Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST
PUBLIC MEETING OF THE BOARD OF DIRECTORS
will be held at 9.30am on Thursday 26 September 2024
Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR

A G E N D A

		LEAD	TIME
1	**Sharing stories – Community Mental Health Engagement and Involvement team - Sharing our lived experience and insights** (verbal)		9.30am
2	**Apologies for absence** (verbal)	MM	10.10am
3	**Declarations of interests and any declarations of conflicts of interest in any agenda item** (enclosure)	MM	-
4	**Minutes of the meeting held on 25 July 2024** (enclosure)	MM	-
5	**Matters arising** (verbal)	MM	-
	5.1 Feedback from Shadow Board of Directors (verbal)	MW	-
6	**Actions outstanding from the public meetings of the Board of Directors** (enclosure)	MM	10.20am
7	**Chief Executive's report** (enclosure)	SM	10.25am
8	**Report from the Chair of the Finance and Performance Committee held on 23 September 2024** (to follow)	CHe	10.35am
9	**Report of the Chief Operating Officer** (enclosure)	JFA	10.40am
10	**Community Mental Health Transformation Update (enclosure)**	JFA	10.50am
	Break		11am
11	**ICB Serious Mental Illness Maturity Index Self-Assessment Response** (enclosure for information)	JFA	11.15am
12	**Report from the Chief Financial Officer** (enclosure)	DH	11.25am
13	**Report from the Chair of the Quality Committee for the meeting held on 12 September 2024** (enclosure)	FH	11.35am
14	**Integrated Patient Safety Report** (enclosure)	NS	11.40am
15	**Safer Staffing Report** (enclosure)	NS	11.45am
16	**Guardian of Safe Working Hours Q1 Report** (enclosure)	CH	11.55am

17	**Report from the Chair of the Workforce Committee for the meeting held on 8 August 2024** (enclosure)	**ZBS**	**12pm**
18	**Annual Equality Diversity and Inclusion (EDI) Workforce Race and Equality Standards (WRES) / Workforce Disability and Equality Standards (WDES) and Gender Pay Gap progress update** (enclosure)	**FS**	**12.05pm**
19	**Report from the Chair of the Mental Health Legislation Committee for the meeting held on 12 September 2024** (enclosure)	**KW**	**12.10pm**
20	**Report from the Chair of the Committees in Common held on 31 July 2024** (enclosure)	**MM**	**12.15pm**
21	**Terms of Reference for the Board of Directors** (enclosure)	**MM**	**12.20pm**
22	**Use of Trust Seal** (verbal)	**MM**	**-**
23	**Any other business**	**MM**	**12.25pm**

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

AGENDA ITEM

3

Declaration of Interests for members of the Board of Directors

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

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

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
Katy Wilburn Non-executive Director	**Non-executive Director** Thirteen Group	None.	None.	None.	None.	None.	None.	None.
Martin Wright Non-executive Director	None.	None.	None.	**Trustee** Roger's Almshouses (Harrogate) .	None.	None.	None.	None.

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

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

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

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Minutes of the Public Meeting of the Board of Directors held on Thursday 25 July 2024 at 9.30am in Inspire@ room, Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Kendall Street, Leeds, LS10 1JR

Board Members		**Apologies**
Mrs M McRae	Chair of the Trust	
Mrs Z Burns Shore	Non-Executive Director	
Mrs J Forster Adams	Chief Operating Officer	
Mrs D Hanwell	Chief Financial Officer and Deputy Chief Executive	
Mr C Henry	Non-Executive Director (Senior Independent Director)	✓
Dr F Healey	Non-Executive Director	
Dr C Hosker	Medical Director	
Ms K Khan MBE	Non-Executive Director	
Dr S Munro	Chief Executive	
Mr D Skinner	Director for People and Organisational Development	
Miss N Sanderson	Director of Nursing and Professions	
Miss K Wilburn	Non-Executive Director	
Mr M Wright	Non-Executive Director (Deputy Chair of the Trust)	

All members of the Board have full voting rights.

In attendance

Mrs C Edwards	Associate Director for Corporate Governance / Trust Board Secretary
Ms K McMann	Head of Corporate Governance
Mr K Betts	Corporate Governance Officer
Ms Angela Macdonald	Prevention and Management of Violence and Aggression (PMVA) Lead Tutor (for minute 24/075)
Ms Gracie Taylor	Prevention and Management of Violence and Aggression (PMVA) Tutor (for minute 24/075)
Ishmael	Service user (for minute 24/075)
Ms Rachel Pilling	Carer Coordinator, Patient & Carer Experience Team (for minute 24/075)
Dr Wendy Neil	Consultant Psychiatrist / Deputy Medical Director / Responsible Officer (for minute 24/082)
Dr Priyanka Bichala	Consultant Psychiatrist and Director of Medical Professional Standards (for minute 24/082)

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

		Action
	Mrs McRae opened the public meeting at 09:30 and welcomed everyone.	
24/075	**Sharing stories – Lived Experience in the Prevention and Management of Violence and Aggression (PMVA) training** (agenda item 1) Mrs McRae welcomed Ms Macdonald and Ms Taylor to the meeting.	

Ms Taylor provided an overview of the team and the focus on prevention of violence and aggression related to clinically related challenging behaviour and de-escalation to baseline behaviours.

She provided an overview of the co-production timeline and the inclusion of service users and carers to develop videos to use within the training. She noted that the approach had drastically evolved, and work had taken place to change the culture away from restraint and to consider all factors to prevent the need for intervention.

She informed the Board of the focus on multi-disciplinary team working and the use of lived experience to understand first hand the effects of restraint. She noted that service users were experts by experience and attended staff training where possible.

The Board were shown two videos of experiences of restraint, both positive and negative, and the impact of this on the service user. The video from the service user included why they felt it was important to be a part of staff training.

Ms Taylor noted that the videos were used in training prior to practical training taking place, and feedback was received from staff that they supported wider understanding and empathy regarding prevention of violence and aggression.

Ms Khan noted the importance of sharing stories, especially given recent events, to acknowledge the human element and the power balance between staff and service users within diverse communities. Mrs McRae noted that there was a focus on restrictive practice in the Mental Health Legislation Committee which reflected the power imbalance and queried if this was covered in the training. Ms Macdonald confirmed that this ran through all the course content and the trauma for staff and service users was recognised, with a focus on Trauma Informed Care. She noted that the team ensured that all training was as inclusive as possible with an open and transparent approach taken with open discussion. Mrs McRae acknowledged it was helpful to know that it was built into the training. Ishmael provided background to his experiences and the impact on his life at the current time, and that he wanted to be involved and support others moving forward.

Dr Healey thanked the team for the presentation and the detail around the approach to the power imbalance was helpful. She acknowledged that there were various reasons for restrictive practice being needed and queried how all needs were considered. Ms Macdonald responded that co-production had been undertaken with Older People and Learning Disability services to ensure different service users' perspectives were included. She noted that most issues were caused by staff responses to service users therefore training was key, and communication was vital to ensure escalation of behaviour did not take place. Ms Taylor added that there was a section in the training about staff approach and the impact on escalation, and it also considered sensory issues for service users.

The Board were informed that the PMVA team received all incidents regarding restraint to review themes and trends to then be able to consider this within the training and any additional requirements for services.

Mr Skinner thanked the PMVA team and services users for the co-production approach and the valuable resource it developed. He acknowledged that it was a small team for the organisation, however the presentation demonstrated the impact and value of the team. He noted that the training was of a high standard compared to other organisations which provided assurance to the Board on the approach taken.

Mrs Forster Adams noted the inspirational approach of the team and offered her thanks for the support provided by the team to Red Kite View. The recognition of good practice was important, along with the co-production element, and this should be the focus of the work moving forward to encourage others to be involved.

Dr Munro thanked the team for their response to the questions which demonstrated the approach to not shying away from having difficult discussions and that approach should remain. She noted it would be helpful to track the impact of the training approach on the use of restrictive practice to demonstrate the power of the training. Dr Hosker added his thanks for the powerful presentation and the focus on co-production demonstrated how important it was.

Mrs McRae concluded that the work was a great example of co-production, and the support provided to staff through the training was good. She reiterated the importance of considering the impact moving forward, and the need to consider benchmarking against other Trusts to demonstrate the impact. She thanked the team for their presentation to the Board.

The Board **thanked** the PMVA Team for attending the Board and providing an update on the training approach.

24/076 **Apologies for absence** (agenda item 2)

Apologies were received from Mr Cleveland Henry, Non-Executive Director.

24/077 **Declaration of interests for directors and any declared conflicts of interest in respect of the agenda items** (agenda item 3)

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

24/078 **Minutes of the previous meeting held on 30 May 2024 and 20 June 2024** (agenda item 4)

Mr Wright noted that minutes from the meeting on 30 May 2024 suggested that the Finance and Performance Committee amended the risk rating for two of the Board Assurance Framework risks, and therefore this should be amended to note that the Commmittee suggested the risks should be upgraded. This amendment was therefore made.

The minutes of the meeting held on 30 May and 20 June 2024 were **received** and subject to the above amendment being made, **agreed** as an accurate record.

24/079 **Matters arising** (agenda item 5)

5.1 Questions from members of the public for the Board of Directors

Mrs McRae noted that two questions had been received from members of the public which would be responded to in the meeting.

1) Question from Dr Pascale Harper regarding Gender ID Service

Dr Hosker provided a response acknowledging the reason for the question being asked given the current situation. He noted that the issue was not due to a lack of drive to improve, the service was passionate and wanted to make a difference, however the issue was due to a mismatch between capacity and demand, including rapid assessment. He added that this was a national problem not just for Leeds. He shared he had been on a call that week and there was a predicted waiting time of 8 years on the waiting list at the current time. He noted that the national Cass Review had recommended a review of adult services, which would take place in due course.

In response to the specific questions raised, he noted that the Board would like to undertake radical work however were not at liberty to do so, therefore there was a continued lens on quality and improvement. He added the Gender ID Service team attended the Board in May 2024 to provide an update on the service including service user driven follow up. He acknowledged that there was a need for more communication, and this needed to be co-designed and co-produced with service users. In relation to the pilot that other organisations had been part of, he confirmed that the Trust put in a bid to be a pilot site but was unsuccessful, however the Trust would use learning from the pilot to implement any improvements.

In relation to the endocrinology question, Dr Hosker confirmed that the Trust did have an advanced guidance service that was functioning and in place. He acknowledged the resistance from some GPs to prescribe medication and that the Trust was supporting this and attempting to be proactive where problems were seen. He added that the service would like to offer more training however due to capacity issues, there was a balance needed between clinics and training.

A member of the public in attendance noted that the community were open to collaboration and that the NHS was least open to this critical friend approach. In their experience the response was not the reality of experience, and Dr Hosker acknowledged that experiences may be different across different areas of the city, and that he accepted more needed to be done.

Mrs McRae noted the recent presentation to Board and that the response from Dr Hosker would be put in writing back to the requestor, with an opportunity for follow up discussion. **CH/CG Team**

2) Question from Mr Frazer regarding cafes on some Trust sites

Ms Sanderson acknowledged that the café facilities on some sites had not reopened following COVID, and that they had been an important socialisation opportunity for service users. She noted that work was underway with the estates team to look at the opportunities available. It was agreed that a more detailed update would be brought to the September 2024 meeting. **NS**

24/080 **Actions outstanding from the public meetings of the Board of Directors** (agenda item 6)

Mrs McRae presented the action log which showed those actions previously agreed by the Board in relation to the public meetings, those that were completed and those that were still outstanding.

Mrs Burns-Shore updated that the Breathing Space action was in progress and an update would be provided at the next meeting.

Ms Sanderson updated that the integrated Patient Safety Report would come to the next meeting in September 2024.

The action related to clinical trials information was noted as closed as the report would be shared in due course.

Dr Munro provided an update regarding the Freedom to Speak Up action noting that the roll out of PSIRF would support staff to raise patient safety concerns. Training through the Learn system would support this with the minimum requirement being an awareness session which would be shared with the Board to raise awareness of the new approach to patient safety.

In relation to the exit interviews action for Workforce Committee, Mr Skinner updated that the team were reviewing the bespoke interview form and free text, and this would be amended to include nuanced questions to support analysis. To date there was a theme related to conversations around personal development happening after resignation, therefore there was a need to bring career conversations earlier into development opportunities. This action was closed.

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

24/081 **Report from the Chief Executive** (agenda item 7)

Dr Munro presented her Chief Executive's report, noting it as read by Board members, drawing particular attention to the national matters regarding the general election which would now lead to an immediate review of productivity in the NHS and a 10-year strategy development. She shared that the Trust would be writing to local MPs with an open offer to meet and to share the Annual Report. She also noted that an additional document had been shared regarding the King's Speech. The publication of the Module 1 report from the

COVID Inquiry had been received since the completion of her report, therefore it was agreed that the NHS Providers summary update would be shared. **CE**

She noted that the pay announcement for NHS staff was expected the following week, and balloting amongst GPs was taking place regarding industrial action. Following the result of this, decisions would then be made to agree the approach to be taken to respond as it would impact on services.

Dr Munro noted that the unannounced CQC visit would be discussed later in the Board, and that in the 'Reasons to be Proud' section of her report she noted the nomination for Ward 2 at the Newsam Centre which demonstrated the work that had taken place following the listening exercise undertaken. She added that work continued with the team and, as there was satisfactory leadership and governance in place, the executive oversight had been stepped down to routine.

Dr Munro informed the Board that the Joint Strategic Needs Assessment for Leeds had been published which detailed important content specific to Leeds regarding demography, including reducing birth rate. It noted that serious mental health data remained static, with an overall reduction in the number of children and young people in specialist in-patient mental health provision. It was agreed that the report would be shared with Board members. **CE**

Mrs McRae acknowledged the work in Forensics Services and the impact it has had. She thanked Dr Munro for her report.

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

24/082 **Annual Responsible Officer & Medical Revalidation Report** (agenda item 8)

Mrs McRae welcomed Dr Wendy Neil and Dr Priyanka Bichala to the meeting to present the Annual Responsible Officer and Medical Revalidation Report.

Dr Neil thanked Dr Bichala and her team for the report, noting that she attended the Board annually to provide assurance around the Trust acting as a designated body for doctors. Dr Neil took the report as read and highlighted the improvements in standards of appraisals for doctors and the impact on engagement and protected time to reflect. She thanked Dr Hosker and Mrs Hanwell for the financial support provided for the equal remuneration of appraisers.

She noted the 100% compliance rate for background checks before doctors started in post which was testament to the work undertaken to support this improvement.

In relation to actions, she highlighted the increased expectations on doctors so there was a need to provide timely and accurate information regarding areas such as risk and safeguarding. She noted the link with the Freedom to Speak Up Guardian to ensure consistent responses to concerns raised via

different approaches to support learning where possible. She added that the evaluation of the work regarding the Managing Concerns about Medical Staff Policy and cultural inclusion ambassadors would be the key focus for the next 12 months.

Mrs Hanwell noted the submission of the report to NHS England, and queried whether it could be used to help with recruitment and retention of medical staff. Dr Neil noted that the report was a combination of information, and it could be used to support job description wording and highlighting certain sections to emphasise areas of importance. She added that teams worked closely with medical education to consider support for higher trainees to encourage substantive employment within the Trust.

Dr Hosker thanked the team for the work undertaken noting the 100% compliance for background checks. He added that the next phase was job planning which was outside the scope of the report but linked to key elements.

Mrs McRae thanked Dr Neil for the comprehensive report and noted her and the Board's retrospective approval for the submission of the report to the NHS England.

The Board **received** the Annual Responsible Officer & Medical Revalidation Report and **noted** the content. The Chair confirmed **approval** for the submission for the report.

24/083 **Report from the Chair of the Finance and Performance Committee for the meeting held on 23 July 2024** (agenda item 9)

Miss Wilburn presented the Chair's reports for the Finance and Performance Committee and took the report as read. She highlighted the improvement in the Out of Area Placement position, which was on trajectory, and acknowledged the reduction in further afield placements. She also noted the development in the Specialist Supported Living Service and the negotiations regarding the liability position, and that the service provided an opportunity to resolve some financial pressure.

She noted the acknowledged change in the presentation of the year end position related to PFI monies, but that this was not a change to the plan but that the accounting process had changed which was reflected in the report.

Miss Wilburn informed the Board that detail regarding agency spend had been provided to the Committee which gave greater detail and understanding on the progress with the work, but this remained behind trajectory. She noted the vacancy freeze in place, and the Committee would continue to monitor the required reduction in medical agency spend.

She also noted the received update from the Estates Team regarding the resolution in place to resolve the outstanding door issues at Red Kite View.

Mrs McRae reiterated the progress made with Out of Area Placements and the and positive impact on service users.

Mrs Forster Adams noted the in-depth conversations that had taken place at the Committee meeting, however noted a matter of accuracy in the Chair's report which stated a cap on admissions had been in place for 12 months however this was incorrect and should state two months of various levels of reduced occupancy. It was agreed that this amendment would be made to the report. **CG Team**

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

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

24/084 **Report of the Chief Operating Officer** (agenda item 10)

Mrs Forster Adams presented her report, taking it as read by the Board with some points to highlight. She noted her thanks to the team working on Out of Area Placements for their team working and the collaborative approach in place. She noted that the position was ahead of plan, but a cautious approach was being taken, with the accommodation issues being worked through with the Council. In relation to Red Kite View, she noted the consistency in workforce challenges regarding substantive nursing staff and recruitment and retention.

She informed the Board that work was underway at a national level regarding EPRR standards for assessment, and an update would be provided to the next Board meeting.

Dr Healey asked for clarification regarding primary care mental health provision by the Trust, and Mrs Forster Adams confirmed the Trust did provide it and it would be clarified in her next report in more depth, however a partnership arrangement was in place for the provision of some primary care mental health services in the Wellbeing service. She noted that detail around partnership and provider collaborative arrangements could be provided to inform the Board of the detail so she would include this within a future report.

Ms Khan queried the timeline for the 111 mental health approach, and Mrs Forster Adams responded that it had been discussed at the Finance and Performance Committee and the issue was with the communication of the arrangements in place as there had been a national signal to undertake a soft launch. She confirmed the relevant teams were working on this at the current time to ensure effective communication to support positive experiences for service users. She provided assurance to the Board that this was being dealt with.

Mrs McRae noted the approval of the Trust Pandemic Plan however there had been a national report that had been critical of the national arrangements. Mrs Forster Adams confirmed the Trust was aware of the report and it was being actively reviewed following the approval of the Trust plan and any amendments requirements would be reviewed.

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

24/085 **Report from the Chief Financial Officer** (agenda item 11)

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

She highlighted the summary table regarding the PFI change in accounting regulations which led to an artificial surplus. She confirmed the position had not changed and it was a presentational surplus only. She informed the Board that month 3 was behind plan but she acknowledged the improvement in the Out of Area Placement position and run rate, and the month position had been supported by non-recurrent monies. She noted the continued focus on making changes recurrent in the budget.

Mrs Hanwell informed the Board of the scale of the financial challenge, and that whilst West Yorkshire was seen as least challenged, in the current landscape the national investigation and rapid intervention regime (I&I) would be enforced on Trusts in segment 4 of the oversight framework; she noted the Trust was currently in segment 2. She added that the regime would be implemented at system level if the overall position was poor, and that it was segmented at system level not individual provider level. She informed the Board that the West Yorkshire Association of Acute Trusts (WYAAT) had entered voluntary consultancy with PwC to review the financial position to improve the deficit which would likely cover phase 1 of the I&I regime. Given the scale of risk, the view was to consider voluntarily adopting this approach with an external reviewer. She noted that preparatory work was underway to review the checklist for the audit if the regime was approached which was helpful to review and consider opportunities.

She highlighted the capital awards, however the award of the perinatal capital was only the resource limit not the cash, therefore the Trust would need to use Trust cash reserves. This was a challenging result as it was not the basis for the business case. The use of Trust cash would require Board approval hence the alert in the report, however this was in the process of trying to be avoided.

She noted the potential changes to the cash regime and due to the cash reserves of the Trust there was pressure in the ICB to review this, therefore she was alerting the Board to potential changes. She added that a mechanism for the trigger of sharing cash reserves across other Trusts could be implemented. Dr Munro added that the strategic risk around the PFI would need investment hence the cash reserves approach. In relation to the lack of provision for the perinatal award, had the Trust used the priority list then investment would have been made in other areas in the first instance. In relation to the cash reserve point, Mr Wright noted that given the PFI position the Trust had good reason to have a cash reserve.

Mrs Hanwell noted that as the ICB position was the determinant of segment position, the £46m deficit at the end of Q1 was a lack of reassurance regarding

segment 2 remaining the position. This represented a challenge for the Trust with the potential for a change to financial regime.

Mrs McRae queried the approval mechanism for the perinatal cash issue, and Mrs Hanwell confirmed that it would need to be fully considered before further agreement, including discussion with the Provider Collaborative. Dr Munro added that the Trust could still be the lead of the Provider Collaborative without the additional beds, but the commissioning contract could change. Mrs Hanwell noted that a short-term view was being taken currently when discussions were taking place externally about the cash, and it was unclear what the capital regime would be at the time of the buy out for the PFI. She confirmed that updates would be provided as discussions progressed.

Dr Healey asked about the implications for not being able to spend the money on other items critical for staff morale and service provision if it had to be spent on the perinatal service and whether this would impact on safety or on wider quality issues. It was noted that the Board would be kept up to date as the position progressed.

Mrs Burns-Shore queried the outcome of an external consultancy review versus the cost. Mrs Hanwell noted that a light touch approach had been taken at WYAAT and feedback was that the costs were not large for a helpful report.

Mr Wright clarified to the Board that the cash reserves discussed were owned by the government and were not in a Trust bank account.

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

24/086 **Operational Priorities Quarter 1 24/25 Update Report** (agenda item 12)

Mrs Hanwell presented the report which was taken as read by the Board. She highlighted the amended format which had received positive feedback at Finance and Performance Committee along with a reduction in the number of overall priorities. The report provided a succinct oversight of the position and linked to the other reports from the Executive Directors.

In relation to the Q1 position, the red rating was due to finances which was to be expected give the position. She noted that good progress was being made elsewhere as shown within the report.

The report format received positive feedback from Board members and Dr Healey requested consideration of an additional column for the expected year end position to track progress.

Mrs McRae queried whether the Workforce Committee were reviewing the medical agency spend in depth, and Mr Skinner confirmed that work was underway, and a reporting structure was in place. Miss Wilburn added that detail was provided at Finance and Performance Committee regarding the financial position for agency spend too.

The Board **received** the Operational Priorities Quarter 1 24/25 update and **noted** the content.

24/087 **Approval of the Data Security & Protection Toolkit** (agenda item 13)

Mrs Hanwell presented the Data Security and Protection Toolkit which had been discussed at Finance and Performance Committee. She noted it was a mandatory self-assessment which was then audited for assurance purposes. She added that there had been an increase in the emphasis on cyber related issues and there would be a change in the toolkit next year to focus on this.

She noted her thanks to everyone involved and that it was a unique and strong position to see positive results across the assessment.

She noted that retrospective approval from the Board was required as the self-assessment had already been submitted to meet the deadline. The Board approved the assessment position.

The Board **received** and **approved** the Data Security & Protection Toolkit.

24/088 **Cyber Security Update Report** (agenda item 14)

Mrs Hanwell presented the Cyber Security update report which had been discussed at Finance and Performance Committee. It demonstrated a good position, with Multi-Factor Authentication processes running concurrently with the aim to reduce to one process in due course.

It was noted that the risk related to Care Director was on the Board Assurance Framework as a contributory risk which was important to acknowledge. Mrs Hanwell noted that the ability to have local access to make changes to the system had been unlocked for the Trust so risk mitigation had been improved but there would be a resource impact.

The Board **received** the Cyber Security Update Report and **noted** the content.

24/089 **Report from the Chair of the Quality Committee for the meetings held on 13 June and 11 July 2024** (agenda item 15)

Dr Healey presented the Chair's reports and took them as read by the Board. She highlighted that the Children & Young People Service and Forensic Service annual reports had been presented. She noted that they were reflective of discussions earlier in the meeting and the progress made was to be celebrated as the services demonstrated the ability to be self-critical and provides assurance into their insight and awareness of issues.

She also noted the level of interaction with other Committees from the Quality Committee perspective, which were good examples of collaborative working.

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

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

24/090 **Report of the Director of Nursing and Professions** (agenda item 16)

Ms Sanderson presented the report and took it as read, noting that it was a shorter report than previous submissions as the focus was on the main priorities for the last two months, in recognition of the discussions at the recent Board Development Day to focus and prioritise content.

She noted the ongoing work regarding culture of care, which was a national programme with the Trust having four inpatient areas involved. Work would continue to be shared through governance routes.

In relation to individualised risk assessments, Ms Sanderson noted the move towards a dynamic risk assessment process to support collaborative working with service users and carers. She added that the suicide and self-harm risk assessment tool was in place for environmental risks in services. She noted that a group had been formed to report into Clinical Environment Group to monitor progress, share learning from risk assessments and sharing actions taken. The focus was on removing blanket decisions and ensuring personalised actions were put in place following assessment.

She informed the Board that PSIRF was launched on 16 July 2024 with a focus on learning and drawing on an open approach to the impact and experiences from service users and staff. The Health Services Safety Investigations Body (HSSIB) had visited as part of a national report on in-patient deaths, and the Trust had received positive feedback on our services.

The Nursing and Midwifery Council (NMC) review had highlighted safeguarding concerns and in response the Trust had reviewed all outstanding outcomes for those staff who are in the process of NMC review.

Ms Sanderson informed the Board about the unannounced CQC inspection that had taken plan on 16 & 17 July 2024 at Red Kite View and Mill Lodge. The visit was done under the new regulatory framework with five key questions being the focus. The Trust was working on the return of data requests following the visit and anticipated that the first draft report would be available in early September which would provide an opportunity to do an accuracy check.

Mrs Burns-Shore queried the length of the pilot for culture of care, and Ms Sanderson responded that it was a three-year programme to support embedding learning across inpatient and community areas. It ranged from executive mentoring and supervision to action learning sets.

Miss Wilburn noted the NMC referrals and suicide attempt data, and that the Board would value an update on how that progressed. She highlighted the sexual misconduct allegations and the link back to the Trust staff survey results, with a need to consider recommendations and the broader action needed. Ms Sanderson agreed and added that there was a need to understand the themes in detail and the outcomes from NMC referrals. She noted that there was a lack of consistency in outcomes from the NMC, and as a Trust we undertook a robust review prior to referral to the NMC. Dr Healey noted the national concerns regarding NMC outcomes and a lack of consistency, and a need to consider local action to ensure that the Trust did not have vulnerable staff in other professions as it was not unique to the NMC and was similar across professional regulators. Dr Hosker agreed and noted that Dr Neil had undertaken analysis of the outcomes of professional procedures, so it made sense to consider this.

Mrs McRae thanked Ms Sanderson for the report.

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

24/091 **Safer Staffing Report** (agenda item 17)

Ms Sanderson presented the report and noted the detail continued to include more than staffing numbers. The focus of the report was on four key areas within Trust services and a detailed analysis had been undertaken to provide the broader picture for the Board.

Registered nurse vacancies continued to be a challenge, however some trainees who had completed nurse training would commence employment in September 2024 at Healthcare Support Worker (HSW) level until individual pins were received. In relation to fill rate, Ms Sanderson noted that it was important to understand that the data could look skewed as there were occasions where two HSWs were needed to fill one registered vacancy, so this impacted on the establishment data. The data was also impacted by observations required based on clinical need. She noted that work continued regarding baseline needs for establishment

Miss Wilburn queried if the Specialist Supported Living Service high vacancy numbers for HSWs was aligned to the current establishment, and Mrs Hanwell confirmed that vacant beds nominally impacted on the nursing need within the service. Mrs Forster Adams added that the Specialist Supported Living Service had a focus on maintaining the workforce and discussions were underway with the Local Authority around establishment numbers and the HSW role.

Mr Wright questioned the timescale for the establishment work and Ms Sanderson noted that the work through the Safer Staffing Group was ongoing, with different approaches in place, including financial considerations. She noted that there would always be a variance in care needs therefore a final position was not possible. Mr Wright requested an explanation be added into the report regarding the results given this would be ongoing.

Mrs Forster Adams noted that she was confident about the safer staffing work and the link to efficiencies, and the importance of establishments was in context with practice and care needs. Mrs McRae added it was important to have the right baseline supported by the correct approach to going above this, to provide confidence in the data and the clinical requirements for doing this.

Dr Healey discussed the production of planned versus actual staffing and the commentary in Quality Committee around this, with the potential to focus on what was needed by the service rather than the establishment. Mrs McRae noted that it was important to know the baseline and control arrangements in place.

Mrs McRae thanked Ms Sanderson for the report.

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

24/092 **Medical Directors Report** (agenda item 18)

Dr Hosker presented his report and highlighted several points. He noted that consultant recruitment was ongoing with work in place related to the medical agency spend, however it was proving slow to recruit to vacancies. He informed the Board of a visit from Professor Martin from Dundee regarding engagement across the medical workforce. The report following the visit would be reviewed by the Executive Team however he noted that the headline feedback was related to recommending the Trust to other trainees. A workshop was held to obtain feedback from medical staff and a plan would be developed.

He noted that the clinical lead roles continued to develop and build an infrastructure, and pharmacy recruitment issues remained, and organisational development work was to take place.

He informed the Board he had recently attended an AI conference with informatics colleagues and work was underway to accelerate work with engagement of the medical workforce to be included in this.

Mr Wright noted the feedback from the work by Professor Martin and added it would be useful to understand areas where there was opportunity to promote the Trust to candidates. Mrs McRae added that there was almost a 50/50 split between recommending training and not doing so. Dr Hosker responded that the Trust was in a better position than others but detail around preferences and approaches to training would impact on the results. Mrs McRae noted that in the context of recruitment it was helpful to consider the report.

Dr Munro added that there was an expectation of having consultants involved in strategic discussions, however there was a range of experience within the consultant workforce and a change in perceptions of roles for doctors in the NHS which accounted for differences in approaches and views on careers and identity of profession. Discussion took place on the importance of

recruitment and career development opportunities aligned to the values of the Trust.

Mrs Forster Adams queried if the clinical leadership development work had taken a coproduction approach including staff engagement for those working on the front line, and Dr Hosker confirmed that a broad set of stakeholders had been involved in co-production and varying approaches were used to ensure inclusion.

Mrs McRae thanked Dr Hosker for the report.

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

24/093 **Guardian of Safe-working Hours Annual Report** (agenda item 19)

Dr Hosker presented the report noting that the Trust had 180 trainees and the Guardian was a mechanism to ensure safety through working practices with an escalation route if required.

He noted that rota gaps continued to be an issue, related to a set number of trainees required to be on call resulting in rota gaps. Direct engagement had taken place by the Guardian with junior doctors.

Mrs McRae thanked Dr Hosker for the report.

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

24/094 **Report from the Chair of the Workforce Committee for the meeting held on 6 June 2024** (agenda item 20)

Mrs Burns-Shore presented the Chair's report highlighting key points related to Oliver McGowan training and the current gap in provision, however reassurance was provided by Mr Skinner that the training was now in place.

She noted that the Violence Prevention Reduction Standard had declared partial compliant initially, but progress was being made and the main actions were now completed. She added that ongoing review would take place via the Committee.

She informed the Board that compulsory training for the medical directorate was an improved position, however job plan compliance was discussed due to the low position which would be monitored. Sickness absence had improved but the target had not yet been met so review would continue in this area too.

Mr Wright noted in relation to sickness absence that there were peaks at various stages of sickness absence and longer-term absence affected the

figures, therefore queried the specific action being taken. Mr Skinner responded that, as part of the efficiency programme to reduce sickness absence, a review of all absences triggering intervention would be undertaken as there would be variance in manager's approaches to this. In relation to longer term sickness absence, he added that most of the cases were in the correct process with a focus on support and return to work for staff members involved. Short term sickness remained a focus to proactively manage this and there was a need to understand where this was managed effectively and where support was needed. It was confirmed that those staff who were off sick related to line management would be supported appropriately.

Dr Muno noted that the reduction in sickness absence was supported by the Health & Wellbeing offer from the Trust, and that work related stress was connected to the nature of the work undertaken. She highlighted that the focus was on what was needed over and above the investment already in place to support this, as the Trust needed to create the right conditions for staff to deliver work in all services. She acknowledged it was unacceptable to have the current level of sickness absence when there was the ability to put initiatives and action in place to support this, and the efficiency element was not the focus.

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

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

24/095 **Report from Director of People and OD** (agenda item 21)

Mr Skinner presented the report as having been read acknowledging the discussion that had already taken place regarding sickness absence. He noted that workforce numbers continued to grow but the message from NHS England was that Trusts were not able to grow their workforce. He noted for the Trust that growth was related to investment and the detail was provided within the report.

He noted that the Board needed to acknowledge the approaching season of short-term sickness, and this would be linked to the flu vaccination campaign.

Mr Skinner highlighted that retention rates were positive compared to national results, and the metrics aligned to the People Plan were detailed within the report.

Dr Healey noted the ethnicity breakdown between substantive and bank staff was stark in difference, and queried whether discussions were needed with bank staff around their choice to work bank shifts over substantive employment. Mr Skinner noted that there was an active bank staff forum and work was ongoing regarding this. The bank staff survey had been undertaken for a considerable length of time, and the narrative was that it was predominantly a choice to work flexibly to suit their requirements, and the Trust also had a good conversion rate from bank to substantive posts. Ms Khan noted that ethnicity and social mobility was important to consider, and

	the ability to move between different service areas to support staff personal mental health was important. It was agreed that the topic would be referred to the Workforce Committee for further consideration and review around ethnicity detail and bank staff choices.	**Workforce Committee**
	The Board **received** the Report from Director of People and OD and **noted** the content.	
24/096	**Violence Prevention Reduction Self-Assessment Standard** (agenda item 23) Mr Skinner presented the report as a follow on from the previous paper and noted that good headway was being made with standard compliance. He noted that work was underway to progress the standards and Workforce Committee had oversight of this. Mr Wright queried the lead for the work moving forward following the departure of the previous post holder. Mr Skinner responded that the post holder had not been replaced and the work had been shared across the wider team. The focus of this work was now operational and an organisational responsibility, therefore he provided assurance that appropriate leads had been identified. Dr Healey clarified that the self-assessment related to staff experiencing violence and that there was a separate workstream related to patient violence. Mrs McRae noted that the report provided reassurance the Trust was managing violence against staff.	
	The Board **received** the Violence Prevention Reduction Self-Assessment Standard and **noted** the content.	
24/097	**Report from the Chair of the Audit Committee for the meeting held on 18 June and 16 July 2024** (agenda item 23) Mr Wright presented the Chair's report from the Audit Committee noting the level of detail provided within the report. He focused on the meeting in July 2024 for areas to alert Board to. In relation to the Risk Management Annual report, he acknowledged that much of the report was clinically focused, therefore there was an opportunity for the Quality Committee to focus on the relevant risks. The recommendation from Audit Committee was for the report to be reviewed by the Quality Committee. Following discussion, it was agreed that the Executive Team would review the necessity of the report and whether there was a requirement for an alternative report or approach.	**Executive Directors**

It was agreed that the Workforce Committee would review and consider the recommendations and outcomes from the Handover of Deployment Internal Audit report.

Workforce Committee

He noted the deferral of the Health & Safety update to a future Audit Committee meeting. He informed the Board of the limited assurance internal audits including the Clinical Governance report, noting that the Committee were happy with the responses to the report and the internal audit team had been requested to review the process for issues that were filtered through the governance processes but were not discussed at Quality Committee to understand this in more detail. He added that a broad use of terms was used in the report and not all areas of clinical governance were reviewed therefore the descriptions used were to be reviewed by internal audit.

He informed the Board that the Quality of Data for Reporting purposes report was related to the Accessible Information Standard and identified a need for wider review therefore the Committee had noted an action for this to be reviewed by the Executive Management Team.

Mrs McRae thanked Mr Wright for the report.

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

24/098 **Report from the Chair of the Mental Health Legislation Committee for the meeting held on 13 June 2024** (agenda item 24)

Ms Khan presented the Chair's report from the Mental Health Legislation Committee and took it as read. She highlighted the detail related to the sections to alert the Board to.

Dr Hosker noted that the Section 136 issue related to the care provided to service users, and this should be same for all service users regardless of a Section 136 being in place or not. The focus was to make sure that efforts were made to normalise the approach across all care provided. He added that the unlawful detention related to a high court ruling which was addressed in the Committee discussion.

It was noted that payment decisions for staff involved in hearings and cancellation payments were discussed at the Committee and clarification was received relating to approval for payments.

Mrs McRae thanked Ms Khan for the report.

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

24/099 **Board Assurance Framework Q1 Update** (agenda item 25)

Dr Munro presented the Board Assurance Framework (BAF), noting that the format had been amended following the internal audit of the BAF. It was a standard requirement for review of risk management in the broadest sense on an annual basis. She noted that work had been undertaken to amend the format and framework to fulfil recommendations from the audit to reflect the risks in a more robust way, however the content had not changed.

The automation through the Datix system was not possible at the current time therefore the decision had been taken considering the upcoming procurement for the risk management system to manually develop the report.

Mrs Burns-Shore asked if the likelihood versus consequence risk scoring could be included moving forward, and this action was agreed. **CE**

Mr Wright noted that limited assurance audits should be considered for BAF implications and Dr Munro responded that this was now considered via the Executive Risk Management Group as a standing agenda item with a further check and balance to be undertaken at the Audit Committee.

Dr Healey added that the BAF format was easier to utilise and understand.

The Board **received** and **approved** the content of the Board Assurance Framework.

24/100 **Terms of Reference for the Board of Directors** (agenda item 26)

Mrs McRae presented the amended Terms of Reference for the Board of Directors.

Mr Wright noted that he was supportive of the reference to the BAF, however he raised concern with the word 'responsibility' as there were members of the Board who did not have responsibility for the BAF. He therefore suggested the use of the word 'ownership' instead.

Mrs Forster Adams noted that there was a shared responsibility by the Board but with layers of different responsibility within that. Mr Wright commented that the Non-Executive Directors could recommend amendments or suggestions but did not have responsibility for the changes, however the BAF was owned by the Board as a whole.

Dr Munro commented that a unitary Board was in operation, and there were arrangements in the constitution to resolve differences in opinion. In high profile cases there were differences in opinion and understanding within the Board, however a unitary Board provided opportunity to ensure collective accountability. She noted that she would welcome a discussion around the principle of a unitary Board and responsibility and ownership.

Mrs McRae noted that ownership was around the agreement to sign off and own the BAF but with acknowledged different responsibilities and roles to get to approval stage. There were differing responsibilities that culminated in a shared Board ownership and commitment to the BAF.

	It was agreed that the wording would be reviewed to reflect an approach that the Board were all in agreement with.	**CE / Executive Directors**
	The Board **received** and **requested further review** of the content of the Terms of Reference for the Board of Directors.	
24/101	**Scheme of Delegation** (agenda item 27) Mrs McRae presented the amended Scheme of Delegation for Board approval and took the report as read. The Board agreed to accept and approve the amended document.	
	The Board **received** and **approved** the content of the Scheme of Delegation.	
24/102	**Use of Trust Seal** (agenda item 28)	
	The Board **noted** the Trust Seal had not been used since the previous Board of Directors meeting.	
24/103	**Any other business** (agenda item 29)	
	There were no additional items of other business.	
24/104	**Resolution to move to a private meeting of the Board of Directors** At the conclusion of business, the Chair closed the public meeting of the Board of Directors at 13:10 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

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Any Other Business (minute 24/021 - agenda item 21 – January 2024) Mrs Burns-Shore and Mrs Hanwell to provide further information regarding the Breathing Space initiative, and potential impact on the Trust, once it becomes available.	**Zoe Burns-Shore / Dawn Hanwell**	Management action	**ONGOING** Mrs Burns-Shore updated that the Breathing Space action was in progress and an update would be provided at the next meeting in September 2024.
Matters Arising - Questions from members of the public for the Board of Directors (minute 24/079 - agenda item 5.1 – July 2024) It was agreed that the response from Dr Hosker would be put in writing to the requestor, with an opportunity for follow up discussion.	**Chris Hosker / Corporate Governance Team**	Management action	**NEW** **COMPLETE** The response has been shared with the requestor.
Matters Arising - Questions from members of the public for the Board of Directors (minute 24/079 - agenda item 5.1 – July 2024) It was agreed that a more detailed update regarding the café spaces on sites would be brought to the September 2024 meeting.	**Nichola Sanderson**	September 2024	**NEW** **COMPLETE** The estates team are currently working up the plans to reestablish the café facility within the Becklin centre. Since the café shut there has been an increase in compliance and for health and safety. The team are establishing a business case

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
			that will set out all the processes that need to be part of the business case to move the project forward. This work will be monitored and taken through the clinical environments group and the estates and facilities committee.
Report from the Chief Executive (minute 24/081 - agenda item 7 – July 2024) The publication of the Module 1 report from the COVID Inquiry therefore it was agreed that the NHS Providers summary update would be shared to the Board.	**Clare Edwards**	Management action	**NEW** **COMPLETE** The report has been shared with the Board.
Report from the Chief Executive (minute 24/081 - agenda item 7 – July 2024) It was agreed the Joint Strategic Needs Assessment for Leeds would be shared with the Board.	**Clare Edwards**	Management action	**NEW** **COMPLETE** The report has been shared with the Board.
Report from the Chair of the Finance and Performance Committee for the meeting held on 23 July 2024 (minute 24/083 - agenda item 9 – July 2024) Mrs Forster Adams noted a matter of accuracy in the Chair's report which stated a cap on admissions had been in place for 12 months however this was incorrect and should state two months of various levels of reduced occupancy. It was agreed that this amendment would be made to the report.	**Corporate Governance Team**	Management action	**NEW** **COMPLETE** This amendment has been made.

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Report from Director of People and OD (minute 24/095 - agenda item 21 – July 2024) It was agreed that the ethnicity pay gap report would be referred to the Workforce Committee for further consideration and review around ethnicity detail and bank staff choices.	**Workforce Committee**	Management action	**NEW** **COMPLETE** This has been included on the Workforce Committee work programme
Report from the Chair of the Audit Committee for the meeting held on 18 June and 16 July 2024 (minute 24/097 - agenda item 23 – July 2024) It was agreed that the Executive Team would review the necessity of the risk management annual report and whether there was a requirement for an alternative report or approach.	**Executive Directors**	Management action	**NEW** **ONGOING** This is on the agenda for the next Executive Management Team meeting for discussion
Report from the Chair of the Audit Committee for the meeting held on 18 June and 16 July 2024 (minute 24/097 - agenda item 23 – July 2024) It was agreed that the Workforce Committee would review and consider the recommendations and outcomes from the Handover of Deployment Internal Audit report.	**Workforce Committee**	Management action	**NEW** **COMPLETE** This has been included on the Workforce Committee work programme
Board Assurance Framework Q1 Update (minute 24/099 - agenda item 25 – July 2024) It was agreed that the likelihood versus consequence risk scoring would be included in the BAF moving forward.	**Clare Edwards**	Management action	**NEW** **COMPLETE** The has been added to the Board Assurance Framework.

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Terms of Reference for the Board of Directors (minute 24/100 - agenda item 26 – July 2024) It was agreed that the wording would be reviewed to reflect an approach that the Board were all in agreement with.	**Executive Directors / Clare Edwards**	Management action	**NEW** **COMPLETE** This is an agenda item for the meeting

CLOSED ACTIONS

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Integrated Patient Safety Report (minute 24/036 - agenda item 14 – March 2024) It was agreed that the content for the integrated patient safety report would be discussed in further detail for future report content.	**Nichola Sanderson / Alison Quarry**	Management action	**COMPLETE** This was on the agenda for the September 2024 Board of Directors.
Chief Executive Report (minute 24/056 - agenda item 7 – May 2024) Dr Hosker to follow up the request for further detail regarding the clinical trials across the Trust and the associated opportunities.	**Chris Hosker**	Management action	**COMPLETE** The action related to clinical trials information was closed as the report would be shared in due course.

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Freedom to Speak Up Guardian Annual Report (minute 24/057 - agenda item 8 – May 2024) It was agreed that there would be a follow up discussion with the Executive Directors to consider if any other work was needed within the existing work programmes to consider opportunities to learn, including near misses, regarding patient safety concerns.	**Executive Directors**	Management action	**COMPLETE** Dr Munro provided an update noting that the roll out of PSIRF would support staff to raise patient safety concerns. Training through the Learn system would support this with the minimum requirement being an awareness session which would be shared with the Board to raise awareness of the new approach to patient safety.
Report from the Chair of the Workforce Committee for the meeting held on 15 April 2024 (minute 24/065 - agenda item 16 – May 2024) The Workforce Committee were asked to consider what a nuanced approach could be in relation to exit interview data for services where there were areas of concern to support the ability to gain data where required.	**Zoe Burns-Shore**	Management action	**COMPLETE** An update was provided to the July 2024 Board of Directors

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

AGENDA ITEM

7

PAPER TITLE:	Chief Executive's Report
DATE OF MEETING:	26 September 2024
PRESENTED BY: (name and title)	Dr Sara Munro, Chief Executive
PREPARED BY: (name and title)	Dr Sara Munro, Chief Executive

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

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

EXECUTIVE SUMMARY

The purpose of this paper is to inform the Board of Directors on some of the activities of the Chief Executive which are undertaken to support the delivery of the Trusts strategic objectives and other important matters for the Board to be apprised of.

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

RECOMMENDATION

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

MEETING OF THE BOARD OF DIRECTORS

26 September 2024

CHIEF EXECUTIVES REPORT

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

1. Our Services and Our People

Social Unrest

I wanted to acknowledge that since the last Board meeting there has been significant unrest across many towns and cities in the country which have been frightening for local communities and citizens, especially where there has been targeted abuse and violence incited by racism and hate crime towards religious groups. Our staff and our service users are directly affected by this, and I am grateful for the work done over the summer to both acknowledge the distress and fear this has caused and to find ways to provide practical and emotional support. This was recognised by many public services as an unprecedented set of events and one we hope does not occur again.

We have been seeking feedback on our response so that we continue to learn and respond to what matters most to people in such difficult circumstances. We do have the ongoing actions from the board development session earlier this year one of which is ensuring we have clear and consistent support and action for staff who experience racial abuse and hate crime during the course of their working roles with us. This will be a priority action for the interim head of EDI which we are in the process of recruiting.

Demand on Services

We continue to see significant pressures across several services where demand outstrips capacity and waiting lists are significant. I wanted to highlight a couple of services in relation to work with partners to look at alternative solutions. Within our ***ADHD service*** the team are looking at the future specification for the service so we can focus on those who require specialist level input. This means we will need to work differently as a system in response to the current level of referrals and those on the waiting list. This is part of ongoing discussions with partners in primary care and the ICB. Similar discussions are happening regarding children's ADHD provision by Leeds Community Healthcare Trust. We are meeting with the chair of scrutiny, ICB colleagues and LCH later this month to discuss the common challenges within the city.

For our ***Gender identity services*** the national team in NHSE are commencing a review of the service specification as referenced in the response to the Cass review. As the current one was only developed within the last 3 years, they are seeking views from a wide range of stakeholders on what needs to be changed/improved going forward. They have also committed to developing a national

all age policy on the use of gender hormones and a review of how the waiting list for clinics are currently managed to alleviate the pressure on local clinics.

Since the last public board meeting work has continued to bring greater stability to our services at Red Kite View and the service development and improvement plan is ongoing. Executive colleagues have recently met with NHSE and provided reports as requested to the ICB to share the plans in more detail. Red Kite View was visited by the Minister Karin Smith earlier this month. This was the ministers first visit to a mental health unit since taking up her cabinet post and her particular focus is on capital investment and policy. It was a great opportunity to share the work we have done, our future plans and the challenges we face with our estates needs and resources available.

We are yet to receive the reports from the CQC visits to our inpatient units at Red Kite View and Mill Lodge which are due this month. The CQC have undertaken a further unannounced inspection to our Mother and Baby Unit on the 10th September. Some minor actions were raised on the day, and we are in the process of responding to follow up data requests.

Learning from events in Nottingham

Following the tragic events last year in which a mental health service user took the lives of 3 members of the public there have been a number of publications from national bodies to ensure the same events do not unfold again. NHSE has produced a range of guidance documents setting out expectations of service delivery models for people with psychosis and complex needs. The expectation is that organisations complete a self-assessment, and these are reviewed by ICB's to identify areas that are working well and areas that need further improvement to meet the needs of this cohort and thereby reduce the risks to the public.

The CQC have also completed several reviews at the direction of the previous Secretary of State, and these have recently been published. This was an organisational focused review, but they have made recommendations for NHSE in addition to the Trust itself.

Within our Trust we have been working through the national guidance to complete the self-assessment which is the first stage in learning from what has happened elsewhere and challenging ourselves on the service we provide and where we believe there are improvements to be made. The self-assessment will be shared with the Board, and I would suggest ongoing monitoring of the actions we identify from that should be reported to the quality sub-committee. A separate paper has been produced for the private Board looking at the intelligence from the CQC review in more detail.

Trust Independent Well led review

The Board is already aware that it is a requirement to independently review ourselves under the 'well-led' framework every 3 years. We have now concluded a comprehensive procurement exercise, and The Value Circle have been selected to do this review for and with us. The team will be reviewing relevant documents, observing sub committees and boards as well as holding individual interviews and focus groups with board members, stakeholders and a cross range of staff and governors over the next two months. We are aiming to have an initial draft to share with the board by the end of November

Coming up

The ***annual staff survey*** launches on the 30th September and we are focusing our efforts to improve our response rate compared to last year. Given the strong relationship between those teams who complete intention plans and subsequent improvement in staff experience we are highlighting this to staff as more reason to have your say to influence change.

There are two important events in October to make the board aware of. It is ***Black History month*** and this year's theme is ***"Reclaiming Narratives,"*** and marks a significant shift towards recognising and correcting the narratives of Black history and culture. By emphasising "Reclaiming Narratives," we shine a brighter light on our stories, allegories, and history. This theme underscores a commitment to correcting historical inaccuracies and showcasing the untold success stories and the full complexity of Black heritage and colleagues in our WREN and People experience team have a range of events planned. The Synergi collaborative is also launching the '***Remembering what is forgotten'*** exhibition which will run for the next 12 months sharing the narratives and experiences of people and projects in the City aimed at tackling racial injustice in mental health.

For this October's ***Speak Up Month***, our theme is ***Listen Up*** and we will be focusing on the power of listening, and the important part which listening plays in encouraging people to feel confident to speak up. We want everyone who works here to feel confident to speak up. Confidence to speak up comes from knowing that if you speak up, you will be listened to, and that appropriate action will be taken. We all have a part to play in listening to one another with respect and compassion.

This Speak Up Month is an opportunity for all of us to show that we are here to listen to one another and our commitment to fostering a Speak Up, Listen Up, Follow Up culture in our teams and throughout Leeds and York Partnership NHS Trust.

A range of site visits are being planned to promote staff survey, speak up month and black history month with great joint working from our respective leads and experts in these areas.

2. National Regional and Local Updates

Industrial action and pay awards

Junior doctors have now accepted the pay award made by the government ending the industrial dispute that has affected the whole of the NHS since early 2023. NHS pay awards announced in July will be put in place next month.

GP Industrial action is on-going and we continue to monitor this to minimise any impact and disruption for our service users and our services.

NHSE Leadership Event

The NHSE executive team held a leadership event with CEOs earlier this month and it was attended by the SoS Wes Streeting who set out candidly the need for change in the NHS because it is broken. Wes made clear this was not a criticism of staff in the NHS but is based on experiences of many patients who simply cannot access the care they need. He went on to say it is not beyond repair but was open about the challenging context of constrained resources that will mean difficult decisions and trade-offs in the short term, but this should not be seen as a sign of the longer-term commitment to the NHS. The development of a 10-year strategy for health will be key to setting out how the government intends to progress the key aims of

- Hospital to community
- Treatment to prevention
- Analogue to digital.

The strategy will be more than a plan for the NHS. It intends to set out what the strategy is for health and within that what is the scope and expectation on the NHS. Consultation with the public and stakeholders will get underway in the coming weeks and the aim is to have the strategy drafted in spring 2025. A key driver for the strategy will of course be the findings from the review just published

by Lord Darzi which sets out some key issues in the way the NHS is run and governed which has made it difficult to make sufficient progress in improving services for patients and the working experience for NHS staff.

In the meantime, the message is clear – we need to deliver on the operational priorities for this year within the resources we already have.

West Yorkshire financial governance review

As noted in previous board papers and discussions NHSE is working with those ICBs who are struggling to operate within their financial allocations. For those systems and trusts that are already off plan they have been required to engage independent support to review financial governance and opportunities to reduce the deficit position they are in.

Within West Yorkshire we have recognised that whilst we are not in the position of being required to seek independent support the financial challenges are significant and there is a risk of non-delivery by the end of the financial year. Therefore, it has been agreed to engage independent support at this stage to help us ensure we have the right level of scrutiny in place and identify further opportunities that ensure we can achieve our financial plans for the year. This work has already been carried out for the West Yorkshire Association of Acute Trusts (WYAAT) and so we are extending that work to secure external support for a system-wide ICS financial review.

Areas highlighted of greatest 'interest' for our system include Continuing Healthcare, High-cost packages of care (mental Health and LD) and out of area placements, Prescribing and Medicines Optimisation and opportunities for system wide solutions to issues facing our Mental Health Providers.

Leeds City Council CEO

Tom Riordan announced earlier this year he would be stepping down from his role as CEO at the council after 14 years. On 23rd September he takes up a new role as a permanent secretary in the Department for Health and Social Care to lead the mission on improving health outcomes. We will of course be keeping in touch with Tom in his new role. Mariana Pexton, the current Director and Strategy and Resources will be taking over as the council's interim Chief Executive, until the recruitment process for a permanent Chief Executive is completed.

3. Reasons to be Proud

Improving Health and Lives Together, a celebration of our partnership work.

- We celebrated co-production and partnership work with inspiring stories and developments from the Trust at our AGM and celebration event on the 30 July.

- "It was an inspiring, stimulating, worthwhile, and truly uplifting afternoon".

Awards and nominations

National Diversity Awards shortlist announced! Friday 4 October 2024 - Liverpool Anglican

- Positive Role Model Award for Gender and Community Organisation Award for Gender - Errol Murray
- Community Organisation Award for LGBT – Gender Outreach Service.

National B.A.M.E Health and Care Awards 2024 shortlist announced! 26 September 2024 – in London

- Clinician of the Year - Nazish Hashmi
- Outstanding Community Organisation - Errol Murrey, Perinatal Mental Health Service
- Inspiring Diversity and Inclusion Lead - Balvinder Dosanjh and Maxine Brook both nominated

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

Around the Trust

Olympic GOLD Medal for Gregg Stevenson
Gregg is the Lived Experience Lead at OpCourage North and was formerly a Mental Health Practitioner and VLSO in the High Intensity Service. Gregg and Lauren, who only started rowing together in January last year, took gold in the mixed double sculls as Great Britain won four rowing medals early on day four in Paris.

Amanda Naylor, the Service Manager for Veterans Mental Health & Wellbeing Service (North of England) & Addictions Plus (Forward Leeds), "We are incredibly proud of his achievement!" said Amanda.

Photo Courtesy of Burnley Express

Dr Sara Munro
Chief Executive Officer
19 September 2024

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

AGENDA ITEM

9

PAPER TITLE:	Report from the Chief Operating Officer
DATE OF MEETING:	26 September 2024
PRESENTED BY: (name and title)	Joanna Forster Adams, Chief Operating Officer
PREPARED BY: (name and title)	Joanna Forster Adams: Chief Operating Officer Contributions from: Alison Kenyon: Deputy Director of Service Development Mark Dodd: Deputy Director of Service Delivery Andrew Jackson: EPRR Lead Edward Nowell: Performance and Information Manager

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

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 sets out where operational challenges affect service delivery and may impact on quality and outcomes for service users. 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 the key areas for Trust Board attention.

It does not report on the wealth of outstanding work undertaken day in and day out by our dedicated staff across our services but draws out the specific areas where issues may affect the quality of care. Much of this is reported and recognised in the Chief Executive report earlier in the Trust Board agenda.

The key areas for alert to the Board are contained within the report.

In summary they are:

- **Access and waiting times** in some services including cumulative and long-standing issues in ADHD, Leeds Autism Diagnostic Service (LADS), Gender Services, Enteral feeding for people with Learning Disabilities. Access to our Leeds based inpatient Children and Young Peoples Mental Health service due to low substantive staffing levels resulting in capped admission and treatment beds.
- **Response times** over a specific period over the summer when we did not meet our standards of a 4-hour response in our Crisis Service.
- **Demand for adult acute admission beds** where we have reported, and continue to focus on, improving flow to enable improvements in meeting the level of demand. This has proved challenging over the summer period where progress has not been as rapid as in the first phase of the programme. This is reported as part of the update on the Improving Patient Flow programme.

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

RECOMMENDATION

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

MEETING OF THE BOARD OF DIRECTORS

September 2024
Chief Operating Officer: Trust Board Report

1. INTRODUCTION

We continue to experience continued challenges as highlighted in previous reports including a sustained demand for admissions into our Acute Service. However, the capacity and flow works continues to have a positive impact resulting in fewer out of area admissions and we are better able to respond to this demand within our own in-patient services. Capacity and flow continue to be a key priority for the organisation (from a quality, safety, and efficiency perspective), which is being managed through a number of workstreams led by our Head of Operations for Acute Services with oversight from our Executive led Improving Patient Flow Programme.

This report sets out where operational challenges affect Care Services delivery and may impact on quality and outcomes for service users. 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 the key areas for Trust Board attention.

It does not report on the wealth of outstanding work undertaken day in and day out by our dedicated staff across our services much of this is reported and recognised in the Chief Executive report earlier in the Trust Board agenda. The Chief Operating Report draws out the specific areas where issues may affect the quality of care and summarises the factors affecting this and our response to them.

The key areas for alert to the Board are contained within the report.

In summary they are:

- **Access and waiting times** in some services including cumulative and long-standing issues in ADHD, Leeds Autism Diagnostic Service (LADS), Gender Services, Enteral feeding for people with Learning Disabilities. Access to our Leeds based inpatient Children and Young Peoples Mental Health service due to low substantive staffing levels resulting in capped admission and treatment beds.
- **Response times** over a specific period over the summer when we did not meet our standards of a 4-hour response in our Crisis Service.

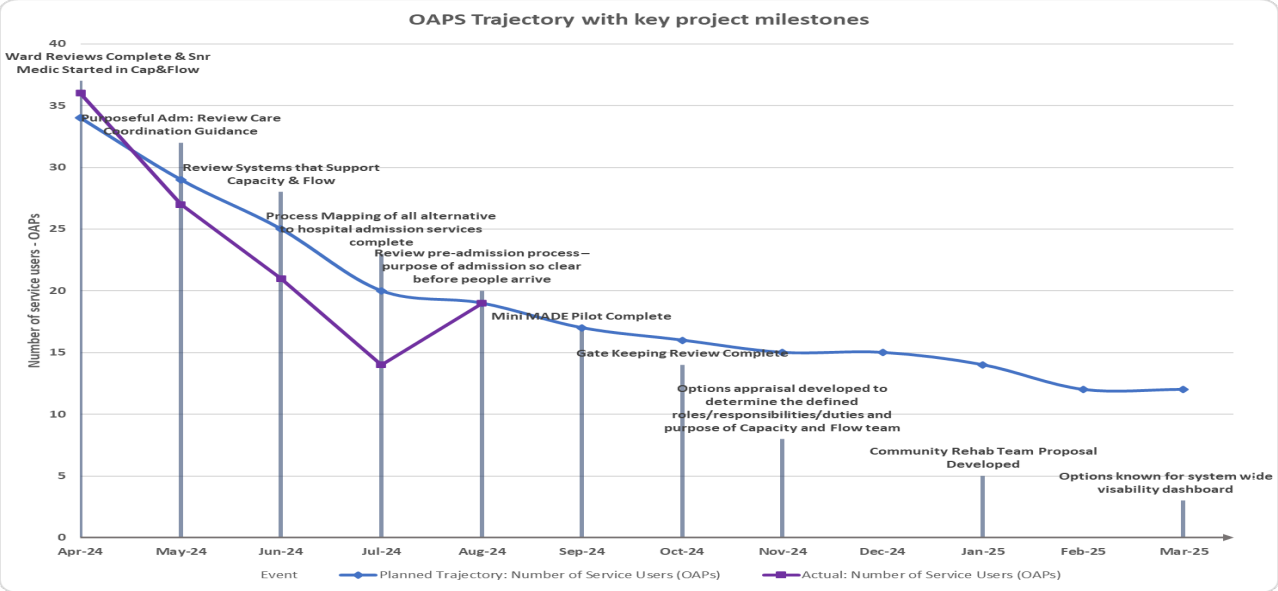
- **Demand for adult acute admission beds** where we have reported, and continue to focus on, improving flow to enable improvements in meeting the level of demand. This has proved challenging over the summer period where progress has not been as rapid as in the first phase of the programme. This is reported as part of the update on the Improving Patient Flow programme.

2. IMPROVING FLOW PROGRAMME

2.1 Programme Update

The improving flow programme plan remains on track, see graph 1, and we are achieving the set milestones and objectives as set out below. The Multi-Agency Discharge Event (MADE) pilot with NHSE is now complete and we had an evaluation session on the 3rd of September. The learning from this process will be applied across our inpatient capacity and barriers to discharge meetings.

Graph 1: OAPS Trajectory and key milestones



2.2 Out of Area Trajectory

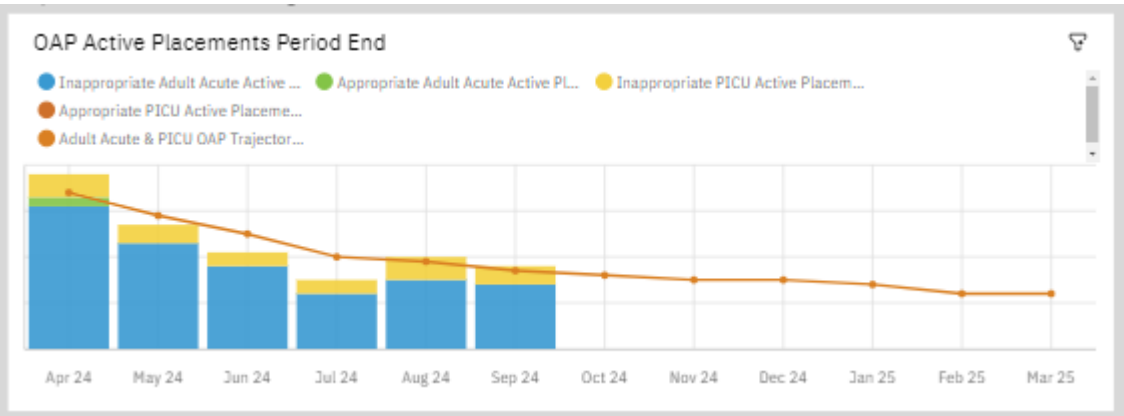
At the end of August 2024, the performance against the Out of Area trajectory was slightly above with 20 service users out of area against a target of 19, see graph 2. As reported previously we protentially could plataueu as a conseuence of no significant improvement in the number of people who are delayed in their disharge due to a lack of housing and other care support outside of hospital (this is an area of focus for the Improving Patient Flow Programme that will need support and action from system partners).

Demand for inpatient beds has been consistent since June and is comparable with 2023 activity. The potential drivers of this sustained high level of demand are being explored and this is where we need to make changes enabling continued focus on improving flow in all parts of Care Services.

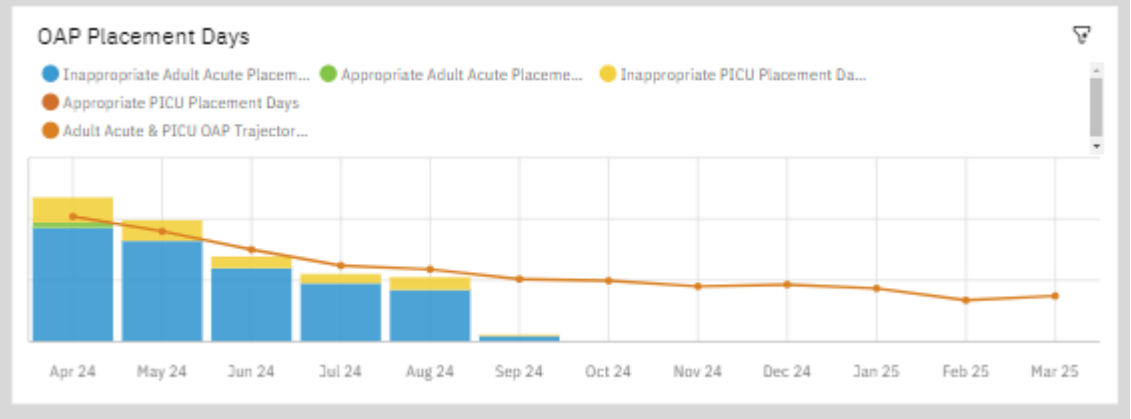
Of particular note is that whilst demand is largely consistent with the same eriod on 2023, the number of our OOA placements has approximately halved.

Whilst we have performed well against the trajectory for occupied bed days, see graph 3, however, we continue to perform slightly over our financial target for out of area placements due to the costs and prices outside of Leeds and the NHS.

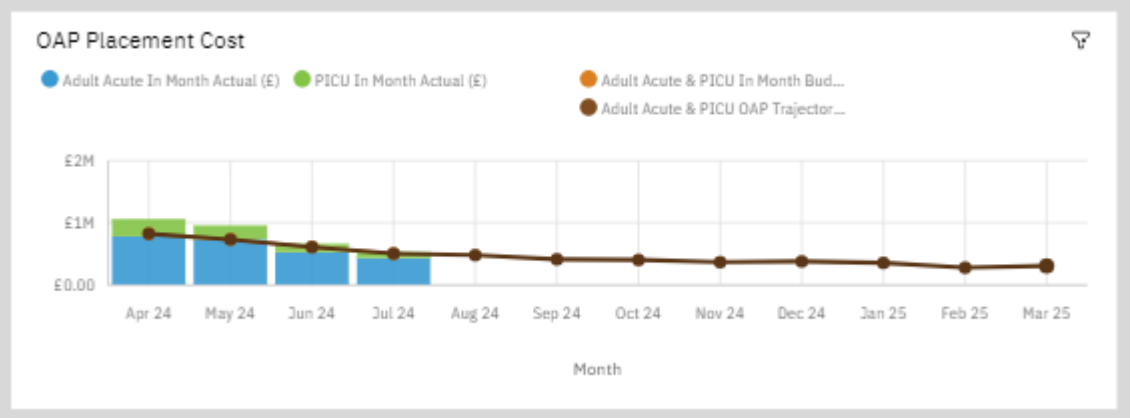
Graph 2: Individual Placements



Graph 3: Placement Days



Graph 4: OAP Placement Cost



We have met with NHSE and ICB colleagues to discuss the challenges faced which have resulted in some long delays for admissions including those in the Emergency department within LTHT. This will be a key area of focus for NHSE, ICB and system colleagues over winter 2024/25. We continue to support people who present to A and E and work hard to minimise delays for people who need admission – we do not want this to be peoples experience. Where this does happen, we are preparing how we monitor and respond appropriately and proportionately to inappropriate waits for people in A and E (awaiting transfer to Acute and Older Adult inpatient beds).

2.3 All placements by type and locality

The team continues to aim for inpatient care as close to home for people as possible (ideally in our Leeds service). Compared to previous reporting we are seeing fewer placements in the South of England, with most concentrated in the North and Northeast. Some treatment is offered in services which are further afield where clinically appropriate including a placement in PICU in Stevenage and two acute placements in Taunton and Norwich.

Image 1: All current placements

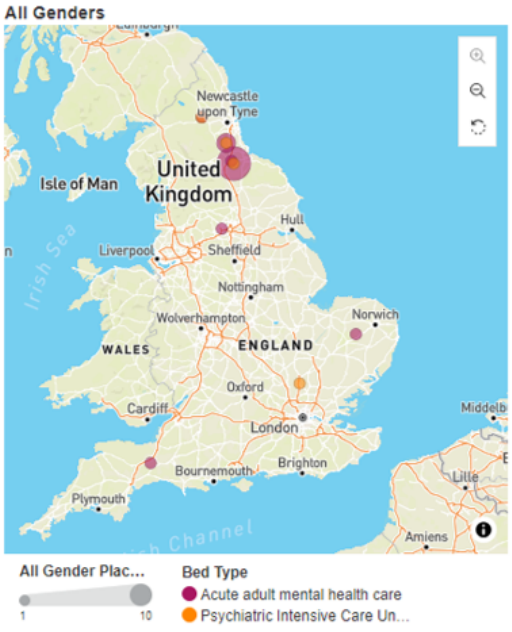


Image 2: Placements started August 2024

2.4 Ongoing Developments

Last time we reported we had identified several key tasks that would support the flow programme:

- We continue to work with the Digital Change Team and a new dashboard has been created where can monitor and manage flow on Care Director. However, further work in ongoing with the clinical team ensure that we capture the data required that populates the dashboard.

- Clinically Ready for Discharge module has now been implemented with our clinical teams and we are monitoring the performance of this through our Governance meetings and the Improving flow programme group.
- The gatekeeping review in the Acute Service Line has been completed with the aim to start testing the alternatives to hospital decision making matrix that has been developed when CRISS gatekeep referrals for admission. Once tested over a 2-month period, we aim to finalise the process.
- We are planning development sessions with the Capacity and Flow Teams for October with the aim of developing an options appraisal for how our capacity and flow teams across the Trust will operate going forward.

3. SERVICE DELIVERY AND KEY PERFORMANCE ESCALATIONS

3.1 ALERT

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

3.1.1 Children and Young Peoples Services (CYPMH): Red Kite View (RKV)

Our stabilisation and improvement approach to our Leeds based children and young people's inpatient service is making progress and is led by an experienced senior leader with considerable experience in CYPMH and is overseen an Executive level. During this initial period, we have continued to work with a reduced occupancy level (50%) which clearly means that some children and young people from West Yorkshire are accessioning their treatment outside of the county. As of the 19th of September, there are 8 young people who would ordinarily be supported in RKV (2 of these young people have planned imminent discharges so it would be inappropriate to repatriate them at this stage). Our aim is to improve this as a priority.

Work undertaken has stabilised the position in Red Kite View (RKV) and the cohort of young people currently receiving treatment there has remained, largely, static. We remain focused on providing high quality intervention so that these young people can recover well and continue their recovery in our communities. The team at RKV work hard to do this and we have seen encouraging recruitment of experience and high calibre staff in the service, including a new Matron supporting with stabilisation, and a new experienced Ward Manager (crucially supporting and developing our Nursing staff in the unit).

As part of our efficiency work aimed at ensuring we have appropriate staffing establishments to meet needs, a review has been undertaken – so that we can always ensure we have staff numbers and skills to meet the treatment, care and intervention needs of young people. This means that we are now looking to increase the number of people we can admit to RKV over the coming weeks. Ideally repatriating young people who are currently receiving their care outside of the county. We have repatriated 1 young person from out of area increasing occupancy above 50%, with a further repatriation planned in the coming days. Partners support

our stabilisation and recovery work through our Provider Collaborative arrangements.

Not only is this a significant step towards recovery and an ability to improve access for the young people of West Yorkshire, but it will enable us to manage our spend in the service and Provider Collaborative more effectively.

National Deaf Children and Adolescent Mental Health Service (CAMHS).

Our National Deaf CAMHS team has been managing a waiting time for initial assessment above the standard we aspire to. This has been due to several factors including recent changes in the clinical presentation people being referred requiring a different approach to assessment, staff vacancies and absence within our 3 small teams. The service has initiated several changes responding to these issues. Waiting times are beginning to reduce within the teams, and this will be further improved with upcoming recruitment. The current waiting times for assessment within the 3 teams: York 12 months, Newcastle 6 months and Manchester 5 months. A trajectory and plan is in place to improve this with operational support to all teams across the different assessment pathways.

3.1.2 Learning Disability Service: Dietetic Provision

A long-standing access issue has resulted in people with enteral feeding requirements who also have learning disabilities, receiving their support from LYPFT staff who are employed to provide more generic support and care of all people accessing our services. This is acknowledged at a system level as an issue we are working to resolve where appropriate to meet people's needs. We have a very small and consequentially from a business continuity perspective, fragile team who are currently much reduced, resulting in a lack of resource to meet any further demand.

This had led to the service pausing to new enteral feeding referrals for service users who are under the care of Children's Learning Disability services in Leeds Community Healthcare (LCH) Services. Previously they transitioned to us for their support as they turn 18. Until this is resolved at a system level, they will continue to receive care from the LCH provided services for their enteral feeding support.

We continue to work with our Trust wide AHP and Dietetic Leads to ensure that we are maintaining patient safety by drawing in colleagues with the expertise, where necessary, to ensure all service users', who currently receive this service from us, have their needs are met fully. The service has also recently engaged a locum Dietitian.

At Executive level, colleagues from Leeds ICB, LCH and LYPFT are meeting to determine how best we meet population needs in our services in the long term.

3.1.3 Regional and Specialist Services: ADHD Waiting Times

The scale of the challenge we face in our ADHD service has been acknowledged as a significant concern at Board, system and a national level. Currently we have 4,400

people waiting in LYPFT for a diagnostic assessment and we are typically receiving in excess of 170 new referrals per month.

Our clinical Lead and team are working with partners in Primary Care to innovate and put in place new approaches and models for diagnosis and treatment, and we are also exploring with ICB colleagues how we best support non pharma support for people experiencing challenges.

The scale of the challenge is considerable, and the Executive team are exploring how immediate improvements can be made and this may include a potential pause in new referrals to LYPFT, allowing for effective signposting to better support for people as we need to be able to clinically prioritise people at most urgent need. Conclusions need to be drawn on how best we do this alongside development of a city-wide comprehensive mode.

3.1.4 Adult Acute: Crisis Resolution assessments within 4hrs

The Crisis 4-hour target has seen a decline from 85% in May to below 60% in July. We have seen a slight improvement in August and are seeing a continuing upward trajectory. The deterioration of this target has been attributed to high sickness rates and vacancies. We are supporting staff to manage their sickness absence and maintaining their wellbeing and we are actively recruiting to posts where we can. We are also in the position of recruiting to our enhanced service which is aimed to improve the consistency and standard of response. Our improved service model is due to go live on the 4th of November with a clear focus on the 4-hour response.

3.2 ADVISE

3.2.1 CONNECT Adult Eating Disorder Service: Community Service

CONNECT Community referral to assessment waiting times (RTA) are currently averaged at 18 weeks. RTA times have been affected by availability of triage appointments. Referral to treatment times (RTTs) have ranged from 4 to 12 weeks depending on the needs of the service users and access to the most appropriate clinician. The service received 80 referrals in July, which represents an increase from 50 in June but remains within the Statistical Process Control (SPC) range for referrals. A review of the access criteria has been completed and a pilot is in progress with an adapted referral criteria to improve access to treatment. Whilst we have seen demand and wait times have increased, the referral to treatment remains within the national standard.

3.2.2 Older Peoples Service: The Willows and Oaks provision

A system wide review of the Oaks has resulted in a temporary repurposing of the resource from a nursing home to a residential care focus for people with dementia. This will have minimal effect on our ability to discharge from The Mount. We have

articulated that the service at the Willows (and the Oaks), whilst clearly of benefit to some of the people of Leeds, will not fully meet the needs of those with the most complex and challenge behaviours resulting from the effects of dementia.

The need for a more defined strategic plan to meet the needs of people with dementia in Leeds should be an area of priority for Leeds health and care system.

3.2.3 CONNECT Adult Eating Disorder Service: In-Patient Service

Registered Nursing (RN) vacancies are forecast to increase to 8 wte by December 2024 as previously reported. We continue to actively recruit to vacancies but have been less successful than anticipated. We are monitoring the staffing position closely and whilst we have vacancies increasing this is balanced off through the ongoing recruitment that is happening. We have recruited one Transfer to Nursing apprentice nurse who will develop and transition to a registered nurse in the long term. This is testing a different approach to Nurse recruitment in light of the national shortages. Disappointingly recruitment had limited success at interview despite a high number of external Nurse Associates applying. We are reviewing the interview process to improve the conversion rate from applicant to successful candidate. In the short term, the Trust Staff Bank have secured a registered nurse to be temporarily deployed as part of our Responsive Workforce team. Despite workforce availability challenges we have continued to deliver care to the service users on the ward without any impact on the quality of care or the capacity required.

3.2.4 Complex Rehabilitation Ward 5 Newsam Centre

Capital funding has been confirmed to relocate the Complex Rehabilitation Inpatient Service on Ward 5 Newsam Centre to the former Parkside Lodge site. Completion of the site development is scheduled for 7th June 2025. An informal extended engagement process is due to commence with staff, service users and families from 2nd September 2024, with support from Communications and Human Resources teams.

3.2.5 Gender Service

The service was recently reviewed by the Regional Commissioning Team ahead of the National Review of Adult Gender Services to be held on the 28 November. The overall feedback was positive. The service has received the KLOEs for the National Review and has provided the necessary feedback ahead of the review. We are not anticipating any concerns being raised with the National Team following the review with the Regional Team.

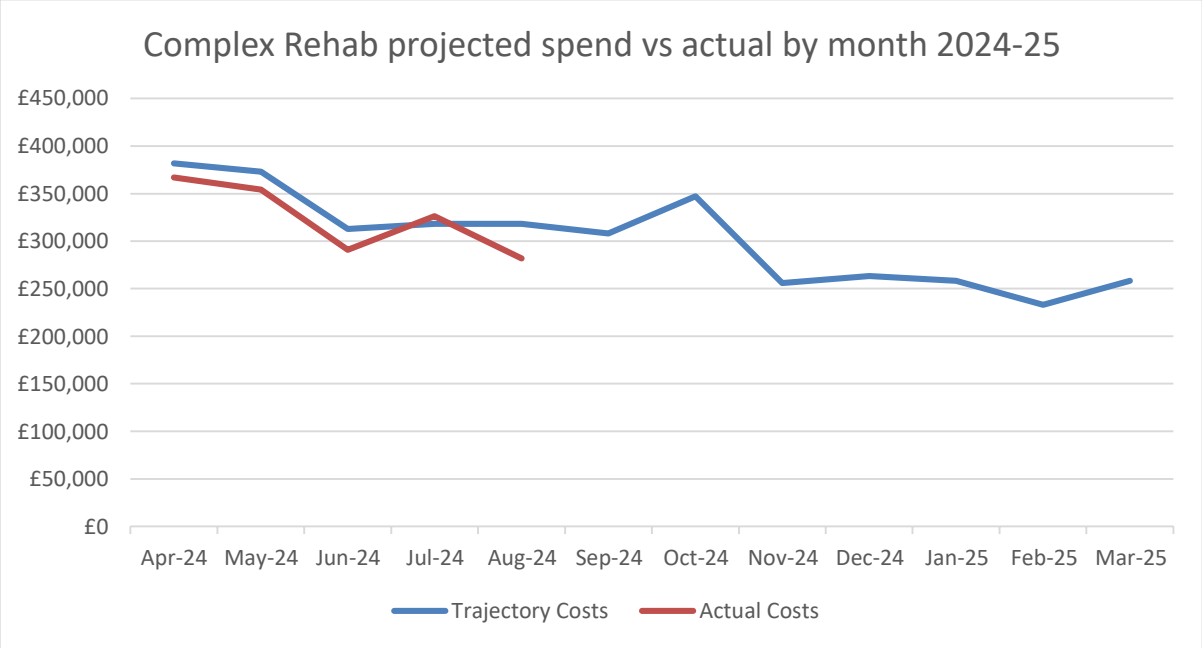
3.3 ASSURE

3.3.1 Complex Rehabilitation: Out of Area Placements

We have seen a reduction in our Complex Rehabilitation out of area placements with the position currently being at 18, with a discharge in August. The service continues to aim for a further reduction and have identified estimated dates of discharge over

the remainder of this year for 8 service users. We continue to improve on our financial trajectory for 2024-25 which aims to deliver further savings across the year, see graph 5. The current saving against plan for the year is approximately £85k.

Graph 5: Complex Rehab Placements Financial Trajectory



4. SERVICE DEVELOPMENT UPDATE

4.1 Coproduction

One of this year's 14 trust priorities and a Care Services strategic objective is to "*Strengthen and firmly embed the co-production approach within care services".* We know as a Board about work which is happening across the Trust, and we aim to embed this approach in all our services. Work is being undertaken in conjunction with the patient experience team within the Nursing Directorate to set out a framework for a consistent approach to coproduction within the organisation. This will include actions to increase the number of people with lived experience employed within the organisation particularly in positions of leadership.

The Service User Network have been approached to coproduce the framework and to set the planned direction and actions to move the trust to a fully coproduction organisation.

As a starting point a mapping exercise is being completed to understand the extent of coproduction within the organisation. Progress is monitored through our Strategic priorities programme and reported at Board level.

4.2 Crisis Transformation Programme

A stock take of the progress of the crisis transformation has been undertaken against the agreed work streams and can be summarised as follows.

Improving access to crisis services – building on the work undertaken as part of the implementation of the mental health strategy during the pandemic the key areas of focus to improve access are as follows, ensuring information is shared across crisis care providers to benefit service users and prevent repetition of providing information, ensuring there is not wrong front door and services are provided by caring and compassionate staff. A workshop to map out the actions needed to achieve this vision is to be held 25th September involving service users, carers, third sector partners, and other system stakeholders.

Optimising Value – this workstream has now completed. It has resulted in a number of changes being implemented into third sector contracts including, a revised specification of the crisis cafes, a revised specification of Oasis (Crisis House), a revised specification for Leeds Survivor Led Crisis Services at Dial House including the CONNECT helpline. The specifications are nearing completion or are already implemented in the case of Oasis.

Evaluation of the Oasis Crisis House – the review undertaken as part of the optimising value workstream was undertaken in conjunction with a separate service evaluation, this has led better integrated working with CRISS, better utilisation of the service and an increase in day visitor capacity.

Evaluation of the Crisis Assessment Unit (CAU) – agreement was secured to complete a yearlong review of CAU once it had been returned to its original purpose as it is currently being utilised as acute bed overflow. This has been challenging to achieve given the current bed pressures. The team are currently planning for this to happen in November.

Evaluation of Crisis cafes – the evaluation undertaken has not been completed. Following discussions with the researcher this week it appears it may not be completed and therefore consideration is being given as to how to move forward.

4.3 111 Mental health Crisis Line

NHS 111 MH Crisis Line went live on the 8th of May and overall is progressing well. Some concerns were raised re limited communications to Primary Care partners. This has been rectified and a briefing on the 111 mental health option has gone out via the Primary Care Bulletin. The Helpline Provider has indicated that the volume of calls from Leeds has surpassed anticipated levels. However, they are yet to turn off the support helpline 0800 number and are running both lines, this means we are not able to accurately calculate the actual activity. There are ongoing discussions on this issue as there are assumptions that some of the same people are calling both numbers and inflating the volume of calls. It is recommended that this is done prior to any contract negotiations as the current contract with Nottingham Community Housing Association (current provider of West Yorkshire Helpline and

Leeds Mental health Support Line) is due for renewal April 2025. West Yorkshire Commissioning Forum are leading on the procurement.

A small number of concerns have been received since the changes about accessing crisis support. We have connected with the people affected to understand their experience. In summary, accessing 111 was a generally positive experience and that referrals to LYPFT are being made. There have been issues where calls have been dropped and the issue is now resolved. Additionally, one individual did report a negative experience of the response from LYPFT staff which is being addressed. We are monitoring the service and will continue to make necessary improvements and changes.

4.4 YAS 999 diversion pilot

LYPFT have agreed to pilot the Mental Health Push Model also named 'Early Response to Mental Health' with Yorkshire Ambulance Service (YAS). The aim of this model is to provide more effective and responsive service for those in mental health crisis by getting them to the right care and the right time. The process involves triaging those who have called in a mental health crisis and were deemed to be a lower acuity and not requiring medical intervention (conveyancing to an ED) they will divert the call to our Street Triage Team who will provide a response as needed. The pilot is due to go live from the 14th of October 2024 and will initially be trialled Mon-Fri 8am-6pm. Governance arrangements with the Yorkshire Ambulance Service are being agreed. A communication plan is to be further developed and set out.

5. EPRR ACTIVITY

5.1 Incidents/ disruption

5.1.1 Industrial Action – Junior Doctors

A pay deal has now been agreed so this is now concluded.

5.1.2 Industrial Action – GPs

GPs have announced industrial action which will follow action short of strike against a series of options (10 in all). The options range from non-participation in IT developments up to restrictions to a 25 patient a day consultation threshold by GPs.

The ICB initially ran daily touchpoints which the EPRR team attended but so far action from GPs has not approached the more disruptive options. Currently a weekly meeting is organised by the ICB for intelligence gathering and sharing action on a place-by-place basis.

5.1.3 Incident – Violent Disorder

Following the tragic murder of three young girls in Southport waves of violent disorder occurred across the country with violence aimed at ethnic minority populations and asylum seekers. The level of violence, threat and intimidation was such that it directly affected the Trust's ethnic minority workforce with some experiencing threatening behaviour and abuse while moving about in our communities or while in their homes.

The Trust raised the issue directly with the ICB and enabled a system wide consideration of risks and ways to mitigate threats to our staff. The Trust itself treated the situation as an ongoing incident implementing incident response arrangements to coordinate work on gathering information about possible threats and coordinate support and advice to staff groups.

The EPRR team linked with ICBs across the north of England recognising that, while Leeds thankfully did not see the violent rioting other cities and towns did, we had staff in these areas who needed information and support.

A debrief is being planned around this incident to identify good practice and also where the response and associated actions could be improved.

5.2 Business Continuity

A new process around business continuity monitoring is being developed for care services. This will involve service line governance groups taking the role of quarterly reporting and monitoring of business continuity plan development, revision and exercising. This meets a longstanding internal audit finding and also ensures local ownership of business continuity processes.

Heads of Operation are asked to ensure that the status of business continuity management systems in the service line are reported to governance groups regularly. This means an update on:

- Status of plans – developing draft or ratified.
- Plans that have been tested.
- Plans being updated following testing.

Business continuity plan maintenance is an annual requirement set by NHS England.

5.3 EPRR Portfolio training

An online portal in Learn is being evaluated currently to manage this process.

Some staff have had updated meetings with the EPRR team to discuss the requirements for 2024-2025 and staff have started progressing the 3 annual requirements. The formal reporting of compliance to NHS England will occur in March 2025, organisations are expected to be at 80% with training.

5.4 Exercises

Training of staff at Aire Court in Chemical, Biological, Radiological and Nuclear arrangements has commenced as a prelude to a live exercise later in the autumn.

An ICT exercise was being planned in conjunction with ICT for October 2024 (rearranged from September). This will be a full day exercise involving a multi-disciplinary approach to managing an attack on Trust IT and communications systems.

The requirement of EPRR commander training means that all tactical and strategic cohorts will have to have had some experience in 2024-25 of either commanding a real incident or an exercise. Given that there are about 60 staff on these cohorts the EPRR team is aiming to give several staff per exercise experience of acting as incident commander. Furthermore, we aim to deliver some large service line wide BC table tops and again staff will be asked to serve as commander.

An exercise for our Loggists is being arranged for October 2024/25.

6. WINTER PREPAREDNESS AND PLANNING

Winter Planning priorities (alongside expectations of NHS organisations for the remainder of the financial year) were shared week commencing 17th September. In advance of this we have been working internally, and with system colleagues to revise our Winter Plan and operating arrangements, so that we can continue to provide appropriate care over the course of Winter 2024/25. Further work is underway, particularly ensuring our services are resilient and that where we interface with other providers, we can work effectively.

A full and operationalised version will be included in papers at the November Public Board meeting for information.

7. RECOMMENDATIONS

- Members of the Finance and Performance Committee are asked to note the content of this report and discuss any areas of concern.
- Identify any further work required and agree timeframes and prioritisation.

Joanna Forster Adams
Chief Operating Officer
September 2024.

Contributions from:
Alison Kenyon, Deputy Director of Service Development
Andrew Jackson Resilience Lead and Corporate Business Manager

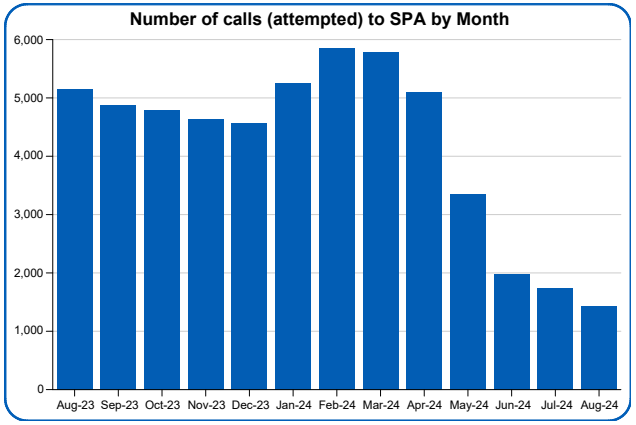
Service Performance - Chief Operating Officer

Services: Access & Responsiveness: Our response in a crisis	Target	Jun 2024	Jul 2024	Aug 2024
Percentage of crisis calls (via the single point of access) answered within 1 minute	-	54.2%	74.6%	73.6%
Percentage of ALPS referrals responded to within 1 hour	-	72.5%	74.4%	77.8%
Percentage of S136 referrals assessed within 3 hours of arrival	-	25.7%	7.0%	9.7%
Number of S136 referrals assessed	-	35	57	31
Number of S136 detentions over 24 hours	0	1	1	0
Percentage of appropriate crisis referrals seen face to face for assessment within 4 hours of referral	90.0%	73.7%	49.1%	57.4%
Percentage of service users who stayed on CRISS caseload for less than 6 weeks	70.0%	79.4%	83.8%	85.5%
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support	50.0%	43.6%	40.3%	39.5%
Percentage of CRISS caseload where source of referral was acute inpatients	-	16.2%	13.7%	22.0%
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services	**Target**	**Jun 2024**	**Jul 2024**	**Aug 2024**
Gender Identity Service: Number on waiting list	-	5,935	6,005	6,074
Deaf CAMHS: average wait from referral to first face to face (inc. telemedicine) contact in days	-	187.55	214.67	190.94
Community LD: Percentage of referrals seen within 4 weeks of receipt of referral	90.0%	67.5%	64.4%	55.6%
Leeds Autism Diagnostic Service (LADS): Assessment to Diagnostic Decision within 26 Weeks (quarterly)	-	60.4%	-	-
Leeds Autism Diagnostic Service (LADS): Percentage starting assessment within 13 weeks (quarterly)	-	38.8%	-	-
CAMHS inpatients: Proportion of people assessed within 7 days of admission (HoNOSCA / GBO) (quarterly)	100.0%	100.0%	-	-
Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency) (quarterly)	-	80.0%	-	-
Perinatal Community: Percentage of routine referrals waiting less than 2 weeks for assessment (quarterly)	85.0%	92.8%	-	-
Perinatal Community: Total number of distinct women seen in rolling 12 months (quarterly)	920	1,008	-	-
Perinatal Community: Face to Face DNA Rate (quarterly)	-	8.4%	-	-
Services: Our acute patient journey	**Target**	**Jun 2024**	**Jul 2024**	**Aug 2024**
Number of admissions to adult facilities of patients who are under 16 years old	-	0	0	0
Crisis Assessment Unit (CAU) bed occupancy	-	96.7%	98.4%	100.5%
Crisis Assessment Unit (CAU) length of stay at discharge	-	38.4	27	41.25
Liaison In-Reach: attempted assessment within 24 hours	90.0%	72.0%	86.7%	74.5%
Bed Occupancy rates for (adult acute excluding PICU) inpatient services:	94.0% - 98.0%	99.4%	100.1%	100.3%
Becklin Ward 1 (Female)	-	101.4%	104.1%	104.7%
Becklin Ward 3 (Male)	-	97.6%	98.2%	98.9%
Becklin Ward 4 (Male)	-	98.5%	100.9%	99.0%
Becklin Ward 5 (Female)	-	100.6%	99.4%	99.0%
Newsam Ward 4 (Male)	-	99.0%	97.8%	99.7%
Older adult (total)	-	90.8%	95.9%	96.7%
The Mount Ward 1 (Male Dementia)	-	73.8%	96.8%	98.6%

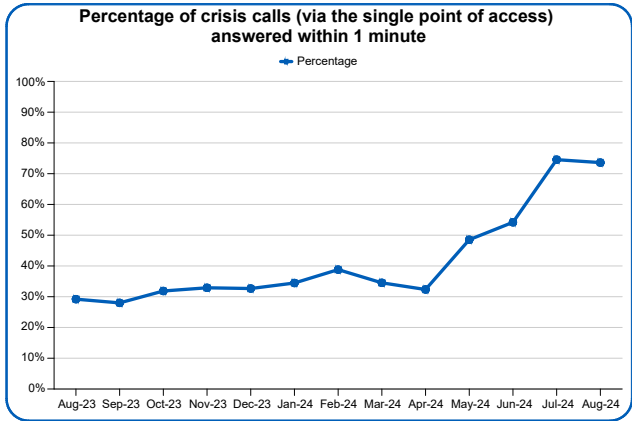
Service Performance - Chief Operating Officer

Services: Our acute patient journey	Target	Jun 2024	Jul 2024	Aug 2024
The Mount Ward 2 (Female Dementia)	-	95.1%	99.6%	91.8%
The Mount Ward 3 (Male)	-	88.8%	86.6%	95.6%
The Mount Ward 4 (Female)	-	100.8%	101.7%	99.8%
Percentage CRFD	-	24.5%	25.5%	37.2%
Out of Area Trajectory Active Placements at Month End	19	21	15	20
Total: Number of out of area placements beginning in month	-	3	5	12
Total: Total number of bed days out of area (new and existing placements from previous months)	-	694	551	533
Acute: Active Placements at Month End	-	18	12	15
Acute: Number of out of area placements beginning in month	-	3	2	8
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	598	475	421
PICU: Active Placements at Month End	-	3	3	5
PICU: Number of out of area placements beginning in month	-	0	3	3
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	96	76	104
Older people: Active Placements at Month End	-	0	0	0
Older people: Number of out of area placements beginning in month	-	0	0	1
Older people: Total number of bed days out of area (new & existing placements from previous months)	-	0	0	8
Cardiometabolic (physical health) assessments completed: Inpatients (quarterly)	80.0%	80.2%	-	-
Services: Our Community Care	**Target**	**Jun 2024**	**Jul 2024**	**Aug 2024**
Percentage of inpatients followed up within 3 days of discharge (Trust Level monthly local tracking)	80.0%	83.3%	78.0%	81.2%
Percentage of inpatients followed up within 3 days of discharge (HCP commissioned services only)	80.0%	84.7%	77.8%	85.5%
Number of service users in community mental health team care (caseload)	-	3,266	3,268	3,250
Percentage of referrals to memory services seen within 8 weeks (quarter to date)	70.0%	78.1%	79.6%	76.0%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50.0%	50.3%	60.3%	62.8%
Early intervention in psychosis (EIP) or at risk mental state (ARMS): Percentage starting treatment within 2 weeks	60.0%	60.0%	52.4%	53.3%
Early intervention in psychosis (EIP) : Percentage of people discharged to primary care (quarterly)	-	59.2%	-	-
Cardiometabolic (physical health) assessments completed: Early Intervention in Psychosis Service (quarterly)	80.0%	78.1%	-	-
Services: Clinical Record Keeping	**Target**	**Jun 2024**	**Jul 2024**	**Aug 2024**
Percentage of service users with NHS Number recorded	-	99.3%	99.3%	99.4%
Percentage of service users with ethnicity recorded	-	81.6%	81.2%	81.1%
Percentage of service users with sexual orientation recorded	-	47.5%	46.7%	46.5%
Services: Clinical Record Keeping - DQMI	**Target**	**Mar 2024**	**Apr 2024**	**May 2024**
DQMI (MHSDS) % Quality %	95.0%	89.5%	88.8%	89.2%

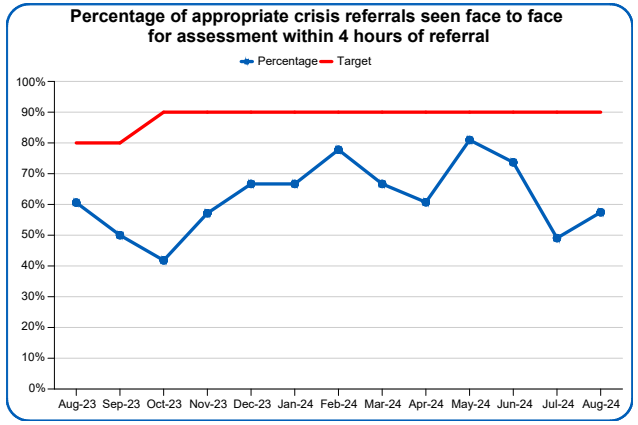
Services: Access & Responsiveness: Our Response in a crisis



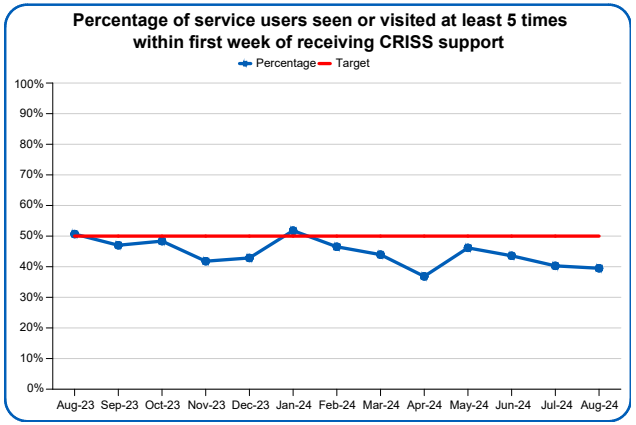
Number of calls : August 1,444



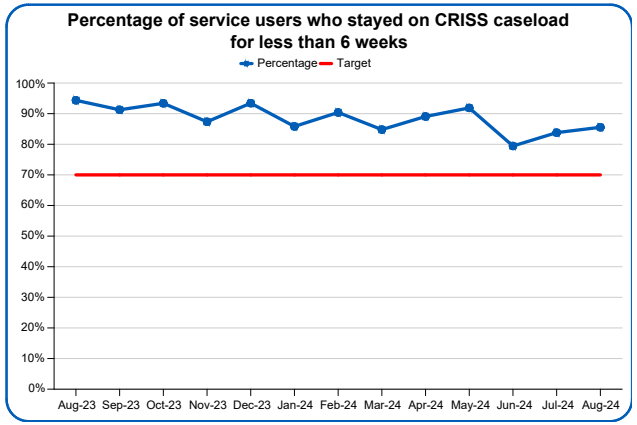
Local target - within 1 minute: August 73.6%



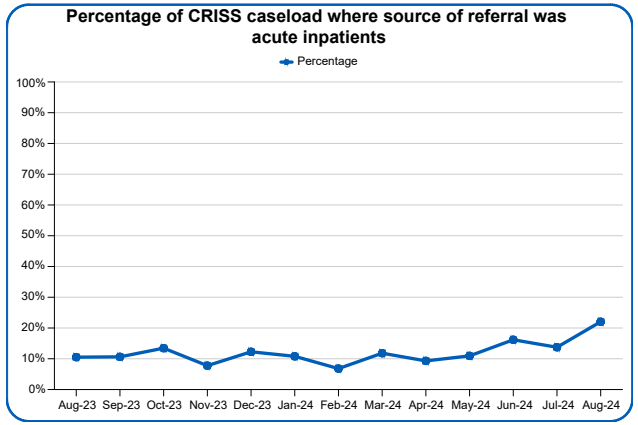
Contactual Target 90%: August 57.4%



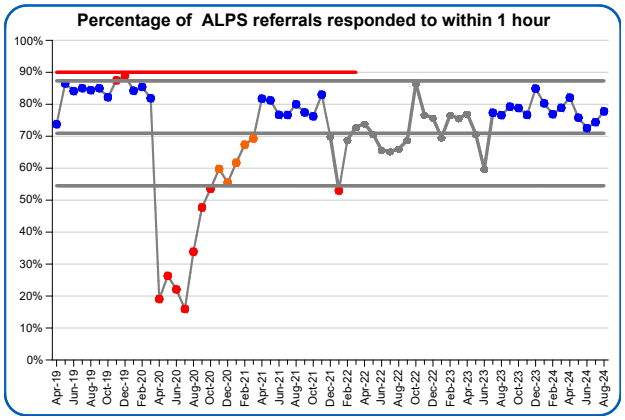
Contractual Target 50%: August 39.5%



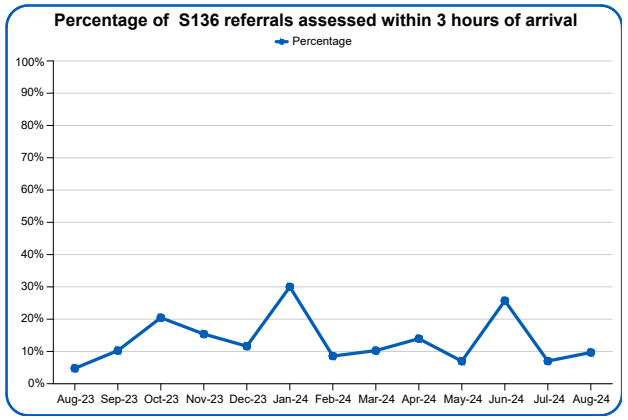
Contractual Target 70%: August 85.5%



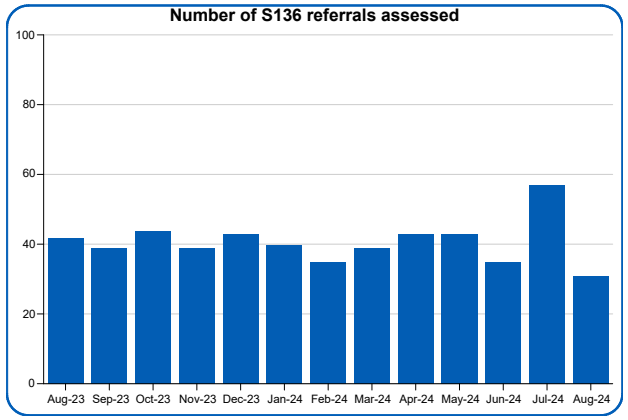
Contractual Target tba: August 22.0%



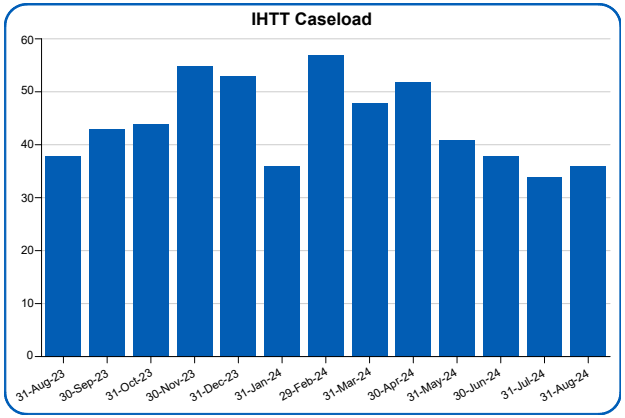
Contractual Target : August 77.8%



Contractual Target : August 9.7%



Total referrals assessed: August 31



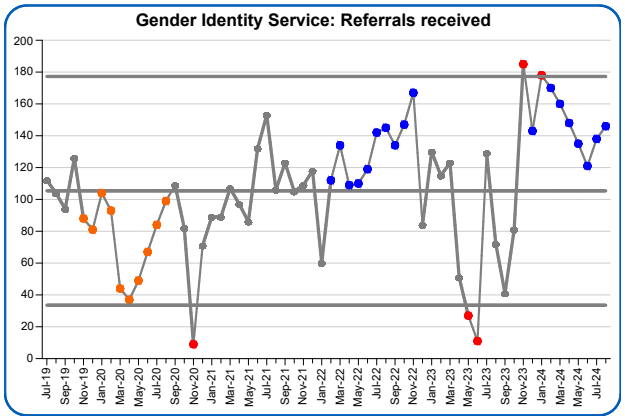
Caseload: August 36

Services: Access & Responsiveness: Our Response in a crisis

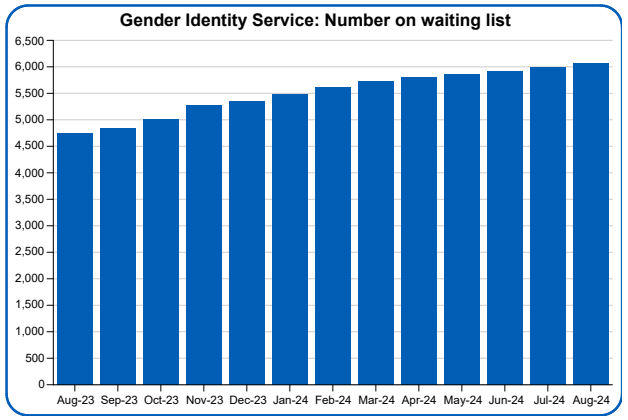
Percentage of S136 referrals assessed within 3 hours of arrival: This position has deteriorated as a result of sickness within the AMHP Team within LYPFT. This has resulted in referrals having to be made to Adult Social Care, their response times, and the delays as a result. We have also experienced some challenges regarding the recording of the assessment. Assessors have been recording the time of the assessment being complete, which can take several hours depending on the potential outcome as opposed when the initial assessment has started.

Number of calls (attempted) to SPA by Month: We have seen the fall in calls to SPA since May 2024 as a result of the new NHS 111 Mental Health helpline becoming live.

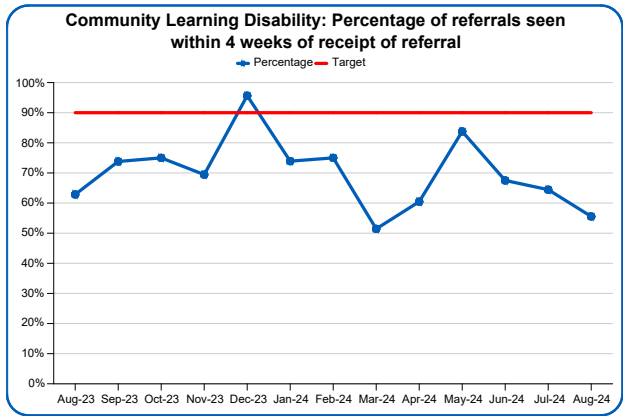
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services



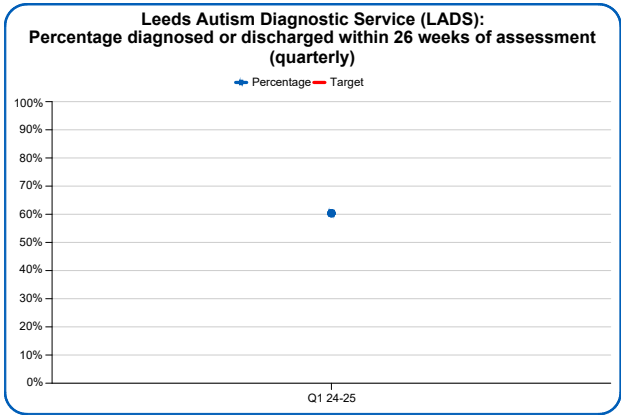
Total referrals: August 146



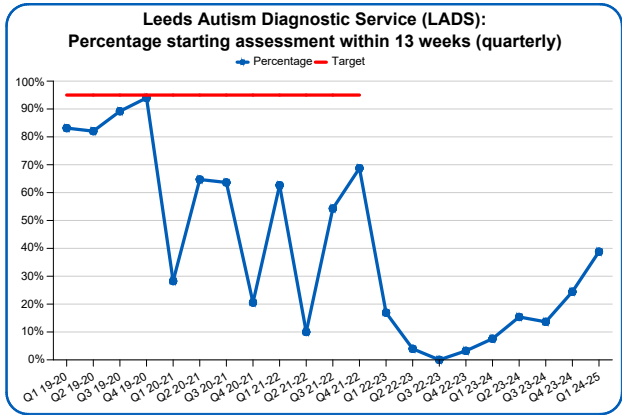
Number on waiting list: August 6,074



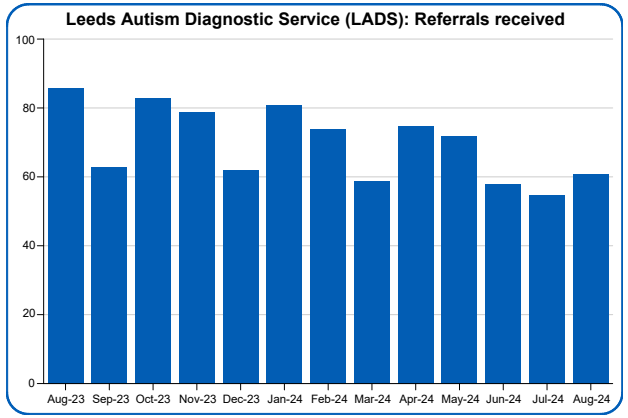
Contractual Target 90%: August 55.6%



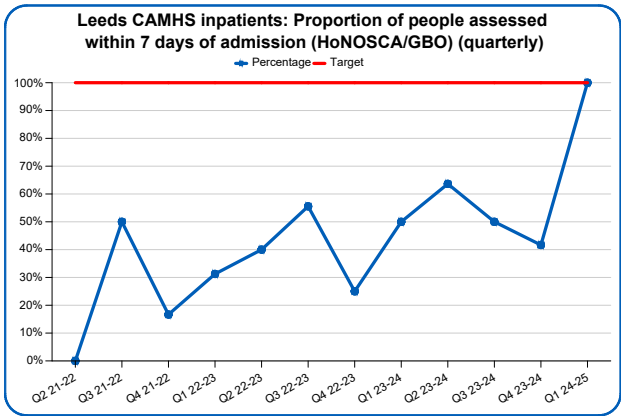
Contractual Target : Q1 60.4%



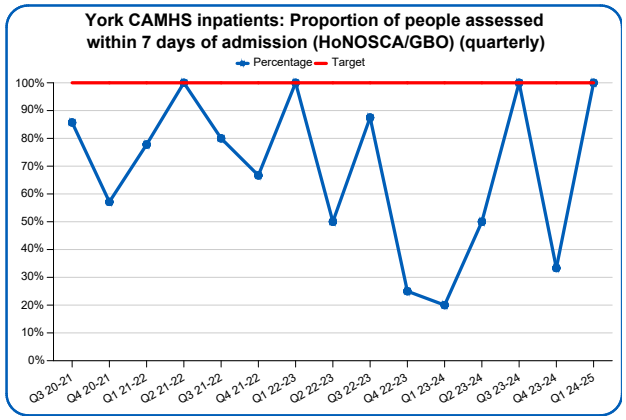
Contractual Target : Q1 38.8%



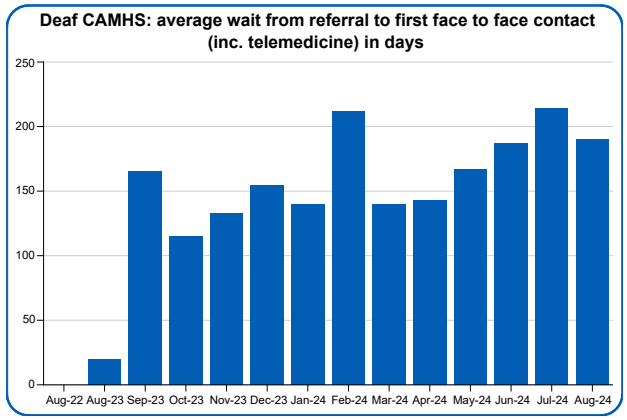
Local measure: August 61



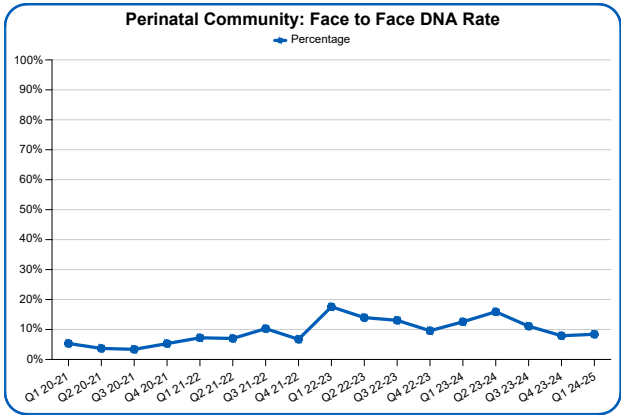
Contractual Target 100%: Q1 100.0%



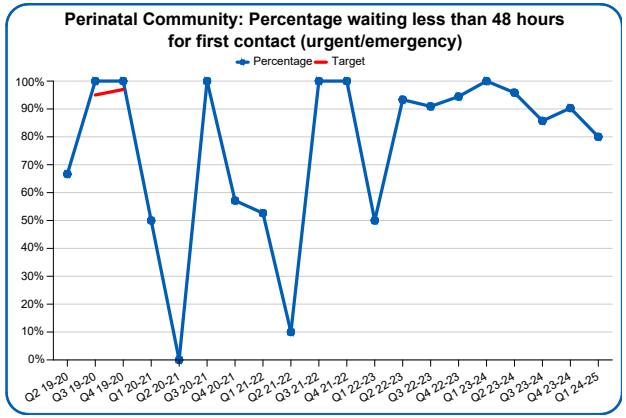
Contractual Target 100%: Q1 100.0%



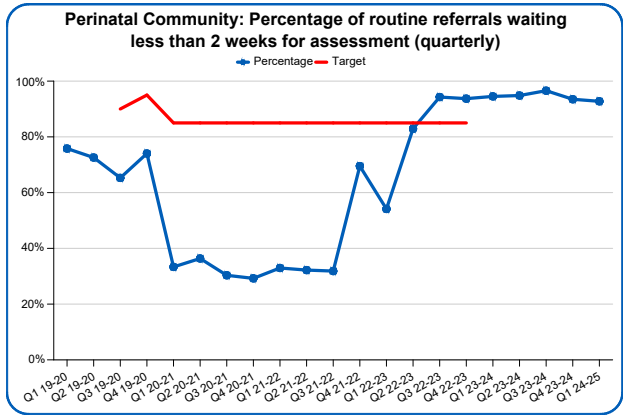
Local measure: August 191



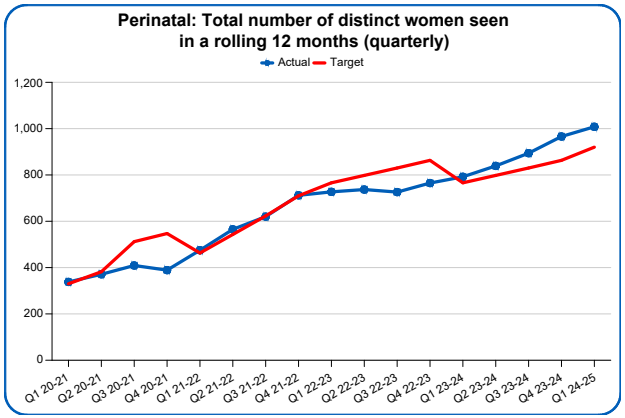
Contractual measure: Q1 8.4%



Contractual Target tba: Q1 80.0%

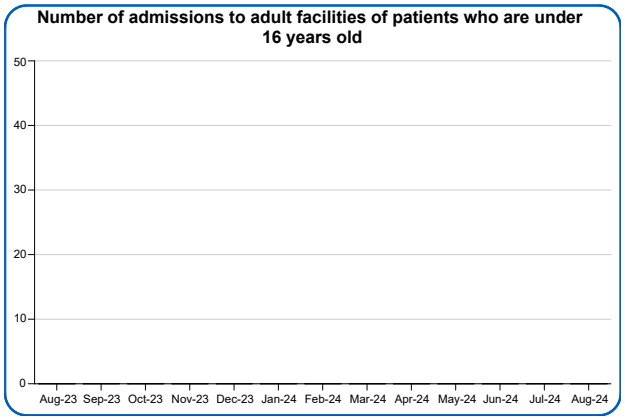


Contractual Target 85%: Q1 92.8%

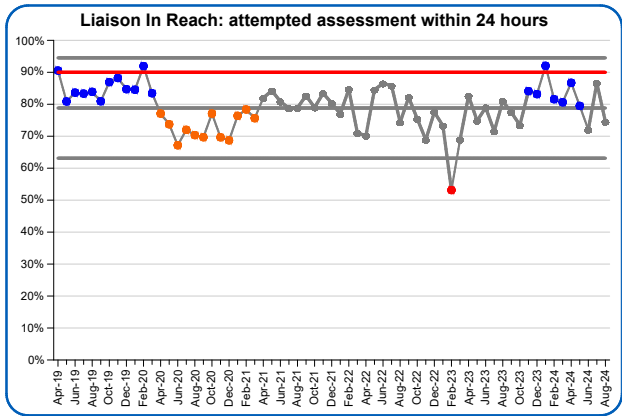


Local measure 920: Q1 1,008

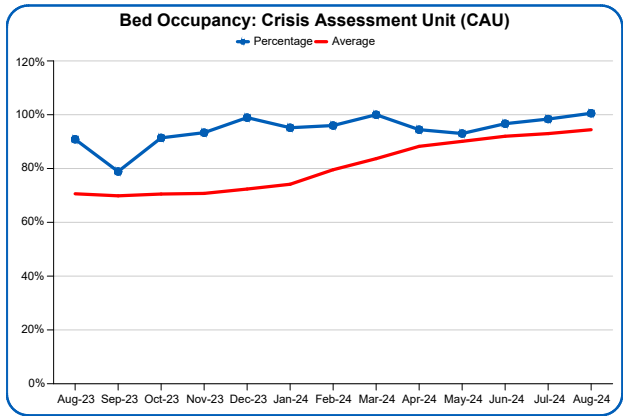
Services: Our acute patient journey



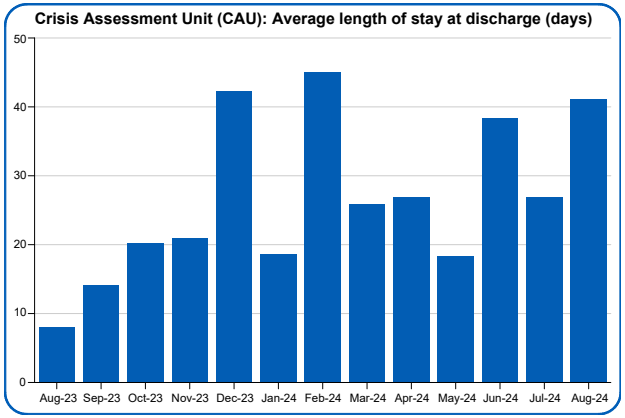
National (NOF) No target : August 0



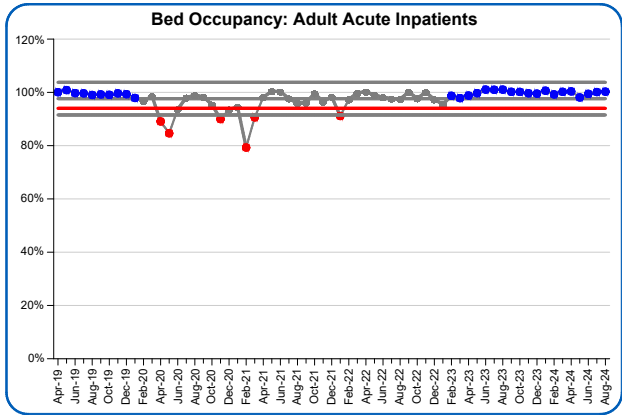
Contractual Target 90%: August 74.5%



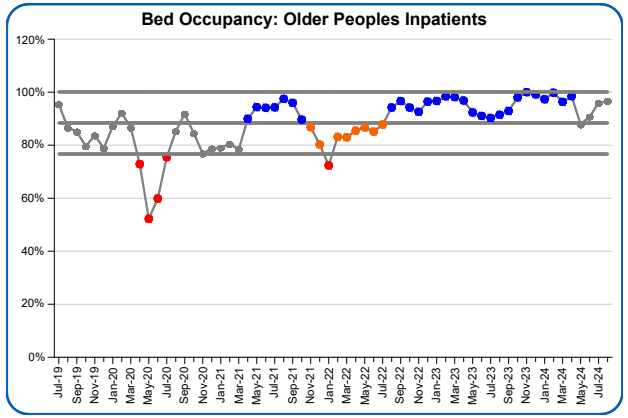
Local measure: August 100.5%



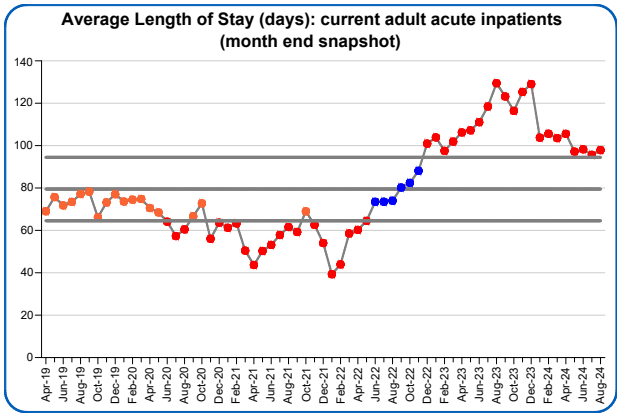
Local measure: August 41 days



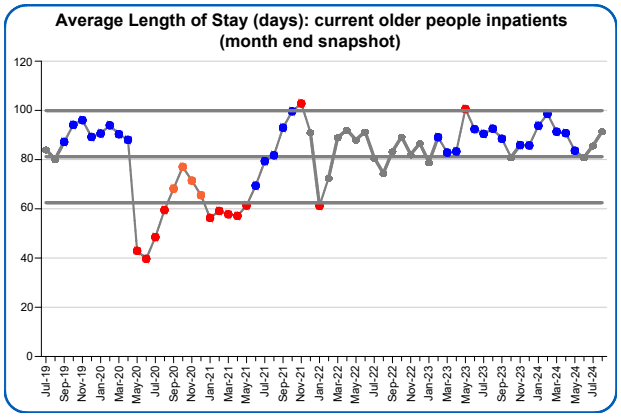
Contractual Target 94%: August 100.3%



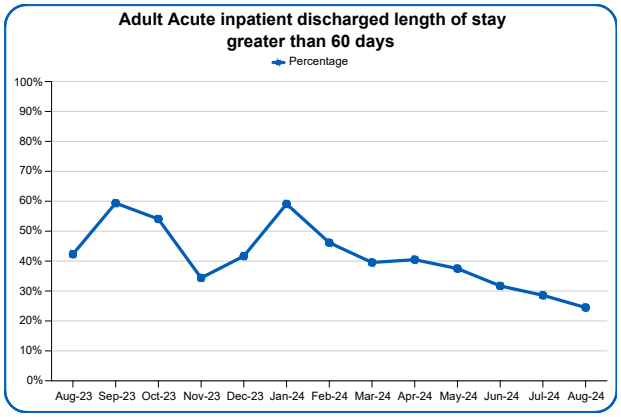
Local measure and target : August 96.7%



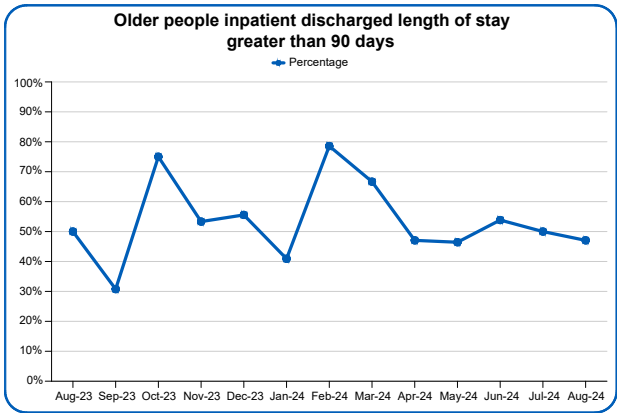
Local tracking measure: August 98 days



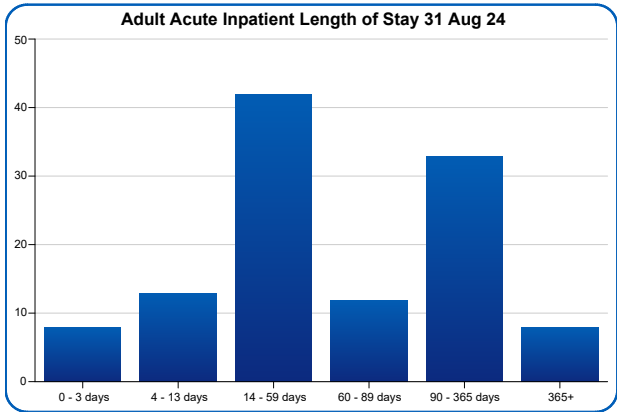
Local tracking measure: August 92 days



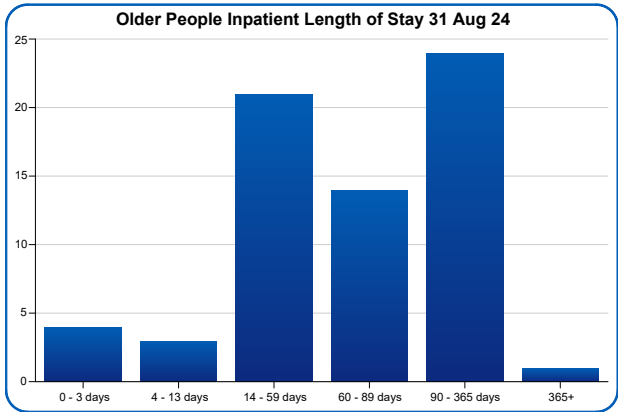
National (LTP): August 24.5%



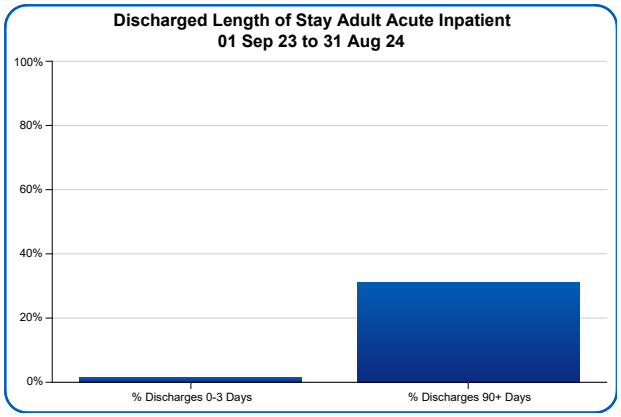
National (LTP): August 47.1%



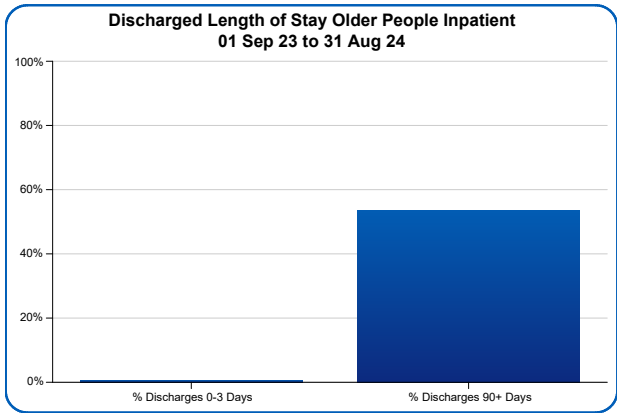
Local activity: 41 people with LOS 90+ days



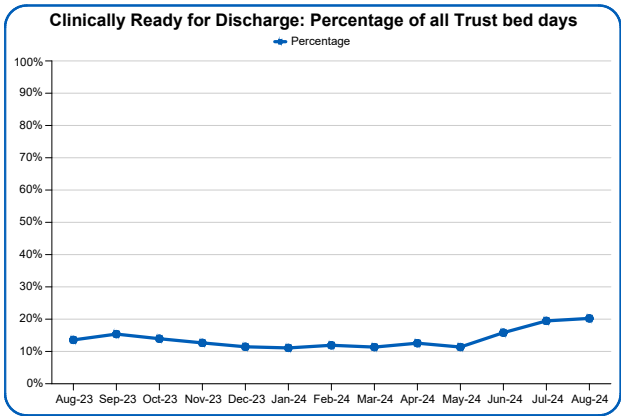
Local activity: 25 people with LOS 90+ days



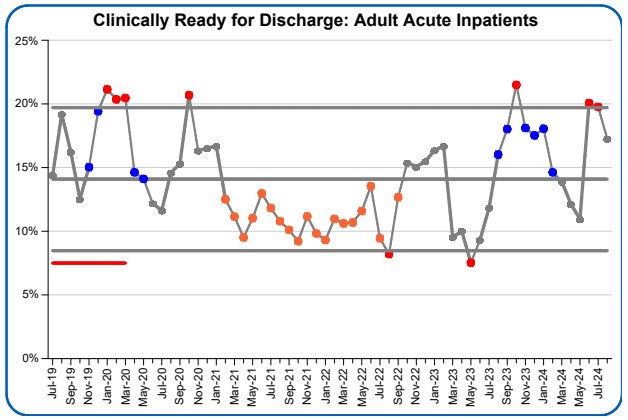
Local activity: % discharged LOS 90+ days = 31.4%



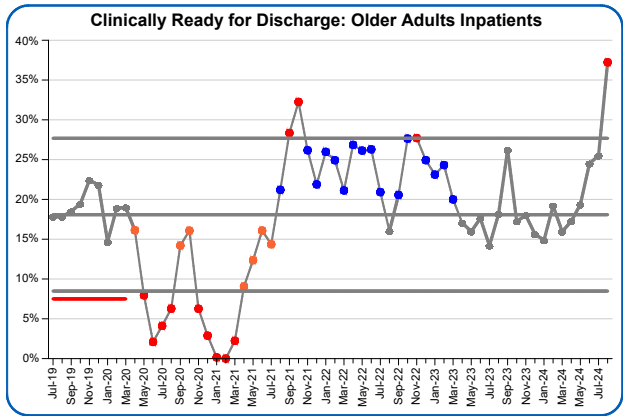
Local activity: % discharged LOS 90+ days = 54.0%



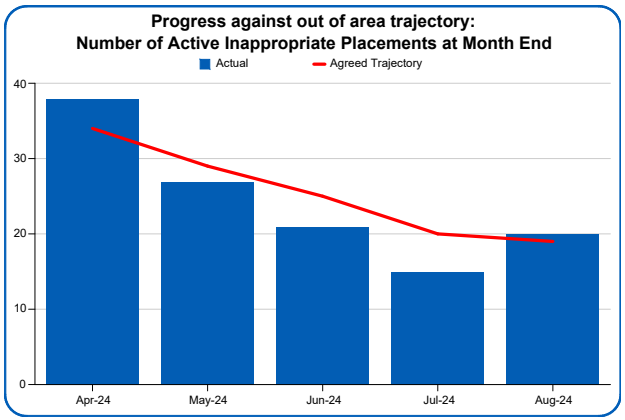
Local tracking measure: August 20.2%



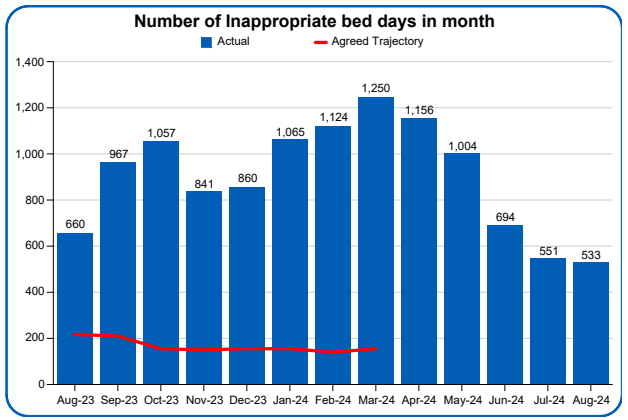
Local tracking measure: August 17.3%



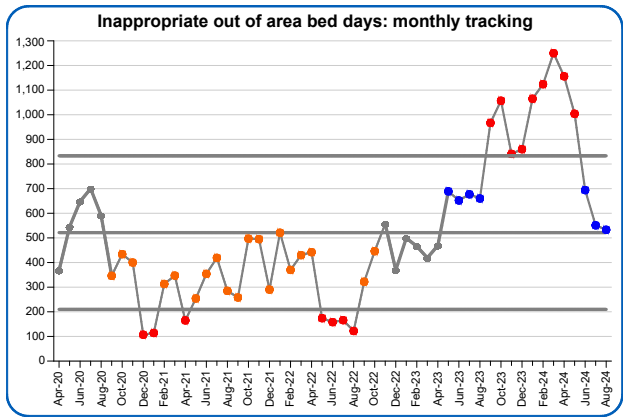
Local tracking measure: August 37.2%



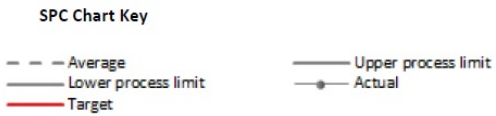
Nationally agreed trajectory (August: 19): August 20 active placements

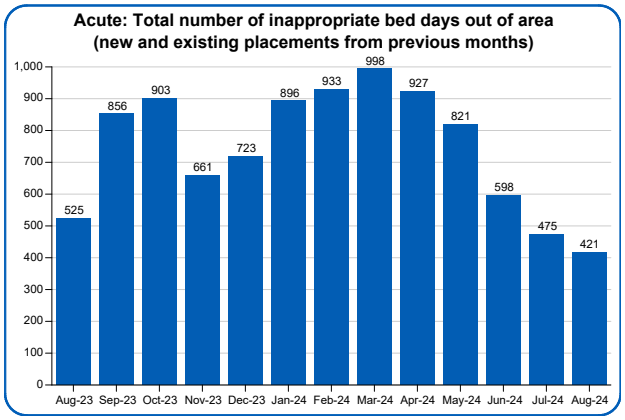


Local tracking measure: August 533 bed days

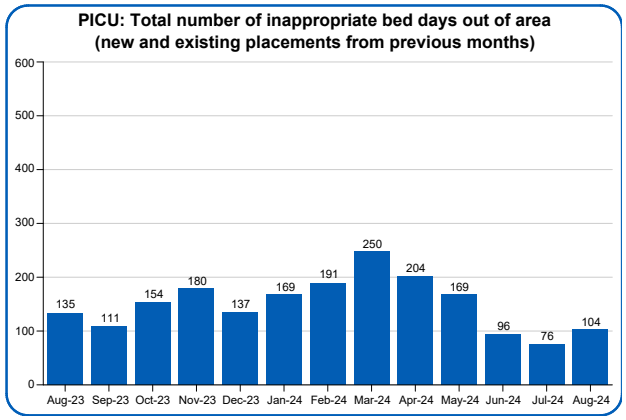


Local tracking measure: August 533 bed days

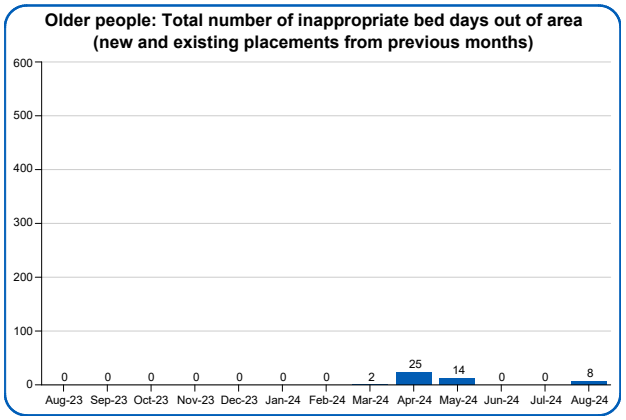




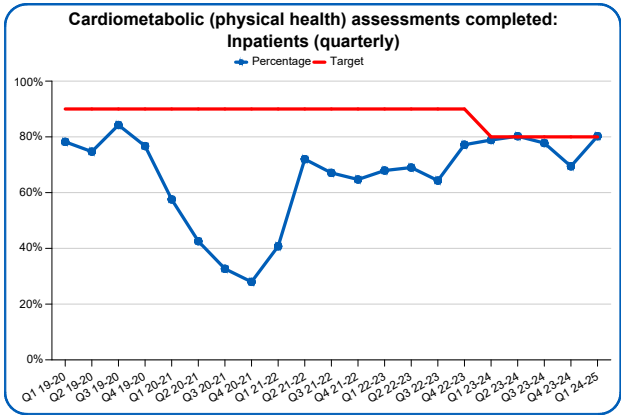
Nationally agreed trajectory (): August 421 days



Nationally agreed trajectory (): August 104 days



Local measure : August 8 days



Contractual target 80%: Q1 80.2%

Services: Our acute patient journey

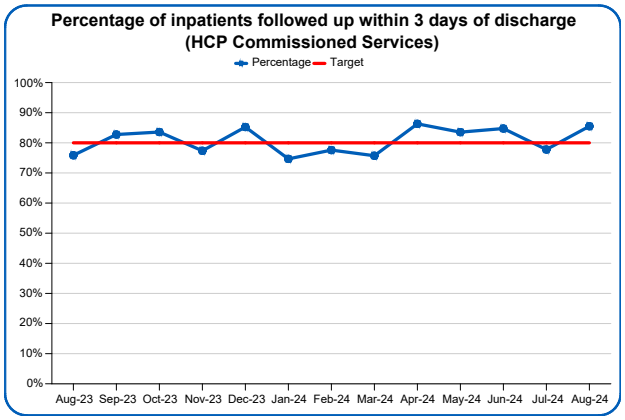
Crisis Assessment Unit (CAU) Average length of stay at discharge (days): The length of stay on CAU has seen an increase as a result of 2 of the 6 beds being occupied by services users who are ready for discharge. The CAU continues to be functioning as an acute ward due to the ongoing capacity and demand challenges across the service.

Average Length of Stay (days) current adult acute inpatients (month end snapshot): Whilst we are seeing an improving picture, we still have a number of complex cases who require additional packages of care to be put in place before they can be discharged and a number who still require access to accommodation in order to be discharged.

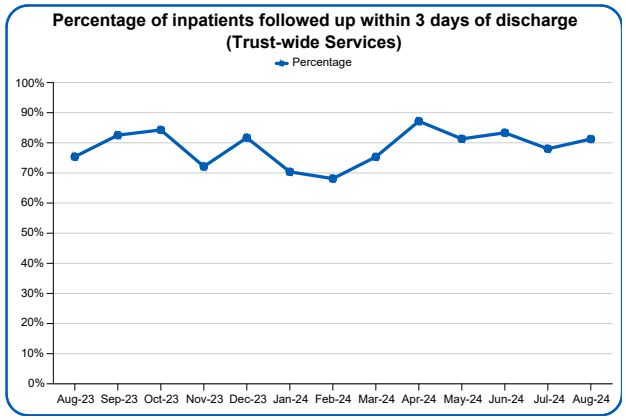
Clinically Ready for Discharge Adult Acute Inpatients: As a result of changing the definitions in relation to Clinically Ready for Discharge, we have seen an increase in the number.

Clinically Ready for Discharge Older Adults Inpatients: As a result of changing the definitions in relation to Clinically Ready for Discharge, we have seen an increase in the number. We are also seeing the delays with organising funding and packages of care continuing to be a challenge, but the service is better sighted on who can be clinically moved at an earlier date which has enabled them to start building processes to support quicker discharges i.e. identifying an estimated date of discharge and convening more frequent ‘barriers to discharge meetings’ as necessary.

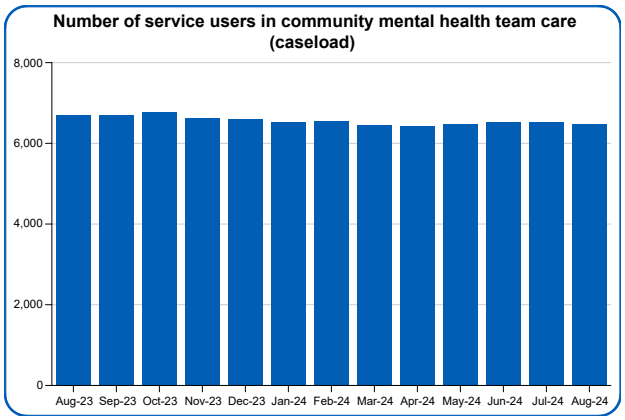
Services: Our community care



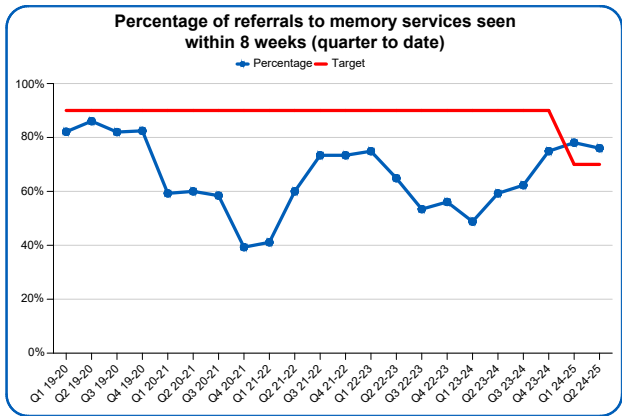
Contractual target 80%: August 85.5%



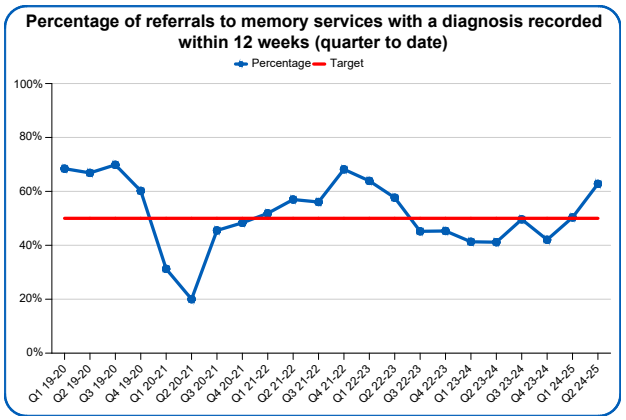
Local Tracking Measure 80%: August 81.2%



Local measure : August 3,225

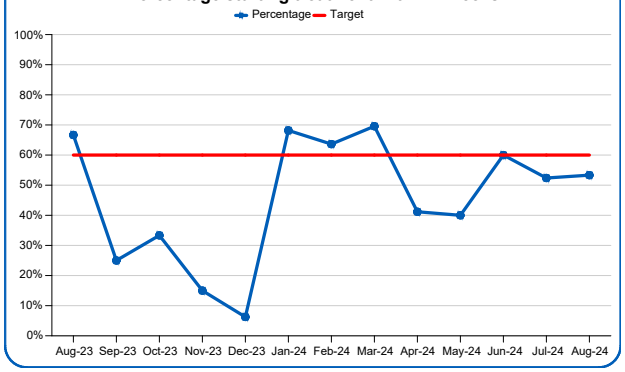


Contractual target 70%: Q2 24-25 76.0%



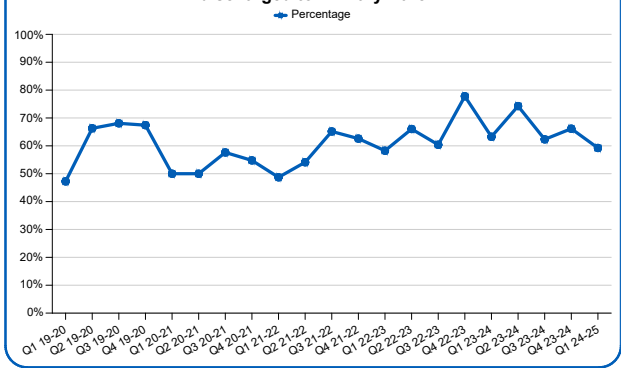
Contractual target 50%: Q2 24-25 62.8%

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



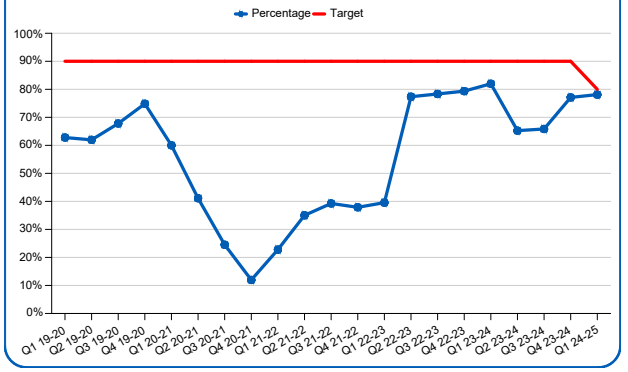
Contractual target 60%: August 53.3%

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



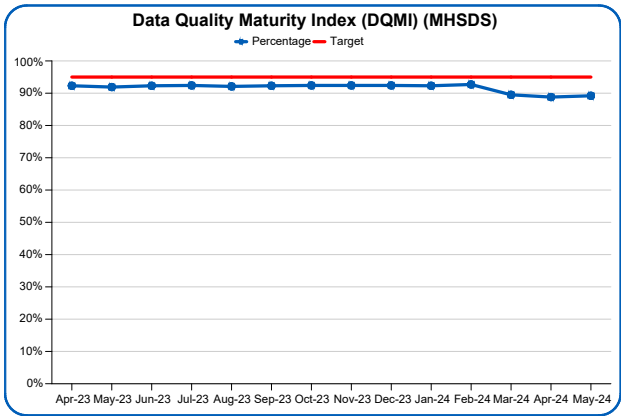
Contractual target tbc: Q1 59.2%

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

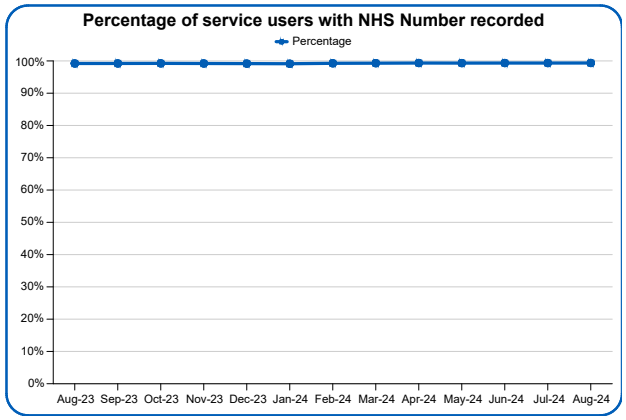


Contractual target 80%: Q1 78.1%

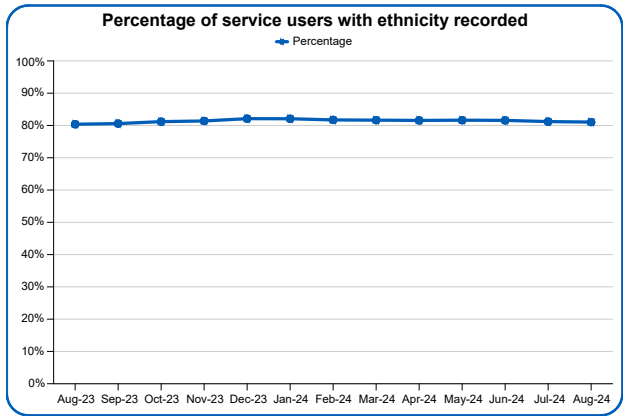
Services: Clinical Record Keeping



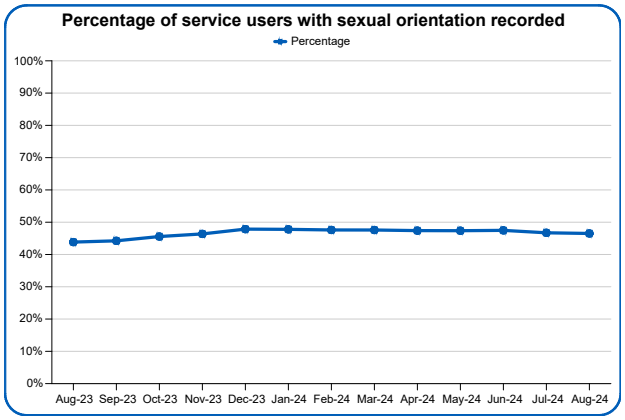
CQUIN / NHSOF Target 95%: May 89.2%



Local measure: August 99.4%



Local measure: August 81.1%



Local measure: August 46.5%

Glossary

Services: Access & Responsiveness: Our response in a crisis	
Percentage of crisis calls (via the single point of access) answered within 1 minute	Of all the telephone calls made to our crisis line that were answered, the proportion that were answered within 1 minute.
Percentage of ALPS referrals responded to within 1 hour	Of all the referrals from Accident & Emergency, to the Acute Liaison Psychiatry Service (ALPS) that were assessed, the proportion that were assessed within 1-hour.
Percentage of S136 referrals assessed within 3 hours of arrival	Of all the Section 136 (S136) referrals assessed, the proportion that were assessed within 3-hours of arrival at the Place of Safety
Number of S136 referrals assessed	The number of Section 136 (S136) referrals receiving their first face-to-face mental health assessment after they were detained under S136.
Number of S136 detentions over 24 hours	Number of Section 136 (S136) detentions that exceeded the 24-hour review period.
Percentage of appropriate crisis referrals seen face to face for assessment within 4 hours of referral	Of all the referrals receiving a face-to-face assessment following referral to the crisis service, the proportion that were assessed within 4-hours of referral.
Percentage of service users who stayed on CRISS caseload for less than 6 weeks	Of all the referrals discharged from Crisis Resolution or Intensive Support Service (CRISS), the proportion that had a length of referral of 6-weeks or less at the time of discharge.
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support	Of all the referrals discharged from Crisis Resolution or Intensive Support Service (CRISS) that were open for at least 7-days, the proportion that had at least 5 successful face-to-face contacts during the first 7-days of service involvement.
Percentage of CRISS caseload where source of referral was acute inpatients	Of all the referrals open to the Intensive Support Service (ISS) at the end of the period, the proportion that were an inpatient at the time of referral.
Services: Access & Responsiveness to Learning Disabilities, Regional & Specialist Services	
Gender Identity Service: Number on waiting list	The number of referrals open at the end of the period where the service user was waiting for an assessment
Deaf CAMHS: average wait from referral to first face to face (inc. telemedicine) contact in days	For all the referrals in Deaf Child and Adolescent Mental Health Services (CAMHS) receiving their first face-to-face or video contact during the period, the average number of days between referral and the first contact.
Community LD: Percentage of referrals seen within 4 weeks of receipt of referral	Of all the referrals to a Community Learning Disability Team that received their first attended, direct contact in the period, the proportion where the contact took place within 28-days of referral.
Leeds Autism Diagnostic Service (LADS): Percentage starting assessment within 13 weeks (quarterly)	Of all the Leeds Autism Diagnostic Service (LADS) referrals receiving their first direct, attended assessment taking place face-to-face or by video, with an 'Autism Assessment' intervention recorded as part of the contact in the period, the proportion where the assessment took place within 91-days of referral.
CAMHS inpatients: Proportion of people assessed within 7 days of admission (HoNOSCA / GBO) (quarterly)	Of all the admissions to a Child and Adolescent Mental Health Services (CAMHS) ward that received either a Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) or Goal Based Outcomes (GBO) assessment, the proportion where either assessment took place within 7-days of admission.
Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency) (quarterly)	Of all the referrals to the Perinatal Community service with an 'Emergency' or 'Urgent' referral priority that received a first direct, attended contact in the period, the proportion where the contact took place within 48-hours of referral.
Perinatal Community: Percentage of routine referrals waiting less than 2 weeks for assessment (quarterly)	Of all the referrals to the Perinatal Community service with a 'Routine' referral priority that received a first direct, attended face-to-face or video contact in the period, the proportion where the contact took place within 14-days of referral.
Perinatal Community: Total number of distinct women seen in rolling 12 months (quarterly)	The total number of women with a direct, attended, face-to-face or video contact, during the 12-months ending in the period; women seen multiple times are counted once.
Perinatal Community: Face to Face DNA Rate (quarterly)	Of all the face-to-face, attended and did not attend (DNA), contacts with the Perinatal Community Team in the period, the proportion of face-to-face contacts that the service user did not attend.

Services: Our acute patient journey	
Number of admissions to adult facilities of patients who are under 16 years old	Number of admissions to inpatient services, excluding Child and Adolescent Mental Health Services (CAMHS), where the service user was aged under 16 on the day of admission.
Crisis Assessment Unit (CAU) bed occupancy	Of the total number of available beds on the ward and the number of days each bed was available, the proportion of those days where a bed was occupied. For example, on a 10-bed ward in the month of April where no beds were unavailable due to maintenance/repairs, etc., there are 300 available bed days. Where there were service users in beds for 150 of those days, this would result in 50% occupancy.
Crisis Assessment Unit (CAU) length of stay at discharge	For all the discharges from the Crisis Assessment Unit in the period, the average number of days each service user stayed on the ward.
Liaison In-Reach: attempted assessment within 24 hours	Of all the service users assessed by Hospital Mental Health Inreach following referral from Leeds Teaching Hospitals Trust (LTHT), the proportion that were assessed within 24-hours of referral.
Bed Occupancy rates for (adult acute excluding PICU) inpatient services:	Of the total number of beds available in the period on Adult Acute wards, excluding Psychiatric Intensive Care Unit (PICU), the proportion where a service user was occupying the bed.
Bed Occupancy rates for individual wards (multiple measures)	Of the total number of beds available in the period on the ward, the proportion where a service user was occupying the bed, including any leave days.
Percentage of CRFD	Of the total number of occupied bed days in the period, the proportion where the service user was ready for discharge from inpatient care.
Out of Area Trajectory Active Placements at Month End (multiple measures)	The total number of out of area placements active at the end of the period, where the placement was not the result of patient choice e.g. where a staff member needed inpatient care.
Total: Number of out of area placements beginning in month (multiple measures)	The total number of all out of area placements that begin during the period.
Total: Total number of bed days out of area (new and existing placements from previous months) (multiple measures)	The total number of occupied bed days that take place as part of an out of area placement during the period, regardless of whether the placement started during or before the period.
Cardiometabolic (physical health) assessments completed: Inpatients (quarterly)	Of the number of service user on a ward at the end of the period, the proportion with all elements of the cardiometabolic assessment completed within the same admission, and during the previous 12-months.
Services: Our Community Care	
Percentage of inpatients followed up within 3 days of discharge (Trust Level monthly local tracking)	Of all discharges from Trust inpatient services, the proportion where the service user received a direct, attended, face-to-face, video or telephone contact within 3-days of discharge (excluding day of discharge).
Percentage of inpatients followed up within 3 days of discharge (HCP commissioned services only)	Of all discharges from Trust Leeds Healthcare Partnership (HCP) commissioned inpatient services, the proportion where the service user received a direct, attended, face-to-face, video or telephone contact within 3-days of discharge (excluding day of discharge).
Number of service users in community mental health team care (caseload)	Number of service users allocated to a named member of staff in an Adult or Older People's community team at the end of the period (waiting list allocations are excluded).
Percentage of referrals to memory services seen within 8 weeks (quarter to date)	Of the number of service users referred to the Memory Assessment Service (MAS) from an external source that do not have a prior Dementia diagnosis, that receive a first direct, attended face-to-face or video contact, the proportion that receive the first contact within 8-weeks of referral.
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	Of all the referrals where the service user receives a Dementia diagnosis in the period, the proportion where the diagnosis was given within 12-weeks of referral.
Early intervention in psychosis (EIP) or at risk mental state (ARMS): Percentage starting treatment within 2 weeks	Of the referrals where a care coordinator allocation starts in the period, or the first direct, attended, face-to-face, video or telephone contact in the referral took place in the period, the proportion where the latest of these two events, took place within 14-days of referral.
Early intervention in psychosis (EIP) : Percentage of people discharged to primary care (quarterly)	Of all the referrals discharged from the Early Intervention in Psychosis service in the period, the proportion where the service user was referred back to Primary Care.
Cardiometabolic (physical health) assessments completed: Early Intervention in Psychosis Service (quarterly)	Of the total number of referrals open to the Early Intervention in Psychosis (EIP) service with a care coordinator allocation active at the end of the period, the proportion with all elements of the cardiometabolic assessment completed during the previous 12-months.

Services: Clinical Record Keeping	
Percentage of service users with NHS Number recorded	Of all the referrals open during the period, the proportion where the service user's NHS number is recorded on their CareDirector record.
Percentage of service users with ethnicity recorded	Of all the referrals open during the period, the proportion where the service user's ethnicity is recorded on their CareDirector record. Where a service user declines to provide an answer, this is counted as complete; however, any ethnicity recorded as 'Unknown' is not counted as complete.
Percentage of service users with sexual orientation recorded	Of all the referrals open during the period, the proportion where the service user's sexual orientation is recorded on their CareDirector record. Where a service user declines to provide an answer or their sexual orientation is recorded as 'Unknown', this is counted as incomplete.
Services: Clinical Record Keeping - DQMI	
DQMI (MHSDS) % Quality %	The Data Quality Maturity Index (DQMI), is a weighted score based on the completeness and quality of several fields in the Trust's Mental Health Services Dataset (MHSDS) submissions to NHS Digital. The score is derived by NHS Digital from the MHSDS submission and published on their website 3-4 months later.

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

AGENDA ITEM

10

PAPER TITLE:	Community Mental Health Transformation Update
DATE OF MEETING:	26 September 2024
PRESENTED BY: (name and title)	Joanna Forster Adams, Chief Operating Officer
PREPARED BY: (name and title)	Alison Kenyon, Deputy Director for Service Development Helen Thurston – interim CMHT Programme Manager

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

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

EXECUTIVE SUMMARY

This paper provides an overview of the transformed community mental health model that has been developed over the last three years. The early adopters of the model went live in March 2024, an evaluation of the impact of these pilots is underway to inform the roll out of the transformed model across Leeds.

It highlights the process of development, along with the challenges faced and identifies some of the successes achieved by the teams. The paper outlines the next steps in the development of community mental health transformation

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

RECOMMENDATION

The Board are asked to note the contents of this report

MEETING OF THE BOARD OF DIRECTORS

26 September 2024

COMMUNITY MENTAL HEALTH TRANSFORMATION PROGRESS REPORT

1. Executive Summary

This paper provides a recap of the transforming community mental health model that has been developed over the last three years. The early adopters of the model went live in March 2024, an evaluation of the impact of these pilots is underway to inform the roll out of the transformed model across Leeds.

2. Introduction and Purpose to the Paper

This paper provides an update on progress of the community mental health transformation programme. The transformation of community services was set in the NHSE Long Term Plan (2019). It is also one of the six core priorities set out in the Leeds Health and Care Partnership Healthy Leeds Plan and one of the strategic priorities of the trust. Ultimately the purpose is to reform community based mental health care to reduce the amount of unplanned care.

Widening proactive access to personalised care, support, and intervention at the earliest point of need is critical to reducing the rate of unplanned care utilisation. The focus of the programme aims to improve outcomes and experience for individuals, and to improve financial efficiency particularly in the context of significant pressures within mental health inpatient services that have impacted in sustainably reducing out of area mental health inpatient placements. It is important to emphasise that the work to transform community mental health provision in Leeds progressing at a time of unprecedented challenges across the health and social care system. Achieving the intentions of transformation and meaningful integration of services additionally requires driving cultural change that takes time. The impacts and challenges identified in the report should be noted in that context.

3. Community Mental Health Transformation Programme

Specific requirements have been set out by NHS England in The Community Mental Health Framework (2019), the Mental Health Implementation Plan 2019 / 20 – 2023 / 24, and the Roadmap for Community Mental Health Transformation (2023). NHS England published a 'Roadmap' for transformed community mental health services in 2022, with an updated version published in May 2023.

Transforming Community Mental Health for Leeds is a partnership of NHS organisations, Leeds City Council, the Voluntary, Community and Social Enterprise (VCSE) sector, and service users/people with lived experience coming together to transform how primary and community mental health services are currently organised and delivered for adults and

older people with ongoing and complex mental health needs. Whilst this national programme is primarily targeted at adults with complex mental health needs, this also incorporates improving access and pathways for young adults in transition from Children and Young Peoples services. Simply put, we are re-shaping the care offer for the adult serious mental illness (SMI) population, with more joined up and holistic care, with timely access to personalised interventions, and with specific attention to the impact of wider determinants on people's mental health and recovery.

Our vision in Leeds is to ensure that people access the right care and support at their earliest point of need and have wide-ranging support closer to home so they can live as healthy and fulfilling lives as possible in their community. The principles of the new model of care we have designed are that people will be able to: access care and support when they need it, manage their condition, or move towards individualised recovery on their own terms, and contribute to and participate in the communities that sustain them, to whatever extent is comfortable to them.

There is a strong body of evidence that accessing interventions for mental health needs in the community, and remaining at home, achieves better longer-term outcomes for individuals. The implementation of the new model of community mental health care aims to provide access to integrated community support and interventions that enable and maintain recovery.

To achieve this in Leeds, the approach included a specific focus on redesigning the model of community mental health care to reinforce and enhance integration through the following design principles:

- Dissolving the barriers between primary and secondary care, and between different secondary care specialist teams
- Strengthening cross-sector collaboration and integrated working with local authorities and VCSE partners
- Moving from a generic 'care coordination' model of care to a proactive intervention-based delivery and Key Worker model.
- Optimising data and information sharing across organisations.
- Maximise continuity of care
- Adopting the principle of inclusivity as opposed to exclusions/criteria.
- Informed by data and qualitative insight to address the racial disparities, social determinants of complex mental health needs, and to reduce the health inequalities within specific local populations.

We will know if we have 'transformed' the community mental health offer in Leeds if we achieve the following four key outcomes:

Outcome	**We will know we have achieved it if…**
Accessing high quality support	The community mental health system across Leeds is transformed so people and their communities can access high quality community based mental health support.

Supporting care options	People and their communities understand the options for support and can access what they need, when they need it and services which will work with them to agree the best options.
Providing innovative, effective, and evidence-based care	People and their communities work in partnership with a responsive workforce that provides innovative, effective, and evidence-based care that places the individual at the centre of decision making.
Partnership working	All partners work in a seamless way to provide people and their communities with the personalised care they need as one health and care system.

Table 1.

With the implementation of the earlier adopter sites testing and expanding new ways of working, it is expected the benefits and cost reductions associated with a more proactive care model become evident leading to a reduction in unplanned care and potentially a reduction in inpatient admissions

Consequently, the numbers of people admitted to acute beds that are unknown/not accessing community services are being monitored as a proxy measure for effectiveness of proactive community intervention in avoiding hospital admission. This links to both quality outcomes and experience for service users and making best use of finite financial resources, with out of area mental health inpatient bed utilisation being a significant cost pressure, and quality impact.

4. Approach to developing a New Integrated Primary and Community Mental Health Model of Care

To develop the new integrated primary-community mental health model of care, a design group was established and utilised information generated from a 90-day learning cycle. This involved several workshops with representation and participation from a wide range of organisations across Leeds and people with lived experience. This level of involvement and engagement has been consistent through out the program.

The program committed to involving people with lived experience and carers, in the design and delivery of services. This meant the efforts to understand people whose voices are ‘easy to ignore’ where included (such as different minority ethnic groups, Romany communities and others). This ensured the service design is responsive to the needs and characteristics of different groups and communities to reduce inequalities in access, experience, and outcomes.

The new service model will operate through Integrated Community Mental Health 'Hubs'. The "hub" teams are made up of people currently working in Community Mental Health Teams, mental health practitioners and support workers currently working in Primary Care Mental Health (part of Leeds Mental Wellbeing service), mental health social workers and a range of third sector roles with a focus on meeting people's needs in a holistic way, including peer support.

To enable access close to people's communities, the hubs are aligned to local care partnerships (LCPs) and designed to meet bespoke local population needs. Investment has been targeted into VCSE organisations aimed at reaching previously underserved communities. This approach aims to improve provision of bespoke and culturally competent care and support within communities, to address health inequalities.

The development of the model and expansion of community-based support has been enabled through targeted investment from NHS England ringfenced to deliver transformation. Within 2023/24 the full year total committed funding through the programme was £4,669k. £2,685k was committed to schemes delivered by Leeds & York Partnership NHS FT. This included £1,769k made up of clinical roles and some programme delivery resource and £916k relates to the Emerge service that provides access to improved pathways for access to specialist intervention and support for young adults (18-25) with more complex emotional needs. Of the total 2023/24 investment, voluntary & Care Sector Enterprises received £1,418k (30%).

5. Sharing the vision for the model

Our vision for the new community mental health offer within Leeds is to; create a radical new model of joined up primary and community mental health that responds to local populations' needs and will remove barriers to access, so that people can:

- Access Care, treatment and support as early as possible
- Live as well as possible in their communities

In order to achieve the vision a move away from a "diagnostic based model" of care, to a "needs based model", where service users are asked "What is wrong with you?" instead of "What has happened to you?" will ensure that the trauma informed approach is applied throughout. The development and adoption of this model has been coproduced and shared extensively and accepted by partners and stakeholders.

6. Findings from the implementation of the new model

The established of the "early implementer" integrated community teams commenced in March 2024 across 3 LCPs/4 PCNs (HATCH, Leeds Student Medical Practice and the Light and West Leeds). The plan is to test and learn from changes and evaluate impacts of changes with a view to embed and scale up across Leeds during 2024/25.

Specific changes introduced include the co-location of teams and introduction of 'anchor days', to facilitate improvements in multidisciplinary working and providing a sense of belonging for the team. The two comments below are taken from staff feedback

"I think staff have worked so hard in connecting with one another, both professionally and socially, such as WhatsApp Groups, communal lunches, and a tuck shop. I think individuals' willingness to tackle change has shown how positive it can be. In the East team we've experienced a real sense of connection, friendliness, and respect for each other's roles.

"The anchor days in general have been a positive place to engage as a wider team, bringing various services together. We've been able to support joint appointments, have warm handovers face to face, with much more ease."

Some of the challenges faced have been getting staff to begin to move from thinking they part of an individual team and moving towards a larger service with different offers.

Since the introduction of joint triaging of referrals by Primary Care Mental Health (PCMH) and Community Mental Health Team (CMHT) practitioners, there has been an increase in activity flowing into the PCMH teams. On average, 60 -80 referrals have been redirected from CMHT to PCMH each month, this suggests the person has been placed within the right service without the need to be first sent back to the GP and waiting for a referral to the correct service. This relatively small shift in integrated ways of working reduces unnecessary activity and costs within the system and increases productivity.

A new Advice and Guidance pathway has been introduced in our early implementer areas. This allows GPs and primary care prescribers access to advice and guidance from a specialist mental health pharmacist or consultant psychiatrist to help maintain people with complex needs within primary care and wider support within their communities; reducing unnecessary referral and hand-offs into secondary care specialist mental health teams that impact consistency of care.

The introduction of the key worker role moves away from the traditional Care Coordinator model. The keyworker may be anyone within the early implementor MDT team, irrespective of role, seniority, or professional background. The role of the keyworker is to maintain a supportive therapeutic relationship. Using this approach the person who knows the service user best or is likely to build the best relationship with the service user is usually allocated the role.

The program is establishing closer links with more specialist community teams within Leeds and York Partnership NHS Foundation Trust (LYPFT). For example, The Crisis transformation programme has revised delivery model for the Crisis resolution and Intensive Support Service to align and co-locate them to the community hubs . This will encourage better working relationships, simplify crisis pathways to ensure that the right level of crisis support to meet needs is accessible at the earliest point, and ultimately to improve outcomes and experience for people with complex mental health needs.

The roll out plan is split into three phases. In order to prepare for the second phase Healthwatch were commissioned to undertake community engagement in preparation for with Beeston and Middleton (Inner South), Bramley, Wortley, and Middleton, Woodsley and Holt Park Local Care Partnership localities. The communities' views about mental health, mental health services, their local area and the key aspects of the Community Mental Health Transformation service model have been gathered. Healthwatch have utilised a comprehensive engagement approach to achieve rich and targeted local insight that provides valuable insight into estates and accessing services that will help to shape the future roll out across the city of Leeds.

The development of this integrated method of operating has required specific and detailed attention to be paid to the governance processes underpinning the quality and safety of care delivered. This has brought challenges due to the existing delivery and contractual requirements within individual organisations each having their own internal governance and decision-making processes and there not being a 'lead provider' within the multiagency delivery model being tested. Positively all partners have collaboratively developed and signed a Partnership Agreement that defines agreed ways of working and has enabled mobilisation in March 2024 to test key components of the new model of care within the early implementer sites. Whilst progressing to this stage has not been achieved within the timeline anticipated, the additional work has made progress in addressing some key partner governance concerns that ultimately puts the mobilisation on a stronger initial footing to ensuring safe and effective care as this mobilises further. Key sticking points have been the infrastructure solutions for ICT/digital to enable sustainable working across multiple record keeping systems, and access to estates for the next phases. The Leeds Health and Care Partnership are offering support through both the Integrated Digital Service and the 'One Leeds Estate' Board. The current operating arrangements are viewed as temporary as they are not sustainable in the longer term. The partnership board will consider the development of a more sustainable operating model in the future.

A newly formed Community Mental Health Transformation Partnership Board has been established, chaired by Dr Christian Hosker, Medical Director. This marks a positive step in transitioning the community mental health transformation from a design programme to the mobilisation and delivery phase, led collaboratively through partners. The Community Mental Health Transformation Partnership Board will oversee the continued development and transformation of community services and evaluate the impact to make best use of resources, key performance indicators and evaluation of service user outcomes. The first

external evaluation report, that is being undertaken by NICHE, is due to be ready for September 2025. There is also an internal evaluation underway.

7. Next Steps

Throughout the remainder of 2024 and into 2025 we will continue to learn and evaluate from the wave 1 “Early Implementor” teams and proceed to scale up to the second and third wave of LCPs. Commence work on the longer-term operating model.

Work has also commenced on the “Focussed Areas” highlighted within the national guidance:

- eating disorders
- complex psychosis and complex emotional needs
- Personality Disorders
- Children and Young Peoples transitions

This work remains in its infancy at present, with an ask of each of the subgroups to produce a report on the following areas in September 2024:

- Gaps in service delivery.
- Required work and time scales.
- Resource implications.

September 2024	Evaluation of early implementer integrated teams completed and assess readiness for scaling up into other LCPs (including staff and service user/patient and carer feedback) Recommendations from review of pathways for eating disorders, complex psychosis and complex emotional needs and business case development in response
November 2024	Scale up into “wave 2” LCPs
March 2025	Assess readiness for scale up of early implementer teams to remaining LCPs
May 2025	Scale up to remainder LCPs

8. Conclusion

This report has outlined the size and scale of the Community Mental Health Transformation Programme, covering the scope and progress made to date, it demonstrated the successes and challenges identified through the early adopter sites that will inform the modifications to the roll out plans for the next phase of the transformation.

9. Recommendation

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

Helen Thurston – interim CMHT Programme Manager
Alison Kenyon – Deputy Director Service Development
September 2024

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

AGENDA ITEM

11

PAPER TITLE:	ICB Serious Mental Illness Maturity Index Self-Assessment Response
DATE OF MEETING:	26 September 2024
PRESENTED BY: (name and title)	Joanna Forster Adams, Chief Operating Officer
PREPARED BY: (name and title)	Mark Dodd, Deputy Director of Operations 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

NHSE 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. This is a coordinated response to the to the recent high-profile case in Nottingham in 2023 which has highlighted the need for services to engage and treat service users who pose a risk of harm.

The coordinated approach by NHSE sets an expectation that ICBs work with providers to review community services who provide intensive and assertive care and treatment to this cohort of service users; ensuring that there are clear policies and practice in place to meet their needs.

Colleagues in the West Yorkshire ICB established a methodology to enable each provider Trust to support the completion of an organisational review. The preliminary findings of these will then feed into the ICB response to NHSE by the deadline of the 30th of September 2024. In LYPFT, the Deputy Director of Operations established a Task and Finish group that coordinated a review and response.

Services involved in this review are developing plans to address the areas for improvement and focus as identified by the work already completed. The task and finish group, established to complete the benchmarking process, will continue to coordinate and progress work against the Maturity Index, findings of the CQC review and emerging guidance and findings. 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?	**State below 'Yes' or 'No'**	If yes please set out what action has been taken to address this in your paper
	No	

RECOMMENDATION

The Board of Directors is asked to receive the Report from Chief Operating Officer on the Review of Policies and Practices in Relation to Assertive and Intensive Community Care, and note the provisional findings reported on.

MEETING OF THE BOARD OF DIRECTORS

26 September 2024

Review of Policies and Practices in relation to Assertive and Intensive Community Care

1. Background

NHSE 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. This is a coordinated response to the recent high-profile case in Nottingham in 2023 which has highlighted the need for services to engage and treat service users who pose a risk of harm. The guidance is introduced by helpfully and clearly setting out:

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. Some people who experience psychosis, particularly where paranoia is present, struggle to access evidenced-based care and treatment. This can be due to core services not being able to meet people's needs, 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 are able to 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; for a very small number of people relapse can also bring a risk of harm to others. Integrated care boards (ICBs) have a duty to provide care and treatment in a way that meets the needs of this group. Improving the care and treatment of individuals who require an intensive and assertive approach from health services is a priority for the NHS.

The coordinated approach by NHSE sets an expectation that ICBs work with providers to review community services who provide intensive and assertive care and treatment to this cohort of service users, ensuring that there are clear policies and practice in place to meet their needs. NHSE have indicated that the review should be used as an opportunity to reflect on the community provision for people with severe and relapsing mental illness to ensure they are receiving and engaging in their care and that the way we organise and deliver our care supports them appropriately and safely.

The scope of the review for coordination by ICB's relates to people who:

- are presenting with psychosis (but not necessarily given a diagnosis of psychotic illness)
- may not respond to, want or may struggle to access and use 'routine' monitoring, support and treatment that would minimise harms

- are vulnerable to relapse and/or deterioration with serious related harms associated (esp. but not limited to violence & aggression)
- have multiple social needs (housing, finance, self-neglect, isolation etc)
- likely present with co-occurring problems (e.g. drug and alcohol use/dependence)
- may have had negative (e.g. harmful and/or traumatic) experiences of mental health services or other functions of the state (e.g. the criminal justice systems)
- concerns may have been raised by family/carers.

Individuals who meet these criteria may be in a variety of services including some provided outside the NHS. Certainly, this is the case in Leeds and York where people are supported in different parts of our services but also by partners the third sector (commissioned in Leeds by the ICB and by LYPFT). What is important is that we review how we ensure that people are supported across the pathway of their care.

The review specifically references services that are dedicated to providing care management with an intensive/ assertive framework. These are, but not exclusively, the following:

- Assertive Outreach Teams (AOT)
- Enhanced Community Mental Health teams (CMHT) Where AOTs do not exist
- Early Intervention in Psychosis teams (EIP)
- Community Forensic Teams (CFT)
- Intensive Home Treatment Teams (IHTT/HBTT).

However, in LYPFT our review is expanding beyond these specified areas to ensure that we maximise learning and make changes where we need to. This report outlines the initial review and describes the next steps.

2. Review Process Established

Colleagues in the West Yorkshire ICB established a methodology to enable each provider Trust to support the completion of an organisational review. The preliminary findings of these will then feed into the ICB response to NHSE by the deadline of 30 September 2024. In LYPFT, the Deputy Director of Operations established a Task and Finish group that coordinated a review and response. The Task and Finish group initially met on a weekly basis to review progress and address any issues that arise as services are completing the tool and methodology set out by our ICB (Appendix A). From a process perspective, our initial completion of the Maturity Index Tool has been submitted to the ICB for them to synthesise findings prior to submission the NHSE on 30 September 2024. This is the initial phase of the work we need to do, and next steps are set out further in this report.

We have involved representatives from services where service users, who fit the criteria as set out above, are part of their caseloads. Initially this includes the Assertive Outreach team, Rehab and Recovery Team, Early Intervention in Psychosis Team (Aspire), the Forensic Outreach Team, Community Mental Health Services and Intensive Support services with representatives from operational and clinical colleagues. To ensure that we are able to thoroughly review and learn from this work, the group includes senior representatives from the Nursing Directorate and clinical colleagues. The West Yorkshire ICB are represented by the Integration Lead and Senior Inpatient Oversight Lead.

Each service, identified above, completed the ICB Maturity Index Self-Assessment Tool, collaboratively between Operational and Clinical colleagues, reviewing their current level of

service provision and their capacity to provide the intensive and assertive care this cohort of service users may need.

The services involved at this stage in the review provide care and treatment to a significant number of service users, in the region of 4000, some of whom will not fall into the complex SMI group identified within the review. As a result, we have seen variation in the responses provided to this review where it is clinically appropriate.

These reviews were aggregated into one report and submitted to the ICB on 20 September 2024. The Maturity Index Tool will help us understand where we have robust mechanisms in place to support those service users who meet the above criteria and identify areas of improvement that are required against each of the 14 domains.

LYPFT do meet ‘best practice’ and provide a dedicated Assertive Outreach Team (AOT) which is well regarded, from which colleagues were represented on NHSE’s Expert Advisory Group and have been involved in supporting the work nationally. This was demonstrated through the AOT response which rated against all domains within the framework that they were meeting the best practice measure, and it was working well or were meeting it albeit some improvement was required. 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.

We would not expect other community services operate the same model as AOT, but it is important that all teams are able to work flexibly to meet people’s needs wherever they present and regardless of the allocated team.

Work in Progress

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 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. Findings from this audit were presented to Trustwide Clinical Governance in June 2024, and 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

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 Quality committee receives a quarterly update.

3. Next Steps

Further detailed analysis will be required to determine any gaps within the 14 domains in the maturity matrix; gaps will vary depending on the population of service users within the different community teams. This work will be completed in collaboration with feedback from the ICB and NHSE once they have reviewed all submissions. It will also consider the

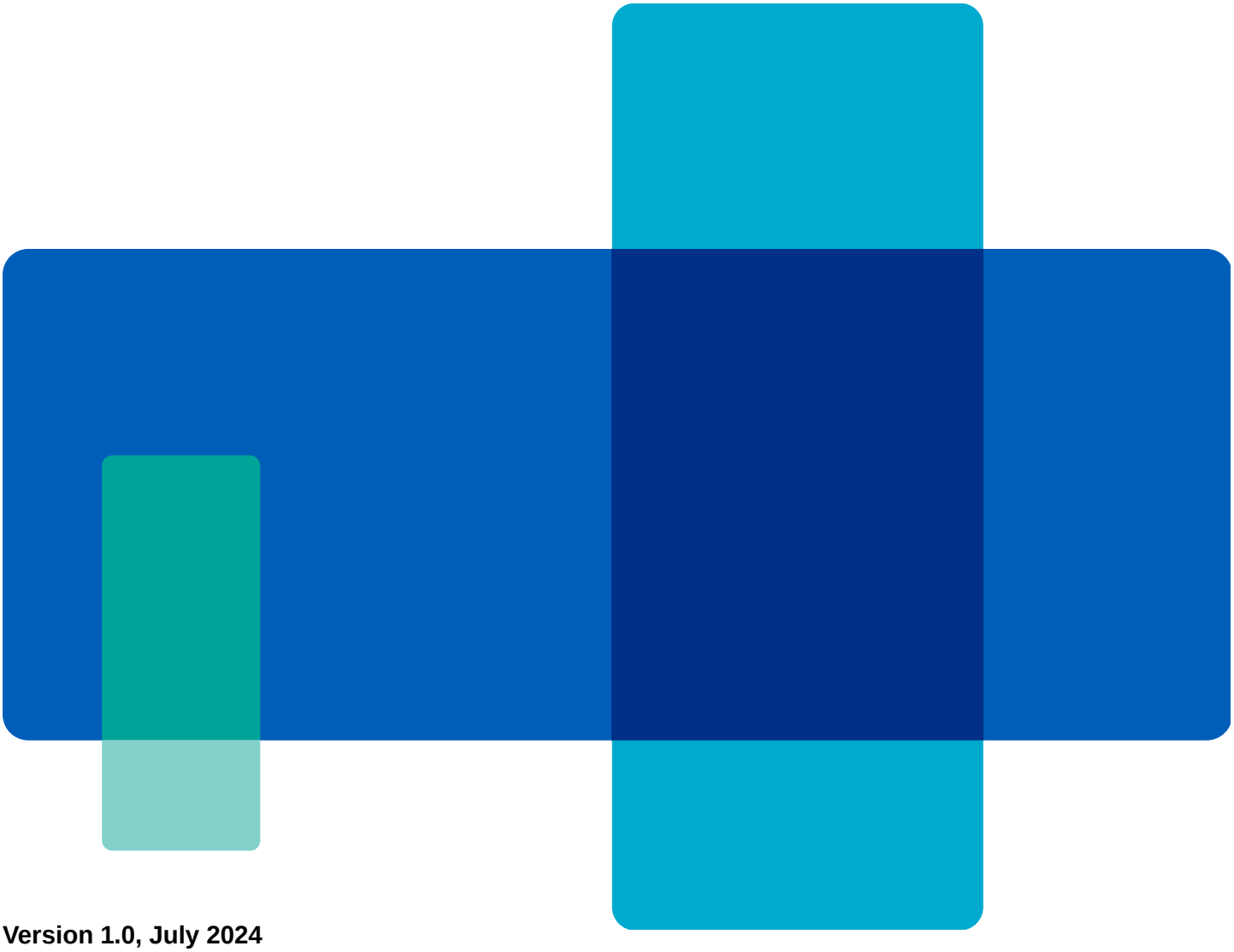
recommendations made in the CQC special report into Nottingham healthcare, our current SI action plan themes and the ongoing work through the care plan and risk assessment groups. The work will be governed though Unified Clinical Governance with oversight from Trust wide Clinical Governance.

A further detailed report will be provided to Quality Committee which will describe the analysis of the 14 domains against care teams and provide assurance into the connectivity of the ongoing varying work themes.

NHS England Midlands

Community Mental Health Service Review

ICB Maturity Index Self-Assessment Tool



Version 1.0, July 2024

Contents

Introduction & Purpose

The purpose of this tool is to support ICBs in their own self-assessment of their current level of service provision and capacity in relation to adequately and safely providing the function of assertive and intensive community support for people with serious mental illness, where engagement is a challenge.

It serves as an enabler for ICBs in bringing together views, perspectives and understanding across different service sectors and pathways to address the 2024/25 operational planning guidance ask as below:

- ‘Review their community services by Q2 2024/25 to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge’ (p24). 2024/25 priorities and operational planning guidance (england.nhs.uk)

The tool consists of 14 domains containing a series of exploratory questions and prompts; these are drawn from an initial review of the NHS England Midlands Region submission of Community Mental Health Services operational policies, standard operational procedures, information related to assertive outreach and intensive support, guidance about dual diagnosis and substance misuse, risk assessment process, and DNA/Cancellation/ Missed Contacts procedures. The tool also draws upon information from NHS England Adult Mental Health Team, in their presentation at the first Midland Community Services Review Task and Finish Group (June 2024).

Assertive outreach and intensive case management related information is drawn from the Dartmouth Assertive Community Treatment Scale (DACTS) (Teague et al 1995), the Dartmouth UIK (DUK), and the Assertive Outreach Handbook (Rob Macpherson and Nathan Gregory). This is to support ICBs in assessing whether they have in place the elements of policy and service provision to support these people’s needs.

Completion of the tool will support ICBs in responding to the questions included in the 14 domains that will be issued with national policy guidance and which ICBs are requested to return to NHS England to confirm policies and practice has been reviewed.

Definition of cohort:

People presenting with psychotic symptoms (irrespective of diagnosis) who are known to mental health services presenting with repeated mental health inpatient admissions. There is involvement with multiple partner agencies/services and the person has multiple social needs (housing, finance, self-neglect, isolation). The person often presents with co-occurring drug and alcohol problems, and may not respond to, want to, or may struggle to access and use ‘routine’ monitoring, support and treatment that would minimise harms. The person is vulnerable to relapse and/or deterioration with serious related harms associated not limited to violence and aggression. The person requires responsive and intensive pro-active support. Concerns may have been raised by family / carers.

Completing the document:

To gain all the perspectives it is best to complete this tool as part of a shared group discussion. Some questions are asking for detail at an operational level about what and how things happen. It is suggested to involve a range of clinicians, providing services across the whole of the pathway, and including operational managers, policy leads responsible for policy development and governance, quality and safety leads, and experts by experience. It would also be worth considering involvement from data analysts and pharmacists.

The questions and prompts have been colour coded against the following three categories:

	These questions form the essential components to be considered and built into the core function of your community mental health services pathway.
	These areas consist of key components which would enhance and grow your service offer to people using your community mental health services.
	These desirable components further broaden the opportunities for improving your community mental health service offer.

What this tool will do?

- It will enable and facilitate a structured and focussed conversation across provider and professional services.
- It will provide structure and shape to those elements of community mental health services that should be in place to provide appropriate assertive outreach and intensive support for people with serious mental illness, and to minimise any risks that may arise.
- Give a rounded picture of where your community mental health service policies and practice are currently against good practice.
- Give an indication of the elements of service that you all feel are working well and those that require more development.

Findings and Actions Table:

This is available at the end of the tool to assist with developing action plans.

Leadership and governance

As a part of this review process systems were invited to identify an SRO for this workstream.
We recommend that utilisation of this document is overseen by those colleagues and signed off through appropriate senior leadership governance channels. For example: ICB SRO, Chair of Mental Health Partnership Board, Trust Medical Director, Trust Director of Nursing, ICB Chief Medical Officer and ICB Chief Nursing Officer.

1. Function of assertive outreach / intensive case management

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Do we know who the population of people with serious mental illness where engagement is a challenge are.	☐	☐	☐	☐		
Guidance suggests there should be criteria in policy and pathways for the assertive outreach / intensive case management function in community service provision. For example, this includes:						
A severe and persistent mental disorder (e.g. schizophrenia, major affective disorders) associated with a high level of disability	☐	☐	☐	☐		
A history of high use of inpatient or intensive home-based care (e.g. more than two admissions or more than 6 months inpatient care in the past two years).	☐	☐	☐	☐		
Difficulty in maintaining lasting and consenting contact with services.	☐	☐	☐	☐		
History of violence or persistent offending.	☐	☐	☐	☐		
Significant risk of persistent self-harm or neglect.	☐	☐	☐	☐		
Poor response to previous treatment.	☐	☐	☐	☐		
Dual diagnosis of substance misuse and serious mental illness that increases risk of negative outcome including contact with forensic services.	☐	☐	☐	☐		
Detained under Mental Health Act (1983, amended 2007) on at least one occasion in the past 2 years.	☐	☐	☐	☐		
Unstable accommodation or homelessness.	☐	☐	☐	☐		
Vulnerable to presenting to crisis or duty services with relapse or deterioration of mental state where serious harm to self / others is identified if intervention / treatment is not provided.	☐	☐	☐	☐		
High level of contact or involvement with emergency services when mental state deteriorates.						
How do we know if the function of assertive outreach / intensive case management is provided in our community mental health services.	☐	☐	☐	☐		

1. Function of assertive outreach / intensive case management (Continued)

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Guidance suggests that the assertive outreach / intensive case management function should have a strong multidisciplinary approach. For example, this includes access to:						
Team leader.	☐	☐	☐	☐		
Clinical psychologists.	☐	☐	☐	☐		
Mental health nurses.	☐	☐	☐	☐		
Occupational therapists.	☐	☐	☐	☐		
Vocational specialists	☐	☐	☐	☐		
Consultant psychiatrists.	☐	☐	☐	☐		
Psychological therapists.	☐	☐	☐	☐		
Substance use specialists	☐	☐	☐	☐		
Social workers (who can operate the Care Act collaboratively).	☐	☐	☐	☐		
Peer support workers.	☐	☐	☐	☐		
Pharmacists.	☐	☐	☐	☐		
Housing support.	☐	☐	☐	☐		
Guidance suggests services providing the function of assertive outreach / intensive case management should have:						
Smaller caseloads. (10-12 cases per staff member).	☐	☐	☐	☐		
Have a high frequency of face-to-face contact from multiple members of the team.	☐	☐	☐	☐		
Work predominantly in the community (as opposed to office based).	☐	☐	☐	☐		
Take responsibility for crisis services, operate out of hours, take responsibility for hospital discharge.	☐	☐	☐	☐		
Offer time-unlimited support and have a no drop out policy.	☐	☐	☐	☐		
Provide assertive engagement mechanisms such as street outreach or use of the Mental Health Act.	☐	☐	☐	☐		
Use engagement and persistence as a constructive rather than a restrictive approach to keeping track of people (E.G through recreational, educational, or social activities).	☐	☐	☐	☐		
Use methods such as outcome measure to establish how well service users are engaged with services.	☐	☐	☐	☐		

2. Clinical Pathways

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Do our policies describe the pathways for:						
CRHT.	☐	☐	☐	☐		
Inpatient admission and discharge.						
• How do we know if our staff follow our inpatient admission and discharge process.	☐	☐	☐	☐		
• Community staff contact during inpatient admission	☐	☐	☐	☐		
• How do we know if our community staff provide inpatient contact during hospital admission.	☐	☐	☐	☐		
Out of area admissions.						
• How do we know if our staff follow the process for out of area admissions.	☐	☐	☐	☐		
Psychological interventions.						
• We have sufficient numbers of staff to support access to NICE recommended psychological therapies for severe mental health problems	☐	☐	☐	☐		
• Do our psychological interventions address antisocial behaviour and potential underlying mental illness.	☐	☐	☐	☐		
Transformed CMH services.						
Assertive or intensive community support.	☐	☐	☐	☐		
Homelessness.						
• For homeless people do our pathways detail approaches to engagement and information sharing.	☐	☐	☐	☐		
People who use substances.						
• Does our pathway for people who use substances describe interventions for drug induced psychosis.	☐	☐	☐	☐		
People with co-morbidities with a particular focus on people with Learning Difficulties and Autism	☐	☐	☐	☐		

2. Clinical Pathways (Continued)

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Rehabilitation services.	☐	☐	☐	☐		
Supported living.	☐	☐	☐	☐		
Forensic services	☐	☐	☐	☐		
Vocational services	☐	☐	☐	☐		
Physical health interventions and how assertive engagement can prevent deterioration.	☐	☐	☐	☐		
Older Adults	☐	☐	☐	☐		
Children and Young people	☐	☐	☐	☐		
How a person steps up and down dependent on need	☐	☐	☐	☐		
How a person moves between different mental health services.	☐	☐	☐	☐		
Pathway escalation / disputes.	☐	☐	☐	☐		
We have some good examples that demonstrate to us that providers outside core services or from other pathways (eg) UEC, can and do bring to attention people with SMI they have some concerns about.	☐	☐	☐	☐		
We have a process for testing that our cross-services communication channels work to trigger an effective response from our MH services.	☐	☐	☐	☐		
We have mechanisms in place that reduces the impact of people accessing different services across different pathways (EG Crisis – CMH – Primary Care)	☐	☐	☐	☐		
Process / Pathway Review						
Have our staff had an opportunity to review or shape how the pathways work.	☐	☐	☐	☐		
Do we review our pathways and have we mapped the process.	☐	☐	☐	☐		
Do we have a forum where clinicians can discuss complex cases within the ICB / provider trust.	☐	☐	☐	☐		
Do we have a forum where clinicians and managers can discuss complex cases across organisational boundaries (i.e. Police, housing support, homeless services, ambulance service, substance use services).	☐	☐	☐	☐		

3. Workforce

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
How do we know if our staff have read our policies for example during staff induction.	☐	☐	☐	☐		
Have we detailed staff support and wellbeing. For example: How do we provide debriefs and support for staff if things go unexpectedly or staff experience harm	☐	☐	☐	☐		
Have we defined the staff sickness management process and process for reallocation of cases, so people are not lost to follow up	☐	☐	☐	☐		
How do we know if our staff receive supervision and reflective practice to discuss cases.	☐	☐	☐	☐		
How do we know if staff are trained in the requirements for delivering the service they work in.	☐	☐	☐	☐		
How do we know if staff follow the process for lone working and is this described in our policies.	☐	☐	☐	☐		
How do we know if staff have caseload management including trigger mechanisms regarding early warning signs and escalating levels of risk	☐	☐	☐	☐		
Are the roles for staff including lead professional / key worker defined.	☐	☐	☐	☐		
Staff along our pathways (inclusive of our assertive outreach function) are sufficiently skilled to support people who may have multiple morbidities (including learning difficulties or autism)	☐	☐	☐	☐		
How do we know if staff have the competencies for the lead professional / key worker roles that we have defined.	☐	☐	☐	☐		
As part of the move away from CPA our service users have access to a suitably experienced and competent named key worker as part of an MDT approach to meet their needs. This is supported by a high quality and dynamic co-produced personalised care plan.	☐	☐	☐	☐		
We are clear that our staff providing support as part of our assertive outreach / intensive case management function have an extensive understanding of psychosis and how it can present, the treatment options (including full range of evidence-based treatments that might be beneficial), harm minimisation and risk management and the use of statutory frameworks.	☐	☐	☐	☐		

4. Risk assessment and safety planning

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
In line with NICE guidance, do our services avoid using risk assessment tools as a predictor of future risk.	☐	☐	☐	☐		
We have sufficient checks in place that inform us that:						
Staff are following risk assessment procedures.	☐	☐	☐	☐		
Staff are following Safeguarding procedures.	☐	☐	☐	☐		
Staff are trained in risk assessment and safety planning.	☐	☐	☐	☐		
Staff are trained in our Safeguarding procedures	☐	☐	☐	☐		
Staff have followed procedures for 48 hour follow up post hospital discharge.	☐	☐	☐	☐		
Staff act upon triggers such as early warning signs to prevent and manage risk	☐	☐	☐	☐		
Our risk assessment process capture red flags and minor early offending (i.e. low-level assaults).	☐	☐	☐	☐		
Our risk assessment process capture early signs of support seeking (IE: ED presentations) with early poor engagement.	☐	☐	☐	☐		
Our risk assessments focus on the person's needs and how to support their immediate and long-term psychological and physical safety	☐	☐	☐	☐		
Our mental health professionals undertake a risk formulation as part of every psychosocial assessment.	☐	☐	☐	☐		
Have we personalised our risk management procedures.	☐	☐	☐	☐		
How do we involve carers and family in risk assessment and safety planning. (even if the person has expressed wishes for the family to not be involved)	☐	☐	☐	☐		
Does our risk assessment process describe risks associated with the illness becoming more continuous and decreasing time to next acute presentation.	☐	☐	☐	☐		
Does our risk assessment process recognise importance of joining up presentation history / episodic care and long-term planning of care.	☐	☐	☐	☐		
Does our risk assessment refer to Multiagency frameworks (Multi Agency Risk Assessment Conference (MARAC), Multi-agency public protection arrangements (MAPPA)						

5. Legislation

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Do our policies refer to:						
The Mental Health Act and Mental Capacity Act.	☐	☐	☐	☐		
Community Treatment Orders	☐	☐	☐	☐		
Processes where a patient is refusing consent.	☐	☐	☐	☐		
The Human Rights Act and its application	☐	☐	☐	☐		
The Care Act.	☐	☐	☐	☐		
Our S117 Policy.	☐	☐	☐	☐		
Are our staff able to access information and support related to legislation	☐	☐	☐	☐		
How do we know if our staff are trained in our policies related to legislation.	☐	☐	☐	☐		

6. Interface with other services

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Do our policies define the role and responsibility of the VCSE.	☐	☐	☐	☐		
We actively collaborate with LD&A services to ensure our service offer is inclusive.	☐	☐	☐	☐		
Do our policies describe links with the Local Authority.	☐	☐	☐	☐		
Do our policies describe links with emergency services such as the Police and Mental Health Response Vehicles.	☐	☐	☐	☐		
Do our policies describe links with housing providers.	☐	☐	☐	☐		

7. Recovery and personalisation

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Are our policies recovery and personalisation focussed.	☐	☐	☐	☐		
Do our policies define outcome measures such as Engagement Measures, DIALOG+, ReQOL.	☐	☐	☐	☐		
Do our policies detail involvement of family and friends.	☐	☐	☐	☐		

8. Meeting the needs of diverse populations

	No, action needed	No, action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Our policies, procedures and practice reflect the changes outlined in the Patient and Carer Race Equality Framework (PCREF)	☐	☐	☐	☐		
Does our workforce reflect the diverse communities in our locality.	☐	☐	☐	☐		
Have we embedded equalities thinking in planning, and reducing inequalities related to support, treatment and for people requiring assertive and intensive engagement?	☐	☐	☐	☐		
We make use of our data /information about our diverse communities to understand the potential barriers to accessing treatment and care for people (EG) BAME, Irish, Mediterranean, and Eastern Europe with serious mental illness.	☐	☐	☐	☐		
We have a good understanding of the rates of referral and rate of detentions under the MHA for mental health services from all our diverse communities.	☐	☐	☐	☐		
Have we adopted new ways of working to prevent people revolving through the criminal justice system, CMHT, inpatients under a section of the MHA.	☐	☐	☐	☐		
We have trained our staff in cultural issues and diversity and is this embedded in our mental health teams	☐	☐	☐	☐		
We have developed strong networks with **LD&A** services, religious and community leaders to facilitate engagement in the planning and development of services to ensure care and treatment is appropriate and responsive.	☐	☐	☐	☐		

9. Medication management

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
How do know if our staff are following our medicines policy.	☐	☐	☐	☐		
How do we know if our staff are following our process for people who are non-concordant with medication.	☐	☐	☐	☐		
How do we know if our staff are following our process for checking and reviewing medication.	☐	☐	☐	☐		
How do we know if our staff are following our process for addressing side effects of treatment and reviewing treatment.	☐	☐	☐	☐		

10. Experts by Experience

Are experts by experience involved in our policy development.	☐	☐	☐	☐		
Are Experts by Experience embedded in our service development work for community mental health services.	☐	☐	☐	☐		
We have involved people delivering and receiving services in having focused conversations about how we best raise our own awareness/stay connected to any potential concerns that may not be directly known to our core services.	☐	☐	☐	☐		
We have included people from our diverse communities to inform our policy and practice delivery (inclusive of people with learning difficulties and autism)						

11. Discharge from services

If people are DNA / cancelling appointments / dropping out of services:						
How do we know if our staff are following our process.	☐	☐	☐	☐		
How do we know if our staff are involving family and friends	☐	☐	☐	☐		
How do we know if our staff are involving GPs	☐	☐	☐	☐		
How do we know if our staff follow a principle of no automatic discharge from community mental health services.	☐	☐	☐	☐		
How do we know if our staff consider other services that exist and have capacity that might better meet the wishes of the person.	☐	☐	☐	☐		
How do we know if our staff agree this route with the person and pass all necessary information to that service.	☐	☐	☐	☐		

11. Discharge from services (Continued)

How do we know if our staff where alternatives do not exist, consider assertive approaches or use of the Mental Health Act.	☐	☐	☐	☐		
How do we know if our staff use the MDT to make decisions to discharge people and record the reasons for discharge.	☐	☐	☐	☐		
How do we know the number of non-agreed discharges to ensure trends can be identified and addressed.	☐	☐	☐	☐		
How do we know if our community mental health services have a low threshold for readmittance.	☐	☐	☐	☐		
How do we know if staff identify any relapse indicators and known harms/risks of relapse if not responded to promptly.	☐	☐	☐	☐		
How do we know if staff identify routes back into community mental health services at the point of discharge.	☐	☐	☐	☐		

12. Data

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Have we undertaken a local mental health needs assessment to help us to understand the population of people with serious mental illness where engagement is a challenge to guide the development of a whole system pathway.	☐	☐	☐	☐		
Do we have a local community mental health data dashboard that displays and organises our own service data to help staff: Look at someone's history of using mental health services. Looks at changes in a range of factors to indicate potential /additional support needs. drive decision making on individuals potentially in need of intensive support	☐	☐	☐	☐		
We routinely review data across our MH pathway where we can identify, respond to and monitor emerging themes and trends (eg) Local reports on serious incidents, patient experience, and patient complaints and compliments.	☐	☐	☐	☐		
Our Teams/services review clinical outcome data in a routine manner to make improvements to the service	☐	☐	☐	☐		
We consider local data and intelligence on populations currently accessing services, as well as those who aren't						
Have we routinely measured and monitored service user experience/satisfaction as part of the development work for community mental health services.	☐	☐	☐	☐		
Is the referral to treatment process reported.	☐	☐	☐	☐		

13. Policy variation control

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Do our policies follow the required conventions for policy management for example:						
Have a version control number.	□	□	□	□		
List the names and title of the authors.	□	□	□	□		
List the name and title of the responsible director / SRO.	□	□	□	□		
Have a review date and are up to date	□	□	□	□		
State the frequency of the policy review.	□	□	□	□		
State the date of approval and the name and details of the person who has approved the policy.	□	□	□	□		
Have an Equality Impact Assessment (EIA).	□	□	□	□		
Detail the frequency of the Equality Impact Assessment (EIA) and when is it due for review.	□	□	□	□		

14. Governance

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Do we have a lead person(s) responsible for policies.	□	□	□	□		
Do our lead person(s) feed into a community mental health planning groups and/or project boards.	□	□	□	□		
Do our community mental health planning group and/or project board have representation from key clinicians.	□	□	□	□		
Do our community mental health planning groups and/or project boards have representation from Trust Executives/Senior Managers.	□	□	□	□		
Do our community mental health planning groups and/or project boards meet monthly.	□	□	□	□		
Do we have a governance structure for policy review, oversight and sign off that includes: Chief Medical Officer, Chief Nursing Officer, system operational governance, quality governance and mental health provider collaborative.	□	□	□	□		
Have we got a mechanism for learning across the system following serious incidents where we get things right and where we don't.	□	□	□	□		

14. Governance (Continued)

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Do we have a culture that takes out blame and where people feel safe to raise concerns.	☐	☐	☐	☐		
We have considered the governance, partnership and monitoring arrangements that support the identification of people who might need intensive and assertive community care, as well as the capacity of local services to provide appropriate levels of care	☐	☐	☐	☐		

Development and contribution to the Maturity Index

Authors & Contacts within the Community Mental Health Programme:

FIRST NAME	SURNAME	EMAIL	JOB TITLE	ORGANISATION
Nathan	Gregory	nathan.gregory5@nhs.net	Programme Manager (Community Mental Health), Midlands Mental Health Team	NHS England – Midlands
Russell	Dunmore	Russell.dunmore@nhs.net	Programme Manager (Community Mental Health), Midlands Mental Health Team	NHS England – Midlands
Jo	Kirk	jo.kirk1@nhs.net	Assistant Director, Midlands Mental Health Team	NHS England – Midlands

Midlands ICB Leads involved in tool design:

FIRST NAME	SURNAME	JOB TITLE	ORGANISATION
Lee	Doyle	Managing Director	Derbyshire Healthcare NHS Foundation Trust
Justine	Hill	Deputy Associate Director, PC & CMGH	Herefordshire & Worcestershire Community Health Trust
Helen	Perfect	Head Community, Older Adult MH Services	Leicester, Leicestershire & Rutland ICB
Kelly	Plant	Mental Health Community Transformation Operational Delivery Manager	Black Country Healthcare NHS Trust
Claire	Potts	General Manager Community	C&W Partnership Trust
Jodie	Shepherd	Head of Services (CMH Coventry)	C&W Partnership Trust
Sarah	Taylor	Service Manager	Nottinghamshire Healthcare NHS Trust

References

- National Confidential Inquiry into Suicide and Safety in Mental Health
- Assertive Outreach Handbook. Editors: Rob Macpherson and Nathan Gregory (Dartmouth Assertive Community Treatment Scale (DACTS) (Teague et al 1995) and Dartmouth UIK (DUK)
- Research evidence and outcome data suggests that the assertive outreach model reduces admissions and promotes effective engagement with the most unwell patients. You can find more information here:
  - Assertive Outreach in Mental Health: A manual for practitioners | Oxford Academic (oup.com)
  - Assertive community treatment in UK practice | Advances in Psychiatric Treatment | Cambridge Core
  - act-dacts-protocol.pdf (case.edu)

Resources

Detailed guidance on proactively planned and effective discharge from acute inpatient mental health services for adults and older adults is available here: https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/#effective-care-across-the-inpatient-pathway
Dartmouth Assertive Community Treatment Scale (DACTS)

ICB:	

Findings and Actions Tables

Domain	Essential	Priority Areas	Enhancers	Priority Areas	Desirable	Priority Areas
1. Function of assertive outreach / intensive case management						
2. Clinical Pathways						
3. Workforce						
4. Risk assessment and safety planning						
5. Legislation						
6. Interface with other services						
7. Recovery and personalisation						
8. Meeting the needs of diverse populations						
9. Medication management						
10. Experts by Experience						
11. Discharge from services						
12. Data						
13. Policy variation control						
14. Governance						

Date Completed:		Review Date:	

ICB:	

Findings and Actions Table

Domain	What was the finding	What is the action	Who will be responsible for the action	When will the action be completed	Has the action been completed	Comments
1. Function of assertive outreach / intensive case management						
2. Clinical Pathways						
3. Workforce						
4. Risk assessment and safety planning						
5. Legislation						
6. Interface with other services						
7. Recovery and personalisation						
8. Meeting the needs of diverse populations						
9. Medication management						
10. Experts by Experience						
11. Discharge from services						
12. Data						
13. Policy variation control						
14. Governance						

Date Completed:		Review Date:	

ICB:	

Completion and Sign-Off

Maturity Index completed by (Governance Committee Membership)

Name	Designation

ICB SRO Signature:				Date	
Trust Medical Director Signature:		Organisation:		Date:	
Trust Director of Nursing signature:		Organisation:		Date:	
ICB Chief Medical Officer Signature:		Organisation:		Date:	
ICB Chief Nursing Officer Signature:		Organisation:		Date:	

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF BOARD OF DIRECTORS

AGENDA ITEM
12

PAPER TITLE:	CFO Finance Report
DATE OF MEETING:	26 September 2024
PRESENTED BY: (name and title)	Dawn Hanwell, Chief Financial Officer and Deputy Chief Executive
PREPARED BY: (name and title)	Jonathan Saxton, Deputy Director of Finance

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

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

EXECUTIVE SUMMARY

At month 5 the Trust's financial position is broadly stable. The income and expenditure position is a deficit at this stage as anticipated but includes some one off income resulting in a lower deficit year to date. LYPFT is one of very few organisations better that plan at this stage. There is still a very significant challenge to continue to improve the run rate and deliver the full year plan and ensure this is sustained on a recurrent basis, so we are in a firm position going into 25/26. The capital position is becoming challenging across system. LYPFT has a specific issue regarding the capital allocation for the perinatal development which is yet unresolved.

It has been agreed to use the investigation and rapid intervention process as an opportunity to anticipate potential deteriorations and help implement any mitigation measures as early as possible across the West Yorkshire System. This process will commence early October 2024.

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

RECOMMENDATION
The Board is asked to: • Note the Trust revenue and capital plans position 2024/25. • Note the intervention that will take place if the West Yorkshire system is significantly off plan

MEETING OF BOARD OF DIRECTORS

26 SEPTEMBER 2024

CHIEF FINANCIAL OFFICER REPORT

1 Introduction

This report provides an overview of the Trust financial position at month 5 2024/25 financial year.

2 Income and Expenditure Performance 2024/25

At month 5 the position reported to NHSE is a £1.0m deficit against the year-to-date planned deficit of £1.4m, £0.4m better than plan. The monthly run rate has improved as the year has progressed, this together with the releasing of £0.8m gainshare from the Collaborative Procurement Partnership has put the Trust in a favourable position against plan.

		Month 5		
Income & Expenditure Budget Position	**Budget Annual £'000**	**Budget YTD £'000**	**Actual YTD £'000**	**Variance YTD £'000**
Income:				
Patient Care Income	217,409	90,587	92,319	1,732
Other Income	30,602	15,151	17,131	1,980
Total Income	**248,012**	**105,738**	**109,450**	**3,712**
Expenditure:				
Pay Expenditure	(187,229)	(78,009)	(76,443)	1,565
Non Pay Expenditure	(56,734)	(27,910)	(32,802)	(4,892)
Total Expenditure	**(243,963)**	**(105,919)**	**(109,245)**	**(3,326)**
Surplus/ (Deficit)	**4,049**	**(181)**	**204**	**385**
System adjustments	**(3,054)**	**(1,285)**	**(1,239)**	**46**
NHSE Adj. Surplus / (Deficit)	**995**	**(1,466)**	**(1,035)**	**431**

Significant items to note are:

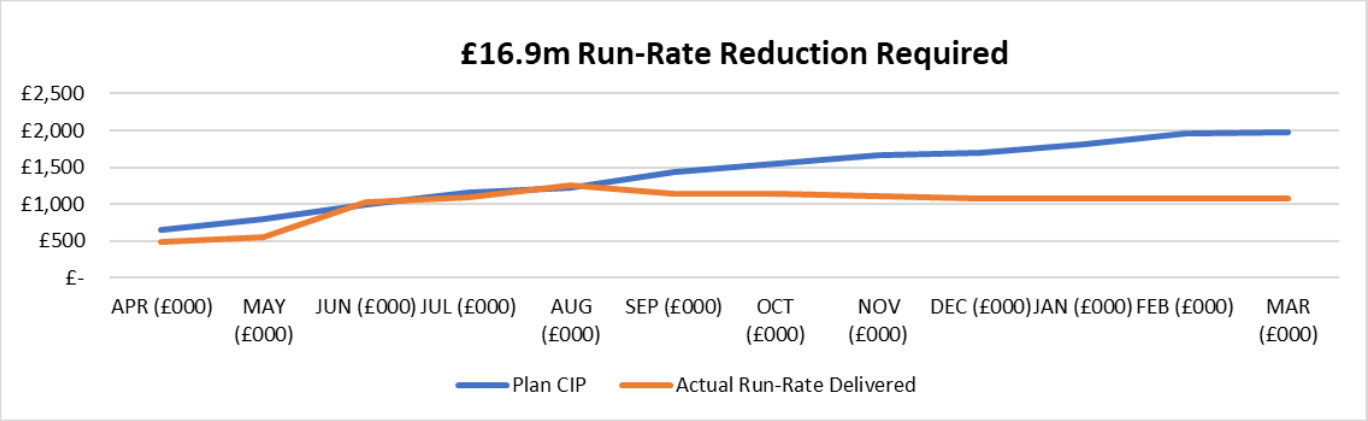
- The year-to-date position is supported by a one-off benefit of £0.8m following the final settlement of gainshare from the Collaborative Procurement Partnership which has now ceased trading.
- Improvements have been made in the Trust's use of agency, bank and overtime, as part of the efficiency programme.
- Agency spend does remain high at £4.1m at month 5, of which 69% is medical agency, however this is a £1.1m reduction in spend when compared to month 5 in 23/24.

- Wards continue as key area of focus for overspending, most notably Adult Acute wards £0.5m and Older Peoples wards £0.8m at month 5.
- Working age Out of Area Placements (OAPs) have reduced significantly in Q1, compared to the exit run rate from 23/24. This expenditure is on trajectory at month 5, however cumulatively is still above trajectory resulting in £0.6m year to date overspend.
- The Specialist Supported Living contract has a £0.3m overspend, following good progress to address the voids and provisional agreement on inflationary uplift. Further work is still required on this contract model.
- The two Provider Collaboratives which the Trust is lead for, Adult Eating Disorders and Children and Young People (CYP) are both currently overspending. Plans are in place to address, and CYP overspend is partially mitigated from investment reserves brought forward.
- Corporate departments, doctors in training and pharmacy continue to underspend, supporting the in-year position.
- Interest receivable remains high, £0.5m better than planned year to date, but rates have reduced recently and are expected to reduce again over the coming months.

3 Efficiency Programme

The Trust efficiency programme for 24/25 is to deliver in year run-rate savings of £16.9m and recurrent budget reductions of £10.8m.

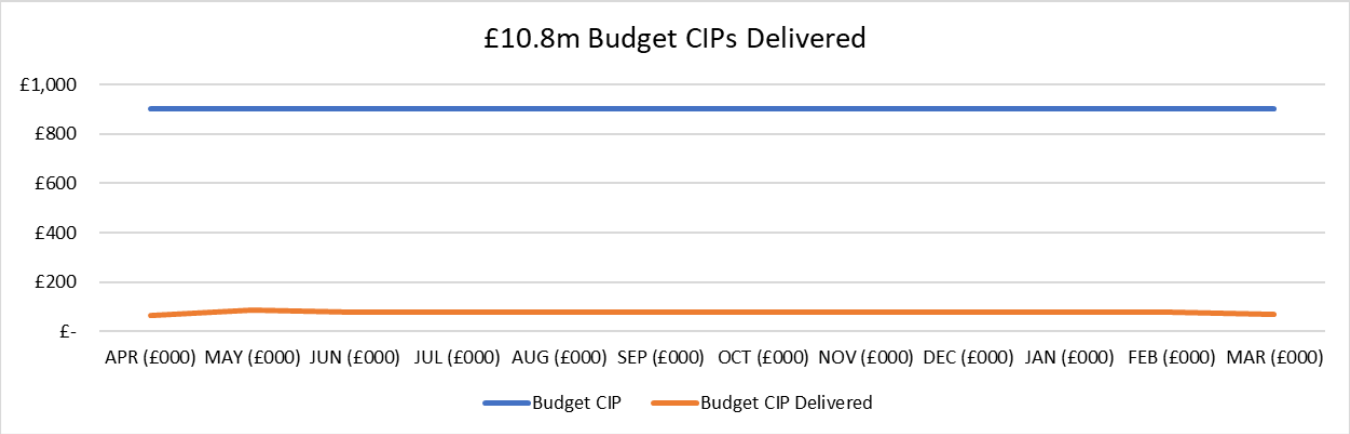
All schemes have been identified and the majority have been assigned trajectories for delivery in 24/25. Actual and forecast reductions in run-rate against planned reductions are shown below:



	APR (£000)	MAY (£000)	JUN (£000)	JUL (£000)	AUG (£000)	SEP (£000)	OCT (£000)	NOV (£000)	DEC (£000)	JAN (£000)	FEB (£000)	MAR (£000)	TOTAL (£000)
Plan CIP	654	793	997	1,164	1,232	1,434	1,555	1,669	1,698	1,813	1,961	1,980	**16,950**
Actual Run-Rate Delivered	483	552	1,021	1,095	1,252	1,145	1,145	1,105	1,085	1,085	1,085	1,085	**12,137**
Variance	(171)	(241)	24	(70)	20	(288)	(409)	(564)	(613)	(729)	(877)	(896)	**(4,813)**
Cumulative Variance	**(171)**	**(412)**	**(388)**	**(457)**	**(437)**	**(725)**	**(1,134)**	**(1,699)**	**(2,312)**	**(3,041)**	**(3,918)**	**(4,813)**	

As at month 5 the Trust had planned £4.8m run-rate reductions, of which £4.4m were delivered (£0.4m behind plan). A prudent forecast of run-rate reductions has been made until the end of the financial year. This demonstrates that further run-rate reductions totalling £4.8m are required before then end of the financial year.

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



	APR (£000)	MAY (£000)	JUN (£000)	JUL (£000)	AUG (£000)	SEP (£000)	OCT (£000)	NOV (£000)	DEC (£000)	JAN (£000)	FEB (£000)	MAR (£000)	TOTAL (£000)
Budget CIP	900	900	900	900	900	900	900	900	900	900	900	900	**10,800**
Budget CIP Delivered	67	87	77	77	77	77	77	77	77	77	77	68	**911**
Variance	(833)	(813)	(823)	(823)	(823)	(823)	(823)	(823)	(823)	(823)	(823)	(832)	**(9,889)**
Cumulative Variance	**(833)**	**(1,647)**	**(2,470)**	**(3,293)**	**(4,117)**	**(4,940)**	**(5,764)**	**(6,587)**	**(7,410)**	**(8,234)**	**(9,057)**	**(9,889)**	

The Trust still needs to deliver £9.9m recurrent budget CIP to ensure that the recurrent budget is in balance. In September Corporate and Care Services have been given targets of a combined £5.2m to be delivered from their recurrent pay budgets, the remaining budget CIP is expected to be delivered from Trust wide schemes predominantly in non-pay budgets. The permanent budgetary savings should be achievable based on current run rate, but given these savings will be required recurrently, further risk assessments will be undertaken to confirm the proposals.

4 Income and Expenditure Forecast

The Trust is required to achieve the income and expenditure plan it has agreed. Deterioration at organisational and /or system level will enhance the levels of scrutiny and intervention.

At this stage the Trust is forecasting to deliver the planned £1m surplus position. However, a detailed review of the forecast was completed at Month 5, which identified a ‘worst case’ risk of a £2.4m deficit, £3.4m off plan. This emphasises the need for acceleration of run-rate improvements over the coming months. A further review of a comprehensive toolkit of productivity and efficiency enablers/ opportunities is being undertaken with executive oversight with the aim of delivering more efficiency schemes in quarter 3 and 4 if possible. In addition, further non recurrent possible flexibilities are being scoped to mitigate any shortfall in delivery.

5 Financial Oversight Framework

As previously outlined, the NHSE approach to addressing concerns regarding systems achieving their financial plans is the investigation and rapid intervention process ("I&I"). Although the West Yorkshire system is not currently in the category for intervention, the system has agreed to use the process as an opportunity to anticipate potential deteriorations and help implement any mitigation measures as early as possible. This follows the work already commissioned by the West Yorkshire Association of Acute Trusts (WYAAT) who undertook a process in quarter one which they found useful and informative. A scope has been agreed and Price Waterhouse Coopers commissioned to undertake a phase 1 review across all organisations starting imminently and lasting approximately 4 weeks. This is largely a desk top review, and a detailed information request is being issued to all organisations. The process will involve interviews with key

stakeholders (mainly Executives). At the end of the review there will be one system wide report with individual chapters for each organisation.

6 Capital Expenditure

6.1 Operational Capital

The Trust's share of the operational capital allocation for West Yorkshire is £4m. At month 5 expenditure is £832k, £260k ahead of plan at this stage due mainly to expenditure at the Mount linked to the perinatal expansion. The forecast remains on plan for the year.

6.2 Public Dividend Capital (PDC)

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

- £11.2m High Intensity (West Yorkshire Complex Rehabilitation Scheme) – approved and progressing.
- £1.6m Urgent and Emergency Care – several proposals to utilise this allocation have been developed since the original business case was deemed not feasible following review with partners. Unfortunately, none of these alternatives have not been taken forward/approved by the national programme and the programme is now closed. This results in a missed opportunity to utilise £1.6m PDC across West Yorkshire Mental Health.
- £1m Electronic Document Management – part of a multi-year funding approval but confirmation required for 24/25.
- £5m Perinatal Expansion - the scheme has been approved but at this stage only as capital resource and not cash backed, i.e. no PDC funds. The implication of this would be the Trust would be required to utilise its own internally generated cash to fund this collaborative scheme. Discussions are ongoing with regional and national colleagues regarding this issue. The scheme is progressing concurrent to these deliberations.

6.3 Lease (IFRS16)

Lease (IFRS16) expenditure is £26k at M5, which is £0.6m behind plan due to the timing of new leases being finalised however, the forecast remains in line with plan for the year. However, it should be noted the planned position does not necessarily equate to funding. Lease funding will be an ICB allocation (like operational capital) and is yet to be confirmed and there is a risk of an overall shortfall across West Yorkshire. All providers are now reviewing their forecast considering this risk (see below).

7 West Yorkshire System Position

7.1 Revenue

Across the West Yorkshire system at month 5 the year-to-date deficit is £79.7m, against a planned deficit of £65.4m, £14.3m adverse to plan. Main drivers of the variance are the under-delivery of efficiencies, industrial action and other pay overspends specific to individual organisations. At this stage the forecast is for the system to achieve its plan but there remains significant risk including unidentified efficiencies. Agency Pay across the system has a year-to-date favourable variance of £3.6m. An agency ceiling of £97.6m has been set by NHSE for 2024/25, plans across the system have a combined total of £88.1m of agency spend.

The non-recurrent deficit support revenue allocation is due to be paid to systems in September. This funding is intended to bring systems back to a break-even plan, with the clear intention that

systems then deliver that plan once this funding is received. For West Yorkshire this support of £50m. As this revenue allocation will be cash backed and therefore increase real cash available to the system, it is the expectation that provider requests for cash support reduce. The revenue support will therefore not be allocated on a proportional basis it will be directly targeted and distributed to the highest deficit and most cash challenged organisations.

Based on month 5 position it is not anticipated that West Yorkshire will trigger enhanced intervention at this stage but as noted due to the approach being adopted it is likely all organisations would be subject to intervention if the aggregate position deteriorates further behind plan.

7.2 Operational Capital

Year to date the system has incurred expenditure of £43.9m which is £17.1m under plan. There is some slippage in schemes across the system and some potential risk that this could impact delivery of the full year operational allocation in some organisations. However, all providers are working together to ensure we can collectively utilise the West Yorkshire allocation. As noted above there is also a risk that the IFRS lease allocation is insufficient and work underway to look at mitigating this. It is becoming increasingly difficult to manage the ICB capital allocation in the context of a somewhat rigid capital regime. This is an increasingly significant challenge alongside revenue and cash issues.

8 Medium Term Financial Planning

Work has commenced at both West Yorkshire and at Leeds place level to understand and begin planning beyond current year, developing a medium-term financial plan. At this stage all organisations are reviewing their “underlying position”, that is the full year recurrent position, stripping out non recurrent items and identifying the impact of any in year issues (e.g. potential pay award shortfall) and emerging cost pressures. A set of standard planning assumptions and inflation factors will then be applied to identify the scale of financial challenge over the 5 years. This work is at an early stage and will be subject to peer review and challenge to ensure a consistent and transparent approach and understanding of the “starting point”. At Leeds place we will use this information together to begin the work to identify the processes and approaches needed to resolve the financial challenge. This work will be reviewed and iterated subject to the wider operational planning guidance and financial settlements as they emerge over coming months.

9 Conclusion

At month 5 the Trusts financial position is broadly stable. The income and expenditure position is a deficit at this stage as anticipated but includes some one off income resulting in a lower deficit year to date. LYPFT is one of very few organisations better that plan at this stage. There is still a very significant challenge to continue to improve the run rate and deliver the full year plan and ensure this is sustained on a recurrent basis, so we are in a firm position going into 25/26. The capital position is becoming challenging across system. LYPFT has a specific issue regarding the capital allocation for the perinatal development which is yet unresolved.

It has been agreed to use the investigation and rapid intervention process as an opportunity to anticipate potential deteriorations and help implement any mitigation measures as early as possible across the West Yorkshire System. This process will commence early October 2024.

10 Recommendation

The Board is asked to:

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

Jonathan Saxton
Deputy Director of Finance
20 September 2024

CAPITAL PROGRAMME - at 31 August 2024	Year to Date			
	Annual Plan £'000	YTD Plan £'000	Actual Spend £'000	YTD Variance £'000
ICS Operational Capital				
Estates Operational				
Health & Safety /Fire/Accessibility/ Backlog	421	80		80
Food Refrigeration/Transport	50	0		0
Security review	200	24	57	(33)
Woodlands Generator	25	0		0
Standardisation of attack alarms	124	0		0
The Mount - ward upgrade scheme	674	0	142	(142)
Wardrobes	20	0		0
Sub-Total	**1,514**	**104**	**199**	**(95)**
IT/Telecomms Operational				
PC Replacement Programme	260	136	154	(18)
IT Network Infrastructure	150	40	4	36
Sub-Total	**410**	**176**	**157**	**19**
Estates Strategic Developments				
Lifecycle contribution	75	0	2	(2)
Red Kite View	100	0		0
St Marys House, North/South Wing/Estate Strategy	450	50		50
Woodhouse Square	150	0		0
Sustainibility & Green Plan	300	0		0
Seclusion - Newsam	200	60	341	(281)
Safes	25	25		25
Seclusion - Clifton	100	0		0
Solar film - PFI estate	20	10		10
Sub-Total	**1,420**	**145**	**344**	**(199)**
IT Strategic Developments				
VM Ware	500	0		0
Sub-Total	**500**	**0**	**0**	**0**
Minor Schemes				
Minor Schemes	182	20		20
2023/24 Completed Schemes	0	127	132	(5)
ICB contingency	7,848	0		0
Sub-Total	**8,030**	**147**	**132**	**15**
Disposals				
ICS	0	0		0
Sub-Total	**0**	**0**	**0**	**0**
Total ICS Operational Capital	**11,874**	**572**	**832**	**(260)**
PDC Funded Schemes				
Complex Rehab	11,190	1,000	253	747
Perinatal	4,992	0		0
EDM	1,009	0		0
MH Urgent Emergency Care	1,637	0		0
Total PDC Funded Schemes	**18,828**	**1,000**	**253**	**747**
IFRS16 Leased Assets				
Leased Buildings	900	600		600
Lease Cars	152	67	28	39
Sub-Total	**1,052**	**667**	**28**	**639**
Disposals				
Leased	(2)	(2)	(2)	0
Sub-Total	**(2)**	**(2)**	**(2)**	**0**
Total IFRS16 Leased Assets	**1,050**	**665**	**26**	**639**
Total Capital Spend	**31,752**	**2,237**	**1,110**	**1,127**

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
13

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chair's Report from the Quality Committee meeting on 12 September 2024
DATE OF MEETING:	26 September 2024
PRESENTED BY: (name and title)	Dr Frances Healey, Non-executive Director and Chair of the Quality Committee
PREPARED BY: (name and title)	Kerry McMann, Head of Corporate Governance

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

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

COMMITTEE DETAILS:	
Name of Committee:	Quality Committee
Date of Committee:	12 September 2024
Chaired by:	Dr Frances Healey, Non-executive Director

KEY DISCUSSION POINTS:

ALERT - Issues to alert the Board to:

- No issues to which the Board needs to be alerted.

ADVISE - Issues to advise the Board on:

- The committee received a report which outlined how the reporting of falls was organised in the Trust, shared current data on reported falls including triangulated data from different data sources, and described the plans for improvement work going forward. It agreed that, while the report provided assurance on the work carried out to ensure the Trust learned from incidents, further information and assurance was required on the work that would be carried out to update the Trust Falls Procedure to make it more evidence based and to ensure training around falls was monitored.

- The committee the received the Research and Development Annual Report for 2023/24. It praised the team's activity over the year but agreed that the report lacked details on the outcomes of the team's work. The committee discussed its role in relation to research and development and agreed an action for Dr Hosker and Mrs Edwards to clarify this.

- The committee reviewed the LY14/2024 and Safeguarding: Sexual Safety (Follow Up) Internal Audit Report, which had received an opinion of significant assurance. The committee agreed that although it had previously received assurance on the improvement work that had focused on sexual safety, it required further assurance on the governance processes in place to ensure individual sexual safety allegations were reviewed, recorded and resolved appropriately.

- The committee reviewed the LY25/2024 – Clinical Governance Internal Audit Report, which had received an opinion of limited assurance. The committee noted that the audit had focused primarily on meeting structures. It discussed the findings and recommendations made within the report and was informed of the work that would be carried out in response to the findings. The committee noted that a follow up audit would be completed once the recommendations had been implemented.

ASSURE – Items to provide assurance to the Board on:

- The committee reviewed the Board Assurance Framework (BAF), paying particular attention to strategic risks one and two (SR1 and SR2). It was assured that SR1 and SR2 were being adequately controlled and acknowledged that the reporting of population health data remained under development.

- The committee reviewed a presentation which provided the highlights of the Older Peoples Service Line's Annual Quality Report, focusing on how the service had scored itself against the LCL Framework and the STEEEP dimensions. It noted the challenges being faced while new members of the Senior Leadership Team became established in their roles, but was pleased to hear that the service had good medical staffing and good medical leadership in place. It was also informed that the service had been working with system partners to influence the development of a Dementia Strategy for Leeds and noted that updates on this would be provided to the Board of Directors in the future.

  Overall, the committee was assured that the service had good systems in place for understanding its quality issues and to drive improvements, and good knowledge of its strengths and weaknesses in relation to learning, culture and leadership. The committee was also assured that the Executive Team had a clear understanding of the service's strengths, weaknesses, challenges and blind spots and how issues were being managed.

- The committee received the Medicines Optimisation Group (MOG) Annual Report for 2023/24. It agreed that the Medicines Optimisation Group was fulfilling its Terms of Reference.

- The committee received a report which contained a high-level overview of data and analysis on the position of all wards staffing against safer staffing levels for the retrospective periods from the 1 January 2024 to 30 June 2024. It noted that all but one clinical shift had a Registered Nurse on duty during the reporting period. The report also provided a detailed analysis on staffing at Red Kite View. The committee agreed that it was assured on the arrangements in place to monitor, support and mitigate any impact of reduced staffing levels or skill mix in relation to patient safety.

- The committee received a report which provided data from Q1 for PALS activity, the concerns and complaints handling process, compliments, claims, central alert system, incidents, serious incidents and inquests. It agreed that the Trust had good systems for understanding quality issues raised through these sources and working to improve them.

- The committee received an update on the work undertaken to change the Trust's approach to clinical risk assessment. It acknowledged the amount of work that had gone into this project and noted that the Trust was now preparing to implement the new approach in October 2024. The report has been attached to this chairs report as an appendix. This report also provides the response for Board of Directors action (P) 24/049.

- The committee received an update on work being undertaken to establish the reporting of key quality data metrics through the Trust's clinical governance arrangements for those who are placed in out of area beds. It noted that reporting to the Quality Committee would commence in October 2024 and thanked those involved in this work.

REFER - Items to be referred to other committees:

- No items to be referred to other committees.

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

RECOMMENDATION

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

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

AGENDA ITEM
14

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Update on Individual Incidents
DATE OF MEETING:	26 September 2024
PRESENTED BY: (name and title)	Nichola Sanderson, Director of Nursing & Professions
PREPARED BY: (name and title)	Soul Abdi, Quality & Patient Safety Lead and Samantha Marshall, Head of Patient Experience, Complaints & Legal Service

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 briefing report is provided to the Board of Directors and Quality Committee to ensure early awareness of significant incidents. This is with the assurance that the governance process around the management of these incident types is being managed through the relevant process and committees. Also of note is that some incidents may have already been notified to board via email at time they occurred.

Those agreed as requiring to be specifically highlighted to the Board and Committee include the following (not exhaustive):

- Any death due to a suspected homicide where victim or perpetrator is under the care of LYPFT.
- Any death or severe harm affecting inpatients (whether occurring in or outside inpatient setting) EXCEPT expected deaths on an end-of-life care pathway.
- Any AWOL incident for patients detained via MOJ.
- Any other incident or concern we have declared requiring a PSII (Patient Safety Incident Investigation) or independent investigation.
- Any complaints that require special/exceptional levels of investigation.
- Any safeguarding incidents that require special/exceptional levels of investigation.

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

RECOMMENDATION
The Board are asked to receive the paper for information

Meeting of the Board of Directors
26 September 2024
Update on Individual Incidents

The data provided within this report is for the period 19 March – 31 July 2024.

1. Critical Incidents and Serious Adverse Events

Ref (datix)/ Level of harm	Service Line	Patient Type	Description	Investigation type
Incidents of serious harm and death in an inpatient setting				
WEBINC-115930/ Severe	Older People Service	Inpatient	Delay in diagnosis and treatment of fractured neck of femur, following inpatient fall.	Joint Comprehensive Review with LTHT
WEBINC-118189/ Severe	Older People Service	Inpatient	Assault on patient by another patient. Hip fracture acquired.	After Action Review
WEBINC-115890/ Death	Adult Acute Services	Inpatient	Death - natural unexpected (inpatient)	Comprehensive Review
WEBINC-116045/ Death	Adult Acute Services	Inpatient	Death - natural unexpected (detained inpatient)	Comprehensive review
Incidents of death or serious harm affecting inpatients not occurring in inpatient setting				
WEBINC-114024/ Severe	Adult Acute Inpatient	Inpatient	Suspected suicide – fall from height. The fall was not on trust premises.	Comprehensive Review
WEBINC-117054/ Death	Adult Acute Services	Inpatient	Suspected suicide – drowning (inpatient - discharged within the last 30 days).	Comprehensive Review
Other incidents we have declared on StEIS as requiring a PSII or independent investigation				
WEBINC-115039/ Death	Community and Wellbeing Services	Community	Suspected suicide - fall from height (outpatient)	Comprehensive Review
WEBINC-115177/ Death	Community and Wellbeing Services	Community	Suspected suicide - Lacerations (outpatient)	Comprehensive review

Ref (datix)/ Level of harm	Service Line	Patient Type	Description	Investigation type
WEBINC-116385/ Death	Community and Wellbeing Services	Community	Attempted suicide - jump from height (outpatient)	Comprehensive review
WEBINC-116479/ Severe	Community and Wellbeing Services	Community	Suicide - hanging (outpatient)	Comprehensive review
WEBINC-113007/ Death	Adult Acute Services	Community	Suspected suicide- hanging	Concise review
WEBINC-116780/ Moderate	Childrens and young peoples services	Inpatient	Self-harm - ingestion of battery	Comprehensive Review
WEBINC-117243/ Moderate	Older Peoples Services	Inpatient	Delay in diagnosis and treatment of fractured wrist - unknown cause	Comprehensive Review
WEBINC-117756/ Death	Community and Wellbeing Services	Community	Death - suspected overdose (awaiting cause of death)	Structured Judgement Review
WEBINC-119824/ Death	Adult Acute Services	Inpatient	Death - suspected suicide (patient was previously an inpatient and discharged within 30 days before their death)	Patient Safety Incident Investigation (PSII)
WEBINC-119242/ Death	Community and Wellbeing Services	Community	Death – suspected suicide by hanging	Structured Judgement Review
AWOL incident for patients detained via MOJ				
WEBINC-117359/ No harm	Forensic inpatient Leeds	Inpatient	AWOL - detained under section 37	Reported to CQC AWOL Procedure adhered to.
WEBINC-117492/ No harm	Forensic inpatient Leeds	Inpatient	AWOL - detained under section 37	Reported to CQC AWOL Procedure adhered to.
WEBINC-117645/ Low harm	Forensic Inpatient York	Inpatient	AWOL - detained under section 37	Reported to CQC AWOL Procedure adhered to.
WEBINE-117524/ No harm	Forensic inpatient Leeds	Inpatient	AWOL - detained under section 37	Reported to CQC AWOL Procedure adhered to.
WEBINC-117885/ No harm	Forensic inpatient Leeds	Inpatient	AWOL - detained under section 37	Reported to CQC AWOL Procedure adhered to.
WEBINC-	Forensic	Inpatient	AWOL - detained under section 37	Reported to CQC AWOL Procedure

Ref (datix)/ Level of harm	Service Line	Patient Type	Description	Investigation type
118038 No harm	inpatient Leeds			adhered to.
WEBINC-115677/ No harm	Forensic inpatient Leeds	Inpatient	AWOL - detained under section 37	Reported to CQC AWOL Procedure adhered to.
WEBINC-116712/ No harm	Forensic inpatient Leeds	Inpatient	AWOL - detained under section 37	Reported to CQC AWOL Procedure adhered to.
WEBINC-117064/ No harm	Forensic inpatient Leeds	Inpatient	AWOL - detained under section 37	Reported to CQC AWOL Procedure adhered to.
WEBINC-115644/ No harm	Forensic inpatient Leeds	Inpatient	AWOL - detained under section 37	Reported to CQC AWOL Procedure adhered to.
WEBINC-116362/ No harm	Forensic inpatient Leeds	Inpatient	AWOL - detained under section 37/41	Reported to CQC AWOL Procedure adhered to.
WEBINC-115467/ No harm	Forensic inpatient Leeds	Inpatient	AWOL - detained under section 37/41	Reported to CQC AWOL Procedure adhered to.
WEBINC-117217 No harm	Forensic inpatient Leeds	Inpatient	AWOL - detained under section 37/41	Reported to CQC AWOL Procedure adhered to.

2. Patient Complaints

Ref (datix)	Service Line	Summary of complaint details
6087	Regional and Specialist Services	An Independent Review in the care provided to the patient has been agreed – we are currently sourcing a reviewer. The review follows extensive communication and review via the complaints process.
3948	Community & Wellbeing Services	Legal advice has been sought to address an issue that has arisen out of an extensive ongoing complaint. The carer of a patient has informed the Trust that they have doctored a number of documents and created emails reporting to be medical staff to share with the patient. Communication has been had with both parties and safeguarding advice and support sought. This matter has now been reported to the Police.

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF BOARD OF DIRECTORS

AGENDA ITEM
15

PAPER TITLE:	LYPFT 6 Month Safer Staffing Review Report
DATE OF MEETING:	26th September 2024
PRESENTED BY: (name and title)	Nichola Sanderson, Director of Nursing
PREPARED BY: (name and title)	Alison Quarry, Deputy Director of Nursing Miriam Blackburn, Professional Lead Nurse Jennifer Connelly, Professional Lead Nurse Adele Sowden, E-Rostering Team Manager

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

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

EXECUTIVE SUMMARY

This paper draws on the NHS National Quality Board (2016) reporting requirements to ensure that nursing and care staffing, capacity and capability is enabled to deliver high quality care and the best possible outcomes for patients whilst balancing quality and financial objectives and acknowledging the ongoing pressures experienced in relation to staffing and resource.

The paper contains a high-level overview of data and analysis to provide the Board of Directors and the public with information on the position of Leeds and York Partnership Trust wards staffing against safer staffing levels for the 6 month period from **1st January 2024 to 30th June 2024.**

This report details that all but one clinical shift had a Registered Nurse on duty during the reporting period.

The second half of the paper focuses on Red Kite View where there is either significant Registered Nurse vacancies and provides data to demonstrate the impact through a series of

quality indicators outlining any mitigation or workstreams to support the current workforce challenges.		
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes please set out what action has been taken to address this in your paper
	No	

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

MEETING OF THE BOARD OF DIRECTORS

26 September 2024

6 Month Safe Staffing Review Paper

(Data period 1 January 2024 to 30 June 2024)

1.0 Introduction

Leeds and York Partnership NHS Foundation Trust (LYPFT) provides inpatient care across 28 Mental Health and Learning Disability Wards. Ensuring that NHS organisations have the right staff, with the right skills in place, has been a key Trust board requirement since the NHS National Quality Board (NQB) issued guidance in 2016.

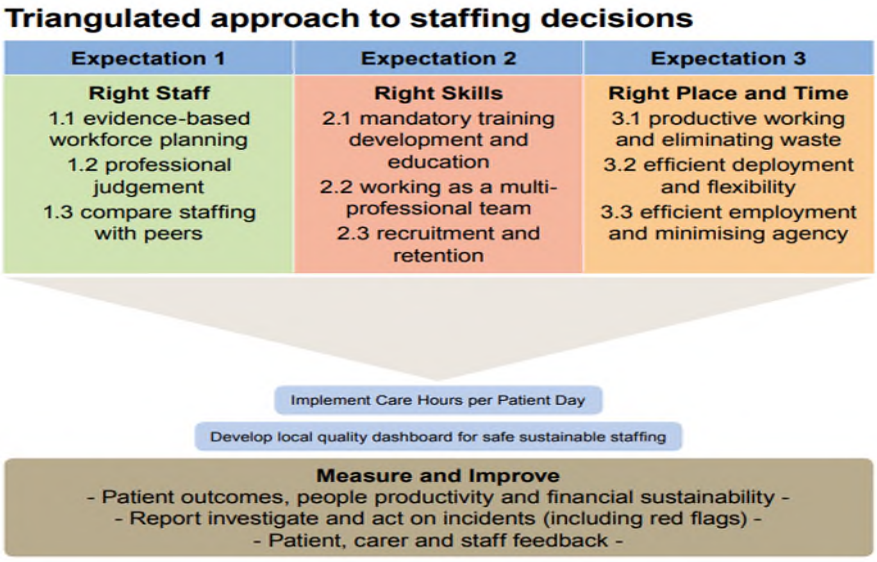
The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18, ensures that providers deploy enough suitably qualified, competent, and experienced staff to enable them to meet all regulatory requirements described in this part of the act. This identifies that staff must receive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

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

The report draws on the above requirements and contains a high-level overview of data and analysis providing the Board with information on the position of all staffing on wards against safer staffing levels for the 6-month period of the 1st of January 2024 to 30th June 2024.

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

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



2.0 The Mental Health Optimal Staffing Tool (MHOST)

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

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

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

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

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

The first MHOST data collection period was completed in September 2023 and shared in the most recent 6-month safer staffing report; this provided the initial data which would begin to support evidence-based workforce planning. A further data collection was completed in March 2024. This data has been analysed and shared with ward teams with a plan to begin applying this when setting staffing establishments. A minimum of two data collection periods are recommended prior to making changes to workforce establishment. Application of this evidence-based tool will provide some quality assurance to this process. This data cannot be used in isolation and should always be triangulated with professional judgement and quality indicators.

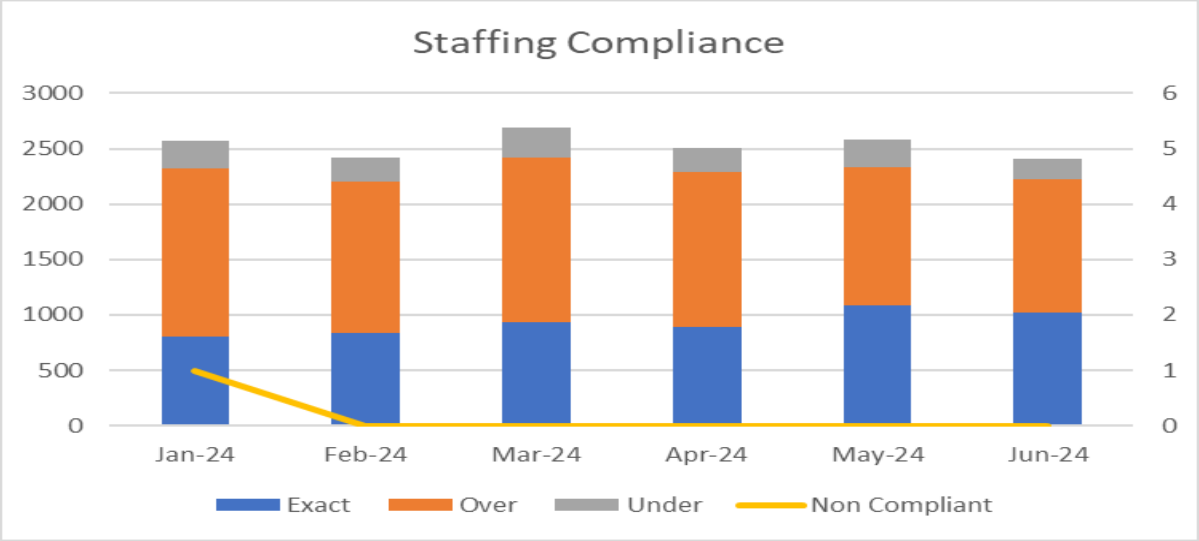
Establishment Reviews

An assessment of the current workforce establishment based on acuity and dependency and informed by an evidence-based tool (MHOST) must be reported to the Trust board and reviewed annually, in accordance with the NQB (2016) and NHS Improvements Developing Workforce Safeguards (2018).

All inpatient areas are currently carrying out an annual safer staffing establishment review with a view to completing this task across all 28 wards by the end of October 2024. The reviews will focus on identifying whether the current planned establishments across inpatient wards remain appropriate to deliver safe and effective care through the application of the triangulated approach including the use of MHOST data, quality outcomes and professional judgement. This will be coordinated by the Professional Lead Nurses with final recommendations being presented to the Executive Director of Nursing and Professions following the completion.

Further to this and part of the Executive Lead Efficiency and Productivity Programme 2024-2025, the Safer Staffing Group will lead on 4 workstreams focussed on achieving quality and efficiencies of our staffing within our inpatient wards. These workstreams include reviewing the roles and responsibilities of members of the Multidisciplinary Team (MDT), effective escalation for significant staffing increases, effective eroster usage and the cultural shift required from services to facilitate this way of working. Each workstream has multidisciplinary membership with a focus on ensuring the effective use of all members of the multidisciplinary team to enhance the delivery of quality care while maximise efficiency. These workstream with be carried out alongside the annual workforce reviews.

3.0 Review of staffing activity from 1st January 2024 – 30th June 2024 -28 Mental Health and Learning Disability Wards.



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

During this period, a total of 15,175 shifts were required to ensure safer staffing in inpatient areas. This is a 1.31% decrease from the previous 6-month reporting period.

- 13790 (90.9%) of the required shifts met/exceeded planned staffing numbers. An increase of 3.3% on the previous 6-month reporting period.
- 1384 (9.1%) of the required shifts did not meet planned staffing numbers. The previous 6-month reporting period had a rate of 12.3%.
- 1 (0.007%) of the shifts did not have a Registered Nurse on duty. The previous 6-month reporting period had a compliance rate of (0.04%)

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

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

Fill Rate Monthly Indicator (Unify) Data

The fill rate monthly indicator data is a further data set to consider alongside measures of quality and safety. The monthly returns which are illustrated in Appendix 2 demonstrate the average % fill rate of RNs and unregistered staff for both day shift and night shifts against the planned establishment.

It is of note that by itself this data does not reflect the total amount of care provided on a ward nor does it demonstrate whether care is safe and effective. The data does not include roles which work across more than one ward and roles that sit outside of a rota such as Ward Managers, Practice Development, and the wider MDT. It does include both substantive and temporary staff.

It should therefore be considered alongside other quality and safety metrics.

Where Registered Nurse fill rate falls below 100% which can be accounted for through vacancies, sickness and other leave, an adjustment to the skill mix is frequently made by the backfilling of Registered Nurse duties with Health Support Workers. This can be seen in the fill rate data whereby the unregistered duties reflect above 100% fill rate accounting for the deficit in Registered Nurses.

During the data period several of the inpatient services can be seen to far exceed the unregistered fill rate, namely the Acute Inpatient Service and Older Adult Service and therefore exceed the planned establishment. This occurs when additional duties have been filled due to increased activity in the clinical area.

Observation and engagement of our service users is one of the key clinical interventions in our inpatient services and is utilised to maintain safety and support recovery. Enhanced observations may require additional staffing above the planned establishment, for example, a service user may require 1 or 2 staff to remain with the service user to support their care and treatment plan. Enhanced observations account for a large proportion of the additional duties and may also include interventions such as physical care needs, falls prevention, escorts and facilitating leave.

The effective use of all members of the multidisciplinary team to enhance the delivery of quality care is being considered as a part of the efficiency and productivity programme. This in turn aims to reduce the number of additional duties required which often are filled by our temporary workforce and therefore provide a more therapeutic and effective experience for the service user through the skills and knowledge of the MDT.

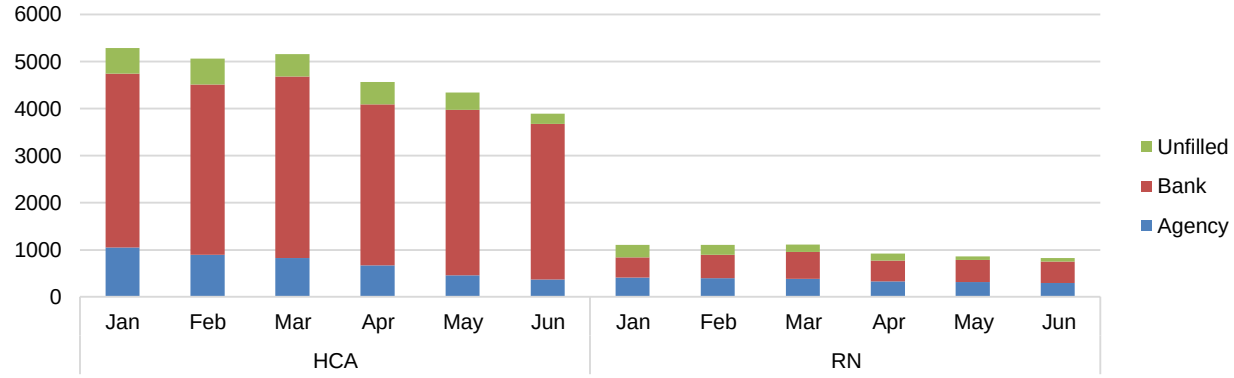
4.0 Exception reports - No Registered Nurse on Duty

The Health and Social Care Act 2008 ensures that providers deploy enough suitably qualified, competent, and experienced staff to enable them to meet all regulatory requirements described in this part of the act. To meet the potential care and treatment needs within any of LYPFT inpatient wards, we aim to maintain at least one Registered Nurse (RN) on duty who can take charge and carry out duties under the Mental Health Act. Where unexpected absences occur such as sickness absence and in turn the local minimum standards would not be achieved, the safe staffing escalation procedure is enacted. This allows for several actions to be carried out such as the use of temporary staffing, overtime, and deployment from other inpatient wards.

During the reporting period, the requirement for one Registered Nurse on duty on each shift was not met on one occasion at 3 Woodland Square on the night of the 22nd January 2024. To support the service, the Registered Nurse from 3 Woodland Square moved to 2 Woodland Square. There was a Band 4 Registered Nursing Associate

(NA) on 3 Woodland Square who was overseen by the Nurse who moved over to support 2 Woodland Square.

5.0 Bank and Agency Staffing



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

A combined total of 34,223 shifts were requested during this period.

- 5929 Registered Nurse shifts were requested. These were filled by Bank Registered Nurses (48.3%) and Agency Registered Nurses (36.2%).

- 15.5% of shifts requested for Registered Nurses remained unfilled. This has reduced from 30.8% in the previous 6 months report.

- 28,294 Health Support Worker shifts were requested. These were filled by Bank Health Support Workers (75.6%) and Agency Health Support Workers (15.1%).

- 9.3% of shifts requested for Health Support Workers remained unfilled. This is a 0.4% reduction in unfilled Health Support Worker shifts compared to the previous 6 monthly report.

During the report period, there was a significant reduction of overall shifts required compared to the previous 6-month report (43,871). There was an 89.7% fill rate for requested shifts to temporary staffing with a decrease in both unfilled Registered Nurse and Health Support Worker shifts on the previous 6-month report.

Good workforce planning includes access to a temporary workforce to manage vacancies and other unavailability and to have nursing staff available to be responsive to service user's needs. This enables flex in staffing capacity as demand fluctuates. The high number of vacant shifts which have been reliant on bank and agency to fill has exceeded this resource for both registered and unregistered staff as demonstrated above. This has been significantly impacted by the high number of Registered Nurse vacancies, which additional Health Support Worker shifts have been created to backfill when no Registered Nurse has been available. When the proportion of temporary staff

becomes too great, this can potentially impact on the quality of care provided as temporary staff are less likely to know the service and service users well, and therefore less able to effectively meet the needs of service users.

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

5.1 The Responsive Workforce Team

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

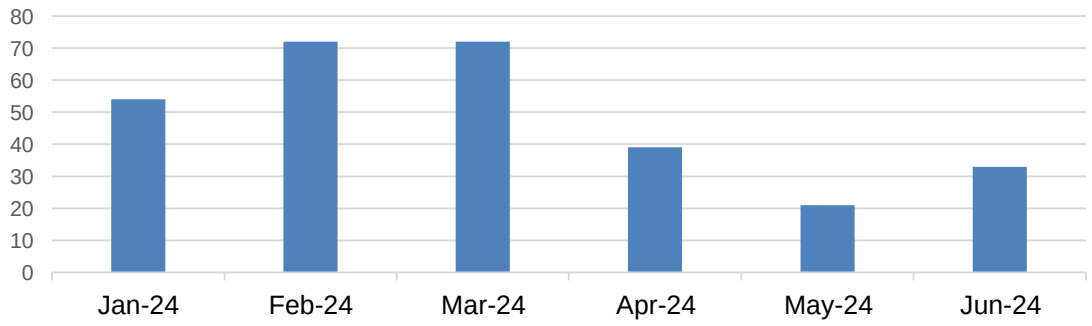
The Responsive Workforce Team comprises of a group of unregistered bank staff who are substantively employed by LYPFT on fixed term contracts and are deployed peripatetically to respond to short-notice service needs.

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

LYPFT currently have a planned reduced number of 12 Health Support Workers (HSWs) working as part of the Responsive Workforce Team across 6 inpatient services. In line with the reduction in Health Support Worker vacancies Trustwide, the reliance on the Responsive Workforce Team is reducing.

5.2 Deployment of Staffing

Redeployed Shifts - All Inpatient Units 1st January – 30th June 2024.



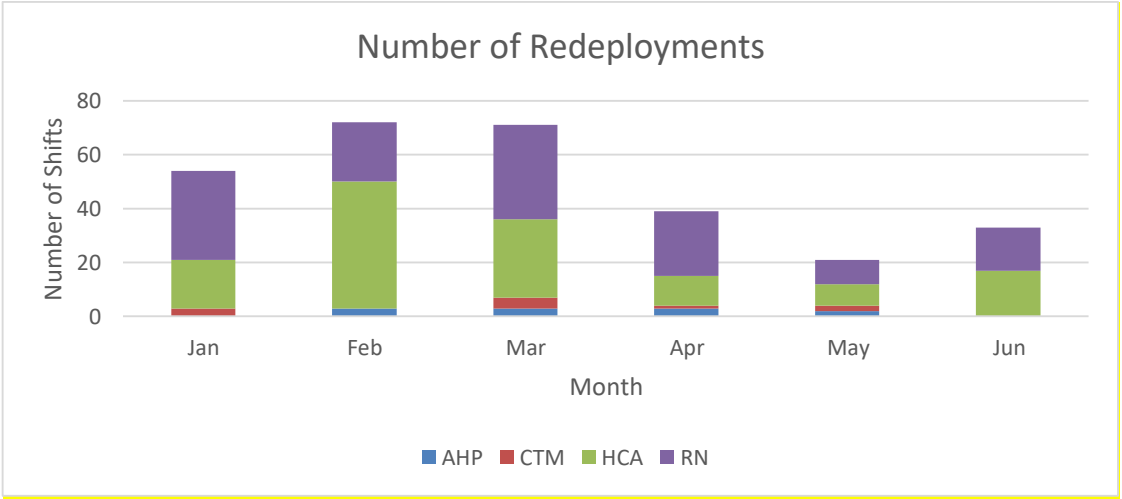
The above graph illustrates a total of 291 staff who were required to be deployed from their home ward to other clinical areas across the 6-month data period to support the

safe staffing of our inpatient areas. This was a significant reduction from the previous 6-month safer staffing report where 558 staff were recorded as being deployed. This is a continual reduction as in the 6-month report at a similar time last year, 838 shifts were recorded as deployed.

The number of staff needing to be deployed significantly reduced in the month of May with 21 staff being deployed against the highest months of February and March when 72 staff were deployed.

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

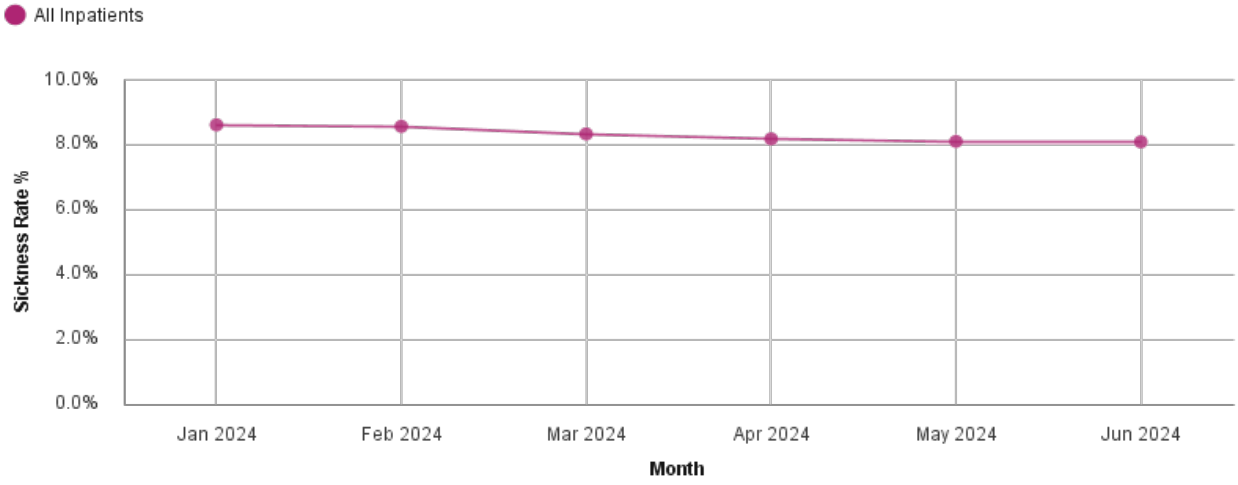
Profession Specific Redeployed Shifts - 1st January – 30th June 2024.



The above graph illustrates profession specific redeployment with the highest number of redeployments during the data collection period being either Health Support Workers or Registered Nurses.

6.0 Inpatient Sickness Absence Unavailability-28 Mental Health and Learning Disability Wards.

The following chart demonstrates the sickness absence rates across the data period 1st January – 30th June 2024 aggregated across all inpatient areas.



The Trusts target for sickness absence according to our Informatics and Performance system (Echo) is 5% indicating that the rate is higher when combining all the wards. This will however vary ward to ward.

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

The introduction of a Critical Incident Staff Support Pathway (CrISSP) which commenced in January 2022 has been instrumental in supporting individual colleagues and teams through responding to all critical incidents that are recorded as high-level harm or through the direct request from Team Managers/Leaders. Together with trained facilitators across the organisation, the initiative has supported over seven hundred colleagues requiring such support. The following table illustrates the number of sessions facilitated and the number of staff supported between 1st January 2024 – 30th June 2024.

Number of sessions	Number of staff supported
46	201

To further support the full CrISSP pathway and ensure local teams are provided with more immediate wellbeing support following an incident, joint Team Leader and Peer Practitioner Training is currently being rolled out Trustwide alongside a Ward Wellbeing Buddying System.

The following table illustrates the number of training sessions delivered and the number of staff attending the sessions from 1st January 2024 – 30th June 2024.

Number of training sessions	Number of staff attending the training session
7	59

The commencement of the Ward Wellbeing Buddying initiative, in collaboration with Wellbeing Team colleagues had been rolled out to several services across the organisation.

7.0 Vacancies - 28 Mental Health and Learning Disability Wards

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

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

All Inpatients

	Band 6 Nurse					
Period	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
Funded	121.50	121.50	121.50	124.20	124.20	124.20
In Post	100.72	101.72	101.72	103.69	102.19	103.19
Vacancy	-20.78	-19.78	-19.78	-20.51	-22.01	-21.01
Percentage	-17.10	-16.28	-16.28	-16.51	-17.72	-16.92

	Band 5 Nurse					
Period	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
Funded	236.72	236.72	236.72	237.02	237.02	237.02
In Post	159.70	167.58	167.66	166.70	163.26	164.06
Vacancy	-77.02	-69.14	-69.06	-70.32	-73.76	-72.96
Percentage	-32.54	-29.21	-29.17	-29.67	-31.12	-30.78

	Band 3 Health Support Worker					
Period	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
Funded	387.07	387.07	391.97	393.34	393.34	393.94
In Post	337.88	330.28	332.99	336.76	339.80	349.25
Vacancy	-49.19	-56.79	-58.98	-56.58	-53.54	-44.09
Percentage	-12.71	-14.67	-15.05	-14.38	-13.61	-11.21

Band 5 Registered Nurse vacancies remain the most challenging role to recruit to with a vacancy rate ranging from 29.17% - 32.54% (69.06 – 77.02 WTE posts). This is a significant reduction from the previous six months data, the vacancy rate for Band 5 Registered Nurses peaked at 106.42 (44.96%) in July 2023 however since that time there has been a 16% decrease in the vacancies to 69.06 (29.17%) in March 2024. Detail of some of the recruitment initiative that have taken place can be found in the next section of the report.

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

7.1 Recruitment and Pipeline Data - 28 Mental Health and Learning Disability Wards

Nursing and Allied Health Professionals (AHP) recruitment activity across inpatients wards 1st January 2024- 30th June 2024.

Role	No of vacancy adverts	Advertised WTE	Appointed WTE	Change in appointed WTE vacancies since 31.10.23
Band 5 Nursing (Non-Preceptee)	67	157.41	28.0	5.0 increase
Band 6 Nursing	73	222	36	7.0 decrease
Band 5 Practitioners/ AHP Roles	13	16.8	16.0	43.0 decrease
Band 6 Practitioners/ AHP Roles	27	35.8	18.0	1.0 increase
Healthcare Support Worker	39	109.0	62.0	8.0 increase
Total	**219**	**541.01**	**157**	**29.0 decrease**

Preceptees 2024

Role	Applied	Successful	Appointed WTE	Waiting to start	Change from 2023
Local	59	48	5	43	10.0 increase
Out of Area	2	0	0	0	31 decrease
Total	**61**	**48**	**5**	**43**	**9 decrease**

The above data consists of 2024 third year students. As part of the local Preceptee Programme we have seen an increase in the number of graduating students this year, coupled with a decrease in the number of Preceptee vacancies across all Trust services, therefore the Out of Area Preceptees that could be attracted and allocated has been significantly decreased this year.

For the reporting period 1st January 2024 – 30th June 2024 there were 219 recruitment episodes for Inpatient Services for Bands 5 and 6 for nursing, Allied Health Professionals and Band 2 and 3 for Healthcare Support Workers raised for 430.01 WTE. Seeing a decrease of 203 recruitment episodes and a decrease of 104.84 WTE

Within these episodes, this resulted in:

- 5230 applications.
- 818 applicants interviewed.

- 232 conditional offers.
- 152 WTE new colleagues starting.

Service Level Agreements (SLA's) are being maintained with time to hire (conditional to unconditional) currently at 22.5 days which sits well below the SLA of 27 days.

Recruitment incentives across hard to fill roles were audited for their return on investment. The finding was taken to the People Resourcing and Retention Group in July 2024, seeing the incentive bonus being used.

- Band 5 Nursing x 4
- Band 6 Nursing x 3
- Allied Health Professionals x 0

Following significant work overhauling the Trust's Recruitment and Selection Policy a Trust Safe Recruitment Statement has been published, along with supporting guidance for Managers on International Recruitment, Reasonable Adjustments in the Recruitment Process, and the launch of Values-Based Recruitment.

International Recruitment is planned to continue throughout the rest of the financial year with the target of recruiting 5 International Mental Health Nurses and 4 Occupational Therapists. This will all be done by direct recruitment to the Trust, seeing the programme move away for using Recruitment Agencies. Full evaluation of the success of International Recruitment and the proposed future plans will be taken to People Organisational Development and Resourcing in November.

7.2 Preceptees

The Practice Learning and Development Team (PLDT) commenced the recruitment engagement with third year nursing students in December 2023 with a Trust Recruitment Event. There has been a reduction in the number of Preceptees that clinical services can support this year in comparison to last year. This is predominantly due to a reduction in the total number of band 5 Registered Nurse vacancies across inpatient services.

The current number of Preceptees expected to come into clinical services in total is 48 and we can confirm that 14 of this group already have start dates and will initially work as Band 4 staff (working to the job plan of an Associate Practitioner until they receive their Nursing and Midwifery and Council (NMC) PIN.

Prior to all the Preceptees starting in their clinical roles, the PLDT are facilitating two study days called "transition training," with the following outcomes:

- An enhanced confidence to translate skills learnt through an undergraduate course to the preceptorship period.
- A better synthesis and networking of the undergraduate course content to provide the platform to practice.
- An understanding of the continuing learning that occurs in all practitioners (everyday, a learning day) such that this lesson provides added confidence in the about-to-qualify-practitioner. The understanding and peace of mind that

those confident practitioners around them do not know everything and no-one expects this from them.
- A better understanding of the debrief and learning process.

Allied Health Professionals Preceptorship

Currently there are 20 Allied Health Professionals (AHP) Preceptees on the Preceptorship register, from Occupational Therapy, Physiotherapy and Dietetic Associate Practitioner. There are 7 new starters on Occupational Therapy Rotation in coming months with potential for 5 more currently on the waiting list. New substantive posts for Allied Health Professional Preceptees and further Occupational Therapy rotation recruitment occur throughout the year.

7.3 International Recruitment

The Trust continues to support the recruitment of internationally educated nurses. In January 2024, we welcomed four nurses who joined our Working Age Acute and Older People's Inpatient Services. The nurses have all passed their Objective Structured Clinical Examinations which enables them to register with the Nursing Midwifery Council here in the UK and are being supported through the Preceptorship Programme to integrate and transition into the nursing workforce.

7.4 Health Care Support Worker Programme

The Trust has worked consistently and proactively to reduce the overall Health Support Worker (HSW) vacancy levels as highlighted in the vacancy data, the number of vacancies for Health Support Workers has reduced during the data collection period.

The Trust has successfully recruited a Clinical Educator for Health Support Workers. The Clinical Educator is developing a pastoral network for Health Support Workers to support the well-being and retention of this workforce, the group will be co-facilitated by Health Support Workers. The group will also offer educational sessions to enhance professional development offered locally, which in turn will improve care quality. There are also work streams ongoing looking at improving the offer of both the induction package for Health Support Workers and the care certificate within the Trust.

7.5 Apprenticeship Strategy / Central Backfill

There was a total of 32 Apprenticeship enrolments between January and June 2024. Additional central backfill funding has been identified from underspend and a further 5 Trainee Nursing Associate (TNA), 5 transfers to nursing (TTN) were created. 3 x MSc Nurse Apprentices will commence in January 2025; 3 Support Workers were appointed with 1 from Working Age Adult Acutes and 2 at Red Kite View.

The Trust is currently supporting 5 Occupational Therapy Assistants (OTAs) in achieving their Occupational Therapy Apprenticeship. 2 of these positions are funded centrally, 1 is funded via the Occupational Therapy rotation & 2 have been service funded. A further 2 Occupational Therapy Apprenticeships have been offered a place on the apprenticeship for September 24. The backfill for these positions will be centrally funded.

One Dietician Apprenticeship is currently studying for a Master's Apprenticeship in Dietetics and Leadership. The backfill for this position is funded by Learning Disability Services.

The Apprenticeship Strategy Implementation Plan has been revised and updated for 2024/25. In February, the Convey Apprenticeship Monitoring System was fully implemented, streamlining the admin processes associated with apprenticeships. This new system provides live dashboards which allow the team to easily identify areas of concern or high performance. In addition, key performance indicators (KPIs) were implemented on March 24, this will hold learning providers to account and ensure high quality programme delivery for our apprentices.

In June, the Department for Education's Employer Performance Dashboard showed that LYPFT's apprenticeship completion rate for this academic year is 85% (Government target is 67% and the national average is 54%). The internal apprenticeship report in June 24 outlined that apprenticeship numbers continue to increase with timely completion of courses increasing. Withdrawals and breaks in learning have also decreased.

Legacy Mentors

LYPFT Legacy Mentors have developed a programme of support for staff in the organisation since the role's inception in August 2023. Initially the primary focus was towards post-preceptorship professionals. However, in response to need, interventions have also included the wider workforce, across pay bands, regardless of the stage of their journey. The starting point is a request for help and support either directly from the mentee, their line manager, or another colleague.

The offer is unique as it transcends the traditional hierarchical boundaries by reiterating the basic principles of care delivery – respect, care, compassion, honesty, diligence, commitment, and professionalism. Legacy Mentors are already seeing a shift in thinking and culture by applying these principles in their mentoring work.

The Legacy Mentors have had 41 individual contacts (by headcount) with substantive staff and conducted 58 individual mentor sessions. Awareness sessions have been delivered to large groups (<80 attendees) of Preceptees, Students, Health Support Workers, as well as other colleagues. Of the 41 contacts they have worked with, 100% have remained working for the Trust.

7.6 Talent Development and Retention

Following significant work by managers and individuals, the Trust has achieved and maintained its KPI for Personal Development Reviews (PDR) of 85%. The review includes a Career Conversation and there is a Career Pathway document and Career Conversation Toolkit to support this as well as two PDR focused sessions offered as part of the 360 Manager Programme.

The Development Roles process has been amended to include trainee posts and will be relaunched shortly following governance sign off. A Career Development Programme was launched in April 24, with sessions running over the next 12 months on topics including Career Planning, Career Journey Conversations with key individuals in the organisation, and sessions focusing on application forms and interview skills. The short sessions are offered virtually and able to book via Learn (the Trusts online training system). Attendees report feeling 'inspired,' 'motivated' and 'enthusiastic' following the sessions.

A 3-month review was completed of the Exit Interview Pilot Project which has collected leaver feedback from over 80 leavers since commencing in Nov 23. Of the 55 clinical colleagues responding, 67% are leaving feeling either positive or very positive 79% feel valued and recognised, 90% felt able to voice any concerns and 87% would recommend the Trust as a place to work. Further thematic analysis of the leaver reasons will be shared with services in Autumn and the longer-term approach for exit data collection across the Trust agreed.

A Flexible Working Advisory Group has been established to support delivery of the Trust Flex Working priority actions. The revised Flex Working Procedure is commencing through the governance process and the flexible working application process is currently being finalised ready for the Communications launch and managers training and support package, work on which will be supported by the West Yorkshire Mental Health Collaborative People Promise Manager. The Team Rostering Pilot Working Group has been formed and a pilot site identified in Acute Services. Team or Self Rostering has proved effective across the NHS in supporting front line workers to achieve better 'shift – life balance' as well as reducing turnover, and achieving improved shift fill rates, reduced bank and agency use and reduced sickness.

8.0 Quality Indicators

The Safer Staffing Steering Group have been working together to identify a series of quality indicators which can be used to triangulate workforce information recommended in the guidance produced by the CNO of England and the National Quality Board[1] in which to support the review of safer staffing levels. More specific guidance for mental health wards has also been developed which has also been used to support the work[2].

The data details a range of metrics across each inpatient service relevant to aspects of patient safety, clinical effectiveness and in turn patient experience and being used to support clinical service establishment reviews alongside care hours per patient day

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

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

(CHPPD) and MHOST data, to understand how staff capacity may affect the quality of care.

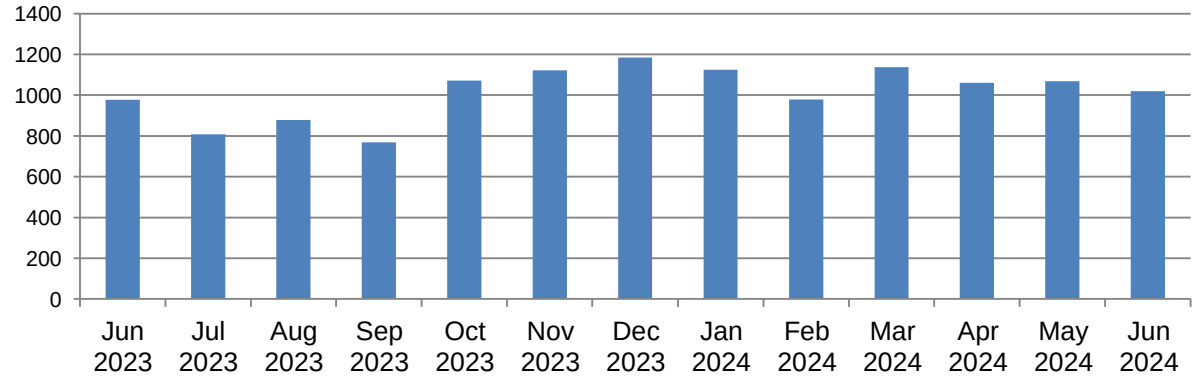
8.1 Incident data- 28 Mental Health and Learning Disability Wards

Total number of Incidents

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

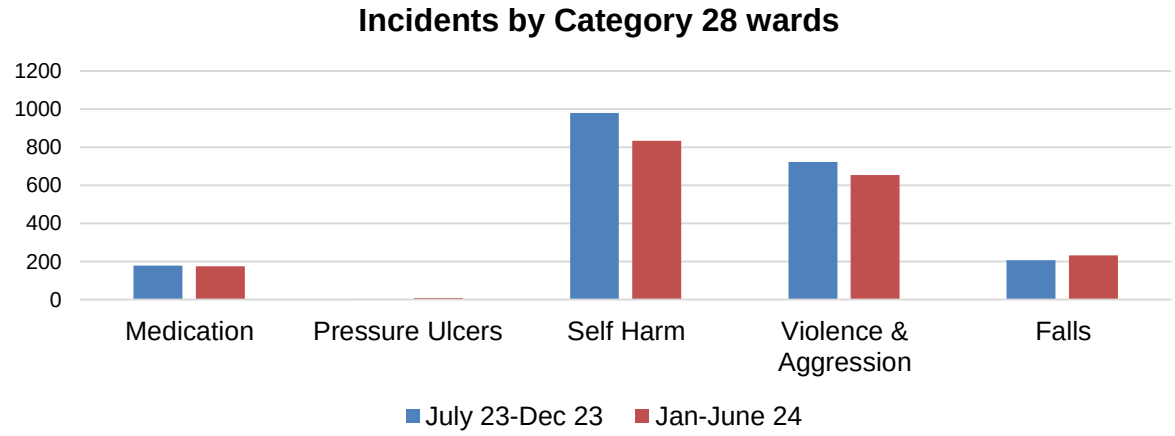
The chart below demonstrates the total number of incidents each month reported for the data period 1st January 2024 - 30th June 2024, it also details the previous six-months. The chart highlights that there was an increase from a total of 6556 incidents reported across the 28 inpatient wards from January to June 24, in comparison to a total number of 5625 in the previous six months. However, the below data evidences that there has been no increase in the number of incidents relating to the patient safety category indicators.

Incidents by Reported date (Month and year) 28 wards



Total Number of incidents by category

The graph below details incidents by category for the period 1st January 2024 – 30th June 2024 and the previous six-month period. A reduction in all incident categories is evident during Jan to June 24 on comparison to the previous six months. The only exception is reported incidents for falls and pressure sore related incidents which has seen a slight increase.



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

Self-Harm
The Suicide Prevention Environmental Survey Action Group is a newly formed group supporting the work of environmental audits with one of the aims to be focused on a review of all inpatient self-harm incidents to inform any changes to the environment that may be required to support patient safety. In response to an increase in the number of incidents in relation to ingestion and headbanging, guidance has been developed to support colleagues in the management of these types of self-harming behaviours. An audit in the headbanging guidance is planned for Mill Lodge later in the year.

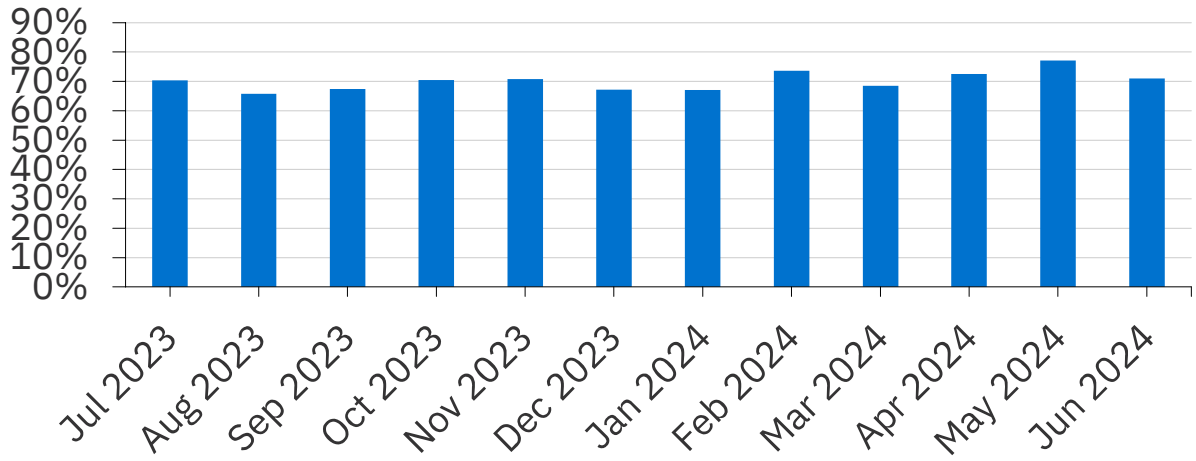
Falls and Pressure Ulcers
The Falls and Pressure Ulcer Improvement Forum meets monthly and reviews all falls reported on datix to identify any individual or thematic learning across care services. The group has recently commenced a quality improvement initiative, focussing on falls prevention in the Older People's Service.

Medicines
Medication errors and themes are discussed within Medicines Safety Committee which is attended by representatives from a range of services. Key messages are taken from the learning and disseminated via Trustwide Communications and via the Unified Clinical Governance Group.
A number of services have local Medicines Management Groups to discuss medication incidents.

As part of some recent learning with regards to medication administration errors, a Medication Competency Framework has been produced which is currently being rolled out in the Trust.

8.2 Clinical Supervision- 28 Mental Health and Learning Disability Wards

The below graph details inpatients compliance rate for clinical supervision.

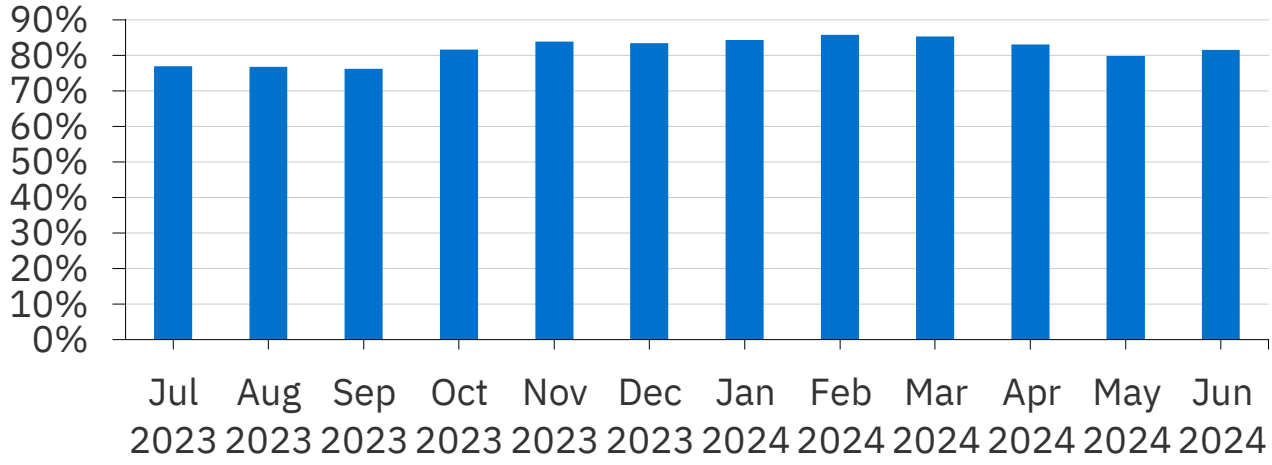


Compliance with clinical supervision has continued to increase over the 6-month period, reaching 77% in May 2024, the highest it had been during the data period.

Effective clinical supervision supports both staff well-being and improves the quality of care delivered to service users. LYPFT have invested in the training of Professional Nurse Advocates across the organisation, a national programme which was launched in response to the pandemic to aid recovery for our workforce. The programme provides the skills to facilitate Clinical Restorative Supervision (CRS) to colleagues and teams in nursing and beyond. Clinical Restorative Supervision Groups are now being offered in all Working Age Adult Acute Wards, Older Peoples Service Inpatients, Red Kite View and Crisis Assessment Unit with the intention of this being increased further,

8.3 Appraisal- 28 Mental Health And Learning Disability Wards

The below graph shows the Inpatients compliance with appraisals.

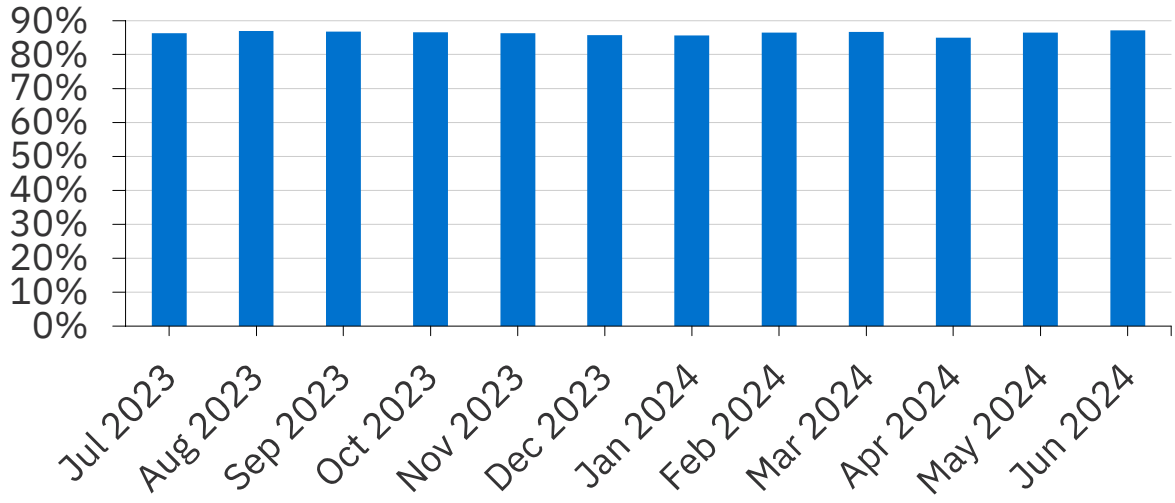


There has been an increase in compliance with appraisals over recent months. Appraisal compliance reached 85% in Feb and March 24 and has remained close to reaching the Trustwide target of 85% on subsequent months.

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

8.4 Compulsory Training- 28 Mental Health and Learning Disability Wards

The below graph shows the Inpatients compliance with compulsory training.

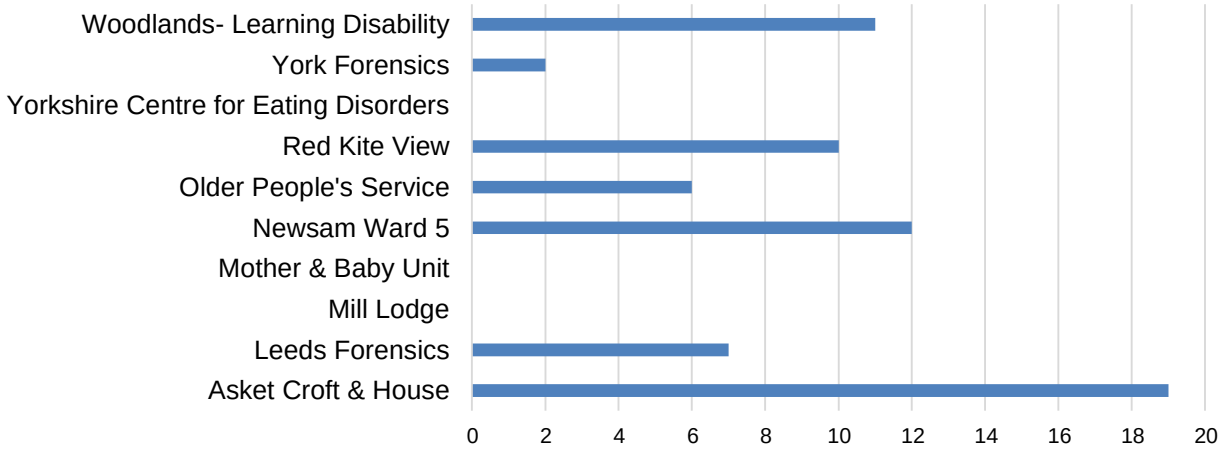


Compulsory training is required to adequately protect service users, our colleagues, visitors, and the public by enabling safe practice by a competent workforce.

The Trust compliance with compulsory training has been consistently above the target of 85% which is consistent with and supports the delivery of safe care.

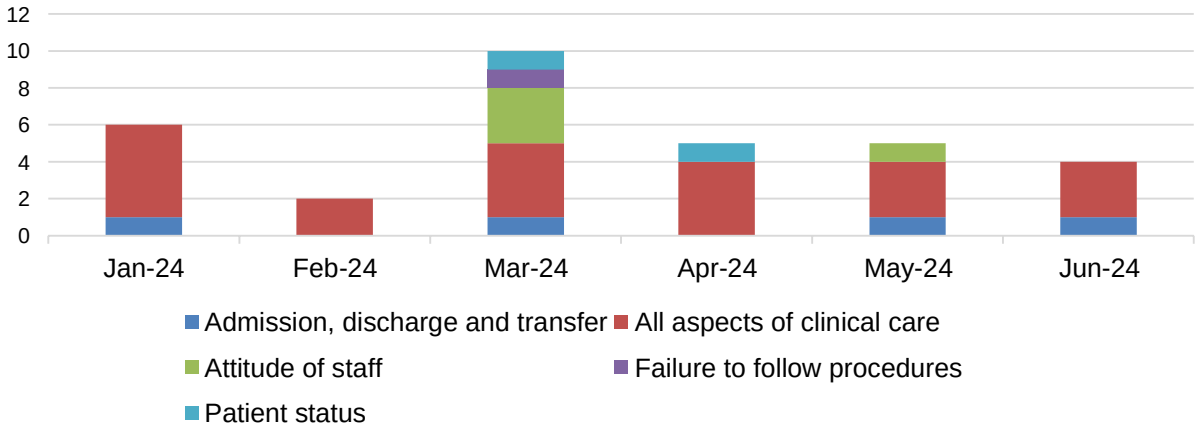
8.5 Compliments - 28 Mental Health and Learning Disability Wards

Below shows the number of compliments received over the data collection period, there was a total of 75 compliments received with the highest numbers being received at Asket Croft/House, Newsam Ward 5, and Woodland Square.



Complaints – 28 Mental Health And Learning Disability Wards

Below shows the number of complaints for inpatient services over the data collection period from when they were first received, and their primary category. There were 25 complaints in the previous reporting period compared to 32 this reporting period. Complaints can be received for many reasons. It would be expected that when more regular and consistent staff are available, there may be a reduction in complaints.

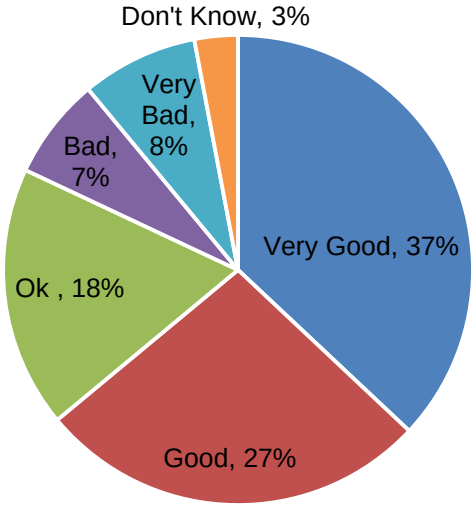


8.7 Have Your Say- 28 Mental Health and Learning Disability Wards

Have Your Say feedback is an important indicator for the quality of care being provided as it gives us direct feedback from the people, we provide care to. Across the inpatient wards who have received Have Your Say feedback, 64% reported that their care was “good” or “very good” and 15% reporting this as “bad” or “very bad”.

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

The below chart shows the reported experience of service users for all inpatient services from Jan-June 2024.



9.0 Red Kite View – Leeds Children and Young People Inpatient Service

The NQB, as key guidance, highlights the core responsibility of all Trusts to ensure there is sufficient and sustainable staffing capacity and capability to always provide safe and effective care to patients. The NQB recommends the use of an evidence-based staffing tool, a series of quality metrics and the use professional judgement to inform safe staffing decisions through a triangulated approach and data should not be viewed in isolation.
The following section of this report provides a focussed analysis of the Children and Young Peoples Mental Health Service (CYPMHS) Inpatient Unit for West Yorkshire (Red Kite View).

Background
Red Kite View is the Children and Young Peoples Mental Health Service (CYPMHS) Inpatient Unit for West Yorkshire provides Mental Health Inpatient care across two wards. Red Kite View opened in 2022 providing specialist inpatient mental health service for children and young people aged 13-18 across West Yorkshire. This consists of Lapwing which is a Psychiatric Intensive Care Unit (PICU) and Skylark which is a General Admissions Unit (GAU).

The service has been experiencing significant workforce challenges over recent months particularly in respect of recruitment, which means that the substantive workforce has been reduced. This service, as a result maintains the highest % of Registered Nurse vacancies across our inpatient areas. This has resulted in the need for the service to gatekeep all inpatient referrals to assess whether the needs of the young person can be safely met within the current workforce provision and safe and effective care can be delivered. The service has operated at a reduced bed capacity during the data period because of this.

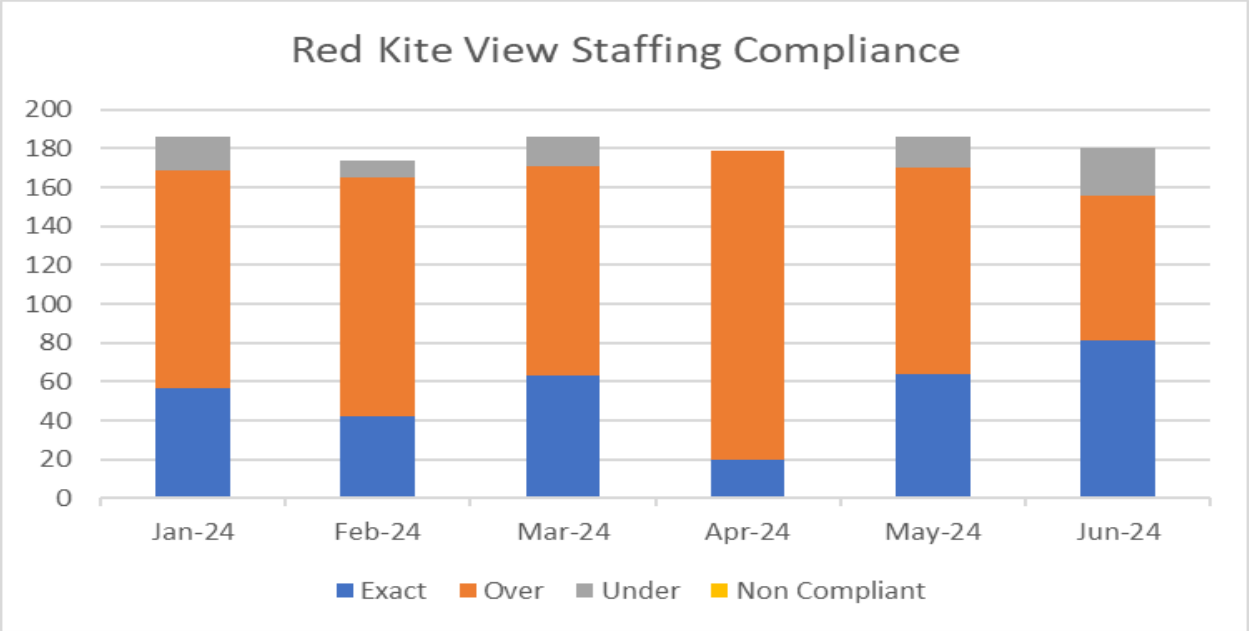
Several young people from across West Yorkshire have been required to receive inpatient care and treatment out of area.

Currently, Lapwing is operating at 50% capacity (N= 4) and Skylark is operating at 50% capacity (N= 8). The availability of beds has fluctuated throughout the data period dependant on the needs of the young person.

Red Kite View budgeted (planned) establishment is made up of Registered Nurses and Health Support Workers. However, it is acknowledged that service user need is about skill mix as well as the staffing numbers and is about other professions as well as nurses. Therefore, the evaluation of safer staffing establishments should be focussed on and including the additional professional specific and alternative roles that all contribute to the provision of care and treatment.
More information about Red Kite View can be found on our website https://www.leedsandyorkpft.nhs.uk/our-services/cypmhs-west-yorkshire/

9.1 Workforce

Review of Staffing Activity Red Kite View- Lapwing and Skylark Wards
The staffing compliance data from 1st January -30th June 2024 in the below graph details whether the wards met the planned numbers of staffing during a shift.



Period	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Exact	57	42	63	20	64	81
Over	112	123	108	159	106	75
Under	17	9	15	0	16	24
Non-Compliant	0	0	0	0	0	0

The staffing compliance data above tells us whether the ward has met the planned numbers of staffing during a shift. However, the planned staffing numbers do not necessarily reflect the staffing need on any given duty as this may fluctuate dependent upon the current patient group and occupancy levels. Planned numbers are based on the whole-time equivalent (WTE), number of staffing posts (establishment) the inpatient wards are funded to deliver care and treatment. Red Kite Views planned staffing numbers are likely to be higher than the actual need due to the reduced occupancy levels during the data period.

The graph demonstrates that.

- During this period, a total of 1091 shifts were required to ensure safer staffing in Red Kite View. This is a 1 % decrease from the previous 6-month period.
- 1010 (93%) of the required shifts met/exceeded planned staffing numbers. An increase of 7% on the previous 6-month period when 86% met or exceeded the required shifts.
- 81 (7%) of the required shifts did not meet planned staffing numbers.
- All shifts had a Registered Nurse on duty.

This information shows that there has been a small reduction in the number of shifts required compared to the previous 6 months. There has been an increase in these shifts meeting the number of staff requested to work. It is important to note that alongside those staff who count within the planned numbers above, there are a range of staff on duty who provide care and support to our service users but sit outside of the planned numbers.

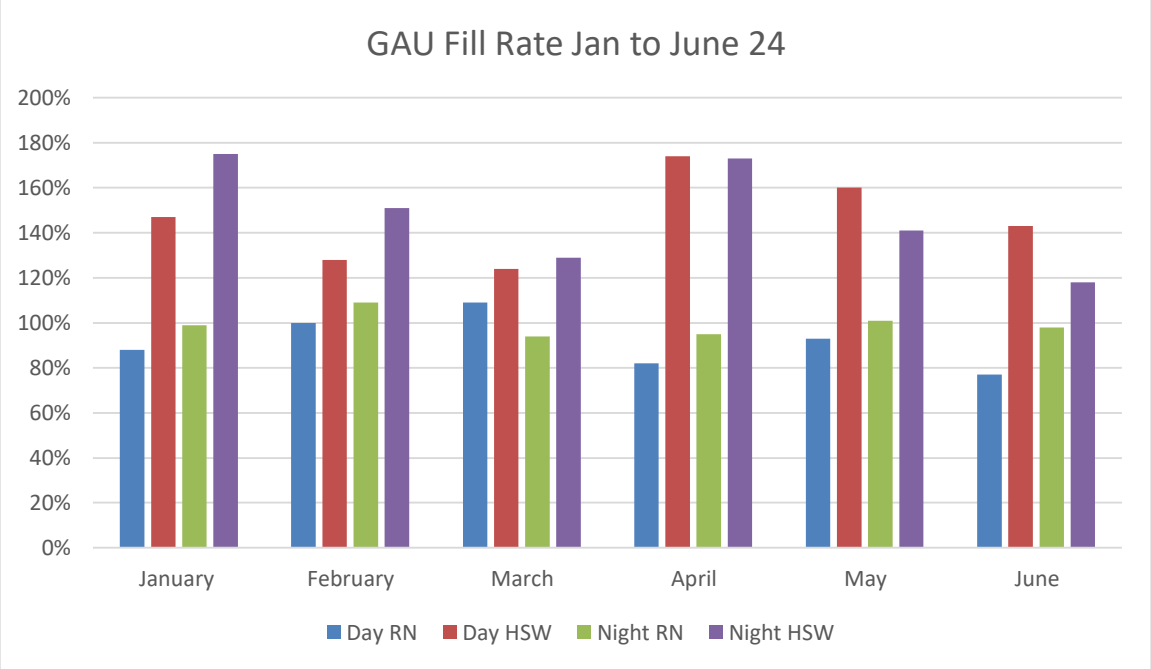
There have been no shifts where there was not a Registered Nurse on duty.

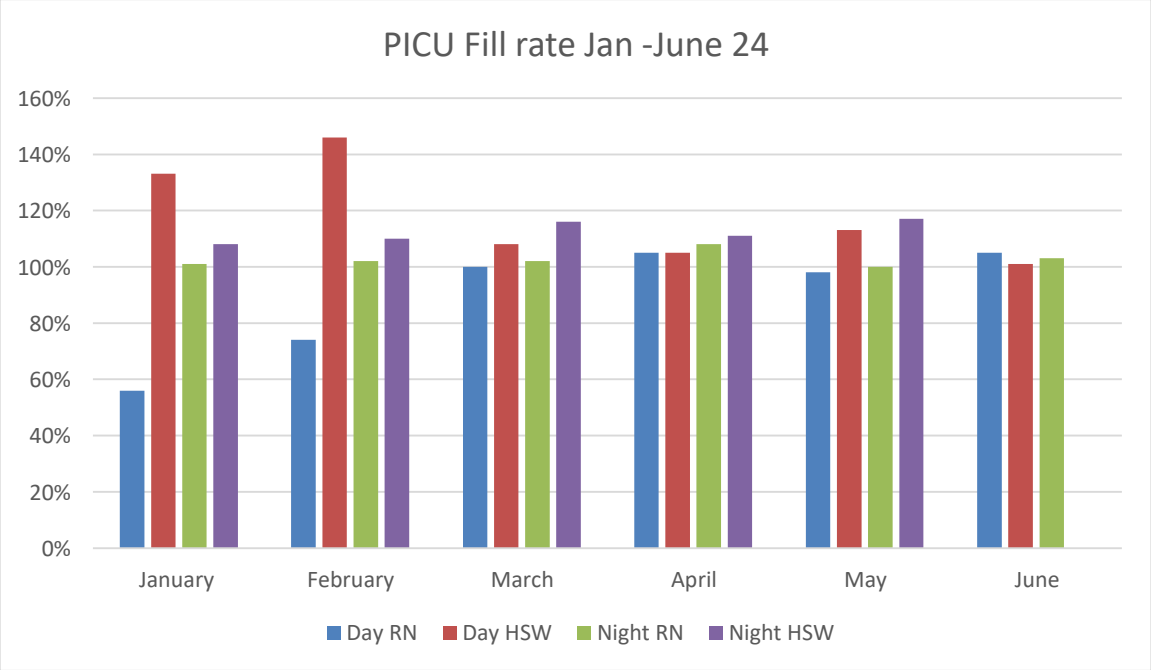
Fill Rate Indicator (Unify) Data

The fill rate monthly indicator (Unify) data demonstrates that the service have maintained a minimum of 77% Registered Nurse rate in June however this has remained close to 100% and at times exceeding this despite the reduced bed capacity. The requirement to maintain the planned Registered Nurse hours is reflected in the ongoing complex needs of the young people being cared for in the service and in particularly young people requiting Naso Gastric feeding which the administering of this intervention remains a Registered Nurse responsibility.

As described earlier, that by itself this data does not reflect the total amount of care provided and the fill rate only includes those roles which are part of the planned establishment and therefore although we may have seen less than 100% of Registered Nurses fill this, it has not accounted for nursing roles in the clinical area at RKV such Practice Development Nurse, Clinical Nurse Specialist, Ward Manager and those nurses that are supernumerary to the shift. RKV have a wealth of professions and wider MDT that work across the service which add significant value to the care of the young people that is not captured in this data.

The fill rate monthly indicator (Unify) data also demonstrates that the service have exceeded the unregistered need above the planned establishment throughout the data period. This is reflected in the complexity of the young people being cared for and additional resource required to support enhanced observations, facilitation of leave and supporting complex interventions such as Naso Gastric feeds.





Throughout the data period the service has experienced a level of activity requiring additional staffing above the planned establishment. This has included between 2- 5 young people requiring Naso Gastric feeding per day administered between 1 and 3 times per day depending on the young person's care and treatment plan. Although the ward has had reduced occupancy the number of young people requiring this intervention has not reduced and accounts for the need to maintain the same level of Registered Nurses on duty to deliver this intervention. Multiple staff may be required to support this intervention alongside the Registered Nurses administering the feed and ongoing monitoring following the intervention is often required. Enhanced

observations have also been required daily to support behaviours that challenge particularly when young people become dysregulated which may at times result in the need for restrictive practice to maintain safety.

Vacancies Red Kite View- Lapwing and Skylark Wards

The below data demonstrates that the number of Registered Nurses has increased and there has been increased reliance on bank and agency staffing. There is a 55.39% vacancy rate for Band 6 Registered Nurses and 56.9% vacancy rate for Band 5 Registered Nurses. The funded establishment for Health Support Workers in the General Admissions Unit has reduced which has reduced the overall vacancy rate.

	Band 6 Nurse					
Period	**Jan 24**	**Feb 24**	**Mar 24**	**Apr 24**	**May 24**	**Jun 24**
Funded	15.40	15.40	15.40	15.40	15.40	15.40
In Post	7.8	7.8	6.8	7.8	7.8	6.8
Vacancy	-7.6	-7.6	-8.6	-7.6	-7.6	-8.6
Percentage	50.07	50.07	55.39	50.07	50.07	55.39

	Band 5 Nurse					
Period	**Jan 24**	**Feb 24**	**Mar 24**	**Apr 24**	**May 24**	**Jun 24**
Funded	21.05	21.05	21.05	21.05	21.05	21.05
In Post	8	10	11	10	9	9
Vacancy	-13.05	-11.05	-10.05	-11.05	-13.05	-13.05
Percentage	61.42	51.9	46.9	51.9	56.9	56.9

	Band 3 Health Support Worker					
Period	**Jan 24**	**Feb 24**	**Mar 24**	**Apr 24**	**May 24**	**Jun 24**
Funded	34.1	34.1	34.1	31.5	31.5	31.5
In Post	25.15	24.15	25.68	27.68	28.68	28.48
Vacancy	-8.95	-9.95	-8.42	-3.72	-2.72	-2.92
Percentage	26.5	29.35	24.83	12.33	9.47	10.04

Although there are significant vacancies within Red Kite View, it is important to acknowledge the range of staff who fall outside the above safer staffing figures but provide care and support for those admitted to the ward, providing profession specific interventions and adding to the quality of the care provided. This includes but is not limited to Occupational Therapists, Occupational Therapy Assistants, Band 4 Health Support Workers, Assistant Support Workers, Psychologists and Psychology Assistants.

However, despite the wide variety of professional groups at Red Kite View, many of the interventions require to be delivered by a Registered Nurse such as nasogastric (NG) feeds, Mental Health Act interventions and medication administration. Therefore, despite the skills and experience of other professions, the Registered Nurse vacancy means the bed capacity needs to remain under review to ensure the right skill mix to deliver the required care and treatment is achieved.

Red Kite View has a range of Bank and Agency Nurses and Health Support Workers who work regularly to support the substantive staff team and service users. This has allowed them to build longstanding relationships within the ward and understand the systems and processes and the needs of individuals on the ward, providing on-going continuity of care. However, there remains a reliance of the need for the responsive use of bank and agency staff.

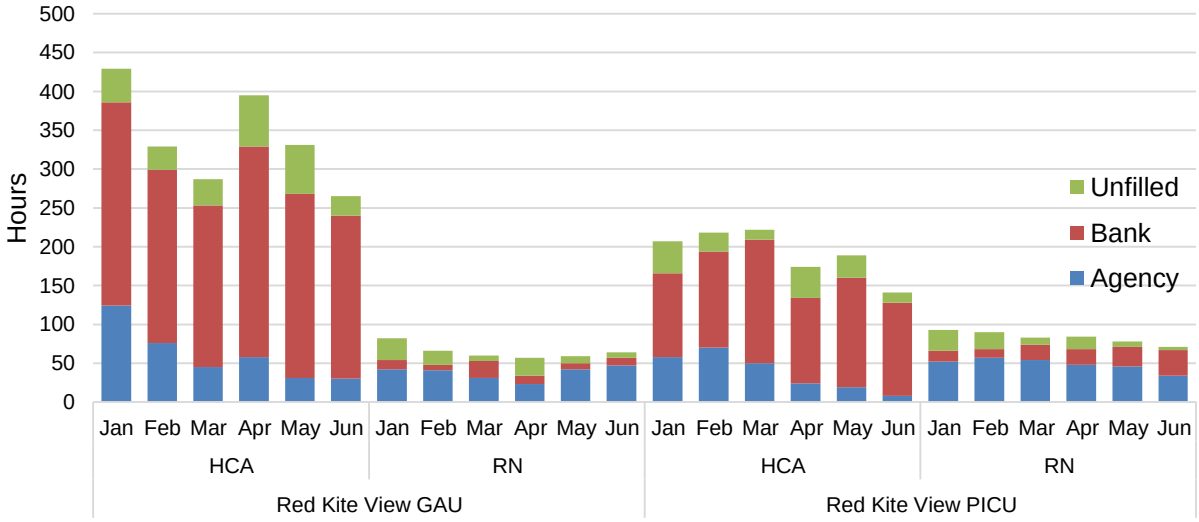
Recruitment Red Kite View- Lapwing and Skylark Wards
The below chart demonstrates the recruitment activity for Red Kite View from 1st January 2024 – 30th June 2024.

Role	No of vacancy adverts	Advertised WTE	Appointed WTE
Band 5 Nursing	4	11	2
Band 6 Nursing	9	14	2
Band 5 Allied Health Professionals	0	0	0
Band 6 Allied Health Professionals	0	0	0
Band 2 & 3 Health Support Workers	2	6	5

The Recruitment Team have supported Red Kite View to appoint one International Nurse which the service is funding to sponsor following the colleague applying for a domestic nursing vacancy. With support from Practice Learning and Development they are now preparing for their OSCE, and on successful completion and receipt of their NMC PIN, the Recruitment Team will raise a certificate of sponsorship and move this colleague onto to Band 5 Staff Nurse contract to remain in Red Kite View. Recruitment undertook an exercise to evaluate all existing Health Support Workers that are internationally educated Mental Health Nurses within the Trust to ensure fairness and equity across all colleagues that could be supported in the same way should they wish to. There were no other examples then. Recruitment have offered to work with Red Kite View HR Business Partner and SLT of Red Kite View to address any lack of training or areas of recruitment that the service feels it would benefit from.

Red Kite View has offered 5 Preceptee places this year for newly qualified nurses. These are due to start in September and are still undergoing pre-employment checks.

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

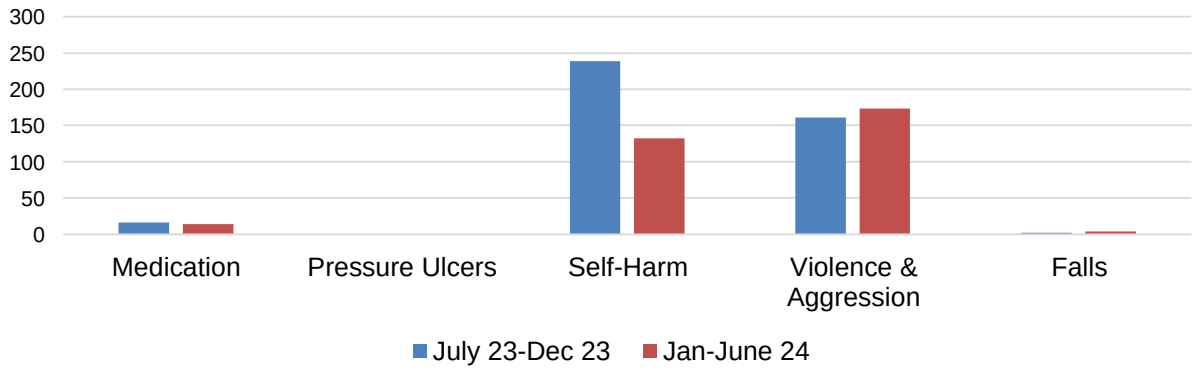


The Responsive Workforce Team - Red Kite View Lapwing and Skylark Wards
Four of the Responsive Workforce Team have supported PICU at Red Kite View during the data period. This has enabled more consistent and appropriately trained staff to deliver care with a reduced reliance of the used of ad hoc bank and agency staff.

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

9.1 Clinical Outcomes

Incidents by category Red Kite View- Lapwing and Skylark Wards



The graph demonstrates a reduction across all incident categories compared with the previous 6 months except for violence and aggression and falls. There has been a significant decrease in self-harm incidents between the data collection period and the previous 6 months. The Leadership Team contribute this reduction to several factors: block booking of agency staff providing consistency and familiarity for service users, the increased offer of therapeutic groups and activities across both wards and a

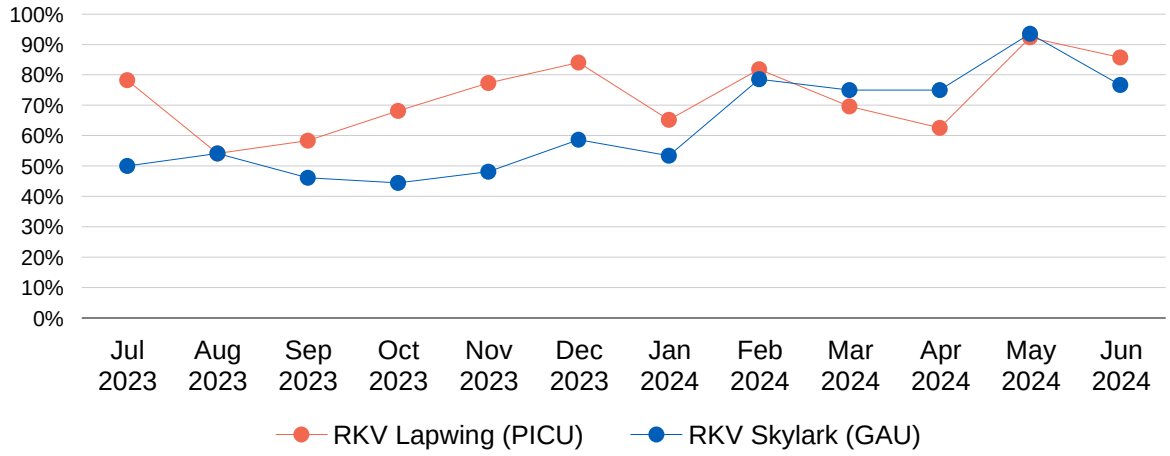
change in client group. It should also be of note that the planned reduction in bed occupancy is likely to in turn reduce the number of incidents and we cannot accurately compare this data collection with the previous 6 months and draw any significant conclusions.

Care Processes

The consistent provision of therapeutic activities and group work delivered across both the wards at Red Kite View, with least 3 groups take place each day. These are led between professionals with the majority being led by the Occupational Therapy Team, Psychologists, Assistant Psychologists, Art Psychotherapists or externally facilitated. The service is in the process of collecting service user feedback on some of the groups that are delivered. Activities on a weekend tend to be service user led in terms of deciding upon what they would like to engage with, and service users also are able to chair the morning sunrise group.

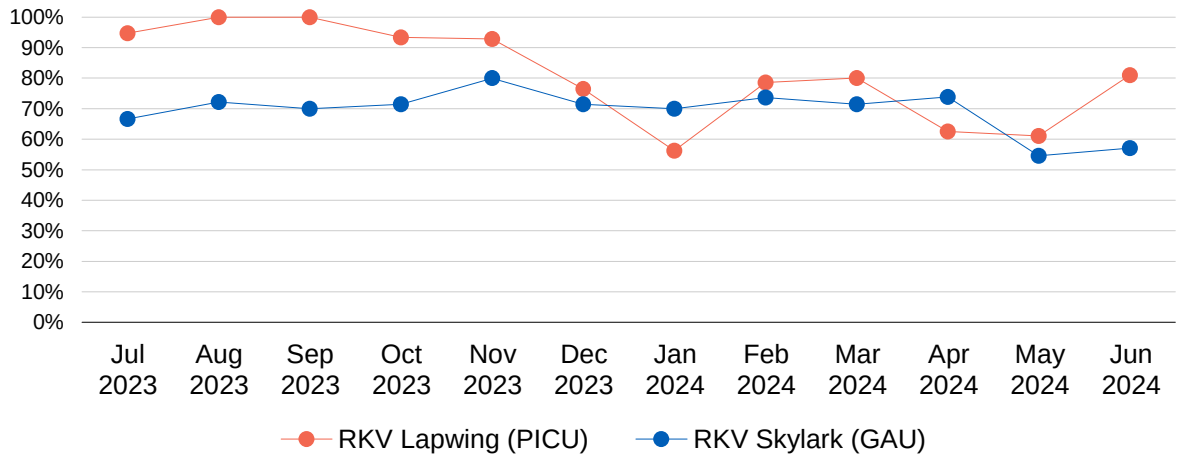
Clinical Supervision Data for Red Kite View- Lapwing and Skylark wards

Clinical supervision rates have increased through the data period with compliance exceeding 85% for both wards in May 24. There is now an increased offer of clinical supervision at Red Kite View with the recent offer of Clinical Restorative Supervision Groups. These groups offer a safe space for staff to reflect on the challenges they face in clinical practice with the aim of improving staff wellbeing, reducing stress, and improving the quality of care delivered to service users.

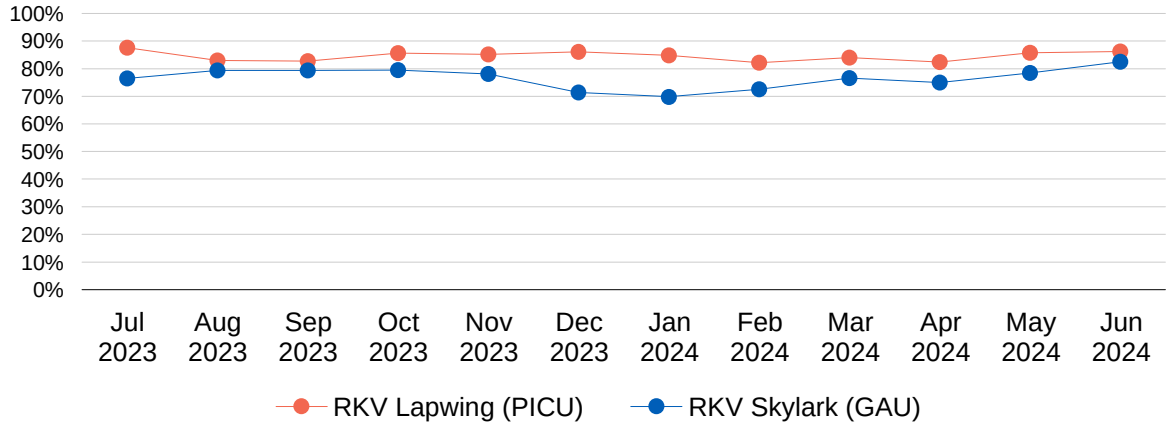


Appraisals Data for Red Kite View- Lapwing and Skylark Wards

Compliance rates for appraisals have fallen below the Trust target of 85% during the data collection period; June 24 Skylark was 57% and Lapwing 80%. High turnover in the band 6 Registered Nurses has contributed to this reduced compliance. Recent expansion of the Leadership Team at Red Kite View should increase capacity to offer appraisals to all staff; the service now has a new Matron role, and the Ward Manager vacancy in the General Admissions Unit has been successfully recruited to with the Manager commencing role recently.



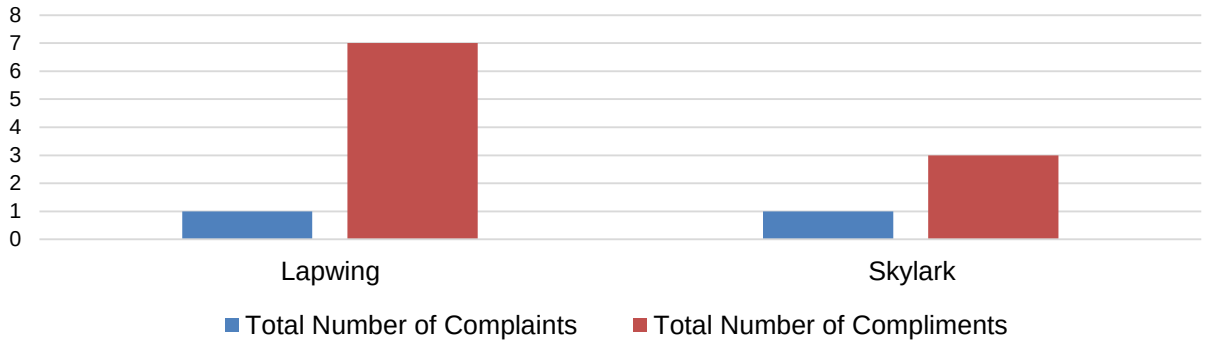
Compulsory Training Data for Red Kite View- Lapwing and Skylark Wards
Compliance rates for mandatory training has increased over the data collection period. The service met the Trustwide compliance rate for compulsory training for June 24 with Lapwing compliance at 86% and Skylark 84%, this demonstrates that staff have the required skills to carry out their roles. The last 12 months of compliance data can be found below.



Red Kite View ensure that they have a Core Day each month which half the staff team attend, with the other half attending the following month. This day supports the delivery of internal or specialist training but also local learning from incidents or positive outcomes within the service. This supports the ongoing development of the team and service and contributes to staff well-being and service user experience.

9.2 Patient Experience- Red Kite View Lapwing and Skylark Wards

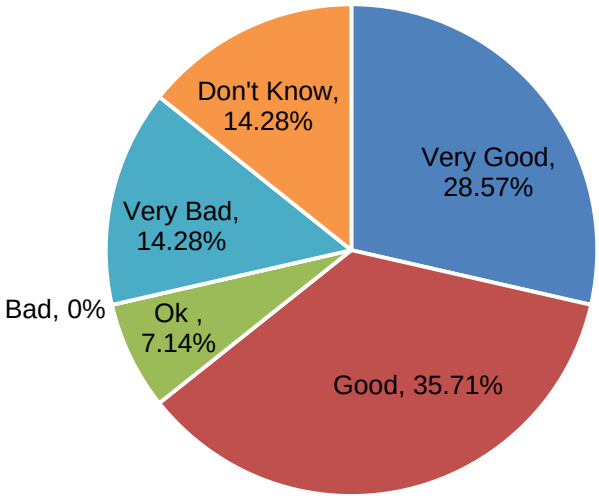
Complaints/Compliments
Below are the total number of complaints and compliments for both wards at Red Kite View during the reporting period. Red Kite View sits in the top 4 reporters of compliments across the inpatient service lines, indicating that positive feedback is received and learned from.



Have Your Say Feedback

The pie chart offers a summary of feedback received within Red Kite View between 1st January 2024 – 30th June 2024. This indicates how service users rate their experience of the service. 64% of respondents report that their care was “good” or “very good”. With 14% reporting that their care was “bad” or “very bad”.

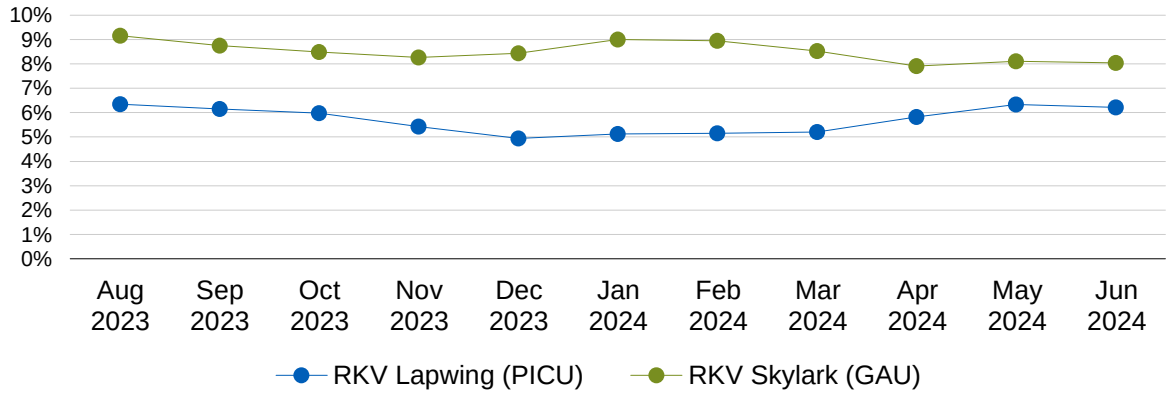
Feedback from service users is an important indication of the quality of care received demonstrating that most of our service users reported a positive experience.



9.3 Staff Experience- Red Kite View Lapwing and Skylark Wards

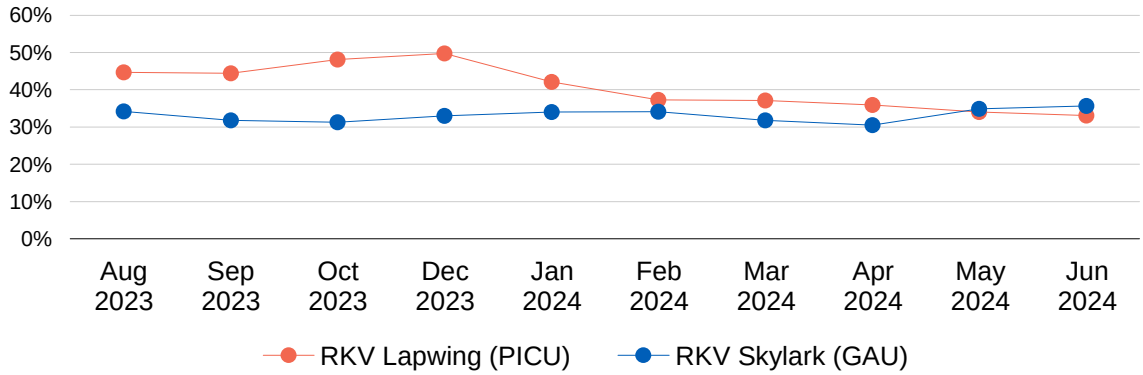
Sickness Absence Rate

Sickness absence rates have remained above the Trust target of 5% for both wards during the data collection period, Lapwing at 6.22% and Skylark at 8% for June 24.



Mental Health/Stress

The below shows the percentage of sickness that is related to mental health or stress.



The People and Resourcing Team and the Health and Wellbeing Service are supporting the service with absence reviews and offering support to individual team members as required.

Wellbeing

The turnover in the service in June 2024 was 6%. There has been an ongoing reduction in turnover within the service according to the data.

The data above indicates good supervision rates and completion of training which may have a positive impact on staff wellbeing. The service has several initiatives to support staff wellbeing, these include a monthly wellbeing steering group and weekly reflective practice groups, formulation and care plan meetings.

MHOST

The MHOST data for Red Kite View has not been included in this report. Data submission has spanned across periods where the bed occupancy level has fluctuated within both wards. This will impact on the validity of the data and subsequently would not provide an accurate account of the staffing establishment required. There is a workstream ongoing to gain a fuller understanding of what the staffing establishment should be for the current reduced bed base, should this need to continue for a further period. Benchmarking data have also been sought from other Trusts to support this piece of work.

Red Kite View Summary

The data and information provided relating to Red Kite View demonstrates how a triangulated approach to review safer staffing is essential and reviewing the 3 overarching areas (right staff, right skills, right time, and place) as set out in the NQB guidance is required to draw any sound conclusions

The service continues to be subject to workforce pressures particularly in relation to Registered Nurse vacancies. However, there are Preceptee Nurses due to commence post in the coming months which should start to reduce the Nursing vacancies. Whilst there are challenges within the Registered Nurse workforce, there is a wealth of skills and experience within the wider multidisciplinary team.

Patient experience data suggests that the majority of patients feel they experience good care. The use of the safer staffing escalation process has allowed for mitigation and management of staffing both proactively and for the ongoing daily decisions. The use of deployment, Responsive Workforce Team and regular bookings of bank and agency staff to support a more consistent approach to the delivery of care and treatment and ensuring staff have the right skills can be suggested to have had a positive impact.

Red Kite View will see more Registered Nurses due to take up positions within the service from July onwards with colleagues returning from maternity leave and Preceptees coming into post. This will begin to increase nursing capacity. Until this time bed occupancy will remain under review to ensure that safe staffing can be provided to meet the needs of the service users.

10.0 Summary

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

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

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

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

Deployment of staff across services continues to be a requirement though this has reduced significantly according to the data, however this should be viewed with caution. Despite all efforts there was one duty recorded with no registered nurse on duty. This is a reduction on the previous data collection period.

All inpatient services (excluding Woodland Square) have completed two data collection periods for the MHOST. This will now lead to establishment reviews across the inpatient services which have already taken place within two wards in older people's services. The aim is to complete all reviews by the end of September 2024.

It is important to acknowledge that despite the nursing vacancies within the Trust, the delivery of care through the multidisciplinary team and the professional specific roles is not captured in the planned staffing establishment and should be considered when reviewing the data. The wider multidisciplinary team brings increased skills and supports the quality of care delivered.

Quality indicators as set out in the NQB have also illustrated an increase in the overall number of incidents however there was a reduction in both self-harm and violence and aggression, two of the areas focused on for the report.

Clinical supervision and appraisal rates have also remained high, with some improvement which are likely in turn to influence staff experience.

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

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

Four workstreams have commenced led through the Safer Staffing Steering Group. The work is focussed on improving the quality of the care and treatment delivered through more effective integration of the multi-disciplinary team as we move away from our inpatient wards being established with predominantly Nursing staff. These workstreams include reviewing the roles and responsibilities of members of the multidisciplinary team, effective escalation for significant staffing increases, effective eroster usage and the cultural shift required from services to facilitate this way of working. These pieces of work will continue to support safe staffing within the inpatient services and ensure patients receive high quality care. This work will run concurrently

with the annual workforce establishment reviews ensuring that baseline staffing figures within our inpatient services continue to meet the needs of the people we care for.

11.0 Recommendations

The Board of Directors is asked to:

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

Authors:

Alison Quarry, Deputy Director of Nursing
Jennifer Connelly, Professional Lead Nurse
Miriam Blackburn, Professional Lead Nurse
Sam Wragg, Recruitment and Resourcing Manager
Adele Sowden, E-Rostering Team Manager

Appendix 1: Care Level Indicators taken from The Shelford Group (2019) Mental Health Optimal Staffing Tool MHOST: Implementation Guidance for Mental Health Inpatient Wards.

Adult Acute Mental Health Wards

Acuity and Dependency Level	Descriptor
Level 1 Low Dependency	Self-caring and able to do most daily living activities of unaided. Patient has capacity to engage with therapeutic interventions. Patient is at predischarge state. Risks can be managed by community services.
Level 2 Medium Dependency	More dependent on ward staff for his/her mental, social or physical health needs. Patient has capacity to engage with therapeutic interventions. May be potential barriers preventing a safe and timely discharge.
Level 3 Medium/High Dependency	Heavily reliant on Ward Team for his / her care. Presents as medium- to high-risk or fluctuating risk. Has high-level mental, social or physical health needs. Low or inconsistent engagement with therapeutic interventions. There may be potential barriers preventing a safe and timely discharge.
Level 4 High Dependency	Dependant on Ward Team for his/ her care. Requires high engagement and intervention. Major mental, social or physical health needs. Presents as high-level risk to self-and/or others. Minimal engagement with therapeutic interventions.
Level 5 Highest Dependency	Requires one to one care. Major mental, social or physical health needs. Is a significant risk to self and/or other people. Leave from the ward isn't allowed other than planned hospital appointments with escort. May be awaiting step up to PICU or low-secure environment.

Child and Adolescent Mental Health Wards

Acuity and Dependency Level	Descriptor
Level 1 Low Dependency	Self-caring and able to do most daily living activities unaided. Core therapeutic interventions are provided. Able to access education services unaided. Can leave the ward without supervision (supported by parents or social services). Proactively engaging with staff to manage risks. Concordant with treatment and care plan. Minor/stable mental illness symptoms, not affecting functioning. Unlikely to self-harm or harm others.
Level 2 Medium Dependency	Self-caring and able to do some daily living activities unaided. Increased staff support required when accessing core therapeutic interventions, education and community services. Able to access education services unaided. Can leave the ward without supervision (supported by parents or social service staff). Proactively engaging with staff to manage risks.

	Concordant with treatment and care plan. Minor/stable mental illness symptoms, which do not affect functioning. Unlikely to self-harm or harm others.
Level 3 Medium/High Dependency	Requires support from staff to meet personal care needs. Requires support when accessing therapeutic interventions, education and community activities. Proactively engaging with staff to manage risks. Not fully concordant with treatment and care plan. Minor/stable mental illness symptoms, not affecting functioning, but which needs staff intervention. Engagement with staff/ward routine is inconsistent, requiring frequent intervention. Moderate mental illness symptoms having definite impact on ability to function. Moderate risk to self and others.
Level 4 High Dependency	Requires direct intervention from staff when attending to personal care needs. Needs one-to-one support from staff when accessing therapeutic interventions, education and community services. Not concordant with treatment and care plan, requiring staff intervention. Social and family issues require staff intervention. Limited engagement with staff. Moderate to high mental-illness symptoms, which significantly influence functioning. Self-harm and risk to others is moderate to high.
Level 5 Highest Dependency	Requires direct input and staff intervention for personal care. Requires constant one-to-one care at all times. Non-concordant with treatment and care plan, requiring constant staff intervention. Engagement with staff/ward routine is inconsistent requiring ongoing intervention. Significant mental illness symptoms having severe effect on functioning. High risk to self and others. For transfer to higher-security care.

<u>Eating Disorder Wards</u>

Acuity and Dependency Level	**Descriptor**
Level 1 Low Dependency	**Diet specific** – Patient is completing all diet in a step-down unit or dining room. Manifests only reduced eating disorder behaviours. Selects portions correctly with little assistance. Challenges self with food. Few compensatory and safety behaviours such as purging, laxative misuse or excessive exercise. Can go on independent snacks and meals. Some preoccupation with food, weight and shape. **Physical health** – Physical observations are recorded at least monthly. Blood investigations are generally within range. Weighed weekly and is restoring or maintaining weight. Accepts medications. **Mental health** – Concordant with care plan. General observation. Patient has leave periods. Patient reports improving wellbeing. Preparing for discharge. Fully engaging in ward activities, willing to engage in recovery focussed sessions. Engages with therapeutic plan and occupations independently or in a group. Can retain information and attention span is much

	improved. Mental health is stable, patient is functioning well. No self-harm or harm to others.
Level 2 Medium Dependency	**Diet specific** – Patient is completing all meals in a step-down unit or dining room. Manifests reduced eating disorder behaviours. Selects portions correctly and with little assistance. Can go on independent meals and snacks off site. Reduced compensatory and safety behaviours such as purging, laxative misuse or excessive exercise. Some preoccupation with food, weight and shape. **Physical health** – Physical observations are recorded up to once daily. Physical observations and bloods taken are generally within range. Weighed weekly and is maintaining or restoring weight. Accepts medication. **Mental health** – Concordant with care plan, General observation. Mental health continues to fluctuate. Anxiety levels around mealtimes may be present. Remains on post mealtime observations. Engaging in therapeutic plan, which may include social eating and meal preparation with some concerns or areas that require support. Engaging in meaningful leisure-based OT groups, may attend but not fully engage in recovery-based sessions. No self-harm or harm to others.
Level 3 Medium/High Dependency	**Diet specific** – Not always managing to eat meals and snacks but usually accepts oral nutritional supplements. Some compensatory eating disordered behaviours may be present, such as purging, laxative misuse and or excessive exercise. Not suitable for a step-down unit. There may be some eating disordered behaviours at the table, such as breaking up or secreting food. May find it difficult or avoids making food choices. **Physical health** – Physical observations are monitored once daily and are stable. Bloods taken weekly and generally within range. Engaging, but struggling to restore weight. Accepts medication. **Mental health** – Intermittently, concordant with care plan, Likely to be on intermittent observations. Mental health fluctuates. Reduced concentration, attention span and recall. High anorexic cognitions around, weight, size and shape. Post meal observations. Some engagement in meaningful ward-based activities either alone or in a group, but unable to concentrate for extended periods. May have some concerns that require further intervention. No self-harm or harm to others.
Level 4 High Dependency	**Diet specific** – Not always managing diet, always or usually refuses oral nutritional supplements. Naso-gastric tube maybe in situ. Manifests compensatory eating disorder behaviours such as purging, laxative misuse and excessive exercise. Eating disordered behaviours likely to be present at the table, e.g. breaking up food, secretion. Patient likely to avoid making menu choices. Risks re-feeding syndrome.

	Physical health – Physical observations recorded at least once daily, and readings fluctuate. Bloods taken more frequently than weekly. Difficulty restoring weight most weeks. Wheelchair may be required off the ward. Restrictions around bathroom use. May require more intense physical interventions. Mostly concordant with medications. **Mental health** – non-concordant with care plan, Higher observations and can have escorted leave off the ward with staff if physical observations are stable. May experience intense anorexic cognitions around weight, shape and size. May engage in ward-based leisure activities with encouragement and support. Difficulties in finding occupations in which to engage independently due to poor concentration, motivation, or high-risk level. On post-meal observations.
Level 5 Highest Dependency	Patient requiring one-to-one care or constant supervision to maintain safety, welfare and care.

Older Age Mental Health Wards

Acuity and Dependency Level	**Descriptor**
Level 1 Low Dependency	Personal care can be managed by one staff, or patient is independent. Has cognitive impairment, but not at risk. Mental state is stable/ predictable. General, hourly observations required. Vital signs are monitored twice daily. Medically stable, requires rehabilitation only. No significant care-package changes required. Ready for discharge. Supportive family able to cope at home. Patient can contribute to care and care planning.
Level 2 Medium Dependency	Patient is on general, hourly observations. Personal care can be managed by one staff. Early warning score trigger point reached, requiring escalation. Normal observation and therapeutic interventions. Mental state fluctuates. Care needs require regular re-evaluation. Increased multi-disciplinary team input. Patient has significant co-morbidity, e.g. an infection. Patient and family are participating in care/care planning.
Level 3 Medium/High Dependency	Has significant mental and physical health problems, which fluctuate. Has co-morbidities, but physical health is stable. At risk, but safety can be maintained with moderately skilled interventions. Daily living activities are managed by two staff and rarely requires one-to-one care. Multiagency discharge, where there has been a change in circumstance/care or package, which is the ward-based nurse's/therapist's responsibility. Increased psychological/emotional and education support required by patient and/or family carers. Patient requires direct supervision and medication to ensure compliance, or has a complex drug regimen, including prolonged preparatory/administration/post-administration care.

Level 4 High Dependency	Has significant on-going care needs, which can be met by two staff. Intermittent observations or one-to-one for part of the day. Significant co-morbidities with fluctuating physical health needs. At risk – has an unpredictable mental state or is likely to harm self or others. Skilled intervention required to maintain safety. Family/carers require increased psychological, educational and emotional support.
Level 5 Highest Dependency	Patient requiring one-to-one care or constant supervision to maintain safety and care.

Perinatal (Mother and Baby) Wards

Acuity and Dependency Level	**Descriptor**
Level 1 Low Dependency	Pre-discharge - Mother fully looks after her baby. Uses home leave appropriately. Engages in activities. Mother-baby interaction is safe and consistent. Attachment is good. Risk level is low. Baby requires no support from staff and is 'general observation' only.
Level 2 Medium Dependency	Mother cares for baby with minimum staff-support i.e. verbal prompts only. Mum is self-caring. Requires accompanied home leave. Mum needs only prompts to engage in activities. Mother and baby interaction shows some attachment, but not consistent or safe. Risk is stable. Agreed care plan in place. Baby needs little support from staff i.e. mother requires verbal prompting and reassurance.
Level 3 Medium/High Dependency	One-to-one observations part of the day. High risk, mother is unpredictable and volatile. Requires supervision when handling her baby and needs help with baby care: bathing, feeding, changing nappies. Needs prompting with self-care. If home leave is allowed, then escort is required. Not engaging in activities. Baby requires planned interventions at specific times. Has a nursery-nurse care plan.
Level 4 High Dependency	One-to-one observations, most of the day. Constant supervision required when engaging with baby. Intermittent support when self-caring; requires verbal and physical prompting. Not engaging in activities. Home leave is not allowed. Mental health seriously impedes mum's ability to care for her baby. May neglect and possibly harm her baby. Behaviour is chaotic. Mother and baby may need transferring to an adult MH unit or PICU.
Level 5 Highest Dependency	Constant supervision and support when undertaking self-care activities. Not engaging in activities. Less or no ability to communicate needs. Mental health severely affects ability to care for her baby. Harm to herself and baby - high risk. Disruptive behaviour that affects the whole ward. Mother and baby may require transfer to adult MH unit or PICU.

Psychiatric Intensive Care

Acuity and Dependency Level	Descriptor
Level 1 Low Dependency	Self-caring – able to do self-care activities unaided. Core therapeutic interventions are provided. Non-PICU patient awaiting discharge or transfer.
Level 2 Medium Dependency	More dependent on ward staff for his/her personal care needs. Requires more than base-level core interventions. Ready for transfer/discharge.
Level 3 Medium/High Dependency	Heavily reliant on ward team for his/her safety and care.
Level 4 High Dependency	Fully dependent on ward team for his/her safety and care. Requires high engagement and frequent interventions. Additional support needed to meet personal care needs.
Level 5 Highest Dependency	Has harmed or may harm self or others. In a de-escalation/extra care area. Secluded patients. Increased support required to meet personal care needs. Possible transfer to a forensic service unit. Complex discharge process.

Forensic Low Secure/ Rehabilitation Wards

Acuity and Dependency Level	Descriptor
Level 1 Low Dependency	Settled, stable and assessed. Engages with treatment and care plan. At pre-discharge phase. Demonstrates insight. Risks are understood and fully engages with management plan. No significant physical, mental or social issues. Observation requirements are 30 minutes to one hourly. Manifests ad-hoc, unpredictable behaviour.
Level 2 Medium Dependency	Some, ad-hoc unpredictable behaviour. Short-term but significant physical, mental and social problems. Active rehabilitation programme in place. Lacking family support, or family needs significant help at home. Risks are known but patient isn't fully engaging with risk-management plan. Requires thirty-minute observations.
Level 3 Medium/High Dependency	Manifests predictable behaviours that require extra observations, otherwise routine observations are 15 to 30 minutes. Has potential to harm self and/or others. Complex discharge process is likely.
Level 4 High Dependency	Newly admitted or patient is being re-integrated after seclusion. Manifests serious aggression and likely to self-harm or harm others. Complex discharge process is likely. 1-1 observation required intermittently.

Level 5 Highest Dependency	Imminent destructive behaviour to self and/or others. If opportunity arises, then patient may wander or abscond. Manifests major physical, mental and social problems. Does not engage with his/her risk management plan. Constant 1-1 observation required.

APPENDIX 2

The below information shows where wards have worked above or below their baseline establishment.

For example, if a ward has 70% Registered Nurse fill rate it means that there have been 30% unfilled Registered Nurse duties. In this case, we would expect to see a Health Support Worker fill rate of 130% where the Registered Nurse deficit has been back filled by Health Support Workers. If a ward is working on its baseline establishment, the Registered Nurse fill rate and Health Support Worker fill rate will add up to 200% However, if the two figures add up to over 200%, this means that the ward has worked above its establishment. This may be due to observation, acuity, escorts or a similar reason.

Two months of this data has been included below.

Safer Staffing: Inpatient Services May 24

Fill rate indicator return

Staffing: Nursing, Care Staff and AHPs

Ward name	Cumulative count	Care Hours Per Patient Day (CHPPD)							Day				Night				Allied Health	
		Registered	Non-registe	Registered	Non-registe	Registered	Non-registe	Overall	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill
WardName	PatientCo	CHPPD_RI	CHPPD_NI	CHPPD_RI	CHPPD_NI	CHPPD_RA	CHPPD_NI	CHPPD_O	AvgFR_RNI	AvgFR_NRI	AvgFR_RN	AvgFR_NRI	AvgFR_RNI	AvgFR_NRI	AvgFR_RN	AvgFR_NRI	AvgFR_RAI	AvgFR_NRA
2 WOODLAND SQUARE	131	8.1	6.5	0.0	0.0	0.0	0.0	14.6	96%	120%	-	-	100%	103%	-	-	-	-
3 WOODLAND SQUARE	109	8.2	18.5	0.0	0.0	0.0	0.0	26.7	68%	176%	-	-	53%	116%	-	-	-	-
ASKET CROFT	564	1.6	2.5	0.0	0.0	0.0	0.6	4.8	96%	85%	-	-	100%	100%	-	-	-	100%
ASKET HOUSE	407	2.0	2.1	0.0	0.0	0.0	0.9	5.0	110%	66%	-	-	100%	101%	-	-	-	100%
BECKLIN CAU	173	4.7	15.6	0.0	0.0	0.0	0.0	20.3	109%	102%	-	-	117%	119%	-	-	-	-
BECKLIN WARD 1	675	2.4	8.2	0.0	0.0	0.0	0.6	11.2	87%	351%	-	-	94%	372%	-	-	-	100%
BECKLIN WARD 3	634	2.4	3.7	0.0	0.0	0.0	0.4	6.5	78%	197%	-	-	87%	137%	-	-	-	100%
BECKLIN WARD 4	679	2.5	3.3	0.0	0.0	0.0	0.4	6.2	88%	165%	-	-	94%	147%	-	-	-	100%
BECKLIN WARD 5	664	2.7	8.5	0.0	0.0	0.0	0.3	11.6	104%	404%	-	-	99%	400%	-	-	-	100%
MOTHER AND BABY AT THE MOUNT	193	5.9	11.3	0.0	0.0	0.0	0.0	17.2	75%	131%	-	-	70%	161%	-	-	-	-
NEWSAM WARD 1 PICU	370	3.8	9.8	0.0	0.0	0.0	0.5	14.1	73%	129%	-	-	81%	142%	-	-	-	100%
NEWSAM WARD 2 FORENSIC	294	3.7	9.4	0.0	0.0	0.0	0.5	13.6	104%	114%	-	-	100%	112%	-	-	-	100%
NEWSAM WARD 2 WOMENS SERVICES	279	4.1	9.6	0.0	0.0	0.0	0.9	14.6	115%	110%	-	-	100%	109%	-	-	-	100%
NEWSAM WARD 3	430	2.6	5.2	0.0	0.0	0.0	0.5	8.3	131%	110%	-	-	100%	102%	-	-	-	100%
NEWSAM WARD 4	641	2.4	3.4	0.0	0.0	0.0	0.6	6.3	97%	192%	-	-	98%	126%	-	-	-	100%
NEWSAM WARD 5	1050	1.4	1.9	0.0	0.0	0.0	1.0	4.3	121%	80%	-	-	81%	119%	-	-	-	100%
NEWSAM WARD 6 EDU	774	1.6	4.8	0.0	0.0	0.0	0.7	7.1	103%	441%	-	-	62%	219%	-	-	-	100%
NICPM LGI	488	3.1	2.1	0.0	0.0	0.0	0.7	5.8	116%	77%	-	-	97%	120%	-	-	-	100%
RED KITE VIEW GAU	280	6.0	17.1	0.0	0.0	0.0	0.0	23.2	93%	160%	-	-	101%	141%	-	-	-	-
RED KITE VIEW PICU	140	9.8	28.9	0.0	0.0	0.0	0.0	38.6	98%	113%	-	-	100%	117%	-	-	-	-
THE MOUNT WARD 1 NEW (MALE)	390	4.2	16.5	0.0	0.0	0.0	0.0	20.7	135%	189%	-	-	102%	299%	-	-	-	-
THE MOUNT WARD 2 NEW (FEMALE)	377	3.9	18.4	0.0	0.0	0.0	0.0	22.3	73%	226%	-	-	107%	288%	-	-	-	-
THE MOUNT WARD 3A	515	3.0	7.9	0.0	0.0	0.0	0.0	10.9	88%	193%	-	-	100%	255%	-	-	-	-
THE MOUNT WARD 4A	624	2.4	6.6	0.0	0.0	0.0	0.0	9.0	88%	208%	-	-	111%	204%	-	-	-	-
YORK - BLUEBELL	295	4.4	7.7	0.0	0.0	0.0	1.0	13.1	141%	90%	-	-	103%	100%	-	-	-	100%
YORK - MILL LODGE	217	6.6	11.2	0.0	0.0	0.0	1.1	18.9	76%	118%	-	-	61%	153%	-	-	-	100%
YORK - RIVERFIELDS	194	5.2	7.5	0.0	0.0	0.0	1.5	14.2	81%	147%	-	-	106%	116%	-	-	-	100%
YORK - WESTERDALE	209	4.9	12.9	0.0	0.0	0.0	1.2	19.0	95%	179%	-	-	135%	104%	-	-	-	100%

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

Safer Staffing: Inpatient Services June 24

Fill rate indicator return

Staffing: Nursing, Care Staff and AHPs

Ward name	Cumulative count	Care Hours Per Patient Day (CHPPD)							Day				Night				Allied Health	
		Registered	Non-registe	Registered	Non-registe	Registered	Non-registe	Overall	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill
2 WOODLAND SQUARE	105	9.2	10.0	0.0	0.0	0.0	1.1	20.3	84%	193%	-	-	114%	103%	-	-	-	100%
3 WOODLAND SQUARE	103	8.6	19.1	0.0	0.0	0.0	0.0	27.7	70%	179%	-	-	56%	129%	-	-	-	-
ASKET CROFT	548	1.5	2.6	0.0	0.0	0.0	0.7	4.9	89%	92%	-	-	100%	103%	-	-	-	100%
ASKET HOUSE	377	2.0	2.3	0.0	0.0	0.0	0.8	5.1	102%	76%	-	-	100%	100%	-	-	-	100%
BECKLIN CAU	174	3.5	15.0	0.0	0.0	0.0	0.0	18.5	91%	108%	-	-	96%	110%	-	-	-	-
BECKLIN WARD 1	669	2.5	6.2	0.0	0.0	0.0	0.4	9.2	95%	278%	-	-	96%	288%	-	-	-	100%
BECKLIN WARD 3	615	2.5	4.0	0.0	0.0	0.0	0.4	6.8	79%	209%	-	-	96%	153%	-	-	-	100%
BECKLIN WARD 4	650	2.3	3.7	0.0	0.0	0.0	0.6	6.6	82%	180%	-	-	87%	170%	-	-	-	100%
BECKLIN WARD 5	664	2.6	8.2	0.0	0.0	0.0	0.3	11.0	101%	428%	-	-	99%	380%	-	-	-	100%
MOTHER AND BABY AT THE MOUNT	230	5.0	9.5	0.0	0.0	0.0	0.0	14.5	86%	159%	-	-	66%	163%	-	-	-	-
NEWSAM WARD 1 PICU	356	3.5	9.9	0.0	0.0	0.0	0.8	14.2	73%	132%	-	-	66%	139%	-	-	-	100%
NEWSAM WARD 2 FORENSIC	270	3.9	9.6	0.0	0.0	0.0	0.4	13.9	99%	105%	-	-	100%	108%	-	-	-	100%
NEWSAM WARD 2 WOMENS SERVICES	270	4.1	10.2	0.0	0.0	0.0	1.0	15.3	99%	113%	-	-	100%	115%	-	-	-	100%
NEWSAM WARD 3	401	2.6	5.8	0.0	0.0	0.0	0.3	8.7	99%	113%	-	-	103%	110%	-	-	-	100%
NEWSAM WARD 4	624	2.3	3.7	0.0	0.0	0.0	0.3	6.4	89%	221%	-	-	98%	147%	-	-	-	100%
NEWSAM WARD 5	1020	1.4	2.1	0.0	0.0	0.0	1.0	4.5	111%	92%	-	-	97%	114%	-	-	-	100%
NEWSAM WARD 6 EDU	738	1.5	6.4	0.0	0.0	0.0	0.6	8.4	102%	689%	-	-	54%	306%	-	-	-	100%
NICPM LGI	474	2.9	2.1	0.0	0.0	0.0	0.7	5.7	104%	80%	-	-	104%	107%	-	-	-	100%
RED KITE VIEW GAU	234	6.3	17.4	0.0	0.0	0.0	0.0	23.7	77%	143%	-	-	98%	118%	-	-	-	-
RED KITE VIEW PICU	120	11.7	29.6	0.0	0.0	0.0	0.0	41.3	105%	101%	-	-	103%	102%	-	-	-	-
THE MOUNT WARD 1 NEW (MALE)	310	4.7	16.2	0.0	0.0	0.0	0.0	20.9	109%	153%	-	-	98%	237%	-	-	-	-
THE MOUNT WARD 2 NEW (FEMALE)	428	3.5	16.2	0.0	0.0	0.0	0.0	19.6	78%	230%	-	-	105%	302%	-	-	-	-
THE MOUNT WARD 3A	533	2.7	5.7	0.0	0.0	0.0	0.0	8.4	87%	144%	-	-	98%	175%	-	-	-	-
THE MOUNT WARD 4A	635	2.4	6.1	0.0	0.0	0.0	0.0	8.5	95%	194%	-	-	100%	204%	-	-	-	-
YORK - BLUEBELL	270	4.4	9.8	0.0	0.0	0.0	0.6	14.8	129%	103%	-	-	103%	123%	-	-	-	100%
YORK - MILL LODGE	231	5.6	10.8	0.0	0.0	0.0	1.8	18.3	78%	144%	-	-	78%	143%	-	-	-	100%
YORK - RIVERFIELDS	205	5.0	6.5	0.0	0.0	0.0	0.2	11.6	89%	140%	-	-	100%	100%	-	-	-	100%
YORK - WESTERDALE	163	5.9	14.8	0.0	0.0	0.0	1.7	22.5	93%	150%	-	-	101%	101%	-	-	-	100%

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

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

AGENDA ITEM

16

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Guardian of Safe Working Quarterly Report Quarter 1: 1st April 2024 to 30th June 2024
DATE OF MEETING:	26 September 2024
PRESENTED BY: (name and title)	Dr Chris Hosker, Medical Director
PREPARED BY: (name and title)	Dr Rebecca Asquith, Guardian of Safe Working Hours

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

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

EXECUTIVE SUMMARY

The purpose of this report is to give assurance to the board that doctors in training are safely rostered and that their working hours are compliant with the Junior doctors contract 2016 and in accordance with Junior doctors terms and conditions of service (TCS). Key points to note are:

- There have been 8 exception reports and 0 patient safety issues recorded in this period
- Junior Doctors Forum met in April 2024 with continued review of ERs and rota gaps. Feedback is also received from Core and Higher Trainee Representatives.

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

RECOMMENDATION

The Board of Directors are asked:

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

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

MEETING OF THE BOARD OF DIRECTORS

DATE 26th September 2024

Guardian of Safe Working Hours Report

Quarter 1: 1st April 2024 to 30th June 2024

1 Executive Summary

The purpose of this quarterly report is to give assurance to the board that doctors in training are safely rostered and that their working hours are compliant with the Junior doctors contract 2016 and in accordance with Junior doctors terms and conditions of service (TCS). The report includes the data from 01.04.2024 to 30.06.2024.

2 Quarter 1 Overview

Vacancies		As in previous reports, and continuing from August 2023, there are 38 Core trainees and 2 NIHR posts. All schemes are full. 5 'FY3s' (trust doctors) started in February 2024 to fill service gaps.					
		As of August 2023 there are 31 established higher training posts, plus one psychotherapy post borrowed from Forensics.					
Rota Gaps		April		May		June	
		CT	HT	CT	HT	CT	HT
	Gaps	11	13	24	15	17	16
	Internal Cover	6	13	18	15	15	16
	Agency cover	0	0	0	0	0	0
	Unfilled	5	0	6	0	2	0
Fill Rate		54%	100%	75%	100%	88%	100%
Reasons for Rota Gaps		Sickness (2) LTFT (9)	Left trust (7) Off rota (3) LTFT (3)	Sickness (9) Vacant (1) LTFT (12) Off rota (2)	Sickness (5) Vacant (3) Left trust (5) LTFT (2)	Sickness (3) Vacant (1) LTFT (9) Off rota (4)	Sickness (4) Vacant (2) Left trust (7) LTFT (3)
Exception reports (ER)		8 exception reports have been submitted in this reporting period. 5 related to 'difference in educational opportunities' as a result of rota vacancies on night shifts leading to the trainee allocated to attend ALPS (for the purpose of					

	increasing emergency training experience) not being able to do so, in order to support provision of the PROC rota across LYPFT sites. There were no patient safety issues or contractual breaches, but ERs are being encouraged to allow GOSW/MEC to monitor impact of such events. 1 report related to 'difference in support available' and also related to no trainee being able to attend ALPS, as above, however in this circumstance the trainees working the shifts were not the ones allocated to attend ALPS, and therefore this did not constitute any loss of educational opportunity. Also no patient safety issues or contractual breaches. The remaining two ERs were both made by one trainee, both outside of the contractual reporting periods. One ER related to missing the 5-10pm break on a non-resident middle tier shift. The second ER related to not being able to conclude a 24 hour non resident shift at the expected time, due to needing to handover to daytime service, leading to the doctor working 4 hours beyond their contractual shift. Both of these ERs would be breaches to incur a fine. Given the submission of the ERs significantly beyond the contractual requirements, this action was not taken by the GOSW. Discussions have been held between the trainee and Post Graduate Director of Medical Education, the GOSW, and the clinical supervisor, to give trainee specific feedback. Additionally, further discussions have taken place between the GOSW, MEC, and PGDME to agree a process whereby if trainees are expecting they will not be able to take their breaks as contractually required during any on call shift, they pro-actively escalate this to the on call consultant in order to discuss and access any necessary supervision in relation to time management and prioritisation of tasks. This will also be communicated by the GOSW at junior doctor inductions moving forwards. Following ERs from 2023 submitted by Foundation Trainees, there has now been progress in relation to the LYPFT Foundation Lead and the LTHT Training Programme Director updating generic work schedules to more accurately reflect psychiatry placements within LYPFT. There remains ongoing work to clarify LTHT are collecting personalised work schedules from Foundation Doctors, although this sits within the remit of LTHT as lead employer.
Fines	None
Patient Safety Issues	None
Junior Doctor Forum (JDF)	The meeting held during the Q1 reporting period took place on 12th April 2024: - The Junior Doctor Committee updated Terms of Reference were discussed and circulated (and have subsequently been approved) - Use of annual leave to permit taking on locum night shifts was discussed, with agreement that this practice should return to ensure no unintended impact of Time Out of Training. This would be a return to pre-pandemic practice. - Two work schedules had not been returned and were being chased up by the GOSW - Rota gaps and ERs for 2023-2024 Q4 were discussed, as per previous quarterly report. - Discussions continue with Less Than Full Time (LTFT) trainees about allocation of on call shifts on non-working days. BMA advice has been requested. - High staffing vacancies at HEE were noted, with agreement that any delays or concerns should be escalated to Educational Supervisors.

	- Wellbeing in Trainee Psychiatrists document was discussed and suggestions to be fed back to Wellbeing Lead for further amendments. - The next JDF was scheduled for 19th July 2024.

3 Conclusion

Exception Reporting has now been in place within the Trust since 2016 with the first ER being made in 2017. We continue to work with the junior doctors and clinical supervisors to ensure that we are developing a culture where ERs are positively received and used as a mechanism to effect change.

4 Recommendations

The Board of Directors are asked:

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

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

Dr Rebecca Asquith
GMC 7151560
Guardian of Safe Working Hours

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

17

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chair's Report from the Workforce Committee meeting on 8 August 2024
DATE OF MEETING:	26 September 2024
PRESENTED BY: (name and title)	Zoe Burns-Shore, Non-executive Director and Chair of the Workforce Committee
PREPARED BY: (name and title)	Rose Cooper, Deputy Head of Corporate Governance

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

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

COMMITTEE DETAILS:	
Name of Committee:	**Workforce Committee**
Date of Committee:	**8 August 2024**
Chaired by:	**Zoe Burns-Shore, Non-executive Director**

KEY DISCUSSION POINTS:

ALERT – Issues to alert the Board to:

- No issues to which the Board needs to be alerted.

ADVISE – Issues to advise the Board on:

- The Committee received the Wellbeing Guardian Report and noted that NHS England had created a new voluntary role of Domestic Abuse and Sexual Violence Ally. The Committee was concerned that this would be a difficult role for someone to undertake in addition to their day job and it was agreed that a further update would be provided once the guidance had been published.

- The Committee received a summary of the findings from the Occupational Therapists workforce planning process and agreed to invite Chris Tissiman, Head of Workforce Planning at the Leeds Health and Care Academy, to a future meeting to discuss strategic workforce planning at a collaborative level and how this could be utilised within the Trust.

- The Committee received a verbal update on the Trust's response to the recent incidents of community unrest and public disorder. The Committee noted that the Trust had triggered its incident response arrangements in order to best coordinate its activities and was taking a measured and evidence-led response to the situation whilst awaiting further guidance from NHS England. The Committee was assured by the Trust's approach to maintaining staff and service user safety and supporting those affected during this difficult time.

- The Committee received an update on absence rates within the Trust in respect of the target to reduce sickness absence by 1% by the end of 2024/25 and noted progress across each of the action areas. The Committee discussed the action regarding the HR Operations team consulting with line managers to ensure a management intervention was in place for all employees whose absence flagged the need for a review indicator and asked for an update to come to a future meeting on how well this intervention was working and if managers were comfortable with the approach.

- The Committee received an overview of workforce mobilisation plans for 2024/25 and understood that the Trust must not expand its workforce and that penalties were in place for growth except when it related to the development of services and had been approved, for example the Perinatal ward expansion. The Committee discussed the projected additional recruitment of 80.5 whole time equivalent staff over 2024/25 which included the slippage activity from last financial year and noted the actions to achieve this and mitigate further slippage. The Committee was pleased to note that managers were adopting a flexible approach to filling roles using different skill mixes if required.

ASSURE – Items to provide assurance to the Board on:

- The Committee received an overview of the Intention Planning process and the commitments to support improvement in staff experience. The Committee commended the simple approach which encouraged teams to take ownership of their results and praised the People Engagement Team on their efforts to support the implementation of this across the Trust, noting the highest number of Intention Plans had been completed to date. The Committee heard that as part of the launch of the 2024 Staff Survey the team planned to share case studies to advertise the process, share learning, and showcase successes to teams across the Trust, particularly those who had yet to take up the offer.

- The Committee received the Trust's refreshed Values and Behaviours Charter and heard how it would be embedded into the employee journey and key policies and procedures. The Committee praised the Charter and provided a few areas of feedback in relation to the terminology used.

- The Committee received the Workforce Performance Report, noted that personal development reviews, clinical supervision, and mandatory training compliance had all maintained a positive position.

- The Committee received an update on the Trust's progress against the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) for 2023/24. The Committee discussed in detail the metrics where there had been unfavourable changes (3 for WRES and 1 for WDES) and heard what factors may be contributing to performance in each area, what work was ongoing to understand this further, as well as what actions were being taken. The Committee was encouraged by the favourable changes across both Standards. The Committee also received the Gender Pay Gap report for 2023/24 and noted the improved position.

- The Committee reviewed the updated 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 also considered the overall risk rating for SR3 and agreed to recommend that it was decreased from a level 16 to a level 12 risk on the basis that the appropriate mitigations were in place.

REFER – Items to be referred to other Committees:

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

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

RECOMMENDATION

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

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

AGENDA ITEM

18

PAPER TITLE:	Workforce Race and Disability Equality Standards and Gender Pay Gap Progress
DATE OF MEETING:	26th September 2024
PRESENTED BY: (name and title)	Fiona Sherburn, Associate Director People, Organisational Development and Resourcing
PREPARED BY: (name and title)	Fiona Sherburn, Associate Director People, Organisational Development and Resourcing

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

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 a summary update on Trust progress against the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) for the period 2023/24. The paper also summarises the gender pay gap report 2023/24, as reported on our Trust website.

The WRES and WDES are national standards that aim to respond to lack of progress in race and disability equality in the NHS. The data identifies areas that aim to address equality gaps and improve the workplace experience for our substantive ethnic minority and disabled colleagues.

The WRES is comprised of 9 metric areas and of these 6 of show a favourable change. However, there are areas where there has been an unfavourable change include-

- The likelihood of white staff being appointed following shortlisting has increased from 1.46 to twice as likely to be appointed.
- The likelihood of ethnically diverse staff entering the formal disciplinary process has increased from a likelihood of 0.32 to 1.93. Again, contributing factors are detailed in

the paper, including the overall reduction in the number of formal disciplinary cases, attributable to the new Disciplinary processes, which is positive.

- Percentage difference between the organisation's Board voting membership and its overall workforce (BME representation). This identifies under-representation, therefore if the number of ethnically diverse Board members remains the same, this disparity will show a year on year increase due to the year-on-year increase in workforce ethnicity representation.

The WDES is comprised of ten metrics and of these nine have shown a favourable change, which is very positive. The area where there has been unfavourable change is as follows.

- Percentage of staff satisfied with the extent to which the organisation values their work, staff survey question. There has been an unfavourable reduction of 2.5%, reducing from 49.9% in 2022 to 47.4% in the 2023 survey. This area will be explored further through discussion with the DaWN staff network to understand this further to inform action.

The Gender Pay Gap (GPG) shows the difference in the average pay gap between men and women. Our GPG reporting data for 2023/24 shows a positive year on year reduction in the median gender pay gap figure. On average women within our trust now earn 98p for every £1 that men earn when comparing median hourly pay (2.3%). In 2020/21 women earned 94p for every £1 that men earned when comparing median hourly pay (5.9%). This identifies a 3.6% reduction in the median GPG.

The GPG incudes bonus pay calculation which is based on the NHS Clinical Excellence Awards (CEA) payments and processes awarded to medical consultants within the Trust. It is positive to note that the median bonus gender pay gap has reduced to 0% indicating increased parity in terms of the distribution to both females and males. It should be noted that for this reporting period an equal distribution award round was in operation which has influenced the median GPG figure.

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

RECOMMENDATION

The Board is asked to:

- Note the 2024 WRES and WDES results.
- Receive assurance that the WRES and WDES data has been submitted in May 2024 in line with national submission requirements and will be published along with the action plan on the Trusts website by the end of September 2024 to meet statutory reporting requirements.
- Note that appropriate action plans will be developed to address areas where performance falls short of expectations.
- Note the Gender Pay Gap (GPG) figures for 2023-24 and to receive assurance that the GPG data has been submitted in-line with reporting requirements.

26th September Board Meeting
Workforce Race and Disability Equality Standards and Gender Pay Gap Progress Report

1 Executive Summary

This paper provides a summary update on Trust progress against the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) for the period 2023/24. The paper includes details of progress against current priority areas and actions. It also summarises the gender pay gap report 2023/24, as reported on our Trust website.

The WRES and WDES are national standards that aim to respond to lack of progress in race and disability equality in the NHS. The data identifies areas that aim to address equality gaps and improve the workplace experience for our substantive ethnic minority and disabled colleagues.

The WRES comprises nine metric areas and six have shown a favourable change which is positive.

However, the following areas have shown an unfavourable change.

- The likelihood of white staff being appointed following shortlisting has increased from 1.46 to twice as likely to be appointed. Contributing factors are detailed within the paper, including a large increase in the number of ethnically diverse candidates who were shortlisted in 2023/24 which can be viewed as positive and a potential result of proactive recruitment within local communities.
- The likelihood of ethnically diverse staff entering the formal disciplinary process has increased from a likelihood of 0.32 to 1.93. Again, contributing factors are detailed, including the overall reduction in the number of formal disciplinary cases, attributable to the new Disciplinary processes, which is positive.
- The percentage difference between the organisation's Board voting membership and its overall workforce (BME representation) shows an under-representation. Although the number of BME staff on the board remains the same there has been a year-on-year increase in workforce ethnicity representation.

The WDES is comprised of 10 metrics, with nine of these have shown a favourable change, which is very positive. The area where there has been unfavourable change is as follows: -

- Percentage of staff satisfied with the extent to which the organisation values their work, staff survey question. There has been an unfavourable reduction of 2.5%, reducing from 49.9% in 2022 to 47.4% in the 2023 survey. This area will be explored further through discussion with the DaWN staff network to understand this further to inform action.

The Gender Pay Gap (GPG) shows the difference in the average pay gap between men and women. Our GPG reporting data for 2023/24 shows a positive year on year reduction in the median gender pay gap figure. On average women within our Trust now earn 98p for every £1 that men earn when comparing median hourly pay (2.3%). In 2020/21 women earned 94p for every £1 that men earned when comparing median hourly pay (5.9%). This identifies a 3.6% reduction in the median GPG.

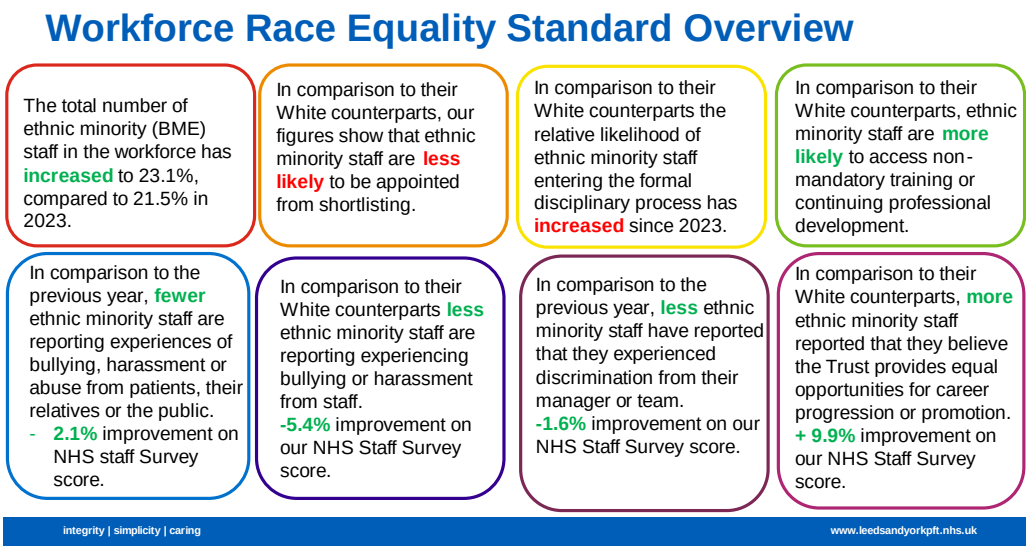
The GPG incudes bonus pay calculation which is based on the NHS Clinical Excellence Awards (CEA) payments and processes awarded to medical consultants within the Trust. It is positive to note that the median bonus gender pay gap has reduced to 0% indicating increased parity in terms of the distribution to both females and males. It should be noted that for this reporting period an equal distribution award round was in operation which has influenced the median GPG figure.

2 WRES and WDES Performance Overview

2.1 WRES

The WRES is comprised of nine metric areas and a summary overview is provided below along with the Trust's Workforce Race Equality Data.

Table 1 Trust's Workforce Race Equality Data



A total of six out of the nine WRES standard metrics have shown favourable change from last year and full details are set out below.

Metric 1

Percentage of staff in Agenda for Change pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

The 2024 data shows that 23% of our workforce (excluding bank) are from an ethnic minority background. An increase of 1.6% when compared to 2023. This is above the current 2021 Census figures for Leeds which identifies that 21% of the population are from an ethnic minority background.

"Relative Likelihood" WRES Metrics Two, Three and Four

The following three metrics indicate the likelihood of ethnically diverse (BME) candidates being appointed from shortlisting, staff entering a formal disciplinary process and staff accessing non mandatory training. A figure of 1.0 suggests an equal position, however the calculation of this data can be affected by small numbers.

Table 2

WRES Metric	Metric Description	2023 Score	2024 Score
2	Relative likelihood of white staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts.	1.46	2.00

Table 2 identifies an unfavourable change in the likelihood of white staff being appointed from shortlisting compared to ethnically diverse staff. The ratio figure for 2024 indicates white staff being twice as likely to be appointed from shortlisting.

There has been a large increase in the number of BME applicants (731) who have reached the shortlisting stage when compared to data from 2023, which in itself is positive. Potential reasons for this increase include focused recruitment activity such as, jobs fairs targeting areas with diverse populations and other activity as part of our widening participation work. However, there is clearly more work to do to understand why this increase in short-listing of BME applicants is not leading to more BME applicants being appointed.

In 2023/24 there was a total of 1012 appointments (excluding bank), where ethnicity was known. Of this total 29.5% of staff appointed were ethnically diverse and 70.5% were white. This is above the ethnicity representation of our overall workforce at 23%.

Table 3

WRES Metric	Metric Description	2023 Score	2024 Score
3	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff.	0.32	1.93

There has been an unfavourable change in the likelihood of ethnically diverse staff entering the formal disciplinary process. During 2023/24 there were a total of sixteen people entering the formal disciplinary process, with six of these being ethnically diverse staff.

It should be noted that overall, there was a reduction in case numbers, which totalled twenty-five in 2022/23, and this indicates a positive step in shifting the focus on incidents to one which focuses on learning and reflection than being punitive.

The new Disciplinary policy, including the early Decision-Making Group (DMG) process has been well embedded in the period in question and is likely to be a major factor in the reduced number of formal disciplinary cases. However the number of BME staff entering a process should not be ignored and further work is required to assess the impact of the DMG in helping to change the culture around the disciplinary process for all staff.

Cultural Inclusion Ambassadors are now included in all DMGs regardless of the nature of the allegations or the ethnicity of the person of the DMG. This is to ensure that bias is not introduced to the process (even if unconsciously) at that point.

Table 4

WRES Metric	Metric Description	2023 Score	2024 Score
4	Relative likelihood of white staff accessing non-mandatory training or CPD	0.93	0.88

The likelihood figure continues to show that ethnically diverse staff are more likely to access non-mandatory training or CPD at 61.3%. This is postive and reflects the continued focus across the Trust to develop and deliver relevant training and CPD to support our diverse workforce. Career development sessions are an example of this, which have been developed through discussion with the Equality and Diversity team and our staff networks to inform the focus and content.

Metrics 5 to 8 Staff Survey Responces

All four of the national staff survey WRES metric areas showing a favourable change, as detailed in Table 5 below.

Table 5

WRES Staff Survey Metrics % Staff- All Ethnic Groups	2021	2022	2023	Year on Year Change		Against Sector Average	
% experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	37.9 %	35.8 %	33.7 %	-2.1%	Favourable	31.4 %	Worse
% experiencing harassment, bullying or abuse from staff in the last 12 months	22.8 %	22.5 %	17.1 %	-5.5%	Significantly favourable	21.0 %	Better
WRES Staff Survey Metrics % Staff- All Ethnic Groups	**2021**	**2022**	**2023**	**Year on Year Change**		**Against Sector Average**	
% believing that the organisation provides equal opportunities for career progression or promotion	42.7 %	42.0 %	51.9 %	9.9%	Significantly favourable	50.5 %	Better
% experiencing discrimination at work from manager/team	13.3 %	11.8 %	10.2 %	-1.6%	Favourable	13.9 %	Better

leader or other colleaugues in the last 12 months							

All four WRES metric areas have shown improvement, with two showing significantly favourable improvement.

We have had significantly favourable change in both percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months and percentage of staff believing that there are equal opportunities for career progression or promotion.

One measure is below our sector average, the question relating to experience of bullying and harassment from patients, relatives or friends.This area continues to be a priority within our People Plan actions with focus on developing timely support and reporting processes for staff experiencing these behaviours.

Table 6

WRES Metric	Metric Description	2023 Score	2024 Score
9	Percentage difference between the organisation's Board voting membership and its overall workforce (BME representation).	-4.8%	-7.7%

Table 6 compares the difference between the Board voting membership and our overall ethnically diverse workforce. The ethnicity representation in our workforce has increased year on year. If this trend continues and the the number of ethnically diverse voting members of the Board remains the same, the disparity will show a year on year increase. The recruitment of a more diverse board is something that will need to be considered as Board members step down.

2.2 WDES

The WDES is comprised of ten metric areas.

Metric 1

This metric looks at the percentage of staff in Agenda for Change pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

The 2024 data shows that 10.4% of our workforce (excluding bank) have a disability or long-term health condition. This is an increase of 2.9% when compared to 2023.

"Relative Likelihood" WDES Metrics Two and Three

Table 7

WDES Metric	Metric Description	2023 Score	2024 Score
2	Relative likelihood of non-Disabled staff being appointed from shortlisting compared to that of	0.87	0.92

	Disabled staff being appointed from shortlisting across all posts.		

The probability figure continues to show that Disabled staff are more likely to be appointed from shortlisting compared to non-disabled staff.

In 2023/24 there were a total of 1002 appointments where Disability status was known. Of this total 11.9% were Disabled, this is above the disability representation of our overall workforce at 10.4%.

Table 8

WDES Metric	Metric Description	2023 Score	2024 score
3	Relative likelihood of Disabled staff entering the formal capability process compared to non-Disabled staff.	0	0

This metric is based on data from a two-year rolling average (2022/23 and 2023/24). During this period there were no Disabled and 2 non-Disabled staff entering the formal capability process on the grounds of performance.

Metrics 4 to 8 Staff Survey Responses

Seven out of the eight national staff survey WDES metric areas show a favourable change, as detailed in Table 9 below. With one area showing a significantly favourable change for the percentage of staff with a Long Term Condition or illness experiencing bullying, harrasment or abuse from patients, relatives, or the public in the last twelve months.

The extent to which staff with a Long Term Condition or illness are satisfied with the extent to which our organisation values their work shows an unfavourable reduction of -2.5%. Data is being shared with teams and services to inform their staff and to gather member views in relation to potential improvement actions and areas of planning at team level to inform staff survey intention plans. Discussion has been taken to the DaWN staff network in May, to share the findings with them and to identify improvement actions.

Table 9

WDES Staff Survey Metrics % Staff with a Long-Term Condition (LTC) or illlness	2021	2022	2023	Year on Year Change		Against Sector Average	
% experiencing harassment,bullying or abuse from patients, relatives or the public in the last 12 months	31.2 %	30.9 %	25.7 %	-5.2%	Significantly Favourable	28.9 %	Better
% experiencing harassment, bullying or abuse from staff in the last 12 months	12.2 %	9.6%	8.7%	-0.9%	Favourable	11.9 %	Better

% experiencing harassment,bullying or abuse from colleaugues in the last 12 months	22.3 %	19.7 %	17.2 %	-2.5%	Favourable	18.9 %	Better
% sayingthe last time that they experienced arassment bullying or abuse at work, they or a colleaugue reported it	66.9 %	59.4 %	61.2 %	1.8%	Favourable	59.9 %	Better
% believing that the organisation provides equal opportunities for career progression or promotion	50.0 %	57.4 %	59.3 %	1.9%	Favourable	56.7 %	Better
% who felt pressure from their manager to come to work when not feeling well enough to work	17.0 %	16.2 %	14.9 %	-1.4%	Favourable	19.4 %	Better
% satisfied with the extent to which their organisation values their work	41.5 %	49.9 %	47.4 %	-2.5%	Unfavourable	45.4 %	Better
% saying their employer has made reasonable adjustments to enable them to carry our their work	N/A	83.5 %	86.5 %	3.0%	Favourable	79.3 %	Better

Metric 9

This focuses on the staff engagment score which is based on three sub themes within the staff survey; motivation, involvement and advocacy.Overall the Trust engagement score is 7.14.

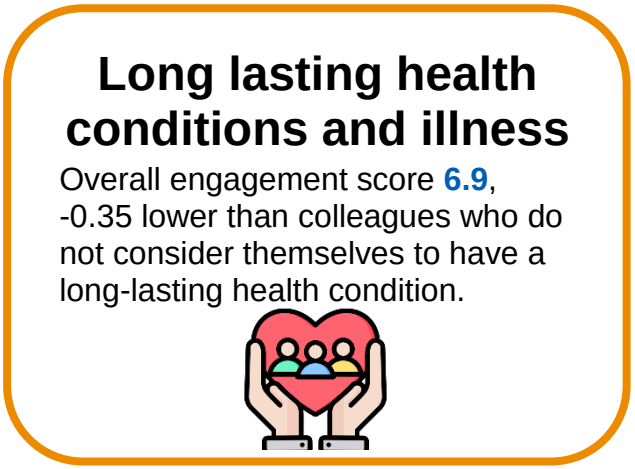


Table 10

WRES Metric	Metric Description	2023 Score	2024 Score
10	Percentage difference between the organisation's Board voting membership and its overall workforce (Disabled representation).	6%	6.6%%

This metric compares the difference between the Board voting membership and our overall Disabled workforce. The data positively identifies that our voting Board membership is over representative of our Disabled workforce by 6.6%.

3. Next Steps Progress

Our WRES and WDES data identify improvement areas and areas where further focus is required to improve the experience of our ethnically diverse and Disabled workforce. Areas of focus include.

- **Staff network development** – continue the effective growth of our EDI staff networks as an essential source of knowledge and peer support.

- **Cultural Inclusion Ambassadors (CIA)** – expand and further develop our CIA programme with communication and engagement to encourage our next cohort of CIA's is underway, with the aim of training up a further cohort of CIA's, who will support recruitment panels and decision-making groups, within our disciplinary process. Their role is to identify and explore issues of culture and conscious or unconscious bias.

- **Recruitment Practice** – continue our Trust wide values based and inclusive recruitment workstream programme of work. This is ongoing significant phased work, with our Recruitment Manager and the Head of Strategic Resourcing. Delivery actions also include a 12-month programme of career development sessions to build skills, confidence, and awareness of opportunities. Undertake a deeper dive to better understand why BME staff who are shortlisted are not then offered the post so that appropriate actions can be developed.

- **Cultural Competence Training** – a number of staff have been trained to deliver cultural competence training and a plan is being developed to roll this training out across the Trust – with a focus on hotspot areas.

4 Gender Pay Gap

The Equality Act 2017 Regulations require all organisations that employ more than 250 staff to publish their gender pay gap (GPG) information annually.

Data for 2023/2024 GPG reporting period has been submitted in line with reporting requirements. A summary of the results for Leeds and York Partnership Foundation Trust can be found on the Government's gender pay gap web pages.

The GPG differs from equal pay in the following way. Equal pay deals with pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman. The gender pay gap shows the differences in the average pay gap between men and women.

Table 11

GPG Reporting Period	2020/2021	2021/2022	2022/2023	2023/24
Average Gender Pay Gap- MEAN	11.4%	10.9%	10.3%	10.5%
Average Gender Pay Gap- MEDIAN	5.9%	5.3%	3.1%	2.3%

Median Gender Pay

Our latest data indicates a substantial positive year on year reduction in the median gender pay gap figure as detailed in Table 11 above. On average women within our Trust now earn 98p for every £1 that men earn when comparing median hourly pay (2.3%).

In 2020/2021 women earned 94p for every £1 that men earned when comparing median hourly pay (5.9%). This identifies a 3.6% reduction in the median GPG.

Mean Gender Pay

Our latest mean (average) gender pay figure indicates a slight negative increase of 0.2% when compared to 2022/2023 data. When comparing the data detailed in Table 11, it shows less than a 1% reduction in the mean GPG over the four-year data period.

It should be noted that although utilising mean averages are useful, that very high or low hourly pay figures can substantially influence and distort the overall figure as detailed in the section below.

Gender Pay Quartile Profile

Table 12 below shows the percentage of females in each pay quartile. The lower quartile represents the lowest salaries in the Trust and the upper quartile represents the highest salaries. The Trust employs more women than men in every quartile. 77.5% of females are employed in the lower quartile, compared to 67.1% in the upper quartile, a 10.4% difference which research has identified can have a negative effect particularly on the mean gender pay gap figure.

Quartile	2020/2021	2021/2022	2022/2023	2023/24
1 Lower Quartile	74.3%	65.5%	74.4	77.5%

2. Lower middle quartile	72.4%	74.2%	72.5%	69.1%
3. Upper middle quartile	73.9%	73.4%	73%	72.9%
4. Upper quartile	66%	74.2%	66.2%	67.1%

Table 12

Bonus Gender Pay Gap

Table 13

Bonus GPG Reporting Period	2020/2021	2021/2022	2022/2023	2023/2024
Average Bonus Gender Pay Gap- MEAN	33%	20.3%	15.7%	16.8%
Average Bonus Gender Pay Gap- MEDIAN	66%	37.5%	36.8%	0%

The bonus pay calculation is based on the NHS Clinical Excellence Awards (CEA) payments and processes awarded to medical consultants within the Trust. Table 13 above highlights the mean and median bonus pay linked to clinical excellence awards.

Median Bonus Gender Pay Gap

It is positive to note that the median bonus gender pay gap has reduced to 0% indicating increased parity in terms of the distribution to both females and males. It should be noted that for this reporting period an equal distribution award round was in operation which has influenced the median GPG figure.

Mean Bonus Gender Pay Gap

The latest mean bonus data identifies a small increase of 1.1% in the bonus gender pay gap. There continue to be several historic CEA awards which are recurrently paid each year. These will influence and may account for this identified increase.

Further work will be undertaken to better understand the reasons for differences in gender pay. This will include analysis by pay band and staff group to identify areas of the organisation where the pay gap is higher and lower than the Trust average so we can target interventions to reduce our overall pay gaps over time.

5 Governance and Assurance

The Trust's WRES and WDES data was submitted in line with reporting requirements i.e. by 31 May 2024 and the data and revised action plan published in September on the Trust's website as per national reporting requirements.

This report was also received by the Workforce Committee on 8th August 2024.

The data will be shared with the staff networks, who have played a key role in contributing to our improvement actions, as well as the Equality, Diversity and Inclusion, Civility and Respect and Strategic Resourcing groups, to ensure that this data feeds into their planning process for improvements.

Full annual data on progress against our WRES and WDES and details of achievements against our improvement actions and future priorities was resented to the People Experience Group in July 2024 as part of the annual Equality and Diversity report.

Work is now underway to develop a reporting framework on the ethnicity pay gap in line with national requirements and further information about this will be provided to the Board when we are clear about the expectations and reporting requirements.

6 Recommendations

The Board is asked to:

- Note the 2024 WRES and WDES results.
- Receive assurance that the WRES and WDES data was submitted in May 2024 in line with submission requirements and that actions published on the Trust website in September 2024 to meet statutory reporting requirements.
- Note the Gender Pay Gap (GPG) figures for 2023-24 and to receive assurance that the GPG data was submitted in line with reporting requirements.

Fiona Sherburn
Associate Director OD and Resourcing
September 2024

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
19

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chair's Report from the Mental Health Legislation Committee meeting on 12 September 2024
DATE OF MEETING:	26 September 2024
PRESENTED BY: (name and title)	Katy Wilburn, Non-executive Director
PREPARED BY: (name and title)	Kieran Betts, Corporate Governance Officer

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

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:	**12 September 2024**
Chaired by:	**Katy Wilburn, Non-executive Director**

KEY DISCUSSION POINTS:

ALERT - Issues to alert the Board to:

- No issues to which the Board needs to be alerted.

ADVISE - Issues to advise the Board on:

- The Committee received an interim report on the availability of section 12 doctors. It was assured that there were a sufficient number of section 12 approved doctors in the Trust. It agreed that it would await a full report on this area so it could better understand why there was a historical lack of availability of doctors to conduct section 12 assessments, whether this issue persisted, and to continue to monitor developments in this area.

- The Committee noted the Hospital Discharge and Community Support Statutory Guidance issued by NHS England and discussed the potential impact of this guidance, in particular, the gap in commissioned services which permitted the discharge of homeless service users into appropriate accommodation in the community. It agreed to highlight this report to a number of internal and external groups and monitor developments in this area.

ASSURE – Items to provide assurance to the Board on:

- The Committee noted that the length of time each service user had been detained to a Section 136 “flex-bed” would be included in the Mental Health Legislation Activity Report going forward so that this issue could be monitored by the Committee.

- The Committee was reassured that any gaps between the services provided by the Trust and local police forces was being monitored through the “Right Care, Right Service” escalation process. It also noted that the Trust was conducting a review of its own internal processes, such as the absence without leave procedure, to ensure that police forces were only contacted when relevant.

- The Committee received the Mental Health Legislation Activity Report for Q1 2024-25 and was assured the plans in place were sufficient to ensure ongoing compliance with all mental health legislation. It was assured that the results of a full audit of the mental health legislation casework had demonstrated that the procedures and processes implemented by the Trust were working as intended.

- The Committee received the representation at MHAMs hearings report and was reassured that service users were adequately informed and supported pre and post hearing, and that had access to a mental health advocate at hearings where it was agreed to be appropriate.

REFER - Items to be referred to other Committees:

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

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

RECOMMENDATION

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

Escalation and Assurance Report

Report from: West Yorkshire (WY) Integrated Care System (ICS) Mental Health, Learning Disability & Autism (MHLDA) Committee-in-Common
Date of the meeting: 31/07/2024

Key discussion points and matters to be escalated from the discussion at the meeting:
Alert/Action:
• Challenges continue to be felt across the CYP Provider Collaborative and in Adult Secure Services, particularly regarding the complexity of patients being referred into the services and resulting financial pressures due to increased use of out of area placements.
Advise:
• Discussions continue with ICB finance in relation to 24/25 SDF funding and whether uncommitted funding for Inpatient Quality, Individual Placement & Support (IPS) and Learning Disabilities will be released this year or used to support ICB financial balance. • Trust Directors of Finance are working together with the ICB to define the scope of any joint efficiency & productivity reviews, building on work started in the Acute Sector through WYAAT • The Committee discussed some of the potential risks regarding the Perinatal Mental Health Collaborative (led by LYPFT) going live in October and recommended the use of the Collaborative Leadership to raise concerns with NHSE if needed.
Assure:
• Maternal Mental Health Service – this is now operational from the 1st July, led via SWYPFT. Although this service is being introduced in phases referrals have been taken from the go live date. • The group discussed some of the highlights from the Kings Speech relating to the reform of the Mental Health Act, and the opportunities to consider collaborative working in our response to its implementation. • There was discussion relating to the care of a young person, whose care crossed physical and mental health services in Leeds and ultimately required joint working across the collaborative and ICB to agree a support package. Lots of learning was shared for both Leeds place and collaborative partners including how recommendations could be built into standard models of development for clinical teams and used as a training program to improve service delivery across all areas.

Report completed by: Keir Shillaker, WY MHLDA Programme Director **Date:** 09/09/2024

Distribution: Chairs and Company Secretaries of Bradford District Care NHS Foundation Trust, Leeds Community Healthcare NHS Trust, Leeds & York Partnership NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust.

Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

AGENDA ITEM

21

PAPER TITLE:	Terms of Reference for the Board of Directors
DATE OF MEETING:	26 September 2024
PRESENTED BY: (name and title)	Merran McRae, Chair
PREPARED BY: (name and title)	Clare Edwards, Associate Director for Corporate Governance

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

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

Following discussion at the Board of Directors meeting on 25 July 2024, it was agreed that the Executive Management Team (EMT) would review the proposed additional wording to the Terms of Reference for the Board of Directors in relation to the Board responsibility for the Board Assurance Framework.

At the EMT meeting on 18 September 2024, it was agreed that the following wording was appropriate:

1) Ensure the Trust has adequate and effective governance and risk management systems in place, including responsibility and oversight of the Board Assurance Framework

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

RECOMMENDATION

The Board is asked to review and ratify the revised Terms of Reference.

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Board of Directors

Terms of Reference

(To be approved by the Board of Directors on 26 September 2024)

.

The Trust has Standing Orders for the practice and procedures of the Board of Directors (Annex 8 of the Constitution). For the avoidance of doubt, those Standing Orders take precedence over these Terms of Reference, which do not form part of the Trust's Constitution.

1 NAME

Board of Directors

2 COMPOSITION OF THE BOARD

The membership of the Board of Directors is determined in accordance with Section 19 of the Trust's Constitution and shall comprise both executive and non-executive directors acting as a unitary Board.

Members

Composition
A non-executive chair
A minimum of 4 and a maximum of 6 other non-executive directors
A minimum of 4 and a maximum of 6 executive directors

The above shall be considered as the composition of the Board, provided at least half the Board excluding the Chair of the Trust comprises non-executive directors who have been determined by the Board to be independent.

For clarity the executive directors who are members of the Board of Directors are:

- Chief Executive
- Chief Financial Officer
- Medical Director
- Director of Nursing and Professions
- Chief Operating Officer
- Director of People and Organisational Development

All members of the Board of Directors shall have one full vote each, with the chair having a second or casting vote should the need arise.

The Board of Directors will appoint one of the independent non-executive directors to be the Senior Independent Director. In consultation with the Chair of the Trust, the Council of Governors will also appoint one of the non-executive directors to be the Deputy Chair of the Trust.

Members of the Board of Directors must ensure that wherever possible they attend every Board meeting (including extraordinary Board meetings when convened). An explanation of non-attendance should be made to the Chair of the Trust. Attendance at meetings will be monitored by the Associate Director for Corporate Governance and shall be reported to the Chair of the Trust and the Council of Governors on a regular basis. Attendance will also be reported annually in the Annual Report.

The Board may invite non-members to attend its meetings on an ad-hoc basis, where it considers this to be necessary and appropriate, and this will be at the discretion of the Chair.

In attendance

Title	Role in the Board	Attendance guide
Associate Director for Corporate Governance	Shall be the Board Secretary, attending all meetings of the Board of Directors and providing appropriate advice and support to the Chair and Board members. This will include ensuring agreement of the agenda with the Chair, collation of papers, taking minutes and keeping proper records of the meeting including any actions to be carried forward. It shall also include the preparation of those corporate governance papers pertaining to the Board of Directors.	Every meeting

In the absence of the Associate Director for Corporate Governance the Deputy Trust Board Secretary will deputise.

2.1 Governor Observers

The role of the governor at public Board of Directors' meetings is to observe, rather than to be part of its work. They are not part of the formal membership of the Board, nor are they classed as in attendance. Governors are invited to observe the Board meetings to get a better understanding of the work of the Trust and to observe non-executive directors appropriately challenging the executive directors for the operational performance of the Trust.

At the meeting the governor observer will be required to declare any interest they may have in respect of any of the items to be discussed (even-though they are not formally part of the discussion). Governors will receive an electronic copy of the public Board papers prior to the meeting. Governor observers will be invited to the public meetings only, by the Corporate Governance Team.

2.2 Associate Non-executive Directors

Associate Non-executive Directors will be invited to attend Board of Directors' meetings (both public and private meetings) as part of their induction. They will be in attendance at the meeting, in the capacity of observer only, unless invited to contribute (in exceptional circumstances) by the Chair. This is so the integrity of the unitary Board and the accountability of the substantive members of the Board is maintained.

Associate NEDs will be invited to the public and private meetings by the Corporate Governance Team and will be sent copies of all Board papers.

3 QUORACY

Number: No business shall be transacted at a meeting of the Board of Directors unless at least one third of the whole number of the members of the Board is present, including at least one executive director and one non-executive director.

Deputies: Where, exceptionally, an executive director is absent from a meeting they may not normally send a deputy in their place. However, attendance to cover absences will be at the discretion of the chair and will be agreed in order to ensure the Board has access to appropriate advice and information. In these circumstances the deputy attending will not have any voting rights and will be recorded as in attendance. Where there are formal acting up arrangements in place the person acting-up into an executive director role may attend and will assume the voting rights of the director they are acting up for. In such circumstances they will be recorded as a member of the Board.

.

Non-quorate meetings: Non-quorate meetings may go forward unless the chair decides otherwise. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

4 MEETINGS OF THE BOARD

All meetings shall be held in public except where matters are deemed confidential on the grounds of commercial sensitivity, personal issues or matters that could cause harm to individuals by the nature of their content. Such matters will be discussed in a separate closed session which will not be attended by members of the public. Any person attending the private Board meeting will be at the discretion of the Chair. Meetings may be held face-to-face or remotely as is considered appropriate.

Remote meetings may involve the use of the telephone and / or electronic conference facilities.

A full set of papers comprising the agenda, minutes and associated reports and papers will be sent to all directors within the timescale set out in Standing Order 3.3.1 in Annex 8 of the Constitution (or as agreed by the Chair).

Copies of the public and private agendas will be sent to members of the Council of Governors prior to any meeting.

The public agenda papers and minutes of each public meeting shall be displayed on the Trust's website.

Frequency: Meetings of the Board of Directors shall be held at such times as the Board may determine. The frequency of meetings shall be agreed by the Board of Directors and will normally be bi-monthly (excluding August and December). The Board may agree to vary that frequency. This shall not preclude urgent meetings being convened at any time in accordance with Standing Order 3.2 in Annex 8 of the Constitution.

The Board has also agreed to hold Strategic Discussion meetings which will normally be scheduled in the months between the formal Board meetings (excluding August). These meetings will be used as protected time to discuss in greater detail matters that may emerge from the formal meetings as well as those which will further inform the work of the Board. Holding a strategic discussion session does not preclude any part of this meeting being constituted as an urgent meeting should the need arise.

Urgent meetings: Urgent meetings shall be convened in accordance with Standing Order 3.2 in Annex 8 of the Constitution.

Minutes: The Associate Director for Corporate Governance, acting in the capacity as Trust Board Secretary shall take the minutes. They will ensure these are presented to the next full business meeting of the Board of Directors for agreement. Minutes may be held either electronically or in paper format but always in a way that is accessible and preserves the continuous record of the meeting.

5 AUTHORITY

The Trust is required to establish a Board of Directors in accordance with the NHS Act 2006 (as may be amended by the H&SC Act 2012), and paragraph 21 of the Trust's Constitution. All members of the Board shall act collectively as a unitary Board with each member having equal liability.

6 ROLE OF THE BOARD OF DIRECTORS

6.1 Purpose of the Board of Directors

The principle purpose of the Trust is the provision of goods and services for the purposes of the health service in England. The purpose of the Board is to ensure the provision of those health services it is commissioned to provide; that these are delivered in line with its strategy; that services are safe and effective and are provided to a high quality; to provide leadership and direction to the organisation; and to ensure it is governed effectively with appropriate systems processes and procedures in place.

The Board will achieve this by:

- Setting and overseeing the strategic direction of the organisation within the overall policies and priorities of the Government, the Trust's regulators, and its commissioners, having taken account of the views of the Trust's members (through the Council of Governors), and the wider community
- Ensuring accountability by holding the organisation to account for the delivery of the strategy; and through seeking assurance that systems of control are robust and reliable
- Shaping a positive culture for the organisation
- Being assured on the work of the executive directors
- Taking those decisions that it has reserved to itself.

The Trust has a Board, made up of executive and non-executive directors, which exercises all the powers of the Trust (as the entity) on its behalf, but the Board may delegate any of those powers to a sub-committee of the Board (made up of directors) or to an executive director. (Arrangements for the reservation and delegation of powers are set out in the Reservation of Powers to the Board of Directors and Council of Governors and Schedule of Decisions/Duties Delegated by the Board of Directors (known as the Scheme of Delegation) and the Terms of Reference of its sub-committees.

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

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

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

6.3 Duties of the Board of Directors

The duties set out below shall not preclude the Board of Directors from reserving powers and duties to itself. These powers and duties shall be set out in the Scheme of Delegation, and, for the avoidance of doubt, where there is a conflict the Scheme of Delegation will take precedence over these Terms of Reference.

The duties of the Board of Directors are to:

- Set the values and strategic direction of the Trust; and ensure the Trust's Strategy and any supporting strategic plans are reviewed as necessary

- Provide leadership to the Trust to promote the achievement of the Trust's 'Principal Purpose' as set out in the Constitution (i.e. the provision of goods and services for the purposes of health services in England), ensuring at all times that it operates in accordance with the Constitution and the conditions of the license as issued by NHS England

- Engage as appropriate with the Trust's membership through the Council of Governors

- Promote and develop appropriate partnerships with other organisations in accordance with the Trust's values and strategic direction

- Oversee the implementation and achievement of the Trust's strategic objectives

- Agree the Trust's Operational Plan

- Ensure the Trust has adequate and effective governance and risk management systems in place, including responsibility and oversight of the Board Assurance Framework

- Monitor the performance of the Trust and ensure the executive directors manage the Trust within the resources available in such a way as to:

    - Ensure the safety of service users and the delivery of high-quality care
    - Ensure the continuous improvement of services
    - Protect the health and safety of service users, employees, visitors and all others to whom the Trust owes a duty of care
    - Make effective and efficient use of the Trust's resources
    - Comply with all relevant regulatory and legal requirements
    - Maintain high standards of ethical behaviour, corporate governance and personal conduct in the business of the Trust
    - Maintain the high reputation of the Trust both with reference to local system and place stakeholders, and the wider community.

- Receive and consider high-level reports on matters material to the Trust detailing in particular, information and action with respect to:

    - Service user and carer experience
    - Clinical quality including safety
    - Performance, including performance against targets and contracts
    - Human resource matters
    - The identification and management of risk
    - Financial performance
    - Matters pertaining to the reputation of the Trust.

- Promote teaching, training, research and innovation in healthcare to a degree commensurate with the Trust's teaching status

- Review and approve any declarations/compliance statements to regulatory bodies prior to their submission

- Review and adopt the Trust's Annual Report and Accounts

- Act as corporate trustee for the Leeds and York Partnership NHS Foundation Trust Charitable Trust Funds.

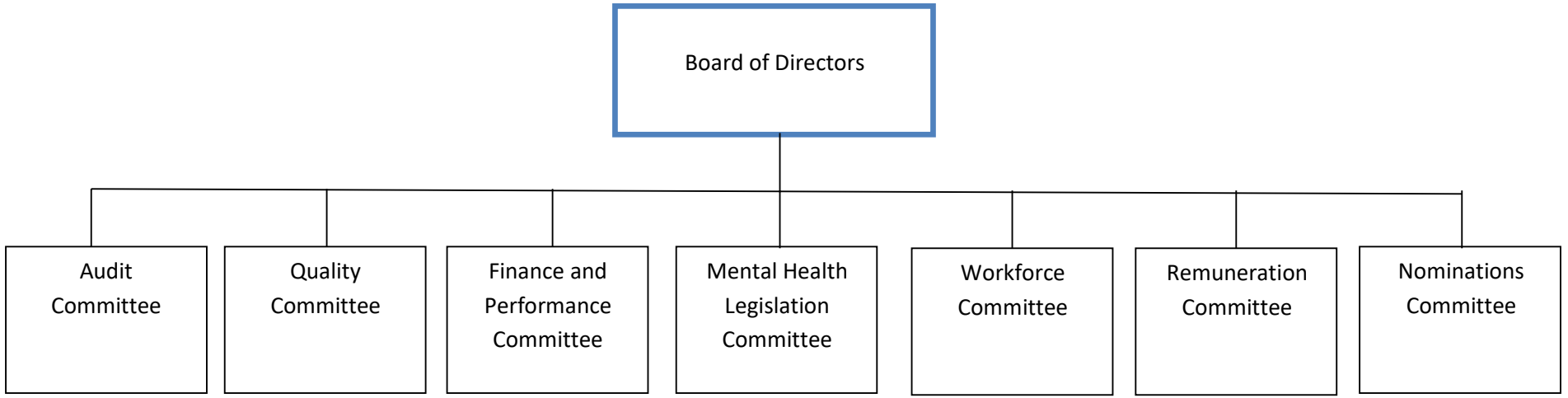
7 RELATIONSHIP WITH OTHER GROUPS AND COMMITTEES

The Board of Directors may delegate powers to formally constituted sub-committees (whose membership is made up of directors). Without prejudicing the formation of any other sub-committee the Board has formally constituted the following:

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

The Executive Team will support the Chief Executive in the implementation of the Board's decisions and will facilitate the efficient and effective working of the Board of Directors by considering and responding to those matters referred to it.

The Board of Directors' reporting structure is detailed below.


Board of Directors
Audit Committee
Quality Committee
Finance and Performance Committee
Mental Health Legislation Committee
Workforce Committee
Remuneration Committee
Nominations Committee

8 DUTIES OF THE CHAIR

The Chair of the Board of Directors shall be the Chair of the Trust. In the absence of the Chair of the Trust, (or in the event of them declaring a conflict of interest in an agenda item) the Deputy Chair shall chair the meeting. Should the Deputy Chair not be available (or where they too have also declared a conflict of interest in an agenda item), the meeting shall be chaired by one of the other independent non-executive directors.

The chair of the Board shall be responsible for:

- Providing leadership to the Board of Directors
- Enabling directors to make a full contribution to the affairs of the Board of Directors ensuring that the Board acts as a cohesive team
- Ensuring the key appropriate issues are discussed by the Board of Directors in a timely manner
- Ensuring the Board of Directors has adequate support and necessary data on which to base informed decisions and monitor that such decisions are implemented
- Providing a conduit between the Council of Governors and the Board of Directors
- Agreeing the agenda with the Associate Director for Corporate Governance
- Directing the conduct of the meeting ensuring it operates in accordance with the Trust's values
- Giving direction to the minute taker
- Ensuring all attendees have an opportunity to contribute to the discussion
- Ensuring the agenda is balanced and discussions are productive, and when they are not productive they are efficiently brought to a conclusion
- Checking the minutes.

In the event of there being a dispute between any 'groups' in the hierarchy (in the case of the Board, this would be between the Board and its the sub-committee committee/s it will be for the chairs of those 'groups' to ensure there is an agreed process for resolution; that the dispute is reported back to the 'groups' concerned; and that when a resolution is proposed the outcome this is also reported back to the 'groups' concerned for agreement.

In the event of their being a dispute between the Board of Directors and the Council of Governors, a dispute resolution process is set out in the Trust's Constitution.

9 REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

The Terms of Reference shall be reviewed and ratified at least annually by the Board of Directors.

In addition to this the Board of Directors must also carry out an assessment at least annually of how effectively it is carrying out its duties and act on any improvements agreed.