Public Meeting of the Board of Directors

will be held at 9.30am on Thursday 28 November 2024
Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR

Agenda

		LEAD	TIME
1	**Sharing stories – Recovery College Update** (verbal)		9.30am
2	**Apologies for absence** (verbal)	MM	10.00am
3	**Declarations of interests and any declarations of conflicts of interest in any agenda item** (enclosure)	MM	-
4	**Minutes of the meeting held on 26 September 2024** (enclosure)	MM	-
5	**Matters arising** (verbal)	MM	-
	5.1 Feedback from Shadow Board of Directors (verbal)	MW	-
6	**Actions outstanding from the public meetings of the Board of Directors** (enclosure)	MM	10.10am
Use of resource			
7	**Chief Executive's report** (enclosure)	SM	10.15am
8	**Trust Five Year Strategy 2024-2029** (enclosure)	SM	10.25am
9	**Report from the Chair of the Finance and Performance Committee for the meetings held on 30 October and 25 November 2024** (to follow)	CHe	10.30am
	9.1 Finance and Performance Committee Terms of Reference (enclosure)	CHe	-
10	**Report from the Chief Financial Officer** (enclosure)	DH	10.35am
	10.1 Amendment to SFI's (enclosure)	DH	-

11	**Health & Safety Annual Report** (enclosure)	**DH**	**10.45am**
12	**Operational Priorities Q2 Update Report** (enclosure)	**DH**	**10.50am**
	Break		**11am**
13	**Report of the Chief Operating Officer** (enclosure)	**JFA**	**11.10am**
14	**EPRR Annual Declaration** (enclosure)	**JFA**	**11.20am**
Patient centred care			
15	**Report from the Chair of the Quality Committee for the meetings held on 10 October and 14 November 2024** (enclosure)	**FH**	**11.25am**
	15.1 Quality Committee Terms of Reference (enclosure)	**FH**	**-**
Workforce			
16	**Report from the Medical Director** (enclosure)	**CH**	**11.30am**
	16.1 Guardian of Safe Working Hours Q2 Report (enclosure)	**CH**	**-**
17	**Report from the Director of Nursing & Professions** (enclosure)	**NS**	**11.40pm**
	17.1 Safer Staffing Report (enclosure)	**NS**	**-**
	Break		**11.50am**
18	**Report from the Chair of the Workforce Committee for the meeting held on 17 October 2024** (enclosure)	**ZBS**	**12pm**
19	**Report from the Director of People & Organisational Development** (enclosure)	**DS**	**12.05pm**
20	**Freedom to Speak Up Guardian Update Report** (enclosure)	**SR**	**12.15pm**
Governance			
21	**Report from the Chair of the Audit Committee for the meeting held on 22 October 2024** (enclosure)	**MW**	**12.30pm**
	21.1 Audit Committee Terms of Reference (enclosure)	**MW**	**-**
22	**Report from the Chair of the Mental Health Legislation Committee for the meeting held on 5 November 2024** (enclosure)	**KW**	**12.35pm**

23	**Chairs Report from the West Yorkshire Mental Health Committee in Common held on 23 October 2024** (enclosure)	**MM**	**12.40pm**
24	**Board Assurance Framework** (enclosure)	**SM**	**12.45pm**
25	**Future Meetings & Work Programme for 2025** (for information only)	**-**	**-**
26	**Use of Trust Seal** (verbal)	**MM**	**-**
27	**Any other business**	**MM**	**12.50pm**

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

AGENDA ITEM

3

Declaration of Interests for members of the Board of Directors

Name	Directorships, including Non-executive Directorships, held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services.	Any substantial or influential connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.	Any other commercial or other interests you wish to declare. This should include political or ministerial appointments (where this is information is already in the public domain – this does not include personal or private information such as membership of political parties or voting preferences)	Declarations made in respect of spouse or co-habiting partner
EXECUTIVE DIRECTORS								
Sara Munro Chief Executive	**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
Nichola Sanderson Director of Nursing and Professions	None.	None.	None.	None.	None.	None.	None.	Partner: **Company Director** Emporia Cumbria Ltd.

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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
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

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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

Minutes of the Public Meeting of the Board of Directors held on Thursday 26 September 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

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
Ms Wendy Tangen	LYPFT Involvement Lead (for minute 24/105)
Ms Helen Thompson	Experience Co-ordinator (for minute 24/105)
Ms Joy McMillian	Community Mental Health Engagement & Involvement Worker (for minute 24/105)
Ms Claire Legg	Community Mental Health Engagement & Involvement Worker (for minute 24/105)
Ms Danielle Lawal	Community Mental Health Engagement & Involvement Worker (for minute 24/105)
Mrs Fiona Sherburn	Associate Director for People Resourcing and Organisational Development (for minute 24/122)

Six members of the public, attended the meeting, including two governors. Two observers from The Value Circle were in attendance.

Action

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

Mrs McRae noted that a question had been received from Unite Union with representatives in the audience. She provided an overview of the detail related to Veolia and the North of England Commercial Procurement Collaborative (NOE CPC). The two specific questions asked of the Trust were:

1. Will you write to Veolia to convey your concerns and encourage a constructive dialogue with Unite the Union?

2. Will you make it clear to Veolia that you expect all companies tendering for consideration by yourselves and your member Trusts to abide by decent labour standards, to respect freedom of association and to refrain from activity that could be considered anti-union?

Mrs Hanwell provided a response as Chief Financial Officer with oversight of the NOE CPC. She noted the understanding that the contract which had given rise to the current dispute was not a contract that had been let using the NOE CPC framework and as such the Trust had no basis to intervene on the matter and had no specific knowledge of the contract.

She confirmed that all Trust frameworks operated using standard NHS terms and conditions which referenced compliance with labour law. It was the Trust understanding that this was a dispute and not a matter of breach of contract or law. Where a contracting authority uses one of the NOE CPC frameworks it was for them to consider which voluntary arrangements they might wish to incorporate into their contract and that was a matter for them. She confirmed that the Trust abided by procurement law and did not impose more specific conditions on supplier frameworks.

Mrs Hanwell noted that as an organisation we encouraged constructive dialogue with unions and had heard the concerns raised. The Trust encouraged Unite and Veolia to reach agreement through existing mechanisms but could not intervene as requested.

Mrs McRae noted that the Board meeting did not allow for discussion about the response and therefore a formal response would be provided via email at the request of the attendees.

Mrs McRae then welcomed the representatives from The Value Circle who were observing the Board meeting as part of an external review for the Trust.

24/105 **Sharing stories – Community Mental Health Engagement and Involvement team - Sharing our lived experience and insights** (agenda item 1)

Mrs McRae welcomed Ms Wendy Tangen to the meeting who noted her thanks to the Board for inviting the team to attend and provide some more detail on the engagement and involvement work undertaken for the Trust and the workers in the team. She noted that there were five team members who worked across four areas, and they were hosted by third sector organisations that supported the Trust and team to undertake the work.

Ms Daniella Lawal informed the Board that she was hosted by The Big Life Group and her motivation was being part of transformation programmes that were changing the community she was a part of, to support those who were marginalised, and to understand how to ensure that they were represented. She noted that work through third sector organisations identified that people felt comfortable in their community, therefore it was valuable that third sector organisations were equal partners in engagement work. From a barriers perspective she highlighted that stories she had been told included that black and Asian women felt unbelieved and that they were exaggerating their condition and were told to stop crying and be strong, which felt like it put them

down. Black men had described how they felt racialised and their demeanour was misunderstood, and refugee and asylum seekers had informed her they did not know where to find help and felt undeserving of services due to hostility. She noted the unconscious bias which was addressed through Trust training regarding cultural competency, and it offered a good starting point to have open and honest discussions. She added that she felt there needed to be more of a focus on anti-racism, including a review of the recruitment process, career development opportunities and ethnicity pay review and representation.

Ms Claire Legg informed the Board that her area of engagement work was focused on people over 55 and she was motivated due to how much change was needed for this group of people following her personal experience of caring for a relative. She noted the benefit of being hosted by the third sector was the support for isolated members of the community who were visited in their own home, and the ability to build trusted relationships with people and open discussion and dialogue. She noted a barrier for some people was transport and an inability to leave the house and socialise as there was a lack of services that would go to their homes and provide transport. She added that this included transport to medical appointments. She also noted that staff in the neighbourhood networks would benefit from training to support their community with mental health needs, and people trained in mental health and wellbeing attending groups would be of benefit. Ms Legg added that there was also feedback noting that there was a lack of menopause support across Leeds.

Ms Joy McMillian informed the Board that she job shared with Ms Legg, and whilst initially her role was for people over the age of 55, she now also covered neurodiverse people. Her motivation was related to her own experiences and not being able to get mental health support, with a gap between primary and secondary care. The draw of the third sector was the ability to link with community organisations. She noted that they had spoken to over 600 people, but the same messages were heard around communication and literacy. There was a need to recognise peoples' ability to understand communication, and to consider those who did not have English as a first language and had translation requirements.

She noted that the Accessible Information Standard was good, but the population were not able to meet that standard, and there were limitations of their digital ability to access translation. She added that older people did not always understand the language of mental health and therefore how to access services, and there was a need to translate the concept as well as the language. In relation to the neurodivergent workstream she was involved in, she noted that outcome statistics for neurodivergent people were poor and talking therapies were not always accessible, therefore there was a need to consider alternative approaches or longer timeframes for neurodivergent people including flexibility around appointment times. She noted that there was a need to build on relationships and trust and develop communication across organisations and services to keep the momentum moving.

Ms Tangen noted the passion and commitment of colleagues within the team to support conversations, and the valuable insight this provided for transformation work.

Mrs McRae thanked the team for their bravery in the roles and their personal experiences. Mrs Forster Adams noted that the presentation was helpful and insightful, adding that there was an agenda item about the Community Mental Health Transformation (CMHT) Programme which had been brought to life through the discussions presented to Board. She added that the culturally diverse communities workstream was important and vital, and queried how much the work was listened to and influenced work around designing services. Ms McMillian responded that the over 55 workstream was not as far advanced so less response had been seen due to the timescales, however the neurodivergent work was being listened to and through the working group there was a genuine willingness to adopt changes, and the agility of the group allowed action. Ms Tangen added that partnership working was extremely important and having colleagues working with them to support local communities was key to making progress.

Dr Healey acknowledged the inspiring presentation and the sense of there being some 'easy wins', and therefore asked if these were on the Trust agenda. Dr Munro confirmed that the approach of the CMHT programme was to reduce people falling between services and provide a more efficient and effective use of services to support access to the relevant agency and service. She noted that there was a need to consider the use of data and information to produce an agile response to the service needs of communities.

Mr Henry thanked the team for the presentation and noted his personal experience of family access to community groups and his motivation influencing him to become a Non-Executive Director. He noted the importance of sharing the stories heard with other individuals across the organisation to hear the simple improvements that could be considered. Ms McMillian added that engagement and insight reports from the work were accessible to provide the detail of the work, and provided an example of how accessibility options online could simply refer to 'change language' to make it more easily understood.

Mrs McRae noted that the stories and suggestions would be picked up for improvement considerations and that work with the local authority and partners was brought to life through the presentation. She thanked the team involved for their time at the Board meeting.

The Board **thanked** the Team for attending the Board and providing an update on their work.

24/106 **Apologies for absence** (agenda item 2)

Apologies were received from Mr Darren Skinner, Director of People and Organisational Development, and Ms Kaneez Khan, Non-Executive Director.

It was noted that Mrs Fiona Sherburn, Associate Director for People Resourcing and Organisational Development, would attend to present agenda item 18 on behalf of Mr Skinner.

24/107 **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.

24/108 **Minutes of the previous meeting held on 25 July 2024** (agenda item 4)

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

24/109 **Matters arising** (agenda item 5)

5.1 Feedback from the Shadow Board of Directors

Mr Wright provided detail on the Shadow Board programme for aspiring directors within organisations and that the Trust had linked with South West Yorkshire Partnership NHS Foundation Trust to deliver it. Attendees were to present papers from the Trust Board meeting outside of their usual working remit. He informed the Board that he had chaired the first meeting the previous day and that it was a useful exercise with attendees who would normally be involved in writing Board papers, so it had been helpful for them to see their use within a Board meeting. A further three sessions were to take place

He noted that there were three items the Shadow Board had asked to be followed up and he would address these at the relevant point on the agenda. It was noted that both Ms Sanderson and Dr Hosker had been through the Shadow Board programme and found it helpful and insightful.

Miss Wilburn queried whether the discussions had been similar to those of the main Board or if they offered a different perspective, and Mr Wright responded that as they were presenting another person's paper with shorter notice to prepare, they were more inclined to ask questions related to their own area. The programme would offer a broader view, and they would move from an operational focus into strategic element as it progressed.

Mrs McRae thanked Mr Wright for mentoring future talent and supporting the programme. Mr Wright noted that other Non-Executive Directors were welcome to attend the future sessions, and Mr Henry confirmed that he had offered to provide informal support to have discussions outside of the Board environment to provide more detail and exposure.

24/110 **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.

It was noted that the action regarding 'Breathing Space' was ongoing and an update would be provided at the November Board meeting.

The action related to the review of the risk management annual report was to be discussed at the Executive Management Team meeting in October 2024.

All other actions were noted as complete.

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

24/111 **Report from the Chief Executive** (agenda item 7)

Dr Munro presented her Chief Executive's report, noting it as read by Board members, and that there were several areas within it that were covered in other reports.

She firstly acknowledged the recent period of social unrest and the distress this had caused for colleagues and communities. The Trust had provided information and guidance and followed this up with requests for feedback which would be reviewed to ensure practical support and guidance moving forward. She acknowledged the ongoing fear and distress and that this had been discussed in the Workforce Race Equality Staff Network (WREN). She referred to the previous Board discussion from WREN and the support requested from the Board regarding hate crime and racial abuse from service users. She noted that work had not progressed as much as anticipated due to staff absence, therefore this was a priority for the new Head of Diversity and Inclusion once they were recruited into post.

She informed the Board of the national work that was ongoing related to the Gender ID Services specification and referral process changes. She noted that the regional team were also providing a programme that felt unaligned to the national programme, so it had been raised as a concern.

She noted that there had been no response from the CQC following their review in July 2024 of the Children and Young People's Service, and that there was no further action from the review of the Mother and Baby Unit.

Dr Munro informed the Board of the combined effort underway in October for the staff survey, Black History Month and Speak Up Month, and confirmed that teams were working collectively to have a presence across services to support feedback from staff across all topics.

She noted that she had attended a recent NHS Leadership Event with a presentation by the Secretary of State and a focus on priorities for the government for healthcare and the NHS moving forward. Details were awaited for the launch of significant engagement for the development of the 10 year strategy for health, including inequities and the role of the NHS in supporting the health of citizens in a wider strategic picture.

She informed the Board that a financial governance review was underway with PWC which Mrs Hanwell would cover in her Board update.

She concluded by noting the Reasons to be Proud section of her report and that four staff had been shortlisted for awards related to diversity work.

Mrs McRae noted the positive news about the new Head of Diversity and Inclusion recruitment, and thanked Dr Munro for her update.

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

24/112 **Report from the Chair of the Finance and Performance Committee for the meeting held on 23 September 2024** (agenda item 8)

Mr Henry presented the Chair's reports for the Finance and Performance Committee and took the report as read. He noted the comprehensive Committee meeting with several items covered in detail in the papers on the agenda for the Board meeting.

He drew attention to the current trajectory for the ICB financial position and potential impact on the organisation which would be picked up in the Chief Financial Officer report. He also noted the challenge of access and waiting times that had been discussed regarding the ADHD service, and the initiatives in place regarding the situation would be covered in the Chief Operating Officer paper and the private Board meeting.

He noted that the finance and performance data noted an improved position for Red Kite View with work ongoing to progress the work. He also highlighted the continued improving position with Out of Area Placements noting that work remained ongoing however the trajectory looked positive with the lingering challenges acknowledged. He noted the financial position with it broadly being on plan for month 5, however the reasons for this included additional income received. He acknowledged the voluntary intervention with PWC to review the financial position. Mrs McRae queried if the ICB situation triggered a mandatory review would that need to be repeated given the voluntary PWC intervention, and Mrs Hanwell confirmed that the voluntary review was being done in alignment with the guidance, therefore it would go straight into the intervention stage.

Mrs McRae thanked Mr Henry 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.

24/113 **Report of the Chief Operating Officer** (agenda item 9)

Mrs Forster Adams presented her report, taking it as read by the Board with key points to highlight. She noted that the report did not represent the wealth of outstanding work across services therefore it was important to note that this

report focused on challenges, however there was a need to acknowledge the good work that took place daily and thank colleagues for their effort.

Mrs Forster Adams informed the Board of significant changes to note, including a deterioration in crisis response reporting within 4 hours. She noted that this had been discussed in the Finance and Performance Committee and explained she was confident that there was not a number of people who had been inappropriately left, however acknowledged that there was work to do in the crisis team to support accurate data recording with support from the informatics team.

She referenced the period of intense review related to the ADHD offer across Leeds including primary care. She noted that the Trust offer was the only NHS offer across the city. Work was taking place at West Yorkshire level but there was an acknowledgement that this needed to be accelerated and expanded. This would be discussed in more detail in the private Board meeting.

In relation to Red Kite View, she noted the stabilised and improved position particularly around staffing and leadership. She noted that there were eight young people who were not in the unit currently who were being reviewed for repatriation as admissions were now taking place at the unit.

She acknowledged the improved position related to patient flow, with thirteen adults in Out of Area Placements inappropriately, therefore work continued with the programme.

She informed the Board that winter planning arrangements were being finalised for the Trust as well as at Leeds level, including patient flow. Currently the Trust did not have sight of data for those service users waiting in A&E departments for admission to mental health inpatient care beds, however these metrics were to be included in the dashboard moving forward as part of winter planning.

Mrs Forster Adams confirmed that the EPRR annual assessment was underway and reminded the Board of the significant change in the process last year. She noted that the assessment had changed again and would be presented to Board in November 2024.

Mr Wright added his support to the Red Kite View position and noted that there had been a discussion in the Finance and Performance Committee regarding the service users who were waiting in A&E departments. He added that the comments from the Shadow Board were positive on the presentation of the Chief Operating Officer report.

Ms Sanderson noted that she had attended the Northeast and Regional Nursing Forum which had a focus on acute trusts, and mental health waiting times in A&E departments was raised. The national advice as part of winter planning was that dynamic risk assessment information would be provided to support decision making for service users in A&E departments by the end of October to support organisational responses. She acknowledged the encouraging messages from acute trusts to admit these service users to beds with mental health support rather than leave them waiting in departments.

Miss Wilburn elaborated on the discussion regarding Out of Area Placements noting that the graphical representation demonstrated that the out of area placement was improving geographically. She noted that for several cases there were barriers for moving them, such as housing support. She acknowledged that this may be a plateau point for the trajectory, which was important for the Board to note. Mrs Forster Adams noted her caution on the progress made as there were now challenges regarding housing and accommodation support which would require collaboration with other agencies for those affected to support repatriation.

Mrs McRae queried whether it was possible to track adverse outcomes for those service users not seen in the crisis team target time, and Mrs Forster reported that there had been no associated incidents because of delays, however acknowledged the experiential issue. She added that those who waited longer than 4 hours were clinically appropriate to wait. Dr Munro noted that the recent Board to Board meeting had focused on Trauma Informed Care and the focus to support and enable services to deliver responses. She added that KPIs measured time targets rather than care continuity which was important to differentiate between.

Mrs McRae thanked Mrs Forster Adams for her report.

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

24/114 **Community Mental Health Transformation Update** (agenda item 10)

Mrs Forster Adams presented the update report, following the discussions heard in Sharing Stories and the link to the transformation agenda. She noted that the report provided a recap of the aims of the transformation programme and next steps. The aim was to provide support closer to home when needed, and primarily targeted adults with complex health needs but did consider transition work for young adults. It involved a fundamental redesign of services, with examples in the report such as joint assessments with primary care, mental health and secondary services. She noted the encouraging work with key workers and therapeutic relationships which was key. There was a focus on advice and guidance for GPs to support those presenting at practices requiring mental health support.

She noted the report detailed the next steps, with the work operating in three local care partnerships across four primary care networks. She added that clinical governance processes were in place to support risk assessment and outcomes, and operational governance processes would continue to be considered and progressed. It was noted that Dr Hosker was the Chair of the CMHT Group which provided support across all areas.

Mr Wright noted this was an area of interest and queried whether there was a focus and process underway to review the IT and data access and resource issues across all teams. Mrs Hanwell commented that the IT issues and governance remained a challenge. Ultimately the plan was to have a shared record, however the primary care provider would record details of the care provided to service users but there was a need to focus on the ability to share

data. She confirmed that work remained in progress and was a priority. She added it was an example of challenges and how to review them in partnership with others. Mrs Forster Adams noted that systems and practices had embedded boundaries that would be reviewed and amended. Dr Munro reminded the Board that the programme did not set out with a new clinical model for delivery, and inherent within the approach was the cultural shift and agile response needed for teams to confidently work together with feedback from local communities to then adapt to the changing needs of the population. She noted that the challenge was to move from current practice and test out new approaches, and consider how to monitor the performance and ability to adapt.

Mrs Burns-Shore queried if the model meant less flexibility, and Mrs Forster Adams responded that it provided more flexibility as the key worker role was not necessarily for the Trust to lead. The infrastructure had third sector involvement so the key worker role would sit where appropriate. Mrs Burns-Shore referred to the feedback from the Sharing Stories item and the positive impact of smaller working groups with more senior people to support changes, and asked how the Trust could influence a move towards this for all areas. Mrs Forster Adams noted that this would be considered moving forward to consider diversity of thought and experience, but decision makers needed to make appropriate changes. Dr Hosker added that the governance across the system would provide the ability to review decision making and appropriate attendance.

Dr Healey acknowledged that the method of change was supporting building of relationships and removing barriers to make improvements, and the monitoring of progress with admissions was positive. She noted that the ICB was good at reviewing data and understanding outcomes and interventions, however there was a need to make sure that measures were in place particularly around suicide for those not in services. Dr Hosker commented that the Mental Health Population Board would set the priorities for the coming year. He acknowledged that all admissions were unplanned and 10% were unknown to services, and this would be linked into consideration of priorities and measures.

Mrs McRae noted the helpful update, and thanked Mrs Forster Adams, adding that further updates would be beneficial for the Board in due course. She reminded the Board of the partnership structures discussion that would take place as part of a future Board Strategic Development Session to ensure awareness of the current position.

The Board **received** the Community Mental Health Transformation Update report and **noted** the content

24/115 **ICB Serious Mental Illness Maturity Index Self-Assessment Response** (agenda item 11)

Mrs Forster Adams presented the report, taking it as read by the Board with key points to highlight. For context she noted that the report was a summary of the process by NHS England, through the West Yorkshire ICB, to surface

intelligence needed in the context of the Nottingham review, to analyse and understand the position, and any areas of concerns. The report provided assurance to the Board that the Trust had undertaken the process with further detail regarding the CQC report to be discussed in the private Board meeting.

Dr Healey noted that the detail could be reviewed in the Quality Committee when appropriate and queried the colour coding within the document. Dr Munro confirmed that it was not a RAG rating on the matrix, instead it referred to the group the recommendations apply to.

Dr Munro confirmed that when the information was aggregated, ICBs would provide a return to NHS England. There was a question to ICBs regarding assurance that service users could access Assertive Outreach Teams which required a yes or no answer, however it was acknowledged that this was not a helpful way to measure services. She noted that there was a need to understand the approach that NHS England would take following the responses, however an aggregated summary assurance would be provided for the ICB.

Mr Henry noted scepticism about the use of the assessment process and how data would be used to present organisational positions as there was a need for consistency in approaches for best results. Mrs Forster Adams noted that it was clear from the guidance that there was a deeper understanding regarding the complexity of services however the approach employed had been challenging. Discussion took place regarding the assessment and detail within the report regarding best practice achieved within the Trust, and it was noted that there was a requirement for assurance that the function was used appropriately. Ms Sanderson noted that the baseline assurance evidenced that the minimum standard of care was met and was equitable for all based on the variety of need.

Mrs Forster Adams noted that different organisations organised services in different ways and may not have a team by the same name but offered services through other structures to provide the fundamental standard of care. Ms Sanderson added that there was no standardised staffing tool for community mental health teams which was consistently noted and requested for nationally to support appropriate approaches.

Mrs McRae acknowledged that this was a response due to a tragic incident however it was being approached with an opportunity to understand and examine services to report in an honest and appropriate way. She thanked Mrs Forster Adams for the report.

The Board **received** the ICB Serious Mental Illness Maturity Index Self-Assessment Response report and **noted** the content

24/116 **Report from the Chief Financial Officer** (agenda item 12)

Mrs Hanwell presented her Chief Financial Officer's report, taking the report as read by Board members and noting the discussion at Finance and Performance Committee.

She highlighted that the Trust was ahead of plan at the end of month 5, but this was supported by a one-off benefit gain, therefore in true terms the organisation was behind plan with ongoing efficiency schemes in place. She acknowledged the concerted effort on improving the run rate to meet trajectories and deliver the financial plan. She noted that the forecast in the report was a worst-case scenario, and the Trust was not forecasting to go off plan.

She noted that there will be a more robust range forecast in month 6 which would include a review of the potential plateau for Out of Area Placements, and it would look at risks for delivering the plan and mitigations in place.

She reiterated the ICB position and regime, noting that collectively the ICB position was £80m in deficit. The deficit agreed with NHS England was £50m therefore the ICB was £30m adrift of the full year target. This had triggered a collective voluntary process for a PWC review, as whilst the ICS was not in the segment to trigger a formal intervention, it was collectively recognised that work was required. The intervention was a 4-week intensive process funded by the ICB that was mainly a desk top exercise to review governance approaches and oversight arrangements, supported by Executive Director interviews. The review would also consider any areas that could be focused on and additional mitigation that could be put in place. A bespoke report would not be received but the Trust would have a chapter in the overall report, and the findings would be brought to Board in due course. She added that any deficit support allocation was strongly predicated to go to those organisations with a planned deficit at the start of the financial year, therefore the Trust would not get any support due to its overall financial and cash position.

Mrs Hanwell referred to the public dividend finance capital schemes and noted that the previously discussed Yorkshire & Humber perinatal scheme had not been successful in being changed, therefore, to ensure good governance a paper would be submitted to the next Board of Directors to formally recognise and accept the use of Trust cash for the development. She added that revenue negotiations were underway to support the position and potential mitigation. **DH**

In relation to the perinatal cash discussion, Mr Wright acknowledged that this had been discussed before, including whether there were other areas that were preferential for spending the cash on. Mrs Hanwell noted that she would clarify this in the paper to Board, however the increase in resources limits was for perinatal therefore there was an inability to spend this elsewhere so the opportunity should be taken.

Mr Wright then referred to a discussion at Finance and Performance Committee and confusion between plan and budget definitions, highlighting it was important to understand this clearly for monitoring cost improvement programme progress.

Mrs Burns-Shore queried whether the PWC review would provide additional opportunities, and whether there was a risk that the report would indicate the removal of cash reserves. Mrs Hanwell responded that the cash position was mitigation for delivering the financial plan, and removal of that would affect

both the Trust and system position. She added that the review probably would not provide any additional opportunity for the Trust or mental health, but it may be helpful for highlighting opportunities in other areas which could be considered.

Mrs Forster Adams queried if there were any schemes for A&E departments linked to mental health waiting times as part of winter funding, and Mrs Hanwell confirmed that there was no link as the allocation was no longer there.

Mr Henry noted that the Board needed to be aware of the detail and the efficiencies devolved to departments should be an area of focus. He noted the content of the Chair's report from Finance and Performance Committee which recommended an upgrade of the financial risk on the Board Assurance Framework which would be discussed within the Executive Team and then come back to Board for formal approval.

Mrs McRae acknowledged the important balance between finance and quality and queried whether there had been a lost opportunity for securing funding related to the £1.6m allocation for Emergency Care. Mrs Hanwell noted that it had been offered to Places for consideration of how to use the allocation and Trusts had put forward business cases to access the money, but this was not submitted within the timeframe. This was therefore a missed opportunity for the allocation which would be highlighted and raised as an issue at system level.

Mrs McRae acknowledged the cash position and queried if there would be any vulnerability in the position related to the PFI. Mrs Hanwell confirmed that changes in the cash regime were unknown therefore there was a need to await and understand the national position which was being tracked.

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

24/117 **Report from the Chair of the Quality Committee for the meeting held on 12 September 2024** (agenda item 13)

Dr Healey presented the Chair's reports and took it as read by the Board. She highlighted the falls item and the link to the Trust STEEEP framework. She also noted the discussion regarding the role of the Committee in relation to Research and Development, with a need for more understanding regarding oversight for the Committee. She identified the helpful work between the Audit and Quality Committees.

In relation to the Board Assurance Framework, she noted that there were no suggested changes however there were further additions to be considered.

Mrs McRae queried the sexual safety and falls issues noted as for alerting the Board to, and Dr Healey confirmed that the Committee would monitor those areas through the work plan.

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

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

24/118 **Integrated Patient Safety Report** (agenda item 14)

Ms Sanderson presented the report and took it as read, noting it was a second iteration of the report to Board and provided a description of moderate and severe incidents that had been reviewed through the clinical governance processes. She noted that feedback received from Dr Healey would be incorporated into the next iteration.

Mr Wright noted that the Shadow Board consensus was that it was the most difficult report to deliver and needed more context adding to it as it was not clear when reading the paper as a standalone item. Ms Sanderson acknowledged the feedback and noted that more detail could be provided in the private part of the Board.

Miss Wilburn queried the number of incidents related to service users who had left services or gone missing, and Ms Sanderson responded that these were incidents predominantly in low secure services and it was helpful to understand that they were usually the same person with multiple associated incidents which affected the overall number reported.

Mr Henry acknowledged the challenges of producing the report and that more detail would risk identifying patients, and whilst there was a need for transparency the appropriate forum for discussion needed to be considered.

Mrs McRae noted that the reason for the report was for all Board members to be sighted on key incidents rather than specific detail. If more detail was required then it should be a private Board paper, however it was less about context and more about outcomes. She therefore requested outcomes to be included in the next iteration of the report. It was agreed that Ms Sanderson would reflect on the feedback received for the report and consider how to approach content. It would be presented to the private Board meeting with more detail to consider how to manage the report moving forward. **NS**

Dr Munro noted that the report was to make the Board aware of incidents, however Quality Committee received assurance reports throughout the year. There was risk of duplication by the Board and therefore there was a balance for the Quality Committee to manage issues in more detail with the Board having an oversight role. Dr Healey added that it was important not to duplicate and to focus on early awareness for the Board with it being entirely appropriate for Quality Committee to have full oversight of detail. It was noted that the report should focus on more recent events that the Board needed to be aware of; due to timing for investigations the detail on outcomes and assurance would not be immediately available. It was agreed that it would be helpful to have the discussion in private Board. Mrs McRae noted that the next paper would provide more context and description to the private Board but without duplication of work undertaken at Quality Committee. Dr Hosker

queried the rationale for more detail being required and Mrs McRae confirmed that this was to provide assurance and clarity on incident review processes,

Mrs McRae thanked Ms Sanderson for the report.

The Board of Directors **received** the Report of the Director of Nursing and Professions and **noted** the content.

24/119 **Safer Staffing Report** (agenda item 15)

Ms Sanderson presented the report and noted the content detailed the last six months information. It focused on staffing levels and then a deeper dive into the Red Kite View detail. She noted that active work was underway regarding organisational priorities for predicted baseline staffing levels led through the Safer Staffing group, which would support a focus on an MDT workforce.

She noted that the data required nationally was presented within the report. Over the past six months there had been a reduction in all forms of extra staffing continuing the positive position. She noted the national drive to move away from international recruitment, and towards recruitment through preceptorships and apprenticeships rather than focusing on formal university training. She confirmed that 14 preceptees were due to join the Trust soon.

In relation to Red Kite View, she noted the higher proportion of AHP roles within services on a daily basis and, despite reduced bed numbers, higher staffing levels had been maintained due to the levels of care needed by service users within the service. It was noted that Mrs Forster Adams and Ms Sanderson had undertaken a recent visit to Red Kite View, and it had been positive to see the enthusiasm from the workforce, and the approach to working with young people which was encouraging other staff to work in the service.

Ms Sanderson summarised that the report described sustained pressures in the workforce, the Health and Well-Being support into services was positive for staff, and there was an overall reduction in nursing vacancies and the use of agency staff.

Mr Wright noted that the Shadow Board had recognised the work underway and therefore queried the strategic risk on the Board Assurance Framework rated as a high-level risk. Mrs Burns-Shore responded noting that discussion had taken place at a recent Workforce Committee meeting regarding the risk level and a potential reduction. She confirmed that this would be discussed again at the next meeting for a final view to be taken, which would consider the wording of the risk relating to culture.

Mrs McRae thanked Ms Sanderson for the report.

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

24/120 **Guardian of Safe-working Hours Q1 Report** (agenda item 16)

Dr Hosker presented the report and took it as read. He provided background detail to the report and the role of the Guardian for junior doctors. He highlighted the data contained with the report regarding out of hours cover and confirmed that there were no areas to escalate to the Board.

Mrs McRae thanked Dr Hosker for the report.

The Board of Directors **received** the Guardian of Safe-working Hours Q1 Report and **noted** the content.

24/121 **Report from the Chair of the Workforce Committee for the meeting held on 18 August 2024** (agenda item 17)

Mrs Burns-Shore presented the Chair's report noting other discussions had covered some key points. She noted the discussion regarding the workforce related strategic risk on the Board Assurance Framework and that this was to be revisited due to the wording of the risk and to ensure that there was agreement across the membership for a potential reduction in risk rating.

She noted the positive discussion regarding management of sickness absence and the approach to back to work discussions and management of absence. Future updates to Committee would include feedback from staff about the impact of the processes. She added that the Committee had received assurance that the Trust was in a better position for recruitment due to flexibility for pathways into roles, however there was a need to maintain oversight of this.

She highlighted the positive review of the values and behaviours charter from the Committee and the approach taken for supporting employee behaviour.

Dr Henry noted that he was unclear about the potential reduction in the strategic risk given the detail within the report to be reviewed under the next agenda item. Whilst he acknowledged it was an improving position in some areas, it was important not to reduce focus and action. Mrs Burns-Shore acknowledged the point and confirmed that this would form the basis of the discussion at the next Committee meeting. Mrs McRae added that the Board Development Programme would also consider risk appetite of the Board.

Mrs Hanwell noted that whilst she understood the notion of filling vacancies, it was important to note that the budget was not available for the staff in posts currently, therefore it was helpful to consider the flexibility and potential different approaches, including consideration of the workforce need in services rather than vacancies as they currently were.

Mrs McRae thanked Mrs Burns-Shore for presenting the report.

The Board **received** the report from the Chair of the Workforce Committee and **noted** the content.

24/122 **Annual Equality Diversity and Inclusion (EDI) Workforce Race and Equality Standards (WRES) / Workforce Disability and Equality Standards (WDES) and Gender Pay Gap progress update** (agenda item 18)

Mrs Fiona Sherburn, Associate Director for People Resourcing and Organisational Development, presented the annual report on behalf of Mr Skinner. She noted that the report had been through the Workforce Committee.

She highlighted that overall, the report presented a positive picture however there were key areas for focus. In the WRES section there were three metrics with unfavourable change. This included white staff appointments following shortlisting which showed an increase of ethnically diverse candidates in shortlisting however there was a need to understand why they were not appointed following interview. She also highlighted the number of ethnically diverse staff in the disciplinary process which had increased. She noted that overall, the number of cases had reduced which was positive, but further work was required to understand the detail for the individual cases and action taken. She noted the difference between diversity on the Board and the wider workforce which had shown an unfavourable change, and she confirmed that this would be considered when Board vacancies became available. She also noted that there was further work to be done with staff networks and opportunities for cultural competency training.

In relation to the WDES report she noted the unfavourable change with the value of work done by the Trust, which was not aligned to other data received, therefore further work was to be done with the DAWN staff network to understand this in more detail.

Dr Healey noted the disparity between bank and substantive staff and the further work to be done to understand the choices of bank staff, and queried whether this could be joined up with the work required following these reports to understand this in greater detail. Mrs Sherburn confirmed that this link would be made.

Miss Wilburn queried how shortlisting more ethnically diverse candidates did not lead to more appointments, and Ms Sherburn confirmed that this was the work that was required to understand these issues and develop appropriate actions.

Dr Henry noted that unconscious biases may be increasing and impacting on the results therefore required review. He noted he was less concerned about the Board diversity as he believed it to be a positive mix, but the other areas required focus.

Mr Wright queried the detail in table 12, and the data for 2021/22, and Mrs Sherburn noted that she had noted the anomaly and would review this. He

then noted the statistic regarding 10% of the workforce having a disability, however there was no detail around how that compared to the Leeds or Yorkshire population which would be helpful to understand. He noted that both the median and mean were used which were different metrics and not always helpful, so it was challenging to reach assurance. He queried the national approach to this, and Mrs Sherburn noted that nationally year on year improvement was expected.

Mr Wright noted that the Shadow Board had noted the gender data regarding senior clinician gender relationships within that group of staff, and there was a feeling that service users should be able to choose to be seen by male or female staff, however there was a heavy bias in favour of female clinicians. Dr Hosker responded that the senior clinician element may be distracting in the data and work was underway which needed to be considered alongside the data.

Mrs McRae noted the comments, and it was agreed that the Executive Management Team would review the reports in more detail to consider actions required. **Executive Management Team**

Mrs McRae thanked Mrs Sherburn for the report.

The Board **received** the Annual Equality Diversity and Inclusion (EDI) Workforce Race and Equality Standards (WRES) / Workforce Disability and Equality Standards (WDES) and Gender Pay Gap progress update and **noted** the content.

24/123 **Report from the Chair of the Mental Health Legislation Committee for the meeting held on 12 September 2024** (agenda item 19)

Miss Wilburn presented the Chair's report from the Mental Health Legislation Committee taking it as read and confirmed that there were no areas to alert the Board to.

She noted the feedback from the Mental Health Education Steering Group regarding the availability of Section 12 doctors, and that an interim report demonstrated many doctors were available therefore a deep dive had been requested into the barriers to their availability.

She highlighted that the NHS England guidance for those service users that were homeless was discussed and this would be further reviewed internally.

From an assurance perspective, she noted that monitoring of the number of patients in flex beds was undertaken but length of stay was not reviewed so this would be looked at to ensure there was no disadvantage to service users. She noted the Committee had also requested further detail regarding cases where the police had not attended as they deemed it not appropriate.

Miss Wilburn noted the low numbers of service users represented at mental health hearings and confirmed that a deep dive had been undertaken and

provided assurance that representation had been offered and was declined, rather than not offered.

Mrs Forster Adams noted that there was potential duplication of work as Section 136 and flex beds had been discussed in the Finance and Performance Committee and work agreed, therefore there was a need to ensure this was not duplicated. It was noted that this would be reviewed to ensure duplication did not take place. Mrs Forster Adams noted that there were many offers across the city in relation to homelessness, but connections were important, therefore she would feed this through to the local authority and public health teams to ensure that this happened.

Mrs McRae thanked Miss Wilburn for the report.

The Board **received** the Chair of the Mental Health Legislation Committee report and **noted** the content.

24/124 **Report from the Chair of the Committees in Common held on 31 July 2024** (agenda item 20)

Mrs McRae presented the update from the Committees in Common, acknowledging the time that had passed since the meeting in July 2024. She noted that the alert item related to Red Kite View had been discussed extensively, and all other items had been covered or were on the agenda for the private Board meeting, therefore there were no further items to highlight.

The Board **received** and **noted** the content of the Report from the Chair of the Committees in Common

24/125 **Terms of Reference for the Board of Directors** (agenda item 21)

Mrs McRae presented the amended Terms of Reference for the Board of Directors, noting that the Executive Management Team had reviewed the amendments and considered the wording appropriate.

The Board agreed the amended Terms of Reference.

Discussion took place regarding the role of aspirant and associate Non-Executive Director roles, and whether this required inclusion in the document. It was noted that constitutionally the Trust only had Associate Non-Executive Directors for upcoming vacancies, therefore this did not require inclusion in the document as the approach to be taken would be considered on an individual basis as required.

The Board **received** and **approved** of the content of the Terms of Reference for the Board of Directors.

24/126	**Use of Trust Seal** (agenda item 22)
	The Board **noted** the Trust Seal had not been used since the previous Board of Directors meeting.
24/127	**Any other business** (agenda item 23)
	There were no additional items of other business.
24/128	**Resolution to move to a private meeting of the Board of Directors** At the conclusion of business, the Chair closed the public meeting of the Board of Directors at 13:05 and thanked members of the Board and members of the public for attending. The Chair then resolved that members of the public would be excluded from the meeting having regard to the confidential nature of the business transacted, publicity on which would be prejudicial to the public interest.

Leeds and York Partnership NHS Foundation Trust

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** Mrs Burns-Shore updated that the Breathing Space action was in progress and an update would be provided at the next meeting in November 2024.
Report from the Chair of the Audit Committee for the meeting held on 18 June and 16 July 2024 (minute 24/097 - agenda item 23 – July 2024) It was agreed that the Executive Team would review the necessity of the risk management annual report and whether there was a requirement for an alternative report or approach.	**Executive Directors**	Management action	**ONGOING** This was discussed at the October Executive Management Team meeting.

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Report from the Chief Financial Officer (minute 24/116 - agenda item 12 – Sept 2024) As the Yorkshire & Humber perinatal scheme had not been successful in being changed, to ensure good governance a paper would be submitted to the Board of Directors to formally recognise and accept the use of Trust cash for the development.	**Dawn Hanwell**	November 2024	**NEW** **COMPLETE** This is on the agenda for the November Board of Directors.
Integrated Patient Safety Report (minute 24/118 - agenda item 14 – Sept 2024) It was agreed that Ms Sanderson would reflect on the feedback received for the report and consider how to approach content. It would be presented to the private Board meeting with more detail to consider how to manage the report moving forward.	**Nichola Sanderson**	January 2025	**NEW** **COMPLETE** This is on the agenda for the January Board of Directors.
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 24/122 - agenda item 18 – Sept 2024) It was agreed that the Executive Management Team would review the reports in more detail to consider actions required.	**Executive Management Team**	Management action	**NEW**

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
Matters Arising - Questions from members of the public for the Board of Directors (minute 24/079 - agenda item 5.1 – July 2024) It was agreed that the response from Dr Hosker would be put in writing to the requestor, with an opportunity for follow up discussion.	**Chris Hosker / Corporate Governance Team**	Management action	**COMPLETE** The response has been shared with the requestor.
Matters Arising - Questions from members of the public for the Board of Directors (minute 24/079 - agenda item 5.1 – July 2024) It was agreed that a more detailed update regarding the café spaces on sites would be brought to the September 2024 meeting.	**Nichola Sanderson**	September 2024	**COMPLETE** The estates team are currently working up the plans to reestablish the café facility within the Becklin centre. Since the café shut there has been an increase in compliance and for health and safety. The team are establishing a business case that will set out all the processes that need to be part of the business case to move the project forward. This work will be monitored and taken through the clinical environments group and the estates and facilities committee.
Report from the Chief Executive (minute 24/081 - agenda item 7 – July 2024) The publication of the Module 1 report from the COVID Inquiry therefore it was agreed that the NHS Providers summary update would be shared to the Board.	**Clare Edwards**	Management action	**COMPLETE** The report has been shared with the Board.

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Report from the Chief Executive (minute 24/081 - agenda item 7 – July 2024) It was agreed the Joint Strategic Needs Assessment for Leeds would be shared with the Board.	**Clare Edwards**	Management action	**COMPLETE** The report has been shared with the Board.
Report from the Chair of the Finance and Performance Committee for the meeting held on 23 July 2024 (minute 24/083 - agenda item 9 – July 2024) Mrs Forster Adams noted a matter of accuracy in the Chair's report which stated a cap on admissions had been in place for 12 months however this was incorrect and should state two months of various levels of reduced occupancy. It was agreed that this amendment would be made to the report.	**Corporate Governance Team**	Management action	**COMPLETE** This amendment has been made.
Report from Director of People and OD (minute 24/095 - agenda item 21 – July 2024) It was agreed that the bank ethnicity data would be referred to the Workforce Committee for further consideration and review around ethnicity detail and bank staff choices.	**Workforce Committee**	Management action	**COMPLETE** The has been added to the work programme for the Committee and escalations / updates will be provided as appropriate
Report from the Chair of the Audit Committee for the meeting held on 18 June and 16 July 2024 (minute 24/097 - agenda item 23 – July 2024) It was agreed that the Workforce Committee would review and consider the recommendations and outcomes from the Handover of Deployment Internal Audit report.	**Workforce Committee**	Management action	**COMPLETE** The has been added to the work programme for the Committee and escalations / updates will be provided as appropriate

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Board Assurance Framework Q1 Update (minute 24/099 - agenda item 25 – July 2024) It was agreed that the likelihood versus consequence risk scoring would be included in the BAF moving forward.	**Clare Edwards**	Management action	**COMPLETE** This has been added to the Board Assurance Framework.
Terms of Reference for the Board of Directors (minute 24/100 - agenda item 26 – July 2024) It was agreed that the wording would be reviewed to reflect an approach that the Board were all in agreement with.	**Executive Directors / Clare Edwards**	Management action	**COMPLETE** The Terms of Reference were approved at the September Board of Directors meeting.

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

AGENDA ITEM 7

PAPER TITLE:	Chief Executive's report
DATE OF MEETING:	28 November 2024
PRESENTED BY: (name and title)	Sara Munro, CEO
PREPARED BY: (name and title)	Sara Munro, CEO

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.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	✓
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	✓
SR6	Digital technologies	✓
SR7	Plan and deliver services that meet the health needs of the population we serve.	✓

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

28 November 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

Service Pressures and Winter Planning

As we head into winter the Board will note from the report of the Chief Operating Officer the work that has been done to ensure we have suitable arrangements in place, with our partners to be able to respond to demand as far as possible. NHSE have put in place a set of asks and expectations on how mental health providers (for all ages) will work with system partners to support A&E and enable sufficient bed capacity to reduce delays in admissions. It is important to acknowledge this will be a challenging period for us. Whilst we have made great progress since April on improving patient flow, we have seen a plateau affect followed by a surge in demand for female beds. The Executive team are working closely with the patient flow team and our women's service to explore all possible options to alleviate the current pressures and create further capacity for the coming weeks.

Adult ADHD Provision

Following the last board meeting where we discussed in private the plans to pause to new referrals – this decision has now been enacted with a wide range of communications. We always anticipated this decision would cause distress and frustration for service users and partners which influenced the extent of the communications that went out. However, given the position we are in with the length of current waits, we must prioritise the limited resource we have to those with the greatest need and free up capacity to work with partners, in particular primary care on the development of new models. We will continue to monitor the situation and provide regular updates to the sub-committee and the Board.

Service visits

Over the past two months it has been a pleasure to spend time in the following services; Red kite view, secure services at Clifton house and Ward 6 adult eating disorder inpatient unit. Spending time meeting with staff and service users and discussing the great work that is taking place as well as having open conversations about the common challenges such as recruitment of band 5 nurses and providing high quality care to patients with complex needs. I know many board members have also been undertaking visits and it is good to see the increased levels of engagement with our teams which is always appreciated, as well as providing valuable insights for board members to inform our leadership and decision making.

Trust Independent Well led review
Thank you to all colleagues and partners who have been providing feedback and evidence to the Value Circle to enable them to complete an independent review under the well-led framework. They have also observed a range of meetings and conducted focus groups with a cross section of junior and senior staff. At the time of writing this paper the draft report is being completed. The Value Circle will go through these draft findings with the board in December and the final report will come to the board in January for sign off and approval of the actions that are recommended. Feedback so far has been positive with no matters raised for action during the review.

2. National Regional and Local Updates

Ministerial Announcements
Since the last board there have been a lot of announcements at a government level. Firstly, the budget on the 30th October 2024 which made a number of spending commitments relevant to the NHS. A separate summary will be circulated that was produced by NHS Providers that provides key information. At the time of writing, we are awaiting further detail from the DHSC about how the allocation for the NHS will be distributed and what this then means for the operational priorities for the NHS for 2025/26.

On the 13th November the Secretary of State for Health made a number of announcements about the expectations of the NHS following the budget which resulted in significant media coverage and attention grabbing 'headlines'. The detail of the proposals were more far ranging than what the media focused on and Rob Webster ICB CEO sent a helpful letter to partners (enclosed) to set out the key messages and strands of work that are still underway.

This ranges from changes to the NHS operating model and oversight framework that have been in development for some time, through to shifting approaches to accountability and responsibility at Trust, ICB and NHSE levels - including the re-introduction of performance league tables and individual organisational accountability for financial and operational performance. Reference has been made to giving greater autonomy and freedoms to Trusts that are performing within expected parameters, freedoms described as those akin to foundation trust status on matters such as use of cash and capital funding. Separate guidance has also been issued for boards on 'insight' and proposals made for the future support and regulation of NHS managers and leaders.

Additional explicit asks from the CEO of NHSE Amanda Pritchard have been made which are to.

1. Live within your means and the budget you have been allocated.
2. Embed improvement in clinical efficiency and productivity.
3. Maintain quality and safety of services.
4. Work together to lay the foundations for neighbourhood care.
5. Maxmisie and stretch the opportunities where improvements and investment have already been made with a particular emphasis on the benefits of tech to productivity and efficiency.

We are expecting further detail to be shared over the coming weeks, to be included in the operating guidance for 2025/26 which is due to be published in December.

Change NHS: help build a health service fit for the future
The DHSC and NHSE have now launched a widespread engagement exercise with the public, staff and stakeholders on the development of a new 10-year health plan for England. Enclosed is a copy of the letter from the Secretary of State which sets out the key questions being asked to inform the review and links to an online portal for responses.

There are already steps underway to combine responses from place, sector and ICB level. The SoS is also hosting face to face public engagement events and NHSE are holding meetings/forums with staff across the NHS as are many charitable and third sector organisations.

Whilst the wider consultation is underway a series of vision and enabler groups have been established that will be tasked with making recommendations to the Department. I have been asked to join the accountability and oversight group to share experiences and views as a provider CEO and sector rep in the ICB. Our first meeting is taking place the week of the board so more information will be shared at the board meeting.

Enabler' groups
Accountability and oversight: *DHSC director general for secondary care Matt Style; and West Yorkshire Integrated Care System CEO Rob Webster.*
Digital: *NHSE chief data and analytics officer Ming Tang; and Tim Ferris, former NHSE national director of transformation, primary care doctor and Harvard Medical School professor of medicine.*
Finance and contracting: *NHSE chief finance officer Julian Kelly; and Bill McCarthy, governor of Leeds Trinity University, former national policy director and leader of NHS regional teams, trusts, and a city council.*
Mobilisation/making it happen: *Sally Warren, DHSC director general for the 10-year plan; and Joanna Killian, Local Government Association CEO.*
People: *Gavin Larner, DHSC workforce director; and Alison Griffin, London Councils CEO.*
Physical infrastructure: *Emily Curtis, DHSC director of capital; and Simon Linnett, former Bedfordshire Hospitals chair, and former Rothschild & Co adviser, including on NHS private finance initiative schemes.*
Research, life sciences and innovation: *Lord Ara Darzi; and NHSE national transformation director Vin Diwakar.*

New Mental Health Act Bill
Long-awaited changes to the Act were introduced to Parliament on 6 November. The MHA has only been reformed twice previously (in 1959 and again in 1983), with amendments to the 1983 act being made in 2007. In 2018 an Independent Review commissioned by DHSC concluded that the current legislation goes too far in removing people's autonomy and does not do enough to protect and support people's ability to make decisions about and influence their own care.

The Independent Review was clear that achieving this change requires both legislative and non-legislative reform of inpatient services. This is backed up by international evidence; Analysis of international comparisons undertaken by the World Health Organisation demonstrate the enablers to a 'rights-based' system of care are enabled by: resource, regulatory and legal frameworks, and models of care. It is vital to reduce the need for people to be detained in the first place. Reform of the Act goes hand in hand with investment in prevention and transformation of community and crisis services through both the NHS Long Term Plan and Building the Right Support.

Implementation of these reforms will be complex. The responsibilities for delivering these reforms cut across DHSC, NHS England, CQC, MoJ and HMCTS, and reforms will apply to both England and Wales. It will take an estimated 8 years to fully implement all the reforms included in the

Mental Health Act Reform Bill. After the Bill has passed, DHSC and NHSE will need to publish statutory guidance, train staff and increase staffing numbers. Reforms will be implemented in phases to ensure that measures are safely and effectively implemented.

West Yorkshire financial governance review

As discussed at the last Board meeting the West Yorkshire ICB commissioned a financial governance review from PwC akin to reviews being carried out in ICBs that are in significant financial difficulty. Whilst the position was not as severe in West Yorkshire at that time the view was a review would be beneficial to help us keep focused on the right actions and mitigations and where beneficial to get recommendations on additional programmes of work to ensure we can deliver on our financial plan as a system. PwC had already completed a review for the acute trusts in West Yorkshire in June and the same approach was then applied to mental health and community Trusts and to the ICB. Draft reports for each organisation were produced and cross cutting areas pulled together for West Yorkshire that were presented at a feedback session on the 12th of November.

We have reviewed the report internally and further discussion on the content and next steps will be covered in the private board. However, to note in the public meeting there were no significant gaps or omissions in the Trust approach to financial governance highlighted in the review. As is often the case an independent review will make suggestions on how to tighten up governance and oversight which is what they have done but it does not make any material difference to our own financial efficiency programme.

Leeds City Council CEO

After an extensive recruitment and selection process Ed Whiting OBE has been appointed as the new permanent Chief Executive of Leeds City Council and take sup his post from the 6th January 2025.

Ed is currently Director of Cities and Local Growth in the Department for Business and Trade and Ministry for Housing, Communities and Local Government, based in Leeds, and is currently leading place-based economic growth partnerships with UK Mayors and other leaders. He has also held senior Civil Service roles in HM Treasury and No 10 Downing Street.

Previously he was Director of Strategy for Welcome, where he led the development of their new organisational strategy and global partnerships, and was the executive sponsor for equity, diversity and inclusion. Ed is very familiar with Leeds having grown up in the city. He now lives in West Yorkshire with his partner, David, and they are foster carers to a young baby.

3. Reasons to be Proud

World Mental Health Day Becklin Centre

Creating a calm and reflecting atmosphere

- The Becklin Centre celebrated World Mental Health Day by bringing Service Users together for relaxation, conversation, games, and music.
- We also wanted to highlight our Becklin Singers group led by Rachel Modest from The Voice.

Leeds Ribbons

- Ellen Scroop, Clinical Team Manager at Emerge Leeds, has been honoured by having her name added to the Ribbons sculpture in Leeds.
- The sculpture celebrates women who have made significant contributions to the city.
- Ellen was nominated by six different people, reflecting the high regard in which she is held.

Health Care Support Worker Day

- Saturday 23rd November was Nursing Support Worker's Day and an opportunity to shine a spotlight on the vital contribution our nursing support workforce makes within LYPFT.
- Nursing support workers have a critical role to play in delivering high quality care and excellent outcomes for patients, however their vital contribution can often go unnoticed, and their value underestimated.
- Nursing Support Workers' Day provides an opportunity to shine a light on their roles and their skills and to say thank you for the essential care they provide every day of the year."
- Read Ozioma's experience of working as a health support worker.

Awards

- Winner - Project of the Year Award (Public Sector) at the Document Manager Awards - Restore Information Management with LYPFT. Well done to Carl Starbuck leading the project at LYPT.
- Shortlisted – Lens Awards 2024 Best Documentary Style Video - LYPFT and Deadline Digital Nomination for Jake's Story - The CONNECT Eating Disorders Service. Please watch this fantastic video.

- Awards on Staffnet – We offer entry support, have an awards calendar and awards nomination support form.

Awards round-up

Congratulations to Errol Murray, Fathers Peer Support Worker in our Perinatal Service.

- Errol has been recognised for his work with both NHS Leeds Perinatal Partners Peer Support Service and Leeds Dads.
  - Received the National BAME Health and Care Awards Outstanding Community Organisation award.
  - Received the UNISON Yorkshire & Humberside Community Award.

Awards round-up

Staffnet 365, wins gold at the MarCom Awards

- Staffnet 365 is a gold winner in the intranet category. The entry is judged by experienced professionals, and we are pleased to receive this recognition.
- MarCom Awards are an international competition for marketing and communications.

Awards on Staffnet – Entry Support, Awards Calendar and Awards Nomination Support Form.

Team of the Month - October

Primary Care Mental Health Team (PCMH), West Hub

This team stresses the importance of wellbeing and partnership working. We have worked together as a mostly virtual team to support each other and our service users during the horrific incidents of the riots taking part in the UK. This has been in the format of service support meetings, clinical supervision and regular team meetings. The service and the team make sure all individuals are supported as equals.

The team are incredibly caring, always going above and beyond supporting colleagues and staff alike.

The Involvement Team - November

- During Inclusion week, the Involvement Team promoted the knowledge and expertise of our colleagues with lived experience, by presenting the work that they have been involved in and the impact that this has had upon services within LYPFT.
- In doing so, the Involvement Team are supporting the trust in creating a culture of inclusion. This work would not have been possible without the hard work of our colleague Debbie, who creates our social media output, and without the insight and expertise of our colleagues with lived experience who are continually teaching us about ways in which the Trust can improve services so that they are Safe, Timely, Effective, Efficient, Equitable and Patient-centered.

Anna

Individual of the Month

Over the past two years, Anna has led a pilot project to develop a Maternal Mental Health Service, addressing a gap in care for women with severe anxiety about childbirth or PTSD from traumatic birthsc. She has provided evidence-based CBT and collaborated closely with maternity services to ensure timely, specialist support for these women. As the sole psychological therapist on the project, Anna has prioritised accessibility, creating a straightforward referral process and reducing barriers to care. Her work has also included innovative solutions like an online trauma management group and support during maternity appointments.

Anna's successful work on this pilot project has directly informed the development of 'Paths' a new regional Maternal Mental Health Service hosted by colleagues in South West Yorkshire Partnership NHS Foundation Trust, which launched in July 2024 and will directly benefit this population of women in Leeds.

R&D

Practice Learning and Development team (PLDT) Embedding Research in Clinical Practice

The team have enabled us to efficiently overcome logistical challenges to embedding research in practice. Adam is also a member of our Mental Health Nurses Research Pathways working group and contributes to the activities required to meet this group's objective.

Adam Maher (PLDT Team Manager) "One of the functions of our team is to evaluate the capacity for all learners to be supported within the Trust (including learners, associates, preceptees and apprentices) to fulfil their role and achieve their potential. We really value collaborating with colleagues in the research team either by supporting learners on placement or by supporting the MESH program."

This month's Research Heroes are Psychologist professions

Psychologists contribute to research in lots of different ways around the Trust. This is from being Co-Applicants, Principal Investigators, supervising DClinPsy projects, completing higher degrees, being interventionists or conducting small scale individual projects. A special interest group (SIG) for research for psychological professions was recently set up. This brings together staff working in psychological professions to think about all things research!

Phil Arthington and Ranil Tan say:
"We know that many psychological professionals carry research skills and knowledge that they may not use in their everyday roles. Others might have an interest in getting involved in research but can be unsure where to start. We think there is untapped potential for our professional group to become more active in using and doing research."

Becklin Halloween Fête

From Leeds to South Africa

How Trust volunteers are having a global impact

- Visitors from the University of Pretoria have been at the Newsam Centre to find out more about our Volunteer Sports Project – a partnership between our Trust Voluntary Services and the University of Leeds.
- The sports project has been running at our Trust since 2019, with students from the University giving their time to deliver sports activities to our service users.
- The visit took place on Wednesday 16 October as part of a programme of shared learning between the universities and allowed us to share ideas around innovative practice.

Dr Sara Munro
Chief Executive Officer
20 November 2024

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

AGENDA ITEM

8

PAPER TITLE:	Improving the health and lives of the communities we serve: from 2025 to 2030 – Our Five-Year Strategy
DATE OF MEETING:	28 November 2024
PRESENTED BY: (name and title)	Dr Sara Munro, Chief Executive
PREPARED BY: (name and title)	Oliver Tipper, Head of Communications

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.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	
SR4	Financial sustainability	
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

EXECUTIVE SUMMARY

This paper presents the Board with the final version of our new five-year strategy for ratification. This follows an extensive development process to refresh its predecessor document: Living our values to improve health and lives 2018 – 2023.

The five-year strategy document is intended to be an accessible overarching narrative that summarises our longer-term vision and how we'll achieve it following our core strategic plans.

Its purpose is to clearly and succinctly communicate our vision, mission and objectives for the next five years, and is intended to be accessible to a broad audience. This could be service users and carers, staff at any level of seniority, prospective employees, or stakeholders and partners.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	Ways to improve the accessibility of the document for people with specific communications needs are included in the paper.
	Yes	

RECOMMENDATION
Board members are asked to ratify the Five-Year Strategy.

MEETING OF THE BOARD OF DIRECTORS

30 NOVEMBER 2023

Improving the health and lives of the communities we serve: from 2025 to 2030 – Our Five-Year Strategy

1 Executive Summary

This paper presents the Board with the final version of our new five-year strategy for ratification (appended). This follows an extensive development process to refresh its predecessor document: Living our values to improve health and lives 2018 – 2023.

The five-year strategy document is intended to be an accessible overarching narrative that summarises our longer-term vision and how we'll achieve it following our core strategic plans. Its purpose is to clearly and succinctly communicate our vision, mission and objectives for the next five years, and is intended to be accessible to a broad audience. This could be service users and carers, staff at any level of seniority, prospective employees, or stakeholders and partners.

Board members are asked to ratify the Five-Year Strategy.

2 Refresh process

The strategy has been through a nine-month development process. It started in March 2024 with a clear briefing on expectations from a Trust Board development session. Since then, a consultation and drafting process has taken place which has included the following groups and individuals:

- Our executive and non-executive directors,
- Our Council of Governors,
- Our Service User Network members,
- Members of our three staff networks, and
- Colleagues in our partner organisations who are contributing to our well-led review process.

Board members will hopefully see how their recent feedback has been taken into consideration, most notably:

- The word count has been significantly reduced,
- There are references to national policy direction e.g. the three Streeting Shifts, and
- There are now visual representations of the core strategic plans which provide the detail on how we'll fulfil our five-year strategy.

It has now been professionally designed in our refreshed brand style and incorporates the key statements and narratives from the LYPFT Brand Book. Once ratified, the digital version will contain hyperlinks to the core strategic plans and other reference material.

3 Next steps

A plan will be finalised for it to be socialised amongst key stakeholder groups of staff, lived experience partners, and health and care partners from January 2025 onwards. This plan will include presenting it back to the specific groups and networks who helped develop it earlier this year (listed above). Members of the Trust Board are welcome to take it to relevant meetings, committees or networks they attend following ratification.

The final version of the strategy will be created in different formats to aid accessibility. These include:

- As a screen-friendly designed document hosted on our website,
- As a printed document which will be circulated to Board members, put on display in our headquarters building, and can also be sent out on request,
- In a digital format that can be 'read aloud' in English and foreign languages by screen reader technology,
- Our existing plan on a page will be adapted into an easy read version for people with learning disabilities or with other such communications needs.

The strategy also prominently displays our alternative formats 'boiler plate' which shows how people can request alternative formats through our Interpretation and Translation Service if required – in line with our commitments under the Accessible Information Standard.

To keep it alive and maintain its profile, colleagues in the Communications Team will create a forward plan of case study examples. These case studies will showcase how the strategy is being delivered by our colleagues and fulfilling our mission of improving the health and lives of the communities we serve by providing outstanding mental health, learning disability and neurodiversity services.

4 Recommendation

The Board of Directors is asked to ratify the five-year strategy.

Author:
Oliver Tipper
Head of Communications
21 November 2024

Leeds and York Partnership
NHS Foundation Trust

Improving the health and lives of the communities we serve: from 2025 to 2030

The five-year strategy of Leeds and York Partnership NHS Foundation Trust

A summary document for anyone interested in where we are now, where we want to be, and how we plan to get there

Contents

Page / Section

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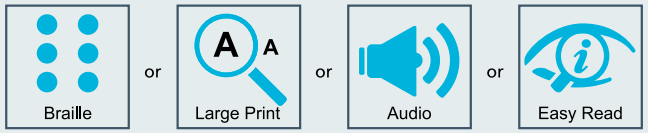


please contact the Interpretation and Translation Support Team on 0113 85 56418/9 or translation2.lypft@nhs.net

Introduction

Foreword from the Chief Executive

Welcome to our five-year strategy for 2025-2030. This document aims to provide anyone interested in us with a simple and accessible explanation of who we are, what we're here for, what we're going to do, and how, to improve the health and lives of the communities we serve.

I am privileged to lead such a committed and talented organisation of people who work tirelessly all year round to provide great care, or who provide the conditions for great care to happen.

Why is our work important? Because we know that even in a modern developed country like ours, people who need help for their mental health, people with learning disabilities and those with neurodiversity* conditions endure inequalities which affects their health and lives. For example, we know that:

- People in the most deprived parts of Leeds, where we provide most of our services, on average die 10 years younger than those in the least deprived areas.
- People with serious mental illness die on average 15 to 20 years earlier than the general population.
- Women with a learning disability die 27 years younger than the rest of the population, and for men its 23 years younger.
- People with a learning disability are 3 to 4 times as likely to die from an avoidable medical cause of death.
- People with neurodiverse conditions struggle to access the services and treatments they need in a timely manner – leading to poorer health and life opportunities.

Power of Partnerships

The word 'partnership' is in our name for a reason. We can only succeed by working effectively with our partners across our health and care systems. They include other NHS trusts, local authorities, third sector organisations**, higher education institutions, independent and private sector bodies and larger health authorities such as integrated care boards and NHS England.

So, I and my executive team will continue to do all we can to influence strategy and policy at local, regional and national level on behalf of mental health, learning disabilities and those with neurodiverse conditions.

National strategy direction

At the time of writing, the government is developing a new 10-year strategy for health. This will set out how it will achieve its three strategic shifts of:

1. Hospital to community,
2. Treatment to prevention, and
3. Analogue to digital.

You'll see references to all three of those shifts in our strategy.

The national 10-year strategy will set out expectations of the NHS, and what is possible within its scope, informed by **Lord Darzi's review published in September 2024.**

We expect the national strategy to be published in Spring 2025, at which time we will review our plans to ensure they align. In the meantime, the message is clear – there will be no new money without reform, and we need to deliver on the operational priorities for this year within the resources we already have.

Creating the conditions for great care

Our staff are our greatest asset. Without them we do not have a service to offer. So, within this strategy you'll find high level commitments to provide a rewarding and supportive place to train and work.

You'll also find our commitments around how we use our resources and what we call our 'strategic enablers'. This includes our ambitions to improve our use of digital technology which is becoming ever more important in providing care.

And we must make the best use of the data we collect to inform and increase our understanding of our populations to provide insight into the best way to care for them.

I hope you find our strategy interesting, informative and motivating. For those who'd like to see our plans in more detail, you can find this on **the strategy page of our website.**

Sara Munro
Chief Executive

*Jargon buster: Neurodiversity

The idea that people experience and interact with the world around them in many ways. There is no one "right" way of thinking, learning, and behaving, and differences should not be viewed as deficits.

In this strategy the words neurodiverse, or neurodiversity, are used in the context of autism spectrum disorder, as well as other neurological or developmental conditions such as ADHD or learning disabilities.

**Jargon buster: Third sector

A range of organisations that are neither public sector nor private sector. It includes voluntary and community organisations (both registered charities and other organisations such as associations, self-help groups and community groups), social enterprises, mutuals and co-operatives.

Who we are

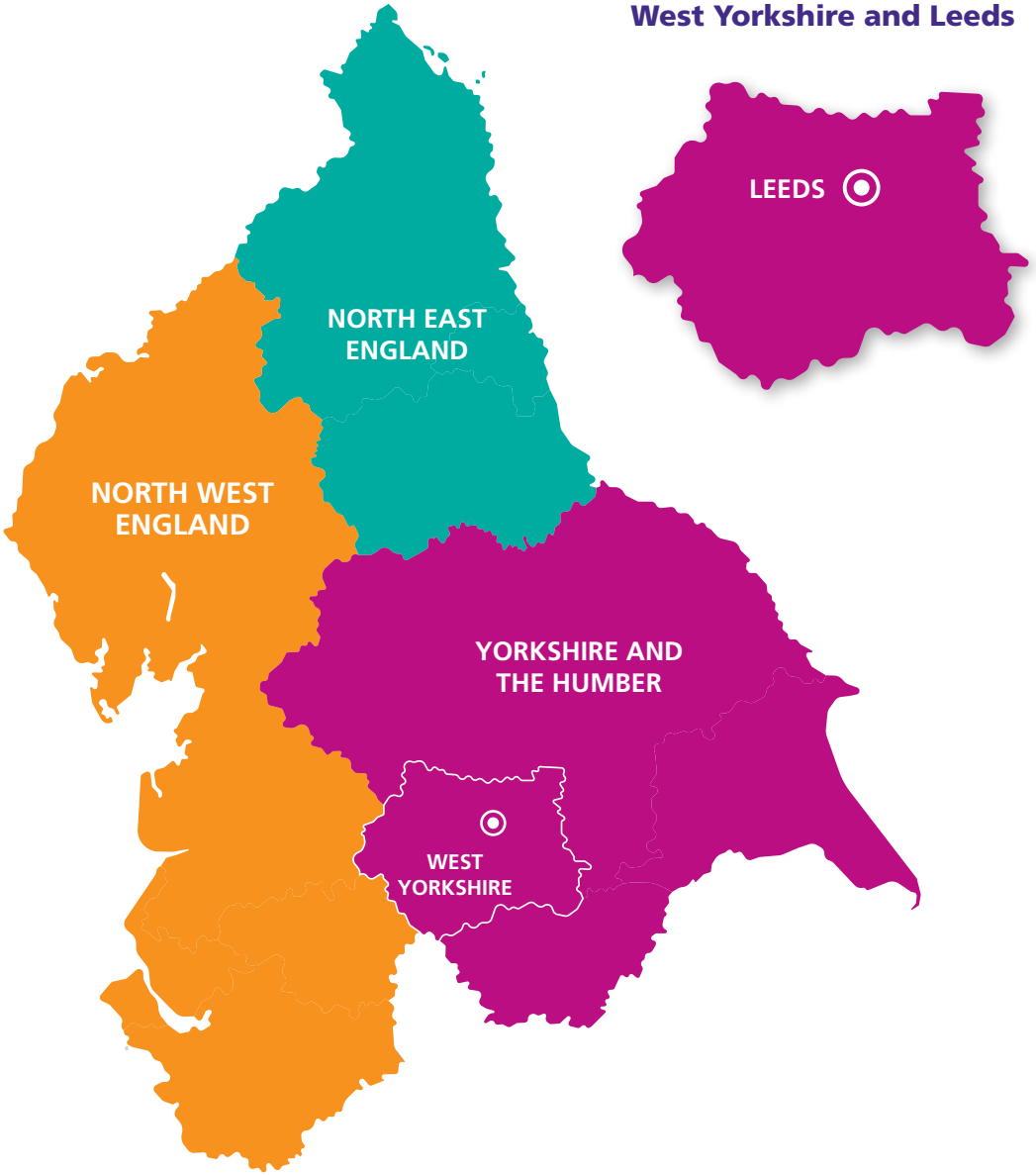
Leeds and York Partnership NHS Foundation Trust is the main provider of mental health, learning disability and adult neurodiversity services in Leeds. We also provide some specialised services across West Yorkshire, across Humber and North Yorkshire, and a few across the North of England.

Areas we serve

The city of Leeds is our 'place' where we deliver the majority of our services.

The county of West Yorkshire is the integrated care system (ICS)* to which we are most aligned.

We also provide specialist services in the Humber and North Yorkshire ICS, as well as across the North East and North West of England.



If you want to find out more about the care services we provide, check out the **care services directory on our website.**

We employ around 3,000 staff. These are a mix of clinical roles like psychiatrists, nurses, psychologists, allied health professionals** and health support workers; and professional support service staff in areas such as digital technology, finance, human resources, estates and research and development (to name only a few).

We value our selfless volunteers who make a huge difference to our service users and work alongside our staff to support the work of our Trust.

We are also proud to be working with our local higher education institutions to nurture the next generation of talent. Every year we train over 300 medical students, around 250 nurses, over 100 allied health professionals and around 25 nursing assiciates.

***Jargon buster:**
Integrated care system (ICS)

An ICS is a partnership of NHS organisations, councils, Healthwatch organisations, hospices, charities and the third sector. Collectively they aim to improve the health and wellbeing of local people in a particular region

****Jargon buster:**
Allied health professionals (AHPs)

Clinicians who work in a variety of settings to diagnose, treat, and rehabilitate patients. They play an important role in modern health and social care services. AHPs you are most likely to meet at LYPFT include physiotherapists, occupational therapists, dietitians and art therapists.

Key facts about us

811k+

people we provide services to

38

services we provide

407

inpatient beds in our wards

£227m

is what we spend on delivering care per year

57

sites we operate from

3,303

substantive staff we employ

616

bank staff who work regular shifts

133

active volunteers

Please note, numbers are based on our 2023/24 annual report

What we are ‘here for’

Our vision and mission statements are the building blocks of our identity. Our vision is our aspiration, and our mission is how we want to achieve it.

Our vision is...

To lead the way in mental health, learning disability and neurodiversity care so the communities we serve can live healthy and fulfilling lives, our people can achieve their personal and professional goals, and everyone can live their lives free from stigma and discrimination.

Our mission is...

To improve the health and lives of the communities we serve by providing outstanding mental health, learning disability and neurodiversity services; to be a great place to work and a great partner to work with.

Our values

We have integrity,

We are caring, and

We keep it simple.

In 2016, we co-created our values with staff, partners, and service users and carers. Since then, they have been adopted and embedded into the culture of our organisation. They are unique to us and are integral to how we go about our business – and our staff go above and beyond to live up to them every day.

You can read more about our **values and our behaviours on our website.**

Our promise

We see over a million service users and carers every year. Our promise to them is that we are dedicated to people-centred care and are proud of the high-quality, specialist mental health, learning disability and neurodiversity services we provide. We actively involve people in their care to empower them to achieve their personal goals and enjoy fulfilling lives.

Our three core strategic objectives

1. **Through our care services:** we deliver great care that is high quality and improves lives.
2. **For our people:** we provide a rewarding and supportive place to work and train.
3. **Using our resources wisely:** we deliver effective and sustainable services.

These three core strategic objectives are underpinned by a range of delivery plans.

To enable us to deliver our three core objectives, we rely on our professional support services. There are too many to describe here. However, we will highlight two in this strategy document which are:

- Quality, and
- Digital Technology.

Read more about them and how we’ll be delivering them on page 24.

The world we operate in

Our local 'place' is Leeds as this is where we provide most of our services. We also have a strong presence within the West Yorkshire health and care system, as well as operating some specialist services across Humber and North Yorkshire, and some across the North of England.

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

We expect that more people, across all ages, will experience mental health and wellbeing challenges over the next five to ten years due to the lasting impact of the Covid-19 pandemic, cost of living crisis and a reduction in local authority and community-based services. This will mean more people requiring our support.

We also must consider potential unknown demand for our services and unmet need. For example, the mental health needs of more vulnerable people and communities who may experience poorer access to healthcare than others (known as health inequalities).

We have an opportunity to shape demand by changing and improving health and care services for people, so that fewer people require crisis or inpatient care, and more people get what they need close to where they live.

Leeds has a total population of around 800,000 people, and its Black, Asian and minority ethnic population has increased by 19% over the last decade. There are inequalities in health and social outcomes for people in the city. For example, there is a 10-year difference life expectancy between those living in the most and least affluent areas.

Nationally, there are inequalities in access to healthcare. People from ethnic minorities experience barriers to accessing care, have poorer mental health and are more likely to be detained under the Mental Health Act than people of white backgrounds.

This is why addressing health inequalities is so important, and why we've set out ambitions in this area that contribute to the wider strategic aims of our local and regional partners.

This includes our role as an Anchor Institution*, recognising and levering our influence as a major employer with significant buying power to maximise benefit for Leeds and its local region.

***Jargon buster: Anchor Institution**

The Trust is part of the Leeds Anchors Network - a group of the city's largest (mainly) public sector employers. They focus on areas where they can make a difference for people as an employer, through procurement, through service delivery or as a civic partner.

Involving people

To understand what matters to the communities we serve, we are and must remain committed to co-creating and co-delivering care services with people who have lived experience.

We must also collaborate with our partners to understand our populations – how they are changing and what they need from us, so that we can provide joined up care that is high quality today and fit for the future.

While service user involvement is well established in some of our care services, we strive towards a consistent approach across all of them.

Being Trauma-informed*

The Trust provides services to people who are often adversely affected by what can be described as 'trauma'. This could be an incident or period in their lives that has contributed to their condition for which the Trust might now need to treat them for.

We aspire to become more trauma-informed in our practice. This is a culture shift requiring us to increase our knowledge of trauma to help us do our jobs better.

It also has benefits to tackling health inequalities. We know that psychological trauma can be caused by individual or ongoing acts such as sexual abuse but also by social factors such as poverty, racism and abuse of people identifying as LGBTQIA+**. Therefore, developing a workforce that understands a diverse range of cultural experiences is important.

***Jargon buster: Trauma-informed care (TIC)**

The Department for Health and Social Care defines TIC as clinical practice that:

- Understands that trauma exposure can profoundly impact an individual's physical, psychological and social development,
- Recognises the symptoms of trauma and continually asks, "what do you need"? rather than "what is wrong with you"?,
- Seeks to avoid re-traumatisation and addresses trauma-related barriers to accessing health and social care (rather than by treating trauma directly).

****Jargon buster: LGBTQIA+**

This stands for lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual. The + represents other identities that are not explicitly included in the acronym.

National objectives

If we are going to be a great partner to work with, we must work in partnership with system partners to support the delivery of our local, regional and national strategies for mental health, learning disabilities and neurodiversity services.

The **NHS Long Term Plan** was published in 2019. It sets out a ten-year vision for health services in England; showing how it will use the NHS long-term funding settlement that was agreed by the Government in July 2018. The Plan includes proposals that are relevant to us and the partnerships we work in. It guarantees investment in community services, promoting greater partnership working between primary and community care.

At the time of writing, we are expecting a new ten-year plan for health in Spring 2025. A lot has changed since 2019 including the impact of the Covid-19 pandemic on both the mental and physical health of the nation, as well as on health and care providers like us. Whatever it says we must work with our partners in how we respond to the challenges it lays out, and we will adjust and augment our strategy accordingly.

Local objectives

In 2023 the Leeds Health and Care Partnership, which includes LYPFT, published the five-year **Healthy Leeds Plan**. Our work actively supports its two main goals of:

1. Reducing preventable unplanned care utilisation across health settings; and
2. Increasing early identification and intervention of physical and mental illnesses.

These goals are focussed on the 26% of the population in Leeds who are living in the 10% most deprived areas.

2023 also saw the publication of the Leeds **Health and Wellbeing Strategy** which we are also actively supporting the delivery of.

We are also actively engaged in delivering the **West Yorkshire Integrated Care Strategy**, published in March 2023, working with our regional partners.

Our three core strategic objectives

At LYPFT we like to keep it simple. Therefore, we've got three clear strategic objectives. They are:

1. **Through our care services:**
   we deliver great care that is high quality and improves lives.
2. **For our people:**
   we provide a rewarding and supportive place to work.
3. **Using our resources wisely:**
   we deliver effective and sustainable services.

To be consistent, we've summarised the key ambitions and actions within these objectives in a series of "we will" statements.

1. Through our care services: we deliver great care that is high quality and improves lives

We are the main provider of mental health and learning disabilities services in Leeds. We also provide specialist services for broader regional and national populations. In total we deliver 38 clinical services organised into what we call 'service lines'.

The following table gives a summary of those service lines:

Service Line (in alphabetical order)	A simple description of what's included in each service line
Acute Services	Our crisis services, inpatient wards and psychiatric intensive care unit for adults experiencing acute mental ill-health.
Children and Young People's Services	Our inpatient mental health services in Leeds and York for those aged 13-18, and our national Deaf Child and Adolescent Mental Health Service.
Community and Wellbeing Services	Our working age community mental health teams and our Healthy Living Service.
Forensic Services	Our secure inpatient and community services in Leeds and York for people with acute mental ill-health, with some also at risk of offending.
Learning Disability Services	Our inpatient, respite and community services for people with a severe learning disability and/or autism, our Health Facilitation team and our Specialised Supported Living Service.
Older People's Services	Our inpatient and community mental health services for people with needs associated with older age in Leeds.
Perinatal and Liaison Services	Perinatal services include inpatient and community services for mothers with acute mental ill-health (before, during and shortly after birth). Liaison services refer to teams working with partners to support people with serious mental illness in hospitals and in the community.
Regional and Specialist Services	Our adult neurodiversity services, our emotional complex needs team (formerly known as personality disorders), our veterans' mental health and gambling addiction services. It also includes our partnership with Forward Leeds to provide drug and alcohol addiction services.
Regional Eating Disorders, Complex Rehabilitation and Gender Identity Services	Our inpatient and community eating disorders services for adults, Rehabilitation and Recovery Services, the Leeds Recovery College, and the Leeds Gender Identity Service.

Find information about all our **care services on our website**

Our five-year plan for Care Services

In 2024 the Trust published a bold and exciting vision for improving the care we provide to the communities we serve. It sets out our objectives and priorities for the next five years to allow us to make significant progress towards achieving that vision.

People are at the heart of everything we do. That includes our service users, our staff, our students and our partners who we deliver care alongside. We've worked with many of them to produce this five-year plan.

We've aligned it to many relevant commitments within the NHS Long Term Plan. A key commitment is that more mental health care should be offered in the community – either within or as close to people's homes as possible, and less care provided in hospital settings. This is in line with the national strategic shift 'from hospital to community'.

The plan also has a focus on tackling wider health inequalities, improving access to those who find it harder to engage, improve people's experiences of LYPFT and their physical health too. This is in line with the current national strategic shift from 'treatment to prevention'.

As well as setting out how we want to change and improve, it also sets out scenarios if we 'do nothing' or just continue what we're doing now. This will mean we may need more inpatient beds to cope with people who are not getting the services they need close to home, poorer outcomes for service users, and represent a poor use of precious NHS resources.

For our Care Services

1. We will co-create and co-deliver care services with people who have lived experience

What this means is:

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

By being an Anchor Institution, we contribute to our local economy through wider skills development and employment opportunities for people who use our services.

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

2. We will collaborate with our partners to understand our populations and provide proactive integrated care*

What this means is:

We understand who our partners are, both locally and regionally, and create the right environments to work with them.

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

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

***Jargon buster: Integrated care**

The aim of integrated care is to join up the health and care services around the requirements of individuals and to remove barriers.

This is hard as health and care services are made up of many different parts, and arrangements for delivering and funding them are complicated.

3. We will provide high quality, equitable and sustainable care services.

What this means is:

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

Our care services deliver equitable access, experience and outcomes.

Our care services are clinically, financially and environmentally sustainable, supported by digital technology and the buildings in which they operate.

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

4. We will improve health inequalities within the communities we serve.

We know that people with severe mental health problems and people with a learning disability often have poorer physical health and die younger than those who don't. Mental health problems are more common in transgender people and around half of rough sleepers are thought to have mental health needs. That is why we are investing significant time and resource in this area.

- We will ensure organisational leaders have the skills, capacity and confidence to embed the Improving Health Equity Strategy into core business.
- We will ensure everyone in the workforce understands their role in improving health equity and they feel empowered to tackle discrimination and promote inclusion in every area of their practice.
- We will embed the consist use of equality and health inequality impact assessments for all significant service changes to improve health equity and mitigate against any adverse impacts.
- We will have a robust process in place to improve health equity through all relevant quality improvement activities.
- We will ensure our services are delivered with a trauma-informed approach, recognising that communication, compassion, and coordination are all important for effective patient-centred care.

Read the full **Care Services Strategic Plan on our website**

Our five-year action plan for care services

Our key activities

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

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

Keeping it simple - our Care Services publish their own annual Plans on a Page which you can **find on our website.**

2. For our people we provide a rewarding and supportive place to work and train

Great care is delivered by great people, and we know that to continue to provide high-quality healthcare services, we need to support our colleagues to be the best they can be at work whilst nurturing and training the next generation of talent.

In early 2024 the Trust published a refreshed three-year People Plan which outlines what current and future staff can expect from us and each other. We're committed to improving the working lives of staff - enabling them to be prepared and supported for whatever lies ahead.

The Plan sets out what we want to achieve under each of the four NHS People Plan ambitions. These are:

Ambition 1: Looking after our People

The wellbeing of our people is important to us, so they can deliver high quality care. We want our people to be safe, healthy, and well both physically and psychologically.

As part of our commitments to look after our people, we will:

- Ensure that our workforce health and wellbeing plan is evidence based and planned strategically,
- Ensure our people have equal access to and use a full range of well-being support – physical, psychological, financial and social,
- Promote a psychologically safe culture and environment which challenges stigma and values lived experience,
- Develop proactive and local health and wellbeing support for all our people,
- Ensure our leaders will have the knowledge, skill and expertise to support wellbeing in the workplace.

We think we'll have been successful if we are:

- In the top 25% of Trusts for our Health and Wellbeing staff survey scores,
- Receiving excellent training feedback from higher education institutions and NHS England education and training departments,
- Maintaining 85% compliance rate with Personal Development Reviews (PDRs),
- A menopause accredited Trust.

Ambition 2: Belonging in the NHS

We will foster a culture of belonging and inclusion, where all our people have a voice, and we will tackle discrimination and inequality gaps.

As part of our commitments to help staff feel they belong, we will:

- Give our people a voice, listening, acting on feedback and involvement in decision making,
- Embed Equality, Diversity, and Inclusion (EDI) into the culture of our Trust,
- Grow collective leaders that reflect Trust values,
- Provide a working environment of civility and respect for our people,
- Improve the experience of those people with a protected characteristic as identified by the Equality Act 2010,
- Embed reward and recognition in our Trust to create a culture of our staff feeling valued.

We think we'll have been successful if we are:

- In the top 25% of national staff survey results for being compassionate and inclusive,
- Increasing leadership programme participation,
- Ensuring our people reflect the communities we serve through widening participation programmes.

Ambition 3: New ways of working and delivering care

This means engaging our people in innovation and improvement to deliver the best possible patient care.

As part of our commitments, we will:

- Grow our Trust and its people through a focused approach to leadership, management and culture development,
- Adopt a collaborative and inclusive People and Organisational Development approach to Trust projects, aligning ourselves to other change drivers e.g. collective leadership and civility and respect,
- Develop Organisational Development (OD) and change management support for the Trust and its staff to facilitate new ways of working and delivering care,
- Continue to build a culture of innovation and improvement in our approach to people development, systems and processes,
- Provide accessible and intuitive software solutions to support People and OD initiatives.

We think we'll have been successful if we are:

- Increasing the opportunity for flexible and agile working,
- Providing service management training effectively,
- Engaging clinical services on the Team Rostering methodology to encourage flexible working options.

Ambition 4: Growing for the future

This means fostering and nurturing talent in health and care careers, expanding and develop our workforce, while embracing new and emerging roles alongside our traditional roles.

We will:

- Ensure the Trust's recruitment processes are safe, effective and reflect best practice,
- Ensure the high-quality education of our future workforce remains embedded in our governance structures, along with support for our educators,
- Increase the number of staff to undertake apprenticeships,
- Implement an innovative approach to talent development, embedding the right culture and improving retention through delivery of our retention strategy,
- Increase the opportunities for flexible working across the Trust, including flexible retirement options,
- Deliver effective workforce planning processes which focus on recruitment and retention, new roles, skills mixing and future supply pathways to ensure a fit for purpose workforce for now and the future.
- Invest in recruiting, retaining and developing our clinical professionals - who are our nursing and health support workers, our doctors, our psychologists, our allied health professionals and social workers, and our pharmacists.

We think we'll have been successful if we:

- Have launched and embedded our Values-based Recruitment programme,
- See at least 75% of staff recommending the Trust as a place to work,
- See at least 75% of our students recommending the Trust as a place to train,
- Increase the number of people undertaking apprenticeships as part of new recruitment or Continuous Professional Development (CPD).

Want more detail?

Read our **People Plan 2024-2027 on our website.**

3. Using our resources wisely: we deliver effective and sustainable services

The Trust has a duty to deliver high quality care whilst providing value for the taxpayer's pound. We receive around £245million a year to deliver services that improve the health and lives of the communities we serve, which comes with a high level of responsibility.

We have a statutory duty to deliver a break-even financial plan every year. This duty applies to all organisations which collectively make up our Integrated Care System and we work together to ensure we achieve this as a whole system.

From April 2024, we started to forecast a significant year end deficit which has increased the need for greater efficiency and productivity. Our Chief Financial Officer is the custodian of our efficiency and productivity duties, and they are subject to rigorous internal and external audits.

The Trust operates within a well-defined corporate governance framework which includes explicit arrangements for:

- setting and monitoring financial budgets,
- delegation of authority for committing resources,
- performance management, and
- achieving value for money.

In April 2024 the Trust's senior leadership team agreed four key areas of focus for its efficiency and productivity measures. They aim to balance patient safety, experience and outcomes, whilst providing the best opportunities for us to achieve our break-even target.

To achieve a consistent year on year breakeven position, we will:

1. Reduce overspending on staffing – also called our pay run-rate,
2. Reduce use of additional temporary staff including reliance on agency staff and locum doctors*,
3. Improve the flow for patients through the health and care system - which is focused on significantly reducing out of area placements (OAPs), and
4. Reduce our spend on non-pay related costs – which relates to the money we spend on everything other than staffing costs.

***Jargon buster: Locum doctor**

This is a fully qualified doctor who temporarily fills a position in a hospital, clinic or practice. The term "locum" comes from the Latin phrase locum tenens, which translates as "place holder".

Estates, capital planning and environmental sustainability

The Trust operates out of around 57 sites, most of which are in Leeds with the others in York and across the North of England. The quality of our estate is critical to the quality of care we provide, as well as the experiences of service users and carers, and the wellbeing and productivity of staff.

Our vision is: to make best use of our most modern fit for purpose estate in line with the One Public Estate* principle, ensuring the needs of our care services and service users leads our estates strategy.

Over the next five years, we will:

- Ensure our estate offers a therapeutic environment for patients, is compliant with safety regulations, and is secure.
- Ensure our estate is efficient and effective for our workforce, and supports modern flexible and agile working,
- Develop our estate to be digitally enabled,
- Work towards achieving our net zero targets across all categories and strive to becoming a Green Trust - read our Green Plan on our website.
- Work closely with our partners to plan and deliver estate solutions across Leeds,
- Secure the future of our PFI buildings** by acquiring some of them, or potentially all of them, depending on clinical needs, to bring them into our control in 2028.

*Jargon buster: One Public Estate

This supports locally-led partnerships of public sector bodies to collaborate around their public service delivery strategies and estate needs. This helps organisations repurpose surplus public estate for housing, regeneration, and other locally determined uses.

**Jargon buster: PFI

The Trust currently operates out of seven buildings in Leeds that were procured through Private Finance Initiative arrangements. These buildings host most of our inpatient services. PFI is a financing approach where we partner with private companies to fund and manage those buildings, and we effectively lease these buildings back over a long period of time. These arrangements are set to expire in 2028.

Our strategic enablers

We have a huge array of professional support services within the Trust that create the conditions for us to provide safe, reliable and effective care. They all do an incredible job to support our front-line colleagues. There are too many to list here.

Our strategy focuses on two ‘strategic enablers’. In other words, two specific areas that will improve and enhance the quality of care for service users. They are Quality, and Digital Technology.

Providing outstanding quality care

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

- The work that we do is often complex,
- Successful outcomes depend on the knowledge of many people being brought together in the right way, and
- The wider work of the organisation needs to create the conditions where quality can flourish.

At the heart of our quality ambitions is our Quality Strategic Plan. It provides us with a framework for delivering the right care, in the right way, every time.

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

To help us fulfil our ambitions and provide a consistent approach, we've adopted the STEEEP definition of quality which is:

S **Safe** – avoiding harm or injury to services users and staff,

T **Timely** – reducing waits and harmful delays,

E **Effective** – based on scientific knowledge for the benefit of all,

E **Efficient** – making best use of ideas and energy, and avoiding wastes of time and resources,

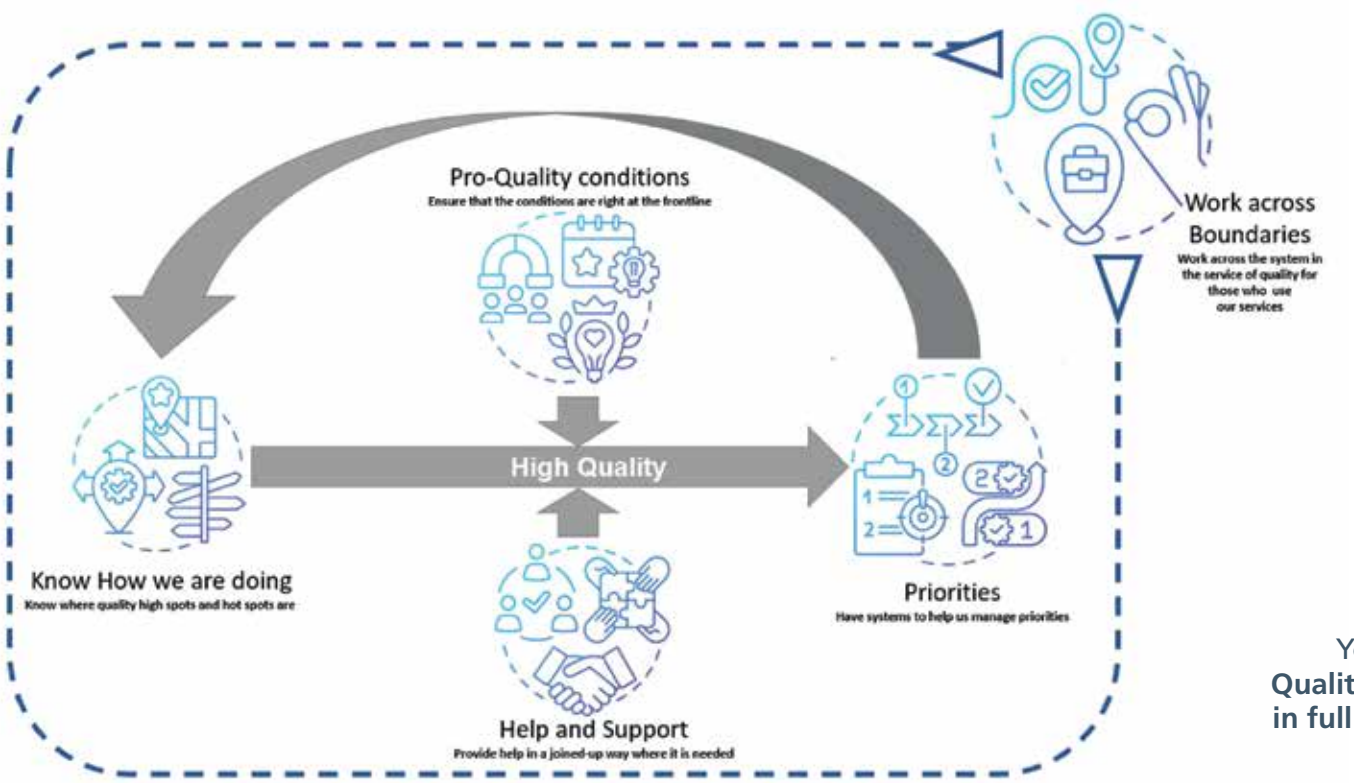
E **Equitable** – Consistent care that does not vary because of location or characteristics,

P **Patient-Centred** – Respective of individual needs and preferences.

To enable us to deliver outstanding quality, we will align our work to the five-point model illustrated below which:

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

The five-point model



You can read our **Quality Strategic Plan in full on our website**

Research and Development

Actively shaping the future of Mental Health Care

Quality care starts with Research and Development (R&D)

We are proud of our R&D team who are dedicated to generating high-quality, innovative research into mental health, learning disabilities and neurodiversity which improves care and changes lives across the UK.

In October 2022 they published a new three-year strategic plan to develop and deliver high quality research for the communities we serve. Their objective will be delivered by:

You can read our full **R&D strategic plan on our website**

Digital Technology

Digital technology has become ever more important in health care. We want our service users to access our services in a way that best suits them, so we must empower them to get the best out of digital technology – recognising that different people have different levels of access and confidence to digital technology.

We want our staff to be able to access the right information, in the right place, at the right time, all the time. This is in line with the current national strategic shift from 'analogue to digital'.

We want to able to make the best use of the data we collect to inform and increase our understanding of the communities we serve and provide insight into the best way to care for them.

We also want to minimise the intrusion of data-collection into care provision.

Our current long term Digital Plan aims to use innovative technology and intelligence to enable safer, inclusive, and more effective care. This means:

- Delivering safe and secure systems,
- Delivering digital solutions that are inclusive, and
- Encouraging and promoting digital innovation.

Our Digital Plan sets out a range of ambitions from the perspective of service users, staff and 'digital practitioners'. We've included some highlights from that plan as follows:

Our digital ambitions from a service users' perspective

We will

- Offer all service users a consultation via video if they prefer.
- Offer family and carers meetings with staff via video if they prefer,
- Enable service users to interact with systems to do things like amend appointments, complete forms and find information about services, conditions and self-help.

Our digital ambitions from a staff perspective

We will

- Collect and share information about outcomes to help patients and clinicians to understand the benefits of an intervention,
- Enable staff to view all information about a patient electronically, even if this is from old, archived records.
- Ensure staff have access to modern equipment across Trust sites and for home working.

Our digital ambitions from a digital practitioner's perspective

We will

- Embrace innovations such as Artificial Intelligence* to improve quality of care, productivity and efficiency,
- Not be constrained by the physical network infrastructure and location – enabling staff to work effectively and efficiently from any device, anytime, anywhere,
- Provide information about the quality of care provided to those who need it as part of our routine reporting.

*Jargon buster: Artificial intelligence

Artificial intelligence (AI) is the science of making machines that can think like humans. The benefits include processing and analysing massive amounts of data very quickly in ways humans cannot.

You can read our **Digital Plan in full on our website**

How we're accountable for delivery

Our Board of Directors is responsible for the day-to-day management of the Trust and is accountable for the operational delivery of services, targets and performance, as well as the development and implementation of our strategy.

The Board meets in public every two months and their reports and papers are published on our website.

The Board has a sub-committee structure beneath it, with a network of governance structures beneath that, to ensure members are connected to the operational front line of delivery. The Board's sub-committee structure is made up of the:

- Audit Committee,
- Quality Committee,
- Finance and Performance Committee,
- Workforce Committee,
- Mental Health Legislation Committee,
- Remuneration Committee, and
- Nominations Committee.

The Board is held to account by our Council of Governors (CoG) which gives staff, service users and the public a voice in helping to shape and influence services provided by our Trust, and for the delivery of our strategic plans.

The CoG is elected from and by our membership. It also includes people appointed from a range of partner organisations. The CoG is chaired by the Chair of the Trust, who ensures a link between the Council and the Board of Directors.

The Trust is independently regulated and inspected by the Care Quality Commission (CQC). They make sure the services we provide are safe, effective, compassionate, high-quality and are encouraged to improve.

The Trust also produces an Annual Report and a yearly Quality Account which gives a summary of our work and how we have performed. The latest copies of which can be found on our website, or printed copies can be provided on request.

Working collaboratively with our partners

We actively engage in strategic work at a regional and local level. We collaborate with other organisations across a range of systems, networks and partnerships to deliver better care.

Many of our services are provided in partnership with local third sector organisations, GPs and primary care, and other statutory organisations such as NHS healthcare providers, local authorities and the police.

We are an active partner within the Leeds Health and Care Partnership, and are represented on the Leeds Integrated Care Board and the Leeds Health and Wellbeing Board.

At a regional level, a lot of our work also takes place within the West Yorkshire Health and Care Partnership Integrated Care System (ICS).

The West Yorkshire Mental health, learning disability and autism collaborative

This work is part of the West Yorkshire Health and Care Partnership's commitment to improving lives and addressing inequalities of our population by working in collaboration across the system. Our aim to achieve a 10% reduction in the gap in life expectancy between people with mental ill-health, learning disabilities and autism, and the general population by 2024.

Humber and North Yorkshire

We have specialist services based in York which are part of the **Humber and North Yorkshire Integrated Care Board**.

Executive Directors

Dr Sara Munro
Chief Executive

Dawn Hanwell
Chief Financial Officer and Deputy Chief Executive

Joanna Forster Adams
Chief Operating Officer

Darren Skinner
Director of People and Organisational Development

Dr Christian Hosker
Medical Director

Nichola Sanderson
Director of Nursing and Professions

Clare Edwards
Associate Director for Corporate Governance

Non-Executive Directors

Merran McRae
Chair of the Trust

Martin Wright
Non-executive Director, Deputy Chair of the Trust, and Chair of the Audit Committee

Dr Frances Healey
Non-executive Director and Chair of the Quality Committee

Zoe Burns-Shore
Non-executive Director and Chair of the Workforce Committee

Cleveland Henry
Non-executive Director, Senior Independent Director, and Chair of the Finance and Performance Committee

Kaneez Khan
Non-executive Director and Chair of the Mental Health Legislation Committee

Katy Wilburn
Non-executive Director

Trust Board as of November 2024

Get in touch and know us better

If you'd like to find out more about the Trust, you can:

Visit our website at **www.leedsandyorkpft.nhs.uk.**

Get our news on X (formerly Twitter) **@LeedsandYorkPFT.**

Follow our **Facebook** and our **Instagram** pages for interesting stories.

Connect and network with us on **LinkedIn**.

Watch and subscribe to our videos on **YouTube**.

Speak to our PALS

If you'd like to speak to us, then our Patient Advice and Liaison Service (PALS) is a good place to start. They offer a free and confidential service to the public.

Tel: **0113 85 55000**

Email: **pals.lypft@nhs.net**.

Our Headquarters

The address for our Trust Headquarters is:

St Mary's House, Main House
St Mary's Road
Potternewton
Leeds
LS7 3JX

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Please let us know if you would like this information, or any resources highlighted in this document, provided in:

- A different language if English isn't your first language.
- Easy read format
- Braille
- Via an advocate
- British Sign Language (BSL)
- Large print

Please contact our Interpretation and Translation Support Team and let them know what format you would like it in.

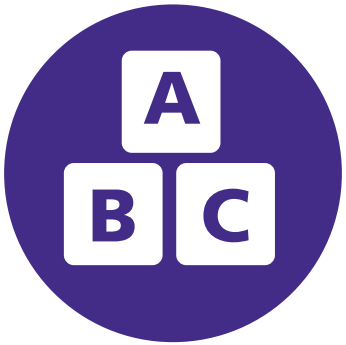
Tel: **0113 85 56418**

Email: **translation2.lypft@nhs.net**

Notes


NHS

Integrity



Simplicity

Caring

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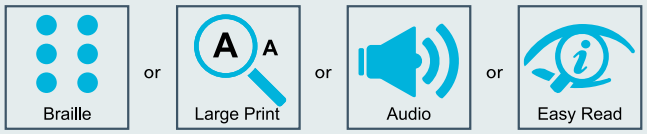


please contact the Interpretation and Translation Support Team on 0113 85 56418/9 or translation2.lypft@nhs.net

Agenda item
9

Meeting of the Board of Directors

Paper title:	Chair's Report from the Finance and Performance Committee meeting on 30 October 2024
Date of meeting:	28 November 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.	✓

This paper relates to the Trust's strategic risk/s (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	✓
SR6	Digital technologies	✓
SR7	Plan and deliver services that meet the health needs of the population we serve.	✓

Committee details:	
Name of Committee:	Finance and Performance Committee – Part A
Date of Committee:	30 October 2024
Chaired by:	Cleveland Henry, Non-executive Director

ALERT – items to alert the Board to

The Committee reviewed the Workforce and Agency Group trajectories at month 6 and noted that the previously positive position had deteriorated, and the Trust was now only marginally ahead of plan. The Committee agreed to alert the Board to this via the Chair's Report. The Committee acknowledged that there may be improvement at month 7 when re-forecasting would take place; however, it noted the risks associated with the Trust's approach of "tail-ending" its cost improvement plans especially given the expected increase in pressure over winter. The Committee asked that some analysis of the impact of the trajectories was provided in the next report.

ADVISE – items to advise the Board on

The Committee received an overview of the Trust's financial performance at month 6 and noted that the position was broadly stable. The Committee noted the risk areas which could worsen the Trust's financial position further as outlined in the paper and noted the potential non-recurrent measures which could help to address the in-year shortfall and support the Trust to deliver its plan. The Committee noted that the West Yorkshire Integrated Care Board (ICB) had moved from a level 2 to a level 3+ rating of the oversight framework and understood that significant accelerated action was required to deliver the Trust's plan and move towards a sustainable position with a particular focus on the productivity and efficiency of the organisation. The Committee agreed that a more detailed discussion on this and the implications for the Trust should take place at the private Board of Directors' meeting in November 2024. The Committee also discussed Provider Collaboratives and agreed that these needed to be covered in more detail in reports to the Committee, noting that there were issues linked to governance and risk allocation that members needed to be fully sighted on. The Committee also noted that the external review by PricewaterhouseCoopers was due to conclude in early November and heard that an update on the findings would be provided at the November Board of Directors' meeting.

The Committee received the report from the Chief Operating Officer and discussed the following areas: the Attention Deficit Hyperactivity Disorder (ADHD) update and agreed that the situation had been managed well; was assured by the update on the work to improve Crisis response times; noted that the Improving Patient Flow Programme was broadly on trajectory; and noted the update on the annual assessment against the Emergency Preparedness, Resilience and Response Core Standards and heard that the Trust had achieved 74% compliance this year and that the outcome would be reported retrospectively to the public Board of Directors' meeting in November 2024.

The Committee received the update on the Digital Plan for 2023-2025 which included updates on progress with replacing the Trust's Electronic Patient Record (EPR) and the Patient Portal both of which were key initiatives relating to the Trust's strategic priorities for 2024/25. The Committee heard that the aim was to have a new EPR provider by mid-2027 ahead of the October 2029 deadline, noted that a review into single solution verses best of breed approach was being undertaken and discussed the potential funding options linked to the Frontline Digitalisation Programme. The Committee also discussed the convergence between EPR systems with both NHS and third sector partners in the region, noted the issues caused by the current lack of interoperability, and highlighted the opportunity for collaboration as part of the West Yorkshire Integrated Care System. With regard to the Patient Portal,

the Committee noted the intention to engage the same solution as Leeds Teaching Hospitals NHS Trust. The Committee also received an update on the Electronic Prescribing and Medicines Administration (EPMA) solution and noted the issue linked to upgrading the current platform. The Committee agreed that the revised business case, partnership agreement and risk share agreement for the Yorkshire and Humber Perinatal Provider Collaborative would provisionally be scheduled for review at the January 2025 meeting, ahead of go-live in April 2025.
ASSURE – items to provide assurance to the Board on
The Committee received the annual update on off-payroll engagements as of 30 September 2024 and noted the position. The Committee received the Estates and Clinical Environments Report, noted that there were no high-risk issues for escalation, and was assured that good progress was being made across the key projects.
REFER – items to be referred to other Committees:
No items to be referred to other Committees.

Recommendation

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

Agenda item
9.1

Meeting of the Board of Directors

Paper title:	Terms of Reference for the Finance and Performance Committee
Date of meeting:	28 November 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.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	✓
SR6	Digital technologies	✓
SR7	Plan and deliver services that meet the health needs of the population we serve.	✓

Executive summary

The Finance and Performance Committee reviewed and approved its terms of reference on the 23 September 2024 and the following amendments were made (all amendments are highlighted in yellow on the attached document):

- Section 2 – added the Director of Nursing and Professions to the list of members as per their request to join the Committee. This has been agreed with the Chair of the Committee. Also updated job titles for some of the Committee's regular attendees.

- Section 7 – ‘Information Management Strategy Steering Group’ updated to ‘Digital Steering Group’.

- Appendix 1 – Updated Schedule of Deputies to reflect that the Deputy Chair of the Committee would chair the meeting in the absence of the Chair and to include a deputy for both the Director of Nursing and Professions and the Director of People and Organisational Development, as agreed at the September Finance and Performance Committee meeting.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? State ‘Yes’ or ‘No’.

No.

Recommendation

The Board is asked to:

- Review the changes made and ratify the revised Terms of Reference.

Finance and Performance Committee

Terms of Reference
(to be ratified by the Board)

1 NAME OF COMMITTEE

The name of this committee is the Finance and Performance Committee.

2 COMPOSITION OF THE COMMITTEE

The members of the Committee and those who are required to attend are shown below together with their role in the operation of the Committee.

Members:

Title	Role in the Committee
Non-executive Director (Committee Chair)	Non-executive directors provide constructive challenge and strategic guidance, and lead in holding the executive to account. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of clinical and other information, and make sure that clinical quality controls, and systems of risk management and governance, are robust and implemented. (Code of Governance for NHS Provider Trusts, NHS England 2022)
Non-executive Director (Additional non-executive member (see section 3) – Chair of the Audit Committee)	Non-executive directors provide constructive challenge and strategic guidance, and lead in holding the executive to account. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of clinical and other information, and make sure that clinical quality controls, and systems of risk management and governance, are robust and implemented. (Code of Governance for NHS Provider Trusts, NHS England 2022)

Non-executive Director (Additional non-executive member (see section 3) – Deputy Chair of the Committee, they must not also be the Chair of the Audit Committee)	Non-executive directors provide constructive challenge and strategic guidance, and lead in holding the executive to account. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of clinical and other information, and make sure that clinical quality controls, and systems of risk management and governance, are robust and implemented. (Code of Governance for NHS Provider Trusts, NHS England 2022)
Chief Financial Officer	Executive lead for financial resources within the Trust. Assurance and escalation provider to the Finance and Performance Committee.
Chief Operating Officer	Executive Director with responsibility for the oversight and delivery and development of Care Services. Assurance and escalation provider to the Finance and Performance Committee.
Director of People and Organisational Development	Executive lead for workforce development. Assurance and escalation provider to the Finance and Performance Committee. ~~Attendance at meetings will be dependent on the agenda items being discussed.~~
Director of Nursing and Professions / Director of Infection Prevention and Control	Executive lead for quality. Assurance and escalation provider to the Finance and Performance Committee.

Attendees

While specified Board members will be regular members of the Finance and Performance Committee any other Board member can attend the meeting on an ad-hoc basis if they wish and will be recognised as a member for that particular meeting and if necessary, will count towards the quoracy. The Committee may also invite other members of Trust staff and partners to attend to provide advice and support for specific items from its work plan when these are discussed at the Committee's meetings.

These could include, but are not exhaustive to, the following individuals:

- Assistant Director of Finance
- Associate Director for Corporate Governance
- Associate Director of Estates and Facilities
- Chief Digital Information Officer
- Deputy Director of Finance
- Head of Procurement
- Managing Director of North of England Commercial Procurement Collaborative
- Managing Director of Thrive by Design (previously mHabitat).

Non-executive directors are also welcome to observe Board sub-committee meetings that they are not a member of as part of their development.

2.1 Governor Observers

The role of a governor at Board sub-committee meetings is to observe the work of the Committee, rather than to be part of its work as they are not part of the formal membership of the Committee. The governor observes Board sub-committee meetings in order to get a better understanding of the work of the Trust and to observe non-executive directors appropriately challenging the executive directors for the operational performance of the Trust.

At the meeting the governor observer will be required to declare any interest they may have in respect of any of the items to be discussed (even though they are not formally part of the discussion). Governors will receive an information pack prior to the meeting. This will consist of the agenda, the minutes of the previous meeting and summaries of the business to be discussed. Governor observers will be invited to the meeting by the Corporate Governance Team. The chair of the meeting should ensure that there is an opportunity for governor observers to raise any points of clarification at the end of the meeting.

2.2 Associate Non-executive Directors

Associate Non-executive Directors will be invited to attend Board sub-committee meetings as part of their induction. They will be in attendance at the meeting, in the capacity of observer only, unless invited to contribute by the Chair in circumstances that support the Associate NEDs' development and understanding. This is so the accountability of the substantive members of the Committee is maintained.

Associate NEDs will be invited to meetings by the Corporate Governance Team and will be sent copies of the meeting papers.

3 QUORACY

Number: The minimum number of members for a meeting to be quorate is three. This should comprise at least one non-executive director and one executive director. Attendees do not count towards this number. If the Chair is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by the Deputy Chair of the Committee.

Deputies Members may nominate deputies to represent them at the Committee on an exceptional basis. Deputies do not count towards quoracy.

Non-quorate meeting: Non-quorate meetings may go forward unless there has been an instruction from the Chair not to proceed with the meeting. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

Alternate chair: The unique character of Board sub-committees is that they are chaired by a non-executive director. If the Chair cannot attend this meeting another non-executive director would chair this Committee. However, if one of the other non-executive directors that is a member of this Committee is also the Chair of the Trust's Audit Committee then they are not eligible to chair this Committee. This is in keeping with best practice to ensure that the Chair of the Audit Committee is seen to be suitably independent. In this circumstance the other non-executive director who is a member of this meeting would be the Deputy Chair for this Committee. In exceptional cases such as a non-executive director vacancy on the Committee, the Chair of the Audit Committee would be asked to chair the meeting if the assigned Chair is unable to attend the meeting.

4 MEETINGS OF THE COMMITTEE

Meetings may be held face-to-face or remotely as is considered appropriate. Remote meetings may involve the use of the telephone and / or electronic conference facilities.

Frequency: The Finance and Performance Committee will meet up to eight times a year or as agreed by the Committee. The Committee will meet following the NHS England quarter close downs and there will be up to another four meetings scheduled each financial year.

Urgent meeting: Any member of the Committee may request an urgent meeting. The Chair will normally agree to call an urgent meeting to discuss the specific matter unless the opportunity exists to discuss the matter in a more expedient manner.

Administrative support: The Corporate Governance Team will provide secretariat support to the Committee.

Minutes: Draft minutes will be sent to the Chair for review and approval within seven working days of the meeting.

Papers: Papers for the meeting will be distributed electronically by the Corporate Governance Team a minimum of three working days prior to the meeting. This is so the circulation of papers is aligned to that of the Board of Directors. Papers received after this date will only be included if decided upon by the Chair.

5 AUTHORITY

Establishment: The Finance and Performance Committee is a sub-committee of the Board of Directors and has been formally established by the Board of Directors.

Powers: Its powers, in addition to the powers vested in the executive members in their own right, are detailed in the Trust's Scheme of Delegation.

In consultation with the Board of Directors, the Committee is able to access independent professional advice and secure the attendance of persons outside the Trust with relevant experience and expertise if it considers this necessary.

Cessation: The Finance and Performance Committee is a standing committee in that its responsibilities and purpose are not time limited. However, the Committee has a responsibility to review its effectiveness annually and on the basis of this review and if agreed by a majority of members the Chair may seek Board authority to end the Finance and Performance Committee's operation.

In addition, the Trust should periodically review its governance structure for continuing effectiveness and as a result of such a review the Board may seek the winding up of the Finance and Performance Committee.

6 ROLE OF THE COMMITTEE

6.1 Purpose of the Committee

The principle purpose of the Finance and Performance Committee is to provide the Board with assurance on financial governance and performance; strategic matters in relation to procurement, estates, information technology and information management; performance against CQUINS; clinical activity and key performance indicators.

6.2 Guiding principles for members (and attendees) when carrying out the duties of the Finance and Performance Committee

In carrying out their duties members of the Committee and any attendees of the Committee must ensure that they act in accordance with the values of the Trust, which are:

- we have integrity
- we are caring
- we keep it simple.

6.3 Duties of the Finance and Performance Committee

The Finance and Performance Committee has the following duties.

i. General governance duties

- ratify plans, policies and procedures relevant to the remit of the Committee, this includes approval of the Trust's Financial Procedure and the Standing Financial Instructions prior to the Board of Directors ratifying them
- develop a forward plan for the work of the Committee that ensures proper oversight and consideration of all mandatory and statutory declarations is scheduled into the business of the Committee
- to review the Board Assurance Framework to ensure that the Board of Directors receives assurances that effective controls are in place to manage strategic risks related to any area of the Finance and Performance Committee's responsibilities.

ii. Financial governance

Receiving assurance that:

- the Trust has high standards of financial management and that financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout
- financial considerations are fully taken into account in decisions within the Trust and that there is effective management of financial and operational business risks in the organisation
- the Trust is reviewing the impact of any issues that may affect mandatory and regulatory financial duties operationally
- the Trust is complying with the Licence holder's duty to operate efficiently, economically and effectively and has effective financial decision-making, management and control in place.

iii. Procurement

Receiving assurance that:

- the Trust's Procurement Plan is driving reductions in all non-pay expenditure and progressing as originally intended
- operational reports are reviewed regarding compliance with effective procurement procedures with lessons learnt being implemented
- the Trust has a system to minimise the risk of Standing Financial Instruction and EU Procurement Law breaches for all Trust non-pay expenditure.

iv. Financial strategy

- review the detailed medium term financial plans as part of the annual Strategic Plan, prior to ratification by the Board of Directors and onward submission to NHS England
- scrutinise the quarterly financial reports to NHS England and provide assurance to the Board of Directors on the continuity of services rating, to ensure compliance with the Risk Assessment Framework
- review and monitor the financial impact and achievement of cost improvement plans.

Receiving assurance:

- regarding the Trust's contracting performance and the robustness of information provided to document activity
- on the on-going development of payment mechanisms and tariff system within the Trust to ensure that these are effective and will be deployed meeting national targets and mandatory guidance.

v. IT and information governance

Receiving assurance:

- approve the Trust's Health Informatics Plan and receive assurance that it is progressing as originally intended
- Chair's reports from the Information Governance Group.

vi. Capital and estates

Receiving assurance that:

- the Trust's Strategic Estates Plan is progressing as originally intended
- actions related to the Trust's capital programme are being taken forward operationally and advising the Board of Directors of issues that needed to be escalated
- action is being taken operationally relating to the Trust's estate from regulatory and statutory bodies and in respect to sustainability.

vii. Performance

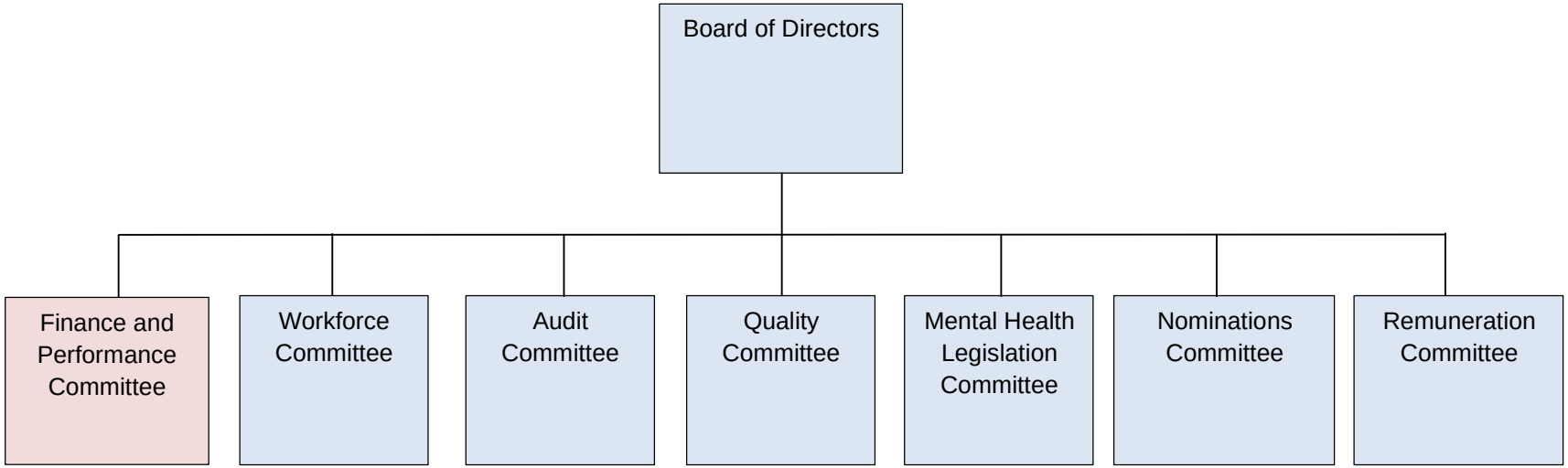
Receiving assurance on the Trust's performance against:

- annual budgets, capital plans, and the Cost Improvement Programme
- quality, innovation, productivity, and prevention plans
- commissioning for quality and innovation plans (CQUIN)
- clinical activity and key performance indicators.

viii. Internal Audit

- The Committee will also review the draft Internal Audit Annual work plan so it can be assured on the sufficiency of the work the Auditors will carry out in respect of matters pertaining to the duties of the Committee. Assurance on the plan's sufficiency (or comments on any matters that should be included) will be provided to the Audit Committee to allow it to approve the overall plan.

7 Links with Other Committees



The Finance and Performance Committee does not have any sub-committees. It is linked to the Information Governance Group as an assurance receiver. The Finance and Performance Committee provides a route of escalation for this group to the Board of Directors. Although this does not preclude any other group being asked to provide assurance. The Committee has a duty to work with other Board sub-committees to ensure matters are not duplicated.

Reporting

The Finance and Performance Committee will receive an assurance report from the Information Governance Group. An assurance and escalation report will be made to the Board of Directors by the Chair of the Committee.

Links with operational processes

The Finance and Performance Committee will receive high level reports from operational functions such as estates, informatics, and the North of England NHS Commercial Procurement Collaborative.

In addition to this, operational groups within the Chief Financial Officer's portfolio will report any significant governance implications by way of highlight reports into the Finance and Performance Committee. Groups dealing with the following areas have thus far been identified:

- Estates Steering Group
- Financial Planning Group
- ~~Information Management Strategy Steering Group~~ Digital Steering Group
- Procurement Steering Group
- Emergency Preparedness Resilience and Response Group (this group sits within the Chief Operating Officer's portfolio).

8 DUTIES OF THE CHAIR

The Chair of the Committee shall be responsible for:

- agreeing the agenda with the Chief Financial Officer and Chief Operating Officer
- directing the conduct of the meeting ensuring it operates in accordance with the Trust's values whilst ensuring all attendees have an opportunity to contribute to the discussion
- giving direction to the secretariat and checking the minutes
- ensuring the agenda is balanced and discussions are productive
- ensuring sufficient information is presented to the Board of Directors in respect of the work of the Committee.

In the event of there being a dispute between any 'groups' in the hierarchy (in the case of this Board sub-committee, this would be between the Board and the Finance and Performance Committee and, in recognition of the nature of matrix working between the work of all Board sub-committees, the Finance and Performance Committee and any other Board sub-committee) it will be for the chairs of those 'groups' to ensure there is an agreed process for resolution; that the dispute is reported back to the 'groups' concerned; and that when a resolution is proposed regarding the outcome this is also reported back to the 'groups' concerned for agreement.

9 REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

The terms of reference shall be reviewed by the Committee at least annually, and then presented to the Board of Directors for ratification, where there has been a change. The Chair must ensure the Committee carries out an annual assessment of how effectively it is carrying out its duties and make a report to the Board of Directors including any recommendations for improvement.

Appendix 1

Schedule of Deputies

Committee Member	Deputy
NED Chair	Deputy Chair of the Committee
NED member	Another NED
NED member	Another NED
Chief Financial Officer	Deputy Director of Finance
Chief Operating Officer	Deputy Director of Operations
Director of People and Organisational Development	Associate Director of Employment / Associate Director for People Resourcing and Organisational Development
Director of Nursing and Professions	Deputy Director of Nursing

Agenda item
10

Meeting of the Board of Directors

Paper title:	CFO Finance Report
Date of meeting:	28 November 2024
Presented by: (name and title)	Dawn Hanwell, Chief Financial Officer and Deputy Chief Executive
Prepared by: (name and title)	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.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

Executive summary

At month 7 the Trust's financial position remains broadly stable. The income and expenditure position is a deficit YTD, as anticipated but the "back loading" of efficiency improvements is a significant risk and unlikely to be delivered in full. The enhanced financial governance arrangements remain in place. The Trust is complying with the vast majority of "grip and control" measures required for challenged systems. More work is required to drive efficiency and productivity, specifically on a recurrent basis as we continue to underpin the position with fortuitous non-recurrent measures. It is vital that the organisation

identifies recurrent savings plans to move towards a sustainable position into 25/26 planning round. At this stage it is not clear if the ICS as a whole will deliver its plan and the consequences of not doing so would significantly impact into next year.

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

Recommendation

The Board is asked to:

- Note the Trust revenue and capital plans position 2024/25.
- Note the intervention that will take place if the West Yorkshire system is significantly off plan.

MEETING OF THE BOARD OF DIRECTORS

25 NOVEMBER 2024

CHIEF FINANCIAL OFFICER REPORT

1 Introduction

This report provides an overview of the Trust financial position at month 7 2024/25 and the issues and risks the Trust is facing.

2 Income and Expenditure Performance 2024/25

At month 7 the Trust reported position is a £0.9m deficit against the year-to-date deficit of £1.2m, £0.3m better than plan. The monthly run rate continues to improve however not at the anticipated required rate. The year-to-date position is underpinned by the significant final year gainshare of the Collaborative Procurement Partnership of £0.8m as well as other fortuitous variances.

The summary reported position is shown in table below

		Month 7		
Income & Expenditure Budget Position	**Budget Annual £'000**	**Budget YTD £'000**	**Actual YTD £'000**	**Variance YTD £'000**
Income:				
Patient Care Income	225,963	131,812	133,637	1,825
Other Income	31,569	20,715	22,296	1,581
Total Income	**257,532**	**152,527**	**155,933**	**3,406**
Expenditure:				
Pay Expenditure	(195,623)	(114,109)	(110,968)	3,140
Non Pay Expenditure	(57,860)	(37,793)	(44,105)	(6,312)
Total Expenditure	**(253,483)**	**(151,901)**	**(155,073)**	**(3,172)**
Surplus/ (Deficit)	**4,049**	**626**	**860**	**234**
System adjustments	**(3,054)**	**(1,789)**	**(1,749)**	**40**
NHSE Adj. Surplus / (Deficit)	**995**	**(1,163)**	**(889)**	**274**

Significant items to note are:

- Due to the central NHS payment mechanism to fund the national Pay Awards, the Trust has an additional 0.7m pressure in year.

- Improvements have been made in the Trusts use of agency, bank and overtime, as part of the efficiency programme, but with medical agency the main high-cost challenge.
- Wards continue as key area of focus for overspending, most notably Adult Acute wards £0.6m and Older Peoples wards £1.1m at month 7.
- Significant improvements (deductions) in Working Age Out of Area Placements (OAPs) had been made in the first half of the year, but activity increased in October, £0.8m is the year to date overspend.
- The Specialist Supported Living contract has a £0.5m overspend, following good progress to address the voids and agreement on inflationary uplift. Further work is still required on this contract model.
- The two Provider Collaboratives which the Trust is lead for, Adult Eating Disorders and Children and Young People (CYP) are both currently overspending. Plans are in place to address, and CYP overspend is partially mitigated from investment reserves brought forward.
- Corporate departments, doctors in training and pharmacy continue to underspend, supporting the in-year position.
- Interest receivable remains high, £0.5m better than planned year to date, but rates have reduced twice this financial year reducing this benefit in year.

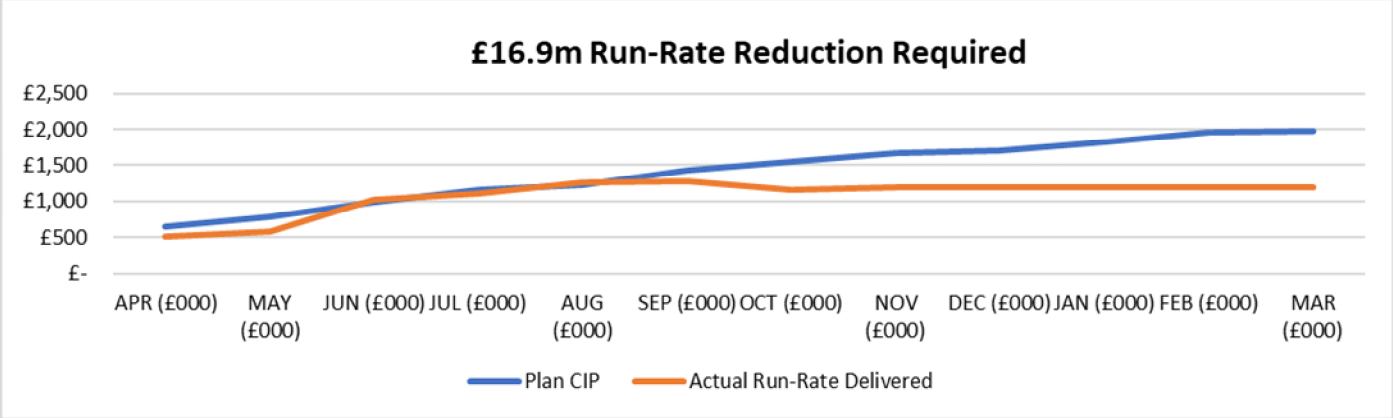
3 Efficiency Programme

The Trust's efficiency programme for 24/25 is to deliver in year run-rate savings of £16.9m. This is based on the external plan which reflects the actual forecast income and expenditure profile compared with prior year.

Separately but linked, the Trust started the financial year with a recurrent £10.8m budget saving programme (recurrent CIP) which is based on the budgets only. This excludes the under/overspends which are reflected in the run rate calculation. This is a lower figure based on what is required to be taken out of our budgets, assuming every service and department is starting from a balanced budget position (therefore a much lower figure).

Due to the national pay awards paid in October, this recurrent budget target has increased by £750k to £11.5m. This brings the gap in the pay award funding to a full year gap of £1.3m. A £500k gap was included in the original budget target for the year based on an assumed 2% AFC pay award, £750k has now been added due to a 5.5% pay award. The pay award is paid to Trusts using a national weighted mechanism, however as mental health Trusts have a higher percentage of pay than other sectors, there is usually a gap in pay award funding.

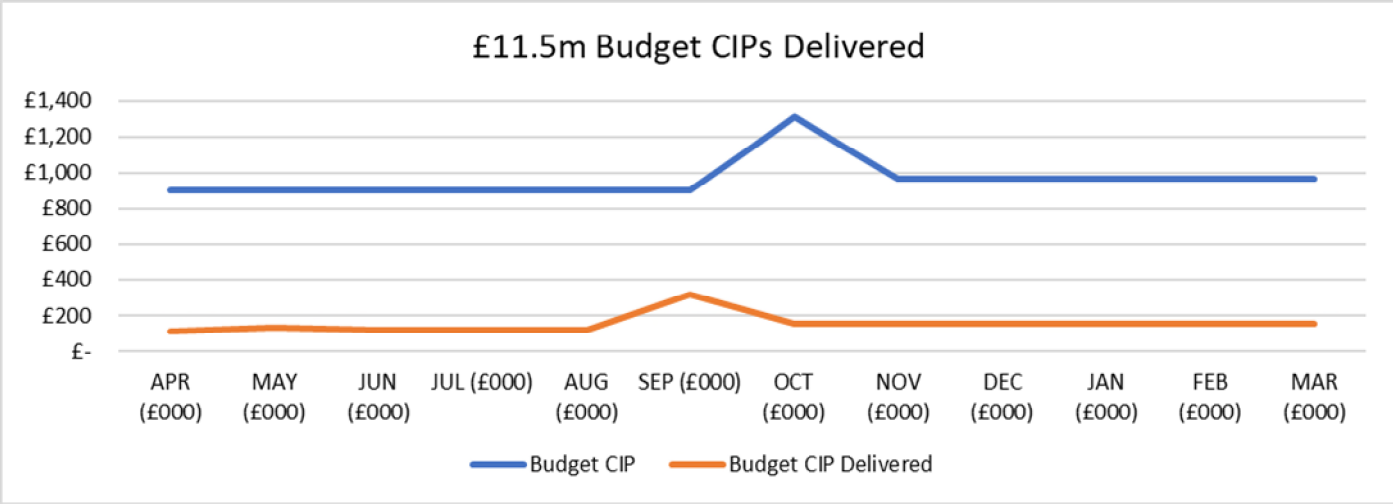
All schemes have been identified and the majority have been assigned trajectories for delivery in 24/25. Actual and forecast reductions in run-rate against planned reductions are shown below:



	APR (£000)	MAY (£000)	JUN (£000)	JUL (£000)	AUG (£000)	SEP (£000)	OCT (£000)	NOV (£000)	DEC (£000)	JAN (£000)	FEB (£000)	MAR (£000)	TOTAL (£000)
Plan CIP	654	793	997	1,164	1,232	1,434	1,555	1,669	1,698	1,813	1,961	1,980	**16,950**
Actual Run-Rate Delivered	514	583	1,024	1,101	1,261	1,276	1,166	1,190	1,190	1,190	1,190	1,190	**12,872**
Variance	(141)	(210)	27	(64)	29	(158)	(389)	(479)	(508)	(624)	(772)	(791)	**(4,078)**
Cumulative Variance	**(141)**	**(351)**	**(323)**	**(387)**	**(358)**	**(516)**	**(904)**	**(1,384)**	**(1,892)**	**(2,516)**	**(3,287)**	**(4,078)**	

As at month 7 the Trust had planned £7.8m run-rate reductions, of which £6.9m were delivered (£0.9m behind plan). A prudent forecast of run-rate reductions has been made until the end of the financial year. This demonstrates that further run-rate reductions totalling £4.1m are required before then end of the financial year.

The below table and graph demonstrate the budget CIP achieved YTD:



	APR (£000)	MAY (£000)	JUN (£000)	JUL (£000)	AUG (£000)	SEP (£000)	OCT (£000)	NOV (£000)	DEC (£000)	JAN (£000)	FEB (£000)	MAR (£000)	TOTAL (£000)
Budget CIP	900	900	900	900	900	900	1,308	963	963	963	963	963	**11,521**
Budget CIP Delivered	110	130	120	120	120	316	152	152	152	152	152	153	**1,829**
Variance	(790)	(770)	(780)	(780)	(780)	(584)	(1,156)	(810)	(810)	(810)	(810)	(810)	**(9,692)**
Cumulative Variance	**(790)**	**(1,561)**	**(2,341)**	**(3,122)**	**(3,902)**	**(4,486)**	**(5,642)**	**(6,452)**	**(7,262)**	**(8,072)**	**(8,882)**	**(9,692)**	

The Trust still needs to deliver £9.7m recurrent budget CIP to ensure that the recurrent budget is in balance. In September Corporate and Care Services have been given targets of a combined £5.2m to be delivered from their recurrent pay budgets, to date £2.9m of schemes have been identified, subject to being approved by the Trust QIA process. The remaining budget CIP is expected to be delivered from Trust wide schemes predominantly in non-pay budgets.

The permanent budgetary savings should be achievable based on current run rate, but given these savings will be required recurrently, further risk assessments will be undertaken to confirm the proposals.

4 Income and Expenditure Forecast

For external reporting the Trust remains reporting a forecast of plan, a £1.0m surplus. We review the forecast monthly and have revised this at month 07 based on latest known working assumptions. It currently reflects a realistic forecast deficit of £2.8m which is £3.9m off plan. This is a net deterioration of £400k compared to M6. However, this is after reflecting in the forecast the emerging OAPs pressure and the full costs of the 24/25 pay awards, which were actioned in month 07. The impact of these pressures has been reduced by additional training & education income, revised assumptions on future agency need and negotiating a reduced price on the PFI catering benchmark uplift.

The M7 forecast still falls well below the required outturn position, if unmitigated. This reinforces the imperative need for continued efforts to make run-rate improvements over the coming months.

There are material one off benefits and flexibilities which will support the position and offset the under delivery of the planned position. These additional flexibilities should also mitigate the risk of further volatility over winter specifically linked to OAPs. On this basis the Trust continues to forecast delivering its overall plan position although not through the recurrent run rate and cost improvement savings it intended to achieve this. The non recurrent items supporting the position generate a significant risk and is not sustainable into 25/26.

5 Capital Expenditure

The Trust’s capital position is detailed in Appendix A

5.1 Operational Capital

The Trust’s share of the operational capital allocation for West Yorkshire is £4m. At month 7 expenditure is £1,400k, £414k ahead of plan at this stage due mainly to expenditure at the Mount linked to the perinatal expansion. The forecast remains on plan for the year.

5.2 Public Dividend Capital (PDC)

The Trust has several planned capital schemes anticipated in year from nationally funded PDC. These are all at different stages as noted below.

- £11.2m High Intensity (West Yorkshire Complex Rehabilitation Scheme) – approved and progressing.
- £1m Electronic Document Management – part of a multi-year funding approval but confirmation required for 24/25.

£5m Perinatal Expansion – It has been confirmed that this funding will be CDEL only. A separate report is being taken to the November Board of Directors to agree the position and implications.

5.3 Lease (IFRS16)

Lease (IFRS16) expenditure is £48k at M7, which is £687k behind plan due to the timing of new leases being finalised, however, the forecast remains in line with plan for the year. However, it should be noted the planned position does not necessarily equate to funding. Lease funding is an ICB allocation (like operational capital) and there is a risk of an overall shortfall across West Yorkshire.

6 West Yorkshire System Position

6.1 Revenue

The month 7 year-to-date position for the ICS was an actual £48.2m deficit against a planned £25.0m deficit; a shortfall/adverse variance against plan of £23.2m. The main reasons for the month 7 adverse variance are slippage on delivery of waste reduction/efficiencies, additional costs of drugs/devices, and pay overspends in part due to shortage of pay award funding, offset in part by an improvement in the ICB prescribing position.

The national approach to oversight of Trusts in National Oversight Framework level 3 has been revised and implemented. Following reporting the Month 6 position, the ICS has now been escalated to level 3+ as part of this process and as a result is subject to weekly reporting to NHSE. Four organisations have indicated significant financial risk and submitted Financial Recovery Plans to the WY ICS System Oversight and Assurance Group meeting for review and challenge. They continue to explore all possible actions to recover their position. No organisation is formally reforecasting non achievement of plan at this stage but this is possible at month 08.

6.2 Operational Capital

Year to date the system has a year-to-date underspend against operational capital plan of £14.1m. Due to the risk of deliverability on some schemes across providers, we have been able to negotiate £30m brokerage with another ICS. This will result in a reduction of £30m in the West Yorkshire allocation for 24/25 and another system allocation will increase by equivalent amount, to ensure the overall national operational envelope remains the same. This brokerage will reverse in 25/26 to match the profile of capital spend. This has significantly reduced risk of in year underspend which would otherwise be lost to the system. LYPFT has transferred £5m to 25/26 as part of this brokerage arrangement.

6.3 PWC Review

As previously reported due to the high level of financial risk West Yorkshire organisations voluntarily commissioned an external review that mirrors the mandated NHSE national specification for systems in level 4 of the oversight framework. The Trust has received it's chapter and the next steps are to review any actions highlighted. The report is focused on short term in year positions and improvements and largely from LYPFTs perspective has not identified any significant opportunities that were not already in train or being considered.

7 Conclusion

At month 7 the Trust's financial position remains broadly stable. The income and expenditure position is a deficit YTD, as anticipated but the "back loading" of efficiency improvements is a significant risk and unlikely to be delivered in full. The enhanced financial governance arrangements remain in place. The Trust is complying with the vast majority of "grip and control" measures required for challenged systems. More work is required to drive efficiency and productivity, specifically on a recurrent basis as we continue to underpin the position with fortuitous non-recurrent measures. It is vital that the organisation identifies recurrent savings plans to move towards a sustainable position into 25/26 planning round. At this stage it is not clear if the ICS as a whole will deliver its plan and the consequences of not doing so would significantly impact into next year.

8 Recommendation

The Board is asked to:

- Note the Trust revenue and capital plans position 2024/25.
- Note the intervention that will take place if the West Yorkshire system is significantly off plan.

Jonathan Saxton
Deputy Director of Finance
22 November 2024

Appendix A

CAPITAL PROGRAMME - at 31 October 2024	Year to Date			
	Annual Plan £'000	YTD Plan £'000	Actual Spend £'000	YTD Variance £'000
ICS Operational Capital				
Estates Operational				
Health & Safety /Fire/Accessibility/ Backlog	421	170	10	160
Food Refrigeration/Transport	50	0		0
Security review	200	24	57	(33)
Woodlands Generator	25	0		0
Standardisation of attack alarms	124	0	46	(46)
The Mount - ward upgrade scheme	674	74	491	(417)
Wardrobes	20	0		0
Sub-Total	**1,514**	**268**	**604**	**(336)**
IT/Telecomms Operational				
PC Replacement Programme	260	171	154	17
IT Network Infrastructure	150	80	1	79
Sub-Total	**410**	**251**	**155**	**96**
Estates Strategic Developments				
Lifecycle contribution	75	25	2	23
Red Kite View	100	0		0
St Marys House, North/South Wing/Estate Strategy	250	150		150
Woodhouse Square	150	0		0
Sustainibility & Green Plan	300	0		0
Seclusion - Newsam	400	100	488	(388)
Safes	25	25		25
Seclusion - Clifton	100	0		0
Solar film - PFI estate	20	20	12	8
Sub-Total	**1,420**	**320**	**502**	**(182)**
IT Strategic Developments				
VM Ware	500	0		0
Sub-Total	**500**	**0**	**0**	**0**
Minor Schemes				
Minor Schemes	182	20	7	13
2023/24 Completed Schemes	0	127	131	(5)
ICB contingency	7,848	0		0
Sub-Total	**8,030**	**147**	**138**	**8**
Disposals				
ICS	0	0		0
Sub-Total	**0**	**0**	**0**	**0**
Total ICS Operational Capital	**11,874**	**986**	**1,400**	**(414)**
PDC Funded Schemes				
Complex Rehab	11,190	2,200	333	1,867
Perinatal	4,992	0		0
EDM	1,009	0		0
MH Urgent Emergency Care	1,637	0		0
Total PDC Funded Schemes	**18,828**	**2,200**	**333**	**1,867**
IFRS16 Leased Assets				
Leased Buildings	900	600		600
Lease Cars	152	87	51	36
Sub-Total	**1,052**	**687**	**51**	**636**
Disposals				
Leased	(2)	(2)	(2)	0
Sub-Total	**(2)**	**(2)**	**(2)**	**0**
Total IFRS16 Leased Assets	**1,050**	**685**	**49**	**637**
Total Capital Spend	**31,752**	**3,871**	**1,781**	**2,090**

Agenda item
10.1

Meeting of the Board of Directors

Paper title:	Standing Financial Instructions – review of SFI 8 Tenders and Contracting
Date of meeting:	28 November 2024
Presented by: (name and title)	Dawn Hanwell, Chief Financial Officer and Deputy Chief Executive
Prepared by: (name and title)	Gerard Enright, Assistant Director of Finance

This paper supports the Trust's strategic objective/s (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	
SO2	We provide a rewarding and supportive place to work.	
SO3	We use our resources to deliver effective and sustainable services.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

Executive summary

SFI 8 Tendering and Contracting has been reviewed by procurement and finance colleagues with the following proposed amendments;

- Updated references to EU legislation (this will be replicated throughout the document as required).

- Updated thresholds for quotation and tenders (£25k & £100k respectively over life of a contract).
- 8.3.5 – Clarification that nationally let contracts are exempt.
- 8.4.4 - Clarification that late tenders can only be accepted prior to the opening of any tenders received.
- 8.4.5 - Clarification that communication to potential suppliers to be carried out through e-tendering portal only.
- 8.4.7 - Addition of compliance with Modern Slavery Act in relation to potential suppliers meeting standards for industry best practice.

The revised SFI 8 is attached as Appendix 1.

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

Recommendation

The Board of Directors are asked to

- Consider the proposed amendments to SFI 8 and feedback any comments.
- Ratify the proposed amendments to SFI 8 Tenders and Contracting.

Leeds and York Partnership NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

SFI 8
Tenders and Quotations review

Director Responsible:	**Chief Financial Officer**
Department:	**Finance**
Date Issued:	**March 2023**
Review Date:	**March 2027**
Ratified By:	**Board of Directors**

CONTENTS

8. TENDERING AND CONTRACTING PROCEDURES

8.1 Duty to comply with Standing Financial Instructions

8.1.1 The procedure for making all contracts by or on behalf of the Foundation Trust shall comply with these Standing Financial Instructions.

8.2 Directives Governing Public Procurement

8.2.1 Directives by the UK Government promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Financial Instructions.

8.2.2 The Foundation Trust shall comply as far as is practicable with the requirements of NHS Improvement guidance" in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health guidance "The Procurement and Management of Consultants within the NHS" (adopted as a separate guidance document by the Trust).

8.3 Formal Competitive Tendering

8.3.1 General Applicability

The Foundation Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);
- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and disposals;

Where the Foundation Trust elects to invite tenders for the supply of healthcare services these Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure.

NHS Supply Chain is the preferred procurement route of all goods for the Trust; if goods are not available via this method then the decision to use alternative sources must be documented. Where tenders or quotations are not required, because expenditure is below the levels defined in the Reservation of Powers to the Board of Directors and Council of Governors and Schedule of Decisions/Duties Delegated by the Board of Directors, the Foundation Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Financial Officer;

8.3.2 Exceptions and instances where formal tendering need not be applied Formal tendering procedures need not be applied where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed £100,000 over the length of the contract (cumulative value); public advertisement will be carried out, however, where required, in compliance with UK legislation. It is a breach of SFI's to split contracts to avoid thresholds.

(b) the requirement is ordered under existing contracts.

8.3.3 Formal tendering and quotation procedures may be waived by officers to whom powers have been delegated by the Chief Executive:

(a) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Foundation Trust record;

(b) where the requirement is covered by an existing contract;

(c) where CPC or other applicable framework agreements are in place and have been approved by the Board of Directors;

(d) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(e) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(f) where specialist expertise is required and there is clear and convincing evidence readily at hand that it is available form only one source;

(g) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different parties for the new task would be inappropriate;

(h) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

(i) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Foundation Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Standards Board for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Chief Financial Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

(j) the goods or materials to be supplied consist of repairs to parts for existing equipment or extensions thereto which, for practical reasons, must be from the same manufacturer;

(k) a Framework Agreement has been established by other public sector bodies, including the Department of Health, and the Head of Procurement has assessed its appropriateness to the Foundation Trust prior to utilisation;

(l) where the market place has a limited number of suppliers below the minimum number required for quotation or tender exercises. (The type of research and evidence carried out must be documented on the waiver submission);

(m) Where an extension to an existing contract can be evidenced to be more effective to the Trust than the alternative of a competitive exercise at that time and such extension is in compliance with UK Legislation. Initial approval by the Head of Procurement will be report to the Audit Committee via the Chief Financial Officer. This extension period must not breach UK thresholds; and/or

(n) Where the Head of Procurement can evidence that cost efficiency can be realised by the Trust through negotiation and or mini competition carried out by the Procurement Department. A comparison of at least the current and proposed supplier must be evidenced. Initial approval by the Head of Procurement will be reported to the Audit Committee via the Chief Financial Officer.

8.3.4 The waiver process should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure. A Single Quotation or Tender Waiver form must be completed and approved in advance for any procurement in excess of £25,000 that has not followed the correct procurement procedure.

8.3.5 Where it is decided that competitive tendering or quotations is not applicable and should be waived the reasons should be documented in an appropriate Foundation Trust record and reported by the Chief Financial Officer to the Audit Committee in a formal meeting. Contracts awarded in conjunction with points (d), (k) (m) have been let through nationally negotiated contracts which have demonstrated best value and have been let in accordance with National Procurement legislation, the Chief Financial Officer is not required to report this to the Audit Committee.

8.3.6 Fair and Adequate Competition

The Board of Directors shall ensure that an electronic system is in place to allow complete transparency of contract opportunities; this system should populate the government's contract finder portal.

Over UK threshold tender opportunities advertised should be subject to adequate pre-qualification criteria to ensure that appropriate suppliers are involved with the process.

The annual declaration of interests update will consider the need for all staff involved in the management and processing of tenders to be included the process.

8.3.7 Building and Engineering Construction Works

Competitive Tendering cannot be waived for building and engineering construction works and maintenance without Departmental of Health approval.

8.3.8 Items which subsequently breach thresholds after original approval

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Foundation Trust record.

8.4 Contracting/Tendering Process

All tender processes shall be undertaken via the Procurement team utilising the Trusts E-Tendering system. Where an alternative tender process is considered this must be approved by the Chief Financial Officer and the tender process below must still be followed with the exception that tenders may be receipted and acknowledged by a third party but must be opened in line with the process in 8.4.3 below.

8.4.1 Invitation to tender

(i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(ii) All invitations to tender shall state that no tender will be accepted unless:

(a) submitted vie the Trust e-tendering portal that the opportunity was advertised on. No paper responses will be accepted.

(b) submissions meet the formal Trust procedure that has been laid down for e-tendering;

(iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable;

(iv) Every tender for building or engineering works (except for maintenance work, when ESTATECODE guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with legislation or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

8.4.2 Receipt, safe custody and opening of tenders

The Trust e-Tendering portal will record all responses to ITT documents that are submitted. The opening of tender responses will be carried out within the portal by the buyer responsible for the tender process. The system will capture information about who is involved with the electronic opening of Tenders.

The date and time of the opening process will be captured in the e-Tendering system.

8.4.3 Admissibility

(i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(ii) Where only one tender is sought and/or received, the Chief Executive and Chief Financial Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Foundation Trust.

8.4.4 Late tenders

(i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer. This would require the responsible buyer to amend the deadline for receipt of tenders on the e-Tendering portal and should allow all bidders the opportunity to resubmit their own bid.
Note: this can only be done if the opening ceremony has not yet taken place.

i) under no circumstances should a tender submission be allowed after the opening ceremony.

8.4.5 Acceptance of formal tenders

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender. These discussions should take place through the e-Tendering portal and any questions and subsequent answers are recorded and shared with all interested parties.
Note: no correspondence should be entered into outside of the e-Tendering portal.

(ii) An award criteria should be prepared alongside the specification to be issued with the ITT. This will consider all aspects of the contract on offer, Price will always be a component of this evaluation.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include inter alia;

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Foundation Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(iv) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate/price current at the time the contract was awarded;

(b) that best value for money was achieved.

(c) All tenders should be treated as confidential and should be retained in line with the retention of records financial procedure and be made available for inspection to comply with the Freedom of Information Act.

8.4.6 Tender reports to the Board of Directors

Reports to the Board of Directors will be made on an exceptional circumstance basis only.

8.4.7 The Trust should ensure that firms submitting tenders follow industry good practice and as a minimum:

(a) All suppliers should work to the Foundation Trust's terms and conditions of contract.

(b) The Trust should confirm that firms tendering for work shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, the Disabled Persons (Employment) Act 1944, the Disability Discrimination Acts of 1995 and 2005 and the Equality Act 2005 and the Modern Slavery Act 2015 and any amending and/or related legislation.

(c) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

(d) The Chief Financial Officer may make or institute any enquiries they deem appropriate concerning the financial standing and financial suitability of approved contractors.

(e) The Director with lead responsibility for clinical governance may make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

8.4.8 Quotation

General position re quotations

Quotations are required where formal tendering procedures are:

(a) not applied;

(b) not required and where the intended expenditure or income exceeds £25,000;

(c) reasonably expected to exceed the limit defined in the Reservation of Powers to the Board of Directors and the Council of Governors and Schedule of Decisions/Duties Delegated by the Board of Directors (excluding vat irrespective of recovery arrangements).

8.4.9 Competitive Quotations

(a) Where quotations are required they should be advertised on the e-Tender portal. The invitations to quote should be based on specifications or terms of reference prepared by, or on behalf of, the Board of Directors;

(b) Quotations should be received through the e-tendering Portal. No correspondence should be entered into outside of the agreed route.

(c) All quotations should be treated as confidential, unless a Purchase Order is raised following the quotation process. This information will then become part of the freedom of Information act. All information should be retained on the e-tendering portal.

(d) The Head of Procurement or a nominated officer should evaluate the responses based upon the award criteria issued with the ITQ. Price will be a consideration but not the only factor in deciding which response offers the best value.

(e) For the purposes of this section where there is a Framework Agreement in place that has been established for use by Public Sector bodies the price contained therein may be used in lieu of a quotation(s).

8.4.10 Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

(a) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(b) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(c) miscellaneous services, supplies and disposals;

(d) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e. (i) and (ii) of this SFI) apply.

(e) when a written quotation has been received, this must be included when raising a requisition for the goods or services quoted. The subsequent Purchase Order should refer to the written quotation to prevent any discrepancy with invoicing.

8.4.11 Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Foundation Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Chief Financial Officer.

8.4.12 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the staff as defined in the Reservation of Powers to the Board of Directors and the Council of Governors and Schedule of Decisions/Duties Delegated by the Board of Directors. These levels of authorisation may be varied or changed. Formal authorisation must be put in writing. In the case of authorisation by the Board of Directors this shall be recorded in their minutes.

8.5. Private Finance for capital procurement (see overlap with SFI No. 12.8)

8.5.1 The Foundation Trust should normally test for PFI when considering significant capital procurement. When the Foundation Trust proposes to use finance which is to be provided by the private sector the following should apply:

(a) The Chief Financial Officer/Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) The business case must be referred to the DOH Private Finance Unit (PFU), as appropriate (for example if a ‘Deed of Safeguard’ is required), for approval or treated as per current guidelines. The Foundation Trust must follow the guidance contained in the NHS Improvement “Significant Investment” guidance. Any investment over a certain size must be reported to NHS Improvement who will assess the impact on our risk rating, which may ultimately preclude the Foundation Trust from progressing with PFI.

(c) The proposal must be specifically agreed by the Foundation Trust Board of Directors in the light of such professional advice as should reasonably be sought in particular with regard to vires.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

8.6 Compliance requirements for all contracts

The Board of Directors may only enter into contracts on behalf of the Foundation Trust within its Provider Licence and shall comply with:

(a) the Foundation Trust's Standing Orders and Standing Financial Instructions;

(b) UK Directives and other statutory provisions;

(c) any relevant directions including the Capital Investment Manual, ESTATECODE and guidance on the Procurement and Management of Consultants;

(d) such of the NHS standard contract conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;

(f) where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited;

(g) In all contracts made by the Foundation Trust, the Board of Directors shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Foundation Trust.

8.7 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts for the employment of other officers, to authorise re-grading of staff, and enter into contracts for the employment of agency staff or temporary staff service contracts.

8.8 Disposals

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the policy of the Foundation Trust;

(c) items to be disposed of with an estimated sale value of less than £10,000, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

8.9 In-house Services

8.9.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Foundation Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

8.9.2 In all cases where the Board of Directors determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist(s);

(b) In-house tender group, comprising a nominee of the Chief Executive, representative(s) of the in-house team and technical support;

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Chief Financial Officer representative. For services having a likely annual expenditure exceeding £500,000, a non-executive should be a member of the evaluation team.

8.9.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

8.9.4 The evaluation team shall make recommendations to the Board of Directors.

8.9.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Foundation Trust.

8.9.6 Applicability of SFIs on Tendering and Contracting to funds held in Foundation Trust (see overlap with SFI No. 17)

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Foundation Trust's funds and private resources.

8.9.7 Cancellation of Contracts

Except where specific provision is made in model Forms of Contracts or standard Schedules of Conditions approved for use within the National Health Service, there shall be inserted in every written contract a clause empowering the Foundation Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation:

- if the contractor shall have offered, or given or agreed to give, any person any gift (exceeding £25) or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract of any other contract with the Foundation Trust;

- or for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Foundation Trust;
- or if the like acts shall have been done by any person employed by him or acting on his behalf (whether with or without the knowledge of the contractor);
- or if in relation to any contract with the Foundation Trust the contractor or any person employed by him/her or acting on his/her behalf shall have committed any offence under the Bribery Act 2010.

8.9.8 Determination of Contracts for Failure to Deliver Goods or Material

There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Foundation Trust may without prejudice cancel the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good (a) such default, or (b) in the event of the contract being wholly cancelled the goods or material remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

8.9.9 Contractors Involving Funds Held on Foundation Trust – shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Act.

Agenda item
11

Meeting of the Board of Directors

Paper title:	Health and Safety Annual Report 2023 - 2024
Date of meeting:	28 November 2024
Presented by: (name and title)	Dawn Hanwell, Chief Financial Officer and Deputy Chief Executive
Prepared by: (name and title)	Warren Duffy, Acting Associate Director of Estates & Facilities

This paper supports the Trust's strategic objective/s (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	
SO2	We provide a rewarding and supportive place to work.	
SO3	We use our resources to deliver effective and sustainable services.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	
SR4	Financial sustainability	
SR5	Adequate working and care environments	✓
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

Executive summary

This Health and Safety Annual Report provides an overview summary of the in-year activity across the Health and Safety workplan within the Trust and is inclusive of positional updates for linked workstreams such as Security and Violence and Aggression.

The report contains reference to both successes and ongoing challenges for the Health and Safety

Team within the reporting period but crucially highlights that there was no enforcement against the Trust for any Health and Safety related incidents and the Trust remained committed to its Health and Safety responsibilities delivered under the guidance of the Health and Safety Committee.

It is clear from the report, despite some positive advancements and work completed within the year, there is still a large element of work to improve on and the Health and Safety Team have created a 2024-2025 workplan to ensure that improvements are made, and reported quarterly to the Audit Committee and Health and Safety Committee.

This report has previously been shared with the Health and Safety Committee and the Audit Committee as well as being made available to other groups, where appropriate.

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

Recommendation

The Board of Directors are asked to accept this annual work plan acknowledge the successes and the challenges for the Health and Safety Team and remain supportive to ensure that improvements and developments can continue to be made throughout 20242025.

NHS
Leeds and York Partnership
NHS Foundation Trust

Leeds & York Partnership NHS Foundation Trust Health & Safety Annual Report

April 2023 - March 2024

NHS
Leeds and York Partnership
NHS Foundation Trust

Contents

1. Executive Summary

This Annual Report will provide the Trust Board with oversight regarding the Health and Safety performance from April 2023 to March 2024. The Trust Board will also be provided with assurance in relation to the actions that are associated with the ongoing improvement measures that are required to ensure the Trust further improves its Health and Safety position. The following points are covered within the report:

- Update on our current position with regards to Health and Safety compliance and training
- Trust wide Health and Safety data (RIDDOR, Datix etc.)
- Update on the 23/24 work plan and introduce the 24/25 work plan

The following successes are to be noted for the reporting period.

- **Health and Safety Audits** – 60 sites were audited and the monitoring methodology of ensuring findings are closed off and complete has been established through Site Meetings with further oversight sent through to Clinical Environments Group
- **Continued collaboration and information sharing across the Private Finance Initiative (PFI) estate** - this will lead into more formal reporting to improve the existing approach between the Special Purpose Vehicle (SPV), FM provider and Trust in order to minimise the potential health and safety risks in the Trust.
- **Reduction in Violence and Aggression incidents** – 11.2% from 22/23 and 2.5% less than the 3year average
- **Reduction in the RIDDORS –** this is also provided with assurance that none of the RIDDORS reported in this period were further reported or investigated by the HSE or CQC.
- **Improvement of 7% to Health and Safety related training –** up to 82% from 75% with further work and specific area's targeted for ongoing improvement

The following areas for improvement are as followed.

- **Health and Safety Team** – The Health and Safety Team primarily comprises of Head of Health and Safety, 2 x Health and Safety Advisors and a Health and Safety administrator. All members of the Health and Safety Team have left employment with the Trust during the 2nd half of the reporting period. The new Health and Safety Team will be in position across Q1 and Q2 of 24/25 – this has impacted some of the 23/24 work plan.
- **NHS Workplace Health and Safety Standards** – given that the Estates & Facilities Department has advanced it's overall governance and reporting, a review of the NHS Workplace Standards need to be undertaken to ensure that the work is not a duplication of other areas.

- **Violence and Aggression** – developing a deeper analysis of how, why, where and what has happened and work with clinical and operational colleagues to understand opportunities for improvement.
- **Further improving membership attendance at the quarterly Health & Safety Committee** – there were 4 successful meetings but some of the attendance levels, although quorate, were low on occasions
- **Review of the Health and Safety Committee Terms of Reference**, standing agenda, frequency of papers and workstreams.

2. INTRODUCTION

The Health and Safey Team will report back into the Health and Safety Committee on a quarterly basis against the 2024/25 workplan.

The Quarterly Report is taken to Health and Safety Committee and Audit Committee once per quarter (4 times per year), for review and comment. This also allows the committee authority to provide a re-focus or for the Health and Safety Team to adopt new actions or priorities to support the Trust on its objectives. At the end of the year, quarterly reports will form the basis for the annual report. The report is also made available to the following groups:

- Audit Committee
- Health and Safety Committee
- Workforce Committee
- Care Services Delivery and Development Group
- Fire Safety Group

All staff and groups across LYPFT can have access to the report upon request, similarly the report will be shared with the PFI partners as we continue to reduce incidents of all nature across the estate portfolio.

Methods of assurance used for monitoring compliance:

- The Chief Financial Officer / Deputy Chief Executive is the lead director for health and safety, and will guide and direct on all such matters, with appropriate advice. They will ensure that appropriate executive leads and internal controls are in place for managing health and safety related risks, and the effectiveness or otherwise of these arrangements is reviewed and formally reported to the Trust Board.
- The Board is alerted to any health and safety matters for escalation through the Audit Committee, and where necessary directly.
- The Health and Safety Committee is a well-established forum for communication with members drawn from management and staff as well as clinical and non-clinical areas. Meetings are held quarterly and promote a culture of understanding and co-operation across LYPFT. Feedback from this committee is highlighted at the Audit Committee.
- The Head of Health and Safety produces a Quarterly Health and Safety Report, on progress, which is directed to the Audit Committee (quarterly), after which it is taken to the Board annually.

- Statistical data is routinely accessed, and key performance indicators (KPIs) have been identified and will support the provision of future assurances of compliance levels; provide a measure of health and safety good practice and any outlying areas which require action or escalation. The KPIs will be seen by the Health and Safety Committee every quarter and will become an embedded practice.
- Site inspections and audits schedule in place.
- Training and staff development supported by annual PDRs.
- Development of Health and Safety Workplan for 2023-24 (Appendices)

This report provides an update on the current provision of Health and Safety management within Leeds and York Partnership NHS Foundation Trust (hereinafter called the Trust) including an overview of achievements and work over the April 2023 – March 2024 period and the work programme for 2024/2025.

3. LYPFT HEALTH AND SAFETY GOVERNANCE

In line with its statutory responsibilities, the Trust has a Health and Safety Committee. This committee currently meets quarterly and reports to the Audit Committee.

The Health and Safety Committee is currently joint chaired by the Deputy Chief Executive / Chief Financial Officer and Trust Staff Side; and its members include the Health and Safety Team, clinical leads and accredited Health and Safety staff side representatives. The Director of Finance / Deputy Chief Executive is the accountable officer for Health and Safety, which has been delegated by the Chief Executive. Day to day responsibility for the Health and Safety programme is delegated to the Acting Associate Director of Estates & Facilities in conjunction with the Health and Safety team.

The Health and Safety Committee receives several reports throughout the year on key Health and Safety risks including RIDDOR, Manual Handling, Fire and Violence and Aggression. These reports are scrutinised by the committee to identify any trends that are developing and action plans put in place for improvements.

The Deputy Chief Executive / Chief Finance Officer and the Acting Associate Director of Estates & Facilities are also members of the Audit Committee thereby ensuring that Health and Safety risks are considered as appropriate in the wider risk mix, and that risks identified in the wider organisational risk assessment processes are formally and quickly brought within the Health and Safety remit.

The Health and Safety Team will continue to play a key role in ensuring management systems are reviewed and all activities are managed appropriately to ensure compliance, but this does not mean Health and Safety is directly their responsibility within the organisation. All members of trust staff within the organisation need to play their part in ensuring Health and Safety is key in all areas of work activity.

4. LYPFT LEGAL POSITION

It is imperative that the Trust keeps it Health and Safety management systems under review in particularly the way in which its activities are managed and organised by senior management. The expected model of “Plan, Do Check and Act” the HSE expect to find is HSG65

Both Health and Safety Executive and Care Quality Commission have investigatory and enforcement powers in relation to health and safety and have an active Memorandum of Understanding clarifying their roles and responsibilities. **See Appendix 1**

Both parties share intelligence of information and incidents, including RIDDOR notifications.

Notwithstanding the fact that legal liabilities affecting Board members, directors, managers & staff of the Trust, the Corporate Manslaughter and Corporate Homicide act 2007 means that companies and organisations, including NHS Trusts can be found guilty of corporate manslaughter because of senior management failures resulting in a gross breach of duty of care where Health and Safety non-compliance has resulted in a fatality.

If prosecutions do take place under Corporate Manslaughter and Corporate Homicide act, it will be of the corporate body and not individuals with typically £million+ fines and other sanctions.

Individuals such as board members, directors, managers and staff can still be prosecuted separately for various Health and Safety offences.

One such case coming to the fore during 23/24 is of charges being authorised by the CPS against North East London NHS Foundation Trust (NELFT), following an investigation by the Metropolitan Police into the death of a service user.

NELFT has been charged with corporate manslaughter under section 1 of the Corporate Manslaughter and Corporate Homicide Act 2007 (“CMCHA”) as well as an offence under section 3 of the Health and Safety at Work etc Act 1974 (“HSWA 1974”).

Additionally, a ward manager at the Trust, has also been charged with gross negligence manslaughter and an offence under section 7 of HSWA 1974.

Gross negligence manslaughter is committed when a death is the result of a grossly negligence act or omission by an individual.

Section 7 imposes a duty for all employees, whilst at work, to take reasonable care for the health and safety of themselves and others who may be affected by their act or omissions at work.

This case demonstrates how vital it is for all Trust staff to continue working collaboratively in order to provide safe and effective measures for all service users, visitors and not least staff.

Sanctions for the HSE against organisations include:-

- ***Prosecution***
- ***Prohibition Notices*** – a means to stop immediately any unsafe work activity
- ***Improvement Notices*** – An order to improve work equipment or processes within strict time limits
- ***Fee for Intervention*** - HSE's hourly recovery rate, was £166 per hour, per inspector during 23/24 This rate will increase to £174 per hour in 24/25. Fee for Intervention is a mechanism whereby an HSE inspector discovers a material breach during a visit, but that the breach does not warrant any other intervention noted above

5. HEALTH AND SAFETY 2023-2024 ANNUAL WORK PLAN

The annual work plan during the year was significantly disrupted due to turn-over in personnel within the team. The Health & Safety Team have had 100% turnover and will not be fully back up to full capacity until Q1 of 2024/25. However, an interim Consultant was brough in on a temporary basis to support the Associate Director of Estates & Facilities and to offer professional advice.

Key notable highlights against the workplan have been;

- **Health and Safety Audit** schedule has been fully completed with actions being taken to Site Meetings and shall be reported accordingly to Clinical Environments Group to ensure full oversight as there are ongoing actions for Clinical Teams, Operational Teams and Estates & Facilities. This will remain a key element of the 24/25 workplan
- **PFI Reporting** – shared data and intelligence is now actively being shared across SPV, Trust and FMco leads and this is reported accordingly to the PFI Steering Group

Key areas for improvement against the workplan have been;

- **NHS Workplace standards** – further analysis and review is required to understand how the Workplace Standards could be utilised effectively in the Trust whilst noting multiple elements of the Workplace Standards are currently being reported through other area's of the Trust.
- **Risk Management (Datix)** – ensure that Datix is fully up to date and risks are reported, monitoring, managed appropriately.
- **Systems and software** – there was some success in 23/24 with the introduction of 'Sypol' – a COSHH database which will ensure the Trust has better access and management of its materials and products that have potential to harm. Further development required regarding the 'Control of Contractors' element of technology.

Priority Area	How will we do this	Key Stakeholders	Year End position
NHS Workplace Health and Safety Standards Phase 2	Establish Working Groups and ensure Directors are aware of their responsibilities for implementation and sign off	All Directors	
Risk Assessments	Review Datix and ensure all areas are updated with suitable actions and action owners	Health and Safety Team	
Violence and Aggression	Review the Trust data in more detail and work with directorate managers and leads in further deep diving into the data to understand the cause of incidents – especially those that are RIDDOR / LTI related. Work with other MH Trusts in benchmarking data	Health and Safety Team / Clinical / Operational Leads	
Incidents – Trend Analysis	Review the Trust data to identify more meaningful supporting narrative surrounding incidents.	Health and Safety Team	
Mandatory Training	Re-review for an up-to-date position on Trust data and ensure that directorate directors and managers are supporting the agenda with regards to Health and Safety Training	Health and Safety Team / Directorate Leads	
Health and Safety Software	Further develop the requirement / need for teams to have suitable systems to improve pro-active management of contractors, products, and systems. Develop suitable business cases which include stakeholder engagement to ensure system utilisation is optimised and that it become a key pillar of our continuing improvement.	Health and Safety Team / Estates & Facilities	
Health and Safety Audits	Continue the second stage of the auditing programme and continue to monitor and close out actions. Develop a positional statement for the Health and Safety Committee to evidence the ongoing improvement work by all involved across the Trust.	Health and Safety Team	
PFI Reporting	Continue to work with all involved across the PFI estate to ensure regular reporting of Health and Safety items.	Health and Safety Team / Estates and Facilities	
Independent Audit	Appoint an Independent Advisor with a defined brief to provide a report on the Trusts position in relation to operational health and safety.	Health and Safety / Estates and Facilities	
Working / Task and Finish Groups	Identify key work streams that require high levels of intensity with regards to governance and assurance. Ensure correct stakeholders are identified with clear terms of reference.	Health and Safety Team	
Policies and Procedures Review	To be amalgamated into the above Working Group but a one-off piece of work should be completed to provide immediate assurance to the Health and Safety Committee that Policies and Procedures are up to date and remain effective.	Health and Safety Team	
SMART Objectives	Provide more concise and defining workplans to enable improved presentation for all stakeholders on the position of our targets.	Health and Safety Team	

Table A. 2023/24 Health and Safety Workplan

6. HEALTH AND SAFETY 2024 - 25 WORKPLAN

A Health & Safety workplan has been devised for 2024 – 25, designed to ensure this builds further on the existing systems and processes in situ and also supplements the 23/24 Annual Work Plan that was especially challenging with the turnover of the H&S Team that time. This includes incorporating the NHS Workplace Health and Safety Standards, developing and building upon links with directorate leads, ensuring NHS Workplace Health and Safety Standards are met or exceeded.

Priority Area	How will we do this	Action Owner
Health and Safety Committee	Review further the Health and Safety Committee Terms of Reference, standing agenda, frequency of papers and workstreams.	Head of Health and Safety
Health and Safety Software	Continue role out of the Sypol COSHH system, which is a full spectrum management system for compliance with COSHH Regulations (as referred to in the 2024-25 programme). Identify a control of contractor solution to fulfil duties for contractor management.	Head of Health and Safety
RIDDOR Reporting	Reporting of Injuries, Diseases & Dangerous Occurrences Regulations (2013); update the process of reporting notifiable incidents to ensure concise and relevant detail is provided to the HSE within legislative time limits.	Head of Health and Safety
Report Data and information	SMART Objectives - Provide more concise and defining workplans to enable improved presentation for all stakeholders on the position of our targets	Head of Health and Safety
Risk Assessments	Review current risk assessment templates available Trust wide; this will be a priority in 2024/25. For example, support the clinical services for with violence and aggression risk assessments.	Head of Health and Safety
Collaboration and Partnership working	Develop Partnership working with statutory bodies, primarily with the Health & Safety Executive to demonstrate the Trust's commitment to Health & Safety and to learn and understand from the HSE's perspective measures expected to keep stakeholders as safe as reasonably practicable	Head of Health and Safety
	Develop Trust Liaison with Regional Trusts; to enable the sharing of best practice, learning from incidents and to ensure LYPFT matches, if not exceeds the Regional approach to Health & Safety issues	Head of Health and Safety
NHS Workplace Standards and Trust Benchmarking	Develop and build upon links with directorate leads, ensuring NHS Workplace Health and Safety Standards are fit for purpose or identify mechanism to provide suitable assurance to the Health and Safety Committee, Audit Committee and other relevant Committees and Groups in the Trust.	Head of Health and Safety
Health and Safety Compliance and Mandatory Training	Work with relevant service leads and provide more regular (quarterly) on progress and use governance framework to suitably escalate where required. Continue to support all services with Health and Safety related training.	Head of Health and Safety

Policies and Procedures	Ensure that all Health and Safety relevant Policies and Procedures and reviewed and managed accordingly within the next reporting period	

Table B. 2024/25 Health and Safety Workplan

7. SECURITY

LYPFT engage with multiple organisations to ensure knowledge is shared and best practice adopted in relation to ongoing security matters across the country.

The Trust Security Manager is an active member of NAHS (National association for healthcare security) and attends the National performance advisory group where best practices are shared and debated.

LTHT Security Review

A Security review was commissioned in September 2021 which was in response to a Health and Safety Executive Audit that was previously undertaken and identified several findings. The report was concluded with an implementation plan. Outlined below are the actions from that plan;

Objective: Implementation Plan – Year 1 (2022/2023)	Target Date	Status
Carry out Trust wide security review that critically reviews all aspects of security management.	Oct 2021	Achieved
Produce summary paper of findings and draft recommendations	Oct 2021	Achieved
Present findings and action plan to the Trust	November 2021	Achieved
Appoint Security Infrastructure Manager	Appointed 1st April 2023	Achieved
Present business case to ESG for the appointment of an independent technical security consultant	Aug 2022	Achieved
Appoint independent technical security consultant for a bespoke designed CCTV and access control system	Oct 2023	Achieved
Commence bespoke security surveys on each building	April 2024	Achieved
Identify location of central security control room	North Wing Aug,2023	Achieved
Present security staffing options for an internal security team	Nov/Dec 2022	Achieved
Agree with clinical colleagues through collaborative leadership and management, clearly defined responsibilities including joint areas in relation to security	April 2022	Achieved
Present security responsibilities and presentation to Directors / Deputy Directors of Nursing / Operations	May 2022	Achieved
Provide update on security review to the health and safety committee	April 2022	Achieved
Provide security update as part of the E-POG presentation	May 2022	Achieved

Table C. Security Implementation Plan 2022/23

Further work commenced in this reporting period with items completed and other items due to be complete in 24/25;

Objective Year 2 (2023/2024)	Target Date	Status
AECOM, to Present bespoke survey drawings to the clinical teams for comment / input	Monthly	Achieved
Present business case to ESG for the next step of security upgrades (CCTV / Access Control)	9th Nov 2022	Achieved
Provide feedback to the Exec lead for which security staffing option is the preferred outcome	January 2025	Ongoing
Review contract arrangements with Mitie Security (Contract extended to April 2025 – pending further – subject too monthly meetings)	Oct 2023	Achieved
Technical designed CCTV / Access control system released for tender	September 2024	Ongoing
Complete 1/3 of security upgrades (approximately 5 sites)	Yet to be agreed	Ongoing
Complete redevelopment of security control room	February 2025	Ongoing

Table D. Security Implementation Plan 2023/24

Although good work has taken place and been achieved in this period, the wider security requirements within the Trust need to be further developed. An extensive workplan is being developed and shall be reported on accordingly in further detail, this will be initiated and managed at the new Security Performance & Assurance Group.

Security Performance & Assurance Group

A Security Working Group has been established within the reporting period and the focus of this Group being the following;

- Improve relationships, governance
- Establish a schedule of Risk Assessments on a site-by-site basis for both infrastructure and for those that occupy the premises – lending into the 'safe space safe people' mantra.
- Review performance of Mitie Security to ensure value for money now that KPIs have been agreed with both the provider and the Trust
- Review future target operating model to identify if there are efficiencies against the current Mitie expenditure whilst noting the Trusts requirements post risk assessments
- Policies and Procedures – continue to review all security related policies and procedures – noting that there are multiple policies due for review in 2024/25.

Security Governance

As per the respective Terms of Reference, Security will feature on a monthly basis to the Estates Steering Group as well as providing the Health and Safety Committee quarterly assurance of it's ongoing workplans

8. VIOLENCE AND AGGRESSION

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

This is set against a backdrop of 3443 reports of violence and aggression, threats and abuse during 23/24 that staff were exposed to (see below)

Whilst this years figure is 2.8% lower based on the three-year average, this masks Violence/assault (Staff) analysis indicating a stubborn, static rate of incidents.

Violence & Aggression Category Summary	Totals (2023/24)	(2022/23)	(2021/22)	Three Year Average
Violence/assault	1513	1587	1212	1437
Violence (Staff)	1114	1322	1119	1185
Verbal/written abuse (staff)	491	657	631	593
Verbal Abuse	239	240	260	246
Violence (Public)	73	58	64	65
Verbal abuse (Public)	13	14	21	16
Total	**3443**	**3878**	**3307**	**3543**

Table E. 2023/24 Violence and Aggression total data

The national violence prevention and reduction (VPR) standard complements existing health and safety legislation and is a data-driven method focusing on colleague health and wellbeing, in a way that is reflective, proactive, preventative, responsible and accountable. All NHS-funded services operating under the NHS standard contract are required to review and self-assess their status against the VPR standard twice a year and provide Board assurance. Performance is to be measured against the standard, as well as the Trust's overall VPR Strategy.

The VPR Strategy was approved by the Board in January 2024, as well as our self-assessment against the VPR standard. The VPR Strategy outlines our vision, intent, objectives and organisational functions and responsibilities in delivering the VPR standard and is supported by a policy which was also approved by the Policies and procedures group in March 2024. Both the Strategy and the Policy has been written collaboratively, and incorporate recent Trust workforce priorities on incidents of hate and domestic violence and sexual safety. It also details the wellbeing support and the established critical incident support, which is provided following any violent incidents.

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

Legal Framework

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

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

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

The World Health Organisation defines violence as:

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

They further state that:

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

Strategic Aims

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

- To create a safer working environment and ensure good practice is replicated Trustwide.
- To encourage the reporting of incidents, by achieving a consistent process so that our colleagues feel that reporting is worthwhile.
- Reduce the number, severity and occasions of incidents of violence and incidents of hate in the Trust.
- Reduce colleague on colleague violence and incidents of hate and strive to become an "anti-hate" organisation.
- Actively work to eradicate any unwanted, inappropriate and/or harmful sexual behaviours towards our people.

- Reduce colleague time lost and absences resulting from violent incidents, incidents of hate and unwanted, inappropriate and/or harmful sexual behaviours.
- Ensuring an effective, proactive and supportive wellbeing and critical incident support pathway following violence and incidents of hate and unwanted, inappropriate and/or harmful sexual behaviours
- Ensure adequate support for those engaging with the criminal justice system.
- Develop and embed an engagement, awareness and communication programme alongside these objectives.

Progress with the Strategic Aims will include measurement against the National Staff Survey (NSS) results, due to be launched in Q3 of 24/25. The NSS is a critical piece of research into how employees feel about working at LYPFT, including safety

9. INCIDENT REPORTING

During the year the Trust was required to report 10 incidents to the Health and Safety Executive under the provision of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences 2013) – See Appendix 2

Overall, there has been a decrease in the number of RIDDOR incidents reported to the HSE over the previous year (24 in the previous year);

2023 RIDDORS	2024 RIDDORS
24	10

Table F. 2023 vs 2024 RIDDORS in LYPFT

There have been no incident investigations by the HSE or CQC

All incidents are reported through the online Datix incident management system and are investigated by the Line Manager concerned and appropriate action taken to reduce the risk of re-occurrence – an overview of all types, categories and locations can be found in **Appendix 2**. A high-level breakdown of these incidents is as followed;

Key incident Category;
- Absconding / Missing Person
- Slips, Trips and Falls
- Violence and Aggression (including both service users and staff)

Key services with highest incidents;
- Adult Acute Services
- Child and Adolescent Mental Health Services (CAHMS)
- Forensic Services
- Older Person Service (OPS)

Key locations with highest incidents;
- Becklin Centre (Ward 1)

- Red Kite View (GAU and PICU)

This data and the insight into where, will allow The Health and Safety Team to carry out a deeper diver and work with the services accordingly, as well as work with other key stakeholders such as Violence and Aggression Leads and The PFI SPV.
The Health and Safety Team automatically receive all copies of staff accident and incidents that are reported and depending on the severity of the accident/incident will undertake a full investigation in conjunction with the manager concerned.

10. HEALTH AND SAFETY COMPLIANCE & TRAINING REVIEW

Despite staffing issues experienced throughout 23/24, 60 Health and Safety Audits were completed during the financial year, exceeding on the 50 planned visits.
The key H&S issues coming out of these audits included:

- Manual Handling Compliance below 85%
- First aid risk assessments not been completed
- ILS training compliance below 85%
- COSHH Data sheets and assessments no longer in date for chemicals on site
- PMVA Training compliance below 85%
- DSE workstation assessments not been completed.

Wherever compliance appears to be sub-optimal, the Health & Safety Team will work & support colleagues with individual responsibilities to ensure that the Trust continues to strengthen the “Safe People, Safe Place” agenda

A review of the inspection and audit process had been proposed to ensure that staff within clinical/non-clinical areas undertake the responsibility for completing these audits themselves as even with the current resource this is a huge undertaking for these audits to be completed by the Health and Safety team on an annual basis. This approach is in line with generally expected legal requirements for managers and supervisors.

The Trust approach to audits and inspections will be reviewed further during 24/25 to ensure that these remain to be proactive and fit for purpose.

From this proposal a key area of work is to undertake central validation work to check and verify the reported compliance. This will involve a member of the Health and Safety team going into areas to check that the reported evidence is in place including examination of management systems, risk assessments and delivery of any mitigating action plans.

Audit issues are addressed structurally for assurance through Site meetings and various groups, i.e. Clinical Environment Group, Estates Steering Group and Health & Safety Committee

Health and Safety issues that cannot be resolved immediately will be risk assessed and as appropriate put onto the trust risk register.

Health and Safety training has been refreshed and reviewed over the year to ensure it is up to date, meets statutory compliance and is accessible to all staff groups.

Health and Safety training is mandatory every 3 years, and the Trust is aligned to the National e-learning programme for this training.

Reports last refreshed on 01/04/2024		**KEY:**	**0-74%**	**75-84%**	**85-100%**
Requirement	**Number compliant**	**Number non-compliant**	**Total Headcount**	**Compliance status**	
High Level Physical Interventions with PSTS and Breakaway Skills	463	82	545	**85%**	
Intermediate Level Physical Interventions with PSTS and Breakaway Skills	121	44	165	**73%**	
Low Level Physical Interventions with PSTS and Breakaway Skills	79	31	110	**72%**	
Moving and Handling Advanced (LD)	101	82	183	**55%**	
Moving and Handling Advanced (OPS)	150	87	237	**63%**	
Moving and Handling Essentials	566	148	714	**79%**	
Moving and Handling Principles	1688	202	1890	**89%**	
Personal Safety Theory	489	41	530	**92%**	
Personal Safety with Breakaway Skills	1057	306	1363	**78%**	
Display Screen Equipment	1697	305	2002	**85%**	
Food Safety Level 1	300	42	342	**88%**	
Food Safety Level 2	476	198	674	**71%**	
Health and Safety General	2876	162	3038	**95%**	
Overall:	**10,063**	**1730**	**11,793**	**82%**	

Table G. 2023/24 Overall Training Compliance for Health and Safety

This 82% training compliance score is an improvement on 2022/23 which was previously reported at 75% - an uplift of 7%. This will remain a focus on the 24/25 workplan with targeted focus on Breakaway Training and Moving and Handling specifically.

11. TRUST RISK REGISTER

Any Health and Safety risks are added to the Trust Risk Register on Datix. Work is needed going forward to ensure that all Health and Safety risks are captured including at a local level. The position is improving but further work is required to embed this.
The Health and Safety / Audit Committee is asked to support that there will be a more comprehensive report on Risk Register in the next report and it will be a feature on the 2024/25 workplan.

12. HEALTH AND SAFETY POLICIES

Health and Safety policies have been developed or reviewed over the reporting period. These include:

- Health and Safety Policy
- Audit and Inspection Policy and Procedure

As with all Health and Safety policies and associated procedures, these are considered live documents, so that even when review dates are published, these may be subject to an earlier review when this is necessary. As an example, the 24/25 work plan includes, “Reporting of Injuries, Diseases & Dangerous Occurrences Regulations (2013); update the process of reporting notifiable incidents to ensure concise and relevant detail is provided to the HSE within legislative time limits.”

Policies & Procedures due developing and for review or update during 24/25 will include:-

Policy/Procedure	Status
Trust Health & Safety Policy	Policy/procedure to be reviewed
RIDDOR Notifications	New policy/procedure
Travel whilst at Work	New policy/procedure
DSE Policy	Policy/procedure to be reviewed
Contractors Health and Safety Procedure	Policy/procedure to be reviewed
Permit to Work Procedure	Policy/procedure to be reviewed
Review of Third Party Risk Assessments	Policy/procedure to be reviewed
Safe Systems of Work Procedure	Policy/procedure to be reviewed
Health and Safety Inspections and Audits Procedure	Policy/procedure to be reviewed

Table H. Health and Safety Policies to be reviewed and updated in 2024/25 as per the 24/25 workplan

13. CONCLUSION

The work plan within the reporting period has been significantly affected by the Health and Safety Team all leaving the Trust. However, it should be noted that primary statutory requirements have been adhered to and that the new Health and Safety Team shall commence in 2024/25 Q1-Q2.
The Trust continues to ensure that the Health, Safety and welfare of all stakeholders, including service users, staff & visitors remains a high priority and a core consideration during service development and delivery. The Health and Safety Team will prioritise improved collaboration and governance in 24/25 given that Health and Safety will only be robustly managed in the Trust when if becomes ‘everyone’s business’.

In terms of governance and in line with its statutory responsibilities, the Trust has an active Health and Safety Committee that met quarterly and currently reports to the Audit Committee – this needs to be developed further to fully embed ‘safe space safe people’ mantra.

Audits, inspections and reviews of policies and procedures were all undertaken during 2023/2024. Training was refreshed and reviewed over the year to ensure it remains up to date, meeting statutory compliance and accessible to all staff groups.

Appendix 1 – Memorandum of Understanding between HSE & CQC
Full version - (https://www.hse.gov.uk/agency-agreements-memoranda-of-understanding-concordats/assets/docs/mou-cqc-hse-la.pdf)

Memorandum of Understanding (MoU) between the Care Quality Commission (CQC) and the Health and Safety Executive (HSE)

March 2024

Introduction

1. This MoU has been agreed between the Care Quality Commission (CQC) and the Health and Safety Executive (HSE) with the support of the Local Government Association (LGA). It applies to both health and adult social care in England. The purpose of this MoU is to help ensure that there is effective, co-ordinated and comprehensive regulation of health and safety for patients, service users, workers and members of the public.

2. It outlines the respective responsibilities of CQC, HSE and local authorities (LAs) in England when dealing with health and safety incidents in the health and adult social care sectors, and the principles that will be applied where specific exceptions to these general arrangements may be justified. The MoU applies to all activities; therefore, it describes the principles for effective liaison and for sharing information more generally.

3. HSE, LAs and CQC will co-operate effectively to enable and assist each other to carry out their responsibilities and functions, and to maintain effective working arrangements for that purpose.

4. Other organisations also have roles or responsibilities for investigation, prosecution and/or oversight in relation to offences in health and adult social care settings – such as ill-treatment or wilful neglect. Appropriate liaison with other prosecutors/regulators/oversight bodies, such as the police, Crown Prosecution Service (CPS) and Safeguarding Adults Boards is essential. Some of these may be signatories to the Work-related Deaths Protocol (WRDP). CQC, HSE and LAs will notify relevant bodies of incidents and agree the coordination of activity or work with them as appropriate to protect patients, service users, workers and the public from risk of harm.

Respective responsibilities for dealing with health and safety incidents

5. CQC is the lead inspection and enforcement body under the Health and Social Care Act 2008 for safety and quality of treatment and care matters involving patients and service users in receipt of a health or adult social care service from a provider registered with CQC.
6. HSE/LAs are the lead inspection and enforcement bodies for health and safety matters involving patients and service users who are in receipt of a health or care service from providers not registered with CQC.

7. HSE/LAs are the lead inspection and enforcement bodies for health and safety matters involving workers, visitors and contractors, irrespective of registration.

8. LAs are also responsible for enforcing food safety regulations in hospitals and care homes.

9. Annex A contains examples of incidents typically falling to CQC and HSE/LAs respectively to illustrate the responsibilities outlined above. The response from the lead body will be in line with their regulatory policies. Their decisions on whether to investigate or take further action will be subject to their guidance and published policies.

General considerations for enforcement responsibilities

10. When considering the circumstances of a specific incident the primary consideration is whether the injured person is a patient/service user and whether the service provider is registered with the CQC. If that is the case the responsible authority will normally be the CQC unless the police have primacy.

11. An enquiry will generally commence with the CQC because a patient/ service user is injured. During the course of the enquiry information may emerge that the service provider is not registered or there may not be a regulated activity taking place or that CQC does not have applicable legislation or sufficient powers to take action. In such circumstances CQC should liaise with HSE/LA regarding why a particular case may revert to the HSE/LA or CQC to jointly investigate with HSE/LA.

12. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 are broad in their concept of the duty to provide care and treatment in a safe way. This duty includes ensuring that the premises used by the service provider are safe to use for their intended purpose and ensuring that the premises and equipment are suitable, properly used and properly maintained. The definition of 'premises' is very broad and includes any building or other structure or machinery physically affixed to the building, any surrounding grounds or a vehicle.

13. Regulation12 (1) of the Regulated Activities Regulations which relates to the need to provide safe care and treatment includes a duty to ensure that the premises used by the service provider are safe to use for their intended purpose.

14. Regulation 13 of the Regulated Activities Regulations which relates to the duty to safeguard service users from abuse and improper treatment includes the duties to establish and operate effective systems and processes in order to prevent abuse of service users; and to effectively investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

15. Although specific health and safety at work (HSW) legislation may exist, such as the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER), it should generally be the case that CQC can adequately enforce using their legislation, without needing recourse to specific legislation. In a limited number of cases CQC may exhaust its enforcement powers and may look to HSE/LA for support.

Incidents where specific circumstances may apply

16. In a small number of cases, more specific criteria may be applied to ensure that the most appropriate body takes charge of the investigation and/or any related action.

These criteria and some examples are set out in Annex B. Any such cases will be considered individually on their merits, taking these criteria into account.

Liaison in relation to individual incidents

17. Where there is uncertainty about jurisdiction or where paragraph 16 applies, the relevant bodies will:

- determine who should have primacy for any regulatory action and whether joint or parallel regulatory action will be conducted;
- keep a record of this decision and agree criteria for review, if appropriate;
- designate appropriate contacts within each organisation to establish and maintain any necessary dialogue throughout the course of the regulatory action; and
- keep duty-holders / providers, injured parties and relatives (where appropriate) informed.

Incident notifications and general information sharing arrangements

18. The statutory requirements for the notification of incidents to CQC and HSE include RIDDOR and CQC's notification requirements.

19. Each party to this MoU will work collaboratively by:
- notifying the other parties as appropriate as soon as possible about information they receive on incidents in the jurisdiction of that body, and
- sharing relevant intelligence and enforcement data

The effectiveness of these arrangements will be subject to a review at least every three years.

Appendix 2 – Trustwide Health and Safety Incidents

Over Seven Day Absences	Aggressive or hostile behaviour	Alleged Assault by patient on staff	Alleged Assault by staff on pt	Assault by patient on staff	Injury caused by sharps / glass / knife etc..	Poor communication staff to staff	Loss of balance	Fall on steps/stairs	Total
136 Suite - Adult	0	0	0	1	0	1	0	0	2
Becklin - Ward 1	1	0	0	0	0	0	0	0	1
Becklin - Ward 5	0	1	0	0	0	0	0	0	1
CAMHS - Red Kite View (PICU)	0	0	1	0	0	0	0	0	1
CREST - SMI	0	0	0	0	1	0	0	0	1
EMERGE	0	0	0	0	0	0	0	1	1
Forensic Services Admin Team Clifton House	0	0	0	0	0	0	1	0	1
Newsam - Ward 1 - PICU	0	0	0	1	0	0	0	0	1
The Mount - Ward 1	1	0	0	0	0	0	0	0	1
The Mount - Ward 2	0	0	0	0	0	0	1	0	1
The Mount - Ward 4	0	0	0	1	0	0	0	0	1
23/24 Totals	2	1	1	3	1	1	2	1	12
22/23 Totals (30)									
21/22 Totals (27)									
Three year Average (23)									

NB Over seven day work related absences do not always result in a RIDDOR notification to the Health & Safety Executive. For example, work related stress, trauma following an incident or even a road traffic accident are not reportable but the circumstances of an incident can still be investigated by enforcing bodies.

23/24 Incidents Care Group & Type	Incident affecting Patient	Incident affecting Staff	Incident affecting Organisation	Incident affecting Visitor / Contractor or Member of the Public	Total
Adult Acute Services	1041	505	164	11	1721
Older Peoples Services	878	338	47	22	1285
Children and Young People Services	769	364	98	16	1247
Forensic Services	348	314	164	6	832
Learning Disability Services	202	138	18	5	363
Eating Disorders and Rehabilitation Services	174	117	46	7	344
Community and Wellbeing Services	41	27	33	28	129
Liaison & Perinatal Services	24	9	11	8	52
Regional and Specialist Services	4	7	2	1	14
Finance Services	0	4	8	0	12
Medical	0	1	1	0	2
Corporate Services Directorate	0	0	1	0	1
Professions and Quality - Corporate	0	0	1	0	1
Workforce Development	0	0	1	0	1
23/24 Totals	3481	1824	595	104	6004
22/23 Totals	3724	2225	758	90	6797
21/22 Totals	2864	1979	796	98	5737
Three year Averages	**3356**	**2009**	**716**	**97**	**6179**

Incidents by Ward/dept/team and Category	Accident/Health and Safety (Patient)	Accident/Health and Safety (Staff)	Slips / Trips / Falls Non-Patient	Slips / Trips / Falls (Patient)	Absconder/Missing person	Fire/Smoking (patient)	Infrastructure	Infrastructure (patient)	Property	Security	Security patient	Security (staff)	Verbal Abuse	Verbal abuse Public	Verbal/written abuse (staff)	Violence (Public)	Violence (Staff)	Violence/assault	Total
CAMHS - Red Kite View (PICU)	6	4	2	4	38	0	5	0	23	12	57	2	15	0	20	2	151	226	567
Becklin - Ward 1	7	5	2	24	119	0	3	0	16	5	25	2	26	0	21	4	102	162	523
CAMHS - Red Kite View (General Adolescent Unit)	8	14	2	1	77	0	7	0	21	10	61	5	8	0	21	1	84	160	480
The Mount - Ward 1	6	2	4	137	4	0	3	0	3	0	3	0	16	1	17	3	73	150	422
Becklin - Ward 5	7	4	1	13	47	0	11	0	11	12	10	2	13	0	20	2	106	71	330
The Mount - Ward 2	8	4	1	51	1	0	5	0	2	0	4	0	5	0	12	5	103	111	312
Newsam - Ward 2 A & T	2	2	1	1	15	0	2	0	4	42	61	2	40	0	55	0	14	49	290
The Mount - Ward 4	12	2	3	67	18	0	1	0	7	1	4	0	7	1	8	4	52	63	250
Westerdale	0	2	1	2	4	0	7	0	7	8	2	0	4	1	64	1	70	11	184
Becklin - Ward 4	6	0	2	16	41	0	2	0	5	3	9	2	3	0	10	1	30	46	176
The Mount - Ward 3	11	2	1	66	5	0	2	0	3	0	1	1	8	0	8	1	20	45	174
CAMHS - Mill Lodge	4	2	0	6	19	0	7	1	2	18	32	4	0	0	7	3	35	25	165
Newsam - Ward 4	4	1	0	2	33	0	2	0	5	6	12	1	6	0	10	1	30	48	161
Becklin - Ward 3	1	0	1	5	14	0	5	0	20	5	1	0	12	0	22	1	15	47	149
Newsam - Ward 1 - PICU	1	2	0	1	6	0	2	0	6	4	0	0	6	0	9	0	26	82	145
136 Suite - Adult	0	0	1	2	8	0	7	0	13	4	1	2	4	0	8	0	23	55	128
Newsam - Ward 2 W	1	2	0	5	7	1	6	2	9	21	21	0	4	0	15	0	14	11	119
Bluebell	1	1	0	6	5	0	6	0	4	8	9	1	6	0	26	0	14	16	103
Newsam - Ward 5 Rehab	1	2	1	1	20	0	0	0	3	2	14	0	5	2	29	0	5	8	93

Yorks Centre for Eating Disorders - YCED Ward 6 NC	7	3	1	4	12	0	2	3	0	4	29	0	1	0	8	0	17	2	93
Asket Croft - Rehab and Recovery	7	0	0	2	12	0	10	0	9	8	2	2	11	1	3	0	5	5	77
Newsam - Ward 3	5	3	1	1	7	0	5	2	1	9	28	1	3	0	7	0	0	0	73
Aspire	0	0	0	3	0	0	5	0	2	1	0	0	5	3	7	23	1	21	71
Woodland Square - Challenging Behaviour Respite	3	1	0	1	1	0	0	0	5	0	0	0	1	0	3	1	49	6	71
Crisis Assessment Unit - BC	0	2	0	2	11	0	1	0	1	2	6	1	7	0	4	0	8	11	56
SSE CMHT OPS	1	1	0	32	0	1	0	0	0	12	0	0	0	0	0	0	0	3	50
Asket House - Rehab and Recovery	2	2	0	2	7	0	2	0	0	6	1	0	5	0	14	0	0	1	42
Rothwell Bungalow- 1 Coppice Head	11	1	0	19	0	0	0	0	0	0	0	0	0	0	0	0	2	1	34
Riverfields	3	1	0	2	5	0	5	0	2	2	0	0	0	0	9	0	1	3	33
Complex Dementia Wraparound	3	0	0	20	1	0	0	0	0	0	0	0	0	0	0	0	3	5	32
Cedar House	1	1	0	14	0	0	0	0	1	0	0	0	0	0	0	0	6	2	25
Mother and Baby Unit	1	0	5	2	0	0	1	1	0	1	2	0	0	0	0	2	3	4	22
Methley Lodge	4	0	0	3	2	0	0	0	2	0	0	0	1	0	0	0	5	4	21
Deaf Service - Manchester	0	0	0	0	0	0	0	0	0	0	0	0	1	2	1	5	0	10	19
ENE CMHT OPS	0	1	0	2	0	0	9	0	3	0	0	0	0	0	1	2	0	1	19
Forensic Services Admin Team Clifton House	0	0	1	0	0	0	1	0	1	15	0	0	0	0	0	0	1	0	19
ENE CLDT	4	2	0	1	1	0	0	1	0	2	0	0	1	0	0	1	1	4	18
3 Woodlands Sq	2	0	1	0	0	0	0	0	1	0	0	0	0	0	1	0	8	4	17
Assertive Outreach	0	0	0	0	0	0	0	0	0	0	0	1	1	1	11	1	0	2	17

26 Harley Rise	2	0	0	2	0	0	0	0	1	0	0	0	1	0	2	0	3	5	16
34 Stainbeck Road	6	1	0	1	0	0	0	0	0	0	0	0	0	0	4	0	2	2	16
NICPM - LGI	5	2	1	4	1	0	1	0	1	0	0	0	0	0	0	0	0	1	16
Beeston Bungalow - 2 Chapel Fold	6	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	6	15
Intensive Support Service	0	1	0	1	2	0	3	0	0	0	0	2	1	0	2	1	1	1	15
E CMHT Adult	0	0	1	0	0	0	4	0	1	2	0	0	2	0	1	0	1	1	13
Reinwood Ave	1	1	0	3	0	0	0	0	0	1	0	1	0	0	0	1	5	0	13
WS CLDT	1	0	0	3	0	0	0	0	3	1	0	0	0	0	2	0	2	1	13
45 Maryfield Ave	1	0	0	8	0	0	0	0	0	0	1	0	0	0	1	0	0	0	11
CAMHS - Red Kite View (Goldfinch)	0	0	0	0	0	0	0	0	0	1	0	0	2	0	0	1	3	4	11
Main Switchboard / Reception / SPA	0	0	0	0	0	0	5	0	1	3	0	2	0	0	0	0	0	0	11
2 Woodlands Sq	3	0	0	4	0	0	1	0	0	1	0	0	0	0	0	0	0	1	10
156 Austhorpe Road	2	0	0	2	0	0	0	0	0	0	0	0	1	0	1	0	1	2	9
49 Gledhow Park Drive	2	1	0	4	0	0	0	0	0	0	0	0	0	0	0	0	2	0	9
Calverley Bungalow - 16	5	3	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	9
Crisis Assessment Service - BC	1	0	0	0	0	0	5	0	0	0	1	1	0	0	1	0	0	0	9
IHTT OPS	0	2	0	1	0	0	3	0	0	0	0	0	0	0	3	0	0	0	9
CREST - SMI	0	1	0	0	1	0	0	0	0	0	0	0	0	0	1	0	2	3	8
EMERGE	0	0	1	0	0	0	1	0	0	0	0	0	1	0	3	1	0	1	8
Forensic Outreach - Leeds	0	2	0	0	1	0	0	0	0	0	0	0	0	0	0	2	1	2	8
LD Intensive Support Team	1	0	0	0	1	0	1	0	0	0	0	1	0	0	0	1	2	1	8
SW CMHT Adult	0	0	0	1	0	0	0	0	1	3	0	0	0	0	1	1	1	0	8
Whinmoor Bungalow - 15 Sledmere Lane	3	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8

ALPS - BC	0	0	0	0	0	0	5	0	0	0	0	0	0	0	0	0	1	1	7
Beeston Bungalow - 1 Chapel Fold	1	1	0	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
Crisis Resolution	0	0	0	0	0	0	3	0	0	0	0	2	0	0	2	0	0	0	7
Rothwell Bungalow - 2 Coppice Head	3	2	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	7
SE CMHT Adult	0	0	0	1	0	0	0	0	2	2	0	0	1	0	1	0	0	0	7
Street Triage	0	0	0	0	1	0	3	0	0	0	0	1	0	0	1	0	1	0	7
8 The Oval	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	1	3	6
Treatment Unit / ECT Team	3	0	0	0	0	0	2	0	0	1	0	0	0	0	0	0	0	0	6
W CMHT Adult	0	1	0	0	1	0	1	0	0	2	0	0	0	0	0	0	1	0	6
Yorks Centre for Eating Disorders - Community and Outreach Team	0	0	0	1	1	0	0	0	0	1	0	0	1	0	1	0	1	0	6
NE CMHT Adult	0	0	0	0	0	0	0	0	2	0	1	0	0	0	2	0	0	0	5
Primary Care Liaison	0	0	0	0	0	0	0	0	3	0	0	0	1	0	1	0	0	0	5
Asket Croft - Recovery Centre	0	0	0	0	0	0	2	0	0	1	0	0	0	0	1	0	0	0	4
Parkwood View Bungalow - 3	0	1	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	4
Transport/Stores Dept - Roseville Rd	0	1	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	4
Deaf Service - York	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	1	3
Estates Dept - SM Hosp	0	0	0	0	0	0	1	0	1	0	0	1	0	0	0	0	0	0	3
Gender ID Service - Management	0	0	0	0	0	0	0	0	1	0	0	1	0	0	1	0	0	0	3
North OPS CMHT	0	0	1	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	3
Physical Health Team	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	3
West OPS CMHT	1	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	3

Acute in-patient and PICU admin	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	2
Care Homes Team	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	2
Core WSY Team only	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	2
ENE Memory Assessment Service	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	2
Forensic Services Admin Team - NC	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	2
Gambling Service Leeds	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	2
Involvement Team / Your Health Matters	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
IT Services - SMH	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	2
Laburnum Cottage	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2
LD Assessment and Referral Team	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	2
Liaison Psychiatry OPS - Beckett Wing	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	2
North Memory Assessment Service	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	2
NW CMHT Adult	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	2
Perinatal - Community team	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	2
Psychotherapy Medical	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	2
Pudsey Bungalow - Ivy Cottage	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2
Pudsey Bungalow - Sunnymeade	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
SSE Memory Assessment Service	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	2
10 The Oval	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Becklin General Admin	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1

Becklin Therapy Suite	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
CAMHS - Red Kite View (Admin Team)	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Chronic Fatigue Service	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Communications Dept	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Deaf Service - Newcastle	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Domestic Department	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Enhanced Care Homes Team	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Enhanced LYPFT and Enhanced NW	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Informatics - SMH	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
LD Health Facilitation	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Locked Rehabilitation Units	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Offender Pathway Development Services	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Outpatients - BC	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Parkwood View Bungalow - 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Perinatal - Outpatients	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
Pharmacy - BC	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Pharmacy - The Mount	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Portering Service - SM Hosp	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Rose	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Safeguarding Team	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
SPA	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
The Mount - Admin & Support Services	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1

Whinmoor Bungalow - 17 Sledmere Lane	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Woodland Square - Assessment & Treatment Unit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Workforce - E-rostering	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
WS CLDT - Ventures	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
YPDT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Total	193	96	41	574	550	3	178	10	223	250	399	44	239	13	491	73	1114	1513	6004

23 - 24 Categories	Adult Acute Services	Community and Wellbeing Services	Older Peoples Services	Children and Young People Services	Eating Disorders and Rehabilitation Services	Learning Disability Services	Regional and Specialist Services	Forensic Services	Finance Services	Liaison & Perinatal Services	Medical	Corporate Services	Professions and Quality	Workforce Development	Totals
Violence/assault	523	22	379	426	21	42	2	92	0	6	0	0	0	0	1513
Violence (Staff)	342	5	253	273	30	91	0	115	0	5	0	0	0	0	1114
Slips / Trips / Falls (Patient)	66	5	378	11	11	80	0	17	0	6	0	0	0	0	574
Absconder/Missing person	282	1	29	134	53	5	0	44	0	2	0	0	0	0	550
Verbal/written abuse (staff)	110	13	51	49	69	18	5	176	0	0	0	0	0	0	491
Security (patient)	65	1	12	150	46	1	1	121	0	2	0	0	0	0	399
Security	46	12	15	41	22	5	0	107	0	1	1	0	0	0	250
Verbal Abuse	78	9	36	28	24	6	1	57	0	0	0	0	0	0	239
Property	78	11	20	46	13	19	1	29	4	2	0	0	0	0	223
Accident/Health and Safety (Patient)	27	3	43	18	17	66	0	12	0	7	0	0	0	0	193
Infrastructure	53	15	23	19	16	2	2	32	4	9	0	1	1	1	178
Accident/Health and Safety (Staff)	15	2	15	21	8	17	0	13	2	2	1	0	0	0	96
Violence (Public)	10	24	15	13	1	4	1	3	0	2	0	0	0	0	73
Security (staff)	19	1	2	11	4	2	0	4	1	0	0	0	0	0	44
Slips / Trips / Falls (Non-Patient)	7	2	11	4	2	3	1	4	1	6	0	0	0	0	41
Verbal abuse (Public)	0	3	2	2	4	0	0	1	0	1	0	0	0	0	13
Infrastructure (patient)	0	0	0	1	3	1	0	4	0	1	0	0	0	0	10
Fire/Smoking (patient)	0	0	1	0	0	1	0	1	0	0	0	0	0	0	3
Total	1721	129	1285	1247	344	363	14	832	12	52	2	1	1	1	6004

Agenda item
12

Meeting of the Board of Directors

Paper title:	2024 – 2025 Organisational Priorities Quarter 2 Progress Report
Date of meeting:	28 November 2024
Presented by: (name and title)	Dawn Hanwell, Chief Financial Officer and Deputy Chief Executive
Prepared by: (name and title)	Amanda Burgess, Head of the 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.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	✓
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	✓
SR6	Digital technologies	✓
SR7	Plan and deliver services that meet the health needs of the population we serve.	✓

Executive summary

This report provides a summary of the Trust's progress against our 2024 – 2025 organisational priorities. This is the second report of 2024 – 2025 setting out how we are initiating our 14 priorities each with an identified lead executive. We have made changes to the reporting approach. This is in order to demonstrate the progress made on each priority specifically, identify where a priority may require attention or further action to ensure its intended outcomes are achieved.

Each slide provides a summary of a priority and details how we are delivering against each of the high-level milestones. We have adopted the 'alert, advise, assure' approach to provide the key messages on whether the defined milestones are being met, alert where matters require escalation or give assurance that a priority is on track.

In total we have 103 high-level milestones for delivery. At the end of quarter two we have:

- 2 milestones are marked as 'alert'
- 15 milestones are marked as 'advise'
- 86 milestones are marked as 'assure'

All our organisational priorities are governed through the executive-led portfolio specific governance groups to ensure monthly oversight and monitoring is achieved. Any escalations are reporting through to the monthly Extended Executive Management Team meetings.

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

Recommendation

The Board of Directors is asked to:

- Consider our position against our 2024/25 organisational priorities at the end of quarter 2.
- Be assured as to the systems and processes in place for monitoring and supporting the delivery of each priorities high-level milestones and underpinning tasks.

Leeds and York Partnership
NHS Foundation Trust

2024 – 2025 Organisational Priorities Report

Quarter 2 Progress Report

Overview and key messages

This the second progress report for 2024 – 2025 and provides a summary of the Trust's progress against our 14 organisational priorities.

The reporting format has been changed to demonstrate at a high level how we are progressing against the key milestones for each priority. We have adopted the 'alert, advise, assure' approach to provide clarity on where we might be going off track, what measures we are putting in place to ensure we deliver the priority and where we are making good progress.

We govern and have oversight of the progress we are making against our priorities through the monthly Extended Executive Management Team meetings. On a quarterly basis assurance is provided through the Finance & Performance Committee and Board of Directors meetings.

At the end of quarter 2, the following priorities are reporting as red (alert):

- **Efficiency and Productivity Programme:** this is our performance against budget, run-rate, reducing medic agency spend and overtime spend.

The following priorities are reporting as amber (advise):

- **People Plan metrics:** this is our performance against sickness absence, compliance with safeguarding supervision and the proportion of BAME staff entering a disciplinary process. Our number of vacancies is also exceeding the target, however this is due to the current vacancy freeze.
- **Co-production:** this is due to the time taken to initiate and commission the co-production baseline assessment and evaluation within our Rehab and Recovery service line. The audit will conclude in quarter 3 enabling the next stage to commence.
- **Strategic Estates Plan:** this is due to the timescales for developing our SEP taking longer than originally anticipated. The draft plan will be presented to the Board of Directors in November 2024.
- **Quality and culture dashboards:** due to resourcing pressures the decision has been taken to revise the timescales for this project. Resources have now been secured to enable the project to get back on track.

2024 – 2025 organisational priorities quarter 2 progress summary

Priority Area	Link	Lead	Exc Owner	Suggest RA	Alert	Advise	Assure
Delivery of our Efficiency and Productivity Programme (total efficiency programme)	LINK	Jonathan Saxton	Dawn Hanwell	Amber	1	1	1
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 (pay efficiencies)	LINK	Jonathan Saxton	Darren Skinner	Green	1	1	8
Delivery of our Inpatient Flow Programme	LINK	Laura McDonagh	Joanna Forster Adams	Green			3
Deliver, evaluate progress and realise the benefits of the Transformed Community Mental Health Service	LINK	Alison Kenyon	Joanna Forster Adams	Green			5
Develop a Care Services-led (LYPFT) improving health inequalities strategic plan	LINK	Sophie Valinakis	Joanna Forster Adams	Green			5
Strengthen and firmly embed the co-production approach within Care Services.	LINK	Alison Kenyon	Joanna Forster Adams	Amber		1	5
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	LINK	Warren Duffy	Dawn Hanwell	Green		6	3
Commence scoping the requirements for a new Electronic Patient Record and associated systems/platform strategy	LINK	Ian Hogan	Dawn Hanwell	Green			8
Provide performance data, insights and reporting, such as the Quality Dashboard to support and enable operational performance understanding and service-led transformation requirements.	LINK	Ian Hogan	Dawn Hanwell	Green			5
Delivery of key People Plan priority metrics	LINK	Andrew McNichol	Darren Skinner	Green		4	15
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%	LINK	Holly Tetley	Darren Skinner	Amber		1	
Implementation of PSIRF across the organisation	LINK	Janet Smith	Nichola Sanderson	Green			9
Procure a system (patient portal) that will enable clinical outcomes to be embedded into clinical services	LINK	Ian Hogan	Chris Hosker	Green			13
Development and implementation of Quality and Culture dashboards for revision in selective services	LINK	Richard Wylde	Chris Hosker	Amber		1	6

Delivery of our Efficiency & Productivity Programme

Our performance at the end of quarter 2

Savings Type	Annual Target	YTD Target	YTD Actual	Status
Budget	£10,800,000	£5,400,000	£914,156	●
Run Rate	£16,950,000	£6,273,731	£5,721,497	ⓘ
Cost Avoidance	£299,245	£94,181	£901,194	✔

% YTD Run Rate Reductions Achieved

% YTD Budget Saving Achieved

Alert, Advise, Assure

Alert:

At the end of quarter 2 we are behind plan against the budget and run-rate elements of our Efficiency and Productivity Programme. We have held two quality impact assessment sessions and have approved 44 non-pay efficiency schemes. Given the size and scale of the efficiency challenge we have identified across services/directorates, the pay budgets that are underspending. Service/directorate leads have been asked to identify pay schemes which will be considered through a quality impact assessment session to be held during quarter 3.

Assure:

For our cost avoidance schemes we are ahead of plan.

Delivery of our pay efficiency schemes

Our performance at the end of quarter 2

Savings Type	Type	YTD Target	YTD Actual	Status
Reducing Bank Expenditure	Run-Rate	£0	£0	✔
Vacancy Management Panel	Cost Avoidance & Run-Rate	£31,681	£173,247	✔
International Recruitment	Run-Rate	£0	£0	✔
Corporate Pause (3M)	Run-Rate	£122,831	£204,715	✔
corporate benchmarking review	Run-Rate	£0	£0	✔
12 Month Vacancies	Cost Avoidance	£472,127	£767,000	✔
Overtime Reduction	Run-Rate	£370,168	£214,435	ⓘ
Medical Agency Reduction	Run-Rate	£812,500	£206,371	●
Non-Clinical Agency Reduction	Run-Rate	£235,476	£329,895	✔
Clinical Agency Reduction	Run-Rate	£264,522	£897,643	✔

Alert, Advise, Assure

Alert:

At the end of quarter 2 we are behind plan with reducing medical agency spend. Although off trajectory, this is an improved position with changes initiated to our systems and processes for agency locums.

Advise:

At the end of quarter 2 we are behind plan with reducing our overtime expenditure. The target we set ourselves for overtime spend was a 100% reduction, which on reflection has been set too high. We have made significant inroads into reducing the overtime spend however it is the intention to reconsider the reducing the target during quarter 3.

Assure:

At the end of quarter 2 we are making good progress with our pay efficiency schemes. We have exec-led governance and oversight in place for this significant Trust-wide priority. There is an action tracker for each of the savings and the trajectories are broken-down into individual service specific targets.

Delivery of our People Plan metrics

Our performance at the end of quarter 2

Ambition	KPI	YTD Target	YTD Actual	Suggested RAG	RAG (Select Red, Amber, Green) Q1	Q2	Latest	Status
Looking After Our People	People Promise 4 theme score -We are safe and healthy.	6.00%	6.50%	Green	Green	Green	Green	✔
	Improve staff sickness levels (0.2% reduction year-on-year to 4%)	5.00%	6.01%	Amber	Amber	Amber	Amber	ⓘ
	Stress and Anxiety	30.00%	38.00%	Amber	Amber	Amber	Amber	ⓘ
	MSK	10.00%	11.50%	Amber	Green	Green	Green	✔
	Compulsory Training	85.00%	86.00%	Green	Green	Green	Green	✔
	Wellbeing Assessments	85.00%	85.00%	Green	Green	Green	Green	✔
Belonging in the NHS	People Promise 3 theme score - We each have a voice that counts	7.10%	7.10%	Green	Green	Green	Green	✔
	Appraisal Compliance	85.00%	85.00%	Green	Green	Green	Green	✔
	Percentage of BAME Colleagues entering Disciplinary Process (WRES)*	1.25%	1.93%	Amber	Amber	Amber	Amber	ⓘ
	Bullying and Harassment (>64%)	64.00%	60.20%	Green	Green	Green	Green	✔
	Percentage of Disabled Staff (staff survey) sharing disability status in ESR	6.00%	8.93%	Green	Green	Green	Green	✔
New ways of working and delivering care	Staff Survey Increase the number of staff reporting positive opportunities for flexible working (75% 2 year progressive Target)	75.00%	72.90%	Green	Green	Green	Green	✔
	Clinical Supervision	85.00%	74.00%	Green	Green	Green	Green	✔
	Safeguarding Supervision	85.00%	60.00%	Amber	Amber	Amber	Amber	ⓘ
Growing for the future	Vacancies	5.00%	12.32%	Red	Green	Green	Green	✔
	Turnover (8-10%)	10.00%	8.79%	Green	Green	Green	Green	✔
	Increase the Internal Bank	550	634	Green	Green	Green	Green	✔
	Monthly Fill Rates - RN	80.00%	92.00%	Green	Green	Green	Green	✔
	Monthly Fill Rates - HCA	80.00%	88.00%	Green	Green	Green	Green	✔

Alert, Advise, Assure

Advise:

Sickness: In quarter 1 we took the decision to amend the Trust sickness absence target to 5% in-year which is aligned with our workforce efficiency plans. At the end of quarter 2 early indications suggest a reduction on the in-month sickness rate from 6.15% down to 5.90% in September. This brings the 12-month average down to 0.1% from 6.01%. Despite our overall sickness absence rate reducing, we are still seeing absence related to stress, anxiety and MSK. Absence reasons will be scrutinised in the coming months as part of the wider workforce efficiency measures.

WRES: Although the overall number of employee relations cases has decreased, WRES cases have increased. We have an improvement group in place that has oversight of all cases with protected characteristics.

Safeguarding supervision: At the end of quarter 2 we are behind the target for safeguarding supervision.

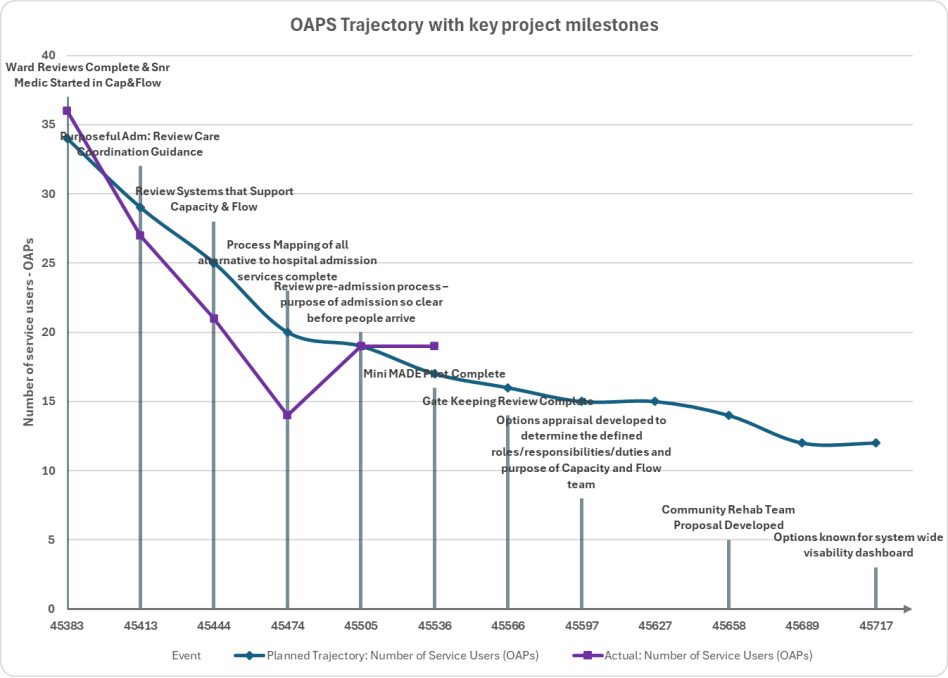
Assure:

Overall, at the end of quarter 2 we making good progress with our metrics. The vacancy metric although recording a rating of 'red' is due to the vacancy freeze we have in place for corporate and non-clinical roles.

Delivery of the Inpatient Flow Programme

Our performance at the end of quarter 2

Objective or Milestone	Start	Finish	Progress	Status
Re-engineer and enact changes that enable improved managing Capacity and Flow across LYPFT	Feb-24	Jun-25	39%	✔
Purposeful Admissions and Interventions across the inpatient pathway	Oct-23	Feb-26	34%	✔
Proactive discharge planning and support	Mar-24	Mar-25	65%	✔



Alert, Advise, Assure

Assure: We are continuing to make good progress with the plans we have set ourselves as part of the Inpatient Flow Programme. During quarter 2 we have reviewed our processes for assessing all service users that are clinically ready for discharge and begun embedding this within the teams. This will be closely monitored through the capacity and governance meetings. In addition, a new dashboard has been created to enable closer tracking of the barriers to discharge.

The alternative to hospital admission matrix is being tested with the teams to utilise when completing gatekeeping assessments, along with weekly complex case review sessions. As part of the pathway working with the community mental health team, we have agreed a standard to allocate a Care Coordinator within 72hours of referrals. This process is being monitored weekly.

Our Multi-Agency Discharge Events (MADE) weekly pilot has concluded with ward 3 at the Becklin Centre. A learning review with NHSE demonstrated a positive outcome. To support proactive discharge planning and support a Standard Operating Procedure and flow chart have been developed to support housing options with clearly defined pathways for the inpatient teams to refer to.

Deliver, evaluate progress and realise the benefits of the Transformed Community Mental Health Service

Our performance at the end of quarter 2

Objective or Milestone	Start	Finish	Progress	Status
Evaluation Group Established	Mar-24	Mar-24	100%	✔
Evaluation Task and Finish Groups Established	Apr-24	May-24	100%	✔
Feedback & Data Collection	Jul-24	Aug-24	100%	✔
1st Gateway Report	Sep-24	Sep-24	100%	✔
Implement early learnings from evaluation	Nov-24	Mar-25	0%	✔

Alert, Advise, Assure

Assure:

In support of the evaluation process, during quarter 2 we will have begun collecting the data and have the Power BI dashboard fully operational. Work does however continue to fully understand what data we want/are required to collect and how we can ensure that we are flowing data from some of our smaller third sector organisations.

The first gateway report was presented to the Partnership Board in September with recommendations endorsed for the future mobilisation process.

Develop a Care Services-led Improving Health Inequalities Strategic Plan

Our performance at the end of quarter 2

Objective or Milestone	Start	Finish	Progress	Status
Presentation given at a Trust Board Workshop	Apr-24	Jun-24	100%	✔
Presentation given at a Council of Governors meeting	Jun-24	Jul-24	100%	✔
Health Inequalities Strategic Plan presented to the Board of Directors for ratification	Nov-24	Nov-24	0%	✔
Consultation on the Health Inequalities Strategic Plan	Jul-24	Aug-24	100%	✔
Implementation of the Health Inequalities Strategic Plan	Aug-24	Oct-24	96%	✔

Alert, Advise, Assure

Assure:

At the end of quarter 2 we are on track with the development of our new Improving Health Inequalities Strategic Plan with the final document being presented to the Board of Directors in November 2024. As part of socialising our plan we are meeting with all key services, teams and attending governance meetings both internally and externally to raise awareness.

We have already begun our ‘must do’ actions associated with initiating the process for Equality Impact Assessments (EIHAs) for service changes.

Complete a refresh of our Estates Strategic Plan

Our performance at the end of quarter 2

Objective or Milestone	Start	Finish	Progress	Status
Strategic Estates Planning Workshop	Jun-24	Jun-24	100%	✔
Agree key Care Services Priorities and understand the estates impact	Jun-24	Jul-24	100%	✔
Draft the Strategic Estates Plan	Jul-24	Aug-24	25%	✔
Begin socialisation and gather feedback	Aug-24	Sep-24	0%	ⓘ
Draft SEP to CEG	Sep-24	Sep-24	0%	ⓘ
Draft SEP to CSDDG	Oct-24	Oct-24	0%	ⓘ
Draft SEP to ESG	Oct-24	Oct-24	0%	ⓘ
Final draft to the Finance & Performance Committee	Nov-24	Nov-24	0%	ⓘ
Final document to the Board of Directors	Nov-24	Nov-24	0%	ⓘ

Alert, Advise, Assure

Advise:

During quarter 2 we have taken the decision to seek the assistance of external expertise to help with compiling our Strategic Estates Plan. We have held several workshops with care services to reaffirm that our future vision, objectives and ambitions are largely still the right things we should be doing. The workshops have helped inform what the future aspirations are for our estate. Our intent is to bring the draft version of the Strategic Estates Plan to the Board of Directors in November 2024, with the final version presented to the Board of Directors in January 2025.

Commence scoping the requirements for a new Electronic Patient Record and associated systems/platform strategy

Our performance at the end of quarter 2

Objective or Milestone	Start	Finish	Progress	Status
Check the market, look at what we know is available and what's up and coming	Apr-24	Jun-24	100%	✔
Review of single solution verses best of bread/low code approach.	Jul-24	Sep-24	80%	✔
Determine requirements, including the potential to continually innovate in this space.	Jul-24	Sep-24	75%	✔
Prioritise our needs as a mental health provider, Mental Health Act/Inpatient/community setting	Jul-24	Sep-24	80%	✔
Engage with the ICB and regional and national colleagues at NHSE.	Jul-24	Sep-24	100%	✔
Understand local partners position and potential for collaboration and convergence	Jul-24	Sep-24	100%	✔
Investigate national funding opportunities – particularly around the recently announced £3.4bn digital transformation funding for 2025/26 to 2027/28	Oct-24	Dec-24	0%	✔
Develop outline Business Case	Jan-25	Mar-25	0%	✔

Alert, Advise, Assure

Assure:

At the end of quarter 2 we have completed a review of which Electronic Patient Record systems are on the market currently and what new systems are on the horizon. We have developed our high-level functional specification, and the technical specification is being finalised. Both aspects will be taken through governance groups during quarter 3.

We have reached out to wider ICB and regional frontline digitalisation colleagues to set out our position and requirements. This has also included early discussions with the London Procurement Partnership concerning the procurement advise and support that will be needed.

Provide performance data, insights and reporting such as the Quality dashboard to support and enable operational performance understanding and service-led transformation requirements

Our performance at the end of quarter 2

Objective or Milestone	Start	Finish	Progress	Status
Echo upgrade	Apr-24	Jun-24	100%	✔
re-establish performance and insight group	Jul-24	Sep-24	80%	✔
Dashboard library signposting	Jul-24	Sep-24	80%	✔
Dashboard outreach & optimisation/rationalisation of insights	Oct-24	Dec-24	0%	✔
Review/lessons learnt	Jan-25	Mar-25	0%	✔

Alert, Advise, Assure

Assure:

At the end of quarter 2 we have established our new governance framework to support the performance and insight work programme. As part of the relaunch work the September Collective Leadership session incorporated the topic of data and insight. In addition, the Staffnet site has been refreshed to enable better signposting, training and review to support our reporting tool, ECHO.

Implementation of PSIRF across the organisation

Our performance at the end of quarter 2

Objective or Milestone	Start	Finish	Progress	Status
Governance	Oct-22	Oct-22	0%	✔
PSIRF orientation	Sep-22	Oct-23	100%	✔
Diagnostic & discovery	Nov-22	Mar-24	100%	✔
Governance & quality monitoring	Jan-23	Jun-24	100%	✔
Communications Plan	Jan-23	Jun-24	94%	✔
Training	Mar-23	Mar-24	100%	✔
Standards	Mar-23	Sep-23	90%	✔
Patient safety incident response planning	Mar-23	Aug-24	100%	✔
Curation and agreement of policy and plan	Mar-23	Dec-24	93%	✔

Alert, Advise, Assure

Assure:

The tasks associated with implementing PSIRF across the organisation are completed. We are however continuing the process of training, communication and engagement to ensure the new policy and plan are fully embedded across the Trust.

Procure a system (patient portal) that will enable clinical outcomes to be embedded into clinical services

Our performance at the end of quarter 2

Objective or Milestone	Start	Finish	Progress	Status
Project Initiation	Apr-24	Jun-24	100%	✔
Initial Market Engagement & Demonstrations	Apr-24	Jun-24	100%	✔
Financial Review	Apr-24	Jun-24	100%	✔
Confirmed specification	Jul-24	Sep-24	100%	✔
Project Governance and delivery group establishded	Jul-24	Sep-24	100%	✔
Business Case Development & Approval, including outline project plan (via IMSG)	Jul-24	Sep-24	80%	✔
Procurement Exercise	Jul-24	Sep-24	80%	✔
Contract Award	Oct-24	Dec-24	0%	✔
Solution Design and Configuration	Oct-24	Dec-24	0%	✔
Phase 1 go live	Oct-24	Dec-24	0%	✔
Full Deployment	Jan-25	Mar-25	0%	✔
Project Review/Lessons Learnt	Jan-25	Mar-25	0%	✔
Optimisation Plan	Jan-25	Mar-25	0%	✔

Alert, Advise, Assure

Assure:

During quarter 2 we have confirmed the specification for the new patient portal application and following a market testing exercise and demonstrations have identified a preferred provider. The outcome of this exercise will be taken through the project governance arrangements during quarter 3.

Development and implementation of Quality and Culture dashboards for revision in selective services

Our performance at the end of quarter 2

Objective or Milestone	Start	Finish	Progress	Status
Complete Proof of concept	Apr-24	Jun-24	100%	✔
Plan developed to integrate to all services	Sep-24	Nov-24	50%	✔
Assign project lead	Oct-24	Nov-24	10%	ⓘ
Set up Project Group	Oct-24	Nov-24	0%	✔
Resocialising of the Dashboard Charter to build engagement will have happened the planning for the develop implementation sessions for STEEEP will have been agreed. - The implementation session for Safe will be underway.	Oct-24	Nov-24	0%	✔
The Outputs From The Safe Session Will Be In Place Within The Services, - the Timely and Efficient workstreams will have been completed. the implementation session for Equitable, Effective and Patient centred will be underway.	Nov-24	Dec-24	0%	✔
The Outputs From The Timely And Efficient Session Will Be In Place - the implementation session for Equitable, Effective and Patient Cantered will be complete Review of all measure to identify common data set across all services initiated	Jan-25	Mar-25	0%	✔

Alert, Advise, Assure

Advise:

During quarter 2 due to resourcing pressures, we have taken the decision to revise the timescales for this project. The original intention was to have integrated the new process across all services by the end of September. Resources have now been secured to establish the governance arrangements and get back on track with beginning to resocialise the Dashboard Charter during quarter 3.

Strengthen and firmly embed the co-production approach within Care Services

Our performance at the end of quarter 2

Objective or Milestone	Start	Finish	Progress	Status
Using a tool developed by Touchstone work with Rethink to undertake an audit of current coproduction within rehabilitation services. Determine whether this approach will work across care services.	Apr-24	Nov-24	41%	✔
Identify funding and staff within the service to support audit	Apr-24	May-24	100%	✔
Undertake audit with Rethink	Jun-24	Aug-24	44%	ⓘ
Reflect on learning from the audit process	Sep-24	Oct-25	0%	✔
Write paper for CSDDG / clinical gevernance to make recommendations whether approach should be rolled out across care services	Nov-24	Nov-24	0%	✔
Propose further objectives based on outcome of discussions	Dec-24	Mar-25	0%	✔

Alert, Advise, Assure

Advise:

At the end of quarter 2 within the Rehab and Recovery service line we have initiated an audit in collaboration with ReThink to provide a co-production baseline assessment and evaluation for our services at Asket Croft and Asket House. The audit will conclude during quarter 3 and will inform how we rollout this approach across our other services.

Agenda item
13

Meeting of the Board of Directors

Paper title:	**Chief Operating Officer's Report including the Winter Plan**
Date of meeting:	28 November 2024
Presented by: (name and title)	Joanna Forster Adams, Chief Operating Officer
Prepared by: (name and title)	Joanna Forster Adams, Chief Operating Officer – Mark Dodd, Deputy Director of Operations – Alison Kenyon, Deputy Director of Service Development – Sophie Valinakis, Head of Health Equity – Cath Hill, Head of Operational 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.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	✓
SR3	Culture and environment for the wellbeing of staff	
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	✓
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	✓

Executive summary

This report is presented to the November Board of Directors' meeting to set out the key management, development, and delivery issues across LYPFT Care Services to highlight any potential impact for the population we serve. It is derived from work with operational, clinical and quality colleagues, where information and intelligence is used alongside experience, to establish where we should prioritise our efforts for improvement (and recovery where necessary). Our established arrangements for operational and clinical governance enable us to highlight key areas for the attention of the Board. It should also be noted that this report has been provided to the Finance and Performance Committee on 25 November which undertook a more detailed scrutiny on behalf of the Board.

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'.**

No

Recommendation

The 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

28 November 2024

Chief Operating Officer's Report and including The Winter Plan

1. INTRODUCTION

This report sets out the key management, development, and delivery issues across LYPFT Care Services so that members of the Board are aware of the potential impact for the population we serve. It is derived from work with operational, clinical and quality colleagues, where information and intelligence is used alongside experience, to establish where we should prioritise our efforts for improvement (and recovery where necessary). Our established arrangements for operational and clinical governance enable us to highlight key areas for the attention of the Board.

Given the recent announcements by NHSE regarding the focus on operational performance and recovery, this report will develop in the coming weeks in line with guidance which will be issued in due course. We are also undertaking a review of our performance oversight arrangements within Care Services. This includes establishing a new Care Services Performance Group which will provide a directorate-wide forum in which we can monitor service line performance against agreed local, system-wide and national performance metrics. These metrics will sit within the definitions of the STEEEP Quality Framework, together with pertinent contractual, constitutional and operational measures, and will be used to inform the Chief Operating Officer's Report to Board.

One area of focus for NHSE operational performance and recovery is the recent issue of a set of required actions for health providers and ICB's in respect of people delayed in Emergency Department settings inappropriately. More detail is provided in the main body of this report.

This month we have not included a routine Emergency Preparedness, Resilience and Response (EPRR) update as a separate paper is presented to the Board which outlines our performance against the national standards which we have been assessed against.

A detailed report on the issues of most concern was presented to members of the Finance and Performance committee in October. Some of this content is included again in this report and has been updated for the purpose of information to the wider Board.

Of particular note are the issues relating to:

- The action taken to pause non-urgent referrals in our Adult ADHD Service.
- Response times within our Crisis Service and the challenge in meeting our standard of achieving assessments within 4 hours of referral.
- Sustained demand for inpatient admissions, with a corresponding slowing in progress (and anticipated improvements) in discharges resulting in an increase in out of area placements.
- Waiting times for admission to mental health beds for service users in the Emergency Departments (ED) of the local Acute Hospitals remains an area of concern.

The full Board level performance report is attached, as normal, in Appendix A.

2. WINTER PLANNING

The most recent version of our winter plan is attached as Appendix B. We have worked internally and with system partners to refresh our operating arrangements over winter. It is a compendium of how we prioritise, manage and support services during this period, alongside our arrangements to respond to incidents and events that may occur over the coming months.

We activated our winter operating arrangements in October. We routinely meet as a strategic group, led by the Chief Operating Officer, supported by a broad membership tactical group which ensures that staff on the front line have the resources and support they require over winter. This is where we would trigger an incident response if needed. We have issued our first cold weather alert of winter 2024/25 and are building on the learning of winter 2023/24 to mitigate and manage any risks to service disruption. We are also actively engaged and influencing at a Leeds, York and West Yorkshire level so we can support the health system to best meet the needs of the population we serve.

3. IMPROVING HEALTH EQUITY STRATEGIC PLAN DEVELOPMENT

In recent months we have undertaken a major piece of engagement work to develop and finalise our new Improving Health Equity Strategic Plan. This was due to be presented to the November public Board meeting for final sign-off, however, given the level of interest from stakeholders, service users, and staff in shaping the document, the final version will be presented for sign off at the January 2025 Board meeting.

Our programme of engagement on our Strategic Plan came to an end in early November. This was highly successful and provided valuable feedback and input to our Strategy.

Our engagement events included:

- Meeting with approximately 500 people through both virtual and face-to-face forums
- Presenting at our Service User Network meetings capturing service users' views directly
- Presenting to a number of internal governance meetings (clinical, operational and corporate) including our Workforce Race Equality Staff Network (WREN), Disability and Wellbeing Network (DaWN) and Rainbow Alliance (LGBTQ+ network)
- Engaging with key system partners e.g. Leeds City Council Public Health Teams, and other system equality leads
- Hosting an open access webinar with over 120 participants from across the Trust and West Yorkshire partners.

The outcome, key themes and interventions that have been identified through the engagement events will be incorporated into the final version of the Improving Health Equity Strategic Plan, which will be presented to the Board in January 2025 for final sign off.

4. STRENGTHENING OUR OPERATIONAL PERFORMANCE MANAGEMENT ARRANGEMENTS

As referenced in the introduction, we have established a Care Services Performance Group. The first meeting of the group took place in mid-November where the purpose of the meeting was discussed and agreed, along with the membership.

The purpose of the group is to ensure that for each service line there is sufficient oversight, scrutiny, check and challenge of service line performance metrics and understand how these metrics contribute to directorate-wide or trust-wide performance and where appropriate system-wide and national metrics. It replaces our previous arrangements which had become duplicative and confused with other governance arrangements within the Trust.

The group will identify any trends in performance; receiving assurance on actions that might be needed, understanding any risks to service delivery and how these will be addressed, considering and where possible resolving any barriers that need addressing. It will also look at any areas of good practice that can be shared across service lines.

The performance metrics reported to the group will be pre-determined and fit with requirements and definitions as set out in the STEEEP Quality Framework.

5. MANAGEMENT AND LEADERSHIP

In recent days there have been significant announcements about the need to transform NHS leadership and management. This is welcomed in LYPFT where we recognise the significant contribution made by Managers and Leaders in all of our services, but without a standard NHS framework of skills, competencies and development. Amanda Pritchard, CEO of NHSE, has announced that Sam Allen, who is the Chief Executive of the North East and North Cumbria Integrated Care Board, will be the National Director for Management and Leadership, NHS England. Sam will be leading on the delivery of this vital work.

It is an ambitious programme with the aim for the service to be the fastest improving health system in the world. We know that we need to attract, train, and retain the best leaders and managers. Healthcare managers and leaders are a crucial member of all healthcare teams and influence the quality of care, the outcomes for patients and the experience of the workforce and culture.

In recent correspondence signalling the start of this work, Sam Allen announced that "*We have a significant opportunity to provide rewarding and fulfilling careers for the best leaders and managers in England, coupled with enviable opportunities for young people starting their careers and those people who want to change careers. Therefore, investing in our managers and leaders should make the NHS an employer of choice from now and into the future. But we all must be honest; we must change how we do things, and this includes setting the standards, behaviours and code of practice and implementing this consistently. The approach of the past is not fit for now, or the future. Reform is therefore a necessity, not a nice to have. This is why the code of practice, standards and behaviours we will set for all managers and leaders will be implemented for all managers and leaders".*

Updates and progress reports will be shared through our committee structure but again it is a welcome direction of travel in LYPFT, building on the work we have already established as part of our leadership development programme and support for Managers to develop in their profession.

6. IMPROVING FLOW PROGRAMME

6.1 Programme Update

The Improving Flow Programme planned actions remain on track, but we are now off plan against the Out of Area trajectory with a number of women requiring inpatient beds at a time when flow through our female service has slowed. Not only is this a major concern impacting on experience and quality of care for people having to be placed outside of Leeds, but it has a significant impact and potential further risk to the achievement of our financial plan.

6.2 Out of Area Trajectory

At the end of October, the total number of service users placed Out of Area was 24 against a trajectory of 16 (see graph 1). Of note, 18 of those 24 service users who were in acute beds were female (although 1 of these placements was appropriate based on clinical need).

In October, we had a total of 15 new Out of Area placements commenced with 10 adult acute and 5 PICU. 11 of the 15 placements were female. All placements had been agreed by both senior clinical and operational leads and were deemed necessary to prevent further deterioration of their mental state. Additionally, the Capacity and Flow Team oversaw 6 Out of Area discharges and 1 service user repatriation back to Leeds PICU.

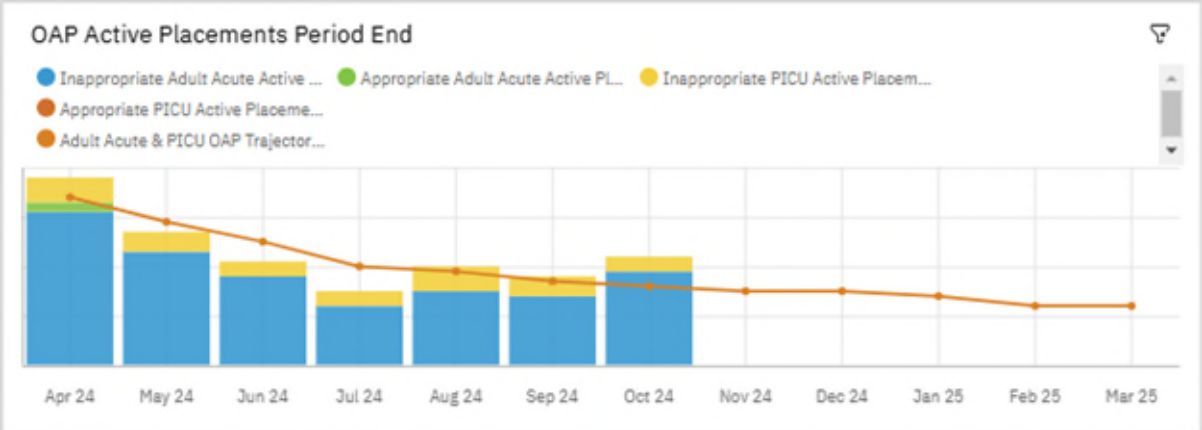
In September we noted that we had seen a small reduction in discharges across the female service and this continued into early October. Early indications of the reasons for the slowing of discharges relates to people taking slightly longer to recover and establishing their care and discharge pathway. Our Capacity and Flow Team is working with clinical teams in the admission process to identify any barriers to discharge and are attempting to resolve them prior to someone being clinically ready for discharge.

The average length of stay across the female service is 63 days against a national average of 41 days (Adult and Older People's Mental Health Service Benchmarking Report 2024). As a result, we benchmark poorly against other mental health trusts across the country. This work is central to our Improving Flow Programme and the work we are doing to reduce length of stay is summarised as:

- Developing a revised criteria/guidance for inpatient admission
- Embedding Formulation on all inpatient wards which agrees the purpose of admission and estimates a discharge date
- Timely allocation of a Care Co-ordinator
- Working with System partners, including housing and adult social care, with escalation processes developed to reduce delays.

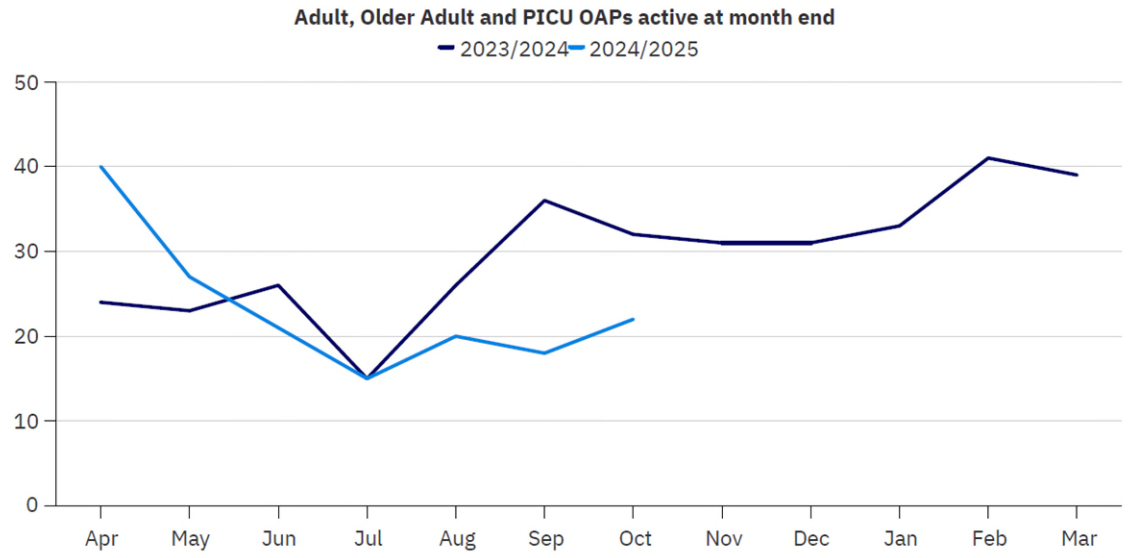
The Chief Operating Officer and Medical Director are liaising closely with the Programme Lead and Clinical Lead to agree any changes to our programme of work and prioritisation as a consequence of the lack of sustained improvement.

Graph 1

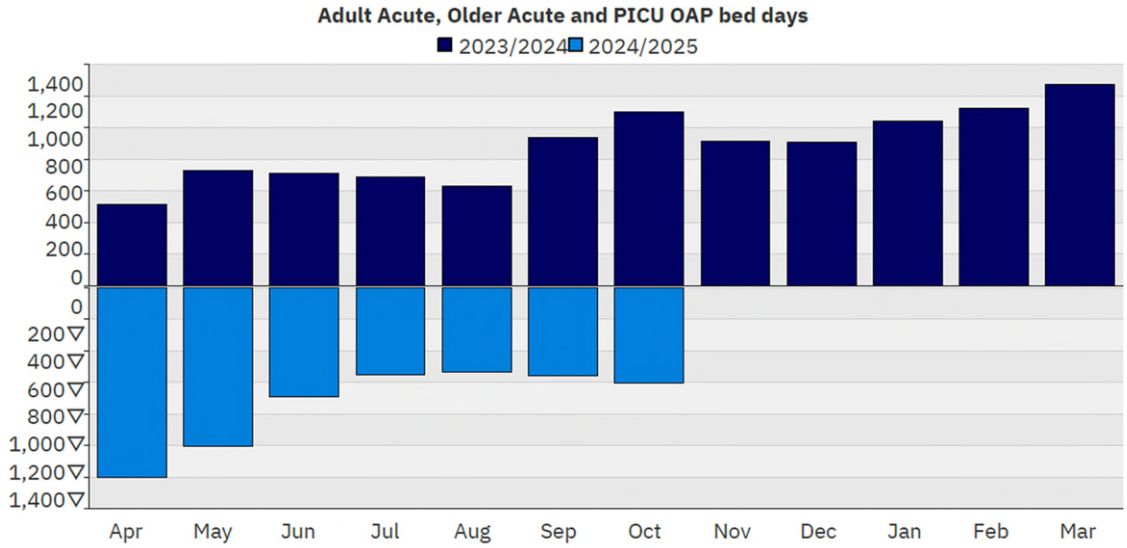


Whilst we did not achieve the trajectory set this month, it is important to note that our position is still favourable in comparison to this time last year and overall, bed days in Out of Area Placements have not increased considerably in October despite the increase in new Out of Area Placements being commenced (see Graphs 2 and 3).

Graph 2



Graph 3



6.3 All placements by type and locality

The Capacity and Flow Team aims to support inpatient care as close to home as possible and this is taken into consideration when we have no locally identified beds in Leeds. We utilise Out of Area beds in Priory Middleton St George which is in the Northeast of England.

Image 1: All placements at month end October 2024

Image 2: Placements started October 2024

6.4 Ongoing Work and Accelerated Work In progress

We are currently working to improve our escalation processes to ensure that all system delays are adequately responded to and addressed. Integral to this is the work with our partners across Leeds to develop a System Visibility Dashboard equivalent to the one that supports live capacity and demand information for physical health services. This has made slower progress at a system level than anticipated but we are using more manualised and localised systems to mitigate this. Our intention is to develop a dashboard and meeting structure to support timely flow and reduced delays for our service users in mental health inpatient wards. The design team have agreed to focus initially on the system level dashboard to help build the senior support and momentum. The dashboard will be ready to trial within the Clinically Ready for Discharge escalation meeting in December.

7. KEY SERVICE DELIVERY AND KEY PERFORMANCE ESCALATIONS

7.1 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 the risks are highest.

7.1.1 Regional and Specialist Services: ADHD waiting times

Following several months of consideration by the Executive Management Team regarding the current demand on the service and its challenge in responding to waiting times, a decision was agreed for a temporary suspension for non-urgent referrals. Working with system partners at a senior level, a plan was derived which supported the suspension of non-urgent referrals and this was activated on the 11 October 2024.

We currently have approximately 4500 people on our waiting list waiting for a diagnostic assessment which is resulting in a potential wait of up to 21 years if the delivery model remains as it currently is. A comprehensive update on the system work to improve the scale and design of the pathway will be provided later in 2024 or in January 2025. In addition to the diagnostic waiting list, we have approximately 250 service users waiting to commence treatment with 700 service users who are on regular annual reviews of their treatment.

In order to provide support to the people who are waiting in our service, we have worked with the GP Confederation in Leeds to put in place a 'support and navigation' offer. This has been a good example of collaboration between partners at a place-based level. Two of the Navigators started in post on the 4 November and have been engaging in their induction. They are expected to start making contact with service users in November. A third navigator joined the team week in commencing 18 November.

Navigators will respond 'reactively' to emails received and 'proactively' to designated patient groups. We are segmenting our waiting list, so we are proactively supporting people in the IMD1 areas of Leeds (those areas categorised as most deprived, recognising the increased risk of inequity of access for people in those areas). We are likely to expand this to do the same for older adults and people with a learning disability who are waiting for access to our diagnostic service.

The triaging/clinical prioritising process for the waiting list continues in development with the aim of finalising this on the return of our Clinical Lead, Dr Mike Smith who has steered and led this work. The service is also meeting with the GP Confederation to further develop the formal project plan process for the developments across the Leeds system.

In response to this decision, we had anticipated an increase in the numbers of concerns and complaints. On the 11 October letters were sent out to the 4648 service users on the waiting list at that time. Since this time, we have had 184 enquiries to our email inbox with 52 service users informing us that they have had a diagnosis with another provider so could be removed from our waiting list. The remainder have made enquiries regarding the support and advice available whilst there is a pause and exploring alternative referral routes outside of the Leeds service, all of whom have been signposted to the Care Navigators. We have also had several returned letters as a result of people no longer residing at their recorded address. We are working

through these to ensure we are able to communicate with those service users through cross-checking their demographic details with NHS digital systems where possible.

A total of 69 enquiries has been made via our Patient Advice and Liaison Service (PALS). There are 9 open formal complaints currently to the ADHD service.

- 1 of those complaints is a joint complaint with LCH which we are formally investigating together as it relates to transitions
- Of those 9 complaints 4 were received after the pause decision on 11 October, the remainder are related to general concerns with waiting times and/or CAMHS assessments being accepted by our adult ADHD service.

Additionally, a Scrutiny working group is scheduled for week commencing the 25 November where the session will be used to understand in depth the issues in Children and Young People and Adult ADHD services. The working group will include Dr Chris Hosker, Medical Director and our ADHD Clinical Lead Dr Mike Smith.

7.1.2 Adult Acute Services: Crisis Resolution assessments within 4 hours

Over the recent months, we have experienced challenges which meant that our performance against the 4-hour standard was reported as below the expected level, and recovery work has been underway for several weeks.
The main issues we identified were data quality where the incorrect prioritisation was recorded, and staff availability due to vacancies and staff absence. In order to ensure we are meeting demand, particularly urgent and emergency demand within 4 hours, we have focussed heavily on how we are capturing the degree of urgency, so we appropriately prioritise these people.

The 4-hour Crisis Response KPI was the subject of a data quality audit conducted in Quarter 2 of 2023/24 by the Performance Team, with support from managers in our CRISS (Crisis Response and Intensive Support Service). The main data quality issue found by the audit was inconsistency in the use and management of the priority of referrals to the service. It is the recorded priority of a referral that is used in the national dataset to determine whether a referral to CRISS should be assessed as:

- Within 4 hours by a priority of '**Very Urgent**'. Referrals recorded as '**Emergency**' are also counted as in scope for 4-hour assessment, but this priority option is not recommended as appropriate for Crisis services
- Within 24 hours by using a priority of '**Urgent / Serious**' or
- Is deemed not in scope for either of these assessment standards by use of the priority of '**Routine**'.

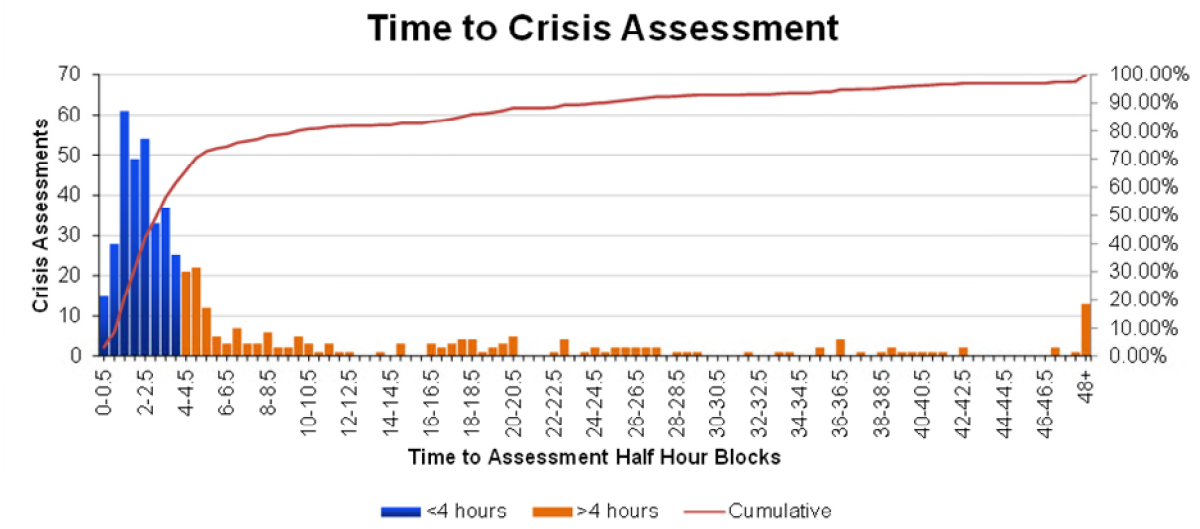
On CareDirector there are prompts where a referral priority can be recorded; first the 'Presenting Priority' is mandated on the initial screen when a referral is made to CRISS. Following this, the 'Case Priority' can be updated following acceptance of a referral. It is expected that where the 'Referring Priority' does not reflect the determined priority at clinical triage the 'Case Priority' is completed.

In Q1 and Q2 of 2024/25 there have been 19 such referrals, with only 1 being seen in 4 hours which indicates these should not have been included in the 4-hour target, but in either the 24-hour assessment standard ('Urgent / Serious') or recorded as routine. These referrals are seen by our Intensive Support Service (ISS) and excluding them from performance data increases compliance to the 4-hour indicator, but by only about 5% per month.

Whilst we continue to work on improving data quality, alongside this we are aiming for all very urgent referrals to be seen and assessed within 4 hours where appropriate. The graph below sets out our response times, this data is accurate up to the end of September 2024. All have been reviewed and are deemed to be within the expected response times based on degree of urgency. Notwithstanding the confused picture in our data (because of quality of categorisation of urgency), we can confirm there have been no incidents relating to harm because of longer response times.

The distribution chart over time will enable members of the Board to understand our responsiveness for the period October 2023 to September 2024 (inclusive).

Graph 4



Clinically, given the current design of our service delivery of the CRISS model, this is concluded to be appropriate. There are 7% of referrals in the same time period which were not assessed within 24 hours. Again, these timescales are clinically assessed as appropriate given the presentation of the individuals being referred (primarily due to support and input from the Harm Reduction Team commissioned for this cohort of people). As of the 24 October, 68% of people have been seen within 4 hours of referral.

The new CRISS model has been adopted which has seen the Crisis Team operating from each of the Intensive Support Service hubs since the 4 November. The aim was the creation of three separate teams to provide Crisis Resolution and Home Treatment

which are aligned to the Community Hubs within the East, South, and West of Leeds. This would mean that both Crisis Resolution and the Intensive Support Services would work as one team within the same locality in order to provide a more effective service.

7.1.3 Crisis Cafes

As the Board will be aware an attempt by the Leeds Crisis Transformation Programme to evaluate the effectiveness of the Crisis Cafes has not been successful. Discussions have been held with the West Yorkshire ICB and a decision has been made to progress a West Yorkshire wide review of the service specification, and key performance indicators over the coming months.

The Crisis Cafes were developed to support A&E departments by reducing the number of attendances of people with mental health. When the first Crisis Cafe opened in Leeds, there was a direct correlation between a drop in number of people with mental health issues attending A&E and the cafe's opening hours. Based on this, additional investment into the Crisis Cafe model was agreed, expanding the provision to 7 days and across three sites. However, the closure of the cafes during COVID and their failure to return to the previous operating model has meant fewer people accessing the Crisis Cafes, and we know there is a small cohort who regularly use them. Given the increase in A&E attendances the current model is obviously not working. Hence the discussion at the West Yorkshire commissioning forum and the agreement to do the review to develop a single specification across West Yorkshire.

The Leeds Office of the ICB has been working with the current provider to remodel their delivery in order to meet the efficiency requirements with a reduced financial envelope (the opportunity was identified through the Optimising Value Workstream of the Crisis Transformation Programme). This reduction has been agreed to be delayed until 1 April 2025. Various options have been shared on how this would be achieved. These include changing opening times (the cafes will open earlier in the day and close before midnight). The ICB has insisted on maintaining 1:1 crisis support rather than a social space, and maintaining a city centre venue (close to A&E departments). The work to develop a consistent specification and KPIs across other West Yorkshire Places will progress alongside these locally agreed changes. The ICB has also requested their engagement with an Equality Impact Assessment process to outline the key impacts, these will be considered at the Population Health Board and shared with LYPFT. Further updates will be brought to the Board.

7.1.4 Emergency Department (ED) waits for mental health admission

We continue to focus on supporting admission or alternative pathways of care for people presenting in ED with acute mental health needs. There is increased scrutiny on how quickly we facilitate transfer and admission to inpatient services when needed and a recent set of action cards have been issued by NHSE setting out the requirements of providers and the ICB in each place. We are now implementing these

requirements, strengthening our escalation and management arrangements, and building a way to have visibility of the data needed.

We continue to strive to be responsive to the needs of the service users who require admission in the ED but must balance this against those waiting for admission in the community, therefore we will always prioritise those in higher need. Where we have service users waiting in the ED for significant periods of time, we will continue to provide additional mental health support via our Acute Liaison Psychiatry Service (ALPS). Where we have service users from other areas attending the ED we offer the same level of support, and we have found that other trusts are experiencing similar capacity challenges resulting in the delays.

7.2 Advise

7.2.1 Children and Young Peoples Services: Red Kite View (RKV)

Following the previously reported stabilisation and improvement approach taken to meet the needs of young people across West Yorkshire who require in-patient care, we can positively report that the planned capacity has been successfully maintained at 10 beds. We currently have 8 service users in Out of Area beds who would require repatriation.

We are currently undertaking a review of the staffing establishment to ensure it meets the needs of the service users that will enable them to further increase the planned capacity by the end of November to 12 beds. Alongside this the team are exploring the option of providing intensive support in the community to avoid hospital admission or facilitate early discharge. This will mean the bed base remains at 12 and the resources freed up from the continued closure of the remaining 4 beds will be redirected into the intensive community support offer as an alternative to admission. This will be explored through the West Yorkshire Children and Young People's Mental Health Services Provider Collaborative as a business case and decisions are scheduled within the financial year.

Further development work is planned for the team at RKV with our Organisational Development Team undertaking a listening event with the whole service including Bank staff. This is planned for November 2024 with the expectation of feedback and further development work being undertaken in early 2025.

NHSE are meeting with the Chief Operating Officer and the Director of Nursing and Professions in early December as a follow up to the process of rapid review initiated when quality concerns were originally shared.

7.2.2 Children and Young Peoples Services: National Deaf Children and Adolescent Mental Health Service (NDCAMHS)

As previously reported to Board, we have seen increased waiting times within our NDCAMHS Service as a result of several factors including staff vacancies and absences, increasing referral numbers and increasing complexity of referrals. We have previously reported challenges in meeting the needs of the service user population with the need to divert and spread clinical resource, resulting in longer waiting times. An increasing need for full team assessments related to neurodiverse assessments is a key component of the challenge faced by the team. We have previously set out that the nature of smaller teams means that where we face workforce availability issues this can impact disproportionately on performance. Recently however a significant improvement in waiting times has been achieved.

In York the expected wait time has reduced to 12 weeks from 50, and in Manchester this has reduced to 16 weeks. The wait time for the Newcastle team has remained at 26 weeks due to very little change in the staffing availability, however the team continues to explore options to improve on the wait times. We continue to aim to achieve an 18-week target, or better, across all teams by May 2025.

7.2.3 Learning Disability Service: Dietetic and Speech and Language Therapy Provision

Dietetic staffing and clinical delivery remain a challenge in the service; however, some progress has been made. System leader colleagues have met and are working towards a transition of enteral feeding to Leeds Community Healthcare (LCH) by April 2025. There are still ongoing discussions about how the gap will be funded but this will be picked up by the system. We continue to deliver a safe level of service through the engagement of a Locum Dietitian, with the permanent Lead Dietician post now being advertised.

A review of the Speech and Language Therapy (SaLT) eligibility criteria has been undertaken by LCH resulting in the potential for referrals from the service where service users have longer term eating and drinking needs. The service has raised with the SaLT team in LCH as a concern and discussions are ongoing with our Leads Allied health Professionals (AHPs) to agree a way forward to ensure our service users' needs are met fully by the right service.

7.2.4 Community and Wellbeing Service: Provision of Electro-Convulsive Therapy (ECT)

ECT is provided to a small number of service users within the Trust where they have not responded to other forms of treatment. Service users undergoing ECT have treatments twice a week and up to 12 treatments in total. It is vital for the success of the treatment that it is regular and uninterrupted. The service that provides ECT is small and has highly skilled staff undertaking all aspects of the treatment. We are currently experiencing significant challenges with gaps in our staffing over the next 2

to 3 months. The team are working hard with other clinical services to ensure that we can continue to deliver the service throughout this period whilst we undergo recruitment. This will mean drawing staff from their current roles for a half or full day a week. We anticipate this will have a minimal impact of the service providing staff but we all recognise the need to continue this service throughout this period.

7.2.5 Gender Service Waiting List

Demand continues to exceed capacity of the service. There are now 6000 people on the waiting list, the longest since May 2019. The Operational Manager and Administrative Lead are meeting monthly to support the management of the waiting lists. This also includes the development of a system to fill cancellation slots and reduce Did Not Attend (DNAs). The current DNA rate in the service is 12% which is the second lowest in the country across all clinics. We have seen a decrease from a 20% DNA rate over the past two years. This has been in part due to the introduction of the Patient Initiated Follow Up (PIFU) approach where service users are not booked appointments by the clinic, but we allow them to determine when they want to be seen. These two approaches enable us to use out clinic appointments more productively ensuring we reduce the amount of clinic time not used.

The service is also developing a system that ensures all those on the waiting list still require an open referral with the service. All service users on the waiting list receive information about our Gender Outreach Workers who provide informal support to those waiting to be seen by the service.

We currently have approximately 500 people who are on the waiting list who may qualify for the Indigo service in Manchester and may wish to transfer. There is a delay to these transfers as Indigo needs to validate the data and discuss within their clinical team as to the appropriateness before a transfer of care is arranged.

Work is ongoing to develop and achieve approval for an Advanced Clinical Practitioner as Lead Clinician in the Gender Service. This will enable us to develop staff from other professions outside of Psychology and Psychiatry to be able to make diagnoses increasing our capacity to do so. Our proposal has now been submitted to NHS England for review.

Work has commenced to collate information for the National Review of Adult Gender Services, which is to be held on 28 November 2024, including a review and update of the current Operational Policy. Staff in the service have engaged in the review of other services, in Exeter and Nottingham, which has helped them understand the expectations of the review. This information will contribute to the forthcoming Cass Review into Adult Gender Services.

7.3 Assure

7.3.1 CONNECT Adult Eating Disorder Service: In-Patient Service

The CONNECT Inpatient Registered Nursing vacancy forecast for December 2024 has further improved since last reported to Board. We expect to have no Band 5 Registered Nurse vacancies and 1 Band 6 Registered Nurse vacancies at the end of Q3.

High observation levels and subsequent reliance on high levels of temporary staffing are driving the inpatient overspend. This is a result of service users who are being nasogastric fed or are at risk of being on enhanced levels of observations. The service is responding to the financial challenges by reviewing the ward staffing establishment in collaboration with the Nursing Directorate. A report is due in Q3 that is likely to recommend increasing the baseline staffing establishment to reduce temporary staffing. In addition, the ward management team have utilised the Nursing Directorate to provide assurance that observations are managed effectively. The ward reviews observation and staffing daily, to ensure there are changes of staffing levels in a timely way.

7.3.2 Forensic Service: Newsam Centre Seclusion Suite

The building work relating to the seclusion suite at The Newsam Centre has been completed through October; however, handover is still to take place as a result of some ‘snagging’ works still to be carried out along with the delivery of the appropriate furniture. Training will be delivered through our Prevention and Management of Violence and Aggression (PMVA) Team who will help the service further develop their skills in the use of the suite. The suite has been a welcome addition to the service and will provide a more suitable environment for those few service users who may need to access the area.

8 SUMMARY AND RECOMMENDATION

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

Joanna Forster Adams
Chief Operating Officer
20 November 2024

Contributions from: Mark Dodd, Deputy Director of Operations; Alison Kenyon, Deputy Director of Service Development; Sophie Valinakis, Head of Health Equality; Cath Hill, Head of Operational Governance

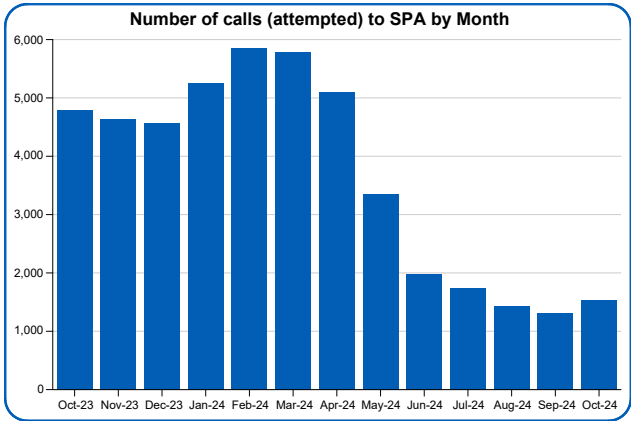
Service Performance - Chief Operating Officer

Services: Access & Responsiveness: Our response in a crisis	Target	Aug 2024	Sep 2024	Oct 2024
Percentage of crisis calls (via the single point of access) answered within 1 minute	-	73.6%	71.9%	72.3%
Percentage of ALPS referrals responded to within 1 hour	-	77.8%	78.6%	65.2%
Percentage of S136 referrals assessed within 3 hours of arrival	-	9.7%	8.2%	9.4%
Number of S136 referrals assessed	-	31	49	53
Number of S136 detentions over 24 hours	0	0	1	1
Percentage of appropriate crisis referrals seen face to face for assessment within 4 hours of referral	90.0%	57.4%	51.2%	65.9%
Percentage of service users who stayed on CRISS caseload for less than 6 weeks	70.0%	85.5%	86.2%	85.3%
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support	50.0%	39.5%	34.8%	36.5%
Percentage of CRISS caseload where source of referral was acute inpatients	-	22.0%	10.5%	7.9%
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services	**Target**	**Aug 2024**	**Sep 2024**	**Oct 2024**
Gender Identity Service: Number on waiting list	-	6,074	6,143	6,200
Deaf CAMHS: average wait from referral to first face to face (inc. telemedicine) contact in days	-	190.94	179.22	200.24
Community LD: Percentage of referrals seen within 4 weeks of receipt of referral	90.0%	55.6%	70.7%	83.7%
Leeds Autism Diagnostic Service (LADS): Assessment to Diagnostic Decision within 26 Weeks (quarterly)	-	-	48.5%	-
Leeds Autism Diagnostic Service (LADS): Percentage starting assessment within 13 weeks (quarterly)	-	-	34.6%	-
CAMHS inpatients: Proportion of people assessed within 7 days of admission (HoNOSCA / GBO) (quarterly)	100.0%	-	100.0%	-
Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency) (quarterly)	-	-	88.0%	-
Perinatal Community: Percentage of routine referrals waiting less than 2 weeks for assessment (quarterly)	85.0%	-	94.7%	-
Perinatal Community: Total number of distinct women seen in rolling 12 months (quarterly)	920	-	1,020	-
Perinatal Community: Face to Face DNA Rate (quarterly)	-	-	10.8%	-
Services: Our acute patient journey	**Target**	**Aug 2024**	**Sep 2024**	**Oct 2024**
Number of admissions to adult facilities of patients who are under 16 years old	-	0	0	0
Crisis Assessment Unit (CAU) bed occupancy	-	100.5%	99.4%	97.3%
Crisis Assessment Unit (CAU) length of stay at discharge	-	41.25	61	28.5
Liaison In-Reach: attempted assessment within 24 hours	90.0%	74.5%	79.8%	84.5%
Bed Occupancy rates for (adult acute excluding PICU) inpatient services:	94.0% - 98.0%	100.3%	100.0%	99.8%
Becklin Ward 1 (Female)	-	104.7%	102.7%	102.1%
Becklin Ward 3 (Male)	-	98.9%	97.5%	98.5%
Becklin Ward 4 (Male)	-	99.0%	98.9%	100.4%
Becklin Ward 5 (Female)	-	99.0%	100.5%	99.0%
Newsam Ward 4 (Male)	-	99.7%	100.2%	99.1%
Older adult (total)	-	96.7%	94.6%	91.1%
The Mount Ward 1 (Male Dementia)	-	98.6%	103.8%	97.9%

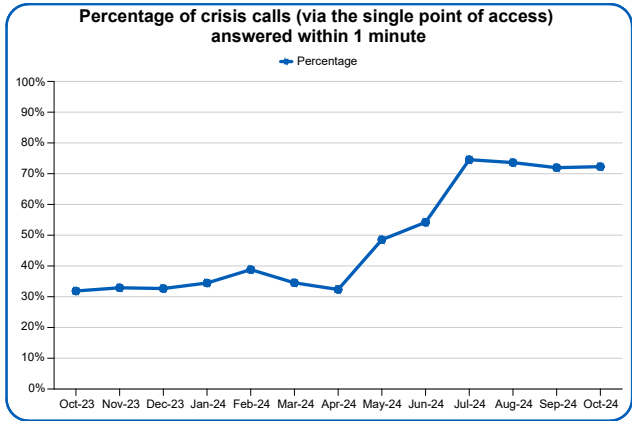
Service Performance - Chief Operating Officer

Services: Our acute patient journey	Target	Aug 2024	Sep 2024	Oct 2024
The Mount Ward 2 (Female Dementia)	-	91.8%	69.8%	74.4%
The Mount Ward 3 (Male)	-	95.6%	101.2%	90.3%
The Mount Ward 4 (Female)	-	99.8%	100.0%	99.2%
Percentage CRFD	-	37.2%	38.3%	39.7%
Out of Area Trajectory Active Placements at Month End	16	20	18	22
Total: Number of out of area placements beginning in month	-	12	11	13
Total: Total number of bed days out of area (new and existing placements from previous months)	-	533	557	604
Acute: Active Placements at Month End	-	15	14	19
Acute: Number of out of area placements beginning in month	-	8	7	9
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	421	429	453
PICU: Active Placements at Month End	-	5	4	3
PICU: Number of out of area placements beginning in month	-	3	4	4
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	104	128	151
Older people: Active Placements at Month End	-	0	0	0
Older people: Number of out of area placements beginning in month	-	1	0	0
Older people: Total number of bed days out of area (new & existing placements from previous months)	-	8	0	0
Cardiometabolic (physical health) assessments completed: Inpatients (quarterly)	80.0%	-	72.2%	-
Services: Our Community Care	**Target**	**Aug 2024**	**Sep 2024**	**Oct 2024**
Percentage of inpatients followed up within 3 days of discharge (Trust Level monthly local tracking)	80.0%	81.2%	76.5%	73.5%
Percentage of inpatients followed up within 3 days of discharge (HCP commissioned services only)	80.0%	85.5%	74.6%	75.3%
Number of service users in community mental health team care (caseload)	-	3,250	3,300	3,313
Percentage of referrals to memory services seen within 8 weeks (quarter to date)	70.0%	76.0%	76.8%	76.5%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50.0%	62.8%	59.4%	64.3%
Early intervention in psychosis (EIP) or at risk mental state (ARMS): Percentage starting treatment within 2 weeks	60.0%	53.3%	85.0%	55.0%
Early intervention in psychosis (EIP) : Percentage of people discharged to primary care (quarterly)	-	-	54.7%	-
Cardiometabolic (physical health) assessments completed: Early Intervention in Psychosis Service (quarterly)	80.0%	-	82.9%	-
Services: Clinical Record Keeping	**Target**	**Aug 2024**	**Sep 2024**	**Oct 2024**
Percentage of service users with NHS Number recorded	-	99.4%	99.3%	99.4%
Percentage of service users with ethnicity recorded	-	81.1%	81.2%	81.5%
Percentage of service users with sexual orientation recorded	-	46.5%	46.8%	46.8%
Services: Clinical Record Keeping - DQMI	**Target**	**May 2024**	**Jun 2024**	**Jul 2024**
DQMI (MHSDS) % Quality %	95.0%	89.2%	88.0%	90.5%

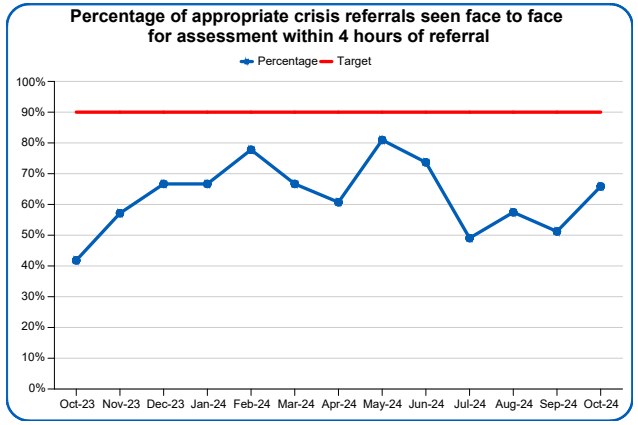
Services: Access & Responsiveness: Our Response in a crisis



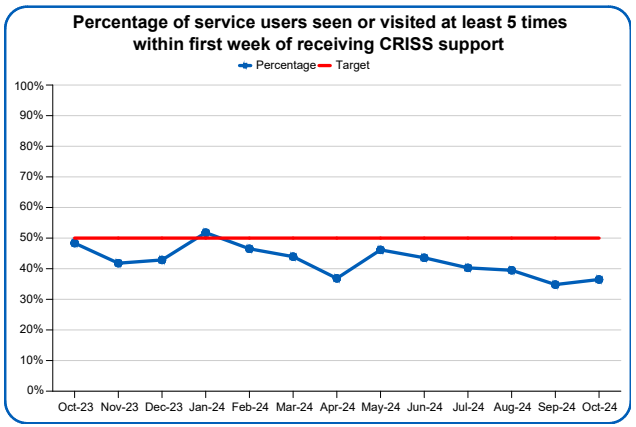
Number of calls : October 1,548



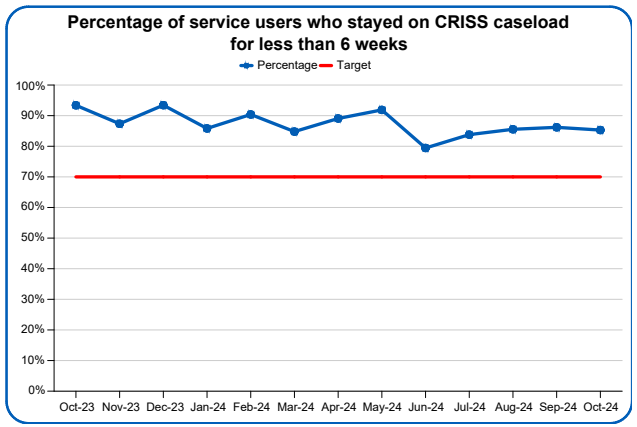
Local target - within 1 minute: October 72.3%



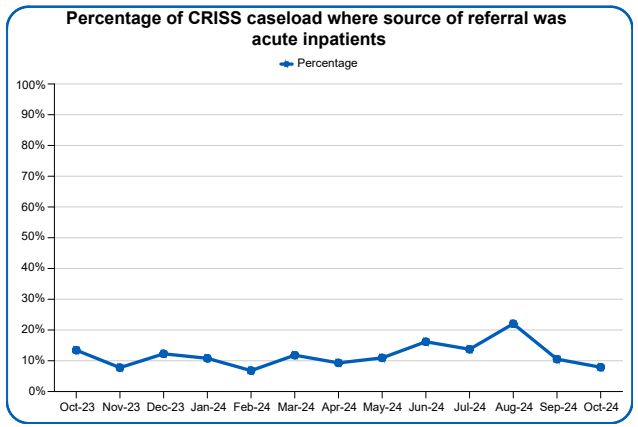
Contactual Target 90%: October 65.9%



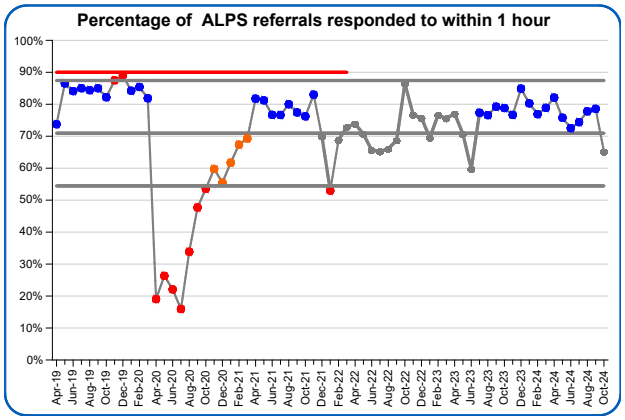
Contractual Target 50%: October 36.5%



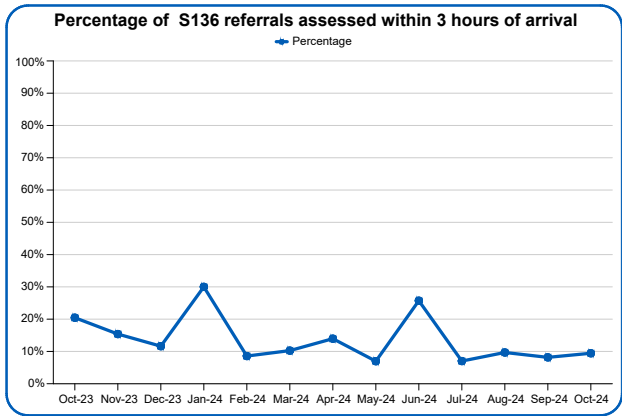
Contractual Target 70%: October 85.3%



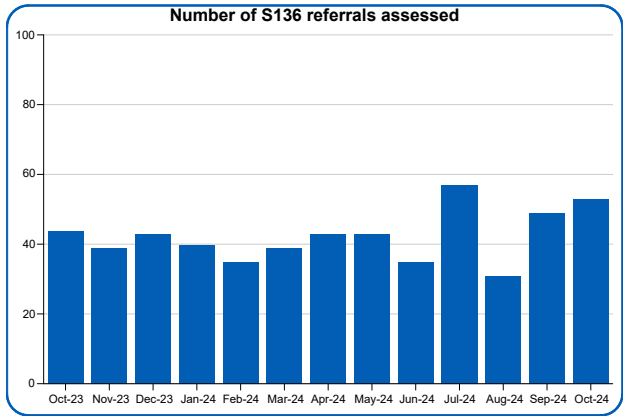
Contractual Target tba: October 7.9%



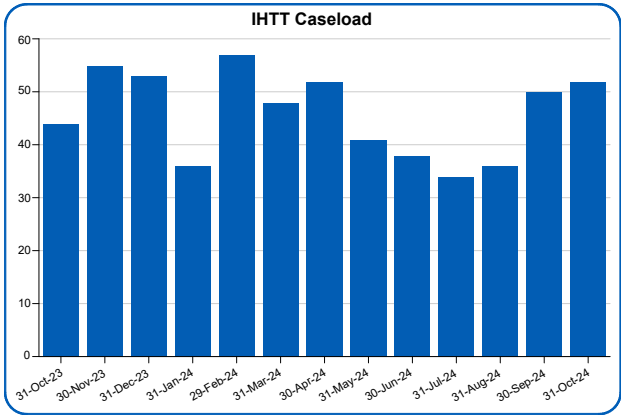
Contractual Target : October 65.2%



Contractual Target : October 9.4%

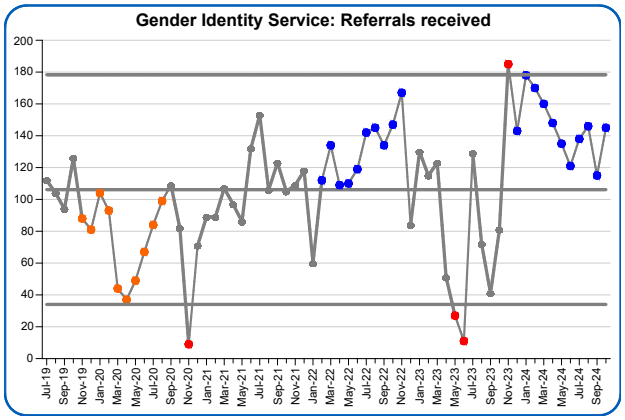


Total referrals assessed: October 53

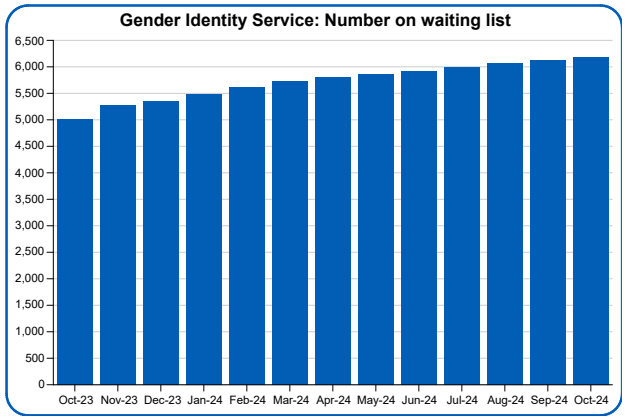


Caseload: October 52

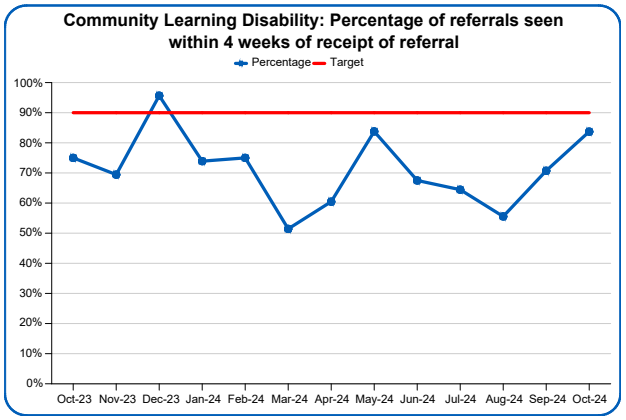
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services



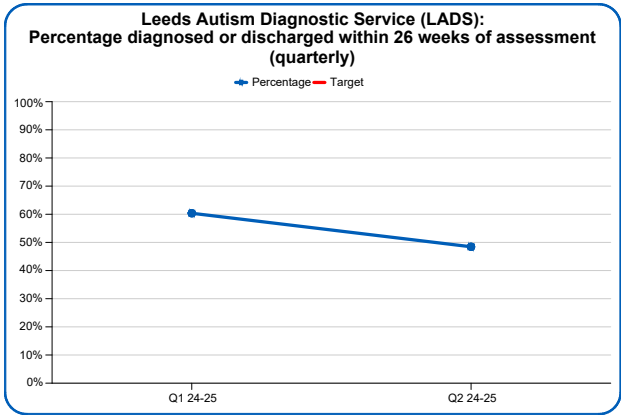
Total referrals: October 145



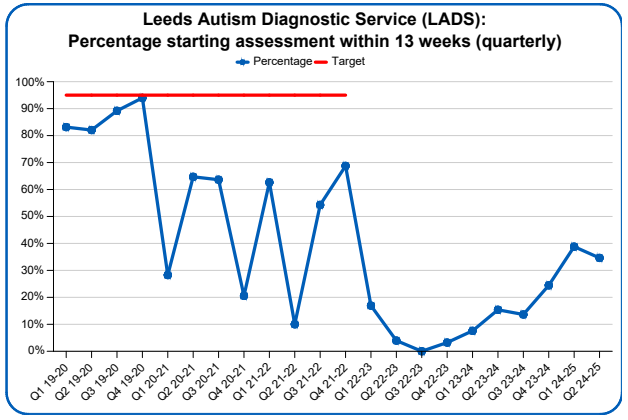
Number on waiting list: October 6,200



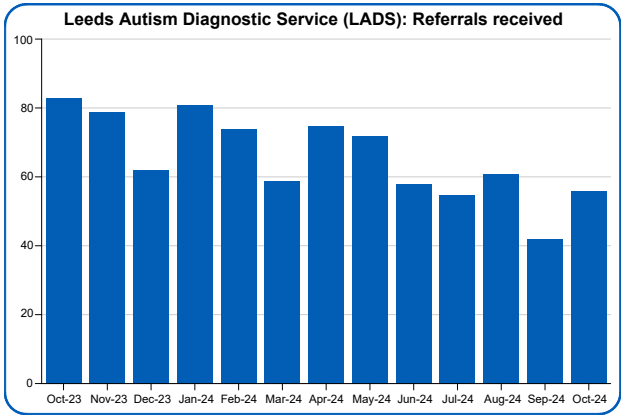
Contractual Target 90%: October 83.7%



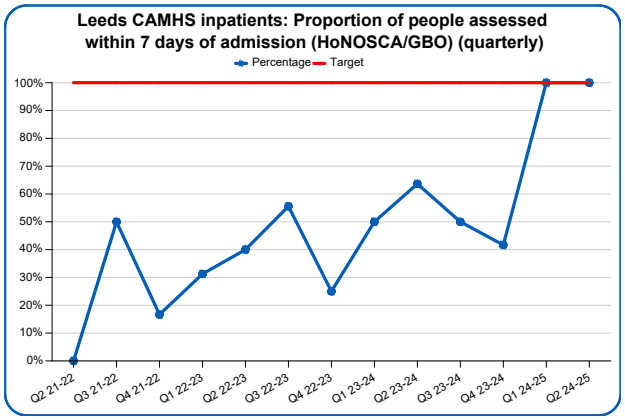
Contractual Target : Q2 48.5%



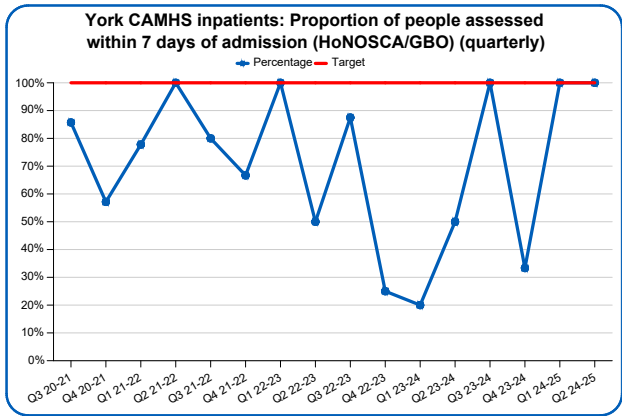
Contractual Target : Q2 34.6%



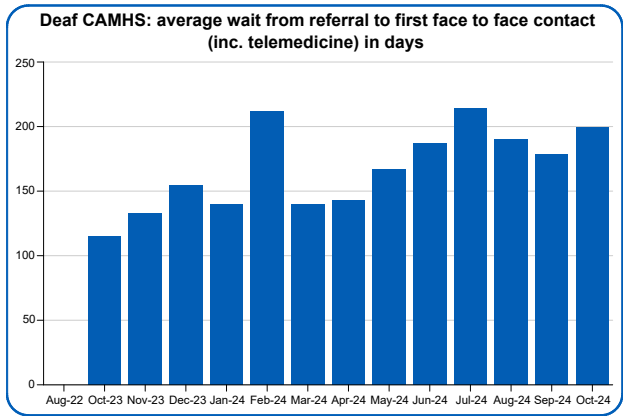
Local measure: October 56



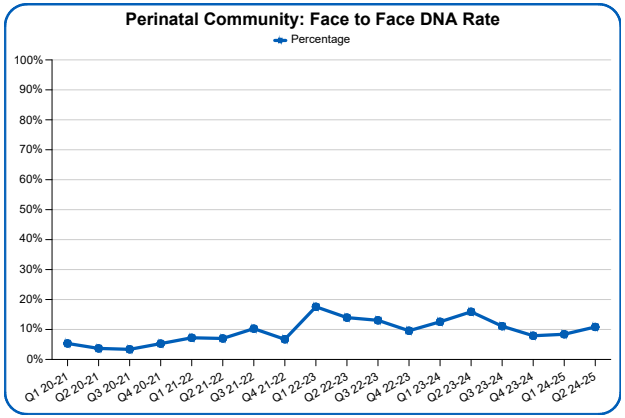
Contractual Target 100%: Q2 100.0%



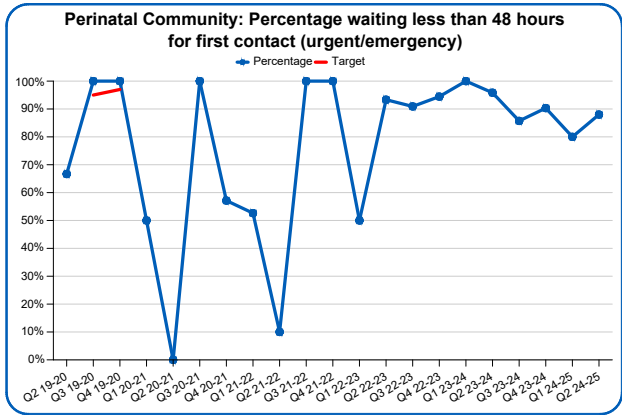
Contractual Target 100%: Q2 100.0%



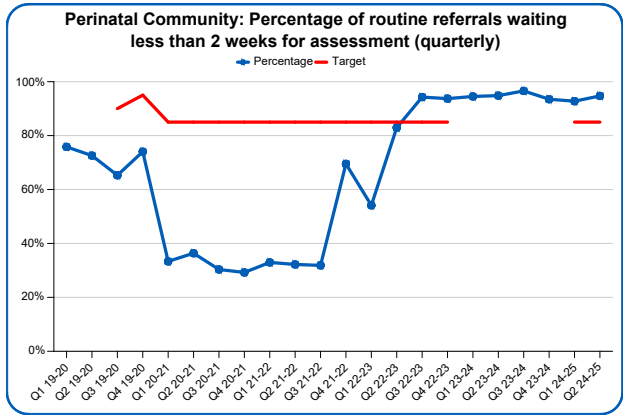
Local measure: October 200



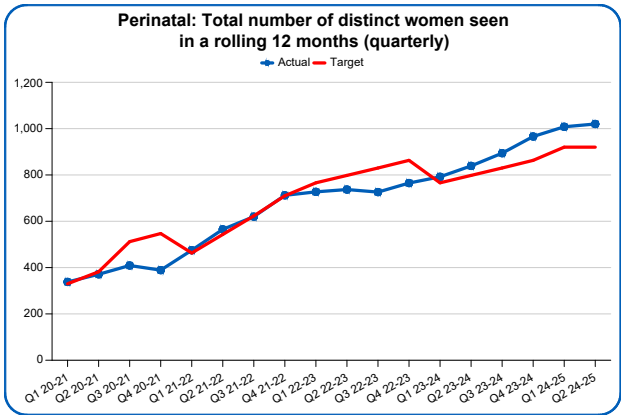
Contractual measure: Q2 10.8%



Contractual Target tba: Q2 88.0%

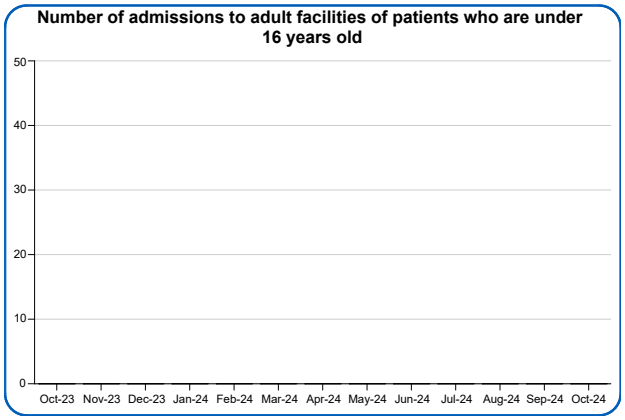


Contractual Target 85%: Q2 94.7%

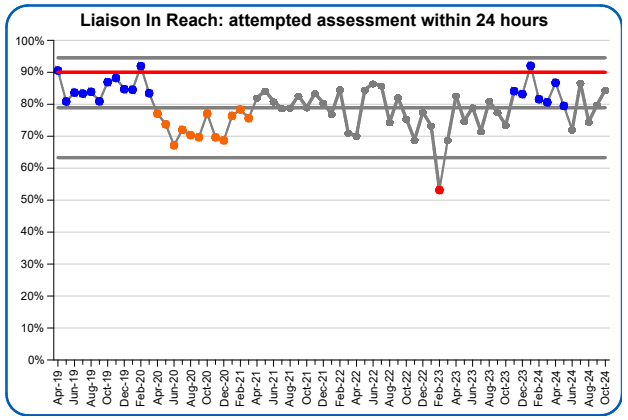


Local measure 920: Q2 1,020

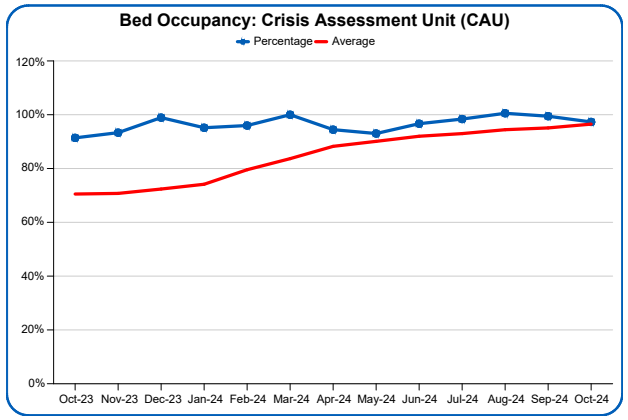
Services: Our acute patient journey



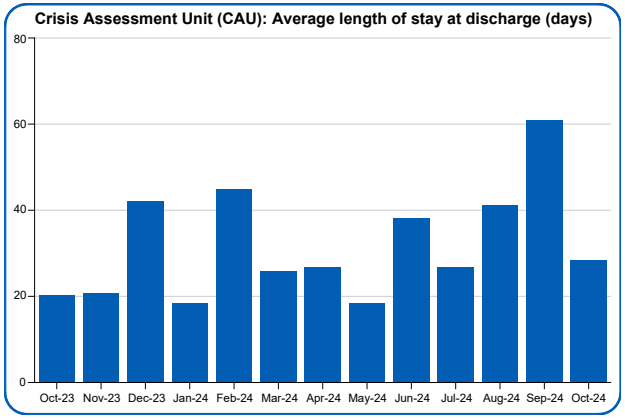
National (NOF) No target : October 0



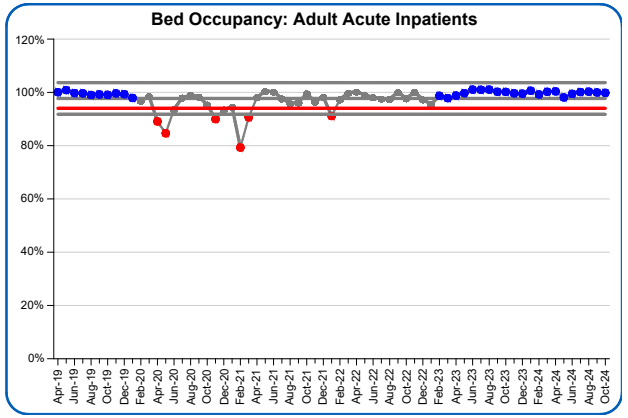
Contractual Target 90%: October 84.5%



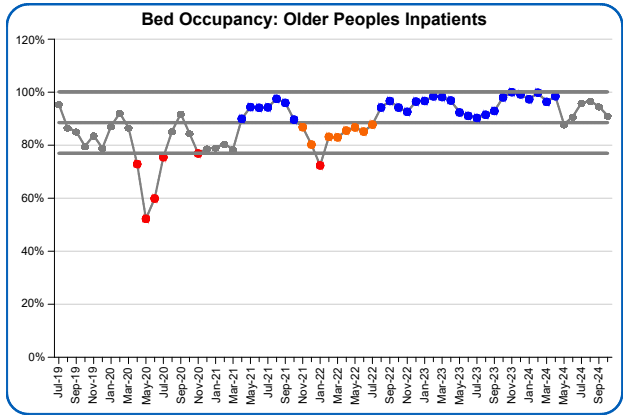
Local measure: October 97.3%



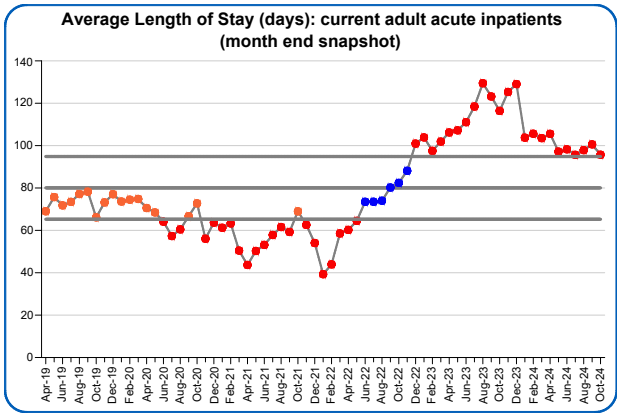
Local measure: October 28 days



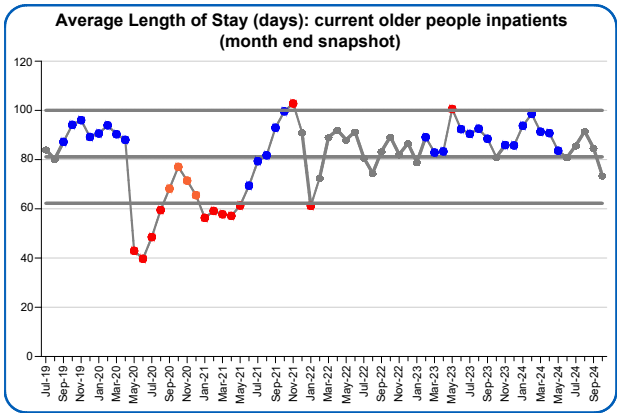
Contractual Target 94%: October 99.8%



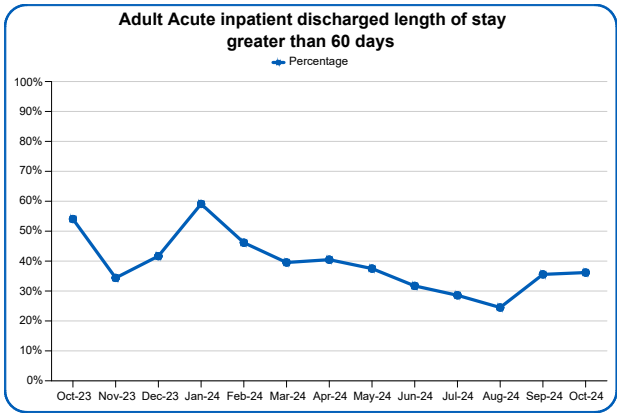
Local measure and target : October 91.1%



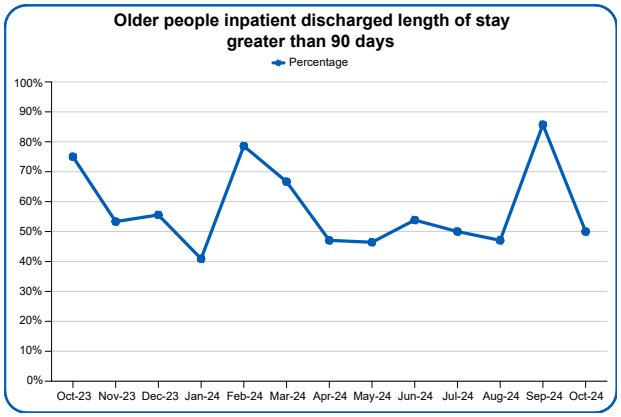
Local tracking measure: October 96 days



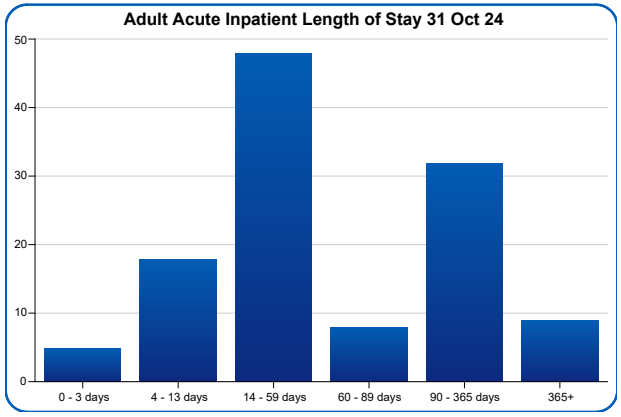
Local tracking measure: October 74 days



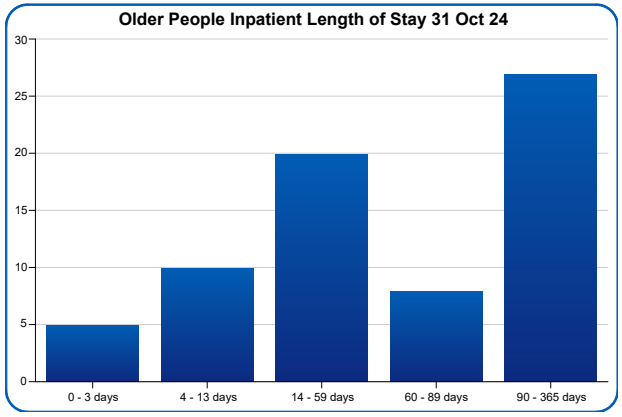
National (LTP): October 36.2%



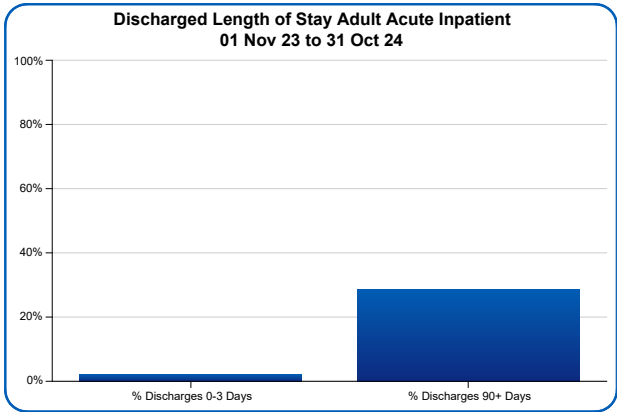
National (LTP): October 50.0%



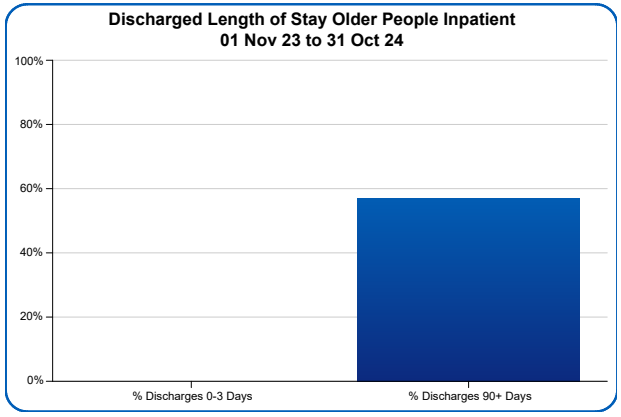
Local activity: 41 people with LOS 90+ days



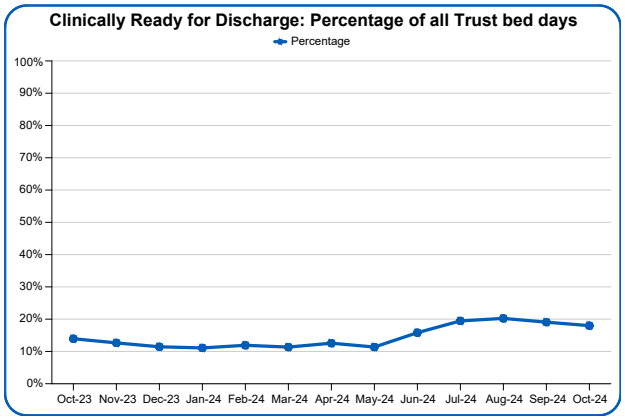
Local activity: 27 people with LOS 90+ days



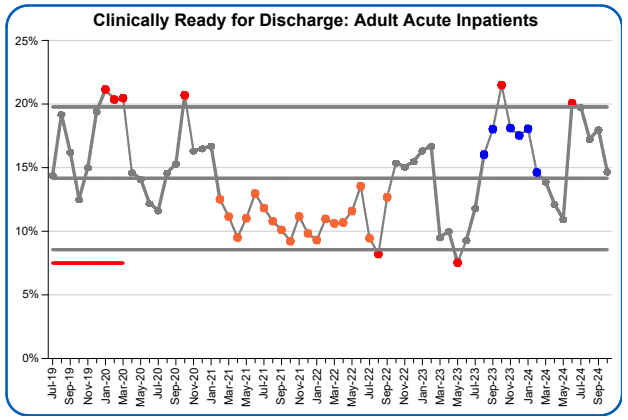
Local activity: % discharged LOS 90+ days = 28.9%



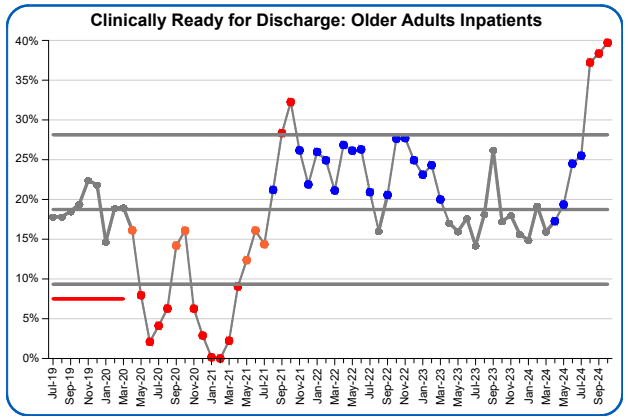
Local activity: % discharged LOS 90+ days = 57.2%



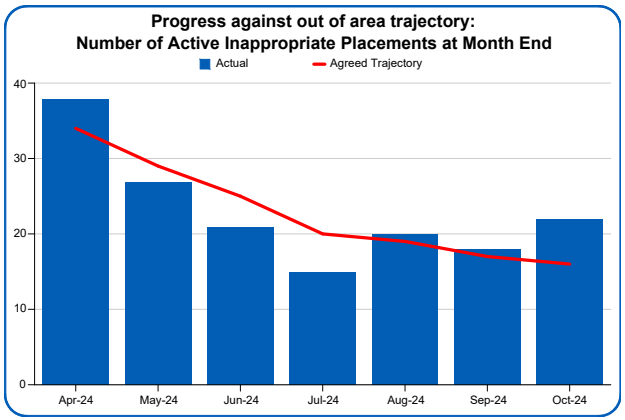
Local tracking measure: October 18.0%



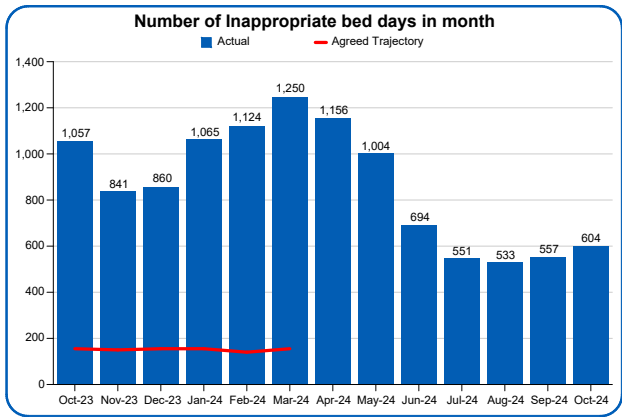
Local tracking measure: October 14.7%



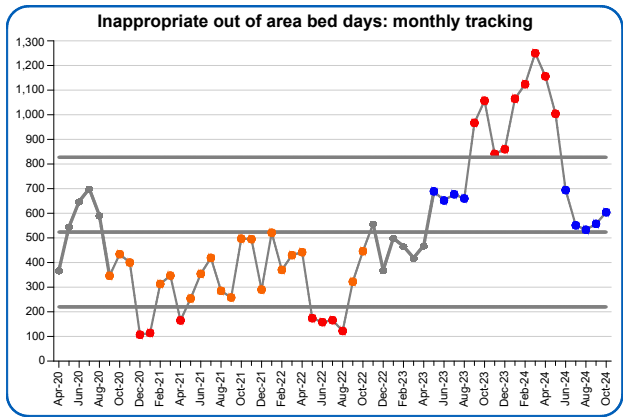
Local tracking measure: October 39.7%



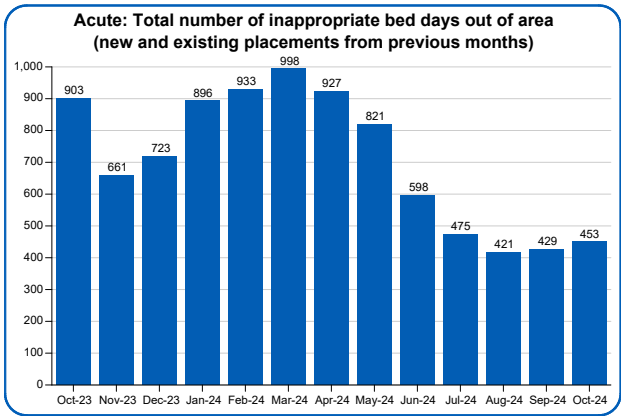
Nationally agreed trajectory (October: 16): October 22 active placements



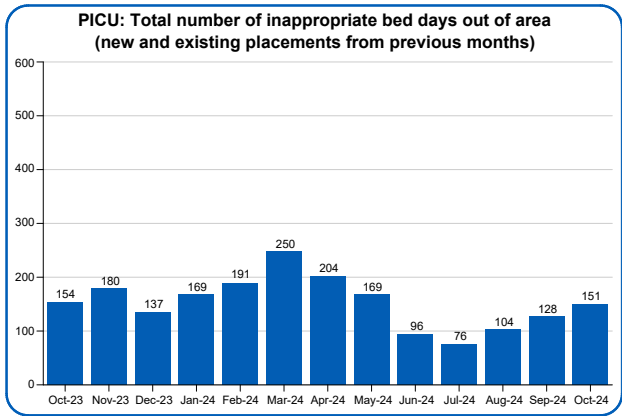
Local tracking measure: October 604 bed days



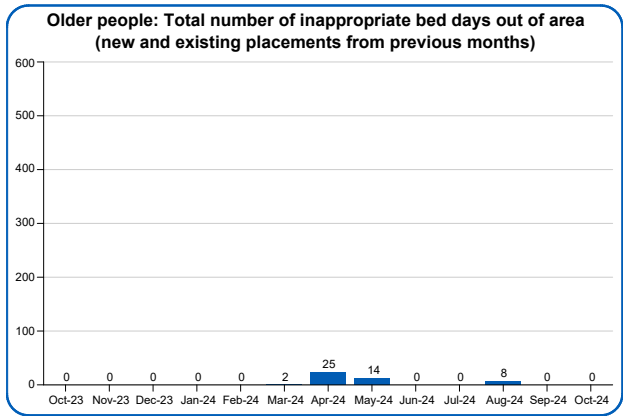
Local tracking measure: October 604 bed days



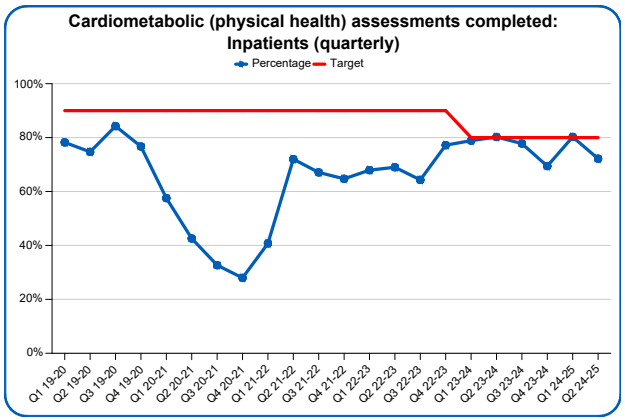
Nationally agreed trajectory (): October 453 days



Nationally agreed trajectory (): October 151 days

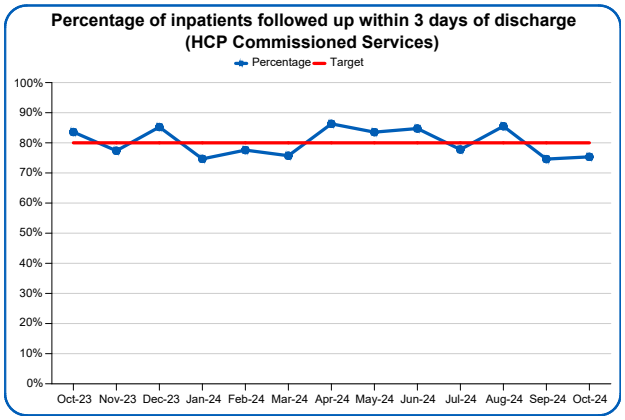


Local measure : October 0 days

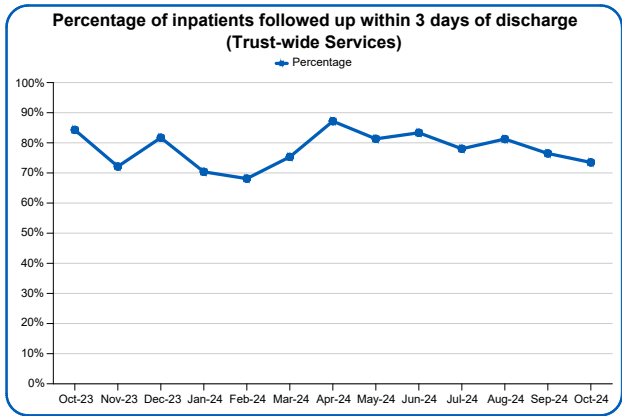


Contractual target 80%: Q2 72.2%

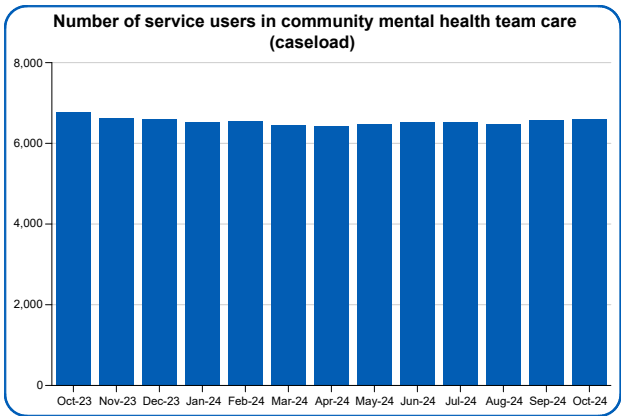
Services: Our community care



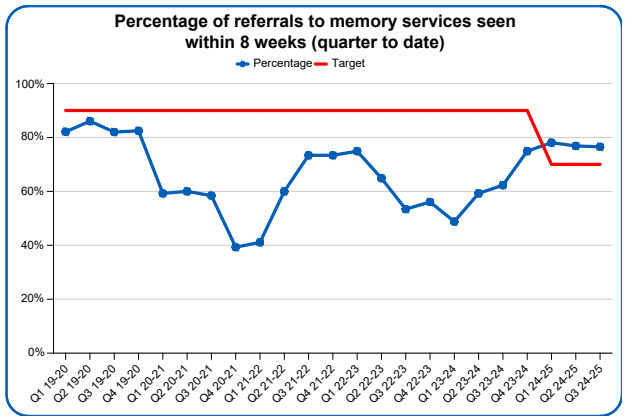
Contractual target 80%: October 75.3%



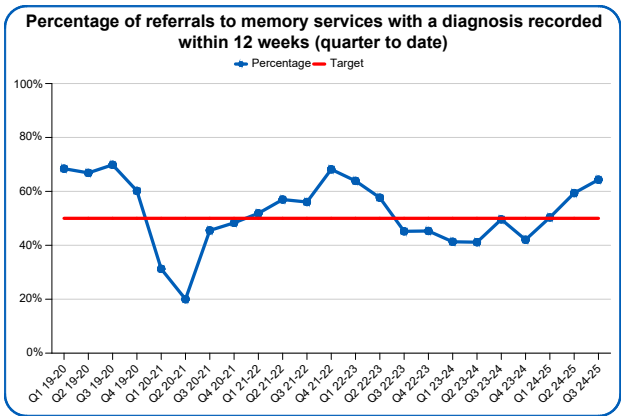
Local Tracking Measure 80%: October 73.5%



Local measure : October 3,225

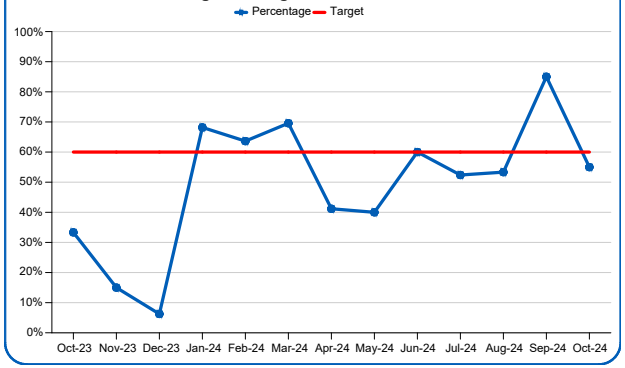


Contractual target 70%: Q3 24-25 76.5%



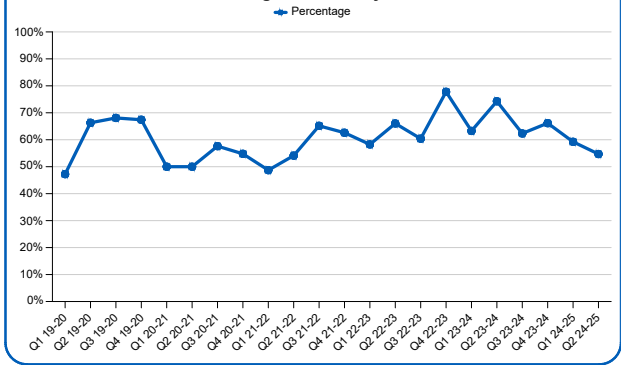
Contractual target 50%: Q3 24-25 64.3%

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



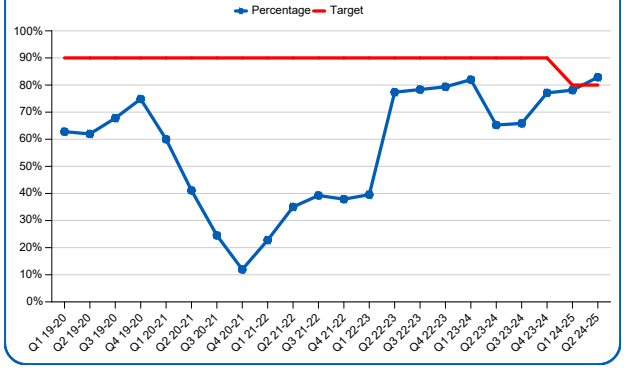
Contractual target 60%: October 55.0%

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



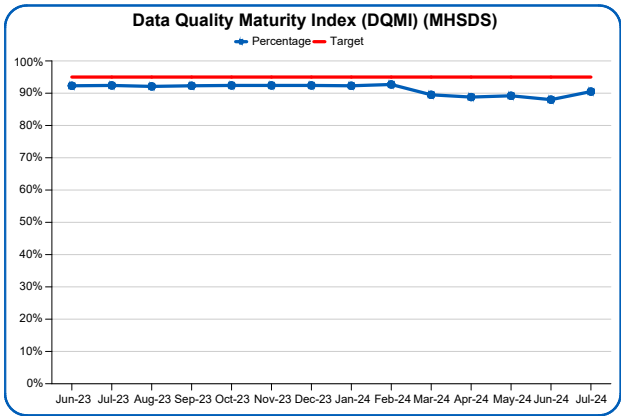
Contractual target tbc: Q2 54.7%

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

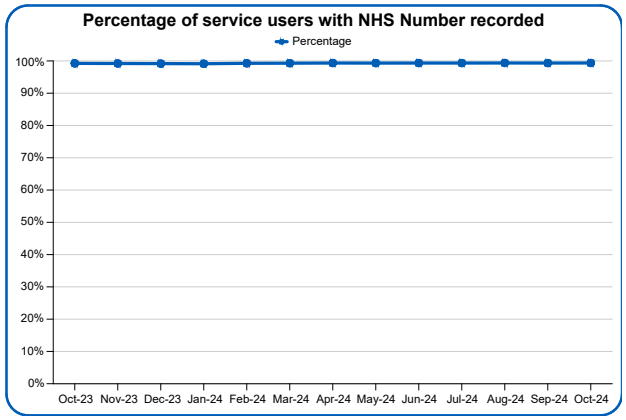


Contractual target 80%: Q2 82.9%

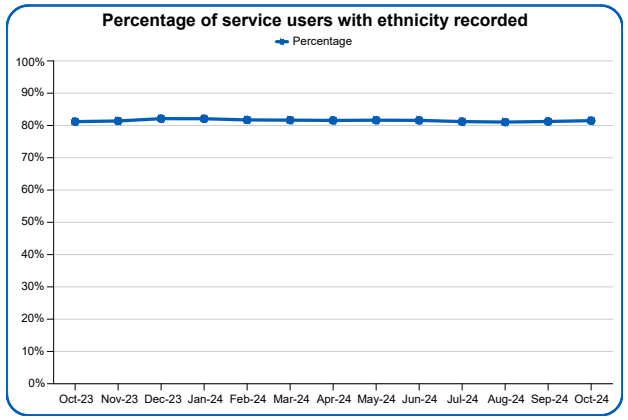
Services: Clinical Record Keeping



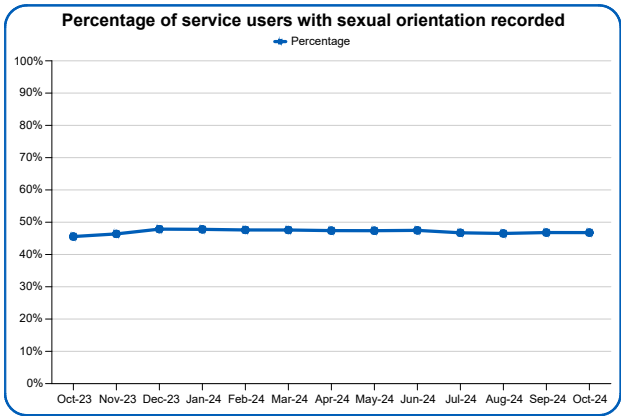
CQUIN / NHSOF Target 95%: July 90.5%



Local measure: October 99.4%



Local measure: October 81.5%



Local measure: October 46.8%

Glossary

Services: Access & Responsiveness: Our response in a crisis	
Percentage of crisis calls (via the single point of access) answered within 1 minute	Of all the telephone calls made to our crisis line that were answered, the proportion that were answered within 1 minute.
Percentage of ALPS referrals responded to within 1 hour	Of all the referrals from Accident & Emergency, to the Acute Liaison Psychiatry Service (ALPS) that were assessed, the proportion that were assessed within 1-hour.
Percentage of S136 referrals assessed within 3 hours of arrival	Of all the Section 136 (S136) referrals assessed, the proportion that were assessed within 3-hours of arrival at the Place of Safety
Number of S136 referrals assessed	The number of Section 136 (S136) referrals receiving their first face-to-face mental health assessment after they were detained under S136.
Number of S136 detentions over 24 hours	Number of Section 136 (S136) detentions that exceeded the 24-hour review period.
Percentage of appropriate crisis referrals seen face to face for assessment within 4 hours of referral	Of all the referrals receiving a face-to-face assessment following referral to the crisis service, the proportion that were assessed within 4-hours of referral.
Percentage of service users who stayed on CRISS caseload for less than 6 weeks	Of all the referrals discharged from Crisis Resolution or Intensive Support Service (CRISS), the proportion that had a length of referral of 6-weeks or less at the time of discharge.
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support	Of all the referrals discharged from Crisis Resolution or Intensive Support Service (CRISS) that were open for at least 7-days, the proportion that had at least 5 successful face-to-face contacts during the first 7-days of service involvement.
Percentage of CRISS caseload where source of referral was acute inpatients	Of all the referrals open to the Intensive Support Service (ISS) at the end of the period, the proportion that were an inpatient at the time of referral.
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services	
Gender Identity Service: Number on waiting list	The number of referrals open at the end of the period where the service user was waiting for an assessment
Deaf CAMHS: average wait from referral to first face to face (inc. telemedicine) contact in days	For all the referrals in Deaf Child and Adolescent Mental Health Services (CAMHS) receiving their first face-to-face or video contact during the period, the average number of days between referral and the first contact.
Community LD: Percentage of referrals seen within 4 weeks of receipt of referral	Of all the referrals to a Community Learning Disability Team that received their first attended, direct contact in the period, the proportion where the contact took place within 28-days of referral.
Leeds Autism Diagnostic Service (LADS): Percentage starting assessment within 13 weeks (quarterly)	Of all the Leeds Autism Diagnostic Service (LADS) referrals receiving their first direct, attended assessment taking place face-to-face or by video, with an 'Autism Assessment' intervention recorded as part of the contact in the period, the proportion where the assessment took place within 91-days of referral.
CAMHS inpatients: Proportion of people assessed within 7 days of admission (HoNOSCA / GBO) (quarterly)	Of all the admissions to a Child and Adolescent Mental Health Services (CAMHS) ward that received either a Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) or Goal Based Outcomes (GBO) assessment, the proportion where either assessment took place within 7-days of admission.
Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency) (quarterly)	Of all the referrals to the Perinatal Community service with an 'Emergency' or 'Urgent' referral priority that received a first direct, attended contact in the period, the proportion where the contact took place within 48-hours of referral.
Perinatal Community: Percentage of routine referrals waiting less than 2 weeks for assessment (quarterly)	Of all the referrals to the Perinatal Community service with a 'Routine' referral priority that received a first direct, attended face-to-face or video contact in the period, the proportion where the contact took place within 14-days of referral.
Perinatal Community: Total number of distinct women seen in rolling 12 months (quarterly)	The total number of women with a direct, attended, face-to-face or video contact, during the 12-months ending in the period; women seen multiple times are counted once.
Perinatal Community: Face to Face DNA Rate (quarterly)	Of all the face-to-face, attended and did not attend (DNA), contacts with the Perinatal Community Team in the period, the proportion of face-to-face contacts that the service user did not attend.

Services: Our acute patient journey	
Number of admissions to adult facilities of patients who are under 16 years old	Number of admissions to inpatient services, excluding Child and Adolescent Mental Health Services (CAMHS), where the service user was aged under 16 on the day of admission.
Crisis Assessment Unit (CAU) bed occupancy	Of the total number of available beds on the ward and the number of days each bed was available, the proportion of those days where a bed was occupied. For example, on a 10-bed ward in the month of April where no beds were unavailable due to maintenance/repairs, etc., there are 300 available bed days. Where there were service users in beds for 150 of those days, this would result in 50% occupancy.
Crisis Assessment Unit (CAU) length of stay at discharge	For all the discharges from the Crisis Assessment Unit in the period, the average number of days each service user stayed on the ward.
Liaison In-Reach: attempted assessment within 24 hours	Of all the service users assessed by Hospital Mental Health Inreach following referral from Leeds Teaching Hospitals Trust (LTHT), the proportion that were assessed within 24-hours of referral.
Bed Occupancy rates for (adult acute excluding PICU) inpatient services:	Of the total number of beds available in the period on Adult Acute wards, excluding Psychiatric Intensive Care Unit (PICU), the proportion where a service user was occupying the bed.
Bed Occupancy rates for individual wards (multiple measures)	Of the total number of beds available in the period on the ward, the proportion where a service user was occupying the bed, including any leave days.
Percentage of CRFD	Of the total number of occupied bed days in the period, the proportion where the service user was ready for discharge from inpatient care.
Out of Area Trajectory Active Placements at Month End (multiple measures)	The total number of out of area placements active at the end of the period, where the placement was not the result of patient choice e.g. where a staff member needed inpatient care.
Total: Number of out of area placements beginning in month (multiple measures)	The total number of all out of area placements that begin during the period.
Total: Total number of bed days out of area (new and existing placements from previous months) (multiple measures)	The total number of occupied bed days that take place as part of an out of area placement during the period, regardless of whether the placement started during or before the period.
Cardiometabolic (physical health) assessments completed: Inpatients (quarterly)	Of the number of service user on a ward at the end of the period, the proportion with all elements of the cardiometabolic assessment completed within the same admission, and during the previous 12-months.
Services: Our Community Care	
Percentage of inpatients followed up within 3 days of discharge (Trust Level monthly local tracking)	Of all discharges from Trust inpatient services, the proportion where the service user received a direct, attended, face-to-face, video or telephone contact within 3-days of discharge (excluding day of discharge).
Percentage of inpatients followed up within 3 days of discharge (HCP commissioned services only)	Of all discharges from Trust Leeds Healthcare Partnership (HCP) commissioned inpatient services, the proportion where the service user received a direct, attended, face-to-face, video or telephone contact within 3-days of discharge (excluding day of discharge).
Number of service users in community mental health team care (caseload)	Number of service users allocated to a named member of staff in an Adult or Older People's community team at the end of the period (waiting list allocations are excluded).
Percentage of referrals to memory services seen within 8 weeks (quarter to date)	Of the number of service users referred to the Memory Assessment Service (MAS) from an external source that do not have a prior Dementia diagnosis, that receive a first direct, attended face-to-face or video contact, the proportion that receive the first contact within 8-weeks of referral.
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	Of all the referrals where the service user receives a Dementia diagnosis in the period, the proportion where the diagnosis was given within 12-weeks of referral.
Early intervention in psychosis (EIP) or at risk mental state (ARMS): Percentage starting treatment within 2 weeks	Of the referrals where a care coordinator allocation starts in the period, or the first direct, attended, face-to-face, video or telephone contact in the referral took place in the period, the proportion where the latest of these two events, took place within 14-days of referral.
Early intervention in psychosis (EIP) : Percentage of people discharged to primary care (quarterly)	Of all the referrals discharged from the Early Intervention in Psychosis service in the period, the proportion where the service user was referred back to Primary Care.
Cardiometabolic (physical health) assessments completed: Early Intervention in Psychosis Service (quarterly)	Of the total number of referrals open to the Early Intervention in Psychosis (EIP) service with a care coordinator allocation active at the end of the period, the proportion with all elements of the cardiometabolic assessment completed during the previous 12-months.

Services: Clinical Record Keeping	
Percentage of service users with NHS Number recorded	Of all the referrals open during the period, the proportion where the service user's NHS number is recorded on their CareDirector record.
Percentage of service users with ethnicity recorded	Of all the referrals open during the period, the proportion where the service user's ethnicity is recorded on their CareDirector record. Where a service user declines to provide an answer, this is counted as complete; however, any ethnicity recorded as 'Unknown' is not counted as complete.
Percentage of service users with sexual orientation recorded	Of all the referrals open during the period, the proportion where the service user's sexual orientation is recorded on their CareDirector record. Where a service user declines to provide an answer or their sexual orientation is recorded as 'Unknown', this is counted as incomplete.
Services: Clinical Record Keeping - DQMI	
DQMI (MHSDS) % Quality %	The Data Quality Maturity Index (DQMI), is a weighted score based on the completeness and quality of several fields in the Trust's Mental Health Services Dataset (MHSDS) submissions to NHS Digital. The score is derived by NHS Digital from the MHSDS submission and published on their website 3-4 months later.

Winter Resilience and Operating Plan

2024/2025

Contents

1. Introduction

The purpose of the Winter Resilience and Operating Plan is to set out the approach that Leeds and York Partnership NHS Foundation Trust (the Trust) will take to maintaining service provision and minimising disruption during the winter of 2024/25.

During winter 2024/25 Systems will be expected to maximise opportunities to continue to support the NHS recovery programme whilst also ensuring continued application of the UK Infection Prevention and Control guidance to prevent and control infection, and to respond to additional demands and pressures as they arise.

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

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

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

1.1 Operating Principles

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

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

1.2 Legislative and Contractual Framework

The development of the LYPFT Winter Resilience Plan 2024/25 has included reference to several additional national guidance documents, including:

- West Yorkshire ICS Strategic Coordinating Group Winter Plan 2024/25
- Leeds System Winter Plan 2024/25
- Managing capacity & demand within inpatient and community mental health, learning disabilities and autism services for all ages (NHS England & NHS Improvement)
- The NHS People Plan
- NHS Mental Health Implementation Plan 19/20-23/24
- Mental Health Transformation Programme; Covid-19 Priorities & Next Steps
- Advancing Mental Health Equalities Strategy.

1.3 Addressing Health Inequalities

Adverse cold weather can put people already experiencing health inequalities at greater risk of ill-health and even death, primarily because it increases the probability of complications from existing disease, and of injury due to falls.

You can reduce the risks associated with exposure to adverse cold weather for those you care for by:

- knowing who is at risk
- being alert to increased cardiovascular, respiratory and other complications from cold exposure
- adapting individual care plans to respond to adverse cold weather
- promoting vaccination for those eligible to reduce risks from COVID-19 and flu
- having action plans in place for your organisation and/or place of work tailored to the local context
- signposting people to sources of support for housing, energy bills and other needs as appropriate, including specific support for those on low incomes

We know fuel poverty is a long-standing health issue: the impact of cold housing on health and the stresses brought on by living in fuel poverty have been recognised for decades by researchers, medical professionals and policy makers alike. Cold housing and fuel poverty can be successfully tackled through policies and interventions if there is a will to do so.

There is a social gradient in fuel poverty: the lower your income the more likely you are to be at risk of fuel poverty. Inequalities that are avoidable are fundamentally unfair, fuel poverty is avoidable, and it contributes to social and health inequalities. Fuel poverty is a longstanding council priority and aligns strongly with the Leeds Best City aim of tackling poverty and reducing inequalities.

Any increase in fuel poverty is concerning, but this issue has recently been amplified due to increases to energy bills and a rise in the cost of living more generally. This has been described as a ‘cost of living crisis’ by think tanks expressing alarm at energy prices and other inflationary pressures, alongside tax rises and benefit reductions that have either been recently introduced or are due to take effect this year.

To compound this issue, we know that British homes are some of the least energy-efficient in Europe, making them harder to keep at a comfortable temperature and more expensive to heat or cool. For example, fewer than half of Leeds’s privately rented or privately owned homes achieved a ‘C’ grade (or better) for their energy-efficiency rating in 2021.

Councils have launched schemes to help residents cut energy bills and homeowners, renters, and landlords of properties without gas central heating can now get energy saving green measures installed free of charge or at a significant discount, thanks to a new Council scheme.

There are many organisations that offer free, impartial and confidential help and advice with all types of debt including rent arrears, council tax and utilities. Many also offer help with other money problems such as benefit issues and budgeting and can be found here: https://www.leeds.gov.uk/leedsmic/energy-fuel-and-food/energy-utility-and-household-bills

If you are working with people experiencing fuel or poverty emergency or crisis, you can apply for support with food, energy and essential household items through the Councils Local Welfare Support Scheme. The Leeds City Council one can be found here: https://www.leeds.gov.uk/benefits/local-welfare-support-scheme , City of York Council can be found here: https://www.york.gov.uk/news/article/1526/new-energy-efficiency-grants-for-homes-not-heated-by-mains-gas .

You can also access Supporting vulnerable people before and during cold weather: healthcare professionals - GOV.UK (www.gov.uk) with action cards. (There are also the same for hot weather).

During cold weather, people may also use malfunctioning or inappropriate appliances to heat their homes. This can increase the risk of carbon monoxide poisoning. When a house is damp as well as cold, mould is more likely to occur. This can increase the risk of illness, especially from asthma.

Further information on who is at risk from cold and why can be found in the AWHP supporting evidence document.

1.4 Where we are now? Current Service Provision & Prioritisation

As described above, services have continued to adapt their method of delivery over the past couple of years, with our services now operating a hybrid model of face to face and virtual clinical activity. Service leaders have supported this by developing detailed updated working instructions so that staff have clarity in order to support their work. Where services have identified issues in relation to backlog and/or waiting lists, work has been undertaken to plan to address these issues, supported where possible by detailed activity plans.

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

Throughout 2024 thus far we have seen significant disruption due to Industrial Action, due to the BMA action relating to Junior Doctors and Consultants. This disruption has been unprecedented and has had an impact to service provision to a greater or lesser degree within services. We are confident that parties have been able to reach an agreement that has put an end to IA however we are facing further action from GPs and we anticipate that this will have an impact on service delivery should it continue through the winter period.

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

1.5 Service Prioritisation: Critical Services

As set out in our 21/22, 22/23 and 23/24 Winter Plans, we previously established and agreed a process of service prioritisation as part of our EPRR business continuity approach. This identifies which services are an essential priority and required to be maintained at full capacity at all times. This will influence our decisions around the use / deployment of resources throughout the winter period. Three levels of priority have been agreed as below:

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

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

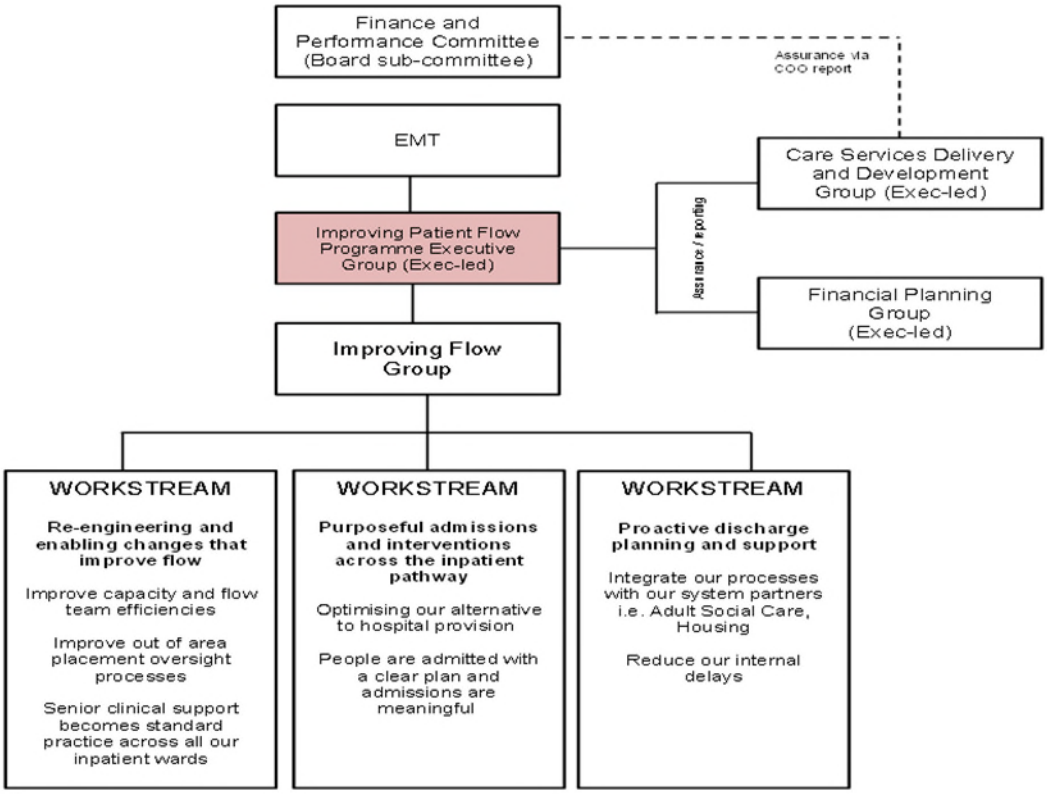
A full list of services and their priority can be found at *Appendix A.*

1.6 Maintaining Flow and Meeting Demand

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

The Improving Flow programme has now been established and 3 workstreams have been agreed on and leads have been 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.

Image 1: Improving Flow Governance Structure.



As well as the three workstreams detailed above, we have also identified several key tasks that would support the flow programme:

- **Digital Change to track flow**: We continue to work with the Digital Change Team and a new dashboard has been created where can monitor and manage flow on Care Director. However, further work in ongoing with the clinical team ensure that we capture the data required that populates the dashboard.
- **Embed Clinically Ready for Discharge (CRfD):** CRfD module has now been implemented with our clinical teams and we are monitoring the performance of this through our Governance meetings and the Improving flow programme group.
- **Completion of the Gatekeeping Review:** The gatekeeping review in the Acute Service Line has been completed with the aim to start testing the alternatives to hospital decision making matrix that has been developed when CRISS gatekeep referrals for admission. Once tested over a 2 month period, we aim to finalise the process.
- **Options appraisal for the Capacity and Flow Teams:** We are planning development sessions with the Capacity and Flow Teams for October with the aim of developing an

options appraisal for how our capacity and flow teams across the Trust will operate going forward.

We have met with NHSE and ICB colleagues to discuss the challenges faced which have resulted in some long delays for admissions including those in the Emergency department within LTHT. This will be a key area of focus for NHSE, ICB and system colleagues over winter 2024/25. We are preparing how we monitor and respond proportionately to inappropriate waits for people in A and E (awaiting transfer to Acute and Older Adult inpatient beds).

We will also ensure that our community-based services maintain the same level of service that meets the needs of service users throughout the winter period, particularly the holiday season. We do not expect any service to close for any period of time during this period.

1.7 Activity and Performance Management

During 2024 services have continued to receive and review activity data, with increasing access to performance dashboards. We have re-established more regular formalised governance relative to performance and activity via our CSDDG and through reinstating our Quality, Delivery and Performance (QDaP) reviews for each service line, led jointly the Deputy Director of Operations. We have also maintained our ‘heat map’ approach for all service lines which is reviewed regularly via a weekly Operational Huddle and highlights area of particular concern or challenge to maintaining service delivery and business continuity.

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

1.8 Service Line Assurance Report

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

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

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

The report template is attached at *Appendix B.*

1.9 Maintaining Safe Staffing

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

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

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

Our aim during the Winter period is to minimise movement of staff between services, recognising that this is disruptive for both staff and service users. Within the last 3 years we have introduced a dedicated ‘responsive workforce’ team who are able to be deployed at pace to areas of emerging or actual staffing pressures.

Staffing pressures have however remained constant (at varying degrees) throughout 2024 – due to periods of increased unavailability of staff, high rates of vacancies and some sustained levels of demand for additional staff in priority services because of service user presentation and acuity. These are now predominantly dealt with through ‘internal’

deployment of staff within the service line (for example, practice development staff or senior clinical staff working directly within the clinical settings), cancelling non-essential activities, or through the ‘day to day’ deployment of staff from one area to another (as set out in the Trust Staffing Escalation Protocol).

Where services are required to move to a period of formal Business Continuity due to sustained staffing pressures - or where levels of activity & demand create pressures that result in an increasing OPEL position - services will enact their business continuity plans and associated OPEL actions. This would also include reviewing the Level 1 on call (CSM on call) arrangements with a view to Heads of Operations mobbing to 7 day working as we did during the Covid Pandemic.

These will include:

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

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

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

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

1.10 Focus on Workforce

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

- **Looking after our people** – with quality health and wellbeing support for everyone
- **Belonging in the NHS** – with a particular focus on tackling inequalities and the discrimination that some staff face
- **New ways of working and delivering care** – making effective use of the full range of our people's skills and experience
- **Growing for the future** – how we recruit and keep our people, and welcome back colleagues who want to return

These areas have influenced and been reflected in our ways of working over the last 3 years and are reflected within our 2024/25 Winter Plan. Our trust People Plan, first published in 2021 and has recently been reviewed and updated 2024-27 following extensive staff engagement and outlines the objectives and action plans aligned with the national People Plan, ensuring that over the next three years we can be confident that we are focusing our efforts in areas that will make the greatest impact.

Workforce is identified as the key risk to every aspect of our system and local winter plans. In relation to the Winter Resilience plan, there is a specific focus on 2 key areas – staff health & wellbeing, and different ways of working to most effectively deploy staff to meet service user need and maintain the continuity of our priority services. Our plans very much reflect the most recent national NHS guidance and advice in relation to preparation for Winter 2024/25 and demand surge, which focus on:

- Provision of Health and Wellbeing Support
- Focus on flu and covid vaccination
- Effective forward planning of deployment and rosters

- Recruitment and retention initiatives to grow, develop and upskill the workforce
- Promotion of resilience and increased flexible working arrangements

1.10.1 Staff Wellbeing

The wellbeing of our staff is our priority, and the objectives set out in Our People Plan ensures staff are being supported to feel safe, healthy and well both physically and psychologically. The Health and Wellbeing Steering Group oversees and coordinates our approach to staff wellbeing and reports through the People and Organisational Development (POD) governance, and bimonthly to our Wellbeing Guardian (Non-Executive Director) at Workforce Committee.

As part of colleagues annual Performance Development Review (PDR) they should maintain an individual Wellbeing Assessment, these are further supported by the Wellbeing Agreement which is completed by staff seeking further health and wellbeing support as a result of a change in their health and wellbeing and/or the diagnosis of a disability, a long-term condition or illness. It can also be following a change to a pre-existing condition.

The extensive health and wellbeing offer to staff is regularly communicated through the monthly wellbeing Wednesday newsletter and hosted on the Staffnet pages, this provision includes rapid access to services such as stress, anxiety and burnout therapy, counselling, physiotherapy, cognitive behaviour therapy (CBT) and our occupational health service.

The health and wellbeing team are available to support any teams or service that are under particular pressure through programme such as CRiSSP, Ward Wellbeing Buddies, Health and Wellbeing Champion network and the Welfare Officer.

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

1.11 System level winter arrangements

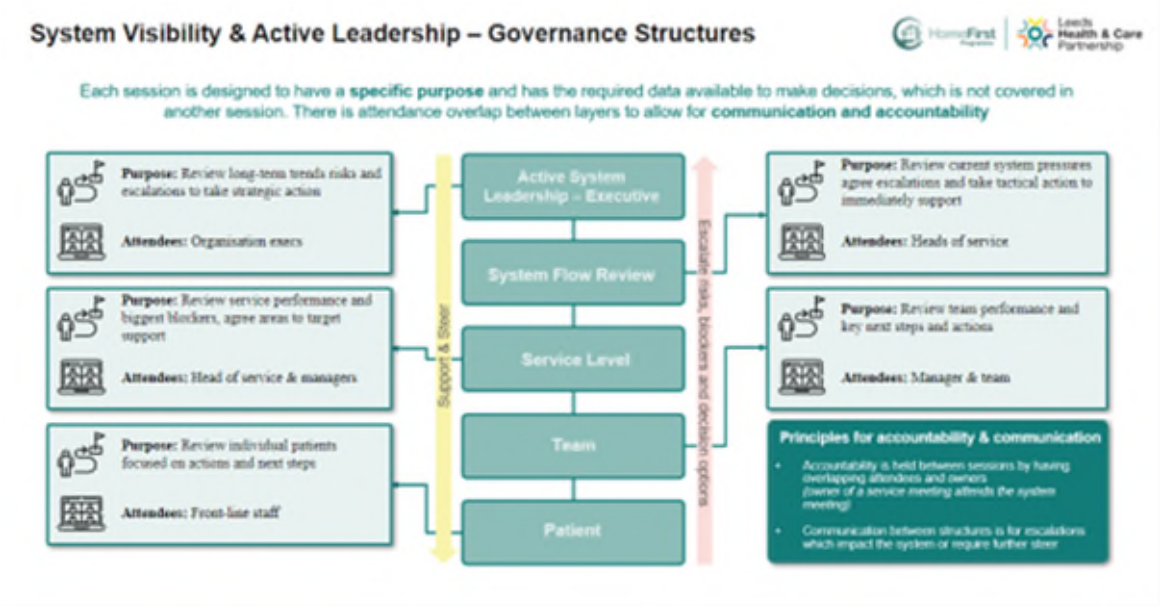
To support the oversight and management of risks over this winter, new Operational Pressures Escalation Level (OPEL) frameworks are being introduced (Community and Mental Health) and the Acute framework in place during winter 23/24 has been reviewed and refreshed. The West Yorkshire System Coordination Centre (SCC) remains, providing

clarity on the governance structures that support patient access. The SCC is a central co-ordination service to providers of care across the ICB footprint, with the aim to support patient access to the safest and best quality of care possible.

The Leeds health and care system will continue to maintain a system OPEL that reflects the wider system pressure and supports system leaders to balance risks.

The Leeds system governance structure for winter 2024/25 has been revised and includes;

- Active System Leadership (listed as System Flow Review in below system governance structure) - fortnightly and as required
- System Resilience Operational Group – stood up as required



We are an integral part of these groups, and there are comprehensive plans and actions specific to mental health within these. The details of the Leeds System Winter Plan are yet to be finalised, we are expecting this to be available by the end of September 2024.

Within the Same Day Response Programme, priority mental health actions relate to

- Increasing capacity within our CRISS service to ensure timely access to mental health services in a crisis

- Ensuring smooth transition from points of access into mental health crisis services
- Increasing capacity of third sector crisis support services, promoting access alternatives to A&E

Within the System Flow Programme, we have specific priority actions relating to

- Ensuring an effective end to end process review for people with complex dementia (both within the Mount and within LTHT), aiming to reduce the number of people in beds with complex dementia who no longer require a hospital bed
- Promoting and embedding implementation of pathways for younger people with mental health and housing needs, who no longer require a hospital admission.

As part of our winter planning, we have set out the key mitigation actions and monitoring processes for each of our identified key risks as follows:

Identified Risk	Mitigation	Monitoring
High levels of staff unavailability as a result of illness / absence	• Daily monitoring and forecasting of staffing situation & absence • Robust planning, e-rostering and use of temporary staff • Increase in responsive workforce capacity • Identification of corporate / support staff able to support delivery • Deployment and redeployment process & plans in place • Group established to oversee deployment and staffing • Workforce governance structures in place	• Weekly service heat maps reviewed at ODG • Deployment and Staffing Group & Workforce Group reports to ODG / workforce structures

Identified Risk	Mitigation	Monitoring
Changes to national response to Covid pandemic requiring further rapid change to service delivery	• Incident Management and IPC arrangements in place and tested; able to resume at pace • Strengthened operational structures in place and well established • Evidence of service ability to respond quickly and flexibly	• Service changes overseen and monitored via ODG and Business Continuity group • Decision logs maintained to record rational and objective of change
Significant delays in dementia pathway resulting in high levels of delayed transfers of care (CRfD) and bed pressures	• Identified priority with Leeds winter plans • Use of winter monies to focus on potential solutions • Partnership planning and delivery with social care	• Performance and activity reports (CRfD and bed occupancy) • Weekly meetings with social care & commissioners • Daily capacity & demand reports
Significant increase in pressure on the acute sector (ED attendances, occupancy & bed pressures)	• Increased capacity in ALPS / Liaison service • Partnership approach with LTHT and system escalation & governance arrangements • ED avoidance assessment area in operation	• Daily capacity / demand report • Performance reporting framework – metrics relating to ED and LTHT mental health activity • Strategic Partnership Group with LTHT

Identified Risk	Mitigation	Monitoring
Severe weather resulting in disruption to services (staffing, access, estates risks such as power outages)	• Business Continuity and Deployment & Redeployment plans in place, supported by strengthened operational management structures • Structures in place to support rapid response • Estates business continuity plans & on-call arrangements • Mutual aid	• Escalation to Business Continuity & Service Delivery Group • Estates, IT & procurement reports via Business Continuity & Service Delivery Group
Reduced engagement of staff as a result of ongoing pressures and repeated changes	• Health & Wellbeing and staff support interventions, leadership packs and oversight group • Mental Health & Wellbeing hub • Enhanced and regular comms and engagement forums (including CEO open sessions) • Local team/ service line communication structures, briefings and virtual staff meetings • Individualised Wellbeing risk assessments and managerial relationships	• Health & Wellbeing governance structures and Workforce committee • HR metrics • Evaluation reports • Staff survey

Identified Risk	Mitigation	Monitoring
Increased pressure on access services and reduced community capacity resulting in increased admission and Out of Area and disruption to pathways	• Increased capacity in clinical triage, CRISS and crisis house • CAU remodelled to provide short term assessment with CRISS • Daily capacity reviews and regular partnership meetings • Assertive monitoring of Out of Area placements (case manager)	• Daily monitoring and reporting (OPEL) • Weekly capacity system meeting with partners • Weekly ICS system call • Routine performance monitoring framework

The risk identified above have been captured in the Enhanced Winter Coordination Group's risk register and will be monitored via that group with risk being a standing agenda item.

2. Responding to surge and demand

The analysis of the data of activity throughout the year spanning the last 10 years shows that we do not generally experience surges in demand as a result of winter, we do experience increased demand and surges at various points throughout the year, but these are not identifiable as seasonal trends therefore it is difficult to predict and plan for a particular period of year. The graphs below show the attendances to the Emergency department and subsequent referrals to our Acute Liaison Psychiatry Service (ALPS) and our admissions to our Female and Male acute wards. Weeks 35 onward on the graphs are considered the winter period, these graphs can be found at appendix D.

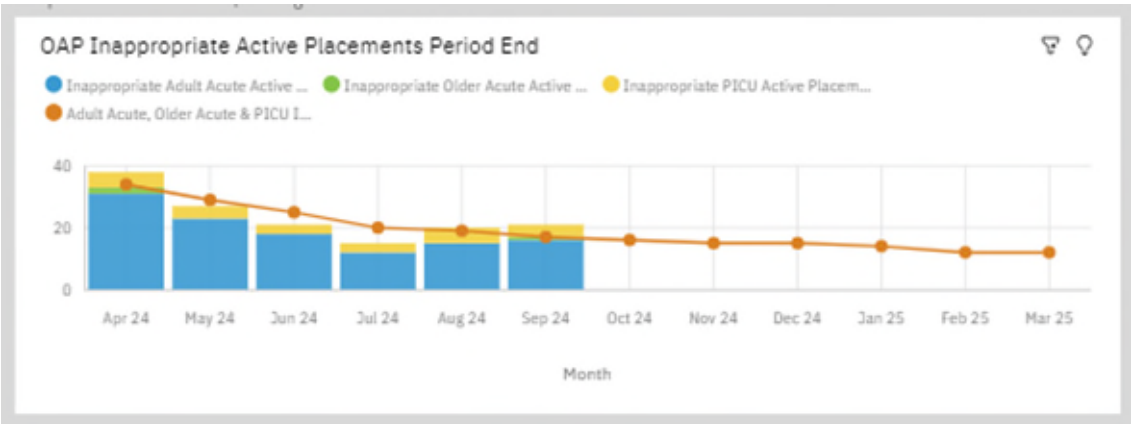
2.1 WAA Out of area trajectory

Throughout 2023/24 we have seen an unprecedented demand for in-patient beds for working aged adults. Whilst the service has seen a significant increase in Out of Area placements during the early part of 2024, evidence suggests that this has not been as a result of increased demand as a result of winter. The service had seen a significant increase in the Length of Stay due to high level of complex need particularly on our

Female acute wards and an increased number of Clinically Ready for Discharge (CRfD) due to internal system blocks and housing needs.

The WAA Acute service has developed an Improving Flow Programme to address the number of inappropriate OOA placements, reduce length of stay and address any delays in discharges. This has resulted in a reduction of the number of inappropriate placements over the year, see graph 1, and this work will continue to meet the demands on our in-patient services across the Trust to ensure we are able to respond to any surges in demand in a timely manner.

Graph 1:



The Leeds System Level OPEL reporting mechanism will monitor all LYPFT OAPS, CRfD by reason code and lost bed days. Further work is ongoing with the System Visibility Report for LYPFT similar to the one already in place for LTHT. A mapping exercise of outflow services is required to determine the metrics to be included in the report.

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

The WAA Adult Acute Service continues to work with the ICB on the three previously identified areas where support is required:

- System visibility/operational oversight/to support discharge management.
- Access to housing and supported accommodation
- Access to 3rd sector support

2.2 Winter staffing levels

Having sufficient experienced staff on duty is a major asset in mitigating disruption, and a key potential risk to delivery throughout the winter period. Staffing pressures have however remained constant (at varying degrees) throughout 2024. Service lines monitor their staffing arrangements and any capacity issues that need addressing are escalated on a regular basis so they can be addressed in a timely fashion.

Winter staffing rotas are not done in advance through the whole winter. However, all teams are frequently reviewing rosters and planning ahead in line with our electronic roster guidelines which ensure rosters are managed effectively and any shortfall can be identified and mitigations put in place.

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

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

3.2 Autumn/Winter vaccination plan

- From the beginning of October 2024 to end of February 2025, the IPC team will offer flu and covid vaccinations to staff and service users in line with JCVI recommendations and eligibility criteria.
- Registered Nurses and Registered Nursing Associates in inpatient areas who are peer to peer vaccinators will be able to offer the flu vaccine to staff working in that area.
- The IPC team will facilitate vaccination clinics within Leeds from October till December. From January till the end of February the IPC team will do walkrounds to wards to offer vaccine to those who have not been vaccinated. They will also attend to teams who request a bespoke vaccination clinic at their base.
- Registered staff on the wards will vaccinate service users with the flu vaccine as soon as possible to ensure early protection.
- The IPC Lead Nurse will report of vaccination uptake figures to NHS England monthly. A report of uptake figures will also be shared at the IPC Committee meeting.

3.3 Outbreak Management

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

4 EPPR response

4.1 Winter Coordination

4.1.1 Enhanced Winter Coordination Group

To manage winter pressures, risks and any resultant disruption we have reconvened the Enhances Winter Coordination Group. This executive lead group comprising a multi-disciplinary team of senior staff has the remit to mitigate the risk of disruption from a wide range of factors ranging from weather to capacity, demand, and flow to infectious outbreaks. The group is supported by a tactical group charged with minimising environmental and weather-related impacts on Trust services.

The Enhanced Winter Coordination group convened on 14 October 2024 and will run until the end of March 2025 with an assessment on the appropriateness of standing down the group to be made in late March 2025. The group reports to the Trust's Executive Management Team.

4.1.2 Winter Tactical Group

The Winter Tactical Group will operate from October 2024 to coordinate all work to mitigate potential winter disruptions. This membership of the group includes:

- EPRR staff
- Estates and Facilities
- Operational Management
- Communications
- Physical Health
- Membership from Mitie and NHS Property Services

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

4.2 Adverse weather

The Trust has an Adverse Weather Plan that has been developed to manage adverse weather that is possible over the winter period. The plan contains the full details of the Trust's risk assessment, impact assessment and mitigation around disruption from adverse weather.

The Trust's EPRR team is registered to receive alerts regarding adverse weather – from the Met Office and flooding information and risks from the Environment Agency.

The Adverse Weather plan describes the process for communications with staff and when all-user e-mail notifications will take place so that services can consult their business continuity actions in preparation for potential bad weather. For example, going to standby with flood defences at a site at high risk of flooding. Requests for these alerts are to be made via the Trust Communications Team:

- In hours: A request to be made by phone to the duty comms officer central number: 0113 85 55989.
- Out of hours: Needs to be raised to comms on call via Director on Call (as per serious incident plan).

For significant threats – amber or red warnings, the Trust would invoke organisational business continuity arrangements aimed at utilising resources to maintain critical clinical and organisational activities.

Incident coordination would also be an option that would be considered for managing widescale disruption and has been used in previous winters to manage disruptive snow events. Incident coordination would follow the principles set out in the Trust Emergency Incident Response Plan.

4.3 Other winter risks

4.3.1 Power disruption

Winter brings with it increased risks to power distribution based on both the impact of storms and supply sided shortages first experienced in winter 2022-2023 with a risk to gas and oil supplies caused by the Ukraine conflict and UK gas storage limitations.

Many of the same factors exist in winter 2024-2025 as previous years and hence the Trust will carry out work to boost resilience around potential outages.

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

4.3.2 Maintaining access to Trust sites.

The Trust's sites are covered by three providers of facilities services: Trust owned and leased sites provided by Trust Estates staff; Leeds PFI sites provided by Mitie and York sites provided by NHS Property Services. All three providers have in place advance warning arrangements via met office alerting, supplemented by EPRR issues warnings.

On receipt of snow or ice warning the providers will mobilise snow clearing and gritting resources to maintain access to sites including an out of hours response.

Joanna Forster Adams: Chief Operating Officer

Mark Dodd: Deputy Director of Operations

Andrew Jackson: EPRR Lead

Laura McDonagh: Head of Operations for Acute Services

Eve Townsley: Head of Operations for Liaison and Perinatal Services

Carl Money: Head of Performance and Informatics

Warren Duffy: Head of Operations for Estates

Alison Quarry: Deputy Director of Nursing

Sophie Valinakis: Head of Health Equity

Holly Tetley: Associate Director of Employment

GLOSSARY

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

Appendix A: Service Priority Categorisation

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

Appendix B

Winter Planning Assurance 2024-25

Introduction

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

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

RAG assurance rating	Choose an item.

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

RAG assurance rating	Choose an item.

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

RAG assurance rating	Choose an item.

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

RAG assurance rating	Choose an item.

5. Risks to escalate

Appendix C

Maintaining Safer Staffing to priority services: Revised Deployment Approach

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

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

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

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

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

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

1. Identification of need

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

- Use of a workforce information dashboard
- Staffing Escalation Protocol

a) Workforce information dashboard

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

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

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

The planned schedule is as follows:

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

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

The Scorecard will include

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

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

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

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

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

Example Dashboard:

Redeployment Dashboard Test

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

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

b) Escalation from Service Lines

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

2. Revised prioritisation of services

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

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

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

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

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

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

3. Identifying staff for redeployment

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

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

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

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

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

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

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

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

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

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

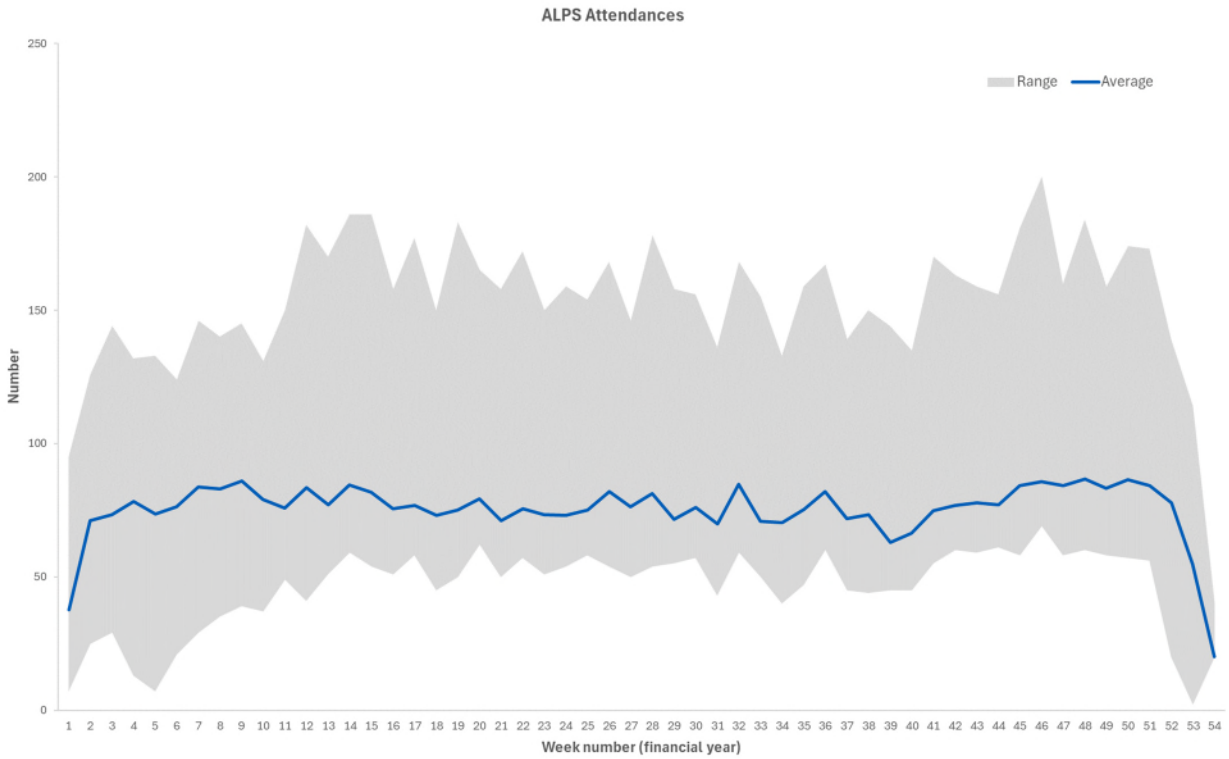
Appendix D

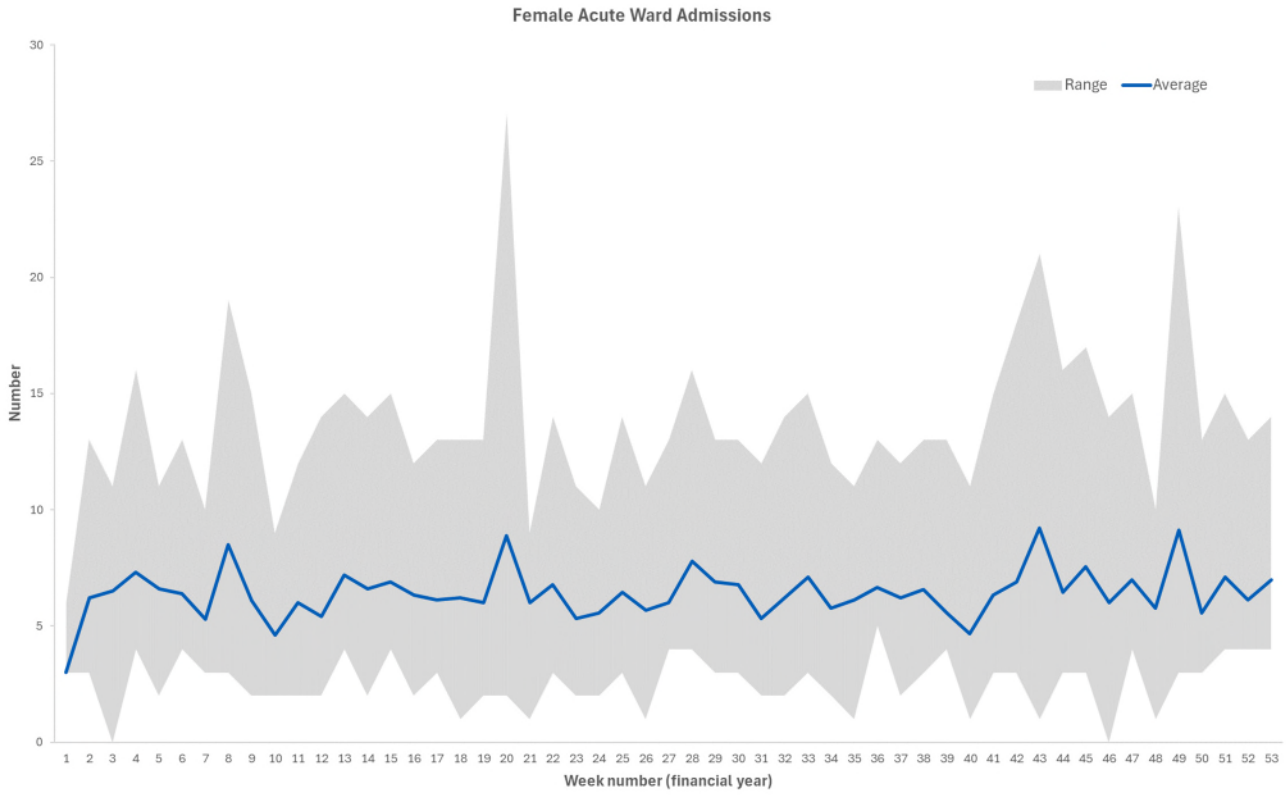
These charts show information on a key set of measures that were identified as being important in the context of winter planning

Data from 2015 onwards was grouped by financial year and week number (where April 1st is week number one, and Winter (December to March) would start from week 35 onwards). The grey area shows the range in values for that week, across years, with the blue line showing the average across years

Broadly, there is limited evidence to suggest a surge in demand over Winter, although some services, in some years, have shown an increase over this period

The time period used includes the COVID pandemic, which reduced the demand on some services and also includes significant service changes, such as the HMHT inreach caseload reduction during 16/17 and bed reduction in Mount wards 3 and 4 over Winter 22/23




Female Acute Ward Admissions
Range
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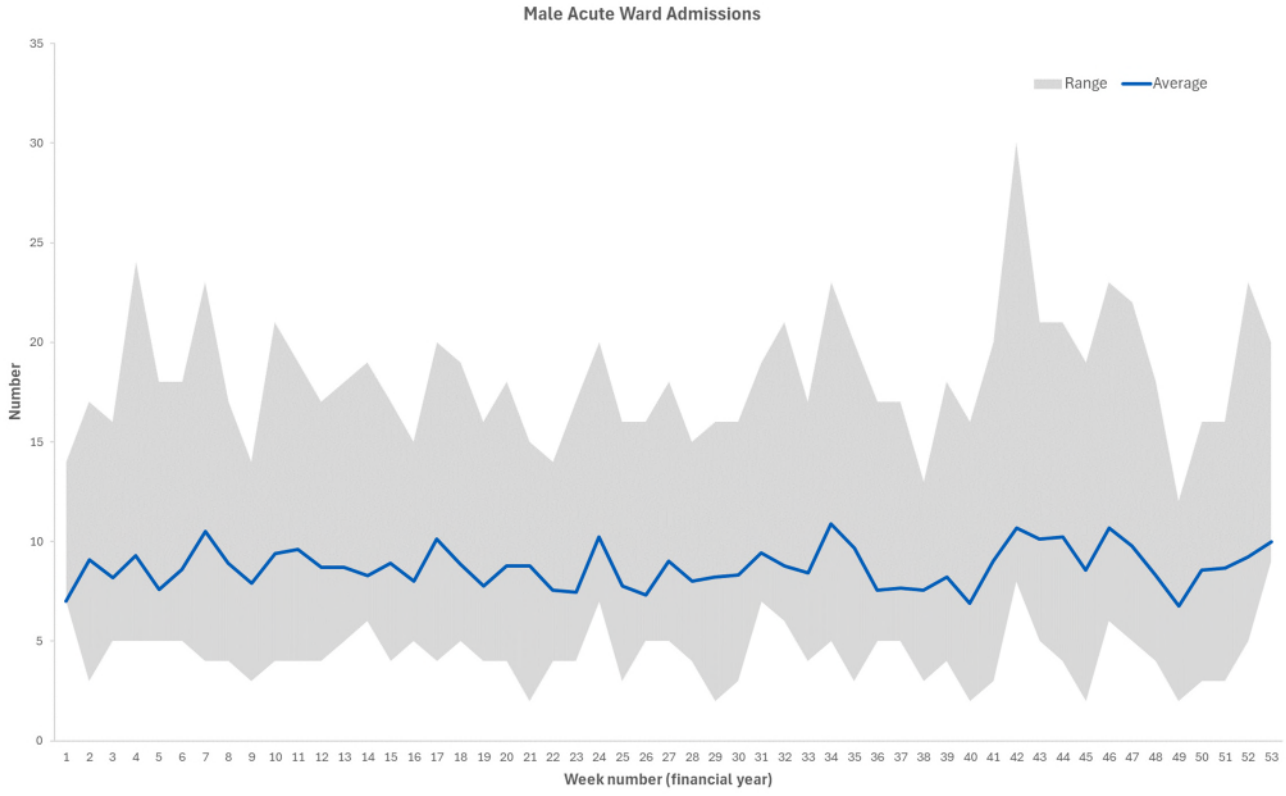
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53
Week number (financial year)


Male Acute Ward Admissions
Range
Average
Number
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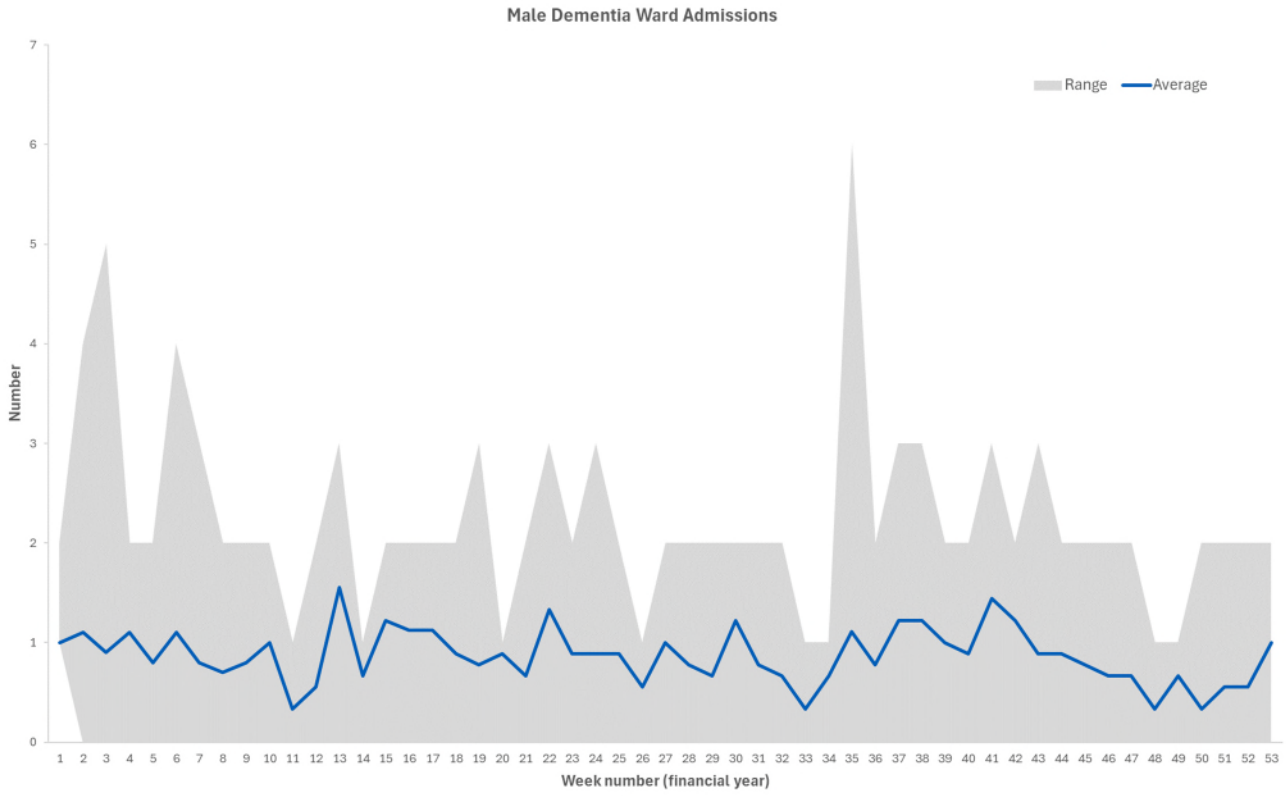
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53
Week number (financial year)


Male Dementia Ward Admissions
Range
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Number
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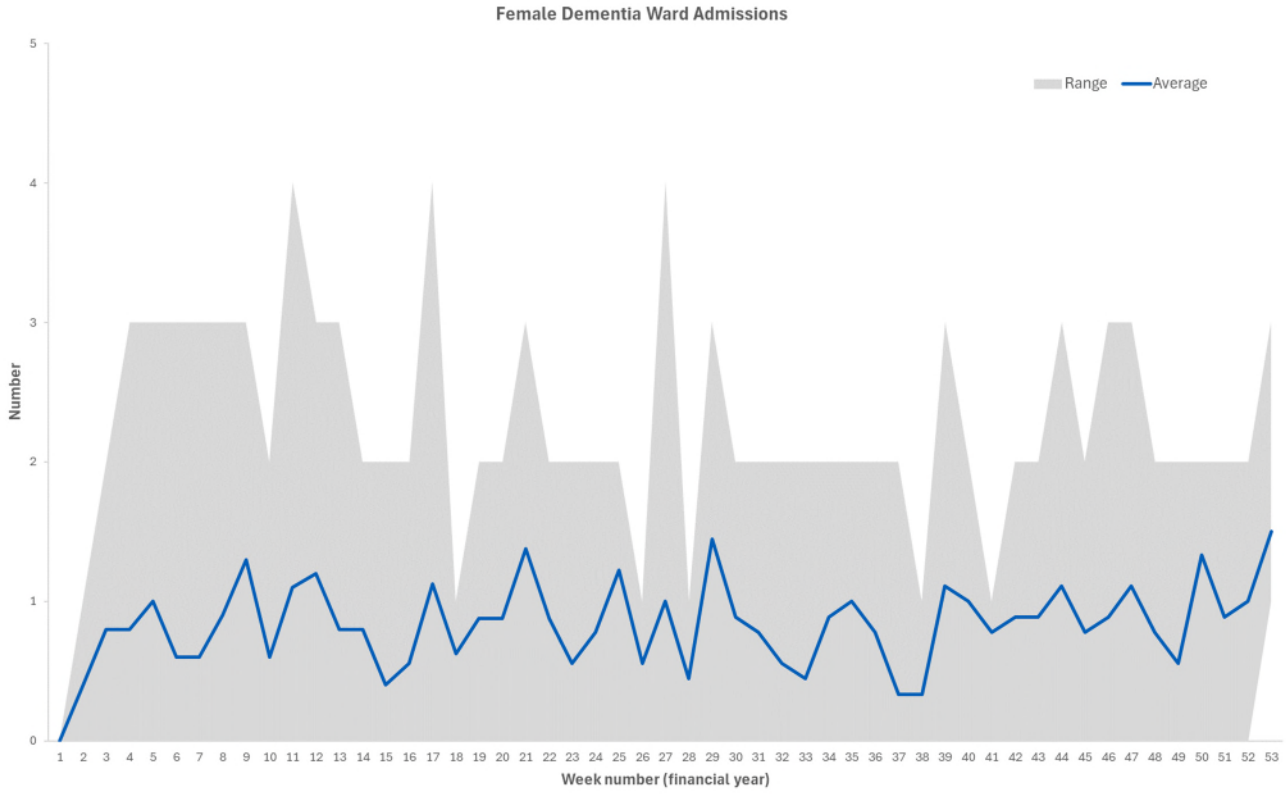
Week number (financial year)


Female Dementia Ward Admissions
Range
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Number
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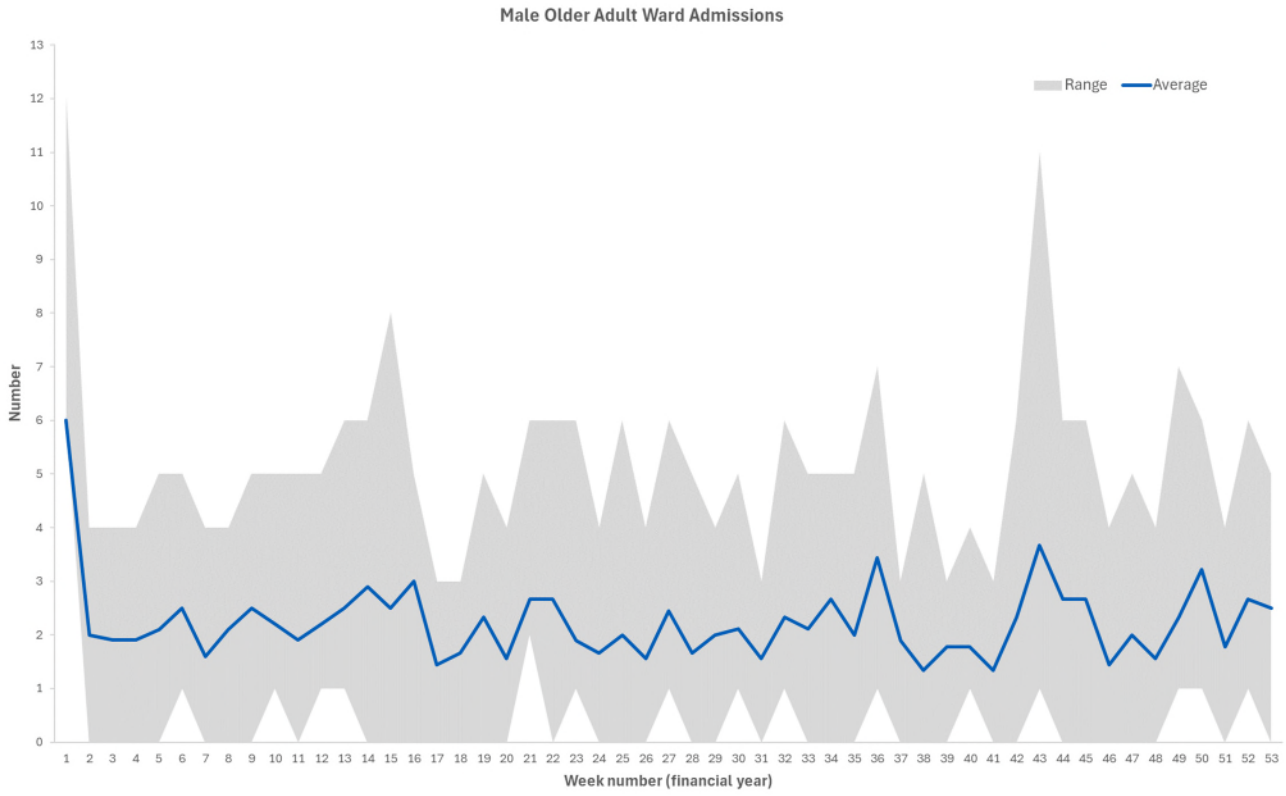
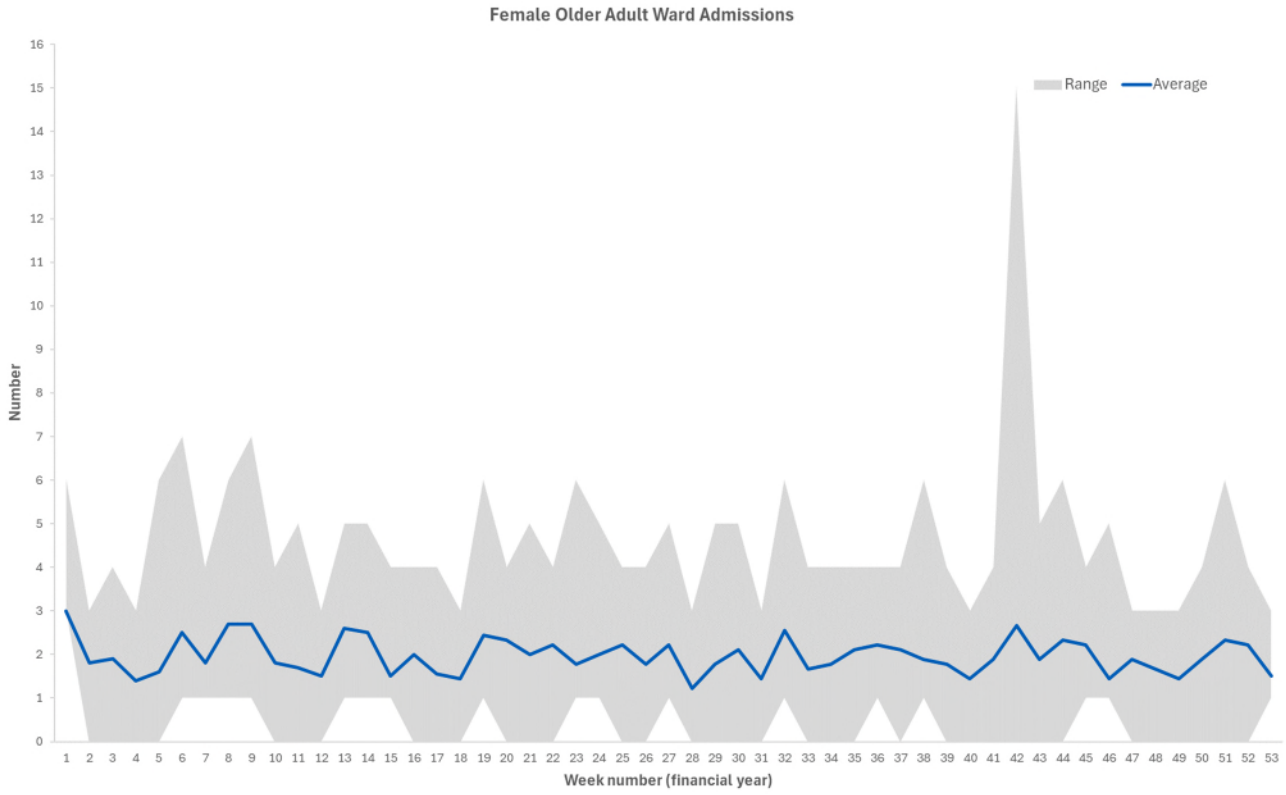
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53
Week number (financial year)


Male Older Adult Ward Admissions
Range
Average
Number
Week number (financial year)

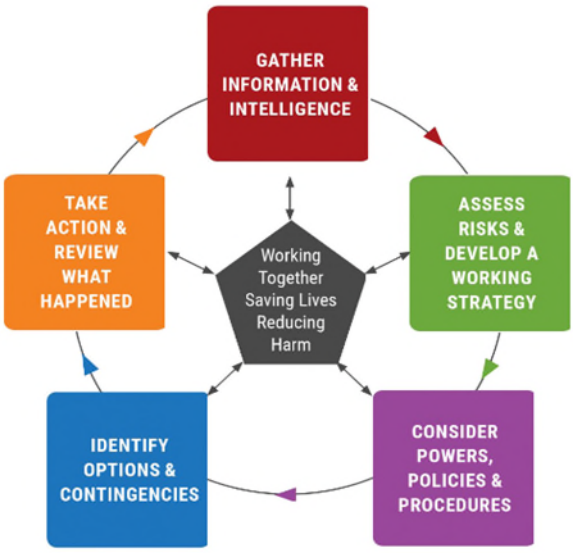

Female Older Adult Ward Admissions
Range
Average
Number
Week number (financial year)

Appendix E

JESIP Decision Making Framework

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

The model is represented diagrammatically below:



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

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

Agenda item
14

Meeting of the Board of Directors

Paper title:	Emergency Preparedness, Resilience and Response (EPRR) Core Standards Assurance Report
Date of meeting:	25 November 2024
Presented by: (name and title)	Joanna Forster Adams, Chief Operating Officer and Accountable Emergency Officer (AEO)
Prepared by: (name and title)	Andrew Jackson, Resilience Lead and Corporate Business Manager Sam Grundy, EPRR 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.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	✓
SR6	Digital technologies	✓
SR7	Plan and deliver services that meet the health needs of the population we serve.	✓

Executive summary

The attached paper describes the declared position of the Trust against NHS England's mandatory core standards for EPRR. The paper also shows the result of a self-assessment by the ICT team of deep dive cyber security standards.

An initial assessment was submitted to the ICB in September of 69%. During October the EPRR team rechecked their assessment and raised the final assessment submission to 74%.

Even at 74% the overall assessment is non-compliant given the very high degree of compliance required by the scoring regime for these standards. However, 74% represents a significant improvement against 2023's score of 26%.

The ICB and the Chief Operating Officer and the EPRR manager discussed the assurance return on 19 November. The ICB accepted the return as a credible reflection of the level of assurance available and provided some further examples of evidence that may be used to support compliance. These have been added to the evidence repository held by the EPRR team. NHSE (Region) are to undertake a "dip test" of evidence from selected Trusts across the region to check compliance with core standards. Details of how this will be undertaken have yet to be shared with the ICB or Trusts.

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'.**

No.

Recommendation

The Board of Directors is asked to note the improvement to the Trust's EPRR compliance score and approve the statement of compliance attached to the report (appendix) that has been signed by the Chief Operating Officer, and Accountable Emergency Officer.

Meeting of the Board of Directors

28 November 2024

Emergency Preparedness, Resilience and Response (EPRR) Core Standards Assurance Report

1 Executive summary

The Trust is required to make an annual declaration of its compliance against NHS England's Core standards for EPRR. This declaration is made by the Trust's Accountable Emergency Officer and is based on an assessment prepared by the EPRR team.

The format of the declaration for 2024 has changed and the ICB has taken a more prominent role in discussing declarations and assurance levels with providers.

The Trust declared a compliance rate of 74% against core standards in its final return to the ICB in October 2024. This was increased slightly from the 69% originally declared in September 2024. However, this compliance rate is still classed as non-compliant.

2 Details of the Declaration and Compliance Level

2.1 Compliance Level

The Trust's declared compliance level of 74% against core standards is classed as non-compliant under the scoring criteria used in the assurance process. The levels of compliance and respective bandings are given below:

- Non-compliant 0-76%
- Partially Compliant 77-88%
- Substantially Compliant 89-99%
- Fully Compliant 100%

Whilst non-compliant, the 74% is a significant improvement from the 26% level of compliance from 2023.

There was also a deep dive assessment of Cyber Security. While this assessment did not affect the overall declared position the Trust only assessed 3 from the 11 Standards as compliant (27%).

2.2 Summary of the declaration made on 31 October 2024

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	1	1	0
Training and exercising	4	1	3	0
Response	5	5	0	0
Warning and informing	4	4	0	0
Cooperation	4	3	1	0
Business Continuity	10	6	4	0
Hazmat/CBRN	10	5	5	0
Total	58	43	15	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Cyber Security	11	3	5	3
Total	11	3	5	3

Table 1 – extract of the 2024 compliance return

The table above shows the 10 domains of EPRR activity, and the standards declared compliant and ones where the Trust declared partially compliant. The deep dive for Cyber Security is also shown above.

2.3 Analysis of the areas of non and partial compliance

15 areas of partial compliance against the core standards were declared in 2024. As shown in the table above, three of the domains accounted for 80% of the partially compliant ratings:

- Training.
- Business Continuity.
- Hazardous Materials / Chemical, Biological, Radiological and Nuclear (HAZMAT/CBRN).

The partially compliant standards are ones that are significantly resource intensive requiring either a significant allocation of EPRR staff and/or significant uptake of training or drafting plans by senior staff. Though these were prioritised in the action plan produced after last year's standards process, the extent of work required means that they will need to become priority areas again in 2025 to make improvements on these standards.

Some examples of these are:

Standard 21- *Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions*. To be compliant in this it requires all our on-call staff to have essentially completed their portfolio training identified in training needs assessments. At the submission date the compliance level was under 25% for most of these staff with only a handful in the 75% and over category.

Standard 47 - *The organisation has business continuity plans for the management of incidents*. A good deal of progress has been made in 2024 but there are still too many services where plans have not been developed or are significantly out of date. EPRR staff are meeting managers to assist in developing these plans but there are over 80 services identified by the EPRR team as requiring a plan (either because it is mandated contractually or because the service is a critical function or both). It will take considerable time to support all these areas with plan development.

In terms of the **HAZMAT/CBRN standards** the Trust has recently been audited by the Yorkshire Ambulance Service (YAS). While the HAZMAT/CBRN standards have been part of the mandatory standards since 2016, the involvement of a subject matter expert from YAS is new. While this is beneficial and now mental health and community Trusts are getting appropriate guidance, the audit identified some issues that will take time to rectify well into 2025.

The Cyber deep dive standards have three standards identified as non-compliant. These are:

- **Standard DD3** - *Resilient Communication during Cyber Security & IT related incidents.*
- **Standard DD4** - *Media Strategy*. This covers the process to communicate with partners during cyber incidents.
- **Standard DD7** - Training Needs Analysis (TNA). This covers the inclusion of cyber security response roles in the organisation's overall training needs analysis.

We are working with senior colleagues in ICT through our EPRRG arrangements so that we can make improvements in these areas relating to cyber security. Updates will be provided to members of the Finance and Performance Committee.

2.4 Impact on resources and EPRR plan

As with the 2023 EPRR standards assurance process, the areas of partial compliance will be priority areas in the 2025/26 EPRR work plan. As mentioned, all three domains with significant partial compliance are resource heavy areas – training staff around their portfolio requirements, business continuity plan development, testing and improvement and the YAS HAZMAT/CBRN audit action plan.

To reduce the impact of training, the EPRR team will explore cost effective e-learning solutions to some of this mandatory training.

3 Conclusion

The current declaration marks a significant improvement on levels of compliance compared to 2023. It is envisaged that several areas of partial compliance will be readily turned round in early 2025 based on work already ongoing.

With proper maintenance of existing areas of compliance therefore and continuity of the resources invested in EPRR into 2025/26, achievement of a higher level of compliance should be achievable.

4 Recommendation

The Board of Directors is asked to note the improvement to the Trust's EPRR compliance score and approve the statement of compliance attached to the report (appendix) that has been signed by the Chief Operating Officer, and Accountable Emergency Officer.

Andrew Jackson
Resilience Lead and Corporate Business Manager
Sam Grundy
EPRR Manager

20 November 2024

North East & Yorkshire Emergency Preparedness, Resilience and Response (EPRR) assurance 2024-2025

STATEMENT OF COMPLIANCE

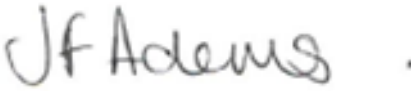
[Leeds and York Partnership NHSE Foundation Trust] has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, [Leeds and York Partnership NHSE Foundation Trust]] will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Non-compliant (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board/governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer: 

31/10/2024

Date signed

25/11/2024	28/11/2024	21/07/2025
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Agenda item
15

Meeting of the Board of Directors

Paper title:	Chair's Report from the Quality Committee meeting on 10 October 2024
Date of meeting:	28 November 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.	✓

This paper relates to the Trust's strategic risk/s (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	✓
SR3	Culture and environment for the wellbeing of staff	
SR4	Financial sustainability	
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

Committee details:	
Name of Committee:	Quality Committee
Date of Committee:	10 October 2024
Chaired by:	Dr Frances Healey, Non-executive Director

ALERT – items to alert the Board to

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

ADVISE – items to advise the Board on

- The committee noted that access was the biggest quality issue for the Gender Identity Service. It was suggested that the Board of Directors should have a discussion to receive reassurance on how the Trust supported and set expectations for those on the waiting list and to agree a strategic position for services with high numbers of individuals on waiting lists and long waiting times. Dr Hosker noted that a national review of adult Gender Identity Services would be taking place and agreed to notify Ms Edwards when the Board discussion should take place.

- The committee received an update on the progress the Trust had made in improving health equity. It noted that the first draft of the new Improving Health Equity Strategy 2024-29 had been developed and work was underway to engage with Trust staff and external partners to agree priorities and objectives. It queried which committee should monitor the delivery of the Improving Health Equity Strategy and it was suggested that, as the development of the Improving Health Equity Strategy was one of the Trust's 14 organisational priorities, the Board of Directors should have oversight of this work.

- The committee reviewed and approved its Terms of Reference. It agreed that a further conversation should take place at the next Board of Directors meeting to consider whether section 6.1 should be updated to acknowledge that the Trust commissioned beds in other providers, e.g. out of area placements, and whether this should also be reflected in the terms of reference for other sub-committees.

ASSURE – items to provide assurance to the Board on

- The committee received and discussed a report which highlighted how the Trust published information related to quality and performance on its website. It agreed that the relevant pages should be reviewed to ensure the content is appropriate and aligned to the Trust's Quality Strategic Plan and noted that the Corporate Governance Team would ensure the information and documents were kept up to date.

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

- The committee reviewed the Preparations for Care Quality Commission Follow-up Internal Audit Report. It noted that the audit had received an opinion of moderate assurance and was reassured that progress was being made with the actions recommended within the report.

- The committee received an update on the progress made following the implementation and roll out of the National Partnership Agreement, Right Care, Right Person. It agreed this was a helpful update and acknowledged this was a complex change that the Trust and partners appeared to be working on together in the right spirit. It noted the governance structure that had been established which would allow any risk and learning to be identified within the Trust and across the system and was assured on the work that had been carried out.

- The committee received a report which outlined the key findings from two surveys that had been developed to gather insights into the performance of outcome measures across services and understand the challenges clinicians faced and the barriers to the effective implementation of outcome measures.

- The committee received presentations from the services within the Rehab. Eating Disorders and Gender Identity Service Line which focused on how the services had scored themselves against the Learning, Culture and Leadership Framework and the STEEEP dimensions of quality to enable the conditions for high quality care to flourish. It recognised that difficulties in accessing data for the timely domain of STEEEP was a common theme for the services. It suggested that the internal audit team could provide advice on best practice in peer trusts around the presentation of waiting list data. It also noted that services may need further support in understanding how equitable they are but was reassured that the Trust was developing an 'Improving Health Equity Strategic Plan' which would set out a framework for services to understand equity in the context of their service.

  Overall, the committee was assured that the services had good systems in place for understanding their quality issues and to drive improvements, and good knowledge of their strengths and weaknesses in relation to learning, culture and leadership. The committee was also assured that the Executive Team had a clear understanding of the services strengths, weaknesses, challenges and blind spots and how issues were being managed.

REFER - Items to be referred to other Committees:

- No items to be referred to other committees.

Recommendation

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

Agenda item
15

Meeting of the Board of Directors

Paper title:	Chair's Report from the Quality Committee meeting on 14 November 2024
Date of meeting:	28 November 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.	✓

This paper relates to the Trust's strategic risk/s (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	✓
SR3	Culture and environment for the wellbeing of staff	
SR4	Financial sustainability	
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

Committee details:	
Name of Committee:	Quality Committee
Date of Committee:	14 November 2024
Chaired by:	Dr Frances Healey, Non-executive Director

ALERT – items to alert the Board to

- No issues to which the Board needs to be alerted

ADVISE – items to advise the Board on

- The committee received and discussed the Annual Report from the Positive and Safe Working Group 2023/24. The committee agreed on the need for inpatient environments to become safer and less stimulating for individuals that are neurodivergent. It also suggested that the Trust should consider setting a target for having zero incidents of prone restraint to administer intramuscular injections.

ASSURE – items to provide assurance to the Board on

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

- The committee received a report which provided a summary of the approach taken by the Trust to develop its efficiency and productivity programme and detailed the second tranche of schemes that had been through a quality impact assessment process. It agreed that it was assured on the process for assessing the efficiencies, the governance arrangements in place to monitor the Trust's efficiency and productivity programme, and the rigour of the quality impact assessment process. It requested that the next report include further information on whether unintended consequences were monitored at service level, trust level or system level, and what metrics were in place for the monitoring these.

- The committee reviewed a presentation which provided the highlights of the Community Mental Health Team's Annual Quality Report, focusing on how the service had scored itself against the STEEEP dimensions of quality to enable the conditions for high quality care to flourish. It acknowledged the challenges faced by the service during the reporting period and was pleased to hear that the service had achieved recovery from business continuity. It was reassured that the leadership team was engaged with the transformation process underway.

  Overall, the committee was assured that the service had good systems in place for understanding its quality issues and to drive improvements, and good knowledge of its strengths and weaknesses in relation to learning and culture. The committee was also assured that 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 and discussed a report which provided data from Q2 for PALS activity, the concerns and complaints handling process, compliments, claims, central alert system, incidents, serious incidents and inquests. It welcomed the establishment of the Suicide Prevention and Self Harm Group.

- The committee received and discussed a report which provided an update on the Quality Improvement Priorities (QIPs) for 2024/25 and the development of the Quality Account for 2024/25.

REFER - Items to be referred to other Committees:

- No items to be referred to other committees.

Recommendation

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

Agenda item
15.1

Meeting of the Board of Directors

Paper title:	Terms of Reference for the Quality Committee
Date of meeting:	28 November 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.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	
SR4	Financial sustainability	
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

Executive summary

The Quality Committee reviewed and approved its terms of reference on 10 October 2024. The following amendments were made (all amendments highlighted in yellow in the attached document):

- Section two and appendix 1a – job titles updated
- Sections three and four – sections added on alternate chair, deputies and urgent meetings (as agreed at Board in September 2023 to ensure consistency across the terms of reference for all sub-committees)

The committee is seeking advice from the board as to whether the wording of responsibilities in the ToR section 6.1 for care the trust 'provides' reflects its responsibilities, as the committee has undertaken responsibility for seeking assurance on the quality of care where the trust purchases out-of-area placements and is working to understand its responsibilities in relation to assurance of quality in partners where it is a lead provider in a provider collaborative delivered by current systems.

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

No.

Recommendation

The Board is asked to:

- Review the changes made and ratify the revised Terms of Reference.
- Consider whether the wording of the committees responsibilities in section 6.1 for care the trust 'provides' reflects its responsibilities, as the committee has undertaken responsibility for seeking assurance on the quality of care where the trust purchases out-of-area placements and is working to understand its responsibilities in relation to assurance of quality in partners where it is a lead provider in a provider collaborative delivered by current systems.

Quality Committee

Terms of reference

1 Name of group / committee

The name of this committee is the Quality Committee.

2 Composition of the group / committee

The members of the committee and those who are required to attend are shown below together with their role in the operation of the committee.

Members: full rights

Title	Role in the group / committee
Non-executive Director	Chair of the meeting. Non-executive directors provide constructive challenge and strategic guidance, and lead in holding the executive to account. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of clinical and other information, and make sure that clinical quality controls, and systems of risk management and governance, are robust and implemented (Code of Governance for NHS Provider Trusts, NHS England 2022)
Non-executive Director	Deputy chair of the meeting. Non-executive directors provide constructive challenge and strategic guidance, and lead in holding the executive to account. In particular, non-executive directors should scrutinise the performance of the executive management in

	meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of clinical and other information, and make sure that clinical quality controls, and systems of risk management and governance, are robust and implemented. (Code of Governance for NHS Provider Trusts, NHS England 2022)
Director of Nursing and Professions ~~and Quality~~ and Director of Infection Prevention and Control	Executive director lead for quality. Chair of the: Patient Experience Group; Trustwide Safeguarding Group; Nursing and Professions Council; and Infection Prevention Control and Medical Devices Group. Assurance and escalation provider to the Quality Committee.
Chief Operating Officer	Executive director with responsibility for oversight and delivery and development of Care Services. Assurance and escalation provider to the Quality Committee.
Medical Director	Joint executive lead for quality. Medical input and Chair of the Trustwide Clinical Governance Group. Assurance and escalation provider to the Quality Committee.
Director of People and Organisational Development	Staff training and development issues related to quality. Assurance and escalation provider to the Quality Committee.
Chief Financial Officer	Executive lead for financial resources including Cost Improvement Programmes. Assurance and escalation provider to the Quality Committee. Attendance at meetings will be dependent on the agenda items being discussed.

While specified board members will be regular members of the Quality Committee any other board member can attend the meeting on an ad-hoc basis if they wish and will be recognised as a member for that particular meeting and if necessary will count towards the quoracy.

2.1 Attendees

The Quality Committee may also invite other members of Trust staff to attend to provide advice and

support for specific items when these are discussed in the committee's meetings.

These could include, but are not exhaustive to, the following individuals:

- Associate Director for Corporate Governance
- Deputy Director of Nursing
- Clinical Directors
- Head of Nursing and Patient Experience
- Professional and Clinical Leads

2.2 Governor Observers

The role of the governor at Board sub-committee meetings is to observe the work of the committee, rather than to be part of its work as they are not part of the formal membership of the committee. The governor observes Board sub-committee meetings in order to get a better understanding of the work of the Trust and to observe non-executive directors appropriately challenging the executive directors for the operational performance of the Trust.

At the meeting the governor observer will be required to declare any interest they may have in respect of any of the items to be discussed (even-though they are not formally part for the discussion). Governors will receive an information pack prior to the meeting. This will consist of the agenda, the minutes of the previous meeting and summaries of the business to be discussed. Governor observers will be invited to the meeting by the Corporate Governance Team. The chair of the meeting should ensure that there is an opportunity for governor observers to raise any points of clarification at the end of the meeting.

2.3 Associate Non-executive Directors

Associate Non-executive Directors will be invited to attend Board Sub-committee meetings as part of their induction. They will be in attendance at the meeting, in the capacity of observer only, unless invited to contribute by the Chair in circumstances that support the ANEDs development and understanding. This is so the accountability of the substantive members of the committee is maintained.

Associate NEDs will be invited to meetings by the Corporate Governance Team and will be sent copies of the meeting papers.

3 Quoracy

Number: The minimum number of members for a meeting to be quorate is three. This should comprise at least one non-executive director and one executive director. Attendees do not count towards this number. If the chair is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by the deputy chair.

Non-quorate meeting: Non-quorate meetings may go forward unless the chair decides otherwise.

Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

Alternate chair: In the absence of the Chair the alternate chair of the meeting will be another non-executive director.

Deputies: Where appropriate, members may nominate deputies to represent them at a meeting. Deputies do not count towards the calculation of whether the meeting is quorate except if the deputy is representing the member under formal "acting up" arrangements. In this case the deputy will be deemed a full member of the committee. It may also be appropriate for attendees to nominate a deputy to attend in their absence. A schedule of deputies can be found in section 10.

4 Meetings of the committee

Meetings may be held face-to-face or remotely as is considered appropriate. Remote meetings may involve the use of the telephone and / or electronic conference facilities.

Frequency: The Quality Committee will meet monthly to transact its normal business.

Urgent meeting: Any committee member may, through the chair, request an urgent meeting. The chair will normally agree to call an urgent meeting to discuss the specific matter unless the opportunity exists to discuss this in a more expedient manner (for example at a Board meeting).

Administrative support: The Corporate Governance Team will provide secretariat support to the committee.

Minutes: Draft minutes will be sent to the chair for review and approval within seven working days of the meeting.

Papers: Papers for the meeting will be distributed electronically by the Corporate Governance Team five working days prior to the meeting. Papers received after this date will only be included if decided upon by the chair.

5 Authority

Establishment: The Quality Committee is a sub-committee of the Board of Directors and has been formally established by the Board of Directors.

Powers: The Quality Committee is constituted as a standing committee of the Trust Board of Directors. The committee is authorised by the Board to investigate and seek assurance on any activity within its terms of reference.

In consultation with the Board of Directors, the committee is able to access independent professional advice and secure the attendance of persons outside the Trust with relevant experience and expertise if it considers this necessary.

Cessation: The Quality Committee is a standing committee in that its responsibilities and purpose are not time limited. It will continue to meet in accordance with these terms of reference until the Trust Board determines otherwise.

6 Role of the committee

6.1 Purpose of the committee

The Quality Committee has responsibility for providing assurance to the Board of Directors on the effectiveness of the:

- Trust's quality, including patient safety, systems and processes
- Quality, including patient safety, of the services provided by the Trust
- control and management of quality, including patient safety, related risks within the Trust.

The quality committee is committed to improving governance on a continuing basis through evaluation and review.

6.2 Guiding principles for members (and attendees) when carrying out the duties of the group / committee

In carrying out their duties members of the committee and any attendees of the committee must ensure that they act in accordance with the values of the Trust, which are:

- we have integrity
- we are caring
- we keep it simple.

6.3 Duties of the group / committee

The Quality Committee is seeking assurance that:

- systems and processes are effective
- quality, including patient safety, of services that the Trust provides is good and continuously improving
- quality of the experience of people using our service is good and continuously improving.

It carries out its duties to provide assurance to the Board of Directors. In addition to this, it is authorised to seek information that will allow it carry out its purpose. It will:

- Seek assurance on systems and processes to ensure monitoring and assessment of the quality, including patient safety, and improvements in services

- Seek assurance on the mechanisms to involve service users, carers, the public and partner organisations in improving services

- Seek assurance on the systems for identifying, reporting, mitigating and managing quality, including patient safety, related risks including the monitoring of incidents, investigations and deaths; and complaints, claims, and compliments

- Review the Board Assurance Framework to seek assurance on behalf of the Board that those strategic risks where it has been listed as an assurance receiver, are being effectively controlled; that the risk score (which has been determined by the executive team) is at the right level; and that any gaps are being addressed appropriately. It may also inform any deep-dive which it may wish to undertake into any area on which is requires further assurance.

- Seek assurance on compliance against the Care Quality Commission's registration and notification requirements and action plans in response to CQC inspection.

- Monitor, scrutinise and provide assurance to the Board of Directors on the Trust's compliance with national standards, including the Care Quality Commission's Fundamental Standards, and the quality elements relating to NHS England's System Oversight Framework, the quality elements within the NHS Standard contract, NICE guidance and CQUIN schemes.

- Seek assurance on the quality impact assessments for key strategic programs of work

- Receive assurance on the work carried out and reported to the Trustwide Clinical Governance Group, including: Quality Plan; Quality Report; Infection Prevention and Control; Safeguarding; Research and Development; Clinical Audit and NICE; Continuous Improvements; and Measuring outcomes across Trust services

- Receive assurance on activity within operational services that contributes to the understanding and improvement of quality, including patient safety, within the Trust.

- Review the draft Internal Audit Annual work plan so it can be assured on the sufficiency of the work the Auditors will carry out in respect of clinical matters. Assurance on this sufficiency (or comments on any matters that should be included) will be provided to the Audit Committee to allow it to approve the overall plan.

- Have oversight of relevant data and specific initiatives in relation to the Equality and Inclusion Agenda as requested by the Board of Directors, recognising the importance of inclusion and accessibility in delivering quality services.

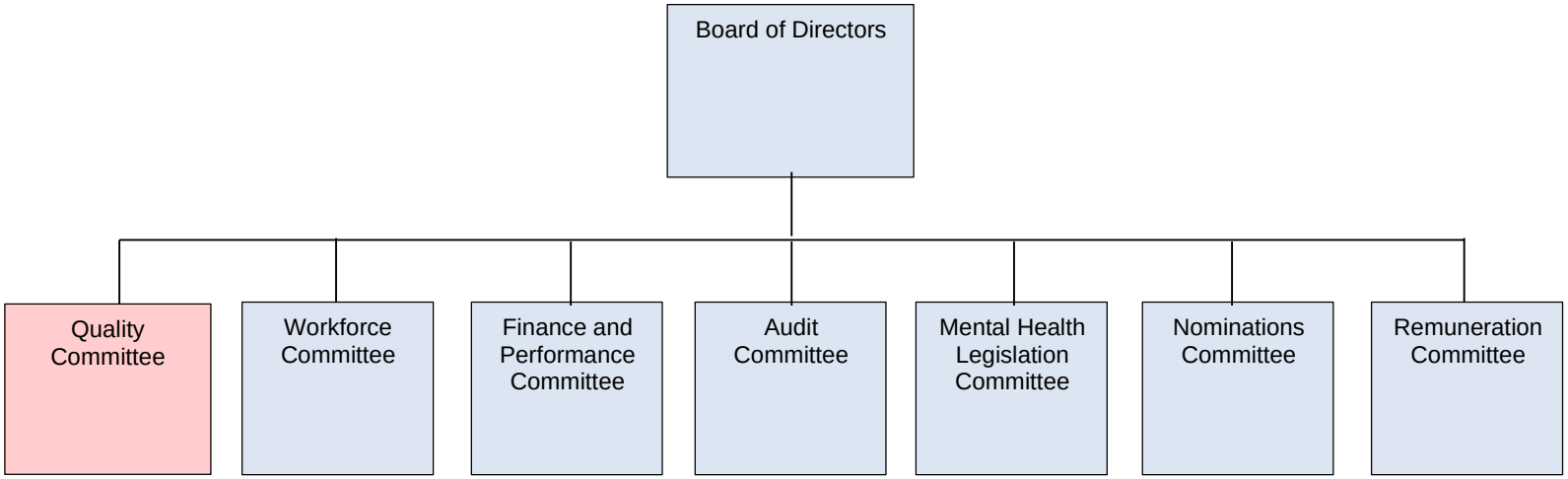
- Carry out the duties of the Maternity Board Safety Champion, with the chair of the committee being the named champion.

- Carry out the role of Hip Fracture, Falls and Dementia Champion

- Carry out the role of Learning from Deaths Champion
- Carry out the role of Children and Young People Champion
- Carry out the role of Resuscitation Champion
- Carry out the role of Safeguarding Champion
- Carry out the role of Palliative and of Life Care Champion

An assurance and escalation report will be made to the Board of Directors by the Chair of the committee.

7 Relationship with other groups and committees



The Quality Committee does not have any sub-committees. It is linked to the Trustwide Clinical Governance Group as an assurance receiver. The Quality Committee provides a route of escalation for this group to the Board of Directors. Although this does not preclude any other group being asked to provide assurance. The committee has a duty to work with other Board sub-committees to ensure matters are not duplicated.

8 Duties of the chairperson

The Chair of the committee shall be responsible for:

- agreeing the agenda with the Director of Nursing, Quality and Professions and the Medical Director
- directing the conduct of the meeting ensuring it operates in accordance with the Trust's values
- giving direction to the Committee Secretariat
- ensuring all members have an opportunity to contribute to the discussion
- ensuring the agenda is balanced and discussions are productive, and when they are not productive they are efficiently brought to a conclusion
- deciding when a matter requires escalation to the Board of Directors
- checking the minutes
- ensuring key information is presented to the Board of Directors in respect of the work of the committee
- ensuring that governor observers are offered an opportunity at the end of the meeting to raise any points of clarification.

In the event of there being a dispute between any 'groups' in the hierarchy (in the case of this Board sub-committee, this would be between the Board and the Quality Committee and, in recognition of the nature of matrix working between the work of all Board sub-committees, the Quality Committee and any other Board sub-committee) it will be for the chairs of those groups to ensure there is an agreed process for resolution; that the dispute is reported back to the 'groups' concerned; and that when a resolution is proposed regarding the outcome this is also reported back to the 'groups' concerned for agreement.

The chair of the Quality Committee will also be the named Maternity Board Safety Champion, with the requirements of the role to be discharged through the committee.

9 Review of the terms of reference and effectiveness

The terms of reference shall be reviewed by the committee at least annually, and then presented to the Board of Directors for ratification. This will also occur throughout the year if a change has been made to them.

In addition to this the chair must ensure the committee carries out an annual assessment of how effectively it is carrying out its duties and make a report to the Board of Directors including any recommendations for improvement.

Appendix 1a

Schedule of deputies

Full member (by job title)	Deputy (by job title)
NED Chair	Second NED
NED member	None
Director of Nursing and Professions ~~and Quality~~ / Director of Infection Prevention and Control	Deputy Director of Nursing
Chief Operating Officer	~~Deputy Chief Operating Officer~~ Deputy Director of Operations
Director of People and Organisational Development	Associate Director
Medical Director	Clinical Director

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

AGENDA ITEM

16

PAPER TITLE:	Medical Director's Report
DATE OF MEETING:	28 November 2024
PRESENTED BY: (name and title)	Dr Chris Hosker. Medical Director
PREPARED BY: (name and title)	Dr Chris Hosker. Medical Director & Directorate SLT

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

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	✓
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

EXECUTIVE SUMMARY

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

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

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

RECOMMENDATION

The Board of Directors is asked to consider the information contained within the report and remain assured that the medical directorate is providing its key functions in a way that is in line with successfully achieving the Trust's objectives.

MEETING OF THE BOARD OF DIRECTORS

28th November 2024

MEDICAL DIRECTOR'S REPORT

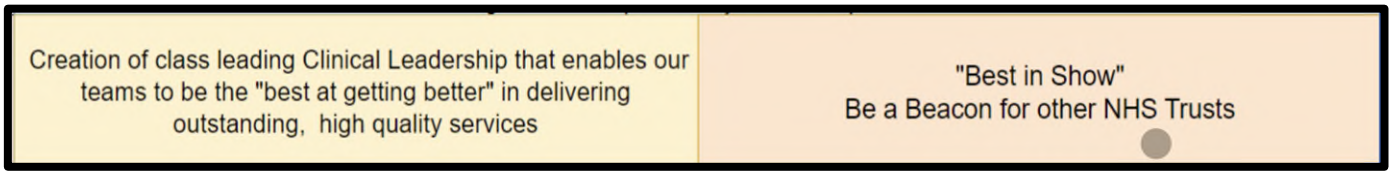
1. EXECUTIVE SUMMARY

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

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

2. DIRECTORATE OVERVIEW

Since September 2023, the Medical Directorate has been focusing on two overarching objectives:



The Directorate continues to provide leadership across key improvement projects as follows:

- Embedding of the STEEEP framework as a singular shared framework for quality
- The production of a quality dashboard
- The alignment and prioritisation of quality across our governance systems
- The measurement and improvement of the conditions that support quality in our services
- The strengthening of clinical leadership
- The focus on measuring and displaying effectiveness through clinical outcome measures

We have also been working hard to better understand medical engagement with the help of Professor Graeme Martin. On the 19th November 2024 it was a pleasure to welcome Professor Martin back into LYPFT to share the thematic findings of his interview work with our consultant and speciality doctor body at our annual Medical Leadership day event.

3. CORE DIRECTORATE FUNCTIONS

3.1 Personnel and structure changes:

Medical Professional Development Centre /Andrew Sims Centre (ASC)

There are no staffing changes to report, but work is being undertaken regarding the Andres Sims Centre and associated staffing costs. Due to reasons outside of ASC control, there have recently been eleven courses/events cancelled. Two of which have been postponed to Q1. The nine cancellations have been due to unviable, low delegate bookings.

3.2 MEDICAL PROFESSIONAL LEADERSHIP

Medical staffing levels – vacancies, recruitment

Since the last report, two consultant appointment panels (AACs) have taken place with consultant appointment offers being made in addictions and older people's services. No applications were received for the post in forensics, Learning Disabilities, Adult Acute inpatients, CMHT, Rough Sleepers or CAMHS. Encouragingly however plans are developing for internal transfers of one consultant into a forensic post and one into a CMHT post.

Consultant vacancies have therefore continued in the:

York Forensic service (1)	Leeds Forensic service (3)
Working Age Adult Female Inpatients (1)	Eating Disorders: Connect (1)
Older Peoples South CMHT (1)	Learning Disabilities (1)
West WAA CMHT (2)	South CMHT (1)
East CMHT (1)	CAMHS IP services: RKV (0.6) and Mill Lodge (1).

Agency spend details:

There continues to be medical agency spend due to the above Consultant vacancies. This will decrease marginally due to the appointment into the Addictions post, and then further as other posts are filled.

As of Q2 there were 18 agency doctors (all levels) booked within LYPFT (a reduction of 3 doctors since the last Medical Directorate report in Q1)

New work:

The Medical Directorate continues to work with Medical Line Managers and Heads of Operations in the recruitment and selection of Consultants and SAS doctors. For Consultant posts, the most consistently problematic areas to recruit into are Forensic Inpatients in Leeds and York, WAA Adult CMHT, Eating Disorders, Community LD and Acute Adult Female Inpatients. These posts continue to be advertised month after month with no appropriate applicants. Plans have therefore been made to modify the roles being advertised to increase their attractiveness.

All agency Locum Consultants have been approached to explore if consideration would be made to apply for Trust locum consultant posts. Most have not chosen to apply; however, one agency Consultant has now been appointed as substantive Consultant Psychiatrist in Addictions through this process. Reasons cited for not wishing to apply for Trust locum/substantive posts were the flexibility that comes with agency work (1 week notice and ability to take breaks without restriction), the remuneration, and difficulties experienced in other Trusts when working substantively particularly around accessing annual leave. Please see appendix I for an overview of all the challenges and mitigations for medical recruitment.

Work taking place:

Specialty and Associate Specialist (SAS) Doctors:

A successful round of substantive SAS doctor recruitment has taken place. There were 36 applicants, 9 of which were shortlisted for 8 posts. 3 have been appointed and are currently going through pre-employment checks. There remain gaps, and more recruitment will take place. The Medical Directorate is also exploring the option of recruiting through the RCPsych medical training initiative (MTI) doctors scheme to fill specialty doctor gaps.

The SAS Development task and finish group have identified clinical areas where a specialist grade post could be developed (Connect are keen for this to be part of the medical staffing in the near future rather than relying on agency consultants). A paper outlining the pathway for progression from SD to Specialist grade has now been written, approved at JLNC and the proposal is to be submitted to the financial planning group before use.

Higher trainees

Discussions continue to take place between all eligible Higher Trainees (HTs) and the Professional Lead who meets regularly and routinely with HTs rotating into the Trust to discuss career

opportunities, providing information about consultant opportunities available to them in LYPFT. A system with medical education is in place to ensure all eligible HTs are contacted.

Job planning status update

The LYPFT consultant job plan process underwent internal audit, receiving limited which generated a number of agreed recommendations. A plan with a timeline has been put in place after review of the audit outcomes.

The immediate priority is to provide assurance that 100% job plans are completed in the specified time frame. Work is currently taking place to work with line managers to update the job plan software platform (L2P) and sign off outstanding job plans. The audit identified that the quality of job plans can be improved and, it has been recognised that training needs to take place with Medical Line Managers on the completion of job plans and use of the online platform, and a date has been identified to carry out this training in January 2025.

Following the audit, an action plan has been put into place which can be seen in appendix II

3.3 Specialty Doctor and Associate Specialist (SAS) Advocate update

Our thanks go to Dr Eve Randall who has now moved on after a successful tenure as the first established SAS advocate.

Dr Abhi Inglis has been welcomed as the new SAS advocate for the Trust as of October 2024. Since the last report, the role has continued to attend to the well-being of the SAS group within the workplace, with individual support and guidance being provided where required. There has been ongoing liaison with the LNC and national SAS advocate group to gain and share pertinent information relating to the SAS group both locally and nationally in terms of developmental opportunities, sharing good practice and employment issues. The role feeds into the Specialty Doctor and Specialist Committee (SASC) focusing on ensuring a forum for general discussion of any workplace concerns impacting health and wellbeing and providing peer support.

The SAS advocate leads the organisation of annual SAS wellbeing days, and regularly surveys SAS colleagues Trust on wellbeing in the workplace. We continue to have regular meetings as a SAS development group with a focus on recruitment and retention of the SAS workforce. Recently we have focused on:

- Continuing to look for opportunities to embed the Specialist role within the Trust. A job description for a Specialist post in the CREST team has been sent to the Royal College of Psychiatrists' for approval. There is also consideration of a potential Specialist role in the CONNECT service

  - A policy is to be implemented for re-introduction of progression through moving from Specialty doctor to Specialist status for those SAS doctors who meet the required criteria and where a service need is established is in progress.

  - A Trust pathway to support Specialty doctors to attain AC approval and work through the portfolio pathway to become a Consultant has been formulated and implemented. Sarah Stevens is the tutor to support the applicants. Regular evaluations of the impact of the program will be carried out

  - Ensuring compliance with the BMA SAS Charter: checks were completed against the new charter in September 2024 with encouraging results

  - Ongoing promotion of the mentoring and coaching offer to SAS doctors in LYPFT including recruitment and training of more SAS doctors as peer-mentors.

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

The Andrew Sims Centre (ASC) is actively enhancing professional business relationships by collectively working with colleagues at LYPFT and the Trusts risk management department co-running the 'Structured Judgement Review Training' on 11th December 2024.

ASC continue to build external relationships with Hospital Trusts in the Acute and Mental Health Trusts. Recently, ASC hosted events for Nottinghamshire Healthcare NHS Foundation Trust and Humber Teaching NHS Foundation Trust.

Due to the increase of ASC running costs specifically the increase in venue hire, a review of ASC costs/charges has taken place along in-conjunction with the Trusts finance manager responsible for ASC. At the time of the review and the increase in charges, ASC continued to take bookings. However, due to the NHS financial pressures, there is a noticeable impact on ASC and bookings. There have been nine cancelled events and two postponed events since the last BoD report which, could have a detrimental impact on ASC finances. To mitigate the risks, a priority review of courses bookings and generated income is being compared to the deficit in budget. ASC are also exploring various marketing strategies to boost income and the possibility of reducing meeting room costs.

The centre also supports the administration of medical study leave for Consultant and SAS Doctors, working closely with the Director of CPD.

3.5 Medical Education

It is with great pleasure to report that Dr Rose Laud, was granted the clinical development award from the University of Leeds in September 2024, for her role in our medical education team whilst on placement as a core trainee with LYPFT for the last 3 years. The new MELM (Medical Education Leadership and Management Team) structure has now been embedded and is working well. Due to an increase in Year 4 medical students a sixth firm lead was appointed (Dr Rehana Sultana) on 1st September 2024.

Following the Senior Leaders Engagement (SLE) meeting with the Deanery which took place on 26th June 2024. The key points to highlight are as follows:

- NHS England Workforce Training & Education thanked the Trust for a positive meeting and stated that the Trust has taken significant measures to improve the education and training of all professional groups
- It was noted that the GMC NTS 2023 overall performance was very good, with positive results in overall performance, supervisor contact and core psychiatry. The Trust was one of the top scorers in the United Kingdom (UK) for the 'feedback' indicator with 79% of trainees sharing that they received at least weekly feedback about their performance from senior colleagues, compared to 58% UK wide. NHS England Workforce Training & Education commended the Trust on this result
- It was noted that the Trust had highlighted key work areas and successes, and NHS England Workforce Training & Education praised the Trust for the excellent work undertaken including:
    - Recreating the Academic Clinical Fellowship (ACF) Trust funded posts (5 ACF's annually, 2 of which are National Institute for Health and Care Research (NIHR) funded). The first two ACF trainees had their Doctor of Philosophy (PHD) accepted
    - Hosting the Yorkshire School of Psychiatry Core Trainee of the Year
    - The Foundation Programme has seen expansion in Psychiatry with 6 new foundation year 1 (FY1) posts this year
    - Higher trainee expansion in general adult, child and adolescent mental health services (CAMHS) and old age psychiatry

Postgraduate doctors in training have agreed a deal with the government which has seen an end to industrial action and a challenging time for MELM.

The Trust annual multi-professional NHSE Workforce Training and Education self-assessment return was submitted on 28th September 2024. There were no exceptions to report throughout the return and excellent examples were provided to show how the Trust meets the learning and development needs for its learners in a multi-professional 'cradle to grave' model of continuous professional development.

The Trust continues to expand its offer for medical and non-medical education opportunities, including:

- Undergraduate medical education – expansion in student placements
- Postgraduate medical education – expansion in core and higher trainee posts as well as foundation placements with LTHT
- Virtual MHN student – placement hours increased and offer extended to Allied Health Professional students
- Virtual placements being offered to OTs in CAMHS

We have an award-winning International Medical Graduate (IMG) induction in postgraduate medical education and an excellent IMG mentor programme and handbook to support IMGs new to the NHS and UK

Feedback was provided to show that the Trust is inclusive of all cultures and encourages individuality to enhance the professional and patient experience

Some excellent examples were provided to show how the Trust develops a sustainable workforce with numerous opportunities available for the workforce to develop into.

Current challenges are:

NHSE Workforce Training and Education continues to have significant staffing issues. They are currently operating with a 10% staff shortage plus a high volume of sickness but recruitment to fill gaps is underway. Workstreams and core business continue to be prioritised however this adds workload pressures internally for medical education and PLDT as there is reduced support compared to previously.

The Trust has started the engagement process with the University of Leeds for consideration of teaching trust status. We need to focus on strategy, innovation and future direction, rather than focusing on our already great placement offers. Continuing this process has been agreed as important by senior educators and the SMT to protect the future of mental health and learning disability care. We owe it to our future workforce and patients to be around the table with University of Leeds and acute Trusts for ongoing parity in physical and mental health care and staff training, research, and innovation.

4. RESPONSIBLE OFFICER

Appraisal and revalidation

In the last quarter (Q2) 39 appraisals were undertaken and 11 recommendations for revalidation were submitted and approved by the GMC. One appraisal was late due to difficulties confirming a suitable date. There were no missed appraisals. An internal audit of the Trust's appraisal process (including medical appraisals) has recently been conducted and the final report is awaited.

Following a recent round of appraiser recruitment 3 new doctors (1 consultant and 2 SAS doctors) have been appointed, bringing the total number of trained appraisers to 25. The number of doctors required to take on the role of appraiser remains subject to ongoing review, especially in light of the ever-increasing number of doctors with prescribed connections to LYPFT (134 currently), and the

governance arrangements required for doctors working in the Trust who have a prescribed connection elsewhere (10 currently) which is currently being reviewed. Since the last report the new appraiser training has been updated incorporating Good Medical Practice 2024 guidance and feedback from previous appraisers and positive feedback has been received with respect to the new content and format.

Managing concerns about medical staff

Since the last report the updated version of the Trust's Managing Concerns About Medical Colleagues (Maintaining High Professional Standards) policy has been ratified and is now embedded into practice. Following a round of recruitment and training there are now 41trained case investigators in the Trust with arrangements in place in Q3 for the Director and Associate Directors of Medical Professional Standards to undertake training as Case Managers.

Since the last report:

- Two doctors have been referred by a member of the public to the GMC. The RO has provided requested information to the GMC. The GMC case is ongoing and, although both doctors have since left the Trust, they remain in regular contact with the RO.
- One doctor who was under GMC investigation which was started during their previous employment has had their case concluded by the GMC with no further action.
- One doctor is currently under GMC investigation which was started during their previous employment. The RO has provided requested information to the GMC.
- One doctor who was previously employed by the Trust was referred by a member of the public to the GMC. The RO has provided requested information to the GMC and the case has been referred by the GMC to the Medical Practitioners Tribunal Service (MPTS).
- One agency doctor was referred by a member of the public to the GMC. The RO has provided requested information to the GMC and the case has been referred by the GMC to the MPTS. The doctor's booking with the Trust has since ended and they are no longer working in the Trust.
- Concerns had been raised regarding the conduct and performance of one agency doctor which did not meet the threshold for referral to the GMC. The RO has liaised with the doctor's RO and appropriate action plans have been put into place. The doctor continues to work in the Trust with no further concerns.

Challenges and work planned for Q3/Q4

The RO annual report shared with the BoD on 25 July 2024 outlined the work planned for the forthcoming year. This report has been submitted to NHSE in accordance with regulatory requirements and has been accepted.

In addition to this programme of work, and prompted by recent specific incidents of concern, it has been agreed to review the process by which medical roles are developed and recruited into. This will be a joint piece of work involving representatives from Medical, Workforce and Care Services with the aim of ensuring that all doctors working in the Trust have the necessary skills and support to deliver high quality, evidence-based care.

5. CLINICAL LEADERSHIP AND QUALITY OF CARE

A Clinical Lead Development Day took place on the 17th of September. Building on previous development sessions and using the co-design feedback gained from the session that took place on June, this development day focussed on the following aims and activities.

1. **The introduction of facilitated Action Learning Sets (ALS):** With support from Julie Thornton from the Trust Organisational Development (OD) Team, Clinical Leads received a tutorial on the Action Learning Set model that has been adopted by the organisation. Following the collective development of an ALS Contract, the group were then supported by Julie to complete 3 ALS rounds.

   Feedback from participants identified that this learning and development opportunity was extremely valuable and useful to the Clinical Leads in relation to their roles and practice. It was agreed that an ALS would be planned for the next session to grow the experience and knowledge of the group and to help the group identify methods for including regular ALS within the Clinical Lead community. The aim is that the ALS should be self-sustaining, and that facilitation should be shared by those participating in the group going forward. The development of the skills necessary to be able to do this is an integral part of the ALS experience that Julie and the OD Team have agreed to continue to support the Clinical Lead community to develop. It is hoped that ALS will provide a practical way of embedding the learning and leadership culture, as outlined in the Trust Quality Strategy, within the Clinical Lead community.

2. **Clinical Lead Relational Co-ordination Survey:** Richard Wylde from the Continuous Improvement Team led a session on the Clinical Lead results from the recent Relational Co-ordination survey that was conducted as part of the shared Head of Operations and Clinical Lead development session that took place in July. The session created a space for the Clinical Leads to explore in greater detail the survey results and to have time to work together to explore the learning outcomes.

3. **Barriers to effective dyad relationships:** Using the outcomes of the two exercises above, a "*Goldfish Bowl*" exercise was facilitated to explore the barriers and thorny issues that impact on effective dyad relationships. The outcomes of this work will be taken into the next shared Head of Operations and Clinical Lead event (planned for the 4th of November).

4. **Clinical Lead induction pack:** Using the outcomes of the Co-production Café event, a practical session was facilitated to prioritise the induction activities that the Clinical Lead felt should be completed by month one, three, six, nine and twelve. The decisions made by the community in relation to this work will be used to create a standardised Clinical Lead induction package which will be available as part of all Trust Clinical Lead recruitment processes going forward.

Clinical Directors have discussed the importance of evaluating the effectiveness of the development sessions and the need to ensure that the work completed within the sessions actively supports the development of the nine components identified within the IHI *Learning, Culture and Leadership* quality model as adopted by the organisation and described within the Trust Quality Strategic plan. The Clinical Directors are working with the Head of Trust Improvement Team to create an action plan to address this need.

Following the development of the Clinical Lead Recruitment Process and the inclusion of the Clinical Lead role within the Trust Career Pathway document, the Clinical Directors reviewed the criteria created to detail the experience and skills necessary to become a Clinical Lead within LYPFT. The amended criteria are as follows:

The Role of Clinical Lead is open to all the clinical professional groups where the applicant can demonstrate experience of working and holding responsibilities at a senior level and are able to evidence

1. *They can lead for quality and understand the role of clinical leadership in delivering quality care.*
2. *Experience of combining clinical expertise with quality improvement knowledge / skills to improve services and service user outcomes.*
3. *Experience of using collective leadership to build and lead teams / services.*
4. *They have the knowledge and experience necessary to build the conditions that create a learning culture that enables staff to develop and services to improve.*
5. *Awareness of their own leadership styles and behaviours and the insight to know when to flex these as situations dictate.*
6. *Experience of establishing expectations and standards for the delivery of high-quality care and effective team working including how to challenge appropriately and disagreeing well.*
7. *Experience of frontline clinical leadership when working with complex cases across professional, partnership and system boundaries.*
8. *Direct clinical experience and expertise within the clinical area and with the service user population that they will be leading.*

The Trust Career Pathway document will be amended to reflect the new criteria, and a conversation has taken place with the Trust Recruitment Team to explore how this work can be used to form the shortlisting criteria used within the Clinical Lead recruitment process.

Following a recent request for support in relation to Clinical Lead roles from a Programme Manager and Workforce Project Lead at the West Health and Care Partnership, a request has been made to share the work carried out within the Trust to develop Clinical Leadership at the West Yorkshire New Roles Group in November. Learning from the development of Clinical Leadership has also been shared with Medical Leads as they explore the development of Medical Leadership within the organisation.

A report was prepared and presented to the Trust QuIK meeting in September which summarised the outcomes from the shared Head of Operations and Clinical Lead development session. A second development session is being planned for the 4th of November.

The Clinical Leadership Experiential Learning and Development opportunity that was described within the previous report continues and a mid-point review has been conducted to assess for progress and effectiveness. One to one sessions continue to focus on the application of the 6 behaviours for good clinical leadership.

6. MEDICINES SAFETY

The pharmacy service is making progress to come out of business continuity. Front line and management vacancies are gradually getting filled (at a rate that the team can manage onboarding,

induction and training processes) and some vacancies have been skill mixed to become non-clinical/ non-registered posts.

The team supported the set-up and ongoing delivery of the Autumn/ Winter covid and flu vaccines campaigns for eligible patients and staff.

There remains a backlog of Medicines Governance and pharmacy service development work, there is a draft recovery plan for the pharmacy service work and the same will be developed for the Medicines Governance work in the new year.

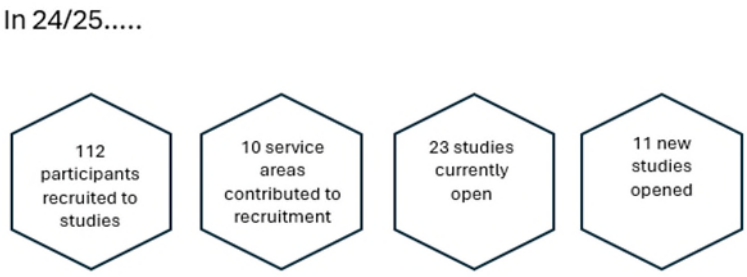
A programme of organisational development designed to allow staff to share views on the service culture began in October 2024.

7. CLINICAL INFORMATION MANAGEMENT

Dr Nick Venters has moved on from his role as Chief Clinical Information Officer after many years of successfully leading on clinical digital innovation in LYPFT. We are in the process of recruiting to a newly created Chief Digital Medical Officer role who will work alongside our digital and informatics colleagues as we continue to move towards our next phase of digital innovation.

8. RESEARCH AND DEVELOPMENT

Research Delivery



Research Staff: Recruitment of new staff to externally funded posts is now much more challenging within the Trust. This is impacting on timelines to recruit staff as well as productivity of the team due to large amounts of time required to complete new administrations processes. This creates a range of risks for the department including breaching contractual obligations, needing to stop or pause active research studies and reputational risk. It is also impacting on staff morale. One member of the research department has started the Mary Seacole training programme.

Staff Development: The latest cohort of our MESH students includes six university nursing students from Leeds Beckett University and Huddersfield University. With eight more from University of Leeds and Leeds Beckett University signed up to take part in January. With these students comes the support and understanding of their assessors and colleagues too and strengthens our links with local universities.

In addition, the Research Champions Network is now set up and running smoothly. Over 20 members of staff now represent their service as the Research link between R&D and their service, and they meet bi-monthly. It has already shown progress, with four of these staff members taking up the opportunity to apply for an NIHR Internship and further expressions of interest for research involvement being expressed from their colleagues to whom they have shared their knowledge and skills with.

Service user feedback: This year's annual report was co-designed with service users. The final version can now be found on our website.

''Working on this project was very rewarding. It was inclusive and interesting. As a Service User it is really frustrating when the outcomes of a research project to which you have contributed are presented in wordy, complex terms. This was an opportunity to improve the accessibility and quality of the information." HEER Group Member

The Patient Research Experience Survey is used to collect feedback from research participants. The responses are used by the R&D team to highlight positive experiences and to identify areas for improvement or change. Here are some replies to the question 'What was positive about your experience of research?'

"I felt that my input was highly valued, even when I had to stop taking the medication. I was always treated with respect and never spoken down to"
"It was like therapy"
"The chance to contribute especially to research into mental illness which has affected so many members of my extended family."

Research Ready School's programme: The Child Oriented Mental Health Innovation Collaborative (COMIC) team delivered a six-week programme to Year 4 children at a local primary school. The children were taught about the research process, the importance of mental health research and how they could get involved in research. By the end of the programme, the children were able to use their knowledge to develop a research question, collect some data and present this as a poster to deliver to the class.

Social media and sharing outputs of research: Members of the research team have delivered workshops with SUN network members and the HEER Group, to discuss the departments use of social media and how outputs of research are shared. Feedback is being taken into consideration for future use of social media platforms and to feedback to study teams to improve the accessibility of research outputs.

9. IMPROVEMENT AND KNOWLEDGE SERVICE

The Improvement & Knowledge Service (IKS) aims to build a culture of continuous improvement and knowledge sharing within the Trust to provide outstanding mental health and learning disability services. It supports, coaches, trains, and facilitates activities and projects to benefit service users, carers, staff, partners, and the wider community. The IKS publishes monthly reports detailing its active projects, other activities, completed annual service quality reports, and progress on its

development plan. This overview highlights key areas from the last 3 monthly reports under the headings of Alerts, Advise and Assure. The full reports are available on request from IKS.

Alerts

- **Capacity constraints across all teams are putting a strain on the IKS**
    - The **Clinical Effectiveness Team** has been understaffed by 2 posts since March 2024 and operates at full capacity, meaning it would struggle to support project leads if a team member were off for a prolonged period. Work will start now to review which activities are supported and which activities will no longer be offered from the team.
    - **Only one staff member (the Senior Improvement Manager) is responsible for coordinating compliance with NICE guidance across the Trust**. The post that was created to bridge this gap currently is not able to undertake the learning needed to fully mitigate the issues due to the other current vacancies in the team.
    - The **Library & Knowledge Services team** is also working at full capacity, further strained by a librarian on maternity leave since April 2024. Although the Library and Knowledge Services Manager can help with some tasks, the team has extended literature search due dates to 20 working days and prioritised searches for direct patient care.
    - The **Improvement team** has a vacancy that is impacting on the amount of support the team can offer. The team is pulling together to cover essential elements of the vacant role and support the Improving Flow Programme and Link role relationship building.
    - **Clinical effectiveness team** - one NICE guidance requires an action plan to achieve full compliance: NG215 (medicines associated with dependence or withdrawal symptoms). Despite initial low engagement due to staff moves within Forward Leeds, the action is with the new Clinical Lead and Clinical Director who are making progress on the implementation which needs to be completed by April 2025.

Advise

- The current situation will inevitably leave gaps in the work planned for this year across the department. Where these exist, there are plans to reinstitute the work when funds for staff are available.

Assurances

- **Commitment to Quality Improvement:** The IKS has demonstrated its commitment to quality improvement through its extensive portfolio of active projects. In August 2024, there were 71 active projects across various service lines. By October 2024, this number had risen to 87 – an increase of 13 for the Clinical Effectiveness Team and 3 within the improvement team. The Library and Knowledge provided 31 literature research in the last 3 months covered by this update.
- **Proactive Management of Capacity Constraints:** Despite staffing shortages, the IKS has implemented internal processes to prioritise projects and manage its workload effectively.
- **Collaborative Working Relationships:** The IKS actively engages with other corporate and clinical teams, fostering a collaborative approach to quality improvement.
- **Positive Staff Feedback:** The IKS consistently receives positive feedback from staff who have used its services, highlighting the team's effectiveness and responsiveness
- **Continuous Development:** The IKS is actively pursuing its development plan, focusing on strengthening its impact measurement, improving NICE guidance processes, and building improvement capabilities across the Trust.
- **Clinical audit Priority Plan 24/25**: overall the agreed projects within the Trust Plan for the current financial years progress as scheduled.

Key Insights

- The IKS plays a vital role in driving continuous improvement, fostering knowledge sharing, and promoting evidence-based practice within the Trust.
- The service faces critical capacity challenges due to staffing shortages, impacting directly on to its operational effectiveness and ability to support the Trust.
- The board can be assured of the IKS's dedication to quality improvement, evidenced by its active project portfolio, collaborative working relationships, positive staff feedback, and ongoing commitment to development.

11. CONCLUSION

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

12. RECOMMENDATION

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

Dr Christian Hosker

Medical Director

November 2024

Appendices

Appendix I: Medical recruitment challenges and mitigation plans

Adult Acute Services	
Challenges	Ongoing reliance on agency consultant cover on Ward 1 Becklin Centre and an inability to support training posts in that unit.
Plans	Investment into the working age acute service has been secured, allowing the job plans for consultants to be brought into line with national guidance, and making LYPFT a competitive employer in the region. All the JDs for the WAA IP service have been updated and are with the College for approval currently.
Working Age (WAA) Community + Wellbeing Service	
Challenges	An agency consultant remains in ENE CMHT following a retirement in December 2023. WAA West CMHT continues to have two consultant vacancies covered by agency locum consultants. An agency locum SD is covering a period of maternity leave too until March 2025. WAA South CMHT has one consultant and one SAS doctor vacancy both covered by agency locums.
Plans	A business case aligned to community transformation was approved in early 2024 and has enabled more attractive CMHT JDs to be created. One internal transfer into a vacant consultant position in West CMHT is now already pending (start date March 2025) with other new posts now being advertised. 2 previous trainees with LYPFT and one due to come to the end of training in 2025 have strongly indicated they will apply for one of the new less than fulltime CMHT posts. Recruitment is taking place for the SAS doctor in South CMHT and is scheduled for 27th November 2024. The vacant CMHT posts continue to be advertised.
Eating Disorders + Rehab	
Challenges	Eating Disorders continues to be a difficult to recruit to post, largely due to the paucity of qualified consultants. There remains one agency consultant in post.
Plans	A less than fulltime substantive consultant will return from a career break on reduced hours in Nov 2024. A skill mix review is being undertaken to better understand the medical staffing requirements, the likely outcome of which will be advertising for a Specialist Grade post rather than Consultant in future. This is still being considered in the service.
Forensic services	
Challenges	The Leeds forensic service has only one substantive consultant and three consultant vacancies which are covered by agency locums.

	There remains one agency consultant locum at Clifton House covering a vacant post.
Plans	Posts and job descriptions have been reviewed and are being advertised now. There is a pending internal transfer of an experienced consultant who will start in the Leeds forensic service in Feb 2025, and a further potential candidate for one of the remaining vacant posts following the medical lead proactively searching for applicants. An experienced SAS Dr was recruited to Clifton House, motivated by the improved offer for SAS Drs to be supported in being able to apply for a consultant post via our new portfolio pathway. It is anticipated that in time this may evolve into an application for the remaining consultant post.
Older Peoples Services	
Challenges	There is a single consultant vacancy covered by an acting up process
Plans	An AAC is taking place in November 2024 for the vacancy in South CMHT created from a consultant resignation. This single vacancy was briefly covered by an agency Consultant until a higher trainee acted up into the vacancy from Q3 with substantive selection and appointment process now live. OPS CMHT and IPs will then be fully recruited should this applicant be successful.
Learning Disability	
Challenges	There remains one consultant vacancy, which is covered by an agency locum consultant. This is proving a very difficult to recruit into post due to the national shortage of LD consultants.
Plans	A new substantive SAS doctor commenced in Q3 due to a vacancy left when the previous SD went into training. A GP has been appointed to bolster the physical health provision.
CAMHs Services	
Challenges	There remains a vacant 0.6 substantive consultant post at Red Kite View. Currently there is an agency consultant covering this post. At Mill Lodge there remains a consultant vacancy due to a resignation. This will be readvertised in Q3 and currently has agency cover in place until January 2025. There is also a 0.6 SD vacancy at Mill Lodge in the day treatment service Willow View.
Plans	There are ongoing discussions with the medical lead and a potential applicant for the consultant post and the post will next be advertised in line with this applicant being able to apply. Both Mill Lodge posts continues to be advertised; but there is discussion ongoing about a possible joint SD post between RKV and Mill Lodge between the medical leads, given how difficult the 0.6 post has been to recruit into.
Specialist Services	

Challenges	There in one consultant vacancy in Forward Leeds.
Plans	The current agency doctor has been appointed to one of the vacancies and commences in November 2024. This change from agency to substantive followed a series of conversations with that individual and the service and professional lead. A 2nd SAS doctor, experienced in addictions will also be starting in post 6th December 2024. This is a fixed term post utilising the second consultant funding as an interim to support the service in the absence of a 2nd Consultant.
Perinatal	
Challenges	One community consultant is due to move internally in March 2025 to West CMHT.
Plans	The clinical lead is actively speaking to potential applicants for this post who have been previous trainees/known consultants interested in perinatal work. A current trainee in the service is also considering acting up for 3 months into this post and this opportunity will be shared widely to all other LYPFT trainees eligible.
CRISS	
Challenges	There will be a vacancy in W ISS in Feb 2025 as the current postholder is moving on to forensics at Newsam. There is also a SD vacancy there currently filled by agency – this has not yet been recruited into as the doctor is on long term sick leave but has now given a retirement date.
Plans	The medical lead in CRISS is updating and leading on advertising the W ISS consultant post. It is likely there will be a need for an agency locum prior to substantive recruitment. This post will also be advertised as an acting up opportunity to current trainees as there is an interested applicant for this. The SD post will be advertised in the next round of SD recruitment for a February starter.

Appendix II

Job planning actions

ACTION	**ACHIEVE BY:**
All job plans need to be completed a minimum of annually, the first one being within 3 months of start date. If there is change to work pattern the job plan needs to be reviewed and updated.	Dec 2024
All consultants to have an up to date agreed (signed off) job plan. If not, then need to have an action plan in place for how to get to this e.g. mediation. This data can be fed back when asked for.	Dec 2024
All consultants to have a job plan meeting with their MLM (Medical Line Manager) and Head of Ops (HoOps) The meeting will generate 3 SMART objectives as a minimum which relate to the service and/or the Trust, for example related to patient access, patient experience, patient safety or financial balance. These can overlap with appraisal objectives but must be able to identify how each contributes to the service. The HoOps can help shape these objectives if they attend – this is optional and not contractual.	Oct 2025
Pilot of the below action within some services eg CRISS, LADS, OPS IPs perinatal/West CMHT: Group job planning meeting introduced *prior to* individual job planning meetings, to understand the needs of the service and how the Consultants can share meeting this demand. Meeting will be with Professional Lead, MLM and the Consultants in the service.	Oct 2025
Having learned from the pilot (above) development of new process by Professional Lead, Medical Directorate staff and MLMs which: • focusses on how to develop meaningful objectives for the service and the individual • includes the HoOps • reflects the service requirements • includes an annual group job planning meeting prior to individual meetings • brings into line the job planning process with the financial year	Nov 2025
Introduce new process for job planning	April 2026

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

AGENDA ITEM

16.1

PAPER TITLE:	Guardian of Safe Working Quarterly Report Quarter 2: 1st July 2024 to 30th September 2024
DATE OF MEETING:	28 November 2024
PRESENTED BY: (name and title)	Dr Chris Hosker, Medical Director
PREPARED BY: (name and title)	Dr Rebecca Asquith, Guardian of Safe Working Hours

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

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	
SR5	Adequate working and care environments	✓
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

EXECUTIVE SUMMARY

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

- There have been 2 exception reports and 0 patient safety issues recorded in this period
- Junior Doctors Forum met in July 2024 with continued review of ERs and rota gaps. Feedback is also received from Core and Higher Trainee Representatives.

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

RECOMMENDATION

The Board of Directors are asked:

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

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

MEETING OF THE BOARD OF DIRECTORS

DATE 26th September 2024

Guardian of Safe Working Hours Report

Quarter 2: 1st July 2024 to 30th September 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 01.07.2024 to 30.09.2024.

2 Quarter 1 Overview

Vacancies		There are a total of 41 Core Training posts and 2 NIHR posts. There are a total of 34 Highter Training posts plus 1 psychotherapy post borrowed from Forensics. All schemes are full. FY3 (trust doctor) recruitment now sits within the Medical Directorate.					
Rota Gaps		July		August		September	
		CT	HT	CT	HT	CT	HT
	Gaps	24	22	13	14	12	9
	Internal Cover	18	22	9	13	11	9
	Agency cover	0	0	0	0	0	0
	Unfilled	6	0	4	1	1	0
Fill Rate		75%	100%	69%	92%	91%	100%
Reasons for Rota Gaps		Sickness (12) LTFT (6) Vacant (2) Off rota (4)	Left trust (5) Vacant (3) Left trust (7) LTFT (7)	Sickness (11) Mat leave (2)	Sickness (4) Vacant (6) Left trust (3) LTFT (1)	Sickness (3) Vacant (4) LTFT (2) Off rota (3)	Sickness (3) Vacant (5) LTFT (1)
Exception reports (ER)		2 exception reports (ER) have been submitted in this reporting period. Both were in relation to loss of educational opportunities when the on call doctor allocated to ALPS was called back to support the PROC rota doctors due to increased volume of work load. On both occasions, the doctor was able to return to					

	support the necessary work and then return to ALPS as intended. No patient safety concerns were raised, nor any breaches of the Terms and Conditions of the Junior Doctor Contract. Both ERs were closed without further action required. Following ERs from 2023 submitted by Foundation Trainees, the generic work schedules issued by LTHT have been updated to more accurately reflect psychiatry placements within LYPFT. There remains ongoing work to clarify LTHT are collecting personalised work schedules from Foundation Doctors as per the contract, although this sits within the remit of LTHT as lead employer.
Fines	None
Patient Safety Issues	None
Junior Doctor Forum (JDF)	The meeting held during the Q2 reporting period took place on 19th July 2024: - No concerns were raised by the representatives of the Junior Doctor Committee (JDC) or Higher Trainee Committee (HTC) - Following discussions with MEC, trainees and the BMA, it is agreed that trainees taking Fridays as their non working day will be asked to work on call shifts that fall on this day. If unable to agree to this, a different non-working day will need to be considered. This is to ensure equity across all trainees. - High staffing vacancies at HEE were noted, with agreement that any delays or concerns should be escalated to Educational Supervisors. - The NHSE sponsorship handbook was reviewed, noting that it is imperative that NHSE are made aware of any changes to the circumstances of sponsored doctors. Additionally, minimal salary requirements for sponsored doctors were noted, which can have implications for those working LTFT. MEC plan to liaise with HR to ensure relevant processes are in place. - The JDC Terms of Reference and Wellbeing in Trainee Psychiatrist documents were approved. - A request was made by GOSW for the Exception reporting details to be added to on-call rotas for ease and to encourage Exception Reporting. - A motion has been passed by the BMA for the term ‘Junior Doctor’ to be replaced with ‘Resident Doctor’. This will be considered further in the next JDF. Careful consideration will need to be given as to the naming of the JDF, JDC, and terminology used within the organisations administration. The BMA are using the term ‘Resident Doctors’ but it is noted that within our organisations and rotas such a term could be confusing (as some ‘junior doctor’ shifts are non-resident) This is also being discussed in other forums. Note that the 2016 contract for ‘doctors and dentists in training’ does not use the term junior or resident doctor. - The next JDF was scheduled for 25th October 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 reports provides an assurance level for the systems in place to support the working arrangements of the 2016 TCS for the junior doctors are working in the Trust and that they are meeting their objective of maintaining safe services

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

Dr Rebecca Asquith
GMC 7151560
Guardian of Safe Working Hours

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

AGENDA ITEM

17

PAPER TITLE:	Director of Nursing and Professions report
DATE OF MEETING:	28 Nov 2024
PRESENTED BY: (name and title)	Nichola Sanderson, Director of Nursing and Professions
PREPARED BY: (name and title)	Nichola Sanderson, Director of Nursing and Professions and members of the Nursing and Professions Directorate Alison Quarry, Deputy Director of Nursing

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.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	✓

EXECUTIVE SUMMARY

The purpose of this report is to provide a quarterly update to Trust Board members in relation to progress across the Directorate of Nursing and Professions. The Directorate continues to progress several workstreams and projects, working with operational and clinical colleagues to improve quality and safety for patients and staff.

Overall the Directorate is driving change for patients and staff and is positively progressing.

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

Board members are asked to note the contents of this report and continue to be assured of the breadth of work, mitigation of risk, progress and oversight across this Directorate and its portfolios.

Meeting of the Trust Board of Directors
November 2024
Director of Nursing and Professions Quarterly Report

This paper provides an update and overview of key programmes of work and progress with the Nursing and Professions Directorate, which centres around the continued ambition to provide safe, effective, high-quality care to all who are involved in LYPFT and the wider ICS.

Risk Assessment and Safety Planning

An implementation plan for the new Risk Assessment and Management Plan (RAMP) template has been agreed. This is planned to go live on Care Director on 25th November 2024. There will be a 3-month transition period, whereby RAMP will be live alongside existing risk assessment forms, after which time FACE and SAMP will be removed from the system as active forms. After the 3 months, previously completed FACE and SAMP assessments will remain available on the patient record as read-only documents.

To support the implementation, a range of resources to provide guidance and support to staff will be available. This includes a Staffnet page, FAQs document, example case studies, good practice guidance, presentations and information sessions. The new Clinical Risk Assessment and Management Procedure C-0011 has been through a period of consultation and is pending approval. It is expected to be ratified in December 2024.

The Trust wide clinical risk training is under review, a recommendation will be made for this training to be compulsory for all clinical staff in patient facing roles; currently it is only compulsory for registered practitioners. The current training will be reviewed, and this will include how to ensure the training is extended to non-registered patient facing roles.

LYPFT hosted a site visit with leading experts from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) and the National Collaborating Centre for Mental Health (NCCMH) on 2nd October 2024. Feedback from the day were attendees reporting that they found it useful and valuable with some powerful reflections to take away. NCISH and NCCMH commented positively on the work LYPFT have done to date and the engagement and coordination of the event.

This is part of the Culture of Care programme, for which LYPFT were selected as 1 of 10 organisations in a year 1 cohort for the personalised approach to risk element of

the programme. The support of this programme will build on and enhance the positive work already underway across the organisation.

Observation and Engagement

There are several initiatives both locally and nationally that we are involved in.

Observations and engagement are often used within mental health inpatient settings as an intervention to support and manage a person's care, safety, and wellbeing. Observation and engagement applies to all service users who are inpatients. Observation and engagement are a skilled clinical intervention that should also be understood as a restrictive practice.

Leeds and York Partnership NHS Foundation Trust have recently undertaken a series of workstreams to strengthen and develop their work around observations and engagement, acknowledging the importance of this intervention and are committed to improving the experience for both service users and colleagues alike.

This work will be completed alongside a national programme taking place on observation and engagement. This has been initiated following the development of the National Guidance on Reducing Harm from Ligatures in Metal Health and Learning Disability in Patient Environments by the Mental Health and Learning Disability Forum. This is in collaboration with experts by experience and the CQC recognising that observation and engagement plays an important role in the reduction of harm.

The areas of the workstream include

- Creating Best Practice Guidance
- Workforce & Training
- Recording & Technology

In December 2024 members of these workstreams will come together in two face-to-face meetings to share the work to date and develop a set of principles for the council to consider, with a view to entering consultation on this by the end of the calendar year.

In the summer of 2023, LYPFT carried out an audit on the implementation of the Trusts Observation and Engagement procedure. This identified areas of good practice and areas for improvement across our inpatient services. A series of actions were identified including a training package developed with colleagues, service users and carers, who shared their experiences of how observation and engagement can be used effectively and how it felt to be observed. This has been made available to colleagues on our learning platform and is a priority training across inpatient wards.

LYPFT is committed to understanding patient experience relating to the use of observation and engagement within our services following on from our training package. A workstream has commenced which is being supported by a number of professionals including the Patient Experience Team to gain more in-depth feedback from those who have experienced the use of observations. The team working on this will ensure that this valuable feedback is sought in a sensitive and trauma informed way. We also want to better understand the quality of the interventions carried out by our staff. Several approaches to look at this will be used, such as an audit of clinical documentation, discussion with clinicians, and direct observation of practice. The patient experience feedback will also support this work.

Our clinical services are also reviewing local practice. Our dementia Inpatient Service has commenced practice evaluation work to understand 'what good looks like', with the aim of efficient, effective and good care; to reduce restrictive practice and improve patient care. This will involve a full review of observation data, both qualitative and quantitative, creating a methodology that can be replicated across other Mental Health Trusts for a comparison and exploration. Several local Trusts are also going to be approached to understand other factors that may play a part in observation and engagement levels, such as environment. As a result of this there may be scope for a quality improvement project. The Dementia Inpatient Service has involved a range of professionals, including those involved in the Trust wide work outlined above, to ensure joined up working and sharing of learning and good practice.

MHOST Tool and Review Nationally for Chief Nurses/SSG Leads

LYPFT recommenced the use of the MHOST tool following a pause in its application due to the pandemic. In addition, the Chief Nursing Officer, Safer Staffing Faculty provided training in the application of the MHOST tool in practice to our Nurse Leaders across out Inpatient Services.

All inpatient areas have recently completed their annual safer staffing establishment review. The reviews have focussed on identifying whether the current planned establishments across inpatient wards remain appropriate to deliver safe and effective care. This has been achieved through the application of the triangulated approach including the use of MHOST data, quality outcomes and professional judgement. This process was coordinated by the Professional Lead Nurses and the final recommendations will be presented to the Executive Director of Nursing and Professions by December 2024.

The Shelford Group Chief Nurses have decided it is the right time to review and update the MHOST and have asked the Deputy Director CNO, Safer Staffing Faculty, and the faculty team to support this work. As part of this review LYPFT engaged in providing feedback on the current version of the tool and identifying considerations of what we would like to see in the next version ahead of the Professional Reference Group.

Our wards over recent years have moved away from a traditional staffing model whereby Registered Nurses and Health Support Workers make up the staffing establishment. It is acknowledged that service user need is about skill mix not just staffing numbers. It is about other MDT professions and how this can be incorporated into the tool to support staffing decisions.

The progress and update in relation to the review and how this will impact on LYPFTs staffing establishment reviews will be reported through the Safer Staffing report.

Practice Learning and Development Team

The Practice Learning and Development Team (PLDT) continue to engage with the University of Leeds and Leeds Beckett. In December 2023 the team attended a recruitment event, actively engaging with 3rd year nursing students. The 3rd year nursing student's mental health cohorts continue to be smaller than usual. We continue to offer a broad range of student placements for AHP's, this now includes paramedics and undergraduate social workers.

There is 47 Registered Nurse Preceptees compared to 32 in 2023, with start dates between the 30th August 2024 and the 31st December 2024. In addition, we have one Registered Nursing Associate, 11 Occupational Therapists, of which six are employed on the OT rotation programme. There are 2 Registered Dieticians. We also have six newly qualified Social Workers, who are being supported on the year of employment (AYSE) programme.

Prior to preceptees commencing their clinical roles, the PLDT facilitated two study days called Transition Training. This will enhance confidence to translate skills learnt through an undergraduate course to the preceptorship period. The Legacy Mentor role complements the existing preceptorship and development programmes by creating an additional layer of support. Funding for the Legacy Mentor role is due to end in March 2025.

Naso-Gastric Enteral Feed Pathway

A Trust Nasogastric (NG) Insertion and Feeding Procedure for inpatients has been developed for the areas of the Trust that provide nasogastric enteral feeding. These areas are Ward 6 Newsam Centre, Red Kite View, NICPM and Mill Lodge, York.

The procedure has been created by the NG Feeding Collaborative Task and Finish Group, which was set up in July 2023. Subsequently this has evolved into the NG Governance Forum. The group has representation from all relevant clinical services, Trust wide subject matter experts and is co led by the Professional Lead for Allied Health Professionals and Nurse Consultant for CONNECT.

The NG insertion and feeding procedure has been created to standardise NG insertion and feeding practice across the four wards in line with national NG standards and guidance.

The procedure includes:

- A pathway for NG feeding, with defined criteria when to NG feed and when to support a food first approach.
- The importance of an exit strategy / plan from the start
- Guidance on the legal and professional framework when NG feeding
- Outline of NG insertion and feeding staff competency training model
- Step by step guidance for inserting and removing an NG tube safely and who can do this
- NG insertion and feeding equipment; what to use and how to use it.
- NG feeding process e.g. ordering and delivery of feeds and who can do this.
- Administration of medication
- Standardised documentation

The above work requires ratification and approval via the governance process. Further updates will be provided.

Reducing Restrictive Practice, Human Rights Decision-Making Framework

In response an increase in incidents of restraint linked to planned care interventions throughout 2023/2024, the Positive and Safe Working Group (PaSWG), (in collaboration with LYPFT's Human Rights Community of Practice (CoP) has developed a Human Rights Decision-Making Framework. This framework is based on an adaptation of the widely recognised FAIR human rights decision-making tool.

The FAIR approach guides clinical staff in applying a human rights-based perspective to decisions involving restrictive interventions. It helps teams understand the facts of the clinical situation and carefully examine how the planned use of a restrictive intervention interacts with the service user's human rights. This ensures that any absolute rights remain protected, and any restriction on non-absolute rights is lawful, legitimate, and proportionate.

The framework further clarifies individual responsibilities, supports the creation of an action plan, and outlines how the care plan will be reviewed. At every stage, the service user's experience and views are placed at the heart of the decision-making process.

By integrating this human rights approach into clinical decisions around restrictive interventions, the framework aims to ensure that such interventions are only used when absolutely necessary and always in the best interest of the service user.

Since its introduction around April 2024, the tool has been recognised nationally as a significant step toward supporting clinical decision making involving restrictive

interventions and reducing the disproportionate and unnecessary use of restrictive interventions. Many other organisations are now looking to adopt the framework into their practice. Throughout 2024-25, the PaSWG will continue rolling out the FAIR decision-making tool and will evaluate its impact on the use of restrictive interventions.

Reduction in Use of Prone Restraint During Incidents of Seclusion

Seclusion is a restrictive intervention which involves the supervised confinement and isolation of a service user, away from others, in an area from which they are prevented from leaving (usually by means of a locked door). It should only be used when there is an immediate necessity and when severe behavioural disturbance likely to cause harm to others, cannot be safely managed in a less restrictive way.

Historically, during incidents of seclusion, staff have only ever been taught to utilise prone restraint to physically hold a person to facilitate a safe exit from the seclusion room. As part of our commitment to reduce the use of prone restraint, the Prevention and Management of Violence and Aggression (PMVA) Team engaged in a focused piece of work at Red Kite View. A change in practice was initiated whereby an alternate safe exit from seclusion, using a seated restraint in the Safety POD was introduced, as opposed to prone restraint on a bed. A safety POD is a specially designed bean bag that maintains the patient's body angle at 135 degrees. This provides optimised chest expansion and lung function and minimises the risk of head trauma during restraint. This work commenced at Red Kite View and has been introduced into training for all clinical staff in all areas. This technique was rolled out within the PMVA training syllabus in December 2023. The PMVA Team will continue to monitor and assess the impact of this intervention on the use of prone restraint throughout 2023-2024. This will be shared with PaSWG as part of the quality improvement plan. Whilst it is too early to determine the long-term impact on the use of prone restraint in seclusion practices, it's notable that between November 2023 and March 2024, only five out of thirty-four seclusion incidents involved prone restraint.

Band 5 to 6 Competency Framework, Occupational Therapy, Nursing and Social Work

National and local workforce data shows us that we lose some registered staff (Nursing and AHPs) from employment post registration in a 2–3-year period. The RCN analysed the latest NMC data of UK-educated nursing staff leaving the register in England between 2021 and 2024. The numbers leaving within 10 years of registering increased by 43%, whilst those leaving within five years rose by 67%.

The Trust provides a clear development programme for preceptees within the first year of their registered employment. This is always positively evaluated. We are aware that to retain registered Band 5 staff, there needs to be investment and clear progression opportunities. The framework is designed to contribute to retaining and supporting registered staff, providing clarity on expectations and improved job satisfaction. An evaluation plan is being developed to understand the impact of using

it in practice.

The Band 5 to 6 competency framework can commence following successful completion of the preceptorship programme (ASYE programme for Social Workers). This framework provides guidance on the required competencies to progress to a Band 6 position. It is designed for use in specific posts where progression from Band 5 to 6 is expected and supported, for example when a Band 6 vacancy has been difficult to recruit into. It may also be useful for existing Band 6 staff to map themselves against to help identify areas for development. This framework is being shared at Tier 3 Clinical Governance meetings, having been signed off at Unified Clinical Governance Group and Nursing and Professions Council.

Seasonal Vaccinations Update

Staff vaccination clinics commenced on the 7th October 2024 with flu and covid vaccines on offer to frontline direct patient staff (non-clinical staff only flu vaccine on offer). This year vaccination clinics are drop-in at the convenience of staff without the requirement to book an appointment in advance.

November vaccination uptake figures are as follows:

- Frontline flu – 811 equating to 33.7%
- Frontline covid – 759 equating to 31.5%
- Inpatient flu – 16
- Inpatient covid – 44

The lower uptake for both covid and flu vaccination is reflected across the region, although it is early in the campaign. Covid vaccination uptake ranges between 9% - 23% across the West Yorkshire NHS organisations and between 14% - 43%. The view is that staff last year experienced vaccine fatigue, this may be the case for this year, but it is too early to evidence this.

Health Services Investigations Body (HSSIB) Investigation Report

HSSIB published the findings in October of their investigation report: Mental Health Inpatient Settings: Creating Conditions for The Delivery of Safe and Therapeutic Care to Adults. The series of investigations was announced by the previous Secretary of State for Health and Social Care in June 2023. A brief summary of the findings included:

Workforce

- Patients did not always feel safe, and staff were not always able to develop therapeutic relationships with patients, workforce challenges were a factor

here. Some inpatient models continued to focus on restrictive rather than relational approaches.
- Care needs of patients have changed, and acuity may now be greater than in the past. Wards were not always staffed to ensure patients could access the skills and knowledge of the MDT.
- The goals of the NHS Long Term Workforce Plan may be unattainable if barriers to implementation are not recognised and addressed.

Built mental health inpatient environments
- Building environments varied. Some were not therapeutic and created unsafe situations for patients and staff.

Social and organisational factors influencing mental health inpatient care.
- The development of psychologically safe and therapeutic environments was not always possible because of demands on services and workforce challenges.
- Availability and access to physical healthcare varied and care pathways between different providers in some locations were limited, increasing the need for patient transfers and impacted on continuity of care. Providers were not always accommodated in single sex accommodation and best practice standards related to sexual safety were not always adhered to.
- Inequalities in care continued to exist, some organisational cultures and individual beliefs continued to negatively influence attitudes towards people's care, including access to physical healthcare.

A number of recommendations were identified for the Department of Health and Social Care, NHS England and The Shelford Group. These include:

- Reviewing and updating the Mental Health Optimal Staffing Tool to support decisions around workforce requirements.
- Review the NHS Long-term plan with considerations of changes in patients' needs and an MDT approach.

Over the next few months, the Nursing Directorate will provide further updates regarding this newly published report.

Chief Nursing Officer NHSE Nurse Leaders Forum and Mental Health and Learning Disability Forum.

Duncan Burton was appointed to the role of Chief Nursing Officer for England and Executive Director at NHS England on 25 July 2024. In September Nichola Sanderson attended the Northeast Yorkshire Regional Directors of Nursing Forum and Mental Health and Learning Disability Forum, where the CNO offered the chance for nurse leaders to discuss how nurses can shape the 10-year health plan. The CNO discussed how we make the profession more attractive to young people to move away from a

reliance on overseas recruitment. Apprenticeships were discussed and how government support is needed to balance these routes into mental health care vs university routes. There is a plan to develop good diverse leaders. Support for new Directors of Nursing was debated, with a plan to develop a pipeline of strong leaders in complex environments. Mental Health inpatient environments was also a priority for the day, and the CNO had undertaken a visit to Southwest London and St George's Mental Health Trust, noting significant transformation in the community services and the estate. Included in this was the advance in digital health care.

Nursing and Midwifery Council Update

An update on the NMC Independent Culture Review (relating in part to timeliness and inequalities of NMC fitness to practice referrals) was provided in the previous Director of Nursing and Professions Board Report. The NMC have launched an improvement plan which includes a survey sent to all Directors of Nursing. This closes at the end of November and a further update will be provided as the plan progresses.

Supporting Research Leadership Roles for Nurses and Midwives

The NIHR (The National Institute for Health and Care Research) has supported the pilot of a hybrid research placement model for pre-registration nursing students working in mental health settings. This placement model will enable nursing students embedded in certain clinical placement areas to be linked with their local NHS Research and Development Team so that they can gain first-hand knowledge and experience of clinical research. The pilot builds on the work initiated at Leeds and York Partnerships NHS Foundation Trust and involves four NHS Mental Health Trusts in England. This work is being led Wendy Andrusjak from the LYPFT Research Team, the MESH programme (Mental Health Student Hybrid Placement programme), and it is great to highlight the great work the Research Team are doing to support our nursing workforce but also how their work has been picked up at this level. The NIHR published an update in the Nursing Times, mentioning the LYPFT MESH programme.

Triangle of Care Patient and Carer Experience

We are pleased to share the Trust was notified in April 2024 that we have retained the one- and two-star Triangle of Care accreditation. This is testament to the hard work of all involved, in particular the Patient Experience Team and signifies the Trust has strategic plans in place to ensure that our teams and services are working towards achieving each of the 6 standards and to encourage a culture where these standards become part of everyone's, everyday practice.

The Chaplaincy Service is transitioning from a mono faith to a multifaith model. This is the preferred model within the NHS, and ensures we provide the broadest possible spectrum of spiritual, religious, and pastoral needs for our patients and staff. As part of this, the Trust now has several volunteer Chaplains, which enhance and support

the improvement in visibility of the service. To help progress a solid understanding of what chaplaincy is, what chaplains do, what skill sets, and training chaplains have, and how the Chaplaincy can be better used, it is important to reach out to colleagues and offer training in these relevant areas. The team have begun rolling out educational opportunities for staff, with more planned for the new year. In January 2025, the team will offer several sessions based on updating staff on the role, skills and place of Chaplaincy in the 21st Century.

Care Quality Committee Update

On the 15th October 2024, Sir Mike Richards published a review of the CQC's single assessment framework and its implementation, and on the 17th October 2024, Dr Penelope Dash published an independent report focusing on the operational effectiveness of the CQC. The review focused on the changes implemented by the CQC following the publication of its strategy in 2021, and their impact, including the introduction of a single assessment framework, the development of a new IT systems, named the regulatory platform and a restructure within the organisation. The review and report concluded several findings and recommendation. This included the following highlights:

- Operational performance was poor, with a stark reduction in activity.
- There were delays in producing reports and the standard of reports was of poor quality.
- Loss of credibility within the health and care sectors due to the loss of sector expertise and wider restructuring, resulting in lost opportunities for improvement
- Concerns around the single assessment framework (SAF) and its application
- Lack of clarity regarding how ratings are calculated and concerning use of the outcome of previous inspections (that often took place several years ago) to calculate a current rating.
- CQC could do more to support improvements in quality across the Health and Care Sector.

The review identified several areas for improvement including:

- Rapidly improve operational performance, fixing the provider portal and regulatory platform, and improve the quality of reports
- Rebuild expertise and relationships with providers
- Review the SAF to make it fit for purpose with clear descriptors and a far greater focus on effectiveness, outcomes and use of resources
- Clarify how ratings are calculated and make the results more transparent

An unannounced CQC visit took place at the Mother and Baby Unit on the 10th September 2024. They advised the inspection had been triggered following a serious

incident in December 2023 and that they had not previous inspected the unit. It was a full comprehensive inspection, which assessed all 5 key questions. (Safe, Effective, Caring, Responsive and Well Lead). The report has not been shared with the Trust to date. The high-level feedback provided to the Trust on the 11th September 2024 highlighted positive findings and areas for improvement for the service. The areas for improvement have resulted in an action plan. One example is that patients would like to have more detailed information on admission. The positive feedback included patients describing feeling supported and listened to. For example, staff had gone the extra mile to provide responsive care. Further updates will be provided when we receive the final report.

The inspection of Red Kite View Services took place in July 2024. The report has not yet been shared with us for actual accuracy, our colleagues at CQC have advised that they cannot give us a time scale for when we can expect to see draft versions of both service reports. CQC

Nichola Sanderson
Director of Nursing & Professions
November 2024

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

AGENDA ITEM 17.1

PAPER TITLE:	LYPFT 2 Month Safer Staffing Review Report
DATE OF MEETING:	28th Nov 2024
PRESENTED BY: (name and title)	Nichola Sanderson, Director of Nursing
PREPARED BY: (name and title)	Alison Quarry, Deputy Director of Nursing 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.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

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 **1st July to 31st August 2024.**

This report details that all clinical shifts had a Registered Nurse on duty during the reporting period.

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.

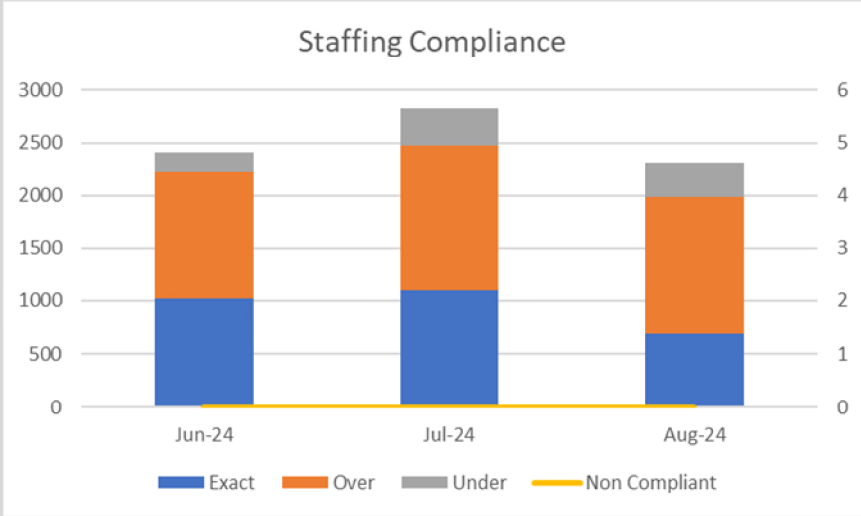
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes please set out what action has been taken to address this in your paper
	No	

RECOMMENDATION

The Board is asked to:

- Note the content of the 2 monthly report.
- 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 – 1st July – 31st August 2024



	Number of Shifts		
	June	**July**	**August**
Exact	1022	1092	694
Over Compliance	1198	1379	1295
Under Compliance	187	364	326
Non-Compliant	0	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 August 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 a decrease in the number of shifts which were staffed exactly as planned and a decrease in the number staffed above the planned number of Registered Nurse (RN) and Health Support Worker (HSW) duties during the month of August 2024. The largest proportion of clinical shifts are working over the planned establishment.

Under Compliant Shifts: There was an increase in the number of clinical shifts that were working under the planned establishment in August 24. However, this data does not consider other MDT roles which are reflected as part of the ward resource and may have formed part of the staffing requirements to meet the clinical need of the ward.

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

Non-Compliant Shifts: This metric represents the number of shifts where no Registered Nurses were on duty. All clinical shifts during the period from 1st July to 31st August 24 had a registered nurse on duty.

MHOST

Two MHOST data collections were completed in September 2023 and March 2024 across 26 Inpatient Wards with a further collection scheduled for September 2024. The MHOST tool is not applicable to Learning Disability settings and therefore has not been used in Woodlands Square. The findings were shared in the most recent 6-month safer staffing report. This evidence-based tool provided the initial data to begin workforce planning; MHOST data alongside professional judgement and quality indicators should be used to complete staffing establishment reviews. A minimum of two data collection periods are recommended prior to making changes to workforce establishment. Application of this evidence-based tool provides some quality assurance to this process. This data cannot be used in isolation and should always be triangulated with professional judgement and quality indicators.

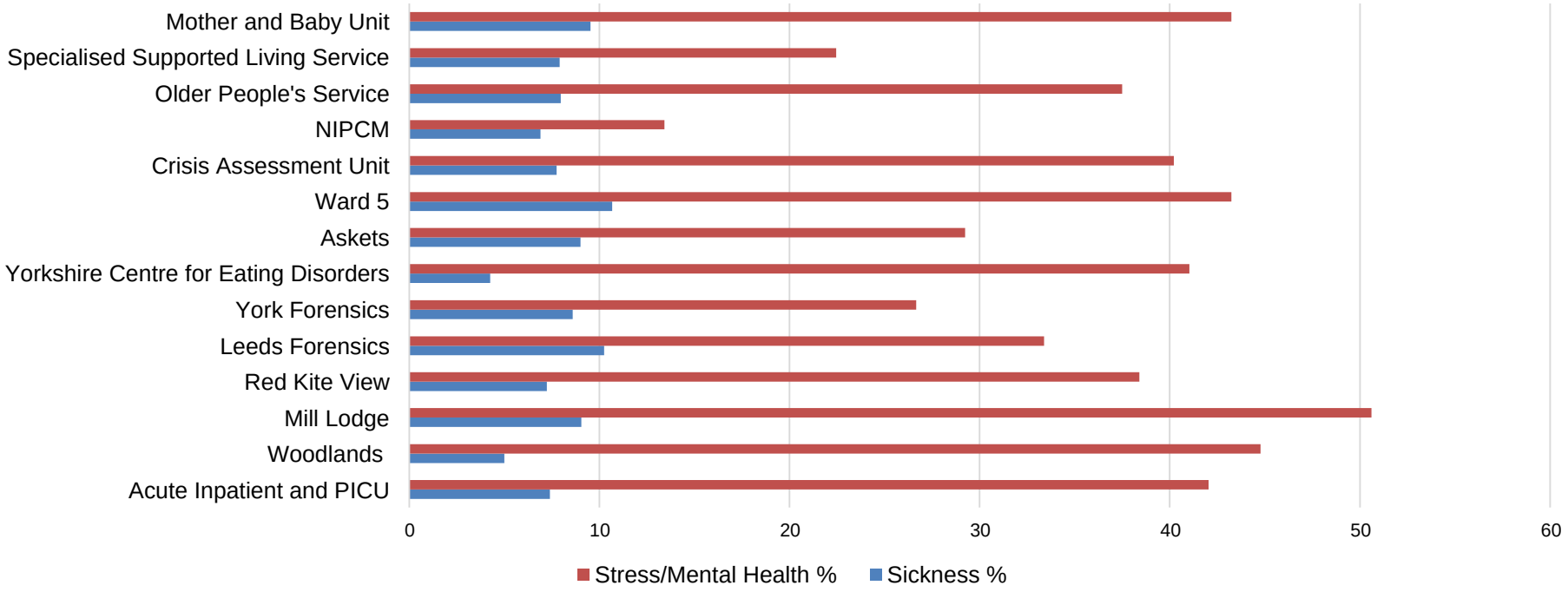
All inpatient areas are currently conducting an annual safer staffing establishment review with a view to completing this task across all 28 wards by the end of October 2024. The reviews will focus on identifying whether the current planned establishments across inpatient wards remain appropriate to deliver safe and effective care through the application of the triangulated approach including MHOST data, quality outcomes and professional judgement. This will be coordinated by the Professional Lead Nurses with final recommendations being presented to the Executive Director of Nursing and Professions following the completion.

SERVICE AREA UPDATES

Sickness Absence

The chart below demonstrates the sickness rate (%) for each inpatient area in August 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.

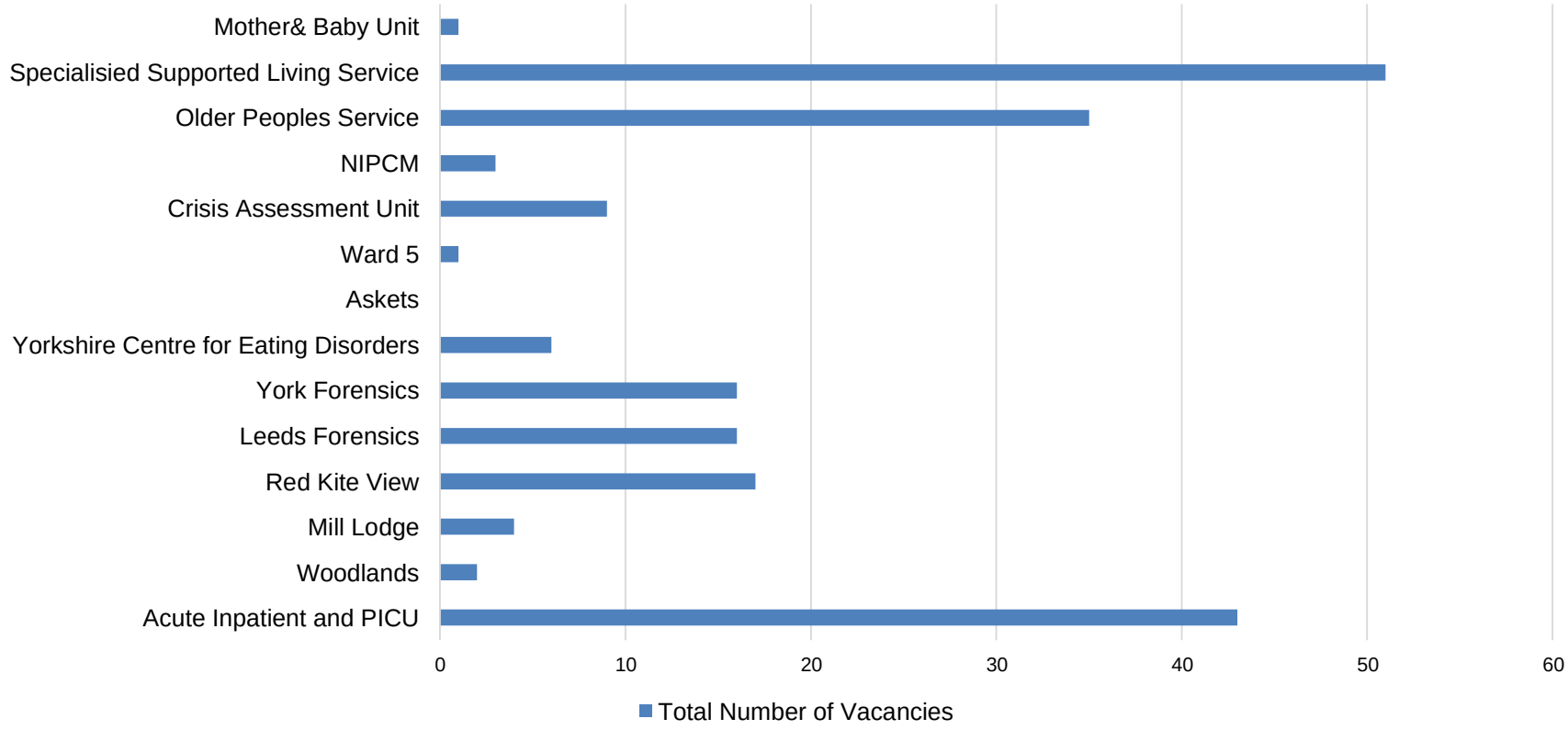
Across the services, YCED and Woodlands Square continue to have reported sickness levels below the Trust target of 6%. Stress/mental health sickness absence accounts for all absence related to stress/mental health and is not only work-related stress.



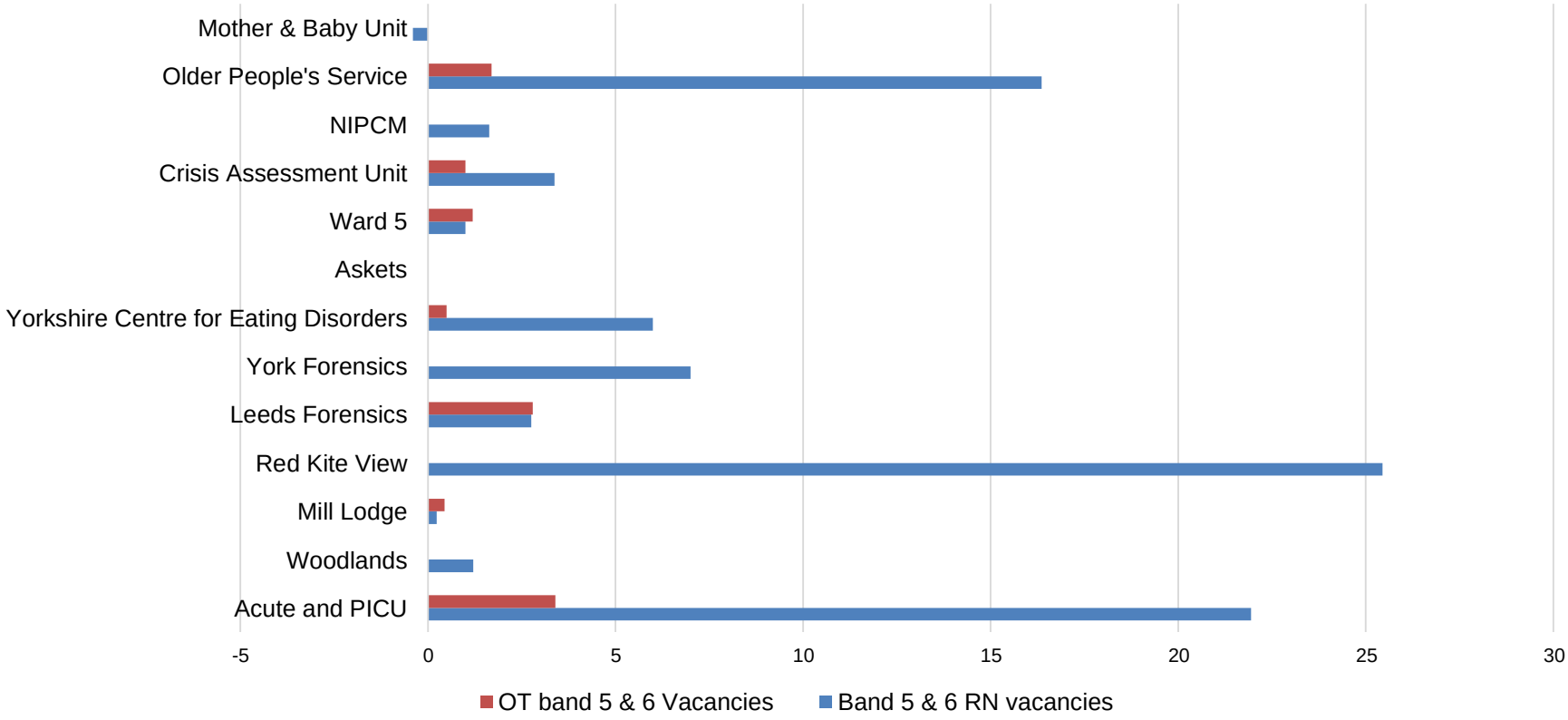
Vacancies

Below indicates the number of vacancies across each service as reported on ECHO in August 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.

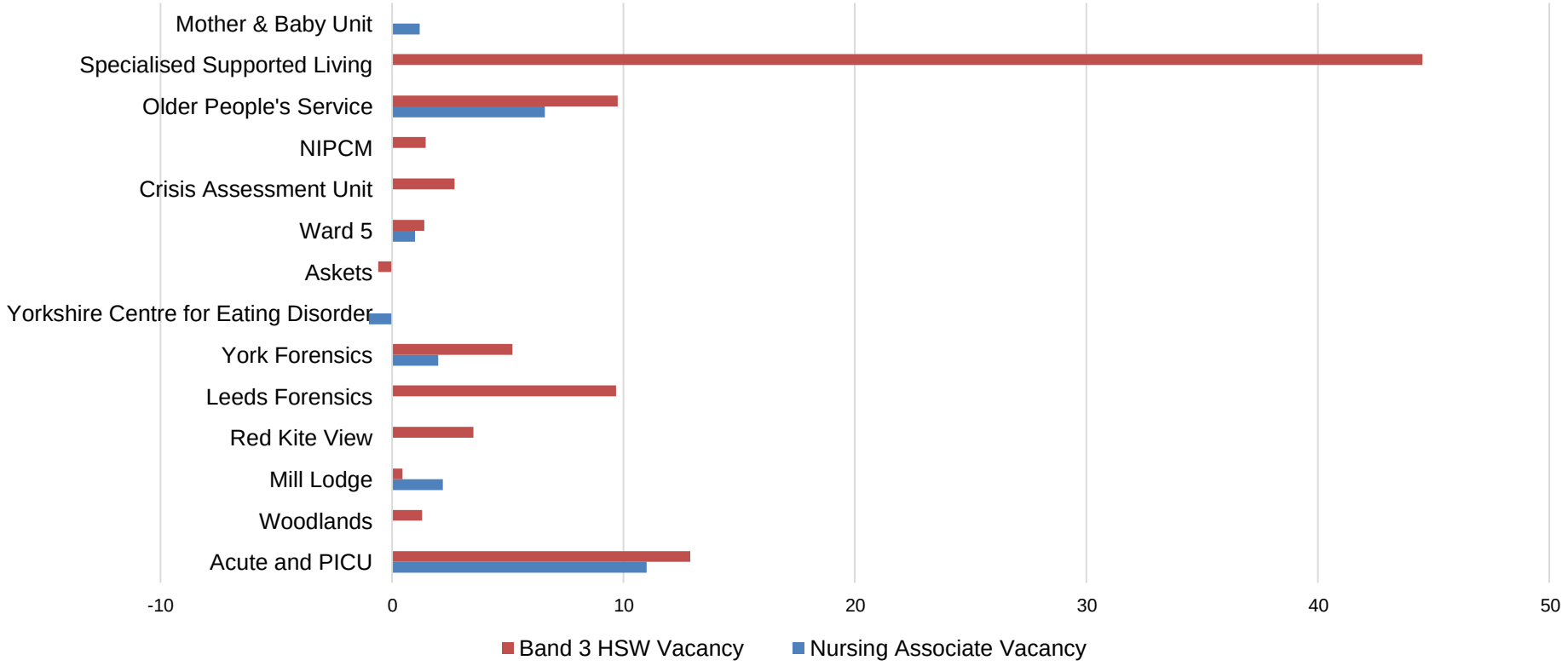
Although Registered Nurses and Health Support Workers are those reported in the establishment figures, it is important to recognise the range of roles within the multidisciplinary teams for providing safe and effective care in our ward environments and this is not captured in the unify data.



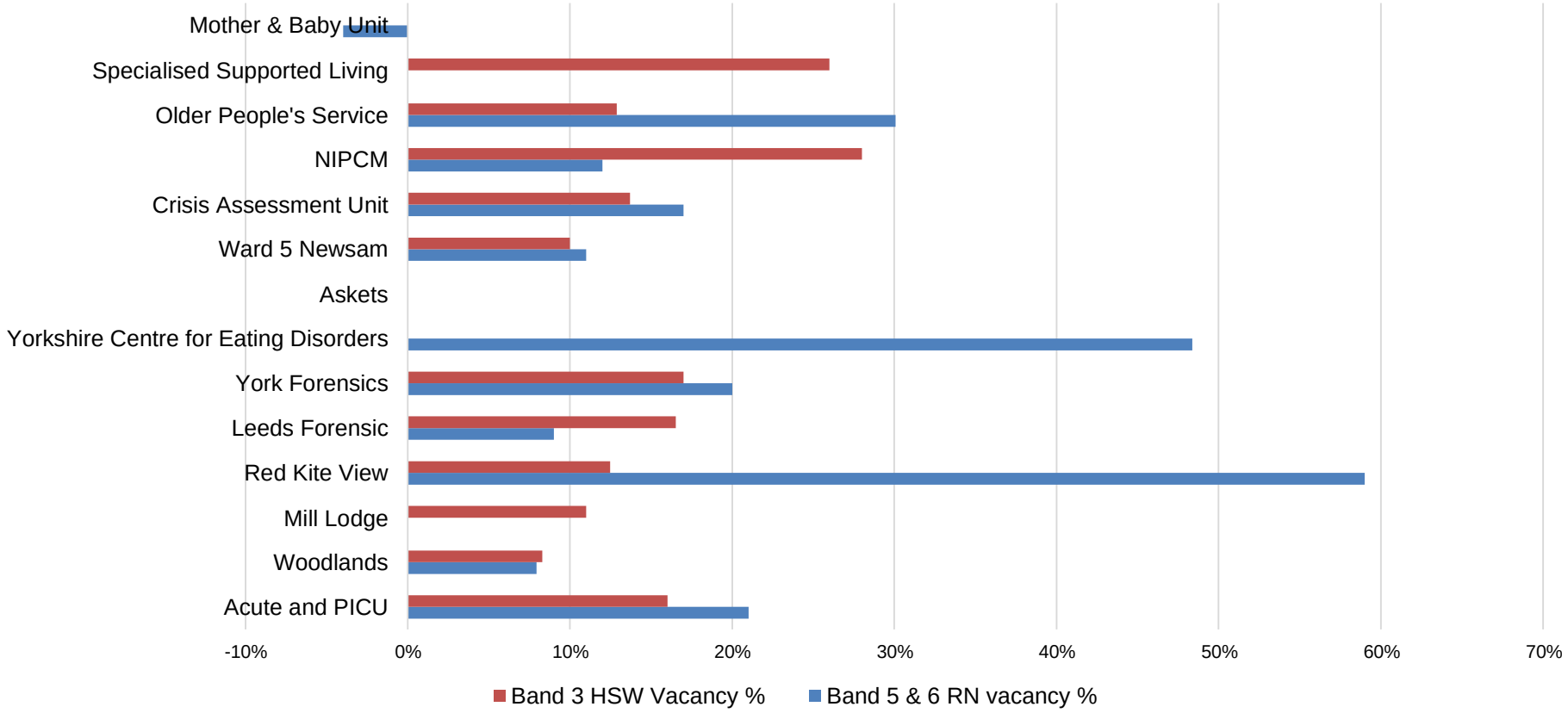
The chart below shows the vacancy rates for Registered Nurses and Occupational Therapists (WTE) across services. This information is a snapshot and taken from the finance data using budgeted establishment for these roles and the vacancy information for August 2024 other than Crisis Assessment Unit data which was gathered from local management due to complexities of recent team changes.



The chart below shows the vacancy rates for Health Support Workers and Nursing Associates (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 August 2024. Some services such as NIPCM and Crisis Assessment Unit do not have Nursing Associates in their staffing establishment.



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.

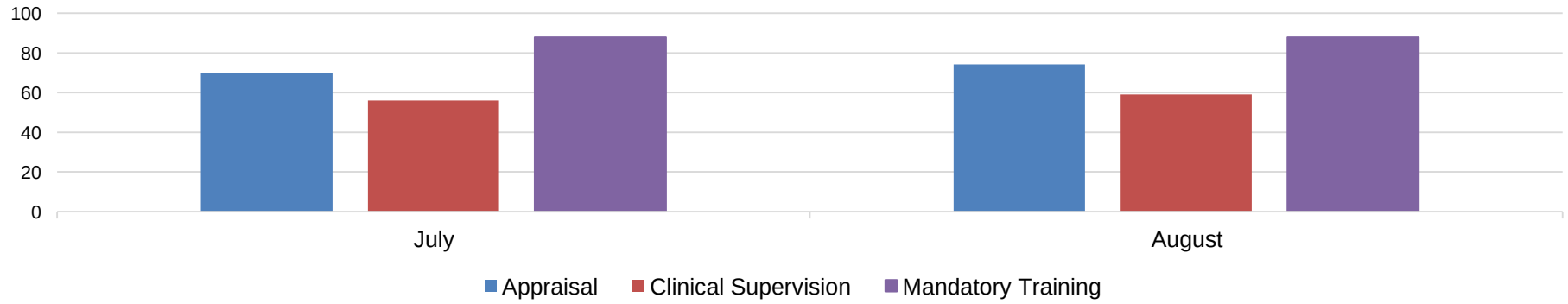


Acute Inpatient and PICU

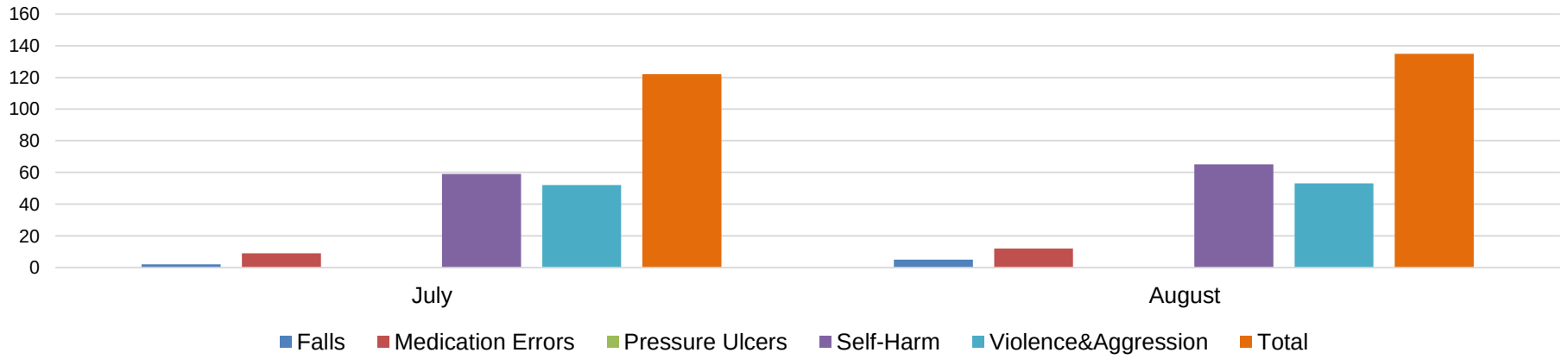
The overall vacancy rate across the Acute Inpatient and PICU Service continues to reduce and staff turnover is below our Trust target at 3.69%. However, the service still maintains many Registered Nurse vacancies as demonstrated by the data. This is predicted to reduce in the coming months due to several Preceptee Nurses due to commence employment in October 2024; this will leave 7 Registered Nurse vacancies. A number of these Registered Nurse vacancies will be filled by Nursing Associates progressing to Registered Nurses. A combination of bank/agency use and the creation of additional new roles within the service, such as Activity Coordinators, has reduced the impact on the service. The data shows Bank and Agency usage contributing to approximately 55% of all work undertaken in the Female Acute Admission Wards and 20% in the Male Acute Wards. The staffing establishment review for Acute Inpatient and PICU will include a review of the Registered Nurse and Health Support Worker ratio to consider whether an adjusted skill mix is required to deliver safe and effective care for service users.

The requirement for additional staffing above the planned establishment has been required within the Female Acute Wards who have experienced the need to use enhanced levels of observation and engagement and escort status to support patient care. This correlates with a higher number of incidents being reported in the Female Acute Wards during the data collection period with the highest proportion of these being self-harm and violence and aggression incidents.

The below charts demonstrate the supervision, appraisal and compulsory training rates for July and August 2024, although Acute Inpatient and PICU have not met the Trust target of 85% for both clinical supervision and appraisals, the service has consistently reached the target for mandatory training.



The table below shows the number of incidents across Acute Inpatients and PICU for the reporting period. The total number of patient safety reported incident has remained similar in number when compared to the previous two months. The highest number of patient safety incidents falls within either Self-Harm or Violence & Aggression, this is consistent with previous months data.

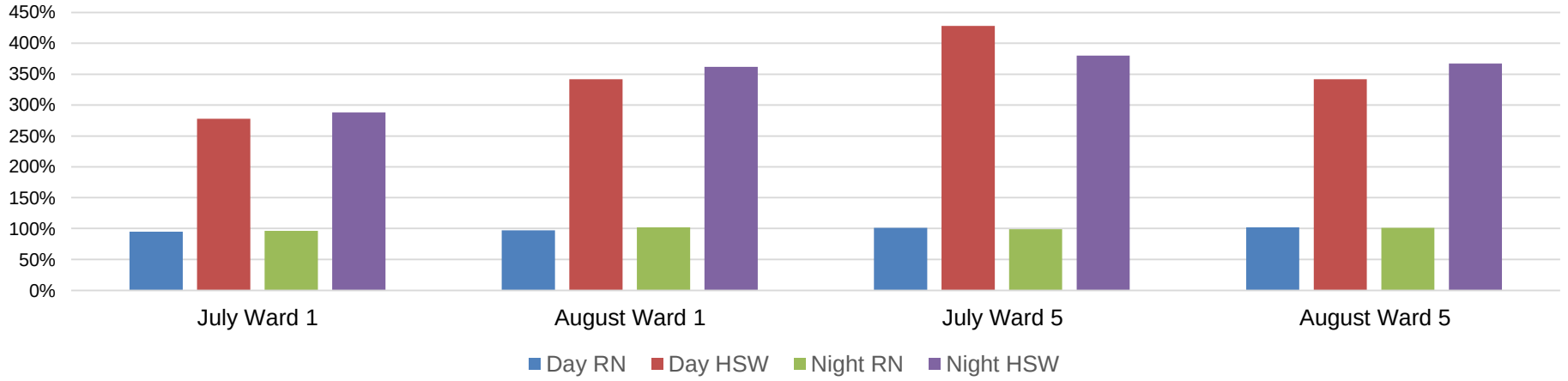


Acute Inpatient and PICU received eight Have Your Say responses in August. One reported their care as “very good” and three reported as “good”, three reported as “Ok” and one reported their care as “very bad”. There were three complaints registered.

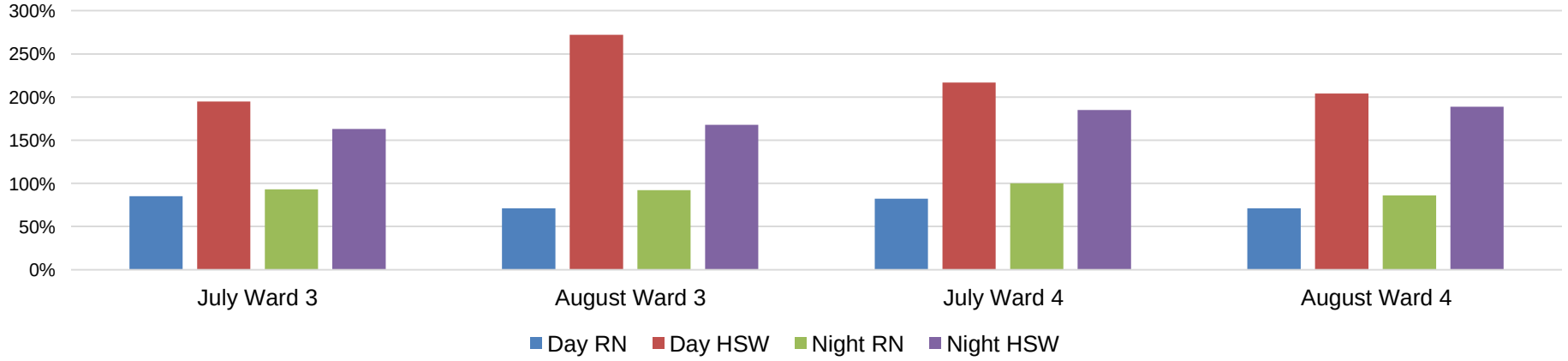
The fill rate monthly indicator (Unify) data demonstrates that the service have maintained a minimum of 77% Registered Nurses during the data collection period and has achieved close to 100% for the majority of clinical shifts. This data does not reflect the total amount of care provided and the fill rate only includes those roles which are part of the planned establishment and therefore although we may have seen less than 100% of Registered Nurses fill this, it has not accounted for nursing roles such as Practice Development Nurse and Ward Manager which are supernumerary to the shift.

The fill rate monthly indicator (Unify) data also demonstrates that the service have significantly exceeded the unregistered need above the planned establishment throughout the data period, this is particularly evident in the Female Acute Wards.

Fill rate- Female Acute Admission July and August 24



Fill rate- Male Acute Admission July and August 24



Red Kite View (Skylark and Lapwing)

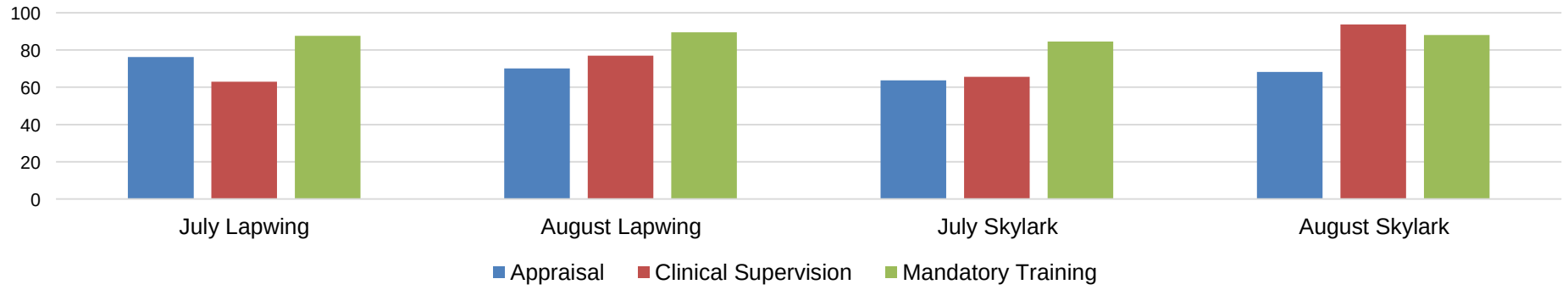
Red Kite View continues to have a high percentage of Registered Nurse vacancies across the wards. However, there are a high number and range of professionals who work within the multidisciplinary team to provide care to the young people within the service and ensure that there are adequate numbers of staff available each day with a range of skills and experience.

The Registered Nurse vacancies are supported by Registered Nursing Associates who do not fall into the traditional safer staffing numbers and are not captured on the unify data. The service also has a number of both registered and non-registered temporary staff who block book shifts, supporting both the continuity of care but also increasing the numbers of registered nurses on duty. Red Kite View continues to support staff to complete Nursing Associate and the top up to nursing route to build capacity within the service in the long term.

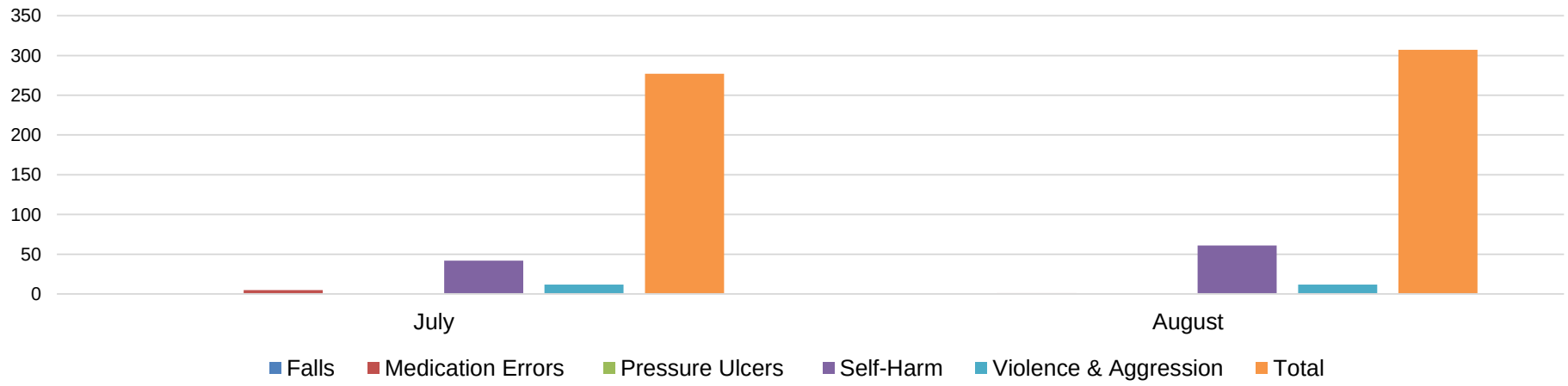
There has been successful recruitment of Registered Nurses due to commence in post in the coming weeks on Lapwing. The staffing establishment review for Red Kite View will include a review of the Registered Nurse and Health Support Workers ratio to consider whether an adjusted skill mix will continue to deliver safe and effective care for service users.

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 current compliance figures for appraisal, clinical supervision and compulsory training. Between July and August there was a significant increase in the recording of clinical supervision across both wards. Clinical supervision is recognised to have positive benefits to both quality care and staff well-being. There was also an increase in compliance with mandatory training.



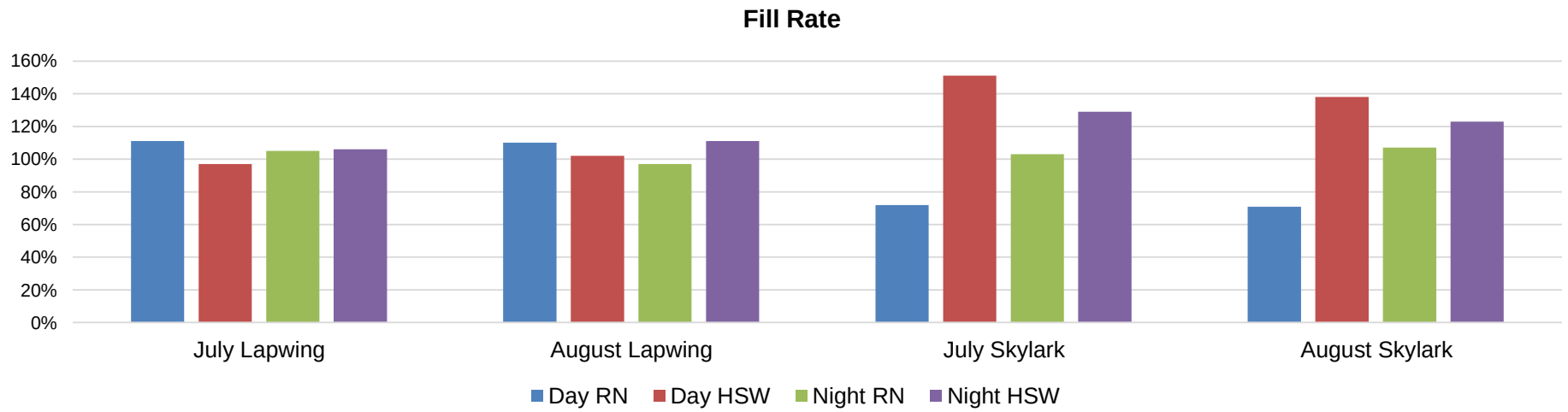
The table below shows the number of incidents across Red Kite View for the reporting period. There was an increase in incidents between the two months, however, as we move into September and October, there is a subsequent significant decrease as a result of on-going review of individuals plans of care and presentation.



There was no Have Your Say feedback recorded in July and August for Red Kite View and one complaint was logged.

The fill rate monthly indicator (Unify) data demonstrates that the service have maintained a minimum of 71% Registered Nurses during the data collection period and has achieved 100% or over on average, across the reporting period on Lapwing. As previously stated, this data does not reflect the total amount of care provided and the fill rate only includes those roles which are part of the planned establishment. Despite the high levels of nurse vacancies within the clinical area, there has been good cover across Lapwing in the reporting period when mapped against the roster template.

The fill rate monthly indicator (Unify) data also demonstrates that the service has exceeded its use of unregistered staff during the reporting period. On Skylark, some of this is to back fill the Registered Nurse deficit. There is evidence on both wards thta at times, have worked above baseline numbers which can be attributed to increased observation levels.

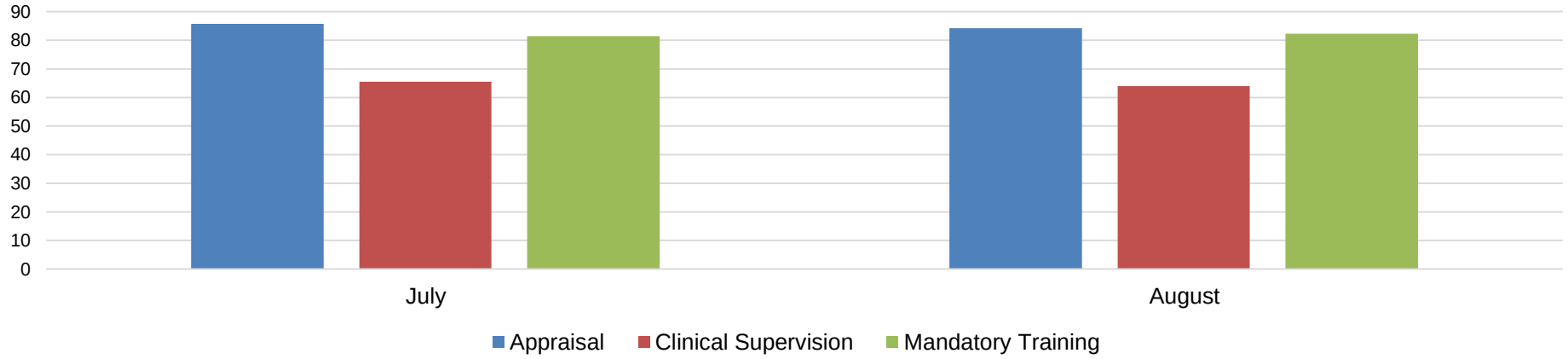


Yorkshire Centre for Eating Disorders

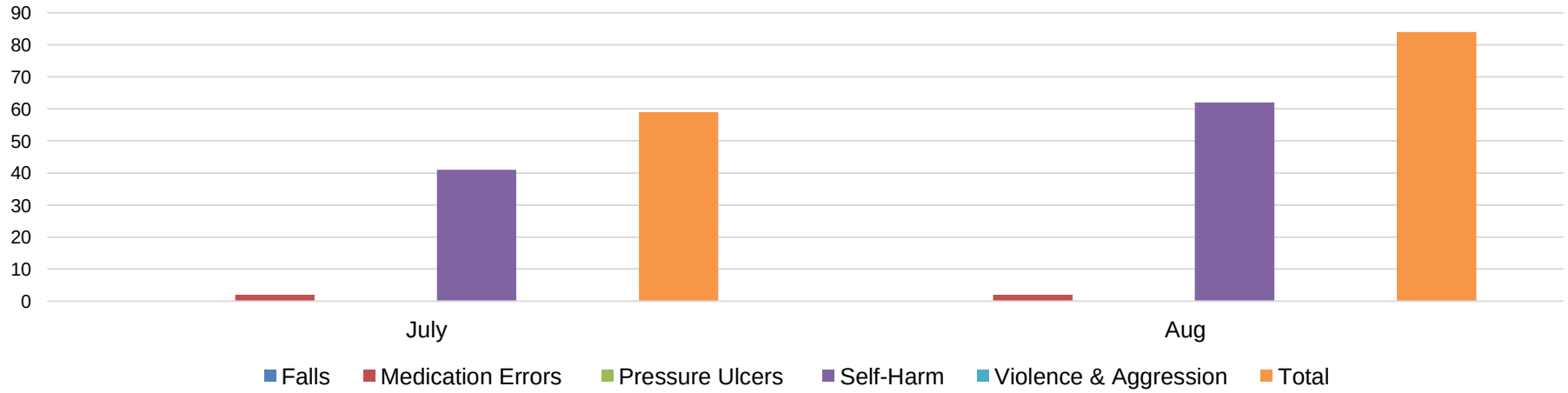
The Yorkshire Centre for Eating Disorders is projected to have a reduction in vacancies over the coming months. The ward has successfully recruited to Nursing Associate posts, who are then due to progress to top up to nursing. The ward has for some time worked above the base line establishment, often backfilled by temporary staff. They have a cohort of staff who pick up regular shifts and support the continuity of care in the service. The service also had 2 Newly Qualified Nurses join the ward who are currently working in a non-registered Band 4 capacity while awaiting their NMC registration. This will also reduce the Registered Nurse vacancy figures once they commence in the RN roles.

The service has seen a sustained period where there has been the requirement for nasogastric feeding for a number of service users. This is a skilled intervention that required specialist training for Registered Nurses. This increased need requires an increased staff presence on the ward to support administration, higher levels of observation and engagement and to undertake day to day ward activities.

The below charts demonstrate the current compliance figures for appraisal, clinical supervision and compulsory training. Between July and August, the figures have remained consistent. Appraisal and mandatory training are above 80%.



The table below shows the number of incidents for Yorkshire Centre for Eating Disorders for the reporting period. There was an increase in the number of self-harm incidents and incidents overall. Around this time, there was increased acuity and care plan reviews took place with a view of reducing incidents.

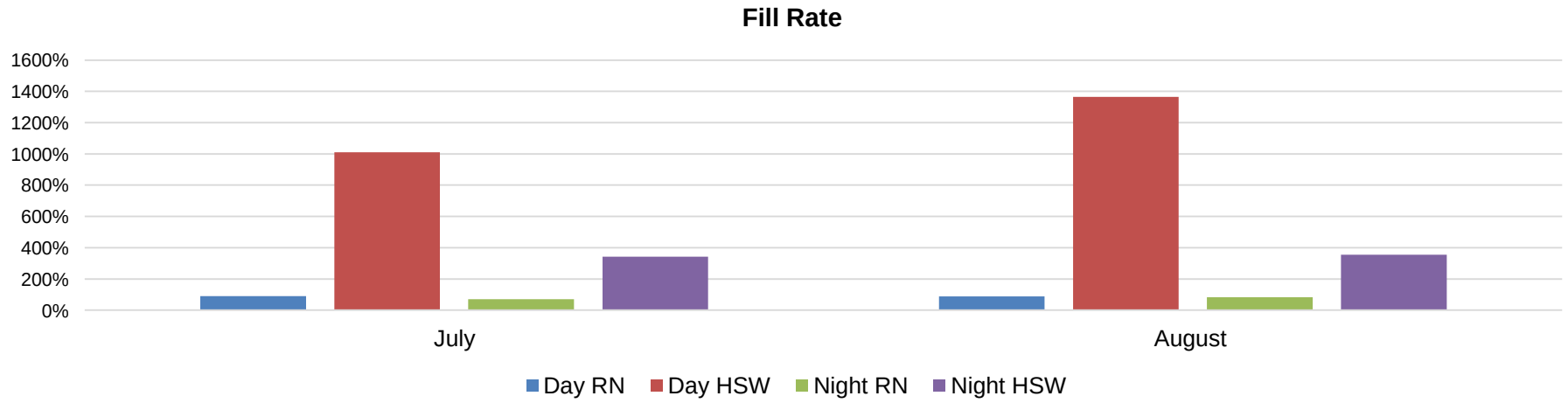


The ward received three Have Your Say responses in August. One reported their care as “very good” and two reported their care was “good”.There was one complaint logged.

The fill rate monthly indicator (Unify) data demonstrates that the service have maintained a minimum of 71% Registered Nurse fill. As previously stated, this data does not reflect the total amount of care provided and the fill rate only includes those roles which are part of the planned establishment.

The fill rate monthly indicator (Unify) data also demonstrates that the service has significantly exceeded its use of unregistered staff during the reporting period. This is particularly evident during the day, and this is due to the increased activity of the ward during these hours including the delivery of nasogastric feeds where required. Increased numbers of staff across the 24-hour period indicate increased levels of observation and engagement throughout the day and night.

The ward has seen a change in the capacity to deliver specialist intervention and increased acuity. The high level of staffing seen has been consistent over a period of time and will be reviewed as part of the Trusts establishment review process.

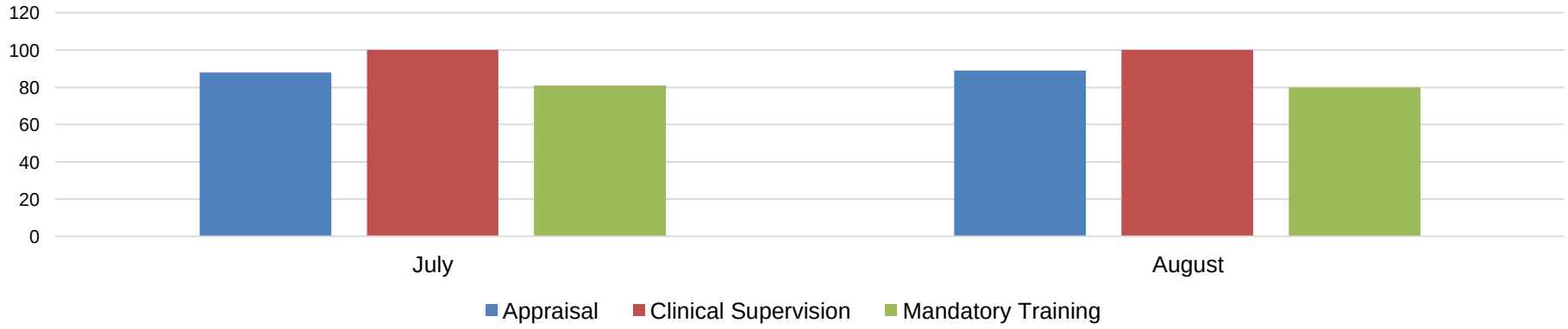


Specialised Supported Living Service (SSLS)

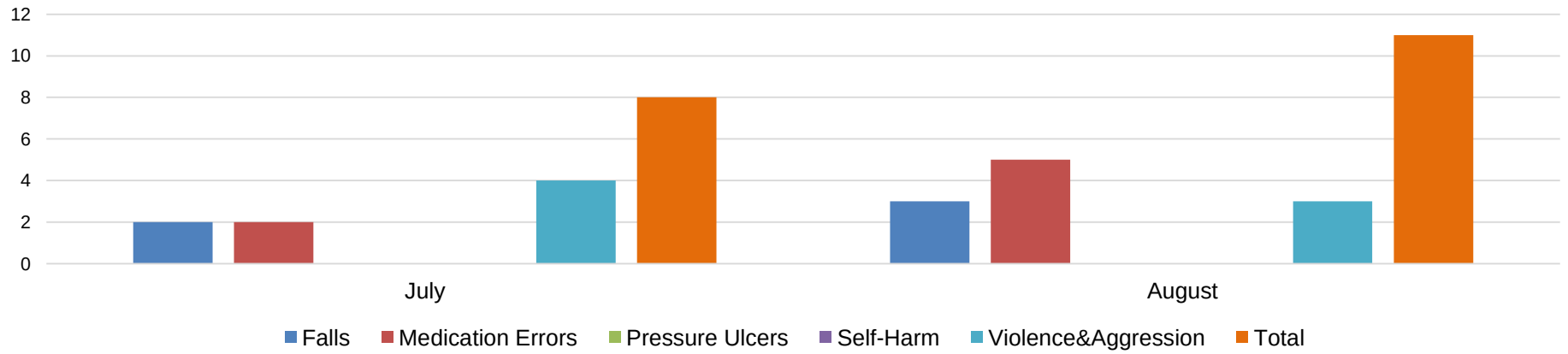
The Specialised Supported Living Service (SSLS) provides accommodation to individuals with learning disabilities and complex health needs at 16 locations across Leeds. The service is predominantly staffed with Support Workers (band 3) or Senior Support Workers (Band 4). The service is funded by Adult 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 recent recruitment event enabled the successful recruitment of four Support Workers who will commence role in the coming months. A further event will be scheduled for November 2024; the positions have been advertised and successful applicants are currently being shortlisted for interview.

The chart below shows the clinical supervision, appraisal, and mandatory training for the SSLS across the reporting period. There has been a slight increase in compliance with Appraisals in August 24 and compliance for clinical supervision has remained at 100% for both July and August 24. Turnover has remained significantly 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 August. The highest number of incidents in this service area fall under medication related incidents, falls, and violence and aggression incidents.



Summary

Our inpatient services continue to see improvement in their overall vacancies and recruitment. 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 a further data collection was completed on March 2024. This data is being used to support staffing establish reviews across inpatient services in LYPFT. This will help to understand if current baseline establishments are appropriate for services and will set recommendations The MHOST 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 outcome of the establishment reviews will be collated and presented to the Director of Nursing and Professions. MHOST data collections continue to be completed every 6 months to support the ongoing safer staffing process, with the most recent data collection period commencing in September 2024.

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.

Additional workstreams through the safer staffing forum alongside the establishment reviews have commenced with focus on improving the quality of care delivered to our service users by ensuring that the MDT are utiised and integrated effectively into the ward teams. The task and finish groups all work toward 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 and include a cultural focus. The evaluation of the workstreams will be reported through future safer staffing reports.

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 of our inpatient settings.

APPENDIX A

Safer Staffing: Inpatient Services August 24

Fill rate indicator return

Staffing: Nursing, Care Staff and AHPs

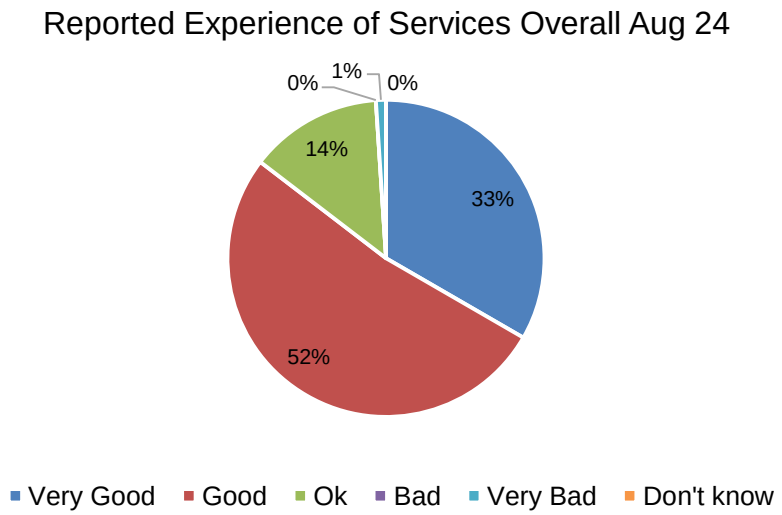
Ward name	Cumulative count over the month of patients	Care Hours Per Patient Day (CHPPD)							Day				Night				Allied Health Professionals	
		Registered Nurses/Midwives	Non-registered Nurses/Midw	Registered Nursing Associates	Non-registered Nursing	Registered allied health professional	Non-registered allied	Overall	Average fill rate - Registered	Average fill rate - Non-registered	Average fill rate - Registered	Average fill rate - Non-	Average fill rate - Registered	Average fill rate - Non-registered	Average fill rate - Registered	Average fill rate - Non-	Average fill rate - registered	Average fill rate - non-registered
2 WOODLAND SQUARE	112	9.3	12.5	0.0	0.0	0.0	0.8	22.7	95%	226%	-	-	100%	171%	-	-	-	100%
3 WOODLAND SQUARE	96	8.8	19.2	0.0	0.0	0.0	0.0	28.0	65%	156%	-	-	100%	108%	-	-	-	-
ASKET CROFT	515	1.7	3.0	0.0	0.0	0.0	0.5	5.3	94%	97%	-	-	100%	102%	-	-	-	100%
ASKET HOUSE	443	2.0	1.9	0.0	0.0	0.0	0.7	4.6	124%	66%	-	-	100%	100%	-	-	-	100%
BECKLIN CAU	187	3.7	15.4	0.0	0.0	0.0	0.0	19.1	106%	115%	-	-	116%	118%	-	-	-	-
BECKLIN WARD 1	714	2.5	7.0	0.0	0.0	0.0	0.5	10.0	97%	342%	-	-	102%	362%	-	-	-	100%
BECKLIN WARD 3	644	2.3	4.4	0.0	0.0	0.0	0.4	7.1	71%	272%	-	-	92%	168%	-	-	-	100%
BECKLIN WARD 4	675	2.1	4.0	0.0	0.0	0.0	0.4	6.5	71%	204%	-	-	86%	189%	-	-	-	100%
BECKLIN WARD 5	675	2.7	7.1	0.0	0.0	0.0	0.6	10.4	102%	342%	-	-	101%	367%	-	-	-	100%
MOTHER AND BABY AT THE MO	209	6.9	8.8	0.0	0.0	0.0	0.0	15.7	105%	101%	-	-	79%	148%	-	-	-	-
NEWSAM WARD 1 PICU	316	4.7	10.5	0.0	0.0	0.0	0.8	16.0	82%	115%	-	-	79%	134%	-	-	-	100%
NEWSAM WARD 2 FORENSIC	279	4.8	10.2	0.0	0.0	0.0	0.9	16.0	121%	113%	-	-	135%	120%	-	-	-	100%
NEWSAM WARD 2 WOMENS SE	298	3.6	9.0	0.0	0.0	0.0	0.8	13.4	92%	101%	-	-	100%	110%	-	-	-	100%
NEWSAM WARD 3	370	2.9	5.8	0.0	0.0	0.0	0.1	8.9	96%	98%	-	-	100%	101%	-	-	-	100%
NEWSAM WARD 4	649	2.4	4.0	0.0	0.0	0.0	0.5	6.9	97%	207%	-	-	97%	177%	-	-	-	100%
NEWSAM WARD 5	1052	1.3	2.1	0.0	0.0	0.0	0.9	4.3	94%	66%	-	-	87%	80%	-	-	-	100%
NEWSAM WARD 6 EDU	504	2.6	11.9	0.0	0.0	0.0	0.8	15.4	99%	1365%	-	-	83%	356%	-	-	-	100%
NICPM LGI	458	3.2	1.8	0.0	0.0	0.0	0.7	5.7	111%	51%	-	-	93%	116%	-	-	-	100%
RED KITE VIEW GAU	247	6.3	16.9	0.0	0.0	0.0	0.0	23.2	71%	138%	-	-	107%	123%	-	-	-	-
RED KITE VIEW PICU	117	12.0	32.4	0.0	0.0	0.0	0.0	44.4	110%	102%	-	-	97%	111%	-	-	-	-
THE MOUNT WARD 1 NEW (MAL	428	3.5	16.8	0.0	0.0	0.0	0.0	20.3	101%	221%	-	-	100%	332%	-	-	-	-
THE MOUNT WARD 2 NEW (FEM	427	3.3	15.2	0.0	0.0	0.0	0.0	18.6	81%	197%	-	-	90%	281%	-	-	-	-
THE MOUNT WARD 3A	593	2.6	7.5	0.0	0.0	0.0	0.0	10.0	87%	217%	-	-	100%	292%	-	-	-	-
THE MOUNT WARD 4A	650	2.4	4.9	0.0	0.0	0.0	0.0	7.3	95%	153%	-	-	98%	160%	-	-	-	-
YORK - BLUEBELL	256	3.9	11.1	0.0	0.0	0.0	0.8	15.8	89%	106%	-	-	100%	124%	-	-	-	100%
YORK - MILL LODGE	160	9.7	13.2	0.0	0.0	0.0	4.8	27.7	102%	105%	-	-	101%	132%	-	-	-	100%
YORK - RIVERFIELDS	248	3.2	5.8	0.0	0.0	0.0	0.1	9.1	56%	156%	-	-	102%	110%	-	-	-	100%
YORK - WESTERDALE	217	4.8	12.1	0.0	0.0	0.0	0.9	17.9	101%	157%	-	-	109%	104%	-	-	-	100%

Appendix B

Have Your Say

The below pie chart shows the data for all inpatient areas who have received Have Your Say feedback during August 2024, 71% reported that their care was “good” or “very good” and 11% reported this as “bad” or “very bad”.

The below chart looks at the services that have been focused on for the main body of the report. This shows the responses to Have Your Say during August 2024. Specialised Supported Living Service did not receive any feedback, 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.



Agenda item
18

Meeting of the Board of Directors

Paper title:	Chair's Report from the Workforce Committee meeting on 17 October 2024
Date of meeting:	28 November 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.	

This paper relates to the Trust's strategic risk/s (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

Committee details:	
Name of Committee:	Workforce Committee – Part A
Date of Committee:	17 October 2024
Chaired by:	Zoe Burns-Shore, Non-executive Director

ALERT – items to alert the Board to

No items to alert the Board to.

ADVISE – items to advise the Board on

The Committee received a verbal Chair's report from the People and Organisational Development (POD) Governance Group and noted the recent changes to the POD governance structure and the work taking place across the Mental Health, Learning Disability and Autism collaborative to align training strategies across the region to support NHS England's move toward shared resources. The Committee also heard that the Trust's strategic objective to reduce sickness absence by 1% was unlikely to be achieved at year end, based on the current position at month 6, but that HR business partners were working with services to develop action plans to address sickness absence cases. The Committee discussed the importance of staff mental health and wellbeing support as a preventative measure to sickness absence, acknowledging that role demands were a key reason for mental health related absence. The Committee considered if there was a culture piece needed on the importance of staff wellbeing and for there to be clearer guidance on how much time staff were allowed to take out of work for wellbeing activities.

The Committee received an update on the delivery of the Trust's People Plan 2024-27 and was pleased to note that good progress had been made against each of the ambitions. The Committee heard about some of the challenges associated with delivering new initiatives which sat across multiple portfolios and doing this in a way that was consistent and not duplicative or burdensome for staff. Ms Burns-Shore agreed to give some thought as to how the Committee could revisit this at a future meeting.

The Committee received a report on the Trust's Retention Strategy for 2024-25 including an update on the high-level action plan and an overview of new starters, leavers and turnover data from April 2021 to March 2024. The Committee supported there being an evaluation into the impact of flexible working from a Trust productivity perspective now that it was embedded in the organisation, and it was agreed that an update on this would be provided at a future meeting if it required further consideration by the Committee. The Committee also received the final data from the Exit Questionnaire Pilot which had now concluded and noted that the results were generally positive and consistent with NHS England's findings. The Committee noted that an overview and key themes from exit interviews would continue to be presented at this Committee and the detailed responses would be shared quarterly with the Heads of Operations and service leads so that any service specific issues could be identified and actioned.

The Committee received an update on the KPIs and Quality Indicators which had been established in order to measure and evaluate the impact of the Collective Leadership programme. The Committee noted that these KPIs used existing data sets to ensure that they were aligned with the Trust's People Plan. It was agreed that the Collective Leadership KPIs would undergo further review and consultation and be brought back to the Committee for consideration if they had changed.

The Committee received the Workforce Performance Report and noted that mandatory training compliance was above the 85% target, staff attrition was currently at around 8% and sickness absence

remained a challenge at 6%. The Committee discussed the variation in vacancy rate across inpatient services and considered how best to receive data on this.

The Committee received a report on Health and Safety and discussed the update on reducing violence and aggression, noting that this was a key risk for the Trust, and was encouraged by the multi-disciplinary approach across different teams. The Committee heard that hot spots for violence and aggression in services had been identified and the team were starting their audit and inspections in these high incident areas. The Committee asked that violence and aggression benchmarking data was included in the next report to provide context and assurance that the Trust was not an outlier.

ASSURE – items to provide assurance to the Board on

The Committee received a report on the use of Spotlight and was encouraged by the update and pleased to hear how the team were continuing to introduce new initiatives for engagement through pilot schemes and measuring the impact to identify the most effective approaches. The Committee also highlighted the importance of utilising Spotlight as a key facet of the Trust's Reward and Recognition Strategy given the current financial constraints and acknowledged the hard work the team put into this.

The Committee reviewed the Board Assurance Framework (BAF) so that it could be mindful of its responsibility to assure that Strategic Risk (SR) 3 was being adequately controlled through the course of the meeting. The Committee was assured that SR3 was being adequately controlled; considered whether it was receiving assurance on any gaps through the reports it was already receiving; and agreed that it did not require any further assurance on the way in which SR3 was being managed. The Committee also considered the potential downgrading of the risk score for SR3 from a level 16 (red) to a level 12 (amber) risk due to the mitigations in place and the actions completed. The Committee supported the proposed reduction in risk score for SR3 and noted that this new position would be presented to the Executive Risk Management Group and then the November Board of Directors' meeting for its endorsement.

The Committee received the Trust's annual multi-professional NHS England Workforce Training and Education Self-Assessment Return for information, noted that there were no exceptions to report throughout the return and that the Trust had been able to evidence how it meets the learning and development needs for its learners.

The Committee received the Wellbeing Guardian Report and discussed the update on the new Domestic Abuse and Sexual Violence Ally role which had been developed by NHS England.

REFER – items to be referred to other Committees:

No items to be referred to other Committees.

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

19

PAPER TITLE:	Report from Director of People and Organisational Development
DATE OF MEETING:	28 November 2024
PRESENTED BY: (name and title)	Darren Skinner (Director of People and Organisational Development)
PREPARED BY: (name and title)	Andrew McNichol (Head of People Analytics and Temporary Staffing)

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.	

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

EXECUTIVE SUMMARY

The purpose of this report is to provide the Board with an overview of the key workforce data and demographics linked to Our People Plan and to highlight the plans in place to support performance in the context of Our People Plan.

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

RECOMMENDATION

The Board is asked to note the contents of this report

Leeds and York Partnership
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS

PEOPLE ANALYTICS REPORT

The purpose of this report if to provide the board with an overview of the key workforce demographics linked to our people and highlight the plans in place to support performance in the context of the Trust People Plan.

Summary of key points:

- The staffing distribution across the organisation reflects a continued high dependency on temporary staffing to meet the patient need. The agency element is being minimised through various workforce efficiency interventions but Bank working still plays a significant role in meeting the demand across all services. Bank workers are being used to backfill vacancy, absence and acuity/activity and this months report explores the distribution.

- The age and ethnicity profile of our workforce is broadly representative of the local population.

- The Trust sickness absence rate for this **quarter** is 6.09**%** This is a decrease from 6.16% for the same period last year

- The rolling **12 month** sickness absence rate is 5.95% (**Oct 24**) and the Trust was one of the top 3 Trust in the region with the highest sickness rates based on the NHS Digital benchmarking data (**July 24**).

- The top five reasons for sickness absence over the last 12 months account for over 72% of all sickness within the Trust.

- PDR compliance has remained compliant at 85% for 9 consecutive months.

- Clinical Supervision compliance continues to fluctuate between 70-80% With all but 5 services within 10% of target. The clinical supervision module expiration is 8 weeks so compliance can fluctuate significantly day to day.

- Compliance has been stable over the 13-month period averaging 86.6%. Small but successive increases were seen between February and August, with a small decrease in performance in September 2023 linked to a new element of training being added. In October 88.23% of staff have in-date mandatory training, above the 85% target. Learning Disability and Autism training was made live in April and, as predicted, has affected the April compliance rate by a reduction of approximately 3%.

Paper Author: Andrew McNichol (Head of People Analytics and Temporary Staffing)
Executive Sponsor : Darren Skinner (Director of People and Organisational Development

1.1 - Our People

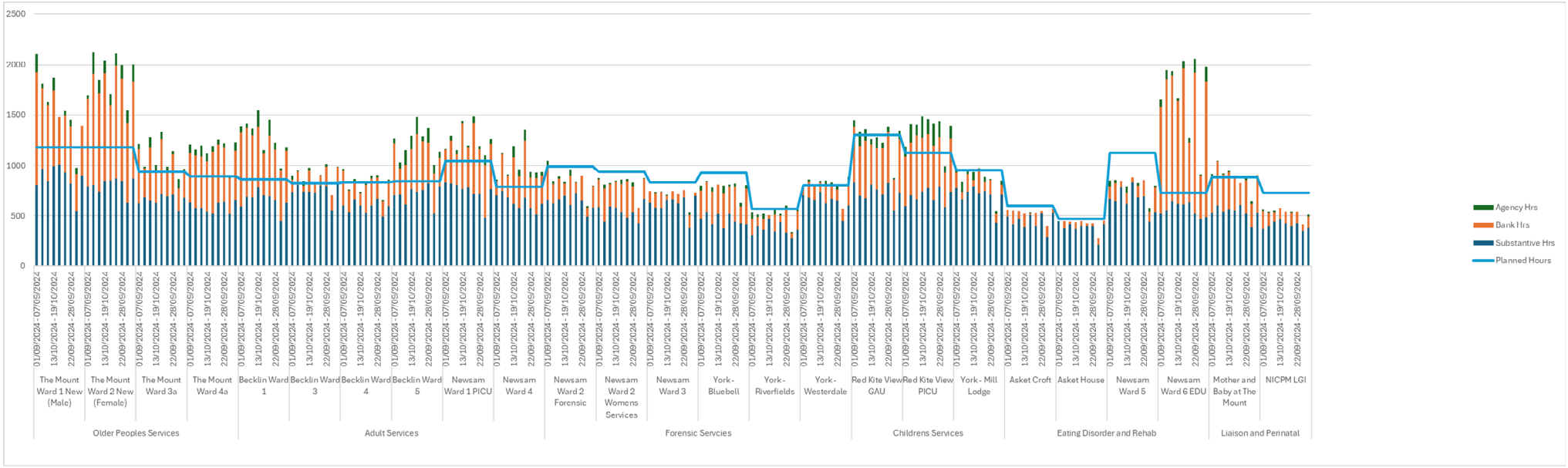
Our people ambitions
Growing for the future

Commitment: Deliver effective workforce planning processes which focus on recruitment and retention, new roles, skills mixing and future supply pathways to ensure a fit for purpose workforce for now and the future.

Resource Distribution and Staffing Fulfilment

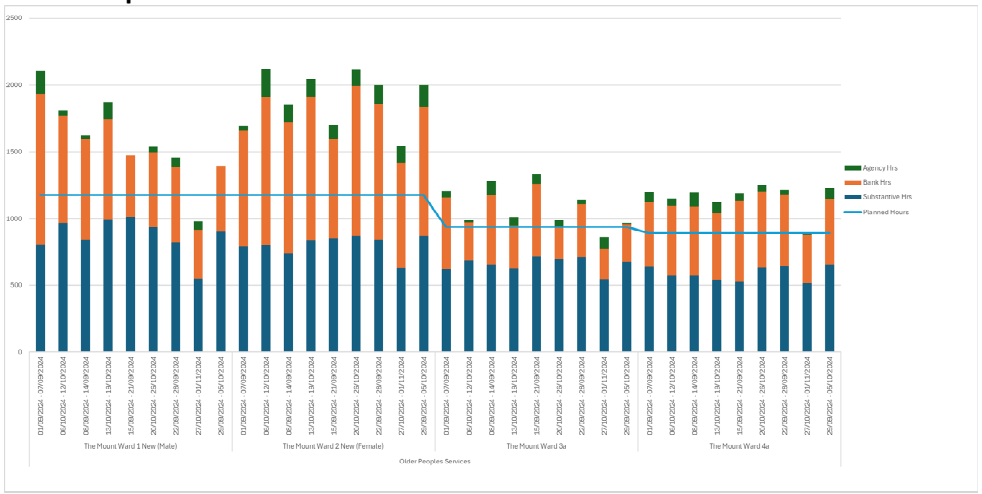
The chart below represents the unit fulfilment distribution for all inpatient services for Sept-Oct 24 by Week/Ward/Service (Blue – Substantive, Orange – Bank, Red – Agency). The scale is deliberately set to demonstrate the overall usage and temporary staffing dependency across the Inpatient Services.

The planned hours represented by the blue line is the RN and HCA requirement for the ward and the bar columns represent the combined RN and HCA hours per 24 day.

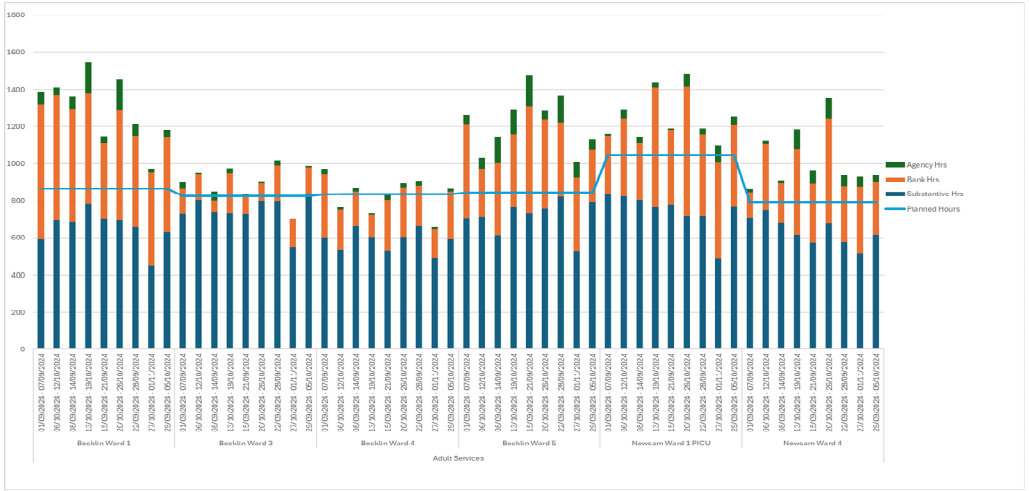


The chart demonstrates the demand over and above the established budget that is being requested to support the additional staffing requirements. An establishment review is currently underway across all services to review the planned hours by unit. E.g. W5 Newsam's planned establishment is currently incorrect on the roster and the ward is meeting with the rostering teams and Finance to address this anomaly.

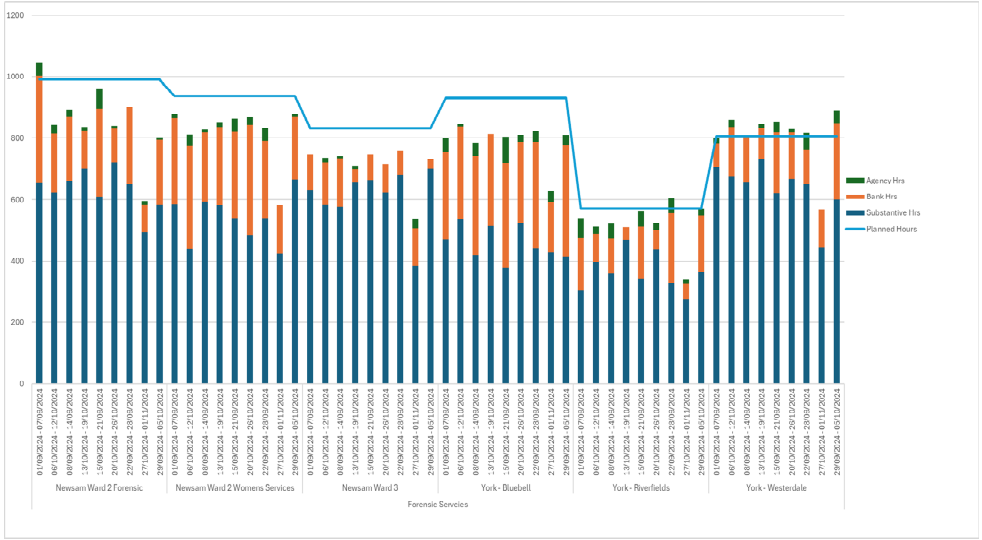
Older Peoples Services



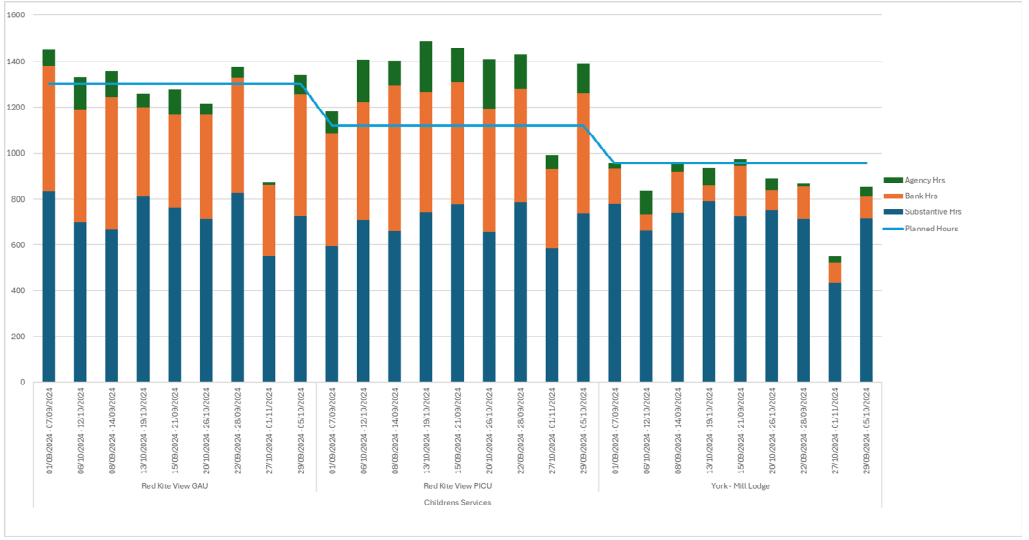
Adult Services



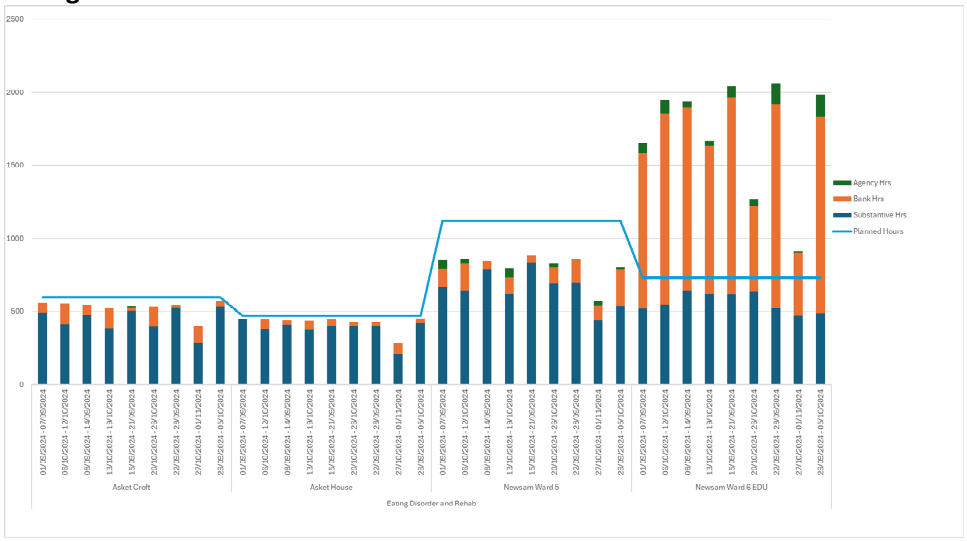
Forensic Services



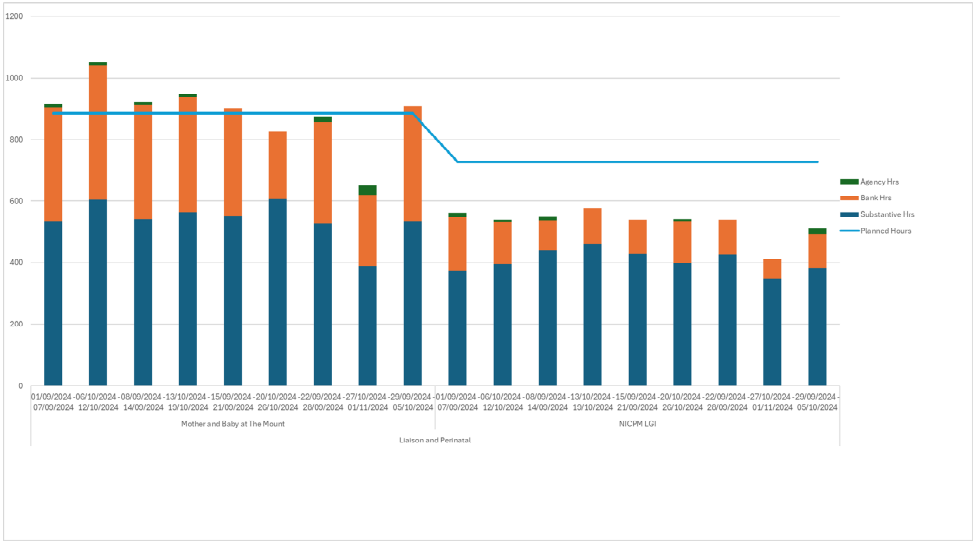
Childrens Services



Eating Disorders and Rehabilitation



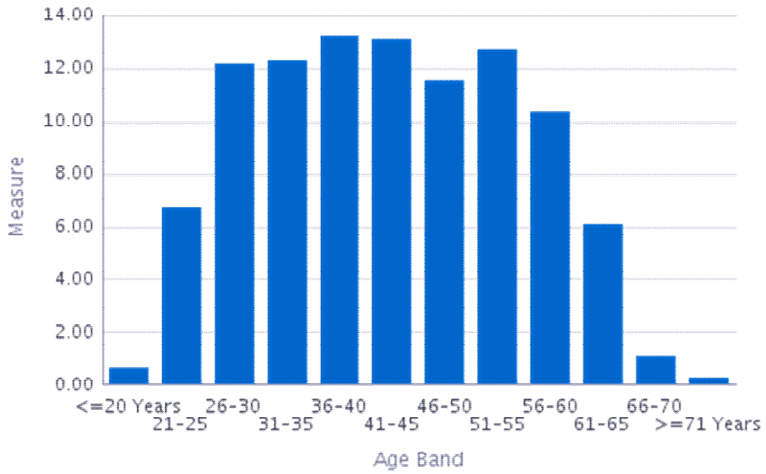
Liaison and Perinatal



1.2 Our People Profile

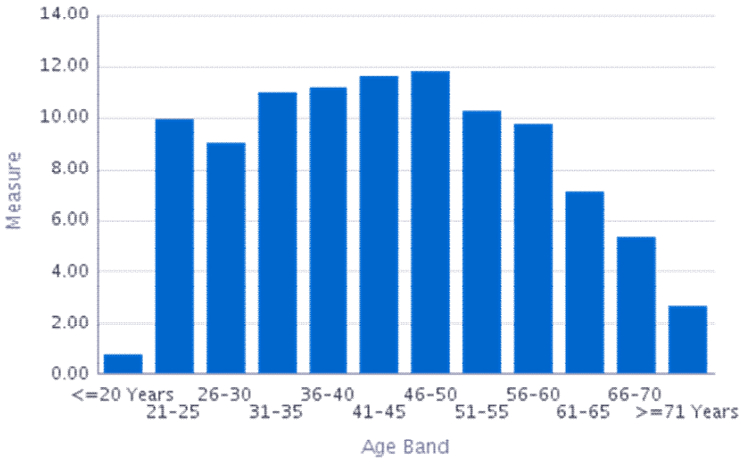
Our People – Substantive

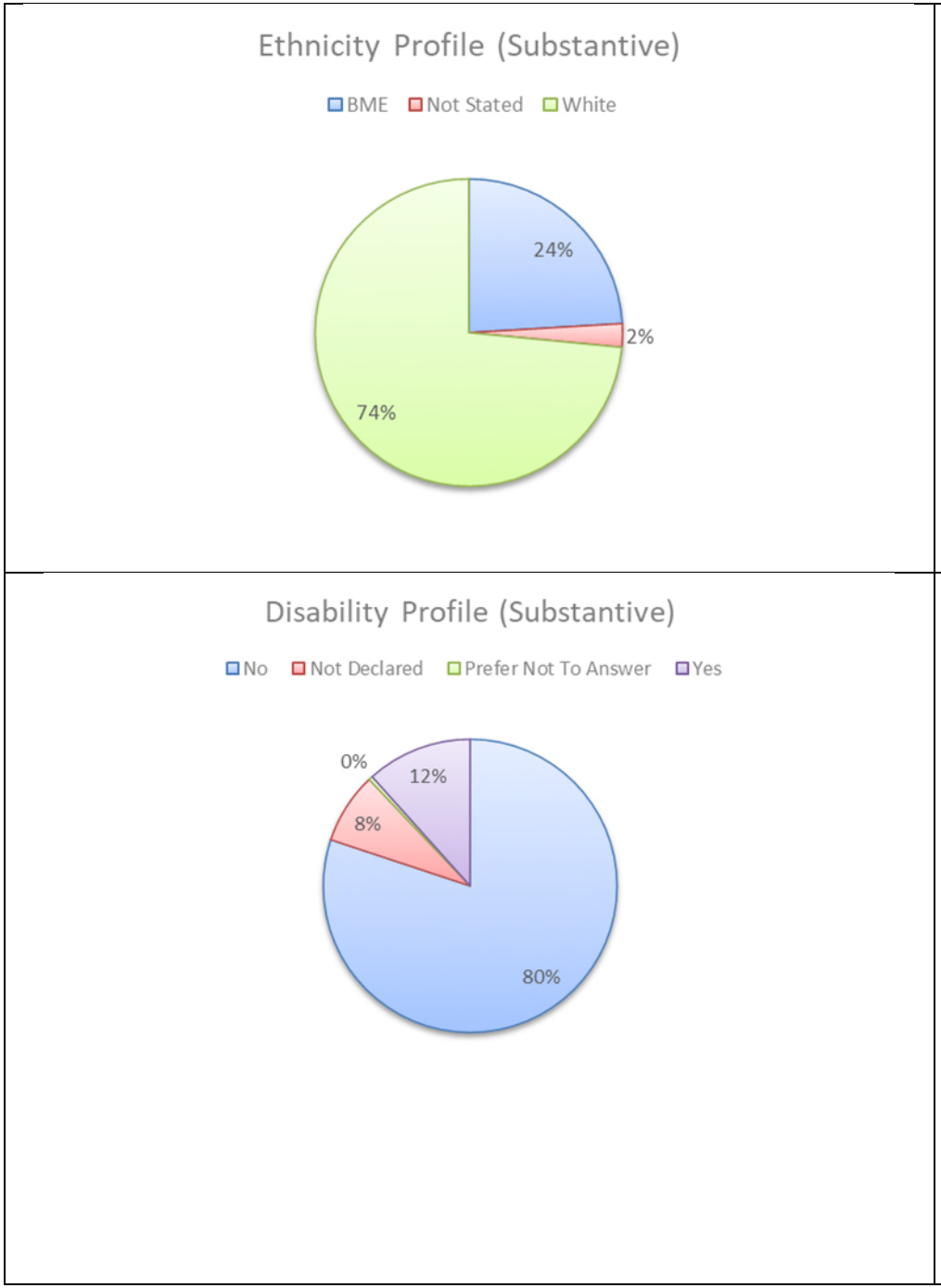
Percentage by Age Band

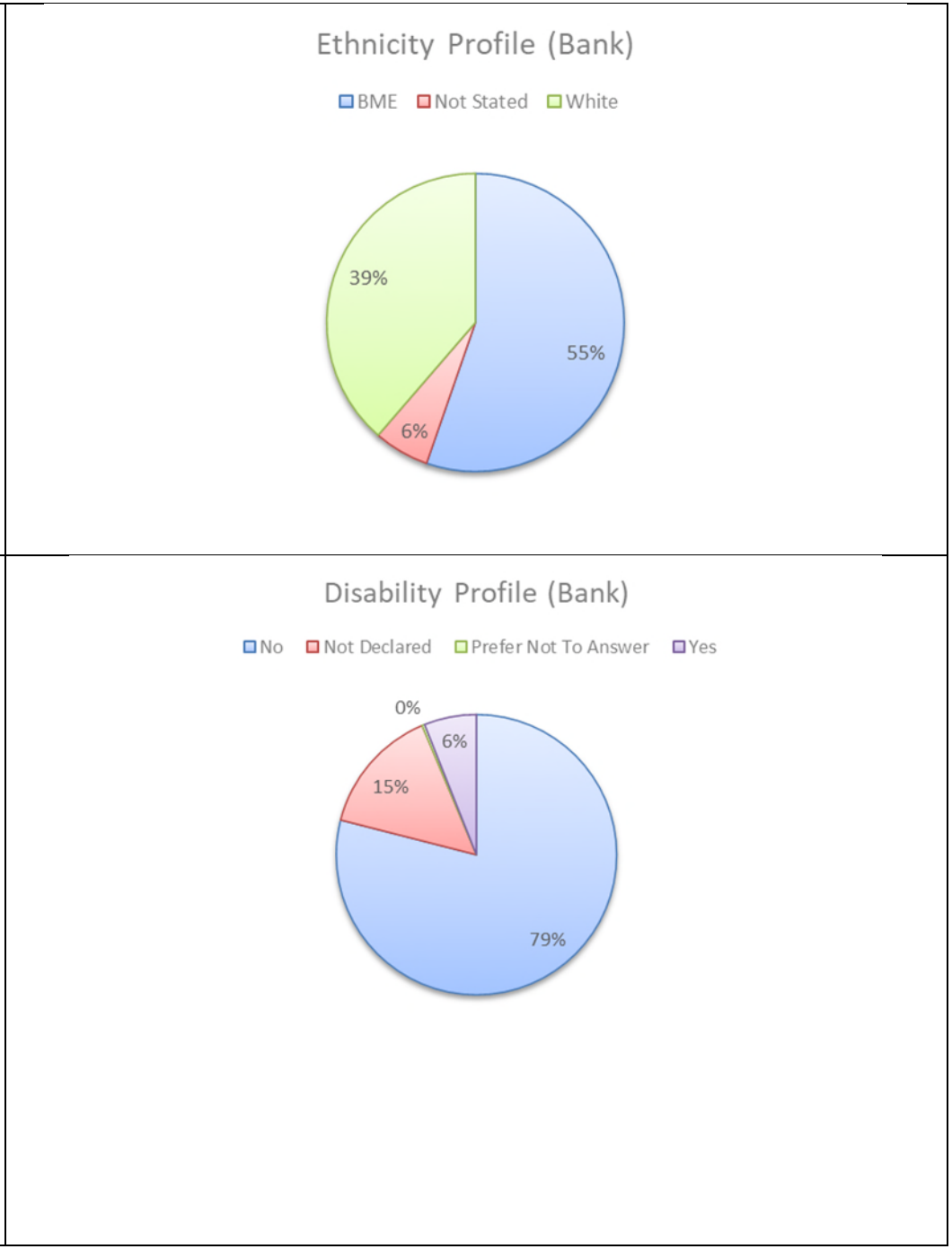


Our People - Bank

Percentage by Age Band

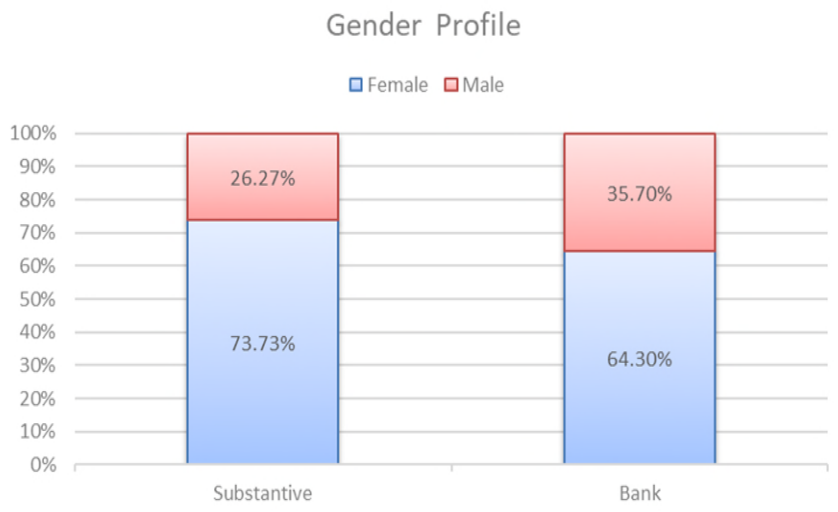


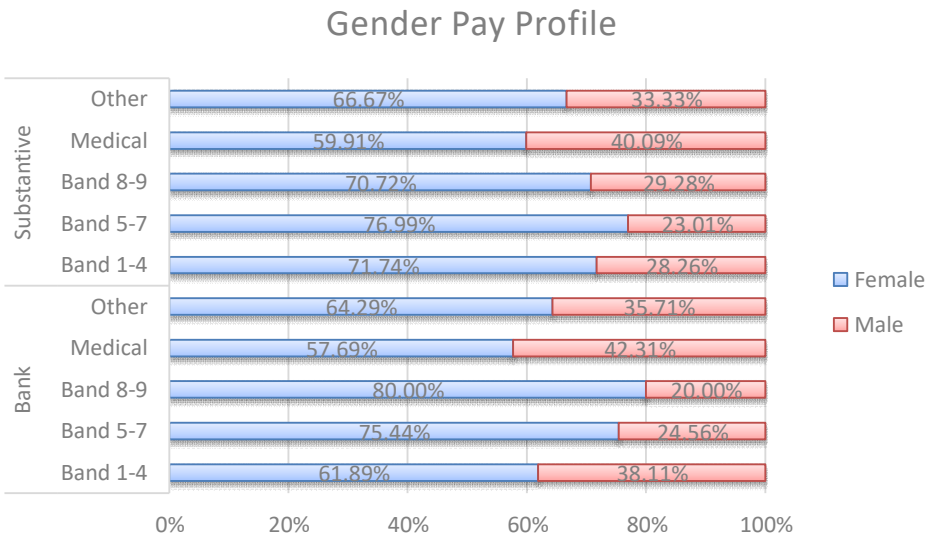

Ethnicity Profile (Substantive)
BME
Not Stated
White
24%
2%
74%


Ethnicity Profile (Bank)
BME
Not Stated
White
39%
55%
6%

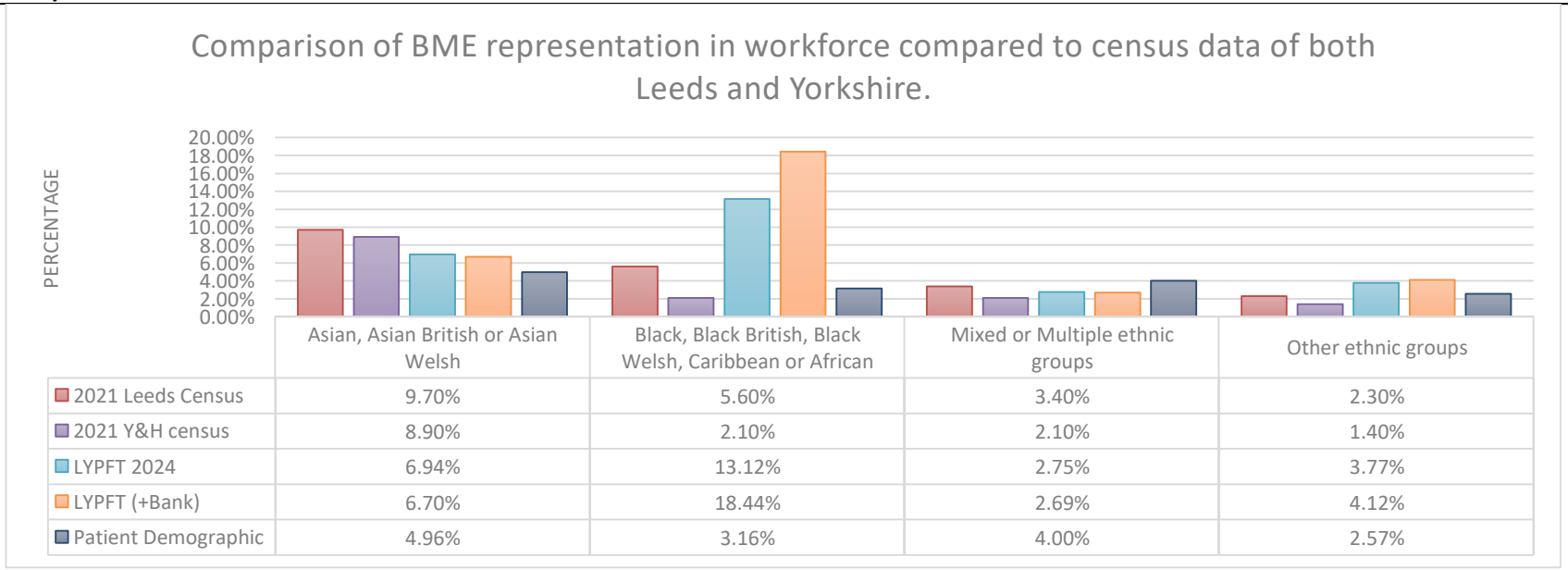
Disability Profile (Substantive)
No
Not Declared
Prefer Not To Answer
Yes
0%
12%
8%
80%

Disability Profile (Bank)
No
Not Declared
Prefer Not To Answer
Yes
0%
6%
15%
79%

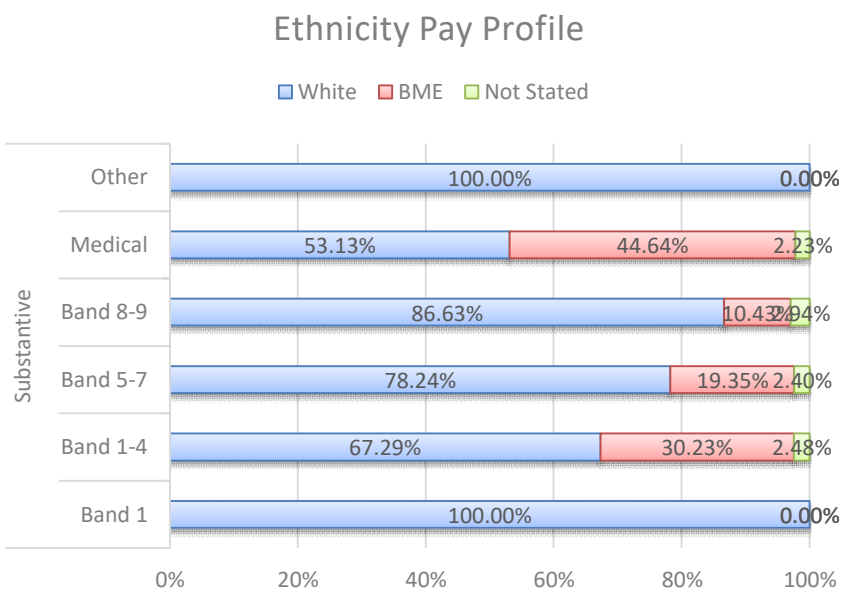




1.3 Our People Representation



	Asian, Asian British or Asian Welsh	Black, Black British, Black Welsh, Caribbean or African	Mixed or Multiple ethnic groups	Other ethnic groups
2021 Leeds Census	9.70%	5.60%	3.40%	2.30%
2021 Y&H census	8.90%	2.10%	2.10%	1.40%
LYPFT 2024	6.94%	13.12%	2.75%	3.77%
LYPFT (+Bank)	6.70%	18.44%	2.69%	4.12%
Patient Demographic	4.96%	3.16%	4.00%	2.57%



Key Points

- The age and ethnicity profile of our workforce is broadly representative of the local population even when considered against the patient ethnicity profile which reflects the impacts of health inequality of the broader Leeds and York census population.

Ethnicity:

- The Trust Asian representation is circa 3% lower than the ONS data for the City and 2% lower than the region.

Age:

- The Trust has a high proportion of employees who are aged between 35 and 64 (approximately 60%) and is slightly under-represented in the lower and higher age bandings. Point to note – The census data include all people up to 20 which distorts the percentage in the census when compared to the working age adults in LYPFT data.

Our people ambitions
Belonging in the NHS

Commitment: Improve the experience of those people with a protected characteristic as identified by the Equality Act

1. To implement the NHS EDI Improvement plan with the following 6 high impact areas:

Action 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

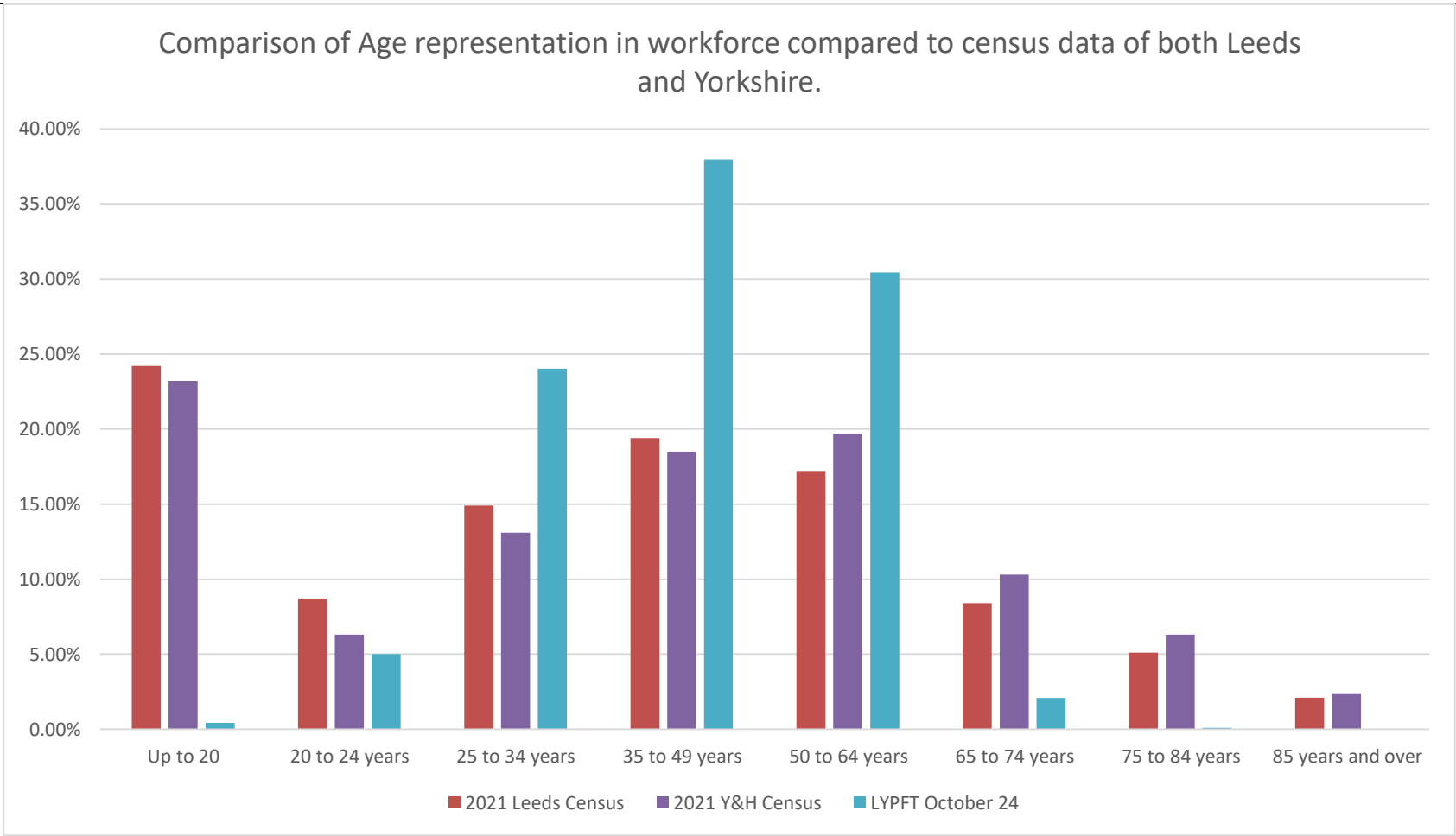
Action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity

Action 3: Develop and implement an improvement plan to eliminate pay gaps. Implement "Mend the Gap" review for medical staff and effective flexible working options. Analyse data to understand pay gaps by protected characteristics and develop an improvement plan.

Action 4: Develop and implement an improvement plan to address health inequalities within the workforce

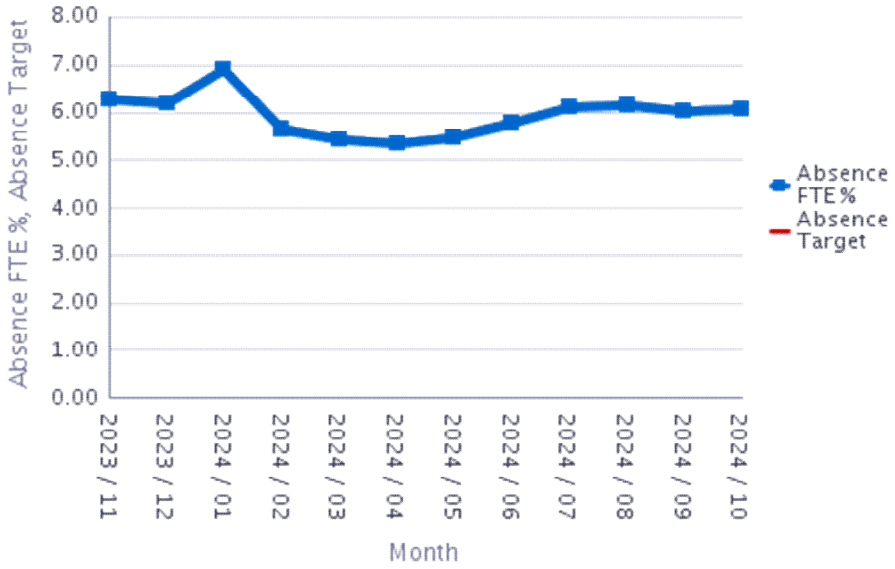
Action 5: Implement a comprehensive induction, onboarding and development programme for internationally recruited staff. - onboarding, development opportunities

Action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. Review data by protected characteristic and set reduction targets. Review disciplinary and employee relations processes - for inconsistency and develop improvement plan. Ensure polices and processes for domestic abuse and sexual safety and support available.


Comparison of Age representation in workforce compared to census data of both Leeds and Yorkshire.
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Up to 20
20 to 24 years
25 to 34 years
35 to 49 years
50 to 64 years
65 to 74 years
75 to 84 years
85 years and over
2021 Leeds Census
2021 Y&H Census
LYPFT October 24

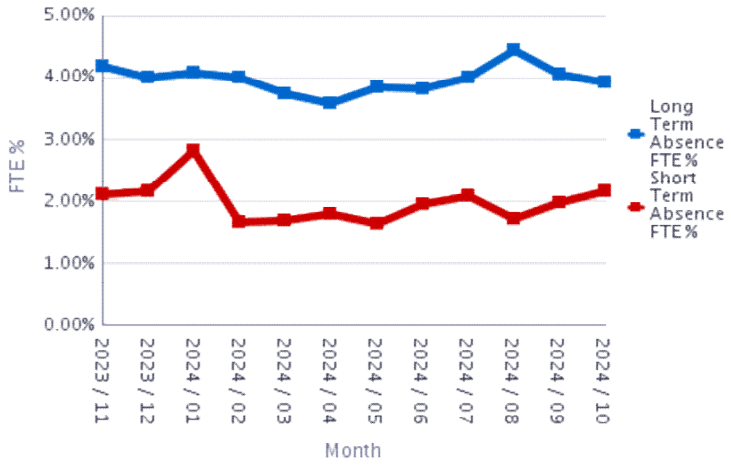
1.4 Our People – Absence

Absence FTE %	Absence Days	Absence FTE	Available FTE
5.95%	74,211	65,483.71	1,099,884.06

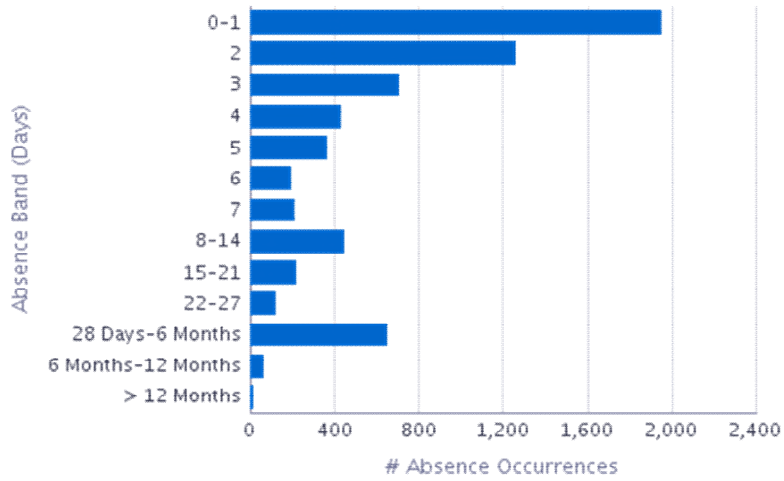


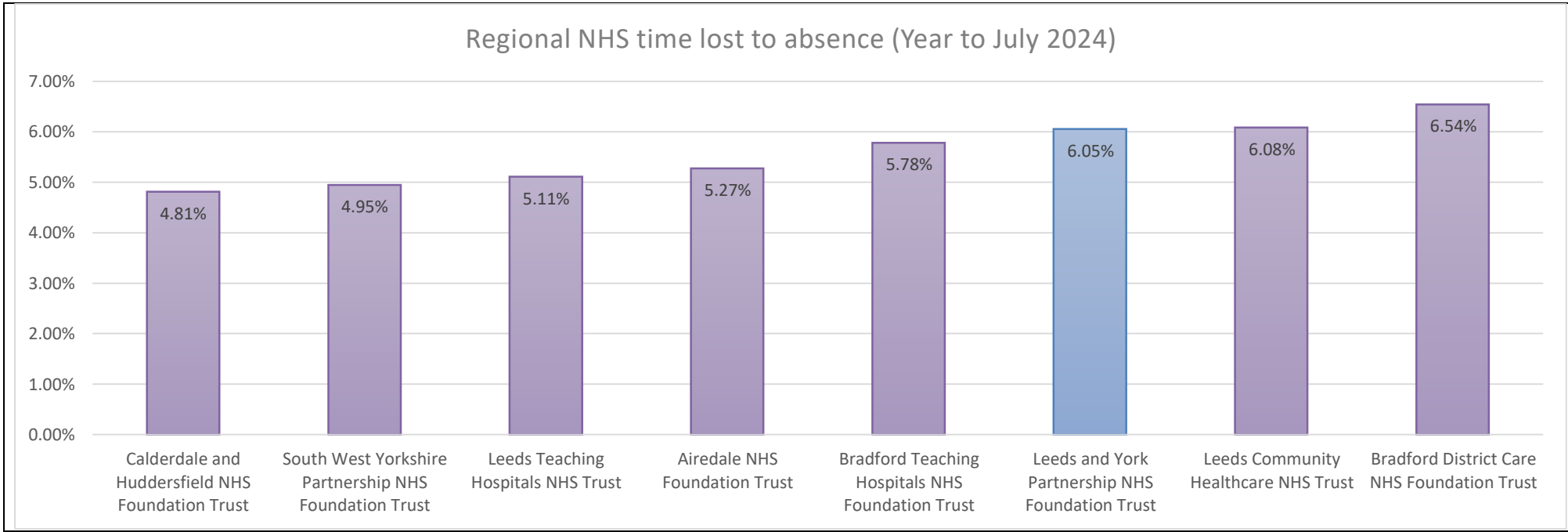
Org L4	Absence Occurrences	LT Absence Occurrences	ST Absence Occurrences
Adult Acute Services	1,081	90	991
Care Services Other	55	5	50
Chief Operating Officer	6	0	6
Children and Young People's Services	531	38	493
Community and Wellbeing Services	441	68	373
Corporate Services	938	114	824
Eating Disorders and Rehabilitation and Gender Services	650	71	579
Forensic Services	635	59	576
Junior Doctors Primary Care Trust	7	0	7
Learning Disability Services	694	98	596
Liaison and Perinatal Services	512	46	466
Northern School Of C & A Pschotherapy	23	4	19
Older Peoples Services	819	83	736
Regional and Specialist Services	262	28	234
WY MHLDA Programme Team	1	0	1
Grand Total	**6,655**	**704**	**5951**

Absence Long-Short Term



Absence by length





Our people ambitions
Looking after our people

Ensure our people have equal access to and use a full range of well-being support – physical, psychological, financial, and social.

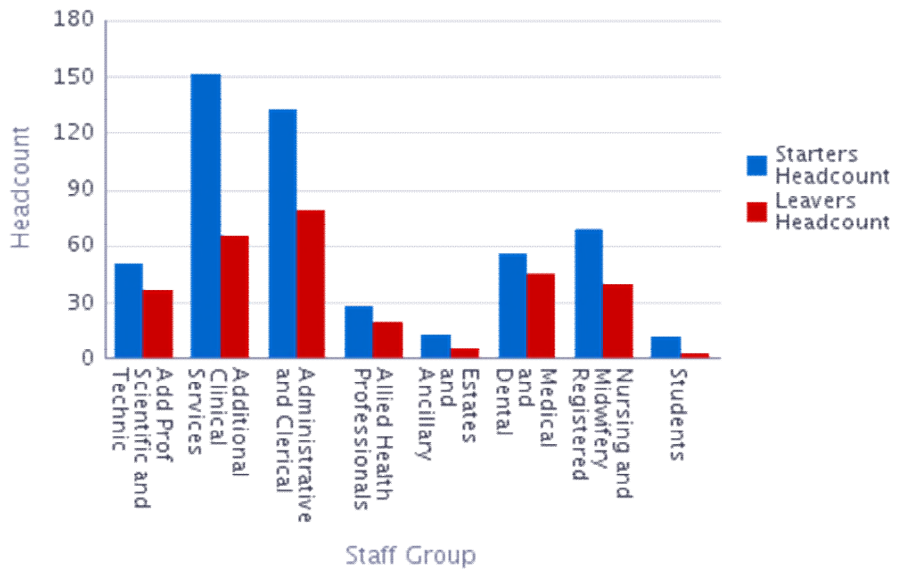
- Continue to develop the Wellbeing and Attendance Policy to reflect a person-centred approach to enabling work. This includes reviewing the wellbeing pathway documents e.g., Anxiety, Stress and Depression and developing the absence improvement group with a focus on wellbeing.
- Evaluate the current Wellbeing and Attendance Policy, to include any forthcoming changes to employment law and best practice and further embed a holistic, people-centred approach to wellbeing.
- Update Wellbeing Toolkit and training for managers to reflect any changes.

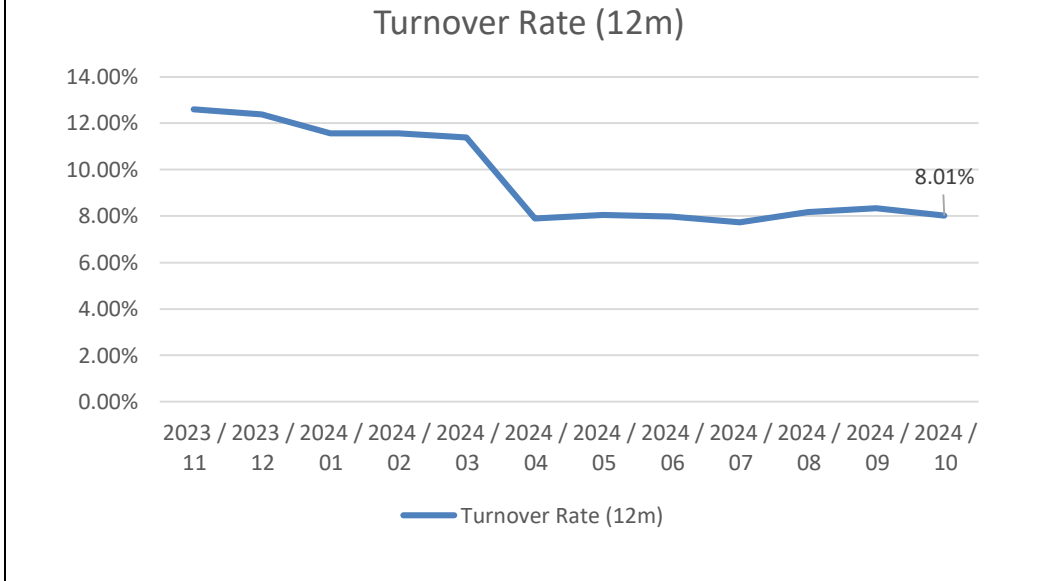
Key Points

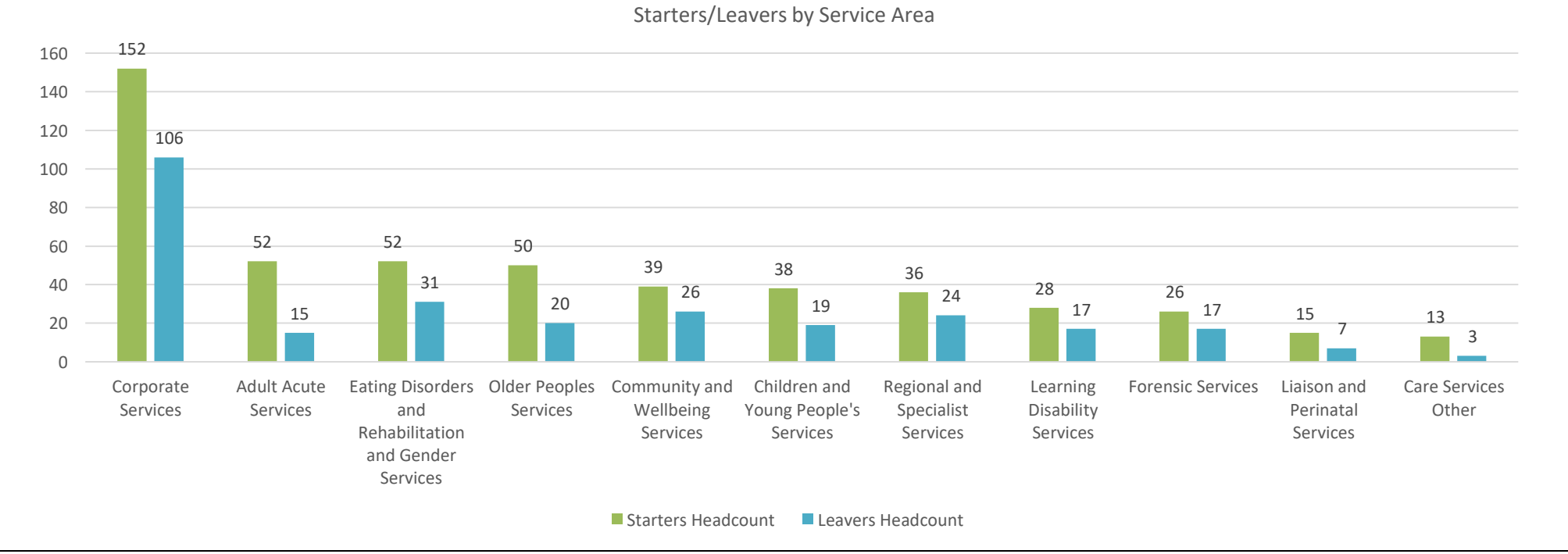
- The Trust sickness absence rate for this **quarter** is 6.09**%** This is a decrease from 6.16% for the same period last year
- The rolling **12 month** sickness absence rate is 5.95% (Oct 24) and the Trust was one of the top 3 Trust in the region with the highest sickness rates based on the NHS Digital benchmarking data (July 24).
- The **top five reasons** for sickness absence over the last 12 months account for over 72**% of all sickness** within the Trust.

Absence Reason	Headcount	Abs Occurrences	Abs Days	%
S10 Anxiety/stress/depression/other psychiatric illnesses	655	896	28,878	38.9
S13 Cold, Cough, Flu - Influenza	1470	2,106	9,466	12.8
S25 Gastrointestinal problems	858	1,124	5,917	8.0
S12 Other musculoskeletal problems	275	363	5,569	7.5
S15 Chest & respiratory problems	269	310	3,894	5.2

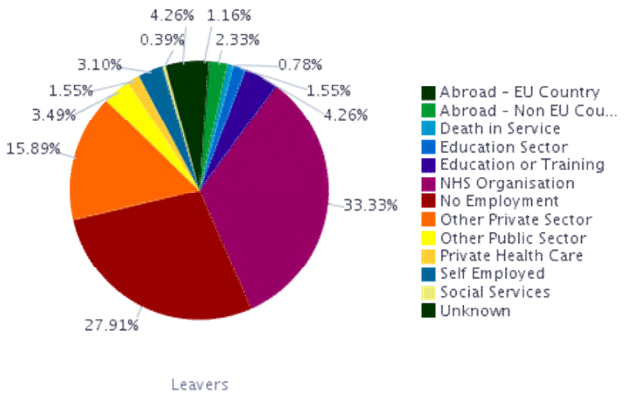
1.5 Our People – Retention



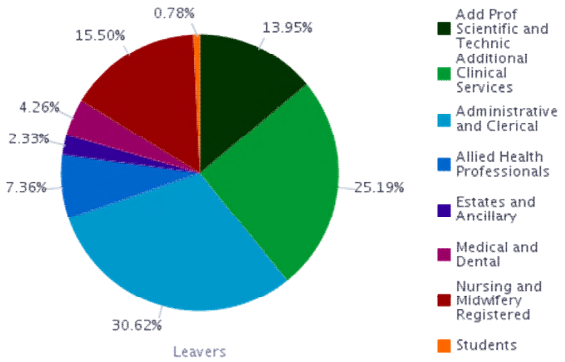




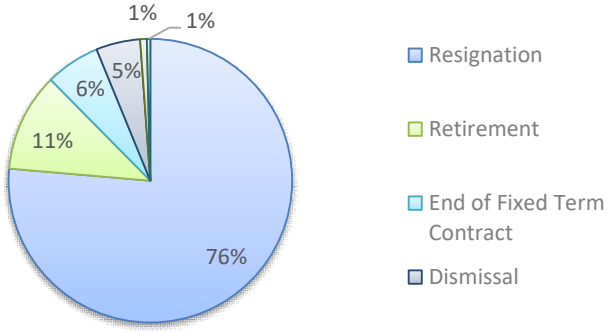
Leaver Destination



Leavers by Staff Group



Leavers by Reason



Our people ambitions
Growing for the future

Develop and implement an innovative approach to talent development, embedding the right culture and improving retention through delivery of our retention strategy.

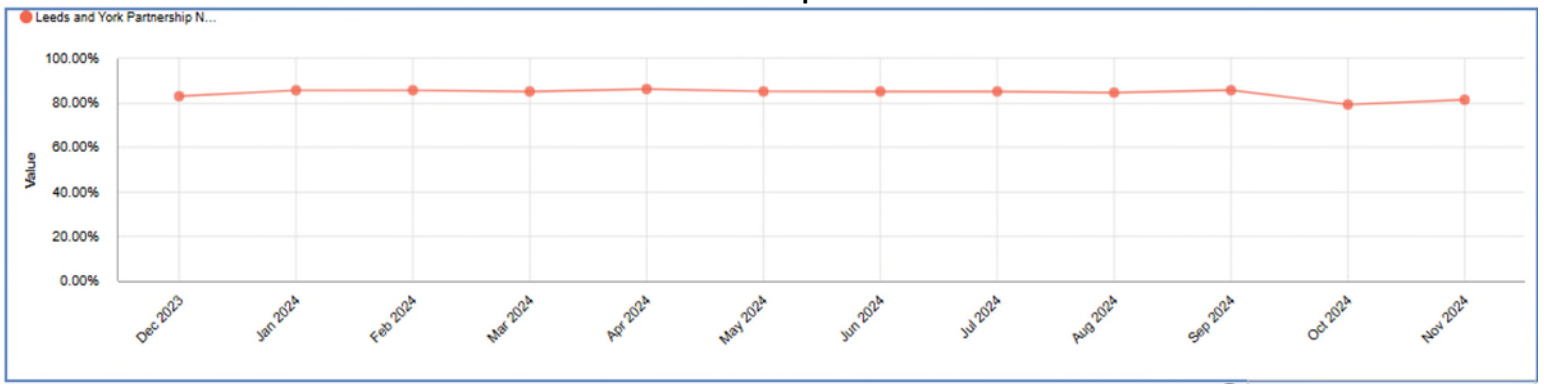
- Pilot the new Succession Planning approach with EMT/SMT
- Launch the new career development programme, using a variety of workshop sessions
- Analyse the data from the exit interview pilot to develop strategies to improve retention
- Ongoing communication and cascade of the launch of Development Roles
- Launch the Stay Conversation approach

Increase the opportunities for flexible working across the Trust, including flexible retirement options.

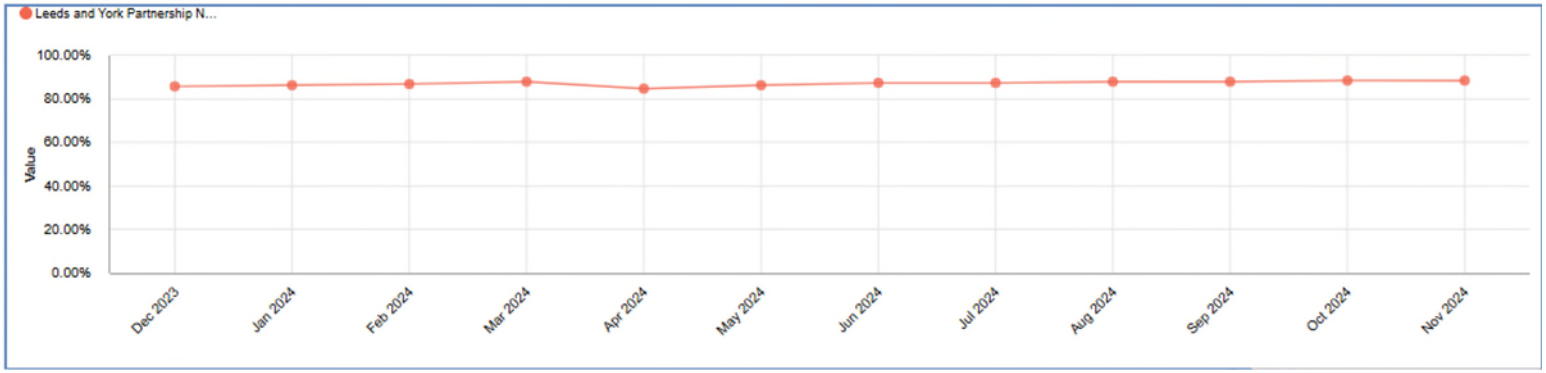
- Develop an engagement strategy to support and champion a cultural shift around flexible working.
- Launch clear communications of Flexible Retirement options and process for colleagues to follow when considering routes
- Revise Flexible working procedure to include application process
- Provide workshops and supporting guidance to improve managers confidence in managing flexible working requests including the incorporation into the manager 360 module.

1.6 Our People – Learning and Development

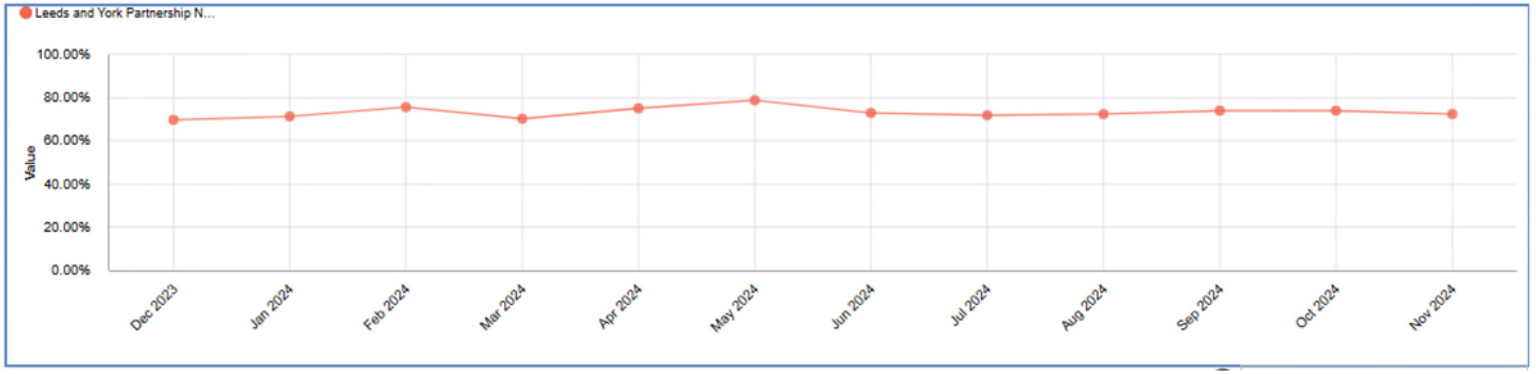
Performance Development Reviews



Compulsory Training



Clinical Supervision



Requirement	Care Group	Number compliant	Number non-compliant	Total Headcount	Compliance status
Annual Appraisal	Adult Acute Services	206	116	322	64%
	Care Services Other	32	5	37	86%
	Chief Operating Officer	2	2	4	50%
	Children and Young People's Services	111	23	134	83%
	Community and Wellbeing Services	177	43	220	80%
	Corporate Services	510	92	602	85%
	Eating Disorders and Rehabilitation and Gender Services	195	37	232	84%
	Forensic Services	173	24	197	88%
	Junior Doctors Primary Care Trust	3		3	100%
	Learning Disability Services	261	61	322	81%
	Liaison and Perinatal Services	160	31	191	84%
	Older Peoples Services	247	66	313	79%
	Regional and Specialist Services	119	17	136	88%
	Trust Board - Executive Directors	5	1	6	83%
	Trust Board - Non Executive Directors	5	2	7	71%

Requirement	Care Group	Number compliant	Number non-compliant	Total Headcount	Compliance status
Clinical Supervision	Adult Acute Services	173	128	301	57%
	Care Services Other	12	5	17	71%
	Children and Young People's Services	104	33	137	76%
	Community and Wellbeing Services	104	58	162	64%
	Corporate Services	8		8	100%
	Eating Disorders and Rehabilitation and Gender Services	170	42	212	80%
	Forensic Services	141	43	184	77%
	Learning Disability Services	86	33	119	72%
	Liaison and Perinatal Services	114	39	153	75%
	Older Peoples Services	188	89	277	68%
	Regional and Specialist Services	105	22	127	83%

Our people ambitions
New ways of working and delivering care

Provide accessible and intuitive software solutions to support People and OD initiatives.

1. Implement the Core Skills Training Framework (CSTF) learning interface (ESR and Learn) to allow transfer of compulsory training between Trusts.

2.Utilise systems data (PDR/LNA/Career conversations) to assess quality and to inform support interventions to guide improvements to people development.

The above new ways of working targets have both been delivered in Q1 and are now built into business as usual for the Trust, informing people development training options and reducing duplication for new starters.

Key Points

PDR

- PDR compliance has remained compliant at 85% for 9 consecutive months.
- October reporting reflects some slippage against target for the first time, particularly in Adult Services.

Clinical Supervision

- Clinical Supervision compliance continues to fluctuate between 70-80% With all but 5 services within 10% of target. The clinical supervision module expiration is 8 weeks so compliance can fluctuate significantly day to day.

Compulsory Training

- Compliance has been stable over the 13-month period averaging 86.6%. Small but successive increases were seen between February and August, with a small decrease in performance in September 2023 linked to a new element of training being added. In October 88.23% of staff have in-date mandatory training, above the 85% target. Learning Disability and Autism training was made live in April and, as predicted, has affected the April compliance rate by a reduction of approximately 3%.

Definition of Staff Groups		
Add Prof Scientific and Technic	APS&T	All Qualified Technical Staff & Pharmacists – e.g. Optometrists, ODPs, General Technicians
Additional Clinical Services	ACS	All Unqualified Nursing Staff, Therapy Staff & Technical & Scientific Staff – e.g. Support Workers, Play Specialists, Physio Assistants
Administrative and Clerical	A&C	All Admin & Clerical Staff – e.g. Clerical staff, Managers, Senior Managers
Allied Health Professionals	AHP	All Qualified AHP Staff – e.g. Physios, Dieticians, Orthoptists
Estates and Ancillary	E&A	All Ancillary and Maintenance Staff – e.g. Domestics, Porters, Housekeepers, Joiners, Craftsman
Healthcare Scientists	HCS	All Scientific Staff – e.g. Biomedical Scientists, Scientists
Medical and Dental	M&D	All Medical Staff – e.g. Junior Doctors, Consultants
Nursing and Midwifery Registered	N&M	All Qualified Nursing Staff – e.g. Staff Nurse, Ward Manager, Health Visitors

Definition of Other Terms		
Black & Minority Ethnic groups	BME	Term used to refer to members of non-white communities in the UK
Full Time Equivalent	FTE	The unit used to show the equivalence to a full time member of staff. Sometime referred to as Whole Time Equivalent (WTE). E.g. a nurse working 30 hours per week would have a FTE of 0.80
Key Performance Indicator	KPI	A type of measurement to evaluate success against a given target
Personal Development Review	PDR	Annual appraisal of staff performance and development

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

AGENDA ITEM
20

PAPER TITLE:	Freedom to Speak Up – Annual Report
DATE OF MEETING:	28 November 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.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

EXECUTIVE SUMMARY

This annual 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 15 November 2024.

There were 61 concerns that were raised through the FTSUG which were informally discussed, resolved or escalated for further investigation via the FTSUG during this period.

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.

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

28 November 2024

Freedom to Speak Up

1 Executive Summary

This annual 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 15 November 2024.

There were 61 concerns that were raised through the FTSUG which were informally discussed, resolved or escalated for further investigation via the FTSUG during this period. All cases have been closed on the system, but there are still ongoing discussions and learning from these cases. Some cases have progressed into service reviews or investigations where follow up is necessary.

Activities the FTSUG service has been involved with includes:

- Promotion of 'Speak Up Month' during October and site visits
- Development and recruitment to the role of FTSU Ambassador
- 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.

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 been recruited via ringfenced expression of interest to Don Valley). Freedom to Speak up Ambassadors have a vital role in:

- Awareness raising – Ensuring workers understand the importance of speaking up, listening up and following up.
- Signposting – Discussing concerns with workers and providing details of speaking up routes as stated in their organisation's Freedom to Speak Up Policy
- Promoting a positive speaking up culture – Supporting their organisation to welcome and celebrate speaking up.

2.3 The FTSUG has developed a new handbook for ambassadors as part of the development programme. Development includes attendance at staff inductions to raise visibility, attendance at team meetings to promote Speak Up work, increased use of Staff Net.

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

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

2.6 Sharing data is important to learn as a trust but care must be taken in ensuring a themed approach rather than identifying individuals. This has been done by sharing the Board report more widely and on Staff Net and identifying opportunities to share learning.

2.7 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.

2.8 We have received 61 concerns. Due to the low number of concerns in some areas 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.

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

Numbers of concerns formally raised	Themes	Outcome
20	Inappropriate behaviour and bullying	Signpost to HR, trade unions, occupational health/wellbeing, line manager, early resolution techniques.
15	Unfair workplace practice e.g. recruitment, disciplinary, workplace adjustments	Referral for service reviews/investigation, review of formal processes, HR involvement in process.
14	Discrimination allegations based on disability, gender or race	Involvement of Head of EDI, review of processes, signpost to HR/Temporary Staffing support.
6	Patient safety concerns	Investigation of concerns, review of processes, signpost to PALS.
6	Security/Parking, Safety/Violence and aggression	Involvement of Estates and Facilities, Review of disabled parking spaces.
1	Detriment from raising concern	Signpost to support outside of LYPFT, once internal support exhausted

2.10 Concerns were received by email (35), phone/text (12), face to face/meeting (7), anonymous letter or email (5), referral from Leeds University (2).

2.11 The professional groupings within this update include Admin (24), Nurses (18), Medic (5), Bank/agency (8), Students (2). Some were also raised anonymously and unidentifiable.

2.12 24 staff colleagues who informally discussed concerns with the FTSUG are from diverse backgrounds and 16 of these concerns were related to issues of race either fully or partially. There were 12 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/service to know their name (49), anonymous (3), happy to be involved in resolution (8), leaver (1).

3.3 Learning includes:

- Provide agreed feedback to line managers that can be given to the service for learning
- Escalation to Estates and Facilities for reviews e.g. disabled car parking, safe spaces
- Review of process for Global Protect where passwords expire and cause log in issues
- Build relationships with the police to resolve situations of violence from patients to staff
- Review of dress code policy for responding to concerns from student wearing niqab
- Swift communications to staff on culture reviews, external factors affecting staff at work
- Work with HR and managers to ensure fair distribution of tickets at Award Ceremonies
- Quicker escalation of concerns to service review/investigations to establish facts/root cause
- Use of third party intervention in meetings to facilitate difficult conversations
- Support staff to exhaust informal stages of procedures before escalation to formal stage
- Include in policy signpost to external sources where internal avenues are exhausted
- Support review of EDI projects including workplace adjustments, sharing of EDI data

4 Positive Feedback

4.1 Feedback forms have a low return rate (7 forms returned), despite reminders being sent, but follow up calls indicate satisfaction with the service. The feedback forms indicated:

- **How did you find out about FTSU?**
  - Word of Mouth (2), Staff Net (2), A colleague (1), Used before (1), Meeting (1)
- **How easy was it to make initial contact?** Very easy 100% (7)
- **Did the Guardian thank you?** Yes 100% (7)
- **How did you find the initial response?** Very helpful 100% (7)

Open Comments:

- “non-judgemental and easy to speak to”;

- “I found the support from you responsive, helpful and proportionate”;
- “Shereen was fantastic throughout. Was approachable, supportive, and understanding everything you want and need in a speaking up Guardian;
- “Nothing ever seemed too much and she was able to make some very important, significant change happen, which I never expected”.

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 The Raising Concerns Policy has been reviewed in line with the NHS England guidelines and is out for consultation with key stakeholders as part of the policy review process. Feedback will be incorporated into the policy where appropriate and good practice will continue.

5.3 Where concerns raised involve multiple issues or serious concerns, we will liaise with HR, OD and service manager on a Service Review, investigation or a review of the recommendations from previous reviews.

5.4 Introduction of a quarterly learning item in Trust News to share learning from concerns with managers and staff networks. We will continue to support cultural improvement work liaising with teams and creating space for staff to speak about their experiences e.g. peer reviews, away days and workshops.

5.5 The following are ongoing and future work plans:

- Launch of learning events across the Trust with FTSU Ambassadors to include learning and feedback from concerns, utilise the online platform and continue news articles
- Case studies to be shared with a focus on disability related concerns for Disability History Month. The theme is Disability, Livelihood and Employment.
- To review the FTSUG service in the light of the Audit and Staff Survey results
- To work with the FTSUGs regionally at other NHS organisations and at Leeds City Council on supporting speaking up in our systems in Yorkshire.
- To continue to focus on staff with protected characteristics in the trust to develop how speaking up can support our 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
28 November 2024

Agenda item
21

Meeting of the Board of Directors

Paper title:	Chair's Report from the Audit Committee meeting on 22 October 2024
Date of meeting:	28 November 2024
Presented by: (name and title)	Martin Wright, Non-executive Director and Chair of the Audit Committee
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.	✓

This paper relates to the Trust's strategic risk/s (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	✓
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	✓

Committee details:	
Name of Committee:	Audit Committee
Date of Committee:	22 October 2024
Chaired by:	Martin Wright, Non-executive Director

ALERT – items to alert the Board to

- None

ADVISE – items to advise the Board on

- The Committee received the "Mental Capacity Act" Internal Audit Report which had been received with an overall opinion of limited assurance. The Committee was reassured that work was ongoing to complete the identified actions in the report within the time period agreed. It also agreed that this report should be referred to the Mental Health Legislation Committee for additional assurance.

- The Committee received the "Job Planning" Internal Audit Report which had been received with an overall opinion of limited assurance. The Committee was reassured that work was ongoing to complete the identified actions in the report within the time period agreed. It also agreed that this report should be referred to the Workforce Committee for additional assurance.

- The Committee agreed that an audit on the "Volunteer Pay Policy" would be added to the 2024-25 Internal Audit Plan. It noted that this audit would be conducted in the time which had been originally allocated for the Data Security and Protection Toolkit assessment which had been deferred to Q1 2025-26 while the Internal Audit Team awaited updated guidance.

- The Committee received data which demonstrated that the Trust was receiving more internal audit reports expressing an overall opinion of limited or low assurance as a percentage compared with previous years. It was reassured by the Internal Audit Team that this was likely due to areas which represented the greatest challenge and risk to the Trust as being identified for audit, improvements in Audit Yorkshire's methodology in assessing controls, and the time allocated for each audit being longer allowing for a more thorough assessment of each audit area.

ASSURE – items to provide assurance to the Board on

- The Committee received the "Board Assurance Framework and Risk Management Arrangements Benchmarking" report and was assured that the Trust had an improved and mature Board Assurance Framework in place.

- The Committee received the Local Counter Fraud Update report. It noted that there was one active investigation of alleged fraud involving the submission of falsified timesheets and that the outcomes of this investigation would be reported to the Committee ahead of its January 2025 meeting. It was reassured on the changes in practice the Trust had implemented which would reduce the risk of fraud in this area going forward.

- The Committee received and noted the contents of the Health and Safety Quarterly Update Report for Quarter 2 2024-25.

- The Committee received and noted the contents of the Health and Safety Annual Report for 2023-24. It noted that this report would be received at the November 2024 Board of Director's meeting.

- The Committee received the Outstanding Audit Actions report and noted that there were two overdue actions as of 27 August 2024. It additionally noted the work which had been undertaken to identify and review all longstanding audit actions to ensure that they were still relevant, and that this would be discussed further at the November 2024 Executive Risk Management Group meeting.

- The Committee received the version of the Board Assurance Framework which had been approved by the Board at its July 2024 meeting and was assured that it was still fit for purpose. It noted several areas where the BAF could be revised ahead of its planned presentation at the November 2024 Board of Director's meeting.

- The Committee received the Tender and Quotation Exception report for the period April – September 2024. It agreed that the format of the report should be revised so that the rationale as to why an exceptions process had been followed for the four items identified in this report could be added for assurance, and that this item should be resubmitted for assurance at the Committee's January 2025 meeting.

- The Committee agreed the amendments which had been made to its Terms of Reference and noted that this would be presented to the Board for ratification.

- The Committee agreed its Cycle of Business for 2025.

- The Committee agreed that its annual objective would be to encourage the improvement of the data it received in various reports received by the Committee so that it included more historical trend data, and where appropriate, benchmarking data.

REFER - Items to be referred to other Committees:

- It was agreed that the limited assurance internal audit report on the "Mental Capacity Act" would be referred to the Mental Health Legislation Committee.

- It was agreed that the limited assurance internal audit report on the "Job Planning" would be referred to the Workforce Committee.

Recommendation

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

Agenda item
21.1

Meeting of the Board of Directors

Paper title:	Terms of Reference for the Audit Committee
Date of meeting:	28 November 2024
Presented by: (name and title)	Martin Wright, Non-executive Director and Chair of the Audit Committee
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.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	✓
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

Executive summary

The Audit Committee reviewed and approved its terms of reference on 22 October 2024. The following amendments were made (all amendments are included in red in the attached document):

- Section 6.3 - Updated Internal Audit to read "The Committee shall ensure that there is an effective Internal Audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive, and Board of Directors." From "NHS Internal Audit Standards".

- Section 8 – Removed the information on how the Chair of the Committee is responsible for ensuring that the Committee Effectiveness process is completed annually as this information was duplicated in Section 9 “Review of the Terms of Reference and Effectiveness”. This information is now contained wholly within Section 9.

In addition, it was noted that the Audit Committee’s responsibilities in section 6.1 for care the Trust ‘provides’ was the same as the Quality Committee’s Terms of Reference. It was noted that should it be agreed that this should be expanded to include the health care provisions the Trust arranges through other providers for the Quality Committee Terms of Reference that this should also be expanded in the Audit Committee’s Terms of Reference.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? State ‘Yes’ or ‘No’.

No.

Recommendation

The Board is asked to:

- Review the changes made and ratify the revised Terms of Reference.

AUDIT COMMITTEE

Terms of Reference

**(approved by the Audit Committee on 22 October 2024
To be proposed for ratification by the Board of Directors on 28 November 2024)**

1 NAME OF COMMITTEE

The name of this committee is the Audit Committee.

2 COMPOSITION OF THE COMMITTEE

The members of the committee and those who are required to attend are shown below together with their role in the operation of the committee.

Members

Title	Role in the committee
Non-executive Director (Chair of the Committee)	Committee chair and responsible for evaluating the assurance given and identifying if further consideration / action is needed. Non-executive directors provide constructive challenge and strategic guidance, and lead in holding the executive to account. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of clinical and other information, and make sure that clinical quality controls, and systems of risk management and governance, are robust and implemented. (Code of Governance for NHS Provider Trusts, NHS England 2022)
2 Non-executive Directors	Responsible for evaluating the assurance given and identifying if further consideration / action is needed. Non-executive directors provide constructive challenge and strategic guidance, and lead in holding the executive to account. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor

	the reporting of performance. They should satisfy themselves as to the integrity of clinical and other information, and make sure that clinical quality controls, and systems of risk management and governance, are robust and implemented. (Code of Governance for NHS Provider Trusts, NHS England 2022)

While specified non-executive directors will be regular members of the Audit Committee any other non-executive can attend the meeting on an ad-hoc basis if they wish and will be recognised as a member for that particular meeting and if necessary will count towards the quoracy.

Attendees

Title	Role in the committee	Attendance guide
Chief Financial Officer	Key responsibilities regarding audit and reporting	Every meeting
Internal Audit representation	Independent assurance providers	Every meeting
External Audit representation	Independent assurance providers	Every meeting
Local Counter Fraud representation	Independent assurance providers	Dependant on the agenda
Associate Director for Corporate Governance	Committee support and advice	Every meeting

The chair of the Audit Committee shall be seen as independent and therefore must not chair any other governance committee either of the Board of Directors or wider within the Trust.

Executive directors and other members of staff may attend by invitation in order to present or support the presentation of agenda items / papers to the committee. In particular, executive directors will be invited to attend a meeting where a limited assurance report has been issued by Internal Audit and is on the agenda to be discussed.

The Chair of the Trust and the Chief Executive will be invited to attend the Audit Committee once per year.

2.1 Governor Observers

The role of the governor at Board sub-committee meetings is to observe the work of the Committee, rather than to be part of its work as they are not part of the formal membership of the Committee. The governor observes Board sub-committee meetings in order to get a better understanding of the work of the Trust and to observe non-executive directors appropriately challenging the executive directors for the operational performance of the Trust.

At the meeting the governor observer will be required to declare any interest they may have in respect of any of the items to be discussed (even-though they are not formally part for the discussion). Governors will receive an information pack prior to the meeting. This will consist of the agenda, the minutes of the previous meeting and summaries of the business to be discussed. Governor observers will be invited to the meeting by the Corporate Governance Team. The chair of the meeting should ensure that there is an opportunity for governor observers to raise any points of clarification at the end of the meeting.

2.2 Associate Non-executive Directors

Associate Non-executive Directors will be invited to attend Board Sub-committee meetings as part of their induction. They will be in attendance at the meeting, in the capacity of observer only, unless invited to contribute by the Chair in circumstances that support the ANEDs development and understanding. This is so the accountability of the substantive members of the committee is maintained.

Associate NEDs will be invited to meetings by the Corporate Governance Team and will be sent copies of the meeting papers.

3 QUORACY

Number: The minimum number of members for a meeting to be quorate is 2. Attendees do not count towards this number.

Deputies: Non-executive directors do not have deputies. Non-core non-executive directors may be asked to attend if there is a risk to the meeting not being quorate.

Attendees should nominate a deputy to attend in their absence. A schedule of deputies, attached at appendix 1, this should be reviewed at least annually to ensure adequate cover exists.

Non-quorate meeting: Non-quorate meetings may go forward unless the chair decides otherwise. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

Alternate chair: If the Chair of the Audit Committee is not available the meeting shall be chaired by one of the other non-executive directors.

4 MEETINGS OF THE COMMITTEE

Meetings may be held face-to-face or remotely as is considered appropriate. Remote meetings may involve the use of the telephone and / or electronic conference facilities.

Frequency: The Audit Committee will normally meet as required but will in any case meet no fewer than four times per year.

Urgent meeting: Any of the committee members may, in writing to the chair, request an urgent meeting. The chair will normally agree to call an urgent meeting to discuss the

specific matter unless the opportunity exists to discuss the matter in a more expedient manner (for example at a Board meeting).

Minutes: Draft minutes will be sent to the chair for review and approval within seven working days of the meeting.

Papers: Papers for the meeting will be distributed electronically by the Corporate Governance Team five working days prior to the meeting. Papers received after this date will only be included if decided upon by the chair.

Private Sessions of the Committee

At least once a year the committee will meet privately with representatives from internal audit and external audit.

At the discretion of the chair of the committee, it may also choose to meet privately with the Director of Finance and any other key senior officer in the Trust as may be required.

Members of the committee will also meet together in private at a frequency determined by the Chair.

5 AUTHORITY

Establishment: In accordance with the NHS Act 2006 and the Code of Governance the Board of Directors is required to establish an Audit Committee as one of its sub-committees.

Powers: The committee is a non-executive committee of the Board of Directors and has no executive powers. The committee is authorised by the Board of Directors to seek assurance on any activity. It is authorised to seek any information or reports it requires from any employee, function, group, or committee; and all employees are directed to co-operate with any request made by the committee.

The committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of persons outside the Trust with relevant experience and expertise if it considers this necessary.

Cessation: The Audit Committee is a standing committee in that its responsibilities and purpose are not time limited. While the functions of the Audit Committee are required by statute the exact format may be changed as a result of its annual review of its effectiveness.

In addition, the Trust should periodically review its governance structure for continuing effectiveness and as a result of such a review the Board may seek to alter the format or the number of non-executive director core members of the Audit Committee.

6 ROLE OF THE COMMITTEE

6.1 Purpose of the Committee

The purpose of the Audit Committee is to provide the Board of Directors with assurance that:

- Clinical, financial reporting, compliance, risk management, and internal control principles and standards are being appropriately applied and are effective, reliable, and robust
- An effective governance framework is in place for monitoring and continually improving the quality of health care provided to service users to enable the Trust's strategic objectives to be achieved.

Objective	How the committee will meet this objective
We deliver great care that is high quality and improves lives	The Audit Committee has a core responsibility to scrutinise the Trust's governance arrangements to determine that these are operating effectively and that the Trust is able to provide high quality care through these arrangements.
We use our resources to deliver effective sustainable care	The Audit Committee exercises scrutiny of the annual financial reporting of the organisation; on-going financial health; and controls designed to deliver efficiency, effectiveness, and economy for all Trust functions

6.2 Guiding principles for members (and attendees) when carrying out the duties of the committee

In carrying out their duties, members of the committee and any attendees of the committee must ensure that they act in accordance with the values of the Trust, which are:

- We have integrity
- We are caring
- We keep it simple.

6.3 Duties of the committee

Notwithstanding any area of business on which the committee wishes to receive assurance the following shall be those items on which the committee shall receive assurance:

Board Assurance Framework

- Be assured that the organisation has in place an effective Board Assurance Framework

- Be presented with the Board Assurance Framework and receive assurance that this presents the up-to-date position in respect of controls, assurances and that gaps are being addressed, and be assured as to the completeness of the information included in the Framework
- Use the Board Assurance Framework to inform the committee's forward work plan, in particular focussing on those gaps that pose a major risk to the organisation.

Quality Report

- Be assured in respect of the process for delivering the Quality Report with the submission of a paper which explains how the Quality Report has been populated.

Risk Management

- Receive assurance as to the Risk Management Process (including structures processes and responsibilities for managing key risks), including the process for capturing and reviewing high and extreme risks
- Carry out the duties of Safety and Risk Champion.

Health and Safety

- Receive an annual report and regular update reports on health and safety management within the Trust
- Have oversight quarterly of the progress against the Health and Safety action plan
- Carry out the duties of the Health and Safety Champion.

Compliance and Disclosure Statements

- Be assured of the action taken by officers who have operated outside of the tender and quotation procedures
- Be presented with notification of any waivers of the Standing Financial Instructions and Standing Orders (for the Board of Directors and Board of Governors) and be assured of their appropriateness.

Annual Accounts and Annual Report

- Be presented with and review the main items / contentious items in the Annual Accounts, taking advice from the Chief Accounting Officer and the External Auditors as to accuracy, prior to advising the Board if the Accounts can be adopted
- Be presented with the ISA260 Report on the Annual Accounts and be assured as to the findings and the management actions agreed, also be assured that either there were no (or otherwise) significant findings

- Be presented with a periodic report setting out the progress against the recommendations made in the ISA 260 reports (pertaining to the last set of annual accounts) and be assured as to progress against recommendations / action plans.

Annual Governance Statement and Head of Internal Audit Opinion

- Be presented with the draft Annual Governance Statement and have an opportunity to input to the content
- Be presented with the final version of the Annual Governance Statement and be assured that it provides an accurate picture of the processes of internal control within the organisation
- Be presented with the Head of Internal Audit Opinion and be assured that this is an accurate assessment of the Trust and also be assured that the opinion is in accordance with the Annual Governance Statement.

Registers

- Be presented with the Losses and Special Payments Report to be assured as to the appropriateness of payments made and that control weaknesses have been addressed
- Be presented with the Sponsorship Register to be assured that it is complete, and that sponsorship received by the organisation / individuals is appropriate and has been applied for according to the procedure
- Be presented with the Hospitality Register to be assured that it is complete, and that hospitality received by individuals is appropriate, proportionate, and unable to be considered an inducement and has been recorded according to the procedure
- Be presented with the register of Management Consultants to be assured that it is complete and that consultants have been appointed appropriately, and according to the procedure.

Internal Audit

- The committee shall ensure there is an effective Internal Audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

    - Consideration of the provision of the Internal Audit service, the cost of the audit function and (where the service is provided in-house) any questions of resignation and dismissal
    - Review and approval of the Internal Audit strategy, operational plan, and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation

- Consideration of the major findings of Internal Audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing with the organisation.

External Audit

- The committee shall review the work and findings of the External Auditor. In addition to this the committee will:

    - Make recommendations to the Council of Governors as to the appointment, reappointment, termination of appointment and fees of the External Auditor, and if the Council of Governors rejects the Audit Committee's recommendations, it will prepare an appropriate statement for the Board of Directors to be included in the Trust's Annual Report
    - Review the audit program of work and fees and discuss with the External Auditor, before audit work commences, the nature and scope thereof
    - Review External Audit reports together with the management response, and the annual governance report (or equivalent)
    - Consider whether it is appropriate and beneficial to the Trust for the External Auditor to undertake investigative and advisory work for the Trust.

Counter Fraud

- The committee's responsibilities regarding counter fraud are governed by Section 47 of the Base Model Contract between Foundation Trusts and PCTs and Schedule 13 of this contract and the duties of the Audit Committee are set out in this contract specifically that:

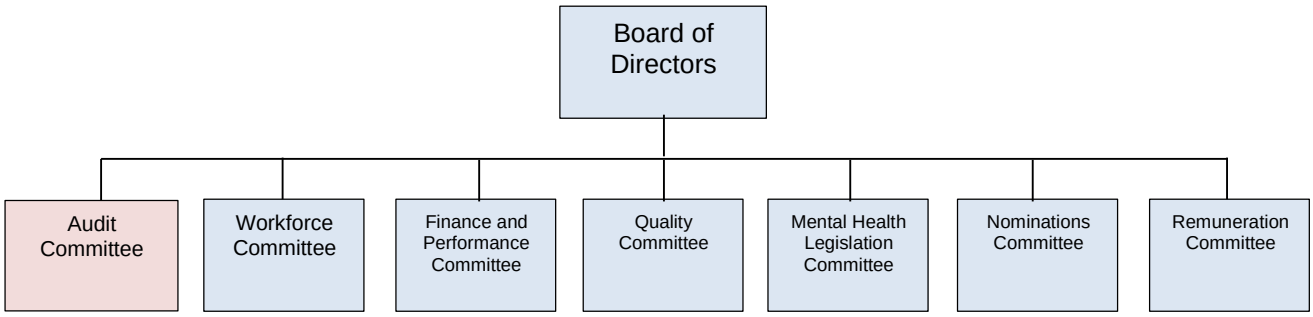
    - The committee shall allow the Local Counter Fraud Specialist service (LCFSs) to attend Audit Committee meetings
    - The committee shall receive a summary report of all fraud cases from the LCFSs
    - The committee shall receive reports from the LCFSs regarding weaknesses in fraud related systems
    - The committee shall receive and review the LCFSs' Annual Report of Counter Fraud Work
    - The committee shall receive the LCFSs' annual work plan for comment.

7 RELATIONSHIP WITH OTHER GROUPS AND COMMITTEES

The Audit Committee is the primary governance committee providing an overarching governance role, having a direct relationship with other Board sub-committees.

The Board sub-committees will provide one of the main sources of assurance to the Audit Committee. However, this assurance will be validated by the work of, and reports from other sources of assurance including, but not exclusively, Internal Audit, External Audit, and Counter Fraud Services.

The following is a diagram setting out the governance structure in respect of assurance.



The committee has a duty to work with other Board sub-committees to ensure matters are not duplicated.

8 DUTIES OF THE CHAIR

The chair of the committee shall be responsible for:

- Agreeing the agenda
- Directing the meeting ensuring it operates in accordance with the Trust's values
- Giving direction to the minute taker
- Ensuring everyone at the meeting has a reasonable chance to contribute to the discussion
- Ensuring discussions are productive, and when they are not productive they are efficiently brought to a conclusion
- Deciding when it is beneficial to vote on a motion or decision
- Checking the minutes
- Ensuring sufficient information is presented to the Board in respect of the work of the committee
- Ensuring the Chair's report is submitted to the Board as soon as possible.
- Ensuring that governor observers are offered an opportunity at the end of the meeting to raise any points of clarification.

~~It will be the responsibility of the chair of the Audit Committee to ensure that the committee carries out an assessment of the committee's effectiveness annually, and ensure the outcome is reported to the Board of Directors along with any remedial action to address weaknesses. The chair will also be responsible for ensuring that the actions to address any areas of weakness are completed.~~

In the event of there being a dispute between any ‘groups’ in the hierarchy (in the case of this Board sub-committee, this would be between the Board and the Audit Committee and, in recognition of the nature of matrix working between the work of all Board sub-committees, the Audit Committee and any other Board sub-committee) it will be for the chairs of those groups to ensure there is an agreed process for resolution; that the dispute is reported back to the ‘groups’ concerned; and that when a resolution is proposed the outcome is also reported back to the ‘groups’ concerned for agreement.

9 REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

The terms of reference shall be reviewed by the committee at least annually, and then presented to the Board of Directors for ratification, where there has been a change.

In addition to this the chair must ensure the committee carries out an annual assessment of how effectively it is carrying out its duties and make a report to the Board of Directors including any recommendations for improvement, along with any remedial action to address weaknesses. The chair will also be responsible for ensuring that the actions to address any areas of weakness are completed.

Schedule of deputies

It may not be necessary or appropriate for all members (or attendees) to have a deputy attend in their absence. If this is the case please state below "no deputy required".

Full member (by job title)	Deputy (by job title)
Non-executive Director (Chair of the Committee).	Either one of the Non-executive Directors.

Attendee (by job title)	Deputy (by job title)
Chief Financial Officer	Deputy Director of Finance
Associate Director for Corporate Governance	Head of Corporate Governance

Agenda item
22

Meeting of the Board of Directors

Paper title:	Chair's Report from the Mental Health Legislation Committee meeting on 5 November 2024
Date of meeting:	28 November 2024
Presented by: (name and title)	Kaneez Khan, Non-executive Director, and Chair of the Mental Health Legislation Committee
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.	✓

This paper relates to the Trust's strategic risk/s (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	
SR5	Adequate working and care environments	✓
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	✓

Committee details:	
Name of Committee:	Mental Health Legislation Committee
Date of Committee:	5 November 2024
Chaired by:	Kaneez Khan, Non-executive Director

ALERT – items to alert the Board to

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

ADVISE – items to advise the Board on

- Challenges regarding safety and security arrangements of Mental Health Act Manager hearings and tribunals, in particular for community patients due to the reduced number of staff present for a hearing, was raised at the Mental Health Legislation Operational Steering Group (MHLOSG) and discussed at the meeting. It was noted that a guidance document to address these challenges would be presented at the MHLOSG and a review of the Trust's Security arrangements would be conducted, and this would additionally be raised at the Clinical Environments Group.

- Challenges regarding the continued rollout of the "Right Care, Right Person" approach continued to be monitored, including delays in police forces attending incidents which occurred on hospital premises. It was noted that a report exploring this had been received by the Quality Committee, and that staff regularly reported incidents at the Police Liaison meetings.

ASSURE – items to provide assurance to the Board on

- The Committee noted that the Mental Health Legislation Activity Report now included data on the average length of stay for service users detained at the Section 136 suite so that the Committee could monitor this information.

- The Committee received the Mental Health Detentions Report for 2023-24 and discussed its contents. It highlighted that the data included in the report suggested that there was an increase in detentions of 72% compared with the previous year, but that this was not consistent with the data reported in the Mental Health Legislation Activity Reports received covering the same period. It agreed that future reports should ensure that the data used in the report examined the same data explored by the Mental Health Legislation Activity Reports.

- The Committee received the Mental Health Legislation Activity Report for Q2 2024-25 and was assured the plans in place were sufficient to ensure ongoing compliance with all mental health legislation.

- The Committee received and discussed the Mental Capacity Act internal audit report which had received an overall opinion of limited assurance. The Committee was assured on the management responses and actions to the recommendations made in the report and agreed that should the area be reaudited that this would be received by the Committee for assurance.

- The Committee discussed its Terms of Reference and agreed that further consideration should be made to whether the Committee's role in gaining assurance that the Trust was tackling health inequalities experienced by service users from minority ethnic backgrounds should be added to its

Terms of Reference. It was agreed that this would be discussed further with other members of the Board of Directors to ensure that this work was not duplicated elsewhere, and that the Committee would consider this further at its February 2025 meeting.

- The Committee completed its Committee Effectiveness review and was assured that no changes were required to be made to its Terms of Reference or practices as a result of this review.

REFER - Items to be referred to other Committees:

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

Recommendation

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

Escalation and Assurance Report

Report from: West Yorkshire (WY) Integrated Care System (ICS) Mental Health, Learning Disability & Autism (MHLDA) Committee-in-Common
Date of the meeting: 23/10/2024

Key discussion points and matters to be escalated from the discussion at the meeting:

Alert/Action:

- There are no alert points to raise.

Advise:

- The group had a discussion following a presentation on the progress made with the West Yorkshire Complex Rehabilitation Programme. It noted that a number of Places had suggested that they would not invest in the Complex Rehabilitation Enhance Support Team (CREST) in 2025/26 and recognised that this could potentially be a lost opportunity for improved outcomes for service users and improved productivity and financial savings, as well as a lost opportunity for shared learning. The group acknowledged that Places and providers had agreed on a suitable model and approach for the delivery of care to the complex rehabilitation population and agreed that an assurance framework was required so providers could be assured that they were delivering the same level of outcome for that population cohort across West Yorkshire. The group also agreed that an evaluation on this new way of working should be completed in six to twelve months' time to review whether service users have better outcomes in the places where this model had been adopted compared to places where the model had not been adopted.

- The group discussed neurodiversity and noted that the models of practice and the demand for services currently varied across Places. It recognised the need for consistent practice across the ICS and clear roles for Place and the ICB.

Assure:

- The group discussed productivity and the work that was being undertaken in each Trust. It noted that there was a lack of benchmarking data for mental health trusts and a lack of guidance on productivity metrics for mental health trusts. It agreed that a shared definition of what 'efficiency' meant would be helpful. It agreed that productivity should be a standing item on future agendas to ensure shared learning and avoid duplication of work. It agreed that the next update should include the outcomes of the PWC review of cost control across the ICB and providers and progress on developing efficiency metrics.

Report completed by: Keir Shillaker, WY MHLDA Programme Director **Date:** 01/11/2024

Distribution: Chairs and Company Secretaries of Bradford District Care NHS Foundation Trust, Leeds Community Healthcare NHS Trust, Leeds & York Partnership NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust.

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

AGENDA ITEM

24

PAPER TITLE:	Board Assurance Framework – Q1 Update
DATE OF MEETING:	28 November 2024
PRESENTED BY: (name and title)	Dr Sara Munro, Chief Executive
PREPARED BY: (name and title)	Clare Edwards, Associate Director 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.	✓

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	✓
SR3	Culture and environment for the wellbeing of staff	✓
SR4	Financial sustainability	✓
SR5	Adequate working and care environments	✓
SR6	Digital technologies	✓
SR7	Plan and deliver services that meet the health needs of the population we serve.	✓

EXECUTIVE SUMMARY

It is a requirement for all Trust Boards to ensure there is an effective process in place to identify, understand, address, and monitor risks. This includes the requirement to have a Board Assurance Framework that sets out the risks to the strategic plan by bringing together in a single place all the relevant information on the risks to the Board being able to deliver the organisation's objectives.

Following the implementation of the amended format in July 2024, the BAF has been updated to be reflective of the position for the end of Q2 to date.

The Board are asked to note the downgrade of Strategic Risk 3 relating to the workforce and culture risk from a level 16 to level 12. This was reviewed and recommended as appropriate at the Workforce Committee and Executive Risk Management Group in October 2024.

All other risks have been reviewed and updated to ensure controls and actions are reflective of the current position.

To confirm, the utilisation of the Datix system to manage the BAF has now ceased, and the presented paper is the version of the BAF to be used moving forward.

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

RECOMMENDATION
The Board is asked to: • Receive the BAF and to be assured of the appropriateness of updates, including risk scoring and mitigating actions. • Acknowledge the amended risk score for SR3.

MEETING OF BOARD OF DIRECTORS

28 November 2024

Board Assurance Framework

1 Executive Summary

It is a requirement for all Trust Boards to ensure there is an effective process in place to identify, understand, address, and monitor risks. This includes the requirement to have a Board Assurance Framework that sets out the risks to the strategic plan by bringing together in a single place all the relevant information on the risks to the Board being able to deliver the organisation's objectives.

2 Board Assurance Framework

2.1 Strategic Objectives

This Board Assurance Framework is informed by Trust strategy and the related strategic objectives. These are:

1. Through our Care Services: we deliver great care that is high quality and improves lives.
2. For our People: we provide a rewarding and supportive place to work.
3. Using our resources wisely: we deliver effective and sustainable services.

2.2 The BAF

Overall responsibility for the BAF sits with the Chief Executive and this is administered by the Associate Director for Corporate Governance who has a co-ordinating role in respect of the information, and for ensuring the document moves through its governance pathway effectively and provides check and challenge to the content.

This BAF sets out the principal risks and how they could impact on the strategic goals.

2.3 Risk Management

Recent work has provided further assurance to the Trust Board that the strategic risks are being appropriately managed and mitigated. This has included full review of the controls and actions in place.

The Board Assurance Framework has seven strategic risks. Each strategic risk has an assigned lead Executive Director who has oversight of the detail within the risk ensure identified actions are appropriate and have correct timeframes.

Board Committees review the BAF at their meetings in order to ensure that the risks remain appropriate and that they is assurance that they are appropriately managed.

The Executive Risk Management Group has oversight of all Trust risks, with specific focus on the strategic risks and risks rated 15 or above. There is a clear escalation route to the Executive Management Team and the Trust Board for any identified risk or action required.

2.4 Structure of the BAF Risk Report

This report helps to focus the Executive and Board of Directors on the principal risks to achieving the Trust's strategic goals and in-year objectives and to seek assurance that adequate controls and actions are in place to manage the risks appropriately.

The BAF is structured and mapped against the three strategic objectives.

Each of the risk scores identifies how the score has been calculated with likelihood and consequence ratings. This is shown as '*LX x CX'* in the main body of the BAF.

BAF Dashboard

Risk ref	Risk Title	Oversight Committee	Lead Executive	Strategic Objectives			Initial risk score	Previous Risk Score				Change	Target risk score	Assurance Rating	Target date
				1	2	3		Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25				
SR1	Quality including Safety Assurance Processes	QC	DoN&P	✓			4	12	12	12	12	⟷	1		31 Dec 25
SR2	Delivery of the Quality Strategic Plan	QC	MD	✓			9	12	12	12	12	⟷	6		31 Mar 25
SR3	Culture and environment for the wellbeing of staff	WC	DoP&OD		✓		12	16	16	16	12	↓	6		30 Apr 25
SR4	Financial sustainability	F&PC	DoF			✓	8	8	8	12	12	↑	4		31 Mar 25
SR5	Adequate working and care environments	F&PC	DoF			✓	8	12	12	12	12	⟷	4		31 Mar 28
SR6	Digital technologies	F&PC	DoF			✓	12	8	8	12	12	↑	4		26 Dec 25
SR7	Plan & deliver services for health needs of the population	F&PC	COO	✓			12	12	12	12	12	⟷	6		31 Jul 25

Strategic Risk 1

BAF Risk SR1 Risk 636	If there is a breakdown of quality including safety assurance processes, we risk not being able to maintain standards of safe practice, meeting population health needs and compliance with regulatory requirements.		
Strategic Objective:	1. We deliver great care that is high quality and improves lives		
Accountable Director	Executive Director of Nursing and Professions	**Initial Risk Score**	4 (L2xC2)
		Current Risk Score	12 (L3x4C)
Oversight Committee	Quality Committee	**Target Risk Score**	1 (L1xC1)
Risk Appetite	High / Open	**Target Date:**	31 December 2025

Controls in place

- Governance structures in place setting out where Quality, safety, compliance and performance are discussed and assurance is received and provided
- Peer review process embedded to review services compliance with CQC fundamental standards of care and regulations
- Annual process in place for reporting on the controls in place in relation to risk to compliance incorporating the Annual Governance Statement Compliance
- System and processes in place to review patient safety incidents and ensure learning is identified.
- Patient Safety Incident Response Framework Policy
- Whistle Blowing Procedure

Details of Assurance

Assurance Rating:	**Partial**

Management / Service Level	**Review Process / Oversight**	**Independent (external / internal audit)**
- Escalation processes - Ward to Board structure - Unified Clinical Governance Group - Patient Story approach - Safeguarding report - Clinical Governance toolkit - Patient safety investigation framework and process - Self-harm / suicide risk assessments - Safeguarding steering group - CQC Project Team - Safer staffing forum and annual establishment review	- Clinical Governance Framework - Board of Directors minutes - Trustwide Clinical Governance Group - Assurance reports incl. Quality & Performance report to Committee / CoG - Clinical Governance Group minutes - Director of Nursing and Professions reports - Quality Committee minutes - Leadership visits - Annual Governance statement - Quality Report - Peer reviews: internal - Safe Staffing report - Infection Control BAF (national) - Executive Risk Management Group - Safer staffing report - Safer staffing escalation procedure	- Assurance report: complaints / PALS - Peer reviews: ICS level - Audit Yorkshire – internal audit programme & reports - CQC preparation evidence - CQC MHA reviews - White Ribbon accreditation

Gaps in assurance / controls:	- Clinical Governance dashboard being developed - Review of clinical governance / effectiveness at Tier 3

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress
Transition to new risk assessment with supporting template & training	Risk Assessment and Care Planning Development Lead	30 December 2024	New template signed off at TWCG in July 24. Governance and sign off for implementation plan. Implementation to commence 25th November with a 3 month transition period onto new template before FACE/SAMP becomes read only,
Development of a suicide prevention plan and Self-Harm Strategy	Professional Lead for Nursing	31 March 2025	Review of current plan being carried out Engagement with citywide work ongoing to inform local plan Working with neighbouring trusts to develop training
Culture of Care Standards Transformation Programmes	Deputy Director of Nursing	31 March 2025	Lauch event attended in May 2024. QI and coaching for pilot sites to commence in September 2024.
Development of clinical governance dashboard and training	Deputy Director of Nursing	3 May 2025	A dashboard to support Tier 3/CIF meetings is being developed to provide consistency of data to be discussed and inform learning ad quality improvement at local governance meetings led by the Heads of Governance and Head of Digital for Nursing and Professions. This will be supported by a training package.
Development of a safer staffing SOP	Deputy Director of Nursing	3 May 2025	A SOP will be developed to support a standardised and consistent approach across inpatient services for the annual safer staffing establishment reviews with the staffing escalation procedure forming part of the document.
Implementation of the Annual Effectiveness Unified Clinical Governance review and Tier 3	Deputy Director of Nursing	30 May 2025	The recommendation from the annual effectiveness review and external audit will be progressed through a series of workshops led by the H of Governance and Clinical Directors and supported by CI/OD. The outcome of the Tier 3 review will be incorporated into this workstream when completed.

Contributory risks at level 12 or above

None

Strategic Risk 2

BAF Risk SR2 Risk 829	There is a risk that we fail to make the improvements outlined in the Quality Strategic Plan and that this has an impact on how we understand and act on the care of those who use our services.		
Strategic Objective:	1. We deliver great care that is high quality and improves lives		
Accountable Director	Medical Director	**Initial Risk Score**	9 (L3xC3)
		Current Risk Score	12 (L4xC3)
Oversight Committee	Quality Committee	**Target Risk Score**	6 (L2xC3)
Risk Appetite	High / Open	**Target Date:**	31 March 2025

Controls in place

- Quality Strategic Plan
- Safe Effective Reliable Care Framework
- LYPFT LCL Framework
- Improvement Methodology
- STEEP Framework
- Trustwide Clinical Governance structure
- Learning from Deaths process
- GAAP framework

Details of Assurance

Assurance Rating: **Partial**

Management / Service Level	Review Process / Oversight	Independent (external / internal audit)
- Escalation processes - Unified Clinical Governance Group - Clinical Governance toolkit - Patient safety investigation framework and process - Annual Service Quality Reports - Quality Improvement and Knowledge Meeting - CLIP report	- Quality Strategic Plan - Clinical Governance Framework - Board of Directors minutes - Medical Director reports - Trustwide Clinical Governance Group - Assurance reports incl. Quality & Performance report to Committee / CoG - Clinical Governance Group minutes - Quality Committee minutes - STEEP Framework - Quality Report - Improvement methodology - Freedom to Speak Up Guardian reporting - Executive Risk Management Group	- Internal Audit reports - CQC preparation evidence - Audit Yorkshire – internal audit programme & reports

Gaps in assurance / controls:

- Multi-disciplinary support and service leadership group
- Development of culture of innovation and improvement
- Data access and availability

Mitigating actions underway for controls and assurance:			
Action	**Lead**	**Target Date**	**Progress**
To develop the relationship between specific support services (for example Continuous Improvement Team, Informatics and Organisational Development Team) and care service through the evolution of existing performance oversight groups such as QDAP.	Deputy Director of Improvement	28 February 2025	The Quality Improvement and Knowledge Group (QuIK) continues to bring together expertise from across specific support services to oversee the production of integrated annual quality service reports from all service lines which reflect the recommendations in the Quality Strategic Plan. The next phase of work is to align this integrated approach to the input and outputs of quality (STEEEP) across all of our oversight groups including QDaP and EPOG. The QuESt Group has now met for the second time, this groups core membership is Research, Clinical Effectiveness, Knowledge and Library Service & the Improvement Team. The purpose of the QuESt group is to enhance patient outcomes, streamline processes, promote evidence-based practices, and support organizational priorities through integrated efforts. The group is meeting with Carl Money to discuss data literacy within the trust and what could be done to improve it.
Development of collective leadership, rollout of the revised Service Annual Reports (supported via the QuIK group) and building improvement capacity and capability programme.	Director for Collaborative Working	31 March 2025	Collective leadership programme continues for 2024/25
Creation of an integrated quality and culture dashboard and the prioritisation of the procurement of a clinical outcomes IT system	Deputy Director of Improvement	31 December 2024	Proof of concept work has been completed with next step to focus on learning and integrating across all services. Project support in place to start developing the PID, along with discussions about other options to support this work, with potential support via the Vacancy Management Panel.
Contributory risks at level 12 or above			
None			

Strategic Risk 3

BAF Risk SR3 Risk 1109	There is a risk that we fail to deliver a culture and environment that recruits, retains, and attends to the wellbeing of staff to enable them to be their best and deliver quality services now and in the future.		
Strategic Objective:	2. We provide a rewarding and supporting place to work		
Accountable Director	Director of People and Organisational Development	**Initial Risk Score**	12 (L3xC4)
		Current Risk Score	12 (L3xC4)
Oversight Committee	Workforce Committee	**Target Risk Score**	6 (L2xC3)
Risk Appetite	High / Open	**Target Date:**	30 April 2025

Controls in place

- Trust People Plan
- Trustwide Retention Plan
- Apprenticeship Strategy
- Leadership and Management Programme
- Leadership Academy programmes
- Collective Leadership Programme
- International Recruitment programme
- Exit Interview process
- Performance Reporting Compliance

Details of Assurance

Assurance Rating: **Partial**

Management / Service Level	Review Process / Oversight	Independent (external / internal audit)
- People & OD structure - Talent & Resourcing Group - PDR Process / Career Conversation Toolkit - In-house bank workforce - Cost of Living Task & Finish Group - Temporary staffing register - Bank Staff Survey / Awards - Workforce and Agency Group	- Board of Directors minutes - Work force Committee minutes - People Plan dashboard - Monitoring via JNCC & JLNC - Monitoring of training and development - Director of People and OD reports - Executive Risk Management Group - OD & Resourcing Group	- Health Education England review - Workforce alliance framework - Audit Yorkshire – internal audit programme & reports

Gaps in assurance / controls:

- Demographic challenges
- National staff supply issues
- Staff training

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress
Further upskilling for managers on workforce planning and how to develop new roles / skill mixing to support services and fill vacancies.	Acting Head of Resourcing	31 December 2025	Career development programme in place alongside the apprenticeship strategy to help upskill individuals. VMP panel in place to provide scrutiny to check and challenge vacancies.

			Workforce plan identifies new roles and opportunities for skill mixing
Widening participation plans to support skill shortages.	Apprenticeship and Widening Participation Manager	30 January 2025	Widening participation plan in place, Reverse recruitment pilot being evaluated before a roll-out plan is developed Apprenticeship strategy in place to support widening participation and address skill shortages
Engagement with services on the importance of leadership and management development including blended along with a development hub to ensure leaners can access development opportunities in a flexible manner.	Head of OD and Learning	31 December 2024	Comprehensive leadership and management programme in place. Range of opportunities to access the development opportunities Regular meetings with services to promote the programme
Engagement with managers about supporting bank staff to integrate into their team/service.	Head of Workforce Information	31 December 2024	Regular meetings with managers and services to promote the use of bank staff and the benefits of integrating them into the team on patient/service user outcomes and retention.
Train the trainer programme for Cultural Inclusion training which will be targeted at teams/services to address issues around culture/equality/diversity and inclusion.	Head of Diversity & Inclusion	1 April 2025	Train the trainer programme completed. Plan is being developed to roll-out the programme and target appropriate services and teams.
Contributory risks at level 12 or above			
None			

Strategic Risk 4

BAF Risk SR4 Risk 619	There is a risk that a lack of financial sustainability results in the destabilisation of the organisation and an inability to meet our objectives.		
Strategic Objective:	3. We deliver effective and sustainable services		
Accountable Director	Chief Financial Officer	**Initial Risk Score**	8 (L2xC4)
		Current Risk Score	12 (L3xC4)
Oversight Committee	Finance & Performance Committee	**Target Risk Score**	4 (L2xC2)
Risk Appetite	High / Open	**Target Date:**	31 March 2025

Controls in place

- Efficiency & Productivity Programme including Cost Improvement Programme
- Capital Plan
- SFIs
- Organisational plans
- Tender and procurement policy / programme
- Out of Area Placement programme
- System partners working arrangements
- Financial modelling and forward forecasting
- External Audit

Details of Assurance

Assurance Rating:	**Partial**

Management / Service Level	**Review Process / Oversight**	**Independent (external / internal audit)**
- Chief Financial Officer governance framework / structure - Task & Finish Groups – Agency Efficiency / Reducing Vacancies / OAP Efficiency - Finance training - Finance skills development - Fraud awareness courses - Budget holder training	- Board of Directors minutes - Finance & Performance Committee minutes - Provider Collaborative reports - Finance & Provider Collaborative meetings - Financial Planning Group - Tender review process - Executive Risk Management Group	- Provider Collaborative Framework – signed risk and gain shares - Leeds Strategic Finance Executive Group - Audit Yorkshire incl. Head of Internal Audit Opinion - Annual Accounts - Capital Planning Forum - Audit Yorkshire – internal audit programme & reports - NHS England – performance metrics

Gaps in assurance / controls:	- Medium term financial forecast required - SSL contact deficit

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress
Develop a MTFF detailing the cost improvement target required to achieve a recurrent underlying break-even position, outlining how the Trust will mitigate future inflationary pressures.	Deputy Director of Finance	31 December 2024	We are currently developing a Trust MTFP, system wide assumptions have been received and this plan will feed into an ICS MTFP
Re-negotiate the contract with LCC	Deputy Director of Finance	31 December 2024	The Trust is currently in the process of negotiating an inflationary uplift with LCC.

Contributory risks at level 12 or above				
Ref	Description	Lead / Responsible Director	Oversight Group	Score
650	Protecting MHIS investment for MH services in this challenging Financial Environment	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	16 (L4xC4)
651	Failure to achieve ongoing CIP requirements and demonstrate efficient and effective care will lead to a deterioration in the financial position.	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	12 (L3xC4)
731	A continuation of agency spend at current levels could negatively impact the Trust in achieving its financial plan and hinder the system to meet it's overall system agency cap	Deputy Director of Finance / Chief Financial Officer	Financial Planning Group	12 (L3xC4)
949	Changes to the capital funding regime may impact on the ability to secure sufficient capital (CDEL) allocations to deliver our long-term capital planning objectives, including reprovision of PFI. Capital resources are allocated to each ICS to help address ICS priorities, there is a risk that LYPFT capital requests may not be prioritised in the context of the other ICS priorities. The operational methodology used for allocating capital resources between organisations may not benefit LYPFT and be lower than historic planned levels. The Health & Social Care bill introduced a requirement to manage within capital allocations, however there is a risk that other system partners do not.	Deputy Director of Finance / Chief Financial Officer	Financial Planning Group	12 (L3xC4)
1147	Failure to re-negotiation of the SSL contract to ensure that is financially viable	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	12 (L4xC3)
1148	Out of Area Placement expenditure increasing threatening the financial sustainability of the Trust	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	16 (L4xC4)
1149	Impact of the growing gap between tariff uplift and Trust inflationary pressures	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	15 (L5xC3)

Strategic Risk 5

BAF Risk SR5 Risk 615	Due to an inability to provide adequate working and care environments we risk being unable to deliver safe and effective services.		
Strategic Objective:	3. We deliver effective and sustainable services		
Accountable Director	Chief Financial Officer	**Initial Risk Score**	8 (L2xC4)
		Current Risk Score	12 (L3xC4)
Oversight Committee	Finance & Performance Committee	**Target Risk Score**	4 (L2xC2)
Risk Appetite	High / Open	**Target Date:**	31 March 2028

Controls in place

- Security Management Policy
- Sustainability Plan (LYPFT Green Plan)
- Estates Strategic Plan
- Capital Planning Programme
- Care Services Strategic Plan
- Infrastructure & Projects Authority process in relation to PFI
- Lone Worker Policy
- NHS Workplace Standards - Health and safety management system
- Estates and Facilities Operational Policy

Details of Assurance

Assurance Rating:	**Partial**

Management / Service Level	**Review Process / Oversight**	**Independent (external / internal audit)**
- Chief Financial Officer governance framework / structure - Operational site meetings - Escalation processes - Risk assessments incl. ligature - Sustainability working groups - Compliance, Risk, Assurance and Governance Groups for Estates & Facilities	- Finance & Performance Committee minutes - Estates Steering Group minutes - Clinical Environment Group minutes - Environment audit programme - PFI demise governance process - Chief Financial Officer reports - PFI BAU and operational contract management - Executive Risk Management Group	- Audit Yorkshire – internal audit programme & reports - Independent Authorising Engineer / Independent Advisor Audits as per the requirements of Premises assurance Model (PAM) - Patient Led Assessment of the care environment (PLACE) - Estates Return Information Collection (ERIC)

Gaps in assurance / controls:	- Limited capital finance availability - Staffing pressures in relation to capacity, recruitment and retention, staffing competence - Integrated governance in relation to PFI demise needs to mature - Older buildings or certain areas are not functional or appropriate for some of our clinical services

Mitigating actions underway for controls and assurance:

Action	**Lead**	**Target Date**	**Progress**
Extreme heating feasibility studies to be undertaken and costed and taken to CEG for discussion.	Head of Operations (Estates & Facilities)	30 January 2025	Reports for Becklin and The Mount completed – report to CEG / ESG required but previously agreed to defer due to other

			priorities. Any amends to timeframes will be reviewed ahead of Summer 25.
Implementation of on-site staff safety alarm system using Capital Allocation via ESG, to address the issues in relation to the alarms. Supplemented with door lock adaptations and local SOPs.	Head of Operations (Estates & Facilities)	30 December 2024	Capital Plan now approved, Project Management provision identified with some minor enabling works and queries complete. Project to formally start in August 24 with a view to complete by the start of 2025. Business Case to go to Estates Steering Group in November 2025.
Health and Safety Audits to be completed on all the Trusts owned, leased and PFI Estate.	Head of Health and Safety	31 March 2025	Schedules being populated by the new Health and Safety Team. This action is on plan but for consistency this date has changed to 31 March 25 to align with quarterly and annual H&S Reporting to Audit Committee.
Security Risk Assessments to be conducted on all the Trusts owned, leased and PFI Estate.	Trust Security Manager	31 December 2024	All buildings will be risk assessed across both physical and infrastructure security by the Trusts Security Team – this is 98% complete and should be completed in November 2024 but additional month provided for any delays. The KPIs and outputs of these are being reported to Clinical Environment Group, Estates Steering Group and Finance and Performance Committee.
Updated 6 Facet Survey / Condition Survey to ascertain the condition and backlog requirement of the Trusts owned Estate.	Head of Operations (Estates & Facilities)	31 March 2025	Review of existing 6F (completed in Feb 2022) now complete. Updated version required to ensure the Directorate is reporting appropriate into ERIC and can also prioritise capital spend. Business Case will be taken to Estates Steering Group by January 2025.

Contributory risks at level 12 or above

Ref	Description	Lead / Responsible Director	Oversight Group	Score
1008	The Trust is unable to meet the NHS Carbon Neutral requirements by 2040 and to implement a sustainable culture within the organisation	Associate Director of Estates & Facilities / Chief Financial Officer	Estates Steering Group	12 (L3xC4)
1168	No onsite alarm system at CMHT bases to ensure safety for staff and service users during clinical visits. Bases affected:- Aire Court, St Marys Hospital (Holly House), St Marys House - South Wing and North wing and Millfield House	Associate Director of Estates & Facilities / Chief Financial Officer	Estates Steering Group / Clinical Environment Group	12 (L4xC3)

Strategic Risk 6

BAF Risk SR6 Risk 635	As a result of insecure, inadequate and poorly utilised digital technologies there is a risk the quality and continuity of services is compromised.		
Strategic Objective:	3. We deliver effective and sustainable services		
Accountable Director	Chief Financial Officer	**Initial Risk Score**	12 (L3xC4)
		Current Risk Score	12 (L3xC4)
Oversight Committee	Finance & Performance Committee	**Target Risk Score**	4 (L2xC2)
Risk Appetite	High / Open	**Target Date:**	26 December 2025

Controls in place

- Digital Strategy
- Cyber Security Policy
- IT Policy
- Data security and protection toolkit
- ICT infrastructure

Details of Assurance

Assurance Rating: **Partial**

Management / Service Level	Review Process / Oversight	Independent (external / internal audit)
- Chief Financial Officer governance framework / structure - Procurement processes incl. requisition approval - Junior Buyer / procurement team training - Category Codes (E Class) - Over £5k approval process - Digital Change Leads - ICT infrastructure - Phishing Exercise - Board level training	- Board of Directors minutes - Finance & Performance Committee minutes - Information Steering Group minutes - Procurement & ICT meeting minutes / action log - Information Governance Group - Cyber monitoring system - CareCerts process - Chief Financial Officer reports - Executive Risk Management Group	- Audit Yorkshire – internal audit programme & reports - NHS Digital - National Cyber Operations Centre portal (returns process) - Penetration Testing - Phishing Exercise

Gaps in assurance / controls:

- Culture, staff ability and aptitude
- Cyber attack awareness

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress
Work with staff through Digital Change Team to understand the barriers to using technology and provide the necessary help and support.	Chief Digital Information Officer	31 January 2025	This is a continual process through our journey to continually deliver effective and efficient digital solutions and forms part of a continual improvement cycle. Engagement through the digital change continues to better understand barriers and to look at solutioning responses. Major

			review of CareDirector forms completed and workflows are currently being reviewed. Engagement planned to understand barriers across nonclinical areas. EPR Programme will also support this action as we evolve and mature through the programme startup
Continued Engagement with Digital Leeds and ICB regarding support around digital literacy.	Chief Digital Information Officer	31 March 2025	Discussions taken place across the ICS and city footprint via CIO and digital leadership groups and meetings. Local Authority have received funding for a digital exclusion lead to support identification and planning for new initiatives to support the addressing of this area. Engaged in discussions regarding support and sharing of knowledge and understanding however direct influence over shared ideas is small and programme being owned/delivered by the local Authority
Deliver cyber communications plan with target on delivering messages and examples of phishing relating to key annual milestones, religious festivals, significant holidays, return to school etc.	Head of Cyber and Networks	26 November 2024	Schedule of themes determined. First comms completed and directed at broader awareness session to further support the most recent internal Phishing exercise. Comms agenda to be presented to November Digital Steering Group (formally IMSG) for final approval of intended themes and frequency
Clinical and Care Service Engagement and involvement throughout EPR scoping, specification and procurement cycle to support views on functional requirements to support future uptake and adoption of a new EPR	Chief Digital Information Officer	31 March 2025	Engagement underway in some areas and planned for all others. Programme board chaired by Medical Director, Clinical directors engaged for initial review of high level functional specification
Usability reviews and NHS APP integration a fixed requirement for patient portal procurement and deployment	Chief Digital Information Officer	31 March 2025	Patient portal review completed, business case developed and being presented in November Digital Steering Group. Recommended solution integrates with NHS to provide a standard user interface and familiar useability

Contributory risks at level 12 or above

Ref	Description	Lead / Responsible Director	Oversight Group	Score
105	The danger of a cyber-attack to the Trust's ICT infrastructure through malicious hacking or system virus infection.	Chief Information Officer / Chief Financial Officer	Information Steering Group	12 (L3xC4)
1223	Advanced will not continue to make the same levels of investment in the growth of CareDirector v6. Going forward Advanced have committed to continue to maintain and support CareDirector v6 for the duration of customers current contract term, but the roadmap will be adjusted to only focus on essential maintenance activities and key legislative/security work.	Chief Information Officer / Chief Financial Officer	Information Steering Group	16 (L4xC4)

Strategic Risk 7

BAF Risk SR7 Risk 1111	There is a risk we fail to understand, plan and deliver services that meet the health needs of the population we serve.		
Strategic Objective:	1. We deliver great care that is high quality and improves lives		
Accountable Director	Chief Operating Officer	**Initial Risk Score**	12 (L3xC4)
		Current Risk Score	12 (L3xC4)
Oversight Committee	Finance & Performance Committee	**Target Risk Score**	6 (L2xC3)
Risk Appetite	High / Open	**Target Date:**	31 July 2025

Controls in place

- Care service governance structure and framework in place to monitor and plan service delivery and development and report ward-to-board and board-to-ward
- Care Services Strategic Plan
- Annual operational planning and prioritisation process
- Trust's People Plan
- Quality Strategic Plan
- Working in partnership with the ICB in relation to marginalised communities
- Partnership with other NHS organisations and community groups across our service delivery areas
- Work to look at inequalities in relation Restrictive Practices and their reduction
- Community Mental Health Transformation Programme
- Utilisation of population health information in the planning and design of services
- EHIA tool
- Out of Area Placement programme to ensure people are appropriately placed according to their need
- Business Continuity Plans

Details of Assurance

Assurance Rating:	**Partial**

Management / Service Level	**Review Process / Oversight**	**Independent (external / internal audit)**
- Chief Operating Officer governance structure and reporting framework - Care Services Strategic Plan implementation programme - Annual planning, monitoring and delivery framework - Business planning process - Update on delivery of the Trust's people Plan - Update on delivery of the Quality Strategic Plan - Waiting times monitoring process - Protected characteristics monitoring - Workforce monitoring reports - Reduction in restrictive practice workstream	- Assurance reports, discussion and actions relating to governance groups including: o Board of Directors o Finance & Performance Committee o Mental Health Legislation Committee o Workforce Committee o Executive Risk Management Group o Care Services Development and Delivery Group o ICB MH Population Board - Chief Operating Officer reports - Annual Service Quality Reports - CSDDG Annual Report - Synergi Group	- Audit Yorkshire – internal audit programme & reports - Contract meetings and monitoring - Provider Collaborative Framework - Community Mental Health Transformation Partnership Board

- Monitoring of the ethnic mix of detained patients and those who access our services Capacity and flow programme	- WREN / DAWN Group	

Gaps in assurance / controls:	- Analytics information available - Systemised ways of working to understand population and measure performance - Health Inequalities Strategy - Business Continuity Management System

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress
Development of Health Inequalities Strategy and supporting work programme	Head of Health Equity	30 November 2024	The new draft Improving Health Equity Strategy, guiding principles and objectives have been shared with the LYPFT Board and Council of Governors for permission to proceed. - Engagement Plan agreed - Engagement has taken place through July – September with all stakeholders to check and challenge this first draft - Final Strategy due at Board 28 November 24.
Development of an Equality Impact Assessment Process	Head of Health Equity	31 December 2024	New guiding policy in development which will enable the Trust to proactively and positively consider how we can help improve health equity and actively work to tackle known inequalities. This is further enabling us to support and evidence the responsibility of LYPFT to reduce inequalities in access, experience and outcomes.
Review the performance reporting framework for service delivery across Care Services	Deputy Director of Operations	31 March 2025	Review of the current arrangements for reporting on performance data at a service line and directorate-wide level.
Consideration of the effectiveness of management of waiting lists across the trust and review of processes.	Deputy Director of Operations & Service Development	31 January 2025	A review of the progress of the 12 tasks within the service lines identified to improve access to services is being undertaken and will be presented to CSDDG in January 2025, with recommendations for action.
Development of a Business Continuity Management System	Head of EPRR	31 March 2025	To ensure the development of a fully formed Business Continuity Management System is in place and available to each service line which will allow assurance there are roust plans in place should an adverse or disruptive event occur.

Contributory risks at level 12 or above

Ref	Description	Lead / Responsible Director	Oversight Group	Score
92	The current level of demand for the gender service is greater than planned level of activity, resulting in a lengthy waiting list for assessment and treatment. In addition, due to the child and adolescent service closure, there are further increasing numbers of transfers from the child and adolescent services which is impacting upon waiting times to access the service for all. This	AHP Lead	Care Services Delivery and Development Group	12 (L4xC3)

	presents a potential risk to service user mental and physical health, due to the inability to access care in a timely way.			
1206	The health needs not being met for transfers from child and adolescent gender services due to increased number of transfers.	AHP Lead	Care Services Delivery and Development Group	12 (L4xC3)
1212	Delayed service user transfer from LTHT to LYPFT inpatients. This has resulted in service users requiring mental health admission remaining in medical beds in LTHT for significant periods of time. There is a potential risk to service users due to not receiving timely and skilled mental health interventions. Additionally, there is a risk to other patients in LTHT and to staff.	CTM	Capacity and Flow Group	12 (L3xC4)
1213	Increased risk of Leeds Service Users being inappropriate sent out of area for care and treatment because of reduced flow across our inpatient services.	Head of Operations	Capacity and Flow Group	16 (L4xC4)
1270	High and increasing waiting list for diagnostic assessment in the Gender identity Service. patients not fully informed of actual wait times, unable to exercise choice re assessment pathway patients not receiving assessment as waiting on our assessment wait list, with associated potential impact on wellbeing and risk.	Operational Manager	Care Service Delivery and Development Group	16 (L4xC4)
1271	Patient waiting times for ADHD medication initiation presents a risk to patients due to a delay in medication commencing	Operational Manager	Care Service Delivery and Development Group	16 (L4xC4)
1273	LADS - unmanageable demand for diagnostic autism assessment is a risk to patients due to lengthy waits for appropriate autism assessment and support	Operational Manager	Care Service Delivery and Development Group	12 (L4xC3)

3 Conclusion

The BAF demonstrates the key strategic risks for the organisation, and the controls and assurance have been updated to reflect the levels of assurance, with actions detailed on further work to be taken.

The document will be updated as per established governance and oversight processes, with links to the identified oversight committees.

4 Recommendation

The Board is asked to:

- Receive the BAF and to be assured of the appropriateness of updates, including risk scoring and mitigating actions.
- Acknowledge the amended format that has taken place aligned to the organisational priorities and objectives, and findings of the internal audit.

Clare Edwards
Associate Director for Corporate Governance & Board Secretary
18 November 2024

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

AGENDA ITEM

25

PAPER TITLE:	Board of Directors Meeting Dates and Work Schedule 2025
DATE OF MEETING:	28 November 2024
PRESENTED BY: (name and title)	Clare Edwards, Associate Director for Corporate Governance
PREPARED BY: (name and title)	Clare Edwards, Associate Director for Corporate Governance

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

THIS PAPER RELATES TO THE TRUST'S STRATEGIC RISK/S (please tick relevant box/s)		✓
SR1	Quality including safety assurance processes	✓
SR2	Delivery of the Quality Strategic Plan	
SR3	Culture and environment for the wellbeing of staff	
SR4	Financial sustainability	
SR5	Adequate working and care environments	
SR6	Digital technologies	
SR7	Plan and deliver services that meet the health needs of the population we serve.	

EXECUTIVE SUMMARY

Attached are the dates for the Board of Directors' meetings in 2025 and the proposed work schedule.

The Board is asked to note the contents of the work schedule for 2025, with the acknowledgement that there may be requirements for amendments throughout the year to reflect priorities and amended reporting timescales.

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

RECOMMENDATION

The Board of Directors are asked to note the detail of the future meetings and work plan.

Leeds and York Partnership
NHS Foundation Trust

MEETINGS OF THE BOARD OF DIRECTORS

2025		
DATE	**START TIME OF PUBLIC BOARD**	**VENUE FOR BOARD MEETING**
Thursday 30 January 2025	9.30am	Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR
Thursday 27 March 2025	9.30am	Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR
Thursday 15 May 2025 (ExtraO meeting – held as a contingency)	1.00pm – 2.00pm	Microsoft Teams
Thursday 29 May 2025	9.30am	Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR
Thursday 19 June 2025 (ExtraO meeting to sign off annual report and accounts / other compliance documents)	9.30am – 10.30am	Microsoft Teams
Thursday 31 July 2025	9.30am	Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR
Thursday 25 September 2025	9.30am	Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR
Thursday 27 November 2025	9.30am	Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR

BOARD STRATEGIC DEVELOPMENT DAYS (No public Board meeting)		
Thursday 27 February 2025	9.30am	Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR
Tuesday 11 March 2025	9:30am	Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR
Thursday 24 April 2025	9.30am	Think@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR
Tuesday 3 June 2025	9:30am	Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR
Thursday 26 June 2025	9.30am	Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR
Tuesday 7 October 2025	9:30am	Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR
Thursday 30 October 2025	9.30am	Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR
Thursday 18 December 2025	9.30am	TBC

Leeds and York Partnership NHS Foundation Trust

Work schedule for the Board of Directors

No.	Item for Agenda	Lead	30 Jan 2025	27 Mar 2025	29 May 2025	19 June 2025	31 July 2025	25 Sept 2025	27 Nov 2025
1. STANDING ITEMS									
1.1	Apologies	-	X	X	X	X	X	X	X
1.2	Directors' Declarations of Interests (paper) / Conflicts of interest (verbal)	CE	X	X	X	X	X	X	X
1.3	Minutes of the last meeting	MM	X	X	X		X	X	X
1.4	Matters arising	-	X	X	X		X	X	X
1.5	Cumulative Action Log	MM	X	X	X		X	X	X
1.6	Chief Executive's Report – public meeting	SM	X	X	X		X	X	X
1.7	Chief Executive's Report – private meeting (verbal)	SM	X	X	X		X	X	X
2. GOVERNANCE									
2.1 (S)	Board Assurance Framework	CE	Q3		Q4		Q1		Q2
2.2 (S)	Use of Trust Seal	CE	As required						
2.3 (S)	Annual declaration of interests (report for information) incl. NED independence	CE			X				
2.4 (S)	Fit and proper person annual declarations	CE/MM			X				
2.5 (S)	Self-certification against condition CoS7 of the provider licence	SM			X				
2.6	Notification of future meeting dates and approval of the work schedule	CE							X
2.7	Review the Board of Directors' Terms of Reference	CE						X	
3. EXECUTIVE DIRECTOR REPORTS									
3.1 (S)	Report from the Chief Financial Officer	DH	X	X	X		X	X	X
3.2 (S)	Report from the Chief Operating Officer	JFA	X	X	X		X	X	X
3.3	Report from the Medical Director	CHos		X			X		X
3.4	Report from the Director of Nursing and Professions	NS	X		X			X	
3.5	Report from the Director of People and OD	DS		X			X		X
4. COMMITTEE UPDATES									
4.1 (S)	Audit Committee Chairs Report	MW	X		X		X		X
4.2 (S)	Finance and Performance Committee Chairs Report	CHe	X	X	X		X	X	X

4.3 (S)	Mental Health Legislation Committee Chairs Report	**KK**		X	X			X	X
4.4 (S)	Quality Committee Chairs Report	**FH**	X	X	X		X	X	X
4.5 (S)	Workforce Committee Chairs Report	**ZBS**	X	X	X		X	X	X
5. PERSON CENTRED CARE									
5.1	Sharing stories	**RP**	X	X	X		X	X	X
5.2 (S)	Freedom to speak up Guardian Annual Report	**SR**			X				
5.3 (S)	Freedom to Speak up Guardian Report update report	**SR**							X
5.4 (S)	Guardian of Safe-working Hours Annual Report (to be presented by RA)	**RA**					X		
5.5 (S)	Guardian of Safe-working Hours Quarterly Report (to be presented by CHos)	**RA / CHos**		Q3			Q4	Q1	Q2
5.6 (S)	Integrated Patient Safety Report	**NS**		X			X		X
5.7 (S)	Safer staffing Report (annual report in Jan)	**NS**	X	X			X	X	
5.8 (S)	Learning from Deaths Report	**CH**			X				X
6. WORKFORCE									
6.1 (S)	Staff survey results (including Bank Staff)	**DS**		X					
6.2 (S)	Annual RO and Medical Revalidation report	**Wendy Neil**					X		
6.3 (S)	Equality Annual Report (including WRES and WDES and Gender Pay Gap final stats)	**DS**						X	
6.4 (S)	Equality Diversity & Inclusion – EDS Standards	**DS**		X					
6.5	Indicative Gender Pay statistics (private Board meeting)	**DS**		X					
6.6	Violence Prevention Reduction Self-Assessment Standard	**DS**					X		
7. PERFORMANCE MONITORING									
7.1 7.1.1 (S) 7.1.2 (S) 7.1.3 (S)	EPRR: - Annual Report - EPRR & BC Policy approval - Assurance sign off	**JFA**			X		X		X
7.2 (S)	Health and Safety Annual Report (after been to Audit committee)	**WD / DH**					X		
7.3 (S)	Approval of the Data Security & Protection Toolkit (self-certification)	**DH**					X		
7.4	Cyber security update report	**IH / DH**	X		X			X	
7.5	Operational priorities quarterly update report	**AB / DH**	Q3		Q4		Q1		Q2
8. PARTNERSHIP WORKING									
8.1	Chair's reports from WYMH Committee in Common	**MM**		X	X		X	X	X
8.2	Chair's reports from ICB	**SM**	As required						
9. EXTRAORDINARY BOARD MEETING (June)									
9.1 (S)	Annual Report from the Audit Committee	**MW**				X			
9.2 (S)	Annual Report from the Mental Health Act Committee	**KK**				X			

9.3 (S)	Annual Report from the Finance and Performance Committee	**CHe**				X			
9.4 (S)	Annual Report from the Quality Committee	**FH**				X			
9.5 (S)	Annual Report from the Workforce Committee	**ZBS**				X			
9.6 (S)	Annual Accounts	**DH / GE**				X			
9.7 (S)	Annual Report	**SM**				X			
9.8 (S)	Annual Governance Statement	**SM**				X			
9.9 (S)	Compliance with the Code of Governance	**SM**				X			
9.10 (S)	Letter of Representation	**DH / GE**				X			
9.11 (S)	Quality Account	**NS**				X			

NB – (S) denotes statutory reporting requirements