Public Meeting of the Board of Directors

will be held at 9.30am on Thursday 29 May 2025
Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR

Agenda

		LEAD	TIME
1	**Apologies for absence** (verbal)	MM	9.30am
2	**Sharing stories – Learning Disabilities Service** (verbal)		9.35am
3	**Declarations of interests and any declarations of conflicts of interest in any agenda item** (enclosure)	MM	-
4	**Minutes of the meeting held on 27 March 2025** (enclosure)	MM	-
5	**Matters arising** (verbal)	MM	-
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	**Report from the Chair of the Finance and Performance Committee for the meetings held on 22 April and 27 May 2025** (to follow)	CHe	10.25am
9	**Report from the Chief Financial Officer** (enclosure)	DH	10.30am
10	**2024 – 2025 Organisational Priorities Quarter 4 Progress Report & 2025 – 2026 New Organisational Priorities** (enclosure)	DH	10.40am
11	**Report of the Chief Operating Officer** (enclosure)	JFA	10.50am
	Break		11am
12	**EPRR**	JFA	11.10am

	12.1 EPRR & Business Continuity Policy (enclosure)		
Patient centred care			
13	**Report from the Chair of the Quality Committee for the meetings held on 10 April and 8 May 2025** (enclosure)	**FH**	**11.20am**
14	**Report from the Director of Nursing and Professions** (enclosure)	**NS**	**11.25am**
	14.1 Review of the Independent Investigation into the Care and Treatment provided to VC (enclosure)	**NS**	**-**
Workforce			
15	**Report from the Chair of the Workforce Committee for the meeting held on 30 April 2025** (enclosure)	**ZBS**	**11.35am**
	15.1 Workforce Committee Terms of Reference (enclosure)	**ZBS**	**-**
16	**Freedom to Speak Up Guardian Annual Report** (enclosure)	**SR**	**11.40am**
Governance			
17	**Report from the Chair of the Mental Health Legislation Committee for the meeting held on 15 May 2025** (enclosure)	**KK**	**11.55am**
18	**Report from the Chair of the Audit Committee for the meeting held on 8 April 2025** (enclosure)	**MW**	**12pm**
19	**Board Assurance Framework** (enclosure)	**SM**	**12.05pm**
20	**Fit and Proper Person Declaration** (enclosure)	**MM**	**12.10pm**
21	**Self-certification against condition CoS7 of the provider licence** (enclosure)	**SM**	**12.15pm**
22	**Use of Trust Seal** (verbal)	**MM**	**-**
23	**Any other business**	**MM**	**12.20pm**

The next meeting of the Board will be held on Thursday 31 July 2025 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	None.	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.	**Director** Lilac Tree Clinic Ltd.	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.	None.

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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.	None.	None.	None.	None.	Partner: **Director** Finnbo Ltd
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	**Director of Group Delivery & Deployment** Optum (UK) (Digital Health sector)	Partner: **Lead Cancer Nurse** Leeds Teaching Hospitals NHS Trust
Kaneez Khan Non-executive Director	**Director** Primrose Consultancy Yorkshire	None	None	None	None	None.	None	None
Katy Wilburn Non-executive Director	None.	None.	None.	None.	None.	None.	None.	None.

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
Martin Wright Non-executive Director	None.	None.	None.	**Trustee** Roger's Almshouses (Harrogate) .	None.	None.	None.	Partner: **Trustee** Roger's Almshouses (Harrogate)

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

Public Board of Directors

Thursday 27 March 2025 at 09:30am

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 of Corporate Governance / Trust Board Secretary
Mr K Betts	Corporate Governance Officer
Ms Rachel Pilling	Carer Co-ordinator, Patient & Carer Experience Team (for minute 25/001)
Ms Jackie Prescott	Member of Service User Network (for minute 25/024)
Mrs Barbara Robinson	Member of Service User Network (for minute 25/024)
Mrs Tracey Needham	Head of People Engagement (for minute 25/043)
Mrs Sarah Turner	People Engagement Lead (for minute 25/043)

Four members of the public attended the meeting.

Action

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

25/024 **Apologies for absence** (agenda item 1)

No apologies for absence were received. The meeting was quorate.

25/025 **Sharing stories – Supporting carers to care with confidence** (agenda item 2)

Mrs McRae welcomed Ms Jackie Prescott and Mrs Barbara Robinson, both members of the Service User Network, and Ms Rachel Pilling, Carer Co-ordinator. Ms Prescott and Mrs Robinson were presenting about how to support carers to care with confidence as some needs for them were not being met currently. Ms Prescott provided detail on her background, family history and the personal impact of having lived experience as a carer for 4 years. Mrs Robinson provided her background related to her son's suicide and her previous knowledge of mental health up to that point.

They provided two carer's stories from carers groups, and the stories provided experiences of looking after and supporting family members with mental illness, including verbal and physical abuse experienced. The recommendations were for more practical help to de-escalate situations, along with more detail around mental health diagnoses and conditions as carers were not always involved in discussions with healthcare professionals. They noted that it was important to remember that carers were involved throughout the lifetime of service users and often had no training to provide support to them and the wider family. They provided an overview of the research and guidance around supporting and training for carers, including NICE guidance, and how this would be of benefit.

It was acknowledged that the Trust had provided training previously to carers however more could be done such as help with challenging behaviour, education, and improving resource materials. Ms Prescott noted that face to face opportunities for carers would be of great benefit as they would have the ability to talk to clinicians and ask questions related to their carer role. The ability to access trusted courses for training such as Kings College was another opportunity that could be explored. It was noted that there were collaboration opportunities with students and universities, and the Recovery College had run a carer specific course that would be helpful to repeat. Ms Prescott noted that Mindwell was a helpful resource but there were gaps that would be good to address and grouping the information into cohorts would be more helpful. They also raised that de-escalation and breakaway training was provided to staff and it would be helpful if it could be made available to carers to form strategies to deal with situations.

They asked the Board for support with specific items, all of which could be delivered on a low budget, such as training and facilitation for the carers meeting, interaction between LYPFT and universities for trainee psychologists, and de-escalation, breakaway and coping strategies training. They noted that there was a carers group with a venue and meetings in place, with the opportunity for staff attendance at this to facilitate the support requested.

	Mrs Burns Shore thanked them for attending and noted that the clear set of asks were reasonable, and the solutions offered were inspiring. Miss Sanderson responded that she would be able to address some of the requests and would work with Louisa Weeks to progress these, including university links and attendance by professionals, and linking with the training team to discuss options. Mr Henry commented that the technology element for resource access could be simple to address, and Ms Prescott noted that Kings College and Mindwell resources were helpful but could be improved with further links available. Dr Hosker noted that the Royal College of Psychiatry had a library of information that would be helpful to access as it had diagnosis specific information. Dr Muno noted that there was a Carers Leeds meeting in a few weeks to discuss opportunities to support carers to she would take the points raised at this meeting there, and Mrs Hanwell would be able to link with Mindwell partners to consider options. It was agreed that a response on updates to the asks for support would be provided to the Board in six months' time, with Miss Sanderson taking the lead on the actions. Mrs McRae asked Ms Prescott and Mrs Robinson to inform the carers group that the points had been listened to, and the Board would act on requests with an update to be provided in due course. She thanked Ms Prescott, Mrs Robinson and Ms Pilling for attending the meeting.	**NS**
	The Board of Directors **thanked** Ms Prescott, Mrs Robinson and Ms Pilling for attending the meeting and sharing their story.	
25/026	**Declaration of interests for directors and any declared conflicts of interest in respect of the agenda items** (agenda item 3)	
	The Board of Directors **noted** that in relation to Mr Cleveland Henry, Non-Executive Director, EMIS had changed its name to Optum. This had been updated on the Board register of interests.	
25/027	**Minutes of the previous meeting held on 30 January 2025** (agenda item 4)	
	The minutes of the meeting held on 30 January 2025 were **received** and **agreed** as an accurate record.	

25/028	**Matters arising** (agenda item 5)
	The Board of Directors **noted** that there were no matters arising.
25/029	**Matters arising: Feedback from the Shadow Board of Directors** (agenda item 5.1) Mr Wright provided an update from the Shadow Board meeting programme which had now concluded and noted attendance at the Board meeting from three participants. He noted it was pleasing to have seen the progress of those who took part in the programme and feedback was positive regarding relationship building with colleagues. He acknowledged the time and effort required for being part of the programme and being invested in it. Mrs McRae thanked those who had attended.
	The Board of Directors **received** an update from the Shadow Board meeting that had taken place on 26 March 2025.
25/030	**Actions outstanding from the public meeting 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 all actions had been completed and updates provided on the action log, with action 19 remaining ongoing and within timeframe.
	The Board **received** the cumulative action log, **agreed** to close the actions that had been completed and **noted** the updates provided for ongoing actions.
25/031	**Report from the Chief Executive** (agenda item 7) Dr Munro presented the Chief Executive's report, taking the content as read, and acknowledging the current challenges nationally and the operational pressures. She noted that the focus on collective leadership and skills and resources within the organisation would continue to support the response to

challenging times, and there would be continued investment in staff professional development.

She noted that an update regarding national changes would be provided in the private Board meeting, however there were no further details behind the headlines already given regarding NHS England and ICB running costs, and it was anticipated detail would be issued over the coming weeks. She added that the Leeds position regarding models for care in health and social care would also be discussed in the private Board meeting.

Mrs McRae thanked Dr Munro for the report.

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

25/032 **Report from the Chair of the Finance and Performance Committee for the meeting held on 25 March 2025** (agenda item 8)

Mr Henry presented the Chair's report from the Finance and Performance Committee meeting on 25 March 2025 which was tabled at the meeting. He acknowledged the progress made to date and the detail provided in the report regarding Committee discussions including financial performance. He noted the focus on risks moving forward including the non-recurrent elements of the financial plan and unidentified CIP. He acknowledged the challenges and different approach needed, including a cultural shift, to live within the financial envelope.

He referred to the detail on workforce agency trajectories and that further work was required for 2025/26 with key efficiencies. He also noted the risk associated with historical budgets and the need to consider approaches and cultural change for 2025/26.

He informed the Board that detail would be covered in the Chief Financial Officer and Chief Operating Officer reports and highlighted the live equity data dashboard for Board, ADHD service position and care navigator risk, and performance data regarding the Crisis and Intensive Support Service (CRISS) service.

Mr Henry acknowledged the improvements in the PLACE data however there was still further work to do, and assurance was provided on progress made to date. Mrs McRae thanked Mr Henry for the report, noting that further points would be covered on the agenda.

	The Board of Directors **received** the Chair's report from the Finance and Performance Committee and **noted** the matters reported on.
25/033	**Report from the Chief Financial Officer** (agenda item 9) Mrs Hanwell presented her Chief Financial Officer's report noting the detailed discussion at Finance and Performance Committee regarding delivery of the financial plan for 2024/25, however there was a need to be realistic in the delivery and effort needed to do that. She noted that there were still recurrent issues to address regarding run rate and historic budgets, and the Executive Team were fully focused on that for 2025/26, however achieving balance and living within resources would be key. She added that the Star Chamber process identified under £3m savings against the £10.5m challenge. In relation to the system position, Mrs Hanwell informed the Board that West Yorkshire ICB had delivered the plan for 2024/25 with £50m non-recurrent support provided and £30m provided for recurrent elective support to achieve the balanced position. She noted that the ramifications for 2025/26 would be considered in the private Board meeting. Mrs McRae noted the regular reminders provided to Board regarding non-recurrent funding and the importance of these. Mr Wright noted the positive delivery of the 2024/25 plan, and queried whether, in relation to the West Yorkshire position, there had been formal changes in policy for some elements and whether technical processes had been used to deliver the plan. Mrs Hanwell responded that it was clear the ICB was assessing performance on run rate not on budget, and that there would be an impact on workforce growth and limitations, and a link to the run rate. Mrs McRae thanked Mrs Hanwell for the report.
	The Board **received** the Chief Financial Officer's report and **noted** the content.
25/034	**Estate Strategic Plan** (agenda item 10) Mrs Hanwell presented the Estate Strategic Plan acknowledging the presentation to Finance and Performance Committee. The outline draft had been presented previously to Board with the final version now submitted for formal approval. She noted that the plan was developed in line with the framework expected for these documents, and it described ambition, objectives and delivery processes but did not provide detail on the

implementation and capital investment plan as there were limitations to the finances available. The complexity of the arrangements in place were evident in the document and it provided a framework and approach to be endorsed. It detailed how to incrementally improve the estate, and a discussion would take place at a future Board Strategic Discussion session regarding the estate plan.

Dr Healey noted that the document acknowledged the complexity of the estate and set out the detail well. She added that it could benefit from further explicit detail regarding safety, equity, and health and safety, as whilst it mentioned ligature risks it did not mention other aspects of the environment linked to self-harm, or the role of the environment in infection control, and whilst a neurodiversity example was included more examples across equity could be given such as wheelchair users and prayer rooms. She noted that the staff wellbeing element could expand on the physical environment impact on the health and safety of staff in areas such as protection from violence and manual handling. Mrs Hanwell responded that a lot of engagement had taken place, and there had been discussions around listing some of the points raised and she understood that they could be made more explicit within the detail for the Trust ambitions and approach.

Mrs Forster Adams noted that it was important to acknowledge the engagement that had taken place and how that approach had helped to focus on future clinical models and operational elements to be delivered through the estate. Mrs Hanwell added that the plan to support clinical models would be focused on neighbourhood approaches and the One Public Estate would be important in delivering key elements of the plan, and she was optimistic about the interface with system and Place.

Miss Wilburn noted that previous reviews had acknowledged that aspiration was needed but within the realms of realistic delivery which was included within the final plan to ensure expectations were realised. Mr Wright acknowledged the complexity within the plan, however financial constraints would be the driver in making difficult decisions moving forward, and this may need to be included in the plan to ensure the audience were aware of the limitations and balance between aspirations and reality. Mrs Hanwell responded that detail regarding technical complexities of the regime of the NHS were not included within the plan but the communication element of socialising the plan would be important as the capital regime may change in the future.

Dr Munro added that there was a need to not raise expectation but also to be ready to mobilise with national capital investment for projects within the Trust outside of core programmes, such as Parkside Lodge.

The Board of Directors approved the Estate Strategic Plan 2025-2030, subject to the noted additions required, and thanked those involved in its

development.

The Board of Directors **received** and **approved** the Estate Strategic Plan subject to the noted amendments being made.

25/035 **Report of the Chief Operating Officer** (agenda item 11)

Mrs Forster Adams presented her report, noting the depth of the discussion at Finance and Performance Committee. She had previously informed the Board of a static performance position, however this month had seen a deterioration in some core services. She noted that there was work underway to understand the detail behind this for services and reminded the Board that the Trust had taken proactive decisions to move towards localised services and, consequentially, this had not allowed for resilience regarding staff unplanned absence in smaller teams which may be impacting on performance. There was a need to build resilience and ways of working to protect against this, but she was confident the position could be recovered. She noted that sickness absence was discussed in detail at the Workforce Committee and was within Trust tolerances for the position overall, and it was important to acknowledge the hard work of teams to work flexibly to respond to this.

She noted the increase in Out of Area Placements and that this would continue to be a priority for 2025/26, along with the Community Mental Health transformation programme.

She referred to the Patient Carer Race Equality Framework (PCREF) Action Plan noting that since the action plan was created there had been further exploration of governance arrangements therefore it would be overseen by the Mental Health Legislation Committee at the current time. Ms Khan queried the finances required for the delivery of PCREF and that there was a need to consider the resource requirements given the importance of the work. Mrs Forster Adams noted that this would be explored through the Mental Health Legislation Committee however there was some limited, dedicated resource across the Trust therefore this may need to be redirected to support the action plan as there was no additional resource or funding.

Mrs Burns Shore queried the impact of ‘stop the clock’ on service provision and service user experience. Mrs Forster Adams responded that when referrals were made for people in crisis, it was acknowledged that when contact was made some service users did not want support immediately. Whilst it was not possible to then ‘stop the clock’ currently, with future decision making it may be possible to note this within the patient record. Mr Henry added that the discussion at Finance and Performance Committee was how to ensure the focus was on the right place rather than being skewed by data.

Mrs McRae acknowledged it was reassuring to hear the debate had taken place.

Dr Healey highlighted the link to the staff survey discussion later in the agenda in relation to the Crisis and Intensive Support Service (CRISS) service as it provided interesting insight as to how to identify services in need of support in the future. Mrs Forster Adams responded that the A&E work was part of the wider patient flow programme.

Discussion took place regarding the large number of actions within the PCREF action plan, and it was noted that this would be reviewed by the Mental Health Legislation Committee as they were derived from the national expectation for the PCREF action plan, however there was a need to streamline and determine areas of focus.

It was confirmed that Workforce Committee would continue to review the triangulation of sickness absence, performance and action required to address issues.

Mrs McRae thanked Mrs Forster Adams for her report.

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

25/036 **Report from the Chair of the Quality Committee for the meetings held on 13 February and 13 March 2025** (agenda item 12)

Dr Healey presented the Chair's Reports from the Quality Committee meetings held on 13 February and 13 March 2025. She noted that she would link with other Committee Chairs regarding content and detail within the report to consider if more needed to be included.

She took the reports as read and noted the assurance provided on processes for QIAs for the efficiency and productivity programme, with further work to do on any negative impacts. She highlighted the systems in place for monitoring physical requirements of service users, and the annual quality report process which demonstrated an increasing maturity in self-assessment regarding the use of the STEEEP model including equity elements. She also noted the ongoing work regarding the Quality Account to make completion less onerous and easier to read and understand.

Mrs McRae thanked Dr Healey for the reports.

	The Board of Directors **received** the Chair's reports from the Quality Committee and **noted** the matters reported on.
25/037	**Report from the Medical Director** (agenda item 13) Dr Hosker presented the report from the Medical Director taking it as read. He highlighted the agency doctor detail within the report and the reduction in use over time was acknowledged and recruitment had supported this progress. He noted that work on the Direct Engagement Model continued. He noted that the Responsible Officer information was included in the report and provided an update to the Board noting that two referrals to the GMC had been investigated and closed, one was a long running case featured in previous reports, and one related to a colleague who had joined the Trust with GMC processes in place. In relation to the Pharmacy service, he updated that there were known issues due to vacancies and this had impacted on the delivery of key functions. The vacancy position had improved however the impact on the team of managing this was now being seen, therefore engagement work had been undertaken to understand this and consider support for improvements. Miss Wilburn noted the previous discussions at Finance and Performance Committee regarding the Direct Engagement Model, and it was agreed it would be discussed further in the private Board meeting. Mr Wright asked for assurance that there were no issues for service user care as part of the GMC investigations, and Dr Hosker confirmed that there were no current issues with current service users, however in one case the GMC review was ongoing, and once concluded the Trust would review the potential for any historic harm. He noted that another colleague was working under an amended framework whilst the investigation was ongoing to ensuring service user safety. Mrs McRae thanked Dr Hosker for the report.
	The Board of Directors **received** the Report of the Medical Director and **noted** the content.
25/038	**Report from the Chair of the Workforce Committee for the meeting held on 6 February 2025** (agenda item 14)

Mrs Burns Shore presented the Chair's report, highlighting the thorough discussion regarding mandatory training and maintaining the position, and aligning content to national requirements. She also noted the success of moving agency staff into the bank which had been a great achievement.

She noted that the Ethnicity Pay Gap discussion had taken place and provided assurance to the Committee that no further action was needed following the referred action from the last Board meeting.

In relation to a previous decision to not recognise carer experience as a protected characteristic following a Council of Governors meeting, she confirmed that this would be discussed in detail at the next Committee meeting before the final agreement being clearly communicated to the Council of Governors.

Mrs McRae thanked Mrs Burns Shore for the report.

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

25/039 **Guardian of Safe Working Hours Quarter 3 Report** (agenda item 15)

Dr Hosker presented the Guardian of Safe Working Hours Quarter 3 Report noting that it contained details of the parameters for working hour arrangements. He noted that the Guardian had power to levy a fine if safe practices were breached, and Mrs Hanwell confirmed discussion had taken place around this and the issue resolved.

Mrs McRae thanked Dr Hosker for the report.

The Board **received** the Chair of the Audit Committee report and **discussed** the content.

25/040 **Safer Staffing Report** (agenda item 16)

Miss Sanderson presented the Safer Staffing Report, taking it as read, and noted that there was a need to amend data on page 186 as it was incorrect.

She highlighted that the recruitment of third year nurses had been successful and they would join the organisation from September onwards as they qualified. She noted that there was little change for ward vacancies, however a good response for experienced staff nurses recently had led to a good recruitment result. The move of nursing associates to registered nurses was

positive and demonstrated the Trust approach to growing talent and succession planning.

She informed the Board that further work would be done to support greater understanding of enhanced observation needs on shifts and the use of bank staff. She also noted the use of psychological professions within some acute wards which had demonstrated the support for staff through supernumerary work. She highlighted that Red Kite View had been previously heavily reliant on temporary staff and a considerable number of those had now moved from bank staff into permanent roles.

She noted that there was an overall improving ability to fill shifts and there had been no shifts with no registered nurses.

Mr Wright noted the link with the discussion regarding run rate and the justification for staffing levels which was being worked on at the current time but queried if there was a timeline for the review to be concluded. Miss Sanderson responded that there were a number of workstreams underway and Quality Committee would have oversight of the work. It was agreed that an update would be brought back to the Board in six months' time. **NS**

Mrs McRae thanked Miss Sanderson for the report.

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

25/041 **Report from the Director of People and Organisational Development** (agenda item 17)

Mr Skinner presented the report noting the format was as previous reports. He highlighted that sickness and the use of bank were a continued focus, with an increase in sickness absence noted, however this included the Christmas period and winter illnesses which would impact on the data. He informed the Board that stress / anxiety, coughs / colds, and MSK remained the top areas of illness and confirmed that the significant work underway to understand this continued to be progressed.

Mr Henry queried the ongoing work regarding triangulation for sickness absence, appraisals and disciplinaries, and Mr Skinner responded that disciplinaries were decreasing and meetings with mangers were held on a regular basis for review and triangulation of data. He added that the cultural dashboard work was ongoing to align performance data and soft data, and the end product would support this work.

Mr Henry queried whether there would be a change in approach to utilise annual leave throughout the year to reduce staff leave being taken at year

end. Mr Skinner noted that there had not been discussion regarding a change in the policy, however the policy was clear that leave could be carried over by exception and the health roster could support the review of how leave was being used each quarter so the system should be used to manage this. It was noted that discussions were ongoing regarding the use of annual leave to support staff wellbeing.

Dr Healey commented on the differing ethnicity profile between substantive staff and bank staff and noted that there was a need to be mindful of this with the EDS paper on the agenda. Mr Skinner confirmed that this was being reviewed, and a deep dive was underway.

Ms Khan queried whether the stress / anxiety sickness absence was work or personal, and if there was any mitigation to address this. Mr Skinner responded that when absence was recorded it did not allow for differentiating between work or personal and only provided a broad reason. In areas where a deep dive had been done it was more likely to be home or personal rather than work related, however the system did not allow for this to be done easily. He added that the Trust had previously undertaken focused areas of work to address key reasons for staff sickness and utilised the West Yorkshire Wellbeing Hub.

Dr Munro added that there was a need to acknowledge the stressful nature of roles and the tools in place to support this, and it needed to be a two-way process for the Trust to provide to support and staff to personally manage it. She noted that Executive Performance Oversight Group (EPOG) discussions included sickness absence levels and identified the specific details for each case. In relation to annual leave she added that staff did not take leave due to the impact on the wider team, therefore there was a need to ensure that this was supported across services. Mrs Forster Adams noted that during COVID lockdown there had been allowances for staff to carry more leave over which had been addressed over recent times, and there was a need for continued messaging regarding the use of leave, and the exceptional circumstances for carry over had supported practice to change.

Mrs McRae thanked Mr Skinner for the report.

The Board **received** the Report from the Director of People and Organisational Development and **discussed** the content.

25/042 **Equality Delivery System report and action plan** (agenda item 17.1)

Mr Skinner acknowledged the report and action plan which was shared for information with the Board.

It was noted that any queries could be addressed outside of the Board meeting.

The Board **received** the Equality Delivery System report and action plan and **noted** the content.

25/043 **Staff Survey Results** (agenda item 18)

Mrs Tracey Needham, Head of People Engagement, and Mrs Sarah Turner, People Engagement Lead, attended the Board meeting to provide detail on the staff survey results. Mrs Burns Shore provided reassurance to the Board that it had also been discussed in detail at the Workforce Committee.

The results had been shared with Board members, therefore a presentation detailing key points for discussion and actions for next steps was given. The work undertaken to focus on response rates was acknowledged, and it was noted that the bank staff questionnaire would change for 2025 in order to be focused specifically on those roles.

It was noted that there had been a positive increase in results for 'We are safe and healthy' and all other elements had declined, however it was important to note that there was a very positive increase in last year's results and results had not reverted to the 2022 position. It was acknowledged that bank staff appeared to have a poorer experience in the results when compared to substantive staff, and the People Engagement Team were attending the bank forum the following week to discuss the results.

Mrs Needham provided detail on trend data which was weighted for substantive staff but not weighted for bank staff. She noted that bank staff data showed continually challenging results. Substantive staff results demonstrated unfavourable changes in areas such as reasonable adjustments to ensure staff could carry out work, strong personal attachment to their team, recognition and reward, and opportunities for development. Bank staff unfavourable changes included satisfaction with level of pay, positive action from work on health and wellbeing, and feeling worn out at the end of a shift, which was the largest unfavourable change in questions for all staff.

In the Workforce Equality Standards it was noted that there was an error in the report regarding indicators 5 and 6 which were incorrectly rated and amended papers would be circulated to Board members. A review of changes compared to last year's results noted discrimination from managers and colleagues was worse than the sector average. In relation to LGBTQ+, whilst there were no mandated standards, the results were reviewed and shared

with the ED&I Team and staff network for action in relation to ongoing workstreams.

The Board were informed that intention planning had increased last year and teams were accessing their service level data more than previously which would support the intention planning process. The use of Echo to provide data at team level had been improved to support access and indicated changes in an accessible way, with a managers guide developed and a toolkit of resources available to allow teams to develop plans and action. It was noted that intention planning remained encouraged not mandated. The NHS Impact Barometer continued to be an area of focus and work with the continuous improvement team for this continued. Mrs Needham noted that the People and Culture Dashboard was under development, as noted by Mr Skinner earlier in the meeting, which allowed for staff survey results to be linked to ongoing work. A deadline on intention planning was to be put in place this year in order to demonstrate improvements made in the results of the next staff survey.

Mr Henry commented that the response rate may be impacted by culture and intention plans not being mandated, and queried the removal of the optional element of intention planning. He noted concern regarding the reliance on bank staff to provide safe services but still having concerning results for this cohort of staff. Mrs McRae acknowledged that a number of bank staff were also substantive staff. It was agreed that the Workforce Committee would review the bank staff results in more detail.

Workforce Committee

Dr Munro noted that bank staff continued to work on substantive contracts and whilst not being dismissive of the concerns raised, it was not appropriate to have the view that staff were mistreated. There was a need to understand the detail behind the results rather than being driven by an emotional response to the results as the high level data did not allow for more detailed discussions. Mr Skinner added that the results showed a significant decline in learning and development, yet data for the online system demonstrated significant access by bank staff to courses. The civility and respect work was hoped to be a significant driver in changing experiences for bank staff, and there was a need to acknowledge the complexity of the data available and the detail behind it.

Discussion took place regarding the importance of belonging for bank staff, and an acknowledgement of the impact of bank staff not being fully part of a team and the impact on access to resources.

Miss Wilburn raised that some issues in the results could not be addressed locally therefore it may not be helpful to make intention planning mandatory. Dr Healey added that Workforce Committee could potentially consider more Trustwide approaches and that there may be potential learning to be taken

	from other organisations who had the highest scores in the staff survey to understand what more could be done to address the results. Mr Wright questioned the validity of results as there were few statistically relevant changes and those who did not respond may be more important to link with. He commented that it was important to demonstrate the difference made as a result of the survey results, whilst acknowledging the complexity of the organisation makes it challenging to enact change for all staff. Dr Munro noted that individual team level data could be dramatically different to higher level data and this led to more meaningful discussions and actions. Mr Skinner acknowledged the points raised and added that there had been significant improvements for teams as a result of intention planning that should be shared to support evidence it made a difference. Mrs McRae queried if there was discussion with local Trusts to understand what action they took and improvement made. She noted that there was a distinction between areas leaders needed to focus on and areas teams could work on themselves, and this challenge should be offered back to staff to note that they had the ability to make changes. It was acknowledged that there were many intelligence touchpoints with bank staff that should be viewed in the round and the relationship between substantive and bank staff was complex and needed to be understood. Therefore the staff survey did not provide an answer but should be viewed in alignment with other data. It was agreed that the Executive Management Team would consider whether intention planning should be mandated and how to address bank and substantive staff result differences through committee or board, or other ongoing workstreams. Mrs McRae thanked the team for attending and presenting the results.	**Executive Management Team**
	The Board **received** and **noted** the content of the Staff Survey update.	
25/044	**Report from the Chair of the Mental Health Legislation Committee for the meeting held on 11 February 2025** (agenda item 19) Ms Khan presented the Chair's report, taking it as read. Miss Sanderson noted that the Right Care Right Person approach was being progressed and a local working group was in place with external agencies in order to make the approach more robust. Miss Wilburn added that robust discussion had taken place regarding the purpose of the Committee. She highlighted that the Mental Health Operational Steering Group fed into the Committee however provided operational level detail which caused friction for the oversight processes and role of the Committee. Dr Hosker added that there had been a move to a AAA format of	

	reporting which would support this moving forward. Miss Sanderson acknowledged that there was more work to do to review the meetings that feed into the operational group and whether other governance routes would be more appropriate.
	The Board **received** and **noted** the content of the Report from the Chair of the Mental Health Legislation Committee.
25/045	**Report from the Chair of the Committees in Common held on 29 January 2025** (agenda item 20) Mrs McRae referred to the report, taking it as read by the Board, noting the discussion regarding the purpose of the Committee, and governance and sharing good practice mechanism of the Committee. She added that the role of provider collaboratives in national dialogue would mean it was a developing picture.
	The Board **received** and **noted** the report from the Chair of the Committees in Common.
25/046	**Annual Declarations Report** (agenda item 21) Mrs McRae presented the report, taking it as read by the Board.
	The Board **received** and **noted** the Annual Declarations report.
25/047	**Leeds Health and Care Partnership – Partner Risks** (agenda item 22) Dr Munro noted that the paper had been shared for information, and that it provided detail to demonstrate the overall ICB position and common risk themes.
	The Board **received** the Leeds Health and Care Partnership Partner Risks report for information.
25/048	**Use of Trust Seal** (agenda item 23) Mrs McRae informed the Board that the Trust seal had been used on the following occasions:

	- Log 134 – Parkside Lodge Scheme Agreement
	  o signed by Dawn Hanwell, Chief Financial Officer, and Clare Edwards, Associate Director of Corporate Governance (19th February 2025)
	- Log 135 – Roseville Lease Agreement
	  o Signed by Sara Munro, Chief Executive, and Dawn Hanwell, Chief Financial Officer (26th March 2025)
	- Log 136 – Merrion House Lease Agreement
	  o Signed by Sara Munro, Chief Executive, and Dawn Hanwell, Chief Financial Officer (26th March 2025)
	- Log 137 – Newsam Centre Deeds of Variation
	  o Signed by Merran McRae, Chair, and Clare Edwards, Associate Director of Corporate Governance (26th March 2025)

	The Board **noted** the use of the Trust Seal.
25/049	**Any other business** (agenda item 24)
	There were no additional items of other business.
25/050	**Resolution to move to a private meeting of the Board of Directors** At the conclusion of business, the Chair closed the public meeting of the Board of Directors at 12:55 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

AGENDA ITEM

6

Open Actions

Log number	Action (including the title of the paper that generated the action)	Person who will complete the action	Meeting to be brought back to / date to be completed by	Update report – comments
19	**Report from the Chief Financial Officer** (minute 25/010 - agenda item 10 – Jan 2025) Ms Burns-Shore queried whether NHS organisations could be expected to share services going forward. Mrs McRae noted that this would be discussed further at the April 2025 strategic board development day and asked Mrs Hanwell to provide information ahead of this session on what shared services the Trust had.	**Dawn Hanwell**	April 2025	**ONGOING**
24	**Sharing stories – Supporting carers to care with confidence** (minute 25/025 - agenda item 2 – March 2025) It was agreed that a response on updates to the asks for support would be provided to the Board in six	**Nichola Sanderson**	September 2025	**NEW**

Log number	Action (including the title of the paper that generated the action)	Person who will complete the action	Meeting to be brought back to / date to be completed by	Update report – comments
	months' time, with Miss Sanderson taking the lead on the action.			
25	**Report from the Chief Financial Officer** (minute 25/040 - agenda item 16 – March 2025) It was agreed that an update regarding the run rate and justification for staffing levels work would be brought back to the Board in six months time.	**Nichola Sanderson**	September 2025	**NEW**
26	**Staff Survey Results** (minute 25/043 - agenda item 18 – March 2025) It was agreed that the Workforce Committee would review the bank staff results in more detail.	**Workforce Committee**	Management action	**NEW** **COMPLETE** This has been included on the Workforce Committee forward plan for agenda items
27	**Staff Survey Results** (minute 25/043 - agenda item 18 – March 2025) It was agreed that the Executive Management Team would consider whether intention planning should be mandated and how to address bank and substantive staff result differences through committee or board, or other ongoing workstreams.	**Executive Management Team**	Management action	**NEW**

Closed Actions

Log number	Action (Including the title of the paper that generated the action)	Person who will complete the action	Meeting to be brought back to / date to be completed by	Update report - comments
23	**Report from the Chair of the Audit Committee for the meeting held on 21 January 2025** (minute 25/019 - agenda item 18 – Jan 2025) Dr Munro confirmed that the "Appraisals: Performance Delivery Reviews" audit report would be discussed by the Executive Risk Management Group, noting that any potential implications on policies would be reported to the Workforce Committee before the audit report was presented back to the Audit Committee.	**Sara Munro**	March 2025	**COMPLETE** This was discussed by the Executive Risk Management Group meeting on 12 March.
22	**Report from the Chief Executive** (minute 25/007 - agenda item 7 – Jan 2025) Mr Wright noted that a review on Place based partnership arrangements had been completed with clear recommendations due to be provided by the end of January 2025. Dr Munro clarified that the recommendations would be shared with the ICB Board by the end of January 2025 and noted that the Board would be updated on this in the future.	**Sara Munro**	March 2025	**COMPLETE** The outcome of the review was shared with board members on 04/03/2025.
21	**Report from the Chair of the Audit Committee for the meeting held on 21 January 2025**	**Dawn Hanwell**	TBC	**COMPLETE**

Log number	Action (Including the title of the paper that generated the action)	Person who will complete the action	Meeting to be brought back to / date to be completed by	Update report - comments
	(minute 25/019 - agenda item 18 – Jan 2025) Mr Wright queried whether the Health and Safety Committee should be expanded to include a clinical representative to provide better clarity on incidents in a clinical environment. Mrs Hanwell agreed to look into this.			Mrs Hanwell confirmed that the membership had been expanded to ensure clinical representation.
20	**Health Equity Strategy** (minute 25/015 - agenda item 15 – Jan 2025) It noted that an annual report on progress made against the strategy would be presented to the Board of Directors, with regular reports to committees. It was agreed that Mrs Forster Adams should identify which committee should have oversight of each action and ensure this was outlined in the first report to the Quality Committee, which would refer actions on to the relevant committee.	**Joanna Forster Adams / Quality Committee**	TBC	**COMPLETE** This had been added to the quality committee action log. It was noted that the Equity Strategy was reporting into the Quality Committee and checks would take place with Committee chairs to ensure workstreams were aligned.
18	**Report from the Chief Executive** (minute 25/007 - agenda item 7 – Jan 2025) Dr Munro confirmed that the planning guidance for 2025/26 which was due to be published on 30	**Sara Munro**	Management action	**COMPLETE** This was circulated on 14 February 2025

Log number	Action (Including the title of the paper that generated the action)	Person who will complete the action	Meeting to be brought back to / date to be completed by	Update report - comments
	January 2025. She agreed to circulate this once it had been published.			
17	**Matters arising: Feedback from the Shadow Board of Directors** (minute 25/006 - agenda item 5.1 – Jan 2025) Miss McMann agreed to circulate the dates of future shadow board meetings.	**Kerry McMann**	Management action	**COMPLETE** This was circulated on 14 February 2025
16	**Matters arising – questions from members of the public** (minute 25/005 - agenda item 5 – Jan 2025) The first question related to the Trust's response to the Southport stabbings, the processes in place for raising concerns about individuals with extreme and violent views and how effectively the Trust worked with other agencies such as social services, police and Prevent teams. Miss Sanderson agreed to provide a response to this question in writing.	**Nichola Sanderson**	Management action	**COMPLETE** The response in writing has been provided
15	**Sharing stories – Red Kite View Parent Peer Support Group** (minute 25/001 - agenda item 1 – Jan 2025)	**Joanna Forster Adams**	Management action	**COMPLETE** The presentation and content provided at Board of Directors in January 2025 was repeated in the WY CYPMH PC Board on 18

Log number	Action (Including the title of the paper that generated the action)	Person who will complete the action	Meeting to be brought back to / date to be completed by	Update report - comments
	Mrs Forster Adams acknowledged that the CYPMHS Provider Collaborative had a high focus on clinical outcomes post-discharge but agreed that further work was required to learn from and improve the post-discharge experience for parents, carers and families. She agreed to raise this at the next meeting of the Provider Collaborative Board.			February 2025 and appropriate actions will be taken forward.
7	**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	**COMPLETE** An update was presented at the public Board of Directors meeting in March 2025
12	**Report from the Director of People & Organisational Development** (minute 24/152 - agenda item 19 – Nov 2024) Mr Wright noted that the chart regarding starters and leavers by service area showed a discrepancy with the data. Mr Skinner noted that the data included junior doctors therefore the Trust was not recruiting as much as the data showed. It was agreed that there would be further integration of the data which would be shared with Mr Wright.	**Darren Skinner**	February 2025	**COMPLETE** Mr Skinner confirmed that this action had been completed

Log number	Action (Including the title of the paper that generated the action)	Person who will complete the action	Meeting to be brought back to / date to be completed by	Update report - comments
13	**Report from the Chair of the Mental Health Legislation Committee for the meeting held on 5 November 2024** (minute 24/156 - agenda item 22 – Nov 2024) Dr Munro discussed the feedback from the committee effectiveness questionnaire, and that there were statutory requirements for the Committee to review with differing views regarding what the Committee was reviewing. Therefore, it was agreed that colleagues would review the Terms of Reference for the Committee to ensure that it was aligned to statutory requirements.	**Chris Hosker / Kaneez Khan / Katy Wilburn / Clare Edwards**	March 2025	**COMPLETE** It was noted that a further meeting had taken place with Miss Wilburn and colleagues from the Health Equity team which confirmed this as complete.
Actions from Committees for the Board of Directors				
	None.			

Agenda item
7.0.0

Meeting of the Board of Directors

Paper title:	Chief Executives Report
Date of meeting:	29 May 2025
Presented by: (name and title)	Dr Sara Munro, CEO
Prepared by: (name and title)	Dr 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.

Recommendation

The Board is asked to note the content of the report.

Meeting of the Board of Directors

28 May 2025

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

Trust Priorities for 2025/26

The Executive team have now finalised our priorities for the year ahead. This has followed extensive review and consideration of the different requirements (national, local, Trust strategic plans), challenges and opportunities we face. A separate report is provided to the Board using the same successful format used for the 2024/25 priorities. The board will also receive a report on the 2024/25 priorities. Those small number of areas where we did not fully achieve what we set out to have carried forward into the year ahead where relevant and been updated accordingly. We are already underway with the relevant governance on project mobilisation for the different schemes for 2025/26, all of which have named executive oversight and progress will be monitored via the Extended EMT. These priorities are also being shared in the engagement events.

Executive Led Engagement events

The board is already aware that we had planned a widespread roll out of engagement sessions in which executive directors accompanied by members of the senior leadership team, communications and engagement team will co present at team and departmental meetings. This was one of our agreed actions in response to the well-led review. A core presentation has been developed which sets out the current national and local context; the refreshed Trust strategy; and then our priorities for 2025/26.

I am pleased to confirm these sessions are now underway and will take place through to the end of July.

They are a mix of virtual and face to face dependent on the meeting type in the service that we have been invited to. We are capturing frequently asked questions and feedback that we can then provide a wider response to towards the end of this engagement phase.

Teaching Trust Application Update

We are continuing to meet on a monthly basis with the University of Leeds to progress our application to be awarded Teaching Trust Status. This is still in the phase of developing and agreeing shared ambitions and objectives covering education, teaching and research. Learning from others who have already been going through this process it is likely to take up to 18-24 months to conclude and we are mindful of ensuring the work required is manageable within existing resources and capacity of colleagues involved.

Industrial Action

The British Medical Association have formally notified NHS Trusts of their intention to ballot members for industrial action. It applies to those who are classed as 'resident doctors' with ballot papers being issued on the 27 May. The dispute is in relation to a lack of an acceptable and timely for offer for 2025/26. We have been notified that there are 60 members in the Trust included in the ballot.

2. Leeds System Update

The Leeds Provider Partnership Review is now getting underway with a launch event for all partners and stakeholders being held on the 30th of May at St Georges Church Leeds. As a Trust we have 25 representatives attending the launch event.

We have commissioned The Value Circle following a procurement exercise to be our preferred partner for the review. We anticipate the work taking between 4-6 months to conclude with recommendations for boards and wider partners. The commissioning partners are LTHT, LYPFT, LCH, Leeds ICB and LCC. We will meet as accountable officers to oversee project milestones and report back to organisations and into the Leeds Partnership Leadership Team meeting, however the detailed delivery of the programme will be managed through an alliance ops group with all organisations having representatives engaged. For LYPFT these are Dawn Hanwell and Joanna Forster Adams. The review process will involve engagement with a much broader set of trust colleagues including the board and more detail will be shared once we

have officially launched the review, and our project partners are up and running.

The Board is also aware, but I am confirming now in the public meeting that from the 1st June I will take on the role of CEO for Leeds Community Healthcare NHS Trust following the departure of their current CEO Selina Douglas. LCH took the decision to defer decisions on recruiting permanently to the role until the Leeds Provider partnership review is concluded. Following extensive discussions, it was agreed by both boards, the ICB and NHSE that I would provide the interim support. This is for an initial 6-month period and a separate report will be provided to the remuneration committees to set out what the priorities and objectives will be and to provide assurance on fulfilling the role of accountable officer for both Trusts.

In other Leeds news, LTHT have completed their recruitment process to appoint a new chair. The process was not successful in 2024, so a second round of recruitment has been carried out and we are awaiting confirmation of the outcome of this.

Leeds City Council Big City Ambition – colleagues from the council will join the board in the private session to seek our views on the new strategy being developed by the council. The aim of the big city ambition is to have one overarching strategy for the city which has the ambition of improving outcomes of the citizens of Leeds by tackling the root causes of all inequalities – poverty. As a key partner we need to contribute to the content of the strategy and consider how it aligns with our own strategic directions and how we can make a meaningful contribution to the big city ambition. There is a direct relevance for us is given the known impact of poverty on the lives of people that contribute too/exacerbate mental health issues and overall outcomes.

3. REGIONAL AND NATIONAL UPDATES

National Announcements and West Yorkshire ICB

There continues to be a regular set of announcements at a national level relating to the future role of NHSE, DHSC and ICBs.

A new permanent secretary has been appointed to the DHSC (replacing Chris Wormald). Samantha Jones will take up the role in the coming months. She has an extensive background in health care both in the

NHS an independent sector, including in Europe and has held roles in government as an advisor to the prime minister Boris Johnson and more recently a NED at DHSC.

Following the decision to abolish NHSE and incorporate it into DHSC Richard Barker formerly the regional director for our region has been announced as the person who will oversee the transition and change programme. Timescales have already slipped, and we do not yet have clarity on the overall programme of work given it will require legislative change.

The NHSE transition team led by Jim Mackey are focusing on the operational priorities for the year ahead, reducing elective waits, winter preparedness and providing further instructions on the changes to ICBs and the role of regions.

The blueprint for ICBs has now been published along with clear expectations on the costs of the ICB staffing models being no more than £18.76 per head of population served. ICBs are to focus on strategic commissioning using population health for the ICB footprint and ensuring suitable contracting arrangements are in place. For West Yorkshire this will result in a 45% reduction in the current staffing costs for the ICB. Significant activity is underway to design a new model for the ICB and once more is known it will be shared with the board. The blueprint refers to a number of areas still being up for review and expectations that some will move from ICBs to providers or to region. This remains unclear in terms of implications for us, but the repeated message is this is aimed at eliminating duplication of functions that are already done by providers.

Oversight of NHS providers performance including operational/clinical/financial/quality will move to regional NHSE teams and we are expecting a blueprint to be published imminently.

The 10-year plans remain a closely guarded document, and we have been advised publication is now expected early July. The information that has been shared has remained consistent in the commitment to developing neighbourhood health and integrated models of care which is in line with the aims of the Leeds provider alliance review.

4. REASONS TO BE PROUD

Celebrations

- Richard Wylde achieved the Certified Professional in Patient Safety (CPPS) certification, marking a distinction in patient safety.
- CPPS certification demonstrates commitment, knowledge, skill, and passion for improving care, safety, and quality.
- The CPPS credential is earned through a thorough exam covering four patient safety domains, showing high proficiency in patient safety standards.

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Awards

- Nomination for our Health Informatics Service, Nasser Mohammed
- Apprentice of the Year, at the Skills for Health Awards
- Awards take place tomorrow, 22 May.
- Nasser has shown unwavering dedication and outstanding contributions to healthcare.
- He has demonstrated exceptional commitment and innovation throughout his Infrastructure Technician Apprenticeship.
- Good luck Nasser!

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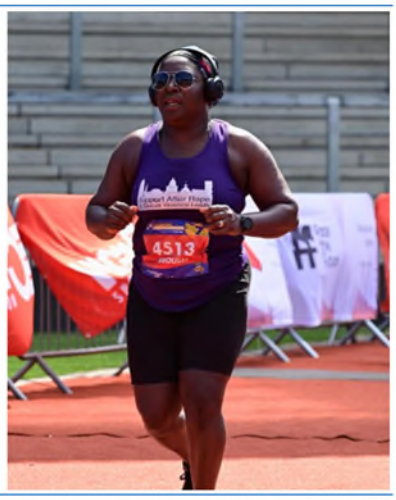
Congratulations

- A huge well done to Brouch Boggon, Mental Health Practitioner in our CREST Service for completing the Leeds Marathon on Sunday 11 May 2025.
- Brouch completed the marathon in 5 hours, 34 minutes and 3 seconds!
- "I am so ever grateful for everyone that have donated for SARSVL raised so far **£665**. Thank you so much for Jeanette Lawson cheering me up at 14miles and Chelsey Holford at 24miles I so needed that. I am grateful that I can give time to complete my dreams and help others and thank you so much for CREST team for cheering me on . It tough but incredible!"



Beat The Blues

- What an incredible start to this year's live music sessions at Becklin!
- Sunshine-filled afternoons of soul-soothing sounds, our service users had a fantastic time enjoying live performances that brought joy, connection, and creativity to the heart of our community.
- A huge thank you to David, Deryk, Katie, and Sean for sharing your music with us, and a special shoutout to one of our talented service users who also took the stage!
- We're so grateful to our amazing staff for supporting and escorting patients to these uplifting events. Your dedication makes moments like these possible.

Reward and Recognition

World Administration and Clerical Professionals Day

A huge congratulations to our winners:

- Asif Masood
- Charlotte Blunn
- Elaine Bickerdyke
- Jane Wright
- Karen Hutchinson
- Lauren Golding
- Sarah Stringer
- Laaiqa Ashfaq
- Laura Hardy
- Michelle Horrobin
- Ruth Bennett
- Sarah Emery
- Lorraine Griffin
- Kathryn Wood

Reward and Recognition

Team of the Month

Team of the Month – Ward 4, The Becklin Centre

March was an incredibly challenging month for Ward 4, beginning with a distressing and unprecedented incident that left a profound impact on staff. Despite the shock and disruption, the team responded with exceptional professionalism, resilience, and compassion, supporting each other and maintaining high standards of care under immense pressure.

Just as the ward began to recover, the sudden and tragic loss of a service user deeply affected everyone. Once again, the team came together, offering emotional support and strength to one another during an incredibly difficult time.

Throughout both events, the leadership shown by our managers, matrons, and senior staff has been outstanding. The commitment and empathy displayed by the ward manager, nurses, occupational therapists, and healthcare support workers have been truly inspiring. Ward 4 has shown what it means to be a united and compassionate team, facing adversity with strength, supporting one another, and continuing to provide dedicated care to those who need it most.

Reward and Recognition

Individual of the Month – Tom Marten, Recruitment Team Manager People and Organisational Development

Tom consistently demonstrates integrity, reliability, and a strong commitment to his colleagues and the Trust. Recently, he took the initiative to clear and set up an entire office at Linden House, ensuring a comfortable and efficient workspace, all while managing his regular duties.

He approaches every task with positivity, resolving issues efficiently without passing them on. His dedication, proactive attitude, and genuine care for his workplace make him a shining example of Trust values and a deserving candidate for Employee of the Month.

Leeds and York Partnership NHS Foundation Trust 42

R&D

This month we want to acknowledge the support of our colleagues in Pharmacy, with particular thanks to Michael Dixon. Research studies involving an Investigational Medicinal Product often require our pharmacy colleagues to adapt and innovate in their work. Michael has been instrumental in evaluating working practices and in upskilling the pharmacy workforce, supporting staff to complete their Good Clinical Practice training in readiness for commercial clinical trial delivery. Thank you!

Michael said: "Pharmacy works with the R&D department to support trials involving medicines within the Trust including storing and dispensing clinical trial medicines to patients, providing advice, as well as providing data to help identify people who are eligible for certain trials. It is important to take part in clinical trials to help to see if future treatments work and can benefit our service users. Research also helps maintain high standards within Pharmacy as we must adhere to the Good Clinical Practice regulations and training".

Actively shaping the future of Mental Health Care 44

Dr Sara Munro
Chief Executive Officer
20 May 2025

Agenda item
8

Meeting of the Board of Directors

Paper title:	Chair's Report from the Finance and Performance Committee meeting on 22 April 2025
Date of meeting:	29 May 2025
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:	22 April 2025
Chaired by:	Cleveland Henry, 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 an overview of the Trust's financial performance at month 12, noted the Trust's revenue and capital plans outturn position for 2024/25 and noted that the West Yorkshire system had delivered a balanced position at year end which meant there would not be any detrimental financial implications for 2025/26. The Committee noted the ongoing challenges linked to budget verses run rate and discussed different approaches to budgeting. The Committee heard about the ongoing work to improve data triangulation within inpatient services and highlighted the need for good quality benchmarking, both of which would help to inform strategic decision making. The Committee also discussed the requirement that providers reduce their corporate cost growth by 50% and heard about the work taking place to verify the information provided and identify where corporate growth had taken place within the organisation. The Committee noted that the Trust was required to produce a costed plan by the end of May 2025 which would be subject to audit.

The Committee reviewed the Workforce and Agency Group trajectories at month 12 which showed that the Trust ended the year behind target trajectory by £2m. The Committee received an update on the work to implement a "master vendor" approach for medical agency staff; discussed Bank expenditure in detail; and received clarity on the process for managing 12-month vacancies. The Committee noted that a thorough review of the trajectories would take place in Quarter 1 with revised trajectories being set to meet the new target for 2025/26. The Committee heard how the Trust was working to ensure that the future workstreams were achievable, did not negatively impact each other and achieved the speed of efficiency required.

The Committee received the update on the work undertaken to deliver the Digital Plan for 2023-2025 and noted progress across the key areas. The Committee discussed what scope there was for digital innovation, growth and development given the Trust's financial, capital and capacity constraints. The Committee agreed that thought needed to be given as to how digital change could positively impact on challenged areas in the organisation. The Committee also agreed on the importance of investing in the right technology, to be delivered at the right pace for the organisation whilst ensuring that teams and services were culturally ready to adopt the changes. It was agreed that a further discussion on these issues would take place, possibly at a future Board Strategic Session.

The Committee received an update on NHS England's Core Standards for Emergency Preparedness, Resilience and Response (EPRR) and supported the overall response to the challenges of the 2024 Core Standards assessment. The Committee noted the reduction in resource within the EPRR team from the end of March 2025 and the impact of this both from a business continuity and training perspective. The Committee noted that low compliance amongst strategic commanders was a risk and agreed on the importance of improving compliance in this area. The Committee also noted the uncertainty around how EPRR would be regulated following the abolition of NHS England.

ASSURE – items to provide assurance to the Board on
The Committee accepted the 2024/25 EPRR Annual Report, noting the breadth of work carried out during the year and the improvement in EPRR Core Standards compliance. The Committee recommended that the Board of Directors approve the report. The Committee received a report which outlined the progress made on the Premises Assurance Model (PAM). The Committee noted that it was a requirement for the PAM to be reported to the Board or one of its committees annually upon submission and agreed to receive an annual report in September / October each year. The Committee reviewed and approved its Annual Report for 2024/25 ahead of submission to the Board in June 2025, subject to a few small amendments.
REFER – items to be referred to other Committees:
The Committee suggested that the Quality Committee may find it useful to receive the PAM update report for information, noting that the PAM provides a risk-based assessment to ensure compliance with CQC Regulation 15.

Recommendation

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

Agenda item
9

Meeting of the Board of Directors

Paper title:	CFO Finance Report
Date of meeting:	29 May 2025
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

The Trust is on budget in month 1 but only due to one off non-recurrent means, this demonstrates the importance of an expedient delivering of the efficiency programme. A capital plan has been approved for the year using a risk based approach involving stakeholders across the Trust.

All provider Trusts have been set the target to reduce Corporate growth by 50%, with plans to do this required by the end of May. Work is underway to complete this work by the end of May with plans coming to board for approval in June.

NHS England has developed an updated Assessment Framework which will replace the current Oversight Framework, setting out how success and areas for improvement will be identified. NHSe will test Operational plan submissions against the metrics and share Trust segmentations over the coming weeks.

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

If yes, please set out what action has been taken to address this in your paper.

Recommendation

The Board is asked to:

- Note the Trust revenue position and capital plan for 2025/26.
- Note the work underway to complete the Corporate Cost reduction plan
- Note the new Performance Assessment Framework for 2025/26

MEETING OF THE BOARD OF DIRECTORS

29 MAY 2025

CHIEF FINANCIAL OFFICER REPORT

1 Introduction

This report provides an overview of the financial position at the end of month 1, 2025/26 financial year. The Finance and Performance committee have also considered a report on the wider issues linked to the financial context within which the Trust is currently operating, this can be discussed in the private board.

In relation to 2024/25 financial year, the Trust achieved it's financial target, a revenue surplus of £1.2m. The pre-audit draft position was considered at the April Finance and Performance committee and the full details will be shown at the board meeting in June.

2 Income and Expenditure Performance 2025/26

The overall summary reported position is shown in table below. This reflects a position broadly on plan overall at this very early stage in the year (deficit of only £38k).

		Month 1		
Income & Expenditure Budget Position	**Budget Annual £'000**	**Budget YTD £'000**	**Actual YTD £'000**	**Variance YTD £'000**
Income:				
Patient Care Income	240,548	20,046	19,863	(183)
Other Income	27,457	2,980	2,980	(0)
Total Income	**268,005**	**23,026**	**22,843**	**(183)**
Expenditure:				
Pay Expenditure	(204,440)	(17,035)	(16,528)	508
Non Pay Expenditure	(58,884)	(5,341)	(5,738)	(397)
Total Expenditure	**(263,324)**	**(22,377)**	**(22,266)**	**111**
Surplus/ (Deficit)	**4,681**	**649**	**577**	**(72)**
System adjustments	**(4,681)**	**(649)**	**(615)**	**34**
NHSE Adj. Surplus / (Deficit)	**0**	**(0)**	**(38)**	**(38)**

A detailed service analysis of variances are shown in appendix 1. The key items of note overall in month 1 position are: -

- Bank expenditure was higher than expected at £0.3m adverse variance. This was largely driven by an increase in enhancement costs due to bank holidays and increased evening and weekend usage of bank working.
- Agency expenditure showed a very marginal positive variance £0.1m. The majority (89%) of agency is related to medical staffing.
- Overall pay expenditure is £0.5m underspent, this comprises the use of bank £1.6m and agency £0.6m, offsetting the permanent vacancies of £2.7m
- Out of area placement (OAP) spend had increased at the end of last financial year. This has reduced but not down to plan trajectory resulting in a £300k overspend in month.
- The Specialist Supported Living contract is £0.1m overspent. More positive conversations with the council are on goings in relation to this contract which should de-risk it over the coming months.
- Overall corporate departments, doctors in training and pharmacy have broadly started the year along the same pattern as they exited the prior year, with significant vacancies and underspend.
- Slippage on reserves/one off flexibilities are supporting the position, this is in the region of £600k.

3 Efficiency Programme

3.1 Run Rate efficiency

The Trust efficiency programme for 2025/26 is to deliver in year run-rate savings of £18.5m. This is the target based on our system plan, which reflects run rate movements year on year (not recurrent internal budget).

Workstreams have been identified to deliver these run-rate reductions and Project Initiation Documents (PIDs) are being finalised for each workstream. It is important to note that the majority of workstreams are a continuation of work underway from the previous year. The workstreams will have oversight through the workforce and agency project board, the inpatient flow programme and the procurement steering group, with assurance though the Finance and Planning Group (FPG) to the Executive team, providing the enhanced rigour and oversight.

The table below is the M1 delivery of the run-rate reductions CIP target. The table shows the status of the schemed/workstreams and the assessed delivery risk. These metrics as well as the absolute values themselves are now an increasingly important component of the financial oversight. This is considered further in a separate report on system risk.

Workstream	Recurrent / Non-recurrent	Status	Delivery Risk	Target YTD (£000)	Delivered YTD (£000)	YTD Variance (£000)	Annual Target (£000)
Interest Receivable	Non-recurrent	Fully Developed	Low	313	447	134	3,750
Technical Flexibility	Non-recurrent	Fully Developed	Low	297	682	385	2,000
CPC Gainshare	Recurrent	Fully Developed	Low	42	42	(0)	500
Reducing Agency 30%	Recurrent	Plans in Progress	Medium	33	225	192	2,600
Reducing Bank 10%	Recurrent	Plans in Progress	Medium	20	(280)	(300)	1,550
OAPs Improvement	Recurrent	Plans in Progress	High	170	(100)	(270)	4,100
Non-Pay Savings	Recurrent	Plans in Progress	Medium	83	2	(81)	1,000
Unidentified	Recurrent	Plans in Progress	Medium	250	0	(250)	3,000
				1,208	**1,018**	**(190)**	**18,500**

At M1 the plans are overall £190k below target, largely due to the issue of bank expenditure and OAPs as noted. Work to identify the unidentified is underway, linked to the corporate benchmarking, digital processes and administration review and the wider budget efficiency review .

3.2 Budget efficiency

The Trust's recurrent internal budgets identified a recurrent £14.5m budget saving programme (recurrent CIP). This is based on allocated budgets not run rate profiles. This does not take account of the variance to budget (i.e. under and overspends) across areas. It is a target figure to balance budgets. assuming every service and department is operating from their opening base budget position, not what is being spent (run rate).

In May indicative targets were given to services and departments with the expectation that they begin to design structures/services that are recurrently affordable within the overall budget. Allocation. There will be a range of risks and implications in undertaking the approach, but it is necessary to ensure a sustained recurrent and clear financial position. An initial assessment is being undertaken over a 4-week period and the outputs of this will be reviewed at a high level in June. The degree of potential redesign required and pace at which this can be undertaken cannot be underestimated but this work runs alongside the efficiency workstreams noted above and it is anticipated that the of many of the existing workstreams will deliver both run rate and budget improvements. Where discrete new workstreams are generated, these will also result in further risk assessments (quality and equity) as per our standard process and assured through the quality committee.

4 Trust Capital Plan 2025/26

The capital planning process for 2025/26 has increased in complexity with the system operational capital allocation now including additional specific purpose allocations linked to delivery of constitutional standards and critical backlog maintenance. These additional allocations are essentially Public Dividend Capital (PDC) as cash will be provided to organisations in receipt of these, whereas the bulk of the operational capital remains non-cash backed. The specific purpose allocations have been allocated to systems to determine prioritisation as well as the core operational capital allocation for 2025/26. The Trust draft capital plan for 2025/26 is shown in Appendix A. The Trust did not receive any of the specific

allocations based on the criteria applied and the specific nature of those allocations.

The capital programme for 2025/26 has been developed in consultation with several key stakeholders. Over the 2024/25 financial year we have continued to risk assess all service requests and a risk assessment of each request has been completed from both an estates and clinical perspective, adopting the Premise Assurance Model (PAM) model for estates and Safe Timely Effective Efficient Equitable Patient-centred (STEEP) model for clinical.

In addition, affordability, capacity to deliver and work already in progress was considered as part of the risk assessment process and informed our indicative capital plan for 2025/26. The indicative plan also considers the minimum backlog requirements to enable the Trust to operate business as usual.

It is extremely challenging to balance how we determine which schemes should be progressed. The dichotomy of ensuring our buildings are kept maintained and statutory compliant, whilst ensuring patient safety and clinical effectiveness/outcomes are not compromised. We have adopted this risk-based approach to help prioritise and refine our list that has been approved at FPG.

4.1 ICS core capital allocation

The historical ICS core capital cover (non-cash) allocation for West Yorkshire also now include allocations previously held centrally for IFRS16 leases. One of the issues with IFRS16 leases is that they vary significantly from year to year, and this now needs to be managed within the core capital cover allocations at system level.

Notwithstanding the complexities, a process of prioritisation at ICS level has been completed and the allocations at Trust level have, following some difficult discussion with system partners, now been agreed. In addition, the Trust will hold a small contingency for the ICS (£2m), which will be reallocated throughout the year. The Trusts core capital allocation is:

- Core allocation - £3.8m
- Perinatal scheme - £5m (rephased from 2024/25)
- System contingency - £2m

4.2 Public dividend Capital (PDC)

The Trust will receive PDC for the Parkside Lodge scheme in 2025/26 following agreement with NHSE/DHSC to rephase some of this funding. The Trusts plan also assumes PDC to support the new Electronic Patient Record system in 2025/26 but this is subject to the next spending review. PDC funding assumptions in plan are:

- Parkside Lodge - £5.6m

- Electronic Patient Record - £2.5m

While there is now agreement for 2025/26, it is undoubted that this process will become more difficult over the coming years in the current financial climate. It is anticipated that aligned to the 10 year plan and following the spring budget a multiyear capital allocation will be announced, which should help may make planning and prioritisation easier. There is also some indication in the planning guidance that systems and Trusts may get more capital flexibility if they deliver balanced revenue plans, but no detail has been provided at this stage.

5 Corporate Benchmarking Cost Reduction

In April NHSE wrote to all provider Trusts detailing that since 2018/19, corporate costs in NHS providers have risen by 40% (£1.85 billion). NHSE requested that all NHS providers reduce their corporate cost growth by 50% by quarter 3 of this financial year. The corporate cost growth has been established using the corporate services annual data collection for 2018/19 (adjusted for inflation, etc) and 23/24 to establish the real growth in corporate costs and a proxy target reduction. The Trust proxy target was to reduce corporate costs by £2.3m with the savings made to support the delivery of financial plans.

The Trust is now in receipt of a ‘Comply or Explain’ template and is working to complete this for the required deadline of 31 May. All plans need to be approved by boards, with boards being fully assured of the benefits of these investments and reconsider the delivery costs within corporate services and opportunities to reinvest this in direct patient care. Board approval can be retrospective. Due to the expediency required in the submission of plans, it is expected that the plan comes for board approval in June.

6 The NHS Performance Assessment Framework for 2025/26

In May NHSE issued a short consultation on the proposed new Performance Assessment Framework for 25/26 which will replace the current Oversight Framework. The approach is based on assessing individual organisational performance against a balanced scorecard of metrics across 4 domains, which are aligned to the national operational priorities. Every ICB and provider will be allocated an “organisational delivery score” across the range of metrics which will combine to provide the overall segment allocated. This indicates its level of delivery from segment 1 (high performing) to segment 4 (poorly performing) with an additional segment 5 to indicate the most intensive support requirement. The segment indicates the degree of support and improvement that is required, and guides where formal intervention may be required

The intention and ambition is that high performing organisations in segment 1 will receive greater autonomy, such as those referenced in the capital planning guidance. However, it is still very unclear how this may all operate. Organisations in segments 3 and 4 will be considered for further support and interventions which may include enforcement activity. Organisations with a segment of 4 will receive a

diagnostic review, and this will determine whether they will enter segment 5 and receive support under the Recovery Support Programme for the most challenged organisations.

NHSE plan to publish the data used to calculate segments in an interactive web-based public accountability tool which will be made available from July 2025. The Trust segment will be shared once NHSE have shared this information. This is clearly an important part of the revised operating model and full detail on this will be shared in due course.

7 Conclusion

The Trust is on budget in month 1 but only due to one off non-recurrent means, this demonstrates the importance of an expedient delivering of the efficiency programme. A capital plan has been approved for the year using a risk based approach involving stakeholders across the Trust.

All provider Trusts have been set the target to reduce Corporate growth by 50%, with plans to do this required by the end of May. Work is underway to complete this work by the end of May with plans coming to board for approval in June.

NHS England has developed an updated Assessment Framework which will replace the current Oversight Framework, setting out how success and areas for improvement will be identified. NHSe will test Operational plan submissions against the metrics and share Trust segmentations over the coming weeks.

8 Recommendation

The Board is asked to:

- Note the Trust revenue position and capital plan for 2025/26.
- Note the work underway to complete the Corporate Cost reduction plan
- Note the new Performance Assessment Framework for 2025/26

Jonathan Saxton
Deputy Director of Finance
23 May 2025

Appendix A – Capital Plan

	Capital plan 2025-26
REPLACEMENT PROGRAMME	**£'000**
Estates	
Health & Safety /Fire/Accessibility/ Backlog	£600
IT	
IT Network Infrastructure	£360
Server/Storage	£30
PC replacement EUL	£360
Cyber security/end point/asset mgt	£170
Total Replacement Programme	**£1,520**
STRATEGIC PROGRAMME	
Estates	
Lifecycle contribution	£300
St Marys House, North Wing Roof	£400
St Marys House, South Wing Roof	£236
St Marys House, North Wing Therapy room	£50
St Mary's Hospital Windows/Doors (sustainability)	£185
St Marys House, North Wing Windows/door (Sustainability)	£220
EV chargers (sustainability)	£60
Completion of Minor Schemes	£105
Water main upgrade (lead) SMH/SMHosp	£150
The Mount Perinatal	£5,000
Accoustics - improvement	£100
Newsam sensory room	£30
PFI anti-ligature radiator covers	£130
Mansafe system - RKV	£25
Woodland square	£30
Clifton House works	£87
Total Strategic Developments	**£7,108**
Data Centre and adjustments (ICB)	£2,036
Total ICS Programme	**£10,664**
PDC Funded Schemes	
EPR developments (tbc)	£2,500
Complex Rehab	£5,600
Total PDC Funded Schemes	**£8,100**
New Leases	
Leased Buildings	£0
Leased Cars	£150
Total New Leases	**£150**
Grand Total	**£18,914**

Agenda item
10

Meeting of the Board of Directors

Paper title:	2024 – 2025 Organisational Priorities Quarter 4 Progress Report & 2025 – 2026 New Organisational Priorities
Date of meeting:	29 May 2025
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

2024 – 2025 quarter 4 organisational priority progress

This report provides a summary of the Trust's progress against our 2024 – 2025 organisational priorities. This is the fourth and final report of 2024 – 2025 setting out our performance with the 14 priorities each with an identified lead executive. Our report demonstrates the progress made on each priority and identifies 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 106 high-level milestones for delivery. At the end of quarter four we have:

- 8 milestones are marked as 'alert'
- 15 milestones are marked as 'advise'
- 83 milestones are marked as 'assure'
- 5 priorities are fully delivered, as per the tasks set out:
    - Implementation of PSIRF across the organisation
    - Strengthen and firmly embed the co-production approach within Care Services
    - Complete a refresh of our Strategic Estates Plan
    - Develop a Health Inequalities Strategic Plan
    - Deliver and evaluate the process of a Transformed Community Mental Health Service

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 reported through to the monthly Extended Executive Management Team meetings.

2025 – 2026 organisational priorities

Through an executive-led process we have agreed a succinct set of 14 organisational priorities. Our suite of 14 organisational priorities have been framed around the NHS England mandated priorities for 2025/26 and aligned with one of our five core strategic plans. Our priorities are seen as the important deliverables for the Trust in 2025/26, providing clarity and focus. To help socialise our priorities we have chosen to set them out as follows:

- Our three organisational goals:
    - How we are operating efficiently
    - How we are improving the quality of our care services
    - How we are running our organisation effectively
- 14 organisational priorities (which sit under a priority goal)
- Underpinning internal priority workstreams (which sit under an organisational priority)
- Underpinning mandated priority workstreams (which sit under an organisational priority)

Our 2025 – 2026 organisational priorities are detailed at appendix **one**. The next steps will include developing a suite of Project Initiation Documents for our largest priority schemes. This is to specify our aims/objectives and set out both the internal and externally mandated key measurable deliverables. We are also developing high level milestones that we will track our progress against and report through to the Board of Directors on a quarterly basis.

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

If yes, please set out what action has been taken to address this in your paper.

Recommendation

The Board of Directors is asked to:

- Consider our position against our 2024/25 organisational priorities at the end of quarter 4.
- 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.
- Note the 2025/26 organisational priorities.

APPENDIX 1 – 2025 – 2026 Organisational Priorities

Organisational priority goal 1: how we are operating efficiently

No	Organisational priority goals	Organisational priorities	LYPFT priority workstreams	Mandated priority workstreams	Exec lead
1	How we are operating efficiently	Delivery of our financial efficiency programme	Progress against our top 10 efficiency schemes (pay/non-pay)	> Planned surplus/deficit > Variance year-to-date to financial plan > Level of confidence in delivery of financial plan > Comparative difference in costs - productivity metric	Dawn Hanwell
2	How we are operating efficiently	Delivery of our workforce efficiency programme	> Achieving an optimal skill mix through right sizing and agreeing the right establishments across all our inpatient wards > Reduce sickness absence by 1% > Digitalisation and process review of administration	> Reduce bank expenditure by 10% > Redesign our corporate workforce using information from Corporate Benchmarking and explore areas of growth since 2022. Consider approaches to integrating teams, repurposing skills and focus. The review to include clinical, managerial and professional leadership structures. (NB. target to reduce corporate cost growth by 50% during Quarter 3.) > Reduce overtime > Reduce agency expenditure by 30% > Ensure 100% of all doctors have an approved job plan	Darren Skinner [workstream leads cross-cut all Exec Team]

Organisational priority goal 2: how we are improving the quality of our care services

No	Organisational priority goals	Organisational priorities	LYPFT priority workstreams	Mandated priority workstreams	Exec lead
3	How we are improving the quality of our care services	Delivery of our Inpatient Quality Transformation /Improving Patient Flow Programme	> Complete a full review of our adult acute clinical model with a focus on our community and crisis service pathways to enable timely discharge, follow up in 72 hours and ensuring the right discharge supports are in place. > To reduce length of stay we will work with system partners and complete a thematic review of supportive accommodation in place across the city, all individuals living from the accommodation and if/when they can be moved on. The focus being to enable adult service users with a long length of stay (over 60/90 days) to be discharged. > Develop a remodelled workforce plan specifically aiming to right size teams and reduce spend > Improve access to inpatient care and treatment > Reducing restrictive practice through least coercive care	> Percentage of adult inpatients discharged with a length of stay exceeding 60 days > Number of adults over the age of 65 with a length of stay beyond 90 days at discharge > Percentage of patients referred to crisis care teams to receive face to face contact within 24 hours > Rate of restrictive intervention use > Out of area placement trajectory compliance	Joanna Forster Adams & Nichola Sanderson
4	How we are improving the quality of our care services	Reducing mental health ED attendances and delays	> Enhancing internal communications and oversight of ED activity systems and processes. > ED action cards issued in 2024 of actions providers need to undertake. Complete a baseline audit of our activity against each of the actions and understand where we have gaps/duplication to inform the areas we need to take forward. > Joint work between ALPs and LTHT A&E on a training opportunity to make an improvement. One area identified is around patient experience which will be scoped out. > Identify all the mental health service users that are attending ED, who are already known to LYPFT and those that are unknown - quantification of volumes and explore the appropriate model.	> Reducing 12hr waits in ED	Joanna Forster Adams & Chris Hosker
5	How we are improving the quality of our care services	Delivering a Transformed Community Mental Health Service	> Optimising LYPFT community services with integrated models of care and treatment (fewer teams – improved clinical pathways) > Community driven reductions in crisis and inpatient admission demand > Community driven expedited discharges > Agreeing and improving the Primary Care service in Leeds > Implentation of the Complex Psychosis Pathway	> Change in the number of people accessing community mental health services with serious mental illness > Percentage of patients referred to crisis care teams to receive face to face contact within 24 hours	Joanna Forster Adams & Chris Hosker
6	How we are improving the quality of our care services	CYPMH Transformation Programme (inc redesign of Tier 3.5/4 models of care)	> Working with place based providers of CYP community services to review the outreach pathway with the goal of preventing admission	> Annual change in the number of children and young people accessing NHS funded mental health services (community providers)	Joanna Forster Adams
7	How we are improving the quality of our care services	Delivering an expanded perinatal inpatient service and provider collaborative			Chris Hosker
8	How we are improving the quality of our care services	Implementation of ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) to replace the DNARCPR (Do Not Attempt Cardiopulmonary Resuscitation) document across the organisation			Chris Hosker

Organisational priority goal 3: how we are running our organisation effectively

No	Organisational priority goals	Organisational priorities	LYPFT priority workstreams	Mandated priority workstreams	Exec lead
9	How we are running our organisation effectively	Delivering Improving Health Equity strategic priorities	> Priorities detailed as part of the Health Equity Strategic Plan		Joanna Forster Adams
10	How we are running our organisation effectively	Create clinical outcome reporting systems enabling the implementation of outcome measures across all our care services			Chris Hosker
11	How we are running our organisation effectively	Development and implementation of Quality and Culture dashboards for revision in selective services			Chris Hosker & Darren Skinner
12	How we are running our organisation effectively	Develop and agree our future FM model across our PFI sites			Dawn Hanwell
13	How we are running our organisation effectively	Conclude the EPR procurement process and develop/ratify the business case for the preferred EPR. In parallel explore and develop options for adding to the existing EPR platform.			Dawn Hanwell
14	How we are running our organisation effectively	Delivery of key People Plan priority metrics	> Priorities detailed as part of the People Plan		Darren Skinner

Leeds and York Partnership
NHS Foundation Trust

2024 – 2025 Organisational Priorities Report

Quarter 4 Progress Report

Overview and key messages

This is the fourth and final progress report for 2024 – 2025 and provides a summary of the Trust's progress against our 14 organisational priorities.

The reporting format demonstrates at a high level how we are progressing against the key milestones for each priority. Using 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 2024 – 2025 of our 14 priorities 5 are fully complete. The remainder will transfer into 2025/26.

The following priorities are reporting as red (alert):

- **Efficiency and Productivity Programme:** this is our performance against our budget savings target.
- **Workforce efficiencies:** this is our performance against the targets we set ourselves for reducing bank expenditure and medical agency spend.
- **Procuring a patient portal system:** although significant progress has been made to procure a patient portal system, we have not managed to deploy the new patient portal application as intended.

The following priorities are reporting as amber (advise):

- **Efficiency and Productivity Programme:** this is our performance against our run-rate savings target.
- **Workforce efficiencies:** this is our performance against the targets we set ourselves for reducing overtime spend.
- **People Plan metrics:** this is our performance against sickness absence, compliance with safeguarding supervision, proportion of BAME staff entering a disciplinary process and staff turnover .
- **Improving Flow Programme:** although significant progress has been made, we have not concluded all the workstreams as planned.
- **Performance and quality dashboards:** although extensive progress has been made, we have not fully concluded the work to initiate new dashboards.
- **Scoping a new EPR:** this is due to revising the timescales for producing the OBC following the outcome of the Spending Review and the need to understand future national funding criteria.

2024 – 2025 organisational priorities quarter 4 progress summary

Priority Area	Link	Lead	Exc Owner	Scheme status	Alert	Advise	Assure
Delivery of our Efficiency and Productivity Programme (total efficiency programme)	LINK	Jonathan Saxton	Dawn Hanwell	Live	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	Live	3	1	6
Delivery of our Inpatient Flow Programme	LINK	Laura McDonagh	Joanna Forster Adams	Live		3	3
Deliver, evaluate progress and realise the benefits of the Transformed Community Mental Health Service	LINK	Alison Kenyon	Joanna Forster Adams	Complete			5
Develop a Care Services-led (LYPFT) improving health inequalities strategic plan	LINK	Sophie Valinakis	Joanna Forster Adams	Complete			5
Strengthen and firmly embed the co-production approach within Care Services.	LINK	Alison Kenyon	Joanna Forster Adams	Complete			6
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	Complete			9
Commence scoping the requirements for a new Electronic Patient Record and associated systems/platform strategy	LINK	Ian Hogan	Dawn Hanwell	Live		1	7
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	Live		1	4
Delivery of key People Plan priority metrics	LINK	Andrew McNichol	Darren Skinner	Live		6	13
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	Live		1	
Implementation of PSIRF across the organisation	LINK	Janet Smith	Nichola Sanderson	Complete			9
Procure a system (patient portal) that will enable clinical outcomes to be embedded into clinical services	LINK	Ian Hogan	Chris Hosker	Live	4	1	8
Development and implementation of Quality and Culture dashboards for revision in selective services	LINK	Richard Wylde	Chris Hosker	Live			7

Delivery of our Efficiency & Productivity Programme

Our performance at the end of quarter 4

Savings Type	Annual Target	YTD Target	YTD Actual	Status
Budget	£10,800,000	£10,800,000	£4,352,430	
Run Rate	£16,950,000	£16,950,000	£13,246,047	
Cost Avoidance	£0	£299,245	£1,855,778	

% YTD Run Rate Reductions Achieved

% YTD Budget Saving Achieved

Alert, Advise, Assure

Alert:

We are forecast to be behind plan at the end of the year against the budget elements of our Efficiency and Productivity Programme. Although our efficiency targets were devolved to service/directorates, we have not managed to meet the targets issued. Those efficiencies that we have identified are still in the 'scoping' phase or will not be delivered in 2024/25.

Advise:

At the end of quarter 4 we are forecasting to be behind our run-rate plan by £3.8m. We have however made good progress against the target.

Assure:

For our cost avoidance schemes we are ahead of plan.

Delivery of our pay efficiency schemes

Our performance at the end of quarter 4

Savings Type	Type	YTD Target	YTD Actual	Status
Reducing Bank Expenditure	Run-Rate	£1,753,349	£0	●
Vacancy Management Panel	Cost Avoidance & Run-Rate	£174,245	£415,119	✔
International Recruitment	Run-Rate	£11,075	£0	●
Corporate Pause (3M)	Run-Rate	£122,831	£245,658	✔
corporate benchmarking review	Run-Rate	£129,816	£0	✔
12 Month Vacancies	Cost Avoidance	£1,416,381	£1,534,000	✔
Overtime Reduction	Run-Rate	£1,110,505	£680,486	ⓘ
Medical Agency Reduction	Run-Rate	£2,525,000	£835,165	●
Non-Clinical Agency Reduction	Run-Rate	£706,429	£668,673	✔
Clinical Agency Reduction	Run-Rate	£793,565	£2,463,422	✔

Alert, Advise, Assure

Alert:

At the end of quarter 4 we have not achieved the trajectories for reducing bank and medical agency expenditure. The plans we set ourselves to reduce the number of bank shifts worked has not seen the reductions as anticipated. In addition, although we have put measures in place that have seen a reduction in medical agency spend, this has not been as significant as expected. Due to pausing international recruitment we have not achieved this target.

Advise:

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 overtime spend however it is the intention to reconsider reducing the target for 2025/26.

Assure:

During 2024/26 we have made 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 4

Ambition	KPI	YTD Target	YTD Actual	RAG (Select Red, Amber, Green)					
				Q1	Q2	Q3	Q4	Latest	Status
Looking After Our People	People Promise 4 theme score -We are safe and healthy.	6.00%	6.50%	Green	Green	Green	Green	Green	✔
	Improve staff sickness levels (0.2% reduction year-on-year to 4%)	5.00%	6.01%	Amber	Amber	Amber	Amber	Amber	ⓘ
	Stress and Anxiety	30.00%	38.00%	Amber	Amber	Amber	Amber	Amber	ⓘ
	MSK	10.00%	12.00%	Green	Green	Green	Amber	Amber	ⓘ
	Compulsory Training	85.00%	88.00%	Green	Green	Green	Green	Green	✔
	Wellbeing Assessments	85.00%	85.00%	Green	Green	Green	Green	Green	✔
Belonging in the NHS	People Promise 3 theme score - We each have a voice that counts	7.10%	7.00%	Green	Green	Green	Green	Green	✔
	Appraisal Compliance	85.00%	82.00%	Green	Green	Green	Green	Green	✔
	Percentage of BAME Colleagues entering Disciplinary Process (WRES)*	1.25%	1.93%	Amber	Amber	Amber	Amber	Amber	ⓘ
	Bullying and Harassment (>64%)	64.00%	66.20%	Green	Green	Green	Green	Green	✔
	Percentage of Disabled Staff (staff survey) sharing disability status in ESR	6.00%	12.18%	Green	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%	73.00%	Green	Green	Green	Green	Green	✔
	Clinical Supervision	85.00%	74.00%	Green	Green	Green	Green	Green	✔
	Safeguarding Supervision	85.00%	56.00%	Amber	Amber	Amber	Amber	Amber	ⓘ
Growing for the future	Vacancies	5.00%	12.03%	Green	Green	Green	Green	Green	✔
	Turnover (8-10%)	10.00%	7.74%	Green	Green	Green	Amber	Amber	ⓘ
	Increase the Internal Bank	550	586	Green	Green	Green	Green	Green	✔
	Monthly Fill Rates - RN	80.00%	84.00%	Green	Green	Green	Green	Green	✔
	Monthly Fill Rates - HCA	80.00%	89.00%	Green	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 March our sickness rate is at 6.01%. We are however continuing to see an increase in absence related to stress, anxiety and MSK. Absence reasons are being scrutinised 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 4 we are behind the target for safeguarding supervision.

Turnover: Although our turnover rate has been relatively stable, at the end of quarter 4 we have seen an increase which is likely to be as a result of the recent environmental context.

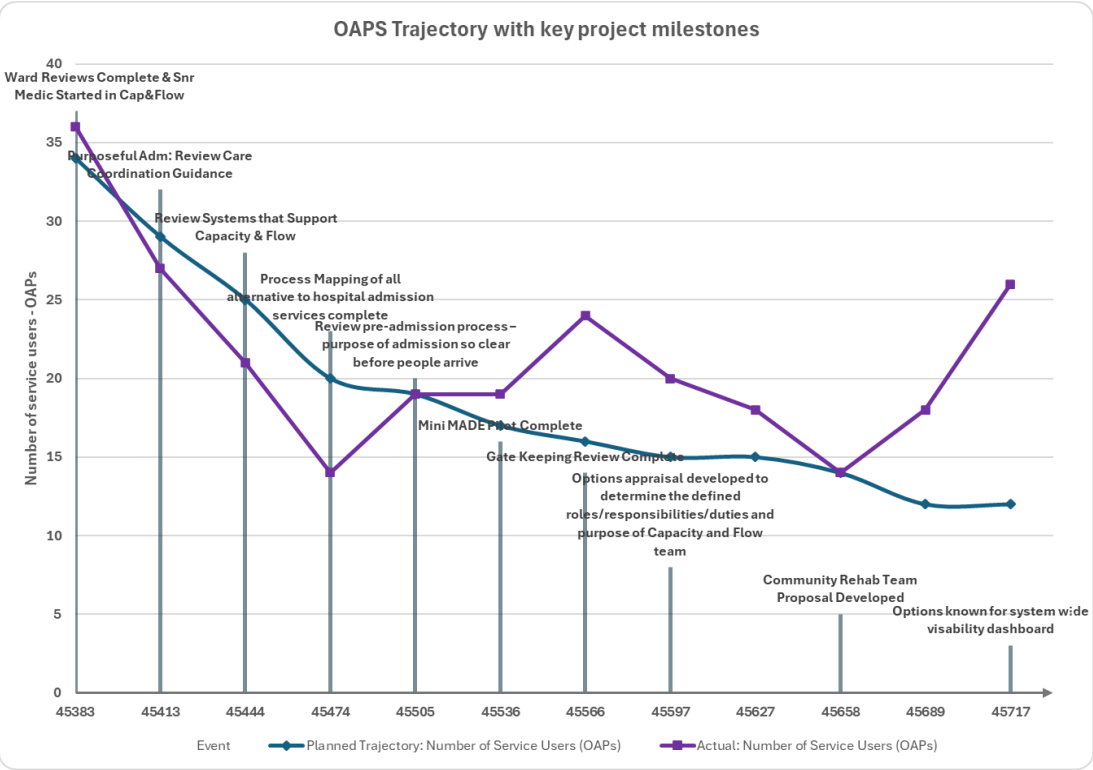
Assure:

Overall, at the end of quarter 4 we continue to make good progress with our metrics.

Delivery of the Inpatient Flow Programme

Our performance at the end of quarter 4

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	75%	ⓘ
Purposeful Admissions and Interventions across the inpatient pathway	Oct-23	Feb-26	75%	ⓘ
Proactive discharge planning and support	Mar-24	Mar-25	83%	ⓘ



Alert, Advise, Assure

Advise: We have made some successful progress with our Improving Flow Programme over the course of 2024/25 despite the continuing out of area placement challenges. To help manage OAP pressures we have begun trialling a 7-day Enhanced Bed Management Team to oversee bed allocation and ensure an efficient use of available resources. The team play a crucial role in managing patient admissions, discharges and improving overall patient flow. Additionally, further bed modelling on the male service and PICU has been completed, with the results being reviewed.

Purposeful admissions and interventions: The gatekeeping template has been successfully piloted during quarter 4 and will be rolled out across Care Services, along with good practice examples. Additionally, the AOT/Inpatient Shared Care Protocol has been reviewed inline with the gatekeeping process and duplication removed. What remains is a set of mutual expectations of each service during an inpatient admission. This will be used to develop standards with the other community services.

Proactive discharge planning: An enhanced housing worker role has been developed alongside ICB, ASC and Housing colleagues that will reside in the Housing Team. In addition, to support our inpatient areas a caseload has been developed for the role detailing all the people who are currently in supported accommodation and ready to bid or actively bidding for housing. We continue to work with system partners to explore low level/step down supported accommodation for our service users.

Deliver, evaluate progress and realise the benefits of the Transformed Community Mental Health Service

Our performance at the end of quarter 4

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	100%	✔

Alert, Advise, Assure

Assure:

During quarter 4, we have now completed the community transformation milestones set for delivery. The rollout of the programme across the city has now concluded and all teams have received a local induction. We will continue to understand and monitor lessons learnt from the early adopter areas. These will be reported in the next gateway evaluation to be presented at the Partnership Board in September 2025.

Further work will continue during 2025/26 with partners to understand what the joint KPI's will be, how data will be collected and how we will measure the quality of the service provided. A separate working group has been established to ensure that the quality of care is being monitored and performance reported.

Develop a Care Services-led Improving Health Inequalities Strategic Plan

Our performance at the end of quarter 4

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	Jan-25	100%	✔
Consultation on the Health Inequalities Strategic Plan	Jul-24	Aug-24	100%	✔
Implementation of the Health Inequalities Strategic Plan	Aug-24	Oct-24	1007%	✔

Alert, Advise, Assure

Assure:

During quarter 4, we have now completed the health equity milestones set for delivery, with the Board of Directors ratifying the strategic plan in January 2025. Implementation of the 4-year work plan is underway.

Complete a refresh of our Estates Strategic Plan

Our performance at the end of quarter 4

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	100%	✔
Begin socialisation and gather feedback	Aug-24	Mar-25	100%	✔
Draft SEP to CEG	Jan-25	Jan-25	100%	✔
Draft SEP to CSDDG	Feb-25	Feb-25	100%	✔
Draft SEP to ESG	Feb-25	Feb-25	100%	✔
Final draft to the Finance & Performance Committee	Mar-25	Mar-25	100%	✔
Final document to the Board of Directors	Mar-25	Mar-25	100%	✔

Alert, Advise, Assure

Assure:

During quarter 4, we have now completed the Estates Strategic Plan milestones set for delivery, with the Board of Directors ratifying the strategic plan in March 2025.

Commence scoping the requirements for a new Electronic Patient Record and associated systems/platform strategy

Our performance at the end of quarter 4

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	100%	✔
Determine requirements, including the potential to continually innovate in this space.	Jul-24	Sep-24	90%	✔
Prioritise our needs as a mental health provider, Mental Health Act/Inpatient/community setting	Jul-24	Sep-24	100%	✔
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	75%	✔
Develop outline Business Case	Jan-25	Mar-25	25%	ⓘ

Alert, Advise, Assure

Advise:

At the end of quarter 4 the high-level functional specification continues to be socialised to ensure wide engagement with operational and clinical staff groups, prior to approval.

We continue to consider all opportunities for national funding. To date and subject to the outcome of the current Spending Review, National funding will only be available from 2026/27 and may potentially be limited to optimisation and convergence programmes. Further information is expected from the National Team in September 2025.

During quarter 4 the EPR Programme Board agreed to a revised timeline for the production of the Outline Business Case (OBC). This is to enable further review and understanding of the convergence and frontline digitalisation funding agenda and impact on EPR procurement.

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 4

Objective or Milestone	Start	Finish	Progress	Status
Echo upgrade	Apr-24	Jun-24	100%	✔
re-establish performance and insight group	Jul-24	Sep-24	100%	✔
Dashboard library signposting	Jul-24	Sep-24	95%	✔
Dashboard outreach & optimisation/rationalisation of insights	Oct-24	Feb-25	95%	✔
Review/lessons learnt	Jan-25	Mar-25	25%	ⓘ

Alert, Advise, Assure

Advise:

At the end of quarter 4 although extensive progress has been made, we have not fully concluded the work to initiate new dashboards. This work will continue into 2025/26 aligned with the quality dashboard and informing the suite of metrics which will enable the measurement of productivity across our services.

Implementation of PSIRF across the organisation

Our performance at the end of quarter 4

Objective or Milestone	Start	Finish	Progress	Status
Governance	Oct-22	Oct-22	100%	✔
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	100%	✔
Training	Mar-23	Mar-24	100%	✔
Standards	Mar-23	Sep-23	100%	✔
Patient safety incident response planning	Mar-23	Aug-24	100%	✔
Curation and agreement of policy and plan	Mar-23	Dec-24	100%	✔

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 4

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	100%	✔
Procurement Exercise	Jul-24	Sep-24	100%	✔
Contract Award	Oct-24	Dec-24	100%	✔
Solution Design and Configuration	Oct-24	Dec-24	50%	ⓘ
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

Alert:

During quarter 4 we have not managed to deploy the new patient portal application as intended. The test environment is built but we are awaiting SMS delivery functionality to enable the Trust to send any content. Wider engagement with clinical services is required with the development, testing and to ensure service level mapping to the necessary digital capabilities is undertaken.

The deployment of the patient portal will continue into 2025/26 as we aim to deploy outcome measures across care services.

Development and implementation of Quality and Culture dashboards for revision in selective services

Our performance at the end of quarter 4

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	100%	✔
Assign project lead	Oct-24	Nov-24	100%	✔
Set up Project Group	Oct-24	Nov-24	100%	✔
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	Mar-25	100%	✔
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	Mar-25	100%	✔
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	100%	✔

Alert, Advise, Assure

Assure:

During quarter 4, we have now completed the quality and culture dashboard milestones set for delivery. New plans have been formulated for the delivery of this priority during 2025/26. A different direction has been taken whilst still being able to initiate the reviewing of all measures to identify a common dataset across all services. The new direction, governed by Quality, Information & Knowledge Group (QuIK) will be underpinned by four workstreams:

1. Organisational wide
2. Team level
3. Aligning and connecting data
4. Know what we are doing with the findings

Strengthen and firmly embed the co-production approach within Care Services

Our performance at the end of quarter 4

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	100%	✔
Identify funding and staff within the service to support audit	Apr-24	May-24	100%	✔
Undertake audit with Rethink	Jun-24	Aug-24	100%	✔
Reflect on learning from the audit process	Sep-24	Oct-25	100%	✔
Write paper for CSDDG / clinical gevernance to make recommendations whether approach should be rolled out across care services	Nov-24	Nov-24	100%	✔
Propose further objectives based on outcome of discussions	Dec-24	Mar-25	100%	✔

Alert, Advise, Assure

Assure:

The tasks associated with this priority have been completed. The objectives set for 2024/25 have informed the scope of the work. Further tasks have been identified for this priority for delivery within 2025/26 which will enable co-production to be embedded.

Agenda item
11

Meeting of the Board of Directors

Paper title:	**Report of the Chief Operating Officer**
Date of meeting:	29 May 2025
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 – Sam Grundy, EPRR Lead – Sophie Valinakis – Head of Health Equity

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 May Board of Directors' meeting to set out the key management, development, and delivery issues across LYPFT Care Services and 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. This report has been presented an discussed in the Finance and Performance Committee.

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

No

Recommendation

The Board is asked to be assured of the work being undertaken to deliver our care services and to manage the range of challenges and issues outlined in the report.

MEETING OF THE BOARD OF DIRECTORS

29 May 2025

Report of the Chief Operating Officer

1. INTRODUCTION

This report sets out the key management, development, and delivery issues across LYPFT Care Services. It aims to summarise and highlight the most significant service delivery issues we are facing.

Primarily the main areas of concern are set out in the “Alert” section of the Service Delivery and Key Performance section of this report (Section 2.1 below). However, as a very high-level summary the most concerning issues include:

- Emergency Department (ED) waits for mental health assessment
- Aspire Provision of Early Intervention in Psychosis Services
- Temporary closure of Oasis Crisis House.

The report continues to provide details of the Improving Patient Flow programme given the risks of a continued reliance on Out of Area acute inpatient capacity. We have also reported on our performance in respect of the timeliness of response to people who are in Crisis. This is an improving picture as set out in detail in the “Advisory” section of this report (Section 2.2 below).

At a very summarised level, the 2025/26 Trust priorities specific to Care Services are set out in the Service Development section of this report (Section 3 below) these are:

- Optimising Community Mental Health Transformation in LYPFT
- Inpatient Quality Transformation Programme (incorporating Improving Patient Flow)
- Reducing waits in the Emergency Department for people requiring mental health admission
- Transformation in Children and Young People’s Mental Health Services.

2 SERVICE DELIVERY AND KEY PERFORMANCE ESCALATIONS

2.1 ALERT

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

2.1.1 Emergency Department (ED) waits for mental health assessment

The 1-hour response rate for the Acute Liaison Psychiatry Service (ALPS) in the Emergency Department has shown a modest improvement, reaching 68% at the end of April.

The service has experienced some operational challenges, including staff sickness, which is now resolving. The team is also in the process of relocating back to the designated office space at St James's Hospital. This move is expected to strengthen integration with the Emergency Department team and support improved responsiveness.

In addition, we are optimistic that the focused work currently underway to refine and enhance our internal processes will help release clinical capacity. This will enable ALPS clinicians to respond more effectively and efficiently, further supporting our commitment to timely and high-quality patient care.

The need to reduce the length of waiting time for people who require admission to mental health inpatient treatment, is a priority area of work and is an imperative as part of the planning requirements. The programme is broadly divided into three key areas:

- Establishing the Reducing ED Waiting Times Working Group: This group is being formed to collaborate across care services, enhancing systems, processes, and communication. It will consist of several workstreams focused on data analysis, NHS England ED action cards, communication, and internal processes. Initial efforts include a process mapping exercise to thoroughly understand current escalation procedures and identify opportunities for efficiency. A follow-up session to look at this in more detail is scheduled for June to advance this strand of work.

- Regular improvement meetings with Leeds Teaching Hospitals Trust (LTHT) Colleagues: We have initiated regular meetings with colleagues from LTHT to address challenges in meeting demand and maintaining flow through Emergency Departments. This group includes Business Intelligence colleagues who are working to develop a shared data set to ensure consistency and provide reliable oversight of activity. The group aims to develop a shared escalation and action plan to minimise delays and improve communication.

- Leadership of Acute Liaison Psychiatry Service (ALPS): The leadership team for the ALPS has focused on improving their response times, achieving some progress while recognising the need for further improvements. The team is scheduled to relocate to office space on the St James site once final estates and workforce issues are resolved.

The programme of work is led by Eve Townsley (alongside her broader role as Head of Operations) and Dr Ankush Vidyarthi, Clinical Director. It will be overseen at an Executive level by the Chief Operating Officer and the Medical Director.

2.1.2 Aspire Provision of Early Intervention in Psychosis Services

As previously reported, the Head of Operations for our Community and Wellbeing Services has been working with colleagues in Aspire to support performance improvement. Currently, performance is considerably below contracted standards, with cardiometabolic monitoring at 40% (against a target of 80%) and the starting treatment within the two-week standard at 45% (against a target of 60%). The leadership team has recently met with Aspire, the ICB and NHS England to reach an agreement on a recovery plan and review the specification of the contract. It has been agreed to consider changes to the delivery model to ensure the core function and purpose of the team is achieved.

We are also working with the leadership team in Aspire to ensure the agreed performance improvements are achieved. The plan targets key metrics, aiming for 60% compliance with the two-week standard by the end of Q1, and full health monitoring implementation by end of Q2. To support progress, regular review meetings have been scheduled between the provider and the Head of Operations.

2.1.3 Oasis Crisis House

The Trust has been advised that at the end of June there will be a temporary closure of Oasis Crisis House for a period of up to 10 weeks so necessary refurbishment work can be carried out. Some external work has been completed with little disruption, but the internal work, which will mean the house has to close, includes increasing bed capacity to 6 rather than 5 bedrooms and improving physical accessibility for guests by creating a fully accessible bedroom and one-to-one support space.

Staff in the Trust's CRISS service are working closely with Oasis to evaluate and mitigate any impact and also ensure the CAU is fully functioning as a Crisis Assessment Unit. Senior leaders in the Leeds Survivor-Led Crisis Service and the West Yorkshire ICB in conjunction with Trust staff are carrying out an impact assessment of the temporary closure which will be presented to the Crisis Transformation Board in June 2025.

Whilst we welcome the enhancements to the facilities at Oasis House, the temporary closure has the potential to impact our service users, our placements out of area and our work to reduce mental health waits in the Emergency Department.

2.2 ADVISE

2.2.1 Acute Flow and Out of Area Placements (OAPs)

The Improving Flow Programme Lead, Laura McDonagh, has evaluated progress to date and drawn conclusions about areas of focus to continue to deliver sustainable improvements that significantly reduce reliance on out of area inpatient capacity.

The evaluation was presented to the Improving Patient Flow Programme Executive Oversight Group and confirmed that the programme delivered measurable progress from

financial years 2023/24 to 2024/25. Notably, it achieved a £1.58m reduction in OAPs expenditure, signalling both enhanced operational efficiency and improved patient outcomes. This was supported by the implementation of enhanced bed management systems, real-time operational dashboards, and strengthened governance frameworks, which collectively improved oversight and responsiveness. Purposeful admission protocols and early discharge planning were introduced to ensure continuity of care and reduce unnecessary delays. Additionally, the programme reinforced its partnerships with Adult Social Care and Housing which played a critical role in addressing barriers and reducing delayed discharges across the care pathway.

Moving forward, the programme will prioritise refining systems, expanding successful pilot initiatives, and developing integrated plans that address mental health, housing and social needs. Regular monitoring and evaluation will ensure that progress is tracked, and necessary adjustments are made to maintain momentum.

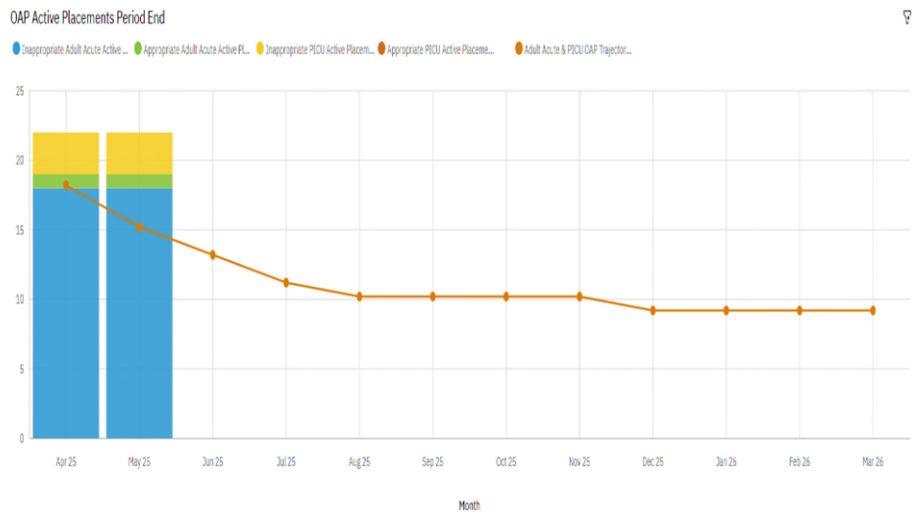
Although the stretch target for 2024/25 was not fully achieved, the programme successfully halved the likelihood of requiring out of area placements by year-end. Notably, the last two months of the year saw an increase in demand, consistent with seasonal trends observed in previous years. This highlights the importance of understanding the historical and emerging trend data and future planning processes, ensuring that capacity is aligned with anticipated demand and that the system remains resilient under pressure.

The financial trajectory established as part of the financial plan submission for 2025/26 is challenging and assumes a further reduction in spend of £4.1m. We are in the final stages of securing potential investment (already included as an assumption in our financial plan) which will be targeted at improving discharge support and facilitation.

It is essential that energy and focus on this work continues. The programme will continue into 2025/26 but will form part of a broader initiative aligned with the national priorities for Inpatient Quality Transformation. This means that Improving Patient Flow will become an established workstream and will incorporate a review of the clinical model for adult acute care. This work will be led by Laura McDonagh (Head of Operations and Programme Lead) and Dr Jamie Pick (Clinical Director) providing consistency and expertise as the work develops further.

Current performance is set out below.

Graph 1



The year has commenced off trajectory, primarily due to increased demand and a slower rate of discharge during Q4 of 2024/25. However, the Capacity and Flow Team is actively addressing this and working at pace to bring the position back on track. In alignment with the 2025/26 Planning Guidance, a Length of Stay (LoS) trajectory has been established and will be closely monitored through the Flow Programme's governance framework. At the time of reporting, there are 18 service users placed in out of area acute wards and 3 in Psychiatric Intensive Care Units (PICU).

The images below show the placements across the country at month end and where those have been placed during April. We continue to keep the majority of placements as close to Leeds as possible; however, due to availability, placements during April have been further afield including the Midlands and London.

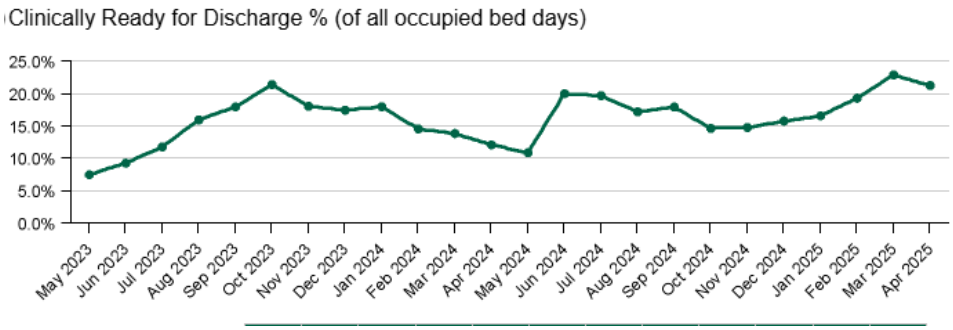
Image 1: All placements at month end April 2025

Image 2: Placements started April 2025

Two key priorities within the Improving Flow Programme are the reduction of service users identified as Clinically Ready for Discharge (CRfD) and the continued decrease in average Length of Stay (LoS). The Acute Service continues to experience elevated CRfD rates, which have shown a steady increase since October 2024, although a modest improvement was observed in April.

In April, Acute Services undertook a focused review of all service users with a LoS exceeding 60 days to identify and implement the necessary interventions to facilitate timely and appropriate discharge.

Graph 2



The Improving Flow Programme represents a significant effort to enhance inpatient flow, reduce OAPs, and improve patient outcomes. Through strategic initiatives and collaboration with system partners, the programme has made substantial progress in addressing key challenges.

Key achievements across the three workstreams demonstrate the programme's commitment to optimising patient flow and ensuring timely, high-quality care is provided closer to home. The implementation of new processes strengthened governance and enhanced collaboration with external partners have contributed to these successes.

Despite not fully achieving the trajectory set for 2024/25, the programme's impact is evident in the reduction of overall bed days in out of area placements and significant cost savings. Continued focus on embedding new processes, addressing delays, and fostering strategic partnerships will be essential for sustaining improvements and achieving the programme's objectives.

Moving forward, the programme will prioritise refining systems, expanding successful pilot initiatives, and developing integrated plans that address both mental health and housing needs. Regular monitoring and evaluation will ensure that progress is tracked, and necessary adjustments are made to maintain momentum.

2.2.2 Adult Acute: Crisis Resolution assessments within 4 hours

We have seen a steady and continued upward trend in performance against both the 4-hour and 24-hour CRISS response targets since the last reporting period. Notably, the West Locality has demonstrated a significant improvement, with a 47% increase in assessments completed within the 4-hour target window. This progress reflects the

ongoing efforts of the clinical teams, who have been working closely with the leadership team and Informatics to ensure accurate and consistent reporting. Previous underperformance was, in part, attributed to inconsistencies in data capture and reporting, which are now being actively addressed.

In addition, we have observed a reduction in staff sickness absence rates, which has positively impacted service responsiveness. While staffing challenges remain, with vacancies across several localities, recruitment is underway (prior to the temporary recruitment freeze). We anticipate offering posts to several of the nursing graduates who will be joining the Trust in September/October time.

Table 1

Locality	Very urgent 4hr Response	Urgent 24hr response
South CRISS	77% ↑	75% ↑
West CRISS	80% ↑	82% ↓
East CRISS	58% ↑	69% ↑
Overall	71% ↑	75% =

The leadership team has identified that the implementation of the new model of CRISS has been challenging across the three localities for different reasons which has contributed to the poor performance in achieving targets. Over this next month, the leadership team will work with each of the teams and the Informatics Team to carry out a process mapping exercise to identify areas of good practice and reduce variation within the model. It is anticipated that this work will highlight opportunities for improvement to support the service in achieving and sustaining the 90% performance target,

2.2.3 Implementation of the Primary Care Principles Framework and Preparing and responding to GP Collective Action

In LYPFT, our Head of Operations for Forensic Services, Josef Faulkner, leads and coordinates our work on preparing for and responding to the impacts of GP collective action. Josef had already started work to implement the required changes across the Trust following the launch of the Primary Care Principles Framework (a Leeds-wide change in provision of GP services).

Through the weekly meetings involving the Leeds office of the West Yorkshire ICB, Leeds Teaching Hospitals Trust (LTHT), LYPFT and Leeds Community Healthcare Trust (LCH) there are notable increases in impacts being faced by both LTHT (primarily) and LCH as a result of reduced GP medication prescribing and test requests on behalf of Secondary Care. There is a concern being raised that some GPs are taking forward collective action that appears not to be strictly in line with the national discussions that have taken place.

Care Services in the Trust have seen minimal impact up to this point, possibly as a result of there being fewer pathways that lead back to the GPs compared to other Secondary Care providers. We are monitoring the situation closely and engaging with the ICB on a weekly basis, who continue to be in regular dialogue with GP colleagues.

We continue to progress work through the implementation of the Primary Care Principles framework (pre-dating the risk of collective action but does require significant changes for us as a secondary care provider). The task and finish group identified a number of key areas of focus:

- Initiating investigations
- Communication (to primary care and service users)
- Waiting Lists and DNAs
- Medication (prescribing and initiating)
- Fit notes
- Onward referrals.

We have established a separate group with a dedicated focus on Community Diagnostic Centres, and we feel confident with the work that has already taken place within the Trust around Fit Notes, Waiting Lists and Communication. We have a good foundation to support us to implement the principles, mitigate the impacts and allow a detailed focus on the more challenging areas.

2.2.4 Supreme Court Ruling on the Equality Act

The announcements regarding the recent Supreme Court ruling that in the Equality Act 2010 ‘sex’ means biological sex, have caused concern amongst staff and service users. Whilst we are awaiting further NHS guidance we continue to operate as usual, with no changes to Trust policies or procedures and we expect that people are treated with respect and compassion. We are though, supporting staff and service users wherever possible given the implications for many people in or connected to the transgender, non-binary and intersex population.

Staff in our Gender Identity Service (GIS) have been working with the Communications Team to provide timely information and assurance to colleagues across the Trust and to our service users. There has been significant media interest in this issue, some of which has featured the Trust and its position statement. This is being actively managed by our Communications Team.

There has also been significant staff engagement, particularly in conjunction with the Rainbow Alliance (the Trust’s LGBTQ+ staff network) and with the GIS leadership team. Additionally, colleagues in the Nursing Directorate are involved in the emerging national work in response to the ruling. Appropriate measures have also been taken in response to an email threat directed at individuals within our services, ensuring their safety and well-being.

The service has experienced a rise in Subject Access Requests, which has posed challenges in meeting the required one-month response timeframe. Efforts are underway to address this demand effectively.

2.2.5 S136 Detentions Receiving Assessments Within 3 Hours

All service users detained under S136 of the Mental Health Act should receive an assessment as soon as is practical within a place of safety. We have had in place a

performance measure that has suggested this is within 3 hours of arrival at a place of safety, which has been reported through our Care Quality Performance Report (CQPR).

This is a locally agreed measure based on suggested best practice; however, there is no national standard that services are measured against. Due to a number of factors, including the volume of detentions, the response times of assessors and the recording times of assessments, we have struggled to achieve more than 30% of detentions being assessed within this time frame.

As this is not a performance indicator that requires external reporting, we have agreed we will remove it from our formal reporting processes. However, we will continue to monitor this at a local level with the intention of maintaining best practice to achieve the commencement of the assessment within 3 hours of detention.

2.2.6 Older Peoples Service: CMHT and Care Home Teams Restructure

We have concluded a formal consultation on changes to the Care Homes Teams (CHT). The staffing resource attached to this team will be integrated into the four Older People's Service (OPS) sectors and will come under the line management of the established Community Mental Health Team (CTMs). The CHT resource remains a protected resource but will be focused within local communities. The current Intensive Care Home Treatment Team (ICHTT) will be integrated into the city-wide Intensive Home Treatment Service, but the staff will retain their specialist role working into Care Homes on an intensive basis.

This means the clinicians based in each respective locality will further develop skills and knowledge relating to the area in which they work and build closer connections to colleagues within the wider community OPS service. This is expected to improve service delivery. This arrangement also has the potential to free up the CHT clinician's time through a reduced number of required duty workers, reduced number of Multi-disciplinary Teams to attend, which can then release time to be spent directly delivering interventions and support in the community.

Structural changes went live on the 28 April 2025. To support staff through this change we held a number of workshops in addition to individual support and engagement. Staff report being engaged in the process and comfortable to progress. We will continue to monitor how these changes have impacted staff and whether the expected improvements manifest in terms of quality and performance. This will be reported at regular checkpoints as part of our clinical and operational governance arrangements.

2.2.7 Complex Psychosis Pathway Business Case

A two-year review of the Trust's rehabilitation services recommended developing a Complex Psychosis Pathway. A business case outlining the proposed pathway will be presented to the Care Services Delivery and Development Group (CSDDG) and the Financial Planning Group (FPG) for approval in June 2025. The pathway aims to:

- Shift from inpatient to primarily community-based care

- Secure recurrent funding for the Community Rehabilitation Enhanced Support Team (CREST)
- Fund additional staffing for Parkside Lodge as a standalone unit.

In late 2024, Bradford, Calderdale, Kirklees and Wakefield ICBs signalled their intention to cease commissioning CREST, while Leeds ICB supported its integration into the Complex Psychosis Pathway. This created a financial risk for the Trust with permanent CREST staff lacking recurrent funding.

To mitigate this, a business case proposes funding CREST staffing and Parkside Lodge staff via savings from the Complex Rehabilitation Out of Area Placement (CR-OAP) budget. The funding gap is approximately £2.7m. We currently have 17 patients in CR-OAPs, with a projected 2025/26 cost of £4m.

During 2024/25, we reduced CR-OAPs from 24 to 17, repatriating 13 patients with CREST's support, saving £1.2m. With an annual placement cost of £235k per patient, we must reduce CR-OAPs to 5. Given Parkside Lodge's expansion to 18 male beds and CREST's entire focus on Leeds, we anticipate zero male CR-OAPs. We forecast 4 female admissions to CR-OAPs, therefore 16 must be repatriated. A clinical review has set estimated repatriation timelines, and the finance team is developing a financial trajectory accordingly.

2.3 ASSURE

2.3.1 Complex Rehabilitation Inpatient Service

The project for the Ward 5 Newsam move to Parkside Lodge is progressing to plan but with a delay in building works now being reported. The tasks within the project include changes to local policies and procedures and aligning them with our other rehabilitation inpatient services, which are expected to be completed in May.

Since it was reported to Board in November 2025, the completion date for building works has been extended to January 2026. A 6-month programme of transition and relocation will be triggered once building timelines are clearer.

2.3.2 Forensic Service: Seclusion Suite

The outstanding works required for the opening of the new seclusion suite at the Newsam Centre have now been completed, with the suite having officially opened on the 14 May 2025. The delay in operationalisation was due to considerable work being required as a result of unanticipated issues that required resolution to ensure the changes would not lead to an increase in restrictive practice for service users.

The provision of a new seclusion suite will be a significant addition to the safe and quality care provided to service users within the Leeds Forensic Inpatient Service. It will also improve the experience for service users who may have previously been admitted to a secure hospital outside of Leeds and those requiring transfer from prison who have had to wait longer than 28 days.

Works have not only been taking place within our Leeds Forensic Inpatient Service, but there have been exciting developments within our York Forensic Inpatient Service. Based at Clifton House, work is progressing, including improvements to all ward environments that will see the reopening of Rose Ward, the closure of Westerdale Ward and the building of a brand-new seclusion suite on Riverfields Ward. These are challenging and complex works, however with close working between the clinical service, NHS Property Services and our Estates & Facilities teams, the overall improvements to the quality and safety of care provided to service users will be significant.

2.3.3 Gender Service: Gender Outreach Workers

The Gender Outreach Workers have received a nomination for a National Diversity Award in the category 'Community Organisation Award for LGBT'. The National Diversity Awards celebrate the excellent achievements of grass-root communities that tackle the issues in today's society, giving them recognition for their dedication and hard work. The team will be informed if they are shortlisted for the award in July 2025, and if shortlisted, the award ceremony will be held in Liverpool in September.

3 SERVICE DEVELOPMENT

3.1 Trust Priorities 2025/26

We are in the process of finalising our Trust priorities for 2025/26 but are building on work that has been running through 2024/25. From a Care Services perspective there are four major programmes of transformation and improvement which theme around:

- **Optimising Community Mental Health transformation in LYPFT**: building on the principles and progress of Community Mental Health Transformation but focused on how we best support and care for people with serious and enduring mental illness in LYPFT, this will closely align to the work across Leeds in partnership with colleagues in Leeds Community Healthcare and in the third sector. It will prepare us to move towards the emerging neighbourhood health model alongside health and care partners in Leeds to best meet the needs of the population we serve.

- **Inpatient Quality transformation programme (incorporating Improving Patient Flow)**: this programme draws together and coordinates the work already ongoing across the Trust which aims to achieve the ambition of the national programme of work. It will include the key programmes of work we already have in place which are critical in 2025/26. These include the inpatient flow programme, reducing length of stay (in line with the performance requirements of the operational plan submission) and the Culture of Care quality improvement work led by the Nursing Directorate.

- **Reducing waits in Emergency Department for people requiring Mental Health Admission**: As set out in Section 2.1.1 above, this programme ensures we have a coordinated approach internally and with partners to minimise waits in

emergency departments for people who require mental health admission. A focus will be to explore a model to support and treat people in a mental health emergency department, or similar approach, in line with emerging thinking nationally and locally.

- **Transformation in Children and Young People's Mental Health**: This is an opportunity supported by the West Yorkshire Mental Health, Learning Disability and Autism Programme Board, Chaired by Dr Sara Munro, to pull together the work of the CYPMH Tier 4 Provider Collaborative and colleagues who commission and deliver community CYPMH across West Yorkshire, to further transform and improve services to meet the needs of young people. It is an exciting development in collaborative working and will be led by Tim Richardson the West Yorkshire Provider collaborative lead and Deputy Director of Children and Young People's Mental Health Services.

For these programmes and others across the Trust, work is being finalised to develop a programme structure, scope, milestones etc and leadership arrangements are being confirmed. A more detailed report will be shared with Board colleagues by the Chief Financial Officer and Deputy Chief Executive.

3.2 National Inpatient Centre for Psychological Medicine

A review of the service has been completed to consider the options for the future service delivery model. The proposal is to develop and pilot a community-based model. This was presented to the Executive Management Team and was supported in principle. The team is now completing detailed financial modelling and planning to be able to begin to develop and test the model.

4 IMPROVING HEALTH EQUITY

At LYPFT, improving health equity (IHE) means creating the conditions for our patients, carers, staff and communities to have the opportunity to attain their full health potential; to ensure, no one is disadvantaged from achieving this potential because of their social position or circumstances; and to embed equity at the heart of everything we do and maximise the Trust's contribution to improving health equity in the populations we serve.

In May 2025 the Quality Committee received and endorsed the overarching governance and reporting arrangements for the delivery of the Trust's IHE Strategic Plan and related action plan, setting out how the Board and its committees would receive assurance on their delivery.

The Committee also received an update on the progress against the year 1 actions and areas of focus, which are:

- **Increasing co-ordination** - increasing coordination in our existing programmes, projects and initiatives focused on improving equity. The aim of this increased coordination will be to amplify the impact of existing initiatives.

- **Building the foundations required** - building the foundations required to make changes for health equity.

The Quality Committee will receive bi-annual updates on progress against the action plan, and the Mental Health Legislation Committee will receive progress reports on the PCREF actions.

5 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

5.1 Generator Fragility at The Mount

On 26 April 2025 the power supply across our services working at the Mount was disrupted for an extended period. Following a 'black start' test, contractors had difficulty reconnecting to mains power leaving the building reliant on the backup generator. The Mother and Baby Unit at the Mount experienced some minor disruption to their power supply but patient safety was not compromised due to the activation of the business continuity plan. The Older People's Service did not experience any disruption.

This issue was escalated via the on-call management arrangements and a business continuity incident was declared. We also informed the West Yorkshire ICB of the incident. The mains power was restored later in the evening and contractors have subsequently performed a full test of generator systems and found no faults. The Head of EPRR will present a debrief report to the EPRR Group on 28 May 2025.

5.2 Business Continuity Plans

The EPRR Team continues to work with services in the Care Service Directorate and Corporate Departments to ensure there are robust, up to date business continuity plans in place. Since last reporting there has been significant progress made, particularly within Care Services.

6 SUMMARY AND RECOMMENDATION

The Board is asked to be assured of the work being undertaken to deliver our care services and to manage the range of challenges and issues outlined in the report.

Joanna Forster Adams
Chief Operating Officer
May 2025

Contributions from:
Mark Dodd, Deputy Director of Operations
Sam Grundy, Head of EPRR
Sophie Valinakis, Head of Health Equity.

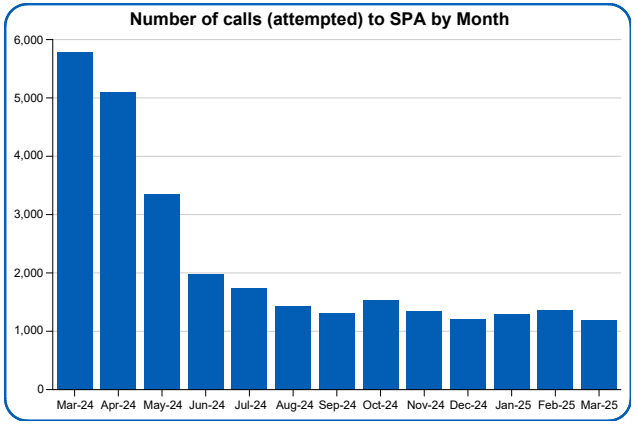
Service Performance - Chief Operating Officer

Services: Access & Responsiveness: Our response in a crisis	Target	Feb 2025	Mar 2025	Apr 2025
Percentage of crisis calls (via the single point of access) answered within 1 minute	-	81.4%	83.0%	-
Percentage of ALPS referrals responded to within 1 hour	-	55.7%	61.3%	67.8%
Number of S136 detentions over 24 hours	0	0	0	0
Percentage of appropriate crisis referrals seen face to face for assessment within 4 hours of referral	90.0%	54.5%	61.3%	71.4%
Percentage of service users who stayed on CRISS caseload for less than 6 weeks	70.0%	83.8%	92.2%	91.9%
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support	50.0%	18.1%	29.0%	34.6%
Percentage of CRISS caseload where source of referral was acute inpatients	-	6.2%	8.4%	4.8%
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services	**Target**	**Feb 2025**	**Mar 2025**	**Apr 2025**
Gender Identity Service: Number on waiting list	-	6,448	6,501	6,596
Deaf CAMHS: average wait from referral to first face to face (inc. telemedicine) contact in days	-	193.05	129.94	124.06
Community LD: Percentage of referrals seen within 4 weeks of receipt of referral	75.0%	54.5%	71.8%	69.7%
Leeds Autism Diagnostic Service (LADS): Assessment to Diagnostic Decision within 26 Weeks (quarterly)	-	-	44.4%	-
Leeds Autism Diagnostic Service (LADS): Percentage starting assessment within 13 weeks (quarterly)	-	-	38.5%	-
CAMHS inpatients: Proportion of people assessed within 7 days of admission (HoNOSCA / GBO) (quarterly)	100.0%	-	61.1%	-
Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency) (quarterly)	-	-	86.4%	-
Perinatal Community: Percentage of routine referrals waiting less than 2 weeks for assessment (quarterly)	85.0%	-	90.6%	-
Perinatal Community: Total number of distinct women seen in rolling 12 months (quarterly)	930	-	984	-
Perinatal Community: Face to Face DNA Rate (quarterly)	-	-	9.1%	-
Services: Our acute patient journey	**Target**	**Feb 2025**	**Mar 2025**	**Apr 2025**
Number of admissions to adult facilities of patients who are under 16 years old	-	0	0	0
Crisis Assessment Unit (CAU) bed occupancy	-	72.0%	79.0%	86.7%
Crisis Assessment Unit (CAU) length of stay at discharge	-	7.8	9.33	10.25
Liaison In-Reach: attempted assessment within 24 hours	90.0%	77.4%	74.2%	78.2%
Bed Occupancy rates for (adult acute excluding PICU) inpatient services:	94.0% - 98.0%	100.1%	99.4%	99.9%
Becklin Ward 1 (Female)	-	103.9%	103.4%	100.0%
Becklin Ward 3 (Male)	-	97.7%	100.6%	100.2%
Becklin Ward 4 (Male)	-	98.2%	96.3%	100.5%
Becklin Ward 5 (Female)	-	100.8%	99.4%	98.3%
Newsam Ward 4 (Male)	-	100.0%	97.4%	100.5%
Older adult (total)	-	92.3%	92.4%	89.5%
The Mount Ward 1 (Male Dementia)	-	86.5%	83.9%	83.8%
The Mount Ward 2 (Female Dementia)	-	97.4%	93.1%	84.0%
The Mount Ward 3 (Male)	-	85.7%	89.5%	90.5%

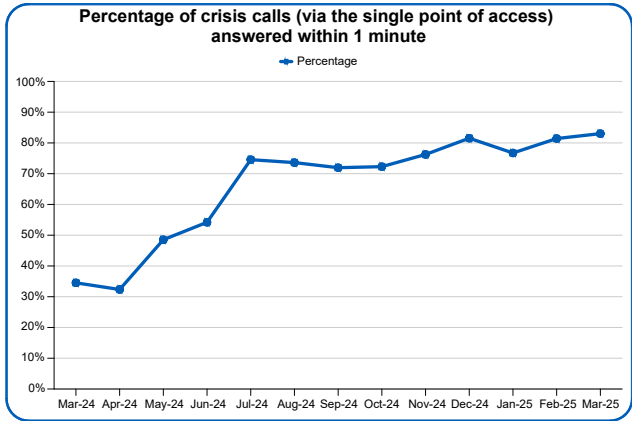
Service Performance - Chief Operating Officer

Services: Our acute patient journey	Target	Feb 2025	Mar 2025	Apr 2025
The Mount Ward 4 (Female)	-	99.0%	100.5%	96.2%
Percentage of Occupied Bed Days Clinically Ready for Discharge	-	37.6%	29.3%	22.2%
Out of Area Trajectory Active Placements at Month End	18	24	32	21
Total: Number of out of area placements beginning in month	-	20	21	11
Total: Total number of bed days out of area (new and existing placements from previous months)	-	545	901	730
Acute: Active Placements at Month End	-	18	25	18
Acute: Number of out of area placements beginning in month	-	16	16	8
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	421	705	599
PICU: Active Placements at Month End	-	6	7	3
PICU: Number of out of area placements beginning in month	-	4	5	3
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	124	196	131
Older people: Active Placements at Month End	-	0	0	0
Older people: Number of out of area placements beginning in month	-	0	0	0
Older people: Total number of bed days out of area (new & existing placements from previous months)	-	0	0	0
Cardiometabolic (physical health) assessments completed: Inpatients (quarterly)	80.0%	-	61.5%	-
Services: Our Community Care	**Target**	**Feb 2025**	**Mar 2025**	**Apr 2025**
Percentage of inpatients followed up within 3 days of discharge (Trust Level monthly local tracking)	80.0%	77.3%	83.5%	82.1%
Percentage of inpatients followed up within 3 days of discharge (HCP commissioned services only)	80.0%	77.6%	83.3%	80.6%
Number of service users in community mental health team care (caseload)	-	3,424	3,458	3,467
Percentage of referrals to memory services seen within 8 weeks (quarter to date)	70.0%	66.7%	72.5%	71.0%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50.0%	53.2%	53.8%	56.2%
Early intervention in psychosis (EIP) or at risk mental state (ARMS): Percentage starting treatment within 2 weeks	60.0%	36.0%	30.4%	47.4%
Early intervention in psychosis (EIP) : Percentage of people discharged to primary care (quarterly)	-	-	52.1%	-
Cardiometabolic (physical health) assessments completed: Early Intervention in Psychosis Service (quarterly)	80.0%	-	44.0%	-
Services: Clinical Record Keeping	**Target**	**Feb 2025**	**Mar 2025**	**Apr 2025**
Percentage of service users with NHS Number recorded	-	99.3%	99.7%	99.7%
Percentage of service users with ethnicity recorded	-	81.7%	81.7%	81.5%
Percentage of service users with sexual orientation recorded	-	46.9%	46.4%	45.7%
Services: Clinical Record Keeping - DQMI	**Target**	**Nov 2024**	**Dec 2024**	**Jan 2025**
DQMI (MHSDS) % Quality %	95.0%	90.5%	90.8%	91.3%

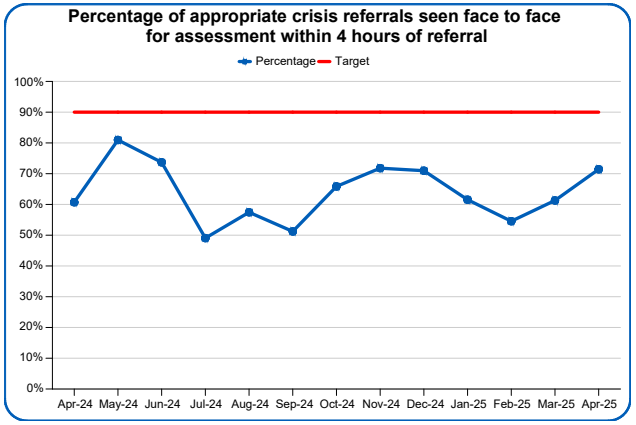
Services: Access & Responsiveness: Our Response in a crisis



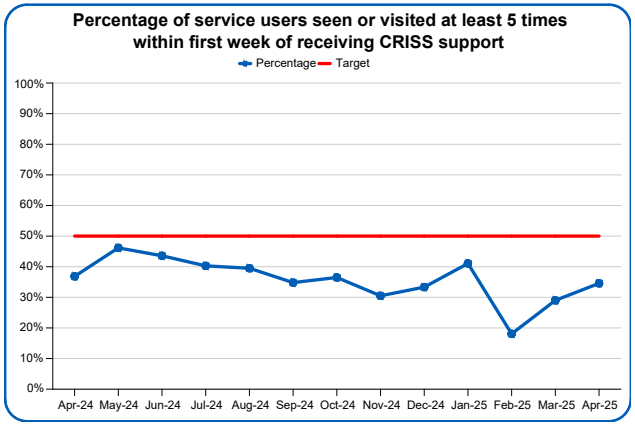
Number of calls : March 1,205



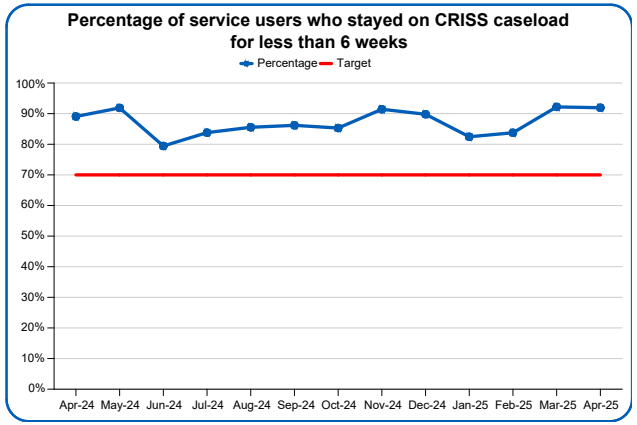
Local target - within 1 minute: March 83.0%



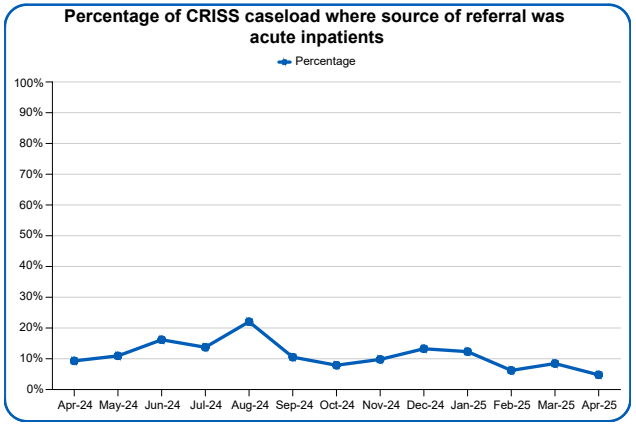
Contactual Target 90%: April 71.4%



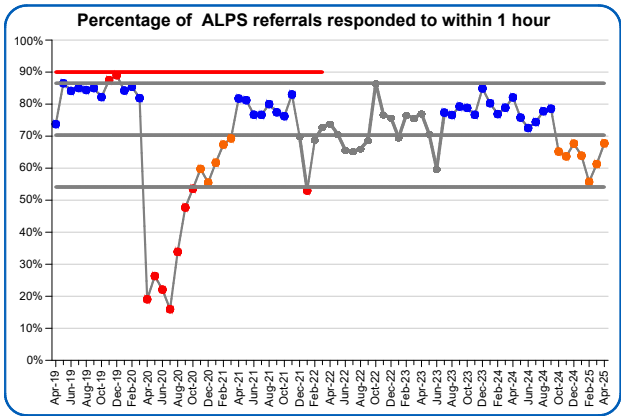
Contractual Target 50%: April 34.6%



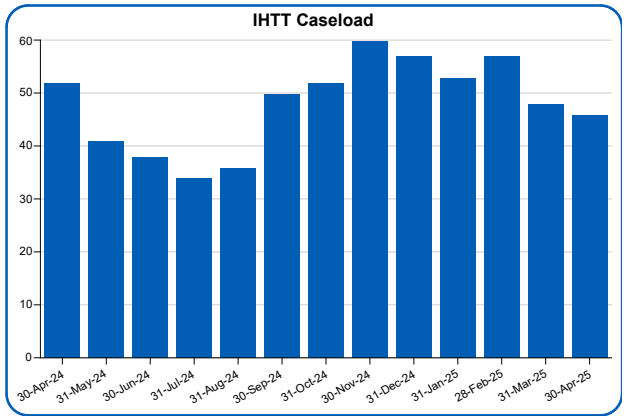
Contractual Target 70%: April 91.9%



Contractual Target tba: April 4.8%

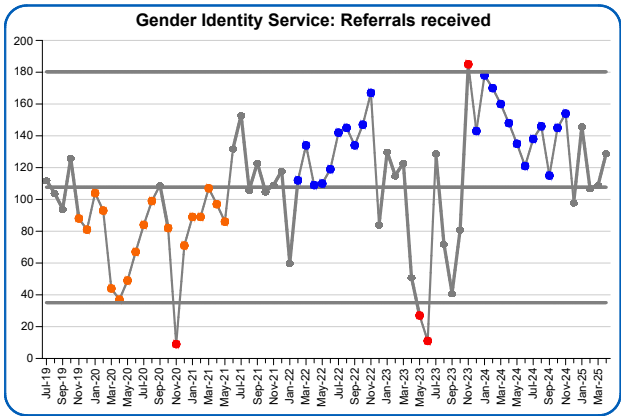


Contractual Target : April 67.8%

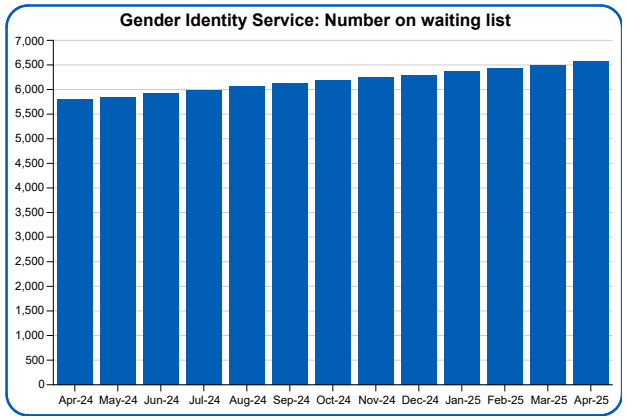


Caseload: April 46

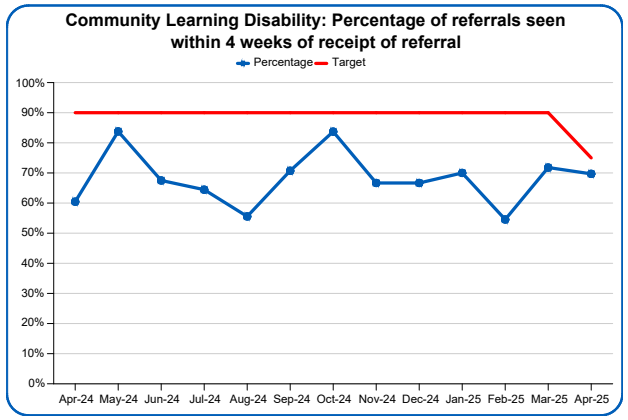
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services



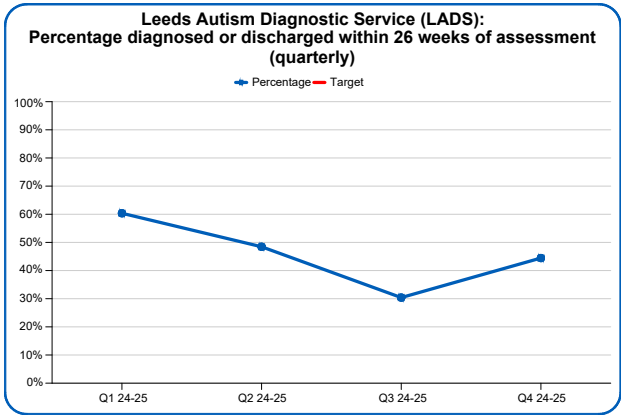
Total referrals: April 129



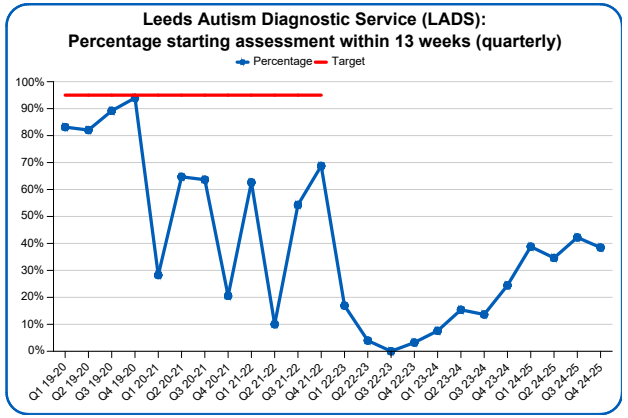
Number on waiting list: April 6,596



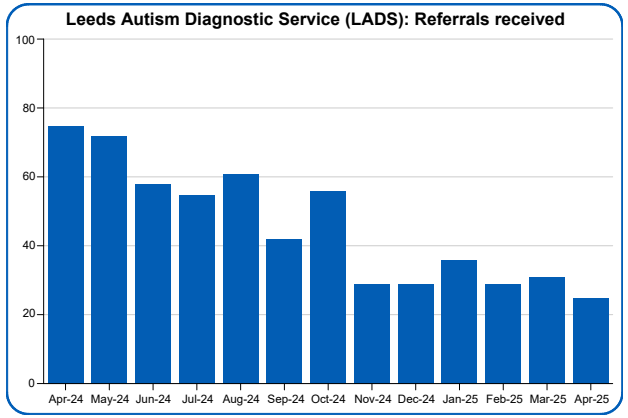
Contractual Target 75%: April 69.7%



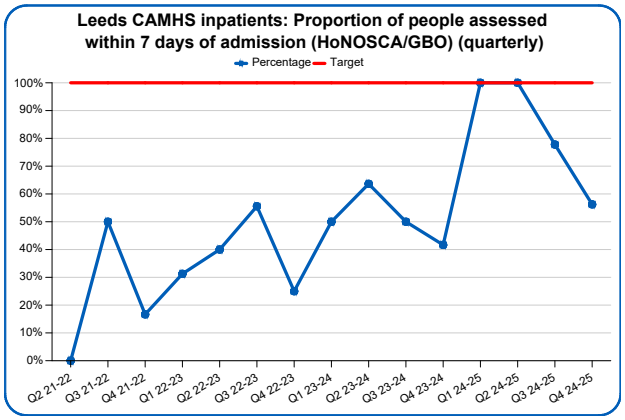
Contractual Target : Q4 44.4%



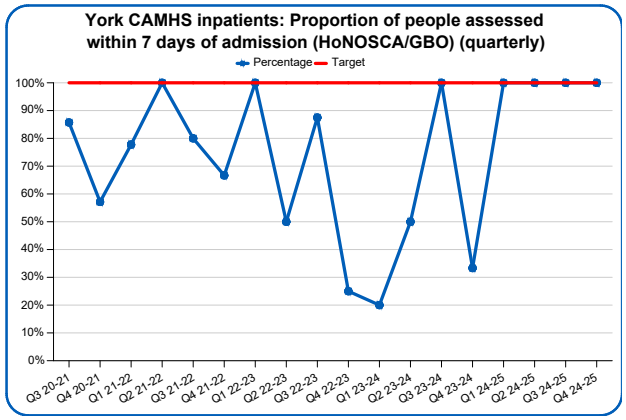
Contractual Target : Q4 38.5%



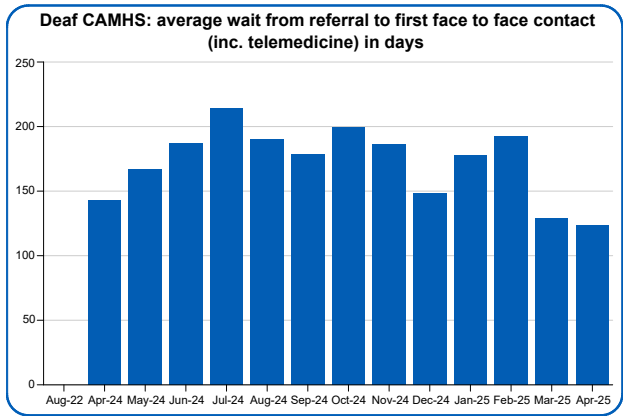
Local measure: April 25



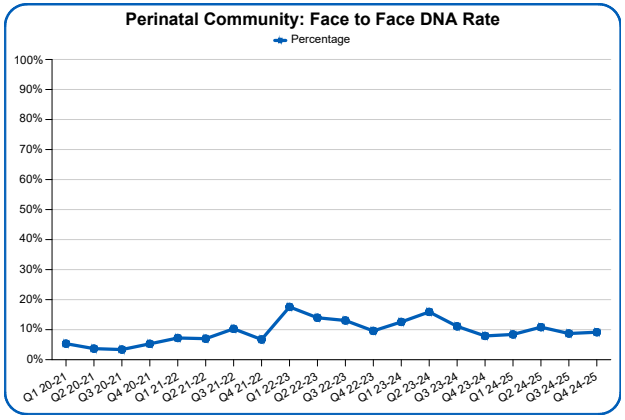
Contractual Target 100%: Q4 56.2%



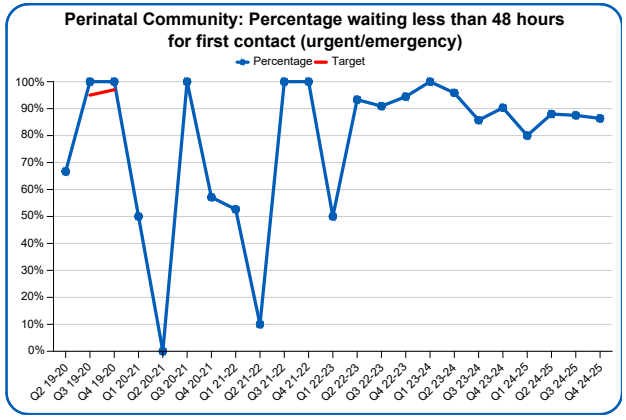
Contractual Target 100%: Q4 100.0%



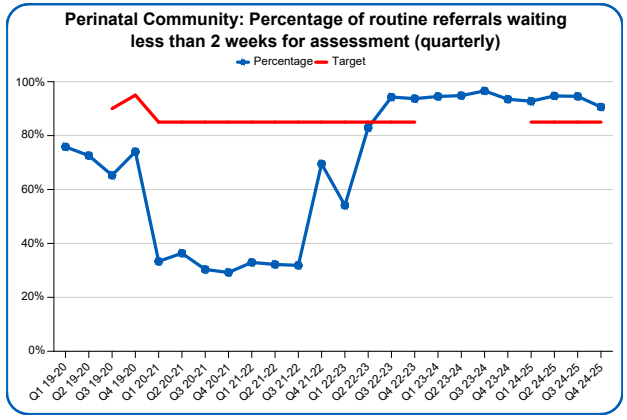
Local measure: April 124



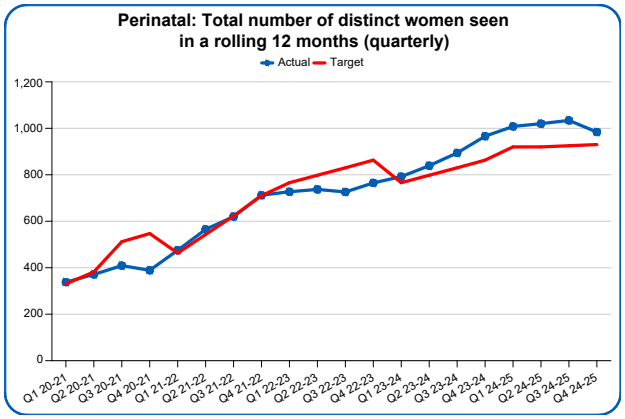
Contractual measure: Q4 9.1%



Contractual Target tba: Q4 86.4%

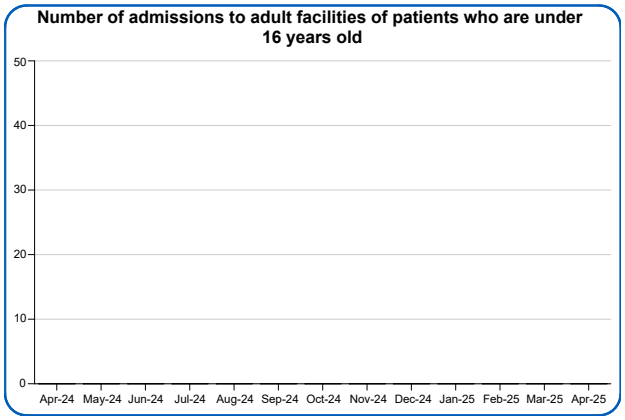


Contractual Target 85%: Q4 90.6%

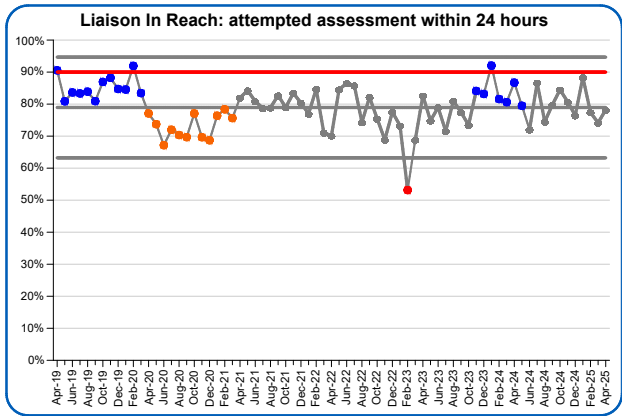


Local measure 930: Q4 984

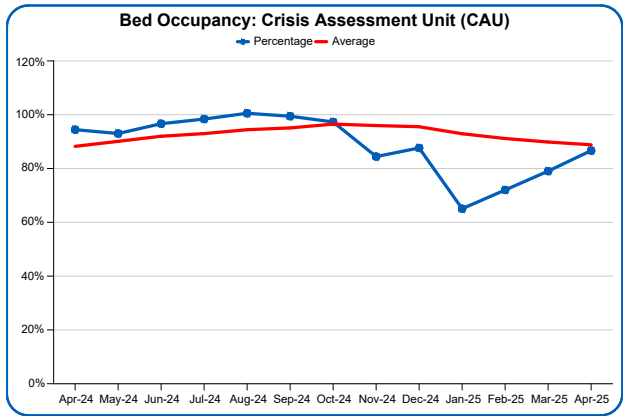
Services: Our acute patient journey



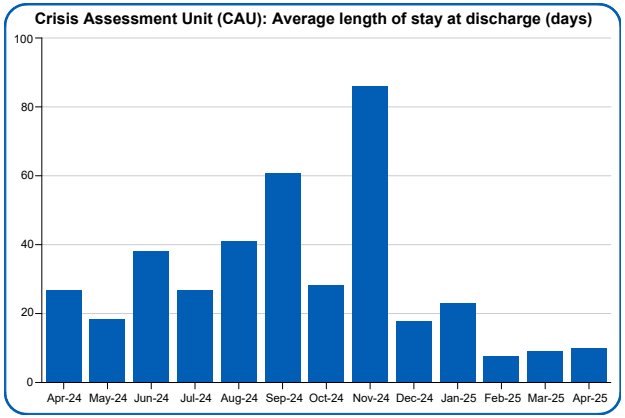
National (NOF) No target : April 0



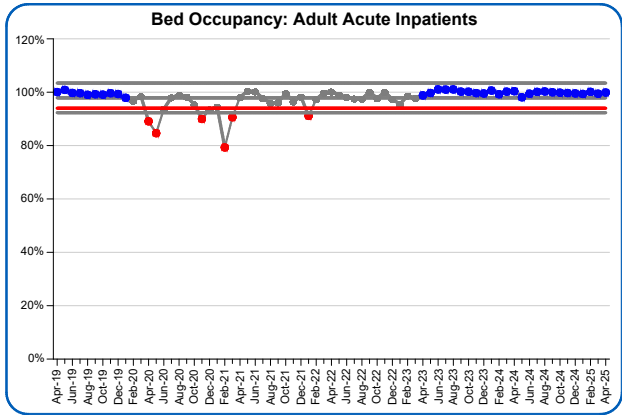
Contractual Target 90%: April 78.2%



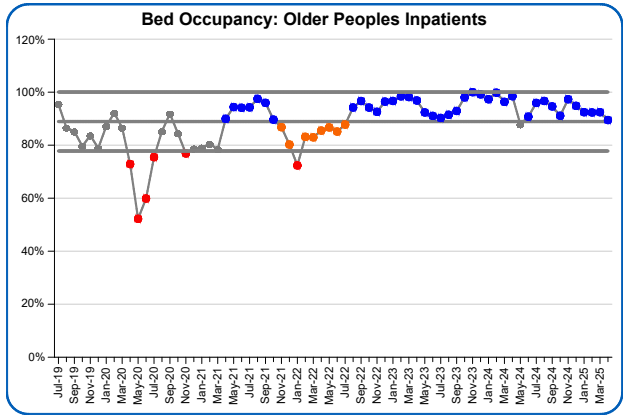
Local measure: April 86.7%



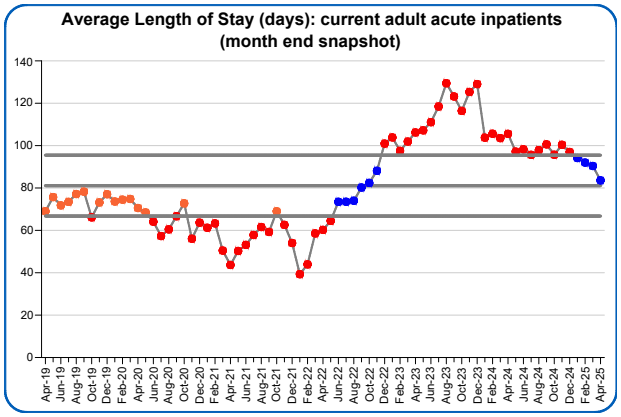
Local measure: April 10 days



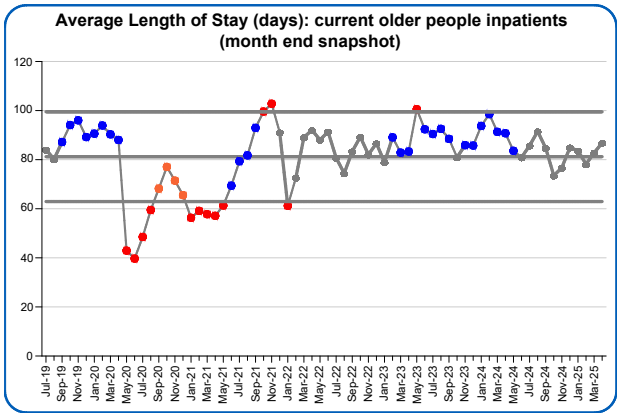
Contractual Target 94%: April 99.9%



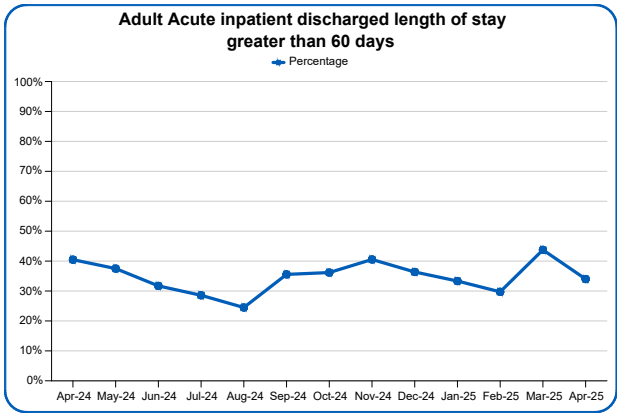
Local measure and target : April 89.5%



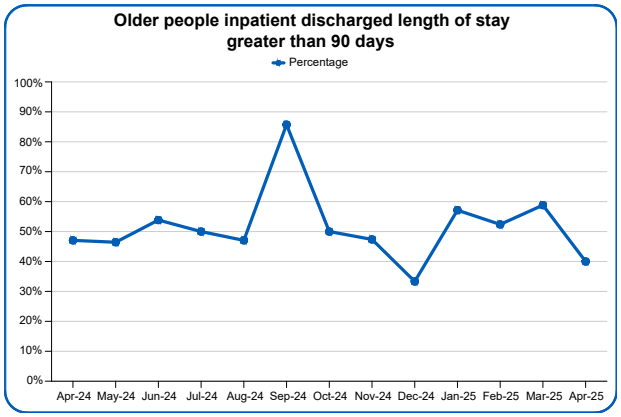
Local tracking measure: April 84 days



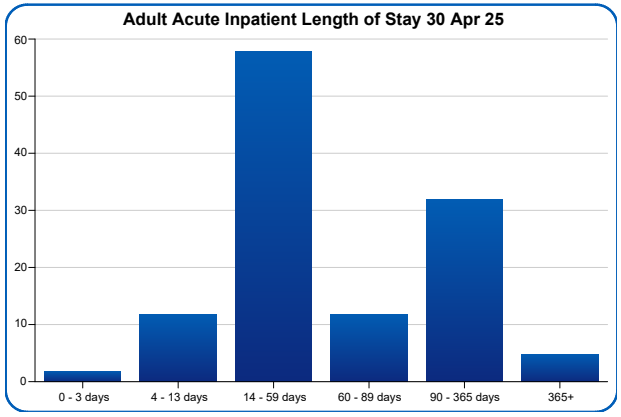
Local tracking measure: April 87 days



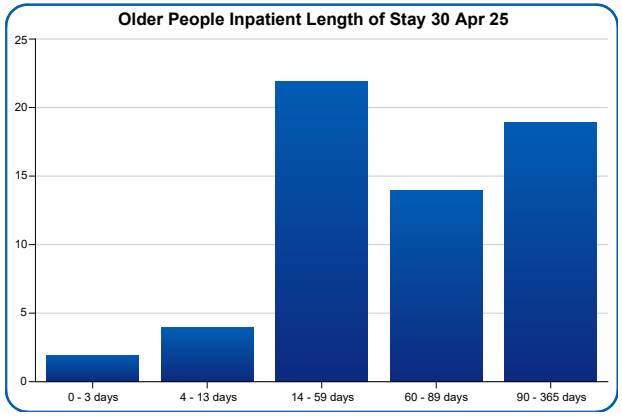
National (LTP): April 34.0%



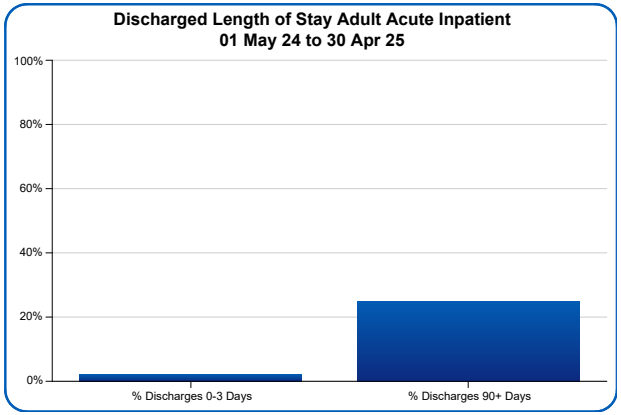
National (LTP): April 40.0%



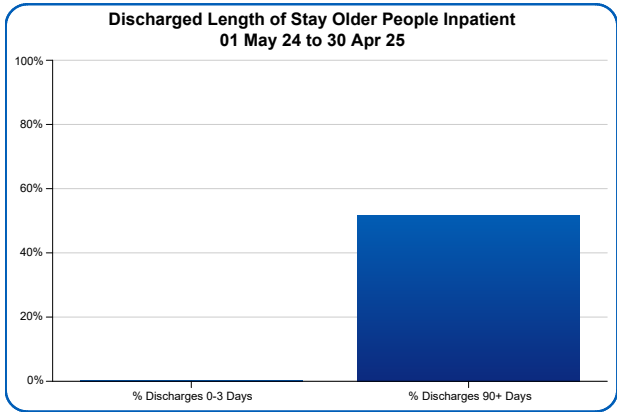
Local activity: 37 people with LOS 90+ days



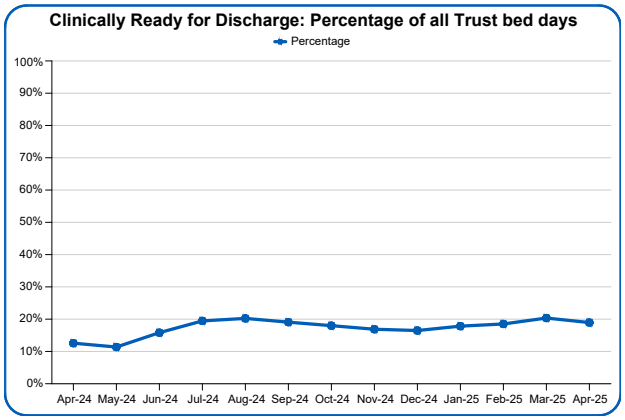
Local activity: 19 people with LOS 90+ days



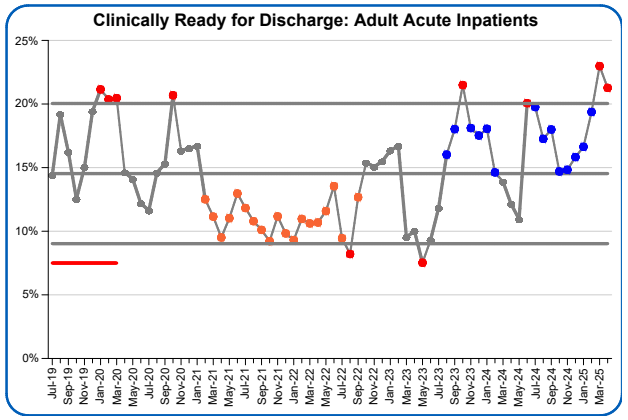
Local activity: % discharged LOS 90+ days = 25.3%



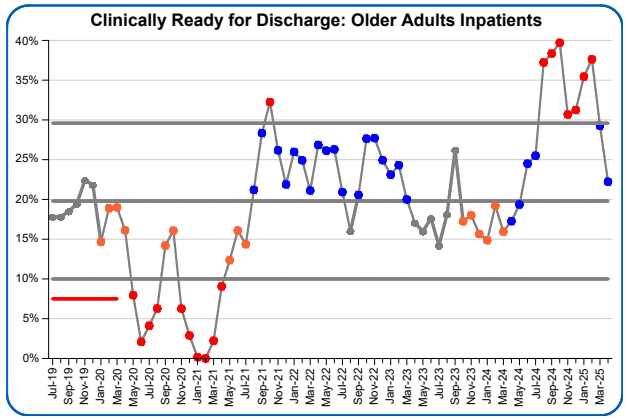
Local activity: % discharged LOS 90+ days = 51.8%



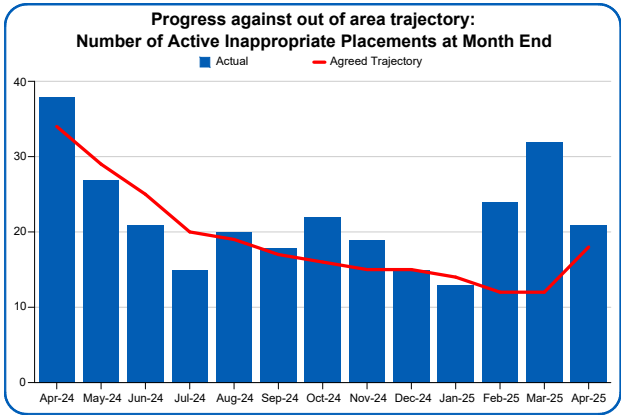
Local tracking measure: April 18.9%



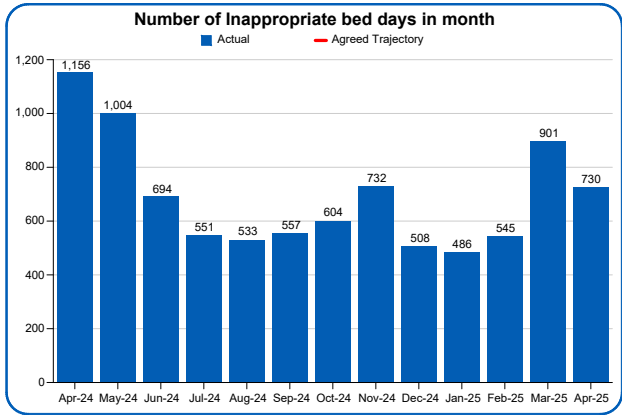
Local tracking measure: April 21.3%



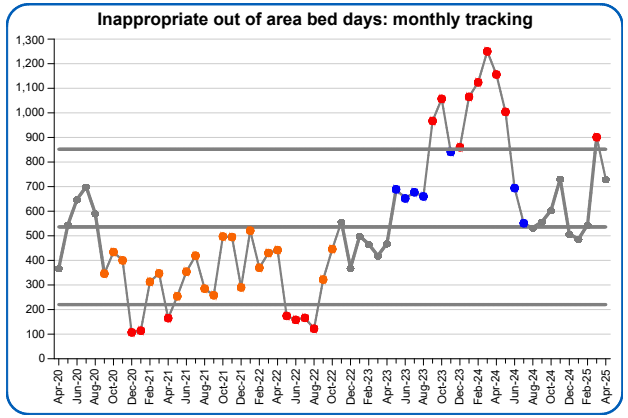
Local tracking measure: April 22.2%



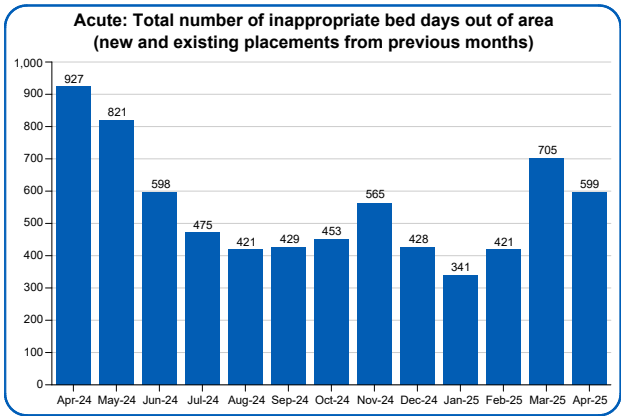
Nationally agreed trajectory (April: 18): April 21 active placements



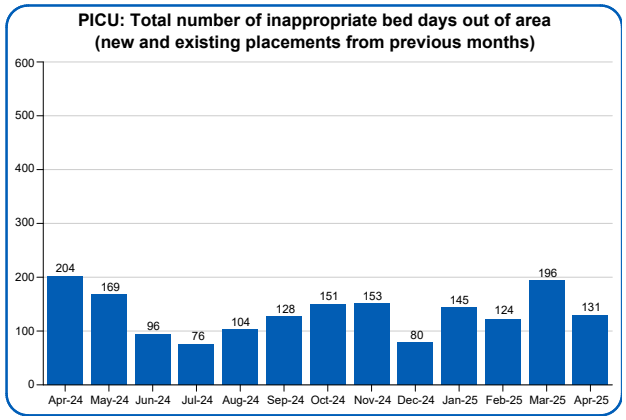
Local tracking measure: April 730 bed days



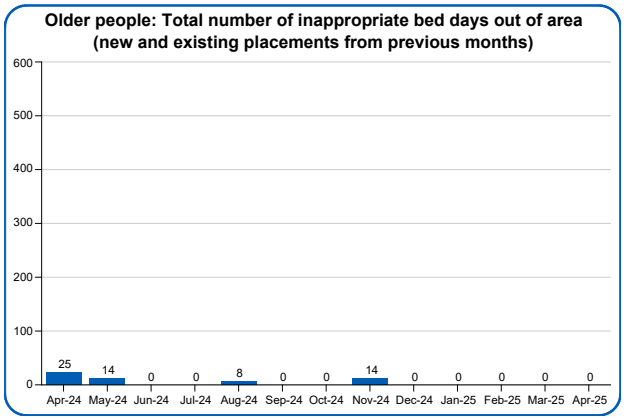
Local tracking measure: April 730 bed days



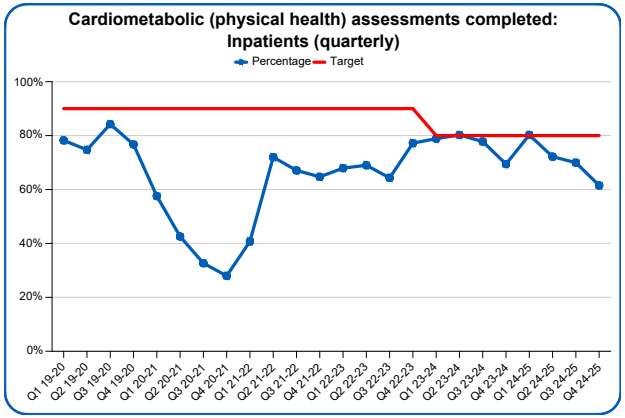
Nationally agreed trajectory (): April 599 days



Nationally agreed trajectory (): April 131 days

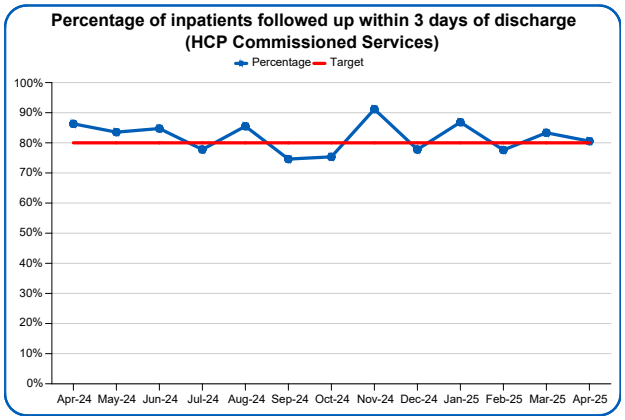


Local measure : April 0 days

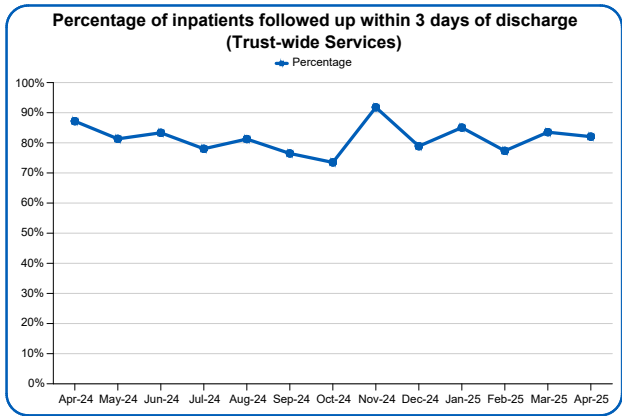


Contractual target 80%: Q4 61.5%

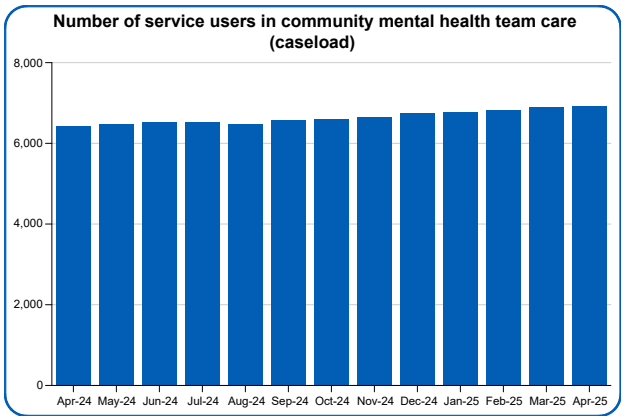
Services: Our community care



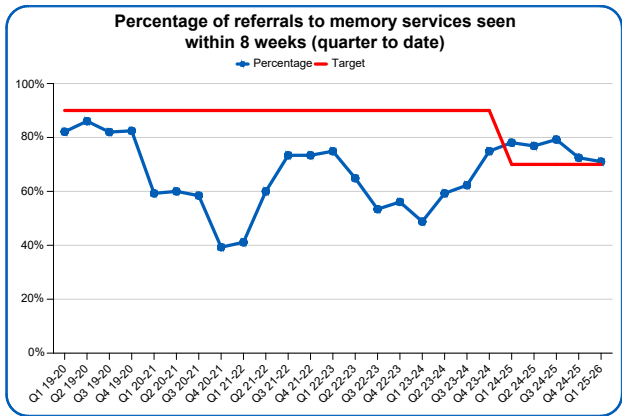
Contractual target 80%: April 80.6%



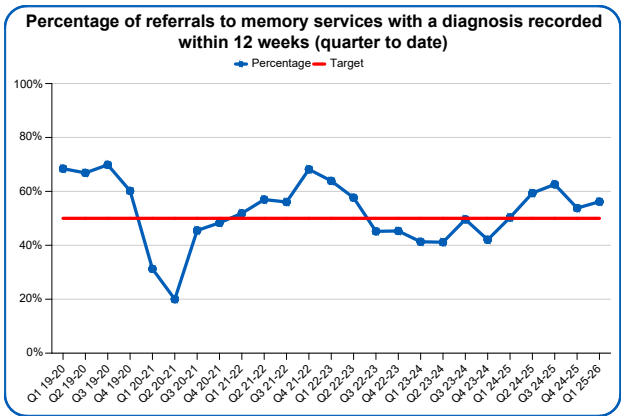
Local Tracking Measure 80%: April 82.1%



Local measure : April 3,225

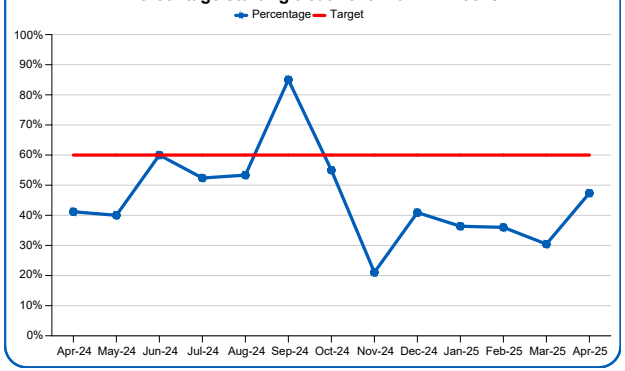


Contractual target 70%: Q1 25-26 71.0%



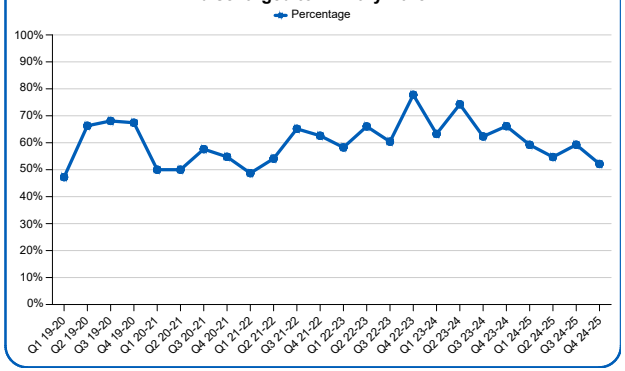
Contractual target 50%: Q1 25-26 56.2%

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



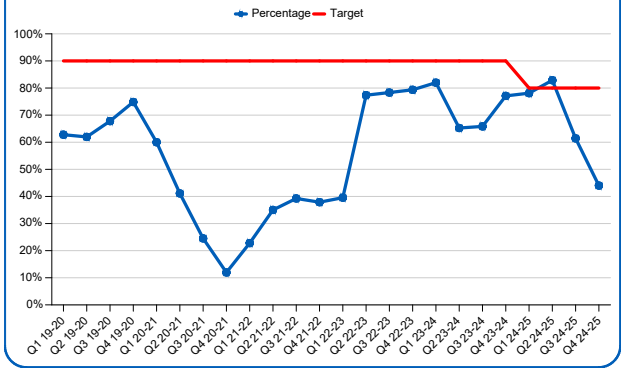
Contractual target 60%: April 47.4%

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



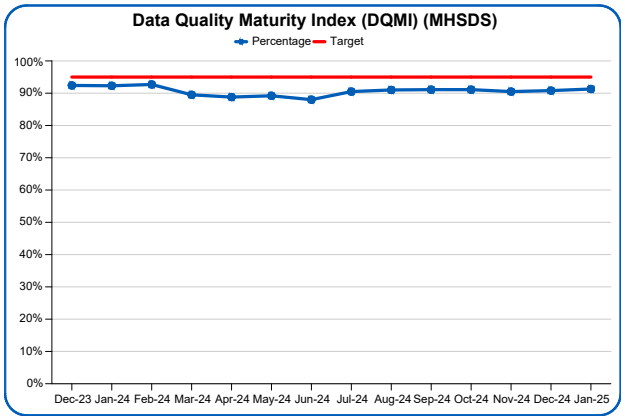
Contractual target tbc: Q4 52.1%

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

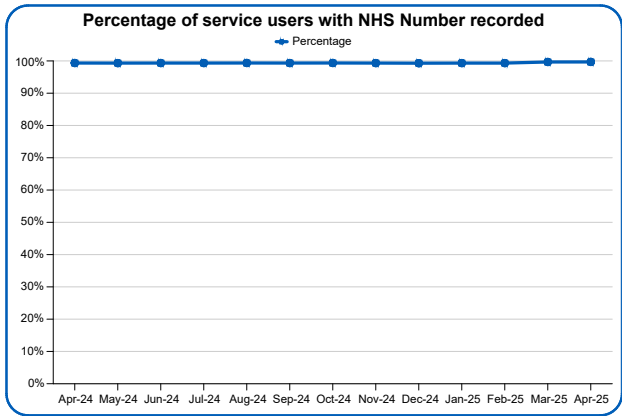


Contractual target 80%: Q4 44.0%

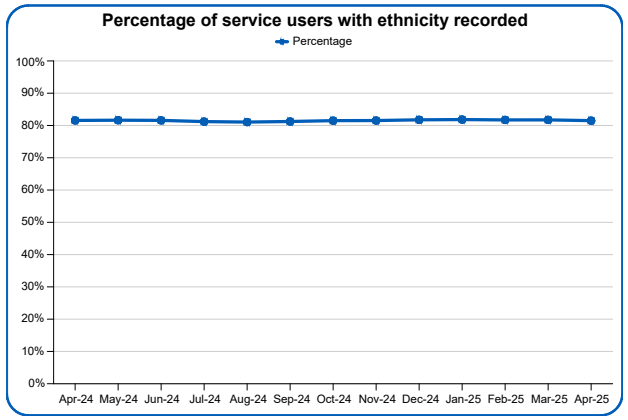
Services: Clinical Record Keeping



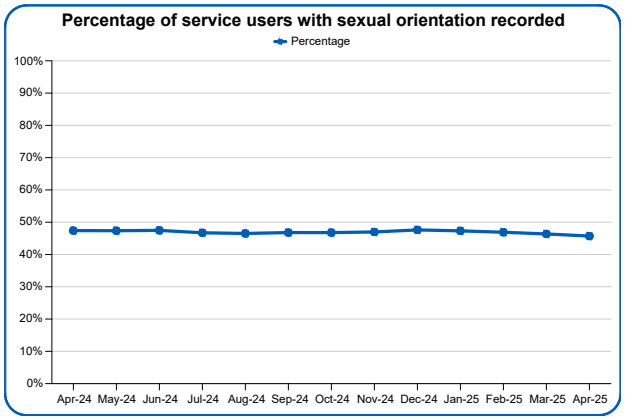
CQUIN / NHSOF Target 95%: January 91.3%



Local measure: April 99.7%



Local measure: April 81.5%



Local measure: April 45.7%

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.
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 Occupied Bed Days Clinically Ready for Discharge	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	Of all the referrals open during the period, the proportion where the service user's ethnicity is recorded on their

recorded	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.

Agenda item
12.1

Meeting of the Board of Directors

Paper title:	EPRR and Business Continuity Policy EP-0005
Date of meeting:	29 May 2025
Presented by: (name and title)	Joanna Forster Adams – Chief Operating Officer and Accountable Emergency Officer
Prepared by: (name and title)	Sam Grundy – Head of EPRR

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 document is for information and comment. It is an updated version of the policy from 2024 that details the Trust's approach to EPRR and Business Continuity as required by NHS England Core Standards. The policy was found to be compliant by NHS England last September but now contains a modified section on training in both the EPRR and Business Continuity sections following the issue of new guidance by NHSE.

The Board of Directors have responsibility for approving this policy before ratification at Policy and

Procedures Group in June 2025.

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 approve the EPRR and Business Continuity Policy.

EPRR and Business Continuity Policy

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

1. This document contains Leeds and York Partnership NHS Foundation Trust's EPRR Policy and Business Continuity Policy.
2. The document sets out the responsibilities within the organisation for business continuity and EPRR (Emergency Preparedness, Resilience and Response)
3. A separate document EP-0018 – Business Continuity Management System Procedure describes the detailed processes around the Trust's systems for training staff on business continuity planning and writing, testing, and revising plans.
4. The document identifies a requirement for all those who provide services, either to the community or to other Trust functions, to have explicit and effective business continuity arrangements commensurate with the scale of their operation.

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

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

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

Amendment detail

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

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

		specifically individuals with responsibilities in plans. • Section 1.1.2 updated with the process for unplanned expenditure due to a disruption (page 9). • Section 1.1.6 (page 13) updated to reflect the new EPRR risk management procedure. • New Appendix 2 created replacing previous appendix due to the introduction of NHS EPRR commander portfolios. • 1.2.6 rewritten to acknowledge the new approach to assessing business continuity arrangements of suppliers.
7	March/April annual review.	• Annual Review • New Appendix 1 – showing commander training portfolios.

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1. THE PROCEDURE

1.1 EPRR Policy Statement

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

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

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

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

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

1.1.1 Roles and Responsibilities

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

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

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

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

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

Other Staff with EPRR responsibilities

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

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

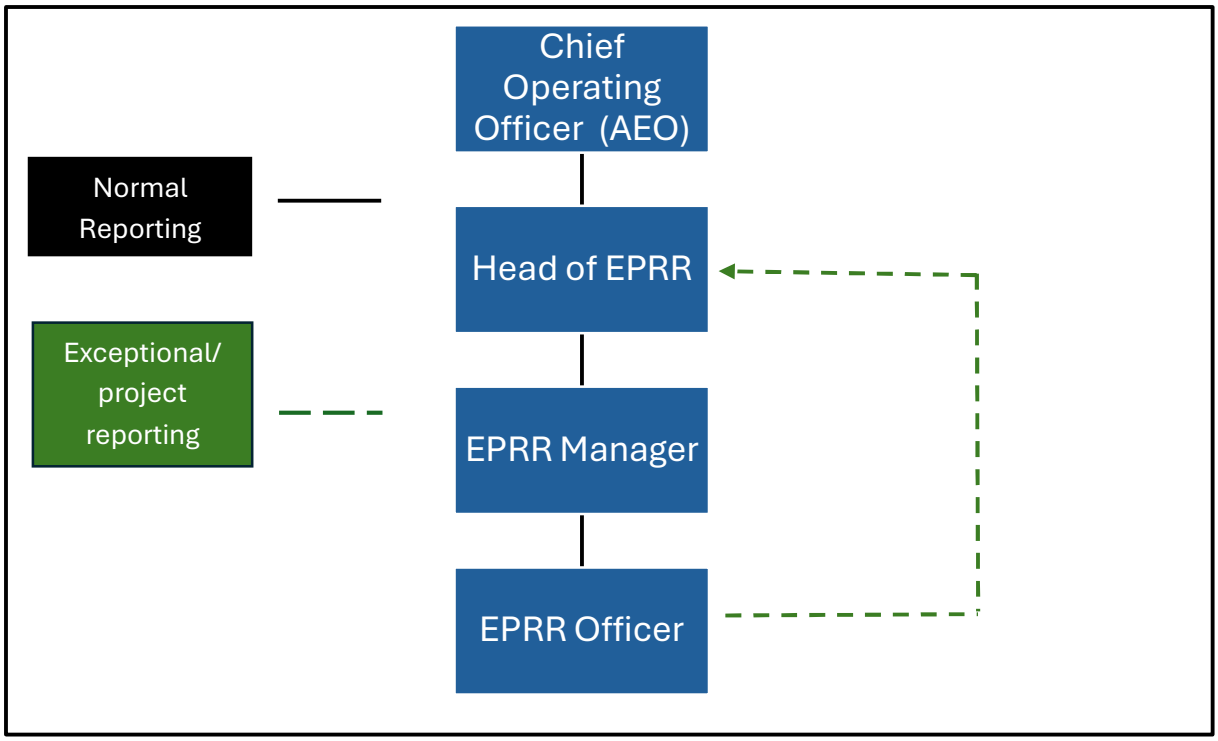
- The Head of EPRR provides day to day management of the EPRR team and supports the AEO with technical advice. The Head of EPRR has responsibility

for plan maintenance, updates, communication in consultation with the Corporate Governance Team following successful ratification of plans and policies at the Policies and Procedures Group.

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

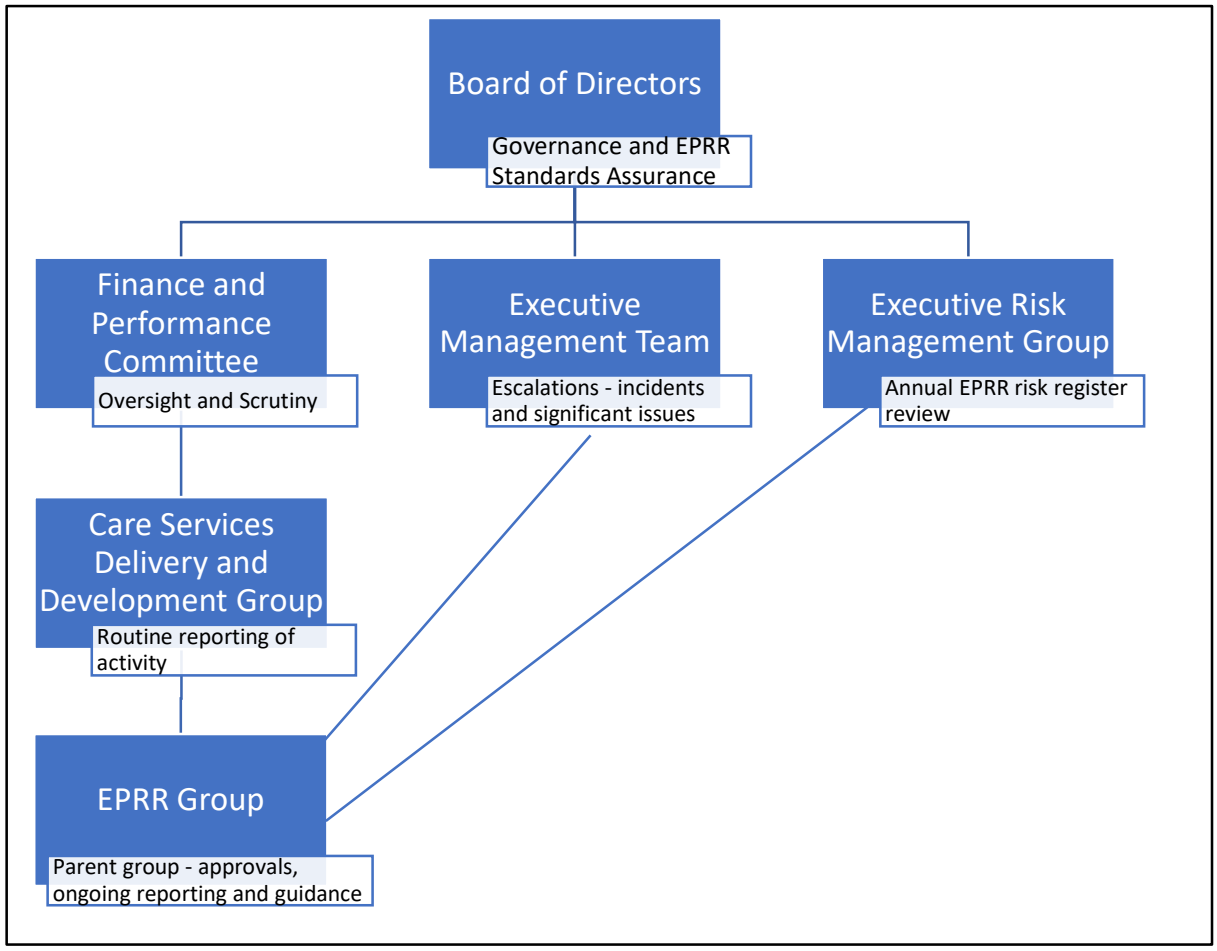
    - The Head of EPRR has responsibility for risk assessments around CBRN/HAZMAT.
    - The EPRR officer has responsibility for equipment checks, procurement of IOR equipment and liaison with staff regarding Initial Operating Response (IOR) boxes.
    - The responsibility for training is shared amongst the EPRR team.
    - CBRN audits will be coordinated by the Head of EPRR and EPRR Manager with Yorkshire Ambulance Services (YAS) staff.
    - The EPRR Group will oversee the CBRN/ HAZMAT programme, audit findings and any equipment requirements.

Reporting lines are shown below, and the Head of EPRR directly reports to the AEO.



1.1.2 Governance and Reporting

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



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

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

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

Non-core Members

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

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

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

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

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

The Executive Management Team is responsible for managing any urgent escalations regarding operational EPRR matters, resource issues such as increased funding for EPRR or the ongoing reporting of significant disruptions/ threats to business continuity.

In the latter category examples such as EU exit and the Covid pandemic illustrate this reporting line.

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

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

Resources

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

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

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

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

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

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

1.1.3 Scope of EPRR

The requirements are for all Trust services to comply with NHS England Core Standards for EPRR as far as these standards apply to the service or directorate.

Services or directorates whose services or responsibilities overlap with specific EPRR areas such as outbreak management, security – lockdown plans will be expected to produce plans in collaboration with the Head of EPRR that meet all specific NHS England EPRR requirements for these plans.

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

1.1.4 Planning EPRR work

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

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

1.1.5 Lessons Learned

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

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

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

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

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

1.1.6 EPRR Risk Management

Incident risk registers

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

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

EPRR Risks

A procedure detailing the Trust's management of EPRR risks (EP-0016) shows how EPRR risks are managed. In summary:

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

Sources of EPRR Risks

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

Risk assessment governance.

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

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

1.1.7 EPRR plans

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

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

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

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

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

1.1.8 Training and Exercising

EPRR Training

EPRR commander training was introduced in June 2022. In 2023 NHSE introduced training portfolios that sought to ensure commanders at strategic and tactical level and EPRR specialists could access training to demonstrate their competence to fulfil their role.

Training requirements are divided as follows with staff required to access training, either online or in person for each competency:

- EPRR specialists (20 mandatory competencies)
- Strategic Commanders (11 mandatory competencies)
- Accountable Emergency Officer (13 mandatory competencies)
- Tactical Commanders (9 mandatory competencies)
- Portfolios for Loggists and for Operational Commanders while indicated in NHS England documentation have not yet been formulated and are not live.

A full list of all requirements can be found in appendix 1.

NHS England has set the target of 80% compliance by cohort by 31 March 2025. Progress against this target is reported to EPRRG and EMT. Logs of attendance on training for all staff are maintained by the EPRR team.

The focus for 2025 has been on providing strategic and tactical commanders with the opportunity to use an exercise to develop their skills in responding to an incident through writing strategic or tactical plans. This has increased staff familiarity with decision making models and ensured they are able to meet several competency requirements as set out above. This series of exercises has also provided the opportunity to test business continuity plans.

EPRR Exercises

The Trust requires all services to hold a business continuity tabletop exercise annually. These are facilitated by the EPRR team. The Trust Business Continuity Management System Procedure EP-0018 describes how teams can meet this requirement.

Communication exercises to test on call arrangements are held every six months. These are debriefed in the EPRR group, and any lessons identified are communicated to relevant staff as per the process described above in section 1.1.5.

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

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

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

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

1.2 Business Continuity Policy Statement

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

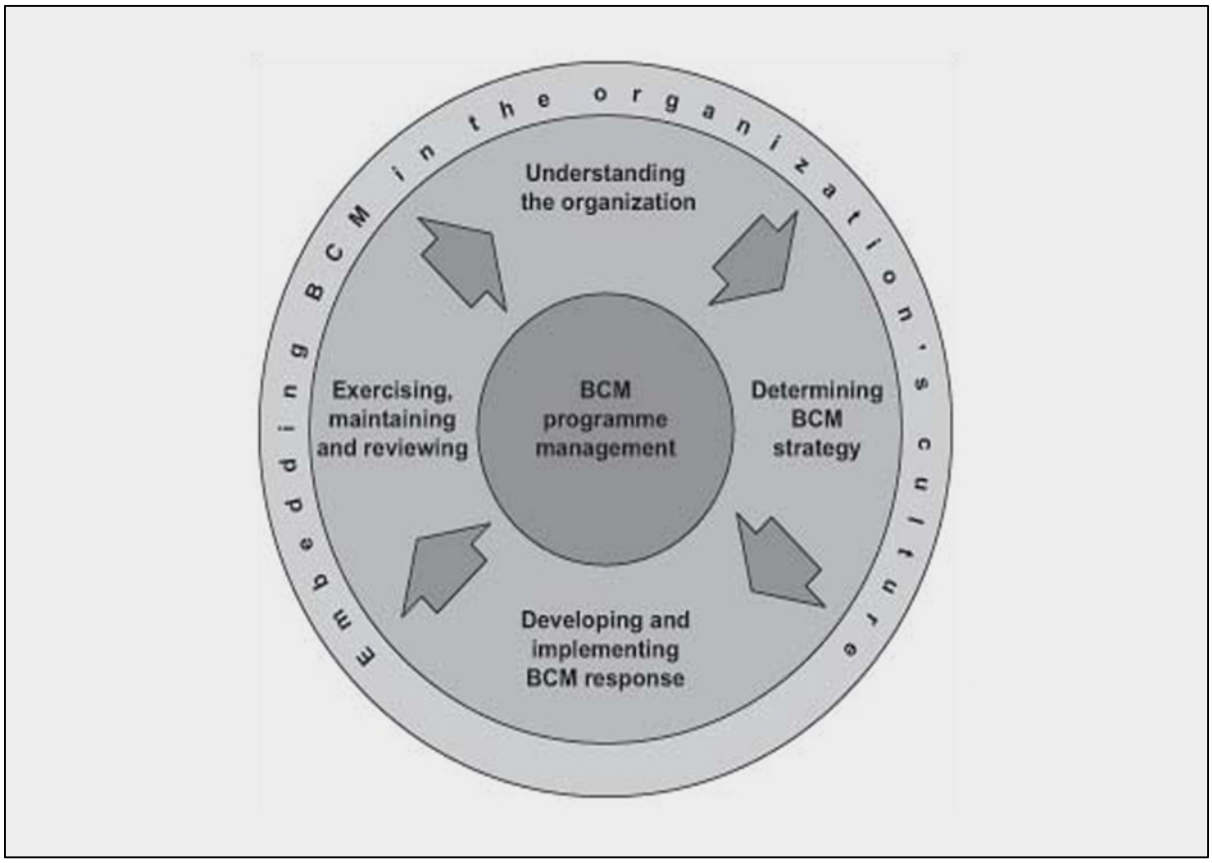
Business continuity management system is defined as:

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

Source: ISO 22301:2012

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

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



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

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

The purpose of the statement is to:

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

The strategic intent of the Trust is to have a comprehensive and properly funded business continuity management system in place that covers the Trusts major strategic activities, its statutory obligations, and its provision of care services to its patients. The Business Continuity Management System Procedure EP-0018 fulfils this intent.

Additional guidance

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

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

1.2.1 Scope

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

Acceptable Risk

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

risks. However, controlled risks should be reappraised annually as part of review of business continuity arrangements.

Dynamic risk assessment

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

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

Limitations and exclusions

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

Statutory, regulatory, and contractual duties

i. Statutory

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

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

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

ii. Regulatory

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

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

NHS funded providers to comply with a comprehensive suite of Emergency Preparedness, Resilience and Response Standards (EPRR). Some of these are business continuity related standards.

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

iii. Contractual

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

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

Interests of stakeholders

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

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

Key services in scope and exclusions from scope

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

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

1.2.2 Objectives and obligations

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

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

v. the environment.
vi. the reputation of the Trust and wider NHS.

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

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

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

- Checking that managers are updating their plans annually.
- Ensuring all plans in their area of responsibility are exercised and a debrief report has been produced in line with the requirements of the Business Continuity Management System Procedure EP-0018.

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

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

- Updating plans.
- Testing plans.

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

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

1.2.3 Resourcing and independent oversight

The Trust's Finance and Performance committee has oversight responsibilities for Business Continuity and discharges this by detailed consideration of the Trust's annual

EPRR plan and assurance declaration which is then presented to the Board of Directors.

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

1.2.4 Training

There is a requirement for the Accountable Emergency Officer, Head of EPRR and EPRR to undertake Business Continuity Awareness Training. The content of this training is being agreed with West Yorkshire ICB. The Trust will fully support this and is working to ensure ongoing professional development of key staff involved in developing business continuity plans.

Currently the EPRR Manager offers one to one training for Business Continuity Plan authors and has produced a handbook for new authors. As at March 2025 there are over 80 plans across the Trust. The EPRR Manager is examining options for more efficient delivery of training using E-Learning. In 2025 training KPIs will be added to existing KPIs within the Business Continuity Management System Procedure EP-0018 in its annual update.

1.2.5 Exercising

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

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

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

1.2.6 External suppliers and contractors

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

- Their operating and financial stability

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

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

1.2.7 Governance and Audit

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

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

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

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

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

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

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

i. **Board and Board Committee reporting**

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

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

ii. **Audit**

Business continuity plans will be reviewed on an annual basis by plan authors and signed off. Any activation of a plan will require a debrief report that will be reviewed at the EPRR group.

Peer review of plans may also be facilitated by the Head of EPRR.

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

iii. **Approval of Business Continuity Plans**

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

iv. **Document control**

Business continuity plans will be referenced using the following format:

Service_ month/date created.

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

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

1.2.8 Communication

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

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

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

1.2.9 Review of the Business Continuity Management System

The Business Continuity Management System Procedure EP-0018 will be reviewed every year and will be reviewed following any significant revision to NHS England's

standards or International Standards. The review will be carried out by the EPRR group.

1.2.10 Continuous Improvement and review

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

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

Appendix 1

EPRR Commander Training Portfolios

In February 2024 NHS England issued revised training requirements for NHS incident command staff and those who may support an incident. These have been introduced at the Trust and relevant staff are undertaking required training and presenting evidence as part of their portfolios. Compliance levels are reported every two months to EPRR Group and to WY ICB upon request.

Strategic Commander Training Portfolio:

Portfolio Reference	Requirements	Frequency	Provider	ICB	Region
SHC01	Strategic Health Commander Portfolio Workbook	Every 3 years	✓	✓	✓
SHC02	Principles of Health Command – Strategic Health Commander	Every 3 years	✓	✓	✓
SHC03	Legal Awareness Training	Every 3 years	✓	✓	✓
SHC04	Defence Contribution to Resilience (or equivalent)	Every 3 years	Optional	✓	✓
SHC05	MAGIC (or MAGIC-Lite)	Every 3 years	Optional	✓	✓
SHC06	Media Training/Awareness	Every 3 years	✓	✓	✓

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SHC07	Working with your loggist	Every 3 years	✓	✓	✓
SHC08	Business Continuity Awareness	Every 3 years	AEO's only	✓	✓
SHC09	Joint Decision-Making Awareness (initially through training and then annually through exercise application)	Annually	✓	✓	✓
SHC10	Local Resilience Forum Awareness	Every 3 years	Optional	✓	✓
SHC11	Specialist Asset Awareness	Every 3 years	Optional	✓	✓
SHC12	EPRR Communications Awareness (initially through training and then annually through exercise application)	Annually	✓	✓	✓

Portfolio Reference	Requirements	Frequency	Provider	ICB	Region
SHC13	Incident Response Plan/Command & Control familiarisation (including through application at an incident or exercise)	Annually	✓	✓	✓
SHC14	Writing a Strategy (including through application at an incident or exercise)	Annually	✓	✓	✓
SHC15	Chair a Strategic Level Meeting	Annually	✓	✓	✓

SHC16	Act as a Strategic Health Commander at an incident or exercise	Annually	✓	✓	✓
SHC17	Act as a Strategic Health Commander at an Incident or exercise with Multi-agency partners	Every 2 years	Optional	✓	✓
SHC18	Accountable Emergency Officers – Role & Expectations Development Session	Every 3 years	✓	✓	✓

Tactical Commander Training Portfolio:

Portfolio Reference	Requirements	Frequency	Provider	ICB	Region
THC01	Tactical Health Commander Portfolio Workbook	Every 3 years	✓	✓	✓
THC02	Principles of Health Command – Tactical Health Commander	Every 3 years	✓	✓	✓
THC03	Legal Awareness Training	Every 3 years	Optional	Optional	✓
THC04	Working with your loggist	Every 3 years	✓	✓	✓
THC05	Joint Decision-Making Awareness (initially through training and then annually through exercise application)	Annually	✓	✓	✓
THC06	Local Resilience Forum Awareness	Every 3 years	Optional	✓	✓

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Portfolio Reference	Requirements	Frequency	Provider	ICB	Region
THC07	Specialist Asset Awareness	Every 3 years	Optional	✓	✓
THC08	EPRR Communications Awareness (initially through training and then annually through exercise application)	Annually	✓	✓	✓
THC09	Incident Response Plan/Command & Control familiarisation (including through application at an incident or exercise)	Annually	✓	✓	✓
THC10	Writing a Tactical Plan (including through application at an incident or exercise)	Annually	✓	✓	✓
THC11	Chair a Tactical Level Meeting	Annually	✓	✓	✓
THC12	Act as a Tactical Health Commander at an incident or exercise	Annually	✓	✓	✓
THC13	Act as a Tactical Health Commander at an Incident or exercise with Multi-agency partners	Every 2 years	Optional	✓	✓

Appendix 1

EPRR Specialist Portfolio:

Portfolio Reference	Requirements	Frequency	Provider	ICB	Region
EPRR01	EPRR Specialist Advisor Portfolio Workbook	Every 3 years	✓	✓	✓
EPRR02	Principles of Health Command – Strategic& Tactical Health Commander	Every 3 years	✓	✓	✓
EPRR03	Diploma in Health EPRR (or equivalent)	Once	✓	✓	✓
EPRR04	Legal Awareness Training	Every 3 years	Optional	✓	✓
EPRR05	Defence Contribution to Resilience (or equivalent)	Every 3 years	Optional	Optional	✓
EPRR06	MAGIC (or MAGIC-Lite)	Every 3 years	Optional	✓	✓
EPRR07	EPRR Media Training/Communications awareness	Every 3 years	✓	✓	✓
EPRR08	Working with your loggist	Every 3 years	✓	✓	✓
EPRR09	JESIP Awareness/Training	Annually	✓	✓	✓

Appendix 1

Portfolio Reference	Requirements	Frequency	Provider	ICB	Region
EPRR10	Structured Debrief Training	Once	✓	✓	✓
EPRR11	CBRN Training (including PRPS)	Every 3 years	✓	✓	✓
EPRR12	ESORT Awareness	Every 3 years	Optional	Optional	✓
EPRR13	HART Awareness	Every 3 years	N/A	N/A	✓
EPRR14	CT Awareness	Every 3 years	N/A	N/A	✓
EPRR15	Senior Emergo Instructor	Once	Optional	Optional	✓
EPRR16	Business Continuity Awareness	Every 3 years	✓	✓	✓
EPRR17	Joint Decision-Making Awareness (initially through training and then annually through exercise application)	Annually	Optional	✓	✓
EPRR18	Local Resilience Forum Awareness	Every 3 years	Optional	✓	✓
EPRR19	Specialist Asset Awareness	Every 3 years	Optional	Optional	✓

Appendix 1

Portfolio Reference	Requirements	Frequency	Provider	ICB	Region
EPRR20	Equality, Diversity & Inclusion within EPRR	Annually	✓	✓	✓
EPRR21	Facilitate a debrief (inc. through exercises with a minimum of one structured debrief within 3 years)	Annually	✓	✓	✓
EPRR22	Undertake a risk assessment	Annually	✓	✓	✓
EPRR23	Develop and maintain plans (EPRR)	Annually	✓	✓	✓
EPRR24	Develop and maintain plans (BCM)	Annually	✓	✓	✓
EPRR25	Develop and deliver training and exercising (internally within your organisation)	Annually	✓	✓	✓

Appendix 2

EPRR Staff and contact details.

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

Role	Name	E-mail	Trust mobile
Accountable Emergency Officer	Joanna Forster Adams	joanna.forsteradams@nhs.net	
Head of EPRR	Sam Grundy	Sam.grundy1@nhs.net	07815 454570
EPRR Officer	Lizzy Bridson	elizabeth.bridson@nhs.net	07966 421256
EPRR mailbox		lmh-tr.EPRR@nhs.net	

Business Continuity Leads for services and corporate directorates are:

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

PART B

3 IDENTIFICATION OF STAKEHOLDERS

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

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

4 REFERENCES, EVIDENCE BASE

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

Standards:

ISO 22301, Societal security — Business continuity management systems — Requirements
ISO 22313, Societal security — Business continuity management systems — Guidance
ISO/TS 22317 Societal security — Business continuity management systems — Guidelines for business impact analysis (BIA)
BS 25999-1:2006 - Business continuity management – Part 1: Code of practice
BS 25999-2 Business continuity management — Part 2: Specification
PAS 2015:2010; Framework for Health Service Resilience
NHS England: Emergency Preparedness, Resilience and Response Framework 2023
NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) 2024

Guidance

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

5 ASSOCIATED DOCUMENTATION (if relevant)

Business Continuity Management System Procedure – EP-0018
EPRR Risk Procedure – EP-0014
Major Incident Response Plan EP-0004
The Risk Management Policy – RM-0001
Risk Assessment & Risk Register Procedure – RM-0004
Lockdown Policy and Procedure – RM-0010
Vehicle Fuel Disruption Plan – EP- 0002
Chemical decontamination plan – EP- 0003

6 STANDARDS/KEY PERFORMANCE INDICATORS (if relevant)

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

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

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

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

7. EQUALITY IMPACT

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

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

Print name: Sam Grundy

Job title: Head of EPRR

Date: 18 March 2025

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

*Delete as appropriate

CHECKLIST

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

This checklist is part of the working papers.

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

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

Agenda item
13

Meeting of the Board of Directors

Paper title:	Chair's Report from the Quality Committee meeting on 10 April 2025
Date of meeting:	29 May 2025
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 April 2025
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

No issues to advise the Board on.

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 throughout the course of the meeting.

- The committee received and discussed a report which contained a high-level summary of the metrics from the 2024 National Staff Survey that were relevant to quality, to enable an understanding of the Trust's culture, processes and the impact on the quality of care.

- The committee received and discussed a report titled "Service User Health & Safety Data''. It agreed that further work was required to define when incidents involving a patient were Health & Safety incidents and therefore assurance and improvement would be best led via the Health and Safety Committee and Audit Committee route or where assurance and improvement would be best led via the clinical quality groups and Quality Committee route, and/or managed through a group like the Clinical Environments Group.

  The committee also agreed that clarity was required on the reporting route for health and safety incidents. It was also suggested that work could be undertaken to review the categories on Datix as the options for reporting linked into definitions and understanding of what incidents affecting patients were Health and Safety incidents (this has become a formal action on the action log).

- It also agreed that clarity was required on the reporting route for health and safety incidents

- The committee received a paper which provided an update on the work being undertaken to embed outcome measures across the Trust and acknowledged the work that had been undertaken since the last update.

- The committee received a paper which provided an update on the progress made against the priorities and aims identified in the Trust's Patient and Carer Experience and Involvement Strategy. It acknowledged the number of involvement and coproduction projects and initiatives offered across the Trust, agreeing that coproduction felt embedded across the Trust.

Overall, the committee agreed that it was assured on the systems and processes in place to involve, and collect feedback from, the Trust's service users and carers. It also recognised the contribution and value that the Patient Experience and Involvement Team brought to the Trust.

- The committee reviewed two presentations which provided the highlights of the Acute Service Line's and the ADHD Service's Annual Quality Reports, focusing on how the services had scored themselves against the Learning, Culture and Leadership (LCL) Framework and how the services had scored themselves against the STEEEP dimensions of quality to enable the conditions for high quality care to flourish.

  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.

- The committee reviewed and approved its annual report for 2024/25.

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.

Agenda item
13

Meeting of the Board of Directors

Paper title:	Chair's Report from the Quality Committee meeting on 8 May 2025
Date of meeting:	29 May 2025
Presented by: (name and title)	Dr Frances Healey, Non-executive Director and Chair of the Quality Committee
Prepared by: (name and title)	Clare Edwards, 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:	8 May 2025
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 agreed the final version of the 2024/25 Quality Account, subject to corrections to one area of data, acknowledging the effort of the teams involved in the collation of the document.

ASSURE – items to provide assurance to the Board on

- The committee approved the approach to make resuscitation training mandated for bank staff within a six-month timeframe, however acknowledged that there may be different requirements in different areas dependent on risk. It noted that the actions would be followed up and monitored via the Workforce Committee for onward monitoring.

- The Committee acknowledged that the current format for the quarterly Combined Complaints, Concerns, PALS, Compliments and Patient Safety Report was data heavy with very detailed charts, and despite welcome improvements in some sections, other sections had limited information on themes, learning and actions taken. The committee agreed that the next quarterly report would be deferred to allow for a full review of data and reporting to the Committee, and resume with a new report format in six months.

- The Committee noted that there was a lack of clarity regarding the process for escalation and oversight of incidents requiring investigation related to spot purchased beds for out of area placements. It was therefore agreed that there was a need to clarify the oversight, escalation and sign off processes for incident investigations when they related to a service user who was in an out of area placement bed.

- The Committee discussed proposed arrangements for governance of the Equity Strategy and acknowledged the previous discussions regarding the governance arrangements as it fell across the organisation. The Committee agreed that the proposed arrangements were sensible, including PCREF oversight remaining with the Mental Health Legislation Committee and made minor suggested to further improve the proposed governance structure.

- The Committee received the Children & Young People Services Annual Quality Reports and was assured that the service line 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, culture and leadership. The committee was also assured that the Executive Team had a clear understanding of the service line's strengths, weaknesses, challenges and blind spots and how issues were being managed.

REFER - Items to be referred to other Committees:
• The legal requirement for Health and Safety Training was referred to the Audit Committee for further discussion and action, acknowledging that discussions were ongoing with neighbouring organisations regarding a joint solution for provision.

Recommendation

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

Agenda item
14

Meeting of the Board of Directors

Paper title:	Director of Nursing and Professions Quarterly Report
Date of meeting:	29 May 2025
Presented by: (name and title)	Nichola Sanderson. Director of Nursing and Professions
Prepared by: (name and title)	Nichola Sanderson Director of Nursing and Professions

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 provides an update and overview of key programmes of work and progress with the Nursing and Professions Directorate which centre around the continued ambition to provide safe, effective, high-quality care to all who are involved in LYPFT and the wider ICS.

The paper includes updates on key projects the team is leading on, both local and national. Included is a brief summary of the overarching report of investigations directed by the Secretary of State for Health and Social Care, which highlights some of the key patient safety recommendations.

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

Recommendation

The committee is asked to be assured of the work in progress within the Nursing and Professions Directorate and how this improves patient care and safety alongside improving the skills and knowledge of the nursing and allied health professionals working across LYPFT.

Meeting of the Board of Directors

May 2025

Director of Nursing and Professions Quarterly Report

This paper provides an update and overview of key programmes of work and progress within the Nursing and Professions Directorate, which centers around the continued ambition to provide safe, effective, high-quality care to all who are involved in LYPFT and the wider ICS.

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)

ReSPECT is a process which creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make decisions or communicate for themselves. The process includes recording a summary of the conversation with a person, their family/those close to them and one or more clinicians. This is recorded on a plan called the ReSPECT form. ReSPECT has been implemented across West Yorkshire NHS Trusts, and we are an outlier. It has been agreed that ReSPECT will be implemented across the in-patient services at LYPFT. A task and finish group is in place and a stakeholder group is in development, which will commence June 2025. The Executive Lead is Chris Hosker, Medical Director, with Marie-Claire Trevett, Deputy Director for Allied Health Professions, Social Workers and clinical workforce development leading the work, supported by Pamela Hayward-Sampson as the Project Lead. This is in the early stage of work and is expected to be completed in 12-18 months. Updates will be provided via TWCG.

CPD Funding

It has been confirmed that we will again be receiving CPD funding from NHS England that can be spent supporting Registered Nurses, Nursing Associates and Allied Health Professionals to access training and development. Although we do not know the exact amount yet, it has been indicated that this will be at a similar level to previous years. This means that there will be ample funding to continue a similar level of support to previous years and also to extend the offer, as historically we have not been able to fully spend previous allocations. So far, we have extended the highly successful Legacy Mentor role for nurses, and they will continue to work with nurses at that critical post preceptorship phase, where they have had a significant impact on retention rates and confidence of the nurses who have access this support. In addition, plans are in place to continue with Clinical Educator roles to support the skills development of trainee nurses and Nursing Associates, which has been identified by both students and universities as having a significant impact on the skills of the future workforce. In addition, we are introducing an AHP Educator role to support registered Allied Health Professionals in the transition period from student to registered Practitioner, with the aim that this will mirror the positive impact we have seen in the nursing focussed roles. We will also support the new training and development process by identifying at the point of application, how the funding can be used to support training that would otherwise come from service budgets, as well as supporting purchasing of training packages that can be used in the longer term, for example activity of daily living training videos.

Catering in Mental Health & Learning Disability Inpatient settings

A new set of national guidance for catering in Mental Health and Learning Disability settings has been published, authored by LYPFT Principal Dietetic Practitioner Amy Pratt. It identifies ways that catering can contribute to tackling physical health inequalities in severe mental illness and learning disabilities, and its fundamental role in treatment for eating disorders. Amy is working with Estates and Facilities colleagues to continually improve our catering provision at LYPFT in line with the new guidance.

The British Dietetic Association guidance provides recommendations for improving patient meal services and provision, for example, ways to avoid menu fatigue for service users who have long lengths of stay in our mental health wards by including them in menu reviews, extending menu cycles and acting on feedback from service users. A further example is constipation and how diet can reduce this for service users. 50% of service users prescribed antipsychotic medication experience constipation, exacerbated by poor fluid intake and poor diet with sedentary periods on the ward. The guidance makes a number of recommendations on how to improve diet and fluid to avoid constipation.

Care Certificate

The Care Certificate is an identified set of standards that non-regulated Health and Social Care Workers are recommended to complete. It was introduced in 2015 following the Cavendish Review and should be the benchmark for staff induction when entering a care role. The Care Certificate enables Health and Social Care Workers to develop the same introductory skills, knowledge, and behaviours to provide compassionate, safe, and high-quality care and support. Providers of Health and Social Care should be able to demonstrate that staff have or are working towards the skills set out in the Care Certificate.

The Care Certificate was introduced into the organisation in 2015 however the number of staff completing this has varied over time with no clear strategy or governance to support the compliance of the initiative. A task and finish group has been created to support the organisation's understanding of the barriers that are experienced regarding the completion of the Care Certificate. Completion of the care certificate training has increased since commencement of this workstream, most recently the Learning Disability Services have achieved 100% completion of care certificate training for all Health Care Support Workers.

A mapping process was completed specifically focusing on the recruitment stage and the use of Learn to support identification and recording of those who have Level 2 training and subsequently will be exempt from the Care Certificate. Learn has been updated to allow this process to be actioned by approving managers. A list of eligible level 2 training has been created to support recruiting managers. This new process will be rolled out Trust-wide in the coming months.

Head of Nursing Post

Miriam Blackburn has been appointed to a 12 month secondment to the Head of Nursing Post. Miriam was the Professional Lead for Nursing and has worked at LYPFT in a number of senior nurse leadership roles.

Nursing and Professions Team Away Day - 24th March 2025.

The Professional Leadership Team (Nursing, AHP, and Psychological Professions) met for the first time

for a facilitated away day. The opportunity was used to build relationships, enhance connections and understand the different leadership structures, capacity, resources, responsibilities, and current workstreams. Each profession identified five priorities and articulated how these have an impact on quality, service user and staff experience. Next steps include improving communication about the work being undertaken and looking at how the capacity of the team is best utilised.

National Early Warning Score 2 (NEWS2)

NEWS2 has been successfully launched across all inpatient services in The Mount, The Becklin Centre (including the ECT department, CAU and 136 Suite) and The Newsam Centre; meaning a total of 19 inpatient clinical units (68%) have been moved over to using NEWS2 from the Modified Early Warning Score (MEWS).

Remaining inpatient clinical areas (Clifton, Asket) are planned to be moved over to NEWS2 over the coming weeks, aiming for all areas to be using NEWS2 by end of May 2025.Training is scheduled for 6 sessions across a 2 week period for all sites.

A NEWS2 audit has commenced with the clinical teams at the Mount. Clinical Team Managers have been provided with a report to highlight the findings and an offer made by the Physical Health In Reach Team (PHIT) to support clinical teams in making improvements. Following discussion with the Practice Development Nurse in Older Peoples Service, the audit results are going to the service Clinical Improvement Forum (CIF) in May 2025 for exploration and action planning; allowing time for individual teams to consider the results and formulate solutions to share. Initial audit findings suggest that staff have adapted well to NEWS2, the main issue is staff continuing to transcribe observations using booklets, paper when taking observations and adding the results to the observation charts later on. This is similar to the findings in MEWS audits and is likely to be custom and practice. This occurred much less when patient observations are taken in the clinic room where the observation charts are to hand. The Physical Health In Reach Team are working with the Clinical Team Managers to address this unsafe practice. Audits for the remaining sites are planned to begin 4 weeks after the launch of the document in that area and feedback will be provided to Clinical Team Managers as well as an offer to attend Clinical Improvement Forums. Once complete the NEWS2 audit will be added to the MEG system and form part of the Trusts annual audit rota. The Physical Health In Reach Team will continue to offer support and training to clinical teams in completing physical health observations and completing the NEWS2 document correctly.

A project report will be drafted to share at the 4 in 1 meeting in August 2025 for comment and will form part of the Physical Health In Reach Team annual report.

For our patients who are pregnant we continue to use the Modified Early Warning Score as NEWS2 is not suitable for use in the 2nd and 3rd trimester due to the escalation of blood pressure increase not being sensitive to lower levels of increase in pregnancy. The Resuscitation Team at LYPFT advise that we will wait until the whole Trust has stopped using MEWS and then adopt the Maternity Early Warning Score, as this is likely to also be called MEWS and there is a potential safety concern with 2 processes with the same name. Staff are supported by the Physical Health In Reach Team and Resuscitation Team regarding physical health monitoring for pregnant patients and the information relating to pregnancy and observation is included in the NEWS2 training. The Resuscitation Team are working with 2 members of the Perinatal Service to develop safe practice as we transition. This has highlighted a gap within the

organisation as we do not currently have any guidelines or policy for supporting pregnant women in our services. For example, ensuring they have the correct dietary advice, access to relevant health care support. A task and finish group is being established to address this. With regarding to CAMHS Inpatient Services, a meeting is being held in June 2025 with the Physical Health In Reach Team, Resuscitation Team and the Children and Young People Service to agree on the best early warning score to replace MEWS.

Risk Assessment and Safety Planning Project

The RAMP has now gone live in LYPFT following a robust process of design and implementation led through a Trust wide group with representation across services. Access to FACE and SAMP was made read only as of the 24th February 2025. The C-0011 procedure has been re-written and is now available on Staffnet for all colleagues. Improvement measures and feedback mechanisms have been identified to inform an evaluation of how this change has impacted on practice. Following a change in leadership, the next phases of work will continue with completion of an initial evaluation of RAMP and a review of the use of Safety Planning in LYPFT.

In terms of evaluation and measuring improvement, a baseline audit of risk assessments is underway, which will be repeated post-implementation to establish if quality has improved. Staff feedback will be gathered to understand the user experience and perceptions on how it has impacted clinical practice. It is still being explored how we can effectively capture service user and carer feedback, which is something that the Personalised Approach to Risk element of the Culture of Care programme that the Trust are a part of, may be able to further support with.

An electronic feedback form remains available for staff to ask questions or to provide feedback during the implementation, which will help to iron out any teething problems and inform initial evaluation.

The next steps of the project, alongside the evaluation of RAMP, will be to review the Trusts current position in relation to Safety Planning. Due to a change in the dedicated leadership of this project, this work will commence once the leadership transition has taken place in the coming weeks ahead.

Response to the independent investigation into the care and treatment of VC.

On 13 June VC tragically killed three people and seriously injured three others in Nottingham. VC pleaded not guilty to three counts of murder but guilty to manslaughter on the basis of diminished responsibility. VC was made the subject of a Hospital Order, under Section 37 of the Mental Health Act 1993. In anticipation of the publication of the Independent Investigation into the Care and Treatment provided to VC each of the provider Trusts within West Yorkshire ICB were requested to complete an organisational review which will was in turn collated into an ICB response and submitted back to NHSE on 30th September 2025.

A series of task and finish groups were initiated to coordinate with each of our community services identified completing a Maturity Index Self-Assessment Tool collaboratively between operational and clinical colleagues to assess their current level of service provision and identify any areas of improvement required. The reviews have been aggregated into an organisational response which in turn was submitted to the ICB.

The first of a series of workshops were held to review each service, actions to identify themes across the organisation and to ensure learning was shared across care services. Each service is now working on the areas for improvement to ensure that they are able to better meet the needs of the population they serve.

The outcomes of the self-assessment tool were able to demonstrate that the organisation had relevant systems, policies and processes in place to support the care and treatment of those with Serious Mental Illness (SMI). However, to provide additional assurance a further piece of work was required to ensure adherence in practice against these areas. A case review was therefore completed following the development of an audit tool which was underpinned by local and national guidance outlined below:

- Statutory guidance: Discharge from mental health inpatient settings
- NICE Guidance: Clinical guideline (CG178) Psychosis and schizophrenia in adults: prevention and management
- Trust procedure: Anti-psychotic medication side effects monitoring and management procedure (C-0047)
- Trust procedure: Did not attend (DNA) procedure (SG-0010)
- NICE: Psychosis and schizophrenia: What monitoring is required?
- NICE: Treatment summaries: Psychoses and related disorders
- Maudsley Prescribing Guidelines
- Leeds Formulary

The results were shared at the workshop before sharing further through local governance groups. This was complemented by a staff questionnaire to explore knowledge, skills and awareness of applying policy to practice and any barriers that front line staff experienced.

A second workshop was held to explore the findings and develop the associated recommendations. The task and finish group continues to monitor the development and implementation of the action plans. Following publication on 5th February 2023 of the independent investigation into the care and treatment commissioned by NHS England. The purpose of the investigation was to identify learning from the care and treatment provided to VC. The investigation focuses on identifying learning at a local, regional and national level to reduce the likelihood of such tragic events. The analysis within the report identifies critical missed opportunities within Nottinghamshire Healthcare NHS Foundation Trust and sets out findings and recommendations to ensure all providers can learn from this tragic incident and work across integrated care boards to ensure that robust plans are in place to reduce the likelihood of such incidents occurring.

The Director of Nursing and Professions led a review of the ten local actions identified in order to understand and explore the findings and provide assurance and/or improvement work for the organisation. The review of the recommendations will be synthesised with existing workstreams underway which are ongoing or have been developed in response to the Trust's analysis and understanding of any gaps in service provision and/or practice.

Nursing Staff Documentation – Task and Finish Group

Quality checks across the organisation aligned to nursing documentation and record keeping have identified a level of inconsistency in practice and quality, which was subsequently identified as an area for development to provide a more standardised approach.

A task and finish group was developed with senior nursing colleagues across the organisation. The aim of the workstream was to work together to identify how we can support nursing colleagues to increase their competence and confidence in this area. It was agreed that improvements to documentation should include the setting out of the Mental State Examination to support assessment and clinical decision making.

An audit was completed across a section of clinical areas with the aim to identify whether nursing documentation aligned to Trust standards, and whether the key components of a Mental State Examination were applied. The audit also looked at the level of compliance in respect of these criteria and the confidence of nursing staff in the application to practice. The audit used both a case notes proforma and an anonymised staff survey. An audit report was produced and was shared in local Clinical Improvement Forums and Clinical Governance meetings.

Recommendations were made from the audit which included the development of a training package on the Mental State Examination (MSE) to support competence and confidence in this area, and the development of a tool which provides a set of guidance to clinical staff and incorporates both the MSE and the 4C's of record keeping. This training package has been delivered to all nursing staff including bank staff who regularly work in the pilot areas. The working group created a guidance tool which nursing staff can refer to in the clinical setting, this was introduced following the training being delivered. A reaudit was completed to measure progress and the impact of the recommendations, a report with the findings has been produced and will be shared in local CIG and Clinical Governance Meetings in the coming months. The re-audit found improvements in the standard and quality of nursing documentation. Further recommendations have been made which include adding the created training package to Learn to ensure this is available Trust wide,

Patient Safety Incident Response Framework

Patient Safety Partners

There had been a pause in recruitment and training of Patient Safety Partners whilst the role was reviewed and revised by the Patient Safety Team. This is to ensure that the contracts, policy and expectations are clear, and patient safety focused. The final drafts for the Trust Policy, Patient Safety Partner agreement, role description and tasks descriptions have been shared with the Patient Experience Team and all members of Unified Clinical Governance for consultation. The documents are now awaiting final approval at the Nursing and Professions Council.

Datix

The existing Datix system was not set up to support the systems thinking and thematic approach required to conduct appropriately PSIRF learning reviews and responses. A new review model was developed in co-production with all service lines willing to be involved, led by the Digital and Patient Safety Teams, and launched November 2024. The changes to the Datix forms allow seamless recording of all PSIRF related data, enables teams to upload information about SWARM Huddles, Fact Finds and After-Action Reviews directly on the system. Dashboards accruing all PSIRF related data have been created and made available by the Patient Safety and Datix teams for all service lines.

PSIRF Training Update

LYPFT initiated a robust training programme around patient safety in conjunction with the launch of PSIRF in June 2024.

- Level 1 – Essential of Patient Safety, 87% of the expected staff have now completed the level 1 training. The Bank staff completion rate for the Level 1 training is 49%, and 582 are enrolled to complete the training. This is being reviewed monthly by the Patient Safety Team and regular communications are in place with the Bank Team Managers.

- Level 2 - Access to Practice. The Patient Safety Level 2 Access to Practice course on Learn is primarily aimed at Band 6 staff and above, both clinical and non-clinical. To date, 243 staff members have completed this training. Unlike Level 1, Level 2 is not compulsory or priority training and there is no defined staff group (other than Band 6 and above) required to complete it. There are issues with the data collection for compliance with this training, with an inability to separate clinical Band 6 staff from non-clinical. It is unclear why all Band 6 staff and above are expected to complete this training, rather than those who it applies to within their job role. This will be included as a challenge to the addressed in the PSIRF annual report for 2025/6.

- After Action Review (AAR) Training. This is aimed at staff Band 6 or above who review incidents as part of their role. This is a voluntary course. An After-Action Review is a multidisciplinary team incident review method facilitated by a trained reviewer to provide independent oversight. It allows learning from these experiences, shaping the way we do things in future. To date, 203 staff members have completed this training.

- Specialist Thematic Review (STR) Training. An in-house training for STR was launched by the Patient Safety Team in March 2025. 14 members of staff (including Aspire staff) will be trained in thematic reviews by end of April 2025.

- Patient Safety Incidents Investigation (PSII) Training. An in-house training for PSII was launched by the Patient Safety Team in April 2025. 23 members of staff will be trained to undertake PSIIs in LYPFT by the end of April 2025.

- Clinical Risk Training - This training offers staff the opportunity to consider the background elements to clinical risk including some of the data on risk incidents. The clinical risk training package has been reviewed and updated to ensure it aligns with LYPFT's new approach to risk assessment, national guidance and evidence base. Rather than an e-learning package followed by 2 separate half-day modules, the content has now been combined into one full day course. Where staff have completed the previous clinical risk training, their accreditation will remain in date. In addition, clinical risk training has previously been compulsory training for registered professionals only, however, this is in the process of changing to be compulsory for all clinical staff working in patient-facing roles.

National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) Score Card 2025

The LYPFT NCISH score card was received in May. This relates to information about patient suicides in LYPFT. This included patient suicide rate, staff turnover and NCISH questionnaire response rate. Key characteristics of patients who died by suicide is also provided. The suicide rate is for a 3-year period, 2020-22, based on date of death/ non-medical staff turnover is for the period 31 October 2022 – 31 Oct 2023, and the questionnaire response rate is between 1 January 2022 to 1 September 2024.

- Suicide Rate - 4.77 (per 10,000 people under Mental Hea;th care 2020-22). Median 4.39
- Staff turnover (non-medical) – 20% between October 2022 and October 2023 (Median 14%)
- NCISH questionnaire response rate -100% (National Rate 91%)
- A significantly higher number comparted to the national data of patients who died by suicide and living alone (This was the period of lockdown)
- A significantly higher number comparted to the national data of those who died by suicide within 3 months of discharge from inpatient care.
- A significantly higher number comparted to the national data of those who died by suicide with a diagnosis of Affective Disorder.

The Director of Nursing and Medical Director will review the findings and provide a more detailed plan over the coming months.

Mental Health Inpatient settings: overarching report of investigations directed by the Secretary of State for Health and Social Care

In June 2023 the Secretary of State announced that HSSIB would undertake a series of investigations focused on Mental Health Inpatient settings. The team visited 40 care areas across 30 Mental Health care providers, meeting with families, patients and staff. It is expected that the findings of the report will contribute to the Long-Term Plan.

The report identified findings using the following headings:

- Safety, investigation and learning culture
- System integration and accountability
- Physical health of patients in Mental Health Inpatient settings
- Caring for people in the community
- Staffing and Resourcing
- Digital support for safe and therapeutic care
- Suicide risk and safety assessment

The report makes several safety recommendations, finding gaps in physical health care, including inconsistent checks, poor emergency response and misattribution of physical health symptoms to mental illness. The report highlights that people with SMI continue to face higher risks of poor physical health and premature death. The nursing and professions directorate will identify key areas of quality improvement work linking with our operational and medical colleagues.

Nichola Sanderson
Director of Nursing & Professions
May 2025

Agenda item
14.1

Meeting of the Board of Directors

Paper title:	Review of the Independent Investigation into the Care and Treatment provided to VC
Date of meeting:	29 May 2025
Presented by: (name and title)	Nichola Sanderson, Director of Nursing & Professions
Prepared by: (name and title)	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

This paper provides an overview of the findings and recommendations following the independent investigation into the care and treatment provided to VC. The paper includes the methodology and approach taken by Leeds and York Partnership NHS Foundation Trust (LYPFT) in response to the expectation that all Trusts need to assure themselves in the areas recommended for improvement that have been highlighted through the findings.

A brief overview of each of the 10 areas for improvement, recommendations and LYPFT's position against these are detailed in the paper.

Furthermore, the paper outlines the associated work carried out to date by the Trust prior to the publication of the independent report in response to the tragic events in Nottingham which has been co-ordinated through a series of collective workshops led by the Nursing and Professions Directorate which have included senior clinicians, senior operational colleagues and representatives from Pharmacy and our Patient and Carer Experience Team. This has included the following

- An analysis of LYPFT's position against the identified areas of concern highlighted in the CQC's findings and recommendations following the publication of a special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust (NHFT)
- The completion of the Maturity Index Tool which was informed by NHSE's recently published guidance to Integrated Care Boards (ICBs) regarding the care of people with severe and relapsing mental illness (SMI) who experience challenges in engaging mental health services.
- A clinical audit to benchmark a series of clinical cases meeting the criteria for those with SMI against relevant LYPFT's policies and procedure, and local and national guidance.
- Engagement in the consultation for the draft Personalised Care Framework which sets out the key actions for delivering the minimum expected levels of care for people across mental health services acknowledging a gap for those with SMI since the move away from CPA.

The task and finish group, established to in response, will continue to coordinate and progress work against the Independent Review findings, Maturity Index self-assessment outcome, findings of the CQC review and emerging guidance in relation to the draft Personalised Care Framework. Progress and updates will be coordinated through our clinical governance arrangements and will report direct to Quality Committee.

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:

- Discuss and note the content of the report.
- Be assured of the arrangements in place to monitor, support and progress the workstream in response to the findings.

Meeting of the Board of Directors

29th May 2025

Review of the Independent Investigation into the Care and Treatment provided to VC

On 13 June VC tragically killed three people and seriously injured three others in Nottingham. VC pleaded not guilty to three counts of murder but guilty to manslaughter on the basis of diminished responsibility. VC was made the subject of a Hospital Order, under Section 37 of the Mental Health Act 1993.

Executive Summary

This paper provides an overview of the findings and recommendations following the independent investigation into the care and treatment provided to VC. The paper includes the methodology and approach taken by Leeds and York Partnership NHS Foundation Trust (LYPFT) with acknowledgement of the expectation that all Trusts need to assure themselves in the areas recommended for improvement that have been highlighted through the findings.

Furthermore, the paper outlines the associated work carried out to date by the Trust prior to the publication of the independent report in response to the tragic events in Nottingham which has been co-ordinated through a series of collective workshops led by the Nursing and Professions Directorate which have included senior clinicians, senior operational colleagues and representatives from Pharmacy and our Patient and Carer Experience Team. This has included the following

- An analysis of LYPFT's position against the identified areas of concern highlighted in the CQC's findings and recommendations following the publication of a special review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust (NHFT)
- The completion of the Maturity Index Tool which was informed by NHSE's recently published guidance to Integrated Care Boards (ICBs) regarding the care of people with severe and relapsing mental illness (SMI) who experience challenges in engaging mental health services.
- A clinical audit to benchmark a series of clinical cases meeting the criteria for those with SMI against relevant LYPFT's policies and procedure, and local and national guidance.
- Engagement in the consultation for the draft Personalised Care Framework which sets out the key actions for delivering the minimum expected levels of care for people across mental health services acknowledging a gap for those with SMI since the move away from CPA.

The SMI workshops established in response to the events in Nottingham will continue to coordinate and progress work against the Independent Review findings and other work outlined above. Progress and updates will be coordinated through our clinical governance arrangements with more detailed reports being received by the Quality Committee. Each recommendation will be owned by a Deputy Director to the Executive Team best aligned to the recommendation who will be responsible for the oversight and progress of work and responsible for any governance process should this be needed.

Background

NHSE commissioned an independent review into the care and treatment provided to VC by NHS services prior to the tragic events of 13 June 2023. The purpose of the review was to identify learning from the care that is delivered by NHS care providers compared with the actual care and treatment provided to VC. The review covers the period from when VC first came into contact with mental health services in May 2020 up to 13 June 2023 when he killed three people and seriously injured three others. The Independent review focuses on identifying learning at a local, regional and national level to reduce the likelihood of the tragic events perpetrated by VC in June 2023.

Summary and Findings

A series of key findings into the main areas below were identified through the review:

- Key findings in relation to VC's care and treatment
- Key findings in relation to VC's diagnosis and medication
- Key findings in relation to VC's capacity
- Key findings in relation to decision making
- Key findings in relation to the use of assertive outreach
- Key findings in relation to the use of out of area placements
- Key findings in relation to the discharge back to primary care
- Key findings in relation to oversight, assurance, risk assessment and management

A series of recommendations have been made which includes two national recommendations and ten local recommendations for the Nottinghamshire Healthcare Trust. **See appendix A**

National Recommendations
It was acknowledged in the review that NHS England is aware of the need to improve the quality and effectiveness across a number of areas and has developed several programmes of work to drive this forward to improve the outcomes and experience for people who use mental health services. It is therefore recommended that national leaders in the next six months must come together to discuss and debate how the needs of people, similar to VC, are being met and how they are enabled to be supported and thrive safely in the community. It was further acknowledged that risk, both to the individual and potentially to others, was not fully understood, managed, documented or communicated in VC's case and therefore should be considered in discussions.

Local Recommendations
The 10 local recommendations identified in the review are made with the anticipation that there will be collaboration across the healthcare system to achieve the required change. Whilst the recommendations are directed at the Trust who provided the care and treatment for VC**, all Trusts need to assure themselves in the areas recommended for improvement.**

It is of note, LYPFT do meet 'best practice' and provide a dedicated Assertive Outreach Team and can demonstrate that they meet the best practice measure through the Maturity Index Self-Assessment. It is however, acknowledged that there is always the ability to strengthen and improve care and treatment delivery across the self-assessment domains. The development of a Complex Psychosis Pathway will further enhance the care and treatment for this cohort of service users. Nonetheless, in the work we are doing we must not be complacent because we have such a team. The key issue is that we need to scrutinise objectively our support for this group of people in light of the findings from the events in Nottinghamshire.

For context, many people who experience psychosis are able to receive evidence-based care and treatment which enables them to recover from their psychotic episode and/or be supported to live a life that is meaningful to them alongside the management of ongoing symptoms. However, some people who experience psychosis struggle to access evidenced-based care and treatment. This can be due to the impact of symptoms such as paranoia or a lack of understanding from the individual that they are unwell.

For this group of people, it is critical that mental health services can meet the person's needs by adapting the approach to engagement, providing continuity of care, and offering a range of treatment options for people experiencing a varying intensity of symptoms. People with these needs can be very vulnerable to harm from themselves and from others. Relapse can also bring a risk of harm to others, though this is a very small number of people.

The paper will now describe LYPFTs position against the recommendations and any identified areas for learning and or/strengthening.

Area for improvement 3 – Recommendation implementation
We are aware that there have been a number of reviews into Trust services, particularly over the last twelve months and there is considerable pressure on the Trust to improve services whilst delivering care for their population. We have not sought to duplicate recommendations but want to emphasise the importance of the Trust ensuring that implementing recommendations results in positive change to quality and safety.

Recommendation
The Trust should ensure that they have implemented the recommendations made by other reviews to date, including from the Serious Incident report and the Care Quality Commission. After a period of no longer than nine months from implementation, the Trust should seek to understand whether the changes made have had a positive impact on the quality and safety of care delivery. Views of those with lived experience must be integral to assure the robustness of the Trust's internal assurance process.

Current position of LYPFT
Actions derived from the recommendations and learning in response to the findings will be developed to include expected outcome and therefore enabling the ability to measure the impact.

Next Steps
To ensure we have our Patient Safety Partners and Lived Experience as part of the process.

Area for improvement 4 – Serious incident policy
We found that the Trust's Serious Incident Policy is not currently in line with the Patient Safety Incident Response Framework (PSIRF). Additionally, there is opportunity for the Trust to better use the outcomes of investigations to identify trends and implement changes to improve patient care and safety.

Recommendation
The Trust needs to ensure that its Patient Safety Incident Response is in line with NHS England's new Patient Safety Framework (PSIRF). Processes should be developed to ensure that subsequent lessons have been embedded in clinical practice and corroborated and supported by people who use the services, their families, carers or support network.

Current position of LYPFT

In LYPFT the move from the 2015 Serious Incidents Framework (SIF) towards PSIRF commenced in December 2022. PSIRF was launched in LYPFT on the 4th of July 2024 with the associated policies and procedures to support.

Next Steps
A review of actions under PSIRF will take place to identify the impact and value added with the learning responses and themes of patient safety events with the focus moving toward expected outcome and how this will be measured.

Area for improvement 5 – Family engagement
We found that whilst there were attempts to actively engage VC's family in aspects of his care, there were important milestones when decisions were not discussed with them. We also found that there were opportunities to co-produce aspects of care planning with VC and his family, particularly around safety and scenario planning.

Recommendation
The Trust should define what positive family engagement looks like. The offer should be developed with people with lived experience – including people who use services, their families, carers or support network, and be informed by all available information. The Trust should then develop processes, in line with national guidance (i.e. the Triangle of Care 22 and the Patient and Carer Race Equality Framework 23), to support effective family engagement.

Current Position of LYPFT

LYPFT have established Service User and Carer forums.

Engagement with family and carers is demonstrated within Leeds and York Partnership NHS Foundation Trust through the Trust's 2-star Triangle of Care accreditation and associated Triangle of Care Strategy. Each service is required to complete a self-assessment tool for annual Trustwide submission to evidence that we are working towards the six standards. A Triangle of Care monthly meeting is in place which is attended by the Leads for each service who support engagement and development in this area. There is 'Carer Awareness and the Triangle of Care' e-learning available to all staff which is priority training for all clinical staff.

We continue to audit against Triangle of Care standards and findings have demonstrated that clinicians were not always recording whether service users gave their consent to share information with carers.

The Rehabilitation Services are responding to a proposal that has been made by some carers of people with complex psychosis to develop a bespoke carers group for carers of this patient population due to their particular needs. This has been included in their recommendations from the Community Transformation Complex Psychosis Focused Area Group

Next Steps
To implement a series of scenario-based workshops for clinicians. The purpose of the workshops are to support colleagues to gain a better understanding of consent, linked to information sharing and confidentiality consent applying 'common sense confidentiality' principles.

Area for improvement 6 – Clinical information sharing

We found that there were limitations in the sharing of clinical information across settings which impacted on the ability of those who were caring for VC to fully understand his needs. The current system capability does not allow for the timely sharing of important clinical information between the Trust and independent providers who are placing the Trust's patients in their services. Additionally, the sharing of information with Primary Care to inform important conversation, for example in relation to potential patient discharges, needs to be improved.

Recommendation
The Trust should develop interoperable systems and processes to enable sharing of necessary clinical and risk-related patient data across clinical care settings. This should include sharing and increasing the visibility of information across primary and secondary care (NHS & independent providers). The purpose of this is to enable shared decision making and risk management with up-to-date information whilst remaining mindful of a person's privacy when identifying necessary information to share.

Current Position of LYPFT
When service users are referred for consideration for an out of area placement, we ensure we share copies of a referral form, the most recent risk assessment, section papers and if the service user is known to services, any care plans/formulations etc. and the GP medication list.

If the service user is placed out of area, we receive written electronic copies of the weekly MDT summary as well as the previous 7 days nursing notes and risk assessment. We endeavour to attend weekly MDTs for all service users, where we cannot, one of the Specialist Practitioners will contact the ward for a comprehensive update. We maintain contact with the wards to receive updates to identify any potential issues that may lead to barriers to discharge and advising about ongoing referrals. Where the service user has a Care Coordinator, we also expect them to attend MDT reviews. Where discharge planning is being considered within the MDT, the Specialist Practitioners will arrange for community colleagues, e.g. ISS representation, Social Worker and other LYPFT Team representation to attend as appropriate. On discharge we receive copies of the discharge summary.

A formal partnership agreement and a data sharing agreement is in place between Leeds and York Partnership NHS Foundation Trust (LYPFT) and Primary Care Mental Health (PCMH) Services with regards to Community Mental Health Transformation. This agreement ensure that all data sharing activities are conducted in accordance with relevant legal, regulatory, and ethical standards.

As part of the ongoing Community Mental Health Transformation Programme, a structured series of multidisciplinary/organisational meetings has been established to support effective case management and risk oversight. These forums provide practitioners with dedicated time and space to collaboratively review complex cases, assess clinical risks, and agree on coordinated care plans.

The meetings are designed to enhance shared decision-making, promote consistency in risk assessment, and ensure timely escalation of concerns where necessary. Participation includes representatives from relevant clinical teams and operational managers, supporting a holistic and accountable approach to service user care.

Next Steps
As part of the Community Mental Health Transformation Programme, a Service Development and Improvement Plan (SDIP) has been implemented to strengthen interoperability and enhance information sharing across system partners. This plan sets out clear objectives to improve digital integration, streamline data exchange, and support more coordinated, person-centred care.

Area for improvement 7 – Across organisational working
We found that, at times in VC's care and treatment, healthcare professionals were making decisions without a full understanding of information held by all organisations involved with VC. There is the opportunity for system partners to come together to review the arrangements in place for proactively sharing information in a timely manner.

Recommendation
The Trust, the Integrated Care Board and system partners (for example the Police) should review and evidence the effectiveness and reliability of communication processes across all system partners relevant to mental health care, treatment and risk management.

Current Position of LYPFT
There are established multi-agency relationships across the Trust's such as through the 'Right Care, Right Person' programme. The Trust also has its own Police Liaison Officer who works closely with care services when requests for information sharing is needed. The Trust also has a multi-agency care planning lead to support complex cases where multiple agencies and system partners are involved in risk management and care planning.

Next steps
A review of the police pathway as part of the wider Acute Care Pathway review is currently underway.

Area for improvement 8 – Governance arrangements
In this case, we identified that structures and processes of the governance framework at all levels of the local healthcare system, were not set up for identification and communication of potential and existing issues which combined to increase risks to users of the Trust's services and others. We found evidence of siloed governance arrangements and little evidence of triangulation of information to enable system wide learning. We found this to be the case from the Integrated Care Board through to Trust processes.

Recommendation
The Trust and the Integrated Care Board should seek support from existing expertise in the area of risk and governance within their organisations. This should be used to develop structures, processes and procedures that demonstrate the capability to identify and communicate potential and existing issues and risks. This will require the system to develop the ability to triangulate safety critical information to inform existing and emerging issues. This should be a data driven process drawing from both clinical and operational sources.

Current Position of LYPFT
LYPFT have establish clinical and operational governance structures and processes in place to identify and review potential and existing issues and risks. Clear escalation processes are in place to escalate concerns across the organisation.

Next Steps
Work is ongoing to ensure services are taking a consistent approach to reviewing data through their governance structures to inform existing and emerging issues and triangulate safety critical information.

Area for improvement 9 – Policy development and review
We found that some Trust policies were out of date and had not been reviewed in a timely way. We also found that there was an acceptance of a drift from policies in day to day practice. In a number of instances,

there was not the resource to deliver care in line with the way in which it was prescribed in the policy. There did not appear to be mechanisms to flag the drift from practice and instigate a review of the policy or understand the variation.

Recommendation
The Trust should ensure that all Trust policies are current, updated and written in a manner that enables staff to practice in line with the policy. Where appropriate, policies should be coproduced with people with relevant lived experience. Policies should include clear guidance for escalation when key deliverables within the policy are not able to be achieved. The Trust should have processes in place to trigger requirements for renewal or review.

Current Position of LYPFT
LYPFT have an established governance process in place to review and renew Trust Policies. This includes an Executive Lead for each policy and a governance route for sign off.

Relevant Lived Experience involvement is evident in the majority of newly developed clinical policies however less so in the review of existing policies.

Next Steps
To increase Lived Experience involvement in both the development and review of Trust policies.

Area for improvement 10 – Peer support
In VC's case we found that he may have benefited from being offered peer support within the Early Intervention in Psychosis (EIP) service. We did not find evidence that he was given the opportunity to meet with people who had a shared experience of diagnosis, care or cultural background. We consider there were limited opportunities to try to engage VC in being curious about his diagnosis and how to keep him well.

Recommendation
As part of the implementation of the community mental health framework, the Trust should ensure that there is a robust peer support offer for those under community mental health services with access to culturally appropriate groups with lived experience. To facilitate a meaningful effective peer support offer, the Trust must consider and have robust mechanisms for recruitment, training, support and supervision and role structure including peer leadership.

Current Position of LYPFT
We currently have a number of Peer Support Workforce in our services, as detailed in the table below:

Service	Role	WTE	Organisation
Rehab & Recovery	Peer Support Worker (Equivalent B3 Afc)	2.0	Leeds Mind
Rehab & Recovery	Pathway Inclusion Worker (Equivalent B5 Afc)	1.0	Touchstone
CREST	Peer Support Worker (Equivalent B3 Afc)	3.0	Touchstone
CREST	Peer Support Lead (Equivalent B4 Afc)	1.0	Touchstone

Both Leeds Mind and Touchstone have robust offers for these roles and their contribution is as follows:

- Recruitment documentation outlines the importance and value of lived experience. Shortlisting and Interviewing involves both services and Experts By Experience
- Peer Support staff with Leeds Mind receive peer support training and facilitation of peer support groups training (I will need to check with Touchstone, but I'm sure they have something similar)
- The Rehab Service have therapeutic boundaries training that focuses on sharing of lived experience
- Peer Support Lead role in CREST enables regular support to the peer support workers, including reflective spaces to explore the impact of their own experiences and work experiences
- Our Peer Support Workers deliver the city wide Hearing Voices Group which is delivered in a peer support group model
- Training is being developed for the wider teams on the purpose and value of peer support to influence culture

Our Pathway Inclusion Worker is also leading on the coproduction developments in the service.

Next Steps
To review the consistency of this offer across the Trust's community services. Implement a Lived Experience Mentoring programme.

Area for improvement 11 – Care planning
The investigators found limited evidence that care planning arrangements were co-produced with VC and his family. Building on area for improvement 5, once the Trust has developed its family engagement offer, arrangements need to be put in place to ensure co-production of care documentation. In VC's case, there was a sense that a shared understanding between clinicians and VC about his diagnosis and factors to keep him well was never fully reached. We did not find evidence that safety planning or scenario planning took place to help support VC and his family.

Recommendation
The Trust must have processes in place to assure themselves that people who use mental health services, their families, carers and/or support network co-produce care plans. Individuals who use services should be involved in their own personal safety planning arrangements including scenario planning.

Current Position of LYPFT
In LYPFT, a new care plan format was implemented in February 2023, which was intended to be simplified, to be written with and for the patient; in collaboration with them and in a language they understand. The care plan includes a list of domains to choose from to encourage consideration of someone's holistic needs, however, it is not necessary to complete all domains but only those relevant, to encourage a person-centred approach.

To measure the quality of care plans, a Trust wide care planning audit has been completed, which looked at indicators such as whether the care plan was completed in a timely manner, whether identified needs, goals and interventions were clear, and whether the service user and family/carers were involved in the plan.

The Risk Assessment and Safety Planning Improvement Project is well under way and will improve the quality of clinical risk assessment, risk formulation, and safety planning. The move away from risk stratification and the use of a new risk template was introduced in November 2024 and the impact will be evaluated in Q1 including family and service user involvement.

Next Steps
Each service has been asked to develop their own action plans. These actions will then be collated and reviewed to establish themes which require Trust wide action. Develop Care Planning training. The Risk Assessment and Safety Planning Improvement Group during Q1 and Q2 will begin a focused piece of work around safety planning.

Area for improvement 12 – Joint clinical decision making
We observed that inpatient services did not appear to always pay sufficient regard to some potentially important clinical insights and longer-term views provided by the EIP team. The EIP team had longitudinal insights into VC's symptoms and their impact upon his behaviour and his ability to engage with a therapeutic regime. This was most notable regarding the EIP's request for the use of depot medication which was considered and dismissed by the inpatient team. Neither was the use of a Community Treatment Order (CTO) under the mental health legislation considered necessary by the inpatient team. In the right circumstances, a CTO can provide an opportunity for an individual to receive a longer period of inpatient care to enable an enhanced understanding for the individual and the clinical team.

Recommendation
The Trust needs to ensure that the voice of all of those involved in the care and treatment of an individual is heard and considered within the context of the long-term planning for an individual's care and treatment. Where consensus is not reached about the best plan of action, there needs to be a clear process to escalate views for further consideration. All professionals need to feel empowered to challenge decisions and have the appropriate mechanisms to do so.

Current Position of LYPFT
LYPFT has recently developed a complex case review escalation process to provide a mechanism to resolve clinical cases whereby the service user either becomes 'stuck' in the system or where a consensus cannot be reached by the MDT.

Next Steps
To review the process to ensure the process would provide a vehicle for escalation where there is difference of opinion which can be enacted by any clinician or professional involved in a service users care to reach a resolve or way forward.

Future work

The Trust are currently engaging colleagues from across the Trust in the consultation of the new Personalised Care Framework (PCF).

The PCF will set out the key actions for delivering the minimum expected level of care for people across mental health services. It does not describe the specific treatment options that people should receive but instead focuses on the universal aspects of personalised care relevant across mental health services.

The PCF responds to feedback from services that there are gaps in guidance on the expectations of some aspects of care delivery for people with SMI since the replacement of CPA with the CMHF.

The PCF has been developed to describe minimum expectations on core care processes. The aim of this framework is to:

1. Make explicit to providers, commissioners, patients and carers the fundamental care processes that should be delivered across mental health services.
2. Reduce variation and improve consistency of care delivered across settings and service types.
3. Support the planning and delivery of services and quality of care.

It is anticipated that the 10 care processes which make up the PCF will enhance the actions already in place in response the tragic events in Nottingham and reflect Areas for Improvement 1 and 2 (Appendix A) and the associated recommendations.

Feedback will be submitted by 23 May 2025 which will be collated with a view to publishing a final version of the Framework by the end of June 2025. It is anticipated that further resources to support implementation will be published in Q2 25/26.

Next Steps
Workstreams will continue to progress the recommendations and actions outlined in this paper with regular workshops taking place to allow a space for those involved to come together to discuss and review the work collectively to ensure we are striving to provide the best possible care and treatment for those that we serve.

Regular updates will be provided through our clinical governance forums with more detailed reports being received by the Quality Committee.

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 progress the workstream in response to the findings.

Alison Quarry
Deputy Director of Nursing
19 May 2025

APPENDIX A

National Recommendations

Area for improvement 1 – Care delivery

We found that the offer of care and treatment available for VC was not always sufficient to meet his needs. This included the service having difficulty in providing VC with support when he did not wish or was unable to maintain contact with services. From conversations with others as part of this review, we believe that the experience of VC was not unique in how some people with severe and enduring mental illness are supported by mental health services.

We recognise that NHS England is aware of the need to improve the quality and effectiveness in a number of areas and has developed several programs of work to drive this forward to improve the outcomes and experience for people who use mental health services. Our findings suggest that there needs to be significant continued focus at all levels to meet the mental health needs of people and the communities served.

Recommendations

NHS England and other national leaders, including people with lived experience, should come together to discuss and debate how the needs of people similar to VC are being met and how they are enabled to be supported and thrive safely in the community.

National leaders should, in the next six months, include, as part of this debate, the following key areas:

- The demands on mental health services have increased over recent years. Services are often delivered across complex multi-agency systems. People who use mental health services frequently have multiple needs that require significant support to enable them to live well. National leaders must meet the needs of those experiencing severe and enduring mental illness.
- What safe and effective delivery of care should look like for those with severe and enduring mental illness. This should include the consistency of oversight of care across inpatient and community services including the use and application of relevant parts of the Mental Health Act.
- The debate should ensure that the resources for the community model of care are sufficient to meet the needs for severe and enduring mental illness and is supported by an appropriate number of inpatient beds in the context of increasing demand and acuity. This must be supported by sufficiently trained and developed workforce, including people with lived experience.
- The dissonance between what people think should be happening, for example care described in national policies and guidance compared to what is actually being delivered in some services.
- The community mental health framework may have led to an unintended consequence of easing of oversight of some people with significant needs through the removal of the Care Programme Approach aspect of care. National leaders should assure themselves that there aren't negative consequences of some of the actions.
- That care for those with severe and enduring mental illness is commissioned and delivered in line with evidence-based practice and co-produced with people with lived experience. Commissioners should assure themselves that services they are commissioning are being delivered as intended.
- Whether the recurring, common themes that are identified in similar reviews are an accepted risk in the system or whether there are fundamental changes that can be made to mitigate these risks further.

Area for improvement 2 - Risk

We found that risk, both to the individual and potentially to others, was not fully understood, managed, documented or communicated in VC's case. Discussion with national experts and those with lived experience suggests that this issue is not isolated to this case.

Recommendations

NHS England should, in the next six months consider:

- How mental health and social care understand the concept of risk, risk assessment and risk management systems to ensure the effective identification and evaluation of risk across all care and public settings, together with the appropriate implementation of adequate safety measures.
- What mechanisms are in place to communicate risk across multiple agencies to hold, share and communicate risk in real time.
- How current mental health services take a dynamic approach to risk management, adapting to manage individuals' fluctuating risk and need.
- Given that The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) is no longer funded to carry out data collection, analysis, and research on patient homicide, there is a requirement at a national level for data that accurately assists with the identification and the likelihood of the risks of particular outcomes.

Agenda item
15

Meeting of the Board of Directors

Paper title:	Chair's Report from the Workforce Committee meeting on 30 April 2025
Date of meeting:	29 May 2025
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:	30 April 2025
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 an update on the work to refresh the objectives within the People Plan Roadmaps for 2025. The Committee noted the progress made over the last six months and supported the streamlined approach for this year. The Committee received assurance on the robust exercise that had taken place to identify the nine top priorities and that these were aligned to the Trust's strategic priorities. The Committee also received the Workforce Performance Report and noted compliance against the Trust's high-level metrics and mandated standards up to the end of February 2025.

The Committee received a review of musculoskeletal (MSK) related absence and levels of compliance with Moving and Handling training which was provided in response to an action from the November 2024 Board of Directors' meeting. The Committee understood that there was not enough integrity in the data to assume any correlation between levels of MSK absence and mandatory training without manually checking all the unknowns. The Committee agreed that there would not be value in doing further work on this and noted that no firm conclusions could be drawn from the exercise.

The Committee received a summary of the Suicide by nurses: update report (2011–2022) as requested by the Quality Committee. The Committee agreed to receive a follow up report on the Trust's suicide prevention work at its December meeting, noting that this work was due to fully restart in the autumn.

The Committee received an overview of the LYPFT NHS England Workforce Trajectory submission as part of the NHS England Operational Planning Round 2025-26. The Committee agreed to receive a further update on workforce planning in six months' time, once the establishment review in the nursing directorate had taken place and there was a clearer understanding of what the staffing establishment needed to be.

The Committee received a verbal update on issues with Emergency Preparedness, Resilience and Response (EPRR) training portfolios compliance and agreed to have oversight of EPRR training compliance via a bi-annual report to the Committee.

ASSURE – items to provide assurance to the Board on

The Committee reviewed the Board Assurance Framework 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 received a verbal update on Bank staff choices which was provided in response to an action from the July 2024 Board of Directors' meeting. The Committee received an overview of the feedback from a recent Bank Staff Forum and heard about the benefits for people choosing to work on the Bank including the flexibility it offers, particularly valuable for immigrant workers, and the opportunity for varied shift patterns / locations and enhanced hours. The option for extended annual leave and career progression opportunities were also noted. The Committee heard that there was a good success rate of Bank staff being fast tracked into substantive healthcare support worker roles. The Committee noted that although the findings were not entirely representative due to the small size of the group in attendance at the forum, it proved a useful learning exercise.

The Committee received a specific update on the work to align compulsory training at the Trust to the UK Core Skills Training Framework which would support the transfer of training records between organisations and help to avoid duplication and reduce costs.

The Committee reviewed and approved its Annual Report for 2024/25 ahead of submission to the Board of Directors' meeting in June 2025 and received an updated version of its Terms of Reference.

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:	Workforce Committee Terms of Reference
Date of meeting:	29 May 2025
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.	

Executive summary

The Workforce Committee reviewed and approved its Terms of Reference on 30 April 2025. The following amendments were made (all amendments are highlighted in yellow in the attached document):

- Page 3 – Removed the Associate Director of People Experience as an attendee of the Committee
- Page 8 – Updated the titles and number of the groups which report to the People and Organisational Development Governance Group

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.

Workforce Committee

Terms of reference

1 Name of committee

The name of this committee is the Workforce Committee.

2 Composition of the committee

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

Members: full rights

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

	information, and make sure that clinical quality controls, and systems of risk management and governance, are robust and implemented. (Code of Governance for NHS Provider Trusts, NHS England 2022)
Director of People and Organisational Development	Assurance on the OD and Workforce aspects of their portfolio in relation to the delivery of the strategic aims, goals and plans relating to staff and legal and statutory HR functions.
Director of Nursing and Professions	Assurance on the professional workforce aspects of the Nursing and Allied Health Professional, Psychology and Psychotherapy staff.
Medical Director	Assurance on the professional workforce aspects of the medical staff.
Chief Operating Officer	Executive Director with responsibility for oversight and delivery and development of Care Services. Assurance and escalation provider to the Workforce Committee.

While specified Board members will be regular members of the Workforce 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.

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

In attendance: in an advisory capacity

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.

Title	Role in the committee	Attendance guide
Associate Director for Corporate Governance	Trust Board Secretary overseeing the information flows of the committees	Each meeting

Title	Role in the committee	Attendance guide
Associate Director for People Resourcing and Organisational Development	Provide information and assurance on organisational development, leadership and management development, talent development and strategic resourcing, including widening participation and apprenticeships	Each meeting
~~Associate Director of People Experience~~	~~Provide information and assurance on wellbeing, equality and diversity, engagement and marketing and communications~~	~~Each meeting~~
Associate Director of Employment	Provide information and assurance on the approach taken to employment practices, policies and processes, partnership working arrangements internally within the Trust and effective change management approaches affecting people	Each meeting
Head of People Analytics and Temporary Staffing	Provision of workforce information and undertaking of analytics as required	As Required
Head of Strategic Resourcing and Talent Development	Provide assurance on vacancies rates, the future direction of workforce skills and skills gaps	As Required
Head of Communications	Provide information and assurance on methods of communication	As Required
Head of Diversity and Inclusion	Provide information and assurance on the equality, diversity and inclusion agenda and plan	As Required
Head of Wellbeing	Provide information and assurance on the health and wellbeing across the Trust	As Required

In addition to anyone listed above as a member, at the discretion of the Chair of the Committee the Workforce Committee may also request individuals to attend on an ad-hoc basis to provide advice

and support for specific items from its work plan when these are discussed in the meetings.

2.1 Governor Observers

The role of 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 and must include at least one non-executive director and one executive director. Attendees do not count towards quoracy. If the Chair is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by the second non-executive director.

Deputies: Where appropriate members may nominate deputies to represent them at a meeting. Deputies do not count towards the calculation of whether the meeting is quorate except if the deputy is representing the member under formal “acting up” arrangements. In this case the deputy will be deemed a full member of the Committee.

It may also be appropriate for attendees to nominate a deputy to attend in their absence.

A schedule of deputies, attached at appendix 1a, should be reviewed at least annually to ensure adequate cover exists.

Non-quorate meeting: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

Alternate chair: In the absence of the Chair the alternate chair of the meeting will be the second non-executive director.

4 Meetings of the committee

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

Frequency: Bi-monthly

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

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 agreed by the chair.

5 Authority

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

Powers: The Workforce Committee is constituted as a standing committee of the Board of Directors. The Committee is authorised by the Board to seek assurance on any activity within its Terms of Reference.

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

Cessation: The Workforce Committee is a standing committee in that its responsibilities and purpose are not time limited. It will continue to meet in accordance with these Terms of Reference until the Trust Board determines otherwise.

6 Role of the committee

6.1 Purpose of the committee

The purpose of the Committee is to provide the Board with assurance concerning all aspects of strategic workforce matters relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients and staff.

Its purpose is also to ensure there is a positive working environment for staff which promotes an open culture that helps staff do their job to the best of their ability.

Trust Strategic Objective	How the committee will meet this objective
We deliver care that is high quality and improves lives	Assurance on the delivery of the Trust's strategic workforce plan
We provide a rewarding and supportive place to work	Assurance on the delivery of the Trust's strategic workforce plan
We use our resources to deliver effective and sustainable services	Assurance on the delivery of the Trust's strategic workforce plan

6.2 Guiding principles for members (and attendees) when carrying out the duties of the committee

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

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

6.3 Duties of the committee

On behalf of the Board of Directors the Committee will:

- Seek assurance on the progress made against the NHS People Plan.

- Seek assurance on the development and the delivery of the Trust's People Plan and have oversight of its key strategic themes which include: health and wellbeing; resourcing; equality and inclusion; engagement and retention; and leading together.

- Carry out the role of Wellbeing Guardian Champion and receive a Wellbeing Guardian Report at every meeting.

- Carry out the duties of the Designated Board Member when an investigation is undertaken regarding a doctor's practice in line with the Managing Concerns About Medical Colleagues (Maintaining High Professional Standards) Policy, with the Chair of the Committee being the Designated Board Member.

- Seek assurance on the development of the workforce to ensure the Trust has productive staff with the skills, competencies, and knowledge to provide safe and effective care.

- Be responsible for signing off any underpinning workforce strategies.

- Seek assurance that the Trust is meeting its legal and regulatory duties in relation to its employees.

- Have oversight of relevant workforce data and specific initiatives in relation to the Equality and Inclusion Agenda as requested by the Board of Directors, recognising that a significant element of the Trust's work to ensure equality and inclusion is with regard to the workforce.

- Seek assurance that the Trust is actively involved and where relevant influencing work taking place at a national, regional, and local level including the work carried out by the West Yorkshire and Harrogate Integrated Care System relating to workforce.

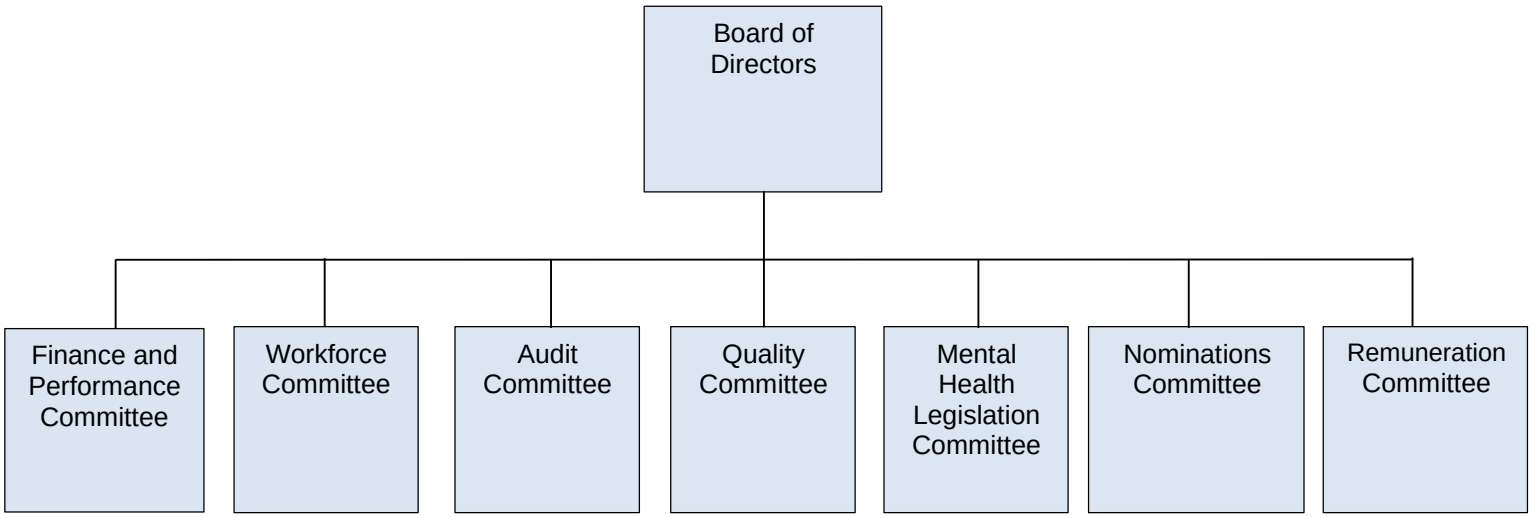
- Seek assurance on progress against the workforce metrics.

- Seek assurance around the risks delegated to it via the Board Assurance Framework. The Committee should determine if the appropriate level of risk has been identified, review the effectiveness of the controls in place relevant to the risks, review and challenge the strength of the assurances provided, identify any gaps in control or assurance and ensure that the risk lead identifies appropriate actions to address such gaps.

- Where necessary seek assurance into any area of work related to workforce and related matters on behalf of the Board.

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

7 Relationship with other groups and committees



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

Reporting

An assurance and escalation report will be made to the Board of Directors by the Chair of the Committee.

Links with operational processes

The Workforce Committee receives a People and Organisational Development Governance Group Chair's Report at each meeting. This report summarises the recent activity of the People and Organisational Development (POD) Governance Group as well as highlight reports from each of the three POD Governance Groups (People OD and Resourcing Group, People Employment Group and People Experience Group).

8 Duties of the chairperson

The Chair of the Committee shall be responsible for:

- Agreeing the agenda and ensuring it is balanced
- Directing the meeting ensuring it operates in accordance with the Trust's values
- Giving direction to the minute taker

- Ensuring everyone at the meeting has a reasonable chance to contribute to the discussion
- Ensuring discussions are productive, and when they are not productive, they are efficiently brought to a conclusion
- Deciding when it is beneficial to vote on a motion or decision
- Checking the minutes
- Ensuring sufficient information is presented to the Board of Directors in respect of the work of the Committee
- Ensuring the Chair's report is submitted to the 'parent' committee as soon as possible
- Ensuring that governor observers are offered an opportunity at the end of the meeting to raise any points of clarification.

It will be the responsibility of the Chair of the Workforce Committee to ensure that it (or any group / committee that reports to it) carries out an assessment of 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 Workforce Committee and, in recognition of the nature of matrix working between the work of all Board sub-committees, the Workforce Committee and any other Board sub-committee) it will be for the chairs of those 'groups' to ensure there is an agreed process for resolution; that the dispute is reported back to the 'groups' concerned; and that when a resolution is proposed regarding the outcome this is also reported back to the 'groups' concerned for agreement.

The Chair of the Workforce Committee will also be the Designated Board Member when an investigation is undertaken regarding a doctor's practice in line with the Managing Concerns About Medical Colleagues (Maintaining High Professional Standards) Policy.

9 Review of the terms of reference and effectiveness

The terms of reference shall be reviewed by the Committee at least annually and be presented to the Board of Directors for ratification where there has been a change.

In addition to this the Chair must ensure the Committee carries out an annual assessment of how effectively it is carrying out its duties and make a report to the Board of Directors including any recommendations for improvement.

Appendix 1a

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)**
NED Chair	Second NED on the Committee
Director of People and Organisational Development	Associate Director for People and Organisational Development
Director of Nursing and Professions	Deputy Director of Nursing (as required)
Medical Director	Deputy Medical Director
Chief Operating Officer	Deputy Director (as required)

Agenda item
16

Meeting of the Board of Directors

Paper title:	Freedom to Speak Up – Update Report
Date of meeting:	29 May 2025
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 report covers the work of speaking up at the Trust from 16 November 2024 – 30 April 2025. There were 32 new concerns that were raised through the FTSUG during this period. (Increase from 29 concerns in the same period last year).

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? **No**

If yes, please set out what action has been taken to address this in your paper.

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

Thursday 29 May 2025

Freedom to Speak Up

1 Executive summary

1.1 This report covers the work of speaking up at the Trust from 16 November 2024 – 30 April 2025. There were 32 new concerns that were raised through the FTSUG during this period. (Increase from 29 concerns in the same period last year). There are also 5 open concerns from the previous report.

1.2 Activities include:

- The FTSUG has been trained as a Counter Fraud Champion and Wellbeing Champion
- Promotion of 'Speak Up' activities and site visits
- Chair of the FTSU Ambassador Network, discussing learning, trends and best practice
- Aligning Trust activity with all national work, learning and guidelines
- Offer all staff who approach the FTSUG support, whether they raise a concern or not

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. The FTSUG and Ambassadors meet regularly to discuss ways to communicate to colleagues and to be visible in the Trust. Recent activity has included attendance at inductions, team meetings, a communication plan and site visits.

2.3 The FTSUG also attends several meetings including Trust Wide Clinical Governance, Civility and Respect, Staffside meeting, Trust Wide Safeguarding Committee, Staff Network meetings, ER Improvement Group, POD Governance, Trauma Informed Council, Collective Leadership Workshop, White Ribbon Group, Sexual Safety Charter, Staff Bank Forum.

2.4 Freedom to Speak Up processes were recently audited and showed *'Significant Assurance'* that the Trust has effective controls in place to support the Trust's commitment to Freedom to Speak Up. The FTSUG will continue to monitor and review FTSU processes. All recommendations and feedback have been acted upon to further improve the service.

2.5 The FTSUG work receives ongoing support from the Chief Executive, the Non-Executive Director with responsibility for speaking up, Director of HR, Deputy Director of Nursing and the trust's Staff Networks. The FTSUG has been sharing learning to make improvements and useful areas of triangulation. Sharing data is important to learn as a trust but care must be taken in ensuring a themed approach rather than identifying individuals.

2.6 The FTSUG is also working at a local and regional level to share learning and best practice including attendance at the FTSU Conference, local meetings with other Guardians across West Yorkshire offering psychological support, Lunch and Learn webinars and personal development including refreshers with the NGO and Regional Meetings across the North.

2.7 The FTSUG also collaborates nationally with the National Guardian Office and has joined an informal peer support group which was set up by the NGO to address some of the challenges faced by culturally diverse FTSUGs where peer support is offered.

2.8 We have received 32 concerns during the last five months. Due to the low number of concerns in some areas these have not been aggregated at a service level. The table below details speaking up concerns raised by themes and a summary of the outcomes:

No of concerns	Themes	Outcomes
11	Unfair workplace practice or process concerns	Case study approach with HR to improve communications including suspension. Signpost to HR, trade unions, occupational health/wellbeing, line manager, early resolution techniques, community links. Signpost to EDI and recruitment team. Reminders and/or clarity on processes for colleagues.
8	Bullying / inappropriate behaviours	Signpost to trade union/occupational health. Review B&H policy and references to FTSUG role. Reminder on values and expectations for teams. Consideration of neurodiverse needs of staff and perception of behaviours.
5	Patient safety concerns	Formal review of incident. Workshop for affected staff to raise concerns / ideas for improvement. Feedback to service for learning and improvement. Clarity on role boundaries. Support for wellbeing.
4	Discrimination allegations race, gender	Signpost to Temporary Staffing Manager, Signpost to HR, Mediation, Clarification of grievance procedures, Feedback provided to senior manager to resolve internally. Attendance at staff networks to share learning/support.
3	Sexual safety concerns - staff	Triangulation with safeguarding and wellbeing team. Signpost to Deputy Director of Nursing. Recommend investigation and cultural improvement activities. Offer support to affected colleagues.
1	Detriment from raising concern	Reflections in impact statement, escalation to NED, discussion with HR and senior managers. Consideration into mediation, investigation, service review. Culture review work pending.

2.9 Initial concerns are by phone/text (14), email (12), face to face (5), referral from FTSUA (1).

2.10 Concerns were raised by Nurses (13), Admin (10), AHPs/Allied (4), Bank/agency (2), Doctor/Medical (1). Some were also raised anonymously and unidentifiable (2). A staff list has been requested from HR to categorise colleagues correctly for high level data.

2.11 Outcomes include:

- Working with colleagues raising a concern to write case studies and impact statements where other colleagues can hear experiences and encourage learning (and empathy)
- Awareness of the changes to the external environment creating uncertainty and reinforcing the aspects of the law that remain unchanged relating to discrimination, victimisation and harassment to assist with supporting colleagues raising a concern.
- Review current policies and send reminder to colleagues on personal responsibilities e.g. home insurance when working from home, mobile phone use whilst driving and on calls.
- Triangulating sexual safety concerns with reporting for cultural improvement interventions
- Follow up on actions from service reviews to ensure action plan covers the areas of concern initially raised and measures for improvement.
- Promote Speak Up activities in targeted areas where barriers may be in place and support.
- Update processes to include if colleagues experience any negative impact raising concerns.
- Review policies and procedures considering FTSUG role.

3 Themes

3.1 A FTSU workshop was held to understand incidents involving patients e.g. violence and aggression. Specific cases involving patient care are being investigated. Learning has been shared with the Deputy Director of Nursing and service from the workshop for discussion.

3.2 Increase in concerns involving Sexual Safety has been triangulated with Safeguarding team. Actions have been taken to increase awareness and reporting. Encourage witnesses to be 'active bystanders' feeling safe to report incidents and use tools to the improve situation.

3.3 Reports of negative impact are very few at the trust so is taken very seriously when it is reported. The Detriment Guidance has been shared with HR colleagues and the Civility and Respect Group. The FTSUG will continue to be fervent in recommending a service review, further investigation or cultural improvement interventions where there are multiple concerns within an area, learning lessons from the actions taken in the Forensic Services Review.

3.4 Concerns where detriment is raised or where barriers may in place to move forward are escalated to the NED with responsibility for speaking up and the CEO. This assists managers with their responsibilities to follow up on concerns based on the guidance from the NGO: "*You (leaders) and your senior colleagues need to communicate that detriment will not be tolerated. When it does occur, it is important that you act – and are seen to act*."

4. Positive Feedback

4.1 Feedback forms have a low return rate (11 forms returned), despite reminders being sent, but follow

up contact indicates satisfaction with the service. The forms indicate that it was 'easy' to contact FTSUG and that the initial response was 'very helpful'.

4.2 Some examples of open comments are below:

- "Thanks Shereen and thank you for your support",
- "Thank you for chasing this and updating me on the next steps",
- "Very helpful feel I was listened to and helped",
- "Thanks for your help and support I now believe that I have now been listen to and that I have done all that would be reasonably expected in my situation",
- "Many thanks for your call - I felt very reassured by your words".

5. Assurances and Future Work

5.1 We are reporting quarterly to the National Guardian Office. In terms of local comparison with neighbouring NHS trusts of a similar size, 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 stakeholder feedback. The policy clarifies that the Guardian does not conduct investigations.

5.3 Due to the level of concerns on bullying, we support early reporting of issues and the Early Resolution and Civility and Respect work, which includes upskilling staff and managers to have early conversations to resolve concerns, embed appropriate behaviours and restore relationships. FTSU also has an action in the Equality Delivery System to be an 'independent support' for colleagues who may want to raise a concern about bullying and harassment.

5.4 Where concerns are raised involving multiple issues or serious concerns, the FTSUG will liaise with HR on a Service Review for that area or a review of the recommendations from previous reviews. Any patterns or trends that are identified are discussed with the CEO.

5.5 We are working across the trust to triangulate cases in a meaningful way. The launch of our learning events has allowed more deeper conversations with managers, Cultural Inclusion Ambassadors, Legacy Mentors and the People Promise manager by sharing learning on themes such as staff engagement, wellbeing, patient safety and clinical governance.

5.6 The Staff Survey Results showed a slight increase in Q25e *I would feel safe to speak up about anything that concerns me in this organisation* and Q25f *If I spoke up about something that concerned me I am confident that my organisation would address my concern*. These results were above average in the sector and we will continue to build on improving results, working with the Associate Director of Employment and managers.

5.7 However, there was a slight decrease in Q20a *I would feel secure in raising concerns about unsafe clinical practice* and Q20b *I am confident that my organisation would address my concern.* The FTSUG will continue activities to follow up on these themes in Intention Plans.

5.8 The Audit identified that the NGO and HEE 'Speak Up', 'Listen Up', and 'Follow Up' training modules are not mandated. Having reviewed the low completion rates at the trust, work will be

done to improve the uptake of ‘Speak Up’ training at the Trust at all levels and that senior managers are encouraged to complete ‘Listen Up’ and ‘Follow Up’ training as part of their responsibilities. The FTSUG is reviewing our training provision for FTSU.

5.9 Following the National Guidance – A review of the speaking up experiences of overseas-trained workers in England the FTSUG will be focusing on tailoring Freedom to Speak Up arrangements accordingly and supports appropriate cultural awareness training working with the EDI team and WREN network to better understand colleagues experiences.

5.10 The Board is asked to self-reflect using the Reflection and Planning Tool for FTSU in preparation for the Board Development Day in November 2025.

6 Recommendation

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

Shereen Robinson
Freedom to Speak Up Guardian
20 May 2025

Agenda item
17

Meeting of the Board of Directors

Paper title:	Chair's Report from the Mental Health Legislation Committee meeting on 15 May 2025
Date of meeting:	29 May 2025
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:	15 May 2025
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

- The Committee received feedback from the Mental Health Legislation Operational Steering Group (MHLOSG). It discussed the following issues:
    - The three-hour target for the commencement of Mental Health Act (MHA) Assessments of service users admitted to the Section 136 Suite had been implemented in response to guidance in the MHA Code of Practice (2015) and as such it was agreed that this target would continue to be monitored. The Committee noted that the Trust had recorded a 0% compliance rate with this target for some time but was reassured that this was due to limitations in data recording rather than a reflection of practice. It was agreed that work would be conducted to improve the recording of this information so the Committee could monitor this area going forward. It also agreed that the Mental Health Legislation Team would investigate whether other Trust's monitored attainment of this target.
    - The discharge of service users subject to a Community Treatment Order (CTO) to temporary or unstable accommodation and the subsequent issues of monitoring and recalling such patients. It was agreed that work to define appropriateness and best practice regarding CTOs would be produced to support this practice going forward.

- The Committee noted the drop in mandatory Mental Health Legislation training compliance for Trust colleagues reported in the Mental Health Legislation Activity Report. It was reassured that this was caused by the Mental Health Legislation Team conducting a manual review of training history on iLearn and noting where colleagues had incorrectly attended "Initial" or "Refresher" training and that work was ongoing to rectify this situation. The Committee noted that Mental Capacity Act and Deprivation of Liberty Safeguards Level 2 training compliance was at 76% as of 14 May 2025.

ASSURE – items to provide assurance to the Board on

- The Committee received the Mental Health Legislation Activity Report for Q4 2024-25 and was assured that the plans in place were sufficient to ensure ongoing compliance with all Mental Health Legislation. It additionally noted the following:
    - That the content of the report had been expanded to include patient demographic information (which was previously received by the Committee through the Annual Mental Health Detentions Report).
    - The possibility of including an Executive Summary to highlight any significant data trends and areas of note in the report would be explored.
    - The use of CTOs in the period had increased and that additional work would be conducted to understand why this was the case.

- The Committee discussed the Mental Health Act: Detentions Internal Audit Report which had been received with an overall opinion of high assurance. The Committee noted that the one minor recommendation made by the report had been completed and commended the Mental Health Legislation Team on this outcome.

- The Committee received a "Summary of the Care Quality Commission (CQC): Monitoring the MHA 2023/24 in Relation to CQC MHA Reviewer Visits to the Trust" report which summarised the CQC's activity and findings during 2023/24 from their engagement with people who are subject to the MHA as well as a review of services registered to assess, treat, and care for people detained using the MHA. It was assured that all actions following CQC MHA Reviewer visits were robustly managed and monitored.

- The Committee received an update on the progress of the "Terminally Ill Adults (End of Life) Bill", AKA the "Assisted Dying Bill". It noted that the Royal College of Psychiatrists had announced that it would not support the Bill in its current form.

- The Committee received and approved the Mental Health Legislation Committee Annual Report for 2024/25. It noted that this report would be presented at the 19 June 2025 Extraordinary Board meeting for final approval.

REFER - Items to be referred to other Committees:

- The Committee noted an issue with the iLearn system which required the Mental Health Legislation Team to manually review the training compliance with all staff at the Trust to ensure that they had correctly attended "Initial" or "Refresher" mandatory Mental Health Legislation training, as the system was unable to automatically assign or monitor the correct training to individual colleagues. It was agreed that this issue would be referred to the Workforce Committee to explore whether an alternative solution could be found.

Recommendation

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

Agenda item
18

Meeting of the Board of Directors

Paper title:	Chair's Report from the Audit Committee meeting on 8 April 2025
Date of meeting:	29 May 2025
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:	8 April 2025
Chaired by:	Martin Wright, 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 "Policy for the Payments and Reimbursement of Service Users, Patients, Carers, and Members of the Public" internal audit report which was received with an overall opinion of low assurance. The Committee was reassured that work was ongoing to complete the identified actions in the report within the time period agreed and the governance process in place in this area. It noted that while the issues raised by the report were significant and were being managed appropriately, that the overall materiality to the Trust in this area was low as each individual payment was typically for a value of £10 or less with the total value of payments amounting to approximately £15,000 a year.

ASSURE – items to provide assurance to the Board on

- The Committee members met with Dawn Hanwell, Chief Financial Officer, and Deputy Chief Executive in a private meeting ahead of the main meeting. The Committee was reassured that there were no items of concern to escalate as a result of this meeting.
- The Committee received an update on the 2024-25 Quality Account and was assured by the process by which the Quality Account had been developed.
- The Committee received the "Mental Health Act – Detentions" internal audit report which was received with an overall opinion of high assurance. The Committee congratulated the teams which had been involved in achieving this outcome.
- The Committee received the Draft Head of Internal Audit Opinion for 2024-25 and noted that this expressed an overall opinion of significant assurance. It noted that this opinion would be finalised based on the remaining elements of the 2024-25 Internal Audit Plan and that this would be reported at the Extraordinary Audit Committee on 17 June 2025.
- The Committee received and approved the Internal Audit Workplan for 2025-26, including the amendments which had been made to the Internal Audit Charter.
- The Committee received and discussed the Health and Safety Quarterly Update for Q4 2024-25. It made several recommendations on how the content of the report could be improved further.
- The Committee received the Tender and Quotation Exception Report for the period of 1 January 2025 – 31 March 2025. It was assured that the one quotation waiver identified in this period had been adequately explained and signed off.

- The Committee received the Losses and Special Payments report for the period from 1 April 2024 to 31 March 2025 and noted the contents.

- The Committee received the declaration for Condition 7 of the Provider Licence ("Continuity of Service") and was assured of the process for reviewing the evidence of the Trust's control systems and processes in place to ensure compliance with the condition. It agreed to recommend that the positive confirmation for Condition 7 of the Provider Licence is endorsed by the Board of Directors at its June 2025 meeting.

- The Committee received and approved the Audit Committee's Annual Report for 2024-25 to be submitted to the June 2025 Board of Directors' meeting for ratification, subject to a minor amendment being completed.

REFER - Items to be referred to other Committees:

- The Committee agreed that the "Mental Health Act – Detentions" internal audit report should be referred to the Mental Health Legislation Committee.

- The Committee agreed that an action regarding the updating of the Health and Safety Committee's Terms of Reference to include a definition of what was understood to comprise "Health and Safety" and what was understood to comprise "Patient Safety" would be remitted to the Quality Committee.

Recommendation

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

Agenda item
19

Meeting of the Board of Directors

Paper title:	Board Assurance Framework 2025/26
Date of meeting:	29 May 2025
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.

All risks have been reviewed and updated to ensure that they are representative of the current position

for strategic risks. This has included score, controls, actions and contributory risks.

The key updates to highlight for the Board are:

- Strategic Risk 4 relating to finance has been upgraded to a level 15 and several contributory risks have been added.

Over the next quarter work will be undertaken to align the strategic risks to the Trust operational priorities to demonstrate clear lines of assurance and mitigation.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? **Yes**

If yes, please set out what action has been taken to address this in your paper.

This is detailed within the strategic risks, specifically strategic risks 1 and 7.

Recommendation

The Board is asked to:

- Receive the BAF and to be assured of the revie that has been undertaken to ensure that this accurately reflects the position as of May 2025, including risk scoring and mitigating actions.

Meeting of the Board of Directors

29 May 2025

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.

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

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 to ensure that the risks remain appropriate and that there 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.

2.5 Strategic Risk Detail Updates

Following a review of the current position in relation to the strategic risks, the key updates are shown below:

- Strategic risk 4 related to finance has been upgraded to a level 15 with additional contributory risks noted

Over the next quarter work will be undertaken to align the strategic risks to the Trust operational priorities to demonstrate clear lines of assurance and mitigation.

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		Q2 23/24	Q3 24/25	Q4 24/25	Q1 25/26				
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 28
SR3	Culture and environment for the wellbeing of staff	WC	DoP&OD		✓		12	16	16	12	12	⟷	6		30 Apr 26
SR4	Financial sustainability	F&PC	DoF			✓	8	8	12	12	15	↑	4		31 Mar 26
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	12	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 Dec 27

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**	4 (L2xC2)
Risk Appetite	High / Open	**Target Date:**	31 December 2025

Controls in place

- Clinical governance structures in place at all tiers of the organisation to embed clinical governance.
- Process in place to review and learn from death supported by Learning from death policy and Learning from Incidents and Mortality
- Peer review process in place with oversight from CQC steering group
- Annual process in place for reporting on the controls in place in relation to risk to compliance incorporating the Annual Governance Statement Compliance
- Process for managing patient safety events supported by PSIRF policy and plan
- Structures and processes in place for staff to raise concerns and escalate issues supported by Whistle Blowing Procedure and Freedom to Speak Up Guardian
- Processes in place to seek and receive patient and carer feedback
- Risk management processes and policies in place to support the identification, management and reporting of incidents and risks
- Safer staffing group and establishment process
- Trust wide working group to implement the Risk Assessment and Management Plan (RAMP)
- Suicide prevention environment survey
- Culture of care programme
- Implementation of Sexual safety standards
- Systems (with supporting policies) in place relating to Safeguarding, physical health, Infection Prevention Control.
- Clinical Supervision training offer in place to support clinical practice.

Details of Assurance

Assurance Rating:	**Partial**

Management / Service Level	**Review Process / Oversight**	**Independent (external / internal audit)**
- Escalation processes - Teir three clinical governance meetings supported by TOR and clinical governance framework. - Escalation mechanism in place from ward to board - Weekly LIMM meeting to review incidents (graded 3 and above) and deaths - Monthly Trust Incident Review Group with a focus on SI reports and overdue actions - Bi-monthly CQC oversight group with overview of peer reviews - Monthly safer staffing group with oversight of staffing levels and annual establishment review	- Clinical Governance Framework - Quarterly combined report reviewed by Quality Committee - 6-monthly Learning from Deaths report to Quality Committee - SI/PSII reports reviewed and signed off at Trust Incident Review Group - Quarterly safer staffing report to Quality Committee - Quarterly reducing restrictive practice report to Quality Committee	- Assurance report: complaints / PALS - Peer reviews: ICS level - Provider collaborative and ICB quality visit - Audit Yorkshire – internal audit programme & reports (list) - Healthwatch external visit - 2019 CQC inspection report, overall rating good - CQC MHA reviews - Significant assurance – sexual safety audit

- Monthly positive safety group with overview of incidents of restraint - Monthly CLIP report shared with services giving an overview of incidents, complaints, PALS - E-rostering system in place - Monthly working group with overview of the implementation of the RAMP - Monthly suicide prevention environment group - Monthly sexual safety group meeting - Monthly falls and pressure ulcer group to review falls and pressure ulcer incidents (graded 3 and above) - Monthly safeguarding report shared with services giving overview of safeguarding training compliance and safeguarding referrals.	- Quarterly sexual safety report to Quality Committee - Evaluation of the implementation of the RAMP to be reported through Quality Committee - Suicide prevention environment group summary supported to clinical environment group and escalated to ESG. - Nursing and Professions highlight report to quality committee - Falls and pressure ulcer group report to quality committee - Peer review reports shared via clinical governance structures - Monthly Executive risk management to review and discuss 15+ risk - Annual quality accounts - Annual Clinical Supervision Training report to Nursing and Professions' Council.	
Gaps in assurance / controls:	- Development of suicide prevention plan and self-harm strategy - Development of Clinical Governance dashboard - Development of safer staffing SOP - End of life care	

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress
Establishment of end of life care steering group to develop clinical practice standards	Deputy Director for AHP's, Social Workers	31 March 2026	Stakeholder and implementation group dates set
Development of a suicide prevention plan and Self-Harm Strategy	Professional Lead for Nursing	30 September 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	Professional Lead for Nursing	30 September 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	Head of Clinical Governance	30 September 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	31 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.	
Contributory risks at level 12 or above					
973	There are no agreed, trust wide, clinical practice standards in place that ensure consistency in regards to the access and storage of DNA CPR and ReSPECT documentation within inpatient areas.		Deputy Director for AHP's, Social Workers	ReSPECT stakeholder group/4 in 1 meeting	15 (L3xC5)

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 2028

Controls in place

- Quality Strategic Plan
- Safe Effective Reliable Care Framework
- LYPFT LCL Framework
- Improvement Methodology
- STEEEP 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 - STEEEP 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**
Development of collective leadership	Director for Collaborative Working	31 March 2026	Collective leadership programme continues for 2025/26
Building improvement capacity and capability programme.	Deputy Director of Improvement	31 March 2026	This work has been hindered due to the vacancy freeze within the organisation. However where possible the Introduction to Improvement sessions are still delivered and individual development on training methodology is given as part of improvement activity if applicable.
Creation of an integrated quality and culture dashboard	Deputy Director of Improvement	31 December 2026	The PID, which is essential for reestablishing the project's scope, objectives, timeline, and governance structure is nearly completed. The realignment of current resources in the Improvement Team to support this is complet, with the Improvement Leads now identified and the first project group meeting took place in January. This core team will expand, ensuring that relevant expertise is available for the foundational planning, design and implementation stages. Supporting Activity Whilst the setting up of the core team has been delayed, there has been good progress on activity that supports the Quality Dashboard as well as the Annual Service Quality Reports, these are: • Engagement of appropriate Executive Leads • Work to understand and integrate each element from the board level and each service • Supporting documents for each STEEEP domain to allow each Executive Lead to integrate service views with the trust wide view • EMT Collective Leadership debate to support the integration and streamlining of data, management of data and data governance.
The prioritisation of the procurement of a clinical outcomes IT system	Clinical Director	30 September 25	NetCall's patient hub was procured to meet Trust objective 13 procure a system (patient portal) that will enable clinical outcomes to be embedded into clinical services. The initial deployment will focus on the collection of outcome measures by service users via the portal, with later phases deploying appointment reminders and clinical correspondence through the portal and NHS App integration.
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 2026

Controls in place

- Trust People Plan
- Trustwide Retention Plan
- Widening Participation 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
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 October 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	15 (L3xC5)
Oversight Committee	Finance & Performance Committee	**Target Risk Score**	4 (L2xC2)
Risk Appetite	High / Open	**Target Date:**	31 March 2026

Controls in place

- Efficiency & Productivity Programme including Cost Improvement Programme
- Revenue & Capital Plan
- Standing Financial Instructions
- 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 - Efficiency Groups – Workforce & Agency Project Board / Inpatient Flow Group / Procurement Steering Group - 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 - PWC West Yorkshire Financial Improvement Support Audit

Gaps in assurance / controls:	- No agreed plan for the recurrent budget £14.5m CIP - SSL contact deficit

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress
Confirmed schemes detailing how the Trust will achieve the £14.5m recurrent budget CIP	Deputy Director of Finance	30 September 2025	Targets have currently been given to services and departments, schemes are being worked up

Re-negotiate the contract with LCC	Deputy Director of Finance	31 March 2026	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	12 (L4xC3)
651	Failure to achieve ongoing recurrent budget 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	16 (L4xC4)
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	16 (L4xC4)
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)
869	Reliance on non-patient income e.g. Commercial & Interest Receivable	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	16 (L4xC4)
649	The impact of financial risk share agreements linked to Provider Collaboratives	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	12 (L3xC4)
1323	Failure to achieve the Trust expenditure run-rate reduction required to meet the Financial plan for the year	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	16 (L4xC4)
1324	The risk that the Facilities management costs of the PFI properties will cost substantially more than the current budget post demise.	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	12 (L4xC3)
1325	Risk that the EPR system cost substantially more than the current EPT system when it is renewed	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	12 (L3xC4)

1326	Financial cost and impact of exiting the PFI	Deputy Director of Finance / Chief Financial Officer	Finance & Performance Committee	12 (L3xC4)

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
- Health and Safety Policy
- Technical Policies (Water, Asbestos, Fire Safety)
- Sustainability Plan (LYPFT Green Plan)
- Strategic Estates Plan
- Capital Project Planning and delivery
- PFI Governance Framework and overarching programme management to support work plans
- 2025 Commissioned 6 Facet Survey
- Compliance, Risk, Assurance, Governance group established locally
- Statutory Returns to NHSE (Premises Assurance Model, Patient Led Assessment of Care Environment, Estates Return Information Collection)

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 - 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 to address backlog maintenance (below condition B) - Limited capital finance availability to fully support the care services aspirations - Staffing pressures in relation to capacity, recruitment and retention, staffing competence etc short against required standards (HTM, HBN, National Standards Cleaning / Catering) - Management and current ownership provision of our estate as a large proportion is managed and invested in by others i.e PFI and NHSPS.

Mitigating actions underway for controls and assurance:			
Action	**Lead**	**Target Date**	**Progress**
Integrated governance to be agreed with Equitix to align with Trust governance framework	Head of Operations (Estates & Facilities)	30 September 2024	Verbal agreement of approach between LYPFT and Equitix. This agreement was reached at an extraordinary meeting between the two organisations, sighted at the PFI Concession Group, and will be ratified at the PFI Joint Steering Group. Action Complete and is in reference to PFI Demise and Lifecycle. Although complete, the action remains under regular review to ensure that our lifecycle requirements are met and that Equitix remedy accordingly. **Complete**
Extreme heating feasibility studies to be undertaken and costed and taken to CEG for discussion.	Deputy Director of Estates and Facilities	30 June 2025	Feasibility complete for Becklin Centre, ongoing at The Mount with reports due back at the start of August and presented to CEG then ESG by September. Reports for Becklin and The Mount complete – report to CEG / ESG required but previously agreed to defer due to other prioritise. Note new Target Date 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.	Deputy Director of Estates and Facilities	30 June 2025	To be complete in June 2025 – project nearly complete. This will reduce the risk (116) of 12
Health and Safety Audits to be completed on all the Trusts owned, leased and PFI Estate, on a periodic basis.	Head of Health and Safety	31 March 2026	This is a rolling programme to satisfy HSE requirements and to assure ourselves of our environment safety. - 2024/25 schedules complete. - 2025/26 underway.
Security Risk Assessments to be conducted on all the Trusts owned, leased and PFI Estate and to be completed on a periodic basis.	Trust Security Manager	31 December 2026	All buildings will be risk assessed across both physical and infrastructure security by the Trusts Security Team in accordance with the agreed schedule. This is a rolling programme; 2024 Risk Assessments are complete 2026 next assessments are scheduled
Updated 6 Facet Survey / Condition Survey to ascertain the condition and backlog requirement of the Trusts owned Estate.	Deputy Director of Estates and Facilities	31 June 2025	Previous review of existing 6F (completed in Feb 2022) now complete. This has prompted us to re-survey.

			Surveyors are currently on site assessing our estate (schedule to complete in June 2025) and outputs will link into capital planning and risk management.
PFI Joint Steering Group	Deputy Chief Executive / Chief Financial Officer Deputy Director of Estates and Facilities	August 2028	Quarterly meetings are maintained, and extraordinary meetings take please where required. Overseen by Exec level directors at respective organisations. Clear agenda with specific focus on business as usual, strategic projects and PFI Demise. This group now has oversight of PFI demise.
PFI LYPFT Concession Group	Deputy Chief Executive / Chief Financial Officer Deputy Director of Estates and Facilities	August 2028	Regular meeting are in place meeting every 2-3 months with a master overarching programme. Formal updates and reports provided for assurance or to seek appropriate support. The workplans are supported by legal reviews and under guidance from the NISTA (formally known as IPA)
PFI Joint Demise Group	Deputy Chief Executive / Chief Financial Officer Deputy Director of Estates and Facilities	August 2028	Established in May 2024 under formal remit set out in Terms of References – a joint working group operationally managing crucial elements of the PFI Demise and reporting into the PFI Joint Steering Group, key features include; - Leases Expiry - Condition Survey - Documentation / Operating Manuals - Formal reporting and monitoring is provided to the Joint Steering Group as well as a Joint Demise Action Plan.
PFI LYPFT Monthly Contract / Performance Monitoring Meetings	Deputy Director of Estates and Facilities	August 2028	Monthly meetings continue to progress with all parties including Mitie FM. Reports are provided to the PFI JSG and will be reviewed for effectiveness ahead of the PFI Demise and to ensure 'Business as Usual' assurance is provided in alignment to the Demise Plans.
Appraise the relevant sub-board committees on an annual basis for the outcomes of the PLACE and PAM outcomes	Deputy Director of Estates and Facilities	31 October 2025	F&P Committee have been appraised in 2025 on our statutory reporting across 2024 and have provided feedback for future reporting in 2025
Green Steering Group	Deputy Director of Estates and Facilities	31 December 2025	Updated 2025 Green Plan has prompted the review of the previously known Sustainability Steering Group. The Group /

			ToRs, Membership and Action plan has been refreshed as the approach will now be organisationally wide oppose to be being delivered from just Estates and Facilities – there are 9 workstreams in alignment with Greener NHS. Heat decarbonisation plans have been produced to help inform route to net zero.		
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		Deputy Director of Estates and 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		Deputy 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 - Digital 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	26 December 2025 (ongoing process)	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 team 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	26 December 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 December 2025 (ongoing process)	Schedule of themes determined. Comms completed and delivered against a number of themes, including broader awareness session to further support the most recent internal Phishing exercise. Continual process and subject matters continue to evolve and flex with need.
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	High Level functional specification developed. Clinical directors engaged for initial review of high-level functional specification and a number of reviews with the wider clinician base completed. Programme board set up and chaired by Medical Director. Outline Business Case in Development. Key stakeholders identified and engaged.
Delivery of EPR functional requirements outside of CareDirector to support emerging need to support clinical pathways and mitigate potential areas of clinical risk and patient safety.	Chief Digital Information Officer	31 December 2025	Review of complementary systems to support areas of development that CareDirector cannot deliver against. Review of integration and interoperability to ensure ability to review and report on all data.
Usability reviews and NHS APP integration a fixed requirement for patient portal procurement and deployment	Chief Digital Information Officer	31 December 2025	Patient portal review completed, business case approved, and solution procured. Project board set up, technical installation complete and configuration underway.
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 Digital Information Officer / Chief Financial Officer	Digital 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 Digital Information Officer / Chief Financial Officer	Digital 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 December 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
- Improving Health Equity Strategic Plan 2025-2029
- PCREF Action Plan 2024-2027
- 'Must do' work on EDS, PCREF and Equality Act duties
- Care Services Performance Meeting and agreed reporting metrics
- Waiting List Management Process in place
- Business Continuity Management System in place

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	- 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 Quality Committee o Executive Risk Management Group	- Audit Yorkshire – internal audit programme & reports - Contract meetings and monitoring - Provider Collaborative Framework - Community Mental Health Transformation Partnership Board

- Update on delivery of the Quality Strategic Plan - Waiting times monitoring process - Protected characteristics monitoring - Workforce monitoring reports - Reduction in restrictive practice workstream - Monitoring of the ethnic mix of detained patients and those who access our service - Capacity and flow programme EPRR monitoring compliance with Business Continuity management system	o Care Services Development and Delivery Group o Care Services Performance Group o ICB MH Population Board - Chief Operating Officer reports - Annual Service Quality Reports - CSDDG Annual Report - WREN / DAWN Group	

Gaps in assurance / controls:	- Health Inequalities Strategy Implementation Plan - Compliance with Business Continuity Management System - Equality Impact Assessment Process

Mitigating actions underway for controls and assurance:

Action	Lead	Target Date	Progress
Implementation Plan for the Improving Health Equity Strategic Plan	Head of Health Equity	31 May 2025	The first draft of the IHE Implementation Plan is drafted.
Set up the IHE Steering Group	Head of Health Equity	30 June 2025	Set up the IHE Steering Group to enable: • Focused Leadership: a clear structure for decision-making, ensuring the IHE Strategic Plan has strong leadership and direction. • Accountability: With dedicated teams overseeing progress, to maintain focus on our objectives and hold all stakeholders accountable. • Coordination: as a hub for communication and collaboration, ensuring that all parties involved are aligned and working efficiently toward shared goals. • Adaptability: As challenges arise, we can quickly assess and pivot strategies to address unforeseen issues effectively.
Development of an Equality & Health Inequality Impact Assessment Process	Head of Health Equity	30 June 2025	New EHIA Policy, guidance and templates 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.
Compliance with the Business Continuity Management system	EPRR Lead	31 May 2025	Work is ongoing to ensure all relevant services have a business continuity plan and that these are regularly reviewed within relevant governance groups and evidence of this is provided to the EPRR Team. It is anticipated that all Care Services Teams will have a business continuity plan by the end of

			October 2025. All Corporate Services Teams will have a plan by May 2026 (Corporate Business Plans support the delivery of Care Services).
Care Services Strategic Plan appendices to be updated by service lines	Deputy Director for Service Development	30 October 2025	The update of the appendices will take place once the 10 Year Plan has been published and there has been consideration of the requirements of this Plan and its impact on our services.

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 presents a potential risk to service user mental and physical health, due to the inability to access care in a timely way.	Operational Manager for the Gender Service	Care Services Delivery and Development Group	12 (L4xC3)
1101	West Yorkshire GPs are declining Connect blood requests for physical health monitoring under instruction from the West Yorks LMC that states eating disorder blood monitoring is not mandatory for GPs. Connect are not commissioned to provide phlebotomy services and do not have access to the necessary systems for requesting and monitoring bloods. This presents a potential risk to service user physical health, due to the inability to access care in a timely way.	CTM	Care Service Delivery and Development Group	12 (L3xC4)
1190	Due to vacancies there is a significant reduction of dietetics resource within the CLDT. Workload is further impacted due to contractual issues related to service users who are enteral fed and require ongoing support from the CLDT dieticians. This presents a potential risk to service user physical health, due to the inability to access care in a timely way.	Clinical Lead	Care Service 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)
1220	Following the CMHT service moving to BAU from BCP status there are legacy issues which present a risk to the overall quality and performance delivery across CMHTs. There is a risk is that the CMHTs are under staffed across professional registered roles and unable to recruit to vacancies.	Head of Operations	Care Service Delivery and Development Group	12 (L4xC3)
1260	The risk of new and emerging pandemics, as shown by COVID19, could have a devastating impact on society and a direct impact on how the Trust continues to provide services.	EPRR Lead	EPRRG	12 (L3xC4)

1263	A supplier of a service that has been identified as critical to one of the Trust main service provision obligations or a key supporting service goes into administration or entirely closes, creating a service provision risk.	EPRR Lead	EPRRG	12 (L3xC4)
1270	ADHD waiting list of 4,700 plus patients for diagnostic assessment, 100 minimum patients added to list each month, waiting time for new non-urgent assessments of 10 years minimum, likely far longer. This presents a potential risk to service user mental health, due to the inability to access care in a timely way.	Operational Manager	Care Service Delivery and Development Group	12 (L4xC3)
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	12 (L4xC3)
1277	Journey and DBT group work programmes with excessive wait times for first contact, assessments completed and treatment commencing. Current wait for groups minimum 6 months which presents a risk that service users cannot access the services they need.	Operational Manager	Care Service Delivery and Development Group	12 (L4xC3)
1289	Physical health team are experiencing caseload and capacity issues and are unable to provide the level of service to meet service user need.	CTM	Care Service Delivery and Development Group	12 (L4xC3)
1306	Lack of specialist addictions midwifery capacity due to vacancies with the risk service users cannot access the level of service required.	CTM	Care Service Delivery and Development Group	10 (L5xC2)

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 revie that has been undertaken to ensure that this accurately reflects the position as of May 2025, including risk scoring and mitigating actions.

Clare Edwards
Associate Director for Corporate Governance & Board Secretary
23 May 2025

Agenda item
20

Meeting of the Board of Directors

Paper title:	Fit & Proper Persons Declarations
Date of meeting:	29 May 2025
Presented by: (name and title)	Merran McRae, Chair
Prepared by: (name and title)	Clare Edwards, Associate Director for Corporate Governance

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

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 Health and Social Care Act 2008 (regulated activities) Regulations 2014 set out requirements by which all directors should be, and continue to be, fit and proper persons by nature of the fact they hold positions of significant responsibility and can maintain the confidence of public, patients and staff.

The Fit and Proper Person Test (FPPT) Framework strengthens and reinforces individual accountability and transparency for board members, enhancing the quality of leadership within the NHS.

The regulations require directors to:

- be of good character
- have the necessary qualifications, competence, skills and experience
- be able by reason of their health (subject to reasonable adjustments) to properly perform tasks intrinsic to the position
- not have been responsible for, contributed to or facilitated any serious misconduct or mismanagement while carrying out a regulated activity
- not to be unfit to hold office on a range of grounds (eg undischarged bankruptcy, criminal convictions, inclusion on barred lists, serious misconduct in the course of carrying out a regulated activity etc).

During March 2025, all Board members were required to complete a self-attestation to confirm that they are in adherence with the FPPT requirements. In addition, annual checks have been conducted to confirm former satisfactory background checks are still current, these include social media searches, health and social care regulators' checks, disqualified directors, insolvency and bankruptcy registers.

Compliance with the requirements will be formally reported to NHS England by 30 June 2025. This will be completed by the Chair, and will provide assurance that all Board members fulfil the requirements of the Fit and Proper Person Test.

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

Recommendation

The Board is asked to be assured that the Trust is fully compliant with the Fit and Proper Person Test and Framework as at the date of this report.

Personal			Appraisal				HR						Suitability					
Name	Main Role	Additional Role	Annual Appraisal	Training & Development	Self Attestation	Declaration of Interest	Disciplinary	Grievance	Whistleblowing	Behaviour	DBS Issues	DBS check	Insolvency Check	Disqualified Directors	Disqualified Trustee	Employment Tribunal	Social Media	Registering Pofessional Body
Chair / Non-Executive Directors																		
Merran McRae	Chair		17-Jun-24	Compliant			No issues identified						No issues identified					N/A
Zoe Burns-Shore	Non-Executive Director		29-May-24	Compliant			No issues identified						No issues identified					N/A
Frances Healey	Non-Executive Director		29-May-24	Compliant			No issues identified						No issues identified					Compliant
Cleveland Henry	Non-Executive Director	Senior Independent Director	25-Jun-24	Compliant			No issues identified						No issues identified					N/A
Kaneez Khan	Non-Executive Director		05-Jun-24	Compliant			No issues identified						No issues identified					N/A
Katy Wilburn	Non-Executive Director		27-Jun-24	Compliant			No issues identified						No issues identified					N/A
Martin Wright	Non-Executive Director	Deputy Chair	05-Jun-24	Compliant			No issues identified						No issues identified					Compliant
c																		
Sara Munro	Chief Executive		17-Jul-24	Compliant			No issues identified						No issues identified					Compliant
Joanna Forster Adams	Chief Operating Officer		12-Jul-24	Compliant			No issues identified						No issues identified					N/A
Dawn Hanwell	Chief Financial Officer	Deputy Chief Executive	08-Jul-24	Compliant			No issues identified						No issues identified					Compliant
Chris Hosker	Medical Director		21-Jun-24	Compliant			No issues identified						No issues identified					Compliant
Nichola Sanderson	Director of Nursing & Professions		01-Jul-24	Compliant			No issues identified						No issues identified					Compliant
Darren Skinner	Director of People & Organisational Development		26-Jun-24	Compliant			No issues identified						No issues identified					Compliant

Agenda item
21

Meeting of the Board of Directors

Paper title:	Declaration for Condition 7 of the Provider Licence (Continuity of Services)
Date of meeting:	29 May 2025
Presented by: (name and title)	Sara Munro, Chief Executive Officer
Prepared by: (name and title)	Rose Cooper, Deputy Head of Corporate Governance 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

The Provider Licence requires the Board to self-certify annually its compliance with Condition 7 of the licence and to confirm that the Trust has the required resources available to it for the next 12 months.

The attached paper sets out this declaration in more detail. The evidence matrix is provided as appendix 1 which includes the statement of compliance and supporting evidence. The executive and senior manager leads were asked to review and confirm that the information provided is consistent with their knowledge and understanding of the controls in place to ensure that the Trust is compliant with Condition 7 of the Provider Licence.

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

No

Recommendation

The Board is asked to be assured of the process for reviewing the evidence of our control systems and processes in place to ensure compliance with Condition 7 of the Provider Licence. The Board is also asked to agree the declaration shown on the attached.

Meeting of the Board of Directors

29 May 2025

Declaration for Condition 7 of the Provider Licence (Continuity of Services)

1 Executive summary

NHS foundation trusts are required to self-certify that they can meet Condition 7 (Continuity of Services) of the NHS Provider Licence. The annual self-certification provides assurance that NHS providers are compliant with this condition of their licence.

On an annual basis, the licence requires NHS providers to self-certify that:

- The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.

The Trust is not required to submit the self-certification to NHS England, but the Board is required to sign off the certificate and have the outcome of the self-certification exercise available upon request.

The Trust intends to make a positive confirmation on the declaration. The rationale for compliance is set out below. Further information can be found in the evidence matrix provided as appendix 1.

2 Condition 7 (Continuity of Services) – Declaration

After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Summary rationale for rating: Having reviewed the financial statements the Board is satisfied that the Trust has the required resources for the period of 12 months, taking all factors into account.

Rating: Confirmed

3 Conclusion

The Trust intends to make a positive confirmation on the declaration for Condition 7 (Continuity of Services) of the NHS Provider Licence. The rationale for this is set out in the paper and further information can be found in the evidence matrix provided as appendix 1.

4 Recommendation

The Board is asked to be assured of the process for reviewing the evidence of our control systems and processes in place to ensure compliance with Condition 7 of the Provider Licence. The Board is also asked to agree the declaration shown on the attached.

Rose Cooper
Deputy Head of Corporate Governance
20 May 2025

PROVIDER LICENCE (Continuity of Services) 2025/26

Under the Provider Licence the Board of Directors is required to certify that it is (or is not) satisfied that it takes all reasonable precautions against the risk of failure to comply with Condition 7 of the Provider Licence (Continuity of Services). To allow this certification to be made the table below sets out how we comply with the licence condition.

SUPPORTING EVIDENCE FOR THE LICENCE CONDITION

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
CoS7 - Availability of resources Requires the Licensee to at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.	**Statement of compliance** The Trust is compliant with this condition, having made a declaration and is declaring a strong financial position. Approval of the Trust's financial plan is discussed at Board and at the Finance and Performance Committee.	**Evidence of compliance** • Financial information and projections are presented to the Board at each meeting • Finance and Performance Committee papers and minutes showing that the Committee is content that the Trust remains financially viable • Operational Plan submission and financial projections for the coming year, again demonstrating on-going financial viability and ability to meet ICB targets • Signed and committed contracts which are predominantly block contracts • CIPs process is in place • Capital programme is kept under constant review through the Finance and Performance Committee and the Board	Lead for evidence = Jonathan Saxton, Deputy Director of Finance with lead director = Dawn Hanwell