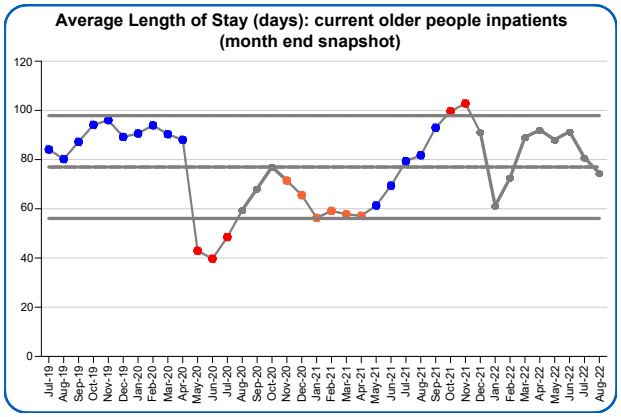
Contractual Target 94%: August 97.5%



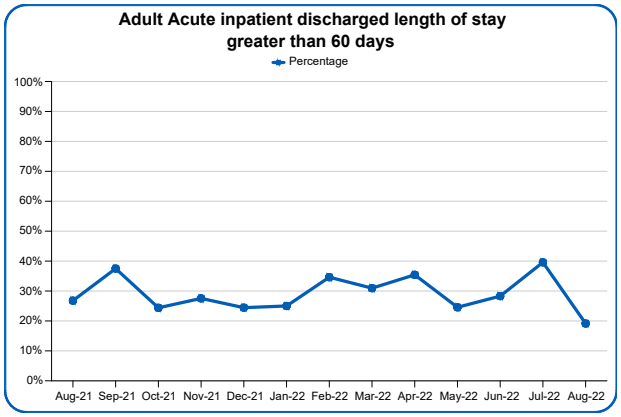
Local measure and target : August 94.2%



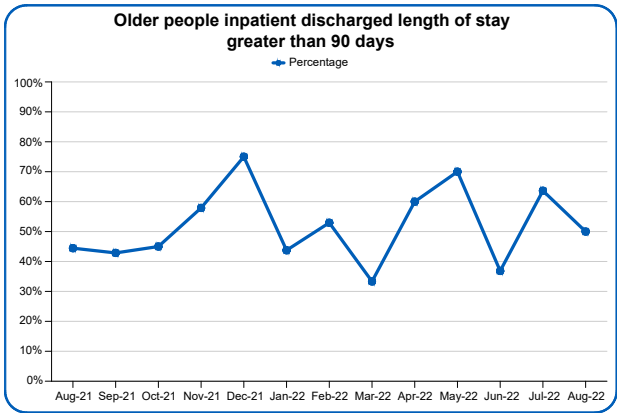
Local tracking measure: August 74 days



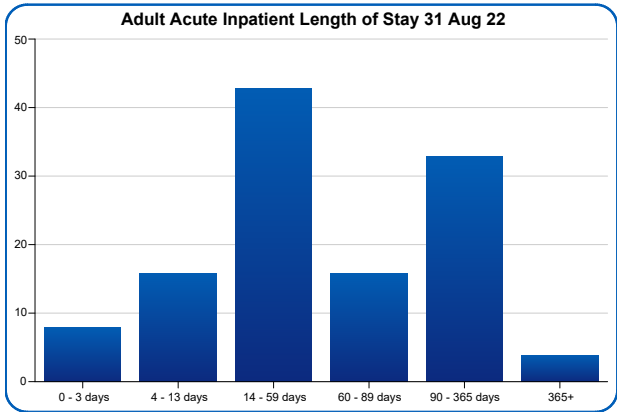
Local tracking measure: August 74 days



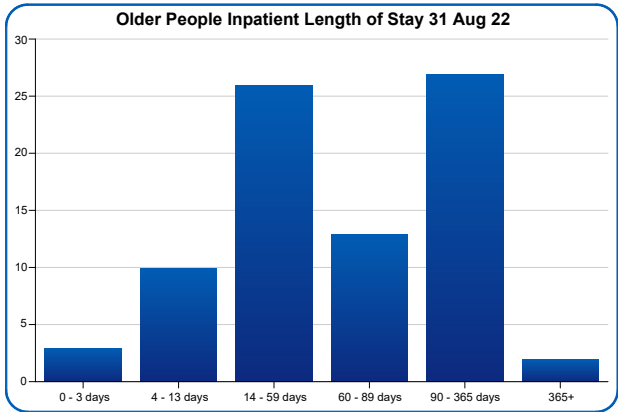
National (LTP): August 19.1%



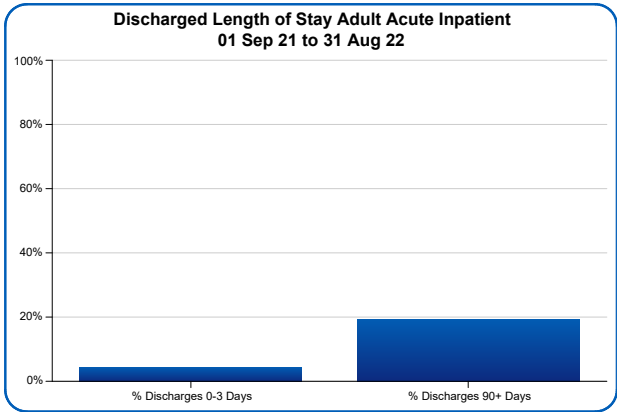
National (LTP): August 50.0%



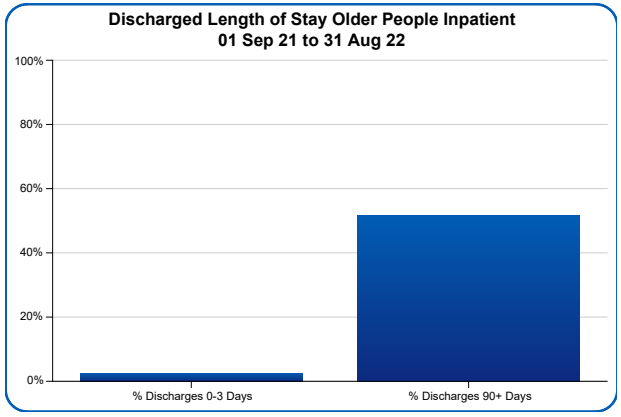
Local activity: 37 people with LOS 90+ days



Local activity: 29 people with LOS 90+ days

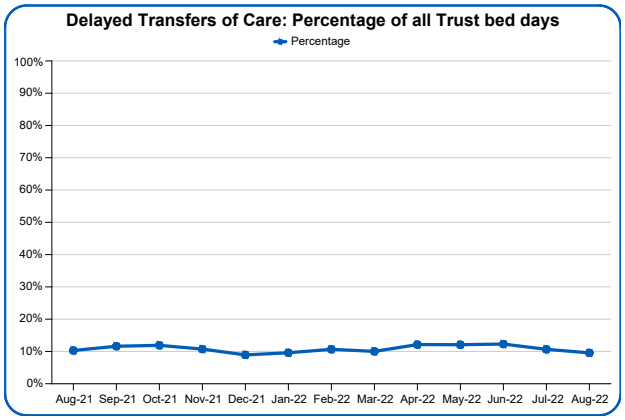


Local activity: % discharged LOS 90+ days = 19.6%

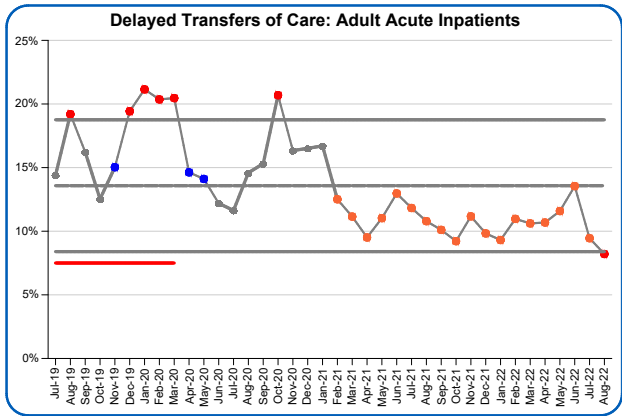


Local activity: % discharged LOS 90+ days = 51.8%

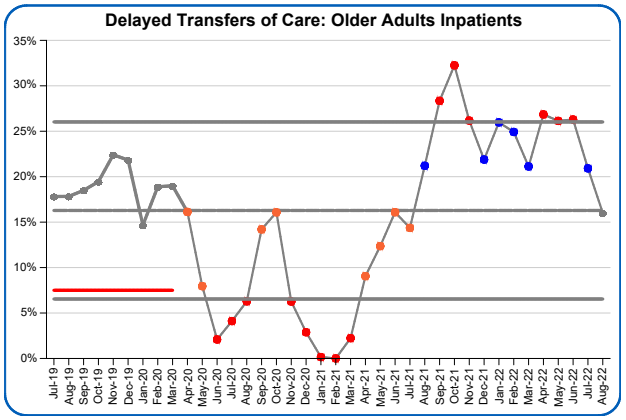
Services: Our acute patient journey (continued)



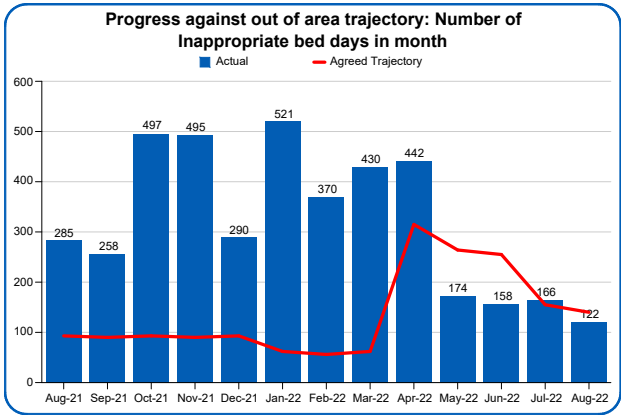
Local tracking measure: August 9.6%



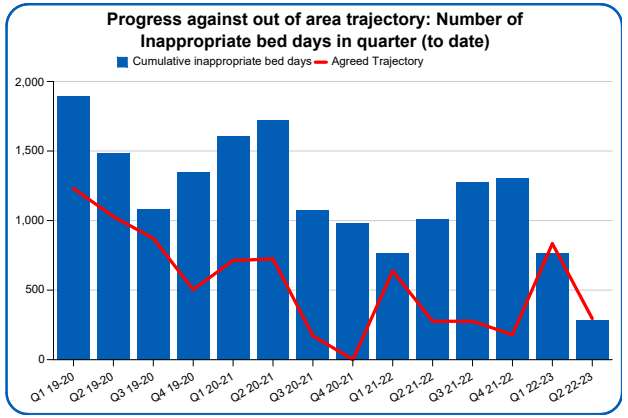
Local tracking measure: August 8.2%



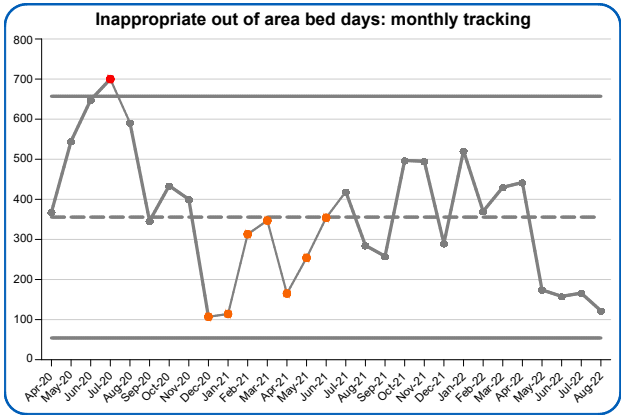
Local tracking measure: August 16.0%



Nationally agreed trajectory (140): August 122 bed days

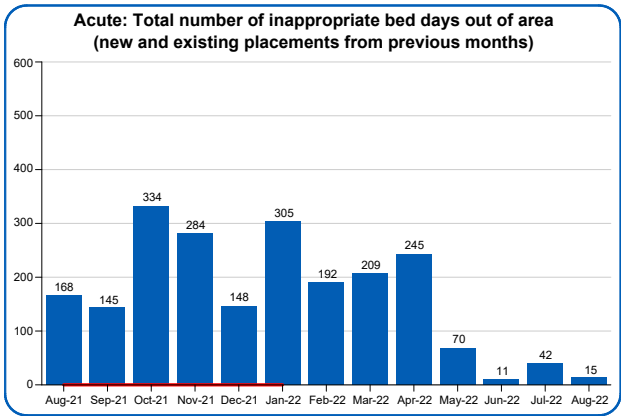


Nationally agreed trajectory (Q2: 295): Q2 288 bed days

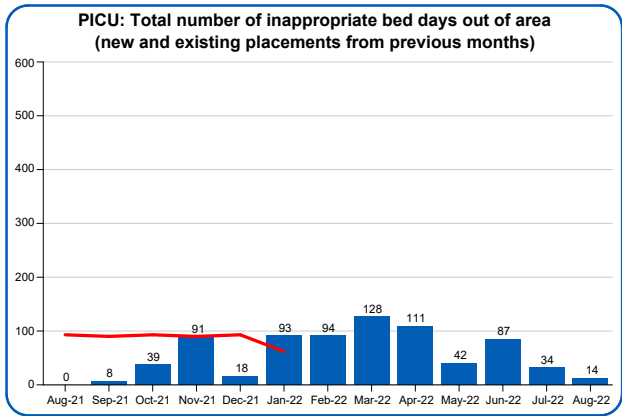


Local tracking measure: August 122 bed days

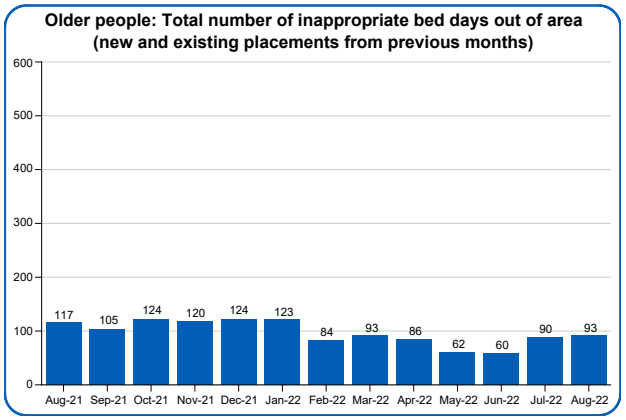
Services: Our acute patient journey (continued)



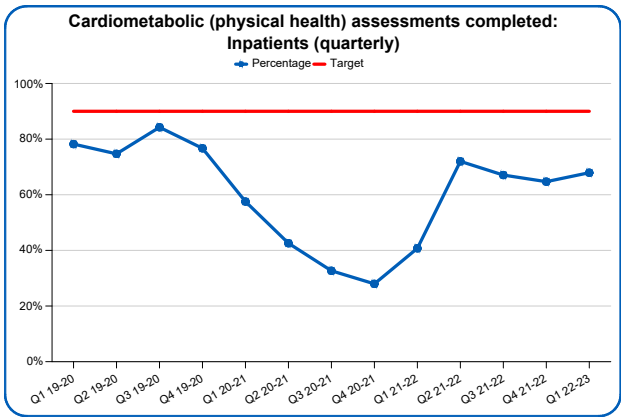
Nationally agreed trajectory (): August 15 days



Nationally agreed trajectory (): August 14 days



Local measure : August 93 days



Contractual target 90%: Q1 67.9%

Services: Our acute patient journey

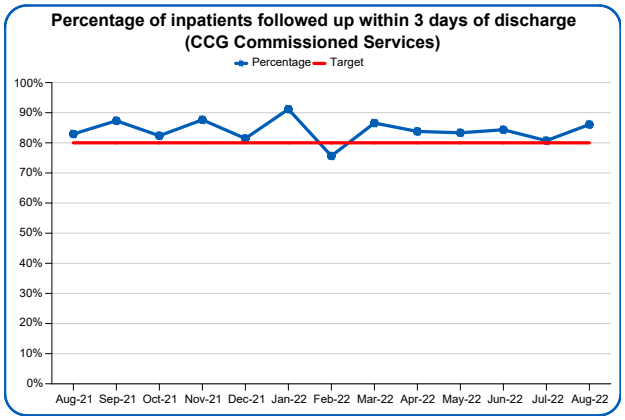
Within the Liaison In reach service, achievement of the 24-hour assessment target has seen a decline in performance with 74.3% of people being seen within 24-hour response time. Staffing challenges, including sickness and vacancies have impacted on capacity to respond. However, we are seeing signs of recovery in September with a reduction in team sickness. This will be a key area of focus for us in the coming weeks and months to ensure that we can maximise our response over the course of the winter period.

Bed occupancy within the Adult Acute inpatient service in August has decreased slightly to 97.5%, falling within the target range of 94-98%. Length of stay in Adult Acute services is continuing to increase which has previously reflected the situation with delayed transfers of care in the service. In recent weeks we have seen a reduction in DTOC combined with increased LOS which correlates with clinical reports of admitted people being more unwell requiring longer periods of crisis recovery and stabilisation.

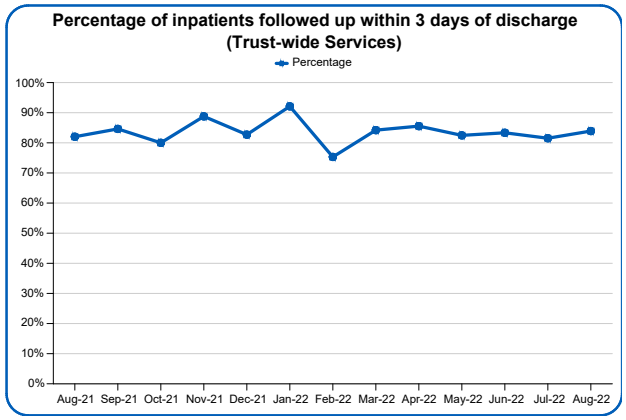
Out of Area Placements continue to be at a level below the agreed trajectory. The ongoing work of the Capacity and Demand team together with clinicians and managers, continues to result in very few people being admitted out of area. We saw a slight increase in demand in July as a response to ward closures, due to Covid and high demand for beds.

The percentage of inpatient bed days where the service user's transfer of care or discharge has decreased in August to 9.6%. Within the Adult Acute service, the reasons for these delays range from Ministry of Justice restrictions, housing, community packages of care and access to specialist placements. In Older Adult services, which carries most of the Trust's delays, these are related to sourcing residential or nursing placements.

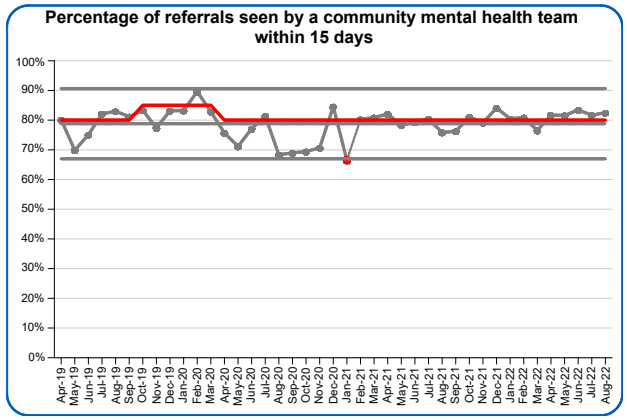
Services: Our community care



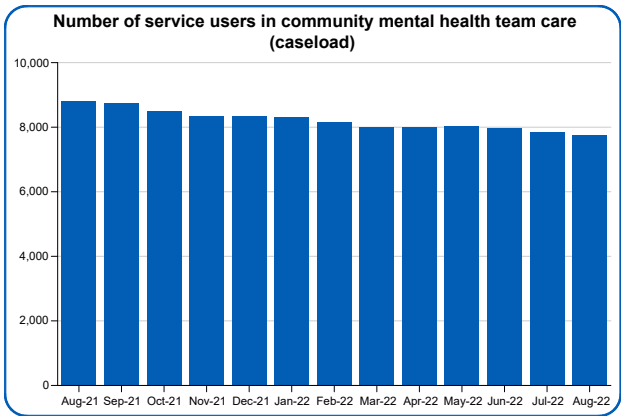
Contractual target 80%: August 86.1%



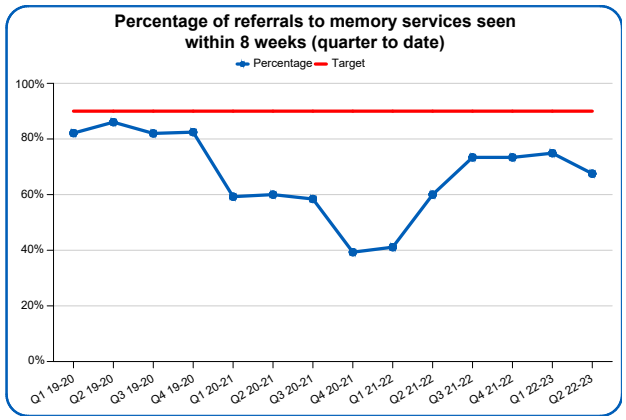
Local Tracking Measure 80%: August 83.9%



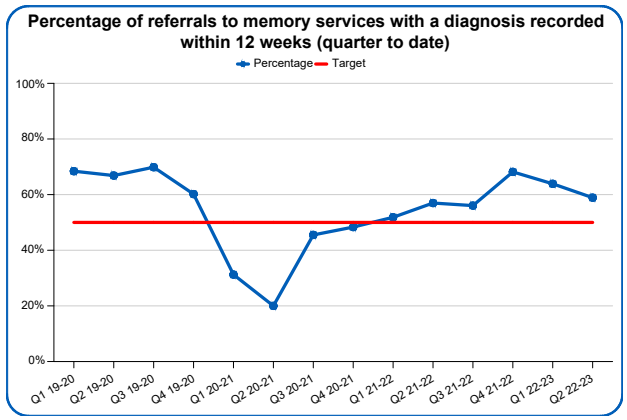
Contractual target 80%: August 82.5%



Local measure : August 3,886



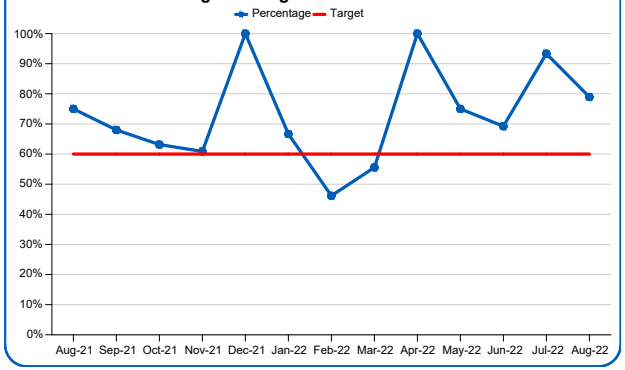
Contractual target 90%: Q2 22-23 67.5%



Contractual target 50%: Q2 22-23 58.9%

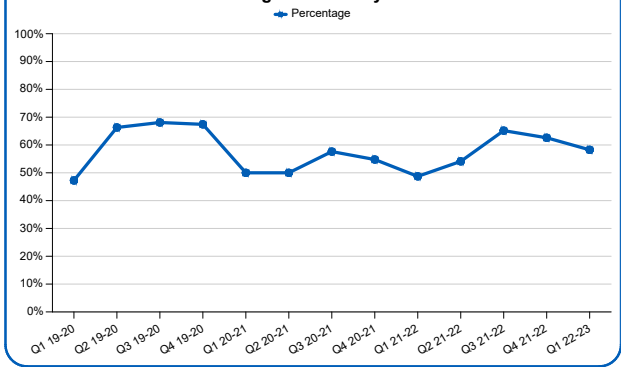
Services: Our community care (continued)

Early Intervention in Psychosis (EIP) or At Risk Mental State (ARMS): Percentage starting treatment within 2 weeks



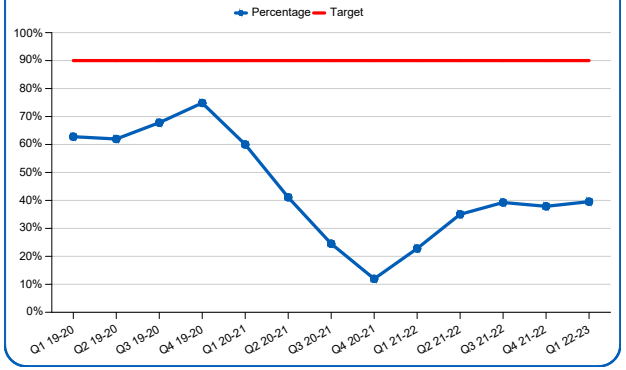
Contractual target 60%: August 78.9%

Early Intervention in Psychosis (EIP): Percentage of people discharged to Primary Care



Contractual target tbc: Q1 58.3%

Cardiometabolic (physical health) assessments completed: Early Intervention in Psychosis Service (position at quarter end)



Contractual target 90%: Q1 39.5%

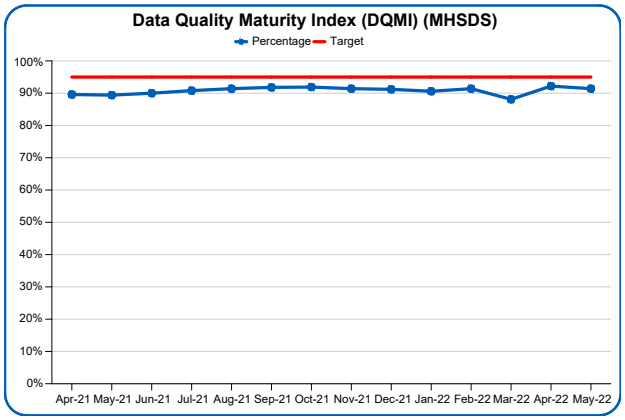
Services: Our community care

The Trust has achieved the 80% target for follow-up within 3 days, achieving 86.1% for CCG commissioned services and 83.9% Trust wide. We continue to routinely follow up all breaches of the standard during the month.

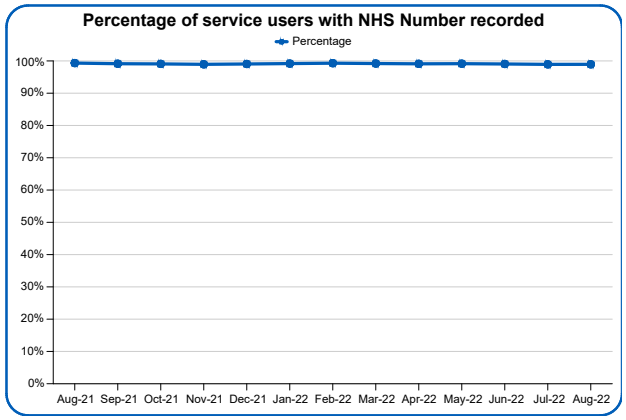
We have seen a continued increase in referrals to MAS and we have largely maintained our clinical contacts at a consistent level. There has been a reduction in the numbers of people seen within the agreed 8 weeks for an assessment which is partly due to staff unavailability, predominantly due to increased vacancies over this period. This has also had a negative impact on the 12-week diagnosis target.

We are continuing to work with the Continuous Improvement Team to evaluate the service to refine how we deliver the service and understand the local variation in service delivery. The team have identified some data quality issues in one locality that they are working on to improve which has also impacted on the performance data.

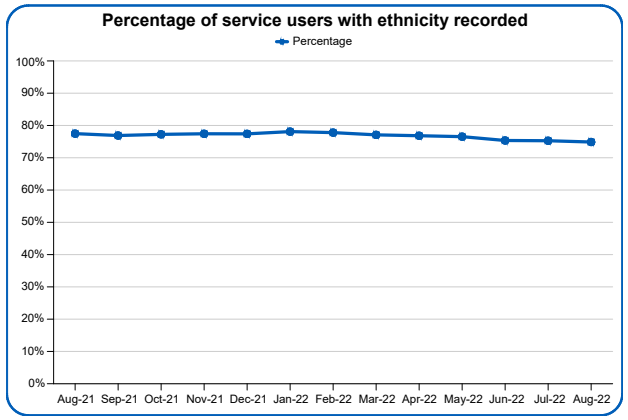
Services: Clinical Record Keeping



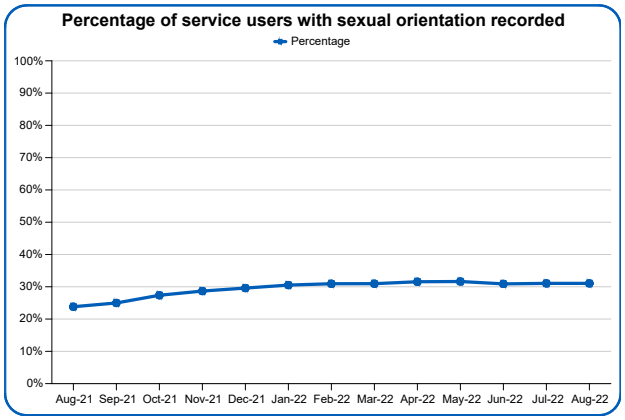
CQUIN / NHSOF Target 95%: May 91.4%



Local measure: August 98.9%



Local measure: August 74.9%



Local measure: August 31.0%

Services: Clinical Record Keeping

Our Informatics team continue to support staff in achieving expected standards of data quality with further support and training on our CareDirector Electronic Patient Record system. At the end of August 98.9% of care records had an NHS number recorded (no change), 74.9% ethnicity (slight decrease) and 31.0% sexual orientation (slight decrease). This will be an area of operational focus for us in October where a session specific to this will identify how best we can make sustained improvements in capturing this information.

Learning Disability Services

Our plan on a page for 2022/23

Leeds and York Partnership
NHS Foundation Trust

1. Where are we now?

- Resetting and recovering following disruption caused by the pandemic
- Providing a service to around 600 people a week, including those receiving care 24 hours a day
- Around 100 people are on our waiting list for community services, with 50 awaiting a first assessment
- All our services are open, apart from Rebound and Hydrotherapy.
- Recruiting staff is our main challenge

2. Where do we want to be in 12-18 months time?

- Better at managing our capacity and the size of our caseloads
- Better at discharging people so more people with a learning disability can live well in their communities
- The future of our Respite and Specialised Supported Living (SSL) Services is well established
- Our Rebound and Hydrotherapy services have reopened

3. How we are going to get there

- Review our Assessment and Referral Team (ART) to ensure they are effective and efficient
- Increase opportunities for face-to-face appointments
- Improve our use of technology for the benefit of staff and service users
- Work with our partners to find a positive and sustainable future for Respite and SSL Services
- Review our Health Facilitation Team to ensure they are delivering best outcomes for service users

4. Improving service user and carer experience

- Invest in our User Involvement Team, including recruiting more people with a lived experience
- Our Involvement Team and our Health Facilitation Team will work closely together to improve co-production with service users – for example improving access to primary care
- Introduce the three 'have your say' questions to collect feedback
- Hold more fun engagement events, like our Jubilee Party!

5. Improving staff experience

- We want to improve the wellbeing of all our people – including those who work in people's own homes.
- Develop our '**Garden of Governance and Wellbeing**' at St Mary's Hospital.
- Continue to support our staff after serious incidents to help them recover and to learn lessons.
- More fun engagement events!

6. How we are reducing health inequalities and improving equality, diversity and inclusion

We will:

- Continue making adjustments for people with a learning disability to access physical health care.
- Play a leading role in the West Yorkshire Challenge – supporting health and care staff in other services to improve the experience of people with a learning disability.
- Support our service users to access health screening and vaccinations.
- Champion the NHS Accessible Information Standard – making health information accessible to people with learning disabilities.
- Ensure people with learning disabilities are represented on our staff networks and recruitment panels

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
14

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Financial Officer Report - Month 5
DATE OF MEETING:	29 September 2022
PRESENTED BY:	Dawn Hanwell, Chief Financial Officer, and Deputy Chief Executive
PREPARED BY:	David Brewin, Assistant Director of Finance

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives	
SO2	We provide a rewarding and supportive place to work	
SO3	We use our resources to deliver effective and sustainable services	✓

EXECUTIVE SUMMARY

This report provides an update of key finance related issues.

The Trust is achieving both capital and revenue plans as at month 5.

We anticipate that system financial metrics will be reintroduced during quarter 2, including agency spending limits and increased scrutiny of efficiency plans. Our immediate focus is to address the unidentified recurrent efficiency requirement and implement actions to mitigate cost pressures including agency spending.

We are working through our revenue and capital forecasts for the year. It is perhaps even more important than in previous years that these are robust and as accurate as possible because of the system wide implications and the need for aggregate delivery of financial targets. We will be taking into account the requirements of our winter planning specifically in our revenue position.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes, please set out what action has been taken to address this in your paper
	No	

RECOMMENDATION

The Board of Directors is asked to note the:

- achievement of the revenue plan position as at month 5.
- capital expenditure position of £1.16m.
- NHS Oversight Framework position.

MEETING OF THE BOARD OF DIRECTORS

29 SEPTEMBER 2022

CHIEF FINANCIAL OFFICER REPORT

1 Introduction

This report provides an update of key finance related issues.

2 Financial Performance 2022/23

At month 5 the Trust reported an actual I&E surplus of £2,326k against a £418k surplus budget position as detailed in table 1 below.

Table 1

		Month 5		
Income & Expenditure Budget Position	**Annual Budget £'000**	**Budget YTD £'000**	**Actual YTD £'000**	**YTD Variance £'000**
Income:				
Patient Care Income	197,611	82,292	82,462	169
Non Operating Income	23,745	9,913	11,800	1,887
Total Income	**221,356**	**92,205**	**94,261**	**2,056**
Expenditure				
Pay Expenditure	159,995	66,589	64,320	(2,269)
Non Pay Expenditure	60,359	25,199	27,616	2,417
Total Expenditure	**220,354**	**91,787**	**91,936**	**148**
Surplus/ Deficit	**1,002**	**418**	**2,326**	**1,908**

The key variances against budgeted plans at month 5: -

Patient Care income
Higher than plan due to Provider Collaborative (Children and Young People and Eating Disorders) activity from outside West Yorkshire. These increases are offset by deferred income linked to slippage on Complex Rehabilitation CREST Team and Afghanistan- veterans team developments.

Other Operating Income
Higher than plan, mainly from additional finance income (interest receivable) linked to recent interest rate rises, and non recurrent gains from commercial activities. These fortuitous income streams are more than offsetting CPC Drive which is performing below plan at this stage due to

supply chain delays resulting in fewer new car registrations. Demand for CPC Drive cars remains strong, and the position is expected to improve in the second half of 2022/23.

Pay Expenditure
Lower than plan due to substantive staff vacancies (partially offset by temporary staffing costs) and recruitment slippage linked to new developments. Medical agency usage is generating a cost pressure and higher than planned clinical support worker bank usage is offsetting in part the number of nursing vacancies.

Non- Pay Expenditure
Higher than plan mainly because of the high number of complex rehabilitation out of area placements, and budget efficiencies not yet identified.

3 West Yorkshire ICS I&E Position 2022/23

The Trust's income and expenditure position is considered in the context of the wider system risks and opportunities to ensure overall system financial balance is achieved in aggregate. We continue to collaborate with partners across the Leeds place and ICS to manage financial risk issues and ensure plan positions are achieved.

West Yorkshire ICS month 5 I&E position is a £10.5m favourable variance, this figure has not yet been presented to committees in the ICS/ICB and remains a draft figure at this stage.

All organisations in each place are working on robust forecasts for the full year as part of a mid-year review at month 6, to identify if any remedial actions over and above what is already in place will be required to deliver financial balance. LYPFT is already overachieving its full year plan position at month 05. There are a number of variables which we are working through in assessing a likely forecast, but at this stage we anticipate it to be in the region of £4m (£2.9m above plan).

4 Capital Expenditure

Cumulative year to date capital expenditure is reported as £1.16m compared to the planned position of £1.93m.

We continue to forecast spending the full £9.14m plan for the year. This plan includes a proportion of Public Dividend Capital (PDC) funding assumed for the refurbishment of Parkside Lodge as a West Yorkshire Complex Care facility. The business case for this was submitted to the NHS England regional team in August following review by a Board sub- committee. We have not yet received confirmation of approval but anticipate this imminently. To avoid any delays we have proceeded with planning this work with our Public Finance Initiative (PFI) partners and incurring cost at low risk.

As previously noted, there is an element of delivery risk for our overall programme due to supply chain/contractor availability, but this should be manageable. Our plan is part of the overall West Yorkshire ICS capital resource limit. As at month 5 the ICS position was £34.5m below plan. Organisations are working closely together to ensure the overall control total limit is delivered for the year as capital is very limited and any underspend cannot be carried forward. To achieve this we may need to agree some "offsetting," which would allow some organisations to overachieve plans if others forecast underspends. In so doing we would not transfer cash between

organisations. A month 6 review across the ICS is taking place to assess the deliverability risks in aggregate and potentially agree some changes to individual forecasts.

5 Single Oversight Framework

The newly published NHS Oversight Framework includes 3 metrics that will be applicable to provider Trusts These are:

- Financial efficiency - variance from efficiency plan:
- Financial stability - variance from break-even
- Agency spending (monitored at system level but target applied to each provider)

In the context of our current financial performance, the areas requiring additional focus are agency spending and recurrent achievement of efficiency plans.

5.1 Agency Spending Limit

In terms of agency spending limits, we have now received confirmation that our share of the system limit is £8.3m for 2022/23 based on a 10% reduction to prior year spending levels. Our continued reliance on agency and locum cover indicates a forecast spend of c£10m (c20% higher than the agency spending limit) in 2022/23. At this point the implications of exceeding the agency spending limit remain unclear and would need to be considered as part of the overall West Yorkshire system agency expenditure limit. A focussed piece of work will be undertaken to address medical agency pressures, recognising the challenging workforce environment.

5.2 Efficiency

We are in the process of reinstating our pre pandemic approach to addressing the efficiency challenge and considering additional measures to increase productivity in the context of ‘reset,’ supported by our Business Intelligence colleagues. The output from Strategic Planning Days will form the basis for identifying our recurrent efficiency programme.

6 PFI Strategic Outline Case

Following the conclusion of the Care Services Strategic plan, work has continued to finalise the option appraisal for the Strategic Outline Case. The detailed work on this will be considered at the October Strategic Board session. In advance of this we have set up discussions with the PFI unit of the Department of Health, the Regional Estate team of NHS England and the Infrastructure Projects Authority who lead on PFI demise on behalf of Cabinet Office. All 3 parties are key to supporting the next steps of our planning on this work.

7 Conclusion

The Trust is achieving both capital and revenue plans as at month 5.

We anticipate that system financial metrics will be reintroduced during quarter 2, including agency spending limits and increased scrutiny of efficiency plans. Our immediate focus is to address the unidentified recurrent efficiency requirement and implement actions to mitigate cost pressures including agency spending.

We are working through our revenue and capital forecasts for the year. It is perhaps even more important than in previous years that these are robust and as accurate as possible because of the system wide implications and the need for aggregate delivery of financial targets. We will be taking into account the requirements of our winter planning specifically in our revenue position.

8 Recommendation

The Board of Directors is asked to note the:

- achievement of the revenue plan position as at month 5.
- capital expenditure position of £1.16m.
- NHS Oversight Framework position.

Dawn Hanwell
Chief Financial Officer and Deputy Chief Executive
23 September 2022

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
15

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Safer staffing
DATE OF MEETING:	29 September 2022
PRESENTED BY: (name and title)	Cathy Woffendin, Executive Director of Nursing, Professions and Quality / Director of Infection Prevention and Control
PREPARED BY: (name and title)	Linda Rose Head of Nursing and Patient Experience Alison Quarry, Professional Lead Nurse Adele Sowden, E-Rostering Team Manager

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	
SO2	We provide a rewarding and supportive place to work.	
SO3	We use our resources to deliver effective and sustainable services.	✓

EXECUTIVE SUMMARY

Leeds and York Partnership NHS Foundation Trust (LYPFT) provides inpatient care across 27 wards. This report is the two monthly update and draws on the requirements of the National Quality Board's (NQB) Safer Staffing expectations. It contains a high-level overview of data and analysis providing Trust Board members with information on the position of all wards staffing against safer staffing levels for the retrospective periods from the 1st June 2022 to the 31st July 2022.

2 Registered Nurse breaches occurred during this period at Asket croft on the 21st July 2022 (night shift) and Ward 3 Mount, on the 15th July 2022 (between midnight and 7am).

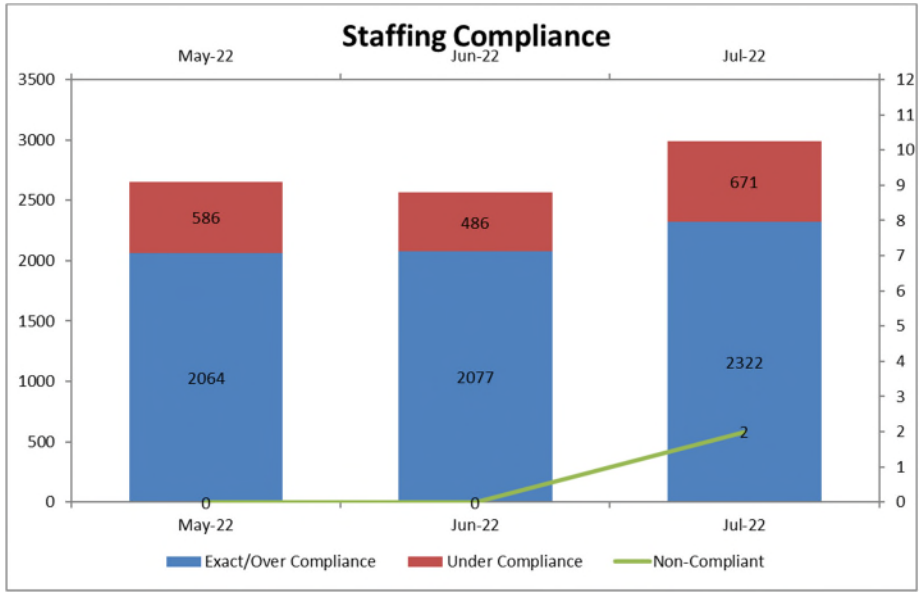
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes please set out what action has been taken to address this in your paper
	No	

RECOMMENDATION

The Board is asked to:

- Note and discuss the content of this report.
- Be assured that there is clear governance in place to mitigate challenges remaining in the system.

Safer Staffing: Inpatient Services – June and July 2022



	Number of Shifts		
	May	**June**	**July**
Exact/Over Compliance	2064	2077	2322
Under Compliance	586	486	671
Non-Compliant	0	0	2

Risks: Registered Nursing vacancies continue to be a major theme across the focussed areas highlighted by the unify data in Appendix A.

Mitigating Factors:

Reduced RN fill rates are mitigated in most of our units by increasing Healthcare Support Worker bookings through Bank and Agency. Ongoing improvements to the recruitment and professions strategies as part of workforce planning, increasingly include the skill mixing of new roles that can support the provision of interventions required to meet service user need. There is a robust escalation process in place to manage unplanned variance in shifts.

Narrative on Data Extracts Regarding LYPFT Staffing Levels on x27 Wards during June and July 2022

Exact or Over Compliant shifts:

During June, the compliance data showed a slight increase in the number of shifts which were staffed exactly as planned or staffed above the planned number of Registered Nurse (RN) and Health support worker (HSW) staff. During July, the compliance data showed a further increase in the number of shifts which were staffed exactly as planned or staffed above the planned number of Registered Nurse (RN) and Health support worker (HSW) staff. The compliance data demonstrates an increase in the overall number of shifts month on month across the data period with an increase of 432 shifts from June to July. The increase in duties have resulted in line with the clinical need of our service users.

Under Compliant Shifts:

During June there was a decrease in the number of shifts that had fewer than the planned number of RN and HSW staff on each shift. During July the number of shifts that had fewer than the planned number of RN and HSW staff on each shift showed an increase. (This data differs from the unify report in Appendix A as this shows the total hours over the month rather than on a shift-by-shift basis). Where there are fewer than planned RN staff on shift it is usual for one or more extra HSWs to back fill the vacant duty and ensure safe staffing levels, where a RN is not available to fill the shift.

Non-Compliant Shifts:

This metric represents the number of shifts where no Registered Nurses were on duty and was breached twice during this period. On the 21st July during the night shift at **Asket Croft**, a bank nurse was booked to work but had to cancel the shift due to testing positive for Covid prior to arrival. No other cover could be found from either bank, agency or overtime and therefore the RN from Asket House covered both units.

On the 15th July on **Ward 3 Mount**, there was no registered nurse on the ward between midnight and 7am. Despite being escalated throughout the day and then to the duty manager there were no staff available throughout the Trust to cover. The RN who had worked the late shift agreed to stay on duty and covered the ward up to midnight and then left the medicine keys with another registered nurse within the building.

No patient safety issues were identified as a result of these two breaches.

INPATIENT WARDS SUMMARY

The sustained pressure noted in the last 6-month review of safer staffing remains and resources continue to be stretched. Teams continue to endure constant challenges whilst striving to meet the needs of service users in a safe and effective way. The use of temporary staff and health support workers are a feature for all teams in terms of the mitigation in place as the impact of the pandemic and national nursing staff shortage levels continue.

The Unify reports across June and July further demonstrate that up to 55% of the inpatient areas had an underfill of Registered Nurses across day and night shifts; and up to 15% of inpatient areas had an underfill of Health support worker staff during the day.

Although there are minimal issues with HSW vacancies, they are still identified as below establishment on a monthly basis. This is due to a change in the baseline position as we have received additional funding for this group. A workstream has been established in response to NHSI/E initiative to reduce

HSW vacancies to 0. The workstream identifies proactive and sustainable recruitment strategies and reducing attrition rates.

The high unavailability of RNs is further pushing additional workstreams to identify alternate roles and we are seeing an increase in business cases for role repurposing. In addition to the gaps being filled by bank and agency staffing and deployment on a shift-by-shift basis; substantive colleagues continue to use goodwill, staying on duty for additional hours.

Since June, there have been a total of 12 outbreaks across services with the Mount experiencing an outbreak on every ward during this period. This included x3 of the 4 Mount wards having an outbreak at the same time. A change in national guidance from covid specific to respiratory guidance around this time meant that there were no dedicated cohorting areas. The new guidance advocated nursing infected patients in their own rooms on their base ward which further complicated staffing capacity as a higher number of staff were often needed to manage individual spaces. Feedback through the Safer staffing group described workforce morale being affected by the requirement to continue to fill in staffing gaps across the wards, however, the nursing budget at the Mount has now been increased and the service will recruit substantively into the additional posts.

In addition to the outbreaks, incident data for the inpatient wards in July shows complaints, incidents and self-harm increasing. This is a particular challenge to triangulate, with a review of this data showing there is no single cause for incidents. However incident forms are now beginning to describe episodes of missed or delayed care. The next Safer staffing group will facilitate a quality impact assessment across a sample number of wards to make clearer any themes related to missed or delayed care or near misses impacting on service user experience where the staffing compliment has a reduced number of RN's.

It is important that staff resilience continues to be supported and work is being progressed to ensure that our colleagues are able to engage in effective clinical supervision; including those areas which were challenged by staffing capacity issues.

GENERAL UPDATES

MHOST Tool

On the 15th August 2022, following discussions with NHSE and NHSI Safer Staffing Lead, Jane Avery, we agreed to temporarily step down the daily collection of MHOST data. This will allow the inpatient teams a helpful pause prior to engaging in NHSE/I facilitated training which is scheduled to take place in October 2022. The training will take teams back to basics whilst upskilling new staff in clinical areas who are not experienced in using the tool. Inpatient services have previously used the tool as a daily activity.

The training will support staff to use the tool on a biannual basis as originally intended over a period of 28 days. The 6-

month Safer staffing paper going to the July 2023 Board will be the first improved data collection period following the training undertaken to use the MHOST tool.

Preceptorship framework

The Nursing/Nursing associates, Social Work and AHP Preceptorship Frameworks have been merged into one MDT Preceptorship Framework using the Four Pillars approach (Clinical, Leadership, Research & Education) to set out standards for our newly registered workforce. We have moved away from a “tick box” approach found in the nursing framework and instead adapted a more helpful reflective approach as modelled in the AHP framework. We are one of the first Trusts across the collaborative to adopt this approach and aim to implement the improved framework with this year’s intake of newly registered colleagues. The current number of Preceptees expected to come into services in total is 39 and we can confirm that x14 of this group already have start dates and will initially work as Band 4 staff (working to the job plan of an Associate Practitioner until they receive their NMC Pins).

International recruitment

The Trust continues to work towards recruiting 10 Internationally recruited nurses (INR’s) by the end of 2022. One nurse is now part of the team on Ward 1 Becklin Centre, with a further two colleagues due to arrive in September following successful completion of the OSCE examination. They will fill positions on Ward 4 Becklin Centre and Mill Lodge by December 2022. A further two potential recruits in Zimbabwe are awaiting confirmation from their Nursing council and a potential 6 recruits from Trinidad and Tobago are waiting to be issued with their nursing licences.

Deployment

As part of our business continuity planning and our commitment to retention of staffing we will need to carefully consider deploying our colleagues differently whilst balancing service users greatest need .The deployment and staffing group have produced Frequently asked Questions and Answers for individuals who are currently being asked to temporarily deploy into the Community and Wellbeing services.

It is also worth noting that Unions, including the Royal College of Nursing and Unison have announced a series of consultative industrial action ballots to be held in the coming months, to take a decision on whether to pursue industrial action over the 2022-23 pay deal. This has been raised to the attention of the deployment and staffing group.

APPENDIX A

Safer Staffing: Inpatient Services – July 2022

Fill rate indicator return

Staffing: Nursing, Care Staff and AHPs

		Care Hours Per Patient Day (CHPPD)							Day				Night				Allied Health Professionals	
Ward name	Cumulative count over the month of patients at 23:59 each day	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Registered Nursing Associates	Non-registered Nursing Associates	Registered allied health professionals	Non-registered allied health professionals	Overall	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - registered allied health professionals (AHP) (%)	Average fill rate - non-registered allied health professionals (AHP) (%)
2 WOODLAND SQUARE	100	11.0	8.6	0.0	0.0	0.0	0.0	19.6	102%	117%	-	-	107%	103%	-	-	-	-
3 WOODLAND SQUARE	84	11.6	20.8	1.4	2.3	0.0	0.0	36.1	83%	165%	100%	100%	103%	147%	100%	100%	-	-
ASKET CROFT	571	1.6	2.4	0.0	0.0	0.8	0.0	4.8	96%	79%	-	-	100%	100%	-	-	100%	-
ASKET HOUSE	352	2.2	2.2	0.0	0.0	1.0	0.0	5.4	103%	56%	-	-	101%	103%	-	-	100%	-
BECKLIN CAU	152	5.1	18.5	0.7	0.0	1.6	0.0	25.9	56%	135%	100%	-	69%	145%	100%	-	100%	-
BECKLIN WARD 1	660	1.8	4.9	0.0	0.0	0.2	0.2	7.0	65%	182%	-	-	59%	243%	-	-	100%	100%
BECKLIN WARD 3	676	1.8	3.7	0.1	0.0	0.2	0.2	6.2	63%	198%	100%	-	69%	193%	-	100%	100%	100%
BECKLIN WARD 4	661	1.9	4.3	0.2	0.0	0.3	0.2	6.9	63%	241%	100%	-	75%	208%	100%	-	100%	100%
BECKLIN WARD 5	669	2.0	4.3	0.0	0.0	0.0	0.2	6.5	70%	183%	-	-	80%	175%	-	-	100%	100%
MOTHER AND BABY AT PARKSIDE	149	9.6	15.7	0.5	0.0	0.5	0.0	26.2	67%	135%	100%	-	52%	130%	100%	-	100%	-
NEWSAM WARD 1 PICU	362	3.4	11.7	0.0	0.0	0.3	0.0	15.5	66%	142%	-	-	69%	188%	-	-	100%	-
NEWSAM WARD 2 FORENSIC	233	4.2	18.1	0.0	0.0	0.6	0.3	23.2	75%	310%	-	-	103%	290%	-	-	100%	100%
NEWSAM WARD 2 WOMENS SERVI	217	4.6	10.7	0.0	0.0	0.0	0.6	15.9	80%	186%	-	-	100%	152%	-	-	-	100%
NEWSAM WARD 3	400	2.3	4.4	0.0	0.0	0.6	0.0	7.3	75%	146%	-	-	100%	103%	-	-	100%	-
NEWSAM WARD 4	633	2.0	3.1	0.0	0.2	0.3	0.0	5.5	62%	191%	-	100%	76%	134%	-	-	100%	-
NEWSAM WARD 5	523	1.9	4.1	0.0	0.0	0.2	0.0	6.2	67%	105%	-	-	66%	124%	-	-	100%	-
NEWSAM WARD 6 EDU	363	3.3	7.0	0.0	0.0	0.6	0.3	11.2	108%	241%	-	-	55%	153%	-	-	100%	100%
NICPM LGI	156	6.5	6.5	0.0	0.0	2.2	0.0	15.3	62%	52%	-	-	68%	161%	-	-	100%	-
RED KITE VIEW GAU	143	10.1	21.7	2.1	0.0	1.0	1.0	36.0	68%	136%	100%	-	52%	173%	100%	-	100%	100%
RED KITE VIEW PICU	437	3.1	7.0	0.0	0.0	0.1	0.0	10.2	47%	104%	-	-	55%	214%	-	-	100%	-
THE MOUNT WARD 1 NEW (MALE)	506	2.8	11.0	0.0	0.0	0.0	0.0	13.9	117%	210%	-	-	77%	271%	-	-	-	-
THE MOUNT WARD 2 NEW (FEMALE	374	3.3	15.5	0.4	0.2	0.0	0.0	19.4	101%	219%	100%	100%	58%	299%	100%	100%	-	-
THE MOUNT WARD 3A	664	1.4	4.8	0.2	0.0	0.0	0.0	6.3	68%	164%	100%	-	100%	207%	100%	-	-	-
THE MOUNT WARD 4A	660	1.2	6.1	0.0	0.0	0.0	0.0	7.4	58%	194%	-	100%	94%	268%	-	100%	-	-
YORK - BLUEBELL	155	6.5	14.3	0.5	0.4	0.7	0.8	23.3	90%	76%	100%	100%	94%	113%	-	-	100%	100%
YORK - MILL LODGE	217	5.0	10.1	0.5	0.2	1.4	1.4	18.6	50%	120%	100%	-	62%	134%	-	100%	100%	100%
YORK - RIVERFIELDS	184	5.0	6.9	0.0	0.0	0.9	0.0	12.8	77%	126%	-	-	101%	100%	-	-	100%	100%
YORK - WESTERDALE	298	4.3	8.4	0.0	0.2	0.4	0.0	13.3	63%	126%	-	100%	104%	136%	-	-	100%	-

APPENDIX A

Safer Staffing: Inpatient Services – June 2022

Fill rate indicator return
Staffing: Nursing, Care Staff and AHPs

		Care Hours Per Patient Day (CHPPD)							Day				Night				Allied Health Professionals	
Ward name	Cumulative count over the month of patients at 23:59 each day	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Registered Nursing Associates	Non-registered Nursing Associates	Registered allied health professionals	Non-registered allied health professionals	Overall	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - registered allied health professionals (AHP) (%)	Average fill rate - non-registered allied health professionals (AHP) (%)
2 WOODLAND SQUARE	93	11.6	8.6	0.0	0.0	0.0	0.0	20.2	104%	116%	-	-	107%	97%	-	-	-	-
3 WOODLAND SQUARE	98	9.0	19.7	1.7	1.2	0.0	0.0	31.6	88%	198%	100%	100%	100%	178%	100%	100%	-	-
ASKET CROFT	529	1.9	2.3	0.0	0.0	0.8	0.0	5.0	125%	63%	-	-	108%	103%	-	-	100%	-
ASKET HOUSE	270	2.9	3.0	0.0	0.0	1.4	0.0	7.2	110%	62%	-	-	100%	100%	-	-	100%	-
BECKLIN CAU	160	5.8	15.8	0.5	0.0	2.8	0.0	24.8	84%	132%	-	-	84%	126%	100%	-	100%	-
BECKLIN WARD 1	640	2.1	5.0	0.0	0.0	0.2	0.2	7.4	68%	188%	-	-	87%	249%	-	-	100%	100%
BECKLIN WARD 3	651	1.9	3.7	0.1	0.1	0.3	0.2	6.3	63%	209%	100%	100%	73%	189%	-	100%	100%	100%
BECKLIN WARD 4	637	1.9	4.7	0.1	0.0	0.4	0.1	7.2	59%	264%	100%	-	80%	216%	100%	-	100%	100%
BECKLIN WARD 5	672	2.0	3.3	0.0	0.0	0.1	0.1	5.5	65%	150%	100%	-	89%	128%	-	-	100%	100%
MOTHER AND BABY AT PARKSIDE	176	7.9	13.1	0.4	0.0	0.3	0.1	21.8	63%	133%	100%	-	63%	134%	-	-	100%	100%
NEWSAM WARD 1 PICU	341	4.1	9.3	0.0	0.0	0.2	0.0	13.6	76%	113%	-	-	78%	129%	-	-	100%	-
NEWSAM WARD 2 FORENSIC	221	4.6	18.2	0.0	0.0	0.6	0.0	23.4	80%	297%	-	-	114%	295%	-	-	100%	-
NEWSAM WARD 2 WOMENS SERVI	210	4.8	11.2	0.0	0.0	0.1	0.6	16.7	90%	194%	-	-	97%	163%	-	-	100%	100%
NEWSAM WARD 3	346	2.7	5.1	0.0	0.0	0.6	0.0	8.4	83%	142%	-	-	100%	112%	-	-	100%	100%
NEWSAM WARD 4	610	2.2	3.1	0.0	0.2	0.3	0.0	5.9	67%	196%	-	100%	89%	132%	-	100%	100%	-
NEWSAM WARD 5	510	2.1	4.0	0.0	0.0	0.2	0.0	6.3	65%	110%	-	-	82%	117%	-	-	100%	-
NEWSAM WARD 6 EDU	338	3.3	8.6	0.0	0.0	0.9	0.2	13.0	98%	253%	-	-	62%	212%	-	-	100%	100%
NICPM LGI	173	5.1	7.0	0.0	0.0	1.6	0.0	13.7	93%	100%	-	-	100%	200%	-	-	100%	-
RED KITE VIEW GAU	156	11.0	20.8	1.5	0.0	0.8	0.0	34.1	71%	124%	100%	-	47%	187%	100%	-	100%	-
RED KITE VIEW PICU	459	3.2	6.6	0.0	0.0	0.2	0.1	10.1	51%	103%	-	-	62%	217%	-	-	100%	100%
THE MOUNT WARD 1 NEW (MALE)	462	3.0	13.4	0.0	0.0	0.0	0.0	16.4	140%	229%	-	-	74%	313%	-	-	-	-
THE MOUNT WARD 2 NEW (FEMALE	358	3.5	15.1	0.3	0.5	0.0	0.0	19.4	97%	237%	100%	100%	71%	291%	100%	100%	-	-
THE MOUNT WARD 3A	626	1.5	4.3	0.2	0.0	0.0	0.0	6.0	67%	159%	100%	-	107%	164%	100%	-	-	-
THE MOUNT WARD 4A	623	1.7	5.1	0.0	0.1	0.0	0.0	6.9	82%	161%	-	100%	104%	218%	-	100%	-	-
YORK - BLUEBELL	150	6.6	15.2	0.0	0.3	0.8	0.7	23.6	92%	76%	-	100%	97%	123%	-	-	100%	100%
YORK - MILL LODGE	236	4.8	8.9	0.0	0.2	2.1	1.4	17.5	53%	107%	-	100%	67%	128%	-	-	100%	100%
YORK - RIVERFIELDS	253	3.9	4.6	0.0	0.0	0.5	0.4	9.4	88%	108%	-	-	100%	110%	-	-	100%	100%
YORK - WESTERDALE	300	3.8	9.3	0.0	0.0	0.4	0.0	13.5	55%	160%	-	-	111%	131%	-	-	100%	-

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
16

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Guardian of Safe Working Quarterly Report Quarter 4: 1 April 2022 to 30 June 2022
DATE OF MEETING:	29 September 2022
PRESENTED BY: (name and title)	Dr Chris Hosker, Medical Director
PREPARED BY: (name and title)	Dr Ben Alderson, Guardian of Safe Working Hours

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	
SO2	We provide a rewarding and supportive place to work.	✓
SO3	We use our resources to deliver effective and sustainable services.	

EXECUTIVE SUMMARY

The purpose of this report is to give assurance to the board that doctors in training are safely rostered and that their working hours are compliant with the Junior doctors contract 2016 and in accordance with Junior doctors terms and conditions of service (TCS). Key points to note are

- There have been 2 exception reports and 0 patient safety issues recorded in this period
- Junior Doctors Forum met in July 2022. Trainees report the middle-tier Red Kite View rota is working well. The HT's wish to switch sides of the rota from East to West (and vice-versa) midway through their 6 month rotation has been agreed and will be implemented from the next rotation date.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes please set out what action has been taken to address this in your paper
	No	

RECOMMENDATION

The Board of Directors are asked:

i. To agree that this reports provides an assurance level for the systems in place to support the working arrangements of the 2016 Contract and TCS for the junior doctors working in the Trust and that they are meeting their objective of maintaining safe services

ii. To provide constructive challenge where improvement could be identified within this system.

MEETING OF THE BOARD OF DIRECTORS

Guardian of Safe Working Hours Report

Quarter 1 April 2022 to June 2022

1 Executive Summary

The purpose of this quarterly report is to give assurance to the board that doctors in training are safely rostered and that their working hours are compliant with the Junior doctors contract 2016 and in accordance with Junior doctors terms and conditions of service (TCS). The report includes the data from 01.04.2022 to 30.06.2022.

2 Quarter 1 Overview

Vacancies		There are 39 Core trainees and 2 NIHR posts					
		There are 5 vacancies in the Higher Trainee establishment					
Rota Gaps		April		May		June	
		CT	HT	CT	HT	CT	HT
	Gaps	9	5	19	8	15	10
	Internal Cover	9	5	18	8	13	10
	Agency cover	0	0	0	0	0	0
	Unfilled	0	0	1	0	2	0
Fill Rate		100%	100%	95%	100%	87%	100%
Exception reports (ER)		1	0	1	0	0	0
		There were 2 ERs raised during this reporting period. No ERs related to patient safety issues.					
Fines		None					
Patient Safety Issues		None					

Junior Doctor Forum (JDF)	Meeting held in July 2022. • The ongoing trial of the bleep-holder (1A) working from home had no further data as in this period no trainees on the rota met the criteria to take this option up. This is an ongoing project. • The 2 exception reports relate to different posts and occurred for different reasons. In April it was recorded that the ward round extended into supervision and therefore supervision was moved to ensure no missed educational opportunity arose. In the other situation a Doctor missed 1 weekly teaching session due to a medical emergency in the unit where they were based. The Doctor acted appropriately and there was no patient safety issue. This second ER was resolved with TOIL. • Red Kite View HT representative stated there were no concerns with the middle-tier rota or the staffing of RKV from their perspective. • Following the previous discussions in JDF it was agreed and enacted that the HT's will spend 6 months of each 'side' of the rota (alternate from West to East, and vice-versa, at the 6 months mid-point of their October-October rotation). This will commence from the next rotation date.

3 Conclusion

Exception Reporting has now been in place within the Trust since 2016 with the first ER being made in 2017. We continue to work with the junior doctors and clinical supervisors to ensure that we are developing a culture where ERs are positively received and used as a mechanism to effect change.

4 Recommendations

The Board of Directors are asked:

i. To agree that this reports provides an assurance level for the systems in place to support the working arrangements of the 2016 TCS for the junior doctors are working in the Trust and that they are meeting their objective of maintaining safe services

ii. To provide constructive challenge where improvement could be identified within this system

Dr John Benjamin Alderson
GMC 6166755, Guardian of Safe Working Hours

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM

17

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Care Services Strategic Plan
DATE OF MEETING:	29 September 2022
PRESENTED BY: (name and title)	Joanna Forster Adams, Chief Operating Officer
PREPARED BY: (name and title)	Alison Kenyon, Deputy Director of Service Development Amanda Burgess, Strategic Development Manager

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives	✓
SO2	We provide a rewarding and supportive place to work	✓
SO3	We use our resources to deliver effective and sustainable services	✓

EXECUTIVE SUMMARY

In October 2021 we engaged with PWC to assist with developing our new Care Services Strategic Plan. Through extensive engagement across our organisation, with people who use our services and our stakeholders we have developed our refreshed ambition for care services over the next 5 to 10 years (2033).

We now have a clear ambition for what we want to deliver in the future, who will deliver our care services and how care services will be delivered in the future. Our ambition aligns with the overall vision for the Trust, *to provide outstanding mental health and learning disability services as an employer of choice*.

The immense challenges brought about by the pandemic, as well as the changing demographics of all our local populations, the continually evolving expectations and needs of our local communities have required the Trust to develop a plan that reflects the range of services we provide now and, in the future. Our new plan for care services also informs the future shape of our estate, ensuring it is fit for the future. Our new priorities include:

1. We co-create and co-deliver care services with people who have lived experience.
2. We collaborate with our partners to understand our populations and provide proactive integrated care.
3. We provide high quality, equitable and sustainable care services.

All our priorities align with our objectives to tackle health inequalities with a specific focus on access, experience and physical health.

Our new priorities will guide our care services work programme and focus over the next five years. We need to expand our implementation plan to not only describe our plans to deliver our three priorities, but also describe how we will deliver our service line aspirations. This will incorporate timescales for delivery, how we will track and govern the progress we make. The

latter being vitally important as we decide how we will use the limited resources we have, as we plan for the next five-years.

Developing our implementation plan is the next step post ratification and is something we need to do alongside our enabling strategic plan leads and wider partners.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes please set out what action has been taken to address this in your paper
	No	

RECOMMENDATION

The Board of Directors are asked to:

- Ratify the Care Services Strategic Plan for 2023 - 2028
- Be assured of the process to develop our Care Services Strategic Plan implementation plan.

NHS
Leeds and York Partnership
NHS Foundation Trust

Care Services Strategic Plan

Leeds and York Partnership
NHS Foundation Trust

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Summary of sections

This page outlines the sections of this document and page numbers for navigation

NHS
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Executive Summary

Leeds and York Partnership
NHS Foundation Trust

We must make changes to our care services so they are fit for the future and sustainable

Our 'burning platform' for change

To develop this Strategic Plan, we have looked at how we provide care, what is working well and where we could make it even better through speaking with our staff, and importantly, the people who use our services. Through this work we have identified important **drivers for change** to our care services. These are summarised below.

1

More people will need mental health care and support in future

We know that the populations we serve are changing. In future, there will be more older people and fewer working age people living in Leeds. This means we can expect higher demand for our older people's mental health services, such as care and support for dementia.

We expect that more people, across all ages, will experience mental health and wellbeing challenges over the next 5+ years due to the impact of the Covid-19 pandemic. This will mean more people requiring our support.

We also must consider potential unknown demand for our services and unmet need. For example, we may not know about the mental health needs of more vulnerable people and communities who may experience poorer access to healthcare than others.

2

Our services are already under pressure and not all of our care service models are future proof

We proudly provide great care to people who use our services. However we know that our staff are under pressure to provide more care to more people, some of whom have complex care needs. We also know that there are some areas in our services that should improve to better support staff to provide great care, and to improve outcomes for people who use our services.

As more people will need mental health care and support in future, we must change our services so that we can respond to higher demand and continue to provide great care. The changes we make should be 'future proof' so that our services are sustainable over the long term.

3

Our care services must change to deliver on national and local strategies

It is important that our Strategic Plan for care services aligns with other mental health strategies so that our services deliver on national and local priorities.

The *NHS Long Term Plan* is a key national strategy that our plan must align to. The Long Term Plan includes many commitments for mental health, including more mental health care being offered in the community and less care provided in hospital settings. Our future care services should be developed in line with this.

Our local 'place' (Leeds) and Integrated Care Systems (West Yorkshire and Harrogate and Humber Coast and Vale) also have defined priorities for mental health and we have a role to play in achieving these as a key provider of mental health across these footprints.

These are the key reasons why we must change our care services to be able to continue providing great care to people who need it. This Care Services Strategic Plan sets out our ambition for the future and the changes we will make in response to these drivers for transformation.

Further detail on the context and case for change can be found in section 2.

Leeds and York Partnership
NHS Foundation Trust

Our new Care Services Strategic Plan sets out our ambition for care services over the next 5 - 10 years

Our priorities and objectives

We have a clear ambition for *what* we want to deliver in the future, *who* will deliver care services, *where* care services will be delivered and *how* care services will be delivered in the future. These all link to our overarching Trust's vision *to provide outstanding mental health and learning disability services as an employer of choice.*

People are at the heart of everything we do both those who we partner with to deliver care, and our teams. We will harness opportunities to understand our other health and care partners and population and work more collaboratively together. By doing this, we will deliver high quality care to all of our people. Our ambitions align with our objectives to tackle health inequalities with a specific focus on access, experience and physical health.

To bring our ambition to life, we have refreshed our priorities and focus for the next 5-10 years and have set ourselves objectives to deliver on.

Our new priorities for our care services:		
1. We co-create and co-deliver care services with people who have lived experience	2. We collaborate with our partners to understand our populations and provide proactive integrated care	3. We provide high quality, equitable and sustainable care services

Objectives for each priority

1.1. Our care services are led together with people who have experience of using our services, working in partnership	2.1. We understand who our partners are (both across the ICS and place) and create the right environments to work with them	3.1. Our care services have the appropriate conditions where high quality care can flourish
1.2. We contribute to our local economy through wider skills development and employment opportunities for people who use our services	2.2. We stay informed about our populations and their holistic care needs and proactively support people	3.2. Our care services deliver equitable access, experience and outcomes
1.3. We lead continuous co-production of care services with our communities and citizens	2.3. We co-design and co-deliver proactive integrated care and support with our partners	3.3. Our care services are clinically, financially and environmentally sustainable, supported by digital and estates
		3.4. We have a sustainable, healthy and engaged workforce whose wellbeing is supported

We recognise that it is important to read this Care Services Strategic Plan alongside other strategic plans within the Trust, such as our *People Plan, our Quality Strategic Plan, our Strategic Estates Plan and our Digital Plan.*

Further details on these plans and how they link to the Care Services Strategic Plan can be found in section 4, the implementation plan. Further detail on the priorities, objectives, accompanying activities and outcomes can be found in section 3, our overall care services strategy.

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We will take key steps to deliver on our priorities and objectives over the next five years

Our key activities

To deliver on our priorities we know that there are key activities we will need to undertake, and many of these will be sequential. The diagram below highlights the activities we will complete to deliver on each objective linked to our priorities.

	Year 1	Year 2	Year 3	Year 4	Year 5
1. We co-create and co-deliver care services with people who have lived experience	Employ people with experience of using our services (obj. 1.1)		Care services led by people who have experience using our services (obj. 1.1)		
	Training and skills for people who use our services (obj. 1.2)	Work experience offered to people with lived experience (obj. 1.2)	Employ people with experience of using our services in operational roles (obj. 1.2)		
	Design approach to co-production (obj. 1.3)	Embed co-production approach (obj. 1.3)	Develop and embed approach to evaluate and continuously improve approach (obj. 1.3)		
2. We collaborate with our partners to understand our populations and provide proactive integrated care	Provide ways for staff to connect with partner organisations (obj. 2.1)	Establish and strengthen relationships with our partners (obj. 2.1)			
	Agree and embed a population health management approach (obj. 2.2)	Identify unmet need in our population (obj. 2.2)			
	Work with our partners to address unmet need in our populations (obj. 2.3)	Establish new ways of working with partners (obj. 2.3)	Use shared community assets creatively with our partners to improve accessibility of our services (obj. 2.3)		
3. We provide high quality, equitable and sustainable care services	Embed research and development into service design and delivery (obj. 3.1)	Embed collective leadership and a culture of continuous improvement (obj. 3.1)			
	Develop a robust approach to measuring and monitoring equity in access, experience and outcomes (obj. 3.2)		Embed equity considerations and requirements into our approach to care service co-design (obj. 3.2)		
	Build capacity, capability and flexibility into our care services workforce (obj. 3.3)	Co-design care services that are environmentally sustainable (obj. 3.3)	Invest in proactive care and community-based support (obj. 3.3)		
	Develop a comprehensive training and skills offering to all staff (obj. 3.4)	Enhance resources to support staff wellbeing (obj. 3.4)			

Further detail on the activities and key milestones can be found in section 5, the implementation plan

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Context and Case for Change

Leeds and York Partnership NHS Foundation Trust

We are a provider of specialist mental health and learning disabilities services

Services we provide

We are the main provider of mental health and learning disabilities services in Leeds and a provider of specialist services for broader regional and **national populations. We deliver a total of 39 services across** nine service lines:

Service Line	Direct Budget £000s	Population Served
Acute	24,911	Leeds
Older People's	17,499	Leeds
Perinatal and Liaison	10,195	Leeds and National
Regional Eating Disorders, Complex Rehabilitation and Gender Identity	16,917	North East, Yorkshire, Leeds & National
Forensics	10,072	Leeds & York
Children and Young People	8,456	West Yorkshire, York, National
Learning Disabilities	6,615	Leeds
Community and Wellbeing	15,928	Leeds
Regional and Specialist	9,700	Leeds, Regional and National

We provide services to **781,000** people

We have **2,929** care services staff

We currently operate across **66** sites

A full list of our current services within each service line can be found in the Appendices A-I.

Our wider partnership context

We operate within a broader health and care system and we proudly work with partners to join up care pathways to improve outcomes for people who use our services. We provide many of our services in collaboration with our partners in our place and Integrated Care Systems (ICSs), as well as regionally and nationally:

- We are part of **two Integrated Care Systems**: West Yorkshire and Harrogate Health and Care Partnership, and Humber Coast and Vale Health and Care Partnership.
- We are part of **Provider Collaboratives** for some of our more specialist services as:
  - Lead Provider for Tier 4 Children and Young People's Mental Health Services (CYPMHS) in West Yorkshire and Lead Provider for Adult Eating Disorders in the North East and Yorkshire region.
  - Lead Provider for the Veterans' Mental Health Complex Treatment Service (VMH CTS) and the Veterans' Mental Health High Intensity Service in the North of England.
  - Lead Provider for the West Yorkshire CREST (Community Rehabilitation Enhanced Support Team) service.
  - Part of the West Yorkshire Adult Secure Provider Collaborative.
- We are part of the **West Yorkshire Assessment and Treatment Units (ATU) collaborative commissioning model**, led by Bradford District Care Foundation Trust.

Our partnership working is driven through established programme and delivery boards, such as the Place-based Partnership Mental Health Delivery Board and the West Yorkshire Specialised Programme Board.

Sources: Leeds and York Partnership Trust website

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In Leeds, where we provide most of our services, there are inequalities in access to care and health outcomes

Summary of current demographics and needs

Leeds has a total population of around **800,000** people. The population is ethnically diverse, with almost a third being Black, Asian or from a ethnic minority population in 2020, an increase from **19%** recorded in the 2011 Census.

There are inequalities in health and social outcomes for people in the city. For example, there is a **11 and 12 year difference in life expectancy** between those living in the most and least affluent areas, for males and females respectively. Nationally, there are inequalities in access to healthcare: there is evidence, for example, that BAME people experience barriers to accessing care and also have poorer mental health. People from BAME ethnic backgrounds are more likely to be detained under the Mental Health Act than people of white backgrounds.

10% of people in Leeds under the age of 25 are likely to have a mental health problem or need support with their emotional wellbeing

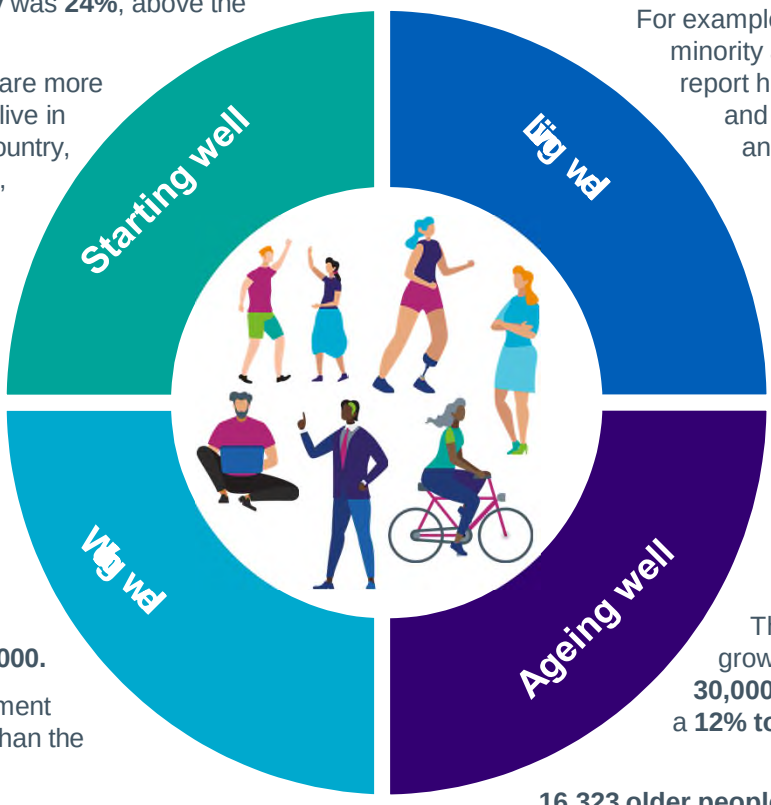
The 2021 Leeds Joint Strategic Assessment outlines that the children and young people population in Leeds is increasingly diverse with increasing deprivation levels. In 2021 the proportion of children in Leeds living in **poverty** was **24%**, above the UK average of **19%.**

Mental health conditions are more common in children who live in poverty, are new to the country, are excluded from school, are in the justice or care systems, have experienced trauma, or have special education needs.

Adults aged 18 and over reporting a clinically significant level of psychological distress increased from 21% in 2019 to 30% in 2020

The 2021 Leeds JSA identifies that the **pandemic** has had a significant impact on the mental health of the Leeds adult population and has exacerbated inequalities in mental health.

For example, Black, Asian and ethnic minority adults were more likely to report higher levels of depression and anxiety, with Bangladeshi and Pakistani men reporting the largest declines in mental health. **Suicide rates** between 2018 - 2020 were **higher in deprived areas** of the city.



People with mental health problems are more likely to be out of employment

The number of people in employment in Leeds is estimated at around **413,000.**

The pre-Covid unemployment rate in Leeds was lower than the national average.

In Leeds, the number of older people who work has increased in the last 20 years. Half of all unpaid carers (around **40,000**) in the city are over 50 years old. This is in keeping with the demographic shift in the city to a population with more older people.

Over 20% of older people (65+) are identified as having a common mental health illness (CMHI) in Leeds

The over 50 population has grown by an estimated almost **30,000** between 2001 and 2019, a **12% to 17%** increase in each of the 50 plus age groups.

16,323 older people in the city are estimated to have depression, of whom **85%** are expected not to be receiving treatment.

The proportion of people living with frailty within the most deprived decile according to IMD is almost three times higher **(22%)** than those who live in the least deprived decile **(8%).**

Sources: Future in Mind: Leeds, Leeds and York Partnership Trust website, Leeds Mental Health Strategy 2020-2025, Leeds JSA

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Health inequalities and poor mental health outcomes are also a challenge across our wider footprints

Challenges in West Yorkshire and Harrogate

The *West Yorkshire and Harrogate MHLDA Strategy* highlights mental health outcome and access issues that are a particular challenge across the system:

- Suicide rates in West Yorkshire and Harrogate are above the national average.
- The number of children and young people with neurodiversity being admitted to specialist mental health inpatient care has increased.
- There is an increasing number of children and young people with behavioural issues being excluded from school and requiring mental health services support.
- Employment levels for people with a mental health condition or a learning disability is lower than the national average.
- There are more adults with a learning disability receiving long term support from local authorities relative to other places in the country, however health-check uptake in this cohort is lower than elsewhere in England.
- The prevalence of problem gambling in West Yorkshire and Harrogate is higher than the national average of **0.9%,** with places such as Leeds having rates as high as **1.3%.**

Our three areas of focus for tackling health inequalities include:

- Access
- Experience
- Physical health

National mental health outcome trends

Even before the pandemic, poor mental health outcomes and inequalities were recognised in the publication of the *Five Year Forward View, and NHS Long Term Plan*. For example, people with severe mental health problems and people with a learning disability often have poorer physical health and die younger than those who don't.
Mental health problems are more common in transgender people and around half of rough sleepers are thought to have mental health needs.

The pandemic has exacerbated mental health issues across England. National lockdowns and shielding have had an impact on the health and wellbeing of the population. The proportion of adults reporting a clinically significant level of psychological distress increased from **21%** in 2019 to **30%** in April 2020, coinciding with the periods of national lockdown. Data from the ONS in May 2021 found that depression rates in the UK have doubled since before the pandemic. Loneliness has increased in older people as a result of the pandemic and for young people, the disruption to education and social interaction is a concern for future mental health. We are yet to understand the long-term impact of the pandemic on our health and care services.

Sources: ONS: Coronavirus and depression in adults, Great Britain, The NHS Long Term Plan, Leeds and York Partnership NHS Foundation Trust Public Meeting of the Board of Directors, Gov.uk: Inequality among lesbian, gay bisexual and transgender groups in the UK: a review of evidence, West Yorkshire MHLDA Strategy

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There are challenges in our care services that we must address to improve outcomes for our service users

Strengths and challenges of current service provision

Over two months, we looked at how we provide care, what is working well and where we could make it even better through speaking with our staff, and importantly, the people who use our services.

Through this assessment we have identified strengths in our care services. For example, we scored 'good' overall in the 2019 CQC inspection, with services being described as 'effective', 'caring', 'responsive' and 'well-led' and outstanding practice identified in some of our services. In addition, we lead in several innovative care services, such as our community eating disorders service, our expanded perinatal inpatient unit and our veterans mental health service. We have well established partnerships in many of our care services, such as our work with the third sector in Leeds OASIS. In some of our services, new and creative staff roles are being created to address skills gaps.

There are however multiple challenges in our care services that we must overcome. Some of these challenges are specific to service areas whereas others are relevant to all of our care services. These are outlined below:

Service user involvement	While service user involvement is well established in some of our care service areas, in others we must improve our approach to meaningfully working with people with lived experience. At present, co-production with service users and carers, and involvement of service users in care delivery, is not embedded in our care services.
Demand for services and long waiting times	Demand has increased, and continues to increase for some of our services, which has led to long waiting times. For example, there are **3157** people on our Gender Identity Service waiting list (Feb 2022 data) and for our LADS service, only **54.3%** of assessments were started within **13 weeks** compared with our **95%** target (Dec 2021 data).
Acuity and complexity of care needs	Our clinical teams are finding that more and more people who use our services require support with multiple, complex and increasingly acute needs. Our services haven't been adapted to respond to this increasing acuity and complexity. In some cases this means that people are cared for in environments that aren't therapeutically optimal for them or others.
Care settings and clinical adjacencies	Many of our clinical settings are not therapeutically supportive or conducive to a person's recovery. Some of our inpatient areas lack access to outdoor space, are on first or second storeys, and some of our service adjacencies (e.g. in Newsam with forensics co-located with our eating disorders and gender identity services) are not clinically appropriate.
Physical health needs of our service users	We have a Healthy Living Service to support our service users with their physical health needs, however our clinical staff report that there are gaps in physical health care support. In our most recent quarterly data capture, **67.1%** of cardiometabolic assessments were completed for inpatients and only **39.9%** in our EIP Service, compared with our **90%** targets.
Staffing pressures and clinical capacity to meet demand	Many of our care services face staffing pressures. This has been particularly apparent during the pandemic where we have experienced several periods of business continuity due to staffing shortages, however recruitment and retention of clinical talent is a longer term challenge for us and a challenge to ongoing provision of safe and high quality care services.

Sources: Leeds and York Partnership Trust website: Gender Identity Service, LYPFT Our People Plan, LYPFT Board Papers January 2022

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The Covid-19 pandemic has presented challenges to our services and many of our services have adapted

Impact on service delivery

Many of our services have had to change how they work to limit the spread of the virus and be flexible to changes in staffing levels during the pandemic. A key change was moving many of our outpatient services from seeing people in person to holding most appointments remotely over video or phone call.

These changes have worked well for some people and less well for others. For some services, such as our Learning Disabilities services, remote appointments have been more challenging as it is often better for staff and service users to communicate face to face.

We also know that there are some people who don't have the technology to be able to access appointments remotely and that this can lead to unequal access to care and support for different people using services that provide care remotely over video call. This challenge of achieving 'digital inclusion', where everyone is able to use digital devices to access care, is important to us and to our partners in the city.

As a result of many services being paused to manage the immediate response to the pandemic, we have a backlog of planned care like the NHS is experiencing across the country. This significant national challenge will be a priority in our local systems and for our care services over the next **12-24 months.**

Accelerating innovation

Although the pandemic has presented these challenges, we have continued to deliver high quality care and have even accelerated innovation in some of our services through the changes we've made.

For example, our CONNECT service for Adult Eating Disorders received an NHS Parliamentary Award (The Excellence in Mental Health Care Award) for going above and beyond to put service users first and for innovative care delivery.

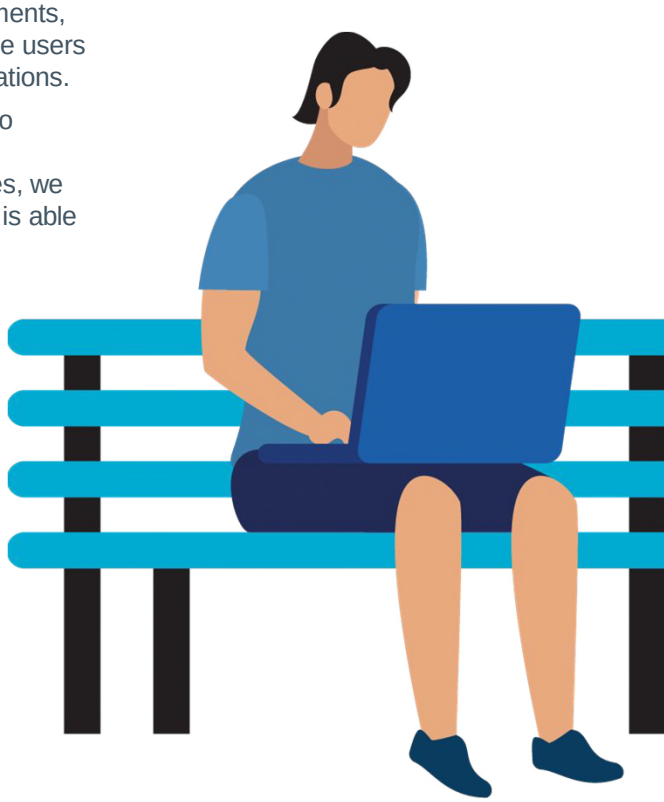
Most of our outpatient services successfully transitioned to be able to complete appointments virtually and remote access to appointments has been sustained in some of our services. Some service users have provided feedback that they prefer remote appointments. For example, from a service user survey completed by the LADS team, it has been identified that if given a choice over how to access appointments, approximately **40%** of service users would prefer remote consultations.

While we see opportunities to continue offering virtual appointments for our services, we recognise that not everyone is able to access these and in some cases it will be safer for people to be seen in person.

Learnings to take forwards

Some of the changes we have made to our services during the pandemic will be sustained over the long term. During the pandemic, our services had to adapt and we will aim to carry forward learnings around service agility and flexibility to support our services to be resilient and adaptable over the longer term.

We will use our lessons learnt from the pandemic to strategically transform into a resilient service that is able to withstand any future events. Now is the ideal time to begin this transformation.



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We must also consider local and national strategic drivers for change to our care services (1 of 2)

National and local mental health policies

As well as looking at how we provide care, we have reflected on what relevant national and local policies mean for the future our care services. Some of these are outlined below.

Policy	Overview	What this means for the future of our care services
NHS Long Term Plan	A ten year plan for delivering sustainable health and care against the backdrop of opportunities for transformation and national challenges, such as the ageing population.	• The commitment to increase mental health care in the community for us means expanding our community and wellbeing services. • The LTP commitment to reduce the number of people with autism and/or a learning disability being admitted into inpatient mental health services means that we must expand our support to people in their own homes and in community settings to provide preventative and proactive support to avoid their care needs escalating.
The national strategy for autistic children, young people and adults: 2021 to 2026	A five year vision for improving the lives of people with autism, built around six themes from access to education and employment through to health inequalities and quality mental health care.	• The strategy aims to reduce waiting times and improve diagnostic pathways to improve access to timely diagnosis - the future of our LADS service should consider this. • The vision for improved community mental health and crisis support for people with autism means we should think about how our community services are accessible for people with autism. • Inpatient care for people who have autism must be provided with consideration of an individual's needs - for our future care services this means having inpatient settings with appropriate environments and care services staff with appropriate skills to support people with autism.
Reforming the Mental Health Act white paper	There has been a public consultation on the White Paper plans to reform the Mental Health Act. This will impact the law on when someone can be detained and receive treatment without consent.	• We should to account for the potential changes to the Act, with the key guiding principles of the reform being: – Choice and autonomy, respecting the service user's choices – Least restriction – Therapeutic benefit, supporting the service user to get better so that they no longer fall within the Act – The person as an individual, treating everyone as different individuals • Examples of proposals include a requirement for care and treatment plans to be developed in partnership with service users in a timely manner for the first time.
West Yorkshire and Harrogate Health and Care Partnership Mental Health and Learning Disabilities Strategy	A five year strategy for the ICS outlining the ambition to improve the mental health of the population.	• Our future services must align to and help to deliver the West Yorkshire and Harrogate MHLDA strategy. • Key areas in the strategy that our care services will be important to deliver on include: reducing requirements for out of area care, development of new ways of providing specialist mental health services, supporting more people to be able to live at home through more community support, and improving physical health for people with mental health problems.

Leeds and York Partnership NHS Foundation Trust

We must also consider local and national strategic drivers for change to our care services (2 of 2)

National and local mental health policies

As well as looking at how we provide care, we have reflected on what relevant national and local policies mean for the future our care services. Some of these are outlined below.

Policy	Overview	What this means for the future of our care services
Humber Coast and Vale Health and Care Partnership Long Term Plan 2019 - 2024	A five year strategy setting out the ambition for the ICS, following its establishment in 2016.	• Our future services must align to and help to deliver the Humber Coast and Vale Health and Care Partnership Long Term Plan and ambition for everyone living in the area to 'start well, live well and age well'. • Key priorities in the plan that are important for us to deliver on include: helping people to look after themselves and stay well, providing services that are joined up across all aspects of health and care, improving the care provided in key areas and making the most of all our resources.
Leeds Mental Health Strategy 2020-2025	The Leeds Mental Health Strategy 2020-2025 sets out eight priorities to improve mental health for people in the city.	• For the care and support we provide to people living in Leeds, our future services must align to and help to deliver on the eight priorities in the Leeds Mental Health Strategy. • For example, we must work with partners in our place to prevent poor mental health in our communities and improve access to employment and skills development for people with mental health problems. • In addition, our care services should 'recognise the impact that trauma or psychological and social adversity has on mental health' and include support to people with a serious mental illness to have better physical health.
Future in Mind: Leeds 2021 - 2026	A five year strategy for improving mental and emotional health and wellbeing for young people up to age 25 in Leeds.	• Our future care service should consider the key priority outcomes in the Future in Mind strategy, in particular those relating to: – Transition between services – Support being provided as close to home as possible – Recognition of the impact of trauma on young people's mental health.

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As we look to the future, we should consider the changing profile of the population we serve

In Leeds we can expect a growing elderly population, with fewer working age adults in the next 10 years

As shown in Figure 01 below, while the Leeds population is forecast to grow by c. 5.4% in total between 2020 and 2036, some age bands have significantly higher growth rates.

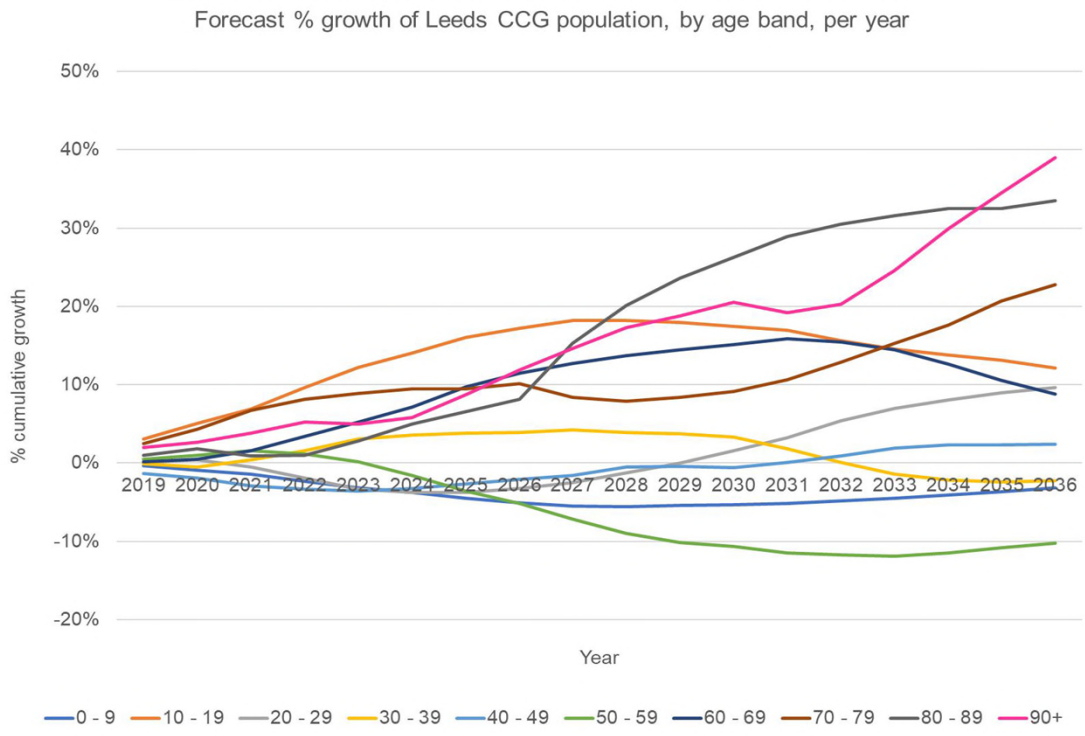
For example, the 90+, 80-89 and 70-79 age groups will see the greatest cumulative growth up to 2036, with a greater proportion of the population of an older age. These populations are typically more frequent users of health and care services, and their care needs can be more complex than other population cohorts, so we can anticipate a rise in demand for our older people's services.

This trend is consistent with national and global population demographic changes

While the data presented below is only for our local population in Leeds, we know that the demographic shift to an ageing population with fewer working age adults is a national and global trend.

We must plan our future care services to be resilient and sustainable so we can respond effectively to this projected increase in demand.

Figure 01



Sources: ONS data, 2018

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Without changing our care services, demand for inpatient care is projected to increase beyond our capacity

We have completed modelling to understand how demand for our care services is expected to change in future.

The modelling outlined below ('do nothing' modelling) shows how demand for our inpatient services, measured through the number of beds required, is projected to grow over the next fifteen years if we make no changes to our current services.

The modelling has identified a need for **more than 100 additional beds** by 2036 if we make no changes to our care services. This would be a significant increase in our bed base that would likely require us to expand our estate. Doing this would not be in line with the national 'left shift' agenda around more care being provided in the community, nor would it support our ambitions around environmental sustainability. We must therefore 'do something' to change our services so that we are able to provide care that supports people to remain at home and provide services that are sustainable and future proof.

Details on the modelling approach, methodology and assumptions are included in the accompanying paper entitled '*Demand and Capacity Modelling Methodology and Outputs*'.

'Do nothing' bed requirement forecast

Service line	Current bed base	'Do nothing' 2036 bed forecast
Adult acute services	132	197 - 204
Children and young people's services	34 (incl. 6 PICU)	26 - 28
ED, R&R, and GI services	67	81 - 84
Forensic services	69	80 - 85
Learning disability services	9	8 - 9
Liaison and perinatal services	16	23
Older people's services	80	103
Total	**407**	**518 - 536**

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We have a ‘burning platform’ for change and we must take this opportunity to set out our 10 year ambition

Changing demographics and forecasted demand

We know that there will be a higher demand for our mental health services in the future, due to our changing population and the impact of Covid-19, which has exacerbated mental health problems as well as had an impact on prevalence of mental health issues.

Based on the way we currently provide care services, demand for our inpatient services are projected to increase significantly over the next 10 - 15 years - this requirement would be difficult for us to achieve and would not be in line with national and local strategies to move more care out of hospital settings and closer to people’s homes.

We therefore must look to deliver mental health care services differently and more efficiently to meet the projected increased demand for our services.

We also know that our Leeds population is becoming increasingly diverse, and that minority population groups often experience health inequalities in relation to access, experience and outcomes. While there are many factors that determine a person’s health, we have a role to play in addressing health inequalities. This means we must provide services that are equitable, and accessible to anyone who needs mental health or learning disabilities care and support. Where we do not have direct influence on wider determinants of health and wellbeing, we must work with our partners on these complex whole system issues.

Challenges to our current service delivery

While we can't change everything, we can focus on changing those things within our gift. As part of this we should consider how best to use existing estates and investment in new estates, aligned to the developing estates strategy. We should also consider how to improve staff satisfaction and wellbeing to both retain and attract staff to the Trust. We should also continue to aim for high quality and innovation, increasing the scope of psychological and creative therapies that we provide and driving digitally-enabled care.

We should address how services will incorporate agile working and flexibility in their delivery to be able to adapt to unexpected external factors. We must take learnings from the pandemic to improve the resilience of our care services and our ability to respond to increased demand that we expect due to the impact of Covid-19 on mental health and wellbeing.

National and local policy drivers for change

Our future care services must be aligned to the national strategic direction for mental health and learning disabilities services to move more care into the community. They should also align with the plans of our place and system partners and promote delivery of integrated care.

Our plan should consider a renewed focus shifting the balance of activity and capability, targeting spend on prevention initiatives and a focus on physical and mental health.

Our future care services should account for the potential changes to the Mental Health Act, particularly around there being patient-centric care which focuses on the autonomy of the individual where they have the capacity to consent or refuse medical treatment.

The following section sets out our overarching care services strategy, detailing our ambition for the future and the key changes to achieve this.

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Overall Care Services Strategy

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We have developed ambition statements and identified core priorities for the future of our care services

Our ambition statements for care services

We have worked with care services staff, service users and carers to develop ambition statements for care services. These bring to life where we want to be in 10-15 years. Our ambition statements for care services aligns to our Trust's vision *to provide outstanding mental health and learning disability services as an employer of choice.* They also align with our health inequalities ambitions to provide better access, experience and physical healthcare.

We will:

- Consider people who use our services and their carers holistically, valuing their skills, strengths and attributes as well as understanding their needs;
- Provide inclusive and accessible services for both people who use our services and their carers;
- Reduce inequalities for people with mental health conditions, addictions and neurodiversity, including ADHD, learning disabilities and/or autism;
- Provide care services that are resilient and sustainable;
- Empower people who use our services and carers to live fulfilling lives;
- Innovate and be creative to develop and deliver services that achieve the desired outcomes for people who use our services and carers;
- Take a preventative and proactive approach to care to promote emotional and mental wellbeing;
- Achieve effective Communication, good Coordination, delivered with Compassion, by working closely with our partners; and
- Involve service users and carers in everything that we do, listening and valuing their views.

Our priorities for care services

Identifying priorities for our care services supports us to make decisions about our care services, particularly when we are deciding how to use limited resources. Our care service priorities form the core part of our strategic plan, are relevant for all of our care services and reflected in our service line aspirations for the future.

Our previous care service priorities

In our most recent care services Strategic Plan we focused on the following three priorities:

- Supporting people in their recovery;
- Supporting people to achieve their agreed goals and outcomes; and
- Supporting staff to promote and coordinate helpful and purposeful practice.

Over the past three years we have put our previous Care Services Strategic Plan into practice and have achieved many of the things we set out to do.

Throughout our work to develop this refreshed Strategic Plan, we identified **three priorities** that were consistently recognised as important by staff, service users and carers. These are outlined on the right.

Our refreshed priorities for care services are:

Priority 1: We co-create and co-deliver care services with people who have lived experience

Priority 2: We collaborate with our partners to understand our populations and provide proactive integrated care

Priority 3: We provide high quality, equitable and sustainable care services

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We have identified objectives for each of our three new priorities for care services

Our new priorities for our care services:		
1. We co-create and co-deliver care services with people who have lived experience	2. We collaborate with our partners to understand our populations and provide proactive integrated care	3. We provide high quality, equitable and sustainable care services

Objectives for each priority

1.1. Our care services are led together with people who have experience of using our services, working in partnership	2.1. We understand who our partners are (both across the ICS and place) and create the right environments to work with them	3.1. Our care services have the appropriate conditions where high quality care can flourish
1.2. We contribute to our local economy through wider skills development and employment opportunities for people who use our services	2.2. We stay informed about our populations and their holistic care needs and proactively support people	3.2. Our care services deliver equitable access, experience and outcomes
1.3. We lead continuous co-production of care services with our communities and citizens	2.3. We co-design and co-deliver proactive integrated care and support with our partners	3.3. Our care services are clinically, financially and environmentally sustainable, supported by digital and estates
		3.4. We have a sustainable, healthy and engaged workforce whose wellbeing is supported

The following pages describe these objectives in further detail and bring to life the impact achieving these will have on people in the future.

Leeds and York Partnership
NHS Foundation Trust

1. We co-create and co-deliver care services with people who have lived experience (1 of 2)

Why is this a priority?

People who have experience of using our services have valuable perspectives on the care and support that we provide. We want to consider these perspectives in all key decisions we make about the way we provide care to help us make changes that will have the most impact for people.

Therefore our strategic plan will focus on how we can develop meaningful service user and carer led services. This is based around three objectives:

Our objectives

1.1. Our care services are led together with people who have experience of using our services, working in partnership

Some of our care services already have people with lived experience working to provide support in peer support roles and this is working well. We will build on this and aim to work in true partnership with people who have experience of using our services to lead our care services collaboratively.

We will achieve this by employing people with lived experience in peer support roles to provide care and support together with our care services staff. We will also establish a leadership and governance structure with experts embedded who have lived experience.

1.2. We contribute to our local economy through wider skills development and employment opportunities for people who use our services

We will create opportunities for people with experience of using our services:

- We will offer work experience at the Trust, whether in a specific role or in multiple areas for breadth of experience;
- We will offer time limited or task-oriented roles for people who would like to work on a flexible basis e.g. supporting with interview panels;
- We will provide substantive employment opportunities.

By doing this we will truly involve people, giving people a platform to encourage others with lived experience to have confidence in sharing their views. Through this we will also contribute to our local economy as an anchor institution, and support social mobility through action on the wider determinants of health.

1.3. We lead continuous co-production of care services with our communities and citizens

All of our services will be co-produced with service users and carers. This means that we will have an embedded team of operational staff, clinical staff, service users and carers to have joint discussions from the outset when re-designing services. This will not be be a 'nice to have' - co-production will be a requirement going forwards.

Our service users and carers will be listened to and their views valued equally to those of our Trust staff. We will work with people to develop and refine our co-production approach that considers inclusivity and accessibility. We will also embed service users into our governance processes to develop sustainable solutions to achieve meaningful co-production.

Leeds and York Partnership
NHS Foundation Trust

1. We co-create and co-deliver care services with people who have lived experience (2 of 2)

What will this mean for people in future?

Achieving our objectives for this priority will have an impact on people who use our services and on our staff. To bring to life what these objectives will mean for people, we have developed fictional 'personas' that describe what people's experiences could be like in future.

On this page we have also included quotes from people we worked with to develop this Care Services Strategic Plan about their ambition for this priority.

My name is Angela and I have just taken part in a six week work experience programme, working within the learning disabilities service involvement team. I also have lived experience and have previously used the Trust's services. The team supported me at first with my digital skills so that I could join Zoom meetings and I used this to lead service user involvement sessions and learning disabilities co-design sessions with clinical and operational staff. Through this I was able to contribute and give my opinion about the future estates for this service, challenging others to think about how to really deliver accessible services.

"We should aspire to be known for co-design and co-production with our local communities and partners. We should be known for being a fair employer and our integrity to deliver gold standard care to our service users." - Quote from Trust care services survey

"I am so proud of myself doing this on my own. I love this job." - Quote from an interview with a Trust service user employed as a coordinator and support worker in the involvement team

We aspire to *"effectively co-designing and co-producing services with staff, service users and carers."* - Quote from Trust care services survey

Leeds and York Partnership
NHS Foundation Trust

2. We collaborate with our partners to understand our populations and provide proactive integrated care (1 of 2)

Why is this a priority?

We are working as a component in a system and contribute to our wider system strategy and place. We are already working as a partner in our system and have some well established provider collaborative programmes (e.g. in the Adult Secure provider collaborative and as the Lead Provider for Tier 4 CAMHS in the ICS).

People with mental health conditions rarely require mental health care services alone. People who use our services also need support from our partners. To improve service user and carer experience we have to work together with partners across the system. This will result in people not having to tell their story more than once, improving their experience of care services that support their holistic needs.

Our objectives

2.1. We understand who our partners are (both across the ICS and place) and create the right environments to work with them

Across our broad range of mental health services we work with a variety of partners across our place, systems, region and nationally. For us to be able to work together effectively to provide great care, it is important for people working in all of our services to know their colleagues in partner organisations and to have strong working relationships with them.

Creating the right environments to build these relationships and to work together will include measures such as:

- Identifying where we could work more closely and effectively with partners and acknowledging that we should invest time and effort to develop new ways of working;
- Aligning incentives with partner organisations;
- Co-locating our staff with their counterparts from partner organisations; and
- Demonstrating behaviours that promote and role model collaboration at all levels.

2.2. We stay informed about our populations and their holistic care needs and proactively support people

We understand the importance of population health management, which is about knowing the health needs of individuals and groups within our population and how these are likely to change in the future. This will help us to understand both the current and future demand for our services but also where there is unmet need in our population across our place. This will enable us to target our health and care support to promote equity of access to our services. We know this isn't something we can do alone; we will work closely with our place partners to define our role in population health management in the city.

Working with our partners, we will also consider wider determinants of health, such as education and housing, and how these factors impact mental health care and support needs currently and in the future. This will consider where we can best support our place partners to prevent the development of mental health problems in our local populations.

2.3. We co-design and co-deliver proactive integrated care and support with our partners

We will work with our partners to co-design and provide integrated, tailored and holistic care to people, regardless of whether they 'meet' traditional service referral criteria.

We will not let anyone 'fall through the gaps' between different services. We will move away from disjointed ways of accessing care and services that have strict referral criteria as we know this can lead to people being referred to multiple different services and having to wait a long time for care. Instead, we will work with our partners to develop simple, coherent and consistent ways for people to access care and support when and where they need it.

Leeds and York Partnership
NHS Foundation Trust

2. We collaborate with our partners to understand our populations and provide proactive integrated care (2 of 2)

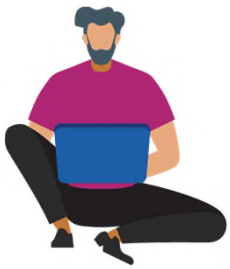
What will this mean for people in future?

Achieving our objectives for this priority will have an impact on people who use our services and on our staff. To bring to life what these objectives will mean for people, we have developed fictional 'personas' that describe what people's experiences could be like in future.

On this page we have also included quotes from people we worked with to develop this Care Services Strategic Plan about their ambition for this priority.

My name is Phil and I'm a mental health nurse within the ALPS service in Leeds General Infirmary. Our team work 24/7 to assess and manage people who present in the emergency department or who have self-harmed. We're now able to see people in a dedicated mental health assessment area in the department, which really helps us to build therapeutic relationships as it feels more confidential and calm than being in an A&E cubicle. I'm now working more closely with colleagues in mental health charities and I can better signpost people I see in A&E to these services. Some of these services have even started to see people who I would previously see regularly in A&E, providing support to them out of hospital - I have been supporting the teams to develop the skills and experience to do this, which has been really rewarding.

We seek *"good partnership working internally and externally providing long-term continuity of care and professionals."* - Quote from Trust care services survey



We aspire to *"increase the diversity of our workforce and professions so that we can deliver services to our local community in a more accessible way through partnership working."* - Quote from Trust care services survey

We would like *"the ability to deliver services where needed; working collaboratively to make best use of resources."* - Quote from Trust care services survey

Leeds and York Partnership
NHS Foundation Trust

3. We provide high quality, equitable and sustainable care services (1 of 2)

Why is this a priority?

The *NHS Long Term Plan* outlines the importance of further 'progressing on care quality and outcomes'. This is based on the recognition that central to care services there should be high quality service provision that meets the needs of all individuals who require care. This is regardless of complexity of need, geographic location and socio-economic factors, such as deprivation.

Our refresh of the *Trust Quality Strategic Plan* highlights the importance of driving compassionate, person centred, safe reliable and effective care to service users and carers.

Our objectives

3.1 Our care services have the appropriate conditions where high quality care can flourish

To achieve high quality services there are a number of dependent factors. This includes having the resources to invest in improving service delivery and a highly capable workforce with appropriate skills and training to deliver quality care. We will use research and development to provide best in class care services. This will include understanding how we can deliver accessible services.

We will invest in innovative care delivery methods, supported by accessible digital tools and technologies. We will enable staff to focus their time on training and development. We will upskill across our service lines, sharing our specialist knowledge with other care staff to deliver consistency across services and share good practice.

3.2. Our care services deliver equitable access, experience and outcomes

We will provide services that are equitable. This means that people will have equal access to care that we provide regardless of their income level, race, employment status, first language or gender. To achieve this, our services will be inclusive - involving a diverse range of people with experience of using our services in decisions about the care we provide will be key to achieve this.

We will monitor how equitable our services are in terms of access, experience and outcomes. This will involve measuring any differences in level of access to services, experiences of care and in mental health outcomes across different population groups. We will use this information to continually identify what we could do differently to achieve equity.

3.3. Our care services are clinically, financially and environmentally sustainable, supported by digital and estates

Not only is it important to design care services that are fit for today's population but it is also important for them to be fit for the future. Our future care services will support us to achieve our zero ambition - by providing more care closer to people's homes and remotely enabled by digital, we will reduce our carbon footprint.

We will continually seek to identify, learn from or lead on innovation in our clinical services to support clinical sustainability and provision of high quality care. This will be supported by our research and development activities.

We have identified areas in our service lines where financial sustainability is a challenge. Our future care services will be efficient as well as high quality, and provide value for money.

3.4. We have a sustainable, healthy and engaged workforce whose wellbeing is supported

We know that in order to deliver quality care services we require a capable workforce who have the necessary capacity to deliver care. In order to achieve this, we will consider how we develop an attractive workforce offering, such as supporting people to develop their skills through access to training events and courses.

We also recognise the importance of supporting the wellbeing of our people. This links very closely to our recent *People Plan*. Our Care Services Strategic Plan will support the delivery of our *People Plan* - for example, we aspire to enable more of our care services staff to meet together in person as we have heard how important this is to promote team wellbeing.

Leeds and York Partnership
NHS Foundation Trust

3. We provide high quality, equitable and sustainable care services (2 of 2)

What will this mean for people in future?

Achieving our objectives for this priority will have an impact on people who use our services and on our staff. To bring to life what these objectives will mean for people, we have developed fictional 'personas' that describe what people's experiences could be like in future.

On this page we have also included quotes from people we worked with to develop this Care Services Strategic Plan about their ambition for this priority.

My name is Harpreet and I work as a mental health nurse in the Deaf CAMHS service. I have profound hearing loss and BSL is my first language. When I was younger I didn't think it would be possible for me to work as a nurse, delivering care to children and young people, although this has always been a passion. The Trust has been supportive to me every step of the way, offering training and career development opportunities with reasonable adjustments. I work independently the majority of the time but I always know that if needed, there are friendly BSL/English interpreters who are flexible around my face-to-face appointments and Zoom group work. I also support other professionals in a formal consultancy role to educate them on how to effectively communicate with deaf children and how to improve accessibility of services.

"The Trust should be known in future for high quality and innovation." - Quote from Trust care services survey

We aspire to be *"a Trust which provides high quality clinical care in fit for purpose estates, delivered by a well trained workforce dedicated to service delivery, teaching, research and innovation."* - Quote from Trust care services survey

We will *"strive to achieve positive outcomes for all service users, their families and communities based on sound clinical models and engagement."* - Quote from Trust care services survey

Leeds and York Partnership
NHS Foundation Trust

We will also make changes within each of our service lines to support delivering our priorities

Our service line aspirations

We have worked with staff across our nine service lines to discuss the aspiration for all of our care services as well as the reasons we need to change. To develop these we have also used information from sources such as the *CQC*, *Royal College of Psychiatrists* and our performance data.

Our 'headline' service line changes have been developed organically and we recognise that this does not represent the full list the ambitions for all service lines (these are included in the relevant Appendices).

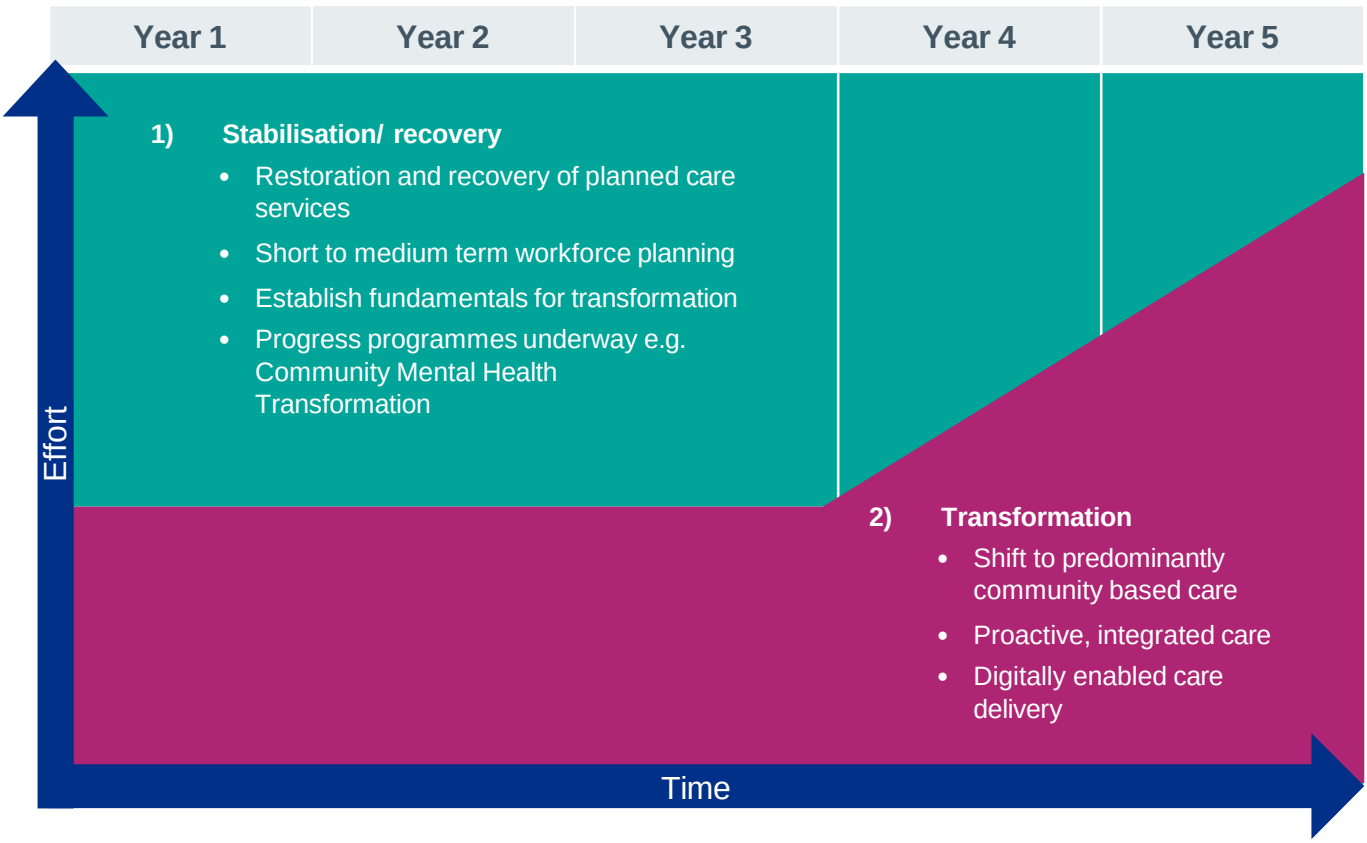
Over the next 10-15 years there are two types of changes that we will be making:

1) **Stabilisation/ recovery**- these are the changes to make over the next five years which will set us up for more ambitious changes in the future. We know that over the next few years we, like all of the NHS, will be focused on recovering our services that have been impacted by the pandemic. We also know that the future national and commissioning direction for mental health services may change. However, we can and should take steps forwards now to set us up for transformational activities in the longer term.

2) **Transformation**- these are the aspirations that we will strive to achieve over the next 10-15 years which will fundamentally shift the way in which we deliver care services. These will be innovative and based on an evidence-base for change. This will take us to a position where we are leaders nationally in delivering on our three priorities, around co-production, collaboration and high quality care services.

The next pages highlight what the key service line aspirations are, indicating which of these are about stabilisation/ recovery and which relate to transformational activities.

Further detail on each of the service line broader aspirations and context behind this can be found in Appendices A-I.



Leeds and York Partnership NHS Foundation Trust

Our headline service line aspirations to deliver on our priorities and objectives (1 of 5)

Our headline service line aspirations

A full summary of service line ambitions can be found in Appendices A-I.

Key:
- Stabilisation/ recovery
- Transformation

Service line	Why do we need to change?	Key changes
Acute	• We have a high number of out of area placements with several internal and external delayed transfers/ discharges. This has an impact on quality of care and on the service user and carer/ family experience. • Our buildings/ clinical environments are not fit to provide modern mental health inpatient care. We have a higher than average number of beds on each ward. The service is located across two sites. We have a mixed gender PICU. • Our Crisis Service (CRISS/ Police Pathway) struggle to meet the demand and needs of the people of Leeds due to the current configuration and pathway with SPA. There is a need to review all crisis services in line with community transformation. • The changing needs of the inpatient population combined with our recruitment and retention challenges require us to review the skills requirements of our workforce.	• Continue our ongoing initiatives on: introducing housing officers addressing clinical variation, formulation and early discharge. • Expand our Intensive Support Service and Crisis Resolution Service by 50%. • Work with Oasis and CAU to enable people with more acute needs to be supported by Oasis. • Pathway improvement work to improve flow across adult acute, forensic and recovery / rehabilitation care pathway. • Stop providing District Control Room (street triage to continue). • Implement city-wide support helpline. • Reduce the number of S136 beds. • Introduce West Yorkshire ICS-wide PICU working arrangement. • Continue to embed a clear and progressive clinical career pathway to support the recruitment and retention of experienced clinical staff, focusing on where there are skills that we require, rather than where there are roles that we require.
Community and Wellbeing	• We are working with place partners to transform community services - this is being driven through the Community Mental Health Transformation and is an important national directive driven by the *NHS Long Term Plan*. • Community services are currently five days a week - demand continues through the weekend, is reflected in referral patterns to acute services. • Many service users are referred multiple times to multiple services in the community; there is a risk that people who need support are 'falling through gaps' in service referral criteria.	• Transform into the new community mental health offer across the Leeds District, where Primary Care Mental Health, Adult Social Care, Third Sector services and WAA CMHS all become integrated into three community hubs. • Expand community services to 7 day provision.

Leeds and York Partnership NHS Foundation Trust

Our service line aspirations to deliver on our priorities and objectives (2 of 5)

Our headline service line aspirations

A full summary of service line ambitions can be found in Appendices A-I.

Key:
- Stabilisation/ recovery
- Transformation

Service line	Why do we need to change?	Key changes
Perinatal and Liaison	• We have an established perinatal community service - the NHS Long Term Plan aims to improve and increase access to perinatal mental health care for women and families. • Ensure we have equitable provision of liaison psychiatry outpatient services across the ICS footprint. • Ensure our liaison teams have access to sufficient space within acute Trust services • The waiting list for NICPM is long and staff capacity is a challenge due to staffing retention. CQC have stated that the premises were not suitable for the purpose they were being used for. • Our MBU is currently in a temporary site (Parkside Lodge) and is scheduled to move back to the Mount during 2022/23.	• Increase our perinatal community service provision and offer support to women, partners and families in alignment with the *NHS Long Term Plan* commitments. • Co-location of liaison psychiatry teams with acute trusts in line with Royal College standards. • Continue providing NICPM in an appropriate estate (acknowledgement that funding direction is likely to influence this) and recruit to address staffing gaps. • Consider our future estate options such as purpose built MBU with therapeutically beneficial environment and co-location with other inpatient services in line with Royal College standards.
Learning Disabilities	• We are working with local authority commissioning partners to ensure the sustainability and future delivery of our supported living services. • We recognise that an important principle of co-production is encouraging peer support, which currently is not delivered within our service. • We currently have some gaps in our preventive support offer, especially in our respite provision.	• Collaboratively redesign the delivery and leadership model of the Supported Living Service so that the service remains competitive, affordable and deliverable. • Employ people with lived experience in involvement co-worker posts. • Add three 'emergency admission' beds for LD respite services. • Establish more integrated working between respite, emergency and Intensive Support Team.

Leeds and York Partnership NHS Foundation Trust

Our service line aspirations to deliver on our priorities and objectives (3 of 5)

Our headline service line aspirations

A full summary of service line ambitions can be found in Appendices A-I.

Key:
- Stabilisation/ recovery
- Transformation

Service line	Why do we need to change?	Key changes
Forensics	• In Leeds, acuity of care needs is increasing and there is a perception that our services may be required to adapt to manage higher risk. • The male forensic pathway is constantly stretched; flow is a challenge between low and medium secure services and there are long waiting lists for beds. Recruitment and retention of staff is a challenge within the service. • Our current environment across both Newsam and Clifton House sites is impacting service user experience. We do not currently meet expected standards for our services as we do not have en-suite facilities and there are limited seclusion facilitates to manage challenging behaviour (e.g no female seclusion at Newsam).	• Expand our community forensics services. • Review / redesign inpatient pathways with aim to reduce delayed transfers of care and discharges. • Integrate and expand our Forensics Psychology service into the community when patients are discharged.
Children and Young People	• We have a new model of care as lead provider for inpatients in West Yorkshire - our links with community CAMHS vary across the West Yorkshire places and care is not fully integrated across care pathways. • We are aware of a current service gap for 18 - 25 year olds in National Deaf CAMHS and the NHS Long Term Plan outlines an expectation that '*by the end of 2023/24 no age-based thresholds are in operation (i.e. no patient should be asked to transition automatically at age 18) and that all services are adapted to better meet the needs of 18-25 year olds as part of a comprehensive offer for 0-25 year olds that reaches across mental health services for CYP and adults*'. • Demand for NG feeding services has increased and at present this is provided only in inpatient settings.	• Introduce a 'day care' facility in both Mill Lodge and Red Kite View to provide an NG feeding service for children and young people with eating disorders who require this intervention and do not otherwise need to be in hospital. • As part of a national network of services to work with NHSE and Trusts nationally to identify the development process for expanding National Deaf CAMHS to include provision for 18 - 25 year olds (options appraisal process currently in progress with service network).. • Further integrate inpatient services with community CAMHS to provide more joined up care across the pathway, strengthening working relationships.

Leeds and York Partnership NHS Foundation Trust

Our service line aspirations to deliver on our priorities and objectives (4 of 5)

Our headline service line aspirations

A full summary of service line ambitions can be found in Appendices A-I.

Key:
- Stabilisation/ recovery
- Transformation

Service line	Why do we need to change?	Key changes
Regional Eating Disorders, Complex Rehabilitation and Gender Identity	• Demand for gender identity services is increasing (there were 3,358 people on our waiting list in Feb 22). We recognise that gender identity is not a mental health disorder and are moving away from this approach. There are current pilots in England of gender identity collaborative models. • Ward 5 - Locked Rehabilitation facility is considered a traditional and unsustainable model, and the environment is not conducive to recovery (e.g. lack of outdoor access). • The CONNECT service for adult eating disorders is relatively new - the care model has already shifted care into the community from inpatient. However we expect there are service gaps between CONNECT and community mental health services, and our ways of working with our system partners could be improved.	• Introduce a community eating disorders service to support people who do not meet referral criteria for CONNECT. • Replace our Recovery Centre with an enhanced community rehabilitation offer. • Establish a system-wide 'quality of life' complex care facility. • Enhance our Assertive Outreach offer. • Move to a 'two tier' gender identity service (with increased role of primary care and third sector partners to support with less complex cases with LYPFT providing support to people with more complex support needs).
Older People's	• Delayed transfers of care in OPS is a challenge (24.9% of transfers were delayed in February) - this is linked to the challenge in access to care home provision for patients to be discharged from the Mount. • Access to appropriate facilities to support older people with acute and intensive care needs isn't available. • The city-wide ambition is for people to receive care in their own homes as much as possible and for as long as possible. • Demand is increasing and is expected to increase further for our memory assessment service.	• Establish access to a specialist long-term facility for people with dementia with complex care needs (use of Dolphin Manor and Willows in short-term). • Potentially establish a dementia PICU for older people with acute and intensive care needs (this would be provided on an ICS footprint). • Aligned with the Leeds city ambition to support people in their own homes as much as possible, enhance the IHTT offer as part of the enhanced community response work that we are doing with the Leeds system (aim to operate at full capacity plus an additional 10% of current capacity). • Co-locate OPS beds with acute site. • Review structure of OPS community teams based on population need. • Evaluate clinical model of, and respond to increase in demand for, Memory Assessment Service.

Leeds and York Partnership NHS Foundation Trust

Our service line aspirations to deliver on our priorities and objectives (5 of 5)

Our headline service line aspirations

A full summary of service line ambitions can be found in Appendices A-I.

Key:
- Stabilisation/ recovery
- Transformation

Service line	Why do we need to change?	Key changes
Regional and Specialist	• Demand for neurodevelopmental services is high and increasing, leading to long waiting lists, and sustainable clinical capacity to meet demand is a challenge (e.g. 54.3% of LADS assessments started within 13 weeks compared to 95% target). • The veterans service are the lead provider for two provider collaboratives, although there is a potential to expand this to be the lead provider across three service tiers. • For the ADHD service, the waiting list is currently 1,800 due to historic under funding of the service and general increase in referrals over the last few years. • Unmet need for addictions support has been identified in two populations: adults with a gaming addiction and children and young people with a gambling addiction. • Alcohol use has increased during the pandemic and fewer people have accessed care. The physical and mental health of people with substance misuse has reported to have worsened. • Within EMERGE and the Pathway Development Service (PDS) unmet need has been identified for people under the age of 18, neurodiverse people and those not meeting current referral/ diagnostic criteria.	• Introduce 'two tier' autism diagnostic service with increased role of primary care / third sector partners for less complex cases and ongoing role for LYPFT in more complex cases. • Introduce system-wide offer for ADHD, with increased role for primary care / other partners for less complex cases (ongoing role for LYPFT in more complex cases). • Expand our ADHD service to include treatment and management support, as well as diagnostics, and introduce service to support children and young people with ADHD in transition to adult services. • Expand our EMERGE and PDS services to include support to people under the age of 18 (14+) and people with neurodiversity. • Stop adult gambling addiction service provision in the and Midlands expand it in new areas (likely Merseyside, Sheffield, Hull). • Start providing a gaming addiction service for adults and a young person's gambling service. • Expand our veterans service in the region, potentially as lead provider across three service tiers (this is dependent on work around new care model development with partners) or through expanding referral criteria.

Leeds and York Partnership NHS Foundation Trust

With these changes, we will be able to provide better care and meet future demand for our services

We have looked at how the changes we've identified will impact the projected demand for our services over the next fifteen years. This is set out below.

The 'do something' modelling outlined below shows the forecast demand for our inpatient services based on the key strategic changes identified for our services and anticipating that Leeds will see a growing elderly population, with fewer working age adults over the next 10 years.

Making these changes will enable us to plan for our services in future without needing additional beds - for some services, we may even be able to reduce the number of inpatient beds. This position is much more closely aligned to the direction of travel of our system and national policy, such as the *Long Term Plan*, to move more care out of hospital settings and into the community to support people closer to home.

Details on the modelling approach, methodology and assumptions are included in the accompanying paper entitled '*Demand and Capacity Modelling Methodology and Outputs*'. Further information on the modelling is also included in the service line appendices (Appendices A - I).

'Do something' bed requirement forecast

Service line	Current bed base	'Do nothing' 2036 bed forecast	Key 'do something' service changes impacting future bed requirements	'Do something' 2036 bed forecast
Adult acute services	132	197 - 204	Expansion of out of hospital acute services, as well as community mental health services, introduction of West Yorkshire PICU working arrangement, work with Oasis partnership.	121 - 126
Children and young people's services	34 (incl. 6 PICU)	26 - 28	'Day centre' NG feeding provision.	21 - 23
ED, R&R, and GI services	67	81 - 84	Expansion of community rehabilitation services and introduction of specialist community eating disorders service.	58
Forensic services	69	80 - 85	Enhancement of community forensics service and collaborative redesign of care pathways.	62 - 63
Learning disability services	9	8 - 9	Addition of emergency inpatient provision for LD services.	11 - 12
Liaison and perinatal services	16	23	Expansion of community perinatal services.	20
Older people's services	80	103	Introduction of complex care facility for people with complex dementia needs, potential co-location of care with acute trust sites, expansion of community-based services (e.g. IHTT) and review of community team structure with view to allocate resource in line with need to support addressing health inequalities.	82 - 84
Total	**407**	**518 - 536**		**375 - 386**

Leeds and York Partnership
NHS Foundation Trust

We have identified key enablers to achieve our aspirations for future care services (1 of 3)

Key enablers to achieve our care services aspirations

Digital, workforce, estates, finance and research and development are the enabling areas to achieve our service line aspirations and our care services priorities. We recognise that there are some dedicated plans within the Trust for a number of these areas, such as our *People Plan*, our *Quality Strategic Plan*, our *Strategic Estates Plan* and our *Digital Plan*. Further details on these plans and how they link to this Care Services Strategic Plan can be found in section 4, the implementation plan.

The table below outlines the how each enabler will help us to achieve our three care services priorities.

Enabler	1. We co-create and co-deliver care services with people who have lived experience	2. We collaborate with our partners to understand our populations and provide proactive integrated care	3. We provide high quality, equitable and sustainable care services
Digital	• Use of technology to support development of service user peer networks • Barriers to digital accessibility addressed and mitigated against, partly through improving staff, service users and carer's digital competency and regardless of digital confidence, context and capability	• Integrated digital systems with our partners regionally, supported by linking the Care Director system to the Yorkshire and Humber Care Record system, reducing the time spent for staff on administrative tasks	• Virtual reality (VR) interventions, such as for therapy (e.g. body image therapy) and service user education • Barriers to digital accessibility addressed and mitigated against • Digital tools, such as apps, developed, for all service users and carers which enable service users to receive care from home and self-manage both physical and mental health aspects of their care
Estates	• Working environments and care settings are inclusive and accessible • Locations of our care services are accessible and enable co-production and co-delivery of care with service users	• Our care services staff are able to meet with colleagues from partner organisations in shared space to collaborate, build relationships and share knowledge	• Care settings are safe, therapeutic environments, conducive to recovery and provision of high quality care • Care services are located with appropriate clinical adjacencies e.g. to facilitate safe and efficient transfers of care and/or flexible access to trained staff • Care settings are inclusive and accessible

Leeds and York Partnership NHS Foundation Trust

We have identified key enablers to achieve our aspirations for future care services (2 of 3)

How each enabler will help to achieve our priorities

Enabler	1. We co-create and co-deliver care services with people who have lived experience	2. We collaborate with our partners to understand our populations and provide proactive integrated care	3. We provide high quality, equitable and sustainable care services
Workforce	• Career progression opportunities are available in the Trust for people with lived experience • Skills development support to care services staff e.g. in co-production	• Potential joint posts with partner organisations (e.g. Voluntary and Community Sector organisations, academic institutions) to promote collaboration • Culture change to support integrated ways of working with partners	• Development opportunities accessible for staff to improve staff satisfaction and support retention • Cultural change to embed non-traditional roles in care service teams • Quality improvement capability building for staff to embed quality improvement culture
Finance	• Funding for employment and skills development offer to people with experience of using our services • Potential investment in training to support care services staff to build skills in co-production	• Clarity on commissioning direction for care services and any new funding available • Potential jointly/ collaboratively funded resources (e.g. roles, buildings, research activity) • Increased transparency with partners on investment priorities to work together to align on shared priorities and identify potential efficiencies	• Clarity on commissioning direction for care services and any new funding available • Investment in priority changes to care services to support development of resilient and sustainable services • Targeted investment to support underserved populations (e.g. improving inclusivity and accessibility of care services) to support provision of equitable care • Clarity on potential funding opportunities for research and development to enable research activity to be embedded in care services

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We have identified key enablers to achieve our aspirations for future care services (3 of 3)

How each enabler will help to achieve our priorities

Enabler	1. We co-create and co-deliver care services with people who have lived experience	2. We collaborate with our partners to understand our populations and provide proactive integrated care	3. We provide high quality, equitable and sustainable care services
Research & Development	• Potential opportunities to identify good practice in co-production and evidence-based for effective peer support models	• Clarity on R&D priorities for key partners and potential opportunities to collaborate on research programmes • Strengthened relationships with colleagues in other organisations through R&D to support integrated working and culture of collaboration	• Research and development embedded in all service lines to enable research to become an integral part of quality service provision and for service models to be evidence-led • New evidence, innovation and good practice communicated with front line teams to identify opportunities to implement

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The outcomes we are aiming to achieve for each of our objectives (1 of 2)

Our outcomes

By achieving our three priorities for care services we will make an impact and affect real change across Leeds and York. We can articulate this impact and change by describing the outcomes that we are working towards, both as an organisation and for broader society. This page and the next describes what these outcomes are and what this means in practice.

Objectives	Outcomes for each objective
1.1. Our care services are led together with people who have experience of using our services, working in partnership	• People with lived experience have meaningful influence over decisions we make as a Trust • More people with mental health conditions, addictions and neurodiversity are employed • Service users benefit from peer support from people with lived experience
1.2. We contribute to our local economy through wider skills development and employment opportunities for people who use our services	• People with mental health conditions, addictions and neurodiversity have career opportunities and aspirations • More people with mental health conditions, addictions and neurodiversity are employed
1.3. We lead continuous co-production of care services with our communities and citizens	• All of our care services are co-produced with people with lived experience • Our care services are inclusive, accessible and equitable
2.1. We understand who our partners are (both across the ICS and place) and create the right environments to work with them	• All of our care services teams knows who their partners are • All of our care services teams create the right environments to work with their partners
2.2. We stay informed about our populations and their holistic care needs and proactively support people	• All of our care services teams and those of our partners where relevant know their populations • We have a holistic view of population need, including unmet need
2.3. We co-design and co-deliver proactive integrated care and support with our partners	• Our populations can access care services that are tailored to their holistic needs • People who use our services and those of our partners do not notice organisational boundaries in their experience of care and support • People who use our services receive care and support close to their homes or in their own homes

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The outcomes we are aiming to achieve for each of our objectives (2 of 2)

Objectives	Outcomes
3.1. Our care services have the appropriate conditions where high quality care can flourish	• All of our care services staff work in environments where high quality care can flourish • Every care service measures their 'STEEEP' outcomes (Safe, Timely, Effective, Efficient, Equitable and People-centred care) • We know where our quality 'high spots and hot spots' are and we use this knowledge to celebrate, learn and continuously improve • People who use our services experience Safe, Timely, Effective, Efficient, Equitable and Person-centred care
3.2. Our care services deliver equitable access, experience and outcomes	• All of our care services our equitable • All people with mental health conditions, addictions and neurodiversity have access to care and support, have an improved experience of care and support and have improved outcomes
3.3. Our care services are clinically, financially and environmentally sustainable, supported by digital and estates	• Our care services are resilient and flexible to changes in demand • People with mental health conditions, addictions and neurodiversity have access to care and support in the community • Our care services are environmentally sustainable and support delivery of our Trust Green Plan
3.4. We have a sustainable, healthy and engaged workforce whose wellbeing is supported	• All of our workforce are happy and satisfied to work for our Trust • All of our workforce are equipped with the appropriate skills and capability to deliver quality care services • All of our workforce feel supported in their wellbeing

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Implementation Plan

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Our Care Services Strategic Plan will be delivered through a number of activities over the next five years

Our key activities

The visual below highlights the key activities for us to deliver on each of our three priorities over the next five years. The following pages detail the key milestones, start dates and owners for each activity in our implementation plan. Our implementation plan is to be refined further to include our delivery plans for achieving all our service line ambitions described in appendices A – I.

	Year 1	Year 2	Year 3	Year 4	Year 5
1. We co-create and co-deliver care services with people who have lived experience	Employ people with experience of using our services (obj. 1.1)		Care services led by people who have experience using our services (obj. 1.1)		
	Training and skills for people who use our services (obj. 1.2)	Work experience offered to people with lived experience (obj. 1.2)	Employ people with experience of using our services in operational roles (obj. 1.2)		
	Design approach to co-production (obj. 1.3)	Embed co-production approach (obj. 1.3)	Develop and embed approach to evaluate and continuously improve approach (obj. 1.3)		
2. We collaborate with our partners to understand our populations and provide proactive integrated care	Provide ways for staff to connect with partner organisations (obj. 2.1)	Establish and strengthen relationships with our partners (obj. 2.1)			
	Agree and embed a population health management approach (obj. 2.2)	Identify unmet need in our population (obj. 2.2)			
	Work with our partners to address unmet need in our populations (obj. 2.3)	Establish new ways of working with partners (obj. 2.3)	Use shared community assets creatively with our partners to improve accessibility of our services (obj. 2.3)		
3. We provide high quality, equitable and sustainable care services	Embed research and development into service design and delivery (obj. 3.1)	Embed collective leadership and a culture of continuous improvement (obj. 3.1)			
	Develop a robust approach to measuring and monitoring equity in access, experience and outcomes (obj. 3.2)		Embed equity considerations and requirements into our approach to care service co-design (obj. 3.2)		
	Build capacity, capability and flexibility into our care services workforce (obj. 3.3)	Co-design care services that are environmentally sustainable (obj. 3.3)	Invest in proactive care and community-based support (obj. 3.3)		
	Develop a comprehensive training and skills offering to all staff (obj. 3.4)	Enhance resources to support staff wellbeing (obj. 3.4)			

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Implementation for priority one and key milestones for each activity

Key activities and milestones

Below highlights the activities, key milestones, start date and activity owner for priority 1: *we co-create and co-deliver care services with people who have lived experience.*

Activity	Key milestones	Start date	Activity owner
1.1. Our care services are led together with people who have experience of using our services, working in partnership			
1.1.1. Establish a leadership and governance structure for experts by experience employed by the Trust	• Governance structure for experts by experience signed off by Executive Board	Year 2	Executive Board
1.1.2. Employ people with experience of using our services as a user or carer in care services peer support roles	• Terms of Reference for all peer support roles created • Training programme rolled out to peer support workers	Year 1	Service user involvement team
1.2. We contribute to our local economy through wider skills development and employment opportunities for people who use our services			
1.2.1. Provide training and skills development opportunities for people who use our services	• Training programme developed • Training programme rolled out	Year 1	Service user involvement team
1.2.2. Create work experience opportunities for people with lived experience	• Work experience opportunities identified by all service lines • Marketing campaign to advertise work experience roles	Year 1	Service user involvement / workforce teams
1.2.3. Employ people with experience of using our services in roles in the Trust outwith care services (e.g. communications, admin)	• Roles identified • Terms of Reference developed with reasonable adjustments clearly outlined	Year 1	Operational team
1.3. We lead continuous co-production of care services with our communities and citizens			
1.3.1. Establish a robust approach to co-production with people who use our services, our local communities and citizens	• Current approach to co-production assessed • Approach to co-production agreed	Year 2	Service user involvement team/ service lines
1.3.2. Embed this approach into all care service areas	• Approach to co-production implemented	Year 3	Service line leads
1.3.3. Develop an approach to evaluating and continuously improving our approach to co-production	• Approach to evaluation agreed and signed off by service user groups and Executive Board • Continuous monitoring approach agreed and implemented	Year 3	Service user involvement team

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Implementation for priority two and key milestones for each activity

Key activities and milestones

Below highlights the activities, key milestones, start date and activity owner for priority 2: *we collaborate with our partners to understand our populations and provide proactive integrated care*

Activity	Key milestones	Start date	Activity owner
2.1. We understand who our partners are (both across the ICS and place) and create the right environments to work with them			
2.1.1. Provide mechanisms for our care services staff to connect with their peers in partner organisations	• Agreement with partner organisations on approach to connecting peers together • Implement agreed approach	Year 1	Service line leads
2.1.2. Establish and strengthen relationships with our partners	• Mapping process of all partners locally, regionally and nationally complete, identifying where relationships require to be developed	Year 2	Executive Board
2.2. We stay informed about our populations and their holistic care needs and proactively support people			
2.2.1. Work with our partners to use our collective skills and experience to identify and understand our populations, taking a population health management approach	• Data on latest population demographics and need profile obtained • Trust role in population health management agreed and implemented	Year 1	Health Informatics team
2.2.2. Identify unmet need in our populations	• Analysis of population data and insights from service line teams, system partners and service users and carers	Year 2	Health Informatics team
2.3. We co-design and co-deliver proactive integrated care and support with our partners			
2.3.1. Work with our partners to address unmet need in our populations, co-designing solutions that make the most of our collective capabilities and capacity	• Scope for areas to redesign agreed with partners based on unmet need insights • Approach to co-design agreed with partners • Services developed to address unmet need	Year 1	Service line leads
2.3.2. Establish new ways of working with partners to minimise the impact of organisational boundaries on a person's experience of care	• Strengths and weaknesses of current ways of working identified • New ways of working agreed and implemented	Year 1	Service line leads
2.3.3. Use shared community assets creatively with our partners to improve accessibility of our services	• Engagement with service users/ carers completed to identify where lack of accessibility • Opportunities for use of community assets identified	Year 2	Service line leads / estates team

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Implementation for priority three and key milestones for each activity (1 of 2)

Key activities and milestones

Below highlights the activities, key milestones, start date and activity owner for priority 3: *we provide high quality, equitable and sustainable care services*

Activity	Key milestones	Start date	Activity owner
3.1. Our care services have the appropriate conditions where high quality care can flourish			
3.1.1. Embed collective leadership, learning and a culture of continuous improvement	• Educational campaign/ training on collective leadership launched	Year 2	Executive Board
3.1.2. Embed research and development into service design and delivery so we have the knowledge, tools and evidence to provide the best care anywhere	• Investment areas for research and development agreed	Year 1	Executive Board
3.2. Our care services deliver equitable access, experience and outcomes			
3.2.1. Develop a robust approach to measuring and monitoring equity in access, experience and outcomes for all of our care services	• Approach to measuring and monitoring access, experience and outcomes agreed and implemented	Year 1	Quality team
3.2.2. Embed equity considerations and requirements into our approach to care service co-design	• Equity considerations identified and agreed • Approach to incorporating equity considerations into service design agreed	Year 3	Service line leads
3.3. Our care services are clinically, financially and environmentally sustainable, supported by digital and estates			
3.3.1. Build capacity, capability and flexibility into our care services workforce	• Plan to address key care services workforce gaps developed • Communications and engagement campaign on training and education offer for care services staff launched	Year 1	Workforce team
3.3.2. Invest in proactive care and community-based support to prevent escalation of care needs requiring more intensive support	• Targeted opportunities for community-first support identified and agreed	Year 3	Service line leads
3.3.3. Co-design new care services and ways of working that promote environmental sustainability	• Opportunities to enhance new and existing estates and working practices identified based on national policy and good practice	Year 2	Estates team

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Implementation for priority three and key milestones for each activity (2 of 2)

Key activities and milestones

Below highlights the activities, key milestones, start date and activity owner for priority 3: *we provide high quality, equitable and sustainable care services*

Activity	Key milestones	Start date	Activity owner
3.4. We have a sustainable, healthy and engaged workforce whose wellbeing is supported			
3.4.1. Develop a comprehensive training and skills offering to all staff	• Existing training and skills offerings to staff clarified • Gaps in training and skills to be addressed identified and agreed	Year 1	Workforce team
3.4.2. Enhance resources to support staff wellbeing	• Opportunities for collaboration spaces for teams to meet together in person identified • Additional skills requirements to support high quality skills delivery identified	Year 2	Workforce team

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How this strategy links to wider plans across our Trust

Our plans across the Trust

Below describes other existing plans across the Trust and how they link to the Care Services Strategic Plan.

Corporate Trust strategy (2018-2023)	The 'Living our values to improve health and lives' Trust strategy highlights our purpose, vision, ambition and values as a Trust which all run as a 'golden thread' through this Care Services Strategic Plan. Any care services design in the future will be aligned to these core values, with us having integrity, keeping it simple and being caring.
Quality Strategic Plan (2018-2022)	Our care services priorities, particularly our third priority (we provide high quality, equitable and sustainable care services), align to the principles set out in the *Quality Strategic Plan*. The objectives for our third priority are closely aligned with the five core areas in our quality plan (creating the conditions, knowing where we can learn from high quality and support improvement where required, helping in a joined up way, developing ways to manage quality).
People Plan (2021-2024)	Our new People Plan sets out our ambitions of looking after our people, belonging in the NHS, new ways of working and delivering care and growing for the future. The plan also sets out how we build an inclusive culture and a workforce of the future, both which are imperative to delivering high quality care services.
Strategic Estates Plan (in development)	We are currently developing a refreshed estates strategy. This will be based on our aspirations for the future of our care services set out in this Care Services Strategic Plan. The estates strategy will consider the options for our future estate that support the delivery of high quality and sustainable care services.
Our Digital Plan (2021-2024)	We have recently launched a refreshed digital plan, that sets out our aim to use 'innovative technology and intelligence to enable safer, inclusive and more effective care'. This highlights key progress to date, our key projects and priority areas for digital in terms of using services, implementing digital, delivering services and partnership working. Our Care Services Strategic Plan is aligned to these project areas, with further detail on this found in Appendix J.
Green Plan (2021-2025)	This plan articulates how we will contribute to achieving the NHS 2040 and 2045 targets with key priorities relating to the delivery of care services being behaviour/ engagement, operational practice, and hybrid working. This is particularly relevant to our Care Services Strategic Plan objective 3:3: *'Our care services are clinically, financially and environmentally sustainable'*.
Research & Development Plan (in development)	We are currently drafting a research and development plan which will highlight our ambition for embedding research activity into our care services. This aligns with one of our objectives in this Care Services Strategic Plan: *'Our care services have the conditions where high quality care can flourish'.* As the research and development plan is developed it will be important that areas of focus for the future align with the strategic direction of our care services.

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Appendix

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Appendix

Contents of our appendix

Our appendix provides supporting and more detailed information on a number of themes, as outlined below.

Appendix no.	File name	Description
A	Acute service line aspiration	
B	Community and Wellbeing service line aspiration	
C	Children and Young People service line aspiration	
D	Regional Eating Disorders, Gender Identity and Complex Rehabilitation service line aspiration	• Who the service line provides services to; • How the service line currently works; • Why the service line should change; • How the service line will change in the future; • How the service line will achieve these changes; • How these changes will make a difference.
E	Forensics service line aspiration	
F	Learning Disabilities service line aspiration	
G	Older People's service line aspiration	
H	Perinatal and Liaison service line aspiration	
I	Regional and Specialist service line aspiration	

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Appendix A: Acute Service Line Aspiration

integrity | simplicity | caring

Our acute services are core mental health services providing care and support to adults in Leeds

Our acute services teams support people living in Leeds with acute mental health problems.

People we care for may already have mental health conditions or they may be experiencing a mental health problem for the first time.

Many people who use our acute services also get support from other service areas, such as community mental health teams and specialist teams. Often this means that a period of acute care is one part of a person's care journey, with support provided by other teams before and after this period.

Our Acute Service Line is made up of the following services:

Crisis Resolution Intensive Support Service (CRISS): Our CRISS team work with people who are experiencing a mental health crisis. The team provide short term intensive support to people in their own homes to help them through the period of crisis.

Crisis Assessment Unit (CAU): Our CAU is an inpatient unit where people experiencing a complex mental health crisis are assessed and supported over a short period. People may go on to need support in our inpatient services, or may be able to go home with or without ongoing support.

Acute Inpatient Services: Our acute inpatient teams care for people with acute mental health needs who need high levels of support that cannot be provided safely out of hospital. This service is available for people with a learning disability and mental health needs and people who are detained under the Mental Health Act.

Psychiatric Intensive Care Service (PICU): Our PICU team supports people with highly acute or complex mental health needs, providing intensive specialist care.

We provide great care to our service users and are proud of the services we provide.

We are committed to providing high quality acute care. This is reflected in recent improvement work we have completed such as our gatekeeping work with CRISS, our work around safety huddles and improving working across service lines and community teams as part of developing pathways.

In our most recent CQC inspection in 2019, we were assessed as 'good', which we have maintained even throughout the challenges posed by the Covid-19 pandemic.

We know from recent work with our city partners that in Leeds we have more challenges with mental health compared to other places in England, and there are inequalities in mental health in our place:

- It is estimated that 106,000 people in Leeds experience a common mental health disorder.
- We know that one third of people in Leeds who get support from crisis services have not previously used mental health services (such as community services).
- More people are admitted to hospital as a result of self-harm in Leeds, compared with the national average.
- Suicide and self-harm admission rates are higher in poorer areas of Leeds, with the highest suicide rates being in middle aged men and highest rates of self-harm in young women.
- Leeds has a higher rate of people subject to the mental health act compared to the England average.

Sources: Leeds and York Partnership Trust website, Mental Health Services Insight Review, Leeds Mental Health Strategy 2020 - 2025, Leeds CCG: Population Data Profiled

We are proud of the services we provide, however there are challenges to ongoing provision of quality acute care

Many of the challenges we have are consistent with those faced by other acute mental health services across the country.

Nationally, issues with recruitment and retention of clinical talent are linked to challenges with building a sustainable mental healthcare workforce.

The Covid-19 pandemic has had an impact on people's mental health, for example through increased social isolation, and the effects of this are expected to be long lasting.

Long waits for non-acute mental health care and support, which are expected to have worsened due to the pause on some non-urgent care during the pandemic, may lead to the development of more acute care needs.

In addition to these national trends, locally we have identified the core challenges we face within our Acute Service Line, which we must address to improve people's outcomes and experiences of care:

- We have a high number of **out of area placements** with several internal and external delayed transfers and discharges. This has an impact on quality of care and on the service user and carer experience.
- Our **buildings and clinical environments** are not fit to provide modern mental health inpatient care. We have a higher than average number of beds on each ward and the service is located across two sites (Newsam and Becklin centre), meaning our teams don't feel connected to each other and we are often required to use secure transport to transfer service users between sites. We have a **mixed gender PICU**, which can lead to out of area placements for people who require care in a gender specific PICU.
- CRISS, our crisis service, **struggle to meet the demand** and needs of the people of Leeds due to the current configuration and pathway with SPA. There is a need to review all crisis services in line with community transformation.
- The **changing needs of the inpatient population,** combined with our recruitment and retention challenges, require us to review the skills requirements of our workforce.

Without change, demand for acute mental health care in Leeds is set to increase beyond our capacity to respond

We have completed demand and capacity modelling to understand how demand for our services is expected to change in future.

The modelling outlined below ('do nothing' modelling) shows how demand for our inpatient services, measured through the number of beds required, is projected to grow over the next fifteen years if we make no changes to our current services.

It is clear from the data that if we 'do nothing', there is an upwards trajectory in bed requirements across all of our acute adult inpatient wards.

The extent of the additional bed requirement is dependent on the potential long-term recurrent impact of Covid-19. If we assume that the long-term recurrent impact of Covid-19 is 'low' (1), by 2028 we will need around 190 beds across adult acute services, and by 2036 we will need around 204. **This is 50 - 70% higher than the bed capacity we currently have.**

For our out of hospital acute services, demand (measured through activity/contact), is also set to increase by 2028 and 2036 if we do not make any changes.

'Do nothing' modelling for adult acute inpatient services and out of hospital services

Adult acute inpatient services	Required beds per year (incl. occupancy) 2019	Beds used in 2019 (occupancy)	Required beds per year (incl. occupancy) 2028 (2)		Required beds per year (incl. occupancy) 2036 (2)		Planned bed capacity
			Best case (1)	Intermediate 1 (1)	Best case (1)	Intermediate 1 (1)	
Becklin Ward 1	22	22 (101%)	33	34	35	37	22
Becklin Ward 3	22	22 (98%)	30	31	32	33	22
Becklin Ward 4	22	22 (100%)	30	31	32	33	22
Becklin Ward 5	22	22 (100%)	33	34	35	36	22
CAU	6	5 (90%)	7	7	9	8	6
Newsam Ward 1 - PICU	12	11 (93%)	19	19	20	21	12
Newsam Ward 4	21	21 (100%	29	30	31	32	21
S136	6	3 (<50%)	4	4	4	4	5
Total	**133**	**128**	**185**	**190**	**197**	**204**	**132**

Acute out of hospital services	Extrapolated contacts 2019(3)(4)	Forecast range of do nothing' contacts 2028 (4)(5)	Forecast range of 'do nothing' contacts 2036(4)(5)
Crisis Resolution	2,828	3,110 - 3,239	3,405 - 3,535
Intensive Support Service	27,232	29,686 - 30,966	32,320 - 33,600
Street Triage	2,363	2,585 - 2,696	2,836 - 2,947
District Control Room	375	342 - 356	375 - 389
SPA Switchboard	5,910	6,604 - 6,882	7,339 - 7,617
Total	**38,645**	**42,326 - 44,138**	**46,275 - 48,087**

*(1)Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes **no** long-term recurrent impact of COVID and the 'Intermediate 1' / 'low' recurrent impact of COVID scenario applies **some** long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.*
(2) Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number.
(3) Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on number of months.
(4) Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.
(5) Range based on 'best case' and 'intermediate 1' scenarios

We will make strategic changes to our acute services to improve care and enable us to meet future demand

To address the challenges we are facing now and set our services up for the future, we must make changes so that we can continue to provide high quality and equitable care to people in Leeds. We have identified a set of key changes to our acute services, shown below.

In developing these, we have considered the overarching strategic priorities for care services, and how the changes we make within the Acute Service Line align and support the delivery of them. Our priorities for care services are:

- *We co-create and co-deliver care services with people who have lived experience*
- *We collaborate with our partners to understand our populations and provide proactive integrated care*
- *We provide high quality, equitable and sustainable care services*

The diagram below highlights how the changes we will make to acute services align with these priorities.

In identifying the key changes for acute care, we have also considered the strategic direction of our local system as well as relevant national policy - our future services must align to the 'left shift' agenda set out in the *NHS Long Term Plan*, moving more care into the community and focusing on early intervention and prevention.

In line with this national direction, our ultimate ambition for our acute mental health services are to support more people to be cared for in the community for as long as possible. We know that this cannot be achieved through changing LYPFT acute mental health services alone, and recognise how important it is for us to continue working closely with community mental health teams and our wider city partners.

Change	Rationale and benefits
Expand our Intensive Support Service and Crisis Resolution Service by 50%	This will mean more people can receive acute care in the community, reducing admissions.
Continue our ongoing initiatives on: • Introducing housing officers • Addressing clinical variation • Formulation • Early discharge	These initiatives aim to reduce average length of stay in acute adult inpatient wards, enabling people to get home as soon as safe and possible for them.
Work with Oasis and CAU to enable people with more acute needs to be supported by Oasis	This will enable more people to be supported outwith acute mental health hospitals. In the long term (5+ years), this may lead to no requirement for a CAU.
Pathway improvement work to improve flow across adult acute, forensic and recovery / rehabilitation care pathway	This will reduce delayed transfers of care /discharges, reducing overall length of stay and enabling service users to be cared for in the most appropriate environment, improving quality and experience.
Stop providing District Control Room (street triage to continue)	This is driven by commissioning changes. It may have an impact on street triage contacts.
Implementation of city-wide support helpline	This will create a clear route for people to access support and avoid calls for support to SPA.
Reduce the number of S136 beds	Relative to elsewhere in the country our S136 capacity is high; our actual requirement is half of our capacity.
Introduce West Yorkshire ICS-wide PICU working arrangement	This will reduce out of area placements and reduce average length of stay for PICU.

With these changes, we will be able to provide better care and meet future demand for our services

We have looked at how the changes we've identified will impact the projected demand for our services over the next fifteen years. This is set out below.

Based on agreed assumptions, it is projected that expansion of out of hospital acute care (as set out in the previous page), enhanced community mental health services and pathway improvement work **could reduce length of stay in our acute adult wards to an average of 32 days with 85% occupancy**. This means our current bed capacity would be sufficient to meet future demand. However, there remains a gap between demand and capacity for PICU-beds, which is likely attributable to the significant number of repatriated patients.

As our service changes are focused on expanding out of hospital support, the 'do something' modelling for **our community-based services (Crisis Resolution, Intensive Support Service) are projected to increase.** This would be expected to increase in line with an increase in capacity as the services are expanded.

The introduction of a city-wide support helpline is projected to prevent around 343 calls to the SPA Switchboard per month (c. 4,000 per year), releasing capacity for the SPA team and redirecting service users to better routes for accessing immediate support.

'Do something' modelling for adult acute inpatient services and out of hospital services

Adult acute inpatient services	Beds available in 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 90% occupancy) 2028		Required beds per year (assuming 90% occupancy) 2036		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) [1]	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) [1]	
Becklin Ward 1	22	22 (101%)	21	22	23	24	22
Becklin Ward 3	22	22 (98%)	18	19	20	21	22
Becklin Ward 4	22	22 (100%)	20	21	22	23	22
Becklin Ward 5	22	22 (100%)	21	22	22	23	22
Newsam Ward 1 - PICU	12	11 (93%)	19	19	20	21	12
Newsam Ward 4	21	21 (100%	17	17	18	19	21
Total	**121**	**120**	**116**	**120**	**125**	**131**	**121**
Non-PICU beds required			**97**	**101**	**105**	**110**	**109**
Female non-PICU beds required			**42**	**44**	**45**	**47**	**44**
Male non-PICU beds required			**55**	**57**	**60**	**63**	**65**

Acute out of hospital services	Extrapolated contacts 2019 [2][3]	Forecast range of 'do nothing' contacts 2036 [3][4]	Forecast range of 'do something' contacts 2028 [3][4]	Forecast range of 'do nothing' contacts 2036 [3][4]	Forecast range of 'do something' contacts 2036 [3][4]
Crisis Resolution	2,828	3,110 - 3,239	4,229 - 4,405	3,405 - 3,535	4,631 - 4,807
Intensive Support Service	27,232	29,686 - 30,966	40,967 - 42,732	32,320 - 33,600	44,602 - 46,367
Street Triage	2,363	2,585 - 2,696	2,585 - 2,696	2,836 - 2,947	2,836 - 2,947
District Control Room	375	342 - 356	-	375 - 389	-
SPA Switchboard	5,910	6,604 - 6,882	5,349 - 5,635	7,339 - 7,617	5,951 - 6,237
Total	**38,645**	**42,326 - 44,138**	**53,129 - 55,468**	**46,275 - 48,087**	**58,019 - 60,358**

(1)Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.
(2)Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals.
(3) contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.
(4)Range based on 'best case' and 'intermediate 1' scenarios

These changes will have an impact on the experiences of staff and people who use our services

While we have identified the impact of the key changes to our service in terms of demand for and capacity of our services, ultimately this is about providing great care to people who need support.

We know that without changing how we provide acute mental health care, we will not be able to keep up with the demand and our services will not be sustainable - this will limit our ability to continue to provide safe, high quality and equitable care.

The ambition we have set out for the Acute Service Line aims to deliver on our wider care services strategic priorities. However we will also aim to impact on outcomes that are specific to our services - will know we are achieving the right outcomes if:

- Service users and their carers are able to access timely, high quality and equitable acute mental health care and support that meets their needs.
- We have zero out of area placements.
- We have an effective crisis pathway that enables smooth transitions between community, inpatient and specialist care.
- Our services are provided by a capable, supported and consistent workforce.
- Our inpatient settings are modern, accessible and inclusive, and our ward environments are conducive to recovery.
- Our staff have career progression opportunities, feel valued and staff retention improves.

To bring to life the impact we hope to have on outcomes for people, we have included below a service user 'persona' with a short story of what their care journey could look like in future, based on the ambition we have set out in this document.

I recently got home from hospital after a few weeks of being quite unwell. I've had depression for a couple of years now and until recently had just been seeing my GP about it. About a month ago I saw my GP and they were quite worried about me - looking back, I really wasn't very well. My GP arranged for me to have some support from the home treatment team who saw me every day for a few days but I wasn't getting better so they decided it was safest for me to go into hospital. Luckily I started to feel better after a couple of days in hospital and I was able to get home again quickly. After I got home from hospital, the home treatment team visited me for about a week, which was really good to have that ongoing support.

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Appendix B: Community & Wellbeing Service Line Aspiration

Our community and wellbeing services provide care and support in the community to adults in Leeds

Together with our city partners, our community and wellbeing teams support people living in Leeds with serious or complex mental health problems.

We support people who are experiencing a mental health problem for the first time as well as people who have long term mental health conditions.

Some people we support may need more intensive or specialist care at times - this means that our service users may get care from different teams depending on their support needs and how these change.

Our Community and Wellbeing Service Line is made up of the following services:

Community Mental Health Teams: We have six Community Mental Health Teams based across three locality hubs in Leeds (Aire Court Community Unit in South Leeds, St Mary's House in North East Leeds and St Mary's Hospital in North West Leeds). These teams work with people either to assess their care and support needs or to provide ongoing care coordination and support.

Healthy Living service: Our Healthy Living Service is sits within our Community & Wellbeing Service Line. This team provide support with physical health and wellbeing to LYPFT service users, working alongside teams from other service lines. The Healthy Living service predominantly supports people while they are in hospital.

Our teams provide great care to our service users and we are proud of how we have innovated and adapted as a service.

A great example of innovation in our service is how we changed our approach to Clozapine titration during the pandemic and the introduction of our rough sleeper service. We also have strong partnerships in our city and benefit from working with organisations form the large and diverse third sector in Leeds. For example, our Early Intervention Psychosis service (EIP) is the only third sector-led EIP team in the country.

We know from recent work with our city partners that in Leeds we have more challenges with mental health compared to other places in England, and there are inequalities in mental health in our place:

- It is estimated that 106,000 people in Leeds experience a common mental health disorder.
- We know that one third of people in Leeds who get support from crisis services have not previously used mental health services, such as community mental health services.
- More people are admitted to hospital as a result of self-harm in Leeds, compared with the national average.
- Suicide and self-harm admission rates are higher in poorer areas of Leeds, with the highest suicide rates being in middle aged men and highest rates of self-harm in young women.
- Leeds has a higher rate of people subject to the mental health act compared to the England average.

Sources: Leeds and York Partnership Trust website, Mental Health Services Insight Review, Leeds Mental Health Strategy 2020 - 2025, Leeds CCG: Population Data Profiled

We know there are challenges in our services that we must address to be able to sustainably provide great care

Like other community mental health services across the country, in Leeds we face a number of challenges within our services:

- Many people need to wait a long time to be seen after they are referred to community mental health services.
- Some people who seek support for their mental health and wellbeing are not able to access it due to referral criteria in many services; this often results in people 'falling through gaps' of different services.
- Staff retention, engagement and satisfaction is a challenge given capacity constraints in our workforce.
- We recognise that people who use our services have a range of needs, such as with their physical health, as well as their mental health and wellbeing needs. However at the moment, we aren't always able to meet people's holistic needs as our ways of working with our partners could improve to enable us to provide more integrated care.
- While we have done some work to improve service user involvement in our services (such as setting up a trauma informed service user reference group), we have more work to do to enable service users and carers to be meaningfully involved in co-production of community services.
- Our teams are often constrained by limited availability of clinical space, meaning that sometimes decisions around whether an appointment / clinical interactions is held remotely or in person are driven by estates constraints rather than clinical judgement.
- We expect demand for our community services to continue to grow, particularly in the aftermath of the Covid-19 pandemic.

We have an exciting opportunity to transform our services through Community Mental Health Transformation

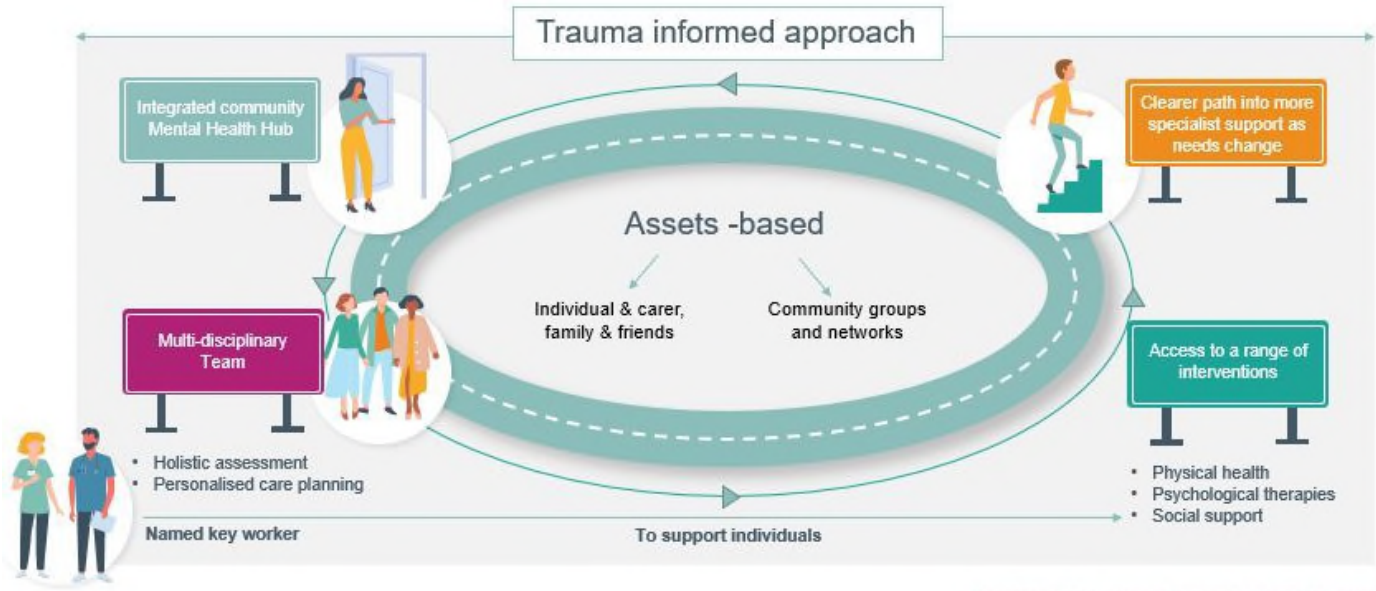
While significant investment in community mental health services has historically been a challenge, the commitments set out in the NHS Long Term Plan (LTP) are an opportunity for us, and our partners, to transform community mental health care.

We are required to deliver on a number of Long Term Plan deliverables (see table below) and this work is being progressed through the Leeds Community Mental Health Transformation (CMHT) programme.

Our ambitions for CMHT in Leeds include:

- Fundamentally transforming the care offer for adults and older adults with a range of severe mental health /co-existing needs through new integrated models of care that enable timely access to high quality, evidence-based, joined-up care.
- Ensuring timely access and reduced waiting times to high quality, evidence-based treatment for adults & older adults with eating disorders, a diagnosis of 'personality disorder' or those in need of community-based mental health rehabilitation.

The shared approach we are moving towards as a whole system in Leeds is shown in the diagram below (*figure source: Leeds CMHT)*.



Transforming Community Mental Health in Leeds

Key deliverables in the NHS Long Term Plan by 2023/24				
Core community model	Transforming care for specific groups	Physical health	Individual Placement and Support	Early intervention in psychosis
A new multiagency community based offer, redesigning community mental health teams around Primary Care Networks through the establishment of integrated community mental health hubs.	Improving access and treatment for older adults and adults with: a diagnosis of personality disorder, in need of mental health rehabilitation, eating disorders.	Increasing the number of people with SMI receiving a comprehensive physical health check.	Supporting more people to participate in the Individual Placement and Support Programme.	Maintaining the 60% Early Intervention in Psychosis access standard and ensuring 95% of services achieve Level 3 NICE concordance.

We have completed modelling to project the impact of this transformation on demand for our community services

The table below outlines demand modelling for our community mental health services.

The data in the first six rows of the table show how demand for core community mental health services are expected to change following implementation of the Leeds CMHT ambitions. This data reflects our assumption that, in keeping the city-wide aspiration to move to an integrated model for community mental health care with primary care, third sector and local authority partners, LYPFT's community mental health expertise will support people in the community with the most complex and severe support needs. In line with the national and local strategic direction to move more care out of hospital settings, our aim is to be able to provide more intensive support to people in the community so that fewer people need to be admitted to hospital. Our assumption is that this investment in community care could reduce referrals to acute mental health services by around 40% and would provide a better experience and outcomes for service users and carers. We expect that our community mental health caseloads will remain broadly similar to our current caseloads, however the intensity of support we provide would increase.

The final row of the table, Community Eating Disorder Service, shows a new planned service, for which there is no historical or forecast data available. This change aims to address the challenge of unmet need for support with eating disorders in our local population. At present, around 500 referrals (annually) are not able to be accepted by our CONNECT service due to the referral criteria - this is a gap in provision. The introduction of a Community Eating Disorder Service aims to address this gap. If we assume that this community-based service would be able to take on 20% of the referrals that are not suitable for CONNECT, we can estimate that this service would have around 850 - 900 contacts per year (based on an average of 8 contacts per referral).

While this information gives us a view of the future demand for community services based on our strategic ambition and our current understanding of the potential impact of these, we recognise that over the next year, CMHT will be progressing detailed work to develop the approach and ways of working for our future integrated community mental health services.

'Do nothing' and 'do something' modelling for adult community and wellbeing services

	Extrapolated contacts 2019 (1)(2)	Forecast range of do nothing' contacts 2028 (2)(3)	Forecast range of 'do something' contacts 2028 (2)(3)	Forecast range of 'do nothing' contacts 2036 (2)(3)	Forecast range of 'do something' contacts 2036 (2)(3)
CMHT Adult East	14,157	15,397 - 16,045	14,873 - 15,917	16,688 - 17,337	16,121 - 17,165
CMHT Adult North East	10,610	11,650 - 12,173	11,184 - 12,022	12,745 - 13,269	12,235 - 13,073
CMHT Adult North West	14,024	15,244 - 15,891	14,725 - 15,768	16,578 - 17,226	16,015 - 17,057
CMHT Adult South East	10,220	11,170 - 11,658	10,723 - 11,504	12,096 - 12,584	11,612 - 12,393
CMHT Adult South West	9,079	9,884 - 10,303	9,489 - 10,158	10,740 - 11,159	10,311 - 10,980
CMHT Adult West	10,449	11,362 - 11,836	10,976 - 11,739	12,385 - 12,859	11,964 - 12,727
ECT Service	849	991 - 1,010	991 - 1,010	1,123 - 1,142	1,123 - 1,142
Family Therapy	372	414 - 428	414 - 428	449 - 464	449 - 464
Healthy Living Team	4,789	5,444 - 5,574	5,444 - 5,574	6,135 - 6,266	6,135 - 6,266
Psychotherapy Medical	1,460	1,583 - 1,645	1,583 - 1,645	1,733 - 1,795	1,733 - 1,795
SALT	84 (*130 in 2021*)	146 - 151	146 - 151	169 - 174	169 - 174
Physical Health Mon + Imp	13,142	14,904 - 15,257	14,904 - 15,257	16,693 - 17,046	16,693 - 17,046
Community Eating Disorder Service					
Total	**89,235**	**98,187 - 101,971**	**95,451 - 101,172**	**107,536 - 111,320**	**104,561 - 110,282**

(1)where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals
(2) contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.
(3)Range based on no long-term recurrent impact of COVID ('best case') and 'intermediate 1' scenario which is based on some long-term recurrent impact of COVID (using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council). For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

Transforming our community services will impact on the experiences of staff and people who use our services

While we have identified the impact of transforming community services in terms of demand for our services, ultimately this is about providing better, more joined up care to people who need support.

We know that we must change how community mental health services in our city work so that we are able to provide sustainable services that are safe, high quality, integrated and equitable.

The ambition we have set out for the Community and Wellbeing Service Line aims to deliver on our wider care services strategic priorities. However we will also aim to impact on outcomes that are specific to our services - will know we are achieving the right outcomes if:

- Service users and their carers are able to access timely, high quality and equitable mental health care and support in their local community.
- Staff working in our community mental health services feel valued, have opportunities to develop new skills and have career progression opportunities.
- People who use our services are meaningfully involved in decisions about their care and changes to community mental health services.
- People experience inclusive and accessible mental health care and support in Leeds.
- Everyone who needs mental health care and support in Leeds is able to access it.
- Fewer people experience acute mental health problems requiring crisis support or inpatient care in hospital.
- Inequalities in mental health outcomes in Leeds are reduced.

To bring to life the impact we hope to have on outcomes for people, we have included below a service user 'persona' with a short story of what their experience of community mental health support could look like in future, based on the ambition we have set out in this document.

I had been feeling really stressed for a long time with lots going on at work and at home, and I didn't know who to talk to about it. I never wanted to bother my GP about these things. One day I went to my local leisure centre and noticed that a new wellbeing hub had opened right next door. At the reception area of the leisure centre I saw a poster with a QR code to a website about the wellbeing hub and saw that they run informal support groups for men. I was a bit skeptical as I'm not someone who's great at talking about their feelings but I tried it and have found it so helpful in understanding more about stress and how my body reacts to stress. I've recommended it to some friends and am now looking to get involved in running some of the group work myself.

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Appendix C: CYPMH Service Line Aspiration

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We provide specialist mental health care and support to children and young people in Leeds, York and regionally

Our Children and Young People Mental Health Services (CYPMHS) teams provide specialist care and support children and young people with mental health problems.

Our CYPMH Service Line is made up of the following services:

CYPMHS inpatient for Humber, Coast and Vale (Mill Lodge): Our team at Mill Lodge provide inpatient care to children and young people aged 13 -18 years old from Yorkshire and Humber.

CYPMHS inpatient for West Yorkshire (Red Kite View): Our team at Red Kite View provide inpatient care to children and young people aged 13 - 18 years old living in West Yorkshire. We are the Lead Provider for inpatient CYPMHS in West Yorkshire and Red Kite View is a new unit. Our aim for Red Kite View is to provide inpatient care no more than 25 miles from people's home and we work closely with other CYPMHS teams across West Yorkshire to achieve this through delivering joined up care.

National Deaf CAMHS (NDCAMHS): We support children and young people aged 0 -18 who have severe to profound hearing loss, have deaf parents, use BSL (British Sign Language) as their first language, experience emotional and/or behavioral issues with a rating of 50 or less on the Children's Global Assessment Scale [CGAS]. We are part of the northern arm of the National Deaf CAMHS service, commissioned by NHS England, with three teams based in York, Manchester and Newcastle.

As our CYPMH services are highly specialised, most of our service users will also receive care from our partner organisations, at different points in their care journey.

We know that in our region, there are challenges with mental health and wellbeing in the population of children and young people:

- 10% of the 250,000 people in Leeds who are under the age of 25 are likely to have a mental health problem or need support with their emotional wellbeing.
- Deaf children are 30 - 50% more likely to experience mental health problems than hearing children.
- 23% of deaf children are recorded as having an additional special educational need.
- The pandemic has had a major impact on children and young people, such as the disruption to education and lack of social interaction during the pandemic.
- Covid-19 restrictions have led to concerns regarding safeguarding and the disengagement of young people, particularly the most vulnerable.
- In 2021 almost 24% of children (under 16s) were estimated to live in poverty in Leeds, compared to 19% nationally.
- Although Leeds rates on indicators like child inpatient admissions for mental health conditions are below national averages, they have risen more sharply in the city in recent years.

Sources: Deaf CAMHS Annual Report 2020, LYPFT website, Consortium for Research in Deaf Education: Education Provision for Deaf Children in England in 2020/2021, Leeds Mental Health Strategy 2020-2025, NHS Long Term Plan, Lifetime prevalence and age of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry.

We are proud of the great care we provide, however we recognise opportunities to make our services even better

We have identified areas where we face challenges in our CYPMH services and where we have opportunities to improve people's outcomes and experiences of care:

- We are facing significant demand pressures, particularly for our inpatient NG feeding service, in both Leeds and York. We are also seeing a consistent demand for inpatient beds.
- We are also aware of a current service gap for 18 - 25 year olds in both CYMPHS and Deaf CAMHS. The 'NHS Long Term Plan' commits to expanding services for 18 - 25 year olds and we recognise that we have a role to play in addressing this unmet demand.
- This year we opened Red Kite View, our new unit for inpatient children and young people mental health services. This is an opportunity for us to consider how we use space, such as activity rooms, creatively for therapeutic interventions.
- We have some challenges with the site at Mill Lodge - young people have fed back that some of the spaces are too small and there is a lack of outdoor space. There is no sensory room, which limits opportunities for therapeutic intervention.
- Our staff have shown great resilience through Covid-19 working under increased workloads and pressure and there are good examples of team working and a culture of support. However, we've heard our staff express a willingness for time and resources to be invested to enable them to attend training and skills development to support them in care delivery and their development.
- In our Deaf CAMHS service, currently there is an unequal balance of deaf and hearing staff in our service and we would like to address this balance and employ more people with lived experience.

Without change to our services, demand for CYPMH inpatient beds will increase in future

The 'do nothing' modelling outlined below shows how demand for our inpatient children and young people's services (measured through the number of beds required) and for National Deaf CAMHS (measured through the number of referrals and 'contacts') is projected to grow over the next fifteen years if we make no changes to our current services.

The data shows an upwards trajectory in bed requirements across all inpatient wards. The extent of the additional requirement is dependent on the potential long-term recurrent impact of Covid-19 (only 'best case' and 'intermediate 1' is shown here).

In interpreting the data it should be noted that Leeds CAMHS inpatient services have, until 2022, been provided in Little Woodhouse Hall, though these services have only been under LYPFT since 2021. Red Kite View opened in 2022 as a West Yorkshire ICS provision with 22 beds, although 6 of these are PICU beds.

Given that Red Kite View is an ICS offer, we are not comparing the current capacity with the forecast demand from Leeds inpatients alone, as there will be additional demand from elsewhere in the system and from service users who repatriated from out of area.

This modelling assumes, therefore, that the bed base identified to support the build and set-up of Red Kite View will be sufficient to meet demand going forward.

For Mill Lodge, however, the modelling shows a projected gap between demand for inpatient beds and current capacity to meet this demand.

For National Deaf CAMHS, the number of referrals to the service is forecasted to increase however the number of contacts are not.

'Do nothing' modelling for Children and Young People inpatient services and National Deaf CAMHS

CYP inpatient services	Beds available in 2019	Beds used in 2019 (occupancy) [3]	Required beds per year (assuming 85% occupancy) 2028 [1]		Required beds per year (assuming 85% occupancy) 2036 [1]		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) [2]	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) [2]	
Leeds CAMHS Inpatients	6*	5* (81%)	10	11	10	11	16 (excl. 6 PICU beds)
CAMHS Inpatients York	15	11 (71%)	15	17	16	17	12
Total	**21**	**16**	**25**	**28**	**26**	**28**	**28 (excl. 6 PICU beds)**

National Deaf CAMHS	Assumed ratio of referrals to contacts	Extrapolated # referrals 2019 [4]	Extrapolated # contacts 2019 [4][5]	# forecast referrals 2028	# forecast contacts 2028 [5]	# forecast referrals 2036	# forecast contacts 2036 [5]
National Deaf CAMHS Service (best case)	15.4	101 (151 in 2021)	2,473 (2,325 in 2021)	154	2,378	148	2,275
National Deaf CAMHS Service ('intermediate 1' case)(2)	15.4	101 (151 in 2021)	2,473 (2,325 in 2021)	154	2,383	148	2,290

(1) Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number
(2)Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.
(3) 2021 value used for Leeds CAMHS inpatients
(4)where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals
(5) contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.

We have identified service changes that will improve outcomes for service users and enable us to meet demand

The key strategic changes we will make to our CYPMH services are to:

- Introduce a 'day care' facility in both Mill Lodge and Red Kite View to provide an NG feeding service for children and young people with eating disorders who require this intervention and do not otherwise need to be in hospital.
- Expand our National Deaf CAMHS service to people aged 18 - 25 in order to provide continuity of care for young people as they transition to adulthood.

The modelling shown below outlines the projected impact of these changes on demand for inpatient care (in Mill Lodge and Red Kite View) and for NDCAMHS.

Based on evidence from an NG feeding day service model in Maudsley Hospital, in York there could be around 20 service users per year who would benefit from a 6-week NG feeding 'day care' intervention. This would reduce length of stay in Mill Lodge by about 30%.

The facility will aim to avoid inpatient admission and/or reduce length of stay, enabling people to remain at home for longer. Our team in Mill Lodge are already implementing this intervention, reducing the number of inpatient beds in the unit from 15 to 12 beds to introduce the service. The modelling projects that this initiative would mean that the existing bed base in Mill Lodge is sufficient until 2036. This scenario assumes an average length of stay of ~80 days (based on the 2018 and 2020 values) rather than ~95 days seen in 2019.

For Red Kite View, demand for an NG day service will be larger than it is for York, in proportion to the size of the population (c. 5-6x larger). We will aim to continue with our existing bed base, as shown in the table.

Expansion of our NDCAMHS service to 18 - 25 year olds is estimated to lead to a ~25% increase in referrals. It is assumed that expansion of the service will come with investment to enable provision for this increased demand.

'Do something' modelling for Children and Young People inpatient services and National Deaf CAMHS

CYP inpatient services	Beds available in 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 85% occupancy for Leeds, 90% for York) 2028 (1)		Required beds per year (assuming 85% occupancy for Leeds, 90% for York) 2036 (1)		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) (2)	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) (2)	
Leeds CAMHS Inpatients	6 (3)	5(3) (81%)	10	11	10	11	16 (excl. 6 PICU beds)
CAMHS Inpatients York	15	11 (71%)	11	12	11	12	12
Total	**21**	**16**	**21**	**23**	**21**	**23**	**28 (excl. 6 PICU beds)**

National Deaf CAMHS	Assumed ratio of referrals to contacts	Extrapolated # referrals 2019 (4)	Extrapolated # contacts 2019 (4)(5)	'Do something' ratio of referrals to contacts	Forecast 'do something' capacity required 2028	Forecast 'do something' capacity required 2036
National Deaf CAMHS Service (best case)	15.4	101 (151 in 2021)	2,473 (2,325 in 2021)	15.4	2,973 (+28%)	2,856 (+23%)
National Deaf CAMHS Service ('intermediate 1' case) (2)	15.4	101 (151 in 2021)	2,473 (2,325 in 2021)	15.4	2,978 (+28%)	2,861 (+23%)

(1) Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number
(2)Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.
(3) 2021 value used for Leeds CAMHS inpatients
(4)where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals
(5) contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.

These changes will have an impact on the experiences of staff and children and young people who use our services

We are proud of the services we provide and are committed to continuing to provide safe, high quality and equitable care. In addition to the strategic changes we have already set out, we will seek to work with our partners to further integrate our services to provide more joined up care across CYPMH care pathways. We will also aim to support our staff in their development and their careers to support the sustainability of our workforce.

The ambition we have set out for our CYPMH services aims to deliver on our care services strategic priorities to:

- Co-create and co-deliver care services with people who have lived experience;
- Collaborate with our partners to understand our populations and provide proactive integrated care; and
- Provide high quality, equitable and sustainable care services.

However we will also aim to impact on outcomes that are specific to our services - will know we are achieving the right outcomes if:

- Children and young people who use our services experience truly joined up care and may not be aware of organisational boundaries when interacting with care services in our system.
- Children and young people who use our services are supported in locations close to their homes or in their own homes.
- We have no CYPMHS out of area placements.
- Children and young people who have experience of our services are meaningfully involved in co-designing our services.
- Our services are inclusive and accessible.
- Children and young people are able to regularly provide feedback on their experiences of our care services using simple, digitally-enabled and efficient methods.
- We influence prevention activity and investment to support young people in our place by working with partners on population health management.
- Young people have opportunities to take on peer support roles in our service.
- Our staff working in CYPMHS have career progression opportunities, feel valued and staff retention improves.

To bring to life the impact we hope to have on outcomes for people, we have included below a service user 'persona' with a short story of what their care journey could look like in future, based on the ambition we have set out in this document.

My name is Cecilia, I'm 14 and I've got an eating disorder. I recently got very ill and had to go into hospital for help with feeding and stabilising my weight. I had been in hospital before and found it quite difficult to go home and get back to school last time because I felt so far behind and I was worried about what people at school would think. This time, after a couple of days in hospital the team spoke to me and my mum about the option of coming into the hospital just during the daytime for the feeding support until I got better. I wasn't sure about it at first but decided to try it and I did get better. I was able to work with the psychologist, which helped, and they recommended some apps that I'm now using most days to try to monitor and manage my emotions.

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Appendix D: ED, Rehab and GI Service Line Aspiration

integrity | simplicity | caring

Our ED, Rehab and GI services provide specialist support to people in Leeds, West Yorkshire and in our region

Our eating disorders, rehabilitation and recovery, and gender identity services (ED, Rehab and GI) Service Line is made up of the following services:

CONNECT (West Yorkshire Adult Eating Disorders Service): We are the Lead Provider for Adult Eating Disorders in the North East and Yorkshire region and our CONNECT service is made up of the community and outreach service and the Yorkshire centre for eating disorders inpatient service at the Newsam centre.

Rehabilitation and Recovery Inpatient Services: Our two rehabilitation and recovery inpatient units (at Asket Croft and Asket House) provide assessment and individualised care packages to people with long-term mental health conditions to support them to live independently and confidently as possible.

CREST (Community Rehabilitation Enhanced support team): Established in 2021, CREST is our new community mental health service supporting people to transition from out of area locked rehabilitation back into the community.

Locked Rehabilitation Service: Our locked rehabilitation service provides inpatient care and support to people, aiming to work with people to reduce risk to themselves or others and support them to increase their independence.

Gender Identity Service: Our gender identity service offers assessment, support and a prescribing service to people aged 17 and over with Gender Dysphoria.

Our ED, Rehab and GI Service Line is made up of different specialist services that respond to different service user needs and support people from different geographies. People who use our ED, Rehab and GI may also get support from other (LYPFT or partner) services, depending on their care and support needs.

Sometimes this means that our services can be one part of a person's overall care journey - this is particularly important for some of our rehabilitation and recovery services, which support people with transitioning from acute care and support people moving from inpatient care to living more independently in the community.

It is important to us to work closely with partners in our place, Integrated Care System (ICS) and region to make any transitions of care and support as smooth as possible for service users.

We are proud of the services we provide, however we recognise some challenges and areas for improvement

We provide great care and support to our service users and are proud of the services we provide, some of which have been recognised and celebrated nationally:

- Our CONNECT service for adult eating disorders received an NHS Parliamentary Award for innovative care delivery. CONNECT is a relatively new care model and has already shifted more care from inpatient settings into the community, enabling more people to be able to receive care closer to their homes.
- Our rehabilitation services teams provide great care and have recently been involved with a research project on improving service user experience.
- People who use our gender identity services report positive experiences with the service.

However we know that in all of our services within the ED, Rehab and GI Service Line, there are some challenges that we must overcome to provide even better care and support:

- There are around 500 referrals to our CONNECT service that we are not able to accept - we think this reflects a current gap in community-based support for people with eating disorders that should be addressed.
- Some of our CONNECT service users find it difficult to access some of our community-based services due to the location of them (e.g. they may be required to travel across West Yorkshire to Halifax to access the service).
- Our inpatient eating disorder beds (Yorkshire Centre for Eating Disorders, YCED), our locked rehabilitation unit and our gender identity service team are based in the Newsam Centre. Newsam is used for multiple services and the current mix of services based at the centre isn't clinically preferable and has an impact on service user experience. This is particularly important for our gender identity service as we recognise that gender identity is not a mental health disorder and are moving away from this approach.
- Our locked rehabilitation service is a traditional and unsustainable model of care and the environment is not conducive to recovery. Some of our rehab services (Asket Croft, Asket House and Assertive Outreach) are currently under review.
- Demand for our gender identity services is increasing - in February 2022 we had 3,358 people on our waiting list. This increase in demand for gender identity services is a national trend and there are pilots of new gender identity collaborative models currently underway across the country.

Without change, demand for our inpatient ED and Rehab services is set to increase beyond our current capacity

We have completed modelling to understand how demand for our ED, Rehab and GI services is expected to change in future.

The modelling outlined below ('do nothing' modelling) shows how demand for inpatient services within our ED, Rehab and GI Service Line, measured through the number of beds required, is projected to grow over the next fifteen years if we make no changes to these services.

It is clear from the data that if we 'do nothing', there is an upwards trajectory in bed requirements across all of our inpatient rehabilitation wards and our YCED.

The extent of the additional requirement is dependent on the potential long-term recurrent impact of COVID (only 'best case' and 'intermediate 1' shown here).

With an assumption of 85 - 90% occupancy as an operational target, **by 2028 in the 'best case' we would have a deficit of 8 beds**, rising to 14 beds in 2036. In the 'intermediate 1' scenario, our deficit would be 11 beds, rising to 17 in 2036.

For our community based and outpatient services, demand (measured through activity/contact), is also set to increase across all areas by 2028 and 2036.

'Do nothing' modelling for our eating disorders, rehabilitation and gender identity services

Inpatient services	Beds available in 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 85-90% occupancy) 2028 (1)		Required beds per year (assuming 85-90% occupancy) 2036 (1)		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) (2)	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) (2)	
Asket Croft	20	19 (96%)	24	25	26	27	20
Asket House	16	14 (89%)	17	18	19	19	15
Newsam Ward 5	17	15 (85%)	19	20	20	21	18
YCED	19	11 (59%)	15	15	16	17	14
Total	**72**	**60**	**75**	**78**	**81**	**84**	**67**

Community / outpatient services	Extrapolated contacts 2019 (3)(4)	Forecast range of do nothing' contacts 2028 (4)(5)	Forecast range of 'do nothing' contacts 2036 (4)(5)
CONNECT	2,391 (8,143 in 2021)	8,729 - 8,997	9,536 - 9,804
Assertive Outreach	11,898	12,996 - 13,446	14,087 - 14,537
CREST	0 (722 in 2021)	793 - 819	845 - 872
Gender Identity	10,984	11,181	11,268
Recovery Centre	3,609	3,927 - 4,077	4,263 - 4,413
Total	**28,822**	**37,625 - 38,519**	**39,999 - 40,893**

(1) Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number
(2)Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.
(3)where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals
(4) contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.
(5) Range based on 'best case' and 'intermediate 1' scenarios

We will make strategic changes to our services to improve care and enable us to meet future demand

To address the challenges we are facing now and set our services up for the future, we must make changes. We have identified a set of key changes to our eating disorders, rehabilitation and gender identity services, shown below.

In developing these, we have considered the overarching strategic priorities for care services:

- *We co-create and co-deliver care services with people who have lived experience*
- *We collaborate with our partners to understand our populations and provide proactive integrated care*
- *We provide high quality, equitable and sustainable care services*

The diagram below highlights how the changes we will make to our eating disorders, rehabilitation and gender identity services align with these priorities.

In identifying the key changes for acute care, we have also considered the strategic direction of our local Integrated Care Systems as well as relevant national policy - our future services must align to the 'left shift' agenda set out in the *NHS Long Term Plan*, moving more care into the community and focusing on early intervention and prevention.

In line with this national direction, our ambition for eating disorders and rehabilitation services are to support more people to be cared for in the community for as long as possible. We recognise that gender identity is not a mental health disorder and are moving away from this approach in line with the direction for gender identity services nationally.

Change	Rationale and benefits
Introduce a community eating disorders service to support people who do not meet referral criteria for CONNECT	This will address currently unmet need by providing a service that is suitable for some of the 500 annual referrals to CONNECT that are not able to be accepted. As this is a community-based service, this will lead to more community contacts and it is also likely to lead to reduced inpatient admissions and average length of stay (ALoS) for our inpatient eating disorders service.
Replace our Recovery Centre with an enhanced community rehabilitation offer Establish a system-wide 'quality of life' complex care facility and womens PD safe house facility Enhance our Assertive Outreach offer	The changes to our rehabilitation services will aim to shift to a social recovery model, with more care in the community, active rehab services and rehab as early intervention. We expect this will have an impact on: • Admissions to Asket Croft / House, which will likely reduce • ALoS at Asket Croft / House, which will likely decrease • Community referrals / contacts, which will increase • ALoS at Newsam Ward 5, which will decrease • Potentially acute inpatient admissions, which would decrease
Move to a 'two tier' gender identity service (with increased role of primary care and third sector partners to support with less complex cases with LYPFT providing support to people with more complex support needs)	Moving to a 'two tier' model for gender identity services will aim to increase overall capacity to respond to increasing waiting lists and referrals. This is unlikely to have a significant impact on LYPFT's activity however it may reduce our waiting list in future as more people waiting for support are able to be supported by primary care. We will also continue to embed peer support workers in our service.

*These may change during the review process for Complex Rehab

This will enable us to provide better care to our service users and meet future demand for our inpatient services

We have looked at how the changes we have identified may impact the projected demand for our services over the next fifteen years and what this means for our capacity.

Significant work has been undertaken through the rehabilitation and recovery service review to identify the 'optimum' service model going forward in order to align with recommended national guidelines, improve service user experience and optimise use of space and resource. The review has identified the need for an integrated community rehabilitation team that provides extensive support to divert and prevent admissions, and also to facilitate early discharge. Through this provision and associated reduced admissions and length of stay, we expect that we can significantly reduce our bed base across Asket Croft and Asket House to a total of 24.

However, should we do this, we will need to undertake work at Asket House and Asket Croft to ensure we have sufficient therapeutic space, consideration given to trauma-informed design, availability of appropriate gender separation of inpatient beds, and availability of clinical space for psychologists / psychiatrists.

We are also considering setting up a 'quality of life' complex care facility, a residence for service users who may otherwise remain in Asket Croft, Asket House or Newsam Ward 5 over the very long-term. We expect that this initiative could lead to a reduced length of stay in these wards. This could give us capacity to use Newsam Ward 5 as a regional centre for locked rehabilitation beds in future.

For our YCED, based on the historical underuse of beds and financial modelling, it is not anticipated that the current bed base of 14 would be expected to justify an increase. Though the forecast future demand could push the bed requirements to c.16 beds, it is hoped that, via the implementation of the community eating disorder team and its impact on reducing admissions and length of stay, the current bed base is sufficient going forward.

Based on this modelling, we expect to plan our bed capacity in line with the data in the 'Planned bed capacity' column in the table below.

'Do something' modelling for our inpatient eating disorders and rehabilitation services

	Beds available in 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 85-90% occupancy) 2028 (1)		Required beds per year (assuming 85-90% occupancy) 2036 (1)		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) (2)	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) (2)	
Asket Croft	20	19 (96%)					20
Asket House	16	14 (89%)					4
Newsam Ward 5	17	15 (85%)					18
YCED (assuming 90% occupancy)	19	11 (59%)	14	15	16	16	14
Total	**72**	**60**	**55**	**57**	**60**	**63**	**56**

(1) Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number
(2)Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

These changes will lead to an increase in activity in some of our community-based services

Given that most of the changes to our services are in line with the national 'left shift' agenda to move more care out of hospital settings, we can expect an increase in many of our community-based services and this is reflected in the 'do something' modelling.

The rows in the table below highlighted in blue (Assertive Outreach, Gender Identity and Recovery Centre) show the areas where changes we will make impact the 'do something' forecasts.

For Assertive Outreach (AO), our ambition to enhance the skill mix in our workforce (e.g. to include psychology, peer support, OT and nurse leadership, physical health, substance misuse, housing) should provide more intensive and targeted support for service users. It is difficult to predict whether this would increase the number of contacts within Assertive Outreach, however it is possible that this would lead to a reduced length of stay for AO service users who need inpatient care as part of their care pathway.

For Gender Identity Services - it is unlikely that the current gender identity secondary care provision will grow. However, the waiting list currently stands at >3,000 people with c.100-120 referrals per week vs. c. 45 new appointments - hence the current capacity is insufficient by c. 50%-60%. As such, primary care and the third sector are expected to need to support the set-up of a two-tier service, supporting provision for this currently unmet demand.

The row in the table highlighted in purple (Community Rehab) shows where we have a new planned service - historical or forecast data is not available as this will be a new service. The introduction of a Community Rehab Team will aim to replace our existing Recovery Centre with dedicated community rehabilitation services in line with NICE and commissioner guidance, as well as national specifications for rehabilitation and recovery. Our ambition is for this service to be staffed with around 28 FTE and with this workforce we expect to have capacity for around 500 - 600 contacts per week.

'Do something' modelling for our community / outpatient ED, Rehab and GI services

Community / outpatient services	Extrapolated contacts 2019 (1)(2)	Forecast range of do nothing' contacts 2028(2)(3)	Forecast range of 'do something' contacts 2028(2)(3)	Forecast range of 'do nothing' contacts 2036(2)(3)	Forecast range of 'do something' contacts 2036(2)(3)
CONNECT	2,391 (8,143 in 2021)	8,729 - 8,997	8,729 - 8,997	9,536 - 9,804	9,536 - 9,804
Assertive Outreach	11,898	12,996 - 13,446	12,996 - 13,446	14,087 - 14,537	14,087 - 14,537
CREST	0 (722 in 2021)	793 - 819	793 - 819	845 - 872	845 - 872
Gender Identity	10,984	11,181	11,181	11,268	11,268
Recovery Centre	3,609	3,927 - 4,077	-	4,263 - 4,413	-
Community Rehab					
Total	**28,822**	**37,625 - 38,519**	**33,699 - 34,442**	**39,999 - 40,893**	**35,736 - 36,480**

(1)where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals
(2) contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.
(3)Range based on no long-term recurrent impact of COVID ('best case') and 'intermediate 1' scenario which is based on some long-term recurrent impact of COVID (using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council)

The changes we make will have an impact on the experiences of our staff and people who use our services

We are committed to continuing to provide safe, high quality and equitable care. The strategic changes we have set out in this document will help us to continue providing great care and support to our service users.

We know that without making these changes, there is a risk that we will not be able to meet future demand for inpatient care and these services will not be sustainable.

The ambition we have set out for our ED, Rehab and GI Service Line aims to deliver on our wider care services strategic priorities. However we will also aim to impact on outcomes that are more specific to our services - will know we are achieving the right outcomes if:

- Service users and their carers are able to access timely, high quality and equitable care and support that meets their needs.
- Service users are empowered to live independent and fulfilling lives as close to home as possible.
- The waiting list for our gender identity service improves.
- Our services are provided by a capable, supported and diverse multidisciplinary workforce.
- We have zero out of area placements for complex rehab.
- Our staff have career progression opportunities, feel valued and staff retention improves.

To bring to life the impact we hope to have on outcomes for people, we have included below a service user 'persona' with a short story of what their care journey could look like in future, based on the ambition we have set out in this document.

My name is Alex and I'm a carer for my brother, Jo, who has schizophrenia. Jo has had some ups and downs in the past year, and has needed to go into hospital a few times. While this has been hard at times, what has been positive is how proactive and flexible the rehab team have been in terms of Jo's care and support. It's been great that Jo has a consistent key contact for support in the rehab team who is able to see him at home or in the recovery centre. They have been able to talk us through options for Jo's care including ways for us to get more support at home when Jo hasn't been so well to avoid another hospital admission.

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Appendix E: Forensic Service Line Aspiration

We provide low secure forensic services in Leeds and York alongside our Integrated Care System partners

Our forensic services teams provide care and support to people with mental health problems who require treatment in a secure setting.

Our Forensic Service Line is made up of the following services:

Low Secure Forensics Service in Leeds: Our forensic team based in Leeds work with service users on pathways from medium secure, adult mental health services and transfer from prison. Our inpatient services in Leeds are at the Newsam Centre. We also have a community outreach support service in Leeds. Our Leeds forensic services are part of the *West Yorkshire Adult Secure Provider Collaborative*, led by South West Yorkshire Partnership Foundation Trust. This is a relatively new partnership made up of the five organisations providing secure care within the West Yorkshire footprint.

Low Secure Forensics Service in York: We also provide low secure adult inpatient mental health services in York at Clifton House, as well as community forensic services and a court assessment and probation liaison service. Our York-based forensic services are part of the Humber Coast and Vale Provider Collaborative.

We know from recent work with the West Yorkshire Provider Collaborative that in West Yorkshire:

- There are inequalities in the length of stay for females, with there being a greater variation in length of stay for females than males.
- There is a variation across providers in the length of stay for males in low secure units.
- There is a greater proportion of people with ethnic minorities receiving West Yorkshire secure services than the proportion of people with ethnic minorities nationally. Overrepresentation is seen particularly with men of black or asian ethnicity.
- Females between the ages of 30 to 39 are the most overrepresented when it comes to admission age.

Sources: West Yorkshire and Harrogate (WY&H) Adult Secure Services Business and Clinical Case for the Lead Provider model

We provide great care to our service users however we recognise challenges in our services that we must address

We have identified areas where we face challenges in our forensic services and where we have opportunities to improve people's outcomes and experiences of care:

- Across the service we are seeing increasing acuity with challenging behaviours which with our current resources, is difficult to respond to and placing a pressure on staff and the environment. Rising acuity alongside rising demand is partially leading to out of area placements. It is important for us now work together across the Provider Collaborative to take a long term view and transform our services so we are set up to respond to future demand while continuing to provide high quality care.
- Delays in transfer or discharge are often a challenge for our services. This means that people sometimes end up in hospital, or other settings, longer than they need to be. One of the reasons behind this is the complexity of forensic care pathways - there are often multiple transition or transfer points for people between different services, and the flow across these isn't well joined up at present. We also often do complex discharge planning that requires work and coordination by multiple professionals, which often takes time. Timely access to support on discharge (e.g. supported housing, community forensic mental health support) also leads to longer admissions.
- There are challenges in the environments of both of our low secure sites, which limits our ability to deliver high quality services. In Clifton House, except for seclusion, our estates are fit for purpose and have a good environment. The Newsam centre has multiple mental health services in addition to forensics. There is a lack of outdoor green space, limited access to quality seclusion facilities and not enough therapeutic space or shared space for group therapy work.

Without change, demand for our low secure inpatient units is set to increase beyond our capacity to respond

We have completed modelling to understand how demand for our services is expected to change in future.

The 'do nothing' modelling outlined below shows how demand for our inpatient services (measured through the number of beds required) and for our community services (measured through number of contacts) is projected to grow over the next fifteen years if we make no changes to our current services.

It is clear from the data that if we 'do nothing', there is an upwards trajectory in bed requirements across all of our forensic inpatient wards.

The extent of the additional bed requirement is dependent on the potential long-term recurrent impact of COVID (only 'best case' and 'intermediate 1' shown here)(1). With an assumption of 85 - 90% occupancy as an operational target, **by 2028 in the 'best case' we would have a deficit of 9 beds**, rising to 11 beds in 2036 - this includes a **significant deficit for Newsam Ward 2** (6 beds) in 2036. In the 'intermediate 1' scenario (1), our deficit would be 10 beds, rising to 16 in 2036 - this includes a significant deficit for Newsam Ward 2 (7 beds) in 2036.

For our community based forensic services, demand is also set to increase by 2028 and 2036.

'Do nothing' modelling for forensic inpatient and community services

Inpatient services	Beds available in 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 85-90% occupancy) 2028 (2)		Required beds per year (assuming 85-90% occupancy) 2036 (2)		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) (1)	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) (1)	
Newsam Ward 2	12	12 (99%)	17	18	18	19	12
Newsam Ward 2 - Women's	11	10 (88%)	13	13	13	14	11
Newsam Ward 3	14	14 (100%)	16	16	17	18	14
Bluebell Ward	10	7 (71%)	8	8	8	9	10
Riverfields	10	6 (61%)	11	11	11	11	10
Westerdale	12	10 (81%)	13	13	13	14	12
Total	**69**	**58**	**78**	**79**	**80**	**85**	**69**

Community services	Extrapolated contacts 2019 (3)(4)	Forecast range of do nothing' contacts 2028 (4)(5)	Forecast range of 'do nothing' contacts 2036 (4)(5)
Community Forensics Team Leeds	2,901	3,224 - 3,367	3,481 - 3,623
Community Forensics Team York	1,047	1,107 - 1,152	1,159 - 1,205
Court & Approved Premises	589	615 - 640	647 - 671
Forensic AHP	1	1	1
Forensic Psychology	2,848	3,143 - 3,283	3,370 - 3,510
Total	**7,386**	**8,090 - 8,443**	**8,658 - 9,011**

(1)Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.
(2) Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number
(3)Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals
(4) Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.
(5) Range based on 'best case' and 'intermediate 1' scenarios

We will make strategic changes to our forensic services to improve care and enable us to meet future demand

To address the challenges we are facing now and set our services up for the future, we must make changes so that we can provide better care to people who use our services. We have identified a set of key changes to our forensic services, shown in the table below.

In developing these, we have considered the overarching strategic priorities for LYPFT care services, however we have also recognised that there are limits on the decisions we can make about our services without working through the provider collaboratives.

In identifying the key changes for our low secure services, we have also considered the strategic direction of our local Integrated Care Systems as well as relevant national policy - our future services must align to the 'left shift' agenda set out in the NHS Long Term Plan, moving more care into the community and focusing on early intervention and prevention.

Our priorities for care services are:

- We co-create and co-deliver care services with people who have lived experience
- We collaborate with our partners to understand our populations and provide proactive integrated care
- We provide high quality, equitable and sustainable care services

The diagram below shows the changes we will make to our forensic services and they align with these priorities.

Change	Rationale and benefits
Expand our community forensics services	This change aims to improve flow out of inpatient based care and enable people to be able to continue their recovery at home with support from community teams. We expect this could reduce average length of stay (ALoS) on inpatient forensic wards.
Review / redesign inpatient pathways with aim to reduce delayed transfers of care and discharges	This change aims to improve ways of working between providers across pathways of care to reduce delayed transfers of care. This will mean that more people are supported in the right environment for their care needs.
Integrate and expand our Forensics Psychology service into the community when patients are discharged	We will aim to make our Forensic Psychology service more integrated so that rather than focusing solely on in-reach provision to service users in inpatient facilities, we will expand this service out into the community to support service users upon their reintegration into wider society and provide the continuity of care.

We have looked at how the changes we've identified will impact the projected demand for our services in future

The 'Inpatient services' table below shows the bed requirement forecast for forensic services in a 'do something' scenario, whereby we assume a minimum reduction in average length of stay (ALoS) of around 35% enabled by the following changes: review and redesign of the inpatient pathway, enhanced community forensic service provision and more timely transfers of care between low and medium secure through pathway development work with the provider collaboratives.

If we are able to achieve this, we expect that we will be able to meet the future demand with our current bed base. In fact, the modelling has found that for Clifton House, the current bed base would be sufficient with an improvement of ALoS of just 10%.

The rows in the 'Community services' table below highlighted in blue (Community Forensics Team Leeds, Community Forensics Team York and Forensic Psychology) show the areas where changes we will make impact the 'do something' forecasts. Our ambition is to provide more forensic care and support in the community, likely through a more intensive service. The 'do something' view of the future reflects this with an increase in the number of contacts per service user - this is assumed to be around 20% over and above the forecast service growth by 2028. Our ambition to integrate and expand our Forensic Psychology service assumes an increase in service activity in line with an average of two contacts per service user.

'Do something' modelling for forensic inpatient and community services

Inpatient services	Beds available in 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 85-90% occupancy) 2028 (1)		Required beds per year (assuming 85-90% occupancy) 2036 (1)		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) (2)	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) (2)	
Newsam Ward 2	12	12 (99%)	11	12	12	12	12
Newsam Ward 2 - Women's	11	10 (88%)	8	9	9	9	11
Newsam Ward 3	14	14 (100%)	10	11	11	12	14
Bluebell Ward	10	7 (71%)	5 (7)	6 (8)	6 (8)	6 (8)	10
Riverfields	10	6 (61%)	7 (10)	7 (10)	7 (10)	8 (10)	10
Westerdale	12	10 (81%)	8 (11)	9 (12)	9 (12)	9 (12)	12
Total	**69**	**58**	**49 (57)**	**54 (62)**	**54 (62)**	**56 (63)**	**69**

Community services	Extrapolated contacts 2019 (3)(4)	Forecast range of do nothing' contacts 2028(4)(5)	Forecast range of 'do something' contacts 2028(4)(5)	Forecast range of 'do nothing' contacts 2036(4)(5)	Forecast range of 'do something' contacts 2036(4)(5)
Community Forensics Team Leeds	2,901	3,224 - 3,367	3,869 - 4,040	3,481 - 3,623	4,177 - 4,348
Community Forensics Team York	1,047	1,107 - 1,152	1,328 - 1,383	1,159 - 1,205	1,391 - 1,446
Court & Approved Premises	589	615 - 640	615 - 640	647 - 671	647 - 671
Forensic AHP	1	1	1	1	1
Forensic Psychology	2,848	3,143 - 3,283	3,263 - 3,408	3,370 - 3,510	3,498 - 3,643
Total	**7,386**	**8,090 - 8,443**	**9,076 - 9,471**	**8,658 - 9,011**	**9,714 - 10,110**

(1) Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number
(2)Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.
(3)Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals
(4) Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.
(5) Range based on 'best case' and 'intermediate 1' scenarios

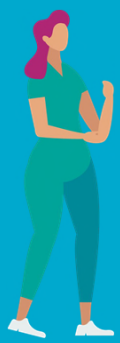
These changes will have an impact on the experiences of staff and people who use our services

We know that without changing how we provide our forensic services, we will not be able to keep up with the demand for our low secure inpatient beds and our services will not be sustainable - this will limit our ability to continue to provide safe, high quality and equitable care.

The ambition we have set out for our Forensic Service Line aims to deliver on our wider care services strategic priorities. However we will also aim to impact on outcomes that are specific to our services - will know we are achieving the right outcomes if:

- Service users and their carers are able to access timely, high quality and equitable forensic mental health care and support that meets their needs.
- We have fewer inpatient admissions to forensic services and provide much more support in the community.
- Service users are cared for in the least restrictive environment as possible, supported by timely transfers and discharge.

To bring to life the impact we hope to have on outcomes for people, we have included below a service user 'persona' with a short story of what their care journey could look like in future, based on the ambition we have set out in this document.



My name is Angela. I was recently in hospital for several months and was really unwell at the beginning of my admission. I have bipolar, and had previously been in hospital but had never been involved with police. This time the police were involved and I was admitted to a forensic unit. Fortunately my mood stabilised quickly with restarting my medication, working with the psychologists and getting outside into the hospital garden with the physiotherapists. I met a social worker on the ward as soon as I started to feel better - it was motivating to talk about getting home this early on in my admission and when it came to the time when the team felt I could go home, everything was ready to go.

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Appendix F: Learning Disabilities Service Line Aspiration

We provide care and support to people with learning disabilities in Leeds

We provide care to support people with learning disabilities (LD) living in West Yorkshire and Harrogate. Most people who use our LD services live in Leeds. Our Learning Disabilities Service Line is made up of the following services:

Community Learning Disability Teams (CLDT): We have several teams working in the community to support people with learning disabilities (a West North-West team, and East North-East team and a South South-East team). Our Health Facilitation Team provides a range of services including supporting people to get an annual health check.

Learning Disability Inpatient Services: Our inpatient services offer respite for people with profound and multiple learning disabilities and for people with challenging behaviour. These services are based in Woodland Square at St. Mary's Hospital.

Learning Disability Specialist Health Planned Care Service (Respite): Our planned respite service, based at 2 and 3 Woodland Square at St. Mary's Hospital, provides intermittent specialist care to adults with challenging behaviour and complex health needs. People who use our services have a learning disability and at least one of: a mental disorder, autism, dementia, multiple physical disabilities, and sensory impairment.

Specialised Supported Living Service (SSLS): Our SSLS supports adults with learning disabilities, physical disabilities and complex needs to live independently. The service is based in Woodland Square at St. Mary's Hospital, however care is provided in service users' housing. The SSLS is our largest LD service with around 250 FTE staff working in the service and around 90 service users being supported at any one time.

Many people who use our services have complex care needs and other conditions, such as a mental health issue or physical disability, in addition to having a learning disability. It is thought that around 20-30% of people with a learning disability have autism.

People with learning disabilities can find it more challenging to communicate their care needs and to access care, particularly through digital routes as access to technology for people with learning disabilities is limited, compared with the general population.

As set out in the West Yorkshire and Harrogate (WY&H) Health and Care Partnership Mental Health, Learning Disability and Autism Strategy (2019 - 2024), we know that there are more people living with a learning disability who have long term support from Local Authorities in WY&H than in other places in England.

National research, such as the Learning Disability Mortality Review Programme (LeDer), has identified significant health inequalities in the adult learning disability population. The LeDer found that average life expectancy for adults with a learning disability is 16 years lower than the general population. People with learning disabilities also experience income inequalities, with a higher rate of deprivation and poverty than the general population.

Sources: Public Health England: Learning disability in Yorkshire and the Humber, our regional Learning Disabilities profile, NHS Long Term Plan

We are proud of the great care and support we provide, however we have identified challenges in our LD services

Our teams provide great care and support to people with learning disabilities.

We are particularly proud of how we involve people with lived experience in the design and delivery of our services, such as through involvement co-worker posts, and we have ambitions to do more of this in future. In 2018, the CQC identified outstanding person-centred care in our Specialised Supported Living Service and rated the service as 'good' overall.

We have, however, identified some key challenges we face within our LD Service Line, which we must address to improve people's outcomes and experiences of care and support:

- Our teams working with people with learning disabilities are finding that more and more people need support with multiple and complex needs. Staff are also finding that more people are accessing services when their care needs are more urgent, meaning staff are usually required to respond more quickly and with more intensive interventions. Our services should adapt to the changing needs of service users to be better set up to support them.
- We know from our most recent CQC inspections that there are improvements to make to our services, such as greater compliance with Trust processes to support care that is safe and high quality, and improving access to therapeutic interventions.
- We also know from feedback from our service users that it is critical for our services to be accessible for everyone, including easy to read labels and reasonable adjustments in both the environment and communication style of staff.
- We have many passionate and committed staff working in our learning disabilities services. However, we have identified sustainability of our learning disabilities workforce as a threat to future service delivery, particularly as demand for care, and complexity of care needs, is increasing. For our community teams in particular, demand often seems to outweigh staff capacity and many staff are working under pressure.

We have completed modelling to understand how demand for our LD services is expected to change in future

The 'do nothing' modelling outlined below shows how demand for our inpatient (measured through the number of beds required) and community (measured through the number of contacts) is projected to grow over the next fifteen years if we make no changes to our current services.

As outlined in the first table below, the current bed base for our inpatient services are forecast to be sufficient to meet demand, irrespective of the long-term impact of Covid-19.

For our community LD services, the number of contacts is projected to increase by 2028 and 2036 if we don't make any changes.

'Do nothing' modelling for our learning disabilities services

Inpatient services	Beds available in 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 85% occupancy) 2028 (2)		Required beds per year (assuming 85% occupancy) 2036 (2)		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) (1)	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) (1)	
2 Woodland Square	5	3 (65%)	4	4	4	5	5
3 Woodland Square	4	3 (74%)	4	4	4	4	4
Total	**9**	**6**	**8**	**8**	**8**	**9**	**9**

Community services	Extrapolated contacts 2019 (3)(4)	Forecast range of do nothing' contacts 2028 (4)(5)	Forecast range of 'do nothing' contacts 2036 (4)(5)
CLDT East North East	6,993	7,627 - 7,871	8,407 - 8,651
CLDT West and South	12,161	13,598 - 14,058	14,760 - 15,220
LD - ART	537	595	650
LD Intensive Support Team	1,764 (*3,038 in 2021*)	3,297 - 3,394	3,665 - 3,762
LD Orthotics	570	626 - 647	687 - 707
Total	**22,025**	**25,743 - 26,565**	**28,169 - 28,990**

(1)Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.
(2) Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number
(3)Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals
(4) Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.
(5) Range based on 'best case' and 'intermediate 1' scenarios

We will make changes to our LD services to enable us to provide better care and support to our service users

To address the challenges we are facing now and set our services up for the future, we must make changes so that we can provide better care to people who use our services. We have identified a set of key changes to our learning disabilities services, shown in the table below.

In developing these changes, we have considered the overarching strategic priorities for LYPFT care services and have also considered the strategic direction of our local system (our Leeds Place and our West Yorkshire and Harrogate Integrated Care System) as well as relevant national policy - our future services must align to the 'left shift' agenda set out in the NHS Long Term Plan, moving more care into the community, focusing on early intervention and prevention, and addressing health inequalities.

Our priorities for care services are:

- We co-create and co-deliver care services with people who have lived experience
- We collaborate with our partners to understand our populations and provide proactive integrated care
- We provide high quality, equitable and sustainable care services

The diagram below shows the changes we will make to our learning disabilities services and they align with these priorities.

Change	Rationale and benefits
Collaborative redesign of the delivery and leadership model of the Supported Living Service so that the service remains competitive, affordable and deliverable.	We are working with local authority commissioning partners to ensure the sustainability and future delivery of our supported living services.
Addition of three 'emergency admission' beds for LD respite services	This change intends to address a system-wide challenge relating to our system ATU. The addition of emergency respite beds intends to reduce avoidable admissions to the ATU and therefore reduce admissions/length of stay to the ATU.
Employment of people with lived experience in involvement co-worker posts.	We recognise that an important principle of co-production is encouraging peer support, which currently is not delivered within our service.
More integrated working between respite, emergency and Intensive Support Team	We currently have some gaps in our preventive support offer and recognise that more integrated working across teams working to provide different levels of support could improve pathways.

We have looked at how these changes will impact the projected demand for our services in future

The impact of the changes on our inpatient services are set out in the first table below if we 'do something' and make changes to our services.

The 'do something' modelling for 2 and 3 Woodland Square assumes that the number of beds in these wards will remain the same.

At present, any 'emergency' mental health needs for service users with a learning disability would be directed towards the Assessment and Treatment Unit in Bradford, which is not the intended use of this facility. To alleviate pressure on the ATU, and to enhance quality of experience for our service users requiring urgent care and support, we are proposing an 'emergency LD facility' of three beds is established, based upon an assumption of 30 admissions per year with ALoS of 30 days and occupancy of around 90%.

The row in the 'Community services' table below highlighted in blue (LD Intensive Support Team) shows the impact of the changes we will make on the 'do something' forecasts. As our ambition is to develop a more integrated service between our LD inpatient offer and the community, we hope to expand our LD Intensive Support Team by around an additional 10% (above expected growth). This is reflected in the modelling with the increase in number of contacts projected for 2028 and 2036.

This would enable us to provide a more intensive support offer to service users in the community and support a more seamless pathway between inpatient and community services.

'Do something' modelling for our learning disabilities services

Inpatient services	Beds available in 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 85% occupancy) 2028[1]		Required beds per year (assuming 85% occupancy) 2036 [1]		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[2]	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact)[2]	
2 Woodland Square	5	3 (65%)	4	4	4	5	5
3 Woodland Square	4	3 (74%)	4	4	4	4	4
Emergency LD facility (*90% occupancy*)	-	-	3	3	3	3	3
Total	**9**	**6**	**11**	**11**	**11**	**12**	**12**

Community services	Extrapolated contacts 2019[3][4]	Forecast range of do nothing' contacts 2028[4][5]	Forecast range of 'do something' contacts 2028[4][5]	Forecast range of 'do nothing' contacts 2036[4][5]	Forecast range of 'do something' contacts 2036[4][5]
CLDT East North East	6,993	7,627 - 7,871	7,627 - 7,871	8,407 - 8,651	8,407 - 8,651
CLDT West and South	12,161	13,598 - 14,058	13,598 - 14,058	14,760 - 15,220	14,760 - 15,220
LD - ART	537	595	595	650	650
LD Intensive Support Team	1,764 (*3,038 in 2021*)	3,297 - 3,394	3,627 - 3,733	3,665 - 3,762	4,032 - 4,138
LD Orthotics	570	626 - 647	626 - 647	687 - 707	687 - 707
Total	**22,025**	**25,743 - 26,565**	**26,073 - 26,904**	**28,169 - 28,990**	**28,536 - 29,367**

(1) Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number
(2)Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.
(3)Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals
(4) Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.
(5) Range based on 'best case' and 'intermediate 1' scenarios

These changes will have an impact on the experiences of people who use our services and our staff

We are ambitious about continually improving the services we provide to continue to provide safe, high quality and equitable care.

The ambition we have set out for our Learning Disabilities Service Line aims to deliver on our wider care services strategic priorities. However we will also aim to impact on outcomes that are specific to our services - will know we are achieving the right outcomes if:

- Service users and their carers are able to access inclusive, timely, high quality and equitable care and support that meets their holistic needs.
- Service users can access information about care and support, including digital access to information.
- We have effective and flexible pathways of care and support that enable smooth transitions between community and inpatient care, when required.
- Service users and carers are meaningfully involved in the design of future services.
- People with lived experience are involved with providing care and support as part of our LD services team.
- Our staff have career progression opportunities, feel valued and staff retention improves.

To bring to life the impact we hope to have on outcomes for people, we have included below a service user 'persona' with a short story of what their care journey could look like in future, based on the ambition we have set out in this document.

I'm Mark and I live in supported living. I really like having my own home and having help from the staff here. The staff helped me to set up a laptop so I can go online and join group classes and meet other people, which I really enjoy. I also go to community groups in person to meet people. Sometimes the community learning disabilities team come to see me at home so I don't have to go to hospital. This is really good for me because I prefer to be in my own home.

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Appendix G: Older People's Service Line Aspiration

Our older people's services are core mental health services providing care and support to people in Leeds

Our older people's services (OPS) teams support older people (people aged 65 and over) living in Leeds with acute and long term mental health problems.

Our Older People's Service Line is made up of the following services:

Older People's Inpatient service: We provide inpatient support to older people with acute mental health needs. We do holistic assessments and provide treatment and rehabilitation across our four wards based at The Mount.

Older People's Community Mental Health services: We deliver home-based care in Leeds across three teams (based at Aire Court, St Mary's House and St Mary's Hospital) and provide interventions and treatments, such as a review of prescriptions and medicines. We also host the Memory Assessment Service which delivers assessment, diagnosis and treatment to people with dementia or mild cognitive impairment.

Intensive Home Treatment Team for Older People (IHTT): We assess and care for older people with complex and acute conditions, supporting people to avoid hospital admission where possible. We support with assessment, formulation, intervention, evaluation and discharge, usually in a person's home. We aim to see referrals to IHTT within 24 hours.

Younger People with Dementia service: We provide assessment, diagnosis and treatment to adults up to the age of 65 with dementia, alongside support for their families and carers. This may include care home, outpatient clinic and hospital consultation.

Care Homes Team: We support people who live in care homes who have mental health conditions and where the person, care home staff or families are at risk. We have two teams, one which delivers care with people with longer term mental health needs, such as dementia, and one team that delivers short-term intensive care home treatment.

Many older people who have mental health problems also have other care and support needs, such as physical health problems, and this means that many of our service users also get care from other organisations in Leeds. We are working with our partners in Leeds to improve care and support for older people.

We know from recent work with our city partners that:

- The number of older people in Leeds estimated to have depression is 16,323.
- Around 85% of older people in Leeds have depression but do not receive treatment.
- There are around 8,700 people living with dementia in Leeds.
- Older people with mental health problems are less likely to access Improving Access to Psychological Therapies (IAPT) services than working age adults.

One of our city priorities outlined in the *Leeds Mental Health Strategy 2020 - 2025* recognises the importance of supporting older people to access mental health services: '*ensure older people are able to access information, support and appropriate treatment that meet their needs*'.

Sources: Leeds Mental Health Strategy 2020-2025, Future in Mind: Leeds, Leeds and York Partnership Trust website, Living with Dementia in Leeds – Our strategy 2020-25

We are proud of the great care we provide, however there are challenges to the sustainability of our current services

As more and more people are living longer, we are seeing increasing demand for health and care services to support older people. This is a global trend and is seen nationally across health and care systems in England as well as in our local place in Leeds.

Locally we have identified some of the core challenges we face within our OIder People's Service Line, which we must address to be able to sustainably provide care and support to older people, and to improve people's outcomes and experiences of care:

- Delayed transfers of care in older people's services is a challenge, with 24.9% of transfers being delayed in February. This means some people are spending longer in hospital than they need to. This is often linked to challenges in accessing care home provision for people to be discharged from our inpatient wards. Our city-wide ambition is for older people to receive care in their own homes as much as possible and for as long as possible. We must work with our city partners to support more people in their own homes and to enable timely discharge for those who do need inpatient care.
- Our inpatient environment is not optimum to support older people with acute and intensive support needs - there is no dedicated unit for supporting older people with particularly acute and complex needs at present. The Mount, where our inpatient wards are based, is not purpose-built for older people's services. Our care settings for older people would be informed by dementia design and should be therapeutically supportive with access to sufficient therapeutic and clinical space.
- We expect demand for our services, particularly our Memory Assessment Service, to increase as more people in Leeds live longer. At the same time we know that we have workforce challenges to meet this increasing demand. For example, from an AHP perspective we have some specific gaps in speech and language therapy for older people, with no commissioned post at present. In addition, we also have gaps in our psychology workforce. The British Psychological Society recommends approximately one psychologist per ward for older people and we do not meet this standard at present.

Without change, demand for our older people's inpatient services is set to increase beyond our capacity to respond

We have completed modelling to understand how demand for our services is expected to change in future.

The 'do nothing' modelling outlined below shows how demand for our inpatient services (measured through the number of beds required) and our community services (measured through number of contacts) is projected to grow over the next fifteen years if we make no changes to our current services. It is clear from the data that if we 'do nothing', we will need more inpatient beds to be able to meet future demand.

The extent of the additional requirement is dependent on the potential long-term recurrent impact of Covid-19. With an assumption of 85 - 90% occupancy as an operational target, by 2028 in the 'best case' we would have a deficit of 8 beds, rising to 23 beds in 2036. In the 'intermediate 1' scenario (1), our deficit would be 12 beds, rising to 23 in 2036. These scenarios include provision for an average of one additional service user per year in Wards 1 and 3, and three per year in Ward 4, based on the assumption that inappropriately placed 'out of area' patients will be repatriated going forwards^.

'Do nothing' modelling for our older people's services

Inpatient services	Available beds 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 85-90% occupancy) 2028 (2)		Required beds per year assuming 85-90% occupancy) 2036 (2)		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) (1)	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) (1)	
Mount W1 Male Dementia *Assuming 90% occupancy*	17	15 (90%)	19	20	22	22	17
Mount W2 Fem Dementia *Assuming 90% occupancy*	15	14 (91%)	15	16	17	17	15
Mount Ward 3 *Assuming 85% occupancy*	24	18 (73%)	23	24	27	27	24
Mount Ward 4 *Assuming 90% occupancy*	24	24 (99%)	31	32	37	37	24
Total	**80**	**70**	**88**	**92**	**103**	**103**	**80**

Community services	Extrapolated contacts 2019 (3)(4)	Forecast range of do nothing' contacts 2028 (4)(5)	Forecast range of 'do nothing' contacts 2036 (4)(5)
Care Homes Team	3,756	4,652 - 4,780	5,621 - 5,748
CMHT OPS ENE	7,577	9,256 - 9,452	10,989 - 11,185
CMHT OPS SSE	4,124	5,019 - 5,126	5,945 - 6,053
CMHT OPS WNW	8,136	9,940 - 10,155	11,726 - 11,941
Complex Dementia Wrap Ar	0 (*2,051 in 2021*)	2,354 - 2,425	2,679 - 2,749
Dementia MH Liaison	734	838 - 865	936 - 963
IHTT OPS	8,490	10,229 - 10,460	11,949 - 12,181
Intensive Care Homes Team	3,592	4,402 - 4,493	5,291 - 5,382
YPDT	1,333	1,397 - 1,464	1,396 - 1,463
Memory Assessment Teams	10,255	11,927 - 12,279	13,634 - 13,986
Total	**38,645**	**42,326 - 44,138**	**46,275 - 48,087**

(1)Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.
(2) Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number
(3)Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals
(4) Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.
(5) Range based on 'best case' and 'intermediate 1' scenarios

We will make changes to our older people's services to improve care and support us to meet future demand

To address the challenges we are facing now and set our services up for the future, we must make changes so that we can provide better care to people who use our services. We have identified a set of key changes to our older people's services, shown in the table below.

In developing these changes, we have considered the overarching strategic priorities for LYPFT care services and have also considered the ambition of our local system in Leeds, as well as relevant national policy - our future services must align to the 'left shift' agenda set out in the NHS Long Term Plan, moving more care into the community, focusing on early intervention and prevention, and addressing health inequalities.

Our priorities for care services are:

- We co-create and co-deliver care services with people who have lived experience
- We collaborate with our partners to understand our populations and provide proactive integrated care
- We provide high quality, equitable and sustainable care services

The diagram below shows the changes we will make to our older people's services and they align with these priorities.

Change	Rationale and benefits
Establish access to a specialist long-term facility for people with dementia with complex care needs (use of Dolphin Manor and Willows in short-term)	Delayed transfers of care in OPS is a challenge (24.9% of transfers were delayed in February) - this is linked to the challenge in access to care home provision for patients to be discharged from the Mount.
Potentially establish a dementia PICU for older people with acute and intensive care needs (this would be provided on an ICS footprint)	Access to appropriate facilities to support older people with acute and intensive care needs isn't available. This would also likely reduce delayed transfers of care.
Aligned with the Leeds city ambition to support people in their own homes as much as possible, enhance the IHTT offer as part of the enhanced community response work that we are doing with the Leeds system (aim to operate at full capacity plus an additional 10% of current capacity)	The city-wide ambition is for people to receive care in their own homes as much as possible and for as long as possible. This change would enable more people to be supported at home - this could lead to fewer inpatient admissions and could facilitate early discharge from hospital with support from IHTT on discharge.
Co-locate OPS beds with acute site	This will enable closer working between mental health and physical health teams with potential benefits of more timely access to physical health support older people in hospital for mental health support.
Review structure of OPS community teams based on population need	This will aim to align our OPS community team resource to population need to support reduction in health inequalities in line with our city ambition.
Evaluate clinical model of, and respond to increase in demand for, Memory Assessment Service.	Demand is increasing and is expected to increase further for our memory assessment service. This will enable us to review the service and plan for future demand.

We have looked at how these changes are forecast to impact projected demand for our inpatient services (1/2)

We have looked at how the changes we have identified may impact the projected demand for our services over the next fifteen years and our capacity to respond.

The table below shows the 'best case' scenario around the long-term impact of Covid-19 (1).

It outlines the impact on our forecast bed requirements if we remove delayed transfers of care (DTOCs) from both our functional and organic average length of stay (ALoS). This could be achieved through access to a specialist long-term facility for dementia (in the short-term, this means use of Dolphin Manor to support the Willows) and through an enhanced IHTT provision facilitate earlier discharge.

These scenarios include provision for an average of one additional service user per year in Wards 1 and 3, and three per year in Ward 4 based on the assumption that inappropriately placed 'out of area' patients will be repatriated going forwards.

Based on this, and assuming the wards will operate at 85-90% occupancy going forward, there would be scope to remove nine of our organic (dementia) beds based on the 2028 projection, although three would need to be reinstated by 2036 to meet demand.

Assuming we are able to have zero delayed transfers of care, the following would be feasible:

- If Mount Wards 1 and 2 continue to operate at around 90% occupancy, we could reasonably reduce our bed base by six beds across the two wards until at least 2036.
- Assuming that Mount Wards 3 and 4 continue to operate at around a 90% level of occupancy, the current bed base of 48 beds could stay the same until 2028.
  - However, unless proposed additional initiatives (e.g. enhanced IHTT, more 'equitable' community provision, co-location on an acute site) provide some additional admission and ALoS reductions beyond the elimination of DTOCs, we would likely need to increase our bed base thereafter.

'Do something' modelling for our older people's inpatient services - 'best case' scenario

Best case scenario	Available beds 2019	Required beds per year 2028 (2)		Required beds per year 2036 (2)		Planned bed capacity
		90% occupancy (85% for Ward 3)		90% occupancy (85% for Ward 3)		
		Incl DTOC	Excl DTOC	Incl DTOC	Excl DTOC	
Mount W1 Male Dementia	17	19	12	22	14	17
Mount W2 Fem Dementia	15	15	11	17	12	15
Mount Ward 3	24	23	19	27	22	24
Mount Ward 4	24	31	29	37	374	24
Total	**80**	**88**	**71**	**103**	**82**	**80**

*(1) Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes **no** long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.*
(2) Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number

We have looked at how these changes are forecast to impact projected demand for our inpatient services (2/2)

We have also looked at the impact of these changes on forecast demand based on an 'intermediate case' scenario around the long-term impact of Covid-19 (1). This adds to the information set out in the previous page, giving us a view of what we can expect our 'do something' bed requirements to look like if there is a long-term impact of the pandemic on older people's mental health.

The table below outlines the impact on our forecast bed requirements if we remove delayed transfers of care (DTOCs) from both our functional and organic average length of stay (ALoS). This could be achieved through access to a specialist long-term facility for dementia (in the short-term, this means use of Dolphin Manor to support the Willows) and through an enhanced IHTT provision facilitate earlier discharge.

These scenarios include provision for an average of one additional service user per year in Wards 1 and 3, and three per year in Ward 4 based on the assumption that inappropriately placed 'out of area' patients will be repatriated going forwards.

It is clear that the long-term impact of Covid-19 does not have a significant impact on our forecast bed requirements, with an increase in the 2036 bed requirement for Ward 3 and 4 by just one compared with the 'best case' scenario shown on the previous page (the 'best case' scenario assumes no long-term impact of Covid-19).

As with the 'best case' scenario, assuming we are able to have zero delayed transfers of care, the following would be feasible:

- If Mount Wards 1 and 2 continue to operate at around 90% occupancy, we could reasonably reduce our bed base by six beds across the two wards until at least 2036.
- Assuming that Mount Wards 3 and 4 continue to operate at around a 90+% level of occupancy, the current bed base of 48 beds could stay the same until 2028.
  - However, unless proposed additional initiatives (e.g. enhanced IHTT, more 'equitable' community provision, co-location on an acute site) provide some additional admission and ALoS reductions beyond the elimination of DTOCs, we would likely need to increase our bed base thereafter.

Based on this modelling, we expect to be able to plan for 26 organic beds and 48 functional beds provided we plan to significantly enhance our community and IHTT older people's services.

'Do something' modelling for our older people's inpatient services - 'intermediate case' scenario

Intermediate case scenario	Available beds 2019	Required beds per year 2028 (2)		Required beds per year 2036 (2)		Planned bed capacity
		90% occupancy (85% for Ward 3)		90% occupancy (85% for Ward 3)		
		Incl DTOC	Excl DTOC	Incl DTOC	Excl DTOC	
Mount W1 Male Dementia	17	20	13	22	14	17 -> 14
Mount W2 Fem Dementia	15	16	11	17	12	15 -> 12
Mount Ward 3	24	24	20	27	23	24
Mount Ward 4	24	32	30	37	35	24
Total	**80**	**92**	**74**	**103**	**84**	**80**

*(1)Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes **no** long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.*
(2) Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number

Our community provision is forecast to increase in line with our ambition to increase support in the community

We have also looked at how the changes we've identified will impact activity within our community older people's services in future. This is based on the 'intermediate 1' [(1)] scenario for the long-term recurrent impact of Covid-19 (i.e. there is some long-term impact of Covid on demand for mental health services).

The row in the table below highlighted in blue (IHTT) shows the impact of the changes we will make on the 'do something' forecast for service activity.

Our OPS IHTT is currently working at around two thirds of capacity given the services hours of operation due to how resource is currently allocated. With additional investment into the service, our ambition would be to operate at 100% capacity and increase the service by an additional 10% of current capacity in order to more intensive support in the community. This would have benefits in terms of outcomes for people, with more people able to be supported in their own homes, as well as support the reduction in future inpatient bed requirements for older people's services.

The rows in the table highlighted in pink (CMHT OPS ENE, CMHT OPS SSE, CMHT OPS WNW) are areas where we have a planned service change without formally quantified service impacts.

CMHT has recently been split into four teams (WNW has become West and North West), though this is not shown in the table. Though not yet implemented, we expect that the geographies in Leeds supported by each of these four teams will be reviewed to enable us to increase and more equitably distribute our workforce in line with the needs of our local population (e.g. considering ethnicity and deprivation level) to support our work to reduce health inequalities. Our intention with this is to enable people at most risk of becoming unwell, or those most in need of support, to be able to access the right support support earlier with the aim of better outcomes for people.

'Do something' modelling for our older people's inpatient services - 'intermediate case' scenario

Community services	Extrapolated contacts 2019[(1)(2)]	Forecast range of do nothing' contacts 2028[(2)(3)]	Forecast range of 'do something' contacts 2028[(2)(3)]	Forecast range of 'do nothing' contacts 2036[(2)(3)]	Forecast range of 'do something' contacts 2036[(2)(3)]
Care Homes Team	3,756	4,652 - 4,780	4,652 - 4,780	5,621 - 5,748	5,621 - 5,748
CMHT OPS ENE	7,577	9,256 - 9,452	9,256 - 9,452	10,989 - 11,185	10,989 - 11,185
CMHT OPS SSE	4,124	5,019 - 5,126	5,019 - 5,126	5,945 - 6,053	5,945 - 6,053
CMHT OPS WNW	8,136	9,940 - 10,155	9,940 - 10,155	11,726 - 11,941	11,726 - 11,941
Complex Dementia Wrap Ar	0 (*2,051 in 2021*)	2,354 - 2,425	2,354 - 2,425	2,679 - 2,749	2,679 - 2,749
Dementia MH Liaison	734	838 - 865	838 - 865	936 - 963	936 - 963
IHTT OPS	8,490	10,229 - 10,460	13,911 - 14,226	11,949 - 12,181	16,251 - 16,566
Intensive Care Homes Team	3,592	4,402 - 4,493	4,402 - 4,493	5,291 - 5,382	5,291 - 5,382
YPDT	1,333	1,397 - 1,464	1,397 - 1,464	1,396 - 1,463	1,396 - 1,463
Memory Assessment Teams	10,255	11,927 - 12,279	11,927 - 12,279	13,634 - 13,986	13,634 - 13,986
Total	**38,645**	**42,326 - 44,138**	**63,695 - 65,266**	**46,275 - 48,087**	**74,466 - 76,037**

(1)Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals
(2) Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.
(3)Range based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

These changes will have aim to make care better for service users and improve staff experience

We know that without changing how we provide our older people's services, we will not be able to keep up with the demand for our inpatient beds in future and our services will not be sustainable - this will limit our ability to continue to provide safe, high quality and equitable care.

The ambition we have set out for our Older People's Service Line aims to deliver on our wider care services strategic priorities and align to the ambition of our city partners and the national direction for future mental health services.

However we will also aim to impact on outcomes that are specific to our services - will know we are achieving the right outcomes if:

- Our service users and their carers are able to access timely, high quality and equitable mental health care and support that meets their needs.
- We have no delayed transfers of care and no out of area placements.
- We have a supported and resilient multidisciplinary workforce.
- Our staff have career progression opportunities, feel valued and staff retention improves.

To bring to life the impact we hope to have on outcomes for people, we have included below a service user 'persona' with a short story of what their care journey could look like in future, based on the ambition we have set out in this document.

I'm Jenny, I'm 70 years old and I am currently getting support for my mood. I've always enjoyed being active and other than my diagnosis of diabetes a few years ago, I am physically well. My mum had dementia and because I know it's in my family, as I get older I often think about it and it's a worry for me. I recently found myself feeling forgetful on occasions and it made me feel really on edge. I started to feel irritable and wasn't sleeping well and felt really low in mood. My GP referred me to the memory assessment service and also suggested I got assessed for talking therapies. It turns out that my memory is fine at the moment, and I'm now getting CBT for my mood, which I'm already finding helpful.

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Appendix H: Perinatal & Liaison Service Line Aspiration

We provide perinatal and liaison services across West Yorkshire, regionally and nationally

Our Perinatal and Liaison Service Line is made up of the following services:

Perinatal Mental Health Service: We support women in Leeds during pregnancy and the first year following their child's birth. This is through an initial assessment (currently taking place at Parkside Lodge as a temporary location in place of The Mount). We offer a variety of support options, including pre-conception counselling, group work, care planning, referral to the Yorkshire and Humber Mother and Baby Unit for inpatient care and an outreach service.

Liaison Psychiatry: We support people with physical health problems who also have mental health support needs. We offer the following:

- Outpatient services: Leeds and West Yorkshire Chronic Fatigue Syndrome/ ME Service and Leeds Psychosexual Medicine Service.
- Acute services: In-reach Liaison Psychiatry Team for adults receiving treatment at Leeds Teaching Hospitals NHS Trust (LTHT) and Acute Liaison Psychiatry Service (ALPS) for people who harm themselves or require acute care.
- Inpatient care: National Inpatient Centre for Psychological Medicine (NICPM), offering eight beds (approximately half of our beds are commissioned for Leeds residents and half for people nationally).

We are based in three locations: The Becklin Centre, Rose Garden Suite at Leeds General Infirmary, St James Hospital and The Newsam Centre.

We know that:

- 1500 women a year have a mental health problem during pregnancy or in the following year.
- The annual cost to the NHS and social care for not being able to access high quality perinatal mental health care is £1.2 billion.
- 30% with a long-term physical health condition are estimated to also have a mental health condition, with depression / anxiety being most common.

Sources: Health Innovation Network South London, Leeds Mental Health Strategy 2020-2025, Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study The Lancet online, , The Costs of Perinatal Mental Health Problems. Centre for Mental Health.

We are proud of the great care we provide, however we know there are some challenges with our services

We have identified some of the core challenges we face within our Perinatal and Liaison Service Line, which we must address to be able to improve people's outcomes and experiences of care and make our services sustainable:

- We have specialist expertise and strong research links in liaison psychiatry. However, there are some challenges in recruitment and retention, particularly for nurses, with the pandemic heightening pressures on the workforce. Recruitment and retention is also a challenge for NICPM, particularly with band 5 nursing staff and consultant posts. These workforce challenges may impact on clinical and financial sustainability of our perinatal and liaison services in future. They can also impact on staff experience and service user experience due to the potential impact on consistency and continuity of clinical teams.
- There is a lack of clarity around the pathway of care for people with medically unexplained symptoms and long term conditions. This means that many people can be referred to multiple different services before they are able to access the right care, and this can lead to delays in people getting the care and support they need. To address this, we should work with our partners, particularly primary care and IAPT, to develop a coherent and consistent pathway for people who are referred from primary care with these issues.
- Estates is a driver for change in several of our services. The NICPM estate was considered by CQC as '*requires improvement… because the premises were not suitable for the purpose they were being used*' and it is expected that this site will be closed in future. Our MBU is now in a temporary site and due to move back to the Mount, a PFI asset. At present, our liaison inreach teams do not have sufficient access to clinical or office space and the current locations of these teams do not support collaborative working with partners in the acute trust.

Without change, demand for our inpatient perinatal and liaison services is set to increase beyond current capacity

We have completed modelling to understand how demand for our services is expected to change in future.

The 'do nothing' modelling outlined below shows how demand for our inpatient services (measured through the number of beds required) and our community services (measured through number of contacts) is projected to grow over the next fifteen years if we make no changes to our current services.

It is evident that there is an upwards trajectory in bed requirements across both inpatient wards.

If we assume 85 - 90% occupancy as our operational target, both wards will have a bed deficit by 2028 and beyond in the 'do nothing' scenario.

'Do nothing' modelling for our perinatal and liaison services

Inpatient services	Available beds 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 85-90% occupancy) 2028 (1)		Required beds per year assuming 85-90% occupancy) 2036 (1)		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) (2)	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) (2)	
NICPM	8	7 (89%)	10	10	11	11	8
Perinatal inpatients	8	8 (98%)	11	11	12	12	8
Total	**16**	**15**	**21**	**21**	**23**	**23**	**16**

Community services	Extrapolated contacts 2019 (3)(4)	Forecast range of do nothing' contacts 2028 (4)(5)	Forecast range of 'do nothing' contacts 2036 (4)(5)
ALPS	5,091	5,610 - 5,869	6,154 - 6,413
Chronic Fatigue Service	2,258	2,487 - 2,648	2,704 - 2,864
HMHT	6,892	8,100 - 8,425	9,118 - 9,442
Liaison Out Patients	1,320 (2,018 in 2021)	2,183 - 2,265	2,406 - 2,487
Perinatal Community	5,520	6,103 - 6,371	6,895 - 7,161
Perinatal Outreach	150	166 - 173	187 - 194
Psychosexual Medicine	939	1,025	1,130
Weight Management	163	180	198
Total	**22,315**	**25,856 - 26,955**	**28,792 - 29,890**

(1) Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number
(2)Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.
(3)Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals
(4) Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.
(5) Range based on 'best case' and 'intermediate 1' scenarios

We will make changes to our perinatal and liaison services to improve care and support us to meet future demand

To address the challenges we are facing now and set our services up for the future, we must make changes so that we can provide better care to people who use our services. We have identified a set of key changes to our perinatal and liaison services, shown in the table below.

In developing these changes, we have considered the overarching strategic priorities for LYPFT care services and have also considered the ambition of our local system in Leeds, as well as relevant national policy - our future services must align to the 'left shift' agenda set out in the NHS Long Term Plan, moving more care into the community, focusing on early intervention and prevention, and addressing health inequalities.

Our priorities for care services are:

- We co-create and co-deliver care services with people who have lived experience
- We collaborate with our partners to understand our populations and provide proactive integrated care
- We provide high quality, equitable and sustainable care services

The diagram below shows the changes we will make to our perinatal and liaison services and they align with these priorities.

Change	Rationale and benefits
Increase our perinatal community service provision and offer support to women, partners and families in alignment with the NHS Long Term Plan commitments	We have an established perinatal community service - the NHS Long Term plan aims to improve and increase access to perinatal mental health care for women and families. More support in the community will aim to support people closer to home. We expect this will reduce average length of stay (ALoS) and admissions for perinatal inpatient beds.
Increase community provision (e.g. crisis cafes to support reduction in ALPS)	We expect that work to develop crisis care pathways and wider work to increase community support could have an impact on reducing ALPS activity in future.
Co-location of liaison psychiatry teams with acute trusts (in both LGI and St James LTHT sites) in line with Royal College standards	Our liaison teams do not have access to sufficient space in acute trusts to be co-located with acute services. We also intend to increase equitable provision of liaison outpatient services across the ICS footprint.
Continue providing NICPM in an appropriate estate (acknowledgement that funding direction is likely to influence this) and recruit to address staffing gaps.	The waiting list for NICPM is long and staff capacity is a challenge due to staffing retention. CQC have stated that the premises were not suitable for the purpose they were being used for.
Consider our future estate options such as purpose built MBU with therapeutically beneficial environment and co-location with other inpatient services in line with Royal College standards.	Our MBU is currently in a temporary site and is due to move back to the Mount - the Mount is a PFI asset and the future direction of this estate is currently unclear.

We have looked at how these changes are forecast to impact projected demand for our inpatient services

We have looked at how the changes we've identified will impact the projected demand for our services over the next fifteen years and our capacity to respond. The table below shows the modelling for our inpatient services.

There is a growth in bed requirement for NICPM beds in the 'do nothing' scenario. Because we don't expect significant changes to NICPM commissioning (e.g. commissioning for additional beds), the 'do something' forecast shown in the table below shows a deficit in planned capacity relative to forecast bed requirements in line with the 'do nothing scenario.

For perinatal inpatients, our ambition is to enhance provision of community-based support in line with the NHS Long Term Plan commitments. We hope this will enable us to to provide care for more service users and also a more intensive service, potentially for longer (e.g. up to two years after birth).

We are expecting our perinatal community team to almost double in size by 2023 (compared to the size of the team in 2019). Though difficult to quantify the impact of expanding our community team, we have made the following assumptions for the 'do something' modelling based on research:

- Expanding our perinatal community team could lead to a reduction in average length of stay (ALoS) from 64 days (our average in 2019) to 56 days - a bed day saving of around 13%. There is some evidence from other facilities that suggests that ALoS could be even lower, in the range of 28 - 35 days, with expansion of community services. However, people who are seen in the community and those requiring inpatient services are distinct, with evidence to demonstrate that where people need admission must be admitted and not cared for in the community.
- There is also evidence that specialised perinatal CMHTs that are closely integrated with a mother and baby unit (MBU) can reduce the number of mother and baby beds required for a large population - one report cites a potential reduction from 0.4 beds for 1,000 births to 0.25 per 1,000 births, a reduction of c. 37%. Given the near doubling of our perinatal community team by 2023, we have assumed that there will be a 20% reduction in our bed requirement.

Based on these assumptions, we believe that the current size of our perinatal inpatient bed base should be sufficient in 2028 though we may have a deficit of 1 bed in 2036. If however we were to sometimes operate at a >90% occupancy, or aim for a further reduction in ALoS, our current bed base would be sufficient.

An ICS-wide 6 bed MBU is currently being explored with our partners, with the potential for us to take on the role of lead provider. This could provide additional capacity for any additional growth in demand.

Based on this modelling, we expect to plan our bed capacity in line with the data in the 'Planned bed capacity' column in the table below.

'Do something' modelling for our perinatal and liaison inpatient services

	Available beds 2019	Beds used in 2019 (occupancy)	Required beds per year (assuming 85-90% occupancy) 2028 (1)		Required beds per year assuming 85-90% occupancy) 2036 (1)		Planned bed capacity
			Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) (2)	Best case (incl. no long-term COVID impact)	Intermediate 1 (incl. some long-term COVID impact) (2)	
NICPM	8	7 (89%)	10	10	11	11	8
Perinatal inpatients	8	8 (98%)	8	8	9	9	8
Total	**16**	**15**	**18**	**18**	**20**	**20**	**16**

(1) Assumes future occupancy rate of 85%-90% (90% used if 2019 value was >90%, 85% used if 2019 value was <85%). Bed numbers are rounded up to the nearest whole number
(2)Based on estimation using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council, the 'Best case' scenario assumes no long-term recurrent impact of COVID and the 'Intermediate 1' scenario applies some long-term recurrent impact of COVID. For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

Our community provision is forecast to increase in line with our ambition to increase support in the community

We have also looked at how the changes we've identified will impact activity within our community perinatal and liaison services in future.

The rows in the table below highlighted in blue (ALPS, Perinatal Community) shows the impact of the changes we will make on the 'do something' forecast for service activity.

Our hope is that the changes we are making to our acute (crisis) and community mental health services together with our system partners to move more care into the community and provide support to people earlier, will reduce the number of people experiencing a mental health crisis and harming themselves. This would have an impact on activity in our ALPS service, with a reduction in demand for the service.

The NHS Long Term Plan outlines an ambition to expand community perinatal mental health capacity to provide for 10% of mothers in the perinatal phase (up to 2 years following birth). We have modelled our 'do something' scenario, modelling through the impact of our proposed services changes to our perinatal mental health service in line with this.

In 2023, this would equate to around 1,000 referrals, which is almost twice the number of referrals we had in 2019. We hope this would enable more service users to be supported in the community and expect that this more intensive community offer could prevent admissions and/or reduce length of stay in MBU.

'Do something' modelling for our community perinatal and liaison services

Community services	Extrapolated contacts 2019[1][2]	Forecast range of do nothing' contacts 2028[2][3]	Forecast range of 'do something' contacts 2028[2][3]	Forecast range of 'do nothing' contacts 2036[2][3]	Forecast range of 'do something' contacts 2036[2][3]
ALPS	5,091	5,610 - 5,869	5,027 - 5,285	6,154 - 6,413	5,514 - 5,773
Chronic Fatigue Service	2,258	2,487 - 2,648	2,487 - 2,648	2,704 - 2,864	2,704 - 2,864
HMHT	6,892	8,100 - 8,425	8,100 - 8,425	9,118 - 9,442	9,118 - 9,442
Liaison Out Patients	1,320 (2,018 in 2021)	2,183 - 2,265	2,183 - 2,265	2,406 - 2,487	2,406 - 2,487
Perinatal Community	5,520	6,103 - 6,371	10,288 - 10,553	6,895 - 7,161	11,617 - 11,883
Perinatal Outreach	150	166 - 173	166 - 173	187 - 194	187 - 194
Psychosexual Medicine	939	1,025	1,025	1,130	1,130
Weight Management	163	180	180	198	198
Total	**22,315**	**25,856 - 26,955**	**29,455 - 30,553**	**28,792 - 29,890**	**32,874 - 33,973**

(1)Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals
(2) Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.
(3)Range based on no long-term recurrent impact of COVID ('best case') and 'intermediate 1' scenario which is based on some long-term recurrent impact of COVID (using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council). For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

These changes will have aim to make care better for our service users and improve staff experience

We know that without changing how we provide our perinatal and liaison services, there is a risk we will not be able to keep up with the demand for our inpatient beds in future and our services will not be sustainable - this will limit our ability to continue to provide safe, high quality and equitable care.

The ambition we have set out for our Perinatal and Liaison Service Line aims to deliver on our wider care services strategic priorities and align to the ambition of our system partners and the national direction for future mental health services.

However we will also aim to impact on outcomes that are specific to our services - will know we are achieving the right outcomes if:

- Service users and their carers are able to access timely, high quality and equitable mental health care and support that meets their needs.
- People are able to access more support in the community, in their own homes or close to their home.
- We have clear, integrated and efficient pathways of care.
- We have a supported and resilient multidisciplinary workforce.

To bring to life the impact we hope to have on outcomes for people, we have included below a service user 'persona' with a short story of what their care journey could look like in future, based on the ambition we have set out in this document.

My name is Andrea. I had my first baby 12 months ago now and am really pleased with how I'm doing. I've got bipolar disorder and was doing well on Lithium before I got pregnant - when I was thinking about having a baby I spoke to my consultant about the risks and my options for medication and support, and we agreed on a plan that felt right for me. During my pregnancy, I had more frequent visits from my CPN and I got support from the perinatal outreach team. I had a planned c-section and when I went home from hospital I had more regular visits from health visitors, the perinatal mental health team and my regular CPN. I had a bit of a wobble in the few weeks after I gave birth so the team worked with me to tweak my meds. I'm now part of a community group of new mums who have experienced mental health issues and really valuing the support we are able to give each other.

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Appendix I: Regional & Specialist Service Line Aspiration

We provide specialist mental health and neurodiversity services to people in Leeds, regionally and nationally

Our Regional and Specialist Service Line is made up of the following services:

Northern Gambling Service (Northern Gambling Clinic): We provide specialist addiction therapy and recovery support to people with gambling addictions and mental health conditions in the North and North Midlands.

Adult Attention Deficit Hyperactivity Disorder (ADHD) Service: We provide specialist assessment, monitoring and management to adults and young people in transition with ADHD in Leeds.

Autistic Diagnostic Service (LADS): We assess and diagnose adults who may have autism in Leeds and offer a one off consultancy appointment post-diagnosis.

Alcohol and Drug Services: Forward Leeds: LYPFT is part of Forward Leeds, delivering assessment, treatment and aftercare to people with drug and alcohol issues.

EMERGE Leeds: Complex Emotional Needs: We work with people experiencing complex emotional needs and interpersonal difficulties, offering care coordination, group work programmes and support for professionals.

Pathway Development Service (PDS)- Yorkshire and Humberside: We support people with personality disorders providing an independent review of care, supporting entry to and during secure unit stays and skills development for community teams.

Veterans' Mental Health Complex Treatment (VMH CTS) and High Intensity - North of England: We are lead providers for two veterans services, supporting people with complex mental health conditions who have worked in the military. This includes care navigation and support during an inpatient stay.

*W*hile some of our services are provided to a wider population, from recent work with our city partners we have important insights about our local population in Leeds that are relevant to our specialist services:

- In Leeds, the rate of problem gambling is estimated to be double the national average. We also know that risk factors for problem gambling include being male (males are four times more likely to have a gambling disorder than females) and being from a BAME background (people from a BAME background are seven times more likely to have a gambling addiction).
- Alcohol related hospital admissions are higher in Leeds than regional and national averages, and are higher in males than in females. M
- ore men access drug and alcohol services than women in Leeds, although women are more likely to have a mental health and substance use diagnosis.
- 30% of adults aged 18 and over reported a clinical significant level of psychological distress in Leeds in 2020, an increase from 21% in 2019.

We also know that:

- 50% of people who have autism also have a diagnosis of anxiety and/ or depression.
- Between 2020 and 2021, there was a 16.2% increase in the most severe gambling addiction referrals to NHS gambling clinics.
- It is estimated that at any one time, around 8000 out of the estimated 30,000 people who gamble pathologically are receiving treatment for a gambling addiction (excludes people treated in the private sector).

Sources: Leeds and York Partnership Trust website, NHS England website, Royal College of Psychiatrists: Rapid Evidence Review of Evidence-based Treatment for Gambling Disorder in Britain, Leeds Beckett University: Problem Gambling in Leeds, Leeds Joint Strategic Assessment 2021, Leeds Mental Health Strategy 2020-2025, Royal College of Psychiatrists: Gambling Disorder

We are proud of the great care we provide, however there are challenges to the sustainability of our current services

We have identified challenges within our Regional and Specialist Service Line, which we must address to be able to sustainably provide specialist care and support to people in future, and to improve people's outcomes and experiences of care:

- We are experiencing **increasing demand** for many of our specialist services. For example in our LADS service, demand is rising and sustainable clinical capacity to meet increasing demand is a challenge for the future - from our most recent performance data, 54.3% of LADS assessments started within 13 weeks compared to our 95% target. We also have a long waiting list for our ADHD service.
- We have identified **unmet need** that our services could address: children and young people with a gambling addiction and adults with a gaming addiction. In addition, we know that alcohol use has increased during the pandemic while fewer people have accessed alcohol use support.
- Our service line includes teams who are experts in their field and some who are recognised nationally for their work. While this capability is strong within the specialist services, we know that professionals working in general mental health services sometimes don't have the **skills, experience** or confidence to support people in their services who also have a specialist need (e.g. an addiction or neurodiversity). There is an opportunity to explore ways to use the expertise in our service to support other professionals to develop their skills in supporting people with specialist care needs.
- Teams working in our services, both in Leeds and in other regional sites, often find it challenging to access **suitable therapeutic space** for consultations with service users, and office space for staff meetings. Sometimes this means that appointments are held remotely through video call, rather than in person, due to estates constraints rather than clinical decision making. For some of our services, such as addictions, it is preferable from a clinical safety perspective, to see service users in person so it is important to have access to appropriate space to enable this.

Activity across all of our regional and specialist services are projected to increase in future

The table below shows the current and forecast demand for regional and specialist services if we make no changes to our services (the 'do nothing' scenario). Demand for our services is measured by 'contacts'.

We have used baseline figures from 2019 except for services that have had significant changes in activity in 2020 or 2021 (this is shown in the table).

The table below shows a range of forecast contacts in 2028 and 2036 - this range reflects the 'best case'(3) and 'intermediate case'(3) scenarios for the long-term recurrent impact of Covid-19 on demand for mental health and neurodiversity support

'Do nothing' modelling for our regional and specialist services

	Extrapolated contacts 2019(1)(2)	Forecast range of do nothing' contacts 2028(2)(3)	Forecast range of 'do nothing' contacts 2036(2)(3)
ADHD	2,842 (*5,772 in 2021*)	7,471 - 7,651	10,211 - 10,391
Emerge Leeds	3,806	5,643 - 5,885	6,932 - 7,174
Gambling Services	1,446	1,732 - 1,780	2,063 - 2,111
Gambling Services NHSE	42 (*1,903 in 2021*)	2,186 - 2,246	2,577 - 2,637
LADS	1,726	2,391 - 2,450	3,239 - 3,298
Pathway Development Service	218	276	325
Veterans HIS Team NE	0 (*2,070 in 2021*)	2,610 - 2,681	3,060 - 3,131
Veterans MH CTS	3,335	4,036 - 4,146	4,678 - 4,789
Total	**13,415**	**26,345 - 27,115**	**33,084 - 33,853**

(1)Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals
(2) Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.
(3)Range based on no long-term recurrent impact of COVID ('best case') and 'intermediate 1' scenario which is based on some long-term recurrent impact of COVID (using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council). For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

We will make changes to our regional and specialist services to improve care and future proof our services

To address the challenges we are facing now and set our services up for the future, we must make changes so that we can provide better care to people who use our services. We have identified a set of key changes to our regional and specialist services, shown in the table below.

In developing these changes, we have considered the overarching strategic priorities for LYPFT care services and have also considered the ambition of our local system, region and relevant national policy - our future services must align to the 'left shift' agenda set out in the NHS Long Term Plan, moving more care into the community, focusing on early intervention and prevention, and addressing health inequalities.

Our priorities for care services are:

- We co-create and co-deliver care services with people who have lived experience
- We collaborate with our partners to understand our populations and provide proactive integrated care
- We provide high quality, equitable and sustainable care services

The diagram below shows the changes we will make to our regional and specialist services and they align with these priorities.

Change	Rationale and benefits
Introduce 'two tier' autism diagnostic service with increased role of primary care / third sector partners for less complex cases and ongoing role for LYPFT in more complex cases	This change aims to better meet demand for autism diagnostic assessments. We expect that this will lead to fewer referrals to our LADS service.
Introduce system-wide offer for ADHD, with increased role for primary care / other partners for less complex cases (ongoing role for LYPFT in more complex cases)	This change aims to better meet demand for ADHD services. We expect that this will lead to fewer referrals to our ADHD service.
Expand our ADHD service to include treatment and management support, as well as diagnostics, and introduce service to support children and young people with ADHD in transition to adult services.	These changes aim to address a current service gap. We expect this will lead to increased referrals due to the expansion of the scope of the service. These changes will require recurrent investment in the service.
Expand our EMERGE and PDS services to include support to people under the age of 18 (14+) and people with neurodiversity	These changes aim to address a current gap in service and meet currently unmet need. This would lead to Increased referrals in line with the expansion of the service.
Stop adult gambling addiction service provision in the and Midlands expand it in new areas (likely Merseyside, Sheffield, Hull). Start providing a gaming addiction service for adults and a young person's gambling service.	These changes aim to address gaps in services and unmet need. We expect these will lead to increased referrals to our services.
Expand our veterans service in the region, potentially as lead provider across three service tiers (this is dependent on work around new care model development with partners) or through expanding referral criteria.	The model of care for veterans services in the region is currently being redeveloped with our partners. We expect these changes would lead to reduced referrals for CTS due to the smaller geography but likely more for TILS.

We have looked at how these changes are forecast to impact projected demand for our services

The table below outlines the 'do something' modelling for our regional and specialist services based on the changes we have identified.

The rows in the table highlighted in blue show the services impacted by the changes outlined on the previous page.

We expect that the shift to a system-wide offer for ADHD services, with more cases managed by primary care in future (potentially with pre and post diagnostic support as well as diagnostic assessments), could lead to around 25% fewer referrals to the service by 2028. An assumption of 25% fewer referrals to LYPFT services by 2028 has also been assumed for the future 'two tier' LADS service.

The 'do something' scenario for Emerge and PDS assumes an expansion to support people aged 14 and over and people with neurodiversity.

The 'do something' forecast for NHSE commissioned Gambling Services shows more contacts in future relative to the 'do nothing' scenario, reflecting the expansion of this service.

The future contacts for our CTS Veterans Services are significantly higher than the 'do nothing' view based on the assumption that we could expand our provision to all three tiers of Veterans services across the North.

'Do something' modelling for our regional and specialist services

	Extrapolated contacts 2019[1][2]	Forecast range of do nothing' contacts 2028[2][3]	Forecast range of 'do something' contacts 2028[2][3]	Forecast range of 'do nothing' contacts 2036[2][3]	Forecast range of 'do something' contacts 2036[2][3]
ADHD	2,842 (*5,772 in 2021*)	7,471 - 7,651	5,603 - 5,783	10,211 - 10,391	7,658 - 7,838
Emerge Leeds	3,806	5,643 - 5,885	5,643 - 5,885	6,932 - 7,174	6,932 - 7,174
Gambling Services	1,446	1,732 - 1,780	2,165 - 2,212	2,063 - 2,111	2,579 - 2,626
Gambling Services NHSE	42 (*1,903 in 2021*)	2,186 - 2,246	2,732 - 2,793	2,577 - 2,637	3,221 - 3,281
LADS	1,726	2,391 - 2,450	1,793 - 1,852	3,239 - 3,298	2,429 - 2,488
Pathway Development Service	218	276	276	325	325
Veterans HIS Team NE	0 (*2,070 in 2021*)	2,610 - 2,681	2,610 - 2,681	3,060 - 3,131	3,060 - 3,131
Veterans MH CTS	3,335	4,036 - 4,146	13,453 - 13,563	4,678 - 4,789	15,594 - 15,704
Total	**13,415**	**26,345 - 27,115**	**34,276 - 35,046**	**33,084 - 33,853**	**41,797 - 42,567**

(1)Where a full year of data is not available for the calendar year, or where the data looks to contain anomalies, a shorter period has been taken and then extrapolated based on the number of months. E.g. if April - Dec was taken as the baseline period, this has been uplifted by 12/9. The appointments / contacts have then been calculated based on the displayed ratio against the extrapolated referrals
(2) Contacts include both attended and DNAs as both are relevant for forecasting future estate requirements.
(3)Range based on no long-term recurrent impact of COVID ('best case') and 'intermediate 1' scenario which is based on some long-term recurrent impact of COVID (using the Centre for Mental Health modelling around impact of COVID, with input from Public Health colleagues at Leeds City Council). For further details see Chapter 3.1 in accompanying paper entitled 'Demand and Capacity Modelling Methodology and Outputs'.

These changes will have aim to make care better for service users and improve staff experience

We know that without changing how we provide our regional and specialist services, there is a risk that our services will not be sustainable and this will limit our ability to continue to provide safe, high quality and equitable care.

The ambition we have set out for our Regional and Specialist Service Line aims to deliver on our wider care services strategic priorities and align to the ambition of our partners and the national direction for future mental health services.

We will know we are achieving the right outcomes if:

- Our service users and their carers are able to access timely, high quality and equitable mental health and neurodiversity care and support that meets their needs.
- Our waiting lists improve, meaning people get access to care more quickly.
- We have a supported and resilient multidisciplinary workforce.
- Our staff have career progression opportunities, feel valued and staff retention improves.
- Our services are considered leading and we are able to use our expertise to influence local and national policy and to promote innovation and collaboration with our partners.

To bring to life the impact we hope to have on outcomes for people, we have included below a service user 'persona' with a short story of what their care journey could look like in future, based on the ambition we have set out in this document.

My name is Leo and I've recently been diagnosed with autism. I referred myself to LADS after speaking to my GP a few months ago. I was initially worried about having to wait a long time to be seen based on what I've heard about waiting lists for autism assessments, but once my referral was received I was contacted by a support worker who offered to speak to me about their experience of being diagnosed with and living with autism. I was able to meet them over a video call and found it helpful to talk through some of my worries. This really helped while waiting for my diagnostic assessment from the LADS team.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
18

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Workforce Race and Disability Equality Standards and Gender Pay Gap Progress Update 2022
DATE OF MEETING:	29 September 2022
PRESENTED BY: (name and title)	Darren Skinner, Director of People and Organisational Development
PREPARED BY: (name and title)	Caroline Bamford. Head of Diversity and Inclusion

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	
SO2	We provide a rewarding and supportive place to work.	✓
SO3	We use our resources to deliver effective and sustainable services.	

EXECUTIVE SUMMARY

The following paper provides an annual summary update on our Workforce Race Equality Standard (WRES) our Workforce Disability Equality Standard (WDES) data and Gender Pay Gap.

In line with Our People Plan, our WRES and WDES data identifies and addresses areas that will improve the workplace experience and representation at all levels for our Black, Asian, and Minority Ethnic (BAME) colleagues and colleagues with a disability or long-term health condition.

When analysing the data, we can adduce progress with the following:

- A significant decrease in the number of BAME staff entering the formal disciplinary process. This has reduced from six cases in 2020/21 to two cases in 2021/2022.
- There has been the largest growth in the number of BAME people in senior clinical roles at Band 8a, from 5 in 2020/21 to 15 in 2021/22.This equates to a 7.4% increase in representation at Band 8a.
- A favourable 3% reduction for staff with a disability or long-term condition reporting feeling pressure to come to work, despite not feeling well enough.
- A favourable continuation of no disabled colleagues entering the formal capability process on the grounds of performance for a second reporting year.
- There has been a substantial 11% favourable increase in disabled staff saying that the last time they experienced bullying, harassment or abuse they or a colleague reported it, this is 8% above the available benchmark.

Although there have been improvements against some of our WRES and WDES metrics, there is a widening gap in experience and satisfaction across several areas, such as experience of bullying and harassment and access to career progression. These are a key focus of Our People Plan to further embed shared priorities and actions to address the systemic inequalities experienced by our ethnic minority and disabled staff.

Our WDES and WRES priority areas of focus continue to be in relation to recruitment practises, bullying and harassment and the development of our staff networks. In addition, a deep dive of our WRES.WDES and wider EDI and staff survey data has commenced. This will inform the development of an EDI dashboard to provide a detailed of performance dashboard, to provide a detailed review of data by service area and identify areas/services of concern.

Further work will be undertaken from October to better understand the reasons for differences in gender pay. This will include analysis by pay band and staff group to identify areas of the organisation where the pay gap is higher and lower than the Trust average so we can target interventions to reduce our overall pay gaps over time.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes please set out what action has been taken to address this in your paper
	Yes	

RECOMMENDATION

The Board of Directors is asked to;

- Note the 2022 WRES and WDES results and progress against actions and current priorities detailed within section 2 of the paper.
- Receive assurance that the WRES and WDES and Gender Pay Gap data has been submitted in August 2022.
- Receive assurance that the WRES and WDES data and actions will be published on the Trust website by 31 October 2022 to meet statutory reporting requirements.

MEETING OF THE BOARD OF DIRECTORS

28 September 2022

Equality and Diversity- Workforce Race and Disability Standard and Gender Pay Gap Progress Update 2022

1. Executive Summary

This paper provides a summary update of our Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) data and Gender Pay Gap data for the reporting period 2021/2022, progress to drive actions and details of actions going forward. This is following submission of the data in August 2022 in line with reporting requirements.

The WRES and WDES are part of the NHS Standard Contract and ensure NHS organisations are compliant with the Equality Act (2010).

In line with Our People Plan, our WRES and WDES data identifies and addresses areas that will improve the workplace experience and representation at all levels for our Black, Asian, and Minority Ethnic (BAME) colleagues and colleagues with a disability or long-term health condition. There is a direct link between equality and outstanding care, therefore the WRES and WDES data provide an important performance and quality marker.

When analysing the data, we can adduce progress with the following:

- A significant decrease in the number of BAME staff entering the formal disciplinary process. This has reduced from six cases in 2020/21 to two cases in 2021/2022.
- There has been the largest growth in the number of BAME people in senior clinical roles at Band 8a, from 5 in 2020/21 to 15 in 2021/22.This equates to a 7.4% increase in representation at Band 8a.
- A favourable 3% reduction for staff with a disability or long-term condition reporting feeling pressure to come to work, despite not feeling well enough.
- A favourable continuation of no disabled colleagues entering the formal capability process on the grounds of performance for a second reporting year.
- There has been a substantial 11% favourable increase in disabled staff saying that the last time they experienced bullying, harassment or abuse they or a colleague reported it, this is 8% above the available benchmark.

Although there have been improvements against some of our WRES and WDES metrics, there is a widening gap in experience and satisfaction across several areas, such as experience of bullying and harassment and access to career progression. These are a key focus of Our People Plan to further embed shared priorities and actions to address the systemic inequalities experienced by our ethnic minority and disabled staff.

The Workforce Race and Workforce Disability Equality Standard data reports provide further data and details of key findings. These can be accessed at Appendix 1 and Appendix 2 of this report.

The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 requires all organisations that employ more than 250 staff to publish their gender pay gap. The gender pay gap shows the differences in the average pay between men and women and the Regulations require both median and mean figures to be reported. There has been a favourable decrease between men and women's pay across all reporting areas. The gender pay gap report provides further data and details of key findings. This can be accessed at Appendix 3 of this report.

Analysis of the pay gap by pay band and staff group will be conducted from October to identify areas of the organisation where the pay gap is higher and lower than the Trust average so we can target interventions to reduce our overall pay gaps over time.

2. Progress update and priority actions

The People Experience team was formed in April 2021 and provided the opportunity to review our Equality Diversity and Inclusion (EDI) work, with the aim of examining and improving the daily working lives of our ethic minority and disabled colleagues. The review allowed us to move away from the previous large numbers of actions and action plans that were making minimal difference, and instead refocus on a few key priority areas. These priorities were decided using an evidence base, utilising key metrics and data, as well as lived experience and personal stories. Overall, we want to deliver meaningful and tangible cultural change.

The identified EDI priorities form the relevant sections of Our People Plan which was launched in March 2022.

Reciprocal mentoring – to support genuine learning exchange through a two-way relationship between individuals that come from diverse, organisational, professional and/or cultural backgrounds. This approach aims to transcend hierarchy and create relationships and interactions which build both individual and organisational value. This will impact on both workplace culture and people engagement, central to Our People Plan ambitions.

A pilot programme, involving ethnic minority colleagues and executive team members ended in March 2022. Following evaluation, the implementation of a larger programme will commence from October 2022 and include managers from across the organisation partnered with our disabled, ethnic minority and LGBTQ+ colleagues.

Staff network development - The effective growth of our EDI staff networks is a priority as they are an essential source of knowledge and peer support. A review has been undertaken with our three EDI networks (Workforce Race Equality, Workforce Disability and Wellbeing and our LGBTQ+ Rainbow Alliance networks) with a focus on consistency and how they can support the delivery of Our People Plan. As part of this process, the chair role now has protected time of up to two days per month. In addition, new Terms of Reference have been approved, providing consistency across the networks for roles and responsibilities, as well as providing essential and welcome administrative support from the People Experience team.

Cultural Inclusion Ambassadors (CIA) - this programme consists of volunteers from ethnic minority backgrounds who have received training from the Royal College of Nursing to sit in

decision-making groups, within our disciplinary and recruitment processes. Their role is to identify and explore further issues of culture, behaviour and conscious or unconscious cultural bias. This initiative is at an early stage and to date there has been positive feedback on CIA impact in both disciplinary and recruitment panels. Impact evaluation will be undertaken by the end of the year, with the aim to expand and widen the programme.

Recruitment Practice - Initial work was undertaken during 2021/22 to process map our recruitment practices, to identify gaps and make recommendations to enhance and improve our processes. This is a significant piece of work, with six high impact actions for inclusive recruitment and promotion. This workstream will commence with the newly structured networks, our Recruitment Manager, and the Head of Strategic Resourcing. This work will be informed by an internal WRES and WDES recruitment audit to map current activity, with progress taking place from September.

Leadership Development - Developing and embedding inclusive and culturally intelligent leadership approaches continues to be a priority area. Evaluation of the learning from the cultural intelligence (CQ) leadership programme has been undertaken and next steps actions are being taken forward. Areas include incorporating cultural intelligence and inclusion modules within our management development programme and mainstream leadership learning and development offers.

In addition, the Head of EDI has been successful in submitting an expression of interest to be one of four trusts nationally to participate in Calibre, a positive action talent and leadership programme for people who identify as neurodiverse or disabled or who have a long-term physical or mental health condition. Engagement and planning work is currently being undertaken with the aim that up to twenty colleagues will participate in the programme commencing in November.

Bullying and Harassment – The percentage of both BAME and Disabled staff reporting experiencing bullying and harassment continues to be a priority area of concern. Our BAME colleagues are reporting a +12% negative experience of bullying and harassment by service users, their families, or the public, in comparison to our white colleagues. Both our BAME and disabled colleagues are reporting experiencing substantially higher levels of bullying and harassment from staff and from managers.

The review of our bullying and harassment procedure is scheduled to take place later this year, and the EDI team will contribute with a focus on learning from good practice, hate crime and how to support staff, managers, and wider teams. This work is being developed through a collective approach with other mental health organisations and led by EDI leads. The Trust wide violence reduction project led by the Associate Director of People Experience will also contribute to this workstream.

EDI Dashboard – Following a race equality board workshop held in June 2022 a deep dive of our WRES/WDES and wider EDI and staff survey data has commenced. This will inform the development of an EDI dashboard to provide a detailed performance dashboard. The aim of this dashboard is to provide a detailed review of data by service area and identify areas/services of concern.

To support and enhance progress, the Trust will be participating in the NHS Employers/NHS Confederation Diversity in Health and Social Care Programme from September 2022. The

programme aims to support organisations to integrate the latest sustainable diversity and inclusion practises.

2.1 Governance and assurance

The work of the EDI team is held accountable through the governance structure of our People Experience Group and then ultimately through the People and Organisational Development Governance Group and the Workforce Committee. An EDI subgroup was established from August, to progress the above priorities, to develop a consistent approach with our networks and to support the delivery of Our People Plan.

Detailed benchmarking will be provided as part of ongoing reporting. Benchmark data is published by the national WRES and WDES teams and is usually available in December/January each year.

3. Next steps

Details of our WRES and WDES summary data and progress against the action areas detailed within this paper have been shared through our staff networks.

In line with reporting requirements, the WRES and WDES data reports and action plans for the period September 2022 to August 2023 will be published via our website by 31 October 2022.

4. Recommendations

The Board of Directors is asked to.

- Note the 2022 WRES and WDES results and progress against actions and current priorities detailed within section 2 of the paper
- Receive assurance that the WRES and WDES and Gender Pay Gap data has been submitted in August 2022.
- Receive assurance that the WRES and WDES data and actions will be published on the Trust website by 31 October 2022 to meet statutory reporting requirements.

Caroline Bamford
Head of Equality and Diversity

14 September 2022

Leeds and York Partnership
NHS Foundation Trust

Appendix 1

Workforce Race Equality Standard Data Report 2022

The first WRES indicator 1 looks at the composition of our workforce (excluding bank) by banding compared with the overall workforce. The tables below show the changes in the overall number of BAME people in each Agenda for Change pay band and the medical workforce over the last two financial years.

Key Findings.

- The percentage of BAME staff employed at LYPFT has increased from 17.5% last year to 20% this year.
- The number of people in non-clinical roles in Bands 6, 7, 8a and VSM show slight growth. However, the number of people in Bands 8b, 8c, 8d and 9 has remained static.
- There has been the largest growth in the number of BAME people in senior clinical roles at Band 8a from 5 in 2020/21 to 15 in 2021/22.This equates to a 7.4% increase in representation at Band 8a.

Table 1- Non-Clinical staff breakdown for 2020/21 and 2021 to 2022

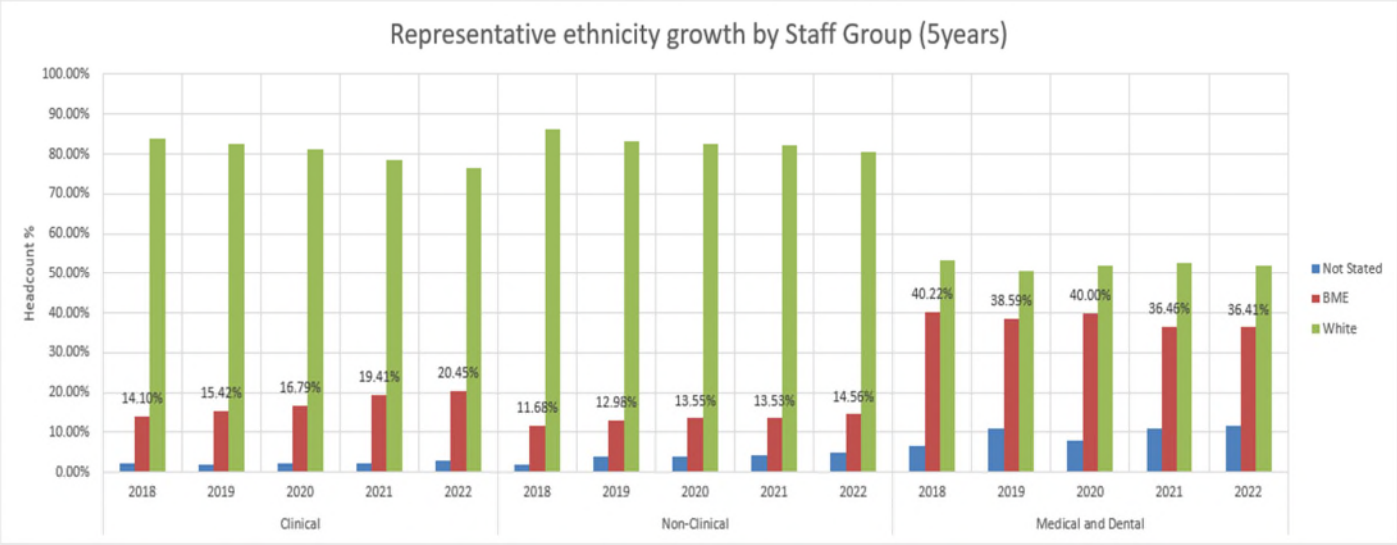
Non-Clinical							
Band	2020/21			2021/22			
	White	BAME	Unknown	White	BAME	Unknown	% BME in band
Band 1	4	0	0	2	0	0	0%
Band 2	105	23	4	103	23	10	16.9%
Band 3	131	28	5	158	32	2	16.6%
Band 4	93	11	1	98	16	1	13.9%
Band 5	57	9	2	56	9	1	13.6%
Band 6	64	9	2	60	12	1	16.4%
Band 7	57	8	5	56	10	4	14.2%
Band 8a	39	7	4	48	8	7	12.6%
Band 8b	14	1	1	16	1	1	5.5%
Band 8c	11	1	1	15	1	2	5.5%

Band 8d	8	0	0	8	0	2	0%
Band 9	0	0	0	2	0	0	0%
VSM	6	0	2	11	1	8	5.2%

Table 2- Clinical staff breakdown for 2020/21 and 2021 to 2022

Clinical							
	2020/21			2021/22			
Band	White	BME	Unknown	White	BME	Unknown	BME in band
Band 1	0	0	0	0	0	0	0%
Band 2	15	4	0	17	5	9	16.1%
Band 3	413	145	8	401	206	16	33.0%
Band 4	76	10	2	97	13	3	11.5%
Band 5	271	72	16	223	72	19	22.9%
Band 6	422	53	7	452	75	8	14.0%
Band 7	165	15	3	203	22	1	9.7%
Band 8a	96	5	1	100	15	6	12.3%
Band 8b	27	4	0	27	3	1	9.6%
Band 8c	23	3	1	28	4	1	12.1%
Band 8d	5	1	0	3	1	0	25.0%
Band 9	1	0	0	1	0	0	0%
VSM	5	0	0	1	0	0	0%
Of which are Medical & Dental							
Consultants	43	32	0	47	30	1	38.4%
of which senior medical manager	0	0	0	0	0	0	0%
Non-consultant career grade	23	15	0	25	13	2	32.5%
Trainee grades	31	28	14	29	29	20	37.1%

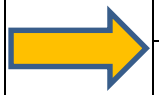
Table 3- Representative ethnicity growth by staff group over 5 years



WRES metrics 2 to 9

The table below details the WRES data over a two- year period, details of key findings and available benchmark data. It should be noted that for WRES metrics 2 to 4 the national benchmark data used was published in 2021. Further benchmark data will be published by the national team in early 2023. Further detailed benchmarking will be undertaken as part of ongoing analysis.

WRES theme/Question		Staff Group	Reporting Period-2021	Reporting Period- 2022	Benchmark 2021	Key Findings
2. Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BAME staff.		White/BAME	1.41	2.12	1.61	Negatively indicates that white staff are over twice as likely to be appointed from shortlisting and this is higher than the currently available benchmark (for 2021) of 1.61.
3. Relative likelihood of BAME staff entering the formal disciplinary process compared to White staff.		White/BAME	1.19	0.33	1.14	Positive reduction which indicates that BAME staff are less likely to enter the formal disciplinary process. This is lower than the currently available benchmark (for 2021) of 1.14. In 2021/22 there was a total of 26 disciplinary cases and two involved BAME staff.
4.Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BAME staff.		White/BAME	0.65	0.83	1.14	During 2021/22, 51% of BAME staff accessed training or CPD. Compared to 42% of white staff. The probability indicator is in the range of no adverse effect.
WRES Theme /Question		Staff Group	Staff Survey 2020	Staff Survey 2021	Benchmark	Key Findings
5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months.		White	25%	26%	26%	Bullying, harassment, and abuse (B&H) by service users, their families, or the public towards our BAME staff is a significant area of concern. Our BAME colleagues are reporting a +12% negative experience than our white colleagues, with incidences unfavourably increased by +6% in 2021, which is +6% higher than our benchmark group.
		BAME	32%	38%	32%	

WRES Theme /Question		Staff Group	Staff Survey 2020	Staff Survey 2021	Benchmark *	Key Findings
6.Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.		White	17%	17%	18%	Unfavourable increase in BAME staff reporting experiencing bullying and harassment from staff via the staff survey of 4%. This equates to the benchmark.
		BAME	19%	23%	23%	
7.Percentage of staff believing that trust provides equal opportunities for career progression or promotion.		White	61%	59%	61%	43% of our BME colleagues are reporting a less positive experience of career progression or promotion, in comparison to white colleagues at 59%. This is a 16% negative gap in reported experience when comparing responses from BAME and white colleagues.
		BAME	42%	43%	47%	
8.Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months.		White	5%	6%	6%	Whilst there has been no reported change over the last year, 14% of our BAME colleagues are experiencing more than double the level of discrimination from managers, compared to our white colleagues. This is an 8% negative gap when comparing responses from BAME and white colleagues.
		BAME	14%	14%	14%	

		Reporting Period-2021	Reporting Period-2022	
9.Percentage difference between the organisations Board voting membership and its overall workforce.		-9.8%	-12.5%	Trusts are required to look at the percentage difference between the organisations Board membership and its overall workforce. The data is disaggregated, by:. • voting membership of the Board • executive membership of the Board. Percentage of Board members from a BME group as of 31st March 2021 was 9.8%, this leads to a difference of -9.8% in comparison to the overall workforce. Percentage of Board members from a BME group has increased to 12.5% as of 31 March 2022, this leads to a difference of -12.5%. The percentage of BME voting Board members was 0% and Executive Board members 0%.

Appendix 2

Workforce Disability Equality Standard Data

Workforce Representation

The first WDES indicator 1 looks at the composition of our workforce (excluding bank) by banding compared with the overall workforce. The table below show the changes in the overall number of Disabled people in Agenda for Change pay band and the medical workforce over the last two financial years.

It should be noted that unknown column in the table below, refers to those staff who have indicated that they prefer not to say, as well as those who have not responded to the disability monitoring question in the staff electronics record system ESR.

Key Findings.

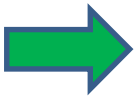
- The percentage of disabled staff employed at LYPFT has increased from 5.7 % last year to 6.3% this year.
- The number of disabled people in clinical roles in Bands 5 to 7 and Bands 8a to 8b show continuing growth. This is particularly evident in clinical Bands 5 to 7 where the percentage of disabled people has increased from 7.8% to 8.6%.
- There has been a positive increase in the likelihood of disabled applicants being appointed following shortlisting.
- A favourable continuation of no disabled colleagues entering the formal capability process on the grounds of performance for a second reporting year.
- There has been a substantial 11% favourable increase in disabled staff saying that the last time they experienced bullying, harassment or abuse they or a colleague reported it. This is 8% above the benchmark.

Table 1- Clinical and non-clinical staff breakdown for 2020/2021 and 2021/202

Non-Clinical							
	2020/21			2021/22			
Bands	Disabled	Non-disabled	Unknown	Disabled	Non-disabled	Unknown	% Disabled in band 2021/22
1 to 4	25	363	33	29	385	31	6.5%
5 to 7	12	130	7	11	190	8	5.3%
8a and 8b	4	62	3	4	72	4	5.0%
8c to VSM	1	36	6	1	37	12	2.0%
Clinical							
1 to 4	31	646	71	36	651	82	4.7%
5 to 7	82	902	73	92	912	71	8.6%
8a and 8b	3	140	5	11	135	6	7.2%
8c to VSM	1	30	8	1	36	8	2.2%
Of which are Medical & Dental							
Consultants	2	67	5	2	72	4	2.6%
Medical Non-consultant career grade	0	37	2	1	37	2	2.5%
Medical trainee grade	1	47	18	1	33	44	1.3%
Other	0	0	0	0	0	0	0%

WDES metrics 2 to 9

The table below details the WDES data over a two- year period, details of key findings and available benchmark data. It should be noted that for WRES metrics 2 to 4 the national benchmark data used was published in 2021. Further benchmark data will be published by the national team in early 2023. Further detailed benchmarking will be undertaken as part of ongoing analysis.

WDES theme/Question		Staff Group	Reporting Period- 2021	Reporting Period- 2022	Benchmark 2021	Key Findings
2.Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting.		Non-disabled	1.20	0.72	1.11	Positive increase in the likelihood of Disabled staff being appointed from shortlisting. The probability indicator is in the range of no adverse effect.
3. Relative likelihood of Disabled staff entering the formal capability process compared to non-Disabled staff.		Disabled	0	0	1.94	This metric applies to capability on the grounds of performance and not ill health. Over the two-year rolling period there have been two formal capability cases (one disabled and one non-disabled). Neither case was on the grounds of performance.
WDES theme/Question		Long Term Condition or illness	Staff Survey 2020	Staff Survey 2021	Benchmark	Key Findings
4. a) Percentage experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months.		With	33%	31%	32%	Favourable 2% decline in bullying, harassment, and abuse (B&H) by service users, their families, or the public towards our staff with a disability or long-term health condition.
		Without	24%	26%	25%	

WDES theme/Question		Long Term Condition or illness	Staff Survey 2020	Staff Survey 2021	Benchmark	Key Findings
4. a) Percentage experiencing harassment, bullying or abuse from manager in last 12 months.		With	14%	12%	13%	Favourable 2% decline in bullying, harassment, and abuse (B&H) from managers towards our staff with a disability or long-term health condition.
		Without	5%	7%	7%	
4. a) Percentage experiencing harassment, bullying or abuse from other colleagues in last 12 months.		With	21%	22%	20%	Slight 1% unfavourable increase in bullying, harassment, and abuse (B&H) from other colleagues towards our staff with a disability or long-term health condition.
		Without	11%	11%	12%	
4. b) Percentage saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.		With	56%	67%	59%	Substantial 11% favourable increase in disabled staff saying that the last time they experienced bullying, harassment or abuse they or a colleague reported it, this is 8% above the benchmark.
		Without	66%	61%	61%	
5. Percentage believe that their organisation provides equal opportunities for career progression or promotion.		With	49%	50%	54%	Slight favourable increase of 1% for staff with a long-term condition to 50%, although this is 4% below the benchmark of 54%. Although
		Without	61%	59%	60%	

WDES theme/Question		Long Term Condition or illness	Staff Survey 2020	Staff Survey 2021	Benchmark	Key Findings
6. Percentage felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.		With	20%	17%	21%	Favourable 3% reduction for staff with a disability or long-term condition feeling pressure to come to work, despite not feeling well enough. This is positively 4% below the benchmark of 21%
		Without	14%	12%	15%	
7. Percentage satisfied with the extent to which their organisation values their work.		With	41%	42%	44%	Slight favourable increase of 1% for staff with a long-term condition with the extent that our trust values their work to 42%, although this is 2% below the benchmark of 44%.As above – comparison to without?
		Without	55%	54%	52%	
8. Percentage with a long-lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to conduct their work		With	82%	81%	79%	81% of staff with a long-term condition reported that the trust had made reasonable adjustments. This is favourably 2% above the benchmark.
9. Staff engagement score.		With	6.7	6.8	6.7	Favourable increase in staff engagement score from 6.7 to 6.8, but still below Trust score of 7.0
		Without	7.4	7.1	7.2	
		Trust	7.2	7.0	7.0	

		Reporting Period-2021	Reporting Period-2022	
10.Percentage difference between the organisations Board voting membership		-6%	-6.2%	Trusts are required to look at the percentage difference between the organisations Board membership and its overall workforce. The data is disaggregated by:. • voting membership of the Board • executive membership of the Board.

and its overall workforce.				Percentage of Board members with a declared disability as of 31st March 2021 was 0%, this leads to a difference of -6% in comparison to the overall workforce. Percentage of Board members with a declared disability remained at 0% as of 31st March 2022, this leads to a difference of -6.2%

Leeds and York Partnership Foundation Trust- Gender Pay Gap Report 2022

The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 introduced a statutory requirement for organisations with more than 250 employees to produce information outlining details of any gender pay gap differences that exist within an organisation. We are required to publish data on the Government Equalities Office website and on the Trust website by 30th March annually.

The gender pay gap differs from equal pay in the following way. Equal pay deals with pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman. The gender pay gap shows the differences in the average pay gap between men and women.

The following includes the statutory requirements of the gender pay gap reporting legislation, along with further context to demonstrate our commitment to equality. The Trust is committed to understanding any differences identified in the gender pay gap report and will undertake further analysis to gain a better understanding as to the reason for the differences and to act where appropriate.

The gender profile of the Trust is 71% female and 29% male.

About the data used for this report

The gender pay gap calculation uses pay data from the pay period in which 31st March each year falls. The main pay gap data in this report includes all staff employed on 31st March on 31st March 2022.

The information provided in this report is drawn from the NHS Staff Electronic Record (ESR) Gender Pay Gap business intelligence reports. These reports have been developed nationally to provide information for NHS organisations on their gender pay gap.

Interpreting the results.

- A **positive** percentage figure reveals that typically or overall, **women** have lower pay or bonuses than men.
- A **negative** percentage figure reveals that typically or overall, **men** have lower pay or bonuses than women.
- A **zero-percentage** figure would reveal no gap between the pay or bonuses of men and women employees or completely equal pay or bonuses overall. This is highly unlikely but could exist where a lot of employees are concentrated in the same pay grade.

Mean and Median Gender Pay Gap

The gender pay gap shows the differences in the average pay between men and women and the Regulations require both median and mean figures to be reported. The mean is the overall average of the sample. Very large or small rates or bonuses can however dominate and distort the figure. The median shows the mid-point salary of any sample, calculated through sorting the hourly rates from lowest to highest and calculating the middle value. The median is not therefore distorted by very small or very large pay rates or bonuses.

Table 1 Mean and Median Pay Gap Trend 2020 to 2022

Results	2020	2021	2022
Average Gender Pay Gap- MEAN	11.4%	10.9%	10.3%
Average Gender Pay Gap- MEDIAN	5.9%	5.2%	3.1%

The data above identifies both a mean and median pay gap for women. The mean pay has been reducing over time and the median pay gap shows a reduction from a 5.2% gap in 202 to a 3.1% gap in 2022.

Table 2 The proportion of mean and women in each pay quartile

Pay quartiles are based on the hourly rate of pay from highest to lowest. This information is split into four quartiles, Upper, Upper Middle, Lower Middle and Lower. The percentage of men and women in each quartile is reported.

Quartile	Female Number	Male Number	Female %	Male %
Lower	587.00	202.00	74.40	25.60
Lower middle	572.00	217.00	72.50	27.50
Upper middle	587.00	218.00	72.92	27.08
Upper	524.00	268.00	66.16	33.84

The table above shows the proportion of males and females in each pay quartile. The lower quartile represents the lowest salaries in the Trust and the upper quartile represents the highest salaries. The Trust employs more women than men in every quartile.74% of employees in the lower quartile are female, compared to 66% in the upper quartile. This equates to an 8% difference when comparing the percentage of women in the lower to the upper quartile.

Bonus Pay Gap

In NHS organisations the main type of pay which fall within the bonus pay category under the gender pay gap regulations are Clinical Excellence Awards. These are paid to NHS consultants and academic GPs.

The proportion of men and women receiving a bonus payment is calculated by counting the number of employees who received a bonus in the 12 months up to 31st March and calculating the percentage of men and women who received a bonus in that period.

The calculation required under the Gender Pay Gap legislation requires us to calculate the percentage of men and women receiving a bonus as a percentage of all men and all women employees in the organisation, rather than the percentage that could have received a bonus. Only limited number of employees are eligible to apply for Clinical Excellence Awards and therefore the calculation is based on a small group of employees.

Table 3 Mean and Median Bonus Pay Gap Trend 2020 to 2022

Results	2020	2021	2022
Average Bonus Gender Pay Gap- MEAN	33%	34.3%	15.7%
Average Bonus Gender Pay Gap- MEDIAN	66%	47.9%	36.8%

The bonus gender pay gap difference has decreased when compared to the previous year. The mean figure reduced by 18.6% and the median figure by 11.1%.

Action to reduce our gender pay gaps

In 2021/22 we looked at our pay gap in more detail to see how we compare to similar organisations, this review indicated that our median gap was around the same as similar organisations.

We continued actions to progress flexible working policies and introduced an agile working policy.

Further work will be undertaken to better understand the reasons for differences in gender pay. This will include analysis by pay band and staff group to identify areas of the organisation where the pay gap is higher and lower than the Trust average so we can target interventions to reduce our overall pay gaps over time.

Our aspiration over time is an increase in the number of women in the upper pay quartile, leading to a further reduction in the overall pay gap. We are also focusing on opportunities through extended flexibilities relating to Clinical Excellence Awards, which in turn will impact on and reduce bonus pay gap.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

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LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Health Education England (HEE) Provider Self-Assessment Report (SAR), Reporting Period: 2021/22
DATE OF MEETING:	29 September 2022
PRESENTED BY: (name and title)	Darren Skinner, Director of People and OD
PREPARED BY: (name and title)	Julie Thornton, Head of OD

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives	✓
SO2	We provide a rewarding and supportive place to work	✓
SO3	We use our resources to deliver effective and sustainable services	✓

EXECUTIVE SUMMARY

All HEE placement providers need to complete an annual Self-Assessment Return (SAR). It is a process by which providers carry out their own quality evaluation against a set of standards. HEE have revised the SAR content for 21/22, which now covers the following:

- Section 1: Organisational details
- Section 2: Contracting
- Section 3a: Quality
- Section 3b: HEE Quality Framework Domain 1 - Learning environment and culture
- Section 3c: HEE Quality Framework Domain 2 - Educational governance and commitment to quality
- Section 3d: HEE Quality Framework Domain 3 - Developing and supporting learners
- Section 3e: HEE Quality Framework Domain 4 - Developing and supporting supervisors
- Section 3f: HEE Quality Framework Domain 5 - Delivering programmes and curricula
- Section 3g: HEE Quality Framework Domain 6 - Developing a sustainable workforce

The template attached is the online version provided by HEE and will be copied directly onto the online portal. Comments to support each question are optional only.

The self-assessment has been completed with the involvement of all relevant Trust Education and Training leads and co-ordinated by the Trust Head of OD. The submission has also been reviewed and approved for onward submission to Trust Board by the Trust People Talent and OD Group.

For Board information only – the education contract is as follows:-

21/22 total LDA £8,525,176
21/22 salaries for doctors in training £1,782,721
21/22 medical placement fees £990,620
21/22 non medical placement tariff £339,756
HEE expect the Trust's Board to have seen the SAR and have approved its submission.
The deadline for submission is 30th September 2022.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes please set out what action has been taken to address this in your paper
	No	

RECOMMENDATION

The Board of Directors are asked to

1. Read and note the contents of the SAR
2. Approve the SAR for submission to HEE

HEE Provider Self-Assessment - 2022

HEE Self-Assessment Tool

HEE Self-Assessment - Introduction
The HEE Self-Assessment (SA) is a process by which providers carry out their own quality evaluation against a set of standards. It is based on the philosophy of continuous quality improvement, the identification of quality improvement potential, the development of action plans, implementation, and subsequent evaluation.

Providers are asked to complete this online form indicating where they have or have not met the standards as set out in the SA. There is the opportunity under most of the questions for providers to provide comments to support their answer, this is optional and not mandatory.

Completing the SA
Some questions within the SA will ask you to provide some further information based on your responses.

Where standards have not been met: In these instances you will be asked to provide some information detailing why the standard has not been met and any work that is underway to ensure it will be met in future.

Where standards have been met: Where you have met the standards, some questions may give you the opportunity to add comments to support your answer.

Responses by Professional Group: In some questions we have asked you to provide a response per professional group. Throughout the SA we have arranged these groups by their regulators. For example, some questions will ask for you to respond for GMC or NMC associated learners or educators.

Further Questions
If you have any queries regarding the completion of the HEE SA, please review the FAQ document. If you still require further information, you can contact your regional HEE Quality Team.

1. Region Selection

Please select your region from the list below:
North East and Yorkshire
Please select your provider from the list below:
NHS Mental Health Trust

2. Please provide details of 3 challenges within education and training that you would like to share with HEE.
(100 word limit on each response)

Example 1: Resourcing dedicated educational and training spaces with reduced estates for learners as increased learner numbers and reintroduction F2F learning following pandemic.

Example 2: Trainers / Educators have multiple roles and multiple demands on their time. Therefore challenging to devote and ringfence sufficient time for the longer term benefits of developing others

Example 3: Setting up a new Social Work pathway within the Trust, something we have not dealt with before.

3. Please provide details of 3 areas of good practice within education and training that you would like to share with HEE.
(100 word limit on each response)

Example 1: Expansion in remunerated trust leads including educational supervisors, FP, CT, ST training, LTFT and well-being lead, MWRES lead in line with trainee expansion and RCPsych Trainees 'valued and supported' standards

Example 2: During 2021 the Practice Learning and Development Team have introduced a Virtual Placement for nursing students. It allows students to learn in a safe supportive environment. The hours contribute to NMC practice hours. The learning from the virtual placement has been shared across Practice partners in the ICS

Example 3: We have set up various training specifically for our NHS Employed SWs to encourage CPD and enhance knowledge and skills and support with SW identity

4. Please tick the box below to confirm that your Self-Assessment response has been signed off at board level before submission back to HEE.

☐ By selecting this box I confirm that the responses in this SA have been signed off at board level

5. Please confirm the date that board level sign off was received:

DD/MM/YYYY
29/09/2022

Section 2 - Contracting

6. Do you have board level engagement for education and training?

X Yes
No

If yes, please provide their name and job title;

Darren Skinner, Director of People and OD

7. Can the provider confirm that the funding provided via the education contract to support and deliver education and training is used for explicitly this purpose?

X Yes
No

If 'yes' please add comments to support your answer;
The Non-medical education committee has oversight of the NMET budget
All HEE funding received is auditable to confirm its sole use for the training of trainee Pharmacists, pharmacy technicians and for any skills investment, for those undertaking Post graduate training

8. Is an activity in the Education Contract being delivered through a third party provider?

☐ Yes
x No

9. Has the provider reported any breaches in relation to the requirements of the NHS Education Contract for any sub-contractor?

☐ Yes
☐ No
x N/A

10. Is the provider able to give assurance that they are compliant with all HEE education and training data requests?

x Yes
No

If 'yes' please add comments to support your answer;
PLD Team meet with local HEI's on a regular basis to ensure all placement requests are met

RAG Quarterly data submitted for pharmacy technicians and trainee pharmacists to HEE regarding whether trainees are meeting their professional and academic requirements

11. Have there been any health and safety breaches that involve a trainee or learner?

☐ Yes
X No

12. Does the provider engage with the ICS for system learning?

x Yes
☐ No

If 'yes' please add comments to support your answer;
The West ICS Psychiatry Trainee Enhancement Forum, Learning environment, assessment placements (LEAP) Board Virtual Placements have been shared across the ICS via the LEAP project and EELE group.
Pharmacists and technicians trainees engage with system learning across the Yorkshire via Buttercups commissioned by HEE

Section 3a - Quality

13. Is the provider aware of the requirements and process for a HEE Quality Intervention, including who is required to attend and how to escalate issues with HEE?

x Yes
☐ No

14. Have any conditions been imposed on the provider from regulators?

	Yes	No	N/A
GDC	☐	☐	☐
GMC	☐	x	☐
GPhC	x	☐	☐
HCPC	☐	x	☐
NMC	☐	x	☐
GOsC	☐	☐	☐
Any other learner groups (*Social work)	x	☐	☐

If yes, please provide further detail:

*Social Work England now have a requirement that 2 pieces of evidence have to be uploaded, one needs to be a personal reflective piece and the other has to be a peer reflective piece.

The General Pharmaceutical Council provide standards of practice and learning outcomes for providers to exemplify how these can be met before approval as registered training site

15. Has the provider actively promoted the National Education and Training survey (NETS) to learners?

x Yes
☐ No

If 'yes' please add comments to support your answer;
Direct contact to trainees from DME and reminders to supervisors. Direct contact with nursing and AHP students and reminders to Education Leads
Pharmacist and technician disseminate the NETS survey to relevant trainees and tutors

16. Has the provider reviewed and where appropriate taken action on the basis of the results of the National Education and Training Survey (NETS)

x Yes
☐ No

If 'yes' please add comments to support your answer;
Discussion and action plan via Trust Medical Education Committee
Results reviewed against training programmes, results difficult to interpret to specific organisational level

17. Does the provider have a Freedom to Speak Up Guardian and do they actively promote the process for raising concerns through them to your learners?

X Yes
☐ No

If 'yes' please add comments to support your answer; if 'no' please provide further detail:
Attends Trust welcome event, Service meetings, staff networks

18. Does the provider have a Guardian of Safe Working, and do they actively promote the process for raising concerns through them to their learners?

x Yes
x No (Pharmacy)

If 'yes' please add comments to support your answer;
Attends induction, chairs JDF, attends Medical education committee, attends orientation Trust Days for nursing students

If no, please add comments to support your answer
Buttercups do provide external support and trainees are provided with escalation points of contact to raise concerns. In pharmacy, we have mentors, line managers, pastoral support and access to our EAP and OH services and senior pharmacy leadership as relevant to discuss / escalate concerns

19. Please confirm whether you have an Equality, Diversity and Inclusion Lead (or equivalent):

x Yes
☐ No

If 'yes' please add comments to support your answer;
In addition to trust lead, also Consultant MWRES lead and IMG lead

20. Please confirm that the provider liaises with their Equality, Diversity and Inclusion Lead (or equivalent) to:

	Yes	No
Ensure reporting mechanisms and data collection take learners into account?	x	☐
Implement reasonable adjustments for disabled learners?	x	☐
Ensure policies and procedures do not negatively impact learners who may share protected characteristics?	x	☐
Analyse and promote awareness of outcome data (such as exam results, assessments, ARCP outcomes) by protected characteristic?	x	☐

	Yes	No
Ensure International Medical Graduates (IMGs) receive a specific induction in your organisation?	x	☐
Ensure policies and processes are in place to manage with discriminatory behaviour from patients?	x	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:
MWRES lead attends EDI group & medical education committee and leads IMG induction

21. Patient Safety and the promotion of a Patient Safety culture is integral to the HEE Quality Framework. Can you confirm as a provider that you have the following:

	Yes	No
A named Board representative for Patient Safety	x	☐
A named Patient Safety Specialist/s	x	☐
A process to ensure that all staff are made aware of and can access the NHS Patient Safety Syllabus Level 1 training on the e-Learning for Healthcare platform	x	☐

If 'yes' please add comments to support your answer;
Implementation plan for Level 1 Mandatory training
Trustwide patient safety process and escalation process applicable to all departments
Actively promoted and accessible. We have Medicines Safety Officer for medicines
Related issues

22. Has the provider developed and implemented a service improvement plan to ensure progression through the Quality and Improvement Outcomes Framework for NHS Funded Knowledge and Library Services?

x Yes
☐ No

If 'yes' please add comments to support your answer;
Paper submitted in June

23. Has the provider been actively promoting, to all learners, use of the national clinical decision support tool funded by HEE?

☐ Yes
x No

if 'no' please provide further detail: further information required on this tool

Section 3b - HEE Quality Framework Domain 1 - Learning environment and culture

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

24. The learning environment is one in which education and training is valued and championed.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (Social Work)	x	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:
Vibrant education committees and Junior Doctors Forum (JDF); FLP; RCPsych FLMS Trainees; The quality of placements is constantly assessed through the use of student feedback both through the new PARE platform and through informal peer networks, creating the structure for awareness and a positive culture within clinical environments. Student feedback issues are raised and managed with HEI partners and within the Trust. This positively drives the culture and expectation within all clinical areas; The Practice Learning and Development Team regularly attend Trust clinical governance meetings and influence the agenda for learners across the Trust;

There is an annual development day targeted at Education Leads and senior mentors which considers the wider cultural changes in education and allows for innovative practices to be showcased and discussed.
The Social Work pathway is very new but to encourage learning we have set up:
Specific Social Work targeted training which includes topics such as Social Work Identity, reflective practice etc. We have also set up various forums where specific social work topics are/can be discussed
Pharmacy professionals work to standards as per General Pharmaceutical Council.
Non Registered staff work towards inhouse standards

25. The learning environment is inclusive and supportive for learners of all backgrounds and from all professional groups.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (Social work)	x	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

- There is a high priority placed on the naming of an Education Lead (EL) for nursing and AHPs within each placement area. In the past year EL's have also been identified for clinical psychology. These individuals take on the responsibility for promoting the quality of the learning environment and linking with the Practice Learning and Development Team.
- Development and recent update of the student placement charter which sets out expectations of the Trust and student during student placement

The forums and sessions are open to all Trust Employed Social Workers but we have also opened it up to other Social Workers from the LA and also from other regional trusts to create links and shared learning. The training sessions are also opened up to other professionals where we have spare places.

26. The organisational culture is one in which all staff, including learners, are treated fairly, with equity, consistency, dignity and respect.

	Yes	No	N/A
GDC Learners	☐	☐	☐

	Yes	No	N/A
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:
No NTS reports of undermining or bullying;
For nursing, psychology and AHPs:

- The PLDT has forged strong links with HEIs and this has led to a much higher awareness of student/learner/trainee wellbeing and also the support for mentors who are in the frontline of everyday contact with learners.
- Every other month an Educational Lead Forum takes place which provides the space for educators and mentors to review their practice and develop the cultures within the clinical areas.
- There is a named contact within the PLDT for each clinical area, both for nursing, AHP and psychology. This delivers both support and challenge for the clinical areas to provide the best possible environments for learners.
- The development of the Nursing and Midwifery Council (NMC) Standards for Student Supervision and Assessment (SSSA) (2018) has led to close partnership working with HEI partners in providing a joined up process that will facilitate the smooth adoption of the standards. This will be a key part of the future culture of the support for undergraduate nursing students

27. There is a culture of continuous learning, where giving and receiving constructive feedback is encouraged and routine.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (Social Work)	x	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:
For nursing, AHP and psychology:

- The quality of placements is constantly assessed through the use of student feedback both through the new PARE platform and through informal peer networks, creating the structure for awareness and a positive culture within clinical environments.
- Student feedback issues are raised and managed with HEI partners and within the Trust. This positively drives the culture and expectation within all clinical areas.

Social work
Evaluation forms completed at the end of each CPD session as well as Employee Welfare check via SWORD survey and 360 degree evaluation yearly.
Pharmacy
All learners are encouraged to ask question and all staff encourage to guide and support

28. Learners are in an environment that delivers safe, effective, compassionate care and prioritises a positive experience for patients and service users.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	☐	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:
DME, Allied HP, Nursing, Psychology educators in Trust Wide Clinical Governance group;
For nursing, psychology and AHP:
The use of the Trust's incident reporting platform (DATIX) allows for the sharing of crucial information when learners are involved in incidents. As a result students can be offered early support and there is an active process to ensure that all parties have relevant knowledge.

29. The environment is one that ensures the safety of all staff, including learners on placement.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐

	Yes	No	N/A
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (Social work)	x	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:
Comprehensive induction, lone worker policies, personal alarms
For nursing, AHP and psychology:
The use of the Trust's incident reporting platform (DATIX) allows for the sharing of crucial information when learners are involved in incidents. As a result students can be offered early support and there is an active process to ensure that all parties have relevant knowledge.
Social work - We have a Placement learning agreement and allocate a Work Place Supervisor and Practice Educator
Learners are accompanied by pharmacy staff and supported to work independently as relevant

30. All staff, including learners, are able to speak up if they have any concerns, without fear of negative consequences.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (Social work)	x	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:
For nursing, psychology and AHPs:
There are strong links with the Trust's Freedom to Speak up Guardian with presentations early in the orientation phase of each learner within HEIs. They are encouraged to see this as an additional avenue of support to share issues regarding poor care, care environments that are not truly supportive and the display of any negative behaviour.
Social work - Evaluations and feedback can be provided anonymously

31. The environment is sensitive to both the diversity of learners and the population the organisation serves.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	☐	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (Social Work)	☐	☐	x

If 'yes' please add comments to support your answer; if 'no' please provide further detail:
Currently supporting international nurses in their transition program (this is similar to a preceptorship program)

32. There are opportunities for learners to take an active role in quality improvement initiatives, including participation in improving evidence led practice activities and research and innovation.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (Social Work)	☐	☐	x

If 'yes' please add comments to support your answer; if 'no' please provide further detail:
For nursing, AHP and psychology:
The Trust has an active training strategy and timetable for issues relating to the LGBT+ agenda and students are invited to be part of the development of this work and participate in the innovative approaches with the organisation

33. There are opportunities to learn constructively from the experience and outcomes of patients and service users, whether positive or negative.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (Social Work)	☐	☐	x

If 'yes' please add comments to support your answer; if 'no' please provide further detail:
All Learners are included in post incident reflections, learning and support

34. The learning environment provides suitable educational facilities for both learners and supervisors, including space and IT facilities, and access to library and knowledge services and specialists.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	☐	x	☐
GPhC Learners	☐	x	☐
HCPC Learners	☐	x	☐
NMC Learners	☐	x	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

if 'no' please provide further detail for each facility:
Post Pandemic, Reviewing space for education and teaching as no dedicated resource
Currently face to face teaching needs to occur off site.
Insufficient work space for discussion and inadequate, accessible or poorly functioning Laptops in order to undertake learning remotely. We do however have access to excellent library and knowledge services

35. The learning environment promotes multi-professional learning opportunities.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (Social Work)	☐	☐	x

If 'yes' please add comments to support your answer;
HEE FLP project – Interprofessional student workshops, Risk training
For nursing, AHP and Psychology:

- The development of the 6-12 months period of preceptorship is an inter-professional period of development which is delivered by professionals from numerous backgrounds within the Trust.
- The development of the Nursing and Midwifery Council (NMC) (2018) Standards for Student Supervision and Assessment (SSSA) has led to close partnership working with HEI partners in providing a joined up process that will facilitate the smooth adoption of the standards. This will be a key part of the future culture of the support for undergraduate nursing students. It necessitates an increase in the inter-professional assessment of nursing students.
- Students and learners have supervision and support from all professional groups within the Trust and participate in multi-disciplinary activity with the clinical environments.
- Access to interprofessional student workshops
- Access to Student Forums
- Access to PLD Team Clinics

Pharmacy learners are invited to formal multi-professional learning events and also have the opportunity to undertake multi-professional learning on a day to day basis

36. The learning environment encourages learners to be proactive and take a lead in accessing learning opportunities and take responsibility for their own learning.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐

	Yes	No	N/A
GOsC Learners	☐	☐	☐
Any other learner groups (Social Work)	☐	☐	x

If 'yes' please add comments to support your answer;
For nursing, AHP and psychology:
All students/trainees are in an environment where they are encouraged to be proactive and guide their learning. Additional learning opportunities are available and discussed. Educators encourage students/trainees to arrange their own additional learning opportunities or communicate their interests.
Pharmacy
Some reluctance however by some staff to register interest and some barriers to Supporting progression such as financial but also willingness / capacity of trainers

Section 3c - HEE Quality Framework Domain 2 - Educational governance and commitment to quality

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

37. There is clear, visible and inclusive senior educational leadership, with responsibility for all relevant learner groups, which is joined up and promotes team-working and both a multi-professional and, where appropriate, inter-professional approach to education and training.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
The Practice Learning and Development Team (PLDT) was established to provide support for students across non-medical professions (nursing, Psychology and Allied Health

Professionals (AHPs)) and is funded by the Non-Medical Education Tariff (NMET). The manager of the Practice Learning and Development Team is a permanent member of the newly formed Trust-wide Education Committee

38. There is active engagement and ownership of equality, diversity and inclusion in education and training at a senior level.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
MWRES lead reports to RO, DME and professional lead
Practice Learning and Development Team manager & Professional leads
More work to do in pharmacy to capture this level of data

39. The governance arrangements promote fairness in education and training and challenge discrimination.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
The Non-medical professional education committee meet bi-monthly and a standing item on the agenda is to review PARE feedback

Process involves discussion with line manager and option for staff to escalate questions / concerns to lead E&T pharmacist / technician as relevant

40. Education and training issues are fed into, considered and represented at the most senior level of decision making.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
Student surveys are shared by the Executive Team and a report on the quality of learning environments is submitted to the Internal Quality Committee on an annual basis. Challenges and concerns as well as successes and opportunities for staff promoted within Senior pharmacy team and operational teams

41. The provider can demonstrate how educational resources (including financial) are allocated and used.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
People, Talent and OD Group

Registration with professional body only possible upon qualification through educational Programmes to demonstrate use of educational resources

42. Educational governance arrangements enable organisational self-assessment of performance against the quality standards, an active response when standards are not being met, as well as continuous quality improvement of education and training.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
Vibrant Trust Medical Education Committee and JDF quarterly. Monthly Doctors in training. Meeting with DME and operational lead. Bi-monthly meeting with Education Leads
Bi-monthly non-medical professional education committee
Pharmacy - For technicians, regular discussion with education provider takes place, for Pharmacist trainees, regular meeting with supervisors takes place to ensure training Standards are being worked towards and / or met. Any issues to escalate / discuss are Escalated internally or to HEE promptly as per due process

43. There is proactive and collaborative working with other partner and stakeholder organisations to support effective delivery of healthcare education and training and spread good practice.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GoC Learners	☐	☐	☐

	Yes	No	N/A
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
Lead employer for CAMHS CT's in LCH and member of WYCT committee. DME member of Regional Mental Health DME forum. Member of Practice Placement Quality Assurance Group at place, member of the LEAP. Board Delivery Group
Pharmacy - Regular placement / rotational opportunities in place with local NHS organisations

44. Consideration is given to the potential impact on education and training of services changes (i.e. service re-design / service reconfiguration), taking into account the views of learners, supervisors and key stakeholders (including HEE and Education Providers).

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	☐	☐	☐
NMC Learners	☐	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
Monthly meeting with all Clinical directors and DME. Multi-professional Educators part Of Trust Wide Clinical Governance. Member of the unified clinical governance group
Pharmacy - Impact of available supervisors assessed to ensure appropriate training available for learners

Section 3d - HEE Quality Framework Domain 3 - Developing and supporting learners

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

45. There is parity of access to learning opportunities for all learners, with providers making reasonable adjustments where required.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
Specific DPGME-operational who line manages all trainees and enables reasonable adjustments. Named Support lead and Champion of Flexible Training. Learners will have opportunity to discuss learning opportunities through initial discussions on placement and have space to explore any learning needs and reasonable adjustments
Pharmacy - Opportunities promoted to all across protected characteristics

46. The potential for differences in educational attainment is recognised and learners are supported to ensure that any differences do not relate to protected characteristics.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
Named IMG lead and specific IMG induction
Pharmacy - Styles, preferences and needs of the learners regularly evaluated to ensure learning can be achieved optimally

47. Supervision arrangements enable learners in difficulty to be identified and supported at the earliest opportunity.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
Named Clinical and educational supervisors report directly into TPDs and DME. Learners will have several interviews during their placement to identify any difficulties or have any concerns feedback to ensure correct support is available and offered;
Regular meetings with named supervisor introduced for all learners

48. Learners receive clinical supervision appropriate to their level of experience, competence and confidence, and according to their scope of practice.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	x	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
All placements have a named GMC approved clinical supervisor aware of trainees needs. Throughout their placement they will have opportunities to meet with assessors and supervisors both formally, through interviews, and informally throughout the daily demands to have supervision and encouraged to seek this adhoc when required

if 'no' please provide further detail:
Mentors available but clinical supervision currently being reviewed and re-implemented To meet the needs of pharmacy staff. More mentors would be helpful

49. Learners receive the educational supervision and support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
Trust invested in additional remunerated educational supervisors in line with FP and CT expansion. Learners will receive this from universities and supported by the trust when on placement

50. Learners are supported to complete appropriate summative and/or formative assessments to evidence that they are meeting their curriculum, professional and regulatory standards, and learning outcomes.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;

See positive ARCP outcomes. School of Psychiatry Core and Higher Trainee of Year trained in the Trust. Specific remunerated Foundation, GP, CT and ST leads. Learners will be supported by university to complete assignments, standards and proficiencies and the trust can support on placement to complete these; As per the requirements of their specific programme of study or inhouse guidance

51. Learners are valued members of the healthcare teams within which they are placed and enabled to contribute to the work of those teams.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
See placement feedbacks, ARCP outcomes and learners 360 appraisal results. Learners are very much a part of any team they are on placement with and encouraged to attend team meetings to help improvements of the service and a have a voice in any changes.

52. Learners receive an appropriate, effective and timely induction and introduction into the clinical learning environment.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;

Induction timetable available on request. Learners will receive an induction within the first week, most of the time their first day, to ensure they are aware of the environment and have an idea of the service areas space and safety.
All staff receive a thorough induction on joining the pharmacy dept in LYPFT

53. Learners understand their role and the context of their placement in relation to care pathways, journeys and expected outcomes of patients and service users.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
Doctors in training specific local induction checklist verified by Educational supervisor available on request. Learners will learn this on induction and orientation to the placement and throughout their time there and will be guided via practice assessors and supervisors and outlined in student initial interviews; Learners undertake rotations to understand the patient journey across the organisation with regards to medication

54. Learners are supported, and developed, to undertake supervision responsibilities with more junior staff as appropriate.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
CT lead on out of hours call pathway, CT medical education tutor leads,
ST tutor leads, Chairs to educational programme, FLP and RCPsych FLMS annual Opportunities. Learners are encouraged to support junior learners when on placement to help develop their leadership skills, provide supervision and support with any work demands. We encourage staff to provide supervision but do require more supervision training to pharmacy professionals for whom CS is not part of training / practice as it is for other health care professionals

Section 3e - HEE Quality Framework Domain 4 - Developing and supporting supervisors

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

55. Formally recognised supervisors are appropriately supported, with allocated time in job plans/ job descriptions, to undertake their roles.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	x	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

if 'no' please provide further detail:
Job plans / JD include partaking and providing supervision but allocated time is not specified

56. Those undertaking formal supervision roles are appropriately trained as defined by the relevant regulator and/or professional body and in line with any other standards and expectations of partner organisations (e.g. Education Provider, HEE).

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐

	Yes	No	N/A
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
DME trains in house and deanery wide for HEE on being GMC approved Clinical and Educational Supervisor. PEAP training now available for HCPC and NMC registered staff. Pharmacy Staff identified as supervisors are required to undertake the HEE educational supervisor Training programme

57. Clinical Supervisors understand the scope of practice and expected competence of those they are supervising.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
All trainees have GMC approved clinical and educational supervisor. Through training as an educator and support HCPC and NMC aware of scope of practice; Relevant training days attended by supervisors

58. Educational Supervisors are familiar with, understand and are up-to-date with the curricula of the learners they are supporting. They also understand their role in the context of leaners' programmes and career pathways, enhancing their ability to support learners' progression.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐

	Yes	No	N/A
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
All trainees have a GMC educational supervisor. New RCPsych curricula rolled out August 2022. In house training underway for supervisors and trainees. NMC and HCPC attend Ed Lead forums and continued support from PLDT Team; All educational supervisors are supported and required to read the responsibilities of undertaking the supervisor role for the individual educational programme

59. Clinical supervisors are supported to understand the education, training and any other support needs of their learners.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
Monthly Consultant and SAS meeting to discuss issues with DME. Education Lead forums for HCPC and NMC with continued support from PLDT Team. CS ask learners about their E&T and advice / signpost to relevant support. ES modules also available to undertake as needed

60. Supervisor performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for continued professional development and role progression and/or when they may be experiencing difficulties and challenges.

	Yes	No	N/A
GDC Learners	☐	☐	☐

	Yes	No	N/A
GMC Learners	x	☐	☐
GPhC Learners	☐	x	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
Medical educator section in appraisal and DME part of new appraiser training. HCPC and NMC appraisals yearly.
if 'no' please provide further detail: Supervisor performance assessed informally via 1-1 / meetings with supervisors and Multisource feedback historically but need to formalise supervisor assessment. Each supervisor has an escalation point of contact and lead / line manager as relevant

Section 3f - HEE Quality Framework Domain 5 - Delivering programmes and curricula

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

61. Practice placements must enable the delivery of relevant parts of curricula and contribute as expected to training programmes.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	☐	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
Practice Learning and Development Leads link with HEIs
Requirement of the registration as a training site by GPC for trainee pharmacists and technicians

62. Placement providers work in partnership with programme leads in planning and delivery of curricula and assessments.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	☐	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
DME part of WYCTC allocation committee and School management committee. Clinicians of all bands contribute to facilitating educational sessions, interviewing, assessments
Lead E&T pharmacy work with operational leads and national standards to deliver the curricula and assessments

63. Placement providers collaborate with professional bodies, curriculum/ programme leads and key stakeholders to help to shape curricula, assessments and programmes to ensure their content is responsive to changes in treatments, technologies and care delivery models, as well as a focus on health promotion and disease prevention.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	☐	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
DME Member of Special Advisory Committee RCPsych. PLD Team are active stakeholders with all local HEI's to support development and the re-writing of NMC and HCPC approved

courses; Lead E&T pharmacy work with operational leads and national standards to deliver the curricula and assessments

64. Placement providers proactively seek to develop new and innovative methods of education delivery, including multi-professional approaches.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	☐	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
HEE FLP fellow 21-22 project was implementation of Interprofessional student learning Workshops. Details available on request
Interprofessional learning options explored this last academic year

65. The involvement of patients and service users, and also learners, in the development of education delivery is encouraged.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	☐	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
Discussion at junior doctors committee and Service user networks on any new educational improvement projects. More SU input into content design helpful but have set national standards to achieve unsure if SU input involved in setting those

66. Timetables, rotas and workload enable learners to attend planned/ timetabled education sessions needed to meet curriculum requirements.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	☐	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
No exception reports received this year for lost educational opportunities due to workload or rota issues. Interprofessional learning events offered, students invited to training opportunities. Inhouse rotas arranged in advance and disseminated to the learner and training teams

Section 3g - HEE Quality Framework Domain 6 - Developing a sustainable workforce

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

67. Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐

	Yes	No	N/A
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
Close workings in the WYCT committee to enable and retain trainees. Collaborative working with HEIs and AHP faculty to coordinate support for learners and provide quality learning experiences that meet requirements of regulatory bodies and individual learner goals. Joint posts developed to gain experience and exposure as well as cross sector learning

68. Does the provider provide opportunities for learners to receive appropriate careers advice from colleagues

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
All educational supervisors ask about and signpost for career advice as part of their role. For nursing and AHP there are Education leads within service areas and also support from Practice learning and development team

69. The provider engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐

	Yes	No	N/A
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
Provider exceptionally concerned HEE planning to remove funded NTN's in ST in Old Age Psychiatry from Yorkshire and Humber Region as not in line with workforce planning or population needs. Response from PGD awaited. Workforce planning for nursing and apprenticeship routes is discussed across various governance forums within the organisation. PLDT in collaboration with the Head of Strategic Workforce has developed a business case to increase the number of nursing apprenticeships we are able to support. There is also an ambition to introduce AHP apprenticeship pathways for both dietetics and occupational therapy. These opportunities will be available to our existing support workforce. Involvement with local and regional WF pharmacy groups to ensure our training is reflective of current, local and regional patient and service need

70. Transition from a healthcare education programme to employment and/or, where appropriate, career progression, is underpinned by a clear process of support developed and delivered in partnership with the learner.

	Yes	No	N/A
GDC Learners	☐	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	x	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer;
Trust hosts an educational SAS scheme for those on outcome 4 due to not getting MRCPsych and supports them back into ST training. LYPFT has an established internal recruitment process for qualifying pre-reg nursing students. This serves to create a simple recruitment process for future nurses and to ensure they have assurance around job roles prior to qualifying. This involves a conversation with each student about vacancies, preference and aspirations. Consideration is given to the number of preceptees which a clinical area can effectively support. It is led by the Practice Learning and Development

Team and supported by recruitment team colleagues and aims to offer opportunities and retain 3rd year mental health nursing students. The process for AHPs is different as this is an external process which targets qualifying students across the HEIs in the region. In 2022, AHP workforce Lead and Rotation Lead will carry out a broader piece of OT recruitment which not only incorporates rotation vacancies, but OT vacancies across the organisation. Both AHPs and Nursing newly qualified staff are placed straight on the preceptorship programme once they have their registration through and gone through all pre-employment requirements. Clear documentation provided to learners to guide their learning journey in pharmacy by way of the pharmacy information book, specific SOP's and learning outcomes for each rotation

END

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
21

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Board Assurance Framework update
DATE OF MEETING:	29 September 2022
PRESENTED BY: (name and title)	Sara Munro – Chief Executive
PREPARED BY: (name and title)	Cath Hill – Associate Director for Corporate Governance

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	✓
SO3	We use our resources to deliver effective and sustainable services.	✓

EXECUTIVE SUMMARY

The Board is reminded that on 30 June 2022 the strategic risks which have been used in the Board Assurance Framework (BAF) were considered with a number of revisions and new risks proposed.

Following the workshop the risk narratives were updated by the Associate Director for Corporate Governance and circulated to the Executive Directors for further comment and consideration. The revised and new risks were then presented to the Board for approval, with the exception of the workforce risk which was further refined and agreed by the Workforce Committee on 1 August 2022.

The risks have been circulated to the responsible leads and executive directors to be populated with the controls, assurances and gaps against these refreshed / new risks.

In order to ensure the information has been fully reviewed the Board is asked to note that work is ongoing and an updated version will be brought to the Strategic Discussion Session on 27 October 2022 for consideration and sign off.

This will then be presented to the Board sub-committees and the Board in accordance with their cycles of business.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes please set out what action has been taken to address this in your paper
	No	

RECOMMENDATION
The Board is asked to: • Note that an updated version of the Board Assurance Framework will be brought to the 27 October Strategic Discussion Session for consideration.

West Yorkshire
Health and Care Partnership
Mental Health, Learning Disabilities & Autism

Escalation and Assurance Report

Report from: West Yorkshire (WY) Integrated Care System (ICS) Mental Health, Learning Disability & Autism (MHLDA) Committee-in-Common
Date of the meeting: 27/07/2022

Key discussion points and matters to be escalated from the discussion at the meeting:
Alert/Action:
• Principles have been agreed for how the collaborative will select future 'coordinating providers' and will now be tested for Forensic CAMHS and Perinatal Mental Health
Advise:
• A workshop is planned with the MHLDA Collaborative, WYAAT and the ICB to test out agreed ways of working • The collaborative is taking a unified approach to discussions with NHSE regarding challenges within the Acute Mental Health Pathway • All partners are contributing to support for collaborative efforts on Workforce recruitment and retention, including increasing diversity.
Assure:
• The profile of MHLDA within the ICB continues to be raised by the Collaborative, and we work with partners to influence national policy and local implementation regarding provider collaboratives • A Consultant in Public Health has been appointed by the collaborative • An Older Peoples Mental Health workstream will be created across WY

Report completed by: Keir Shillaker, WY MHLDA Programme Director **Date:** 02/08/2022

Distribution: Chairs and Company Secretaries of Bradford District Care NHS Foundation Trust, Leeds Community Healthcare NHS Trust, Leeds & York Partnership NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust.