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 25 January 2024
Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR

A G E N D A

		LEAD
1	**Sharing stories – Emerge Involvement Strategy** (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 30 November 2023** (enclosure)	**MM**
5	**Matters arising** (verbal)	**MM**
6	**Actions outstanding from the public meetings of the Board of Directors** (enclosure)	**MM**
7	**Chief Executive's report** (enclosure)	**SM**
8	**Report from the Chief Operating Officer** (enclosure)	**JFA**
9	**Report from the Chief Financial Officer** (enclosure)	**DH**
10	**Safer Staffing Report** (enclosure)	**NS**
11	**Operational Priorities Q3 Update Report** (enclosure)	**DH**
12	**Board Assurance Q3 Update Report** (enclosure)	**SM**
13	**Quality Strategic Plan** (enclosure)	**CH**
14	**Violence and Aggression Strategy** (enclosure)	**DS**
15	**Report from the Chair of the Workforce Committee for the meeting held on 5 December 2023** (enclosure)	**ZBS**
16	**Report from the Chair of the Quality Committee for the meeting held on 11 January 2024** (enclosure)	**FH**
17	**Report from the Chair of the Finance and Performance Committee held on 23 January 2024** (to follow)	**KW**
18	**Report from the Chair of the Audit Committee for the meeting held on 16 January 2024** (enclosure)	**MW**
19	**Appointment of Senior Independent Director** (enclosure)	**MM**

20	**Use of Trust Seal** (verbal)	**MM**
21	**Any other business**	**MM**

The next meeting of the Board will be held on Thursday 28 March 2024 at 9.30 am
Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR

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 30 November 2023 at 9.30am in Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR

Board Members

		Apologies
Mrs M McRae	Chair of the Trust	
Mrs Z Burns Shore	Non-Executive Director	
Mrs J Forster Adams	Chief Operating Officer	
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 and Professions	
Miss K Wilburn	Non-Executive Director	✓
Mr M Wright	Non-Executive Director (Deputy Chair of the Trust)	

All members of the Board have full voting rights

In attendance

Mrs C Edwards	Associate Director for Corporate Governance / Trust Board Secretary
Miss K McMann	Head of Corporate Governance
Mr K Betts	Corporate Governance Officer
Ms J Masterson	Pathway Inclusion Co-ordinator (for minute 23/126)
Ms A Nila	Inpatient Recovery Worker (for minute 23/126)
Ms C Mailey	Inpatient Recovery Worker (for minute 23/126)
Ms A Beswick	Occupational Therapist (for minute 23/126)
Mrs R Pilling	Carer Coordinator, Patient and Carer Experience Team (for minute 23/126)

Six members of the public attended the meeting including three governors

		Action
	Mrs McRae opened the public meeting at 09.30am and welcomed everyone. She noted this was the first public Board meeting for both Ms Burns-Shore, Non-Executive Director, and Mrs Edwards, Associate Director for Corporate Governance.	
23/126	**Sharing stories – Service User Involvement at the Recovery Centre** (agenda item 1) Mrs McRae welcomed Ms Masterson, Ms Nila, Ms Beswick and Ms Mailey to the meeting, noting they were attending to talk about service user engagement at the Recovery Centre. Ms Masterson provided an overview of the service and partnership working with other agencies including Touchstone. She commenced the presentation	

with artwork from a service user and described the initial set up of the engagement work with the focus of breaking down barriers. She explained that the approach taken was based on partnership working with service users to improve services, to encourage the empowerment of service users to voice their experiences and views, and to support this service user engagement meetings are chaired by service users where possible.

Ms Masterson noted that her colleagues undertake the engagement role on a voluntary basis as an addition to their main role.

She went on to explain that to encourage partnership working, no ID badges are worn at meetings to ensure all attendees feel equal. She added that feedback from the work had been positive from service users, with them feeling empowered and able to voice their views.

Ms Masterson noted that through working in collaboration with the service users four videos had been made regarding the service, along with an audio interview with a service user which was played for the Board.

Ms Masterson commented that to date there had not been many set backs or challenges, but the main issue was the fluctuation of service user involvement due to their recovery journey, however this was overcome with flexibility from the team to support individual needs.

The team noted that the focus for 2024/25 would be staff training to support engagement with service users to be at the fore of all work that is undertaken within the service. The Board heard how the team felt proud of the work that had been done to date, and the impact it had on service users, and wanted this to continue. It was also noted that one of the service users wanted to become a healthcare support worker because of the engagement work that they have been a part of, which the Board agreed was an outcome that should be celebrated.

Mr Henry joined the meeting.

Mrs McRae thanked the team for their presentation and noted the importance of co-production within services.

Mrs Forster Adams acknowledged the work undertaken by the team and the value co-production brought to services, and how it sat at the heart of the organisational approach. She noted that the engagement process in place within the service could be used as a model for learning in other services and the experiences of the team would be of benefit to sharing this.

Dr Healey commended the team on the approach of ‘learning through doing’ and questioned if there was any support required from the Board. Ms Masterson confirmed that management support for the involvement work was in place and supported progress to be made, but acknowledged and thanked the Board for their offer of future support.

Ms Khan thanked the team for their presentation and commented that the focus of their approach was firmly based in equity and giving power back to

service users. She noted her advocacy of the payment process and protected time for the service users to be involved.

Dr Hosker commented on the consideration of the impact the involvement process had on treatment outcomes, as the patient centred approach would be of benefit for co-production of care plans to support the recovery process. The team confirmed that, if they could be, service users were involved in the co-production of their care plans, however if they were unable to then staff ensured the focus remained on a patient centred approach to care.

Miss Sanderson reflected on the inspirational work undertaken by the team and how it was of benefit to the service users and staff within the service.

Mrs McRae thanked the team for attending and providing the presentation.

The Board **thanked** Ms Masterson, Ms Nila, Ms Beswick, Ms Mailey and Mrs Pilling for attending the Board and raising awareness of the service user involvement approach and the important impact this had on the engagement and inclusion of service users.

23/127 **Apologies for absence** (agenda item 2)

Apologies were received from Miss Katy Wilburn, Non-Executive Director.

23/128 **Declaration of interests for directors and any declared conflicts of interest in respect of the agenda items** (agenda item 3)

The Board noted that Mrs Burns-Shore had been added to the declaration of interest register and Mrs Grantham had been removed as she had left her position as Non-Executive Director. No other Board member had a change in declaration and no member declared a conflict of interest in any agenda item.

23/129 **Minutes of the previous meeting held on 28 September 2023** (agenda item 4)

The minutes of the meeting held on 28 September 2023 were **received** and **agreed** as an accurate record.

23/130 **Matters arising** (agenda item 5)

It was noted there were no matters arising that were not either on the agenda or on the action log.

23/131 **Actions outstanding from the public meetings of the Board of Directors** (agenda item 6)

Mrs 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.

Mrs McRae advised the Board that the annual one-to-one meetings with governors had now concluded, and organisational priorities would be a focus of a future Board Strategic Discussion.

It was agreed the action relating to the future operating model of the Andrew Sims Centre could be removed from the log as this would be managed outside of the Board of Directors meeting.

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

23/132 **Report from the Chief Executive** (agenda item 7)

Dr Munro presented her Chief Executive's report drawing particular attention to collective leadership and integrated governance. Dr Munro noted that the collective leadership work focused on ensuring services worked together however the clarity on the governance processes supporting this required further work. She noted that to review this, an information collation process was underway to review the current position for integrated governance, and consideration of any action required would then take place in the New Year.

Dr Munro also drew attention to the Institute for Healthcare Improvement Conference and the opportunity this brought to showcase examples of work regarding co-production and engagement was positive. She also noted the feedback from service users regarding their experiences of engagement and how it made a difference to their care.

With regard to the individual complex case that the Executive Team had been involved in, Dr Munro noted that this would be discussed in more detail in the private Board meeting however it was important to reference due to the significant input provided and also the fact that a full independent review would be undertaken to understand the learning from the case.

Dr Munro also commended the Synergi Collaborative Centres work referenced within her report, and the project regarding health inequalities 'Remembering What's Forgotten' which the Trust funded, noting all the events that would take place.

From an ICB perspective, she updated the Board that the consultation on the operating model had closed, and the proposals would follow in due course.

Ms Khan commented that it was positive that the Trust was leading with a model based on compassion regarding the international conflict rather than an extremist approach taken elsewhere.

Mr Wright noted the ICB governance arrangements and questioned if there would be an impact for the Trust. Dr Munro commented that the financial pressures had highlighted that there was a lack of clarity regarding the governance arrangements therefore a group had been established to support transparency regarding financial decision making. As part of the wider system, she noted that the financial position remained a challenge and would require

continued focus, including the consideration of budgets, targets and capital for 2024/25. She confirmed that there was not a requirement for the Trust to identify many additional Cost Improvement Programmes, however there would be a requirement for some technical adjustments. The Board acknowledged that much of the financial deficit was within the acute sector, however due to the ICB approach to collaboratively tackle this there was a risk that this could be of detriment to the mental health sector. Mrs Hanwell added that this will be discussed further in the private Board meeting.

Mrs McRae acknowledged the Pastoral Care Award and commended the winners of this. She also commented on the importance of the system wide financial approach within Leeds however noted that the consequence of this for the Mental Health Sector must be acknowledged.

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

23/133 **Report from the Chief Operating Officer** (agenda item 8)

Mrs Forster Adams presented her Chief Operating Officer's report, noting that the key points had been discussed at the Finance and Performance Committee. She noted that the key message throughout the report was there had been no significant changes which was important in the context of the operational climate. She commented that operational risks were known and managed, however the Trust was cognisant of the impact on safety and staff.

She noted that there remained a workforce vacancy challenge however there had been improvements made which would be covered within subsequent papers in the meeting.

She informed the Board of the work undertaken for the Winter Plan which was enclosed within the report, and provided assurance that there would be a collaborative focus on capacity and flow throughout winter with other partners within the healthcare sector. She noted that the winter co-ordination work had commenced.

Mrs Forster Adams then acknowledged the pressure within the Trust's acute services including the Out of Area Placement (OAP) position. She drew attention to the increased waiting times for the Neurodiversity Service and informed the Board that a summit regarding this would be held on 4 December 2024 with colleagues across the system to consider action required.

She noted an error within the Finance and Performance Committee Chair's report which noted that the ADHD medication issues were 'internal', when this should read 'international' and outlined that the international shortage of ADHD medication impact would be more fully understood in the coming weeks.

Corporate Governance Team

She highlighted some of the key areas relating to improvement and collaboration including the commencement of the Mill Lodge estates work

which will support the trial of an Eating Disorders Day Service and the Perinatal Service expansion.

With regards to recruitment, Mrs Burns-Shore advised that the Board should be cautious as recruitment would not remedy all workforce issues as there was a requirement for redesign too. She also questioned whether any of the Emergency Planning learning could be applied to a business as usual approach. Mrs Forster Adams commented that during emergency responses the focus was on reducing risk to maintain safety however that had a detrimental impact on both staff and service users which required a careful balance. However, she noted that through emergency planning processes a strengthened evaluation of risk across services was now in place. Dr Hosker added that responding to maintain safety and quality required huge effort that could not be maintained long term. Mr Henry noted that the challenge was to consider how to use modelling and data to rapidly respond in those exceptional situations.

Dr Healey raised the opportunity to consider research funding opportunities to review service changes implemented and demonstrate benefit. Dr Hosker agreed with the suggestion and agreed that he would review the opportunities available. **CH**

Dr Healey then queried the figures relating to OAPs and the delivery of the trajectory. Mrs Forster Adams informed the Board that advice was required regarding information in the public domain for OAPs and the requirement for trajectory planning as currently there were different data sets relating to this. She noted that a future Board Development session would focus on this work. Dr Munro suggested an approach for data could include presenting the worst case and best case scenarios.

Ms Khan provided feedback to the Board regarding a positive visit she had undertaken to the Perinatal service, and the sense of calmness within the service and the benefit to service users. She also acknowledged the progress made with the Forensics Service and Red Kite View.

Mr Wright confirmed that the Finance and Performance Committee focused on the detail noted within the report and provided assurance of oversight processes. He also endorsed the requirement for an in-depth discussion at a future Board session relating to OAPs. He highlighted the statistics relating to the ADHD waiting times and the importance of the Board having sight of this as it was an area of increasing difficulty.

Mrs McRae noted the requirement for the risk associated with industrial action to remain on the radar of the Board and the focus on approaches to workforce issues would be overseen by Workforce Committee with a discussion at a future Board Strategic Discussion. Mr Henry commented on the ADHD Service challenges and the link to workforce and recruitment. Dr Munro commented that there was no national model for ADHD therefore the summit would provide opportunity to discuss the options to tackle the issue.

Mrs McRae thanked Mrs Forster Adams for her comprehensive report.

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

23/134 **Chief Financial Officer's Report** (agenda item 9)

Mrs Hanwell presented her Chief Financial Officer's report noting the financial position of the Trust remained reasonably robust despite a deterioration in the in-year position in October. She assured the Board a prudent approach to financial planning was being taken regarding the forecast for the year end in order to account for worst case scenarios.

Linked to workforce shortages, she noted that the Cost Improvement Programme target needed to be considered in conjunction with vacancy levels and recruitment.

Referencing the Strategic Finance Executive Group (SFEG), she commented that this had been established to create rigour regarding statutory body decision making relating to system wide financial challenges.

Mrs Hanwell commented that whilst capital funds were being used to support revenue funds, it has been confirmed that there would be capital available for the perinatal service expansion.

Ms Khan raised a query relating to the contracting for voluntary sector services and Mrs Hanwell confirmed that there was no intention to amend these contracts in 2024/25. Discussion took place regarding voluntary sector contracts and the impact on services, and Mrs Hanwell and Ms Khan agreed to discuss this further outside the meeting.

Mrs McRae noted that the establishment of SFEG should support all financial discussions to be undertaken in a more collaborative manner.

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

23/135 **Report from the Medical Director** (agenda item 10)

Dr Hosker presented his report and drew the attention of the Board to the potential issue that the proposed pay deal for consultants may well impact on other workforce groups. He added that with regards to recruitment, progress had been made with five consultant appointments since the last Board update and this should therefore lead to multiple reductions in agency spend and consideration to different options for service provision.

With regard to paper medical case notes, Dr Hosker confirmed that progress had been made and the case notes could now be accessed via the electronic patient record system.

Discussion took place regarding the provision of Human Rights training and Ms Khan noted she would cover this within her Chair's report from the Mental Health Legislation Committee.

Mr Wright queried the issue noted within the report regarding delayed invoice payments by the Andrew Sims Centre. Dr Hosker confirmed that this had been a historic issue and an accelerated pay process was now in place to address this. Mrs Hanwell added that the underlying procurement issues were being dealt with which would further mitigate this concern.

Mr Wright asked for clarity regarding the vacancy management process to which Dr Hosker noted the 'Mind the Gap' process would cover the medical workforce. Regarding the ongoing sponsorship issues for the medical workforce, Mrs McRae queried whether they were now resolved, and Dr Hosker confirmed that this remained ongoing for the international recruitment process but was being addressed. Mr Skinner noted that there was no backlog regarding the appointment process for sponsorship recruitment. Dr Hosker and Mr Skinner agreed to discuss this further to provide clarity to the Board on implementation of the process and position. **CH/DS**

The Board **received** the Medical Director's report and **noted** the content.

23/136 **Guardian of Safe Working Q2 Report** (agenda item 11)

Dr Hosker then presented the Guardian of Safe Working Quarterly Report. He noted that the report was a routine quarterly update and there were no significant areas to escalate for the attention of the Board.

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

23/137 **Report from the Director of Nursing and Professions** (agenda item 12)

Miss Sanderson presented her Director of Nursing and Professions report and acknowledged the wider work of the Patient and Carer Engagement Team. She highlighted the work being undertaken by the Chaplaincy Team regarding multi-faith rooms and confirmed that the feedback received during service user engagement had been positive regarding the availability and use of the rooms.

She provided the Board with assurance that the Patient Safety Incident Response Framework (PSIRF) continued to be rolled out, which replaced the National Reporting and Learning System (NRLS) approach.
In terms of workforce, Miss Sanderson noted the preceptee uptake and nursing student numbers, and the benefit this would bring to the organisational workforce.

She drew attention to the work undertaken regarding the Clinical Governance structure, and the framework for reporting and assurance that was included

within the body of the report. She also noted the work being undertaken regarding environmental risk assessments and the focus on self-harm and suicide prevention.

Miss Sanderson acknowledged the Chief Nursing Officer Award for Healthcare Support Workers that she had presented to a Healthcare Support Worker within the Assertive Outreach Team. She also highlighted the Synergi Leeds partnership with the Trust and the recognition provided to this at the HSJ Awards, Mental Health Innovation of the Year and Race Equality Awards.

Dr Healey asked Miss Sanderson whether the Mental Health Optimal Staffing Tool (MHOST) would help identify 'typical' patient groups in order to consider establishment requirements. Miss Sanderson discussed the work undertaken regarding staffing numbers and workforce design to support the clinical needs in different environments.

Mrs Burns-Shore acknowledged the success of the clinical supervision pilot. She then raised concern regarding professional judgement being used to override staffing tools and questioned the assurance in place for this process. Miss Sanderson confirmed that professional judgment was used ongoingly throughout the day due to the changing clinical picture of service user requirements to ensure safe care is provided. Dr Munro added that the development of safe staffing tools was to support safe decision making in conjunction with professional judgement and patient needs.

Regarding the multi-faith rooms, Ms Khan noted that they required updating in order to be suitable for all faiths, and Mrs Burns-Shore added that the terminology of calling them multi-faith rooms may also need to be considered. Miss Sanderson acknowledged that work was underway in relation to this.

Mr Wright commented that it would be beneficial to include patient and carer experience within the Clinical Governance Framework and reference this within the approach taken. Miss Sanderson agreed to take an action to incorporate this within the framework diagram.

NS

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

23/138 **Safer Staffing Report** (agenda item 13)

Miss Sanderson presented the Safer Staffing Report noting it provided a high-level overview of data and analysis and gave the Board information on the position of the staffing on all wards against safer staffing levels for the retrospective periods from the 1 July to 30 September 2023.

Miss Sanderson noted that there would be a move for the report to become more descriptive to highlight the impact on patient care and safety when wards or services were operating below minimum staffing levels.

Mrs McRae thanked Miss Sanderson for her reports.

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

23/139 **Report from the Director of Organisational Development and People** (agenda item 14)

Mr Skinner presented his report and highlighted that the key message for the Board related to the refresh of the Trust People Plan that was underway, noting that this would be socialised with staff in January 2024 with a plan for implementation across the organisation in April 2024.

Mr Skinner confirmed that the position regarding staff survey response rates had improved since the compilation of the report. He confirmed the substantive staff return rate was 52% and bank staff return rate was 26%. He acknowledged the effort made by teams to achieve this response rate.

With regards to the staff vouchers scheme, Mr Skinner updated the Board that this was still awaiting NHS England approval. he explained that this delay would mean the vouchers would not be issued before Christmas, however if approval is received the vouchers would be issued in January 2024.

Mr Skinner noted the ongoing work programmes regarding staff health and wellbeing, and the new Head of Wellbeing who commenced in post earlier in November 2023.

Mr Skinner confirmed that additional NHS England approval was required for non-clinical A&C staff agency spend, and a process had been implemented to meet this requirement. The vacancy management panel was noted to provide a check and challenge approach to staffing options and resource.

He also acknowledged the Pastoral Care Award from NHS England and the recognition this provided for the work of the international recruitment team and the support they provided to this cohort of staff.

Mr Henry raised how the potential non-approval of vouchers may impact on staff. Mr Skinner confirmed that staff had been made aware that if approval was not given this would be an external decision. Dr Munro acknowledged this concern, and highlighted the Coffee Van rounds would still be taking place and could be used as a communication method for updating staff on the vouchers. It was agreed that the dates for the van visits would be circulated to the Non-executive Directors to support their attendance if available. **SM/CE**

Mr Wright acknowledged the exit interview figures and the opportunity this provided to collect feedback from staff. He then commented on the Trustwide newsletter noting that whilst the content was interesting the size of the document was problematic from a mailbox size perspective and questioned whether there was opportunity to review this. Mr Skinner confirmed that Mr Oliver Tipper, Head of Communications, would be able to review this and consider alternative options. **OT**

	The Board **received** the Director of Organisational Development and People's report and **noted** the content.	
23/140	**Operational Priorities Q2 Update Report** (agenda item 15) Mrs Hanwell presented the update report and noted that the content had been discussed in detail at the Finance and Performance Committee. she explained that the report demonstrated the activity underway however work continued to focus on the relational aspect of this and cross cutting themes. Mrs Hanwell noted that there was opportunity to review the priorities and remove any that were no longer required. Mr Henry endorsed the fact that there were a high number of priorities, and the opportunity to remove should go some way to address this. Mrs Burns-Shore questioned the change impact process to consider the value and impact of the priorities. Mrs Hanwell acknowledged that this was important to consider moving forward.	
	The Board **received** and **noted** the content of the Operational Priorities Q2 report.	
23/141	**Health and Safety Annual Report** (agenda item 16) Mrs Hanwell presented the Health and Safety Annual Report and provided assurance to the Board that the detail had been discussed at an extraordinary meeting of the Audit Committee. Mrs Hanwell noted that the report formed the annual assurance process for the Board for Health and Safety. She explained that the report included the approach underway to support health and safety being part of everyone's business, and whilst the work related to violence and aggression and musculoskeletal health (MSK) following the HSE visit in 2019 was underway, it remained an area of challenge. Dr Healey commented on the link between restrictive practice and violence and aggression, and queried whether there was opportunity to demonstrate synergy across the two workstreams using both lenses to streamline any actions. Dr Munro acknowledged the suggestion of viewing the data together, however noted there was a balance required as several elements of violence and aggression were not connected to restrictive practice. It was agreed that the approach to this would be discussed by the Executive Team to provide clarity on the workstreams and data, and opportunities to align activity. Mr Wright acknowledged the range of topics covered within health and safety and the challenge this presented for the team to collate these within the annual report. He noted that the team therefore required the support of the Board and staff across the organisation to progress health and safety activity. Mrs Hanwell added that the Trust was currently without a Head of Health and Safety and the complexity of the topic required integration within all teams. Mrs Burns-Shore commented that there may be opportunity for each of the Executive Director reports to include a dedicated section for Health and	**Executive Team**

Safety. She also questioned whether the data relating to 'other' incidents could have been masking an area that may be a cause for concern. Discussion took place regarding the opportunity for inclusion of health and safety data in director reports, and the benefit this may present from regulatory perspective.

Dr Healey added it may be helpful to undertake a deep dive into this part of the data to understand the content. It was noted that work was in progress, via the Audit Committee, to consider what constituted a health and safety incident, which would impact on the use of the 'other' category. It was agreed that a review of the incidents under the heading 'other' would be completed to understand the detail. **DH**

The Board **received** and **noted** the content of the Health and Safety Annual Report.

23/142 **EPRR Assurance Report** (agenda item 17)

Mrs Forster Adams presented the EPRR assurance report and expressed her thanks to the team for the work undertaken to complete the assessment. She acknowledged that the amended core standards and rigorous assessment process had been challenging to complete. She informed the Board that the outcome of the self-assessment process and evidence submission was a result of non-compliance for the Trust, with 26% compliance overall. She noted that this was a positive result compared to the sector results, however, with non-compliance results featured across the region.

Mrs Forster Adams confirmed that work was underway to address the position, and work commenced on 29 November with the Executive Team and Senior Leaders to discuss the approach to training requirements which would need to be in place by July 2024. She also noted that the EPRR compliance oversight would now sit with the Board.

Mr Wright commented that the compliance position should be considered in conjunction with significant assurance internal audit results for EPRR. He noted that assurance could be taken from the Trust's previous experience in recent years regarding emergency planning and the organisational response.

Mrs Forster Adams informed the Board that there remained a lack of clarity regarding a non-compliance rating from a regulatory perspective, explaining that NHS England were in the process of seeking legal advice on this, and feedback on this would be received in due course.

Mr Henry acknowledged that areas of non-compliance were affected by technical elements of the core standards whilst experience demonstrated and provided assurance on the Trust's ability to respond. Mrs Forster Adams noted the rigour applied was welcomed given the importance of emergency planning and response.

The Board **received** and **noted** the content of the EPRR Assurance Report.

23/143	**Cyber Security Update Report** (agenda item 18) Mrs Hanwell presented the update report and noted the Trust remained in a robust position. She informed the Board that a cyber incident event was recently undertaken and the learning from the session would inform the update of the strategy and response plan. She added that cyber security had been discussed in detail by the Finance and Performance Committee. Dr Hosker asked whether the phishing exercise had been reviewed, and Mr Henry noted that the risk remains high but the current position for the Trust was strong. Mrs Hanwell confirmed that it would be reviewed via the Information Governance Group to consider the outcomes and action required. The Board **received** and **noted** the Cyber Security Update Report.	
23/144	**Board Assurance Framework** (agenda item 19) Dr Munro presented the Board Assurance Framework (BAF) and noted that this had been updated as part of the business cycle. She confirmed that the strategic risk relating to the PFI would be discussed in detail at the Private Board of Directors meeting. Dr Healey requested that the term 'quality including safety' be used in the BAF in order to ensure that they are not treated as separate items. It was noted that this would be amended as part of the update process. The Board **received** and **noted** the content of the Board Assurance Framework.	**Executive Directors**
23/145	**Report from the Chair of the Workforce Committee for the meeting held on 5 October 2023** (agenda item 17) Mrs Burns-Shore presented the Chair's report for the Workforce Committee and acknowledged that it had been completed by Miss Grantham prior to her leaving her role. She highlighted the positive performance related to Personal Development Reviews and the impact on retention. She also noted the importance of a holistic approach to the review of the People Plan. Mr Skinner drew the attention of the Board to the appendix included within the report regarding the NHS Forward Plan mapping which demonstrated the positive position of the Trust. The Board of Directors **received** the Chair's report from the Workforce Committee and **noted** the matters reported on.	

23/146	**Report from the Chair of the Quality Committee for the meetings held on 10 October 2023 and 16 November 2023** (agenda items 21.1 and 21.2) Dr Healey presented her chair's report for the Quality Committee meetings and alerted the Board to the non-achievement of CQUINs relating to outcome monitoring in perinatal mental health services. She confirmed that this was linked to wider discussions regarding outcome measures at the Quality Committee and opportunities to consider data collection methods moving forward. She acknowledged that there was a need to consider how to resolve this issue. In relation to clinical outcomes and learning, Dr Hosker commented that IT solutions had limitations for patient reported data, and the support for the portal was part of the list of operational priorities. He noted that there would be an option for a business unit to support this work, but that this would be a costly option. Mrs Hanwell added that the patient reported outcomes could be a consideration for the Digital Inclusion Team and acknowledged that the NHS log in required was an issue for the use of the portal. Mr Henry added that there may be learning available from Leeds Community Healthcare Trust as they appeared to have resolved the portal issue. Mrs McRae noted that this was a significant yet complicated piece of work that required resolution. Dr Munro agreed that the Executive Team would consider the work programme required to resolve the issue of outcome measures, considering the various requirements of services. Dr Healey then raised concerns related to the quality dashboard and a requirement to clarify understanding on what the dashboard would include and exclude. She also noted it would be important for the Board to understand the current position regarding development plans for both Board level and Committee level data. Mrs McRae acknowledged Dr Healey's comments and added it could form part of a discussion at a Board Strategic Discussion moving forward. It was therefore agreed that a future Board Strategic Discussion regarding operational priorities and objectives would also include data required to support this. Mr Henry added that this would add clarity to the discussion around what the quality dashboard should provide. The Board of Directors **received** the Chair's report from the Quality Committee and **noted** the matters reported on.	**Executive Team** **CE**
23/147	**Report from the Chair of the Finance and Performance Committee for the meetings held on 24 October 2023 and 28 November 2023** (agenda items 22.1 and 22.2) Mr Henry presented the Chair's report from the Finance and Performance Committee meetings and provided assurance to the Board that the information presented to the Committee was scrutinised and discussed in detail. He noted that assurance was provided to the Committee regarding the financial position, EPRR compliance and the ADHD position which had	

already been covered in the reports from the Chief Operating Officer and Chief Financial Officer.

Mr Henry also noted the challenge relating to the perinatal expansion and capacity management processes.

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

23/148 **Finance and Performance Committee Terms of Reference** (agenda item 22.3)

The amended Terms of Reference for the Finance and Performance Committee were presented for ratification to the Board and were ratified.

The Board **considered** and **ratified** the amended Terms of Reference for the Finance and Performance Committee.

23/149 **Report from the Chair of the Audit Committee** (agenda item 23)

Mr Wright presented the report from the Audit Committee and noted the assurance provided to Board. He alerted the Board to the results of three internal audits received by the Committee.

With regards to the Security Management internal audit with a low assurance finding, he confirmed that the Audit Committee had received assurance that a detailed plan had been developed to support the level of urgency required to address the issues identified. He informed the Board that a re-audit would take place in March 2024.

He noted that the two internal audits with findings of limited assurance related to E-Rosering and Sexual Safety both had action plans and follow up audits in place to address the actions required.

Mrs Hanwell commented that the internal audit reports were useful tools to identify areas of work requiring focused action and results demonstrated the correct identification of areas to scrutinise.

Mr Wright confirmed that the internal audit rolling programme would review all key risks. He also noted that the attendee from Audit Yorkshire at the last Audit Committee meeting complimented the Trust on the approach to internal audit and the responses provided for action.

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

23/150	**Report from the Chair of the Mental Health Legislation Committee held on 7 November 2023** (agenda item 24) Ms Khan presented her Chair's report from the Mental Health Legislation Committee meeting that had taken place on 7 November 2023. She noted the 'Right Care, Right Person' agenda and the assurance provided to the Committee that the appropriate meetings were in place to support vulnerable service users. She also confirmed that the Human Rights Training was previously provided by an external company, but this would be moving to internally provided training.
	The Board of Directors **received** the Chair's report from the Mental Health Legislation Committee and **noted** the matters reported on.
23/151	**Mental Health Legislation Committee Terms of Reference** (agenda item 24.1) The amended Terms of Reference for the Mental Health Legislation Committee were presented for ratification to the Board and were ratified.
	The Board **considered** and **approved** the amended Terms of Reference for the Mental Health Legislation Committee.
23/152	**Notification of Future Meeting Dates and Work Schedule** (agenda item 25) Mrs Edwards presented the future meeting dates and work schedule for 2024/25 to the Board. She noted that there were two dates currently being held for the extra meeting to approve the annual report and accounts and explained that this would be confirmed in due course. She also noted that the work schedule may require flexibility to accommodate amended deadline or priorities for the Board to review.
	The Board **noted** the future meeting dates and work schedule for the Board of Directors meetings in 2024/25.
23/153	**Review and Approval of Terms of Reference** (agenda item 26) Mrs Edwards noted that there had been two minor amendments to the Board of Directors Terms of Reference. The title of the Director of Nursing and Professions had been amended to reflect Miss Sanderson's current title, and any reference to NHS Improvement had been amended to NHS England. The Board approved the amendments made and the revised document.

	The Board **considered** and **approved** the amended Terms of Reference for the Board of Directors.
23/154	**Use of the Trust's seal** (agenda item 27)
	It was noted the seal had not been used since the last meeting.
23/155	**Any other business** (agenda item 28) Mr Wright referred to the Safer Staffing report (agenda item 13) and queried the figures contained within the tables relating to average fill rates and staffing levels for registered and non-registered staff, which were 100% and 300% respectively. Miss Sanderson noted that the figure may be related to the individual case that had been ongoing where enhanced observations had been in place as part of an NHS England care package, therefore unusual circumstances had affected the figures. Dr Munro also commented that the figures may link to the use of the e-rostering system as there was a requirement to provide clarity of exceptional packages of care via the system, which would then provide accountability oversight for the Board. Mr Wright confirmed he was satisfied with the explanation provided.
	The Board **noted** the additional item of other business.
23/156	**Resolution to move to a private meeting of the Board of Directors** At the conclusion of business, the Chair closed the public meeting of the Board of Directors at 13:00 and thanked members of the Board and members of the public for attending. The Chair then resolved that members of the public would be excluded from the meeting having regard to the confidential nature of the business transacted, publicity on which would be prejudicial to the public interest.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

6

Cumulative Actions Report for the Public Board of Directors' Meeting

OPEN ACTIONS

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
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) 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	**ONGOING** Work has been undertaken to check the data presented which is correct and the public report has been amended to add the clarification as requested. The wider piece of work around interpretation of the data (positive / negative) has been delayed due to long-term sickness within the EDI team and the priority has been to ensure that business as usual activities have been supported. This work will be instigated once the post-holder returns to work.
Report from the Chair of the Quality Committee for the meetings held on 14 September 2023 (minute 23/116 - agenda item 17 – September 2023) Dr Munro noted that once the impact of the changes within Datix for patient safety incident reporting 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	**CLOSED** Any issue for escalation relating to the impact of changes within Datix for patient safety reporting will be escalated via the Executive Risk Management Group as per the established governance process.

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Report from the Chief Operating Officer (minute 23/133 - agenda item 8 – November 2023) Amendment required on the Finance and Performance Committee Chair's report to correct 'internal to 'international' in relation to the ADHD medication issues	**Corporate Governance Team**	Management action	**COMPLETE** The amendment has been made to correct the document
Report from the Chief Operating Officer (minute 23/133 - agenda item 8 – November 2023) Dr Hosker agreed to review the opportunity for research funding to review service changes.	**Chris Hosker**	Management action	**COMPLETE** R&D Clinical Lead updated there are 2 aspects to the proposed Mill Lodge Day Unit research opportunities: 1. Research to understand why some young people require inpatient treatment for eating disorders which will enable the day service to target identified treatment to needs. This project has commenced (acronym: EDIP) and has been funded by the commissioners. It has been live for 6 months and is on track to be completed within the 18 month time limit. 2. Connected research at concept stage, but once conceptualised will need funding/ support. The aim will be focused on assessing the impact of the day service and analysing feedback from service users.

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 23/135 - agenda item 10 – November 2023) Dr Hosker and Mr Skinner to discuss the sponsorship recruitment process in order to provide clarity to the Board on implementation of the process and position.	**Chris Hosker / Darren Skinner**	January 2024	**ONGOING** Recruitment process clarified however discussions remain ongoing relating to funding allocation available for medical roles requiring sponsorship.
Report from the Director of Nursing and Professions (minute 23/137 - agenda item 12 – November 2023) Miss Sanderson to incorporate patient and carer experience into the Clinical Governance framework diagram.	**Nichola Sanderson**	Management action	**COMPLETE** Patient and carer experience has been incorporated into the Clinical Governance framework diagram
Report from the Director of Organisational Development and People (minute 23/139 - agenda item 14 – November 2023) The dates for the van visits to be circulated to the non-Executive Directors to support their attendance if available.	**Sara Munro / Clare Edwards**	Management action	**COMPLETE** The dates for the coffee van visits have been circulated to the Board for attendance where possible

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 Director of Organisational Development and People (minute 23/139 - agenda item 14 – November 2023) Mr Oliver Tipper, Head of Communications, to review the format of the Trust wide newsletter and consider alternative options due to mailbox size issues	**Darren Skinner / Oliver Tipper**	January 2024	**ONGOING** A review of the Trust's flagship internal communications bulletin 'Trustwide' is in progress, including the consideration of new technologies to improve the content and structure of the bulletin. A phased implementation of changes to Trustwide will commence in February 2024 with the implementation of a new technological solution (which should reduce the email size), followed by a review of our editorial guidelines and the launch of any new product(s), in early April 2024.
Health and Safety Annual Report (minute 23/141 - agenda item 16 – November 2023) The Executive Team will discuss the approach to restrictive practice and violence and aggression workstreams to provide clarity on opportunities to align activity.	**Executive Directors**	Management action	**COMPLETE** Confirmation provided that the two workstreams for restrictive practice and violence and aggression are aligned and opportunities to connect activity are in place.
Health and Safety Annual Report (minute 23/141 - agenda item 16 – November 2023) A review of the incidents under the heading 'other' within the Health and Safety incident data to be completed to understand the detail.	**Dawn Hanwell**	January 2024	**COMPLETE** Following discussion at the Executive Risk Management Committee (ERMG), the incidents noted as 'other' have been reviewed and confirmation provided that recategorization takes place to ensure appropriate category allocation. The risk management team will review the use of 'other' as an incident sub-category in order to consider opportunity to amend the dop down list options. This will be overseen via ERMG.

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
Board Assurance Framework (minute 23/144 - agenda item 19 – November 2023) Dr Healey requested that the term 'quality including safety' be used in the BAF in order to ensure that they are not treated as separate items. It was noted that this would be amended as part of the update process.	**Executive Directors**	Management action	**CLOSED** The planned review of the management process for the Board Assurance Framework over Q4 23/24 will include the link with the STEEP framework approach and quality / safety to ensure appropriate terminology is utilised.
Report from the Chair of the Quality Committee for the meetings held on 10 October 2023 and 16 November 2023 (minute 23/146 - agenda items 21.1 and 21.2 – November 2023) Dr Munro agreed that the Executive Team would consider the work programme required to resolve the issue of outcome measures, considering the various requirements of services.	**Executive Directors**	Management action	**COMPLETE** This will be included in the Trust objective and priority setting for 2024/25
Report from the Chair of the Quality Committee for the meetings held on 10 October 2023 and 16 November 2023 (minute 23/146 - agenda items 21.1 and 21.2 – November 2023) It was agreed that a future Board Strategic Discussion regarding operational priorities and objectives will also include data required to support this.	**Clare Edwards**	Management action	**COMPLETE** This has been incorporated in the work programme for the Board Strategic Discussions in 2024/25

Leeds and York Partnership NHS Foundation Trust

CLOSED ACTIONS

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Report from the Chief Executive (minute 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
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	**AGREED TO BE REMOVED FROM BOARD ACTION LOG** Discussions will continue to take place regarding the funding model but this is no longer a Board action.
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	**COMPLETED** The annual one to one meetings with governors are now complete and Organisational Priorities will be scheduled to be reported to Council of Governors

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
Actions outstanding from the public meetings of the Board of Directors (minute 23/103 - agenda item 6 – September 2023) 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) 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) 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
Ratification of the Workforce Committee Terms of Reference (minute 23/115 - agenda item 16.1 – September 2023) 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.

NHS
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NHS Foundation Trust

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
7

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Executive's Report
DATE OF MEETING:	25 January 2024
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

25 JANUARY 2024

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

Happy New Year and a huge thanks to all those teams who have worked so hard to keep services running through the most challenging period, working as they do unsocial hours, over bank holidays etc during a period in which we have seen severe pressure on our acute services for adults and older adults. In fact, during my time as CEO of the Trust this winter has been the most challenging in terms of capacity and demand on our acute services.

This has been at the same time as two periods of industrial action by doctors and is testament to the planning, leadership of teamwork of colleagues that meant this unprecedented level of action was well managed with minimal disruption. This week I learnt that the regional director Richard Barker has written to give commendation to the Trusts in West Yorkshire for the management of the industrial action to mitigate disruption and risks to patient safety.

We await further updates nationally on the progress of negotiations and whether further industrial action is likely. However, the ongoing pressure on our services both in demand and acuity remains regardless and will be covered further in the update from the chief operating office.

Despite the challenges over the past few weeks our teams, wards and services have also found time to bring festive cheer to patients and colleagues through ward parties and events and the coffee van doing the rounds again to all our main sites for staff to enjoy a hot drink and festive snacks. We know this seemingly small gesture is very much appreciated by staff.

In December I spent some time visiting the forensic services at The Newsam which included the forensic outreach team and the three inpatient wards. I was joined by the new Head of Operations for the service Josef Faulkner. It was a great opportunity to hear about the future plans as well as get honest feedback on how we need to further improve communication on the service action plan to all staff. The new clinical lead for the service should be starting shortly and the improvement work will continue to be overseen by Dr Hosker, Medical Director on behalf of the Executive team.

2. Our Partnerships, National and Local

Update on NHS Planning Guidance for 2024/25

It is typical for NHSE to issue planning and priorities guidance to the NHS for the forthcoming financial year in late December each year. However, on 22 December 2023, NHSE wrote to ICBs and Trusts to advise that discussions with Government were not yet concluded that it would not be possible to publish the 2024/25 priorities and planning guidance until the new calendar year. At the time of writing this report we have still not received the planning guidance but do expect it before the actual board meeting so can give a verbal update when we meet.

However, the board can be assured that we have already begun the planning for our trust priorities for 2024/25. The Deputy CEO/CFO chaired a workshop of the senior leadership team on the 17th January which surfaced each directorates key priorities – based on existing strategic plans, operational pressures, and assumptions about what will be in the planning guidance. Further work will take place to refine these, assess the impact and resource requirements with a combined draft plan considered at the next senior management meeting on the 14th February. Timescales will be tight to meet the proposed submission deadlines indicated for ICB sign off and NHSE submission, so we keep this under close review.

The financial challenges for the next year are significant and as a Trust and a Leeds based system we are aligning our assumptions and commitments to forecasting a financial balance which will be covered further by the Deputy CEO/CFO.

West Yorkshire Integrated Care Board Updates

ICB Joint Forward Plan Requirements
Further guidance for the development of ICB Joint Forward Plans (JFP) was issued by NHSE on 22 December 2023. This reaffirms the requirement of ICBs to develop JFPs which act as a shared delivery plan for the Integrated Care Strategy as well as the requirement to refresh this annually. The expectation is that these refreshed JFPs reflect a continuation of priorities agreed last year, updated to reflected revised assumptions and priorities in the operational planning guidance. There is also a requirement to ensure closer alignment with the 2024 / 25 ICB capital plan.
A more detailed update on the JFP refresh process will be shared at the March 2024 ICB Board meeting.

Integrated Care Partnership Board, 5 December 2023
The West Yorkshire Partnership Board of NHS, local authority and voluntary, community and social enterprise (VCSE) health and care leaders, known as our ICP, met in-person on 5 December 2023 at Halifax Town Hall and the meeting was live-streamed online. The meeting was attended by the Trust Chair.

The meeting in public included a deep dive into the progress to date and further plans for two of the 10 big ambitions, - reducing the gap in healthy life expectancy and preventing suicide - including hearing directly from the Suicide Prevention Coproduction Coordinator and one of the volunteers based at Leeds MIND on the benefits of suicide prevention work.

Prior to the Partnership Board meeting, ICP members also met for an in-person development session on system working and public sector finances, following the Government's Autumn Statement. The discussion focused on planning for in-common challenges faced across the health

and care system, and how partners can continue to best support and work with one another to minimise risks across the system.

NHSE Chair Visit to West Yorkshire
The Chair of NHSE, Richard Meddings, has taken up the invitation to visit our West Yorkshire Health and Care Partnership. The visit will take place in February this year and aims to include an in-person service visit and the opportunity for health and care leaders to discuss the latest issues and opportunities with him.

Senior Leadership Appointments

Director of Adults and Health in Leeds City Council
Caroline Baria has been appointed with immediate effect to the permanent role of Director of Adults and Health for Leeds following an Employment Committee held just before the Christmas break. Caroline has been part of the Adults and Health directorate since 2017 when she joined the council as Deputy Director Integrated Commissioning and has extensive experience in Local Authority adults and health in other local authorities prior to this.

Leeds Community Healthcare NHS Trust CEO
Selina Douglas has been appointed as the new Chief Executive at Leeds Community Healthcare NHS Trust (LCH). Selina has a background in adult social care, and brings extensive experience to the LCH role, having worked for 20 years across a range of high level strategic and operational positions within the NHS, the public sector and a national charity. Selina is expected to start in post in April 2024.

COVID-19 Inquiry

During the COVID-19 pandemic, we lived through the most extraordinary times and our collaboration allowed us to work together to support staff and local communities. Whilst we have seen lower levels of covid infections and outbreaks compared to previous years COVID-19 continues to impact on many people's lives, especially those who lost loved ones, people who remain clinically extremely vulnerable and those affected by long COVID.

The UK COVID-19 Inquiry has carried a very high profile within the media, with senior and former politicians, and executives giving evidence. On 12 December 2023, the Inquiry opened its sixth investigation: the Care Sector across the UK (Module 6) preliminary hearings planned for early 2024 and public hearings planned for spring 2025.

Module 6 will investigate the impact of the pandemic on the publicly and privately funded adult social care sector in England, Scotland, Wales and Northern Ireland. It will consider the consequences of government decision-making – including restrictions imposed – on those living and working within the care sector, as well as decisions concerning capacity in hospitals and residents in adult care and residential homes.

It will also address the steps taken in adult care and residential homes to prevent the spread of COVID-19 and examine the capacity of the adult care sector to respond to the pandemic.

ICB Operating model consultation conclusion and next steps

The formal staff consultation on the proposed changes to the NHS WY ICB Operating Model structures closed on 24 November 2023. During the staff consultation process 664 individual responses were received via the dedicated email address and feedback form. The feedback received was themed to understand and highlight key issues emerging throughout the consultation. Many of the staff responses raised multiple points relating to various themes, leading to 912 distinct comments being identified. The responses have been broken down into themes, including structures, job descriptions and human resources (HR) processes.

Staff feedback, questions and comments received through the consultation methods have been used to support the review of the proposed structures. These have been used to either confirm or adjust the operating model structures, published as part of the consultation process launched on 26 September 2023. The changes to ICB organisational structures across directorates and Places vary. Some have been confirmed and others adjusted because of consultation and consideration of the feedback.

The NHS WY ICB Corporate People Team and managers will continue to support the organisational change process aiming to minimise the impact and disruption. The NHS WY ICB Staff Networks will continue to provide support and advocacy for their members.

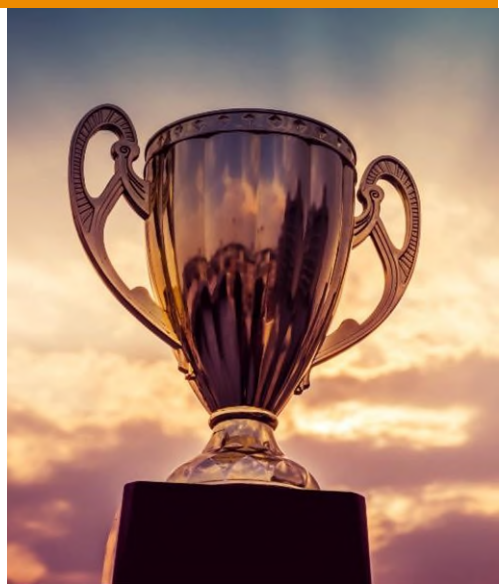
3. Reasons to be Proud

AWARD SHOUT-OUTS

- **LYPFT is a White Ribbon Accredited Organisation !**

White Ribbon Accreditation is a commitment made by workplaces to work towards transformational culture change in their staff culture, systems and communities. You can join hundreds of organisations across England and Wales in making a commitment to make work a safe place for everyone.

- **Rose Laud** - LYPFT Core Trainee Teacher Award for August 2023- January 2024



EMERGE

Donkey Sanctuary Support

A young man from Leeds who spent two years struggling with alcohol and drug dependency says support from The Donkey Sanctuary in Leeds and EMERGE Leeds has given him a reason to live again.

TEAM OF THE MONTH
LEEDS AUTISM DIAGNOSTIC SERVICE (LADS)

Nomination:
“The Leeds Autism Diagnostic Service (LADS) have been working incredibly hard to reduce the waiting times for service users on their waiting list. The team have reduced the assessment time from 18 months to 12 months, which is a massive achievement in just a couple of months! .”

Judges:
"What an incredible example of really putting the service user at the centre of processes and delivering such an impactful difference - Thank you.“

"The Leeds Autism Diagnostic Service has demonstrated a significant service improvement with reducing waiting times under difficult circumstances."

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!

Name: Dr Zumer Jawaid
Role: Consultant Psychiatrist -Older People's including Young-Onset Dementia

- Principal Investigator on the QMIN -MC study, recruiting service users undergoing a brain MRI as part of their diagnosis in memory services. Dr Jawaid has facilitated service-wide involvement, encouraging research engagement across the YPWD team.
- We would also like to thank the MAS Clinicians, Trainees and Nurses for identifying and referring eligible service users to R&D.

R&D

Research & Development

Dr Zumer Jawaid
Consultant Psychiatrist -Older People's including Young -Onset Dementia

"We thank the LYPFT R&D team for enabling us to embed a research culture in our YPWD team."

Dr Sara Munro
Chief Executive Officer
18 January 2024

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:	25 January 2024
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 faced across our Care Services.

This month the report includes:

- **Emergency preparedness, resilience and response (EPRR) planning and management.** We have seen continued Industrial Action through December and January, which continues to be well managed and mitigated by those involved, with minimal disruption to our service users despite the other challenges faced by services at this time of year.
- **Service delivery and key performance escalations.** In summary, the most significant risks and challenges faced and experienced by our service managers continue to be sustained demand within our acute in-patient service, workforce supply, and sustained demand in our core and more specialist services.

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 Trust Board is asked to consider the content of this report and highlight any concerns, further intelligence or additional assurance required.

MEETING OF THE BOARD OF DIRECTORS

25 January 2024

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.
This month the report includes:

- **Emergency preparedness, resilience and response (EPRR) planning and management.** We have seen continued Industrial Action through December and January, which continues to be well managed and mitigated by those involved, with minimal disruption to our service users despite the other challenges faced by services at this time of year.

- **Service delivery and key performance escalations.** In summary, the most significant risks and challenges faced and experienced by our service managers, continue to be sustained demand within our acute in-patient service, workforce supply, and sustained demand in our core and more specialist services. (Appendix A is the Board level dataset for performance and service delivery).

- **Service development**. In summary: in regard to the Community Mental Health Transformation Programme the governance arrangements for the proposed early adopter sites have been agreed which will allow them to move forward; an update on the system that is used by the NHS 111 to link callers who dial 111 and select the option mental health crisis, into existing local mental health crisis/support lines; the work with Forum Central to support third sector providers, where needed, to be able to meet NHS Contract standards and have in place Business Continuity Plans; and details of the Neurodiversity Summit.

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:

- The ongoing need for additional Out of Area inpatient capacity, as a result of the ongoing demand within our acute in-patient service (resulting in quality, operational and financial risks).

- Continuing 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 international shortage of key medicines for people with ADHD.

- The development of the Care Services planning priorities for the year 2024/25.

2. EPRR PLANNING AND MANAGEMENT: Advisory

The section below summarises the activity of the EPRR team since the date of the last report.

2.1. Industrial Action

Since the drafting the last update in November 2023, Junior Doctors' industrial action took place on:

- 20 December 2023 (07:00) to 23 December 2023 (07:00) – 72 Hours
- 3 January 2024 (07:00) to 9 January 2024 (07:00) – 144 Hours.

The latter period amounts to the longest strike action in NHS history and was the first period of action spanning a weekend. Both periods of industrial action occurred at times when staff numbers were reduced due to annual leave and pressures on capacity and flow was at, very likely, their highest levels.

The Incident planning and response arrangements again worked effectively, and the following mitigating solutions were once again adopted:

- The Medical Education department sought staff to cover the medical on duty (PROC rota) and EOC rotas that are covered by junior doctors.

- Tactical group developing and checking plans for both in hours and out of hours pathways.

- Services ensuring in-hours pathways were adequately covered from a managerial and medical perspective.

The response to industrial action has now become an effective process with staff clear about roles, using time trusted techniques (including evaluation and learning) and performing well, despite the difficulties caused by the disruption. After approaching 12 months of disruption, techniques of managing industrial action have become well developed across our services.

The impact on services were most pronounced in the cancellation of memory assessments in older people's community teams, which is an activity carried out largely by junior doctors. Liaison was the next service to be affected. The extent of

disclosed cancelled activity was relatively small as most outpatient and community activity was rebooked and not formally cancelled.

Due to the way on-the-day numbers of junior doctors were being collated (i.e. asking for confirmation of attendance) during a number of live incident coordination meetings, the Trust reported higher than average numbers of doctors taking industrial action. This inaccuracy was suspected at the time, but within the constraints of junior doctors being instructed by the BMA that they do not have to confirm attendance on the day of industrial action, the numbers were the best the Trust had to disclose. Following January's industrial action, the Medical Education Team validated the data process which revealed that numbers originally identified were overstated and actual numbers were consistent with other mental health providers. We are confident that payroll adjustments for staff who did take action have been appropriately and accurately calculated.

2.2. NHS EPRR core standards assurance 2023

Work on the recommendations from the core standards 2023 assurance continues. This is being done in collaboration with the West Yorkshire ICB and amongst mental health trusts across Yorkshire and Humber. Current areas of work are:

- Mutual aid – a mutual aid agreement for support if a signatory Trust is without an EPRR lead or if a Trust is involved in a long duration incident and needs additional EPRR support, is being finalised for independent ratification by all parties.

- Collaborative planning – North East & Yorkshire Low and Medium Secure Adult Mental Health Services Evacuation Framework – this is a joint plan covering how Trusts with low and medium secure services would request mutual aid if they faced a disruption needing them to evacuate an inpatient site. It is being approved by participating parties at the moment.

2.3. Other EPRR activity

The EPRR team is re-working parts of the Trust Business Continuity Management System following recommendations from NHS England, to drive up the numbers of teams with up-to-date plans across services. The recent expansion of the EPRR team with the appointment of a Deputy Head of EPRR has allowed more time to be devoted to this important area of resilience.

3. SERVICE DELIVERY AND KEY PERFORMANCE ESCALATIONS

We continue to experience significant challenges as highlighted over previous months, including a sustained demand for admissions into our Acute Inpatient Service, and longer than average lengths of stay with continued levels of delayed transfers of care, resulting in insufficient admission capacity. This continues to be a key recovery priority for the organisation (from a quality, safety, and efficiency perspective), which is being managed through the Inpatient Flow Oversight Group.

Through December and January, we experienced sustained demand (with no change, accompanied by very low levels of leave for inpatients over the period which is in contrast to previous years). This resulted in periods where admission capacity was zero. Due to the significant risks for people requiring crisis admission, we mobilised an urgent response from senior colleagues from the Local Authority and the Leeds ICB to facilitate discharge of patients into alternative accommodation than would ordinarily be available. This has had some success, and this urgency is being sustained and embedded in our normal ways of working.

Significant planning was undertaken in the months leading up to the winter period and we continue to work through our "Enhanced Winter Coordination" arrangements. We manage and oversee delivery responding to disruption (including industrial action), surges in activity, changes in workforce availability, outbreaks and winter conditions affecting operations. To date, our planning and management has resulted in a robust and comprehensive response that has meant minimal disruption to our service users even when pressures have been experienced in other parts of the system. We have seen our staff in Liaison and Crisis Services respond to the demands positively, particularly to those service users presenting to A&E services, in order to avoid any unnecessary delays when these services face the challenges of this time of year.

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 Line – Inpatient Capacity

We continue to see a sustained pressure for inpatient acute admissions, with the number of out of area admissions remaining in the mid to high 30s. As of the 12 January the number was at 36 in total, as detailed in table 1 below. The demand has remained constant through the period since the last report. More recently, as a result of this, we engaged senior colleagues within the Local Authority, ICB and Housing Providers to support access to suitable discharge options including housing availability and address some of the factors that result in delays for this cohort.

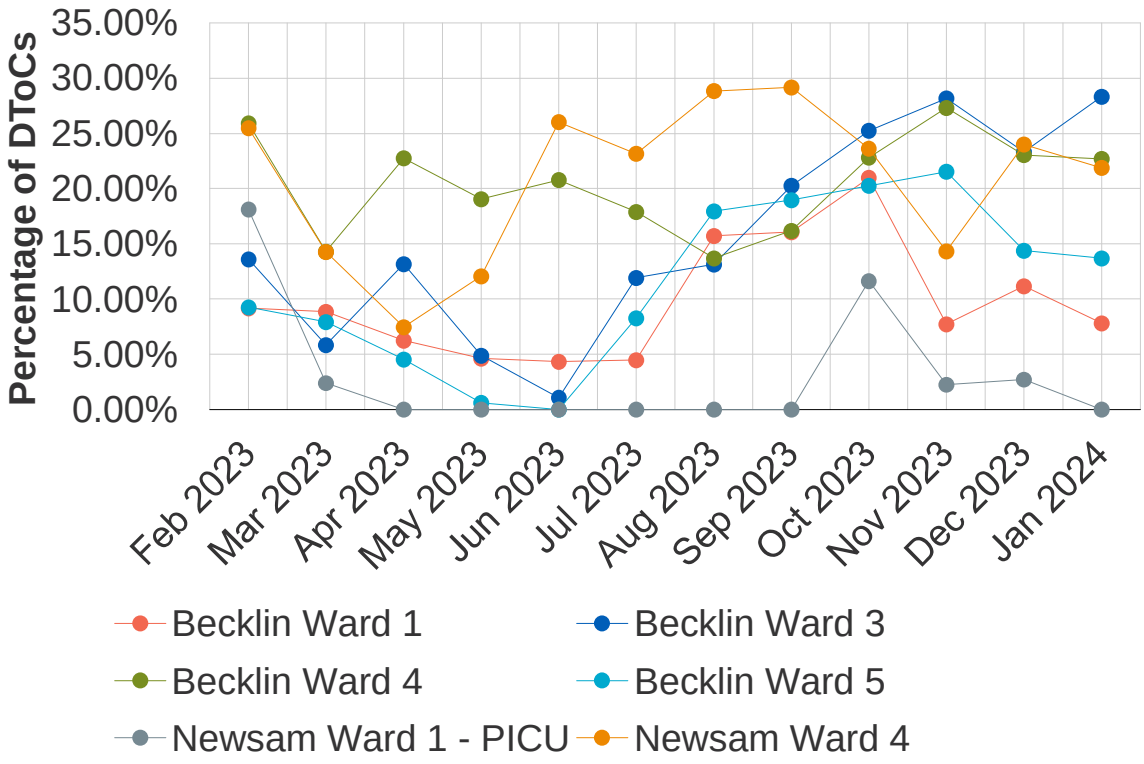
Table 1

Position at	Current OOA placements
Male Acute	17
Male PICU	5
Female Acute	14
Female PICU	0
TOTAL	36

We continue to see consistent levels of delayed transfers of care which is impacting on our ability to respond to the increased demand, see graph 1. The number has risen to 24, two of whom are in out of area placements. We have seen a change in

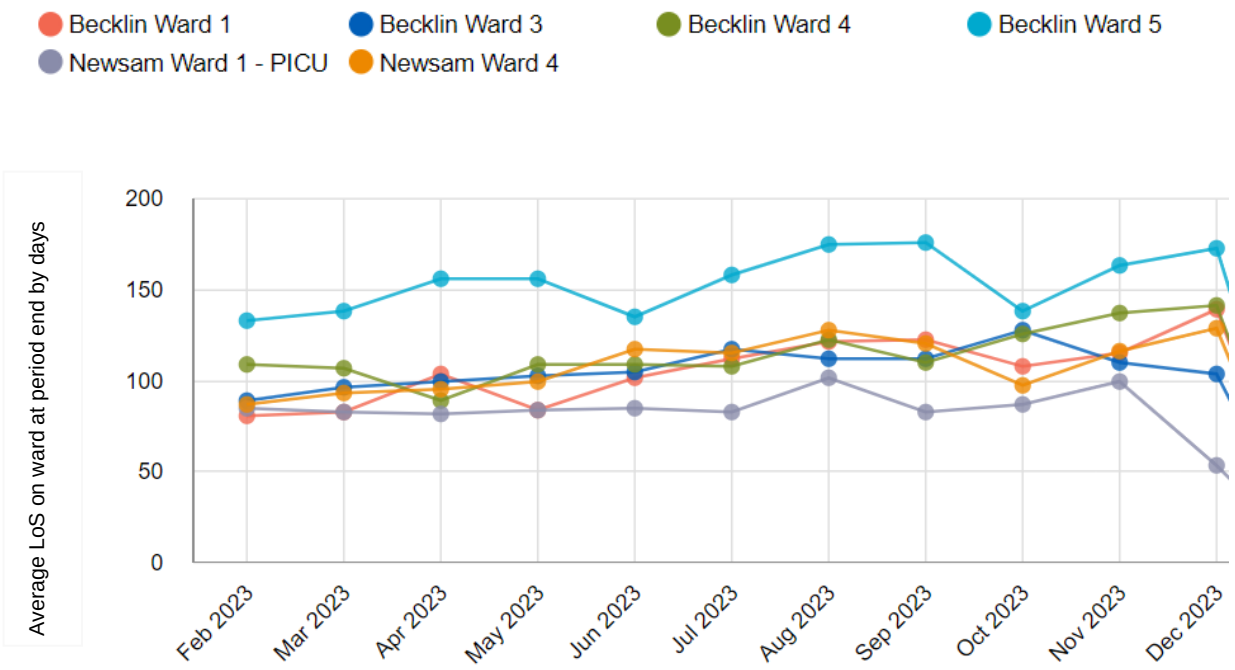
the split between male and female, with an increase in male delay to 18 and reduction in females to 6. The number requiring suitable housing has reduced following the recent response from system partners, however this remains at 13. The remainder is split between those needing other NHS placements (9) and those needing suitable onward care packages (2).

Graph 1



We are also experiencing an increased length of stay. This is particularly evident on one of our female acute wards however most wards have seen an increase over the period since the last report, see graph 2 below. This has been contributed to by the delays as discussed previously and the higher level of need required by some service users.

Graph 2



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

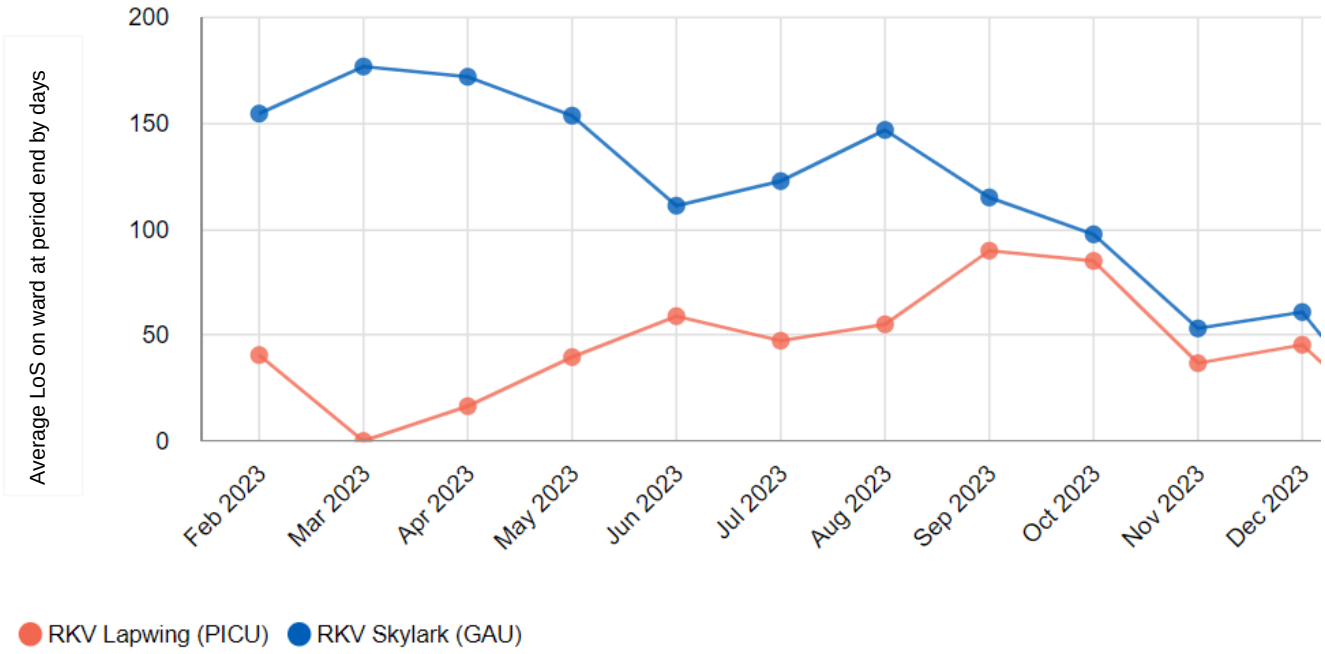
3.1.2 Children and Young Peoples Services: Red Kite View Staffing

Red Kite View continues to face significant registered nursing vacancies. The current position has remained stable at 53% vacancies on Lapwing (PICU), and 56% on Skylark (the General Adolescent Unit) since September/October 2023, following the recruitment of newly qualified registered nurses. We have, however, been unable to realise the recruitment trajectory since October due to ongoing recruitment challenges.

We continue to use a higher percentage of temporary staff to ensure we maintain safe staffing levels. Whilst it is a challenge and creates additional work for established staff, and less stability when using a higher percentage of temporary staff, we are careful to put additional measures in place to ensure this does not detrimentally impact on the care of the young people in the unit.

The length of stay of service users on both wards continues to improve, indicating that the staffing position is not impacting on the care of the young people, see graph 3. Occupancy on GAU is currently limited more by the higher level of need of the young people, such as the ability to care for a limited number of young people who require specialist feeds, where we continue to experience growing demand.

Graph 3



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

The Mental Health Assessment space at St James University Hospital (SJUH) is now complete, we are waiting for a final decision on accommodation for the Acute Liaison team (ALPS) within the Emergency Department (ED). The leadership team continues to work with colleagues to ensure that the whole team can be accommodated in the ED.

An agreement has been reached for the design, works required and furniture for the ALPS Assessment Room. However, the LTHT project lead has been unable to provide a start date for works as yet.

3.1.4 Neuro-developmental Service: ADHD

As Board members will be aware, there has been an international shortage of the medication Lisdexamfetamine which is widely used within the service and within Primary Care. As a result, the service continues to operate under business continuity measures with reduced core activity, which has a further negative impact on the response times for those on the waiting list.

The impact of business continuity so far has been:

- Approximately 35 new assessments have been removed between 3 November 2023 and 14 January 2024. The service has completed urgent assessments where necessary.
- 120 medication initiation appointments have been diverted to carry out urgent medication reviews as a result of the shortage. The service estimates 24

service users have not been able to commence medication due to the diversion of resource.

- Medication interventions that had already started at the time of going into business continuity have been completed.

The service continues to provide support to Primary Care colleagues as per the ICB ask as the overall shortage is expected to continue until April.

3.2 ADVISE

3.2.1 Community and Wellbeing Service

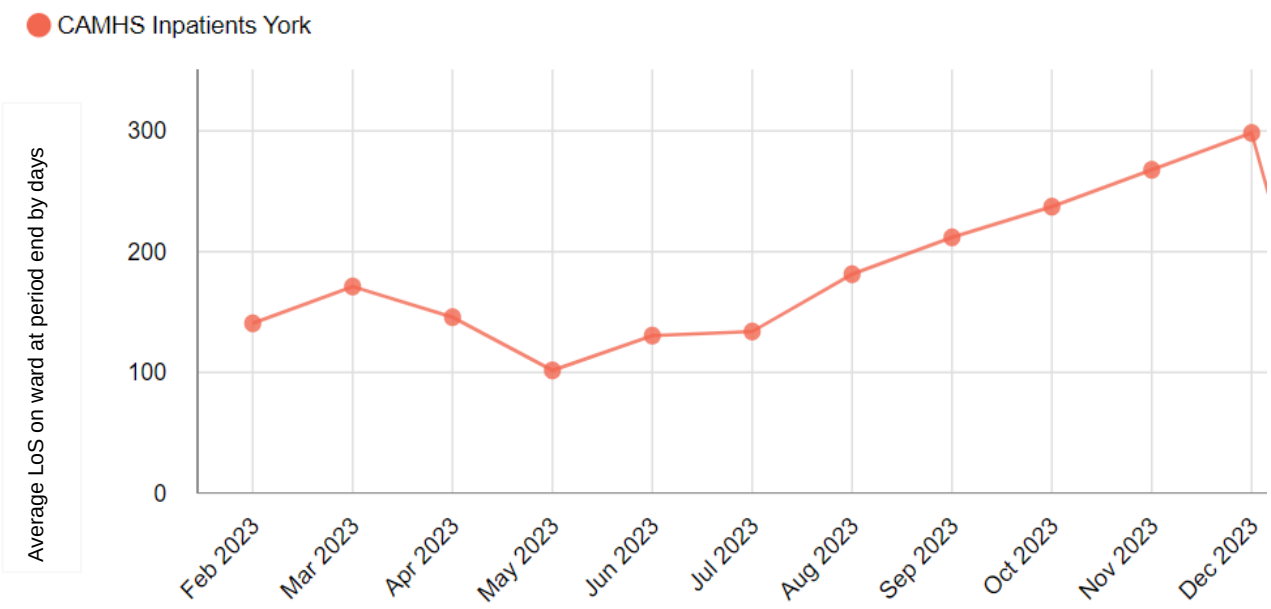
We continue to see our Community Services stabilise further with referrals and caseload remaining stable. The workforce has also remained stable, remaining at a constant level.

The service continues to work towards the go-live for Community Mental Health Transformation, with caseload transfers starting in February in preparation, due to staff moving bases. The service is also working through the restructure of Care Director to reflect these changes. The implementation of joint triaging with Primary Care Mental Health has resulted in an increased number of cases being redirected to Prminary Care Mental Health (as many as 55%) from CMHT. These initial impacts are in line with the ambitions of the programme, with people being referred into and receiving input from the right service at the right time without having to experience multiple assessments.

3.2.2 Children and Young Peoples Services

We have seen an increase in the length of stay at Mill Lodge since July 2023, see graph 4. This is as a result of a number of young people requiring complex packages of care to facilitate discharge. The leadership team at Mill Lodge are monitoring the position closely and are liaising with the Provider Collaborative to develop plans to improve the position.

Graph 4

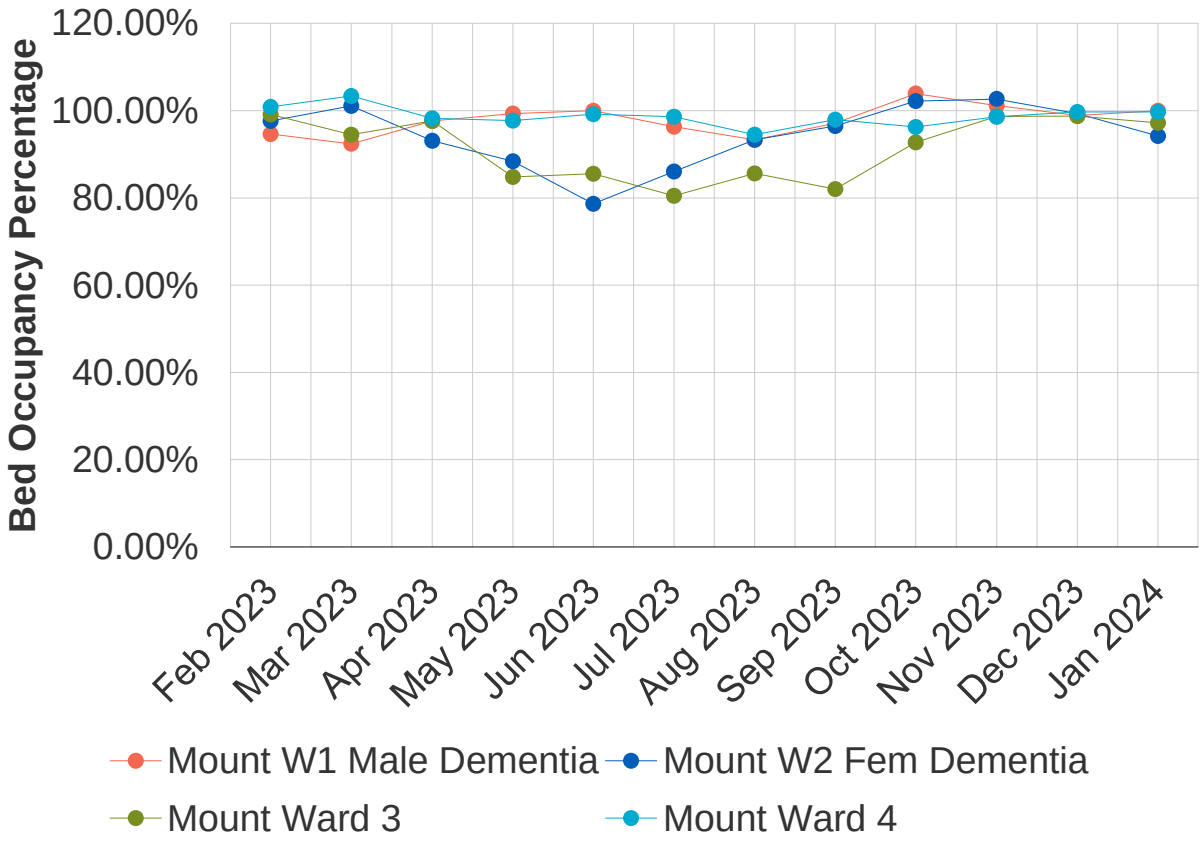


3.2.3 Older Peoples Service: Inpatient Capacity

We continue to experience a sustained demand for beds for people with dementia and functional disorders, with unusually complex and high levels of care and all wards are running at or near to 100%, see graph 5.

The service continues to use the capacity of all wards flexibly, with functional wards admitting service users with dementia. This is clinically overseen to ensure the patient mix and clinical care is appropriate. Whilst the demand has remained high for beds in our Older peoples Services, we have not placed any service users in out of area placements. This is testament to the flexible way the service responds to the needs of the service user group and utilising alternatives to hospital, such as our intensive home treatment teams, to support people at home wherever possible.

Graph 5



As previously reported, we have continued to work with system colleagues resulting in a decrease in the number of delayed discharges for people, with 9 people delayed who require onward care placements. I

3.2.4 Rehabilitation Services: Capacity and Flow

Delayed transfers of care within the rehabilitation services have continued to reduce, with only 2 people currently delayed in our open rehab services. One is related to housing and the other is as a result of the lack of a suitable onward care placement.

The team is working to identify suitable onward pathways and to identify any potential delays early to ensure that appropriate patient flow from our acute inpatient services is optimised. This continues to be monitored through the IFOG meeting.

3.2.5 Gender Service

Gender Service demand continues to exceed the capacity of the service. Ongoing difficulties nationally and locally remain with shared care agreements, some GPs/LMCs are unwilling to initiate hormone treatment upon request and/or continue with prescribing once stabilised by the Gender Service. This has been escalated to NHS England.

A referral processing backlog, previously reported, has been fully recovered by the administration team. Our newly implemented children and young people transfer

policy has led to an increased referral rate (226 in Q2), which is expected to reduce in Q4 (this is in line with the anticipated impact from the changes implemented). There has been a significant increase in average reported waiting time during Q3 which may be related to variations in referral rates, further investigation is required to better understand this.

Following work to inform an NHS England Deep Dive session in September 2023, together with continuous discussions and networking by staff within the service with the purpose of developing our offer further, we have been invited to submit a business case to increase our staffing. The leadership team is working with colleagues to negotiate this further with NHS England and further updates will be provided in March 2024.

3.2.6 Care Services Operational Planning

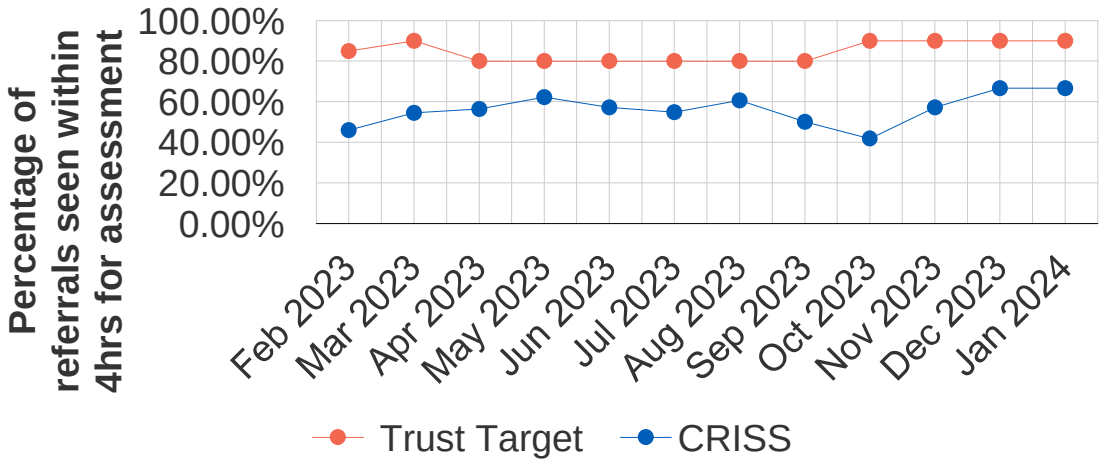
As we near the end on the financial year we are beginning to plan our priorities for next year. We are in the process of updating our position on our priorities for this past year in order to provide updates at the planning session that is scheduled in late January 2024. This will enable us to agree and refresh each of the service line objectives for the coming year. These will then enable us to agree the strategic priorities for the organisation.

3.3 ASSURE

3.3.1 Adult Acute Services: CRISS Assessment with 4 hours

We have seen an improvement in the *assessment within 4 hours* target since October 2023, see graph 6. The service had experienced some data quality issues as new staff joined the team through September and October. The team developed a bespoke training package for new staff and now seen an improvement in data quality. There is a recognition that there is still some work to do in this area to achieve the target of 90% but they are confident this can be achieved.

Graph 6



3.3.2 Forensic Service: Senior Leadership recruitment

Since the last report, Josef Faulkner has now moved into the role of Head of Operations and has had a significant impact of leading the service through the development of the action plan following the Attain Review.

We continue to experience gaps in leadership at Matron and Clinical Lead level, however we have been able to appoint to either post since late November. Hannah Wilkinson will be moving into the Matron role over the next month or two. Hannah currently works as the Matron for the Male Pathway within our Acute Service. Patti Boden will be joining as Clinical Lead within the next couple of months. Patti currently works for NAVIGO as Service manager within Community Services, and also has extensive Forensic experience from previous roles.

3.3.3 Complex Rehabilitation: Out of Area Placements

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 in the process of developing plans for 6 service users to support their transition to placements outside of hospital. However, we continue to achieve financial trajectory and expect to achieve this by year end. All service users in out of area placements have or will be reviewed by CREST to ensure their placements are meeting their needs and to identify potential pathways that can be accelerated to facilitate discharge.

3.3.4 Regional and Specialist Services: NSCAP

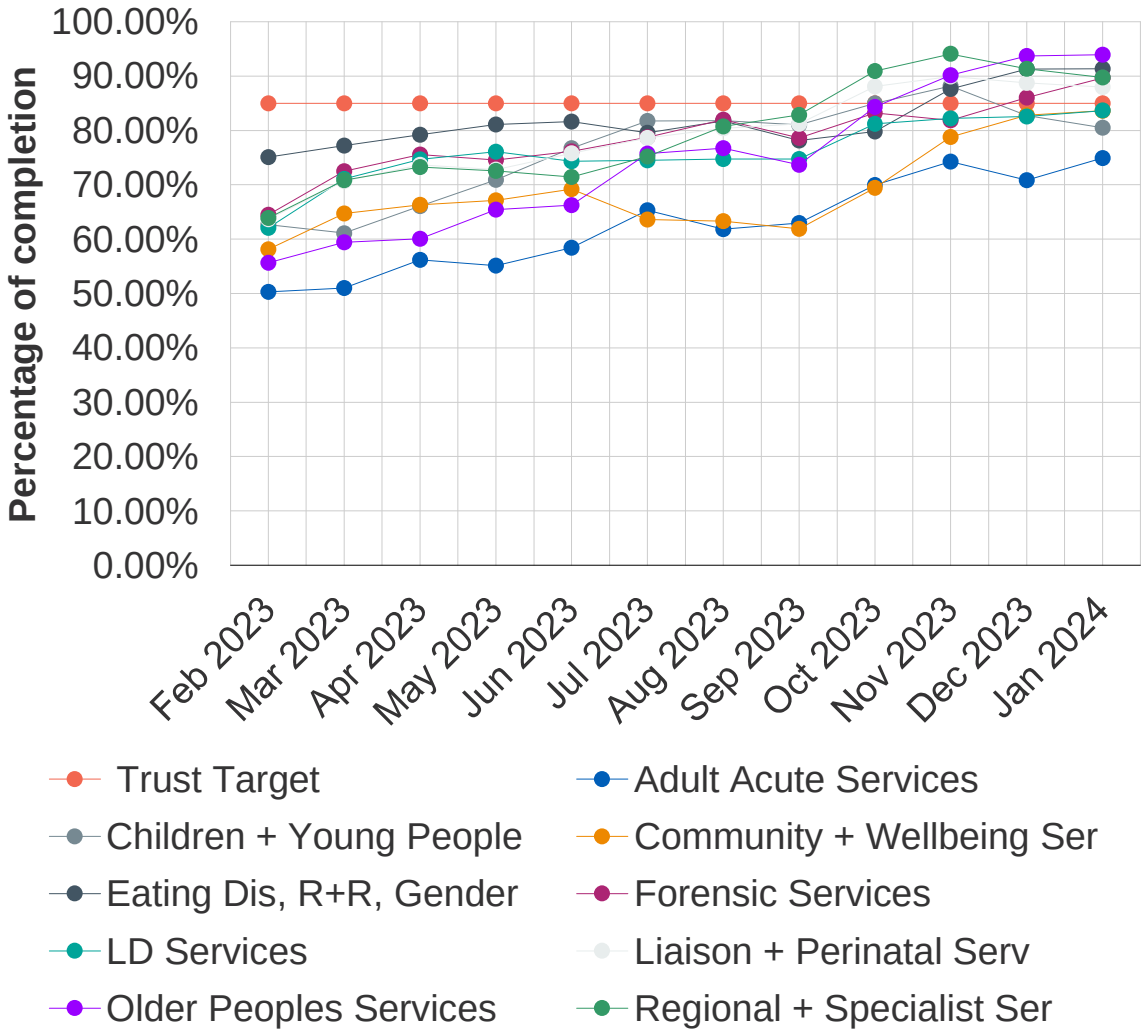
We are currently undertaking work to determine the future of operating model for NSCAP following the outcome of the tender process. We are revisiting the original proposal for the NSCAP service with NHS England following further due diligence concerning the future viability of the contract. Further meetings are scheduled in January with NHS England to consider our position and next steps.

3.3.5 Care Service Appraisals

Despite the significant challenges some services have faced throughout recent times, we continue to see a sustained position in the completion of appraisals, see graph 7.

Whilst some areas continue to struggle to achieve our target, the improvement demonstrates the support of care services staff to and managers to ensure that its professional and personal development is central to our work together.

Graph 7



4. SERVICE DEVELOPMENT

4.1 Community Mental Health Transformation Programme

Further to discussions with system partners, agreement of the governance arrangements for the proposed early adopter sites have been agreed, which will allow them to move forward. These sites are in the final stages of planning and preparation for the go-live date at the end of March 2024.To avoid further delay, LYPFT has agreed to assume the role of data controller and a Memorandum of Understanding is being developed for partners to agree to the revised ways of working.

As the program begins the transition from a program to business as usual, an assessment against the national roadmap has been updated. The Operational Delivery Board and the Programme Board will be reviewing the gaps to develop the priorities for development.

4.2 Use of 111 in Mental Health Services

The NHS Long Term Plan ambition is that anyone experiencing mental health crisis can access 24/7, age-appropriate mental health community support via NHS 111. This change requires the technical amendments to the National Interactive Voice Response system that is used by the NHS 111, to link callers who dial 111 and select the option mental health crisis into existing local mental health crisis/support lines' telephony platforms.

To access crisis mental health support via 111 the caller will have to make a number of selections to ensure they are connected to the right local mental health helpline on the IVR system - dependent on age, location and time of day (due to the proposed model of connecting multiple crisis line providers to the IVR and also complexities with the geography and not being able to rely on geolocation in West Yorkshire). The call will then be connected to the relevant helpline/crisis team telephony platform where it will be managed in the same way as currently exists if an individual had called the mental health helpline directly.

We are currently working with our West Yorkshire Partners and ICB colleagues to progress this work and a Full Quality Impact Assessment (QIA) and Equality Impact Assessment (EIA) has been completed with appropriate mitigations being put in place to address any concerns. We are engaged with the 111 Task and Finish Group are working to develop a memorandum of understanding between the Yorkshire Ambulance Service, our Mental Health Support Line and our Crisis Service. The mobilisation date for this change is the 1 April 2024.

4.3 Third Sector and Business Continuity

LYPFT commission a number of third sector providers to support the delivery of clinical services (a detailed paper about these contracts and the process to secure and manage them will be presented in February 2024). These contracts are standard NHS contracts. Holders of NHS contracts are required to meet certain standards, one of which is the requirement to ensure that the provider has appropriate business continuity plans. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded services, to show they can deal with such incidents while maintaining services. This is undertaken through the Emergency Preparedness Resilience and Response program.

LYPFT has agreed to work with Forum Central to support third sector providers where needed to be able to meet these standards on a proportionate basis. Further updates will be provided as these progresses.

4.4 Neurodiversity Summit

As outlined in the update from the Deputy Director of Operations on Service Delivery and Performance, the waiting times to access the LADS and ADHD service remain beyond the time limit expected for these services.

This is a common picture across West Yorkshire (WY) Integrated Care Board and nationally. LYPFT continues to work in partnership with the WY Neurodiversity Programme to achieve the programme objectives.

- To improve consistency in Autism and ADHD services, reduce wait time and barriers to access.
- To improve the availability of person centred, needs led, holistic support.
- To implement the 'Right to Choose' agenda consistently across West Yorkshire.
- To continue to embed co-production in the neurodiversity review, working with people with lived experience and professionals to create shared perspectives and learning to shape services.

The escalation of the severity of the situation was presented to the WY Integrated Care Board Executive last Autumn which commissioned a summit to develop innovative ways to address the issues.

In December 2023 150 people from health and social care, education, individuals with lived experience, third sector, NHS England and local councillors attended the event, where an appreciative enquiry approach was taken to develop a series of recommendations. These have now been distilled down specific actions, responsible owners and timescales for implementation will be developed at a second workshop to be held at the end of February 2024.

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

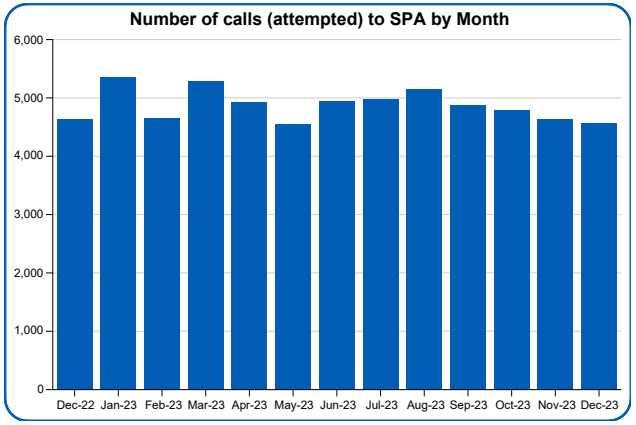
Service Performance - Chief Operating Officer

Services: Access & Responsiveness: Our response in a crisis	Target	Oct 2023	Nov 2023	Dec 2023
Percentage of crisis calls (via the single point of access) answered within 1 minute	-	31.9%	32.9%	32.7%
Percentage of ALPS referrals responded to within 1 hour	-	78.8%	76.7%	84.9%
Percentage of S136 referrals assessed within 3 hours of arrival	-	20.5%	15.4%	11.6%
Number of S136 referrals assessed	-	44	39	43
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%	41.8%	57.1%	66.7%
Percentage of service users who stayed on CRISS caseload for less than 6 weeks	70.0%	93.4%	87.3%	93.4%
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support	50.0%	48.4%	41.8%	42.9%
Percentage of CRISS caseload where source of referral was acute inpatients	-	13.4%	7.8%	12.3%
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services	**Target**	**Oct 2023**	**Nov 2023**	**Dec 2023**
Gender Identity Service: Number on waiting list	-	5,018	5,290	5,358
Deaf CAMHS: average wait from referral to first face to face (inc. telemedicine) contact in days	-	115.26	133.25	154.82
Community LD: Percentage of referrals seen within 4 weeks of receipt of referral	90.0%	75.0%	69.4%	95.7%
Leeds Autism Diagnostic Service (LADS): Percentage starting assessment within 13 weeks (quarterly)	-	-	-	13.6%
CAMHS inpatients: Proportion of people assessed within 7 days of admission (HoNOSCA / GBO) (quarterly)	100.0%	-	-	52.9%
Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency) (quarterly)	-	-	-	85.7%
Perinatal Community: Percentage of routine referrals waiting less than 2 weeks for assessment (quarterly)	-	-	-	96.6%
Perinatal Community: Total number of distinct women seen in rolling 12 months (quarterly)	830	-	-	894
Perinatal Community: Face to Face DNA Rate (quarterly)	-	-	-	11.1%
Services: Our acute patient journey	**Target**	**Oct 2023**	**Nov 2023**	**Dec 2023**
Number of admissions to adult facilities of patients who are under 16 years old	-	0	0	0
Crisis Assessment Unit (CAU) bed occupancy	-	91.4%	93.3%	98.9%
Crisis Assessment Unit (CAU) length of stay at discharge	-	20.38	21	42.33
Liaison In-Reach: attempted assessment within 24 hours	90.0%	73.5%	84.1%	83.2%
Bed Occupancy rates for (adult acute excluding PICU) inpatient services:	94.0% - 98.0%	100.2%	99.7%	99.5%
Becklin Ward 1 (Female)	-	102.1%	100.0%	99.9%
Becklin Ward 3 (Male)	-	99.9%	99.5%	99.3%
Becklin Ward 4 (Male)	-	100.3%	99.8%	99.9%
Becklin Ward 5 (Female)	-	99.1%	99.2%	98.8%
Newsam Ward 4 (Male)	-	99.5%	99.7%	99.8%
Older adult (total)	-	98.0%	100.0%	99.2%
The Mount Ward 1 (Male Dementia)	-	103.9%	101.2%	98.8%
The Mount Ward 2 (Female Dementia)	-	102.2%	102.7%	99.4%

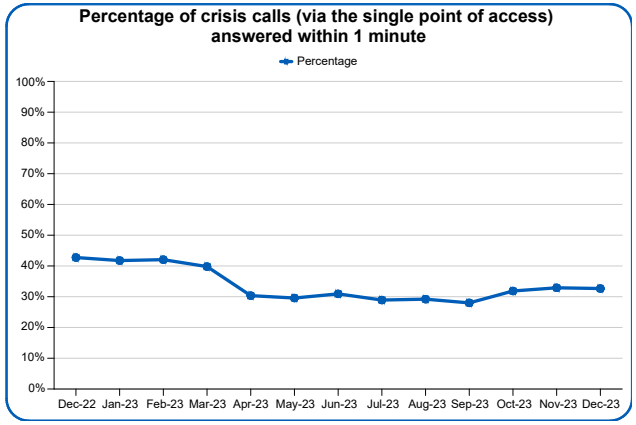
Service Performance - Chief Operating Officer

Services: Our acute patient journey	Target	Oct 2023	Nov 2023	Dec 2023
The Mount Ward 3 (Male)	-	92.7%	98.7%	98.7%
The Mount Ward 4 (Female)	-	96.2%	98.6%	99.7%
Percentage of delayed transfers of care	-	13.9%	12.6%	11.4%
Total: Number of out of area placements beginning in month	-	25	15	20
Total: Total number of bed days out of area (new and existing placements from previous months)	155	1,057	841	860
Acute: Number of out of area placements beginning in month	-	20	10	18
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	903	661	723
PICU: Number of out of area placements beginning in month	-	5	5	2
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	154	180	137
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%	-	-	77.8%
Services: Our Community Care	**Target**	**Oct 2023**	**Nov 2023**	**Dec 2023**
Percentage of inpatients followed up within 3 days of discharge (Trust Level monthly local tracking)	80.0%	84.3%	72.1%	81.7%
Percentage of inpatients followed up within 3 days of discharge (HCP commissioned services only)	80.0%	83.6%	77.4%	85.2%
Number of service users in community mental health team care (caseload)	-	3,389	3,323	3,305
Percentage of referrals seen within 15 days by a community mental health team	80.0%	66.4%	67.0%	79.0%
Percentage of referrals to memory services seen within 8 weeks (quarter to date)	90.0%	56.8%	57.0%	62.3%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50.0%	47.5%	47.7%	49.6%
Early intervention in psychosis (EIP) or at risk mental state (ARMS): Percentage starting treatment within 2 weeks	60.0%	33.3%	15.0%	6.2%
Early intervention in psychosis (EIP) : Percentage of people discharged to primary care (quarterly)	-	-	-	62.3%
Cardiometabolic (physical health) assessments completed: Early Intervention in Psychosis Service (quarterly)	90.0%	-	-	65.8%
Services: Clinical Record Keeping	**Target**	**Oct 2023**	**Nov 2023**	**Dec 2023**
Percentage of service users with NHS Number recorded	-	99.2%	99.2%	99.2%
Percentage of service users with ethnicity recorded	-	81.2%	81.4%	82.1%
Percentage of service users with sexual orientation recorded	-	45.6%	46.4%	47.9%
Services: Clinical Record Keeping - DQMI	**Target**	**Jul 2023**	**Aug 2023**	**Sep 2023**
DQMI (MHSDS) % Quality %	95.0%	92.4%	92.1%	92.3%

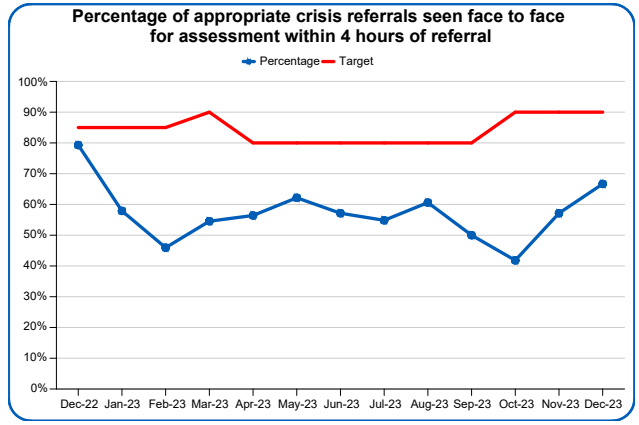
Services: Access & Responsiveness: Our Response in a crisis



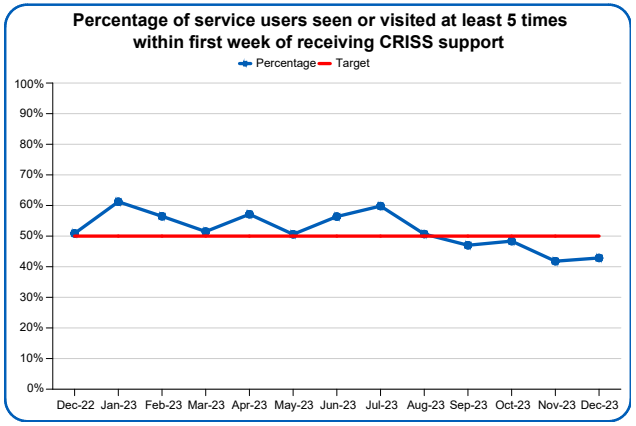
Number of calls : December 4,587



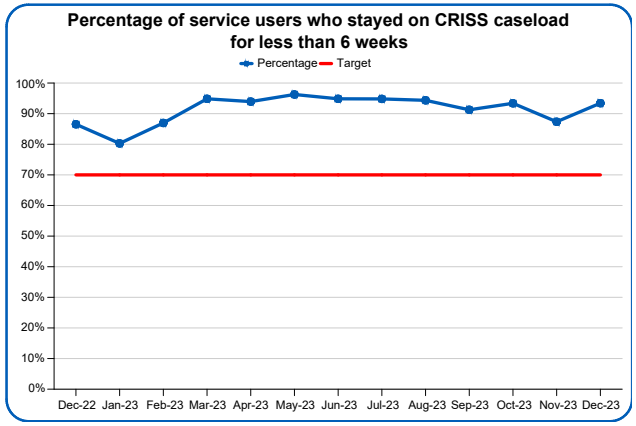
Local target - within 1 minute: December 32.7%



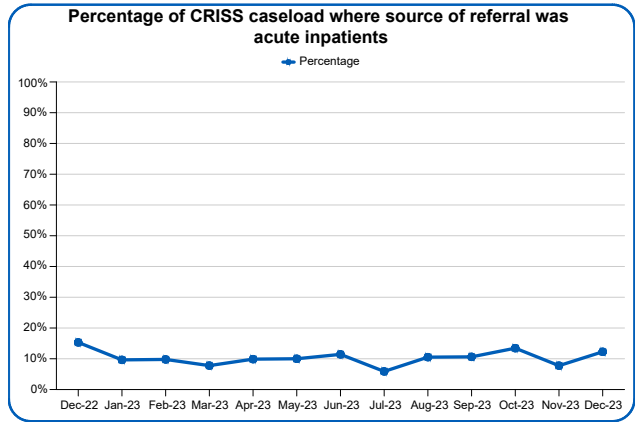
Contactual Target 90%: December 66.7%



Contractual Target 50%: December 42.9%

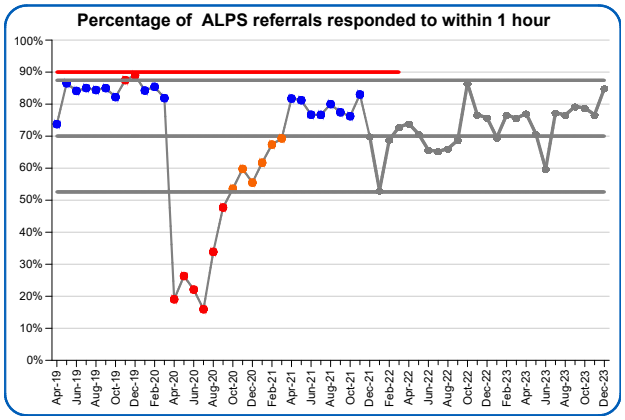


Contractual Target 70%: December 93.4%

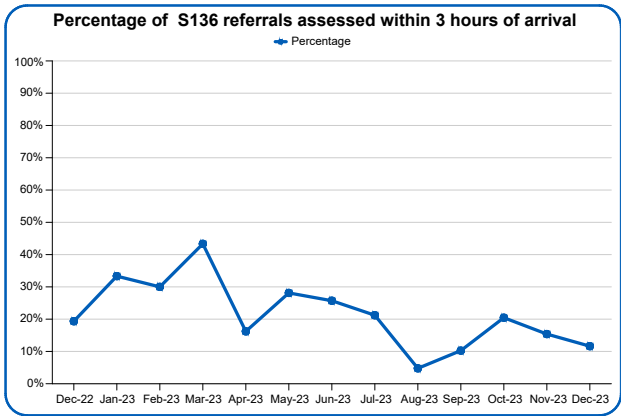


Contractual Target tba: December 12.3%

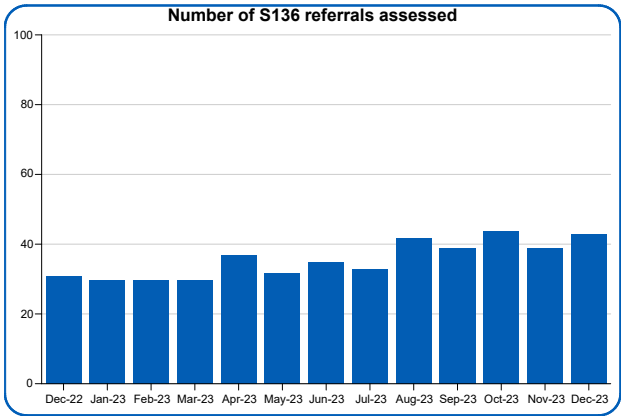
Services: Access & Responsiveness: Our Response in a crisis (continued)



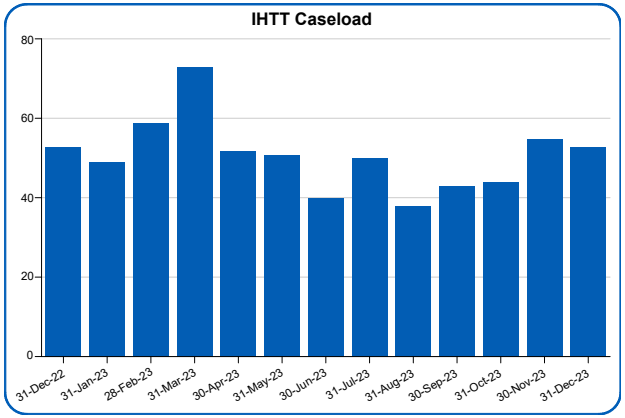
Contractual Target : December 84.9%



Contractual Target : December 11.6%

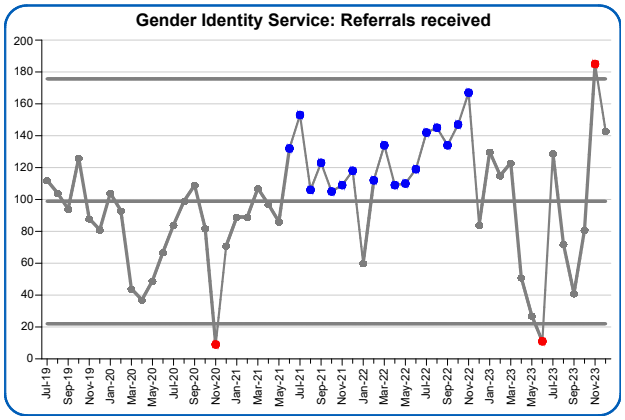


Total referrals assessed: December 43

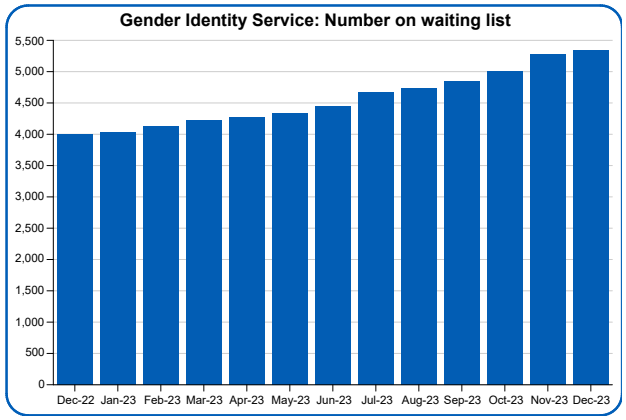


Caseload: December 53

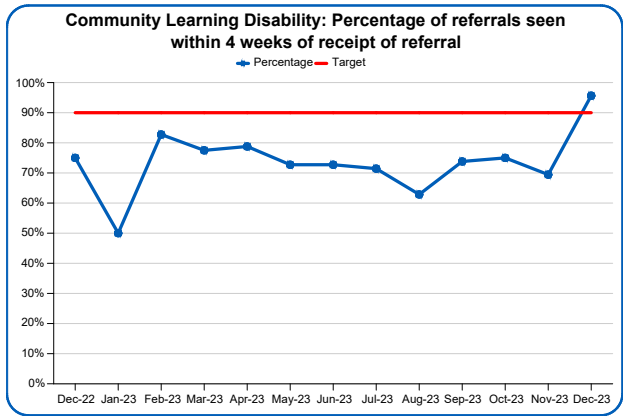
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services



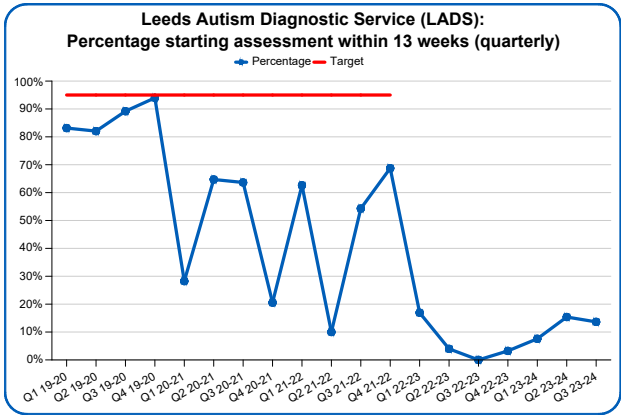
Total referrals: December 143



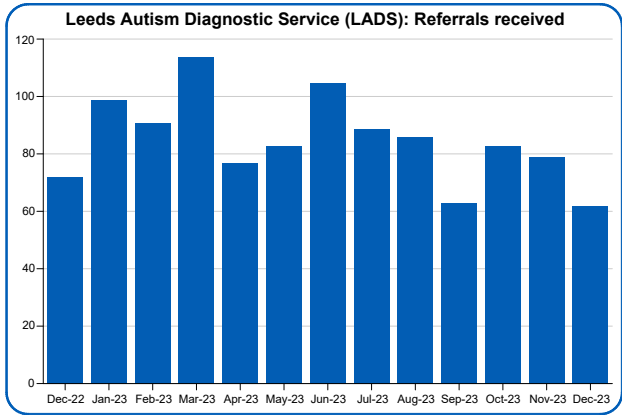
Number on waiting list: December 5,358



Contractual Target 90%: December 95.7%

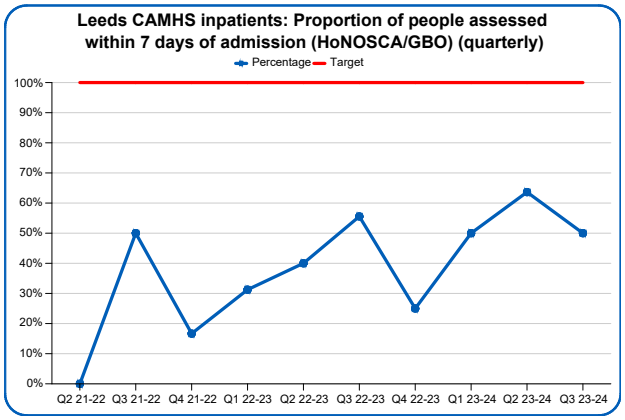


Contractual Target : Q3 13.6%

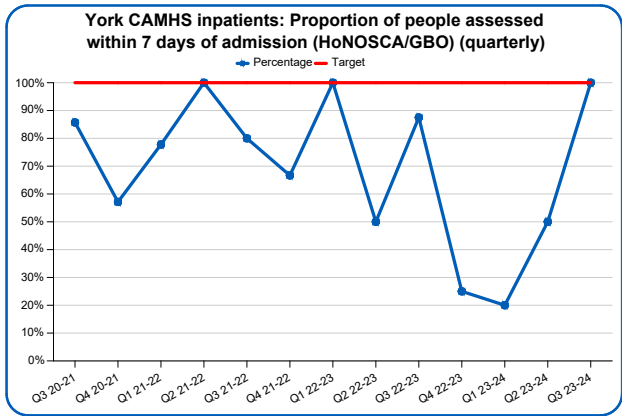


Local measure: December 62

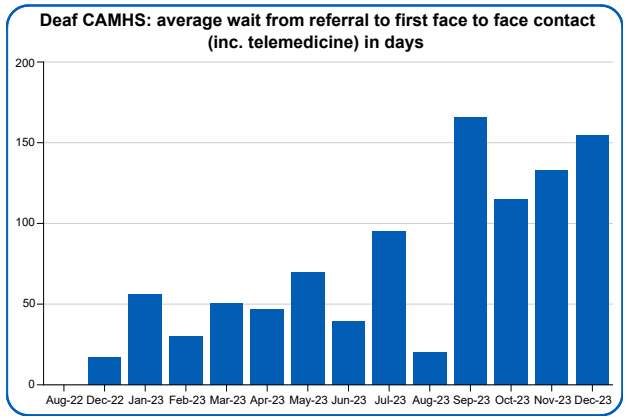
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services (continued)



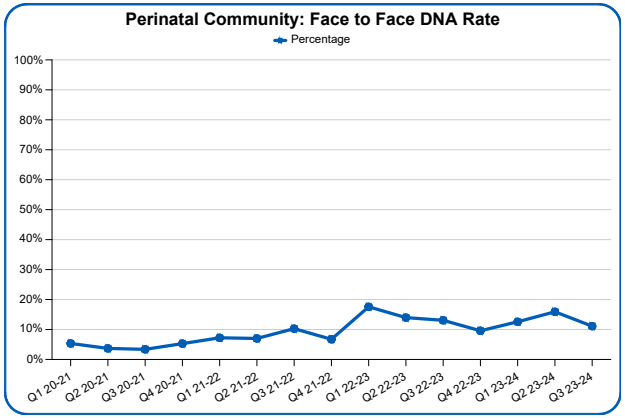
Contractual Target 100%: Q3 50.0%



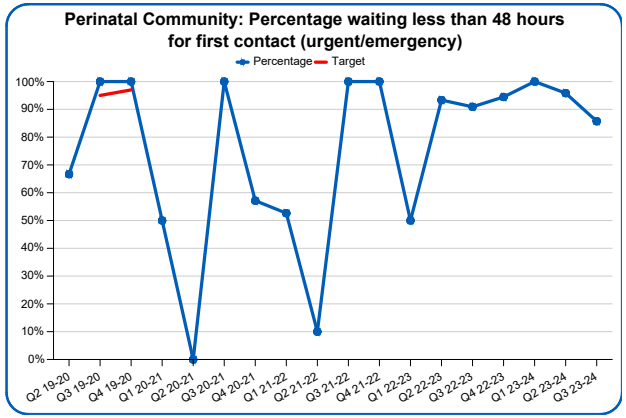
Contractual Target 100%: Q3 100.0%



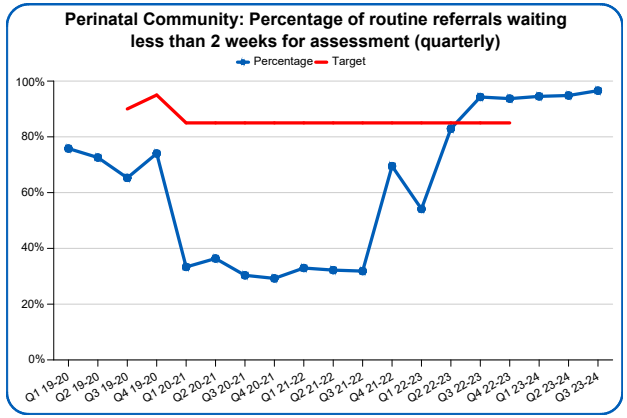
Local measure: December 155



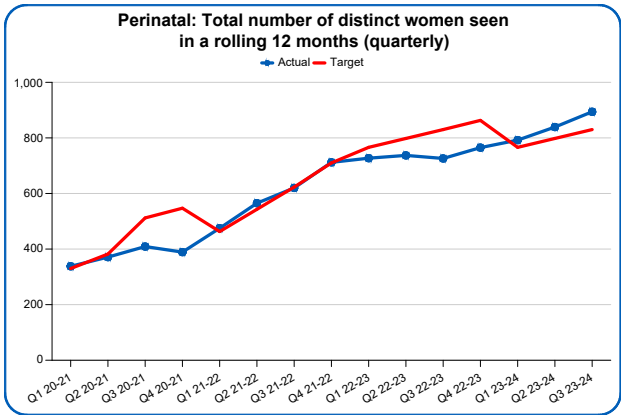
Contractual measure: Q3 11.1%



Contractual Target tba: Q3 85.7%

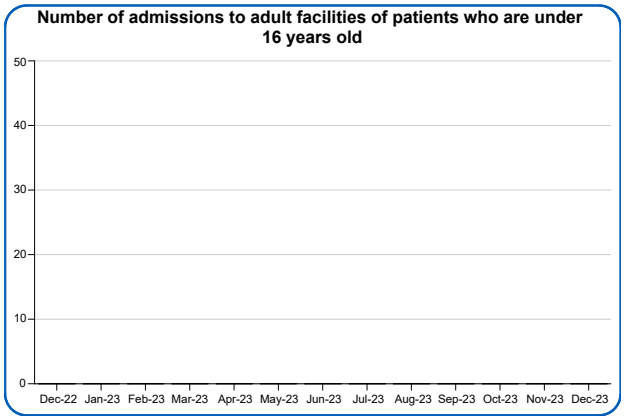


Contractual Target : Q3 96.6%

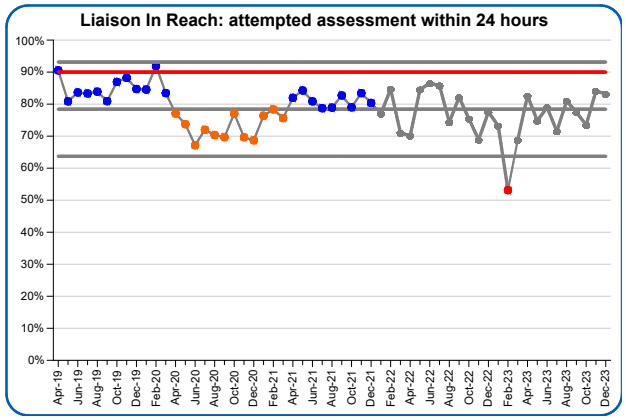


Local measure 830: Q3 894

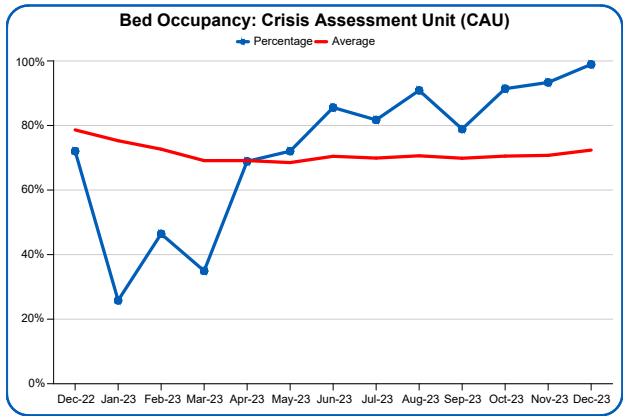
Services: Our acute patient journey



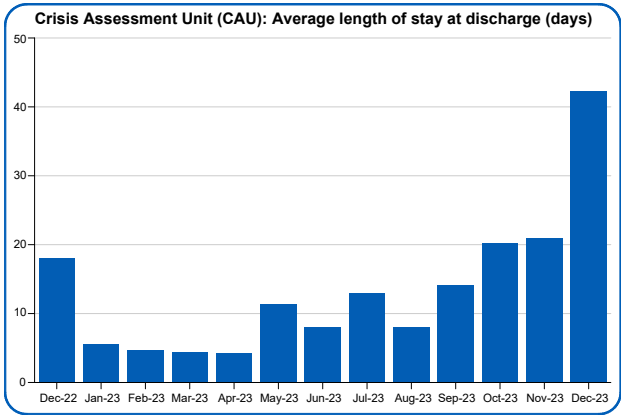
National (NOF) No target : December 0



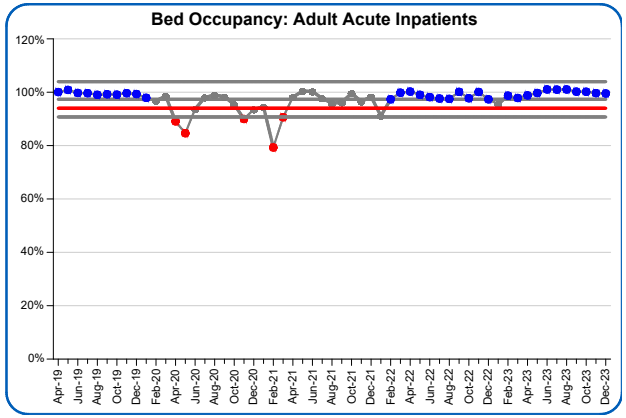
Contractual Target 90%: December 83.2%



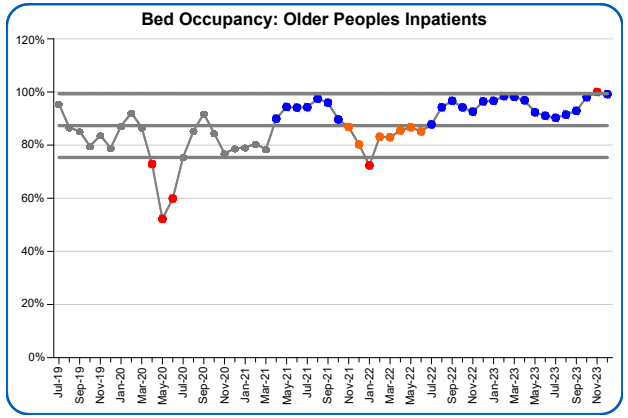
Local measure: December 98.9%



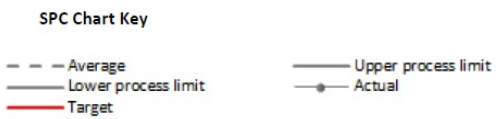
Local measure: December 42 days

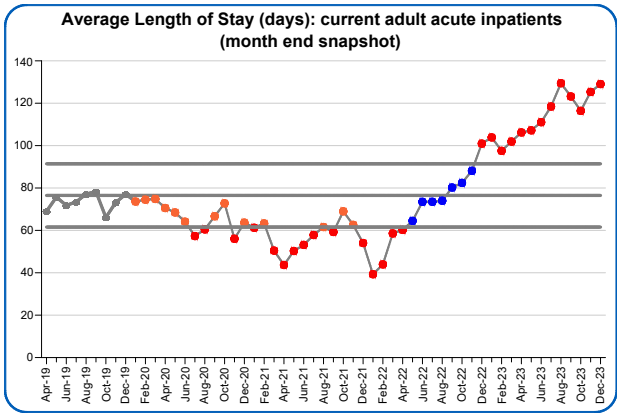


Contractual Target 94%: December 99.5%

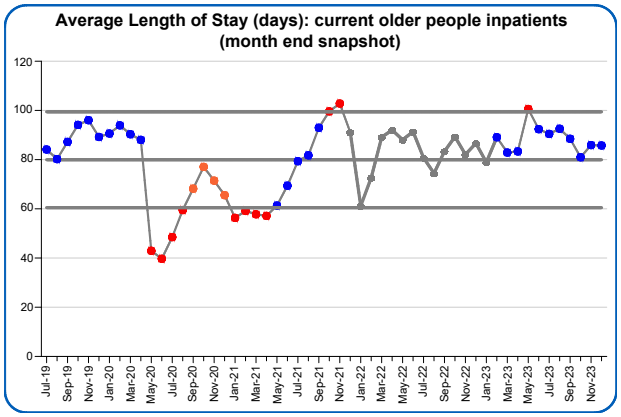


Local measure and target : December 99.2%

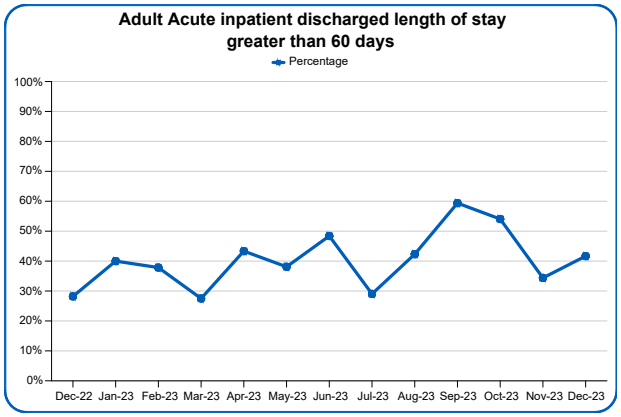




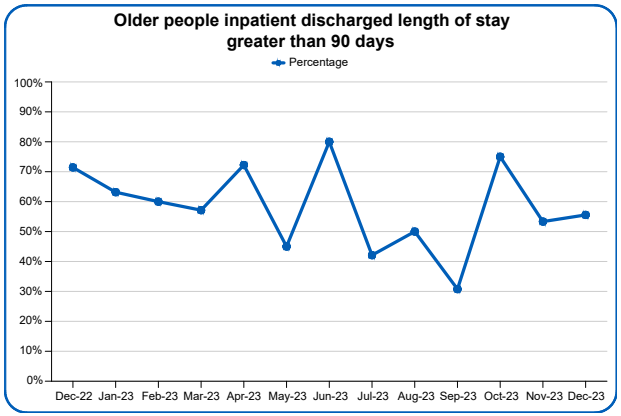
Local tracking measure: December 129 days



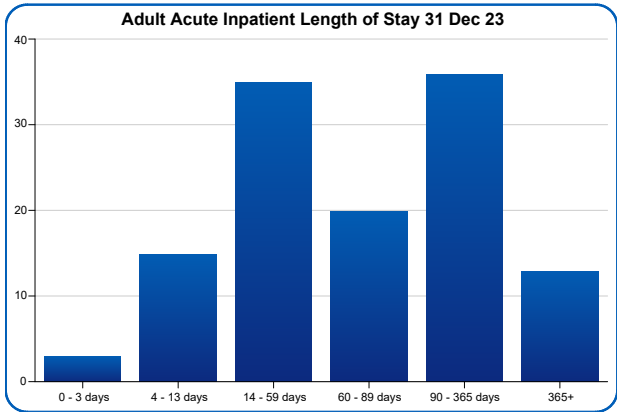
Local tracking measure: December 86 days



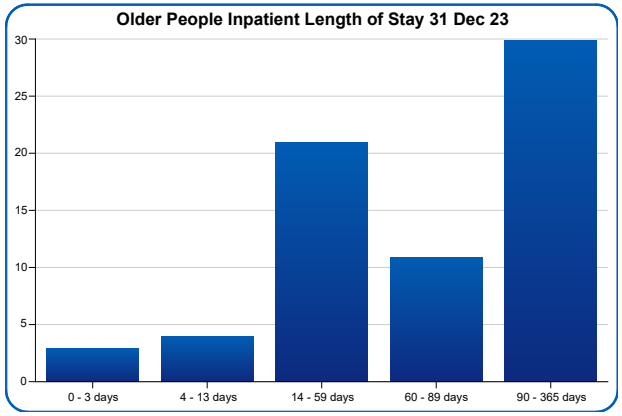
National (LTP): December 41.7%



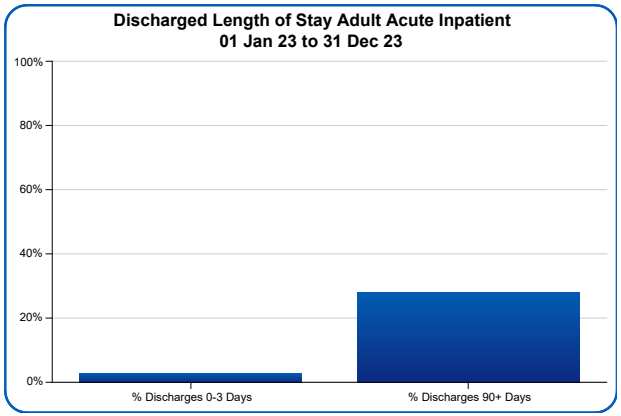
National (LTP): December 55.6%



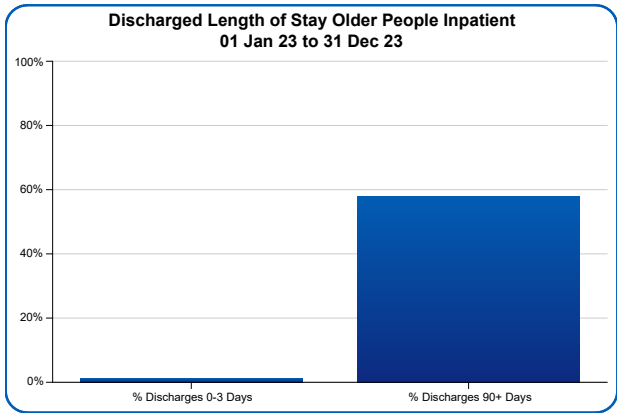
Local activity: 49 people with LOS 90+ days



Local activity: 30 people with LOS 90+ days

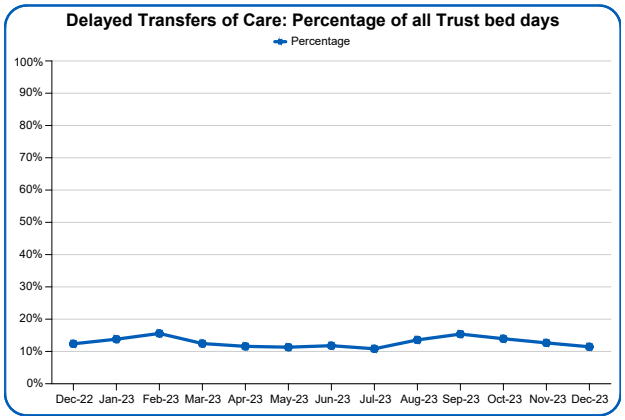


Local activity: % discharged LOS 90+ days = 28.3%

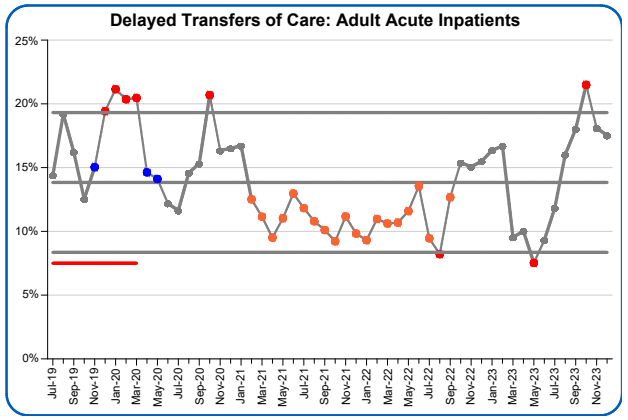


Local activity: % discharged LOS 90+ days = 58.0%

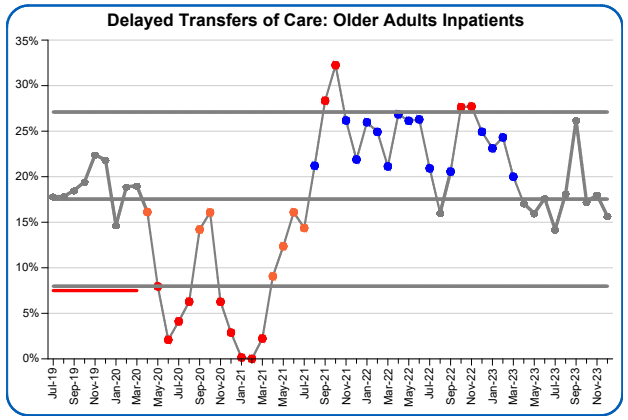
Services: Our acute patient journey (continued)



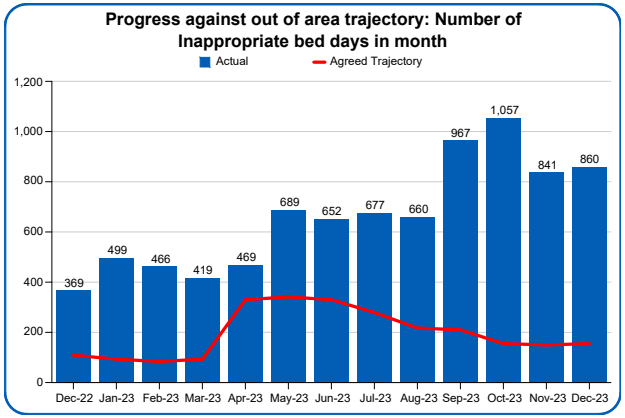
Local tracking measure: December 11.4%



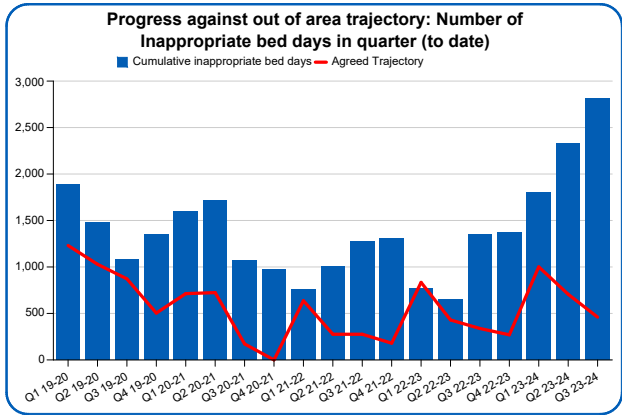
Local tracking measure: December 17.5%



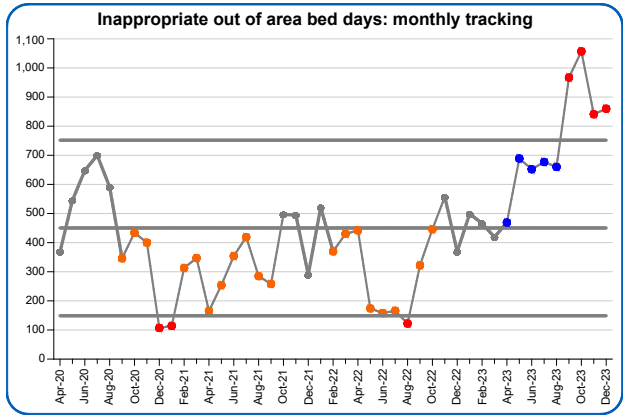
Local tracking measure: December 15.7%



Nationally agreed trajectory (155): December 860 bed days

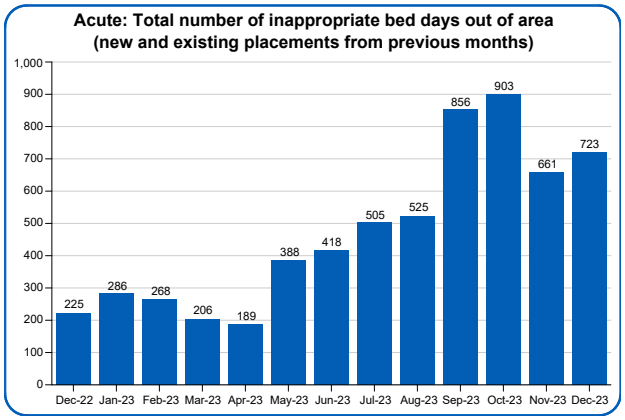


Nationally agreed trajectory (Q3: 460): Q3 2,819 bed days

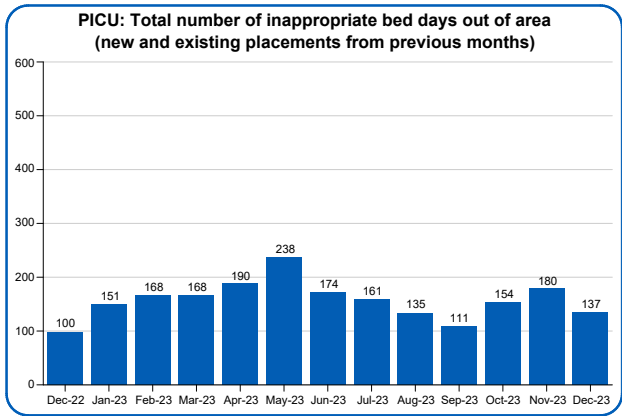


Local tracking measure: December 860 bed days

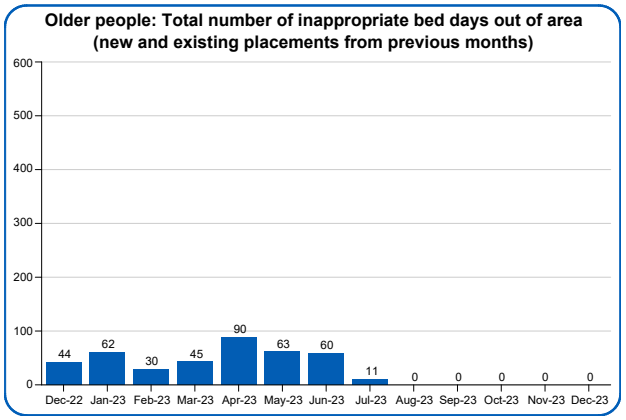
Services: Our acute patient journey (continued)



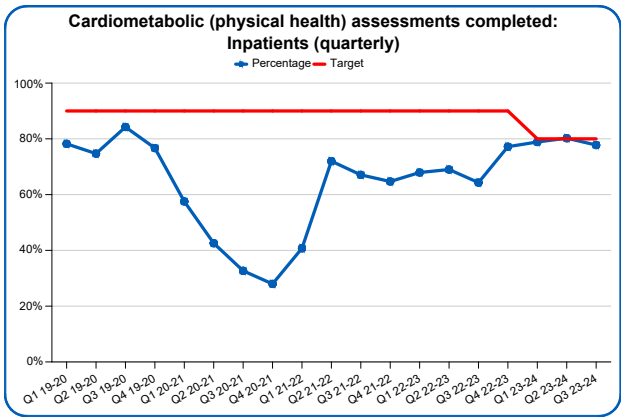
Nationally agreed trajectory (): December 723 days



Nationally agreed trajectory (): December 137 days

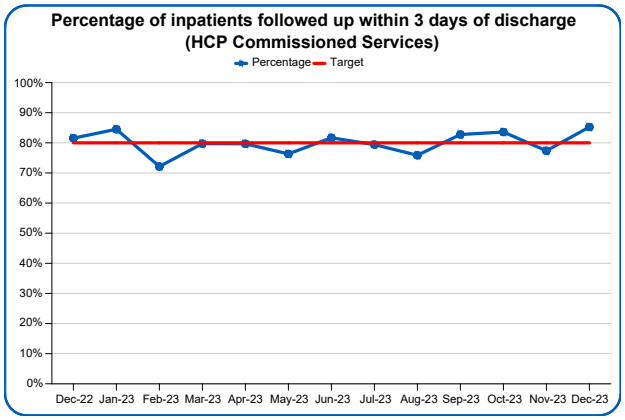


Local measure : December 0 days

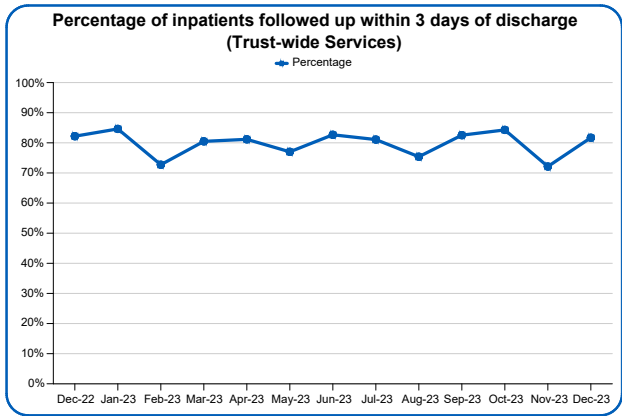


Contractual target 80%: Q3 77.8%

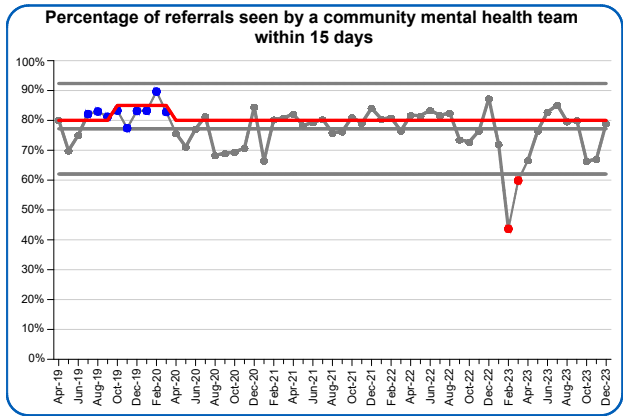
Services: Our community care



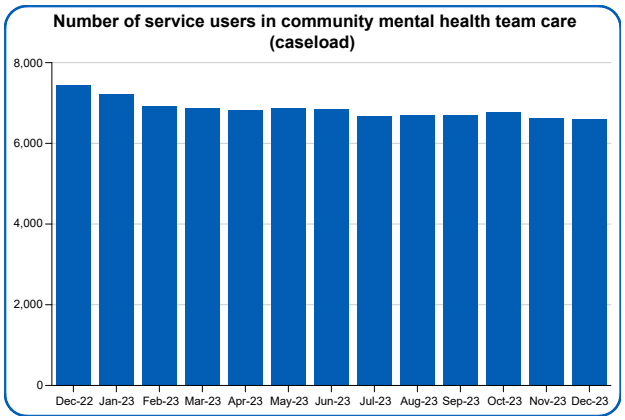
Contractual target 80%: December 85.2%



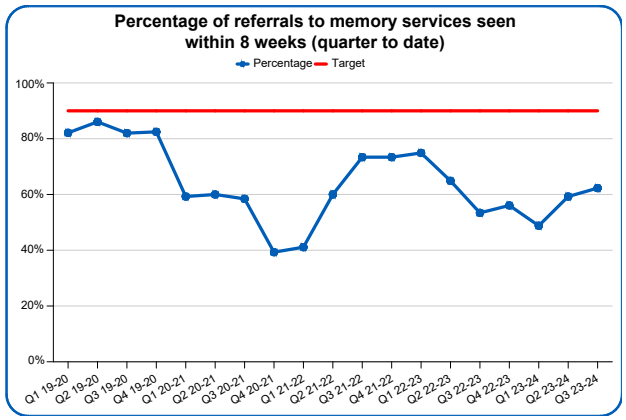
Local Tracking Measure 80%: December 81.7%



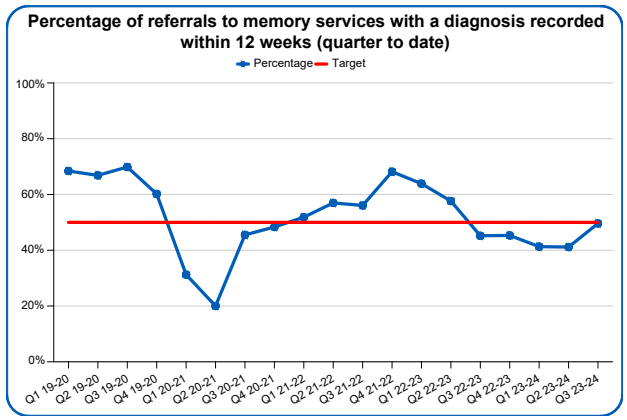
Contractual target 80%: December 79.0%



Local measure : December 3,305



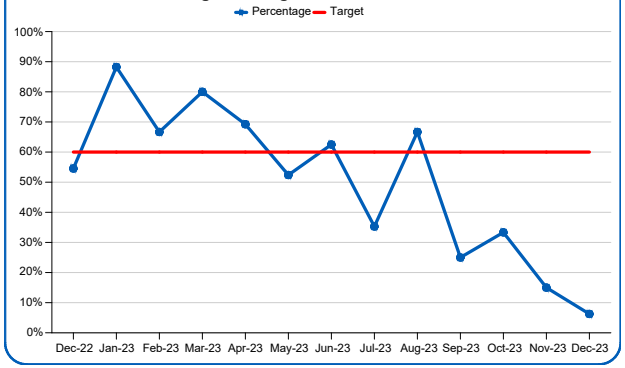
Contractual target 90%: Q3 23-24 62.3%



Contractual target 50%: Q3 23-24 49.6%

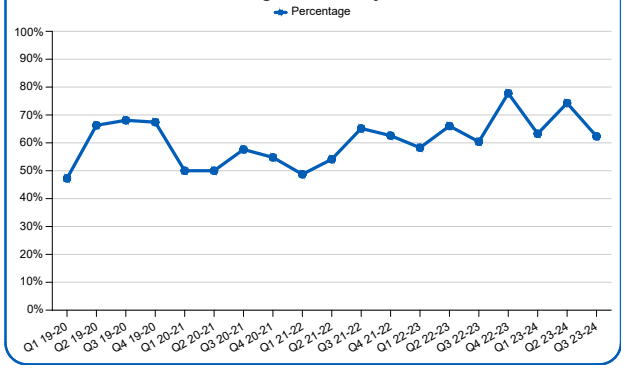
Services: Our community care (continued)

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



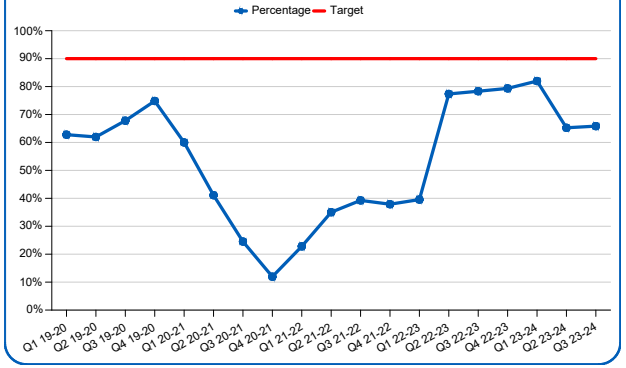
Contractual target 60%: December 6.2%

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



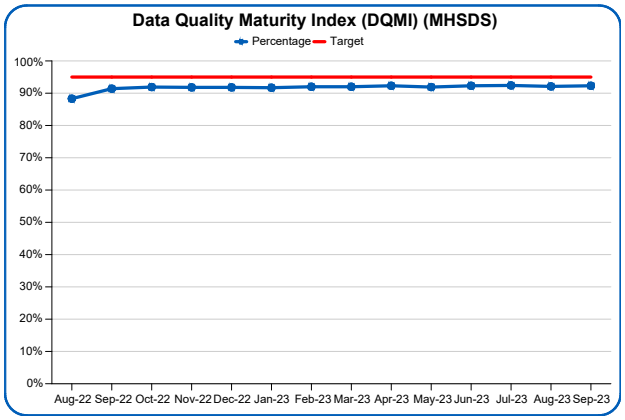
Contractual target tbc: Q3 62.3%

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

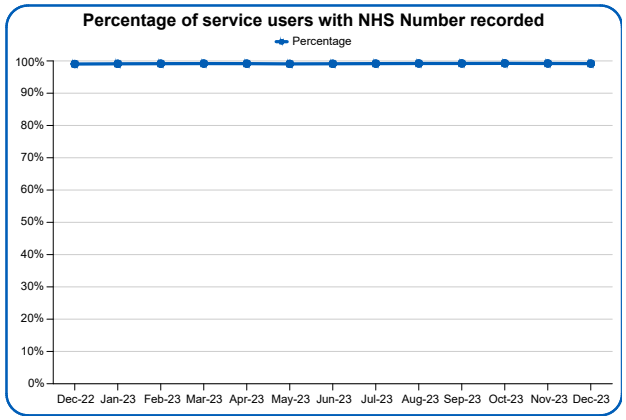


Contractual target 90%: Q3 65.8%

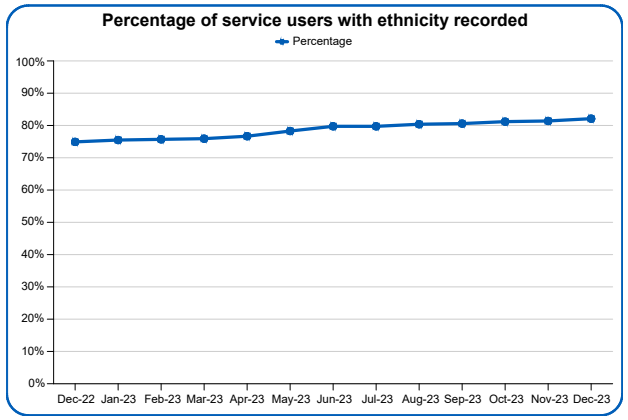
Services: Clinical Record Keeping



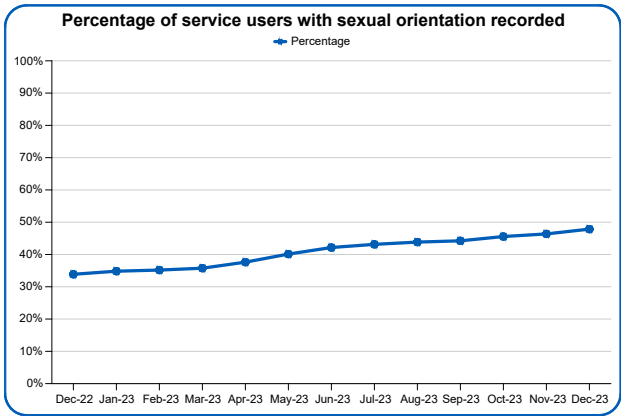
CQUIN / NHSOF Target 95%: September 92.3%



Local measure: December 99.2%



Local measure: December 82.1%



Local measure: December 47.9%

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:	25 January 2024
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 demonstrates that the financial position of the Trust remains robust in the context of an increasingly challenging financial climate. As at month 9 there is a £162k revenue year to date surplus, an improving in month position. There remains several risks and pressures in the overall 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 a key focus. It is recognised that there needs to be an improvement in the delivery of productivity and efficiency into 24/25 as the recurrent benefits in year have not been realised at the scale originally aimed for.

The Trust position needs to be taken with consideration of the wider system's financial challenge, and the potential for further stretch across organisations to support the overall position. This is reflected in the balance sheet review work and the holding back of any further allocations. The enhanced financial governance controls continue to be in place across the whole system.

Work to support a balanced financial plan for 24/25 across the Leeds place is progressing but the challenge is significant, and we await final planning guidance to confirm the clear scale of requirements.

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 9 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 that work continues on 24/25 planning.

MEETING OF THE BOARD OF DIRECTORS

25 JANUARY 2024

CHIEF FINANCIAL OFFICER REPORT

1 Introduction

This report provides an overview of financial performance at month 9 2023/24.

2 Year to date Income and Expenditure Performance 2023/24

At month 9 the Trust revenue position has improved to a £162k surplus 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 £9.4m year to date, this is £0.5m higher than it was at the same point last financial year. Year to spend has reduced to 7.2% 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) remains high, year to date spend is £3.9m above year-to-date budget, driven predominantly by the exceptional pressure in Working Age and PICU.
- The unidentified CIP target equates to £3.2m year to date adverse variance against budget.

Progress is being made against the ongoing efficiency thematic areas described below, however fortuitous mitigations, predominantly substantive vacancies and interest receivable continue to reduce the pressures in the position.

3 Revenue Forecast

There remains a good degree of confidence that the breakeven plan will be achieved. This together with the unwinding of the CPC redundancy provision results in Trust forecast outturn position to a £2.2m surplus as reported to the ICB.

4 Capital Expenditure

At month 9 overall capital expenditure is £3.1m, which is £0.5m behind plan (details in Appendix B).

The operational capital envelope at month 9 is £0.5m ahead of plan, which is mainly due to the timing of expenditure on backlog & sustainability schemes and expenditure on the Electronic Document Management Scheme. The is phasing and the Trust continues to forecast within the ICS capital envelope for 23/24.

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 23/24 includes funding to support the Trusts EDM project rollout (£0.9m) and Mental Health Urgent and Emergency care (MH UEC) funding of £0.6m. We aim to spend these funds by the year end. We had previously reported a risk on the MH UEC but have agreed a plan with partners for its utilisation to support place-based services. An issue remains with the business case for development of 6 additional inpatient perinatal beds at the Mount as the business case has still not been approved. 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 M9. 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, IFRS 16 funding is now part of ICS allocations, to be managed collectively across West Yorkshire.

5 ICB Financial Position

5.1 Revenue

Due to the actions taken in December and the additional funds received into the system to mitigate the industrial action, the year to date ICB position has improved to a £28.1m deficit against a £8.2m deficit plan, £19.9m worse than plan.

The ICB forecast is a 5.9m deficit against a breakeven plan. This is a direct result of the industrial action in December. At this stage it is anticipated that additional funds will be received to mitigate this deficit.

Included within the work to revise the system forecast position before Christmas was a request for providers to undertake a balance sheet exercise comparing their 19/20 balance sheet to the expected end of year 23/24 balance sheet and explain the variances. It is hoped through this work that any additional flexibility in organisations can be identified to close the system risk in the balanced forecast. Key areas that have been focussed on have been goods received and invoiced, deferred income, accrued income, year end accruals and provisions. This work is being summarised and reviewed at system DOFs group at the end of January.

5.2 Capital

Year to date, ICB Capital expenditure against the operational capital plan in £30.0m 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 has changed from being centrally managed to each ICB receiving an allocation to manage within. This was based on 22/23 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 23/24. This remains an area of significant concern for this & future years given the allocations are anticipated to be significantly less than needs based plans.

6 2024/25 Operational Planning in Leeds Place

At the point of writing full planning guidance for 24/24 has not been issued. An update was issued pre-Christmas stating no expected fundamental changes to the priorities set in 23/24. There remains an emphasis on recovering core service delivery and productivity and a continued focus on reducing use of temporary staffing. The financial framework will remain consistent, including commitment to the Mental Health Investment Standard (MHIS). It has been signalled that work is underway to agree a standard set of metrics that all executive teams and Boards should use to as a minimum to track productivity alongside service delivery.

As part of West Yorkshire planning, work continues at Leeds place utilising the newly formed Strategic Finance Executive Group (SFEG) to agree the framework and approach to achieving financial balance. Through this process we will ultimately agree the revenue resources (contracts) for each NHS statutory provider and the available resources for other commissioned services in Leeds. This is a new collaborative way of working. The aim is for this to be as fair and transparent as possible, with equitable distribution of stretch and challenge in the context of the place-based priorities, which include commitment to the MHIS. The current assessed scale of the financial challenge equates to an overall savings requirement in the region 7%, but this is a moving figure subject to refinement and final confirmation of allocations once planning guidance is released. SFEG has agreed to commit each organisation to try to identify 5.5% savings, through efficiency plans and reductions in cost pressures. In addition, more systemic solutions and transformation approaches are being reviewed working with population boards.

Internally at LYPFT we have begun our detailed planning process for 24/25 to confirm and agree a smaller set of organisational priorities, building on the existing strategic plans of each directors' portfolio areas. An initial workshop has been held with the Senior Leadership and the priority areas reviewed and discussed. These will be further refined and agreed at the February meeting. In 24/24 we will ensure an explicit alignment of these priorities to our productivity and efficiency plans. This aims to ensure that as we deliver our priorities, we also deliver our financial plan and savings targets. This again builds on the approach we have begun in 23/24, with our four thematic areas of efficiency.

The national timetable currently set out requires system operational and financial plans to be completed by the end of February. This is a very challenging timetable, and it is unlikely that any submission at that stage will be comprehensive and complete. We will aim to have a detailed plan for scrutiny and final ratification through the Board at our March/April meeting.

7 System Capital Planning 2024/25

Capital planning across the system has also commenced with the 10 provider trusts, coming together to review indicative plan requirements for 24/25 at the end of January. The Board is reminded that the capital allocation is a single system allocation for which the ICB is ultimately accountable, but which they must work with partners to prepare and agree. The final plan will require all organisations to sign off as deliverable within the distribution of the allocation. There is significant risk attached to 24/25 capital as the full year effect of the merging of IFRS16 leases

within the overall operational capital, puts additional stretch on an already over committed allocation.

To support the work of medium-term capital planning work has also commenced on a refreshed system wide Capital Infrastructure Plan. This is intended to capture in a single plan all of the capital investment priorities and risks across the whole of the ICB, for estate, digital and medical equipment inclusively. It is a national requirement to develop this plan and the timescale is expected to be quarter one 24/25. Detailed guidance has not yet been released but West Yorkshire has commenced the preparatory work.

8 Conclusion

This report demonstrates that the financial position of the Trust remains robust in the context of an increasingly challenging financial climate. As at month 9 there is a £162k revenue year to date surplus, an improving in month position. There remains several risks and pressures in the overall 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 a key focus. It is recognised that there needs to be an improvement in the delivery of productivity and efficiency into 24/25 as the recurrent benefits in year have not been realised at the scale originally aimed for.

The Trust position needs to be taken with consideration of the wider system's financial challenge, and the potential for further stretch across organisations to support the overall position. This is reflected in the balance sheet review work and the holding back of any further allocations. The enhanced financial governance controls continue to be in place across the whole system.

Work to support a balanced financial plan for 24/25 across the Leeds place is progressing but the challenge is significant, and we await final planning guidance to confirm the clear scale of requirements.

9 Recommendation

The Board of Directors is asked to:

- Note the revenue and capital position at month 9 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 that work continues on 24/25 planning.

Jonathan Saxton
Deputy Director of Finance
18 January 2024

		Month 6		
Income & Expenditure Budget Position	**Budget Annual £'000**	**Budget YTD £'000**	**Actual YTD £'000**	**Variance YTD £'000**
Income:				
Patient Care Income	214,988	161,241	163,468	2,227
Other Income	31,657	23,743	25,796	2,053
Total Income	**246,646**	**184,984**	**189,263**	**4,280**
Expenditure:				
Pay Expenditure	(179,683)	(134,609)	(130,068)	4,541
Non Pay Expenditure	(66,963)	(50,374)	(59,033)	(8,659)
Total Expenditure	**(246,646)**	**(184,983)**	**(189,101)**	**(4,118)**
Surplus/ (Deficit)	**0**	**0**	**162**	**162**

Key – Underspend / (overspend)

The significant year to date variances are:

Income:

- Patient Care income is £2.2m 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 £1m 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 £0.3m 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 £23.5m. 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 December there was an increase of 144WTE substantive staff since April.
- Offsetting the overall underspend in Pay, the Trust has incurred £9.4m agency expenditure year to date, this is £0.5m higher than this point last year as detailed in Appendix C. Also, as a result of substantive vacancies, bank & overtime expenditure is £9.9m year to date.

Non-Pay

- Out of area placements (OAPs) expenditure is a significant pressure and is £3.9m above budget (£4.2m WAA, partially offset with a £0.3m underspend in Complex Rehab, older

People is on budget). 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 £0.4m over budget due to OAPs
- Excess packages of care costs in the WY CAMHS PC has contributed towards a £0.2m overspend within the collaborative that is offset with additional income profiled into the position.
- Year to date the unidentified cost improvement target generated £3.2m adverse variance

Appendix B

CAPITAL PROGRAMME - at 31 December 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	210		210
Security review	150	150		150
Cold water taps to bedrooms	100	100	87	13
Sub-Total	**550**	**460**	**87**	**373**
IT/Telecomms Operational				
IT Network Infrastructure	150	120	18	102
Server/Storage	30	15	13	2
Cyber security	50	50		50
Sub-Total	**230**	**185**	**31**	**154**
Estates Strategic Developments				
Newsam Centre (Doors)	75	75	25	50
Red Kite View	50	25		25
St Marys House, main house	1,080	1,080	1,933	(853)
Sustainibility & Green Plan	150	100		100
Seclusion Review	400	100	30	70
Safes	119	119	119	(0)
Sub-Total	**1,874**	**1,499**	**2,108**	**(609)**
IT Strategic Developments				
Integration System	50	50		50
Voice recognition	140	40		40
EPR developments	50	25		25
Electronic document management	277	0	302	(302)
EPMA Community model	100	0		0
Smartphones	60	40	47	(7)
Sub-Total	**677**	**155**	**348**	**(193)**
Contingency Schemes				
Contingency	305	210	301	(91)
2022/23 Completed Schemes			158	(158)
Sub-Total	**305**	**210**	**460**	**(250)**
Disposals				
ICS	0	0	(10)	10
Sub-Total	**0**	**0**	**(10)**	**10**
Total ICS Operational Capital	**3,636**	**2,509**	**3,024**	**(515)**
PDC Funded Schemes				
Electronic document management (PDC)	922	400		400
MH UEC (PDC)	581	81		81
Total PDC Funded Schemes	**1,503**	**481**	**0**	**481**
IFRS16 Leased Assets				
Lease Cars	200	140	73	67
Leased Buildings	1,000	500	0	500
Sub-Total	**1,200**	**640**	**73**	**567**
Disposals				
Leased	0	0	(6)	6
Sub-Total	**0**	**0**	**(6)**	**6**
Total IFRS16 Leased Assets	**1,200**	**640**	**67**	**573**
Total Capital Spend	**6,339**	**3,630**	**3,090**	**540**

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
10

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Safer Staffing Six Monthly Report
DATE OF MEETING:	25 January 2024
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 Miriam Blackburn, Professional Lead Nurse Adele Sowden, E-Rostering Team Manager Cassie Good, Head of Strategic Resourcing

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 six monthly update and draws on the requirements of the National Quality Board's (NQB) Safer Staffing expectations.

The paper contains a high-level overview of data and analysis providing Trust Board members with information on the position of all wards staffing against safer staffing levels for the retrospective periods from the 1st May 2023 to 31st October 2023.

The exception reports identify x7 Registered Nurse non-compliant duty where there was no RN on duty across this period.

The report also contains a more focused analysis of the Acute Inpatient and PICU Service to demonstrate how individual service areas use data and information as set out by the NQB using a triangulated approach including the use of MHOST data to address and inform decision making relating to safer staffing to enable safe and effective care to be delivered.

(The Appendix also includes the October and November 2023 Unify report for information. There were 0 non-compliant duties during this period).

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

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

RECOMMENDATION
The committee is asked to: • Note the content of the 6 monthly report and the progress in relation to key work streams. • Be assured that arrangements are in place to monitor, support and mitigate any impact of reduced staffing levels or skill mix in relation to patient safety.

Leeds and York Partnership NHS
NHS Foundation Trust

Meeting of the Quality Committee

11th January 2023

LYPFT 6 Month Safe Staffing Review Paper

(Data period 1st May 2023 to the 31st October 2023)

1.0 Introduction

Leeds and York Partnership NHS Foundation Trust (LYPFT) provides inpatient care across 28 mental health and learning disability wards. Ensuring that NHS organisations have the right staff, with the right skills in place, has been a key trust board requirement since the NHS National Quality Board (NQB) issued guidance in 2016.

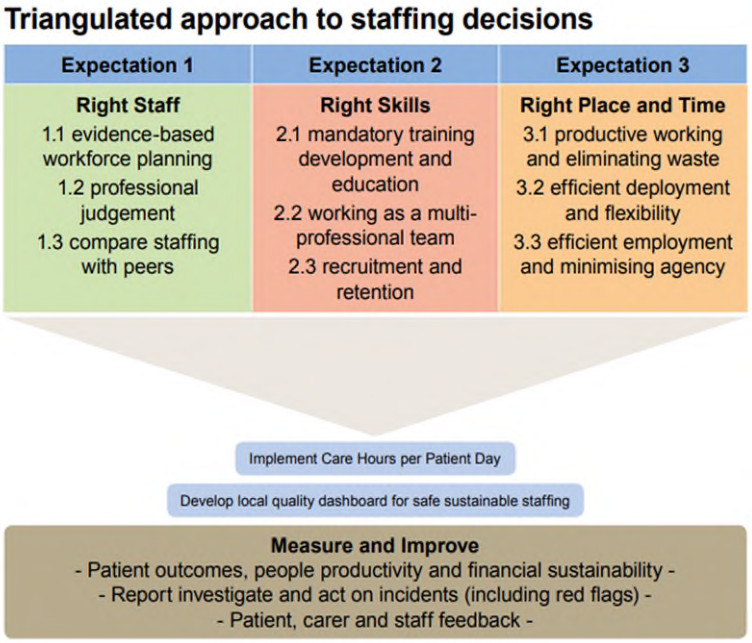
The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18, ensures that providers deploy enough suitably qualified, competent and experienced staff to enable them to meet all regulatory requirements described in this part of the act. This identifies that staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities.

The purpose of this report is to inform the Trust Board and the public of the latest position in relation to staffing LYPFT inpatient wards and the wider workforce plan to provide assurance that the standards required to deliver safe and effective care are being met.

The report draws on the above requirements and contains a high-level overview of data and analysis providing the Board with information on the position of all wards staffing against safer staffing levels for the 6-month period of the 1st May 2023 to 31st October 2023.

The report in addition to providing an overview across all inpatient wards, demonstrates how individual service areas use data and information as set out by the NQB using a triangulated approach to address and inform decision making relating to safer staffing and workforce planning. This is illustrated in the report through a focussed analysis of the Acute Inpatient and PICU (Psychiatric Intensive Care Unit) Service, highlighting current workforce challenges, the effective mitigation and management of any workforce risks and ensuring that the services have the right staff, right skills at the right place and the right time to enable safe and effective care to be delivered.

The flow chart below supports providers of NHS services with the delivery of the right staff, with the right skills, in the right place at the right time (National Quality Board 2016) and has been used to provide a framework for the illustration of safer staffing:



2.0 The Mental Health Optimal Staffing Tool (MHOST)

The Mental Health Optimal Staffing Tool (MHOST) was created with the support of Health Education England, in recognition that there was no published, evidenced based mental health workforce tool which could be used in mental health hospitals. It has been developed alongside clinical leaders and workforce staff in mental health trusts and rigorously tested and validated. The tool is free of charge to all NHS Trusts in England and LYPFT started to test its use in 2019 when we became licensed to use it.

The tool, which cannot be used in isolation as professional judgement has to be applied to make it viable, describes how fluctuating patient clinical presentation can affect the number of nursing staff required to provide patient care. It uses a set of care level indicators on a scale of 1-5 which measure the dependency/acuity of patients in different settings (see appendix 1). These are now being used by ward leads at LYPFT to record patient acuity and dependency.

Once the data has been recorded, the toolkit incorporates the skill mix (derived from the budgeted establishment) and the financial headroom (24%) applicable to the ward and then issues a recommended nursing and healthcare support worker staffing level per ward measured as Care Hours Per Patient Day (CHPPD) and Full-Time Equivalents (FTE).

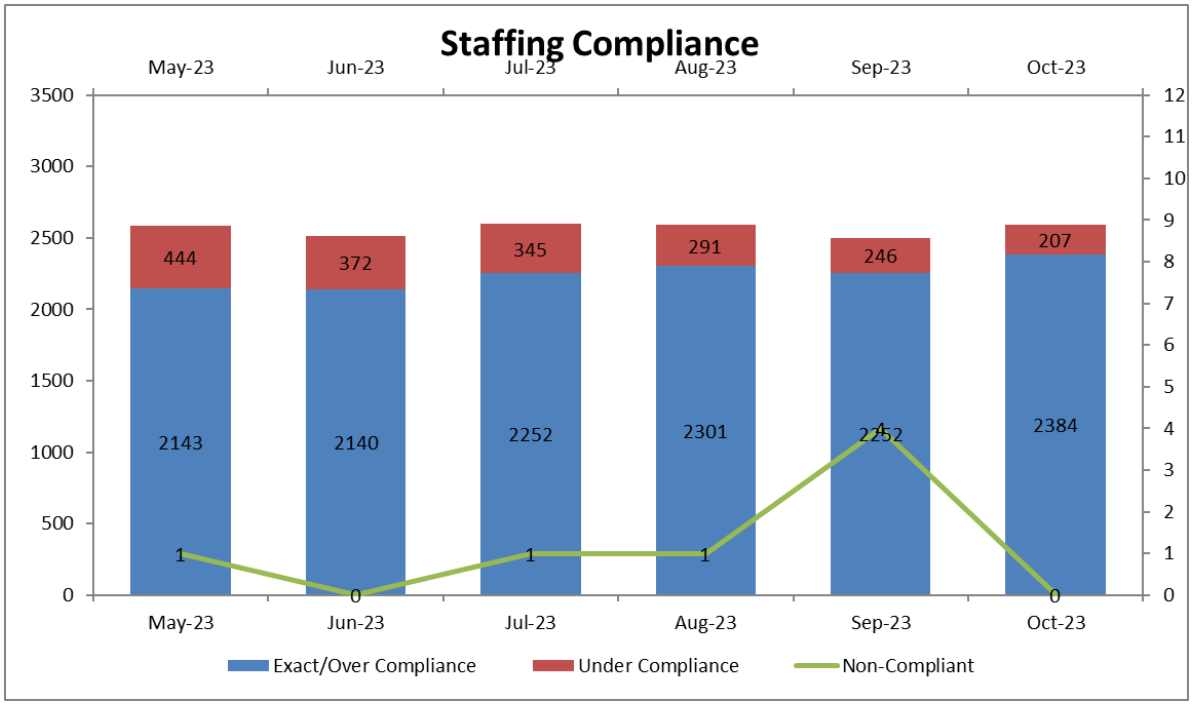
Training on the use of the MHOST tool was first delivered in LYPFT in 2018/2019 but since this time, significant changes in leadership and teams has occurred alongside the decision to pause data collection during the pandemic. A refresh of the training was therefore delivered by NHSE with leaders from across 26 of our inpatient wards (the tool does not support the use in LD inpatients) who have met the required competency level for the use of the tool and in turn ensuring its validity and reliability.

All attendees of the training carried out an inter-rater reliability assessment to provide assurance that the required standard had been met to appropriately assess the levels of care required by patients as defined by the tool**.**

The Safer Staffing Group have been working collectively with inpatient services and operational colleagues to enact the MHOST tool implementation plan with the first data collection period being completed in September 2023, which has provided the data to support evidence-based workforce planning alongside professional judgement and quality indicators.

Recommended indicators to support the triangulation of data as described in the National Quality Board for each service have been discussed in the Safer Staffing Group, which were in turn being further developed through clinical service governance groups. The data has now been shared with leaders of our inpatient wards to inform safe staffing establishment reviews.

3.0 Review of staffing activity from 1st May 2023 to 30th October 2023



The staffing compliance data above tells us whether the wards met the planned numbers of staffing during a shift. However, the planned staffing numbers do not necessarily reflect the staffing need on any given duty as this may fluctuate dependent upon the current patient group. Planned numbers are based on the whole-time equivalent (WTE) number of staffing posts (establishment) the inpatient wards are funded to deliver care and treatment.

During this period a total of 15,377 shifts were required to ensure safer staffing in inpatient areas. This is a 0.09% increase from the previous 6-month reporting period.

- 13472 (87.6%) of the required shifts met/exceeded planned staffing numbers. An increase of 6.03% on the previous 6-month reporting period.
- 1905 (12.3%) of the required shifts did not meet planned staffing numbers. The previous 6-month reporting period had a compliance rate of 18.91%.
- 7 (0.04%) of the shifts did not have a Registered Nurse on duty. The previous 6-month reporting period had a compliance rate of (0.05%)

The data demonstrates that there was an increase in the number of shifts where the planned staffing numbers were met/exceeded and a decrease in the number which did not meet planned staffing numbers. This indicates that the number of staff required to deliver safe and effective care has increased. The number of shifts without a Registered Nurse on duty has decreased.

In some cases, there may be shifts where the required shifts did not meet the planned duty and this will not have impacted on care provided or workload for staff members, for example if there were a large proportion of the service users on leave.

4.0 Exception reports - No Registered Nurse on Duty

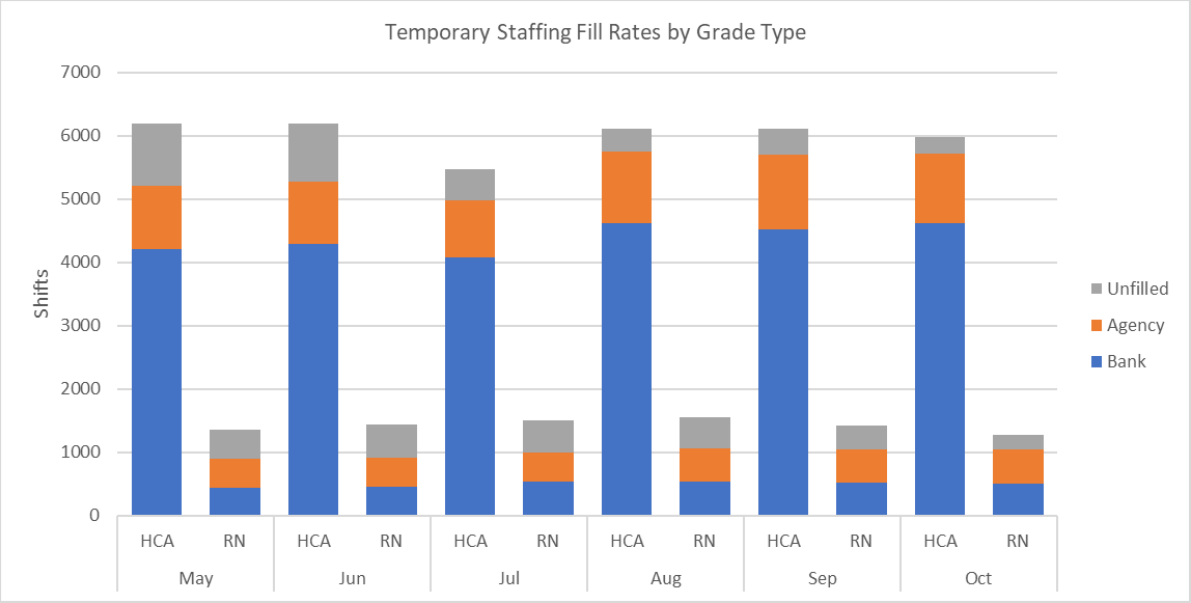
The Health and Social Care Act 2008 ensures that providers deploy enough suitably qualified, competent, and experienced staff to enable them to meet all regulatory requirements described in this part of the act. To meet the potential care and treatment needs within any of LYPFT inpatient wards, we aim to maintain a minimum of x1 Registered Nurses on duty who can act as 'Nurse in Charge' and carry out duties under the Mental Health Act. Where unexpected absences occur such as sickness absence and in turn the local minimum standards would not be achieved, the safe staffing escalation procedure is enacted. This allows for several actions to be carried out such as the use of temporary staffing, overtime, and deployment from other inpatient wards. However, despite efforts a total of 7 occasions were recorded where a Registered Nurse has been required to take charge across 2 inpatient wards within the same unit during the data period. A risk assessment is carried out with the clinical service and Duty Manager to identify where the least impact is likely to be experienced should a Registered Nurse be required to 'take charge' across 2 wards.

Clifton Forensic Services - Riverfields Ward had a total of 6 occasions where there was no Registered Nurse on the night duty. The Registered Nurse based themselves on one of the adjacent wards whereby a greater service user dependency was identified than that of Riverfields Ward, which is a recovery and rehabilitation ward where a significant proportion of service users self-medicate as part of their recovery plan.

Learning Disabilities Respite Unit - Woodland Square had a total of 1 occasion where there was no Registered Nurse on the night duty. The Registered Nurse based themselves on the adjoining ward and the Nursing Associate remained on the ward and was able to administer medication and was responsible for shift co-ordination which falls within their existing roles and responsibilities. Regular contact was kept with the Registered Nurse.

No incidents which were impacted by staffing were reported during these duties.

5.0 Bank and Agency Staffing



The above chart demonstrates the significant contribution Bank and Agency temporary staffing make to care delivery to mitigate unavailability and additional duties above planned establishment where demand has fluctuated. The graph above, counts the actual number of shifts worked by headcount, which is different from the staffing compliance chart and shows the number of shifts that had the right number of staff.

A combined total of 43,871 additional shifts were requested during this period.

- 8,655 Registered Nurse additional shifts were requested. These were filled by Bank Registered Nurses (34.2%) and Agency Registered Nurses (35%).
- 30.8% of shifts requested for Registered Nurses remained unfilled. Reduced from 41% in the previous 6 months. This 10% increase in fill rate has been filled by Agency Registered Nurses.
- 35,216 Health support worker additional shifts were requested. These were filled by Bank HSW's (72.4%) and Agency HSW's (17.9%).
- 9.7% of shifts requested for Health Support Workers remained unfilled. This is an 8.1% reduction in unfilled Health Support Worker shifts compared to the previous 6 months.

During the report period, there was a small reduction of overall shifts required compared to the previous 6 months (362). There was an 86.1% fill rate for additional shifts with a decrease in both unfilled Registered Nurse and Health Support Worker shifts on the previous 6 months.

Good workforce planning includes access to a temporary workforce to manage vacancies and other unavailability and to have nursing staff available to be responsive to service user's needs. This enables flex in staffing capacity as demand fluctuates.

The high number of vacant shifts which have been reliant on bank and agency to fill has exceeded this resource for both registered and unregistered staff as demonstrated above. This has been significantly impacted by the high number of Registered Nurse vacancies, which additional Health Support Worker shifts have been created to backfill when no Registered Nurse has been available. When the proportion of temporary staff becomes too great, this can potentially impact on the quality of care provided as temporary staff are less likely to know the service and service users well, and therefore less able to effectively meet the needs of service users. Positively, there has been a decrease across the data period of the number of unfilled shifts relating to Health Support Worker duties and Registered Nurse duties have decreased by 10%

To mitigate the potential impact on the quality of care a number of these shifts have been carried out by substantive staff working additional duties or bank staff/agency staff who work regularly in a preferred clinical area and therefore are familiar with both the patient group and service. In turn, this offers continuity of care and any potential negative impact on the quality of care provided.

5.1 The Responsive Workforce Team

Fluctuating activity, acuity changes, staffing unavailability and seasonal pressures are part of the standard operational demands. The Responsive Workforce Team (RWT) was created in order to improve the way our services respond to these challenges, improve quality and consistency of care whilst reducing our dependency on external agencies.

The Responsive Workforce Team comprises a group of unregistered bank staff who are substantively employed by LYPFT on fixed term contracts and are deployed peripatetically to respond to short-notice service needs.

The primary function of the Responsive Workforce Team is to provide short-term cover for hard to fill posts, by a team of skilled, internally trained, peripatetic workers to avoid staff shortages and inflated agency costs. The deployment of the Responsive Workforce Team is more planned and managed than the use of bank staff, and (unlike bank staff) the responsive workforce staff waive the ability to self-select the location of work and the shifts worked.

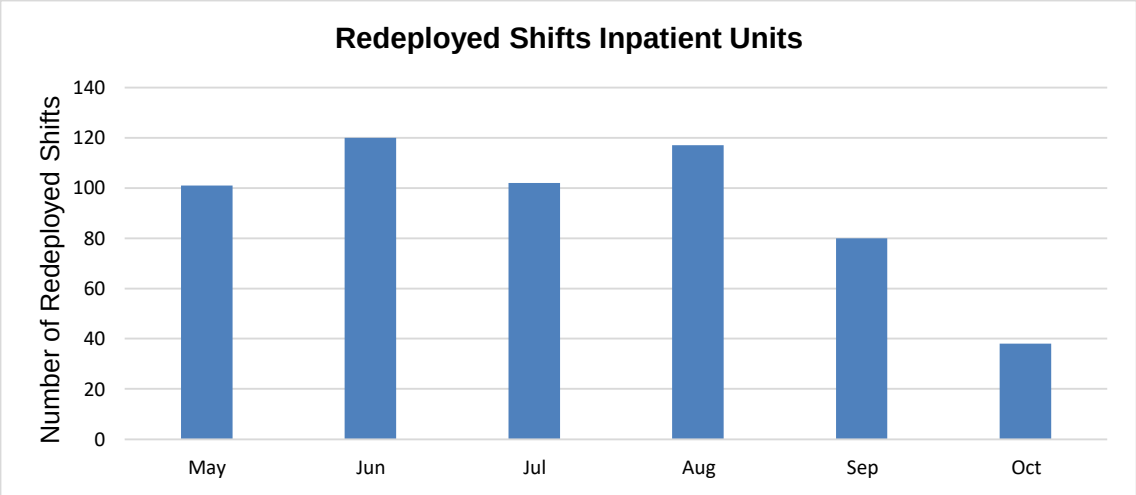
The Responsive Workforce Team was set up in response to the pandemic and the exacerbated workforce pressures. Projection data is proactively analysed and shared with the Safer Staffing Group including vacancies, sickness, and unavailability (e.g. maternity leave) and this data combined with operational insight, provides a projection at 1, 2 and 4 weeks on all issues affecting the potential ability to meet safe staffing.

LYPFT currently have 15 Health Support Workers (HSWs) working as part of the Responsive Workforce Team across 6 inpatient services.

Further work is now being progressed in collaboration with the Safer Staffing Group to identify how we can use the distribution of the Responsive Workforce Team more dynamically to respond to the daily fluctuating demands in a more responsive way as opposed to the planned deployment and rostering projections.

5.2 Deployment of Staffing

Redeployed Shifts - All Inpatient Units 1st May 23 – 31st October 23.



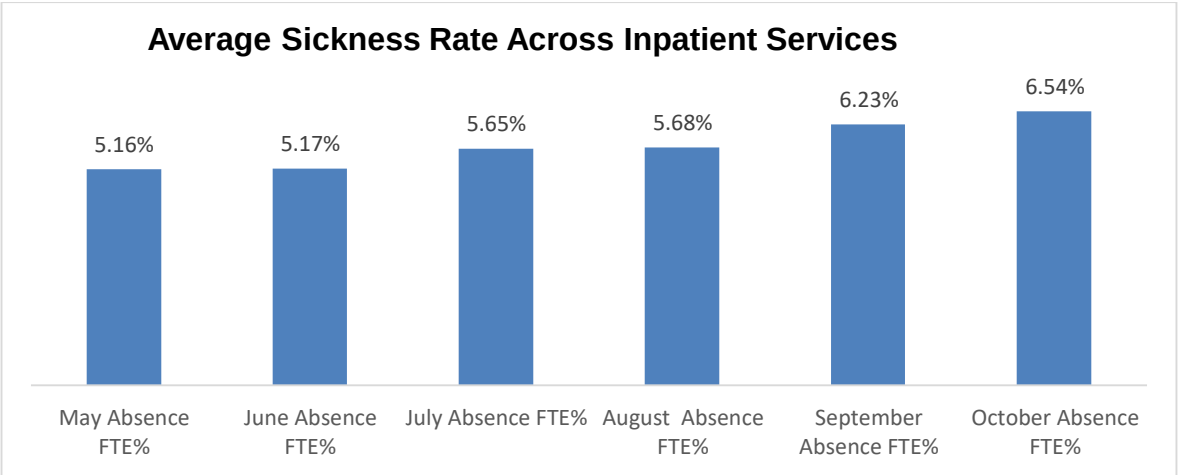
The above graph illustrates a total of 558 staff who were required to be deployed from their home ward to other clinical areas across the 6-month data period to support the safe staffing of our inpatient areas. This was a significant reduction from the previous 6 months where 838 staff were recorded as being deployed.

The number of staff needing to be deployed significantly reduced in the month of October with 38 staff being deployed against the highest month, June where 120 staff are recorded as being deployed.

This data needs to be approached with some level of caution due to the reliance on manual adjustment of the rota to capture the deployments which is known to be less accurate for the deployment of Health Support Workers, particularly when this is within their own service area.

6.0 Inpatient Sickness Absence Unavailability

The following chart demonstrates the sickness absence rates across the data period 1st May 2023 to 31st October 2023.



During this period sickness absence across all inpatient services on average, ranged from 5.16% to a peak of 6.54%. This is a reduction in average sickness from the previous 6 months where the average ranged between 7.15% to a peak of 9.31%.

The Trusts target for sickness absence according to our Informatics and Performance system (Echo) is 6%. The above graph demonstrates that the average across the inpatient units was below target until September, followed by an increase which has been exceeded to the end of the reporting period. It is important to recognise that this is an average across all inpatient wards and some individual areas have higher sickness rates than the Trust target.

The Trust has made considerable progress in supporting colleagues with health and wellbeing needs. Workforce pressures are known to be a contributory factor impacting on wellbeing and subsequent higher than usual sickness absence rates.

The introduction of a Critical Incident Staff Support Pathway (CrISSP) which commenced in January 2022 has been instrumental in supporting individual colleagues and teams through responding to all critical incidents that are recorded as high-level harm or through the direct request from Team Managers/Leaders. Together with trained facilitators across the organisation, the initiative has supported over five hundred colleagues requiring such support. The following table illustrates the number of sessions facilitated and the number of staff supported between 1st May 2023 and 31st October 2023.

Number of sessions	Number of staff supported
27	125

To further 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 currently being rolled out Trust wide alongside a Ward Wellbeing Buddying system.

The following table illustrates the number of training sessions delivered and the number of staff attending the sessions to date.

Number of training sessions	Number of staff attending the training session
15	121

The commencement of the Ward Wellbeing Buddying initiative, in collaboration with Wellbeing Team colleagues had been rolled out to:

- Acute Inpatient and PICU Service
- Leeds Forensic Inpatient Services
- CYPMHS at Red Kite View and Mill Lodge
- York Forensic Service
- Older Adult Inpatient Service

This will be extended to the remaining inpatient services in the coming months.

7.0 Vacancies

Vacancy management identifies how the organisation effectively manages its vacancies and workforce size.

The table below breaks down the funding allocated to Band 3, Band 5 and Band 6 posts by headcount. It also identifies how many staff were in post and the vacancy factor by month.

All Inpatients

	Band 6 Nurse					
Period	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Funded	120.50	121.50	121.50	121.50	121.50	121.50
In Post	98.55	99.88	103.88	100.72	102.32	101.52
Vacancy	-21.95	-21.62	-17.62	-20.78	-19.18	-19.98
Percentage	-18.22%	-17.79%	-14.50%	-17.10%	-15.79%	-16.44%

	Band 5 Nurse					
Period	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Funded	238.52	236.72	236.72	236.72	236.72	236.72
In Post	140.97	134.57	130.30	133.70	140.90	154.50
Vacancy	-97.55	-102.15	-106.42	-103.02	-95.82	-82.22
Percentage	-40.90%	-43.15%	-44.96%	-43.52%	-40.48%	-34.73%

	Band 3 Health Support Worker					
Period	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Funded	352.47	386.07	387.07	387.07	387.07	387.07
In Post	332.90	334.50	332.65	330.45	327.98	332.17
Vacancy	-19.57	-51.57	-54.42	-56.62	-59.09	-54.90
Percentage	-5.55%	-13.36%	-14.06%	-14.63%	-15.27%	-14.18%

Band 5 Registered Nurse vacancies remain the most challenging role to recruit to with a vacancy rate ranging from 34.73% - 44.96% (82.22 – 106.42 WTE posts). Over the last 6 months the vacancy rate for Band 5 Registered Nurses peaked at 106.42 (44.96%) in July however since that time there has been a 10% decrease in the vacancies to 82.22 (34.73%) in October. Detail of some of the ways recruitment has taken place can be found in the next section of the report.

As the most challenging role to recruit to, Band 5 vacancies are highly dependent upon new registrants graduating from Universities in September/ October each year. Additional Band 5 vacancies are also created because of successful career progression and the current Band 5 nursing workforce moving into Band 6 opportunities within the Trust. There are however, a number of Band 5 staff that move to other organisations to gain promotion where internal applications fail.

7.1 Recruitment and Pipeline Data

Nursing and AHP recruitment activity across inpatients wards 1/05/23 – 31/10/23

Role	No of vacancy adverts	Advertised WTE	Appointed WTE	Change in appointed WTE vacancies since 31.4.23
Band 5 Nursing (Non Preceptee)	63	106.5	23.0	14.4 increase
Band 6 Nursing	104	148.55	43	25.0 increase
Band 5 Practitioners/ AHP Roles	160	304.0	56.0	55.0 increase
Band 6 Practitioners/ AHP Roles	28	21.0	10.0	7.0 increase
Healthcare Support Worker	67	182.8	54.0	28.02 increase
Total	**422**	**762.85**	**186**	**129.42 increase**

Preceptees 2023*

Role	Applied	Appointed WTE
Local	33	33
Out of area	34	31
Total	67	64

**This data does not include any preceptee that was recruited as a service BAU recruitment.*

The above data consists of 2023 third year students as part of the local preceptee programme.

- 67 students completed career conversations to be allocated a preceptee post.
- 3 students withdrew.
- Combining local and out of area placements, the 2023 cohort totalled 64 WTE.

For the reporting period 1st May 2023 – 31st October 2023 there were 422 recruitment episodes for Inpatient Services raised for 534.85 WTE.

Within these episodes, this resulted in:

- 3,452 applications
- 775 applicants interviewed
- 226 conditional offers
- 186 WTE Nursing, AHP and additional clinical new colleagues starting.

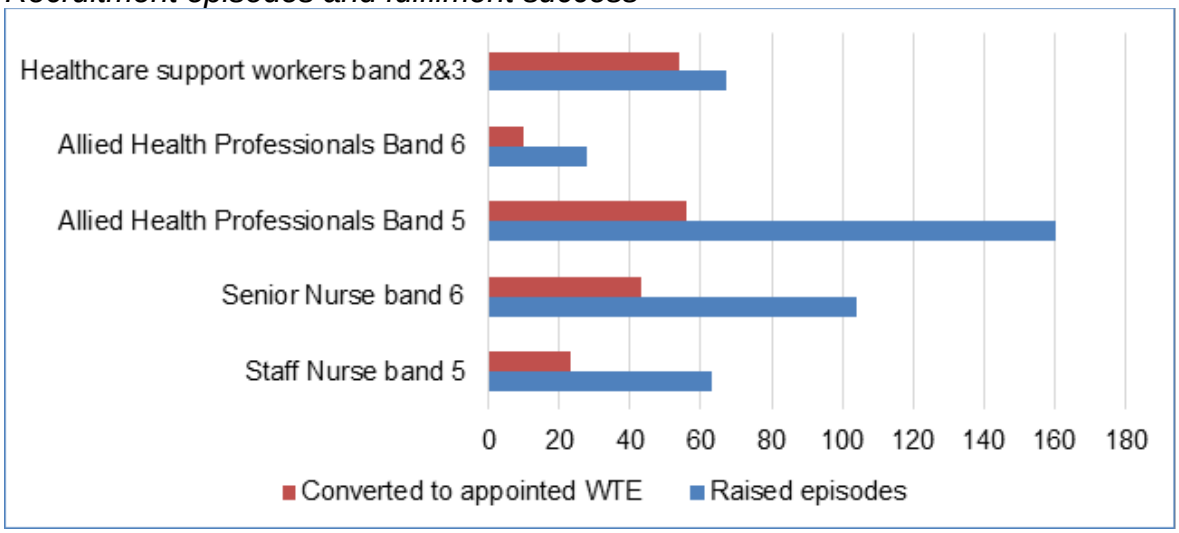
Service Level Agreements (SLA's) are being maintained with time to hire (conditional to unconditional) currently at 23 days which sits well below the SLA of 27 days.

Recruitment incentives across hard to fill roles were audited for their return on investment. The finding was taken to People Resourcing and Retention Group in July 2023, where approval was granted by the Group to keep the current recruitment incentives in place for a further 12 months so that improvement could be made to data collection and reporting to properly analyse return on investment.

A significant amount of work has been undertaken in 2023 to improve multiple recruitment processes, including a large project to overhaul the Trust's current Recruitment and Selection policy with focus on safe recruitment, including important risk mitigating changes to the Healthcare Professionals Condition to Practice Procedure. An audit of the DBS Update Service Project and action plan to improve uptake, an audit of the Trust's current applicant tracking system Trac to ensure its fit for purpose, an audit and renewal of the Trust's LinkedIn Recruiter license to continue the move towards proactive recruitment, reducing agency spend and increasing talent pipeline and implementing improved reporting on recruitment equality, diversity and inclusion following recommendations from the Trust's recent ED&I audit.

This is in addition to creating service specific recruitment plans for areas of the Trust experiencing high recruitment challenges which require bespoke marketing campaigns, and dedicated resourcing projects for Out of Area supporting Growing for the Future.

Recruitment episodes and fulfilment success



7.2 Preceptees

The Practice Learning and Development Team (PLDT) commenced the recruitment engagement with third year nursing students in December 2022 with a Trust Recruitment event. There had been a significant reduction in third year nursing students from our local universities. LYPFT have therefore been required to extend their engagement regionally to fulfil our preceptee recruitment vacancies.

A shortfall of 40 candidates for 2023 preceptorship programme from local universities was acknowledged and therefore a new Out of Area (OOA) recruitment campaign for all universities across the country was developed. This was done in 3 cohorts due to the volume of applicants.

Results

- 32 Leeds students appointed as part of the long-standing agreement.
- 32 OOA students appointed under the new scheme.
- 64 preceptees in total for September 2023 = 51% increase on 2022.

We have continued to offer a broad range of student placements for Allied Health Professionals (AHP), 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 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.

Prior to all the preceptees starting in their clinical roles, the PLDT have facilitated two study days called "transition training", with the following outcomes achieved:

- An enhanced confidence to translate skills learnt through an undergraduate course to the preceptorship period.
- A better synthesis and networking of the undergraduate course content to provide the platform to practice.
- An understanding of the continuing learning that occurs in all practitioners (everyday, a learning day) such that this lesson provides added confidence in the about-to-qualify-practitioner. The understanding and peace of mind that those confident practitioners around them do not know everything and no-one expects this from them.
- A better understanding of the debrief and learning process.

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. 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 main themes of the one-to-one work so far are:

- Increasing confidence
- Improving delegation skills
- Career advice
- Personal/professional development
- Pre-retirement career conversation

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 not only stay within the Trust but also to stay well and in the right roles for them.

7.3 International Recruitment

LYPFT welcomed three International Nurses (IN) into the Trust with investment in internal resources to continue to grow our International Nurse Recruitment programme over the next 2 years. LYPFT are currently working with internal and external stakeholders to review established systems and processes which will help the international recruits transition into the country and ensure robust pre-employment checks and a supportive pastoral package are embedded. The pastoral package is also expanding, further supported by the 'Stay and Thrive' funding which is allowing us to introduce reciprocal mentoring and an annual calendar of cultural transition events.

We continue to work closely with our mental health collaborative partners from the Yorkshire and Humber region together with colleagues from NHS England in looking at national International Nurse Recruitment priorities, measuring progress against plans and timescales, identifying risks, and formulating plans to mitigate/avoid risks. This has enabled good decision making whilst maintaining consistency and equity across the regional providers.

7.4 NHS England Health Care Support Worker Programme

We have worked consistently and proactively to reduce our overall Health Support Worker (HSW) vacancy levels as members of the NHSE HSW programme[1] and are in the process of developing a HSW Strategy to focus on:

- Responding to increased demand for HSWs, supporting the delivery of the ambitions laid out in the Elective Recovery Plan, the Long-Term Plan and Winter Surge Planning.
- Reducing reliance on temporary staffing, therefore increasing quality of care and driving efficiencies.
- Supporting a diverse and inclusive workforce by widening access to the HSW role.

[1] https://www.england.nhs.uk/nursingmidwifery/healthcare-support-worker-programme/

The National programme has four strategic objectives as follows which will form the structure of the strategy:

- Attraction
- Innovative Recruitment
- Learning and Development
- Recognition and Value

Work on the programme to date has included the creation of promotional recruitment materials such as a virtual tour. This has also included regular recruitment campaigns supported via Indeed, Heart Radio campaigns and regional/place-based collaboration.

7.5 Apprenticeship Strategy / Central Backfill

To maintain and improve working relationships with internal stakeholders, engagement activities have taken place across several areas of LYPFT. The team have engaged with Ward Managers and Matrons around the Trust's ambition of one apprentice HSW per ward, which has created a renewed interest in recruiting to these posts in some services.

In June, monthly apprenticeship progress reports were implemented to all services. Operational Managers are also provided with performance updates in relation to the Trust's strategic apprenticeship objectives.

In July, an Apprenticeship Prospectus was launched for external candidates to promote LYPFT as an employer of choice for apprenticeships. The team has continued to actively engage in Leeds Collaborative Apprenticeship Working Group and T Level Steering Group.

7.6 Centralised Backfill Funding

Centralised funding to cover the cost of 20% 'off the job' time for Nursing and AHP Apprenticeships has enabled recruitment of 8 Trainee Nursing Associates and 3 Transfer to Nursing Apprentices, who started on the programme in October.

Further recruitment in October resulted in offers being made for 2 centrally funded apprentice Occupational Therapist and 7 Transfer to Nursing (top-ups) post. These apprentices, in addition to two Nursing Associate deferrals are planned to start on the programme in February 2024

7.7 Talent Development and Retention

Personal Development Reviews (PDR) incorporating a Career Conversation are a key element of the Trust's inclusive Talent Development Framework supporting every colleague to be their best self, identify their aspirations and provide appropriate support and development to enable them to progress in their careers.

Focused work is ongoing to raise the Trustwide PDR compliance rate with 83% compliance being reached against a KPI of 85%. This is a result of a significant amount

of work from our managers and individuals to engage in the process and new Perform system.

A Social Work Career Pathway has been developed and incorporated into the Trust's Career Pathway document, available for all staff to access on Staffnet.

A Development Roles process was launched in September to provide a consistent approach 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 an individual to achieve the competencies required of the substantive role and pay band. The process includes clear advice for monitoring performance and competence development and outlines the steps for individuals who do not meet the expectations of the role, despite being trained and supported to do so.

A new Exit Interview process has been launched which includes an easily accessible Smartsurvey link. Individuals can either complete the questionnaire independently or following an exit interview with their manager or if preferred another member of the Management Team or People & OD Directorate. Individuals and Managers are engaging well in the new process, which will enable the Trust to identify and understand any patterns and trends across the organisation.

Flexible Working – the recommendations of the Flexible Working Group have been supported by the Trust with work commencing now on the identified priority areas: procedure and process review, support and guidance for managers, engagement of pilot sites to test recommended approaches. These priorities will support the culture change needed to adopt an organisation wide YES mindset and approach.

8.0 Quality Indicators

The Safer Staffing Group have been working together to identify a series of quality indicators which can be used to triangulate workforce information recommended in the guidance produced by the CNO of England and the National Quality Board[2] in which to support the review of safer staffing levels. More specific guidance for mental health wards has also been developed which has also been used to support the work[3].

The data details a range of metrics across each inpatient service relevant to aspects of patient safety, clinical effectiveness and in turn patient experience and being used to support clinical service establishment reviews alongside care hours per patient day (CHPPD) and MHOST data, to understand how staff capacity may affect the quality of care.

[2] https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf

[3] https://www.england.nhs.uk/wp-content/uploads/2022/03/Safer_staffing_mental_health.pdf

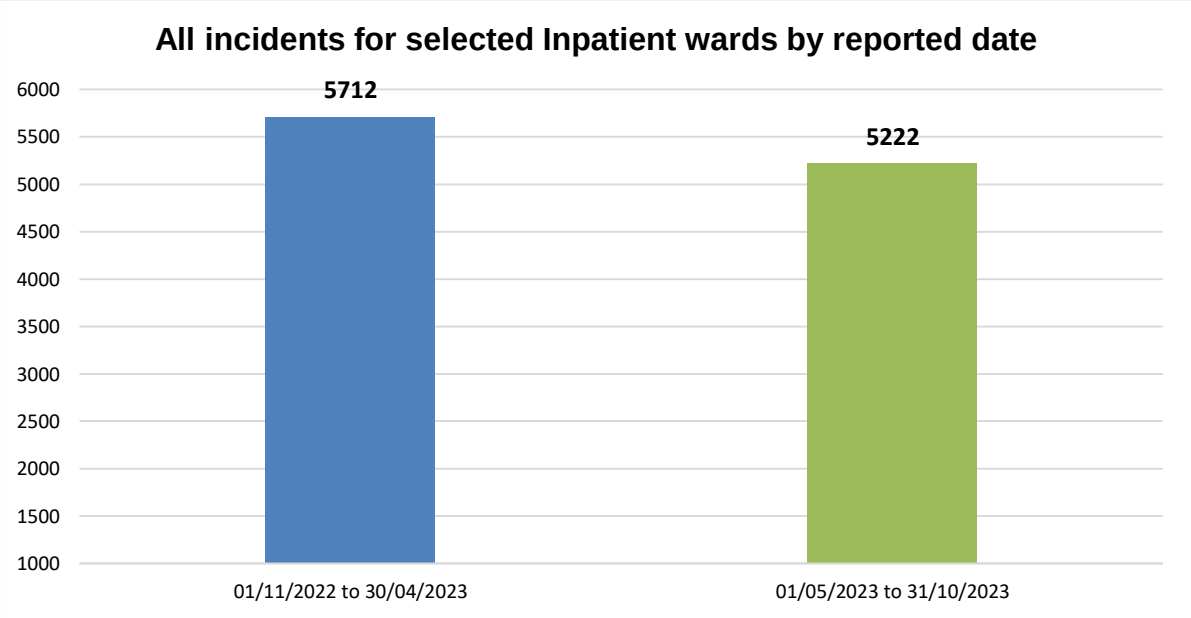
8.1 Incident data

Total number of Incidents

The number of incidents experienced and reported is impacted by many variables however, there is a wealth of evidence which suggests a relationship between the number of Registered Nurses and patient safety, with evidence suggesting nursing workforce and staffing levels and clinical patient outcomes are correlated.

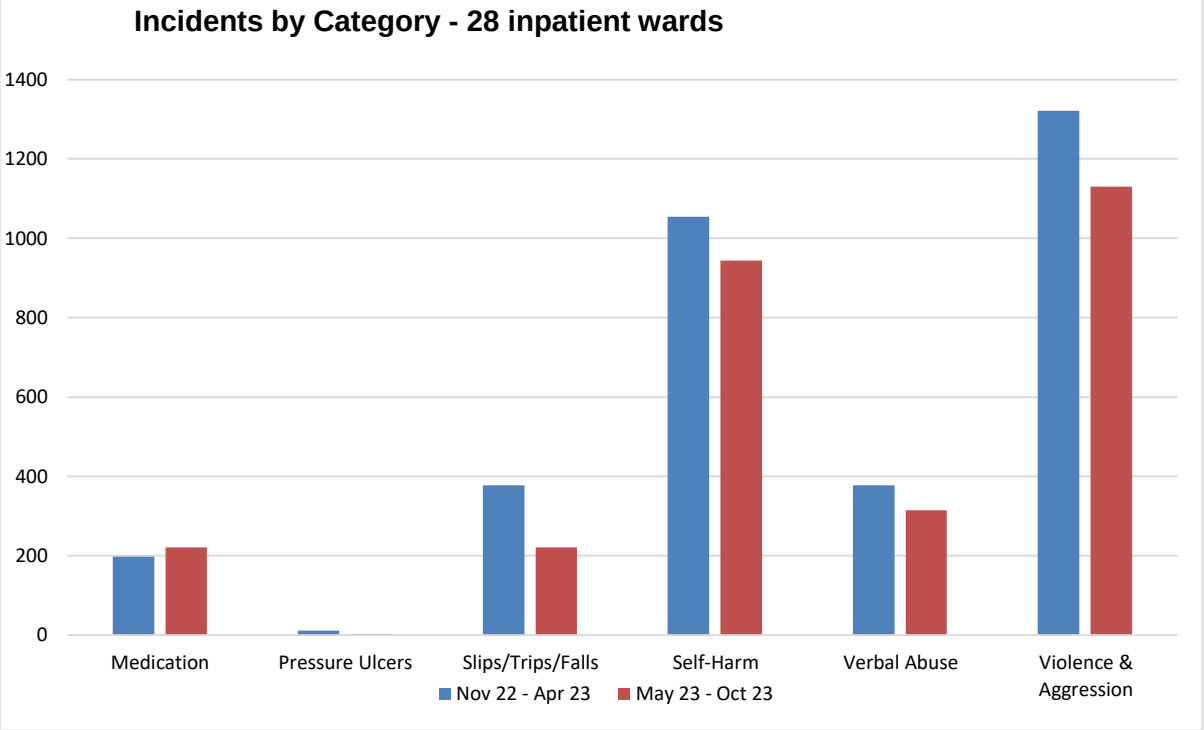
The comparison chart below demonstrates the total number of incidents reported for the data period 1st May 2023 to 31st October 2023 against the six-month previous to this period.

The chart highlights that there was a decrease of 490 incidents in the overall number of incidents reported across the 28 inpatient wards.



Total Number of incidents by category

The graph below details incidents by category for the period May to October 23 and the previous six-month period. A reduction in all incident categories is evident during May to October 23 on comparison to the previous six months. The only exception is medication related incidents which has seen a slight increase.



A series of clinical improvement initiatives and workstream are also currently being progressed to support the reduction of service user harm which may also account for a reduction in incident data alongside the impact of staffing and workforce.

Violence and Aggression
The Positive and Safe Working Group provides leadership and oversight in many quality improvements initiatives that are impacting directly on our inpatient activity. Care planning meetings, reflective forums, post incident reviews and post incident de-briefs are becoming valuable in staff sharing concerns, problem solving to reduce recurrence of incidents that may result in violence and aggression that in turn may require the use of restrictive practice. Several wards have adopted safety huddles to address issues around conflict behaviour such as violence and aggression, self-harm and/or absconding; proactively identifying situations that may require restrictive interventions and seeking alternative collaborative solutions to avoid escalation.

Self-Harm
A working group to focus on the development and implementation of a self-harm strategy has recently been established. Several pieces are underway identifying learning from other organisations to learn what has worked well with lived experience involvement. In response to an increase in the number of incidents in relation to ingestion and headbanging, guidance has been developed to support colleagues in the management of these types of self-harming behaviours. Further actions include training for staff in line with the NICE Guidance.

Falls and Pressure Ulcers
The Falls and Pressure Ulcer Improvement Forum meets bi-monthly and all incidents of severity 3 and above are discussed to identify any individual or thematic learning

across care services. The group will be commencing a quality improvement initiative planned for early 2024, focussing on falls prevention in the older people's service.

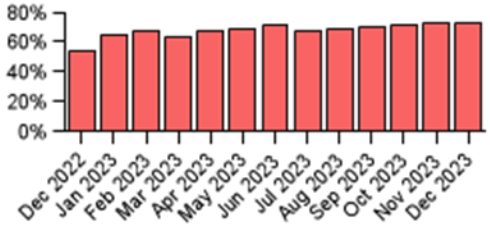
Medicines
Medication errors and themes are discussed within Medicines Safety Committee which is attended by representatives from a range of services. Key messages are taken from the learning and disseminated via Trustwide Communications and via the Unified Clinical Governance Group.

A number of services have local Medicines Management Groups to discuss medication incidents.

As part of some recent learning with regards to medication administration errors, a group of Practice Development Nurses have produced a new Medication Competency Framework which is currently being rolled out in the Trust.

8.2 Clinical Supervision

The below graph details Trust wide compliance rate for clinical supervision.

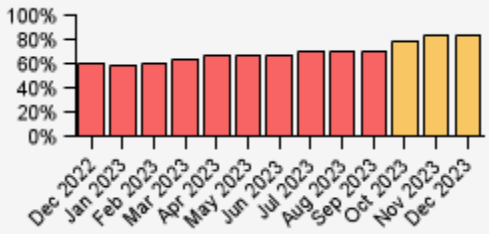
Indicator	Target	Aug 2023	Sept 2023	Oct 2023	Trend
Clinical Supervision	85.00%	68%	69.77%	71.67%	

Compliance with clinical supervision has continued to increase over the 6-month period, reaching 71.67% in October 2023, the highest it had been during the data period.

Effective clinical supervision supports both staff well-being and improves the quality of care delivered to service users. LYPFT have invested in the training of Professional Nurse Advocates across the organisation, a national programme which was launched in response to the pandemic to aid recovery for our workforce. The programme provides the skills to facilitate clinical restorative supervision (CRS) to colleagues and teams in nursing and beyond. A current evaluation of the effectiveness of CRS is currently being carried out.

8.3 Appraisal

The below graph shows the Trust wide compliance with appraisal.

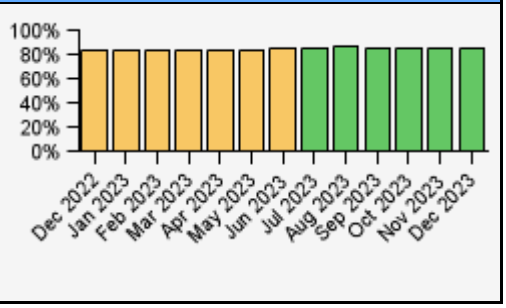
Indicator	Target	Aug 2023	Sept 2023	Oct 2023	Trend
Appraisals	85.00%	71%	70.54%	78.21%	

There has been considerable increase in compliance with appraisals over recent months. As noted earlier in the report, in November, appraisal compliance hit 83%, an increase of 13% since September.

There is a proven link between our colleagues being clear about what is expected of them, having regular feedback on their performance and agreeing to development needs and how this impacts the services we provide. Therefore, ensuring that our workforce have regular performance reviews has a positive impact on our services.

8.4 Compulsory Training

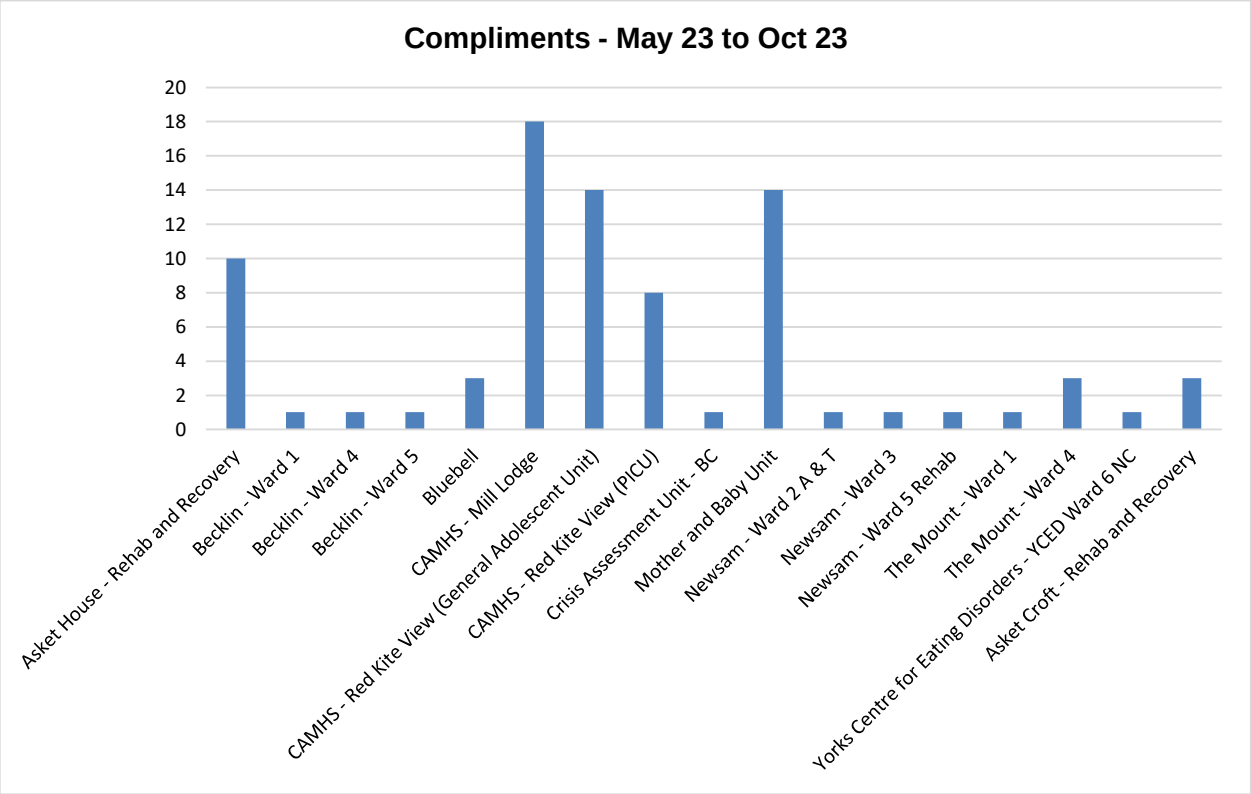
The below graph shows the Trust wide compliance with compulsory training.

Indicator	Target	Aug 2023	Sept 2023	Oct 2023	Trend
Compulsory Training	85.00%	86%	86.11%	86.29%	

Compulsory training is required to adequately protect service users, our colleagues, visitors, and the public by enabling safe practice by a competent workforce.

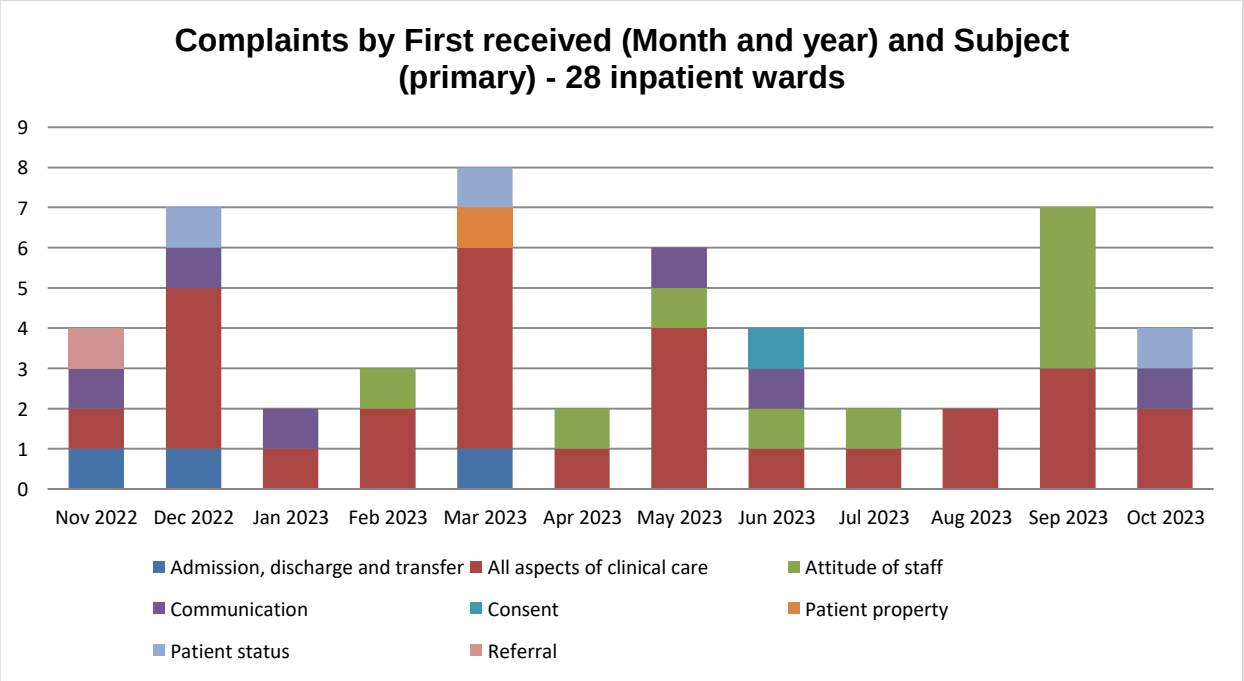
Since July the Trust compliance with compulsory training has been consistently above the target of 85% which is an improvement on the previous 6 months and supports the delivery of safe care.

8.5 Compliments



8.6 Complaints

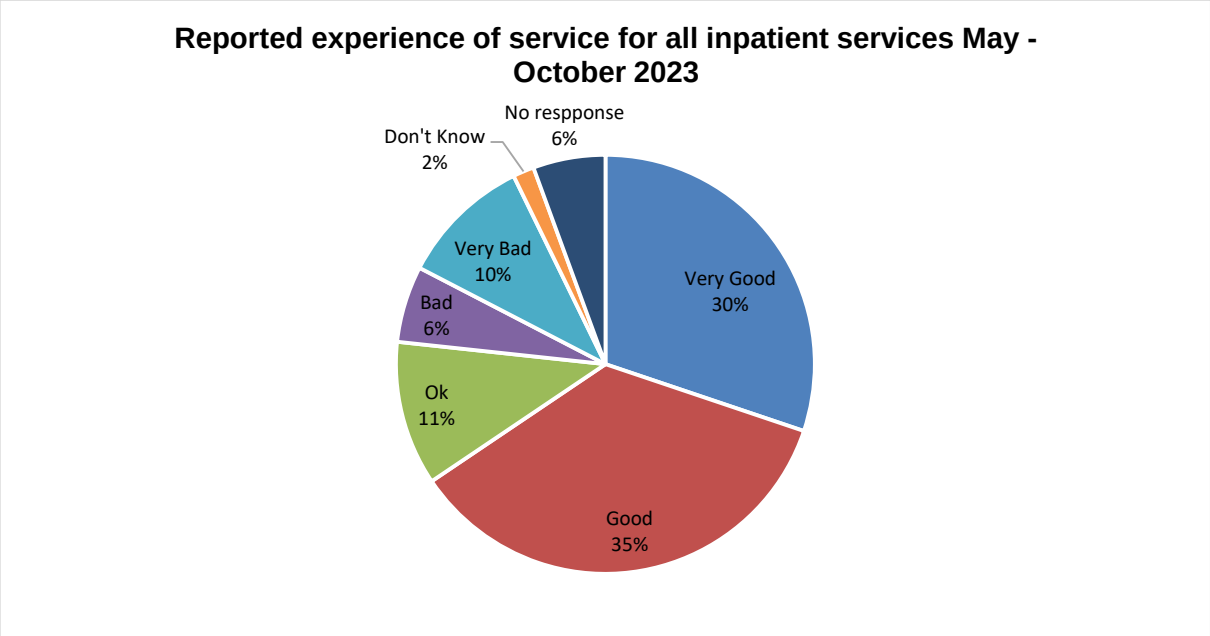
Below shows the number of complaints over the past 12 months. There were 26 complaints in the previous reporting period compared to 25 this reporting period. Complaints can be received for many reasons. It would be expected that when more regular and consistent staff are available, there may be a reduction in complaints.



8.7 Have Your Say

Have Your Say feedback is an important indicator for the quality of care being provided as it gives us direct feedback from the people we provide care to. Across the inpatient wards who have received Have Your Say feedback, 65% reported that their care was “good” or “very good” and 16% reporting this as “bad” or “very bad”.

A high proportion of service users report good care. It would be expected that increased consistency in the staff teams would continue to see increasing reports of good care. Patient feedback is an important aspect to review when considering establishment reviews.



9.0 Acute Inpatient & PICU Service

The NQB, as key guidance, highlights the core responsibility of all Trusts to ensure there is sufficient and sustainable staffing capacity and capability to always provide safe and effective care to patients. The NQB recommends the use of an evidence-based staffing tool, a series of quality metrics and the use professional judgement to inform safe staffing decisions through a triangulated approach and data should not be viewed in isolation.

The following section uses the Acute Inpatient and PICU Service data and information to demonstrate through a focused analysis, the considerations which have been taken by the service when carrying out safe staffing decisions. It further demonstrates how this has influenced the management and mitigation to address workforce challenges to ensure safe and effective care is delivered and how quality outcome data and clinical improvement work supports the ongoing decision-making regarding the staffing establishment.

Background

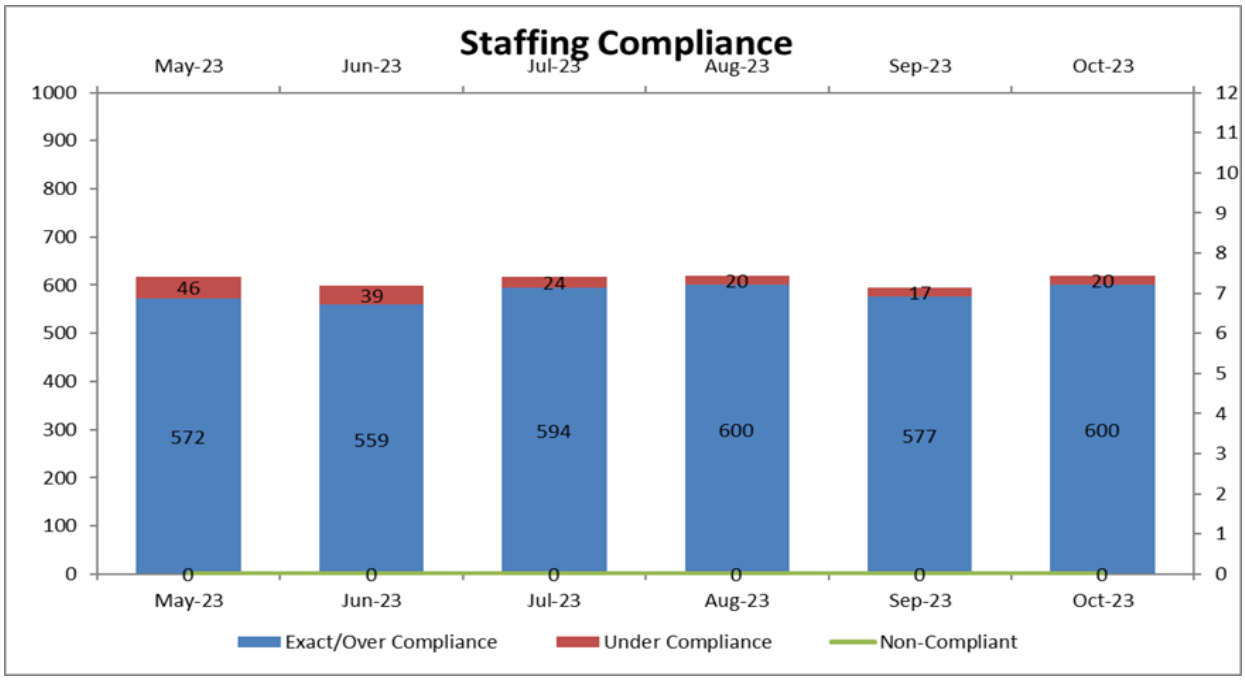
The Acute Inpatient and PICU Service provides mental health inpatient care across five acute wards, which consists of three male wards and two female wards which are 22 bedded except for ward 4 Newsam, which is a 21 male bedded unit. In addition, there is a Psychiatric Intensive Care Unit (PICU) ward which is a 12 bedded mixed sex accommodation.

The acute inpatient's budgeted (planned) establishment is made up of Registered Nurses and Health Support Workers. However, it is acknowledged that service user need is about skill mix as well as the staffing numbers and is about other professions as well as Nurses and therefore the evaluation of safer staffing establishments should be focussed on and including the additional professional specific and alternative roles that all contribute to the provision of care and treatment.

9.1 Workforce

Review of Staffing Activity

The staffing compliance data from 1st May to 31st October 2023 in the below graph details whether the wards met the planned numbers of staffing during a shift.



The graph demonstrates that.

- During this period a total of 3,668 shifts were required to ensure safer staffing in the Acute Inpatient and PICU Service. This is a 2.12% decrease from the previous 6-month period.
- 3,502 (95%) of the required shifts met/exceeded planned staffing numbers. An increase of 3% on the previous 6-month period.
- 166 (5%) of the required shifts did not meet planned staffing numbers.
- All shifts had a RN on duty.

Vacancies

	Band 6 Nurse					
Period	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Funded	26.00	26.00	26.00	26.00	26.00	26.00
In Post	25.30	25.30	27.30	25.50	27.30	26.30
Vacancy	-0.70	-0.70	1.30	-0.50	1.30	0.30
Percentage	-2.69%	-2.69%	5.00%	-1.92%	5.00%	1.15%

	Band 5 Nurse					
Period	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Funded	70.80	70.80	70.80	70.80	70.80	70.80
In Post	34.16	34.16	32.96	30.96	32.36	38.36
Vacancy	-36.64	-36.64	-37.84	-39.84	-38.44	-32.44
Percentage	-51.75%	-51.75%	-53.45%	-56.27%	-54.29%	-45.82%

	Band 3 Health Support Worker					
Period	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Funded	84.12	84.12	84.12	84.12	84.12	84.12
In Post	79.01	78.37	79.01	76.01	75.33	72.93
Vacancy	-5.11	-5.75	-5.11	-8.11	-8.79	-11.19
Percentage	-6.07%	-6.84%	-6.07%	-9.64%	-10.45%	-13.30%

The data demonstrates that the number of Registered Nurses has decreased and there has been less reliance on bank and agency staffing with less shifts unfilled.

The service has an overall vacancy rate of 23% which includes x 2 Occupational Therapists; however this has been mitigated through the block booking of bank/agency staff which supports the delivery of consistency of care and treatment to the service user group. The service also has access to Physiotherapy, Dieticians and Speech and Language Therapist and 3 Psychologists. This ensures access to the right support from the right professional in a responsive and timely way.

The introduction of Activity Coordinators across the service has increased the offer of therapeutic activities and group work. The opportunity to engage service users in meaningful therapeutic activity benefits patient outcomes, optimises their experience of care and enhances personal recovery.

Practice Development Leads support the leadership across the service and support staff development.

Recruitment

The below chart demonstrates the recruitment activity for the Acute Inpatient and PICU Service between May and October 23.

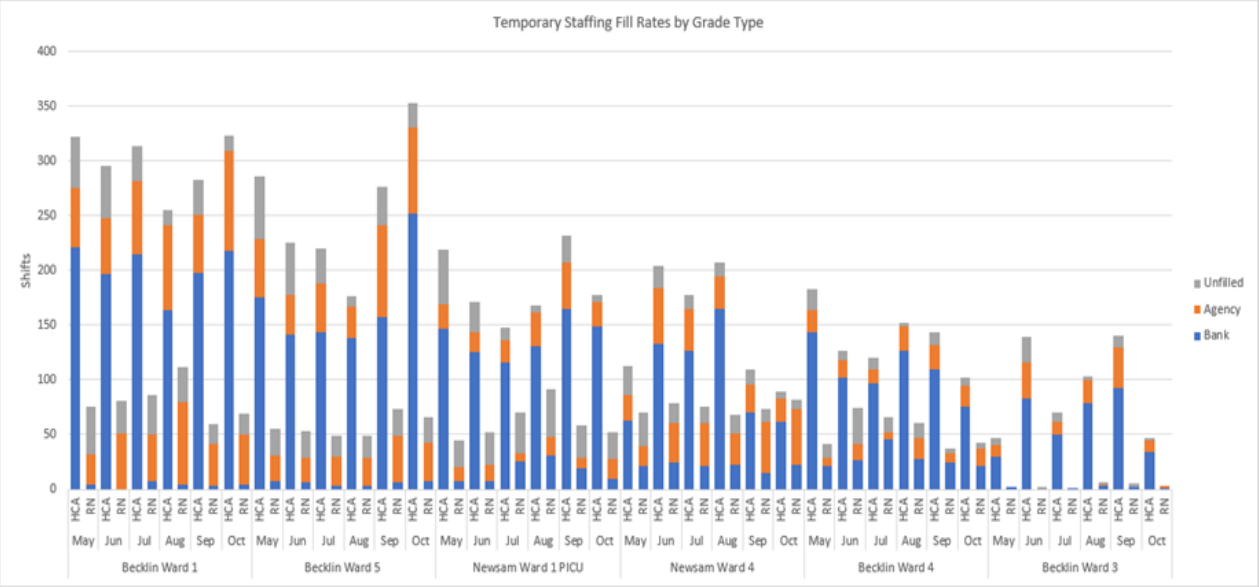
Role	No of vacancy adverts	Advertised WTE	Appointed WTE
Band 5 Nursing	2	6	4
Band 6 Nursing	4	10	1
Band 5 Allied Health Professionals	5	5	0
Band 6 Allied Health Professionals	4	4	0
Band 2 & 3 HSW's	14	32	4

The first values based recruitment pilot has taken place within the Acute Inpatient Wards 1 and 5. Rolling out new and improved values based and inclusive recruitment and selection training. The pilot saw an increase in application from a previous average of 36 to 148 applications. Shortlisting and interviews have taken place, and a full evaluation of the pilot is being undertaken to assess the quality of the programme and application to appointment success.

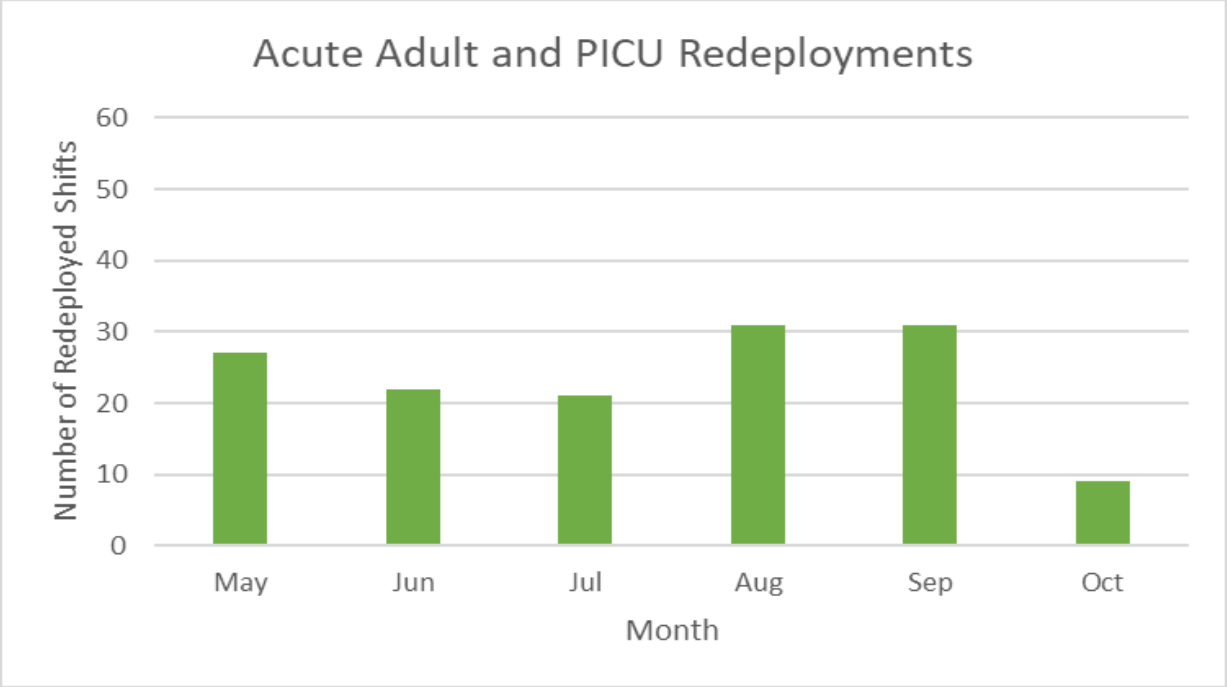
The service has successfully recruited 20 Preceptee Registered Nurses who have commenced in role from September/October 2023, with a local preceptee induction being created to support this group above the Trust Induction and Preceptee Framework Programme. 5 INR have been recruited with 2 recently commencing in post. This will evidence a further reduction in the Band 5 Registered Nurse vacancies as colleagues commence in post.

Bank and Agency

The chart below demonstrates the contribution Bank and Agency staffing make to the service and how the temporary staffing resource is used to manage fluctuating demand, such as an increase in a service user's level of observation and engagement whereby additional staff would be required to deliver this intervention.



Deployment
The graph below illustrates a total of 141 staff who were deployed to a ward within the Acute Inpatient and PICU Service across the 6-month data period to support safe staffing. This is a significant reduction from the previous 6 months where 548 staff are recorded as being deployed.



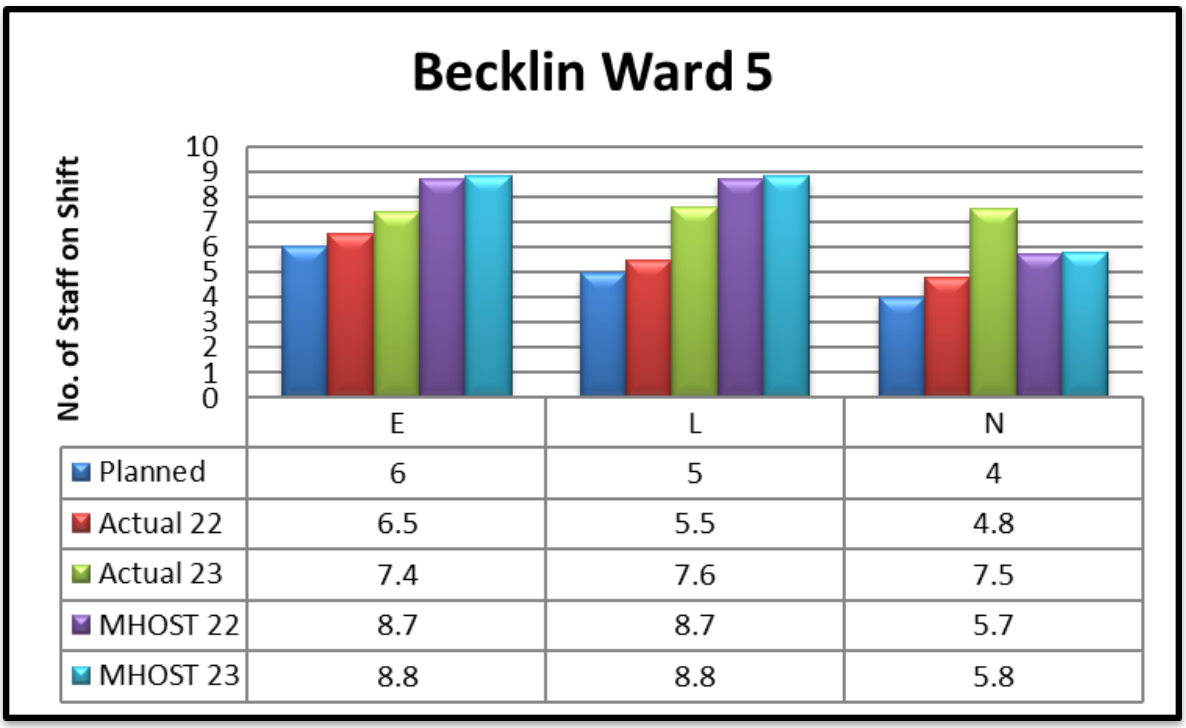
The Responsive Workforce Team
Two of the 15 Responsive Workforce Team have supported the Acute Inpatient and PICU Service during the data period. This has enabled more consistent and appropriately trained staff to deliver care with a reduced reliance of the used of ad hoc bank and agency staff.

MHOST
The MHOST data collection was completed in the Acute Inpatient and PICU Service during the month of September. Each ward submitted individual data and received recommended MHOST staffing levels.

An example of the MHOST outputs for Ward 5 Becklin (Female) and Ward 4 Becklin (Male) have been illustrated below. However, all ward data has been analysed as part of the review and has identified similar outcomes with no outliers or anomalies relating to the recommended staffing numbers.

Ward	MHOST Multipliers	Average number of services users per day	MHOST recommend hours/FTE per dependency level	
			Hours	FTEs
Becklin 5	MHOST 1	2.35	5.3	1.0
	MHOST 2	4.00	6.1	1.1
	MHOST 3	7.23	8.1	1.5
	MHOST 4	4.15	13.5	2.5
	MHOST 5	2.3	25.5	1.1

The data demonstrates the different care level indicators per service user (see Appendix A).

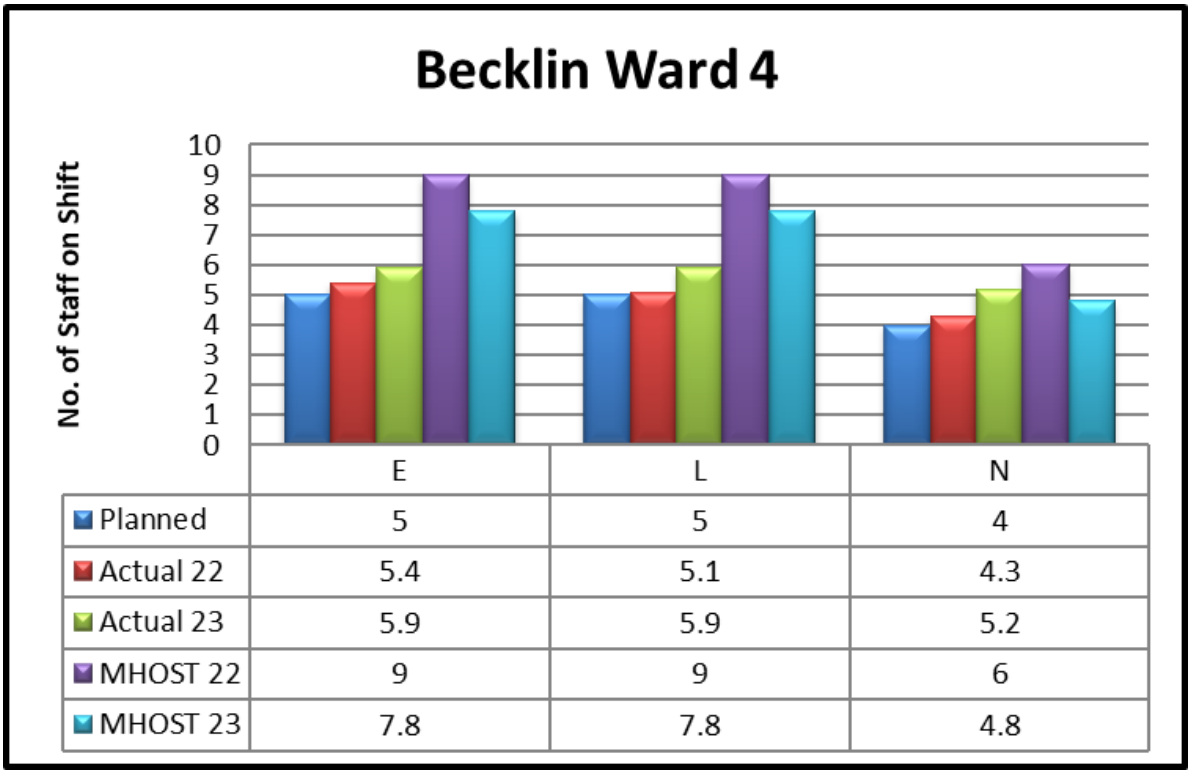


	E	L	N
Planned	6	5	4
Actual 22	6.5	5.5	4.8
Actual 23	7.4	7.6	7.5
MHOST 22	8.7	8.7	5.7
MHOST 23	8.8	8.8	5.8

The recommended MHOST staffing levels tell us that by headcount Ward 5 requires an additional 1.4 WTE on the early shift, 3.8 WTE on the late shift and 1.8 WTE on the night shift.

This reflects similar data to that collected in 2022 and offers an explanation to the ongoing need to use bank and agency staffing.

Ward	MHOST Multipliers	Average number of services users per day	MHOST recommend hours/FTE per dependency level	
			Hours	FTEs
Becklin 4	MHOST 1	5.30	5.3	1.0
	MHOST 2	9.78	6.1	1.1
	MHOST 3	3.43	8.1	1.5
	MHOST 4	2.91	13.5	2.5
	MHOST 5	1	25.5	1.1



	E	L	N
Planned	5	5	4
Actual 22	5.4	5.1	4.3
Actual 23	5.9	5.9	5.2
MHOST 22	9	9	6
MHOST 23	7.8	7.8	4.8

The recommended MHOST staffing levels tell us that by headcount Ward 4 requires an additional 2.8 WTE during the day and 0.8 during the night shift. This is a reduction in headcount from the data collected in 2022. However, although the ward has worked approx. 1 WTE above planned numbers the actual numbers fall below the MHOST recommended headcount.

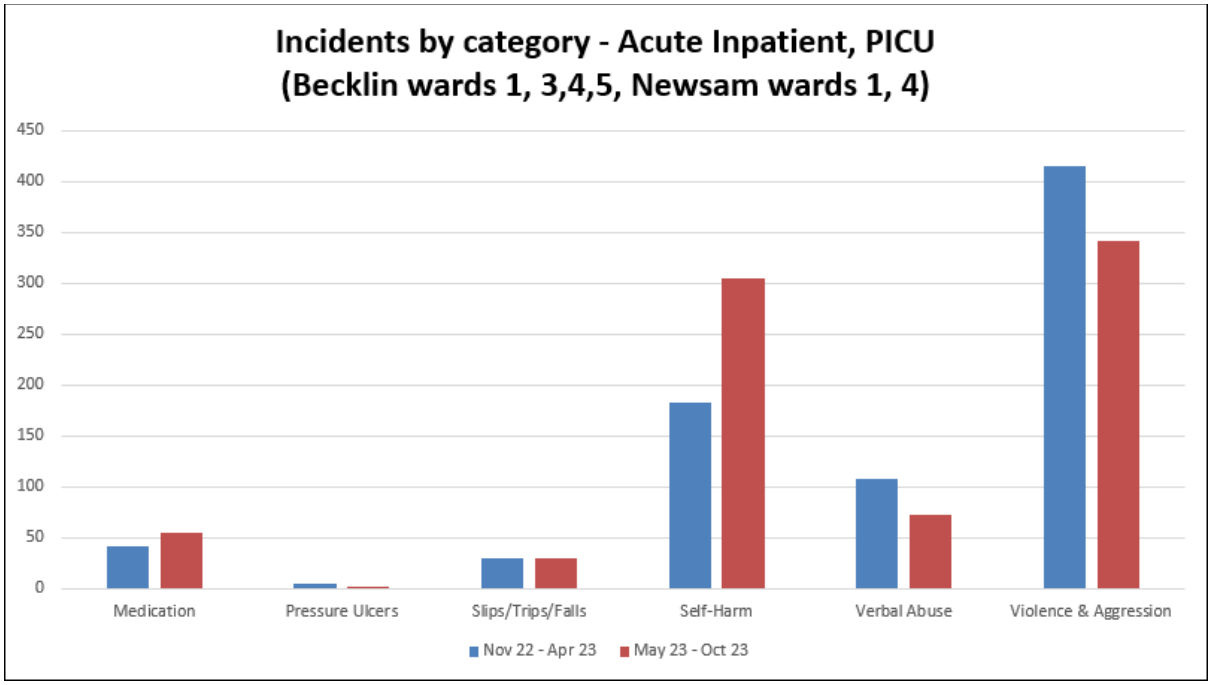
It is important to note that the tool cannot be used in isolation as professional judgement has to be applied alongside quality indicators to make it viable. The delivery of care through the MDT and the professional specific roles, which are not captured in the planned staffing establishment are likely to account for this. A further data collection would be recommended prior to making any changes to staffing establishment.

Quality Metrics

In additional to the MHOST data, mental health quality metrics need to be considered when making safe staffing decisions and reviewing the planed establishment. The quality metrics provide insight into how effective the service is in meeting service user's needs.

9.2 Clinical Outcomes

Incident data

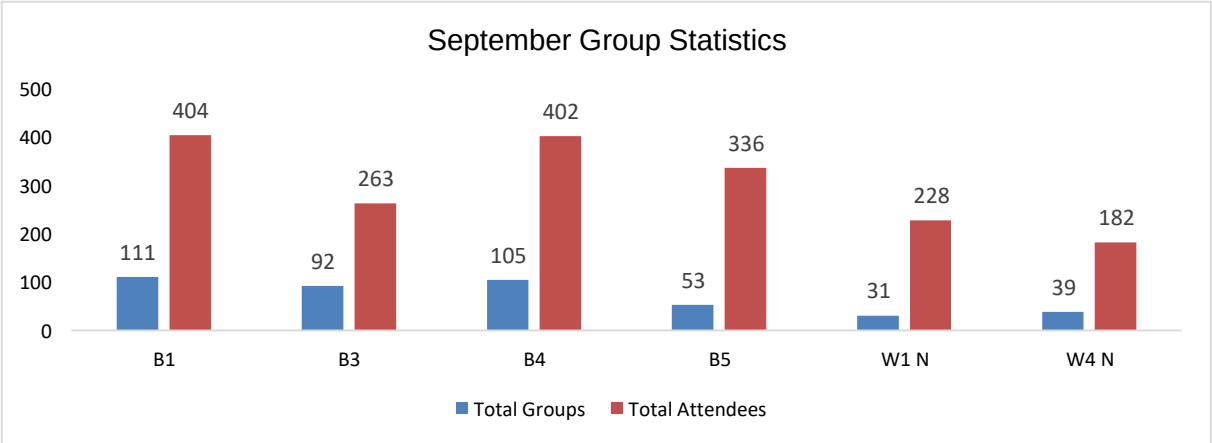


The graph demonstrates a reduction across all incident categories compared with the previous 6 months except for medication and self-harm. Workstreams within LYPFT and service specific improvement work have been developed address these areas of potential service user harm.

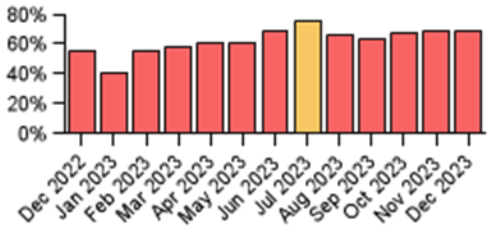
Care Processes

The consistent provision of therapeutic activities and group work is now being delivered following the recruitment of an Activity Coordinators and Occupational Therapy Assistants across all wards. Partnership working with various third sector organisations and volunteers has enabled the service to offer a wide variety of groups.

The graph below details the total number of groups offered in each ward in September and the total number of attendees. Groups were attended a total of 1800 occasions in September across the Acute Inpatient and PICU Service.



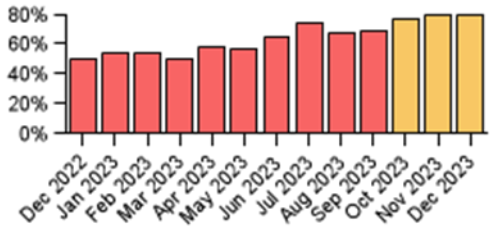
Clinical Supervision Data for the Acute Inpatient and PICU Service

	Target	Aug 2023	Sept 2023	Oct 2023	Trend
Clinical Supervision	85.00%	66%	63.03%	66.67%	

Clinical supervision rates have predominantly increased through the data period however remain below the Trust target of 85%.

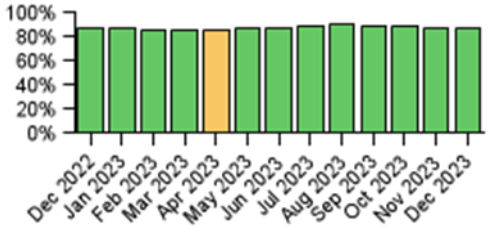
Effective clinical supervision supports both staff well-being and improves the quality of care delivered to service users. This introduction of additional and more flexible approaches to clinical supervision was piloted across the Acute Inpatient Wards for a 3-month period. Compliance was significantly low in this area and positive results were observed with compliance rates rising to above the Trust target at 86% on the pilot ward. The leadership Team reported an improvement in staff morale during this period with increased enthusiasm to engage in quality improvement initiatives. In addition, it provided the opportunity for clinicians to reflect on the care offered, find potential solutions to complex clinical cases which supported decision making. This in turn improved the quality of interventions delivered.

Appraisals Data for the Acute Inpatient and PICU Service

Indicator	Target	Sep 2023	Oct 2023	Trend
Appraisals	85.00%	69.03%	77.36%	

Compliance rates fall slightly below the Trust target of 85%. however ongoing improvement is evident increasing 77.36% in October, this is the highest it has been for over 12 months.

Compulsory Training Data for the Acute Inpatient and PICU Service

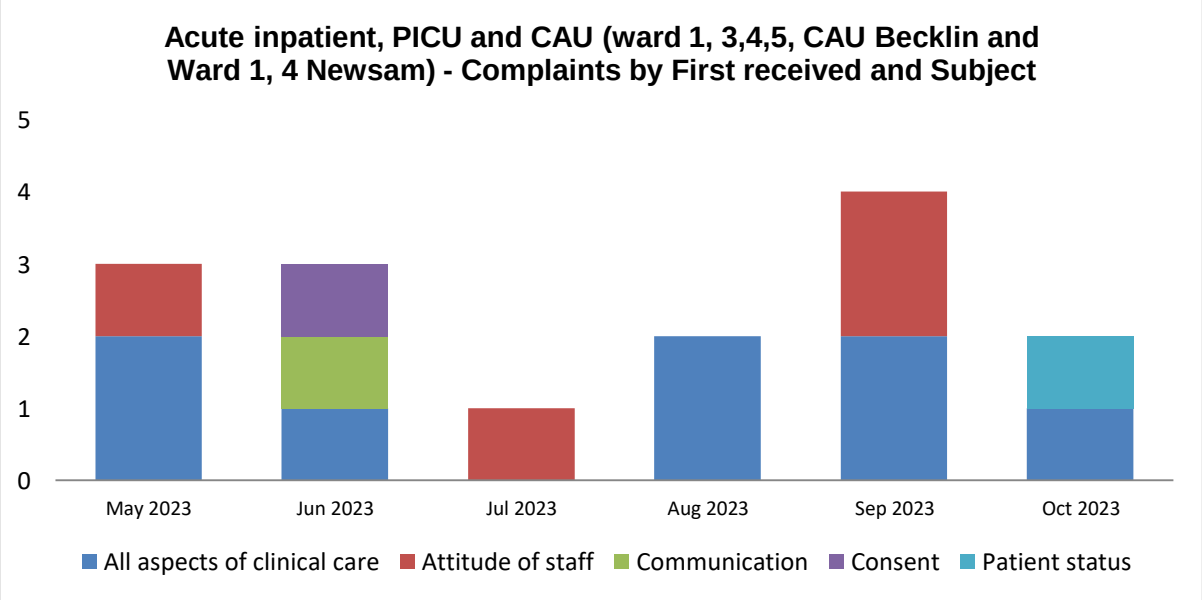
Indicator	Target	Sep 2023	Oct 2023	Trend
Compulsory Training	85.00%	89.46%	88.43%	

The service has met the Trust wide compliance rate for compulsory training over the 6-month period with it being 88.43% for October and demonstrates that staff have the required skills to carry out their roles.

In addition to compulsory training the Practice Development Team facilitate the delivery of various teaching sessions including subject matter experts such as the Mental Health Legislation, Physical Health, Professional Practice Lead for Restrictive Practice, and Pharmacy which supports staff in their continued professional development.

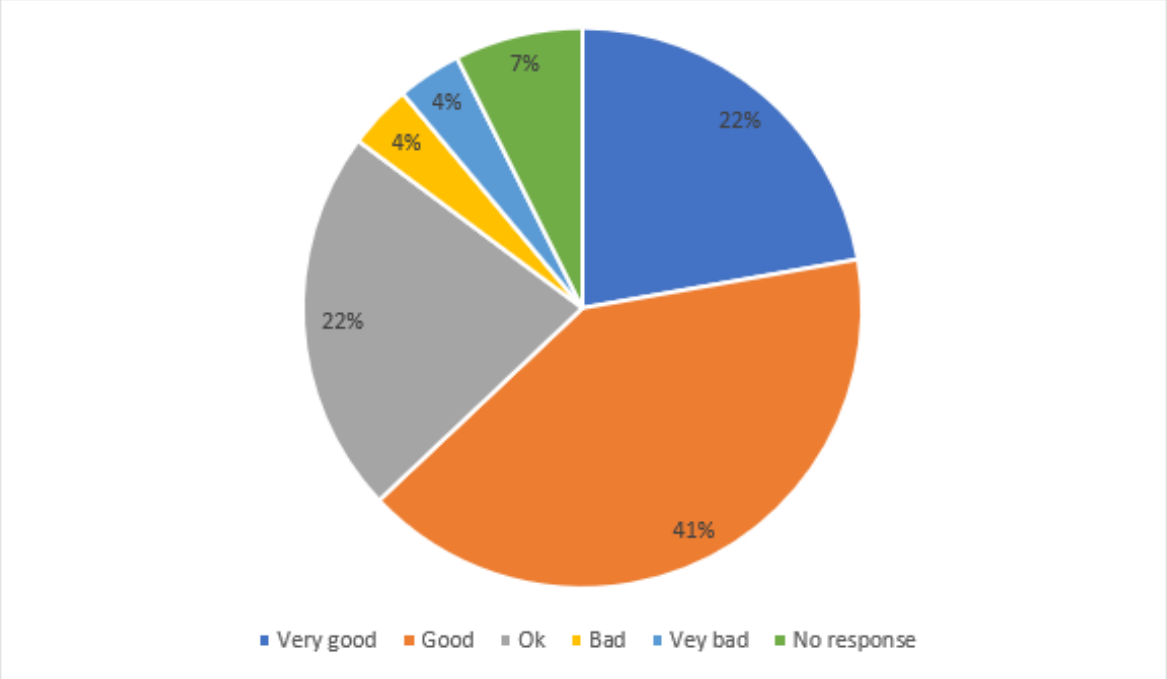
9.3 Patient Experience

Complaints



The above graph details the category of complaints received during the period May-October 23 in the Acute Inpatient and PICU Service. There were 15 complaints received in total during this period.

Have Your Say Feedback

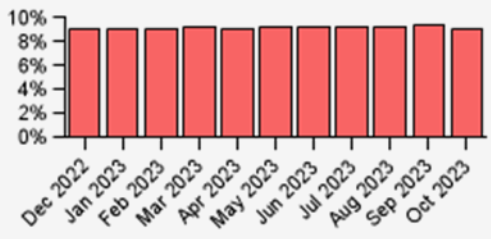
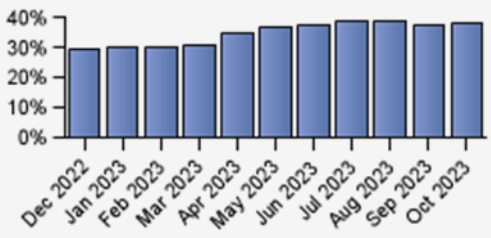


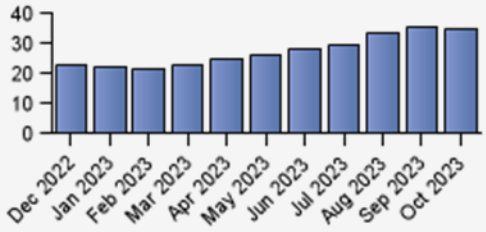
The chart offers a summary of feedback received within the Acute Inpatient Service over the last 6 months which indicates how service users rate their experience of the service. 63% of respondents report that their care was “good” or “very good”. With 8% reporting that their care was “bad” or “very bad”.

Feedback from service users is an important indication of the quality of care received demonstrating that the majority of our service users reported a positive experience.

9.4 Staff Experience

Sickness absence

Indicator	Target	Sep 2023	Oct 2023	Trend
Sickness Absence Rate	6.00%	9.32%	9.11%	
Sickness Absence Stress MH %		37.75%	38.22%	

Ave MH FTE Length of Episode	36	35	

Sickness absence is currently reported as 9.11% 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, with the average length of episode for mental health sickness absence at 35 days. The People and Resourcing Team and the Health and Wellbeing Service are supporting the service with absence reviews and offering support to individual team members as required.

Wellbeing

The focus on wellbeing in the Acute Inpatient and PICU Service has positively impacted on retention within the service. There has been a 100% retention of Band 5 Registered Nurses over the past 12 months. There have been various workstreams to support the health and wellbeing of the workforce within the service which has in turn supported retention.

The overall turnover of the service falls below the Trust target at 4.76%.

The service has a well-established wellbeing group that meets monthly and is dedicated to improving staff experience. Many of the staff are CrISSP (Critical Incident Staff Support Pathway) trained facilitators and/or well-being buddies.

The service has recently developed a wellbeing suite with the involvement of the team with a plan to open in January 2024. The service has also created a Standard Operation Procedure (SOP) to enable staff to use the gym facilities.

Acute Inpatient and PICU Service Summary

The data and information provided relating to the Acute Inpatient and PICU Service demonstrates how a triangulated approach to review safer staffing is essential and reviewing the 3 overarching areas (right staff, right skills, right time and place) as set out in the NQB guidance could potentially mislead should this be reviewed in isolation or offer false assurance.

The service continues to be subject to workforce pressures with sustained vacancy rates particularly in relation to Band 5 Registered Nurses. However, the ongoing commitment from the service to target recruitment improvement initiatives and the commitment to staff experience through induction, continued development and the focus on wellbeing has meant that the vacancy gap has reduced and will continue to reduce over the coming months.

The MHOST data suggests that an increased planned establishment is required, however the tool has only taken into consideration the planned staffing numbers made up of Registered Nurses and Health Support Workers and has not considered the wealth of professional specific roles and alternate roles that support to deliver the care and treatment to our service users through an MDT approach.

Patient Experience data suggest predominantly positive feedback within the service and the use of the safer staffing escalation process has allowed for mitigation and management of staffing both proactively and for the ongoing daily decisions. The use of deployment, Responsive Workforce Team and regular bookings of bank and agency staff to support a more consistent approach to the delivery of care and treatment and ensuring staff have the right skills can be suggested to have had a positive impact.

The service will continue to review data and a second MHOST data collection is recommended before any recommendation regarding establishment review is made.

10.0 Summary

This paper sets out the shared local and national workforce challenges for our inpatient services and the continuous and assertive efforts required to ensure that service users receive the highest quality care despite sustained pressures resulting from long standing workforce supply. It is widely understood that having the right number of appropriately qualified, competent, and experienced staff enables the delivery of high-quality care.

The paper provides the high-level data to demonstrate the position in relation to staffing LYPFT inpatient wards and the wider workforce plan to provide assurance that the standards required to deliver safe and effective care are being met. The use of information and data of the Acute Inpatient and PICU Service is used in the paper to draw a focused analysis to how this data can be used to influence the management and mitigation to address workforce challenges to ensure safe and effective care is delivered, and how quality outcome data and clinical improvement work supports the ongoing decision-making regarding the staffing establishment.

Despite the sustained pressures with workforce supply, the report demonstrates that the ongoing efforts and initiatives driven by the recruitment and retention strategies and the focus on wellbeing have positively impacted safer staffing with a series of improvements being noted in the data period, including a reduction in Nursing vacancies, the decreased use of temporary staffing and unfilled duties and the reduction in the need to enact deployment.

LYPFTs Preceptee recruitment campaign proved successful in the recruitment of 64 newly qualified Registered Nurses which will in turn will make a significant contribution to further reducing the Registered Nurse vacancies.

The backfilling of Registered Nurse duties for those vacancies that remain with Health Support Workers, continues to offer some assurances that safe staffing numbers are being reached. The use of the Responsive Workforce Team to flex to the predicted needs of clinical services has evidently had a positive impact in providing a consistency to the care needs of service users.

Deployment of staff across services continues to be a requirement and despite all efforts there were seven duties recorded with no Registered Nurse on duty.

The first data collection using the MHOST tool has now been completed in September with data outputs being shared with clinical services to analyse and apply professional judgement to the data. The delivery of care through the MDT and the professional specific roles which is not captured in the planned staffing establishment should be considered when reviewing the data.

Quality indicators as set out in the NQB have also illustrated a reduction in the overall number of incidents and across most categories of incidents, which could be attributed to the identified workforce improvements and in turn in the consistency and quality of care and treatment provided.

Clinical supervision and appraisal rates have also improved within the data period reflecting an improved staff experience.

Patient experience data suggest most service users report a good experience relating to their care and treatment.

Despite improvements being evident and the positive impact of the ongoing workstreams relating to workforce the ongoing challenges remain. The clear focus on staff wellbeing must continue as a means of supporting the retention of existing and newly recruited staff. Working alongside clinical services we need to continue to enact the recruitment and retention strategies and support teams to identify the skills, competencies and interventions required in specific areas for the service user group to ensure that the right care and treatment is delivered at the right time that will enable the best outcomes. All services are committed to ensuring that patients receive the highest quality care, however, to ensure that this is achievable there must be sufficient numbers of staff with the right levels of skills and training.

11.0 Recommendations

The Quality Committee is asked to:

- Note the content of the 6 monthly report and the progress in relation to key work streams.
- Be assured that arrangements are in place to monitor, support and mitigate any impact of reduced staffing levels or skill mix in relation to patient safety.

Authors:
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Adele Sowden, E-Rostering Team Manager

Leeds and York Partnership NHS
NHS Foundation Trust

APPENDIX 2

Safer Staffing: Inpatient Services October 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
WardName	PatientCo	CHPPD_RN	CHPPD_NR	CHPPD_RN	CHPPD_NR	CHPPD_RA	CHPPD_NR	CHPPD_OV	AvgFR_RN	AvgFR_NR	AvgFR_RN	AvgFR_NR	AvgFR_RN	AvgFR_NR	AvgFR_RN	AvgFR_NR	AvgFR_RA	AvgFR_NR
2 WOODLAND SQUARE	111	8.7	7.7	0.0	0.0	0.0	0.0	16.4	83%	124%	-	-	100%	100%	-	-	-	-
3 WOODLAND SQUARE	99	8.4	22.3	0.0	0.0	0.0	0.0	30.7	65%	191%	-	-	100%	137%	-	-	-	-
ASKET CROFT	589	1.6	2.5	0.0	0.0	0.0	1.0	5.1	99%	92%	-	-	106%	100%	-	-	-	100%
ASKET HOUSE	494	1.7	1.8	0.0	0.0	0.0	0.6	4.1	118%	73%	-	-	100%	103%	-	-	-	100%
BECKLIN CAU	170	7.6	17.2	0.0	0.0	0.0	0.0	24.8	96%	138%	-	-	93%	148%	-	-	-	-
BECKLIN WARD 1	696	2.3	6.3	0.0	0.0	0.0	0.5	9.1	77%	295%	-	-	99%	288%	-	-	-	100%
BECKLIN WARD 3	681	2.1	3.0	0.0	0.0	0.0	0.4	5.5	73%	169%	-	-	90%	118%	-	-	-	100%
BECKLIN WARD 4	684	2.1	3.5	0.0	0.0	0.0	0.4	6.0	70%	188%	-	-	89%	159%	-	-	-	100%
BECKLIN WARD 5	676	2.4	7.2	0.0	0.0	0.0	0.1	9.7	87%	323%	-	-	96%	324%	-	-	-	100%
MOTHER AND BABY AT THE MOUNT	222	7.2	7.7	0.0	0.0	0.0	0.0	14.9	114%	68%	-	-	92%	125%	-	-	-	-
NEWSAM WARD 1 PICU	370	4.3	9.9	0.0	0.0	0.0	0.6	14.8	87%	127%	-	-	89%	140%	-	-	-	100%
NEWSAM WARD 2 FORENSIC	372	3.2	7.9	0.0	0.0	0.0	0.0	11.1	123%	218%	-	-	104%	195%	-	-	-	-
NEWSAM WARD 2 WOMENS SERVICES	219	4.9	13.5	0.0	0.0	0.0	1.0	19.4	91%	273%	-	-	100%	182%	-	-	-	100%
NEWSAM WARD 3	404	2.4	5.9	0.0	0.0	0.0	0.7	8.9	152%	161%	-	-	100%	121%	-	-	-	100%
NEWSAM WARD 4	648	2.5	3.7	0.0	0.0	0.0	0.4	6.6	79%	225%	-	-	94%	134%	-	-	-	100%
NEWSAM WARD 5	527	2.2	4.7	0.0	0.0	0.0	1.4	8.3	88%	122%	-	-	70%	153%	-	-	-	100%
NEWSAM WARD 6 EDU	279	4.2	13.6	0.0	0.0	0.0	1.6	19.4	107%	423%	-	-	54%	228%	-	-	-	100%
NICPM LGI	234	6.4	4.6	0.0	0.0	0.0	1.6	12.6	123%	81%	-	-	94%	129%	-	-	-	100%
RED KITE VIEW GAU	295	4.9	13.2	0.0	0.0	0.0	0.0	18.1	66%	96%	-	-	92%	111%	-	-	-	-
RED KITE VIEW PICU	108	12.2	48.4	0.0	0.0	0.0	0.0	60.6	75%	142%	-	-	93%	143%	-	-	-	-
THE MOUNT WARD 1 NEW (MALE)	451	3.5	14.0	0.0	0.0	0.0	0.0	17.5	158%	178%	-	-	93%	307%	-	-	-	-
THE MOUNT WARD 2 NEW (FEMALE)	475	3.1	14.5	0.0	0.0	0.0	0.0	17.6	80%	222%	-	-	92%	288%	-	-	-	-
THE MOUNT WARD 3A	575	2.5	6.9	0.0	0.0	0.0	0.0	9.4	78%	178%	-	-	98%	235%	-	-	-	-
THE MOUNT WARD 4A	639	2.3	5.7	0.0	0.0	0.0	0.0	8.0	83%	175%	-	-	95%	175%	-	-	-	-
YORK - BLUEBELL	310	3.8	8.0	0.0	0.0	0.0	0.9	12.6	115%	96%	-	-	162%	101%	-	-	-	100%
YORK - MILL LODGE	236	6.2	11.1	0.0	0.0	0.0	2.4	19.7	77%	139%	-	-	77%	148%	-	-	-	100%
YORK - RIVERFIELDS	155	6.4	10.3	0.0	0.0	0.0	2.0	18.7	80%	171%	-	-	101%	133%	-	-	-	100%
YORK - WESTERDALE	186	6.2	13.5	0.0	0.0	0.0	1.4	21.1	55%	145%	-	-	100%	104%	-	-	-	100%

Leeds and York Partnership NHS
NHS Foundation Trust

Safer Staffing: Inpatient Services November 23

Fill rate indicator return

Staffing: Nursing, Care Staff and AHP

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
WardName	PatientCo	CHPPD_RN	CHPPD_NR	CHPPD_RN	CHPPD_NR	CHPPD_RA	CHPPD_NR	CHPPD_O	AvgFR_RN	AvgFR_NR	AvgFR_RN	AvgFR_NR	AvgFR_RN	AvgFR_NR	AvgFR_RN	AvgFR_NR	AvgFR_RA	AvgFR_NR
2 WOODLAND SQUARE	112	8.7	8.8	0.0	0.0	0.0	0.0	17.5	90%	162%	-	-	103%	127%	-	-	-	-
3 WOODLAND SQUARE	99	8.5	22.4	0.0	0.0	0.0	0.0	30.9	71%	184%	-	-	91%	143%	-	-	-	-
ASKET CROFT	540	1.7	3.2	0.0	0.0	0.0	0.9	5.8	100%	114%	-	-	113%	117%	-	-	-	100%
ASKET HOUSE	480	1.6	2.0	0.0	0.0	0.0	0.5	4.1	111%	85%	-	-	100%	100%	-	-	-	100%
BECKLIN CAU	168	8.2	15.7	0.0	0.0	0.0	0.0	23.9	100%	139%	-	-	99%	124%	-	-	-	-
BECKLIN WARD 1	660	2.2	7.4	0.0	0.0	0.0	0.0	9.6	73%	345%	-	-	91%	320%	-	-	-	-
BECKLIN WARD 3	657	2.5	3.2	0.0	0.0	0.0	0.4	6.2	95%	184%	-	-	95%	138%	-	-	-	100%
BECKLIN WARD 4	659	2.4	4.6	0.0	0.0	0.0	0.3	7.3	86%	256%	-	-	90%	212%	-	-	-	100%
BECKLIN WARD 5	655	2.4	5.4	0.0	0.0	0.0	0.4	8.2	90%	249%	-	-	99%	237%	-	-	-	100%
MOTHER AND BABY AT THE MOUNT	165	8.4	10.5	0.0	0.0	0.0	0.0	18.9	105%	70%	-	-	84%	132%	-	-	-	-
NEWSAM WARD 1 PICU	358	4.6	12.2	0.0	0.0	0.0	0.8	17.6	91%	150%	-	-	97%	187%	-	-	-	100%
NEWSAM WARD 2 FORENSIC	358	2.9	9.6	0.0	0.0	0.0	0.3	12.8	99%	235%	-	-	101%	208%	-	-	-	100%
NEWSAM WARD 2 WOMENS SERVICES	195	5.2	14.9	0.0	0.0	0.0	1.5	21.7	87%	301%	-	-	100%	170%	-	-	-	100%
NEWSAM WARD 3	420	2.3	5.6	0.0	0.0	0.0	0.6	8.5	117%	169%	-	-	103%	115%	-	-	-	100%
NEWSAM WARD 4	628	2.8	4.7	0.0	0.0	0.0	0.5	8.0	93%	281%	-	-	104%	203%	-	-	-	100%
NEWSAM WARD 5	510	2.4	4.3	0.0	0.0	0.0	1.9	8.6	103%	112%	-	-	72%	135%	-	-	-	100%
NEWSAM WARD 6 EDU	266	4.2	14.4	0.0	0.0	0.0	1.7	20.3	93%	521%	-	-	61%	225%	-	-	-	100%
NICPM LGI	240	6.4	4.0	0.0	0.0	0.0	1.3	11.7	137%	69%	-	-	92%	120%	-	-	-	100%
RED KITE VIEW GAU	319	5.6	18.0	0.0	0.0	0.0	0.0	23.7	119%	165%	-	-	97%	181%	-	-	-	-
RED KITE VIEW PICU	77	16.7	41.5	0.0	0.0	0.0	0.0	58.2	77%	113%	-	-	99%	124%	-	-	-	-
THE MOUNT WARD 1 NEW (MALE)	425	3.4	13.2	0.0	0.0	0.0	0.0	16.6	145%	172%	-	-	98%	284%	-	-	-	-
THE MOUNT WARD 2 NEW (FEMALE)	462	3.3	11.1	0.0	0.0	0.0	0.0	14.3	81%	163%	-	-	100%	220%	-	-	-	-
THE MOUNT WARD 3A	592	2.4	4.1	0.0	0.0	0.0	0.0	6.5	85%	127%	-	-	98%	115%	-	-	-	-
THE MOUNT WARD 4A	621	2.4	6.1	0.0	0.0	0.0	0.0	8.5	89%	182%	-	-	106%	192%	-	-	-	-
YORK - BLUEBELL	293	4.4	7.8	0.0	0.0	0.0	1.1	13.3	172%	102%	-	-	152%	106%	-	-	-	100%
YORK - MILL LODGE	210	6.2	10.4	0.0	0.0	0.0	2.5	19.1	67%	111%	-	-	68%	142%	-	-	-	100%
YORK - RIVERFIELDS	151	5.6	8.5	0.0	0.0	0.0	1.4	15.6	90%	146%	-	-	108%	98%	-	-	-	100%
YORK - WESTERDALE	202	5.2	13.5	0.0	0.0	0.0	0.5	19.2	61%	186%	-	-	117%	107%	-	-	-	100%

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:	2023 – 2024 Organisational Priorities Quarter 3 Progress Report
DATE OF MEETING:	25 January 2024
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 third 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 234 underpinning tasks for delivery. At the end of quarter three we have:

- 47 tasks that have been completed
- 159 tasks are reporting a rating of green (on track)
- 16 tasks are reporting a rating of amber (action incomplete – implementation slipped but will be delivered on time)
- 6 tasks are reporting a rating of red (action incomplete – timescales not achievable)
- 6 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). • 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 25 JANUARY 2024

2023 – 2024 ORGANISATIONAL PRIORITIES QUARTER 3 PROGRESS REPORT

1. Purpose

This report provides a summary of the Trust's progress against our 2023 – 2024 organisational priorities. This is our third 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 three

At this penultimate quarter point, we have continued the review of all our priorities in readiness for the 2024/25 planning round. This has largely been realignment of timescales now we have a better understanding of what will, and what will not be delivered in 2023/24, and therefore transfer into 2024/25. This has also meant that we have taken the decision to suspend some schemes as the original intent has changed.

We have also made some good progress on some of the tasks that we have been consistently reporting a rating of amber or red. These are:

- **Improve the experience of people with a protected characteristic as identified by the Equality Act 2010:** We have now agreed that we will begin monitoring the progress we are

making against the new EDI plan from 1 March 2024. This year has given the opportunity to fully review the EDI framework in order to identify our priority areas and target ambitions ensuring alignment with the refreshed People Plan.

- **Community and wellbeing service line:** This service line have reached their target of holding service away days and ensuring all teams have clear objectives/expectations, ahead of the first phase of community transformation programme go-live. The service line is now awaiting the 2023 results of the Community Mental Health Service User Survey to determine if they have made improvements in at least two areas.
- **Children and young people S136 arrangements:** We have now concluded the work with system partners to reach an agreement, within the funding envelope, for the Section 136 facility cover arrangements at Red Kite View.

We have also delivered some significant schemes in quarter 3, including:

- **Trust Headquarters:** Opening of Main House on 30 October 2023 following extensive renovation to become the new Trust Headquarters.
- **Quality dashboard framework:** The definitions for the sections of the Quality Dashboard framework has been agreed which now provides the overarching framework.
- **CQC:** We have re-established our governance arrangements in preparedness for a CQC inspection. This has enabled the embedding of our quality and patient safety peer review process and the governance helping address any actions. The new CQC regulatory framework will begin rollout across the Trust from January 2024.

2.1.1 Key highlights at the end of quarter three

Each lead has assessed the progress they have made at the end of quarter three with all underpinning tasks, to determine how we are delivering 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 234 underpinning tasks for delivery. At the end of quarter three we have 47 tasks that have been completed. 159 are reporting a rating of green (on track). 6 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 three we have 16 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.

- **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; however, we are also reviewing alternative solutions used across the health sector. This is linked with improving efficiency, inclusion and user experience.

- **Care Services Plan: Adult Acute**
  - **Create capacity and flow through the acute pathway that enables a reduction in unwarranted clinical variation**
  - 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 are working with our city-wide partners in Adult Social Care to help address the housing issues associated with delayed transfers of care which will, in-turn, reduce our length of stay. These actions are detailed as part our recovery plan monitored through our out of area placement exec-led governance group.
  - **Ensuring safe staffing levels across our adult acute services**
  - **Complete a skill mix review across our inpatient services:** We are continuing to experience workforce challenges across the adult acute service. Working closely with the nursing directorate, the service is gathering the workforce data utilising MHOST (Mental Health Optimal Staffing Tool). This tool helps provide a triangulation of the outcome with quality indicators to inform decisions regarding the right establishment and skill mix. An initial dataset has been collected and analysed and it is recommended that a second dataset be collected prior to making any workforce decisions. This second dataset will conclude in March 2024.

- **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. All organisations have agreed that we can commence the 'wave 1' launch from 11th March 2024, with a Shared Partnership Agreement

and specific Memorandum of Understanding in place to provide a safe and effective operating framework. Not all elements of the programme will be implemented at 'wave 1' i.e. single point of referral. In preparation for the launch, the community team are concluding the restructuring and transfer of caseloads.

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.**
  - **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. The service line Clinical Lead is now leading new care planning and outcome measure implementation to aid the delivery of these important priorities.

- **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 and design an affordable solution:** 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 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 to reflect a conclusion by March 2025 at the latest.

- **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 now named 'Willow View'. Work to the estate at Mill Lodge is progressing to programme. Unfortunately, recruitment continues to remain a challenge with a recent medical, family therapist and dietician recruitment processes proving unsuccessful. The

risk remains of our ability to recruit that may impinge any delay to the opening of the new unit in April 2024.

- **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:** We are revisiting the original proposal for the NSCAP service with NHS England following further due diligence concerning the future viability of the contract. Further meetings are scheduled in January with NHS England to consider our position and next steps.

  - **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. We have now successfully recruited into some key posts with individuals started in December 2023. We have also agreed our estate operating arrangements with a permanent base in Manchester and Sheffield (Regus office). We have adopted the use of Regus membership cards within Preston, Liverpool and Newcastle. A space to run clinics in Blackpool is also being identified.

- **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 continues to be significantly over plan. Our four key areas of focus in our efficiency and productivity programme will continue into 2024/25.

- **Green plan**
  - **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, with other systems being considered as part of the capital programme and Green Implementation Plan.

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

At the end of quarter three we have 6 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.

- **Flexible but safe access to Trust system from any location:** The Software Defined Wide Area Network (SD-WAN) has successfully been deployed across all Trust sites. New firewall hardware has been implemented at Red Kite View and St Mary's House and now operational. However, reliance on third parties such as BT/VM to deliver and terminate the fibre connectivity and some civil works at a small number of sites is causing a delay in full completion. Given these delays we have set a revised timescale of March 2024.

- **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 and is currently with the lenders for final approval. 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, we are working towards a programme end date of 31 July 2024.

- **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 difficult. Demand for beds has increased at a time when our length of stay and delayed transfers of care position is challenging, which has resulted in a continued use of out of area beds. We plan to extend our block contract for Acute beds with the Priory Group until March 2024. The Acute Service has developed a recovery plan which includes the actions from the MADE event. Our exec-led Inpatient Flow Oversight Group continues to monitor progress on a monthly basis.

- **Care Services Plan: Regional and Specialist Services**
  - **Improving mental health services for people with autism and ADHD:**
    - We have produced 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. To be considered as part of the 2024/25 funding development pressures.

3. Cross-cutting themes and interdependent tasks

As part of our quarterly reporting we share a Gantt chart 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 reviewing our priorities at the quarter three stage, our interdependent tasks are revisited to ensure timescales continue to align and are therefore reflective of the task to be delivered.
The themes emerging also demonstrate the alignment with our five core strategic plans. 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).
- 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.

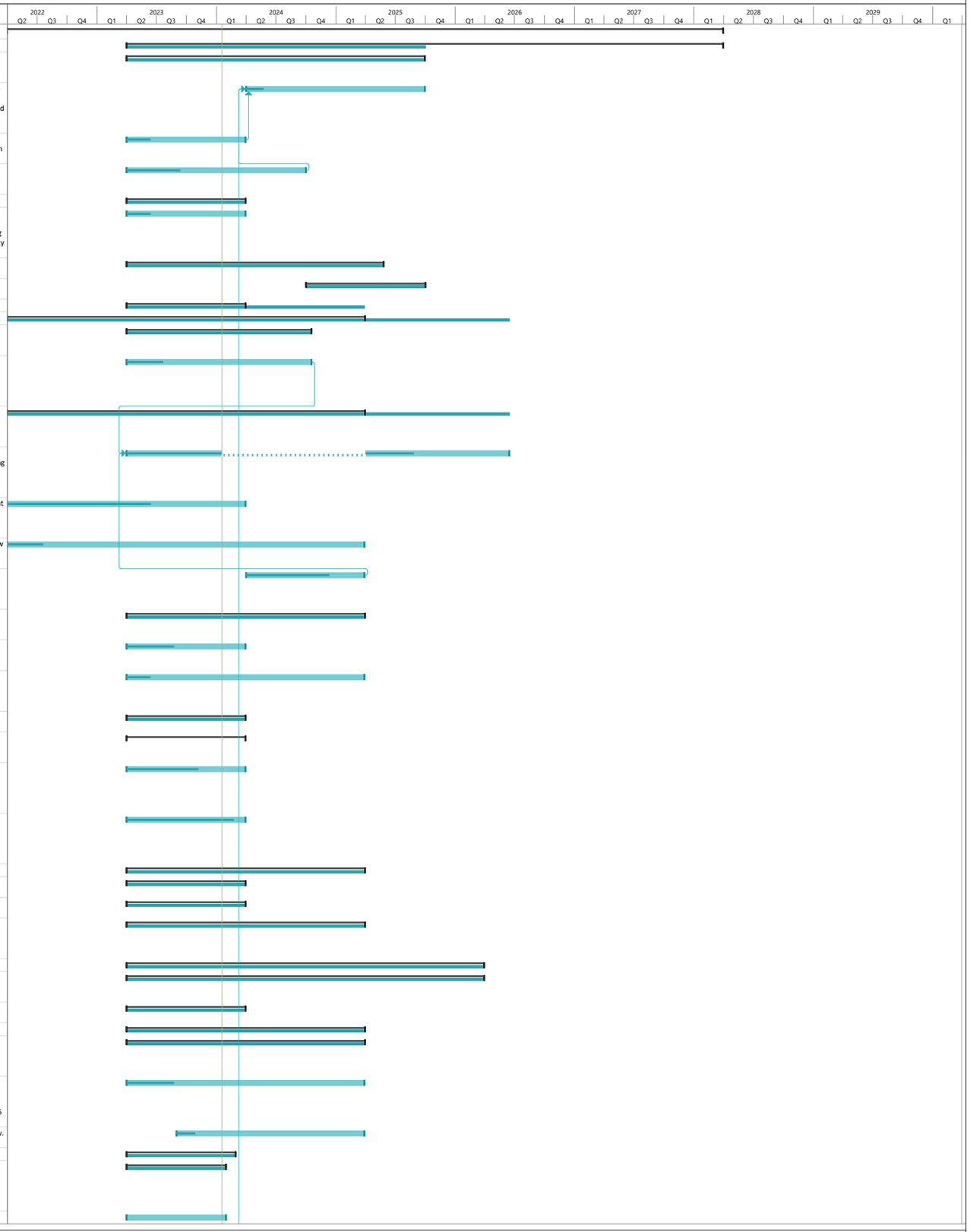
Dawn Hanwell
Chief Financial Officer

Amanda Burgess
Head of the Programme Management Office

25 January 2024

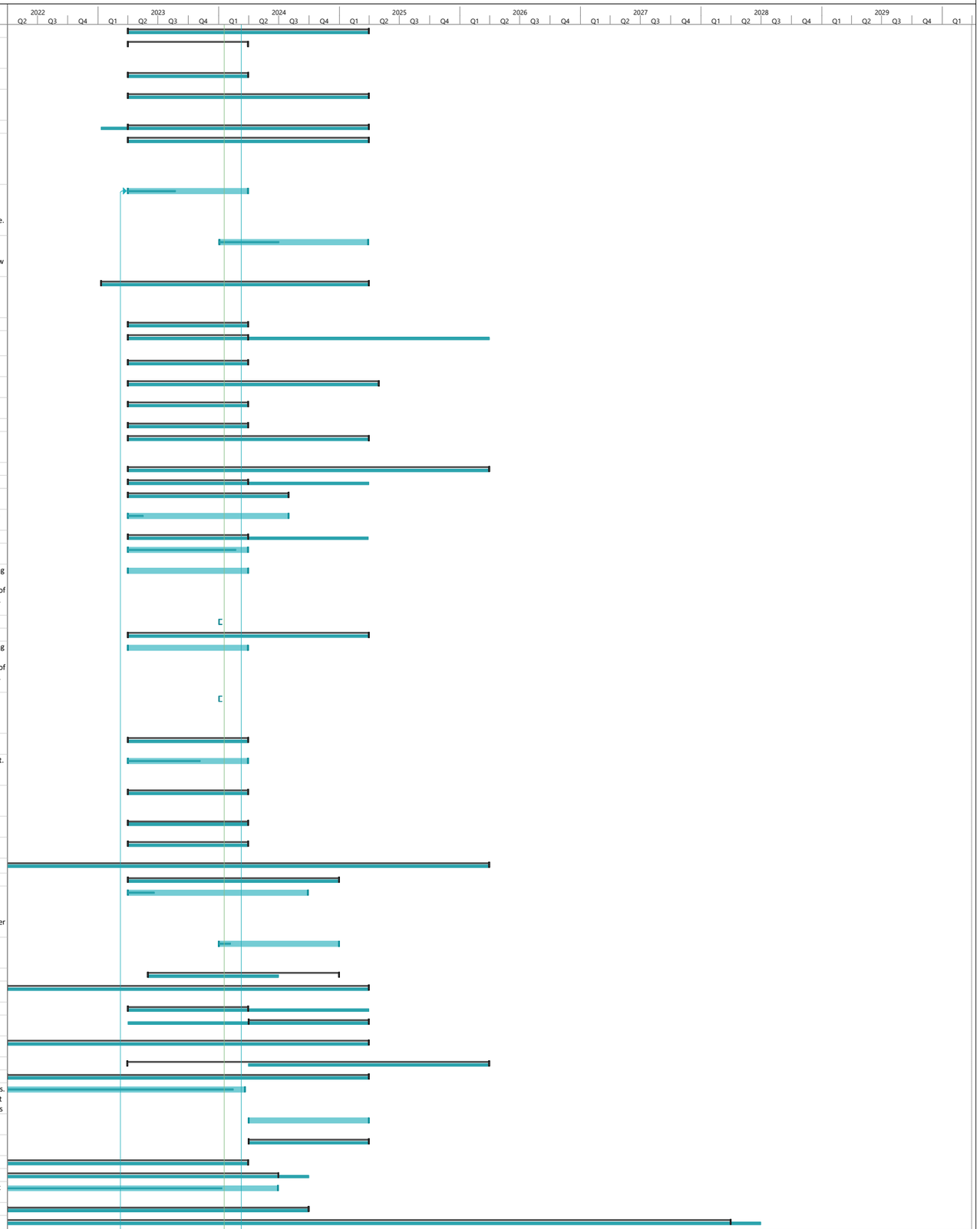
Trust Organisational Priorities 2023 - 2030: Quarter 3 Progress Report

ID	Task Mode	Q3 RAG	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**	**45%**	
2						**Adult Acute**	**1306 days**	**Sat 01/04/23**	**Fri 31/03/28**	**L.McDonagh**	**23%**	
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	Mon 29/09/25	L.McDonagh	10%	Significant pressures and challenges in the acute service line remain and demand for beds has increased at a time when our LOS and DTOC position is challenging. We plan to extend our block contract with the Priory until March 2024.
5						Reduce unwarranted clinical variation	262 days	Sat 01/04/23	Fri 29/03/24	L.McDonagh	20%	We are working with our partners in ASC and Housing to address DTOCs and to reduce length of stay. This is an action in our recovery plan.
6						Formulation to be embedded across the acute inpatient service	393 days	Sat 01/04/23	Mon 30/09/24	L.McDonagh	30%	New psychologist is now in post and we are continuing with the roll out of formulation across the remaining wards.
7						**Ensuring safe staffing levels across our adult acute services**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**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%	This work is progressing - The original skill mix plan was paused as the Acute Inpatient and PICU service have been working with the Nursing Directorate to gather data utilising the MOHOST tool and triangulating the outcome with quality indicators.
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%**	
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**	**782 days?**	**Fri 01/04/22**	**Mon 31/03/25**	**A Toolan**	**44%**	
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**	**A Toolan**	**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	A Toolan	20%	Recruitment and retention is improving. Caseload sizes increasing but regular caseload supervision is helping maintain flow. 3 workshops now completed, and an action plan has been agreed with multi-pronged approach to improving the wider community offer.
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**	**A Toolan**	**43%**	
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	A Toolan	60%	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	A Toolan	60%	Soft launch in November with consultation being provided at St George's Crypt to staff. Some workforce challenges. Anticipated full roll out in April- May 2024.
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.	261 days?	Mon 01/04/24	Fri 28/03/25	Fiona Lowis & Alex Perry	70%	Primary care therapies are being fully utilised as fully recruited to. Workforce plan in place, however some limitations due to recruitment / retention challenges in the secondary care element.
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**	**A Toolan**	**20%**	
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	A Toolan	40%	Awaiting results from 2023 service user survey response, evaluation and themes. Amy Harker invited to service line management meeting.
26						Introduction and use of routine outcome measures (ReQol, DIALOG+) with over 65% of service users having two or more recorded	522 days	Sat 01/04/23	Fri 28/03/25	Debbie Thrush	10%	Clinical Lead for Community & Wellbeing service line has a new element to her role leading on new care planning approaches, and implementing outcome measures will be incorporated into this work.
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**	**A Toolan**	**75%**	
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**	**75%**	
31						Each Team to develop service/team objectives, using team/service away days.	262 days	Sat 01/04/23	Fri 29/03/24	A Toolan	60%	Team away days in CMHT are being rolled out aligned to Transformation. Wave 1 staff have received 2 introductory time out days. Further induction days in team bases being planned. Wave 2 & 3 staff will be provided with the same offer as each mobilises.
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	90%	This work is almost completed. Role planning has started to be embedded using a 'top down' approach. Non registered roles are feeling more embedded within teams and their contributions valued as part of wider MDT offer.
33						**Older people's services**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**E.Townsley**	**57%**	
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**	**75%**	
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**	**58%**	
43						**Forensic services**	**783 days**	**Sat 01/04/23**	**Tue 31/03/26**	**J.Faulkner**	**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**	**J.Faulkner**	**49%**	
50						**Implementation of the new safer staffing model across our Leeds forensic services.**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**J.Faulkner**	**63%**	
53						**Learning disability services**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**P.Johnstone**	**19%**	
54						**Working collaboratively with our Local Authority commissioning partners we will redesign the delivery and leadership model for our Specialised Supported Living Service.**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**P.Johnstone**	**16%**	
55						Recommence planning and negotiation with LCC contracts and commissioning partners re SSL contract	522 days	Sat 01/04/23	Fri 28/03/25	P.Johnstone	20%	No further feedback from local authority in terms of the review that has been undertaken. No current indication of what the thinking or plan is. Appears less likely that timescale of March 2024 will be achieved. Moved into 24/25 priorities.
56						Design affordable management model for the delivery of SSL, derived from a detailed options appraisal	412 days	Fri 01/09/23	Fri 28/03/25	P.Johnstone	10%	The task continues to be dependent on findings of LA review. (see above). Moved into 24/25 priorities.
57						**Improving our Health Facilitation Team offer**	**240 days**	**Sat 01/04/23**	**Thu 29/02/24**	**P.Johnstone**	**50%**	
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	Wed 31/01/24	P.Johnstone	0%	Programme Suspended



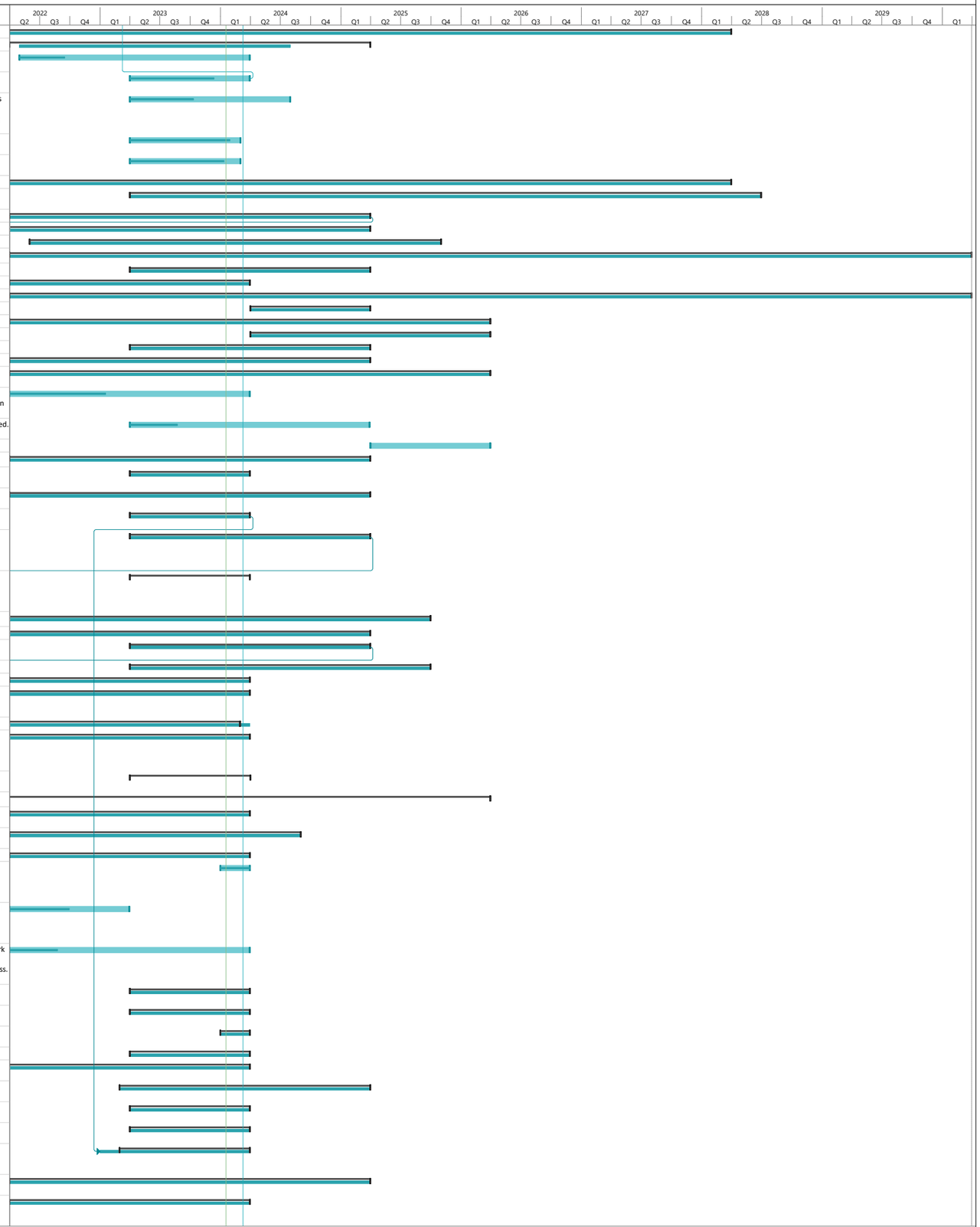
Trust Organisational Priorities 2023 - 2030: Quarter 3 Progress Report

ID	Task Mode	Q3 RAG	Q2 RAG	Q1 RAG	Mover	Task Name	Duration	Start	Finish	Lead	% Complete	Progress Update
61						**Perinatal and liaison**	**522 days?**	**Sat 01/04/23**	**Mon 31/03/25**	**P.Fotherby**	**34%**	
62						**Working towards our focus of providing more care in the community, early intervention and prevention, we will increase our perinatal community provision**	**260 days**	**Sat 01/04/23**	**Fri 29/03/24**	**P.Fotherby**	**57%**	
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**	**20%**	
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**	**22%**	
73						**Children and young people**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**N.Mant**	**60%**	
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.**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**N.Mant**	**40%**	
75						Implementation of the new Alternative to hospital provision within Mill Lodge	262 days	Sat 01/04/23	Fri 29/03/24	N.Mant	40%	Alternative to hospital now formally named "Willow View". Very positive progress with estates. Working well with the team to minimise impact on the wider unit. Currently on target for completion date. Recruitment remains a challenge.
76						Complete evaluation of the Alternative to Hospital provision within Mill Lodge	324 days	Wed 03/01/24	Fri 28/03/25	N.Mant	40%	Project plan clear re: data capture requirement to be embedded within systems. HNY workstream continue to meet regularly which will determine KPI's used within Willow View and wider HNY footprint.
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**	**580 days**	**Tue 10/01/23**	**Mon 31/03/25**	**N.Mant**	**67%**	
80						**Ensure the stability of Red Kite View**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**N.Mant**	**80%**	
82						**Rehabilitation, eating disorders and gender identity**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**R.Carroll**	**65%**	
83						**Reducing the number of complex rehab out of area placements**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**R.Carroll**	**100%**	
86						**Complete R&R and AOT review and implement recommendations for a Complex Psychosis Service**	**544 days**	**Sat 01/04/23**	**Wed 30/04/25**	**R.Carroll**	**45%**	
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**	**82%**	
96						**Development of our locked and rehabilitation pathways**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**R.Carroll**	**80%**	
98						**Introduction of a community eating disorders service to support people who do not meet the referral criteria for CONNECT.**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**R.Carroll**	**45%**	
101						**Gender ID: continuing waiting list management**	**783 days**	**Sat 01/04/23**	**Tue 31/03/26**	**R.Carroll**	**75%**	
104						**Regional & Specialist Services**	**262 days?**	**Sat 01/04/23**	**Sun 31/03/24**	**D.Rowley**	**35%**	
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%	Approached NHS E to discuss viability of the contract, paper submitted to EMT for January meeting.
107						**Improving mental health services for people with autism**	**262 days?**	**Sat 01/04/23**	**Sun 31/03/24**	**D.Rowley**	**28%**	
108						Rollout of autism training for LYPFT staff	262 days	Sat 01/04/23	Fri 29/03/24	D.Rowley	90%	Training cooordinator in role, schedule is being created and bookings commencing.
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						Reduction of internal waits within the pathway.		Mon 01/01/24	Fri 28/03/25	D.Rowley	0%	To commence from Q4
111						**Improving our services for people with ADHD**	**522 days?**	**Sat 01/04/23**	**Mon 31/03/25**	**D.Rowley**	**0%**	
112						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.
113						To communicate the reality of the ADHD position with stakeholders and the general public, and to work with stakeholders across the pathway review the model for ADHD services across Leeds.		Mon 01/01/24	Fri 28/03/25	D.Rowley	0%	To commence from Q4
114						**Improving our services for people with a gambling addiction**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**D.Rowley**	**60%**	
115						Mobilisation of the expanded clinics across the NE and NW	262 days	Sat 01/04/23	Fri 29/03/24	D.Rowley	60%	Recruitement progressing well, CTM has commenced in post. We have sites confirmed for 5/6 clinics, sixth has a interim option while obtaining a site in Blackpool.
116						**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%**	
118						**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%**	
120						**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%**	
123						**Our Digital Plan**	**1066 days?**	**Tue 01/03/22**	**Tue 31/03/26**	**B.Fawcett**	**46%**	
124						**Deployment of a Patient Portal**	**458 days**	**Sat 01/04/23**	**Tue 31/12/24**	**B.Fawcett**	**13%**	
125						Deliver technical solution and conduct controlled trials	392 days	Sat 01/04/23	Fri 27/09/24	I.Hogan	15%	Waiting on Advanced to support activation of Patient Portal within our environment. We are also reviewing alternative solutions used across the health economy underway to determine economies of scale, efficiencies, inclusion and user experience.
126						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.
127						**Develop the link to the Yorkshire & Humber care record**	**414 days**	**Thu 01/06/23**	**Tue 31/12/24**	**I.Hogan**	**28%**	
130						**Assess and co-design an inclusive digital transformation programme for the Trust**	**782 days**	**Fri 01/04/22**	**Mon 31/03/25**	**I.Hogan**	**47%**	
133						**Deployment of Electronic Document Management System**	**262 days?**	**Sat 01/04/23**	**Sun 31/03/24**	**I.Hogan**	**50%**	
136						**Replace/ retire the need for physical smart cards across the Trust**	**261 days**	**Mon 01/04/24**	**Mon 31/03/25**	**I.Hogan**	**47%**	
140						**To ensure that Trust defences against cyber threats are affective**	**782 days**	**Fri 01/04/22**	**Mon 31/03/25**	**I.Hogan**	**63%**	
143						**Streamline the process for on-boarding staff**	**783 days**	**Fri 31/03/23**	**Tue 31/03/26**	**I.Hogan**	**0%**	
146						**Flexible but safe access to trust system from any location**	**782 days**	**Fri 01/04/22**	**Mon 31/03/25**	**I.Hogan**	**63%**	
147						Deployment of Software Defined Wide Area Network	515 days	Fri 01/04/22	Wed 20/03/24	I.Hogan	95%	SD-WAN has successfully been deployed across all Trust sites. New firewall hardware implemented at Red Kite View and St Mary's House and now operational. Reliance on third parties
148						Deployment of access to systems directly from the internet	261 days	Mon 01/04/24	Mon 31/03/25	I.Hogan	0%	Project planned to commence in 2024/25
149						**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%**	
151						**Integration of Care Director with the NHS SPINE**	**545 days**	**Tue 01/03/22**	**Sun 31/03/24**	**I.Hogan**	**90%**	
153						**Feed data to GP systems directly from Care Director**	610 days	Tue 01/03/22	Sun 30/06/24	I.Hogan	65%	
154						Send GP letters and patient discharge notifications directly to GP systems	610 days	Tue 01/03/22	Fri 28/06/24	I.Hogan	80%	Will not be achieved until June 2024, following achievement of EDM.
155						**ICE integration across the organisation**	**652 days**	**Fri 01/04/22**	**Mon 30/09/24**	**I.Hogan**	**50%**	
157						**Strategic Estates Plan**	**1696 days?**	**Fri 01/10/21**	**Fri 31/03/28**	**D.Hanwell**	**33%**	



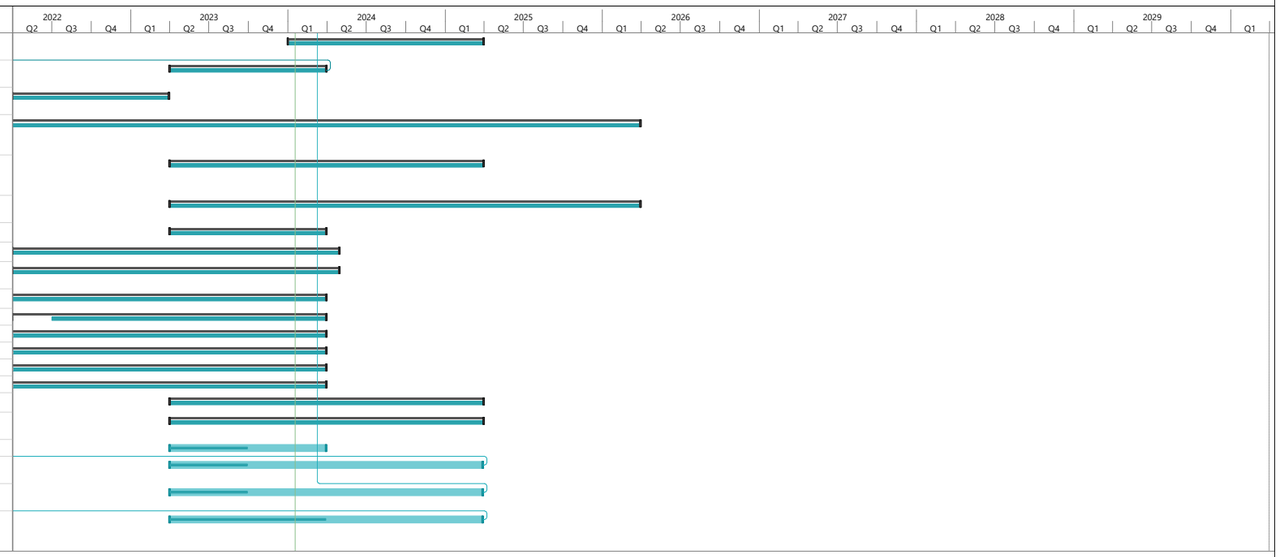
Trust Organisational Priorities 2023 - 2030: Quarter 3 Progress Report

ID	Task Mode	Q3 RAG	Q2 RAG	Q1 RAG	Mover	Task Name	Duration	Start	Finish	Lead	% Complete	Progress Update
158						**Develop our PFI Estate**	**1696 days**	**Fri 01/10/21**	**Fri 31/03/28**	**J.Campbell**	**25%**	
160						**Enabling key clinical service changes through our estate**	**782 days**	**Fri 01/04/22**	**Mon 31/03/25**	**J.Campbell**	**53%**	
161						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
162						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	70%	Works on site have commenced in Nov23 and currently on programme for March 2024 completion.
163						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	40%	The Deed of Variation is almost complete subject to lenders approval. Project costs being evaluated with current programme suggesting Jul 24 completion. Work is ongoing work to reduce this completion date.
164						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%	There has been a delay from the SPV in receiving the benchmarking report despite repeated formal requests.
165						Renovation of our inpatient wards as part of the PFI lifecycle arrangement	242 days	Sat 01/04/23	Fri 01/03/24	J.Campbell	85%	PFI lifecycle programme is on schedule. The Trust have contributed to a 2024/25 lifecycle plan.
166						**Owned Estate**	**1696 days**	**Fri 01/10/21**	**Fri 31/03/28**	**J.Campbell**	**22%**	
171						**Organisational preparedness for the ceasation of our PFI concession in 2028**	**1371 days**	**Sat 01/04/23**	**Fri 30/06/28**	**J.Campbell**	**30%**	
173						**Ensuring our services are safe and secure**	**782 days**	**Fri 01/04/22**	**Mon 31/03/25**	**J.Campbell**	**55%**	
175						**Working with partners on new developments**	**805 days**	**Tue 01/03/22**	**Mon 31/03/25**	**J.Campbell**	**30%**	
179						**Optimising our Estate**	**894 days?**	**Wed 01/06/22**	**Sat 01/11/25**	**J.Campbell**	**42%**	
182						**Green Plan**	**2087 days**	**Fri 01/04/22**	**Sun 31/03/30**	**J.Campbell**	**22%**	
183						**Achieve Our Sustainable targets**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**J.Campbell**	**28%**	
186	✓					**SDAT Assessment**	**522 days**	**Fri 01/04/22**	**Sun 31/03/24**	**J.Campbell**	**100%**	
188						**Networking, Comms & Engagement**	**2087 days**	**Fri 01/04/22**	**Sun 31/03/30**	**J.Campbell**	**20%**	
207						**Review Bottled Water Provision**	**261 days**	**Mon 01/04/24**	**Mon 31/03/25**	**J.Campbell**	**7%**	
211						**Cooking, Food Provision and Waste Review**	**1043 days**	**Fri 01/04/22**	**Tue 31/03/26**	**J.Campbell**	**27%**	
220						**Trust Transport Strategy**	**522 days**	**Mon 01/04/24**	**Tue 31/03/26**	**J.Campbell**	**15%**	
223						**Climate Change & Resiliance**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**J.Campbell**	**20%**	
225						**IT Equipment & Printing**	**782 days**	**Fri 01/04/22**	**Mon 31/03/25**	**J.Campbell**	**2%**	
229						**Energy, Cooling, Water: Improve Efficiency, Management & Monitoring**	**1043 days**	**Fri 01/04/22**	**Tue 31/03/26**	**J.Campbell**	**24%**	
230						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
231						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.
232						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
233						**Our Medical Strategy**	**782 days?**	**Fri 01/04/22**	**Mon 31/03/25**	**C.Hosker**	**67%**	
234	✓					**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**	**100%**	
237						**We wish to continue to maintain the current high standards by which concerns regarding doctors are managed**	**782 days**	**Fri 01/04/22**	**Mon 31/03/25**	**V.Lovett**	**57%**	
242						**We wish to continue to maintain our excellent medical education and training.**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**V.Lovett**	**70%**	
244						**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**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**V.Lovett**	**67%**	
247						**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**	**75%**	
250						**Nursing and professions strategy**	**1697 days?**	**Mon 01/04/19**	**Tue 30/09/25**	**N.Sanderson**	**65%**	
251	✓					**Improving Retention of Professions**	**1043 days**	**Thu 01/04/21**	**Mon 31/03/25**	**A.Quarry & M.Trev**	**100%**	
253						**Implementation of the Patient Safety Incident Response Framework (PSIRF)**	**522 days?**	**Sat 01/04/23**	**Mon 31/03/25**	**C.Wardle**	**63%**	
257						**Implementation of patient safety outcomes**	**653 days?**	**Sat 01/04/23**	**Tue 30/09/25**	**A.Quarry**	**27%**	
261						**Improved service user experience**	**522 days**	**Fri 01/04/22**	**Sun 31/03/24**	**S. Marshall**	**65%**	
264	✓					**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%**	
266						**Implementing research, development and new technologies**	**762 days**	**Thu 01/04/21**	**Fri 01/03/24**	**A.Quarry, M.Claire·**	**60%**	
268						**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.Marshall**	**50%**	
270						**Working towards a 'good/outstanding' CQC rating for all services when next inspected**	**260 days?**	**Sat 01/04/23**	**Mon 01/04/24**	**A.Quarry**	77%	
276						**People Plan**	**1303 days?**	**Thu 01/04/21**	**Tue 31/03/26**	**D.Skinner**	**64%**	
277						**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%**	
282	✓					**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%**	
284						**Keep our people protected, safe and well at work**	**522 days**	**Fri 01/04/22**	**Sun 31/03/24**	**F.Dodd**	**35%**	
285	✓					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%	Complete
286						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%	Becklin Room is completed and funding has been approved to progress further site updates.
287						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	Fri 29/03/24	H.Tetley	20%	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.
288	✓					**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%**	
290						**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**	**67%**	
294						**Embed Equality, Diversity and Inclusion in the culture of our Trust**	**66 days**	**Mon 01/01/24**	**Sun 31/03/24**	**F.Dodd**	**78%**	
297						**Grow collective leaders that reflect Trust values**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**F.Sherburn & A.Ear**	**75%**	
299						**Provide a working environment of civility and respect for our people**	**545 days**	**Tue 01/03/22**	**Sun 31/03/24**	**H.Tetley**	**69%**	
303						**Improve the experience of those people with a protected characteristic as identified by the Equality Act 2010**	**544 days**	**Wed 01/03/23**	**Mon 31/03/25**	**F.Dodd**	**38%**	
306	✓					**Develop an agile workforce who can deliver effectively in their roles**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**H.Tetley**	**100%**	
308						**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%**	
310						**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**	**76%**	
314						**Provide accessible and intuitive software solutions to support People and OD initiatives**	**782 days**	**Fri 01/04/22**	**Mon 31/03/25**	**A. McNichol**	**4%**	
317						**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**	**77%**	



Trust Organisational Priorities 2023 - 2030: Quarter 3 Progress Report

ID	Task Mode	Q3 RAG	Q2 RAG	Q1 RAG	Mover	Task Name	Duration	Start	Finish	Lead	% Complete	Progress Update
321						**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%**	
325						**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**	**80%**	
327						**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**	**100%**	
329						**Promote the one Leeds workforce model, removing barriers to cross-organisational and cross-functional working to enable new models of service delivery**	**1304 days**	**Thu 01/04/21**	**Tue 31/03/26**	**H.Tetley**	**75%**	
334						**Work with partner organisations to collaborate on introducing and embedding new roles and the sharing of resources where this benefits the system**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**F.Sherburn & A.Earnshaw**	**50%**	
336						**Embed reward and recognition in our Trust to create a culture of our staff feeling valued**	**783 days**	**Sat 01/04/23**	**Tue 31/03/26**	**F.Dodd**	**17%**	
339						**Psychological Professions Strategic Plan**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**S.Prince**	**100%**	
345						**Quality Strategic Plan**	**543 days**	**Fri 01/04/22**	**Tue 30/04/24**	**R.Wylde & C.Mone**	**75%**	
346						**Embedding clinical outcome measures across our clinical services**	**543 days**	**Fri 01/04/22**	**Tue 30/04/24**	**R.Wylde & C.Money**	**75%**	
349						**Research & Development**	**587 days**	**Sat 01/01/22**	**Sun 31/03/24**	**S.Cooper**	**75%**	
350						**Create a culture of research being core business**	**522 days**	**Fri 01/04/22**	**Sun 31/03/24**	**S.Cooper**	**75%**	
352						**Developing a skilled workforce**	**587 days**	**Sat 01/01/22**	**Sun 31/03/24**	**S.Cooper**	**75%**	
354						**Actively engage a network of key stakeholders**	**545 days**	**Tue 01/03/22**	**Sun 31/03/24**	**S.Cooper**	**75%**	
356						**Effectively disseminate research outputs and Impact**	**545 days**	**Tue 01/03/22**	**Sun 31/03/24**	**S.Cooper**	**75%**	
358						**Influence regional and national agendas**	**545 days**	**Tue 01/03/22**	**Sun 31/03/24**	**S.Cooper**	**75%**	
360						**Finance Strategy**	**522 days?**	**Sat 01/04/23**	**Mon 31/03/25**	**J.Saxton**	**36%**	
361						**We use our resources to delivery effective and sustainable services**	**522 days?**	**Sat 01/04/23**	**Mon 31/03/25**	**J.Saxton**	**36%**	
362						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
363						Develop and monitor a plan to reduce agency spend (medical and non-medical)	522 days	Sat 01/04/23	Fri 28/03/25	J.Saxton	25%	Number of initiatives on-going
364						Develop and monitor a plan to reduce out of area placements (complex rehab and adult acute)	522 days	Sat 01/04/23	Fri 28/03/25	J.Saxton	25%	Number of initiatives on-going
365						Develop and monitor a plan to reduce our vacancy position by looking at opportunities to redesign within existing establishment	522 days	Sat 01/04/23	Fri 28/03/25	J.Saxton	50%	Number of initiatives on-going

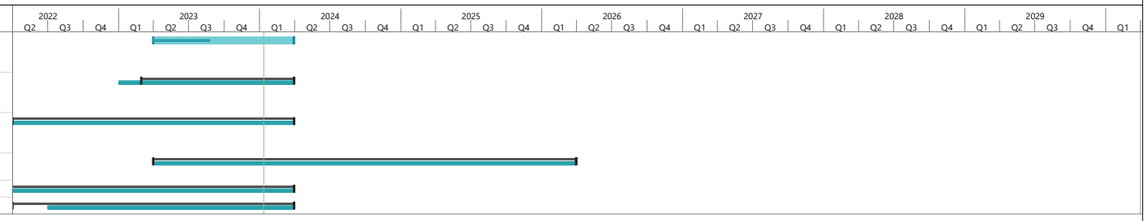


Trust Organisational Priorities 2023 - 2030: Quarter 3 Progress Report - interdependencies across schemes

ID	Task Mode	Q3 RAG	Q2 RAG	Q1 RAG	Mover	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**	**45%**			
2						**Adult Acute**	**1306 days**	**Sat 01/04/23**	**Fri 31/03/28**	**L.McDonagh**	**23%**			
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	Mon 29/09/25	L.McDonagh	10%	Significant pressures and challenges in the acute service line remain and demand for beds has increased at a time when our LOS and DTOC position is challenging. We plan to extend our block contract with the Priory until March 2024.	5,6,364	13
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%**			
11						Conclude the evaluation of the Crisis Assessment Unit	151 days	Tue 29/10/24	Mon 26/05/25	L.McDonagh	10%	Work with the improvement team is ongoing. Data has been collected and is being analysed and reviewed by the team.	10	
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%**			
13						Build up team to be providing both therapeutic and activities for service users (linked to skill mix review and elimination of OOAP)	262 days	Wed 02/10/24	Wed 01/10/25	L.McDonagh	40%	Remaining posts to be advertised in the New Year.	4	
16						**Community and wellbeing**	**782 days?**	**Fri 01/04/22**	**Mon 31/03/25**	**A Toolan**	**44%**			
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**	**A Toolan**	**43%**			
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	A Toolan	60%	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.	18,42,90,23	169
43						**Forensic services**	**783 days**	**Sat 01/04/23**	**Tue 31/03/26**	**J.Faulkner**	**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**	**J.Faulkner**	**49%**			
46						Work with CMHT colleagues to identify those ready to step out of specialised care and to agree transition pathways	118 days	Thu 19/10/23	Fri 29/03/24	J.Faulkner	50%	12 SUs identified to transfer to WAA CMHS during December and January. Ongoing work as a part of the community recovery workshops continues. FOT and PCMHS to develop their relationships and pathways.	18	
47						To identify service users outside natural clinical flow in secure under CMHT and agree transition to FOLS, also to ensure all service users have a link care coordinator	118 days	Thu 19/10/23	Sun 31/03/24	J.Faulkner	100%	FOT now care coordinate SUs within secure services. The wider LYPFT community recovery work continues, where FOT are a key member of this group.	18	
61						**Perinatal and liaison**	**522 days?**	**Sat 01/04/23**	**Mon 31/03/25**	**P.Fotherby**	**34%**			
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**	**22%**			
70						To re-integrate ALPS within the emergency department at SJUH to improve responsiveness and experience of those who attend in crisis	261 days	Mon 01/04/24	Fri 28/03/25	P.Fotherby	50%	New SDEC facility opened in December 2023 with an additional high risk assessment room and some multi-purpose rooms. A decision is imminent on the ALPS team accommodation in SJUH.	69	
73						**Children and young people**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**N.Mant**	**60%**			
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.**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**N.Mant**	**40%**			
75						Implementation of the new Alternative to hospital provision within Mill Lodge	262 days	Sat 01/04/23	Fri 29/03/24	N.Mant	40%	Alternative to hospital now formally named "Willow View". Very positive progress with estates. Working well with the team to minimise impact on the wider unit. Currently on target for completion date. Recruitment remains a challenge.	162	
82						**Rehabilitation, eating disorders and gender identity**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**R.Carroll**	**65%**			
86						**Complete R&R and AOT review and implement recommendations for a Complex Psychosis Service**	**544 days**	**Sat 01/04/23**	**Wed 30/04/25**	**R.Carroll**	**45%**			
88						Re-design service delivery model for complex psychosis clinical pathway, with greater emphasis on community care.	479 days	Fri 30/06/23	Tue 29/04/25	R.Carroll	50%	Developed PID - sets out case for change and new pathway principles. Awaiting stakeholder feedback then take to SDG. New implementation action needed (if business case approved) for 2024/25.	87	
89						Establish Complex Psychosis Practitioners within PCN/CMHT sites embeding rehab skills/resources within CMHT/PCN hubs	262 days	Sat 01/04/23	Sun 31/03/24	R.Carroll	100%	Start date March 2024. Recruitment has been given the go ahead and commenced. However, it will be March 2024 before people in post at the earliest.	18	
91						Rescope rehab inpatient bed demand for community rehab units	241 days	Mon 01/04/24	Sat 01/03/25	R.Carroll	0%	Dependent on implementation of CP Pathway. Continue action 2024/25.	87	
96						**Development of our locked and rehabilitation pathways**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**R.Carroll**	**80%**			
97						Implementation of an enhanced clinical model of care delivery on Locked Inpatient ward at the Newsam Centre, based upon NICE guidance and GIRFT rehabilitation recommendations.	262 days	Sat 01/04/23	Fri 29/03/24	R.Carroll	80%	Recruitement to the ward 5 workforce mobilisation plan is on schedule.	87	
123						**Our Digital Plan**	**1066 days?**	**Tue 01/03/22**	**Tue 31/03/26**	**B.Fawcett**	**46%**			
133						**Deployment of Electronic Document Management System**	**262 days?**	**Sat 01/04/23**	**Sun 31/03/24**	**I.Hogan**	**50%**			
135						Rollout of system complete/ Deploy update to Datix system.	261 days	Mon 01/04/24	Mon 31/03/25	I.Hogan	0%	Project planned to commence in 2025	254	
140						**To ensure that Trust defences against cyber threats are affective**	**782 days**	**Fri 01/04/22**	**Mon 31/03/25**	**I.Hogan**	**63%**			
142						Assessment against ISO 27001/Cyber Essentials and migrate key backend infrastructure services to Cloud based services	261 days	Mon 01/04/24	Fri 28/03/25	I.Hogan	10%	Work to understand requirements and national direction of travel for cyber standards underway	141	
143						**Streamline the process for on-boarding staff**	**783 days**	**Fri 31/03/23**	**Tue 31/03/26**	**I.Hogan**	**0%**			
144						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	315	145
145						Deployment of replacement system	521 days	Tue 02/04/24	Tue 31/03/26	I.Hogan	0%	Project planned to commence in 2024/25	144	
157						**Strategic Estates Plan**	**1696 days?**	**Fri 01/10/21**	**Fri 31/03/28**	**D.Hanwell**	**33%**			
166						**Owned Estate**	**1696 days**	**Fri 01/10/21**	**Fri 31/03/28**	**J.Campbell**	**22%**			
169						Understand the impact of community transformation on our locality hubs	522 days	Sat 01/04/23	Fri 28/03/25	J.Campbell	10%	To be considered in the review of the Strategic Estates Plan	20	
250						**Nursing and professions strategy**	**1697 days?**	**Mon 01/04/19**	**Tue 30/09/25**	**N.Sanderson**	**65%**			
268						**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.Marshall**	**50%**		**15**	
276						**People Plan**	**1303 days?**	**Thu 01/04/21**	**Tue 31/03/26**	**D.Skinner**	**64%**			
284						**Keep our people protected, safe and well at work**	**522 days**	**Fri 01/04/22**	**Sun 31/03/24**	**F.Dodd**	**35%**		**173,253**	
297						**Grow collective leaders that reflect Trust values**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**F.Sherburn & A.Earnshaw**	**75%**			
298						Evaluate the impact of the rollout of the collective leadership programme and developing inclusive leaders programme and to co-create the forward plan to deliver continuous development and improvement	262 days	Sat 01/04/23	Fri 29/03/24	F.Sherburn & A.Earnshaw	75%	We are completing an evaluation after each workshop and intervention and learning from this used to shape the programme going forward. Outline development programme for 2024 is being developed for the CEO to review/comment on.	30,54,248	
308						**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%**			

Trust Organisational Priorities 2023 - 2030: Quarter 3 Progress Report - interdependencies across schemes

ID	Task Mode	Q3 RAG	Q2 RAG	Q1 RAG	Mover	Task Name	Duration	Start	Finish	Lead	% Complete	Progress Update	Predecessors	Successors
309						Following a 12 month data gathering process, utilise systems data (appraisals/ LNA/Career conversations) to assess quality and to inform support interventions to guide improvements to	262 days	Sat 01/04/23	Fri 29/03/24	F.Sherburn & A.Earnshaw	40%	We are continuing to monitor our progress. The data is being collated in our iLearn system to support the data anaysis. Work is underway to deliver this for year end.	29,234,235,23	
310						**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**	**76%**		**242**	
317						**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**	**77%**		**28,246,252,32**	
336						**Embed reward and recognition in our Trust to create a culture of our staff feeling valued**	**783 days**	**Sat 01/04/23**	**Tue 31/03/26**	**F.Dodd**	**17%**		**190**	
349						**Research & Development**	**587 days**	**Sat 01/01/22**	**Sun 31/03/24**	**S.Cooper**	**75%**			
350						**Create a culture of research being core business**	**522 days**	**Fri 01/04/22**	**Sun 31/03/24**	**S.Cooper**	**75%**		**267**	



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:	Board Assurance Q3 Update Report
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 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.

Following approval at the Board of Directors in November 2023, the BAF is now populated with the seven strategic risks from the Strategic Risk Register, due to the removal of the standalone PFI strategic risk; the relevant detail is now included in strategic risk 5 related to the Trust estate.

In February 2024, a Board Strategic Discussion will take place to discuss and agree the Trust's strategic objectives and priorities for the coming year. Following this discussion, a full review of the BAF will take place to ensure that it is reflective of the associated high-level risks aligned to the objectives. It is anticipated that this will take place in Q1 of 2024/25.

The Board is reminded that the BAF is presented here for assurance on its completeness as of January 2024.

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.
- Note the proposal for full review in Q1 of 2024/25 aligned to the organisational priorities and objectives once agreed in February 2024.

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 solutic 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)	Jonathan 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	Jonathan 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	Jonathan 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	Jonathan Campbell / Dawn Hanwell	Estates Steering Group	9	9	9	9
1142	The increasing frequency and severity of periods of summer time 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 and *Millfield House*	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 Physical 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-24
SR5	Care Services Strategic Plan	Board approved	Sep-22
SR5	Discussions with IPA (Infrastructure & Projects Authority) regarding PFI demise	Regular dialogue with the IPA managed through the PFI Expiry Health Check process. Action plan integrated into the PFI Concession Group Work Plan.	Ongoing
SR5	Risk Assessments in place and regularly reviewed regarding lone working	Care Services to regularly review Risk Assessments	Ongoing

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 developed , Ongoing meetings	Mar-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	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

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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

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:	Quality Strategic Plan Update
DATE OF MEETING:	Thursday 25 January 2024
PRESENTED BY: (name and title)	Chris Hosker
PREPARED BY: (name and title)	Richard Wylde and Chris Hosker

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

EXECUTIVE SUMMARY

This paper supports the proposed refresh of the Quality Strategic Plan for 2024 – 2029. This refresh is based on feedback from the previous Quality Strategic Plan, it does not change the principles set out in the 5 core domains, but now also shows how each of the domains are linked and with each explanation of the domains clearer.

There is also the supporting Quality Strategic Plan Activity Report that highlights the main progress in the last period.

The action needed from Quality Committee is to give approval for the Quality Strategic Plan for roll out and to be assured from the activity plan that work to embed the Quality Strategic Plan continues.

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

1. Approval of the refreshed Quality Strategic Plan
2. Assurance of the implementation of the plan

MEETING OF THE BOARD OF DIRECTORS

25 JANUARY 2024

Quality Strategic Plan Update

1 Executive Summary

1.1 This paper supports the proposed refresh of the Quality Strategic Plan for 2024 – 2029. This refresh is based on feedback from the previous Quality Strategic Plan, it does not change the principles set out in the 5 core domains, but now also shows how each of the domains are linked and with each explanation of the domains clearer.

1.2 There is also the supporting Quality Strategic Plan Activity Report that highlights the main progress in the last period.

1.3 The action needed from Quality Committee is to give approval for the Quality Strategic Plan for roll out and to be assured from the activity plan that work to embed the Quality Strategic Plan continues.

2 Quality Strategic Plan Refresh

2.1 The Quality Strategic Plan has been refreshed based on feedback from across the organisation, from front line members of staff to the board. The original plan, though comprehensive, was overwhelming in its detail and size and whilst the 5 domains were well received after explanation, it was hard to understand how they linked.

2.2 Following this feedback, the refresh of the strategy would split the document in to 2 parts. The first would be a document that just focused on the principles of the Quality Strategic Plan, the second would outline the activity that was taking place, or planed for, to support either the delivery of the Quality Strategic Plan as a whole or supporting activity for the individual domains.

2.3 Both these documents are included within the submission of this paper.

2.4 Following approval of the Quality Strategic Plan by Quality Committee, the next steps will be to continue with the activities that are already underway, start to socialise the refreshed plan at all levels of the organisation and begin to map out what needs to be planned for the 2024/5 Activity Plan.

3 Conclusion

3.1 The refreshed Quality Strategic Plan is more accessible, with supporting activity underway and new activity identified.

3.2 This refreshed strategy will also be used to better understand how the Quality Strategic Plan can support the other trust strategies.

4 Recommendation

- Approval of the refreshed Quality Strategic Plan
- Assurance of the implementation of the plan

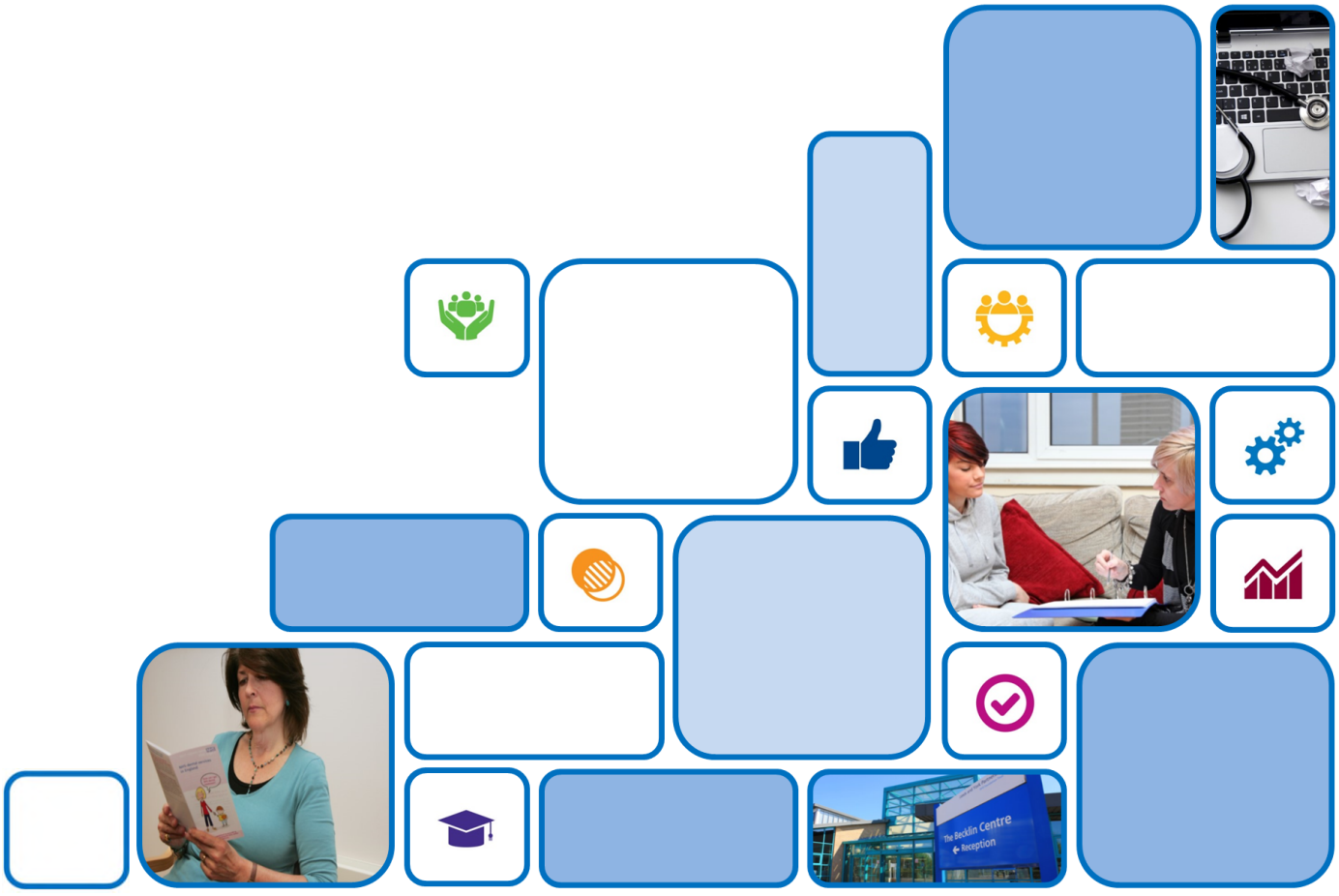
Name of author/s	Richard Wylde	Chris Hosker
Title/s	**Deputy Director of Improvement**	**Medical Director**

Date paper written 17/01/2024

Leeds and York Partnership
NHS Foundation Trust

Quality

Strategic Plan 2023 – 2028



Quality Strategic Plan
2023 - 2028

Contents

Foreword

I am honored to present LYPFT's three-year Quality Strategic Plan. This is the second LYPFT quality focused strategy and is built firmly on the foundations created by its predecessor. As the Medical Director, I recognize the paramount importance of ensuring the highest standards of mental health care for our community. The strategic plan that we have developed embodies our commitment to excellence, innovation, and, above all, the improved mental health of those we serve.

In these challenging times, our dedication to quality care is more crucial than ever. This document outlines our strategic vision, objectives, and the collaborative efforts required to elevate our mental health services by attending to the elements that will allow quality to flourish.

I extend my gratitude to all of you whose expertise and passion shape our services daily. Through this strategic plan, we aim to meet the high expectations for services that we all share by fostering an environment where individuals can find solace, support, and empowerment through the course of their mental health journeys.

I invite you to really delve into the details of this plan with the aim of fully owning it, wherever you work in the organisation. Together, we can build a robust foundation for quality that is resilient to the challenges and prioritises the mental health and well-being of every individual we serve.

When I first became an NHS consultant in 2008, there was a building focus on quality across the NHS and a growing ambition to deliver high quality care for all. It was clear that this would require huge sustained collective efforts and culture change to become a reality. Those efforts have been very palpable in LYPFT during the intervening years and when I became Medical Director for LYPFT in 2020 I was extremely grateful to inherit a proud legacy of quality improvement that had been driven by my predecessor, Claire Kenwood. Having witnessed the organization start to make productive strides towards consistent quality improvement I am determined to work with all of you to maintain those gains and build upon them.

The Quality Strategic Plan is our road map to achieving the aim of delivering high quality care through every interaction in LYPFT. This latest version has at its heart, an intention to weave quality into the fabric of our organisation. That is only going to be possible if the Quality Strategic Plan is something that is owned, understood, and implemented by all of us, from Board to Ward. I was therefore keen that we harnessed all the evidence and technical knowledge in the first iteration and translated that into something that we can all, own, use and be guided by, at every level, as we strive to make LYPFT an organisation that provides uniformly high-quality mental health care.

Dr Chris Hosker
Medical Director

Introduction

Our aim is to create the conditions in all areas of the organisation for quality to be experienced.

A first crucial step in achieving that is for staff to be clear what quality is. Quality can mean different things to different people, and confusingly, there are multiple definitions of 'quality' across the NHS and our regulators.

Within LYPFT we believe that quality is about making healthcare safe, timely effective, efficient equitable and patient centered (*STEEEP*) and it is important this now becomes the singular definition of quality that we all commit our efforts to.

In 2018 the first LYPFT Quality Strategic Plan was agreed at Board following extensive discussions with the Council of Governors, Board, senior leaders, and consultation clinical governance forums.

The plan was underpinned by the philosophy that the organisation exists to provide high quality continuously improving care, and that this occurs at the point of every contact in the service of this purpose.

The Trust delivers 19 services all with different drivers and needs. To ensure that each service is supported, changes to the way we are structured (*flattened hierarchy, collective and distributed leadership, enhanced and aligned clinical leadership, refreshed clinical governance*) have already been undertaken with the mantra that we centralise by principle, while enabling delivery to be diverse enough for each service and service user.

We believe that quality care should be experienced at the point of contact between the clinician and those using our services. We know that to achieve this we need to have an approach that acknowledges:

- The work that we do is often complex.
- Successful outcomes depend on the knowledge of many being brought together in the right way.
- The wider work of the organisation is to create the conditions where quality can flourish.
- The Quality Strategic Plan is central to the delivery of our ambitions for quality care, job satisfaction for our staff and meeting the financial challenges facing the NHS.
- It provides us with a framework for delivering the right care, in the right way, each and every time.
- Our approach to quality creates real challenges and tensions.
- We must allow our people take ownership of quality, but also maintain an oversight and consistent approach to quality together for the entire organisation.
- We must use the best international evidence, but also build on the local experience of our service users, carers and staff to drive change.

Our Strategic Priorities

The vision for Leeds and York Partnership NHS Foundation Trust (LYPFT) is to provide outstanding mental health and learning disability services as an employer of choice. Our ambition is to support our service users and carers, our staff, and the communities we serve to live healthy and fulfilling lives.

To help us to work together to fulfil this ambition, our approach to quality must be universal across all areas of the organisation. By understanding how our quality (*Safe, Timely, Effective, Efficient, Equitable and Patient-centered care*) impacts on the services we provide we will undoubtedly encounter challenges and tensions.

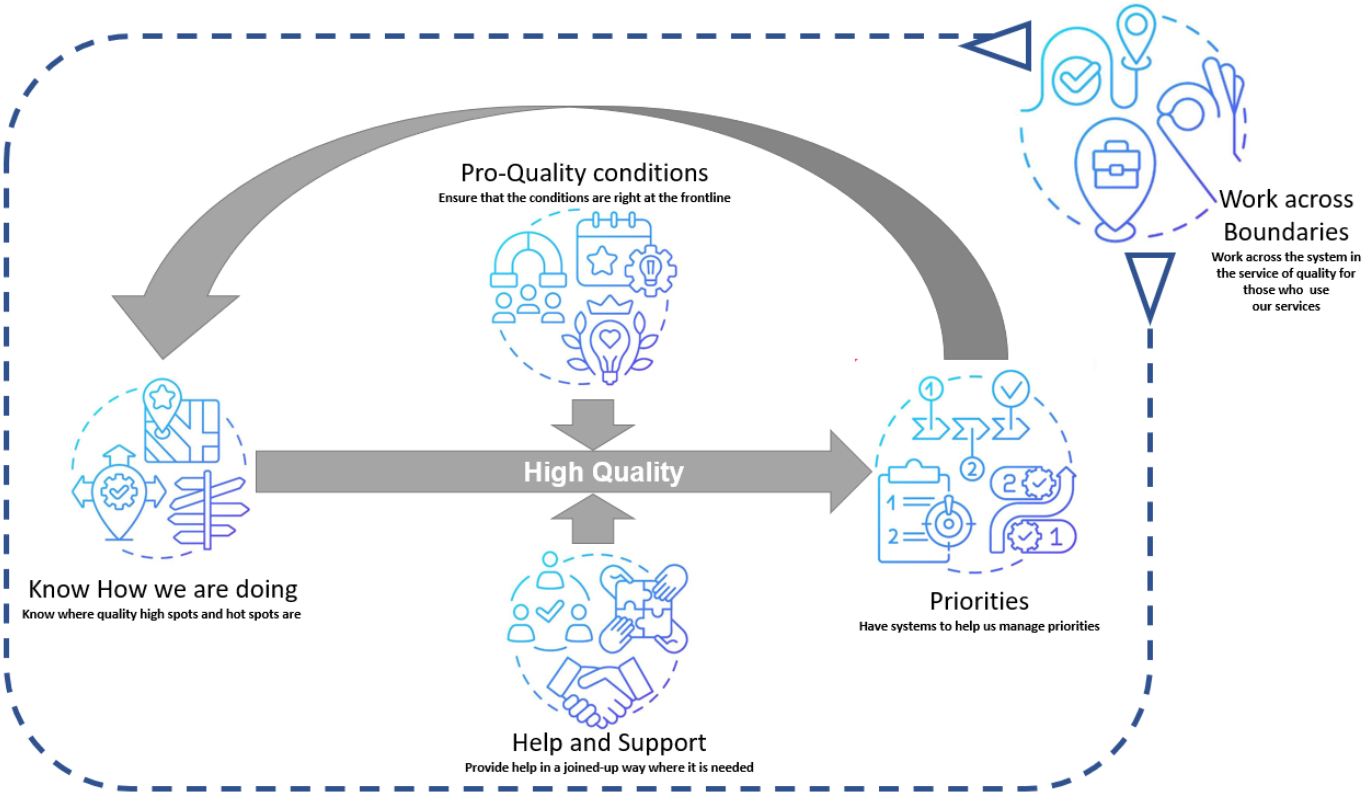
Our approach needs to help people take ownership of quality yet bring it together for the entire organisation. It must take the best international evidence, as well as build on local experience of our service users, carers, and staff. It must acknowledge the many ways we can see and improve quality yet provide a systematic and integrated whole. It must see quality as what happens in order to deliver the care for those who use our services, whilst acknowledging the contribution of all our staff. Quality within the organisation should be experienced at the frontline, yet led from every level, and every service, including the top.

Most of all, we need to start by placing our service users, carers and families at the heart of what we do. We will learn how best to build our services through our relationships with individuals and their support networks.

Our Model

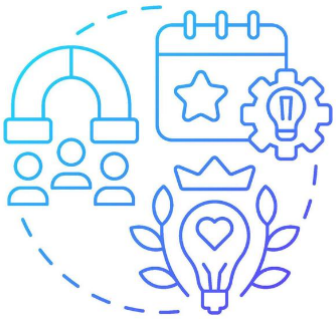
To enable us to deliver our quality strategic priorities we have built on the work of the previous Quality Strategic Plan to enable a connected view of the 5 areas which:

- Uses the evidence to build **pro-quality conditions** for quality care to flourish.
- Establishes a system that helps us **know how we are doing** floor to Board.
- Provides **help and support** where it is needed and does this in a joined-up way.
- Develops systems to ensure that we can set and deliver **priorities** with clarity and equity.
- Uses our integration skills to **work across boundaries** and systems with partners to make sure that we deliver joined-up high quality care.



These five components of the Quality Strategic Plan will support the organisation to deliver high quality care, by creating the conditions in which quality can flourish and ensuring there is an environment in which individuals/teams/services can come together where the challenges and opportunities we face cannot simply be resolved through technical fixes. This is where responsibility for the solution is greater than one person's and requires learning, even by those with expertise, to identify and embed the solution. We know that leadership is crucial, but we also need to know how we are currently doing, what our priorities are to ensure our efforts are concentrated in the right area, and to build the right relationships across the system to deliver quality across the continuum of care.

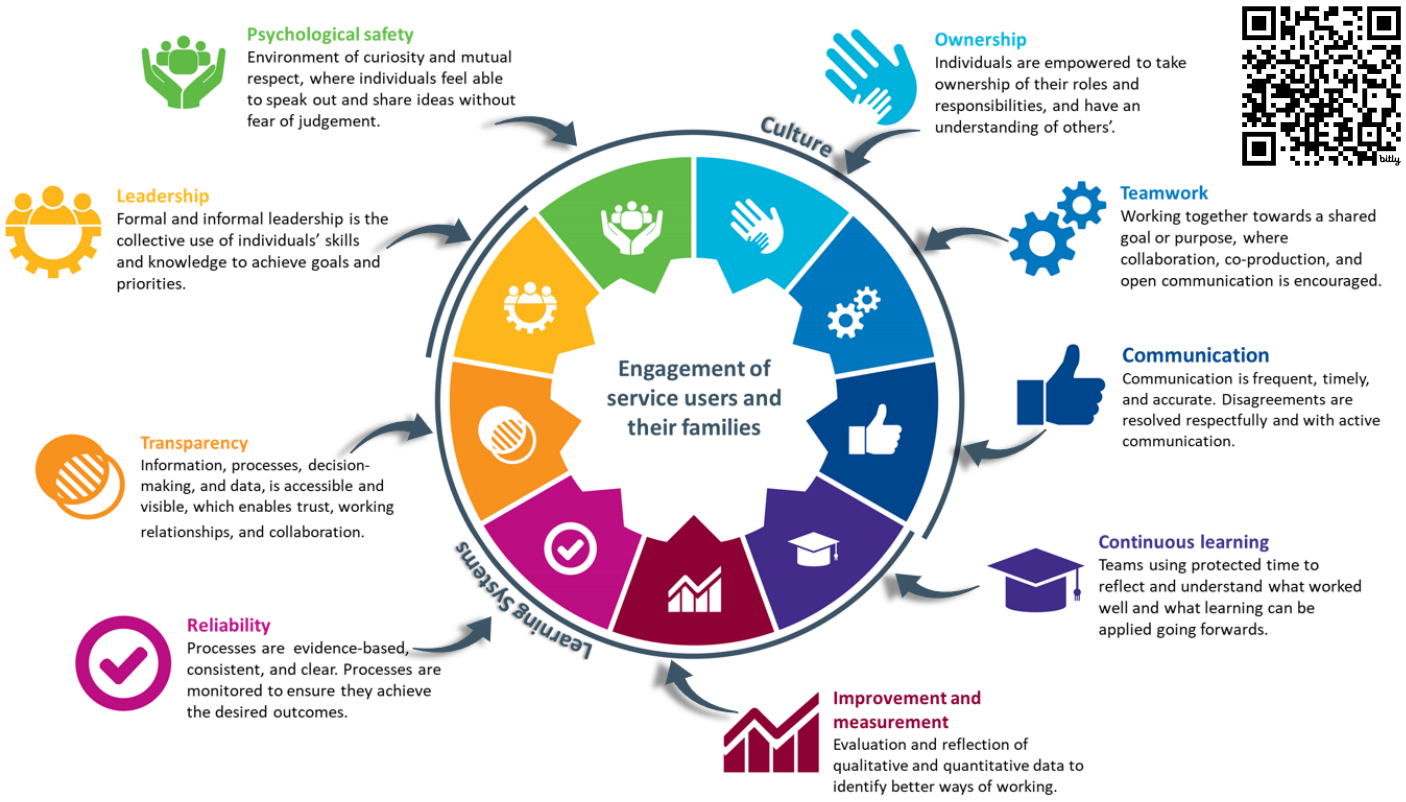
1.1 Pro-Quality Conditions



To develop the Pro-Quality Conditions, we use the Learning Culture and Leadership Framework, which was adapted from the IHI's 'Framework for Safe, Reliable and Effective Care'. This framework summarises the leadership, culture and learning conditions needed for organisations to build on quality and safety initiatives and to allow services to provide great care.

At the core of the framework is the engagement of service users and their families.

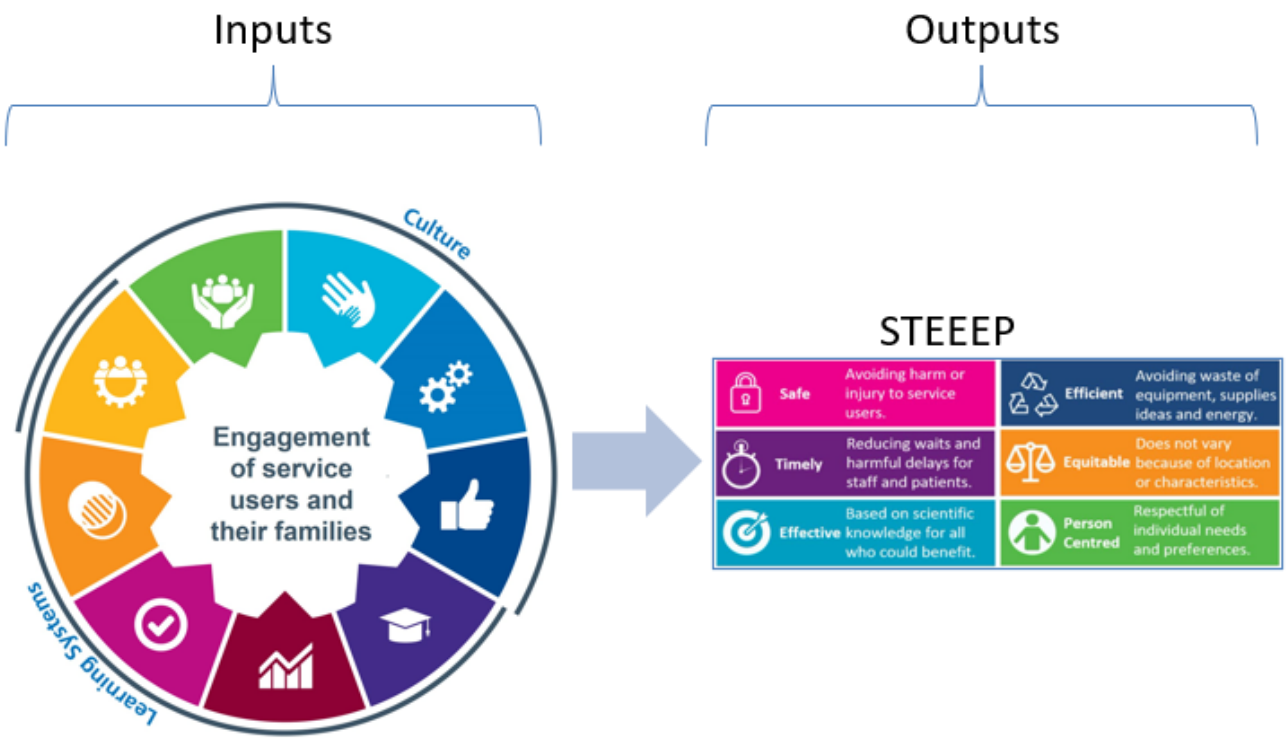
The framework defines culture - in relation to quality - as *'the product of individual and group values, attitudes, competencies and behaviours that form a strong foundation on which to build a learning system'*. The components include a clear ownership framework, coupled with psychologically safe environments in which to question and learn. It includes a focus on teamwork and the ability to communicate and build the right relationships to integrate care. This includes the ability to negotiate and to 'disagree well'.



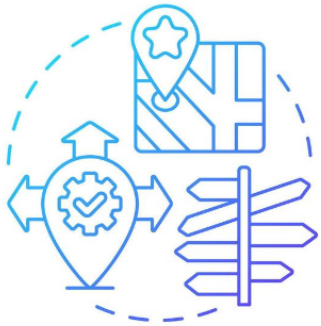
The learning system is *'characterised by its ability to self-reflect and identify strengths and defects, both in real time and in periodic review intervals'*. It includes the transparency required to ensure that we offer reliable care each and every time, coupled with the need to learn from when things go wrong and from best practice. There must be an ability to improve, and that improvement should be driven by measurement and outcomes.

Leadership is the linchpin between both the Learning System and the Culture. It is the leadership that should provide the conditions for all the components to thrive. Leaders are accountable for creating the conditions for good decisions to be made that lead to actions.

The Learning Culture and Leadership Framework provides the Pro-Quality Conditions (inputs) which ensure that the positive outputs will be experienced by those we care for across all the 6 domains of quality.



1.2 Know How We Are Doing

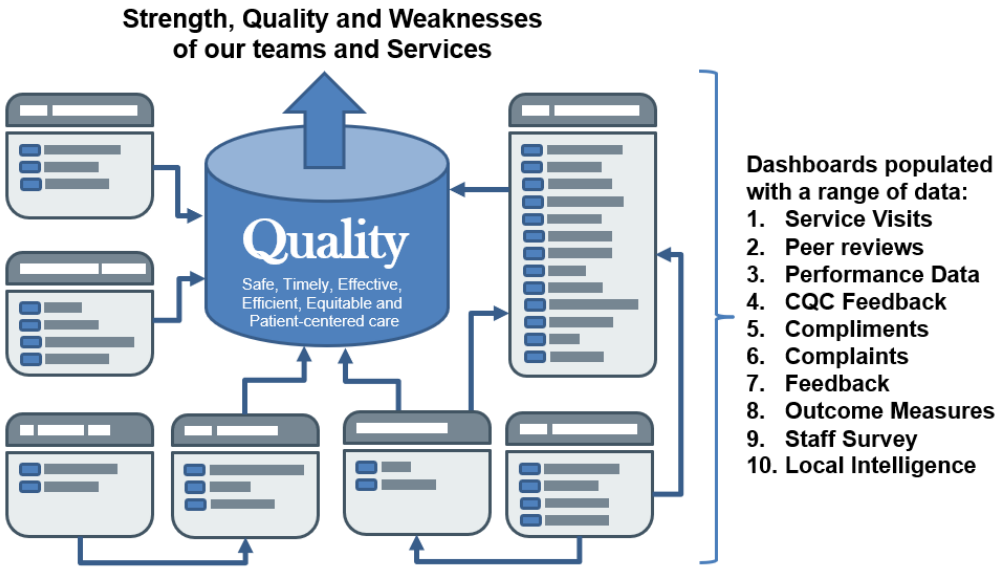


Knowing the quality, strengths and weaknesses of our teams and services – the 'bright lights and hot spots' - will identify the good practice we can learn from and where more support is needed. The need for data to drive improvement at every level in the organisation was reflected in our specification for procurement of a new electronic patient record in 2018. Across the organisation, we already have many ways of assessing quality. These include: service visits and peer reviews; the metrics that make up our combined quality and performance report to our Board; Care Quality Commission feedback; compliments, complaints and service user feedback and outcome measures.

All these information sources will be integrated into our plan to develop both Quality and Culture 'dashboards'.

We will use various sources of intelligence, including our data and peer-to-peer visits to ensure that we identify where early support should be deployed to help teams reflect and improve. We also need to support teams by creating an electronic solution to link their data and their plans for improvement so that they can track their own actions. This solution must also provide access for service lines and an organisation-wide perspective.

This accessibility will provide the opportunity for peer support and learning across the organisation and further strengthen the Trust's approach to learning and providing the evidence of change. This will make us better able to assure ourselves, the Board, our commissioners and our regulators. The technical improvements in the collection, storage and access of data are all necessary but they alone will not improve quality. They must go hand-in-hand with good leadership, a nurturing culture and learning development, if teams are to embed a continuous improvement approach.



1.3 Help and Support

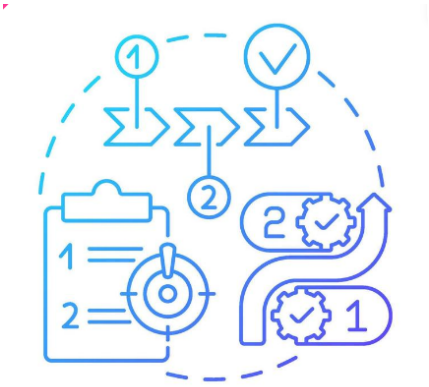
We have a variety of ways to support teams to improve: Project support; organisational development; clinical governance; continuous improvement; audit; service evaluation; and use of national guidance.

Where teams have a good awareness of the areas they need to improve, it is vital that the right support is offered in a way that will make a difference. This will depend on the issue concerned, not the skill set of the person seeking or offering help. Where teams are unable to articulate this need – or indeed have not seen a need to improve – this becomes even more important.

To meet this challenge, we must ensure that we work in an integrated way. Our aim will be to ensure key support services are able to come together at the same time to build a collective coordinated support package, rather than these individual functions working independently of each other when supporting teams and services.

The next step will be the work with teams to develop an integrated offer and the processes and practices to support this.

1.4 Priorities



There will be a balance between locally owned quality objectives and goals, alongside overarching national and Trust priorities. We know that when we have multiple, competing, or contradictory priorities this works against our efforts to improve quality and safety.

When priorities are viewed as 'imposed' and are not owned, there is less likelihood of them being completed and evidence shows us that quality improvement carried out in this way can make things worse. However, it is also the case that as an organisation we are regulated, commissioned and subject to policy and evidence base that will define and shape our priorities.

Presently there are a number of ways that teams, services and the Trust set priorities. We need to develop ways in which these priorities are collaboratively agreed upon but can be revised as needed when new learning occurs from either inside or outside the organisation.

Where individuals and teams can implement an idea or priority activity, they should be able to do so. However, where the impact of it spans wider than their service, there needs to be a wider approach to implementation.

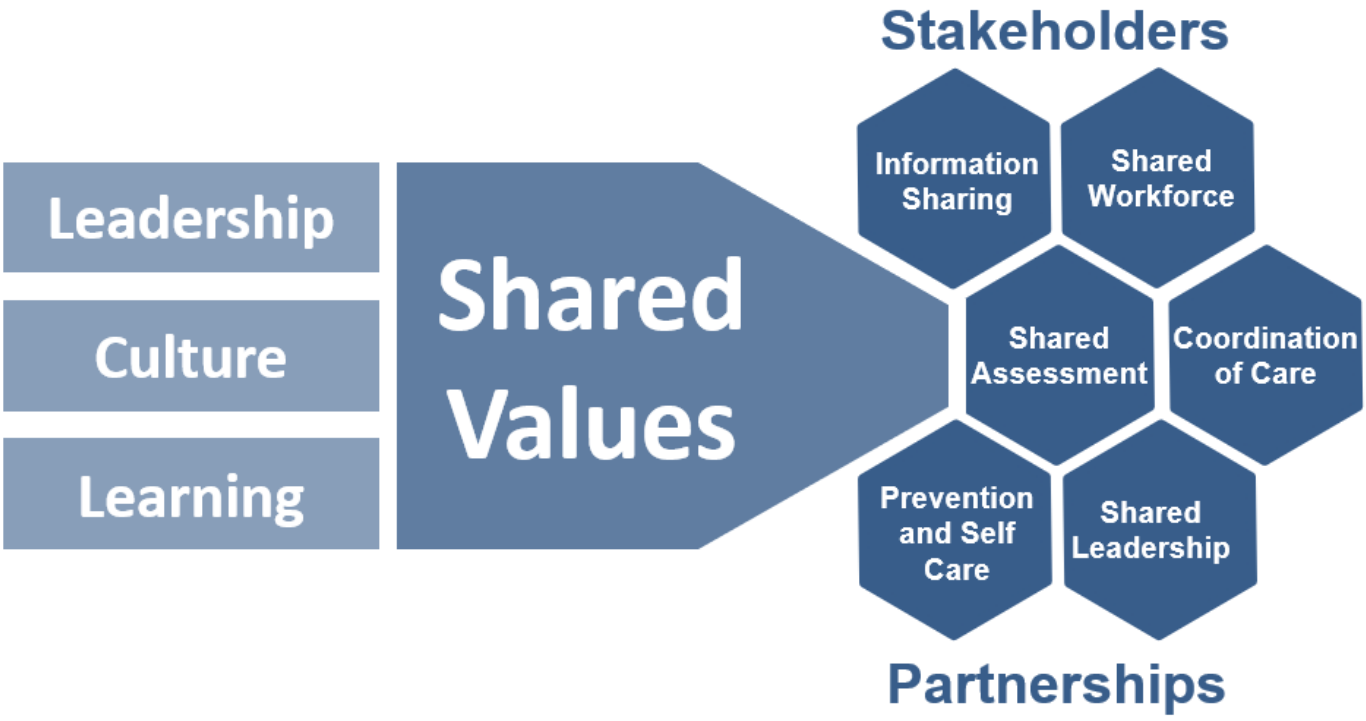
1.5 Work Across Boundaries

There is an emergence of models that put not just organisational integration, but systems integration at their heart. These include Place-based plans, Accountable Care Organisations; Sustainability and Transformation Partnerships; Accountable Care Systems and Integrated Care Systems.

These models reflect the evidence that cross-cutting problems require collaboration by multiple organisations and experts. As expertise deepens and becomes narrower, the problems we face are becoming broader and multifaceted. Clinically for example, we know that we are faced with complex problems that require expertise beyond that of the multi-disciplinary team; often requiring work across multiple organisations or sectors to give the person-centred care an individual needs.

The models equally draw on evidence that shows integration based on having the right relationships across systems is essential to maintaining quality in a world where resources are becoming tighter.

Building the leadership, culture and learning to support integration and collaboration *within our organisation* at every level will build the same skills, values and attitudes required to serve our population *across boundaries* and care pathways.



Oversight and Governance of the Trust Quality Strategic Plan

Accountability and delivery of the Trust Quality Plan will come from the Quality Committee, which will delegate the day-to- day delivery and oversight to the Trust-wide Clinical Governance Group (TWCG).

Any team or service specific Trust Quality Plan activity will be overseen by the respective Service Line, through service development and clinical governance meetings. These will report to TWCG and the Quality Committee.

Each clinical Service will provide an Annual Service Quality Report that now reflects the 5 areas of the Quality Strategic Plan.

Resource implications of implementing this strategic plan have been considered and will be mostly met by realigning existing resources.

How we will deliver the Quality Strategic Plan

It is clear that there is a lot of great work currently underway across the Trust which will support elements of the Quality Strategic Plan. However, the plan also highlights the gaps that need to be closed so that our organisation can develop into a place where quality is embedded and becomes the ‘norm’.

Whilst the Quality Strategic Plan outlines the ambition of what we want to achieve, it will be supported by a yearly delivery plan that sets out the tasks, action and activities that will be the focus of that year.

Quality Strategic Plan – Activity Report

Report title: 2023/4 Activity Plan	Date: 28/11/2023

Over-arching Project Status and Summary

Overall RAG	Summary
G	The work on the Quality Strategic Plan (QSP) continues to build. The main highlight is the revised QSP which still has the 5 components at its core, but with a clearer connection between how the components are linked, is in the process of ratification. There has been good progress made on the Learning, Culture and Leadership framework, with this now being available as an interactive session with teams completing it in real time. The Annual Service Quality Reports had a new structure launched this year which has received very positive feedback. Following on from this there is a new draft process out to consultation to aid the Quality Committee. This process has been redesigned which further helps the services to focus on the quality of their service and the conditions needed for it, as well as having a process for just the service to inform Quality Committee the level of quality they are delivering – this is a real floor to board process.

Risks / Issues

RAG	Risk / Issue	Mitigating Action	Action Date	Responsible Owner
A	STEEEP is not always used when trying to understand Quality within the organisation	TBC		
A	The QSP isn't understood or used to support the other organisational strategies	TBC		

Workstream Status and Activity Update

BRAG	Workstream	Stage	Aim	Headline Next Actions
A	Wks 1 – Raise Awareness	Start Out	To raise awareness across the organisation of the QSP and its components	Meeting with Clinical Directors to help it embed into clinical services. Meet with other executives to see how the QSP is linked to the other strategies.
G	Wks 2 – Application **Pro-Quality Conditions**	Implementation	To embed the LCL framework as a key development tool for teams and services. This framework summarises the leadership, culture and learning conditions needed for organisations to build on quality and safety initiatives and to allow flourishing services to provide great care.	• Continue to explore the use of Menti Meter for real time use of LCL • Following a successful first meeting with NHS Wales and Grand River Hospital (Ontario, Canada), continue to explore the resources each organisation has to support the framework. • Start to explore how corporate services can apply the framework. • Continue to support the Collective Leadership programme for 2024, after a successful 2023 programme – leadership is the linchpin in the LCL framework
A	Wks 3 – Application **Know How We Are Doing**	Define and Scope	Knowing the quality, strengths and weaknesses of our teams and services will identify the good practice we can learn from and where more support is needed.	• Quality and Culture dashboards • Annual Service Quality Report Process
	Wks 4 - Application **Help and Support**	To be scoped 2024		
	Wks 5 – Application **Priorities**	To be scoped 2024		
A	Wks 6 – Application **Work Across Boundaries**	Implementation	By using different approaches to help support integration and collaboration within our organisation and where there is need to work across boundaries.	Currently the main focus has been on the use of Relational Coordination to support teams and groups to look how they relate across care pathways and activities. There has been use of the Relational Coordination methodology at board level, senior leadership level and team level.

High Level Measures

Title	Baseline	Goal	Current
Number of Services with a completed LCL	TBC	TBC	TBC
Number of Services with their own STEEEP measures	TBC	TBC	TBC

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:	Draft Violence Prevention and Reduction Strategy and self-assessment against the Violence Prevention and Reduction Standard
DATE OF MEETING:	25 January 2024
PRESENTED BY: (name and title)	Frances Dodd - Associate Director for People Experience
PREPARED BY: (name and title)	Frances Dodd - Associate Director for People Experience

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 Foundation Trust (LYPFT) is committed to reducing violence, as identified within Our People Plan, under the strategic priority of "Belonging in the NHS". This supports the overall NHS People Plan promise to prevent violence, so that "staff should never be fearful or apprehensive about coming to work". This demonstrates our commitment to the health and wellbeing of colleagues, as well as recognising the negative impact that poor health and wellbeing can have on service user care.

The national violence prevention and reduction (VPR) standard (see here) complements existing health and safety legislation and is a data-driven method focusing on colleague health and wellbeing, in a way that is reflective, proactive, preventative, responsible and accountable.

All NHS-funded services operating under the NHS standard contract are required to review and self-assess their status against the VPR standard twice a year and provide Board assurance. Performance is to be measured against the standard, as well as the Trust's overall VPR Strategy. Both the draft Strategy and our self-assessment against the VPR standard is detailed within this paper.

The draft VPR Strategy within this paper outlines our vision, intent, objectives and organisational functions and responsibilities in delivering the VPR standard. Once approved, the Strategy will be supported with a policy, outlining its implementation.

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
Members of the Board of Directors are asked to review and agree the Violence Prevention and Reduction Strategy, as well as the self-assessment against the VPR Standard

Leeds and York Partnership
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS

25 January 2024

Draft Violence Prevention and Reduction Strategy and self-assessment against the Violence Prevention and Reduction Standard

1 Executive Summary

Leeds and York Partnership Foundation Trust (LYPFT) is committed to reducing violence, as identified within Our People Plan, under the strategic priority of "Belonging in the NHS". This supports the overall NHS People Plan promise to prevent violence, so that "staff should never be fearful or apprehensive about coming to work". This demonstrates our commitment to the health and wellbeing of colleagues, as well as recognising the negative impact that poor health and wellbeing can have on service user care.

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All NHS-funded services operating under the NHS standard contract are required to review and self-assess their status against the VPR standard twice a year and provide Board assurance. Performance is to be measured against the standard, as well as the Trust's overall VPR Strategy. Both the draft Strategy and our self-assessment against the VPR standard is detailed within this paper.

The draft VPR Strategy within this paper outlines our vision, intent, objectives and organisational functions and responsibilities in delivering the VPR standard. Once approved, the Strategy will be supported with a policy, outlining its implementation.

2 Background of the Strategy

The attached VPR Strategy is an essential document that is needed to achieve the VPR standard, as well as providing the Trust with some clear objectives to prioritise workstreams. It was presented to the People Experience Group and People and Organisational Development (POD) in January 2023, and at this POD Group it was requested the strategy be further developed and hence, following numerous rounds of consultation, with various key services, such as Red Kite View, Acute, Forensics, as well as Health and Safety, our Staff networks, Staffside, People Employment, Equality, Diversity

and Inclusion (EDI) and Wellbeing, this Strategy now covers a wider remit. As detailed above, this Strategy has been written collaboratively, but now also incorporates recent Trust workforce priorities on incidents of hate and domestic violence and sexual safety. It also details the wellbeing support and the established critical incident support, which is provided following any violent incidents. This paper and accompanying VPR Strategy was presented and approved at the People and Organisational Development Group in November 2023 and also the Workforce Committee in December 2023.

The implementation of the VPR Strategy will be led and monitored from within the Violence and Reduction Steering Group, but receive input from other groups, as detailed in the Strategy. The delivery and impact of this Strategy will be monitored and part of achieving the standard requires reporting to the Board twice a year.

3. Review against the VPR standard

Following the six monthly assessment against the VPR standard (as here) please see the current compliance rating as below. More detail is provided in the excel attachment, as well as outstanding actions, with accompanying timescales.

As of 5 November 2023, when self-assessing against the standard, we are partially compliant. Out of a total of 43 areas, 20 areas are complete, with 23 still outstanding. All outstanding actions are on track and many are dependent on this VPR Strategy being approved and embedded.

Overall Rating - Standard	Current Compliance Rating	Target Compliance Rating	Pending Actions
PLAN			8
DO			5
CHECK			6
ACT			4

Table one: Compliance against the VPR Standard

4 Recommendation

Members of the Board are asked to review and agree the Violence Prevention and Reduction Strategy, as well as the self-assessment against the VPR Standard.

Frances Dodd
Associate Director of People Experience
12/01/2024

Leeds and York Partnership
NHS Foundation Trust

VIOLENCE PREVENTION AND REDUCTION STRATEGY

October 2023 – Draft 2

Contents:

1. Background

Leeds and York Partnership Foundation Trust (LYPFT) is committed to reducing violence, as identified within Our People Plan, under the strategic priority of “Belonging in the NHS”. This supports the overall NHS People Plan promise, so “people should never be fearful or apprehensive about coming to work”.

This strategy outlines our vision, intent, objectives, organisational functions and responsibilities in delivering this promise. It will be supported with a Violence Prevention and Reduction policy, outlining the delivery and implementation of this strategy within our Trust, with the aim of achieving the NHS National Violence Prevention and Reduction Standard. This will also be linked to the Security Management Policy, which incorporates both the physical security of premises and the reduction of security related risks to our People.

2. Our Vision

Our Vision is to create a culture where our people feel encouraged to report all incidents of violence, to constantly strive to reduce the number and severity of violent and hate incidents and to proactively provide effective wellbeing and critical incident support.

3. Our Legal Framework

NHS Employers have a duty to protect the health, safety and welfare of staff under the 1974 Health and Safety at Work Act. This includes assessing the risk of violence and taking steps to reduce it as required under the Management of Health and Safety at Work Regulations 1999.

The Health and Safety Executive (HSE) defines violence at work as:

“Any incident in which an employee is abused, threatened or assaulted in circumstances relating to their work”. This covers the serious or persistent use of verbal abuse, which the HSE say, *“can add to stress or anxiety, thereby damaging an employee’s health”*. It also covers our people assaulted or abused outside their place of work, for example, while working in the community, when the incident relates to their work.

The World Health Organisation defines violence as:

“*the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, developmental impact, or deprivation*”.

They further state that:

“Violence against health workers is unacceptable. It has not only a negative impact on the psychological and physical well-being of health-care staff, but also affects their job motivation. As a consequence, this violence compromises the quality of care and puts health-care provision at risk. It also leads to immense financial loss in the health sector”.

4. Strategic Aims

In considering the vision and the above definitions, our Trust objectives for Violence Prevention and Reduction are as follows:

- To create a safer working environment and ensure good practice is replicated Trustwide.
- To encourage the reporting of incidents, by achieving a consistent process so that our colleagues feel that reporting is worthwhile.
- Reduce the number, severity and occasions of incidents of violence and incidents of hate in the Trust.
- Reduce colleague on colleague violence and incidents of hate and strive to become an “anti-hate” organisation.
- Actively work to eradicate any unwanted, inappropriate and/or harmful sexual behaviours towards our people.
- Reduce colleague time lost and absences resulting from violent incidents, incidents of hate and unwanted, inappropriate and/or harmful sexual behaviours.
- Ensuring an effective, proactive and supportive wellbeing and critical incident support pathway following violence and incidents of hate and unwanted, inappropriate and/or harmful sexual behaviours
- Ensure adequate support for those engaging with the criminal justice system.
- Develop and embed an engagement, awareness and communication programme alongside these objectives.

5. Purpose

The aim of this strategy is to achieve a safer environment which makes our People feel more secure, so that as stated in the People Promise, they “should never be fearful or apprehensive about coming to work”, ensuring they are emotionally supported and safe. This will be achieved through collaborative working to reduce the incidents and severity of violence, including incidents of hate.

The implementation of the Strategy will ensure we develop consistent measurements, manage information and intelligence in all parts of the organisation and share good practice. It will enable simple yet effective processes and ensure effective and proactive wellbeing and critical incident support to protect our people, service users and visitors.

6. Legislation & Guidance

The following legislation covers violence at work:

- Health and Safety at Work Act 1974 (HASAWA)

- Employers Duty of Care
- Management of Health and Safety at Work Regulations 1999
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)
- Safety Representatives and Safety Committees Regulations 1977
- Health and Safety (Consultation with Employees) Regulations 1996.
- The Corporate Manslaughter and Corporate Homicide Act 2007
- Protection from Harassment Act 1997 – Legislation.gov.uk
- Assaults on Emergency Workers (Offences) Act 2018
- Equality Act 2010 - Legislation.gov.uk
- Offences against the person legislation
- Section 39 Criminal Justice Act 1988

7. NHS Violence Reduction and Prevention Standard

Under the NHS Standard Contract 2021/22, all organisations providing NHS services should have regard to the Violence Prevention and Reduction Standard (General Condition 5) and are required to review their status against it and provide Board assurance that they have been met twice a year.

The NHS Violence Prevention and Reduction Standard was introduced in December 2020, and provides a risk-based framework supporting a safe and secure working environment for NHS people, safeguarding them against abuse, aggression and violence.

The standard uses the Plan, Do Check, Act (PDCA) approach, which is an iterative four-step management method to validate, control and achieve continuous improvement of processes. The Trust will undertake a self-assessment against the standard twice a year, and this assessment will be formally reviewed by the Director of People and Organisational Development (POD) and presented to the Workforce Committee and the Board.

8. Organisational responsibilities

Operational responsibilities that support the implementation of this strategy as well as the NHS Violence Prevention and Reduction Standard, are as below.

The Board is responsible for ensuring that this strategy is implemented and tracking progress of its delivery. Key responsibilities are defined within the NHS Violence Prevention and reduction Standard and include management of the violence prevention and reduction workstreams, ensuring appropriate and sufficient resources are allocated and underpinned by organisational risk assessments.

The Trust has a nominated Executive Director, the Director of People and Organisational Development and a Trust Lead, as Associate Director for People Experience on introducing the violence prevention and reduction standard within the Trust. Responsibility for the various deliverables within the standard are with the groups below.

9. Organisational functions

Violence Prevention and Reduction Steering Group

This group's function is to achieve and embed the NHS Violence Prevention and Reduction Standard, which is a risk-based framework to support a safe and secure working environment for our people. The group is to provide a self-assessment and action plan against the standard twice a year and report through the People and Organisational Development (POD) governance structure, ensuring all outstanding actions are implemented in collaboration with the groups below.

It is important to note that the national Violence Prevention and Reduction Standard, is there to complement existing health and safety legislation.

Positive and Safe Care Working Group

The Positive and Safe Working Group supports the Trust's obligation under the Human Rights Act (1998), Equality Act (2010), Mental Health Act (1983), Health and Safety Act (1974), and other related legislation as amended to show commitment to reducing unnecessary restrictive interventions and supporting the delivery of positive and proactive care.

Aims:

- Represent organisational commitment to restrictive intervention reduction at a senior level.
- Ensure accountability for continual improvements in service quality through the delivery of positive and proactive care.
- Coordinate the development, and drive the strategic agenda, associated with reducing restrictive interventions in the Trust.
- Provide a conduit for the escalation of cultural and practice issues related to restrictive interventions.
- Report to the Executive Team about work which helps to keep colleague and service users safe.

Risk, Health, and Safety Management

Risk Management

Our mission is to protect our patients, visitors, colleague and members of the public from death, injury, and illness, and to meet legal obligations and protect the Trust's assets and reputation by minimising financial loss and poor publicity.

Health and Safety

All colleagues have responsibility for their own and others' health and safety and must co-operate in health and safety arrangements, notably mandatory training to enable them to carry out their work safely. Union-appointed Safety Representatives have an important and valued role in representing the interests of all colleagues (including those who are not in a union), consulting with management and supporting the Trust's health and safety arrangements.

Health and Safety Committee

The Health and Safety Committee has a major role in ensuring that our people have a safe and secure working environment. It also has a statutory role in monitoring the Trust's health and safety, security and fire safety arrangements to ensure compliance with the relevant legislative requirements.

In addition, the Committee is consultative and designed to undertake the Trust's obligations under health and safety legislation to consult with colleagues. The Committee will assure the Board of Directors regarding the effectiveness of health and safety, security, and fire safety arrangements within the Trust.

Sexual Safety Group

The Sexual Safety Group was developed to oversee the implementation of the Sexual Safety standards across the inpatient services in LYPFT and where applicable community services. It is represented by Sexual Safety Leads identified from clinical services, Professional Leads, Safeguarding, Patient Experience, Clinical Governance, and other clinical and corporate staff. The purpose of the group at present is to ensure that the Sexual Safety Standards are implemented within inpatient services across LYPFT.

The group reports into Trust-Wide Clinical Governance (TWCG) on a quarterly basis, whilst also shares learning with Unified Clinical Governance Group (UCGG) and the Learning from Incidents and Mortality Meeting (LIMM). The main duties of the group are as follows, which includes completing actions relating to the implementation of the standards and monitoring compliance:

- Oversee the implementation of the Sexual Safety Standards across the inpatient wards in LYPFT and where applicable community to ensure we provide safe services for our patients and environments for our staff.
- Identify specific work streams that will support the implementation of the standards.
- Engage appropriate stakeholders in the group and consider a communication plan to promote the standards within LYPFT.
- Consult, agree and sign-off the Sexual Safety Policy, including any subsequent updates during the lifetime of the project.
- Evaluate the effectiveness of the Sexual Safety Project, which include implementation of the standards.

- Review of quarterly analysis of sexual safety incidents report, including no harm/low harm incidents for learning.
- Receive overview of discussions/actions around quarterly analysis report submitted to TWCG and shared at LIMM/UCGG, for learning.

People Experience Group Meeting

The People Experience Group is one of four workforce governance groups established to support the delivery of the key people experience elements of the LYPFT People Plan and other Trust strategic plans. The group will be responsible for the development and enhancement of Engagement, Equality, Diversity and Inclusion (EDI) and Wellbeing for our people. The work of the People Experience Group will be in full partnership with other workforce governance groups and key operational, professional and clinical stakeholders across the Trust.

Clinical Environments Group

The Clinical Environments Group actively supports effective and collaborative working between clinical services, estates, support services and PFI providers, by ensuring that clinical environmental risks are being assessed, identified and risk managed to a consistent standard across the clinical environments. They will supporting the early identification of key environmental risks and concerns arising from site meetings, matron reports and health and safety audits and monitoring of agreed action plans to resolve these. This will include the identification of solutions including these that can be resolved locally and support further escalation where appropriate, making recommendations to the estate steering group for change should financial approval be necessary.

Associated Policies and Procedures

- Lone Working Policy
- Positive and Safe Policy
- Bullying, Harassment and Victimisation Policy Statement and Procedure
- Social Media Policy
- Freedom to Speak Up: Raising Concerns Procedure
- Prevent Strategy Implementation
- Safeguarding Adults
- Safeguarding and Promoting the Welfare of Children
- Safeguarding Supervision Policy
- Safeguarding Allegations Against A Colleague Procedure
- Procedure for the Positive and Safe Support for People who may Present with Behaviour that Challenges
- Missing Service User Procedure
- The Use of Seclusion and Long Term Segregation Procedure
- Search of Service Users, Visitors and their Property Procedure
- Procedure Following an Alleged Criminal Offence

- The Management of Incidents, Including Serious Incidents Procedure
- Procedure Following an Alleged Criminal Offence
- Complaints Management Procedure
- Risk Management Policy
- Clinical Risk Assessment and Management Policy
- Equality, Diversity and Human Rights Policy
- Security Management Policy
- Domestic Violence Procedure
- Patient Risk Assessment
- Mental Health Act 1983
- The Use of Seclusion and Segregation Procedure
- Health and Safety Policy
- Sexual Safety Policy

VIOLENCE PREVENTION AND REDUCTION STANDARD TOOLKIT - COMPLIANCE

Client	Leeds and York Partnership Foundation Trust
Prepared By	Frances Dodd
Assessment Date	19/01/2024
Overall Compliance Rating	PARTIALLY COMPLIANT

Overall Rating - 2021/22 Standard	Current Compliance Rating	Target Compliance Rating	Pending Actions
PLAN			8
DO			5
CHECK			6
ACT			4

PLAN - Overall rating										
VPR Standard Indicator	Current Compliance Rating	Target Compliance Rating	Current position	Actions required to achieve indicator compliance	Action Priority	Responsible officer	Target implementation date	Current status	Evidence of compliance	Links/risk assesments
The board (non- exec and exec members) endorses the violence prevention and reduction policy										
The organisation has developed a violence prevention and reduction strategy which has been endorsed by the board and is underpinned by the relevant legislation and government guidance.	✓	✓	Currently in progress		HIGH		31/12/2023	Overdue		
The organisation has developed a violence prevention and reduction policy which has been endorsed by the board and is underpinned by workforce and workplace risk assessments.	✗	✓	To be completed after Strategy approved in Dec 2023	The organisation should develop a violence prevention and reduction policy which should be endorsed by the board and underpinned by workforce and workplace risk assessments.	HIGH		31/03/2024	On-schedule		
The organisation has engaged with key stakeholders, including trade unions, health and safety representatives and other appropriate stakeholders.	✓	✓	Completed		HIGH			Complete		
The organisational risks associated with violence have been assessed and shared with appropriate stakeholders in the sustainability and transformation partnership (STP) or integrated care system (ICS).	✗	✓	To be completed after Strategy approved in Dec 2023	Organisational risks associated with violence should be assessed and shared with appropriate stakeholders in the STP/ICS.	HIGH		31/07/2024	On-schedule		
The senior management (the chief executive and the board) is accountable for the violence prevention and reduction strategy and policy, and this is clearly set out in both documents.	✓	✓	In Strategy and to be duplicated into Policy		MEDIUM			Complete		
Senior management is informed about any disparity trends for violence and aggression against groups with protected characteristics, and a full equality impact assessment has been developed and made available to all stakeholders.	✗	✓	Data not currently collected for all protected characteristics - to be actioned along EDI high impact actions	Meaningful data relating to disparity trends for violence and aggression against groups with protected characteristics should be collected and shared with senior management. A full equality impact assessment should be developed and made available to all stakeholders.	MEDIUM		31/07/2024	On-schedule		
Clearly defined objectives and performance criteria										
The violence prevention and reduction objectives and expected performance criteria outcomes have been incorporated into the policy.	✓	✓	Set out in Strategy and to be duplicated into Policy		MEDIUM			Complete		
There are practical and efficient methods for measuring status against the objectives identified and agreed by the senior management team in consultation with key stakeholders.	✗	✓	To be developed with Policy	Practical and efficient methods for measuring status against the objectives should be identified and agreed by the senior management team in consultation with key stakeholders.	MEDIUM		31/03/2024	On-schedule		
The organisation is compliant with relevant health and safety legislation and any other applicable statutory legislation, and this has been validated, ie via the organisation's auditors.	✓	✓	Currently in progress		HIGH			Complete		
Inequality and disparity in experience for any staff groups with protected characteristics have been addressed, and this is clearly referenced in the equality impact assessment.	✗	✓	Data not currently collected for all protected characteristics - to be actioned along EDI high impact actions	Inequality and disparity in experience for any staff groups with protected characteristics should be addressed and clearly referenced in the equality impact assessment.	HIGH		31/07/2024	On-schedule		
Violence prevention and reduction plans recorded, implemented and maintained										
Plans have been developed and documented for achieving violence prevention and reduction objectives, and the outcomes are clearly set out in the policy.	✗	✓	Once Strategy and objectives approved - to be developed	Plans should be developed and documented for achieving violence prevention and reduction objectives. Expected outcomes should be clearly set out in the policy.	MEDIUM		31/03/2024	On-schedule		

VPR Standard Indicator	Current Compliance Rating	Target Compliance Rating	Current position	Actions required to achieve indicator compliance	Action Priority	Responsible officer	Target implementation date	Current status	Evidence of compliance	Links/risk assesments
The plans are updated and maintained to consider improvements, lessons learnt and updated risk assessments, annually as a minimum schedule.	✗	✓	Once Strategy and objectives approved - to be developed	Plans should be updated and maintained at least annually and consider improvements, lessons learnt and updated risk assessments.	MEDIUM		31/03/2024	**On-schedule**		
Risk assessments are available to managers, their staff, trade union representatives and other relevant stakeholders.	✗	✓	To be developed with Policy	Risk assessments should be made available to managers, their staff, trade union representatives and other relevant stakeholders.	MEDIUM		31/03/2024	**On-schedule**		
The plans are reviewed in consultation with subject matter experts pertaining to the Equality Act 2010.	✓	✓	EDI and network chairs consulted and part of development		MEDIUM			**Complete**		

Do - Overall rating

VPR Standard Indicator	Current Compliance Rating	Target Compliance Rating	Current position	Actions required to achieve target compliance rating	Action Priority	Responsible officer	Target implementation date	Current status	Evidence of compliance	Links/risk assesments
Board members approve resources										
The senior management assesses and provides the resources required to deliver the violence prevention and reduction objectives.	✓	✓	Occurs through governance structure and regular reporting		MEDIUM			Complete		
A designated board-level (director) manages the violence prevention and reduction workstream and ensures appropriate and sufficient resources are allocated to the function (which is underpinned by an organisational risk assessment).	✓	✓			MEDIUM			Complete		
Regular workforce engagement										
The senior management team regularly provides accessible communications on the violence prevention and reduction objectives and priorities.	✗	✓	To occur once Strategy and objectives agreed - comms person already in place	The senior management team should provide regular accessible communications on the violence prevention and reduction objectives and priorities.	MEDIUM		31/03/2024	**On-schedule**		
Communications cover all staff groups and functions within the organisation.	✓	✓			MEDIUM			Complete		
The recognised trade unions are consulted and involved in the development of violence prevention and reduction objectives.	✓	✓			MEDIUM			Complete		
A diversity lens is applied to objectives development, to provide due diligence for Public Sector Equality Duty, and this is validated by the subject matter expert pertaining to the Equality Act 2010.	✓	✓			HIGH			Complete		
Clear roles, responsibilities and training										

VPR Standard Indicator	Current Compliance Rating	Target Compliance Rating	Current position	Actions required to achieve target compliance rating	Action Priority	Responsible officer	Target implementation date	Current status	Evidence of compliance	Links/risk assesments
The organisational roles and responsibilities across all levels are clearly set out in a violence prevention and reduction policy.	✓	✓	Already set out in the Strategy and will be duplicated		MEDIUM		31/03/2024	**On-schedule**		
A training needs analysis (violence) informed by the risk assessment has been undertaken, and suitable and sufficient training and support are accessible and provided to all staff.	✗	✓	To be developed as part of the Policy	A training needs analysis (violence) informed by the risk assessment has been undertaken, and suitable and sufficient training and support are accessible and provided to all staff.	MEDIUM		31/03/2024	**On-schedule**		
Regular risk assessment										
Violence prevention and reduction workforce and workplace risk assessments are managed and reviewed as part of an ongoing process and documented in the appropriate organisational risk registers.	✗	✓	To be set out in the Policy	An on-going process to manage and review violence prevention and reduction workforce and workplace risk assessments should be established and documented in appropriate organisational risk registers.	MEDIUM		31/03/2024	**On-schedule**		
Violence risks are co-ordinated across the organisation, and are accessible and shared with senior management and all appropriate stakeholders.	✗	✓	Consistent approach to be set out in the Policy	Violence risks should be co-ordinated across the organisation, shared with senior management and made accessible to all appropriate stakeholders.	MEDIUM		31/03/2024	**On-schedule**		
Identified violence risks and their mitigations/controls are communicated to all staff in regular bulletins.	✗	✓	To be set out in the Policy and part of the Comms work	Identified violence risks and their mitigations/controls should be communicated to all staff in regular bulletins.	MEDIUM		31/03/2024	**On-schedule**		

Check - Overall rating

VPR Standard Indicator	Current Compliance Rating	Target Compliance Rating	Current position	Actions required to achieve target compliance rating	Action Priority	Responsible officer	Target implementation date	Current status	Evidence of compliance	Links/risk assesments
Process to assess violence prevention and reduction performance										
The efficiency and effectiveness of the violence prevention and reduction plans and processes are assessed and reviewed as a minimum every six months or following organisational changes or serious incidents.	✗	✓	To be decided in the policy	The efficiency and effectiveness of the violence prevention and reduction plans and processes should be assessed and reviewed as a minimum every six months or following organisational changes or serious incidents.	HIGH		31/03/2024	**On-schedule**		
The senior management is directly accountable for ensuring that the system is working effectively and providing assurance that the violence prevention and reduction objectives are being achieved.	✗	✓	to be decided in the policy	Senior management should be directly accountable for ensuring that the organisation's violence prevention and reduction system is working effectively and for providing assurance that the violence prevention and reduction objectives are being achieved.	HIGH		31/03/2024	**On-schedule**		
Staff members are actively encouraged to report all incidents, including near misses.	✗	✓	to be part of the comms campaign	Staff members should be actively encouraged to report all incidents, including near misses.	HIGH		31/03/2024	**On-schedule**		
Data is traceable retrievable and accessible										
Violence data is managed in accordance with the General Data Protection Regulations (GDPR)	✓	✓			HIGH			**Complete**		
Violence data is frequently analysed using primary metrics to support the violence prevention and reduction assessments and inform the audit process.	✓	✓			HIGH			**Complete**		
Violence data is analysed using the demographic make-up of the workforce, including age, sex, ethnicity, disability and sexual orientation.	✗	✓	The data is currently not analysed in this way - to be part of high impact actions 2024	Violence data should be analysed using the demographic make-up of the workforce, including age, sex, ethnicity, disability and sexual orientation.	HIGH		31/03/2024	**On-schedule**		
The protection and storage of data about violence follows the organisation's information governance policies.	✓	✓			HIGH			**Complete**		

VPR Standard Indicator	Current Compliance Rating	Target Compliance Rating	Current position	Actions required to achieve target compliance rating	Action Priority	Responsible officer	Target implementation date	Current status	Evidence of compliance	Links/risk assesments
Data collected about violence assures that the processes are effective and identifies where lessons can be learnt and that the policy objectives are being achieved.	✓	✓			HIGH			Complete		
Established audit and assurance process for violence prevention and reduction										
A process exists for auditing violence prevention and reduction performance and ensuring that associated systems are effectively managed and assessed regularly.	✓	✓			HIGH			Complete		
The audit outcomes inform a regular senior management review held at least twice a year.	✓	✓			HIGH			Complete		
Process for corrective and preventative actions for violence prevention and reduction										
All incidents are logged, reviewed, assessed and any corrective actions are recorded within acceptable timeframes, and where this may be prolonged by investigations and or staff support, this is recorded and communicated to senior management, relevant staff and stakeholders.	✗	✓	This process to be part of the Policy	All incidents should be logged, reviewed, assessed and any corrective actions recorded within acceptable timeframes. Where this may be prolonged by investigations and or staff support, appropriate records should be maintained and communicated to senior management, relevant staff and stakeholders.	HIGH		31/03/2024	**On-schedule**		
The violence prevention and reduction risk registers are updated accordingly.	✗	✓	To be developed as part of the policy	The violence prevention and reduction risk registers should be informed by incident data and updated accordingly.	HIGH		31/03/2024	**On-schedule**		

Act - Overall rating

VPR Standard Indicator	Current Compliance Rating	Target Compliance Rating	Current position	Actions required to achieve target compliance rating	Action Priority	Responsible officer	Target implementation date	Current status	Evidence of compliance	Links/risk assesments
Board reviews the violence prevention and reduction performance										
A senior management review is undertaken twice a year and as required or requested to evaluate and assess the violence prevention and reduction programme, the findings of which are shared with the board.	✓	✓			HIGH			Complete		
Inputs to the process include: - local risk management system (data about violent incidents) - risk registers - audit and governance reports that include violence performance - lessons learned (STP and ICS level) - review of the violence prevention and reduction processes - risk assessments (workplace and workforce) - triangulated with WRES and WDES - staff experiences (causation themes, impact on health and wellbeing, consequences, etc) - Serious Incidents - NHS Staff Survey, local or pulse surveys - local HR intelligence (staff recruitment and leavers rates, absenteeism or retention rates) - key stakeholders. - trade union concerns raised through the health and safety committee meetings with chief constable or designated representative, police and crime commissioners, etc.	✗	✓		The senior management review should incorporate all relevant inputs as required by the standard.	HIGH	To be developed in the	31/03/2024	**On-schedule**		
Violence prevention and reduction policy updated with lessons learned										
Following the senior management review (twice a year) the violence prevention and reduction lead updates as necessary the objectives, policy, plans and supporting processes required to deliver the outcomes.	✓	✓			HIGH			Complete		
Informed decisions at senior management level										
Senior management has enough information from the violence prevention and reduction performance inputs to make informed decisions about the violence prevention and reduction policy, and this information is based on credible intelligence and risk assessments.	✗	✓		Senior management should be provided with enough information from the violence prevention and reduction performance inputs that is based on credible intelligence and risk assessments to enable them to make informed decisions about the violence prevention and reduction policy.	HIGH	To be developed as part of the Policy	31/03/2024	**On-schedule**		

VPR Standard Indicator	Current Compliance Rating	Target Compliance Rating	Current position	Actions required to achieve target compliance rating	Action Priority	Responsible officer	Target implementation date	Current status	Evidence of compliance	Links/risk assesments
Violence prevention and reduction forms part of the overall organisational strategy and workforce planning process and is closely aligned to the STP and ICS planning arrangements.				Violence prevention and reduction should form part of the overall organisational strategy and workforce planning process and be closely aligned to the STP and ICS planning arrangements.	HIGH	To be developed as pa	31/03/2024	**On-schedule**		
Staff receive timely responses to incident investigations, and where this may be prolonged by process requirement, this is recorded and communicated to staff, senior management and relevant stakeholders.				Staff should be provided with timely responses to incident investigations. Where this may be prolonged by process requirement, appropriate records should be maintained and communicated to staff, senior management and relevant stakeholders.	-	To be developed as pa	31/03/2024	**On-schedule**		

Chair's Report

AGENDA ITEM

15

Name of the meeting being reported on:	Workforce Committee
Date your meeting took place:	5 December 2023
Name of meeting reporting to:	Board of Directors – 25 January 2024

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 efficiency and productivity and the work being undertaken in response to the NHS Long Term Workforce Plan. The Committee noted that the POD Governance Group had agreed to withdraw the Trust's current retirement policy given the significant changes to the NHS Pension Scheme in favour of a set of principles and guidance for staff which would include a reduced break in service for retire and return which was consistent with other trusts. The Committee noted that the new twenty-four-hour break was a positive step forward in terms of expediting staff returning to work; however, it was not compulsory, and staff retained the option to take a longer break if preferred.

- The Committee received and agreed the Violence Prevention and Reduction (VPR) Strategy, including the objectives for VPR, and the self-assessment against the VPR Standard. The Committee noted that the Trust was required to review and self-assess its status against the VPR Standard twice a year and provide assurance to the Board. The Committee heard that as of November 2023, the Trust was rated partially compliant when self-assessed against the Standard. The Committee received assurance on progress with the action plan to achieve compliance and noted that all outstanding actions were on track.

- The Committee received a report which detailed the findings, recommendations and action planning that is underway to address Internal Audit's opinion of limited assurance in relation to how effectively the e-Rostering system is being used across the Trust. The Committee discussed some of the factors which had contributed to the finding of limited assurance and sought assurance on some of the areas identified as requiring further action and

improvement which included roster rule breaks, the volume of under-utilised hours, and the use of agency staff to fill some premium rate shifts. The Committee was assured that good progress was being made to address the findings of the report ahead of the follow up audit in August 2024.

- The Committee noted the recent changes to the Health and Wellbeing Guardian guidance from NHS England and supported the Wellbeing Guardian and the new Head of Wellbeing to undertake a review of the format of the Wellbeing Guardian Report.

Things on which the Board is to be assured:

- The Committee noted good progress with some of the Trust's key performance indicators: compulsory training compliance had stayed at 86% despite additional training requirements being introduced for some frontline staff and Personal Development Review (PDR) compliance was at a record high of 83%. The Committee heard that spot checks had been undertaken using the audit facility on Learn which showed that good quality appraisals were taking place. The Committee also noted that targeted interventions were taking place in areas with consistently low PDR compliance. The Committee also received an update on vacancies and noted that band 5 nursing and healthcare support worker vacancies had been steadily reducing over recent months.

Items to be referred to other Board sub-committees:

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

Report completed by:	Kaneez Khan December 2023

AGENDA ITEM

16

Chair's Report

Name of the meeting being reported on:	Quality Committee
Date your meeting took place:	11 January 2024
Name of meeting reporting to:	Board of Directors – 25 January 2024

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.

Things on which the Board is to be assured:

- The committee reviewed an extract from the Board Assurance Framework which detailed strategic risks one and two so that it could be mindful of its responsibilities to assure that these risks were being adequately controlled through the course of the meeting.

- The committee reviewed and supported the draft Quality Strategic Plan for 2024-2029, subject to some minor amendments. It welcomed the simple format of the document and the priorities section which provided a clear vision that would be easier to communicate to staff and easier for staff to understand.

- The committee received the Safer Staffing six-month update which contained a high-level overview of data and analysis on the position of all wards staffing against safer staffing levels for the retrospective periods from the 1 May 2023 to 31 October 2023. It welcomed the new format of the report which provided more data. It was pleased to hear that, despite the sustained pressures with workforce supply, the ongoing efforts and initiatives driven by the recruitment and retention strategies and the focus on wellbeing had positively impacted safer staffing with a series of improvements being noted in the data period, including a reduction in nursing vacancies, the decreased use of temporary staffing and unfilled duties, and the reduction in the need to enact deployment.

  The committee acknowledged that although part of the report presented staffing data in the format prescribed nationally for monthly publication, this showed percentages of shifts filled compared to establishment, whereas in reality the Trust's wards often required more staff than this depending on the number of patients and acuity. It noted that this specific report contained a more detailed picture of one unit's staffing needs that illustrated the differences between staff establishments, staff required, and shifts filled. It noted that this report could be helpful to the Board to prevent the nationally required publication from being misinterpreted.

- The committee reviewed the Combined Quality and Workforce Performance Report. It was pleased to see an improved position regarding the number of vacancies across the trust, the number of staff with appraisals in the last 12 months, and the percentage of staff receiving clinical supervision. It also acknowledged the increase in the number of positive responses received from the Have Your Say survey and thanked the teams involved in work to improve the gathering of this information from inpatient and community services.

- The committee reviewed and discussed a briefing on the timeliness of the completion of Serious Incident investigations within LYPFT, following concerns raised by coroners regarding delays in completing investigation reports into Serious Incidents at the Tees Esk and Wear Valleys NHS Foundation Trust. It was reassured by the information provided.

- The committee received an update on the progress made with the production of the Quality Account for 2023/24 and was assured on the work that had taken place to involve service users and carers in the development of the document. It asked for a timeline of steps to publication to be provided to Quality Committee.

- The committee received a report which provided an update on the Trust's CQC readiness work plan and further detail on national updates from the CQC, including the CQC's new regulatory approach and the annual state of health care and adult social care in England. The paper also provided assurance on the completion of actions following the 'Preparation for the CQC' internal audit report. It asked for a report to provide assurance on our quality oversight of out of area placements.

- The committee received the Learning from Deaths Q2 report which provided a summary of the learning from deaths within the Trust between July 2023 and September 2023. It reviewed the mortality data and information provided and was assured on the work ongoing within the Trust to improve mortality reporting and recording and the learning across the organisation.

- The committee received a report which summarised the findings and recommendations from the Report of the Independent Review into how Data Relating to Deaths is Processed and Reported at Norfolk and Suffolk NHS Foundation Trust (NSFT) and considered any opportunities for improving the processing and reporting of deaths within Leeds and York Partnership. It agreed that it was reassured on the work that had taken place, noting that work to make improvements was ongoing.

- The committee received an update from the Trustwide Safeguarding Group and was pleased to hear that the Trust had received White Ribbon Accreditation in response to the work undertaken to prevent men's violence against women and girls.

- The committee received an update on the two periods of industrial action in December 2023 and January 2024. It was reassured that although there had been up to 78% of doctors taking strike action at one time, this had been well managed which meant the Trust had only cancelled a small number of appointments. The committee thanked those who provided cover, made arrangements to maintain services and were part of the incident co-ordination and response efforts during the periods of industrial action in December 2023 and January 2024.

Issues to advise the Board on:

- The committee discussed the progress made towards the 2023/24 Quality Improvement Priorities (QIPs). The committee noted that in November all QIPs were rated yellow (on track with challenges) or amber (delayed). It was agreed that Ms Sanderson would provide data on current progress at the Board meeting.

- The committee reviewed the Combined Quality and Workforce Performance Report. It discussed the data showing the number of self-harm incidents and physical restraints in November 2023, both of which had increased. It noted the wider work underway to make improvements in these areas.

- The committee reviewed a list which specified the types of issues that the committee and Board should have oversight of. It was agreed that the list would be shared with the Executive Management Team for review and then presented to a Board of Directors meeting.

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

18

Name of the meeting being reported on:	Audit Committee
Date your meeting took place:	16 January 2024
Name of meeting reporting to:	Board of Directors – 25 January 2024

Key discussion points and matters to be escalated:

Issues to which the Board needs to be alerted:

- The committee was informed of capacity issues within the Health and Safety Team and the Estates Team. It noted there was a ban on non-clinical agency spend and identified that this was a potential risk for the organisation.

Issues to advise the Board on:

- The Committee was informed of requests to defer four internal audits from 2023/24 to 2024/25 (Environmental Sustainability: Green Plan; Provider Collaboratives – Perinatal; Children and Young Peoples Services; and Contract Management). The committee discussed the reasons for this and agreed to support the deferral of these reports.

- The committee discussed the Management of Policies audit report which had been returned with an overall opinion of limited assurance. It agreed that it was reassured following discussion on the steps that would be taken to address the issues identified in the report and noted that a follow up audit should be completed in early 2024/25. The committee welcomed the plan to write a policy on the development of policies. It noted the importance of this being embedded across the Trust so that staff knew when a document should become a formal policy, as opposed to local guidance, and follow the relevant governance processes.

- The Committee discussed the Waiting List Management audit report which had been returned with an overall opinion of limited assurance. The Committee was reassured that the recommendations in the report had been implemented and that a follow up audit to verify the implementation of those recommendations would be completed before the end of the 2023/24 financial year.

- The committee received and discussed a report which provided an update on health and safety matters within the Trust during quarter 3. It noted a significant reduction of reported RIDDOR and Lost Time Incidents in 2023/24 but was reassured that this was being reviewed.

Things on which the Board is to be assured:

- The Committee received the Internal Audit Progress Report and was pleased to note that the Medicines Management audit and Fire Safety follow-up audit had been returned with an overall opinion of significant assurance, and the Digital Strategy audit had been returned with an overall opinion of high assurance. It congratulated the Teams responsible for this outcome. It also noted that a follow-up of additional limited assurance reports had been added to the internal audit plan in advance of the year-end Head of Internal Audit Opinion.

- The Committee received the Local Counter Fraud Progress Report and discussed its content.

- The committee received and discussed a report which provided an update on health and safety matters within the Trust during quarter 3. It was introduced to Mr Edward Braisher, who had been appointed as an Interim Health and Safety Consultant, and noted his plans to review and make improvements to the terms of reference for the Health and Safety Committee, health and safety inspections, training compliance and compliance with the NHS Workplace Standards. It also noted that Mr Braisher would be focusing on how health and safety reporting to the Audit Committee and Board could be improved.

- The committee received an update on the significant audit risks that had been identified by KPMG for 2023-24 and noted that the final audit plan, fee and value for money risk assessment would be presented to the committee in April 2024. It was informed that, although the application of IFRS16 to PFI liabilities would be fully adopted for the first time in 2023/24, the other audit risks identified were similar to those identified in previous years.

Items to be referred to other Board sub-committees:

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

Report completed by:	Martin Wright, January 2024.

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:	Approval of the appointment of the Senior Independent Director
DATE OF MEETING:	25 January 2024
PRESENTED BY: (name and title)	Merran McRae, Chair of the Trust
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 will be aware that it is required to appoint a Senior Independent Director (SID) as per the Code of Governance and the Constitution.

Since 1 May 2022 Mr Cleveland Henry has carried out the role of the SID; however, he comes to the end of this two year appointment on 30 April 2024. The Chair of the Trust has spoken with Mr Henry, and he has agreed to continue in this role for a further two years at which point a successor will be identified and put forward to the Board for appointment.

This is a Board appointment but one which has the support of the Council of Governors. At the Council meeting on 1 February 2024, the Council will be advised of this Board appointment and its support sought. The timing of the paper to the Council will be in time for Mr Henry's second term of appointment to commence in May 2024.

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:

- Agree to appoint Cleveland Henry as the Senior Independent Director for a second period of two years with effect from 1 May 2024
- To note that if agreed, the Board's decision will be presented to the Council of Governors at its February 2024 meeting for support