Leeds and York Partnership
NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST
PUBLIC MEETING OF THE BOARD OF DIRECTORS
will be held at 9.30 am on Thursday 30 May 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 – West Yorkshire PICU Redesign Update** (verbal)	
2	**Apologies for absence** (verbal)	**MM**
3	**Declarations of interests and any declarations of conflicts of interest in any agenda item** (enclosure)	**MM**
4	**Minutes of the meeting held on 28 March 2024** (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	**Freedom to Speak Up Guardian Annual Report** (enclosure)	**SR**
9	**Report from the Chair of the Finance and Performance Committee held on 23 April and 28 May 2024** (to follow)	**ClH**
10	**Report from the Chief Financial Officer** (enclosure)	**DH**
11	**Operational Priorities Quarter 4 23/24 Update Report** (enclosure)	**DH**
12	**Trust Strategy Update** (enclosure)	**SM**
13	**Report of the Chief Operating Officer** (enclosure)	**JFA**
14	**EPRR:**	
	14.1 Annual Report (enclosure)	**JFA**
	14.2 EPRR & Business Continuity Policy (enclosure)	**JFA**
	14.3 Assurance Approval (enclosure)	**JFA**
15	**Report from the Chair of the Quality Committee for the meetings held on 11 April and 9 May 2024** (enclosure)	**FH**
16	**Report from the Chair of the Workforce Committee for the meeting held on 15 April 2024** (enclosure)	**ZBS**
17	**Safer Staffing Report** (enclosure)	**NS**

18	**Guardian of Safe-working Hours Q4 Report** (enclosure)	**CH**
19	**Report from the Chair of the Audit Committee for the meeting held on 16 April 2024** (enclosure)	**MW**
20	**Board Assurance Framework** (to follow)	**SM**
21	**Fit & Proper Persons Test Annual Declaration** (enclosure)	**MM**
22	**Provide Licence Compliance Declaration** (enclosure)	**MM**
23	**Use of Trust Seal** (verbal)	**MM**
24	**Any other business**	**MM**

The extraordinary meeting of the Board will be held on Thursday 20 June 2024 at 8.00 am
Via Microsoft Teams

AGENDA ITEM

3

Declaration of Interests for members of the Board of Directors

Name	Directorships, including Non-executive Directorships, held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services.	Any substantial or influential connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.	Any other commercial or other interests you wish to declare. This should include political or ministerial appointments (where this is information is already in the public domain – this does not include personal or private information such as membership of political parties or voting preferences)	Declarations made in respect of spouse or co-habiting partner
EXECUTIVE DIRECTORS								
Sara Munro Chief Executive	**Sector Representative** West Yorkshire Integrated Care Board	None.	None.	**Trustee** Workforce Development Trust	None.	None.	None.	None.
Dawn Hanwell Chief Financial Officer and Deputy Chief Executive	None.	None.	None.	None.	None.	None.	None.	None.
Chris Hosker Medical Director	**Director** Trusted Opinion Ltd.	None.	**Director** Lilac Tree Clinic Ltd.	None.	None.	None.	None.	Partner: **Director** Trusted Opinion Ltd.
Joanna Forster Adams Chief Operating Office	None.	None.	None.	None.	None.	None.	None.	Partner: **Director of Public Health** Middlesbrough Council and Redcar and Cleveland Borough Council Partner: **Chair** The Junction Charity

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

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NON-EXECUTIVE DIRECTORS								
Merran McRae Chair	**Director** Finnbo Ltd	None.	None.	**Trustee** Hollybank Trust **Trustee** Yorkshire Sculpture Park	None.	None.	**Deputy Lieutenant** West Yorkshire Lieutenancy	None.
Zoe Burns-Shore Non-executive Director	**Executive Director for Customer Delivery** Money and Pensions Service	None.	None	None	None.	None	None.	None
Frances Healey Non-executive Director	None	None.	None	**Trustee** The National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	None	None	**Visiting Professor** University of Leeds **Advisory Role and Peer Reviewer** Research studies and potential research studies related to patient safety	None
Cleveland Henry Non-executive Director	**Director** 63 Argyle Road Ltd.	None	None	**Chair of the Board of Trustees** Community Foundations for Leeds	None	None	**Group Delivery & Deployment Director** EMIS Group (Digital Health sector)	Partner: **Lead Cancer Nurse** Leeds Teaching Hospitals NHS Trust

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Kaneez Khan Non-executive Director	**Chief Executive Officer** Primrose Consultancy Yorkshire	None	None	**Chair of the VCSE Voices Panel** West Yorkshire Health and Care Partnership	**Faith and Community Co-ordinator** Wellsprings Together	None.	None	None
Katy Wilburn Non-executive Director	**Non-executive Director** Thirteen Group	None.	None.	None.	None.	None.	None.	None.
Martin Wright Non-executive Director	None.	None.	None.	**Trustee** Roger's Almshouses (Harrogate) .	None.	None.	None.	None.

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

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

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

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Minutes of the Public Meeting of the Board of Directors held on Thursday 28 March 2024 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

Ms Alison Quarry	Deputy Director of Nursing
Mrs C Edwards	Associate Director for Corporate Governance / Trust Board Secretary
Miss R Cooper	Deputy Head of Corporate Governance
Mr K Betts	Corporate Governance Officer
Mr E Murray	Partner Peer Supporter, Perinatal Services (for minute 24/023)
Mr Alex Lambert	Service User, Partner Peer Support (for minute 24/023)
Ms L Weeks	Patient and Carer Experience Lead (for minute 24/023)
Miss Tracey Needham	Head of People Engagement (for minute 24/033)
Mrs Sarah Turner	People Engagement lead (for minute 24/033)
Miss Amy Harker	People Engagement Practitioner (for minute 24/033)
Mr Andrew McNichol	Head of People Analytics and Temporary Staffing (for minute 24/033)

Two members of the public attended the meeting, including one governor.

Action

Mrs McRae opened the public meeting at 09:30 and welcomed everyone.

Mr Adderley, member of the public, attended the public Board meeting to raise awareness of autism training, specifically related to the Oliver McGowan Training programme. Mr Adderley highlighted the importance of training across all staff groups supported by service users and those with lived experience as this provides an opportunity to understand different stories and experiences. He noted the National Breaking Point campaign and the impact on social care and health as a result of this. He offered to be part of training for staff and Mrs McRae noted that she had his contact details to progress this

discussion as appropriate. The Board thanked Mr Adderley for this attendance and awareness raising of the training.

24/023 **Sharing stories – Perinatal Service – The importance of supporting and involving dads** (agenda item 1)

Mrs McRae welcomed Mr Errol Murray and Mr Lambert to the Board, and they provided an overview of the Perinatal Partner Support Service. Mr Murray informed the Board that the Partner Support Service commenced in 2015 and provided support to partners of those mothers who needed mental health support following the birth of their child. He highlighted that the key to the service was offering peer support, providing opportunities for friendships and provided support to approximately one hundred dads a month through the Leeds Dads Group. He noted that the service was one of 5 nationally providing this support for partners. He highlighted that the service did not provide clinical support, but could signpost partners if required, but focused on connections for partners outside of the formal mental health service.

He provided the Board with details on the services and activities available through the service. He highlighted 'Rethink Men' which was a quarterly activity held at Leeds Market to provide opportunities to link into the community and showcase the services on offer, and links with other agencies and organisations to provide wrap around engagement.

The focus for the future of the service was a focus on engagement to understand what support partners want and need.

The Board watched a video that was played in GP Surgeries providing details on how to access the service. A second video was shown providing experience from a partner who has accessed the service, Maz, and the benefit that this provided. He noted that the service had provided support to navigate the challenges faced whilst his partner received mental health support.

Mr Lambert then shared his experiences of the service to the Board, noting that he accessed this following the admission of his partner for mental health care. He explained how the service had supported him during a lonely time, and provided support as he lived out of area and was visiting each day to see his partner. He expressed how grateful he was to the service for the support he received, and informed the Board his partner was now back at work.

Mrs McRae thanked Mr Murry and Mr Lambert, noting how grateful the Board were for personal stories. Dr Hosker added that the consistency in the offer across the region was a key area that the Provider Collaborative would need to review.

Mrs Forster Adams thanked Mr Murray and Mr Lambert for the presentation and queried the demand for female partners through the service and whether this had started to change. Mr Murray noted that female partners were accessing the service however the numbers were not static so the demand varied.

Dr Munro acknowledged that the experiences presented demonstrated the value of the service and the importance of providing support to partners. She

added that the impact on mental health moving forward for partners is immeasurable. Mr Lambert noted that the service broadened his knowledge and awareness of mental health and supported talking amongst partners.

Miss Wilburn queried the cultural diversity for those partners accessing the service, and Mr Murry responded that the diversity of partners who accessed the service did not correlate with that of mothers accessing clinical services. The service has an inclusion worker who undertakes work with mothers that positively impacts on partners, and the focus moving forward was on outreach work to target communities. Joint sessions with mothers and partners were held at discharge to support ongoing care. He noted that during the COVID pandemic initially contact to the service declined, however this then increased demonstrating the impact of isolation on mental health.

Ms Khan thanked the team for the presentation and noted her hope for future expansion within the service, and how important it was to share personal experiences. Dr Hosker added that it would be important to ensure the Trust fed through to regional work programmes to support future expansion, and Mr Lambert offered support in the future with this.

Discussion took place regarding potential financial support for partners who are required to travel to visit their partners whilst they are receiving mental health care, and the importance of ensuring access to this to provide an equitable service.

Mr Murray noted how important the service was for creating an environment for partners to talk and share their experiences to provide peer support.

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

The Board **thanked** Mr Murray, Mr Lambert and Ms Weeks for attending the Board and raising awareness of the Perinatal Partner Support Service and the important impact this had on the support provided to partners of service users.

24/024 **Apologies for absence** (agenda item 2)

Apologies were received from Miss Nichola Sanderson, Director of Nursing and Professions, and Mrs Zoe Burns-Shore, Non-Executive Director.

It was noted that Mr Henry, Non-Executive Director, would be arriving to the meeting in due course.

24/025 **Declaration of interests for directors and any declared conflicts of interest in respect of the agenda items** (agenda item 3)

The Board noted that no Board member had a change in declaration and no member declared a conflict of interest in any agenda item.

24/026 **Minutes of the previous meeting held on 25 January 2024** (agenda item 4)

The minutes of the meeting held on 25 January 2024 were **received** and **agreed** as an accurate record.

24/027 **Matters arising** (agenda item 5)

Dr Hosker noted that there was currently an IT outage across the region however this was not affecting systems of LYPFT, however colleagues may be required to support this.

24/028 **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 were completed and those that were still outstanding.

Mr Skinner provided an update on the EDI and WRES data and the action was noted as complete.

It was noted that the review of the Trust newsletter had been completed and the action was noted to be complete.

Dr Munro updated that the action relating to the Emerge Service was complete and the service had been linked into NHS Provider Confederation and the supporting strategy.

It was agreed the action relating to the Breathing Space initiative would remain ongoing whilst this was progressed and the detail for the organisation understood.

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

24/029 **Report from the Chief Executive** (agenda item 7)

Dr Munro presented her Chief Executive's report drawing particular attention to the update on industrial action and the junior doctor vote for further action, although no dates had been announced. She noted that the Staff Survey was an item on the agenda, and had seen significant improvement since 2018, and the current staff benefit platform was online and being accessed.

She informed the Board that a Collective Leadership session was held earlier that week which had seen strong engagement across leaders with a focus on the challenges for the year ahead to balance the financial regime and delivery of organisational priorities.

Service visits to The Mount had showed that staff have ability to book hotel accommodation for those travelling to the service, but Dr Munro noted it was underutilised therefore there was further need to consider how to raise awareness to ensure the budget was used and families were supported.

Dr Munro highlighted the publication of the 'Too Hot to Handle' report which detailed the experience of colleagues from diverse backgrounds and discrimination. The report was scheduled into the work plan for the Board in June 2024 to focus on this for further discussion and support across the organisation.

She informed the Board that the national planning guidance had not been received, however the Trust had submitted plans for operational targets and the financial plan.

She noted the second summit on neurodiversity for West Yorkshire had been held across the region and supported by a number of agencies, including lived experience; the first set of actions following the summit were being refined currently.

Dr Munro highlighted the new national Mental Health Strategy which would replace the long-term plan subject to political processes with the aim for summer publication. There would be five areas of focus within the plan including out of area placements and the quality improvement programme for inpatient MH Services. Whilst there were significant challenges at the current time, she noted that the NHS England league table had been published with West Yorkshire being in the top 5 for delivery against the long-term plan commitments. She noted that this is an important celebration of the work undertaken and is important for staff morale and recognition.

Miss Wilburn queried the publication of the feedback from the neurodiversity summit, and Dr Munro confirmed that a full report would be published and publicly shared once complete.

Mrs McRae thanked Dr Munro for the report.

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

24/030 **Report from the Chair of the Finance and Performance Committee for the meeting held on 25 March 2024** (agenda item 8)

Miss Wilburn presented the Chair's report for the Workforce Committee highlighting the discussion regarding Red Kite View and recovery actions linked to capped admissions, and the impact of this moving forward for the establishment. It was noted that due to the capping of admission service users were being sent to out of area placements.

Miss Wilburn noted the month 11 financial position and that this would be discussed later in the Board meeting. She highlighted the assurance provided

to the Board as detailed within the report, including the procurement department improvements and cyber security update.

Mrs McRae thanked Miss Wilburn for the update detailed within the report.

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

24/031 **Report from the Chief Operating Officer** (agenda item 9)

Mrs Forster Adams presented her Chief Operating Officer's report, noting that the key points had been discussed at the Finance and Performance Committee, and were contained in the Chair's report.

Mrs Forster Adams highlighted the out of area placements trajectory in the report was still being refined until the operational plan was submitted in early May 2024. She noted it had been helpful to focus on this at the Board Development Session in February 2024, with a further update scheduled for the Board of Directors in May 2024.

Mrs Forster Adams noted the impact of the capped admissions at Red Kite View and out of area placements, and provided detail on those being treated out of area and that repatriation would be addressed when this was clinically inappropriate due to their acute illness. She added that there were two young people in hospitals across West Yorkshire however they required specific clinical intervention that was currently unable to be provided at Red Kite View. This would be included in future Chief Operating Officer reports to provide assurance and oversight.

With regards to the Specialised Supported Living service, she highlighted that progress was being made with oversight by the Trust and colleagues in local authority. It was noted that the expansion of the Gender Service was unlikely to be viable however optimisation of any opportunity would still be reviewed.

Mrs Forster Adams noted that the implementation of the 111 operational plan had been delayed due to technology issues, and updates would be provided as more information was available. She also informed the Board that an update regarding the Deaf CAMHS service would be provided to the Finance and Performance Committee at the next meeting in relation to the York service provision.

Mrs Forster Adams informed the Board that Willow View in York was due to go live in the coming weeks, which provided opportunity to lead the way in the provision of eating disorders in the future. She added good progress was being made in forensic services following the previous work undertaken with the team.

Ms Khan queried themes in relation to staff retention at Red Kite View, and Mrs Forster Adams noted there were no consistent themes. She added that the leadership team were planning to meet with colleagues to understand any action required for staff retention, including viability and potential for transfer

of staff. Mrs Quarry added that learning from previous service reports and outcomes relating to transfer of staff, and recognition of the impact of movement of staff across services and redeployment, would be considered.

In relation to seclusion facilities, Mrs Forster Adams confirmed service provision requirements were being met and adaptations were made to appropriately utilise this facility.

Mrs Hanwell queried the formal evaluation process for Williow View, to which Mrs Forster Adams confirmed this would take place with the potential for earlier opportunities for learning available through provider collaboratives. It was acknowledged that evaluation would be beneficial for potential future opportunities and estate provision flexibility for any service opportunities.

Following his attendance at an Audit Committee Chairs meeting, Mr Wright provided assurance to the Board that discussion had taken place regarding the EPRR standards highlighting shared experiences across organisations. He asked whether there was an update in relation to the Community Mental Health Transformation roll out. Mrs Forster Adams confirmed it was unknown at the current time, however staff feedback had been positive, including from third sector staff. She added that there had been a change in referrals rejected, and that demonstrated more direct referrals in pilot sites which was a positive impact for performance that would be evaluated as progress was made. She noted that medical staffing continued to be a focus for the transformation work to ensure appropriate care was provided. It was agreed that an updated regarding this work would be provided in six months' time, including evaluation undertaken. Mr Wright requested to undertake a service visit to the Community Mental Health Service and Mrs Forster Adams agreed to arrange this at a suitable time. **JFA** **JFA**

Mrs McRae queried the assessment of the new commissioning framework process, and Mrs Forster Adams confirmed that it would be routed through ICS but would be incorporated in a future Chief Operating Officer report.

Mrs McRae thanked Mrs Forster Adams for her comprehensive report.

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

24/032 **Chief Financial Officer's Report** (agenda item 10)

Mrs Hanwell presented her Chief Financial Officer's report, and highlighted the position had deteriorated due to the financial issues that the Board were well sighted on, including staffing and out of area placements. She acknowledged that despite this, the position was that the financial commitments would be delivered to the ICB, resulting in the challenge into next year remaining substantial.

She noted that capital funding would be a challenge moving forward, however she still anticipated slippage for the perinatal beds would remain but was not

confirmed yet, however the Trust was working on the assumption that this would remain in place.

Mrs McRae noted that the Board appreciated the challenges faced and would have oversight of the efficiency programme via the Finance and Performance Committee next year.

Miss Wilburn informed the Board that it had been agreed that vacancy management panel feedback would be fed through Finance and Performance Committee to understand any impact on the efficiency schemes. The Board agreed that this was a beneficial way of reviewing this.

Ms Khan acknowledged that Mrs Hanwell had consistently kept the Board aware of the financial position throughout the year which was helpful, including the challenges faced and the position moving forward.

Mrs McRae noted that further discussion would take place in the private Board meeting, and thanked Mrs Hanwell for her report.

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

24/033 **Staff Survey Results** (agenda item 11)

Mrs McRae thanked the team for attending to present the presentation. Miss Tracey Needham, Head of People Engagement, introduced the team in attendance:

- Mrs Sarah Turner, People Engagement Lead
- Miss Amy Harker, People Engagement Practitioner
- Mr Andrew McNichol, Head of People Analytics and Temporary Staffing

Miss Needham acknowledged the support from colleagues to deliver the staff survey and intention plans. She noted that the Staff Survey was a mandated piece of work to measure trends over time from the workforce.

Mrs Turner provided an overview of the response rate which was 50.2% response rate (up on last year by 6.2%) and noted that this was due to a heavy engagement plan, including a communication campaign, site visits and service visits at weekends.

She provided an overview of the substantive staff results, and the alignment to the elements of the People Plan. She noted that this year there was high performance in five key areas including staff engagement and morale. The results were below sector in two themes related to learning, however this was not a significant decrease in performance.

Mrs Turner highlighted the highest scoring areas and provided an overview of the favourable changes, including the favourable declines related to staff feeling emotionally exhausted and having work frustrations. With regards to unfavourable changes, she noted the three themes relating to team working

but that these were not statistically significant, however it was important to ensure they were reviewed and actioned as necessary.

Miss Harker provided an overview of the Bank Staff results noting significant improvement that was potentially related to the method of delivery. The Trust was awaiting national bank staff survey data so could currently only compare results to substantive staff. She noted bank staff results were underperforming in seven key areas compared to substantive staff however it was important to note that not all questions were included for bank staff. She provided an overview of the favourable changes in results related to immediate manager support and engagement. She noted the unfavourable changes which had seen a general decline in the civility and respect theme for bank staff. Issues had been identified regarding access to wards and this had impacted on the equipment related question.

An overview was provided regarding the RAG rated tables for both substantive and bank staff which demonstrated the results were the best results for substantive staff since 2018, however the bank staff data was showing a year-on-year deterioration. The Workforce Equality Standards were described, and it was noted that the Workforce Race Quality Standards (WRES) were all showing favourable changes and the Workforce Disability Quality Standards (WDES) only one demonstrated unfavourable decline.

Mrs Turner highlighted to the Board two new questions related to unwanted sexual behaviour in workplace. She noted that the question related to unwanted sexual behaviour from patient and service users was primarily experienced by substantive staff. It was acknowledged that there was concern regarding fourteen colleagues who had experienced this on more than ten occasions. The Board were informed that a Sexual Safety Group had been established since 2019 and there were a number of initiatives in this area. With regards to unwanted sexual behaviour from colleagues, it was noted that this was primarily reported by substantive staff and the results were ahead of the sector average. Context had been provided by HR colleagues and it was noted that the figures from HR did not align to those in the survey therefore more needed to be done to understand this position. The Trust had signed up to the national Sexual Safety Charter and was currently mapping its status against the commitments and an improvement plan would then be developed. It was also highlighted that the Trust had been awarded White Ribbon Status to reduce violence and harassment against women. The Board were informed that alignment of programmes and measures would take place, and this would be reported to NHS England in July 2024.

The Board were informed that the volunteer survey had been undertaken for the first time with a 24.5% response rate which demonstrated positive uptake. The results showed that volunteers provided more favourable scores for 10 out of 14 questions which was a good start to understand the volunteer experience which could now be built upon. It was noted that the data could be used to promote volunteering.

It was highlighted that the engagement and morale indicators for substantive staff were above the sector average for both. There was no sector comparison available for bank staff however the results were below substantive staff.

Miss Needham provided an overview of the importance of intention plans and that if completed there was more likely to be an increase in response rates in the following year. The survey results were now available to all staff via various methods and intention planning was underway in some services, with others due to commence this once the presentations of results were complete. The Board were informed that work was underway to include bank staff results in team level presentations. The Workforce Committee would receive a report on key areas within the survey results and next steps.

Miss Needham asked the Board to support making intention planning mandatory as part of business planning processes given the positive impact that it has.

Mrs Hanwell highlighted that a team of more than ten staff were needed to complete intention planning, however any action taken was positive and different options were available.

Dr Healey acknowledged the work undertaken and noted that some questions were linked to the Quality Committee remit therefore requested that this be brought to the Committee. It was confirmed that this had already been reviewed and would be shared in due course. She added that it was important to learn from those leaders who have positive results and share this, and Miss Needham noted that this was the area of focus moving forward, along with learning from other organisations when the data was available.

Miss Wilburn acknowledged it was helpful to have and understand the data and that issues could not all be addressed at team level. She noted that on flexible working the Trust scored above average and asked whether this should be used as recruitment focus. Mr Skinner confirmed that it was and there was a national driver to improve flexibility for working and support staff retention. He added that the self-rostering pilot was supporting flexible working which would be reviewed in due course. Miss Needham noted that the results would be presented to all governance groups to demonstrate improvements in recruitment.

Mr Henry acknowledged the impressive results however expressed concern regarding bank staff results and their unacceptable experiences and questioned how it linked to performance management. Mr Skinner agreed with the concern and noted that there were issues with reporting through channels to then act on. He noted engagement was in place but the challenge about poor behaviour to bank staff was acknowledged, and this would need to link to how bank shifts were allocated culturally. The transient nature of bank staff was challenging for comparing data, but the behaviour issues do exist therefore should be managed.

Mr McNichol noted difficulty in relation to the context of the questions and the use of substantive staff questions for bank staff. He added that the use of Freedom to Speak Up Guardians and forums for open discussion about experiences were also important. It was noted that future work would be done nationally to contextualise the questions and remove ambiguity to provide more relevant questions and data.

Mrs Forster Adams sought confirmation that formal escalation lines of reporting and investigation regarding inappropriate behaviour were being undertaken. Mr McNichol provided confirmation that this was taking place for each case.

Ms Khan noted that detail had been provided through the presentation that concerns previously raised regarding bank staff experiences in relation to culture were being acted upon. She raised concern regarding the results relating to sexual harassment and physical violence against staff and it was agreed that the Workforce Committee would review the data in more detail related to bank staff and their experiences. It was noted that the Sexual Safety group would also report through to Workforce Committee. **ZBS / DS**

Dr Munro noted disappointment with the bank survey results despite the efforts made to support them as part of an integrated workforce. She was reassured by the combination of intention planning and data for cross cutting actions however noted the challenge around sharing the wellbeing offer to staff to improve their awareness of this and ensure the right actions were in place. She acknowledged that bank shifts would likely be in areas with high levels of incidents and there was a need to understand the nature of the work versus the risk posed, alongside the consideration of tolerance levels of staff to ensure zero tolerance was taken. Mrs McRae added that it was important to track improvements now that the data was available.

Mr Wright raised that communication at handover was critical to engage with bank staff, and attending at the end of shifts would be more beneficial than requesting their attendance at meetings. He acknowledged that this was an approach to consider for future engagement including at evenings and weekends. Discussion took place regarding the ability to understand the data by bandings, however Miss Needham confirmed that access to the raw data in that way was not available. Dr Munro added that moderation of the data includes factors to address banding in the results to level out the response rates.

Mrs McRae queried where the data regarding learning would be discussed, and it was confirmed that this would be reviewed at Quality Committee. Dr Hosker also noted that the learning and leadership framework survey could be linked to the results to create connection with the learning results from the staff survey.

Mr McNichol noted that there was shared disappointment regarding the bank staff survey, and it was important to acknowledge the impact of the pay award not including bank staff, along with the impact of the deregistration of key bank staff following conduct process implications when reviewing the results.

MM thanked all the team for the presentation and confirmed that the Executive Team would discuss the support request for mandatory intention planning and provide feedback. **Executive Team**

The Board **received** the Staff Survey results and **noted** the content.

24/034 **Report from the Chair of the Quality Committee for the meetings held on 8 February and 14 March 2024** (agenda item 12)

Dr Healey presented the Chair's report and highlighted the discussion regarding the Quality Impact Assessment process for the efficiency programme.

She noted the discussion regarding observation audits and next steps to be taken, and that the Quality Committee had linked this through to Workforce Committee due to the undertaking of observations by bank and agency staff. It was acknowledged that this may impact on the quality of observations due to potential limitations of any therapeutic relationship with bank staff and service users. Mrs Quarry noted observations should be done by the most skilled workers but acknowledged that they were undertaken by bank staff which could impact on continuity of care.

Dr Healey noted the briefing on 'Right Care, Right Person' was a valuable update to the Committee to provide assurance given the public scrutiny and complexity of geography for services. She noted that Quality Committee would continue to have sight of this. She also noted the update on the Quality Account provided to the Committee to note the progress made and the subsequent submission to Board in due course.

Mrs McRae thanked Dr Healey for the Chair's report.

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

24/035 **Report from Director of Nursing and Professions** (agenda item 13)

Ms Quarry presented the Director of Nursing and Professions' report which noted good progress made through the work programme for quality and safety. She highlighted recruitment and retention, and that despite the challenges for the workforce, the Trust had placements available from September onwards for nursing students which was a positive position compared to previous years. She noted that this linked to work undertaken regarding retention, and the support provided to staff via mentor and nurse educator roles.

Mrs Quarry noted the continued work relating to culture of care, and the first collaborative peer review had been undertaken across the ICS, by colleagues from external Trusts. The feedback would be reviewed through the appropriate governance process and learning would be fed back. She added that themes across the ICS would be shared for learning opportunities.

The Board were informed that the Trust had signed up to the Culture of Care programme which was to support cultural change across the organisation and had significant funding attached to it via NHS England, along with resources for implementation. This would be of benefit to service users and the Trust workforce.

Ms Khan noted the positive feedback on multi-faith rooms. Mr Henry acknowledged the positive position for student placements and queried financial implications. Mrs Quarry confirmed that the financial implications were positive if these were used for existing roles.

Mrs McRae thanked Mrs Quarry for presenting the report.

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

24/036 **Integrated Patient Safety Report** (agenda item 14)

Ms Quarry presented the integrated Patient Safety report which highlighted serious incidents complaints for escalation to the Board. She noted that the paper set out the detail and investigation requirements, and discussion took place as to whether this met the expectations for Board oversight requirements.

Dr Healey acknowledged the balance between level of detail and service user confidentiality. She noted that clarity was required regarding the patient cohort included and right level of information that provided assurance at the right level for Board discussions in public board, as learning was managed via established governance forums.

Mrs McRae confirmed it was a helpful report however further expansion may be required on the descriptions for incidents and complaints.

Mr Henry queried the sensitive nature of detail in a public Board meeting and Mrs McRae noted it would require submission to the private Board meeting if more detail was provided. She added that there was a need to confirm the rationale for the information and whether it was more beneficial at public or private Board meetings. Dr Munro noted that the Trust had a responsibility to be open and transparent when harm occurred in services, and there was a need to understand detail limitations due to external processes in some instances. She added that there was a balance threshold for Quality Committee assurance with escalation to the Board via Chairs reports for specific detail where required. It was noted that there would be further discussion in the private Board meeting to support the detail to be shared. Dr Munro noted that there was a session planned for Board Strategic Discussion dates in 24/25 regarding improvement and deep dives, and this would include the wider governance structure in place to support Board awareness for this issue.

Mrs McRae noted that it may be helpful to have more detail in the report for a discussion in private Board meetings. It was agreed that this would be discussed in further detail for future report content. **NS / AQ**

The Board **received** the Integrated Patient Safety report and **noted** the content.

24/037 **Safer Staffing Report** (agenda item 15)

Ms Quarry presented the Safer Staffing report acknowledging the amended format which was the proposed option moving forward to move away from narrative and provide data to improve transparency of performance. She noted this would include quality indicators to demonstrate impact on patients and service users, a move to widen thinking around ward staff as a multi-disciplinary team, and the approach to allocation of job roles to support quality of care.

Mrs Quarry highlighted that there had been one shift with no registered nurse on duty, however provided assurance that this was assessed at the time and mitigation was in place to provide ward co-ordination and medication safety. She confirmed that no issues were reported as a result of this.

She noted the continued acuity dependency leading to working above establishment and the impact on staffing levels. She highlighted the inconsistency with clinical supervision and work was underway to understand how this could be embedded across more responsive service areas.

Mrs Forster Adams acknowledged the helpful format of the report and noted that the information related to vacancies for registered staffing in acute inpatient services may be impacted by lag time of data reporting, however the narrative correlated with the data presented which was positive to see.

Mrs McRae acknowledged that the correlation between sickness and full recruitment to vacancies may be looked at in future and that there was a need to ensure block booking for bank staff was well communicated to staff in the context of rostering, financial planning and quality.

Mr Henry noted that it would be helpful to understand the oldest vacancy within the data. Mr Skinner confirmed that this could be provided to ensure the appropriate context as work was already undertaken around this to understand the position. Mrs Quarry also confirmed that skill mix reviews were undertaken for those vacancies that are challenging to recruit to.

Mrs McRae thanked Mrs Quarry for the report.

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

24/038 **Report for Medical Directorate** (agenda item 16)

Dr Hosker presented the report noting the content. He expressed his thanks to colleagues for the support provided for conferences that had been held in recent weeks. He also noted the industrial action and formally thanked colleagues for efforts made to support these periods of time.

He acknowledged the recruitment detail provided within the report but noted agency spend had stabilised however not significantly reduced. He added that there was regional scoping regarding payments made to ensure consistency.

He noted the successful clinical excellence awards round and national award recognition for one of the Trust consultants.

Mrs Hanwell queried the locum job plan requirements and Dr Hosker confirmed job plan arrangements were agreed at commencement of locum working but this was not an annual process. Discussion took place regarding Programmed Activity (PA) allocation and Supporting Professional Activities (SPA) allocation. It was noted that locums receive one SPA to support revalidation however their focus is on clinical work in services which should result in a positive impact on productivity on the wards to support discharge.

Mr Henry queried the efficiency for MediViewer on clinical time, and Dr Hosker confirmed efficiencies should be seen as access to historical case notes would be of benefit to the overall patient care. He noted that there was no benefit within the programme regarding freeing up of clinical time. Mrs Hanwell commented that post project evaluation for digital projects should focus on clinical impact to support step change in productivity and efficiency along with the financial implications, and that benefits realisation should understand benefits in the wider sense.

Mr Henry asked whether the Care Director situation would impact on forms and workflows. Dr Hosker responded that undertaking this work in advance would be of benefit for any translation needed to move to a new system in the future, therefore should continue to progress. Mrs Hanwell added that local adaptations could be continued regardless of the Care Director position.

The Board **received** and **noted** the content of the Medical Directorate Report.

24/039 **Guardian of Safe Working Hours Quarterly Report** (agenda item 17)

Dr Hosker provided the Board with an overview of the report and highlighted trainee doctor concerns. He noted Foundation Year doctors had flagged training access issues and confirmed that this was being addressed and would be continually reviewed.

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

24/040 **Report from the Chair of the Mental Health Legislation Committee for the meeting held on 6 February 2024** (agenda item 18)

Ms Khan presented the report from the Mental Health Legislation Committee and noted the assurance provided to Board. Ms Khan highlighted the challenges for equality through the provider selection regime.

She noted that there would be a future focus from Synergi at a Committee meeting to discuss the positive impact to date through the outreach team. She

linked this back to the discussion at the start of Board related to the diversity of engagement and how this can be supported.

Mr Wright raised a query relating to the legal process alluded to in the report due to community treatment orders and the implications of this. Dr Hosker confirmed a judgement had been reached and an appeal had not been indicated, therefore the assumption was that it was now a legal requirement. He noted that this would particularly impact on the outreach team however the numbers were not alarming, and work was being undertaken to address this. Mr Wright added that there may be potential for wider implications beyond community services and virtual appointment access as there was a move towards that. Dr Hosker confirmed that there was no impact on other assessment processes as this was an interpretation of law for virtual assessments related to the Mental Health Act. Dr Munro confirmed it would be picked up by the national team due to the potential for eligibility for compensation.

Mrs McRae noted that it was good to see information regarding Mental Health advocates and acknowledged that whilst this needed to be progressed further due to poor results it was positive it had commenced. In relation to the disproportionate outcomes for black men for the outreach team, Mrs Forster Adams noted that there was a need to have the recommendations from Synergi in the first instance to fully understand what this may be. Mrs McRae noted that there had been repeated issues and the link to Synergi, therefore there was a need to understand the outcomes. Dr Munro added that assertive outreach interventions could be classed as coercive to keep people in the community for treatment and the service should be able to demonstrate access to support prior to service user admission. She added that the assertive outreach model needed consideration to understand where the benefit should be seen. Ms Khan highlighted the lack of engagement from schools was negatively impacting on outcomes as it was not part of the wider approach at the current time. Mrs Forster Adams informed the Board that there was a focused session on health equity and priorities in June 2024 that would support discussions around priorities and areas to influence. She noted the disproportionality issues raised and therefore there was a Board opportunity to consider the influencing ability through this session.

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

24/041 **Report from the Chair of the Workforce Committee for the meeting held on 15 February 2024** (agenda item 19)

Ms Khan presented the Chair's report for the Workforce Committee noting the sexual harassment report and link to health and wellbeing. She also noted the improvement in nursing vacancies and appraisals.

She highlighted the review of the Board Assurance Framework during the Committee to ensure assurance regarding the ongoing work to mitigate the associated strategic risk.

She added it was positive to see the focus on progression support for bank staff as per the data presented in reports.

Mrs McRae referred to the substantive staff survey results regarding the Trust being a learning organisation and how this was going to be managed. Mr Skinner confirmed that a group was in place regarding compulsory training, and this was monitored via the Learn system and associated data analysis.

Mrs McRae thanked Ms Khan for the update provided.

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

24/042 **Report from Director of People and Organisational Development** (agenda item 20)

Mr Skinner presented the Director of People and Organisation Development report acknowledging the amended format regarding the presentation of data for which feedback was welcomed.

He highlighted the positive response regarding representation within the workforce aligned to the local population. He added that the sickness absence rate continued to be a significant challenge for the organisation, and that there was a requirement to balance being a caring and compassionate organisation with addressing sickness absence. It was noted that the top recorded reason for absence was mental health/stress/anxiety which was in line with the national picture.

He highlighted the positive improvement in PDR rates, and that compulsory training compliance remains stable. He added that there was better reporting around disability and ethnicity, although there was a requirement for all staff including Board members to register their personal data for this.

Mr Henry noted that the workforce people growth was encouraging however other discussions and charts did not reflect this, therefore he queried if the growth was due to additional services being taken on. Mr Skinner confirmed that was the case.

Mrs McRae queried the sickness figures and noted that percentage by service would be a useful figure for understanding the detail further. She acknowledged that long- and short-term sickness had dropped in January and was pleased that discussions with local organisations were taking place for learning opportunities for sickness management. Mr Skinner confirmed a deep dive was to take place regarding short term sickness and the appropriate use of the management process for these staff.

Mrs McRae raised how staff are engaged with regarding mental health/stress/anxiety and how we could support this. Mr Skinner noted that some of the reasons were not work related, however he acknowledged that further work could be undertaken to understand whether personal related stress can be supported. He added that when sickness was registered there

	was an automatic pathway that offered support to staff dependent on their needs. Mr Henry noted the previous presentation about age groups for staff across services and whether there was potential issue to consider. Mr Skinner informed the Board that discussions were undertaken in appropriate ways and a number of staff do retire and return but it was an issue, and a risk that was considered and acknowledged. Discussion took place regarding trend data for mental health absences to support a more detailed understanding of the position and consider whether initiatives were having a positive impact. Mrs McRae agreed that the data presented to Board was helpful with an acknowledged detailed discussion at Workforce Committee. Mr Skinner added that deep dive data regarding leavers was to be presented at Workforce Committee. Mrs Forster Adams queried whether there was consideration for flexibility regarding the presentation of reports in order to present information in an amended way. Mrs McRae noted that data should be presented in a way to best convey the message for the Board. It was agreed that this would be discussed further outside of the meeting.	**JFA / SM**
	The Board **received** the report from Director of People and Organisational Development and **noted** the content.	
24/043	**Cyber Security Update Report** (agenda item 21) Mrs Hanwell presented the Cyber Security Update report which provided an update on key issues, including the Board training that had been provided and undertaken. Mrs Hanwell confirmed that as an organisation the Trust was maintaining cyber resilience as much as possible. Ms Khan left the meeting.	
	The Board **received** the Cyber Security Update report and **noted** the content.	
24/044	**Report from the Chair of the West Yorkshire Mental Health Committee in Common** (agenda item 22) Mrs McRae presented the report from the Chair of the West Yorkshire Mental Health Committee in Common. She noted that there were no issues for escalation to the Board and highlighted the decision to postpone the Perinatal Mental Health Provider Collaborative decision until October 2024. She noted that the Committee were assured regarding the responsibility agreement and terms of reference detail.	

	The Board **received** the report from the Chair of the West Yorkshire Mental Health Committee in Common and **noted** the content.
24/045	**Board Assurance Q4 Update Report** (agenda item 23) Dr Munro presented the Board Assurance Framework update report and noted that Chair's reports had stated the discussions that had taken place at Committees. She confirmed that an update of the controls had taken place, and a full review would be undertaken in Q1 of 2024/25 as previously discussed.
	The Board **received** and **noted** the content of the Board Assurance Q4 Update Report.
24/046	**Annual Declarations of Interests** (agenda item 24) Mrs Edwards noted the content of the report and provided assurance to the Board that there were no concerns or issues for escalation regarding the annual review process. She highlighted that the Board was to acknowledge the content of the declared interests, and that all NEDs had made a declaration of independence.
	The Board **received** and **noted** the Annual Declarations of Interests.
24/047	**Use of the Trust's seal** (agenda item 25) The Board noted the seal had been used once since the last meeting in respect of: • Log 132 - Renewal of lease for 3rd floor premises, Don Valley House, Saville Street East, Sheffield, between LYPFT and Trafalgar Court Northern Limited – signed 28 March 2024 DH confirmed this premises was where the NOE CPC operated from.
	The Board **noted** the use of the seal since the last meeting.
24/048	**Any other business** (agenda item 26)
	There were no additional items of other business.

24/049	**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 13:30 and thanked members of the Board and members of the public for attending. The Chair then resolved that members of the public would be excluded from the meeting having regard to the confidential nature of the business transacted, publicity on which would be prejudicial to the public interest.

Leeds and York Partnership NHS Foundation Trust

Cumulative Actions Report for the Public Board of Directors' Meeting

OPEN ACTIONS

AGENDA ITEM

6

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Any Other Business (minute 24/021 - agenda item 21 – January 2024) Mrs Burns-Shore and Mrs Hanwell to provide further information regarding the Breathing Space initiative, and potential impact on the Trust, once it becomes available.	**Zoe Burns-Shore / Dawn Hanwell**	Management action	**ONGOING**
Report from the Chief Operating Officer (minute 24/031 - agenda item 9 – March 2024) It was agreed that an update, including evaluation undertaken, would be provided to the Board in six months regarding the Community Mental Health Transformation roll out.	**Joanna Forster Adams**	September 2024	**NEW** **COMPLETE** This is listed for the Board of Directors meeting in September 2024.
Report from the Chief Operating Officer (minute 24/031 - agenda item 9 – March 2024) Mrs Forster Adams to arrange a service visit to Community Mental Health Service for Mr Wright.	**Joanna Forster Adams**	Management action	**NEW**

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
Staff Survey Results (minute 24/033 - agenda item 11 – March 2024) The Workforce Committee would review the data in more detail related to bank staff and their experiences regarding sexual harassment and physical violence	**Darren Skinner / Zoe Burns-Shore**	Management action	**NEW**
Staff Survey Results (minute 24/033 - agenda item 11 – March 2024) The Executive Team would discuss the support request for mandatory intention planning and provide feedback.	**Executive Team**	Management action	**NEW**
Integrated Patient Safety Report (minute 24/036 - agenda item 14 – March 2024) It was agreed that the content for the integrated patient safety report would be discussed in further detail for future report content.	**Nichola Sanderson / Alison Quarry**	Management action	**NEW**
Director of People and Organisational Development (minute 24/042 - agenda item 20 – March 2024) It was agreed that the presentation of reports and data to Board would be discussed further outside of the meeting to consider alternative options.	**Joanna Forster Adams / Sara Munro**	Management action	**NEW**

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
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	**COMPLETE** 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.
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	**COMPLETE** A review of the Trust's flagship internal communications bulletin 'Trustwide' has been undertaken including the consideration of new technologies to improve the content and structure of the bulletin.
Sharing Stories – Emerge Involvement Strategy (minute 24/001 - agenda item 21 – January 2024) Dr Munro to discuss opportunities to influence national policy related to the lived experience involvement approach.	**Sara Munro**	Management action	**COMPLETE** The Emerge Service are linked into NHS Provider Confederation and the supporting strategy.

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
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MEETING OF THE BOARD OF DIRECTORS

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

30 May 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

Industrial Action
Since the last board we have not had any periods of industrial action and at the time of writing none have been indicated. Consultants have voted to accept the pay offer for 2023/24 and Speciality doctors have been recommended to accept their pay offer. Junior doctors remain in negotiation with the government. There is no indication when the pay awards for all NHS staff for 2024/25 will be announced.

Teaching Trust Status
Prior to becoming a foundation trust the predecessor organisation was classified as Teaching Trust with the University of Leeds. The university has now developed a new process for organisations to seek teaching trust status with them. After initial meetings with the University, we have formally written to them to begin the process of applying to be a recognised teaching trust. Key colleagues will work together on the submission, and it is expected to take approximately 12 months to complete. We have a wealth of evidence already generated by the Director of Medical Education and Practice Learning team that will put is in a strong position with the application and the University have indicated they fully support us taking this forward. Teaching Trust status is important in terms of attracting and retaining our future workforce.

MP Visit
On the 1st May we hosted a visit from the Labour MP who is the shadow minister for women and mental health - Abena Oppong-Asare and the NHS confederation. Abena was in Leeds to give a keynote speech at the annual mental health network conference. The focus of the visit was to share the work of the Synergi collaborative, and the session was led by Sharon Prince, accompanied by colleagues from a range of organisations in the city including public health, VCSE, lived experience advisors and the city council. Showcasing the approach to systemic change through grass roots engagement with communities was very well received by Abena and we have made an offer to help shape future policy going forward.

Brand Refresh launch
The Board have had previous updates and presentations on the work we have done to refresh our brand, so it better reflects the service we provide and the communities we serve. After extensive engagement and design work we are now going live with the ‘new brand’ and this was presented

at the last council of governors meetings. We are suing what is described as soft launch, moving over our various communication templates and updating signage when it is opportunistic to do so. This will also underpin the refresh of trust strategy which is covered in a separate briefing paper.

NHS
Leeds and York Partnership
NHS Foundation Trust

Our refreshed brand identity

Oliver Tipper, Head of Communications

May 2024

Leading the way in **mental health, learning disability** and **neurodiversity care** | integrity | simplicity | caring

- Our strapline: ***Leading the way in mental health, learning disability and neurodiversity care***
- The development of a brand proposition statement (also known as our promise)
- Revised vision and mission statements – which form part of our refreshed "Plan on a Page"
- A creative theme of "Here for . . ." which gives us a unique way of communicating our brand identity
- A bold new visual style, with bright colours and fab new imagery featuring our staff
- New tone of voice guidance to help us keep it simple when communicating verbally or in writing
- All detailed in our comprehensive 'Brand Book'
- If you just want the headlines check out 'Our Brand Identity The Basics' z card.

NHS
Leeds and York Partnership
NHS Foundation Trust

What's not changed

- Our name and logo (top right)
- Our values

We have integrity
We treat everyone with respect and dignity, honour our commitments and do our best for our service users and colleagues.

We keep it simple
We make it easy for the communities we serve and the people who work here to achieve their goals.

We are caring
We always show empathy and support those in need.

Leading the way in **mental health, learning disability** and **neurodiversity care** | integrity | simplicity | caring

2. Our Partnerships, National and Local

NHSE National Leadership Event

On the 1st May I attended the national meeting attended by CEOs from provider trusts and ICBs along with the executive team for NHSE. Key themes from the day included.

- There is a lot to be proud of in terms in increased access, quality and outcomes across the NHS but we must work hard to get the message through, especially for our staff.
- The financial settlement is better than what was expected, and systems must ensure they are working hard to operate within their allocations without comprising staff engagement and patient safety.
- We shouldn't underestimate the tail of covid and its impact both on how we provide services but also on demand.
- Tools, data packs and resources are being developed by NHS Impact for the sectors in the NHS to support approaches to continuous improvement.
- Important to keep planning for the long term and having a bridge between the challenges now and where we want to be. The tech investment will help with this.
- Productivity measures and metrics are there as a tool for staff engagement and improvement. More will be created for the community/mental health/primary care sectors.

West Yorkshire ICB

The board has now reviewed and amended the cycle of business and public board meetings will now be held 4 times per year. Therefore, there has been no public meeting since our last Board and the next one is scheduled for the 25th of June.

Leeds

Tom Riordan, CEO of Leeds City Council has announced he will be stepping down later this year after serving as the Chief Executive for 14 years. He has been a visible and committed leader to partnership working and 'Team Leeds's and has recommended his successor is someone who can carry forward the same ethos above all else.

The new CEO for Leeds Community Trust Selina Douglas has now started in post. We have had the chance to meet as part of her induction and she is keen to ensure like us we have a strong partnership between our organisations and in the city.

3. Reasons to be Proud

This month is a bumper edition of reasons to be proud following the national Positive Practice Awards for Mental health…

Positive Practice Awards - Winners

- Children and young people's mental health services - Red Kite View
- Mental health rehabilitation and/or recovery services - Joint winners CREST
- Specialist Services - Op Courage

Positive Practice Awards – Highly Commended

Highley commended

- Integrated Physical and Mental Health - Health Facilitation Team
- Learning Disabilities and/or Autism - Intensive Support Team
- Addressing Inequalities - Synergi Leeds and Gender Outreach Workers
- Acute inpatient care - Acute (Becklin) and Red Kite View
- Older adult functional mental health services - Older Peoples Service, the Mount
- Specialist Services - North Assertive Outreach

Service user feedback

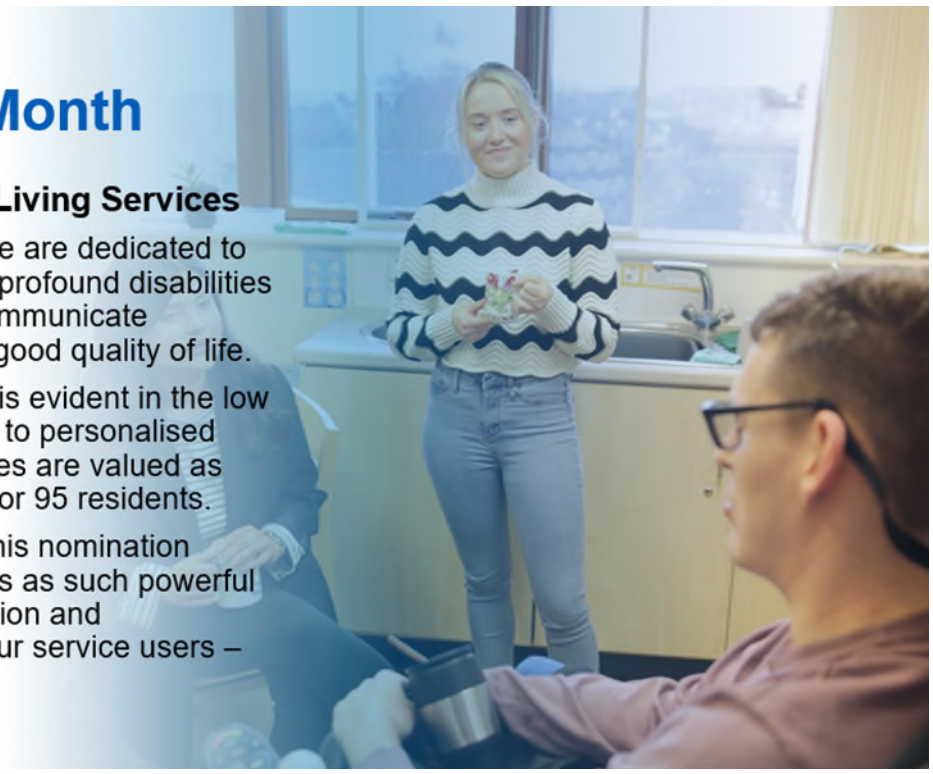
Nathan Johnson

- “My experience of being supported by the Community Mental Health Team (CMHT) and Kate Spooner and Jon specifically was especially good. Always person centred and encouraging when I was at my lowest point and experiencing the roller coaster of psychosis, and hearing voices and paranoia. Their support and the support of the CMHT helped me to regain control of my life and start my path to recovery from a period of severe mental illness.”

Ian Dowd

- “My Mum is in Ward 4 and has been for a few months with acute mental health problems but is starting to improve. All of the staff have been wonderful, do a fantastic job day after day, are professional, compassionate and caring. They are patient and kind, and I could go on and on... That's from the Consultants to the Student Nurses and Receptionists.”

Team of the Month



Specialist Supported Living Services

- The teams in this service are dedicated to helping individuals with profound disabilities express themselves, communicate effectively, and enjoy a good quality of life.
- Our staff's commitment is evident in the low turnover and dedication to personalised care, ensuring residences are valued as homes across 16 sites for 95 residents.
- **Judges' comments:** This nomination brought tears to my eyes as such powerful examples of the dedication and compassion shown to our service users – thank you.

Research and Development

This month we take the opportunity to celebrate Claire Paul, Professional Lead for Allied Health Professions.

- Claire is a current Principal Investigator (PI) for both MoreRESPECT study and SCEPTRE study.
- Claire is a very supportive and proactive PI and the Research and Development Team value her input. She consistently demonstrates great commitment for her role and goes over and beyond to demonstrate confidence in operating as a site PI.

"I have always been interested in research from an evidence-based perspective. However, after leading my own small scale research project as part of a master's programme, I wanted more active involvement. This led to me completing a NIHR research internship. Since then, I have been principal investigator or co-applicant on several NIHR studies. "

Dr Sara Munro
Chief Executive Officer
22 May 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:	Freedom to Speak Up Report
DATE OF MEETING:	30 May 2024
PRESENTED BY: (name and title)	Shereen Robinson, Freedom to Speak Up Guardian
PREPARED BY: (name and title)	Shereen Robinson, Freedom to Speak Up Guardian

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 covers the work of speaking up at the Trust since the current Freedom to Speak Up Guardian (FTSUG) has been in post from 16 October 2023 to 30 April 2024. There were 32 concerns that were raised through the FTSUG which were informally discussed or resolved via the FTSUG during this period. Activities the FTSUG service has been involved with includes:

- Progressed with induction into LYPFT, the role and ways of working
- Continues to make connections across the trust to share learning and embed the work
- Expand the role of FTSU Ambassadors to include Counter Fraud and Cultural Inclusion
- Attended the national FTSU Conference with other FTSUGs to share best practice
- Attends a regional network with access to support and debrief
- Offered all staff who approach the FTSUG support, whether they raise a concern or not
- Aligning with all national work, learning and guidelines.

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 recommended to approve the report and continue its support to embed our speaking up work.

MEETING OF THE BOARD OF DIRECTORS

30 MAY 2023

Freedom to Speak Up

1 Executive Summary

This report covers the work of speaking up at the Trust since the current Freedom to Speak Up Guardian (FTSUG) has been in post from 16 October 2023 to 30 April 2024.

There were 32 concerns that were raised through the FTSUG which were informally discussed or resolved via the FTSUG during this period.

Activities the FTSUG service has been involved with includes:

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- Offered all staff who approach the FTSUG support, whether they raise a concern or not
- Aligning with all national work, learning and guidelines.

The Board is recommended to approve the report and continue its support to embed our speaking up work.

2 Main body of the paper

2.1 The recommendation that trusts should have an agreed approach and a policy to support how organisations respond to concerns was one of the recommendations from the review by Sir Robert Francis into whistleblowing in the NHS.

2.2 The Trust has a FTSUG and 5 ambassadors (1 ambassador has recently left the Trust and 1 ambassador is on maternity leave). The FTSUG and Ambassadors meet regularly to discuss ways to communicate to staff and to be visible in the Trust. Recent activity has included attendance at staff and preceptorship inductions, staff wellbeing and Mr Coffee events, team meetings, international recruits celebration events, renewal of posters across the Trust and site visits where concerns are raised.

2.3 The Guardian also attends a number of meetings including Trust Wide Clinical Governance, PSIRF Oversight Group, Civility and Respect, Staffside meeting, Trust Wide Safeguarding Committee, Staff Network meetings, ER Improvement Group, POD Governance and EDI Committee and other relevant meetings.

2.4 The FTSUG work receives strong ongoing support from the Chief Executive, the Non-Executive Director with responsibility for speaking up work, Director of HR, the trust's Workplace Race Equality Network (WREN) and the wider Trust.

2.5 The FTSUG has been making connections with areas where specific learning is to be shared to make improvements and has had meetings with HR to build relationships with the team, support the work of Early Resolution and request data from the staff survey results and useful areas of triangulation. Sharing data is important to learn as a trust but care must be taken in ensuring a themed approach rather than identifying individuals.

2.6 The FTSUG is also working at a local and regional levels to share learning and best practice including attendance at the FTSU Conference, local meetings with other Guardians across West Yorkshire with psychological support, Lunch and Learn webinars and personal development and Regional Meetings across the North. The FTSUG also works nationally with the National Guardian Office and NHS England in developing speaking up in the wider health and care system through sharing data and reflection.

2.7 We have received 32 concerns. Due to the low number of concerns these have not been aggregated at a service level but the table below shows the number of concerns by themes and a summary of the outcomes.

The table below details speaking up concerns raised within the Trust.

Numbers of concerns formally raised	Themes	Outcome
15	Inappropriate behaviour and bullying	Signpost to HR, occupational health, line manager, trade union or HR process, early resolution where appropriate
6	Unfair workplace practice e.g. recruitment, disciplinary, workplace adjustments	Referral for service reviews, review of formal processes, HR intervention
5	Discrimination allegations based on disability, gender or race	Involvement of Head of EDI, review of processes, involvement of HR
4	Patient safety concerns	Investigation of concern, review of processes, signpost to PALS
2	Violence and aggression (1), detriment from raising concern (1)	Involvement of Estates and Facilities, signpost outside of LYPFT

2.8 Concerns were received by email (18), anonymous letter or email (3), phone/text (6), face to face/meeting (4), referral from Leeds University (1).

2.9 The professional Groupings within this update include 15 Admin, 8 Nurses/Medic, 3 Bank. Some were also raised anonymously.

2.10 13 staff colleagues who informally discussed concerns with the FTSUG are from diverse backgrounds and 7 of these concerns were related to issues of race either fully or partially.

There 6 concerns concerning physical and mental health issues including access to workplace adjustments.

3 Themes

3.1 We see a significant number of staff using FTSU. Staff report being supported and heard.

3.2 There were a high number of concerns involving colleagues not wanting managers to know their name indicating psychological safety is low in some areas with staff writing anonymous emails/letters or being anxious when raising the concern with the FTSUG about whether the service will know who raised the concern. Although this makes it more difficult to resolve concerns, relationships are being built with HR and OD to help with interventions and triangulation that can be put in place to address inappropriate behaviour.

3.3 Pressures on turnover, vacant posts, bed shortages and stress can have an impact on teams and lead to patient concerns being raised. Specific cases involving patient care are being investigated.

3.4 There were concerns from Bank staff about different treatment that has been explored including race. There have been concerns around general recruitment and selection processes that are also being investigated.

3.5 Staff have raised concerns that they considered linked to racism, sexism and disability discrimination. There was also a high number of cases involving an impact on mental health having an impact on resilience and perception where occupational health was signposted.

3.6 Staff raised concerns about the lack of support during our processes e.g. during investigation not being clear on the process, managers not having specific training on HR processes and unfair treatment during performance management and disciplinary processes. Students also raised concerns during placements about process and unfair treatment from managers.

3.7 There was an example of where parking issues escalated into violence and aggression leading to staff safety issues when attending sites daily.

4 Positive Feedback

4.1 Feedback forms have a low return rate but follow up emails indicate satisfaction with the service. Some examples are below:

"I found my interaction with Shereen very helpful. She took time to speak to me and allowed me to voice my concerns and ensured there was a safe place for me to share my story. Following our interaction, I felt reassured that my concerns were taken seriously and will be dealt with. Thank you".

Thanks for your help and support throughout this procedure . Much appreciated. If I need require further assistance, I know I can contact freedom to speak.

"Good news, I think I got the result I needed with regards to conversations with managers. If you had not have stepped in, this would not have been resolved"

"Thank you for listening to me and asking if I was ok"

5. Assurances and Future Work

5.1 We are reporting quarterly to the National Guardian Office. The FTSUG is meeting staff from across all business units of the trust at different roles and levels. In terms of local comparison with neighbouring NHS trusts, we evaluate well in terms of staff who speak up.

5.2 Due to the level of concerns on relating to allegations of bullying, we support the Early Resolution and Civility and Respect work which includes upskilling staff and managers to have early adult conversations to resolve concerns, embed appropriate behaviours and restore relationships. Any patterns or trends that are identified are discussed with the CEO.

5.3 We will continue to support inclusion initiatives including workplace adjustment, specific diversity training and social media.

5.4 Where concerns area raised involving multiple issues or serious concerns we will liaise with HR and OD on a Service Reviews for that area or a review of the recommendations from previous reviews.

5.5 Recommendations from the Too Hot to Handle report by Brap and Roger Kline for FTSU training in understanding systemic racism and noticing patterns of discrimination. FTSU Ambassadors will now be trained as Cultural Inclusion Ambassadors.

5.6 We are working across the trust to triangulate cases in a meaningful way by sharing case studies with WREN and data with trade unions, staff engagement, wellbeing, employee relations team, patient safety and clinical governance to improve and learn from trends.

5.7 The following are ongoing and future work and plans.

- To continue to raise the need for service reviews where multiple concerns arise
- To review the FTSUG service in the light of the Staff Survey results we receive
- To work with the FTSUGs regionally at other NHS organisations and at Leeds City Council on supporting speaking up in our systems in Leeds
- To review and update the FTSUG policy
- To continue to build the work and ensure its development - increasing active Ambassadors
- To continue to focus on staff with protected characteristics in the trust to see how speaking up can support these staff when needed.

6. Conclusion

6.1 The FTSUG work continues to receive support from the trust and its leadership. The FTSUG role allows staff voices to be heard and followed up in the trust and supports providing excellent clinical care and having a just and compassionate culture.

7. Recommendation

7.1 The Board is recommended to approve the report and continue its support to embed our speaking up work.

Shereen Robinson
Freedom to Speak Up Guardian
20 May 2024

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

9

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chair's Report from the Finance and Performance Committee meeting held on 23 April 2024
DATE OF MEETING:	30 May 2024
PRESENTED BY: (name and title)	Cleveland Henry, Non-executive Director and Chair of the Finance and Performance Committee
PREPARED BY: (name and title)	Rose Cooper, Deputy Head of Corporate Governance

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

COMMITTEE DETAILS:	
Name of Committee:	Finance and Performance Committee
Date of Committee:	23 April 2024
Chaired by:	Cleveland Henry, Non-executive Director

KEY DISCUSSION POINTS:

ALERT - Issues to alert the Board to:

No issues to which the Board needs to be alerted.

ADVISE - Issues to advise the Board on:

- The Committee received an overview of the draft 2023/24 financial outturn performance (subject to external audit) and noted that the Trust had achieved a surplus broadly in line with its planned forecast and had met its objective from the Integrated Care Board (ICB); however, it was mindful that the Trust had technically posted a deficit as a consequence of fixed asset impairments which were excluded from the financial performance measurement and did not count toward the ICB control total.

- The Committee received a report on the work being undertaken by the Digital Service and was concerned to note the delays in the delivery of work by Advanced, the Trust's supplier of healthcare systems, and that further delays were expected which could impact on the Trust's ability to complete key projects. The Committee was reassured to note that the team planned to undertake a dependency mapping and risk assessment exercise against Advanced and other key suppliers in order to better understand the risks and impacts for

the Trust. The Committee also discussed the need to utilise existing technology better and more efficiently in the Trust in order to realise the benefits of technology that was already enabled but may not be being transacted fully. The Committee supported this approach, noting the shift in culture that would be required to achieve this. The Committee asked what the Trust could learn from other organisations in terms of how we could improve our own use of technology, systems, and data reporting. Mr Hogan confirmed that he was looking into this and planned to bring a report to a future Board of Directors' meeting.

- The Committee received key updates from the Clinical Environments Group and the Estates Steering Group and noted that the Private Finance Initiative (PFI) benchmarking exercise undertaken by Equitix had identified that catering services would fall outside the benchmark meaning that an increase in costs would be necessary. The Committee heard that negotiations were ongoing with the facilities management provider and that nursing and dietetics teams had been involved in the discussions to minimise the impact on quality and patient choice.

ASSURE – Items to provide assurance to the Board on:

- The Committee received the debrief report following the cyber exercise that took place on the 25 October 2023. The Committee heard that the event had been successful and that an action plan had been developed following the exercise which was being monitored by the Emergency Preparedness, Resilience and Response Group, and that there were no issues of concern to be alert to.

Items to be referred to other Committees -

The Committee did not refer any items to other Board sub-committees.

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 update provided.

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
10

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	CHIEF FINANCIAL OFFICER REPORT - MONTH 1
DATE OF MEETING:	30 May 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

Overall, the 23/24 financial year has been a challenging one and progress against the four thematic efficiency areas have not progressed as much as originally aimed for resulting in the Trust exiting 23/24 with a deteriorating run-rate. This is largely driven by the sustained high levels of OAPs, agency and high inpatient staffing levels. However, the revenue and capital financial plans for 23/24 have been fully achieved in year, albeit the revenue position through a range of non-recurrent benefits, meaning reduced flexibility in 2024/25. It is recognised that there needs to be an improvement in the delivery of productivity and efficiency entering into 2024/25 and work has begun internally to progress this.

At month 1 in 2024/25 there has been a £1m deficit in month, OAPs, agency and inpatient staffing levels continue to be the issue areas highlighting the pace needed in the impact of the Trust efficiency plans. The capital programme is progressing well and is slightly ahead of plan at month 1.

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 delivery of the revenue and capital plans for 2023/24.
- Note the risks and issues in the underlying Trust run-rate entering into 2024/25.

MEETING OF THE BOARD OF DIRECTORS

30 MAY 2024

CHIEF FINANCIAL OFFICER REPORT

1 Introduction

This report provides an overview of the draft 2023/24 financial outturn performance, including Integrated Care System (ICS) position, the Financial position Month at 1 24/25 and Estates related updates.

2 Income and Expenditure Performance 2023/24

The unaudited draft accounts which were submitted on time to NHS England and are currently undergoing external audit, report a deficit of £458k, as shown in the table below. However, this includes a technical expenditure charge/movement of £2.5m at year end due to fixed asset impairments (downward asset valuations). Excluding this technical item (which is not included in system control totals) the Trust delivered a £2.1m surplus, broadly in line with its agreed forecast surplus of £2.2m, which forms part of the overall West Yorkshire position.

Table 1

		Month 12		
Income & Expenditure Budget Position	**Budget Annual £'000**	**Budget YTD £'000**	**Actual YTD £'000**	**Variance YTD £'000**
Income:				
Patient Care Income	214,988	214,988	226,803	11,815
Other Income	31,657	31,657	36,508	4,851
Total Income	**246,646**	**246,646**	**263,311**	**16,666**
Expenditure:				
Pay Expenditure	(179,683)	(179,683)	(181,556)	(1,873)
Non Pay Expenditure	(66,963)	(66,963)	(82,213)	(15,250)
Total Expenditure	**(246,646)**	**(246,646)**	**(263,769)**	**(17,124)**
Surplus/ (Deficit)	**0**	**0**	**(458)**	**(458)**

Detail variance analysis has been reported through the Finance and Performance Committee throughout the year. The significant financial pressure/risks areas of note which have materialised are:-

- Agency expenditure was £11.2m for the year, representing 6.2% of the total pay bill (ICB in aggregate has a target of no more than 3.7%).

- Out of Area Placements (OAPs) which peaked in quarter 4 at an average of 40 patients per month, resulted in full year expenditure of £ 10.2m across working age adults and PICU (against a non-recurrent budget of £3m).

- Inpatient wards incurred significant overspends of £3.6m due to additional use of bank/ agency/ other skill mix.

- Specialist Supported Living ended the year at £1m deficit, linked to underfunding on pay awards and the contractual mechanism where voids (tenant vacancies) are not paid.

As also previously noted, despite the above pressures, the revenue position throughout the year was predominantly underpinned and supported by fortuitous mitigations including substantive vacancies, slippage on development reserves, commercial income including significantly high levels of interest receivable (due to cash balance and interest rates). The efficiency approach developed for 24/25 continues to focus on these high-risk financial pressures, and the availability of fortuitous mitigations has diminished.

3 Capital Expenditure

The total capital expenditure for the year was £6.1m. This included the full utilisation of our agreed ICS operational allocation £3.8m, and public dividend funding for digital of £1.6m. The balance of £0.6m was related to IFR16 leases which have now been included in the ICS position at the year end.

There were no material changes to forecast spend as previously assessed. Due to a partially completed scheme to redevelop Newsam seclusion suite alongside some other minor slippage, we were able to complete some other backlog works to ensure full utilisation of resources and reduce the impact on 24/25. Detail of expenditure has been reported through the Finance and Performance committee.

4 ICS Financial Position 23/24

4.1 Revenue

Due to actions taken earlier in the year and additional funds received into the system to mitigate industrial action, the overall draft 23/24 outturn across the ICS was a broadly balanced position (£170k surplus). This was split £4.2m deficit in provider organisations, offset by a surplus of £ 4.4m held by the ICB.

4.2 Capital

In 23/24, ICB capital expenditure was fully managed in line with the ICB operational capital envelope. Additional allocations received in year, increased the original envelope (£159.5m) to £172.4m and the ICB will report operational capital expenditure of £172.4m. These values exclude any impact of IFRS16. Whilst the ICB overall was potentially at risk of exceeding its IFRS16 capital expenditure limit, flexibility identified at regional level enabled this risk to be mitigated/offset.

It remains a significant concern for future given the allocations are anticipated to be significantly less than needs based plans, as IFRS16 becomes a set target within the overall capital allocation.

5 2024/25 Plans

5.1 Revenue

In March the Board agreed the Trust submission of a balanced revenue plan (excluding a PFI accounting adjustment resulting in a technical planned deficit of £0.9m). It was noted that final operational planning guidance had only just been published and that a revised plan would need to be submitted in May.

Two adjustments were made to the final plan submitted in May:-

Cost Uplift Factor (CUF)
National planning assumptions on inflation were amended, reducing the CUF by 0.20%. Previously the NHS tariff uplift assumptions had been 1.9% CUF less 1.1% efficiency. This was adjusted to 1.7% less 1.1%. This equated to £425k reduction in income with assumption that costs estimates would reduce by equivalent. Based on the Trusts planned expenditure profile this expected reduction in inflationary expectations has not materialised This generates a further £425k cost pressure, which has been added to the efficiency requirement to remain at a balanced plan.

PFI Adjustment
As noted above due to how PFI contracts are accounted for under revised accounting rules, the Trust submitted a £0.9m deficit. The ICB acknowledged this was out with Trust control and did not require the Trust to meet the additional pressure at that point of submission in March. However, as a direct result of additional funds being passed to the system for depreciation, the ICB has allocated a further £1m additional income to ensure that the Trust has a fully breakeven plan. This funding is neutral. During the year depreciation will be monitored as a separate item and significant variances between organisations may mean a transfer of resource.

The table below shows the impact of the two adjustments, and the final revenue plan

	£m
Plan submitted 21st March	**-0.9**
0.2% CUF Change	-0.4
Additional Efficiency Target	0.4
Additional Income to offset the PFI Adj.	1.0
Final plan submitted 26th April	**0.1**

The final plan includes a cost improvement/efficiency challenge of 16.9m (7%)

The system final revenue plan as submitted in May was still £99m deficit. The current working assumption is that this can be reduced to £50m deficit, but no additional improvement is expected from LYPFT. Four Acute providers are expected to improve positions and ICB level core funding slippage/anticipated new in year funds are also expected to support reducing the deficit to £50m.

5.2 Capital

In March the Trust submitted a capital plan in line with its indicative share of the ICB allocation of £3.4m. Since that point the system has agreed to “over-plan” by 5% which is allowable in the guidance but assumes slippage will occur to bring systems back to plan. In West Yorkshire the 5% is being held as a system contingency (£7.8m) but for the purposes of submission must be shown in provider plans, so for presentational purposes only it is included in the LYPFT plan.

6 Month 1 Revenue position

As in previous years there has been no requirement to formally report a month 1 position to external regulators, although we have shared our high-level position with the ICB. This shows an adverse variance against plan of £339k as detailed below, the actual run rate deficit is a £1m in month;

		Month 1		
Income & Expenditure Plan Position	**Plan Annual £'000**	**Plan YTD £'000**	**Actual YTD £'000**	**Variance YTD £'000**
Income:				
Patient Care Income	216,858	18,073	18,057	(16)
Other Income	35,615	3,961	4,104	143
Total Income	**252,473**	**22,034**	**22,161**	**127**
Expenditure:				
Pay Expenditure	(175,166)	(14,729)	(15,387)	(658)
Non Pay Expenditure	(77,212)	(7,985)	(7,792)	192
Total Expenditure	**(252,378)**	**(22,714)**	**(23,180)**	**(466)**
Surplus/ (Deficit)	**95**	**(680)**	**(1,019)**	**(339)**

The significant variances against plan are:

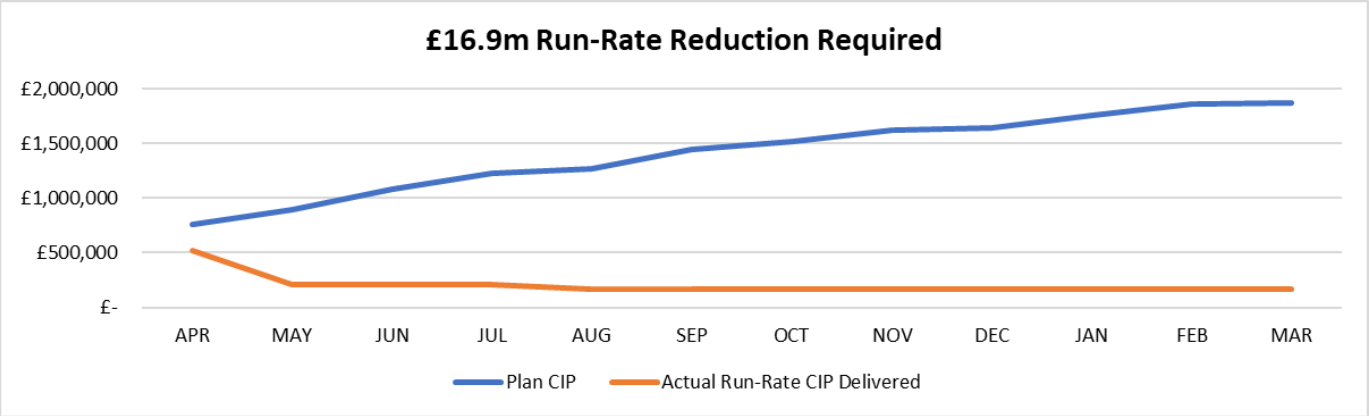
- Other income is £143k ahead of plan, in the main due to interest receivable being £75k better than plan and small timing differences in Research & Development and Training income.
- Pay is £658k worse than plan due to permanent pay being £457k higher than planned levels and bank being £255k higher than plan, reducing this agency is £61k lower than plan.
- Non-pay is £192k under plan due to minor underspends across a wide range of subjective lines, £40k in Premise expenditure, £40k in non-clinical supplies etc.

7 Efficiency Challenge 24/25

The Trust efficiency programme for 24/25 is to deliver run-rate savings of £16.9m and budget reductions of £10.8m. Building on the work begun back in March 2023, the Trust has agreed five key areas of focus that will underpin the financial measures to deliver plan in 24/25. All the measures are in recognition of the need to balance patient safety, experience and outcomes, whilst providing the organisation with some headroom to recover its financial position. The Financial Planning Group (FPG) will be the conduit for monitoring progress against all five areas:

- Reducing Pay Run-Rate
- Reducing the reliance of agency & locum
- Rostering Review
- Non-pay actions
- OAPs Trajectory

All schemes have now been put onto the Efficiency Hopper for 24/25 and the majority have been assigned trajectories for delivery in 24/25. A number of schemes have already started delivering reductions in run-rate as shown below



APR (£)	MAY (£)	JUN (£)	JUL (£)	AUG (£)	SEP (£)	OCT (£)	NOV (£)	DEC (£)	JAN (£)	FEB (£)	MAR (£)	TOTAL
758,902	893,824	1,081,880	1,222,389	1,272,640	1,443,763	1,521,717	1,623,597	1,642,716	1,755,268	1,859,345	1,873,959	**16,950,000**
519,430	207,776	207,776	207,776	166,833	166,833	166,833	166,833	166,833	166,833	166,833	166,833	**2,477,425**

In April the Trust needed £759k of run-rate reductions, however only £519k were delivered, this is a gap of £240k.

At this stage there have not been any budget reductions transacted, however there are a number of schemes awaiting FPG approval and will start delivering from month 2.

8 2024/25 M1 Capital Position

The distribution of the operational capital budget between estates and information technology is still being finalised as we risk assess and prioritise schemes across both areas. However operational expenditure is underway on agreed pre commitments and brought forward schemes. At month 1 £0.2m has been spent. The perinatal scheme for which we expect national funding continues to be progressed, although no business case approval has still not been confirmed.

9 Estates Update

The Board will note as one of the organisational priorities we will refresh the strategic estates plan. At NHS England national level there is a requirement for all 42 ICSs to submit a 10-year Infrastructure Strategy by 31st July 2024. Guidance on how to complete this work was published at the end of March alongside planning guidance, but in anticipation and in preparation West Yorkshire commissioned NHS Property service last autumn to coordinate manage and oversee the production of a plan for West Yorkshire. The main emphasis is on estate put the strategy needs to all anticipated strategic expenditure on digital technology and major medical equipment. The intended aim of these strategies is to help inform NHS England in producing a nationally agreed set of infrastructure priorities informed and shaped by local needs and requirements. There is a clear link to informing the future settlements with Treasury through the spending reviews.

The Trust has been actively engaged with the work as part of a core project team, and in supporting key data collections on existing asset base information. A very draft plan will be submitted at end of May but this is not required to be complete or have been through any formal governance. The approach being taken is to define requirements at both organisation and place level. The final submission will need to include a prioritisation process by the ICS to identify “top” priorities. How this prioritisation will be undertaken is yet to be defined but will be driven by factors linked to delivering the clinical priorities and long term plan requirements, improving productivity, better use of digital and workforce, and sustainability requirements. Clearly from LYPFTs needs based position there is a minimum top two strategic priorities related to the PFI expiry and the electronic patient record as these are both must dos in terms of capital requirement. The Board will be kept informed of this

process and the final plan as it develops through June/July. It is anticipated that a draft plan across the whole ICS will be ready by end of June. There is still a significant amount of work to achieve this.

10 Conclusion

The 23/24 financial year was a challenging year and progress against the four thematic efficiency areas were not progressed as much as originally aimed for resulting in the Trust exiting 23/24 with a deteriorating run-rate. The revenue and capital financial plans for 23/24 were fully achieved in year, albeit the revenue position through a range of non-recurrent benefits, meaning reduced flexibility in 24/25. It is recognised that there needs to be an improvement in the delivery of productivity and efficiency entering into 24/25 and work has begun internally to progress this.

At month 1 in 24/25 there has been a £1m deficit in month, this is £339k adverse to plan due to the phasing of the efficiencies required in year. FPG will be we reviewing all cost improvement plans and controls in place noting the pace of delivery as an additional level of financial governance may be required during the year. The capital programme is progressing well and is slightly ahead of plan at month 1.

11 Recommendation

The Board of Directors is asked to note and consider:

- the delivery of the revenue and capital plans for 23/24.
- the final plan and the month 1 financial position in 24/25.
- the ongoing work to complete and ICS Infrastructure plan.

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 4 Progress Report
DATE OF MEETING:	30 May 2024
PRESENTED BY: (name and title)	Dawn Hanwell, Chief Financial Officer
PREPARED BY: (name and title)	Amanda Burgess, Head of the Programme Management Office

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 quarter 4 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 four we have:

- 95 tasks that have been completed
- 94 tasks are reporting a rating of green (on track for delivery in 2024/25 or beyond)
- 14 tasks are reporting a rating of amber (action incomplete – implementation slipped but will be delivered on time during 2024/25 or beyond)
- 24 tasks are reporting a rating of red (action incomplete during 2023/24 – timescales not achievable)
- 7 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.

Appendix three sets out the 2025/25 organisational priorities. All 14 priorities are derived from one of our five core strategic plans and are seen as the important deliverables for the Trust in 2024/25, providing clarity and focus.

Appendix four sets out the process by which we assess the quality impact of our efficiency and productivity programme.		
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. • Ratify our 2024 – 2025 organisational priorities (appendix three), noting reporting will commence from the end of quarter one. • Note the guidance for quality impact assessing our efficiency and productivity programme (appendix four)

Leeds and York Partnership
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS

THURSDAY 30 MAY 2024

2023 – 2024 ORGANISATIONAL PRIORITIES QUARTER 4 PROGRESS REPORT

1. Purpose

This report provides a summary of the Trust's progress against our 2023 – 2024 organisational priorities. This is our fourth and final progress report for 2023/24 providing an overall summary of the progress we have made against each of the high-level objectives taken from each directorates' 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.

This report also details our 2024 – 2025 organisational priorities (**appendix three**).

For information, **appendix four** sets out the process for quality impact assessing our efficiency and productivity programme.

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 four

At the end of quarter four, we have continued the review of all our priorities as part of 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:

- **Enabling key clinical service changes through our estate:** We have now commenced the work at the Newsam Centre to renovate the seclusion facility, ensuring it complies with agreed standards. The new facility will open in August 2024.

- **Improving our services for people with a gambling addiction:** We have successfully mobilised the expansion of the gambling clinics across the north east and north west.

We have also delivered some significant schemes in quarter 4, including:

- **Violence and aggression:** We now have in place an approved strategy and policy document setting out our vision, objectives and guidelines for the prevention and management of violence and aggression.
- **Civility and respect:** Following the NHS England Civility and Respect Toolkit we have now published our commitment to developing a culture of civility and respect across the Trust.
- **Deployment of electronic document management (EDM) system:** We have successfully rolled out the EDM system across the Trust.
- **Deployment of office hotelling software:** We have successfully deployed Matrix our desk and room booking software solution across all our sites.
- **Alternative to hospital admission at Mill Lodge:** We have successfully opened a new day service for children and young people with an eating disorder/disordered eating.

2.1.1 Key highlights at the end of quarter four

Each lead has assessed the progress they have made at the end of quarter four 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 four we have 95 tasks that have been completed. 94 are reporting a rating of green (on track for delivery in 2024/25 or beyond). 7 tasks have been suspended.

The following sections 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 four we have 14 tasks with an amber rating. These tasks are as follows:

- **People Plan:**
  - **Keep our people protected, safe and well at work**
  - **Implementation of wellbeing rooms for our workforce:** We have made a great start in identifying and making targeted improvement to our estates and facilities, focussing on clinical sites where staff are patient-facing and for colleagues working flexibly. We have established four wellbeing rooms at our major sites. All sites have been reviewed to assess what the potential is for development of further wellbeing rooms based on the capital funding available and scope. Our new People Plan updated for 2024 - 2027 is to align with the Strategic Estates Plan to reaffirm our organisational commitment and funding to support developing wellbeing spaces across the remaining sites.

  - **Provide accessible and intuitive software solutions to support People and OD initiatives**
  - **Develop and implement an intuitive, integrated workflow management solution to replace the SW process**: We have commenced a piece of scoping work with the SharePoint external development team to discuss transitioning the SW process onto SharePoint workflow. The objective has been added to the new People Plan for delivery in 2024/25 and is one of our key efficiency measures.

- **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. The intention is for the programme to continue however, given Advanced notification to withdraw from the mental health electronic patient record market at the end of our current contract, we are reviewing alternative solutions used across the health sector. A key requisite for any 'new' provider will be NHS App integration. This objective will continue for delivery by December 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**
  - **Reduce 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 overall, our length of stay has increased across all wards. This is an identified workstream as part of the Improving Flow Programme for delivery in 2024/25.

  - **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. Upon recommendation a further dataset was completed in March 2024 and analysis is underway. This analysis will inform any decision-making and next steps during 2024/25.

- **Care Services Plan: Community and wellbeing**
  - **To progress all service developments inclusive of Community Transformation, EIP, Rough Sleepers Mental Health Service, Urgent Treatment Centres and Physical Health Services.**
  - **Improved mental health understanding and response within Urgent Treatment Centres**
  - We are continuing to develop our mental health services in the community as a part of the Community Transformation programme. The first 'wave 1' rollout commenced on 11 March 2024, with early implementor sites enacting key elements of the model. This includes team days, joint triage and helpful conversations. The workforce modelling work continues and preparation of focused areas in advance of the 'wave 2 and 3' rollouts, including any learning from the 'wave 1' pilot.
    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 as part of the community transformation pilot sites and across the services. This includes the new four week wait target outcome measure which will be a focus for 2024/25.

- **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. This is following further due diligence concerning the future viability of the contract. Regular meetings are scheduled as NHS England supports the Trust to identify a suitable alternative training supplier that can meet the requirements set out in the contract, ensuring trainees receive the necessary training to complete the programme.

- **Rehabilitation, eating disorders and gender identity**
  - **Continue the development of the West Yorkshire Complex Rehabilitation Enhanced Support Team (CREST)**
  - **Develop and implement a Complex Emotional Needs pathway**: The service has launched and is open to referrals, however it has not fully recruited to all posts. The service will require further recruitment to enable full implementation. It is anticipated that this will be completed by the end of September 2024.

- **Finance Plan:**
  - **We use our resources to deliver 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. We have refreshed our trajectories for these two significant schemes with progress/action taken through a number of key governance forums. Our four key areas of focus in our efficiency and productivity programme will continue into 2024/25.

- **Nursing & Professions Plan:**
  - **Improved service user experience**
  - **Work to a standard of 'Nothing about me, without me':** A number of initiatives have been underway in working towards this standard. We are currently considering how best to achieve this objective in a meaningful way, linked with a recent internal audit. This includes how our service users are involved in decisions at all levels from assessment, care planning, risk planning, through to discharge. This objective will be ongoing into 2024/25.

2.3 Priorities with a rating of red (action incomplete in 2023/24 – timescales not achievable)

At the end of quarter four we have 24 tasks with a red rating. These tasks are as follows:

- **People Plan:**
  - **Ensure our people have access to the full range of well-being support, physical, psychological, financial and emotional.**
  - **Revisit and implement a revised Partnership Agreement for the provision of Occupational Health**: Monthly SLA meetings continue with our occupational health provider to work through the gaps identified in the partnership agreement. The provider has shared data to give some assurance that there are mitigations for any issues in service delivery. The action will be carried into the new People Plan and has been raised at Workforce Committee.
  - **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. This action has been carried over into the new People Plan. Improving our sickness absence rate is also one of our efficiency measures.
  - **Provide a working environment of civility and respect for our people**

- **Violence and aggression strategy and policy framework:** We have made good progress in establishing our Board approved strategy and policy for the prevention and management of violence and aggression. We are however yet to fully understand the impact and evaluate its effectiveness. An evaluation of the impact and delivery has been carried over into the new People Plan, with a new objective set.

- **Medical Plan:**
  - **We wish to continue to maintain the current high standards by which concerns regarding doctors are managed:** The process to review and update the Trust's Procedure for Managing Concerns about Doctors has taken longer than originally anticipated. This has been due to the need to thoroughly consult both internally and with the BMA on its content. We now have a finalised procedure which will be ratified during quarter one of 2024/25.

- **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. 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. We have endeavoured to escalate these delays within these organisations and will continue to do so. Revised timescale for delivery is the end of June 2024.
  - **Integration of Care Director with the NHS SPINE:** Our system supplier Advanced have been working with NHSE to ensure connectivity to the SPINE, that will enable deployment through CareDirector across the Trust. Regrettably, as Advanced are withdrawing from the mental health EPR market, our confidence in this being a priority piece of work for them feels great. We are continuing our discussions with Advanced to try and reach a solution.

- **Care Services Plan: Adult Acute**
  - **Create Capacity and flow through the acute pathway that enable a reduction in the number of people placed out of area:** Our aim is to eliminate inappropriate out of area placements linked to our efficiency area of focus. Out of area pressures within the adult acute service continues to be extremely difficult. Demand for inpatient beds remains consistently high and length of stay continues to be greater than expected. Both demand and delayed discharges continues to impact on poor flow and the use of out of area placements continues to exceed 40 (acute and PICU combined). The Improving Flow Programme has now been established and with three key workstreams agreed and leads identified. Immediate key actions have been completed, including a review of all inpatients by senior clinical and operational staff.

- **Care Services Plan: Community & Wellbeing**
  - **To progress all service developments inclusive of Community Transformation, EIP, Rough Sleepers Mental Health Service, Urgent Treatment Centres and Physical Health Services**
  - **Establish Rough Sleepers Mental Health Service:** We have encountered delays to the full rollout of the Rough Sleeper Mental Health Service due to difficulties in recruiting to the lead psychologist post. The intention is to review the service go-live timescales and establish the partnership from April 2024.

- **To understand the experience and care quality through implementing and utilising outcome measures, audits, service evaluations and feedback to truly improve care.**
  - **Improvements made from the Community Mental Health Service User Survey:** We have made improvements resulting from the Community Mental Health Service User Survey 2022 with improved scores for 2023 in at least two areas. We are currently awaiting the 2023 survey results to provide a comparator. This measure will be carried over into 2024/25.

- **Improve the wellbeing for all, including self, making it central to what we do**
  - **Workforce development, to create a diverse workforce where recruitment, retention and development is a priority for all colleagues and all roles:** Through extensive work to progress workforce initiatives and attract suitable candidates, vacancy rates across community mental health services remain on average at 25-30%. This objective will remain in 2024/25 with a further review to understand which initiatives have been more successful than others. A key focus will be on the O/T workforce to create a professional lead for the service. An element of their role will be to focus on retention and promotion to different groups across all protected characteristics.

- **Care Services Plan: Older Peoples Services**
  - **Complete the evaluation of the Memory Assessment Service:** We made a commitment to ensure that an evaluation of the Memory Assessment Service was completed following implementation of the new model, pre-pandemic. We have now agreed the scope and terms of reference for the evaluation with system partners and will commence this in earnest as a key objective during 2024/25.

- **Care Services Plan: Forensics Service**
  - **Create capacity and flow through our Leeds forensic inpatients and improving our forensic outreach (FOT) provision:** We will integrate our forensic psychology service into the community when service users are discharged. The new Leeds community model roll out is delayed due to funding constraints and the psychology resource in place is not sufficient to cover ongoing therapy in the community. Reflective forums can be established with the intent, when funding is available, to increase psychology resource for the community team.

- **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 what the future model of delivery should be. The short-term plan is to focus upon filling any voids. The overall timescales for this have moved to reflect a conclusion by March 2025 at the latest.

- **Care Services Plan: Perinatal & Liaison**
  - **Working towards our focus of providing more care in the community, early intervention and prevention, we will increase our perinatal community provision**
    - **Increase the availability of specialist PMH community care for women from 12 months after birth to 24 months.** Aligned with the Long Term Plan this continues to be a key area of focus for the team and improve data collection. Process measures have been put in place within the team with assistance from practice development practitioners to ensure compliance. In addition, we are working with Leeds ICB to ensure the Maternal Mental Health offer continues past the pilot stage. The launch is anticipated to be from June 2024.

- **With support from the WY ICS continue to provide a NICPM service: Work is underway with system colleagues to explore the future service model for NICPM.** Intent is to develop an options appraisal during 2024/25 as a key delivery objective.

- **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:** Willow View Day unit became operational on 8 April 2024, a new alternative to hospital service for children and young people with an eating disorder. Due to recruitment challenges with key roles the unit is only accepting step down cases from Mill Lodge or Inspire. Once key roles have been recruited full operations will commence, with service referrals being accepted from community partners. This is anticipated for June 2024.
  - **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:** The project to implement the 18-25 pilot team has been delayed due to difficulties in recruiting to key clinical roles. We are anticipating that the service will go live in July 2024.

- **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. Given financial pressures we have not approved the autism business case. We have funded part of the ADHD business case with the appointment of a SAS doctor in April 2024. We are continuing to work as part of the WYICB NDS programme with our shared long-term objective to improve the waiting list position. These schemes are to be considered as part of the 2024/25 funding development pressures.

3. Cross-cutting themes and interdependent tasks

As part of our quarterly report we share a Gantt chart setting out our interdependent tasks and key themes that are emerging. The themes demonstrate how several individuals/teams are collaborating in order to successfully deliver an overall theme.

The interdependent tasks show 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 four stage, our interdependent tasks are revisited to ensure timescales continue to align and are therefore reflective of the task to be delivered. An updated Gantt chart for all our interdependent tasks can be found at **appendix two**.

4. 2024 – 2025 Organisational Priorities

Through an executive-led process we have agreed a succinct set of 14 organisational priorities. All 14 priorities are derived from one of our five core strategic plans and are seen as the important deliverables for the Trust in 2024/25, providing clarity and focus. Our 2024 – 2025 organisational priorities are detailed at **appendix three**.

We are currently in the process of finalising the high-level tasks underpinning each of the 14 priorities. For some of the priorities we already have detailed project plans in place. It is the intention to report progress on a quarterly basis, with the first report to the Board of Directors in July 2024. Progress reports on the detailed delivery plans from each of our five strategic plans will continue through our executive-led governance groups.

5. Quality impact assessing our efficiency and productivity programme

The National Quality Board published guidance for commissioners and provider organisations in June 2012 regarding how the quality impact of cost improvement plans should be assessed. **Appendix four** sets out the guidance as an aide memoir and follows the recent assurance reports on our 2024 – 2024 efficiency and productivity programme presented to the Quality Committee.

This year's efficiency and productivity programme encompasses the following five areas:

1. Reducing use of additional temporary staff including reliance on agency staff and locum doctor spend.
2. Reviewing rostering practice and implementing additional controls for better roster management across clinical, non-clinical, corporate and medical functions.
3. Reducing our pay run-rate through revised workforce models, reducing vacancies and agreeing the right establishments across all our inpatient wards.
4. Reviewing our non-pay spend which includes a number of approved cost saving schemes i.e. taxi spend, room hire and utility bills.
5. Improving flow for patients we aim to reduce our use of out of area placements.

Governance arrangements are in place to closely monitor these vitally important areas and all feature as part of our organisational priorities.

6. 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.
- Ratify our 2024 – 2025 organisational priorities (appendix three), noting reporting will commence from the end of quarter one.
- Note the guidance for quality impact assessing our efficiency and productivity programme (appendix four)

Dawn Hanwell
Chief Financial Officer

Amanda Burgess
Head of the Programme Management Office

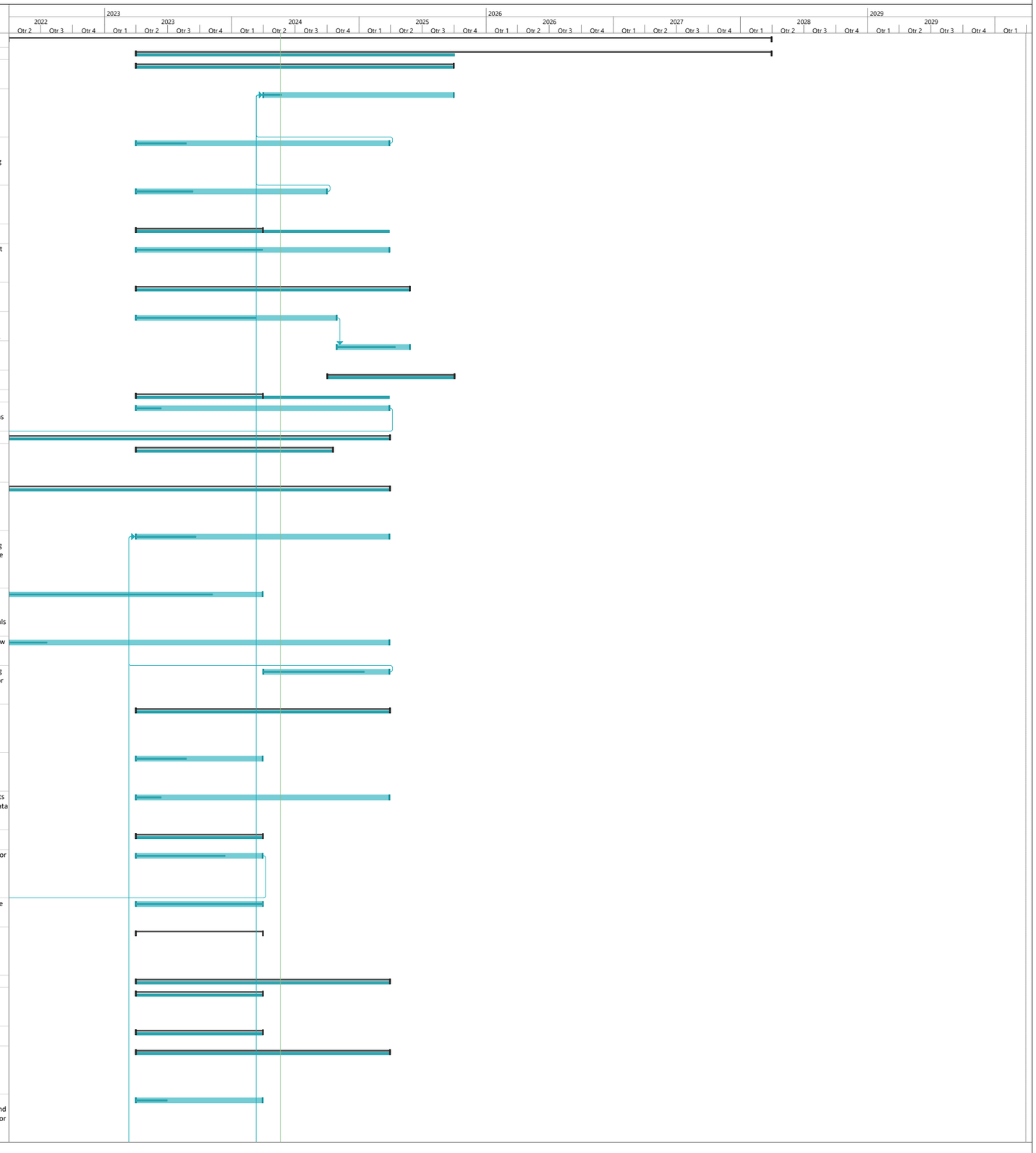
20.05.24

APPENDIX 3: 2024 – 2025 ORGANISATIONAL PRIORITIES

No.	Strategic Plan	Strategic priority	Exec owner	Primary governance oversight
1	Care Services	Delivery of our Inpatient Flow Programme	Joanna Forster Adams	Improving Flow Programme Group
2	Care Services	Deliver, evaluate progress and realise the benefits of the Transformed Community Mental Health Service	Joanna Forster Adams	Community Transformation Board
3	Care Services	Develop a Care Services-led (LYPFT) health inequalities strategic plan	Joanna Forster Adams	Care Services Delivery & Development Group
4	Care Services	Strengthen and firmly embed the co-production approach within Care Services.	Joanna Forster Adams	Care Services Delivery & Development Group
5	Estates	Complete a refresh of our Strategic Estates Plan for approval by the Board of Directors which supports the future model for our clinical services and informs the expiry of our PFI concession	Dawn Hanwell	Estates Steering Group
6	Digital	Commence scoping the requirements for a new Electronic Patient Record and associated systems/platform strategy	Dawn Hanwell	Information Management Steering Group
7	Digital	Provide performance data, insights and reporting, such as the Quality Dashboard to support and enable operational performance understanding and service-led transformation requirements.	Dawn Hanwell	Quality, Delivery & Performance Group for each service line
8	Efficiency	Delivery of our efficiency and productivity programme	Dawn Hanwell	Financial Planning Group
9	Care Services	Deliver revised workforce models and reduce vacancies for Care Services through right sizing and agreeing the right establishments across all our inpatient wards, compliance with safer staffing, safety and quality provision.	Darren Skinner	People & OD Group
10	People	Delivery of key People Plan priority metrics (define list of metrics)	Darren Skinner	People & OD Group
11	People	Develop a range of tools and training to support managers promote wellbeing at work and support the wellbeing of their staff and teams, linked with the need to reduce our sickness absence rate by 1%	Darren Skinner	People & OD Group
12	Quality	Implementation of PSIRF across the organisation	Nichola Sanderson	Trust-wide Incident Review Group
13	Quality	Procure a system that will enable clinical outcomes to be embedded into clinical services	Chris Hosker	Trust-wide Clinical Governance Group
14	Quality	Development and implementation of Quality and Culture dashboards for revision in selective services	Chris Hosker	Trust-wide Clinical Governance Group

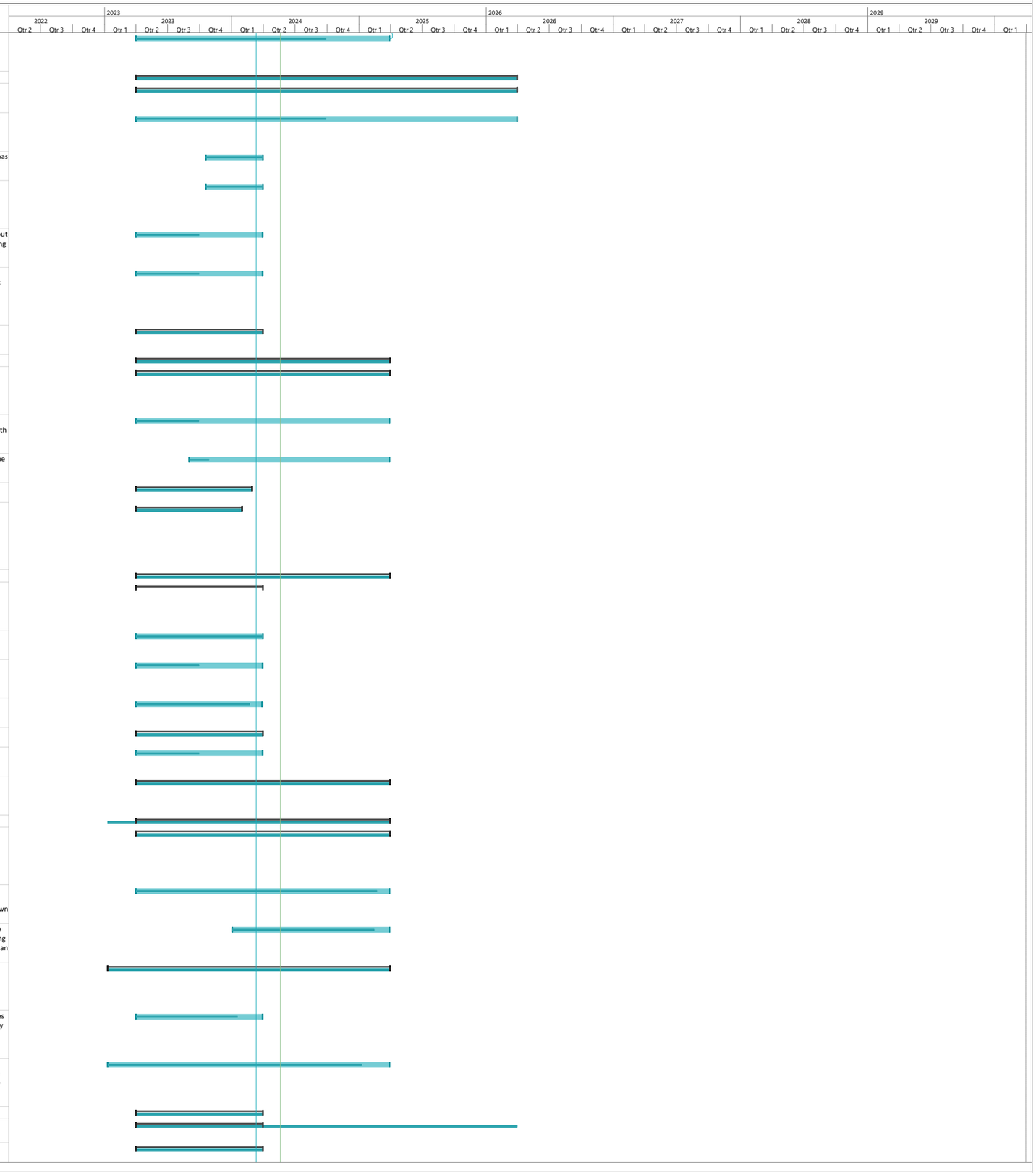
Trust Organisational Priorities 2023 - 2030: Quarter 4 Progress Report

ID	Task Mode	Q4 RAG	Q3 RAG	Q2 RAG	Q1 RAG	Mover	Task Name	Duration	Start	Finish	Lead	% Comple	Progress Update
1							**Care Services Strategic Plan**	**1565 days?**	**Fri 01/04/22**	**Fri 31/03/28**	**J.Forster-Adams**	**60%**	
2							**Adult Acute**	**1306 days**	**Sat 01/04/23**	**Fri 31/03/28**	**L.McDonagh**	**33%**	
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%	Demand for inpatient beds remains consistently high and length of stay continues to be higher than expected. This along with delayed discharges continues to impact on poor flow and the use of out of area placements continues to exceed 40.
5							Reduce unwarranted clinical variation	522 days	Sat 01/04/23	Fri 28/03/25	L.McDonagh	20%	Clinical variation has reduced but overall LOS has increased across all inpatient wards and it is therefore difficult to measure. This is an action detailed as part of our Improving Flow Programme. Timescales transferred into 2024/25.
6							Formulation to be embedded across the acute inpatient service	393 days	Sat 01/04/23	Mon 30/09/24	L.McDonagh	30%	Formaulation roll out continues but we are slightly behind with the delay due to psychology recruitment and sickness. This objective is being embedded through SDIP in 24/25
7							**Ensuring safe staffing levels across our adult acute services**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**L.McDonagh**	**50%**	
8							Complete a skill mix review across our inpatient services	522 days	Sat 01/04/23	Fri 28/03/25	L.McDonagh	50%	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**	**65%**	
10							Develop and implement a new model for CRISS	413 days	Sat 01/04/23	Mon 28/10/24	L.McDonagh	60%	Model proposal has now been signed off and the implemention planning phase has begun. Management of Change process is being mapped out with support from HR.
11							Conclude the evaluation of the Crisis Assessment Unit	151 days	Tue 29/10/24	Mon 26/05/25	L.McDonagh	80%	Evaluation has been completed and the paper will be discussed in the Improving Flow Programme and Crisis Transformation Board.
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%**	
15							Develop and implement a health inequalities delivery plan	522 days	Sat 01/04/23	Fri 28/03/25	J.Forster-Adams	10%	On track for the development of our strategic plan with full implementation to be achieved by the end of March 2025 as set out in the operational plan.
16							**Community and wellbeing**	**782 days?**	**Fri 01/04/22**	**Mon 31/03/25**	**L.Shepherd**	**49%**	
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**	**L.Shepherd**	**40%**	
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**	**L.Shepherd**	**40%**	
20							Ongoing development of Mental Health Services in the Community as a a part of the community transformation. This includes workforce modelling, model operationalising, pilot roll out and full	522 days	Sat 01/04/23	Fri 28/03/25	L.Shepherd	24%	Programme still ongoing. The first wave roll out was completed on 11 March, early implementator sites enacting key elements of the model including team days, joints triage and helpful conversations.
21							Established Rough Sleeper Mental Health Service	522 days	Fri 01/04/22	Fri 29/03/24	L.Shepherd	80%	Delay to full roll out following recruitment slippage of lead psychologist. In post for April 2024, meeting booked to review service timeframes and establish firm partnership go-live date. Consultation and formulation with professionals is underway.
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	261 days?	Mon 01/04/24	Fri 28/03/25	Fiona Lowis & Alex Perry	80%	Primary care therapies in place and being delivered, staffing issues resolved with team fully staffed. Skills gap remains for neuropsychology
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**	**L.Shepherd**	**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	L.Shepherd	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%	As part of transformation, including new 4 week wait targets outcome measures to be a focus in 2024/25. The current data indicates a low percentage of completion.
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**	**L.Shepherd**	**85%**	
28							Ongoing Workforce development, to create a diverse workforce where recruitment, retention and development is a priority for all colleagues and all roles.	262 days	Sat 01/04/23	Fri 29/03/24	L.Shepherd	70%	Due to issues with HRBP allocation the work has stalled. Prior support was given to promote adverts to diverse communities. Final data required to review current breakdowns of diversity across PCs for the workforce.
29							For at least 85% of team members to have an appraisal and career conversation at least annually	262 days	Sat 01/04/23	Sun 31/03/24	L.Shepherd	100%	At 84.3% for year end of appraisals across service line. Some slippage due to staff absence and new staff in post.
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**	**Sun 31/03/24**	**J.Faulkner**	**100%**	
33							**Older people's services**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**Paul Fotherby**	**68%**	
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**	**P. Fotherby**	**50%**	
37							**Expansion of The Willow model with the opening of Dolphin Manor**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**Paul Fotherby**	**100%**	
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**	**Paul Fotherby**	**58%**	
41							Complete the evaluation of the memory assessment service	262 days	Sat 01/04/23	Fri 29/03/24	B Alderson / C Parsons	25%	No firm progress. However, during the last few weeks internal discussion with community ops manager, HoOps and clinical lead to articulate LYFPT view of terms of reference for review, will then be discussed with system partners.



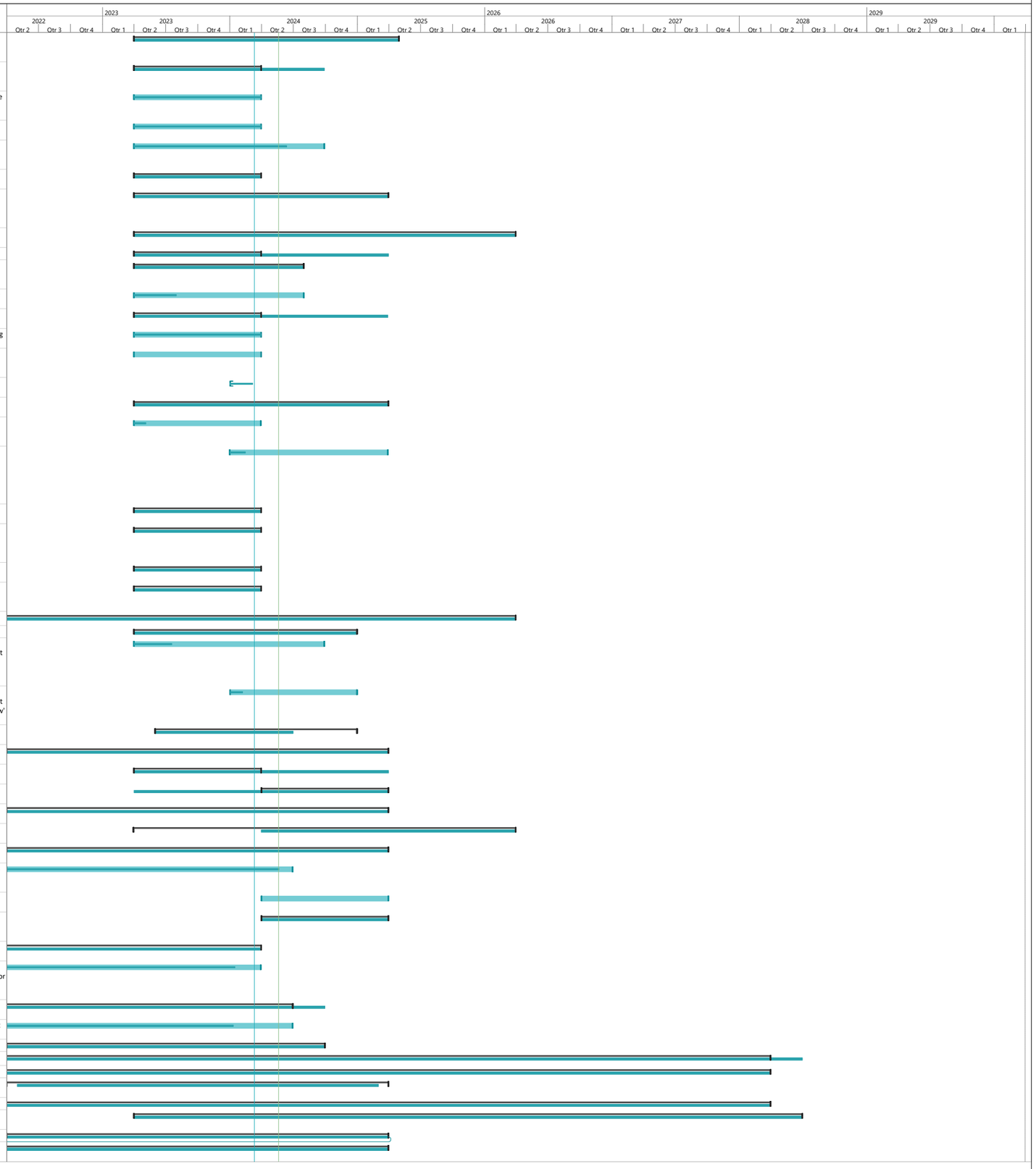
Trust Organisational Priorities 2023 - 2030: Quarter 4 Progress Report

ID	Task Mode	Q4 RAG	Q3 RAG	Q2 RAG	Q1 RAG	Mover	Task Name	Duration	Start	Finish	Lead	% Comple	Progress Update
42							Engagement with all aspects of the Community Transformation Programme, including model development and engagement	522 days	Sat 01/04/23	Fri 28/03/25	P. Fotherby / B Alderson / G Wormald	75%	Work and engagement ongoing through transformation governance programme. Will be part of 24/25 objectives.
43							**Forensic services**	**783 days**	**Sat 01/04/23**	**Tue 31/03/26**	**J.Faulkner**	**68%**	
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**	**58%**	
45							We will integrate our forensic psychology service into the community when service users are discharged.	783 days	Sat 01/04/23	Mon 30/03/26	J.Faulkner	50%	The new Leeds community model roll out is delayed due to lack of funds, psychology resource is not enough to cover ongoing therapy in the community, however reflective forums can be established along with individual queries.
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	Sun 31/03/24	J.Faulkner	100%	Transfers to CMHT have taken place, overall FOT caseload has reduced.
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%	Completed
48							Implementation of an enhanced community provision within both our Leeds and York services	262 days	Sat 01/04/23	Fri 29/03/24	J.Faulkner	50%	The Leeds FOT are now fully recruited to. Delay to the roll out of the new community model as a result of funding not being available. In York the model development is still in the very early design stages.
49							Review social worker model within the Leeds system to create more collaboration between the two community teams (FOT, Forensic social worker team). Improved governance of service users care and cost	262 days	Sat 01/04/23	Fri 29/03/24	J.Faulkner	50%	We now have a new acting clinical operations manager in place, work underway to develop local working instructions across both sites. Social Worker embedded in York team
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**	**100%**	
53							**Learning disability services**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**P.Johnstone**	**30%**	
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**	**18%**	
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	25%	LA have not really agreed on or discussed any alternative delivery model. Short term plan is to focus on void filling with Head of Op's taking lead role with a commissioning lead at LCC.
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 is still dependent on the wishes and decisions of the LA - once the voids issue is attended to there may be a greater appetite to develop a revised delivery model.
57							**Improving our Health Facilitation Team offer**	**240 days**	**Sat 01/04/23**	**Thu 29/02/24**	**P.Johnstone**	**100%**	
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%**	
61							**Perinatal and liaison**	**522 days?**	**Sat 01/04/23**	**Mon 31/03/25**	**Eve Townsley**	**55%**	
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**	**Sun 31/03/24**	**P.Fotherby**	**80%**	
63							To increase access for women with moderate/complex to severe PMH difficulties	262 days	Sat 01/04/23	Sun 31/03/24	E. Townsley	100%	Maintained progress with the target and reviewed and agreed the target for the trajectory for next year.
64							Increase the availability of specialist PMH community care for women from 12 months after birth to 24 months	262 days	Sat 01/04/23	Fri 29/03/24	E. Townsley	50%	Working with informatics to follow up on this. We are now able to capture this data, however there are concerns that the team are not completing the D.O.B for babies. This has now been followed up with the team.
65							Work with Leeds ICB to ensure the Maternal Mental Health offer continues past the pilot stage	261 days	Sat 01/04/23	Thu 28/03/24	E. Townsley	90%	Launch likely to be first of June. Recruitment has been undertaken and interim plans are in pace.
66							**With support from the WY ICS continue to provide a NICPM service**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**Eve Townsley**	**50%**	
67							Complete a full review of the NICPM service	262 days	Sat 01/04/23	Fri 29/03/24	E Townsley	50%	Had meetings with ICB colleagues and looking at working group to develop an options appraisal. This work will be further progressed during 2024/25.
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**	**Eve Townsley**	**39%**	
73							**Children and young people**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**N.Mant**	**91%**	
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**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**N.Mant**	**93%**	
75							Implementation of the new Alternative to hospital provision within Mill Lodge	522 days	Sat 01/04/23	Fri 28/03/25	N.Mant	95%	Willow View Day unit became operational on the 8th April 2024. Due to recruitment challenges with key roles the opening has been staged an initially only accepting step down cases from Mill Lodge or Inspire.
76							Complete evaluation of the Alternative to Hospital provision within Mill Lodge	324 days	Wed 03/01/24	Fri 28/03/25	N.Mant	90%	Information for evaluation will be collected and shared on a weekly basis with the PC. Standardised KPI information along with monthly reporting will be shared by informatics and plan in place to do such.
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**	**87%**	
78							Implementation of the 18-25 pilot team	262 days	Sat 01/04/23	Fri 29/03/24	N.Mant	80%	Project start delayed due to recruitment of roles. Some roles succesfully recruited (SDOW/Admin/Interpreter) though key clinical roles not in place (Psychology). Anticipating service will go live in July 2024.
79							Complete the evaluation of the 18-25 pilot	580 days	Tue 10/01/23	Fri 28/03/25	N.Mant	90%	Plans in place to create additional forms on CD to capture non-routine information and COMIC well engaged with the project to enable recruitment of R&D roles. Will commence alongside project start.
80							**Ensure the stability of Red Kite View**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**N.Mant**	**100%**	
82							**Rehabilitation, eating disorders and gender identity**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**R.Carroll**	**78%**	
83							**Reducing the number of complex rehab out of area placements**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**R.Carroll**	**100%**	



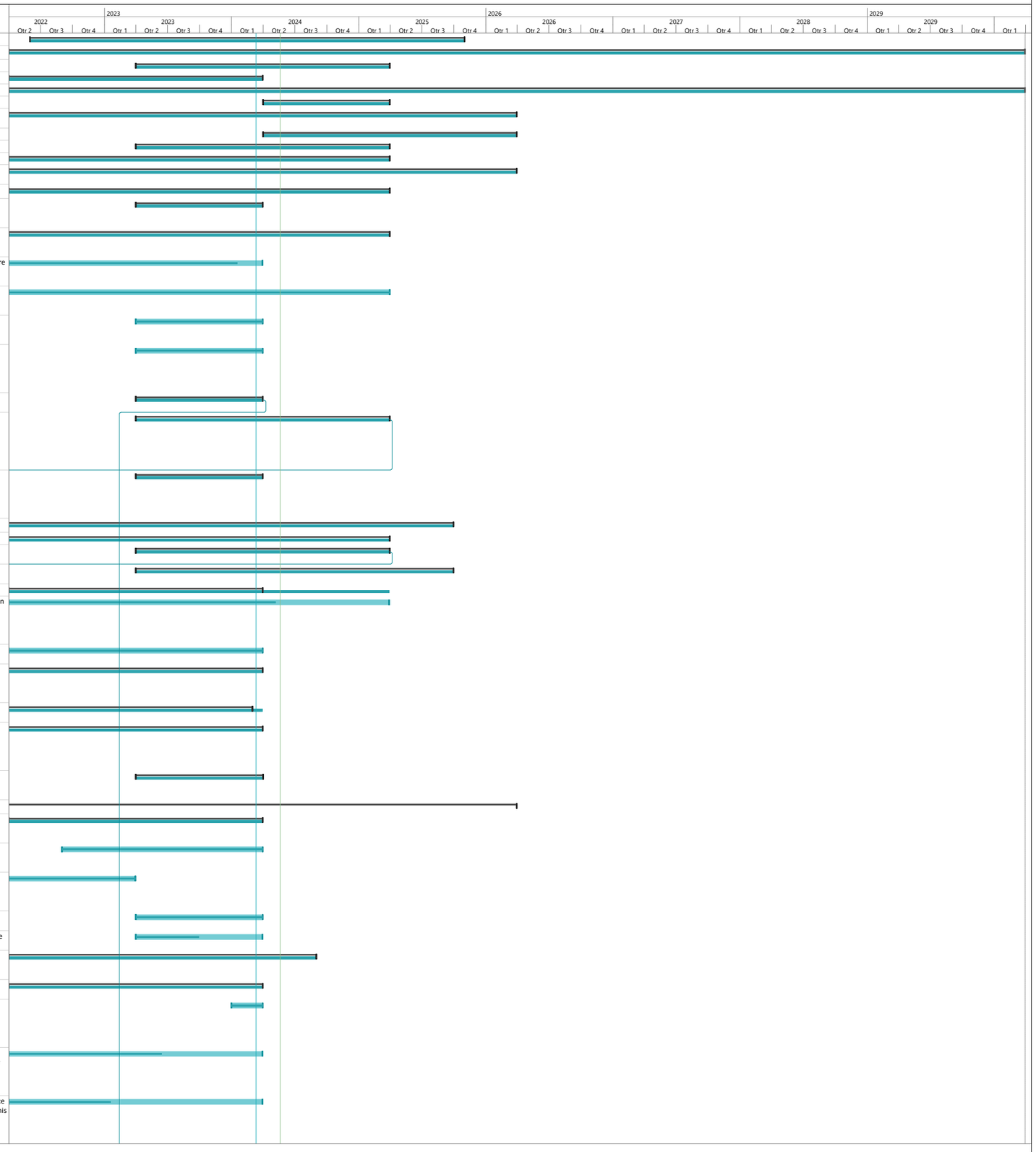
Trust Organisational Priorities 2023 - 2030: Quarter 4 Progress Report

ID	Task Mode	Q4 RAG	Q3 RAG	Q2 RAG	Q1 RAG	Mover	Task Name	Duration	Start	Finish	Lead	% Comple	Progress Update
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**	**56%**	
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**	**91%**	
93							Work with ICB places to ensure that a consistent service offer with equity across all 5 places.	262 days	Sat 01/04/23	Sun 31/03/24	R.Carroll	100%	Parity of access to repatriation service across all areas. There are differences in need between places with variation in numbers of patients placed out of area.
94							Develop and implement an enhanced annual clinical review process	262 days	Sat 01/04/23	Sun 31/03/24	R.Carroll	100%	Completed.
95							Develop and implement a Complex Emotional Needs pathway.	392 days	Sat 01/04/23	Fri 27/09/24	R.Carroll	80%	The service has launched and open to referrals, not fully recruited. The service will require further recruitment to enable full implementation. Continue action 30/09/24.
96							**Development of our locked and rehabilitation pathways**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**R.Carroll**	**100%**	
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**	**80%**	
101							**Gender ID: continuing waiting list management**	**783 days**	**Sat 01/04/23**	**Tue 31/03/26**	**R.Carroll**	**78%**	
104							**Regional & Specialist Services**	**262 days?**	**Sat 01/04/23**	**Sun 31/03/24**	**D.Rowley**	**57%**	
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**	**25%**	
106							Implementation of phases 1 - 3	349 days	Sat 01/04/23	Tue 30/07/24	D.Rowley	25%	Communication with NHS E established, we have put notice in and awaiting confirmation of exit action plan.
107							**Improving mental health services for people with autism**	**262 days?**	**Sat 01/04/23**	**Sun 31/03/24**	**D.Rowley**	**37%**	
108							Rollout of autism training for LYPFT staff	262 days	Sat 01/04/23	Sun 31/03/24	D.Rowley	100%	Training plan is finished, 417 people trained to date. Offering weekly slots from March 2024.
109							Subject to the 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.
110							Reduction of internal waits within the pathway.		Mon 01/01/24	Fri 28/03/25	D.Rowley	15%	To commence from Q4.
111							**Improving our services for people with ADHD**	**522 days?**	**Sat 01/04/23**	**Mon 31/03/25**	**D.Rowley**	**10%**	
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	10%	Some funding has been received from the business case. Appointment of SAS doctor in April 2024.
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.	325 days?	Mon 01/01/24	Fri 28/03/25	D.Rowley	10%	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**	**100%**	
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**	**100%**	
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**	**100%**	
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**	**100%**	
123							**Our Digital Plan**	**1066 days?**	**Tue 01/03/22**	**Tue 31/03/26**	**B.Fawcett**	**52%**	
124							**Deployment of a Patient Portal**	**458 days**	**Sat 01/04/23**	**Tue 31/12/24**	**B.Fawcett**	**16%**	
125							Deliver technical solution and conduct controlled trials	392 days	Sat 01/04/23	Fri 27/09/24	I.Hogan	20%	Timescales extended to December 24 due to impact of Advanced's notification of withdrawing form MH EPR market at the end of our currnet contract. Engagement, technical discussions and requirements underway with potential suppliers.
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%	Timescales extended to December 24 due to impact of Advanced's notification of withdrawing form MH EPR market at the end of our currnet contract. Key requisite for any 'new' provider will be NHS App intergration.
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**	**69%**	
140							**To ensure that Trust defences against cyber threats are affective**	**782 days**	**Fri 01/04/22**	**Mon 31/03/25**	**I.Hogan**	**73%**	
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**	**66%**	
147							Deployment of Software Defined Wide Area Network	587 days	Fri 01/04/22	Fri 28/06/24	I.Hogan	95%	Delays with external partners continue. Escalated as high as possible. Date revised to end of June. This is outside of our control.
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%**	
152							Deployment of Spine connectivity for Care Director trust wide	545 days	Tue 01/03/22	Fri 29/03/24	I.Hogan	90%	Advanced are withdrawing from the MH EPR Market. We have little confidence of this being a priority piece of work for them. Regrettably, at the present time we believe this will not be delivered.
153							**Feed data to GP systems directly from Care Director**	610 days	Tue 01/03/22	Sun 30/06/24	I.Hogan	75%	
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**	**70%**	
157							**Strategic Estates Plan**	**1696 days?**	**Fri 01/10/21**	**Fri 31/03/28**	**D.Hanwell**	**38%**	
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**	**55%**	
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**	**50%**	
173							**Ensuring our services are safe and secure**	**782 days**	**Fri 01/04/22**	**Mon 31/03/25**	**J.Campbell**	**60%**	
175							**Working with partners on new developments**	**805 days**	**Tue 01/03/22**	**Mon 31/03/25**	**J.Campbell**	**31%**	



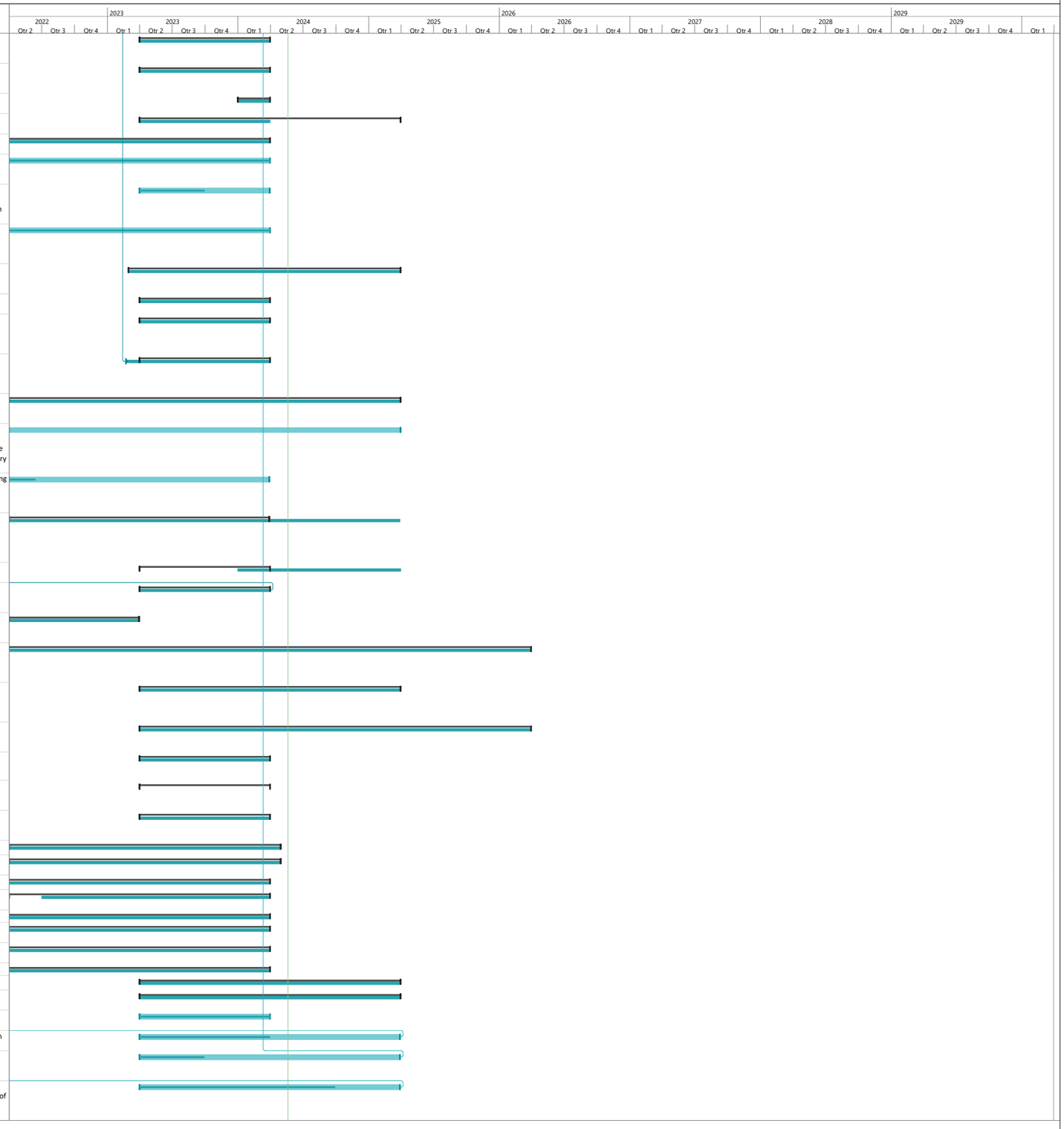
Trust Organisational Priorities 2023 - 2030: Quarter 4 Progress Report

ID	Task Mode	Q4 RAG	Q3 RAG	Q2 RAG	Q1 RAG	Mover	Task Name	Duration	Start	Finish	Lead	% Complete	Progress Update
179							**Optimising our Estate**	**894 days?**	**Wed 01/06/22**	**Sat 01/11/25**	**J.Campbell**	**55%**	
182							**Green Plan**	**2087 days**	**Fri 01/04/22**	**Sun 31/03/30**	**J.Campbell**	**23%**	
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**	**21%**	
206							**Review Bottled Water Provision**	**261 days**	**Mon 01/04/24**	**Mon 31/03/25**	**J.Campbell**	**7%**	
210							**Cooking, Food Provision and Waste Review**	**1043 days**	**Fri 01/04/22**	**Tue 31/03/26**	**J.Campbell**	**31%**	
219							**Trust Transport Strategy**	**522 days**	**Mon 01/04/24**	**Tue 31/03/26**	**J.Campbell**	**15%**	
222							**Climate Change & Resiliance**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**J.Campbell**	**20%**	
224							**IT Equipment & Printing**	**782 days**	**Fri 01/04/22**	**Mon 31/03/25**	**J.Campbell**	**2%**	
228							**Energy, Cooling, Water: Improve Efficiency, Management & Monitoring**	**1043 days**	**Fri 01/04/22**	**Tue 31/03/26**	**J.Campbell**	**27%**	
232							**Our Medical Strategy**	**782 days?**	**Fri 01/04/22**	**Mon 31/03/25**	**C.Hosker**	**97%**	
233							**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%**	
236							**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**	**97%**	
237							Review and update the Trust procedure for Managing Concerns about Doctors.	522 days	Fri 01/04/22	Fri 29/03/24	V.Lovett	90%	The policy has been delayed due to staffing changes. We are now back on track, with the policy being ratified during quarter 1.
238							Develop an annual investigations update programme	782 days	Fri 01/04/22	Mon 31/03/25	V.Lovett	100%	NHSE and NHSR have confirmed that external training can only be delivered. We are planning with NHSR future training for Q2.
239							Work to increase the number of consultants trained and available to provide pastoral support	262 days	Sat 01/04/23	Sun 31/03/24	V.Lovett	100%	Complete
240							Develop a regional network with expertise in the investigation of concerns about doctors who, for reasons of complexity or conflict of interest, cannot be investigated internally	262 days	Sat 01/04/23	Sun 31/03/24	V.Lovett	100%	Complete
241							**We wish to continue to maintain our excellent medical education and training.**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**V.Lovett**	**100%**	
243							**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**	**93%**	
246							**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.**	**262 days?**	**Sat 01/04/23**	**Sun 31/03/24**	**V.Lovett**	**100%**	
249							**Nursing and professions strategy**	**1697 days?**	**Mon 01/04/19**	**Tue 30/09/25**	**N.Sanderson**	**80%**	
250							**Improving Retention of Professions**	**1043 days**	**Thu 01/04/21**	**Mon 31/03/25**	**A.Quarry & M.Tr**	**100%**	
252							**Implementation of the Patient Safety Incident Response Framework (PSIRF)**	**522 days?**	**Sat 01/04/23**	**Mon 31/03/25**	**C.Wardle**	**69%**	
256							**Implementation of patient safety outcomes**	**653 days?**	**Sat 01/04/23**	**Tue 30/09/25**	**A.Quarry**	**40%**	
260							**Improved service user experience**	**522 days**	**Fri 01/04/22**	**Sun 31/03/24**	**S. Marshall**	**82%**	
261							Work to a standard of 'Nothing about me, without me'	782 days	Fri 01/04/22	Fri 28/03/25	S. Marshall	70%	The team is considering how best to achieve this objective in a meaningful way which involves clinical services in how service users are involved in decisions at all levels from assessment, care planning, risk planning, through to discharge.
262							Accessible method to collect PREMs linked directly to care delivery.	522 days	Fri 01/04/22	Sun 31/03/24	S.Marshall	100%	Completed
263							**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%**	
265							**Implementing research, development and new technologies**	**762 days**	**Thu 01/04/21**	**Fri 01/03/24**	**A.Quarry, M.Claire-Trevett**	**60%**	
267							**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**	**100%**	
269							**Working towards a 'good/outstanding' CQC rating for all services when next inspected by the Care Quality Commission**	**262 days?**	**Sat 01/04/23**	**Mon 01/04/24**	**A.Boden/ A. Quarry**	100%	
275							**People Plan**	**1303 days?**	**Thu 01/04/21**	**Tue 31/03/26**	**D.Skinner**	**70%**	
276							**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%**	
277							Continue to develop targeted interventions to support staff in response to the cost of living crisis	413 days	Thu 01/09/22	Sun 31/03/24	H.Tetley	100%	Complete
278							Develop and introduce a sustainable solution to implementing and delivering the Critical Incident Staff Support Pathway (CrISSP) within the Trust	261 days?	Fri 01/04/22	Fri 31/03/23	F.Dodd	100%	Complete
279							Rollout and evaluate the impact of the menopause support offer	262 days	Sat 01/04/23	Sun 31/03/24	F.Dodd	100%	Complete
280							Revisit and implement a revised Partnership Agreement with OH	262 days	Sat 01/04/23	Fri 29/03/24	H.Tetley	50%	Monthly SLA meetings continue with the provider and some of the gaps identified in the partnership agreement have
281							**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%**	
283							**Keep our people protected, safe and well at work**	**522 days**	**Fri 01/04/22**	**Sun 31/03/24**	**F.Dodd**	**53%**	
284							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
285							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	522 days	Fri 01/04/22	Fri 29/03/24	F.Dodd	60%	We have established Wellbeing Rooms at 4 major sites. All sites have been reviewed to assess what the potential is for development of Wellbeing Rooms based on the capital funding available and scope.
286							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	40%	Increased reporting to care services has started to take place and regular reporting to CSDDG will take place quarterly. This action has been carried over into the 24-27 People Plan.



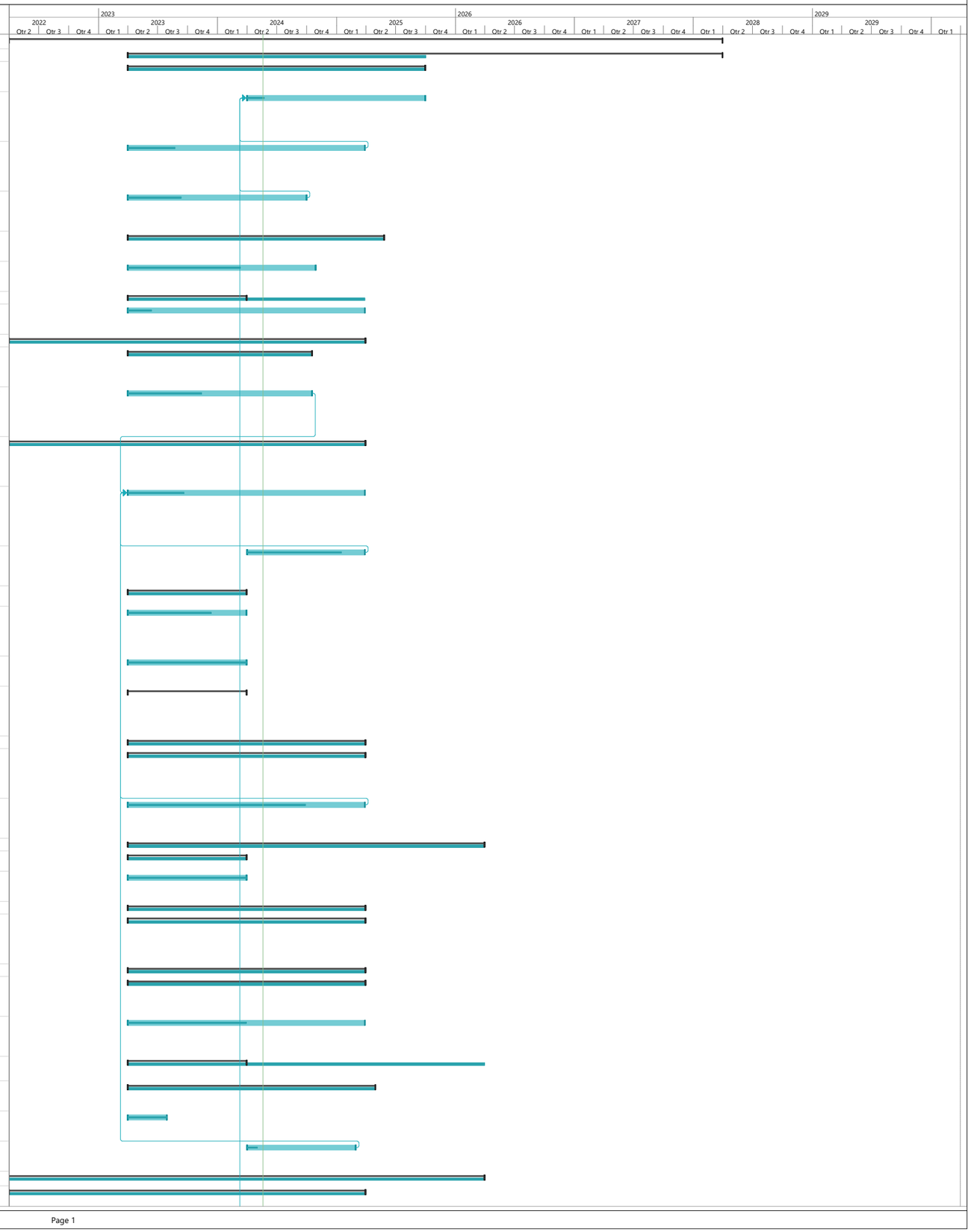
Trust Organisational Priorities 2023 - 2030: Quarter 4 Progress Report

ID	Task Mode	Q4 RAG	Q3 RAG	Q2 RAG	Q1 RAG	Mover	Task Name	Duration	Start	Finish	Lead	% Complete	Progress Update
287							**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%**	
289							**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%**	
293							**Embed Equality, Diversity and Inclusion in the culture of our Trust**	**66 days**	**Mon 01/01/24**	**Sun 31/03/24**	**F.Dodd**	**100%**	
296							**Grow collective leaders that reflect Trust values**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**F.Sherburn & A.Earnshaw**	**100%**	
298							**Provide a working environment of civility and respect for our people**	**545 days**	**Tue 01/03/22**	**Sun 31/03/24**	**H.Tetley**	**90%**	
299							Review and implement the Prevention and Management of Violence and Aggression policies and resulting action	522 days	Fri 01/04/22	Sun 31/03/24	F.Dodd	100%	New policy and strategy have been approved.
300							Evaluate the impact of the Prevention and Management of Violence and Aggression Policies, review and develop forward plan	262 days	Sat 01/04/23	Fri 29/03/24	F.Dodd	50%	The Violence Prevention and Reduction strategy and policy are complete and approval given. An evaluation of the impact and delivery is deferred over to the new people plan with a new objective set.
301							Following the NSEI Civility and respect toolkit to gather information and demonstrate the need for a Trustwide approach	545 days	Tue 01/03/22	Sun 31/03/24	H.Tetley	100%	A commmunication strategy is now in place to educate and share the content of the civility and respect framework. Cultural competence training has been commissioned specifically as a result of the civility and respect work.
302							**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**	**50%**	
305							**Develop an agile workforce who can deliver effectively in their roles**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**H.Tetley**	**100%**	
307							**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**	**100%**	
309							**Develop Organisational Development (OD) and change management support to facilitate new ways of working and delivering care**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**F.Sherburn & A.Earnshaw**	**100%**	
312							**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%**	
313							Develop and implement an intuitive, integrated workflow management solution to replace the SW process	782 days	Fri 01/04/22	Mon 31/03/25	A. McNichol	0%	People Analytics Senior Leadership have met with the sharepoint external development team to discuss transitioning the SW process onto sharepoint workflow. The objective has been added to the new People Plan for delivery in 2025.
314							Implement a safer staffing acuity software solution across inpatient services	521 days	Fri 01/04/22	Thu 28/03/24	A. McNichol	10%	The SafeCare system supports clinicians in the daily recording of patient acuity linked to the safer staffing agenda. NHSE have now amended the guidance to suggest that daily recording is not a requirement.
315							**Deliver an effective workforce plan, which focuses on recruitment and retention and future supply pathways, and which incorporates Trust Learning Needs Analysis (LNA)**	**521 days**	**Fri 01/04/22**	**Fri 29/03/24**	**F.Sherburn & A.Earnshaw**	**70%**	
319							**Develop and deliver the best experience for those who join the Trust**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**F.Sherburn & A.Earnshaw**	**100%**	
323							**Develop and implement an innovative approach to talent development, and which aligns to the Trust Workforce plan**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**F.Sherburn & A.Earnshaw**	**80%**	
325							**Work with partner organisations to deliver joint leadership and career development programmes**	**261 days**	**Fri 01/04/22**	**Fri 31/03/23**	**F.Sherburn & A.Earnshaw**	**100%**	
327							**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%**	
332							**Work with partner organisations to collaborate on introducing and embedding new roles and the sharing of resources where this benefits the system**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**F.Sherburn & A.Earnshaw**	**50%**	
334							**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**	**33%**	
337							**Psychological Professions Strategic Plan**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**S.Prince**	**100%**	
338							**All psychological practice is safe, caring and compassionate, effective, cost effective, responsive and well led.**	**260 days**	**Sat 01/04/23**	**Sun 31/03/24**	**S.Prince**	**100%**	
341							**To focus on workforce development to ensure the sustainability of our skilled and knowledgeable staff.**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**S.Prince**	**100%**	
343							**Quality Strategic Plan**	**543 days**	**Fri 01/04/22**	**Tue 30/04/24**	**R.Wylde & C.Mo**	**100%**	
344							**Embedding clinical outcome measures across our clinical services**	**543 days**	**Fri 01/04/22**	**Tue 30/04/24**	**R.Wylde & C.Money**	**100%**	
347							**Research & Development**	**587 days**	**Sat 01/01/22**	**Sun 31/03/24**	**S.Cooper**	**100%**	
348							**Create a culture of research being core business**	**522 days**	**Fri 01/04/22**	**Sun 31/03/24**	**S.Cooper**	**100%**	
350							**Developing a skilled workforce**	**587 days**	**Sat 01/01/22**	**Sun 31/03/24**	**S.Cooper**	**100%**	
352							**Actively engage a network of key stakeholders**	**545 days**	**Tue 01/03/22**	**Sun 31/03/24**	**S.Cooper**	**100%**	
354							**Effectively disseminate research outputs and Impact**	**545 days**	**Tue 01/03/22**	**Sun 31/03/24**	**S.Cooper**	**100%**	
356							**Influence regional and national agendas**	**545 days**	**Tue 01/03/22**	**Sun 31/03/24**	**S.Cooper**	**100%**	
358							**Finance Strategy**	**522 days?**	**Sat 01/04/23**	**Mon 31/03/25**	**J.Saxton**	**57%**	
359							**We use our resources to delivery effective and sustainable services**	**522 days?**	**Sat 01/04/23**	**Mon 31/03/25**	**J.Saxton**	**57%**	
360							Delivering a robust and sustainable efficiency plan	262 days	Sat 01/04/23	Sun 31/03/24	J.Saxton	100%	acheived
361							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	50%	The run-rate is reducing across the year but now lower than 23/24 spend
362							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%	A new Improving Flow Programme has been established, however OAPs have increased across the year. A revised trajectory has been set for 2024/25.
363							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	75%	Vacancies have consistently reduced across the year with a net increase of staff of 171WTE. However no new redesign of services has taken place



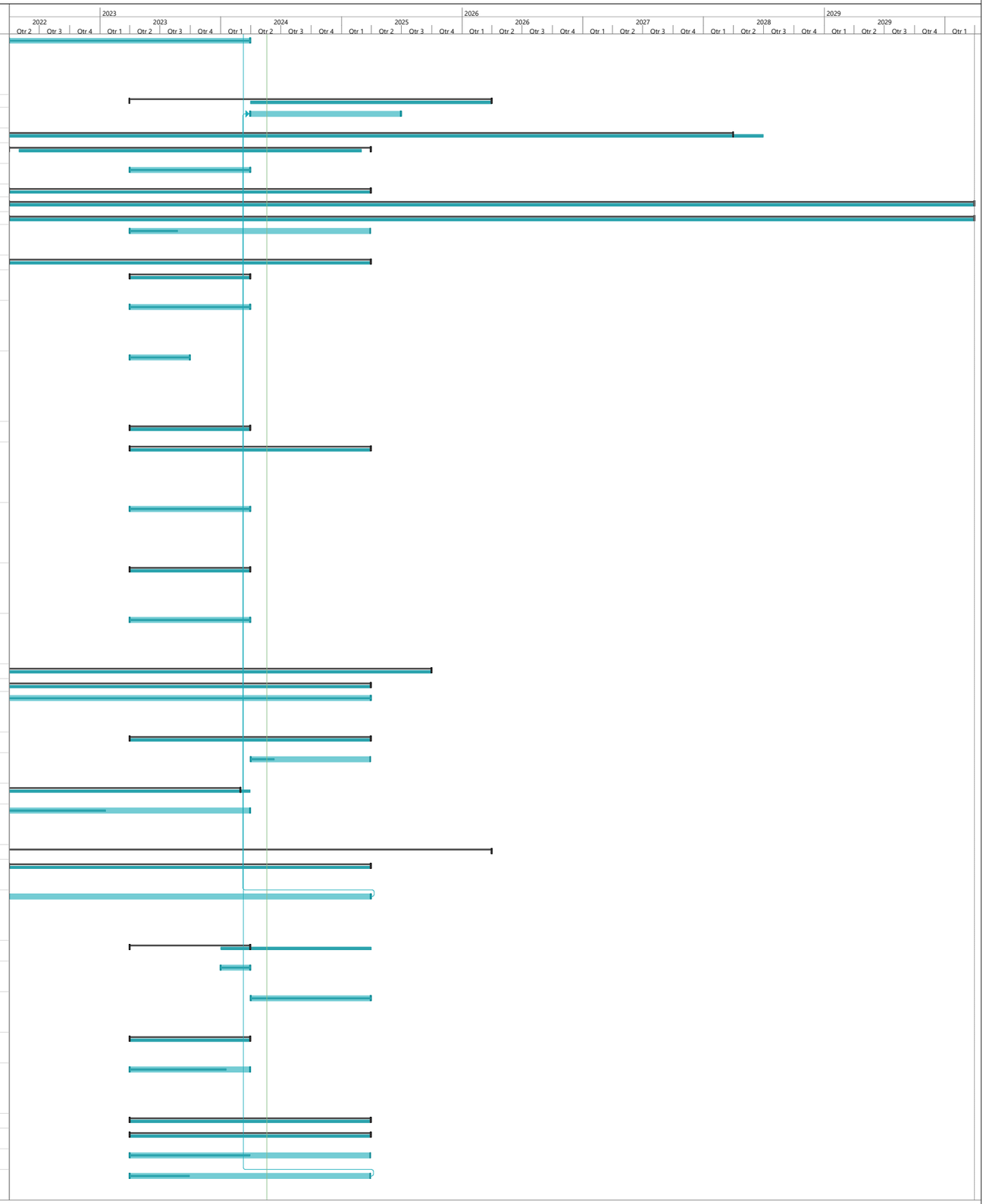
Trust Organisational Priorities 2023 - 2030: Quarter 4 Progress Report - interdependencies across schemes

ID	Task Mode	Q4 RAG	Q3 RAG	Q2 RAG	Q1 RAG	Mover	Task Name	Duration	Start	Finish	Lead	% Comple	Progress Update	Predecessors	Successors
1							**Care Services Strategic Plan**	**1565 days?**	**Fri 01/04/22**	**Fri 31/03/28**	**J.Forster-Adams**	**60%**			
2							**Adult Acute**	**1306 days**	**Sat 01/04/23**	**Fri 31/03/28**	**L.McDonagh**	**33%**			
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%	Demand for inpatient beds remains consistently high and length of stay continues to be higher than expected. This along with delayed discharges continues to impact on poor flow and the use of out of area placements continues to exceed 40.	5,6,362	13
5							Reduce unwarranted clinical variation	522 days	Sat 01/04/23	Fri 28/03/25	L.McDonagh	20%	Clinical variation has reduced but overall LOS has increased across all inpatient wards and it is therefore difficult to measure. This is an action detailed as part of our Improving Flow Programme. Timescales transferred into 2024/25.		4
6							Formulation to be embedded across the acute inpatient service	393 days	Sat 01/04/23	Mon 30/09/24	L.McDonagh	30%	Formaulation roll out continues but we are slightly behind with the delay due to psychology recruitment and sickness. This objective is being embedded through SDIP in 24/25		4
9							**Complete a review of the crisis pathway that will determine the future of the Crisis Assessment Unit**	**563 days**	**Sat 01/04/23**	**Tue 27/05/25**	**L.McDonagh**	**65%**			
10							Develop and implement a new model for CRISS	413 days	Sat 01/04/23	Mon 28/10/24	L.McDonagh	60%	Model proposal has now been signed off and the implemention planning phase has begun. Management of Change process is being mapped out with support from HR.		11
14							**Health Inequalities**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**J.Forster-Adams**	**10%**			
15							Develop and implement a health inequalities delivery plan	522 days	Sat 01/04/23	Fri 28/03/25	J.Forster-Adams	10%	On track for the development of our strategic plan with full implementation to be achieved by the end of March 2025 as set out in the operational plan.		267
16							**Community and wellbeing**	**782 days?**	**Fri 01/04/22**	**Mon 31/03/25**	**L.Shepherd**	**49%**			
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**	**L.Shepherd**	**40%**			
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	L.Shepherd	40%	Wave 1 has gone live and learning form new MDT structures and pathways feeding into evaluation. The link with Emerge has developed and the team are supporting a flexible approach to ease transistion and pathways.		20,47,46,89
19							**To progress all service developments inclusive of Community Transformation, EIP, Rough Sleepers Mental Health Service, Urgent Treatment Centres and Physical Health Services**	**782 days?**	**Fri 01/04/22**	**Mon 31/03/25**	**L.Shepherd**	**40%**			
20							Ongoing development of Mental Health Services in the Community as a a part of the community transformation. This includes workforce modelling, model operationalising, pilot roll out and full	522 days	Sat 01/04/23	Fri 28/03/25	L.Shepherd	24%	Programme still ongoing. The first wave roll out was completed on 11 March, early implementator sites enacting key elements of the model including team days, joints triage and helpful conversations.	18,42,90,23	169
23							Development of psychological interventions for people with SMI, within both primary care therapies and therapies as a part of the enhanced	261 days?	Mon 01/04/24	Fri 28/03/25	Fiona Lowis & Alex Perry	80%	Primary care therapies in place and being delivered, staffing issues resolved with team fully staffed. Skills gap remains for neuropsychology		20
27							**Improve the wellbeing for all, including self, making it central to what we do**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**L.Shepherd**	**85%**			
28							Ongoing Workforce development, to create a diverse workforce where recruitment, retention and development is a priority for all colleagues and all roles.	262 days	Sat 01/04/23	Fri 29/03/24	L.Shepherd	70%	Due to issues with HRBP allocation the work has stalled. Prior support was given to promote adverts to diverse communities. Final data required to review current breakdowns of diversity across PCs for the workforce.		315
29							For at least 85% of team members to have an appraisal and career conversation at least annually	262 days	Sat 01/04/23	Sun 31/03/24	L.Shepherd	100%	At 84.3% for year end of appraisals across service line. Some slippage due to staff absence and new staff in post.		308
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**	**Sun 31/03/24**	**J.Faulkner**	**100%**			**297**
33							**Older people's services**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**Paul Fotherby**	**68%**			
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**	**Paul Fotherby**	**58%**			
42							Engagement with all aspects of the Community Transformation Programme, including model development and engagement	522 days	Sat 01/04/23	Fri 28/03/25	P. Fotherby / B Alderson / G Wormald	75%	Work and engagement ongoing through transformation governance programme. Will be part of 24/25 objectives.		20
43							**Forensic services**	**783 days**	**Sat 01/04/23**	**Tue 31/03/26**	**J.Faulkner**	**68%**			
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**	**100%**			
51							To recruit to vacant posts, utilising recruitment incentives, new skill mixes for wards and media campaigns	262 days	Sat 01/04/23	Sun 31/03/24	J.Faulkner	100%	Nearly all posts recruited to, some nursing vacancies and HSW vacancies remain however significant improvement		315
53							**Learning disability services**	**522 days**	**Sat 01/04/23**	**Mon 31/03/25**	**P.Johnstone**	**30%**			
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**	**18%**			**297**
61							**Perinatal and liaison**	**522 days?**	**Sat 01/04/23**	**Mon 31/03/25**	**Eve Townsley**	**55%**			
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**	**Eve Townsley**	**39%**			
69							Engagement with the project team in the redesign of the high risk assessment room and safe flexible space at LGI and SJUH EDs.	522 days	Sat 01/04/23	Fri 28/03/25	E. Townsley	50%	LGI site is completed and St James site have plans to be done. Furniture on order. This is progressing.		70
82							**Rehabilitation, eating disorders and gender identity**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**R.Carroll**	**78%**			
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**	**56%**			
87							Develop a place-based clinical pathway for comlpex psychosis, aligning the existing R&R, AOT and	87 days	Sat 01/04/23	Sun 30/07/23	R.Carroll	100%	Completed		88,91,97
90							Community Transformation implement wave 2 upscaled complex psychosis pilot across PCN footprint	241 days	Mon 01/04/24	Fri 28/02/25	R.Carroll	10%	Recruitment commenced, delays due to procurement.		20
123							**Our Digital Plan**	**1066 days?**	**Tue 01/03/22**	**Tue 31/03/26**	**B.Fawcett**	**52%**			
140							**To ensure that Trust defences against cyber threats are affective**	**782 days**	**Fri 01/04/22**	**Mon 31/03/25**	**I.Hogan**	**73%**			



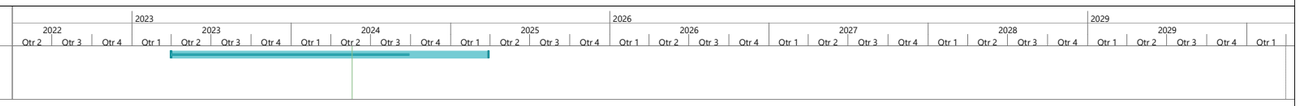
Trust Organisational Priorities 2023 - 2030: Quarter 4 Progress Report - interdependencies across schemes

ID	Task Mode	Q4 RAG	Q3 RAG	Q2 RAG	Q1 RAG	Mover	Task Name	Duration	Start	Finish	Lead	% Comple	Progress Update	Predecessors	Successors
141							Deployment of: password software, cloud-based back-ups, multi-factor authentication, privileged access management, phishing exercise software, update cyber policies in-line with national standards, employ a cyber team	522 days	Fri 01/04/22	Sun 31/03/24	I.Hogan	100%	All activities complete.		142
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	313	145
157							**Strategic Estates Plan**	**1696 days?**	**Fri 01/10/21**	**Fri 31/03/28**	**D.Hanwell**	**38%**			
160							**Enabling key clinical service changes through our estate**	**782 days**	**Fri 01/04/22**	**Mon 31/03/25**	**J.Campbell**	**55%**			
162							Renovation of Mill Lodge to enable the opening of an eating disorders day service	262 days	Sat 01/04/23	Sun 31/03/24	J.Campbell	100%	Scheme succesfully handed over.		75
173							**Ensuring our services are safe and secure**	**782 days**	**Fri 01/04/22**	**Mon 31/03/25**	**J.Campbell**	**60%**			**283**
182							**Green Plan**	**2087 days**	**Fri 01/04/22**	**Sun 31/03/30**	**J.Campbell**	**23%**			
188							**Networking, Comms & Engagement**	**2087 days**	**Fri 01/04/22**	**Sun 31/03/30**	**J.Campbell**	**21%**			
190							Develop and implement an incentive scheme and reward staff for tracking and reducing their own carbon footprint.	522 days	Sat 01/04/23	Fri 28/03/25	J.Campbell	20%	Would propose that we prioritise calculating our own Trust carbon footprint before we encourage staff to reduce their own. Move to 2024/25		334
232							**Our Medical Strategy**	**782 days?**	**Fri 01/04/22**	**Mon 31/03/25**	**C.Hosker**	**97%**			
233							**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%**			**308**
234							Undertake an analysis of the current training/support provided to doctors and, if appropriate, develop an annual update training programme focusing on appraisal and revalidation	262 days	Sat 01/04/23	Sun 31/03/24	V.Lovett	100%	Complete		308
235							Recruit, train and support a further 3-6 appraisers to provide us with sufficient capacity to deliver the number of annual appraisals needed to support the revalidation requirements of the doctors who have a prescribed connection with the Trust	132 days	Sat 01/04/23	Sat 30/09/23	V.Lovett	100%	Complete		308
241							**We wish to continue to maintain our excellent medical education and training.**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**V.Lovett**	**100%**			**309**
243							**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**	**93%**			**315**
245							Complete an analysis of leavers in the past three years to have a baseline of reasons and services with low retention and develop an action plan. This includes the offering of exit interviews for consultants and SAS doctors.	262 days	Sat 01/04/23	Sun 31/03/24	V.Lovett	100%	Complete		315
246							**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.**	**262 days?**	**Sat 01/04/23**	**Sun 31/03/24**	**V.Lovett**	**100%**			**308**
247							Develop and implement with OD and external partners a leadership development programme pathway, with clear internal and external offers which can match the particular needs of	262 days	Sat 01/04/23	Sun 31/03/24	V.Lovett	100%	Complete		297
249							**Nursing and professions strategy**	**1697 days?**	**Mon 01/04/19**	**Tue 30/09/25**	**N.Sanderson**	**80%**			
250							**Improving Retention of Professions**	**1043 days**	**Thu 01/04/21**	**Mon 31/03/25**	**A.Quarry & M.Tr**	**100%**			
251							Reduce turnover in nursing/AHP staff leaving the organisation by ensuring clinical teams reflect the scope of practitioners at every level	1043 days	Thu 01/04/21	Mon 31/03/25	A.Quarry, M.Clare-Trevett	100%	Completed		315
252							**Implementation of the Patient Safety Incident Response Framework (PSIRF)**	**522 days?**	**Sat 01/04/23**	**Mon 31/03/25**	**C.Wardle**	**69%**			**283**
253							Procurement of a cloud-based Risk Managememet System that complies with PSIRF requirements	261 days	Mon 01/04/24	Fri 28/03/25	C.Wardle / Janet Smith	20%	Meeting being scheduled with the Deputy Director of IT to progress. Continued discussion with Head of Performance and Infomatics.		135
265							**Implementing research, development and new technologies**	**762 days**	**Thu 01/04/21**	**Fri 01/03/24**	**A.Quarry, M.Claire-Trevett**	**60%**			
266							Develop and implement a portfolio of research opportunities for nursing/AHP staff aligned with the National Nursing Research Strategy and AHP strategy	783 days	Thu 01/04/21	Fri 29/03/24	A.Quarry, M.Claire-Trevett	60%	We have scoped out the senior nursing and AHP job descriptions and the research component. Next phase of work is to fully embed within the nursing/AHP roles.		348
275							**People Plan**	**1303 days?**	**Thu 01/04/21**	**Tue 31/03/26**	**D.Skinner**	**70%**			
312							**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%**			
313							Develop and implement an intuitive, integrated workflow management solution to replace the SW process	782 days	Fri 01/04/22	Mon 31/03/25	A. McNichol	0%	People Analytics Senior Leadership have met with the sharepoint external development team to discuss transitioning the SW process onto sharepoint workflow. The objective has been added to the new People Plan for delivery in 2025.		144
319							**Develop and deliver the best experience for those who join the Trust**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**F.Sherburn & A.Earnshaw**	**100%**			
321							Evaluate the effectiveness of onboarding and the impact on retention and delivery of continuous improvement	66 days	Mon 01/01/24	Sun 31/03/24	F.Sherburn & A.Earnshaw	100%	Complete		315
322							Evaluate the use of work experience/internships in terms of experience and recruitment impact. Continuous improvement of the scheme	261 days	Mon 01/04/24	Mon 31/03/25	F.Sherburn & A.Earnshaw	100%	Complete		315
323							**Develop and implement an innovative approach to talent development, and which aligns to the Trust Workforce plan**	**262 days**	**Sat 01/04/23**	**Sun 31/03/24**	**F.Sherburn & A.Earnshaw**	**80%**			**315**
324							Roll out of talent management framework with supporting infrastructure to support succession planning/linked to internal recruitment and a 'grow our own' model, based on evaluation of pilot	262 days	Sat 01/04/23	Fri 29/03/24	F.Sherburn & A.Earnshaw	80%	Work to commence in 2024/25 - delayed start date due to introduction of board development programme		315
358							**Finance Strategy**	**522 days?**	**Sat 01/04/23**	**Mon 31/03/25**	**J.Saxton**	**57%**			
359							**We use our resources to delivery effective and sustainable services**	**522 days?**	**Sat 01/04/23**	**Mon 31/03/25**	**J.Saxton**	**57%**			
361							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	50%	The run-rate is reducing across the year but now lower than 23/24 spend		315
362							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%	A new Improving Flow Programme has been established, however OAPs have increased across the year. A revised trajectory has been set for 2024/25.		4



Trust Organisational Priorities 2023 - 2030: Quarter 4 Progress Report - interdependencies across schemes

ID	Task Mode	Q4 RAG	Q3 RAG	Q2 RAG	Q1 RAG	Mover	Task Name	Duration	Start	Finish	Lead	% Complete	Progress Update	Predecessors	Successors
363							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	75%	Vacancies have consistently reduced across the year with a net increase of staff of 171WTE. However no new redesign of services has taken place		315



Quality impact assessing our efficiency and productivity programme

1. Background

The National Quality Board published guidance for commissioners and provider organisations in June 2012 regarding how to undertake an assessment of provider cost improvement plans (CIPs) and the potential impact on quality.

Understanding the potential impact on service quality of cost improvement schemes (efficiency and productivity), skill mix reviews, service redesign and developments is essential for the Trust, in order to continue to maintain and improve service standards. Having a systematic process in place supports such understanding and is a vital part of informed decision making. It is an essential part of continuous quality improvement and shared learning and supports the Trust's Care Quality Commission (CQC) registration and compliance with the CQC fundamental standards.

As part of NHS England's planning process, we are required to deliver a balanced net system financial position. This includes the achievement of an agreed efficiency target. All ICBs and providers are asked to develop their efficiency and productivity programmes, that generate efficiency savings, raise productivity and improve outcomes within allocated resources. All viable schemes detailed as part of each providers' efficiency and productivity programme must be subject to a quality and equality impact assessments.

2. Principles of the quality and delivery impact process

The quality and delivery impact assessment process promotes a systematic exploration of both quantitative and qualitative information and, encourages triangulation that helps assess the quality impact of efficiency plans and service changes. The approach is intended to promote and facilitate clinical engagement and leadership, to ensure that staff involved in the provision of direct care and those leading services locally are fully engaged in the process of identifying potential efficiency plans and assessing the potential impact of these on all three areas of quality: outcomes, safety and experience of care.

The delivery impact assessment determines whether there is clear evidence to support the proposed financial savings, there is both the capacity and capability within the service to successfully deliver the scheme within the current financial year, and finally whether key stakeholders have been involved in the development of the scheme.

3. Our process to date

As part of the planning process the expectation is that each provider has a fully developed efficiency and productivity programme before the start of each financial year. Firstly, demonstrating approaches to understanding where productivity may have been lost over the course of the pandemic and how we are working to reset this. Secondly, how we can release efficiency savings.

All providers are asked to utilise the data available through Model Hospital, Lord Carter, benchmarking and improvement programmes to identify priorities for productivity and efficiency

improvement. Particularly at a system level the plans need to major on the areas for collaboration and streamlining of systems and processes at scale.

We have used the data available, broken this down into categories and aligned with each executive director's portfolio. Each executive director, along with their deputies/leaders have had the opportunity to review the long-list of potential schemes and determine their viable short-list. The short-list of schemes is quality impact assessed to determine any consequential quality and delivery impact.

4. Quality impact assessment governance

We have a well-established process in place for assessing all efficiency/productivity schemes. The responsibility for quality and equality impact assessing each efficiency scheme sits with the identified lead and supported by the lead executive director. Leads are supported through this process by finance and the PMO.

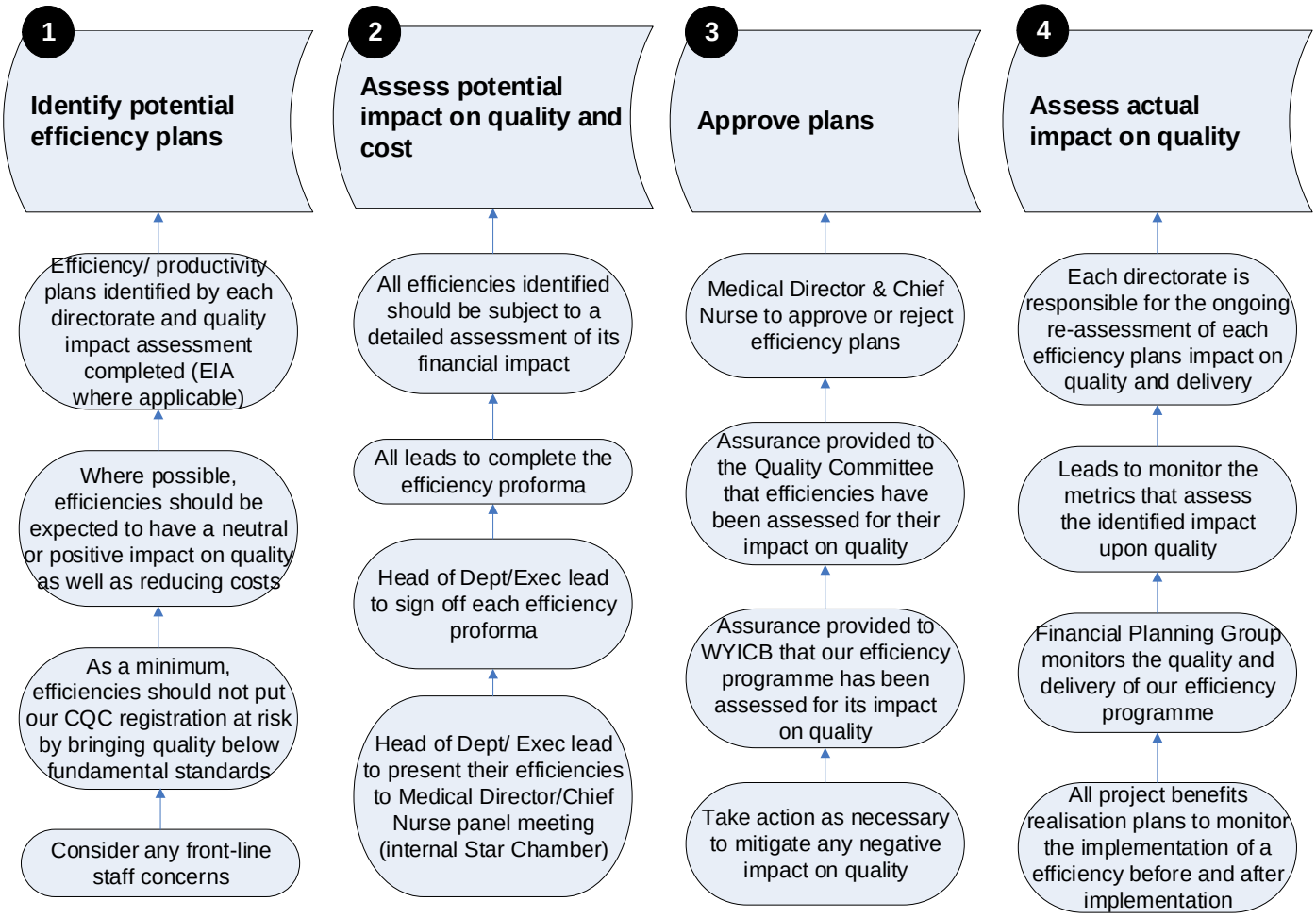
The responsibility for the final approval of each efficiency scheme rests with the Chief Nurse and Medical Director, supported in this work collaboratively with their executive colleagues.

In order to facilitate the sign off process we hold an internal efficiency session (this can also be described as a Star Chamber). Chaired by the Chief Nurse and Medical Director, this session enables all directorates the opportunity to present their efficiencies and fair, transparent and proportionate challenge is made by the Director of Nursing, Medical Director and other Executive Team colleagues present.

The Financial Planning Group is set up to provide routine assurance and oversight related to the quality and financial impact of existing efficiency schemes. This group meets on a monthly basis and is chaired by the Chief Financial Officer. The ongoing process of assessing the actual impact on quality and delivery is routinely undertaken by each responsible exec-led governance group and escalated through to the Financial Planning Group.

All accepted plans are presented to the Quality Committee (a board sub-committee) where assurance is provided on the rigour of the quality and delivery impact assessment process.

The following diagram sets out the four stages in this process.



5. How schemes are assessed

The National Quality Board guidance recommends that the quality and delivery impact of all efficiency schemes is understood using the 5x5 management of risk matrix. All our efficiency schemes are quality impact assessed using the 5x5 risk matrix across all three elements of: safety; experience; and clinical effectiveness.

The table below sets out the scoring matrix. A high score demonstrates a greater adverse quality impact of the efficiency scheme, a lower weighted score demonstrates a greater benefit of the cost improvement scheme. Each of the scores is then weighted for impact and significance using a scale from 0 to 25. This is to provide an assessment of where the greatest impact may occur following implementation of the efficiency scheme.

Score		**1**	**2**	**3**	**4**	**5**
		Insignificant	**Minor**	**Moderate**	**Major**	**Catastrophic**
1	**Rare**	1	2	3	4	5
2	**Unlikely**	2	4	6	8	10
3	**Moderate**	3	6	9	12	15
4	**Likely**	4	8	12	16	20
5	**Almost certain**	5	10	15	20	25

As part of the scoring process each service must identify any foreseen areas of impact and what metrics have been identified that will measure the impact.

We are also required to assess the probable delivery of each proposed efficiency scheme. This is an assessment of:

- Whether there is clear evidence to support the proposed financial savings.
- Whether there is both the capacity and capability within the service line/directorate to successfully deliver the scheme within the current financial year.
- Whether key stakeholders have been involved in the development of the scheme.

As part of assessing our 'long-list' of schemes we have completed a high-level assessment of the deliverability of each scheme. The table below sets out the scoring matrix.

Low risk of non-delivery	High probability of delivery	**GREEN**
Medium risk of non-delivery	Medium probability of delivery	**AMBER**
High risk of non-delivery	Low probability of delivery	**RED**

Where required, all leads are asked to assess whether an equality impact assessment is necessitated for each scheme. The EIA form is completed providing the detail of the impacts identified and any mitigation plans in place.

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:	Trust Strategy Refresh Process
DATE OF MEETING:	30 May 2024
PRESENTED BY: (name and title)	Dr Sara Munro, Chief Executive.
PREPARED BY: (name and title)	Oliver Tipper, Head of Communications. Amanda Burgess, Strategic Development Lead.

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 gives a brief outline of how we are refreshing our five-year Trust Strategy document. This document intends to be an accessible overarching narrative that summarises our five-year organisational vision and our core strategic plans. Its purpose is to communicate our vision, mission, and objectives for the next five years to a broad audience.

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 support and approve the Trust Strategy refresh process outlined in the appended paper.

MEETING OF THE TRUST BOARD OF DIRECTORS

30 MAY 2024

Trust Strategy Refresh Process

1 Executive Summary

This paper gives a brief outline of how we are refreshing our five-year Trust Strategy document.

This document intends to be an accessible overarching narrative that summarises our five-year organisational vision and our core strategic plans. Its purpose is to communicate our vision, mission and objectives for the next five years to a broad audience.

2 Strategy refresh outline

The Trust is refreshing its five-year strategy document. This will succeed the previous version: Living our values to improve health and lives 2018 – 2023. It is the right time to do this for three main reasons set out below.

Firstly, the previous plan was published in 2018 following an extensive co-production exercise where we refreshed our vision, values and strategic objectives. It broadly set out our strategic position at that point in time. However, a lot has changed since then, notably the impact of the Covid-19 pandemic, and the strategy's five-year timeframe elapsed in 2023.

Secondly, over the past two years we've been in the process of refreshing our brand identity. As part of this work we engaged staff, lived experience partners and stakeholders, receiving hundreds of survey responses and holding focus groups. The new brand identity was launched earlier this year and includes elements such as a new organisational strapline and proposition statement, a refreshed vision and mission statements, a new tone of voice guide and a bold new visual identity. This needs to be reflected in our new strategy document.

Finally, we have refreshed (or are in the process of refreshing) our core strategic plans and enabling plans. These are our:

- Care Services Strategic Plan,
- People Plan,
- Strategic Estates Plan (due to be refreshed this year),
- Quality Strategic Plan, and

- Digital Plan

These can be found on the strategy page of our website.

These plans set out in detail our strategic direction within each of the core areas they represent over the next few years. It is right that we have such documents that go into a high level of detail on the actions we'll be taking to achieve our goals. However, it is also right that we create something that communicates their intentions in a more accessible way to a wider audience.

2.1 Strategy refresh process and timeline

We aim to present the new strategy document to Trust Board on 26 September 2024. To get to this point, we will take the following steps:

- Research and content gathering - working with strategic leaders to source accurate material,
- Sense checking a first draft with executive directors,
- Consultation on a draft version with our non-executive directors, our Council of Governors, and a range of critical friends including our staff networks, our Service User Network members, and key stakeholders within the local health and care system (who will also contribute to our well-led review),
- Consolidation of feedback from the consultation process,
- Designing the document in the Trust's new brand style,
- Presentation to Trust Board in September for ratification.

At this point we will socialise the document and its key messages with staff, stakeholders and the public via internal and external communications and engagement.

3 Recommendation

The Board is asked to support and approve the Trust Strategy refresh process outlined above.

Authors
Oliver Tipper
Head of Communications

Amanda Burgess
Strategic Development Lead

23 May 2024

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

13

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Report from the Chief Operating Officer
DATE OF MEETING:	30 May 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 we are facing.

This month the report includes:

- **Emergency Preparedness Resilience and Response (EPRR) Update Report**. The paper provides a summary of the current areas of work being carried out by the EPRR team and areas where support by senior operational and corporate staff is required to make the Trust more resilient. In particular, business continuity progress and attendance at training events and exercises. 2024/25 is set to be a challenging 12 months due to major pieces of work around EPRR improvement plans and EPRR portfolio training and with continuing uncertainty around further industrial action.

- **Service delivery and key performance escalations.** The most significant risks and challenges faced by our service managers and leadership teams continue to be sustained demand within our acute in-patient service and workforce supply across all areas, particularly within our Children and Young Peoples in-patient service at Red Kite View. (Appendix A contains the agreed Board-level dataset for performance and service delivery).

- **Service development**. In summary, NHS England has requested expressions of interest for the development of 24/7 community mental health services covering a population of 30,000 to 50,000 people. The Trust entered a three-year project with Hub of Hope during the last financial year. The launch of the three earlier adopter sites in March continues to progress well and early indications are that service user and staff experience of operating in a more integrated team is making improvements.

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

May 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:

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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 include:

- The continued need for additional Out of Area inpatient capacity, due to the ongoing demand and challenges with patient flow through our services, resulting in quality, operational and financial risks. A Board development session was held in March 2024 to outline the key issues and set out our plans for recovery. The improving flow programme is now weeks into implementation and performance is closely monitored and managed. At this stage the position is improving but we are behind the planned trajectory.

- The ongoing challenges to the delivery of the service at Red Kite View in light of the staffing vacancies, particularly the more senior nursing vacancies on both wards.

- A lack of resolution of the pay dispute with non-consultant level medical staff, which now includes specialty doctors and special grade doctors (SAS doctors) with the ongoing uncertainty and risk of industrial action being triggered.

- Continued overspending across our Trust-wide inpatient services as a result of additional staffing, combined with medical staffing financial pressures, underfunding in the Specialist Supported Living Service and out of area placement costs.

2. EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE (EPRR) ACTIVITY

2.1 Incidents/Disruption

2.1.1 Industrial Action

No industrial action has been notified at the current time. Both SAS doctors (specialist grade doctors and speciality doctors) and junior doctors have mandates until later in 2024. There is a positive indication that there may be an imminent resolution between the Government and the BMA representing SAS doctors, However, there is no indication of a resolution with Junior doctors at this stage.

2.1.2 NICPM (National Inpatient Centre for Psychological Medicine)

Water ingress at Brotherton Wing has been identified as posing a risk to electrical supply to the NICPM as well as Leeds Teaching Hospitals NHS Trust (LTHT) services based in the building. An MoU (outlining the arrangements in the event of an incident) is with LTHT executive directors for consideration and this is being followed up with executive directors at LTHT. Remedial building work appears to be delayed pending a £7.5 million capital scheme.

2.2 Business Continuity (BC)

Following the EPRR assurance standards in September 2023, we have refined and strengthened our approach to business continuity. The new process focuses on engaging with staff in services who may not have had previous experience of business continuity planning. We are mindful that further work with senior medical staff in particular is needed.

The new business continuity process has been commenced in several service lines. Monitoring of progress is undertaken through our governance arrangements and concerns in regard to progress would be escalated via the Finance and Performance Committee. Our planning assumption is that the process of moving to fully compliant plans will take around 26 months.

Work with corporate services is also progressing; in particular a utility failure business continuity plan is being developed with estates colleagues.

2.3 EPRR Portfolio training

The EPRR Portfolio process continues to be problematic. A list of available training has been circulated and this training is rated in terms of whether it will satisfy the requirement of the competency element. The “green rated” courses/training/ activities should be completed as soon as possible while “amber” courses are also being done by some staff and evidence submitted to EPRR.

EPRR leads are working with the ICB to firm up training needs and external training provision. A trial version for strategic training will be developed within 4 weeks for evaluation. The due date for portfolio completion was July 2024; however, this is no longer in force, and a revised date has not yet been given by NHS England.

The EPRR team is also working with the Learning Management team to build a recording and reporting system in Learn for the portfolio training. Currently, any evidence is being sent to the EPRR team for storage in personal folders for all those required to maintain an EPRR commander portfolio.

2.4 EPRR Assurance action plan development

The EPRR assurance review identified considerable areas where work is needed to fully meet standards. An indicative plan was developed in November 2023. However, given changes to the understanding of requirements, work at an ICB level on sharing best practice and also uncertainty regarding future arrangements, this plan will need redrafting and may need periodic updates throughout 2024. A revised plan will go to April’s EPRR Group and then onto the Finance and Performance Committee.

As of the date of this paper, no clear decision has been made for the 2024 assurance process. The entire process is changing considerably in 2025 given feedback on the 2023 process.

An internal audit was carried out around planning for improvements following the 2023 NHS England review. The opinion was that within the limitations and

uncertainty around the future direction of EPRR assurance, there was significant assurance that we were dealing with required actions effectively.

2.5 Working collaboratively

While a plan for joint working in Low and Medium Secure services is in place and is being approved by the signatory bodies, other services do not have similar plans. A proposal paper for joint planning for evacuation in perinatal and CYPMH (Children and Young People's Mental Health – Inpatient provision) was presented to the Provider Collaborative Board last month with the request that this work be approved for development.

In the Northwest region work is about to begin on acute and older persons evacuation planning on a collaborative basis, recognising that given intense bed pressure that an internal solution to the loss of a ward would not be achievable. EPRR leads in this area are in contact with colleagues in the Northwest and there is a North of England Mental Health EPRR leads' meeting where collaboration across the north of England occurs.

2.6 Chemical, Biological, Radiological and Nuclear (CBRN) arrangements

As an NHS funded organisation under core standards the Trust must have arrangements in place to treat and manage contaminated self-presenters at any of its publicly accessible sites. As a mental health Trust ,decontamination is not expected for biological, radiological, or nuclear type contamination however, it is for chemical contamination.

Chemical decontamination carried out in non-specialist arenas is deemed to be improvised decontamination and the Trust holds approximately 16 boxes containing products and guidance to facilitate improvised decontamination at locations across its footprint.

Training is also required for reception staff and nursing staff at all locations where we have risk assessed a potential for having to carry out a CBRN response. Given

numbers, we are exploring e-learning for this which will allow staff to do a relatively short course at their convenience rather than a formal Teams meeting.

Additionally, the EPRR team are working with an expert from YAS (the Yorkshire Ambulance Service) to develop an audit approach to CBRN in mental health organisations prior to audits commencing by YAS. The acute sector has had these CBRN audits for several years. The Trust will be an early implementer of the new requirements, working with YAS to identify changes in practice and procedures that are required and will receive a baseline audit conducted by YAS later this year.

3 SERVICE DELIVERY AND KEY PERFORMANCE ESCALATIONS

We continue to experience significant challenges as highlighted in previous reports including a sustained demand for admissions into our Acute Service, with sustained lengths of stay with increased delayed transfers of care, resulting in high levels of out of area placements. Capacity and flow continues to be a key priority for the organisation (from a quality, safety, and efficiency perspective), which is being managed through a number of workstreams led by our Head of Operations for Acute Services with oversight from our Executive led Improving Patient Flow Programme.

3.1 Alert

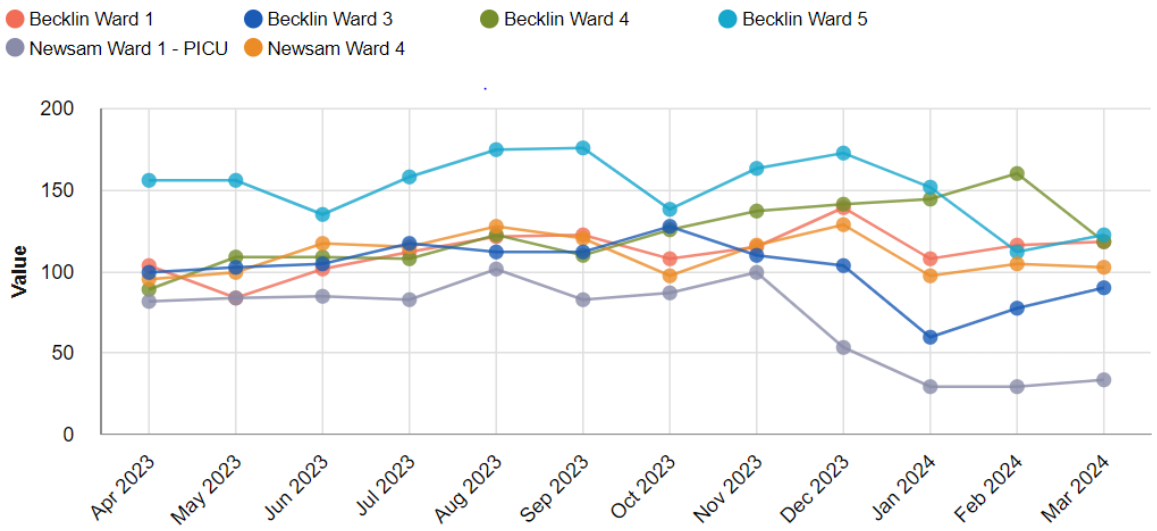
This section sets out the key areas of concern for care services that have been identified through our governance arrangements. These updates relate to the areas where services face most challenge and where risks are highest.

3.1.1 Acute Service Line: Inpatient Capacity and Flow

The demand for inpatient beds remains consistently high with lengths of stay continuing to be higher than expected (see graph 1). This, along with delayed discharges (see graph 2) continues to impact on poor flow, and the use of out of area placements continues to in the high 30's (acute and PICU particularly) (see table 1). More recently we have had three service users placed from the Older People's

Services, however all three have recently been repatriated either to a bed in Leeds or to a community placement.

Graph 1: Average length of stay by ward.



Graph 2: Percentage of Delayed Transfers of Care by ward.

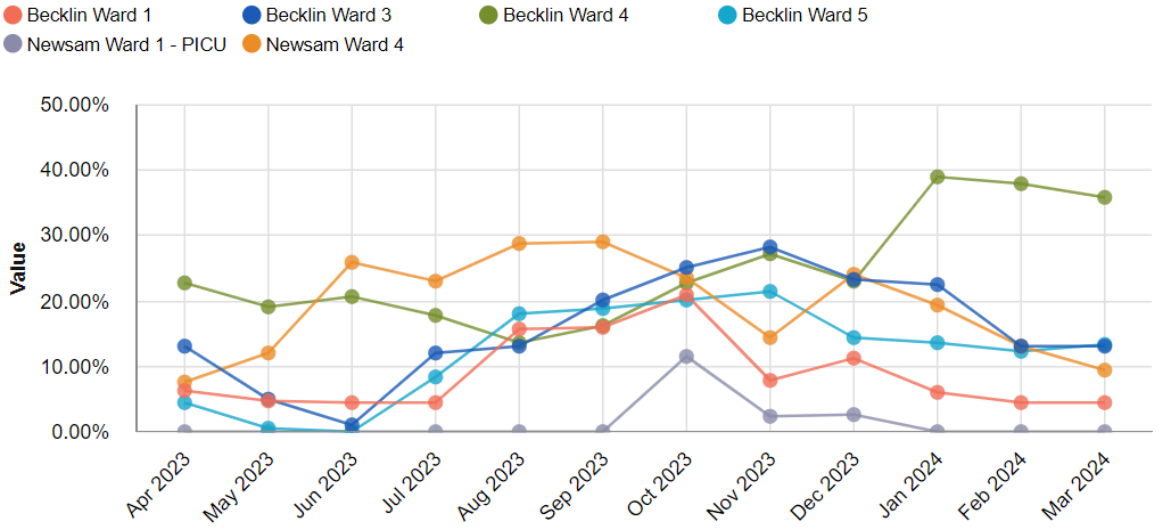
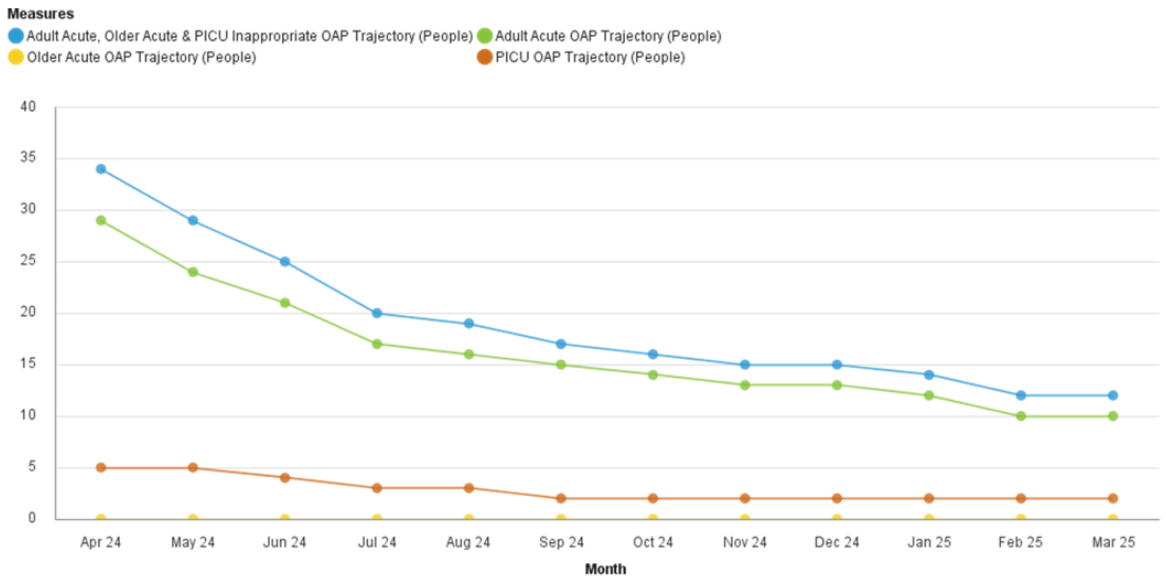


Table 1: Out of Area Placements by gender and type.

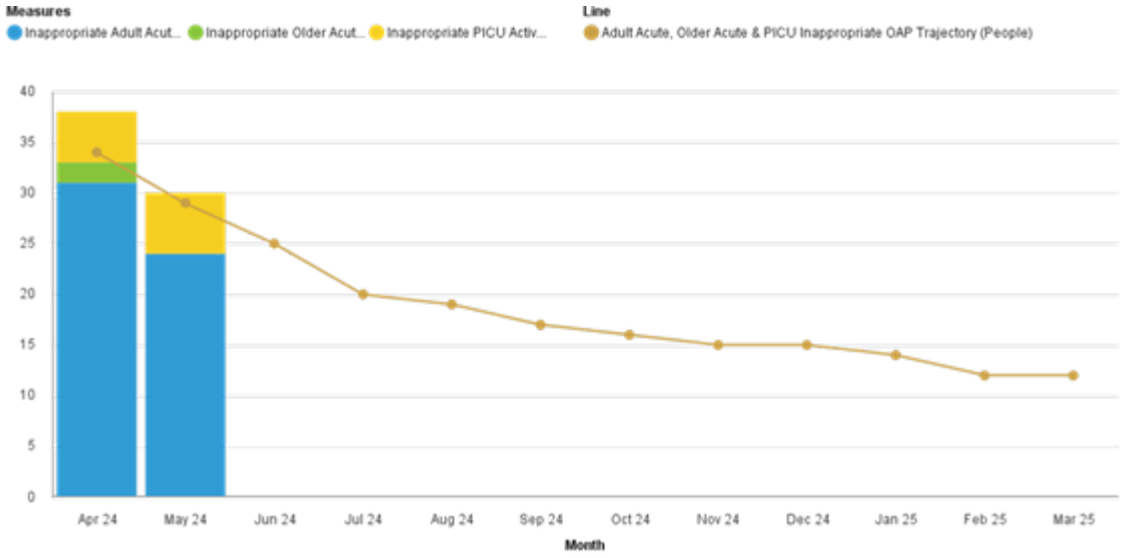
Position at 10 May 2024	Current Out of Area Placements
Male Acute	12
Male PICU	2
Female Acute	17
Female PICU	3
TOTAL	**34**

The recovery plan and associated financial implications is a priority for Care Services and the Trust. We have agreed an improvement trajectory (see graph 3) which we are working hard to achieve. We have achieved an improved position but are behind target to early May. We anticipate this will continue to improve as the programme gathers momentum through the rest of May and into June.

Graph 3: Out of area trajectory



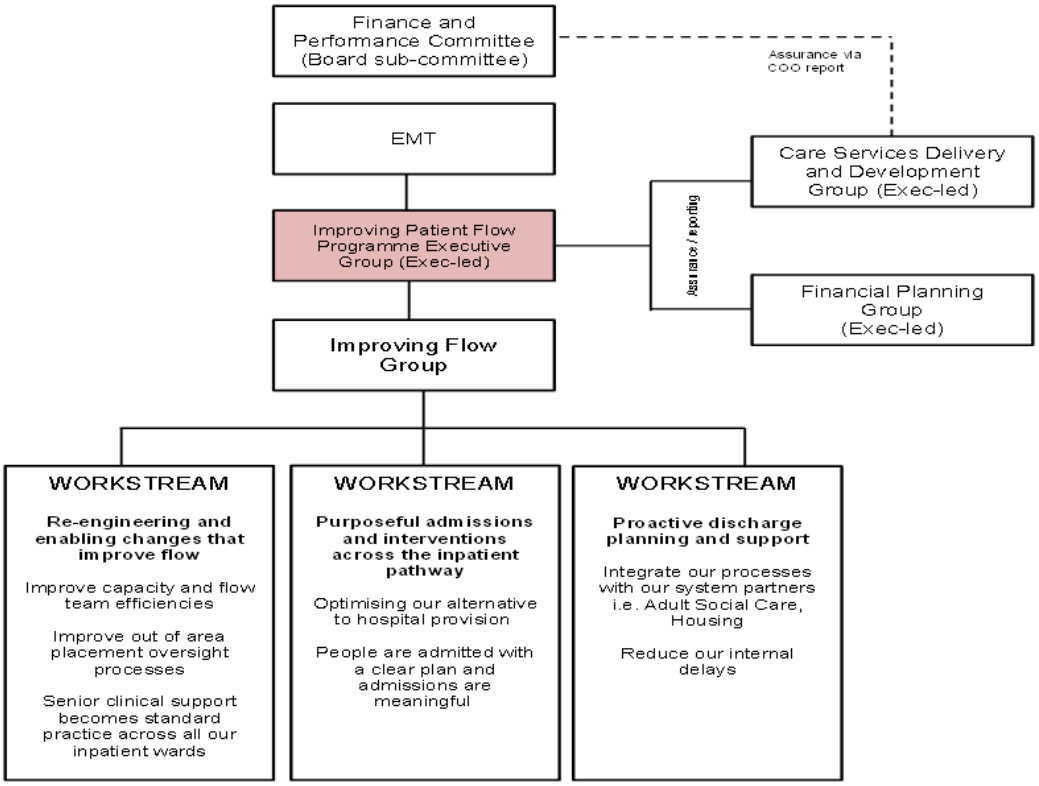
Graph 4: Performance against Out of Area trajectory



The Improving Flow programme has now been established and three workstreams have been agreed and leads for these identified. The three workstreams focus on enabling changes to improve flow, ensuring all admissions are purposeful, and we have proactive discharge planning and support in place. These workstreams are underpinned by a robust governance structure as set out in image 1 below.

Immediate key actions have been completed, including the scope and programme governance being clearly defined and a review of all inpatients by senior clinical and operational staff to clearly identify discharge pathways.

Image 1: Improving Flow Governance Structure.



Whilst we continue to utilise Out of Areas Placements, our Capacity and Flow Team maintain responsibility for those services users in the placements. They have a clearly defined process that ensures all options within the Trust are exhausted before approaching other providers for placements. Where service users are placed out of area, the Specialist Practitioner within the team acts as a Case Manager for these placements ensuring that service users get the appropriate level of care within an environment that meets their needs. The Specialist Practitioner also acts as a point of contact for service users' relatives to ensure those local links are maintained and we are responsive to their concerns where necessary. The team also maintains good working relationships with providers, meeting with their managers regularly to ensuring quality standards are maintained. The team is reintroducing regular quality visits to providers to provide an increased level of assurance. These visits have been reduced in the past due to the capacity of the team to undertake these.

The team also monitors the distance from home these placements are for all service users. We continue to have a contract with the Priory Group at their hospital in

Middleton St George, enabling us to maintain placements in the North of England. However, due to the national challenges for mental health capacity we have had to use placements further afield as detailed in image 2.

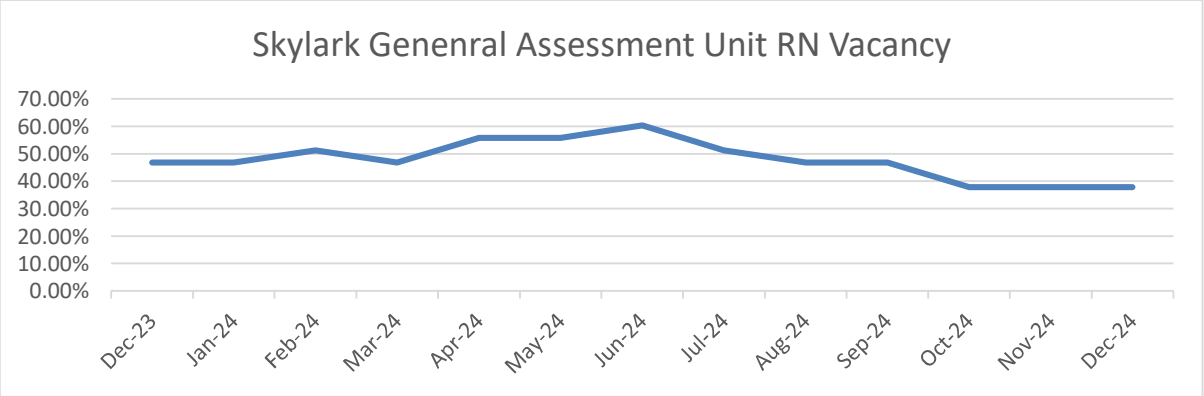
Image 2: All placements by type and locality

3.1.2 Children and Young Peoples Services: Red Kite View Staffing

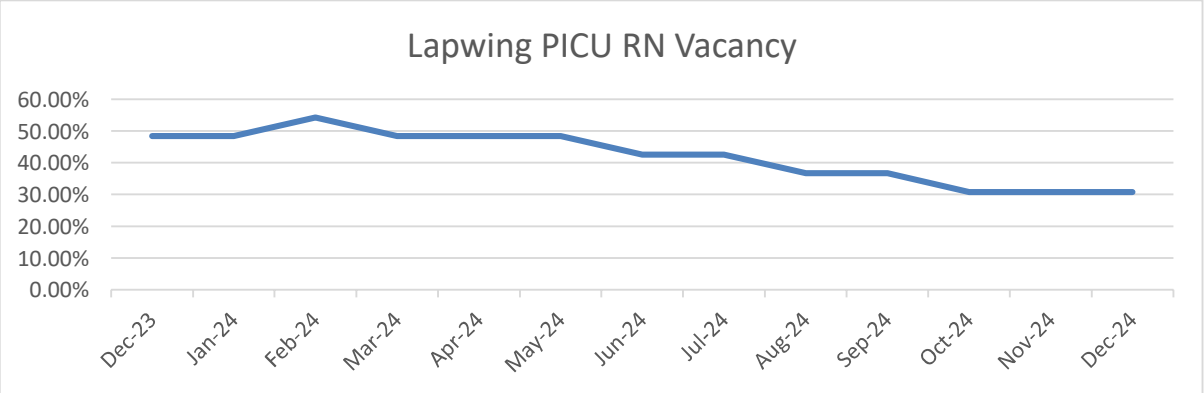
Red Kite View (RKV) has been operating with a nursing vacancy rate of between 45-55% for the last 12 months. During this extended period of nursing staff shortages, it has become business as usual for both management and members of the Multi-Disciplinary Team (MDT) to regularly step in to cover shifts on both wards including weekends. We have tried creative recruitment solutions including: secondments and developmental opportunities; attending job fairs and local universities; advertising in nursing journals; and have looked to recruit international nurses. The service has set out a recovery trajectory for both wards at Red Kite View for the next 8 months, see

graphs 5 and 6. However this will not see all registered nursing (RN) posts recruited to fully and does not account for any further posts that may become vacant during this time.

Graph 5: Skylark RN vacancy trajectory.



Graph 6: Lapwing RN vacancy trajectory.



A paper detailing the options for short-term stabilisation has been presented detailing several options. Approval was given for the service to seek mutual aid from partners via the West Yorkshire Children and Young Peoples Provider Collaborative (PC) Board. As yet, we have not had any offers of support for staffing for RKV. Therefore, the service is coming together with the PC Executive Group to explore other options which may include reducing the capacity at RKV taking into consideration the impact on the young people requiring admission to the service.

Whilst the above plan is to maintain the current level of service, there evidence from delivering the service for two years and what is happening within the service at Mill

Lodge, that we need to consider other changes to the service to meet the needs of the population we serve. We are, therefore, considering what changes can be made to the service delivery model, including options such as a day service and outreach support. This work will be undertaken with our colleagues within the Provider Collaborative and Social Care sector to enable alternatives to inpatient care to be offered safely and effectively.

3.2 Advise

3.2.1 Community and Wellbeing Service: Care Coordinator allocation

Since the last report the allocation of a Care Coordinator for service users who are current inpatients, has significantly improved. The service has implemented a weekly reporting system that tracks all referrals to ensure they are allocated within a timely manner. At present we are seeing all referrals for Care Coordination being allocated within a 5-day period. Anecdotal evidence from the inpatient service regarding delays, has been where Care Coordination is requested from other services i.e. Aspire, however these referrals were made to the wrong team initially. This is continually being monitored by the service.

This approach to the allocation of Care Coordinators has had a knock-on effect to other referrals within the service as a result of the ongoing staffing challenges, currently reporting a 27% vacancy rate across all areas. The service had 18 service users waiting for the allocation of a Care Coordinator at the time of writing this report. This waiting list is under continual monitoring to ensure any changes in risk presentation or need are responded to, with all cases receiving regular contact from the service whilst waiting for allocation.

3.2.2 CONNECT Adult Eating Disorder Service: Community vacancies.

Psychology staffing gaps (currently 45% vacancy rate), due to vacancy and maternity leave, continue to affect waiting times for treatment. As a result of increased staffing gaps, in January the service reviewed waiting times for psychological intervention (group and individual therapy). Following discussion with the Adult Eating Disorder (AED) Provider Collaborative Board and AED Clinical

Governance, we temporarily reduced the number of initial assessments so that people did not have to wait twice (once before assessment and again to start treatment). This was implemented in February and we reviewed this in April and expect to resume all assessment slots in mid-May.

Waiting times in January 2024:

- Initial assessment 12 weeks.
- 1:1 therapy 6 months.
- CBT group 3 months.
- MANTRA (Maudsley Model of Anorexia Nervosa Treatment for Adults) group 2 months (MANTRA group waiting time is unaffected).

Current waiting times:

- Initial assessment 18 weeks.
- 1:1 therapy 3 months.
- CBT group 2 months.
- MANTRA group 2 months.

The following actions have been taken to mitigate waiting times:

- 2 members of staff starting MANTRA training and requiring an individual therapy caseload which has increased capacity.
- New Trainee Clinical Psychologist placement commenced in April.
- Prioritising referrals according to risk (physical health risk). High risk referrals are offered urgent assessments.

Further actions are also being taken that will fully recover waiting times:

- We have successfully appointed a CBT therapist on a 12-month secondment who is due to start in June.
- CBT therapist returning from maternity leave in July.
- A permanent CBT therapist recruited, start date in October.

We expect to fully recover our waiting times by October 2024.

The first phase of a structured job planning and caseload management project will begin in May 2024 with a 'time and motion' study and a project completion date of August 2024. This project is expected to increase productivity and governance of all activity. The dietetic service has been adapted temporarily to mitigate maternity leave and a secondment resulting in increased flow so that service users will receive their dietetic assessment and 2 or 3 review sessions before leaving the dietetics pathway and re-joining as needed.

3.2.3 Forensic Services: Seclusion facilities

The service continues to experience challenges with regard to the provision of seclusion facilities across our low-secure footprint. At Clifton House, both seclusion suites have been recently out of action due to them sustaining significant damage by one service user. The seclusion suite on Westerdale has undergone repairs and is now operational. The suite on Bluebell requires substantial work that has only recently commenced and will take several weeks to complete. This has been impacted by the lead-in time for some replacement fixtures and fittings. The plans for the development of the seclusion facilities at Clifton have been supported by the Finance Planning Group and supported by the Humber and North Yorkshire provider collaborative (PC), however this has not yet progressed due the lack of funding but is recognised as a priority for the PC and the service.

The seclusion suite at Newsam remains unavailable due it continuing to be used for a service user requiring long-term segregation. A West Yorkshire PC funded exceptional package of care is in place, with additional care interventions delivered by our ward occupational therapy colleagues. Fortnightly 'Person of Concern' meetings are held specifically regarding the service user led by the Provider

Collaborative, with attendance by Leeds forensic ward and service management and clinical leadership, Adult Social Care Social Workers, PC colleagues (Quality Lead and Case Manager) and the Assuring Transformation Lead. Additionally, the Director of Nursing has signed the memorandum of understanding (MOU) with Mersey Care, who are lead provider for the NHS England commissioned HOPE(S) programme. This is designed to implement a clinical model based on 'a philosophy of person centred, human rights-based care, which includes an unconditional, relentlessly positive approach to reducing long term segregation'. Signing the MOU is our formal commitment to implement and deliver the clinical model for our service user in long term segregation. The roll out of HOPE(S) training has already started, with a number of clinical ward colleagues having already undertaken the two-day training.

The work has commenced on the new seclusion facilities at Newsam. The building works are anticipated to take 12 weeks; however, we do not yet have an estimated date for commissioning the suite.

3.2.4 LD Services: Specialist Supported Living Service (SSL)

SSL continues to experience a high number of voids, currently at 10 across the service, which is contributing to an overspend within the service at around £330k. Discussions are progressing between the Trust's Director of Finance and Chief Operating Officer and their counterparts within Leeds City Council (LCC). The Head of Operations for the service is working directly with colleagues in LCC to swiftly and effectively fill the voids to ease both financial pressure on the Trust and better use the voids to assist the Local Authority's position. Oversight of this is being provided through the Finance and Performance Committee and is a key part of our 2024/25 financial plan.

3.2.5 Liaison and Perinatal Services: development of appropriate assessment space and ALPS (Acute Liaison Psychiatry Service) office space in Leeds Teaching Hospitals NHS Trust (LTHT)

The assessment space at Leeds General Infirmary (LGI) is now operational and the space at St James University Hospital (SJUH) will soon be ready for use. The challenge remains regarding office space for the ALPS team at SJUH. An initial

solution was identified however this has been reallocated internally within Leeds Teaching Trust (LTHT). Options are still being explored and it is recognised the importance of having the ALPS based within the emergency department at SJUH to maintain the responsiveness of the team and build those working relationships. The requirement to return the office space currently being used by the team back to its previous use has become more urgent of late therefore the service is working at pace to find a suitable solution.

3.2.6 Older Peoples Service: Impact on ward 2 at the Mount resulting from Mother and Baby Unit (MBU) expansion:

The service is continuing to work with colleagues within the Liaison and Perinatal service line and with our project management team to understand impact and possible opportunities of the expansion of the MBU service at the Mount. The plans for both services have seen several iterations, and a suitable option has been settled on. All involved have taken a holistic approach to ensure that all staff and service users who use the site are considered when making plans for the alteration of the layout of the building.

3.2.7 Gender Service

The business case to recruit staffing from the children's Gender Identity Development Service (GIDS) was approved by NHS England (NHSE), however none of the GIDS staff took the opportunity to apply to work with us. We are currently waiting for an update from NHSE regarding next steps, however NHSE have helpfully confirmed that funding is still approved for four additional clinical posts (1.0 wte Specialty Doctor, 1.0 wte Speech and Language Therapist, 0.4 wte General Practitioner) and the funding for 1.0 wte Band 3 Administrator to support these roles.

Since July 2023 the service has received referrals for all those 17-year-old service users who were identified to transition to adult services following the changes to the children's services. This has resulted in approximately 400 additional referrals being added to the waiting list during this period. The number of referrals from GIDS has now plateaued to between 20 and 30 referrals per month. It has been reported that our adult service took around 78% of those transferred from GIDS between July and

December 2023 (313 service users). The disproportionate numbers of referrals have been as a result of the Newcastle Clinic closing to referrals, Sheffield not taking referrals until the age of 18 and that the Nottingham Clinic being purely for people who resided in the area.

Of those patients transferred from GIDS we are prioritising those that had already commenced treatment:

Age Profile (years)	Number of People
17.0 -17.5	8
17.5 -18.0	18
18.0 -18.5	29
18.5 -19.0	15
19 +	3

NHS England has made arrangements nationally for all under 18 year-old people transferred from GIDS to be provided with mental health support from their local Child and Adolescent Mental Health Services (CAMHS). The recently published Cass Review recommended the commissioning of a gender service for 17 – 25 year-olds and we await further details regarding this from NHS England.

3.2.8 Neuro-developmental Service: ADHD

The waiting list continues to be of major concern within the service, with the number of service users waiting to be seen being 4844 at the time of writing. The service is currently undertaking work to review the waiting list to ensure that everyone on it is still appropriate to be on the list or is still wanting to be seen. It is anticipated that, as most of the referrals are from the transient student population, there may be some service users who have moved away from the area and no longer require access to the service in Leeds.

Recently, concerns have arisen regarding the pressures within Children and Young People's (CYP) Community Services regarding their capacity to meet the needs of young people referred for ADHD and Autism Spectrum Disorder (ASD) assessments. It is anticipated that some of these young people will 'age out' before

they are seen within CYP Services and will be transferred to adult waiting lists. At present we do not have the level of data to determine the impact this would have on the service. We will be escalating this through the Children & Young People and Learning Disability & Neurodiversity Population Boards along with the Active System Executive Leadership Group to ensure we have a system-wide approach to meet the needs of this population.

3.3 Assure

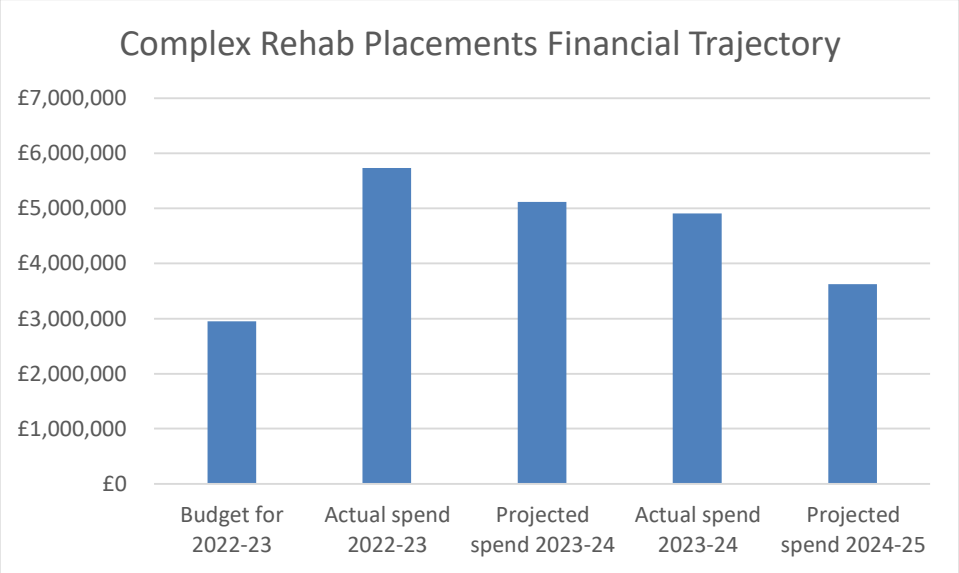
3.3.1 Children and Young Peoples Services: Mill Lodge Day Service (Willow View)

The service opened on the 8 April using a staged approach due to some essential posts not yet being in place. We are only able to currently offer a step-down provision from hospital without the eating disorder provision. One of the recruited dietitians has agreed a start date of 13 June which will support the increased provision the service can offer. All the other posts have been recruited to and are currently being processed via the recruitment processes.

3.3.2 Complex Rehabilitation: Out of Area Placements

We have seen a reduction in our Complex Rehabilitation Out of Area Placements with the position currently being at 21. The service continues to strive to reduce this number further and has identified estimated dates of discharge over the coming year for 12 service users. The service is implementing an approach based on Care and Treatment Reviews (CTR) to improve and support discharge planning. We have exceeded our financial trajectory for 2023/24 and have set a new trajectory for 2024/25 which aims to deliver further savings across the year, as shown below in graph 7.

Graph 7: Complex Rehab Placements Financial Trajectory



3.3.3 Gender Service: Patient Initiated Follow-Up (PIFU)

The Patient Initiated Follow-Up (PIFU) project has been implemented. We anticipate that this will reduce the number of routine follow-up appointments, releasing capacity for additional activity, including initial contacts, assessments and enabling increased capacity on caseloads.

4 SERVICE DEVELOPMENT

4.1 Expression of Interest 24/7 Community Service Pilot

NHS England has requested expressions of interest for the development of 24/7 Community mental health services covering a population of 30,000 to 50,000 people, which equates to the population size of one Primary Care Network (PCN). In partnership with other statutory and voluntary community and social enterprises (VCSE) organisations. The proposal is to submit a bid for up to £2.5m per year (non-recurrent) guaranteed for 2 years. Following an engagement event with stakeholders, service providers, service users, third sector and social care, a draft service model has been proposed which is now being developed into the required business case.

The bid will focus on supporting working age adults with complex needs to step down from inpatient services with a wraparound service put in place to support community-based recovery and support. The bid will also provide services which offer rapid and open access for people experiencing mental health problems and their carers with the aim of maintaining wellness.

Discussions have begun with partners on potential locations for the service and it is likely this will need to be within an existing building which may need further registration with the CQC. Location of the building will influence the location of the PCN selected.

The expression of interest will need to be agreed by all partner organisations prior to submission by the end of May.

4.2 Hub of Hope

The Trust entered a three-year project with Hub of Hope during the last financial year. Hub of Hope is a mental health support database, provided by Chasing the Stigma, a leading mental health charity, bringing together local, national, community, third sector, private and NHS mental health support and services together in one place. Hub of Hope is available through an application for mobile technology and a website.

The Hub of Hope development team together with the service development team and website management team have worked to embed the Hub of Hope link into the Trust's website. In addition, service details have been collated and uploaded to the Hub of Hope to enable service providers in Leeds to access service details.

The next stage of the project is to provide publicity and raise awareness of the link and app and provider Hub of Hope ambassador training. This will be available for a range of staff across a range of providers.

Below is a screen shot from the webpage at www.hubofhope.co.uk

Hub of Hope

If you or someone you know is facing mental distress, you're not alone. The Hub of Hope is a comprehensive directory of support services available near a town, city, or postcode you provide. There is no personal information required.

The Hub of Hope also lists services for family members and friends, ensuring everyone can find the help they need, whether it's for themselves or someone they care about. The services and support listed on the Hub of Hope are not only for when things become unbearable – a crisis point. They are also for those times when we notice we are starting to struggle, or when we need extra support as we start to emerge from a particularly difficult time.

Access the Hub of Hope.

4.3 West Yorkshire Provider Collaborative for Children and Young People

The Deputy Director of Operations has reported on the challenges facing the CYP inpatient service within Red Kite View with regard to staffing.

The team have presented a paper to members of the Executive Team outlining options for support, further analysis and consideration is being given to these options. In addition, the team are considering the learning emerging from this exercise which includes

- Is the operating model fit for purpose?
- Could alternative approaches to escalation of issues be undertaken sooner?
- Could alternative workforce models be appropriate?

The consideration to reducing capacity for the unit will add to the financial challenge the PC faces. £1m of transitional funding has ended from NHS England that was to support high-cost packages of care in Out of Area Placements. Reduction in capacity adds to the financial pressure and an associated financial recovery plan is being developed.

4.4 Community Mental Health Transformation

The launch of the three earlier adopter sites in March continues to progress well and early indications are that service user and staff experience of operating in a more integrated team is making improvements. Early indications suggest there has been a considerable rise in referrals to primary care mental health services. This is being corroborated and monitored to ensure this element of the service does not become

overwhelmed and waiting times escalate further. Leeds Community Healthcare, as the provider of this element of the service, has been asked to address this.

The business case to support the recruitment of additional medical staff has not yet been approved by the Partnership Board which meets in May 2024.

It should ne noted that the Partnership Board will hold its first meeting in May as the Board transition from Programme Board to Partnership Board.

4.5 Chronic Fatigue Service and Long Covid Service

Leeds Place ICB, through the Long-Term Conditions Population Board, has commenced a review of the Chronic Fatigue Service and Long Covid Service to consider the longer term future predominantly of the Long Covid Service. Further updates will be brought through our governance arrangements in due course.

4.6 Liaison and Diversion Service

The Liaison and Diversion Service is due to be retendered in the next two months and discussions with Wakefield Council, as Lead Provider, have commenced to consider future options. A more detailed proposal is being developed.

5 SUMMARY

We continue to manage and lead a response to 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:

Mark Dodd, Deputy Director of Operations
Alison Kenyon, Deputy Director of Service Development
Andrew Jackson, EPRR Lead and Corporate Manager

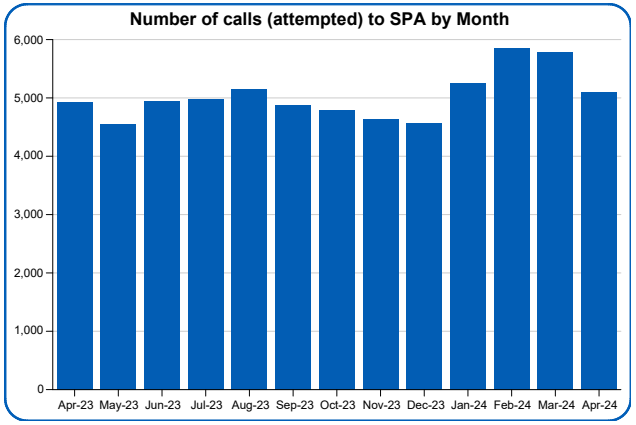
Service Performance - Chief Operating Officer

Services: Access & Responsiveness: Our response in a crisis	Target	Feb 2024	Mar 2024	Apr 2024
Percentage of crisis calls (via the single point of access) answered within 1 minute	-	38.8%	34.5%	32.3%
Percentage of ALPS referrals responded to within 1 hour	-	76.9%	78.9%	82.1%
Percentage of S136 referrals assessed within 3 hours of arrival	-	8.6%	10.3%	14.0%
Number of S136 referrals assessed	-	35	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%	77.8%	66.7%	60.7%
Percentage of service users who stayed on CRISS caseload for less than 6 weeks	70.0%	90.4%	84.8%	89.1%
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support	50.0%	46.5%	43.9%	36.8%
Percentage of CRISS caseload where source of referral was acute inpatients	-	6.8%	11.8%	9.3%
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services	**Target**	**Feb 2024**	**Mar 2024**	**Apr 2024**
Gender Identity Service: Number on waiting list	-	5,626	5,745	5,821
Deaf CAMHS: average wait from referral to first face to face (inc. telemedicine) contact in days	-	212.08	140.44	143.85
Community LD: Percentage of referrals seen within 4 weeks of receipt of referral	90.0%	75.0%	51.4%	60.5%
Leeds Autism Diagnostic Service (LADS): Percentage starting assessment within 13 weeks (quarterly)	-	-	24.4%	-
CAMHS inpatients: Proportion of people assessed within 7 days of admission (HoNOSCA / GBO) (quarterly)	100.0%	-	40.0%	-
Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency) (quarterly)	-	-	90.3%	-
Perinatal Community: Percentage of routine referrals waiting less than 2 weeks for assessment (quarterly)	-	-	93.5%	-
Perinatal Community: Total number of distinct women seen in rolling 12 months (quarterly)	863	-	966	-
Perinatal Community: Face to Face DNA Rate (quarterly)	-	-	7.9%	-
Services: Our acute patient journey	**Target**	**Feb 2024**	**Mar 2024**	**Apr 2024**
Number of admissions to adult facilities of patients who are under 16 years old	-	0	0	0
Crisis Assessment Unit (CAU) bed occupancy	-	96.0%	100.0%	94.4%
Crisis Assessment Unit (CAU) length of stay at discharge	-	45.14	26	27
Liaison In-Reach: attempted assessment within 24 hours	90.0%	81.6%	80.6%	86.7%
Bed Occupancy rates for (adult acute excluding PICU) inpatient services:	94.0% - 98.0%	99.2%	100.2%	100.4%
Becklin Ward 1 (Female)	-	100.6%	99.9%	102.6%
Becklin Ward 3 (Male)	-	100.0%	100.7%	99.2%
Becklin Ward 4 (Male)	-	100.2%	101.8%	99.7%
Becklin Ward 5 (Female)	-	97.2%	98.8%	99.8%
Newsam Ward 4 (Male)	-	98.2%	99.8%	100.5%
Older adult (total)	-	99.8%	96.3%	98.5%
The Mount Ward 1 (Male Dementia)	-	99.3%	98.9%	101.4%
The Mount Ward 2 (Female Dementia)	-	106.4%	99.6%	100.2%

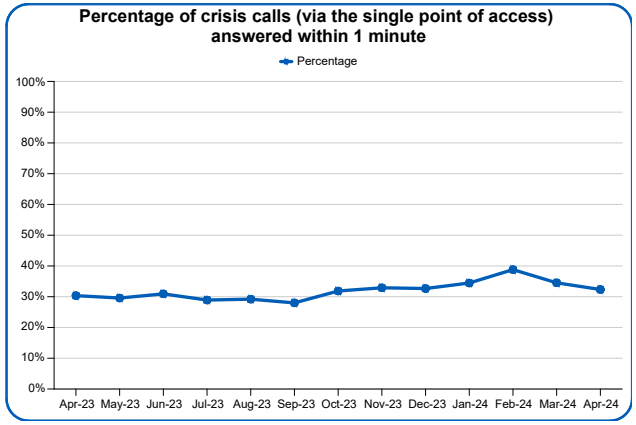
Service Performance - Chief Operating Officer

Services: Our acute patient journey	Target	Feb 2024	Mar 2024	Apr 2024
The Mount Ward 3 (Male)	-	94.5%	87.7%	91.0%
The Mount Ward 4 (Female)	-	100.5%	100.5%	102.4%
Percentage of delayed transfers of care	-	19.2%	15.9%	17.3%
Out of Area Trajectory Active Placements at Month End	34	-	-	38
Total: Number of out of area placements beginning in month	-	29	17	20
Total: Total number of bed days out of area (new and existing placements from previous months)	-	1,124	1,250	1,156
Acute: Active Placements at Month End	-	-	-	31
Acute: Number of out of area placements beginning in month	-	22	10	12
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	933	998	927
PICU: Active Placements at Month End	-	-	-	5
PICU: Number of out of area placements beginning in month	-	7	6	6
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	191	250	204
Older people: Active Placements at Month End	-	-	-	2
Older people: Number of out of area placements beginning in month	-	0	1	2
Older people: Total number of bed days out of area (new & existing placements from previous months)	-	0	2	25
Cardiometabolic (physical health) assessments completed: Inpatients (quarterly)	80.0%	-	69.4%	-
Services: Our Community Care	**Target**	**Feb 2024**	**Mar 2024**	**Apr 2024**
Percentage of inpatients followed up within 3 days of discharge (Trust Level monthly local tracking)	80.0%	68.1%	75.3%	87.2%
Percentage of inpatients followed up within 3 days of discharge (HCP commissioned services only)	80.0%	77.6%	75.7%	86.3%
Number of service users in community mental health team care (caseload)	-	3,284	3,231	3,225
Percentage of referrals to memory services seen within 8 weeks (quarter to date)	70.0%	71.6%	74.9%	75.6%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50.0%	39.6%	42.1%	41.1%
Early intervention in psychosis (EIP) or at risk mental state (ARMS): Percentage starting treatment within 2 weeks	60.0%	63.6%	69.6%	41.2%
Early intervention in psychosis (EIP) : Percentage of people discharged to primary care (quarterly)	-	-	66.2%	-
Cardiometabolic (physical health) assessments completed: Early Intervention in Psychosis Service (quarterly)	90.0%	-	77.1%	-
Services: Clinical Record Keeping	**Target**	**Feb 2024**	**Mar 2024**	**Apr 2024**
Percentage of service users with NHS Number recorded	-	99.3%	99.3%	99.3%
Percentage of service users with ethnicity recorded	-	81.7%	81.7%	81.6%
Percentage of service users with sexual orientation recorded	-	47.6%	47.6%	47.4%
Services: Clinical Record Keeping - DQMI	**Target**	**Nov 2023**	**Dec 2023**	**Jan 2024**
DQMI (MHSDS) % Quality %	95.0%	92.4%	92.4%	92.3%

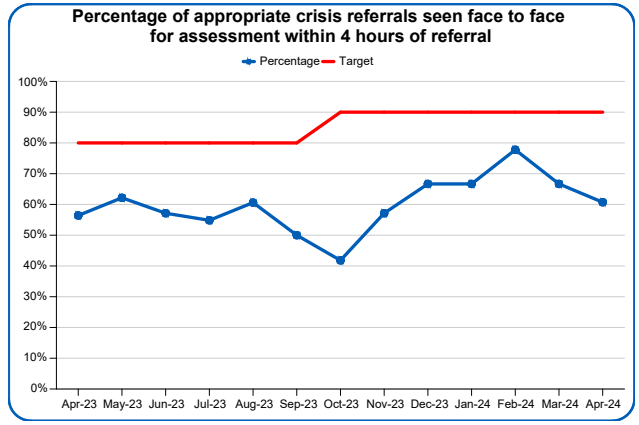
Services: Access & Responsiveness: Our Response in a crisis



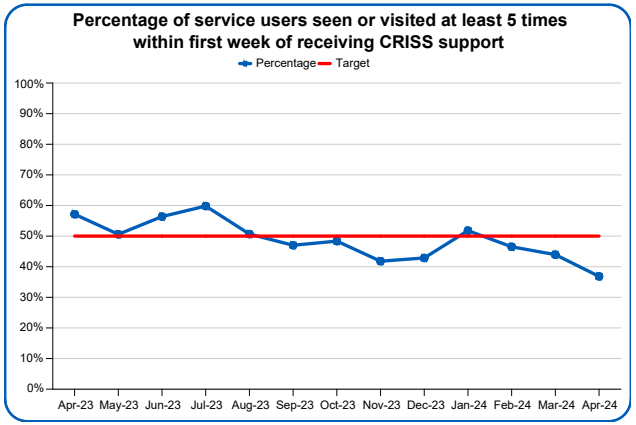
Number of calls : April 5,112



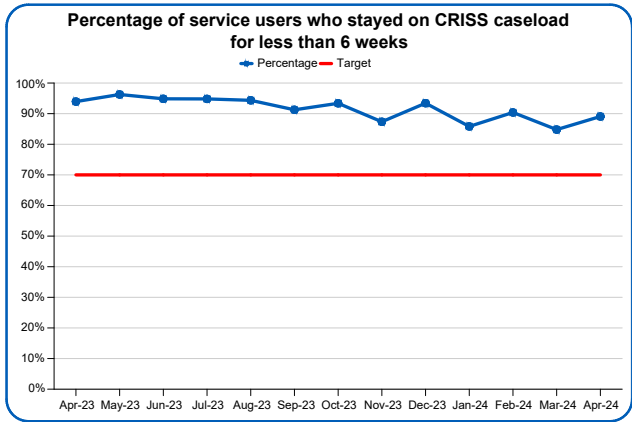
Local target - within 1 minute: April 32.3%



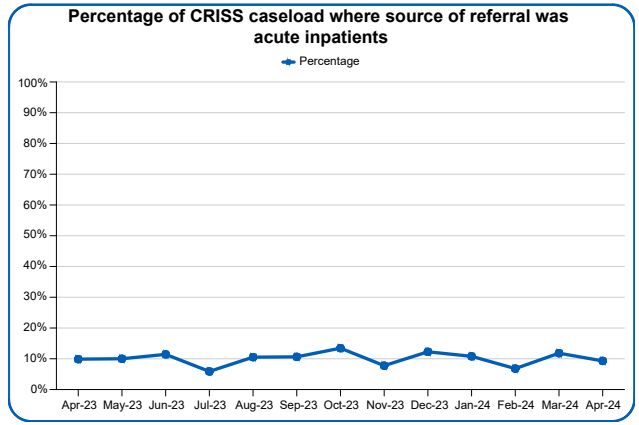
Contactual Target 90%: April 60.7%



Contractual Target 50%: April 36.8%

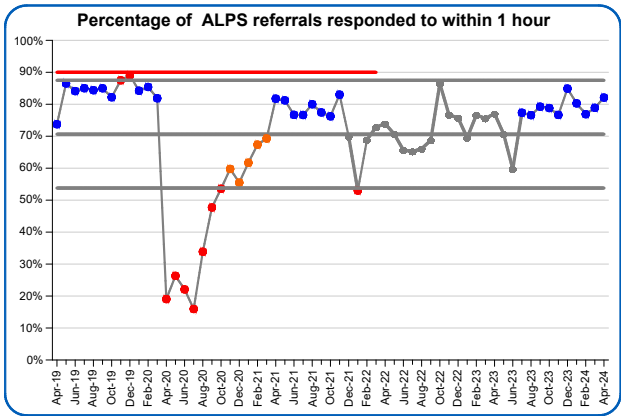


Contractual Target 70%: April 89.1%

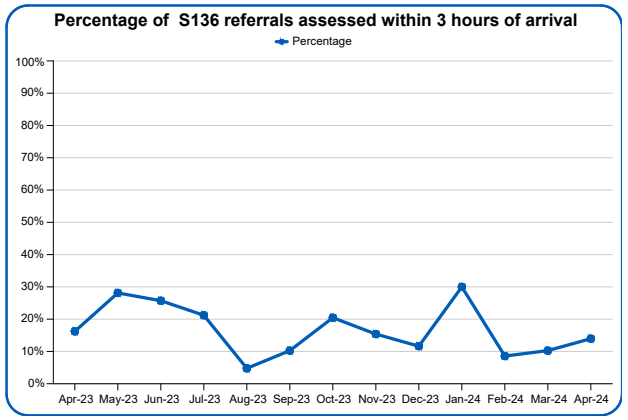


Contractual Target tba: April 9.3%

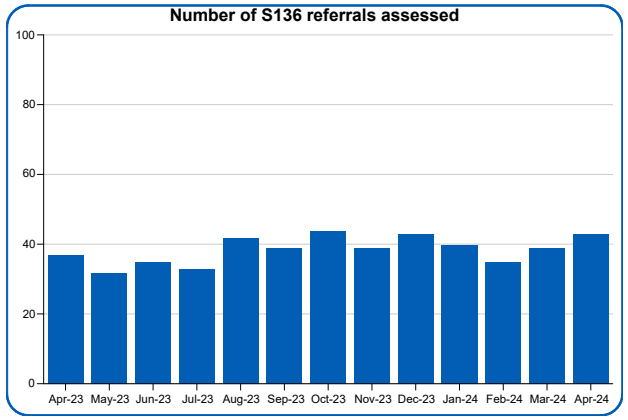
Services: Access & Responsiveness: Our Response in a crisis (continued)



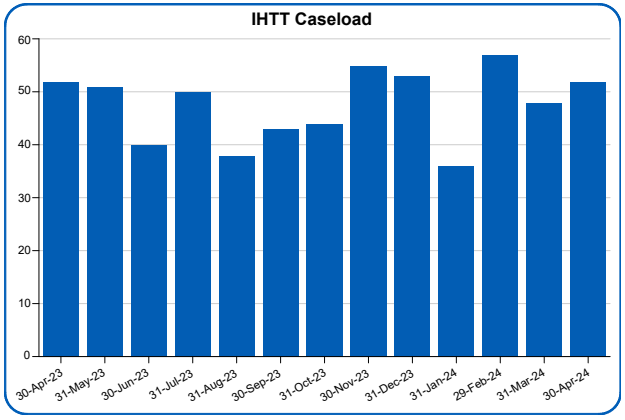
Contractual Target : April 82.1%



Contractual Target : April 14.0%

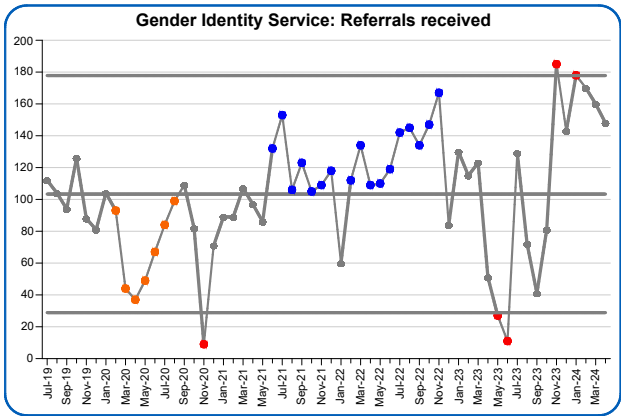


Total referrals assessed: April 43

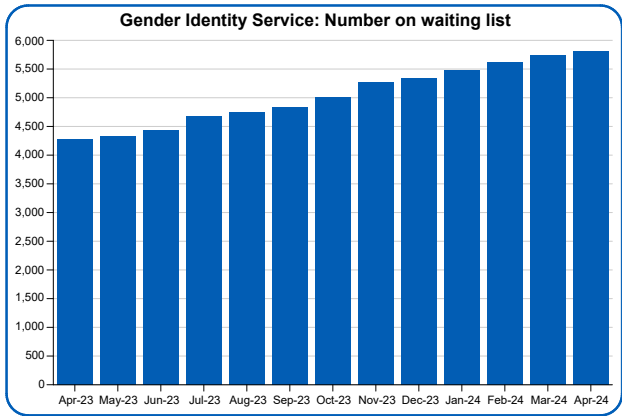


Caseload: April 52

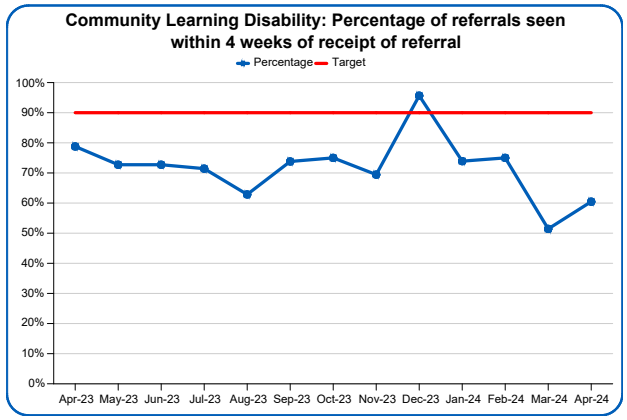
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services



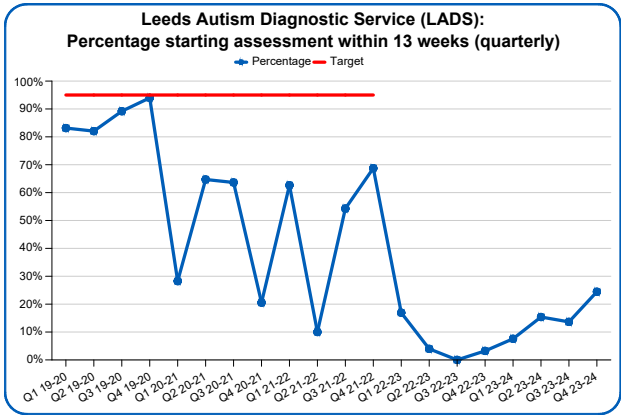
Total referrals: April 148



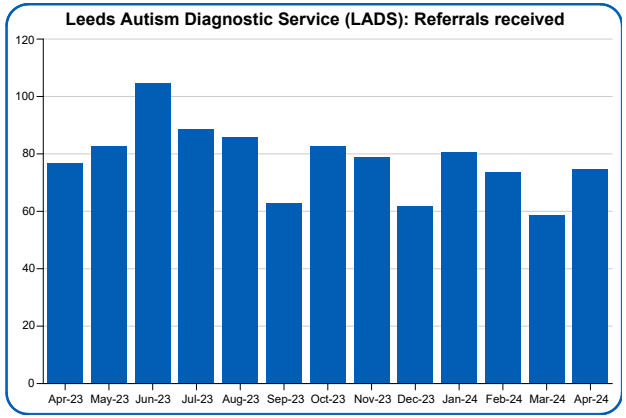
Number on waiting list: April 5,821



Contractual Target 90%: April 60.5%



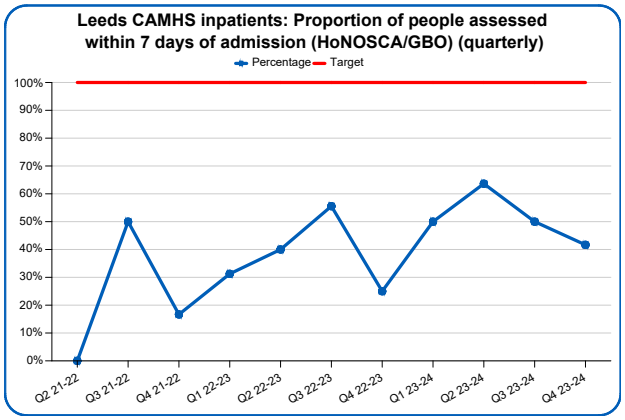
Contractual Target : Q4 24.4%



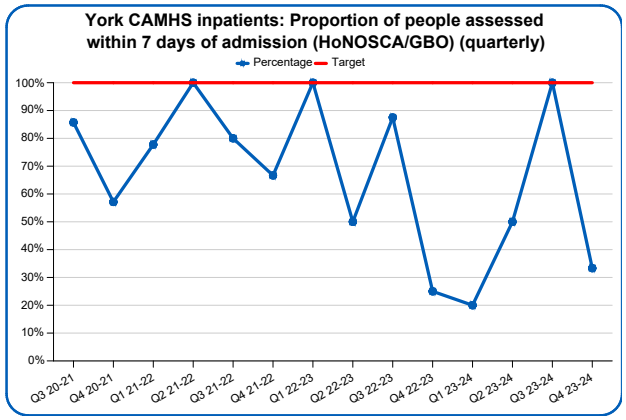
Local measure: April 75

SPC Chart Key

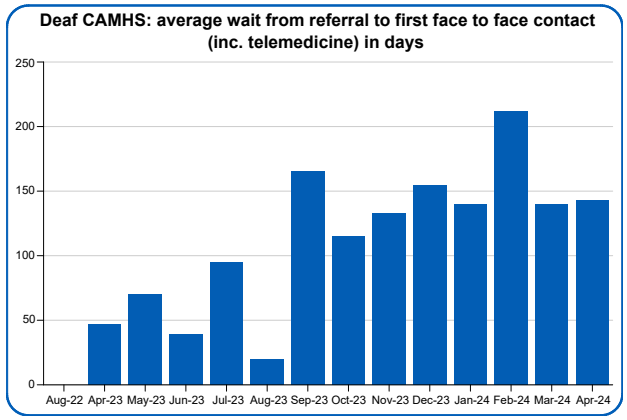
- Average
- Lower process limit
- Target
- Upper process limit
- Actual



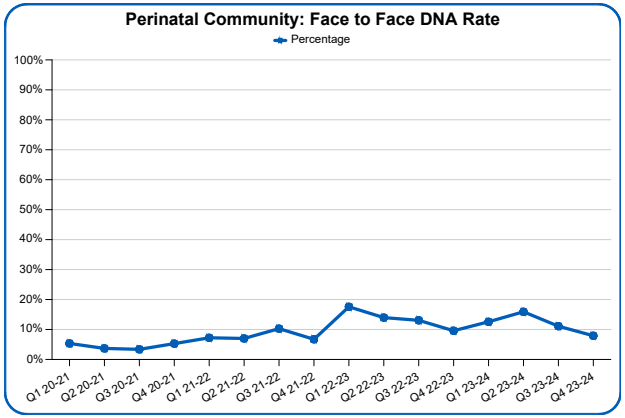
Contractual Target 100%: Q4 41.7%



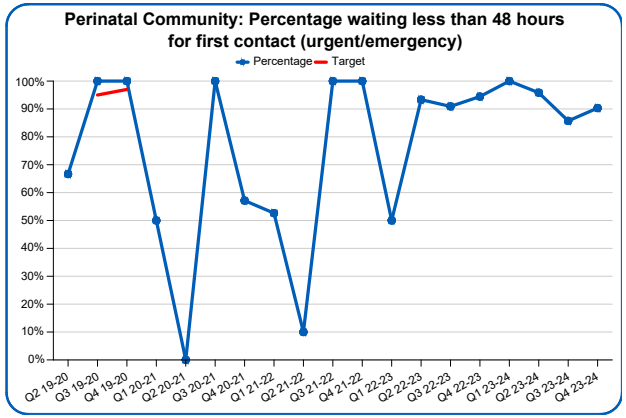
Contractual Target 100%: Q4 33.3%



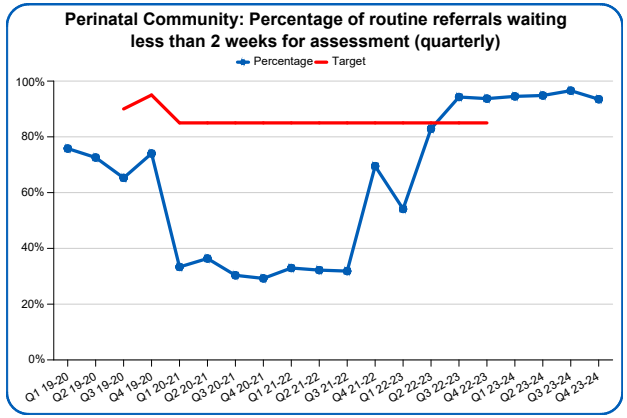
Local measure: April 144



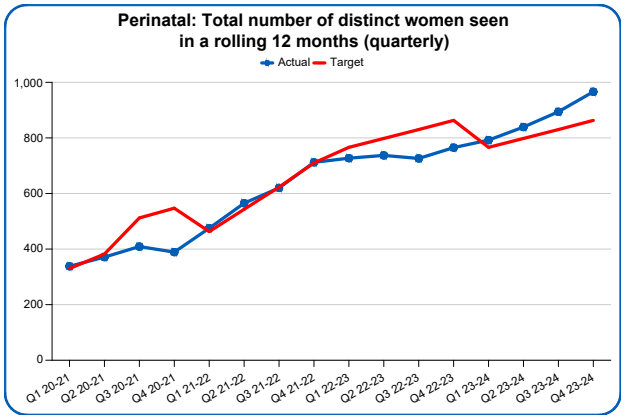
Contractual measure: Q4 7.9%



Contractual Target tba: Q4 90.3%

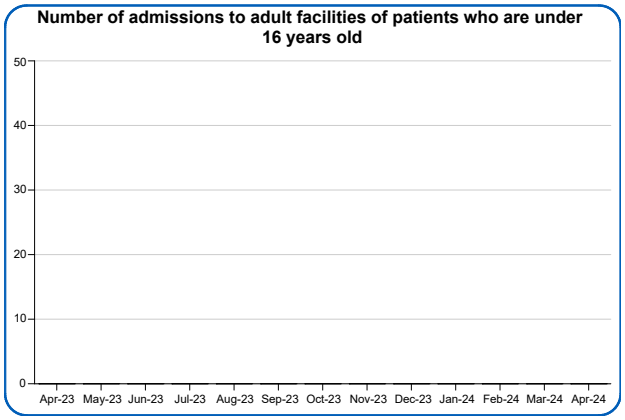


Contractual Target : Q4 93.5%

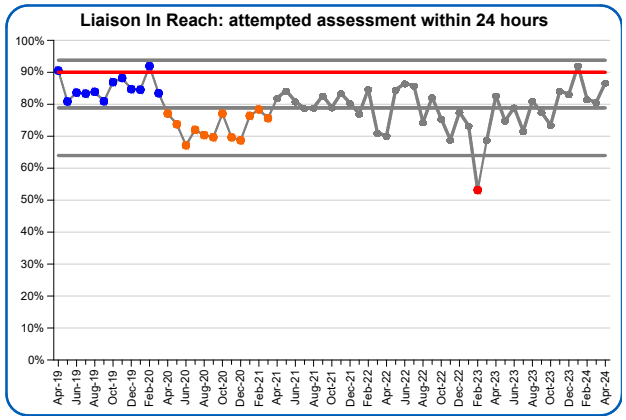


Local measure 863: Q4 966

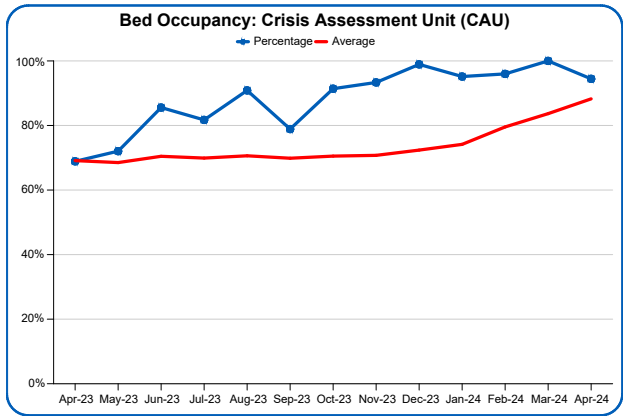
Services: Our acute patient journey



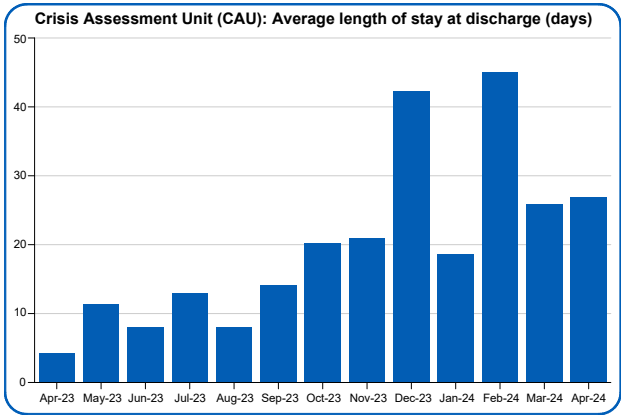
National (NOF) No target : April 0



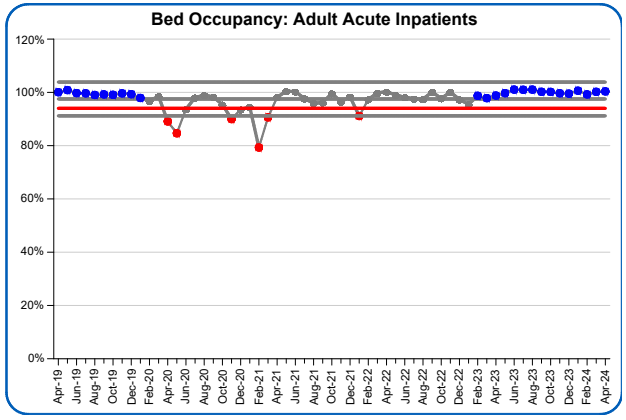
Contractual Target 90%: April 86.7%



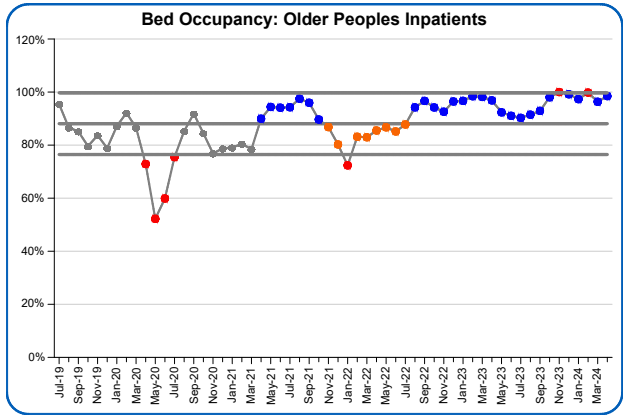
Local measure: April 94.4%



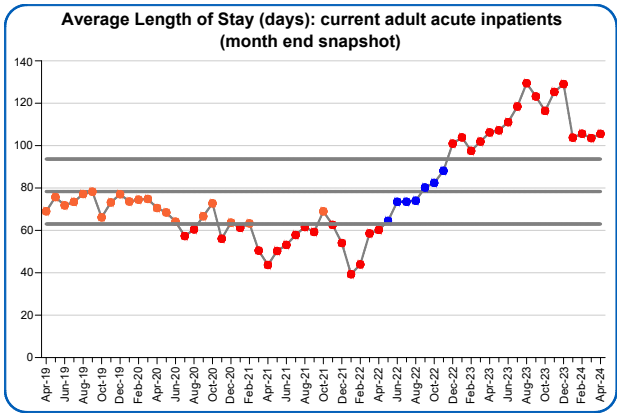
Local measure: April 27 days



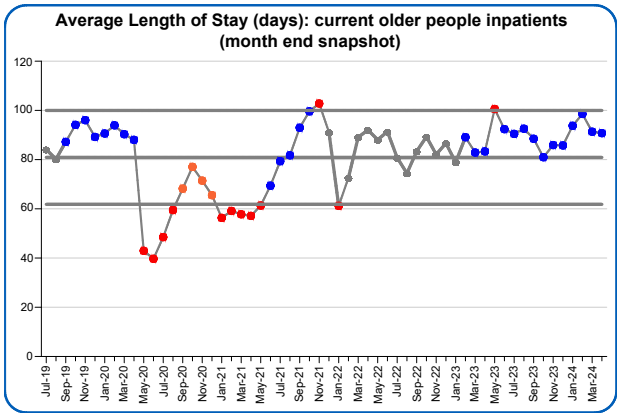
Contractual Target 94%: April 100.4%



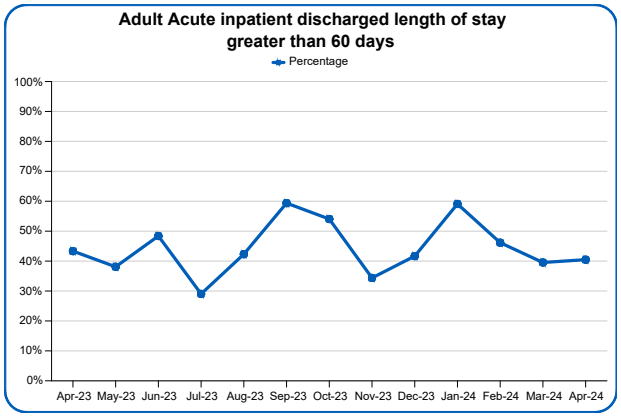
Local measure and target : April 98.5%



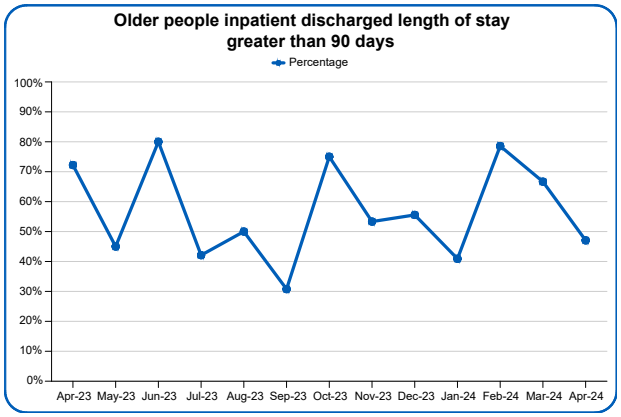
Local tracking measure: April 106 days



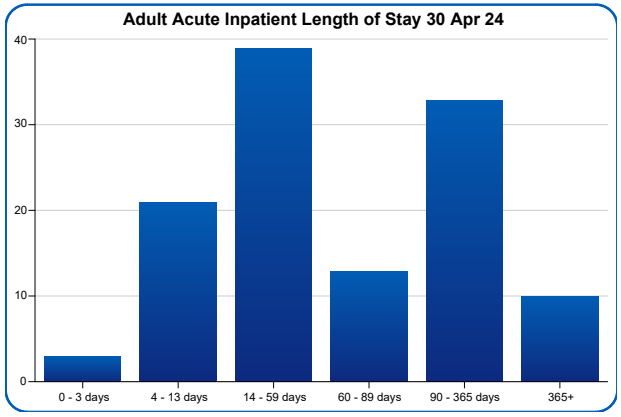
Local tracking measure: April 91 days



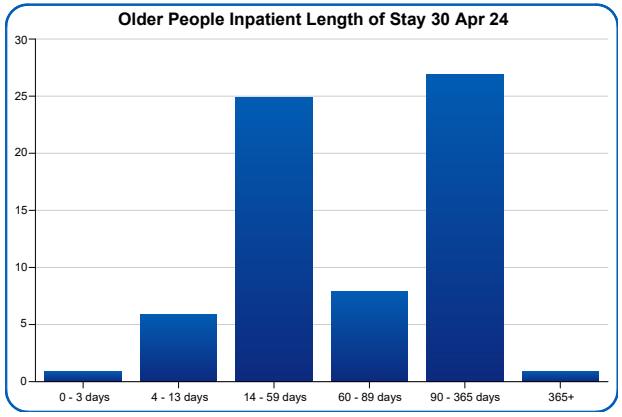
National (LTP): April 40.5%



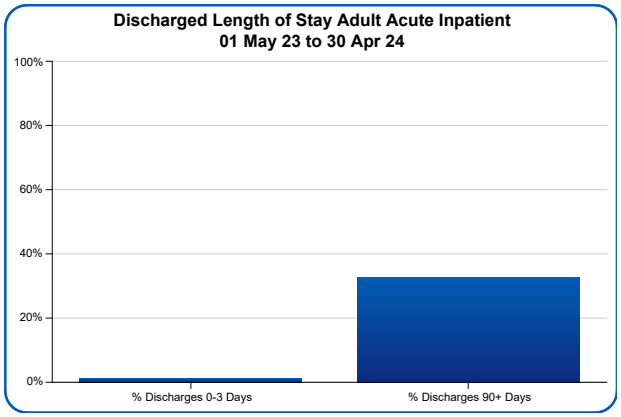
National (LTP): April 47.1%



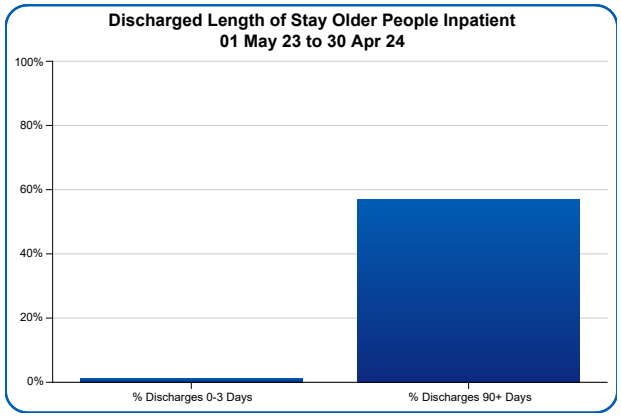
Local activity: 43 people with LOS 90+ days



Local activity: 28 people with LOS 90+ days

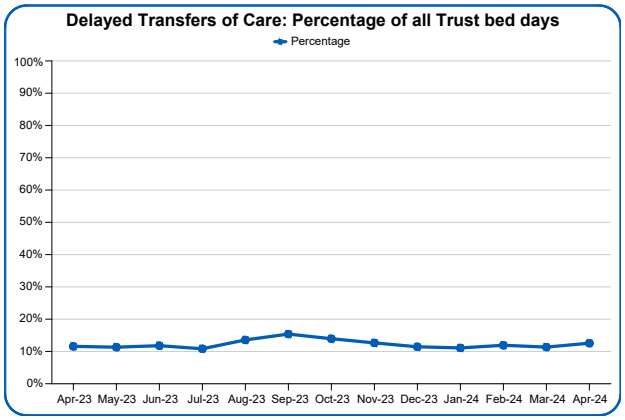


Local activity: % discharged LOS 90+ days = 33.0%

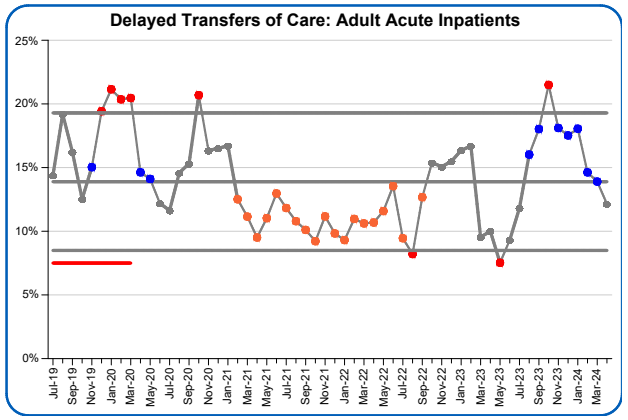


Local activity: % discharged LOS 90+ days = 57.3%

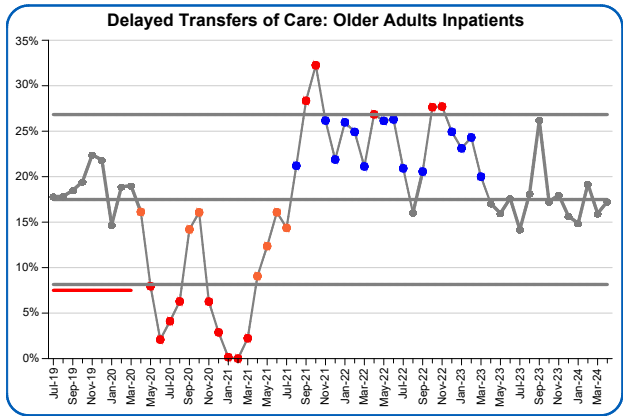
Services: Our acute patient journey (continued)



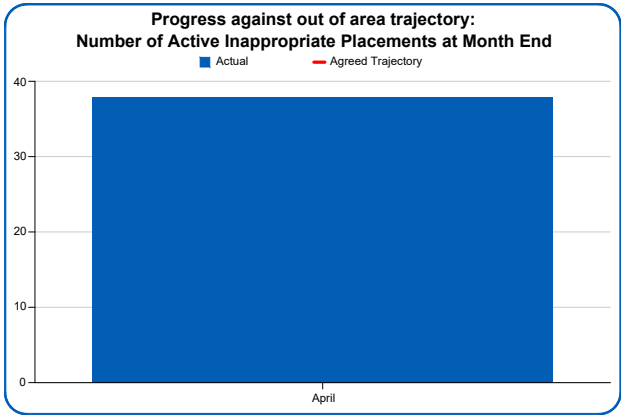
Local tracking measure: April 12.6%



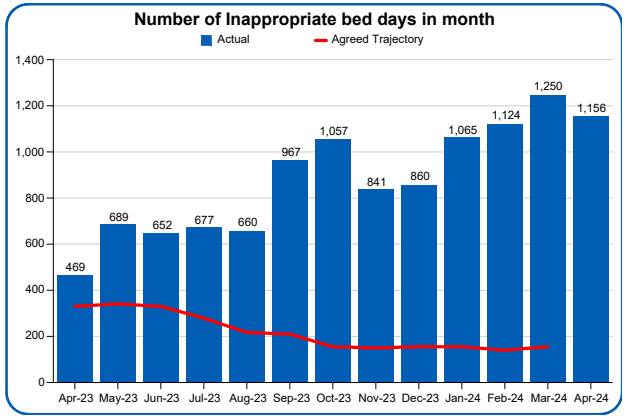
Local tracking measure: April 12.1%



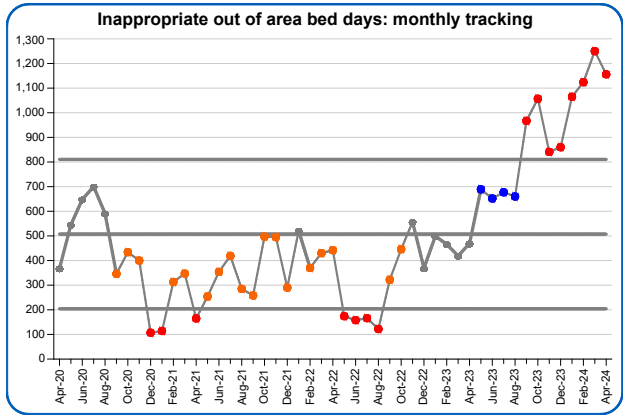
Local tracking measure: April 17.3%



Nationally agreed trajectory (April: 34): April 38 active placements

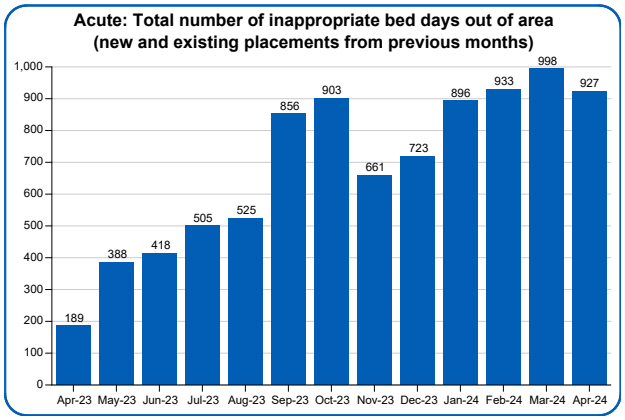


Local tracking measure: April 1,156 bed days

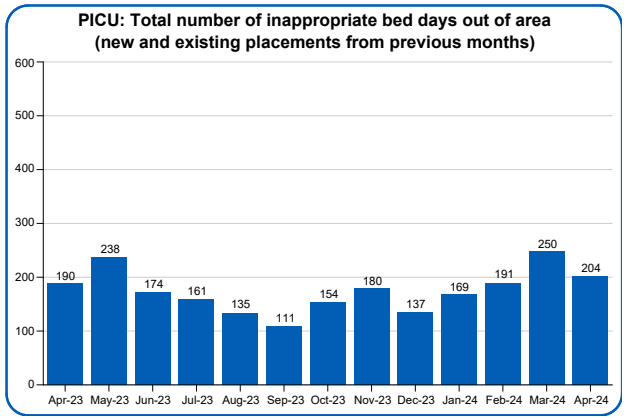


Local tracking measure: April 1,156 bed days

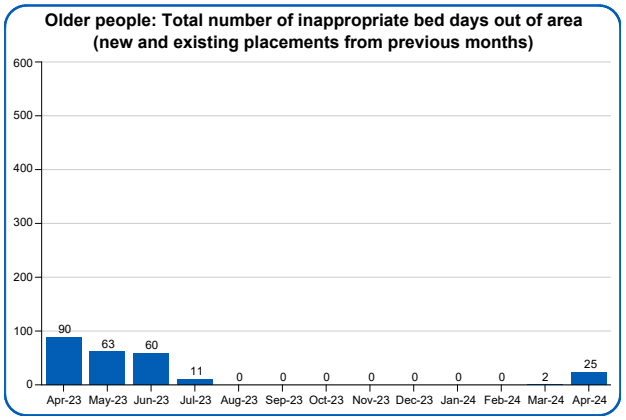
Services: Our acute patient journey (continued)



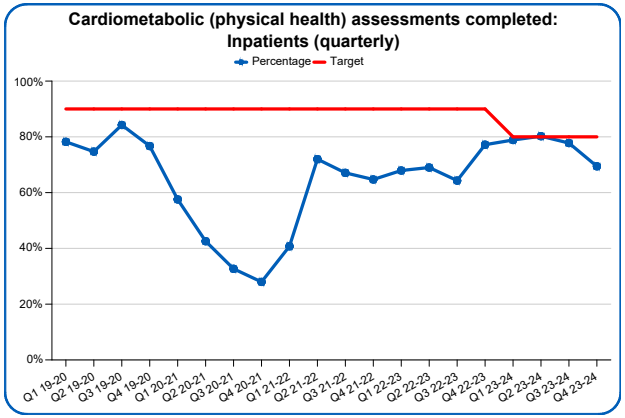
Nationally agreed trajectory (): April 927 days



Nationally agreed trajectory (): April 204 days

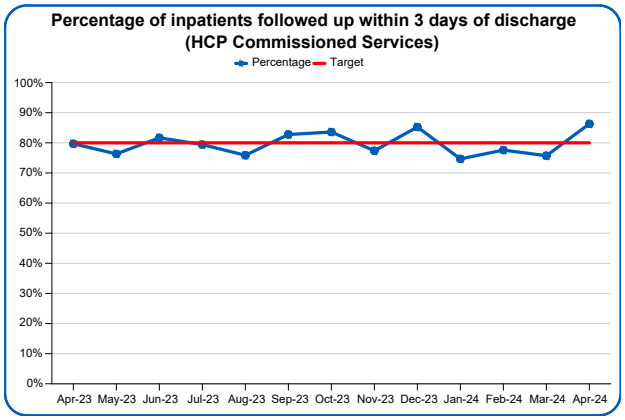


Local measure : April 25 days

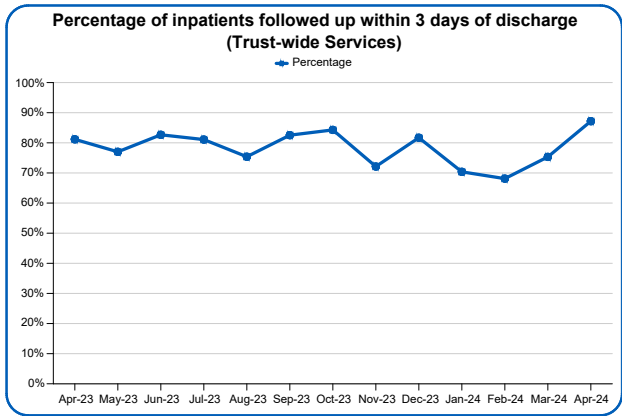


Contractual target 80%: Q4 69.4%

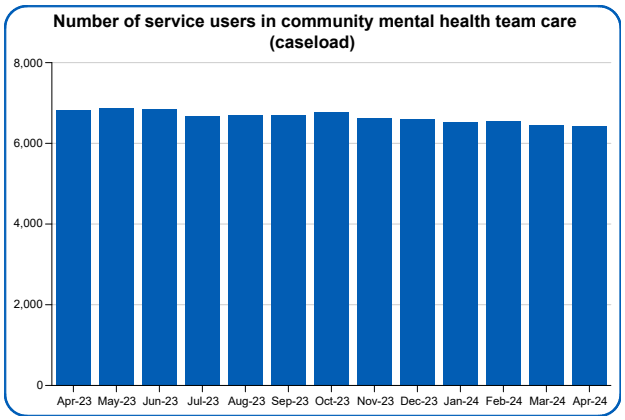
Services: Our community care



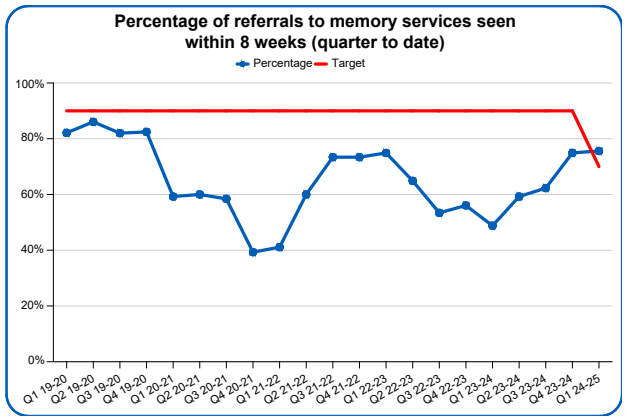
Contractual target 80%: April 86.3%



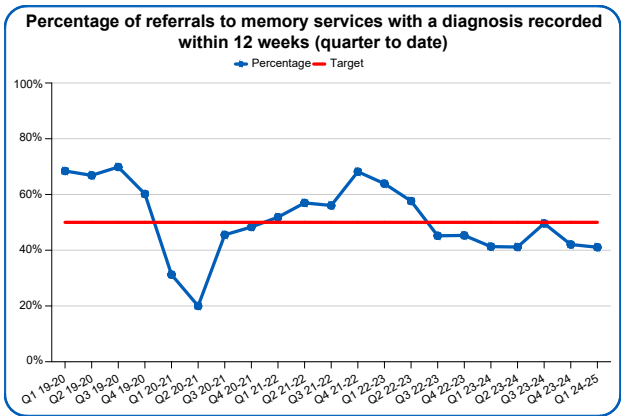
Local Tracking Measure 80%: April 87.2%



Local measure : April 3,225



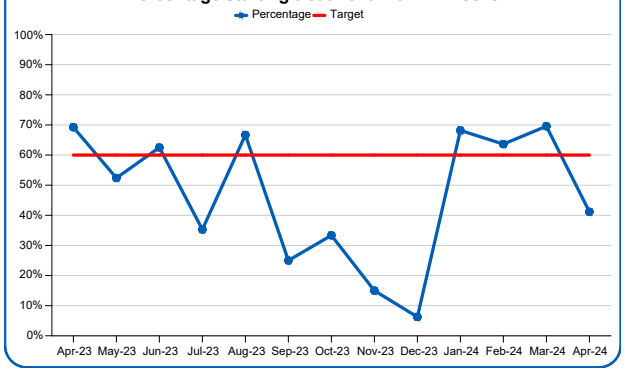
Contractual target 70%: Q1 24-25 75.6%



Contractual target 50%: Q1 24-25 41.1%

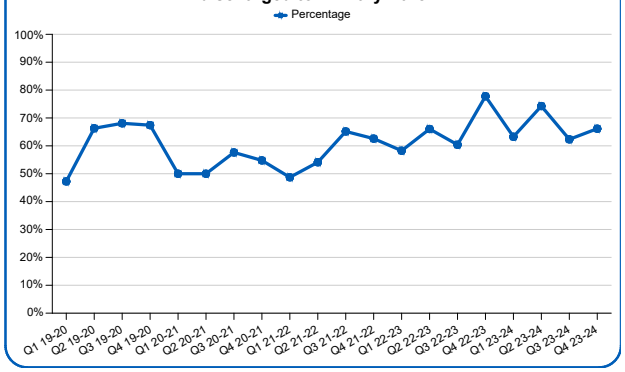
Services: Our community care (continued)

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



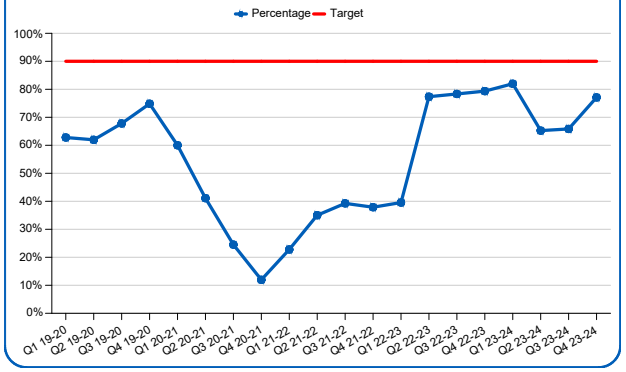
Contractual target 60%: April 41.2%

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



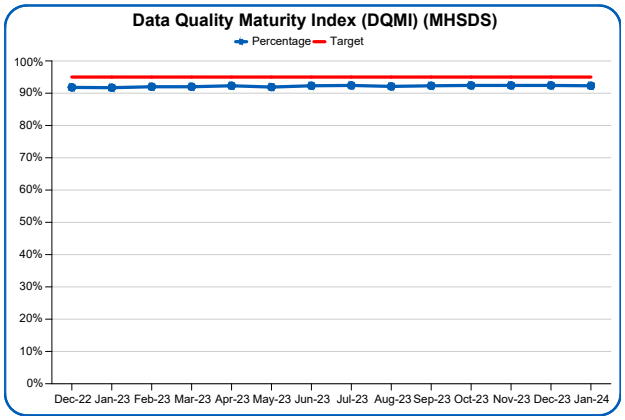
Contractual target tbc: Q4 66.2%

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

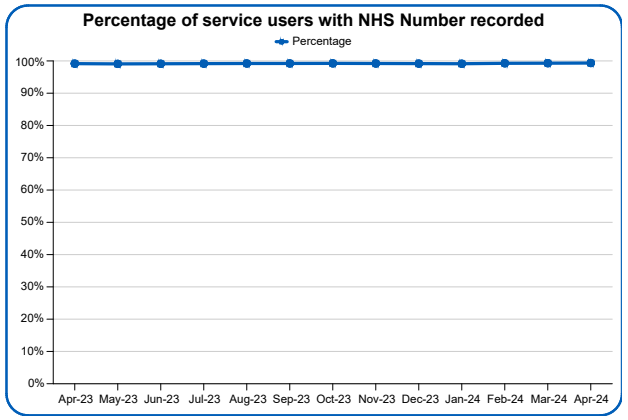


Contractual target 90%: Q4 77.1%

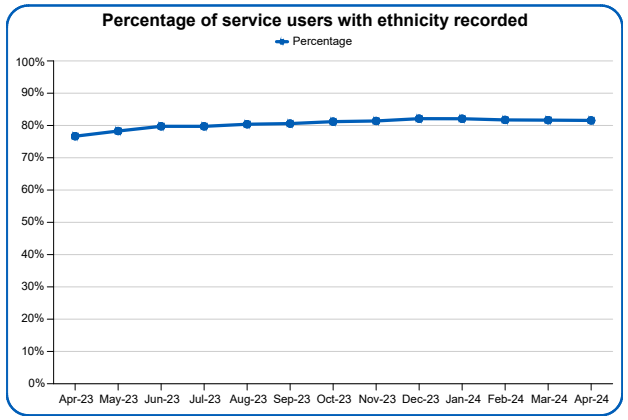
Services: Clinical Record Keeping



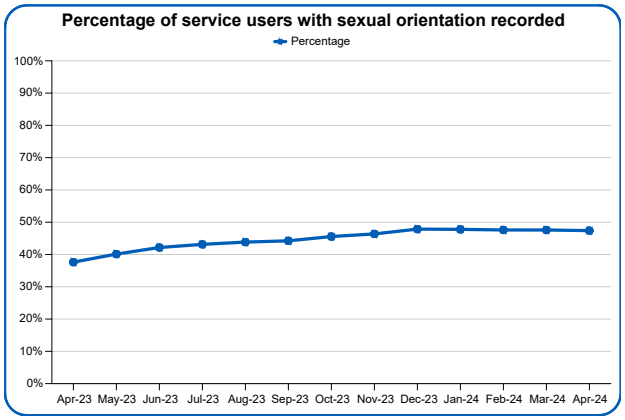
CQUIN / NHSOF Target 95%: January 92.3%



Local measure: April 99.3%



Local measure: April 81.6%



Local measure: April 47.4%

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
14.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Annual EPRR Report 2023-2024
DATE OF MEETING:	30 May 2024
PRESENTED BY: (name and title)	Joanna Forster Adams - Chief Operating Officer and Accountable Emergency Officer
PREPARED BY: (name and title)	Andrew Jackson – Resilience Lead and Corporate Business Manager

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

EXECUTIVE SUMMARY

The attached document summarises the EPRR teams work over the year from 1 April 2023 to 30 March 2024. NHS England have made it a mandatory requirement for a report to be made to Board not less than annually by the Accountable Emergency Officer.

The report covers the assurance standards and work to improve on the areas of partial and non-compliance for 2024, the other work carried out in 2023-2024, the new impact of NHS commander portfolios for staff at the trust along with a report on the main disruptive incidents in the year.

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 approve 2023-2024's annual EPRR report and note the breadth of work carried out during the year.

Leeds and York Partnership NHS Foundation Trust

Emergency Preparedness, Resilience and Response (EPRR)

Annual Report 2023-2024

1. Introduction

The Trust, as an NHS funded organisation, is required to comply with NHS England's Core Standards for EPRR. One of these standards requires that *the Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually.*

This report meets this requirement and covers the period from 1 April 2023 to 31 March 2024.

2. Report Regarding EPRR Activities in 2023-2024

2.1. 2023 NHS England EPRR Core Standards

The Trust achieved 26% compliance with core standards in 2023. This is classed as non-compliant. This was against a radically different assessment regime with new compliance criteria and based on submission of evidence against each of the 58 relevant standards by NHS England staff.

Overall, the Trust positions was:

Category	**Compliant**	**Partially Compliant**	**Non-compliant**
NHS England assessment	**15**	**42**	**1**

To place this into context, all organisations in the Yorkshire and Humber area were assessed as non-compliant.

A detailed action plan has been developed to improve the Trust's compliance in areas identified as non-compliant and partially compliant. The Trust's EPRR team are working with colleagues in the West Yorkshire ICB and with all other mental health Trusts in the Yorkshire and Humber area to share best practice and develop improved EPRR arrangements to improve scores across the area.

2.2. Statement of readiness

The Trust has increased its EPRR resource in 2024 and staff are engaged in work to improve EPRR arrangements across all domains of NHS EPRR core standards. Coordinated collaborative working across all NHS bodies in the area and in particular with Mental Health providers across Yorkshire and Humber is occurring to share best practice and develop new plans and arrangements. The Trust is confident it can meet its responsibilities regarding EPRR in the coming year.

3. Overview of Readiness Activities in 2023-2024

In response to the 2023 EPRR core standards the EPRR team has:

3.1. Business Continuity

In response to criticism in the 2023 EPRR core standards process the EPRR team has redesigned the Business Continuity process making it accord more closely with the NHS England toolkit. This includes a new business continuity handbook for staff to help them develop their service plans.

The Trust's maintenance of business continuity plans will take time to improve – many services while having plans have not updated these recently. NHS England expect annual revision or at least checking of the continuing accuracy of business continuity plans.

Engagement sessions with staff have been taking place and this has been aimed at encouraging staff who would have to take part in the response (band 6 and 7 nurses for example) to get an understanding of how business continuity plans are developed and how they are used.

3.2. Risk Management

Risks in the context of EPRR differ from business-as-usual risks in that there is a requirement to recognise risks from other risk registers on the Trust's EPRR risk register and to maintain "cloud on the horizon" type risks on the risk register indefinitely – e.g. the risk of another pandemic.

Following discussions in 2023 with executive directors at Executive Risk management group an approach based on an EPRR risk management procedure that, while being complaint with the Trust's Risk Management Policy, covers additional requirements such as a dedicated EPRR risk register, a managed escalation to the Trust's risk register, escalation of risks to the ICB and on to the regional risk register and active sharing of risks with other NHS bodies. This new procedure is set to be ratified in May 2024.

3.3. Chemical, Biological, Radiological and Nuclear (CBRN)

In 2023's NHS England review the Trust scored poorly in relation to this domain of activity. Considerable work has been done around this area in 2023-2024:

- The exercise carried out in September 2023 at the Becklin Centre has been debriefed and significant learning is currently being included in planning documents and the next exercise planned for later in 2024.
- The team has developed revised training materials for training reception staff and responders.
- A system of checking on decontamination boxes and contents including expiry dates of PPE is in place.

- A risk assessment process is being developed that identifies the risk of having to deal with a CBRN incident in Trust locations – this will govern location of decontamination boxes and staff training requirements.

3.4. EPRR plans, Policies and Procedures

NHS England EPRR Core Standards requires plans and policies to be current (defined as being no more than one year old) and hence all EPRR documents are being reviewed, where deemed non-compliant updated with NHS England recommendations and additional plans developed to meet any identified gaps.

Additionally, the EPRR team are developing local working instructions to cover processes around communication tests, checking EPRR equipment and other team duties. These are signed off in the EPRR Group.

3.5. EPRR training

Formal portfolios for Health Commanders at tactical and strategic level are now mandated for NHS organisations. Identification of training requirements and sources of some training has been problematic as has getting clarification about exact syllabus requirements.

For the Trust about 60 staff are required to do one of the three published portfolios (Those on executive on call – Strategic, those on the clinical manager on call – Tactical and EPRR mangers – EPRR specialist).

The EPRR team are working on assisting those with portfolio responsibilities to carry out requisite training by providing updates to available courses and a series of meetings advising of the rollout of training.

3.6. Incidents

3.6.1. IT outage – Virgin Media Cable May 2023

This incident started on 23 May 2023 when an alert was received by EPRR from the Becklin centre about loss of access to Care Director and Electronic Prescriptions. This was resolved by ICT staff but shortly afterwards a second outage occurred that affected huge parts of Leeds.

The second outage was discovered to be affecting major parts of Leeds and was caused by a contractor for a new internet cable provider severing the main virgin net cable into the city. The outage affected other NHS bodies in the city. The Trust declared a business continuity incident and established command and control structures.

The incident severed all access to cloud hosted applications initially although for building based staff a workaround was developed by ICT. Community based staff and staff who were home based could not use the Trust wide area network or applications until the Virgin Media cable was restored.

3.6.2. St Mary’s Hospital Security Incident

This incident involved a service user coming onto St Mary's Hospital site and threatening staff in the West Working Age Adult Community Team. This prompted an attempt to impose lockdown on the site which was not done effectively or in a coordinated manner.

The Chief Operating Officer was personally involved in the incident as a meeting they were attending was affected by the lockdown attempt and observed the issues with attempting to lockdown buildings.

Issues identified in the EPRR team's facilitated debrief largely concurred with a review by Internal Audit about security arrangements, the lack of a security strategy, how security incidents are managed and communication shortcomings.

3.6.3. Heatwave Response

The Trust enacted its heatwave plan on two occasions in June 2023 and one occasion in September when faced with temperatures in the high 20s Celsius. The Trust stands up a heatwave planning group every May to coincide with the onset of Heat Health Alert system run by UK Health Security Agency.

The planning group becomes a response group when heatwave is announced and manages the detailed response around distribution of equipment, water and cooling products and advice.

A debrief was held at the end of summer 2023 and the main issues were:

- Still heat issues with some of our inpatient units – while some small improvements are being explored the lack of air conditioning in much of our inpatient estate does impact on staff and patients during heat events.
- Some of the portable air-cooling equipment makes little or no difference on reducing heat.
- More timely messaging to patients and carers around heat events.
- More consideration in business continuity plans around disruption caused by extreme weather is required.

3.6.4. Industrial Action

Industrial action by medical staff has continued in 2023-2024. The extent of action took up significant EPRR resources and meant other activities had to be postponed as 2023 progressed.

For all notified action the Trust instituted command and control arrangements centred on the Industrial Action Coordination group chaired by an executive director - normally the Chief Operating Officer.

During periods when industrial action was not announced detailed planning work continued as did risk assessment and communication with stakeholders. This occurred in the Industrial Action Planning Group and Tactical Group.

Debriefing the incident proved difficult given its duration but a debrief process did result in findings around:

- Recording medical staff absence on E-roster
- Future composition of medical rotas required assessment in terms of numbers of staff on these rotas.
- The need to be more focussed on risk to patients caused by disruption and factor in clinical lead attendance at meetings.
- Disproportionate impacts on older peoples' services and particular Memory Services.

Generally, instances of action were effectively managed, and no adverse consequences occurred in any period of action.

3.7. Exercise and Testing

Two significant exercises took place in 2023-2024. These are described below:

3.7.1. Chemical Decontamination Exercise September 2023

This exercise was held at the Becklin Centre and featured a response to three self-presenters (portrayed by staff) entering the Becklin Centre reporting having white power thrown on them at a bus stop nearby.

The exercise simulated a decontamination response at reception involving reception staff and nursing staff. A tactical command was established elsewhere within the Becklin Centre that lead the response.

The purpose of the exercise was to give staff the experience of decontaminating patients, experience of being involved in an incident command structure and being a tactical commander. Loggist were also involved to give these key members of the incident team experience of maintaining an incident log.

External interest was high for the exercise and observers from most of Yorkshire and Humber's Mental health trusts attended as well as NHS England. Overall the exercise was viewed positively by participants and observers and considerable learning was identified to improve arrangements. These were included in an action plan from the debrief session.

3.7.2. ICT Exercise October 2023

The exercise looked at a significant cyber attack on the Trust that disrupted access to clinical systems, threatened data security and breached information governance regulations by disclosing personal information obtained via the attack on a foreign website.

Participants include much of the senior ICT team along with representatives from care services and pharmacy. An operational and tactical command was set up in different rooms to simulate real life division of command structures.

Lessons were learned in staging such a complex day long exercise that will be factored into 2024's exercise later in the year. In terms of lessons for improving response arrangements the following were main findings:

- Understanding care service ICT services and applications restoration priorities.
- Ensuring staff used existing business continuity plans in exercises and understood requirements.
- Overarching Cyber response plan identifying responsibilities, limitations and expectations for care services in developing mitigations when key systems are compromised.
- Issues over how different levels of command maintain contact, report and escalate needs considering and testing in future exercises.

3.7.3. Business Continuity Tabletop exercises

NHS England requirements specify that business continuity plans should be tested annually. This is a major undertaking given the Trust has around 75 separate business continuity plans. A number of exercises were run in 2023-2024 but as part of changes to business continuity arrangements services will be basked to run their own discussion exercises going forward and the EPRR team will provide larger exercises on a cyclical basis to service lines or to test interconnected business continuity plans.

Plans tested in 2023 were:

Plan	Date tested
Infection prevention and control	28 April 2023
Learning Disabilities community plans	15 May 2023
Gambling Services	18 May 2023
Personality Disorder Service	19 May 2023
Safeguarding	5 June 2023
Acute Inpatient Services	13 June 2023
Procurement	19 June 2023
Veterans	20 June 2023
Recruitment Team	3 July 2023
Nursing	3 July 2023
Neuro Developmental Service	24 July 2023
Forensics	4 August 2023
People analytics and temporary staffing	13 September 2023

4. Conclusions

2023-2024 was another busy year for the team. Ongoing industrial action posed challenges on team resources to cover meetings, situational reporting, and liaison with all parts of the response. The addition of two new initiatives – the new EPRR assurance process and the requirements of portfolio training also proved challenging.

However, the EPRR team increased to three staff from January which will enable a more effective response to the new challenges being introduced by NHS England into 2024 and beyond.

5. Recommendations

The Board of Directors is asked to approve 2023-2024's annual EPRR report and note the breadth of work carried out during the year.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
14.2

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	EPRR and Business Continuity Policy
DATE OF MEETING:	30 May 2024
PRESENTED BY: (name and title)	Joanna Forster Adams - Chief Operating Officer and Accountable Emergency Officer
PREPARED BY: (name and title)	Andrew Jackson – Resilience Lead and Corporate Business Manager

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

EXECUTIVE SUMMARY

The attached policy is an updated version of the policy approved in 2023 by the Board of Directors. The Board approving this policy is an NHS England EPRR standard requirement. The policy was assessed as compliant by NHS England in September 2023.

There have been some alterations to the attached and section 3 – the Business Continuity Management System (BCMS) previously appended does not need Board approval so has been removed. This BCMS will be included in a new EPRR procedure.

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 approve the EPRR and Business Continuity Policy.

Leeds and York Partnership NHS
NHS Foundation Trust

EPRR and Business Continuity Policy

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

1. This document contains Leeds and York Partnership NHs Foundation Trust's EPRR Policy and Business Continuity Policy.
2. The document sets out the responsibilities within the organisation for business continuity and EPRR (Emergency Preparedness, Resilience and Response)
3. A separate document EP-0016 – Business Continuity Management System describes the detailed processes around the Trust's systems for training staff on business continuity planning and writing, testing, and revising plans.
4. The document identifies a requirement for all those who provide services, either to the community or to other Trust functions, to have explicit and effective business continuity arrangements commensurate with the scale of their operation.

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

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

Document title	Business Continuity and EPRR Policy
Document Reference Number	EP-0005
Key searchable words	*Business continuity, emergency, incident, response, disruption, contingency, EPRR, emergency planning,*
Executive Team member responsible (title)	Chief Operating Officer
Document author (name and title)	Andrew Jackson, Resilience Lead and Corporate Business Manager
Oversight and endorsement of the procedural document	EPRR Group (Chaired by the Accountable Emergency Office)
Date	
Approved by (Committee/Group)	Board of Directors
Date approved	
Ratified by	Policies and Procedures Group
Date ratified	
Review date	May 2025
Frequency of review	*Annual*

Amendment detail

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

		assurance role to both EMT and annually to Board.
	8/5/19: 1.2.10 page 15 Training section revised to reflect status of the leadership in crisis training. The use of training materials at team level and the targeted band 7 training also added.	Requirement to carry out TNAs for all staff was felt unnecessary and too ambitious by care service BC leads and has been changed to more role specific training
	Appendix 3 - revised extensively in light of moving away from a TNA for all staff	National occupational standards inserted and a table or required and recommended training
	Code changed from RM-0030 to EP-0005.	Procedure moved to the Emergency Planning and Business Continuity section on StaffNet.
3	2021 review – learning for training and issues from the Covid debrief.	New impact assessment documentation – designed to simplify this process developed and attached. New approach to training and training needs assessment
4	2022 review in light of full EPRR standards being issued in July 2022 and the introduction of the PHC training programme.	• Minor amendments to title, • Removed template BC plan and BC assessment as any changes to these will mean version in this document is obsolete. • Changed reference to the BC international standard
5	2023 review in light of Internal Audit review June 2023 and the new EPRR assurance Standards compliance items.	• AEO identified as COO. • BCMS enlarged and moved to a separate section. • Separated EPRR policy from Business Continuity policy for clarity. • New governance content reflecting changes to EPRR standards
6	May 2024 – annual review and addition of issues emerging from 2023 NHS E review of EPRR and also new BC approach from early 2024.	• BCMS system (Formerly section 3) removed and incorporated into a new EPRR procedural document. • Expanded section on CBRN and HAZMAT (page 8) • New appendix 2 – NHS E requirement to identify

		specifically individuals with responsibilities in plans. • Section 1.1.2 updated with the process for unplanned expenditure due to a disruption (page 9). • Section 1.1.6 (page 13) updated to reflect the new EPRR risk management procedure. • New Appendix 2 created replacing previous appendix due to the introduction of NHS EPRR commander portfolios. • 1.2.6 rewritten to acknowledge he new approach to assessing business continuity arrangements of suppliers.

CONTENTS

1. THE PROCEDURE

1.1 EPRR Policy Statement

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

- The Health and Social Care Act 2022.
- The NHS Act 2006.
- The Civil Contingencies Act 2004 and subsequent Cabinet Office guidance issued under emergency planning guidance.
- All other legislation or Government Office guidance that refers to planning for and responding to emergencies.

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

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

This policy is required by NHS England Core Standard for EPRR 2.

1.1.1 Roles and Responsibilities

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

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

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

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

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

Other Staff with EPRR responsibilities

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

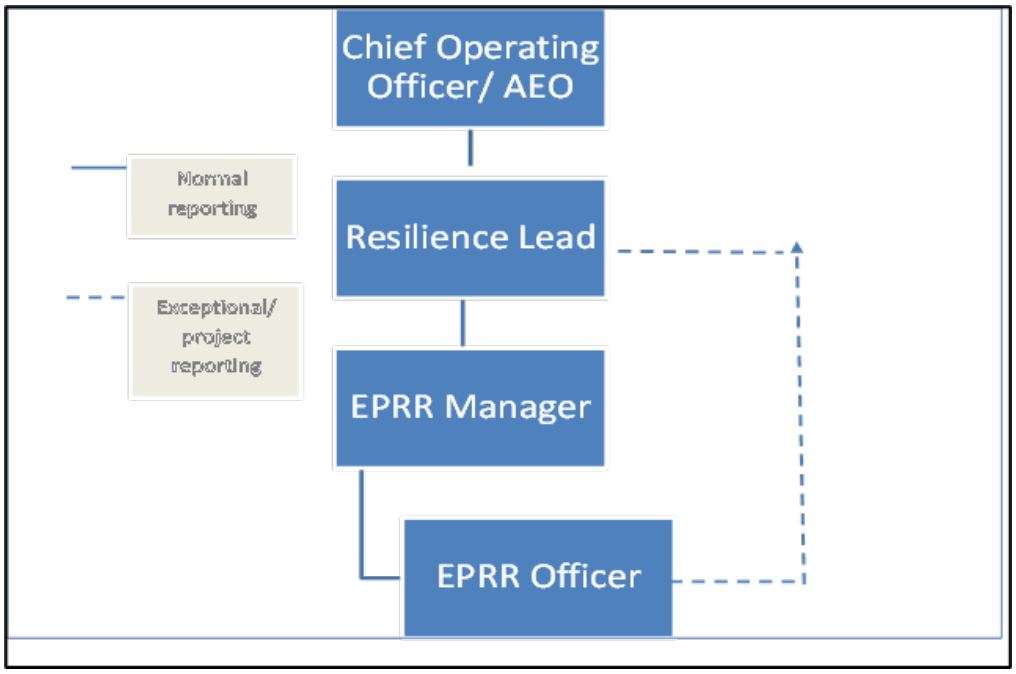
- The Chief Financial Officer/Deputy Chief Executive will provide cover for the AEO if the AEO is unable to fulfil duties due to absence.

- The Resilience Lead provides day to day management of the EPRR team and supports the AEO with technical advice. The Resilience Lead has responsibility for plan maintenance, updates, communication in consultation with the Corporate Governance Team following successful ratification of plans and policies at the Policies and Procedures Group.

- **CBRN and HAZMAT Responsibilities**. The Resilience Lead and members of the EPRR team have responsibility for the operational response and readiness of the Trust for CBRN and HAZMAT incidents and specifically as a Mental Health and Learning Disabilities Trust for improvised decontamination response, training and equipment checking.

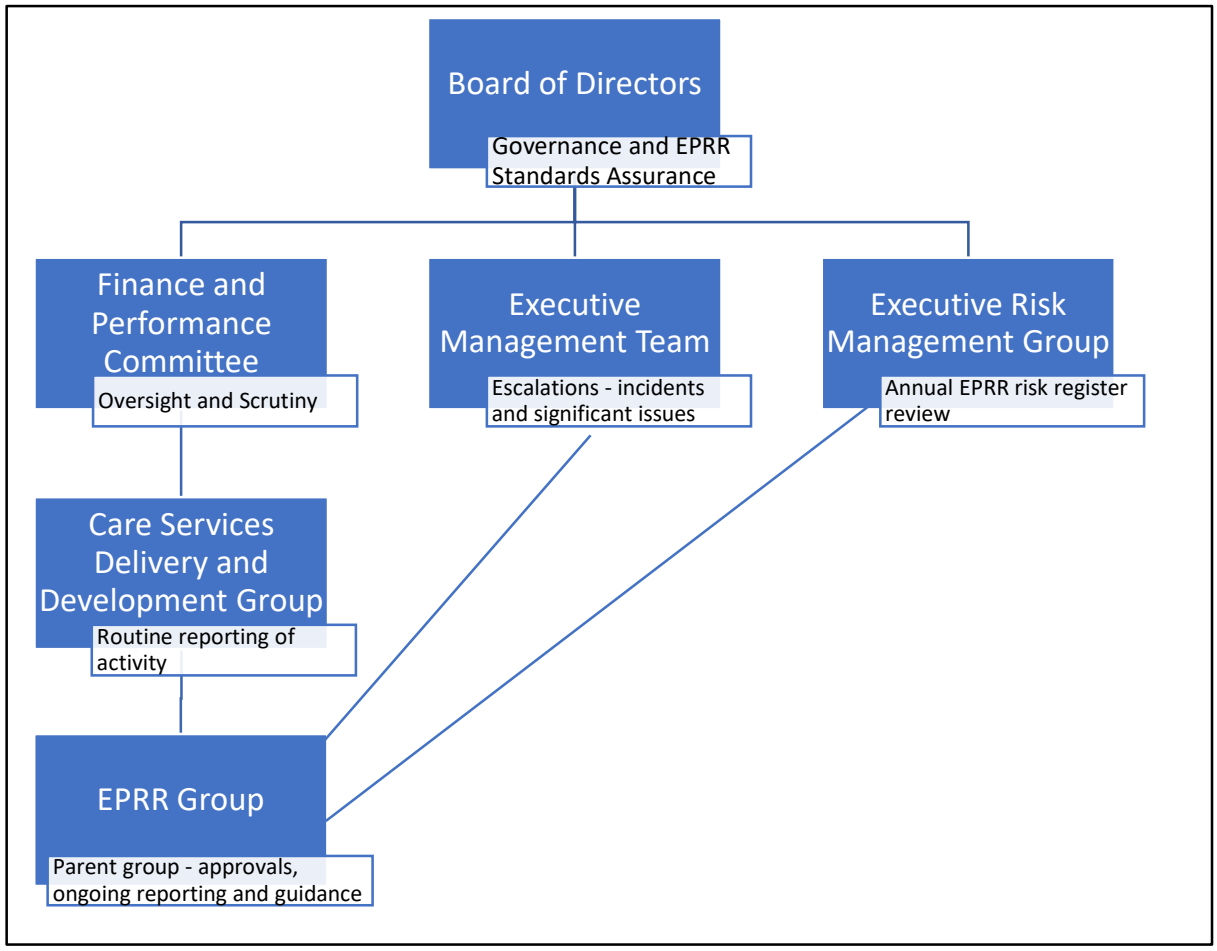
    - The Resilience Lead has responsibility for risk assessments around CBRN/HAZMAT.
    - The EPRR officer has responsibility for equipment checks, procurement of IOR equipment and liaison with staff regarding Initial Operating Response (IOR) boxes.
    - The responsibility for training is shared amongst the EPRR team.
    - CBRN audits will be coordinated by the Resilience Lead and EPRR Manager with Yorkshire Ambulance Services (YAS) staff. For 2024 the EPRR Manager is working with YAS to develop an audit approach for Mental Health Trusts and the deployment of the IOR (covering improvised decontamination).
    - The EPRR Group will oversee the CBRN/ HAZMAT programme, audit findings and any equipment requirements.

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



1.1.2 Governance and Reporting

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



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

Member	Role
Chief Operating Officer	Accountable Emergency Officer for EPRR/ Chair
Deputy Chief Operating Officer	Deputises as chair in the absence of the Chief Operating Officer
Resilience Lead and Corporate Business Manager	Operational lead for EPRR
Head of Operations - Learning Disabilities Service	Care Service Business Continuity Lead

Member	Role
EPRR Officer	CBRN and equipment/ testing updates
EPRR Manager	Business Continuity and CBRN/HAZMAT updates
Head of Operations - Acute care	Care Service Business Continuity Lead
HR Systems Manager	Business continuity lead - Workforce
Head of Physical Health and Infection Prevention & Control	Nursing and Professions Business Continuity lead and Pandemic flu/ infectious disease advice
Head of Operations (Estates & Facilities)	Business Continuity lead – Facilities and Estates
Chief Information Officer	Business Continuity lead – ICT services
Head of Communications	Communications support
Head of Operational Governance	Operational governance linkage
Head of Procurement	Supply chain resilience
Head of Medical Development and Operations	Business Continuity lead – medical directorate
Head of Sustainability	Sustainability and adaption
Head of Health and Safety	Health and safety considerations in planning and response and link to security

Non-core Members

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

The Non-executive EPRR champion will be invited to attend one meeting per year.

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

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

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

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

The Executive Risk Management Group approve the EPRR risk management process and review the EPRR risk register annually. They also receive escalations from the EPRR Group for inclusion on the Corporate Risk Register.

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

Resources

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

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

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

The following procedure would be adopted regarding unplanned expenditure required to manage a disruption and has been agreed with the Finance Directorate:

- One of the EPRR incident team to contact the Deputy Director of Finance or the Associate Director of Finance with details of the incident.
- Finance will then release a budget code to the EPRR team.
- EPRR team will use the budget code to incur expenditure.
- The Finance team will send weekly financial reports to the EPRR team to advise the total to spend.
- Reports on the expenditure will be reported through the Financial Planning Group to the Finance & Performance Committee.

These resources would be applied across the Trust but by Finance and EPRR working collaboratively there would be a process to ensure expenditure was justified and wholly or largely required to manage the consequences of a disruption or incident.

1.1.3 Scope of EPRR

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

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

1.1.4 Planning EPRR work

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

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

1.1.5 Lessons Learned

All exercises are debriefed and for major exercises - live exercises and those exercises contained in the annual plan a full debrief report is produced to identify lessons. This contains an action plan with actions allocated to named officers with an agreed implementation date so that lessons identified may be acted upon and appropriate action taken to ensure that plans are amended. These plans are reviewed in the EPRR group.

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

An action tracker is a permanent agenda item at the EPRR group – this action tracker is a compilation of all lessons identified from incidents, exercises and issues raised by other EPRR colleagues. The tracker ensures that lessons identified at exercises or incidents are responded to appropriately by a clearly defined owner to an agreed timescale.

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

Lessons identified that indicate any ongoing risk to the organisation will also be captured on the EPRR risk register and escalated to the Trust's Executive Risk Management Group for consideration in including in the corporate risk register.

1.1.6 EPRR Risk Management

Incident risk registers

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

The decision to escalate any risk from the incident risk register to the EPRR risk register or Trust's corporate risk register is governed by an assessment at the conclusion of the incident around likelihood of repetition of the incident type.

EPRR Risks

A new procedure detailing the Trust's management of EPRR risks (EP-0016) has been developed to describe how EPRR risks are managed. In summary:

- An EPRR risk register will be maintained with risks from the West Yorkshire community risk register, West Yorkshire LHRP risk register, North East and Yorkshire EPRR risk register and via risk sharing within the local EPRR community.
- Risks identified in Business Continuity Plans will be consistent with those identified in the EPRR risk register.
- This risk register will be reviewed every four months at the EPRR Group and annually by the Executive Risk Management Group.
- An escalation process will see any risk assessed as needing wider consideration:
    - Risk rating of over 15.
    - Impacts on any key organisational objective/s.
    - Requires wider discussion around mitigations.
    - May need to be discussed in other Trust governance meetings.

Sources of EPRR Risks

NHS England's Core Standards for EPRR require organisations to consider the risks to the population they serve. To do this means that a wide ranging approach is required as described in the EPRR Risk Management Procedure.

Risk assessment governance.

The EPRR Group is the main governance for a for EPRR risks and discharges this responsibility via scheduled reviews and the standing item of any new risk identification of EPRR Group agendas.

The Executive Risk Management Group provides oversight and assurance regarding the thoroughness of EPRR risk identification, assessment, and timely completion of mitigations. This group is also the point of escalation for risks from the EPRR group and reviews the EPRR risk register annually to assure that the register is being maintained properly.

1.1.7 EPRR plans

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

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

Where required, other external subject matter experts are drawn upon to inform and contribute to EPRR plans. For example, Yorkshire Ambulance Service's CBRN/HAZMAT lead would be consulted to inform the Trust CBRN/HAZMAT plan.

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

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

1.1.8 Training and Exercising

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

EPRR Training

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

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

EPRR Exercises

The Trust requires all services to hold a business continuity tabletop exercise annually. These are facilitated by the EPRR team. Additionally, communication exercises to test on call arrangements are held every six months. These are debriefed in the EPRR group, and any lessons identified are communicated to relevant staff as per the process described above in section 1.1.5.

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

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

The focus for 2024 is chemical decontamination and the reasoning is that this is an area where considerable EPRR staff time has been devoted to training in 2022-2023 as well as the participation of the Trust in a city-wide exercise in 2022. Additionally, new guidance on CBRN/HAZMAT has been circulated in 2023 which requires staff training to be amended.

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

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

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

1.2 Business Continuity Policy Statement

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

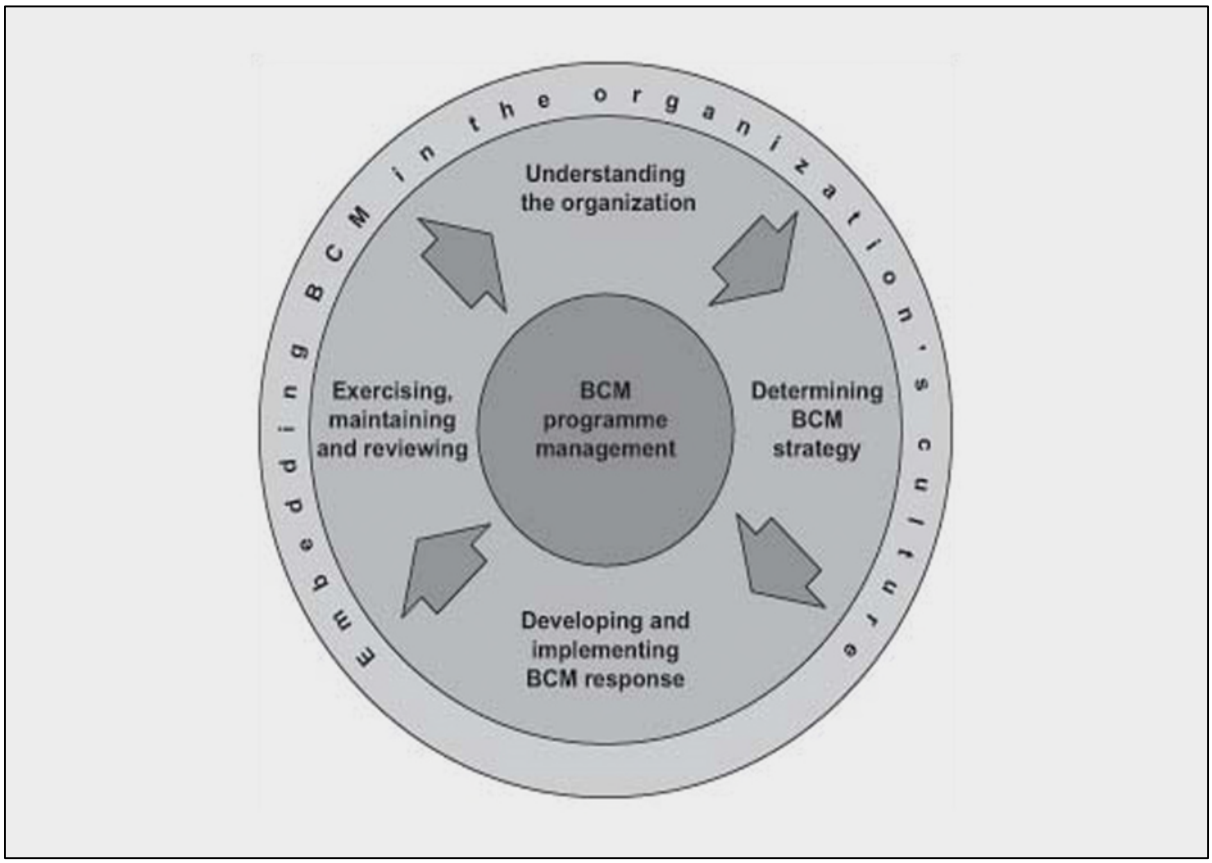
Business continuity management system is defined as:

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

Source: ISO 22301:2012

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

This policy/ statement is required by NHS England Core Standard for EPRR 44.



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

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

The purpose of the statement is to:

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

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

Additional guidance

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

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

1.2.1 Scope

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

Acceptable Risk

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

business continuity strategies to deal with such risks. However, controlled risks should be reappraised annually as part of review of business continuity arrangements.

Dynamic risk assessment

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

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

Limitations and exclusions

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

Statutory, regulatory, and contractual duties

i. Statutory

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

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

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

ii. Regulatory

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

NHS England's role in monitoring providers' emergency preparedness arrangements under *the Health and Social Care Act 2012* is discharged by the requirement of all NHS funded providers to comply with a comprehensive suite of Emergency Preparedness, Resilience and Response Standards (EPRR). Some of these are business continuity related standards.

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

iii. Contractual

The NHS Standard Contract Service Condition SC 30 Emergency Preparedness, Resilience and Response require providers to comply with NHS England's EPRR standards.

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

Interests of stakeholders

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

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

Key services in scope and exclusions from scope

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

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

1.2.2 Objectives and obligations

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

i. the continuity of clinical care of service users.
ii. the safety of service users, carers, staff, and the public.
iii. the buildings, assets, and infrastructure of the Trust.
iv. the interests of key stakeholders.
v. the environment.
vi. the reputation of the Trust and wider NHS.

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

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

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

- Checking that managers are updating their plans annually.
- Ensuring all plans in their area of responsibility are exercised and a debrief report has been produced.

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

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

- Updating plans.
- Testing plans.

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

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

1.2.3 Resourcing and independent oversight

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

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

1.2.4 Training

In June 2022 NHS England introduced new training requirements based the Principles of Health Command course. Appendix 1 expands on this requirement.

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

A Business Continuity handbook has also been produced to assist staff in developing business continuity arrangements.

1.2.5 Exercising

Each business continuity plan will be tested annually by services in a tabletop/ discussive exercise which will be carried out by services' staff based on their business continuity risks. The teams will be asked to send back a template report debriefing the exercise with any lessons identified, new risks or issues for wider assessment by the EPRR team. Lessons identified will be dealt with as appropriate as described in the process at 1.1.5.

A risk-based approach will be adopted for selecting plans for EPRR team to exercise in wider and more detailed exercises. The criteria being if the service is exposed to a significant risk of disruption, or an identified risk may impact adversely on a specified team or location. Any additional time, for example unused contingency allowance, will be used to exercise services plans where an EPRR team coordinated exercise has not been done for a protracted period.

As part of Data Security & Protection Toolkit work the Trust will also run a cyber or IT based scenario annually. Services will be invited to exercise the ICT disruption component of their business continuity plans.

1.2.6 External suppliers and contractors

The Trust has developed a procedure for reviewing the business continuity arrangements of suppliers and sub-contractors. This procedure adopts a risk based approach looking at stratifying supplier reviews based on:

- Their operating and financial stability
- Type of item they supply and ease of obtaining alternatives.
- Any known downstream supply chain issues the supplier itself may face.

The stratification will determine the frequency business continuity arrangements are reviewed. The procedure also considers additional assurance regarding the adequacy of business continuity arrangements as part of assessment procedures to allow companies on to procurement tiers by NHS logistics and other procurement hubs,

1.2.7 Governance and Audit

In terms of governance responsibilities, the Finance and Performance Committee has oversight of the Trust's wider EPRR processes including Business Continuity.

Escalations regarding Business Continuity such as performance issues with developing plans, exercising plans or completing any required actions will be made to the Executive Management Team.

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

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

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

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

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

i. **Board and Board Committee reporting**

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

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

ii. **Audit**

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

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

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

iii. **Approval of Business Continuity Plan**

The requirement to have business continuity arrangements in place sits with management. Therefore, the policy requires that business continuity plans are approved in each service's governance structure and signed off on the plan itself by the person accountable for business continuity planning in the service.

iv. **Document control**

Business continuity plans will be referenced using the following format:

Service_ month/date created.

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

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

1.2.8 Communication

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

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

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

1.2.9 Review of the Business Continuity Management System

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

1.2.10 Continuous Improvement and review

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

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

Appendix 1

EPRR Commander Portfolios

In June 2022 NHS England issued revised training requirement for NHS incident command staff and those who may support an incident. A formal training course – Principles of Health Command (PHC)has been devised that will be standard across the NHS. So far PHC training has been delivered at Strategic and Tactical Levels to the NHS and most relevant staff have been on this course.

For the Trust relevant staff is given below:

Staff description	Role	Course requirements
Executive Directors and Deputies/ Other senior management on the Director on call rotas.	Strategic Commanders	Principles of Health Command at Strategic Level
Staff on the “CSM” on call rota (Operational managers bands 8a-8c)	Tactical Commanders	Principles of Health Command at Tactical Level
Resilience Lead, EPRR Manager	EPRR Specialists	Principles of Health Command at Strategic Level Principles of Health Command at Tactical Level

In 2023 the requirement to undertake training portfolios was also introduced for staff in the above categories. These have been introduced at the Trust and relevant staff are commencing required training and presenting evidence as part of their portfolios.

Appendix 2

EPRR Staff and contact details.

This schedule gives the names and contact details of the AEO and EPRR team to aid understanding of roles and responsibilities throughout this procedural document.

Role	Name	E-mail	Trust mobile
Accountable Emergency Officer	Joanna Forster Adams	joanna.forsteradams@nhs.net	
Resilience Lead	Andrew Jackson	Andrew.jackson8@nhs.net	07974 173236
EPRR Manager	Sam Grundy	Sam.grundy1@nhs.net	07815 454570
EPRR Officer	Lizzy Bridson	elizabeth.bridson@nhs.net	07966 421256
EPRR mailbox		lmh-tr.EPRR@nhs.net	

Business Continuity Leads for services and corporate directorates are:

Care Services	Peter Johnston
	Hannah Wilkinson
Estates and Facilities	Warren Duffy
Workforce	Andrew McNichol
Nursing and Professions	Alison Quarry
Medical	Vickie Lovett
ICT	Ian Hogan
Supplies and Procurement	Nichola Woodhead
Finance	Gerard Enright

PART B

3 IDENTIFICATION OF STAKEHOLDERS

The table below should be used as a summary. List those involved in development, consultation, approval, and ratification processes.

Stakeholder	Level of involvement
EPRR group	Review draft document
Business continuity leads	Review draft document
Board of Directors	
Policy and Procedure Group	Ratification

4 REFERENCES, EVIDENCE BASE

The following documents, standards and guides were used to develop this Business Continuity Management Framework:

Standards:

ISO 22301, Societal security — Business continuity management systems — Requirements
ISO 22313, Societal security — Business continuity management systems — Guidance
ISO/TS 22317 Societal security — Business continuity management systems — Guidelines for business impact analysis (BIA)
BS 25999-1:2006 - Business continuity management – Part 1: Code of practice
BS 25999-2 Business continuity management — Part 2: Specification
PAS 2015:2010; Framework for Health Service Resilience
NHS England: Emergency Preparedness, Resilience and Response Framework 2015
NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) 2023

Guidance

The Business Continuity Institute – *Good practice guidelines 2010: A Management Guide to Implementing Global Good Practice in Business Continuity Management*
NHS England: Business Continuity Management Toolkit 2016
NHS England: (NHS Commissioning Board) Business Continuity Management Framework (service resilience)
NHS England: A Business Continuity Management System Strategy Outline
Cabinet Office: *Emergency Preparedness 2012 – Chapter 6 Business Continuity Management*
Feedback by NHS England on 2023's standard submission – October 2023

5 ASSOCIATED DOCUMENTATION (if relevant)

The following Trust documents are relevant to the Business Continuity Management Framework and Policy:

Major Incident Response Plan EP-0004
The Risk Management Policy – RM-0001
Risk Assessment & Risk Register Procedure – RM-0004
Lockdown Policy and Procedure – RM-0010
Vehicle Fuel Disruption Plan – EP- 0002
Chemical decontamination plan – EP- 0003

6 STANDARDS/KEY PERFORMANCE INDICATORS (if relevant)

The relevant standards are drawn from NHS England's EPRR standards and are:

Number	Standard
Core Standard 1	Senior Leadership
Core standard 2	EPRR Policy Statement
Core standard 3	EPRR Board reports
Core Standard 4	EPRR work programme
Core Standard 5	EPRR Resource
Core Standard 6	Continuous improvement
Core Standard 7	Risk assessment
Core Standard 8	Risk Management
Core Standard 9	Collaborative planning

In terms of the Business Continuity and EPRR Policy the following key performance indicators exist.

1. All relevant services have approved business continuity plans.
2. All plans are subject to an annual review/ exercise, the date of which is notified to the Resilience lead.
3. At least one formal live exercise of a business continuity plan is done every year, or a real incident necessitates use of a business continuity plan.
4. Business continuity related risks are reviewed annually and compared to risks on the community risk registered held by West Yorkshire Local Resilience Forum.

7. EQUALITY IMPACT

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. Consideration must be given to any potential impacts that the application of this policy/procedure might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender, and sexual orientation).

Declaration: The potential impacts on the application of this policy/procedure have been fully considered for all nine protected groups. Through this process I ~~have~~ / have not identified any potential negative impacts for any of the nine protected groups.

Print name: Andrew Jackson

Job title: Resilience Lead and Corporate Business Manager

Date: 20 May 2024

If any potential negative impacts are identified the Diversity Team must be contacted for advice and guidance: email; diversity.lypft@nhs.net.

*Delete as appropriate

CHECKLIST

To be completed and attached to any draft version of a procedural document when submitted to the appropriate group/committee to support its consideration and approval/ratification of the procedural document.

This checklist is part of the working papers.

	Title of document being newly created / reviewed:	Yes / No/
1.	**Title**	
	Is the title clear and unambiguous?	*Yes*
	Is the procedural document in the correct format and style?	*Yes*
2.	**Development Process**	
	Is there evidence of reasonable attempts to ensure relevant expertise has been used?	*Yes*
3.	**Content**	
	Is the Purpose of the document clear?	*yes*
5.	**Approval**	
	Does the document identify which committee/group will approve it?	*Yes*
6.	**Equality Impact Assessment**	
	Has the declaration been completed?	*Yes*
7.	**Review Date**	
	Is the review date identified?	*Yes*
	Is the frequency of review identified and acceptable?	*Yes*
8.	**Overall Responsibility for the Document**	
	Is it clear who will be responsible for co-ordinating the dissemination, implementation, and review of the document?	*Yes*

Board of Directors			
Final signoff of the Business Continuity and EPRR Policy as required by standards.			
Name	*Sara Munro*	Date	*TBC*

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM 14.3

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	EPRR Board Assurance Statement
DATE OF MEETING:	30 May 2024
PRESENTED BY: (name and title)	Joanna Forster Adams - Chief Operating Officer and Accountable Emergency Officer
PREPARED BY: (name and title)	Andrew Jackson – Resilience Lead and Corporate Business Manager

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

EXECUTIVE SUMMARY

The attached document meets the requirement of NHS England EPRR standard 5 - *the Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties*.

The Resilience Lead has prepared the attached statement showing the resource allocation to EPRR work in 2024-2025, the staff directly and indirectly deployed and the arrangements that show that EPRR has the organisational status to undertake its work.

The Accountable Emergency Officer has used this information and other sources of assurance to prepare their statement of assurance to the Board that they believe the Trust has adequate resources, capabilities, and arrangements to discharge its EPRR duties.

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 endorse the attached statement declaring that the organisation has sufficient resources to discharge its EPRR duties.

Leeds and York Partnership
NHS Foundation Trust

The Accountable Emergency Officer's

Board Statement of Emergency Preparedness, Resilience and Response (EPRR) Assurance 2024

Presented to the Board of Directors on 30 May 2024

1. Responsibility

As Accountable Emergency Officer (AEO) under the terms of section 46 of the Health and Social Care Act 2012 I have the responsibility for[1]:

- securing that the Trust is properly prepared for dealing with a relevant emergency,
- securing that the Trust complies with any requirements mentioned in this section (of the Act),
- providing the Board with such information as it may require for the purpose of discharging its functions under this section (of the Act).

I am also responsible under NHS England Mandatory Standards (Standard 1) for directing the EPRR portfolio[2].

2. The purpose of EPRR

As an NHS funded organisation, the Trust needs to be able to plan for and respond to a wide range of incidents that could threaten health of the community or patient care. The Trust needs to also ensure statutory and regulatory requirements and expectations are discharged as part of its arrangement for managing responses and maintaining resilience.

This work is referred to in the health service as Emergency Preparedness, Resilience, and Response or EPRR. EPRR as defined by NHS England's Core standards covers the following domains of activity:

1. Governance,
2. duty to risk assess,
3. duty to maintain plans,
4. command and control,
5. training and exercising,
6. response,
7. warning and informing,
8. co-operation,
9. business continuity,
10. chemical biological radiological nuclear (CBRN) and hazardous material (HAZMAT).

[1] https://www.legislation.gov.uk/ukpga/2012/7/section/46 Accessed 31/1/2024

[2] https://www.england.nhs.uk/wp-content/uploads/2022/07/PRN00236ii-nhs-core-standards-for-eprr-june-2023-v2.xlsx Accessed 31/1/2024.

This statement has been prepared to assure the Board of Directors that EPRR resources and arrangements are adequate to cover the responsibilities mandated under NHS England requirements as required by NHS England EPRR core standard 5.

3. Statement of resources allocated to EPRR.

3.1. Direct resources

The Trust's EPRR complement is:

Role	Grade	Full/Part time or hours
Resilience Lead	8c	Full time
EPRR Manager	7	Full Time
EPRR Officer	5	Full Time

This staffing resource, which was increased in January 2024 with the recruitment of the EPRR manager post is a significant investment in EPRR and stands favourably compared with other mental health and community providers.

The EPRR team has a small administrative budget to cover training materials and courses, stationery, and equipment. Additional resources are made available from the Chief Operating Officer's budget for larger items of expenditure.

In terms of resources to respond to, or manage the consequences of, a disruptive event the EPRR team has agreed a process of allocation of funds and recording expenditure in conjunction with the Deputy Director of Finance:

- One of the EPRR incident team to contact the Deputy Director of Finance or the Associate Director of Finance with details of the incident.
- Finance will then release a budget code to the EPRR team.
- EPRR team will use the budget code to incur expenditure.
- The Finance team will send weekly financial reports to the EPRR team to advise the total to spend.
- Reports on the expenditure will be reported through the Financial Planning Group to the Finance & Performance Committee.

3.2. Indirect resources

The Trust operates a process of specified business continuity leads for all services. These are nominated by respective directors and cover clinical as well as corporate services. The role of the business continuity lead is to:

- Attend and represent their service at the Trust's Emergency Preparedness, Resilience and Response Group.
- Be a point of contact for those responsible for developing business continuity plans in their respective services.
- Encourage the completion of business continuity planning, exercising and review within their services and ensure at least quarterly reporting of

progress with business continuity plans at appropriate service governance fora.

A memorandum of understanding for mutual aid has also been drafted in 2024 to facilitate support to any signatory trust that requires additional trained EPRR staff to support an incident response or to offer advice to any signatory where their EPRR lead is unavailable.

4. Organisational Status of EPRR at the Trust

The EPRR team requires adequate organisational status to conduct its work and to be able to escalate risk and issues to appropriate tiers of management. The following describes how the trust has secured the organisational status of the EPRR team:

- The Resilience Lead reports directly to the Chief Operating Officer/ Accountable Emergency Officer. The Resilience Lead also attends the Care Services Delivery and Development group as part of the care services senior team.
- The EPRR Lead attends the Executive Management Team periodically to update the Executive Directors on significant issues regarding EPRR. Additionally, the Resilience Lead will attend the Executive Risk Management Team annually for a formal review of EPRR risks.
- The governance group charged with coordinating EPRR work is chaired by the Accountable Emergency Officer and attended by the entire EPRR team.
- The trust has a non-executive EPRR champion. In 2024 this is the Trust Chair. The EPRR champion receives copies of all EPRR group papers and meets quarterly with the Resilience Lead. They are also invited to an EPRR group meeting annually.

5. Capacity and capabilities of the EPRR team

5.1. The role of the EPRR team

The role of the EPRR team is covered in detail in the Trust's Business Continuity and EPRR Policy. However, in summary, the main responsibilities of the EPRR team are to:

- Develop plans and procedures with colleagues and with other agencies to respond to disruptive risks,
- Train staff in their roles as part of an incident response team,
- Facilitate the creation of business continuity plans by all relevant services,
- Advise management prior to, during and after a disruption,
- Consult with stakeholders and partner to plan and prepare for disruptions.

5.2. Relevant Qualifications

Both the Resilience Lead and EPRR Manager hold the required Diploma in Health Emergency Planning. The EPRR Officer has completed the award in Health Emergency Planning.

The Resilience Lead and EPRR Officer hold the level 3 Award in Education and Training (AET) required to be able to train any aspect of EPRR to staff. The EPRR manager is due to complete the AET training this year.

5.3. Capacity to meet EPRR requirements.

The table below represents total available days per the EPRR team staffing complement. These days have been allocated to both departments/ non EPRR domain activities.

Staff	Total days	AL	B Hol	available
AJ	260	38	8	214
SG	260	35	8	217
LB	260	28	5	227
				658

Plan areas	Days	Percent
Office admin/directorate meetings/illness	25	3.8%
Vacancy - Maternity	95	14.4%
Training - team	22	3.3%
Contingency/ incident response	25	3.8%
1. Governance	25	3.8%
2. duty to risk assess,	20	3.0%
3. duty to maintain plans,	50	7.6%
4. command and control,	20	3.0%
5. training and exercising,	80	12.2%
6. response,	20	3.0%
7. warning and informing,	33	5.0%
8. co-operation,	23	3.5%
9. business continuity,	140	21.3%
10. chemical biological radiological nuclear (CBRN) and hazardous material (HAZMAT).	80	12.2%
	658	**100.00%**

The planned days for EPRR cover all required areas of activity with specific areas of low compliance given priority – business continuity, training and exercising and CBRN/HAZMAT.

A time allowance has been given to contingency which from the perspective of EPRR will represent continued response to disruptions – the ongoing industrial action risk and potentially weather-based disruptions.

These time allocations have been reflected in the annual plan against specific topics, plans, and exercises.

5.4. Accountable Emergency Officer statement of assurance

In making the statement I have considered the following:

- The description of resources and plan allocation above,
- The significant assurance given by an Internal Audit review in March 224 about the EPRR improvement plan,
- The increased in EPRR staffing numbers from January 2024,
- Overview and scrutiny of all EPRR activity via the EPRR group that I chair.
- Out of hours and on call response has been thoroughly evaluated in 2023-2024 due to industrial action and oversight by the industrial action planning groups.

I consider that the Trust has sufficient resources to conduct its EPRR duties and make improvements on 2023's EPRR core standards level of compliance. In my role as Accountable Emergency Officer, I ask the Board to approve this statement of assurance.

Signed..... Chief Operating Officer & Accountable Emergency Officer

Date.....

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
15

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chairs Report from the Quality Committee meeting held on 11 April 2024
DATE OF MEETING:	30 May 2024
PRESENTED BY: (name and title)	Dr Frances Healey, Non-executive Director and Chair of the Quality Committee
PREPARED BY: (name and title)	Kerry McMann, Head of Corporate Governance

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

COMMITTEE DETAILS:	
Name of Committee:	Quality Committee
Date of Committee:	11 April 2024
Chaired by:	Dr Frances Healey, Non-executive Director

KEY DISCUSSION POINTS:

ALERT - Issues to alert the Board to:

No issues to which the Board needs to be alerted.

ADVISE - Issues to advise the Board on:

No issues to advise the Board on.

ASSURE – Items to provide assurance to the Board on:

- The committee had sight of strategic risks one and two on the Board Assurance Framework 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 the draft Quality Account for 2023/24 and was assured on the progress made with the production of the document.

- The committee reviewed a report which set out the amendments made to the quality impact assessment scoring of the Trust's Efficiency and Productivity Programme. The committee noted that the scores for a number of schemes had changed due to a prior misunderstanding of the scoring framework and was reassured that the lower scores included in this report reflected the original discussion by the Quality Impact Assessment (QIA) Panel on 19 January 2024. The committee welcomed the report and praised the thoroughness of the quality impact assessment that had been undertaken.

- The committee reviewed and approved its annual report for 2023/24.

Items to be referred to other Committees:

The committee did not refer any items to other Board sub-committees.

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 update provided.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

15

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chairs Report from the Quality Committee meeting held on 9 May 2024
DATE OF MEETING:	30 May 2024
PRESENTED BY: (name and title)	Dr Frances Healey, Non-executive Director and Chair of the Quality Committee
PREPARED BY: (name and title)	Kerry McMann, Head of Corporate Governance

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

COMMITTEE DETAILS:	
Name of Committee:	Quality Committee
Date of Committee:	9 May 2024
Chaired by:	Dr Frances Healey, Non-executive Director

KEY DISCUSSION POINTS:

ALERT - Issues to alert the Board to:

No issues to which the Board needs to be alerted.

ADVISE - Issues to advise the Board on:

No issues to advise the Board on.

ASSURE – Items to provide assurance to the Board on:

- The committee had sight of strategic risks one and two on the Board Assurance Framework so that it could be mindful of its responsibilities to assure that these risks were being adequately controlled through the course of the meeting.

- The Committee received an update on the work being undertaken to review the Trust's approach to clinical risk assessment, and the expected timelines in relation to approval and implementation. A further progress update will be provided at a future meeting.

- The committee reviewed a presentation which provided the highlights of the Acute Service Line's Annual Quality Reports, focusing on how the service had defined and scored itself against the Learning, Culture and Leadership Framework and the STEEEP dimensions of quality to enable the conditions for high quality care to flourish. It was assured that the service had good systems in place for understanding its quality issues and to drive improvements, the service had good knowledge of its strengths and weaknesses in relation to learning, culture and leadership and the Executive Team had a clear understanding of the service's strengths, weaknesses, challenges and blind spots and how issues were being managed.

- The committee received a report which provided data from Q4 for PALS activity, the concerns and complaints handling process, compliments, claims, central alert system, incidents, serious incidents and inquests. It agreed that the Trust had good systems for understanding quality issues raised through these sources and working to improve them and discussed further potential improvements to the report.

- The committee reviewed and approved the Quality Account. It noted that the sections on learning from deaths and the CQUIN scheme were incomplete and would be approved by the Board of Directors on 20 June 2024.

- The committee discussed the current arrangements established to ensure the quality of out of area placements and supported a proposal to move to arrangements where key quality surveillance metrics for out of area placements are reported as a matter of routine through the Trust's clinical governance arrangements, including to Quality Committee where that is the case for in-trust patients.

- The committee received a paper which provided an update on the progress made against the priorities and aims identified in the Patient and Carer Experience and Involvement Strategy. It was assured on the systems and processes in place to involve, and collect feedback from, the Trust's service users and carers.

- The committee received and discussed a report which contained a high-level summary of the metrics from the 2023 National Staff Survey that were relevant to quality, to enable an understanding of the Trust's culture, processes and the impact on the quality of care.

Items to be referred to other Committees:

The committee did not refer any items to other Board sub-committees.

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

RECOMMENDATION

The Board of Directors is asked to note the update provided.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

16

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chair's Report from the Workforce Committee meeting held on 15 April 2024
DATE OF MEETING:	30 May 2024
PRESENTED BY: (name and title)	Zoe Burns-Shore, Non-executive Director and Chair of the Workforce Committee
PREPARED BY: (name and title)	Rose Cooper, Deputy Head of Corporate Governance

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

COMMITTEE DETAILS:	
Name of Committee:	Workforce Committee
Date of Committee:	15 April 2024
Chaired by:	Zoe Burns-Shore, Non-executive Director

KEY DISCUSSION POINTS:

ALERT - Issues to alert the Board to:

No issues to which the Board needs to be alerted.

ADVISE - Issues to advise the Board on:

- The Committee reviewed a statement of reassurance issued by Health Assured, the Trust's Employee Assistance Programme (EAP), confirmed that no further clarifications or reassurance was needed and supported the Head of Wellbeing exploring ways to gain staff feedback on EAP and Occupational Health services. The Committee discussed the results of the Staff Survey questions on sexual safety, noted the Trust's benchmark position and agreed that the priority going forward was to track internal data over time to see reductions.

- The Committee received an update on the current workstreams of the Health and Safety Team, noted that the report provided an interim position but felt there was a lot of work still to do and agreed to review a further update on health and safety in six months' time.

- The Committee discussed the requirement for the Trust to reduce its agency spend to 3.2% of establishment and understood that agency usage was now overseen by the Workforce and Agency Group which would be developing a trajectory to achieve the target reduction in spend. The Committee agreed to monitor this on an ongoing basis.

ASSURE – Items to provide assurance to the Board on:

- The Committee received the Workforce Performance Report and was pleased to see an improved position in relation to nursing vacancies, personal development reviews and mandatory training compliance and recognised the efforts that had gone into making these improvements.

- The Committee received an update on the Trust's People Plan for 2021-24, highlighted the positive feedback detailed in the case studies and the progress reflected in the key performance indicator dashboard and thanked those colleagues involved in delivering the plan. The Committee agreed to review data on how the new Spotlight platform was being used across the Trust on a bi-annual basis going forward, noting that this was to become the main reward and recognition mechanism for staff.

- The Committee received a six-monthly update on phase two of the work to support Collective Leadership across the Trust and agreed to monitor the impact of the programme via a set of metrics which would be included in future reports.

- The Committee received an overview of the leaver data for the Trust over the last 12 months drawn from the national Electronic Staff Record system and the findings of the six month Exit Interview Pilot. The Committee reviewed the Trust's leaver data and noted that overall, it was consistent with national NHS leaver data trends in terms of when and why staff were leaving the organisation. The Committee also noted there had been good engagement with the Exit Interview Pilot, reviewed the data provided and supported the next steps which included cross referencing the information with other datasets and ensuring that the issues identified were already covered by existing action plans.

- The Committee reviewed Strategic Risk 3 on the Board Assurance Framework so that it could be mindful of its responsibility to assure that the risk was being adequately controlled through the course of the meeting. The Committee also reviewed and approved its Annual Report ahead of submission to the Board of Directors in June 2024.

Items to be referred to other Committees -

The Committee did not refer any items to other Board sub-committees.

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 update provided.

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

AGENDA ITEM

17

PAPER TITLE:	LYPFT 2 Month Safer Staffing Review Report
DATE OF MEETING:	30 May 24
PRESENTED BY: (name and title)	Nichola Sanderson Director of Nursing and Professions
PREPARED BY: (name and title)	Miriam Blackburn, Professional Lead Nurse Jennifer Connelly, Professional Lead Nurse Adele Sowden, E-Rostering Team Manager

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

EXECUTIVE SUMMARY

This paper draws on the NHS National Quality Board (2016) reporting requirements to ensure that nursing and care staffing, capacity and capability is enabled to deliver high quality care and the best possible outcomes for patients whilst balancing quality and financial objectives and acknowledging the ongoing pressures experienced in relation to staffing and resource.

The paper contains a high-level overview of data and analysis to provide the Board of Directors and the public with information on the position of Leeds and York Partnership Trust wards staffing against safer staffing levels for the 2 month period from the **1 February 2024 to 31 March 2024.**

This report details that there were no clinicals shift that had no Registered Nurse was on duty in the inpatient areas.

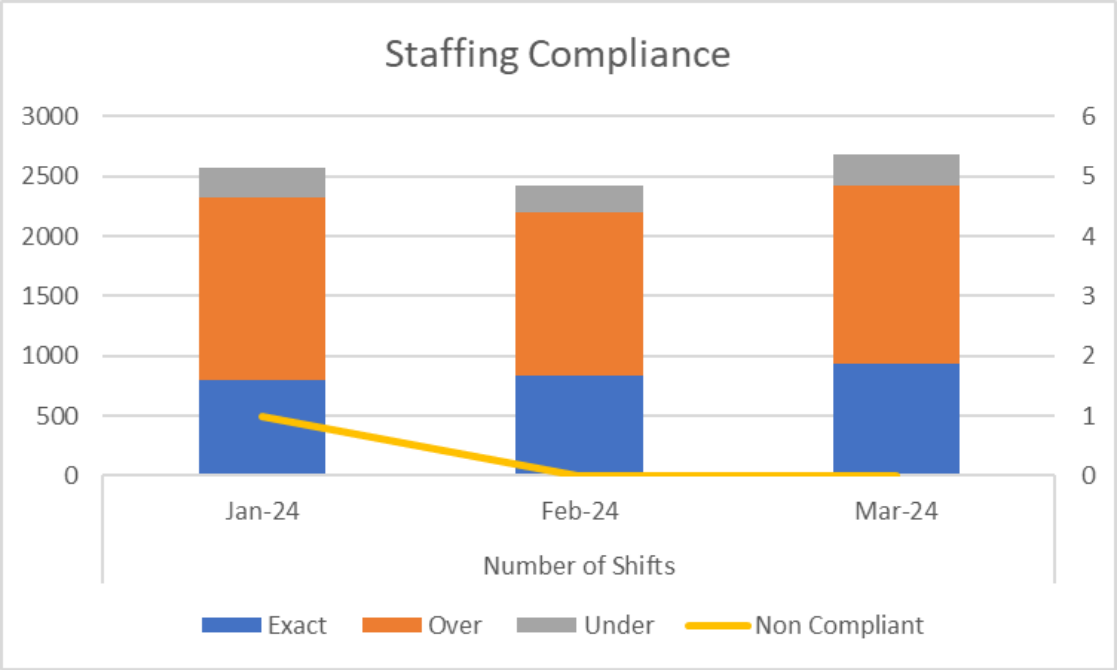
For this report, the Specialised Supported Living Service (SSLS) has been included. This service provides accommodation to individuals with learning disabilities and complex health needs at 16 locations across Leeds. This is not an inpatient area and therefore, it is not an area usually covered within the report. However, due to the number of vacancies across the service, it has been included. The core teams within SSLS consist of Health Support Workers and Senior Support Workers.

The paper draws focus to 4 clinical areas where there is either significant Registered Nurse and Health Support Worker vacancies or are using significantly higher numbers of staff above the planned establishment and provides data to demonstrate the impact through a series of quality indicators outlining any mitigation or workstreams to support the current workforce challenges.

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 2 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.

Safer Staffing: Inpatient Services – March 2024



	Number of Shifts		
	January	**February**	**March**
Exact	803	835	932
Over Compliance	1521	1365	1488
Under Compliance	247	217	268
Non-Compliant	1	0	0

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

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

Narrative on Data Extracts Regarding LYPFT Staffing Levels on x28 Wards during March 24: This is the whole time equivalent (WTE) number of staffing posts the inpatient wards are funded for, to deliver planned level of care and interventions within their speciality by shift.

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

Exact or Over Compliant shifts: The compliance data demonstrated an increase in the number of shifts which were staffed exactly as planned or staffed above the planned number of Registered Nurse (RN) and Health Support Worker (HSW) duties during the months of February 2024 and March 2024. The largest proportion of clinical shifts are working over the planned establishment.

Under Compliant Shifts: The compliance data demonstrates a reduction in the number of shifts during the 2-month period that had fewer than the planned number of Registered Nurses and Health Support Workers on each shift. Where there are fewer than planned Registered Nurses on shift, it is usual for one or more extra Health Support Workers to back fill the vacant duty and ensure safe staffing levels where a Registered Nurse is not available to fill the shift.

Non-Compliant Shifts: This metric represents the number of shifts where no Registered Nurses were on duty. All clinical shifts during the period from 1st February to 31st March 2024 had a registered nurse on duty.

MHOST- The first MHOST data collection period was completed in September 2023 and shared in the most recent 6-month safer staffing report; this provided the initial data which would begin to support evidence-based workforce planning. A further data collection was completed in March 24, this data is currently being analysed and it is anticipated that this will be available to share with clinical areas by the end of May 24. This data cannot be used in isolation and should always be triangulated with professional judgement and quality indicators.

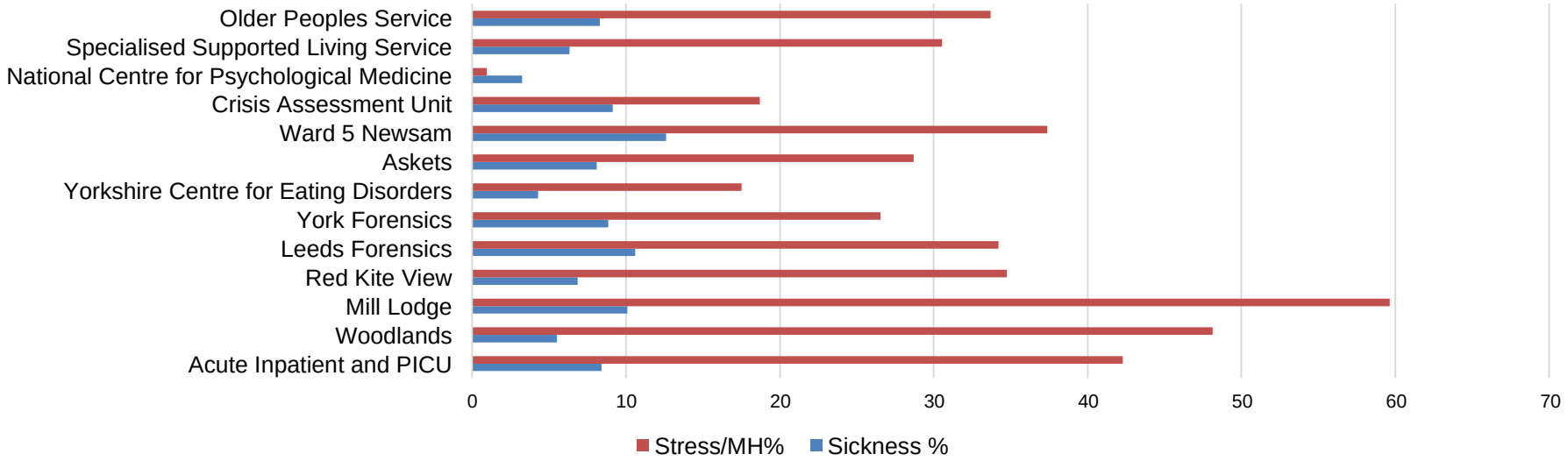
Due to the absence of a MHOST tool for Learning Disability, Woodlands Square have been unable to participate in the MHOST data collection. All other inpatient areas have submitted MHOST data for both data collection periods.

SERVICE AREA UPDATES

Sickness Absence

The chart below demonstrates the sickness rate (%) for each Inpatient area in March 2024 and of those periods of sickness, what percentage is related to stress/mental health as reported on the E-Rostering system. Service lines have been reported together where possible and provide an average across the wards.

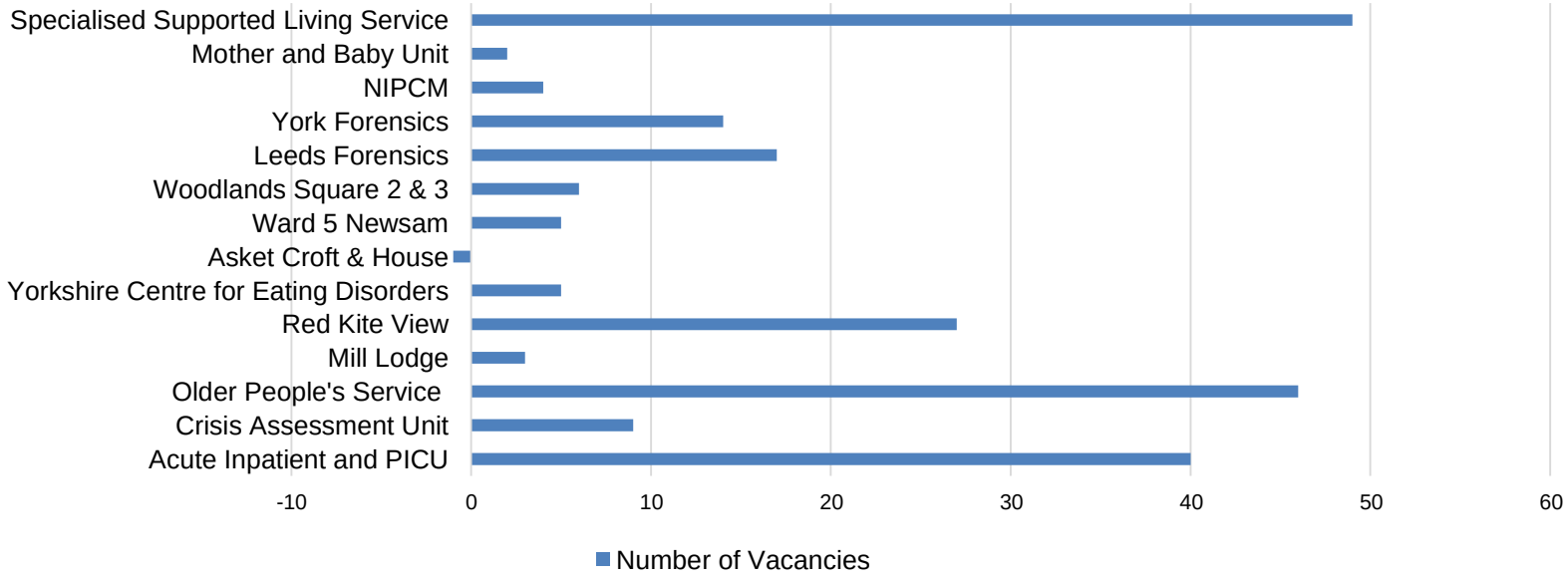
Across the services, YCED, NICPM and Woodlands Square have reported sickness levels below the Trust target of 6%. Stress/mental health sickness absence accounts for all absence related to stress/mental health and is not only work-related stress.



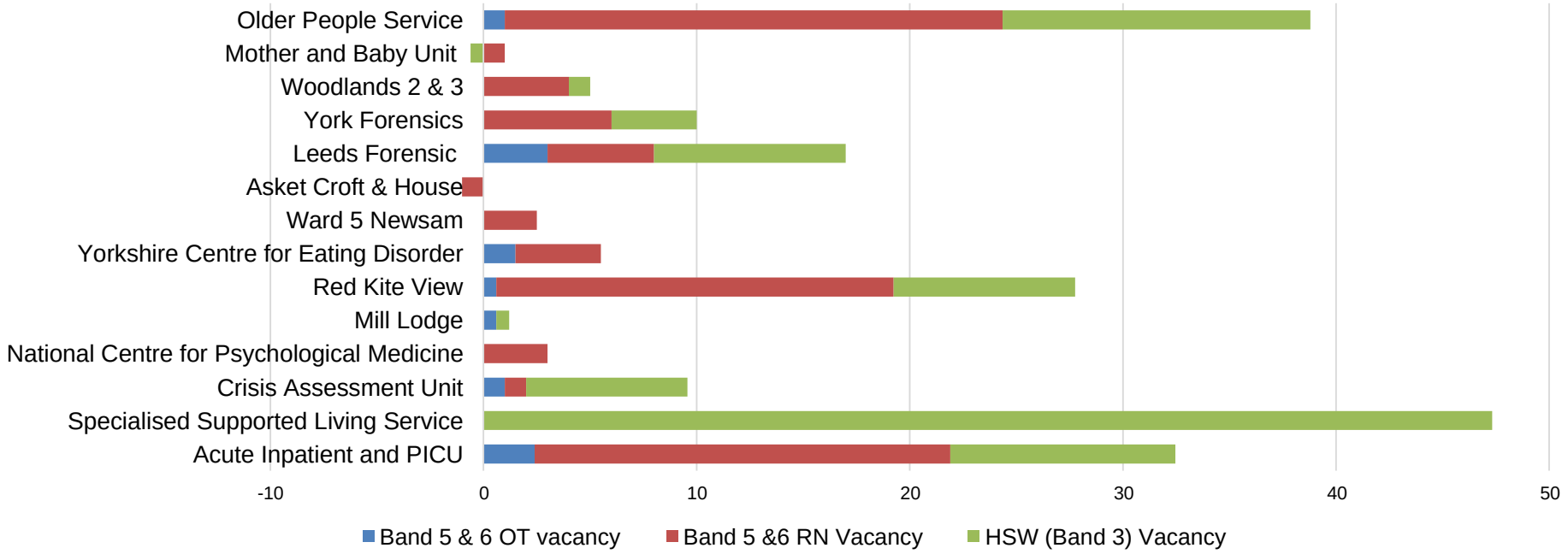
Vacancies
Below indicates the number of vacancies across each service as reported on ECHO in March 2024. This is across the multidisciplinary teams and not solely related to Registered Nurses and Health Support Workers which are traditionally viewed in the safer staffing figures.

Although Registered Nurses and Health Support Workers are those reported in the establishment figures, it is important to recognise the range of roles within the multidisciplinary teams for providing safe and effective care in our ward environments and this is not captured in the unify data.

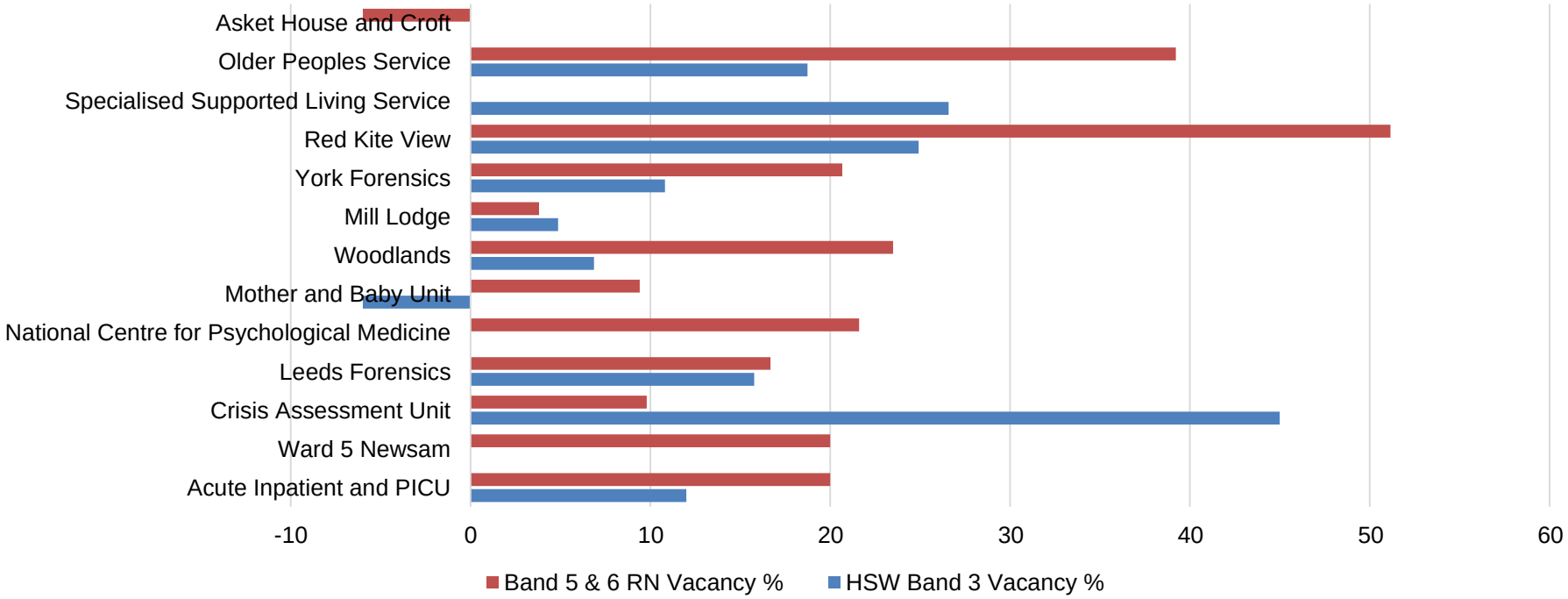
Many services also have Band 3 Trainee Nursing Associates (TNA), Band 4 Nurse Associates (NA) and Band 4 Health Support Workers (HSW) as part of the establishment.



The chart below shows the vacancy rates for Registered Nurses, Band 3 Health Support Workers, and Occupational Therapists (WTE) across services. This information is a snapshot and taken from the finance data using budgeted establishment for these roles and the vacancy information for March 2024.



Due to the varied headcount of the services covered, the chart below has been included to show the vacancies for Registered Nurses and Health Support Workers by percentage. This shows that despite Older Peoples Services having the higher number of Registered Nurse vacancies, Red Kite View has the highest percentage of Registered Nurse vacancies.



For this paper, there will be a focus on four clinical areas where there is either significant Registered Nurse or Health Support Worker vacancies or are using significantly higher numbers of staff above the planned establishment. This part of the paper will provide data to demonstrate the impact through a series of quality indicators outlining any mitigation or workstreams to support the current workforce challenges.

Have Your Say and complaints data for the reporting period can be found in the appendices, this information gives some indication of the reported patient experience within services.

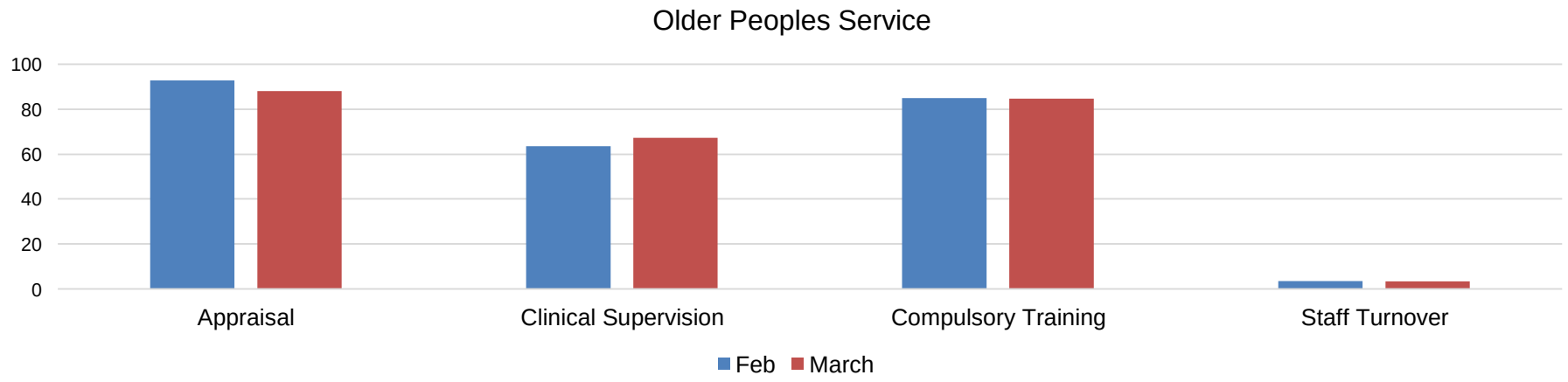
Older Peoples Services (Mount wards 1, 2, 3 and 4)

The Older Peoples Service have continued to see successful recruitment of Health Support Workers, which will support the reduction of Health Support Worker vacancies as new starters commence in post. The use of bank and agency along with substantive staff working additional bank shifts has enabled the service to continue to provide consistency on the wards.

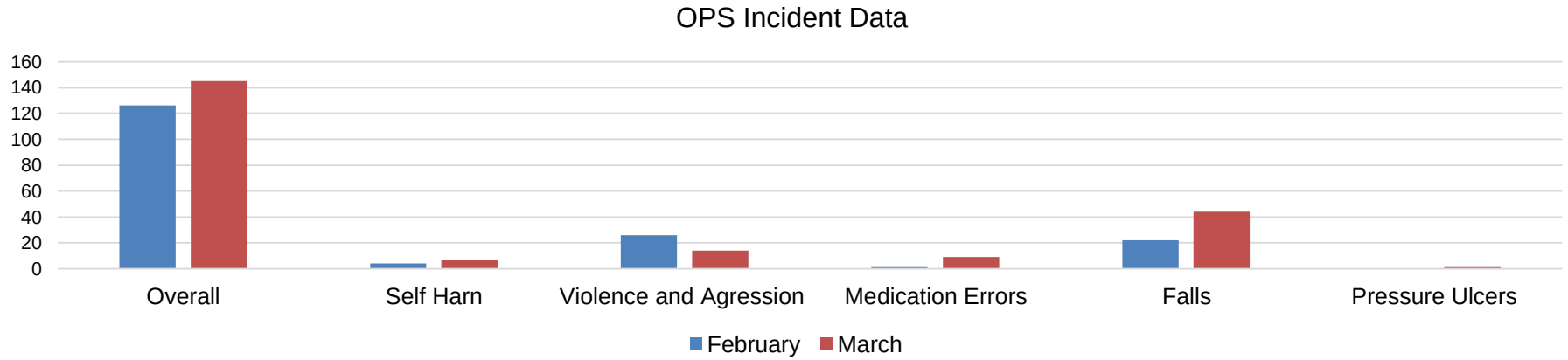
The service also has staff in Band 4 positions across the wards in both Nurse Associate and Assistant Practitioner roles supporting the service users as part of the establishment, which are not reflected in the vacancy data for Registered Nurses and Health Support Workers, though increasing the shifts filled within the establishment. The team also includes Allied Health Professions in the ward environment delivering profession specific interventions and providing care and support of the service users on the ward.

The chart below shows appraisal rates above the Trust target of 85% and compulsory training rates slightly lower than the target. Clinical supervision rates are lower than the Trust target, though saw some improvement month on month during the data period. Maintaining good levels of appraisal, compulsory training and supervision can have a positive impact on patient care and staff wellbeing. They have maintained low turnover rates.

The service received 16 Have Your Say responses during the period and of these, 62.5% (10) reported that their care was “good” or “very good” with a further 12.5% (2) reporting their care was “ok”. One reported “don’t know”. There was one complaint received during the reporting period and any learning will be shared with the service.



Below is the incident data for the service within the reporting period. In March, incidents of violence ad aggression were at the lowest levels within a 12-month period between May 2023 an April 2024 however there was an increase in falls and pressure ulcers. The Trust holds a regular group to review falls and pressure ulcers within the organisation which supports ongoing learning.



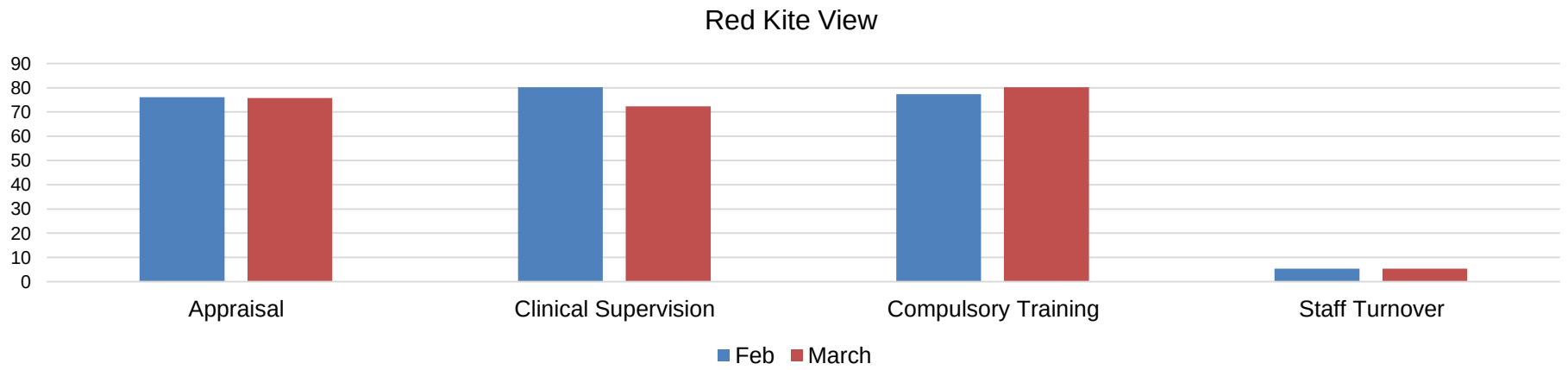
Red Kite View (Skylark and Lapwing)

Red Kite View continues to have a high percentage of vacancies and both long term and short-term sickness across staffing groups. Both wards continue to have members of temporary staff who block book shifts which supports continuity of care. Alongside the Registered Nurses and Band 3 Health Support Workers, there are Band 4 staff, including Nursing Associates, Band 2 Assistant Health Support Workers and Trainee Nurse Associates working within the ward and bringing additional skills and experience. The vacancies within senior nursing roles are being reviewed with the service to identify any additional support and/or changes to the operational and clinical model to enable the continuation of the delivery of safe and effective care.

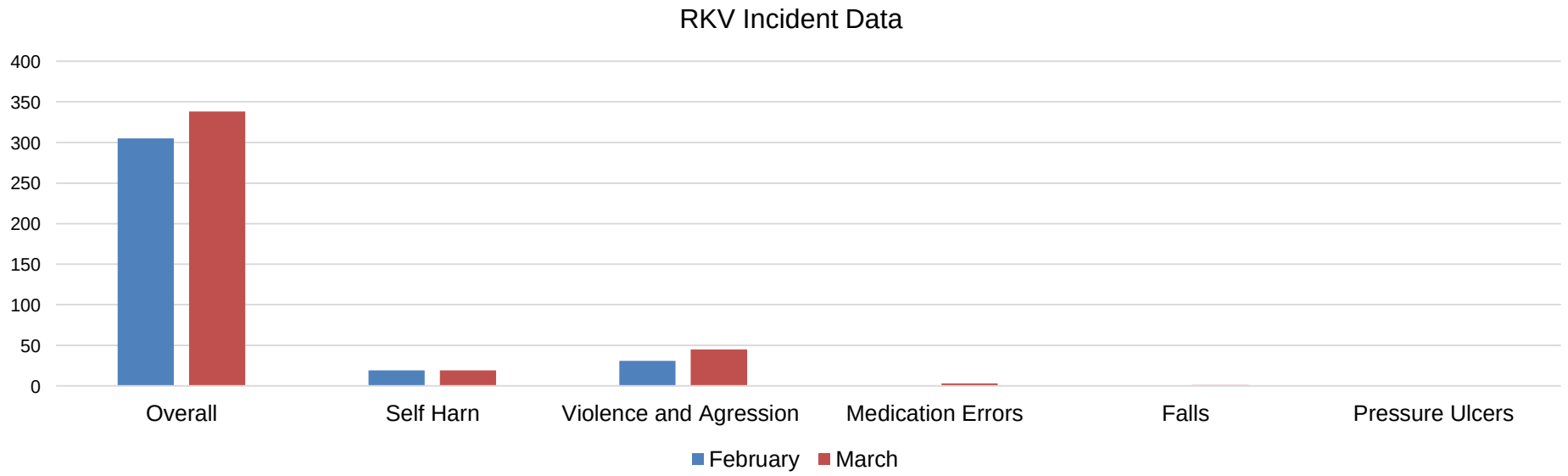
Admissions to the unit are risk assessed to ensure the needs of the young person can be safely met prior to admission. This is particularly relevant to any young person requiring nasogastric feeding which is a complex nurse specific clinical intervention.

Below are the supervision, appraisal and compulsory training rates for February and March and although they have not met the Trust target of 85%, these have maintained a consistent level falling just below. This indicates that staff are continuing to receive both supervision and training, which will have an impact on supporting staff wellbeing and patient safety.

No complaints were received during the reporting period.



The table below shows the number of incidents across Red Kite View for the reporting period. February saw a reduction in incidents from the previous two months. There has been a reduction in self-harm incidents since December which has been maintained.



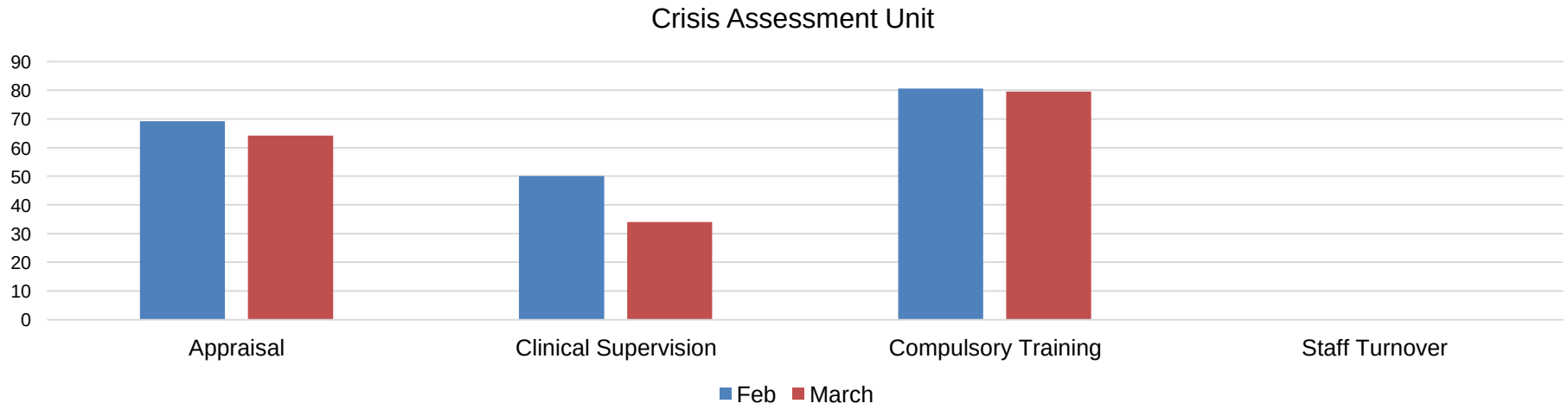
Crisis Assessment Unit (CAU)

The Health Support Worker vacancies in CAU have recently all been recruited to, and successful applicants will commence position soon. The current Health Support Worker vacancy is being mitigated through a combination of bank/agency usage and the Responsive Workforce Team. The service has x1 Registered Nurse vacancy which will be imminently advertised. The service has a gap in Occupational Therapist provision; a rotational Occupational Therapist is due to commence post in July 2024 with the plan to recruit a substantive Occupational Therapist shortly following. The service also plans to recruit an Activity Coordinator, this will increase the offer of therapeutic activities and group work. This will also support the acknowledgement and recognition of safer staffing being made up traditionally of nursing roles and a move toward a more multidisciplinary team approach. Turnover has remained below target at 0% during the data collection period.

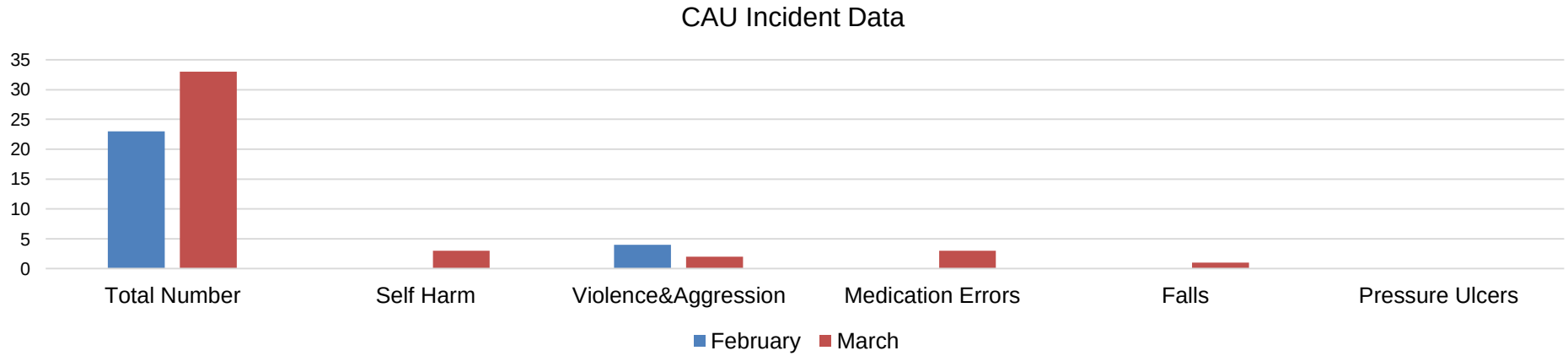
CAU is using numbers slightly above the establishment to meet the care needs of the service users admitted to the clinical area. This has been impacted by the increase in the number of detained service users being admitted and increased use of flex beds within the section 136 suite.

The chart below shows the clinical supervision, appraisal and mandatory training for CAU across the reporting period. There has been a decrease in compliance in all areas in March. Compliance for clinical supervision has remained significantly under target during the data period, there is a plan to complete a focussed piece of work supported by the Professional Lead Nurse with the aim to improve compliance in this area.

CAU received no complaints during the data collection period but had three complaints which remained open to the service during this period. One Have Your Say response was received, stating that care received was “Ok.”



The below table shows the number of incidents in CAU during the reporting period, with the breakdown of those incidents reviewed as part of safer staffing. This shows a similar number of incidents over the 2-month period with a slight increase in March. There have been several violence and aggression related incidents with one incident resulting in a long-term sickness absence.

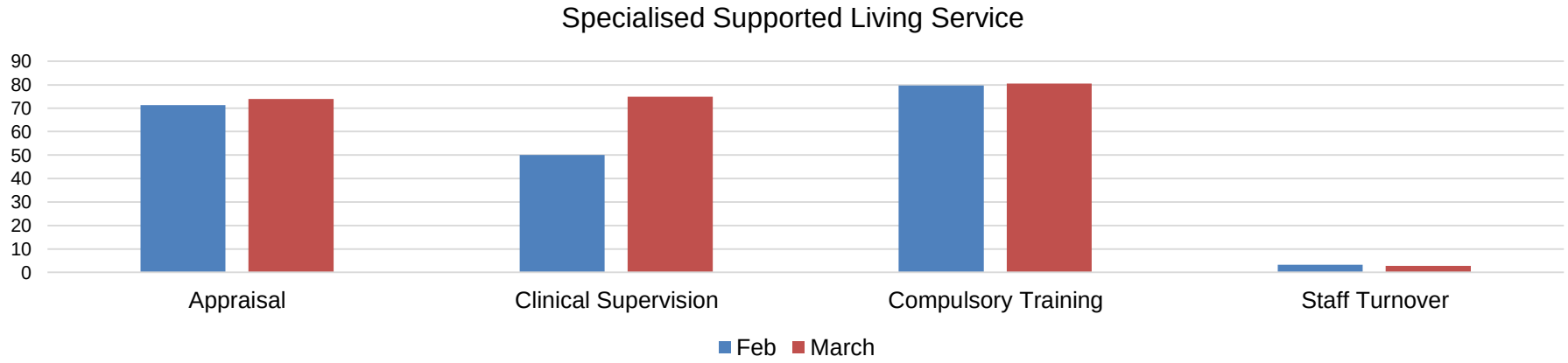


Specialised Supported Living Service (SSLS)

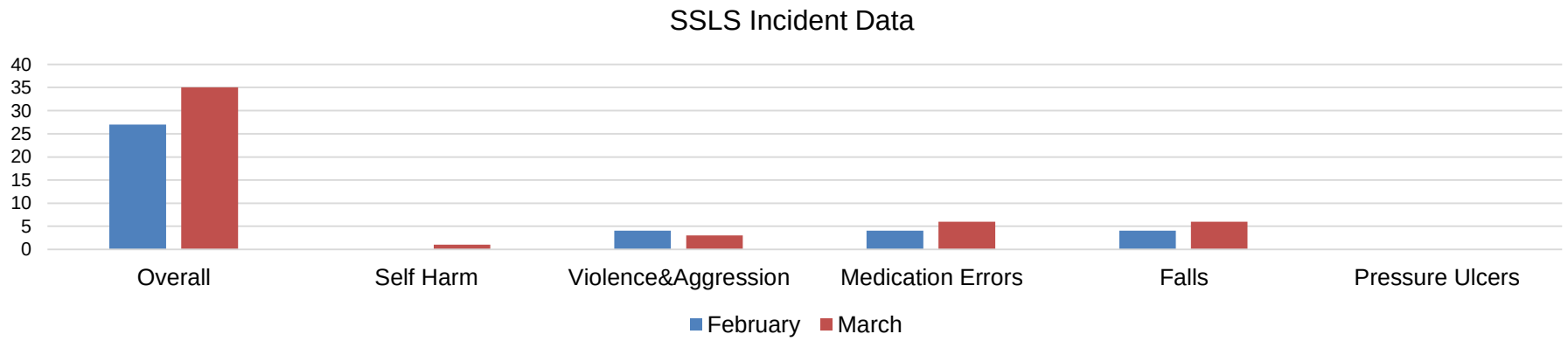
The Specialised Supported Living Service (SSLS) provides accommodation to individuals with learning disabilities and complex health needs at 16 locations across Leeds. The service is predominantly staffed with Support Workers (band 3) or Senior Support Workers (Band 4). The service is funded by Adult Social Care for 250 WTE; 90% of this workforce is made up of either Senior or Support Workers, the remaining 10% being either band 6 or 7 staff (registered and non-registered) who have more of an operational and leadership role within the service. The current Support Worker vacancies are mitigated through a combination of substantive staff working additional bank shifts and temporary staffing. The service has seen some successful recruitment initiatives; this in time will support the reduction of Support Worker vacancies. The service recently held an apprentice recruitment event which enabled the successful recruitment of fourteen apprentices, two successful applicants have the correct qualifications which enables them to go directly into a band 3 Support Worker role. All successful applicants will commence position imminently.

The chart below shows the clinical supervision, appraisal and mandatory training for the SSLS across the reporting period. There has been an increase in compliance in all areas in March. Turnover has remained below target of 10% during the data collection period.

SSLS received no complaints during the data collection period and there were no open complaints to the service during this period. The service holds an annual Your Say event which offers various approaches to providing feedback. A detailed report is generated following these events which is shared widely.



The below table shows the number of incidents in the SSLS during the reporting period, with the breakdown of those incidents reviewed as part of safer staffing. This shows a similar number of incidents over the 2-month period with a slight increase in March. The highest number of incidents in this service area fall under medication related incidents, falls, and violence and aggression incidents.



Summary

Several of our inpatient services have seen improvement in their overall vacancies and recruitment particularly in HSW recruitment albeit several of these remain in the recruitment pipeline. However ongoing workforce challenges in a small number of services remain high and therefore vacancies continue to be featured on the risk register. The need for additional staffing above the planned establishment has also been required particularly to support enhanced observations in several of our services. Staffing pressures are currently mitigated through the combination of the Responsive Workforce Team, temporary staffing and substantive staff working additional bank shifts.

The first MHOST data collection period was completed in September 2023 and shared in the most recent 6-month safer staffing report; this provided the initial data which would begin to support evidence-based workforce planning. A further data collection was completed on March 24, this data is currently being analysed and is anticipated that this will be available to share with clinical areas in May. This data cannot be used in isolation and should always be triangulated with professional judgement and quality indicators, some of which have been detailed in this report.

The delivery of care through the multidisciplinary team and the professional specific roles which is not captured in the planned staffing establishment should be considered when reviewing the data. Workstreams continue around establishment reviews, effective roster creation and shifting the approach of safer staffing away from only considering the traditional roles of Registered Nurses and Health

Support Workers towards a more multidisciplinary team approach, this in turn will increase the quality of care delivered to our services users.

Recommendations:

The Board is asked to:

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

APPENDIX A

Safer Staffing: Inpatient Services March 24

Fill rate indicator return

Staffing: Nursing, Care Staff and AHPs

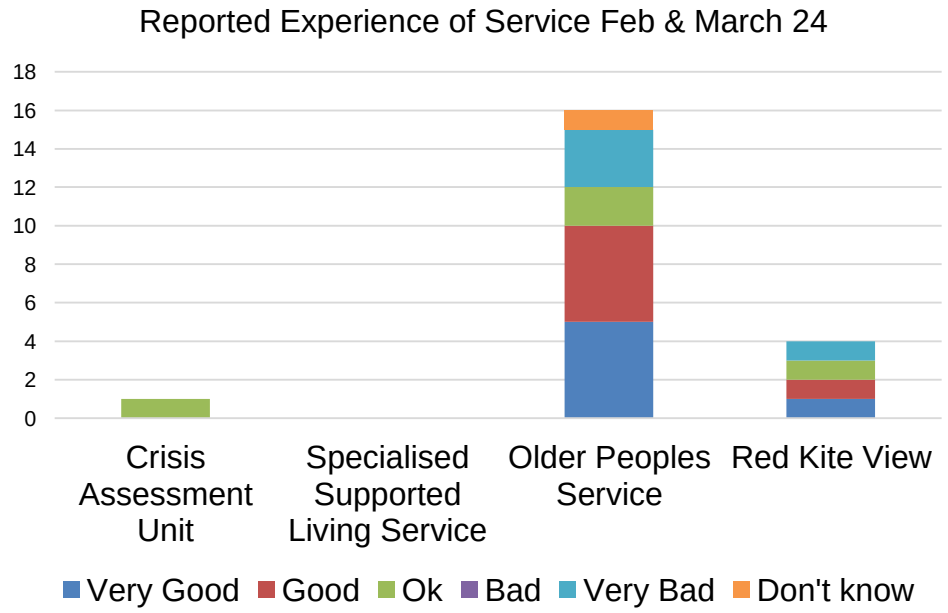
Ward name	Cumulative count	Care Hours Per Patient Day (CHPPD)							Day				Night				Allied Health	
		Registered	Non-registered	Registered	Non-registered	Registered	Non-registered	Overall	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill
WardName	PatientCo	CHPPD_RN	CHPPD_NI	CHPPD_RN	CHPPD_NI	CHPPD_RA	CHPPD_NI	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	114	8.7	7.9	0.0	0.0	0.0	0.0	16.6	87%	136%	-	-	100%	101%	-	-	-	-
3 WOODLAND SQUARE	107	8.6	18.0	0.0	0.0	0.0	0.0	26.6	78%	161%	-	-	50%	116%	-	-	-	-
ASKET CROFT	591	1.4	2.5	0.0	0.0	0.0	0.6	4.5	85%	90%	-	-	100%	100%	-	-	-	100%
ASKET HOUSE	434	1.9	2.1	0.0	0.0	0.0	0.7	4.7	106%	81%	-	-	100%	100%	-	-	-	100%
BECKLIN CAU	186	7.3	16.7	0.0	0.0	0.0	0.0	24.0	94%	146%	-	-	99%	137%	-	-	-	-
BECKLIN WARD 1	681	2.4	6.5	0.0	0.0	0.0	0.6	9.5	85%	272%	-	-	94%	308%	-	-	-	100%
BECKLIN WARD 3	687	2.2	3.8	0.0	0.0	0.0	0.4	6.4	77%	221%	-	-	92%	158%	-	-	-	100%
BECKLIN WARD 4	694	2.4	4.3	0.0	0.0	0.0	0.4	7.1	88%	210%	-	-	96%	215%	-	-	-	100%
BECKLIN WARD 5	674	2.6	9.7	0.0	0.0	0.0	0.1	12.3	98%	582%	-	-	97%	468%	-	-	-	100%
MOTHER AND BABY AT THE MOUNT	135	9.2	14.2	0.0	0.0	0.0	0.0	23.3	85%	118%	-	-	75%	134%	-	-	-	-
NEWSAM WARD 1 PICU	362	4.3	10.1	0.0	0.0	0.0	0.4	14.8	85%	126%	-	-	85%	147%	-	-	-	100%
NEWSAM WARD 2 FORENSIC	301	3.5	11.3	0.0	0.0	0.0	0.7	15.5	95%	135%	-	-	100%	143%	-	-	-	100%
NEWSAM WARD 2 WOMENS SERVICES	301	4.3	9.7	0.0	0.0	0.0	0.7	14.6	120%	110%	-	-	110%	123%	-	-	-	100%
NEWSAM WARD 3	427	2.4	5.4	0.0	0.0	0.0	0.4	8.1	99%	112%	-	-	103%	101%	-	-	-	100%
NEWSAM WARD 4	650	2.4	4.1	0.0	0.0	0.0	0.3	6.8	83%	243%	-	-	100%	172%	-	-	-	100%
NEWSAM WARD 5	1054	1.4	2.4	0.0	0.0	0.0	0.7	4.4	113%	96%	-	-	84%	150%	-	-	-	100%
NEWSAM WARD 6 EDU	409	3.0	11.6	0.0	0.0	0.0	0.9	15.6	103%	627%	-	-	66%	290%	-	-	-	100%
NICPM LGI	460	3.3	2.0	0.0	0.0	0.0	0.7	6.0	119%	72%	-	-	94%	113%	-	-	-	100%
RED KITE VIEW GAU	317	5.5	13.7	0.0	0.0	0.0	0.0	19.3	109%	124%	-	-	94%	129%	-	-	-	-
RED KITE VIEW PICU	149	9.6	26.6	0.0	0.0	0.0	0.0	36.2	100%	108%	-	-	102%	116%	-	-	-	-
THE MOUNT WARD 1 NEW (MALE)	438	3.3	10.7	0.0	0.0	0.0	0.0	14.0	153%	139%	-	-	90%	217%	-	-	-	-
THE MOUNT WARD 2 NEW (FEMALE)	463	3.3	13.3	0.0	0.0	0.0	0.0	16.5	79%	194%	-	-	99%	259%	-	-	-	-
THE MOUNT WARD 3A	544	2.8	7.7	0.0	0.0	0.0	0.0	10.5	92%	206%	-	-	95%	249%	-	-	-	-
THE MOUNT WARD 4A	662	2.2	5.9	0.0	0.0	0.0	0.0	8.1	78%	195%	-	-	100%	192%	-	-	-	-
YORK - BLUEBELL	283	4.2	8.7	0.0	0.0	0.0	0.7	13.6	118%	92%	-	-	118%	103%	-	-	-	100%
YORK - MILL LODGE	273	5.3	7.8	0.0	0.0	0.0	1.0	14.1	80%	97%	-	-	83%	142%	-	-	-	100%
YORK - RIVERFIELDS	217	3.9	7.1	0.0	0.0	0.0	0.5	11.5	59%	171%	-	-	110%	102%	-	-	-	100%
YORK - WESTERDALE	180	6.5	17.9	0.0	0.0	0.0	1.2	25.6	65%	190%	-	-	140%	140%	-	-	-	100%

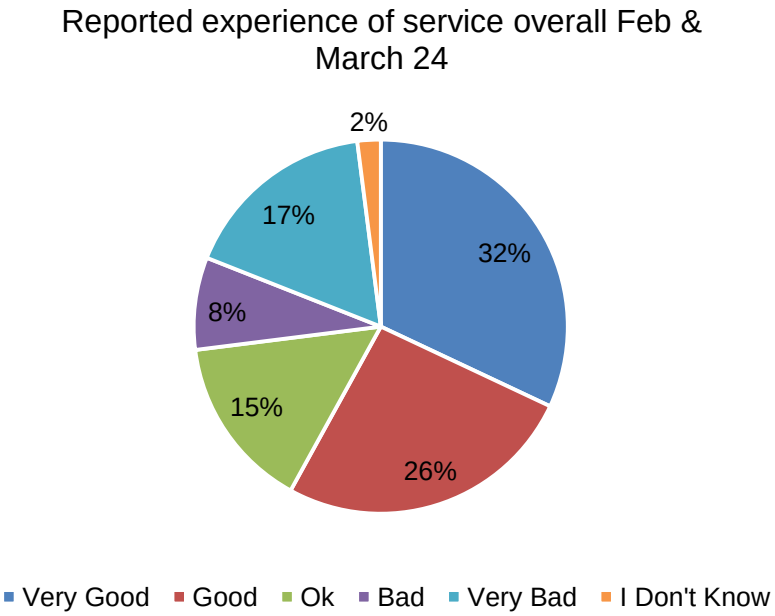
*** Allied health professionals refer only to Occupational therapists that are included in the ward establishment**

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 wards within this report who have received Have Your Say feedback, 61% reported that their care was “good” or “very good” and 17% reporting this as “bad” or “very bad”. SSLS data is generated from an annual Your Say event, a report is created following these events and shared with the service.

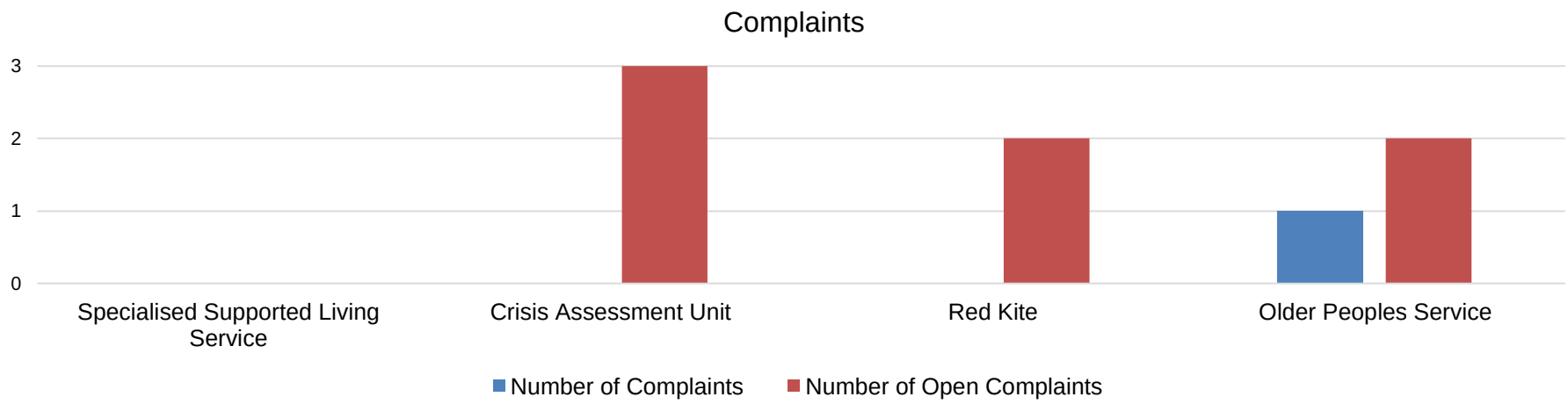
The below pie chart shows the data for all inpatient areas who have received Have Your Say feedback, 58% reported that their care was “good” or “very good” and 25% reported this as “bad” or “very bad”.





Complaints

Below are the number of complaints received during the report period and the number of complaints open during the reporting period for the four clinical areas that are the focus of this report.



Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

18

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Guardian of Safe Working Quarterly Report Quarter 4: 1st January 2024 to 31st March 2024
DATE OF MEETING:	30 May 2024
PRESENTED BY: (name and title)	Dr Chris Hosker, Medical Director
PREPARED BY: (name and title)	Dr Rebecca Asquith, Guardian of Safe Working House

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

EXECUTIVE SUMMARY

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

- There have been 3 exception reports and 0 patient safety issues recorded in this period. No fines have been issued.
- Junior Doctors Forum met in April 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 of Directors are asked:

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

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

MEETING OF THE BOARD OF DIRECTORS

30 May 2024

Guardian of Safe Working Hours Report

Quarter 4: 1st January 2024 to 31st March 2024

1 Executive Summary

The purpose of this quarterly report is to give assurance to the board that doctors in training are safely rostered and that their working hours are compliant with the Junior doctors contract 2016 and in accordance with Junior doctors terms and conditions of service (TCS). The report includes the data from 01.01.2024 to 31.03.2024.

2 Quarter 3 Overview

<table>
<tr><td colspan="2" rowspan="2">Vacancies</td><td colspan="6">As in previous reports, and continuing from August 2023, there are 38 Core trainees and 2 NIHR posts. All schemes are full. 5 ‘FY3s’ (trust doctors) started in February 2024 to fill service gaps.</td></tr>
<tr><td colspan="6">As of August 2023, there are 31 established higher training posts, plus one psychotherapy post borrowed from Forensics. There is one vacancy in Intellectual Disability.

The business case to expand the number of higher training posts, as requested by NHSE Workforce, Training and Education was approved by the Financial Planning Group. This has resulted in the Trust gaining an additional CAMHS, GA and OA post to the establishment. NHSE Workforce, Training and Education have included these posts in round 1 and round 2 of national recruitment.</td></tr>
<tr><td colspan="2" rowspan="2">Rota Gaps</td><td colspan="2">January</td><td colspan="2">February</td><td colspan="2">March</td></tr>
<tr><td>CT</td><td>HT</td><td>CT</td><td>HT</td><td>CT</td><td>HT</td></tr>
<tr><td rowspan="3"></td><td>Gaps</td><td>16</td><td>9</td><td>7</td><td>14</td><td>7</td><td>17</td></tr>
<tr><td>Internal Cover</td><td>13</td><td>9</td><td>7</td><td>14</td><td>5</td><td>17</td></tr>
<tr><td>Agency cover</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
</table>

	Unfilled	3	0	0	0	2	0
Fill Rate		81%	100%	100%	100%	71%	100%
Reasons for Rota Gaps		Reasons for rota gaps include sickness, vacant shifts (through recruitment gaps), other unplanned leave, statutory leave, Less Than Full Time working, and being off rota.					
Exception reports (ER)		3 exception reports have been submitted in this reporting period. All reports were in relation to missed educational opportunities related to the ALPS early implementer project. This project is trialling one trainee (CT) being based with ALPS during their on-call shift to improve out of hours emergency psychiatry experience. There were no patient safety issues or contractual breaches, but ERs are being encouraged to allow GOSW/MEC to monitor impact of any rota gaps or busy on calls on these educational opportunities, prior to its formal implementation in August 2024. There remain ongoing discussions with the LYPFT Foundation Lead and the LTHT Training Programme Director in relation to the previously submitted ERs by Foundation Doctors based at The Mount in Q3, and a plan to review the work schedules issued by LTHT. Additionally, a number of recommendations have been made by the DME, FY Lead, and DPGME – Training Lead, following their investigation of feedback from DiT placed at The Mount.					
Fines		None					
Patient Safety Issues		None					
Junior Doctor Forum (JDF)		The meeting held for the Q4 reporting period took place on 12th April 2024: - ERs discussed as above. - Discussions continue with Less Than Full Time (LTFT) trainees about allocation of on call shifts on non-working days. BMA advice has been requested. - Discussions took place around DiT using annual leave to allow taking on locum shifts. Agreed it is appropriate to return to this (pre-pandemic) expectation. A meeting is being arranged with BMA to discuss further. - Discussions held regarding large staff vacancies at The Deanery and for trainees to escalate to Educational Supervisors if any delays as a result.					

	- Wellbeing in Trainee Psychiatrists document discussed and suggestions to be fed back to Wellbeing Lead for further amendments. The next JDF is planned for 19th July 2024.

3 Conclusion

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

4 Recommendations

The Board of Directors are asked:

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

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

Dr Rebecca Asquith
GMC 7151560
Guardian of Safe Working Hours

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
19

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Report from the Chair of the Audit Committee for the meeting held on 16 April 2024
DATE OF MEETING:	30 May 2024
PRESENTED BY: (name and title)	Martin Wright, Non-executive Director
PREPARED BY: (name and title)	Kieran Betts, Corporate Governance Officer

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

COMMITTEE DETAILS:	
Name of Committee:	**Audit Committee**
Date of Committee:	**Tuesday 16 April 2024**
Chaired by:	**Martin Wright, Non-executive Director**

KEY DISCUSSION POINTS:

ALERT - Issues to alert the Board to:

None.

ADVISE - Issues to advise the Board on:

- The Committee noted that not all audits which were agreed to be deferred were automatically included in the audit plan for the following financial year. Instead, the process was for the Internal Audit Team to consider all key strategic objectives and priorities of the Trust at the time the internal audit plan was drafted, which may result in deferred plans not being included in the plan as they were considered lower priority than other audit areas. This process had resulted in the planned audit for Care Plans and Clinical Risk Assessments (Follow Up) to not be included at all in the 2024-25 plan, and the Out of Area Placements audit to be included on the reserve list for the 2024-25 plan.

- The Committee was informed of requests to defer two internal audits from 2023-24 to the 2024-25 audit planning (Care Plans and Clinical Risk Assessment (Follow Up), and Patient

Flow). The Committee discussed the reasons for this and agreed to support the deferral of these reports.

- The Committee noted that a number of audit actions had been identified as being overdue at the end of March 2024. The Committee was reassured that work was being done to address these outstanding actions and noted that there was a mitigating factor in that the system used for tracking internal audit actions was switched at the end of March 2024 which obfuscated this development.

- The Committee noted that a wider review of the tender and quotation process was currently under review in light of new procurement regulations expected to be introduced in Autumn 2024. The Committee agreed that in the interim only the justification for quotation waivers would be reported to the Committee, while it would continue to receive tender waivers in full.

ASSURE – Items to provide assurance to the Board on:

- The Committee received the Quality Account Progress Update 2023-24 and was assured by the process by which the Quality Account had been developed.

- The Committee received and approved the Draft Internal Audit Plan for 2024-25 and the amendments made to the Internal Audit Charter.

- The Committee received the Internal Audit Progress Report and was pleased to note that the Modern Slavery Act (Follow Up); the Management of Policies (Follow Up); and the Emergency Preparedness, Resilience, and Response audits had been returned with an overall opinion of significant assurance.

- The Committee received a verbal update on the Head of Internal Audit Opinion. The Committee noted that the Trust was working towards receiving a positive outcome when the Head of Internal Audit Opinion was finalised in June 2024. The Committee also noted the praise the Executive Team received from the Internal Audit Team for its engagement and support with the process.

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

- The Committee received and discussed the contents of the Health and Safety Quarterly Update report for Q4 2023-24. It suggested several ways in which this report could be improved for future quarterly update reports.

- The Committee received and approved the final external audit plan for 2023-24. It noted that the external audit fees had been finalised and agreed. It also received the Value for Money Risk Assessment conducted by the external audit team and was assured that no significant weaknesses had been identified in any of the three risk areas assessed.

- The Committee received the Draft Annual Governance Statement and agreed that this statement presented a consistent view based on internal controls and recommended no amendments to the statement aside from some minor amendments to be made to the work done by the Quality Committee.

- The Committee received the Board Assurance Framework (BAF) and was assured that it was fit for purpose. It noted that work was being conducted to review the strategic risks included in the BAF. It noted that all Board Sub-Committee Chairs should be consulted so that their feedback could be captured as part of this review.

- The Committee received the Tender and Quotation Exception Report for January – March 2024, the Losses and Special Payments Report for 2023-24, and the Going Concern and Use of Specialist Advisors Report for 2023-24 and was assured by their contents.

- The Committee received and approved the Audit Committee Annual Report for 2023-24, ahead of it being circulated to the Board of Director's meeting in June 2024.

Items to be referred to other Committees –

- The Committee discussed an employee liability case which had been included as part of the Losses and Special Payments report received by the Committee. It agreed that such cases may present a reputational risk for the organisation. It agreed to suggest that employee liability cases should be discussed further at Workforce Committee meetings, and that patient liability cases should be discussed further at Quality Committee meetings for additional assurance.

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

RECOMMENDATION

The Board is asked to note the contents of the Chair's Report which summarises the discussions held at the April Audit Committee meeting.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
21

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Board of Directors' annual declarations
DATE OF MEETING:	30 May 2024
PRESENTED BY: (name and title)	Merran McRae, Chair
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 Health and Social Care Act 2008 (regulated activities) Regulations 2014 set out requirements by which all directors should be, and continue to be, fit and proper persons by nature of the fact they hold positions of significant responsibility and can maintain the confidence of public, patients and staff.

Following the 2019 Kark Review of the original Fit and Person Test, a Fit and Proper Person Test (FPPT) Framework was introduced in Summer 2023 with the aim of strengthening and reinforcing individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS.

The new framework introduced a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all Board directors, a new way of completing references with additional content whenever a director leaves an NHS Board, and extension of the applicability to some other organisations, including NHS England and the CQC.

The regulations require directors to:

- be of good character
- have the necessary qualifications, competence, skills and experience
- be able by reason of their health (subject to reasonable adjustments) to properly perform tasks intrinsic to the position
- not have been responsible for, contributed to or facilitated any serious misconduct or mismanagement while carrying out a regulated activity
- not to be unfit to hold office on a range of grounds (eg undischarged bankruptcy, criminal convictions, inclusion on barred lists, serious misconduct in the course of carrying out a regulated activity etc).

During March 2024, all Board members were required to complete a self-attestation to confirm that they are in adherence with the FPPT requirements. In addition, annual checks have been conducted to confirm former satisfactory background checks are still current, these include social media searches, health and social care regulators' checks, disqualified directors, insolvency and bankruptcy registers.

Compliance with the requirements will be formally reported to NHS England by 30 June 2024. This will be completed by the Chair, and will provide assurance that all Board members fulfil the requirements of the Fit and Proper Person Test.

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

RECOMMENDATION

The Board is asked to note:

- That the Trust is fully compliant with the Fit and Proper Person Test and Framework as at the date of this report.

Personal	Appraisal				HR					Suita		
Name	Annual Appraisal	Training & Development	Self Attestation	Declaration of Interest	Disciplinary	Grievance	Whistleblowing	Behaviour	DBS check	Insolvency Check	Disqualified Directors	Disqualified Trustee
Chair / Non-Executive Directors												
MM	07-Jun-23	Compliant	Complete		Compliant					Compliant		
ZBS	N/A	Compliant	Complete		Compliant					Compliant		
FH	06-Jun-23	Compliant	Complete		Compliant					Compliant		
CH	07-Jun-23	Compliant	Complete		Compliant					Compliant		
KK	07-Jun-23	Compliant	Complete		Compliant					Compliant		
KW	N/A	Compliant	Complete		Compliant					Compliant		
MW	06-Jun-23	Compliant	Complete		Compliant					Compliant		
Executive Directors												
SM	13-Jul-23	Compliant	Complete		Compliant					Compliant		
JFA	10-Jul-23	Compliant	Complete		Compliant					Compliant		
DH	10-Jul-23	Compliant	Complete		Compliant					Compliant		
CH	26-Jun-23	Compliant	Complete		Compliant					Compliant		
NS	03-Aug-23	Compliant	Complete		Compliant					Compliant		
DS	03-Jul-23	Compliant	Complete		Compliant					Compliant		

bility		
Employment Tribunal	Social Media	Registering Pofessional Body
		N/A
		N/A
		Complete
		N/A
		N/A
		N/A
		Complete
		Complete
		N/A
		Complete
		Complete
		Complete
		Complete

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
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MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Condition 7 of the Provider Licence (Continuity of Services) – Declaration
DATE OF MEETING:	30 May 2024
PRESENTED BY: (name and title)	Merran McRae, Chair
PREPARED BY: (name and title)	Rose Cooper, Deputy Head of Corporate Governance

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

EXECUTIVE SUMMARY

The Provider Licence requires the Board to self-certify annually its compliance with Condition 7 of the licence and to confirm that the Trust has the required resources available to it for the next 12 months.

The attached paper sets out this declaration in more detail. The evidence matrix is provided as appendix one which includes the statement of compliance and supporting evidence. The executive and senior manager leads were asked to review and confirm that the information provided is consistent with their knowledge and understanding of the controls in place to ensure that the Trust is compliant with Condition 7 of the Provider Licence.

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 be assured of the process for reviewing the evidence of our control systems and processes in place to ensure compliance with Condition 7 of the Provider Licence. The Board is also asked to agree the declaration shown on the attached.

Trust Board Self-Certification 2023/24

1. Introduction

NHS foundation trusts are required to self-certify that they can meet Condition 7 (Continuity of Services) of the NHS Provider Licence. The annual self-certification provides assurance that NHS providers are compliant with this condition of their licence. On an annual basis, the licence requires NHS providers to self-certify that:

- The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.

The Trust is not required to submit the self-certification to NHS England, but the Board is required to sign off the certificate and have the outcome of the self-certification exercise available upon request.

The Trust intends to make a positive confirmation on the declaration. The rationale for compliance is set out below. Further information can be found in the evidence matrix provided as appendix one.

2. Condition 7 (Continuity of Services) - Declaration

After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Summary rationale for rating: Having reviewed the financial statements the Board is satisfied that the Trust has the required resources for the period of 12 months, taking all factors into account.

Rating: Confirmed

PROVIDER LICENCE (Continuity of Services) 2023/24

Under the Provider Licence the Board of Directors is required to certify that it is (or is not) satisfied that it takes all reasonable precautions against the risk of failure to comply with Condition 7 of the Provider Licence (Continuity of Services). To allow this certification to be made the table below sets out how we comply with the licence condition.

SUPPORTING EVIDENCE FOR THE LICENCE CONDITION

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
CoS7 - Availability of resources Requires the Licensee to at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.	**Statement of compliance** The Trust is compliant with this condition, having made a declaration and is declaring a strong financial position. Approval of the Trust's financial plan is discussed at Board and at the Finance and Performance Committee.	**Evidence of compliance** • Financial information and projections are presented to the Board at each meeting • Finance and Performance Committee papers and minutes showing that the Committee is content that the Trust remains financially viable • Operational Plan submission and financial projections for the coming year, again demonstrating on-going financial viability and ability to meet ICB targets • Signed and committed contracts which are predominantly block contracts • CIPs process is in place • Capital programme is kept under constant review through the Finance and Performance Committee and the Board	Lead for evidence = Jonathan Saxton, Deputy Director of Finance with lead director = Dawn Hanwell