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 30 November 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 – Service User Involvement at the Recovery Centre** (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 28 September 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	**Report from the Medical Director** (enclosure)	**CHos**
11	**Guardian of Safe Working Q2 Report** (to follow)	**CHos**
12	**Report from the Director of Nursing and Professions** (enclosure)	**NS**
13	**Safer Staffing Report** (enclosure)	**NS**
14	**Report from the Director of Organisational Development and People** (enclosure)	**DS**
15	**Operational Priorities Q2 Update Report** (enclosure)	**DH**
16	**Health and Safety Annual Report** (enclosure)	**DH**
17	**EPRR Assurance Report** (enclosure)	**JFA**
18	**Cyber Security Update Report** (enclosure)	**DH**
19	**Board Assurance Framework** (enclosure)	**SM**
20	**Report from the Chair of the Workforce Committee for the meeting held on 5 October 2023** (enclosure)	**ZBS**
21	**Report from the Chair of the Quality Committee for the:**	**FH**
	21.1 Meeting held on 10 October 2023 (enclosure)	**FH**

	21.2 Meeting held on 16 November 2023 (enclosure)	**FH**
22	**Report from the Chair of the Finance and Performance Committee for the:**	**CHe**
	22.1 Meeting held on 24 October 2023 (enclosure)	**CHe**
	22.2 Meeting held on 28 November 2023 (to follow)	**CHe**
	22.3 Finance and Performance Committee Terms of Reference (enclosure)	**CHe**
23	**Report from the Chair of the Audit Committee for the meetings held on 17 October 2023 and 17 November 2023** (enclosure)	**MW**
24	**Report from the Chair of the Mental Health Legislation Committee held on 7 November 2023** (enclosure)	**KK**
	24.1 Mental Health Legislation Committee Terms of Reference (enclosure)	**KK**
25	**Notification of future meeting dates & Work Schedule** (enclosure)	**CE**
26	**Review and Approval of Terms of Reference** (enclosure)	**CE**
27	**Use of Trust Seal** (verbal)	**MM**
28	**Any other business**	**MM**

The next meeting of the Board will held on Thursday 25 January 2024 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*
Zoe Burns-Shore Non-executive Director	None	None.	None	None	None.	None	None.	None
Frances Healey Non-executive Director	None	None.	None	**Trustee** The National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	None	None	**Visiting Professor** University of Leeds **Advisory Role and Peer Reviewer** Research studies and potential research studies related to patient safety	None

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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
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

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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.
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**	**ZB-S**	**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

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Minutes of the Public Meeting of the Board of Directors held on Thursday 28 September 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
Mrs C Bamford	Head of Diversity and Inclusion (for minute 23/106)
Mr S Angus	Cultural Inclusion Ambassador (for minute 23/106)
Mrs R Pilling	Carer Coordinator, Patient and Carer Experience Team (for minute 23/0106)
2 members of the public	

Action

Miss McRae opened the public meeting at 09.30 am and welcomed everyone. She noted this was the last public Board meeting that Miss Grantham would be attending, although her term of office would not be ending until 14 November, adding she would still be carrying out her role until then.

23/099 **Apologies for absence** (agenda item 2)

No apologies were received from any member of the Board.

23/100 **Declaration of interests for directors and any declared conflicts of interest in respect of the agenda items** (agenda item 3)

The Board noted there was a change to Dr Healey's declaration of interest as she had been appointed as a Trustee of The National Confidential Enquiry into Patient Outcome and Deaths (NCEPOD). No other Board member had a change in declaration and no member had declared a conflict of interest in any agenda item.

23/101	**Minutes of the previous meeting held on 27 July 2023** (agenda item 4)	
	The minutes of the meeting held on 27 July 2023 were **received** and **agreed** as an accurate record.	
23/102	**Matters arising** (agenda item 5) It was noted there were no matters arising.	
23/103	**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. It was agreed the action relating to the National COVID Inquiry could be removed from the log and that updates would be brought to the Board as they occurred. In regard to the action relating to a discussion with Dr Wendy Neil about the refresh of the policy for Managing Concerns, Mr Skinner advised that the refresh would be programmed into the People and Organisational Development governance processes and that Dr Neil's comments would be picked up as part of a future review. It was agreed this action should be closed. Miss McRae advised the Board that the annual one-to-one meetings with governors were still ongoing and the matter of when and how the Organisational Priorities would be reported to governors would be discussed with the governance team as part of the overall outcomes and actions from these one-to-one meetings. Miss McRae also suggested there was a session on the Board Strategic Discussion programme to look at how the Board worked with governors going forward. Mrs Hill agreed to put this onto the forward plan.	**CHill / CE**
	The Board **received** the cumulative action log and **noted** the content.	
23/104	**Report from the Chief Executive** (agenda item 7) Dr Munro presented her Chief Executive's report drawing particular attention to the forthcoming strike action, noting there were no discussions being undertaken on a national level and as such it was expected there could be further disruption in the lead up to Christmas. Dr Munro also drew attention to the 'NHS 75 Big Thank You' events that had taken place over recent months which had reached a large number of staff in the Trust, recognising the huge amount of work undertaken by the Staff	

Engagement and Experience Team to arrange these events, for which she thanked the team.

With regard to the independent review that had been undertaken in the Forensic Services, following a number of concerns that had been raised through the Freedom to Speak up Guardian, Dr Munro reported that a number of events had been undertaken over summer to engage with staff from the service to advise of the findings and recommendations. She added the improvement plan to come out of this review would be overseen by a group led by the Medical Director.

Dr Munro then advised the Board of the National Inclusion Week running from 25 September to 1 October, adding this was an opportunity to run a communications and engagement campaign to promote the role of the Trust's staff networks. She added this would allow staff to share their personal reasons for supporting inclusion and the impact this had, thereby encouraging more colleagues to get involved.

Miss Grantham noted the work of the People and Organisational Development team and commented on the way the function had developed during her time on the Board and the importance of them being able to take time out and celebrate as part of the NHS 75 events.

Mr Wright drew attention to the independent review of Forensic Services and asked how the Board would be kept informed of progress with the improvement plan. Dr Hosker acknowledged the importance of keeping the Board informed and suggested updates could be provided through the Medical Directors' report to the Board. Dr Munro suggested the Attain report could be shared with members of the Board for information. Dr Hosker also suggested the latest draft of the improvement plan was about to be shared with staff and this could also be circulated to members of the Board. **CHos**

The Board agreed that non-executive directors should visit the Forensic Service wards at the Newsam Centre as part of their programme of service visits. Mrs Hill agreed to ensure this was added to the programme of visits. **CHill**

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

23/105 **Report from the Chief Operating Officer** (agenda item 8)

Mrs Forster Adams presented her Chief Operating Officer's report, noting this had been discussed in detail at the Finance and Performance Committee earlier in the week. She highlighted some of the key areas of concern including workforce availability particularly in the Community and Mental Health Teams, adding the staff who had been deployed into these teams as part of the recovery plan had now returned to their substantive posts and work was ongoing to recruit to the vacancies in the team which was contributing to an improving picture. However, Mrs Forster Adams noted that as we move into winter the added pressure of flu and COVID would add to the variability in workforce levels.

With regard to patient flow, Mrs Forster Adams noted this had been discussed at length in the Finance and Performance Committee meeting and the impact this was having on Out of Area Placements (OAPs), adding these were currently at a high level. However, she explained that most of the Leeds OAPs had been admitted into the Middleton St George's facility and as such this gave an opportunity to provide in-reach to those service users and for Trust staff to continue to support them.

Mrs Forster Adams then drew attention to other matters outlined in the report, including the continued improvement in meeting the Crisis 4-hour target through July and August; the six additional perinatal beds which had been commissioned for the Yorkshire and Humber region; the chemical decontamination live exercise which was carried out at the Becklin Centre with operational staff and the significant amount of EPRR Training for directors and senior managers which will commence in November 2023.

In regard to industrial action, Mrs Forster Adams advised the Board of the preparations being carried out by the tactical team to minimise the impact of the forthcoming round of industrial action, noting that staff were working hard to ensure any disruption to services was minimal and the safety of service users was at the forefront of those plans.

Mr Wright noted the Finance and Performance Committee focused on the areas of concern outlined in the report with the impending industrial action and the Out of Area Placements being two key issues that were the focus of the discussion. With regard to flow and OAPs, Mrs Forster Adams explained that whilst previous work had indicated the Trust had the right number of inpatient beds overall, what was emerging was a different presentation of illness which was impacting on how those beds were used, and that going forward there needed to be more work to understand what the medium-term demand would look like from a pathway and system perspective.

The Board discussed the issue of flow, delayed transfers of care and Out of Area Placements, noting there were issues not just for this Trust but for the system as a whole and system partners were looking at this in various forums.

Miss Grantham asked if firstly there was sufficient capacity for staff with data analytics skills. She also asked what assurance there was to ensure the Trust had the capacity to develop and therefore retain staff, particularly nursing staff, thereby ensuring there were a sufficient number of staff with the right development to deliver services. In terms of staff retention and development, Miss McRae noted it would be helpful for the Workforce Committee to look at this and understand why people might leave.

With regard to data analytics, Dr Hosker noted the executive team had agreed to have a discussion about the potential to use AI to develop and interpret predictive data which would free up some capacity for staff. Mrs Forster Adams also noted that whilst the Trust had the right people to do the analysis and support the work around flow and OAPs, there was often an issue with freeing up those staff to carry out the work given the workforce challenges the Trust faced. In response to a question about what the Board could do to support this, Mrs Forster Adams noted that just bringing in more people

wouldn't solve the issue and asked the Board to be clear about what the key priorities were, so staff could maintain focus on those matters.

Mr Henry joined the meeting.

Mr Wright noted that Out of Area Placements had been looked at in some detail by the Board at a previous discussion session, that it was not an easy problem to solve and it might be helpful to spend time understanding the complexity and the underlying issues that impact on this across the Trust and wider system. Mr Wright suggested this could be something added to the Board Strategic Discussion programme. Mrs Forster Adams welcomed this as a suggestion.

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

23/106 **Sharing stories –** (agenda item 1)

Miss McRae welcomed Caroline Bamford, Head of Diversity and Inclusion and Samual Angus, Cultural inclusion Ambassador to the meeting. Mrs Bamford firstly outlined the role of the Cultural Inclusion Ambassador, noting the role was voluntary and had been introduced to help bring about a shift in culture at the Trust ensuring a fair experience for all. She explained they will be tackling issues such as employee relations and our disciplinary procedure, ensuring that fewer staff face formal investigation unnecessarily and tackling the disparity between white and black and minority ethnic candidates when it comes to recruitment and promotion.

Mr Angus then explained why he had decided to become an Ambassador and the way in which he carried out the role alongside his substantive duties in the Trust. He explained something of the demands of the role, including making time to read and digest the documentation, maintaining impartiality and curiosity, challenging the decisions taken, bringing a different perspective to the discussion, and ensuring the process had been fair. Mr Angus also spoke about the support he provided to staff through the process and also about the support he received from his line manager should a case be particularly difficult. Mrs Bamford then outlined the support structure in place for the Ambassadors to ensure their well-being.

Mr Henry then asked about what was being done to ensure managers were increasing their cultural inclusion awareness. Mr Skinner referenced the ongoing 360 manager training programme which picked this up. He also thanked Mr Angus for the support and challenge he brought to processes on behalf of colleagues.

Miss Granthan spoke about the benefits of volunteering for roles such as this and the career development opportunities they offered. She suggested that Mr Angus' experience might be used as a way of promoting such opportunities.

Ms Khan suggested the role should not be voluntary and have to be carried out alongside a substantive role, but could be remunerated or have sufficient time allowed away from their substantive role to carry out these extra duties. Mr Angus acknowledged that preparation is sometimes carried out in his personal time and occasionally meetings run over his normal finish time, but he indicated he was usually given sufficient time to carry out the role without an adverse impact on his personal life. He also noted that his manager supported the time needed for his Ambassador role as it was seen as something that enhanced his wider role in the Trust.

Ms Khan left the meeting.

The Board **thanked** Mrs Bamford and Mr Angus for attending the Board and raising awareness of the role of the Cultural Inclusion Ambassadors.

23/107 **Chief Financial Officer's Report** (agenda item 9)

Mrs Hanwell presented her Chief Financial Officer's report noting the Trust was on plan with the revenue and capital targets at month 5 and was forecasting delivery overall for the year, despite there being a level of volatility in the system which would likely impact the Trust going forward.

She explained that whilst the Trust was focusing on the right four thematic areas, there remained a number of risks to the revenue position which would impact planning going forward into 2024/25. Mrs Hanwell advised the position needed to be taken with consideration of the wider system's financial challenge which could further impact on the Trust. She also explained that enhanced financial governance controls were now in place across the system to help manage the emerging picture.

Mrs Hanwell then highlighted some of the key information in the report, including the impact IFRS 16 (relating to the treatment of capital leases) would have on the Trust's financial plan going forward, noting that mid-year an allocation had been made and this would need to be managed within the West Yorkshire ICB capital envelope and that partners were being asked to review their lease position in order to manage the overall impact of this.

With regard to the six additional in-patient beds in the Perinatal Service, Mrs Hanwell reported the Trust had been notified of its successful bid for funding to support the development of the beds for the Yorkshire and Humber Provider Collaborative at the Mount. She added that a design brief and business case were being developed to support this, and that part of the criteria for the decision was the ability of the provider to expedite this scheme in-year as the capital was only available for use in 2023/24, she also noted that work was required at pace to ensure this was completed in the timescale. However, Dr Munro noted that expectations were being managed as to when the unit would be fully functioning, noting April 2024 may be too soon for this.

Mrs Hanwell then outlined a new national initiative for the NHS to make inroads to procurement and reduce the number of frameworks being operated. She outlined the impact this would have on the Trust, but also the

impact for the North of England Commercial Procurement Collaborative (NoECPC) in needing to be accredited in order to be able to manage any of these frameworks; explaining the risk and opportunities this poses to the operation of the Collaborative.

With regard to the five-year PFI Expiry Health Check which was undertaken in July by the Infrastructure and Projects Authority on behalf of the Cabinet Office, Mrs Hanwell reported that a feedback report had been received with an overall rating of red/amber which signalled major additional work was equired to achieve target readiness. She explained there was an acknowledgement that the Trust had been delayed in progress due to uncertainty and delayed decision making in relation to the Strategic Outline Case. She added the report set out a series of recommendations which had been incorporated into a workplan for the PFI Concession Steering Group, and that progress would be monitored through the Finance and Performance Committee.

With regard to the future of the PFI estate, Miss McRae asked whether this had been communicated to staff. Mrs Hanwell confirmed there had been a number of communications to staff. She also noted the decisions around the PFI estate it would inform the refresh of the Estates Strategy.

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

23/108 **Safer Staffing Report** (agenda item 10)

Miss Sanderson presented the Safer Staffing Report noting this provided a high-level overview of data and analysis and which gave the Board information on the position of the staffing on all wards against safer staffing levels for the retrospective periods from the 1 May to 30 June 2023. With regard to the exceptions, Miss Sanderson indicated the report identified one Registered Nurse (RN) non-compliant duty where there was no RN on duty within the Forensic Service due to the late notification of sickness absence. However, Miss Sanderson assured the Board of the steps taken to mitigate this, advising there were no patient safety issues as a result.

Miss Sanderson then drew out some of the key themes from the report including the high number of vacancies which impacted on staffing levels overall.

The Board **received** and **considered** the report from the Safer Staffing Report.

23/109	**Guardian of Safe Working Q1 Report** (agenda item 11) Dr Hosker then presented the Guardian of Safe Working Quarterly Report. He noted this covered the months of April, May and June and that during that period there were three exception reports with no safety issues recorded in the period. The Board **received** and **noted** the Guardian of Safe Working Quarterly Report.	
23/110	**Annual Equality Diversity and Inclusion (EDI) Workforce Race and Equality Standards (WRES) / Workforce Disability and Equality Standards (WDES) and Gender Pay Gap progress update** (agenda item 12) Mr Skinner presented the WRES and WDES information, noting there was a statutory requirement to report this annually. He explained it was generally a good news story in regard to both the WRES and WDES metrics although he acknowledged there was still work to be done. In regard to WDES data, Mr Skinner also noted that the number of people reporting a disability had increased which enabled people to be better supported in the workplace. With regard to the Gender Pay Gap data, Mr Skinner noted the Trust was required to publish the data and explained the detail behind these metrics. Miss Grantham questioned the percentage point change as illustrated in the report and asked that this be clarified for the reader before it was published on the website. Mr Skinner agreed to do this. The Board discussed the report. In response to a question about a disparity in the report between what it states is happening and what staff perceive is happening. Mr Skinner explained a lot of the data came from the staff survey but that not all staff completed the survey. However, he added that a lot of work had been done through the WREN and DAWN staff networks to understand the experience of staff. Dr Healey asked if the data was being interpreted correctly in the narrative, and whether the ratios reported as being positive could also be seen as negative. Mr Skinner agreed to ask the team look at this again. The Board **received** and **noted** the WRES, WDES and the Gender Pay Gap data and **agreed** this should be published on the Trust's website.	**DS** **DS**
23/111	**Health Education England (HEE) Annual Self-assessment Report (SAR)** (agenda item 13) Mr Skinner presented the self-assessment report noting the guidance had now changed and there was no need for the Board to receive and sign off the	

assessment and could in future be signed by the Director of People and Organisational Development.

However, having received the report the Board noted and supported the content.

Dr Munro expressed disappointment there had been a dip in medical training, suggesting industrial action might have had an impact on the uptake of this. Miss Grantham noted that Dr Sharon Nightingale had attended the Workforce Committee to talk about the training offer to students.

It was agreed that in future Mr Skinner would sign off the self-assessment and only if there was an issue for escalation would this be reported to the Workforce Committee through the People and OD Chair's report.

The Board **received** the Health Education England (HEE) Annual Self-assessment Report (SAR) and **noted** the content.

23/112 **Approval of a change to the Scheme of Delegation** (agenda item 14)

Mrs Hill explained that in light of the changes to the way in which NHS England was now governing the requirements for the Trust's arrangements for Emergency Preparedness Resilience and Response (EPRR), there was a need to include new information in the Matters Reserved section of the Scheme of Delegation which set out those matters that only the Board can now deal with, noting these had previously been delegated to the Finance and Performance Committee. Mrs Hill listed these items as being:

- Receive and ratify the EP-0005 - Business Continuity and EPRR Policy and Business Continuity Management System Procedure
- Receive and approve the EPRR Annual Report
- Receive and confirm the EPRR assurance declaration annually.

The Board **approved** the change in the Matters Reserved section of the Scheme of Delegation in relation to EPRR.

23/113 **EPRR and Business Continuity and EPRR Policy and Business Continuity Management System** (agenda item 14.1)

Mrs Forster Adams presented the EPRR and Business Continuity and EPRR Policy and Business Continuity Management System, noting this was one of the items that must now come to the Board for approval. She noted the document had been through a number of governance groups in the organisation including approval at the Policy and Procedures Group.

The Board **received** and **ratified** the EPRR and Business Continuity and EPRR Policy and Business Continuity Management System.

23/114	**Report from the Chair of the Workforce Committee for the meeting held on 3 August 2023** (agenda item 16) Miss Grantham presented her report from the Workforce Committee meeting that had taken place on 3 August 2023. The Board asked about the Oliver McGown training and whether this would be on-line. Mr Skinner confirmed it was expected this would be available on-line although he noted that further information on the training package was still awaited. The Board **received** and **noted** the matters detailed in the chair's report from the Workforce Committee.	
23/115	**Ratification of the Workforce Committee Terms of Reference** (agenda item 16.1) Mr Wright noted the Finance and Performance Committee had looked at their Terms of reference in the last meeting, and in the interests of consistency suggested the quoracy for the Finance and Performance Committee and other Board committees should be reviewed to ensure they were consistent. Mrs Hill asked the Board to approve this version of the Terms of reference ahead of the Corporate Governance Team looking across the Terms of Reference for all the committees to ensure consistency. However, it was agreed the quoracy for the Finance and Performance Committee should be three in line with other committees and this change should be made. The Board **received** and **ratified** the amended Terms of Reference for the Workforce Committee.	**Corp Gov Team**
23/116	**Report from the Chair of the Quality Committee for the meetings held on 14 September 2023** (agenda item 17) Dr Healey presented her chair's report for the Quality Committee meeting that had taken place on 14 September, and drew attention to the main items considered at the meeting for escalation to the Board. Miss McRae noted the report had alerted the Board to NHS England 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. Dr Healy indicated this had been included as an item for alert because there were a number of changes that would occur, including how deaths were described, which may impact on the culture of how people respond to and report on incidents and deaths, which was also bring an element of complexity to the reporting regime. Dr Munro confirmed there would be changes to the Datix reporting system to meet the new requirements which were still being worked through, and that assurance would go through the Executive Risk Management Group for oversight of how the new system was being implemented and any implications for Trust processes. Dr Munro	

	noted that once the impact had been assessed by the risk management Team an update could be brought back to the Board for wider assurance.	**NS**
	The Board **received** and **noted** the matters detailed in the chair's report from the Quality Committee.	
23/117	**Ratification of the Quality Committee Terms of Reference** (agenda item 17.1) The Board received the Terms of Reference for the Quality Committee. Mr Henry noted these included a reference to the committee having the power to engage an external advisor with the support of the Board of Directors. It was agreed that it was good practice to have this as an option for all committees of the Board and whilst it would be rarely used, it would provide an independent route for advice and reporting should it ever be required.	
	The Board **considered** and **ratified** the amended Terms of Reference for the Quality Committee.	
23/118	**Report from the Chair of the Finance and Performance Committee for the meeting held on 26 September 2023** (agenda item 18) The Board received the Chair's report from the Finance and Performance Committee meeting that had taken place on 26 September 2023. Noting much of the meeting was focused on the details in the Chief Operating Officer's report and the Chief Financial Officer's report as discussed in previous Board agenda items.	
	The Board of Directors **received** the Chair's report from the Finance and Performance Committee and **noted** the matters reported on.	
23/119	**Approval of an amendment to the Trust's constitution** (agenda item 19) Mrs Hill reminded the Board that under the Health and Social Care Act 2012 the responsibility for approving changes to the Constitution and its Annexes sat with the Board of Directors and the Council of Governors. She outlined the changes noting these were mainly minor in terms of impact, which included those that would ensure consistency across a number of sections of the Constitution or that were updating information already in the document.	
	The Board **considered** and **approved** the proposed changes noting these would then be presented to the Council of Governors on 1 November for similar consideration and approval.	

23/120 **Use of emergency powers to make a change to the Constitution** (agenda item 19.1)

Mrs Hill outlined the change to the Constitution which had required the use of the Board's emergency powers. She noted that a change in quoracy for the Council of Governors had already been agreed by the Governors at their July meeting and had received in-depth consideration prior to that approval. However, she noted that due to the sequence of meetings, had the emergency powers not been used it would not have been possible to appoint a new non-executive director at the September extraordinary Council of Governors' meeting due to those quoracy issues.

The Board noted the reasons for needing to use the emergency powers which had been done on behalf of the Board by the Chair and Chief Executive having consulted with two non-executive directors. The Board supported the change to the Constitution in relation to the quoracy rules for the Council of Governors.

The Board **noted** the use of the emergency powers in making a change to the Constitution, **supported** the rationale for taking this action and also **ratified** the change made to the Constitution.

23/121 **West Yorkshire (WY) Integrated Care System (ICS) Mental Health, Learning Disability and Autism (MHLDA) Committee-in-Common Chair's report (AAA report)** (agenda item 20)

Miss McRae presented the MHLDA Committee-in-Common chair's report. In particular she noted the Committee had discussed concerns about the changes to the NHS 111 for people in mental health crisis; noting it had been confirmed that local crisis lines would still be able to be used.

The Board **received** the MHLDA Committee-in-Common Chair's report and **noted** the content.

23/122 **Use of the Trust's seal** (agenda item 21)

The Board noted the Trust's seal had been used on two occasions since the last meeting which were as follows:

- Log 130 – Settlement deed for suite 5a, 5th floor of 'Platform Leeds' with Bruntwood Platform Leeds Limited – 1 September 2023.
- Log 131 – Renewal of lease for Units A and A1, Springwell Road Leeds – 1 September 2023.

The Board **noted** the seal had been used on two occasions since the last meeting.

23/123	**Report from the Chair of the Mental Health Legislation Committee for the meeting held on 1 August 2023** (agenda item 15) Ms Khan presented her Chair's report from the Mental Health Legislation Committee meeting that had taken place on 1 august 2023. In particular she noted the Committee was working well and there were no specific matters to draw the attention to the Board. However, she added there were some difficulties around the operation of the Mental Health Act Managers Forum and it was agreed these would be picked up outside the meeting.
	The Board **received** the report from the Chair of the Mental Health Legislation Committee and **noted** the matters reported on.
23/124	**Any other business** (agenda item 22)
	There Board noted there were no items of other business.
23/125	**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 12:35 and thanked members of the Board and members of the public for attending. The Chair then resolved that members of the public would be excluded from the meeting having regard to the confidential nature of the business transacted, publicity on which would be prejudicial to the public interest.

Leeds and York Partnership NHS Foundation Trust

Cumulative Actions Report for the Public Board of Directors' Meeting

OPEN ACTIONS

AGENDA ITEM

6

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Report from the Chief Executive (minute 23/080 - agenda item 7 – July 2023) 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	**COMPLETE** 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 was presented to the Workforce Committee in October 2023 and the detail on this is contained within the Chair's Report
2023/24 Organisational Priorities – quarter 1 progress report (minute 23/081 - agenda item 8 – July 2023) 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.	**Clare Edwards / Merran McRae**	Management action	**ONGOING** The annual one to one meetings with governors are still ongoing and the matter of when and how the Organisational Priorities would be reported to governors would be discussed with the governance team as part of the overall outcomes and actions from the one to one meetings.

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 Medical Director (minute 23/084 - agenda item 11 – July 2023) 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.
Actions outstanding from the public meetings of the Board of Directors (minute 23/103 - agenda item 6 – September 2023) **NEW -** Miss McRae suggested there was a session on the Board Strategic Discussion programme to look at how the Board worked with governors going forward.	**Clare Edwards**	Management action	**COMPLETED** This item has been added to the forward plan for Board Strategic Discussions
Report from the Chief Executive (minute 23/104 - agenda item 7 – September 2023) **NEW -** Dr Munro suggested the Attain report could be shared with members of the Board for information. Dr Hosker also suggested the latest draft of the improvement plan was about to be shared with staff and this could also be circulated to members of the Board.	**Chris Hosker**	Management action	**COMPLETED** Report circulated to the Chair and Non-Executive Directors along with a summary version and associated action plan.
Report from the Chief Executive (minute 23/104 - agenda item 7 – September 2023) **NEW -** The Board agreed that non-executive directors should visit the Forensic Service wards at the Newsam Centre as part of their programme of service visits. Mrs Hill agreed to ensure this was added to the programme of visits.	**Clare Edwards**	Management action	**COMPLETED** This item has been added to the programme for service visits and will be included in future planning

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 Equality Diversity and Inclusion (EDI) Workforce Race and Equality Standards (WRES) / Workforce Disability and Equality Standards (WDES) and Gender Pay Gap progress update (minute 23/110 - agenda item 12 – September 2023) **NEW -** The Board questioned the percentage point change as illustrated in the report and asked that this be clarified for the reader before it was published on the website. The Board also questioned if the data was being interpreted correctly in the narrative, and whether the ratios reported as being positive could also be seen as negative. Mr Skinner agreed to ask the team look at these issues.	**Darren Skinner**	Management action	
Ratification of the Workforce Committee Terms of Reference (minute 23/115 - agenda item 16.1 – September 2023) **NEW -** The Board agreed the Corporate Governance Team would look across the Terms of Reference for all the committees to ensure consistency in the generic detail.	**Corporate Governance Team**	Management action	**COMPLETED** Consistency check completed and suggested amendments made to Nominations Committee and Remuneration Committee in order to ensure consistency across all committees. Terms of Reference to be approved at next Committees in 2024, then ratified at Board.
Report from the Chair of the Quality Committee for the meetings held on 14 September 2023 (minute 23/116 - agenda item 17 – September 2023) **NEW -** Dr Munro noted that once the impact had been assessed by the risk management Team an update could be brought back to the Board for wider assurance.	**Nichola Sanderson**	Date of Board meeting to be advised	

NHS
Leeds and York Partnership
NHS Foundation Trust

CLOSED ACTIONS

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Report from the Chief 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	**AGREED BY THE BOARD TO REMOVE THIS ACTION** Updates will be brought to the Board as they occur
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) 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) 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	**CLOSED** Update provided in the meeting.
Report from the Chief Executive (minute 23/080 - agenda item 7 – July 2023) 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
Report from the Chief Operating Officer (minute 23/082 - agenda item 9 – July 2023) 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 Chair of the Audit Committee for the meeting held on 18 July 2023 (minute 23/092 - agenda item 20 – July 2023) 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

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
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MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Executive's Report
DATE OF MEETING:	30 November 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.

MEETING OF THE BOARD OF DIRECTORS

30 NOVEMBER 2023

CHIEF EXECUTIVES REPORT

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

1. Our Services and Our People

Industrial Action
Following an intense period of industrial action by both consultant and junior doctors in October we are now in a period of pause by the unions. Consultants and SAS doctors are being balloted currently on whether they want to take industrial action in the future. We have been informed negotiations are underway between government and the unions but do not know the nature of those. Junior doctors can continue to take industrial action but at the time of writing we have not been notified of any planned strikes.

Our Collective Leadership Journey
On the 27th November we will hold our final workshop of this calendar year. We have progressed through a series of events over the year building shared goals, building our shared knowledge, and now identifying key areas of action where we can apply a collective leadership approach to achieve better outcomes. A key area of service improvement that has demonstrated this in action over the past 12 months has been the stabilisation of our CMHT through a combination of actions including redeployment of staff for a 6-month period. The service has now seen significant stability in its core workforce, maintaining reductions in caseload sizes, improved response times to new referrals and recently seeing an improved picture in recruitment.

We are building on more examples of collective leadership in action and that will be a feature of the work next year. The group are being explicitly engaged now on how we achieve ***Integrated governance*** across our care services and corporate services to enable consistency of governance as close to the front line as possible which will also give clear line of sight for assurance on decision making. Whilst we have made great progress over the past 3 years (in spite of covid) to develop greater consistency around clinical governance, expanding the capacity of clinical leadership and better aligning operational management and clinical leadership we now need to go a step further in integrating these functions/roles/responsibilities. A small task and finish group I am chairing has been established that will drive the work over the next 6 months and regular updates will be provided to the board. The board should also note that this will take into due consideration relevant existing work such as the development of integrated dashboards, ongoing work to support CQC compliance, improvements to how we govern policies and procedures etc.

Executive Service Visits
In October executive team members were able to visit all the inpatient wards at the Becklin and some of the Wards at The Mount. It enabled direct discussion with the ward staff focusing on the current context they are operating in, recruitment, morale, team development, risk management, cross ward support/development/learning, patient flow and care pathways. The themes and findings are consistent with the issues that have been raised through regular executive reports to the board from the Chief Operating Officer and it should be noted how impressed we were with the level of commitment, motivation and focus on the quality of patient care and supporting staff.

Complex Case support
Several members of the Executive team have been working with partners in Leeds to provide support to a complex case of a young person residing in LTHT with community care provided by LCH.

At the request of partners, we have now taken further action to directly provide and coordinate the care plan in collaboration with Bradford District Care Trust. I am notifying the Board because we have asked our adult CLDT to provide the ongoing care coordination to this young person sooner than they would do typically. The response from our CLDT and the leadership team has been exceptional and the impact for the patient and their family has been very positive.

The ICB in conjunction with the NHSE regional team is commissioning an independent review to ensure the right lessons and actions are taken to improve care provision in complex cases.

Institute for Health Improvement (IHI) conference
Earlier this month we co-hosted a conference on coproduction and improvement in collaboration with the IHI and NHSE. It was a great opportunity to showcase the work that we have been doing in the trust to an international audience from a range of health and care sectors. Conference attendees were able to join in learning visits to our teams such as Learning Disability, Recovery college and Emerge. Several colleagues from patient experience and involvement and the continuous improvement team gave conference presentations. It can be easy to lose sight of the progress we have made and the commitment of our teams to keep improving especially in how we work differently with our service users and carers. Service users also gave direct feedback at the conference on the changes they have seen, and the ongoing commitment of the Trust and I wanted to highlight this to give thanks and also encouragement for this important work to continue.

2. Our Partnerships, National and Local

Synergi Collaborative and Remembering What's Forgotten (in brief)
Hopefully the board is already aware that the Synergi Collaborative won a HSJ award for Mental health innovation of the year this month. This is a fantastic award to recognise both the level of partnership working and the ambition to make a difference to our diverse communities in Leeds.

Remembering What's Forgotten is a co-produced, hybrid 12-month programme and exhibition to unearth, amplify and showcase the people, initiatives and lived experience championing mental health equality for Black and Asian communities in Leeds. The focus on these specific communities is because of their disproportionate detention via the Mental Health Act.
A collaboration between Synergi-Leeds and Words of Colour, in partnership with Leeds City Council and Leeds and York NHS Foundation Trust, and co-produced with Touchstone, Heritage

Corner and Khadijah Ibrahiim / Leeds Young Authors, *Remembering What's Forgotten* is based on the recognition that much of the work challenging ethnic inequalities, racial justice and institutional, interpersonal and systemic racism in mental health has been led by grassroots projects, local communities and third sector organisations. Yet much of the campaigning, impactful initiatives and creative and mentoring approaches have not been captured or archived, which is a city-wide and regional loss – all of which isn't news to you. The project will be publicly launched on **Monday 27th November 2023 (date subject to change)** as a press and community announcement. Throughout the year, most of the work will happen behind the scenes alongside scheduled announcements over the next 12 months.

Operational and Financial Priorities for 2023/24

All ICBs and NHS providers received a letter from NHS England (NHSE) on 8 November 2023 advising on the funding to be provided this financial year. There is a list of actions that all systems are required to take to manage the financial and performance pressures created by industrial action. This followed discussions between NHSE and Government.

Plans were requested from all systems by 22 November 2023 covering finance, activity and waiting times / lists. We have been actively involved in these plans but to note the performance and activity focus is primarily on acute care (Urgent and emergency care, ambulance response times and elective recovery waiting times). We remain committed as a system to achieving a system financial balance for the end of this year. Once submitted, the expectation is that there will be meetings scheduled from 27 November 2023 with each ICB Executive Team and their provider colleagues to agree proposed actions. Further information will be shared via the Director of Finance report and in the private board meeting.

The Kings Speech

His Royal Highness King Charles III delivered his first speech on 7 November 2023. This focussed on growing the economy, strengthening society and crime reduction. Health-specific announcements included tackling smoking by raising the age of sale for tobacco products and implementing the NHS Long Term Workforce Plan, both of which we support and look forward to supporting as plans develop. However, what was notable in its absence was reference to the reform of the Mental Health Act which has triggered significant criticism and concern from all those organisations involved in the work over the past 5 years to design a modern legal framework for mental health. We have been advised nationally that work will continue behind the scenes across government departments to keep this on the legislative agenda.

Ministerial Changes

The Board will be aware there has been a cabinet reshuffle in government which has resulted in a new Secretary of State for Health being appointed – Victoria Atkins. There has also been change in two junior minister post in the department however Maria Caulfield MP remains the minister responsible for mental health.

National NHSE meeting

On the 8th November NHSE Executive team convened a face to face meetings with provider and ICB chief executives. The focus of the meeting was.

- Current challenges and risks for the NHS, including a discussion on the role of boards short and long term.

- The ask for the remainder of this financial year on the money and the service delivery priorities covered in separate correspondence.
- Planning for 2024/25.
- Political context and the year ahead.
- Progressing the long-term workforce plan for the NHS.

Post Long Term Plan for Mental Health

The national mental health and learning disability team in NHSE have begun an engagement exercise to shape the next wave of priorities for the sector following the long-term plan which comes to an end in its commitments next year. The underlying assumption is there will not be any significant increase in funds available and therefore what do we prioritise within existing resources learning from what we have achieved over the past 5 years. Themes to date include:

- Continuing focus on the Quality if inpatient care which is already underway.
- Model of adult acute care.
- Crisis care.
- Children and young people mental health– session with national colleagues
- Autism and ADHD service provision.
- Continued focus on workforce supply/shape and the need for capital investment in both inpatient and community care.

West Yorkshire ICB Meeting

TH epublic board meeting this month covered a focused discussion on primary care provision including the rise in demand, increased investment, interface with wider health and care services, transformation and innovation and ensuring there is the right workforce for the future. In addition to regular reporting on performance, finance, winter preparedness and risk a detailed update was provided on the development of the new operating model.

The development of an ICB Operating Model is focused on ensuring we can deliver our key strategic priorities whilst meeting the Government's target to reduce running costs by 20% by April 2024 and 30% by April 2025. In practice, this all needs to be delivered in one step.

The staff consultation process commenced on Tuesday 26 September 2023 and was launched via a virtual All Staff Briefing. This was supplemented by local ICB Directorate and Place briefings and supported by the publication of a staff consultation document made available to all staff on the ICB Share Board containing the background and rationale underpinning the proposed ICB Operating Model and structures for each ICB directorate and Place.

To support staff and facilitate feedback, a dedicated email address has been established on the ICB Share Board. All feedback received via this method is being collated, themed and forwarded for review by the appropriate ICB Director or Place Accountable Officer, and frequently asked questions (FAQs) are updated following this. Director led briefings continue to be scheduled in every directorate and Place to ensure staff remain engaged in the process and feedback / learning is captured and acted upon ahead of the next phase of the process.

Regular meetings with Trade Union representatives (Staff Side) continue, led by the ICB Director of People, Kate Sims and will do so throughout the consultation process to maintain the crucial two-way dialogue aimed to address any issues or concerns as they arise. Arising from this, the

staff consultation process has been extended by two weeks and now closes on Friday 24 November 2023.

Following closure of the staff consultation process, a post consultation report will be produced which will aim to respond to the staff consultation engagement acting on feedback received, including any changes to structures published as part of the consultation documentation on 26 September 2023. Following further discussion and agreement with Staff Side representatives the final post consultation report will be published on Monday 11 December 2023, supplemented by an All Staff Briefing and local ICB Directorate and Place briefings.

The outcome of the consultation will inform the final ICB Operating Model which will then move to implementation in early 2024.

Leeds ICB

There are several updates specific to the Leeds partnership to note this month. First in October we hosted a visit from **Staten Island** (New York) provider partnership to learn more about how the work together to provide integrated care across multiple organisations focused on particular outcomes or population groups. A range of sessions were attended by LYPFT colleagues covering workforce, finance, contracting, digital, governance etc. We also shared how we work in Leeds to stimulate debate and reflection. We will continue to work in a learning collaborative with Staten Island and we have agreed a range of steps to review and improve how we are currently working in Leeds over the coming months.

As part of this we have now changed the **financial governance and decision-making arrangements** in Leeds. We have nominated a place-based Director of Finance lead (Simon Worthington LTHT) and established a strategic finance executive group of statutory NHS partners that will hold the responsibility and accountability for the use of NHS resources (money) allocated to the Leeds system. There are several workstreams now being established that will form the basis of our city financial plans for 2024/25.

Finally, the new **Health and Wellbeing strategy** has now been finalised and board members will have separately received information about a public launch event being held on the 7th of December at the Leeds Museum.

International Conflict – Acknowledging Local Impact

As war continues in the Ukraine, and conflict in the Middle East escalates, the consequences are felt in our communities and workforce. In response to the very distressing events and ongoing situation in Israel and Gaza we sent out an all-staff communication with a focus on the personal impact for colleagues and our communities to encourage a compassionate response - without forming or encouraging opinion or speculation on the political situation. We will gather feedback from staff to understand if further information/communication is seen as helpful.

Covid Inquiry

During the COVID-19 pandemic, we lived through the most extraordinary times and were often faced with making the most difficult of decisions. The testimony provided to the COVID-19 Inquiry, which has been set up to examine the UK's response to and impact of the pandemic and learn lessons for the future, has been covered substantially in the media. Whilst it continues to focus on government level preparation and response the evidence covered in recent weeks has started to cover the role of the NHS due to witness testimony from the Permanent Secretary for the DHSC

Sir Chris Wormald and former CEO of NHSE Lord Stevens. It is fair to say that some of the testimony will have been upsetting to staff and communities especially for those who lost loved ones during the pandemic. The Inquiry's work is guided by its Terms of Reference and more information is available on the UK COVID Inquiry website.

3. Reasons to be Proud

NHS Pastoral Care Quality Award

- **International nurses and midwives**
  - LYPFT has achieved the NHS Pastoral Care Quality Award.
  - We have been recognised for our work in international recruitment and commitment to providing internationally educated nurses and midwives with high-quality pastoral care.
  - This award is part of the NHS England International Recruitment Programme. It supports NHS organisations in increasing and developing their international recruitment plans.
  - It is awarded to Trusts who offer safe arrival, induction, and provision of support for new people joining the NHS workforce and prioritising the wellbeing of internationally educated nurses and midwives.
  - Well done everyone!

Becklin Halloween Fete

Trust Occupational Therapy Event

Tuesday 7 November at Catch Leeds.

"I am completely overwhelmed by the passion and dedication shown by the OTs who attended the event, I am sure that today was the start of something bigger in strengthening the community of OTs within LYPFT. I am proud to be an Occupational Therapist and today has inspired me more by the stories that were shared about the importance of occupations and the impact this has on people with lived experience. "

Rebecca Wharton, Practice Development Lead Occupational Therapist

#OTWEEK23 #LYPFTOT

Well done to Asket House

Excellent feedback on Care Opinion

Everyone was very welcoming and friendly - Posted by Julian914

"I was a bit wary due to my illness and wondering whether I was ready to go to Asket House. Everyone was very welcoming and friendly.

Staff were very friendly and polite. If they had time to hel,p they would. They deserve a pay raise, in my opinion . All in all, the kitchen staff and cleaners went above and beyond as well.

I made a full recovery and I have a few things to do every day now, that's because I was looked after so well at Asket House "

Team of the Month
West and North West CMHT

Nomination:
"I was part of the redeployment within the trust and was redeployed to this team. I just wanted to nominate a team who in tough times continue to offer the service users an empathic friendly support. I met a friendly team, from the team administrators, the clinical staff and the managers who were caring, holistic and working hard to meet the needs of the service users under immense pressure."

Judges:
"The Trust is very grateful to those who volunteered to be redeployed to CMHT in pressured times. It is great to hear how this was useful for personal development and growing understanding of the wider Trust. Particularly fantastic to hear that the team were so welcome and supportive."

Research Heroes

We are recognised and rewarded

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

Thank you for making a difference!

- This month we would like to recognise Dr Tom Riley for his support as a Super Referrer for the DIAMONDS RCT study!
- After our meeting, Tom went away and not only thought about people on his own caseload who might meet the eligibility criteria for the study, but also made his colleagues aware of the study and encouraged them to identify service users from their caseloads too.

Email: research.lypft@nhs.net

R&D
Research &
Development

Dr Tom Riley
Core Trainee Doctor

Dr Sara Munro
Chief Executive Officer
23 November 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:	30 November 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

This 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 we are facing.

This month the report includes:

- **Emergency preparedness, resilience and response (EPRR) planning and management.** We have seen continued Industrial Action through September and October, which have been managed extremely well by those involved, with minimal disruption to our service users. We have also conducted two EPRR exercises, one for chemical decontamination and one for IT.

- **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, with material vacancies in our core services and

sustained demand in our core mental health and more specialist services. (Appendix A is the Board level dataset for performance and service delivery).

- **Service development.** We continue to progress the Perinatal Inpatient expansion with the final business case being finalised for submission to NHSE. Discussions are progressing with the ICB in regard to the ongoing access challenges for the Neurodiversity Service. The Community Mental Health Transformation progression has been delayed and discussions are ongoing with Leeds Community Healthcare (LCH) and ICB colleagues to progress the transformation agenda.

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

30 November 2023

Chief Operating Officer: Trust Board Report

1. INTRODUCTION

This 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 we are facing.

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- **Service development.** We continue to progress the Perinatal Inpatient expansion with the final business case being finalised for submission to NHSE. Discussions are progressing with the ICB in regard to the ongoing access challenges for the Neurodiversity Service. The Community Mental

Health Transformation progression has been delayed and discussions are ongoing with Leeds Community Healthcare (LCH) and ICB colleagues to progress the transformation agenda.

Primarily the main areas of concern are set out in the "Alert" section of the Service Delivery and Key Performance section of this report (Section 3 below). However, as a very high-level summary the most concerning issues as Chief Operating Officer include:

- Preparing to manage care delivery through winter (including capacity and flow in our inpatient services) with on-going uncertainty and risks of medical staff industrial action, and unusual variations in sickness across our workforce.
- The ongoing need for additional Out of Area inpatient capacity (resulting in quality, operational and financial risks).
- The launch of EPRR training portfolios which demand a considerable time requirement from our leadership community.
- Increased length of waiting for access to ADHD and Autism diagnostic services, together with the internal shortage of key medicines for people with ADHD.

2. EPRR PLANNING AND MANAGEMENT: Advisory

The section below summarises the activity of the EPRR team in the period, which aims to mitigate adverse impacts for service users and our staff.

2.1 Industrial action

Since the last update in September 2023, industrial action took place on:

- 19 and 20 September – 48 hours (Consultants)
- 20 to 23 September – 72 hours (Junior Doctors)
- 2 to 4 October – 72 hours (Consultants and Junior Doctors)

The Trust's incident management arrangements were activated for all three periods of industrial action at both strategic and tactical levels (The Incident Coordination Group (ICG) and Tactical Group, respectively).

The alignment of Junior Doctor and Consultant industrial action provided a stern test of arrangements. However, robust rotas were developed using those staff not taking industrial action and covered services to an acceptable level.

Our focus during this round of action was to strengthen our understanding and proactive mitigation of risks to the quality of care; rallying our Clinical leadership body as part of our tactical arrangements to enable more focus on clinical quality in our assessments of readiness.

Since the last period of industrial action, no further action has been called. Talks are, at the time of writing, still ongoing between the Government and Consultants. Specialty Doctors now have authority to carry out a ballot for industrial action which closes, along with another Consultant ballot, on 18 December 2023.

In terms of Junior Doctors, their current mandate runs from 14 September 2023 to 29 February 2024.

The Hospital Consultants and Specialists Association (HCSA) also announced on 15 November a ballot result in favour of industrial action. This will only affect us minimally due to a very small number of members being employed by our Trust.

Work has been done by services in preparation for any industrial action announcements in December and January when, due to the holidays, the Trust often has reduced levels of staffing. This is to ensure that services are resilient through the period before, during and after Christmas.

Both the Industrial Action Planning Group and the Tactical Group continue to meet to ensure the Trust can readily move into incident arrangements if industrial action is announced.

2.2 NHS EPRR Core Standards Assurance 2023

This new process has proven to be extremely time consuming and ultimately the outcome has been very disappointing, not reflective of the work, commitment and

rigour of our EPRR team. An additional paper details the full outcome of this year's process and the action planning required to improve the position for 2024.

2.3 Other EPRR activity

2.3.1 Chemical decontamination live exercise – Becklin Centre

A cold debrief was held in October and a debrief report has been issued. The exercise was well received by those taking part, including colleagues attending from NHS England and Mental Health and Community Trusts across Yorkshire.

Improvements have been identified which will be included in revised planning and training going forward into 2024. A further live exercise is being tentatively planned for 2024.

2.3.2 EPRR training for directors and senior managers

The Trust is required to commence EPRR training for its cohort of strategic commanders by issuing the portfolio and available training to all relevant staff in December. The EPRR lead is meeting with affected staff at the end of November to explain requirements and discuss how the Trust responds to this significant change to training expectations for staff.

Similar engagement work is being planned for the tactical cohort (operational managers at 8a to 8c) in January.

This training will undoubtedly improve consistency and capability of our leadership team in respect of managing and leading our response to incidents. Nonetheless, the considerable time and commitment required should not be underestimated. The details of this together with a means of measuring, tracking, and supporting progress will be shared through Board committees and ultimately with members of the Trust Board (in line with the now regulatory requirements of NHSE EPRR).

2.3.3 IT cyber exercise

A full-day exercise was held in October that involved ICT staff, operational management and EPRR staff. The exercise involved a cyber-attack on the Trust and a theft of confidential patient and staff data.

To simulate two different command structures, we separated the operational group (ICT staff) from the tactical command group comprising operational management who work in clinical services.

A debrief is being organised and the subsequent report will be circulated to the Finance and Performance Committee following its approval by attendees. Learning and required improvements will feature in the report and any actions will be monitored in the EPRR Group chaired by the Chief Operating Officer.

2.3.4 Winter Resilience and Operating Plan 2023/24

Attached, in Appendix B, for Board information is the 2023/24 Winter Resilience and Operating Plan which builds on the approach we have taken in previous years to ensure we have a shared understand of our operating principles through winter and plans for the key issues which face us as a healthcare provider over the winter months.

Our Winter Coordination group reconvenes effective from 27 November so that we have a core group of leads from across the organisation overseeing, coordinating, and responding to the issues we may face. This is led by the Chief Operating Officer in her role as Accountable Emergency Officer.

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. Our Deputy Directors and Head of Operational Governance are working closely to continue to embed our Operational Governance arrangements to be able to respond to the changing demands within Care Services. The Board level dataset outlining key service delivery performance is attached in Appendix A.

We continue to experience significant challenges as highlighted in the previous report, including a sustained demand for admissions into our Acute Service, with sustained lengths of stay and increased delayed transfers of care resulting in 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).

As previously reported, throughout summer we have completed a number of workshops with the Forensic Service in Leeds. The findings and outputs from these workshops have supported the development of an improvement plan aimed at addressing the areas of concerns raised. The action plan has been shared across the service, with all staff contributing to its development. This work continues to be led by Dr Chris Hosker (Medical Director) supported by colleagues at Executive and senior leadership level.

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.

3.1.1 Acute Service – Inpatient Capacity

We have continued to see sustained pressure for inpatient acute admissions, with the number reaching an unprecedented total of 40 at one point. As of the 14 November the number was at 33 in total, as detailed in table 1 below. We have recently seen an increase in the demand for male inpatient beds resulting in an increase of male Out of Area Placements. We are still fully utilising the Crisis Assessment Unit as a female only unit to ensure we maintain a sexually safe environment for these service users.

Table 1

Position at	Current OOA placements
Male Acute	12
Male PICU	4
Female Acute	15
Female PICU	2
TOTAL	33

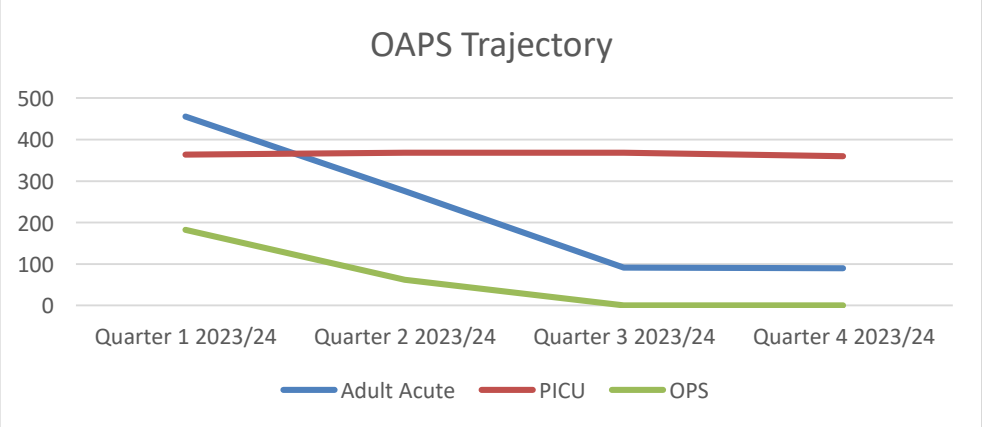
We continue to see consistent levels of delayed transfers of care which are impacting on our ability to respond to the increased demand. The number has risen to 22 (9 female & 13 male) in total across the Acute service, with 18 of the 22 requiring suitable accommodation in order to facilitate discharge. We are working with housing and our colleagues in the Local Authority to reduce the number of delays. The work of the Inpatient Flow Oversight Group (IFOG) has further developed since September, such that we are now actively working on system level actions (supported by ICB colleagues). The following operational work is now well in progress and will gather momentum in the coming weeks and months of winter 2023/24.

Table 2

Priority area	Details	ICB lead	LYPFT Lead	Stakeholders
Housing	**Creating visibility of housing options & availability** Reviewing the processes to access housing support including options around housing navigators Creating MDT pull model	Eloise Pearson & Stacey Wade	Helen Magnus (Laura McDonagh)	Karla Gallon (THU) Adrian Smith Julie Staton Beth Knowle /Sharon Kaur (Barry & Julie from Gateway) Sue Voice & Narinda – housing officers
System Flow visibility, support and governance	**Can we create a dashboard and collaborative leadership structure akin to the physical acute?** Need to include: Data & coding Service and flow maps to include visibility of capacity across the system and delay codes within transitional support Meeting Structures Right Representation	Nicola Nicholson & Stacey Wade	Laura McDonagh	Karl Money – LYPFT data Graham Hyde Richard Irvine
3rd Sector Support	**Options of care navigator role to help pull model into third sector support** Including the Peer Support workers role clarification and optimising that role and care navigation of wider VCSE offers in the community	Caroline Townsend	Hannah Wilkinson (Laura McDonagh)	Caroline Townsend Pip Goff Martin Bishop
Social work assessments	Visibility of timeframes to be included in the above Use of interim placements	Nicola Nicholson Eloise Pearson	Laura McDonagh	Max Naismith With the DTOC meeting group

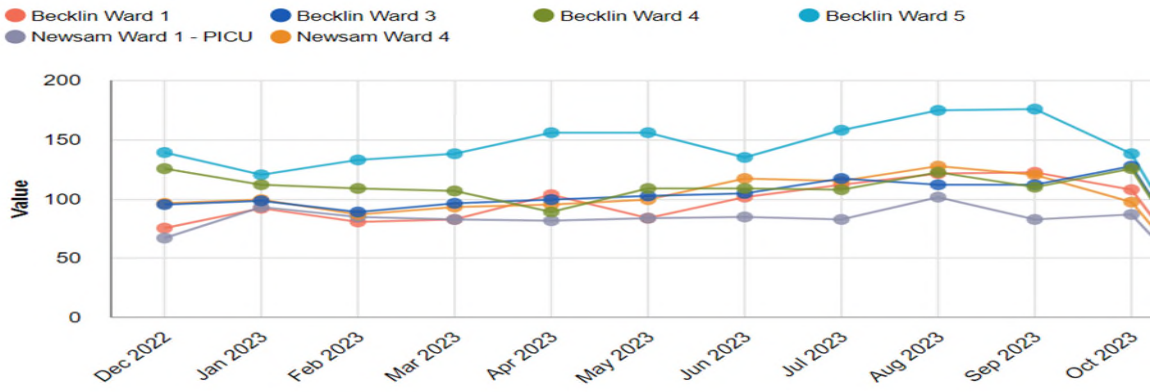
We have revised our Out of Area Placement trajectory to reduce the number of placements over the remainder of this financial year (see graph 1) this will be monitored through IFOG.

Graph 1



We are also experiencing an increased length of stay, particularly on one of our female acute wards. Whilst we have seen a slight improvement through October, in some areas, we have not recovered to where we would expect this to be (see graph 2).

Graph 2



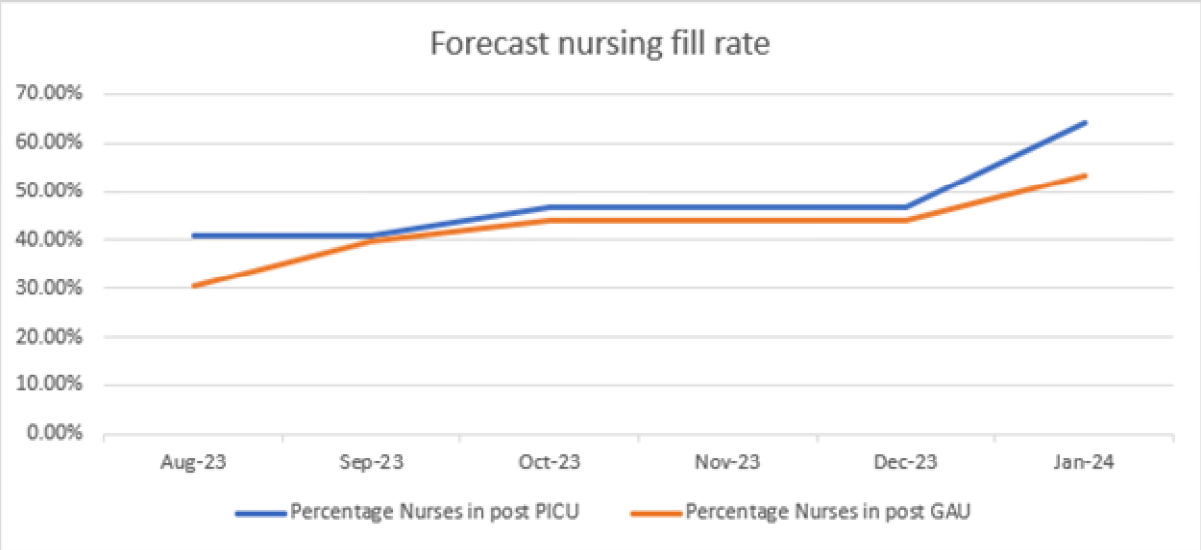
Where we have insufficient inpatient capacity, we continue to place most of our service users in the provision we have contracted at the Priory Unit, Middleton St George. Our Acute Service leadership team continue to work with medical colleagues and senior clinicians to ensure we provide effective in reach and offer continuity of care for these people whilst outside Leeds.

3.1.2 Children and Young People's Services: Red Kite View Staffing

Red Kite View continues to face significant registered nursing vacancies. However, there has been further improvement with a number of newly qualified registered nurses joining the service. The current position is 53% vacancies on Lapwing (PICU) (improved from 59% in August) and 56% on Skylark (the General Adolescent Unit) (improved from 69% in August) which is in line with our planned trajectory. The service continues to rely significantly on bank and agency staff to provide the cover required. The service leadership team, alongside colleagues in the Nursing Directorate, has reviewed the correlation between incidents and the number of bank and agency staff in post. This analysis has concluded there was no statistically significant increase in incidents with a higher proportion of bank and agency staff, indicating the work that has been done to both induct and support these temporary staff maintains safe care within the units. The improved staffing position in October has allowed PICU to increase capacity to 5 beds after a sustained period of admitting up to 4 young people as a maximum. The service plans to increase to 6

beds which is full capacity, once new staff are fully trained. The leadership team continues to monitor the staffing forecast as displayed below.

Graph 3



Despite the staffing position, the team has taken significant steps forward to develop the service for young people. This includes the near conclusion of the neurodevelopmental assessment pathway, which has already assessed 11 young people who were previously undiagnosed. Post discharge follow-up from the social work team is another development, supporting a “Softer Landing” for young people following their stay in Red Kite View. This has also allowed the service to gather feedback from service users post discharge. We have seen an improvement in the flow through the service and, working alongside provider collaborative and community colleagues, this has positively impacted on meeting demand for Tier 4 beds across West Yorkshire. Currently there are no young people waiting for a PICU bed, and there is one person in an out of area bed awaiting repatriation to GAU. Young people have been engaged with interviews post-discharge to give a view on their care. These interviews have been recorded and will be shared with the staff group to be used as training and induction tools. Overall, the feedback from service users has been very positive and has allowed a focus on what’s important to them.

A recent admission caused a significant number of incidents, some of which required police support. These incidents are currently being investigated as a cluster of incidents reported to StEIS. The service will monitor these closely and is working with the Nursing Directorate and the provider collaborative quality hub. Early

learning, debriefs and reflective practice have been completed in the team on PICU, and depending on the outcome from the serious incident an action plan may be developed.

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

Work on the small high risk assessment space and further spaces in the Leeds Teaching Hospital NHS Trust (LTHT) Emergency Departments has made little progress since last reported. The Head of Operations continues to work with LTHT to make progress.

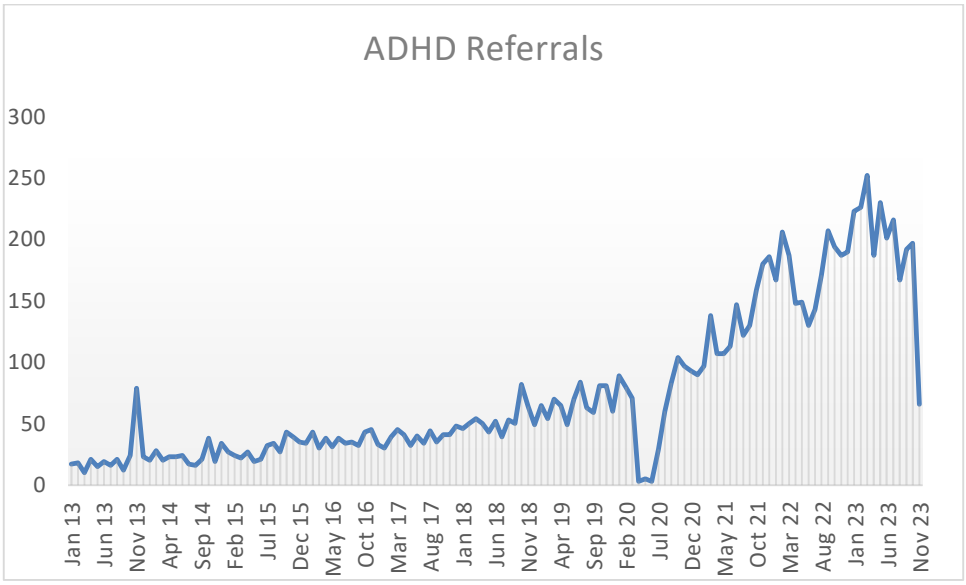
Agreement has been reached on the design, works required and the furniture requirements for the Leeds General Infirmary (LGI) Acute Liaison Psychiatry (ALPs) assessment space. However, we have been unable to establish a start date for the work. We have requested an update from the Estates Lead at LTHT and escalated appropriately for further support from more senior colleagues in LYPFT and LTHT.

The assessment space development on the St James' University Hospital site is part of the larger project work to develop the Same Day Emergency Care clinical area within the Chancellor Wing. The ALPs assessment space forms the next stage of the project, with the entire project expected to be completed in early 2025.

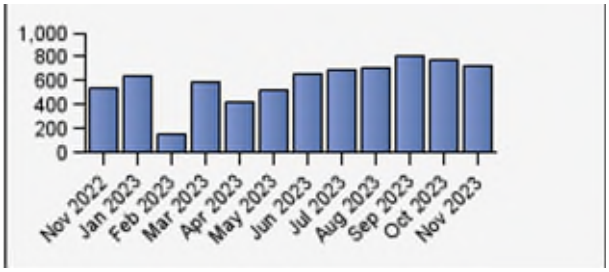
3.1.4 Neuro-developmental Service: ADHD

We continue to see a high-level of referrals for the service resulting in increasing waiting times. Over the last 6 months we have seen average referrals of 201 per month. Graph 4 shows the growth of referrals since service inception, by comparison, 10 years ago the service received an average of 17 referrals per month. The waiting time for those seen has increased from 425 days in April 2023 to 776 days in October 2023 (Graph 5). However, this waiting time does not reflect the expected waiting times for those on the waiting list. The waiting list has now increased to 3900, which means an estimated wait time of up to 20 years for the last person to join the waiting list if provision remains static across Leeds.

Graph 4



Graph 5



Work across the West Yorkshire health and care system continues to develop a strategic response to the level of need; furthermore, the development and agreement of a policy will help provide a consistent approach across the region. “Right to Choose” is a focus with two key pieces of work being started:

- The development of a single commissioning policy for “Right to Choose”
- The development of a quality standard for Any Qualified Provider (AQP). When in place, this will ensure an assured standard of assessment which particularly supports primary care for shared care.

Other work includes sharing of service data to support system planning and the consideration of a single referral hub for West Yorkshire. The Trust's ADHD service is engaged and is actively contributing to work across West Yorkshire.

As Board members have been made aware, there is an international shortage of the medication Lisdexamfetamine which is widely used within the service and within Primary Care. We anticipate a high number of service users will run out of supplies without a suitable alternative. The ICB has, therefore, asked the service to be available to advise Primary Care with the support with these service users. It is anticipated stocks will increase into early 2024. However, service users who have stopped the medication will need to be titrated back onto it and Primary Care colleagues will continue to seek support from the service with this. As a result, the service has been supported to respond to the ask of ICB colleagues given the seriousness of the situation. This means that our focus is on the support and management of people currently receiving the medication which is now in short supply. This means until supply is restored, we will not be appointing for new referrals. This situation will be under close review of our senior leadership team through the Trust Wide Clinical Governance Group and Operational Delivery and Performance Group.

3.2 Advise

3.2.1 Community and Wellbeing Service

Our Working Age Community Mental Health Teams (CMHT's) continue to stabilise and recover from the period when they were in business continuity (which was invoked as a result of the level of vacancies), All previously deployed colleagues returned to their normal posts in August and there has not been any significant increase in caseloads. The majority of all individual caseloads are under 35 service users, with some under 25 and lower. What this means clinically is that staff are continuing to be in a position to deliver recovery focused, and more robust planned care. We are also seeing a steady improvement in our vacancy rate, with the recent recruitment of experienced registered nurses, including the retention of an agency nurse currently working in the service and an international occupational therapist. We are seeing less staff leaving and more staff expressing an interest to work with the service. For the first time in two years the service has remained below the Trust's

10% staff turnover measure. We remain on track with recruitment and retention following intensive support, engagement and focus on the wellbeing of staff. We continue to actively recruit, and are pursuing the recruitment of an additional 12 Occupational Therapists (including developmental roles) and legacy mentors.

We are starting to see an increase in the rate of referrals. This is as a result of referrers seeing the service in the process of returning to normal and the service working collaboratively with other services across the Trust to support transitions between those services. Whilst we have seen an increase in referrals, by changing the way the service works with their colleagues in Primary Care, we are seeing a more efficient way of handling referrals and subsequently a reduction in the number of referrals being converted onto the CMHT caseload. As way of an example, in October, the number of referrals where CMHT was identified as not being the service to best meet the needs for an individual was 52.42% of all referrals that month. Our work on Community Transformation enables people to receive care, support and treatment that best meets their needs (which we continue to develop and work hard with partners to achieve).

3.2.2 Children and Young Peoples Services

After a prolonged period of activity, the capital work for the alternative to hospital admission provision for Mill Lodge commenced on the 20 November 2023. This will provide care and support to young people with eating disorders and is a new and innovative approach being trialled in our unit in York. We continue to plan for full implementation in April 2024, and whilst our first round of recruitment to additional roles was unsuccessful, we are looking at creative and different roles to support the young people who will be using the service. Given the nature of the service we are implementing outcomes and evaluation methodologies to assess clinical quality and outcome improvements, alongside important work to determine if this model can help support more young people through services to recovery.

As part of the business case for the Humber and North Yorkshire ICB Provider Collaborative, our modelling is anticipating that we will: reduce the number of out of area beds used for young people with eating disorders; reduce the number of young people admitted to the acute hospital requiring nasogastric feeding; reduce the

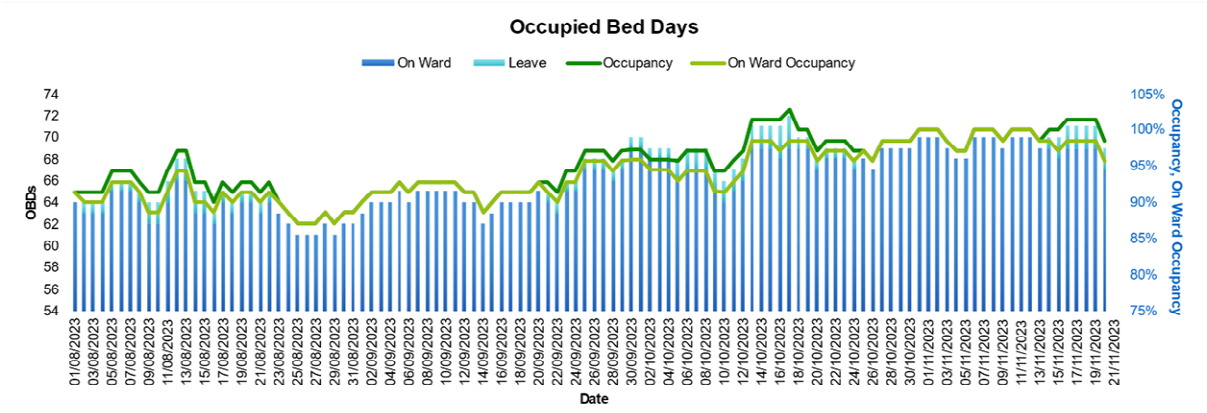
number of young people within Mill Lodge presenting with eating disorders or complex disordered eating; and reduce the length of stay for those that are admitted.

The key performance indicator suite which will monitor these improvements forms part of the project plan and will include qualitative and quantitative metrics. The project team is working closely alongside the Humber and North Yorkshire (HNY) workstream for alternatives to hospital admission, which in turn reports into the HNY Inpatient workstream group. It is anticipated that the service will initially care for up to 4 young people, with a plan to enhance this to 6-8 as the service develops.

3.2.3 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.

Graph 6



The service has managed this through a flexible approach to admission, using the capacity on the functional wards to meet the demand.

However, it is of note that we have not placed any service users in an Out of Area Placement in recent months. This is especially important for older people, as multiple transfers for people with dementia can be disorientating and result in a less positive experience.

We are also experiencing our lowest rate of delayed transfers of care for some time, currently this is ten people, all of whom require a suitable onward placement either within NHS or Local Authority placements. This is in part, along with other system initiatives including:

- The development of The Willows,
- The successful partnership focus we have with Local Authority colleagues on active management of delays,
- The commissioning of “Reconnect” care homes for people with more complex needs,
- The implementation of Admiral Nursing (previously reported to Board),
- Having a dedicated Social Worker, on secondment from the Local Authority, funded by the ICB, who is part of the in-patient team. They are able to respond to the needs of the service user group and make the necessary links to other care providers to support their discharge. The pilot was due to end in November; however, this has been extended to the end of March 2024 in response to the needs of the service and the early successes the role has achieved.

3.2.4 Rehabilitation Services: capacity and flow

Delayed transfers of care within the Rehabilitation Services continues to reduce, currently seven people, five of whom are awaiting suitable placements. Improved management of delays has been achieved following the introduction of a Delayed Discharge meeting, including stakeholders from the ICB and Leeds City Council . Bed occupancy remains consistently at near 100%, with length of stay continuing to increase slightly month on month. As expected, this negatively impacts flow from the Acute to Rehabilitation in-patient services and is being monitored through the IFOG meeting.

3.3 Assure

3.3.1 Adult Acute Services: Intensive Support Service pilot (ISS)

In response to our Acute Service out of area position and increased length of stay across our inpatient wards, we commenced a ‘facilitating early discharge’ pilot on Ward 1 (Becklin Centre). Facilitating early discharge is a Core Fidelity Standard of NHS MH Crisis Services, and is the process by which our Intensive Support Service (ISS) identifies and works with patients who are still acutely unwell and commence

home treatment. In order for early discharge to be facilitated, the presenting risks and symptoms must have reduced to a point where home treatment is safe for the service user, their family and ISS colleagues. We hope this pilot will improve on seamless transfer of care from inpatient services to ISS, whilst supporting our service users in the least restrictive environments. Staff in the Acute Services have a time-out session planned at the end of November to review the pilot and to consider how to implement this across all our acute wards. Further discussion will also need to occur with our community colleagues to ensure they are supportive of this move. We will continue to monitor progress of this pilot through the IFOG.

3.3.2 Forensic Service: Senior leadership recruitment

We have seen gaps and changes in some of the key senior leadership roles within the service. Following a series of changes and appointments in the Senior Operational Leadership Team, we will welcome Josef Faulkner as the Head of Operations effective from 1 December 2023. Josef is an experienced mental health operational senior manager and has previously worked as the Head of Operations for our Community and Wellbeing service line. Alongside this we are recruiting to the Matron post at the Newsam Centre and the Clinical Lead for the service during the latter part of November. These roles will consolidate and focus on the work we are doing to support staff to continue their strength-based planning and ambition for services into the future.

Thank-you to Sarah Russo, who has been working in the role of Interim Head of Operations in our Forensic Services for well over a year. Sarah has led many of the changes in our Forensics Services and has played a key role over the last few months in listening to the experiences of staff through and beyond the pandemic; ultimately building a plan which will support staff to continue to develop the services we offer.

3.3.3 Complex Rehabilitation: Out of Area Placements (OAPs)

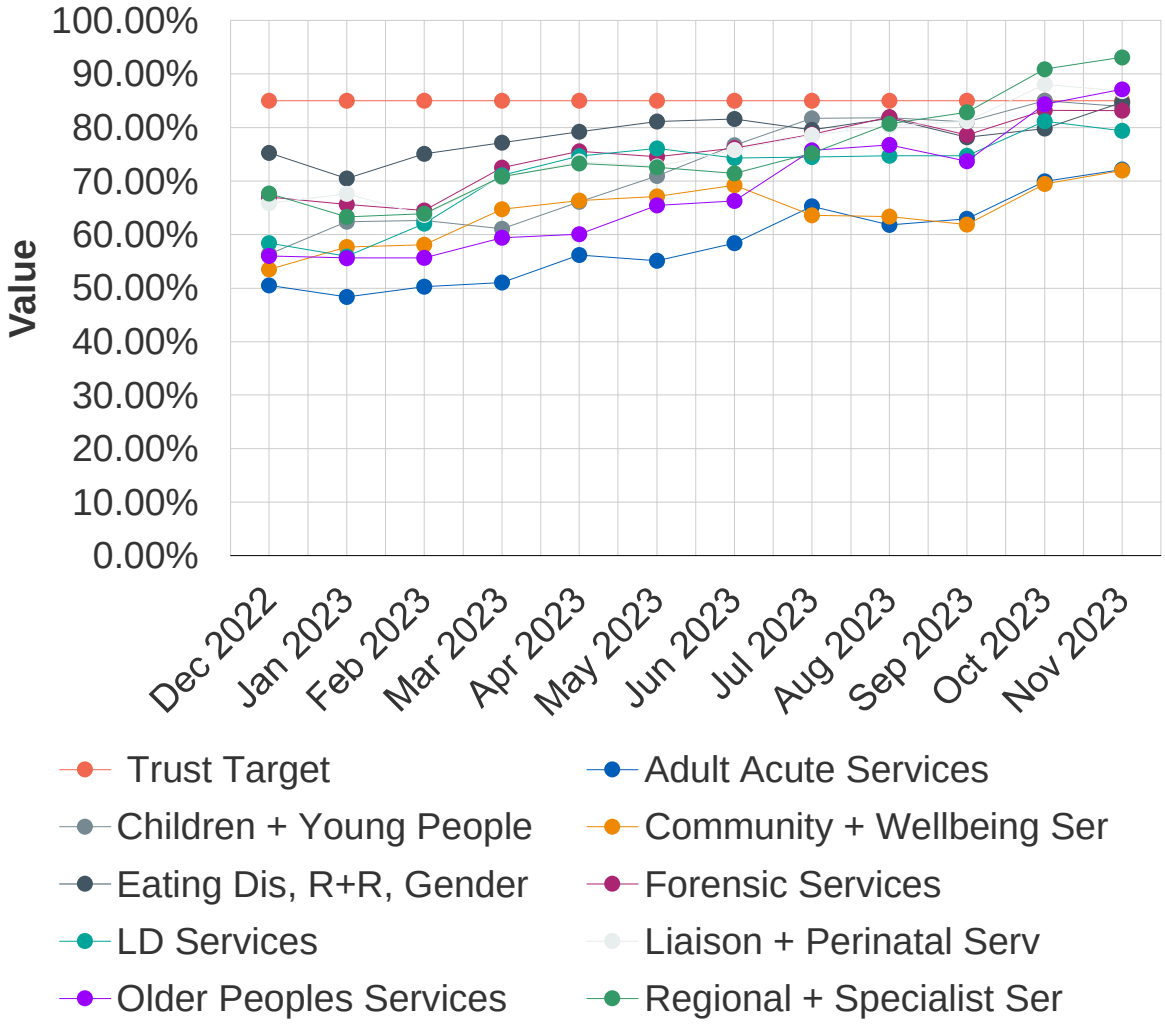
Complex Rehabilitation Out of Area Placements continue to present a financial risk to the organisation and, as part of IFOG are an area of focus. We are currently ahead of financial trajectory with our monthly spend reducing from £447k in April to £399k in October.

There are currently 27 service users in OAPs (13 female and 14 male), reduced from 30 in June. We are anticipating that implementing Care and Treatment Reviews (CTRs) will accelerate OAPs discharges. This has been delayed due to changeover in our Case Manager and is now planned to be implemented from January 2024.

3.3.4 Care Service appraisals

Despite the significant challenges services have faced throughout recent times, we have seen an improved response to the undertaking of appraisals to support staff (see graph 7 below). Whilst some areas are yet to achieve our target, the improvement demonstrates the support of care services staff and managers to ensure that its professional and personal development is central to our work together.

Graph 7



3.3.5 Head of Operations recruitment

Following some changes in the Senior Operational Leadership team, we have recruited two new Heads of Operations. One of the candidates has been appointed from within the Trust and one from the Probation Service in South Yorkshire. Both come with a proven record as Operational Managers and we are looking forward to them joining the team. The vacancies have enabled us to make other changes to the structure supporting three of our substantive Heads of Operations to move into other service lines in Care Services. This has allowed us to offer them different opportunities whilst retaining their knowledge and experience within the directorate which we are sure will benefit Care Services as a whole.

4. SERVICE DEVELOPMENT

4.1 Perinatal expansion

The Board will be aware of the proposals to expand the Mother and Baby Unit inpatient beds as part of the development of the Perinatal Mental Health Provider Collaborative. In the last week the clinical and workforce model has been agreed and the business case is being prepared and submitted to NHS England for consideration.

4.2 Community Mental Health Transformation

The planned start of the implementation of the new community mental health model has been delayed due to complexities of the clinical and operational governance of the new model. Discussions to resolve these have been held with Leeds Community healthcare, the ICB and third sector colleagues to resolve at pace. A revised date for implementation in the new year is being set.

4.3 Health Facilitation

The Health Facilitation Team within the Learning Disability Service has been successful in securing resource to improve the uptake of cancer screening within the Learning Disability population. There are two key objectives within the proposal:

- The development and delivery of training for frontline workforces to increase cancer screening uptake, ensure appropriate urgent cancer two-week wait referrals are made in Primary Care, and reduce the number of lost appointments due to people with learning disabilities not attending or not being brought to their appointments.
- A focus on cervical screening uptake via a Primary Care Network based pilot project to develop a best practice model in respect of the cancer screening process for people with learning disabilities in Primary Care.

The funding is for two years and amounts to £144k. This is a key programme of activity to reduce the health inequalities for people with a Learning Disability.

5. 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 through a whole system approach. The report highlights the most significant service delivery and development challenges we face but importantly sets out where service delivery has stabilised or where improvements have been made in Care Services.

Joanna Forster Adams
Chief Operating Officer

Contributors:

Andrew Jackson, EPRR Lead

Mark Dodd, Deputy Director of Operations

Alison Kenyon, Deputy Director of Service Development

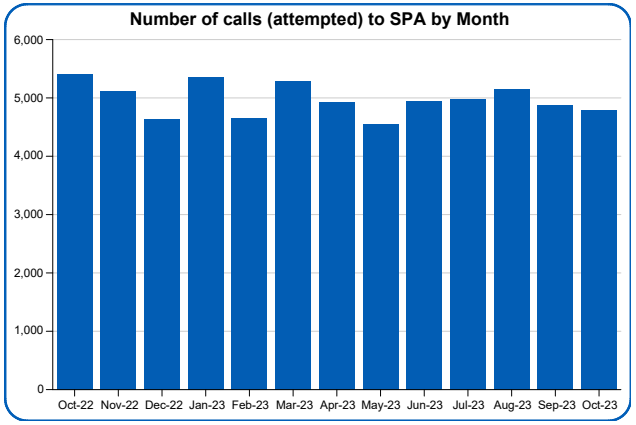
Service Performance - Chief Operating Officer

Services: Access & Responsiveness: Our response in a crisis	Target	Aug 2023	Sep 2023	Oct 2023
Percentage of crisis calls (via the single point of access) answered within 1 minute	-	29.2%	28.0%	31.9%
Percentage of ALPS referrals responded to within 1 hour	-	76.6%	79.2%	78.8%
Percentage of S136 referrals assessed within 3 hours of arrival	-	4.8%	10.3%	20.5%
Number of S136 referrals assessed	-	42	39	44
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	90.0%	60.6%	50.0%	41.8%
Percentage of service users who stayed on CRISS caseload for less than 6 weeks	70.0%	94.4%	91.3%	93.4%
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support	50.0%	50.7%	47.0%	48.4%
Percentage of CRISS caseload where source of referral was acute inpatients	-	10.5%	10.6%	13.4%
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services	**Target**	**Aug 2023**	**Sep 2023**	**Oct 2023**
Gender Identity Service: Number on waiting list	-	4,753	4,851	5,018
Deaf CAMHS: average wait from referral to first face to face (inc. telemedicine) contact in days	-	20.71	166.19	115.26
Community LD: Percentage of referrals seen within 4 weeks of receipt of referral	90.0%	62.9%	73.8%	75.0%
Leeds Autism Diagnostic Service (LADS): Percentage starting assessment within 13 weeks (quarterly)	-	-	15.4%	-
CAMHS inpatients: Proportion of people assessed within 7 days of admission (HoNOSCA / GBO) (quarterly)	100.0%	-	61.5%	-
Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency) (quarterly)	-	-	95.8%	-
Perinatal Community: Percentage of routine referrals waiting less than 2 weeks for assessment (quarterly)	-	-	94.8%	-
Perinatal Community: Total number of distinct women seen in rolling 12 months (quarterly)	798	-	839	-
Perinatal Community: Face to Face DNA Rate (quarterly)	-	-	15.9%	-
Services: Our acute patient journey	**Target**	**Aug 2023**	**Sep 2023**	**Oct 2023**
Number of admissions to adult facilities of patients who are under 16 years old	-	0	0	0
Crisis Assessment Unit (CAU) bed occupancy	-	90.9%	78.9%	91.4%
Crisis Assessment Unit (CAU) length of stay at discharge	-	8.19	14.17	20.38
Liaison In-Reach: attempted assessment within 24 hours	90.0%	81.0%	77.5%	73.5%
Bed Occupancy rates for (adult acute excluding PICU) inpatient services:	94.0% - 98.0%	101.0%	100.2%	100.2%
Becklin Ward 1 (Female)	-	103.5%	103.8%	102.1%
Becklin Ward 3 (Male)	-	101.6%	99.4%	99.9%
Becklin Ward 4 (Male)	-	99.6%	102.1%	100.3%
Becklin Ward 5 (Female)	-	101.3%	95.9%	99.1%
Newsam Ward 4 (Male)	-	99.1%	99.8%	99.5%
Older adult (total)	-	91.5%	92.9%	98.0%
The Mount Ward 1 (Male Dementia)	-	93.3%	97.1%	103.9%
The Mount Ward 2 (Female Dementia)	-	93.3%	96.4%	102.2%

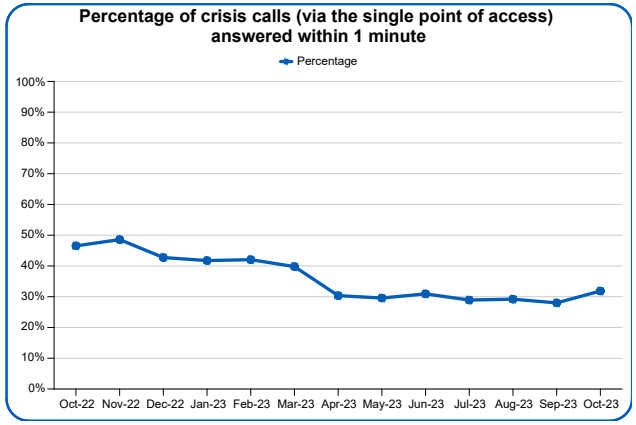
Service Performance - Chief Operating Officer

Services: Our acute patient journey	Target	Aug 2023	Sep 2023	Oct 2023
The Mount Ward 3 (Male)	-	85.6%	82.0%	92.7%
The Mount Ward 4 (Female)	-	94.5%	97.9%	96.2%
Percentage of delayed transfers of care	-	13.6%	15.4%	13.9%
Total: Number of out of area placements beginning in month	-	19	28	25
Total: Total number of bed days out of area (new and existing placements from previous months)	155	660	967	1,057
Acute: Number of out of area placements beginning in month	-	16	25	20
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	525	856	903
PICU: Number of out of area placements beginning in month	-	3	3	5
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	135	111	154
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)	-	0	0	0
Cardiometabolic (physical health) assessments completed: Inpatients (quarterly)	80.0%	-	80.2%	-
Services: Our Community Care	**Target**	**Aug 2023**	**Sep 2023**	**Oct 2023**
Percentage of inpatients followed up within 3 days of discharge (Trust Level monthly local tracking)	80.0%	75.4%	82.5%	84.3%
Percentage of inpatients followed up within 3 days of discharge (HCP commissioned services only)	80.0%	75.9%	82.8%	83.6%
Number of service users in community mental health team care (caseload)	-	3,359	3,352	3,389
Percentage of referrals seen within 15 days by a community mental health team	80.0%	79.7%	80.0%	66.4%
Percentage of referrals to memory services seen within 8 weeks (quarter to date)	90.0%	60.8%	59.3%	56.8%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50.0%	42.2%	41.1%	47.5%
Early intervention in psychosis (EIP) or at risk mental state (ARMS): Percentage starting treatment within 2 weeks	60.0%	66.7%	25.0%	33.3%
Early intervention in psychosis (EIP) : Percentage of people discharged to primary care (quarterly)	-	-	74.3%	-
Cardiometabolic (physical health) assessments completed: Early Intervention in Psychosis Service (quarterly)	90.0%	-	65.2%	-
Services: Clinical Record Keeping	**Target**	**Aug 2023**	**Sep 2023**	**Oct 2023**
Percentage of service users with NHS Number recorded	-	99.2%	99.2%	99.2%
Percentage of service users with ethnicity recorded	-	80.4%	80.6%	81.2%
Percentage of service users with sexual orientation recorded	-	43.8%	44.2%	45.6%
Services: Clinical Record Keeping - DQMI	**Target**	**May 2023**	**Jun 2023**	**Jul 2023**
DQMI (MHSDS) % Quality %	95.0%	91.9%	92.3%	92.4%

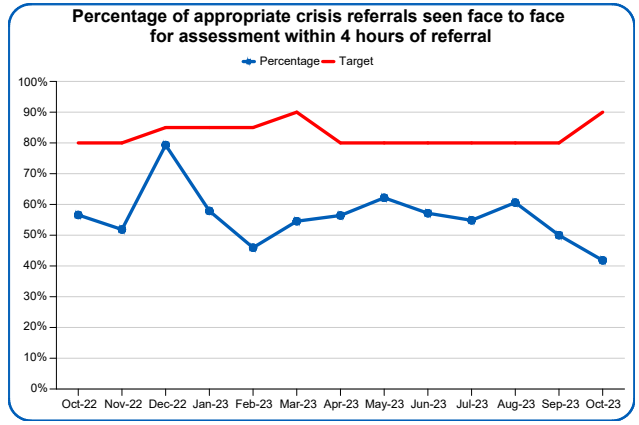
Services: Access & Responsiveness: Our Response in a crisis



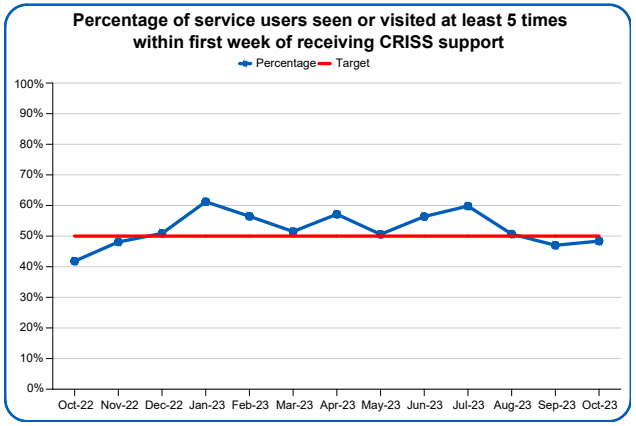
Number of calls : October 4,796



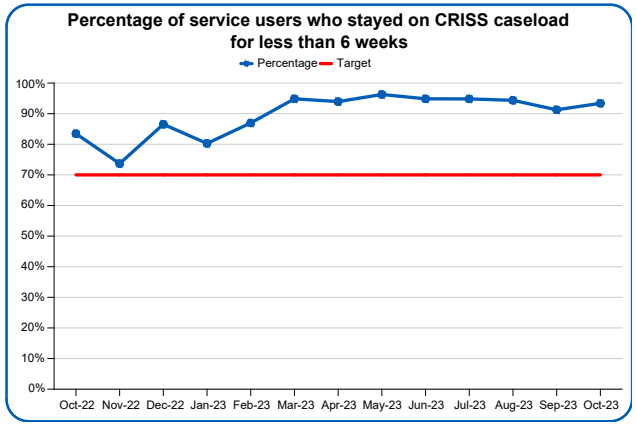
Local target - within 1 minute: October 31.9%



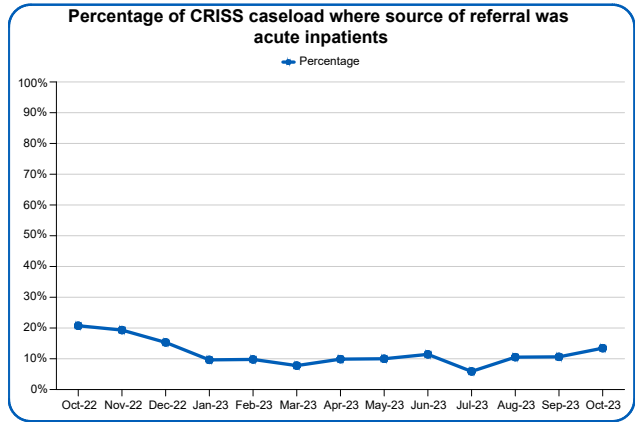
Contactual Target 90%: October 41.8%



Contractual Target 50%: October 48.4%

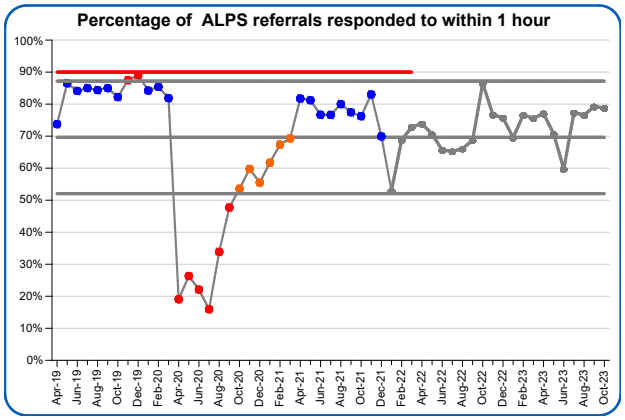


Contractual Target 70%: October 93.4%

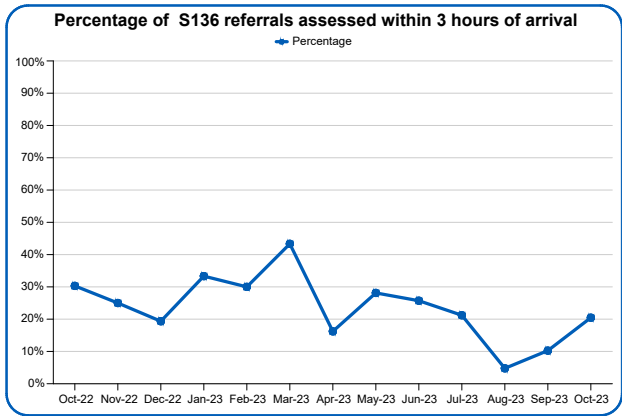


Contractual Target tba: October 13.4%

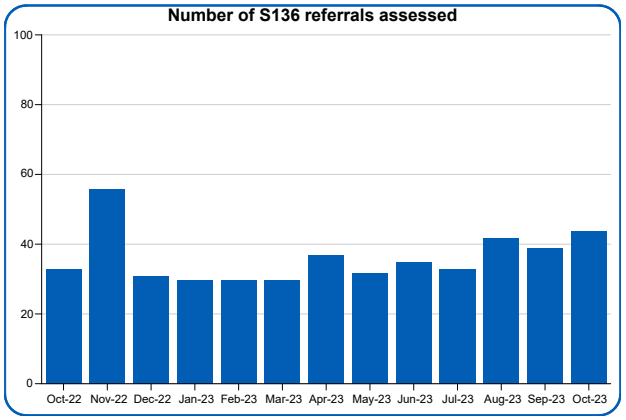
Services: Access & Responsiveness: Our Response in a crisis (continued)



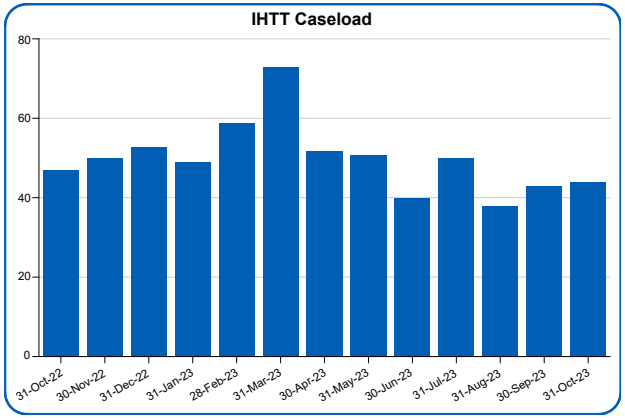
Contractual Target : October 78.8%



Contractual Target : October 20.5%

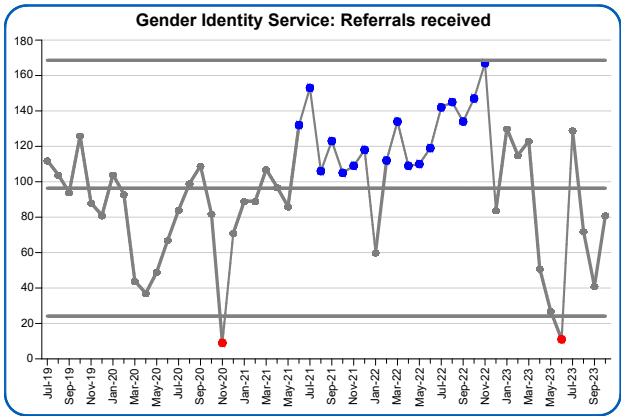


Total referrals assessed: October 44

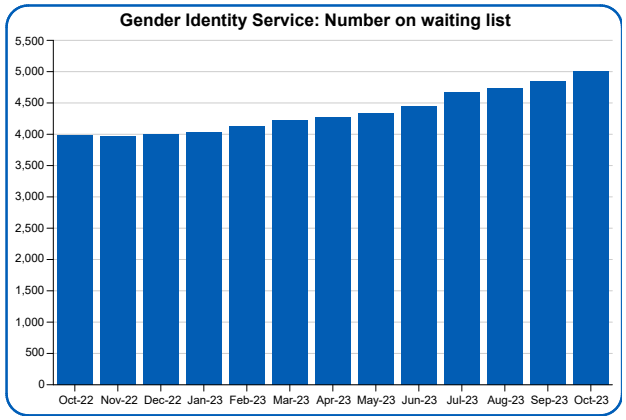


Caseload: October 44

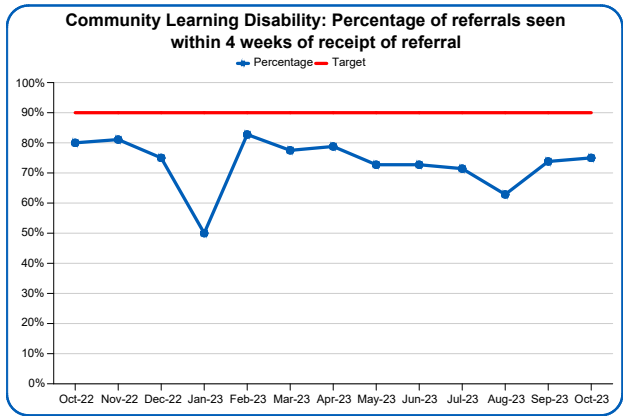
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services



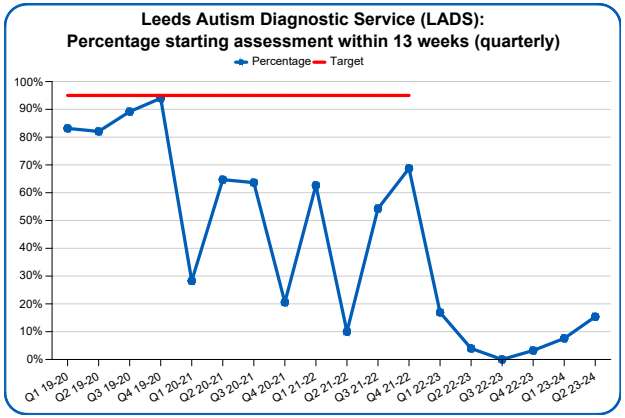
Total referrals: October 81



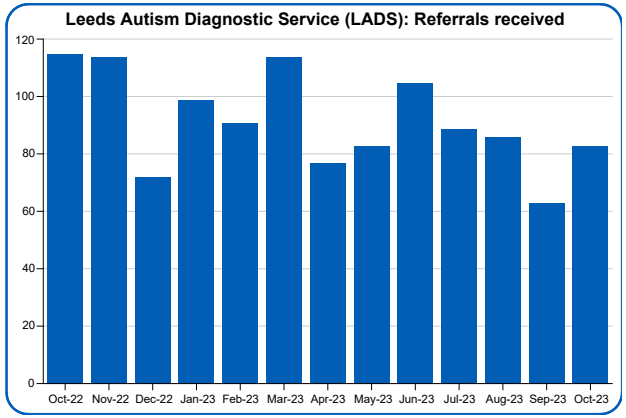
Number on waiting list: October 5,018



Contractual Target 90%: October 75.0%

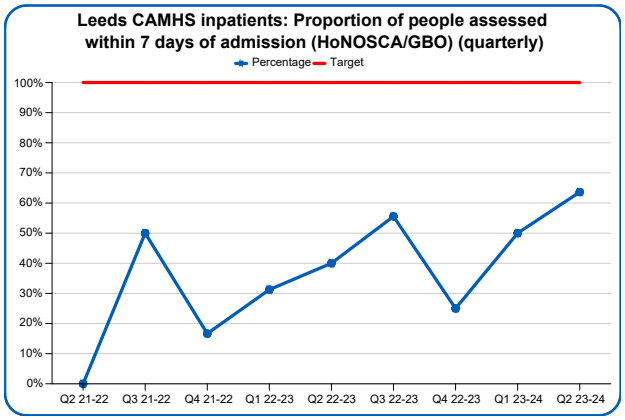


Contractual Target : Q2 15.4%

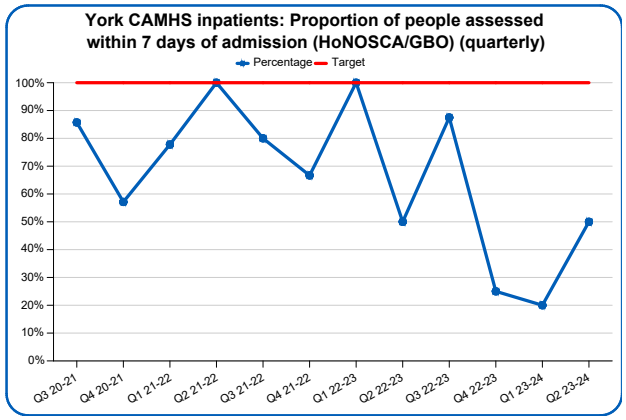


Local measure: October 83

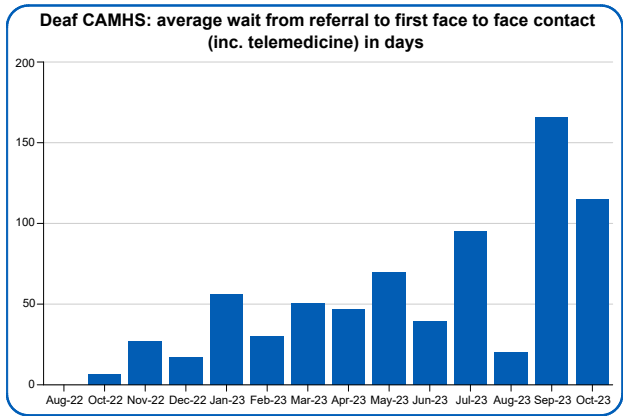
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services (continued)



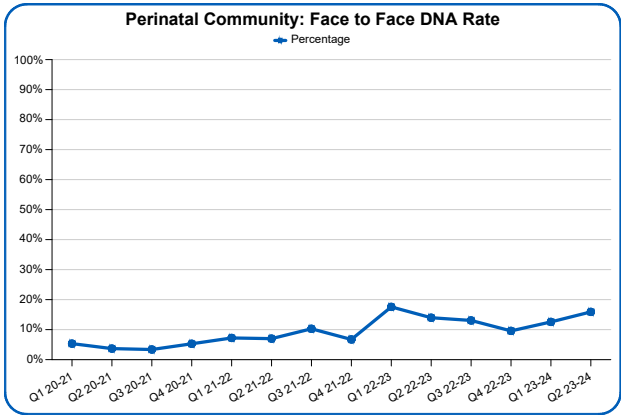
Contractual Target 100%: Q2 63.6%



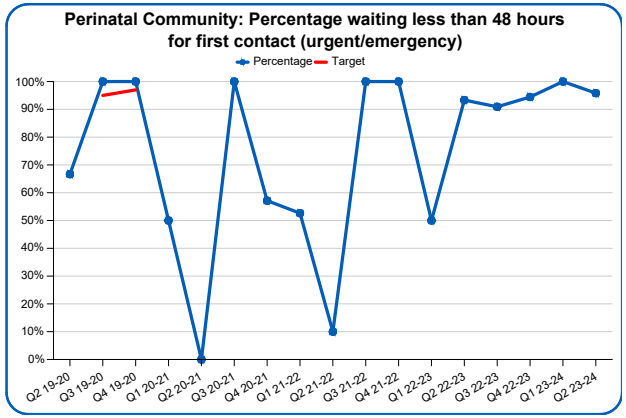
Contractual Target 100%: Q2 50.0%



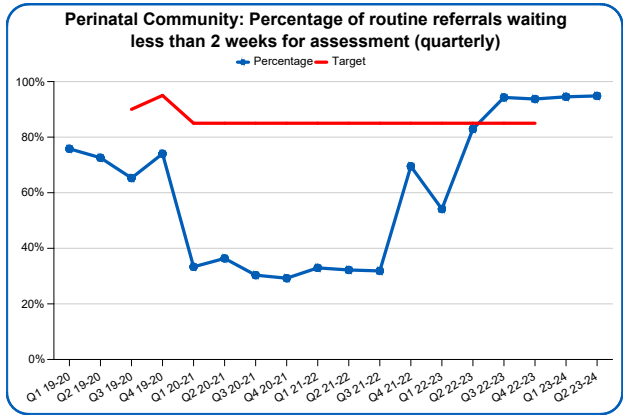
Local measure: October 115



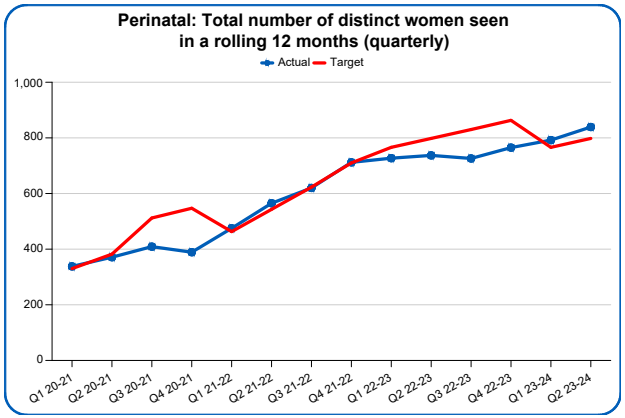
Contractual measure: Q2 15.9%



Contractual Target tba: Q2 95.8%

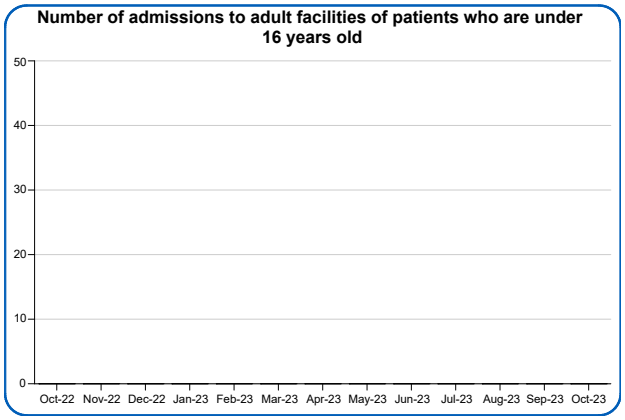


Contractual Target : Q2 94.8%

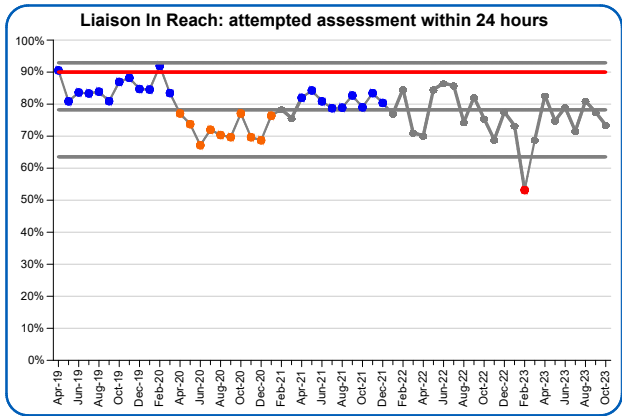


Local measure 798: Q2 839

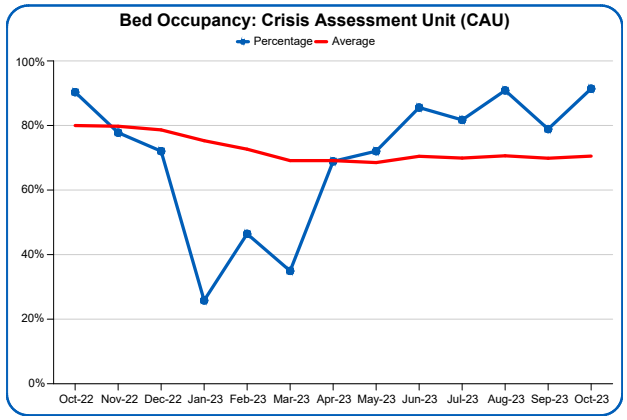
Services: Our acute patient journey



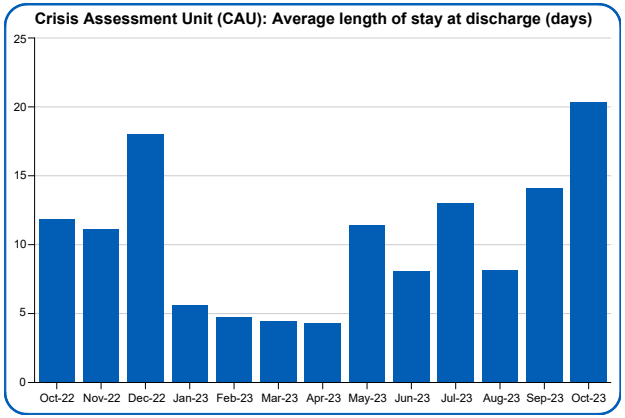
National (NOF) No target : October 0



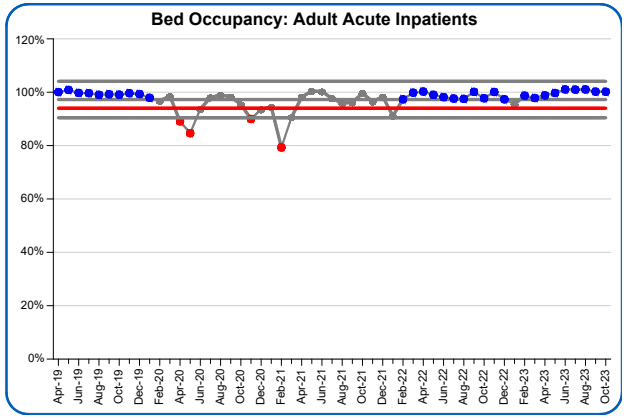
Contractual Target 90%: October 73.5%



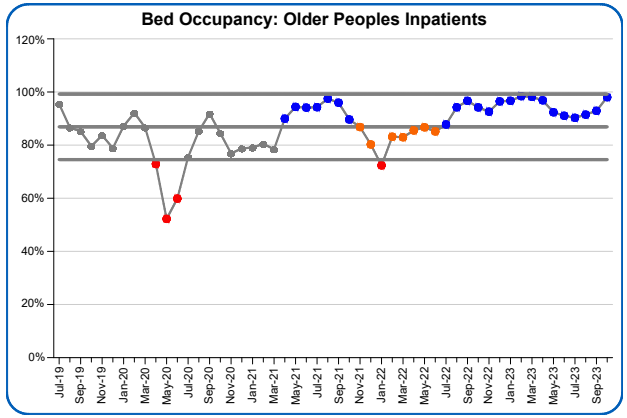
Local measure: October 91.4%



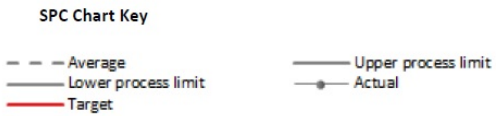
Local measure: October 20 days

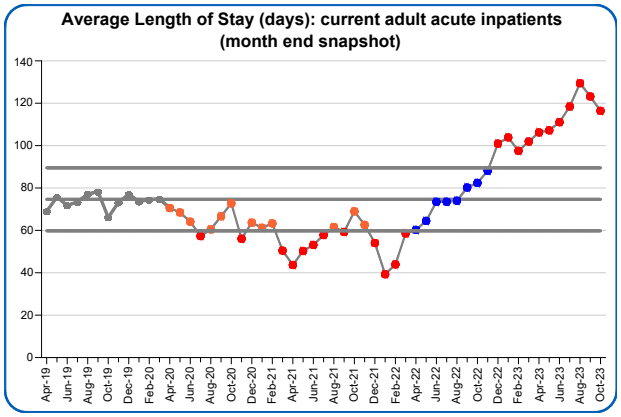


Contractual Target 94%: October 100.2%

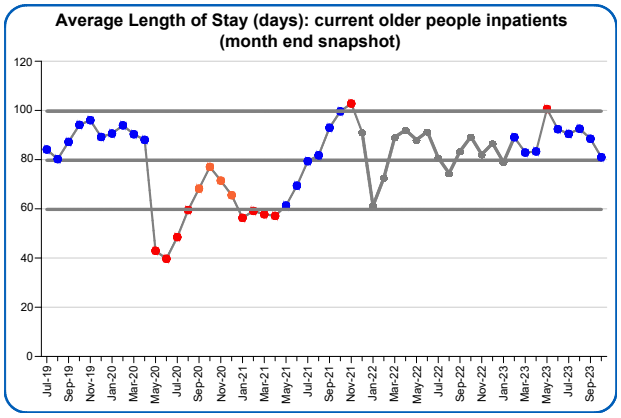


Local measure and target : October 98.0%

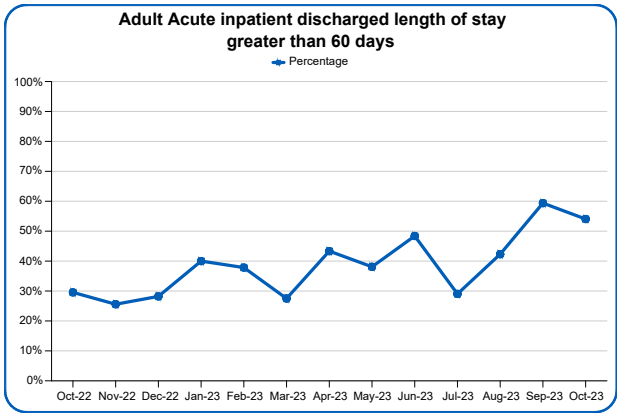




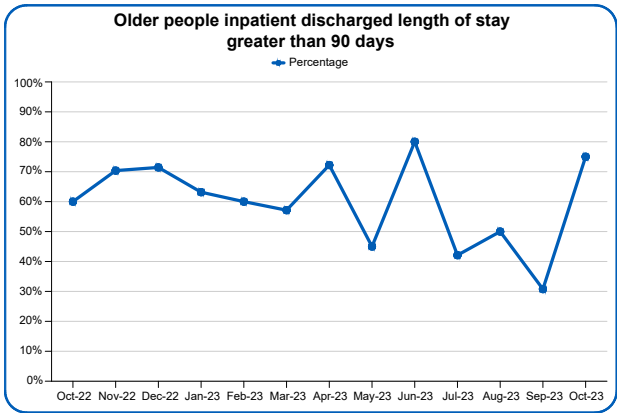
Local tracking measure: October 116 days



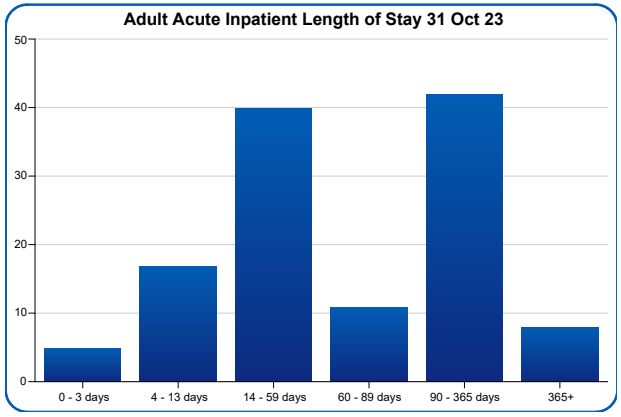
Local tracking measure: October 81 days



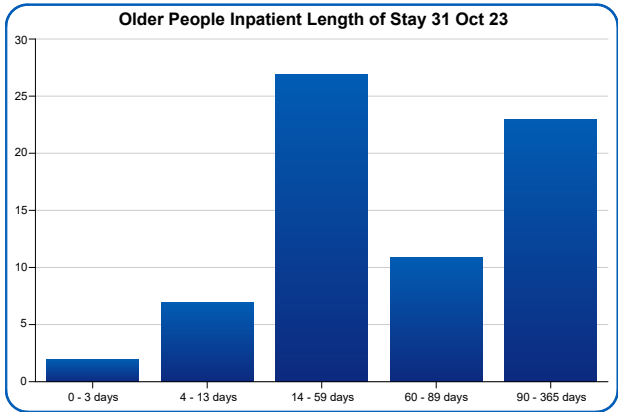
National (LTP): October 54.1%



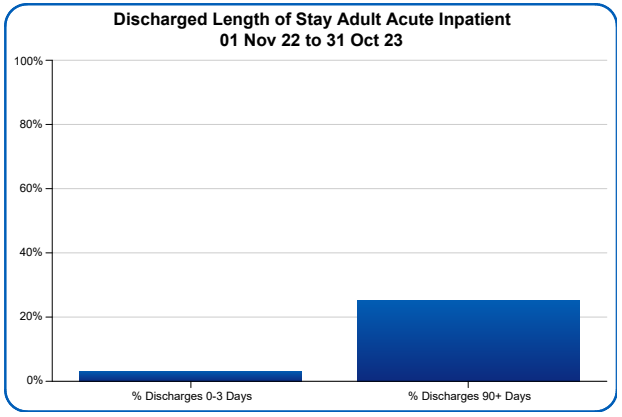
National (LTP): October 75.0%



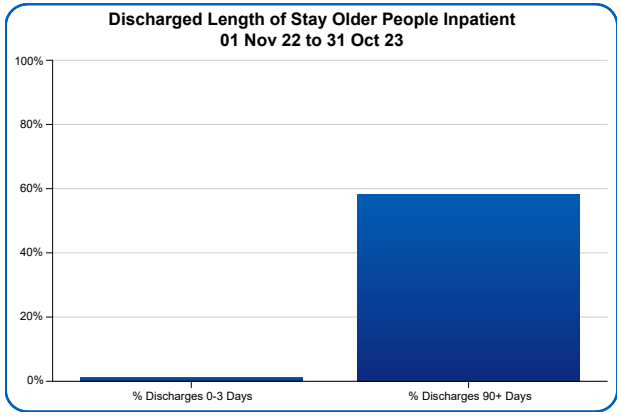
Local activity: 50 people with LOS 90+ days



Local activity: 23 people with LOS 90+ days

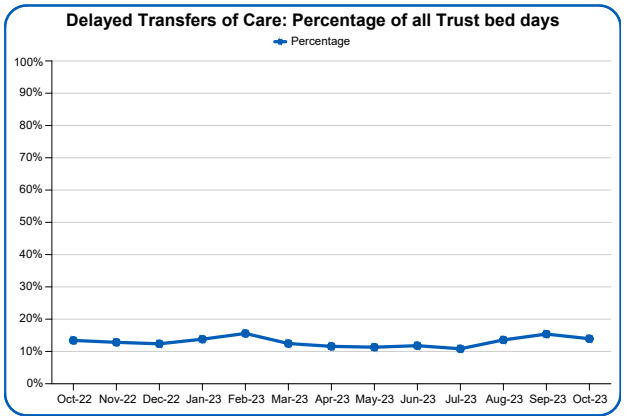


Local activity: % discharged LOS 90+ days = 25.4%

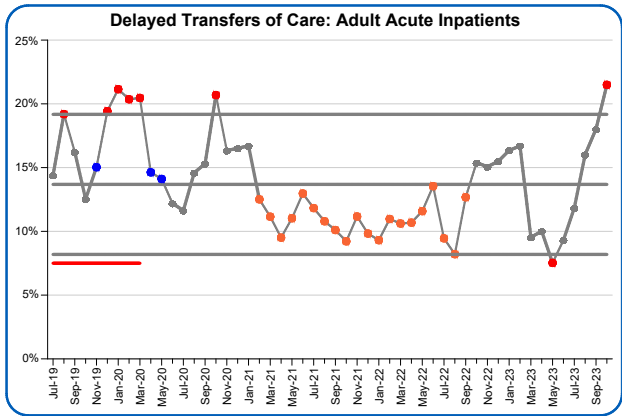


Local activity: % discharged LOS 90+ days = 58.6%

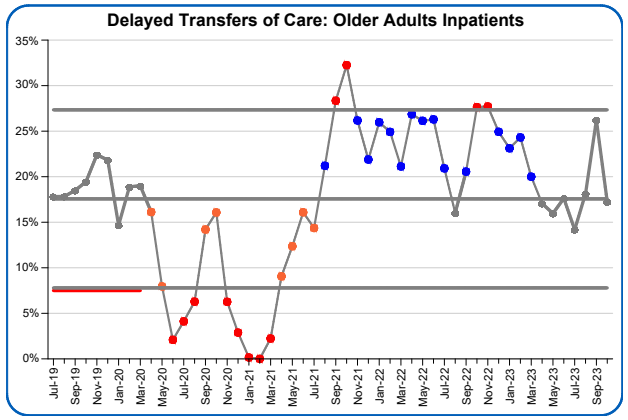
Services: Our acute patient journey (continued)



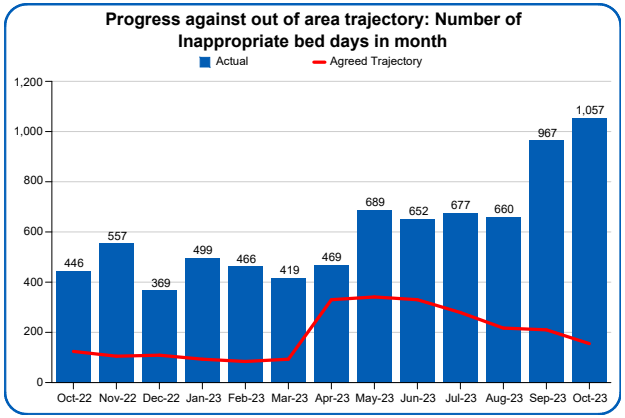
Local tracking measure: October 13.9%



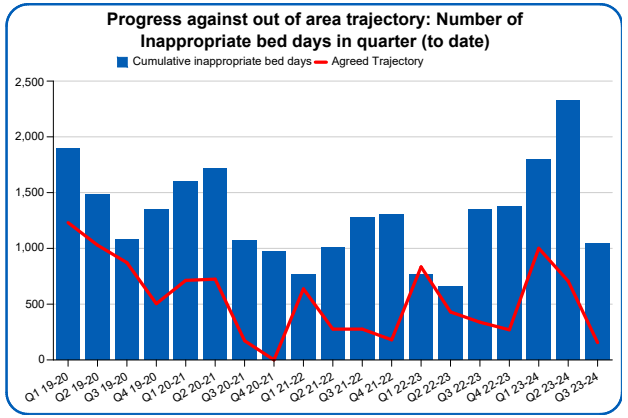
Local tracking measure: October 21.5%



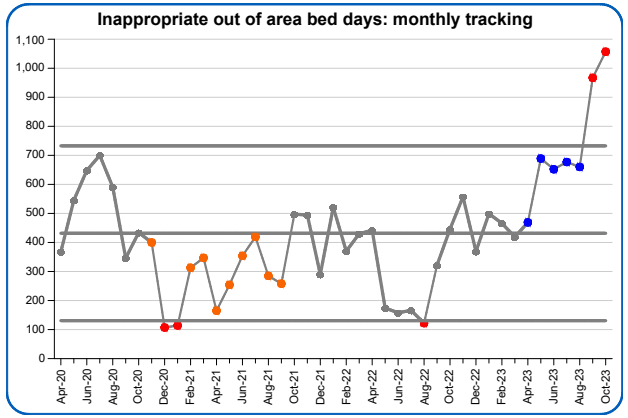
Local tracking measure: October 17.2%



Nationally agreed trajectory (155): October 1,057 bed days



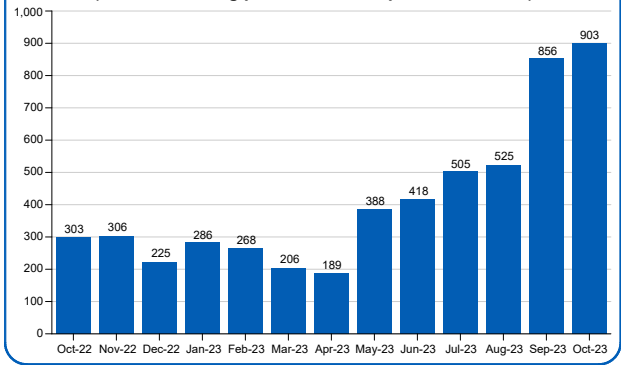
Nationally agreed trajectory (Q3: 155): Q3 1,057 bed days



Local tracking measure: October 1,057 bed days

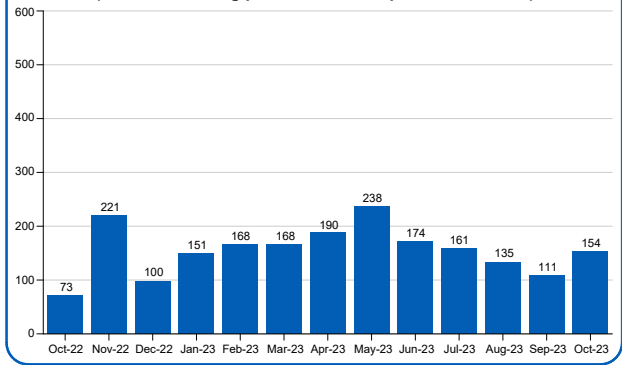
Services: Our acute patient journey (continued)

Acute: Total number of inappropriate bed days out of area (new and existing placements from previous months)



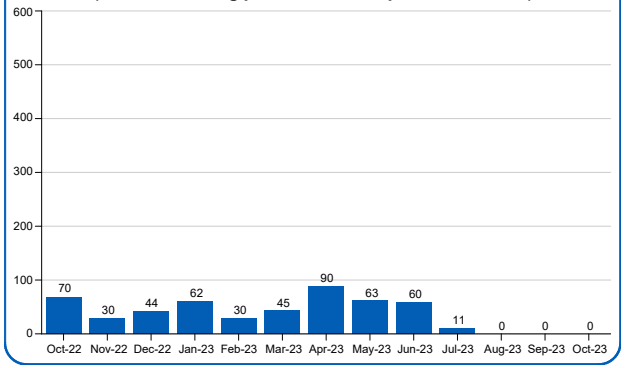
Nationally agreed trajectory (): October 903 days

PICU: Total number of inappropriate bed days out of area (new and existing placements from previous months)



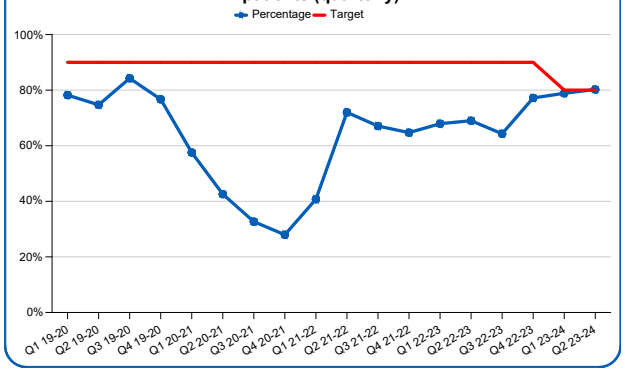
Nationally agreed trajectory (): October 154 days

Older people: Total number of inappropriate bed days out of area (new and existing placements from previous months)



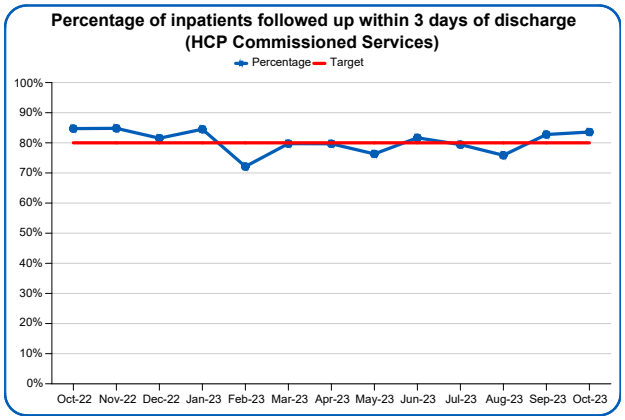
Local measure : October 0 days

Cardiometabolic (physical health) assessments completed: Inpatients (quarterly)

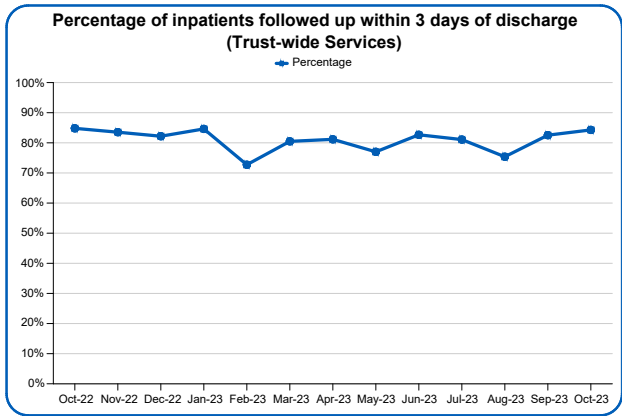


Contractual target 80%: Q2 80.2%

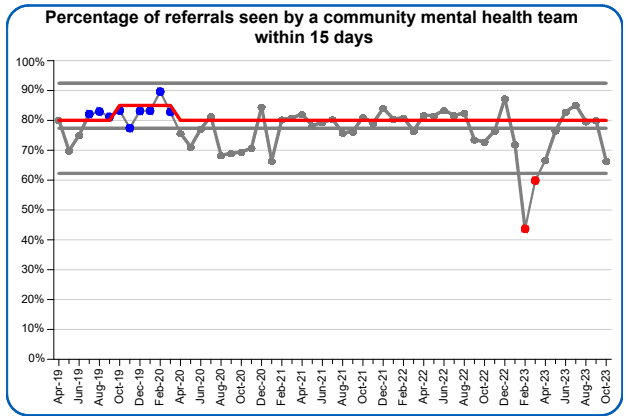
Services: Our community care



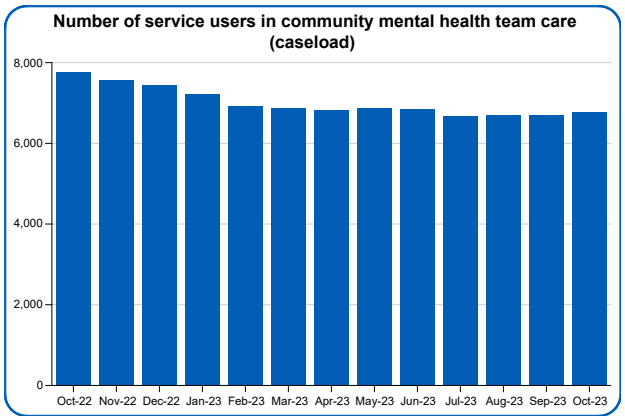
Contractual target 80%: October 83.6%



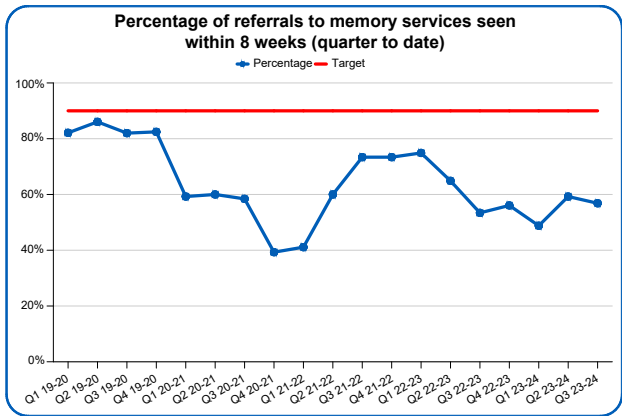
Local Tracking Measure 80%: October 84.3%



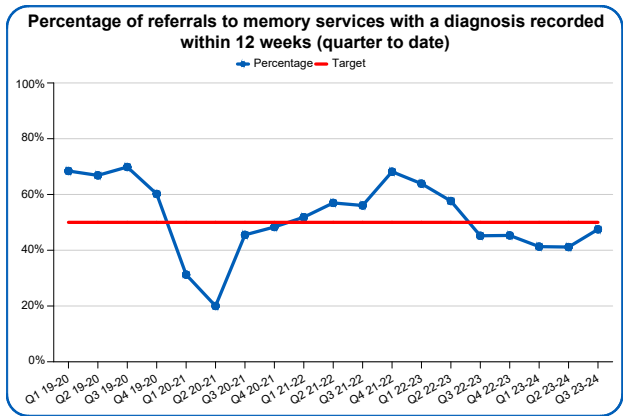
Contractual target 80%: October 66.4%



Local measure : October 3,351



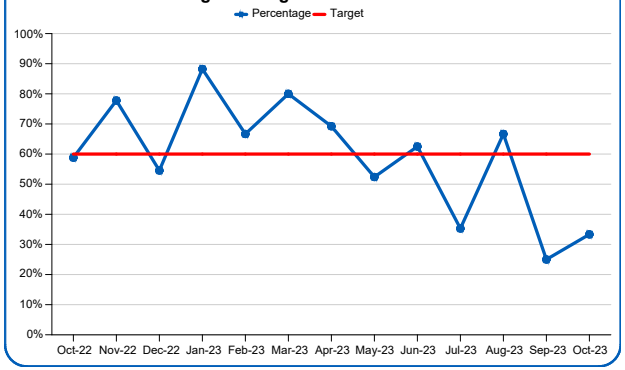
Contractual target 90%: Q3 23-24 56.8%



Contractual target 50%: Q3 23-24 47.5%

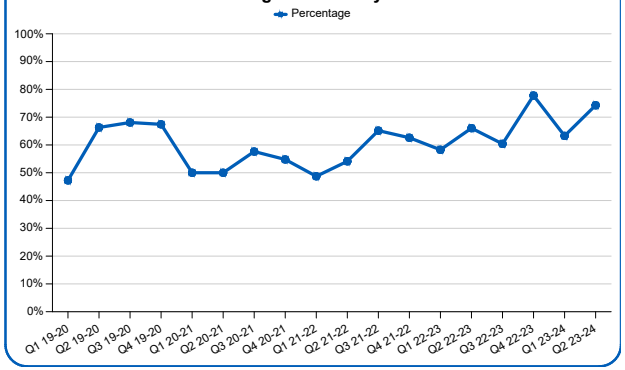
Services: Our community care (continued)

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



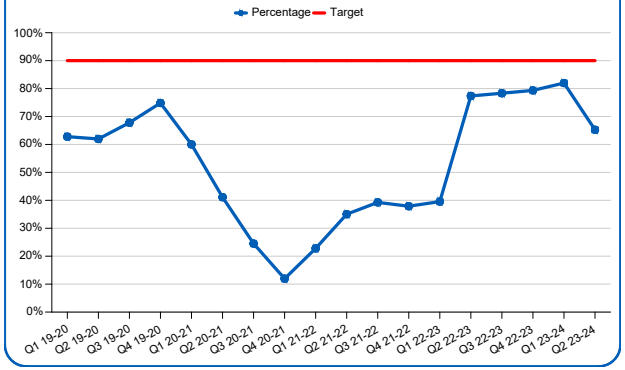
Contractual target 60%: October 33.3%

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



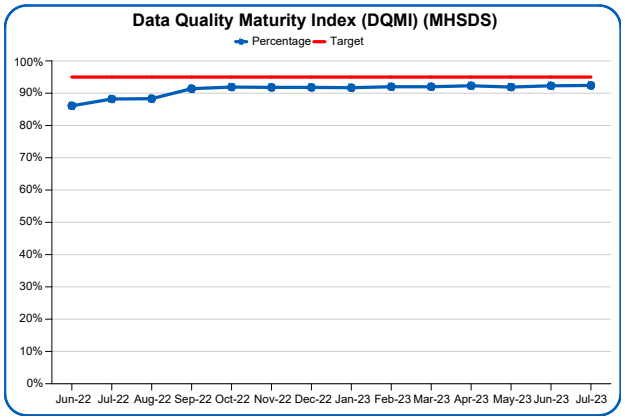
Contractual target tbc: Q2 74.3%

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

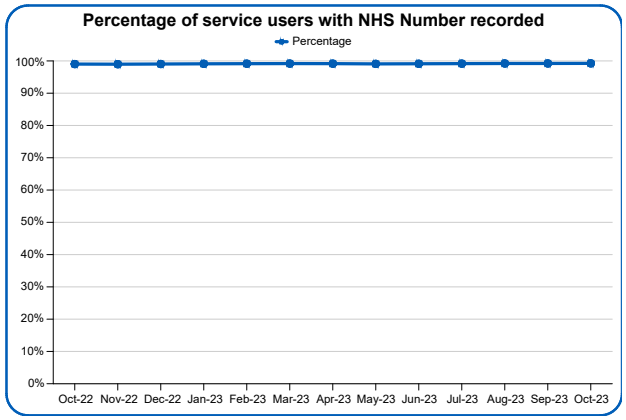


Contractual target 90%: Q2 65.2%

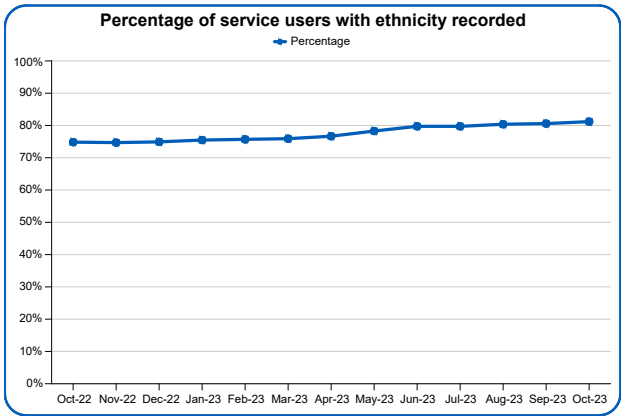
Services: Clinical Record Keeping



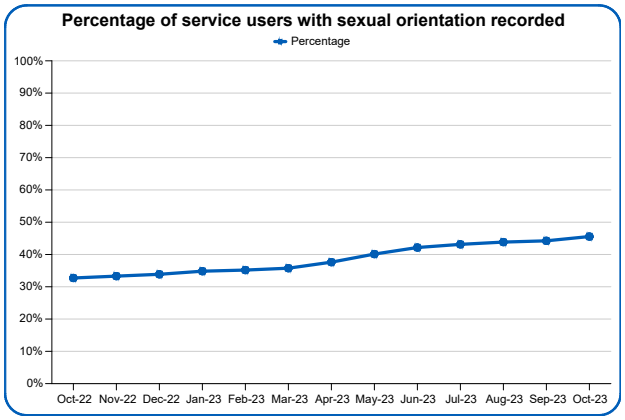
CQUIN / NHSOF Target 95%: July 92.4%



Local measure: October 99.2%



Local measure: October 81.2%



Local measure: October 45.6%

Leeds and York Partnership NHS
NHS Foundation Trust

Winter Resilience and Operating Plan

2023/2024

Contents

1. Introduction

The purpose of the Winter Resilience and Operating Plan is to set out the approach that Leeds and York Partnership NHS Foundation Trust (the Trust) will take to maintaining service provision and minimising disruption during the winter of 2023/24.

During winter 2023/24 Systems will be expected to maximise opportunities to continue to support the NHS recovery programme whilst also ensuring continued application of the UK Infection Prevention and Control guidance to prevent and control infection, and to respond to additional demands and pressures as they arise.

It is recognised that Winter plans will need to be integrated and developed in partnership across each system, but also iterative and able to adapt to competing demands. Now, more than ever we know that effective resilience will only be achieved during the winter period through effective system and partnership working with our NHS, Social care, Third Sector / VCS partners, with the general public, with the people that use our services, and with our staff.

The plan details the Trust Operating Objectives for the Winter period, the arrangements in place to effectively manage clinical and operational delivery of services, and the actions that will be taken to mitigate anticipated risks during this period. This includes:

- Reference to underpinning legislative and other key frameworks in place
- The identification of critical services
- Assessment of readiness for our clinical and corporate support services
- Identification of risks to service provision
- Identification of current and planned mitigations, including processes and systems in place
- Maintaining the wellbeing of our staff and service users
- Links to EPRR structure and wider system incident response

1.1 Operating Principles

In line with national guidance and developed system plans, we have a number of operating principles and objectives that underpin the development of our Winter Plan building on learning from previous years. Our operating principles and aims are to:

- Minimise disruption to service users, carers and our staff.
- Maintain access, responsiveness and flow through services, in partnership where required, ensuring emergency access / urgent care is sustained throughout.
- Maintain and protect safe, high-quality service delivery
- Maintain all elements of service delivery in accordance with our agreed & current operating models wherever possible.
- Continue to deliver all services for as long as is practicable in times of increased escalation, and any suspended or restrictions to services will be recovered as soon as is possible.
- Continue to develop and implement sustainable and effective services that are able to respond to the 'on the day' demands of the population.
- Seek to actively identify and address health inequalities across our services, and the specific challenges faced by minority groups.
- Ensure proactive leadership and management arrangements - including enhanced operational leadership and management across 24 hours, 7 days per week - that allow us to continue to adapt and respond as things change.
- Support our staff to prepare for and respond to the pressures and challenges we face through winter and will actively promote and support staff physical and mental wellbeing in order to support enhanced and ongoing resilience. This will include access to both Flu and Covid vaccinations.
- Work as a proactive system partner, ensuring clear integrated plans and governance structures are in place for early escalation and mitigation of emerging / unexpected / external pressures.
- Ensure that our contingency plans and emergency measures are evaluated to understand the impact they will have and mitigate risks wherever possible.

1.2 Legislative and Contractual Framework

The development of the LYPFT Winter Resilience Plan 2023/24 has included reference to several additional national guidance documents, including:

- West Yorkshire ICS Strategic Coordinating Group Winter Plan 2023/24
- Leeds System Winter Plan 2023/24

- Managing capacity & demand within inpatient and community mental health, learning disabilities and autism services for all ages (NHS England & NHS Improvement)
- The NHS People Plan
- NHS Mental Health Implementation Plan 19/20-23/24
- Mental Health Transformation Programme; Covid-19 Priorities & Next Steps
- Advancing Mental Health Equalities Strategy.

1.3 Addressing Health Inequalities

A key thread throughout the work, and in line with national priorities, has been a focus on health inequalities – the widening gaps around health equity throughout the pandemic had been of particular focus for us as a Mental Health and Learning Disability provider. Systems, again, have been asked to pay particular attention to advancing equalities for groups facing inequalities across different mental health pathways (such as BME communities, LGBT+ communities, older people, children and young people and people with a disability / other significant physical health needs), with specific reference to

- Access
- Experience
- Physical health

Our approach to this has been to seek to scope and understand current health inequalities across our current services and populations (recognising these will vary between services and populations), and then seek to tackle and reduce these through targeted interventions / actions.

Each service has previously developed a specific Health Inequalities improvement action as part of our approach to reset and recovery. These are then underpinned by wider LYPFT or system interventions such as the Leeds system Synergi programme, the work of the clinical services inclusion team, and joint work between the Rainbow Alliance and Mesmac (a third sector partner) to survey and explore the experiences of the LGBT+ communities who use our services. This work will continue be taken forward during the winter period.

1.4 Where we are now? Current Service Provision & Prioritisation

As described above, services have continued to adapt their method of delivery over the past couple of years, with our services now operating a hybrid model of face to face and virtual

clinical activity. Service leaders have supported this by developing detailed updated working instructions so that staff have clarity in order to support their work. Where services have identified issues in relation to backlog and/or waiting lists, work has been undertaken to plan to address these issues, supported where possible by detailed activity plans.

We continue to experience operational pressures across services, especially in terms of increased demand, recovering backlogs of treatment and care, ongoing constraints in how we can deliver care, disruption due to ongoing Covid-19 outbreaks. This occurs in the context of significant wider system pressures, which are already evident as we move into winter.

Throughout 2023 thus far we have seen significant disruption due to Industrial Action, more latterly due to the BMA action relating to Junior Doctors and Consultants. This disruption is unprecedented and has had an impact to service provision and we anticipate this to continue into the early part of Winter.

Our workforce availability, wellbeing and resilience is key in maintaining our ambition for minimal disruption to service delivery throughout the winter so this is where much of our effort and support will be focused. We now have well established contingency arrangements and measures to maintain staffing availability and in particular to maintain delivery of our access, crisis and in-patient priority services at all times.

1.5 Service Prioritisation: Critical Services

As set out in our 21/22 and 22/23 Winter Plans, we previously established and agreed a process of service prioritisation as part of our EPRR business continuity approach. This identifies which services are an essential priority and required to be maintained at full capacity at all times. This will influence our decisions around the use / deployment of resources throughout the winter period. Three levels of priority have been agreed as below:

Priority 1 services	These key services are essential priority and are required to be maintained at full capacity. Normal staffing numbers and skill mix will be maintained. This includes 24/7 inpatient services, supported living houses and urgent access / crisis services.

Priority 2 services	There services need to be maintained, but may safely be delivered at a reduced capacity or alternate skill mix. This will be informed by an assessment of service user need, risk and vulnerability using our agreed clinical RAG rating process. Services may therefore be reduced or consolidated, and some staff redeployed into priority 1 services
Priority 3 services	These services could be reduced to a minimum level of delivery or could be stepped down entirely. The majority of staff are therefore likely to be redeployed into priority 1 services (or into priority 2 services as part of a revised skill mix to release other staff to priority 1 services)

Priority 1 services have been identified as our inpatient wards (excluding respite services) and services that people use to access mental health services in a crisis (CRISS & Section 136, ALPS, Hospital In-reach, Liaison service, Learning Disability Intensive Support Team, and Older Peoples IHTT (crisis and home treatment) service.

A full list of services and their priority can be found at *Appendix A.*

1.6 Maintaining Flow and Meeting Demand

A key aspect of maintaining Operational Delivery during the winter period will be processes that are in place to maintain and monitor flow and meet demand.

We have established and refreshed a number of systems for monitoring and maintaining flow through our inpatient services, with specific emphasis on our Acute, PICU, Older Peoples and Rehabilitation services.

The current systems that are in place to deliver and support this include:

- Daily monitoring and reporting of occupancy, demand and delayed transfers of care
- Daily reports on out of area bed use, and external capacity
- Completion of a weekly ‘heat map’ for each service line to identify pressures and risks
- Discussion and escalation at Service Line meetings and at the Operational Delivery Group meeting as required.
- Weekly meetings with our adult social care partners and commissioners to support flow, accelerated discharge and focus on delayed transfers of care (DToC).
- The establishment of the Inpatient Flow Oversight Group (IFOG)

We continue to deliver our enhanced our Bed Management and Capacity processes to support the anticipated Winter demands. These continue to include a dedicated Out of Area placement nurse, to support our aim of reducing any (clinically inappropriate) out of area placements in line with the national NHS E/I aspiration.

1.7 Activity and Performance Management

During 2023 services have continued to receive and review activity data, with increasing access to performance dashboards. We have re-established more regular formalised governance relative to performance and activity via our Operational Delivery Group (ODG) and through reinstating our Quality, Delivery and Performance (QDaP) reviews for each service line, led jointly the Deputy Director of Operations. We have also maintained our 'heat map' approach for all service lines which is reviewed regularly via a weekly Operational Huddle and highlights area of particular concern or challenge to maintaining service delivery and business continuity.

Our activity and performance continue to be monitored through a monthly submission to ICB Commissioners and completion of mandated NHS England returns for specialised commissioned services. Our Service Delivery and Performance is now reported to the Board as part of the Chief Operating Officer Board report on a bi-monthly basis.

1.8 Service Line Assurance Report

As part of our Winter Plan, each service line is required to complete and provide an assurance template that confirms the service line has adequate confidence in their processes and planning in relation to:

- **Staffing** (planning, cover arrangements and disruption mitigation)
- **Surge and Capacity** (Service response to manage surge and increased demand)
- **Severe winter weather** (Ability to operate within significant periods of adverse weather)
- **Outbreaks** (Ability to manage Covid & Flu outbreaks).

This detailed assurance (with plans for additional actions and assurance as required) forms part of our comprehensive Winter / Emergency planning approach and ensures effective oversight and support for our services.

The report template is attached at *Appendix B.*

1.9 Maintaining Safe Staffing

Having sufficient experienced staff on duty is a major asset in mitigating disruption, and a key potential risk to delivery throughout the winter period.

During the initial stages of Covid-19 the Trust developed a formalised approach to deployment & redeployment of staff in order to maintain minimum safe staffing levels, particularly within the agreed priority services. This was revised following a period of review and feedback from staff, as well as a formal evaluation of effectiveness and impact. Our current Deployment & Redeployment process can be found at *Appendix C.*

Operational staffing arrangements, staffing pressures and the forecast staffing position across care services are reviewed within each of the service line management meetings, reporting to the Operational Delivery Group (ODG) and linking closely to the Trust governance structures relating to workforce planning and recruitment & retention.

Our aim during the Winter period is to minimise movement of staff between services, recognising that this is disruptive for both staff and service users. Within the last 2 years we have introduced a dedicated ‘responsive workforce’ team who are able to be deployed at pace to areas of emerging or actual staffing pressures.

Staffing pressures have however remained constant (at varying degrees) throughout 2023 – due to periods of increased unavailability of staff, high rates of vacancies and some sustained levels of demand for additional staff in priority services because of service user presentation and acuity. These are now predominantly dealt with through ‘internal’ deployment of staff within the service line (for example, practice development staff or senior clinical staff working directly within the clinical settings), cancelling non-essential activities, or through the ‘day to day’ deployment of staff from one area to another (as set out in the Trust Staffing Escalation Protocol).

Where services are required to move to a period of formal Business Continuity due to sustained staffing pressures - or where levels of activity & demand create pressures that result in an increasing OPEL position - services will enact their business continuity plans and associated OPEL actions.

These will include:

- Escalation internally and externally with partners (via system Silver)
- 'Internal' redeployment of staff across service line to meet priority service needs
- Deployment of clinically qualified senior staff into direct clinical roles
- Cancelling of non-priority activities, study leave and 'ad-hoc' annual leave

- Facilitate early discharge (utilising CRISS / IHTT for increased home support)
- Use of non-designated ward / bed space (such as de-escalation areas or additional bed capacity) to create capacity

- Review of clinical activity across all service lines with reduction to release capacity and maintain priority & essential services
- Use of volunteers from other services who have identified willingness to be redeployed to priority services when required
- Use of administrative / corporate support staff within care services

- Consider step down of services in non-priority category (supported by impact & risk assessments and mitigation)
- Implement formal redeployment processes across care services and corporate support services to maintain minimum staffing and delivery of priority services

1.10 Focus on Workforce

The NHS People Plan for 2020/21 clearly sets out the national aims and objectives in relation to our workforce moving forward, with a key focus on 4 areas:

- **Looking after our people** – with quality health and wellbeing support for everyone
- **Belonging in the NHS** – with a particular focus on tackling inequalities and the discrimination that some staff face

- **New ways of working and delivering care** – making effective use of the full range of our people's skills and experience
- **Growing for the future** – how we recruit and keep our people, and welcome back colleagues who want to return

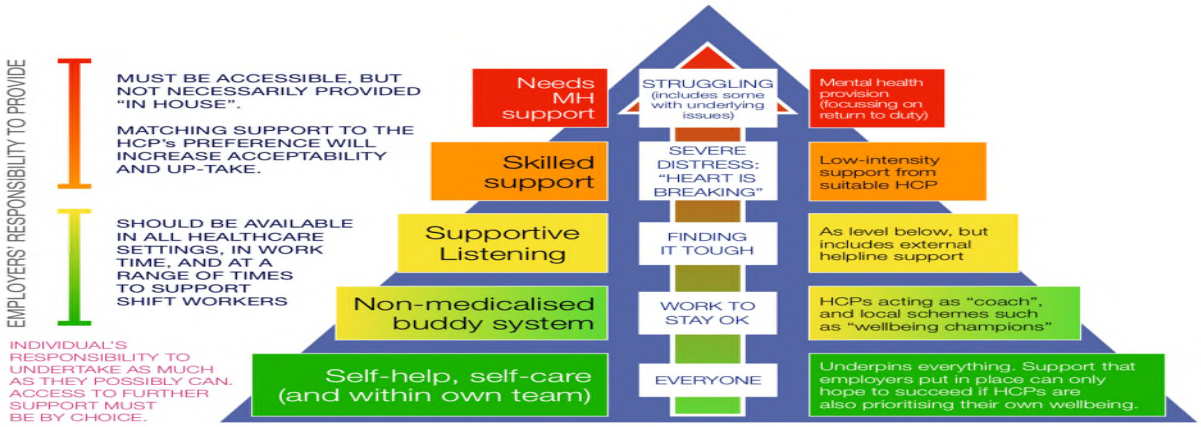
These areas have influenced and been reflected in our ways of working over the last 3 years and are reflected within our 2023/24 Winter Plan.

Workforce is identified as the key risk to every aspect of our system and local winter plans. In relation to the Winter Resilience plan, there is a specific focus on 2 key areas – staff health & wellbeing, and different ways of working to most effectively deploy staff to meet service user need and maintain the continuity of our priority services. Our plans very much reflect the most recent national NHS guidance and advice in relation to preparation for Winter 2022/23 and demand surge, which focus on:

- Provision of enhanced Health and Wellbeing Support
- Focus on flu and covid vaccination
- Effective forward planning of deployment and rosters
- Recruitment and retention initiatives to grow, develop and upskill the workforce
- Promotion of resilience and increased flexible working arrangements

1.10.1 Staff Wellbeing

The health, welfare and wellbeing of our staff is a key Trust priority. We have established a staff health and wellbeing group which oversees and coordinates our approach to staff wellbeing and have drawn on the framework developed by Dr Alys Cole King (shown below) to offer graded levels of support to staff and optimise preparedness, wellbeing and functioning. We recognise that the ongoing pandemic has already had a significant physical, mental and psychological impact on our staff, and that this will continue through the winter period.



Dr Alys Cole-King & Dr Linda Dykes with input of BCUHB Staff Welfare and @HCW_Welfare Collaboratives

We maintain individual Wellbeing Assessments for all staff across the Trust and use these to support decisions around deployment of staff and staff wellbeing initiatives. A staff Health and Wellbeing Hub is established and strengthened arrangements have been maintained to support staff who are absent from work and support their return to work. These arrangements will be maintained and further developed during the Winter period.

In addition, we play an active role in the Leeds One Workforce Programme (a set of continuing collaborative projects relating to workforce support and development) and the West Yorkshire ICS staff health and wellbeing hub.

1.11 System level winter arrangements

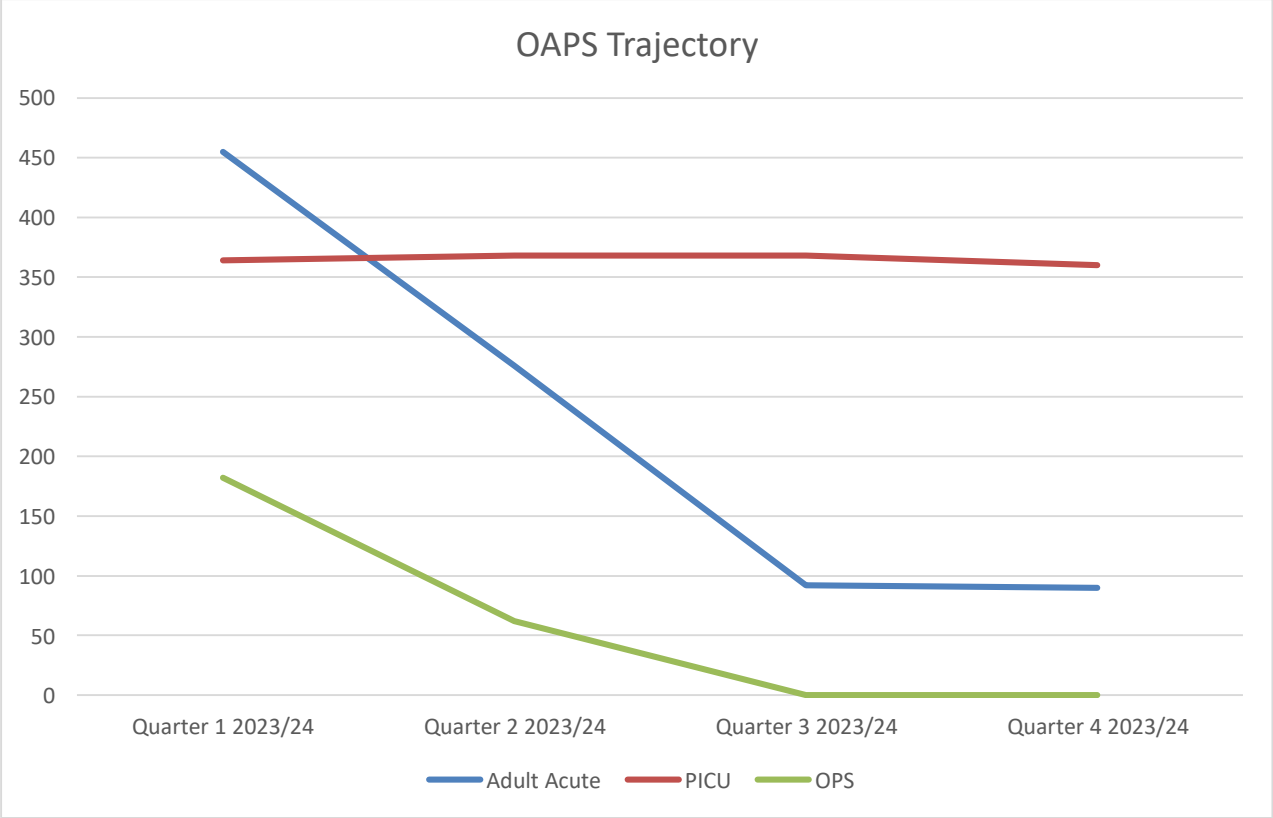
In preparation for Winter 2023/24 the ICB has further developed the System Coordination for Health and Social across the system. The System Co-ordination Centre (SCC) policy builds on the System Control Centres document released by NHS England (NHSE) in October 2022 as part of the 2022/2023 winter plan. System Control Centres are now identified as System Co-ordination Centres (SCCs) in recognition of a revised purpose, capability, and core function.

The SCC exists to be a central co-ordination service to providers of care across the ICB footprint, with the aim to support patient access to the safest and best quality of care possible. The SCC is responsible for supporting interventions across the ICS on key systemic issues that influence patient flow. This would include a concurrent focus on Urgent and Emergency Care (UEC) and the system's wider capacity including, but not limited to, NHS111, Primary Care, Intermediate Care, Social Care, Urgent Community Response and Mental Health services.

2. Responding to surge and demand

2.1 WAA Out of area trajectory

Throughout 2023 we have seen an increased and sustained demand for in-patient beds for working aged adults. In-patient Flow Oversight Group (IFOG). Whilst the service has seen a significant increase in Out of Area placements evidence suggests that this has not been as a result of increased demand. The service has seen a significant increase in the Length of Stay due to high level of complex need particularly on our Female acute wards and an increased number of Delayed Transfers of Care (DToCs) due to internal system blocks and housing needs. The WAA Acute service has worked with the Informatics Team to establish a recovery trajectory through the remainder of 20233/24, see graph 1. The service has been unable to effectively model the demand due to the variations they have seen over recent years.



Graph 1

The Leeds System Level OPEL reporting mechanism will monitor all LYPFT OAPS, DToCs by reason code and lost bed days. Further work is ongoing with the System

Visibility Report for LYPFT similar to the one already in place for LTHT. A mapping exercise of outflow services is required to determine the metrics to be included in the report.

Weekly DTOC meetings will now be chaired by the Head of Operations for the Working Aage Adult (WAA) Acute Service who will be responsible for any escalations required within the Trust and the wider Leeds system. The meetings will also have representation from Adult Social Care, Housing and the Leeds office of the ICB. The service is exploring the role of Hospital based Social Workers with ASC in order to facilitate discharges for those service users with social care needs.

The WAA Adult Acute Service with the ICB have identified the 3 mains areas where support is required:

- System visibility/operational oversight/to support DTOC management.
- Access to housing and supported accommodation
- Access to 3rd sector support – we will look to refocus the role of the discharge peer support workers

The WAA Acute Service is re-launching gate keeping by the Crisis Team, facilitating early discharge with Intensive Support Service (ISS) and are working closely with Ward Consultants and CTMs. They also working with the Digital Change and Informatics team to develop Care Director processes and dashboards to produce sufficient data in a timely way to monitor capacity and demand.

The current use of the Crisis Assessment Unit (CAU) will be audited to consider how these 6 beds will fit in with the current position and CRISS proposal. This is supported by our clinical effectiveness team.

2.2 MADE outputs and planning:

The Multi-Agency Discharge event (MADE) was undertaken to understand the reasons for the delayed transfers of care within our inpatient units for working age adults, Psychiatric Intensive Care Unit (PICU), older people, and rehabilitation wards (including locked rehabilitation). The outputs of the workshop have been constructed into an action plan

which is now being implemented and overseen within the IFOG. Overall, there are two sets of actions, one focussed on actions internal to LYPFT and the other that requires a coordinated response from system partners such as the city council, third sector and other NHS providers.

2.2.1 Internal actions:

- 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

2.2.2 Systemwide actions:

- 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

At the system coordination group (a city-wide system group) it was agreed that the system would prioritise access to housing, third sector provision and discharge to access. It is anticipated that 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.

2.3 Winter staffing levels:

Having sufficient experienced staff on duty is a major asset in mitigating disruption, and a key potential risk to delivery throughout the winter period. Staffing pressures have however remained constant (at varying degrees) throughout 2023. Service lines monitor their staffing arrangements and any capacity issues that need addressing are escalated on a regular basis so they can be addressed in a timely fashion.

Winter staffing rotas are not done in advance through the whole winter. However, all teams are frequently reviewing rosters and planning ahead in line with our electronic roster

guidelines which ensure rosters are managed effectively and any shortfall can be identified and mitigations put in place.

3. Supporting the health of our people and patients over the winter

In order to maintain the health and well being of our patients and staff, the IPCC will coordinate the Flu and Covid vaccination programme.

3.1 Autumn/Winter vaccination plan

- From mid- September 2023 to end of February 2024, the IPC team will offer flu and covid vaccinations to staff and service users in line with JCVI recommendations and eligibility criteria.
- Registered Nurses and Registered Nursing Associates in inpatient areas who are peer to peer vaccinators will be able to offer the flu vaccine to staff working in that area.
- The IPC team will facilitate vaccination clinics within Leeds from October till December. From January till the end of February the IPC team will do walkrounds to wards to offer vaccine to those who have not been vaccinated. They will also attend to teams who request a bespoke vaccination clinic at their base.
- Registered staff on the wards will vaccinate service users with the flu vaccine as soon as possible to ensure early protection. Due to capacity issues the IPC team will not be able to support this intervention from October till December due to clinics.
- The IPC Lead Nurse will report of vaccination uptake figures to NHS England monthly. A report of uptake figures will also be shared at the IPC Committee meeting.

3.2 Outbreak Management

- During working hours, the IPC team will stand up outbreak management meetings where an outbreak has been identified of any causative organism.
- Once IPC have been notified of two or more service users presenting with symptoms, IPC response time should be within 2 hours Monday to Friday 8am till 4pm.
- An outbreak meeting will be held which will inform clinicians on the ward of standard infection precautions they should implement to safeguard others.
- From 8am till 5pm Monday to Friday, the IPC team will provide a telephone advisory service and respond to staff/service queries.

4. EPPR response

4.1 Adverse weather

The Trust has two plans that have been developed to manage adverse weather that is possible over the winter period. The two plans below contain the full details of the Trust's risk assessment, impact assessment and mitigation around disruption from adverse weather.

- The Flood plan.
- The Cold weather plan.

The Trust's EPRR team is registered to receive alerts regarding adverse weather – form the Health Protection Agency/ Met Office and flooding information and risks from the environment agency.

On receipt of a weather of flood alert the EPRR team will notify the Trust Communication function tom issue an all-user e-mail notification and services with vulnerability to the impacts of the adverse weather will be contacted and asked to consult their business continuity actions in preparation for potential bad weather. For example, going to standby with flood defences at a site with a high environment agency flood risk score. For significant threats – amber or red, the Trust would invoke both organisational business continuity arrangements aimed at utilising resources to maintain critical clinical and organisational activities.
Incident coordination would also be an option that would be considered for managing widescale disruption and has been used in previous winters to manage disruptive snow events.

4.2 Other winter risks

4.2.1 Power disruption

Winter brings with it increased risks to power distribution based on both the impact of storms and supply sided shortages first experienced in winter 2022-2023 with a risk to gas and oil supplies caused by the Ukraine conflict and UK gas storage limitations.
Many of the same factors exist in winter 2023-2024 as last year and hence the Trust will carry out work to boost resilience around potential outages.

- The Trust will implement a series of black start tests – simulating a power cut and testing the back-up generators and their control systems ability to detect the outage and then activate and power the building.
- Emergency lighting equipment will be checked to ensure it is in place and is still effective. This includes checking in wards stocks of torches and on LED safety lights issued to services across the Trust.
- Communication equipment checking will be requested for all in patient areas – these are ward business continuity mobile phones.

4.2.2 Maintaining access to Trust sites.

The Trust's sites are covered by three providers of facilities services: Trust owned and leased sites provided by Trust Estates staff; Leeds PFI sites provided by Mitie and York sites provided by NHS Property Services. All three providers have in place advance warning arrangements via met office alerting, supplemented by EPRR issues warnings. On receipt of snow or ice warning the providers will mobilise snow clearing and gritting resources to maintain access to sites including an out of hours response.

4.3 Working collaboratively – the Winter Tactical Group

The Winter Tactical Group commenced meeting in October 2023 to coordinate all work to mitigate potential winter disruptions. This membership of the group includes:

- EPRR staff
- Estates and Facilities
- Operational Management

- Communications
- Physical Health
- Membership from Mitie and NHS Property Services

Its role covers adverse weather response, power outage mitigation, disruption to other utilities and response to disruptive snow regarding site access. The group will report to the Trust executive lead Enhanced Winter Coordination Group.

Mark Dodd: Deputy Director of Operations

Andrew Jackson: EPRR Lead

Laura McDonagh: Head of Operations for Acute Services

Paul Fotherby: Head of Operations for Liaison and Perinatal Services

Carl Money: Head of Performance and Informatics

Warren Duffy: Head of Operations for Estates

Alison Quarry: Deputy Director of Nursing

GLOSSARY

Term	Explanation
Business Continuity	The capability of the organisation to continue delivery of products or services at acceptable predefined levels following a disruptive incident.
Business continuity incident	A business continuity incident is an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. (This could be a surge in demand requiring resources to be temporarily redeployed).
Command and control (and communication)	Often referred to as $C^{3.}$ The exercise of vested authority through means of communications and the management of available assets and capabilities, in order to achieve defined objectives.
Critical incident	A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions.
EPRR	This refers to Emergency Preparedness, Resilience and Response - this term covers all aspects of responding to emergency incidents and disruptive events in the NHS.
Mitigation	Measures taken to reduce an undesired consequence
Mutual aid agreement	Pre-arranged understanding between two or more entities to render assistance to each other
OPEL	Operating Pressures Escalatory Limits - this is the NHS England Framework governing how health providers reflect their position regarding capacity, demand and flow and the necessary actions to take to try to alleviate these pressures.
SiTRep	Situation Report - a teleconference or report detailing the current situation affecting a service, department or site. This is used as a basis to formulate action to manage the incident or problem.

Appendix A: Service Priority Categorisation

PRIORITY SERVICES	
CRISS Older Peoples IHTT LD Intensive Support Team MH Primary Care ALPS & LTHT Liaison Inreach Section 136 suite Veterans High Intensity Service	All crisis / urgent access services
Acute Wards & PICU CAU Mount wards Asket Wards Mill Lodge Mother & Baby Unit YCED (Ward 6) Complex Rehab (Ward 5) Forensic Wards 3 Woodlands Square Supported Living	Inpatient services and Supported Living Houses – maintain 24/7 Some reduction in full MDT availability in some teams, which will be managed by cross cover or redeployment (depending on requirements) Minimum staffing requirements being reviewed & confirmed in partnership with nursing directorate
NICPM	Maintain as a priority ward unless LTHT require ward space.
Maintain but can reduce / redeploy some staff	
CMHTs CLDTs Assertive Outreach Community R&R CONNECT community team Community Forensic Team Community Perinatal Deaf CAMHS Physical Health Team Care Homes Team Recovery College (telephone & online support) Forward Leeds (Addictions) PD Network LADS & ADHD Gender service Gambling service Chronic Fatigue & Liaison Outpatients Psychosexual medicine Offender PD services Veterans service	These services can all operate currently on a reduced number of staff, but have a requirement to maintain some access and an active caseload, including direct contact (including some face to face contact) with some service users. All service users have been RAG rated and this informs the required capacity and skill mix for the team Some staff are therefore available for redeployment from these teams.
Could step down	
LD Involvement Team PD Pathway Development Service 2 Woodland Square	These services can be closed to new referrals and stepped down, with only emergency contact cover in place

Appendix B

Winter Planning Assurance 2023-24

Introduction

The questions below are focussed on the key resilience principles that need management consideration. After brief, a brief narrative can you RAG rate your assessed level of preparedness.

1. **Staffing** – do you have effective plans in place to mitigate disruption caused by reduced workforce, annual leave, and the Christmas holiday period?

RAG assurance rating	Choose an item.

2. **Surge and capacity** – have you assessed the effectiveness of your plans to manage surge and increased capacity during the winter? For services that interface with other providers have you assessed likely impact on work from these providers facing surge?

RAG assurance rating	Choose an item.

3. **Severe winter weather** – assessment of the services ability to continue to operate faced with significant periods of snow/ ice

RAG assurance rating	Choose an item.

4. **Outbreaks** –what is your assessment of your services ability to manage outbreaks in teams and on wards

RAG assurance rating	Choose an item.

5. Risks to escalate

Appendix C

Maintaining Safer Staffing to priority services: Revised Deployment Approach

This paper aims to set out the agreed approach to deployment & redeployment of staff in order to maintain minimum safe staffing levels within the agreed priority services of the Trust, as a result of significant and sustained reduced staff availability as a result of Winter and/or other pressures.

Both during and following implementation, the redeployment process has been reviewed through a number of processes (such as ongoing redeployment forums, some facilitated discussions with ward / team managers, and through the wider Trust evaluation and staff feedback processes). The feedback and learning have been considered and incorporated into this revision, which has also been developed through discussions with operational, clinical and professional leads.

This revision also sets out a revised approach to the prioritisation of services, based on significant discussion across Care Services and beyond, including through the Operational Delivery Group.

For a small number of ad-hoc / single instance requirements for additional staff in order to maintain safe staffing levels, the standard approaches of seeking additional staff, negotiating changes with local staff (such as cancelling training or ad-hoc leave) and moving staff on a shift by shift basis based upon need will be applied (as set out in the Staffing Escalation Protocol, which can be found at Appendix 3 of the Clinical & Operational Staffing Redeployment process).

However, when the need for additional staff to maintain minimum staffing is more sustained (or when actual or predicted levels of absence exist across a large number of services), an alternative approach is required.

Deployment & Redeployment has been overseen by a dedicated group, which includes operational, clinical / professional and work force representatives. This was stood down during 2023 as the ned for such a group had reduced, with the proviso that should the demand require in the future this would be stood up to respond to that need.

1. Identification of need

In order to identify a sustained need, a number of potential factors will be considered:

- Use of a workforce information dashboard
- Staffing Escalation Protocol

a) Workforce information dashboard

Utilising existing workforce information systems and data capture processes, a collection of KPI’s will be compiled into a dashboard with an embedded RAG rating system to

identify potential sustained staffing shortages. The dashboard will act as an early warning system enabling us to make informed, evidence based decisions about potential / actual need for additional staff to maintain safe staffing.

The dashboard will be produced and distributed at 2 separate intervals (weekly and 4 weekly forecasting) to effectively capture and manage both short-term spikes and trend trajectories at ward level across the organisation.

The planned schedule is as follows:

Weekly Report: Capturing a 7 day forecast for the coming week which will aggregate data to capture areas consistently struggling and trends in staffing availability.

4 Week Reporting: Aligned to the Ward rosters, this report is an extension of the 7 day forecast report but allows for a greater projection to determine whether planned absence/leavers/starters will contribute to the ability to staff the ward safely.

The Scorecard will include

- ***Covid Related Absence -*** All Covid related absence is recorded under the "Other Absence" code in the Healthroster system in real time by ward managers and has been utilised throughout the Covid period to provide the National SitRep data to NHS Digital

- ***Total Unavailability-*** a combination of all types of unavailability affecting the units' ability to Safely Staff this includes Sickness, Annual Leave, Maternity, Study & Other absence (Jury Duty, Compassionate leave etc). Wards are profiled to accommodate an unavailability of 24%.

- ***Unfilled Roster -*** The number of hours that remain unfilled after all shifts have been rostered, sent to Bank/Agency for cover this would incorporate vacancies and shifts not covered due to the above unavailability reasons.

- ***Redeployed People Hours -*** where action has already been taken to support the unit and staff from outside the service have been utilised

- ***Vacancy rate –*** indicator of the level of vacancy in the service, which will impact on consistency of staffing and capacity of the ward to manage an increased unavailability

Example Dashboard:

Redeployment Dashboard Test

Unit	Covid Absence %	Total Unavailability %	Unfilled Roster %	Redeployed People Hrs	Current Vacancies
Newsam Ward 5	10.1 %	25.4 %	3.8 %	201.00	6%
Becklin Ward 1	6.9 %	12.4 %	8.8 %	0.00	4%
Becklin Ward 3	14.8 %	38.9 %	12.1 %	0.00	11%

In addition to the above, real time information can be drawn from the system as required on a daily basis to better understand and predict safer staffing issues as they arise and are escalated from the daily reports and through clinical / operational routes below.

b) Escalation from Service Lines

There are some additional clinical & operational factors that will have an impact on both staffing requirements and safety within services – these include, for example, high levels of acuity, enhanced observations, incidents of significance and bed occupancy. Where these factors exist and this results in a requirement to increase staffing for a sustained period, this will be escalated to the Head of Operations (or in their absence via the ward matron or designated deputy) using the Staffing Escalation Protocol.

2. Revised prioritisation of services

In line with the previous process, we have maintained an approach of prioritising services using the following criteria:

Priority 1 services	These key services are essential priority and are required to be maintained at full capacity. Normal staffing numbers and skill mix will be maintained. This includes 24/7 inpatient services, supported living houses and urgent access / crisis services.
Priority 2 services	There services need to be maintained, but may safely be delivered at a reduced capacity or alternate skill mix. . This will be informed by an assessment of service user need, risk and vulnerability using our agreed clinical RAG rating process. Services may therefore be reduced or consolidated, and some staff redeployed into priority 1 services
Priority 3 services	These services could be reduced to a minimum level of delivery or could be stepped down entirely. The majority of staff are therefore likely to be redeployed into priority 1 services (or into priority 2 services as part of a revised skill mix to release other staff to priority 1 services)

The key change is that, whereas a number of services were previously stepped back to minimum staffing providing only emergency or signposting cover, the vast majority of services have moved into the 'priority 2' grouping. This reflects a specific wish to maintain a level of direct service provision across all services, reflecting both national & local drivers to carry on providing as many services as possible, and recognising the impact of some services (in terms of escalation of clinical presentation and significant increased waiting lists) of the previous redeployment approach. The revised service priority groups are therefore shown at Appendix 3.

This has been debated at some length, with a number of different views considered. The impact of this approach is that, rather than identify services to step down immediately, services within the priority 2 group will have identified a number of staff that are available to be redeployed, and this will be agreed with the staff in advance. The service will be able to proactively plan – and clearly articulate – the potential impacts of those staff being redeployed, and will be able to plan to mitigate & manage these accordingly. This approach was strongly advocated and favoured by both the clinical and operational leaders.

It is however essential to recognise that, as part of this approach, if safer staffing cannot be maintained through the redeployment of the identified staff, then it will be necessary to consider releasing additional staff from these services (and therefore further reducing their

capacity & operational delivery) or stepping down some services entirely in order to release additional capacity. This approach is described below.

3. Identifying staff for redeployment

In the first instance, for low level and short term additional staffing requirements to maintain agreed minimum staffing levels, the usual local actions will be taken to seek to meet these (as set out in the Staffing Escalation Protocol). These include (but are not limited to)

- Review of current staffing requirements on the ward (including enhanced observations and any escorted patient leave)
- Seeking additional bank staff or overtime
- Cancelling training & rostered management days
- Cancelling 'ad hoc' annual leave in negotiation with the member of staff
- Moving of staff from other clinical areas whilst maintaining agreed minimum safe staffing numbers

However, once a priority 1 service has been identified as having a sustained requirement for additional staffing, the 'redeployment group' will utilise available information to determine the number of staff required and an appropriate skill mix, supported by additional members from the clinical & operational leadership teams as required.

Appropriate staff will then be identified using a hierarchy as below, working from the top until the identified need is met

1. *Volunteers* - cohort of staff who have self-identified as willing to be redeployed and have completed the redeployment proforma identifying skills & areas of preference. This includes volunteers from non-clinical / corporate services (based on positive experience previously)

2. *Cohort of 'early redeployees'* - identified specific groups of staff who would be redeployed in initial wave (generally clinical staff not undertaking direct clinical roles; this may include partial redeployment, as previously)

3. *Identified proposed redeployees from Amber priority services* (services that will be reducing staff & operating differently but maintained)

4. *Additional redeployment from Amber priority services (*with assessment of associated risks / impacts and how these could be managed; this may result in a service being stepped down to minimum cover)

5. *Stepping down of non- priority 1 services* - services that will be stepped down or reduced to minimum cover to release further staff. This would require IRT approval.

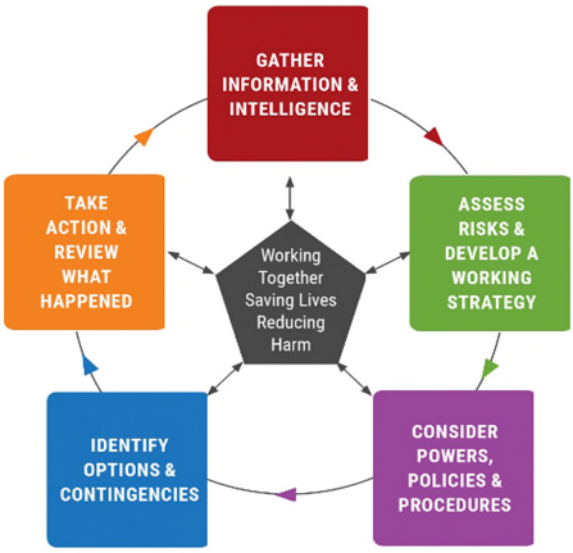
A pre-determined duration for all redeployments will be agreed to ensure we can meet the needs of the sustained requirement for additional resource as well as manage the expectations of the 'home' service, redeployed service and individual staff members.

Appendix D

JESIP Decision Making Framework

We have specifically and purposefully utilised the decision-making framework set out in the Joint Emergency Services Interoperability Principles (JESIP) programme to provide evidence based consistency. The decision model aims to bring together all available information, reconcile objectives and make effective joint decisions. The model focuses on gathering the available information and intelligence to assess impacts & risks and develop agreed plans and strategies, including an assessment of options and contingencies. The framework works in a cyclic process, whereby actions are then reviewed and outcomes assessed, which forms the basis of information to support further decision making. Decision making is supported by reference to core values.

The model is represented diagrammatically below:



The JESIP principles underpin all elements of our incident response and have been consistently used as the basis for our decision-making framework.

The use of the principles and decision-making framework has supported us to approach decision making in a dynamic way, which has been essential throughout the frequently changing context of the last 18 months and is recognised as being a key requirement for our current and future plans.

Appendix E

Leeds System Winter Plan

Leeds Health & Care Partnership

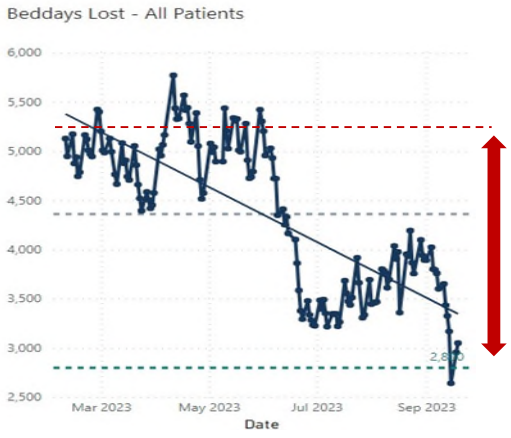
Winter Planning Session Four

11th Oct 2023

Heading into winter from a strong position

Leeds Health & Care Partnership

Hospital Live NR2R Length of Stay has decreased by over 2000 since March 23



Open in Power BI
System Flow Summary
Data as of 19/09/23, 17:01
Filtered by **Date** (22/09/2022 - 20/09/2023)

Key Service Changes since 2022/23

	Admission avoidance 	Home Based services 	Short Term beds 	Process times 
Demand		Increase demand on Pathway 1	Decrease demand on Pathway 2	
Capacity	• Loss of the Same Day Response Service • Reduced weekend CAPS capacity. CAPS now Mon-Fri (was 7 days 22/23) • Recruitment of staff into UTC • Improved Agency pick up from agency staff to support the UTC especially St Georges • Increase demand forEnd of Lifecare • Local care direct triage of	• Improvement work to increase capacity in Reablement • Development of ShortTerm Assessment Service • Option of Home for Assessment pathway	• Reduced bed base in the CCB compared to this time last year • Empty bed in the CCB (circ. 3550 beds) • Improvement work to decrease length of stay in CCB • Decrease use of Spot Purchased beds • HIT team commissioned for another year 9 beds	• Increase use of Trusted Assessors • Single referral pathway to Active Recovery • Mental Health & Housing Support in the TOC • Housing Support officer in LYPFT • Best Outcome panel in place to address SW challenges early in assessment • System Visibility Dashboard & Active System Leadership meeting • Brokerage team now in place rather than agency • Decision Management Tool to speed up decision making in extremis • Requested Shorten time for home care Providers to pick up packages

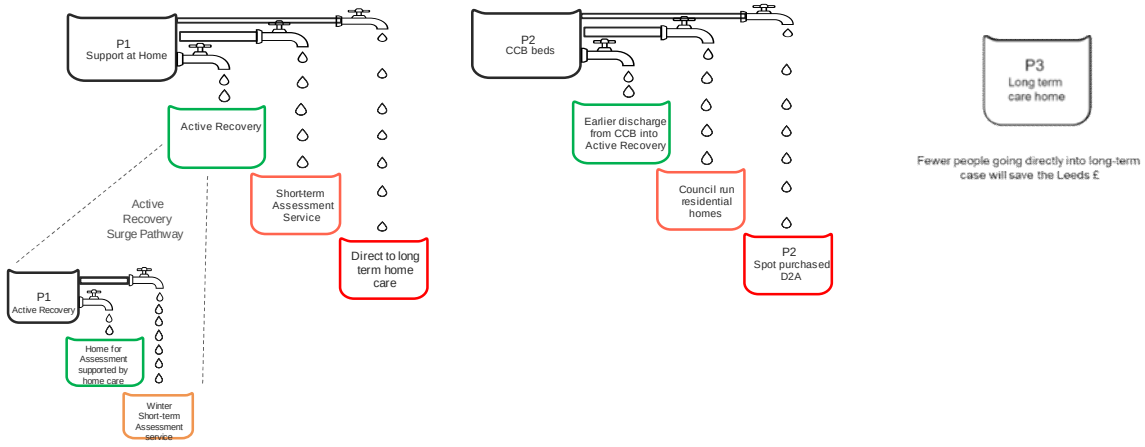
Changes in ASC pressures since 22/23

Oct 2022		Oct 2023
30 **Interim Placements**	→	**1** **Interim Placement**
67 **Outstanding ISA**	→	**30** **Outstanding ISA**
44 days **To Allocate hospital SW referral**	→	**16 days** **To Allocate hospital SW referral**

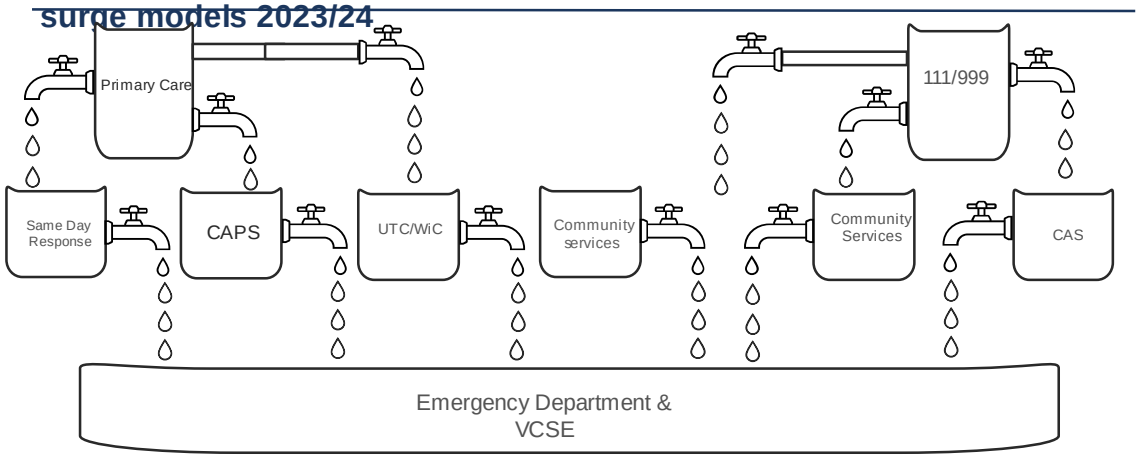
Pre-planned Multi-Agency Discharge Event

Reablement/ Active Recovery Discharge MADE	Monday 6th November 2023 In person ROOM TBC Time: 24pm	Wednesday 3rd January 2024 In person ROOM TBC Time: 911pm	Wednesday 3rd April 2024 In person ROOM TBC Time: 911pm
CCB MADE	Monday 13th November 2023 In Person ROOM TBC Time: 24pm	Tuesday 9th January 2024 In Person ROOM TBC Time: 24pm	Thursday 4th April 2024 In Person ROOM TBC Time: 24pm

Discharge Pathways



Leeds Attendance & Admission Avoidance Capacity overflows & surge models 2023/24



- Recruitment into the UTC service will help to minimise the impact of the loss of SDR.

Leeds Discharge Pathway 1 – Winter 2023/24

ACUTE HOSPITAL

Active Recovery Service
Including Reablement & NHT

Winter Short Term Assessment Service
(for those people who do not meet the Reablement or Specialist Service criteria)

Lots of other specialist services within P1

Examples of the people who might need the winter bridging service
Long Term Needs identified already
Increase POC needed
Meets exclusion criteria assistance of 2

- Improved outcomes for people
- Reduces the risk of legal challenge to the council in terms of charging policy
- Cost saving for the council in long term care prescriptions
- Cost saving on last year in the number of beds being used
- Review after winter the capacity gains in Active Recovery and how we want to manage this cohort of people going forward

Additional Capacity Plans

	Leeds Winter plan		Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
	Demand modelling LTHT (bed deficit at 96% occupancy)	baseline		0	0	150	178	150	180
	Capacity gap after mitigation from currently funded discharge schemes (beds)			-18	-70	18	14	-30	2
	Additional impact of the admission avoidance schemes that will further reduce bed demand in hospital specifically			-40	-92	-4	-8	-52	-20
	Confirmed Discharge schemes (already funded)								
System Impact	Beds Released			18	70	132	164	180	178
Acute Hospital capacity	LTHT Beckett wing wards		0	0	0	30	60	60	60
Pathway 1	LTHT Home Telemetry (children's, ERCP, Cardiac, Renal) capacity on pathway		0	5	10	16	18	22	25
Pathway 1&2	Home First Improvement		0	8	25	41	41	41	41
Pathway 1	Home Ward Frailty within HomeFirst		5	5	5	15	15	15	15
Pathway 1	Winter Bridging Service		0	0	30	30	30	30	25
Pathway 2	The Oaks @ Dolphin Manor (works dependent)		0	0	0	0	0	12	12
	Admission/Attendance avoidance								
System Impact	Capacity change since 22/23		3	-1,318	-772	-602	-599	-597	-594
Primary Care	Same Day Response service in primary care		1350	0	0	0	0	0	0
Primary Care	ARI paeds hub		672	672	672	840	840	840	840
Primary Care	AARC... Adult Acute Respiratory Clinic...Primary Care adult resp provision for 111 and 999		0	0	544	544	544	544	544
Primary Care	LCD triage of UCR calls (prior to passing to LCH) Ambulance avoidance against June baseline		4	4	tbc	tbc	tbc	tbc	tbc
Community Reposnse	HomeFirst (enhance community response)		3	4	6	8	11	13	16
Admission avoidance	LTHT SDEC enhancements		0	22	22	22	22	22	22
Community Reponse	Falls service increase		0	6	6	6	6	6	6

Agreement in the session on the 11 th Oct:

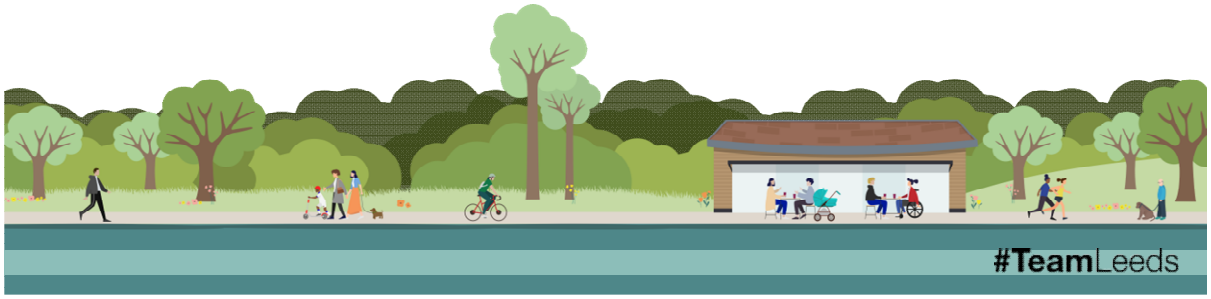
Agreed to track the winter capacity plan in SROG weekly
LTHT bed deficit will be monitored as the number of people awaiting TCI in ED and the number of ESA in use
Weekly review will be a quick check of whether actions are on track
Detailed review meetings will be scheduled in advance of the predicted peak periods

Agreed areas for winter investment

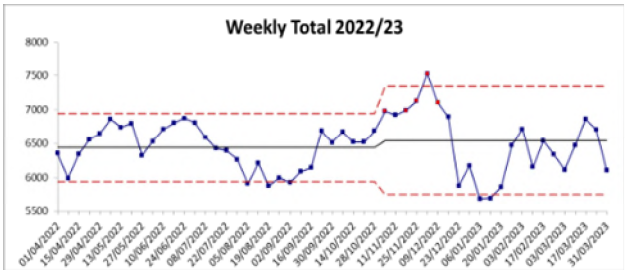
Winter Pot Proposals	Winter Pot Agreed Schemes (confirmed)	Period	% allocation remaining
Discharge support - Winter Bridging service to provide care at home	First tranche short term assessment service - 13,860 hours of domiciliary care approx. 15 starts/ week, 2 week LoS, 30 case load	22 weeks	60%
Discharge support - Enablers to care at home e.g. equipment	N/A		100%
Additional clinical support for high dependency placements e.g. 1:1 within CCB	N/A		100%
Flex to core services at times of pressure as required	AARC... Adult Acute Respiratory Clinic...Primary Care adult resp provision for 111 and 999 136 appt/ week	20 weeks	0%
Intermediate Care Beds (block/spot purchase) in extermis	N/A		

Leeds Health & Care Partnership

Planning for the peaks in demand for Intermediate Care

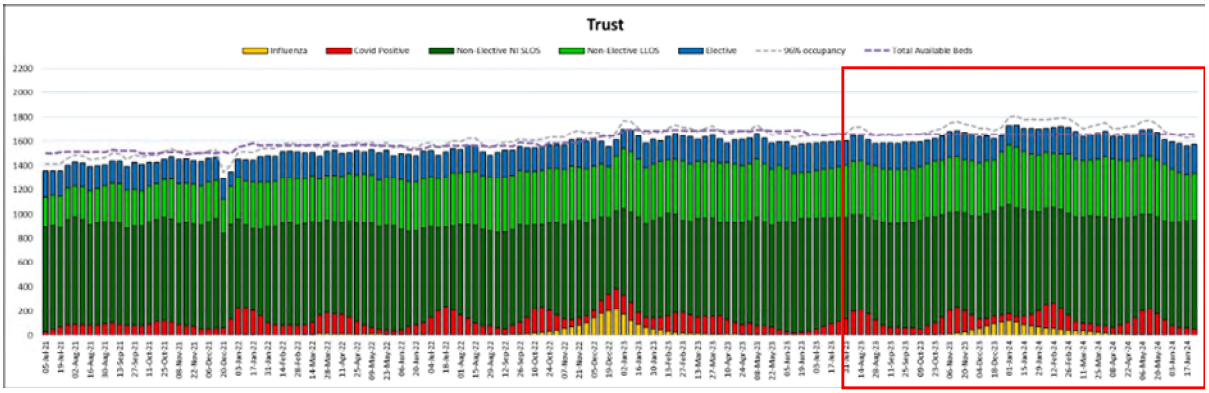


Urgent Care Demand Profile

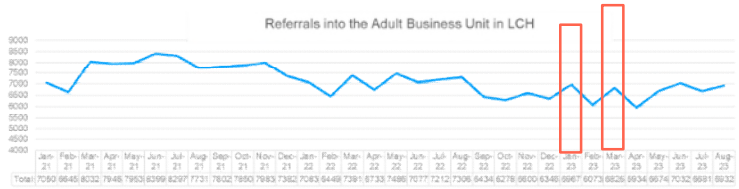


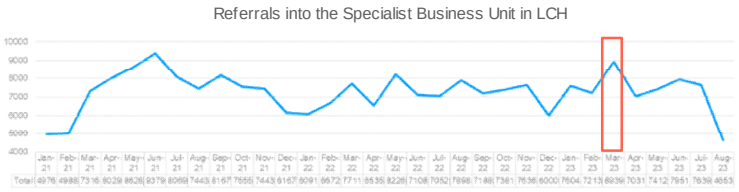
LTHT - Bed Modelling outputs

Scenario 1 – Most likely case



Demand into Intermediate Care





Sudden peaks in demand

New Referrals into ASC

Leeds Winter plan	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Predicted demand ASC (new referrals to ASC)		3200	3448	3136	3599	3213	3552

Key Peaks to plan for and opportunities to discuss

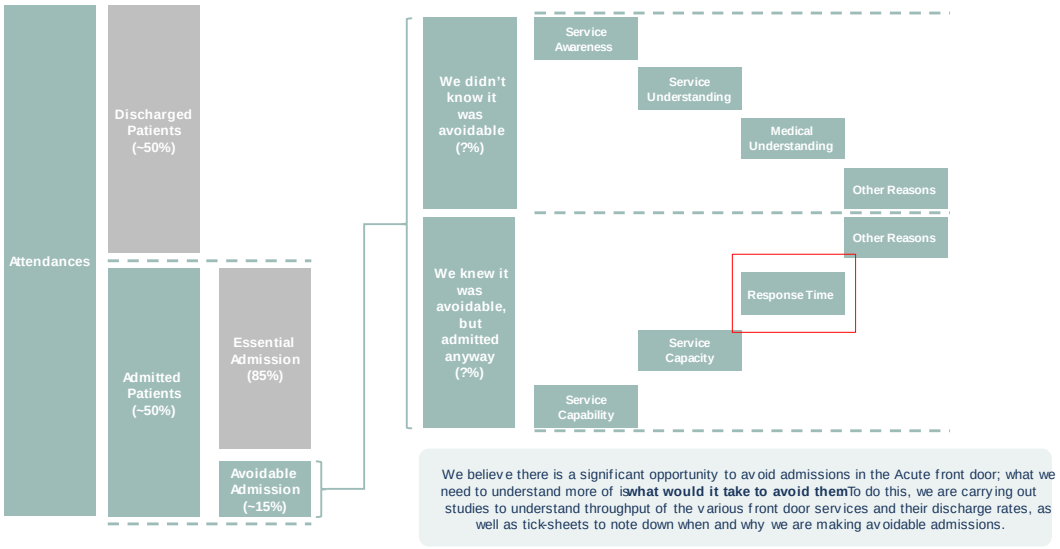
Organisation	Peak Period
Urgent primary Care	Nov (this was Strep)
NHS The Leeds Teaching Hospitals NHS Trust	6-20th Nov 1st Jan – 11th March
NHS Leeds Community Healthcare NHS Trust	Jan and March peaks
Leeds City Council ASC new referrals	Nov Jan circ 12% rise Mar

What are our opportunities to plan for these in advance?

To consider:

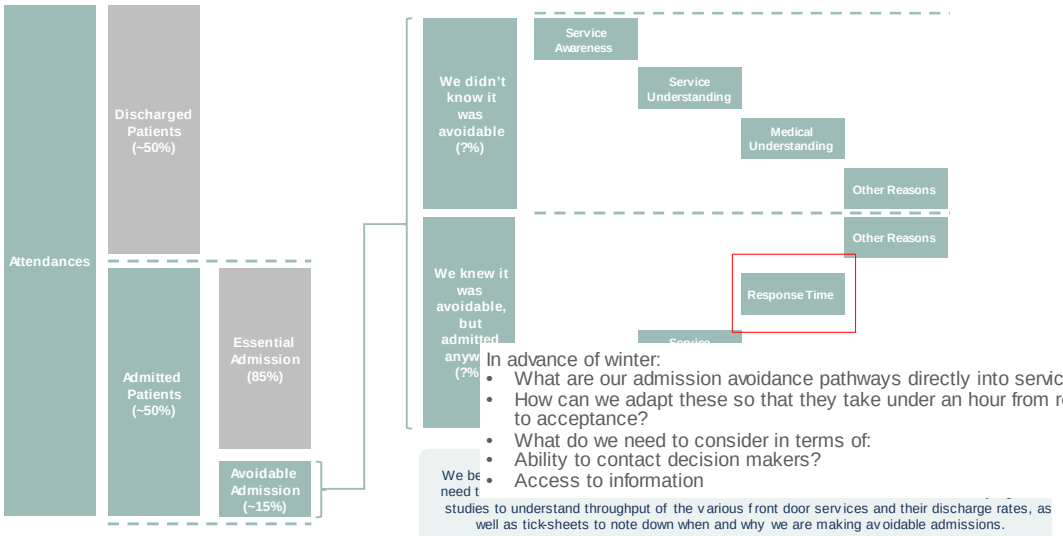
- Adding in additional capacity – agency/bank staff
- Scheduling in MADE
- Maximising trusted assessment processes
- Determining our essential elements of service
- Staff Training and redeployment (LCH STAR model)
- Staff portability
- Voluntary sector support

Enhanced Care at Home – What we need to understand



We believe there is a significant opportunity to avoid admissions in the Acute front door; what we need to understand more of is **what would it take to avoid them**. To do this, we are carrying out studies to understand throughput of the various front door services and their discharge rates, as well as tick-sheets to note down when and why we are making avoidable admissions.

Enhanced Care at Home – What we need to understand



In advance of winter:

- What are our admission avoidance pathways directly into services?
- How can we adapt these so that they take under an hour from referral to acceptance?
- What do we need to consider in terms of:
- Ability to contact decision makers?
- Access to information

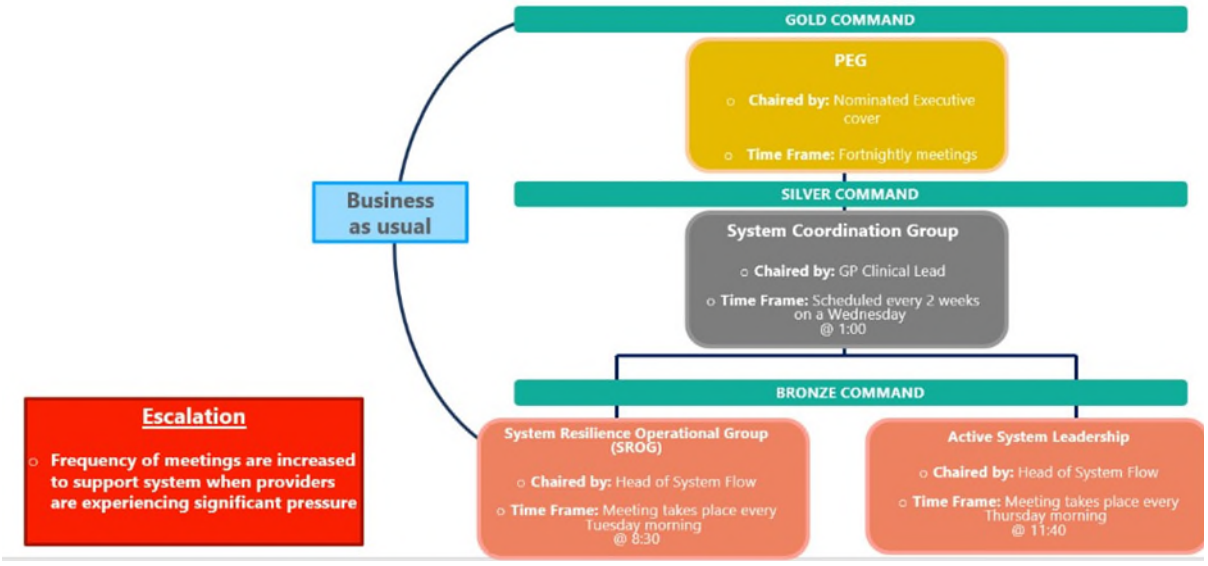
studies to understand throughput of the various front door services and their discharge rates, as well as tick-sheets to note down when and why we are making avoidable admissions.

Workstreams coming out of the Winter Table -Top session

	Maximising Trusted Assessment through access to social care systems to avoid rework between paper and electronic systems- allow input directly into CIS	Resource pool to log our system coordination meetings	Linking in the council internal resilience structure to the system resilience structure by linking them callsystems to support coordinating any incidents at the weekend	Review of the Decision Management tool and organisational BCPs
Steps to take				
Steps to take				

Do we want to do our own table -top exercise?
What would be helpful?

Currently there are System Resilience Groups operating at operational, tactical and strategic levels;



The Process of an Escalation Call to the System

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A service within the system has reported OPEL 4 and they require mutual aid from the wider system to support demand or capacity. They send an email to the Planning Mailbox to prompt an escalation meeting to be scheduled

The Planning Inbox will produce a ping alert to PII Business Unit Management and the Integration Manager for System Flow.

Key Point of contact:
Stacey Wade or Kathryn Jeffreys

There is a populated rota saved on SharePoint that PII Management would review to identify who would be covering an escalated meeting on that specific date. They would then contact that person to notify them that a meeting will be taking place

The person facilitating the escalated meeting would log onto SharePoint, where they would have access to a distribution list to schedule the meeting on MS Teams.

The person facilitating the escalated meeting would send an MS Teams meeting invite via Microsoft Outlook from the Planning Mailbox marking the invite as Urgent.

The system would then prioritise that meeting to ensure all services are represented. An appropriate deputy would attend if anyone was unable to represent their service to ensure the meeting is quorate.

The escalated meeting would then take place and the person facilitating would capture actions and record them on the System Resilience Action Log also saved on SharePoint.

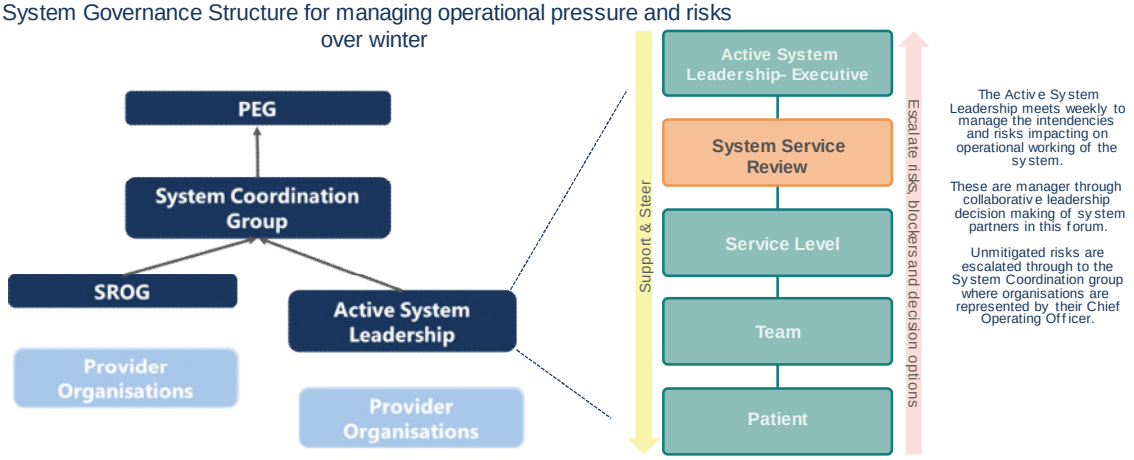
The actions and any additional notes taken would be circulated following the meeting. The documents would be saved on SharePoint as a record of the meeting taking place.

KLOE-1.2: How will you assure that each part of the system is delivering against its roles and responsibilities?

Leeds Health & Care Partnership

What is the mechanism for system partners to hold one another to account for delivering on their roles and responsibilities?
How have key interdependencies between parts of the system been identified, and how will they be managed?
What are the key risks to delivery of the plan in each part of the system, and how will they be mitigated?

System Governance Structure for managing operational pressure and risks over winter

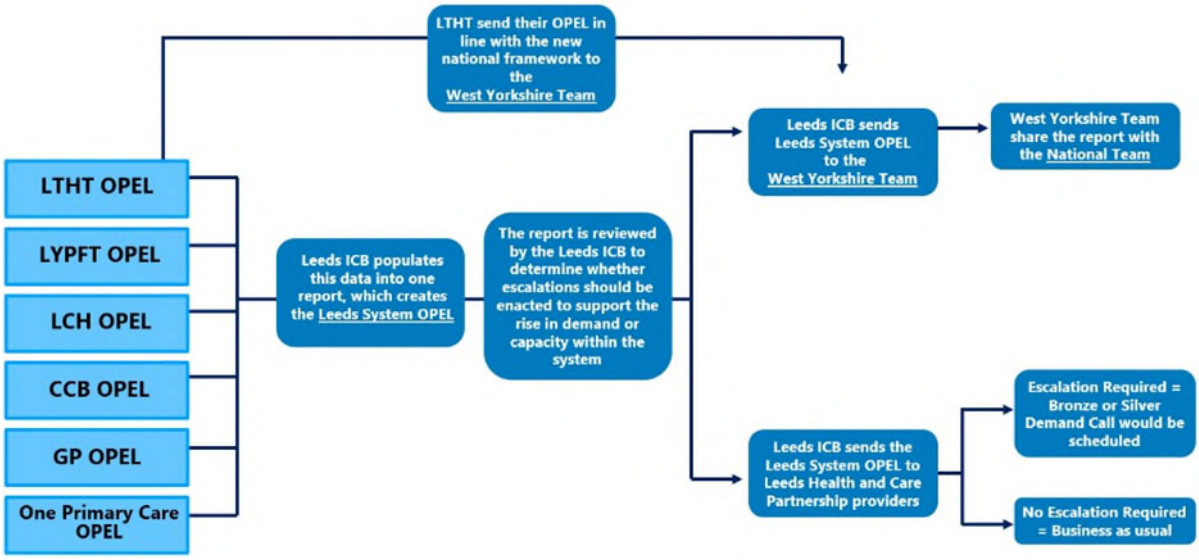


The Active System Leadership meets weekly to manage the intendencies and risks impacting on operational working of the system.

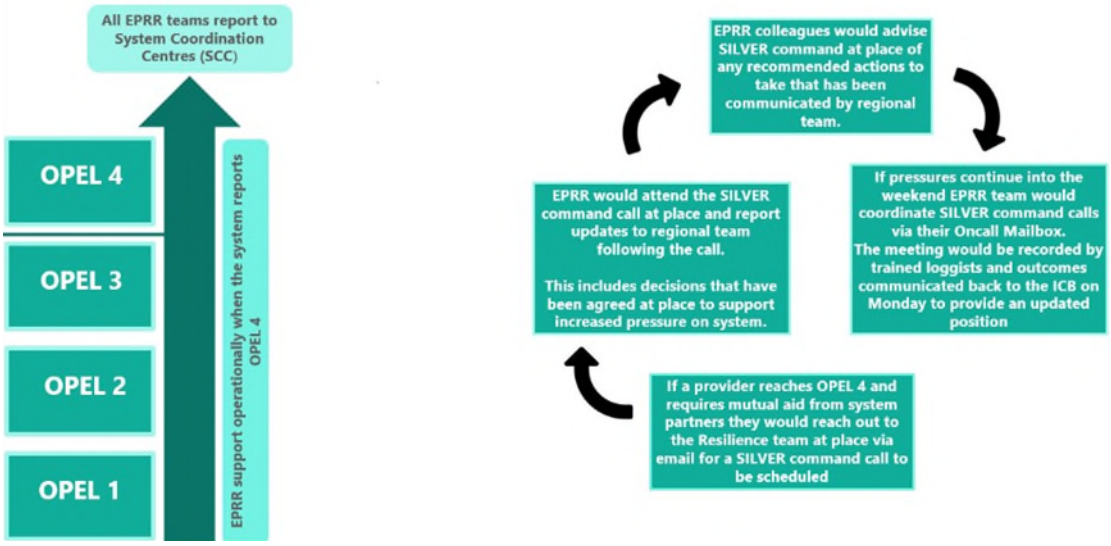
These are manager through collaborative leadership decision making of system partners in this forum.

Unmitigated risks are escalated through to the System Coordination group where organisations are represented by their Chief Operating Officer.

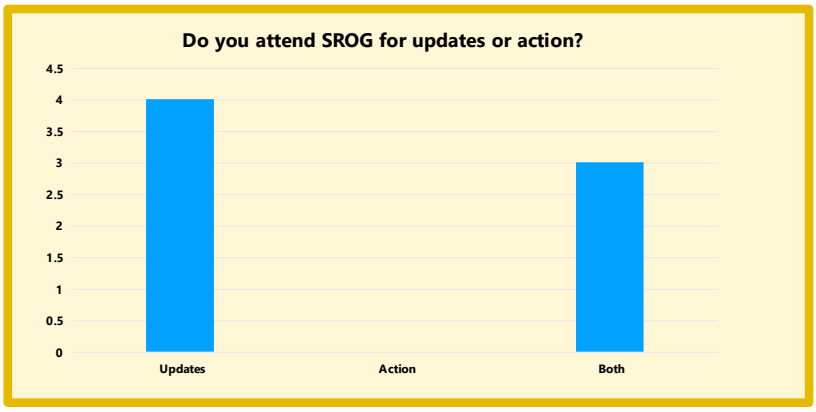
OPEL



EPRR Functions



Feedback from the SROG SLIDO Poll



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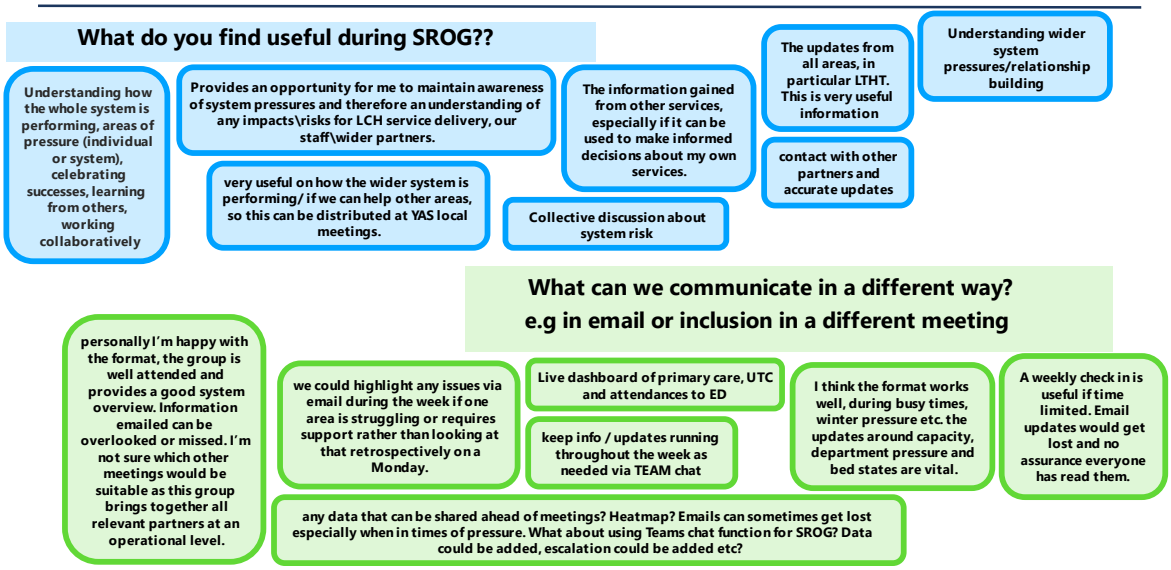


Actions from Winter Planning Workshop (11th October)

Area	Action	Owner
Comparison of winter	Review the Key Service Changes since 2022/23 slide to include any other key changes from organisations	ALL
Winter capacity plan	Review the capacity plan for winter and refresh trajectory in line with most up to date plans	Scheme owners
Winter capacity plan	Schedule in winter capacity plan review meetings in advance of the peaks in demand (Dec & Feb)	Stacey Wade for all to attend
System Resilience Structure	Stand up the SROG meetings to 45 minutes weekly, structure to focus on OPEL and DMT actions and review of terms of reference	Stacey Wade for all to accommodate in their diaries
EPRR & System Resilience Structure	TO investigate if the provider EPRR network coordinated by Rebecca Todd could support the System Resilience Structure	Stacey Wade
Decision Management Tool	Review the threshold for DMT actions in relation to the new OPEL framework to ensure we are taking actions at appropriate levels of pressure	All
Preparing for peaks in demand	LCC Care Delivery teams are already looking at staff bank model of pre-trained staff for essential services	Karla Gallon
Reablement Enhance Model	Reablement to review the Enhance model to see if the third sector services can support peaks in demand	Karla Gallon
Technology	All to review if technology could support staff to work more efficiently and create capacity	All
Trusted Assessor Pathways	Review and refresh of the Trusted Assessor pathways	Adult Social Care, LCC & TOC
Admission avoidance	Rapid admission avoidance pathways into beds (council residential homes and CCB) to be confirmed	Karla Gallon & Louise Idle
Admission avoidance	Review of the Fast track identification in emergency care environments	Gill Warner and Lizzie Kumar
Carers Leeds	Carers Leeds involvement into the admission avoidance pathways?	Louise Idle

Surge Plans
System Decision Management Tool

	A	B	C	D	E	F	G	H	I	J
Trigger & Decision Level (Org/SROG/ Silver)	SILVER action (OPEL 4)	SROG action (OPEL 3)	SILVER action (OPEL 3)	SILVER action (OPEL 4)	SROG action (OPEL 3)	SROG action (OPEL 3)	SROG action (OPEL 3)	SROG action (OPEL 3)	SILVER action (OPEL 4)	SROG action (OPEL 3)
Action	HALO to co-locate and communicate with Ed management team to devise a plan	Social Work Representation at A&E	Mobilise available capacity within the system to support contact centres	ICB linked GP sessions to be redeployed to ED	Operational staff to be redeployed to support with administrative tasks	TOC band 6 Case Managers to attend the ward MDT and Target communicating actions to relevant services including Social Work	Reablement waiting list in hospital to be rereviewed to assess peoples needs.	Senior Review of the Pathway 1 to look at quick wins with 3rd sector Increase Home fur Assessment Offer	Early warning required from Hospital to CCC and Bed Brokerage of an escalated position for Staffing to be mobilised if needed	TnC to liase with Neighbourhood Team hubs to establish if discharges can be brought forward
Benefit	HALO can redirect into alternative pathways SDEC/PCAL etc Reduce patients being admitted to ED HALO would be able to update & communicate pressures back to YAS on a regular basis	Increase admission avoidance	Supports admission avoidance and presentation at GP Practices and A&E. Supports demand on ERS and Yorkshire Ambulance Service (YAS)	Increased capacity to stream patients that need primary care (and not emergency care) away from ED	Mobilising staff with skill to mobilise the gaps	To offer support to MDT decision making and targeted communication to assist in discharge flow.	Enhanced business as usual model via the single route of referral service. List will be reviewed twice daily and will be first task of the day	Risk based approach to discharging people from hospital who are waiting for pathway 1 services.	Mutual aid can be sourced between bed service and brokerage by Management service Resilience in place for brokerage as Systems can be accessed by phone or computer	To expediate discharge flow where possible.
Consequence/ impact	loss of Operation commander for the Leeds area. System wide pressures only 1 HALO in place unable to cover both hospital sites	Loss of the SW workforce to support the current workload Need to use people who are familiar with working in this way and familiar with the systems in ED	Staff that are deployed may be needed in their own service due to high demand on system	Different criteria in ED in comparison to Primary Care	Patient access to practice	May impact flow of referral management and have negative impact on flow.	Workforce to be realigned to support this daily task	Needs agreement that the service leads will be diverted to this work. Follow up checks Needs P card to allow the individual funds	Dependent on communication from hospital.	Neighbourhood Teams put under increasing pressure and planned visits may need to be cancelled within the community.
Point of contact	YAS Lynsey Higman	Adult Social Care Marcia Richards	LCD Kerry Hammond	ICB Sarah Forbes	ICB Sarah Forbes	LCH Gill Warner	Active Recovery Karla Gallon	Adult Social Care Marcia Richards	CCC and Bed Brokerage Mark Philott	LCH Gill Warner & Debbie Gallon
	SUPPORTING URGENT CARE					SUPPORTING HOSPITAL DISCHARGE				

Surge Plans
System Decision Management Tool

Leeds Health & Care Partnership

	K	L	M	N	O	P	Q	R	S
Trigger & Decision Level (Org/SROG/ Silver)	SROG action (OPEL 3)	SILVER action (OPEL 4)	SILVER action (OPEL 4)	SILVER action (OPEL 4)	SILVER action (OPEL 4)	SILVER action (OPEL 4)	SILVER action (OPEL 4)	SILVER action (OPEL 4)	SILVER action (OPEL 4)
Action	Continue proactive contact between virtual ward (respiratory) and LTHT respiratory wards, and virtual ward (frailty) with SDEC for options to pull out of acute beds	Cease home visiting and pull mobile GPs into centres	We could also increase our resource, with extra funding, in both our Hospital to Home and Home Comfort service, to support transport home from hospital (including chaperoning and fellow home) and settling in.	Fill all empty CCBs within 48 hours	LCD to mobilise home visiting capacity	Outstanding ISA list to be reviewed with the 3rd sector and ASC to determine if low level packages can be safely bridged by a third sector offer	Neighbourhood Teams reach out to Hospices to support with syringe driver visits and ongoing palliative care support	Twilight and Night service would maximise any opportunities	Primary Care Additional Clinics to be maximised No SDR currently in operation. Enhanced Access and Children's Ambulatory Service(CAPS)
Benefit	Increased capacity in the hospital setting	Increased capacity in the hospital setting.	Supports demand on ERS and Yorkshire Ambulance Service (YAS) Prevents patients experiencing long waiting times	Risk based approach to discharging people from hospital who are waiting for pathway 2 services.	Additional capacity within the community to support patients following discharge.	Our Home Comfort team could work with families to provide short term support whilst waiting for a care package.	To assist with supporting patients at EOL and families.	Patients can be discharged from hospital later in the day knowing they have support to be provided on an evening	Immediate increased capacity across General Practice and the wider system (such as NHS111 and the Local CAS) which in turn, as proven, reduced attendances at the Emergency Department and other urgent care services.
Consequence/ Impact	Business as usual model that would be maximised during times of escalation	Different skill set / knowledge base required for hospital level care to that of core General Practice. Ceasing home visit will likely result in increased 999 calls.	A risk of this not effectively working, is not receiving sufficient notice that we would receive additional funding to recruit additional staff for a winter surge. Recruitment, training of staff and honorary contracts can take time	Needs agreement from the providers to accept people and flex the admission times	Extra hours would need to be funded ad hoc. LCD would need up to 24 hours notice to enact	Care package may take longer to put in place than anticipated, or the family member are not able to support as first intended. The patient may then be at risk from not receiving care that fully meets their needs.	Caseload would have to be reprioritised May impact upon Hospice work flow and capacity.	Twilight and Night service run on minimal staff with agreed criteria additional CLaSS shifts would be offered if needed to manage flow	Increased funding required to secure the additional workforce to mobilise. This action would take longer to enact due to the staff pool for CAPS being much smaller than what was available previously through Same Day Response.
Point of contact	LCH Gill Warner	ICB Sarah Forbes	Third Sector Julie Skelton	Care Delivery / Bed Bureau Nicola Nicolson	LCD Kerry Hammond	Third Sector Julie Skelton	LCH Gill Warner & Debbie Gallon	LCH Gill Warner & Debbie Gallon	GP Confed Jane Sadler
SUPPORTING COMMUNITY CAPACITY									

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM

9

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Financial Officer Report - Month 7
DATE OF MEETING:	30 November 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 has demonstrated that the financial position of the Trust remains reasonably robust in the context of an increasingly challenging financial climate. As at month 7 there is a £87k year to date deficit, a deteriorating in month position. There are several risks and pressure in the revenue financial position that are largely fortuitously offset by high levels of vacancies, slippage on reserved investment and high levels of interest receivable. Progress against the four thematic efficiency areas remains key to deliver a break-even position at the end of the financial year.

The position needs to be taken with consideration of the wider system's financial challenge and the recent work to reset a system wide financial balance for the year. The position indicates an increasing challenge for 24/25 and the Leeds Place has begun collective work to address this. It should also be noted that enhanced financial governance controls continue to be in place across the whole system.

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 7 and the actions being taken to ensure plan is delivered, in the context of the wider system challenges and work to achieve financial balance.
- Note the work commenced on 24/25 planning.

MEETING OF THE BOARD OF DIRECTORS

30 NOVEMBER 2023

CHIEF FINANCIAL OFFICER REPORT

1 Introduction

This report provides an overview of financial performance at month 7 2023/24.

2 Year to date Income and Expenditure Performance 2023/24

2.1 Year to Date Position

At month 7 the Trust income and expenditure deficit has increased to £87k, against a 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 £7.5m year to date, this is ££0.7m higher than it was at the same point last financial year. Year to spend is 7.5% 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) increased in October, year to date spend is £2.9m above year-to-date budget, driven predominantly by the exceptional pressure in Working Age and PICU.
- The unidentified CIP target equates to £2.5m year to date adverse variance against budget.

Progress is being made against the four ongoing efficiency thematic areas, the detail of which is reported to Finance & Performance Committee, and fortuitous mitigations, predominantly substantive vacancies and interest receivable reduce the pressures in the position.

2.2 Forecast Position

A detailed forecast has been produced. 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

At month 7 capital expenditure is reported as £2.5m, which is £0.3m behind plan (details in Appendix B).

The operational capital envelope at month 7 is £0.5m ahead of plan, which is mainly due to the timing of expenditure on St Marys House and the associated backlog/sustainability schemes and expenditure on the Electronic Document Management (EDM) Scheme. The Trust continues to forecast within the ICS capital envelope for 2023/24.

Public Dividend Capital (PDC) capital expenditure is £0.2m behind plan due to the timing of funds being released centrally for the EDM. PDC for 2023/24 includes funding to support the Trusts EDM project rollout (£0.9m) and Mental Health Urgent and Emergency care (MH UEC) funding of £0.6m, which was agreed last year as part of a 3-year plan. Work continues with partners across West Yorkshire in the Complex Care programme to agree plans for how the MH UEC capital may be utilised as original plans to develop a West Yorkshire wide Complex Emotional Needs facility are not required. Firm plans will need to be agreed by January 24 or this allocation is potentially at risk.

The business case to support the development of 6 additional inpatient perinatal beds at the Mount has recently been submitted and whilst we await confirmation, we continue to progress the design and agree a procurement process for the enabling works. As this scheme is being funded from national capital slippage there is some risk to the funding, although we have had verbal assurance that this is a low risk and can be managed.

Expenditure for IFRS16 Leases is £0.6m behind plan at M7. The Trusts requirements in relation to leases remains forecast at £0.6m, which is £0.6m less than plan (£1.2m) as previously reported. This funding has to date been held centrally; however, the expectation is that from M8, this funding will become part of ICS allocation, to be managed collectively across West Yorkshire (see below).

4 ICB Financial Position

4.1 Revenue

The ICB position at month 7 is a £55.0m deficit against a planned £8.9m deficit, £46.1m 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 officially remained a £25m deficit at this point in line with the submitted plan, however recent forecasts suggested a potential worsening position of £117m deficit.

On 8 November 2023 NHSE wrote to all Integrated Care Systems informing them of an additional £800m would be injected into the NHS to address the financial and operational consequences of industrial action over the last year, the letter also asked systems to undertake a rapid two-week exercise to agree actions to deliver a number of priorities for the rest of the financial year. The priorities are:

- achieve financial balance
- protect patient safety

- prioritise emergency performance and capacity
- protect urgent care, high priority elective and cancer care
- make progress on elective and primary care recovery programmes.

The Directors of Finance have been meeting to discuss and agree the approach to submitting a revised balanced financial forecast for 2023/24 over recent weeks. It should be noted that the plans to deliver a balanced financial position for 2023/24 include known risks and are also subject to uncertainties over the next four months. Nevertheless, the level of risk feels to be of a magnitude that should be manageable, and as such, it has been recommended that a balanced financial forecast is submitted.

Further detail has been discussed in the Finance and Performance Committee, and will be updated in the private Board of Directors.

4.2 Capital

Year to date, ICB Capital expenditure against the operational capital plan is £22.6m 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, however, all providers recognise that delivery ultimately must be against the allocation of £159.5m. All these values exclude any impact of IFRS16.

IFRS16 capital expenditure has to date been outside the operational capital envelope. Treatment for this year is changing from being centrally managed to each ICB receiving an allocation to manage within. This was based on 2022/23 outturn and immediately resulted in a significant risk/shortfall in West Yorkshire; however, a review of forecasts and opportunities identified at regional level continue to mitigate the risk for 2023/24. This remains an area of significant concern for future years given the allocations are anticipated to be significantly less than needs based plans.

5 2024/25 Operational Planning in Leeds Place

The Leeds Place have recently established a Strategic Finance Executive Group (SFEG), comprising 3 executive Board members (including Chief Executives and Chief Finance Officers) from the 4 NHS organisations in Leeds (3 providers and the Leeds Place ICB). This group has been established in the context of ensuring a collective approach to strategic financial planning for the NHS resources in Leeds and to provide oversight and guidance to the Leeds Committee of the West Yorkshire Integrated Care Board.

SFEG has agreed a collective high-level approach for 24/25 service and financial planning, recognising and considering the developing wider governance, including the role of population boards. In advance of formal national planning guidance and using assumptions agreed at ICB levels the indicative scale of financial challenge for 24/25 is currently being assessed and work is ongoing in organisations to validate and challenge these assessments and identify the current savings that can be offset against them.

In November SFEG agreed 5 workstreams intended to address any agreed system gap. Project leads have been agreed for each workstream consisting of CEO / Operational / Finance support

leads from members of SFEG and project plans for these workstreams have also been agreed. All project plans have timelines to complete initial work by mid-December to coincide with the wider ICB planning timetable. It is the aim and intent of the Leeds place to have a robust transparent process for agreeing resource allocations for 24/25 which is fair and reasonable, that can deliver operational planning priorities and achieve the required statutory financial balance.

6 Conclusion

This report has demonstrated that the financial position of the Trust remains reasonably robust in the context of an increasingly challenging financial climate. As at month 7 there is a £87k year to date deficit, a deteriorating in month position. There are several risks and pressure in the revenue financial position that are largely fortuitously offset by high levels of vacancies, slippage on reserved investment and high levels of interest receivable. Progress against the four thematic efficiency areas remains key to deliver a break-even position at the end of the financial year.

The position needs to be taken with consideration of the wider system's financial challenge and the recent work to reset a system wide financial balance for the year. The position indicates an increasing challenge for 24/25 and the Leeds Place has begun collective work to address this. It should also be noted that enhanced financial governance controls continue to be in place across the whole system.

7 Recommendation

The Board is asked to:

- Note the revenue and capital position at month 7 and the actions being taken to ensure plan is delivered, in the context of the wider system challenges and work to achieve financial balance.
- Note the work commenced on 24/25 planning.

Jonathan Saxton
Deputy Director of Finance
24 November 2023

Income & Expenditure Budget Position	Budget Annual £'000	Month 7 Budget YTD £'000	Actual YTD £'000	Variance YTD £'000
Income:				
Patient Care Income	214,988	126,710	127,278	569
Other Income	31,657	17,167	20,183	3,017
Total Income	**246,646**	**143,876**	**147,461**	**3,585**
Expenditure:				
Pay Expenditure	(179,683)	(104,604)	(100,873)	3,731
Non Pay Expenditure	(66,963)	(39,272)	(46,675)	(7,403)
Total Expenditure	**(246,646)**	**(143,876)**	**(147,548)**	**(3,672)**
Surplus/ (Deficit)	**0**	**0**	**(87)**	**(87)**

Key – Underspend / (overspend)

The significant year to date variances are:

Income:

- Patient Care income is £0.6m better than budget as a result of timing; income has been received earlier in the year than expected for small projects.
- In Other Income, interest received is £0.8m ahead of budget as a result of the increase in the bank of England base rate.
- Additional income of £0.7m 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 £1.5m 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 £18.7m. 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, in October there was an increase of 37.68WTE substantive staff.
- Offsetting the overall underspend in Pay, the Trust has incurred £7.5m agency expenditure year to date, this is £0.7m higher than this point last year as detailed in Appendix C. Also, as a result of substantive vacancies, bank & overtime expenditure is £7.5m year to date.

Non-Pay

- Out of area placements (OAPs) expenditure is a significant pressure and is £2.9m above budget within £3.1m in acute adult services and £0.1m in older peoples services, reduced by a £0.2m underspend in Complex Rehab. 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 maintained at £0.2m over budget due to OAPs
- Excess packages of care costs in the WY CAMHS PC has contributed towards a £0.7m overspend within the collaborative that is offset with additional income profiled into the position.
- Year to date the unidentified cost improvement target generated £2.5m adverse variance

Appendix B

CAPITAL PROGRAMME - at 31 October 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	150		150
Security review	150	50		50
Cold water taps to bedrooms	100	100	90	10
Sub-Total	**550**	**300**	**90**	**210**
IT/Telecomms Operational				
IT Network Infrastructure	150	60	17	43
Server/Storage	30	15	7	8
Cyber security	50	50		50
Sub-Total	**230**	**125**	**23**	**102**
Estates Strategic Developments				
Newsam Centre (Doors)	75	75	25	50
Red Kite View	50	0		0
St Marys House, main house	1,080	1,080	1,658	(578)
Sustainibility & Green Plan	150	50		50
Seclusion Review	400	0	10	(10)
Safes	119	119	96	23
Sub-Total	**1,874**	**1,324**	**1,788**	**(464)**
IT Strategic Developments				
Integration System	50	50		50
Voice recognition	140	0		0
EPR developments	50	25		25
Electronic document management	277	0	208	(208)
EPMA Community model	100	0		0
Smartphones	60	30	47	(17)
Sub-Total	**677**	**105**	**255**	**(150)**
Contingency Schemes				
Contingency	305	150	154	(4)
2022/23 Completed Schemes			158	(158)
Sub-Total	**305**	**150**	**312**	**(162)**
Disposals				
ICS	0	0	(10)	10
Sub-Total	**0**	**0**	**(10)**	**10**
Total ICS Operational Capital	**3,636**	**2,004**	**2,459**	**(455)**
PDC Funded Schemes				
Electronic document management (PDC)	922	200		200
MH UEC (PDC)	581	0		0
Total PDC Funded Schemes	**1,503**	**200**	**0**	**200**
IFRS16 Leased Assets				
Lease Cars	200	105	55	50
Leased Buildings	1,000	500	(6)	506
Sub-Total	**1,200**	**605**	**49**	**556**
Disposals				
Leased	0	0	(6)	6
Sub-Total	**0**	**0**	**(6)**	**6**
Total IFRS16 Leased Assets	**1,200**	**605**	**43**	**562**
Total Capital Spend	**6,339**	**2,809**	**2,502**	**307**
Capital Funding Source:				
ICS Operational Capital	3,636	2,004	2,459	(455)
Public Dividend Capital (PDC)	1,503	200	0	200
IFRS16 Leased Assets	1,200	605	43	562
Total	**6,339**	**2,809**	**2,502**	**307**

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

AGENDA ITEM
10

PAPER TITLE:	Medical Director's Report
DATE OF MEETING:	30th November 2023
PRESENTED BY: (name and title)	Dr Chris Hosker. Medical Director
PREPARED BY: (name and title)	Dr Chris Hosker, Medical Director & Directorate SLT

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.	X
SO2	We provide a rewarding and supportive place to work.	**X**
SO3	We use our resources to deliver effective and sustainable services.	**X**

EXECUTIVE SUMMARY

The purpose of this report is to inform the Board of Directors of the current state of the Medical Directorate and in doing so provide assurance that it is functioning in a way that promotes the success of the Trust, its patients, its staff and the wider public, while also managing any current risks that are positioned as potential barriers to that success.
The paper's scope therefore covers the key functions that sit within the Medical Directorate and provides an update of key work within each one.

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

That the Board of Directors considers the information contained within the report and remains assured that the medical directorate is providing its key functions in a way that is in line with successfully achieving the Trust's objectives.

MEETING OF THE BOARD OF DIRECTORS

November 2023

MEDICAL DIRECTOR'S REPORT

1. EXECUTIVE SUMMARY

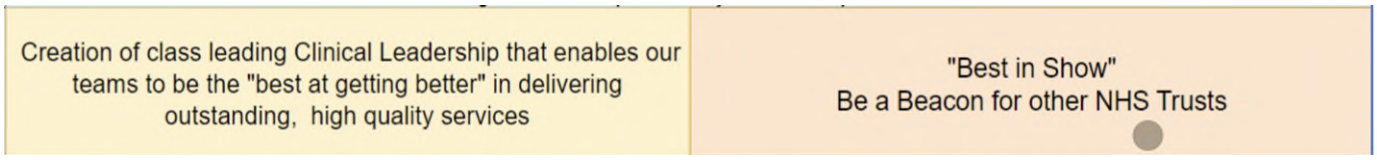
The purpose of this report is to advise the Board of Directors of the status of the Medical Directorate and in doing so, provide assurance that it is functioning in a way that promotes the success of the Trust, its patients, its staff and the wider public, while also managing any current risks that are positioned as potential barriers to that success.

The paper's scope therefore covers the key functions that sit within the Medical Directorate and provides an update of key work within each one.

2. DIRECTORATE OVERVIEW

The Directorate SLT came together in September 2023 to review progress against our 5 key priorities that were set in 2020: ***Developing world class clinical leadership; Transforming services towards a "best in show" standard; Excelling in research; Harnessing collaborative advantage; Leading through and beyond Covid***.

We have made considerable progress with these and have decided to focus on two closely related priorities from 2023-26:



Since the last report the directorate has had to continue work closely with operational and professional colleagues to mitigate the impact of the junior doctors' industrial action. I am once again hugely grateful to those who created the cover plans and to our consultants and speciality doctors who worked extra overnight shifts to maintain the on-call rotas. We wait to hear what the next phase of industrial action will involve. We have been working hard to reduce the agency spend and I am pleased to be able to report that we have made a number of successful consultant and speciality doctor appointments, including across some historically difficult to fill positions.

I would like to thank Dr Gopi Narayan who has left the directorate role of Clinical Director to take up a Clinical Director role in the Perinatal Mental Health Provider Collaborative. Dr Monique Schelhase has been successfully appointed as an interim replacement Clinical Director and will commence in December.

3. CORE DIRECTORATE FUNCTIONS

3.1 Personnel and structure changes:

Medical Professional Development Centre /Andrew Sims Centre (ASC)

ASC are currently running with a gap in the staffing model due to a long-term sickness absence which, has identified a risk due to the number of events booked through to Q4. Finances have been identified for funding to recruit a fixed term band 3 post and we received 79 applications. A successful appointment has been made and awaiting to confirm a start date.

Over the last 12 months, there has been an increase in non-payment of invoices from external venues used by ASC. The risk of non-paid invoices is impacting on ASC reputation as the number of external venues (which is where core business is carried out) is becoming very limited. On one occasion, a venue would not engage with ASC due to another LYPFT team (not ASC) owing funds to the venue. The non-payment of invoices has been escalated with colleagues in finance and procurement where interim arrangements have been put into place to reduce the risk of non-payment which, is also being monitored on the risk register.

Medical Education Centre and Medical Directorate Administrators

Both teams have worked hard in continuing to support the work in planning for the periods of medical industrial action which, has been challenging along with maintaining business as usual.

3.2 MEDICAL PROFESSIONAL LEADERSHIP

Medical staffing levels – vacancies, recruitment

In Q2, one Appointment Advisory Committee (AAC) has taken place with one substantive consultant appointment made in older people's services. No applicants were received for the forensic posts at Clifton House, Learning Disabilities, WAA Adult Acute, WAA CMHT and West ISS despite these being re-advertised. Following an internal expression of interest, one consultant moved internally from West ISS to Ward 4 Newsam Centre. However, at the start of Q3, we have successfully recruited a forensic consultant who will be working at Clifton House starting in March 2024.

Consultant vacancies continue in the York Forensic service (2), Leeds Forensic service (3) Working Age Adult Female Inpatients (1), Eating Disorders Connect (2), Older Peoples Service the Mount

(1), Learning Disabilities (2), West WAA CMHT (2), South CMHT (1), West ISS (1) and RKV CAMHs (1). There is a further vacancy as of Q4 in CAMHs services, Mill Lodge.

There continues to be significant agency spending due to consultant vacancies. Agency rates continue to increase, and this is reflected within our current agency bookings.

Agency spend details.

As of the 30th September 2023 there were 22 agency doctors booked within LYPFT, this is a reduction of 8 doctors since the last Medical Directorate report in Q1.

Work taking place.

The Medical Directorate continues to work with Medical Line Managers and Heads of Operations in the recruitment and selection of consultants. There continue to be recruitment hot spots in Eating Disorders, Forensic Inpatients, Learning Disability, Adult Acute services and Adult CMHT. These posts are routinely advertised month after month with no applicants, or applicants who are not eligible to apply.

Discussions continue to take place between higher trainees (HTs) and the Professional Lead and CD (for recruitment and selection) who meet regularly and routinely with HTs rotating into the Trust to discuss career opportunities, providing information about consultant opportunities available to them in LYPFT.

Following the success of the event “From Higher Trainee to Consultant: Your Career in our Hands” in March this year, another event is being planned for March 2024 in conjunction with the new appointment of the Director of CPD.

Key issues

It has come to light that we are unable to shortlist some Speciality Doctor applicants without them having a Certificate of Sponsorship for their visa. These applicants are filtered out by recruitment even before shortlisting, but we are aware that some (who have worked in LYPFT as Core Trainees) have been rejected at this stage who would likely be appointable candidates. To prevent missing such applicants it would be preferable to be able to offer ongoing sponsorship to enable this group

to go through to the shortlisting stage of recruitment. We risk missing out on high calibre applicants to neighbouring Trusts otherwise.

The vacancy management panel process to approve “mind the gap” payments for medium term gaps in medical cover has added to difficulty in arranging and confirming remuneration in these scenarios. It would be preferable if the VMP was not required for these situations. The impact of not being able to make a rapid decision with the relevant and key people within each service is likely to add to patient safety issues and further reliance on agency spending.

Specialty Doctors

The task and finish group have identified clinical areas where a specialist grade post could be developed (CREST) alongside looking at existing SAS doctors working towards becoming recognised for what they are doing now.

An opportunity from HEE regarding an investment opportunity for non-recurrent funding extended to SAS doctors was circulated and we have submitted a bid. The bid would provide additional PAs to recruit two existing consultant or Specialty Doctors into the role of CESR Tutor, the responsibility of which is to support the development, implementation, oversight and review of a designated CESR pathway for SAS doctors working in LYPFT.

This would provide enhanced career and professional development options and access to senior positions within the Trust such as applying for consultant posts, or working as acting consultants, which is currently not available through a formal, structured and supportive programme such as this. The SAS workforce deserves to be valued and respected and have access to the opportunities that other doctors do, particularly with clear access to career development offers. The implementation of this pathway will raise the profile of SAS doctors in LYPFT, improve morale and retention and inspire newly appointed SAS doctors to develop their career aspirations. Enabling career promotion to more senior levels allow too for enhanced remuneration through the formalising and accreditation of skills and experience.

Higher trainees

We are now working through the trajectory of HTs completing training in 2024/5, which is aiding the work taking place along with the feedback from the HT conference and from individual conversations with potential applicants.

Medical recruitment challenges and mitigation plans

Adult Acute Services	There is an agency consultant who is covering a consultant vacancy on WD1 inpatient unit at Becklin Centre. Ward 4 Newsam Centre, now has a substantive consultant in post from August 2023 which created a vacancy in West ISS due to an internal move. The 2 agency CTs covering trainee vacancies on WD1, have been filled by Trust Doctors who started in post in August 2023. A Trust Doctor was also appointed to work in West ISS.
Working Age (WAA) Community + Wellbeing Service	WAA South CMHT has one consultant vacancy. One agency SD will remain in South CMHT as substantive recruitment was made to the other vacant SD post – to start Feb 2024. In March 2024 a further consultant retirement is expected in South CMHT. There is ongoing discussion with a specific HT applying for this post. A retirement is planned in ENE CMHT too by the end of Q4 and an agency locum has been booked to start whilst the post is advertised. WAA West CMHT continues to have two consultant vacancies, and agency consultants are in place covering the vacancies whilst these posts are out to advert.
Eating Disorders + Rehab	Eating Disorders continues to be a vacancy hot spot. There is currently one agency consultant in post and two consultant vacancies are advertised with external medical agencies but covered internally. The substantive consultant works on reduced hours and the AS acting RC has reduced hours further too to take up a leadership role. There is an applicant for one of the Consultant posts for which the AAC is Nov 2023. (current HT).
Forensic services	York forensic based psychiatry is wholly provided by agency doctors overseen by the clinical and medical lead. AACs scheduled in October received one applicant who was appointed and will be starting in Q4. Forensics continues to remain a hot spot for medical recruitment challenges. The Leeds forensic service has three consultant vacancies, all of which are covered by agency locums. These posts and job descriptions have been reviewed.
Older Peoples Services	The new and additional East, North and West consultant started in Q2. The Mount inpatients have a vacancy on WD4 due to an internal move to the South CMHT - this is currently covered by an agency consultant and there is one applicant for Nov AAC for this post.
Learning Disability	There are two consultant vacancies. The service is continuing to review the service and what is needed regarding staffing levels. There is one agency locum consultant in place.
CAMHs Services	Red Kite View currently has one consultant vacancy which is covered by an agency consultant and is currently out to advert.

	At Mill Lodge there is now only one substantive consultant. The second substantive consultant, requested a career break from August 2023 but will continue working 3 sessions in R&D. An agency doctor is in post to cover the career break clinical sessions.

Current state of medical line management

The draft line management structure has been developed by creating areas of responsibility for a number of medical line managers. Work is taking place to identify the number of programmed activities (PAs) which are vacant to support remuneration of the restructure.

Job planning status update

Continues to be on the Medical Directorate workplan. Currently 53% of SAS and Consultants have completed and signed job plans; the remainder are either complete but not signed, in progress or overdue.

Clinical Excellence Awards

The 2023-24 Local Clinical Excellence Awards (LCEAs) scheme was launched, and 23 applications have been received. A review panel is being arranged for applications who do not reach the threshold of the criteria. Applicants will receive the outcomes of their applications in Q4.

3.3 Specialty Doctor and Associate Specialist (SAS) Advocate update

The role continues to involve linking in with colleagues to check on well-being of the SAS group within the workplace particularly during the recent ongoing industrial action.

We aim to have the next wellbeing day in March 2024. Final plans will be formulated next week. The day will likely include a team building activity, a motivational speaker and potentially a relaxation activity but with plenty of less structured time to offer one another peer support and time for reflection.

Specialist role formation task and finish group ongoing: job description for a Specialist role in the CREST team in completion phase. Once appointed this could act as a first steppingstone for the Trust in establishing these roles more widely. A policy for re-introduction of progression through re-grading in the mould of the old associate specialist policy is being formulated and a proposal has been submitted for introduction of a Trust pathway to support Specialty doctors to attain AC approval and CESR along with bid for funding.

Peer support sessions have been incorporated as part of the SAS committee meeting with relevant speakers invited focussing on key development, employment and wellbeing topics for SAS doctors.

Plans have been made to improve the mentoring offer to SAS doctors in LYPFT including recruitment and training of more SAS doctors as peer-mentors.

Ongoing liaison with the LNC and national SAS advocate group has been underetaken to gain and share pertinent information relating to the SAS group both locally and nationally in terms of developmental opportunities, sharing good practice and employment issues.

3.4 Medical Continuing Professional Development (CPD) and the Andrew Sims Centre

The Andrew Sims Centre (ASC) have continued to build their professional business relationships with Trusts and organisations to provide high quality CPD training. Recently, ASC ran a large Conference for Humber Teaching NHS Foundation Trust to celebrate excellence and innovation in mental health which received excellent feedback which we have had consent to upload as a testimonial on the external facing ASC website.

ASC are currently working with LYPFT Deaf CAMHS (North) to host a UK special online series with an international speaker from the US. To our knowledge, this training has not been recently available to access directly from the specialist speaker in the UK.

ASC are focussed on promoting the centre to other Trusts, organisations and delegates. Recently, ASC team held an exhibition at the NHS Providers Annual Conference & Exhibition at Liverpool on 14th & 15th November 2023. This offered the opportunity to network with other providers and increase awareness to other organisations in the UK with the aim of building strong business relationships. The Chair of LYPFT was also in attendance at this event who was delighted that ASC were representing LYPFT.

Work is taking place with colleagues in finance to review the budget position and financial modelling of the ASC.

3.5 Medical Education

The Trust welcomed the return of junior doctor inductions face to face from August 2023 following the outcomes of a trainee led quality improvement project. This had improved feedback about satisfaction and confidence in starting their placement and on calls. This helps address areas of improvement form the GMC survey 2022. The recent GMC junior doctor survey 2023 overall was pleasing but did show areas of improvement needed in clinical and educational supervision of our foundation doctors and increased emergency experience for our core trainees. Dr Sharon Nightingale Director of Medical Education has provided an improvement action plan to NHS England following consultation at the Trust Medical Education Committee.

We are delighted to appoint Dr Zumer Jawaid as the Director of Medical Continuous Professional Development (CPD) from 1st November 2023. This is a new role that replaces the AMD for CPD and extends beyond supporting SAS and consultant study leave and the Andrew Sims Centre. Zumer will be an essential member of MELM (Medical Education Leadership and Management Team) and work with the DME and Medical Professional Lead to enable higher trainees to want to transition to the Trust's future consultant workforce and support our new and established consultant and SAS workforce to remain in the Trust.

The Trust partially funded two academic clinical fellows in core training back in 2019; now have 3 posts all fully funded from NHIR. I am delighted to announce that our first NHIR funded ACF Dr Anna Taylor has been successful in her PhD application. Anna will continue to work in LYPFT for the NHIR funded clinical time during her PhD. This is such a big step towards rebuilding the academic psychiatry pathway in Leeds. It is a great example of joint working between University of Leeds, R&D, MELM and our clinical services.

Finally, the main continued challenge for MELM (Medical Education Leadership and Management Team) remains the recurrent medical industrial action. MELM continues to work closely with the Industrial Action Planning Group and Industrial Tactical Group to ensure patient safety during Industrial action by co-ordinating necessary backfilling of the junior doctor and consultant workforce. A final challenge this quarter is the stepping down in January 24 of the regional higher training programme directors for general adult psychiatry, old age psychiatry and medical psychotherapy supported administerial by LYPFT medical education. In line with the medical strategy succession planning and being employer of choice, we have some excellent internal candidates applying for the TPD roles.

3.6 RESPONSIBLE OFFICER

Appraisal and revalidation

In the last quarter (Q2) 34 appraisals were undertaken and 6 recommendations for revalidation were approved by the GMC. There were no missed appraisals.

Following a recent round of appraiser recruitment 5 doctors (2 consultants and 3 SAS doctors) have been appointed, bringing the total number of trained appraisers to 31. This increase in the number of appraisers has enabled the wider work of the Medical Directorate with respect to reducing medical agency spending through the appointment of new Trust-grade and FY3-grade doctors to be supported since these doctors provide clinical input into services however are required to have annual appraisals as per all other doctors for whom LYPFT is their Designated Body. A business case to review and standardise the remuneration of appraisers has been submitted for approval at the next meeting of the Trust's Financial Planning Group scheduled for 21 November 2023.

Since the last report the first Appraisal Development Forum offering a face-to-face meeting has taken place. This was well attended and reviewed the structure and format of the meetings and enabled feedback to be received regarding the new appraisal forms which have been in use since in Q1. Regular meetings have continued with L2P to ensure that the appraisal documentation meets the needs of doctors while also fulfilling the statutory requirements of the GMC and a Trustwide Casenote audit has been launched enabling doctors to evidence their compliance with Good Medical Practice criteria in this domain.

Managing concerns about medical staff

The current version of the Managing Concerns About Medical Colleagues (Maintaining High Professional Standards) policy is currently being reviewed in conjunction with colleagues in the Workforce Directorate to ensure that it is fit for practice. The expectation is that this review will be completed, and the updated version ratified for use by Q4.

Since the last report there have been no new concerns raised about doctors in the Trust which have reached the threshold for investigation. One preliminary investigation has concluded with locally agreed actions for the doctor and one case opened for investigation by the GMC before the doctor joined the Trust has been closed with no further action. The GMC have also advised that they have opened two new investigations into doctors who previously worked in the Trust. They have advised that neither investigation includes any patient safety concerns relating to when the doctors were in the employ of LYPFT and requested information to assist with the investigations has been provided to the GMC.

4 CLINICAL LEADERSHIP AND QUALITY OF CARE

The Clinical Lead Development afternoon that was planned for the 20th of July 2023 was unfortunately cancelled due to industrial action. A number of the current Clinical Leads are medics by profession and, along with other non-medical Clinical Leads, were needed to support care delivery within their respective services. Further attempts to re-arrange the development session for

October were also impacted by further industrial action. The re-arranged session will now take place on the 16th November 2023.

A paper summarising the Clinical Leadership Development work completed to date was written and presented to the Trust Workforce Committee meeting on the 3rd of August 2023. As well as summarising the outcomes of work completed to date, the paper described how this work has been used to underpin leadership development activities and initiatives and outlined the plans for future work and next steps.

A process for the recruitment of Clinical Leads has been written and piloted in practice with two Clinical Lead recruitment opportunities. Reflections and feedback from the pilot implementation will be used to amend and develop the first draft of the documented process. Work has commenced to co-design and co-produce with people with lived experience and experience of being part of a Clinical Lead recruitment process, members of the Patient Experience Team, and People Resourcing and Organisational Development Team, the service user involvement process for Clinical Lead recruitment.

A small focus group discussion has been held with two Clinical Leads who were willing to share their induction experiences and reflections. Their feedback has been documented and is being used to create a standardised induction package resource tool that will be available for all new Clinical Leads recruited into the role. The aim is to share the draft resource tool wider with other Clinical Leads for their feedback and input. This task was a core request identified by Clinical Leads in their focus group feedback on the skills and attributes of good clinical leaders and forms an important “you said, we did” action.

Clinical Lead Support Forums have continued during this quarter with a further 3 meetings held.

A Clinical Lead repository has been created on TEAMs. This repository provides a shared space for Clinical Leads to pose questions and request support and houses a number of documents, papers and leadership resources for Clinical Leads to refer to and use.

Work has been carried out to contribute to the development of a Trust Career Pathway document. The document aims to support career conversations and to outline the progression / career development opportunities available with the organisation. Work has been completed to detail the experience required for those members of staff that wish to become clinical leaders to enable them to create their personal and professional clinical leadership development plans.

5 MEDICINES SAFETY

The pharmacy service remains in business continuity due to carrying numerous vacancies as well as sickness absence.

Recruitment of GPhC registered staff (Pharmacists and Pharmacy Technicians) continues to prove challenging (and time-consuming), due to a national shortage of registered pharmacy professionals which is unlikely to resolve soon. Pharmacy managers continue to work with the HR/ OD team to mitigate this and consider new roles for non-registered staff to relieve registered staff of operational tasks thus enabling them to focus on their professional roles. A different approach of holding information-giving webinars for potential applicants is currently being tried for the frontline registered posts currently out to advert.

With senior pharmacy staff still providing frontline service and management cover non-urgent medicines governance or pharmacy service development work remains paused. The pharmacy service is currently supporting the Trusts Autumn/ Winder Covid and Flu Vaccination of patients and staff.

6 CLINICAL INFORMATION MANAGEMENT

The focus of this reporting period has been on the delivery of electronic document management across the organisation. We now have more than 100 teams using the system and feedback has been overwhelmingly positive. Frontline staff have been supported with a combination of e-learning and floorwalkers to ensure that they understand the functionality. Unfortunately, we continue to await the electronic link which will bring further documents from care director in the Paris archive into this system. These are significant and complicated upgrades affecting not only Mediviewer, but also our plans for electronic ordering of tests and links to Outlook diaries. It is hoped that the update will be completed soon.

The digital change team have worked with the community mental health team to pilot the electronic prescribing of depot antipsychotics. This project has been a success, and we are therefore progressing wider implementation, including the use of the same processes for Clozapine prescribing. The delivery of the new care planning process is now complete with the old form having been made read only.

Work continues to support the community transformation programme. Nationally we have been supporting NHS England in developing an “EPR Optomisation Playbook”, and regionally in helping steer the approach to future care planning within the ICB. Finally, our clinical team have been integral to the appointment of a new CIO to lead our digital strategy.

7 RESEARCH AND DEVELOPMENT

Ten new research studies have been opened in the last quarter. This includes MoreRESPECT: A Randomised controlled trial of a sexual health promotion intervention for people with severe mental illness delivered in community mental health setting. We are the host for this large study meaning the finances comes through our organisation and it allows us to attract Research Capacity Funding from the study. We have launched the new 360 Manager training on ‘The Future of Mental Healthcare’ and in October we delivered the first, fully booked session. The aim of the training is to help managers understand the importance of research to the organisation, service users and staff. The Research department have also been involved in supporting the revision of a session on ‘Writing for Publication’ led by the library. The first revised session was delivered in September. In September the Research committee awarded a range of pump priming grants to staff across the organisation. These are small grants which can be used by staff to further a research idea. We have a range of staff currently involved in application for research funding either as co-applicants on grants or for personnel fellowship schemes. We have 1 Nurse and 1 SLT who have just completed a 6 month-NIHR internship.

The Child Orientated Mental Health Innovation Collaborative (COMIC) hosted a participatory methods event jointly with Leeds University, 90 people attended and positive feedback from the event was received. This build on previous event in June and aimed to foster collaborative relationship across the region for participatory methods for children in research.

8 IMPROVEMENT AND KNOWLEDGE SERVICE

We continue to build a culture within the Trust that uses knowledge and improvement to provide outstanding mental health and learning disability services.

To give a more aligned service offering, the consultation for the formal merger of the current functions of Continuous Improvement and the People and Change function, into one Improvement Team is almost complete. There is a delay in the final stage due to unplanned leave so we will wait until everyone is back at work to sign off the changes.

Currently, only one staff member (Senior Improvement Manager) is responsible to co-ordinate compliance with NICE guidance across the Trust. This is a serious risk as non-one in the Trust has knowledge and expertise on how to support the NICE process across services and how to monitor and report activities on completion of baseline assessment. We are in the process of recruiting a Band 6 post (Senior Clinical Effectiveness and Improvement Facilitator) - subject to banding panel. This new post will help to support the Senior Improvement Manager, be responsible of the NICE process within the Trust and managing the Clinical Effectiveness Team.

The table below outlines the active projects that the Improvement and Knowledge service are currently supporting. Overall, there are 97 active projects; however, some projects have been undertaken across more than one service (or service line) as shown below:

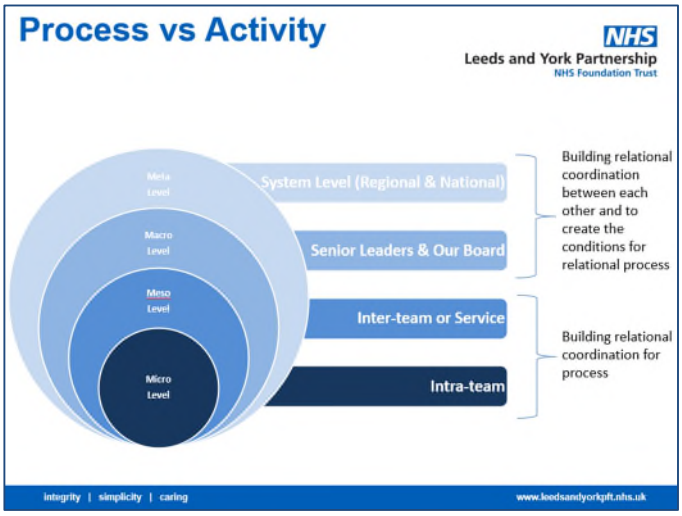
Service Line	Clinical Audit	Improvement
Adult Inpatients (n=14)	11	3
Children & Young People (n=11)	7	3
Community & Wellbeing (n=13)	8	6
Corporate & Other (n=22)	11	11
Eating Disorders, R&R and Gender (n=9)	4	5
Forensics (n=4)	4	0
Learning Disabilities (n=3)	2	1
Liaison & Perinatal (n=8)	4	4
Older People Services (n=22)	13	11
Regional & Specialist (n=6)	6	1

During this last period, we have been involved in some amazing opportunities to share some of the magnificent work that happens within the Trust, these were...

- In September we were approached by the IHI (Institute for Healthcare Improvement) to present our journey of using the Learning Culture and Leadership framework (formally Safe Reliable Effective Care) at a learning event for NHS Wales Executive – Improvement Cymru as part of a learning event for their Health Boards. The session was well received and generated some great discussion around how they different Health Boards can utilise the

framework better. Following the session, we also received some good feedback... “We really appreciate your time and open sharing. We have received really positive feedback and you have galvanised practical action in a way we have previously struggled so big win!! Thanks so much.” - Kate Mackenzie, Head of Improvement Analytics, NHS Wales Executive

- In October we presented the work we are doing with Relational Coordination at the 2023 RC Roundtable hosted by Johns Hopkins University. The presentation received positive feedback, especially the view we gave around how the meta and macro levels (system, senior leaders and board) build relational coordination between each other to create the conditions for relational processes at lower levels, and with the meso and micro levels (Inter-team or Service and Intra-team) build relational coordination for the process.



- We co-designed and co-hosted, with the Experience of Care Team - NHS England, the Health Improvement Alliance Europe (HIAE) Multi–Day meeting. This was the HIAE in-person event that took place on 14-15 November in Leeds. The theme of the meeting was Improving together: partnering with people. We welcomed 73 attendees from England, Northern Ireland, Scotland, Wales, Estonia, Denmark, Belgium, and Iceland. We had 3 teams from the Trust present to all the attendees, these were Child Oriented Mental Health Innovation Collaborative (COMIC), Patient and Carer Experience and Involvement and the Improvement and Knowledge Service. The agenda also included the “Go See” visits, where the attendees chose to visit one of the following services:
    - **Learning Disability service** ‘Bigger Better Labels’ using coproduction across the healthcare system to make medication labelling easier to read and enable people to take their medication safely.
    - **Recovery College**, learning modules co-produced and co facilitated by staff members and lived experience partners for everyone by everyone
    - Driving co-produced improvements in the **Emerge Service** (Personality Disorder network) Lived Experience staff members employed at a leadership level

The planning and delivery of the event in a truly collaborative way shows what can be achieved where you have different perspectives but provide the time and space so those involved can agree on a shared goal. The event's formal feedback and evaluation will be finished by mid-December, but the informal feedback has been positive.

Looking forward to the next period, along with supporting all the different services, we will be looking to collaborate with Improvement Cymru, Wales and Grand River Hospital, Ontario around further development of resources for the Learning Culture and Leadership framework. We will also be starting to work on what is needed to embed an organisation-wide approach to improvement that is aligned with NHS IMPACT (IMproving PAtient Care Together) as we know that “Every NHS provider that has achieved a rating of “outstanding” from the CQC has a systematic approach to quality improvement” - Rob Wakefield, Head of Corporate Functions, NHS IMPACT

9 MENTAL HEALTH LEGISLATION COMPLIANCE

We continue to provide mandatory training in relation to MHA/MCA/DoLS. Staffing pressures and strike action have had an adverse effect on attendance, but figures remain stable. We are continuing to review how we deliver training, and in the new year will be providing some of the initial training sessions in person.

Requirement	Number compliant	Number non-compliant	Total Headcount	Compliance status

Mental Capacity Act and DoLS Level 2	862	185	1047	82%
Mental Health Act (Inpatient) Level 2	280	80	360	78%
Mental Health Legislation Awareness Level 1	1344	249	1593	84%
Overall:	**2486**	**514**	**3000**	**83%**

In addition to our mandatory training provision, we continue to provide bespoke training for clinical teams. In this quarter, this has included running a mock tribunal for preceptee nurses, report writing for the rehabilitation teams and more in depth sessions relating to assessments of capacity.

The Human Rights training programme is nearing completion, and this will be supported by evaluation by the British Institute of Human Rights and a paper to the board laying out next steps.

We have carried out further recruitment of Mental Health Act Managers (MHAMs) to cover the cohort of MHAMs whose contracts are due to end in January 2024. We have been working hard to ensure that the cohort of MHAMs reflects the diversity of people that use our services.

10 CONCLUSIONS

This extensive report provides an overview of the major pieces of work being conducted within the medical directorate and the areas of work that required ongoing focus and support.

11 RECOMMENDATIONS

The Board are asked to consider the information contained within this report on the key functions of the medical directorate and to be assured that the work being conducted is commensurate with the challenges being faced and in line with the wider Trust strategy.

Dr Christian Hosker

Medical Director

November 2023

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 2: 1st July 2023 to 30th September 2023
DATE OF MEETING:	30th November 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.	**x**
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 has been 1 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:

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

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

MEETING OF THE BOARD OF DIRECTORS

30 NOVEMBER 2023

Guardian of Safe Working Hours Report

Quarter 1 July 2023 to September 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 01.07.2023 to 30.09.2023.

2 Quarter 2 Overview

Vacancies		As in previous reports, and continuing from August 2023, there are 39 Core trainees and 2 NIHR posts. A number of 'FY3s' were recruited from August 2023 to fill Doctors in Training and service gaps.					
		As of August 2023 there are 31 established higher training posts plus one psychotherapy post borrowed from Forensics. There is one vacancy in Intellectual Disability.					
Rota Gaps		July		August		September	
		CT	HT	CT	HT	CT	HT
	Gaps	34	10	22	9	15	11
	Internal Cover	30	10	19	9	15	11
	Agency cover	0	0	0	0	0	0
	Unfilled	5	0	3	0	0	0
Fill Rate		88%	100%	86%	100%	100%	100%
Reasons for Rota Gaps		Reasons for rota gaps include sickness, vacant shifts (through recruitment gaps), other unplanned leave, statutory leave, Less Than Full Time working, and being off rota. Figures do not include numbers for those taking part in Industrial Action (IA) as consultant cover was arranged to maintain the Out of Hours Rota during these times.					
Exception reports (ER)		There was 1 ER raised during this reporting period. This related to an unfilled vacancy on the PROC rota which					

	resulted in increased work load and working over scheduled shift. Payment made in line with doctors preferences. No ERs related to patient safety issues or missed training opportunities.
Fines	None
Patient Safety Issues	None
Junior Doctor Forum (JDF)	The meeting held in the Q2 reporting period took place on 4th August 2023. • There were 3 exception reports (as noted in the Q1 report) discussed. 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. 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. A further JDF meeting was held outside of this reporting period, on 27th October 2023, and will be included in the Q3 report.

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:	Director of Nursing and Professions report
DATE OF MEETING:	30 Nov 23
PRESENTED BY: (name and title)	Nichola Sanderson, Director of Nursing and Professions
PREPARED BY: (name and title)	Nichola Sanderson, Director of Nursing and Professions and members of the Nursing and Professions Directorate

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 provide a quarterly update to Trust board members in relation to progress across the Directorate of Nursing and Professions		
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
Board members are asked to note the contents of this report and continue to be assured of the breadth of work, mitigation of risk, progress and oversight across this Directorate and its portfolios.

Meeting of the Trust Board of Directors

30 November 2023

Director of Nursing, Quality and Professions Quarterly Report

This paper provides an update and overview of progress with the Nursing and Professions Directorate, which centres around the continued ambition to provide safe, effective, high-quality care to all who are involved in LYPFT and the wider ICS. The paper continues to focus on 3 key elements of Patient and Carers, Patient Safety and Professions and Performance. This report does include some repetition to previous board reports with the aim of providing a history and recognising that board members may be at different stages of their oversight.

Patients and Carers

1. Patient Experience

The Patient and Care Experience and Involvement strategy year 3 review, provides an oversight of the exciting and proactive work by all involved. The Service User Network has so far had thirty-six people participating in projects and activities. Twenty-seven people supported staff recruitment in interviews or as part of panel discussions and over thirty inpatients got involved through completing surveys or attending online SUN meetings. One inpatient has become an active member of two project groups which meets online.

Lived experience partners have worked with the Patient and Carer Experience Team and other colleagues to co design and co deliver learning and practice development workshops, including the Health Support Worker induction programme**.** Co designing and co delivering with lived experience partners, we now regularly deliver two workshops:

- A carer awareness workshop to explore the importance of involving carers in the care of our service users.
- A workshop exploring what it can feel like as a service user being supported by LYPFT.

The Patient and Carer Experience Team worked with the Chaplaincy Service to ask service users, relatives, carers, and staff for their views about faith rooms at our hospital sites. An online survey, workshops, and open days at the Becklin Centre faith room gave lots of ideas and opinions. One theme ran throughout: the faith rooms are a significant resource to the Trust. They have the potential to be an ‘oasis’ for service users, staff, and carers during sometimes life shattering experiences. This is also true for people who want to practice their religion or have space to be still and reflect. Everyone believed in the value of the rooms. Improving the use of the rooms has the

potential to make a meaningful contribution to the Trust. The findings will be used to develop faith room provision at all our Trust sites in the future.

This year we have linked with existing carer support groups. It's been good to hear that several service specific carer support groups have started again this year providing peer support, education, and opportunities to feedback to that service. We continue to work with Carers Leeds and Leeds Young Carers Support Service. We are also members of the Leeds Carers Partnership.

It's important that we learn from carers about their experiences of our services. Carers can complete the 'Have Your Say' questionnaire, but we've also trialled a 'Carers Reported Experience Measure' with some services in the Trust. Carer experiences from peer reviews, serious incident investigations, partner organisations and interviews with carers, provides valuable feedback and we will be exploring how this can be more widely shared and used for learning across the Trust.

2. Safer Staffing Initiatives

The Mental Health Optimal Staffing Tool (MHOST) is an evidenced based mental health workforce tool. The tool describes how fluctuating service user acuity can affect the number of registered staff required to provide service user care. It uses a set of care level indicators on a scale of 1-5 which measure the dependency/acuity of service users in different settings.

LYPFT now have sufficient staff with the required knowledge to use the tool, and as a result the Safer Staffing Group will work together with operational colleagues to enact the implementation plan, with the first data collection period taking place in September 2023 to provide an evidence base for safe staffing decisions.

MHOST data should not be used in isolation as professional judgment needs to be applied to make the tool viable, along with quality indicators to support any decision making. It is through the triangulation of quality indicators, benchmarking data, and professional judgment that the information should be used to support establishment reviews.

Through the Safer Staffing Steering Group, inpatient services have been identifying potential quality indicators to take back to their governance forums to agree to support the scrutiny of data.

Data collection takes place for x 28 days between September and March and the results will be shared with clinical services. These services will be supported by the Professional Leads for Nursing in order to work collaboratively to influence establishment setting using all the information as described.

The information across our inpatient services will be shared through our 6 month safer staffing report with the first paper being circulated in January 2024. In conjunction with the MHOST tool, the bi-monthly safer staffing board report requires further development to ensure a broader assurance in relation to the direct impact for patients sub-optimal staffing levels. The current report does not triangulate static risks

associated with the dynamic and varied care pathways we provide across our inpatient services. The safer staffing report will be adapted over the next few months and the board will see a change in focus to care pathways rather just numbers.

3. Closed Culture Panorama Work

At the regional Director/Deputy Director of Nursing Steering Group it was agreed that each of the Trusts in the West Yorkshire Mental Health Learning Disability and Autism Services Provider Collaborative (LYPFT, SWYPFT, BDCFT) work more closely on the quality assurance agenda. Developing processes to identify, action and improve the culture of care within each of our services.

Leads from each organisation, supported by the ICS Senior Inpatient Oversight Lead for the Mental Health Learning Disability & Autism Program, developed a framework detailing a collaborative peer review process to be adopted by the Trusts. This framework flows through three subsections:

- Section A – data that could be drawn from existing Trust systems.
- Section B – the considerations needed within a pre-visit discussion to help identify particular areas of focus before a service visit takes place.
- Section C – the Key Lines of Enquiry to be addressed on a service visit.

This collaborative approach is not intended to duplicate or replace local processes, but to add another 'fresh pair of eyes' to challenge local thinking and provide clear benchmarking of what is working well across the collaborative to support learning and improvement.

It was agreed that we be the first Trust to pilot a collaborative review, with a peer review visit scheduled to take place on 12 December 2023 at Ward 2, the Mount. Colleagues from Bradford District Care Trust will be leading the review assisted by South West Yorkshire Foundation Trust.

Local governance process will be followed to ensure scrutiny, oversight, and signing off of the resulting peer review report, as well as sharing the outcome of the visit at the Director/Deputy Director of Nursing Steering Group.

In January 2022, LYPFT began its collaboration with the British Institute for Human Rights (BIHR). The BIHR are a charity organisation whose primary purpose is the promotion of human rights. They have worked with many public bodies, including NHS Trusts, providing advice and training to enable them to live up to their duties under the Human Rights Act 1998.

Throughout 2022-23 we have rolled out a Human Right training programme, this has included.

- Workshop With People Accessing Services & Their Loved Ones.
  A half day online workshop for people accessing LYPFT's Services, as well family/carers. This workshop's aim was to increase human rights knowledge

and confidence as well as support people to map their experiences to human rights and identify key areas to address in staff sessions.

- Human Rights Capacity Building
  A two-part online human rights learning programme designed to build staff's knowledge and confidence in human rights and embedding this into their practice.

- A Human Rights Approach to Policy workshop
  A bespoke online workshop for staff to learn more about a human rights approach to internal policy making.

- Human Rights Practice Leads Programme
  The aim of this programme is to support the long-term embedding of human rights learning and development within LYPFT. Practice Leads who have attended an intensive 8 session course can cascade learning within the Trust as well as supporting others with human rights decision making.

Throughout 2024 we will build on the foundation of the training programme. Through a newly developed LYPFT Human Right Community of Practice, we will develop a strategy for adopting and fully integrating a human rights-based approach.

4. Synergi Leeds Partnership HSJ Award Winner 2023

Synergi Leeds, a partnership between LYPFT, Public Health and the Voluntary Care Sector, was named Mental Health Innovation of the Year at the awards ceremony on 16 November 2023. The partnership was also a Finalist in the Race Equality Award. The national HSJ Awards recognise outstanding contributions to healthcare across the country. This year they received a record-breaking 1,456 entries and Synergi Leeds was among the 223 projects and individuals to reach the final. The HSJ judges said that they *'were impressed by the passion and enthusiasm displayed by the team. It is clear that this programme is well organised and is achieving positive outcomes and demonstrating an exemplary use of the voice of lived experience. The forming of relationships across boundaries to create real system transformation is to be commended'.*

It was a delight and a privilege to present Julie McGrath, Healthcare Support Worker in our Assertive Outreach Team, with this year's prestigious Chief Nursing Officer award for Support Worker excellence. The Chief Nursing Officer Awards for Healthcare Support Workers (HCSWs) rewards the enduring compassion and vital contribution made by people in these roles in England and their exceptional support of nursing practice. The esteemed award coincided with Nursing Support Worker's Day celebrations.

Patient Safety

1. Patient Safety Incident Response Framework (PSIRF)

The Trust is in the preparation phase for PSIRF and the project team continue to work through several tasks to prepare for its implementation. The Trust continues to work to meet all the required standards set out in the PSIRF supporting documentation. We continue to benchmark progress against these to identify and implement the steps required as we transition to the new framework. The PSIRF Oversight Group meets monthly to steer the development of the framework across the Trust and gain assurance around key pieces of work, which currently includes the development PSIRF Policy and Plan. The Patient Safety Team link in with our ICB and provider collaborative colleagues to ensure they are sighted on our progress and have opportunity to provide comment on our approach in implementing PSIRF.

The project team recognise the challenges in communicating the ongoing work across the Trust and are seeking to provide regular updates through different mediums, including the Unified Clinical Governance Group, Service Line Clinical Governance Meetings, a monthly update to Trust-wide Clinical Governance Committee, and a monthly update included within the Trust-wide Communication.

The Patient Safety Team have commenced a rollout of training for staff on facilitating "after action reviews" and a refresh of requirements as set out within the Duty of Candour. We are currently piloting the after action review process, and this has been well received within services. The project team are also developing a toolkit to help support staff to think about the appropriate learning response to utilise and are linking into ongoing work within the Falls and Pressure Ulcer Group to think how to effectively use learning responses.

The team is actively working to recruit Patient Safety Partners (PSP's) within the Trust. The purpose of this role is for PSPs to work alongside staff, patients, service users and families to influence and improve safety within our services. PSP's will be patients, service users, carers, family members or other lay people with a keen interest in patient safety. We have advertised the opportunity on the Trust public facing website alongside a role description and frequently asked questions. Details have also been shared through our Service User Involvement and Engagement Networks.

Learning From Patient Safety Events (LFPSE) is an external automated incident reporting system to capture anonymised patient safety incidents that have occurred in the Trust. LFPSE replaced the National Reporting and Learning System on October 2023.

2. Sexual safety

LYPFT became an early adopter of the national Sexual Safety Collaborative in 2019, which was organised by the Royal College of Psychiatry, CQC, and NHS Improvement and was established in response to the CQC report Sexual Safety on Mental Health Wards. The Trust chose 3 wards in Acute Inpatient Services, and 1 ward in Eating Disorders Service to pilot the work and a Sexual Safety Group was set up in 2019 to support the pilot sites.

The pilot sites raised awareness of sexual safety amongst staff on the ward and helped clarify what the terms meant, which in turn helped change clinical practice and made their teams acutely aware of sexual safety when care planning and raising concerns. The sites also collected data about patient experiences with sexual safety, which supported the development of the sexual safety standards and resources through the Sexual Safety Collaborative.

In 2022 a Sexual Safety Group was formed and met monthly to agree how the work and learning from the pilot would be embedded across the organisation. A decision was taken early on to have an initial focus on the in-patient areas with a plan to roll out beyond at the appropriate time. This was tasked with focusing on writing a policy, developing an information leaflet that could be used by both staff and service users, identifying Sexual Safety Leads within services and creating a 'checklist' for the leads to begin embedding the work. An intranet site with resources for staff and developing

training is currently underway. Whilst training is being developed, Sexual Safety Leads have been raising awareness in wards/services using the information leaflet, policy, and other resources developed through the Sexual Safety Group, or that have been provided nationally.

Services currently involved in the roll-out of the standards have been asked to add Sexual Safety as an agenda item within their Clinical Governance meetings. A quarterly analysis of sexual safety incident data and actions are reported to Trust-Wide Clinical Governance by the Clinical Governance Team, along with a report on the project's progress. The learning is then shared at the Learning from Incidents and Mortality Meeting (LIMM), to see whether a further look into investigating trends is required. The report is also shared for learning at Unified Clinical Governance Group and the Sexual Safety Group, to ensure that the learning is disseminated through clinical services.

As part of the standards there is a requirement to improve organisational culture. To understand the culture of sexual safety within the organisation, a survey was sent to Inpatient Services in April 2023. The results showed that 58% of staff reported that they understand their roles and responsibilities when it comes to sexual safety in their area of work. In addition, 93% of staff felt comfortable in raising concerns about service user sexual safety. Moreover, 83% of staff felt that their sexual safety concerns would be acted upon if reported to their line manager. The sexual safety culture will be re-assessed during 2024 to understand if there have been improvements.

An audit of sexual safety has also recently been completed in LYPFT by Yorkshire Audit. The audit reviewed the sites that were involved in the initial pilot as part of the Sexual Safety Collaborative. There was significant learning and actions from the audit which are being actioned and fed back through the Sexual Safety Group. This also includes recommendations to improve the policy, which is currently in progress.

Professions and Performance

1. Clinical Supervision

Nationally and locally there has been increased pressure on clinicians to meet the demands of increased workloads, which at times can lead to clinicians feeling overwhelmed. There are multiple ways of supporting staff but ensuring nursing colleagues have access to supervision when most needed is crucial. The Nursing Directorate set out a proposal for clinical supervision which incorporated a variety of options for nursing colleagues. Opportunistic supervision and observed practice are crucial in a fast pace clinical setting where nursing colleagues are adapting to rapidly changing clinical needs and demands.

Ward 4 at the Newsam Centre was identified as the pilot area to test out the proposal for clinical supervision. The pilot was carried out over a 3 month period with the plan to roll out this approach gradually to other clinical area, making any required changes identified during the pilot. During the pilot nursing staff were encouraged to use the following options as a form of clinical supervision: opportunistic supervision, reflective practice group and observed practice

The aim was to test if these options increased compliance with supervision and whether improvements were seen with staff wellbeing. Clinical restorative supervision groups were also available during the pilot stage. The restorative model of clinical supervision is recognised as an approach to support reflective practice, which can help build practitioners' resilience by focusing on the supervisee experience, aiming to sustain their wellbeing and their motivation at work.

The supervision handbook was also available as an optional extra, with the aim to support recording and documentation of clinical supervision. Time was afforded to engaging with the team to support the understanding of the benefits of clinical supervision to patient care and the wellbeing of colleagues prior to the commencement of the roll out and ensuring that there was an understanding of the framework and how this should be applied.

The pilot demonstrated that providing nursing staff with the options of clinical supervision increased compliance. Significant results have been evidenced with compliance rates shifting from 16% to above the Trust target at 86%. Nursing staff who attended the Clinical Restorative Supervision Groups reported an improvement in their wellbeing and a reduction in stress levels. Attendees also reported that the groups provided a safe space for them to openly discuss their emotions, and all reported that they would recommend the group to a colleague. The focus group concluded that the type of supervision nursing staff found most helpful was opportunistic, reporting that this type of supervision provided the opportunity to reflect and find potential solutions to complex clinical cases as required. The engagement process has commenced across other services with a plan to roll out this approach.

2. Workforce

We hosted approximately 65 2nd year nursing students from Leeds University at a welcome event this month. At the event we described our guaranteed job offer scheme and talked about what being a nurse meant to the Director of Nursing and things she would have wanted to be told at the same stage in her training. This was further complemented by market style representation from a significant proportion of our services. There was also the opportunity to experience mock career conversations and mock interviews to support the job offer process which will be made at the start of 2025.

The University of Leeds and Leeds Beckett University 3rd year nursing student cohorts have been smaller than usual; therefore, we have engaged with a lot more regional universities for recruitment of preceptees. Leeds Trinity is starting Mental Health Nurse Training and Social Work as part of a new degree programme from January 2024. We are working closely with the university to support this programme.

We have continued to offer a broad range of student placements for Allied Health Professional's, and this now includes Paramedics and Undergraduate Social Workers as well as continuing to offer 'Think Ahead' training for Social Workers. The AHP faculty is supporting new and innovative leadership and project-based placements and is currently offering 17 student placements within the faculty, on projects such as workforce recruitment, understanding the role of physiotherapy in learning disabilities and pastoral support for international recruits. We have also successfully appointed

5 international Occupational Therapists who are in post and 2 further Occupational Therapy Apprentices who are due to start training.

Currently we have 49 preceptees who have started in the Trust, with a further 12 colleagues who are due to start shortly. Prior to all the preceptees starting in their clinical roles, the PLDT have facilitated two study days called “transition training”.

The Legacy Mentor role is a new national post designed to support professional staff in the early stages of their careers, particularly those who have recently qualified and have completed Preceptorship. The role was established in August 2023 as a retention strategy and comprises of one WTE Band 6 post in a job-share arrangement which is flexibly delivered across 4 weekdays. The role complements the existing preceptorship and development programmes by creating an additional layer of support for those individuals who may request or require it.

The vision for the work over the 12-month funding commitment is to establish a support and development system that benefits individuals on a professional and personal level and assures a higher level of retention within the Trust. We will do this by supporting people to retain staff and to stay well and in the right roles for them.

The Trust is delighted to have been awarded the NHS Pastoral Care Quality Award in recognition of the hard work and dedication for the work in international recruitment. This is positive news for all concerned and will aid our ongoing commitment to recruitment and retention of staff.

3. Self-Harm and Suicide Prevention

The Trusts Ligature Anchor Point Assessment Procedure (C-0057) is due to be reviewed in January 2024. The organisation has been involved in a national piece of work alongside other Mental Health Trusts, NHS England and the CQC, related to the way in which these assessments are carried out and documented. This national ligature harm minimisation guidance has now been published by the Care Quality Committee, EbEs and Nursing academics.

In response to the national piece of work, LYPFT have reviewed the Ligature Anchor Point Assessment, which in future will be known as the Suicide Prevention Environmental Survey. Whilst the assessment process will continue to assess, manage, and mitigate risks related to ligature anchor points, the new procedure also focuses on other risks related to self-harm and suicide within the inpatient environments across the organisation. The procedure aims to identify risks, remove these where possible and mitigate residual risk through individualised risk assessment, care planning and the therapeutic environment and engagement. The final draft of the procedure is due to be reviewed in the Clinical Environments Group in November 2023 with the aim to have this ratified at the Policy and Procedures Group in December 2023.

A pilot took place on one of the male acute wards at the Becklin Centre during the summer. This provided the Trust with an opportunity to review the procedure further and provide feedback to the national team. Services were given the opportunity to comment on the initial draft and their feedback has been received.

Suicide Prevention Environmental Surveys are planned to commence in January 2024 across all inpatient sites. Members of the Nursing Directorate will be present to support the first assessment within each service. Matrons/Operational Managers, Ward Managers and Facilities and Estates colleagues will complete assessments together. Several of the Suicide Prevention Environmental Surveys are already confirmed, with work ongoing to ensure all assessments are booked in January or early February. Oversight of the outcomes of Suicide Prevention Environmental Surveys will be through the Clinical Environments Group. The Trusts risk register will be updated following the round of assessments.

In September 2021, a Task and Finish Group was established to review the Trusts Clinical Risk Assessment and Management Procedure (C-0011). The Task and Finish Group brought together a range of professionals from different backgrounds. A review of the procedure took place which was ratified by the Trusts Policies and Procedures Group in October 2022.

As part of the work, the group reviewed national guidance and information, particularly from the National Confidential Enquiry of Suicide including their review of clinical risk assessment tools. It is understood from the NCISH key messages relating to risk assessment in mental health services, that:

- Risk assessment tools should not be seen as a way of predicting future suicidal behaviour.
- Risk is not a number, and risk assessment is not a checklist. Tools if they are used (for example as a prompt or a measure of change) need to be simple, accessible, and should be considered part of a wider assessment process. Treatment decisions should not be determined by a score.
- Risk assessment is not a stand-alone or one-off process.
- Staff should be trained in how to assess, formulate, and manage risk.
- Families and carers should have as much involvement as possible in the assessment process, including the opportunity to express their views on potential risk.
- The management of risk should be personalised.

Although the procedure has been updated and the key messages used to support this, the work resulted in wider discussion relating to the reviewing of the use of the Functional Analysis Care Environments Risk Profile (FACE Risk Profile) and Safety Assessment and Management Plan (SAMP), within LYPFT, and bringing us in line with national guidance. It is important to note that NCISH state that no one tool is better than another however, the group aims to move away from the use of a risk assessment ‘tool’, and instead shift the emphasis on the clinical process of risk assessment, to be underpinned by training, and using a template that supports clinicians to document their findings in a structured but streamlined way. Due to a period of deployment into the Community Mental Health Services, the task and finish group was paused in January 2023.

A temporary Risk Assessment and Care Planning Development Lead post had been created to lead the ongoing review of the Clinical Risk Assessment process within

LYPFT. This individual came into post in August 2023 following the end of deployment into the Community Mental Health Services. With the commencement of the post holder, there has been significant progress in planning the review of our processes, with the task and finish group beginning again in November 2023. The Lead has worked with members of the organisation and a Project Manager to develop a clear plan to ensure that the aims of the group are achieved and evaluated.

The aim of the workstream will be to:

- Propose and consult on potential changes to the risk assessment tools used within the organisation.
- Work with clinical services to set clear expectations in relation to safety planning.
- Lead a roll out of potential changes to clinical practice.
- Evaluate the changes made within the organisation.
- Update the Clinical Risk Assessment and Management Procedure in line with any changes and ensure monitoring processes are in place as business as usual.
- Evaluate clinical risk and safety planning training and ensure these are updated to reflect any changes to practice or guidance.

Engagement from across the organisation has been positive.

The workstream requires close links with the Self Harm Strategy Development and Suicide Prevention workstreams and this has been clearly outlined within the group's terms of reference. A governance structure has been established to ensure clear lines of escalation and reporting.

Within the Suicide Prevention and Self-Harm Group there is due to be a review and refresh of the LYPFT Suicide Prevention Plan and the "10 ways to improve safety toolkit" from NCISH. Further actions include the introduction of a Self-Harm Strategy and associated work, including training for staff in line with the NICE Guidance. This will be supported by understanding the Trust's current position in relation to meeting the NICE Guidance for Self-Harm assessment, management and preventing recurrence. Baseline assessments have been completed.

Following the publication of the Suicide Prevention Strategy 2023-2028 the Trust has contributed to the development of the Leeds Public Health Action Plan for Suicide Prevention. The Trust continues to work with colleagues across the city to support the delivery of the actions. There remains ongoing work within the Trust to refresh the Trust Suicide Prevention Strategy and to align this work alongside the self-harm strategy. These two workstreams have some similarities and to ensure a joined-up approach reducing duplication and potential silo working. We continue to look at wide engagement within the Trust Group including clinical and professional colleagues, service users and/or carers as well as third sector and public health. A workplan is being developed to be shared for consideration within the Self Harm and Suicide Prevention Group

4. Clinical Governance

Clinical Governance Restructure

Following an extensive consultation process for choosing a preferred new clinical governance structure, it was collectively agreed by service representatives (mixture of Clinical Directors, Clinical Leads, Heads of Ops, Heads of Clinical Governance, and Professional Leads) and wider staff (through open forums and a survey) that the formation of a single Unified Clinical Governance Group (UCGG) is the preferred new arrangement that we wanted to move towards.

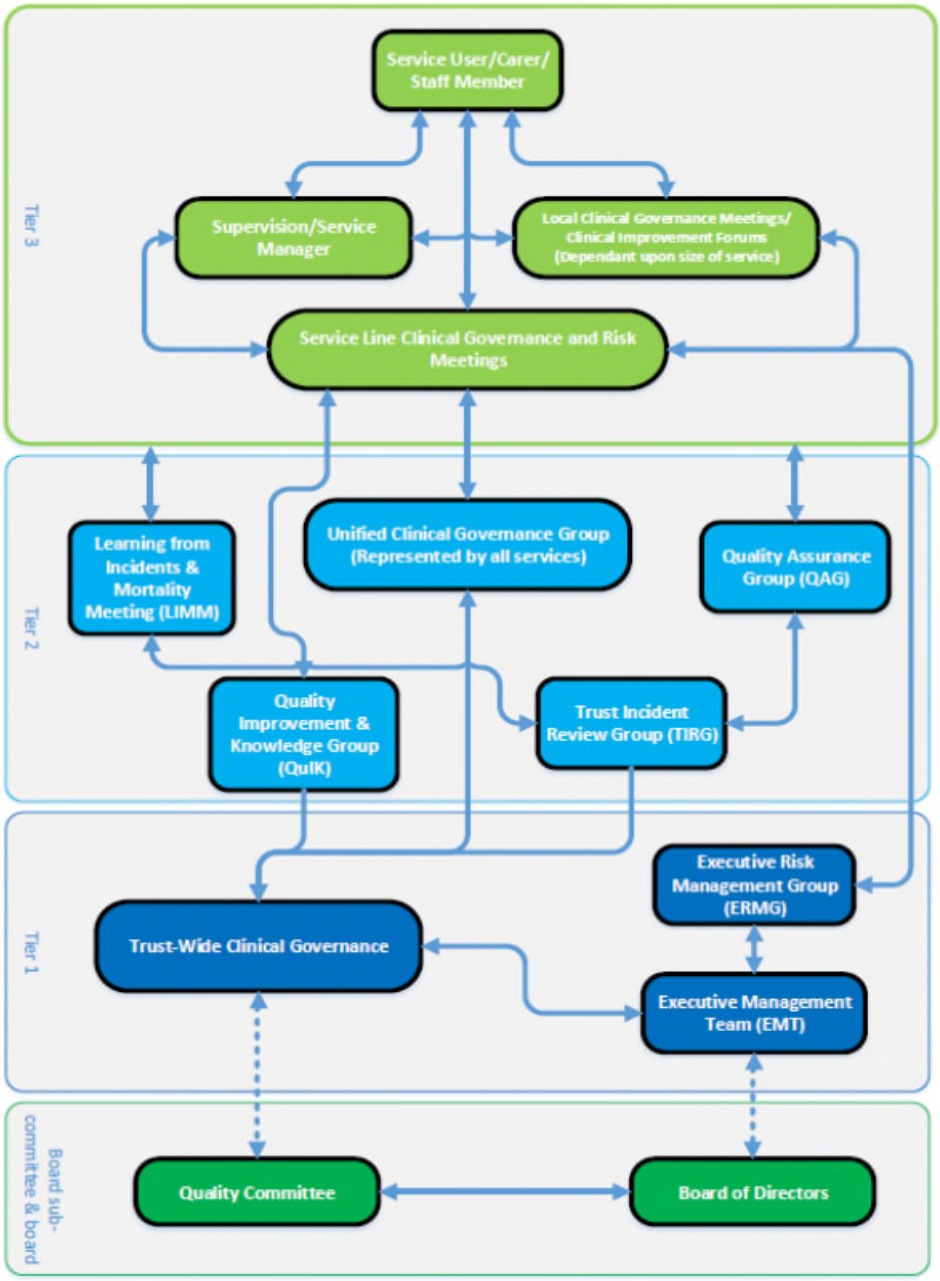
The diagram below shows the new UCGG and where it sits in our improved ward-to-board clinical governance structure. The new arrangement has been split into three tiers to make it easier for people to refer to a particular level of clinical governance.

Tier 3: Refers to the part of the structure closest to our front-line services and staff, who have multiple routes to share and receive information, learning and raise concerns related to clinical governance.

Tier 2: Consists of the meetings where people from different services can collectively meet to discuss escalated matters from Tier 3, collectively learn, problem solve, and share decisions to improve clinical care for our service users and carers.

Tier 1: Our Trust-wide Clinical Governance and other executive groups provides a good oversight structure and opportunity to escalate concerns, issues, learning and progress with activities to our executive colleagues.

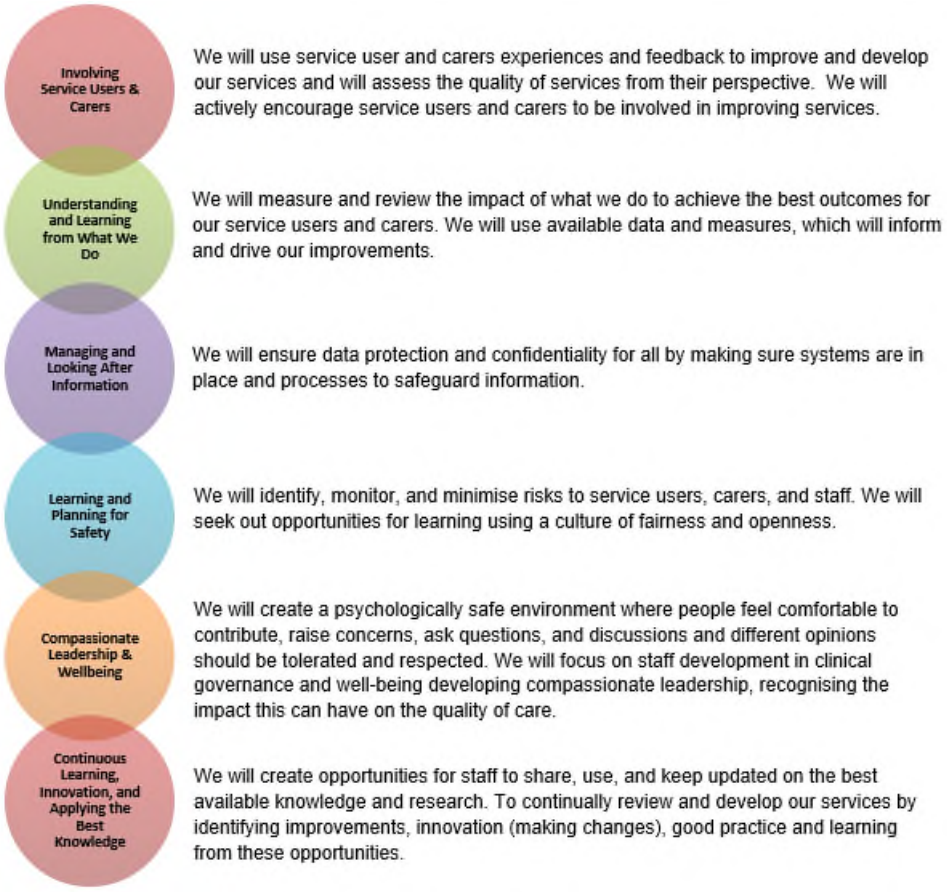
Board Sub-Committee and Board Meetings: This represents our highest level and path to providing organisational assurance & oversight.



LYPFT Clinical Governance Framework

In addition to the new structure, a clinical governance framework was also developed that could be consistently applied across all our meetings, documentation, and to be on the same page about what we mean by "clinical governance". After extensive discussions, the 7 pillars of clinical governance were voted as the best fit for our Trust, but with some further refinement to the language on pillars to better reflect our services and our service user/carer needs.

The result was the LYPFT Clinical Governance Framework (below) which we have updated to consider more up to date clinical practices and ways of working. It also links with our already adopted STEEEP (Safe, Timely, Effective, Efficient, Equitable, and Person Centred) quality model and IHI's Safe, Reliable and Effective Care Framework, which are the conditions for quality to flourish and are set out in our Trust's Quality Strategy.



Current Progress and Impact

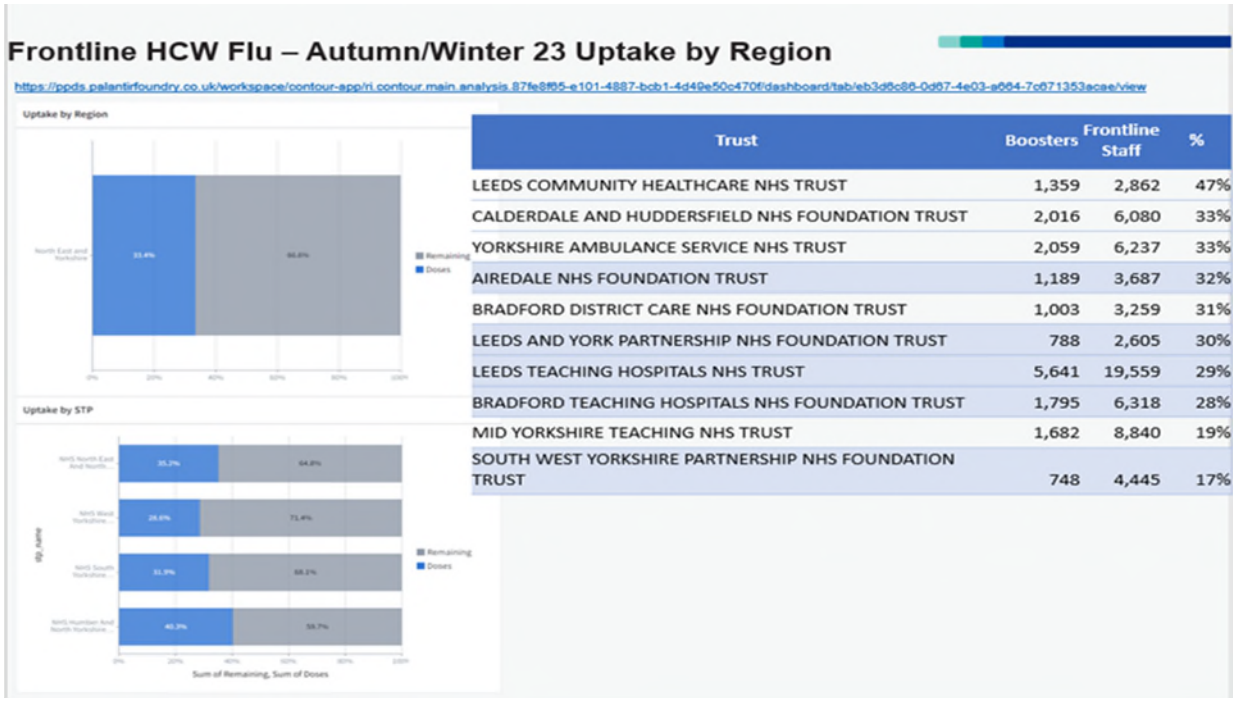
The Unified Clinical Governance Group continues to operate monthly with consistently good attendance across services. Continuous improvement actions identified for the meeting are being picked up via the learning section of the meeting. The first annual evaluation of the UCGG was completed following a survey that was sent out to members of the group. This report was finalised and fed back to the UCGG with opportunity to consider improvements.

The findings included improvements in collaboration and communication between services, as well as overall improvement in learning and discussion/decision making. Areas for further improvements were also noted, such as the need to close the communication loop between escalated matters to Trust Wide Clinical Governance (TWCG) and feeding back the outcome to UCGG. This has now been resolved through a standing agenda item at UCGG, which brings back feedback and learning from the previous months TWCG meeting, this is then shared back with Tier 3 services.

The Clinical Governance Team have been supporting services and staff with the implementation of the Clinical Governance Framework, using the toolkit resources that were developed and applying the framework in practice through Tier 3 terms of references and meeting agendas. The UCGG and TWCG terms of references and agendas have also been updated in line with the framework, supporting an improved, consistent 'ward to board' structure.

5. Infection Prevention and Control

The annual flu and Covid vaccination campaign for staff and patients began in October. The table below provides the current update by region on the flu/covid vaccination uptake.



Trust	Boosters	Frontline Staff	%
LEEDS COMMUNITY HEALTHCARE NHS TRUST	1,359	2,862	47%
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	2,016	6,080	33%
YORKSHIRE AMBULANCE SERVICE NHS TRUST	2,059	6,237	33%
AIREDALE NHS FOUNDATION TRUST	1,189	3,687	32%
BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	1,003	3,259	31%
LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	788	2,605	30%
LEEDS TEACHING HOSPITALS NHS TRUST	5,641	19,559	29%
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	1,795	6,318	28%
MID YORKSHIRE TEACHING NHS TRUST	1,682	8,840	19%
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	748	4,445	17%

The national target figure for covid vaccination uptake has been reduced to 59% from 75%. The flu target remains at 75%. A common theme is reluctance or outright opting not to have vaccines on offer by healthcare staff.

SVOC have given a verbal order for all staff to receive the covid vaccine from individual organisations. The PGD has been amended to reflect this, and the Executive Team have agreed to now offer the Covid vaccination to all staff groups. This has been widely communicated across the Trust and there has been an initial increase in uptake of non-clinical staff having the covid vaccine. Update by staff for the flu vaccine is currently at 32% and covid vaccine at 22%.

UKHSA guidance on managing healthcare staff with symptoms of a respiratory infection or a positive COVID 19 test result has been amended and staff are no longer required to carry out LFD testing when symptomatic. Therefore, the Trust will not provide staff with LFD test kits to test for covid infection when presenting with respiratory symptoms. If staff choose to complete an LFD test and this returns a positive result, they should stay off work until at least 5 days after the day of testing and return to work only if well enough to do so.

In light of new guidance from the Department of Health we are revisiting who we provide BCG vaccinations to. This will include:

- Employees carrying out aerosol generating procedures, to include Dentists, Dental Nurses, Hygiene Therapist and Speech and Language Therapists.
- Community staff who may have repeat visits to patients and accrue significant periods of time spent with the patient, this will include Community Nursing Staff, Community Psychiatric Nurses, and Health Visitors.
- Staff working in substance misuse departments.
- Staff working regularly with asylum seekers or TB patients.
- Staff who are from a high incidence TB country (see NICE guidance above)

The BCG healthcare vaccinations paper was approved and signed off at the Physical Health, Infection Control Committee meeting. The paper will now be circulated to all LYPFT service areas for implementation. The proposal is to continue to offer IGRA testing to all new staff who will have contact with patients and have not had BCG vaccination, staff who cannot provide documentary evidence of an IGRA test within 5 years, or a BCG scar check in an OH department. If positive this will be followed up with a chest clinic/GP referral, but if negative, there will only be a progression to BCG in the staff roles mentioned in section one of this document.

Conclusion

The Board is asked to receive the findings of this report and acknowledge that whilst we continue to have challenges, it is important to recognise the commitment to continue to strive and develop the best and safest care and clinical safety.

We continue to work locally and across the ICB to learn from partners and share areas of good practice.

As we move on from Covid both nationally and locally we are now seeing a return to pre covid planning within our infection control practices. This is positive for the organisation.

Incredible work has been undertaken in supervision and this is acknowledged within the report. In addition, and finally the Board is asked to recognise the work that is ongoing with regards to all aspects of clinical safety and patient care.

Nichola Sanderson
Director of Nursing, and Professions
30 November 2023

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:	Safer staffing
DATE OF MEETING:	30th 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 July 2023 to 30th September 2023.

The exception reports identify x6 Registered Nurse non-compliant duties where there was no RN on duty across this period which occurred within the Forensic Service and Learning Disabilities Service.

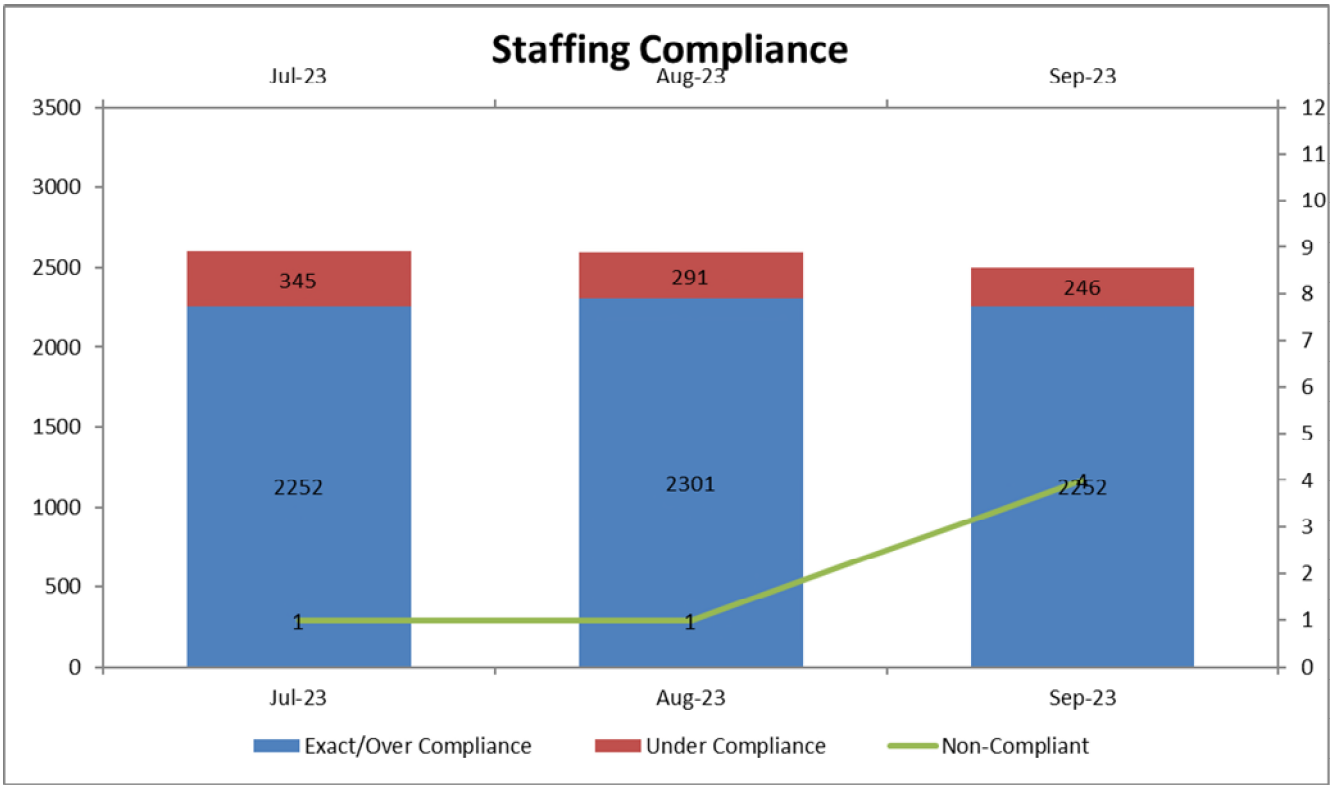
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes please set out what action has been taken to address this in your paper
	No	

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 – July, August, and September 23



	Number of Shifts		
	July	**August**	**September**
Exact/Over Compliance	2252	2301	2252
Under Compliance	345	291	246
Non-Compliant	1	1	4

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

Mitigating Factors:

Reduced Registered Nurse 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 July, August, and September 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:
The compliance data demonstrated an increase in the number of shifts which were staffed exactly as planned or staffed above the planned number of Registered Nurse (RN) and Health Support Worker (HSW) duties during the months of July, August, and September 2023.

Under Compliant Shifts:
The compliance data demonstrates an increase in the number of shifts during the 3 month period that had fewer than the planned number of Registered Nurses and Health Support Workers on each shift. Where there are fewer than planned Registered Nurses on shift, it is usual for one or more extra Health Support Workers to back fill the vacant duty and ensure safe staffing levels where a Registered Nurse is not available to fill the shift.

*(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 (Exceptions):
This metric represents the number of shifts where there was no Registered Nurse on duty. During July, August, and September this occurred on x 6 occasions.

York Forensics, Clifton House, Riverfields Ward
30th July 23, 6th August 23, 10th Sept, 18th Sept and 23rd Sept 2023
All duties without Registered Nurse cover occurred on the night duty, where late sickness absence had occurred across the service. The staffing escalation procedure was enacted; however, Registered Nurse cover was not identified and therefore to mitigate the absence of a Registered Nurse on duty, the number of substantive Health Support Workers from the service were increased where possible (2 of the duties). The Registered Nurse based themselves on Bluebell Ward or Westerdale Ward, whereby a greater service user dependency and clinical need was identified than of Riverfields Ward, a recovery and rehabilitation ward where a significant proportion of service users self-medicate as part of their recovery plan. A Registered Nurse from the adjacent ward provided support and held the medication keys. The Registered Nurse from the day duty worked beyond their duty finish time to administer any nighttime medication.

Woodlands Square
3rd September 2023
This occurred on the night duty due to late sickness absence. The remaining Registered Nurse in the service was deployed to Woodlands 3 and provided support throughout the duty and the Nursing Associate remained on Woodlands 2. The Nursing Associate administered medication and was responsible for shift co-ordination which falls within their existing roles and responsibilities.

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 27%. There is a 46% Band 5 Registered Nurse vacancy rate and 44% Occupational Therapist vacancy rate across the service. Sickness absence combining of both long-term and short-term, is at 9.32% 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 the use of regular bank/agency Registered Nurses are used, and block bookings are made to support consistency and continuity of care.

The requirement for additional staffing above the planned establishment has been particularly prevalent within the male acute wards who have experienced the need to use high levels of enhanced observation and engagement. There has been a high number of incidences of self-harm in the female acute wards relating to a small number of service users, with some of these incidents requiring escort and treatment at the acute hospital trust.

Deployment of staff within the Acute Service has been reduced in frequency but continues to occur on occasion across the service to maintain appropriate staffing numbers and competencies to deliver care to this service user group.

The service has successfully recruited x20 Preceptee Registered Nurses who will commence during October 2023 and x5 International Registered Nurses who are awaiting a confirmed start date. The vacancy rate for Band 5 Registered Nurses will reduce significantly following commencement of these posts. In addition, an internationally recruited Occupational Therapist has recently commenced employment within the service. All wards have an Activity Coordinator in post, this new role within the service has increased the offer of therapeutic activities and as a result a decrease in incidents has been evident since commencement of these roles.

Older People's Services (Mount Wards 1, 2, 3 and 4)

The Mount currently have x3 Band 6 Registered Nurse vacancies and x17 Band 5 Registered Nurse vacancies across the service. There is an anticipated reduction in vacancies over coming weeks as those in the recruitment pipeline, progress and commence in post including x4 Preceptee Registered Nurses.

The sickness rate is 8.31% across the service which falls above the Trust target.

There has been a recent uplift to the Band 3 establishment in the service which has impacted the vacancy rate while the service recruited into the new posts. This has been due to the introduction of three Activity Coordinators across the Dementia Wards. They have also introduced Psychology Assistants within each service at the Mount which are currently in the recruitment process.

Members of the responsive workforce are currently supporting the Mount wards. During September there were infection outbreaks over 2 weeks at the Mount which impacted on higher numbers of staff required to adhere to the infection control protocols. The use of enhanced observation remains high to support service users and has in turn impacted on an increase in staffing levels.

Mill Lodge

Mill Lodge has no Registered Nurse vacancies. The sickness rate is 6.17%. There are however x2 Registered Nurses currently on maternity leave which has been backfilled through substantive Registered Nurses or Health Support Workers working voluntary additional duties above their contracted hours or through the use of bank and agency staffing.

In September there was a significant increase in incidents compared to August, which were attributed to a small number of young people who were admitted during this month with complex needs and a high level of dependency, including support to administer Naso Gastric feeds. The number of staff on duty was increased during this period to respond to this.

Red Kite View (Skylark and Lapwing)

Red Kite View continues to have significant Registered Nurse vacancies. The vacancy rate for Registered Nurses in September was 59% for PICU and 61% for GAU. The service has X1 Registered Nurse currently on maternity leave. Three Preceptee Registered Nurses have been recruited, however will not commence in post until 2024. There have been x 2 Band 5 Registered Nurses commence in September. The use of bank and agency staff are being used to support the service which also includes the use of the responsive workforce team and training specific to working with young people is being delivered to this group of staff, to develop the required competencies and skills.

PICU continues to operate with a reduced number of beds with a risk assessment being carried out regarding staffing needs for each referral to aid decision making.

The service has seen a reduction in self-harm incidents since May 2023.

GAU (Skylark) currently has a sickness rate of 8.75% with 31% of this being related to mental health/stress which the service has seen a gradual reduction of over the last 12 months. PICU (Lapwing) has a current sickness rate of 6.14% in line with the Trust target. There has been no reported long-term sickness in September.

Asket House and Asket Croft (Rehabilitation and Recovery wards)

Asket Croft has no current Registered Nurse vacancies. The sickness absences rate is currently 11.14%. This is made up of a combination of both long-term and short-term absence. The service works closely with Asket House to share resources across

the service, to ensure any staffing gaps are covered and safety and quality is maintained.

Asket House currently has x1 Band 5 Registered Nurse vacancy. In addition, there is a part-time Band 5 Registered Nurse secondment opportunity. Both positions are currently in the recruitment process. The service has increased the Occupational Therapists provision following a skill mix review with successful recruitment of a Band 5 Occupational Therapist. The sickness absence rate is currently meeting the Trust target of 6%. Substantive staff have voluntarily worked additional duties to support any vacant duties resulting from sickness and any non-effective duties and there has therefore been a reduced reliance on bank and agency staffing.

Newsam Ward 5 (Locked Rehabilitation)

Ward 5 has an overall Registered Nurse vacancy rate of 28% which equates to 3 Registered Nurse vacancies. Registered Nurse vacancies are mitigated using bank and agency staffing and a number of block bookings have been made to support the continuity of care to the service user group. The service is currently over recruited for Health Support Workers from previous deployments. This increases the number of regular staff on the ward and the backfill of Registered Nurse duties.

The newly recruited Advanced Nurse Practitioner will commence role in November 2023. This role will provide senior leadership to the nursing team with the intention to aid development and support the retention of the nursing workforce.

Sickness absence rates have seen a slight decrease to 12% across the data period, which is made up of several short-term absences and x 1 Registered Nurse long term absence.

The ward has recently recruited a Band 5 Registered Nurse and a Band 5 International Registered Nurse who are awaiting confirmation of start dates.

Newsam Ward 6 Yorkshire Centre for Eating Disorders (YCED)

Ward 6 has an overall vacancy rate of 24% which includes a 10.24% Registered Nurse vacancy. The ward continues to experience the need for increased levels of enhanced observations and therefore the need to increase 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 and Agency Health Support Workers to support consistency and continuity of care.

The ward has an overall sickness absence rate of 4.84% which is predominantly short-term sickness absences. 30% of these sickness absences have been identified as stress/mental health which are predominantly non-work related.

Mother and Baby Unit

The ward has x 1 Registered Nurse vacancy and there are x2 Registered Nurses currently on maternity leave which have been backfilled through substantive Registered Nurse or Health Support Workers working voluntary additional duties above their contracted hours or through the use bank and agency staffing.

Sickness absence rates fall below the Trust average at 4.08%.

Crisis Assessment Unit (CAU)

The ward has no Registered Nurse vacancies and 1.5 WTE Health Support Worker vacancies. The sickness absence rate is 8%. Sickness absences are a combination of both long-term and short-term absences with 17% being related to stress/mental health.

The CAU is working closely with the Acute Inpatient Wards to support capacity and flow and staffing has been increased to support a higher level of acuity and dependency when required.

NICPM

NICPM has a 30% Band 5 Registered Nurse vacancy rate and no Health Support Worker vacancies. This has required the use of regular bank and agency staff to support the required staffing levels and Registered Nurse vacancy rates have been backfilled through Health Support Workers when no Registered Nurse has been available. Sickness absence rates have seen a decrease to 4.19%.

The service has successfully appointed an experienced Band 5 Registered Nurse who has recently commenced in post. There are x2 Band 5 Preceptee Registered Nurses who are due to commence in post with x1 Band 5 Registered Nurse vacancy remaining. The service was not successful in recruiting an experienced RN and therefore will open the recruitment process to newly qualified nurses.

Registered Nurse vacancies had resulted in the temporary reduction in beds from 8 to 6. However, the additional two beds were opened in October 2023 following the commencement in post of the newly recruited Registered Nurses.

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

Ward 2 (female) has a vacancy rate of 22% for Registered Nurses and 19.8% for Health Support Workers. Sickness absence is above Trust target at 30.2% for Registered Nurses and 11.6% for Health Support Workers. The vacancy and sickness absence gaps have been mitigated through the support of the responsive workforce team and the use of bank and agency staffing. Additional support has been identified through the Leadership Team, HR, and Occupational Health to address the levels of sickness absence.

Ward 2 (A+T) has also experienced a reduced vacancy rate of 10% for Registered Nurse vacancies from previous months. There are no Health Support Worker vacancies. Sickness absence is above Trust target at 20.1% for Registered Nurses and 13% for Health Support Workers. None of the absences are work related.

Ward 3 has a vacancy rate of 40% for Registered Nurses however there are no Health Support Worker vacancies. The sickness rate is below the Trust target at 4.2% for Registered Nurses and 3.4% for Health Support Workers.

There are x3 Preceptee Registered Nurses who have recently commenced employment which has supported the reduction of Registered Nurse vacancies across the service. An ongoing recruitment campaign for the service continues to take place and there will be a specific focus on the recruitment of Trainee Nursing Associate positions for all three wards.

Clifton House (Forensic wards Riverfields, Westerdale and Bluebell)

The vacancy rate has reduced at Clifton House to 14% with a 19% Registered Nurse vacancy rate which consists of x4 Band 6 Registered Nurses and x2 Band 5 Registered Nurses. The vacancy gaps have been mitigated through internal deployment of staff within the service and the use of regular bank and agency Registered Nurses to support consistency and continuity of care. 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.

X3 Preceptee Registered Nurses have commenced employment at Clifton House, this has supported the reduction of the Band 5 Registered Nurse vacancy.

The service has an 8.99% sickness rate. Sickness absence includes some long-term sickness absences within the service, however no themes for absence which have been identified.

There have been five duties which have not had a Registered Nurse on duty (see non–compliant duties exceptions report) with mitigations being put in place to reduce the safety and quality impact on these duties. The reintroduction of the Forensic Night Coordinator, which is a supernumerary Senior Registered Nurse role across the Forensic Service, has been re-commenced in November as Registered Nurse vacancies have reduced. This is therefore likely to reduce the likelihood of a ward having no Registered Nurses available to take charge of the duty.

2 and 3 Woodland Square

Woodland Square continues to experience staffing challenges with a current overall vacancy rate of 19% which includes a 28% Registered Nurse vacancy across both wards. The vacancy gaps have been mitigated through internal redeployment and the block booking of x 2 Agency Registered Nurses who predominantly work night duties.

Work continues to be progressed to upskill the staff team to work competently across both clinical areas in the service.

The service has not been successful in recruiting to the Registered Nurse vacancies. However, following a skill mix review and quality impact assessment, the service plans to recruit a Band 6 Occupational Therapist and Band 4 NA as opposed to a Registered Nurse to enhance the clinical offer. The Band 6 Occupational Therapy post, which is new to the service, 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 2 WSQ at 3.10% and 3 WSQ at 5.69%. There has been one duty which has been non complaint with no Registered Nurse on duty (see non–compliant duties exception report).

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 Registered Nurse vacancies.

It is acknowledged that our reliance on newly Registered Nurses continues to be our most significant means of recruiting Band 5 Registered Nurses into the organisation, despite our continuous attempts to attract experienced Registered Nurses. September has seen the start of approximately 60 newly qualified Nurses (Preceptees) joining the organisation with this continuing throughout October. The Preceptee Nurses will require a period of induction and transition and will be supported through a preceptorship framework over the next 12 months, however the positive impact on service user care and deliver is likely to be seen and experienced over the next few months.

Staffing pressures where Registered Nurse vacancies exist 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 several of the Inpatient Services where vacancies are high.

It has been reported that the daily deployment of staff previously required to ensure safe staffing numbers has reduced, alongside the need for those roles that usually sit outside of safer staffing numbers to deliver or support clinical care - Practice Development Nurses, Occupational Therapists, Forensic Shift Coordinator, to step into the clinical numbers.

Work across the organisation continues through 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.

The Biannual data collection of the Mental Health Optimal Staffing Tool (MHOST), an evidence-based set of care level indicators to assess patient acuity and dependency has taken place in September, and the outputs will be reviewed by the Safer Staffing Group in November. Services are currently identifying the indicators required to triangulate the data, which will in turn support the establishment review of our inpatient areas.

LYPFT continues to place a clear focus on staff wellbeing through the priorities set out in the People Plan, 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 July 23

Fill rate indicator return

Staffing: Nursing, Care Staff and AHPs

Ward name	Cumulative count over the month of patients at 23:59 each day	Care Hours Per Patient Day (CHPPD)							Day				Night				Allied Health Professionals	
		Registered Nurses/Midwives	Non-registered Nurses/Midwives	Registered Nursing Associates	Non-registered Nursing Associates	Registered allied health professionals	Non-registered allied health professionals	Overall	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - registered allied health professionals (AHP) (%)	Average fill rate - non-registered allied health professionals (AHP) (%)
2 WOODLAND SQUARE	104	10.1	8.3	0.0	0.0	0.0	0.0	18.4	93%	106%	-	-	103%	123%	-	-	-	-
3 WOODLAND SQUARE	90	10.6	21.0	1.6	1.5	0.0	0.0	34.5	80%	197%	100%	100%	57%	146%	100%	100%	-	-
ASKET CROFT	565	1.7	2.6	0.0	0.0	0.5	0.0	4.9	105%	97%	-	-	113%	94%	-	-	100%	-
ASKET HOUSE	487	1.7	1.9	0.0	0.0	0.2	0.1	3.9	117%	77%	-	-	100%	100%	-	-	100%	100%
BECKLIN CAU	152	6.9	17.0	1.3	0.0	0.1	0.0	25.2	82%	136%	100%	-	93%	132%	100%	-	100%	-
BECKLIN WARD 1	693	2.2	6.2	0.2	0.0	0.2	0.0	8.8	77%	299%	100%	-	97%	323%	100%	-	100%	-
BECKLIN WARD 3	679	2.3	2.7	0.3	0.1	0.1	0.2	5.6	79%	180%	100%	100%	89%	131%	100%	-	100%	100%
BECKLIN WARD 4	687	2.1	4.2	0.0	0.0	0.2	0.1	6.6	66%	256%	100%	-	92%	187%	-	-	100%	100%
BECKLIN WARD 5	678	2.1	4.6	0.1	0.1	0.0	0.2	7.1	66%	226%	100%	100%	94%	192%	-	-	-	100%
MOTHER AND BABY AT THE MOUNT	136	9.1	18.0	0.4	0.0	0.0	0.0	27.5	85%	94%	100%	-	70%	190%	-	-	-	-
NEWSAM WARD 1 PICU	342	4.1	10.2	0.1	0.0	0.4	0.0	14.7	73%	124%	100%	-	84%	134%	-	-	100%	-
NEWSAM WARD 2 FORENSIC	332	2.7	14.4	0.0	0.0	0.4	0.3	17.7	69%	398%	-	-	103%	324%	-	-	100%	100%
NEWSAM WARD 2 WOMENS SERVICES	284	3.1	12.0	0.0	0.0	0.4	0.5	16.0	63%	344%	-	-	100%	202%	-	-	100%	100%
NEWSAM WARD 3	429	2.0	5.8	0.0	0.0	0.4	0.2	8.5	67%	226%	-	-	103%	152%	-	-	100%	100%
NEWSAM WARD 4	675	2.3	5.0	0.0	0.0	0.1	0.2	7.7	80%	339%	-	100%	89%	218%	-	-	100%	100%
NEWSAM WARD 5	504	2.3	4.3	0.0	0.0	0.8	0.3	7.7	92%	103%	-	-	68%	132%	-	-	100%	100%
NEWSAM WARD 6 EDU	274	4.4	14.1	0.0	0.0	0.9	0.6	19.9	103%	464%	-	-	60%	250%	-	-	100%	100%
NICPM LGI	156	8.9	4.7	0.0	0.0	2.3	0.0	15.9	109%	41%	-	-	88%	123%	-	-	100%	-
RED KITE VIEW GAU	392	3.2	10.1	0.7	0.0	0.0	0.0	13.9	62%	133%	100%	-	67%	121%	100%	-	-	-
RED KITE VIEW PICU	99	11.0	46.4	1.3	0.0	0.0	0.0	58.7	45%	125%	100%	-	77%	139%	100%	-	-	-
THE MOUNT WARD 1 NEW (MALE)	418	3.7	12.9	0.0	0.0	0.0	0.0	16.6	114%	177%	-	-	95%	263%	-	-	-	-
THE MOUNT WARD 2 NEW (FEMALE)	400	3.4	13.1	0.7	0.2	0.0	0.0	17.3	92%	238%	100%	100%	87%	261%	100%	100%	-	-
THE MOUNT WARD 3A	499	2.7	5.4	0.3	0.0	0.0	0.0	8.3	73%	129%	100%	-	91%	153%	100%	-	-	-
THE MOUNT WARD 4A	642	2.1	5.6	0.0	0.1	0.0	0.0	7.9	77%	177%	-	100%	92%	198%	-	100%	-	-
YORK - BLUEBELL	274	3.0	8.7	0.8	0.0	0.4	0.3	13.1	60%	90%	100%	-	100%	124%	-	-	100%	100%
YORK - MILL LODGE	286	5.5	6.7	0.2	0.0	1.3	0.7	14.4	81%	97%	100%	-	79%	121%	-	-	100%	100%
YORK - RIVERFIELDS	182	4.2	7.7	0.0	0.0	0.5	0.9	13.3	53%	143%	-	-	97%	113%	-	-	100%	100%
YORK - WESTERDALE	190	5.6	14.5	0.0	0.4	0.6	0.6	21.7	47%	153%	-	100%	101%	133%	-	-	100%	100%

Safer Staffing: Inpatient Services August 23

Fill rate indicator return

Staffing: Nursing, Care Staff and AHPs

Ward name	Cumulative count	Care Hours Per Patient Day (CHPPD)							Day				Night				Allied Health	
		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
2 WOODLAND SQUARE	115	9.3	7.3	0.0	0.0	0.0	0.0	16.6	97%	113%	-	-	100%	113%	-	-	-	-
3 WOODLAND SQUARE	108	8.6	18.1	0.6	0.8	0.0	0.0	28.2	79%	191%	100%	100%	86%	135%	100%	100%	-	-
ASKET CROFT	586	1.5	2.6	0.0	0.0	0.7	0.0	4.8	88%	98%	-	-	100%	102%	-	-	100%	-
ASKET HOUSE	495	1.8	1.7	0.0	0.0	0.2	0.2	3.9	122%	66%	-	-	110%	100%	-	-	100%	100%
BECKLIN CAU	169	6.7	15.3	0.7	0.0	0.1	0.0	22.8	90%	134%	100%	-	96%	128%	100%	-	100%	-
BECKLIN WARD 1	706	2.4	5.2	0.1	0.0	0.2	0.5	8.3	88%	222%	-	-	97%	290%	100%	-	100%	100%
BECKLIN WARD 3	693	2.0	3.0	0.2	0.1	0.1	0.2	5.6	76%	178%	100%	100%	81%	164%	100%	-	100%	100%
BECKLIN WARD 4	679	2.1	4.7	0.0	0.0	0.2	0.2	7.1	63%	293%	100%	-	91%	215%	-	-	100%	100%
BECKLIN WARD 5	691	2.1	4.1	0.1	0.1	0.0	0.2	6.6	76%	202%	100%	100%	87%	207%	100%	100%	-	100%
MOTHER AND BABY AT THE MOUNT	159	8.7	12.0	0.3	0.0	0.0	0.0	21.0	92%	80%	100%	-	81%	137%	-	-	-	-
NEWSAM WARD 1 PICU	362	3.8	9.8	0.0	0.0	0.8	0.0	14.4	70%	131%	-	-	79%	126%	-	-	100%	-
NEWSAM WARD 2 FORENSIC	354	2.7	11.5	0.0	0.0	0.3	0.3	14.9	78%	307%	-	-	101%	280%	-	-	100%	100%
NEWSAM WARD 2 WOMENS SERVICES	285	3.4	11.0	0.0	0.0	0.5	0.4	15.2	80%	315%	-	-	101%	187%	-	-	100%	100%
NEWSAM WARD 3	434	2.1	5.7	0.0	0.0	0.3	0.3	8.3	84%	215%	-	-	115%	149%	-	-	100%	100%
NEWSAM WARD 4	645	2.3	5.2	0.0	0.0	0.1	0.2	7.9	73%	354%	100%	-	92%	220%	-	-	100%	100%
NEWSAM WARD 5	525	2.1	4.4	0.0	0.0	0.7	0.2	7.4	87%	109%	-	-	64%	141%	-	-	100%	100%
NEWSAM WARD 6 EDU	239	4.4	14.3	0.0	0.0	1.1	0.1	20.0	88%	353%	-	-	53%	216%	-	-	100%	100%
NICPM LGI	186	7.2	4.5	0.0	0.0	2.0	0.0	13.6	99%	52%	-	-	90%	124%	-	-	100%	-
RED KITE VIEW GAU	388	3.4	10.5	0.3	0.0	0.0	0.0	14.2	62%	131%	100%	-	84%	116%	-	-	-	-
RED KITE VIEW PICU	118	10.1	42.4	1.1	0.0	0.0	0.0	53.6	55%	129%	100%	-	75%	139%	100%	-	-	-
THE MOUNT WARD 1 NEW (MALE)	405	3.7	17.8	0.0	0.0	0.0	0.0	21.5	115%	266%	-	-	84%	342%	-	-	-	-
THE MOUNT WARD 2 NEW (FEMALE)	434	3.0	14.8	0.9	0.1	0.0	0.0	18.8	98%	337%	100%	100%	78%	316%	100%	-	-	-
THE MOUNT WARD 3A	531	2.5	5.1	0.2	0.0	0.0	0.0	7.8	78%	129%	100%	-	85%	157%	100%	-	-	-
THE MOUNT WARD 4A	615	2.2	6.0	0.0	0.0	0.0	0.0	8.2	81%	176%	-	-	87%	182%	-	-	-	-
YORK - BLUEBELL	279	3.4	9.8	0.3	0.0	0.4	0.6	14.5	82%	94%	100%	-	111%	138%	-	-	100%	100%
YORK - MILL LODGE	261	5.6	9.3	0.0	0.3	1.6	0.7	17.5	79%	127%	-	100%	67%	165%	-	-	100%	100%
YORK - RIVERFIELDS	186	3.9	8.0	0.0	0.0	0.0	0.8	12.8	49%	156%	-	-	94%	110%	-	-	-	100%
YORK - WESTERDALE	180	5.2	16.4	0.0	0.5	0.5	0.8	23.4	38%	197%	-	100%	101%	131%	-	-	100%	100%

*** Allied health professionals refers only to Occupational therapists that are included in the ward establishment**

Safer Staffing: Inpatient Services September 23

Fill rate indicator return

Staffing: Nursing, Care Staff and AHPs

Ward name	Cumulative count over the month of patients at 23:59 each day	Care Hours Per Patient Day (CHPPD)							Day				Night				Allied Health Professionals	
		Registered Nurses/Midwives	Non-registered Nurses/Midwives	Registered Nursing Associates	Non-registered Nursing Associates	Registered allied health professionals	Non-registered allied health professionals	Overall	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - registered allied health professionals (AHP) (%)	Average fill rate - non-registered allied health professionals (AHP) (%)
2 WOODLAND SQUARE	100	9.5	9.2	0.1	0.0	0.0	0.0	18.8	89%	131%	100%	-	100%	127%	-	-	-	-
3 WOODLAND SQUARE	104	8.5	17.1	1.4	0.9	0.0	0.0	27.8	77%	190%	100%	100%	100%	131%	100%	100%	-	-
ASKET CROFT	596	1.3	2.5	0.0	0.0	0.8	0.0	4.6	80%	98%	-	-	100%	103%	-	-	100%	-
ASKET HOUSE	460	1.9	1.9	0.0	0.0	0.5	0.0	4.2	123%	71%	-	-	107%	110%	-	-	100%	-
BECKLIN CAU	142	7.7	19.6	0.8	0.0	0.1	0.0	28.2	86%	138%	100%	-	89%	147%	100%	-	100%	-
BECKLIN WARD 1	685	2.1	5.7	0.2	0.0	0.2	0.4	8.6	70%	288%	100%	-	93%	285%	100%	-	100%	100%
BECKLIN WARD 3	656	2.2	3.9	0.4	0.0	0.2	0.2	6.9	84%	247%	100%	100%	84%	237%	100%	-	100%	100%
BECKLIN WARD 4	674	2.3	4.1	0.0	0.0	0.2	0.1	6.7	77%	232%	-	-	102%	191%	-	-	100%	100%
BECKLIN WARD 5	633	2.2	5.9	0.1	0.0	0.0	0.2	8.3	87%	249%	-	100%	77%	289%	100%	-	-	100%
MOTHER AND BABY AT THE MOUNT	191	6.8	9.9	0.0	0.0	0.0	0.0	16.7	91%	75%	-	-	80%	148%	-	-	-	-
NEWSAM WARD 1 PICU	356	3.7	11.1	0.0	0.0	0.8	0.0	15.6	70%	138%	-	-	79%	171%	-	-	100%	-
NEWSAM WARD 2 FORENSIC	331	3.2	10.0	0.1	0.0	0.2	0.0	13.5	98%	338%	100%	-	100%	395%	-	-	100%	100%
NEWSAM WARD 2 WOMENS SERVICES	240	4.1	12.9	0.0	0.0	0.4	0.5	17.9	87%	323%	-	-	97%	214%	-	-	100%	100%
NEWSAM WARD 3	410	2.3	5.5	0.0	0.0	0.3	0.3	8.6	124%	172%	100%	-	100%	132%	-	-	100%	100%
NEWSAM WARD 4	624	2.5	4.0	0.0	0.0	0.1	0.1	6.8	82%	232%	100%	-	93%	170%	100%	-	100%	100%
NEWSAM WARD 5	508	2.2	4.2	0.0	0.0	1.0	0.1	7.5	91%	109%	-	-	65%	135%	-	-	100%	100%
NEWSAM WARD 6 EDU	270	4.8	18.0	0.1	0.0	1.4	0.0	24.3	116%	711%	100%	-	70%	300%	-	-	100%	-
NICPM LGI	180	7.5	4.7	0.0	0.0	1.6	0.0	13.8	101%	61%	-	-	93%	110%	-	-	100%	-
RED KITE VIEW GAU	359	3.5	10.9	0.5	0.0	0.0	0.0	14.9	60%	137%	100%	-	84%	122%	100%	-	-	-
RED KITE VIEW PICU	87	13.9	53.7	1.4	0.0	0.0	0.0	69.0	56%	146%	100%	-	92%	118%	-	-	-	-
THE MOUNT WARD 1 NEW (MALE)	408	3.4	14.9	0.0	0.0	0.0	0.0	18.3	106%	242%	-	-	83%	306%	-	-	-	-
THE MOUNT WARD 2 NEW (FEMALE)	434	3.0	16.2	0.4	0.3	0.0	0.0	19.8	82%	267%	100%	100%	78%	342%	100%	100%	-	-
THE MOUNT WARD 3A	492	2.5	8.2	0.2	0.0	0.0	0.0	10.9	69%	201%	100%	-	90%	248%	100%	-	-	-
THE MOUNT WARD 4A	619	2.1	5.5	0.0	0.1	0.0	0.0	7.7	82%	174%	-	100%	86%	174%	-	100%	-	-
YORK - BLUEBELL	294	3.4	8.0	0.4	0.0	0.5	0.4	12.8	88%	97%	100%	-	118%	106%	-	-	100%	100%
YORK - MILL LODGE	240	6.2	8.6	0.0	0.4	1.4	0.9	17.5	82%	107%	-	100%	76%	138%	-	-	100%	100%
YORK - RIVERFIELDS	173	4.6	8.8	0.0	0.0	0.8	0.6	14.8	62%	166%	-	-	90%	120%	-	-	100%	100%
YORK - WESTERDALE	171	5.7	15.7	0.0	0.0	0.6	0.4	22.4	43%	179%	-	-	108%	109%	-	-	100%	100%

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:	Director of People and Organisational Development Quarterly Report
DATE OF MEETING:	30 November 2023
PRESENTED BY: (name and title)	Darren Skinner, Director of People and Organisational Development
PREPARED BY: (name and title)	Dr Frances Dodd, Associate Director People Experience Fiona Sherburn, Associate Director for People Resourcing and OD Holly Tetley, Associate Director of Employment

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 of the Director of People and Organisational Development for the Board of Directors at Leeds and York Partnership NHS Foundation Trust, sets out the detail of work undertaken by the directorate during the third quarter of 2023 (August 2023 – November 2023) and the detail around issues pertaining to our organisational workforce situation and the work undertaken to mitigate, address and support our workforce and workforce issues.

Quarter three continued to see significant challenges for the organisation in terms of workforce particularly in respect of national recruitment and retention issues, pay disputes between the government and various trade unions and significant system financial pressures and cost saving and efficiency measures required, all impacting on the work of the People and Organisational Development team. We have commenced work as part of Our People Plan refresh with planning of engagement with colleagues across the Trust, for a launch in April 2024. The format of this report is set out by each function within the directorate, the key achievements in the third quarter, as well as challenges and priorities going forward.

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 contents of this report.

MEETING OF THE BOARD OF DIRECTORS

30 November 2023

Director of People and Organisational Development Quarterly Report

Executive Summary

This report of the Director of People and Organisational Development for the Board of Directors at Leeds and York Partnership NHS Foundation Trust, sets out the detail of work undertaken by the directorate during the third quarter of 2023 (August 2023 – November 2023) and the detail around issues pertaining to our organisational workforce situation and the work undertaken to mitigate, address and support our workforce and workforce issues.

Introduction

Quarter three continued to see significant challenges for the organisation in terms of workforce particularly in respect of national recruitment and retention issues, pay disputes between the government and various trade unions and significant system financial pressures and cost saving and efficiency measures required, all impacting on the work of the People and Organisational Development team. We have commenced work as part of *Our People Plan* refresh with planning of engagement with colleagues across the Trust, for a launch in April 2024. The format of this report is set out by each function within the directorate, the key achievements in the third quarter, as well as challenges and priorities going forward.

People Experience Team

The People Experience Team comprise of People Engagement, Health, and Wellbeing (including Critical Incident Staff Support Pathway (CrISSP)), Equality, Diversity and Inclusion, and Communications.

People Engagement

We have seen the launch of the 2023 NHS Staff Survey and following a heavyweight communications and engagement campaign the team have successfully delivered higher response rates than 2022. As of 20 November, the response rates for our substantive colleagues are at 49% (2022 was 44%) and Bank response rates is at 21% (2022 was 15%). Using daily response rate data, the team have been able to determine that the extensive engagement roadshow activity, getting out into services and talking with our colleagues, has positively impacted these response rates. Furthermore, this year we now have 47 teams who will be able to access team-level data, up from 32 teams in 2022, which is a significant increase in delivering data and possible intention planning to smaller teams. We are now spending the

last week targeting individual teams who are currently below the suppression level to try and increase these numbers. Fieldwork closes on 24 November 2023, and we are waiting for confirmation in December of topline data release dates, which we have been advised are now delayed. Both our current supplier, IQVIA, and the National Coordination Centre are implementing new dashboards for 2023.

Due to the launch of new dashboards for 2023 data, we will be reviewing our data reporting models during January 2024 and making necessary adjustments to standard written, bespoke and online (Echo) reporting models which will be a significant workload. Additionally, once we have team-level data we are looking to change our approach to sharing this with our colleagues and teams and are considering how we can do this via Engagement Roadshows in spring 2024, at the same time as Trust wide communications. We are in the final year of our four-year contract with our current provider, so are now in discussions with Procurement over retendering the contract for 2024 onwards. There seems to be some new suppliers in the National Staff Survey supplier market who are providing very different platforms and dashboards.

We will be running the Coffee Van again in the lead-up to Christmas, visiting 11 sites during the day, evenings and weekends to thank our colleagues for all their hard work. We are also trying to identify a plan to visit the NOECPC site which would be an additional twelfth site. Individual clinical teams we are unable to visit, such as SSL community teams, will again be provided with hampers. The schedule will run from Monday 11 December until Friday 22 December 2023.

Plans for another Coffee Van initiative will be developed for March 2024, taking into consideration religious and school holidays during that time. This will conclude our last approved spending on this activity.

Following a business case submission to NHS England for Staff Reward Vouchers, we continue to await a decision from NHSE and HM Treasury on whether we can issue any vouchers to colleagues. In the background, we are continuing to work with Workforce Data Analytics and Finance to enable our new Reward & Recognition platform (Spotlight) to launch around 11 December. However, it is increasingly unlikely that NHSE or HM Treasury will respond in time for Christmas. Our fallback is to launch and issue vouchers in January 2024, should approval be given.

We are also working with Procurement on an offer from *Each Person*, to move over to a paid version on the platform via a contract amendment. This would only happen if we were given HM Treasury approval to issue the vouchers. Purchasing such a large number of e-vouchers via *Each Person*, using the paid model of their platform would in essence give us cashback funding which would cover the cost of the 12-month paid licence and provide us with an additional £6k cashback to spend on the platform on other initiatives in 2024 and beyond.

We have undertaken a reward and recognition planning day to start to review the status of our Award offers to determine a more cohesive Reward and Recognition Plan for 2024. During the first quarter of 2024, we will be developing a new plan for approval via relevant governance groups and FPG to consider funding for activities during April 24 to March 2025.

Health and Wellbeing

Our People Wellbeing Lead continues to lead the ward wellbeing buddying initiative, in collaboration with wellbeing team colleagues to the acute and Newsam Centre forensic inpatient services and Red Kite View. This support is being rolled out to Mill Lodge with preliminary discussions taking place with the inpatient wards at Clifton House and The Mount. Due to changes in the wellbeing team and the increasing demand on this initiative some areas have new buddies and colleagues in the wider people engagement and communication team have offered to provide this support to identified areas.

Our new Head of Wellbeing – Victoria Small commenced with us on Monday 20 November. Victoria's background is from NHS England where she was leading on delivering the Growing Occupational Health and Wellbeing Together strategy as part of the wider NHS People Plan which has just been included in the 2023/24 NHS priorities and operational planning guidance and the Long-Term Workforce Plan. She mainly delivered both the People and Identity drivers to grow and develop the occupational health and wellbeing workforce. She has previously worked in national and regional policy positions in workforce, health and wellbeing and stakeholder management, in addition to local primary care trust health promotion delivery.

Critical Incident Staff Support Pathway

Since mid-April 2022, the People Wellbeing Lead has responded to 226 incidents either via Datix notifications or direct contact from clinical managers/leaders in terms of offering post incident peer support sessions. The following table provides the highlight data from all sessions delivered since January 2022, which includes the pilot data, and the number of colleagues supported in these sessions.

No of sessions	**No of colleagues supported**
123	**564**

Team Leader and Peer Practitioner training

To support the full CrISSP pathway and ensure local teams are provided with more immediate wellbeing support following an incident, joint Team Leader and peer Practitioner training is being rolled out trust wide. The following table provides the highlight data of number of sessions delivered since November 2022 and the number of colleagues supported in these sessions. 7 more sessions are currently planned in 2024 with a further 37 colleagues already booked in.

No of training sessions	**No of colleagues attending the training session**
15	**121**

Communications

The Communications Strategic Plan is in production following a full team away day on 6 October. The plan aims to capture the team's purpose, aims, objectives and action plan for the next 2-3 years. Outputs from the away day are also informing a learning needs analysis and a professional development plan for the team. This includes how we will be collectively addressing requirements of the Accessible Information Standard, the Equality Act, and national digital accessibility standards. The Head of Communications is scheduling meetings with executive colleagues to engage them in the development of this plan to ensure it delivers on their expectations.

Staffnet 365, we are now on track to launch our new staff intranet, Staffnet 365, in February 2024. We are calling it Staffnet 365 as it will be part of our Microsoft 365 Office Suite and it will be available on any device, from any location, 365 days a year. Other benefits include a better search function getting time pressured colleagues to the information they need more quickly, plus a much-improved content management system for the 100+ super users who regularly update their content. The project is being led by the Digital Communications Officer and is a joint venture between our Communications and Informatics teams. The construction is now taking take place over three phases.

We anticipate launching our new brand and visual identity early in 2024. This will include:

- A new brand proposition (or brand promise statement)
- A new strapline – a short statement which clearly describes our function following feedback from focus groups,
- A new tone of voice guide to improve the way we communicate in different circumstances, and
- A new visual identity to help differentiate us from our partners and competitors.

The work is being led by the Head of Communications and is overseen by a project group including the chief executive, deputy chief executive and chief operating officer.

Progress towards Community Mental Health Transformation has seen a lot of work taking place to support the Community Mental Health Transformation. Whilst the future delivery plan of the project is unclear, the benefits already realised from the work are being showcased through communications, on the Mindwell Leeds website.

The Communications Team is reviewing its internal communications bulletin, Trustwide. Trustwide is currently a weekly email bulletin that goes to every member of LYPFT on Tuesdays. The review is looking at the following aspects:

- Content and structure – including whether we should split it into different products,
- Editorial guidance – what articles should / shouldn't be going in

- Tone of voice, and
- Delivery systems to improve design, structure and gain access to analytical data.

The work is being led by our Communications and Marketing Manager and is being overseen by the People Experience Group. The project is currently in the insight and research phase, gathering feedback from colleagues and looking at industry best practice.

LYPFT is leading the communications for the West Yorkshire Collaborative Bank project. This new app-based system will create a shared pool of available and well-trained health and care workers who can fill any unfilled shifts in mental health, learning disability and autism services across West Yorkshire. This is a partnership between Bradford District Care Trust and South West Yorkshire Trust, and will give those who sign up greater flexibility to work across a wider variety of sites and services. It will also offer more opportunities for learning and development. We're planning to pilot the project in December ahead of its launch next year.

A five-point year ahead plan for recruitment marketing was approved by the People Resourcing and Retention Group on 28 September 2023. This includes taking a more strategic approach to recruitment marketing to attract new talent to the organisation. The work is being led by the Communications and Strategic Resourcing teams. A workshop to scope and sequence the work is planned for December 2023.

The winter vaccinations campaign is being led by our Communications Officer. The focus has been to use real-life examples of a cross section of colleagues having their jabs at work. As of 20 November 33% of all LYPFT colleagues have had at least one of the winter vaccinations this year, 37.2% of 'frontline' colleagues have had a Flu jab, and 26.3% have had their Covid-19 booster.

We are working on a comprehensive communications and engagement plan to support the future of our current Private Finance Initiative (PFI) estate. This is a highly complex and sensitive programme of work. In late September we agreed an overarching narrative describing the context we are operating in, and setting expectations for the future i.e., the Department of Health and Social Care expects us to acquire our PFI estate for future inpatient provision at the end of its lease term in 2028.

The Communications Team led on a campaign for Inclusion Week 2024 which ran in September 2024. It engaged three senior executives who shared their very personal perspectives and experiences of inclusion/exclusion in private and professional lives. Colleagues were encouraged to sign up to the Trust's Inclusion Ally pledge. This is a long-term campaign that can be tied into others throughout the year.

As part of the violence prevention and reduction work, we have been supporting colleagues whose focus is specifically on tackling hate crime. This month we've run some internal comms around a pilot project we're involved in with West and North Yorkshire Police.

The LYPFT Communications team has been encouraging colleagues in care and support services to enter the annual Positive Practice in Mental Health Awards. The deadline for submissions is 1 December and so far, we have been notified of 14 entries being submitted or worked on.
This year LYPFT Comms has taken a more proactive approach to entering industry awards, including sponsoring training and sharing best practice resources.

The way we respond to patient safety incidents is changing in late 2023, with the Patient Safety Incident Response Framework (PSIRF) replacing the current Serious Incident Framework. It will represent a fundamental shift in the way NHS organisations investigate incidents and will allow us to focus our resources in areas where there is the greatest opportunity for learning.

Over winter we'll be playing our part in the Leeds Together We Can and the national Stay Well campaigns to provide our service users with the information they need to look after themselves and choose the most suitable health services. Information will be provided digitally, including on our website and social media, and in-print via leaflets and posters to our Leeds-based services. We are reporting into the Winter Planning Tactical Group on this work.

We will be sharing news of colleagues celebrating over the Christmas period – including the Carol Services led by our Chaplaincy Service. Our activity will include holding a special Christmas All Staff Huddle where we will aim to celebrate our colleagues' achievements and thank them for their hard work.

Organisational Development and Resourcing

The Organisational Development and Resourcing team comprise of Recruitment and Resourcing, Organisational Development and Health Education Support Service (HESS).

The team continues to play a key role in supporting the Trust reduce its agency spend and the number of vacancies as part of the Trusts 2023/2034 Efficiency and Productivity (E&P) Programme.

To date we have: -

- Established an agency approval process for all non-clinical agency requests from October 2023 onwards. Following the launch of the new process no requests for non-clinical agency have been approved and alternative resourcing solutions have been suggested including the use of bank colleagues and fixed term contracts.

- Reviewed the use of clinical/medical and non-clinical agency to ensure the funding position for agency usage is in place and that any expenditure is correctly coded to the right budget.

- A medical staffing workshop took place on 30 November 2023 to review the Trust's medical staffing establishment and consider alternative skill mixing and new roles to address the high agency spend linked to medical staffing shortages.

In terms of reducing the number of vacancies a weekly Vacancy Management Panel has been established to review each vacancy before they are advertised. This work has introduced some helpful check and challenge to the use of fixed term contracts, encouraged long standing vacancies to be advertised and the introduction of new roles. In addition, a review of all posts that have been vacant for over 12 months has taken place and work is now underway to develop robust recruitment and resourcing plans for these posts.

The first values-based recruitment pilot took place within the Acute Inpatient wards 1 and 5. The pilot saw an increase in application from a previous average of 36 to 148 applications. Shortlisting and interviews are underway and a review of the quality of the applicants will be undertaken to assess if the new approach has helped improve the quality of applicants.

To support flexible working, which is a key component to the NHS 15-year Workforce Plan to help the attraction and retention of colleagues a Flexible Working group has been established. The group is focused on understanding the barriers to flexible working within teams and services and developing with the service strategies to overcome these barriers so that there is a consistent ethos of flexible working across the whole Trust. As part of this work the Trust has also participated in a Citywide Flexible working group which produced a Flexible Working web resource and series of workshops (one of which was facilitated by the Trust to explore ‘the art of possible’), share case studies and what’s working well in other organisations.

As part of the Trust’s Retention Strategy a new exit interview process has been launched with an easily accessible survey link. Individuals can either complete the exit questionnaire independently or completed following a formal exit interview. The exit interview can be undertaken by the leavers line manager, or if preferred by another member of the management team or representative from the People and OD directorate. Targeted engagement is taking place to encourage every leaver to engage in the process. The data gathered from the exit interviews will be collated into a thematic analysis to identify profession and / or service trends to inform appropriate action.

A Development Roles policy and procedure was launched in September to ensure that there is a consistent process across the organisation for development roles. The process allows managers to recruit to a lower banded role for a defined period while undertaking a structured training and development programme to support the individual achieve the competencies required of the substantive role and pay band. The process includes clear advice for monitoring performance and competence development and dealing with individuals who do not meet the expectations of the role, despite being trained and supported to do so.

The roll-out of the 360 Manager programme continues to be rolled out across the Trust. There are good levels of engagement with managers and to date 173 colleagues (managers and aspiring managers) have attended at least one workshop, with 40 percent of participants being at band 7.

The Collective Leadership Programme held its final workshop for 2023 with a focus on how to make good decisions.

Key priorities for

The following are key priorities for the OD and Resourcing department over the next quarter:

- Development of a new procedural document to support the work on reducing agency expenditure. The document will help ensure managers are clear about the process for recruiting agency spend, particularly considering new guidance from NHS England.

- A review and refresh of the Trusts Strategic Workforce Plan, which ends on 31 March 2024. The proposal is to combine this with the refreshed People Plan which will be launched on 1 April 2024.

- Further development of the new Development Roles policy and procedure to include Trainee roles and provide clarity on the differences between development, trainee, and apprenticeship roles.

- Development of a new module for the 360 Manager programme i.e., Managing a Service. This will be targeted at current and aspiring service leaders and will focus on developing skills around leading on direction, engaging with your people and enablement.

- Complete the evaluation of the 360 Manager by the end of February 2024 – a year after it launched and use the feedback to develop the programme further.

- Scope and implement a CPD programme for the Trust's internal coaches – this will include performance coaching, coaching for collective leadership and team coaching.

- Develop the Collective Leadership programme for 2024 - with a focus on skills development, team, and individual coaching.

- Develop and implement Board Development programme following the comprehensive training needs analysis that is currently underway.

There are several key risks / challenges for the department and its work programme. These include:

- Work pressures within services that hinder the ability of colleagues to attend the 360 Manager programme,
- A lack of information about the national NHS Workforce Plan which may limit the Trust's workforce planning ambitions,
- A general lack of engagement from some services with respect to the Workforce Planning Strategy,
- The on-going issues around national staffing shortages in health and social care and lower than anticipated student nurses in 2024 which will add further pressure to the resourcing agenda.
- Slower than planned progress in delivery of the DBS programme due to a lack of engagement by individuals and services.

Plans are in place to mitigate as far as possible the above risks and these are regularly discussed at the POD Governance meetings.

People Employment

The People Employment team have proposed an early resolution and mediation approach to grievances which was presented to the People Employment Group with engagement from an ACAS expert, and this work will be implemented in early 2024 which will be an alternative to

formal grievance proceedings. Work has been undertaken to create a consistent workforce information dashboard for HRBPs to use with services as part of the performance conversations in addition to a revised Disciplinary Policy and Toolkit for managers which has been evaluated with stakeholder engagement and audit requirements incorporated.
The team have supported the employment and legislative elements of the approach to Development and Trainee roles as part of the New Roles group work. This has included the development of a revised contract template and agreement with service and professional leads. A Trust position was agreed via the People Resourcing and Retention Group to support sponsorship for existing colleagues in registered healthcare practitioner and social care roles which includes Support Workers in Specialised Supported Living (SSL). As a result of this we have been able to progress applications and support two colleagues within SSL, retaining them in a service which experiences recruitment challenges.

We have undertaken a review of learning from the Cox v NHS Commissioning Board (Operating as NHS England) employment tribunal case which was brought in relation to race discrimination. The development of an action plan has been undertaken and training regarding unconscious bias and anti-racism via a joint license arrangement with partners across Leeds as part of the Leeds Health and Care Academy Skills Boosters will be available for all colleagues.

The team have several challenges that are facing the team:

- Staffing levels due to resource shortage in both HR operational roles and HRBP roles and potential for 'burn out' across the People Employment Team who have been covering vacancies.
- Employment Tribunal (constructive dismissal claim and discrimination claim). Awaiting probability of success assessment from legal advisors.
- Risk of redundancy claim as part of an organisational change programme.
- Capacity in the organisation to release managers for training which will impact on the culture shift to new employment policies and approach, which could result in increased employee relations cases, colleague turnover and colleague satisfaction.
- Managing competing priorities from workforce challenges and directives – both internally and external. This may impact on the service' ability to be proactive and responsive to service need.
- CMHT Transformation – the go live date for implementation of the first pilot continues to be delayed, which will impact on the ability to deliver.
- Industrial Action continues to significantly impact on the ability to deliver business as usual. The team have had oversight of the planning and preparation for industrial action, including development of FAQs and guidance of support, representation at all planning and tactical groups and discussion with staff side leads as part of good partnership working.
- Changes to the NHS Pension Scheme has had an impact on current policy which required HRBP oversight and legal advice.

The key priorities for the next quarter will be:

- Appointment of new team members who will require induction and introduction to the Trust – HR Business Partner, HR Manager & HR advisor.
- Roll out of new Performance Support Procedure – in Q4.
- Development of a proposal to introduce an Employee Relations Caseworker system.

- Review of Terms of Reference for the Absence Improvement Group and Employee Relations Improvement Group to ensure fit for purpose.
- Ensure the Job Evaluation Policy is reviewed and launch in Q4.
- Focus on the implementation of a new retirement principles to replace current policy. Including changes approach to Retire and Return.
- Implementation of the Annual Leave Exchange Scheme in early January 2024.
- Continued development between People Employment and Organisational Development Team on the Trust approach to early resolution and mediation. Draft an Early Resolution Policy to replace the Bullying and Harassment and Grievance Policies. Recruitment to early resolution courses as part of 360 manager development programme and a 4-day mediation course to be delivered across the MH collaborative.
- Re-launch of revised Disciplinary Policy and Toolkit for managers.
- Civility and respect – feedback to services from diagnostic work planned before the end of year – local action plan and corporate interventions to be agreed.
- Agreement of Civility & Respect Executive Statement and framework of support and development in line with Framework.
- Completion of the 2023/24 LCEA Round. Feedback and evaluation of 2023/24 Scheme to inform 2024/45 Scheme.
- Approval and Ratification of updated version of Trust Procedure for Managing Concerns about Medical Colleagues Policy.
- Significant support required for a Management of Change in Adult Acute – CRISS Transformation and implementation of the review of Street Triage.
- HR support to the Perinatal Expansion including review of the clinical model and workforce requirements.
- HRBP support into Children and Young People with ongoing workforce plans, including the S136 proposal which includes increased Health Support Worker workforce to cover 24-07, changes to estate changes in admission service at Mill Lodge.
- In collaboration, devise service-led strategic workforce planning workshops.
- Refresh of Financial Support Fund – financial crisis support in partnership with Cost-of-Living Task and Finish Group.

Conclusion

This report to The Board covers just some of the activity undertaken by the People and Organisational Development team which has been delivered in the third quarter of the year. The team play a pivotal role in the day-to-day running of the organisation and are a key enabler to the deliver of safe and effective service delivery.

Recommendation

The Board is asked to note the contents of this report.

Darren Skinner
Director of People and Organisational Development
20 November 2023

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
15

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	2023 – 2024 Organisational Priorities Quarter 2 Progress Report
DATE OF MEETING:	30 November 2023
PRESENTED BY: (name and title)	Dawn Hanwell, Chief Financial Officer and Deputy Chief Executive
PREPARED BY: (name and title)	Amanda Burgess, Head of the PMO

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 a summary of the Trust's progress against our 2023 – 2024 organisational priorities. This is our second progress report of 2023/24 and is set out to provide an overall summary of the progress we have made against each of the high-level objectives taken from directorate Strategic Plan's.

In total we have 109 high-level objectives and 232 underpinning tasks for delivery. At the end of quarter two we have:

- 30 tasks that have been completed
- 168 tasks are reporting a rating of green (on track)
- 25 tasks are reporting a rating of amber (action incomplete – implementation slipped but will be delivered on time)
- 5 tasks are reporting a rating of red (action incomplete – timescales not achievable)
- 4 tasks have been suspended

The Gantt chart at **appendix two** details all our interdependent tasks. The information displayed is based upon the successor's team tasks i.e. it is the successor team whose start or end date is controlled by the predecessor.

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: • Consider our position against our 2023/24 organisational priorities (appendix one). • Note the five new priorities which cross-cut into 2024/25. • Be assured as to the systems and processes in place for monitoring and supporting the delivery of each high-level objective and underpinning tasks. • Consider the Gantt chart at appendix two setting out the interdependent tasks, noting the key themes emerging align with our five core strategic plans.

MEETING OF THE BOARD OF DIRECTORS
THURSDAY 30 NOVEMBER 2023

2023 – 2024 ORGANISATIONAL PRIORITIES QUARTER 2 PROGRESS REPORT

1. Purpose

This report provides a summary of the Trust's progress against our 2023 – 2024 organisational priorities. This is our second progress report of 2023/24 and is set out to provide an overall summary of the progress we have made against each of the high-level objectives taken from directorate Strategic Plan's.

Included as part of this report is a summary of our interdependent tasks (appendix two) demonstrating the alignment of themes and timescales.

2. 2023/24 priorities status summary

As a Trust we have five core strategic plans (Quality, Care Services, Estates, Digital, People). In addition to our core strategic plans, we also have in place a further seven cross-cutting plans. All our plans describe a set of deliverables for delivery which have been refined to generate our 2023/24 organisational priorities. Our strategic planning framework provides a structure that aligns our individual, team and directorate high-level objectives and underpinning tasks.

All our plans have milestones detailed in an overarching Gantt chart. This has been developed to provide a picture of the large-scale priorities we have to deliver over the next one to five years, with a particular focus on the first year (2023/24).

2.1 Progress we have made at the end of quarter two

At this halfway point, we have taken the opportunity to review all our priorities. We have reflected on whether our priorities are still the right things we should be doing, what is genuinely achievable within the original timescales set, what we know is not, where timescales need to change and is there anything we can de-prioritise. This has been an important exercise in advance of embarking upon the 2024/25 planning round. We are beginning to get a clear understanding of the priorities that will now transfer into 2024/25 from 2023/24. We can then assess which priorities may require funding in 2024/25 in order to achieve our plans.

2.1.1 Key highlights at the end of quarter two

During quarter two as part of rebasing some of our priorities, our services have reconsidered new objectives for delivery. These include:

- **Perinatal expansion:** we have been successful in our bid to expand our perinatal inpatient service by a further six beds. This is an exciting opportunity for the Trust and the service which will see part of The Mount site being redesigned to accommodate the expansion.
- **ICE (Integrated Clinical Environment):** working with our partners at LTHT we have agreed to the deployment of ICE integration to the ease the process of obtaining blood results directly from the pathology laboratory.
- **Upgrade of EPMA:** there is an opportunity to upgrade our e-prescribing system as the community module becomes available.
- **Patient safety:** one of our organisations key objectives is ensuring patient safety. We have reframed our safety priorities around the implementation of:
    - Patient safety outcomes
    - Risk assessment and care planning processes
    - Self-harm strategy
    - Ligature audit system and process
- **CQC:** our preparedness for a CQC visit and ensuring we are aspiring to achieve a 'good/outstanding' CQC rating of our services at the next inspection.

In our quarter one report we reported a rating of amber for two of our schemes. We are now back on track to conclude the evaluation of our Crisis Assessment Unit. We have also stabilised our working age adult community services after a significant period of business continuity measures being in place.

2.1.2 Progress made at the end of quarter two

Each lead has assessed the progress they have made at the end of quarter two with all underpinning tasks, to determine how we are delivering against each overarching objective. A summary of the progress we have made can be found at **appendix 1**. This Gantt chart includes a traffic light system to identify if each task has been completed (blue), on track (green), action incomplete – implementation slipped but will be delivered on time (amber) and action incomplete – timescales not achievable (red).

In total we have 109 high-level objectives and 232 underpinning tasks for delivery. At the end of quarter two we have 30 tasks that have been completed. 168 are reporting a rating of green (on track). 4 tasks have been suspended.

The following sections will provide a summary exception report for the tasks rating as amber or red.

2.2 Priorities with a rating of amber (action incomplete – implementation slipped but will be delivered on time)

At the end of quarter two we have 25 tasks with an amber rating. These tasks are as follows:

- **People Plan**
  - **Keep our people protected, safe and well at work**
  - We are identifying and implementing improvement measures to increase the rate of managers completing return to work meetings within 48 hours of a team member returning to work. Further work is to be done to support managers through this process and to ensure that this metric is achieved.
  - **Improve the experience of people with a protected characteristic as identified by the Equality Act 2010**
  - We are behind schedule with developing, publishing and monitoring the progress we have made with the 3-year EDI plan. This is due to a need to fully review the EDI framework in order to, identify our priority areas and targets ambitions ensuring alignment with the refreshed People Plan.

- **Estates Plan**
  - **Enabling key clinical service changes through our estate**
  - Our clinical services have been working with a design team to redesign the seclusion facility at the Newsam Centre to ensure it fully complies with agreed standards. A legal document (Deed of Variation) has been progressed between Equitix (SPV partner), the Trust and our legal teams. This is required as the intention is to extend the footprint of the building. Given the time it has taken to progress the Deed of Variation the scheme completion date has moved to the first quarter of 2024/25.

- **Digital Plan:**
  - **Deployment of a Patient Portal**
  - **Presentation through NHS login. Trust wide deployment of Patient Portal where appropriate:** A presentation on the Patient Portal functionality has been conducted with Advanced, our clinical information system supplier. NHS England are looking to provide a log-in to the CareDirector portal, however delays have occurred in NHS England rolling out the programme, with the focus currently on delivering this across acute Trusts in the first instance. The intention is for the programme to continue, as planned, with a controlled trial in one of our services within the current financial year. Our original timescales have been extended from end of March 2024 to September 2024.

  - **Assess and co-design an inclusive digital transformation programme for the Trust**
  - **Deploy and embed the inclusive transformation programme Trust-wide:** Deployment has commenced with early adopters. Deployment has started within the learning disability service but wider deployment held back, given resource challenges across community services and requirement for further evidence of impact from IMSG. Timescales extended from March 2024 to March 2025.

- **Care Services Plan: Adult Acute**
  - **Create capacity and flow through the acute pathway that enable a reduction in the number of people placed out of area**
    - We are closely monitoring and exploring different approaches to how we can reduce unwarranted clinical variation across our acute inpatient wards. We have found that although clinical variation has reduced, our length of stay has increased across all wards. We have developed an action plan through a MADE event held earlier in the year. This is now being cumulated into an overall recovery plan for acute flow.

  - **Ensuring safe staffing levels across our adult acute services**
    - **Complete a skill mix review across our inpatient services:** We had 25 new preceptees started within the adult acute service in July. We are however, continuing to experience workforce challenges across the service, with the Crisis and Street Triage teams merging for six months to aid service pressure. We are working closely with the Safer Staffing Group to review the skill-mix of the workforce and reviewing against service need. Our delivery timescales have been changed to reflect the challenges experienced to the end of the financial year.

- **Care Services Plan: Community and wellbeing**
  - **To progress all service developments inclusive of Community Transformation, EIP, Rough Sleepers Mental Health Service, Urgent Treatment Centres and Physical Health Services.**
  - **Improved mental health understanding and response within Urgent Treatment Centres**
    - We are continuing to develop our mental health services in the community as a part of the Community Transformation programme. The workforce and operationalising of the model work has now been concluded for the pilot areas. Unfortunately, the pilot rollout scheduled to begin in October has been delayed until November at the earliest. Joint executive meetings between the Trust, Leeds Community Healthcare Trust and Leeds Office of the ICB are being convened to agree a suitable solution.
      Multi-partner citywide work around Urgent Treatment Centres continues to progress slowly. This scheme is outside of the control of the Trust with the delivery timescales being changed to reflect a conclusion by March 2025.

  - **To understand the experience and care quality through implementing and utilising outcome measures, audits, service evaluations and feedback to truly improve care.**
    - **Improvements made from the Community Mental Health Service User Survey:** We have made improvements resulting from the Community Mental Health Service User Survey 2022 with improved scores for 2023 in at least two areas. We are currently awaiting the 2023 survey results to provide a comparator.
    - **Introduction and use of routine outcome measures (ReQol, DIALOG+) with over 65% of service users having two or more recorded:** The NHS roadmap identifies the need to use three outcome measures for transformed services. Progress in the use of outcome

measures is slower than anticipated. Following new guidance from NHS England and the ICS, the plan is to use REQoL and Dialog+ with work underway to roll these out in the community transformation pilot sites and across the services. The Primary Care Mental Health Service are already utilising the REQoL outcome measure. Delivery timescales for this have changed to March 2025 to reflect the rollout plan.

- **To improve collective leadership throughout our teams through the creation of psychological safety, role clarity and clear expectations teams/individuals hold of each other.**
  - **Each Team to develop service/team objectives, using team/service away days:** The community and wellbeing service line leadership continue to develop their collective leadership, creating a caring and compassionate environment as a leadership team to work in. Team away days have taken place for all primary health services, with good outputs including role clarity. Rough Sleepers is holding more than one time out and development sessions. There have been leadership/management time outs for PCMHS/CMHT. We are yet to hold away days for individual CMHT teams however, anticipate these will have taken place before the end of the financial year.

- **Care Services Plan: Learning disability services**
  - **Working collaboratively with our Local Authority commissioning partners we will redesign the delivery and leadership model for our Specialised Supported Living Service (SSL)**
    - **Recommence planning and negotiation with Leeds City Council (LCC) contracts and commissioning partners re SSL contract and future delivery model:** Meetings are underway between the Trust, LCC and WYICB colleagues to agree next steps for the SSL service and which option to proceed with. Our executive team and director counterparts at LCC have met (September 2023) to assess the existing service model, future viability and affordability of the service.
      The outcome of these discussions with our local authority partners will inform the future delivery model for the service. The overall timescales for this have moved from October 2023 to March 2024.

- **Care Services Plan: Children and young people**
  - **Introduce the Alternative to Hospital Service in both Mill Lodge to provide a service for children and young people with eating disorders/disordered eating, reducing length of stay and admissions for young people with these presentations**
    - We are implementing a new alternative to hospital service for people with an eating disorder at Mill Lodge. A new service model and workforce to deliver this new scheme has been established and recruitment underway. Unfortunately, the initial round of recruitment was unsuccessful for key roles. We are working with the workforce team to explore alternative approaches to recruitment to extract suitable candidates. There is a risk however that our ability to quickly recruit could delay the opening of the new unit. The changes to the Mill Lodge estate are progressing and are scheduled to commence on Monday 20 November.

- **Care Services Plan: Regional & Specialist Services**
  - **Determine the future of operating model for NSCAP following the outcome of the tender process.**
  - **Implementation of NSCAP review phases 1 – 3:** A proposal has been developed and approved through governance for the review of the NSCAP service. This includes three discreet phases of work. Phase one included the cessation of the small clinical service which is due to conclude in October 2023. Phase two includes redesigning the teaching model of delivery to ensure the future viability of the service within the revised funding envelope. Both phases include a management of change plan for the workforce within the service. The outcome of phase two will inform phase three which is the future estate provision for the service.

  - **Improving our services for people with a gambling addiction**
  - We are underway with the mobilisation of the expanded gambling clinics across the northeast and northwest. Delays have been experienced for the recruitment to some of the roles across the new patches. We have now successfully recruited into some key posts with individuals expected to start during December. We have also agreed our estate operating arrangements with a permanent base in Manchester and Sheffield (Regus office). We are adopting the use of Regus membership cards within Preston, Liverpool and Newcastle. The website development is underway and will be live by the end of 2023.

- **Finance**
  - **We use our resources to delivery effective and sustainable services**
  - **Develop and monitor a plan to reduce agency spend (medical and non-medical) and out of area placements (complex rehab and adult acute):** Our aim to reduce agency and out of area placement spend are two key elements of our efficiency programme. We have exec-led governance arrangements in place to drive this work forward, aligned closely with the vacancy management workstream. The Trust's agency and out of area expenditure is significantly over plan.

- **Green plan**
  - **Networking, communications and engagement**
  - **Assessment of sustainability factors in all that we do:** Our aspiration as part of the Greener NHS agenda is to ensure we consider the sustainability factors in any strategic decision/investment we make. There are various standard templates available which we need to consider and agree which has the best fit within our Trust. Revised timescales for delivery by March 2025**.**
  - **Reduce paper use by 10%**
  - Our aspiration as an organisation is to reduce paper use by 10% of our current levels. An assessment needs to be undertaken of our existing paper use in order to understand our baseline measurement and trajectory. We aim to have this in place by March 2024.
  - **Reduce medical waste**

- As part of the Greener NHS Plan we are developing a plan to understand where we can activity reduce medical waste. One area the region have agreed to explore is around medication which we are connected into. Revised timescales for delivery by March 2025.
  - **Improving the efficiency, management and monitoring of energy, cooling, water**
- We are exploring other systematic measures to automate our energy efficiency use across our owned and leased estate. Consideration has been given to an Infogrid pilot, however further exploration is needed to understand the benefit of the pilot at this stage.

2.3 Priorities with a rating of red (action incomplete – timescales not achievable)

At the end of quarter two we have 5 tasks with a red rating. These tasks are as follows:

- **Digital Plan:**
  - **Feed data to GP systems directly from Care Director:** The plan to send GP letters and patient discharge notifications directly to GP systems has been delayed. This is due to a technical issue which has delayed the testing of the link between Big Hand and Care Director. Work is still planned to deliver this within this calendar year, however the scheme will not be fully achieved until June 2024, following the deployment of the electronic document management solution.

- **Care Services Plan: Adult Acute**
  - **Create Capacity and flow through the acute pathway that enable a reduction in the number of people placed out of area**
  - Our aim is to eliminate inappropriate out of area placements linked to our efficiency area of focus. Out of area pressures within the adult acute service continues to be extremely challenging with demand being consistently high and a normalised occupancy of over 100%. Discharges across our working age adult acute wards has declined because of the complexity of the cases we are managing in our acute setting, with length of stay increasing. Our need to engage city-wide partners in aiding the pressures is required, building on the successful MADE event held in June. Extensive analysis of the cross-cutting data to truly understand the issues has been underway over the first half of the year. Our exec-led governance group supporting this work is considering whether a review of the out of area placement trajectory is required. First and foremost, this can only be considered once we have fully developed a recovery plan for acute flow, which is to be approved during quarter three and will go some way to reducing our out of area position.

- **Children and young people**
  - **Ensure the stability of Red Kite View**
  - **Confirm the S136 commissioning arrangements with Leeds ICB:** We are working with our system partners to progress a business case for the long-term sustainability of the Section 136 cover arrangements at Red Kite View. The on-call arrangements previously explored have generated significant challenge and concern. We are alternatively exploring the use of a responsive workforce to support S136 cover which would bring the costs closer

to funding envelope. The business case is to be reconsidered in quarter three with system partners.

- **Care Services Plan: Regional and Specialist Services**
  - **Improving mental health services for people with autism and ADHD:**
  - We have produced a two business cases setting out a series of options for how we might improve the delivery of our autism diagnostic and ADHD services. To date both business cases have not been approved however alternative options have been explored to maintain the service through translating the people on a secondment in the service into permanent roles. Working as part of the WYICB NDS programme our shared long-term objective is to improve the waiting list position. This priority is to be considered as part of the 2024/25 funding development pressures.

3. Cross-cutting themes and interdependent tasks

As part of the quarter one report a Gantt chart was shared setting out our interdependent tasks and key themes that are emerging. This report demonstrated how several individuals/teams are collaborating in order to successfully deliver an overall theme.

The interdependent tasks showed how realigning our timescales helps to set out what we need in place for delivery by one team to enable another team to progress the next step. As part of the review of all our priorities at this quarter two stage, each service has collectively revisited the timescales, to make sure they are reflective of the task to be delivered. For example, this has been undertaken for our replacement risk assessment system (currently Datix), integrated workflow solution (SW replacement) and also the interdependent tasks linked with reducing out of area placements in adult acute and complex rehab services.

The themes emerging also demonstrate the alignment with our five core strategic plans. A separate piece of work is underway to align the Medical, Psychological Professions and Allied Health Professions plans with the People Plan, given the cross-cutting themes shared across each of the profession specific plans.

An updated Gantt chart for all our interdependent tasks can be found at **appendix two**.

4. Recommendations

The Board of Directors are asked to:

- Consider our position against our 2023/24 organisational priorities (appendix one).
- Note the five new priorities which cross-cut into 2024/25.
- Be assured as to the systems and processes in place for monitoring and supporting the delivery of each high-level objective and underpinning tasks.
- Consider the Gantt chart at appendix two setting out the interdependent tasks, noting the key themes emerging align with our five core strategic plans.

Dawn Hanwell
Chief Financial Officer

Amanda Burgess
Head of the Programme Management Office

22 November 2023

Trust Organisational Priorities 2023 - 2030: Quarter 2 Progress Report

ID	Task Mode	Q2 RAG	Q1 RAG	Mover	Task Name	Duration	Start	Finish	Lead	% Complete	Progress Update
1					**Care Services Strategic Plan**	**1565 days?**	**Fri 01/04/22**	**Fri 31/03/28**	**J.Forster-Adams**	37%	
2					**Adult Acute**	1306 days	Sat 01/04/23	Fri 31/03/28	L.McDonagh	24%	
3					**Create capacity and flow through the acute pathway that enable a reduction in the number of people placed out of area**	653 days	Sat 01/04/23	Tue 30/09/25	L.McDonagh	20%	
4					Eliminate inappropriate out of area placements	392 days	Mon 01/04/24	Wed 04/02/26	L.McDonagh	10%	Out of area pressures continues to be challenging with demand being consistently high. Developing a recovery plan for acute flow which will be approved during quarter 3. In addition we are reviewing the role and function of the capacity & flow team.
5					Reduce unwarranted clinical variation	262 days	Sat 01/04/23	Fri 29/03/24	L.McDonagh	20%	The clinical variation has reduced but our length of stay has increased across all wards resulting in a MADE action plan.
6					Formulation to be embedded across the acute inpatient service	393 days	Sat 01/04/23	Mon 30/09/24	L.McDonagh	30%	We have embeded formulation in wards 1 and 4 at Becklin. Currently working with ward 4 Newsam with plans to further roll out to the remaining wards with the commencement of new psychologist in early Nov. Timescales for completion moved to 1 Oct 2024.
7					**Ensuring safe staffing levels across our adult acute services**	151 days	Sat 01/04/23	Fri 27/10/23	L.McDonagh	20%	
8					Complete a skill mix review across our inpatient services	262 days	Sat 01/04/23	Fri 29/03/24	L.McDonagh	20%	We are working with the safer staffing group at data collection and then reviewing against service need
9					**Complete a review of the crisis pathway that will determine the future of the Crisis Assessment Unit**	563 days	Sat 01/04/23	Tue 27/05/25	L.McDonagh	32%	
10					Develop and implement a new model for CRISS	413 days	Sat 01/04/23	Mon 28/10/24	L.McDonagh	40%	Model proposal completed and presented to ODG. Presented to ODG in Sept. Further work to be undertaken on the model for bringing back to ODG in Nov/Dec 2023.
11					Conclude the evaluation of the Crisis Assessment Unit	151 days	Tue 29/10/24	Mon 26/05/25	L.McDonagh	10%	Working with Improvement team to audit and review previous 12 month activity of Crisis Assessment Unit that will inform the direction of travel.
12					**Ensuring high quality, therapeutic inpatient care which is close to home**	262 days	Wed 02/10/24	Thu 02/10/25	L.McDonagh	40%	
14					**Health Inequalities**	262 days	Sat 01/04/23	Sun 31/03/24	J.Forster-Adams	10%	
16					**Community and wellbeing**	513 days?	Sat 01/04/23	Tue 18/03/25	J.Faulkner	35%	
17					**Transition WAA CMHS out of BC, into stabilisation and recovery. Recovery is aligned with a move to a transformed population/community-based approach**	406 days	Sat 01/04/23	Fri 18/10/24	J.Faulkner	20%	
18					Collectively redesign the way we deliver our services (AOT, Emerge, FOT) exploring pathway interfaces, service alignments and services offer to identify and implement improvements.	406 days	Sat 01/04/23	Thu 17/10/24	J.Faulkner	20%	All deployed colleagues have returned to their substantive roles. Indiviudal caseloads remain low, the coming months will give an indicaiton on the sustainability of the recovery. New starters continue to join the teams over quarter 3.
19					**To progress all service developments inclusive of Community Transformation, EIP, Rough Sleepers Mental Health Service, Urgent Treatment Centres and Physical Health Services**	782 days?	Fri 01/04/22	Mon 31/03/25	J.Faulkner	31%	
20					Ongoing development of Mental Health Services in the Community as a apart of the community transformation. This includes workforce modelling, model operationalising, pilot roll out and full staff consultation.	522 days	Sat 01/04/23	Mon 15/06/26	J.Faulkner	40%	The Community Transformation Pilot roll out scheduled for Oct has been delayed until at least November. Decision being made in October as to go live. Requiring Exec to Exec & ICB discussions.
21					Established Rough Sleeper Mental Health Service	522 days	Fri 01/04/22	Fri 29/03/24	J.Faulkner	50%	All colleagues in post, phase 1 roll out due to go live in November and on course, with phase 2 planned for quarter 4.
22					Improved Mental Health understanding and response within Urgent Treatment Centres	782 days	Fri 01/04/22	Fri 28/03/25	Kellie McLoughlin	10%	Real lack of any direction from ICB/System on UTCs. MH now in the strategy, however no further updates/meetings.
23					Development of psychological interventions for people with SMI, within both primary care therapies and therapies as a part of the enhanced offer.	262 days?	Mon 01/04/24	Tue 01/04/25	Fiona Lowis & Alex Perry	40%	Continues to develop, with all posts in Primary Therapies now recruited to. Aligned with PCMHS. Wellbeing Practitioner trainees all in post, new recruit to train posts going out. Positive developments around therapy.
24					**To understand the experience and care quality through implementing and utilising outcome measures, audits, service evaluations and feedback to truly improve care**	522 days?	Sat 01/04/23	Mon 31/03/25	J.Faulkner	19%	
25					Improvements made resulting from the Community Mental Health Service User Survey 2022 with improved scores for 2023 in at least 2 areas.	262 days	Sat 01/04/23	Fri 29/03/24	J.Faulkner	40%	Awaiting results from 2023 survey to provide comparison. Work to improve the service has continued.
26					Introduction and use of routine outcome measures (ReQol, DIALOG+) with over 65% of service users having two or more recorded	568 days	Sat 01/04/23	Sat 31/05/25	D.Thrush	10%	Following new guidance from NHS England and the ICS, the plan is to use REQoL and Dialog+ with work underway to roll these out in the pilot sites and across the services.
27					**Improve the wellbeing for all, including self, making it central to what we do**	262 days	Sat 01/04/23	Sun 31/03/24	J.Faulkner	55%	
30					**To improve collective leadership througout our teams through the creation of psychological safety, role clarity and clear expectations teams/individuals hold of each other**	260 days	Sat 01/04/23	Fri 29/03/24	J.Faulkner	65%	
31					Each Team to develop service/team objectives, using team/service away days.	262 days	Sat 01/04/23	Fri 29/03/24	J.Faulkner	60%	Service Line leadership continues to develop their collective leadership, creating a caring and compassionate environment as a leadership team to work in. Team away days have taken place for all PH services, with good outputs including role clarity.
32					To establish a role development working group, where all roles are considered and defined (including both long established roles e.g. nursing, and the newer 'non-clinically registered' roles).	262 days	Sat 01/04/23	Fri 29/03/24	Debbie Thrush	70%	The Role Development Group has been established with clarity on role improvements and assurances (e.g. competency frameworks).
33					**Older people's services**	522 days	Sat 01/04/23	Mon 31/03/25	E.Townsley	43%	
34					**Maintain safe staffing numbers, improve experience and outcomes across our older adult inpatient services**	262 days	Sat 01/04/23	Sun 31/03/24	E.Townsley	38%	
37					**Expansion of The Willow model with the opening of Dolphin Manor**	262 days	Sat 01/04/23	Sun 31/03/24	E.Townsley	50%	
40					**Support people to remain in their own homes as much as possible by contribute to the development of the older adults aspects of the Community Transformation Programme**	522 days	Sat 01/04/23	Mon 31/03/25	E.Townsley	42%	
43					**Forensic services**	783 days	Sat 01/04/23	Tue 31/03/26	S.Russo	52%	
44					**Create capacity and flow through our Leeds forensic inpatients and improving our forenstic outreach (FOT) provision**	783 days	Sat 01/04/23	Tue 31/03/26	S.Russo	49%	
50					**Implementation of the new safer staffing model across our Leeds forensic services.**	262 days	Sat 01/04/23	Sun 31/03/24	S.Russo	63%	
53					**Learning disability services**	152 days	Fri 01/09/23	Sun 31/03/24	P.Johnstone	14%	
54					**Working collaboratively with our Local Authority commissioning partners we will redesign the delivery and leadership model for our Specialised Supported Living Service.**	152 days	Fri 01/09/23	Sun 31/03/24	P.Johnstone	16%	
55					Recommence planning and negotiation with LCC contracts and commissioning partners re SSL contract	262 days	Sat 01/04/23	Fri 29/03/24	P.Johnstone	20%	Exec-led discussions with LCC have been held (Sept 2023). Senior deputy director at LCC ™ is now leading a process to assess future viability and affordability. This work includes the future model for the service.

Trust Organisational Priorities 2023 - 2030: Quarter 2 Progress Report

ID	Task Mode	Q2 RAG	Q1 RAG	Mover	Task Name	Duration	Start	Finish	Lead	% Complete	Progress Update
56					Design affordable management model for the delivery of SSL, derived from a detailed options appraisal	152 days	Fri 01/09/23	Fri 29/03/24	P.Johnstone	10%	The task is dependent on findings of LA review. (see above).
57					**Improving our Health Facilitation Team offer**	153 days	Sat 01/04/23	Tue 31/10/23	P.Johnstone	30%	
59					**Working collaboratively with our system partners address the challenges related to the system ATU and determine whether there is a need for 'emergency admission' , crisis, or 'step-up' beds for LD respite services in Leeds (alligned to respite and IST)**	219 days	Sat 01/04/23	Wed 31/01/24	P.Johnstone	0%	
60					Participate in a scoping review with partners	219 days	Sat 01/04/23	Tue 30/01/24	P.Johnstone	0%	There was a confirmation that there can be no new investment into a step up service. Business case for step up service that was submitted was not affordable and will not progress. Multi agency review to be commissioned. Scheme suspended.
61					**Perinatal and liaison**	522 days?	Sat 01/04/23	Mon 31/03/25	P.Fotherby	13%	
62					**Working towards our focus of providing more care in the community, early intervention and prevention, we will increase our perinatal community provision**	522 days	Fri 01/04/22	Fri 29/03/24	P.Fotherby	17%	
66					**With support from the WY ICS continue to provide a NICPM service**	262 days	Sat 01/04/23	Sun 31/03/24	P.Fotherby	10%	
68					**Working with our partners in LTHT to improve the experience of those presenting to the Emergency Department in mental health crisis**	522 days?	Sat 01/04/23	Mon 31/03/25	P.Fotherby	12%	
73					**Children and young people**	521 days	Sat 01/04/23	Mon 31/03/25	N.Mant	17%	
74					**Introduce the Alternative to Hospital Service in both Mill Lodge to provide a service for children and young people with eating disorders/disordered eating, reducing length of stay and admissions for young people with these presentations.**	480 days	Sat 01/04/23	Fri 31/01/25	N.Mant	15%	
75					Implementation of the new eating disorders day service	262 days	Sat 01/04/23	Fri 29/03/24	N.Mant	20%	Business case for AHA provision approved. Project and mobilisation plan written. Increased estate costs needs to be addressed, though currently within plan. Estates work is scheduled to commence on 20.11.23.
76					Complete evaluation of the Alternative to Hospital provision within Mill Lodge	285 days	Mon 01/01/24	Fri 31/01/25	N.Mant	10%	Service working alongside HNY workstream to develop KPI suite.
77					**Implement a pilot assessment service within NDCAMHS for Young People aged 18-25 to better understand the needs of this population informing a future business case for intervention**	521 days	Sat 01/04/23	Mon 31/03/25	N.Mant	9%	
80					**Ensure the stability of Red Kite View**	262 days	Sat 01/04/23	Sun 31/03/24	N.Mant	40%	
81					Confirm the S136 commissioning arrangements with Leeds ICB	262 days	Sat 01/04/23	Fri 29/03/24	N.Mant	40%	Meetings occuring with ICB to progress business case for long term S136 cover. Suggestion of on-call explored though significant challenge and concern around this. Latest options explore greater use of responsive workforce to support S136 cover which brin
82					**Rehabilitation, eating disorders and gender identity**	262 days	Sat 01/04/23	Sun 31/03/24	R.Carroll	59%	
83					**Reducing the number of complex rehab out of area placements**	262 days	Sat 01/04/23	Sun 31/03/24	R.Carroll	75%	
86					**Complete R&R and AOT review and implement recommendations for a Complex Psychosis Service**	327 days	Sat 01/04/23	Mon 01/07/24	R.Carroll	41%	
92					**Continue the development of the West Yorkshire Complex Rehabilitation Enhanced Support Team (CREST)**	262 days	Sat 01/04/23	Sun 31/03/24	R.Carroll	75%	
96					**Development of our locked and rehabilitation pathways**	262 days	Sat 01/04/23	Sun 31/03/24	R.Carroll	70%	
98					**Introduction of a community eating disorders service to support people who do not meet the referral criteria for CONNECT.**	262 days	Sat 01/04/23	Sun 31/03/24	R.Carroll	30%	
101					**Gender ID: continuing waiting list management**	783 days	Sat 01/04/23	Tue 31/03/26	R.Carroll	61%	
104					**Regional & Specialist Services**	262 days	Sat 01/04/23	Sun 31/03/24	D.Rowley	44%	
105					**Determine the future of operating model for NSCAP following the outcome of the tender process**	349 days	Sat 01/04/23	Wed 31/07/24	D.Rowley	10%	
106					Implementation of phases 1 - 3	349 days	Sat 01/04/23	Tue 30/07/24	D.Rowley	10%	We have developed a proposal detailing 3 phases of work which has been consider by SDG/FPG. A high level MOC plan developed and implemented for phase 1 (clinical model) with the service closing at the end of October 2023. Project arrangements in place
107					**Improving mental health services for people with autism**	262 days	Sat 01/04/23	Sun 31/03/24	D.Rowley	45%	
108					Rollout of autism training for LYPFT staff	262 days	Sat 01/04/23	Fri 29/03/24	D.Rowley	90%	We have successfully recruited to the training coordinator role and they commenced in post in September. Training will will be available to book onto from quarter 4.
109					Subject to the autism business case outcome, implementation of the agreed option for autism	262 days	Sat 01/04/23	Sun 31/03/24	D.Rowley	0%	Business case not approved due to no funding. Options being explored to maintain situation through permanent roles rather than secondments. Secondments run out at the end of August. Objective will not be achieved and requires revising.
110					**Improving our services for people with ADHD**	262 days	Sat 01/04/23	Sun 31/03/24	D.Rowley	0%	
111					Subject to the ADHD business case outcome, implementation of the agreed option for ADHD	262 days	Sat 01/04/23	Fri 29/03/24	D.Rowley	0%	Business case not approved due to no funding. Options being explored to maintain situation through permanent roles rather than secondments. Secondments run out at the end of August. Objective will not be achieved and requires revising.
112					**Improving our services for people with a gambling addiction**	262 days	Sat 01/04/23	Sun 31/03/24	D.Rowley	60%	
113					Mobilisation of the expanded clinics across the NE and NW	262 days	Sat 01/04/23	Fri 29/03/24	D.Rowley	60%	Mobilisation has commenced. We have successfully appointed into the CTM role who starts on 1st December. Also x2 band 6 and a band 7 practioner have been recruited for the north west. Also have an agreed estate solution via Regus.
114					**Connectivity of the Emerge service across the primary care network linked with the rollout of Community Transformation**	262 days	Sat 01/04/23	Sun 31/03/24	D.Rowley	35%	
116					**As part of Forward Leeds improve services for people with an addiction**	262 days	Sat 01/04/23	Sun 31/03/24	D.Rowley	40%	
118					**Improving our services for Veterans and supporting Trust Commitment to the Armed Forces Covenant**	262 days	Sat 01/04/23	Sun 31/03/24	D.Rowley	85%	
121					**Our Digital Plan**	**1066 days?**	**Tue 01/03/22**	**Tue 31/03/26**	**I.Hogan**	39%	
122					**Deployment of a Patient Portal**	218 days	Tue 02/01/24	Thu 31/10/24	I.Hogan	10%	
123					Deliver technical solution and conduct controlled trials	392 days	Sat 01/04/23	Fri 27/09/24	I.Hogan	10%	Timescales extended from end of March 2024 to September 2024. To fully understand which services trials should take place i.e. CFS
124					Presentation through NHS login. Trust wide deployment of Patient Portal where appropriate	261 days	Tue 02/01/24	Mon 30/12/24	I.Hogan	10%	NHS England unable to give timescales on delivery of log-in for Care Director portal at this time. Priority is with acute Trusts.
125					**Develop the link to the Yorkshire & Humber care record**	371 days	Tue 01/08/23	Tue 31/12/24	I.Hogan	17%	
128					**Assess and co-design an inclusive digital transformation programme for the Trust**	522 days	Fri 01/04/22	Sun 31/03/24	I.Hogan	47%	
129					Build an Inclusive Digital Transformation Programme in collaboration with Thrive by Design	261 days	Fri 01/04/22	Fri 31/03/23	I.Hogan	100%	Programme designed with Thrive by Design and reporting into IMSG.

Trust Organisational Priorities 2023 - 2030: Quarter 2 Progress Report

ID	Task Mode	Q2 RAG	Q1 RAG	Mover	Task Name	Duration	Start	Finish	Lead	% Complete	Progress Update
130					Deploy and embed the inclusive transformation programme trust wide	522 days	Sat 01/04/23	Fri 28/03/25	I.Hogan	20%	Deployment started with learning disability service but wider deployment held back with resource challenges in CMHT and requirement for further evidence of impact from IMSG. Timescales extended from March 2024 to March 2025.
131					**Deployment of Electronic Document Management System**	262 days?	Sat 01/04/23	Sun 31/03/24	I.Hogan	43%	
134					**Replace/ retire the need for physical smart cards across the Trust**	522 days	Sat 01/04/23	Mon 31/03/25	I.Hogan	37%	
138					**To ensure that Trust defences against cyber threats are affective**	522 days	Fri 01/04/22	Sun 31/03/24	I.Hogan	30%	
141					**Streamline the process for on-boarding staff**	783 days	Fri 31/03/23	Tue 31/03/26	I.Hogan	0%	
144					**Flexible but safe access to trust system from any location**	782 days	Fri 01/04/22	Mon 31/03/25	I.Hogan	57%	
147					**Present key data generated by LYPFT systems through the Yorkshire & Humber Care Record and Professional Portal**	261 days	Mon 01/04/24	Mon 31/03/25	I.Hogan	0%	
149					**Integration of Care Director with the NHS SPINE**	545 days	Tue 01/03/22	Sun 31/03/24	I.Hogan	72%	
155					**Strategic Estates Plan**	**1761 days?**	**Fri 01/10/21**	**Fri 30/06/28**	**D.Hanwell**	24%	
156					**Develop our PFI Estate**	1696 days	Fri 01/10/21	Fri 31/03/28	J.Campbell	25%	
158					**Enabling key clinical service changes through our estate**	522 days	Sat 01/04/23	Mon 31/03/25	J.Campbell	39%	
159					Renovation of Parkside Lodge to become a male 16 bed Complex Care Facility.	502 days	Sun 01/05/22	Fri 29/03/24	J.Campbell	20%	Programme on hold
160					Renovation of Mill Lodge to enable the opening of an eating disorders day service	262 days	Sat 01/04/23	Fri 29/03/24	J.Campbell	30%	The business case for the scheme has been approved and the contractor selected following the procurement exercise. Work scheduled to commence in November 2023.
161					Renovation of the seclusion facility at the Newsam Centre to ensure in-line with agreed standards	349 days	Sat 01/04/23	Tue 30/07/24	J.Campbell	30%	The Deed of Variation has been drafted and the scheme is ready to go out to tender. Completion date moved to the first quarter of 2024/25.
162					Undertake a benchmarking exercise with our PFI provider. This will incorporate our catering provision.	242 days	Sat 01/04/23	Fri 01/03/24	J.Campbell	90%	We expect tp receive the benchmarking report by 31/10/2023.
163					Renovation of our inpatient wards as part of the PFI lifecycle arrangement	242 days	Sat 01/04/23	Fri 01/03/24	J.Campbell	50%	PFI lifecycle programme on target and is now being managed and monitoring at the monthly PFI Contract Sign off Meeting.
164					**Owned Estate**	1696 days	Fri 01/10/21	Fri 31/03/28	J.Campbell	15%	
169					**Organisational preparedness for the ceasation of our PFI concession in 2028**	1371 days	Sat 01/04/23	Fri 30/06/28	J.Campbell	20%	
171					**Ensuring our services are safe and secure**	782 days	Fri 01/04/22	Mon 31/03/25	J.Campbell	45%	
173					**Working with partners on new developments**	805 days	Tue 01/03/22	Mon 31/03/25	J.Campbell	16%	
177					**Optimising our Estate**	894 days?	Wed 01/06/22	Sat 01/11/25	J.Campbell	31%	
180					**Green Plan**	**2087 days**	**Fri 01/04/22**	**Sun 31/03/30**	**J.Campbell**	22%	
181					**Achieve Our Sustainable targets**	522 days	Sat 01/04/23	Mon 31/03/25	J.Campbell	28%	
184	✓				**SDAT Assessment**	522 days	Fri 01/04/22	Sun 31/03/24	J.Campbell	100%	
186					**Networking, Comms & Engagement**	2087 days	Fri 01/04/22	Sun 31/03/30	J.Campbell	19%	
187					Implemented Sustainability champions across the organisation	544 days	Wed 01/03/23	Fri 28/03/25	J.Campbell	50%	We need to develop a job role specification for the Sustainability Champions so we are clear on their role and what we expect them to do. Move to 2024/25
188					Develop and implement an incentive scheme and reward staff for tracking and reducing their own carbon footprint.	522 days	Sat 01/04/23	Fri 28/03/25	J.Campbell	20%	We are proposing to prioritise calculating our own Trust carbon footprint before we encourage staff to reduce their own. Move to 2024/25
189					Mandate carbon literacy training for all staff.	261 days	Mon 01/04/24	Fri 28/03/25	J.Campbell	20%	Developing the Carbon Literacy training materials to make available training to staff. Start with E&F team. eLearning mentioned in Q1 update is only half the training, a follow up workshop must also be attended to achieve certification.
190					Weigh appraisals more heavily towards sustainability credentials	261 days	Tue 01/04/25	Mon 30/03/26	J.Campbell	10%	No further progress made on this
191					Update and implement business case template to consider negative and positive assessment of sustainability factors (such as increased energy use) in relation to strategic decision making and future investments	544 days	Wed 01/03/23	Fri 28/03/25	J.Campbell	15%	
192					Paper Use is reduced to below 10% of current levels	284 days	Wed 01/03/23	Fri 29/03/24	J.Campbell	5%	
193					Elimination of non-clinical single use plastic from LYPFT identified in the Single Use Plastics directive and NHS Plastics Pledge	261 days	Tue 01/04/25	Mon 30/03/26	J.Campbell	20%	No further progress made on this
194					Elimination of all single use plastic products	1043 days	Fri 01/04/22	Mon 30/03/26	J.Campbell	20%	No further progress made on this
195					End the use of single use PPE and Biodegradable workwear is made standard and singleuse plastics entirely phased out	1043 days	Fri 01/04/22	Mon 30/03/26	J.Campbell	0%	
196					Set the objective that every staff member is 'fully engaged' in carbon literacy by 2030	262 days	Sun 01/04/29	Fri 29/03/30	J.Campbell	10%	Could be achieved earlier if the carbon literacy training became a mandatory training module. NHS England lisence agreement with The Carbon Literacy Project ends October 2025
197					Develop and implement the provision for all teams to have access to green social prescribing	522 days	Sat 01/04/23	Fri 28/03/25	J.Campbell	5%	No further progress made on this. Rescheduled for 2024/25
198					Treat more patients at home to reduce carbon emissions because of their travel	522 days	Sat 01/04/23	Fri 28/03/25	J.Campbell	60%	CAMA tool in development by Thrive by Design, however disappointly the consultation with Trust staff received a limited response.
199					Develop and implement a plan for the reduction of all nutritional products such as enteral feeds/ nutritional supplements oral waste	261 days	Mon 01/04/24	Mon 31/03/25	J.Campbell	0%	No further progress made on this.
200					Develop and implement a plan to reduce medical waste, i.e., overprescribing medications	782 days	Fri 01/04/22	Fri 28/03/25	J.Campbell	10%	Engaging with Trust and Regional pharmacists. Consultant Support to embed. Timescales revised to March 2025.
201					Review Sustainability and associated policies to incorporate Green Plan actions and targets Incorporation of sustainability onto meeting agendas	262 days	Sat 01/04/23	Fri 29/03/24	J.Campbell	80%	Environmental policy draft to be finalised by November. Responsible Parking Policy did not go out to consultation - this needs to be picked up. EV Charging Policy required. Waste Policy required. Sustainability item on E&F meeting agendas
202					Implement a mandatory environmental/ sustainability impact assessment framework on every policy/ procedure document that is produced	261 days	Mon 01/04/24	Mon 31/03/25	J.Campbell	0%	No further progress made on this, although examples from other Trusts that could be adapted.
203					Implement a policy of engaging with patients to not only address their own wellbeing but also, to be responsible citizens in protecting the environment and reducing emissions	261 days	Tue 01/04/25	Mon 30/03/26	J.Campbell	20%	No further progress made on this
204					Implement an ISO management standard for Environmental Management (EMS) and/or Sustainability/ Social Value standard.	261 days	Tue 01/04/25	Mon 30/03/26	J.Campbell	15%	Discussed with NOE CPC and ISO 14001 certification may not be required for the due diligence. All they have requested at the moment is the draft Environmental Policy which reflects the ISO 14001 framework. They will share due diligence audit feedback.
205					**Review Bottled Water Provision**	261 days	Mon 01/04/24	Mon 31/03/25	J.Campbell	7%	
209					**Cooking, Food Provision and Waste Review**	1043 days	Fri 01/04/22	Tue 31/03/26	J.Campbell	27%	
218					**Trust Transport Strategy**	522 days	Mon 01/04/24	Tue 31/03/26	J.Campbell	15%	
221					**Climate Change & Resiliance**	262 days	Sat 01/04/23	Sun 31/03/24	J.Campbell	20%	
223					**IT Equipment & Printing**	782 days	Fri 01/04/22	Mon 31/03/25	J.Campbell	2%	

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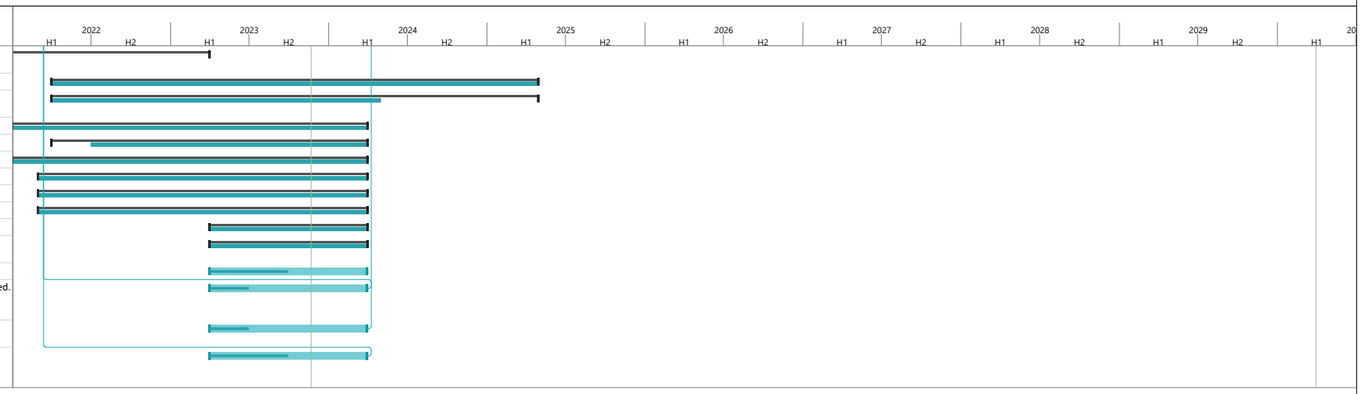
ID	Task Mode	Q2 RAG	Q1 RAG	Mover	Task Name	Duration	Start	Finish	Lead	% Complete	Progress Update
227					**Energy, Cooling, Water: Improve Efficiency, Management & Monitoring**	1043 days	Fri 01/04/22	Tue 31/03/26	J.Campbell	24%	
228					Begin to introduce AI to automate energy efficiency within the Trust estate	522 days	Fri 01/04/22	Fri 29/03/24	J.Campbell	40%	No further progress made on this. Other systems to be considered as part of the capital programme and Green Plan Implementation Plan
229					PFI Provider moves to 100% renewal energy	522 days	Sat 01/04/23	Fri 28/03/25	J.Campbell	20%	No further progress made on this - further enquiries required.
230					100% of energy is produced on-site	261 days	Tue 01/04/25	Tue 31/03/26	J.Campbell	0%	No further progress made on this
231					**Our Medical Strategy**	**522 days?**	**Fri 01/04/22**	**Sun 31/03/24**	**C.Hosker**	65%	
232					**We wish to continue to maintain the high standards of medical appraisal and revalidation**	262 days	Sat 01/04/23	Sun 31/03/24	V.Lovett	73%	
235					**We wish to continue to maintain the current high standards by which concerns regarding doctors are managed**	522 days	Fri 01/04/22	Sun 31/03/24	V.Lovett	63%	
240					**We wish to continue to maintain our excellent medical education and training.**	262 days	Sat 01/04/23	Sun 31/03/24	V.Lovett	60%	
242					**We want to foster a culture of inclusion and belonging in our medical workforce that allows us to train and recruit future psychiatrists and healthcare professionals, and be able to work together to deliver sustainable patient care**	262 days	Sat 01/04/23	Sun 31/03/24	V.Lovett	60%	
245					**All consultants and SAS doctors have a clear agreed job plan which links with the doctor's appraisal and vice versa where they have protected time to focus on career development as a medical leader.**	260 days?	Sat 01/04/23	Sun 31/03/24	V.Lovett	73%	
248					**Nursing and professions strategy**	**1566 days?**	**Mon 01/04/19**	**Mon 31/03/25**	**N.Sanderson**	52%	
249					**Improving Retention of Professions**	1043 days	Thu 01/04/21	Mon 31/03/25	A.Quarry & M.Treve	50%	
251					**Implementation of the Patient Safety Incident Response Framework (PSIRF)**	522 days?	Sat 01/04/23	Mon 31/03/25	C.Wardle	21%	
255					**Implementation of patient safety outcomes**	**652 days?**	**Sat 01/04/23**	**Tue 30/09/25**	**A.Quarry**	**3%**	
259					**Improved service user experience**	522 days	Fri 01/04/22	Sun 31/03/24	S. Marshall	65%	
262	✓				**Carers want to feel valued as a partner in care. Together we need to develop dedicated carer support across the organisation and with city wide partners.**	1044 days	Wed 01/04/20	Sun 31/03/24	S.Marshall	100%	
264					**Implementing research, development and new technologies**	762 days	Thu 01/04/21	Fri 01/03/24	A.Quarry, M.Claire-Trevett	50%	
266					**Need to increase the number of people who become involved in how are services are provided, including people from diverse backgrounds to meet the needs of people living in our communities.**	1306 days	Mon 01/04/19	Sun 31/03/24	S.Ahmed	80%	
268					**Working towards a 'good/outstanding' CQC rating for all services when next inspected**	**196 days?**	**Sat 01/04/23**	**Mon 01/01/24**		**49%**	
274					**People Plan**	**1303 days?**	**Thu 01/04/21**	**Tue 31/03/26**	**D.Skinner**	60%	
275					**Ensure our people have access to the full range of well-being support, physical, psychological, financial and emotional**	522 days?	Fri 01/04/22	Sun 31/03/24	F.Dodd	89%	
280	✓				**Promote a psychologically safe culture and environment which challenges stigma and values the lived experience**	632 days	Fri 01/04/22	Sun 01/09/24	F.Dodd	100%	
282					**Keep our people protected, safe and well at work**	522 days	Fri 01/04/22	Sun 31/03/24	F.Dodd	23%	
283	✓				Continue the evaluation through the wellbeing assessment to ensure colleagues who are adopting hybrid working remain safe and well at work and implement necessary changes	66 days	Mon 01/01/24	Sun 31/03/24	F.Dodd	100%	We have rolled out the wellbeing assessment process for line managers to continually review their team member support requirements when working flexibly.
284					Start to make identified and targeted improvement to estates and facilities, focussing on clinical sites where staff are patient-facing and those colleagues working in an agile way i.e. hybrid worker	261 days	Fri 01/04/22	Thu 30/03/23	F.Dodd	50%	Working alongside the Estates team we are rolling out the implementation of wellbeing rooms on major sites and supporting the hot desk working spaces across the Trust.
285					Identify and implement improvement measures, to increase the rate of managers completing return to work meetings within 48 hours of the colleagues returning to work	522 days	Fri 01/04/22	Sun 31/03/24	H.Tetley	0%	We are working with line managers to ensure return to work interviews are undertaken within 48hrs of return. Further work is to be done to support managers through this process.
286	✓				**Ensure our leaders will have the knowledge, skill and expertise to support wellbeing in the workplace**	262 days	Sat 01/04/23	Sun 31/03/24	F.Dodd	100%	
288					**Give our people a voice, listening, acting on feedback and involvement in decision making**	262 days	Sat 01/04/23	Sun 31/03/24	F.Dodd	83%	
292					**Embed Equality, Diversity and Inclusion in the culture of our Trust**	66 days	Mon 01/01/24	Sun 31/03/24	F.Dodd	93%	
295					**Grow collective leaders that reflect Trust values**	262 days	Sat 01/04/23	Sun 31/03/24	F.Sherburn & A.Earn	50%	
297					**Provide a working environment of civility and respect for our people**	545 days	Tue 01/03/22	Sun 31/03/24	H.Tetley	46%	
301					**Improve the experience of those people with a protected characteristic as identified by the Equality Act 2010**	284 days	Wed 01/03/23	Sun 31/03/24	F.Dodd	0%	
302					Develop and publish a 3-year EDI plan, detailing priorities and targeted ambitions	284 days	Wed 01/03/23	Sun 31/03/24	F.Dodd	0%	Delayed due to a full review of EDI, priority areas and reporting and People Plan scheduled for completion end of year.
303					Monitor and review progress against the EDI plan and review workforce demographic and personal experience data to inform the EDI plan and future ambitions	22 days	Fri 01/03/24	Sun 31/03/24	F.Dodd	0%	Delayed due to a full review of EDI, priority areas and reporting and People Plan scheduled for completion end of year.
304	✓				**Develop an agile workforce who can deliver effectively in their roles**	262 days	Sat 01/04/23	Sun 31/03/24	H.Tetley	100%	
306					**Continue to build a culture of innovation and improvement in our approach to people development, systems and processes**	262 days	Sat 01/04/23	Sun 31/03/24	F.Sherburn & A.Earnshaw	40%	
308					**Develop Organisational Development (OD) and change management support to facilitate new ways of working and delivering care**	284 days	Wed 01/03/23	Sun 31/03/24	F.Sherburn & A.Earnshaw	31%	OD model and triage process drafted. A comms / engagement plan will be developed in quarter 3 to support the implementation of the work.
312					**Provide accessible and intuitive software solutions to support People and OD initiatives**	522 days	Fri 01/04/22	Sun 31/03/24	A. McNichol	40%	
315					**Deliver an effective workforce plan, which focuses on recruitment and retention and future supply pathways, and which incorporates Trust Learning Needs Analysis (LNA)**	522 days	Fri 01/04/22	Sun 31/03/24	F.Sherburn & A.Earnshaw	57%	
319	✓				**Develop and deliver the best experience for those who join the Trust**	326 days	Mon 01/01/24	Mon 31/03/25	F.Sherburn & A.Earnshaw	100%	
323					**Develop and implement an innovative approach to talent development, and which aligns to the Trust Workforce plan**	262 days	Sat 01/04/23	Sun 31/03/24	F.Sherburn & A.Earnshaw	70%	
325					**Work with partner organisations to deliver joint leadership and career development programmes**	261 days	Fri 01/04/22	Fri 31/03/23	F.Sherburn & A.Earnshaw	30%	
327					**Promote the one Leeds workforce model, removing barriers to cross-organisational and cross-functional working to enable new models of service delivery**	1043 days	Thu 01/04/21	Mon 31/03/25	H.Tetley	65%	
332					**Work with partner organisations to collaborate on introducing and embedding new roles and the sharing of resources where this benefits the system**	522 days	Fri 01/04/22	Sun 31/03/24	F.Sherburn & A.Earnshaw	50%	
334					**Embed reward and recognition in our Trust to create a culture of our staff feeling valued**	262 days	Sat 01/04/23	Sun 31/03/24	F.Dodd	50%	
337	✓				**Psychological Professions Strategic Plan**	**783 days**	**Thu 01/04/21**	**Sun 31/03/24**	**S.Prince**	100%	
338	✓				**All psychological practice is safe, caring and compassionate, effective, cost effective, responsive and well led.**	260 days	Sat 01/04/23	Sun 31/03/24	S.Prince	100%	

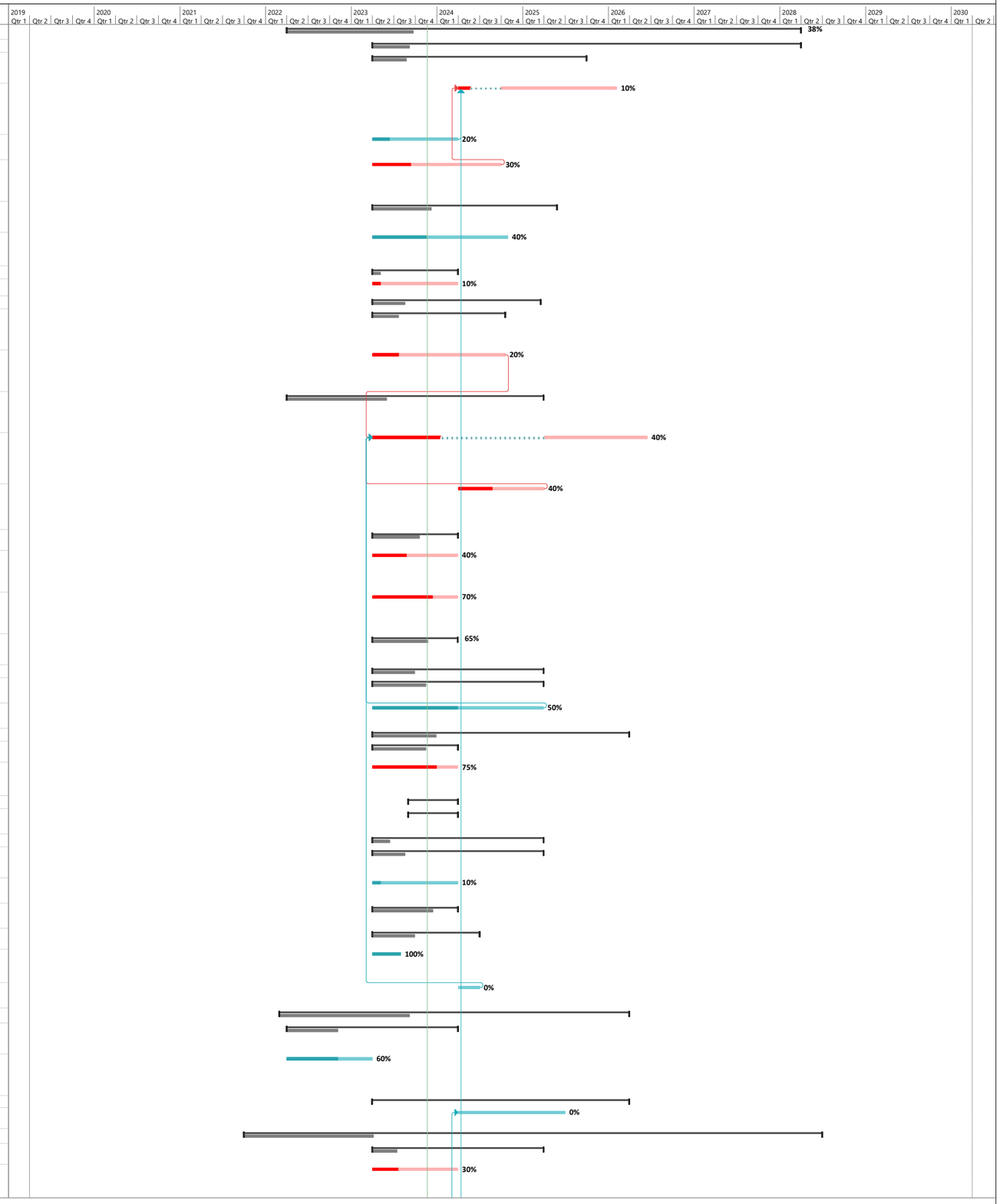
Trust Organisational Priorities 2023 - 2030: Quarter 2 Progress Report

ID	Task Mode	Q2 RAG	Q1 RAG	Mover	Task Name	Duration	Start	Finish	Lead	% Complete	Progress Update
341					**To focus on workforce development to ensure the sustainability of our skilled and knowledgeable staff.**	523 days	Thu 01/04/21	Sat 01/04/23	S.Prince	100%	
343					**Quality Strategic Plan**	**804 days**	**Fri 01/04/22**	**Wed 30/04/25**	**R.Wylde & C.Mone**	61%	
344					**Embedding clinical outcome measures across our clinical services**	804 days	Fri 01/04/22	Wed 30/04/25	R.Wylde & C.Money	61%	
347					**Research & Development**	**587 days**	**Sat 01/01/22**	**Sun 31/03/24**	**S.Cooper**	50%	
348					**Create a culture of research being core business**	522 days	Fri 01/04/22	Sun 31/03/24	S.Cooper	50%	
350					**Developing a skilled workforce**	587 days	Sat 01/01/22	Sun 31/03/24	S.Cooper	50%	
352					**Actively engage a network of key stakeholders**	545 days	Tue 01/03/22	Sun 31/03/24	S.Cooper	50%	
354					**Effectively disseminate research outputs and Impact**	545 days	Tue 01/03/22	Sun 31/03/24	S.Cooper	50%	
356					**Influence regional and national agendas**	545 days	Tue 01/03/22	Sun 31/03/24	S.Cooper	50%	
358					**Finance Strategy**	**262 days?**	**Sat 01/04/23**	**Sun 31/03/24**	**J.Saxton**	**38%**	
359					**We use our resources to delivery effective and sustainable services**	262 days	Sat 01/04/23	Sun 31/03/24	J.Saxton	38%	
360					Delivering a robust and sustainable efficiency plan	262 days	Sat 01/04/23	Fri 29/03/24	J.Saxton	50%	On plan and forecast to meet plan
361					Develop and monitor a plan to reduce agency spend (medical and non-medical)	262 days	Sat 01/04/23	Fri 29/03/24	J.Saxton	25%	The plan to reduce agency expenditure is not fully developed. The Trust expenditure is significantly over plan
362					Develop and monitor a plan to reduce out of area placements (complex rehab and adult acute)	262 days	Sat 01/04/23	Fri 29/03/24	J.Saxton	25%	The plan to reduce OAPs spend is not fully developed. The Trust is significantly over plan
363					Develop and monitor a plan to reduce our vacancy position by looking at opportunities to redesign within existing establishment	262 days	Sat 01/04/23	Fri 29/03/24	J.Saxton	50%	Number of initiatives on-going



2023 - 2024 Organisational Priorities: quarter 2 interdependent tasks

ID	Task Mode	Q2 RAG	Q1 RAG	Movement	Task Name	Duration	Start	Finish	Lead	% Complete	Progress Update	Predecessors	Successors
1					**Care Services Strategic Plan**	**1565 days?**	**Fri 01/04/22**	**Fri 31/03/28**	**J.Forster-Adams**	**38%**			
2					**Adult Acute**	**1306 days**	**Sat 01/04/23**	**Fri 31/03/28**	**L.McDonagh**	**24%**			
3					**Create capacity and flow through the acute pathway that enable a reduction in the number of people placed out of area**	**653 days**	**Sat 01/04/23**	**Tue 30/09/25**	**L.McDonagh**	**20%**			
4					Eliminate inappropriate out of area placements	392 days	Mon 01/04/24	Wed 04/02/26	L.McDonagh	10%	Out of area pressures continues to be challenging with demand being consistently high. Developing a recovery plan for acute flow which will be approved during quarter 3. In addition we are reviewing the role and function of the capacity & flow team.	5,6,362	13
5					Reduce unwarranted clinical variation	262 days	Sat 01/04/23	Fri 29/03/24	L.McDonagh	20%	The clinical variation has reduced but our length of stay has increased across all wards resulting in a MADE action plan.		4
6					Formulation to be embedded across the acute inpatient service	393 days	Sat 01/04/23	Mon 30/09/24	L.McDonagh	30%	We have embeded formulation in wards 1 and 4 at Becklin. Currently working with ward 4 Newsam with plans to further roll out to the remaining wards with the commencement of new psychologist in early Nov. Timescales for completion moved to 1 Oct 2024.		4
9					**Complete a review of the crisis pathway that will determine the future of the Crisis Assessment Unit**	**563 days**	**Sat 01/04/23**	**Tue 27/05/25**	**L.McDonagh**	**32%**			
10					Develop and implement a new model for CRISS	413 days	Sat 01/04/23	Mon 28/10/24	L.McDonagh	40%	Model proposal completed and presented to ODG. Presented to ODG in Sept. Further work to be undertaken on the model for bringing back to ODG in Nov/Dec 2023.		11
14					**Health Inequalities**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**J.Forster-Adams**	**10%**			
15					Develop and implement a health inequalities delivery plan	262 days	Sat 01/04/23	Fri 29/03/24	J.Forster-Adams	10%	We are recruiting a Head of Inequalities with interviews taking place w/c 6 November.		266
16					**Community and wellbeing**	**513 days?**	**Sat 01/04/23**	**Tue 18/03/25**	**J.Faulkner**	**35%**			
17					**Transition WAA CMHS out of BC, into stabilisation and recovery. Recovery is aligned with a move to a transformed population/community-based approach**	**406 days**	**Sat 01/04/23**	**Fri 18/10/24**	**J.Faulkner**	**20%**			
18					Collectively redesign the way we deliver our services (AOT, Emerge, FOT) exploring pathway interfaces, service alignments and services offer to identify and implement improvements.	406 days	Sat 01/04/23	Thu 17/10/24	J.Faulkner	20%	All deployed colleagues have returned to their substantive roles. Individual caseloads remain low, the coming months will give an indicaiton on the sustainability of the recovery. New starters continue to join the teams over quarter 3.		20,47,46,89
19					**To progress all service developments inclusive of Community Transformation, EIP, Rough Sleepers Mental Health Service, Urgent Treatment Centres and Physical Health Services**	**782 days?**	**Fri 01/04/22**	**Mon 31/03/25**	**J.Faulkner**	**31%**			
20					Ongoing development of Mental Health Services in the Community as a apart of the community transformation. This includes workforce modelling, model operationalising, pilot roll out and full staff consultation.	522 days	Sat 01/04/23	Mon 15/06/26	J.Faulkner	40%	The Community Transformation Pilot roll out scheduled for Oct has been delayed until at least November. Decision being made in October as to go live. Requiring Exec to Exec & ICB discussions.	18,42,9	167
23					Development of psychological interventions for people with SMI, within both primary care therapies and therapies as a part of the enhanced offer.	262 days?	Mon 01/04/24	Tue 01/04/25	Fiona Lowis & Alex Perry	40%	Continues to develop, with all posts in Primary Therapies now recruited to. Aligned with PCMHS. Wellbeing Practitioner trainees all in post, new recruit to train posts going out. Positive developments around therapy.		20
27					**Improve the wellbeing for all, including self, making it central to what we do**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**J.Faulkner**	**55%**			
28					Ongoing Workforce development, to create a diverse workforce where recruitment, retention and development is a priority for all colleagues and all roles.	262 days	Sat 01/04/23	Fri 29/03/24	J.Faulkner	40%	Wellbeing continues to be a central focus, evidence with approach to deployed colleagues and improvements to induction. New third sector roles embedded within teams, provide diversity including new roles and partners. TNAs have been completed.		315
29					For at least 85% of team members to have an appraisal and career conversation at least annually	262 days	Sat 01/04/23	Fri 29/03/24	J.Faulkner	70%	Service line appraisal completion is at 70%, however this remains below the target and the drive for at least 85% of colleagues to have a completed appraisal. Focus on individuals and managers is taking place.		307
30					**To improve collective leadership througout our teams through the creation of psychological safety, role clarity and clear expectations teams/individuals hold of**	**260 days**	**Sat 01/04/23**	**Fri 29/03/24**	**J.Faulkner**	**65%**			**296**
33					**Older people's services**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**E.Townsley**	**43%**			
40					**Support people to remain in their own homes as much as possible by contribute to the development of the older adults aspects of the Community Transformation Programme**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**E.Townsley**	**42%**			
42					Engagement with all aspects of the Community Transformation Programme, including model development and engagement	522 days	Sat 01/04/23	Fri 28/03/25	E.Townsley / B Alderson / G Wormald	50%	Model development in progress. Monitoring undertaken by the Transformation Programme Board.		20
43					**Forensic services**	**783 days**	**Sat 01/04/23**	**Tue 31/03/26**	**S.Russo**	**52%**			
50					**Implementation of the new safer staffing model across our Leeds forensic services.**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**S.Russo**	**63%**			
51					To recruit to vacant posts, utilising recruitment incentives, new skill mixes for wards and media campaigns	262 days	Sat 01/04/23	Fri 29/03/24	S.Russo	75%	Our HSW posts have been successfully recruited into. Additional OT posts are being explored alongside other vacant posts for skill mix of physical health / specialist nurse roles.		315
53					**Learning disability services**	**152 days**	**Fri 01/09/23**	**Sun 31/03/24**	**P.Johnstone**	**20%**			
54					**Working collaboratively with our Local Authority commissioning partners we will redesign the delivery and leadership model for our Specialised Supported Living Service.**	**152 days**	**Fri 01/09/23**	**Sun 31/03/24**	**P.Johnstone**	**16%**			**296**
61					**Perinatal and liaison**	**522 days?**	**Sat 01/04/23**	**Mon 31/03/25**	**P.Fotherby**	**13%**			
68					**Working with our partners in LTHT to improve the experience of those presenting to the Emergency Department in mental health crisis**	**522 days?**	**Sat 01/04/23**	**Mon 31/03/25**	**P.Fotherby**	**12%**			
69					Engagement with the project team in the redesign of the high risk assessment room and safe flexible space at LGI and SJUH EDs.	262 days	Sat 01/04/23	Fri 29/03/24	P.Fotherby	10%	Routine meetings/engagement in place. Works not yet complete. Being closely monitored.		70
82					**Rehabilitation, eating disorders and gender identity**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**R.Carroll**	**59%**			
86					**Complete R&R and AOT review and implement recommendations for a Complex Psychosis Service**	**327 days**	**Sat 01/04/23**	**Mon 01/07/24**	**R.Carroll**	**41%**			
87					Develop a place-based clinical pathway for complex psychosis, aligning the existing R&R, AOT and Newsam WS.	87 days	Sat 01/04/23	Sun 30/07/23	R.Carroll	100%	Review completed and presented to SDG.		88,91,97
90					Community Transformation implement wave 2 upscaled complex psychosis pilot across PCN footprint	66 days	Mon 01/04/24	Mon 01/07/24	R.Carroll	0%	Will commence following completion of pilot. Linked with the clinical psychosis pathway redesign.		20
121					**Our Digital Plan**	**1066 days?**	**Tue 01/03/22**	**Tue 31/03/26**	**I.Hogan**	**38%**			
138					**To ensure that Trust defences against cyber threats are affective**	**522 days**	**Fri 01/04/22**	**Sun 31/03/24**	**I.Hogan**	**30%**			
139					Deployment of: password software, cloud-based back-ups, multi-factor authentication, privileged access management, phishing exercise software, update cyber policies in-line with national standards, employ a cyber team	261 days	Fri 01/04/22	Thu 30/03/23	B.Fawcett	60%	Multi factor authentication and privillaged acess is being deployed across the Trust. Migration to new data centre config with cloud services sceduled to complete by October. Proposal to update policies received and under consideration.		140
141					**Streamline the process for on-boarding staff**	**783 days**	**Fri 31/03/23**	**Tue 31/03/26**	**I.Hogan**	**0%**			
142					Assessment of the tools available to replace the SW process	327 days	Sun 31/03/24	Mon 30/06/25	I.Hogan	0%	Project planned to commence in 2024/25	313	143
155					**Strategic Estates Plan**	**1761 days?**	**Fri 01/10/21**	**Fri 30/06/28**	**D.Hanwell**	**24%**			
158					**Enabling key clinical service changes through our estate**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**J.Campbell**	**39%**			
160					Renovation of Mill Lodge to enable the opening of an eating disorders day service	262 days	Sat 01/04/23	Fri 29/03/24	J.Campbell	30%	The business case for the scheme has been approved and the contractor selected following the procurement exercise. Work scheduled to commence in November 2023.		75



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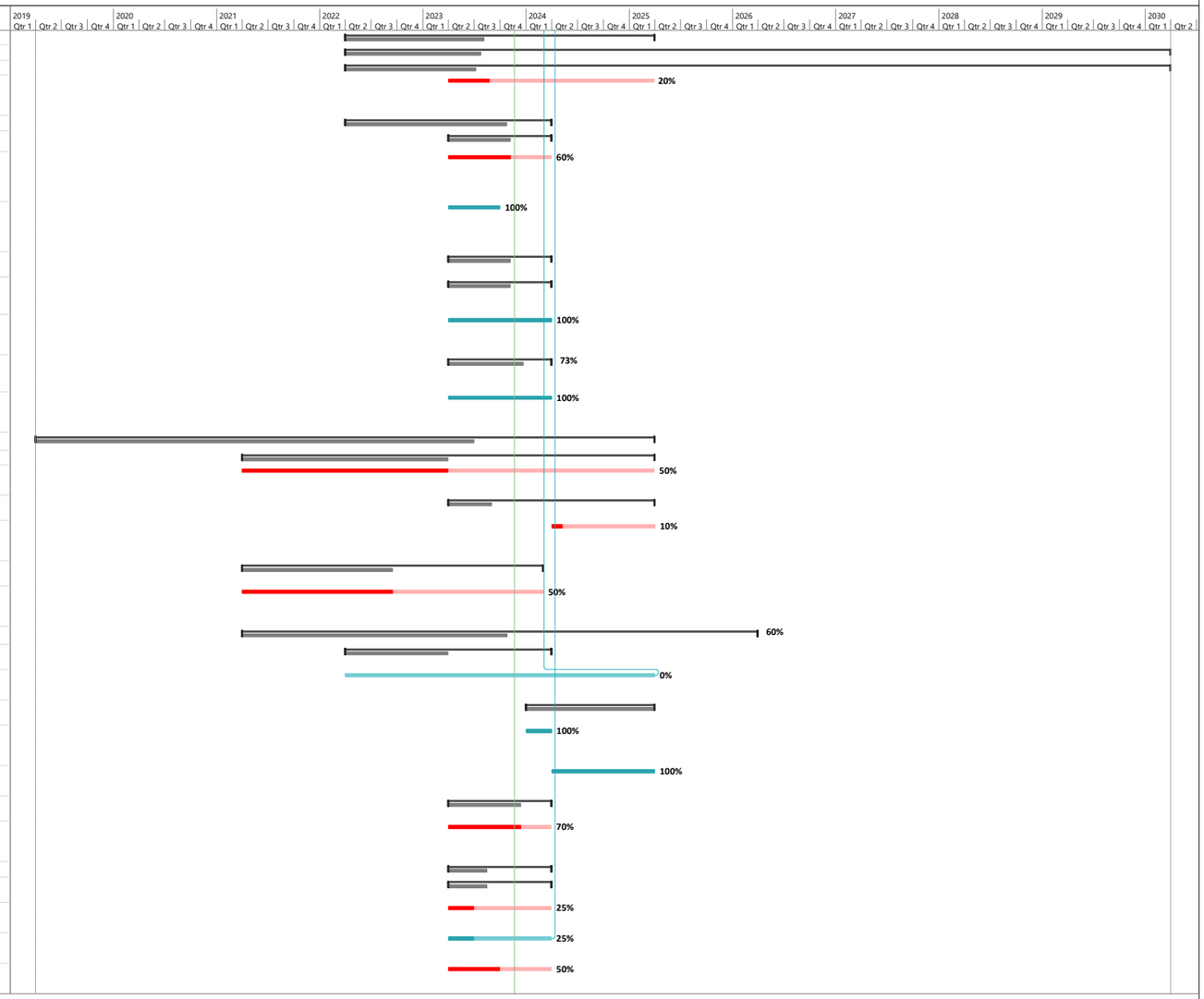
2023 - 2024 Organisational Priorities: quarter 2 interdependent tasks

ID	Task Mode	Q2 RAG	Q1 RAG	Movement	Task Name	Duration	Start	Finish	Lead	% Complete	Progress Update	Predecessors	Successors
171					**Ensuring our services are safe and secure**	**782 days**	**Fri 01/04/22**	**Mon 31/03/25**	**J.Campbell**	**45%**			**282**
180					**Green Plan**	**2087 days**	**Fri 01/04/22**	**Sun 31/03/30**	**J.Campbell**	**22%**			
186					**Networking, Comms & Engagement**	**2087 days**	**Fri 01/04/22**	**Sun 31/03/30**	**J.Campbell**	**19%**			
188					Develop and implement an incentive scheme and reward staff for tracking and reducing their own carbon footprint.	522 days	Sat 01/04/23	Fri 28/03/25	J.Campbell	20%	We are proposing to prioritise calculating our own Trust carbon footprint before we encourage staff to reduce their own. Move to 2024/25		334
231					**Our Medical Strategy**	**522 days?**	**Fri 01/04/22**	**Sun 31/03/24**	**C.Hosker**	**65%**			
232					**We wish to continue to maintain the high standards of medical appraisal and revalidation**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**V.Lovett**	**73%**			**307**
233					Undertake an analysis of the current training/support provided to doctors and, if appropriate, develop an annual update training programme focusing on appraisal and revalidation	262 days	Sat 01/04/23	Fri 29/03/24	V.Lovett	60%	The structure and content of the appraisal development forums (ADFs) to be reviewed following feedback from appraisers with a view to considering reducing the duration of ADFs but adding an annual half day refersher.		307
234					Recruit, train and support a further 3-6 appraisers to provide us with sufficient capacity to deliver the number of annual appraisals needed to support the revalidation requirements of the doctors who have a prescribed connection with the Trust	132 days	Sat 01/04/23	Sat 30/09/23	V.Lovett	100%	Recruitment for new medical ppraisers has taken place on 6th October 2023, where we successfully recruited an additional 5 appraisers. Consisting of 2 consutants and 3 SAS Doctors. All of whom are attending appraiser training on 29 October.		307
240					**We wish to continue to maintain our excellent medical education and training.**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**V.Lovett**	**60%**			**308**
242					**We want to foster a culture of inclusion and belonging in our medical workforce that allows us to train and recruit future psychiatrists and healthcare professionals, and be**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**V.Lovett**	**60%**			**315**
244					Complete an analysis of leavers in the past three years to have a baseline of reasons and services with low retention and develop an action plan. This includes the offering of exit interviews for consultants and SAS doctors.	262 days	Sat 01/04/23	Sun 31/03/24	V.Lovett	100%	A process is in place for this and the work is managed through the Good Medical Practice Assurance Group	315	
245					**All consultants and SAS doctors have a clear agreed job plan which links with the doctor's appraisal and vice versa where they have protected time to focus on career**	**260 days?**	**Sat 01/04/23**	**Sun 31/03/24**	**V.Lovett**	**73%**			**307**
246					Develop and implement with OD and external partners a leadership development programme pathway, with clear internal and external offers which can match the particular needs of different roles.	262 days	Sat 01/04/23	Sun 31/03/24	V.Lovett	100%	Leadership development programme pathway in place.		296
248					**Nursing and professions strategy**	**1566 days?**	**Mon 01/04/19**	**Mon 31/03/25**	**N.Sanderson**	**52%**			
249					**Improving Retention of Professions**	**1043 days**	**Thu 01/04/21**	**Mon 31/03/25**	**A.Quarry & M.Trevett**	**50%**			
250					Reduce turnover in nursing / AHP staff leaving the organisation by ensuring clinical teams reflect the scope of nursing practitioners at every level	1043 days	Thu 01/04/21	Fri 28/03/25	A.Quarry & M.Trevett	50%	AHP career pathway has been completed and available on staffnet.		315
251					**Implementation of the Patient Safety Incident Response Framework (PSIRF)**	**522 days?**	**Sat 01/04/23**	**Mon 31/03/25**	**C.Wardle**	**21%**			**282**
252					Procurement of a cloud-based Risk Managememet System that complies with PSIRF requirements	261 days	Mon 01/04/24	Mon 31/03/25	C.Wardle	10%	Meeting planned with new Deputy Director of IT and Head of Infomatics to discuss procurment process. Awaiting confrmation of date		133
264					**Implementing research, development and new technologies**	**762 days**	**Thu 01/04/21**	**Fri 01/03/24**	**A.Quarry, M.Claire-Trevett**	**50%**			
265					Develop and implement a portfolio of research opportunities for nursing/AHP staff aligned with the National Nursing Research Strategy and AHP strategy	762 days	Thu 01/04/21	Thu 29/02/24	L.Rose	50%	Scoping of Senior Nursing JDS and research componenet currently taking place. AHP link to research committee and promotion of opportunities and support available.		348
274					**People Plan**	**1303 days?**	**Thu 01/04/21**	**Tue 31/03/26**	**D.Skinner**	**60%**			
312					**Provide accessible and intuitive software solutions to support People and OD initiatives**	**522 days**	**Fri 01/04/22**	**Sun 31/03/24**	**A. McNichol**	**40%**			
313					Develop and implement an intuitive, integrated workflow management solution to replace the SW process	782 days	Fri 01/04/22	Mon 31/03/25	A. McNichol	0%	Revisiting the SW process will require collaboration across the People Analytics and IT teams. This scheme will transfer into 2024/25 for delivery.		142
319					**Develop and deliver the best experience for those who join the Trust**	**326 days**	**Mon 01/01/24**	**Mon 31/03/25**	**F.Sherburn & A.Earnshaw**	**100%**			
321					Evaluate the effectiveness of onboarding and the impact on retention and delivery of continuous improvement	66 days	Mon 01/01/24	Sun 31/03/24	F.Sherburn & A.Earnshaw	100%	Complete	315	
322					Evaluate the use of work experience/internships in terms of experience and recruitment impact. Continuous improvement of the scheme	261 days	Mon 01/04/24	Mon 31/03/25	F.Sherburn & A.Earnshaw	100%	Complete	315	
323					**Develop and implement an innovative approach to talent development, and which aligns to the Trust Workforce**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**F.Sherburn & A.Earnshaw**	**70%**			**315**
324					Roll out of talent management framework with supporting infrastructure to support succession planning/linked to internal recruitment and a 'grow our own' model, based on evaluation of pilot	262 days	Sat 01/04/23	Fri 29/03/24	F.Sherburn & A.Earnshaw	70%	Talent management rolled out as part of PDR process and compliance rates have increased. Proposals to pilot an approach to succession planning will go to EMT on 18th October.	315	
358					**Finance Strategy**	**262 days?**	**Sat 01/04/23**	**Sun 31/03/24**	**J.Saxton**	**38%**			
359					**We use our resources to delivery effective and sustainable services**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**J.Saxton**	**38%**			
361					Develop and monitor a plan to reduce agency spend (medical and non-medical)	262 days	Sat 01/04/23	Fri 29/03/24	J.Saxton	25%	The plan to reduce agency expenditure is not fully developed. The Trust expenditure is significantly over plan		315
362					Develop and monitor a plan to reduce out of area placements (complex rehab and adult acute)	262 days	Sat 01/04/23	Fri 29/03/24	J.Saxton	25%	The plan to reduce OAPs spend is not fully developed. The Trust is significantly over plan		4
363					Develop and monitor a plan to reduce our vacancy position by looking at opportunities to redesign within existing establishment	262 days	Sat 01/04/23	Fri 29/03/24	J.Saxton	50%	Number of initiatives on-going		315



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Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
16

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Health and Safety Annual Report 2022/23
DATE OF MEETING:	30 November 2023
PRESENTED BY: (name and title)	Dawn Hanwell – Chief Financial Officer & Deputy Chief Executive
PREPARED BY: (name and title)	Jonathan Campbell – Associate Director of Estates and Facilities

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

Health and Safety Annual Report for the 2022/2023 financial year. The report summarises the final position for health and safety matters for the year end.

The following points are covered within the report:

1) Update on our current position with regards to Health and Safety compliance – this will be in relation to NHS Workplace Health and Safety Standards, Trust compliances and industry standards.
2) Trust wide Health and Safety data (Lost Time Incidents, RIDDOR, Datix etc.)
3) Our Priorities and Future Work – explain how we will prioritise how we are improving health and safety compliance in 2023/2024.

The following successes are to be noted:

1) Workplace Standards – the first phase of the NHS Workplace Health and Safety Standards has achieved high level of completion and compliance and will now enable the Health and Safety Team to develop on these foundations to move forward improving compliances and working with dedicated workstream leads into Phase 2.
2) Health and Safety Audits – all sites were audited and the monitoring methodology of ensuring findings are closed off and complete has been established through Site Meetings which has seen a significant improvement in closing off findings.
3) Greater collaboration with all departments to identify strengths and weaknesses which will enable the Health and Safety Team to develop actions into the next phase of NHS Workplace Standards and general health and safety working practices across

the Trust.

4) Improved collaboration and information sharing across the Private Finance Initiative (PFI) estate which will lead into more formal reporting to improve the existing approach between the Special Purpose Vehicle (SPV), FM provider and Trust in order to minimise the potential health and safety risks in the Trust.

The following areas for improvement are as followed.

1) NHS Workplace Health and Safety Standards – continue to close gaps as we move forward from Phase 1 to Phase 2 and begin our closer engagement with directorate leads.
2) Violence and Aggression – develop a deeper analysis of how, why, where and what has happened and work with clinical and operational colleagues to understand opportunities for improvement.
3) Improve membership attendance at the quarterly Health & Safety Committee – there were 4 successful meetings but some of the attendance levels, although quorate, were low.
4) Review the Health and Safety Committee Terms of Reference, standing agenda, frequency of papers and workstreams.
5) Improve PFI reporting and establish a joint methodology for reporting where possible with PFI partners to ensure the flow of information from Monthly PFI Sign-Off Meetings > PFI Joint Steering Group is coherent.
6) Establish a working group which meets monthly to ensure more frequent oversight and reporting of existing and new audits and attain independent advisor audits to ensure we remain well governed.

The report also outlines methods of assurance for monitoring compliance throughout the next financial year.

It should also be noted that the report has been reviewed and scrutinised by the Audit Committee.

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 Board of Directors is asked to review the Health and Safety Annual Report and acknowledge and note the content.

NHS
Leeds and York Partnership
NHS Foundation Trust

Leeds & York Partnership NHS Foundation Trust

Health & Safety Annual Report

April 2022 - March 2023

1. Executive Summary

This Annual Report will provide the Trust Board with oversight regarding the Health and Safety performance from April 2022 to March 2023. The Trust Board will also be provided with assurance in relation to the actions that are associated with the ongoing improvement measures that are required to ensure the Trust further improves its Health and Safety position. The following points are covered within the report:

- Update on our current position with regards to Health and Safety compliance – this will be in relation to NHS Workplace Health and Safety Standards, Trust compliances and industry standards.
- Trust wide Health and Safety data (Lost Time Incidents, RIDDOR, Datix etc.)
- Our Priorities and Future Work – explain how we will prioritise how we are improving health and safety compliance in 2023/2024.

The following successes are to be noted for the reporting period.

1) Workplace Standards – the first phase of the NHS Workplace Health and Safety Standards has achieved high level of completion and compliance and will now enable the Health and Safety Team to develop on these foundations to move forward improving compliances and working with dedicated workstream leads into Phase 2.
2) Health and Safety Audits – all sites were audited and the monitoring methodology of ensuring findings are closed off and complete has been established through Site Meetings which has seen a significant improvement in closing off findings.
3) Greater collaboration with all departments to identify strengths and weaknesses which will enable the Health and Safety Team to develop actions into the next phase of NHS Workplace Standards and general health and safety working practices across the Trust.
4) Improved collaboration and information sharing across the Private Finance Initiative (PFI) estate which will lead into more formal reporting to improve the existing approach between the Special Purpose Vehicle (SPV

The following areas for improvement are as followed.

1) NHS Workplace Health and Safety Standards – continue to close gaps as we move forward from Phase 1 to Phase 2 and begin our closer engagement with directorate leads.
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3) Improve membership attendance at the quarterly Health & Safety Committee – there were 4 successful meetings but some of the attendance levels, although quorate, were low.
4) Review the Health and Safety Committee Terms of Reference, standing agenda, frequency of papers and workstreams.
5) Improve PFI reporting and establish a joint methodology for reporting where possible with PFI partners to ensure the flow of information from Monthly PFI Sign-Off Meetings > PFI Joint Steering Group is coherent.
6) Establish a working group which meets monthly to ensure more frequent oversight and reporting of existing and new audits and attain independent advisor audits to ensure we remain well governed.

The Health and Safey Team will use ‘SMART Objectives’ in detail to support its priorities across the 2023-24 Health and Safety Programme and report back into the Health and Safety Committee on a quarterly basis. The 2022-23 SMART Objectives are attached in the Appendices for reference.

The Quarterly Board Report is taken to Health and Safety Committee and Audit committee once per quarter (4 times per year), for review and comment. This also allows the committee authority to provide a re-focus or for the Health and Safety Team to adopt new actions or priorities to support the Trust on its objectives. At the end of the year, quarterly reports will form the basis for the annual report. The report is also made available to the following groups:

- Audit Committee
- Health and Safety Committee
- Operational Delivery and Performance Group (ODG)
- Workforce Committee
- Fire Safety Group
- Joint Governance and Operational Groups

All staff and groups across LYPFT can have access to the report upon request, similarly the report will be shared with the PFI partners as we continue to reduce incidents of all nature across the estate portfolio.

Methods of assurance used for monitoring compliance:

- The Chief Financial Officer / Deputy Chief Executive is the lead director for health and safety, and will guide and direct on all such matters, with appropriate advice. They will ensure that appropriate executive leads and internal controls are in place for managing health and safety related risks, and the effectiveness or otherwise of these arrangements is reviewed and formally reported to the Trust Board.
- The Board is alerted to any health and safety matters for escalation through the Audit Committee, and where necessary directly. Additionally, there is an appointed Head of Health and Safety who is dedicated to ensure processes in place to support health and safety are robust, delivered, monitored, and reviewed effectively.
- The Health and Safety Committee is a relatively well-established forum for communication with members drawn from management and staff as well as clinical and non-clinical areas. Meetings are held monthly and promote a culture of understanding and co-operation across LYPFT. Feedback from this committee is highlighted at the Audit Committee.
- The Head of Health and Safety produces a Quarterly Health and Safety Report, on progress, which is directed to the Audit Committee (quarterly), after which it is taken to the Board annually.
- Statistical data is beginning to be routinely accessed and key performance indicators (KPIs) have been identified and will support the provision of future assurances of compliance levels; provide a measure of health and safety good practice and any outlying areas which require action or escalation. The KPIs will be seen by the Health and Safety Committee every month and will become an embedded practice.
- Site inspections and audits schedule in place.
- Training and staff development supported by annual PDRs.
- Development of Health and Safety Workplan for 2023-24 (Appendices)

2. 2022-23 Health and Safety Programme

The following points are some of the high-level summary points of note during the 2022-23 Health and Safety Programme.

- Violence and Aggression (V&A) remains the most prominent type of incident. These have remained comparable to the previous financial year and therefore have not seen a reduction albeit reporting of incidents has increased.

- The NHS Workplace Health and Safety Standards completion rate currently stands at 95%, meaning the required Board 95% target has been achieved. The Health and Safety Team will complete the remaining 5% and continue to embed and the audit the standards in FY 23/24 (p23). Collaboration with Estates Team is also taking place as part of the newly adopted CRAG (Compliance, Risk Assurance, Governance) Framework.

- Overall Moving and Handing Mandatory Training is at 75% completion. Further details are provided in the training section.

- Overall, thirty-nine audits have been completed across the Trust this reporting year. This means the target of 100% of audits have been completed. A detailed breakdown of audit outcomes can be found in the audit section (p26).

- The number of claims in the financial year stands at 6. This is lower than the previous quarter, as NHS Resolution audit their files and any claims where there has not been any movement for some time they have been closed. Any of the recently closed claims could open again in the future if the claimant decides to pursue the claim again.

- Continue to support Estates & Facilities on backlog / minor works / maintenance and strategic projects. The Health and Safety Team have contributed significantly to assist projects across the estate portfolio carrying out various roles from reviewing Risk Assessments and Method Statements, providing regular site visits during construction projects, and offering advice to both internal and external colleagues.

- Incidents – the Trust has recorded a total of 7,644 and has been able to categorise and break down into relevant sections. The standout areas of incidents are Violence and Aggression (2,955) and Patient slips, trips, and falls (767) both of which we will continue to work with clinical colleagues to priorities a reduction. There has also been 682 security incidents and 294 fire incidents – Health and Safety remain in collaboration with these teams to reduce the incident figures where possible and note in this report that both Fire and Security actively review this

data as part of their workstream. The following tables provides an indication of all incidents across sites.

Incidents	2022/2023												
	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	2022/2023
Incidents	508	765	616	671	669	547	706	573	642	701	620	626	7,644
Accident (public)	2	2							1		1	1	7
Accident/Health and Safety (Patient)				13	22	26	19	12	14	16	14	14	205
Accident/Health and Safety (Staff)	15	9	9	17	10	7	5	13	9	7	3	8	112
Fire/Smoking	8	11	11	15	15	9	18	11	12	11	11	9	141
Fire/Smoking (patient)	12	9	10	12	9	12	27	6	16	18	13	9	153
Infrastructure	36	30	29	32	37	33	25	20	25	14	14	13	308
Infrastructure (patient)	2	4	5	6	3	8	4	4		1	3	2	42
Infrastructure (staff)	5	5	4	4	5	5	4	21	9	4	7	4	77
Other	64	99	46	54	65	46	59	43	69	58	56	48	707
Other (Organisation)	4	3	6	2	3	12	10	5	4	12	9	8	78
Other (public)		1			1	1	1	3		3	4	1	15
Property	11	15	9	8	10	20	22	14	7	17	11	17	161
Property (patient)	12	24	8	20	27	27	49	29	13	18	18	28	273
Security	23	35	18	26	29	23	23	29	16	31	24	24	301
Security (patient)	17	35	20	29	26	18	32	14	25	44	34	27	321
Security (staff)	5	4	3	1	8	6	7	3	6	8	4	5	60
Slips, Trips, Falls (Patient)	46	57	61	65	53	63	68	49	80	80	85	60	767
Slips, Trips, Falls (Non-Patient)	3	7	6	5	3	3	4	5	4	7	9	7	63
Verbal Abuse	25	20	20	21	22	18	11	24	15	19	18	23	236
Verbal abuse (Public)	2	1	1	1	4		2	2				1	14
Verbal/written abuse (staff)	47	68	72	51	49	42	71	41	58	67	41	41	648
Violence (Public)	5	1	4	5	7	2	9	8	4	3	1	7	56
Violence (Staff)	74	148	127	149	123	99	105	83	109	109	92	103	1,321
Violence/assault	72	153	134	135	138	67	131	134	146	154	148	166	1,578

We will liaise with neigbouring mental health trusts to benchmark incident data and share trends including remedial actions. It should be noted that the high level of incidents supports the ongoing development of a ‘proactive’ safety culture and reporting of incidents for improved learning and the Health and Safety Team continue to request that all departments incident report according, irrespective of how low or high significance one believes an incident to be.

3. 2023-24 Health and Safety Programme

The following area's will be the priority areas for the Health and Safety Team on the 2023-24 Health and Safety Programme.

- NHS Workplace Health and Safety Standards – further develop and complete the first phase of the workstream and move into Phase 2 – closer interaction with directorate leads to ensure they are aware of their responsibilities.
- Review in year trends across incidents to ensure 'like for like' data is being captured and report to enable the Trust to further identify strong and weaker areas of safety.
- Control of Contractors (CDM Regulations) – develop software to ensure that the Trust and in particular Estates & Facilities, manage the risk surrounding contractors in a more robust manner. This will have realised benefits from a safety perspective, procurement, and sustainability too.
- Control of Substances Hazardous to Health (COSHH Regulations) - develop software to ensure that the Trust and its departments move towards a digital solution in order to evidence positive working practices and provide teams the ability to store documents / evidence in a proactive way.
- Provide improved transparency across the management provision of Risk through the Datix system.
- Establish Health and Safety Working Groups for the area's featured in this report to ensure that there is robust governance and clear actions plans / action owners who shall contribute and assist the Health and Safety Team in providing greater assurance to the board by way of completing actions and providing robust evidence.

These priorities will be amalgamated into a SMART programme in order to provide key specific measures to enable the Health and Safety Team to quantify progress.

4. NHS Workplace Health and Safety Standards

The progress of the workplace standards was supported with the establishment of the Health and Safety Team which now includes the Head of Health and Safety, and two Health and Safety Advisors. These appointments have enabled significant progress on Phase 1 of the Workplace Health and Safety Standards programme and helped achieve 95% completion throughout 22/23 for Phase 1.

The methodology for managing this workstream is akin to that of HSG65 model '*Successful Health and Safety Management'* which will continue to be the monitoring approach for NHS Workplace Health and Safety Standards, this is:

- **Plan** - Say what you want to happen.
- **Do** - make sure there are systems in place to provide resources to do the job.
- **Check**- make sure the work is being done safely.
- **Act** - listen to problems and success and make improvements.

There has been significant collaborative working across departments within the Trust, with stakeholders being proactive and engaging in their respective areas. This has improved health and safety relations across the organisation, and we have seen an increase in participation as we develop the standards further. This has given the Health and Safety Team confidence that departments are engaged and have a pro-safety culture that we will continue to develop in the coming year.

In relation to the Workplace Health and Safety Standards and by the end of the financial year (22/23), our targets were to:

- Have 95% of all outstanding actions complete in Phase 1
- Have each section of the standards completed by at least 20% to ensure each area has undergone some level of scrutiny.
- Identified 100% Executive Sponsor and their deputies to own their section of the workplace standards document – a key driver for the implementation and further development into Phase 2.

Every 20% completion of actions instigated a quality check audit to ensure that the actions identified satisfy the criteria laid down by the standards as part of our quality assurance process.

The NHS Workplace Health and Safety Standards Management action plan progress summary for Phase 1 can be found below.

Objective	RAG	Status
Host a monthly progress meeting with Head of Health and Health and Safety Advisor to continually monitor progress	Complete	Frequent meetings have been ongoing since starting the standards.
Every 20% completion of actions will instigate an audit to ensure that the actions identified satisfy the criteria laid down by the standards.	Complete	Ongoing as a QA mechanism but initial audits are underway
Meet with each individual stakeholder and sponsor nominated by the board.	Ongoing	A training presentation that provides an overview of what the Workplace Standards are has been presented to the Board in April 22. Ongoing work is occurring between sponsors and the Health and Safety Team and will carry on into FY 23/24 and beyond to solidify progress into Phase 2-4.
Ensure that the board report contains a quarterly report on progress.	Ongoing	Each board report contains a progress monitoring section for each area of the Workplace Standards, to review progress.
Maintain action plan that summarises the workplace standards and how they will be achieved.	Ongoing	An Excel Spreadsheet has been developed, which monitors each required action. This includes an evidence section to demonstrate how we have achieved compliance.
Develop awareness training for Trust wide communication.	Ongoing	A training presentation that gives an overview of what the Workplace Standards are and was presented to the Board in April 22. This presentation will be available for the wider Trust in 23/24 therefore, this will be carried over into 23/24.
Create specific Workplace Standards page on Staffnet.	Ongoing	Work on the standards has been ongoing throughout the financial year.
Create documented policy related to workplace standards and its use.	Complete	The Health and Safety Policy has been revised, along with Audit and Inspection Policy and Procedure and relates to the Workplace Standards.
Develop an internal audit schedule for future checking and compliance of standard.	Ongoing	An Excel Spreadsheet has been developed, which monitors each required action, this includes an evidence section to demonstrate how we have achieved compliance. The standards are monitored against Trust Policies and Procedures and legal and regulatory standards.
Develop a policy, timeline, and agreement around external auditing of the Trust against the workplace standards.	Ongoing	The Health and Safety Team have been audited by Audit Yorkshire and Workplace Standards form a primary pillar of the Team's work and this was demonstrated during the audit.

Obtain 100% completion by end of FY.	Ongoing	The NHS Workplace Standards are now at 95% for Phase 1. The remaining 5% of actions require further consultation which will be completed in 23/24 and this will allow the next stage of audit and reporting into Phase 2

The overall positional summary is shown in the Appendices for each relevant standard section as we prepare to enter into Phase 2.

The NHS Workplace Health and Safety Standards (Phase 1) are at an advanced stage and high level of compliance for this phase but it should be noted that there is significant ongoing piece of work to do which will include stakeholders across the Trust, each with an accountable Executive Director.

It is anticipated that the next stage of the NHS Health and Safety Workplace Standards will be progressed at a more measured pace as we look to engage and hold a series of Task and Finish Groups with each directorate lead so we can demonstrate both collective leadership and working with directorate leads to truly understand the specific elements of each of the services.

It should be noted that the NHS Workplace Health and Safety Standards are a regular review and moment in time assessment of processes and procedures and that the likelihood of being 100% compliant is unlikely giving the changing dynamics of services demands, regulation and policy change, staff turnover and resource available to meet demand.

5. Trust Health and Safety Risk

These are some of the key areas where the Trust is seeking ongoing compliance our own policies and procedures and the Health and Safety Team will continue to support all directorates in pro-active management with a focus on regularly reviewing risk assessments, policies, and procedures. This is summarised as followed.

- Review of current risk assessments occurring Trust wide, this will be a priority in 2023/24. For example, support the clinical services for *'New and expectant mothers'* risk assessment needs to be produced and link in with HR to establish one set of documents.
- Establish and overarching Health and Safety Risks Assessment for the Estates & Facilities Directorate to demonstrate pro-active action management for the high-level management requirements.
- Review of existing policies and procedures
- Continue to manage existing risks on Datix and support action and risk owners, existing risks on Datix are as followed.

In addition to the risk management provision on Datix, other compliances are reported on below.

- Inductions need to be standardised as far as possible; this will include provision for temporary workers. Standard induction is on Staffnet, use of this is being checked during audits. Longer term, the induction will need to be updated and ensure that the standardised version is used by all, and that existing staff also receive this to ensure that we have a current induction for all colleagues. Meeting is being scheduled with HR to standardise Trust Induction Process.
- The H&S Team are developing a business case to introduce Sypol, which is a full spectrum COSHH management system for compliance with COSHH Regulations (as referred to in the 2023-24 programme).
- Checking display of up-to-date health and safety / first aid posters has been included within clinical audits as there have been gaps in signage compliance and accurate details on the posters.
- Face Fit Testing compliance is low throughout the Trust – review requirements given the change in legislation and guidance.
- First aid risk assessments are not always completed (as per FE-0029).

These findings will form part of the 2023-24 Health and Safety Programme.

5.1 Trust Health and Safety Compliance

This section will provide an overview of what legislation the Health and Safety Team will monitor and how it will work with relevant stakeholders to ensure demonstrable efforts to achieve compliance with the regulations. The Following table provides an outline of the legal requirements that the Health and Safety Team will monitor and report in all future reports.

Health and Safety at Work etc. Act 1974
Management of Health & Safety at Work Regulations 1999
Manual Handling Operations Regulations 1992
Control of Substances Hazardous to Health (COSHH) 2002
Display Screen Equipment Regulations 1992
Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) 2013
Provision and Use of Work Equipment Regulations (PUWER) 1998
Construction (Design and Management) Regulations (CDM) 2015
Health and Safety (Sharp Instruments in Healthcare) Regulations 2013
Health & Safety Information for Employees Regulations (Amendment) 2009
Health & Safety Consultation with Employees Regulations 1996 and Safety Representatives and Safety Committees Regulations 1977
Personal Protective Equipment (PPE) Regulations 1992
The Health and Safety, First Aid at Work Regulations 1981

Further details of the position as of April 2023 can be found in the appendices of this report.

6. Trust-Wide Health and Safety Data

A lost time incident (LTI) is an instance where at least one full shift has been lost due to a work-related incident, excluding the day of the incident. If the employee is unable to carry out their duties for more than 7 days, this then becomes a RIDDOR reportable incident in accordance with the Reporting of Injuries, Diseases and Dangerous Regulations 2013 (RIDDOR). Psychological injury such as stress, anxiety etc do not fall under RIDDOR or LTI recorded data.

In 22/23 the Trust had 61 lost time incidents in total, which is comparable to 2021/22 with 61 incidents. Of the 61 lost time incidents, 45 were related to violence and aggression and only 4 were related to slips, trips, and falls. Other incidents represented a number of 12.

	LTI Categories - Incidents FY 22/23												
INCIDENT CATEGORY	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**TOTALS**
H&S Accident	0	1	2	3	0	0	0	1	1	1	1	1	**11**
Violence & Aggression	2	4	8	3	6	1	3	3	5	2	0	8	**45**
Slips, Trips & Falls	0	0	0	2	0	1	0	0	0	0	0	1	**4**
Verbal Abuse	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Manual Handling	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other (Infrastructure & Security)	0	0	0	1	0	0	0	0	0	0	0	0	**1**
TOTAL	2	5	10	9	6	2	3	4	6	3	1	10	**61**

6.1 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) incidents are where more than 7 days are lost (not including the day of the incident) or a specified injury is sustained (as identified in the Regulations). In **22/23 the Trust had 27 RIDDOR** incidents in total, this is an increase of 2 from 21/22.
Of the 27 RIDDOR incidents, 21 were related to violence and aggression and only 2 were related to slips trips and falls.

An initial incident is reported on Datix, which is then reviewed by the designated Datix handler as per Trust Policy. Should this be identified as a RIDDOR, then this **must** be notified to the Health and Safety Team at the earliest opportunity. In conjunction with this, the Health and Safety Team monitor Datix incidents they receive and follow up on an incident if it looks as though it might be RIDDOR reportable.

This ensures RIDDOR Guidance and provide the necessary advice / steps needed (i.e., checking if it is a workplace related physical injury). If this is the case, RIDDOR HSE report is produced by the Datix handler, with the Health and Safety Team overseeing, and is uploaded to Datix for central record keeping.

The Health and Safety Team has been reviewing each Datix report that comes in relating to work related injury, to establish whether they are potential RIDDORs and following up with the call handler as required. This proactive approach could be one of the reasons why the number has increased. In 23/24 these will continue to be monitored to establish whether there is anything that can be done to reduce RIDDORs. As the majority of the RIDDORs last year were related to violence and aggression, again this is something that will be investigated at a service and operational level and looked at on a trust wide level in the Violence Prevention and Reduction Steering Group.
Of the RIDDORS reported to date in 22/23, the outstanding majority related to violence against staff.
Of the RIDDORs reported in 21/22, the majority also related to violence against staff.

	RIDDOR Categories - Incidents FY 22/23												
INCIDENT CATEGORY	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**TOTALS**
RIDDOR - All	1	2	3	4	3	0	5	0	2	0	3	4	**27**
Injury - Slips and trips	0	1	0	0	0	0	0	0	1	0	0	0	**2**
Violence	1	0	3	2	3	0	5	0	0	0	3	4	**21**
Injury - Manual Handling (people)	0	1	0	2	0	0	0	0	0	0	0	0	**3**
Other	0	0	0	0	0	0	0	0	1	0	0	0	**1**
Injury - Manual Handling (objects)	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Reportable Diseases	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Dangerous Occurrences	0	0	0	0	0	0	0	0	0	0	0	0	**0**

	RIDDOR Categories - Incidents FY 21/22												
INCIDENT CATEGORY	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**TOTALS**

RIDDOR - All	4	0	3	2	2	1	1	3	0	3	2	4	**25**
Injury - Slips and trips	0	0	0	1	0	0	0	0	0	1	0	1	**3**
Violence	4	0	3	1	2	1	1	3	0	2	1	3	**21**
Injury - Manual Handling (people)	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other	0	0	0	0	0	0	0	0	0	0	1	0	**1**
Injury - Manual Handling (objects)	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Reportable Diseases	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Dangerous Occurrences	0	0	0	0	0	0	0	0	0	0	0	0	**0**

6.2 Violence and Aggression

Violence and aggression continue to be the most prominent type of incident across the Trust. Security management, which takes into account violence and aggression factors is being reviewed in addition to the already established Violence Prevention and Reduction Steering Group.

The tables below highlights the number of violence and aggression LTI's and RIDDORS compared to overall LTI and RIDDOR incidents.

LTI's related to Violence & Aggression:

Year	Total LTI's (V&A & overall)	% V&A related
Current Year: 2022/23	45/61	74%
Previous Year: 2021/22	43/61	70%

Year	LTI Incident Rate overall	LTI V&A Rate
Current Year: 2022/23	184	136
Previous Year: 2021/22	166	117

RIDDORs related to Violence and Aggression:

Year	RIDDORS	RIDDOR V&A%
Current Year: 2022/23	21/27	78%
Previous Year: 2021/22	21/25	84%

Year	RIDDOR Incident Rate overall	RIDDOR V&A Rate
Current Year: 2022/23	81	63
Previous Year: 2021/22	68	57

It is anticipated with greater collaboration between clinical, operational, health and safety and security teams we will improve on how the Trust manages these incidents.

There has been progress in various areas:

- A pop-up box on DATIX detailing all wellbeing support – with live links, which appears automatically when reporting violent incidents.
- Proactive critical incident support for violent incidents.
- A developed dashboard for all violence reporting within the trust – broken down within services and types of incidents.
- A trial of DATIX reporting for incidents of hate in various services/wards – to feed into this work.

To gain progress towards achieving the NHS Violence prevention and reduction standard, the following will occur with the agreed timescales:

- **Strategy** - Following an initial presentation to People and Organisational Development Governance Group earlier this year, a second draft of the Violence Prevention and Reduction

strategy will be sent out for consultation in October 2023. . The second draft will focus on incidents of Hate, Sexual Safety as well as our increased wellbeing support following violent incidents.

- **A self-assessment** of compliance against the NHS National Violence and Prevention standards will be prioritised to assess where we are as a Trust. Once the self-assessment is completed, a resulting action plan will be developed, detailing the areas and timescales to gain the standard.
- **Governance** - The strategy, self-assessment and action plan will be is to be taken through the most applicable Trust governance route (by November 2023) for final approval to Workforce Committee (in December). The self-assessment of the standard is then to be taken to Board of Directors scheduled for late December 2023 for final sign off.

It is important to note that the National Violence Prevention and Reduction Standard, is there to complement existing health and safety legislation.

For additional data presentation please refer to Appendix 1.

6.3 Audit and Inspection

The two-year audit programme from FY 22/23 was developed, implemented, monitored, and maintained by the health and safety team. The audits that were completed were undertaken on the audit software (IAuditor Safety Culture). This meant the audits could be carried out electronically which reduced any delays in issuing the report to those who need it. The programme schedule is shown below.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
HEALTH AND SAFETY SITE AUDITS												
H&S audits of clinical areas carried out 22/23	0	0	4	1	1	1	1	9	4	3	2	5
H&S Estates audits carried out 22/23	0	0	0	2	0	2	0	0	1	0	0	3

Positive themes:

- The attitude and time given to the process by all stakeholders demonstrated a proactive approach.
- Stakeholders using it as an opportunity to ask pertinent health and safety questions to develop their own understanding.
- The desire to improve health and safety knowledge and processes.

High Performing Compliance:

- Well-kept and maintained clinical rooms.
- Drug fridges at the correct temperature
- Controlled and medicine drug cabinets are kept locked.
- The move to the MyKitCheck trolleys has been complete in all clinical rooms.

Negative themes:

- First Aid Risk Assessment not complete
- Quarterly Inspections by ward managers or designate not complete (compliance has however seen improvement)
- Inconsistent lone working controls
- Display Screen Equipment (DSE) risk assessments not complete
- Manual Handing Risk Assessments not complete

Procedural Improvements

- Close out meeting occurs at the end of the audit.
- Actions are monitored with the action holder on a frequent basis at site meetings and in some instances in a more frequent period dependant on risk.
- We introduced priority ratings so auditees could further priorities actions and understand why some actions are more important than others.
- Introduction of inspections to support the audit process and promote health and safety in general.

- The Health and Safety Team developed a new Audit and Inspection Policy and have revised the Audit and Inspection Procedure, to reflect changes in the process and to ensure the information is clearer to follow for Trust staff. This included developing a flowchart and clear step by step guidance, defining the difference between an audit and inspection as well as the different types of audit and inspections. It also introduced time frames to complete actions and a priority actions table.

6.4 Enforcing Authority Contact

The Health and Safety Executive (HSE) have issued a letter to all NHS Trusts in the UK which details they will be re-inspecting several Trusts on their management of risks from workplace violence and aggression and musculoskeletal practices. LYPFT may receive a further visit due to previously being inspected and work is underway to ensure full compliance against the previous inspection. It should be noted that any outstanding actions now form part of the Security Audit action plan which will complete by March 2024.

6.5 Claims against the Trust

The data below shows the number of claims within the reporting period. The value of claims is not recorded as it can take considerable time for claims to come to fruition.

Nature of Incident	No of Incidents
Assault	4
Slip or Trip	1
Hit by Object	0
Workplace (Health, Safety and Welfare)	0
Defective Tools/Equipment	0
Unlawful detention	0
Manual Handling	1
Sharps Injury	0
Directors' and Officers' Liability Claim	0
Breach of GDPR	0
Lifting/Loading/Unloading	0
Professional Indemnity Claims	0
Electric Shock	0
Totals	**6**

NHS Resolution will have audited their files and any claims where there has not been any progress for a period of time have been closed. Any of the recently closed claims could open again in the future if the claimant decides to pursue the claim again.

Payments to staff in relation to work related incidents are generated internally through Trust processes or by a formal claim through NHS Resolution.

In 2022-23, the Trust internally approved 7 ex-gratia payments for claims made by staff for loss/damage or injury caused at work (£8,691). These are summarised in the table below:

# of incidents	Total value	Description
2	£532	Damage to glasses during an incident with a service user
3	£7,969	Damage to teeth during an assault by a service user
1	£90	Physiotherapy required following planned restraint
1	£100	Parking fine

In addition, there were 4 claims made by staff through NHS Resolution in 2022-23 (£38,317). These are summarised in the table below:

# of incidents	Total value	Description
2	£20,000	Slips, trips and falls
1	£10,000	Injury occured whilst trying to restrain a service user
1	£8,317	Claimant was assaulted by a service user

These costs are as 31 March 2023.

Claims made through NHS Resolution are limited in cost to £10,000 excess for employers' liability. The total estimated value of the above claims was £121,000.

Full details of ex-gratia payments are reported to the Audit Committee in the Losses and Special Payments report.

6.6. Occupational Health

Employee Assistance Programme (EAP) - Health Assured

- During the period of 1st March 2022 to 28th February 2023, the annualised utilisation for Leeds and York Partnership NHS Foundation Trust is 14.1%, calculated as counselling and advice calls against employee headcount of 3,570.
- A total of 503 calls have been logged within the current reporting period.
- 473 of these were counselling calls, and 30 of these were advice calls.
- Counselling calls account for 94.0% of all calls, sitting above our benchmark of 74.0% by 20.0%
- Anxiety was the most common reason, accounting for 28.1% of overall counselling engagement. This was followed by Low Mood 14.0% and Bereavement 8.2%.

	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Total
Mental Health	31	19	13	21	27	16	21	21	23	20	12	14	238
Relationships	7	7	2	0	4	6	0	4	9	14	0	2	55
Life Event	11	9	9	0	0	2	0	2	2	7	3	5	50
Work	4	2	10	2	0	6	0	4	6	4	0	1	39
Service Enquiry	8	1	0	5	2	3	3	3	4	6	1	0	36
Legal	1	5	0	4	2	5	2	3	4	4	0	0	30
Trauma	0	7	2	0	5	0	0	10	5	0	0	0	29
Physical Health	0	0	2	0	0	0	5	0	2	1	3	0	13
Parental Support	2	1	0	3	0	0	0	0	0	0	2	0	8
Self Identity	0	0	0	0	0	0	0	0	0	0	0	5	5
Financial	0	0	0	0	0	0	0	0	0	0	0	0	0
Whistleblowing	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	64	51	38	35	40	38	31	47	55	56	21	27	503

- Advice calls accounted for 6.0% of all calls made by LYPFT colleagues to Health Assured. The benchmark for advice calls is 26%, so we are sitting under this figure by 20%.
- Out of all the advice calls, employment was the most common reason, accounting for 63.3% of overall advice engagement. This was followed by Divorce & Separation (Legal) 23.3% and Criminal 6.7%.

	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Total
WR - Role	4	2	4	0	0	3	0	3	0	0	0	0	16
WR - Demands	0	0	3	2	0	0	0	0	5	2	0	0	12
WR - Support	0	0	1	0	0	2	0	0	1	2	0	0	6
Disciplinary	0	0	2	0	0	0	0	0	0	0	0	0	2
Bullying/Harassment	0	0	0	0	0	0	0	0	0	0	0	1	1
Grievance	0	0	0	0	0	0	0	1	0	0	0	0	1
WR - Relationships	0	0	0	0	0	1	0	0	0	0	0	0	1
Grand Total	4	2	10	2	0	6	0	4	6	4	0	1	39

- The online portal has received a total of 353 hits within the current reporting period.

In terms of formal counselling engagement there has been:

- 12 referrals for face-to-face counselling, with a total of 69 sessions being delivered.
- 15 referrals for structured telephone counselling, with a total of 100 sessions being delivered.
- 42 referrals for online counselling, with a total of 182 sessions being delivered.
- 3 referrals for online CBT counselling, with a total of 8 sessions being delivered.

6.7 Training

Mandatory training

Providing suitable and relevant training for employees is a legal requirement and essential to ensuring employees can work safely, this also provides management with a level of assurance that their teams are health and safety competent and confident in their roles. Employee training needs are identified in one-to-ones, as well as previously defined training required for a particular role. The ability to provide a range of training options online has allowed the Trust to continue to meet its legal and moral obligations in these areas.

Moving and Handling Training:

Following the recovery plan for Covid the period of update was extended by six months to ensure that staff were working in the clinical areas. These extensions have been rolling back since January 2023 and will bring the compliance back in line with the compulsory training matrix by the end of June 2023. The learning management system is having some work in the background to fully align the training to staff groups to ensure more efficient use of the systems, and a better user experience for the staff booking on. This will be trialled and rolled out for other compulsory training once in place and working.

PMVA (Prevention and Management of Violence and Aggression)

The recovery plan has been completed and the role back of update extensions is completed. The PMVA lead and team have completed work towards certification of the BiLD standards, which will mean that the Trust is fully compliant with the legislation to reduce restrictive practice. This has been a rigorous process. Both moving and handling and PMVA are working together to roll out safety pods for managing service users during physical interventions so that neither staff or service users have to go all of the way to the floor. This reduces the risk of injury to both service users and staff and is currently being rolled out across the Trust.

A joint group have put together an exemption process for training to ensure the processes are documented as part of our safe systems of work it will part of the Standard Operating Procedure, which is currently going through a governance process.

Health and Safety Training compliance 2022-23

Requirement	Number compliant	Number non-compliant	Total Headcount	Compliance status
Food Safety Level 1	281	31	312	**90%**
Food Safety Level 2	444	213	657	**68%**
Health and Safety	2655	214	2869	**93%**
High Level Physical Interventions with PSTS and Breakaway Skills	381	134	515	**74%**
Intermediate Level Physical Interventions with PSTS and Breakaway Skills	93	48	141	**66%**
Low Level Physical Interventions with PSTS and Breakaway Skills	68	47	115	**59%**
Moving and Handling Advanced (LD)	116	60	176	**66%**
Moving and Handling Advanced (OPS)	150	57	207	**72%**
Moving and Handling Essentials	531	152	683	**78%**
Moving and Handling Principles	1488	308	1796	**83%**
Personal Safety Theory	475	33	508	**94%**
Personal Safety with Breakaway Skills	799	495	1294	**62%**
Overall:	**7481**	**1792**	**9273**	**81%**

**The data analyses for each dataset in this report represents a 'snapshot in time,' i.e., it captures the end of every month (unless specified) and therefore doesn't account for a full trend pattern (daily/weekly). For this reason, each section has a narrative to explain the data in more context and in turn provide a more accurate viewpoint.*

7. Health and Safety Priorities for 2023/2024.

The reporting year of 22/23 has been a successful year for the Health and Safety Team in terms of development, improvement, and culture. Staff engagement has been a key focus which has seen improvements to employee involvement. This has been a particular area of success and one in which we will continue to build and focus on. The improvements and success areas that have been detailed in this report will form the basis of our plans for future development and improvement. Whilst we have made excellent progress, the momentum gained this year must continue to ensure further progress.

The Board has invested in health and safety which will accelerate our plans for further improvement in coming financial year and beyond – and develop a clear understanding on roles and responsibilities. This is a statement of intent for the organisation that we take the health and safety of our staff seriously and that we will continue to strive for improvements at all available opportunities.

The Health and Safety Team will continue to embed the audit and inspection process at the Trust and will collaborate with colleagues to ensure the new Policy and Procedure for audit and inspections is adopted by the Trust, this will include expanding the audit and inspection programme as determined by the business requirements at the Trust.

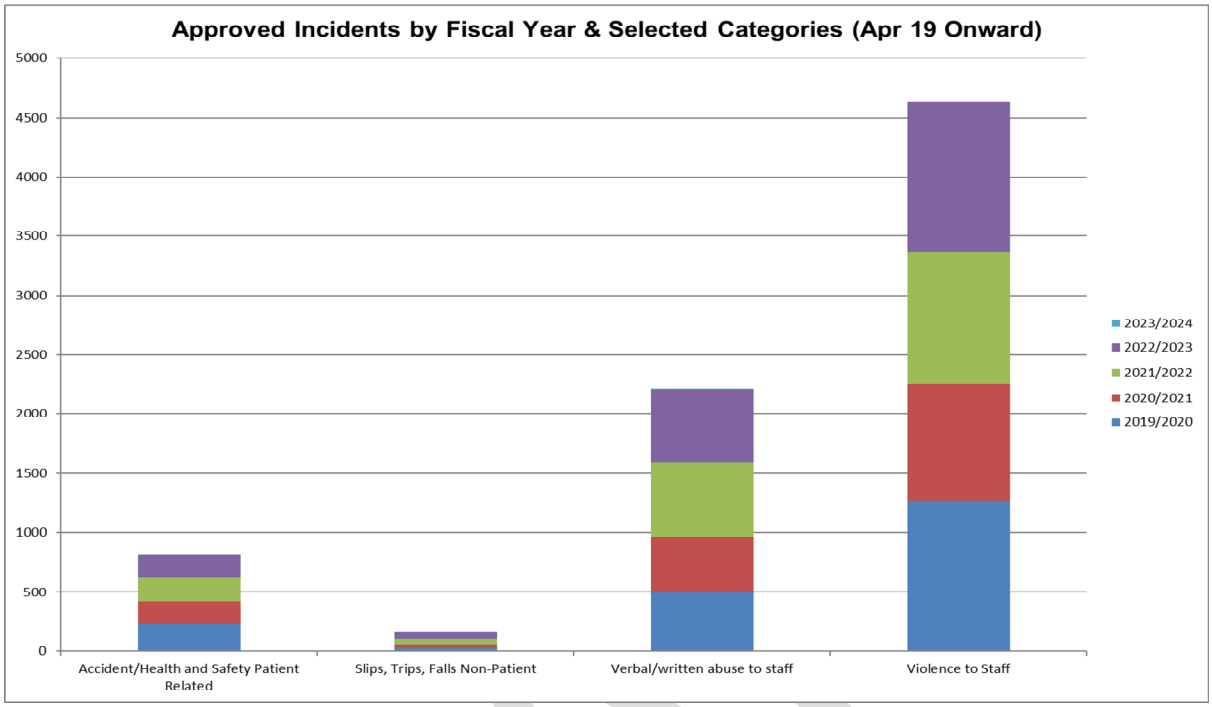
The priorities for the Health and Safety Team which will be the driver across the 2023-24 year will be.

Priority Area	How will we do this	Key Stakeholders
NHS Workplace Health and Safety Standards Phase 2	Establish Working Groups and ensure Directors are aware of their responsibilities for implementation and sign off	All Directors
Risk Assessments	Review Datix and ensure all areas are updated with suitable actions and action owners	Health and Safety Team
Violence and Aggression	Review the Trust data in more detail and work with directorate managers and leads in further deep diving into the data to understand the cause of incidents – especially those that are RIDDOR / LTI related. Work with other MH Trusts in benchmarking data	Health and Safety Team / Clinical / Operational Leads
Incidents – Trend Analysis	Review the Trust data to identify more meaningful supporting narrative surrounding incidents.	Health and Safety Team
Mandatory Training	Re-review for an up-to-date position on Trust data and ensure that directorate directors and managers are supporting the agenda with regards to Health and Safety Training	Health and Safety Team / Directorate Leads
Health and Safety Software	Further develop the requirement / need for teams to have suitable systems to improve pro-active management of contractors, products, and systems. Develop suitable business cases which include stakeholder engagement to ensure system utilisation is optimised and that it become a key pillar of our continuing improvement.	Health and Safety Team / Estates & Facilities
Health and Safety Audits	Continue the second stage of the auditing programme and continue to monitor and close out	Health and Safety Team

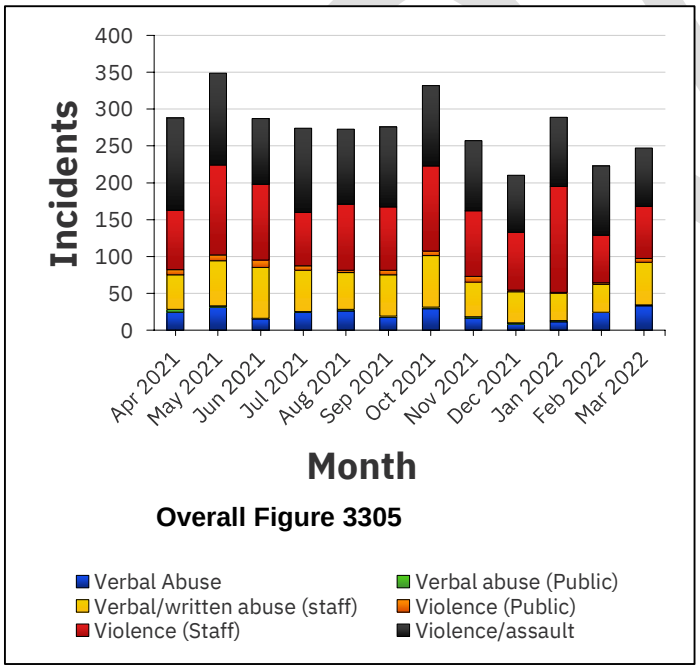
	actions. Develop a positional statement for the Health and Safety Committee to evidence the ongoing improvement work by all involved across the Trust.	
PFI Reporting	Continue to work with all involved across the PFI estate to ensure regular reporting of Health and Safety items.	Health and Safety Team / Estates and Facilities
Independent Audit	Appoint an Independent Advisor with a defined brief to provide a report on the Trusts position in relation to operational health and safety	Health and Safety / Estates and Facilities
Working / Task and Finish Groups	Identify key work streams that require high levels of intensity with regards to governance and assurance. Ensure correct stakeholders are identified with clear terms of reference.	Health and Safety Team
Policies and Procedures Review	To be amalgamated into the above Working Group but a one-off piece of work should be completed to provide immediate assurance to the Health and Safety Committee that Policies and Procedures are up to date and remain effective.	Health and Safety Team
SMART Objectives	Provide more concise and defining workplans to enable improved presentation for all stakeholders on the position of our targets	Health and Safety Team

Appendices

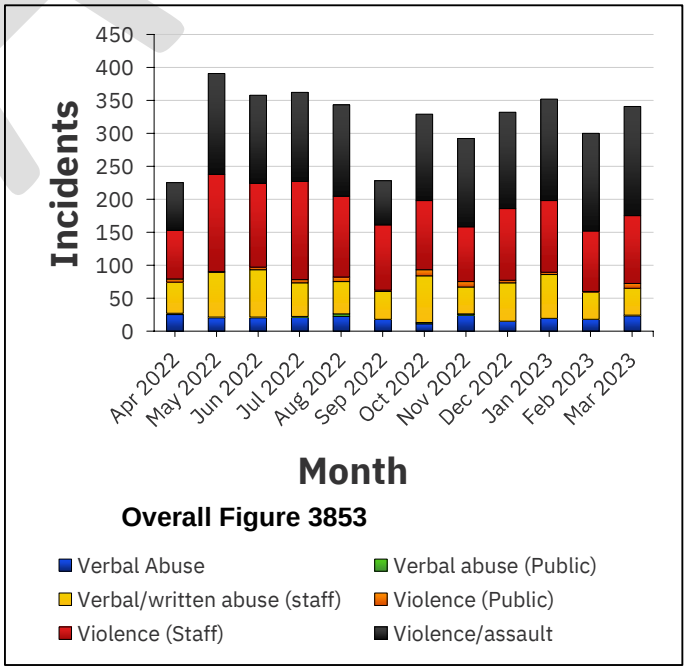
Appendix 1 - Annual Accident Statistics Violence and Aggression



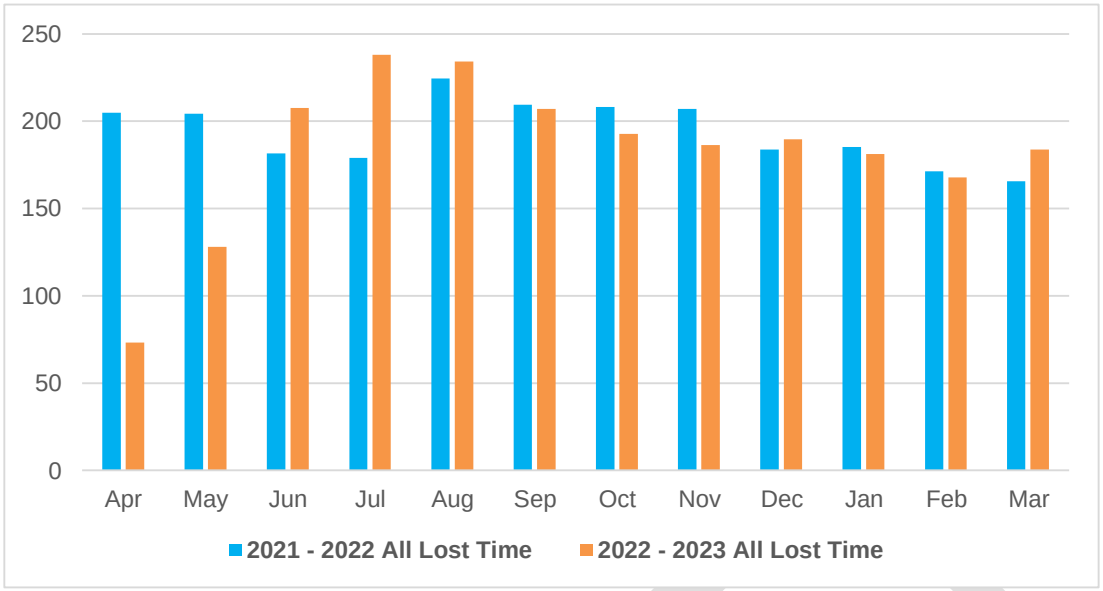
Violence & Aggression incidents April 21/22



Violence & Aggression incidents 22/23



The top bar chart incorporates all incidents relating to health and safety incidents across the Trust from Datix. The below graphs show the breakdown of Datix violence and aggression incidents (physical and psychological. These increased in 2022/23.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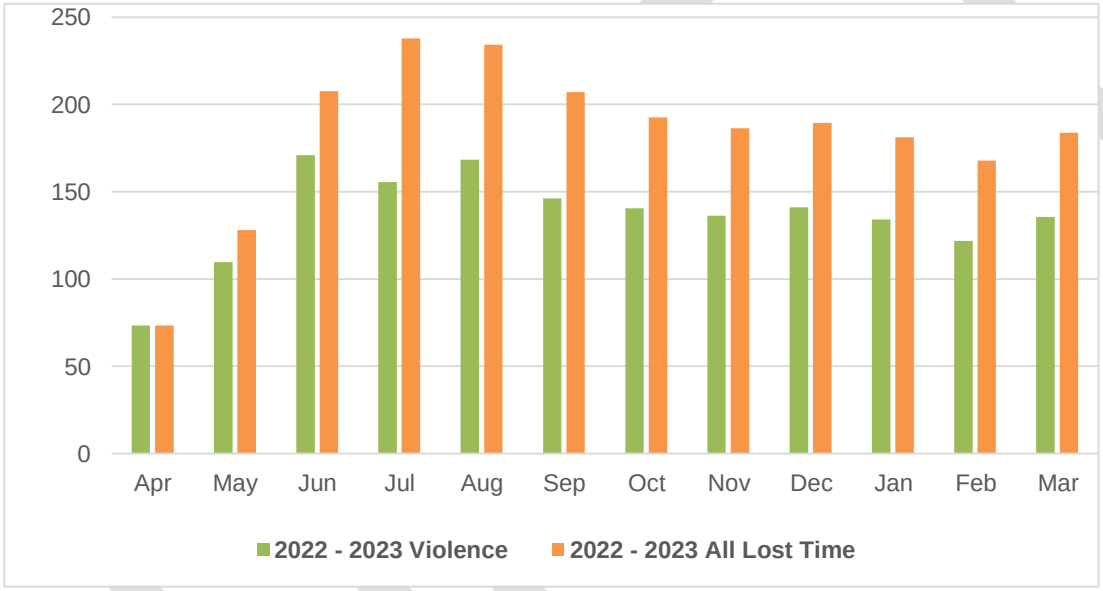
2021 - 2022 All Lost Time
2022 - 2023 All Lost Time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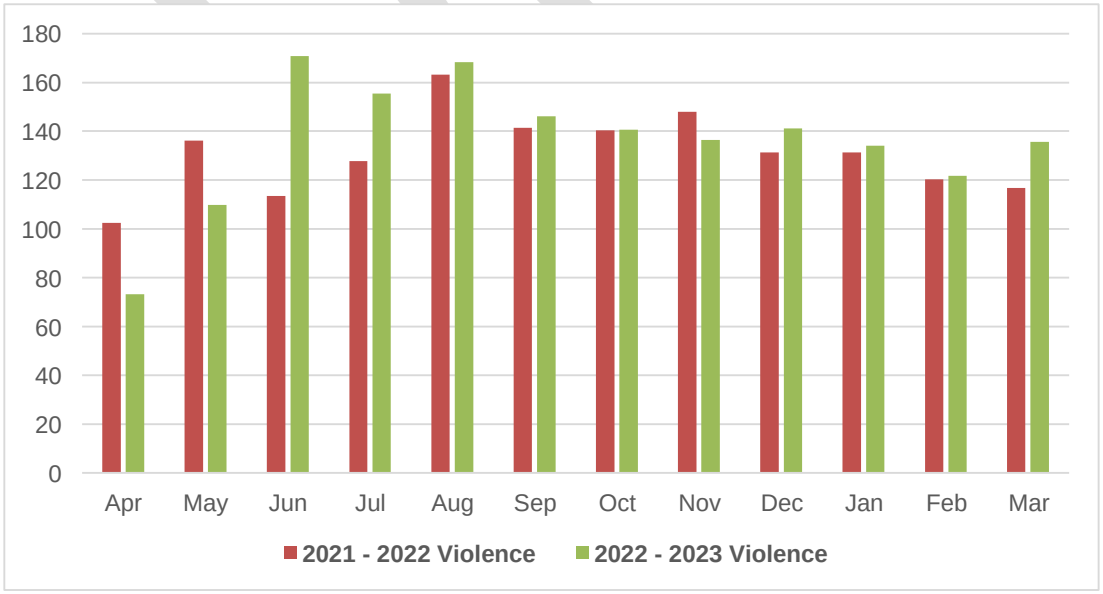
2022 - 2023 Violence
2022 - 2023 All Lost Time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2021 - 2022 Violence
2022 - 2023 Violence

Appendix 2 - NHS Workplace Health and Safety Standards Phase 1

Workplace Standard Subject	Owner	Progress
Section A - The management of health and safety	Associate Director of Estates & Facilities	90% complete - Exec Sponsor and Operational Lead identified
Section B - Incident reporting	Associate Director of Estates & Facilities	100% complete - Exec Sponsor and Operational Lead identified
Section C – Provision of occupational health service	Head of Occupational Health and Wellbeing SWYFT	100% complete - Exec Sponsor and Operational Lead identified
Section D – Slips and trips	Associate Director of Estates & Facilities	97% complete - Exec Sponsor and Operational Lead identified
Section E – Musculoskeletal disorders/moving and handling	Lead Moving and Handling Advisor/interim PMVA manager	100% complete - Exec Sponsor and Operational Lead identified
Section F – Electric profiling beds	Lead Moving and Handling Advisor/interim PMVA manager	100% complete - Exec Sponsor and Operational Lead identified
Section G – Violence and aggression/challenging behaviour	Security Advisor	97% complete - Exec Sponsor and Operational Lead identified
Section H – Lone Working	Deputy Chief Operating Office	58% complete - Exec Sponsor and Operational Lead identified
Section I – Work-related stress	Head of HR Operations	96% complete - Exec Sponsor and Operational Lead identified
Section J – Bullying and harassment	Head of HR Operations	100% complete - Exec Sponsor and Operational Lead identified
Section K – Hazardous substances/management of sharps	Associate Director of Estates & Facilities	95% complete - Exec Sponsor and Operational Lead identified
Section L – Work equipment, Provision and use of work and lifting equipment, Display screen equipment	Associate Director of Estates & Facilities	100% complete - Exec Sponsor and Operational Lead identified
Section M – The Workplace	Associate Director of Estates & Facilities	95% complete - Exec Sponsor and Operational Lead identified
Section N - Radiation	N/A	Not applicable
Section O – First aid	Deputy Director of Nursing	100% complete - Exec Sponsor and Operational Lead identified
Section P – Working time directive	Head of HR Operations	93% complete - Exec Sponsor and Operational Lead identified
Section Q – New and expectant mothers	Head of HR Operations	100% complete - Exec Sponsor and Operational Lead identified

Appendix 3 - SMART Objectives and Targets 22/23

The SMART Objectives for 2022-23 are shown overleaf.

OBJECTIVE	SPECIFIC MEASURE	PROGRESS/COMMENTS
Hold appropriately attended safety committees	At least three per FY, minimum of 80% attendance (Head of Health and Safety)	Due to not achieving 80% compliance last FY, this action has been carried over. 4 Meetings are scheduled to be conducted this year in each quarter.
Review risk assessments	100% of NHS risk assessments to be reviewed and re-dated by FY end 22/23 (Head of Health and Safety)	The Trust Risk assessment profile is continuously being reviewed and the Health and Safety Team are working with Trust areas to identify any gaps in the Trust risk profile which need assessment. Areas identified
Use LTI benchmark for 22/23 and compare for 23/24 for violence related incidents to established whether they have decreased in light of the work being done	Monitor throughout the year, full comparison at the end of the year	Violence and aggression incidents have remained at a similar level during 21/22 and 22/23 (43 and 45 incidents respectively). This action will therefore form part of the actions for 23/24 working in conjunction with the Violence and Reduction Group to reduce this figure.
Health and Safety team to attend violence reduction meetings	Attend 100% of meetings	The Health and Safety Team have attended all the Violence Reduction Meetings in 22/23 ensuring any concerns and queries from the Health and Safety Team are represented. The Team will also continue to attend the group in 23/24.
Health and Safety Team to support the development of violence and aggression risk assessments	Support in the delivery of violence and aggression risk assessments for the Trust. The forms part of the violence and aggression group where the assessments are currently being reviewed	Health and Safety Team are attending the violence and aggression meetings and will support with the development of the risk assessments.
Audits carried out to programme	90% completed to programme (permissible to move an audit for one month and still be in target)	A new 2-year plan has been developed for 23/25. This will be continuously monitored as per business needs.
Health and safety team to attend monthly site meetings	Attend 100% of meetings	The Health and Safety Team are and will continue to attend the site meetings in 23/24, giving a health and safety update at each meeting. There are on occasions due to urgent matters where attendance might not be possible, but apologies and a H&S update are provided to the chair and

OBJECTIVE	SPECIFIC MEASURE	PROGRESS/COMMENTS
		meeting admin, to ensure good communication to Trust staff.
Training packages to be delivered to the workforce on NHS Health and Safety Workplace Standards	A training presentation to be delivered to staff and be readily available on StaffNet	A training presentation that gave an overview of what the Workplace Standards are was presented to the Board in April 22. This presentation will be available for the wider Trust in 23/24. Therefore, this will be carried over into 23/24.
Complete an audit on the NHS Workplace Health and Safety Standards	By the end of the FY the goal is to complete one audit on the NHS Workplace Standards	NHS workplace standards audit is included in the 2-year audit programme.
Ensure all Health and Safety Trust Policy and Procedures are reviewed and revised in line with timeframes and do not go overdue	Develop and review policy and procedures as required for Health and Safety Management	Lone Working, Noise, Sharps Training, Events Safety, Contractor Management all require revision.
Support with any external enforcement agency audits and visits	Support with any external agency visits (HSE / Environmental Agency / CQC)	It is likely the Trust will be visited by an external agency and the Health and Safety Team will take a leading role in any visits which may occur.
To review lone working lone working arrangements and ensure they are appropriate from a Trust perspective	Undertake a review of all lone working arrangements across the Trust and ensure policy and procedural documents are all aligned so that the Trust has a clear route of compliance	A lone working group has been established taking place on a 4-weekly basis.

Legislation	Progress/Gaps
Health and Safety at Work etc. Act 1974	• There is nothing specifically required by the Act that hasn't already been summarised below.
Management of Health & Safety at Work Regulations 1999	• Workplace Health and Safety Standards: The Trust keep their health and safety management systems under review and has introduced the NHS Health & Safety Workplace Standards Framework to monitor and review legal responsibilities. • Review of current risk assessments, this will be dealt with as a priority in 2023/24 and forms part of the Health and Safety team's SMART actions for 23/24. • New and expectant mothers' risk assessment has been produced. This will link in with HR to establish one set of documents. • Inductions need to be standardised as far as possible; this will include provision for temporary workers. Standard induction is on Staffnet, use of this is being checked during audits. Longer term, the induction will need to be updated and ensure that the standardised version is used by all, and that existing staff also receive this to ensure that we have a current induction for all colleagues. • Contractor and access induction procedure has been reviewed and is on StaffNet.
Manual Handling Operations Regulations 1992	• See entry above re risk assessment and manual handling. • Standardised risk assessment has been put together for manual handling which has been uploaded to Datix. • Safe system of work - Task, Individual, Load, Environment (TILE) assessment' documents are being circulated where required and are scheduled for completion.
Control of Substances Hazardous to Health (COSHH) 2002	• COSHH is now being covered during estates audits and audits within clinical areas – complete, issues are addressed as they are picked up. Spill kit non-compliance found relating to COSHH. The Health and Safety Team also field requests when products are used. The Health and Safety Team are looking into developing a training package for COSHH. • COSHH Folders have been updated for Domestic Staff, by the domestic teams following a series of audits. • The Health and Safety Team are developing a business case to introduce Sypol, which is a fully integrated COSHH management system.

Legislation	Progress/Gaps
Display Screen Equipment Regulations 1992	• Questions relating to DSE checklists form part of the Health and Safety Team's formal audit programme. This checks compliance against DSE standards and ensures the policy is being adhered to. The Health and Safety Team are making Trust areas aware of the DSE Team / Occupational Health as applicable.
Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) 2013	• The Health and Safety Team have been monitoring and reviewing all RIDDOR incidents by (i) Checking Datix reports (ii) advising colleagues during audits and site meetings of the RIDDOR process. The RIDDOR process has been updated via Policy and Procedure RM-0002 – The Management of Incidents Including Serious Incidents.
Provision and Use of Work Equipment Regulations (PUWER) 1998	• Condition and use of work equipment is now included within audits and inspections – completed as and when audits and inspections are carried out. The Facilities Team also conduct workplace checks and all Trust areas should be completing quarterly inspection checklist which includes workplace equipment. Workplace equipment is also assessed through applicable risk assessments.
Construction (Design and Management) Regulations (CDM) 2015	• Construction phase health and safety plans needed for all construction work - checked during all audits, included as standard item in audit checklist. • Ongoing work with Estates Department and all contractors to ensure compliance.
Health and Safety (Sharp Instruments in Healthcare) Regulations 2013	• Management of sharps bins is covered in the audits of clinical areas to ensure compliance at ward level – this is routinely covered, and compliance levels are high. Trust policy states sharps bins should not be more than 2/3 full, and bins have indicator lines on them to gauge fullness. This information is being relayed during audits.
Health & Safety Information for Employees Regulations (Amendment) 2009	• Checking display of up-to-date health and safety posters has been included within clinical audits. This is an ongoing action as we audit the organisation.
Health & Safety Consultation with Employees Regulations 1996 and Safety Representatives and	• Staff side provide strong representation to Trust Health and Safety issues and sit on many committees and groups. Health and Safety Team work closely with Staff side for policies, procedures, and other workplaces issues, to ensure staff input is reflected in the H&S Teams work.

Legislation	Progress/Gaps
Safety Committees Regulations 1977	
Personal Protective Equipment (PPE) Regulations 1992	• During the audits of clinical areas there have been few/if any issues relating to PPE. Compliance is very high in relation to PPE for Covid 19 - Established during audits of clinical areas. • PPE Regulation change. The Trust already supplies PPE to agency and bank workers and will continue to monitor its effectiveness.
The Health and Safety, First Aid at Work Regulations 1981	• Audits have identified that first aid posters are not always filled out with the up-to-date contact details and are sometimes not on the wall. • First aid risk assessments are not always completed (as per FE-0029).

Health and Safety 2023-24 workplan

Ref	Action	Responsible Role	Target Date Completion	Date of actual	Action Progress/Update
1	**NHS Workplace Health and Safety Standards** – continue to close gaps as we move forward from Phase 1 to Phase 2 and begin our closer engagement with directorate leads.	Head of Health and Safety	March 2024		
2	**Violence and Aggression** – develop a deeper analysis of how, why, where and what has happened and work with clinical and operational colleagues to understand opportunities for improvement	Associate Director for People Experience / Head of Health and Safety	March 2024		
3	**Violence and Aggression Strategy** - following an initial presentation to POD earlier this year, the second draft of the Violence prevention and reduction strategy has been out for further consultation and has now been updated. This updated version includes more detailed focus on incidents of hate, as well as our increased wellbeing support	Associate Director for People Experience	December 2023		
4	**Violence and Aggression** - **A self-assessment** of compliance against the standard is currently underway, to assess where we are as a trust. Once the self-assessment is completed, a resulting action plan will be developed, detailing the areas and timescales to gain the standard.	Associate Director for People Experience	December 2023		
5	**Violence and Aggression** - **Governance** - the strategy, self-assessment and action plan is to be taken through the People Experience governance, then POD governance structure (20 November 2023) and for final approval to Workforce Committee on 5 December 2023. The self-assessment of the standard is to be taken to Board late December 2023.	Associate Director for People Experience	December 2023		
6	**Improve membership attendance at the quarterly Health & Safety Committee** – there were 4 successful meetings but some of the attendance levels, although quorate, were low.	Health and Safety Committee	March 2024		

7	**Review the Health and Safety Committee** Terms of Reference, standing agenda, frequency of papers and workstreams.	Head of Health and Safety	December 2023		
8	**Improve PFI reporting** and establish a joint methodology for reporting where possible with PFI partners to ensure the flow of information from Monthly PFI Sign-Off Meetings > PFI Joint Steering Group is coherent.	Head of Health and Safety	December 2023		
9	**Establish a working group** which meets monthly to ensure more frequent oversight and reporting of existing and new audits and attain independent advisor audits to ensure we remain well governed.	Head of Health and Safety	December 2023		
10	**Review in year trends** across incidents to ensure 'like for like' data is being captured and report to enable the Trust to further identify strong and weaker areas of safety.	Head of Health and Safety	March 2024		
11	**Control of Contractors (CDM Regulations**) – develop software to ensure that the Trust and in particular Estates & Facilities, manage the risk surrounding contractors in a more robust manner. This will have realised benefits from a safety perspective, procurement, and sustainability too.	Head of Health and Safety / Head of Operations (Estates and Facilities)	March 2024		
12	**Control of Substances Hazardous to Health (COSHH Regulations)** - develop software to ensure that the Trust and its departments move towards a digital solution in order to evidence positive working practices and provide teams the ability to store documents / evidence in a proactive way.	Head of Health and Safety	March 2024		
13	**Provide improved transparency** across the management provision of Risk through the Datix system.	Head of Health and Safety	March 2024		
14	**Review of current risk assessments** occurring Trust wide, this will be a priority in 2023/24. For example, support the clinical services for 'New and expectant mothers' risk assessment needs to be produced and link in with HR to establish one set of documents.	Head of Health and Safety / Head of Operations (Estates and Facilities)	March 2024		

15	**Establish and overarching Health and Safety Risks** Assessment for the Estates & Facilities Directorate to demonstrate pro-active action management for the high-level management requirements.	Head of Health and Safety / Head of Operations (Estates and Facilities)	March 2024		
16	**Review of existing policies and procedures** - develop a rolling programme to identify any policies or procedures that are due to expire.	Head of Health and Safety / Head of Operations (Estates and Facilities)	March 2024		
17	**Inductions need to be standardised** as far as possible; this will include provision for temporary workers. Standard induction is on Staffnet, use of this is being checked during audits. Longer term, the induction will need to be updated and ensure that the standardised version is used by all, and that existing staff also receive this to ensure that we have a current induction for all colleagues. Meeting is being scheduled with HR to standardise Trust Induction Process	Head of Health and Safety / HR	September 2024		
18	**The H&S Team are developing a business case to introduce Sypol**, which is a full spectrum COSHH management system for compliance with COSHH Regulations (as referred to in the 2023-24 programme).	Head of Health and Safety	December 2023		
19	**Checking display of up-to-date health and** safety / first aid posters has been included within clinical audits as there have been gaps in signage compliance and accurate details on the posters.	Head of Health and Safety	December 2023		
20	**Face Fit Testing compliance** is low throughout the Trust – re-review requirements given the change in legislation and guidance.	Head of Health and Safety	December 2023		
21	**First aid risk assessments** are not always completed (as per FE-0029).	Head of Health and Safety	March 2024		
22	**Quarterly Inspections** by ward managers or designate not complete (compliance has however seen improvement)	Head of Health and Safety	December 2023		
23	**Inconsistent lone working controls -** Lone Working Group is establishing policy, procedure, and systems to improve lone working across the organisation.	Service Manager, Personality Disorder and Neurodevelopmental Services	March 2024		

24	**Display Screen Equipment (DSE**) risk assessments not complete - continual review required and reported at Health and Safety Committee	Head of Health and Safety / Occupational Health	December 2023		
25	**Moving and Handing Risk Assessments** not complete - continual review required and reported at Health and Safety Committee	Lead Moving and Handling Advisor/ PMVA manager	December 2023		
26	**Independent Audit -** Appoint an in Independent Advisor with a defined brief to provide a report on the Trusts position in relation to operational health and safety	Head of Health and Safety	March 2024		
27	**Working / Task and Finish Groups -** Identify key work streams that require high levels of intensity with regards to governance and assurance. Ensure correct stakeholders are identified with clear terms of reference.	Head of Health and Safety / Head of Operations (Estates and Facilities)	December 2023		
28	**Policy and Procedure Review -** To be amalgamated into the above Working Group but a one-off piece of work should be completed to provide immediate assurance to the Health and Safety Committee that Policies and Procedures are up to date and remain effective.	Head of Health and Safety / Head of Operations (Estates and Facilities)	December 2023		
29	**Health and Safety Audits -** Continue the second stage of the auditing programme and continue to monitor and close out actions. Develop a positional statement for the Health and Safety Committee to evidence the ongoing improvement work by all involved across the Trust.	Head of Health and Safety	March 2024		
30	**SMART Objectives** - Provide more concise and defining workplans to enable improved presentation for all stakeholders on the position of our targets	Head of Health and Safety	December 2023		

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
17

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF THE DIRECTORS

PAPER TITLE:	EPRR Core Standards Assurance
DATE OF MEETING:	30 November 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 2023 process for assessment of EPRR core standards has differed markedly from prior years. Following a trial in the West Midlands in 2022, the NHS Northern Region has adopted a process whereby organisations submit evidence against each core standard for 2023. Additionally, the core standards have been significantly strengthened for this year – suggested evidence has been made compulsory compliance items and these, for many standards, have been increased markedly. These revisions were issued to EPRR teams in June 2023 for a 29 September 2023 submission.

The Trust's compliance level notified after the review of evidence and a check and challenge process was 15 compliant standards, 42 partially compliant and one non-compliant standard. This gave an overall rating of non-compliant compared to a partially compliant rating in 2022. This fall in ratings was a feature in the West Midlands pilot in 2022 and has largely been replicated across the Norther Region. All Mental Health Trusts in the Yorkshire and Humber received a non-compliant rating.

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 ratify the attached compliance statement and to note the attached report that gives further details of the outcome of this year's assessment, the themes in terms of areas of difficulty and the approach to developing a comprehensive action plan to rectify the situation.

MEETING OF THE BOARD OF DIRECTORS

30 NOVEMBER 2023

EPRR Core Standards Assurance

1. Introduction

This paper summarises the process, outcomes, and next steps regarding the annual EPRR Core Standards assurance. It has been a requirement for NHS funded organisations to assess against NHS England Core Standards for EPRR since 2014 and has, until 2023's process, been a self-assessment. 2023's EPRR assurance process has been an external assessment by NHS England based on evidence submitted by Trust's to a portal on NHS Futures.

The formal declaration of assurance signed by the Chief Operating Officer/ Accountable Emergency Officer is also appended to this paper.

This new process, trialled in the West Midlands region in 2022, has been trialled across the NHS's Northern Region. It is believed that this will be rolled out nationally in 2024.

2. Outcomes

2.1. 2023's assurance level

The Trust has been declared non-compliant with NHS England Core standards for EPRR for 2023. This is a reduction from 2022's declaration of partially compliant. The compliance levels are set at:

Non-compliant:	0% to 76%
Partially compliant:	77% to 88%
Substantially compliant:	89% to 99%
Fully compliant:	100%

Following a significant deterioration in scores when the new process was conducted in the West Midlands, the Resilience Lead and Accountable Emergency Officer alerted the trust executive directors that it was likely that a similar reduction in scores would occur across the Northern Region. Additionally, the Locality Director, Anthony Kealy, also wrote to Chief Executives on 6 September indicating expected deterioration of scores associated with the introduction of the new arrangement.

Overall, the Trust was assessed as compliant with fifteen standards, partially compliant with 42 standards and non-compliant with one standard. Feedback from other mental health Trust's across Yorkshire and the Humber has shown all Trusts were rated as non-compliant as were our partner NHS organisations in Leeds and the West Yorkshire ICB.

In terms of the partially compliant standards the reasons behind these being declared partial can and for many did relate to dates documents or reports were drafted or reviewed at governance meetings. There was a hard cut off on 29 September and no evidence after this date would be accepted. In other examples, procedures developed by the EPRR team were judged to be not fully implemented by NHS England's reviewers. Many of the standards therefore related to well-developed systems where one or two compliance items were found to be absent or required further development.

2.2. Changes to standards and standards and their applicability to Mental Health Trusts

The example below shows the new process for standard 1:

	A	B
	Supporting Information - including examples of evidence – pre-2023	2023 additional requirements to column A and 2024's additional requirement.

Senior Leadership	• Name and role of appointed individual • AEO responsibilities included in role/job description"	1. The Accountable Emergency Officer (AEO) is clearly an Executive (Board level) Director, within the organisation which is evidenced through job title, job description or structure chart. 2. The role of AEO should be described in the job description and/or EPRR policy and outlines their accountability, authority, and responsibilities with regards to EPRR. 3. The job description should contain as a minimum a line regarding the role of AEO being undertaken by that post. 4. The AEO should be attendee of the Local Health Resilience Partnership (LHRP). 5. AEOs may choose to be supported by other directors in the day-to-day management of EPRR, however it must be clear that they are unable to delegate functions noted (or accountability) as being undertaken specifically by the AEO. • For 2024 - the organisation should outline how the role will be maintained in the absence of the AEO (sickness or leave), noting the requirement to have post held at executive level.

This detailed specification of what was prior to 2023 examples of evidence and the insistence that all newly specified criteria are met before the standard is rated as compliant has been replicated across all 58 standards applicable to mental health trusts.

In addition to these changes was the new requirement around plans and procedures. NHS England have now defined “in date” to mean under 12 months old at the date of the submission of evidence. This meant that the EPRR lead had to redraft 90% of the Trusts EPRR plans and policies in the period between mid-June and September and ensure they had gone through governance (including the Board for the EPRR and Business Continuity Policy).

A lesson learned from one plan which was marked by NHS England as partially complaint is that even if plans are in date, if they do not include the latest guidance issued by NHS England then these will not be considered compliant – this could mean more than one revision annually for plans and procedures.

While this does bring clarity to now knowing what evidence and new processes are needed to be compliant with the standards, this information was only made available to EPRR leads in June 2023 for a submission date of 29 September 2023.

This increased specification for all the standards has also made some standards which had questionable applicability to mental health Trusts under the old pre 2023 criteria much more apparent. The principal areas, all assessed as partially compliant except 63 which is non-compliant, are:

Standard	Subject	Requirement	Issue
14	Countermeasures	Support mass countermeasure distribution and mass vaccination	The holding and distribution of countermeasures beyond anti-viral medication and covid/ influenza vaccines is not a recognised capability of mental health trust. Neither is the capability to carry out mass vaccination in a community setting.
19	Excess fatalities	Surge capability and role in supporting regional disaster mortuary arrangements	The Trust does not (since the closure of High Royds Hospital) have a mortuary. While some issues around this area were covered in the incident plan NHS England wanted details of how the Trust would support such an incident.
61	Equipment - Preventative Programme of Maintenance (HazMat/ CBRN)	Programme of checks and calibration of equipment. Disposal procedures.	The Trust has boxes at sites with reception to enable staff to decontaminate self-presenters who have been contaminated in the community. The requirements in this standard appeared aimed at acute and ambulance trusts with specialised equipment.
63	Hazmat/CBRN training resource	Requirement for EPRR staff training trust staff to have done train the trainer courses.	The train the trainer course is run by Yorkshire Ambulance Trust but is only offered to ambulance and acute hospital staff. Therefore, currently there is no way for mental health trusts to meet this standard.
65	PPE Access	Requirements around fit testing FFP3 masks and 24/7 access to these masks.	The Trust as a mental health trust has never had this capability – some trusts who have a community service such as Bradford Care Trust may be better able to meet this standard.

2.3. Themes

There are some broad themes in terms of the outcome and feedback from NHS England. The main ones are explored below.

- **Training and exercising**

Most standards relating to training were found to be partially complaint. The NHS has introduced EPRR portfolios for health commanders which are aligned to national standards for civil contingencies. This process is currently being rolled out and training being sourced, the syllabus clarified and expected attainment levels being determined and hence for most organisation, given the still existing gaps in this training, these standards were very difficult to meet in 2023.

- **Business Continuity**

While the overarching Business Continuity system and policy were deemed complaint, the practical application of this through care services and corporate directorates revising plans each year, carrying out annual impact assessments and participating in annual tabletop exercises was found to be patchy. Some services still do not have complete plans and some have very outdated plans.

Internal reporting and performance reporting to governance groups around key performance indicators were also identified as requiring improvement.

- **Communications**

All standards within the domain were rated as partial. Comments from NHS England stressed the need for wider stakeholder involvement, more consideration social media use in an emergency and use of methods to contact patients in an emergency. Testing of 24/7 access to communications staff was also noted by NHS England.

- **Collaboration and mutual aid**

NHS E noted that while evidence of collaboration was offered, there was no overarching governance around mutual aid agreements, information sharing in emergencies.

- **Chemical, Biological, Radiological and Nuclear (CBRN) processes**

Many of this domain's standards were rated as partial. Some from a training perspective as Trust EPRR staff are not accredited trainers. It should be noted that the supplier of this training – the ambulance service - is not required to, and has not, offered this to mental health and community Trusts. Other findings were around training needs assessments for staff requiring specialist CBRN training and some around content of plans.

2.4. Implications

While it has always been implicit that the annual EPRR Core Standards assessment is an organisational assessment and not an assessment purely of the EPRR function, the new approach makes this clear. NHS England have made recommendations around other services plans, procedures, and policies as well as new requirements for reporting through governance groups and board. Training and the training needs assessment processes are also an area of focus in this assessment and recommendations around this have been made.

NHS England share outcomes of these assessments with the Care Quality Commission as part of information sharing arrangements. NHS England and the ICB have been asked about the implications of this and particularly given the impact on all Trusts scores across the region and that the new process has not been rolled out nationally until 2024. As of the date of this paper the Trust has not had any information in this respect.

2.5. Positives and negatives with the new process

Positives

- The new standards give clear guidance on what is expected for each standard for the first time.

- They should ensure that declarations from all organisations are accurate and based on assessed evidence.
- They should raise standards over time.

Negatives

- The notice given to prepare for these new standards was far too short for such a significant change – around 10 weeks.
- The method of assessment is very rigid – there is no visiting the Trust by assessors nor is there any interaction (question and answer session) between the assessor and EPRR staff. It is all documentation based. An initial assessment is followed by a rating and a five-day period to challenge NHS England's rating with additional documentation (that predates the final date for submissions – for 2023 this was 29 September 2023).
- Assessors are not always familiar with all types of NHS bodies they are reviewing and from the Trust's perspective the assessor's unfamiliarity with mental health trusts did affect the assessment.
- Some standards do not appear relevant to mental health trusts.

If NHS England are receptive to modifying their approach to this process in 2024 many of these negative aspects can be resolved.

2.6. Action plans and collaboration

The EPRR team are developing a comprehensive action plan to address the areas where the trust was not assessed as compliant. This action plan will be monitored in the EPRR Group chaired by the Chief Operating Officer. Progress will be detailed in the Chief Operating Officer's report to the Board of Directors and the Finance and Performance Committee.

The Trust will be required to also detail progress to the West Yorkshire Local Health Resilience Partnership meeting quarterly.

The EPRR team are also working across the area with fellow teams to share good practice and compliant plans and to improve some of the collaboration domain EPRR scores by developing mutual aid and memoranda of understanding.

3. Conclusions

This year's EPRR Core Standard outcome is very disappointing and across the area EPRR staff and Accountable Emergency Officers have made their concerns felt to NHS England around the management of this process and its timescales for implementation particularly alongside the challenging EPRR commander portfolio work stream also taking place.

The assurance process in previous years has been more subjective leading to less consistency and effective moderation across organisations. Therefore, while the increased clarity, scrutiny, ambitions, and moderation from a regulator is welcomed this needs to be consistently applied with assessment against only relevant standards across all Organizations to be meaningful.

However, the Trust's EPRR team and Accountable Emergency Officer are committed to improving the compliance level in next year's assessment and thereby improving the organisation's ability to manage disruptions and respond to incidents.

4. Recommendations

The Board of Directors is asked to ratify the attached compliance statement and to note the attached report that gives further details of the outcome of this year's assessment, the themes in terms of areas of difficulty and the approach to developing a comprehensive action plan to rectify the situation.

Andrew Jackson
Resilience Lead and Corporate Business Manager
30 November 2023

Appendix

North East & Yorkshire Emergency Preparedness, Resilience and Response (EPRR) assurance 2023-2024

STATEMENT OF COMPLIANCE

Leeds and York Partnership NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Leeds and York Partnership NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Non-compliant (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board/governing body along with the enclosed action plan and governance deep dive responses.

JF Adams

Signed by the organisation's Accountable Emergency Officer

14 November 2023

Date signed

28/11/2023	30/11/2023	31/07/2024
Date of Board/governing body meeting – Finance and Performance Committee	Date presented at Public Board	Date published in organisations Annual Report

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
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LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Cyber Security Update
DATE OF MEETING:	30 November 2023
PRESENTED BY: (name and title)	Dawn Hanwell, Chief Financial Officer and Deputy Chief Executive
PREPARED BY: (name and title)	Ian Hogan, Chief Information Officer

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

Cyber Security Dashboard (enclosure)

- Multi-Factor Authentication system implemented across the trust July 2023.
- Privileged Access Management system implemented for most servers in the trust, small number of servers will be addressed as they are moved into cloud services.
- Phishing exercise conducted in August 2023 (Results analysed and staff have been informed). Follow up exercise planned for Spring 2024.
- Penetration Test scheduled to be completed December 2023.
- New server back-up system deployed.
- Cyber strategy under review, including policy review and gap analysis with external consultancy (in progress).
- Live Cyber Event incident response successfully undertaken with EPRR, debrief and associated actions/updates planned for November / December 2023.
- Updates to actions from this year's DSP Toolkit need to be evidenced, as per the plan, prior to the commencement of the next audit in Spring 2024.
- A submission for further central funding has been successful for investment in additional IT network security (network segmentation) and for vulnerability scanning for "The internet of Things" device types (e.g. CCTV cameras).

The Trust maintains a robust position and continues to invest in the appropriate technologies to improve our cyber defenses.

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
Note the Trust position in relation to its cyber defences.

National Cyber Security Centre

Leeds and York Partnership NHS Foundation Trust

10 steps to Cyber Security

Home and mobile working

- Agile working policy is complete.
- Protect data in forms of encryption at rest and in transit.

Managing user Privileges

- Number of privileged (admin) accounts have been reduced.
- Privileged Access Management procured and deployment to most servers - to be completed Dec 23

Network security

- New firewalls upgraded/Cloud firewall to be completed.
- Protecting the networks from attack.
- Two factor authentication completed.
- New back-up software installed.

Incident Management

- Establish and test incident and disaster recovery capability.
- Establish a new cyber incident response plan

User education and awareness

- Network & IT policies created covering acceptable and secure use of systems.
- DSP mandatory training includes cyber security training.
- Phishing exercise conducted in August 23.

Secure configuration

- Password management system procured and deployed.
- Apply security patches however many devices are not connected to the network.
- Baseline build for devices has been completed.

Malware prevention

- Anti-malware defenses have been implemented across client devices.
- Advanced Threat protection (ATP) is active across Windows 10 devices.
- Windows Defender is active across Windows 10 devices outstanding.
- Windows 7 complete, server 2008 in progress to be completed Nov 23

Monitoring

- Establish strategy & policies
- CareCERT reporting to and from NHSE including critical incidents.
- Resources to monitor of critical systems and on-going Pen Test software.
- Establish new software for security information logging

Removable media controls

- Policy created to cover media controls including Data Loss Prevention (DLP).

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:	Board Assurance Framework as at the end quarter 3
DATE OF MEETING:	30 November 2023
PRESENTED BY: (name and title)	Sara Munro, Chief Executive
PREPARED BY: (name and title)	Clare Edwards, Associate Director for Corporate Governance

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

EXECUTIVE SUMMARY

Overall responsibility for the BAF sits with the Chief Executive and this is administered by the Associate Director for Corporate Governance who has a co-ordinating role in respect of the information, and for ensuring the document moves through its governance pathway effectively and provides check and challenge to the content.

The BAF is populated with the eight strategic risks from the Strategic Risk Register. Each risk is assigned to a lead Executive Director. Each individual risk has been:

- Reviewed and updated where required on behalf of the lead director by the relevant senior manager to ensure that: the content is up to date; it adequately describes the controls and assurances in place; the gaps are adequately described; and any high level actions are articulated
- Provided to the lead executive director who has ensured the details overall are up to date as of November 2023, including the current risk rating.

The BAF in its entirety will be presented to those Board sub-committees named as an assurance receiver, in order for them to be assured of the completeness of the detail and that they are sufficiently and appropriately assured in relation to the risks, and that any gaps are being sufficiently managed and mitigated.

The Board is reminded that the BAF is presented here for assurance on its completeness as of November 2023.

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:

- Receive the BAF and to be assured of its completeness, including risk scoring and mitigating actions.

BOARD ASSURANCE FRAMEWORK OVERVIEW											
Strategic Objective	Risk appetite	Strategic Risk	Quarterly Assurance Rating				Changes in strategic risk score	Executive Lead	Assuring Committee	Current Risk Score	Change
			Q3	Q4	Q1	Q2					
1. We deliver great care that is high quality and improves lives	**ons. It is classed as 'high' in relation to that openness but the board would not take risks that either compromise our with the core regulatory and legislative frameworks within which it has a licence to operate.**	**(SR1) (Risk 636) If there is a breakdown of quality including safety assurance processes, we risk not being able to maintain standards of safe practice, meeting population health needs and compliance with regulatory requirements.**	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	SR1 - (November 2023) The risk score for SR1 remains the same. This recognises the risk is well controlled and has robust governance arrangements in place. In relation to staffing, workforce issues are specifically picked up in SR3, but it should be noted that any issues around safe staffing as a consequence of those workforce issues have robust reporting arrangements.	Nichola Sanderson (Director of Nursing, Professions and Quality)	Quality Committee	**12**	➔
		SR2. (Risk 829) There is a risk that we fail to make the improvements outlined in the Quality Strategic Plan and that this has an impact on how we understand and act on the care of those who use our services.	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	SR2 - (November 2023) The score for this risk has remained the same. to reflect the interconnectivity there is with the workforce risk / issues and the ability to make quality improvements within a workforce that has its current challenges.	Chris Hosker (Medical Director)	Quality Committee	**12**	➔
		SR8. (Risk 1111) There is a risk we fail to understand, plan and deliver services that meet the health needs of the population we serve.	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	SR8 - (November 2023) It was agreed this risk score will stay the same because we are as far ahead as we can be with the work and the systems processes and procedures needed at this point are in place and effective.	Joanna Forster Adams (Chief Operating Officer)	Finance and Performance Committee	**12**	➔
2. We provide a rewarding and supporting place to work		**SR3. (Risk 1109)There is a risk that we fail to deliver a culture and environment that recruits, retains, and attends to the wellbeing of staff to enable them to be their best and deliver quality services now and in the future.**	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	SR3 - (November 2023) the risk score for SR3 has remained the same the scale of the workifrce risk and the direct impact this is having on the ability to provide current services has not changed since the last review of the BAF.	Darren Skinner (Director of HR)	Workforce Committee	**16**	➔

3. We use our resources to deliver effective and sustainable services	**ave a risk appetite which is 'open' to considering all potential options and solutio compliance with its duty of care to staff and patients or compromise compliance**	**SR4. (Risk 619) There is a risk that a lack of financial sustainability results in the destabilisation of the organisation and an inability to meet our objectives.**	Partial(remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	SR4 - (November 2023) the score for this risk has been increased to refelct the uncertainty around CIPs both at a system and Trust level, noting this will likely impact service delivery.	Dawn Hanwell (Chief Financial Officer)	Finance and Performance Committee	**12**	↑
		SR5. (Risk 615) Due to an inability to provide adequate working and care environments we risk being unable to deliver safe and effective services.	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	SR5 - (November 2023) the score for SR5 remains the same. There is a regional workshop to look at the impact of national capital regime and how the West ICS will be impacted by this. When the outcome of the workshop is known and the impact on the Trust's estate is evaluated there will be a further review of the risk score.	Dawn Hanwell (Chief Financial Officer)	Finance and Performance Committee	**12**	→
		SR6. (Risk 635) As a result of insecure, inadequate and poorly utilised digital technologies there is a risk the quality and continuity of services is compromised.	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	SR6 - (November 2023) there is an acknowledgement that there have a number if incidents and this may impact on the risk score. However; we awaiting the outcome of a debrief on the incident to determine if there are any gaps in our controls which might impact on the scoring of this risk.	Dawn Hanwell (Chief Finance Officer)	Finance and Performance Committee	**8**	→

Strategic Objective	1. We deliver great care that is high quality and improves lives			Risk appetite	3 - Open ('High')
Strategic Risk		Initial Risk Score	4	Committee	Quality Committee
(SR1) (Risk 636) If there is a breakdown of quality including safety assurance processes, we risk not being able to maintain standards of safe practice, meeting population health needs and compliance with regulatory requirements.		Current Risk Score	12	Executive lead	Nichola Sanderson (Director of Nursing, Professions and Quality)

Assurance rating (quarterly) (limited, partial, significant)	Q3 (end December 2022)	Q4 (end March 2023)	Q1 (end June 2023)	Q2 (end September 2023)
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Risk Lead / responsible director	Overseeing group	Q3 (end December 2022)	Q4 (end March 2023)	Q1 (end June 2023)	Q2 (end September 2023)
	There are no contributory risks on the risk register						

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principal risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR1	Governance structures in place which sets out where Quality, safety, compliance and performance are discussed and assurance is received and provided	Following an internal restructure of our 2 operational caregroups to 9 service lines and an internal consultation of a future model of clinical governance and a focus on strenghtening clinical and professional leadership the new Unified Clinical Governance arrangements commenced in July 22. The monthly meeting has representative from 9 operational service lines, Clinical Directors Heads of Clinical Governance, Professional leads , chaired by the Deputy Director of Nursing, with monthly reports to TWCG and issues escalated to Quality Commitee and other relevant sub commitees as required.A Clinical goverence toolkit has also been produced and is shared with all new NEDs as part of their induction pack .In addition there is executive oversight of the reporting arrangements through the executive led groups with assurance reports to the board sub commitees which will identify any risks to quality,safety,compliance or performance impacting on regulatory requirements.The organisation commissioned Deloittes to undertake a Well Led Review, the findings of which were fed back in Jan 22 with positive recognition that work was underway to move to one overarching governance meeting, in addition the Governance Assurance Accontabilityand Performance framework [GAAP] was audited and given siginificnat assurance.Our current Organisational CQC rating is GOOD following the last in inspection in 2019.	Jan-22
SR1	Head of Clinical Governance and Regulation Team in place to oversee compliance with CQC standards, risk registers,serious incidents and the implemetation of the new Patient Safety Incident Response Framework	CQC peer reviews recommenced from April 22,with a focus on ensuring previous actions have been embedded and sustained within service areas.Reports from all peer reviews are provided through the Trusts governance structures and updates provided to Trust wide Clinical Goverence to ensure oversight.Regular updates in relation to risks, serious incidents are discussed at LIMM and TIRG and any areas of concern are reported to Quality Commitee or provided to trust Board through the quarterly DON reports and updates from the Quality Commitee chairs report. In April 22 a Board development session was held to appraise board members of the organisational preparedeness and planned changes to the CQC framework.A task and finish group has been set up to develop a PID to oversee the implemetation of the new Patient Safety Incident Review Framework ,progess of which is reported through to TWCG and Quality Commitee.PSIRF workshops have been established from February 2023 for all staff and NEDs to attend	Jul-22
SR1	Annual process in place for reporting on the controls in place in relation to risk to compliance incorporating the Annual Governance Statement Compliance with the provider Licence	The Annual Governance Statement was signed off by the Audit Committee, the Auditors and the Chief Executive for 2021/22. Self certification were signed off by the board for 2021/221 which also highlighted if there were any risks to compliance for 2021/22 and how these would be addressed. The Board has also confirmed compliance with all standards of the Provider licence and the self certification and this has been published on the Trust Website	Jun-22
SR1	Serious Incident reporting and investigation process in Place	NHSE investigation reports were presented to CQC inspectors as part of the Well Led Review which received an overall CQC rating of GOOD. All Si reports are investigated under the current Serious Incident Framework and reported through our Internal governance arrangments with opportunities to share learning . Quarterly reports are provided to Quality Commitee. In addition an audit on Learning from deaths was undertaken in April 2019 which gave significant assurance	May-19

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*

SR1	Establishement of the ICB and changes to system working since July 22	Terms of Reference considered as part of system groups and expectations and internal and external reporting structures are being agreed with relevant representation across partner organisations	Dec-23
SR1	Ongoing risk of future Covid variants and other associated infections which may impact on our ability to deliver same standard of care to our service users	Booster programme for both flu and Covid 19 in place.Clear PPE guidance in place across the organisation with access to IPC team for advise and guidance.Director of Infection Prevention and Control[DIPC] receives daily outbreak reports from the IPC team advising of number of positive cases across the organisation and provides monthly updates to Quality Commitee and escalates to executive colleagues as required. In addition clear outbreak management of infections is in place for all staff as guidance DIPC also attends NHSE external meetings to obtain national and regional updates	Mar-23

Strategic Objective	1. We deliver great care that is high quality and improves lives			Risk appetite	3 - Open ('High')
Strategic Risk		Initial Risk Score	9	Committee	Quality Committee
SR2. (Risk 829) There is a risk that we fail to make the improvements outlined in the Quality Strategic Plan and that this has an impact on how we understand and act on the care of those who use our services.		Current Risk Score	12	Executive lead	Chris Hosker (Medical Director)

Assurance rating (quarterly) (limited, partial, significant)	Q3 (end December 2022)	Q4 (end March 2023)	Q1 (end June 2023)	Q2 (end September 2023)
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q3 (end December 2022)	Q4 (end March 2023)	Q1 (end June 2023)	Q2 (end September 2023)
	There are no contributory risks on the risk register						

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principal risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR2	Quality Plan	The Quality Strategic Plan is now under review, however the 5 core areas will remain unchanged.	Sep-22
SR2	The IHI 'Safe Effective Reliable Care Framework' has been adopted and adapted for the organisation	This was set out in the Strategic Quality Plan which was reviewed by the Trustwide Clinical Governance Group, the Quality Committee and the Board	Sep-18
SR2	Improvement methodology adopted and adapted for the organisation	IHI methodology has been adopted and is being rolled out and embedded across the Trust	Mar-19
SR2	"The culture of innovation and improvement needs to be developed" The revised Service Annual Reports	The revised Service Annual Reports template was supported by the Clinical Directors, Medical director, Clinical Governance and signed off at TWCG. As of Jan 23, all new Service Annual Reports will be based on the revisesd template and services will continue to be offered support when completing them.	Feb-23

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
SR2	The establishment of a multi-disciplinary group to support change (from local teams to organisational wide priorities)	To continue to develop the relationship between specific support services for example Continuous Improvement Team, Informatics and Organisational Development Team.	ongoing
SR2	The culture of innovation and improvement needs to be developed	This is linked to the work around collective leadership, the rollout of the revised Service Annual Reports (supported via the QuIK group) and the building improvement capactiy ad capability programme.	ongoing

Strategic Objective	2. We provide a rewarding and supporting place to work			Risk appetite	
				3 - Open ('High')	
Strategic Risk		**Initial Risk Score**	**12**	**Committee**	Workforce Committee
SR3. (Risk 1109)There is a risk that we fail to deliver a culture and environment that recruits, retains, and attends to the wellbeing of staff to enable them to be their best and deliver quality services now and in the future.		**Current Risk Score**	**16**	**Executive lead**	**Darren Skinner** (Director of HR)

Assurance rating (quarterly) (limited, partial, significant)	Q3 (end December 2022)	Q4 (end March 2023)	Q1 (end June 2023)	Q2 (end September 2023)
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	**Description**	**Lead / responsible director**	**Overseeing group**	**Q3 (end December 2022)**	**Q4 (end March 2023)**	**Q1 (end June 2023)**	**Q2 (end September 2023)**
1099	Disruption of service delivery due to the impact of the workforce taking industrial action over pay and conditions of employment.	Holly Tetley / Darren Skinner	People and Organisational Development Group	N/A	16	12	6

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principal risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR3	Workforce plans in place. Service and Trust wide, . Workforce Matric in place. Trust wide Retention plan and Apprenticeship Strategy/ implementation plan in place. Systemwide work underway to support join recruitment and selection events and share learning.	HEE review of workforce plans, Recruitment and Retention Group monitor plans which are overseen by the Workforce Committee. Workforce planning KPIs form part of the People Plan dashboard which are reviewed at Workforce Committee and appropriate sub groups. Refresh of plans will take place in early 2024.	Feb-23
SR3	Clear policy in place to support new PDR process along with a Career Conversation Toolkit for staff and managers. Oversight of compliance by Workforce Committee with an Appraisal compliance task and finish group in place with clear actions that are monitored and reviewed monthly. Compliance reports sent monthly to services.	Compliance discussed at Workforce Committee and its sub groups. Monitoring of compliance at the task and finish group with remedial action taken as necessary. Compliance rates are increasing and at Nov 2023 stood at 81 percent - slightly below Trust target of 85 perent.	Feb-23
SR3	Trust wide Leadership and Management pathway in place. Access to Leadership Academy programmes such as Mary Seacole. Collective Leadership phase two programme in place. Monitoring of attendance overseen by Workforce Committee and its sub groups.	Monitoring by Workforce Committee and Talent and OD group using the People Plan dashboard.	Feb-23
SR3	The Trust has a well-established in-house Bank workforce of both bank only and substantive staff with a bank contract. On-going recruitment plan in place. Neutral vendor arrangement in place with a collective of 10 agencies which is overseen by the Workforce Alliance framework as our tier 1 provider. Access is also available to registered suppliers as a tier 2 option.	Fill rates are monitored reports to safter staffing and recruitment and retention groups.	Feb-23
SR3	Workforce plan in place to address business critical services during strike action. Strong relationships with trade union colleagues to understand appetite for strike action.	EPPR Team fully aware and plans in place. Monitoring by JNCC, JLNC and People Employment Team.	Feb-23
SR3	Cost of Living Task and Finish group established to review and propose supportive measures to address challenges associated with the cost of living increases.	EMT oversee and approve support measures as these are developed and implemented. Recently meeting approved 11 recommendations (05/11/22).	Feb-23

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
SR3	SupplySide of staff is a national risk.	International Recruitment to help mitigate national supply issues. Further upskilling on new roles to support services and fill vacancies. Widening participation plans to support skill shortages	Apr-24
SR3	Staff /management engagement in the importance of appraisals is low. Capacity issues impacting on compliance issues. New PDR system has appeared to have negatively impacted on compliance rates.	Line manager training on the importance of high quality PDRs. Training and support on moving to a new PDR system.	Apr-24

SR3	Capacity to release staff to attend the programme	Engagement with services on the importance of leadership and management development. Blended approach being offered along with a development hub to ensure leaners can access development opportunities in a flexible manner.	Apr-24
SR3	Temporary staffing availability and inclusive cultures on the wards.	The temporary staffing register provides temporary workers the ability to choose the shifts and wards on which they wish to work.Engagement with managers about supporting bank staff to integrate into their team/service. Bank Staff Survey, Bank Forums and Bank Staff Awards to support the engagement of bank workers.	Jan-24

Strategic Objective	3. We use our resources to deliver effective and sustainable services			Risk appetite	
				3 - Open ('High')	
Strategic Risk		Initial Risk Score	8	Committee	Finance and Performance Committee
SR4. (Risk 619) There is a risk that a lack of financial sustainability results in the destabilisation of the organisation and an inability to meet our objectives.		Current Risk Score	8	Executive lead	Dawn Hanwell (Chief Financial Officer)

Assurance rating (quarterly) (limited, partial, significant)	Q3 (end December 2022)	Q4 (end March 2023)	Q1 (end June 2023)	Q2 (end September 2023)
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q3 (end December 2022)	Q4 (end March 2023)	Q1 (end June 2023)	Q2 (end September 2023)
649	Provider Collaborative Risks: CAMHS tier 4 (Red Kite View) revenue gap and Provider Collaboratives risks for CAMHS and Adult Eating Disorders as Lead provider and risk share implications associated with other Provider Collaboratives in development (WY Secure and HC&V CAMHS and Secure Provider Collaboratives). Risk impact relates to spend on out of area placements above baseline funding levels. In addition, similar risk linked to HC&V provider collaboratives for CAMHS and Adult Secure.	Jonathan Saxton / Dawn Hanwell	Finance & Performance Committee	9	9	9	9
650	Protecting MHIS investment for MH services in this challenging Financial Environment	Jonathan Saxton / Dawn Hanwell	Finance & Performance Committee	5	5	5	5
651	Failure to achieve ongoing CIP requirements and demonstrate efficient and effective care will lead to a deterioration in the financial position.	Jonathan Saxton / Dawn Hanwell	Finance & Performance Committee	9	9	9	12
653	Failure to maintain existing services and attract new services in competitive/ tendering processes	Jonathan Saxton / Dawn Hanwell	Finance & Performance Committee	9	9	9	9
731	Increasing agency spend could cause a deterioration in the Trusts regulatory Finance Score.	Jonathan Saxton / Dawn Hanwell	Financial Planning Group	9	9	9	9
834	The Trust is vulnerable to fraud by inadequate systems and processes or those in a position to bypass controls. The risk is both internal and external and involves intent to evade detection	Gerard Enright / Dawn Hanwell	Audit Committee	5	5	5	5
869	LYPFT planned financial position relies on non-core income from CPC and non-recurrent interest receivable to break-even	Jonathan Saxton / Dawn Hanwell	Finance & Performance Committee	9	9	9	9
949	Changes to the capital funding regime may impact on the ability to secure sufficient capital (CDEL) allocations to deliver our long term capital planning objectives, including reprovision of PFI. Capital resources are allocated to each ICS to help address ICS priorities, there is a risk that LYPFT capital requests may not be prioritised in the context of the other ICS priorities. The operational methodology used for allocating capital resources between organisations may not benefit LYPFT, and be lower than historic planned levels. The Health & Social Care bill introduced a requirement to manage within capital allocations, however there is a risk that other system partners do not.	Jonathan Saxton / Dawn Hanwell	Financial Planning Group	12	12	12	12
1147	Failure to re-negotiation of the SSL contract to ensure that is is financially viable	Jonathan Saxton / Dawn Hanwell	Finance & Performance Committee	N/A	N/A	N/A	12
1148	Out of Area Placement expenditure increasing threatening the financial sustainability of the Trust	Jonathan Saxton / Dawn Hanwell	Finance & Performance Committee	N/A	N/A	N/A	12

1149	Inflationary pressures not being funded through tariff uplift	Jonathan Saxton / Dawn Hanwell	Finance & Performance Committee	N/A	N/A	N/A	9
1150	Not recruiting to vacant Finance roles and operating with limited capacity	Jonathan Saxton / Dawn Hanwell	Finance & Performance Committee	N/A	N/A	N/A	12

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principal risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR4	Good working relationships established with system partners. Actively engaging with place and ICB and provider collaborative partners and putting forward proposals that promote efficient and effective models of care.	Signed contracts with key commissioners in place, minutes of discussions with place, ICB and provider collaborative partners demonstrate good working relationships and good progress on key priority investments including agreeing the safer staffing business case and access to mental health investment standard growth in 21/22 and 22/23, based on a list of jointly agreed priority investments in efficient and effective models of care. Further positive joint working with NHS E and West Yorkshire mental health providers resulted in agreeing a funding baseline for CAMHS Provider Collaborative and NHSE approval to operate as Lead Provider. Throughout 2022/23 we have continued to engage in regular and positive dialogue with Leeds place based colleagues to promote efficient and effective models of care. Evidence of growing business from existing partners including CAMHS and adult secure developments in North Yorkshire, Community Transformation developments in Leeds and West Yorkshire as lead for Complex Rehab pathway, and winning tenders provides further assurance.	Jun-22
SR4	Commissioning activity around new and existing business is monitored through the Financial Planning Group: attended by Chief Financial Officer, Chief Operating Officer and Director of Nursing, Professions and Quality.	Agendas and minutes from Financial Planning Group and further assurance provided to Finance & Performance Committee in relation to new and existing business. Service reviews with commissioners demonstrate there is a process of providing assurance to the executive directors in relation to commissioning activity. Minutes of meeting demonstrating and evidencing assurance.	Jun-22
SR4	Oversight by Finance and Performance Committee: in relation to financial and clinical impact of tenders, in the context of the overall sustainability of the organisation.	Assurance papers are provided to the Finance and Performance Committee which is scrutinised by the non-executive directors on behalf of the Board.	Jun-22
SR4	Tender opportunities are reviewed by Financial Planning Group on a case by case basis along with considerations of whether to bid or not bid on any given tender. (led and including executive directors)	Operational metrics are presented to the Financial Planning Group for assurance in respect of tender opportunities. Follow-up audit carried out and significant assurance provided.	Jun-22
SR4	Partnership working arrangements in Leeds and ICB level, to ensure strategic influence is maintained on how resources are distributed and management of system wide risks (including city wide Director of Finance forum, Partnership Executive Group).	Minute of the emerging citywide governance and decision making meetings, including Director of Finance Group show a level of assurance on the partnership working arrangements across the city. Minutes of West Yorkshire Mental Health CFOs group (includes lead ICB CFO for mental health) and other key strategic partnership roles (Programme Director for WYICS MHLD&A and CCG Lead CFO for mental heath) provides evidence of maintaining influence on how resources are distributed. Minutes of numerous WYICS MHLD&A work streams including Transformation funding opportunities we have secured and business cases for ATU and complex care. LYPFT dedicated finance input to support WY ICS mental health work streams ensures visibility of funding opportunities and assurance that funding is distributed fairly. LYPFT CFO is the ICS CFO Capital lead on the ICS capital and estates Board, which influences capital allocation within the ICS.	Jun-22
SR4	As part of the Operational planning for 2023/24 financial year the Trust will develop a Cost Imporvement Programme to deliver the efficiencies required to meet agreed financial trajectories, assist productivity and improve outcomes and the experience for our service users.	A paper was apprved at FPG in March 2023 to produce a full CIP for the 2023/24 financial year focussing on 4 key areas: 1. Reducing agency spend 2.Reducing out of area pressures (complex rehab and adult acute) 3.Reducing our vacancy position by looking at opportunities to redesign within existing establishment 4.Exploring all opportunities/categories to improve productivity and efficiency The Trust will utilise the data available through Model Hospital, Lord Carter, benchmarking and improvement programmes to identify priorities for productivity and efficiency improvement. As part of our previous CIP governance, the FPG will continue to provide oversight of our whole programme	Mar-23
SR4	Regular ongoing dialogue with Provider Collaborative partners to agree risk share and actions to minimise and mitigate financial risk Regular monitoring of Provider Collaborative activity levels. Regular engagement with NHS E to ensure the baseline funding for provider collaborative/NCMs is sufficient. Performance metrics developed to track performance and progress against financial target. LYPFT exposure to c34% of the Provider Collaborative financial risk via proposed risk share for WY Provider collaborative based on population. Risk impact relates to spend on out of area placements above baseline funding levels. In addition, similar risk linked to HC&V provider collaboratives for CAMHS and Adult Secure, value yet to be agreed for risk share. Red Kite View staffing and non pay proposal discussed and agreed with partners and reflected within the overall CAMHS Tier 4 Provider Collaborative expenditure plans. Provider collaborative go live for CAMHS Tier 4 is contingent on securing sufficient funding to cover expenditure plans.	Signed Adult Eating Disorders Provider Collaborative risk share agreement. Confirmation from Chief Financial Officers of each provider within the collaborative that the risk share proposals for Adult Secure and CAMHS Tier 4 provider collaboratives are agreed (final sign off once funding baselines confirmed prior to go live dates). Activity and finance monitoring returns presented to WY Specialised MHLDA Programme Board.	Jul-21
SR4	Robust budgetary control framework and budget holder training in place	There is online training on Staffnet and opportunity to attend Finance Skills Development courses for all budget holders. Financial training for managers is also an integral part of the management essential training programme that is being developed. The internal audit of the budgetary and accounting control framework has provided significant assurance.	Apr-22
SR4	Consistent achieved of organisational plans in the context of system control targets.	Accounts audited at the end of 2022/23 to verify the financial outturn. Monthly reporting in 23/24 provides assurance that the Trust is on track to achieve the LYPFT element of the system control target.	Jul-22

SR4	Participate in capital planning forum across the ICS	Longer term capital requirements under review and development of 5 year capital plan as part of ICS capital regime. CFO engaged in ICS capital working group and ICS Capital Board to influence strategic approach to capital planning and allocations. Submitted Expression of Interest relating to new hospitals programme to register our financial requirements.	Apr-22
SR4	Financial modelling and forward forecasting in place to identify risks early.	Financial Plans submitted to NHSE included a detailed assessment of cost pressures and commissioning intentions based on wide ranging engagement within the Trust. Subsequently, monthly financial monitoring returns and quarterly forecasting provided to NHSE, Leeds Place based forecasting and ICS reporting and forecasting update each month.	Jun-22

Significant gaps in control / assurance		**Actions**	**Deadline**
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
SR4	Weakening of financial governance and controls as consequence of focus on clinical operational work and reduced capacity to attend to efficiency plans.	Fully re-establish our process for identifying longer-term CIPs (gap in control) during COVID response. Mitigated by current underlying run rate. Trustwide engagement in Strategic Planning events, in conjunction with budget rebasing exercise (engaging Care Groups to target areas for consideration) to inform and develop our approach to identifying longer term cost improvement plans. The approach involves full diagnostic and full sharing of information relating to cost pressures, agency spend, service line financial performance, action planning to address income and expenditure mismatches. Undertake self assessment of financial governance which will be subject to an internal audit.	Mar-23
SR4	Excess expenditure not covered by exceptional income	Mitigated by current underlying run rate, and our enhanced focus on corrective actions/plans to mitigate significant cost pressures. Financial Planning Group principles and business case process for assessing cost pressures and investment requests that are not supported by additional income.	Dec-23

Strategic Objective	3. We use our resources to deliver effective and sustainable services		Risk appetite	
			3 - Open ('High')	
Strategic Risk		**Initial Risk Score**	**8**	**Committee**	Finance and Performance Committee
SR5. (Risk 615) Due to an inability to provide adequate working and care environments we risk being unable to deliver safe and effective services.		**Current Risk Score**	**12**	**Executive lead**	Dawn Hanwell (Chief Financial Officer)

Assurance rating (quarterly) (limited, partial, significant)	Q3 (end December 2022)	Q4 (end March 2023)	Q1 (end June 2023)	Q2 (end September 2023)
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	**Description**	**Lead / responsible director**	**Overseeing group**	**Q3 (end December 2022)**	**Q4 (end March 2023)**	**Q1 (end June 2023)**	**Q2 (end September 2023)**
9	The majority of operational estate is not under the direct ownership/control of the Trust and is managed through contract/lease arrangements with third parties.(NHS Property services and Equitix). There is risk of unacceptable delays in executing identified environmental changes and also responsiveness to maintenance requests if these contracts are not robustly managed and process are not clearly understood by all parties involved (3 way relationships exist with sub contracting arrangements between property owners, maintenance providers and Trust staff)	Jonothan Campbell / Dawn Hanwell	Estates Steering Group	6	6	6	6
125	The estate is not being used in an agile manner due to it being inflexible	Jonothan Campbell / Dawn Hanwell	Estates Steering Group	6	6	6	6
128	Delay in rolling out clinical strategy to which the SEP is aligned may result in delays or the provision of interim solutions, resulting in abortive costs	Jonothan Campbell / Dawn Hanwell	Estates Steering Group	4	4	4	4
700	The Trust does not have a dedicated decant facility capable of receiving service users evacuated from a ward or unit due to an emergency - fire, flood, loss of power or other environmental/ security threat.	Andrew Jackson	Emergency Preparedness Resilience and Response Group	12	12	12	12
1008	Sustainability -The Trust is unable to meet the NHS Carbon Neutral requirements by 2040 and to implement a sustainable culture within the organisation	Jonothan Campbell / Dawn Hanwell	Estates Steering Group	12	12	12	12
1010	The trust is unable to maintain the condition of all our properties to Category B standard (as defined by NHSI/E) through financial constraints, inability to access areas to undertake improvements or changes to operational practice	Jonothan Campbell / Dawn Hanwell	Estates Steering Group	9	9	9	9
1142	The increasing frequency and severity of periods of summertime extreme heating will place significant additional pressures on the Trust's ability to operate, its estate and its ability to provide care to all its service users.	Andrew Jackson / Dawn Hanwell	Estates Steering Group	N/A	N/A	16	12
1151	All doors in South Wing are not anti barricade. There are ligature risks in rooms and staircase. Doors can be locked from inside, staff do not have keys to open. CCTV does not cover main entrance.	Victoria Waddinton / Joanna Forster Adams	Estates Steering Group / Clincial Envionrments Group	N/A	N/A	N/A	15
1168	No onsite alarm system at CMHT bases to ensure safety for staff and service users during clinical visits. Bases affected:- Aire Court, St Marys Hospital (Holly House), St Marys House - South Wing and North wing	Caroline Gattie / Joanna Forster Adams	Estates Steering Group / Clincial Envionrments Group	N/A	N/A	12	12

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principal risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR5	Surveys, Audits of the Physicaal environment	6 facet survey/ Premises assurance Model (PAM)/ Patient Led Assessment iof the care envirnment (PLACE)/ Estates Return Information Collection (ERIC)/ Internal Audit	Jul-22
SR5	sustainability programmes and improvmenets	Sustainability working groups established , Sustainability team established	Sep-22

SR5	Dedicated backlog maintenance within capital budget	Capital planning documentation	Jul-22
SR5	Policy and procedures to manage the estate	Polies, procedures and standard operating procedures	Jul-22

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
SR5	Healthcare Planning Exercise / Discussions with NHSE/ IPA	SOC being developed , Ongoing meetings	Oct-22

Strategic Objective	3. We use our resources to deliver effective and sustainable services			Risk appetite	
				3 - Open ('High')	
Strategic Risk		Initial Risk Score	12	Committee	Finance and Performance Committee
SR6. (Risk 635) As a result of insecure, inadequate and poorly utilised digital technologies there is a risk the quality and continuity of services is compromised.		Current Risk Score	8	Executive lead	Dawn Hanwell (Chief Finance Officer)

Assurance rating (quarterly) (limited, partial, significant)	Q3 (end December 2022)	Q4 (end March 2023)	Q1 (end June 2023)	Q2 (end September 2023)
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q3 (end December 2022)	Q4 (end March 2023)	Q1 (end June 2023)	Q2 (end September 2023)
8	Failure to derive maximum clinical and business benefits from digital technologies	Bill Fawcett / Dawn Hanwell	Information Steering Group	6	6	6	6
105	The danger of a cyber-attack to the Trust's ICT infrastructure through malicious hacking or system virus infection.	Bill Fawcett / Dawn Hanwell	Information Steering Group	12	12	12	12
1143	Allocate Software host the Trusts Healthroster, Temporary Staffing, E-Rota (Jnr Drs), Expenses and "Loop" software solutions. Allocate have an engineering data processing centre in North Macedonia which they utilise for processing tier 3 systems errors and data queries. North Macedonia is not in the EEA therefore is not an accepted as a country by the ICO for processing personal data.	Andrew McNichol / Darren Skinner	People and OD Group	N/A	N/A	N/A	3

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principal risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR6	Monthly calls between Procurment and the ICT department led by the CIO	Procurement processes have now been implemented. The Procurement team have a processes in place to ensure all requisitions are scrutinised and processed within Trust policy and best practice. Junior Buyers raising orders are trained to check category codes (E Class) and ensure that descriptions on purchase orders are clear, they know to query any orders for cloud software, website maintenance and telephony with IT directly to ensure that what is being ordered is in line with current Trust policies. All orders over £5k will escalate to the category lead for additional checks and approval. Weekly Junior Buyers meetings are held to provide a forum for discussion around workloads and to flag any issues that have been raised in the week so the whole team can discuss and learn from them. Any orders raised incorrectly would be discussed in this forum. The e class Category codes ensure an additional level of approval prior to budgetary approval. This technical approval is used to ensure that relevant IT colleagues have sight of requisitions prior to budgetary approval as well as providing procurement additional assurance that any requisitions they receive to process are known and approved by IT. Category codes that carry a technical approval also mean that buyers can return requisitions that have not been raised with the correct category.	Jan-23
SR6	CareCert alerts are received from NHS Digital on a weekly basis to key stakeholders within Informatics. These alerts are reviewed and actioned regularly within the teams.	The monitoring of these alerts are overseen by the Information Governance Group (IGG) on a monthly basis and the CIO oversees the process. A new Cyber monitoring system has been installed to provide detailed reporting on vulnerabilities .	Jan-23
SR6	The ICT infrastructure has firewalls, intrusion prevention, virus protection software and e-mail protection systems that are continually updated to prevent attack. A working programme to improve our awareness and response to threats is in place. Alerts received from NHS Digital are closely monitored, actioned on a regular basis.	Penetration testing was be conducted by an independent accredited organisation (SEC-1 LTD) Nov 2022. This included internal and external testing of the infrastructure to highlight any serious issues or vulnerabilities . Internal audit also provided significant assurance on the IT security and housekeeping arrangements The ICT infrastructure has firewalls, intrusion prevention, virus protection software and e-mail protection systems that are continually updated to prevent attack. A Phishing exercise was conducted in November 2022 and a further Phishing exercise is planned in April 2023. A working programme to improve our awareness and response to threats is in place. Alerts received from NHS Digital are closely monitored, actioned on a regular basis. This reports into Information Governance Group (IGG). CareCert alerts are received from NHS Digital on a weekly basis to key stakeholders within informatics. these alerts are reviewed and actioned regularly within the teams. Data security and protection toolkit audit Cyber security audit IG Toolkit in particular information security which includes patching updating of systems malware cyber security etc	Feb-23
SR6	Data security and protection toolkit audit	Internal audit of data security and protection toolkit provided moderate risk rating but high assurance. The Penn tesk has now been completed and this rating has been rivised upwards. The DSP toolkit for 2023 completed in June 2023 Takes account of this and concludes high assuruance and moderate risk which has been presented to the Trust Board	Feb-23
SR6	Cyber Security audit	DSP ToolKit audit on data security and protection provided significant assurance in August 2022. The next Cyber Security Audit is scheduled to take place in Q3 of 2023/24.	Aug-23
SR6	Requirement to test the Trusts defences against a cyber attack	Conduct a Penetration test exercise across the Trust to expose weaknesses in the Trusts cyber defences with follow up action programme to address areas of concern.	Mar-23
SR6	IG Toolkit in particular Information security which includes patching, updating of systems, malware, cyber security etc.	DSP ToolKit audit on data security and protection provided significant assurance in June 2023	Jun-23
SR6	Procurement review all web site expenditure with IT prior to giving approval to purchase.	Procurement and IT meet monthly to assess all technology procurements over £10K for the Trust.	Feb-23

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
SR6	Cultural and staff ability and aptitude was preventing optimum and appropriate use of technology	Work with staff through Digital Change Team and Thrive by Design and OD team to understand the barriers to using technology and provide the necessary help and support. Thrive by Design implementation of digital inclusion programme.	Mar-23
SR6	Requirement to improve knowledge of staff of the dangers of a cyber attack on the Trust	Conduct Phishing exercises across the Trust to expose the dangers of opening suspicious e-mails with follow up programme.	Dec-23

Strategic Objective	3. We use our resources to deliver effective and sustainable services		Risk appetite
			3 - Open ('High

Strategic Risk	Initial Risk Score	12	Committee
SR7. (Risk 1110) If we fail to achieve solutions for PFI provision we will incur quality and financial risks for the organisation.	Current Risk Score	16	Executive lead

Assurance rating (quarterly) (limited, partial, significant)	Q3 (end December 2022)	Q4 (end March 2023)	Q1 (end June 2023)	Q2 (end Sep
	Partial	Partial	Partial	Par

Contributory risks from the directorate risk register				Risk Score		
Datix Ref	Description	Lead / responsible director	Overseeing group	Q3 (end December 2022)	Q4 (end March 2023)	Q1 (end June 2023)
1006	demise of PFI in 2028	Dawn Hanwell	Estates Steering Group	16	16	16
1010	Condition of property	Dawn Hanwell	Estates Steering Group	12	12	9
125	Using sub optimal premises	Dawn Hanwell	Estates Steering Group	9	9	6

Key controls in place		Assurance that controls are effective
Ref	*The main controls/systems in place to manage principal risks*	*Sources of assurance that demonstrate the controls are effective*
SR7	Healthcare planning exercise	Work with our healthcare planners PWC has concluded. We now have a Board approved Care Services Strategic Plan which outlines our future clinical strategy and requirements for bed base.
SR7	Development of Strategic Outline Case	Draft version of the SOC presented to the Board in December 2022. Final version incorporating a revised financial case to be approved by Board in March 2023.
SR7	Discussions with Treasury, NHSE, ICB	Awareness at National and Regional Level around the pending issues with the PFI demise
SR7	Lifecycle Maintenance	Ongoing Lifecycle maintenance of properties - both PFI and lease and owned
SR7	Stakeholder engagement	Continuing to engage with stakeholders across the WYICS concerning the Trust's PFI scenario. Support received from WYICS CE. Log of engagement in place.
SR7	Care Services Strategic Plan	Board of Directors ratified the Care Services Strategic Plan

Significant gaps in control / assurance		Actions
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*
SR7	Long term Estates Plans concerning the PFI Estate	Development and approval of the SOC for submission to NHSE. Continue to refine the SOC shortlist in preparation for compilation of the Outline Business Case (OBC).

SR7	IPA (Infrastructure & Projects Authority) PFI expiry checklist	Complete a table top review of the Trust's level of compliance with the PFI expiry checklist ahead of our next review in July 2023.
SR7	Development of governance and assurance framework to establish, manage and monitor PFI expiry strategy	Developing an internal governance group associated with preparing for the ceasation of the PFI concession.
SR7	Stakeholder engagement / communication strategy	Development of communication and lobbying campaign concerning the Trust's PFI concession expiry. Continue to engage with DHSC / IPA / NHSE to seek support and guidance

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Finance and Performance Committee
Dawn Hanwell (Chief Finance Officer)
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Q2 (end September 2023)
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Date
Date of assurance
Nov 2021 - Sept 2022
Mar-23
Sep-22
Feb-23
Mar-23
Sep-22

Deadline
Target date for completion
Sep-23

Jul-23
ongoing
Ongoing

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Strategic Objective	1. We deliver great care that is high quality and improves lives		Risk appetite	3 - Open ('High')	
Strategic Risk		Initial Risk Score	12	Committee	Finance and Performance Committee
SR8. (Risk 1111) There is a risk we fail to understand, plan and deliver services that meet the health needs of the population we serve.		Current Risk Score	12	Executive lead	Joanna Forster Adams (Chief Operating Officer)

Assurance rating (quarterly) (limited, partial, significant)	Q3 (end December 2022)	Q4 (end March 2023)	Q1 (end June 2023)	Q2 (end September 2023)
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q3 (end December 2022)	Q4 (end March 2023)	Q1 (end June 2023)	Q2 (end September 2023)
TBC	There a number of services which have long waits to access assessment and treatment, delaying diagnosis and treatment and not meeting a number of populations groups health needs. Services include Gender, ADHD, LADS, CFS, MAS	Mark Dodd:Deputy Director of Service Delivery	Operational Delivery and Performance group	16	16	16	16
TBC	Lack of (or inadequate use of) public health intelligence to inform resource allocation.	Carl Money (Head of Performance) and Alison Kenyon (Deputy Director of Service Development)	Organisational Development Group	12	12	12	12
TBC	Community Transformation Programme is not realised within timescales	Josef Faulkener (Head of Operations)	Community Transformation Board	9	9	9	12
TBC	There are a number of services who due to workforce challenges (vacancies and absence) are not able to deliver the expected capcaity or quality of care impacting on recovery rates and clinical outcomes for service users. These include CMHT's, Forensics, LD Psychology	Mark Dodd:Deputy Director of Service Delivery	Operational Delivery and Performance group	16	16	16	12
TBC	People who have an SMI are more likely to smoke, be overweight, abuse addictive substances, be unable to work, be in the lower socioeconomic groups and die earlier than the general population, therefore we may not provide services to people with SMIs to assist with leading healthy lifestyles.	Joanna Forster Adams (Chief Operating Officer)/Nichola Sanderson (Director of Nursing and Professions)	Service Development Group	16	16	16	16

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principal risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR8	Robust performance monitoring and actions to address waiting times	QDAP Reports at Operational Delivery Group with summarised perfromance reporting through Chief Operating Officer Report.	Oct-23
SR8	People Plan implementation	Workforce Committee Performance reports and updates on delivery of the People Plan	Nov-23
SR8	Monitoring of the ethinic mix of detained patients. Reduction in Restrictive Practices inequalities work led by Wendy Tangen. Engagement with the Synergi programme, WREN, health inequalities	ICB MH Population Board, MHL committee and Service Development Group	Jan-23
SR8	Paritcpate as partners in the Population Health Boards of the Leeds Office of the ICB to influence the prioritisation of the mental wellbeing of the population and improve the health inequalities and disadvatages people with an SMI expereince	Addressing Health Inequalities through Service Delivery Group	Oct-23
SR8	Community Transformation Programme instrastucture established with Executive level involvement and oversight/progress reports to Trust Board.	Updates provided to the Board through the Chrief Operating Officer's report. Routine oversight through the LYPFT Service Development Group	Sep-23
SR8	Annual Service Quality Reports	Quality Committee	Oct-23

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
SR8	Analytics regularly reviewed in Service Deveopment Group in relation to population health needs,	Establishment of a set of data and information which informs decision making in respect of service development	Mar-24
SR8	Systematised ways of working at Service level to understand their populations and measure performance of achieving health care needs,	Head of Peformance and Deputy Director of Service Delivery to enhance the format of QDAPprocess to ensure that this is development and embedded as business as usual.	Mar-24
SR8	Care Service Strategic Plan implementation programme under development with measures to be established to measure compiance.	Service Development Group	Apr-24
SR8	There is an annual plan relating to Addressing Health Inequalities through Services Delivery - this needs to be developed into a startegy for the Orgnaistion which steers progress.	Chief Operating Officer to develop the infrasture to enable this. Head of Health inequalities recruited to, start date in the new year, focus will be to develop the health inequalities strategy and delivery plan for the trust.	Mar-24

Chair's Report

AGENDA ITEM

20

Name of the meeting being reported on:	Workforce Committee
Date your meeting took place:	5 October 2023
Name of meeting reporting to:	Board of Directors – 30 November 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 received the People and Organisational Development Governance Group Chair's Report which included updates on Civility and Respect, the Trust's Retention Strategy, and International Recruitment. The Committee noted that the Workforce Development Fund from NHS England had been significantly reduced this year which could have a direct impact on staff being able to access training on areas such as non-medical prescribing and trauma informed care. The Committee also noted that a self-assessment of the NHS Violence Prevention and Reduction Standard was being undertaken and that a report on this would come to the December meeting.

- The Committee received the Wellbeing Guardian Report and noted that the Trust's new Head of Wellbeing was due to start in November. The Committee also noted that an additional question relating to domestic violence and sexual assault had been added to the NHS Annual Staff Survey and discussed what measures had been put in place to prepare and support staff with this.

- The Committee recognised that it needed greater assurance on health and safety matters relating to workforce as per Principle One of the Wellbeing Guardian Framework. It was agreed that the Trust's new Head of Health and Safety would join the Workforce Committee as a regular attendee to present updates and assurance.

- The Committee received an update on the Collective Leadership programme and suggested some areas for further consideration including the use of collective leadership principles in recruitment, gathering feedback from the rest of the organisation as to what

collective leadership needs to be, consistency across the Trust's various management and development offers, and how collective leadership can be systematised so that it can be sustained long term.

Things on which the Board is to be assured:

- The Committee reviewed a report which highlighted the key actions and reforms required as part of the NHS Long Term Workforce Plan and what this means for the Trust's People Plan. This paper has been attached as an appendix to the Chair's Report for information.

- The Committee supported the approach being taken to refresh the People Plan for 2024 which aims to provide an overview of the resource, funding, and development needs across the Trust. The Committee suggested that a small number of strategic priorities were identified, and that analysis was undertaken regarding effort verses expected impact in order to make the best use of resources.

- The Committee noted progress with some of the Trust's key performance indicators: compulsory training compliance had stayed at 86%, Personal Development Review compliance had increased to 71.2% and clinical supervision compliance was at 68%.

- The Committee discussed the results and comments received as part of its effectiveness review, noted the areas where it had performed well and those which required further consideration to ensure the Committee remains effective. The Committee acknowledged that further direction may need to be given as to the length, purpose, and assurance requirements of the reports that it receives as per its work schedule. The Committee also agreed to keep the frequency of its meetings under review.

Items to be referred to other Board sub-committees:

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

Report completed by:	Helen Grantham November 2023

MEETING OF THE WORKFORCE COMMITTEE

5 October 2023

NHS Long Term Workforce Plan

1 Executive Summary

The purpose of this paper is to highlight the key actions and reforms required as part of the NHS Long-Term Workforce Plan and how this reads across to the Trust's People Plan.

2. Background to the NHS Long Term Plan

The NHS was commissioned by the government to produce an NHS Long Term Workforce Plan setting out future demand and supply requirements, and the actions and reforms needed to support the overall strategy for the NHS.
The Plan sets out modelling of NHS workforce demand and supply over a 15-year period and the resulting shortfall. It details the actions that will be taken in the coming years to address the identified shortfall in addition to, and building on, actions and investment already committed over the next two years.
The case for change is driven by some key demographic changes including

- *Current NHS Vacancies total over 112,000. This does not consider vacancies within social care.*
- *There is a growing population with life-expectancy increasing by 13 years since 1948.*
- *The number of people aged over eighty-five is estimated to grow 55% by 2037,*
- *Inaction is forecast to leave a shortfall of between 260,000 and 360,000 staff by 2036/37.*

It is clear that insufficient workforce, in both numbers and skill mix, impacts on patient experience, service capacity and productivity, and ability to transform the way we look after our patients.
In light of the above the NHS needs a robust and effective plan to ensure we have the right number of people, with the right skills and support in place to be able to deliver the kind of care people need now and in the future.
Given these significant gaps in the workforce coupled with the demographic changes the Long-Term Plan is the first step in a new iterative approach to NHS workforce planning. The model will be regularly updated to inform operational and strategic planning as circumstances change.
The plan is an ambitious one which focuses on the following three key areas

- **Train** significantly more staff so that the NHS has the right number of doctors, nurses and midwives, GPs, dentists, allied health professionals - such as physiotherapists, pharmacy staff and other staff.

This section of the plan makes up the bulk of the commitments set out in the plan. The modelling plan estimates that compared with 2022, there will need to be an overall increase of between 50 and 65 per cent in domestic education and training across the eight staff groups by 2030/31, to reduce the current significant reliance on international recruitment and temporary staffing and close the workforce shortfall.
The plan seeks to increase both the number and proportion of registered NHS staff working in primary and secondary care.

- **Retain** a greater proportion of the NHS workforce by allowing greater flexibility and career progression and improving culture, leadership, and wellbeing, while continuing to focus on equality and inclusion.
- **Reform** the way the NHS works so that healthcare staff have the right multidisciplinary skills and can harness new digital and technological innovations, allowing them to focus on patient care.

Although this is a fifteen-year plan – it is important to note that funding has to date only been secured for two years. It is also worth highlighting that some of the ambitions will be challenging to achieve. For example, improving productivity relies on investment in buildings, technology, and equipment; retention issues will not be addressed quickly and may not be at the required level to meet supply targets nor does the plan address pay and pay progression issues which are a key driver for many staff leaving the NHS. Finally, this is a plan for the NHS, and it does not address social care. Without this many of the ambitions set out in the plan may be missed.

3. Responding to the NHS Long-Term Plan

The Trust already has a comprehensive People Plan, which seeks to support the Trust's aspiration to be an employer of choice and attract and retain a high-quality workforce. Much of the work underway as part of the delivery of the plan supports the aspirations of the NHS Long-Term Plan.
Appendix one details the high-level aspirations of the NHS Long-term Plan and cross references this with the Trust's People Plan.
Although there are a number of gaps within the People Plan, these relate to the national plans to train more staff and reform the delivery of some training. As further details emerge the Trust will need for example to:-

- Ensure there are sufficient placement, preceptee vacancies and supervision capacity to adapt to the increase in clinical trainees,
- Revise its plan for Nurse Associates in line with national expectations and funding.
- Revise its plan for Nurse Training routes in line with national expectations and funding, as well as considering skills mixing within existing establishments.

The Trust will refresh its People Plan as further details and funding commitments emerge.

4. Conclusion

The NHS Long-Term Workforce Plan does provide the Trust with greater clarity over the work that will be undertaken nationally to help resolve the workforce challenges.
The Trust's own People Plan details a range of comprehensive actions that already align with the aspirations of the Long-Term Workforce Plan and as such will ensure that the Trust is able to response appropriately to the work that will be progressed nationally.
As noted above the key gaps in the Trust's People Plan relate to the national investment and reforms to the training of clinical staff. The Trust's People plan will be refreshed and updated appropriately as further information about these changes emerge.

5. Recommendation

- Note the significant work that is already underway as part of the Trust's People Plan which will address and respond to the Long-Term Workforce Plan,

- Note that the current gaps in the Trust's People Plan relate to the plans to train more staff. The Trust will respond to these demands in line with national guidance and funding.

Appendix one.

Long Term plan requirements	Trust's People Plan	Gaps/action to address any gaps
Train - double medical school places to 15,000 by 2031/32, - pilot a medical degree apprenticeship with 2,000 medical students training through this route by 2031/32, - Shorten medical students' time in medical school from five years to four years, - Increase mental health nursing and learning disability nursing by 93 per cent and 50 per cent, respectively. - Increase the number of registered nurses to train through an apprenticeship route from 9 percent to 20 percent. - Increase the number of allied health professionals (AHPs) training via an apprenticeship route from 6 percent to 30 percent. - Increase the number of training places for pharmacists by nearly 50 per cent to around 5,000 places. - Recruit at scale the number of health care support workers and work in partnership with Jobcentre Plus where appropriate and continue with a national recruitment programme. - Develop a novel approach to apprenticeship funding that supports employers with the cost of employing an apprentice.	The Trust has a plan in place to maximise the number of NA, TTN and MSc Routes it can accommodate via the apprenticeship route at the moment. The Trust take a partnership approach to recruiting at scale Health Care Support Workers and has an associated strategy and programme of work which covers the five strategic objectives within the national recruitment programme. This includes working with the voluntary sector, Job Centre Plus and other widening participation partners. The Trust has a comprehensive apprenticeship strategy in place which will maximise the current financial resources	The Trust will refresh its People Plan to respond to these requirements as further details and funding becomes available. Ensure the Trust has placement, preceptee vacancies and supervision capacity to adapt to this increase. The Trust will revise its plan for Nurse Training routes in line with national expectations and funding, as well as considering skills mixing within existing establishments.

	available.	
Retain - Improve the culture of the NHS to aid retention via cultural reviews to understand how working environments could be improved for staff. - Modernise the NHS pension scheme, to support staff partially retire or return to work seamlessly and continue building their pension after retirement. - On-going commitment to the national funding allocated for continuing professional development (CPD) for nurses, midwives, and allied health professionals. - Improve childcare support to help NHS staff to stay in work, - Invest in occupational health and wellbeing services,	The Trust already reviews the annual staff survey results and develops action plans to respond to staff feedback. The Trust is currently developing an engagement strategy to support staff engagement. Plans are in place to develop staff network delivery plans aligned to the people plan commitments. The Trust has a range of staff reward and recognition strategies in place. The Trust has implemented and promotes the benefits of the NHS Pension scheme to all staff. The Trust is developing a flexible working policy and approach to support staff to retire and return using the new pension flexibilities. The Trust promotes and encourage the full usage of the CPD monies linked to career aspirations. Staff have access to childcare vouchers. The Trust has a comprehensive health and well-being office in place including access to a dedicated physiotherapist and	

- reviewing people management systems, to support career development. - Provide better support to staff throughout their career, - Boosting flexible working opportunities - Improve the culture and leadership.	financial wellbeing support. There is a clear Talent management strategy in place to support on-going career development for all staff. Staff have access to a range of development opportunities to support their career development. A flexible working policy is being developed to promote and support staff work in a way that supports their work/life balance. The Trust has developed a 360-degree manager programme which is available to all staff along with coaching and mentoring for all staff. The Collective leadership programme is supporting the development of an open and compassionate culture. The Trust is implementing the Civility and Respect Framework.	
Reform - support the development of staff to enable them to take advantage of innovative technology including AI. - Expand enhanced, advanced, and associate roles to offer modernised careers and career progression.	Thrive by Design are delivering a Staff Digital Skills Self-Assessment and creating a forum for staff to discuss their digital challenges. There is a New Roles group in place to support the development of new roles and career progression of staff including associate nurses, assistant practitioners.	The Trust will revise its plan for NAs in line with national expectations and funding.

- Increasing training places for nursing associates – staff to build a workforce of 64,000 nursing associates by 2036/37. - Increasing training places for physician associate – staff to establish a workforce of 10,000 by 2036/37.	The Trust has a plan in place to maximise the number of NA it can accommodate via the apprenticeship route at the moment.	
- Grow the number and proportion of NHS staff working in mental health, primary and community care by 73 per cent by 2036/37, to meet the ambition to deliver more preventive and proactive care across the NHS.	The Trust has a comprehensive workforce plan in place to support the growth of staff working in MH – this is done in line with expansion monies.	

Fiona Sherburn
Associate Director for People Resourcing and OD
October 2023

AGENDA ITEM

21.1

Chair's Report

Name of the meeting being reported on:	Quality Committee
Date your meeting took place:	10 October 2023
Name of meeting reporting to:	Board of Directors – 30 November 2023

Key discussion points and matters to be escalated:

Issues to which the Board needs to be alerted:

- The committee received a report which provided an overview of the progress made against the 2023/24 CQUIN (Commissioning for Quality and Innovation) initiatives pertaining to mental health services. When discussing a CQUIN relating to routine outcome monitoring in the perinatal service it was informed of challenges relating to IT systems and data management which would likely impact the achievement of this CQUIN.

Things on which the Board is to be assured:

- The committee 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 reassurance on the Trust's work to manage the impact of industrial action on service users.
- 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 was informed that the Quality Strategic Plan would be shared with the Quality Committee in December 2023 before being submitted for final approval by the Board of Directors in January 2024.

Issues to advise the Board on:

- The committee recevied a report which provided an update on the current 90-day cycle work which was started with the aim of identifying and embedding clinical outcome measures across the Trust. The committee noted that following the completion of this work, outcome measures would be embedded within some services but not in many of the Trust's core services. It discussed some of the barriers for services in embedding outcome measures, which included lack of capacity, lack of IT support, and members of staff seeing this as a 'tick box' exercise. The committee noted the need for a patient portal.

The committee recognised that the Quality Strategic Plan referenced outcome measures as a method of understanding the quality, strengths and weaknesses of the Trust's teams and services. It agreed on the importance of outcome measures being a priority in the Trust.
Items to be referred to other Board sub-committees: • No items to be referred to other Board sub-committees.

Report completed by:	Dr Frances Healey, October 2023

AGENDA ITEM

21.1

Chair's Report

Name of the meeting being reported on:	Quality Committee
Date your meeting took place:	16 November 2023
Name of meeting reporting to:	Board of Directors – 30 November 2023

Key discussion points and matters to be escalated:

Issues to which the Board needs to be alerted:

- The committee received a report which outlined the progress made in quarter two against the 2023/24 Quality Improvement Priorities (QIPs). The committee noted that all QIPs were rated yellow (on track with challenges) or amber (delayed).

- The committee received data showing the progress made against CQUIN15b 'routine outcome monitoring in perinatal mental health services'. It noted that the figures were at 13% for Perinatal Inpatient Services and 20% for Perinatal Community Services and therefore the CQUIN would likely not be achieved.

Things on which the Board is to be assured:

- The committee received the Combined Complaints, Concerns, PALS, Compliments and Patient Safety Report which contained data from quarter two. The committee was pleased to read a compliment that had been received by Red Kite View. It noted that the highest reported category for PALS contacts in Q2 was 'communication' and requested further details to be provided at a future meeting. Overall, the committee agreed that the Trust had good systems for understanding quality issues raised through these sources and working to improve them and discussed further potential improvements to this report.

- The committee received the Restrictive Interventions Annual Report for 2022/23. It noted that there had been a 65% increase in the use of physical restraint in 2022/23 when compared to the previous year but acknowledged that this may have been due to the opening of Red Kite View. It also recalled previous discussions regarding the use of physical restraint at the Yorkshire Centre for Eating Disorders to provide life-saving treatment. The committee reviewed the data provided and discussed improvements to data on the use of physical restraints and agreed an action related to better understanding of the use of rapid tranquilisation.

- The committee received an update on the implementation of the Patient Safety Incident Response Framework (PSIRF) and Learning from Patient Safety Events (LFPSE). It acknowledged that the Trust had already embedded many elements of PSIRF, noting that the existing reporting on falls, the thematic review undertaken into inpatient suicides, previous discussions about the need for a self-harm strategy and learning from deaths reports.

- The committee reviewed a briefing explaining how restrictive intervention data in trust reports was defined and how this differed from the NHS national statistics for the Trust.

- The committee received an update on the actions taken in response to an internal audit into sexual safety that had received an opinion of limited assurance. The committee agreed that it was reassured by the actions taken in response to the report, acknowledging the delivery of these actions would be reported to Audit Committee but that the Quality Committee had an ongoing role in Safeguarding assurance.

- The committee 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 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.

Issues to advise the Board on:

- The committee received a report which provided an update on the development of the refreshed quality dashboard and the culture dashboard. It noted that this was an extensive piece of work that would take some time to complete. The committee discussed the project and noted the level of integration that was desired for the dashboards. It welcomed the style of engagement and focus on all aspects of STEEEP and observed that the proposed content could work well as a limited number of high-level quality indicators for board-level scrutiny of improvement over time, but that different indicators might be required so any service specific trends or issues could be spotted and action could be taken. Overall it welcomed the quality data that would be included in the dashboards but acknowledged that it would not be sufficient to replace the Combined Quality and Workforce Performance Report.

Items to be referred to other Board sub-committees:

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

Report completed by:	Dr Frances Healey, October 2023

Chair's Report

AGENDA ITEM

22.1

Name of the meeting being reported on:	Finance and Performance Committee
Date your meeting took place:	24 October 2023
Name of meeting reporting to:	Board of Directors – 30 November 2023

Key discussion points and matters to be escalated:

Issues to which the Board needs to be alerted:

- No issues to alert the Board on.

Issues to advise the Board on:

- The Committee received an overview of financial performance, noted the Trust's income and expenditure deficit position as at the end of September 2023 and discussed the West Yorkshire Integrated Care Board's (ICB) financial position in detail. The Committee noted that going forward all requests for non-clinical agency staff would need to go through the ICB and NHS England for approval and heard that the Trust's governance processes were being adapted accordingly and work was ongoing to mitigate any risks associated with this. The Committee discussed the list of efficiency schemes in detail and associated project costs; and considered the quality and equality impact assessment process and if this needed to be simplified given the scale of the CIPs programme. The Committee also discussed the key variances by department and noted that work was ongoing with teams and services to rebase historic budgets with a view to reducing variances.

- The Committee discussed the exceptional packages of care in the West Yorkshire Children and Young People's (CYP) Provider Collaborative (PC) and heard that work was ongoing to understand the scale of the issue and the associated risks and consider how it could be budgeted for going forward. The Committee noted that the Board was due to receive the Red Kite View post project evaluation report at the February 2024 Strategic Discussion along with any learning from the CYP PC partnership arrangements. It was agreed that this remit would be broadened to include the issues relating to payments for exceptional packages of care and governance and risks in provider collaboratives more generally.

- The Committee received the annual update on off-payroll engagements as of 30 September 2023 and noted the relatively high number of engagements for corporate services which were largely made up of posts within estates and IT departments. The Committee noted the high costs associated with these posts and received assurance that the intention was to fill them with substantive staff.

- The Committee sought assurance around Advanced Healthcare's commitment to continuing to resource and develop CareDirector as required. The Committee noted that the Trust would need to continue to apply pressure with senior level colleagues at Advanced Healthcare in order to maintain robust supplier / customer relations and to ensure they continued to develop CareDirector's functionality and additional wrap around products as required. The Committee noted that this risk and corresponding mitigation was recorded on the Trust's risk register.

Things on which the Board is to be assured:

- The Committee received an update on cyber security and noted that good progress was being made against the key projects. The Committee noted that consideration was being given to pooling some resources at a regional level with West Yorkshire mental health partners to increase staff skill mix and resilience across the patch. The Committee agreed that the findings of the upcoming live cyber exercise would come to a future meeting. The Committee also discussed last year's cyber-attack which had significantly affected the use of electronic patient record software in other trusts and asked to receive the findings and learning from this to inform future cyber exercises and contingency planning.

Items to be referred to other Board sub-committees:

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

Report completed by:	Name of Chair and date: Cleveland Henry – November 2023

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

AGENDA ITEM

22.3

PAPER TITLE:	Terms of Reference for the Finance and Performance Committee
DATE OF MEETING:	30 November 2023
PRESENTED BY: (name and title)	Cleveland Henry, Non-executive Director and Chair of the Finance and Performance 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 Finance and Performance Committee reviewed and approved its terms of reference on the 26 September 2023 and the following amendments were made (all amendments are highlighted in yellow on the attached document). As agreed by the Board, a consistency check has been carried out across all Board sub-committee terms of reference, any amendments as a result of this exercise have been highlighted in green.

- Pages 1 & 2 – Amendment to the role description of the non-executive directors, as defined by the Code of Governance for NHS Provider Trusts, NHS England 2022.
- Page 2 – Sentence added which says that any other Board members can attend the meeting on an ad-hoc basis and be recognised as a member for that meeting and if necessary, count towards the quoracy.
- Pages 2 & 3 – 'Head of Facilities' updated to 'Associate Director of Estates and Facilities'. 'Head of Procurement' and 'Assistant Director of Finance' added to the list of attendees.
- Page 3 – New paragraph added regarding governor observers at Committee meetings.
- Page 3 – Amendment to the role of Associate Non-executive Directors at Committee meetings.
- Page 3 – Change to the quoracy rule so that it is consistent with other Board sub-committees (3 members to be quorate and must include at least one NED and one ED).

- Page 4 – Under the frequency of meetings, removal of the statement that up to four of the eight meetings a year will be deemed as strategic meetings. This is because the Committee felt it was not reflective of how meetings were being run.

- Page 4 – New paragraph added regarding requesting an urgent meeting.

- Page 4 – Updated to reflect the current practice of circulating paperwork a minimum of three working days before the meeting and the reasons for this.

- Page 5 – 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 7 – 'Payment by Results tariff system' updated to 'payment mechanisms and tariff system'.

- Page 7 – The Committee's duty to approve the Trust's Health Informatics Plan has been added to the list of duties under IT and Information Governance.

- Page 9 – 'Information Steering Group' updated to 'Information Management Strategy Steering Group' plus a note to reflect that the Emergency Preparedness Resilience and Response Group sits within the Chief Operating Officer's portfolio.

- Page 11 – Chief Operating Officer's deputy changed from 'Deputy Chief Operating Officer' to 'Deputy Director of Operations'.

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.

Finance and Performance Committee

Terms of Reference
(to be ratified by the Board)

1 NAME OF COMMITTEE

The name of this committee is the Finance and Performance 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 (Committee Chair)	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 (Additional non-executive member (see section 3) – Chair of the Audit 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 (Additional non-executive member (see section 3) – Deputy Chair of the Committee, they must not also be the Chair of the Audit 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)
Chief Financial Officer	Executive lead for financial resources within the Trust. Assurance and escalation provider to the Finance and Performance Committee.
Chief Operating Officer	Executive Director with responsibility for the oversight and delivery and development of Care Services. Assurance and escalation provider to the Finance and Performance Committee.
Director of People and Organisational Development	Executive lead for workforce development. Assurance and escalation provider to the Finance and Performance Committee. Attendance at meetings will be dependent on the agenda items being discussed.

Attendees

While specified Board members will be regular members of the Finance and Performance 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. The Committee may also invite other members of Trust staff and partners to attend to provide advice and support for specific items from its work plan when these are discussed at the Committee's meetings.

These could include, but are not exhaustive to, the following individuals:

- Assistant Director of Finance
- Associate Director for Corporate Governance
- Associate Director of Estates and Facilities
- Chief Information Officer
- Deputy Director of Finance

- Director of Thrive by Design (previously mHabitat)
- Head of Procurement
- Managing Director North of England Commercial Procurement Collaborative.

Non-executive directors are also welcome to observe Board sub-committee meetings that they are not a member of as part of their development.

2.1 Governor Observers

The role of a 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 Associate NEDs' 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.

Deputies Members may nominate deputies to represent them at the Committee on an exceptional basis. Deputies do not count towards quoracy.

Non-quorate meeting: Non-quorate meetings may go forward unless there has been an instruction from the Chair not to proceed with the meeting. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

Alternate chair: The unique character of Board sub-committees is that they are chaired by a non-executive director. If the Chair cannot attend this meeting another non-executive director would chair this Committee. However, if one of the other non-executive directors that is a member of this Committee is also the Chair of the Trust's Audit Committee then they are not eligible to chair this Committee. This is in keeping with best practice to ensure that the Chair of the Audit Committee is seen to be suitably independent. In this circumstance the other non-executive director who is a member of this meeting would be the Deputy Chair for this Committee. In exceptional cases such as a non-executive director vacancy on the Committee, the Chair of the Audit Committee would be asked to chair the meeting if the assigned chair is unable to attend the meeting.

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: The Finance and Performance Committee will meet up to eight times a year or as agreed by the Committee. The Committee will meet following the NHS England quarter close downs and there will be up to another four meetings scheduled each financial year.

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.

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 a minimum of three working days prior to the meeting. This is so the circulation of papers is aligned to that of the Board of Directors. Papers received after this date will only be included if decided upon by the Chair.

5 AUTHORITY

Establishment: The Finance and Performance Committee is a sub-committee of the Board of Directors and has been formally established by the Board of Directors.

Powers: Its powers, in addition to the powers vested in the executive members in their own right, are detailed in the Trust's Scheme of Delegation.

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 Finance and Performance Committee is a standing committee in that its responsibilities and purpose are not time limited. However, the Committee has a responsibility to review its effectiveness annually and on the basis of this review and if agreed by a majority of members the Chair may seek Board authority to end the Finance and Performance Committee's operation.

In addition, the Trust should periodically review its governance structure for continuing effectiveness and as a result of such a review the Board may seek the winding up of the Finance and Performance Committee.

6 ROLE OF THE COMMITTEE

6.1 Purpose of the Committee

The principle purpose of the Finance and Performance Committee is to provide the Board with assurance on financial governance and performance; strategic matters in relation to procurement, estates, information technology and information management; performance against CQUINS; clinical activity and key performance indicators.

6.2 Guiding principles for members (and attendees) when carrying out the duties of the Finance and Performance 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 Finance and Performance Committee

The Finance and Performance Committee has the following duties.

i. General governance duties

- ratify plans, policies and procedures relevant to the remit of the Committee, this includes approval of the Trust's Financial Procedure and the Standing Financial Instructions prior to the Board of Directors ratifying them
- develop a forward plan for the work of the Committee that ensures proper oversight and consideration of all mandatory and statutory declarations is scheduled into the business of the Committee
- to review the Board Assurance Framework to ensure that the Board of Directors receives assurances that effective controls are in place to manage strategic risks related to any area of the Finance and Performance Committee's responsibilities.

ii. Financial governance

Receiving assurance that:

- the Trust has high standards of financial management and that financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout
- financial considerations are fully taken into account in decisions within the Trust and that there is effective management of financial and operational business risks in the organisation
- the Trust is reviewing the impact of any issues that may affect mandatory and regulatory financial duties operationally
- the Trust is complying with the Licence holder's duty to operate efficiently, economically and effectively and has effective financial decision-making, management and control in place.

iii. Procurement

Receiving assurance that:

- the Trust's Procurement Plan is driving reductions in all non-pay expenditure and progressing as originally intended
- operational reports are reviewed regarding compliance with effective procurement procedures with lessons learnt being implemented
- the Trust has a system to minimise the risk of Standing Financial Instruction and EU Procurement Law breaches for all Trust non-pay expenditure.

iv. Financial strategy

- review the detailed medium term financial plans as part of the annual Strategic Plan, prior to ratification by the Board of Directors and onward submission to NHS England
- scrutinise the quarterly financial reports to NHS England and provide assurance to the Board of Directors on the continuity of services rating, to ensure compliance with the Risk Assessment Framework
- review and monitor the financial impact and achievement of cost improvement plans.

Receiving assurance:

- regarding the Trust's contracting performance and the robustness of information provided to document activity
- on the on-going development of payment mechanisms and tariff system within the Trust to ensure that these are effective and will be deployed meeting national targets and mandatory guidance.

v. IT and information governance

Receiving assurance:

- approve the Trust's Health Informatics Plan and receive assurance that it is progressing as originally intended
- Chair's reports from the Information Governance Group.

vi. Capital and estates

Receiving assurance that:

- the Trust's Strategic Estates Plan is progressing as originally intended
- actions related to the Trust's capital programme are being taken forward operationally and advising the Board of Directors of issues that needed to be escalated
- action is being taken operationally relating to the Trust's estate from regulatory and statutory bodies and in respect to sustainability.

vii. Performance

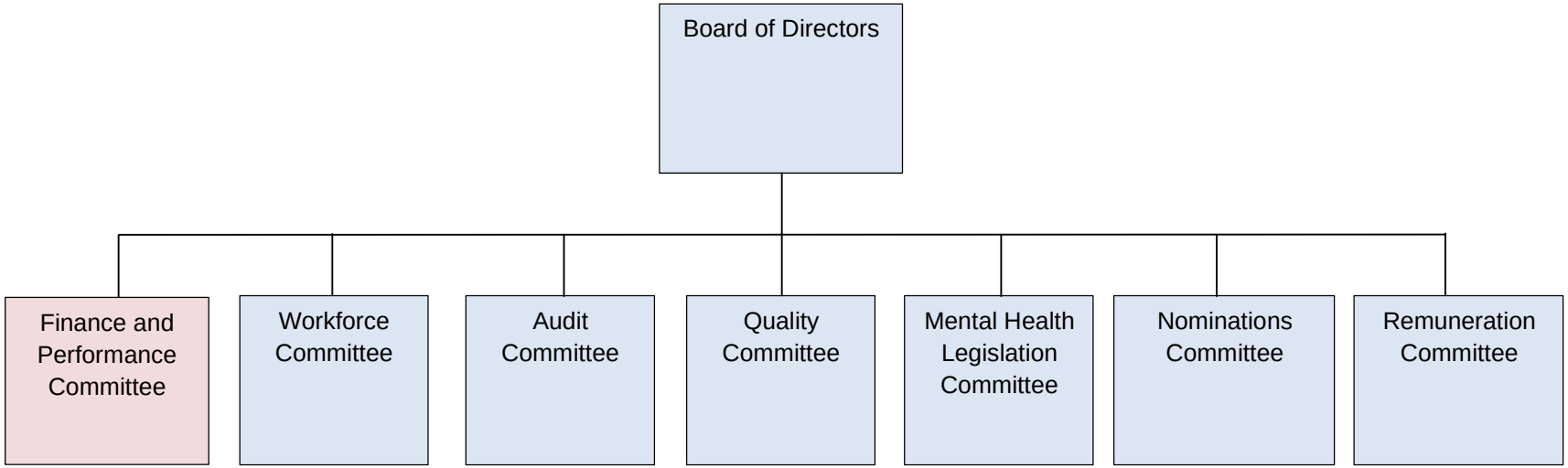
Receiving assurance on the Trust's performance against:

- annual budgets, capital plans, and the Cost Improvement Programme
- quality, innovation, productivity, and prevention plans
- commissioning for quality and innovation plans (CQUIN)
- clinical activity and key performance indicators.

viii. Internal Audit

- 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 Links with Other Committees



The Finance and Performance Committee does not have any sub-committees. It is linked to the Information Governance Group as an assurance receiver. The Finance and Performance 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.

Reporting

The Finance and Performance Committee will receive an assurance report from the Information Governance Group. An assurance and escalation report will be made to the Board of Directors by the Chair of the Committee.

Links with operational processes

The Finance and Performance Committee will receive high level reports from operational functions such as estates, informatics, and the North of England NHS Commercial Procurement Collaborative.

In addition to this, operational groups within the Chief Financial Officer's portfolio will report any significant governance implications by way of highlight reports into the Finance and Performance Committee. Groups dealing with the following areas have thus far been identified:

- Estates Steering Group
- Financial Planning Group
- Information Management Strategy Steering Group
- Procurement Strategy Steering Group
- Emergency Preparedness Resilience and Response Group (this group sits within the Chief Operating Officer's portfolio).

8 DUTIES OF THE CHAIR

The Chair of the Committee shall be responsible for:

- agreeing the agenda with the Chief Financial Officer and Chief Operating Officer
- directing the conduct of the meeting ensuring it operates in accordance with the Trust's values whilst ensuring all attendees have an opportunity to contribute to the discussion
- giving direction to the secretariat and checking the minutes
- ensuring the agenda is balanced and discussions are productive
- ensuring sufficient information is presented to the Board of Directors in respect of the work of the Committee.

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 Finance and Performance Committee and, in recognition of the nature of matrix working between the work of all Board sub-committees, the Finance and Performance 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.

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, where there has been a change. 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.

Appendix 1

Schedule of Deputies

Committee Member	Deputy
NED Chair	Another NED who is not the chair of the Audit Committee (as chair)
NED member	Another NED
NED member	Another NED
Chief Financial Officer	Deputy Director of Finance
Chief Operating Officer	Deputy Director of Operations

Chair's Report

AGENDA ITEM
23

Name of the meeting being reported on:	Audit Committee + Extraordinary Audit Committee
Date your meeting took place:	17 October 2023 + 17 November 2023 (extraordinary)
Name of meeting reporting to:	Board of Directors – 30 November 2023

Key discussion points and matters to be escalated:

Issues to which the Board needs to be alerted:

- The Committee received a low assurance report on Security Management. It noted that work to clarify the individual and collective responsibilities to address the issues raised in the report had commenced. It was assured by the measures in place to address the low assurance opinion and noted that the key actions identified in the report were planned to be addressed by 31 March 2024.

- The Committee discussed two limited assurance reports which had been received for the Utilisation of the E-Rostering System and Safeguarding: Sexual Safety. It was assured by the steps to address the issues identified in each of these reports. It additionally agreed that a plan to address the issues presented in the E-Rostering report would be received at its January 2024 meeting and noted that a follow-up audit for Safeguarding: Sexual Safety was scheduled to be conducted in February 2024.

Issues to advise the Board on:

- The Committee agreed to defer the planned internal audits for both 'Clinical Governance' and 'Health Inequalities' based on management requests received to defer these audits.

- The Committee set an additional annual objective to review and improve the succinctness of the papers received by the Committee.

Things on which the Board is to be assured:

- The Committee received the Business Continuity Planning audit report which expressed a significant assurance opinion and the Data Security and Protection Toolkit audit report which expressed a moderate risk and high assurance opinion.

- The Committee noted that the key performance indicators for both the submission of and management responses to internal audit recommendations were at 100%.

- The Committee received the Risk Management Annual Report and noted that the report demonstrated continued improvement within the risk management systems and processes.

- The Committee received the Local Counter Fraud Progress Report and noted its contents.

- The Committee noted that there were 14 outstanding audit actions to be completed. It additionally noted that discussions on how updates were received for audit actions would be held at the Executive Risk Management Group meeting on 15 November 2023 to ensure that updates were received in a timely manner.

- The Committee received the Board Assurance Framework and was assured that it was fit for purpose.

- The Committee received the Tender and Quotation Exception Report, the Losses and Special Payments Report, and the Management Consultancy Report and discussed their contents.

- The Committee reviewed its Terms of Reference and agreed that they required no amendments.

- The Committee agreed its Cycle of Business plan for 2024.

- The Committee received the Health and Safety Annual Report for 2022-23 and noted its content.

- The Committee received the Health and Safety Quarterly Update for Quarter 2 of the 2023-24 financial year and noted its content.

Items to be referred to other Board sub-committees:

None.

Report completed by:	Martin Wright, November 2023.

Chair's Report

AGENDA ITEM

24

Name of the meeting being reported on:	Mental Health Legislation Committee
Date your meeting took place:	Tuesday 7 November 2023
Name of meeting reporting to:	Board of Directors (30 November 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 an outstanding action remained with the CareDirector Team to update CareDirector so that it recorded mental health act tribunal hearing outcomes. The Committee requires this information so that it is able to monitor whether there is any disparity experienced by service users from different ethnic backgrounds in having their hearing dates delayed. The Committee agreed an update which included planned implementation dates should be received by the CareDirector Team by February 2024.

- The Committee continued to monitor the rollout of the "Right Care, Right Person agenda" as part of a national agenda to reduce police being called as first responders to health incidents. It noted a change in response observed in West Yorkshire Police who have adopted this agenda. The Committee noted that the Police Liaison Meetings had re-commenced which would provide the Trust the opportunity to co-operate with regional police services regarding this issue.

- The Committee agreed on the amendments made to the Committee's Terms of Reference and recommends that the Board of Directors ratify the changes.

- The Committee approved its Cycle of Business plan for 2024.

Things on which the Board is to be assured:

- The Committee received the Mental Health Act Detention Report 2022-23 and noted its contents.

- The Committee received the Mental Health Legislation Activity Report for Q2 2023-24 and was assured the plans in place were sufficient to ensure ongoing compliance with all mental health legislation.

- The Committee reviewed the two risks relating to mental health legislation on the Risk Register and was assured that these risks were being appropriately managed.

Items to be referred to other Board sub-committees:

None.

Report completed by:	Kaneez Khan – November 2023

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

24.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Terms of Reference for the Mental Health Legislation Committee
DATE OF MEETING:	30 November 2023
PRESENTED BY: (name and title)	Kaneez Khan, Non-executive Director
PREPARED BY: (name and title)	Kieran Betts, Corporate Governance Officer

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 Mental Health Legislation Committee reviewed and approved its terms of reference on 7 November 2023. The following amendments were made (all amendments are highlighted in yellow on the attached document):

- Page 1 and Page 2 – Defined the role of a Non-executive Director using the definition provided by the Code of Governance for NHS Provider Trusts, NHS England 2022.

- Page 1 and Page 10 – Amended the job title "Director of Nursing, Quality, and Professions" to "Director of Nursing and Professions".

- Page 4, Section 4: Meetings of the Committee – Standardised the content across all Board Sub-Committee ToRs.
    - Added details on administrative support to be provided by the Corporate Governance Team.
    - Added that papers will be distributed for the meeting five working days before the meeting date.
    - Deleted duplicate information on how meetings can be held face-to-face or remotely already contained within this section.

- Page 5, Section 5: Authority - added that the MHLC is able to access independent professional advice and professional outside of the Trust where necessary with consultation with the Board of Directors, to reflect the powers outlined in NHS

England's Code of Governance for NHS Providers Trust.

- Page 8, Section 7: Relationship with other Groups and Committees - added a note that "The committee has a duty to work with other Board sub-committees to ensure matters are not duplicated" underneath the diagram.

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 and ratify the Terms of Reference.

Leeds and York Partnership
NHS Foundation Trust

Mental Health Legislation Committee

Terms of Reference

**(Approved by the Mental Health Legislation Committee on 7 November 2023
To be ratified by the Board of Directors on 30 November 2023)**

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1 NAME OF COMMITTEE

The name of this committee is the Mental Health Legislation 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: full rights

Title	Role in the committee
Non-executive Director	Committee Chair and responsible for evaluating the assurance given and identifying if further consideration / action is needed. 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 and responsible for evaluating the assurance given and identifying if further consideration / action is needed. 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)
Medical Director	Executive Director with MHL Knowledge
Director of Nursing~~, Quality,~~ and Professions	Executive Director with links to CQC

Attendees:

Title	Role in the committee	Attendance guide
Associate Medical Director for Mental Health Legislation	Advisory and technical expertise	Every meeting
Head of Service (Adult Social Care, Leeds)	Linkage to Local Authority	Every meeting
Head of Mental Health Legislation	Advisory and technical expertise	Every meeting
Deputy Chair of Mental Health Act Managers Forum	MHAM's perspective, experience, and concerns	Every meeting
Chair of the MHL Operational Steering Group	Linkage to Services, Chair of the MHL Operational Steering Group	Every Meeting
Associate Director for Corporate Governance	Linkage to Board and other sub-committees	As required

In addition to anyone listed above as a member, at the discretion of the chair of the committee, 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 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 attend the meeting in the capacity of observer only, unless invited to contribute (in exceptional circumstances) by the Chair. 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 one Non-executive Director and the Medical Director. 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 Deputy Chair.

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 1, 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: The unique character of Board sub-committees is that they are Non-executive Director chaired. The Mental Health Legislation Committee has two Non-executive Director members hence the role of the chair will automatically fall to the other Non-executive Director if the chair is unable to attend.

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: The Mental Health Legislation Committee will normally meet every three months or as agreed by the Committee.

Urgent meeting: Any Committee member 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.

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 dates of the meeting. ~~by Corporate Governance Team.~~

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.

~~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.~~

5 AUTHORITY

Establishment: The Mental Health Legislation Committee is a sub-committee of the Board of Directors and has been formally established by the Board of Directors.

Powers: The MHL Committee's powers are detailed in the Trust's Scheme of Delegation. The Mental Health Legislation Committee has delegated authority to oversee the management and administration of the Mental Health Act 1983, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards / Liberty Protection Safeguards. The Committee is authorised by the Board to investigate and seek assurance on any activity within its terms of reference. The Committee is authorised by the Board to approve the appointment, re-appointment and make decisions in respect of remuneration to the Trusts Mental Health Act Managers.

The Board will be cited on any decisions taken in respect of Mental Health Act Managers via the Chair's report. The delegated powers will be reviewed by the Board at a minimum of three yearly intervals. 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 MHL Committee is a standing committee in that its responsibilities and purpose are not time limited. However, the Committee has a responsibility to review its effectiveness annually and on the basis of this review and if agreed by a majority of members the Chair of the committee may seek Board authority to end the Mental Health Legislation Committee's operation.

In addition, the Trust should periodically review its governance structure for continuing effectiveness and as a result of such a review the Board may seek the winding up of the Mental Health Legislation Committee.

This committee was implemented as a part of the 2013 governance review.

6 ROLE OF THE COMMITTEE

6.1 Purpose of the Committee

Objective	How the committee will meet this objective
Governance and compliance	The MHL Committee provides assurance to the Board regarding compliance with all aspects of the Mental Health Act 1983 and subsequent amendments and on compliance with all aspects of mental health legislation including, but not limited to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards / Liberty Protection Safeguards.

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

The MHL Committee has the following duties:

Mental Health Legislation

- The Committee will monitor and review the adequacy of the Trust's processes for administering the Mental Health Act 1983 and subsequent amendments and on compliance with all aspects of mental health legislation including the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards / Liberty Protection Safeguards.
- Formally submit an annual report on its activities and findings to the Board of Directors.
- Consider and make recommendations on other issues and concerns in order to ensure compliance with the relevant mental health legislation and to promote best practice by adherence to the codes of practice.
- Review the findings of other relevant reports functions, both internal and external to the organisation, and consider the implications for the governance of the organisation

Mental Health Act Managers' Forum

- The Mental Health Legislation Committee will ensure that the Mental Health Act Managers' Forum is supported to share experience, promote shared learning and raise concerns, where appropriate both amongst themselves and, with the Trust Board and management
- The Mental Health Legislation Committee will act as arbiter of any disputes in the work of Mental Health Act Managers arising either through the Mental Health Act Managers Forum or from individuals

Performance and Regulatory Compliance

- Will receive assurance from the MHL Operational Steering Group regarding the flow of Mental Health Act inspection reports and related Provider Action Statements.
- Will receive assurance from the MHAMs Forum regarding training, learning and development.
- To provide relevant assurance to the Board as to evidence of compliance with the Care Quality Commission registration and commissioning requirements related to Mental Health Act.

Training, Clinical Development and Guidance

- To monitor and recommend action to ensure there are adequate staff members/skill mix trained in the application of mental health legislation and there is sufficient training provided to maintain the required competency levels within clinical teams.
- To oversee the development and implementation of good clinical practice guidelines and effective administrative procedures in regard to the Mental Health Act and Mental Capacity Act 2005 and the Deprivation of Liberty

Safeguards / Liberty Protection Safeguards and advise on any other matters pertinent to MCA within the Trust

Assurance

- To ensure adequate quality control arrangements are in place to enable:
  - An Annual Mental Health Act report
  - Continuous monitoring arrangements
  - The agreed board reporting process

- To ensure there is an agreed programme of clinical audit and mechanisms for following up actions arising
- Receive the Board Assurance Framework and ensure that sufficient assurance is being received by the Committee in respect of those strategic risks where it is listed as an assurance receiver
- Receive the quarterly documentation audit to be assured of the findings, how these will be addressed and progress with actions.

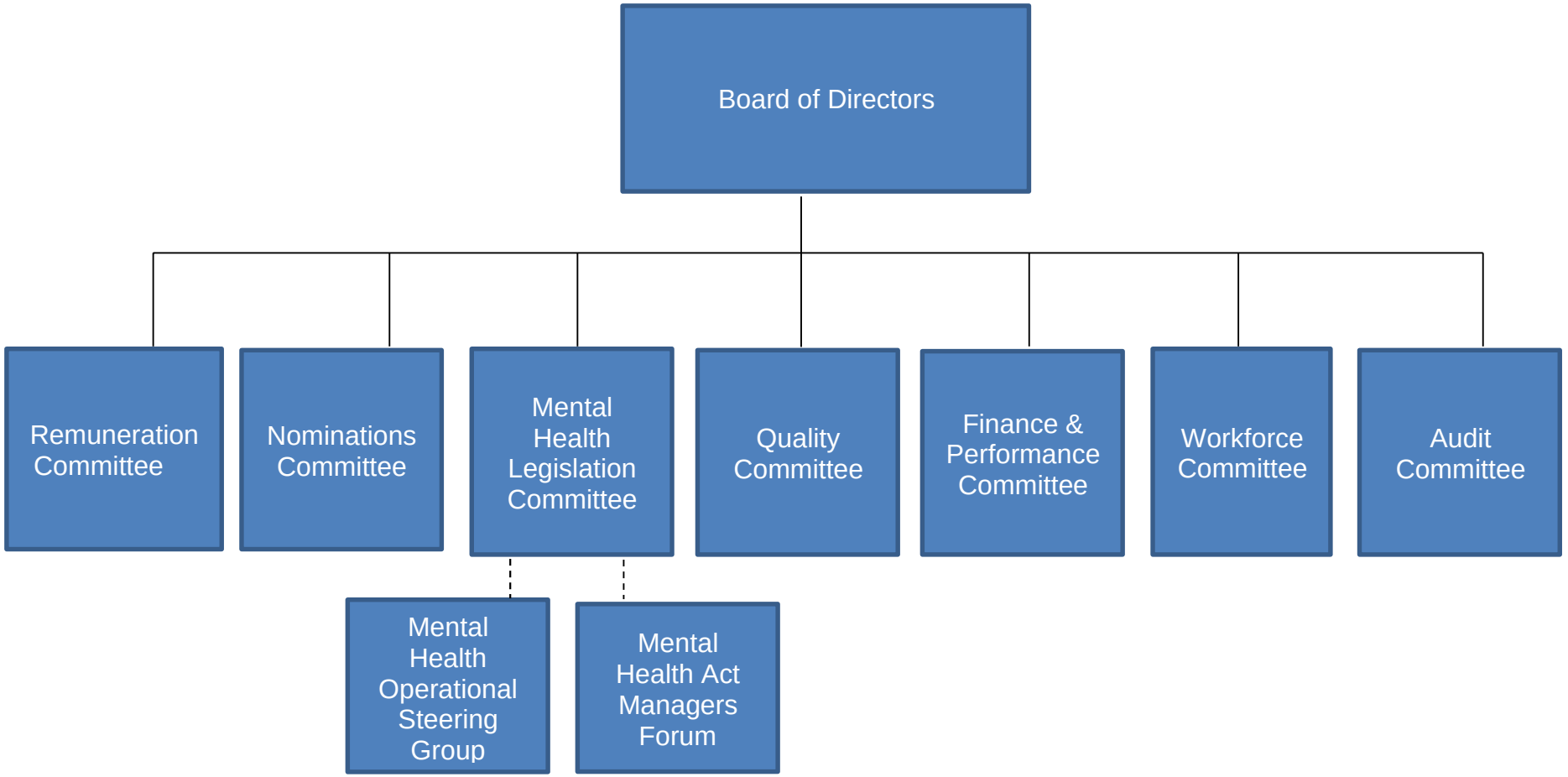
Service user and carer involvement

- To ensure there is a mechanism for service users, carers, and other groups with an interest to contribute to discussions and agreement on proper use of the relevant legislation, with particular regard to the experience of compulsory detention and its therapeutic impact
- Consider any feedback received from service user surveys

Internal audit

- The Committee will 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.

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 Trust 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.

It will be the responsibility of the chair of the Committee to ensure that it (or any group that reports to it) carries out an assessment of effectiveness annually, and ensure the outcome is reported to the Trust Board along with any remedial action to address weaknesses. The chair will also be responsible for ensuring that the actions to address any areas of weakness are completed.

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 Mental Health Legislation Committee and, in recognition of the nature of matrix working between the work of all Board sub-committees, the Mental Health Legislation 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 the outcome this is also reported back to the 'groups' concerned for agreement.

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.

Appendix 1

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)**
Non-executive Director (Chair)	Non-executive Director
Non-executive Director	None
Medical Director	Executive Director (ideally with knowledge and experience of MHL)
Director of Nursing~~, Quality~~ and Professions	Deputy Director of Nursing

Attendee (by job title)	**Deputy (by job title)**
Associate Medical Director for Mental Health Legislation	No deputy available to attend this Committee
Head of Service (Adult Social Care, Leeds)	Service Delivery Manager
Associate Director for Corporate Governance	Head of Corporate Governance
Head of Mental Health Legislation	Mental Health Legislation Team Leader / Law Advisor
MHA managers' nominated individual	Another MHA Manager
Chair of the Mental Health Legislation Operational Steering Group	Deputy Chair of the Mental Health Legislation Operational Steering Group

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
25

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Board of Directors Meeting Dates and Work Schedule 2024
DATE OF MEETING:	30 November 2023
PRESENTED BY: (name and title)	Clare Edwards, Associate Director for Corporate Governance
PREPARED BY: (name and title)	Clare Edwards, Associate Director for Corporate Governance

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

EXECUTIVE SUMMARY

Attached are the dates for the Board of Directors' meetings in 2024 and the proposed work schedule.

The Board is asked to note that for the extraordinary meeting to sign off the Annual Accounts etc. we are currently holding two dates. Please continue to hold both these dates until the date for closedown is confirmed by NHS Improvement.

The Board is asked to note the contents of the work schedule for 2024, with the acknowledgement that there may be requirements for amendments throughout the year to reflect priorities and amended reporting timescales.

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 dates for the Board of Directors' meeting and the content of the work schedule for 2024.

Meeting Schedule 2024 – Board of Directors

2024		
DATE	**START TIME OF PUBLIC BOARD**	**VENUE FOR BOARD MEETING**
Thursday 25 January 2024	9.30am	Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR
Thursday 28 March 2024	9.30am	Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR
Thursday 30 May 2024	9.30am	Create@2 room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR
Thursday 13 June 2024 (ExtraO meeting – held as a contingency)	1.00pm – 2.30pm	Microsoft Teams
Thursday 25 July 2024	9.30am	Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR
Thursday 26 September 2024	9.30am	Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR
Thursday 28 November 2024	9.30am	Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR
PRIVATE STRATEGIC DISCUSSION SESSIONS (No public Board meeting)		
Thursday 29 February 2024	Not applicable	Room TBC, The Newsam Centre, Seacroft Hospital, York Rd, Leeds LS14 6UH
Thursday 25 April 2024	Not applicable	Board Room, Ground Floor, St Mary's House - Main House, St Mary's Road, Leeds, LS7 3JX
Thursday 27 June 2024	Not applicable	Room TBC, Red Kite View, Green Hill Road, Armley, Leeds, LS12 3BY
Thursday 31 October 2024	Not applicable	Board Room, Ground Floor, St Mary's House - Main House, St Mary's Road, Leeds, LS7 3JX

Annual Cycle of Business for the Board of Directors 2024

BOARD OF DIRECTORS	AUTHOR / LEAD DIRECTOR	25 January 2024	28 March 2024	30 May 2024	TBC (ExtraO)	25 July 2024	26 September 2024	28 November 2024
STANDING ITEMS								
Apologies	-	X	X	X	X	X	X	X
Directors' Declarations of Interests (paper) / Conflicts of interest (verbal)	CE	X	X	X	X	X	X	X
Minutes of the last meeting	MM	X	X	X		X	X	X
Matters arising	-	X	X	X		X	X	X
Cumulative Action Log	MM	X	X	X		X	X	X
Chief Executive's Report – public meeting	SM	X	X	X		X	X	X
Chief Executive's Report – private meeting	SM	X	X	X		X	X	X
PERSON CENTRED CARE								
Sharing stories	-	X	X	X		X	X	X
Freedom to speak up Guardian Annual Report	SR			X				
Freedom to Speak up Guardian Report update report	SR							X
Guardian of Safe-working Hours Annual Report (to be presented by RA)	Rebecca Asquith					X		
Guardian of Safe-working Hours Quarterly Report (to be presented by CHos)	Rebecca Asquith / CHos		Q3 (O,N,D)	Q4 (J,F,M)			Q1 (A,M,J)	Q2 (J,A,S)
Chief Operating Officer's Report	JFA	X	X		X	X	X	X
Medical Director's report	CHos		X			X		X
Director Nursing and Professions' report	NS		X			X		X
Quality Account	NS				X			
Quality Committee Chairs Report	FH	X	X	X		X	X	X
Mental Health Legislation Committee Chairs Report	KK		X	X			X	X
Safer staffing Report	NS	X		X		X		X
WORKFORCE								
Report from the Director of People and OD	DS		X			X		X
Staff survey results (including Bank Staff)	DS / Frances Dodd		X					
Annual RO and Medical Revalidation report	Wendy Neil					X		
Equality Annual Report (including WRES and WDES and Gender Pay Gap final stats)	DS						X	
Indicative Gender Pay statistics (private Board meeting)	DS		X					
Workforce Committee Chairs Report	ZBS	X	X	X		X	X	X
PARTNERSHIPS								
Chair's reports from WYMH Committee in Common	MM	As required						

BOARD OF DIRECTORS	AUTHOR / LEAD DIRECTOR	25 January 2024	28 March 2024	30 May 2024	TBC (ExtraO)	25 July 2024	26 September 2024	28 November 2024
Chair's reports from ICB	SM	As required						
GOVERNANCE								
Board Assurance Framework	CE	Q3 (O,N,D)	Q4 (J,F,M)			Q1 (A,M,J)		Q2 (J,A,S)
Use of Trust Seal	CE	As required						
Annual declaration of interests (report for information)	CE		X					
NEDs independence	CE		X					
Fit and proper person annual declarations	CE/MM		X					
Annual Report from the Audit Committee	MW				X			
Annual Report from the Mental Health Act Committee	KK				X			
Annual Report from the Finance and Performance Committee	CHe				X			
Annual Report from the Quality Committee	FH				X			
Annual Report from the Workforce Committee	ZBS				X			
Annual Accounts	DH				X			
Annual Report	SM				X			
Annual Governance Statement	SM				X			
Compliance with the Code of Governance	SM				X			
Compliance with Licence: - CoS7 Availability of Required Resources - G6 Systems for Compliance - FT4 Corporate Governance Statement - S151(5) Self Certification for Governor Training	SM				X			
Letter of Representation	DH				X			
Approval of the Data Security & Protection Toolkit (self-certification)	DH					X		
Audit Committee Chairs Report	MW	X		X		X		X
EPRR: - Annual Report - EPRR & BC Policy approval - Assurance sign off	JFA			X		X		X
Notification of future meeting dates and approval of the work schedule	CE							X
Review the Board of Directors' Terms of Reference	CE							X
Review of NED Champion requirements	CE / KM		X					
Health and Safety Annual Report (after been to Audit committee)	AH / DH					X		
Cyber security update report	BF / DH		X			X		X
Operational priorities quarterly update report	AB / DH	Q3		Q4		Q1		Q2

BOARD OF DIRECTORS	AUTHOR / LEAD DIRECTOR	25 January 2024	28 March 2024	30 May 2024	TBC (ExtraO)	25 July 2024	26 September 2024	28 November 2024
USE OF RESOURCES								
Report from the Chief Financial Officer	**DH**	X	X	X		X	X	X
Finance and Performance Committee Chairs Report	**CHe**	X	X	X		X	X	X

Leeds and York Partnership
NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

AGENDA ITEM

26

PAPER TITLE:	Terms of Reference for the Board of Directors
DATE OF MEETING:	30 November 2023
PRESENTED BY: (name and title)	Clare Edwards, Associate Director for Corporate Governance
PREPARED BY: (name and title)	Clare Edwards, Associate Director for Corporate Governance

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

EXECUTIVE SUMMARY

The Board is asked to note that it is required to review its Terms of Reference annually to ensure they are up to date and fit for purpose.

The Associate Director for Corporate Governance reviewed the Terms of Reference and has suggested two changes which are:

1. Change the title of the 'Director of Nursing, Quality and Professions' to the 'Director of Nursing and Professions' to ensure it reflects her current title.
2. Change 'NHS Improvement' references to 'NHS England' to reflect the organisational changes.

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 and ratify the revised Terms of Reference.

Leeds and York Partnership NHS
NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Board of Directors

Terms of Reference
(For approval by the Board 30 November 2023)

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The Trust has Standing Orders for the practice and procedures of the Board of Directors (Annex 8 of the Constitution). For the avoidance of doubt, those Standing Orders take precedence over these Terms of Reference, which do not form part of the Trust's Constitution.

1 NAME

Board of Directors

2 COMPOSITION OF THE BOARD

The membership of the Board of Directors is determined in accordance with Section 19 of the Trust's Constitution and shall comprise both executive and non-executive directors acting as a unitary Board.

Members

Composition
A non-executive chair
A minimum of 4 and a maximum of 6 other non-executive directors
A minimum of 4 and a maximum of 6 executive directors

The above shall be considered as the composition of the Board, provided at least half the Board excluding the Chair of the Trust comprises non-executive directors who have been determined by the Board to be independent.

For clarity the executive directors who are members of the Board of Directors are:

- Chief Executive
- Chief Financial Officer
- Medical Director
- Director of Nursing and Professions
- Chief Operating Officer
- Director of People and Organisational Development

All members of the Board of Directors shall have one full vote each, with the chair having a second or casting vote should the need arise.

The Board of Directors will appoint one of the independent non-executive directors to be the Senior Independent Director. In consultation with the Chair of the Trust, the Council of Governors will also appoint one of the non-executive directors to be the Deputy Chair of the Trust.

Members of the Board of Directors must ensure that wherever possible they attend every Board meeting (including extraordinary Board meetings when convened). An explanation of non-attendance should be made to the Chair of the Trust. Attendance at meetings will be monitored by the Associate Director for Corporate Governance and shall be reported to the Chair of the Trust and the Council of Governors on a regular basis. Attendance will also be reported annually in the Annual Report.

The Board may invite non-members to attend its meetings on an ad-hoc basis, where it considers this to be necessary and appropriate, and this will be at the discretion of the Chair.

In attendance

Title	Role in the Board	Attendance guide
Associate Director for Corporate Governance	Shall be the Board Secretary, attending all meetings of the Board of Directors and providing appropriate advice and support to the Chair and Board members. This will include ensuring agreement of the agenda with the Chair, collation of papers, taking minutes and keeping proper records of the meeting including any actions to be carried forward. It shall also include the preparation of those corporate governance papers pertaining to the Board of Directors.	Every meeting

In the absence of the Associate Director for Corporate Governance the Deputy Trust Board Secretary will deputise.

2.1 Governor Observers

The role of the governor at public Board of Directors' meetings is to observe, rather than to be part of its work. They are not part of the formal membership of the Board, nor are they classed as in attendance. Governors are invited to observe the Board meetings 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 electronic copy of the public Board papers prior to the meeting. Governor observers will be invited to the public meetings only, by the Corporate Governance Team.

2.2 Associate Non-executive Directors

Associate Non-executive Directors will be invited to attend Board of Directors' meetings (both public and private meetings) as part of their induction. They will be in attendance at the meeting, in the capacity of observer only, unless invited to contribute (in exceptional circumstances) by the Chair. This is so the integrity of the unitary Board and the accountability of the substantive members of the Board is maintained.

Associate NEDs will be invited to the public and private meetings by the Corporate Governance Team and will be sent copies of all Board papers.

3 QUORACY

Number: No business shall be transacted at a meeting of the Board of Directors unless at least one third of the whole number of the members of the Board is present, including at least one executive director and one non-executive director.

Deputies: Where, exceptionally, an executive director is absent from a meeting they may not normally send a deputy in their place. However, attendance to cover absences will be at the discretion of the chair and will be agreed in order to ensure the Board has access to appropriate advice and information. In these circumstances the deputy attending will not have any voting rights and will be recorded as in attendance. Where there are formal acting up arrangements in place the person acting-up into an executive director role may attend and will assume the voting rights of the director they are acting up for. In such circumstances they will be recorded as a member of the Board.

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Non-quorate meetings: 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 BOARD

All meetings shall be held in public except where matters are deemed confidential on the grounds of commercial sensitivity, personal issues or matters that could cause harm to individuals by the nature of their content. Such matters will be discussed in a separate closed session which will not be attended by members of the public. Any person attending the private Board meeting will be at the discretion of the Chair. 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.

A full set of papers comprising the agenda, minutes and associated reports and papers will be sent to all directors within the timescale set out in Standing Order 3.3.1 in Annex 8 of the Constitution (or as agreed by the Chair).

Copies of the public and private agendas will be sent to members of the Council of Governors prior to any meeting.

The public agenda papers and minutes of each public meeting shall be displayed on the Trust's website.

Frequency: Meetings of the Board of Directors shall be held at such times as the Board may determine. The frequency of meetings shall be agreed by the Board of Directors and will normally be bi-monthly (excluding August and December). The Board may agree to vary that frequency. This shall not preclude urgent meetings being convened at any time in accordance with Standing Order 3.2 in Annex 8 of the Constitution.

The Board has also agreed to hold Strategic Discussion meetings which will normally be scheduled in the months between the formal Board meetings (excluding August). These meetings will be used as protected time to discuss in greater detail matters that may emerge from the formal meetings as well as those which will further inform the work of the Board. Holding a strategic discussion session does not preclude any part of this meeting being constituted as an urgent meeting should the need arise.

Urgent meetings: Urgent meetings shall be convened in accordance with Standing Order 3.2 in Annex 8 of the Constitution.

Minutes: The Associate Director for Corporate Governance, acting in the capacity as Trust Board Secretary shall take the minutes. They will ensure these are presented to the next full business meeting of the Board of Directors for agreement. Minutes may be held either electronically or in paper format but always in a way that is accessible and preserves the continuous record of the meeting.

5 AUTHORITY

The Trust is required to establish a Board of Directors in accordance with the NHS Act 2006 (as may be amended by the H&SC Act 2012), and paragraph 21 of the Trust's Constitution. All members of the Board shall act collectively as a unitary Board with each member having equal liability.

6 ROLE OF THE BOARD OF DIRECTORS

6.1 Purpose of the Board of Directors

The principle purpose of the Trust is the provision of goods and services for the purposes of the health service in England. The purpose of the Board is to ensure the provision of those health services it is commissioned to provide; that these are delivered in line with its strategy; that services are safe and effective and are provided to a high quality; to provide leadership and direction to the organisation; and to ensure it is governed effectively with appropriate systems processes and procedures in place.

The Board will achieve this by:

- Setting and overseeing the strategic direction of the organisation within the overall policies and priorities of the Government, the Trust's regulators, and its commissioners, having taken account of the views of the Trust's members (through the Council of Governors), and the wider community
- Ensuring accountability by holding the organisation to account for the delivery of the strategy; and through seeking assurance that systems of control are robust and reliable
- Shaping a positive culture for the organisation
- Being assured on the work of the executive directors
- Taking those decisions that it has reserved to itself.

The Trust has a Board, made up of executive and non-executive directors, which exercises all the powers of the Trust (as the entity) on its behalf, but the Board may delegate any of those powers to a sub-committee of the Board (made up of directors) or to an executive director. (Arrangements for the reservation and delegation of powers are set out in the Reservation of Powers to the Board of Directors and Council of Governors and Schedule of Decisions/Duties Delegated by the Board of Directors (known as the Scheme of Delegation) and the Terms of Reference of its sub-committees.

6.2 Guiding principles for members (and attendees) when carrying out the duties of the Board

In carrying out their duties, members of the Board and any attendees at the meeting must ensure 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 Board of Directors

The duties set out below shall not preclude the Board of Directors from reserving powers and duties to itself. These powers and duties shall be set out in the Scheme of Delegation, and, for the avoidance of doubt, where there is a conflict the Scheme of Delegation will take precedence over these Terms of Reference.

The duties of the Board of Directors are to:

- Set the values and strategic direction of the Trust; and ensure the Trust's Strategy and any supporting strategic plans are reviewed as necessary

- Provide leadership to the Trust to promote the achievement of the Trust's 'Principal Purpose' as set out in the Constitution (i.e. the provision of goods and services for the purposes of health services in England), ensuring at all times that it operates in accordance with the Constitution and the conditions of the license as issued by NHS England

- Engage as appropriate with the Trust's membership through the Council of Governors

- Promote and develop appropriate partnerships with other organisations in accordance with the Trust's values and strategic direction

- Oversee the implementation and achievement of the Trust's strategic objectives

- Agree the Trust's Operational Plan

- Ensure the Trust has adequate and effective governance and risk management systems in place

- Monitor the performance of the Trust and ensure the executive directors manage the Trust within the resources available in such a way as to:

    - Ensure the safety of service users and the delivery of high-quality care
    - Ensure the continuous improvement of services
    - Protect the health and safety of service users, employees, visitors and all others to whom the Trust owes a duty of care
    - Make effective and efficient use of the Trust's resources
    - Comply with all relevant regulatory and legal requirements
    - Maintain high standards of ethical behaviour, corporate governance and personal conduct in the business of the Trust
    - Maintain the high reputation of the Trust both with reference to local system and place stakeholders, and the wider community.

- Receive and consider high-level reports on matters material to the Trust detailing in particular, information and action with respect to:

    - Service user and carer experience
    - Clinical quality including safety
    - Performance, including performance against targets and contracts
    - Human resource matters
    - The identification and management of risk
    - Financial performance
    - Matters pertaining to the reputation of the Trust.

- Promote teaching, training, research and innovation in healthcare to a degree commensurate with the Trust's teaching status

- Review and approve any declarations/compliance statements to regulatory bodies prior to their submission

- Review and adopt the Trust's Annual Report and Accounts

- Act as corporate trustee for the Leeds and York Partnership NHS Foundation Trust Charitable Trust Funds.

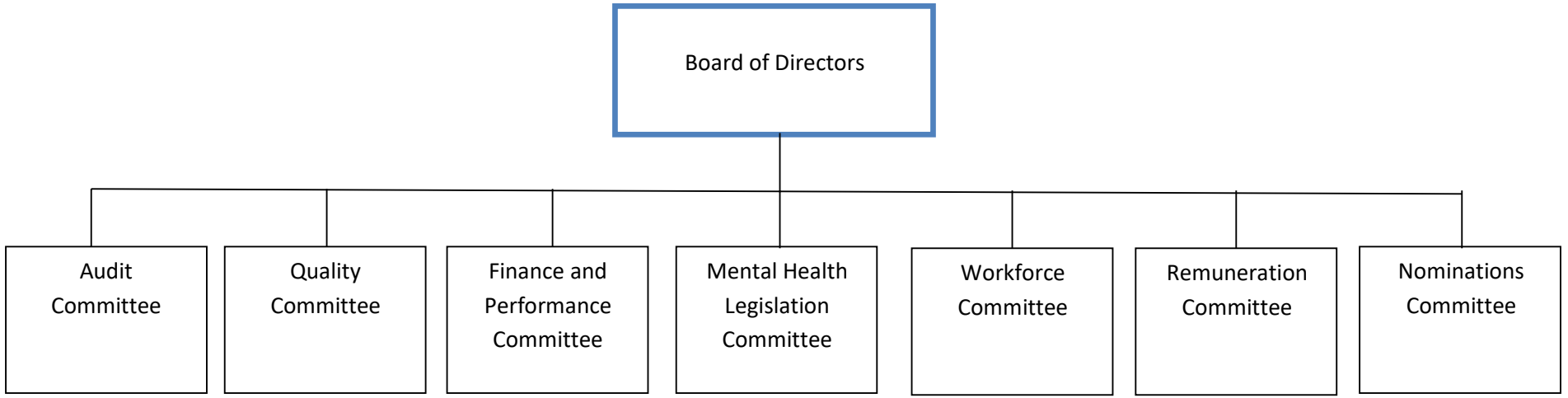
7 RELATIONSHIP WITH OTHER GROUPS AND COMMITTEES

The Board of Directors may delegate powers to formally constituted sub-committees (whose membership is made up of directors). Without prejudicing the formation of any other sub-committee the Board has formally constituted the following:

- Audit Committee
- Quality Committee
- Mental Health Legislation Committee
- Workforce Committee
- Finance and Performance Committee
- Remuneration Committee
- Nominations Committee

The Executive Team will support the Chief Executive in the implementation of the Board's decisions and will facilitate the efficient and effective working of the Board of Directors by considering and responding to those matters referred to it.

The Board of Directors' reporting structure is detailed below.


Board of Directors
Audit Committee
Quality Committee
Finance and Performance Committee
Mental Health Legislation Committee
Workforce Committee
Remuneration Committee
Nominations Committee

8 DUTIES OF THE CHAIR

The Chair of the Board of Directors shall be the Chair of the Trust. In the absence of the Chair of the Trust, (or in the event of them declaring a conflict of interest in an agenda item) the Deputy Chair shall chair the meeting. Should the Deputy Chair not be available (or where they too have also declared a conflict of interest in an agenda item), the meeting shall be chaired by one of the other independent non-executive directors.

The chair of the Board shall be responsible for:

- Providing leadership to the Board of Directors
- Enabling directors to make a full contribution to the affairs of the Board of Directors ensuring that the Board acts as a cohesive team
- Ensuring the key appropriate issues are discussed by the Board of Directors in a timely manner
- Ensuring the Board of Directors has adequate support and necessary data on which to base informed decisions and monitor that such decisions are implemented
- Providing a conduit between the Council of Governors and the Board of Directors
- Agreeing the agenda with the Associate Director for Corporate Governance
- Directing the conduct of the meeting ensuring it operates in accordance with the Trust's values
- Giving direction to the minute taker
- Ensuring all attendees 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
- Checking the minutes.

In the event of there being a dispute between any 'groups' in the hierarchy (in the case of the Board, this would be between the Board and its the sub-committee committee/s 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 the outcome this is also reported back to the 'groups' concerned for agreement.

In the event of their being a dispute between the Board of Directors and the Council of Governors, a dispute resolution process is set out in the Trust's Constitution.

9 REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

The Terms of Reference shall be reviewed and ratified at least annually by the Board of Directors.

In addition to this the Board of Directors must also carry out an assessment at least annually of how effectively it is carrying out its duties and act on any improvements agreed.