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 28 September 2023
Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR

A G E N D A

		LEAD
1	**Sharing stories – The cultural inclusion ambassador programme** (verbal)	
2	**Apologies for absence** (verbal)	**MM**
3	**Declarations of interests and any declarations of conflicts of interest in any agenda item** (enclosure)	**MM**
4	**Minutes of the meeting held on 27 July 2023** (enclosure)	**MM**
5	**Matters arising** (verbal)	**MM**
6	**Actions outstanding from the public meetings of the Board of Directors** (enclosure)	**MM**
7	**Chief Executive's report** (enclosure)	**SM**
8	**Report from the Chief Operating Officer** (enclosure)	**JFA**
9	**Report from the Chief Financial Officer** (enclosure)	**DH**
10	**Safer Staffing Report** (enclosure)	**NS**
11	**Guardian of Safe Working Q1 Report** (enclosure)	**CHos**
12	**Annual Equality Diversity and Inclusion (EDI) Workforce Race and Equality Standards (WRES) /Workforce Disability and Equality Standards (WDES) and Gender Pay Gap progress update** (enclosure)	**DS**
13	**Health Education England (HEE) Annual Self Assessment** Report (SAR) (enclosure)	**DS**
14	**Approval of a change to the Scheme of Delegation** (enclosure)	**CHill**
14.1	**EPRR and Business Continuity and EPRR Policy and Business Continuity Management System** (enclosure)	**JFA**
15	**Report from the Chair of the Mental Health Legislation Committee for the meeting held on 1 August 2023** (enclosure)	**KK**
16	**Report from the Chair of the Workforce Committee for the meeting held on 3 August 2023** (enclosure)	**HG**
16.1	**Workforce Committee Terms of Reference** (enclosure)	**HG**

17	**Report from the Chair of the Quality Committee for the meetings held on 14 September 2023** (enclosure)	**FH**
	17.1 Quality Committee Terms of Reference (enclosure)	**FH**
18	**Report from the Chair of the Finance and Performance Committee for the meeting held on 26 September 2023** (to follow)	**CHe**
19	**Approval of an amendment to the Trust's constitution** (enclosure)	**CHill**
	19.1 Use of emergency powers to make a change to the Constitution (enclosure)	**CHill**
20	**West Yorkshire (WY) Integrated Care System (ICS) Mental Health, Learning Disability & Autism (MHLDA) Committee-in-Common Chair's report (AAA report)** (enclosure)	**MM**
21	**Use of Trust Seal** (verbal)	**MM**
22	**Any other business**	**MM**

The next meeting of the Board will held on Thursday 30 November 2023 at 9.30 am
Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR

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 *Organisation helping employers in the public, private and charity sector to develop their workforce through increasing productivity, improving learning supplies and helping to boost the skills of their employees.*	None.	None.	None.	None.
Dawn Hanwell Chief Financial Officer and Deputy Chief Executive	None.	None.	None.	None.	None.	None.	None.	None.
Chris Hosker Medical Director	**Director** Trusted Opinion Ltd.	None.	None.	None.	None.	None.	None.	Partner: **Director** Trusted Opinion Ltd.

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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.*
Nichola Sanderson Director of Nursing and Professions	None.	None.	None.	None.	None.	None.	None.	Partner: **Company Director** Emporia Cumbria Ltd.
Darren Skinner Director of People and Organisational Development	**Director** Skinner Consulting Ltd.	None.	None.	None.	None.	None.	None.	None.

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NON-EXECUTIVE DIRECTORS								
Merran McRae Chair	**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** Yorkshire Sculpture Park *Independent charitable trust and registered museum.*	None. .	None. .	None.	Partner: **Director** Finnbo Ltd *Management consultancy*
Helen Grantham Non-executive Director and Deputy Chair	None	None.	None	None	None	None	None	Partner: **Director and co-owner** 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	**Visiting Professor** University of Leeds **Advisory Role and Peer Reviewer** 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	**Chair of the Board of Trustees** 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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Kaneez Khan Non-executive Director	**Director** Primrose Consultancy Yorkshire *Management Consultancy firm*	None	None	**Faith and Community Co-ordinator** Wellsprings Together *Charity which offers guidance for individual parish churches who are looking to reflect and develop their community activities in rural as well as urban areas.*	None	None.	None	None
Katy Wilburn Non-executive Director	**Non-executive Director** Thirteen Group *Housing Association*	None.	None.	**Trustee** Daisy Chain *A charity which supports and empowers autistic and neurodivergent individuals through the provision of holistic person-centred services, whilst promoting training, wellbeing, inclusion and acceptance regionally and nationwide.*	**Trustee** Daisy Chain *A charity which supports and empowers autistic and neurodivergent individuals through the provision of holistic person-centred services, whilst promoting training, wellbeing, inclusion and acceptance regionally and nationwide.*	None.	**Head of Transformation** First Choice Homes Oldham *Housing Association*	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	**NS**	**DH**	**CHos**	**JFA**	**DS**	**MM**	**HG**	**KK**	**FH**	**CHe**	**MW**	**KW**
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

Minutes of the Public Meeting of the Board of Directors held on Thursday 27 July 2023 at 9.30 am in Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR

Board Members		**Apologies**
Miss M McRae	Chair of the -=Trust	
Mrs J Forster Adams	Chief Operating Officer	
Miss H Grantham	Non-executive Director	
Mrs D Hanwell	Chief Financial Officer and Deputy Chief Executive	
Mr C Henry	Non-executive Director (Senior Independent Director)	✓
Dr F Healey	Non-executive Director	
Dr C Hosker	Medical Director	
Ms K Khan MBE	Non-executive Director	
Dr S Munro	Chief Executive	
Mr D Skinner	Director for People and Organisational Development	
Miss N Sanderson	Director of Nursing, Quality and Professions	
Mr M Wright	Non-executive Director (Deputy Chair of the Trust)	

All members of the Board have full voting rights

In attendance	
Mrs C Hill	Associate Director for Corporate Governance / Trust Board Secretary
Miss K McMann	Head of Corporate Governance
Mr K Betts	Governance Assistant
Mr O Tipper	Head of Communications
Ms J Robinson	WRAP Lived Experience Facilitator (for minute 23/072)
Mr S Burton	Head of Recovery College (for minute 23/072)
Ms S Gibbons	Assistant Psychologist (for minute 23/072)
Mrs R Pilling	Carer Coordinator, Patient and Carer Experience Team (for minute 23/072)

		Action
	Miss McRae opened the public meeting at 09.30 am and welcomed everyone.	
23/072	**Sharing stories – the Recovery College Wellness Recovery Action Plan (WRAP) Course** (agenda item 1) Miss McRae welcomed Ms Robinson, Mr Burton and Ms Gibbons to the meeting, noting they were attending to talk about a course run by the Recovery College, which was the Wellness Recovery Action Plan (WRAP). Ms Robinson first shared her story and her experience of being unwell. She explained how her mental ill-health had impacted her life and told the Board of the important role the Leeds Recovery College and the WRAP course had played in her recovery. She spoke about how the WRAP had helped her to understand herself, her illness and also the role the WRAP had played in identifying when she was becoming unwell. Ms Robinson then explained how	

she had used her own experience to become a WRAP Lived Experience Facilitator, and how she was able to help and support other people in developing their own WRAP.

Ms Gibbons then spoke about the facilitation of the course, noting this had been all the more powerful having people involved who have lived experience of the WRAP course. Mr Burton then outlined the role and function of the Recovery College and the way in which courses were delivered. With regard to WRAP he explained this was one of the core courses which was attended by not only service users, but also staff, and how the WRAP focused on self-compassion and was used to support mental wellness more widely.

Ms Khan noted the difficulty some people have in talking about mental health and therefore asked about the referral route. It was noted the route was through self-referral which was accessed through the Recovery College website. Ms Khan commented this was a really useful service which would benefit many people. The Board supported the WRAP being used by both staff and service users and the need to ensure this was embedded and at the forefront of the delivery of services to our patients.

In response to a question about what the Board could do to help support the delivery of the programme, Mr Burton highlighted some of the practical difficulties experienced by the service in terms of premises in which to deliver courses and also the need for a simple booking process to allow easy access to courses.

The Board suggested the Recovery College should be added to the list of service visits. **CHill / RC**

The Board **thanked** Ms Robinson, Mr Burton and Ms Gibbons for attending the Board and raising awareness of the WRAP course and the important impact this had on the wellbeing of service users and also staff.

23/073 **Apologies for absence** (agenda item 2)

Apologies were received from Mr Cleveland Henry, Non-executive Director.

23/074 **Declaration of interests for directors and any declared conflicts of interest in respect of the agenda items** (agenda item 3)

The Board noted there were no changes to Board members' declarations of interest and no member had declared a conflict of interest in any agenda item.

23/075 **Minutes of the previous meeting held on 25 May 2023** (agenda item 4)

It was noted that Ms Khan's title had been incorrectly recorded. Mrs Hill agreed to amend this.

The minutes of the meeting held on 25 May 2023 were **received** and **agreed** as an accurate record, subject to a change in Ms Khan's title

23/076 **Minutes of the previous extraordinary meeting held on 22 June 2023** (agenda item 4)

It was noted the start time for the extraordinary meeting had been incorrectly recorded as 13:30 and should have been 15:30. Mrs Hill agreed to amend this.

The minutes of the meeting held on 22 June 2023 were **received** and **agreed** as an accurate record, subject to a change in the recording of the start time.

23/077 **Matters arising** (agenda item 5)

There were no matters arising.

23/078 **Actions outstanding from the public meetings of the Board of Directors** (agenda item 6)

Miss McRae 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.

The Board **received** the cumulative action log and **noted** the content.

23/079 **Annual Responsible Officer and Medical Revalidation report** (agenda item 13)

Dr Neil presented the Annual Responsible Officer and Medical Revalidation report. She noted this set out the key requirements for compliance with regulations and key national guidance and that it provided a review of how these requirements were being met, and also provided assurance on compliance and details of what improvements were being made over time.

Dr Neil then spoke about the report in some detail. In particular she noted that: all doctors had received an appraisal and were revalidated; and a peer review had been undertaken with South West Yorkshire NHS Foundation Trust which had concluded the Trust's Appraisal and Revalidation Team had robust processes in place, and were able to manage the workload. She also noted there had been a review of remuneration for the doctors who carried out appraisals, recognising the extra work this created and that remuneration was not in line with the amount paid by other organisations, adding this needed more consideration. Finally, she suggested the policy for managing concerns needed to be revisited to ensure the steps taken were proportionate.

	The Board discussed the report. It talked about the appraisal process to better understand how these were carried out and noted the importance of ensuring conversations were meaningful to the doctors. The Board also sought to understand how the appraisal process linked to supervision, noting both these link through to doctors being registered to practice. However, it was noted the Trust's overall appraisal and supervision metrics do not include doctors, due to medical appraisal and supervision having a statutory standing.	
	Mr Skinner welcomed the suggestion that the policy for managing concerns was reviewed and agreed to pick this up with Dr Neil outside the meeting.	**DS / WN**
	The Board **received** the Annual Responsible Officer and Medical Revalidation report. It **agreed** this provided sufficient assurance of compliance with regulations and key national guidance and **agreed** this should be signed by the Chair of the Trust.	
23/080	**Report from the Chief Executive** (agenda item 7)	
	Dr Munro presented her Chief Executive's Report to the Board. She drew attention to the work that had been ongoing to ensure services were safely managed during periods of industrial action. She added that there had been a recent announcement about the dates of the forthcoming Junior Doctors' strike in August, noting this would then be followed by industrial action by consultants.	
	Dr Munro referenced the improved position in relation to performance within the Community Mental Health Teams, noting this would be looked at in more detail in the Executive Performance and Oversight Group. She drew attention to the reduction in case-loads and the data which showed there was now a response to referrals in less than two weeks.	
	With regard to the NHS Workforce Plan, Dr Munro noted this had been launched on the 30 June and a more detailed briefing would be brought to the September Board meeting, which would include an assessment of what this meant for the Trust's People Plan and shared workforce actions in the Leeds Health and Care Academy.	**DS**
	Dr Munro also referenced the report by Dr Geraldine Strathdee in respect of mental health inpatient care, noting a briefing paper on this would be provided at the September Board meeting.	**NS**
	Dr Munro then referenced the celebrations in respect of NHS75, noting that at the highly successful Annual Members' Day there had been a number of presentations made by service users, carers and staff detailing how the NHS had made a difference to them. She highlighted the huge amount of work that had been undertaken to make the day a success and formally thanked the Communications Team, the Patient Experience Team, the Corporate Governance Team, the Andrew Sims Centre and the service users who had been involved in the project management of the day.	

Mr Wright referenced the ICB operating model and the need to make 30% savings, and asked when more details would be released in relation to this and whether it would have any impact on the Trust. Dr Munro explained that ahead of the review of costs in the ICB, those staff who carried out work directly for the Trust and its partners had already transferred into the Trust, and as such would not be part of that review. Dr Munro indicated that no further details had been released about the operating model and as such any potential impact was as yet unknown but it was being kept under review.

With regard to a question about pay awards, Mr Skinner explained the process by which Pay Review Bodies assess and make recommendations on the level of awards. He then explained the process by which the unions consider the offer. Mrs Hanwell then explained the funding implications for pay awards, and the potential impact this may have on the Trust's budgets, noting the government would indicate if it would fully or partially fund any award.

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

23/081 **2023/24 Organisational Priorities – quarter 1 progress report** (agenda item 8)

Mrs Hanwell presented the quarter 1 progress report in respect of the Trust's key priorities. She noted this report had been discussed by the Executive Directors where it was recognised there needed to be further work to pull out the thematic interdependencies.

Dr Munro then explained it had been agreed the Senior Management Team would review the priorities on a regular basis, which would allow further analysis of the information on progress against the priorities and better triangulation with other metrics.

The Board discussed the report, including the format. In particular it noted that whilst the report needed to include an update on all the agreed priorities, a focus on those that were rated red and a summary of the key successes might provide a more succinct report for the purpose of assuring the Board.

It was noted this report should be shared with the governors and Miss McRae agreed to look at how this could be done, taking account of the timing of the Council of Governors' meetings through the year. **MM**

With regard to the recruitment to the Rough Sleepers team, Mrs Forster Adams referenced the recent successful recruitment campaign, noting that four new members of staff were in the process of being offered positions.

Miss McRae asked about the Autism and ADHD service, noting there were two business cases setting out a series of options for the delivery of these services and how it might be improved. Mrs Hanwell explained that to date both business cases had not been approved due to the significant funding required and that alternative options were being explored to ensure there was a properly commissioned service.

The Board **received** and **discussed** the Quarter 1 report on progress against the Trust's organisational priorities.

23/082 **Report from the Chief Operating Officer** (agenda item 9)

Mrs Forster Adams presented her Chief Operating Officer's report. She framed the report in the context of there being increased collaboration across the service lines to address some of the common themes identified within the report. In particular she referenced the community stabilisation plan which was resulting in positive outcomes; addressing the impact of any disruption caused by industrial action; and the inpatient flow oversight group and its work to bring together service lines to look at how issues can be addressed.

She then spoke about the significant risks and challenges faced by services which were: workforce supply in those areas where there were material vacancies in core services; sustained demand in core mental health services and also more specialist services; the ongoing disruption as a result of the impact of industrial action and incidents; and waiting times for the Neurodiverse and the Gender services.

With regard to the Multi Agency Discharge (MADE) Event, Mrs Forster Adams noted this had been very well supported across the health and social care sector in Leeds, adding this work would feed into the inpatient flow and Out of Area Placements work.

With regard to the Supported Living Service, Mrs Forster Adams drew attention to there being several vacancies in that service, noting this had resulted in a significant contract income shortfall since the move to individualised funding. She added the Trust was currently liaising with the Leeds ICB and Leeds City Council to agree how this shortfall would be address as a health and care system.

The Board received and considered the Chief Operating Officer's report

Miss Grantham asked about the MADE event and where the outputs from this would be reported. Mrs Forster Adams explained this work was predominantly focussed around the flow of patients in and out of the acute trust, and the impact this had across the wider system. She added that using a common methodology had provided a better understanding of the impact on mental health services, which then helped inform some of the internal issues for the Trust and provide a platform to find sustainable solutions.

Miss McRae noted there was an outcome report on Red Kite View. Mrs Forster Adams explained there were a number of strands to this report and asked for guidance on which Board committee this should be reported through. It was agreed that given the report's cross cutting themes it would go to a Board Strategic Discussion session. Mrs Hill agreed to add this to the forward plan. **CHill**

Mr Wright asked about inpatient acute service bed capacity and whether there needed to be a review of the number of beds needed to deliver the service.

Mrs Forster Adams advised that bed capacity had been modelled as part of the work to develop the Care Services Strategic Plan, and this had concluded the number of beds was at the right level. However, she observed that bed occupancy would fluctuate, and this would, from time-to-time result in Out of Area Placements (OAPs). She added that whilst the last round of bed modelling had indicated there was the right number of beds, this continued to be kept under review along with the impact the wider health and social care sector had on occupancy, flow and OAPs, and the development of the community service offer to allow people to be treated outside of an inpatient setting.

Mr Wright then asked if there was the right balance of gender specific beds. Mrs Forster Adams explained it was more of a challenge to get the balance right and explained some of the factors that feature in deciding if an OAP is made.

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

23/083 **Chief Financial Officer's Report** (agenda item 10)

Mrs Hanwell presented her Chief Financial Officer's report regarding the financial position as at month 3. She reported that the Trust's financial performance had further deteriorated in-month with a c£200k deficit. She added that whilst the focus needed to be on reducing key areas of expenditure within the Trust, the position also needed to be taken in consideration of the wider system's financial challenge, noting this could further impact on the Trust's efficiency target. To manage the emerging financial position, Mrs Hanwell assured the Board that enhanced financial governance controls were now in place across the system.

With regard to capital, Mrs Hanwell drew attention to a possible opportunity linked to the Perinatal Provider Collaborative in regard to additional inpatient capacity. She noted the scoping work was progressing at risk because the Trust was not the chosen provider, she explained the rationale for this was that the Trust had expressed an interest in providing this facility. She then explained that NHS England would, in due course, confirm which provider would take this scheme forward and the initial scoping work had been undertaken with that in mind.

Mrs Hanwell then reported the Commercial Procurement Collaborative Limited Liability Partnership (CPP LLP) would be formally closing down as an entity. She explained this was required following the national retender process for category procurement services and the process had now commenced to formally close the Company.

Mrs Hanwell then assured the Board on the arrangements regarding the Procurement Team and the leadership which was now in place. She also outlined the work to look at implementing a new procurement system, noting work was progressing and was at pilot stage.

Miss McRae asked about the Vacancy Management Group. Mrs Hanwell noted this was required as part of the system financial management arrangements; that it was not designed to slow down or block recruitment, but provided check and challenge into the process.

Mr Wright noted the efficiency programme in place within the Trust would help to address the deficit as reported at month 3. He did, however, note that the ICB deficit was a much bigger issue and asked how this might be perceived nationally and whether it could lead to invoking special measures at any point in the future. Mrs Hanwell noted it was still early days and it was not possible to say if the measures in place would address the ICBs deficit or what action NHSE or the Department of Health might take in the future

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

23/084 **Report from the Medical Director** (agenda item 11)

Dr Hosker presented his Medical Director's report noting it had been written in the context of a period of industrial action by both the Junior Doctors and Consultants. He added that a significant amount of capacity within the directorate had been allocated to providing safe in-hours and out-of-hours cover to clinical services during the periods of industrial action.

He then drew attention to the work of the Andrew Sims Centre (ASC) in particular an event led by the ASC to remember the late Professor Andrew Sims who passed away earlier this year. Dr Hosker reported this had brought together past and present medical directors, Royal College Presidents and Deans, and staff from across the region. He added the event was a huge success and as a result, the ASC had been approached by external stakeholders to provide event management for similar large events. Dr Hosker also noted he had been approached about ensuring the longevity of the Andrew Sims Centre. Mrs Hanwell added there would need to be further discussions on the operating and funding model and welcomed a conversation taking place and agreed to pick this up with Dr Hosker outside the meeting. **DH / CHos**

With regard to medical agency costs, Dr Hosker noted the work to manage not only agency spend, but to increase substantive appointments to medical vacancies.

Finally, Dr Hosker thanked Dr Ben Alderson noting he was stepping down as Guardian of Safe Working (GoSW) having held the position for the past three years. Dr Hosker noted that Dr Rebecca Asquith had taken up the post of GoSW with effect from 1 June 2023 and that she would be providing reports to the Board in future.

The Board discussed the report, in particular noting the difficulty in recruiting to consultant vacancies for posts in the Forensic Service at the Newsam Centre, the Learning Disabilities service, the Adult Acute service and CMHT

teams. However, Dr Hosker outlined some ongoing work to fill these vacancies.

The Board **received** and **considered** the report from the Medical Director.

23/085 **Guardian of Safe Working Annual Report** (agenda item 12)

Dr Hosker then presented the Guardian of Safe Working Annual Report. He noted this was an aggregation of the previous four quarter reports and that it also provided more information about the process followed to ensure safe working arrangements.

The Board **received** and **noted** the Guardian of Safe Working Annual Report.

23/086 **Report from the Director of Nursing, Quality and Professions** (agenda item 14)

Miss Sanderson presented her Director of Nursing, Quality and Professions Report. She highlighted the areas of work being undertaken in relation to: closed cultures; the Patient Safety Incident Response Framework **(**PSIRF); embedding of the ligature policy; and the ongoing arrangements for working with partners across the ICS in terms of learning and sharing good practice.

With regard to the CQC, Miss Sanderson noted the Trust had been allocated a new CQC relationship team, adding there had been a meeting in May to support the transition from the existing team in preparation for the implementation of the new CQC single assessment framework.

Miss Sanderson then spoke about the ligature policy and outlined some of the work to look at the clinical environment 'through the eyes' of the service user in terms of risks and how these might be mitigated.

The Board received and considered the report and supported the format. With regard to clinical supervision and the pilot that had been carried out, Miss Sanderson confirmed this way of carrying out supervision would be rolled out across other services and become business as usual.

Mrs Hanwell asked about the new ligature policy and if there were any particular areas which had been identified as needing investment. Miss Sanderson indicated that nothing of significance had been identified to date and assured the Board the assessments were being carried out in collaboration with colleagues from estates who can provide a particular lens to the risk assessments. Miss Sanderson also assured the Board that if there were consistent themes or issues identified which would impact more widely across the Trust, the Clinical Environments Group would identify such matters. Miss Sanderson also reported that good practice was shared with mental health partners outside of the Central Alerting System (CAS) and this learning was also considered within the Trust.

The Board **received** and **noted** the Director of Nursing, Quality and Professions report.

23/087 **Safer Staffing Report** (agenda item 15)

Miss Sanderson presented the Safer Staffing Report. She explained this provided an overview and consolidation of the information presented in the bi-monthly reports. Miss Sanderson added it contained a high-level overview of data and analysis on the position of the staffing on all wards against safer staffing levels and was for the retrospective period from the 1 November 2022 to the 30 April 2023.

In particular, Miss Sanderson drew attention to the work to recruit, retain and develop the nursing workforce; and the work to increase the student workforce, attracting people from outside Leeds alongside putting in place appropriate preceptorship arrangements to support newly qualified staff.

Miss Grantham supported the information provided in the report to allow the triangulation of data. Mr Wright noted the number of staff off sick with stress related illnesses. He noted this was looked at by the workforce committee and asked if there was anything to feedback in terms of reasons for this or key themes. Miss Grantham noted this was referenced in her report later in the agenda.

The Board **received** the Safer Staffing Report and **noted** the content.

23/088 **Report from the Director of People and Organisational Development** (agenda item 16)

Mr Skinner presented his report noting the volume of work undertaken in the first quarter of the year. He drew attention to the publication of the NHS Long-term Workforce Plan and assured the Board on the work being undertaken to ensure the Trust's People Plan was aligned to the Plan for the NHS more widely.

Mr Skinner also drew attention to the Trust having received the status of "Gold Award 2023" in the Employer Recognition Scheme, noting this was part of the Armed Forces Covenant to which the NHS was committed. Mr Skinner also noted the Workforce Team had been shortlisted in the CIPD Awards for *Best Health and Wellbeing Initiative Public/Third Sector,* adding the award ceremony was taking place on 21 September 2023 in London. He explained the examples selected to go forward for nomination were the Critical Incident Staff Support Pathway, the Menopause Group, and the Cost-of-Living Initiatives and Support.

Mr Skinner also referenced the staff thank you event "The Big Thank You Carnival" held at the end of June. He paid tribute to the team who had organised the event and noted the positive feedback that had been received from the staff who had attended.

	The Board **received** and **noted** the report from the Director of People and Organisational Development.
23/089	**Approval of the Data Security and Protection Toolkit (self-certification)** (agenda item 17) Mrs Hanwell presented the retrospective toolkit self-certification, noting the Trust was declaring compliant. She added there was an independent audit carried out which had supported the declaration, although she noted there were some improvements recommended which had been accepted.
	The Board **received** the self-certification Data Security and Protection Toolkit and **noted** and **supported** the compliant declaration.
23/090	**Cyber security update report** (agenda item 18) Mrs Hanwell presented the cyber security update report which set out the work undertaken and completed in regard to safeguarding the Trust's digital systems.
	The Board **received** and **noted** the content of the cyber security update report,
23/091	**Emergency Preparedness Response and Resilience Annual Report (EPRR)** (agenda item 19) Mrs Forster Adams presented the EPRR annual report, noting that in the past it was sufficient for this to be received by a committee of the Board. However, she explained that with a change in the NHS England standards it was now required to come to and be approved by the Board. Mrs Forster Adams noted the huge amount of work now required to meet the new NHSE standards, adding this was underway including the development of two substantial policy documents which would also need to come to the Board in September. Mr Wright noted the report had been received and supported by the Finance and Performance Committee.
	The Board **received** and **approved** the EPRR Annual Report.

23/092 **Report from the Chair of the Audit Committee for the meeting held on 18 July 2023** (agenda item 20)

The Board received the Chair's report from the Audit Committee meeting that had taken place on 18 July 2023. In particular Mr Wright drew attention to:

- The Health and Safety Annual Report, noting this had been delayed in coming to the committee and was expected to come back to the October meeting.
- The governance arrangements for provider collaboratives, noting there needed to be further consideration as to how this was reported through the Board committee structure.
- The Hospitality Sponsorship and Gifts registers, noting these had been received by the committee which had raised a question around the definitions for each of these as set out in the policy, adding the committee had recommended these were reviewed to assist staff in their considerations.
- Reducing the load on non-executive directors in reading papers in advance of the meeting, with a suggestion there was a robust executive summary to assist with preparation for meetings.
- The use of electronic signatures and the suggestion there was a Trust policy on how these were used and applied, adding this was something that had been remitted to the Finance and Performance Committee.

Dr Munro noted the suggestion about executive summaries and suggested this was something that should be picked up by the Board at a future discussion session. Mrs Hill agreed to add to the forward plan. **CHill**

The Board of Directors **received** the Chair's report from the Audit Committee and **noted** the matters reported on.

23/093 **Report from the Chair of the Quality Committee for the meeting held on 6 June 2023** (agenda item 21)

The Board received the Chair's report from the Quality Committee meeting that had taken place on 6 June 2023. In particular Dr Healey drew attention to:

- A consideration of the committee's responsibilities in terms of its role in oversight and assurance of regulation related activities, such as CQC, and agreed to update its terms of reference to include this.
- The committee's observation in terms of the number of different reports and action plans received by services and an acknowledgement that additional support may be needed to support services in consolidating actions and recommendations.

The Board of Directors **received** the Chair's report from the Quality Committee and **noted** the matters reported on.

23/094	**Report from the Chair of the Workforce Committee for the meeting held on 8 June 2023** (agenda item 22) The Board received the Chair's report from the Workforce Committee meeting that had taken place on 8 June 2023. In particular Miss Grantham drew attention to sickness related to stress and anxiety, and assured the Board this was looked at on a regular basis by the committee through the Wellbeing Guardian's report.
	The Board **received** the report from the Chair of the Workforce Committee and **noted** the matters reported on.
23/095	**Report from the Leeds Committee of the WY ICB – 5 July 2023** (agenda item 23)
	The Board **received** the report from the Leeds Committee of the WY ICB and **noted** the matters reported on.
23/096	**Use of the Trust's seal** (agenda item 24)
	It was noted the seal had not been used since the last meeting.
23/097	**Any other business** (agenda item 25) Miss McRae noted this was the last public Board meeting for Mrs Hill and thanked her for all her hard work in supporting the Board, its committees and also individual Board members during her time as Associate Director for Corporate Governance and as Trust Board Secretary. Ms Kahn also noted the passing of Heather Nelson, Chief Executive of Black Health Initiative, a member of the Trust's Synergi partnership. This was noted by the Board and condolences offered to her family.
	There Board noted the items of other business.
23/098	**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 13:05 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

AGENDA ITEM

6

Cumulative Actions Report for the Public Board of Directors' Meeting

OPEN 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 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 Audit Committee for the meeting held on 18 April 2023 (minute 23/062 - agenda item 13 – May 2023) It was suggested that as part of that session there was an assurance piece on compliance with the new Code of Governance. Miss McRae suggested there was some further thought on how the best way to do this for the Board.	**AD for Corporate Governance**	Management action	**REQUEST TO CLOSE THIS AS A BOARD ACTION** This has been put on the forward plan and will be picked up at a future Board Strategic Discussion session
Sharing stories – the Recovery College Wellness Recovery Action Plan (WRAP) Course (minute 23/072 - agenda item 1 – July 2023) **NEW -** The Board suggested the Recovery College should be added to the list of service visits.	**Cath Hill / Rose Cooper**	Management action	**CLOSED** This has been added to the forward list of service visits

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
Annual Responsible Officer and Medical Revalidation report (minute 23/079 - agenda item 13 – July 2023) **NEW -** Mr Skinner welcomed the suggestion that the policy for managing concerns is reviewed and agreed to pick this up with Dr Neil outside the meeting.	**Darren Skinner / Wendy Neil**	Management action	
Report from the Chief Executive (minute 23/080 - agenda item 7 – July 2023) **NEW -** With regard to the NHS Workforce the Board noted this had been launched on the 30 June and a more detailed briefing would be brought to the September Board meeting which would include an assessment of what this means for our own People Plan and shared workforce actions in the Leeds Health and Care Academy and West Yorkshire Provider collaborative.	**Darren Skinner**	November 2023 Board of Directors' meeting	**ONGOING** A presentation was delivered on 18 September to governors and members of the Board on the Strategic Workforce Planning which covered the significant elements of the NHS Workforce Plan for the NHS. A more detailed paper will be presented to the Workforce Committee and a briefing will go to the Board following that committee meeting.
Report from the Chief Executive (minute 23/080 - agenda item 7 – July 2023) **NEW –** It was agreed a more detailed update on the report by Dr Geraldine Strathdee in respect of mental health inpatient care would be provided at the September Board meeting.	**Nichola Sanderson**	September 2023 Board of Directors' meeting	**CLOSED** This has been included on the September Board agenda for the private meeting
2023/24 Organisational Priorities – quarter 1 progress report (minute 23/081 - agenda item 8 – July 2023) **NEW -** It was suggested this report should be shared with the governors and Miss McRae agreed look at how this can be done, taking account of the timing of the Council of Governors' meetings through the year.	**AD for Corporate Governance / Merran McRae**	Management action	

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 23/082 - agenda item 9 – July 2023) **NEW –** The Board agreed the outcome report on Red Kite View. would go to a Board Strategic Discussion session. Mrs Hill agreed to add this to the forward plan.	**Cath Hill**	Management action	**CLOSED** This has been provisionally programmed in for the Strategic Discussion Session in February 2024
Report from the Medical Director (minute 23/084 - agenda item 11 – July 2023) **NEW -** Dr Hosker and Mrs Hanwell agreed to look at the future operating and funding model outside of the meeting.	**Dawn Hanwell / Chris Hosker**	Management action	**ONGOING** There have been initial considerations as to how the right business model for the Andrew Sims Centre can be arrived at to secure its future financial sustainability.
Report from the Chair of the Audit Committee for the meeting held on 18 July 2023 (minute 23/092 - agenda item 20 – July 2023) **NEW –** it was agreed the suggestion about executive summaries for Board and sub-committee papers and should be picked up at a future discussion session. Mrs Hill agreed add this to the forward plan for a strategic discussion session.	**Cath Hill**	Management action	**CLOSED** This has been added to the forward plan for the Board Strategic Discussion Session programme

NHS
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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
Sharing stories – Update on the work of the Service User Network (SUN), presented by the co-chairs (minute 23/050 - agenda item 1 – May 2023) Mr Skinner noted the discussions around career opportunities and invited a more detailed discussion about what these routes might look like. Mr Khan and Mr Skinner agreed to pick this up outside of the meeting. It was agreed that Mrs Pilling would forward Mr Kahn's contact details to Mr Skinner.	**Rachel Pilling**	Management action	**COMPLETED**
Freedom to Speak up Guardian Annual Report (minute 23/60 - agenda item 11 – May 2023) Mr Verity presented the Freedom to Speak up Guardian Annual Report. Miss McRae asked about the training 'Speak Up, Listen Up, Follow Up' and this could be found. Mr Verity indicated it had been agreed this would not be mandatory for all staff but was available on the e-Learning system through a simple search. Miss McRae asked the non-executive directors to seek out this training.	**Non-executive directors**	Management action	**CLOSED**

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:	28 September 2023
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.

Leeds and York Partnership
NHS Foundation Trust

CEO report to the Board of Directors

28 September 2023

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

Industrial Action

The dispute between the BMA and the government regarding pay continues and the Trust has had to manage and mitigate further episodes of industrial action during August and September, with more action already planned for October. The core team that oversees our management of the industrial action continue to do an outstanding job of robust planning, ongoing engagement, and communication to support all those affected, including colleagues and service users.

NHS 75 Big Thank You Events

The summer of celebrating NHS 75 and holding "thank-you" events has now concluded with lots of fantastic footage, pictures and feedback from all the teams who took the opportunity to get together and show their appreciation for the work they do. Board members and governors received a more detailed update on the Trust's approach to reward and recognition at the Board to Board meeting this month. And just to note the team are already on with planning events for the rest of the year and into 2024.

Independent Forensics Review

The Board has been briefed previously on the independent support commissioned by the Executive Team to engage with staff across our Forensic Service to identify where we need to improve leadership, management, support, and engagement. This was in response to concerns being raised through several routes, including the Freedom to Speak up Guardian, line management and HR colleagues. Attain completed the review and have held several sessions over the summer to feedback the findings directly to staff within the service. The sessions were very well attended, and this approach has been well received. A comprehensive action plan has now been developed. Key to this is recruiting a substantive leadership team of clinical lead and head of operations; bringing greater clarity to the membership roles and responsibilities of the senior leadership team; establishing an executive chaired oversight group which will have representation from across the different teams and departments and will ensure delivery of the agreed actions. Dr Hosker will take the executive lead for the oversight group and all directors are ensuring they provide the right support as required, including supporting for team development, wellbeing, and engagement.

National Inclusion Week 25th September to 1st October

During this week of the Board meeting, it is National Inclusion Week. "Founded by Inclusive Employers. National Inclusion Week (NIW) is a week dedicated to celebrating inclusion and taking action to create inclusive workplaces. The theme for NIW 2023 is ***Take Action, Make Impact***, a call to action for all in the organisation, from leaders to I&D professionals, teams and individuals.

Take Action Make Impact is a powerful message which aims to get organisations and individuals thinking about what actions they can take and what positive impact these actions could and should have for marginalised colleagues.

In the Trust we have been running a communications and engagement campaign to promote the role of our staff networks, sharing our personal reasons for supporting inclusion, the impact this has and encouraging more colleagues to get involved.

Our Collective Leadership Journey

Earlier this month we came together for the second in-person session held this year on developing our culture of collective leadership. Once again it was very well attended by colleagues from across clinical and corporate teams and feedback on the day was very positive. Below is an info-graphic which captures the key focus of the session which included aligning our personal, professional and collective purpose so we build our shared knowledge and shared goals. We took the opportunity during the session to note and reflect on the current context within which we are operating both financial, but also in the context of the number of national level incidents and inquiries. Our discussion was on what this means for our own culture and to connect with the importance of this work we are doing on collective leadership.

When we come back together in November, we will begin to focus in more detail on shaping the way we work together on areas identified by the group such as our decision making, governance, networks and managing demand.

2. Our Partnerships, National and Local

National Context

<u>Countess of Chester and Lucy Letby</u>

On Friday 18 August 2023, neonatal nurse Lucy Letby was found guilty of seven counts of murder and six counts of attempted murder for her actions at the Countess of Chester Hospital. The Board will already be aware that the Government has ordered a statutory inquiry that will look at the circumstances surrounding the deaths and incidents, including how concerns raised by clinicians were dealt with, the handling of concerns, the effectiveness of governance and what actions were taken by regulators and the wider NHS.

We have already sent out a Trustwide communication to all staff in response to this case, reinforcing the ways in which we support staff to speak out and raise concerns. Our Freedom to Speak Up Guardian has also increased the number of visits to sites for open drop-ins. As noted above we have also discussed these matters in forums such as the Collective Leadership workshop and as an Executive Team.

Several letters have been received from NHS England (NHSE) following the verdict, seeking actions from the Board in relation to, for example, not appointing 'unfit'

directors and ensuring clear and robust mechanisms for staff to be able to speak out safely such as through the Guardian.

One of the substantial debates following the verdict has been the regulation of senior managers in the NHS and whether this should now be mandated. This was one of the discussions at the recent event pulled together by NHSE for all chairs and chief executives in NHS organisations on 6 September 2023. Quality and safety, leadership, management and culture were all themes explored at the event.

In terms of regulation of managers, this has been considered by several reviews over the years, with governments stopping short of regulation. This has been due to several factors, such as multiple regulation of clinical managers (for example, most provider chief executives in West Yorkshire are clinicians). At this point, it is unclear whether regulation will follow.

There are of course other inquiries also underway such as the COVID inquiry, the Essex inquiry into deaths of people in receipt of mental health services and we have the recent publication by Geraldine Strathdee, conducted following the incidents at Edenfield in Greater Manchester.

Board members are asked to ensure that they continue to visibly support and advocate for our open culture of speaking up, and ensuring we focus on learning lessons and embedding our culture of continuous improvement. We will be having further discussions as a Board at our development session on the 12 October to explore the issues in more detail and to reflect on what this means for us and the Trust.

West Yorkshire Partnership Board

The most recent quarterly meeting of the Integrated Care Partnership, also referred to as the Partnership Board, took place virtually on 5 September 2023 and was live streamed for public access. The afternoon included a virtual development session for senior leaders from across local authorities, the NHS and the VCSE sector on accountability and strategic delivery of our 10 Big Ambitions, working with ICB Organisational Development and Public Health colleagues. This was a follow-up to the in-person development session in March 2023 in Leeds.

The meeting in public was held via Microsoft Teams and included an update on the delivery of the West Yorkshire People Plan, a focus on supporting young people leaving care into employment, and the approval of a joint agreement on partnership working between the Partnership and the West Yorkshire combined Authority (WYCA) with West Yorkshire Mayor, Tracy Brabin. The next Partnership Board meetings will be held in public on 5 December 2023 and on 5 March 2024.

West Yorkshire Integrated Care Board (WYICB)

The WYICB held its first annual meeting on the 19 September reflecting on the first 12 months since its inception. The annual report is available on the website.

This was followed by a public board meeting which included a focus on the work of the West Yorkshire Mental Health, Learning Disability and Autism Collaborative. The

board held a listening session earlier in the day, where people with lived experiences facilitated powerful and open discussions on where we need to make improvements and where we are making progress. Myself, Keir Shillaker (Programme Directo)r and Therese Patten (CEO at Bradford District Care Trust) presented the work we do across the whole of our collaborative, which was very well received. The areas we discussed, in terms of challenges which the whole system is responsible for, or where we need to lobby and influence nationally, included:

- The impact of poverty and austerity in local communities which affects mental health
- Addressing inequalities in access and outcomes for our diverse communities and increasing our understanding and approach to intersectionality
- Rising the demand in mental health needs of children and young people and the need for more focus on prevention and early intervention within schools and families
- The significant rise in waiting lists for people of all ages for assessment and diagnosis of ADHD or autism
- Rising demand which is difficult to quantify
- Balancing the challenges of short-term funding/outcome measures with the longer term needs of some of our most vulnerable service users
- Improving integration between primary and secondary care
- The need for significant capital investment in all our estate (hospital and community)
- Supporting our existing workforce and maximising recruitment opportunities.

We were pleased to publicly note at the meeting that NHSE has now confirmed they want us to expand the inpatient provision for specialist perinatal beds which our Trust is the lead for. We have also now resolved the concerns we had with regard to the NHS111 line becoming the only contact point for people in crisis. NHSE have formally responded to us to advise this policy will be changed and existing crisis and helplines should continue to be provided/advertised. There are further areas of the national policy standards that we are working through to ensure it is safe and effective.

The WYICB supported our programme of work and areas of focus which include a West Yorkshire summit on neurodiversity which we will be held on the 4 December. The board also agreed the medium-term financial plan for West Yorkshire should be explicit in what is possible to address in terms of the capital needs for our sector, resources to support the neurodiversity services in addition to the commitment to deliver the mental health investment standard as a minimum.

3. Reasons to be Proud

Once again it has been an action-packed couple of months for our Reasons to be Proud celebrations, which we showcase both here and in the monthly all staff huddles.

ARMED FORCES COVENANT

EMPLOYER RECOGNITION SCHEME

GOLD AWARD 2023

GOLD FOR OUR VETERANS SERVICE

"We are proud to be an NHS Trust that supports people who've served in our armed forces, both as an employer and as a caring organisation.

We recognise the value that veterans, reservists, cadets and their families bring to society, and we go the extra mile when it comes to supporting them to be part of Team LYPFT.

The Gold Award is a fantastic achievement and a testament to our commitment."

-Joanna Forster Adams, Chief Operating Officer and Emergency Accountable Officer

AWARD SHOUT-OUTS

- **Ian Mobley and Indie** - Pets As Therapy volunteer received a 2023 PAT Impact Award for his work at St Mary's Hospital.
- **Daniel Romeu** – Winner of the Core Trainee Outstanding Teacher Award.
- **Michael Farrall** – Winner of Higher Trainee Outstanding Teacher Award.
- **COMIC Research** - Commendation award at #NIHRAwardsYH for contribution to Public Engagement.

AWARD SHOUT-OUTS

- **Synergi Leeds** - has been shortlisted for two HSJ Awards in the following categories:
  - Mental Health Innovation of the Year
  - NHS Race Equality Award
- **Leeds Perinatal Services Team** - has been shortlisted for the RCPsych Awards Psychiatric Team of the Year: Working-Age Adults.
- **LYPFT –** the Trust has been shortlisted at this year's English Veterans Awards for Employer of the Year!
- **RKV** - Nominated at The Annual Brick Awards by the Brick Development Association for sustainability.
- **Open for nominations:**
  - Positive Practice in Mental Health, Primary Care Impact Awards 2023, Medipex NHS Innovation Awards and entries open for the HSJ Partnership Award 2024

CRISIS TEAM – Team of the Month

Nomination:
Despite severe staff shortages, the crisis team continues to provide excellent service to those seeking advice or urgent assessments. They are committed to ensuring proper care is given and have achieved impressive performance indicators, despite limited resources and facing significant changes within the service.

Judges:
"Evidence of strong commitment to delivering high quality, timely care to service users despite the huge challenges."

"What an incredible team! Thank you."

Research Heroes

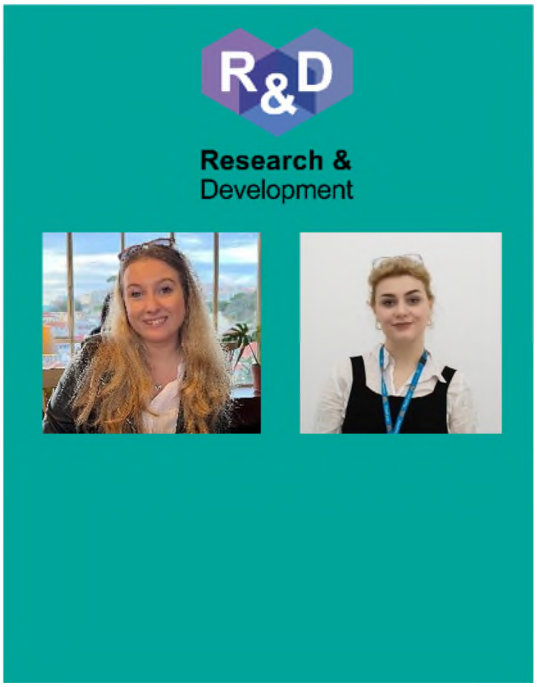
Research Heroes are individuals who are part of a hidden army of staff supporting research across LYPFT.

This month we are celebrating nurses across the Trust in different roles and different capacities within research.

Thank you for making a difference!

- **Hannah Shephard, was a Student Nurse within LYPFT**
- **Imogen Kinkaid, Staff Nurse Newsam Ward 4**
- **Tendai Dhliwayo, Memory Nurse in Memory Services at St Mary's Hospital**

These are just some of the many people who work in the trust that help to support research by spreading awareness of opportunities and helping to recruit to research studies. Get involved: **research.lypft@nhs.net**



Graham & Sarah Climbed Ben Nevis

Communications Officer, Sarah Firth, who is currently on an 18-month secondment and Graham Parker, who recently rejoined us to cover for Sarah, climbed the UK's highest mountain earlier this month to raise funds for a specialist Limb Reconstruction Unit.

They are raising money for to buy a specialist exercise bike for the physio department at the Northern General Hospital who put Graham back on his feet after a serious car crash.

They are are at 90% of their target. If you want to help them, get over the line, you can support them on **Just Giving>.**

Forward Leeds Relay Race

Race to Eliminate Hep C

- For World Hepatitis Day 2023 (28 July) Forward Leeds joined with staff from other services to run a relay across the city to raise awareness of the disease.
- **Catherine Stephenson** and **Andy Johnson** from LYPFT joined staff from Forward Leeds, the Viral Hepatitis team at St James's University Hospital, the Hepatitis C Trust and Leeds Council's Public Health team.
- **Watch here** - Race to Eliminate Hep C: World Hepatitis Day on **YouTube.>**

Perinatal Family Teddy Bears Picnic

The aim was to support inclusion and work with partner organisations to improve health outcomes. It was a positive event to engage our perinatal service users and to highlight the support available to them and their families.

- The Perinatal team held a Perinatal Family Picnic Event on 31 August
- A fun day to showcase the support available for perinatal service families in our communities in Leeds.
- There was a surprise visit from Councillor Salma Arif.

Dr Sara Munro
28 September 2023

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

8

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Report from the Chief Operating Officer
DATE OF MEETING:	28 September 2023
PRESENTED BY:	Joanna Forster Adams: Chief Operating Officer
PREPARED BY:	Joanna Forster Adams: Chief Operating Officer Contributions from: Alison Kenyon: Deputy Director of Service Development 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 aims to summarise and highlight the most significant service delivery issues faced across our Care Services.

This month the report includes:

- **Emergency Preparedness, Resilience and Response (EPRR) Planning and Management.** The most significant risks and how these have been managed with the aim of minimising impact for our service users. In particular a focus on the impact of Medical staff industrial action over the summer
- **Service Delivery and Key Performance Escalations.** In summary, the most significant risks and challenges faced and experienced by our services continue to be workforce supply (where we continue to have material vacancies in our core

services), sustained demand in our core mental health and more specialist services, and ongoing disruption as a result of the impact of industrial action and incidents.		
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, further intelligence or additional assurance required.

MEETING OF THE BOARD OF DIRECTORS

September 2023

Chief Operating Officer: Trust Board Report

1. Introduction

The report sets out the key management, development, and delivery issues across LYPFT Care Services. It aims to summarise and highlight the most significant service delivery issues faced across our Care Services.

This month the report includes:

- **Emergency Preparedness, Resilience and Response (EPRR) Planning and Management.** The most significant risks and how these have been managed with the aim of minimising impact for our service users. In particular a focus on the impact of Medical staff industrial action over the summer
- **Service Delivery and Key Performance Escalations.** In summary, the most significant risks and challenges faced and experienced by our service managers continue to be workforce supply (where we continue to have material vacancies in our core services), sustained demand in our core mental health and more specialist services, and ongoing disruption as a result of the impact of industrial action and incidents.

Primarily these are set out in the “Alert” section of the service delivery and performance section of this report but as a very high-level summary the most concerning issues as Chief Operating Officer include:

- Sustained pressure in our Acute inpatient services (including workforce and demand issues) where this has ultimately resulted in a prolonged period of out

of area placements (above our planned trajectory). Notwithstanding the quality and experience issues well documented for our service users for those supported in high occupancy wards as well as those in facilities outside Leeds, the financial challenge at this point in Quarter 2 being £1.2m.

- Vacancies and workforce availability in our:
    - Community Mental Health Services
    - Acute services
    - Children and Young People's Red Kite View Unit.
- Ongoing disruption due to industrial action, incidents, and preparation for winter pressures.
- Growing (and significant) waiting times in Neurodiversity services, Gender Identity services, Chronic Fatigue service.

Overarching these key risks and challenges, is the relentless and sustained pressure this creates for managers, clinicians and other staff working across our services. Whilst working towards sustainable solutions, ensuring we support staff wellbeing so they can continue to provide high quality, safe and effective care is our priority with the support of colleagues from the broader Organisation.

2. EPRR Planning and Management: Advisory

The section below summarises the key areas of focus and risk over the summer period.

2.1 Medical Staff Industrial Action

Since the last update in July, industrial action has intensified. Junior doctors were balloted in August and again voted to continue industrial action. With 71.25% (44,079) of all eligible junior doctors voting, the result at 98.37% (43,340) voting to continue. In LYPFT we have 115 junior doctors (eligible to take industrial action).

There were both consultant and junior doctors periods of industrial action in August 2023:

- Junior doctors – 11 August to 15 August
- Consultants – 24 to 26 August.

We planned for the increased risk of the adverse impact of industrial action, due to the levels of planned annual leave. This meant that the number of non-striking consultants and juniors, available to cover absence, was lower. Nonetheless, our tactical and strategic teams worked hard to put arrangements in place such that our safety and service delivery impacts were minimised. In actuality, we have calculated that approximately 50% of our junior doctors took part in action, and up to 5% of Consultant staff took action during August.

September 2023 has seen both consultants and junior doctors taking industrial action.

19/20 September – Consultant medical staff (with 18% of our staff taking action).

20 to 23 September – Junior medical staff (approximately 62% of staff taking action).

20 September has seen the first combined day of action. Planning for this period of action progressed effectively and as of the 22 September no direct adverse incidents have been reported.

A significant challenge lies in early October when both junior doctors and consultants plan to take simultaneous action over 72 hours. Planning is well underway with an established process and way of working is being actively reviewed as this is becoming business as usual for the foreseeable future.

A verbal update relating to industrial action will be given at the Board of Directors meeting as further intelligence emerges.

2.2 NHS EPRR Core Standards Assurance 2023

We are compiling evidence for submission against the 2023 NHS core standards (for upload by the end of September). There are two significant changes in our requirements this year:

- New mandatory areas of compliance which were issued relatively late (June 2023). For example, all EPRR plans and polices are required to be less than

12 months since the last review and approval. As a result, most EPRR plans have required review and progression through the approval process.

- Collation and upload of evidence against the requirements of new standards (similar to the processes involved in CQC inspection).

This new process has been demanding on time and effort, at the same time as managing the risks and mitigations related to industrial action. Nonetheless, it does provide all NHS organisations with detailed structure and descriptors behind the standards for the first time. The submission of detailed evidence to support submissions should reduce the risk of inconsistency across the NHS and aims to increase the preparedness, resilience, and response of all NHS organisations.

2.3 EPRR Training for Directors and Senior Managers

As part of the national work to improve EPRR across the NHS, there are significant training requirements across NHS organisations. In LYPFT this is a requirement for all Directors, Senior Leaders, and Managers (those who could be in the position of managing and leading an incident response). The first step of this is the successful completion of the Principles of Health Command training.

NHS England have set a standard of 100% compliance with this training by December 2023. At this stage we have achieved 59% compliance with strategic level training and 81% compliance at tactical level. This is overseen through our EMT (Executive Management Team) governance arrangements.

Additionally, Directors and Senior Managers are required to complete a substantial portfolio of training commencing in November 2023.

2.4 Chemical Decontamination Live Exercise

The EPRR team working with operational management at the Becklin Centre ran a live chemical decontamination exercise on 8 September 2023. The exercise tested arrangements for providing improvised decontamination to members of the public presenting at the Becklin centre following an incident. Initial findings were positive around the response to the incident from clinical staff. There was learning in respect of communication between the operational and tactical command, use of expertise in

the incident room and liaison between the commander and his loggist from the hot debrief after the end of the exercise.

A cold debrief is to be held in early October and report and action plan will result.

2.5 Security Incident at St Mary's Hospital 24 August 2023

Following an incident at St Mary's Hospital in August (resulting in no harm), a debrief was undertaken so that findings can be included in the work being undertaken to improve our security arrangements across the Trust.

A number of findings were concluded consistent with the actions emerging from the recent review.

3. Service Delivery and Key Performance Escalations

The ongoing challenges faced in maintaining high quality service delivery, have been managed and monitored through our operational governance arrangements. Care Services, having recently reviewed the Operational Governance arrangements are continuing to embed a robust and standard approach to the operational governance that demonstrates clear lines of reporting. Our newly appointed Head of Operational Governance has recently started in post and is working with services to support the ongoing embedding and development of the operational governance processes, with the aim of achieving consistently high-quality care delivery for our populations.

We continue to experience some significant challenges and pressures in key areas but with no new or unexpected concerns emerging over the summer. We have sustained demand across services and for admission, predominantly for women, sustained length of stay in hospital and resultant high levels of out of area placements. Capacity and flow continue to be a key priority for the organisation (from a quality, safety, and efficiency perspective), which is being managed through the Inpatient Flow Oversight Group (led by the Chief Operating Officer).

Our Forensic Service staff have engaged in a series of workshops following the work undertaken with Attain, a listening exercise which took place earlier in the year. The findings and outputs from these workshops have resulted in identifying important areas of development for the service and the Trust. We are now finalising an improvement plan and a series of co-designed interventions that will enable the

service to develop into the future. This work will be led by Dr Chris Hosker (Medical Director) supported by colleagues at Executive and senior leadership level.

Work is ongoing with the Community and Wellbeing Service, and other community services in LYPFT, to enhance our community offer for Leeds people. A series of workshops has commenced to promote more integrated working across all services. However, we continue to have significant vacancies currently in our CMHT's with all deployed staff returning to their substantive posts during August. We continue to develop recruitment strategies within the service, and we are expecting to meet the recruitment trajectory set out previously.

3.1 Alert

This section sets out the key areas of concern for care services that have been identified through our governance arrangements. These updates relate to the areas where service face most challenge and where risks are highest.

Acute Service Line – Inpatient Capacity

We continue to see sustained pressure for inpatient Acute admission, in particular across our female wards. This has resulted in high numbers of out of area placements as of the 14 September as detailed in table 1 below. We are also fully utilising the Crisis Assessment Unit, which had been converted to female only during August to try to respond to the increased demand for female beds, and the Oasis Crisis beds capacity during this time reducing any flexibility in the system. We have seen some impact on people awaiting transfer from Leeds Teaching Hospitals, which is a priority area of work for us particularly heading into winter where we anticipate seeing increased demand. We continue to see consistent levels of delayed discharges and transfers of care.

Table 1

Position at	Current OOA placements	Waiting for admission
Male Acute	7	3
Male PICU	3	0
Female Acute	21	2
Female PICU	1	0
TOTAL	32	5

In order to provide better in reach and support to our service users in out of area hospitals, we have purchased additional capacity in Cynet, Middleton St George where most of our service users are now receiving care. Our Acute Service leadership team are working with Medical colleagues and senior clinicians to ensure that we provide effective in reach and offer continuity of care for these people whilst outside Leeds.

We have also identified a data quality issue resulting in under reporting of out of area bed days. The table below shows the variance, and these changes are now reflected in our performance data attached in appendix A. The business intelligence and performance team are seeking to ensure this problem is fully resolved.

	Total					
	OAPs beginning in month			OAP bed days in month		
Month	Original	Updated	*Increase*	Original	Updated	*Increase*
May-23	-	-	-	682	689	*7*
Jun-23	13	16	*3*	633	652	*19*
Jul-23	7	12	*5*	521	677	*156*
Aug-23	15	19	*4*	560	660	*100*

The outputs from the recent MADE (Multiagency discharge event) have now been agreed and are set out below in 2 parts. The first set relates to LYPFT actions and the second to partners in the Leeds health and care system.

The internal actions fall into the following broad categories,

- Improving systems and processes around capacity and flow such as the Purposeful inpatient admission process and governance of the process
- Improving the capture and utilisation of data and information
- Service redesign
- Workforce redesign.

The systemwide actions are categorised into,

- Access to housing and appropriate accommodation
- Access to specialist placements provided by independent and third sector partners such as female rehabilitation, Oakwood Hall
- Areas of service provision by third sector

- Supporting positive risk taking such as discharge to assess.
- Access to support services over 7 days.

The action plan will be moved forward at pace as the actions are key to supporting the overall capacity and flow issues and reducing the out of area placements.

A comprehensive update on workplan, resultant forecasts and specific additional actions undertaken by IFOG will be provided and reported to the Finance and Performance Committee in November 2023.

Children and Young Peoples Services: Red Kite View Staffing

Red Kite View continues to face significant registered nursing vacancies, with a slight improvement with 59% vacancies on Lapwing (PICU), but a deterioration to 69% on Skylark (the General Adolescent Unit). Absence is being covered by use of bank staff primarily with some reliance on agency staffing and additional hours for substantive staff. During September and October, the service is expecting a number of preceptee registered nurses to start in the service which will have a positive impact on the current establishment. Supporting these staff in their first year of work with us will be important so that we build and retain our workforce for the future. We will need the support of others across the Organisation given the significant staffing challenges faced in the service.

Liaison and Perinatal Services: Development of appropriate assessment space in Leeds Teaching Hospitals

Despite the positive update to the Board previously, work on the small high risk assessment space and further spaces in the LTHT Emergency Departments suitable for the appropriate care of service users, has not progressed any further. The Head of Operations is working hard to accelerate this work with LTHT, and he has actively reinstated project meetings. However, there is now a further review of agreed plans which will establish when works will be completed and will also consider other improvements that will be required to improve the quality design of the area.

Neuro-developmental waiting lists

As previously reported, the Neuro-Developmental Service continues to see high rates of referrals and subsequent long waiting times. We are working with ICB

(Integrated Care Board) colleagues in Leeds and in West Yorkshire, but no immediate improvements are anticipated.

3.2 Advise

Community and Wellbeing Service: Vacancies and workforce availability

Our working age community mental health teams (CMHT's) continue to experience significant workforce challenges. Staff deployed into CMHT's as part of the stabilisation plan have returned to their substantive roles through August. This has been offset to an extent with the recruitment of 16 Community Mental Health Practitioners to date and the recruitment of 8 preceptee registered nurses expected in post through September and October. The service continues to actively recruit and anticipates recruiting an additional 12 Occupational Therapists and legacy mentors.

Disappointingly the planned October 'go live' date for the early implementer integrated community mental health hubs as part of the transformation programme, has been delayed. This is because some partners are keen to understand the operational model, and its implications, in more detail.

A revised date of mid-November will allow time for further engagement, the development of governance and full agreement on new ways of working. It is important that programme partners take the time to make sure the right foundations are in place given the positive progress that has been made over the course of the programme. This will be confirmed when the Community Mental Health Transformation Board meets again in mid-October, and a communications update will follow.

Work will continue to be progressed including the testing of new roles and support offers like community wellbeing connectors and peer support, and testing new forms of community support through grant funding schemes that support people with complex and ongoing mental health needs in their communities.

Children and Young Peoples Services

The Humber and North Yorkshire Provider Collaborative has confirmed the costs and funding route of the estates works for the alternative to hospital admission provision for Mill Lodge. The service is planning for a service start date of April 2024.

Liaison Services

NICPM (National inpatient centre for psychological medicine) has recently reopened the waiting list for West Yorkshire service users and plans to increase their bed base to 8 by the end of September. The Service Leadership Team are currently working through the waiting to identify those service users who will be admitted to these additional beds throughout September.

Older Peoples Service: Inpatient Capacity

The inpatient service continues to experience a sustained demand for beds for people with dementia with unusually complex and high levels of care. The Service also has several cases where complex housing situations have contributed to delayed discharge. The review of provision for this client group across the system has been included in our MADE action plan. However, it is positive that the service has not had any service users placed in out of area beds for the past two months.

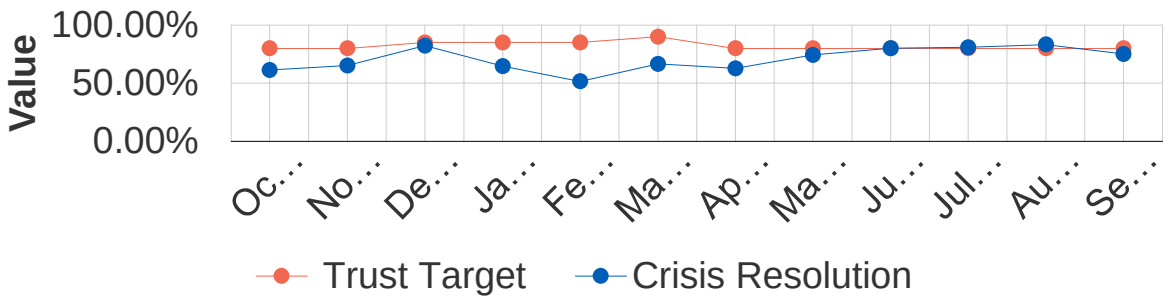
Rehabilitation Services: Capacity and flow

Asket Centre and House had increased delayed transfers of care between February and April 2023. This was due to improved reporting, allowing for more understanding and active management, following the introduction of improved flow governance. Since then our DTOC's have subsequently reduced. Bed occupancy remains consistently near 100% and length of stay has remained consistent within process limits. This does, however, have an impact on the flow from the Acute in-patient services as there are several service users waiting to transfer into the rehabilitation service.

3.3 Assure

Adult Acute Services: Crisis Response

We have seen a continued improvement in meeting the Crisis 4-hour target through July and August, (81% and 83% respectively), with the response rate maintaining a position above the 80% target, see graph 1.



Graph 1

Complex Rehabilitation: Out of area placements

Complex Rehabilitation out of area placements continue to present a financial risk to the organisation. The service has been on target and currently exceeding the financial trajectory set for OAPs. Monthly spend has reduced from £219k in April, £116k in May, -£144k in June and -£81k in July. There are currently 27 service users in OAPs (13 female and 14 male), reduced from 30 in June. Of these, 3 are ready for discharge and awaiting accommodation.

We are carefully considering a potential correlation with the increase in our OAP's issues in Adult services, where we are potentially seeing young people with complex needs who we are supporting in an acute hospital setting. We are working on understanding the clinical mix of patients and the potential identification of a cohort of people who may have, at other times, been referred to complex rehabilitation provision – and result in out of area placements (where no specialist provision is available in West Yorkshire). This will take careful and considered work which will be overseen and coordinated through IFOG.

Perinatal In-Patient Service

The Perinatal In-Patient Service has been commissioned to provide an additional 6 beds for the Yorkshire and Humber Region. A project team are working together to establish the changes to the clinical and operational model, as well as the design and build of the additional inpatient facility. This will require some displacement of other services and alternate use of office and clinical space.

4. Summary

We continue to manage a range of challenges in the delivery of consistent and sustainable high-quality care for all people needing our support. The report highlights the most significant service delivery and development challenges we face but it is important to note the improvements made in some services where we are seeing progress in line with our stabilisation, recovery and reset work. Looking to the future, we continue to see some improvement in successful recruitment particularly in our more specialist provision. However, workforce availability in our core service remains a major concern where demand continues to be high. We are hopeful that the, to date, very successful progress made as part of the transformation of community services continues and that we resolve the issues which have resulted in the delay to November 2023.

Joanna Forster Adams

Chief Operating Officer

Contributors:

Andrew Jackson, EPRR Lead

Mark Dodd, Deputy Director of Operations

Alison Kenyon, Deputy Director of Service Development

September 2023

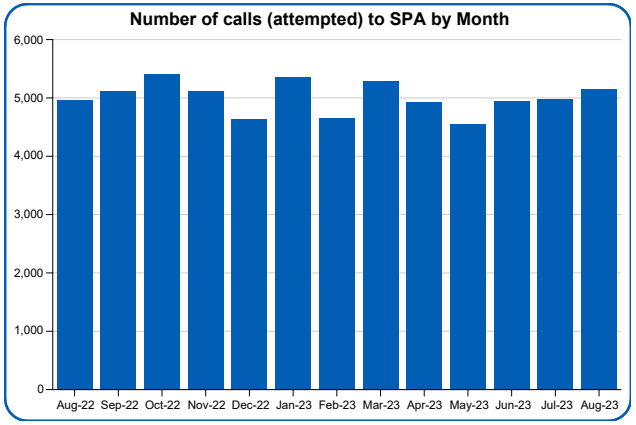
Service Performance - Chief Operating Officer

Services: Access & Responsiveness: Our response in a crisis	Target	Jun 2023	Jul 2023	Aug 2023
Percentage of crisis calls (via the single point of access) answered within 1 minute	-	30.9%	28.9%	29.2%
Percentage of ALPS referrals responded to within 1 hour	-	59.7%	77.4%	76.6%
Percentage of S136 referrals assessed within 3 hours of arrival	-	25.7%	21.2%	4.8%
Number of S136 referrals assessed	-	35	33	42
Number of S136 detentions over 24 hours	0	0	0	0
Percentage of appropriate crisis referrals seen face to face for assessment within 4 hours of referral	80.0%	57.1%	54.8%	60.6%
Percentage of service users who stayed on CRISS caseload for less than 6 weeks	70.0%	94.8%	94.8%	94.4%
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support	50.0%	56.4%	59.8%	50.7%
Percentage of CRISS caseload where source of referral was acute inpatients	-	11.4%	5.9%	10.5%
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services	**Target**	**Jun 2023**	**Jul 2023**	**Aug 2023**
Gender Identity Service: Number on waiting list	-	4,453	4,683	4,753
Deaf CAMHS: average wait from referral to first face to face (inc. telemedicine) contact in days	-	39.64	95.63	20.71
Community LD: Percentage of referrals seen within 4 weeks of receipt of referral	90.0%	72.7%	71.4%	62.9%
Leeds Autism Diagnostic Service (LADS): Percentage starting assessment within 13 weeks (quarterly)	-	7.6%	-	-
CAMHS inpatients: Proportion of people assessed within 7 days of admission (HoNOSCA / GBO) (quarterly)	100.0%	42.9%	-	-
Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency) (quarterly)	-	100.0%	-	-
Perinatal Community: Percentage of routine referrals waiting less than 2 weeks for assessment (quarterly)	-	94.5%	-	-
Perinatal Community: Total number of distinct women seen in rolling 12 months (quarterly)	766	792	-	-
Perinatal Community: Face to Face DNA Rate (quarterly)	-	12.6%	-	-
Services: Our acute patient journey	**Target**	**Jun 2023**	**Jul 2023**	**Aug 2023**
Number of admissions to adult facilities of patients who are under 16 years old	-	0	0	0
Crisis Assessment Unit (CAU) bed occupancy	-	85.6%	81.7%	90.9%
Crisis Assessment Unit (CAU) length of stay at discharge	-	8.15	13.07	8.19
Liaison In-Reach: attempted assessment within 24 hours	90.0%	79.0%	71.5%	81.0%
Bed Occupancy rates for (adult acute excluding PICU) inpatient services:	94.0% - 98.0%	101.0%	101.0%	101.0%
Becklin Ward 1 (Female)	-	104.8%	101.6%	103.5%
Becklin Ward 3 (Male)	-	99.7%	99.6%	101.6%
Becklin Ward 4 (Male)	-	100.6%	100.7%	99.6%
Becklin Ward 5 (Female)	-	100.6%	99.4%	101.3%
Newsam Ward 4 (Male)	-	99.4%	103.7%	99.1%
Older adult (total)	-	91.0%	90.3%	91.5%
The Mount Ward 1 (Male Dementia)	-	100.0%	96.3%	93.3%
The Mount Ward 2 (Female Dementia)	-	78.7%	86.0%	93.3%

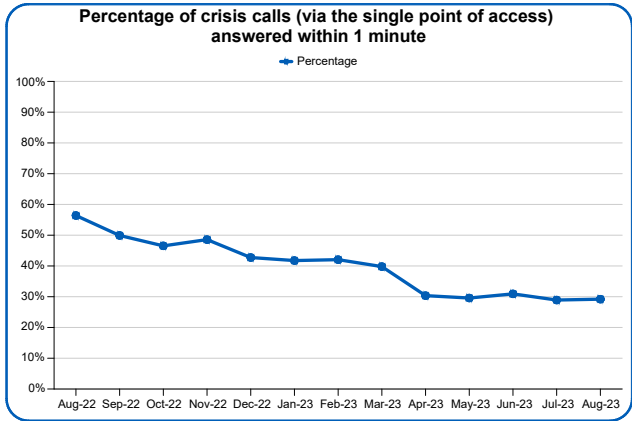
Service Performance - Chief Operating Officer

Services: Our acute patient journey	Target	Jun 2023	Jul 2023	Aug 2023
The Mount Ward 3 (Male)	-	85.5%	80.5%	85.6%
The Mount Ward 4 (Female)	-	99.2%	98.6%	94.5%
Percentage of delayed transfers of care	-	11.8%	10.8%	13.6%
Total: Number of out of area placements beginning in month	-	16	12	19
Total: Total number of bed days out of area (new and existing placements from previous months)	217	652	677	660
Acute: Number of out of area placements beginning in month	-	15	10	16
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	418	505	525
PICU: Number of out of area placements beginning in month	-	1	2	3
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	174	161	135
Older people: Number of out of area placements beginning in month	-	0	0	0
Older people: Total number of bed days out of area (new & existing placements from previous months)	-	60	11	0
Cardiometabolic (physical health) assessments completed: Inpatients (quarterly)	80.0%	78.9%	-	-
Services: Our Community Care	**Target**	**Jun 2023**	**Jul 2023**	**Aug 2023**
Percentage of inpatients followed up within 3 days of discharge (Trust Level monthly local tracking)	80.0%	82.7%	81.1%	75.4%
Percentage of inpatients followed up within 3 days of discharge (HCP commissioned services only)	80.0%	81.7%	79.4%	75.9%
Number of service users in community mental health team care (caseload)	-	3,434	3,351	3,359
Percentage of referrals seen within 15 days by a community mental health team	80.0%	82.8%	85.2%	79.7%
Percentage of referrals to memory services seen within 8 weeks (quarter to date)	90.0%	48.8%	53.6%	60.8%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50.0%	41.3%	37.5%	42.2%
Early intervention in psychosis (EIP) or at risk mental state (ARMS): Percentage starting treatment within 2 weeks	60.0%	62.5%	35.3%	66.7%
Early intervention in psychosis (EIP) : Percentage of people discharged to primary care (quarterly)	-	63.3%	-	-
Cardiometabolic (physical health) assessments completed: Early Intervention in Psychosis Service (quarterly)	90.0%	82.0%	-	-
Services: Clinical Record Keeping	**Target**	**Jun 2023**	**Jul 2023**	**Aug 2023**
Percentage of service users with NHS Number recorded	-	99.1%	99.2%	99.2%
Percentage of service users with ethnicity recorded	-	79.7%	79.7%	80.4%
Percentage of service users with sexual orientation recorded	-	42.2%	43.1%	43.8%
Services: Clinical Record Keeping - DQMI	**Target**	**Mar 2023**	**Apr 2023**	**May 2023**
DQMI (MHSDS) % Quality %	95.0%	92.0%	92.3%	91.9%

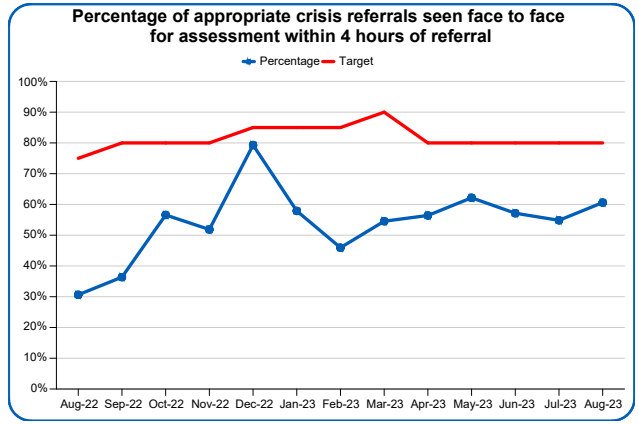
Services: Access & Responsiveness: Our Response in a crisis



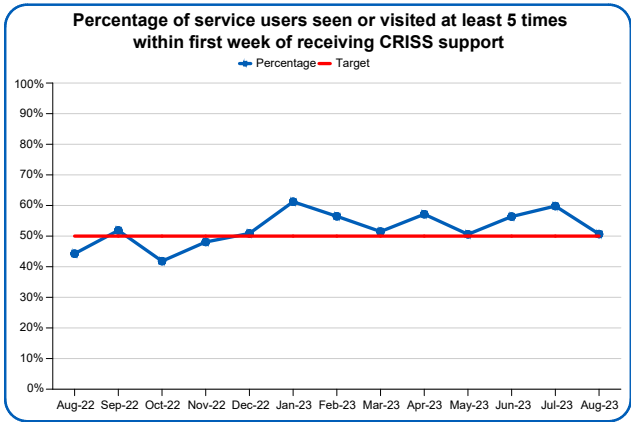
Number of calls : August 5,166



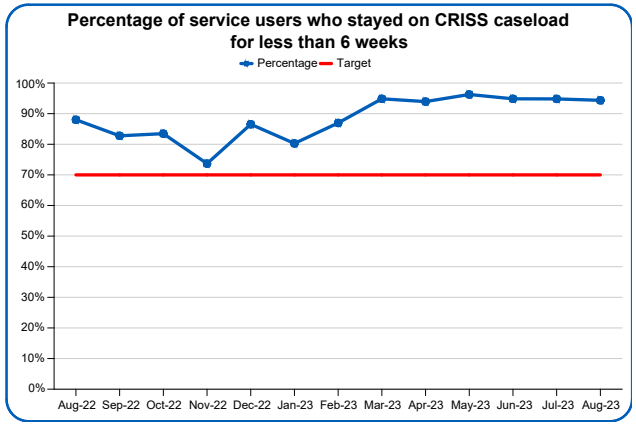
Local target - within 1 minute: August 29.2%



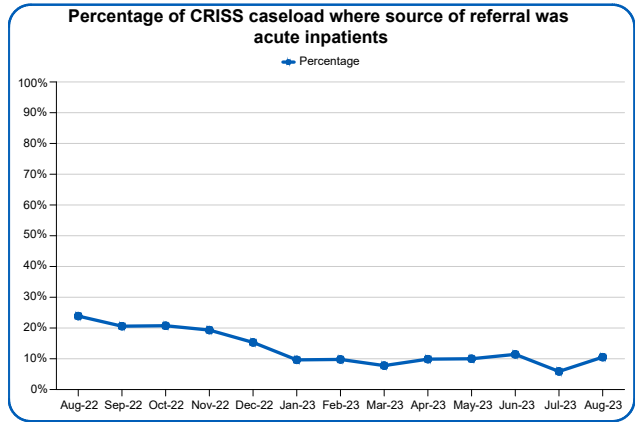
Contactual Target 80%: August 60.6%



Contractual Target 50%: August 50.7%

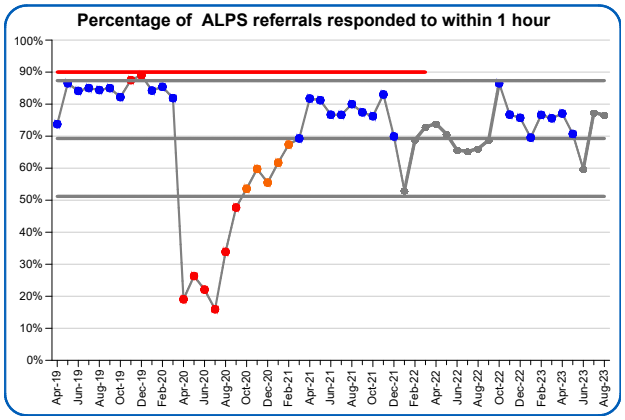


Contractual Target 70%: August 94.4%

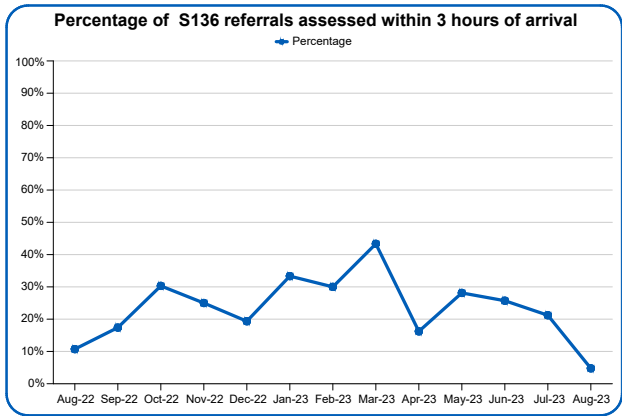


Contractual Target tba: August 10.5%

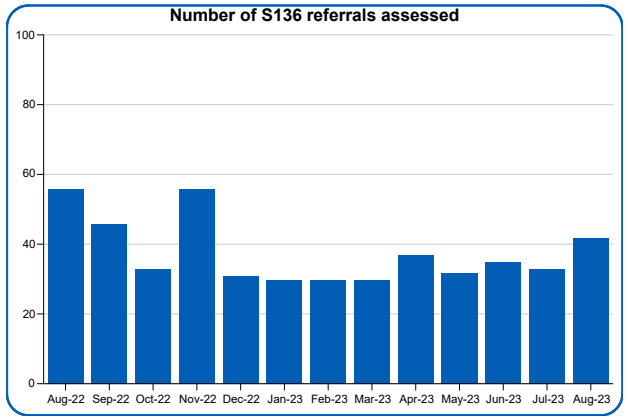
Services: Access & Responsiveness: Our Response in a crisis (continued)



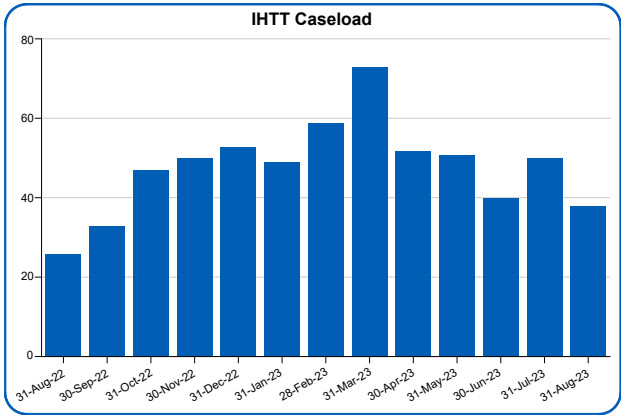
Contractual Target : August 76.6%



Contractual Target : August 4.8%

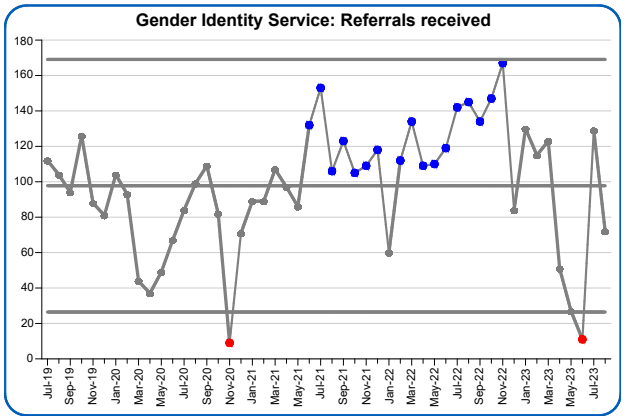


Total referrals assessed: August 42

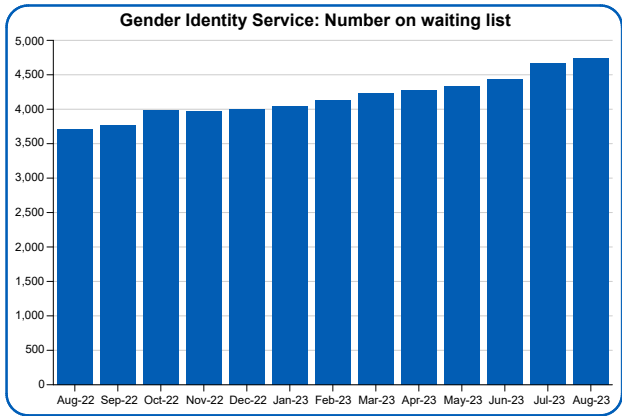


Caseload: August 38

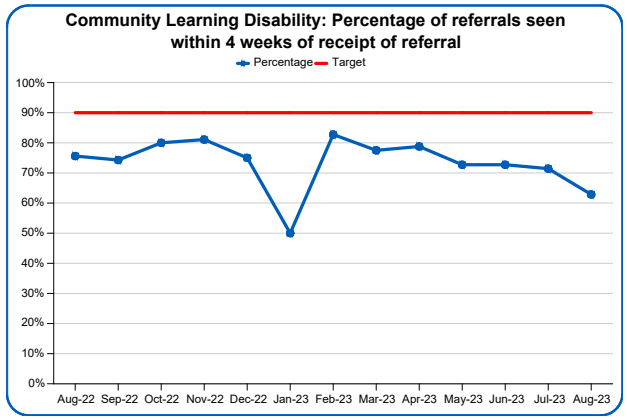
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services



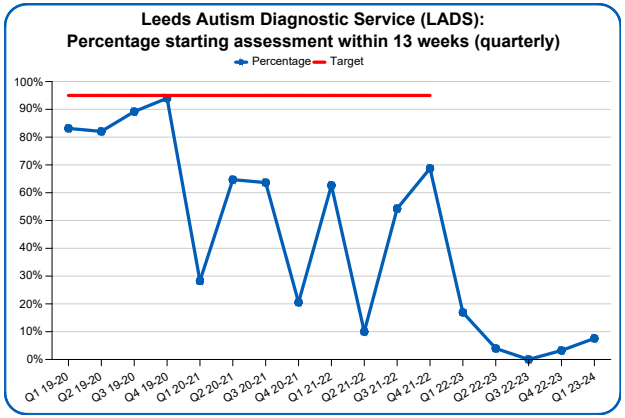
Total referrals: August 72



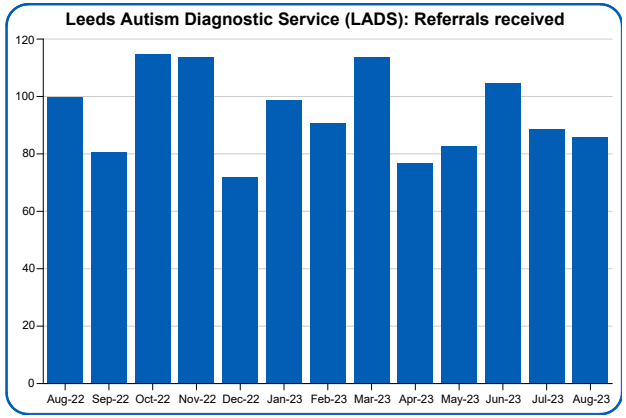
Number on waiting list: August 4,753



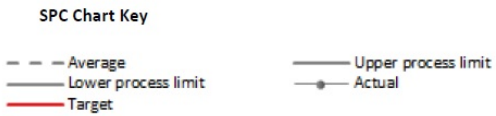
Contractual Target 90%: August 62.9%

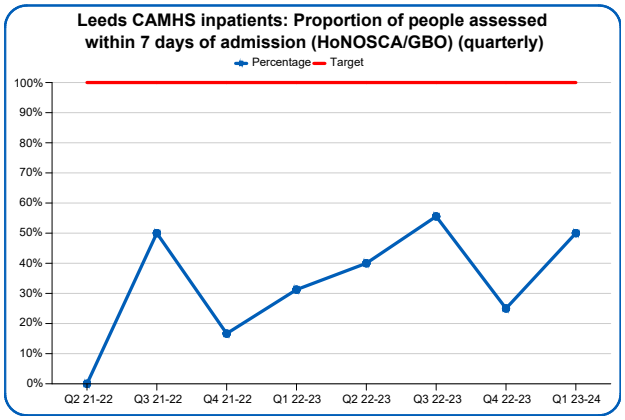


Contractual Target : Q1 7.6%

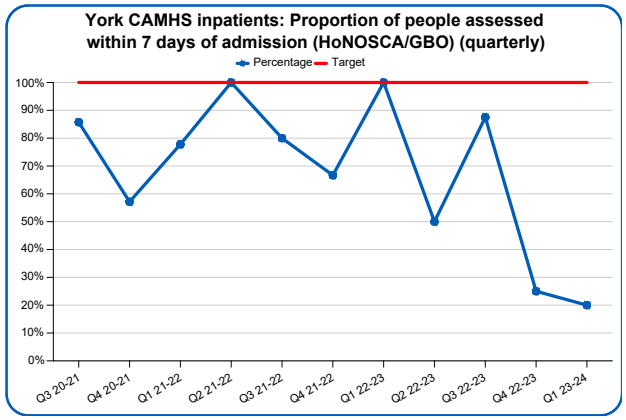


Local measure: August 86

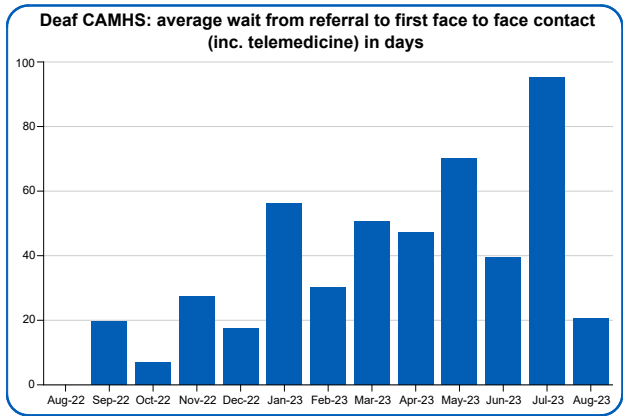




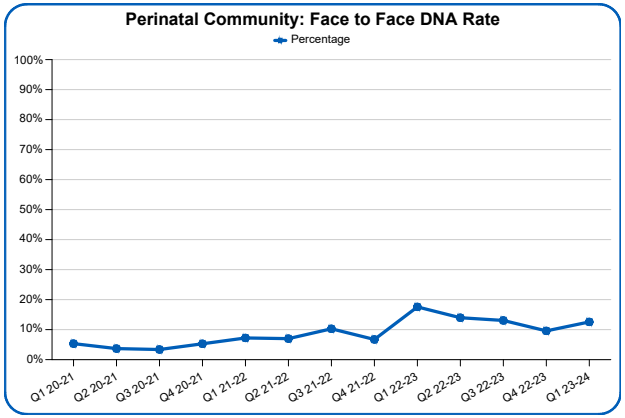
Contractual Target 100%: Q1 50.0%



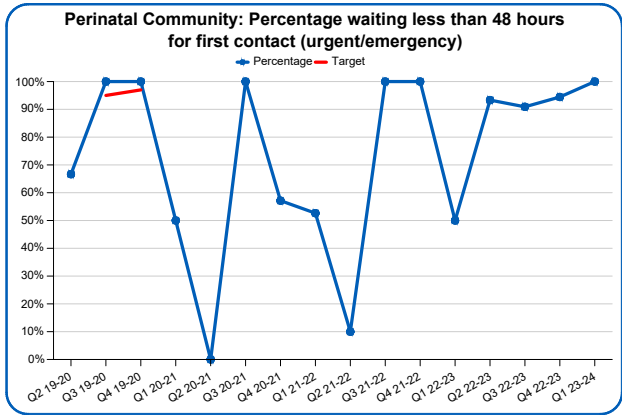
Contractual Target 100%: Q1 20.0%



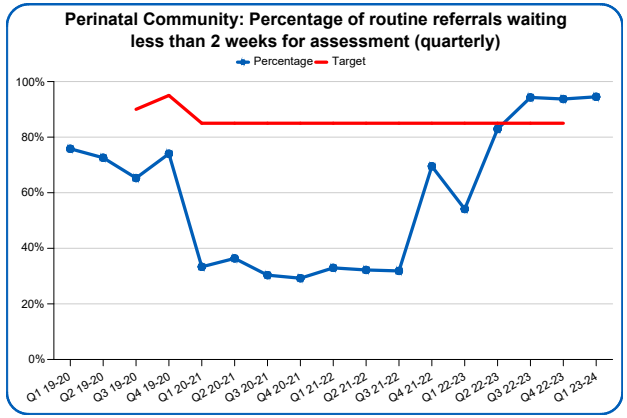
Local measure: August 21



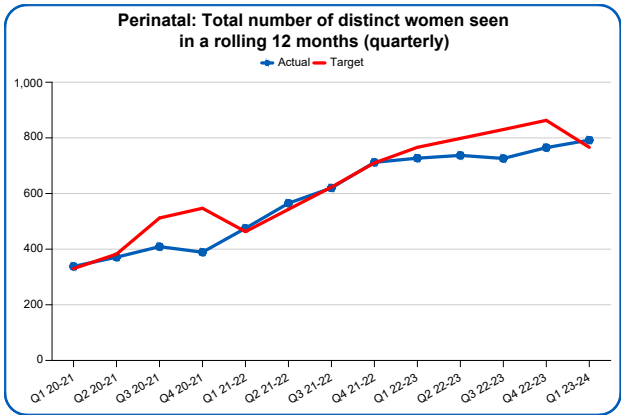
Contractual measure: Q1 12.6%



Contractual Target tba: Q1 100.0%

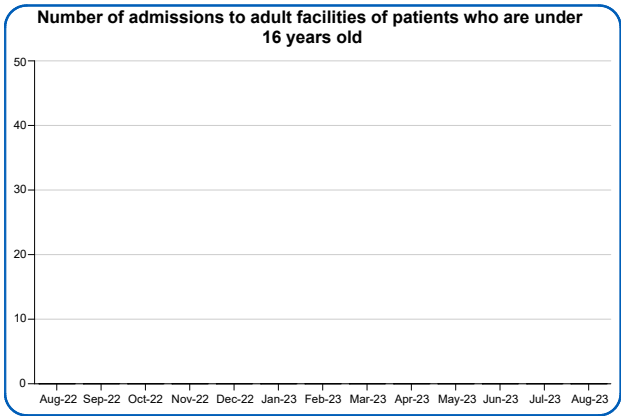


Contractual Target : Q1 94.5%

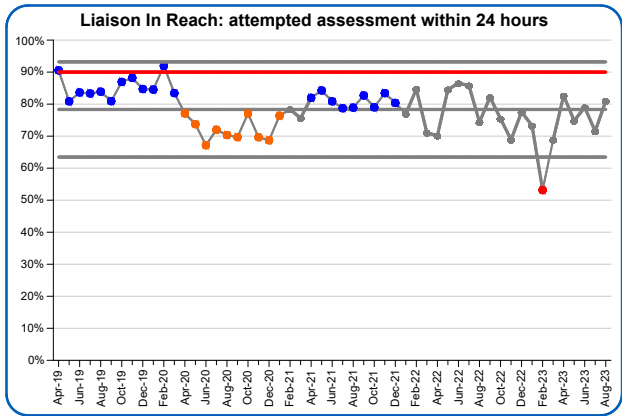


Local measure 766: Q1 792

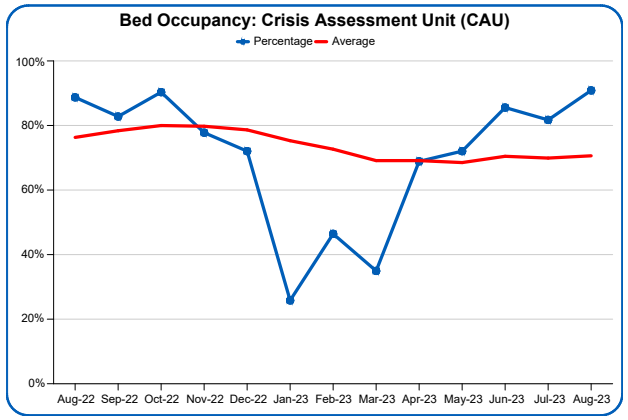
Services: Our acute patient journey



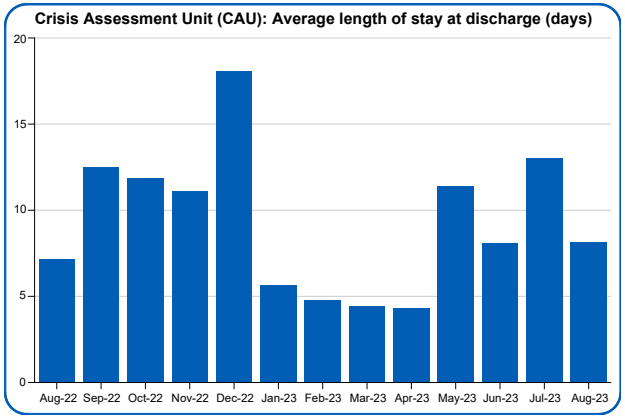
National (NOF) No target : August 0



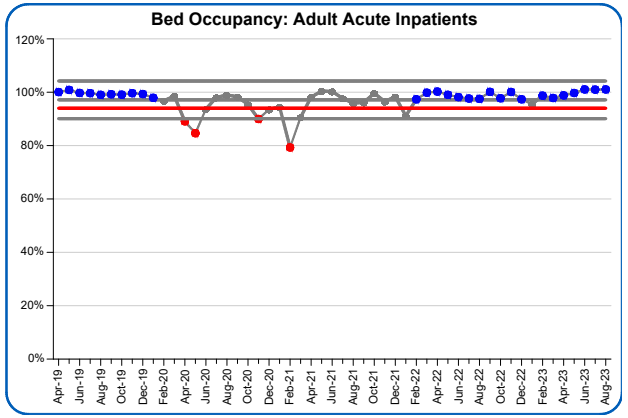
Contractual Target 90%: August 81.0%



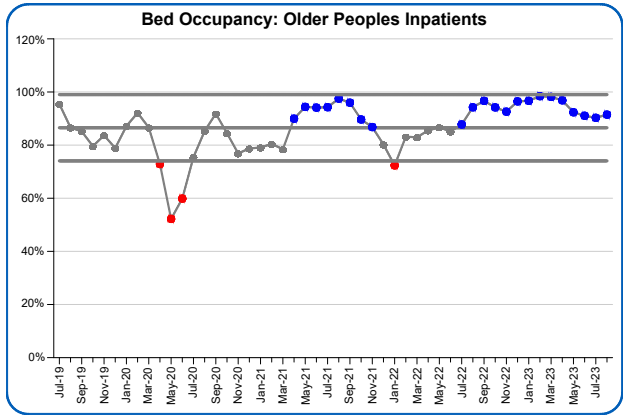
Local measure: August 90.9%



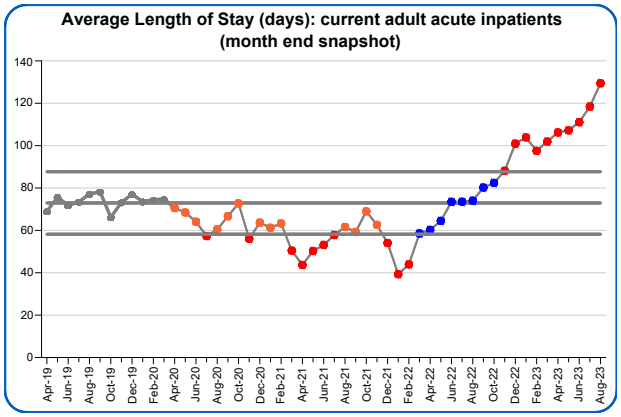
Local measure: August 8 days



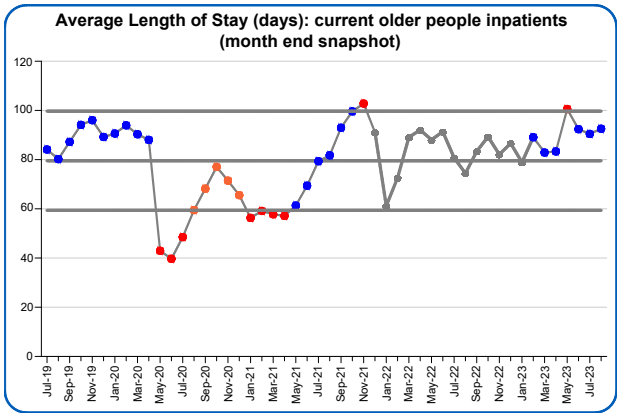
Contractual Target 94%: August 101.0%



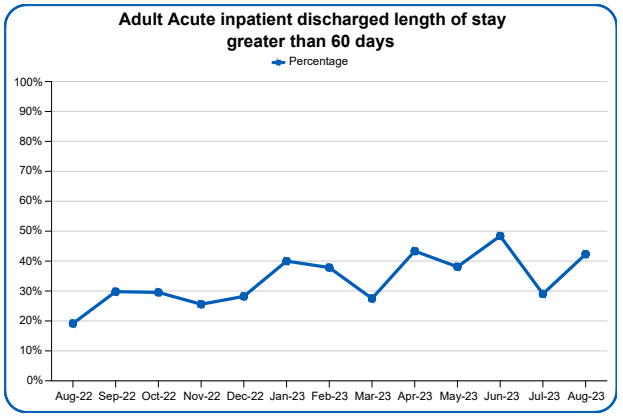
Local measure and target : August 91.5%



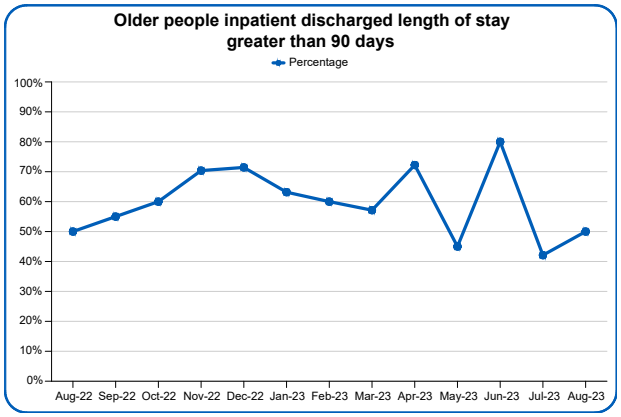
Local tracking measure: August 129 days



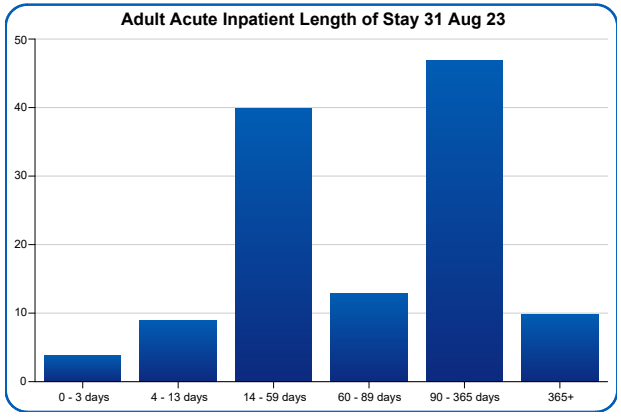
Local tracking measure: August 93 days



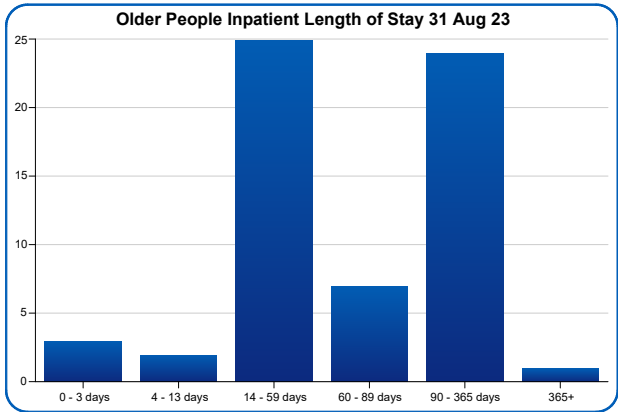
National (LTP): August 42.3%



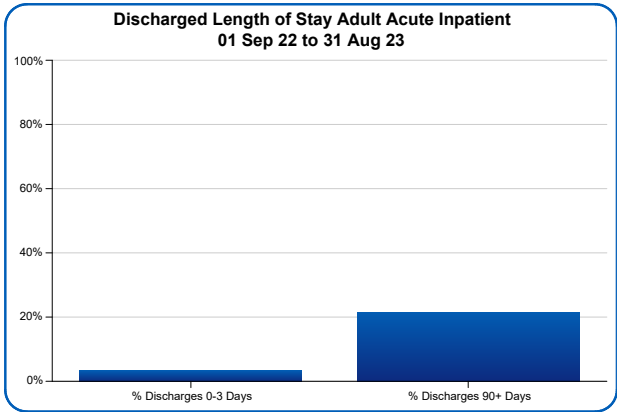
National (LTP): August 50.0%



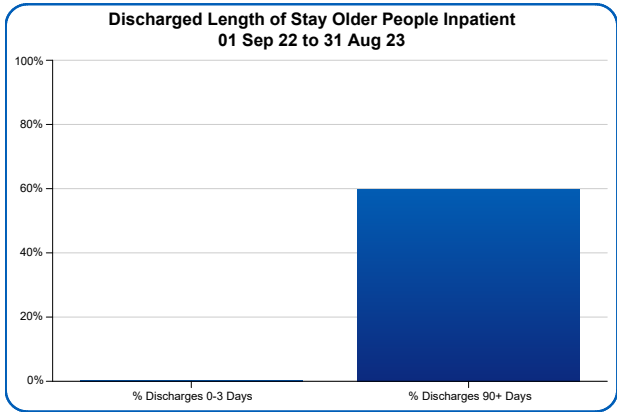
Local activity: 57 people with LOS 90+ days



Local activity: 25 people with LOS 90+ days

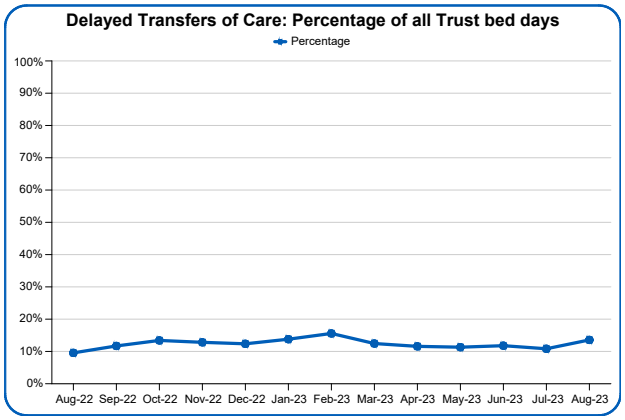


Local activity: % discharged LOS 90+ days = 21.7%

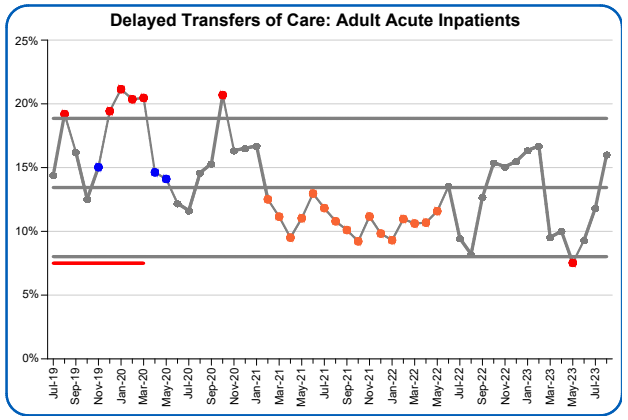


Local activity: % discharged LOS 90+ days = 60.2%

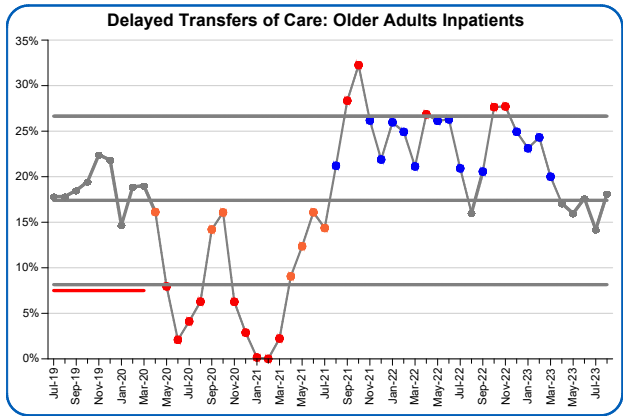
Services: Our acute patient journey (continued)



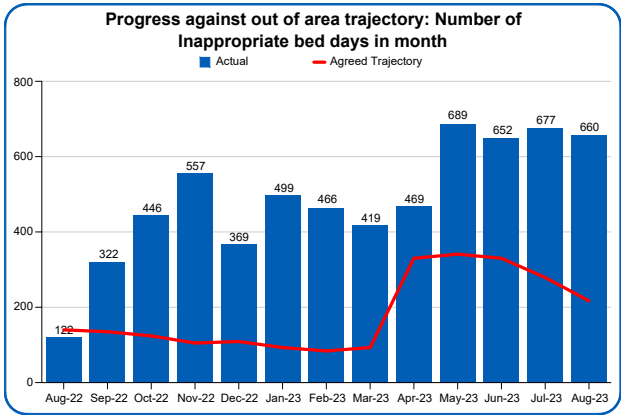
Local tracking measure: August 13.6%



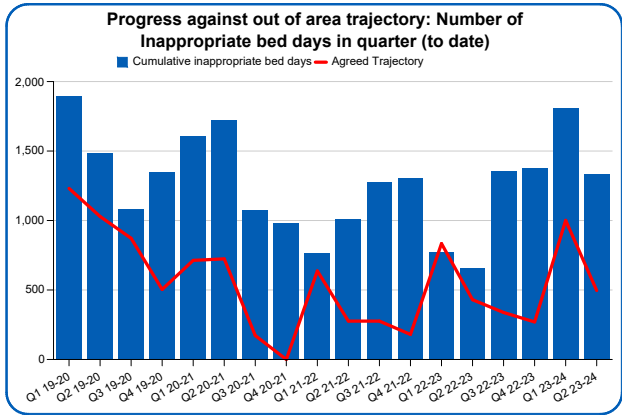
Local tracking measure: August 16.0%



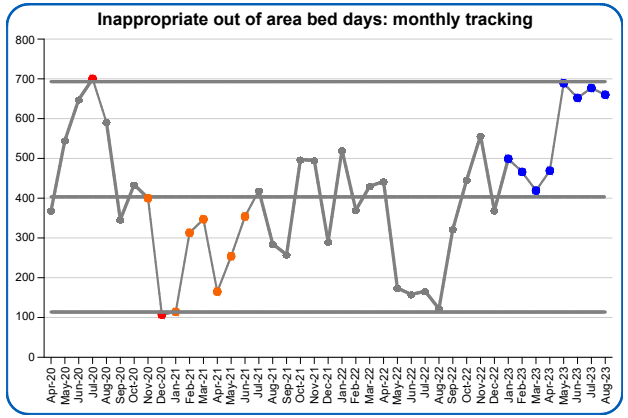
Local tracking measure: August 18.1%



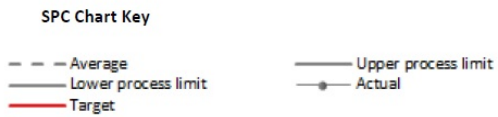
Nationally agreed trajectory (217): August 660 bed days



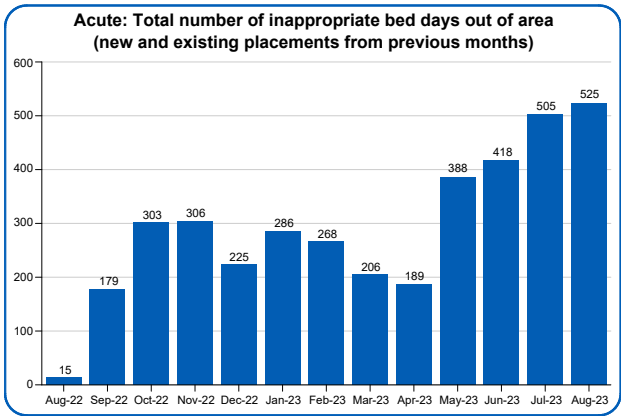
Nationally agreed trajectory (Q2: 496): Q2 1,337 bed days



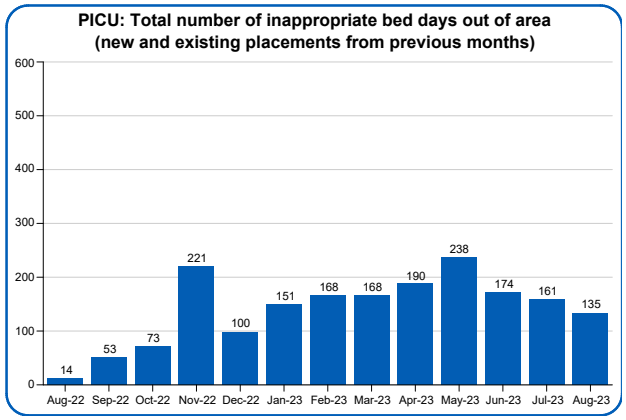
Local tracking measure: August 660 bed days



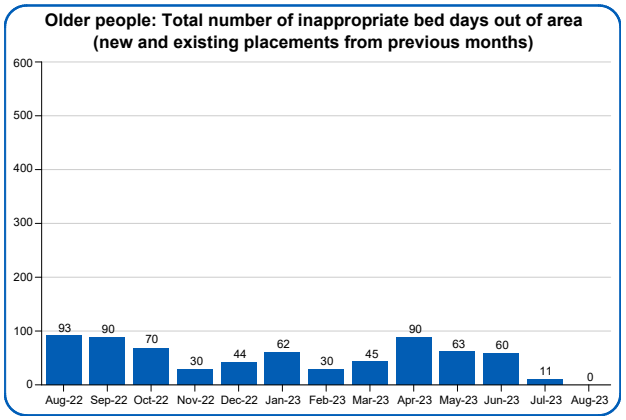
Services: Our acute patient journey (continued)



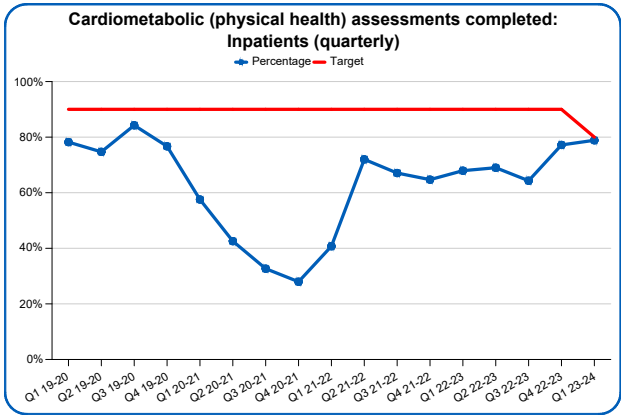
Nationally agreed trajectory (): August 525 days



Nationally agreed trajectory (): August 135 days



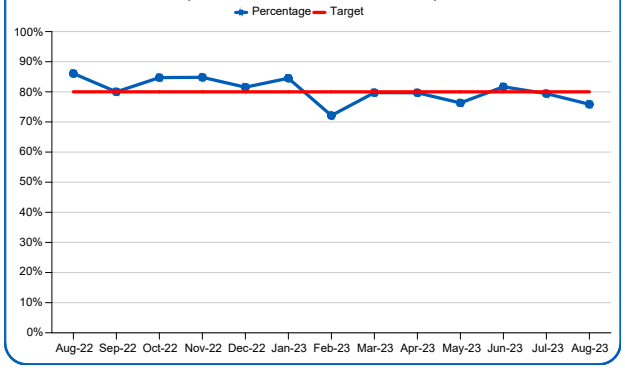
Local measure : August 0 days



Contractual target 80%: Q1 78.9%

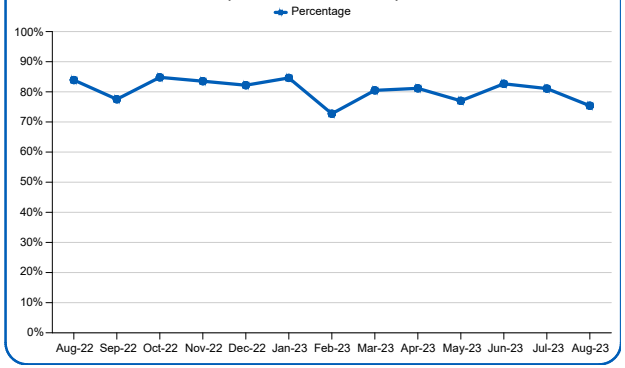
Services: Our community care

Percentage of inpatients followed up within 3 days of discharge (HCP Commissioned Services)



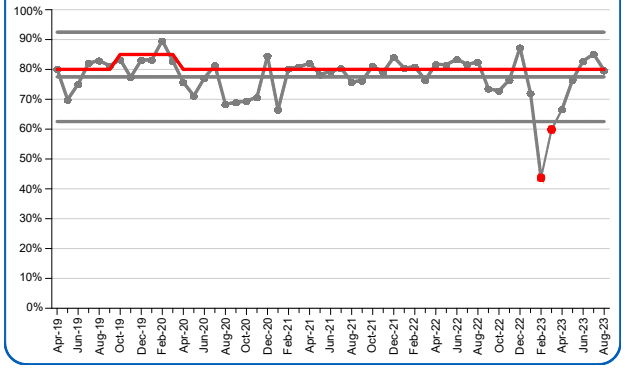
Contractual target 80%: August 75.9%

Percentage of inpatients followed up within 3 days of discharge (Trust-wide Services)



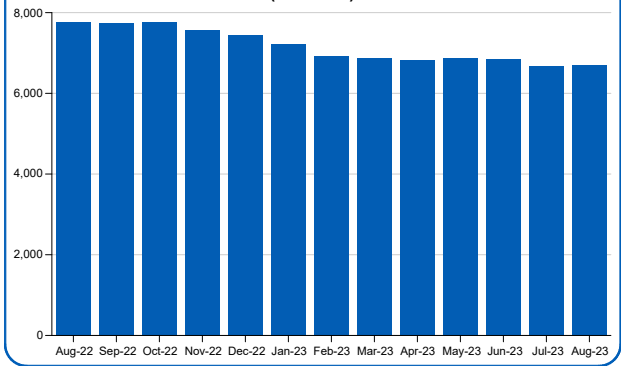
Local Tracking Measure 80%: August 75.4%

Percentage of referrals seen by a community mental health team within 15 days



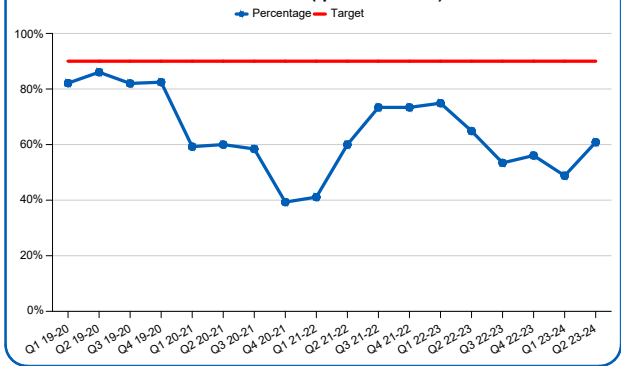
Contractual target 80%: August 79.7%

Number of service users in community mental health team care (caseload)



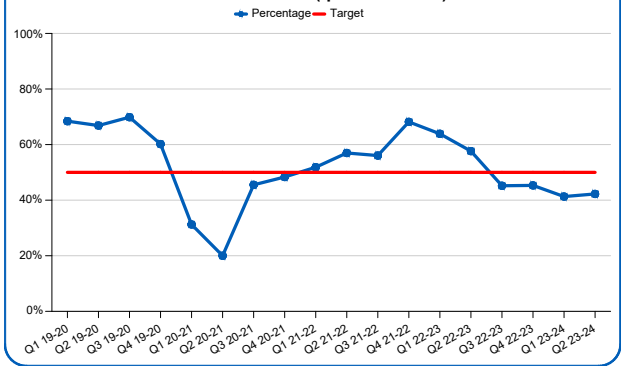
Local measure : August 3,351

Percentage of referrals to memory services seen within 8 weeks (quarter to date)



Contractual target 90%: Q2 23-24 60.8%

Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)

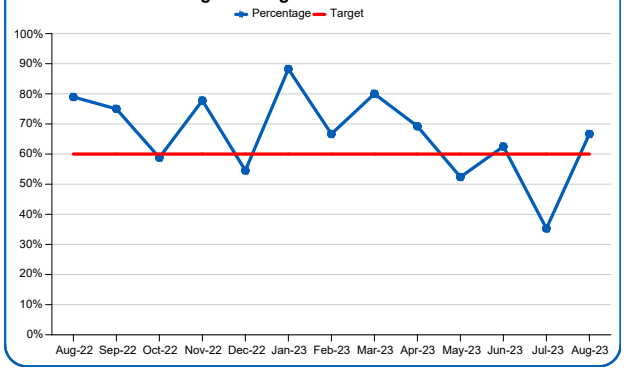


Contractual target 50%: Q2 23-24 42.2%

SPC Chart Key

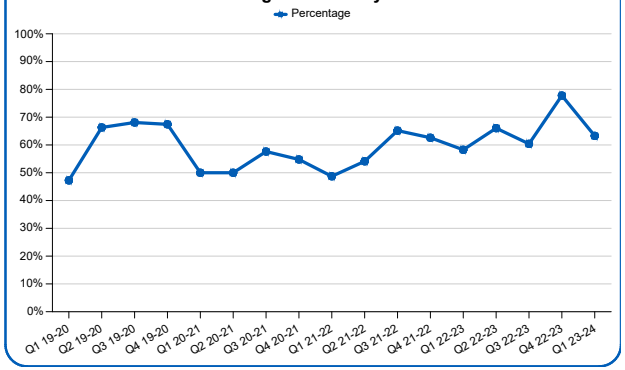
Services: Our community care (continued)

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



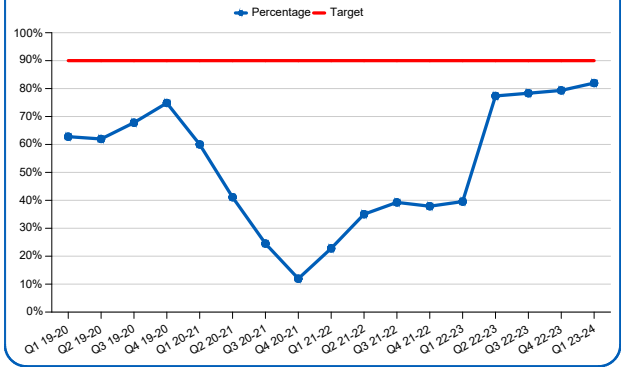
Contractual target 60%: August 66.7%

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



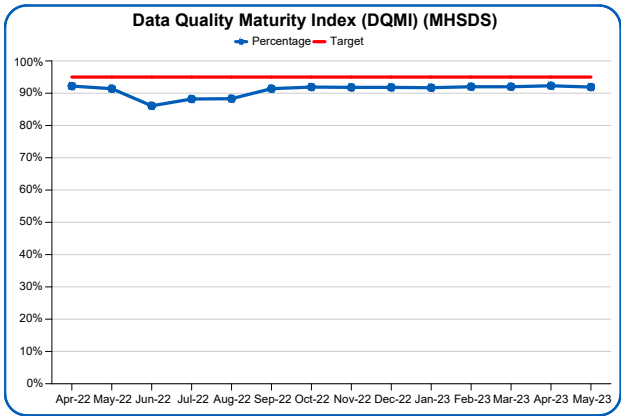
Contractual target tbc: Q1 63.3%

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

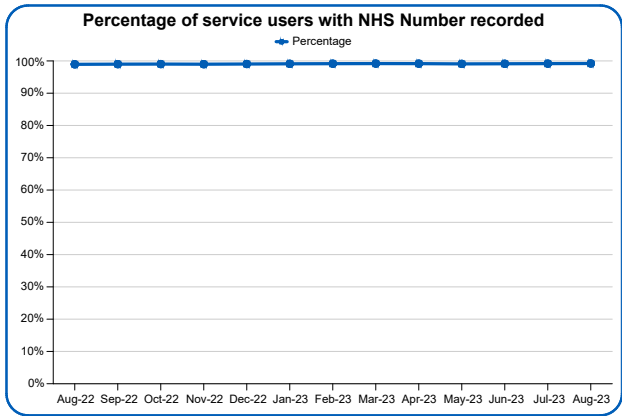


Contractual target 90%: Q1 82.0%

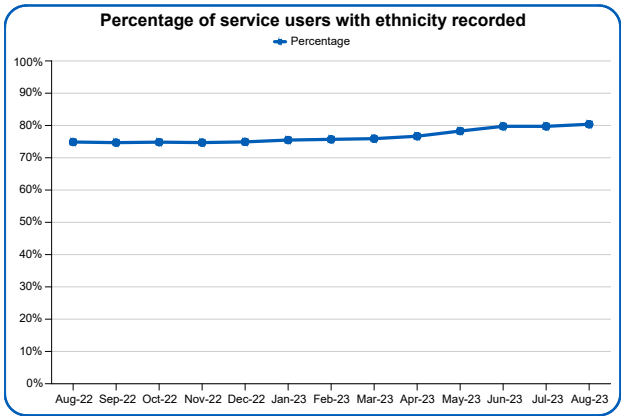
Services: Clinical Record Keeping



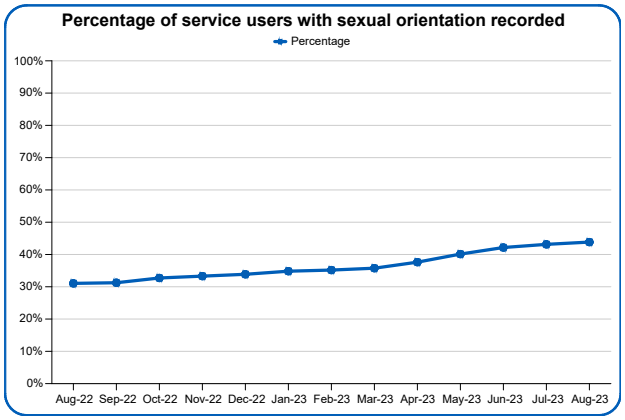
CQUIN / NHSOF Target 95%: May 91.9%



Local measure: August 99.2%



Local measure: August 80.4%



Local measure: August 43.8%

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
9

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Financial Officer Report - Month 5
DATE OF MEETING:	28 September 2023
PRESENTED BY:	Dawn Hanwell, Chief Financial Officer, and Deputy Chief Executive
PREPARED BY:	Jonathan Saxton, Deputy 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 overview of financial performance at month 5 2023/24. It also provides a brief update on some other key areas of work in the Directorate.

The Trust is on plan with its revenue and capital targets at Month 5 and is forecasting delivery overall for the year. However there remains a number of risks to revenue position which will impact the planning going forward into 2024/25. The position needs to be taken with consideration of the wider system's financial challenge that could further impact on the Trust. Enhanced financial governance controls are now in place across the system.

The Procurement landscape is changing significantly in the coming months which presents a number of risks and opportunities for the NOE CPC, and there is significant work underway

Detailed work linked to PFI expiry has begun. There will be resource implications to support this, including securing appropriate external expertise and advice where necessary.

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 revenue and capital position at month 5 and the actions being taken to ensure plan is delivered, in the context of the wider system challenges.
- Note other progress updates in relation to procurement and PFI.
- Support the approach to oversight and assurance on the PFI contract.

MEETING OF THE BOARD OF DIRECTORS

28 SEPTEMBER 2023

CHIEF FINANCIAL OFFICER REPORT

1 Introduction

This report provides an overview of financial performance. It also includes updates on some other key work in the directorate at this time.

2 Income and Expenditure Performance 2023/24

2.1 Year to date

At month 5 the Trust reported an income and expenditure surplus of £0.1m, against budgeted breakeven position. The details of key variances are shown at a subjective level in appendix A. Included in the position are key risk issues:

- Agency expenditure is £5.6m year to date, a deteriorating position (£0.7m higher than at the same period last financial year) and representing 7.8% of the total pay bill (ICB in aggregate has a target of no more than 3.7%) of pay bill.
- Out of Area Placements (OAPs) are net £1.2m above year-to-date budget, driven predominantly by the exceptional pressure in Working Age and PICU.
- The unidentified CIP target equates to £1.8m year to date adverse variance against budget.

Progress is being made against the ongoing efficiency thematic areas, and this is described below, however fortuitous mitigations predominantly substantive vacancies and interest receivable continue to offset the overall position, resulting in the small surplus at month 5.

2.2 Forecast

The first detailed forecast exercise for the year has been undertaken. There remains a high degree of volatility and uncertainty in some areas, linked to the pace at which tangible impacts, because of the work on the Trust efficiency areas can be realised. It is not anticipated that the Trust will fully meet the efficiencies targets in year, and that OAPs and agency spend specifically will be a challenge. However, despite this, due to the level of flexibility and other mitigations (slippage on developments and fortuitous income / vacances), meeting the breakeven target for the year is still anticipated. This position has been reported to the ICB.

3 Capital Expenditure

As at the end of August, capital expenditure for 2023/24 is reported as £1.6m which is broadly in line with plan (details in Appendix B). There are no specific concerns at this point with delivering the full operational capital programme. However, we may have some timing issues with decisions on spending national PDC monies, specifically in relation to the Urgent and Emergency Care capital which is allocated to the Trust on behalf of the West Yorkshire Complex Rehabilitation Care programme. Work is still ongoing validating potential scenarios linked to this.

The Trust has also recently been notified of a successful bid (up to £6m PDC funding) to support the development of 6 additional inpatient perinatal beds for the Yorkshire and Humber Provider Collaborative at the Mount. A design brief and business case are currently being developed to support this. As part of the criteria for decision was the ability of the provider to expedite this scheme in year and capital is only available for use in 2023/24, work is required at pace to ensure this is completed in year.

NHS England has recently indicated that IFRS16 (capital lease funding) which was previously managed nationally outside of ICB allocations, is likely to be devolved to ICBs part way through this financial year. If this is the case, there is likely to be an overall financial pressure within West Yorkshire and each organisation is being asked to robustly review their proposed spend on lease agreements. Work is ongoing as part of the estates planning to reduce the impact of prospective new leases.

4 ICB Financial Position

The ICB revenue position at month 5 is a £38.8m deficit against a planned £8.7m deficit, £30.1m off plan. The key drivers of this variance are the under-delivery against high-risk efficiencies, excess inflationary and pay award pressures, costs associated with industrial action and other pressures specific to individual organisations. The forecast remains a £25m deficit in line with the submitted plan. Enhanced financial controls remain in place across all organisations as a consequence of this position.

Year to date the ICB Capital expenditure against the operational capital plan in £15.7m behind, this is a similar position to that reported in 2022/23 at this stage of the year. In planning, providers were allowed to ‘over plan’ by 5% against the control total allocation to recognise there may be potential slippage in the year. The total plan with the 5% included is £167.5m, currently a £0.5m overspend on this value is forecast, however, all providers recognise that delivery ultimately must be against the allocation of £159.5m. All these values exclude any impact of IFRS16 as noted above.

5 Medium Term Financial Planning

NHSE require each ICB to develop a joint forward plan by the end of September 2023. As a result, work has begun on a collective system medium term financial plan, across all partner organisations. Phase one of the plan has been for each organisation to establish an underlying run-rate exiting 2023/24, to fully understand the “unmitigated” recurrent position going into 2024/25. This has then been overlaid with a consistent set of assumptions around inflation, tariff uplifts, growth and an efficiency requirement of a 2.6% recurrently per annum. For our Trust this exercise results in an unmitigated risk of approximately £27.5m by 2026/27. This is mainly

because of the cumulative effect of the recurrent efficiency requirement. This is a very high-level planning assumption start point. Clearly there is much work to be progressed at organisation, place and system level to support the ongoing medium-term planning. Work has begun to review the assumptions and the future efficiency opportunities through the financial planning group, and this will now link into the work regarding operational planning for 2024/25 which will begin in the autumn.

6 Procurement

NHS England have recently launched an initiative seeking to rationalise and de-duplicate the framework landscape. This has implications both for LYPFT as an organisation but also for the North of England Commercial Procurement Collaborative (NOE CPC), which the Trust operates. The NOE CPC delivers a number of frameworks to NHS customers. It is a framework host. A framework is where suppliers of specific services go through a process to become pre -approved on a framework, which subsequently makes the tendering process easier and quicker for customers.

Within the national initiative, all current framework hosts, are being asked to apply to become "Accredited". Once framework hosts have completed accreditation in December 2023, a pilot phase will be undertaken to approve frameworks from accredited hosts in 3 specific category areas. This will commence in January 2024, and go-live in April. Actual roll out will continue, Category-by-Category, over a longer period of time, to be determined. The key point to also note is that the standard NHS Contract is expected to be updated to direct all NHS organisations (through their ICB) to only use 'Approved' frameworks going forward.

This model presents risks and opportunities for NOE CPC. The strategic intent and direction to reduce the number of frameworks in the wider NHS is correct. The key risks are initially ensuring accreditation as a host and the administrative burden of seeking the approvals. The longer term and potentially more significant risks are which frameworks NOE CPC may be approved to deliver and the commercial and operational impact of this the hub, specifically in relation to the income received through frameworks.

Accreditation will also impact the Trust, outside of NOE CPC. That is, facing a stronger mandate to only use approved/endorsed routes to market from April 2023. This direction will limit choice but should deliver greater value and assurance.

The Board is asked to note this national development and the work that the NOE CPC is actively engaged in to secure its position as an accredited framework host. Further detailed progress will be reported through the Finance and Performance Committee.

7 PFI Contract

A 5 year PFI Expiry Health Check was undertaken in July, which is a requirement managed by the Infrastructure and Projects Authority (IPA) on behalf of Cabinet Office. In attendance were colleagues from Department of Health and NHS England. A feedback report has been received with an overall rating of Red/Amber (major additional work required to achieve target readiness). There was acknowledgement that the Trust has been delayed in progress due to uncertainty and delayed decision making in relation to the Strategic Outline Case.

The report sets out a series of recommendations which are now incorporating into a workplan for the PFI concession steering group which has been set up chaired by the CFO. A tender has been undertaken to have a full legal contract review to also support the workplan. There are some key activities needed to be undertaken quite quickly, in conjunction and through negotiation with our PFI partner. Internally the other key piece is the refresh of the Trust Strategic Estates Plan as this will drive a lot of decision making. A scoping exercise to identify additional resources is under way including appropriate specialist external advisors. The Trust is part of a network through the IPA with other organisations undertaking PFI expiry within the next 5-7 years, which will be a useful forum.

The intention is to report progress and provide assurance through the Finance and Performance Committee with key milestones and decisions coming to the Board at appropriate points. The Board is asked to endorse this approach.

8 Conclusion

The Trust is on plan with its revenue and capital targets at Month 5 and is forecasting delivery overall for the year. However there remains a number of risks to revenue position which will impact the planning going forward into 2024/25. The position needs to be taken with consideration of the wider system's financial challenge that could further impact on the Trust. Enhanced financial governance controls are now in place across the system.

The Procurement landscape is changing significantly in the coming months which presents a number of risks and opportunities for the NOE CPC, and there is significant work underway

Detailed work linked to PFI expiry has begun. There will be resource implications to support this, including securing appropriate external expertise and advice where necessary.

9 Recommendation

The Committee is asked to:

- Note the revenue and capital position at month 5 and the actions being taken to ensure plan is delivered, in the context of the wider system challenges.
- Note other progress updates in relation to procurement and PFI.
- Support the approach to oversight and assurance on the PFI contract.

Jonathan Saxton
Deputy Director of Finance
21 September 2023

		Month 5		
Income & Expenditure Budget Position	**Budget Annual £'000**	**Budget YTD £'000**	**Actual YTD £'000**	**Variance YTD £'000**
Income:				
Patient Care Income	213,308	88,878	88,533	(345)
Other Income	31,492	13,121	16,546	3,425
Total Income	**244,800**	**102,000**	**105,079**	**3,080**
Expenditure:				
Pay Expenditure	(177,568)	(73,729)	(71,493)	2,236
Non Pay Expenditure	(67,232)	(28,271)	(33,457)	(5,187)
Total Expenditure	**(244,800)**	**(101,999)**	**(104,950)**	**(2,951)**
Surplus/ (Deficit)	**0**	**0**	**129**	**129**

The significant year to date variances are:

Income:

- Patient Care income is £0.3m behind plan as income has been deferred in line with slippage in expenditure as a result of lead times in recruitment.
- In Other Income, interest received is £0.6m ahead of budget as a result of the increase in the bank of England base rate.
- Additional income of £1.1m for the West Yorkshire Child and Adolescent Mental Health Provider Collaborative (WY CAMHS PC), has been profiled into the position to offset increased expenditure in exceptional packages of care.
- Commercial income is also £1.7m ahead of budget year to date due to significant increased activity and gain shares.

Pay

- Significant substantive vacancies have led to an underspend in establishment budgets of £13.1m. Actions to reduce the vacancy position are being managed through the Reducing Vacancy group. The level of vacancies by month can be seen in Appendix D.
- Offsetting the overall underspend in Pay, the Trust has incurred £5.6m agency expenditure year to date, this is £0.6m higher than this point last year as detailed in Appendix C. Also, as a result of substantive vacancies, bank & overtime expenditure is £5.4m year to date.

Non-Pay

- Out of area placements (OAPs) expenditure is a significant pressure and is £1.4m above budget. £1.3m within acute adult services and £0.1m in Older Peoples Services. The actions to improve this position will be managed through the Patient Flow group set up to oversee the work of the acute care excellence programme.
- Activity in the West Yorkshire Adult Eating Disorder Provider Collaborative has also increased and the collaborative is £0.2m over budget due to OAPs
- Excess packages of care costs in the WY CAMHS PC has contributed towards a £1.1m overspend within the collaborative that is offset with additional income profiled into the position.

- Year to date the unidentified cost improvement target generated £1.8m adverse variance

Appendix B

CAPITAL PROGRAMME - at 31 August 2023	Year to Date			
	Annual Plan £'000	YTD Plan £'000	Actual Spend £'000	YTD Variance £'000
ICS Operational Capital				
Estates Operational				
Health & Safety /Fire/Accessibility/ Backlog	300	90		90
Security review	150	0		0
Cold water taps to bedrooms	100	100	50	50
Sub-Total	**550**	**190**	**50**	**140**
IT/Telecomms Operational				
IT Network Infrastructure	150	30	17	13
Server/Storage	30	0	0	(0)
Cyber security	50	0		0
Sub-Total	**230**	**30**	**17**	**13**
Estates Strategic Developments				
Newsam Centre (Doors)	75	75	25	50
Red Kite View	50	0		0
St Marys House, main house	1,080	900	1,083	(183)
Sustainibility & Green Plan	150	50		50
Seclusion Review	400	0		0
Safes	119	119	20	99
Sub-Total	**1,874**	**1,144**	**1,129**	**15**
IT Strategic Developments				
Integration System	50	0		0
Voice recognition	140	0		0
EPR developments	50	0		0
Electronic document management	277	0	116	(116)
EPMA Community model	100	0		0
Smartphones	60	20	47	(27)
Sub-Total	**677**	**20**	**163**	**(143)**
Contingency Schemes				
Contingency	305	90	74	16
2022/23 Completed Schemes			155	(155)
Sub-Total	**305**	**90**	**229**	**(139)**
Disposals				
ICS	0	0	(10)	10
Sub-Total	**0**	**0**	**(10)**	**10**
Total ICS Operational Capital	**3,636**	**1,474**	**1,577**	**(103)**
PDC Funded Schemes				
Electronic document management (PDC)	922	100		100
MH UEC (PDC)	581	0		0
Total PDC Funded Schemes	**1,503**	**100**	**0**	**100**
IFRS16 Leased Assets				
Lease Cars	200	75	38	37
Leased Buildings	1,000	0	(6)	6
Sub-Total	**1,200**	**75**	**32**	**43**
Disposals				
Leased	0	0	(6)	6
Sub-Total	**0**	**0**	**(6)**	**6**
Total IFRS16 Leased Assets	**1,200**	**75**	**26**	**49**
Total Capital Spend	**6,339**	**1,649**	**1,603**	**46**

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
10

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Safer staffing
DATE OF MEETING:	28 September 2023
PRESENTED BY: (name and title)	Nichola Sanderson, Executive Director of Nursing and Professions/ Director of Infection Prevention and Control
PREPARED BY: (name and title)	Alison Quarry, Deputy Director of Nursing Jennifer Connelly, 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 28 wards. This report is the two monthly update and draws on the requirements of the National Quality Board's (NQB) Safer Staffing expectations.

The paper 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 May 2023 to 30th June 2023.

The exception reports identify x1 Registered Nurse non-compliant duty where there was no RN on duty across this period which occurred within the Forensic Service.

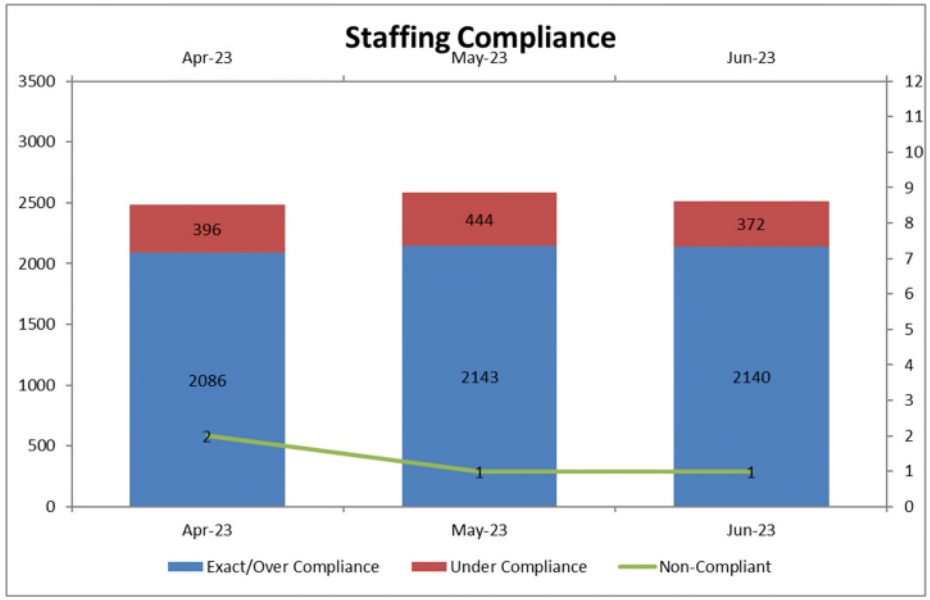
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes please set out what action has been taken to address this in your paper
	No	

RECOMMENDATION

The Board is asked to:

- Discuss and note the content of the 2 monthly report.
- Be assured of the arrangements in place to monitor, support and mitigate the impact of reduced staffing levels and skill mix in relation to quality and safety in inpatient settings.

Safer Staffing: Inpatient Services – May, June 23



	Number of Shifts		
	April	**May**	**June**
Exact/Over Compliance	2086	2143	2140
Under Compliance	396	444	372
Non-Compliant	2	1	0

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

Mitigating Factors:

Reduced RN fill rates are being partially mitigated in many of our units by increasing Healthcare Support Worker (HSW) duties through Bank and Agency staffing to reach minimum staffing numbers. Ongoing improvements to the recruitment strategy and a multi-professional approach to a review of establishments, continues to be progressed.

Narrative on Data Extracts Regarding LYPFT Staffing Levels on x28 Wards during May and June 23: This is the whole time equivalent (WTE) number of staffing posts the inpatient wards are funded for to deliver planned level of care and interventions within their speciality by shift.

Staffing compliance: This tells us whether the wards met the planned numbers of staffing during a shift. The planned staffing numbers do not necessarily reflect the actual staffing need on any given duty as this may fluctuate dependent on current patient group and need.

Exact or Over Compliant shifts:

Under Compliant Shifts:
*(Note this differs from the unify report in Appendix A which shows the total hours over the month rather than on a shift-by-shift basis).

Non-Compliant Shifts: This metric represents the number of shifts where no Registered Nurses were on duty.

This occurred once on 21st of May within Clifton Forensic Service were there was no RN cover for the night shift on **Riverfields Ward.**

The non-compliant shift occurred following late notification relating to sickness absence. The staffing escalation procure was followed; however, no RN cover was identified despite efforts. The medication keys were held by the Westerdale Ward RN. The duty on-call manager remained in contact throughout the duty. An incident report was completed to reflect the non-compliant duty and no further incidents were reported during the duty.

No further non-compliant shifts were recorded during May and June.

Service area updates

Working age adult (Becklin Wards 1,3,4 and 5, Newsam ward 1 (PICU) and 4

The vacancy rate across the Acute Inpatient and PICU service remains high, with an overall vacancy of 25%. There is a 51.75% RN vacancy rate and 16.67% Occupational Therapist (OT) vacancy rate across the service. Sickness absence, which is a combination of both long-term and short-term, is at 9.17%, which exceeds the trust sickness absence target of 6%. Over a third of these sickness absences have been identified as non-work-related stress/mental health.

Vacant duties are being reduced using bank and agency staff; however, to mitigate the risk and the impact on quality-of-care focus has been placed on the use of regular bank/agency RN's through block bookings to support consistency and continuity of care.

Deployment of staff across the Acute Service also continues to take place to maintain safe staffing numbers and provide the appropriate skill set to deliver care to this service user group. There have also been occasions where the deployment of Acute Services staff has been required to meet the safer staffing needs of other clinical services. In addition, the responsive workforce team has been deployed to the service to reduce the need for adhoc bank and agency HSW usage and to increase the consistency of care to reduce the impact on the quality of care provided.

The service has successfully recruited x 20 Preceptee RNs who will commence in September/October 2023 which is expected to have a significant positive impact on the workforce challenges and reduction in RN vacancies. A further x5 International Nurses have been recruited who are expected to join later in the year.

Crisis Assessment Unit (CAU)

The ward currently has no current RN vacancies following x2 Band 6 RNs who have recently commenced in post. The ward has an overall staffing vacancy rate of 15%. The sickness absence rate is 7.29% which exceeds the trust sickness absence target of 6%. Sickness absences are a combination of

both long-term and short-term absence with 36% being related to stress/mental health.

Older Peoples Services (Mount wards 1, 2, 3 and 4)

This service continues to focus on the recovery plan aligned to the ongoing and significant staffing deficits of RN/RNA in the service which has included the closure of 10 beds across the service. The introduction of new roles following a skill mix review has taken place to enhance the safety and quality of care delivered and support the ongoing work focused on recruitment and retention. The service has seen the introduction of activity coordinator roles across the 4 wards and is currently in the recruitment process for Assistant Psychology posts. Additional HSW roles across the 4 wards have also been identified.

The current overall vacancy rate across the service is 35% which has been further compounded by a sickness absence rate of 8% which has remained consistent over the data period. A third of absences have been recorded as non-work-related stress with colleagues being supported through the appropriate wellbeing support.

The RN vacancy rate averages 35-40% across the service, however it is predicted this will reduce to 25% by October following the x8 Newly Qualified RNs who will join the service in Autumn.

There remains a significant reliance on bank and agency RNs to mitigate vacant duties. The block booking of temporary staff is in place to increase the level of continuity and consistency of care. In addition, RN duties are backfilled through HSWs which includes the deployment of the responsive workforce team to the service.

The requirement for additional staffing above the planned establishment has been reduced across May and June in comparison to the previous month with a lesser need for enhanced observations within the service and occupancy levels have reduced averaging around 90%.

Mill Lodge

Mill Lodge had been able to recruit successfully to all vacant RN posts however due to x2 RNs who are due to commence on maternity leave x1 B5 post in currently being advertised to cover the maternity gap. The current vacancy rate across all staff groups averages 2% following the outstanding HSW vacancy which has been recruited to and commenced in post.

The sickness absence rate for the service is 7% in line with the trust target and 43% of sickness is in relation to mental health/stress/anxiety (non-work related) with no current themes identified. Colleagues are currently being supported through appropriate wellbeing support and RN unavailability continues to be mitigated using substantive RN's working additional duties and HSW backfill. Mill Lodge have also been able to support other services through the deployment of staff when their staffing levels have permitted.

Red Kite View (Skylark and Lapwing)

The service is currently operating with significant vacancies across both wards. Lapwing has an overall vacancy rate of 36% with a 59% RN vacancy rate and a 7% sickness rate.

The ward therefore has been required to utilise roles that ordinarily sit outside of safer staffing numbers taking up position to deliver or support clinical care - Practice development nurses; Occupational therapists; Band 6 staff working clinical shifts instead of having management days and Ward managers going into the clinical numbers have all been necessary.

Skylark has an overall vacancy rate of 22% and a 69% RN vacancy with a sickness rate of 10%.

Ward occupancy has remained under constant review and staffing levels have been considered in relation to each referral to inform admission decisions.

High levels of bank and agency staffing have been required to meet the service staffing requirements along with support from the responsive workforce team deployed to RKV to proactively provide continuity of care through the use of HSWs to backfill the RN gaps.

The service has recently had a B6 RN join with a further B5 RN who had been successfully appointed to a B6 post. In addition, there are x7 Newly Qualified RNs, x 2 International

Nurses, x2 B6 and x1 experienced B5 RN who are due join the service between September and January.

Asket House and Asket Croft (Rehabilitation and Recovery wards)

Asket Croft has an overall vacancy rate of 9% with no RN vacancies. Sickness absences, which is a combination of both long-term and short-term absence is currently 11.42% which exceeds the trust sickness absence target of 6%. The service works closely with Asket House to share resources across the service to ensure safety and quality is maintained.

Asket House currently has an overall vacancy rate of 3% with x1 RN band 5 vacancy which is currently being advertised. The service has increased the OT provision following a skill mix review with the successful recruitment of a band 5 OT. Sickness absence rates remain low at Asket House with a current rate of 4.48%, which is below the trust wide target of 6%. Substantive staff have voluntarily worked additional duties to support any vacant duties resulting from sickness and any non-effective duties and therefore a reduced reliance on bank and agency staffing.

Where the service has had above the required staffing establishment on duty, colleagues have supported other services across LYPFT through temporary deployment. Colleagues are supported through the leadership team to access regular clinical supervision to reduce any potential impact on staff wellbeing.

Newsam Ward 5 (Locked Rehabilitation)

Ward 5 has an overall vacancy rate of 22% and the RN vacancy rate is 27.5%. RN vacancies are mitigated using bank and agency staffing and the service is currently using a small number of RNs through block booking where possible. An Advanced Nurse Practitioner role, which is a new post to the service, has recently been recruited and the applicant will be imminently commencing in post. The post will provide senior leadership to the nursing team with the intention to support the retention of the nursing workforce.

There have been no non-compliant RN duties however on x 1 occasion the RN from the Late duty was required to remain on duty beyond their shift time until an RN was deployed from another service due to a late absence.

Sickness absence rates have seen a slight decrease to 11.55% across the data period with several short-term absences and x 1 RN long term absence.

Newsam ward 6 Yorkshire Centre for Eating Disorders (YCED)

Ward 6 has an overall vacancy rate of 18% which includes a 10.24% RN vacancy. The ward continues to experience the need for increased levels of enhanced observations and therefore increased staffing levels above planned establishment. This has resulted in higher usage of bank and agency staff; however, the service has focused on the use of regular bank/agency HSWs to support consistency and continuity of care. A staffing establishment review is currently being carried out to reflect the clinical model and planned changes to reflect the increase in acute beds and reduction in recovery beds within the ward.

Staff morale remains positive, and the ward has seen a sustained reduction in incidents relating to violence and aggression, with positively only one incident being reported in June 2023.

The ward has an overall sickness absence rate of 7.01% which is predominantly short- term sickness absences, this exceeds the trust sickness absence target of 6%. 45% of the absences have been identified as stress/mental health which are mainly non-work related.

Mother and baby unit

The ward has x 1 RN vacancy and an overall staffing vacancy rate of 8% with no reported concerns relating to staffing. x2 RNs are currently on maternity leave which has placed additional pressure on RN staffing, however vacant duties are predominantly filled by the existing team working additional duties or where no RN can be identified this has been backfilled by HSWs. Sickness absence rates report below the trust target at 4.8% with absences being predominantly short-term.

The frequency of the need for staff from this service being deployed to other services has now been reduced. The number of reported incidents has remained low with a total of 5 incidents in June 2023 despite a reported increase in the

need for enhanced observation and engagement and increased dependency during June 2023.

National Inpatient Centre for Psychological Medicine (NICPM)

NICPM has a 29% RN vacancy rate and no HSW vacancies. This has required the use of regular bank and agency staff to support RN staffing levels. Sickness absence rates have seen a decrease reducing to 4% absence rate. There is an ongoing recruitment drive to recruit outstanding vacancies and the service has recently successfully appointed an experienced band 5 RN and x 2 Band 5 Newly Qualified RNs who will commence in September. This will leave 1 unfilled band 5 RN vacancy which is currently out to advert.

Workforce pressures and RN vacancies had resulted in a temporary reduction in beds from 8 to 6, However, these beds will now re-open following the commencement in post of the newly recruited RN.

Newsam wards (Forensic wards 2 (F), 2(A&T) and 3)

Ward 2 (female) has a vacancy rate of 42% for RN and 19.8% for HSW. Sickness absence is above trust target of 6% at 44.1% for RN's and 9.9% for HSW. The vacancy and sickness absence gaps have been mitigated through the support of the responsive workforce team and using bank and agency staffing. There has been a recognition of themes relating to both work related, and non-work-related stress with additional support implemented through the Leadership Team, HR and Occupational Health to address the high levels of absence.

Ward 2 (A+T) has a vacancy rate of 40% for RN and 9.6% for HSW. Sickness absence has improved in June; however, RN sickness remains above the trust target at 16% and HSW sickness rate at 15.1%. None of the absences have been identified as being work related.

Ward 3 has a vacancy rate of 42% for RN and 14.7% for HSW. The sickness rate is below the trust target at 4.2% for RN and HSW sickness at 3.4%.

All three wards are due to have a preceptee RN start in October which will support the reduction of RN vacancies. An

ongoing recruitment campaign for the service continues to take place and there will be a specific focus on the recruitment of Nursing Associate positions for all three wards.

Clifton House (Forensic wards Riverfields, Westerdale and Bluebell)

The current vacancy rate at Clifton House is 17% with a 26% RN vacancy rate which includes x 4 B6 RN's and x4 B5 RN's. The vacancy gaps have been mitigated through internal deployment of staff within the service, the use of regular bank and agency RNs to support consistency and continuity of care and backfill through HSW. Although deployment ordinarily occurs internally between the forensic wards at Clifton house, on occasion Mill Lodge located in the same geographic area has been required to support staffing numbers.

x3 Newly Qualified B5 RN are due to commence employment at Clifton House in October, this will support the reduction of the band 5 RN vacancy.

The service has an 8.28% sickness rate, which exceeds the trust sickness absence target of 6%. Sickness absence includes both short-term and long-term sickness absences within the service, however no themes for absence have been identified.

There has been one duty which has been non complaint with no RN on duty (see non–compliant duties exception report).

2 and 3 Woodland Square

Woodland Square has been experiencing an increase in the staffing challenges with a current overall vacancy rate of 17% which includes a 28% RN vacancy across both wards. The vacancy gaps have been mitigated through the block booking of x 2 Agency RNs who predominantly work night duties. The vacancies also include a B6 Occupational Therapy post which is new to the service following a skill mix review within the service which will enable the delivery of specific specialist interventions such as sensory integration. This post is part of the current recruitment drive.

The sickness absence rate for both wards has been below the trust target of 6%, with 2WSQ at 2.4% and 3 WSQ at 5.41%.

Summary

The ongoing workforce challenges and pressures faced by inpatient services remain despite sustained efforts and several improvement initiatives taking place. Our workforce risks remain high, on the risk register and of the x28 wards, only a small number of services have been able to successfully recruit to all RN vacancies.

It is acknowledged that our reliance on newly registered nurses continues to be our most significant means of recruiting Band 5 RNs into the organisation despite our continuous attempts to attract experienced RNs. Both nationally and locally the number of student nurses graduating has been significantly reduced, which is reflected in the number of newly qualified nurses joining LYPFT from local universities in September. Additional efforts to focus on the recruitment of Newly Qualified Nurses outside of the local area have been required to encourage LYPFT as an employer of choice which has positively resulted in the recruitment of a further 32 out of area Student Nurses expected to join the organisation over the next few months, hence some success in reducing our overall nursing vacancies by approx. 60 vacancies in total.

Staffing pressures continue to being partially mitigated in many of our units by increasing Healthcare Support Worker (HSW) duties through Bank and Agency staffing to reach minimum staffing numbers. The Responsive Workforce Team, a group of unregistered staff temporarily contracted to be deployed peripatetically to respond to short-notice service needs continue to be a necessity and have supported a number of the inpatient services.

The daily deployment of staffing continues to be required to ensure safe staffing numbers are being maintained and as a result guiding principles have been developed to support clinical staff and managers to apply these principles to balance safety with staff wellbeing.

Positively, services are reporting that the need for the roles that usually sit outside of safer staffing numbers taking up position to deliver or support clinical care - Practice development nurses; Occupational therapists; Band 6 staff working clinical shifts instead of having management days

and Ward managers going into the clinical numbers has reduced.

A number of services in their commitment to ensuring patients receive the highest quality care whilst in receipt of services are currently developing and/or implementing workforce models which support the introduction of multi professional roles and non-registered roles acknowledging the need for a different approach due to significant gaps in the Nursing profession. These changes to establishment are reviewed through the safer staffing group and learning shared across services.

LYPFT continues to place a clear focus on staff wellbeing, and this must continue as a means of providing focus on retaining existing and newly recruited staff.

Recommendations:

The Board is asked to:

- Discuss and note the content of the report.
- Be assured of the arrangements in place to monitor, support and mitigate the impact of reduced staffing levels and skill mix in relation to quality and safety in inpatient settings.

APPENDIX A

Safer Staffing: Inpatient Services May 23

Fill rate indicator return

Staffing: Nursing, Care Staff and AHPs (Allied Health Professional)

Ward name	Cumulative count	Care Hours Per Patient Day (CHPPD)							Day				Night				Allied Health	
		Registered	Non-registe	Registered	Non-registe	Registered	Non-registe	Overall	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill
WardName	PatientCo	CHPPD_RN	CHPPD_NR	CHPPD_RN	CHPPD_NR	CHPPD_RA	CHPPD_NR	CHPPD_Ov	AvgFR_RN	AvgFR_NR	AvgFR_RN	AvgFR_NR	AvgFR_RN	AvgFR_NR	AvgFR_RN	AvgFR_NR	AvgFR_RA	AvgFR_NR
2 WOODLAND SQUARE	107	9.7	7.4	0.0	0.0	0.0	0.0	17.1	94%	112%	-	-	100%	103%	-	-	-	-
3 WOODLAND SQUARE	100	9.2	16.5	1.8	2.8	0.0	0.0	30.2	83%	192%	100%	100%	80%	168%	100%	100%	-	-
ASKET CROFT	571	1.6	2.6	0.0	0.0	0.6	0.0	4.8	95%	95%	-	-	100%	98%	-	-	100%	-
ASKET HOUSE	476	1.8	1.9	0.0	0.0	0.7	0.0	4.4	118%	75%	-	-	100%	103%	-	-	100%	-
BECKLIN CAU	134	7.6	19.0	1.2	0.0	0.0	0.0	27.8	75%	131%	100%	-	103%	132%	-	-	-	-
BECKLIN WARD 1	672	2.3	6.5	0.2	0.0	0.0	0.0	8.9	78%	280%	100%	-	91%	337%	100%	-	-	-
BECKLIN WARD 3	676	2.2	2.8	0.3	0.1	0.3	0.2	6.0	72%	196%	100%	100%	95%	168%	100%	100%	100%	100%
BECKLIN WARD 4	698	2.0	3.8	0.0	0.0	0.3	0.0	6.1	67%	198%	100%	-	89%	177%	-	-	100%	100%
BECKLIN WARD 5	676	2.1	5.2	0.0	0.0	0.0	0.3	7.7	72%	238%	100%	100%	97%	225%	-	100%	-	100%
MOTHER AND BABY AT THE MOUNT	153	9.8	9.2	0.0	0.0	0.0	0.0	19.0	100%	53%	-	-	91%	103%	-	-	-	-
NEWSAM WARD 1 PICU	339	4.3	11.9	0.0	0.0	0.7	0.2	17.1	78%	125%	-	-	83%	188%	-	-	100%	100%
NEWSAM WARD 2 FORENSIC	370	2.5	11.9	0.0	0.0	0.3	0.3	15.0	71%	366%	-	-	104%	297%	-	-	100%	100%
NEWSAM WARD 2 WOMENS SERVICES	310	2.9	11.0	0.0	0.0	0.3	0.4	14.6	68%	310%	-	-	97%	230%	-	-	100%	100%
NEWSAM WARD 3	433	2.1	5.6	0.0	0.0	0.6	0.3	8.6	80%	234%	-	-	110%	145%	-	-	100%	100%
NEWSAM WARD 4	647	2.2	3.7	0.0	0.0	0.0	0.0	5.9	65%	214%	-	100%	92%	162%	-	-	-	-
NEWSAM WARD 5	482	2.3	4.2	0.0	0.0	0.8	0.3	7.6	92%	90%	-	-	65%	134%	-	-	100%	100%
NEWSAM WARD 6 EDU	378	3.7	12.6	0.0	0.0	0.9	0.0	17.1	130%	479%	-	-	64%	352%	-	-	100%	-
NICPM LGI	126	10.0	7.3	0.0	0.0	2.8	0.0	20.1	85%	63%	-	-	90%	119%	-	-	100%	-
RED KITE VIEW GAU	286	4.4	11.7	0.8	0.0	0.0	0.0	17.0	63%	91%	100%	-	76%	118%	100%	-	-	-
RED KITE VIEW PICU	148	8.2	36.5	0.0	0.0	0.0	0.0	44.8	50%	140%	-	-	88%	150%	-	-	-	-
THE MOUNT WARD 1 NEW (MALE)	431	3.9	11.9	0.0	0.0	0.0	0.0	15.8	158%	191%	-	-	102%	260%	-	-	-	-
THE MOUNT WARD 2 NEW (FEMALE)	411	3.6	18.9	0.5	0.3	0.0	0.0	23.3	103%	430%	100%	100%	93%	387%	100%	-	-	-
THE MOUNT WARD 3A	526	2.5	4.9	0.3	0.0	0.0	0.0	7.7	71%	147%	100%	-	90%	171%	100%	-	-	-
THE MOUNT WARD 4A	636	2.4	7.3	0.0	0.1	0.0	0.0	9.8	88%	274%	-	100%	92%	282%	-	100%	-	-
YORK - BLUEBELL	257	3.4	8.0	0.7	0.0	0.5	0.2	12.8	68%	67%	100%	-	105%	113%	-	-	100%	100%
YORK - MILL LODGE	277	5.2	6.8	0.6	0.0	1.3	0.5	14.4	82%	99%	100%	-	72%	137%	-	-	100%	100%
YORK - RIVERFIELDS	155	4.3	8.8	0.0	0.0	1.0	0.0	14.0	44%	141%	-	-	93%	103%	-	-	100%	-
YORK - WESTERDALE	277	4.2	10.2	0.0	0.4	0.2	0.4	15.5	55%	163%	-	100%	103%	146%	-	100%	100%	100%

APPENDIX A

Safer Staffing: Inpatient Services June 23

Fill rate indicator return

Staffing: Nursing, Care Staff and AHPs

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		Registered	Non-registered	Registered	Non-registered	Registered	Non-registered	Overall	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill
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*** Allied health professionals refer only to Occupational therapists that are included in the ward establishment**

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
11

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Guardian of Safe Working Quarterly Report Quarter 1: 1 April 2023 to 30 June 2023
DATE OF MEETING:	28 September 2023
PRESENTED BY: (name and title)	Dr Chris Hosker, Medical Director
PREPARED BY: (name and title)	Dr Rebecca Asquith, Guardian of Safe Working House

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 3 exception reports and 0 patient safety issues recorded in this period
- Junior Doctors Forum met in August 2023. Junior doctor industrial action has commenced during this reporting period, with no related patient safety issues. Clarification has been given about rest days being taken around IA.

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 agree this report 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
- To provide constructive challenge where improvement could be identified within this system.

MEETING OF THE BOARD OF DIRECTORS

DATE 28th September 2023

Guardian of Safe Working Hours Report

Quarter 1 April 2023 to June 2023

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 01.04.2023 to 30.06.2023.

2 Quarter 4 Overview

Vacancies		There are 39 Core trainees and 2 NIHR posts					
		There are 5 vacancies in the Higher Trainee establishment					
Rota Gaps		January		February		March	
		CT	HT	CT	HT	CT	HT
	Gaps	37	16	8	8	23	13
	Internal Cover	35	16	8	8	21	13
	Agency cover	0	0	0	0	2	0
	Unfilled	2	0	0	0	0	0
Fill Rate		95%	100%	100%	100%	91%	100%
Exception reports (ER)		There were 3 ERs raised during this reporting period. No ERs related to patient safety issues or missed training opportunities. 2 ERs relate to additional workload or time worked over in the context of unfilled vacancies during on call shifts, resolved by payment. 1 ER relates to time worked over during routine work, with a resolution of TOIL. The resolutions were in line with the individual Drs preferences.					
Fines		None					
Patient Safety Issues		None					

Junior Doctor Forum (JDF)	Meeting held on 4th August 2023. • There were 3 exception reports, as noted above. None of these related to patient safety incidents. The CT's were satisfied with the agreed resolutions. • Following BMA ballot of junior doctors, periods of Industrial Action (IA) have taken place in April,… No ER's relate to planned industrial action. It has been confirmed that trainees are entitled to take rest days following IA as per their work schedules. Medical Education (MEC) are reviewing trainees affected by previous incorrect advice in this regard and arranging resolution accordingly. • Discussions continue with Less Than Full Time (LTFT) trainees about allocation of on call shifts on non-working days.

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 Rebecca Asquith
GMC 7151560
Guardian of Safe Working Hours

MEETING OF THE BOARD OF DIRECTORS

DATE 28th September 2023

Guardian of Safe Working Hours Report

Quarter 1 April 2023 to June 2023

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 01.04.2023 to 30.06.2023.

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		CT	HT	CT	HT	CT	HT
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Exception reports (ER)		There were 3 ERs raised during this reporting period. No ERs related to patient safety issues or missed training opportunities. 2 ERs relate to additional workload or time worked over in the context of unfilled vacancies during on call shifts, resolved by payment. 1 ER relates to time worked over during routine work, with a resolution of TOIL. The resolutions were in line with the individual Drs preferences.					
Fines		None					
Patient Safety Issues		None					

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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 Rebecca Asquith
GMC 7151560
Guardian of Safe Working Hours

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
12

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Workforce Race Equality and Workforce Disability Equality Standards and Gender Pay Gap Report 2022
DATE OF MEETING:	28 September 2023
PRESENTED BY: (name and title)	Caroline Bamford, Head of Diversity and Inclusion
PREPARED BY: (name and title)	Frances Dodd, Associate Director of People Experience and Caroline Bamford, Head of Equality and Diversity

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 paper provides a summary update on our Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) data for the reporting period 2022/2023 and our subsequent priority action areas. This is following data submission in May 2023, compliant with the revised submission requirements introduced this year. The WRES and WDES progress against previous actions will be published on our website in September 2023, in line with national reporting requirements. It also summarises the gender pay gap figures for 2022-23, as reported on our Trust website.

As detailed in Our People Plan, the WRES and WDES data identifies areas that will address equality gaps and improve the workplace experience for our substantive ethnic minority and disabled colleagues. The two standards are comprised of a series of measures, to compare the workplace and career experience of staff. These are comprised of workforce and staff survey experience data. There is a direct link between equality and outstanding care meaning the WRES and WDES provide an important performance and quality marker.

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 2023 WRES and WDES results and progress against priorities.
- Receive assurance that the WRES and WDES data was submitted in May 2023 in line with revised submission requirements and that actions will be published on the Trust website by the end of September 2023 to meet statutory reporting requirements.
- Note the Gender Pay Gap figures for 2022-2023.

MEETING OF THE BOARDOF DIRECTORS

28 September 2023

Equality and Diversity
Workforce Race and Disability Standard and Gender Pay Gap Progress Update 2023

1 Executive Summary

This paper provides a summary update on our Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) data for the reporting period 2022/2023 and our subsequent priority action areas. This is following the data submission in May 2023, compliant with the revised earlier submission requirements introduced this year. The WRES and WDES progress against previous actions will be published on our website in September 2023, in line with national reporting requirements. It also summarises the gender pay gap figures for 2022-23, as reported on our Trust website.

As detailed in Our People Plan, the WRES and WDES data identifies areas that will address equality gaps and improve the workplace experience for our substantive ethnic minority and disabled colleagues. The two standards are comprised of a series of measures, to compare the workplace and career experience of staff. These are comprised of workforce and staff survey experience data. There is a direct link between equality and outstanding care meaning the WRES and WDES provide an important performance and quality marker.

2 Performance Overview

Our 2023 data identifies overall significant progress when compared to our 2022 data, against both the WRES and WDES measures, identifying that our current Equality, Diversity and Inclusion (EDI) priorities, as detailed in Our People Plan are having an impact in tackling discrimination and inequality. Largely the metrics show substantive favourable changes with 79% of areas improving, compared to 2022 results. The following sections highlight specific examples and see appendix 1 and 2 for full details.

2.1 WRES

The 2023 ethnicity data identifies improvement in seven out of the nine WRES metric indicators. Progress areas include experiences of discrimination at work (-2%), bullying and harassment from

service users (-2%), the likelihood of entering the formal disciplinary process and the likelihood of being appointed following shortlisting, all which are encouraging.

Progress areas relating to ethnically diverse staff or applicants are as follows:

- Workforce representation is now at 21.4%, this is a 1.5% increase when compared to last year.
- The probability of ethnically diverse applicants being appointed following shortlisting has increased. For 2022, white applicants were more than twice as likely to be appointed and this figure has reduced to 1.46 times more likely.
- The probability of ethnically diverse staff entering the formal disciplinary process has again decreased this year to 0.32 times less likely than white staff.
- Ethnically diverse staff are 0.93 times more likely than white staff to access non-mandatory training or Continuing Professional Development (CPD).
- The percentage of ethnically diverse staff experiencing bullying and harassment from patients, carers or members of the public has reduced by 2%.
- The reported experiences of discrimination at work by ethnically diverse staff, from managers or colleagues has decreased by 2%.
- There has been an increase in ethnically diverse representation on our Trust Board.

2.2 WDES

The 2023 WDES results demonstrate improvements in eight out of the ten metric areas. These areas include experiences of bullying and harassment from managers (-2%), experiences of bullying and harassment from members of the workforce (-2%), staff feeling that their work is valued (+8.4%), feeling that the Trust provides equal opportunities for career progression (+7.4%) and staff sharing that they have a disability (+1.3%) which is again encouraging.

Progress areas relating to disabled staff or applicants are as follows:

- The number of staff who have recorded a disability or long-term health condition via ESR has increased by 1.3% to 7.5%.
- The probability of disabled applicants being appointed following shortlisting has increased to 0.87. This is now within the national range aiming to be within 0.8 and 1.25.
- The number of staff entering the formal capability process on the grounds of performance has reduced to zero.
- The percentage of staff experiencing bullying or abuse from patients, relatives or the public has decreased slightly (0.3%).
- The reported experiences of bullying or harassment from a manager has reduced by 2% and reported experiences of bullying and harassment from colleagues has reduced by 2%.
- A 7% increase in the percentage of staff reporting feelings that the trust provides equal access to career progression.

- The percentage of staff saying that they had felt pressure from their manager to come to work when not feeling enough to perform their duties has reduced slightly by 1%.
- An 8% increase in the percentage of staff saying they are satisfied with the extent to which our organisation values their work.
- The percentage of staff reporting that our Trust has made reasonable adjustments to enable them to do their work has increased by 2.5%.
- There has been an increase in disability representation on our Trust Board.

3. Next steps - progress

Although the metrics above identify tangible progress, there are also areas of concern which are EDI's priority actions for this year. These are as follows:

- There has been no reduction in the percentage of ethnically diverse staff experiencing bullying and harassment from staff (23%). Although this reflects the national average, it is an area of continuing focus through our civility and respect work.

- There has been a slight (1%) reduction in the percentage of ethnically diverse staff reporting feeling that the trust provides equal access to career progression. The current figure (43%) is 8% below the national average.

Continued focus on these priority areas is occurring and focused actions over the next twelve months are as follows.

- **Staff network development –** continue the effective growth of our EDI staff networks as an essential source of knowledge and peer support.

- **Cultural Inclusion Ambassadors (CIA) –** expand and further develop our CIA programme. The programme is comprised of volunteers who have received training to participate as members of decision-making groups, within our disciplinary process. Their role is to identify and explore issues of culture and conscious or unconscious bias. Established in 2022, the evaluation has identified positive impacts both on the results of the process and as a learning/development opportunity for our CIA's.

- **Recruitment Practice –** continue our Trust wide values based and inclusive recruitment workstream programme of work. This is ongoing significant phased work, with our Recruitment Manager and the Head of Strategic Resourcing. The EDI team is contributing to this work including reviewing and revising inclusive recruitment training for appointing managers and development of a consistent representative recruitment panel approach by March 2024.

- **Bullying and Harassment –** continue our Trust wide civility and respect and reducing violence and aggression programmes of work. The EDI team is contributing to this collective work and is leading a focus on hate crime in collaboration with our staff networks to develop

a consistent approach and process to support staff, managers and wider teams by March 2024.

- **Reciprocal mentoring (RM) –** deliver and evaluate our second RM programme and development of a proposed future ongoing Trust-wide model by September 2023. A task group has been established to inform the future model with focus on equality groups within nursing and AHP professions, including our international recruits. The impact will be evaluated relating to both workplace culture and people engagement, central to Our People Plan ambitions.

4. Governance and Assurance

Details of our WRES and WDES summary data and progress against the action areas detailed within this paper will be shared through our staff networks and reported via the Board. Our WRES and WDES data and action plan progress will be published in line with reporting requirements via our website, in September 2023.The data will be shared with several groups, such as the Equality, Diversity and Inclusion, Civility and Respect and Strategic Resourcing, to ensure that this data feeds into their planning process for improvements.

5. Gender Pay Gap 2022-2023

The Gender gap report for 2022-23 was submitted in March 2023 and is reported on the Trust website. Our next report for 2023-2024 is due in March 2024. Details are as in the tables below, with a comparison over the past five years (please note 2020 was not reported due to covid).

The median gender pay gap figure is the difference between the hourly pay of the median man and the hourly pay of the median woman. The median for each is the man or woman who is in the middle of a list of hourly pay ordered from highest to lowest paid. Whereas the mean (average) gender pay gap figure uses hourly pay of all employees to calculate the difference between the mean hourly pay of men, and the mean hourly pay of women. Please see the Trust's figures in the tables below.

Results	2018	2019	2021	2022	2023
Average Gender Pay Gap- MEAN	11.3%	11.5%	11.4%	10.9%	10.3%
Average Gender Pay Gap- MEDIAN	2.4%	4.4%	5.9%	5.3%	3.1%

Table 1 - Average Gender Pay Gap

As identified in the table, in 2023 women earn 97p for every £1 that men earn when comparing median hourly pay, resulting in women's median hourly pay being 3.1% lower than men. When comparing mean (average) hourly pay, women's mean hourly pay is 10.3% lower than men.

Results	2018	2019	2021	2022	2023
Average Bonus Gender Pay Gap-MEAN	83.3%	5.5%	33.0%	20.3%	15.7%
Average Bonus Gender Pay Gap-MEDIAN	3.7%	60.2%	66.0%	37.5%	36.8%

Table 2 - Average Bonus Gender Pay Gap

As identified in Table 2, women earn 63p for every £1 that men earn when comparing median bonus pay, resulting in women's median bonus pay being 36.8% lower than men. When comparing mean (average) bonus pay, women's mean bonus pay is 15.7% lower than men. Of those who received bonus pay, the results are 48.5% of women and 51.5% of men.

6. Recommendations

The Board of Directors is asked to:

- Note the 2023 WRES and WDES results and progress against priorities.
- Receive assurance that the WRES and WDES data was submitted in May 2023 in line with revised submission requirements and that actions will be published on the Trust website by the end of September 2023 to meet statutory reporting requirements.
- Note the Gender Pay Gap figures for 2022-2023.

Frances Dodd and Caroline Bamford
Associate Director of People Experience and Head of Equality and Diversity

14 September 2023

Leeds and York Partnership
NHS Foundation Trust

Appendix 1

Workforce Race Equality Standard Data

The first WRES indicator looks at the composition of our workforce (excluding bank) by banding compared with the overall workforce. Currently 21.4% of our workforce (excluding bank) are from an ethnic minority background. An increase of 1.4% when compared to 2022. This is in line with the current 2021 Census figures for Leeds which identifies that 21% of the population are from an ethnic minority background.

Ethnic minority representation has increased to 56% within our bank workforce.

WRES theme/Question	Staff Group	Reporting Period 2021-2022	Reporting Period 2022-2023	Benchmark 2022	Key Findings
Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BAME staff.	White/BAME	2.18	1.46	1.81	The probability of ethnically diverse applicants being appointed following shortlisting has increased. For 2022, white applicants were more than twice as likely to be appointed and this figure has reduced to 1.46 times more likely.
Relative likelihood of BAME staff entering the formal disciplinary process compared to White staff.	White/BAME	0.33	0.32	1.02	The probability of ethnically diverse staff entering the formal disciplinary process has again decreased this year to 0.32 times less likely than white staff.
Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BAME staff.	White/BAME	0.83	0.93	1.09	During 2022/23, 45.5% of ethnically diverse staff accessed training or CPD. Compared to 42% of white staff.

WRES Theme /Question	Staff Group	Staff Survey 2021	Staff Survey 2022	Benchmark	Key Findings
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months.	White	26%	26%	26%	Positive 2% reduction in the percentage of ethnically diverse staff experiencing bullying, harassment, and abuse (B&H) by service users, their families, or the public. Although a positive reduction this figure is 4.5% above our benchmark group.
	BAME	38%	36%	31.5%	
WRES Theme /Question	Staff Group	Staff Survey 2021	Staff Survey 2022	Benchmark	Key Findings
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White	17%	16%	17%	A positive slight (0.5%) decrease in ethnically diverse staff reporting experiencing bullying and harassment from staff.
	BAME	23%	22.5%	23%	
Percentage of staff believing that trust provides equal opportunities for career progression or promotion.	White	59%	62%	61%	42% of our ethnic minority colleagues are reporting a less positive experience of career progression or promotion, in comparison to white colleagues. This is 8% below the national benchmark score of 50%.
	BAME	43%	42%	50%	
Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months.	White	6%	5%	6%	Positive 1% reduction in the percentage of ethnically diverse staff experiencing discrimination at work from a manager or team leader.
	BAME	14%	12%	14%	

Workforce Disability Equality Standard Data

Workforce Representation

The first WDES indicator looks at the composition of our workforce (excluding bank) by banding compared with the overall workforce. Currently 7.5% of our workforce (excluding bank) have declared a disability or long-term health condition, an increase of 1.3% compared to 2022. This is 3.8% above the currently available national 2021 WDES benchmark figure at 3.7%.

WDES theme/Question	Staff Group	Reporting Period 2022-2023	Reporting Period 2022-2023	Benchmark 2022	Key Findings
Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting.	Disabled	0.72	0.87	1.11	Probability of being appointed from shortlisting is 0.87 times higher for disabled applicants.
Relative likelihood of Disabled staff entering the formal capability process compared to non-Disabled staff.	Disabled	13.5	0	1.94	During 2022/23 no disabled or non-disabled staff entered the formal capability process on the grounds of performance.
WDES theme/Question	Long Term Condition or illness	Staff Survey 2021	Staff Survey 2022	Benchmark	Key Findings
Percentage experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months.	With	31%	31%	32%	There was a favourable slight (0.3%) decrease in the percentage of disabled staff experiencing bullying or harassment from patients, relatives, or the public.
	Without	26%	26%	25%	
Percentage experiencing harassment, bullying or abuse from manager in last 12 months.	With	12%	10%	12%	Favourable 2% decline in bullying, harassment, and abuse (B&H) from managers towards our staff with a disability or long-term health condition.
	Without	7%	5%	7%	
Percentage experiencing harassment, bullying or abuse	With	22%	20%	19%	Favourable 2% decline in bullying, harassment, and abuse (B&H) from other

from other colleagues in last 12 months.	Without	11%	11%	12%	colleagues towards our staff with a disability or long-term health condition.
Percentage saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	With	67%	60%	60%	A negative 7% decrease in the percentage of disabled staff who said that they had reported harassment and bullying the last time they had experienced it.
	Without	61%	65%	60%	
WDES theme/Question	Long Term Condition or illness	Staff Survey 2021	Staff Survey 2022	Benchmark	Key Findings
Percentage believe that their organisation provides equal opportunities for career progression or promotion.	With	50%	57%	56%	A positive 7% increase in the percentage of disabled staff who reported believing that our trust provides equal opportunities for career progression.
	Without	59%	60%	61.5%	
Percentage felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	With	17%	16%	19%	A positive 1% reduction in the percentage of disabled staff reporting feeling pressure to come to work when not feeling well enough. This is positively 3% below the benchmark of 19%.
	Without	12%	10%	13%	
Percentage satisfied with the extent to which their organisation values their work.	With	42%	50%	44%	Favourable 8% increase in the percentage of disabled staff reporting satisfaction with the extent our trust values their work. This is 6% above the national benchmark figure of 44%.
	Without	54%	55%	53%	
Percentage with a long-lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to conduct their work	With	81%	83.5%	79%	83.5% of disabled staff reported that the trust had made reasonable adjusts. This is favourably 4.5% above the benchmark.
Staff engagement score.	With	6.8	6.8	6.7	The engagement score for disabled staff remains at 6.8. This is positively above the disabled staff national benchmark score of 6.7.
	Without	7.1	7.1	7.2	
	Trust	7.2	7.0	7.0	

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:	NHS England (NHSE) provider Self-Assessment Report (SAR), Reporting Period: 2022/23
DATE OF MEETING:	28 September 2023
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 22/23, which now covers the following:

Section 1. This section asks you to provide details of (up to) 3 challenges within education and training that you would like to share with us.

Section 2. This section asks you to provide details of (up to) 3 achievements or good practice within education and training that you would like to share with us.

Section 3. This section asks you to confirm your compliance with the contractual key performance indicators of the NHS Education Contract. This should be completed once on behalf of the whole organisation.

Please note for section 3, we are sharing the following areas of non-compliance with the KPI's

Question 14
Has the Provider submitted a bi-annual return on their progress with the conditions of this contract, the contents of which are satisfactory to HEE?

Medical Response – We have not been asked to as MLE is yearly. Happy to do so if a return is sent.

Other professions response – We have not been asked to submit a bi-annual return, happy

to do so if a return is sent

Question 17
Have Programme specific widening participation plans been provided?

Medical Response – we are not sure where this fits within the SAR however we do have a MWRES, IMG lead, F3 lead, clinical attaché lead and educational SAS scheme – details of all their roles that widens participation into psychiatry training can be given if requested.

Section 4. This section asks you to confirm your compliance with the quality, library, reporting concerns and patient safety training contractual key performance indicators of the NHS Education Contract. This should be completed once on behalf of the whole organisation**.** It is important that those responsible for these areas are able to feed into this section.

Section 5. This section asks about your policies and processes in relation to equality, diversity and inclusion and should normally be completed by your nominated placement provider EDI lead.

Section 6 - 11. These sections ask you to self-assess your compliance against the Education Quality Framework and standards. Each section must be completed once on behalf of the whole organisation.

There is an opportunity to share examples of good practice. You are asked to confirm whether you meet the standard for all professions / learner groups, or provide further details where you do not meet or partially meet the standard (s). Where you are reporting exceptions you are asked to provide the professions impacted and a summary of the challenges you face in meeting the standard.

Section 12. Final sign-off.

The template attached is the online version provided by NHSE and will be copied directly onto the online portal.

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 Darren Skinner, Director of People and OD.

For Board information only – the education contract is as follows:-

22/23 Total LDA £9,183k
22/23 salaries for doctors in training £1,964k
22/23 medical placement fees £1,086k
22/23 non medical placement tariff £505k
NHE expect the Trust's Board to approve the SAR ready for submission before the deadline of 31st October 2023 via the online portal.

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 NHSE

NHS England Self-Assessment for Placement Providers 2023

1. The Placement Provider Self-Assessment Tool

Introduction

The Placement Provider 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 to provide comments to support your answer.

Completing the SA

This year the self-assessment **saves your progress at the end of each page - please use the save and next page button**. You can come back and amend or change your responses at any time prior to completing the final submission box in section 12 (just remember to save at the end of the page for any changes you make). Anyone completing any part of this self-assessment can do so using the same link, supplied to you by your regional NHS England WT&E quality team. **Please note only one person should use the link at any one time (you must close the web link in order for someone else to access the survey questions) this will avoid overwriting previous entries.**

Your region and trust name has been pre populated - **please do not amend this.**

You can print a copy of the self-assessment (on the last page, please skip through to the end and use the print button) at any time prior to and after submission. Please note that only questions with responses will print.

To support a flexible approach to completing the SA, you can move freely around the SA without being forced to complete questions or sections prior to moving to another section (**just remember to save each update at the end of each section, even if you only partially complete a section**). All sections are however mandatory so it is important that you undertake a final check that every question has been completed prior to submission. In the event that a question or section has not been answered after submission, the SA will be returned to you for completion.

Where free text comments are available the word or character limits are shown within each question.

The SA does not support the upload of attachments, in the event that we require any evidence as part of your submission we will contact you separately after submission.
This submission should be completed for the whole organisation, it is therefore important that those responsible for each section are able to feed into and contribute to the response.

The sections of the SA

Section 1. This section asks you to provide details of (up to) 3 challenges within education and

training that you would like to share with us.

Section 2. This section asks you to provide details of (up to) 3 achievements or good practice within education and training that you would like to share with us.

Section 3. This section asks you to confirm your compliance with the contractual key performance indicators of the NHS Education Contract. This **should be completed once on behalf of the whole organisation.**

Section 4. This section asks you to confirm your compliance with the quality, library, reporting concerns and patient safety training contractual key performance indicators of the NHS Education Contract. **This should be completed once on behalf of the whole organisation**. It is important that those responsible for these areas are able to feed into this section.

Section 5. This section asks about your policies and processes in relation to equality, diversity and inclusion and should **normally be completed by your nominated placement provider EDI lead.**

Section 6 - 11. These sections ask you to self-assess your compliance against the Education Quality Framework and standards. Each section must be completed once on behalf of the whole organisation.

There is an opportunity to share examples of good practice. You are asked to confirm whether you meet the standard for all professions / learner groups, or provide further details where you do not meet or partially meet the standard (s). Where you are reporting exceptions you are asked to provide the professions impacted and a summary of the challenges you face in meeting the standard.

Section 12. Final sign-off.

Further Questions
If you have any queries regarding the completion of the SA, please review the FAQ document. If you still require further information, you can contact your regional NHS England WT&E quality team.

Question 2 – 9 Region and Provider Selection

Please do not amend the region you have been allocated to. If you feel this is incorrect please continue to complete the SA and email your regional NHS England WT&E quality team. *

10. Training profession selection

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

Please select from the list below those professional groups your organisation currently train, please select all those which apply. Please select only one option for each row.

	Yes we train in this professional group	N/A we do NOT train in this professional group
Advanced Clinical Practice	x	☐
Allied Health Professionals	x	☐
Dental	☐	X
Healthcare Science	☐	X
Medical Associate Professions	☐	X
Medicine Postgraduate	X	☐
Medicine Undergraduate	X	☐
Midwifery	☐	X
Nursing	x	☐
Paramedicine	X	
Pharmacy	X	☐
Psychological Professions	x	☐

11. Section 1 - Provider challenges

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks you to provide details of (up to) 3 challenges within education and training that you would like to share with us. Please consider whether there are any challenges which impact your ability to meet the education quality framework standards. Please select the category which best describes the challenge you are facing, along with a brief description/narrative of the challenge (*the character limit is set at 1000 characters*). In the event you cannot find an appropriate category select other and add the category at the start of your narrative.

Example 1:

Please provide your narrative in the comments box

Availability of PS/PA registered to support learners on placement. The PLDT is addressing this by promoting the LEAP training and updating the PARE register. The PLDT are also addressing how staff ‘self-declare’ they are competent to support our learners to a high standard.

Example 2:

Please provide your narrative in the comments box

Improving Foundation Programme psychiatry experience is a key challenge for LYPFT this year. The NTS feedback from FP is poor and out of keeping with longstanding positive feedback from all other medical training grades. It is predominantly linked to dissatisfaction with induction, educational supervision, out of hours work and adequate core placement experience. FP year 1 undertake out of hours rotas in the acute trust. Prior to NTS results, locally we identified that they are missing increasing amount of core psychiatry placement due to being on call and post on call at the acute trust and taking leave only in non on call times. An action plan to improve induction, educational supervision and reduce impact of out of hours rotas on psychiatry experience is underway and has been sent to the quality team. This will be reviewed at the next MLE.

Example 3:

Please provide your narrative in the comments box

Challenges regarding funding for education pathways such as Apprenticeships. We have many staff who are interested in apprenticeships such as the trainee nursing associates, transfer to nursing, OT apprenticeships, but unfortunately, we are only able to support a few of these due to the salary costs whilst training and need to be able to back fill them to ensure safe staffing levels are maintained. No funding is currently available to support back-fill costs.

12. Section 2 - Provider achievements and good practice

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks you to provide details of (up to) 3 achievements within education and training that you would like to share with us. Please select the category which best describes the achievement you wish to share, along with a brief description/narrative (*the word limit is set at 1000 characters*). In the event you cannot find an appropriate category select other and add the category at the start of your narrative.

Example 1:

Please provide your narrative in the comments box

Virtual placements have been run again by the PLDT. These have had a hugely positive response from participants who were multi-professional. Learners interestingly reported the virtual placement encouraged teamwork skills and coherence which they had not necessarily experienced before. The placement offers a chance to develop decision making and leadership skills in a safe environment. The virtual placement also adds capacity to the placement circuit. Feedback supported the benefits of having a multi-professional working placement and the value of the learning achieved as a whole.

Example 2:

Please provide your narrative in the comments box

5 years ago, the Trust decided to self-fund 2 x core training posts in psychiatry to enable trust funded academic clinical fellows (ACF) to reinstate an academic psychiatry pathway in West Yorkshire. With close working with the University of Leeds, the Trust now hosts 5 ACF's annually, 2 of which are now fully NHIR funded. The first of our ACF to move into ST4 general adult psychiatry has just had the PhD application accepted. The same ACF has also been nominated and received Yorkshire School of Psychiatry Core Trainee of the Year 2022.

Example 3:

Please provide your narrative in the comments box

The PLDT facilitate a number of different clinics/forums/ initiatives for our substantive staff as well as learners in the trust. We have a fortnightly online learners' forum for all leaners, a fortnightly face to face drop-in clinic, monthly and quarterly forums specific to Health Support Workers and Associates as well as on-line and face to face forums to support staff and education leads with their needs in supporting learners. The PLDT have developed a buddy system for trainee nursing associates which encourages peer to peer support for TNAs within the trust as well. These all promote the value we place on supporting learners and colleagues at LYPFT.

13. Section 3 - Contracting and the NHS Education Contract

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks you to confirm your compliance with the contractual key performance indicators of the NHS Education Contract (2021-24). This should be completed once on behalf of the whole organisation. Please select only one option for each row. There is an option to provide additional comments to support your answer, this is restricted to 2000 characters.

Please confirm your compliance with the contractual key performance indicators of the NHS Education Contract.
This should be completed once on behalf of the whole organisation. Please select only one option for each row.

	Yes	No
There is board level engagement for education and training at this organisation.	x	☐
The funding provided via the education contract to	x	☐

	Yes	No
support and deliver education and training is used explicitly for this purpose.		
We undertake activity in the Education Contract which is being delivered through a third party provider	☐	X
We have NOT reported any breaches in relation to the requirements of the NHS Education Contract for any sub-contractor	x	☐
We are fully compliant with all education and training data requests	x	☐
There have been NO health and safety breaches that involve a student, trainee or learner	x	☐
We continue to engage with the ICS for system learning	x	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

There is board level engagement for education and training at this organisation.

Director of HR oversees education and training engagement and enables DME and PDLT to discuss via governance structure. DME and Director of nursing attend Trust wide clinical governance chaired monthly by medical director and ensure multi- professional education at heart of all services and patient safety.

The funding provided via the education contract to support and deliver education and training is used explicitly for this purpose.

The DME oversees and quality assures all undergraduate and postgraduate medical education budgets with named lead in finance.

We undertake activity in the Education Contract which is being delivered through a third party provider

All medical education activity is undertaken in house or at the MRCPsych course delivered as a collaboration with LYPFT, West ICS and University of Leeds.

The SLT has agreed that any inhouse teaching that the Trust estates cannot accommodate will be provided off site and from September 3 x year, a whole medical CPD event for all grades F2F will be held off site as a hybrid option to online weekly teaching requested by following covid recovery focus groups.

We continue to engage with the ICS for system learning

Six monthly the Trust's Andrew Sims Education centre hosts the West ICS Trainee Engagement forum, trainee led and attended by the West ICS mental health Trusts MD, CEO, HR and DME's

LYPFT are not compliant with the following KPI's

Question 14
Has the Provider submitted a bi-annual return on their progress with the conditions of this contract, the contents of which are satisfactory to HEE?

Medical Response – We have not been asked to as MLE is yearly. Happy to do so if a return is sent.

Other professions response – We have not been asked to submit a bi-annual return, happy to do so if a return is sent

Question 17
Have Programme specific widening participation plans been provided?

Medical Response – we are not sure where this fits within the SAR however we do have a MWRES, IMG lead, F3 lead, clinical attaché lead and educational SAS scheme – details of all their roles that widens participation into psychiatry training can be given if requested.

All other professions response – The widening participation plans have been evidenced in the SAR would include the following
Educational Leads, Educational Lead Forums, Learners Forums, Practice Learning and Development Leads for nurse/NA, AHPs, SW, Psychology. Link with NHS England through LEAP and Faculty, through this work provide support for regional educational provision. Undertake PARE audits of placement settings'. In addition, have suggested to add that Trust staff have opportunities to take part in HEI selection event. There are reasonable adjustments plans in liaison with HEI's and supporting HSW's to apply for TNA, or AHP apprenticeship courses.

Signature

X I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Dr Sharon Nightingale, Director of Medical Education Sharon.nightingale@nhs.net

Adam Maher, Practice Learning & Development Team Manager adam.maher@nhs.net

14. Section 4 - Education Quality

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks you to confirm your compliance with the quality, library, reporting concerns and patient safety training contractual key performance indicators of the NHS Education Contract.

This should be completed once on behalf of the whole organisation. It is important that those responsible for these areas are able to feed into this section. There is an option to provide additional comments to support your answer, this is restricted to 1000 characters.

Can you confirm as a provider that you...
Please select only one option for each row.

	Yes	No	N/A
Are aware of the requirements and process for an education quality intervention, including who is required to attend and how to escalate issues.	X	☐	☐
Have 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	☐
Have a Freedom to Speak Up Guardian and they actively promote the process for raising concerns through them to their learners	X	☐	☐
Have a Guardian of Safe Working (if postgraduate doctors in training are being trained), and they actively promote the process for raising concerns through them to their learners	X	☐	☐

If ‘yes’ please add comments to support your answer; if ‘no’ please provide further detail:

Placement quality for learners is monitored via PARE (placement assessment record and evaluation) system where learners gather information on placement settings, evaluate placements, also audits of placements are undertaken every two years in collaboration with HEIs. Ongoing support is provided by HEIs and the Practice Learning and Development Team (PLDT) for learners and educators/supervisors/assessors. Learner reflective forum in place, offering peer support and additional contact with PLDT. Library service available online accessed via intranet (Staff net) and onsite at The Mount Hospital. Reporting concerns whilst on placement at LYPFT is introduced to learners at placement preparation workshops at their university, through induction when attending settings, via Staff net and through conversation with their educator/supervisor/assessor and local team including manager, speak up guardians can

also be accessed as required to raise concerns. Learners coming to LYPFT are required to complete mandatory training including manual handling, if relevant training required b y LYPFT is not fulfilled by the professional course university then this is provided by LYPFT, for Break Away training for Speech and Language Therapy students. Learners are included in incident debriefs, when they directly affected, and offered well-being support and opportunity to contributed to lessons learnt. Equality, Diversity, and Inclusion is integral to practice and the experience as a learner, at LYPFT learners have access to training and information about all support services such as WREN, DAWN and Rainbow Alliance.

LYPFT regularly supports and attends the MLE meetings and had a recent successful SLE with no requirements for quality interventions.

DME regularly attends the monthly deanery/DME meetings.

LYPFT have not developed a SIP to ensure progression through the quality and improvement outcomes framework for the NHS but would be keen to receive feedback and examples of this from other organisations. Quality and Improvement outcomes are a standing agenda item on quarterly TMEC and have lead consultant for this area. DME is also a key member of Trust Wide Clinical Governance to ensure any service changes do not impact on quality and ability to train the future workforce.

GoSW is Dr Rebecca Asquith who replaced Dr Ben Alderson on 1st May 2023.

As an organisation, have you been referred to a regulator for education and training concerns in the last 12 months (with or without conditions) (e.g., GMC, GDC, HCPC, NMC, etc)
Note: we are not seeking information about the referral of an individual learner.

X **We have not** been referred to a regulator

☐ **We have** been referred to a regulator and the details are shared below.

Did you actively promote the National Education and Training survey (NETS) to all healthcare learners?

X Yes

☐ No

Please briefly describe your process for encouraging responses; including your organisations response rate (for the 2022 NETS) and your plans to improve this for the next NETS:

PLD Team manager actively emails education leads and learners to encourage responses, will also high light the NETs survey during PLDT clinics with learners and orientation days.

DME repeatedly actively emails all junior doctors and trainers to encourage responses and gives examples of learning and improvements that have taken place by completing the survey.

Have you reviewed and where appropriate taken action on the outcome of the results of the National Education and Training Survey (NETS)

X Yes

☐ No

Please provide a brief description of the action you have taken as a result; if 'no' please provide further details including your plans to use the NETS data for quality improvement activity in the future:

NETS is discussed at Trust Medical Education Committee and any action taken for improvement as required. The next TME is in September when the results of the recent NTS will be reviewed and an action plan reviewed and/or agreed around the areas of FP, internal teaching programme and induction.

Patient Safety and the promotion of a Patient Safety culture is integral to the Education Quality Framework. Please provide the following information:

Name and email address of your Board representative for Patient Safety	Nichola Sanderson Nichola.sanderson@nhs.net
Name and email address of your non executive director representative for Patient Safety	Dr Frances Healey frances.healey@nhs.net
Name and email address of your Patient Safety Specialist/s	Alison Quarry- alison.quarry@nhs.net Catherine Wardle catherine.wardle@nhs.net Lisa Dempster lisa.dempster1@nhs.net Sam Marshall Samantha.marshall1@nhs.net Miriam Blackburn Miriam.blackburn@nhs.net
What percentage of your staff have completed the	93%

patient safety training for level 1 within the organisation (%)

Signature

X I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Dr Sharon Nightingale, Director of Medical Education Sharon.nightingale@nhs.net

Adam Maher, Practice Learning & Development Team Manager adam.maher@nhs.net

15. Section 5 - Equality, Diversity and Inclusion

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks about your policies and processes in relation to equality, diversity and inclusion and should normally be completed by your nominated EDI lead. There is an option to provide additional comments to support your answer, this is restricted to 1000 characters.

Please confirm whether your organisation has an Equality, Diversity and Inclusion Lead (or equivalent):

X Yes

☐ No

If 'yes' please add comments to support your answer sharing details of governance and links with education and training alongside the nominated name of your EDI lead for education and training; if 'no' please provide further detail

The PLDT plays an important role in ensuring that learning environments promotes equality, diversity and are inclusive and that each learner is treated fairly with dignity and respect and enabled to give their best. PLDT host an orientation event where learners are made aware of the Trusts Freedom to Speak up Guardian and encouraged to use 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. The PLDT has developed strong links with HEIs, and this has led to a much higher awareness of student/learner wellbeing.

The PLDT works in collaboration with placement areas and HEIs to assess the needs of learners and provide reasonable adjustments to minimise disadvantages for learners with disabilities. An example of this is good practice is when the PLDT have supported an inclusive placement for an out of area learner who identifies as profoundly deaf and is non-verbal. PLDT and the clinical service carried out a lot of preparatory work to determine the support that the learner and their interpreter would need and comprehensively assessed risk within the learning environment. The

learner was able to attend and successfully complete their placement with supportive systems in place, such as having access to rotas in advance to ensure interpreter availability, facilitating supervision to the interpreter. The learner was subsequently supported by the PLDT to share their story as an example of best practice at a Clinical Educator Network meeting. There are also examples of placement areas which are developing good practice such as creating easy read placement documents and assessments to support neurodivergent learners.

The PLDT supports the ethos of ensuring that equality, diversity and inclusion is respected not only amongst the workforce but also for our service users. An example of this is the teaching and learning done with learners on virtual placement hosted by the PLDT, where learners are given scenarios where they discuss and formulate plans for a range of service users some of whom have protected characteristics ensuring their rights are respected.

Dr K Shaik is Medical WRES and IMG lead. She provides a West Yorkshire wide IMG for core and higher trainees in psychiatry.

Please confirm that you liaise with your Equality, Diversity and Inclusion Lead (or equivalent) to...
Please select only one option for each row.

	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	☐
Ensure International Graduates (including International Medical Graduates) receive a specific induction into your organisation?	X	☐
Ensure policies and processes are in place to manage with discriminatory behaviour from patients?	X	☐
Ensure a policy is in place to manage Sexual Harassment in the Workplace?	X	☐

If ‘yes’ please add comments to support your answer; if ‘no’ please provide further detail:

IMG induction programme can be supplied. Award winning and now rolled out to all West ICS psychiatry IMGs

All junior doctor managed by DPGME- operational lead with expert knowledge of MHPS, GMC GMP, NHSe exception reporting and Trust's wellbeing and attendance policy.

Postgraduate Deans and their teams are keen to consider responses and initiatives and share good practice. Please share details on EDI initiatives that are specific to or have an impact on education and training in your organisation and the email address for someone we can contact to discuss this further.

Sharon.nightingale@nhs.net - Director of Medical Education

For education and training, what are the main successes for EDI in your organisation?

The Trust has well established staff networks WREN, DaWN and Rainbow Alliance and further areas linked to health and wellbeing from an EDI perspective. For example, the wellbeing pathway process and offer, a holistic approach to support wellbeing including Leeds Recovery College, our networks, menopause support and Critical Incident support.

IMG induction

MWRES lead

New starter buddying system

Single line manager for all junior doctors employed by LYPFT

DME runs a clinical interview skills and formative assessment of communication skills course for all CT1's in psychiatry across West, East and North Yorkshire. This enables early identification of those trainees needing additional support with communication skills via enhanced supervision and mentoring.

Lead medical tutor for clinical attaches seeking FP competencies to apply to CT in psychiatry and also F3's considering psychiatry as a career.

For education and training, what are the main challenges for EDI in your organisation?

Still discrepancy in IMG pass rates for MRCPsych examinations versus British graduates- LYPFT working with School of Psychiatry and RCPsych to keep improving equity.

Signature

X I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Dr Sharon Nightingale, Director of Medical Education Sharon.nightingale@nhs.net
Adam Maher, Practice Learning & Development Team Manager adam.maher@nhs.net
Caroline Bamford, Head of Diversity and Inclusion caroline.bamford@nhs.net

16. Section 6 - Assurance Reporting: learning environment and culture

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 2000 characters per text box. **This section should be completed once on behalf of the whole organisation,** however it is important that those responsible for these areas are able to feed into this section.

Thinking about the learning environment and culture of your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

The organisational culture is inclusive of learners of all cultural backgrounds and encourages individuality as a positive way to engage the demographic of service users we support and bring a richness of experience to the professionals within our services. Coaching underpins the ethos of development within the organisation, promoting reflection to inform continuing professional development, constructive feedback is encouraged for learners, those who support them and the service users/carers they support. Feedback is sought regularly. Communication is a key part of clinical culture, whilst adhering to confidentiality, this enables the safety of all and is compassionate to service users, carers and staff including learners. Freedom to speak up is actively supported and promoted. Learners are encouraged to undertake roles in service development and quality assurance work, this engages them as member of the team and wider organisation and bring valuable insights to inform care. They are encouraged to as curious questions and be involved in debriefs to learn from experiences whilst in clinical settings. There are educational settings such as the library service that can aid learning and research for

learners on placement and additional training which can be accessed via Staff net and other organisational and external opportunities.

Virtual Placement: development to offer hours of practice to Pre-registration Mental Health Nurse, two weeks online with clinical area and service user case studies to inform a team approach to care. Educational workshops to inform knowledge and care plans for case studies. Recently offered to Occupational Therapy students who were on placement at LYPFT whilst Virtual placement running, offered valuable experience for all learners to understand different professional roles and work together. Plan to expand offer to other Allied Health Professionals, Psychology and Social Work learners.

For medical

- Monthly junior doctor meeting with DME and operational lead to proactively address any workplace or educational challenges. This has kept Exception report to GoSW to exceptional low and reduced time needed in JDF for 'concerns' discussions. This along with West ICS Trainee enhancement forum has maintained high morale and sense of feeling valued in the junior doctor workforce.
- Consultant lead for 'FY3' trust doctors to enable application to core training in psychiatry.
- Interprofessional learning programme for student nurses and medical students – programme can be supplied as required.
- Multiple areas of multi-professional bite sized teaching programmes delivered by the junior doctors to the MDT- examples of timetables can be supplied.
- CIP team rolling teaching programme for junior doctors- programme can be supplied as needed.
- Career ladder in medical education from core trainee undergraduate tutor, Higher trainee lead in medical education management team, SAS tutor through to consultant undergraduate and postgraduate named tutors. All roles are job planned with protective time.
- Balint groups for undergraduate and postgraduate doctors with protected time
- Contact Sharon.nightingale@nhs.net - Director of Medical Education to discuss any of above

Quality Framework Domain 1 - Learning environment and culture
Please select only one option for each row.

	We meet the standard for all professions / learner groups	**We have exceptions to report** and provided narrative below
The learning environment is one in which education and training is valued and championed.	X	☐
The learning environment is inclusive and supportive for learners of all backgrounds and from all professional groups.	X	☐
The organisational culture is one in which all staff, including learners, are	X	☐

	We meet the standard for all professions / learner groups	**We have exceptions to report** and provided narrative below
treated fairly, with equity, consistency, dignity and respect.		
There is a culture of continuous learning, where giving and receiving constructive feedback is encouraged and routine.	X	☐
Learners are in an environment that delivers safe, effective, compassionate care and prioritises a positive experience for patients and service users.	X	☐
The environment is one that ensures the safety of all staff, including learners on placement.	X	☐
All staff, including learners, are able to speak up if they have any concerns, without fear of negative consequences.	X	☐
The environment is sensitive to both the diversity of learners and the population the organisation serves.	X	☐
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.	X	☐
There are opportunities to learn constructively from the experience and outcomes of patients and service users, whether positive or negative.	X	☐
The learning environment provides suitable educational facilities for both learners and supervisors, including space and IT facilities, and access to library and	X	☐

	We meet the standard for all professions / learner groups	We have exceptions to report and provided narrative below
knowledge services and specialists.		
The learning environment promotes multi-professional learning opportunities.	X	☐
The learning environment encourages learners to be proactive and take a lead in accessing learning opportunities and take responsibility for their own learning.	X	☐

Areas of exception
Please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

- ☐ **All professions**
- ☐ **Site specific**
- ☐ Advanced Clinical Practice
- ☐ Allied Health Professionals
- X Dental
- X Healthcare Science
- X Medical Associate Professions
- ☐ Medicine Postgraduate
- ☐ Medicine Undergraduate
- X Midwifery
- ☐ Nursing
- ☐ Paramedicine
- ☐ Pharmacy
- ☐ Psychological Professions

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

Professions highlighted not within the Trust

Signature

X I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Dr Sharon Nightingale, Director of Medical Education Sharon.nightingale@nhs.net

Adam Maher, Practice Learning & Development Team Manager adam.maher@nhs.net

17. Section 7 - Assurance Reporting: educational governance and commitment to quality

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether the you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. **This section should be completed once on behalf of the whole organisation,** however it is important that those responsible for these areas are able to feed into this section.

Thinking about the educational governance and commitment to quality of your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you to would like share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Practice Learning and Development Team manager is a key member of the People Talent and OD group, Chairs the Non-Medical Professional Education Committee meeting and attends Recruitment and Retention, assuring education at the heart of patient safety and workforce planning.

DME key member of Trust Wide Clinical Governance and Trust wide People, Talent and OD group assuring education at heart of patient safety and workforce planning.
Sharon.nightingale@nhs.net

Quality Framework Domain 2 - Educational governance and commitment to quality
Please select only one option for each row.

	We meet the standard for all professions / learner groups	**We have exceptions to report** and provided narrative below
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.	X	☐
There is active engagement and ownership of equality, diversity and inclusion in education and training at a senior level.	X	☐
The governance arrangements promote fairness in education and training and challenge discrimination.	X	☐
Education and training issues are fed into, considered and represented at the most senior level of decision making.	X	☐
The provider can demonstrate how educational resources (including financial) are allocated and used.	X	☐
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.	X	☐
There is proactive and collaborative working with	X	☐

	We meet the standard for all professions / learner groups	We have exceptions to report and provided narrative below
other partner and stakeholder organisations to support effective delivery of healthcare education and training and spread good practice. Consideration is given to the potential impact on education and training of service changes (i.e. service re-design / service reconfiguration), taking into account the views of learners, supervisors and key stakeholders (including WT&E and Education Providers).	X	☐

Areas of exception
Please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

- ☐ **All professions**
- ☐ **Site specific**
- ☐ Advanced Clinical Practice
- ☐ Allied Health Professionals
- X Dental
- X Healthcare Science
- X Medical Associate Professions
- ☐ Medicine Postgraduate
- ☐ Medicine Undergraduate
- X Midwifery
- ☐ Nursing
- ☐ Paramedicine
- ☐ Pharmacy
- ☐ Psychological Professions

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

Professions highlighted not within the Trust

Signature

x I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Adam Maher adam.maher@nhs.net Practice Learning and Development Team Manager

Dr Sharon Nightingale, Director of Medical Education Sharon.nightingale@nhs.net

18. Section 8 - Assurance Reporting: developing and supporting learners

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

Thinking about how you develop and support learners within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

The practice learning and development team have created a virtual placement that has been developed since 2021. Within these last 12 months we have created video content with use of actors, developed immersive and interactive tasks and worked closely with learners and Higher Education Institutes to improve the model. Learners supported fictitious service users, updating care plans, safety plans, formulations, and daily case notes whilst able to practice leadership skills, coordinating their teams and delegating tasks in various different practice settings. In April 2023 we integrated occupational therapy learners within the placement with positive effect and impact, to support a multidisciplinary aspect and promote working together to provide care to service users.

The practice learning and development team also created a corporate leadership placement to support capacity and extended opportunities for our learners to see the corporate side of nursing

and professions. This was provided to 2 x 3rd year students in January 2023, and they were blended into a clinical area to ensure clinical skills and practice was still an element of the placement for one or 2 days a week every week of their placement. The rest of the time they supported creation of virtual placement content, attended meetings with team members regarding education and workforce, supporting international nurse and health support worker recruitment inductions and had oversight of the work that comes into the practice learning and development team within the Nursing Professions and Quality Directorate.

For medical

- CT FACS (Formative assessment of Clinical skills) and FOCAS (medical student equivalent) designed and implemented regionally by DME to develop and support clinical interview skills
- MWRES and F3 lead
- Buddying system for new starters
- HT communication skills mentor for CTs- DME/TPDs match and supervise HT's mentoring CT's needing help with developing communication and leadership skills.

Quality Framework Domain 3 - Developing and supporting learners
Please select only one option for each row.

	We meet the standard for all professions / learner groups	**We have exceptions to report** and provided narrative below
There is parity of access to learning opportunities for all learners, with providers making reasonable adjustments where required.	X	☐
The potential for differences in educational attainment is recognised and learners are supported to ensure that any differences do not relate to protected characteristics.	X	☐
Supervision arrangements enable learners in difficulty to be identified and supported at the earliest opportunity.	X	☐
Learners receive clinical supervision appropriate to their level of experience, competence, and confidence, and according to their scope of practice.	X	☐

	We meet the standard for all professions / learner groups	**We have exceptions to report** and provided narrative below
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.	X	☐
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.	X	☐
Learners are valued members of the healthcare teams within which they are placed and enabled to contribute to the work of those teams.	X	☐
Learners receive an appropriate, effective and timely induction and introduction into the clinical learning environment.	X	☐
Learners understand their role and the context of their placement in relation to care pathways, journeys and expected outcomes of patients and service users.	X	☐
Learners are supported, and developed, to undertake supervision responsibilities with more junior staff as appropriate.	X	☐

Areas of exception
Please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

- [ ] **All professions**
- [ ] **Site specific**
- [ ] Advanced Clinical Practice
- [ ] Allied Health Professionals
- X Dental
- X Healthcare Science
- X Medical Associate Professions
- [ ] Medicine Postgraduate
- [ ] Medicine Undergraduate
- X Midwifery
- [ ] Nursing
- [ ] Paramedicine
- [ ] Pharmacy
- [ ] Psychological Professions

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

Professions highlighted not within the Trust

Signature

- [x] I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Sapphire Ackroyd, sapphireackroyd@nhs.net Practice Learning and Development Lead Nurse for Pre-Registration Nursing

19. Section 9 - Assurance reporting: developing and supporting supervisors

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

Thinking about how you develop and support supervisors within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

The practice learning and development team support practice assessors, supervisors, and educators through regularly education lead forums, peer support sessions online, face to face support clinics set up across multiple sites in the trust. The team are available for any ad hoc information or queries during office hours, and we have also spent a lot of time creating a Staffnet page for staff and learners to access useful resources, information, and details of events. The practice learning and development team are also creating self-declaration workshops to further ensure quality of assessment of learners and support to staff members.

DME and/or DPGME meet all new Consultants in LYPFT and provide a medical education induction as a clinical and educational supervisor. This includes discussions on their background in medical education and talent spotting future educationalists.

DME/DPGME delivers in house CPD for educators – this past year multiple sessions on the new curriculum and two full day F2F days on being a clinical and educational supervisor. Course details and feedback can be supplied.

DME delivers clinical and educational supervisors in psychiatry training for the Yorkshire and Humber School of Psychiatry. Returning F2F at the deanery for first time post pandemic December 2023.

Quality Framework Domain 4 - Developing and supporting supervisors
Please select only one option for each row.

	We meet the standard for all professions / learner groups	**We have exceptions to report** and provided narrative below
Formally recognised supervisors are appropriately supported, with allocated time in job plans/ job descriptions, to undertake their roles.	X	☐
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.	X	☐

	We meet the standard for all professions / learner groups	**We have exceptions to report** and provided narrative below
Education Provider, WT&E). Clinical Supervisors understand the scope of practice and expected competence of those they are supervising.	X	☐
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 learners' programmes and career pathways, enhancing their ability to support learners' progression.	X	☐
Clinical supervisors are supported to understand the education, training and any other support needs of their learners.	X	☐
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.	X	☐

Areas of exception
Please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

- ☐ **All professions**
- ☐ **Site specific**
- ☐ Advanced Clinical Practice

- [ ] Allied Health Professionals
- [X] Dental
- [X] Healthcare Science
- [X] Medical Associate Professions
- [ ] Medicine Postgraduate
- [ ] Medicine Undergraduate
- [X] Midwifery
- [ ] Nursing
- [ ] Paramedicine
- [ ] Pharmacy
- [ ] Psychological Professions

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

Professions highlighted not within the Trust

Signature

- [x] I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Sapphire Ackroyd, sapphireackroyd@nhs.net Practice Learning and Development Lead Nurse for Pre-Registration Nursing

20. Section 10 - Assurance reporting: delivering programmes and curricula

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

Thinking about how you deliver programmes and curricula to support training within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

There is a dynamic and well-established Practice Learning and Development Team (PLDT) that actively supports and promotes practice education across the Trust. It is closely involved in the development of curricula and standards to support students, including Nursing, Nursing associate, AHP, Social worker, & psychology.

Psychology has had noticeable success in hosting a training clinic for MSc in Family Therapy and Systemic Practice at University of Leeds. This supports a range of registered professionals to train in psychological expertise and increases the diversification of the psychological professions.

For medical

- Curricula and eportfolio demonstration in Trust induction for new starters in psychiatry.
- MELM (medical education management and leadership team) deliver psychiatry curriculum updates as free inhouse CPD to Trust trainers and delivered two clinical and educational supervisors update CPD days this reporting year- agenda and feedback can be supplied.

Quality Framework Domain 5 - Delivering programmes and curricula
Please select only one option for each row.

	We meet the standard for all professions / learner groups	**We have exceptions to report** and provided narrative below
Practice placements must enable the delivery of relevant parts of curricula and contribute as expected to training programmes.	X	☐
Placement providers work in partnership with programme leads in planning and delivery of curricula and assessments.	X	☐
Placement providers collaborate with professional bodies, curriculum/ programme leads and key stakeholders to help to shape curricula, assessments and programmes to ensure	X	☐

	We meet the standard for all professions / learner groups	**We have exceptions to report** and provided narrative below
their content is responsive to changes in treatments, technologies and care delivery models, as well as a focus on health promotion and disease prevention.		
Placement providers proactively seek to develop new and innovative methods of education delivery, including multi-professional approaches.	X	☐
The involvement of patients and service users, and also learners, in the development of education delivery is encouraged.	X	☐
Timetables, rotas and workload enable learners to attend planned/ timetabled education sessions needed to meet curriculum requirements.	X	☐

Areas of exception
Please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

☐ **All professions**
☐ **Site specific**
☐ Advanced Clinical Practice
☐ Allied Health Professionals
X Dental
X Healthcare Science
X Medical Associate Professions
☐ Medicine Postgraduate
☐ Medicine Undergraduate
X Midwifery
☐ Nursing

- [ ] Paramedicine
- [ ] Pharmacy
- [ ] Psychological Professions

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

Professions highlighted not within the Trust

Signature

X I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Adam Maher adam.maher@nhs.net Practice Learning and Development Team Manager

Dr Sharon Nightingale, Director of Medical Education Sharon.nightingale@nhs.net

21. Section 11 - Assurance reporting: developing a sustainable workforce

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

Thinking about developing a sustainable workforce within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Development of apprenticeship pathway for occupational therapists. This offers routes of progression for existing support workforce. It is built on an equitable trustwide recruitment process.

Succession planning taking place for physiotherapists. Recruitment risk highlighted given the upcoming retirement plans and system wide difficulties in recruiting externally to mental health settings. Consider apprenticeship pathway to train up existing physio support staff.

Proposal in place for contract for OT rotation to be made permanent. It is currently 27 months. Having a permanent contract would be a recruitment and retention tool given current challenges of recruiting to band 5 OT posts.

Reviewing the recruitment process for OT graduates. At present we expect final year students to apply via external adverts. Whereas final year nurses who are on placement with us are offered a more simplified accessible selection process. We are looking to establish a similar pathway for OT students who had their final placement in the organisation. LYPFT are training cognitive behavioural therapist posts where a qualified role is guaranteed at end of qualification in CBT

The organisation has committed to international recruitment of occupational therapists and mental health nurses. This financial year the target is to recruit 5 OTs and 10 mental health nurses. Recruitment consists of both direct NHS adverts and supply through agencies which has been identified and are on the relevant procurement frameworks

For medical

DME and DPGMEs are active members of the Yorkshire School of Psychiatry and Specialist advisory committees at the RCPsych.

DME meets regularly with other mental health Trust DMEs in Yorkshire and Humber region to discussions region wide practice and challenges.

The West ICS mental health Trust Directors meet bi-annually with the trainees to improve patient safety and training at the West Yorkshire Trainee Enhancement Forum.

DME meets quarterly with the University of Leeds Psychiatry leads to enable ACF pathway, R&D and proactively plan challenges such as undergraduate expansions.

DME meets monthly with MD, professional lead and clinical directors to workforce plan and talent spot future consultant candidates.

Trust provides an annual ‘becoming a consultant’ CPD day for all higher trainees in psychiatry country wide.

Trust provides an annual Medical Leadership and Management CPD day for all higher trainees, SAS and Consultants in LYPFT.

Quality Framework Domain 6 - Developing a sustainable workforce
Please select only one option for each row.

	We meet the standard for all professions / learner groups	We have exceptions to report and provided narrative below
Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	X	☐
Does the provider provide opportunities for learners to receive appropriate careers advice from colleagues	X	☐
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.	X	☐
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.	X	☐

Areas of exception
Please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

☐ **All professions**

☐ **Site specific**

Advanced Clinical Practice
Allied Health Professionals
X Dental
X Healthcare Science
X Medical Associate Professions
Medicine Postgraduate
☐ Medicine Undergraduate
X Midwifery

Nursing

☐ Paramedicine

Pharmacy
Psychological Professions

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

Professions highlighted not within the Trust

Signature

X I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Adam Maher adam.maher@nhs.net Practice Learning and Development Team Manager

Dr Sharon Nightingale, Director of Medical Education Sharon.nightingale@nhs.net

22. Section 12 - Final Submission

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

Before completing your final submission please ensure you have:
1. Completed all questions within the Self-Assessment (including the free text sections)
2. Received Board level sign off for your submission

Board level sign-off

☐ I confirm that the responses in this SA have been signed off at board level

Name, email address and role of Board representative for education and training

Darren Skinner, Director of People and OD Darren.skinner3@nhs.net

Please confirm the date that board level sign off was received:

DD/MM/YYYY
28/09/2023

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
14

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Changes to the Matters Reserved to the Board of Directors
DATE OF MEETING:	28 September 2023
PRESENTED BY: (name and title)	Cath Hill, Acting Associate Director for Corporate Governance
PREPARED BY: (name and title)	Cath Hill, Acting Associate Director for Corporate Governance / Andrew Jackson, Resilience Lead and Corporate Business 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 Board is reminded it is required to have a document which sets out those matters that are reserved to itself and those that are delegated to committees or individuals. This is a high-level document which links to other statutory documents (such as the Standing Financial Instructions and the Accounting Officers Memorandum) and its committee's Terms of Reference.

In light of the changes to the way in which NHS England is now governing the requirements for the Trust's arrangements for Emergency Preparedness Resilience and Response (EPRR), there is a need to include a new section with the items which only the Board can now deal with (previously delegated to the Finance and Performance Committee). These are as follows:

6. Emergency Preparedness Resilience and Response (EPRR)	
6.1	Receive and ratify the EP-0005 - Business Continuity and EPRR Policy and Business Continuity Management System Procedure
6.2	Receive and approve the EPRR Annual Report
5.3	Receive and confirm the EPRR assurance declaration annually

	State below 'Yes' or 'No'	If yes please set out what action has been taken to address this in your paper

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**No**	

RECOMMENDATION

The Board is asked to note those items which are now reserved to itself in accordance with the new requirements of NHSE in relation to the EPRR standards and approve the inclusion of these items in Matters Reserved to the Board in a new Section 6.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

14.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	2023-2024 Business Continuity and EPRR Policy statements and the Business Continuity Management System
DATE OF MEETING:	28 September 2023
PRESENTED BY: (name and title)	Joanna Forster Adams, Chief Operating Officer and Accountable Emergency Officer
PREPARED BY: (name and title)	Andrew Jackson, Resilience Lead and Corporate Business 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 attached document is a complete update to the Trust's Business Continuity and EPRR policy along with the Trust's Business Continuity Management System description. Major changes have been required because guidance and suggested content have now been made mandatory compliance items in the 2023 NHS EPRR standards and there is now a formal requirement for this policy documents to be approved in Public Board meetings.

The document is a strategic overview of how the Trust aims to meet NHS England EPRR standards and how it aims to embed best practice around EPRR and business continuity in the Trust's operational processes.

The document has been through a thorough review, consultation and approval process through our normal governance routes. The Emergency Preparedness Resilience and Response (EPRR) Group approved this document on 11 September 2023, it has been reviewed by the Executive Management Team at their September meeting and the Policies and Procedures Group have approved this for upload to Staffnet, subject to Board ratification.

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 attached document has been through a robust governance process prior to being presented to Board
- Consider and ratify the Trust's Business Continuity, EPRR Policy and Business Continuity Management System document, noting the significant changes to the required response and commitment from NHS bodies to new EPRR requirements.

Leeds and York Partnership NHS
NHS Foundation Trust

Business Continuity, EPRR Policy and Business Continuity Management System

The key messages the reader should note about this document are:

1. This document contains Leeds and York Partnership NHs Foundation Trust's EPRR policy and Business Continuity Policy.
2. The document sets out the responsibilities within the organisation for business continuity and EPRR (Emergency Preparedness, Resilience and Response)
3. This document contains the overarching Trust approach to business continuity management via its business continuity management system.
4. The document identifies a requirement for all those who provide services, either to the community or to other Trust functions, to have explicit and effective business continuity arrangements commensurate with the scale of their operation.

This policy/procedure may refer to staff as qualified/registered/professional or other such term to describe their role. These terms have traditionally referred to individuals in a clinical role at band 5 or above. Please note that the use of these terms **may or may not** include nursing associates or associate practitioners (band 4). For clarification on whether a nursing associate or associate practitioner is an appropriate person to take on the identified roles or tasks in this policy/procedure please refer to the job description and job plan for the individual or local risk assessment.

DOCUMENT SUMMARY SHEET
ALL sections of this form must be completed.

Document title	Business Continuity and EPRR Policy
Document Reference Number	EP-0005
Key searchable words	*Business continuity, emergency, incident, response, disruption, contingency, EPRR, emergency planning,*
Executive Team member responsible (title)	Chief Operating Officer
Document author (name and title)	Andrew Jackson, Resilience Lead and Corporate Business Manager
Approved by (Committee/Group)	Board of Directors
Date approved.	TBC
Ratified by	Policy and Procedure Group
Date ratified.	TBC
Review date	30 June 2024
Frequency of review	*Annual*

Amendment detail

Version	Amendment	Reason
2.1	8/5/19: s 1.2.3 P 8 defined the responsibilities of business continuity leads	Recommendation from the 2018 Internal Audit of BC arrangements
	8/5/19 s1.2.3 P9 - clarified that it is a service managers responsibility to ensure their service has adequate BC arrangements	
	8/5/19: Created a new section 1.2.4 on page 9 regarding governance and reporting	To reflect the role of the Operational Delivery Group in care service business continuity planning and the assurance role to both EMT and annually to Board.

	8/5/19: 1.2.10 page 15 Training section revised to reflect status of the leadership in crisis training. The use of training materials at team level and the targeted band 7 training also added.	Requirement to carry out TNAs for all staff was felt unnecessary and too ambitious by care service BC leads and has been changed to more role specific training
	Appendix 3 - revised extensively in light of moving away from a TNA for all staff	National occupational standards inserted and a table or required and recommended training
	Code changed from RM-0030 to EP-0005.	Procedure moved to the Emergency Planning and Business Continuity section on StaffNet.
3	2021 review – learning for training and issues from the Covid debrief.	New impact assessment documentation – designed to simplify this process developed and attached. New approach to training and training needs assessment
4	2022 review in light of full EPRR standards being issued in July 2022 and the introduction of the PHC training programme.	• Minor amendments to title, • Removed template BC plan and BC assessment as any changes to these will mean version in this document is obsolete. • Changed reference to the BC international standard
5	2023 review in light of Internal Audit review June 2023 and the new EPRR assurance Standards compliance items.	• AEO identified as COO. • BCMS enlarged and moved to a separate section. • Separated EPRR policy from Business Continuity policy for clarity. • New governance content reflecting changes to EPRR standards

CONTENTS

1. THE PROCEDURE

1.1 EPRR Policy Statement

Leeds and York Partnership NHS Foundation Trust (the Trust) is fully committed to discharging its role in relation to NHS Emergency Preparedness, Resilience and Response (EPRR) standards. The Trust is also committed to ensuring it meets the requirements of:

- the Health and Social Care Act 2022,
- the NHS Act 2006
- The Civil Contingencies Act 2004 and subsequent Cabinet Office guidance issued under Emergency Planning guidance.
- All other legislation or government Office guidance that refers to Planning for and responding to Emergencies.

The Trust's strategic objectives from the 5-year (2018-2023) Trust strategy and priorities are also acknowledged in terms of EPRR implications below.

Trust Strategic Objective	EPRR implications and supporting action
We deliver great care that is high quality and improves lives.	*Priority 3 Supporting staff to promote and coordinate helpful and purposeful practice.* Training provided by EPRR staff will always put the patient at the centre of a response and plans are patient focussed in terms of thinking about avoidance of impacts on patient care.
We provide a rewarding and supportive, place to work.	*Priority 3 Staff support and health and wellbeing. The EPRR team's focus will be on supporting staff post incident via debriefs and ensuring support is available when required. Exercises will consider the importance of staff wellbeing and support during and after an incident.*
We use our resources to deliver effective and sustainable services.	The EPRR team is involved in working with services in developing business continuity plans that focus on service delivery in a disruption as well as supporting in the adaptation agenda around climate change.

1.1.1 Roles and Responsibilities

Ultimately as Accountable Officer the Chief Executive has responsibility to ensure the organisation can continue to function at appropriate levels following a disruptive event. Under the Health and Social Care Act 2014, the specific responsibility for ensuring arrangements are in place falls to the executive director nominated by the Trust as Accountable Emergency Officer (AEO) who is the Trust's Chief Operating Officer.

This role is non delegable and while another director may assist in attending meetings and other duties the AEO retains accountability and responsibility for the items (I to iv below).

With direct regard to business continuity and EPRR the publication *the role of 'Accountable Emergency Officers' for Emergency Preparedness, Resilience and Response (*NHS England, December 2012*)* specifies that the AEO has responsibility for:

i. Ensuring that the organisation is compliant with the EPRR requirements as set out in the civil contingencies act (2004), the NHS planning framework and the NHS standard contract as applicable.
ii. Ensuring that the organisation is properly prepared and resourced for dealing with a major incident or civil contingency event.
iii. Ensuring their organisation, and any providers they commission, have robust business continuity planning arrangements in place which reflect standards set out in the Framework for Health Services Resilience (PAS 2015) and ISO 22301.
iv. Ensuring the organisation has a robust surge capacity plan that provides an integrated organisational response and that it has been tested with other providers and parties in the local communities served.
v. Additionally, the AEO has the responsibility for ensuring that the EPRR team via the Resilience Lead
    - Report to the Board annually on work done in the year.
    - Prepare an assessment of compliance against NHS England's Assurance standards annually for ultimate Board Approval.
    - Report via the Chief Operating Officers Report to Board and Finance and Performance Committee to every public Board meeting with a section containing EPRR updates.

Operationally, each executive director has responsibility for ensuring and assuring the Accountable Emergency Officer that all services within their portfolio have effective business continuity plans that are tested annually and revised following any issues emerging from testing/ activation.

Other Staff with EPRR responsibilities

- To support the role of the AEO, a non-executive director, currently the Chair of the Trust, will act as EPRR champion.

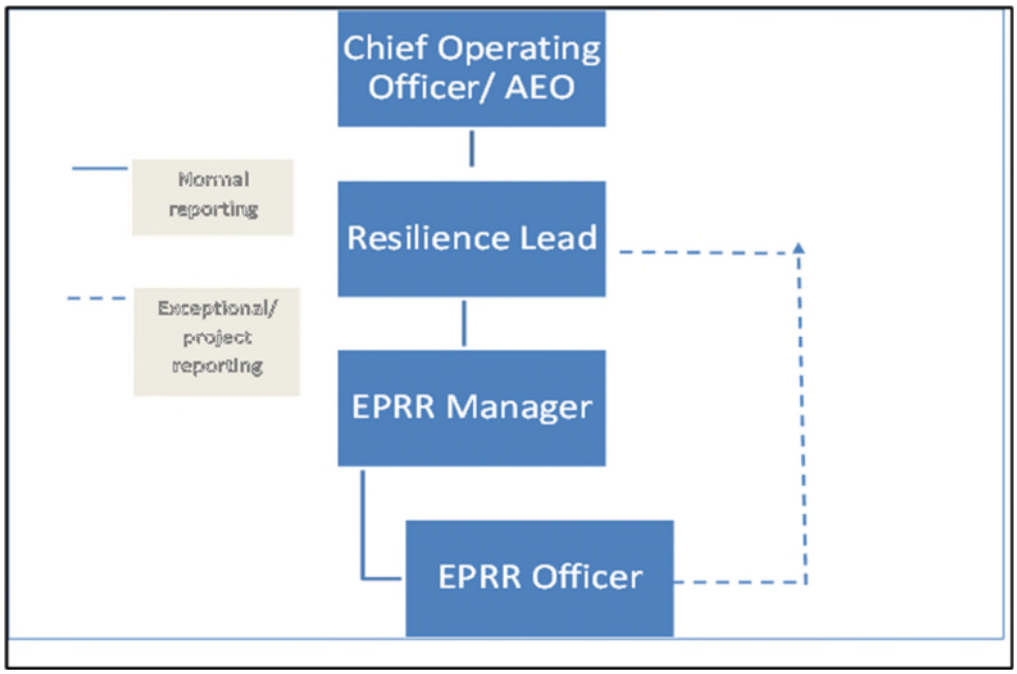
- The Chief Financial Officer/Deputy Chief Executive will provide cover for the AEO if the AEO is unable to fulfil duties due to absence.

- The Resilience Lead provides day to day management of the EPRR team and supports the AEO with technical advice. The Resilience Lead has responsibility for plan maintenance, updates, communication in consultation with the

Corporate Governance tam following successful ratification of plans and policies at the Policies and Procedures group.

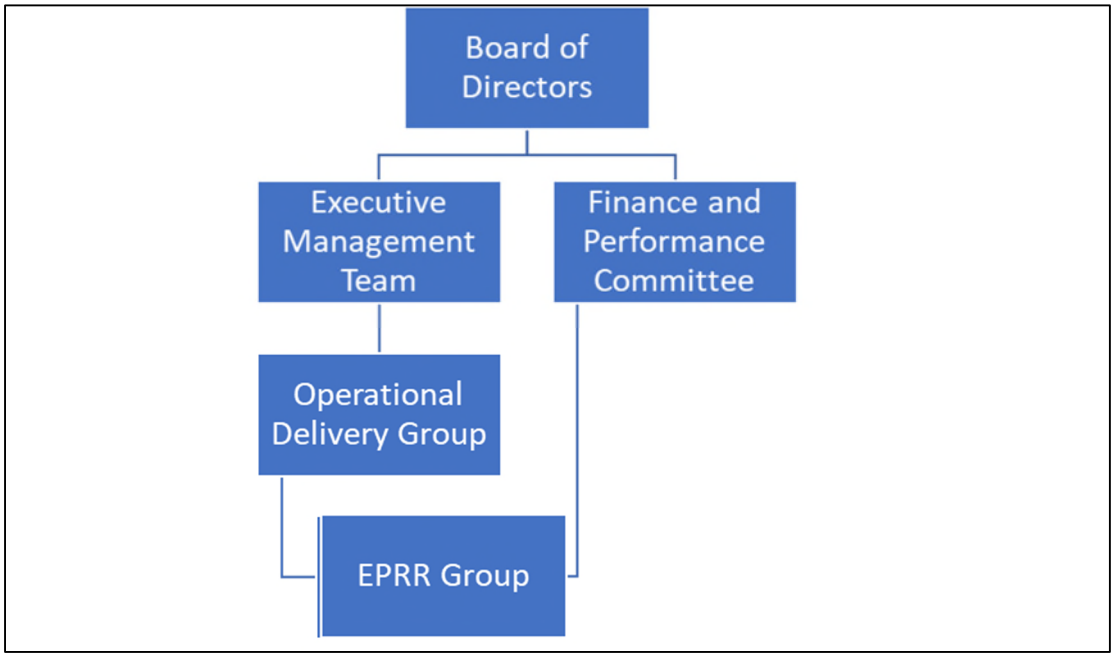
The Resilience lead and members of the EPRR team have responsibility for

Reporting lines are shown below, and the Resilience Lead directly reports to the AEO.



1.1.2 Governance and Reporting

The Trust has an Emergency Preparedness, Resilience and Response Group chaired by the Accountable Emergency Officer and attended by senior operational and corporate staff/ service business continuity leads. The group's reporting structure is below.



The EPRR Group comprises membership from across the Trust and is chaired by the AEO. Membership is:

Member	Role
Chief Operating Officer	Accountable Emergency Officer for EPRR/ Chair
Resilience Lead and Corporate Business Manager	Operational lead for EPRR
Head of Operations - Learning Disabilities Service	Care Service Business Continuity Lead
Head of Operations - Acute care	Care Service Business Continuity Lead
HR Systems Manager	Business continuity lead - Workforce
Head of Physical Health and Infection Prevention & Control	Nursing and Professions Business Continuity lead and Pandemic flu/ infectious disease advice
Head of Operations (Estates & Facilities)	Business continuity lead – Facilities and Estates
Chief Information Officer	Business continuity lead – ICT services
Head of Communications	Communications support
Head of Procurement	Supply chain resilience
Head of Medical Development and Operations	Business continuity lead – medical directorate
Head of Sustainability	Sustainability and adaption
Head of Health and Safety	Health and safety considerations in planning and response and link to security
EPRR Officer	BC and CBRN updates
EPRR Manager	(New role in the process of recruitment)

Non-core Members

Title	Role in the group
Assistant Director of Finance	Business continuity lead – Finance Directorate
Head of Corporate Governance	Corporate responsibility and compliance with constitution/ licence

The EPRR Group has direct responsibility for directing the Trust's response to the EPRR and Business continuity agenda. It has representation at senior level from across all relevant services and directorates.

The Operational Delivery Group is the reporting group for EPRR issue affecting the Trust care services and allows for wider clinical and operational consideration of any key EPRR matters.

Oversight of the EPRR function is provided by the Trust's Finance and Performance Committee which is a committee of the Trust Board. This group provides initial oversight of EPRR assurance declarations, and any issues escalated via the Chief Operating Officer's report which contains a section about EPRR in every report.

The Executive Management Team is responsible for managing any urgent escalations regarding operational EPRR matters, resource issues such as increased funding for EPRR or the ongoing reporting of significant disruptions/ threats to business continuity. In the latter category examples such as the EU exit situation and Covid pandemic illustrate this reporting line.

The Board of Directors receive the annual EPRR report, the declaration against NHS England EPRR standards and annual approval of the Trust's Business Continuity Policy, EPRR Policy and Business Continuity management System document.

Resources

The EPRR function has its own administrative budget for training and incidental expenditure, and the Resilience Lead attends senior operational groups.

Additional resources for the core EPRR function would, and previously have been sought via the Trust's business case process and agreed by the Executive Management Team.

Additional resources are deployed by agreement of the Executive Management Team. The Chief Finance Officer has created a specific budget code to be used following senior finance staff approval for excess expenditure associated with disruptive incidents.

1.1.3 Scope of EPRR

The requirements are for all Trust services to comply with NHS England Core Standards for EPRR as far as these standards apply to the service or directorate. In particular, services or directorates whose services or responsibilities overlap with specific EPPR areas such as outbreak management, security – lockdown plans will be expected to produce plans n collaboration with the Resilience Lead that meet all specific NHS England EPRR requirements for these plans.

The Trust will work with partner NHS bodies, particularly other West Yorkshire Mental Health Trusts on areas of joint interest. In terms of joint development of plans and other resilience arrangements, the Trust works closely with both Mitie and NHS Property Services in developing plans covering facilities. Both these organisations re invited to tactical planning meetings as necessary.

1.1.4 Planning EPRR work

An annual plan is developed by the EPRR team and approved by the EPRR Group. The plan includes areas of activity across all the domains of EPRR and includes actions required to improve areas assessed as non-compliant in the annual EPRR assurance process.

The EPRR annual plan is monitored by the EPRR Group and specifically by the AEO in consultation with the Resilience Lead. Updates and areas of slippage are also communicated via the Chief Operating Officer's report to Board.

1.1.5 Lessons Learned

All exercises are debriefed and for major exercises - live exercises and those exercises contained in the annual plan a full debrief report is produced. This contains an action plan with actions allocated to named officers with an agreed implementation date. These plans are reviewed in the EPRR group.

In the event of an incident a debrief report will also be produced – this may be escalated for review in one or more of the EPRR Groups parent groups – often at the Executive Management Team.

For incidents where there has been, or there was a significant risk of, harm to patients then the Trust Incident review group would request a fact find/ debrief report and this report would be subject to scrutiny by the Trust Incident Review Group.

Lessons learned that indicate any ongoing risk to the organisation will also be captured on the Trust's Datix risk management system.

1.1.6 Risk Assessment

Incident risk registers

The Resilience lead has responsibility for maintaining a risk register for each identified incident. This document is reviewed by the group leading the response at a frequency determined separately for each incident depending on the pace of change of the incident and expected duration. For example, a “big bang” incident may see daily review of the register; whereas a “slow burn” incident such as the pandemic or industrial action may see the register reviewed weekly or bi-weekly.

The decision to escalate any risk from the incident risk register to the Trust’s business as usual risk register is governed by an assessment at the conclusion of the incident around likelihood of repetition of the incident type.

Horizon scanning and EPRR risks

The Resilience Lead in consultation with the EPRR group will also maintain a number of risks linked to an assessment of the community risk register and the Trust’s risk profile, i.e., the likelihood these risk will adversely impact the Trust. Risks assessed as relevant are included on the Trust’s Datix risk register as EPRR risks. These are signed off by the AEO and maintained either solely or in collaboration with identified officers by the Resilience Lead. The Trust’s risk management process involves overall monitoring of actions, reviews and completion of actions and the Resilience Lead will be notified of any risk approaching a milestone in this way.

EPRR only risks are reviewed twice per year by the EPRR group. In terms of risk tolerance – risks classified as low risk are archived as live risk. These are still reviewed for any changes that may require re-assessment, however.

Risk assessment governance

Extreme EPRR risks are escalated to the Executive management Team by the AEO. These may, depending on the views of the Executive Management Team be escalated to Board.

The Datix risk system records any changes, re-assessments and updates to risks and these are auditable.

Escalation of any risk for consideration as a risk to be held by the Local Health Resilience Partnership is via the West Yorkshire Emergency Planning Managers meeting which is chaired by the ICB.

1.1.7 EPRR plans

The Trust maintains a suite of EPRR plans to manage specific disruptions as well as service specific business continuity plans. These plans are developed by the Resilience Lead in consultation with subject matter experts. These plans may also, depending on subject matter, be taken through other governance routes but are always approved by the EPRR Group. Given the EPRR groups intentional broad-based composition these plans receive cross organisation scrutiny and input.

Plans are shared with other Mental Health Trusts, both locally with West Yorkshire Trusts but also via the North of England Mental Health EPRR leads group across the North of England. This latter group, given its breadth of coverage, is the main group where approaches to EPRR incident management and plans are shared and consulted upon.

Development of plans is based on two main influences. Firstly, the requirements of the NHS England EPRR standards which specifies several plan requirements. Secondly, the risk profile of the rust and from any risk assessments is also a driving factor in plan development.

The EPRR plans are all individually numbered (EP- 0001 and onwards) and located within the Emergency Planning and Business Continuity section of Policies and Procedures on StaffNet.

1.1.8 Training and Exercising

The Trust is committed to training staff and exercising EPRR arrangements. A training schedule is published annually and is a standing item on the EPRR groups agenda.

EPRR Training

The Trust has conducted a training needs assessment against the new requirements for NHS commanders. This is included at appendix 1. The attendance of strategic and tactical commanders at the Principles of Health Command training has been monitored at Executive Management Team.

Personal training and exercise attendance portfolios are also required as part of EPRR training and the Resilience Lead and EPRR team are committed to enabling staff to meet training and exercising requirements via frequent tabletop and more detailed exercises. Exercises are notified via the EPRR group and at the parent groups.

EPRR exercises

The Trust requires all services to hold a business continuity tabletop exercise annually. These are facilitated by the EPRR team. Additionally, communication exercises to test on call arrangements are held very six months. These are debriefed in the EPRR group, and any lessons learned communicated to relevant staff.

The EPRR team develop exercises to test response to a disruption as part of the annual exercise plan. Thes plans are tested on a rotational basis unless a specific need to test is identified by:

- NHS England directive
- An incident indicates a need to test a specific plan.
- Specific management requests

The focus for 2023 is Chemical decontamination and the reasoning is that this is an area where considerable EPRR staff time has been devoted to training in 2022-2023 as well as the participation of the Trust in a city-wide exercise in 2022.

Logs of attendance at training events and debrief reports are maintained by the EPRR team.

Every three years a command post exercise and live exercise will be carried out.

As part of Data Security & Protection Toolkit work the Trust will also run a cyber or IT based scenario annually.

1.2 Business Continuity Policy Statement

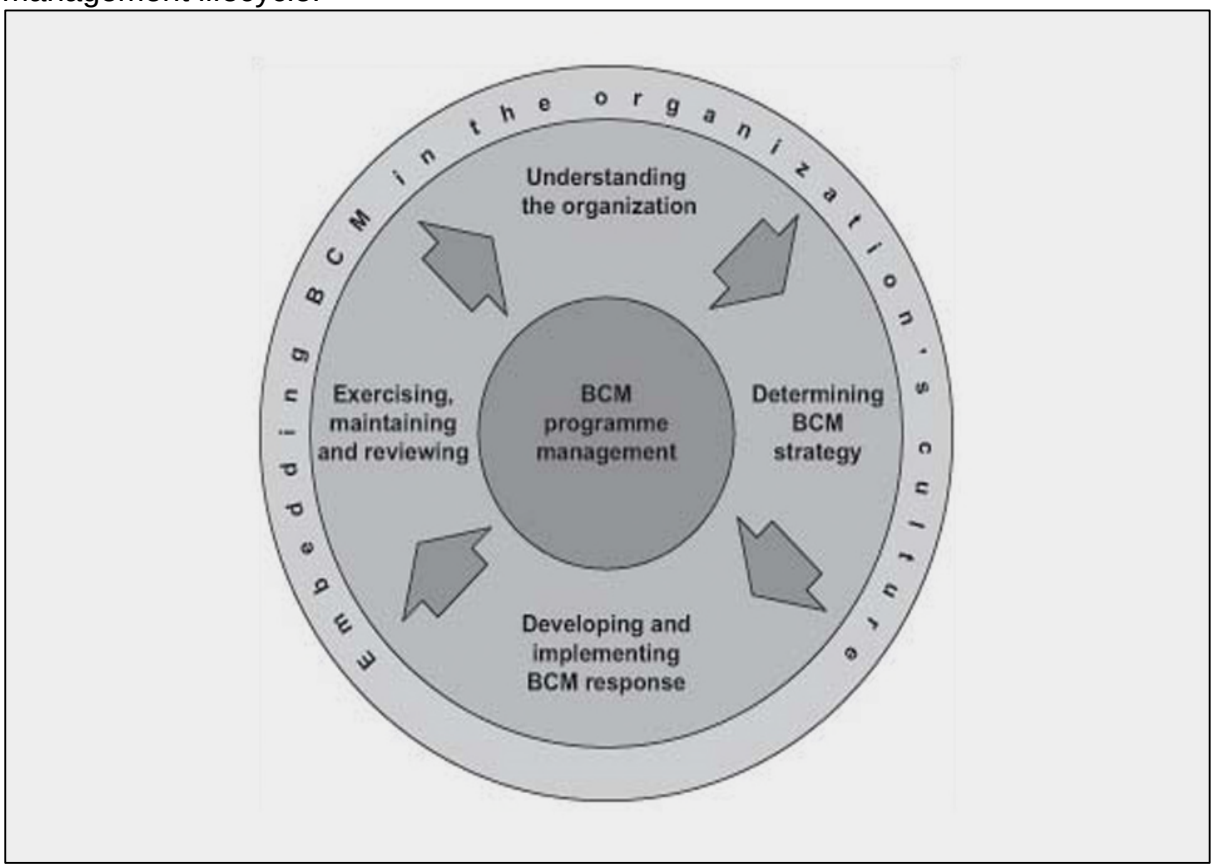
Leeds and York Partnership NHS Foundation Trust commits to the development and maintenance of a business continuity management process as defined below. The trust's approached to business continuity is aligned to the international standard ISO 22301 - *Security and resilience – Business continuity management systems.*

Business continuity management system is defined as:

A holistic management process that identifies potential threats to an organization and the impacts to business operations of those threats, if realized, might cause, and which provides a framework for building organizational resilience with the capability for an effective response that safeguards the interests of its key stakeholders, reputation, brand, and value-creating activities.

Source: ISO 22301:2012

Business continuity management is best understood as a programme of work that includes the interrelated processes below which are linked into a business continuity management lifecycle.



Source: BS 25999-1:2006 Business continuity management – Part 1: Code of practice

To ensure that this programme of work is properly resourced, supported and maintained requires effective governance processes. One part of this governance process is this Business Continuity Management Framework Policy.

The purpose of the statement is to:

- Demonstrate organisational support for the business continuity programme.
- Identify responsibilities for business continuity.
- Describe the approach to business continuity management adopted by the Trust and relevant standards that influence this response.
- Describe the testing and revision processes for plans.

The strategic intent of the Trust is to have a comprehensive and properly funded business continuity management system in place that covers the Trusts major strategic activities, its statutory obligations, and its provision of care services to its patients.

Additional guidance

As well as IS0 22301, the following documents have been consulted in the development of the Trust's approach to Business Continuity.

- PAS 2015:10 – Framework for Health Service Resilience
- ISO 22313 - Societal security — Business continuity management systems — Guidance
- [BSI] BS 25999-2 Business Continuity Management, Part 1 Code of Practice
- [BSI] BS 25999-2 Business Continuity Management, Part 2 Specification
- ISO 22398:2013, Societal security – Guidelines for exercises
- ISO/TS22317 Societal security — Business continuity management systems
- Guidelines for business impact analysis (BIA

1.2.1 Scope

The following section defines the scope of the business continuity management strategy for the Trust.

Acceptable Risk

The Trust expects that all identified business continuity risks are assessed and where relevant subject to any risk reduction/ mitigation actions that are cost effective to employ to reduce the likelihood or impact of the disruptive event. Any remaining risk of disruption should be evaluated in the same manner as currently required under the Trust's Risk Management processes and if deemed to be a controlled risk then there may be no need to develop any further business continuity strategies to deal with such risks. However, controlled risks should be reappraised annually as part of review of business continuity arrangements.

Dynamic risk assessment

As part of preparation of business continuity plans a dynamic approach will be taken to risk assessment. New risk or changes to risk informed by exercises, incidents or information sharing with other partners will lead to revised risk assessments or inclusion of new risks in the risk assessment process used to develop plans.

New risk such as the impact of climate change and heatwave or contractual or social changes such as the NHS recruitment problem to the wider UK changes such as those caused by the impact of EU exit have been assessed in the past few years.

Limitations and exclusions

Generally, every service within the Trust is required to participate in business continuity management. As part of assessments by executive directors some small, non-clinical service functions may be deemed as not required to maintain full business continuity arrangements.

Statutory, regulatory, and contractual duties

i. Statutory

The Civil Contingencies Act 2004 imposes duties on certain bodies to have in place business continuity arrangements. While this requirement was directly attributed to category 1 responders in the Act, subsequent NHS England instruction requires all NHS funded bodies to behave (with due regard to their size) as though they were category 1 responders.

The responsibility for monitoring the arrangements of providers *given to CCGs in the Health and Social Care Act 2012 section 252a has been moved to the Integrated care Boards with the Health and Social care Act 2022.*

The Health and Safety Act 1974 requires employers to ensure the health, safety, and welfare of employees while at work.

ii. Regulatory

One of the Care Quality Commission's key lines of enquiry supporting the safe domain looks at how well are potential risks to the service anticipated and planned for in advance. Specific prompts consider how a provider prepress for disruptive events such as adverse weather and disruption to staffing.

NHS England's role in monitoring providers' emergency preparedness arrangements under *the Health and Social Care Act 2012* is discharged by the requirement of all NHS funded providers to comply with a comprehensive

suite of Emergency Preparedness, Resilience and Response Standards (EPRR). Some of these are business continuity related standards.

The EPRR standards are reviewed and updated annually, and the Trust must make a formal declaration of compliance against the standards. This declaration is prepared by the Resilience Lead, reviewed by the Accountable Emergency Officer, and will then be approved by the Finance and Business Committee.

iii. Contractual

The NHS Standard Contract Service Condition SC30 Emergency Preparedness, Resilience and Response require providers to comply with NHS England's EPRR standards.

These standards include a requirement to align the Trust's Business Continuity Management System (BCMS) to the ISO standard 22301. The approach in this document does this.

Interests of stakeholders

The Trust will ensure that its plans are shared with stakeholders who work with the Trust to provide services or who are dependent upon services provided by the Trust. In some cases, the Trust may need to develop joint plans with key stakeholders for specific responses to the threat of disruption.

As part of the methodology used to develop plans each service will carry out an analysis of the impact upon stakeholders if services are affected by disruptive events.

Key services in scope and exclusions from scope

All clinical services are in scope and all corporate services whose output products/ services support the delivery of clinical services are in scope.

Any exclusion from the scope of the business continuity programme must be agreed by the responsible executive director and endorsed at the Trust's executive team meeting.

1.2.2 Objectives and obligations

The objective of the Trust's Business continuity programme is to develop a business continuity response to identify and control disruptive events that may adversely affect.

i. the continuity of clinical care of service users.
ii. the safety of service users, carers, staff, and the public
iii. the buildings, assets, and infrastructure of the Trust

iv. the interests of key stakeholders.
v. the environment
vi. the reputation of the Trust and wider NHS

The overall objective of effective business continuity management supports the Trust's five strategic objectives and is strongly linked to the Trust's goal of people experiencing safe care.

The Trust also has the obligation to maintain, exercise and refine its business continuity arrangements and to work in partnership with partner bodies under several NHS England EPRR standards.

Business Continuity Lead: The coordination of business continuity planning in each clinical care group and corporate directorate has been delegated to a specific business continuity lead. These managers are tasked with ensuring that the business continuity plans, and maintenance of these plans is carried out within their specific services/ directorates and includes:

- Checking that managers are updating their plans annually.
- Ensuring they are leasing with the Trust's Resilience Lead to organise an annual exercise of their plans.

Notwithstanding the role of business continuity leads, it remains the responsibility of each service manager to ensure that their services have adequate business continuity arrangements.

The Business Continuity Lead is required to present an update to their management team or governance group with Business Continuity responsibility twice a year regarding compliance with:

- Updating plans
- Testing plans

The Trust's Resilience Lead has responsibility for reviewing business continuity plans and other related plans against the requirements of NHS England guidance and aligned international standards.

The EPRR team have responsibility for updating and manging the governance pathway for EPRR Policies and Plans. The Corporate Governance team will ensure that plans are stored on the EPRR plan section of the Trust's Intranet, and that updated or new plans are informed to all staff via the Trust wide Communication Bulletin.

1.2.3 Resourcing and independent oversight

The Trust's Finance and Performance committee has oversight responsibilities for Business Continuity and discharges this by detailed consideration of the Trust's annual EPRR plan and assurance declaration which is then presented to the Board of Directors.

Resources related to business continuity are covered in the previous EPRR statement.

1.2.4 Training

In June 2022 NHS England introduced new training requirements based the Principles of Health Command course. Appendix 1 gives the training needs assessment against all the relevant national occupational standards for staff dependent on their roles.

The Trust will fully support this and is working to ensure ongoing professional development of key staff involved in developing business continuity plans.

1.2.5 Exercising

Each business continuity plan will be tested by a tabletop exercise annually. The results of the exercise will be assessed on the exercise review form (appendix 4). Action plans regarding any improvements identified and timescales will be sent to the EPRR group for monitoring.

More detailed live exercises will be carried out every year of one service business continuity plan. These live exercises will be fully debriefed and a debrief report and action plan will be produced by the Resilience Lead for consideration at the EPRR group.

An annual exercise will be carried out to test one of the other Trust wide EPRR plans. Every three years a command post exercise and live exercise will be carried out.

As part of Data Security & Protection Toolkit work the Trust will also run a cyber or IT based scenario annually.

1.2.6 External suppliers and contractors

The Trust will request business continuity plans from all organisations providing services in our PFI/ NHS property Service owned buildings. These will be reviewed by the Resilience Lead and business continuity leads from care services, information technology and communications and Estates to ensure the plans are robust and complement Trust plans.

At the date of drafting these would be:

- NHS Property Services
- MITIE

Both these organisations work with the Trust to manage infrastructure related risks and disruptions and are involved in exercises and planning when appropriate.

In addition, the Trust needs to have copies of business continuity plans from services who work with Trust clinical services and support services and hence who are integral in provision of our services. These are obtained via relevant management teams who work with these providers.

These are reviewed annually and any issues for internal trust planning are identified and manged through the Trust's business continuity plans and other EPRR plans.

1.2.7 Governance and Audit

The Business Continuity Management System will be approved by the Trust Board.

In terms of governance responsibilities, the Executive Management Team has responsibility for overseeing the Trust's response to all aspects of Emergency Preparedness, Resilience and Response including the elements concerning Business Continuity Management.

The Operational Delivery Group is the parent group for the EPRR group and receives an update regarding EPRR issues at every meeting.

The Trust's EPRR group, chaired by the Accountable Emergency Officer, has operational oversight of the development of Business Continuity Management arrangements and review of the annual workplan.

The Board will receive the annual report of EPRR activity and draft NHS England EPRR standards compliance declaration for review and agreement before the Trust makes its declaration to NHS England.

Individual service and directorate business continuity plans will be signed off in relevant governance groups and reviewed by the Trust's EPRR group.

Action plans deriving from either incidents or exercises will be monitored by the EPRR group and any issues requiring escalation will be sent to the Finance and Performance Committee.

i. **Board and Board Committee reporting**

The annual declaration against NHS England's EPRR standards will be approved the Trust Board of Directors after previously being reviewed and discussed at the Trust's Finance and Performance Committee.

The annual report will be presented to the Finance and Business Committee and then will be presented at Trust Board of Directors.

ii. **Audit**

Business continuity plans will be reviewed on a cyclical basis by the Resilience lead. Any activation of a plan will require a debrief report being produced to be reviewed at the EPRR group.

Peer review of plans may also be facilitated by the Resilience Lead.

External review by the Trust's internal auditors occurs to review the overall effectiveness of the Trust's business continuity management systems. Thes frequency of these reviews is considered by the Trust's Audit Committee.

iii. **Document control**

Business continuity plans will be referenced using the following format:

Service_ month/date created.

Business continuity plans will be held electronically on the Trust in the on call shared folder: http://staffnet2/clinicalstaff/oncalllogs/Pages/CTM-Documents.aspx

Any paper copies of plans will be the responsibility of local services to keep up to date. Any changes to plans will be notified via a service business continuity leads.

1.2.8 Communication

The responsibility for communicating business continuity management strategy to staff will via identified business continuity leads in services and directorates.

Periodic updates regarding plans will be made via Trust wide e-mails.

The Business Continuity Institute organises a business continuity awareness week each year. As part of this the Resilience Lead will use this week to increase awareness across the Trust regarding business continuity and the overall business continuity management strategy.

1.2.9 Review of the Business Continuity Management System

The Business Continuity Management Framework will be reviewed every year and will be reviewed following any significant revision to NHS England's standards or International Standards. The review will be carried out by the EPRR group, and a revised draft will be considered by the Finance and Performance Committee.

1.2.10 Continuous Improvement and review

As part of the business continuity and EPRR process a continuous improvement cycle of plans review, test and refinement is in place. Any exercise will be followed up by a debrief report designed to identify improvements and offer assurance regarding the effectiveness of plans.

Any business continuity or critical incident is also followed up, as a minimum by a debrief process but if the incident is sufficiently serious then by referral into the Trust's Serious Incident process in addition.

1.3 Context

1.3.1 Definition

A Business Continuity Management System (BCMS) *is that part of the overall management system that establishes, implements, operates, monitors, reviews, maintains and improves business continuity. (***ISO 22313)**

A BCMS emphasizes the importance of:

- understanding the organization's needs and the necessity for establishing business continuity management policy and objectives.
- implementing and operating controls and measures for managing an organization's overall business continuity risks.
- monitoring and reviewing the performance and effectiveness of the BCMS; and
- continual improvement based on objective measurement.

1.3.2 Scope of Business Continuity in the Trust

The scope of services included in the Trust's BCMS are specified below:

- Clinical services provided under NHS contracts.
- Key corporate services supporting clinical services.
- Services provided to third parties where these parties will require assurance around business continuity arrangements.

Third party business continuity arrangements.

Estates and Facilities

The greatest part of the Trust's clinical estate is provided under either private finance arrangements or via NHS Property Services. In terms of risk, the assurance regarding business continuity of:

- NHS Property Services relating to Clifton House and Mill Lodge
- Mitie via the SPV – Becklin Centre, The Mount, Newsam Centre, Asket Croft and House

Business continuity plans will be requested annually via the Estates team at the Trust from these two stakeholders and reviewed by the EPRR team. Any clarification or implications for Trust continuity will be escalated to Estates and Facilities management for discussion with these parties as part of normal contract discussions.

Contracted clinical Services.

The Trust delivers some clinical services via contracts with other care providers/ third sector bodies. The business continuity plans for these bodies will be requested by the EPRR team via the clinical contracts manager.

Suppliers

Assurance from suppliers other than those on NHS Supply chain who undertake their own due diligence on national suppliers is assured in the following manner.

NHS Commercial Procurement Collaborative

Trust Procurement department – the Trust procurement department will obtain copies of business continuity arrangements from suppliers maintained under local arrangements with a value of transaction determined annually by the Resilience Lead in consultation with the Head of Procurement. These will be reviewed by the EPRR team, and any identified issues escalated to the Head of Procurement.

1.3.3 Objectives of the Trust Business Continuity Management System

The objectives of the Trust BCMS are to Protect**:**

- the continuity of healthcare activities.
- the health of persons affected by disruptive situations.
- the buildings, assets and infrastructure of the Trust.
- the interests of key stakeholders.
- the environment; and
- the reputation and of the Trust and its relationship with regulators and the wider community.

1.3.4 The requirement to undertake business continuity management.

This section covers the key requirements that necessitate the Trust's business continuity management processes.

Statutory

- **The Civil Contingencies Act 2004** places a responsibility on category 1 responders to *create business continuity plans to ensure that they can continue to exercise critical functions in the event of an emergency.*

While, as a Mental Health and Learning Disability Trust, Leeds and York Partnership NHS Foundation Trust is not a category 1 organisation.

However, NHS England and the Department of Health and Social Care (DHSC) expect them to plan for and respond to emergencies and incidents in a manner which is relevant, necessary and proportionate to the scale and the services they provide. (NHS Emergency Preparedness Resilience and Response Framework 2022)

- **Health and Social Care Act 2012.** This act imposes a responsibility on NHS England to:
    - Be properly prepared for dealing with an emergency.
    - and must monitor and control all service providers to make sure they too are prepared.

Regulatory

- **NHS England's Emergency Preparedness, Resilience and Response (EPRR) standards**

All NHS organisations and providers of NHS funded care must develop, maintain and continually improve their business continuity management systems (BCMS). This means having suitable plans which set out how each organisation will maintain continuity in its services during a disruption from identified local risks and how they will recover delivery of key services in line with ISO 22301. Organisations must:

- make sure that there are suitable financial resources for their BCMS and that those delivering the BCMS understand and are competent in their roles.
- set out how finances and unexpected spending will be covered, and how unique cost centres and budget codes can be made available to track costs.
- develop business continuity strategies for continuing and recovering critical activities within agreed timescales, including the resources required such as people, premises, ICT, information, utilities, equipment, suppliers and stakeholders.
- develop, use and maintain business continuity plans to manage disruptions and significant incidents based on recovery time objectives and timescales identified in the business impact analysis.

- **CQC Essential Standards of Quality and Safety**

These standards cover requirements regarding business continuity in several of the outcomes (10H is particularly important).

Contractual

- **NHS Standard Contract – Service Condition 30**

Under this service condition:

- Each Party must have and maintain an up-to-date Business Continuity Plan
- If there is a Significant Incident or Emergency the Provider must comply with its Business Continuity Plan
- The Provider must notify the Co-ordinating Commissioner as soon as reasonably practicable and, in any event, no later than 5 Operational Days following the activation of its Business Continuity Plan

1.3.5 Roles with BCMS

The duties within the organisation are as follows:

Staff group	Duties	Expected competencies
Business Continuity Leads	Business Continuity Leads have responsibility for: • The implementation of the Business continuity process in all areas within their directorate or service • Ensuring that all service areas undertake a full business impact assessment at least annually. • Ensuring that each service area in their directorate develops and reviews a business continuity plan at least annually	Basic understanding of the business continuity process Attendance at introduction to business continuity training session
Associate Director and Heads of Operations	Associate Directors have responsibility for: • Ensuring the EPRR, BC and BCMS policy statement is	PHC for tactical commanders

Staff group	Duties	Expected competencies
	disseminated and implemented within their area of responsibility. Implementation will include completing Business Impact Assessments, drawing up Business Plans and reviewing both at least annually. • Confirming that their services have carried out a review of the business continuity arrangements annually. • Ensuring that business continuity is considered periodically at a relevant business or governance meeting in their directorate. • Nominating a Business Continuity lead and reviewing the Business Continuity's leads performance of their duties.	
Accountable Emergency Officer	The Accountable Emergency Officer has responsibility for declaring compliance with NHS England's Emergency Preparedness, Resilience and Response standards. To discharge this duty, they chair the Trust's Emergency Preparedness, Resilience and Response Group and ensure that all care groups, directorates and services are compliant with this policy and business continuity requirements.	PHC for Strategic Commanders Business continuity course
Resilience Lead	The Resilience Lead will support and advise Business Continuity	PHC for EPRR leads.

Staff group	Duties	Expected competencies
	leads developing their plans, testing and exercising processes.	Diploma in Health Emergency Planning Business continuity course
Emergency Preparedness, Resilience and Response Group	The Emergency Preparedness, Resilience and Response Group has responsibility for: • ensuring that the policy is disseminated to Associate Directors • monitoring compliance • reporting progress to the Finance and Business Committee • communicating relevant messages to all staff • reviewing any activations of plans or events where plans were not activated but ought to have been	N/A
Finance and Performance Committee	The Finance and Business Committee has responsibility for approving the policy and oversight of business continuity arrangements within the Trust	N/A
Chief Executive	The Chief Executive of the Trust has overall responsibility for business continuity management within the organisation and: • must ensure that there are effective systems in place for compliance with the Care Quality Commission's	PHC at Strategic level

Staff group	Duties	Expected competencies
	Essential Standards of Quality and Safety.	
All Staff	All staff members are responsible for: • co-operating with the development and implementation of Trust policies as part of their normal duties and responsibilities • for reporting any adverse experience or difficulties in implementing this policy or where practice is not in accordance with this policy	Optional – attendance at a business continuity tabletop
Operational management	Matrons, Clinical Operations managers and Equivalents will be responsible for ensuring that the appropriate members of staff are made aware of the policy and its associated documents, the Major Incident and their respective Service Business Continuity Plan	PHC – Tactical Course

1.3.6 Risk Process relating to Business Continuity

The Trust undertakes risk assessments when preparing business continuity plans. These assessments consider risks from the community risk register in terms of their impact on each service's business continuity. Given the geographical spread of services provided by the Trust those carrying out risk assessment can add additional local risks to the process.

The core risks assessed against are:

Risk	Category
Pandemic illness	Natural Hazzard
Flood risk – building or adjacent community	Natural Hazzard

Risk	Category
Snow, extreme cold	Natural Hazzard
Heatwave	Natural Hazzard
Drought	Natural Hazzard
Poor air quality	Natural Hazzard
Loss of critical business equipment	Infrastructure
Loss of utilities to the buildings– light, heat, water	Infrastructure
External telecommunications failure – land line and mobiles	Infrastructure
Internal IT network failure – loss of e-mail, communications and access to systems	Infrastructure
Key Supplier failure	Infrastructure
Inability to recruit, low staffing numbers	Operational difficulty
Surge in demand for services	Operational difficulty
Adverse Contractual or legislator changes affecting service provision	Operational difficulty
Strike or industrial action affecting services	Industrial action
Vehicle fuel disruption due to tanker driver or other industrial action	Industrial action
Fire in a service location/ site	Accident
Air or water pollution incident near a site	Accident
Cyber-attack disrupting IT and communications	Malicious attack
Chemical, Biological, radiological or nuclear attack/ contamination	Malicious attack
Attack on the transport network	Malicious attack
Attack on crowded places	Malicious attack
Disrupted transport network – pre-planned e.g., sporting event	Other
Disrupted transport network – unplanned e.g., demonstration, civil disobedience	Other

These feature in the assessment document used prior to all Business continuity plans are developed and those with responsibility for plan maintenance in services are asked to review these risks annually.

EPRR risks are considered at the EPRR Group three time a year when any themes or increasing risks of disruption may be approved by the AEO to go on the Trust risk register.

These risks will be reviewed by the Trust's Executive Risk Management Group in addition to the EPRR group.

The Trust uses the 5 by 5 matrix to assess risks that are recorded on the DATIX risk register and risks escalated from broader EPRR work as well significant risk to business continuity are recorded on this system. Initially drafter by the Resilience Lead each risk requires approval by the Accountable Emergency officer.

In terms of risk appetite any risk where risk reduction strategies have reduced to a low level in terms of consequences are archived. However, these risks are still visible to the Resilience Lead who will review the continuing existence of control measures recorded against the risk.

1.3.7 Resources

Resource commitments for business continuity are determined by the Accountable Emergency Officer in consultation with executive director colleagues.

The EPRR team have an administrative budget for training and incidental items (documentation, standards, guidance books etc).

Business continuity leadership at service level is via designated directorate and services business continuity leads who act as coordinators for business continuity activity within their respective services.

Additional staffing resources would be dealt with via the Trust's business case process based on lesson learned from debriefs indicating that issues with resources contributed to inadequate training, planning or response.

1.3.8 Communication strategy 2023-2024

Staff understanding business continuity has undoubtedly been increased by the 2020-2023 Pandemic. Most staff have a grasp of the basic principles of the need to preserve and stabilise business critical activities and allow less critical activities to stand down.

Senior staff have a greater understanding of the process having been involved in the impact and risk assessment process and drafted their own plans.

Awareness training has been carried out in the past via full day sessions to Business Continuity Leads as well as the Business Continuity Institute's (BCI) business continuity week publicity. For Business Continuity week 2024 the EPRR team will use the BCI's communication products and hold awareness events across the Trust.

The geographical spread of services both in Leeds as well as across the North of England and the need to engage these staff is an additional area that will be a focus of the communication strategy in 2023-2024.

In terms of broadening understanding of business continuity in 2024 The EPRR team will work with colleagues to consider several new strategies to introduce business continuity to more staff:

- Induction content
- E-learning
- Presentations at team level

1.3.9 Organisational strategy, operating environment and risk profile

Strategy

Organisationally, the Trust has the strategy of preserving access and crisis services and hence identifying these as the most critical services. The former because they alleviate pressure across the care system and the latter because of patient need and risk. This approach prefigures all business continuity strategies developed across services around redeployment of staff, recovery priorities and stand down of activities.

As part of the Leeds health economy stakeholder impact also features in terms of business continuity planning. The interdependency of admissions from Leeds Teaching Hospitals, particularly when the acute trust is under intense operating pressure, and ward business continuity arrangements are exercised in tabletops and discussed with staff in formulating business continuity plans.

The Trust's strategy also looks outward to MH partners in West Yorkshire recognising that working with these partners is essential for the Trust's overall resilience. The Trust participates in regular practitioner planning meetings with both Bradford Care NHS FT and Southwest Yorkshire NHS FT as well as, when necessary, developing common approaches to disruptions such as decant accommodation and low and medium secure evacuation planning.

The Trust is a mental health and learning disabilities provider serving largely urban areas of Leeds with some service provision in York. The Trust also

provides some specialised services across the North of England by staff based either from home or at several community sites.

Operating Environment

Leeds being major population centre brings with it heighted risks associated with potential terrorist incidents given iconic sites and large entertainment events. Additionally, disruption to transport by both planned and unplanned public marches, demonstrations and events are a feature of the city.

Although the Trust has inpatient units and around 360 beds, the bulk of its clinical activity is delivered in community settings and in patients' homes. This spread of activity means that from a risk profile building based risks as would be found with acute providers as well as risks found in community settings are all subject to assessment when carrying out business continuity assessments.

While most services are delivered to the Leeds Heath economy the Trust provides low secure services at York as well as tier 4 Child and Adult Mental Health Services into York. Furthermore, through its regional services service line specialised mental health services are provided across the North of England and hence plans need to be agile enough to cope with several different locations/ threat and risk profiles and environmental factors.

Most of the Trust's estate is provided either through Private Finance arrangements – Leeds Estate or via NHS Property Services – York Estate. This means that there is significant reliance on these providers for business continuity arrangements that protect and mitigate estate risks.

Risk Profile

Risk assessments are drawn from the community risk register and cover risk to both building based (fire, flood, power outage) and community based (severe weather, disruption to transport, fuel disruption). Commonalities exist around information and communication systems and of course staff. The environmental factors mentioned above are also included in service risk assessments and considered as part of response arrangements.

The cumulative business continuity risk assessments give a useful and broad-based assessment from all services about the specific key risk affecting the Trust and this is also coupled from data from actual disruptive incidents.

The Trust is particularly vulnerable to disruptions to IT, communications, and data loss either via accidents, errors, or equipment failures or via deliberate cyber threats. This portfolio of risks (see section 1.6) is the highest rated risk in most impacts and risk assessments and is underpinned by the reliance of staff for our electronic care record system and EPMA system in addition to the extent

that community and home working staff rely on stable wide area network solutions such as global protect.

The chronic staffing shortage affecting the NHS also underscores the Trust's risk profile and no doubt this vulnerability, exacerbated when impacted by the pandemic, also contributes to the key business continuity risk facing care services. Most services consistently rate that in the same scoring as loss of IT mentioned above and this is reflected when services assess against the risk of surge and inability to recruit/ low staffing number risks detailed in the table in section 1.6.

Other significant contributors to the risk profile are:

- Loss of power to inpatient services – borne out by disruptions to several sites in the last few years.
- Pandemic illness – which prior to 2020 rarely rated higher than a moderate risk on business continuity plans but now is often rated as high or extreme risk.

Continuous observation and analysis by the EPRR team while conducting impact and risk assessments as well as from incidents will ensure that the Trust continues to be sighted on its risk profile. This is a dynamic process and potentially in the 2024 business continuity assessment round heatwave and industrial action may also become significant parts of the risk profile.

1.3.10 Outsourced activities and suppliers of products and suppliers.

As mentioned above the Trust's most significant outsourced activities are related to provision of the Trust's clinical estate by the SPV and NHS Property Services. Related business continuity plans from NHS Property services and Mitie (in relation to Leeds PFI provided accommodation). In addition, these two partners are asked to jointly plan around disruptions and shared risks – illustrations included the risk to food supplies following Brexit (with Mitie that resulted in a food disruption plan) and with both partners around ensuring the Trust had robust arrangements in winter 2022-2023 to mitigate the risk of rotating power outages.

Other major suppliers and contacted bodies will be reviewed on a three yearly cycle unless intelligence suggests any specific risk to the Trust's ongoing business continuity s present with a specific supplier or contractor when the supplier/ contractor's business continuity arrangements will be reviewed annually.

The Trust will also rely on due diligence conducted by NHS Supply chain in relation to national contractors and suppliers and North of England Commercial Procurement Collaborative for contracts or suppliers sourced via this body.

1.3.11 The BCMS process in detail

1.1. Risk Assessment

All work regarding impact assessments will follow the Trust risk management policy and procedures. This means the use of the five-by-five matrix regarding impacts and likelihood. The Trust will record all identified risks emerging from impact assessment in connection with carrying out the business continuity programme in the appropriate risk register depending on the nature of the impact and extent of impact on the Trust.

Risks to business continuity (i.e., the risk of disruptive events) will be subject to risk treatment strategies to minimise the likelihood or impact of the event. Any risks to business continuity posed by disruptive events that have not been adequately mitigated should then have business continuity strategies developed to ensure that the Trust can manage to provide services should these disruptive risks crystallise.

As part of annual review of business continuity plans all business continuity risks should be reviewed (including those deemed adequately managed) to ensure that controls cited are still in place and working properly. In addition, any new risks should be factored into the risk assessment.

Risks will be monitored and reviewed by relevant service governance fora. Mitigation and reduction strategies will also be reviewed in these fora to ensure acceptance of the residual risks is documented.

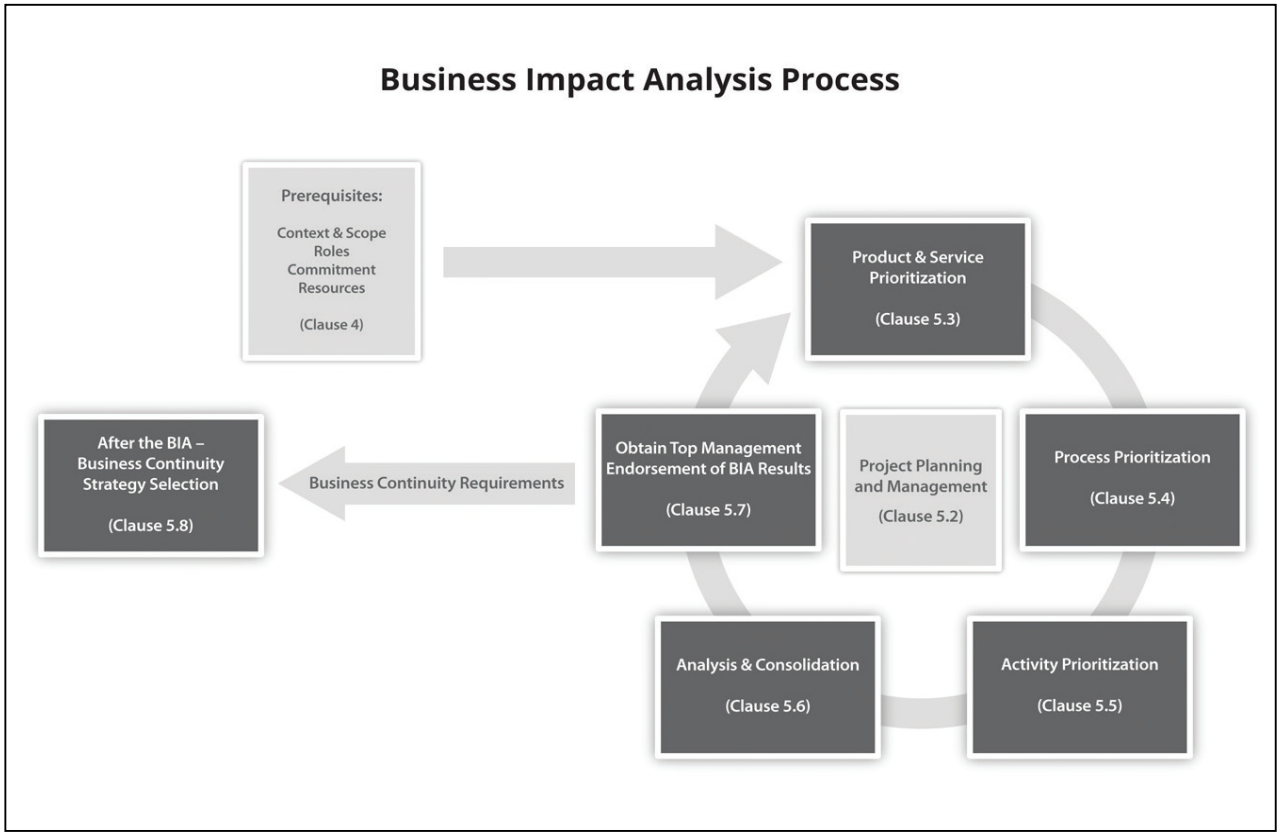
EPRR risks are recorded on the Trust's DATIX register and are reviewed every 6 months by the EPRR Group.

1.3.12 Business Impact Analysis

Business impact analysis is defined by *ISO 22301: Societal security — Business continuity management systems — Requirements* as a process of analysing activities and the effect a business disruption might have on them. The diagram below illustrates this process.

The business impact assessment should be done annually for all business continuity plans as part of plan revision. The Trust's standard impact assessment and risk assessment document should be used across all services.

The business impact assessment is discussed with services to enable them to understand how their critical activities are affected over time by disruption. It enables business continuity plans to describe and prioritise activities based on sound understanding of tolerance to disruption.



Source: Technical Specification ISO/TS 22317: Societal security — Business continuity management systems — Guidelines for business impact analysis (BIA)

The process will cover:

i. **Initial scoping** – understanding the service, scope, organisational structures, the rules, and regulations affecting the service/s, stakeholder's expectations, and interdependencies.
ii. **prioritization** - identifying for each service being analysed the impact of disruption against the following categories:

- Impact on the care or safety of service users
- Impact on staff or public safety
- Legal and regulatory
- Financial, claims, losses
- Obligations to Partners
- Loss of reputation/ public confidence
- Working and service delivery environment
- Impact on suppliers

The impact is assessed dynamically over time to establish:

The maximum tolerable period of disruption for the service (*The time it would take for adverse impacts, which might arise because of not providing a service to become unacceptable*). This will be stated in terms of hours or days.

The recovery time objective for the service (*the period of time following an incident within which a service must be resumed*). This will be a point within the maximum tolerable period of disruption and will be set with recognition of the time to start up the service if it has ceased operating.

iii. **Resource alignment**

As part of the assessment staff are asked to identify critical resources, the impact of these being disrupted and what the service will do to mitigate loss of critical assets.

As part of thinking about disruption staff are asked to consider the disruption if it affected:

- IT, communications and access to data
- Suppliers
- Obligations to or dependencies with third parties
- Equipment and resources
- Staff
- Accommodation

iv. **Risk assessment**

Risk assessment is used as part of the assessment phase of business continuity planning to identify the specific risk that may cause disruption to the service. This is in the context of each services' risk profile – some risks will affect the service more than others. As a mental health and learning disability trust there is often a clear distinction between risks to inpatient services and those to community services that may precipitate a risk to business continuity.

By using risk assessment and subsequent risk mitigation strategies, services may be able to make themselves more resilient to disruption and potentially avert the need to enact business continuity plans for some types of risks.

1.3.13 Business Continuity Plans

A business continuity plan is defined as: documented procedures that guide organizations to respond, recover, resume, and restore to a pre-defined level of operation following disruption.

The Trust will hold plans at service and support function level, i.e., each commissioned service/ collection of services as well as all major corporate services. The Trust's incident response plan will be used for organisation wide business continuity events.

Plans should follow the standard Trust template. This template is the responsibility of the Resilience Lead to review annually and amend based on incidents or any regulatory requirements. The template will have a revision date and reference number on it to identify the latest version in use.

Plans should be reviewed annually or following a disruptive event which required plan activation. Plans should be reviewed by the relevant service manager or head of service in conjunction with identified business continuity leads for the service and directorate. The Resilience Lead will be available to offer any technical support to this review process. The Emergency Preparedness, Resilience and Review Group will monitor progress regarding plan reviews.

The EPRR Group will monitor plans are in place across the organisation and it is required that governance groups in service lines and senior team meetings in corporate services monitor their own performance against completeness of business continuity plans. The following criteria is the minimum acceptable content of such reporting:

- Number of identified plans needed for the service/directorate.
- Number of business continuity pan reviews/ impact assessments carried out.
- Number of finalised plans
- Number of tabletop exercises done

1.3.14 Testing and exercising business continuity plans

All business continuity plans are required to be tested annually and as a minimum with a tabletop exercise. Lessons identified in these exercises will be captured by the EPRR team and a schedule (report) will be sent to the team identifying:

- Any training needs identified.
- Any amendments or corrections to business continuity planning assumptions including exposure to risk, impact assessment inconsistencies or changes to plan administration.
- Any amendments to response arrangements or areas of good practice identified for inclusion in the plan and with wider applicability to other plans.

Infrastructure testing is also done annually – all Trust generators have a black start test as part of winter planning arrangements.

Command post exercises are run as a part of live exercises with teams asked to react to elements of the live exercise. This usually occurs as part of the annual live exercise and the annual IT exercise.

As mentioned, a live exercise is run annually – this is designed to test specific EPRR plans but also the affected services internal business continuity arrangements.

All exercises are debriefed and a debrief report with action plan is produced. Actions are monitored via the EPRR group.

1.3.15 BCMS monitoring and evaluation.

The Trust is developing a comprehensive series of key performance indicators for the business continuity management systems:

i. **Business impact assessments** – percentage carried out per year against number of business continuity plans needing these impact assessments. Target for 2023-4 75% - rising by 10 percent for 2024-5
ii. **Business continuity plans** in place against number of series identified as requiring a plan 2023-4 75% target - rising by 10% in 2024-5. This is the initial KPI in place since 2022 and reported to the Board in the annual report.
iii. **Number of plans exercised against plans in place** – the later number will the same number as in KPI ii above. Target 2023-4 is 75% rising by 10% in 2024-5.
iv. **Supplier plans reviewed** – this will be compliance with the strategy of reviewing a third of all supplier plan per year.
v. **Audit** – KPI is to maintain or improve on current level of significant assurance.

These KPIs will feature in the Chief Operating Officer reporting to the Finance and Performance Committee and Board. A cumulative position statement on the KPIs at the end of March each year will feature in the annual report.

1.3.16 Business Continuity Audit

The Trust's will commission via its annual audit plan an annual review of the Trust's business continuity management system. The scope of this review will be agreed by the AEO, Resilience Lead and auditors at the commencement of each audit to ensure that there is full coverage of the entire BCMS over the course of a three-year cycle.

The output of these audit will be agreed as draft reports with the AEO, Resilience Lead and in charge auditor and a final report will be prepared with an agreed action plan. This will be structured to have specific completion dates and identified responsibility for implementation. The EPRR Group will monitor the action plan and the report will be reviewed in accordance with Trust processes for oversight of audit reviews. The findings of the internal audit review will be reported to first Board that occurs after

report finalisation as part of the formal reporting by the Chief Operating Officer/ AEO's board report.

The EPRR group will review the BCMS process and documentation annually as part of a user audit process and suggest any improvements to process, documentation or required training.

1.3.17 BCMS continuous improvement

The BCMS is subject to a continuous improvement cycle based on:

- Audit review
- User review and feedback
- EPRR group annual review
- Comments and feedback from any form of business continuity training or exercising.
- The EPRR teams ongoing monitoring against KPIs and standards
- The outcome and debrief reports from exercising and incidents.

The reviews will identify either non-compliance with the BCMS or any design flaws in the Trust's BCMS – both types of findings will result in recommendation and an action plan to correct these.

All reviews will be in the form of written documentation – reports or assessment forms that identify the area of observed weakness or non-compliance.

The EPRR team will maintain a combined action plan for EPRR group review to ensure action is being implemented as agreed. The Resilience Lead will be responsible for including any necessary changes in to a revised BCMS process.

1.3.18 Assurance of commissioned providers/ supplier BCPs

The Trust uses a significant number of third parties to deliver its key objectives. These range from its providers of clinical environments to those delivering contracted services. Additionally, the Trust relies on the providers of goods and services based on contracts negotiated nationally via NHS Supply Chain, the North of England Commercial Procurement Collaborative (NOE CPC) or individually by the Trust's Procurement team.

The Trust adopts a criterion based on risk to identify which suppliers are subject to annual checks – this is based on the impact to the Trust's overall ability to provide services should these suppliers face significant disruption. On this basis both NHS Property Services and the SPV including Mitie are subject to annual assessments.
A high proportion of Trust supplies a reobtained via national or regional contracts and hence the Trust's strategy in this respect is to rely on the verification of Business

Continuity Arrangements done by respective commissioning bodies when companies register, i.e., NHS Supply Chain or NOE CPC.

For contracted suppliers that the Trust manages directly then these organisations will be asked initially to supply copies of business continuity plans for review by:

- The EPRR team
- Procurement Team
- Clinical contracting Manager

Each year any provider who the three officers above feel constitutes additional risk based on the criteria below will be asked to complete an assurance return.

- Single supplier – no alternatives
- Extent of business done
- The supplier's own operating risk
- Concerns from the review of business continuity plans

The return will ask for assurance across the suppliers entire BCMS including the extent to which plans are tested, training for the suppliers' staff and details of their calculation of maximum period of tolerable disruption and recovery time.

Any failure by suppliers to respond to this validation process will be escalated to the AEO and Chief Financial Officer to take this matter forward at executive level with the supplier concerned.

Appendix 1

Relevant National Occupational Standards for Civil Contingencies and Required Training Interventions

In June 2022 NHS England issued revised training requirement for NHS incident command staff and those who may support an incident. A formal training course – Principles of Health Command has been devised that will be standard across the NHS. This will be delivered to all three levels of command – Strategic, Tactical and Operational.

The three skills for justice competencies for incident command are:

SFJ CCA G1 Respond to emergencies at the strategic level	All those on Executive on call
SFJ CCA G2 Respond to emergencies at the tactical level	All those on CSM on call
SFJ CCA G3 Respond to emergencies at the operational level	All those on CFTM on duty

The new initiative also directs that support staff are included in EPRR training - the following roles are indicated in the NHS England document.

- Ward staff
- Specialist service staff
- Pharmacy
- Pathology
- Security
- Supplies
- Porters
- Administration
- Communications, including switchboard.
- Human Resources

The following tables are replicated from the NHS England document *Minimum Occupational Standards for Emergency Preparedness, Resilience and Response (EPRR) (Version 1.0 June 2022)*

Appendix 1

Skills For justice NOS	Chief Executive Officer	Accountable Emergency Officer	Strategic Commander	Tactical Commander	Operational Commander	EPRR Specialist / Adviser	Business Continuity Lead	Comms Officer	Command Support Role	On Call staff	Loggist
SFJ CCA A1 Work in cooperation with other organisations	O	O	M	M	M	M	M	M	O	M	-
SFJ CCA A2 Share information with other organisations	O	O	M	M	M	M	O	M	O	M	
SFJ CCA A3 Manage information to support civil protection decision making	-	-	M	M	M	M	-	O	O	M	O
SFJ CCA B1 Anticipate and assess the risk of emergencies	-	O	M	M	M	M	-	-	-	-	-
SFJ CCA C1 Develop, maintain and evaluate emergency plans and arrangements			O	O		M			O		
SFJ CCA D1 Develop, maintain and evaluate business continuity plans and arrangements		O	O	O	O	M	M				
SFJ CCA D2 Promote business continuity management		M				M	M	O			
SFJ CCA E1 Create exercises to practice or validate emergency or business continuity arrangements						M	M				

Appendix 1

Skills For justice NOS	Chief Executive Officer	Accountable Emergency Officer	Strategic Commander	Tactical Commander	Operational Commander	EPRR Specialist / Adviser	Business Continuity Lead	Comms Officer	Command Support Role	On Call staff	Loggist
SFJ CCA E2 Direct and facilitate exercises to practice or validate emergency or business continuity arrangements						M					
SFJ CCA E3 Conduct debriefing after an emergency, exercise or other activity		O	M	M	M	M	M		O	O	
SFJ CCA F1 Raise awareness of the risk, potential impact and arrangements in place for emergencies			O	O		M	M	M			
SFJ CCA F2 Warn, inform and advise the community in the event of emergencies	O		M	O	O	M		M			
SFJ CCA G1 Respond to emergencies at the strategic level	O	O	M			M				M	
SFJ CCA G2 Respond to emergencies at the tactical level				M		M				M	
SFJ CCA G3 Respond to emergencies at the operational level					M	M	O			M	
SFJ CCA G4 Address the needs of individuals during the initial response to emergencies			O	M	O	M			O	M	

Appendix 1

Skills For justice NOS	Chief Executive Officer	Accountable Emergency Officer	Strategic Commander	Tactical Commander	Operational Commander	EPRR Specialist / Adviser	Business Continuity Lead	Comms Officer	Command Support Role	On Call staff	Loggist
SFJ CCA H1 Provide on-going support to meet the needs of individuals affected by emergencies			M	M	O	M				O	
SFJ CCA H2 Manage community recovery from emergencies	M	O	M	O	O	M				O	

Key: O – optional for the role (to be developed through CPD)

M – Mandatory for the role

PART B

3 IDENTIFICATION OF STAKEHOLDERS

The table below should be used as a summary. List those involved in development, consultation, approval, and ratification processes.

Stakeholder	Level of involvement
EPRR group	Review draft document
Business continuity leads	Review draft document
Emergency Preparedness, Resilience and Response Group	Approval
Policy and Procedure Group	Ratification

4 REFERENCES, EVIDENCE BASE

The following documents, standards and guides were used to develop this Business Continuity Management Framework:

Standards:

ISO 22301, Societal security — Business continuity management systems — Requirements
ISO 22313, Societal security — Business continuity management systems — Guidance
ISO/TS 22317 Societal security — Business continuity management systems — Guidelines for business impact analysis (BIA)
BS 25999-1:2006 - Business continuity management – Part 1: Code of practice
BS 25999-2 Business continuity management — Part 2: Specification
PAS 2015:2010; Framework for Health Service Resilience
NHS England: Emergency Preparedness, Resilience and Response Framework 2015
NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) 2023

Guidance

The Business Continuity Institute – *Good practice guidelines 2010: A Management Guide to Implementing Global Good Practice in Business Continuity Management*
NHS England: Business Continuity Management Toolkit 2016
NHS England: (NHS Commissioning Board) Business Continuity Management Framework (service resilience)
NHS England: A Business Continuity Management System Strategy Outline
Cabinet Office: *Emergency Preparedness 2012 – Chapter 6 Business Continuity Management*

5 ASSOCIATED DOCUMENTATION (if relevant)

The following Trust documents are relevant to the Business Continuity Management Framework and Policy:

Major Incident Response Plan EP-0004
The Risk Management Policy – RM-0001
Risk Assessment & Risk Register Procedure – RM-0004
Lockdown Policy and Procedure – RM-0010
Vehicle Fuel Disruption Plan – EP- 0002
Chemical decontamination plan – EP- 0003

6 STANDARDS/KEY PERFORMANCE INDICATORS (if relevant)

The relevant standards are drawn from NHS England's EPRR standards and are:

Number	Standard
Core Standard 1	Senior Leadership
Core standard 2	EPRR Policy Statement
Core standard 3	EPRR Board reports
Core Standard 4	EPRR work programme
Core Standard 5	EPRR Resource
Core Standard 6	Continuous improvement
Core Standard 7	Risk assessment
Core Standard 8	Risk Management
Core Standard 9	Collaborative planning

In terms of the Business Continuity and EPRR Policy the following key performance indicators exist.

1. All relevant services have approved business continuity plans.
2. All plans are subject to an annual review/ exercise, the date of which is notified to the Resilience lead.
3. At least one formal live exercise of a business continuity plan is done every year, or a real incident necessitates use of a business continuity plan.
4. Business continuity related risks are reviewed annually and compared to risks on the community risk registered held by West Yorkshire Local Resilience Forum.

7. EQUALITY IMPACT

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. Consideration must be given to any potential impacts that the application of this policy/procedure might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender, and sexual orientation).

Declaration: The potential impacts on the application of this policy/procedure have been fully considered for all nine protected groups. Through this process I ~~have~~ / have not identified any potential negative impacts for any of the nine protected groups.

Print name: Andrew Jackson

Job title: Resilience Lead and Corporate Business Manager

Date: 22 July 2023

If any potential negative impacts are identified the Diversity Team must be contacted for advice and guidance: email; diversity.lypft@nhs.net.

*Delete as appropriate

CHECKLIST

To be completed and attached to any draft version of a procedural document when submitted to the appropriate group/committee to support its consideration and approval/ratification of the procedural document.

This checklist is part of the working papers.

	Title of document being newly created / reviewed:	Yes / No/
1.	**Title**	
	Is the title clear and unambiguous?	*Yes*
	Is the procedural document in the correct format and style?	*Yes*
2.	**Development Process**	
	Is there evidence of reasonable attempts to ensure relevant expertise has been used?	*Yes*
3.	**Content**	
	Is the Purpose of the document clear?	*yes*
5.	**Approval**	
	Does the document identify which committee/group will approve it?	*Yes*
6.	**Equality Impact Assessment**	
	Has the declaration been completed?	*Yes*
7.	**Review Date**	
	Is the review date identified?	*Yes*
	Is the frequency of review identified and acceptable?	*Yes*
8.	**Overall Responsibility for the Document**	
	Is it clear who will be responsible for co-ordinating the dissemination, implementation, and review of the document?	*Yes*

Board of Directors			
Final signoff of the Business Continuity and EPRR Policy as required by standards.			
Name		Date	

Chair's Report

AGENDA ITEM

15

Name of the meeting being reported on:	Mental Health Legislation Committee
Date your meeting took place:	1 August 2023
Name of meeting reporting to:	Board of Directors (28 September 2023)

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 noted that police responses to mental health incidents were likely to change under the rollout of the "Right Care, Right Person model" as part of a national agenda to reduce police being called as first responders to health incidents, and developments in this area will continue to be monitored.

- The Committee received the Consent to Treatment Audit Report which also included a review of Section 62 powers. It noted the issues raised, and supported the recommendations suggested by the report. It also agreed that a Task and Finish Group should be set up to investigate how to examine potential solutions to reduce the risk of medicines being prescribed to service users without correct lawful authority.

- The Committee received an audit report on the use of Section 5 (2) powers being used across the Trust, noted the issues raised and supported the recommendations suggested by the report.

Things on which the Board is to be assured:

- The Committee received the NICHE report which had been used by NHS England to create an improvement plan for Children and Young People's Mental Health Inpatient Services. The Committee was reassured on the arrangements in place at the Trust to monitor the safe use of restrictive interventions on service users.

- The Committee received the Mental Health Legislation Activity Report for Q1 2023-24 and was assured the plans in place were sufficient to ensure ongoing compliance with all mental health legislation.

Items to be referred to other Board sub-committees: None.	
Report completed by:	Kaneez Khan – September 2023

Chair's Report

AGENDA ITEM

16

Name of the meeting being reported on:	Workforce Committee
Date your meeting took place:	3 August 2023
Name of meeting reporting to:	Board of Directors – 28 September 2023

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 heard about the proposed Oliver McGowan Training on Learning Disability and Autism which was due to become mandatory for all CQC registered organisations. The Committee noted that considerable resource would be required to deliver the proposals and the team were currently assessing what work needed to be undertaken as well as looking at opportunities for collaboration across the West Yorkshire Mental Health, Learning Disabilities and Autism Collaborative.

- The Committee noted that an internal audit into the use of the e-Rostering system had been returned with limited assurance and requested to receive an action plan at a future meeting.

Things on which the Board is to be assured:

- The Committee discussed sickness absence due to stress and anxiety and the mechanisms in place for analysing hotspot areas and was assured that the POD governance arrangements had sufficient oversight of this area. The Committee also considered the Trust's approach to the management of staff absence and received assurance on the new Employee Wellbeing and Managing Attendance Procedure and agreed that an evaluation of the procedure would be presented to a future meeting.

- The Committee received an update on the development of Formal Clinical Leadership from Dr Lyndsey Charles. The Committee was significantly assured on the rigour with which processes were followed to improve formal clinical leadership within the organisation and with the evidence base used; recognised the importance of this work in terms of improving staff culture; and agreed that this was an accomplished piece of work. The Committee also sought assurance that the clinical leadership work was consistent with the wider management development work taking place in the POD directorate.

- The Committee reviewed the detailed action plan to tackle bullying and harassment towards Bank colleagues in response to the Bank Survey 2021 which showed that the experience of Bank colleagues was consistently worse than that of their substantive colleagues and was assured that the 2022 Bank Staff Survey results had shown improvement across all nine People Promise themes.

- The Committee received a report on the Trust's Workforce Race Equality Standard, Workforce Disability Equality Standard data for 22-23 and priority action areas and a summary of the gender pay gap figures for 22-23. The Committee noted the encouraging improvements in this year's data, with favourable changes in 79% of areas and suggested some ways to develop the report further such as including WRES and WDES benchmarking data with partners at a West Yorkshire 'Place' level and for pay information to be broken down by all protected characteristics, not just gender.

- The Committee noted progress with some of the Trust's key performance indicators: compulsory training compliance was at a record high of 86% and both Personal Development Review and clinical supervision compliance were at 70%.

- The Committee discussed the development of a Hate Crime Pathway and supported the proposed zero-tolerance approach to hate crimes. The Committee also received an update on the ongoing work to progress the violence prevention and reduction standard.

- The Committee reviewed and approved its updated Terms of Reference.

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 2023

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

AGENDA ITEM

16.1

PAPER TITLE:	Terms of Reference for the Workforce Committee
DATE OF MEETING:	28 September 2023
PRESENTED BY: (name and title)	Helen Grantham, Non-executive Director and Chair of the Workforce Committee
PREPARED BY: (name and title)	Rose Cooper, Deputy Head of 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 asked to note that each Board sub-committee is required to review its terms of reference annually to ensure they are up to date and reflect the work of the committee.

The Workforce Committee reviewed and approved its terms of reference on the 3 August 2023. The following amendments were made (all amendments are highlighted in yellow on the attached document):

- Page 1 – Amendment to the role descriptions of the non-executive directors, as defined by the Code of Governance for NHS Provider Trusts, NHS England 2022.
- Page 3 – Amendment to the role of Associate Non-executive Directors at Committee meetings.
- Page 4 – Updated to reflect the current practice of circulating paperwork five working days before the meeting.
- Page 5 – 'Powers' section updated to reflect what is stated in NHS England's Code of Governance for NHS Provider Trusts.
- Page 6 – Updated wording to reflect the duties of the Designated Board Member when an investigation is undertaken regarding a doctor's practice in line with the Managing Concerns About Medical Colleagues (Maintaining High Professional Standards) Policy.
- Page 8 – Updated wording to reflect the duties of the Designated Board Member when an investigation is undertaken regarding a doctor's practice in line with the Managing Concerns About Medical Colleagues (Maintaining High Professional Standards) Policy.

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 review the changes made and ratify the revised Terms of Reference.

WORKFORCE COMMITTEE

Terms of Reference

(Approved by the Committee on 3 August 2023
To be ratified by the Board of Directors on 28 September 2023)

1 NAME OF COMMITTEE

Workforce Committee

2 COMPOSITION OF THE COMMITTEE

Members: full rights

Title	Role in the committee
Non-executive Director (Chair of the Committee)	Non-executive directors provide constructive challenge and strategic guidance, and lead in holding the executive to account. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of clinical and other information, and make sure that clinical quality controls, and systems of risk management and governance, are robust and implemented (Code of Governance for NHS Provider Trusts, NHS England 2022)
Non-executive Director	Non-executive directors provide constructive challenge and strategic guidance, and lead in holding the executive to account. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of clinical and other information, and make sure that clinical quality controls, and systems of risk management and governance, are robust and implemented. (Code of Governance for NHS Provider Trusts, NHS England 2022)

Director of People and Organisational Development	Assurance on the OD and Workforce aspects of their portfolio in relation to the delivery of the strategic aims, goals and plans relating to staff and legal and statutory HR functions
Director of Nursing, Quality and Professions	Assurance on the professional workforce aspects of the Nursing and Allied Health Professional, Psychology and Psychotherapy staff
Medical Director	Assurance on the professional workforce aspects of the medical staff
Chief Operating Officer	Executive Director with responsibility for oversight and delivery and development of Care Services. Assurance and escalation provider to the Workforce Committee

In attendance: in an advisory capacity

Title	Role in the committee	Attendance guide
Associate Director for Corporate Governance	Trust Board Secretary overseeing the information flows of the committees	Each meeting
Associate Director for People Resourcing and Organisational Development	Provide information and assurance on organisational development, leadership and management development, talent development and strategic resourcing, including widening participation and apprenticeships	Each meeting
Associate Director of People Experience	Provide information and assurance on wellbeing, equality and diversity, engagement and marketing and communications	Each meeting
Associate Director of Employment	Provide information and assurance on the approach taken to employment practices, policies and processes, partnership working arrangements internally within the Trust and effective change management approaches affecting people	Each meeting
Head of People Analytics and Temporary Staffing	Provision of workforce information and undertaking of analytics as required	As Required

Title	Role in the committee	Attendance guide
Head of Strategic Resourcing and Talent Development	Provide assurance on vacancies rates, the future direction of workforce skills and skills gaps	As Required
Head of Communications	Provide information and assurance on methods of communication	As Required
Head of Diversity and Inclusion	Provide information and assurance on the equality, diversity and inclusion agenda and plan	As Required
Head of Wellbeing	Provide information and assurance on the health and wellbeing across the Trust	As Required

In addition to anyone listed above as a member, at the discretion of the chair of the committee may also request individuals to attend on an ad-hoc basis to provide advice and support for specific items from its work plan when these are discussed in the meetings.

2.1 Governor Observers

The role of the governor at Board sub-committee meetings is to observe the work of the Committee, rather than to be part of its work as they are not part of the formal membership of the Committee. The governor observes Board sub-committee meetings in order to get a better understanding of the work of the Trust and to observe non-executive directors appropriately challenging the executive directors for the operational performance of the Trust.

At the meeting the governor observer will be required to declare any interest they may have in respect of any of the items to be discussed (even though they are not formally part of the discussion). Governors will receive an information pack prior to the meeting. This will consist of the agenda, the minutes of the previous meeting and summaries of the business to be discussed. Governor observers will be invited to the meeting by the Corporate Governance Team. The chair of the meeting should ensure that there is an opportunity for governor observers to raise any points of clarification at the end of the meeting.

2.2 Associate Non-executive Directors

Associate Non-executive Directors will be invited to attend Board sub-committee meetings as part of their induction. They will be in attendance at the meeting, in the capacity of observer only, unless invited to contribute by the Chair in circumstances that support the ANEDs development and understanding. This is so the accountability of the substantive members of the Committee is maintained.

Associate NEDs will be invited to meetings by the Corporate Governance Team and will be sent copies of the meeting papers.

3 QUORACY

Number: The minimum number of members for a meeting to be quorate is three and must include either the non-executive director responsible for workforce or the Director of People and Organisational Development. Attendees do not count towards quoracy. If the chair is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by the second non-executive director.

Deputies: Where appropriate members may nominate deputies to represent them at a meeting. Deputies do not count towards the calculation of whether the meeting is quorate except if the deputy is representing the member under formal "acting up" arrangements. In this case the deputy will be deemed a full member of the committee.

It may also be appropriate for attendees to nominate a deputy to attend in their absence.

A schedule of deputies, attached at appendix 1a, should be reviewed at least annually to ensure adequate cover exists.

Non-quorate meeting: Non-quorate meetings may go ahead unless the chair decides not to proceed. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

Alternate chair: In the absence of the Chair the alternate chair of the meeting will be the second non-executive director.

4 MEETINGS OF THE COMMITTEE

Meetings may be held face-to-face or remotely as is considered appropriate. Remote meetings may involve the use of the telephone and / or electronic conference facilities.

Frequency: Bi-monthly

Urgent meeting: Any member of the committee may request an urgent meeting. The chair will normally agree to call an urgent meeting to discuss the specific matter unless the opportunity exists to discuss the matter in a more expedient manner.

Minutes: The Corporate Governance Team will provide secretariat support to the Committee. Draft minutes will be sent to the chair for review and approval within seven working days of the meeting.

Papers: Papers for the meeting will be distributed electronically by the Corporate Governance Team five working days prior to the meeting. Papers received after this date will only be included if agreed by the chair.

5 AUTHORITY

Establishment: The Workforce Committee is a sub-committee of the Board of Directors and has been formally established by the Board of Directors.

Powers: The Workforce Committee is constituted as a standing committee of the Board of Directors. The Committee is authorised by the Board to seek assurance on any activity within its terms of reference.

In consultation with the Board of Directors, the committee is able to access independent professional advice and secure the attendance of persons outside the Trust with relevant experience and expertise if it considers this necessary.

Cessation: The Workforce Committee is a standing committee in that its responsibilities and purpose are not time limited. It will continue to meet in accordance with these terms of reference until the Trust Board determines otherwise.

6 ROLE OF THE COMMITTEE

6.1 Purpose of the Committee

The purpose of the committee is to provide the Board with assurance concerning all aspects of strategic workforce matters relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients and staff.

Its purpose is also to ensure there is a positive working environment for staff which promotes an open culture that helps staff do their job to the best of their ability.

Trust Strategic Objective	How the committee will meet this objective
We deliver care that is high quality and improves lives	Assurance on the delivery of the Trust's strategic workforce plan
We provide a rewarding and supportive place to work	Assurance on the delivery of the Trust's strategic workforce plan
We use our resources to deliver effective and sustainable services	Assurance on the delivery of the Trust's strategic workforce plan

6.2 Guiding principles for members (and attendees) when carrying out the duties of the committee

In carrying out their duties members of the committee and any attendees of the committee must ensure that they act in accordance with the values of the Trust, which are:

- We have integrity
- We are caring
- We keep it simple.

6.3 Duties of the committee

On behalf of the Board of Directors the committee will:

- Seek assurance on the progress made against the NHS People Plan.

- Seek assurance on the development and the delivery of the Trust's People Plan and have oversight of its key strategic themes which include: health and wellbeing; resourcing; equality and inclusion; engagement and retention; and leading together.

- Carry out the role of Wellbeing Guardian Champion and receive a Wellbeing Guardian Report at every meeting.

- ~~Carry out the duties of the Doctors Disciplinary Champion, with the chair of the committee being the named champion.~~

- Carry out the duties of the Designated Board Member when an investigation is undertaken regarding a doctor's practice in line with the Managing Concerns About Medical Colleagues (Maintaining High Professional Standards) Policy, with the Chair of the Committee being the Designated Board Member

- Seek assurance on the development of the workforce to ensure the Trust has productive staff with the skills, competencies, and knowledge to provide safe and effective care.

- Be responsible for signing off any underpinning workforce strategies.

- Seek assurance that the Trust is meeting its legal and regulatory duties in relation to its employees.

- Have oversight of relevant workforce data and specific initiatives in relation to the Equality and Inclusion Agenda as requested by the Board of Directors, recognising that a significant element of the Trust's work to ensure equality and inclusion is with regard to the workforce.

- Seek assurance that the Trust is actively involved and where relevant influencing work taking place at a national, regional, and local level including the work carried out by the West Yorkshire and Harrogate Integrated Care System relating to workforce.

- Seek assurance on progress against the workforce metrics.

- Seek assurance around the risks delegated to it via the Board Assurance Framework. The committee should determine if the appropriate level of risk has been identified, review the effectiveness of the controls in place relevant to the risks, review and challenge the strength of the assurances provided, identify any gaps in control or assurance and ensure that the risk lead identifies appropriate actions to address such gaps.

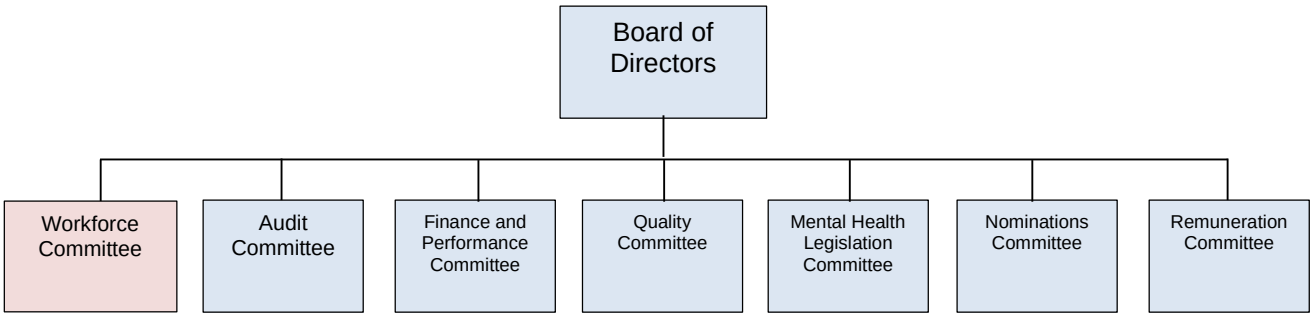
- Where necessary seek assurance into any area of work related to workforce and related matters on behalf of the Board.

- The committee will also review the draft Internal Audit Annual work plan so it can be assured on the sufficiency of the work the Auditors will carry out in respect of matters pertaining to the duties of the committee. Assurance on the plan's sufficiency (or

comments on any matters that should be included) will be provided to the Audit Committee to allow it to approve the overall plan.

7 RELATIONSHIP WITH OTHER GROUPS AND COMMITTEES

The committee has a duty to work with other Board sub-committees to ensure matters are not duplicated.



The Workforce Committee does not have any sub-committees. It is linked to the People and Organisational Development (POD) Governance Group as an assurance receiver. The Workforce Committee provides a route of escalation for this group to the Board of Directors. Although this does not preclude any other group being asked to provide assurance.

Reporting:

The Workforce Committee receives a People and Organisational Development Governance Group Chair's Report at each meeting. This report summarises the recent activity of the People and Organisational Development (POD) Governance Group as well as highlight reports from each of the four POD Governance Groups (People Experience Group, People Talent and OD Group, People Resourcing and Retention Group, and People Employment Group).

An assurance and escalation report will be made to the Board of Directors by the Chair of the Committee.

8 DUTIES OF THE CHAIR

The chair of the committee shall be responsible for:

- Agreeing the agenda
- Directing the meeting ensuring it operates in accordance with the Trust's values
- Giving direction to the minute taker
- Ensuring everyone at the meeting has a reasonable chance to contribute to the discussion
- Ensuring discussions are productive, and when they are not productive, they are

efficiently brought to a conclusion
- Deciding when it is beneficial to vote on a motion or decision
- Checking the minutes
- Ensuring sufficient information is presented to the Board of Directors in respect of the work of the committee
- Ensuring the Chair's report is submitted to the 'parent' committee as soon as possible
- Ensuring that governor observers are offered an opportunity at the end of the meeting to raise any points of clarification.

In the event of there being a dispute between any 'groups' in the hierarchy (in the case of this Board sub-committee, this would be between the Board and the Workforce Committee and, in recognition of the nature of matrix working between the work of all Board sub-committees, the Workforce Committee and any other Board sub-committee) it will be for the chairs of those 'groups' to ensure there is an agreed process for resolution; that the dispute is reported back to the 'groups' concerned; and that when a resolution is proposed regarding the outcome this is also reported back to the 'groups' concerned for agreement.

~~The Chair of the Workforce Committee will also be the named Doctors Disciplinary Champion, with the requirements of the role to be discharged through the committee.~~

The Chair of the Workforce Committee will also be the Designated Board Member when an investigation is undertaken regarding a doctor's practice in line with the Managing Concerns About Medical Colleagues (Maintaining High Professional Standards) Policy.

9 REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

The terms of reference shall be reviewed by the committee at least annually and be presented to the Board of Directors for ratification where there has been a change.

In addition to this the chair must ensure the committee carries out an annual assessment of how effectively it is carrying out its duties and make a report to the Board of Directors including any recommendations for improvement.

Schedule of deputies

It may not be necessary or appropriate for all members (or attendees) to have a deputy attend in their absence. If this is the case, please state below "no deputy required".

Full member (by job title)	**Deputy (by job title)**
Director of People and Organisational Development	Associate Director for People and Organisational Development
Director of Nursing, Quality and Professions	Deputy Director of Nursing (as required)
Medical Director	Deputy Medical Director
Chief Operating Officer	Deputy Director (as required)

AGENDA ITEM

17

Chair's Report

Name of the meeting being reported on:	Quality Committee
Date your meeting took place:	14 September 2023
Name of meeting reporting to:	Board of Directors – 28 September 2023

Key discussion points and matters to be escalated:

Issues to which the Board needs to be alerted:

- The committee received the Combined Complaints, Concerns, PALS, Compliments and Patient Safety Q1 Report. It was informed that NHS England would be changing the national systems used by the Trust to report patient safety incidents which would require the Trust to make changes to the patient safety incident reporting form on Datix.

Things on which the Board is to be assured:

- The committee reviewed an extract from the Board Assurance Framework which detailed strategic risks one and two so that it could be mindful of its responsibilities to assure that these risks were being adequately controlled through the course of the meeting.

- The committee received the Q1 Learning from Deaths Report and the Learning from Deaths Annual Report for 2022/23. It also received a summary report on the learning from deaths pilot that commenced in 2023 to review the best methods of disseminating learning in a meaningful and effective way. Whilst acknowledging insights from the pilot, the committee noted that in adopting PSIRF there would be an increasing focus on changes to systems to reduce the risk of future harm. The committee discussed the government announcement of the new approach that would be taken by the police to ensure those requiring urgent mental health support received timely care from the most appropriate agency. It was agreed that a report would be produced to review the impact of this on quality. Overall, the committee was assured on the work ongoing within the Trust to improve mortality review and to improve actions in response to findings across the organisation.

- The committee reviewed the Combined Quality and Workforce Performance Report. It was pleased to see the increase in compliance with mandatory training, appraisals and clinical supervision and thanked the teams involved for their work to improve compliance rates.

- The committee received the Infection Prevention and Control (IPC) of Medical Devices Annual Report for 2022/23 and the Infection Prevention and Control Board Assurance Framework. It discussed the Covid-19 vaccination process and was reassured that for 2023 the Trust would continue to offer Covid-19 vaccinations to all staff and service users. It agreed that it was assured that the Trust continued to follow all national infection, prevention and control guidance

and that the Director of Infection, Prevention and Control had daily oversight of any positive cases and outbreak management within the Trust.

- The committee received the Medicines Optimisation Group Annual Report for 2022/23. It agreed that the Medicines Optimisation Group was fulfilling its Terms of Reference.

- The committee received the Research and Development Annual Report for 2022/23. It was pleased to hear that the team had returned to face-to-face engagement activities and suggested that governors could be invited to engagement events run by the team. The committee recognised the work carried out throughout the year to raise awareness of the Research Team across the organisation and create a culture of research being core business.

- The committee received the Combined Complaints, Concerns, PALS, Compliments and Patient Safety Q1 Report and Annual Report for 2022/23. It discussed the concerns raised by coroners regarding delays in making final versions of serious incident investigation reports by the Tees Esk and Wear Valleys NHS Foundation Trust and agreed that assurance should be provided at a future meeting on the timeliness of the completion of serious incident investigations within LYPFT. The committee agreed that the Trust had good systems for understanding quality issues raised through these sources and working to improve them.

- The committee received the Safeguarding Annual Report for 2022/23. It noted the work undertaken in relation to domestic abuse and welcomed the flexible approach used to deliver the safeguarding training, which included on-site group training, virtual training and the development of a video, and encouraged the team to seek executive support where needed for any outstanding gaps in completion.

- The committee received reassurance on the Trust's work to manage the impact of industrial action on service users.

Issues to advise the Board on:

- The committee acknowledged that the report of the independent review into how data relating to deaths is processed and reported at Norfolk and Suffolk NHS Foundation Trust (NSFT) was published on 28 June 2023. It was informed that the Trust would be reviewing the recommendations made within the report to assess the Trust's position and develop an action plan for any improvements needed, and that this would be shared with the committee at a future meeting. In the interim the committee encouraged definitional clarity in all committee papers providing data related to deaths.

- The committee acknowledged that the report of the independent rapid review into data on mental health inpatient settings, chaired by Dr Geraldine Strathdee, was published on 28 June 2023. It was noted that a paper would go to the private Board of Directors meeting on 28 September 2023 which would review the recommendations made within the report, assess the Trust's position and identify any actions needed to make improvements.

- The committee acknowledged the outcome of the trial of Lucy Letby and noted that this would be discussed in further detail by the Board of Directors at a future meeting.

- The committee acknowledged that the Government had announced a new National Suicide Prevention Strategy on 11 September 2023. It noted that this would be discussed by the Board of Directors at a future meeting.

Items to be referred to other Board sub-committees:

- Workforce Committee - The committee noted the work undertaken by the Safeguarding Team in relation to domestic abuse and agreed that the workforce committee should consider the domestic abuse issues related to staff.

  Workforce Committee – It was suggested that the Workforce Committee should receive assurance on the processes for dealing with safeguarding concerns raised between colleagues.

- Workforce Committee - The committee discussed the government announcement of the new approach that would be taken by the police to ensure those requiring urgent mental health support receive timely care from the most appropriate agency. It was agreed that the Workforce Committee would receive further information as to how the police respond to violence and aggression from service users against staff.

Report completed by:	Dr Frances Healey, September 2023

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

AGENDA ITEM

17.1

PAPER TITLE:	Terms of Reference for the Quality Committee
DATE OF MEETING:	28 September 2023
PRESENTED BY: (name and title)	Dr Frances Healey, Non-executive Director and Chair of the Quality Committee
PREPARED BY: (name and title)	Kerry McMann, Head of 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 Quality Committee reviewed and approved its terms of reference on 14 September 2023. The following amendments were made (all amendments highlighted in yellow in the attached document):

- Page four – sentence added regarding the committee's ability to obtain legal or other independent advice (in line with NHS England's Code of Governance for Provider Trusts)

- Page five – Duties amended to reference the committee's role in relation to the CQC (agreed at the June 2023 Quality Committee meeting)

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 review the changes made and ratify the revised Terms of Reference.

Quality Committee

Terms of Reference

(To be approved by the committee on 14 September 2023
To be ratified by the Board of Directors on 28 September 2023)

1 NAME OF GROUP

The name of this committee is the Quality Committee.

2 COMPOSITION OF THE COMMITTEE

The members of the committee and those who are required to attend are shown below together with their role in the operation of the committee.

Members

Title	Role in the committee
Non-executive Director	Chair of the meeting. Non-executive directors provide constructive challenge and strategic guidance, and lead in holding the executive to account. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of clinical and other information, and make sure that clinical quality controls, and systems of risk management and governance, are robust and implemented (Code of Governance for NHS Provider Trusts, NHS England 2022)
Non-executive Director	Deputy chair of the meeting. Non-executive directors provide constructive challenge and strategic guidance, and lead in holding the executive to account. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of clinical and other information, and make sure that clinical quality controls, and systems of risk management and governance, are robust and implemented. (Code of Governance for NHS Provider Trusts, NHS England 2022)

Title	Role in the committee
Director of Nursing, Professions and Quality and Director of Infection Prevention and Control	Executive director lead for quality. Chair of the: Patient Experience Group; Trustwide Safeguarding Group; Nursing and Professions Council; and Infection Prevention Control and Medical Devices Group. Assurance and escalation provider to the Quality Committee.
Chief Operating Officer	Executive director with responsibility for oversight and delivery and development of Care Services. Assurance and escalation provider to the Quality Committee.
Medical Director	Joint executive lead for quality. Medical input and Chair of the Trustwide Clinical Governance Group. Assurance and escalation provider to the Quality Committee.
Director of People and Organisational Development	Staff training and development issues related to quality. Assurance and escalation provider to the Quality Committee.
Chief Financial Officer	Executive lead for financial resources including Cost Improvement Programmes. Assurance and escalation provider to the Quality Committee. Attendance at meetings will be dependent on the agenda items being discussed.

While specified board members will be regular members of the Quality Committee any other board member can attend the meeting on an ad-hoc basis if they wish and will be recognised as a member for that particular meeting and if necessary will count towards the quoracy.

Attendees

The Quality Committee may also invite other members of Trust staff to attend to provide advice and support for specific items when these are discussed in the committee's meetings.

These could include, but are not exhaustive to, the following individuals:

- Associate Director for Corporate Governance
- Deputy Director of Nursing
- Clinical Directors
- Head of Nursing and Patient Experience
- Professional and Clinical Leads

2.1 Governor Observers

The role of the governor at Board sub-committee meetings is to observe the work of the committee, rather than to be part of its work as they are not part of the formal membership of the committee. The governor observes Board sub-committee meetings in order to get a better understanding of the work of the Trust and to observe non-executive directors appropriately challenging the executive directors for the operational performance of the Trust.

At the meeting the governor observer will be required to declare any interest they may have in respect of any of the items to be discussed (even-though they are not formally part for the discussion). Governors will receive an information pack prior to the meeting. This will consist of the agenda, the minutes of the previous meeting and summaries of the business to be discussed. Governor observers will be invited to the meeting by the Corporate Governance Team. The chair of the meeting should ensure that there is an opportunity for governor observers to raise any points of clarification at the end of the meeting.

2.2 Associate Non-executive Directors

Associate Non-executive Directors will be invited to attend Board Sub-committee meetings as part of their induction. They will be in attendance at the meeting, in the capacity of observer only, unless invited to contribute by the Chair in circumstances that support the ANEDs development and understanding. This is so the accountability of the substantive members of the committee is maintained.

Associate NEDs will be invited to meetings by the Corporate Governance Team and will be sent copies of the meeting papers.

3 QUORACY

Number: The minimum number of members for a meeting to be quorate is three. This should comprise at least one non-executive director and one executive director. Attendees do not count towards this number. If the chair is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by the deputy chair.

Non-quorate meeting: Non-quorate meetings may go forward unless the chair decides otherwise. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

4 MEETINGS OF THE GROUP

Meetings may be held face-to-face or remotely as is considered appropriate. Remote meetings may involve the use of the telephone and / or electronic conference facilities.

Frequency: The Quality Committee will meet monthly to transact its normal business.

Administrative support: The Corporate Governance Team will provide secretariat support to the committee.

Minutes: Draft minutes will be sent to the chair for review and approval within seven working days of the meeting.

Papers: Papers for the meeting will be distributed electronically by the Corporate Governance Team five working days prior to the meeting. Papers received after this date will only be included if decided upon by the chair.

5 AUTHORITY

Establishment: The Quality Committee is a sub-committee of the Board of Directors and has been formally established by the Board of Directors.

Powers: The Quality Committee is constituted as a standing committee of the Trust Board of Directors. The committee is authorised by the Board to investigate and seek assurance on any activity within its terms of reference.

In consultation with the Board of Directors, the committee is able to access independent professional advice and secure the attendance of persons outside the Trust with relevant experience and expertise if it considers this necessary.

Cessation: The Quality Committee is a standing committee in that its responsibilities and purpose are not time-limited. It will continue to meet in accordance with these terms of reference until the Trust Board determines otherwise.

6 ROLE OF THE GROUP

6.1 Purpose of the Group

The Quality Committee has responsibility for providing assurance to the Board of Directors on the effectiveness of the:

- Trust's quality, including patient safety, systems and processes
- Quality, including patient safety, of the services provided by the Trust
- control and management of quality, including patient safety, related risks within the Trust.

The quality committee is committed to improving governance on a continuing basis through evaluation and review.

6.2 Guiding principles for members (and attendees) when carrying out the duties of the Quality Committee

In carrying out their duties members of the committee and any attendees of the committee must ensure that they act in accordance with the values of the Trust, which are:

- we have integrity
- we are caring
- we keep it simple.

6.3 Duties of the Quality Committee

The Quality Committee is seeking assurance that:

- systems and processes are effective
- quality, including patient safety, of services that the Trust provides is good and continuously improving
- quality of the experience of people using our service is good and continuously improving.

It carries out its duties to provide assurance to the Board of Directors. In addition to this, it is authorised to seek information that will allow it carry out its purpose. It will:

- Seek assurance on systems and processes to ensure monitoring and assessment of the quality, including patient safety, and improvements in services

- Seek assurance on the mechanisms to involve service users, carers, the public and partner organisations in improving services

- Seek assurance on the systems for identifying, reporting, mitigating and managing quality, including patient safety, related risks including the monitoring of incidents, investigations and deaths; and complaints, claims, and compliments

- Review the Board Assurance Framework to seek assurance on behalf of the Board that those strategic risks where it has been listed as an assurance receiver, are being effectively controlled; that the risk score (which has been determined by the executive team) is at the right level; and that any gaps are being addressed appropriately. It may also inform any deep-dive which it may wish to undertake into any area on which is requires further assurance.

- Seek assurance on compliance against the Care Quality Commission's registration and notification requirements and action plans in response to CQC inspection.

- Monitor, scrutinise and provide assurance to the Board of Directors on the Trust's compliance with national standards, including the Care Quality Commission's Fundamental Standards, and the quality elements relating to NHS England's System Oversight Framework, the quality elements within the NHS Standard contract, NICE guidance and CQUIN schemes.

- Seek assurance on the quality impact assessments for key strategic programs of work

- Receive assurance on the work carried out and reported to the Trustwide Clinical Governance Group, including: Quality Plan; Quality Report; Infection Prevention and Control; Safeguarding; Research and Development; Clinical Audit and NICE; Continuous Improvements; and Measuring outcomes across Trust services

- Receive assurance on activity within operational services that contributes to the understanding and improvement of quality, including patient safety, within the Trust.

- Review the draft Internal Audit Annual work plan so it can be assured on the sufficiency of the work the Auditors will carry out in respect of clinical matters. Assurance on this sufficiency (or comments on any matters that should be included) will be provided to the Audit Committee to allow it to approve the overall plan.

- Have oversight of relevant data and specific initiatives in relation to the Equality and Inclusion Agenda as requested by the Board of Directors, recognising the importance of inclusion and accessibility in delivering quality services

- Carry out the duties of the Maternity Board Safety Champion, with the chair of the committee being the named champion.

- Carry out the role of Hip Fracture, Falls and Dementia Champion

- Carry out the role of Learning from Deaths Champion

- Carry out the role of Children and Young People Champion

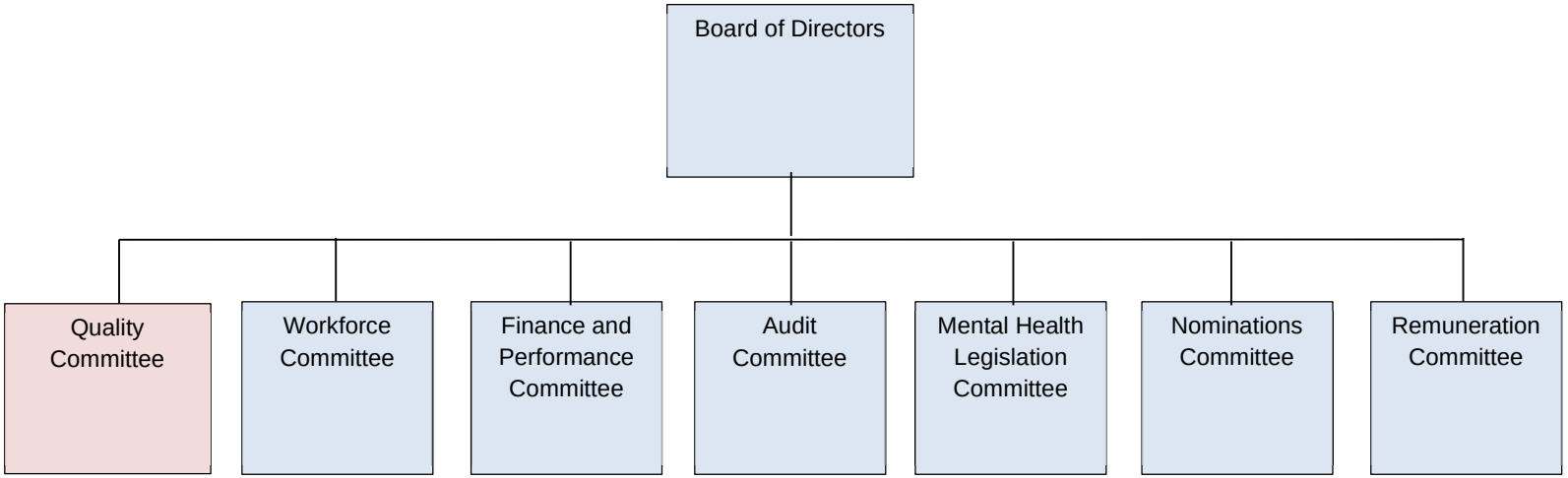
- Carry out the role of Resuscitation Champion

- Carry out the role of Safeguarding Champion

- Carry out the role of Palliative and of Life Care Champion

An assurance and escalation report will be made to the Board of Directors by the Chair of the committee.

7 Links with Other Committees



The Quality Committee does not have any sub-committees. It is linked to the Trustwide Clinical Governance Group as an assurance receiver. The Quality Committee provides a route of escalation for this group to the Board of Directors. Although this does not preclude any other group being asked to provide assurance. The committee has a duty to work with other Board sub-committees to ensure matters are not duplicated.

8 DUTIES OF THE CHAIR

The Chair of the committee shall be responsible for:

- agreeing the agenda with the Director of Nursing, Quality and Professions and the Medical Director
- directing the conduct of the meeting ensuring it operates in accordance with the Trust's values
- giving direction to the Committee Secretariat
- ensuring all members have an opportunity to contribute to the discussion
- ensuring the agenda is balanced and discussions are productive, and when they are not productive they are efficiently brought to a conclusion
- deciding when a matter requires escalation to the Board of Directors
- checking the minutes
- ensuring key information is presented to the Board of Directors in respect of the work of the committee
- ensuring that governor observers are offered an opportunity at the end of the meeting to raise any points of clarification.

In the event of there being a dispute between any 'groups' in the hierarchy (in the case of this Board sub-committee, this would be between the Board and the Quality Committee and, in recognition of the nature of matrix working between the work of all Board sub-committees, the Quality Committee and any other Board sub-committee) it will be for the chairs of those groups to ensure there is an agreed process for resolution; that the dispute is reported back to the 'groups' concerned; and that when a resolution is proposed regarding the outcome this is also reported back to the 'groups' concerned for agreement.

The chair of the Quality Committee will also be the named Maternity Board Safety Champion, with the requirements of the role to be discharged through the committee.

9 REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

The terms of reference shall be reviewed by the committee at least annually, and then presented to the Board of Directors for ratification. This will also occur throughout the year if a change has been made to them.

In addition to this the chair must ensure the committee carries out an annual assessment of how effectively it is carrying out its duties and make a report to the Board of Directors including any recommendations for improvement.

10 SCHEDULE OF DEPUTIES

Committee Member	Deputy
NED Chair	Second NED
NED member	None
Director of Nursing, Professions and Quality / Director of Infection Prevention and Control	Deputy Director of Nursing
Chief Operating Officer	Deputy Chief Operating Officer
Director of People and Organisational Development	Associate Director
Medical Director	Clinical Director

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
19

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Proposed changes to the Constitution and it Annexes
DATE OF MEETING:	28 September 2023
PRESENTED BY: (name and title)	Cath Hill, Acting Associate Director for Corporate Governance
PREPARED BY: (name and title)	Kerry McMann, Head of 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

It is good governance to review the Trust's Constitution from time to time to ensure it is consistent with legislation and still reflects the needs of the organisation. Attached is a list of the proposed changes.

The Board is reminded that under the Health and Social Care Act 2012 the responsibility for approving changes to the Constitution and its Annexes lies with the Board of Directors and the Council of Governors. This Board is being asked to consider and approve the proposed changes before these are presented to the Council of Governors on 1 November for similar consideration and approval.

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

This Board is being asked to:

- Consider and approve the proposed changes before these are presented to the Council of Governors on 1 November for similar consideration and approval.

List of proposed changes for the Constitution and its Annexes

Section	Para	Original text	Proposed text	Rationale
Annex 4 (List of Appointed Governors)	1	York Council for Voluntary Services	York Centre for Voluntary Service	This reflects the change in name for this organisation
Annex 6 (Partner organisation governors)	12.3.4	York Council for Voluntary Services	York Centre for Voluntary Service	This reflects the change in name for this organisation
Annex 7 (Standing Orders - Council of Governors)	4.12.3	None	Non-quorate meetings may go ahead unless there has been an instruction from the Chair not to proceed with the meeting. Any decisions made at the non-quorate meeting must be approved by at least one third of the whole number of governors elected or appointed, including a public governor, a carer governor, a service user governor, a staff governor and an appointed governor.	To clarify that different methods can be used to the approve decisions made at non-quorate meetings of the Council of Governors.

Section	Para	Original text	Proposed text	Rationale
Annex 10 Annual Members' Meeting quoracy	5.2	If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Council of Governors determine. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting the number of members present during the meeting is to be a quorum.	If no quorum is present within half an hour of the time fixed for the start of the meeting, the number of members present during the meeting is to be a quorum.	Due to the planning and costs associated with the Annual Members' Meeting, it would not be appropriate to hold the meeting again one week later.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

19.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Use of emergency powers to make a change to the Constitution
DATE OF MEETING:	28 September 2023
PRESENTED BY: (name and title)	Cath Hill, Acting Associate Director for Corporate Governance
PREPARED BY: (name and title)	Kerry McMann, Head of 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 asked to note that in order to make any changes to the Trust's Constitution this must first be approved by the Board of Directors, the Council of Governors and then presented at the next Annual Members Meeting.

The constitution and scheme of delegation allow the Chair and Chief Executive to use 'emergency powers' to approve a change to the constitution on behalf of the Board of Directors. To use these powers, they must consult with at least two non-executive directors and must report the exercise of these powers at the next formal meeting of the Board.

On 11 September 2023, the emergency powers were used to approve a change to the constitution on behalf of the Board of Directors. The change related to the quoracy requirements for the Council of Governors and was proposed to make it easier to run quorate meetings. The change was agreed by the Council of Governors at its last meeting on 4 cJuly 2023 and was due to be reviewed by the Board of Directors at its meeting on 28 September 2023. The emergency powers were used to ensure that the extraordinary Council of Governors' meeting on 18 September 2023, at which the appointment of a new non-executive director was due to be ratified, would be quorate. Helen Grantham and Martin Wright were consulted on this change and both supported the change.

The new wording relating to the quoracy requirements for Council of Governors' meetings:

4.10.1 No business shall be transacted at a meeting of the Council of Governors unless at least one third of governors elected or appointed are present, including a public governor, a carer governor, a service user governor, a staff governor and an appointed governor.

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 exercise of the emergency powers by the Chair and Chief Executive to approve a change to the constitution on behalf of the Board of Directors
- Be assured that two non-executive directors were consulted about this change
- Be assured that the Council of Governors discussed and supported this change at its meeting on 4 July 2023.

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: 26/07/2023

Key discussion points and matters to be escalated from the discussion at the meeting:
Alert/Action:
• In relation to NHS111 a detailed letter that outlines the concerns and challenges faced is to be cascaded which is to include the lack of clarity and guidance and that this will have a significant and negative impact to the WY population and should be noted on Trust risk registers.
Advise:
• Due to the ICB operating model review there is a high degree of uncertainty for staff at ICB and Place level, all are to consider this impact on colleagues as part of regular interactions with place and system colleagues. • The CinC agreed to write to NHSE with a consideration on the development of the additional Mother & Baby Unit beds. • The NHSE ambition to provide support to individuals with complex needs that require specific therapy via Maternal Mental Health services has been agreed to be recurrently funded by all five places within the same timescales and criteria and over time the CinC would like this service to be overseen by the WY Commissioning Hub if resourced to do so. • A Neurodiversity summit will take place on the 14th November 2023 that will bring together clinical and professional experts alongside wider partners in education, elected members, voice of people with lived experience and others to be clear on the challenges faced.
Assure:
• The collaborative is continuing to strengthen relationships with Primary Care which includes the vice Chair of the MHLDA Partnership Board being from Primary Care. • A sector response to the ICB operating model has been gained by collaborative workshops and we await the ICB response.

Report completed by: Keir Shillaker, WY MHLDA Programme Director **Date:** 27/07/2023

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.