Leeds and York Partnership
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS
will be held at 9.30 am on Thursday 28 March 2019
in Think@ Room, Horizon Leeds (3rd Floor), 2 Brewery Wharf, Kendell Street, Leeds, LS10 1JR

A G E N D A

Members of the public are welcome to attend the Board meeting, which is a meeting in public not a public meeting. If there are any questions from governors, service users, members of staff or the public please could they advise the Chair or the Associate Director for Corporate Governance in advance of the meeting (contact details are at the end of the agenda). *

Please help the Trust in our initiative to be more paper light. At our Board meetings we will provide copies of the public agenda but we will not have full printed packs of the Board papers available. If you intend to come to the meeting but are unable to access the papers electronically the please contact us at corporategovernance.lypft@nhs.net to request a printed copy of the pack and we will bring this for you to the meeting.

		LEAD
1	**Sharing Stories – Robert Baskind: Consultant Psychiatrist and Clinical Lead for Leeds Adult ADHD service** (verbal)	
2	**Apologies for absence** (verbal)	**SP**
3	**Declaration of interests for directors and any declared conflicts of interest in respect of agenda items** (enclosure)	**SP**
4	**Minutes of the previous meeting held on 28 February 2019** (enclosure)	**SP**
5	**Matters arising**	
6	**Actions outstanding from the public meetings of the Board of Directors** (enclosure)	**SP**
7	**Chief Executive's Report** (enclosure)	**SM**
PATIENT CENTRED CARE		
8	**Report from the Chair of the Quality Committee for the meeting held on 12 March 2019** (enclosure)	**JB**

9	**Report from the Chair of the Mental Health Legislation Committee for the meeting held on 21 March 2019** (verbal)	**MS**
	9.1 Changes to the remuneration of the Mental Health Act Managers (enclosure)	**MS**
10	**Report from the Chair of the Finance and Performance Committee for the meeting held on 26 March 2019** (verbal)	**SW**
11	**Report from the Chair of the joint extraordinary Finance and Performance and Quality Committee meeting held on 26 March 2019** (verbal)	**SW**
12	**Combined Quality and Performance Report** (enclosure)	**JFA**
13	**Guardian of Safe-working Quarterly Report – Quarter 3** (enclosure)	**CK**
14	**Report from the Medical Director** (enclosure)	**CK**
15	**Mortality Review: Learning from deaths** (enclosure)	**CK**
16	**Report from the Director of Nursing, Professions and Quality** (enclosure)	**CW**
17	**Safer staffing report** (enclosure)	**CW**
WORKFORCE		
18	**Workforce and organisational development report** (enclosure)	**CH**
USE OF RESOURCES		
19	**Report from the Chief Financial Officer** (enclosure)	**DH**
GOVERNANCE		
20	**Approval of the Data Security and Protection Toolkit** (enclosure)	**DH**
21	**Freedom to Speak up Board action plan and strategic policy** (enclosure)	**SM**
22	**Annual Declarations of Interest, Non-executive Directors' Independence, and Fit and Proper Person declarations** (enclosure)	**CHill**
23	**Leeds Providers Integrated Committees in Common (LPICC) Programme Directors' Report** (enclosure)	**SP**

24	**Use of the Trust's seal** (verbal)	**SP**
25	**Glossary** (enclosure)	**SP**
26	***Chair to resolve that members of the public 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***	**SP**

The next public meeting will be held on Thursday 25 April 2019 at 9.30 am
Venue to be confirmed

* Questions for the Board of Directors can be submitted to:

Name: Cath Hill (Associate Director for Corporate Governance / Trust Board Secretary)
Email: chill29@nhs.net
Telephone: 0113 8555930

Name: Prof Sue Proctor (Chair of the Trust)
Email: sue.proctor1@nhs.net
Telephone: 0113 8555913

AGENDA ITEM

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Declaration of Interests for members of the Board of Directors

Name	Directorships, including Non-executive Directorships, held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services.	Any substantial or influential connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.	Any other commercial or other interests you wish to declare. This should include political or ministerial appointments (where this is information is already in the public domain – this does not include personal or private information such as membership of political parties or voting preferences)	Declarations made in respect of spouse or co-habiting partner
EXECUTIVE DIRECTORS								
Sara Munro Chief Executive	None.	None.	None.	None.	None.	None.	None.	None.
Dawn Hanwell Chief Financial Officer and Deputy Interim Chief Executive	None.	None.	None.	None.	None.	None.	None.	Partner: Director of Whinmoor Marketing Ltd.
Claire Holmes Director of Organisational Development and Workforce	None.	None.	None.	None.	None.	None.	None.	Partner: Business Partnership OVT Manager, British Red Cross (Central Region)
Clare Kenwood Medical Director	None.	None.	None.	None.	None.	None.	None.	Partner: CEO of Malcolm A Cooper Consulting
Cathy Woffendin Director of Nursing, Quality and Professions	None.	None.	None.	None.	None.	None.	None.	None.

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

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NON-EXECUTIVE DIRECTORS								
Susan Proctor Non-executive Director	**Owner / director** SR Proctor Consulting Ltd Independent company offering consultancy on specific projects relating to complex and strategic matters working with Boards and senior teams in health and faith sectors. Investigations into current and historical safeguarding matters.	None.	None.	None.	**Associate** Capsticks Law firm. **Independent Chair** Safeguarding Adults Board North Yorkshire Count Council	None.	**Member** Lord Chancellor's Advisory Committee for North and West Yorkshire **Chair** Safeguarding Group, Diocese of York **Member** Royal College Veterinary Surgeons' Veterinary Nurse Council **Chair** Adult Safeguarding Board, North Yorkshire	Partner: Employee of Link

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John Baker Non-executive Director	None.	None.	None.	None.	None.	**Professor** University of Leeds	None.	None
Helen Grantham Non-executive Director	**Director and Co-owner,** Entwyne Ltd	**Director and Co-owner,** Entwyne Ltd	**Director and Co-owner,** Entwyne Ltd	None	None	None	None	None
Andrew Marran Non-executive Director	**Chairman** **Leeds Students Residences Ltd** Delivering housing and accommodation services across Leeds **Non-executive Director** **MoreLife (UK) Ltd** Delivers tailor-made, health improvement programmes to individuals, families, local communities; within workplaces and schools **Non-executive Director** **My Peak Potential Ltd** An organisational development company that specialises in leadership and management development using the outdoors as a vehicle for learning **Non-executive Director** **Rhodes Beckett Ltd** A University associated	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
	company which developed a Wellbeing app and website to provide access to staff.							
Margaret Sentamu Non-executive Director	None.	None.	None.	**President Mildmay International** Pioneering HIV charity delivering quality care and treatment, prevention work, rehabilitation, training and education, and health strengthening in the UK and East Africa.	None.	None.	None.	None.
Susan White Non-executive Director	None.	None.	None.	None.	None.	None.	None.	None.
Martin Wright Non-executive Director	None.	None.	None.	**Trustee** of Roger's Almshouses (Harrogate) A charity providing sheltered housing, retirement housing, supported housing for older people,	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	**CW**	**DH**	**CK**	**JFA**	**CH**	**SP**	**MS**	**HG**	**SW**	**JB**	**AM**	**MW**
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

AGENDA ITEM

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Minutes of the Public Meeting of the Board of Directors held on Thursday 28 February 2019 at 9:30 am in Jimi's Community Room, The Old Fire Station, Gipton Approach, Gipton, Leeds, LS9 6NL

Board Members		**Apologies**
Prof S Proctor	Chair of the Trust	
Prof J Baker	Non-executive Director	
Mrs J Forster Adams	Chief Operating Officer	
Miss H Grantham	Non-executive Director	
Mrs D Hanwell	Chief Financial Officer and Deputy Chief Executive	
Mrs C Holmes	Director of Organisational Development and Workforce	
Dr C Kenwood	Medical Director	✓
Mr A Marran	Non-executive Director	
Dr S Munro	Chief Executive	
Mrs M Sentamu	Non-executive Director	
Mrs S White	Non-executive Director (Deputy Chair of the Trust)	
Mrs C Woffendin	Director of Nursing, Quality and Professions	
Mr M Wright	Non-executive Director (Senior Independent Director)	

All members of the Board have full voting rights

In attendance

Mrs C Hill	Associate Director for Corporate Governance / Trust Board Secretary
Four members of the public	

		Action
	The Chair opened the public meeting at 9.30 am. She welcomed members of the Board and those observing the meeting. Prof Proctor welcomed Mr Marran to the Board noting that this was the first meeting following his appointment as a non-executive director.	
19/023	**Sharing Stories** (agenda item 1) Prof Proctor welcomed Mrs Natalka Webster who had used the services of the National Inpatient Centre for Psychological Medicine (NICPM) and had come to the meeting to talk about her positive experience of the service. She talked about the help and support the service had provided and how this had significantly contributed to her recovery. The Board discussed Mrs Webster's experience of the service. Mrs Webster noted that on first entering the service she had experienced some anxiety as she had not known what to expect. She suggested that one way in which she could help	

	support other service users when they enter the service would be to share her story. Mr Tipper agreed to contact Mrs Webster to look at how her story could be used and promoted.	**OT**
	Mrs Webster also expressed a desire to do some voluntary work within the Trust. Mrs Woffendin agreed to speak to her about this. Mrs Woffendin also agreed to provide Mrs Webster with details of the forthcoming patient experience and engagement workshop that would be taking place in March, which would allow a further opportunity for her to share her experience.	**CW** **CW**
	Prof Baker asked about the support that is offered to carers who have to travel long distances in order to visit and support service users and what provision is made by the Trust for carers. It was noted that in relation to NICPM the service would contact the carer and discuss with them what support they need. The Board noted the importance of supporting carers, particularly where they need to travel long distances.	
	The Board **thanked** Mrs Webster for attending the Board and sharing her story. Directors **acknowledged** the points raised by Mrs Webster, noting that these were important in helping to inform the discussion at the Board meeting.	
19/024	**Apologies for absence** (agenda item 2) Apologies were received from Dr Kenwood, Medical Director.	
19/025	**Declaration of interests for directors and any declared conflicts of interest in respect of agenda items** (agenda item 3) The Board noted that Mr Marran had submitted his declaration of interest form to the Trust Board Secretary and that these had been added to the matrix. The Board noted that there were no other changes to directors' declarations of interests. It was also noted that no director at the meeting advised of any conflict of interest in relation to any agenda item.	
19/026	**Minutes of the previous meeting held on 31 January 2019** (agenda item 4) In relation to minute 19/011, it was agreed that there had been two duplicated words which would be removed from the last paragraph on page 7. In regard to minute 19/015, Mrs Holmes noted that the Workforce Disability Metrics were expected in September and that as such the report to the Board would be received in October, not September as stated in the minutes. Mrs Hill agreed to amend the minutes.	

The minutes of the meeting held on 31 January 2019 were **received** and **agreed** as an accurate record subject to the amendments outlined above.

19/027 **Matters arising** (agenda item 5)

In regard to minute 19/015 and the issue of the policy in relation to clinical supervision, Mrs Grantham asked what completion date for the review of this policy would be. Mrs Holmes agreed to provide a verbal update to the Board in May. **CH**

19/028 **Actions outstanding from the public meetings of the Board of Directors** (agenda item 6)

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

With regard to the Board holding a development session in relation to the Leeds Plan, Population Health Management and the Joint Strategic Needs Analysis (JSNA), Dr Munro noted that the Leeds system was looking to refresh the Leeds Plan based on the JSNA and the learning from the Population Health Management. She added that a Board development session would be scheduled after this refresh. Mrs White sought assurance that the Trust had had the opportunity to contribute to the JSNA. Dr Munro assured the Board that the Trust had participated in determining the priorities.

The Board noted that there were a number of items scheduled for future Board development and strategic discussion sessions and asked that a copy of the plan is presented at the March meeting. **CHill**

Mrs Holmes spoke about the action in relation to the workforce governance arrangements and the task and finish group that had been set up to look at workforce reporting and key performance indicators. She noted that the level of input required from the informatics team was greater than had been initially anticipated and that the team had competing priorities in relation to the new care records system, noting that it needed to focus on this. In light of this Mrs Holmes advised that once the team was able to free up resources it would then be able to provide input to the work of the task and finish group.

Mrs Holmes also noted that she was looking at the workforce governance structure and would be making some proposals as to the changes needed. She noted that this was happening alongside the work of the Task and Finish group and that it was anticipated that an update would be brought back to the Board. **CH**

The Board **received** a log of the actions and **noted** the details, the timescales and progress.

19/029 **Chief Executive's report**

Dr Munro presented the Chief Executive's report. She firstly drew attention to the Staff Survey noting that the results were now in the public domain and that the Trust had received good results in relation to staff engagement and the safety culture within the organisation. She added that there was still more work to do in relation to equity of opportunities for BAME staff and also the health and wellbeing of staff. She noted that the survey helps to reinforce the priorities for the Trust, and that it was moving in the right direction in relation to many of the areas reported on in the survey.

With regard to the draft operational plan, Dr Munro reported that this had been submitted to NHS Improvement on the 12 February and that no specific feedback had been received at the present time. She added that the Trust had been participating in system assurance meetings led by NHS England and NHS Improvement to help ensure that all the plans in Leeds and in West Yorkshire & Harrogate align. With regard to contracts, she noted that negotiations were still ongoing in relation to specific details, but that it was expected these would be concluded shortly.

Dr Munro also advised that the Trust was on plan to meet its control total for 2018/19, noting that whilst there was some risk within individual budgets overall the control total would be achieved.

With regard to the next CQC inspection, Dr Munro reported that there had been no communication from the CQC as to when this might take place. She added that there would be a Board development session in April which would look at the work that had been undertaken since the last inspection and the preparations for the next inspection.

Mrs White asked about the Out of Area Placements and whether the improvements had been maintained. Mrs Forster Adams assured the Board that the improvements had been maintained and that there was work ongoing to look at what had contributed to this. She spoke about the work being carried out by the Out of Area Co-ordinator; the reduction in the length of stay out of area for service users; and the improvement in flow.

Prof Proctor asked if since the last Board meeting there had been any breaches or instances of non-compliance in safe staffing levels. Mrs Woffendin advised that there had not been any. The Board then discussed the way in which staff in preceptorship are supported.

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

19/030 **Report from the Chair of the Quality Committee for the meetings held on 12 February 2019** (agenda item 7)

Prof Baker presented a report on the work of the Quality Committee for the meetings held on 12 February 2019. In particular, he drew attention to:

- The breach of the European Union Directive on falsified medicines. Noting that the Directive came into force the 1 February 2019, and work was underway in conjunction with Leeds Teaching Hospital Trust to look at how it moves to becoming compliant. Prof Baker noted that the Committee had received assurance that non-compliance was a current position faced by many other NHS, pharmaceutical, and manufacturing organisations, and that it had been assured that the other medicine management processes and systems in place within the Trust were robust

- The Annual Quality and Safety Report from the Learning Disability Service, noting that the Committee had commended the high-quality report which had given an insight into the complex and varied service that was provided. He added that the committee had been assured of the developmental work that was underway

- The 'out of hours' provision for the Learning Disability Service, noting that the committee had discussed the aspirations for the provision of this element of the service. Prof Baker noted that a business case had been submitted to the commissioners and that it had welcomed further work to understand what a revised service provision could be.

With regard to out of hours provision, Dr Munro advised that a proposal is being put together to support Transforming Care in Leeds, and that there had been discussions with the CCG in relation to the intensive support offer. She also noted that there would be a proposal to the West Yorkshire and Humber Strategic Group which would look to set up an integrated Board in relation to Learning Disabilities which would then report into the Mental Health Programme Board. She agreed to bring an update back to the March Board in the Chief Executive's report. **SM**

The Board **received** the report from the chair of the Quality Committee and **noted** the matters raised.

19/031 **Use of the Trust's seal** (agenda item 8)

The Board noted that since the January Board meeting the seal had been used on two occasions. It noted that the documents sealed were:

- Log 115 – Lease for 2150 Thorpe Park 2019 – 2022
- Log 116 – Lease for Suite 4, 1st floor, Ramini House, Halifax.

The Board **noted** the occasions on which the seal had been used.

19/032 **Glossary** (agenda item 9)

The Board received the glossary.

19/033	**Resolution to move to a private meeting of the Board of Directors** (agenda item 10) At the conclusion of business the Chair closed the public meeting of the Board of Directors at 10.35 and thanked members of the Board and members of the public for attending. The Chair then resolved that members of the public 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.

Signed (Chair of the Trust) …….

Date …….

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

6

Cumulative Action Report for the Public Board of Directors' Meeting

OPEN ACTIONS

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Sharing Stories (minute 19/023 - agenda item 1 – February 2019) **NEW -** Mrs Woffendin agreed to speak to Mrs Webster about volunteering. Mrs Woffendin also agreed to provide Mrs Webster with details of the forthcoming patient experience and engagement workshop	**Cathy Woffendin**	Management Action	**COMPLETED**
Sharing Stories (minute 19/023 - agenda item 1 – February 2019) **NEW -** Mr Tipper agreed to contact Mrs Webster to look at how her story could be used and promoted.	**Oliver Tipper**	Management Action	**COMPLETED**

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
Sharing Stories (minute 19/001 – January 2019 - agenda item 1) It was agreed that the Board needed to understand the boundaries of confidentiality and how this can impact on a carer's involvement. Dr Kenwood agreed to facilitate this session and Mrs Hill agreed to add this to the Board's forward plan.	**Claire Kenwood / Cath Hill**	Management Action	**ONGOING** This has been noted on the Board 's forward plan and Dr Kenwood is to consider how this is to be taken forward
Workforce and organisational development report (minute 19/015 – January 2019 – agenda item 15) Mrs Holmes agreed to speak with Staffside in relation to diversity and inclusion and whether the trade unions were promoting this within their own recruitment of the cohort of stewards.	**Claire Holmes**	Management action	**ONGOING** This matter will be raised at the next JNCC
Combined Quality and Performance Report (CQPR) (minute 19/011 – January 2019 - agenda item 11) Dr Munro suggested that it would be helpful for the Board to look again at the Joint Strategic Needs Analysis and the pilot work in relation to Population Health Management, both of which will feed into the refreshed Leeds Plan, and to invite key people to come and talk to the Board about these areas of work. She agreed to work with Mrs Hill to look for a date when this can be programmed into the Board's schedule.	**Sara Munro / Cath Hill**	Management action	**ONGOING** This session will be factored in following the refresh of the Leeds Plan and has been added to the forward plan

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
Combined Quality and Performance Report (CQPR) (Minute 18/218 – November 2018 – agenda item 11) With regard to Statistical Process Control (SPC) Charts, Mrs Forster Adams advised that the Executive Team had discussed the potential for the use of these. It was suggested that it might be helpful to have a Board workshop on this matter. Prof Proctor asked the Executive Team to look at how this could be brought forward into a future Board discussion session. Mrs Hill agreed to add this to the forward programme.	**Executive Team** **and** **Cath Hill**	Management Action	**ONGOING** As part of the work with the Institute of Healthcare Improvement, Nikki Copper has shared her vision of the operational team level dashboards and operational delivery group dashboards that could be SPC or run charts depending on the metric, that allows the high performing / hotspots to be identified more easily. Following discussions between Richard Wylde, Nikki Cooper and Samantha Riley (NHS Analytics), LYPFT are now on the waiting list for the 90 minute interactive 'Making data count for Trust Boards' session. The next steps are for LYPFT to agree a date with NHS Analytics for the session to take place on.
Report from the chair of the Quality Committee (Minute 18/170 - Agenda item 8– September 2018) So the Board is better sighted on Learning Disability services, Mrs Forster Adams and Mrs Nikki Cooper are to review how Learning Disability performance data can be incorporated into the CQPR.	**Joanna Forster Adams and Nikki Cooper**	Management action	**ONGOING** The metrics to be included are in the process of being identified and will be incorporated into the report

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
Workforce and organisational development report (minute 19/015 – January 2019 – agenda item 15) With regard to equity in access to CPD, it was agreed that the executive team would consider whether it had assurance that CPD is being resourced and accessed in an equitable manner across the different professions and how this would be fed back to the Board either directly or through its committee structure.	**Executive Team**	Management action	This will be discussed at the Executive Team Timeout in March and a verbal update provided to the Board
Actions outstanding from the public meetings of the Board of Directors (minute 19/028 - agenda item 6 – February 2019) **NEW -** The Board noted that there were a number of items scheduled for future Board development and strategic discussion sessions and asked that a copy of the plan is presented at the March meeting.	**Cath Hill**	March Board of Directors' meeting	**COMPLETED** This has been included on the March agenda
Safer Staffing Six-monthly Report (Minute 18/220 – November 2018 – agenda item 13) Prof Proctor asked for an update on the outcome of the multiplier tool be brought back to the Board in March.	**Cathy Woffendin**	March Board of Directors' meeting	**COMPLETED** This has been included in the Director of Nursing and Professions March report

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Report from the Chair of the Quality Committee for the meetings held on 12 February 2019 (minute 19/029 - agenda item 7 – February 2019) **NEW -** Dr Munro noted that there would be a proposal to the Yorkshire and Humber Strategic Group which would look to set up an integrated Board in relation to Learning Disabilities which would then report into the Mental Health Programme Board. She agreed to bring an update back to the March Board in the Chief Executive's report.	**Sara Munro**	March Board of Directors' meeting	**COMPLETED** This has been included in the Chief Executive's Report
Chief Executive's report (minute 19/007 – January 2019 - agenda item 7) Dr Munro noted that the executive team had discussed the Gender Identity Service and that any investment should result in additional staff to support those already experiencing the pressure within the system. Dr Munro noted additional funding was being discussed with NHS England and that an update would be brought to the March Board meeting.	**Sara Munro**	March Board of Directors' meeting	A verbal update will be provided at the March Board meeting
Matters arising (minute 19/027 - agenda item 5 – February 2019) **NEW -** In regard to minute 19/015 and the issue of the policy in relation to clinical supervision, Mrs Grantham asked what completion date for the review of this policy would be. Mrs Holmes agreed to provide a verbal update to the Board in May.	**Claire Holmes**	May Board of Directors' meeting	

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Actions outstanding from the public meetings of the Board of Directors (minute 19/028 - agenda item 6 – February 2019) **NEW -** Mrs Holmes also noted that she was looking at the workforce governance structure and would be making some proposals as to the changes needed. She noted that this was happening alongside the work of the Task and Finish group and that it was anticipated that an update would be brought to the Board.	**Claire Holmes**	May Board of Directors' meeting	
Chief Executive's report (minute 19/007 – January 2019 - agenda item 7) Dr Munro agreed to bring an update back to the March Board in relation to the work of the 'Culture Club'.	**Sara Munro**	May Board of Directors' meeting	**ONGOING** The Culture Club will be convened from April a further update will be brought to the Board in due course
Safe Staffing report (Minute 18/174 - Agenda item 12– September 2018) It was noted that when staff move around the ward and work in different places there is often a difficulty in orientating themselves to the different processes and procedures in different in patient areas due to processes and procedures not being systematised on the wards. Mrs Forster Adams agreed to pick this up through the acute care excellence collaborative.	**Joanna Forster Adams**	May Board of Directors' meeting	**ONGOING** This paper will need to go to the Finance and Performance Committee prior to it coming to Board. it has therefore been agreed that the report will come to the May Board meeting

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Workforce and organisational development report (Minute 18/223 – November 2018 – agenda item 18) With regard to the proposals for the governance and reporting of workforce to the Board, Mrs Holmes advised that since the report had been written there had been discussions with the Chair and Chief Executive where it had been agreed that a task and finish group be established to look at workforce reporting, key performance indicators and the measures required to be reported on and where. Mrs Holmes indicated that a report on the outcome of the considerations would be brought back to the Board in early 2019.	**Claire Holmes**	July Board of Directors' meeting	**ONGOING** In relation to the data that will be reported within the governance structure, the completion of this action will be reliant on the Task and Finish Group being able to conclude its considerations with the support of the Informatics Team.
Workforce and organisational development report (minute 19/050 – January 2019 - agenda item 15) Mrs Holmes agreed to bring a report back to the Board in September in relation to the Workforce Disability Equality metrics.	**Claire Holmes**	October Board of Directors' meeting	
Safer Staffing Summary Report (minute 19/012 – January 2019 - agenda item 12) Mrs Woffendin agreed to share benchmarking data in regard to nursing vacancies once a year through the Safer Staffing report.	**Cath Woffendin**	November Board of Directors' meeting	

CLOSED ACTIONS

(3 MONTHS PREVIOUS)

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
Sharing Stories (minute 19/001 – January 2019 - agenda item 1) With regard to the wait to receive treatment experienced by Ms Alikhanizadeh's daughter in the last few months, Mrs Forster Adams agreed to as the Personality Disorder service look into this specific matter and to liaise with her personally.	**Joanna Forster Adams**	Management Action	**CLOSED** Mrs Forster Adams has asked members of the Personality Disorder team to meet with the family
Community Redesign update (minute 19/013 – January 2019 - agenda item 13) The Board agreed to have a strategic session to understand how the Trust is embracing the digital agenda. Dawn Hanwell agreed to facilitate this session. Mrs Hill agreed to schedule this in for later in the year.	**Dawn Hanwell / Cath Hill**	Management action	**THE BOARD IS ASKED TO CLOSE THIS AS A BOARD ACTION** This has been factored into the Board to Board meeting in September between the Board of Directors and the Council of Governors
Workforce and organisational development report (minute 19/050 – January 2019 - agenda item 15) Mrs Holmes agreed to bring a more detailed report back to the Quality Committee in July in relation to progress against the apprenticeship levy.	**Claire Holmes**	July 2019 Quality Committee meeting	**THE BOARD IS ASKED TO CLOSE THIS AS A BOARD ACTION** This has been factored into the Quality Committee schedule of work

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
Combined Quality and Performance Report (CQPR) (Minute 18/198 - agenda item 10 – October 2018) There was a request to look at the graphs in relation to the crisis service in the performance report and whether these could show the data broken down by male and female service users; whether this could also show if a person was calling on behalf of the themselves or someone else; and whether there was some way of capturing if the person calling received the advice they required. Mrs Forster Adams reminded the Board that the information system in relation to calls was currently under review that these issues were timely and agreed to feed these suggestions into the review.	**Joanna Forster Adams**	Management Action	**COMPLETED** These comments have been provided to the Head of Performance who will be undertaking changes in relation to the crisis telephone access line.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
7

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Executive's Report
DATE OF MEETING:	28 March 2019
PRESENTED BY: (name and title)	Dr Sara Munro – Chief Executive
PREPARED BY: (name and title)	Dr Sara Munro – Chief Executive

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

EXECUTIVE SUMMARY

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

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

RECOMMENDATION

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

MEETING OF THE BOARD OF DIRECTORS

Thursday 28th March

Chief Executive Report

The purpose of this report is to update the Board on the activities of the Chief Executive. This report will cover significant events during February and March 2019.

1. Staff Engagement and Service Visits

There are two main themes I want to highlight from the service visits conducted over the last two months. First is the focus on identifying each of our services as a speciality in its own right and creating a culture which supports and enables these services to thrive through integrated compassionate leadership. This all connects with our aspirations for the culture club we will be establishing.

Second is the recurring conversation with our services about staff support and wellbeing. We know the work our staff do can be emotionally and psychologically demanding and if not well supported, affects their health and wellbeing and the care they provide to our service users and carers. Each of the services I visited shared with me how the support and wellbeing of staff is very much embedded in the teams and is having a positive impact on retention, morale and ultimately patient care. What was clear from talking to a larger group of clinical leads is that there is more to do so this is in place for every team and equally we need to ensure our managers and leaders are supported just as much as front line staff. This will come as no surprise to the board given our staff survey results and absence reports due to stress. Claire Holmes is identifying ways in which we can do more for our staff over the coming months.

Complex Mental Health Service for Veterans

This was my first visit to the team that have now been up and running for 12 months. Whilst initially contracted for 2 years we have already had confirmation it will be commissioned for a further two years taking us to 2022. The team is now almost fully established with full caseloads and it was great to hear the stories of the work they are doing. The team possess a specialist combination of skills which include experience themselves within the armed forces and mental health expertise which is required to effectively engage with the veteran's population.

National Inpatient Centre for Psychological Medicine

It was great to visit the team the day after our last patient story from a service user who had been on the NICPM last year. The staff were delighted to know the Board had heard the story and continues to support the work they are doing. Work is ongoing to develop the business case for the new unit and with NHSE on future commissioning arrangements. Following the visit I have written to Claire Murdoch the NHSE lead for mental health seeking her oversight and support to get the service nationally commissioned.

Forensic Services at Clifton House

The Board is already aware of the improvement journey our forensic services have been on and this has been my second visit in the past three months. It was a great opportunity to reinforce our support and appreciation to the staff for the hard work they have put in which is having an impact staff experience and on the quality of care they are providing which was evident in recent Mental Health Act visit by the CQC. The service is not without its challenges most notably in recruitment of consultant psychiatrists but they have had success in filling all nursing posts.

I was also able to meet with the manager and clinical lead for the forensic outreach service. This is a service we are expanding in line with wider developments in the Humber Coast and Vale STP and our ambition to transform the model of forensic care to support more people out of hospital. The team is approximately up to 50% establishment now and working with local partners to establish what the service will offer.

Meeting with Clinical Leads

Each of our service lines has a dedicated operational manager and a clinical lead. The clinical lead roles are varied both in terms of time, professional background of the post holder and remit. The purpose of the meetings was to begin a conversation about how we better support each of our services as specialist services in their own right, and to do this ensuring the clinical leads have the tools they need to drive services forward. As an executive team we have agreed that integrated leadership at a service line level is essential to ensuring all our clinical services can be outstanding and this was very much welcomed by our clinical leads. We will continue to work with our leaders to ensure we are providing the right development for them individually and as a leadership team over the coming months. This will be aligned with our work on the 'Culture Club', staff survey results and the findings from the work with the IHI.

Senior Leadership Team

Our senior leadership team consists of executive directors and their direct reports. We meet on a bi-monthly basis and have agreed to move away from a traditional meeting style to a workshop approach which will focus on culture, leadership and impact. We held our first new style workshop this month and in the context of our staff survey results and ambition for integrated leadership at service lines we debated and reflected on how our behaviour as senior leaders and each interaction we have across the organisation role models and reinforces the culture we want. The outcome being our staff are developed and supported sufficiently that they are empowered and enabled to lead from the front line.

2. Regulatory Matters

NHSI/E

New regional structures come into effect from the 1 April with Richard Barker as the regional lead for our region. Work is ongoing on wider re-organisation of the teams in NHSE and NHSI that will report in to these new regions including alignment of specialised commissioning.

A consultation is currently underway on proposed legislative changes that will have an impact on the NHS including potential changes to Foundation Trust freedoms, capital allocations, roles and relationships between commissioners and providers. This will be discussed further with the Board to ensure we submit a response to the consultation. There will also be a response from the Leeds System and the West Yorkshire and Harrogate Integrated Care System. Should any changes be agreed and implemented it is not expected they would take effect before April 2022.

EU Exit

The Trust has complied with all the requirements set out from the Department of Health and Social Care to put in place adequate preparations in the event of a no deal. Further information is provided in part of the Board meeting.

3. System Updates

West Yorkshire and Harrogate ICS

The March Senior Leadership Group (SLEG) meeting was a development session with all those who will be members of the partnership board being invited. This was chaired by Cllr Swift and facilitated by the Kings Fund. The focus of the session was on how the partnership board will work in order to add value to the work of the ICS. The board will be a large group and some of the actions involved practical suggestions for the meetings as well as ideas on what we want to achieve. What was clear was the unanimous view that we need to maintain the inclusive approach in the ICS involving all partners equally and avoiding a narrow focus on the NHS. Secondly, the clear commitment that everything starts in place and where people live was reinforced. The challenge will be ensuring meaningful and ongoing public involvement through this Board and always checking back on ourselves that what we are focusing on are the right things from the point of view of the citizens of West Yorkshire and Harrogate. The first formal partnership board meeting is scheduled to take place in June 2019 and its first priority will be to oversee and finally approve the 5 year strategy for West Yorkshire and Harrogate which is mandated in the long term plan.

Leeds System

During March there have been meetings of the Partnership Executive Group and the Board to Board both of which have covered the following important pieces of work.

System performance during the winter months – There was significant partnership planning and preparation in the lead up to winter 18/19 and to date as a system performance has been significantly better than the previous year. There has been robust inter agency working and proactive management of flow in and out of the hospital in particular to ensure safe patient care. Phil Corrigan is now stepping down from chairing the SRAB and I have agreed to take over the chair along with Cath Roff from Adult Social Care.

Workforce Strategy for the City and Health and Care Academy – following a recommendation from the CQC we have now developed a draft workforce strategy for the city which we will do further engagement work on over the next three months before it is finalised. I am the SRO for this work along with the academy development. The strategy has been developed in response to the key drivers in the city of shortage in existing workforce; inclusive growth strategy; changing models of care in the future.

Through the strategy we have now brought together the academy and the workforce strategy for the city establishing the health and care academy as the delivery mechanism. We have made significant progress in the past 6 months of engaging all partners and beginning the mobilisation of the academy in April. However there is still significant work to do to achieve the original ambitions. Key to this is maintaining strong links with the universities and being more outward facing. The emerging priorities of the national workforce strategy led by Julian Hartley and Dido Harding are consistent with the work we are doing in Leeds and we have submitted responses to those from the Trust, Leeds system and the mental health, LD and autism collaborative.

The Academy concept was originally created through the Leeds Academic Health Partnership Board chaired by Sir Alan Langlands Vice Chancellor at the University of Leeds and we continue to provide progress reports to this board. The LAHP board also enables us to connect in to wider academic work on personalised medicine, health tech and digital

developments in the region. The LAHP has also secured a conference presentation on the academy at the Association of Academic Health Centres Global Issues Forum in Washington in May 2019 which myself and Jenny Lewis from LTHT will be attending.

Mental Health and Learning Disability Collaborative

The collaborative and myself and have tasked with reviewing and providing assurance (or not) that all CCGs are complying with the Mental Health Investment Standard in the operational planning round for 2019/20. This has been a significant piece of work and at the programme board on the 21 March 2019 we were able to confirm that the investment standard is being achieved and the targeted growth in all services and for children and young people is being met.

We decided to undertake more detailed work that will track what the investment is actually being spent on over the year and the impact this will have on those in receipt of services. This will enable us to build in more robust oversight, challenge and evaluation to ensure money is being invested to good effect.

We are also in the process of reviewing the work streams of the collaborative in preparation for a check and challenge session in May with the ICS leadership team. This will then support the completion of the 5 year strategy required for the West Yorkshire and Harrogate Partnership which will need to demonstrate plans to implement the long term plan for mental health learning disability and autism. We are also aware that there will continue to be money made available nationally that we can access through the ICS to support priority areas from the long term plan.

I have established a core cross-partnership team that will lead on the strategy work pending the start of the new programme director in June. Interim programme management capacity has also been secured to maintain momentum. Additional input to the board has been arranged in the form of local authority representation and a trainee consultant in public health who will focus on the suicide prevention work, addressing health inequalities and how population health management approaches may feature in the longer term strategy.

A West Yorkshire and Harrogate board for transforming care and learning disability services will now be established from April, chaired by Helen Hirst, the accountable officer for Bradford CCGs. This will report into the collaborative programme board and will enable us to provide a much stronger focus on learning disability services going forward. We have also agreed and identified senior locality authority representation on this board.

The Committees in Common met and received an update on work to date, plans for the programme review and recruitment of the new programme director. They also agreed to postpone the planned NED and governor engagement session until June due to a clash with an event for governors regionally and to enable the stocktake to be completed which we will then share and pre planning work to be done for the future strategy. The chair role of the Committees in Common has been undertaken by Professor Proctor for the last 12 months. As per our memorandum of understanding after 12 months a new chair is selected and it was agreed Angela Monaghan from South West Yorkshire will take the chair for the next 12 months.

Leeds Providers Committee in Common

The third meeting of the committee took place in March and a separate summary will be provided in due course. Key areas to make the Board aware of include

- The introduction of the new GP contract which supports the development of primary care networks and the implementation of a broader multi-disciplinary approach to meet the needs of populations of 30 – 50,000 people. This work is being aligned to the development of local care partnerships in Leeds and an update was provided to LPICC on how this is being progressed.
- Developing a new integrated approach to frailty which will be overseen by LPICC and Dr Chris Mills is the SRO. Joanna Forster Adams is ensuring we have the right engagement from our clinical services in this work stream as it provides an opportunity to integrate mental health within the new approach.
- Urgent Treatment Centres. We have agreed to take a partnership approach and make a proposal to the commissioners on what we believe would be the right model for Leeds. Again this is an area where we are keen to have mental health integral to this new development which has been welcomed.

- Future role and remit of LPICC. A stocktake has been done after 6 months and it was recognised that there is still work to do on the future of LPICC and how it supports the delivery of the Leeds Plan which is being refreshed. We agreed to hold a workshop with a more strategic focus in three months and to secure senior representation from the regional team of NHSE/I and the ICS. We also agreed to secure an independent chair and agree how we will do this at the workshop.

4. Reasons to be proud

Your Health Matters on National TV

Channel 5 news broadcast a feature on the importance of health checks for people with a learning disability because nationally uptake is very poor. Our service was featured in because of the work they have done to support people with a learning disability and primary care teams to enable more people to have their health check. This work is led by the team at Your Health Matters including Dean Milner-Bell who produce accessible information that is free for anyone to access on the Easy on The II website. If you haven't seen it the link is below.
https://www.youtube.com/watch?v=b2FKhbc7Ie8&pbjreload=10

Praise for the quality of our Sustainability Reporting

"*I'm very pleased to inform you that your organisation has been judged to have excellent sustainability reporting as part of your public annual report*".

The Sustainable Development Unit (SDU) conducted an analysis of all provider and Clinical Commissioning Group (CCG) annual reports to evaluate sustainability content. 55 trusts and 42 CCGs (around 22%) have been selected for recognition out of 432 organisations across England.

National award for Core Trainee

Dr Zoe Goff, a Core Trainee with us has done exceptionally well and received the Royal College of Psychiatrists, Old Age Faculty, Mohsen Naguib Prize. This prize was originally established in memory of the late Dr Mohsen Naguib. Dr Naguib originated from Egypt and

worked at the Maudsley Hospital, notably in the area of paraphrenia. He died suddenly at the age of 44, leaving a young family. SHOs, SpRs, specialty trainees ST 1-6 or new consultants in the UK presenting work undertaken during the training period are eligible, as are comparable colleagues in Europe. Zoe presented brilliantly against tough competition including an associate professor and 2nd year PhD student and we have already shared our congratulations with her for such a fantastic achievement so early on in her career.

Visit from NHS Providers

In February we hosted a visit from Saffron Cordrey, Director of Strategy with NHS Providers. Saffron met with the Chair, CEO and some executive directors before visiting our eating disorder service and acute inpatient unit at the Becklin Centre. Saffron shared her experiences straight after through social media and was highly complementary about the services she visited, the passion and commitment to service users and high levels of staff support.

Dr Sara Munro
Chief Executive
21 March 2019

AGENDA ITEM

8

Chair's Report

Name of the meeting being reported on:	Quality Committee
Date your meeting took place:	12 March 2019
Name of meeting reporting to:	Board of Directors – 28 March 2019

Key discussion points and matters to be escalated:

At the Quality Committee meeting that took place on the 12 March 2019 the following items were discussed:

- The Committee noted the developments of the Trust's complains management process that had taken place over the last 15-months'. That developmental work had been undertaken by the Complaints Team working closely with care services. Following a discussion that had taken place at the Committee meeting in November 2018, an additional piece of work had been undertaken to further strengthen the Trust's complaints management process. The Committee received an update on this additional work and supported the recommendation of the Complaints Team agreeing the timeframe, with each complainant, for the response to their complaint. Up until that point, the Trust had set a blanket target of 20-days and 30-days for responding to each complaint. The Committee received assurance on the Trust's internal systems for monitoring complaints, with little changes being proposed to those.

- The Committee received an update on the production of the Quality Account 2018/19, which included a quarter three position on the 2018/19 quality improvement priorities (QIPs) and actions; and an update on the previously agreed 2019/20 QIPs. Discussions took place on each of these areas and feedback was captured from the Committee members for the development of this work. The next stage with the production of the Quality Account 2018/19 is consultation with stakeholders which will start the 1 April 2019, it was agreed that this Quality Account will be presented to the Committee at the April 2019 meeting.

Report completed by:	Name of Chair and date: Prof John Baker 18 March 2019

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

9.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Mental Health Act Managers Remuneration
DATE OF MEETING:	28 March 2019
PRESENTED BY: (name and title)	Margaret Sentamu, Chair of the Mental Health Legislation Committee
PREPARED BY: (name and title)	Sarah Layton (Mental Health Act Officer) and Cath Hill (Associate Director for Corporate Governance)

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

EXECUTIVE SUMMARY

The Mental Health Legislation Committee met on the 21 March 2019 and considered the remuneration for Mental Health Act Managers. They considered the current position and were assured of the current rates paid to MHAMs. They also made a recommendation in relation to compulsory training; suggesting that MHAMs are paid a payment of £60 when all compulsory training is completed.

The committee has also asked to Board to consider granting delegated authority to the committee to make future decisions around remuneration so these do not have to be referred to the Board for approval.

The attached paper sets this out.

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

RECOMMENDATION

The Board is asked to:

- Be assured that the rates paid to the Trust's Mental Health Act Managers remain competitive; that these are set at the maximum of that paid to MHAM in other organisations and that this is not a barrier to recruitment.
- Agree that mandatory e-learning be remunerated at one session fee (£60); payment to be made once all training has been completed
- Agree to delegate authority to the committee for decisions in relation to the remuneration of the Mental Health Act Managers and if agreed that the Terms of Reference should be amended.

MEETING OF THE BOARD OF DIRECTORS

28 March 2019

Mental Health Act Managers' Remuneration

1 Introduction

Mental Health Act Managers (MHAMs) are a 'committee' of people authorised by the Board to exercise the power of 'discharge' under section 23 of the Mental Health Act 1983 (the Act) on behalf of the Trust.

The Mental Health Act Code of Practice states at paragraph 38.4:

> *'A managers' panel may consist of three or more people who are:*
>
> - *Members of the organisation in charge of the provider (e.g. the chair or non-executive directors), or*
> - *Members of a committee or sub-committee which is authorised for the purpose.'*

MHAMs must not be officers i.e. employees of the Trust[1]. However an honorarium fee is paid to MHAMs who are appointed to carry out this role. The Code of Practice at paragraph 38.6 confirms,

> *'People do not become employees or officers simply because they are paid a fee for serving on managers' panels.'*

2 The purpose of this paper

The purpose of this paper is to respond to the following two questions:

- Is the current remuneration for MHAMs at the Trust comparable to other similar organisations (see section 2.1 below)
- Should MHAMs receive an honorarium fee for completion of compulsory training (see 2.2 below).

[1] Mental Health Act 1983 s23(5)

2.1 Current remuneration rates

Table 1 below sets out the Trust's current rate of payment to Mental Health Act Managers and table 2 is benchmarking data for fees paid to MHAMs at other similar organisations (rates confirmed with organisations by Mental Health Legislation Team in November 2018).

Table 1 – LYPFT reimbursement rates

Element	Amount paid by the Trust
Hearing (single cases only)	£60 (max 4 hours)
Training (half day)	£60
Training (full day)	£80
Training (e-learning)	Nil
Mileage	45p/mile (NEDs receive 56p/mile)
Public transport costs (inc. car parking)	Reimbursed on receipt

Table 2 – Other organisations' reimbursement rates

NHS Trust	Payment	Mileage
Rotherham Doncaster and South Humber NHS Foundation Trust	£40 / per 4 hour session. Includes x1 contested hearing and x1 uncontested hearing OR 3-4 uncontested hearings.	45p
Bradford District Care NHS Foundation Trust	£46 per 4 hour session X1 contested hearing X2 uncontested hearing	45p
Tees, Esk and Wear Valley NHS Foundation Trust	£25 Per hearing Chair £30 Per hearing	45p
Sheffield Health and Social Care NHS Foundation Trust	£60 per 4 hour session	37.4
Humber NHS Foundation Trust	£40 per 4 hour session Chair £50 per 4 hour session	43p / 53p depending on cc of car
South West Yorkshire Foundation Trust	£50.31 per 4 hour session	56p
NAViGO Health and Social Care CIC	£50 per hearing	44p
Derbyshire Healthcare NHS Foundation Trust	£30 per 4 hour session 1 contested 3-4 uncontested	45p
NTW	£30 (hearing and training)	45p
Private Hospitals	**Payment**	**Mileage**
The Retreat (York)	£55 per 4 hour session	45p
Priory Group	£60 per half day session	Nil
York House	£55 per 4 hour session	40p
Cheswold Park Hospital	£55 per hearing, additional £25 for 2nd hearing	45p

Based on the data provided in tables 1 and 2, the remuneration rates paid by the Trust remain competitive when compared with other NHS and private organisations. The Mental Health Legislation Team also report that there is no problem with attracting applicants for vacant roles.

The Board is, therefore, asked to be assured that the rates paid to the Trust's Mental Health Act Managers remains competitive, are set at the maximum of that paid to MHAM in other organisations and is not a barrier to recruitment.

2.2 Compulsory Training

MHAMs are required to complete compulsory training in the below areas. Time take to complete e-learning modules is not currently remunerated.

Table 3

Training	Delivery method	Duration / Frequency
Trust Induction (includes Fire, Safeguarding, Infection Control)	Face to face	Full day – attendance remunerated at £80
Fire (refresher - initially covered during induction)	Face to Face E-Learning	1 Hour Refresher – 3 yearly
Safeguarding Adults (refresher – initially covered during induction)	E-Learning	1 hour Refresher – 3 yearly
Information Governance	E-learning	2 Hours Annual refresher (30 mins)
Equality and Diversity	E-learning / face to face	2 hours Refresher – 3 yearly
Personal Safety Theory	E-Learning	30 minutes – once only
Health & Safety	E-Learning	45 Minutes – 3 yearly

Table 4. MHAMs compliance 28 Feb 2019

Requirement	Number compliant	Number non-compliant	Total Headcount	Compliance status
Equality and Diversity	16	30	46	35%
Health and Safety	12	34	46	26%
Information Governance	33	13	46	72%
Moving and Handling Principles	5	41	46	11%
Personal Safety Theory	7	39	46	15%
Safeguarding Adults	22	24	46	48%

To help with the uptake of the completion of compulsory training and to ensure that our MHAMs are supported to complete this the Mental Health Act Legislation Committee considered the proposal that MHAMs be paid one-off payment of £60 (the fee for one session) on completion of all compulsory training.

The committee considered this proposal. It noted that making a payment for the completion of compulsory training was in line with the support we provide to bank staff. The committee supported this proposal and agreed to recommend this to the Board.

3 Terms of reference for the committee

When considering the remuneration for Mental Health Act Managers the committee noted that it does not have delegated authority to make remuneration decisions, without referring these back to the Board each time. Given that the totality of remuneration of MHAMs is small in comparison to other areas of remuneration, and that there is representation on the committee from the executive team, the committee agreed that it would seek permission to change its terms of reference to include decision in relation to remuneration.

The committee therefore seeks delegated authority to agree the remuneration for MHAMs within its meetings, noting that any decisions taken would be reported back to the Board through the chair's report. It also asks that if permission to change the terms of reference is agreed that this paper is evidence of that and the Terms of Reference will be considered agreed in relation to this change.

4 Recommendation

Having considered the information presented above the Board is asked to:

- Be assured that the rates paid to the Trust's Mental Health Act Managers remain competitive; that these are set at the maximum of that paid to MHAM in other organisations and that this is not a barrier to recruitment.
- Agree that compulsory e-learning be remunerated at one session fee (£60); payment to be made once all training has been completed
- Agree to delegate authority to the committee for decisions in relation to the remuneration of the Mental Health Act Managers and if agreed that the Terms of Reference should be amended.

Sarah Layton / Cath Hill
Mental Health Legislation Officer / Associate Director for Corporate Governance
22 March 2019

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
12

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Combined Quality Performance Report
DATE OF MEETING:	28 March 2019
PRESENTED BY: (name and title)	Joanna Forster Adams - Chief Operating Officer
PREPARED BY: (name and title)	Joanna Forster Adams - Chief Operating Officer Cathy Woffendin – Director of Nursing and Professions Claire Holmes –Director of Workforce Dawn Hanwell – Chief Finance Officer and Deputy Chief Executive

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

EXECUTIVE SUMMARY

The document brings together the high level metrics we report and use in the management process set against our current strategic objectives to enable the Board to consider our performance. It reports performance against the mandated standards contained within:

- The regulatory NHSI Single Oversight Framework
- The Standard Contract metrics we are required to achieve
- The NHSE Contract
- The Leeds CCG Contract

In addition to the reported performance against the requirements above, we have included further performance information for our services, our financial position, workforce and our quality indicators. It is underpinned by a more detailed and expansive set of performance metrics used across our management and governance processes at all levels of the organisation.

The report includes narrative where there are concerns about performance and further includes highlights where we have seen sustained improvement or delivery.

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 content of this report and discuss any areas of concern. • identify any issues for further analysis as part of our governance arrangements.

Leeds and York Partnership
NHS Foundation Trust

Lead Director: Joanna Forster Adams, Chief Operating Officer

Date: March 2019 (reporting February 2019 data, unless otherwise specified)

Introduction

Unless otherwise specified, all data is for February 2019

Key themes to consider this month:

Access:
The newly developed access measure for our Perinatal community service (percentage of routine referrals seen within 2 weeks) achieved 100% during February. The 15 day access target for our community mental health teams also moved back on track in February. However, February saw both the Acute Liaison Psychiatry Service (ALPS) and the Liaison in-reach team dip below their access trajectories against their targets of 1 hour and 24 hours respectively. Staffing issues again impacted within ALPS with the team now encouraged to escalate issues more quickly so that alternative staffing can be put in place. In supporting the ALPS team, the in-reach team performance was affected. For the Leeds Autism Service (LADS), the focus for 2019/20 will move to an access target of 13 weeks from referral to assessment; early data included in this report shows an improving picture.

Capacity:
February saw a continued reduction in the number of acute and PICU inappropriate out of area bed days (the lowest number since April 2018). However, following an increase in referrals and demand for admission in the last couple of weeks of February alongside acute bed occupancy over 100% for the month and a rise in delayed transfers of care, the picture is of a deteriorating position at month end with 11 remaining out of area in comparison to only 5 at the end of January.

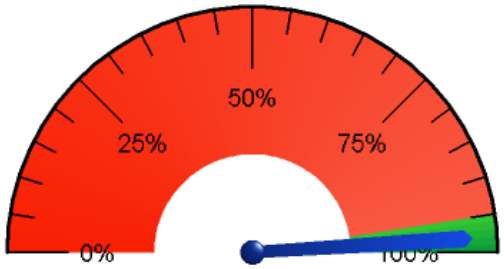
Quality:
During 19/20, a new Commissioning for Quality and Innovation (CQUIN) measure will be introduced to monitor performance against a 3 day follow up target post discharge with an 80% target. The 3 day measure had already been identified as a priority for the trust during 18/29 and the Trust has shown performance above the 80% threshold in three of the last 4 months.
Service user experience is an important part of the measure of quality. The handling of complaints is a useful indicator of how an organisation views learning from experience. The percentage of draft reports following a complaint completed within 20 days has improved considerably over the course of the year rising from 20% in April to 67% in January. This improvement over the year is also reflected in the percentage of responses sent to the complainant within 30 days.

Work in Progress:
Following the go-live of the electronic transfer of inpatient discharge summaries and outpatient letters during February, the Trust remains on track to make performance data available from March onwards and reported from the April CQPR onwards.
As the plans for the implementation of the new redesign of our community services come to fruition, considerable work is underway to provide the supporting infrastructure across our clinical, HR, finance and incident reporting systems. This work is staged throughout February and March and is likely to affect data and reporting during these months as the changeover occurs. A new suite of key performance metrics will also be gradually introduced post the April go-live to evidence the impact of the changes.
Work is also ongoing to set up some new measures within our Learning Disabilities service.

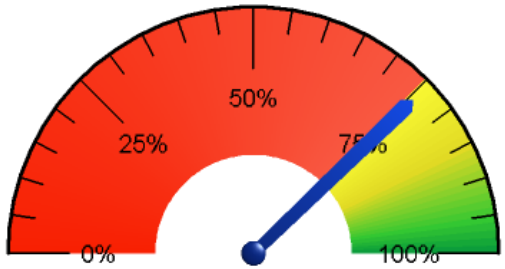
Performance

Our Service Performance

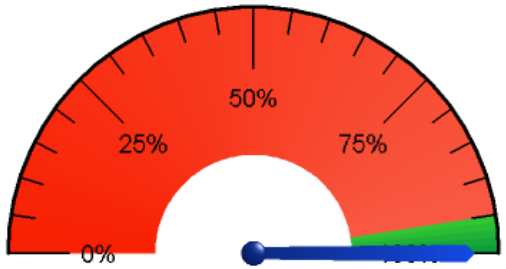
Access & Responsiveness: Our response in a Crisis



Percentage of referrals to the crisis team with a crisis plan in place within 24 hours of referral

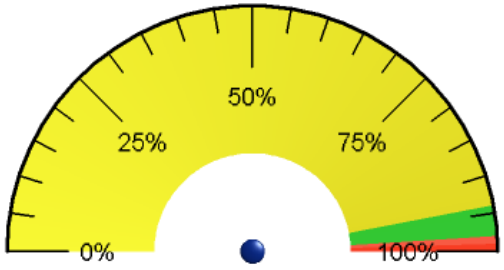


Percentage with Timely Access to a MH Assessment by the ALPs team in the LTHT Emergency Department (1 hour)



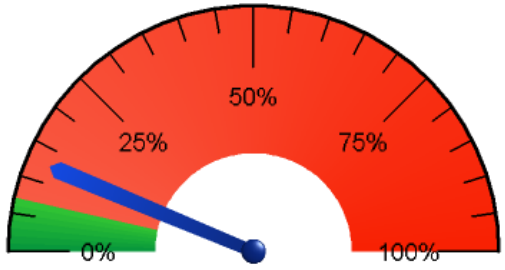
Percentage of admissions to inpatient services that had access to crisis resolution / home treatment teams

Our Acute Patient Journey

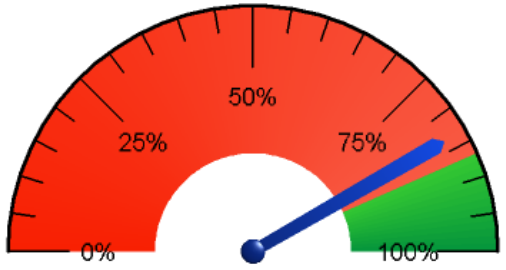


101.4%

Bed Occupancy rates for (adult acute) inpatient services

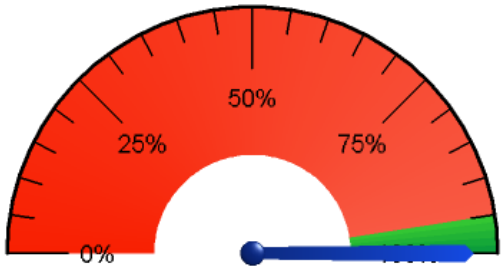


Percentage of Delayed Transfers of Care

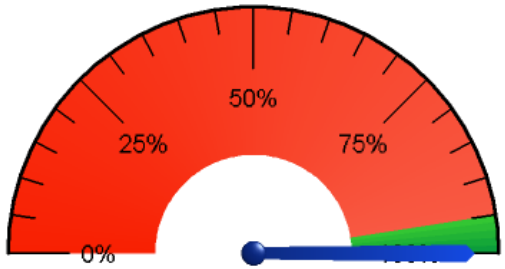


Liaison In-Reach: attempted assessment within 24 hours

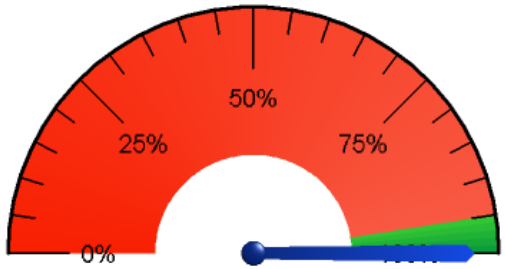
Access & Responsiveness: Our Specialist Services - Quarter 3



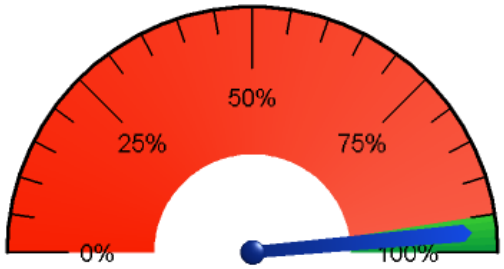
CAMHS inpatients: Honosca & CGAS: % completed at discharge (quarterly) Q3



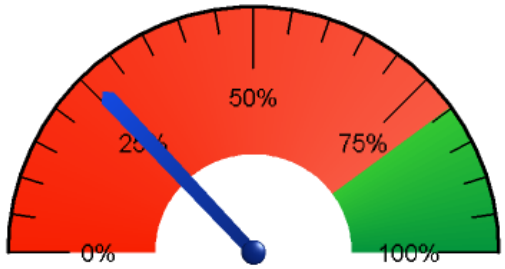
CAMHS inpatients: Honosca & CGAS: % completed at admission (quarterly) Q3



Forensics: HCR20: Percentage completed within 3 months of admission (quarterly) Q3

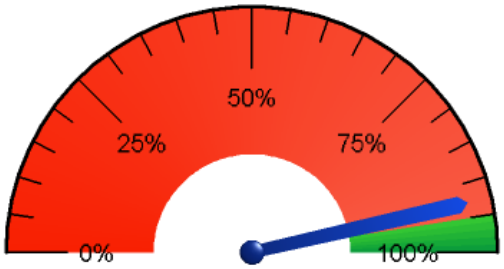


Forensics: HCR20 & HoNOS Secure: Percentage completed (LOS greater than 9 months) (quarterly) Q3

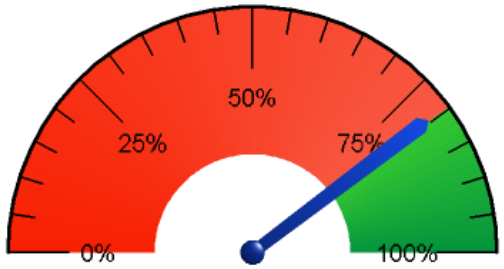


Leeds Autism Diagnostic Service (LADS): Percentage receiving a diagnosis within 26 weeks of referral (quarterly) Q3

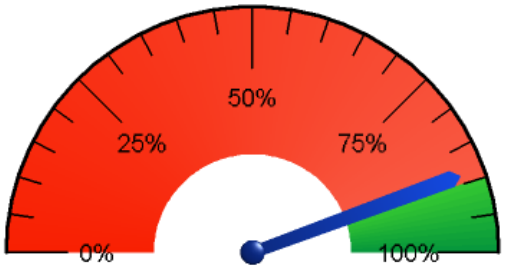
Our Community Care



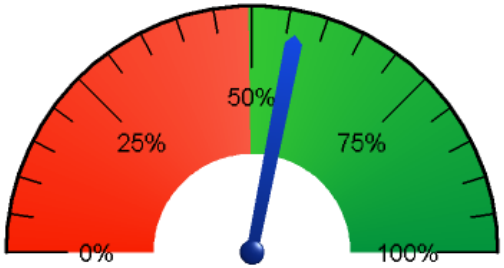
Percentage of inpatients followed up within 7 days of discharge



Percentage of referrals seen (face to face) within 15 days of receipt of referral to a community mental health team

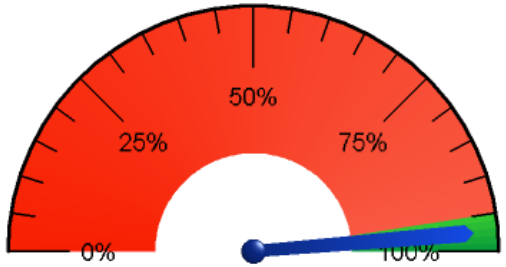


Waiting Times Access to Memory Services; Referral to first Face to Face Contact within 8 weeks (quarter to date)

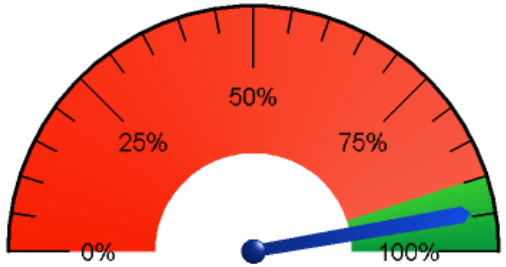


Memory Services – Time from Referral to Diagnosis within 12 weeks

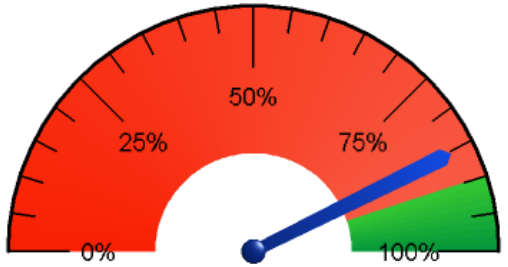
Clinical Record Keeping: Mandated requirements



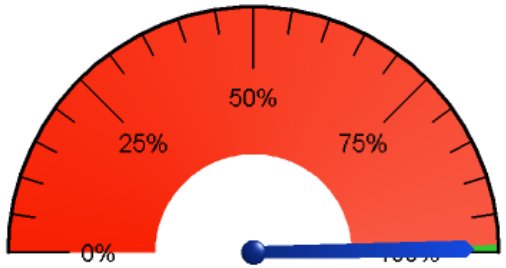
Data Quality Maturity Index (MHSDS)



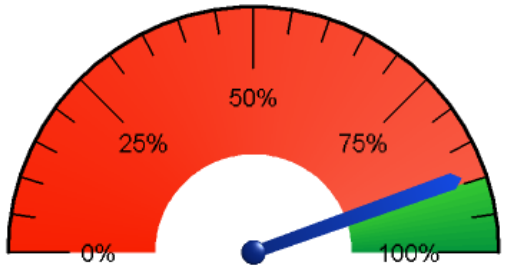
Percentage of service users with ethnicity recorded (service users seen in month)



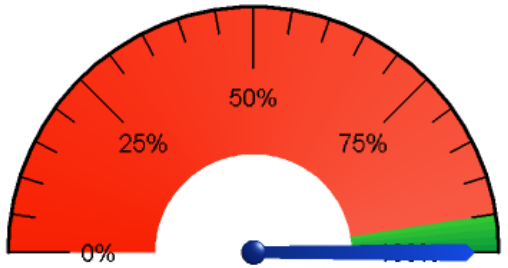
Percentage of service users with ethnicity recorded (NHS Standard Contract)



Percentage of NHS number recorded

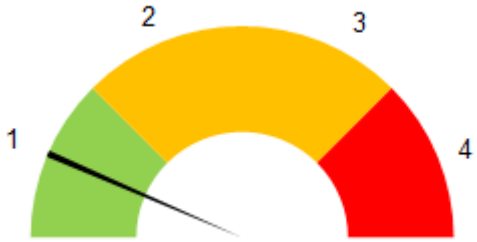


Proportion of in scope patients assigned to a cluster

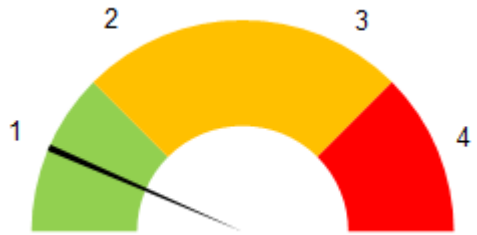


NHS Classic Safety Thermometer Percentage of Harm Free Care

Finance

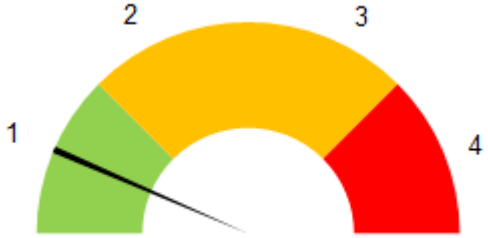


Single Oversight Framework – Finance Score

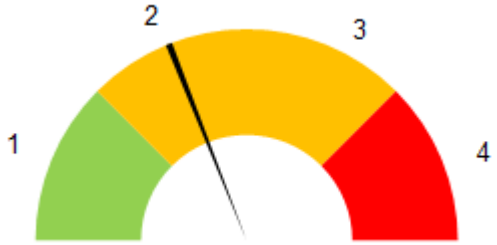


Income and Expenditure Position (£000s)

Cost Improvement Programme (£000s)

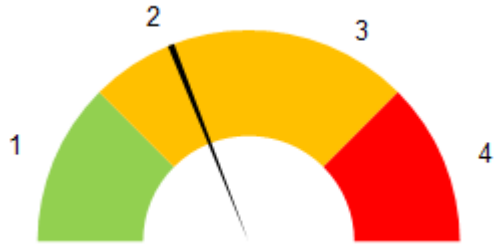


Cash (£000s)



83.99% of plan

Capital (£000s)



Agency spend (£000s)

Service Performance – Chief Operating Officer

Services: Access & Responsiveness: Our response in a crisis	Target	Dec-18	Jan-19	Feb-19
Percentage of crisis calls (via the single point of access) answered within 1 minute	-	79.8%	76.7%	78.2%
Percentage of referrals to the crisis team with a crisis plan in place within 24 hours of referral	95%	99.0%	95.4%	98.0%
Percentage of admissions gatekept by the crisis teams	95%	100%	100%	100%
Percentage of ALPS referrals responded to within 1 hour	85%	71.8%	81.8%	75.7%
Services: Access & Responsiveness: Our Specialist Services	**Target**	**Dec-18**	**Jan-19**	**Feb-19**
Gender Identity Service - Median wait for those currently on the waiting list (weeks)	-	33.4	33.1	33.4
Gender Identity Service: Number on waiting list	-	1,281	1,350	1,381
Leeds Autism Diagnostic Service (LADS): Percentage receiving a diagnosis within 26 weeks of referral (quarterly)	80%	26.0%	-	-
Leeds Autism Diagnostic Service (LADS): Percentage receiving an assessment within 13 weeks	-	22.2%	40.4%	60.9%
CAMHS inpatients: Honosca & CGAS: % completed at admission (quarterly)	95%	100%	-	-
CAMHS inpatients: Honosca & CGAS: % completed at discharge (quarterly)	95%	100%	-	-
Deaf CAMHS: wait from referral to first face to face contact in days (monthly)	-	43.4	70.4	57.6
Forensics: HCR20: Percentage completed within 3 months of admission (quarterly)	95%	100%	-	-
Forensics: HCR20 & HoNOS Secure: Percentage completed (LOS greater than 9 months) (quarterly)	95%	97.1%	-	-
Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency)	-	-	-	-
Perinatal Community: Percentage waiting less than 2 weeks for first contact (routine)	-	-	-	100%
Perinatal Outreach: Average wait from referral to first contact (all urgencies)	-	-	-	-

Service Performance – continued

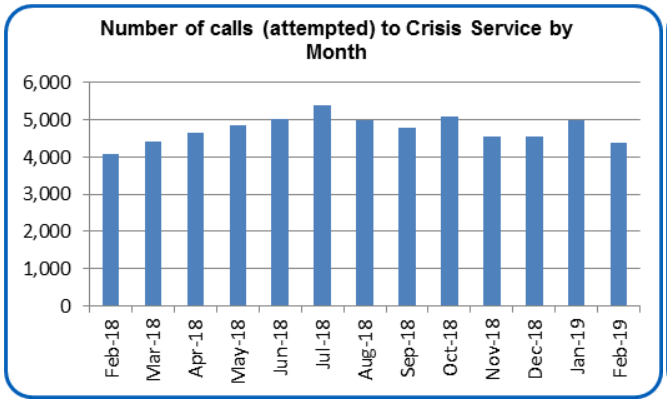
Services: Our acute patient journey	Target	Dec-18	Jan-19	Feb-19
Number of admissions to adult facilities of patients who are under 16 years old	-	0	0	0
Crisis Assessment Service (CAS) bed occupancy	-	91.4%	88.2%	93.5%
Crisis Assessment Service (CAS) length of stay at discharge	-	9.3	6.3	7.2
Liaison In-Reach: attempted assessment within 24 hours	87%	79.3%	86.9%	83.4%
Bed Occupancy rates for (adult acute excluding PICU) inpatient services:	94-98%	98.9%	99.8%	101.4%
• Becklin – ward 1	-	98.2%	100.0%	101.7%
• Becklin – ward 3	-	95.3%	99.3%	102.1%
• Becklin – ward 4	-	99.9%	98.5%	100.3%
• Becklin – ward 5	-	100.6%	100.9%	102.8%
• Newsam – ward 4	-	100.6%	100.2%	101.4%
• Older adult (total)	-	89.9%	88.4%	93.4%
• The Mount – ward 1	-	92.6%	95.3%	100.0%
• The Mount – ward 2	-	76.8%	96.1%	98.1%
• The Mount – ward 3	-	92.7%	81.9%	79.9%
• The Mount – ward 4	-	93.4%	85.3%	99.3%

Service Performance – continued

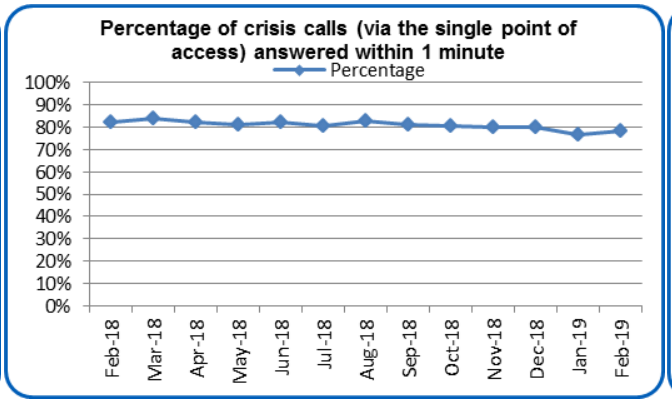
Services: Our acute patient journey	Target	Dec-18	Jan-19	Feb-19
Percentage of delayed transfers of care	<7.5%	13.6%	12.4%	12.5%
Number of out of area placement bed days versus trajectory (in days: cumulative per quarter)	-	+626	+108	+101
Acute: Number of out of area placements beginning in month	-	12	2	16
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	368	322	182
PICU: Number of out of area placements beginning in month	-	1	4	5
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	4	26	51
Older people: Number of out of area placements beginning in month	-	0	0	0
Older people: Total number of bed days out of area (new & existing placements from previous months)	-	0	0	0
Services: Our community care	**Target**	**Dec-18**	**Jan-19**	**Feb-19**
Percentage of inpatients followed up within 7 days of discharge	-	96.0%	97.1%	93.8%
Percentage of inpatients followed up within 7 days of discharge (quarterly data)	95%	96.06%	-	-
Number of service users in community mental health team care (caseload)	-	5,056	4,898	4,860
Percentage of referrals seen (face to face) w/in 15 days by a community mental health team	80%	89.0%	76.7%	83.3%
Percentage of referrals to memory services seen (face to face) within 8 weeks (quarter to date)	90%	90.0%	85.2%	88.7%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50%	72.8%	64.6%	59.9%
Services: Clinical Record Keeping	**Target**	**Dec-18**	**Jan-19**	**Feb-19**
Data Quality Maturity Index for the Mental Health Services Dataset (MHSDS)	95%	97.3%	97.4%	97.4%
Percentage of service users with ethnicity recorded (service users seen in month)	90%	94.5%	94.5%	94.4%
Percentage of service users with ethnicity recorded (NHS Standard Contract)	90%	85.0%	85.1%	85.2%
Percentage of NHS number recorded	99%	99.5%	99.4%	99.5%
Percentage of in scope patients assigned to a mental health cluster	-	89.7%	89.4%	89.1%
Timely Communication with GPs: Percentage notified in 7 days (CPA Care Plans only) (quarter to date)	-	36.4%	43.9%	38.3%

Access & Responsiveness: Our response in a Crisis

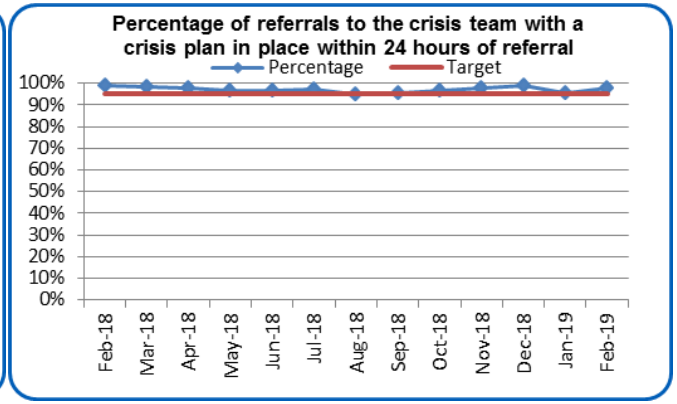
Unless otherwise specified, all data is for February 2019



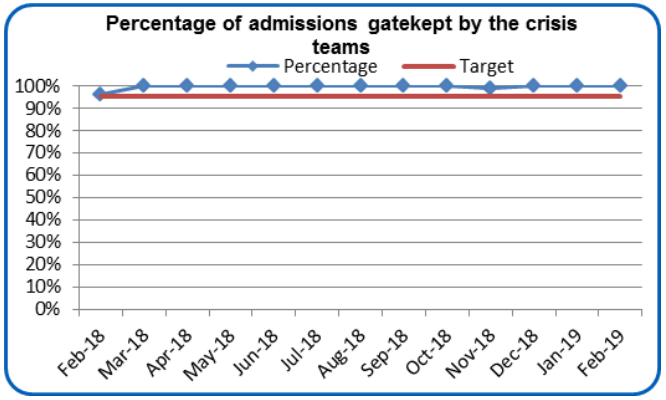
Feb calls: 4,370



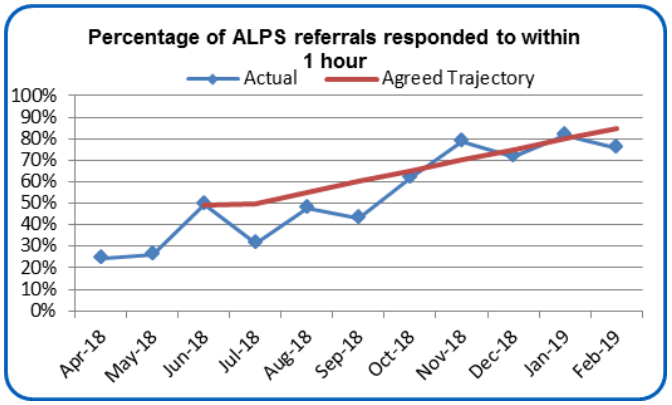
Local target: within 1 minute: Feb: 78.2%



Local target: 95%: Feb: 98%



Local target: 95%: Feb: 100%



Contractual target: 85%: Feb: 75.7%

Access & Responsiveness: Our response in a Crisis continued

Accessibility and responsiveness is a key area of focus in our improvement and development work. Whilst many of the changes are not due to take place until the Community Services Redesign goes live in April, the role of our Single Point of Access (SPA) has already begun to change to a more defined role providing an access point for secondary care referrals. The team has now relocated to its own dedicated room at the Becklin Centre and will continue to triage referrals for urgent same day face-to-face crisis assessment and direct less urgent referrals through to other appropriate secondary care teams.

Temporary staff are being recruited to provide clinical triage support to SPA to assist with appropriate signposting (with one full time, experienced staff member already in post). In the meantime, the Crisis Assessment Service (CAS) is continuing to provide clinical support in addition to its own assessment work. Communications have gone out city-wide to provide clarity on the core function of our SPA which will be to focus on ensuring people are directed to the most appropriate secondary care service.

From April, the SPA will no longer be providing an out of hours telephone support function; this will be provided by an extended support line in the third sector. This should assist with improving the response time to answer the phone within SPA (currently 78% within 1 minute and 94% within 5 minutes).

Additional changes as a result of the Community Services Redesign should also provide a strengthened gatekeeping function with increased capacity to support crisis resolution including assurance of high quality, collaborative crisis plans being in place.

The provision of an Acute Liaison Psychiatry service (ALPs) at both LGI and St James's is another critical part of our crisis support offer. Whilst performance has remained over 70% for the last 4 months, the Trust was not able to achieve the trajectory set with commissioners for continued improvement into February (75.7% responded to within 1 hour against a trajectory of 85%). The service received a high volume of referrals for the month at a time when capacity was impacted by staff sickness and two members of staff leaving for other posts. When capacity allowed, support was given from the in-reach team and bank staff were utilised but operational performance was still impacted. The vacancies have since been appointed to and the team are working closely with HR to resolve sickness issues. The team have also been encouraged to escalate staffing issues so that additional support can be provided more quickly going forwards.

Access & Responsiveness: Our Specialist Services

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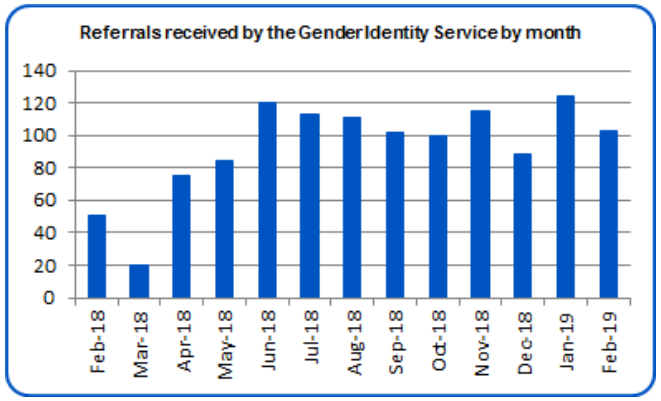
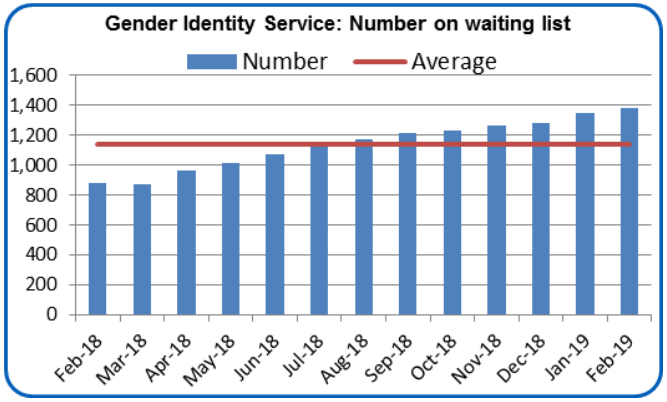
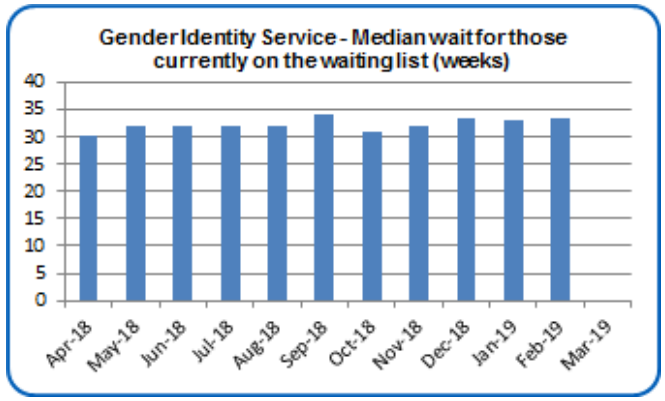


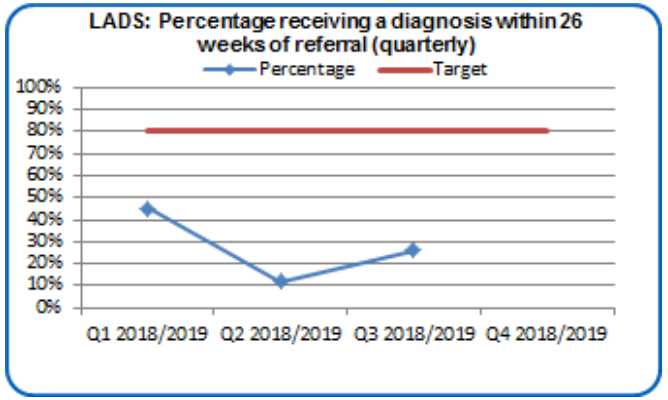
Total referrals: Feb: 103



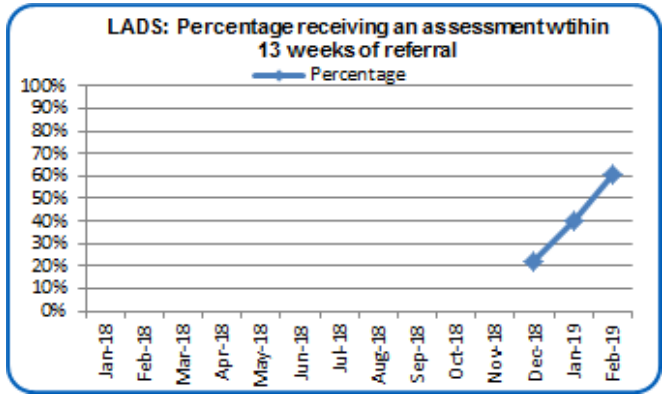
Total waiting: Feb: 1,381



Median wait: Feb: 33.4 weeks



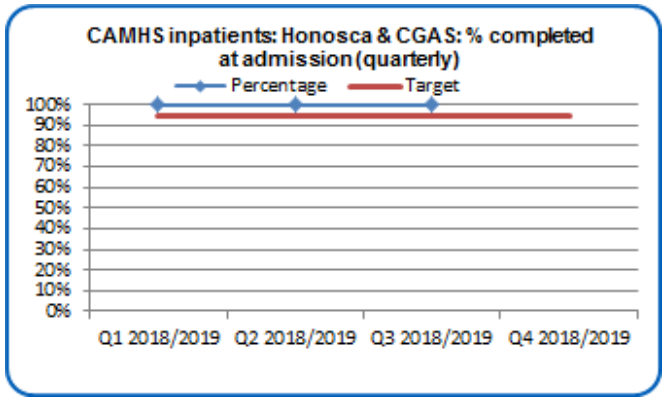
Local contractual target: 80%: Q3: 26.0%



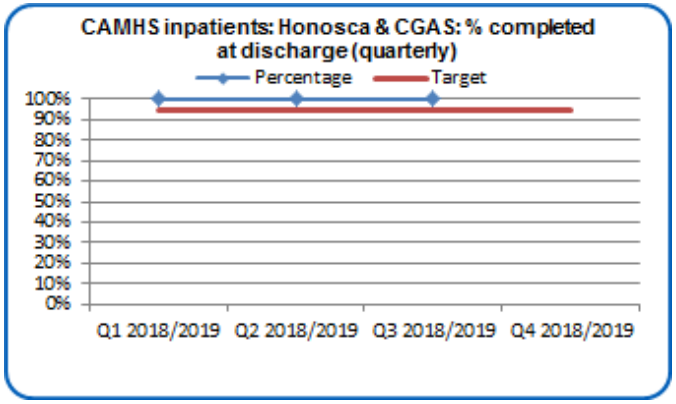
Local contractual measure from April 19 onwards: Feb: 60.9%

Access & Responsiveness: Our Specialist Services continued

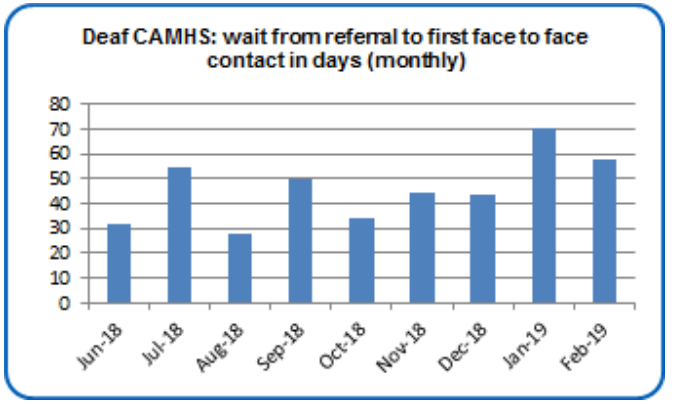
Unless otherwise specified, all data is for February 2019



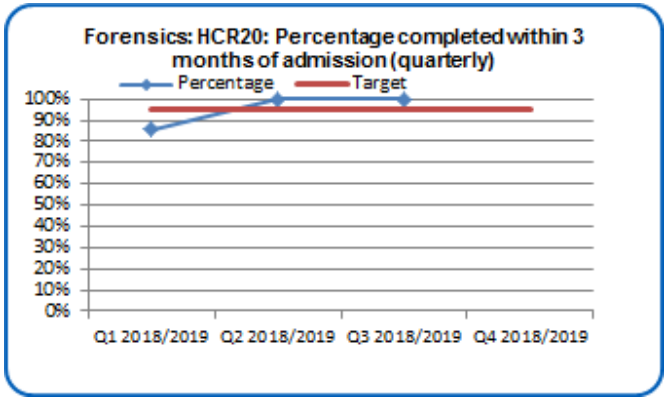
Contractual target: 95%: Q3: 100%



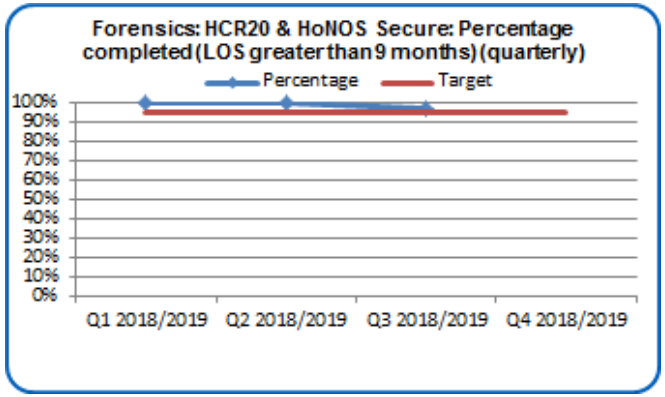
Contractual target: 95%: Q3: 100%



Local measure: Feb: 57.6 days



Contractual target: 95%: Q3: 100%



Contractual target: 95%: Q3: 97.1%
(not met for one service user in Q3)

Access and Responsiveness: Our Specialist Services continued

Please note the majority of performance measures for our more specialist local and regional services are updated on a quarterly basis.

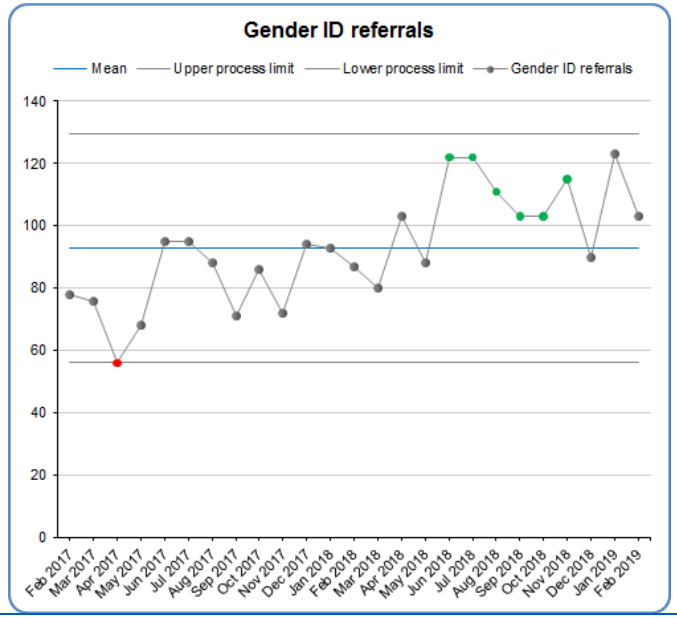
Newly added this month are 3 measures for our Perinatal service:

- Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency)
- Perinatal Community: Percentage waiting less than 2 weeks for first contact (routine)
- Perinatal Outreach: Average wait from referral to first contact (all urgencies)

During February, there were no recorded urgent/emergency first contacts for the community team and no first contacts recorded for the outreach team. However, 100% of routine referrals seen for a first contact in February were seen within 2 weeks of referrals to the community team. (N.B. trend charts will be included once more data is available).

Also new this month is the inclusion of the 13 weeks referral to assessment measure for the Leeds Autism Service (LADS) that will come into effect via the Leeds CCG contract in April 2019. April data will be used as a baseline to set a trajectory to achieve 95% in 2019/20.

The area of focus from a contractual perspective continues to be our Gender Identity service where we continue to see volumes of demand which far outweigh the scale of the commissioned service. As the below statistical process chart demonstrates, although the number of referrals received remains within process limits, 8 of the last 9 months were above average with a run of 6 months above the average. This is referred to as special cause variation and suggests an upward trend that is not just the result of natural variation.



Access and Responsiveness: Our Specialist Services continued

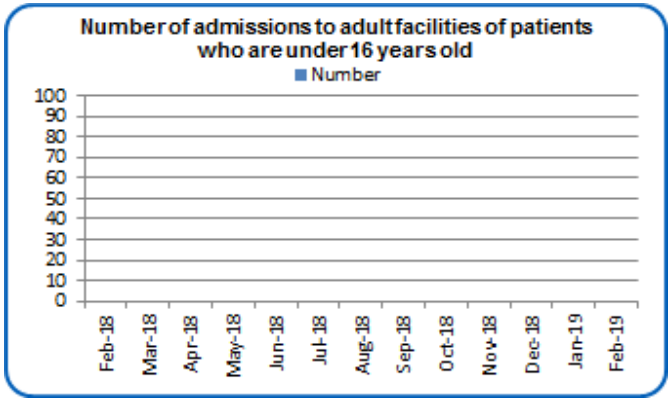
As previously reported, the Gender Identity service is also experiencing some medical staffing issues due to sickness with further recruitment underway as well as part time staff being offered an increase in hours to provide additional cover. The service is also in discussion with the national team about the possibility of combining the current hormone and diagnostic appointments and a request has been made for additional funding for additional staff recruitment on the basis of such consistently high demand. We continue to work with commissioners to seek a short term solution to support improved access and treatment as part of our contracting negotiations.

Due to the reduction in available appointments to complete the assessment process (due to medical staffing levels), the Gender service has seen deterioration in the median wait for first assessment for those currently on the waiting list from 33.1 to 33.4 weeks. It should be noted that the anticipated waiting time for any new referral received is now in the region of 87 weeks based on capacity and the current waiting list. In order to support the team and the waiting times pressures, the service has embarked on a Service Improvement Programme, sponsored by the Director of Workforce.

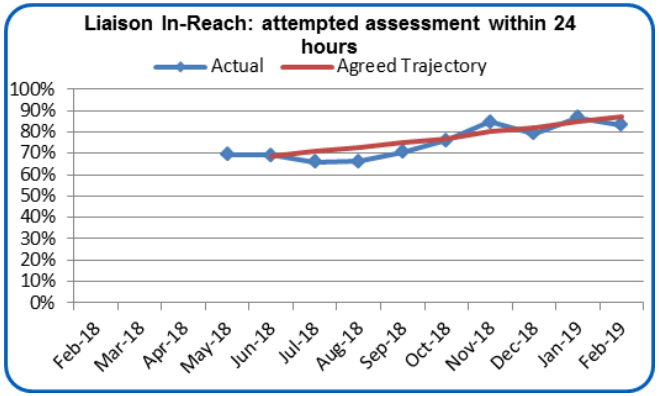
The next development for the report will be the inclusion of metrics to show more about our Learning Disability service.

Our Acute Patient Journey

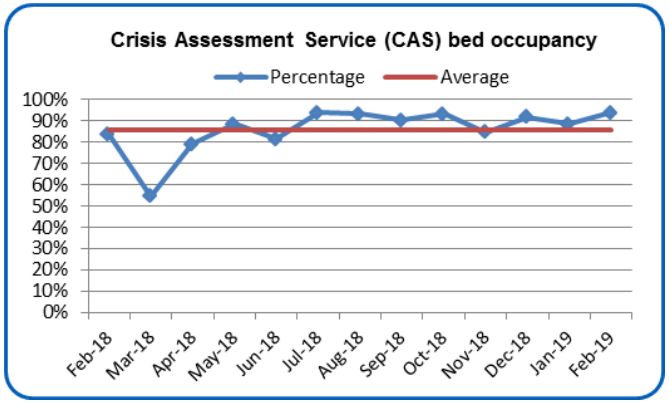
Unless otherwise specified, all data is for February 2019



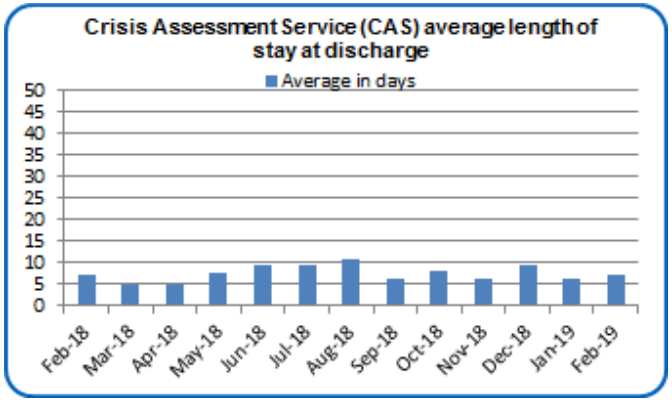
National (SOF): no target: Feb: 0



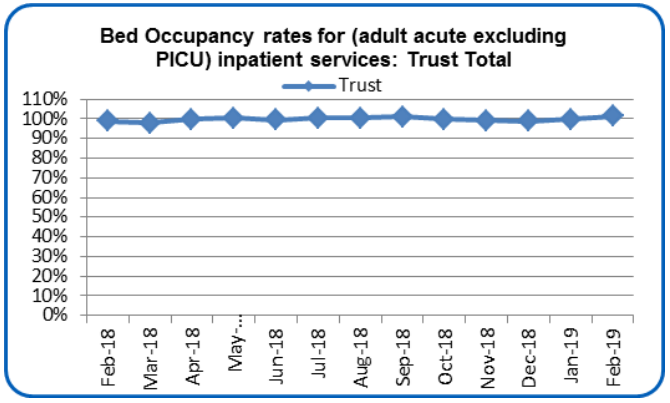
Local contractual target: 87%: Feb: 83.4%



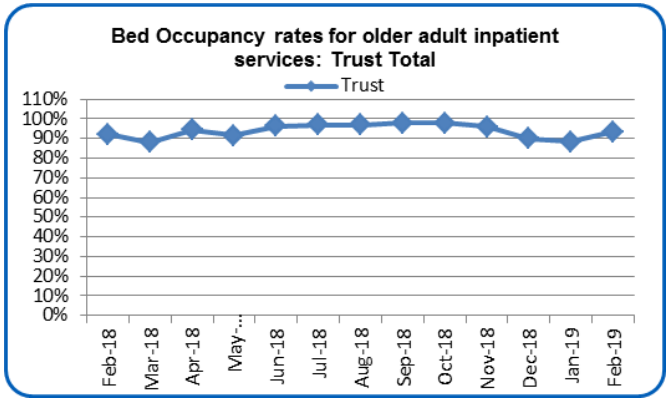
Local measure: 95%: Feb: 93.5%



Local measure: Feb: 7.2 days



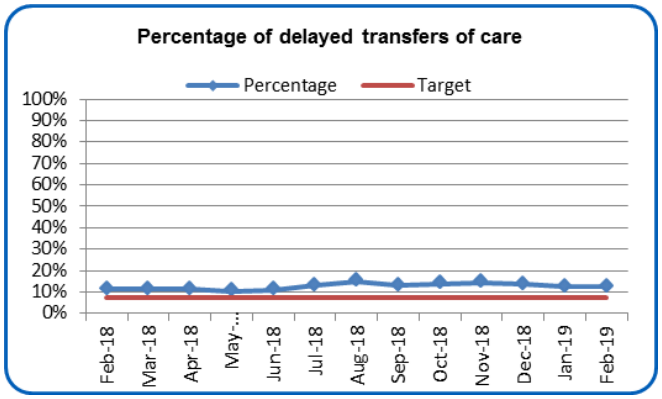
Local Contractual target: 94-98%: Feb: 101.4%



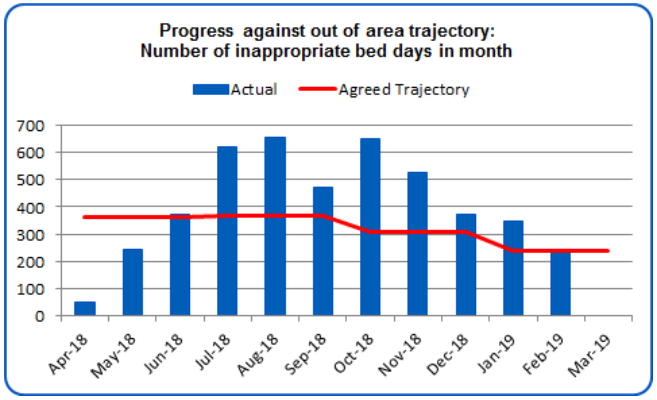
Local measure: Feb: 93.4%

Our Acute Patient Journey continued

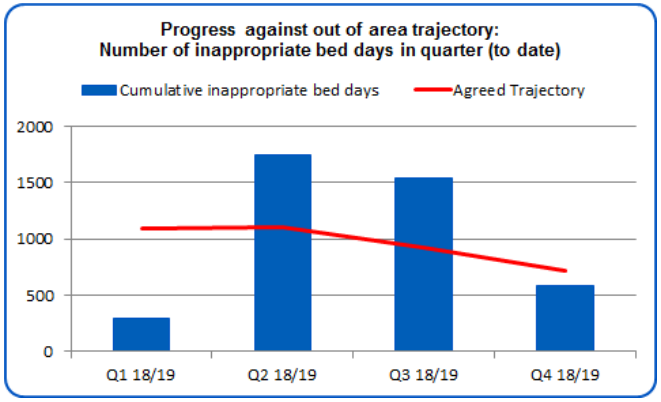
Unless otherwise specified, all data is for February 2019



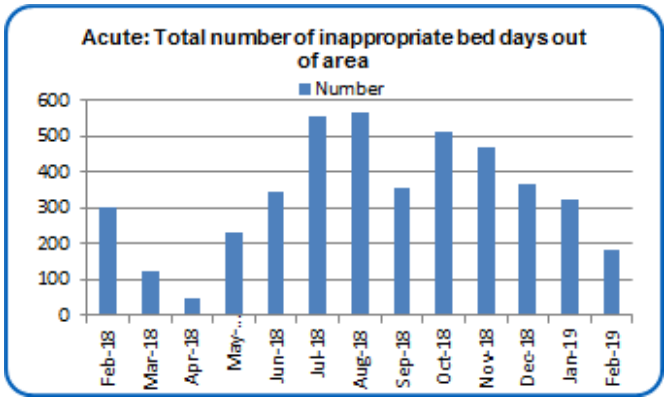
Local target: <7.5%: Feb: 12.52%



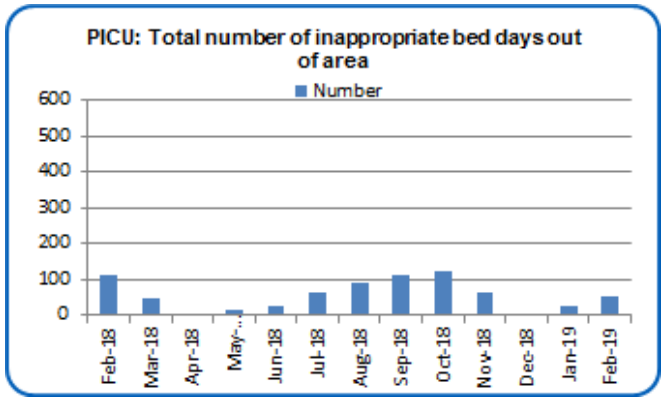
National trajectory: Feb: 233 days



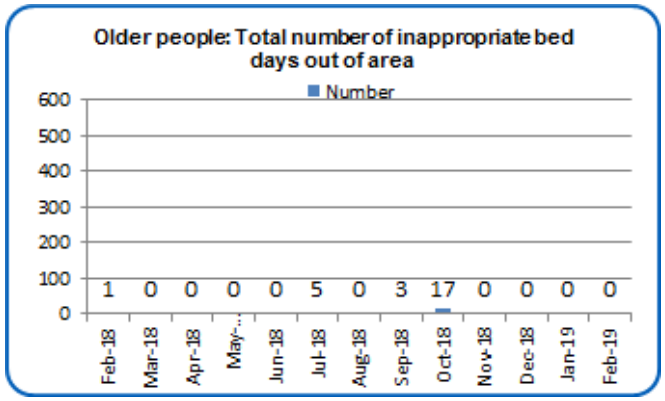
National trajectory: 95%: Q4 to date: 581 days



Local measure: Feb: 182 days



Local measure: Feb: 51 days



Local measure: Feb: 0 days

Our Acute Patient Journey continued

During February, the Trust was just short of achieving its trajectory of 87% response within 24 hours for liaison in-reach services dropping from 86.9% in January to 83.4% in February. There was a knock on effect seen due to support given to the ALPS team who had an extremely busy month and slightly lowered response times for initial self-harm assessments for medically admitted patients. However, there were also some strong performances with the older people's teams and the working age team at the Leeds General Infirmary exceeding the target at 88%. The Trust continues to look at ways of supporting the ALPS team at busy times to avoid a negative impact on the in-reach service.

Bed occupancy remains high across our acute inpatient wards rising above 100% in February. Whilst discharge rates remained consistent, there was an increase in adult acute referrals and demand for admission in the second half of the month that resulted in a steep rise in out of area placements towards the end of the month that will also impact into March. During February, there were 16 new adult acute placements sent out of area compared with only 2 in January. The increase in demand on adult acute wards is likely to have caused the increase in bed occupancy and length of stay in the crisis assessment unit as services worked to accommodate demand.

As at 28th February 2019, Inappropriate out of area placements:

	28th February
Number remaining out of area	11 (Adult) 0 (PICU) 0 (Older Adult)
Of these:	
Longest number of days to month end	206 (Adult)
Shortest number of days to month end	3 (Adult)

Whilst February saw the lowest number of inappropriate bed days in month (233) since April 2018, this was due more to the reduction in placements remaining out of area at the end of January (only 5 remained out of area) that rose to 11 at the end of February.

The Leeds CCG has recognised the difficulties being experienced in managing out of area placements and has agreed to fund a number of schemes for 2019/20 around the themes of admission avoidance, reducing length of stay & clinical variation and reducing delayed transfers of care. These include:

- Crisis Café Extension
- Intensive discharge facilitation
- Project Manager for rehabilitation review

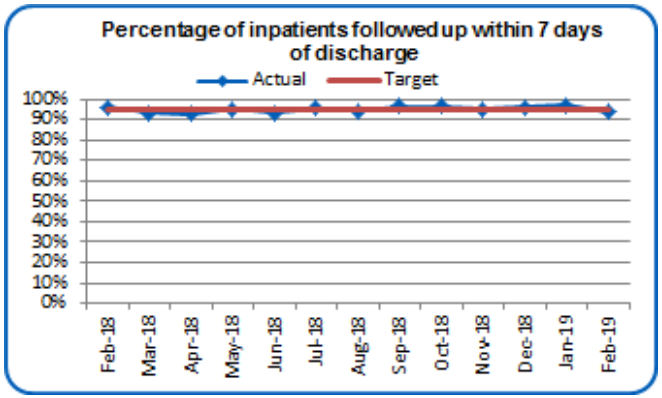
Our Acute Patient Journey continued

Delayed transfers of care also increased for adult acute inpatients rising from 10.9% to 13.7% January to February. The root cause of the increase was the complexity of service users requiring highly supported accommodation. A new team is currently being established within acute inpatients to focus on finding suitable accommodation for delayed transfers of care. Two clinical managers are already in place with interviews for a social worker taking place this week and recruitment of a housing officer to follow shortly. Within older people's services, delayed transfers of care dropped from 26.8% to 22.8% in February. This was largely due to a couple of people with very complex needs being placed and discharged from hospital (small numbers of discharges can have a marked impact on the overall percentage). However, the length of stay for ward 1 at the Mount has also shown a reduction since the Enhanced Care Homes team (ECHT) became fully operational, providing support for reducing delayed transfers of care. Substantive recruitment is underway for the ECHT and optimism is high for the continued impact of this service.

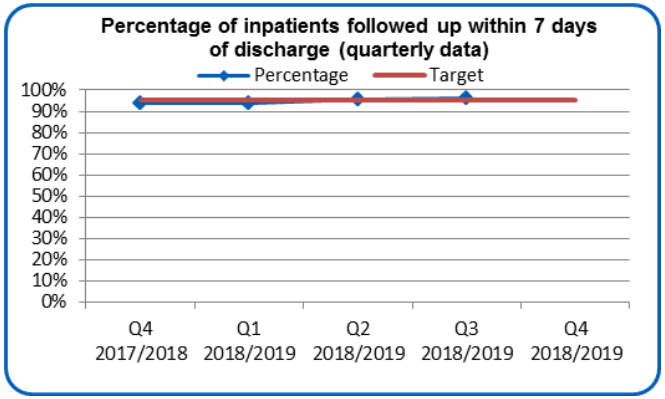
Reducing avoidable admissions, tackling unwarranted variation in length of stay and finding solutions to delayed transfers of care with our partners remain a challenge for 2019/20. It is hoped that the redesign of our community services with more intensive home based treatment, more consistent gatekeeping prior to admission and in-reach support to assist discharge will prove effective in assisting patient flow from April onwards.

Our Community Care

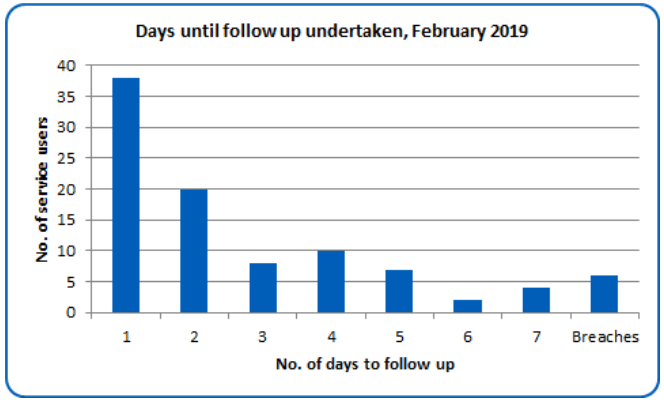
Unless otherwise specified, all data is for February 2019



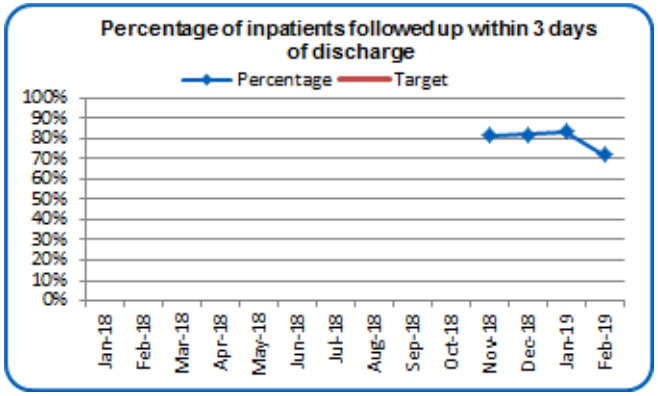
Local monthly target: 95%: Feb: 93.8%



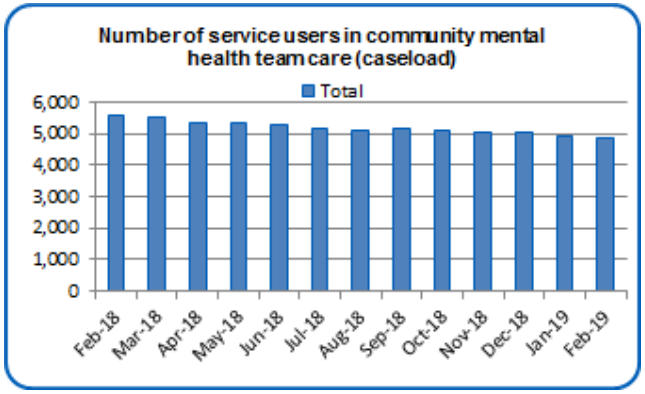
National (SOF) target: 95%: Q3: 96.06%



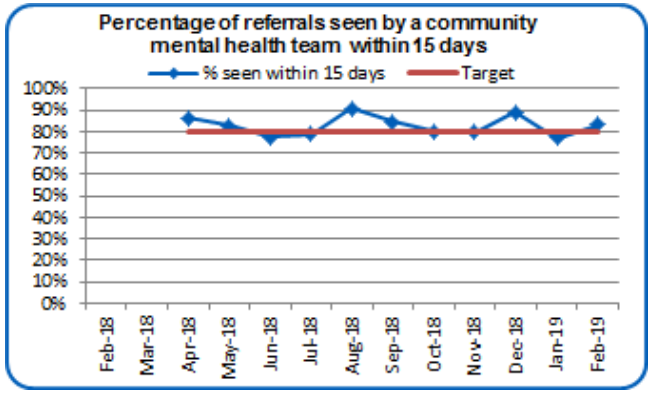
Local measure



Contractual target from April 19: 80%: Feb: 71.9%



Local measure: Feb: 4,860



Local contractual target: 80%: Feb: 83.3%

Our Community Care continued

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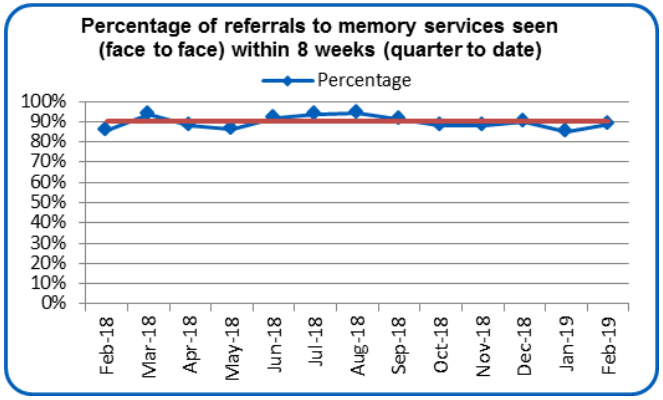
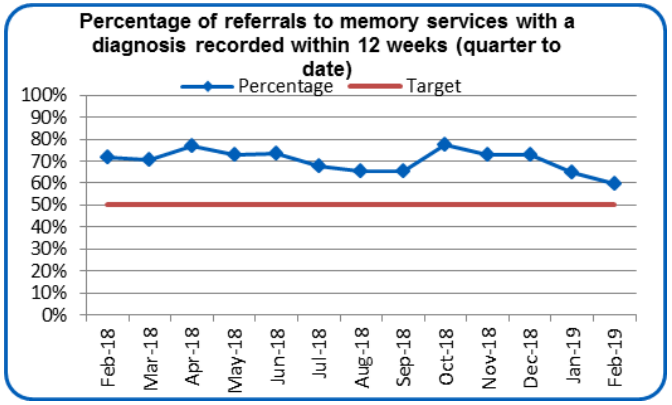


Local contractual target: 90%: Q4 to date: 88.7%



Local contractual target: 50%: Q4 to date: 59.9%

Our Community Care continued

The Community Services Redesign project reaches go-live from April 2019. The changes are intended to maximise clinical outcomes and provide a high quality experience for our services users. We are currently developing a number of KPIs that will be ready towards the end of Quarter 1 to assess performance against the new standards set for the redesigned services and begin evaluation of the impact the changes are having.

The Trust narrowly missed the 7 day follow up target in February with 6 breaches of the target:

- 3 were completed within 9 days of discharge
- In 2 cases follow up was missed in spite of numerous attempts to make contact with the service user. In one instance, contact was made with a family member. In the other, discharge was to the service user's probation worker and housing worker; the service user had no fixed abode and the contact number provided was not working.
- In one case, the service user went abroad after discharge without leaving a contact number. Plans are being arranged to support the service user on their return to the UK.

The 7 day target is monitored on a quarterly basis by NHS Improvement as part of the Single Oversight Framework; for the quarter to date, the Trust remains above the 95% threshold in spite of the dip in February.

From April 2019, the 3 day follow up metric the Trust has already been monitoring will become a CQUIN with a target of 80%. Whilst the Trust has been above 80% for the last few months, performance dipped below to 71.9% in February.

Performance against the 15 day Community Mental Health Team (CMHT) access target returned to above standard during February but is just under target for the quarter to date at 79.5%.

The Trust continues to remain above the 50% target from referral to diagnosis for Memory Services but the gradual decline in performance has been noted and is expected to improve under the Memory Assessment Service as part of the Community Services Redesign. Work previously undertaken by the memory team (e.g. initial complex reaction to diagnosis and later stages of dementia) will move to the CMHTs allowing the Memory Assessment Service to focus on the diagnostic process.

Clinical Record Keeping: Mandated requirements

This set of mandated data recording issues includes a significant issue of on-going concern where some teams and services are struggling to communicate with GP's within our locally contracted standards. Whilst we are targeting improvement actions in these areas we anticipate that improvements specified in our EPR re-provision will enhance this further in future.

Data Quality Maturity Index - DQMI (MHSDS)

This metric includes the mean measurement of the following criteria:

- Ethnic category
- General Medical Practice Code (patient registration)
- NHS Number
- Person stated gender code
- Postcode of usual address
- Organisation code (code of commissioner)

An expanded version of the DQMI will be a CQUIN for 19/20. Achievement of the CQUIN money will be based on achieving 90-95%. The impact of the changes is currently being assessed but already suggests that changes in recording practices will be required in order to achieve compliance. Some of these may not be possible until CareDirector is implemented as our new patient record in November 2019.

Trust performance 97.36%
National (SOF) Target 95%

Ethnicity recorded (seen patients)

This relates to service users who have been physically seen by our services, rather than those that are accepted and waiting. We are now achieving this target.

Trust Performance 94.38%
Local Target 90%

Ethnicity (NHS Standard Contract)

This measure is based on all records submitted via the mental health services dataset (MHSDS) each month (any open referral whether they have been seen or not and any admission/discharge). This measure also forms part of the Data Quality Maturity Index in the Single Oversight Framework.

Performance is lower in the Specialist and Learning Disabilities Care Group (SS&LD) where waiting times are longer but improvement continues to be seen. February saw the care group's highest year to date performance at 80.7%.

Weekly reports are being sent out to individual services where this data is missing.

This measure will not form part of the National Contract for 19/20 but will remain one of the measures used to calculate the Data Quality Maturity Index.

Trust Performance 85.21%
National Target 90%

Clinical Record Keeping: Mandated requirements

NHS Number This metric measures the completeness of NHS numbers populated within the central reporting system. Since the introduction of weekly reporting and chasing by the data quality team, recording has gradually improved with the target now being consistently met. It is likely that this measure will not form part of the National Contract for 19/20 but will remain one of the measures used to calculate the Data Quality Maturity Index. **Trust Performance 99.5%** **National Target 99%**	**Proportion of in scope patients assigned to a cluster** The Trust remains just under 90% for the proportion of patients assigned a cluster. Reminders have been issued to staff about the importance of clustering. This is likely to form part of the measures in the Leeds CCG contract for 19/20. Following the redesign of the Community Services due to go live in April, the community mental health teams will not cluster until the 6 week assessment period is completed; this is a change from current practice that defines clustering as eligible after the 2nd face to face contact. **Performance 89.09%** **No Target Agreed – measured against 90%**
Timely Communication with GPs notified in 7 days (CPA care plans only) This currently is an NHS contract service condition. The requirement includes discharge or any significant change in treatment (including CPA reviews) that requires action by the GP. This metric currently only reports against the electronic transfer of CPA care plans. The electronic transfer of both inpatient discharge letters and outpatient letters went live in mid-February. These will be reported as separate KPIs under this measure from April onwards (March data). The old process of posting CPA letters is continuing in parallel until we are confident that the closing of the care plans on our clinical system (that triggers the electronic transfer) is routinely happening and all GP practices are downloading the information. **Trust Performance: 38.3% (Q4 to date)** **Monthly performance: 34.8% (February)**	

Quality and Workforce metrics: Tabular overview

Services: Clinical Record Keeping	Target	Nov-18	Dec-18	Jan-19
Data Quality Maturity Index for the Mental Health Services Dataset (MHSDS)	95%	97.3%	97.3%	97.3%
Percentage of service users with ethnicity recorded (service users seen in month)	90%	94.0%	94.5%	94.4%
Percentage of service users with ethnicity recorded (NHS Standard Contract)	90%	84.9%	85.0%	85.0%
Percentage of NHS number recorded	99%	99.5%	99.5%	99.4%
Percentage of in scope patients assigned to a mental health cluster	-	89.7%	89.7%	89.5%
Timely Communication with GPs: Percentage notified in 7 days (quarterly)*	-	-	31.3%	-
Quality: Our effectiveness	**Target**	**Nov-18**	**Dec-18**	**Jan-19**
Number of healthcare associated infections: C difficile	<8	0	0	0
Number of healthcare associated infections: MRSA	0	0	0	0
Mental Health Safety Thermometer: Percentage of harm free care (point prevalence survey)	-	88.8%	87.8%	89.9%
Classic Safety Thermometer: Percentage of harm free care (point prevalence survey)	95%	98.5%	98.4%	99.5%
Percentage of service users in Employment	-	15.2%	15.1%	15.7%
Percentage of service users in Settled Accommodation (definition amended in Aug 18)	-	79.8%	80.0%	79.9%
Quality: Caring / Patient Experience	**Target**	**Nov-18**	**Dec-18**	**Jan-19**
Friends & Family Test: Percentage recommending services (total responses received)	-	80.9% (41)	71.8% (23)	74.6% (59)
Mortality:		-	-	-
· Number of deaths reviewed	Quarterly	-	136	-
· Number of deaths reported as serious incidents	Quarterly	-	5	-
· Number of deaths reported to LeDeR	Quarterly	-	0	-
Number of complaints received	-	18	5	13
Percentage of complaints acknowledged within 3 working days	-	100.0%	100.0%	100.0%
Percentage of complaints allocated an investigator within 3 working days	-	78.0%	75.0%	77.0%
Percentage of complaints with a draft report completed within 20 working days	-	50.0%	27.0%	67.0%
Percentage of complaint responses sent to the complainant within 30 working days	-	63.0%	77.0%	77.0%
Number of enquiries to the Patient Advice and Liaison Service (PALs)	-	106	129	179

Please note that new metrics are only reported here from the month of introduction onwards.
*This data is for CPA care plans automatically transferred to the GP only and began in mid-August

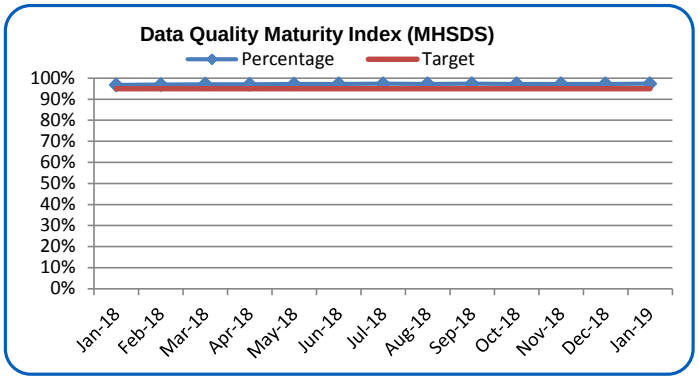
The Mental Health Safety Thermometer measures the proportion of patients that are harm free on a single day each month. It includes self harm, psychological safety, violence & aggression, omissions of medication and restraints (inpatients only)
The Classic Safety Thermometer measures the proportion of patients that are harm free on a single day each month. It includes pressure ulcers, falls, urinary infection in patients with catheters and treatment for VTE

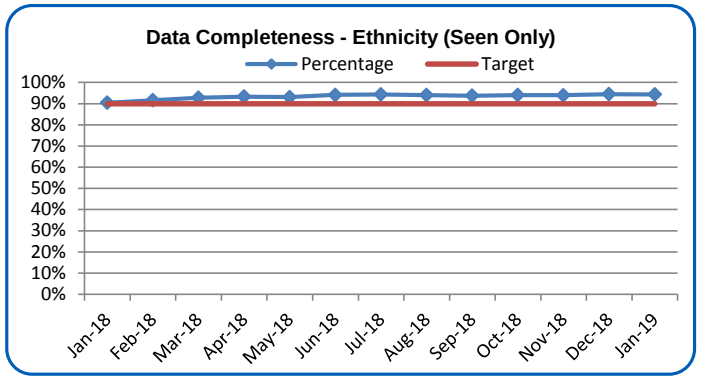
Quality and Workforce metrics: Tabular overview

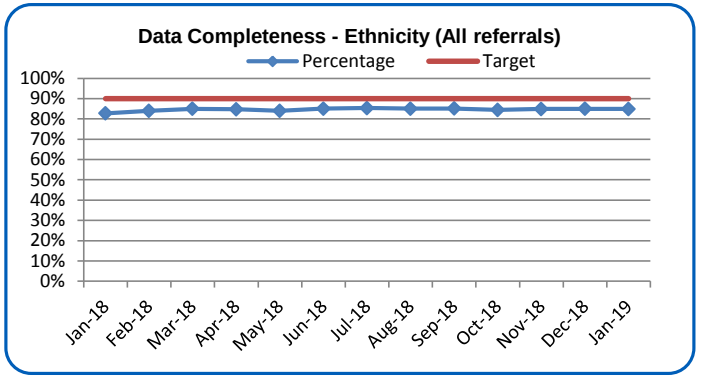
Quality: Safety	Target	Nov-18	Dec-18	Jan-19
Number of incidents recorded	-	1,013	975	1,047
Percentage of incidents reported within 48 hours of identification as serious	100%	100% (2)	100% (1)	100% (3)
Number of never events	0	0	0	0
Number of restraints	-	98	102	147
No. of patients detained under the Mental Health Act (includes Community Treatment Orders/conditional discharges)	-	468	482	485
Adult acute including PICU: % detained on admission		64.0%	70.2%	55.8%
Adult acute including PICU: % of occupied bed days detained		83.4%	85.4%	81.8%
Flu uptake (moving CQUIN target: >75% = full payment)**	75%	69.0%	77.3%	77.0%
Number of medication errors	Quarterly	-	111	-
Percentage of medication errors resulting in no harm	Quarterly	-	91.9%	-
Safeguarding Adults: Number of advice calls received by the team	-	70	50	47
Safeguarding Adults: Percentage of advice calls to safeguarding that resulted in a referral to social care		7.14% (5)	6% (3)	6.4% (3)
Safeguarding Children: Number of advice calls received by the team	-	39	24	26
Safeguarding Children: Percentage of advice calls to safeguarding that resulted in a referral to social care		5.13% (2)	12.5% (3)	38.5% (10)
Number of falls	-	69	46	70
Our Workforce	**Target**	**Nov-18**	**Dec-18**	**Jan-19**
Percentage of staff with an appraisal in the last 12 months	85%	74.3%	76.9%	76.9%
Percentage of mandatory training completed	85%	87.2%	87.5%	87.4%
Safeguarding: Prevent Level 3 training compliance (month end snapshot)	85%	92.0%	92.0%	93.0%
Percentage of staff receiving clinical supervision	85%	52.6%	61.0%	68.0%
Staff Turnover (Rolling 12 months)	8-10%	10.2%	10.3%	9.9%
Sickness absence rate (Rolling 12 months)	4.6%	4.7%	4.8%	4.8%
Percentage of sickness due to musculoskeletal issues (MSK; rolling 12 months)	14.7%	14.4%	13.9%	13.9%
Percentage of sickness due to Stress (rolling 12 months)	15.0%	31.0%	32.6%	32.9%
Band 5 inpatient nursing vacancies as a percentage of funded B5 inpatient nursing posts (percentage)	-	23.4%	23.7%	25.0%
Band 5 inpatient nursing vacancies (number)	-	51.5	55.7	58.7
Band 6 inpatient nursing vacancies as a percentage of funded B6 inpatient nursing posts (percentage)	-	2.5%	2.3%	3.7%
Band 6 inpatient nursing vacancies (number)	-	2.0	2.0	3.2
Band 5 other nursing vacancies as a percentage of funded B5 non-inpatient nursing posts (percentage)	-	21.1%	27.2%	29.1%
Band 5 other nursing vacancies (number)	-	20.5	22.4	30.4
Band 6 other nursing vacancies as a percentage of funded B6 non-inpatient nursing posts (percentage)	-	+1.6%	0.0%	0.0%
Band 6 other nursing vacancies (number)	-	+3.75	0.0	0.0
Percentage of vacant posts (Trustwide; all posts)	-	11.0%	10.71%	9.80%

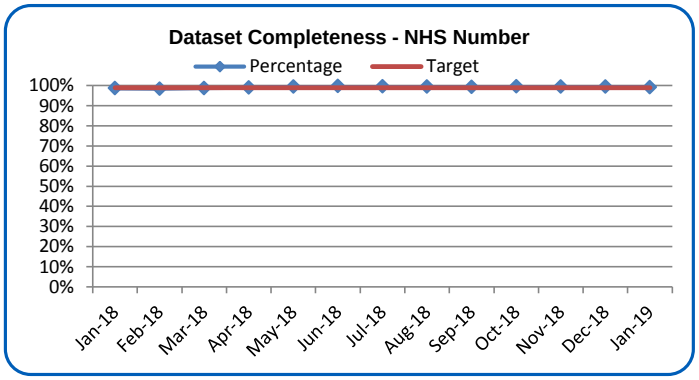
Nursing vacancies excludes nursing posts working in corporate/development roles

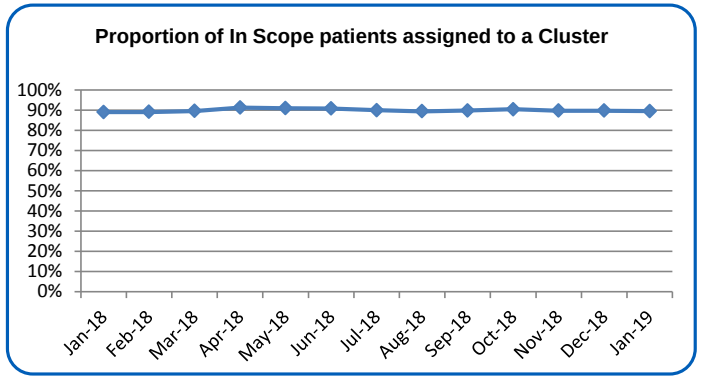
12 month trend: Clinical Record Keeping

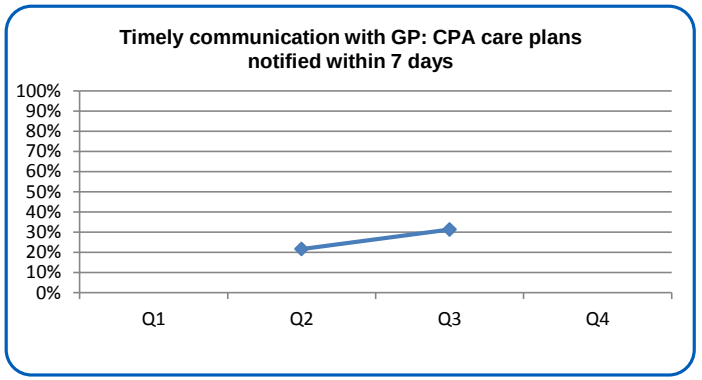






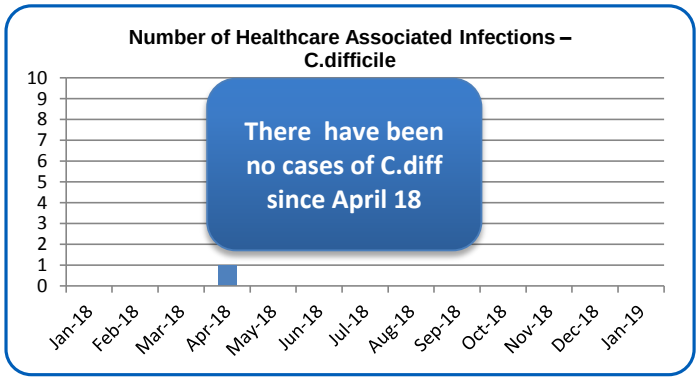


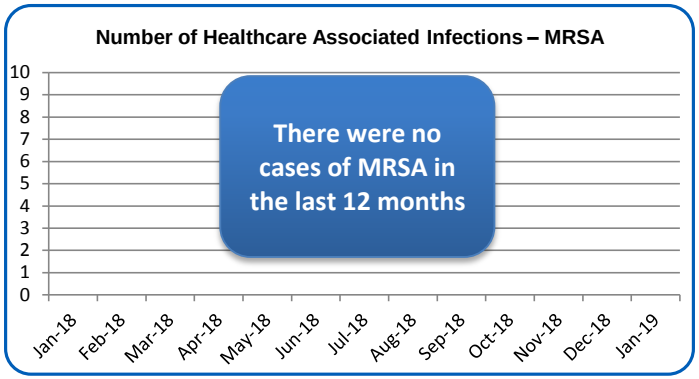


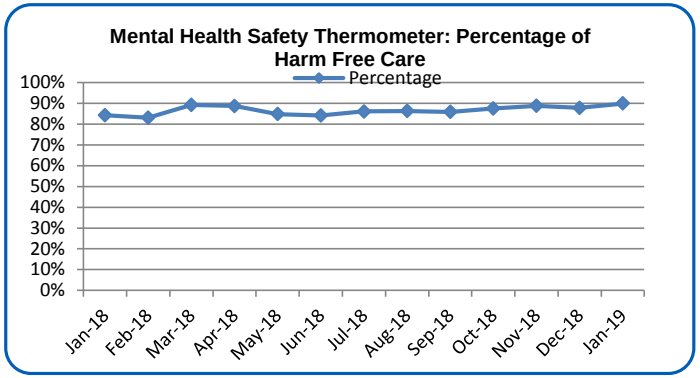


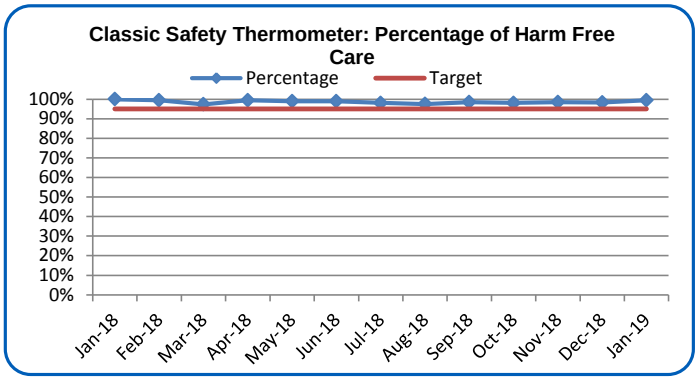
Please note that new metrics are only reported from the month of introduction onwards.

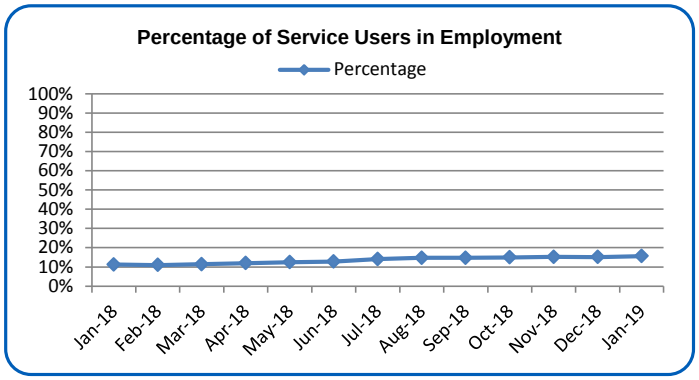
12 month trend: Quality: Effectiveness

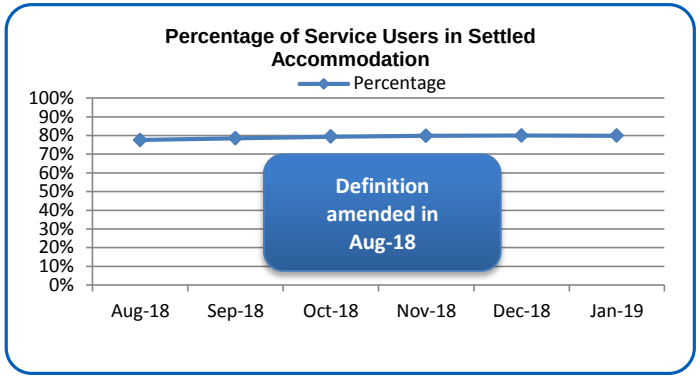




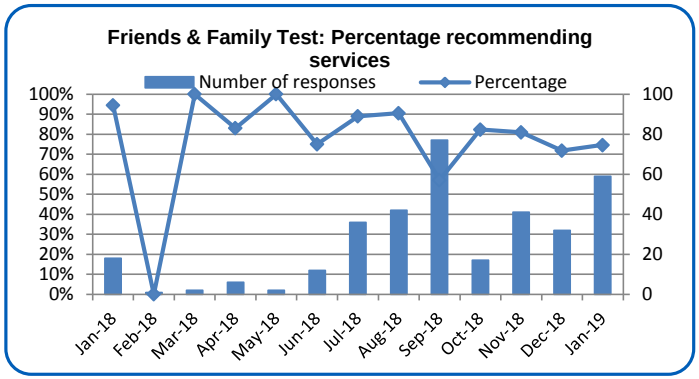


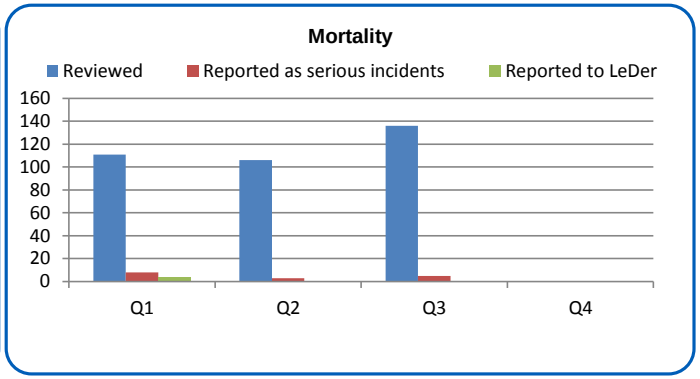


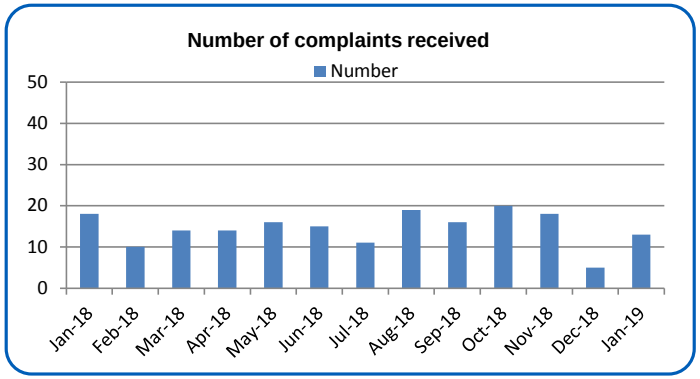


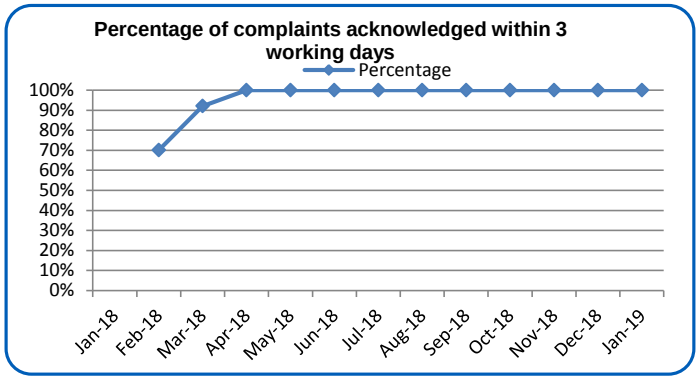


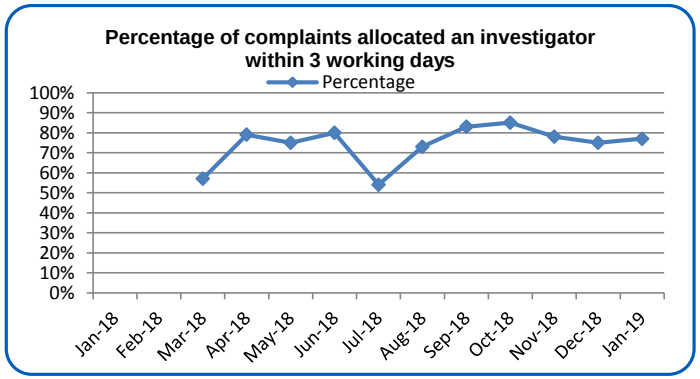
12 month trend: Quality: Caring/Patient Experience

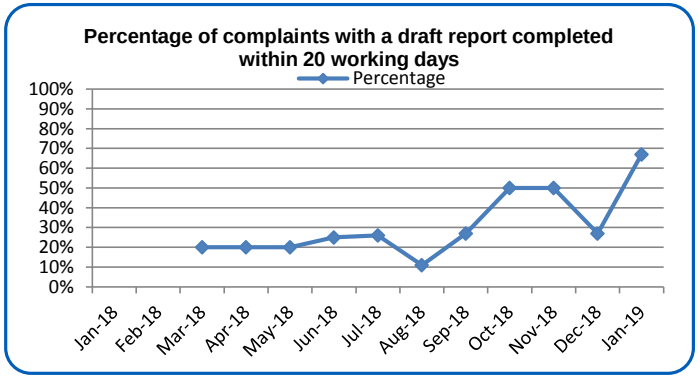


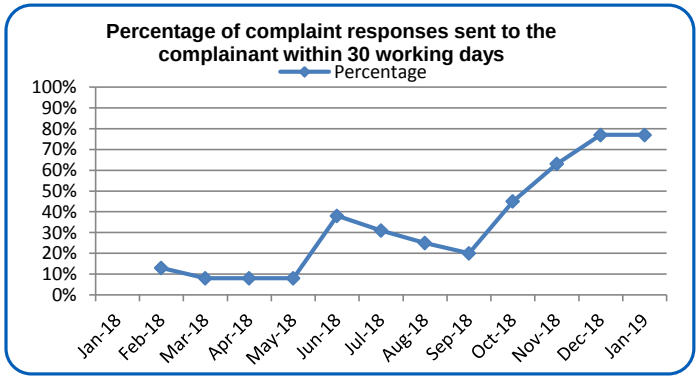


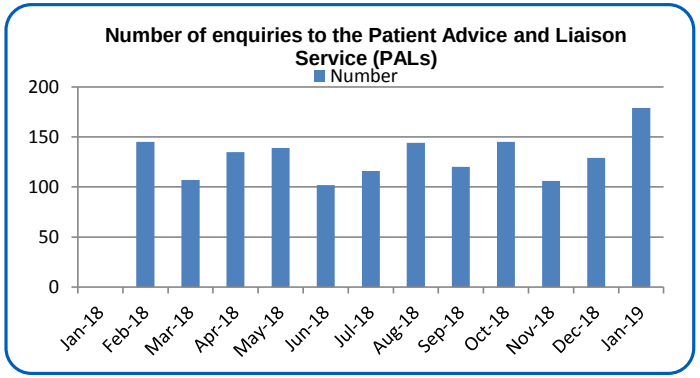




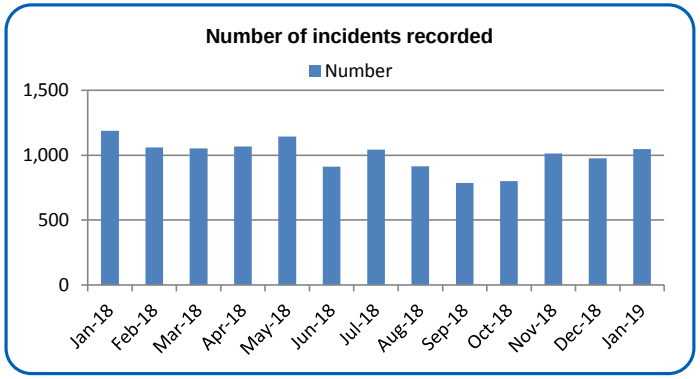


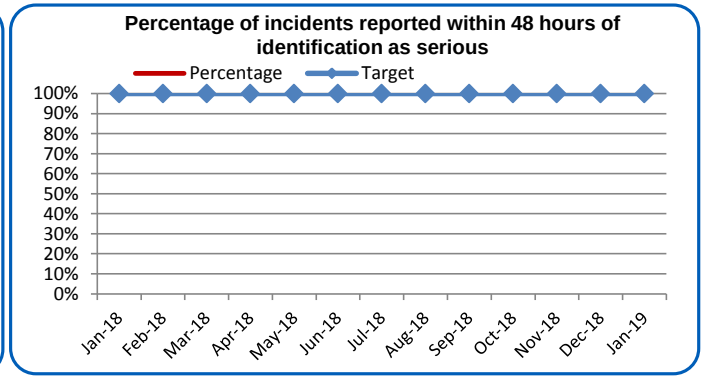


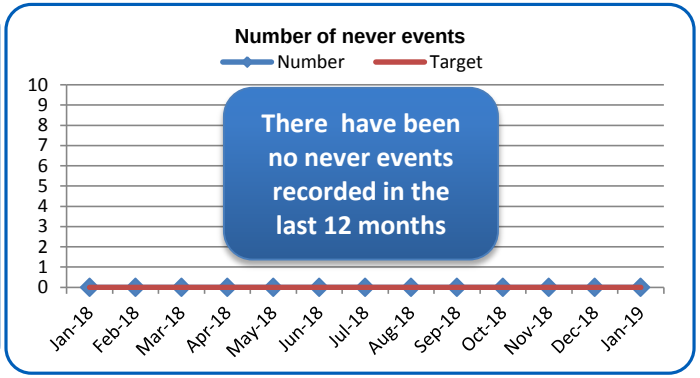


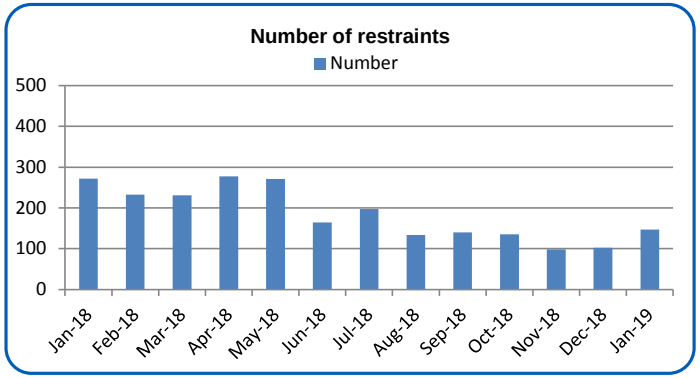


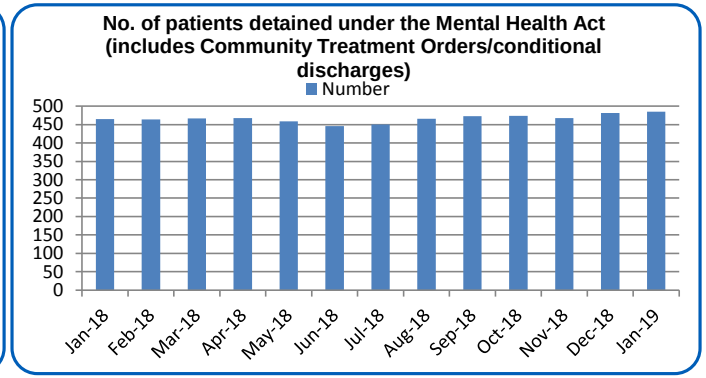
12 month trend: Quality: Safety

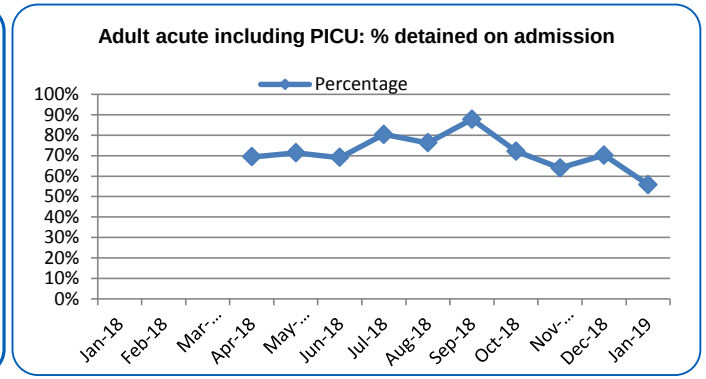


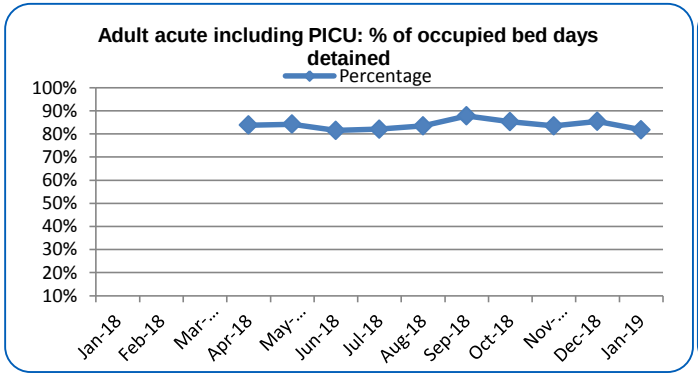


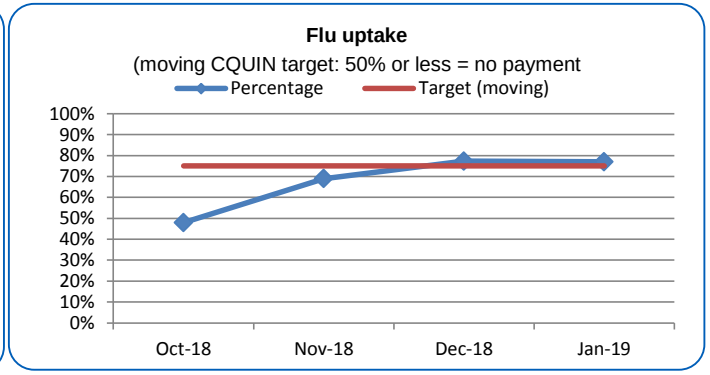




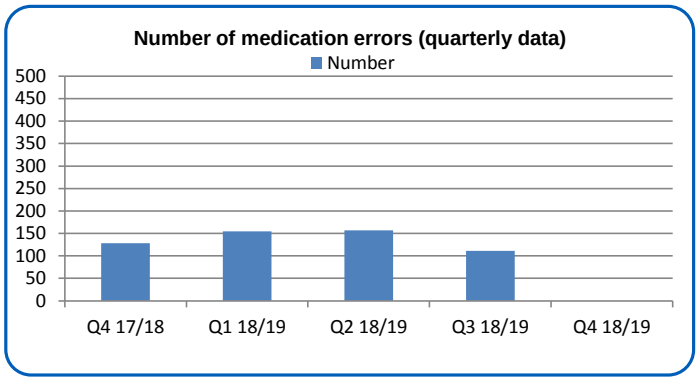


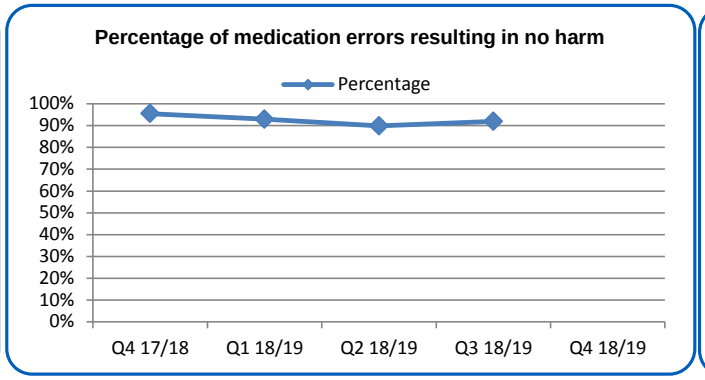


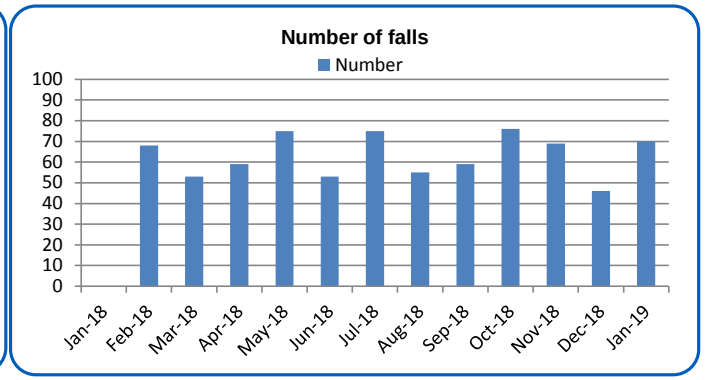


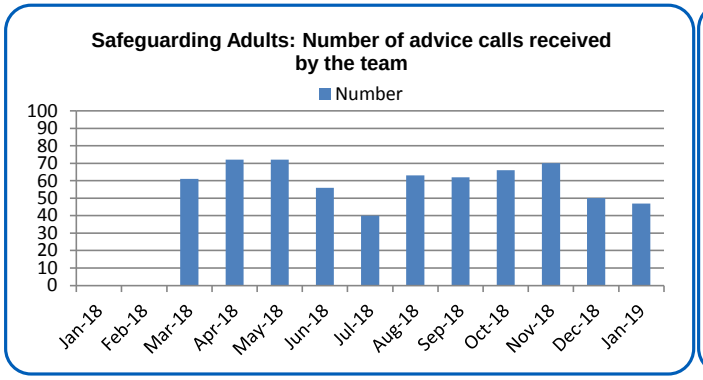


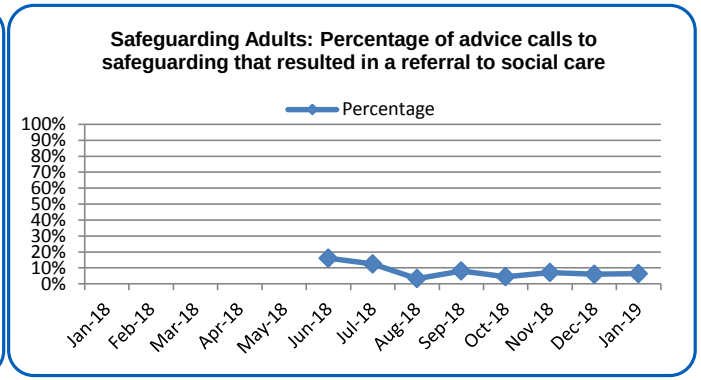
12 month trend: Quality: Safety - continued

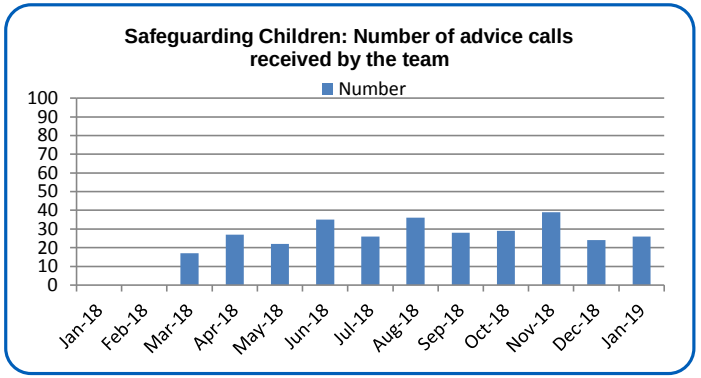


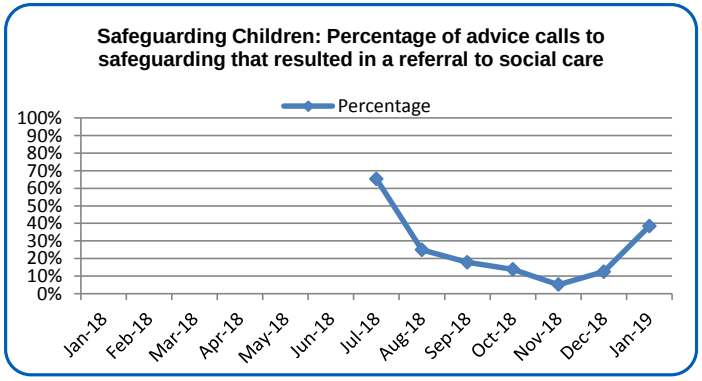




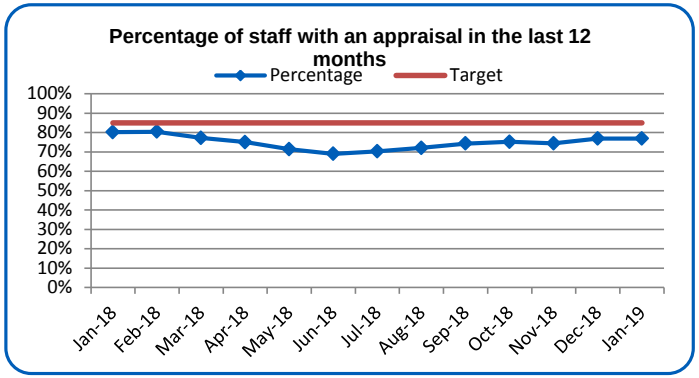


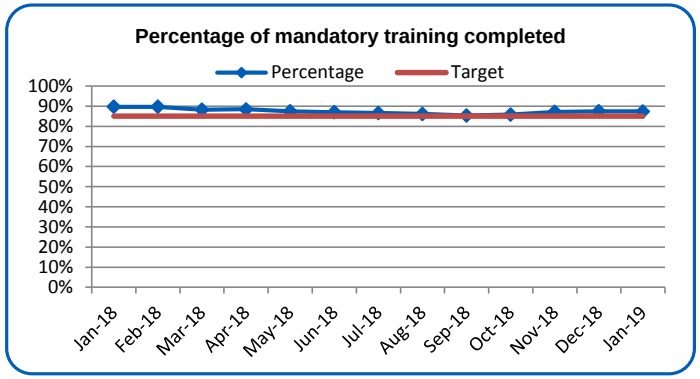


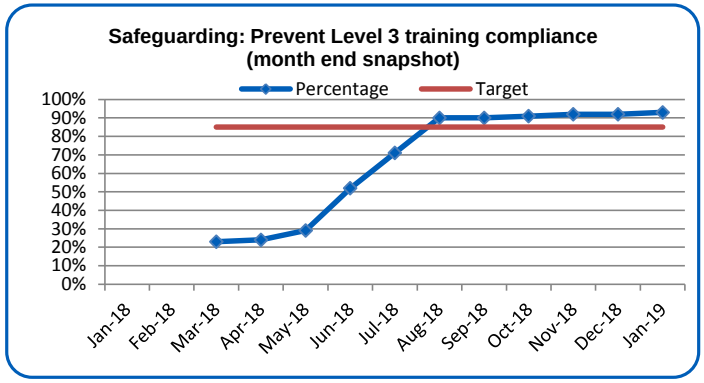


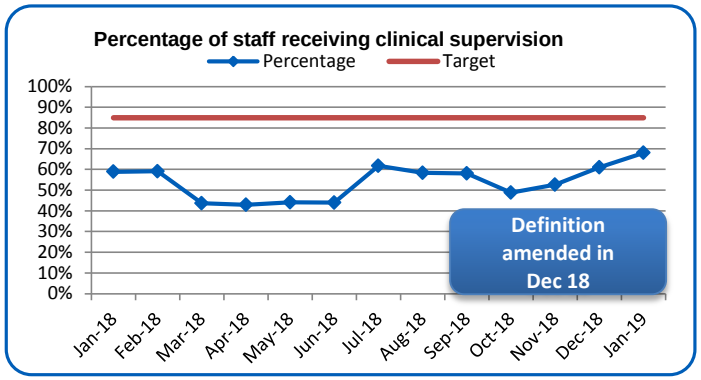


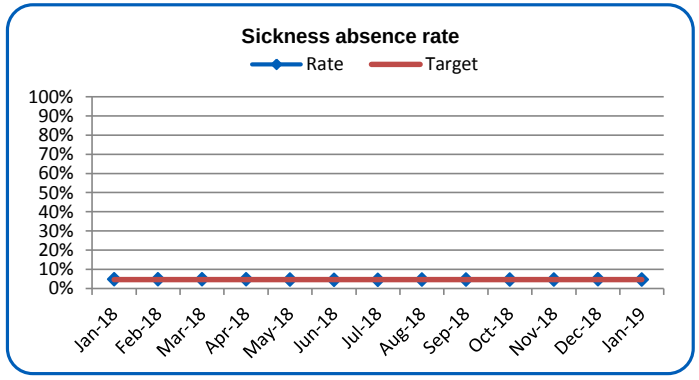
12 month trend: Our Workforce

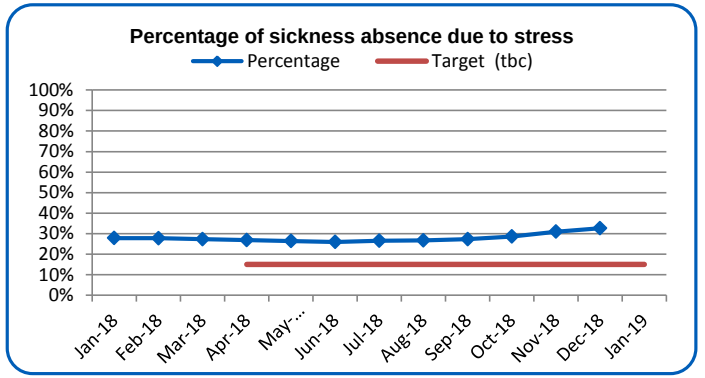


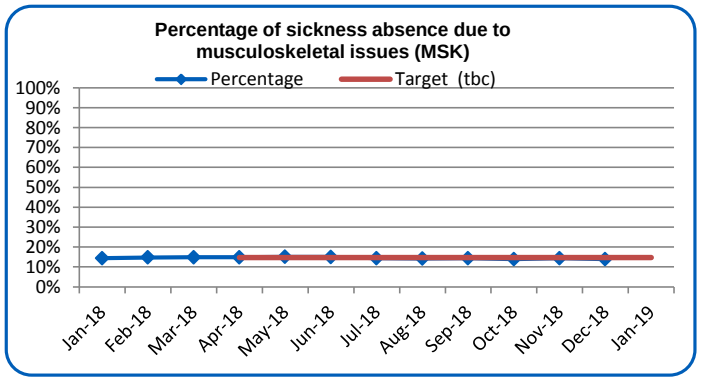




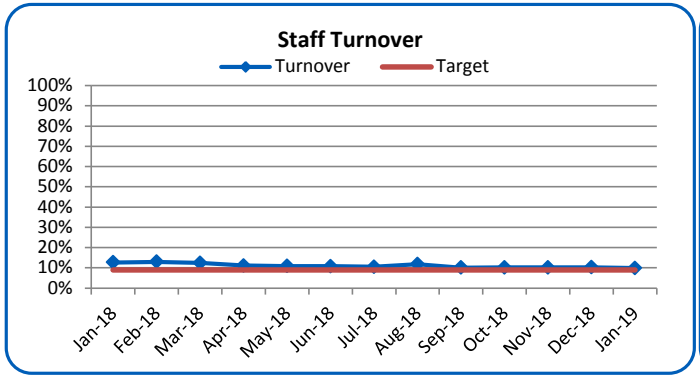


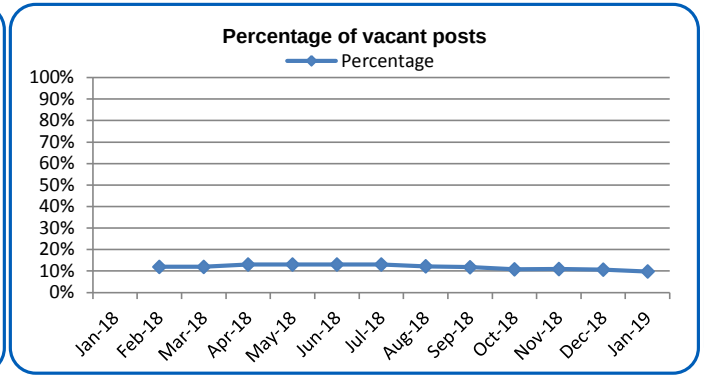


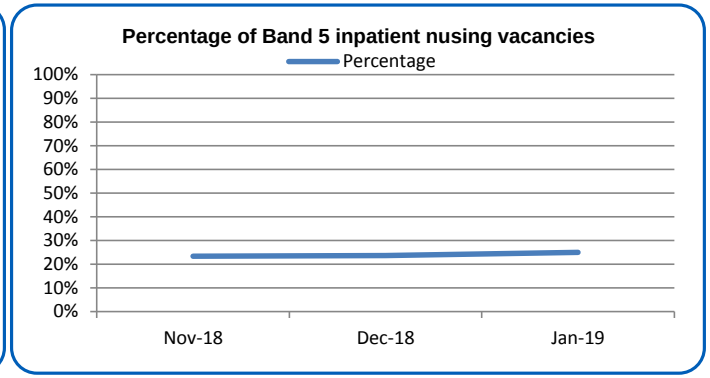


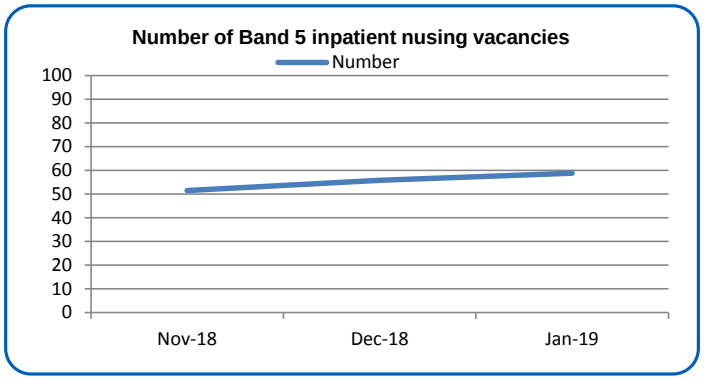


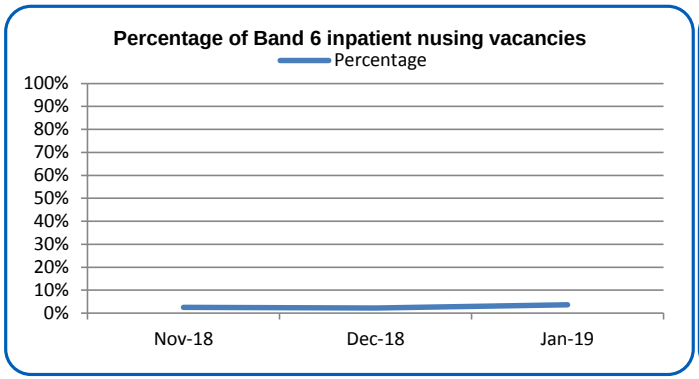
12 month trend: Our Workforce - continued

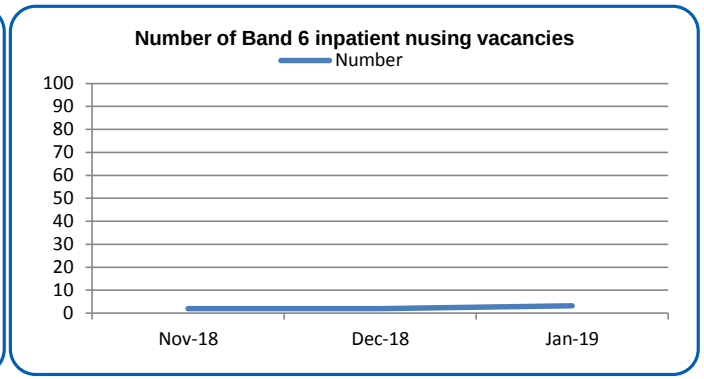




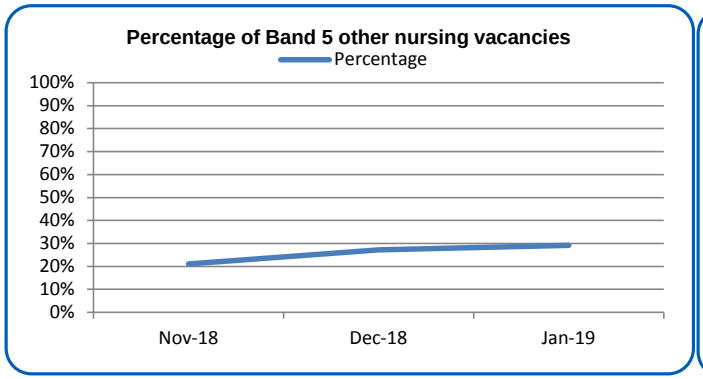


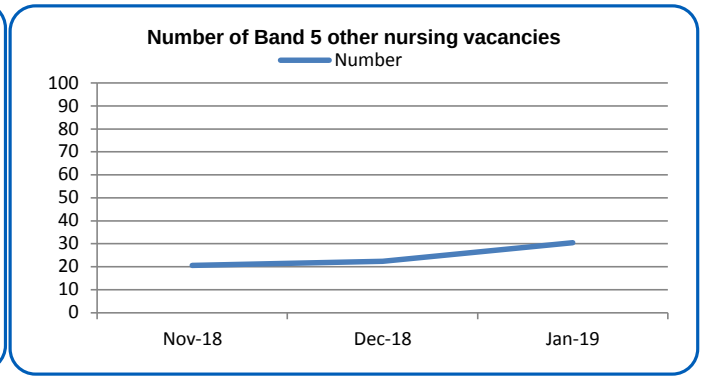


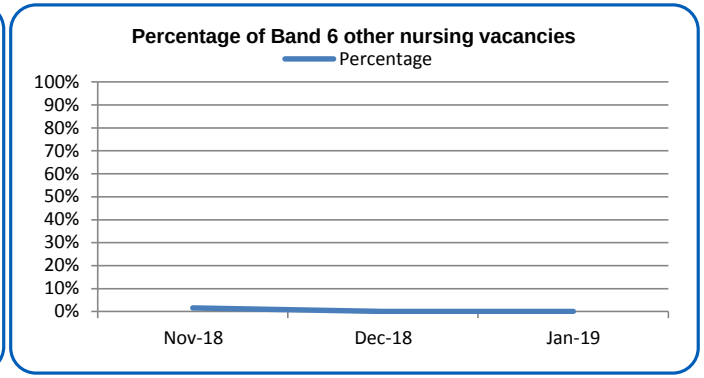


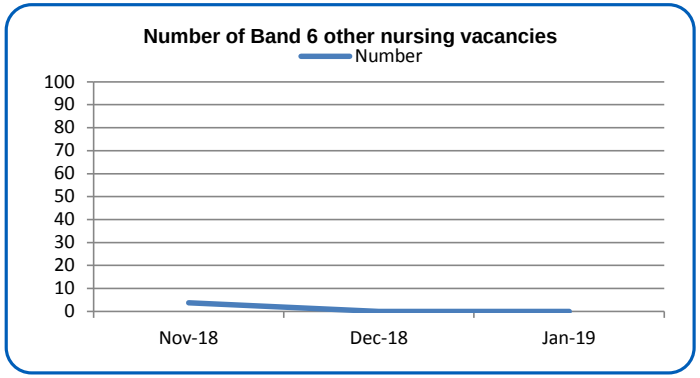


12 month trend: Our Workforce - continued









Local intelligence

Points to note:

DECEMBER:

Communication with GPs: The electronic transfer of care plans began in August. Posting of letters has continued as there are a number of practices rejecting or not downloading the care plans once deliverd to their system. This has been raised with the CCG. Further communications have been issued to GP practices ahead of sending inpatient discharge summaries and outpatient letters to GPs from mid-February onwards.

Patient Experience: The key findings of the external patient experience and involvement report were shared with Trust board colleagues and governors in January. The key recommendation was to establish a strategic steering group which will be led by the Director of Nursing, Profession and Quality. The focus of this steering group will be to develop a patient experience, involvement and carers strategy. A workshop is being organised to take place in March to engage with service users, carers and key stakeholders to consider the priority areas for carers, service users in relation to involvement and experience. Progress reports will be presented to the Quality committee every 6 months, the first of which is tabled for July.

Complaints: Although the number received in December is low, a review of previous years has shown that a drop in December is not unusual. Over the course of the year, monitoring of the time taken to respond to the complainant has shown an increase from 8% within 30 days in April to 77% in December.

Flu vaccinations: Data for December shows the Trust has achieved over the 75% threshold to receive full payment for the CQUIN; a significant improvement on last year.

Workforce: The percentage of staff with a completed appraisal in the last 12 months has increased to 76.9% whilst the percentage of staff receiving clinical supervision has increased to 61%. Work continues through the workforce validation group to ensure the system is being proactively updated as and when appraisals and clinical supervision occurs. The sickness data has been included for November and December to provide a more up to date position. The absence levels have increased slightly on October and November and are in breach of the cumulative target. The increase in absence due to mental health related illness and stress is steadily increasing and work continues to improve our staff support. An HR Project Manager has been appointed to support the move from the First Care recording system to ESR. As part of this move, individual staff members report absence directly to the manager enabling the manager to respond more effectively. Part of the project manager's remit will be to review the effectiveness of our current absence management procedures and advise on recommendation for improvement. The percentage of Band 5 nursing vacancies has increased this month on account of the embedding of the Community Redesign Structure within the establishment figures. Activity has commenced to recruit to these posts. Mandatory training compliance remains consistently above target.

JANUARY:

Record Keeping: Communication with GPs: The electronic transfer of discharge summaries and key outpatient letters began as planned in mid-February. As data becomes available, it will be included within this report. Performance for the transfer of CPA plans (began mid-August) continues to improve based on quarter to date information for Q4.

Safety: Whilst the number of uses of restraint increased during January, the trend data shows that this is still in line with the reduction in numbers seen in the last 6 months in comparison with the 6 months prior. There was 1 service user who remained in the 136 suite for longer than 24 hours in January, bringing the year to date total to 13.

Patient Experience: The percentage of draft reports following a complaint completed within 20 days has improved considerably over the course of the year rising from 20% in April to 67% in January. This improvement over the year is also reflected in the percentage of responses sent to the complainant within 30 days.

Workforce: Following feedback from professional groups as to the appropriate number of clinical supervision sessions per annum, the Trust has taken the decision to review the minimum number of clinical supervision sessions for each 12 month period. The policy now requires a minimum of 6 sessions in each 12 month period and will be measured on the basis of supervision taking place in the previous 60 days for rolling reporting purposes. This prevents some of our professional groups who adhere to their profession's standards for clinical supervision from appearing to breach the Trust standards. This change was made during February and will be reported from February data onwards. Performance for January (based on supervision taking place in the previous 6 week period) has improved rising from 61% in December to 68% in January. Recruitment to the nursing posts required as part of the community redesign due to go live at the end of March is underway.

Finance – Chief Financial Officer and Deputy Chief Executive

Unless otherwise specified, all data is for February 2019

This section highlights performance against key financial metrics and details known financial risks as at February 2019. The financial position as reported at month 11 is within plan tolerances.

Finance	Target	Dec-18	Jan-19	Feb-19
Single Oversight Framework: Overall Finance Score	1	1	1	1
Single Oversight Framework: Income and Expenditure Rating	1	1	1	1
Income and Expenditure: Surplus		£19.92m	£25.16m	£28.75m
Cost Improvement Programme versus plan (% achieved)	100%	99.51%	99.72%	99.63%
Cost Improvement Programme: achieved		£2.10m	£2.36m	£2.62m
Single Oversight Framework: Cash Position Liquidity Rating	1	1	1	1
Cash Position	-	£65.84m	£65.27m	£68.06m
Capital Expenditure (Percentage of plan used) (YTD)	100%	109.43%	77.10%	83.99%
Single Oversight Framework: Agency Spend Rating	1	2	2	2
Agency spend: Actual	-	£4.00m	£4.30m	£4.70m
Agency spend (Percentage of capped level used)	-	108.00%	103.00%	104.00%

Finance

Single Oversight Framework – Finance Score The Trust achieved the plan at month 11 with an overall Finance Score of 1.	**Income and Expenditure Position (£000s)** £28.75m surplus income and expenditure position at month 11. Overall net surplus £2.91m better than plan due to additional support for out of area placement pressures (pressure now fully mitigated) and improvement in commercial activities. Achieved a rating of 1 (highest rating).
Cost Improvement Programme (£000s) CIP performance at month 11 is £0.01m below plan, £2.62m CIP achieved (99%) compared to the planned position of £2.63m	**Cash (£000s)** The cash position of £68.1m is £2.35m above plan at the end of month 11 and achieved a liquidity rating of 1(highest rating).
Capital (£000s) Capital expenditure (£4.08m) is behind plan at month 11 (83.99% of plan).	**Agency spend (£000s)** Compares actual agency spend (£4.7m at month 11) to the capped target set by the regulator (£4.5m at month 11). The Trust reported agency spending 4% above the capped level and achieved a rating of 2.
Areas of Financial Risk as at 2019 • OAPs run rate deterioration. • Wards overspending. • Agency spending run rate.	

Glossary

Acronym	Full Title	Definition
AHP	Allied Health Professionals	**Allied Health** is a term used to describe the broad range of **health professionals** who are not doctors, dentists or nurses. **Allied Health Professionals** aim to prevent, diagnose and treat a range of conditions and illnesses and often work within a multidisciplinary **health** team to provide the best patient outcomes. Examples of AHP's include psychologists, physiotherapists, occupational therapists, podiatrists and dieticians.
ALPS	Acute Liaison Psychiatry Service	Our Acute Liaison Psychiatry Service (ALPS) consists of a team of multidisciplinary mental health professionals who have specific expertise in helping people who harm themselves or have acute mental health problems. The team operates over a 24 hour period, seven days a week, assessing men and women over the age of 18 years who are experiencing acute mental health problems and present to either of the Leeds' Emergency Departments, or those who have self-harmed and are in either St James's Hospital or LGI. Healthcare professionals can make referrals into ALPS 24 hours a day, seven days a week by calling our Trust's switchboard
ASC	Adult Social Care	Providing Social Care and support for adults.
CAS	Crisis Assessment Service	The Leeds Crisis Assessment Service (CAS) is a city-wide acute mental health service. It offers assessment to people 18 years and over who are experiencing acute mental health problems that may pose a risk to themselves and/or others, who require an assessment that day or within the next 72 hours. Our Crisis Assessment Service (CAS) works across health, social care and the voluntary sector to improve access to appropriate mental health services.
CAU	Crisis Assessment Unit	The CAU is predominantly an assessment unit with overnight facilities for service users aged 18 years or over, who are experiencing an acute and complex mental health crisis, and require a short period of assessment and treatment.
CCG	Clinical Commissioning Group	Clinical Commissioning Groups (CCGs) commission most of the hospital and community NHS services in the local areas for which they are responsible.
CGAS	Children's Global Assessment Scale	The Children's Global Assessment Scale (CGAS), adapted from the Global Assessment Scale for adults, is a rating of functioning aimed at children and young people aged 6-17 years old. The child or young person is given a single score between 1 and 100, based on a clinician's assessment of a range of aspects related to a child's psychological and social functioning. The score will put them in one of ten categories that range from 'extremely impaired' (1-10) to 'doing very well' (91-100).

Acronym	Full Title	Definition
CMHT	Community Mental Health Team	There three CMHTs and each covers an area of Leeds – WNW, SSE and ENE.
CTM	Clinical Team Manager	The Clinical Team Manager is responsible for the daily administrative and overall operations of the assigned clinical teams. The person is responsible for the supervision of all employed clinical staff. They serve as the primary leadership communications link between the teams and departments throughout the organisation. The Clinical Team Manager is responsible to ensure the overall smooth day to day operations, employee engagement and a high quality patient experience while achieving departmental and organisational goals.
CPA	Care Programme Approach	The Care Programme Approach (CPA) is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. You might be offered CPA support if you: are diagnosed as having a severe mental disorder.
CQPR	Combined Quality Performance Report	A report detailing the Trust's performance throughout a given month.
CQUIN	Commissioning for Quality and Innovation	The Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care.
DTOC	Delayed Transfer of Care	A delayed transfer of care occurs when a patient is ready for discharge from acute or non-acute care and is still occupying a bed.
EPR	Electronic Patient Records	The system used to store patient records electronically.
GP	General Practitioner	General practitioners (GPs) treat all common medical conditions and refer patients to hospitals and other medical services for urgent and specialist treatment. They focus on the health of the whole person combining physical, psychological and social aspects of care.
HCR20	Historical, Clinical, Risk Management - 20	The Historical, Clinical, Risk Management-20 (HCR-20) is an assessment tool that helps mental health professionals estimate a person's probability of violence
HoNOS	Health of the Nation Outcome Scales	The Health of the Nation Outcome Scale (Working Age Adults) is a means of measuring the health and social functioning of people of working age with severe mental illness
Honosca	Health of the Nation Outcome Scales Child and Adolescent Mental Health	The Health of the Nation Outcome Scale (Children and Adolescents) is a means of measuring the health and social functioning of children and adolescents with severe mental illness
KPI	Key Performance	A quantifiable measure used to evaluate success

Acronym	Full Title	Definition
	Indicator	
LADS	Leeds Autism Diagnosis Service	The Leeds Autism Diagnostic Service (LADS) provides assessment and diagnosis of people of all intellectual ability who may have autism who live in Leeds.
LeDeR	Learning Disability Mortality Review	The Learning Disabilities Mortality Review (LeDeR) programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives.
LGI	Leeds General Infirmary	Leeds General Infirmary, also known as the LGI, is a large teaching hospital based in the centre of Leeds, West Yorkshire, England, and is part of the Leeds Teaching Hospitals NHS Trust.
LOS	Length of Stay	Length of stay is a whole number which is calculated as the difference between the admission and discharge dates for the provider spell.
LTHT	Leeds Teaching Hospital Trust	Leeds Teaching Hospitals NHS Trust is an NHS trust in Leeds, West Yorkshire, England.
LYPFT	Leeds & York Partnership Foundation Trust	Leeds and York Partnership NHS Foundation Trust provides mental health and learning disability services across Leeds and York.
MDT	Multi-Disciplinary Team	A multidisciplinary team is a group of health care workers who are members of different disciplines (professions e.g. Psychiatrists, Social Workers, nurses, physio or occupational therapists), each providing specific services to the patient .
MH	Mental Health	A person's condition with regard to their psychological and emotional well-being.
MHSDS	Mental Health Services Dataset	The Mental Health Services Data Set (MHSDS) contains record-level data about the care of children, young people and adults who are in contact with mental health, learning disabilities or autism spectrum disorder services.
MSK	Musculoskeletal	A musculoskeletal (MSK) disorder is any injury, disease or problem with your muscles, bones or joints.
Never event	Never Events	Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
OAP	Out of Area Placements	Out of area placements refers to a person admitted to a unit outside their usual local services.
PICU	Psychiatric Intensive Care Unit	Leeds Psychiatric Care Intensive Service (PICU) provides intensive and specialist care and treatment for adult service users with mental health needs, whose risks and behaviours cannot be managed on an open acute ward.
S136	Section 136	Section 136 is an emergency power which allows service users to be taken to a place of safety from a

Acronym	Full Title	Definition
		public place, if a police officer considers that you are suffering from **mental** illness and in need of immediate care.
SOF	Single Oversight Framework	Oversees NHS trusts and NHS foundation trusts, helping us to determine the level of support they need.
SPA	Single Point of Access	Single Point of Access offers mental health triage for routine, urgent and emergency referrals, information and advice 24 hours a day, 7 days a week, and 365 days per year.
SS&LD	Specialist and Learning Disabilities Care Group	One of the Care Groups within the Leeds & York Partnership Foundation Trust.
Tier 4 CAMHS	Tier 4 Child Adolescent Mental Health Service-	Child and Adolescent Mental Health (CAMH) Tier 4 Children's Services deliver specialist in-patient and day-patient care to children who are suffering from severe and/or complex mental health conditions that cannot be adequately treated by community CAMH Services.
TOC	Triangle of care	The 'Triangle of Care' is a working collaboration, or "therapeutic alliance" between the service user, professional and carer that promotes safety, supports recovery and sustains well-being principles.

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
13

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Guardian of Safe Working Quarterly Report – Quarter 3
DATE OF MEETING:	28 March 2019
PRESENTED BY: (name and title)	Dr Claire Kenwood, Medical Director
PREPARED BY: (name and title)	Liz Cashman, 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.	✓

EXECUTIVE SUMMARY

This paper provides an overview of the key areas within the junior doctors contract to provide assurance. Key issues to note are

- Vacancies continue in core training mitigated by Trust doctors and the impact of core training vacancies has moved through to higher training.
- Out of hours rota shifts continue in the main to be filled with either internal locum shifts or agency cover
- Exception reports have needed no further action
- Improvements have been made to improve closure of exception reports by clinical supervisors
- Concerns about lone working have been addressed
- Work space/accommodation in two locations (Aire Court and Newsam Centre raised at TMEC) was noted as an issue. This was escalated to the Workforce and OD group and we continue to work to ensure doctors have access to appropriate workspaces.

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 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

MEETING OF THE BOARD OF DIRECTORS

28 March 2019

GUARDIAN OF SAFE WORKING QUARTERLY REPORT
Quarter 3 – October 2018 to December 2018

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 01.10.18 to 31.12.18. A glossary of terms is provided in Appendix A.

2 Quarter 3 overview

Vacancies		There were 7 vacancies in the Core Trainee establishment. 4 Trust doctors have been employed to cover the vacancies; 2 of these participate in the OOH rotas.					
		There are 4 vacancies in the Higher Trainee establishment					
Rota Gaps		October		November		December	
		CT	HT	CT	HT	CT	HT
	Gaps	23	7	46	10	38	13
	Internal Cover	16	7	23	10	29	13
	Agency cover	5	0	2	0	5	0
	Unfilled	2	0	1	0	4	0
Fill Rate		99%	100%	99%	100%	98%	100%
Exception reports (ER)		1	0	0	0	1	0
		2 in total. Both relating to reduced staffing on shift and resolved with no further action.					
Fines		None					
Patient Safety Issues		None					
Junior Doctor Forum		Meeting held in January. Items of note were: • ERs not being closed as supervisor unavailable on Allocate x 1. This is being addressed by Medical Education and in future they will ensure that all					

	clinical supervisors have Allocate accounts each rotation. 2 instances where clinical supervisor have retired without inputting review of ER on Allocate systems despite having completed the review with the CTs. In future non-compliance with documentation will be escalated to medical director. • CTs raised concerns re lone working policy in event of reduced staffing on night shifts. It was decided that CTs will contact Switchboard to inform of their whereabouts and safety plan. Work space/accommodation in two locations (Aire Court and Newsam Centre raised at TMEC) was noted as an issue. This was escalated to the Workforce and OD group and we continue to work to ensure doctors have access to appropriate workspaces.

3 Conclusion

Exception Reporting has now been in place within the Trust for almost 2 years. 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.

There are a number of rota gaps due to ongoing low levels of psychiatric recruitment nationally; however these are in the main being filled by either Trust doctors or out of hours Trust locums.

4 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 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 new system

Dr Elizabeth Cashman
GMC 6128434
Guardian of Safe Working Hours
13 March 2019

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
14

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Medical Directors Report – Focus on Quality Improvement and EPR Update
DATE OF MEETING:	28 March 2019
PRESENTED BY: (name and title)	Claire Kenwood - Medical Director
PREPARED BY: (name and title)	Claire Kenwood - Medical Director Richard Wylde – Head of Improvement and Knowledge

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

EXECUTIVE SUMMARY

This paper gives an overview of progress made with the Quality Strategic Plan and an update on the EPR. In particular, this paper focuses on section 1 and 3 of the Quality Strategic Plan, and how LYPFT measures against the CQC guide for assessing quality improvement in a healthcare provider.

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 consider the information provided and discuss the content further if needed to gain assurance of the progress made to date and highlighted future work, in order to build a culture centred on quality improvement.

MEETING OF THE BOARD OF DIRECTORS

28 March 2019

MEDICAL DIRECTORS REPORT – FOCUS ON QUALITY IMPROVEMENT AND EPR UPDATE

1 Executive Summary

This paper gives an overview of progress made with the Quality Strategic Plan and an update on the EPR. In particular, this paper focuses on section 1 and 3 of the Quality Strategic Plan, and how LYPFT measures against the CQC guide for assessing quality improvement in a healthcare provider.

2 Quality Strategic Plan.

The Trust wide Quality Strategic Plan was approved by the Board in February 2018 and draws on the White Paper from the Institute for Healthcare Improvement called 'A Framework for Safe, Reliable and Effective Care' January 2017. A 6 monthly update was submitted and accepted by the Quality Committee on the 12th March to highlight the progress made and to give a high level indication of what will happen over the next 6 months.

Whilst all areas within the Quality Strategic Plan are progressing, recently we have been most active in Section 1 and 3 of the plan.

2.1 Section 1 - The conditions that allow quality care to flourish

The framework at the centre of 'The conditions that allow quality care to flourish' is also the foundation of the collaboration we are participating in with the Institute for Healthcare Improvement (IHI). The IHI will undertake an assessment and analysis of the existing culture, strategies, policies, and priorities at the trust and identify what is needed to adopt a comprehensive and effective framework for building capacity, capability and the cultural foundation to promote and sustain value based healthcare and quality improvement.

2.2 Section 3 - Provide help and support in a joined up way

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

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

To meet this challenge we must ensure that we work in an integrated way and a good example of this was the work undertaken in the Forensics service. This work acted as a 'proof of concept' to show the real benefits of working in an integrated way and utilised a Logic Model to easily articulate on one page the plan.

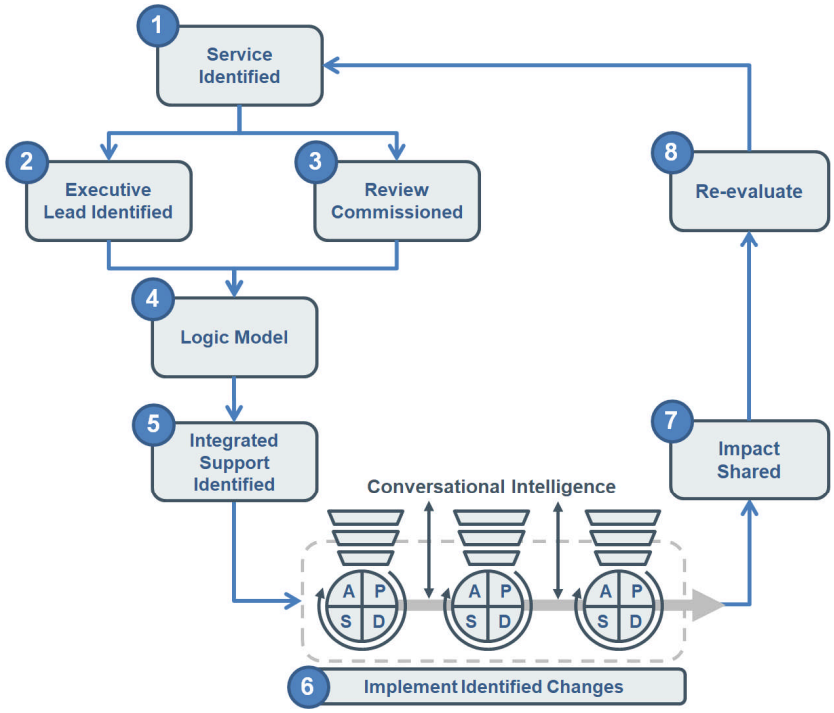
INPUTS		OUTPUTS		OUTCOME		
		Activities	Participation	Short	Medium	Long

Responding to the Forensic service external review June 2017

SITUATION	WHAT WE INVEST	WHAT WE DO	WHO WE REACH	SHORT TERM	MEDIUM TERM	ULTIMATE IMPACT
In November 2016 the forensic services were rated as requiring improvement after a CQC inspection earlier in the year. Of concern, this rating included safe and effective domains Other concerns expressed within the service included: • Increased sickness in all professional groups • High staff attrition rates • Recruitment difficulties • Ward closures against a backdrop of insufficient staffing • Concerns across a wide range of staff about difficult relationships and team dynamics • 'patient safety' issues identified within the CQC report An external review was commissioned from NTW Forensic services and this was received and shared with staff in spring 2017 A Quality Improvement plan is now being devised around the actions within this report.	• The time, effort and inclusive method that was used to gain staff feedback as part of the external review • Reponses to the 24 actions held within it • Extra management capacity (wte 8C) • Additional Executive attention – 1PA medical director time, Interim COO focus • 0.5 wte OD support 8a • 0.2 wte improvement support 8a • Additional administrative support for the program • Extra OD, Comms and engagement capacity and resource to support • Service evaluation time from continuous improvement team	• Share the report with staff groups and frame this within the improvement work required • Build a new communications plan to support two way widespread engagement and communication • Work with staff on the recommendations in a way that will stimulate the right culture: -the right relationships -the right balance of psychologically safe and accountable clear structures - culture of continuously improving compassionate care - collective leadership; the partnership of clinical and operational leaderships distributed across the service • Ensure that we evaluate and monitor the effects on patient experience, care and outcomes • Work with commissioners to ensure that we maximise the contribution of service on both sites for the future as full contributors to the STP and regional plans	Those who use our service, those who care about them. Commissioners and STP partners All of our staff within the forensic service at every grade and background All of our staff in services which work alongside, refer to or from or support forensic services	• Establish the Quality Improvement Group • Start with a 'safety first' approach within the services given the high level of concerns. • Test and gain feedback on the Communications platforms • Commission baselines for patient outcomes and experience • Commission an inclusive process to develop a thematic bottom up review of how we could improve conditions and staff wellbeing at work • Support QI interventions already occurring at the frontline • Engage with the professional leads for the service and understand how they might work as a team to provide collective leadership for the Service • Establish and consult on the plan to recruit to the Service Clinical Lead. • Establish the operational / clinical leadership structure for each team and develop an understanding of the resources, strengths and challenges for each of them • Scope the patient flow for the service with attention to the 'space between teams' • Refresh the working of referral MDT working to ensure that there is role and decision making clarity that also makes best use of the whole team		Services that provide the best of care to those requiring a forensic setting as measured by: -patient outcome data -patient experience data -Positive feedback from carers - efficient and effective smooth patient flow through our services -On-going positive commissioning intentions - ability to participate with partners for a comprehensive regional service characterised by a high level of professional mutual respect and ease flow through the system -psychologically safe learning cultures; high degrees of respectful problem solving relationships - -Outstanding CQC rating

The success of this approach is going to be the focus of the next Senior Leaders Forum taking place on the 27th March which is being organised by Claire Holmes and her team.

Reviewing the approach taken with the Forensic Service, a guide has been produces that is going to be used with the Acute Care Excellence programme and also as part of the Gender Identity Service work.



1. Service Identified – This will be done through quantitative and qualitative from national, regional and local sources.

2. Executive Lead Identified – The Executive lead will be the one who has most relevance to the situation. Leading quality is an important part of their role and how they support quality improvement work to be delivered.

3. Review Commissioned – Depending on the area/service this maybe commissioned externally, internally or done locally.

4. Logic Model – Logic models are a type of structured diagram which connects Outcomes with Activities and specifies Reach (or target groups) for those activities.

5. Integrated Support Identified – From the Logic Model, an integrated support formulation is created to deliver the outcomes identified. This will consist of, but not limited to, Operational and Clinical leadership, OD CI and HR.

6. Implement Identified Changes – The different work streams commence, which may have serval cycles until the desired outcome is reached.

7. Impact Shared – Learning share through different channels.

8. Re-evaluate – A date is set and a re-evaluation is completed to ensure the changes have been sustained or if further work is required.

The Continuous Improvement team have been working with the Gender Identity Service since December to scope a future improvement project. The service is complex and multifaceted, with a multi-disciplinary team and a care pathway comprising various processes and sub-processes. The Continuous Improvement team have been carrying out an intensive scoping exercise in order to better understand the service and how it works. This scoping will result in a final report recommending key areas for improvement and proposing an approach for delivering those improvements.

The scoping work has included in-depth interviewing, detailed process mapping, desktop analysis and in-context observation. The in-context observation has involved the Continuous Improvement Advisor being co-located with the Gender Identity Service on a regular basis. This has revealed insights and intelligence which would not have been identified through interviewing and process mapping alone. In addition, and perhaps most importantly, it has also enabled the Continuous Improvement Advisor to build strong, constructive and trusting relationships with members of the service. This in turn has improved the quality of the data collected through interviewing and process mapping, as well as helping to build the case for change and maintain enthusiasm and motivation for the improvement project.

3 Measures against the CQC guide for assessing quality improvement in a healthcare provider.

In March 2018 the CQC releases a "Brief guide: assessing quality improvement in a healthcare provider", which was produced to ensure the CQC inspection teams always assess the presence and maturity of a quality improvement (continuous improvement) approach within a provider organisation. This is across 3 levels of maturity - Signs of a mature quality improvement approach across the organisation, Signs of a developing approach to quality improvement across the organisation and Signs that a quality improvement approach is not present.
https://www.cqc.org.uk/sites/default/files/20180404_9001395_briefguide-quality_improvement_healthcare_provider%20v1.pdf

Whilst we are at the start of our improvement journey, using the CQC guide we can demonstrate signs of a mature quality improvement approach against the following statements taken from the guide:

Statement from the guide	Our Evidence
1. Quality strategy available on website and intranet that explicitly mentions quality improvement and sets the organisation's quality improvement goals	The Quality Strategic Plan is available on the intranet as well as the public face website. The Quality Strategic Plan does not specifically mention quality improvement, however it is part of the framework found in section 1 of the plan. This will be updated further following the report from the IHI that will include building quality improvement capacity and capability. The organisations quality improvements goals can be found in the Trusts Quality Accounts.
2. Quality appears to be the priority at the Board from agenda and minutes, with a specific report on quality that is accessible publicly.	The minuets from board meetings are available on our public face webpage; these include the highlight report from Quality Committee.
3. The Board looks at data as time series analysis, and makes decisions based on an understanding of variation	The Trust is currently on the waiting list for 'Making data count for Trust Boards' which is run for NHS Analytics. Several staff from LYPFT were able to attend the recently run

	event by NHS Analytics in Leeds on moving from RAG to SPC.
4. Clear and consistent improvement method for the organisation, and demonstrable across all areas/operations of the organisation.	The Continuous Improvement Team follow the Institute for Healthcare Improvements 'Model for Improvement'. This basic model forms the foundations for all of our improvement work. During financial year 2019/20 the improvement team are planning to build upon this basic concept, by developing an improvement project checklist to incorporate broader essential change elements. Most recently, the Leeds Autism Diagnostic Service have successfully used the Model for Improvement in a number of areas of their pathway, aiming to improve their services Key Performance Indicator score. In April 2019 Improvement Teams website will be updated, with the aim of being more user friendly and informative.
5. Presence of a central team dedicated to supporting quality improvement, with expertise in the improvement method and tools.	The Continuous Improvement Team of Leeds and York Partnership NHS Foundation Trust current employ 1x administrator, 2x Improvement advisors, 1x Improvement Trainer and 1x Improvement Lead.
6. Plan for building improvement skills at all levels of the organisation, with a large proportion of the organisation (and at all levels) having developed improvement skills.	In September 2018 the improvement team recruited a trainer. Having only been in post a short amount of time, the training facet of the team is still in its early stages. However, the team is shortly due to launch its interim training options for the trust, to include 'Introduction to improvement (Bronze), Practical Improvement Skills (Silver) and Improvement Project Accredited (Gold). Peripheral training such as Leading for Improvement, Improvement Fundamentals, Sponsoring Improvement and Bitesize Improvement are additional short courses scheduled for release later in the financial year.
7. Structures in place to oversee quality improvement work, with multiple executive directors involved in regular	All Improvement projects or activities commence with a scoping exercise which is initiated by requestors of our services submitting a New Work Request form. On this form, a project lead and project sponsor is identified by the area who would like

provider-level overview.	our support. Formalising governance structures around projects or activities we engage resides with the requesting area. The improvement team reports project and activity progress to the Head of Improvement and Knowledge and the Medical Director every 6 weeks.
8. Robust, regular and local support in place across all areas of the organisation to support teams using QI to solve complex quality issues.	The continuous improvement team are transitioning the skills and culture of the resources available from Improvement Project Managers to Improvement Coaches. This transition has been influenced by the readiness of the organisation to accept sustainable improvement approaches. At any one point in time the team can be supporting 14 improvement related projects/activities. The ability of the improvement team to support services is often restricted by the priorities of the areas requesting our support.
10. Demonstrable use of measurement on a routine basis to monitor progress of QI work against outcomes and ensure sustained improvement.	The improvement team work with requestors of our services to plan the on-going collection and analysis of data for improvement monitoring purposes. This is instigated by the model for improvements 'how will we know a change is an improvement' step.
11. All Executive team and clinical leaders are able to talk about their role in leading quality improvement, supporting teams in their quality improvement work and developing a context and culture within the organisation for quality improvement to occur	Part of the diagnostic undertaken by the IHI will focus on our ability to foster a culture of Leadership for improvement.
12. A majority of staff across multiple areas of the	This is the case for some team across the organisation, especially for those that have had involvement with the

organisation and from a variety of backgrounds are able to talk about the provider's quality improvement approach, how they have been involved and the difference it has made.	Continuous Improvement Team. To help raise the profile of the improvement work across the organisation the Continuous Improvement Team are sharing the great work that is happening via Twitter - @LYPFT_CI

4 Progress of the EPR Programme

One of the earliest decisions of the Board was that we would go live with the very latest version of Caredirector to prevent us having to undertake a significant upgrade soon after go-live. We have just taken delivery of the new version and our impression is really positive. The user interface is an improvement on the last iteration, with a simpler, modern user experience and timeline views of patient's histories. We are continuing with the workshops to design forms and processes along with our efforts to gather requirements from around the organisation.

Our development of a portal to view legacy data from PARIS has passed its proof of concept stage and the approach looks to have paid off. Now that we have the actual system to develop, the coming months will become extremely busy as we configure the system ready for testing and training.

5 Conclusion

In conclusion, whilst significant progress has been made, we know that we are still at the start of our quality improvement journey. The work with the IHI will enable us to get a high level of engagement around a focused set of organisational aims, a common view of the system, and the method and path for achieving the aims. We will gain consensus on the key priorities for capability building which will be identified through the discovery process and define a clear strategy that closely link the capability building with the results-based initiative. There will also be a focus on the critical role of leaders in fostering a culture centred on quality improvement.

6 Recommendation

The Board are asked to consider the information provided and discuss the content further if needed to gain assurance of the progress made to date and highlighted future work, in order to build a culture centred on quality improvement.

Dr Claire Kenwood and Richard Wylde
Medical Director and Head of Improvement and Knowledge
15 March 2019

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
15

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Learning from Deaths Quarter 3
DATE OF MEETING:	28 March 2019
PRESENTED BY: (name and title)	Dr Claire Kenwood. Medical Director
PREPARED BY: (name and title)	Pamela Hayward-Sampson. Patient Safety and Risk Lead

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

EXECUTIVE SUMMARY

All Trusts are required to provide quarterly mortality data to the Trust Board.

This paper includes the mortality data for Quarter 3. There has been an increase in the number of Unexpected, Unexplained deaths in the third quarter. A review of the unexpected, unexplained deaths for the last 6 months indicates a higher number of female deaths in this category compared to previous years, and whilst it is not possible to state the statistical significance of this local data it does reflect the national trend. The annual report of learning from deaths, linking themes and actions, will explore this further.

In addition the Learning from Incidents and Mortality Group reviews all deaths recorded weekly via the incident reporting system or via the NHS Spine. Consideration is given if there are any potential concerns relating to care or learning. If this requires further exploration a lower level of review takes place.

There has been progress joining learning across the system with a planned meeting with LTHT to share intelligence on deaths in their services that we currently record but triage rather than investigate in depth.

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 requested to:

i. Consider the mortality data and information provided within this report.
ii. Receive this information for assurance of the work ongoing within the Trust to improve mortality review and data collection.

MEETING OF THE BOARD OF DIRECTORS

28 March 2019

MORTALITY REVIEW – LEARNING FROM DEATHS
QUARTER 3 (01 October – 31 December 2018)

1 Executive Summary

This paper provides the board with the mortality data for Quarter Three, 2018-19 along with key themes from the learning identified.

The mortality data is collated weekly at the Learning from Incidents and Mortality Meeting (LIMM), where all deaths are reviewed and actions agreed with regards to level of investigation.
The information is obtained from the Trust Incident reporting system (DATIX) and from the NHS PAS system, to ensure all deaths are discussed. We continue to use the Mazars coding for deaths as agreed with the Northern Alliance. In addition to this, we also comply with reporting all Learning Disability Deaths to Bristol University, via the LeDer system.

The Trust continues to actively participate with the Northern Alliance Mortality Review Group to share findings and to develop regional wide learning from themes. At the meeting January 2019 it was evident that all the northern mental health trusts are reviewing deaths in a similar way, utilising the Mazars coding system. Some trusts are not undertaking any level of review for patients coded as not our deaths; however LYPFT continues to undertake a short case note review for each reported death prior to coding. Whilst these deaths are not subject to any further review (unless a concern is noted at the time of initial review) they are given some scrutiny by the Safety and Risk Lead and Serious Incident Investigators. The majority of the patients categorised under the *not our deaths* code are patients who are over the age of 80 years, with minimal input from the memory services team. The remainder are predominantly patients seen by the in reach mental health team at Leeds Teaching Hospital in an advisory capacity, with the physical health problem being the primary concern. A large number of these patients were not known to mental health services prior to referral. Further mortality review of these cohorts of patients would not provide any additional

learning for our organisation. If any of these patients is known to LYPFT prior to referral to then an additional review takes place as part of LYPFT's mortality review.

The Trust is working with Public Health as part of our suicide prevention strategy and is meeting with LTHT to establish a formal process for joint mortality reviews in the future.

2 Mortality Data - Quarter 3

Quarter 3 Learning From Deaths and Incidents	**Total**
Total number of deaths reported 01 October – 31 December 2018	**130**
Awaiting Cause of Death confirmation	**21**
LYPFT not the primary provider of care	**74**
ENE 1 (Expected Natural Death -Expected to occur within a timeframe)	**10**
ENE 2 (Expected Natural Death - Expected death but not expected in the timeframe)	**4**
UN 1 (Unexpected Death from Natural Causes i.e. cardiac arrest/stroke)	**2**
EU (Expected Unnatural Death i.e. alcohol or drug dependency)	**0**
UN 2 (Unexpected Natural Death from natural cause but did not need to be)	**0**
UU (Unexpected Unnatural Death)	**8**

Of the 8 Unexpected, Unexplained (UU) deaths, the Serious Incident Framework applied in 5 cases and were subject to a comprehensive review, 1 case is awaiting the cause of death, 1 case has been reported by another Trust who are leading the comprehensive review and 1 case had limited contact with the trust and was not in receipt of any services for some months prior to their death. In the last 6 months there has been an increase in unexpected, unexplained deaths in females compared to previous years. This change in demographics reflects the national NCISH data. The cause of death for those deaths coded as UU was as follows:

Cause of Death	
Hanging	4
Self-Poisoning	1
Suffocation and Helium inhalation	1
Drowning	1
Awaiting Confirmation	1

13% of the total deaths reviewed at the Learning from Incidents and Mortality Review Group were subject to a further more in-depth review, this included the 5 which met the SI Framework and 12 where subject to a Structured Judgement review process.

Two deaths were reported via the LeDer process.

3 Key Learning from deaths identified

As the reviews for the patient deaths in Q3 have not all yet been completed, the learning identified in this paper relates to the reviews completed during Q2. The percentage of deaths reviewed in Q2 identifying service and delivery problems was 4.5%. This percentage is a reflective of previous quarters and remains relatively unchanged.

The key learning identified from the 4.5% included the following:

- Family involvement in care planning
- Responsiveness to individual need i.e. telephone contact when a home visit would have provided more information
- Missed opportunities to provide expert support for substance misuse in inpatient units as a result of limited resources available

Good practice learning included:

- Well planned discharge from inpatient unit to community services
- High standard of inpatient care provided
- Compassionate care and recovery focused work provided

As a result of the learning identified a number of action plans have been developed by the responsible clinical teams. From February 2019 onwards any common actions will be documented on a quality improvement trust wide action plan, linking the actions to specific QI work streams.

Examples of recent changes to practice as a result of learning from the mortality review process include a pilot of Safety Planning, commencing in February 2019 for a 3 month period. This has been developed as a result of themes from Serious Incidents, including limited or no safety plan, family involvement in safety planning and limited formulation. A formal evaluation, including patient feedback will be completed at the end of the pilot. A second piece of work around formulation has also been progressed in response to the learning from deaths, which will result in mandated formulation training for all clinical staff.

4 Conclusion

The Board is requested to:

- Consider the mortality data and information provided within this report.
- Receive this information for assurance of the work ongoing within the Trust to improve mortality review and the learning across the organisation.

Pamela Hayward-Sampson
Safety and Risk Lead
14 March 2019

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
16

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Director of Nursing, Professions and Quality quarterly report
DATE OF MEETING:	28 March 2019
PRESENTED BY: (name and title)	Cathy Woffendin, Director of Nursing, Professions and Quality
PREPARED BY: (name and title)	Cathy Woffendin, Director of Nursing, Professions and Quality

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

EXECUTIVE SUMMARY

The Director of Nursing, Professions and Quality commenced employment with the Trust on the 1 March 2018.This is the third Quarterly report which highlights the progress against key objectives within this portfolio for the last 3 months.

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

RECOMMENDATION

The Board is asked to note the contents of this report and the progress made within key objectives of this portfolio

Meeting of the Trust Board

28 March 2019
Director of Nursing and Professions Quarterly Report

Executive Summary

The Director of Nursing and Professions commenced employment with the Trust on the 1 March 2018.This is the third quarterly report which highlights the progress against key objectives within this portfolio for the last three months.

1 Patient Experience and Involvement:

The Independent and external review of the Trusts Patient Experience and Involvement systems and processes led by Professor Mark Gamsu, from Leeds Beckett University was completed and the findings and recommendations were presented to Trust board in January and to the Council of Governors in February. The key recommendations from this report were;

- The development of a Strategic Steering group chaired by an Executive Director to agree the priorities around patient experience, carers and Involvement for the next 12 months.
- To facilitate a cultural shift across all levels of the organisation of ensuring that patient/carer experience and involvement is every ones business.
- In conjunction with service users, carers and key stakeholders to develop a Patient Experience and Involvement Strategy.
- To ensure that we continue to progress the work within Triangle of Care to achieving stage 2 and within this improve our offer to carers.
- To consider and explore other patient experience and feedback tools in addition to the nationally mandated Friends and Family test which is particularly limited for mental health and Learning disability services.

A workshop is planned for the 22nd March at the Metropolitan hotel in Leeds with over 100 service users, carers and key stakeholders expected in attendance. The event will be co facilitated with Richard Jackson and his team from Voluntary Action Leeds-Leeds voices and members of LYPFT. The overview of the day is to agree how we could work differently with service users, carers and key partners and to understand what our shared key priorities are in relation to patient experience, carers and Involvement for the next 12 months. During the day there will be a sharing of service user/carer stories which identifies some good

practice but also areas of learning which has resulted in improvements to practice. Individuals present will also be invited to be part of the future meeting structures which are been established to drive this work forward and monitor progress against priority areas.

Work is in progress to restructure the current substantive team and capacity issues will be addressed through highlighting achievable priority work streams as an interim measure.

Friends and Family Test (FFT)

FFT cards continue to be delivered by hand to services across the clinical areas and are kept on display alongside publicity posters and a post box for completed cards. The Patient Experience team (PET) collects the completed cards and the data is inputted and analyzed centrally. Monthly updates are provided through internal governance reports and clinical leads in individual services/wards who are also notified of the feedback received about their service. This enables service leads to have a conversation with service users, families and carers by following up on the actions and learnings from the data using the 'You said we did' feedback framework.

In January 59 responses were received and 74.5% of those responses were extremely likely or likely to recommend LYPFT services to friends and family.

Volunteers and training

We have recruited 5 volunteers and they are supporting the team with the FFT work. The volunteers have also helped and supported the team at training events and Service User Network [SUN] meetings including induction events and the SUN question time. We have an ambitious target to continue to recruit more volunteers via our volunteer recruitment team and have developed a Welcome Pack to support our ambition to better equip people to take part in genuine involvement opportunities.

We have developed a unique training programme for staff, service users and carers and the aim of the training is to provide participants with an overview of Patient Experience and Involvement in a participative style and includes group work exercises.The Three training sessions we have held so far from November 2018 to Feb 2019 have been very popular with staff, service users and carers booking onto the course and the feedback has been very positive.

Carers

Services are currently completing self-assessments and identifying carer leads as part of our application for year 2 Triangle of care accreditation. During March The PET will support services to complete the self-assessments and are also leading on a single qualitative carer's feedback survey tool as part of the accreditation.

2 NHSi Retention Programme:

The NHSi retention initiative is halfway through the yearlong project, with a number of actions already implemented. These include improving and simplifying the recruitment of nurse graduates, offering career conversations, promoting research careers and inviting bank staff to take a contract. Further initiatives are due to start in spring, including a 'transfer' process simplifying internal recruitment, to support individuals to gain more experience, without having to leave the organisation. There will also be a re-launch of retire and return opportunities, enabling people to extend their careers, whilst supporting good health and well-being.

Of particular note are the improved routes into nursing. Since the introduction of the Nursing associate (NA) role, more than 50 health support workers have expressed an interest in Nursing associate or Nurse training. Our first 4 Nursing Associates have qualified and been offered the same simplified process of recruitment as the nurse graduates, enabling them to take up the band 4 vacancies that were available in the organisation. There are a further 3 Associate Practitioners and 16 Nursing Associates currently in training via the apprenticeship scheme, with the NA's due to qualify in 2020. Another cohort of NA's will commence in autumn and recruitment is underway for this. The Calderdale Competency workforce tool has been used to identify and define the role of support staff in acute in-patient services which has increased staffs skill set and confidence to consider further development opportunities and career progression. The development of new roles is imperative in retaining and attracting staff and providing opportunities both clinically and academically. Work is ongoing with universities to consider new training pathways and to secure additional funding streams through Health Education England to support continuous professional development.

Work continues to promote internships and research fellows within the organisation. We have had 3 individuals apply for the internships, two of whom have been successful and the other advised to apply for the Pre-CAF position. The call has gone out for applicants for the next intake of internships and nursing professional and preceptorship leads have been asked to encourage additional applicants as we had no Nurse applicants to recent cohorts.

The clinical academic research fellows who commenced in post in October 2018 have a clear support and supervision network in place. They have been approached to present at the AHP CPD day on the 7th June to promote these development opportunities and their progress to date.

The various retention initiatives are having some effect as our overall turnover has reduced from 15.4% in the previous 12 months, to 13.1% as of January 2019. However for the 2 target groups, Nurses and Occupational Therapist's (OTs) there has been a mixed success. For Nurses the turnover has reduced from 14.3 % to 12.4% and there continues to be a steady reduction in vacancy rates. For Allied Health Professional's (AHPs) (including OT's) the turnover rate continues to rise and has gone from 15.9% to 16.9% throughout the duration of the initiative. Of particular concern is the difficulty attracting more experienced

staff and we are seeing an emerging need to use locums at band 6 and 7 level. This requires further investigation and there will be more focussed work looking at leaver trends, carrying out exit interviews and monitoring of OT vacancies. In addition we need to better understand if this fits with the national picture for retention of AHP's, as historically we have not experienced recruitment challenges for OT's.

Work continues in securing newly qualified staff which is proving to be effective as 71 of our third year students due to qualify later this year have been offered preliminary employment based on the usual recruitment checks and have identified their preferred areas of work upon qualification.

Currently the organisation loses 17% of its staff through retirement, these are extremely experienced and skilled staff, many of which would prefer to return on a reduced number of days with more flexible contracts. To facilitate this, individual contracts will be considered and a revised Retire and Return Scheme will be communicated to staff and implemented in early April 2019. Work has also taken place with our Bank staff offering them opportunities to work permanently approximately 30 staff have shown an interest and are currently been progressed through our HR and operational teams.

3. NHSi Moving to Good

The organisation was visited by the NHSi National team on the 18th July as part of the moving to good CQC programme. The team were impressed with our focus and progress on our CQC action plans, key objectives and provided contact details to buddy up with Pennine Care NHS Foundation Trust (Requires Improvement) and partnered with an outstanding Trust which is Newcastle upon Tyne Hospitals NHS Foundation Trust. The next NHSi moving to good event is not until the end of the month.

4. Safer Staffing Dependency Tool

Our NHSi liaison colleague Lyn McIntyre, who was leading on the safer staffing tool for mental health and learning disability services has left the NHSi and has not been replaced and subsequently the tool has still not been published . In view of the importance of accessing the tool we contacted Keith Hurst directly which resulted in him agreeing to share his work and for us to use the latest dependency scoring and training examples which we received in early February 2019.The dependency scoring and training has been disseminated to all inpatient areas and we have held a number of information sessions where colleagues from wards have tested out scenarios with each other to become familiar with the dependency scoring for their wards and to ensure we record this consistently.

The Reporting team have created a template to capture the data on a daily basis and this is being used 7 days a week, and commenced on 11th February running for the next 4-6 months, which will allow us to collect a more robust picture of variance in activity to support our discussions of additional funding requirements with our commissioners. The longer term ambition is to integrate the new patient system (Care Director) with the workforce e-roster system which will enable the Trust to triangulate the fluctuating acuity of patients; the care

hours required and the corresponding deployment of resources to meet the requirement. The acuity scores will be processed against a set of algorithms via a platform that bridges the gap between Care Director and e-Roster. Keith Hurst is supportive of adopting this approach and we should hear by early April. There are alternative platforms we can use if this is not successful.

To date all wards are reporting no issues or problems using the tool on a daily basis, they feel it captures the right information and is easy to collate the information into the excel spread sheet. The acute and learning disability wards are capturing data once a day whilst the Forensic wards have chosen to collect the data on each shift. This is purely an individual ward decision as there is no evidence that the information should vary too significantly due to the continued requirement of professional judgment on a shift by shift basis.

The progress around this work will continue to be reported through the Safer staffing steering group and the Financial Planning group with a further update to Trust board in May and November as part of the 6 monthly safer staffing reports.

5. CQC Project Group/CQC Update:

The CQC project group chaired by the Director of Nursing, Quality and Professions continues to meet monthly to provide oversight on progress across all MUST DO and SHOULD DO actions. All plans are on target with no dates surpassed. A separate session has been arranged with Trust board members in April 2019 to provide an update of the progress and preparation to date in relation to this year's inspection process.

6. Quality Account

Providers of NHS Healthcare are required to publish a Quality Account each year. These are required by the Health Act 2009 and the terms set out in the NHS [Quality Accounts] Regulations 2010.It is recommended that the Quality Account is an easy read document accessible to all. This year's Quality Account is being developed in line with national guidance provided in the Department of Health Quality Account Toolkit 2010/11; the Quality Account Regulations, and any guidance from NHS England [NHSE] and NHS Improvement [NHSI].A paper outlining the areas for consideration of this year's Quality Account and particularly the Quality improvement priorities was presented to Quality Committee in December 2018, followed by a further paper on the 12th March providing the full draft Quality Report and Account for consideration. The paper was received favourably and the author Rebecca Le Hair was congratulated on the work undertaken to date.

7. Flu Campaign

For the first time, the organisation has achieved the full CQUIN payment and has surpassed its target of 75% achieving 78.8% of staff having received the flu inoculation at the end of February. This is a tremendous achievement in ensuring that both our service users and

staff are protected. I would like to thank the hard work and dedication of the Infection Prevention team who tirelessly led this campaign with support from other staff immunisers.

8. Smokefree Update

The updated smoke free and nicotine management policy has been ratified by the policies and procedures group. Due to the significant changes in public health guidance (i.e. the recommendation of e-cigarettes as a quitting aid) the current version will remain on Staffnet until there is agreement and clarification on the supply of e-cigarettes. The policy will have an 'under review' note added and the review date has been extended; to make the new policy available now would confuse staff when there is no supply for e-cigarettes within the Trust.

Whilst vending machines were considered as an outlet for e-cigarettes, the Head of Facilities has clarified with the landlords that this is not acceptable; therefore a recommendation has been made that the Trust supplies e-cigarettes to service users as part of a quit attempt or abstinence whilst an inpatient.

Ward staff have been consulted on any changes needed to the current designated areas, and new signage to indicate that these are now vaping areas only is in the process of being identified. Amanda Bailey continues to train staff both formally and on an ad-hoc basis on delivering very brief advice, and as smoking cessation practitioners. The smoke free steering group is a valuable forum for clinical staff to test scenarios on how to manage the challenges of implementing a smoke free policy. Patient information materials are under development with a focus on easy read formatting to make these accessible for all.

9. Recommendation:

The Board is asked to note the content of this paper and the progress made against key objectives within this portfolio.

Cathy Woffendin
Director of Nursing, Quality and Professions
12 March 2019

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
17

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Safer staffing report
DATE OF MEETING:	28 March 2019
PRESENTED BY: (name and title)	Cathy Woffendin, Director of Nursing, Professions and Quality
PREPARED BY: (name and title)	Linda Rose, Head 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.	✓

EXECUTIVE SUMMARY

The purpose of this report is to provide assurance of the current position with regard to the National Quality Board (NQB) Safer Staffing requirements across the two operational care services in Leeds and York Partnership NHS Foundation Trust, to the Board of Directors and the public.

The report provides assurance of the process in place to ensure detailed internal oversight and scrutiny of safer staffing levels across 27 inpatient units for the period from the 1st January 2019 to the 31st January 2019 and the 1st February 2019 to the 28th February 2019.

Included in this report is a progress update on the testing of the use of the Learning Disability and Mental Health Optimal Staffing Tool across all inpatient areas which started on the 11th February 2019.

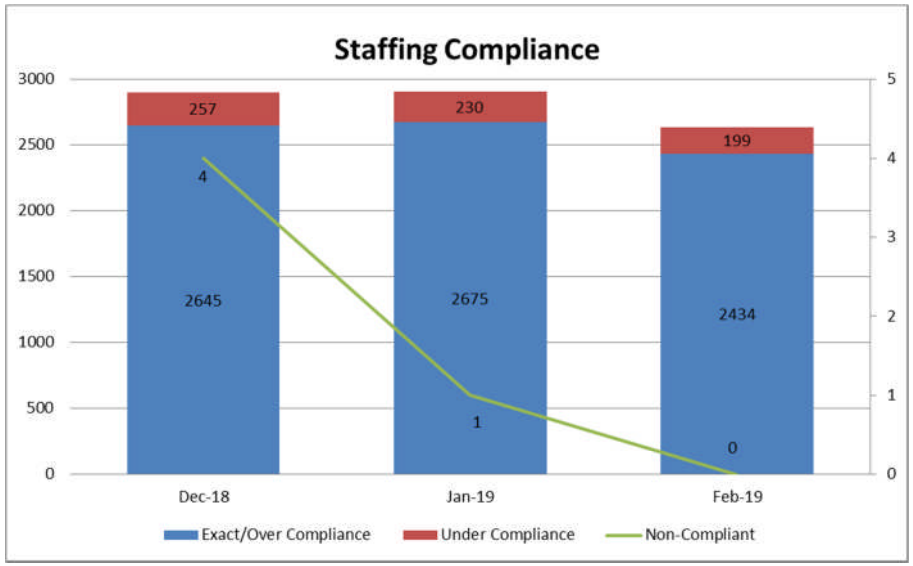
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes please set out what action has been taken to address this in your paper
	No	

RECOMMENDATION

The Board is asked to:

- Review and discuss the staffing rates and updates provided in the report.

Safer Staffing: Inpatient Services – January and February 2019



	Number of Shifts		
	December	**January**	**February**
Exact/Over Compliance	2645	2675	2434
Under Compliance	257	230	199
Non-Compliant	4	0	0

Risks: Registered Nursing vacancies continue to be a major theme across the focussed areas highlighted by the unify data Appendix A and Appendix B.

Mitigating Factors:

Reduced RN fill rates are being mitigated in the majority of our units by increasing Healthcare Support Worker bookings through Bank and Agency and ongoing improvements to the recruitment strategy. There is a robust escalation process in place to manage unplanned variance in shifts.

Narrative on Data Extracts Regarding LYPFT Staffing Levels on x27 Wards during January and February 2019

Exact or Over Compliant shifts:

During January the compliance data showed a decrease in the number of shifts which were staffed exactly as planned or staffed above the planned number of Registered Nurse (RN) and Health support worker (HSW) staff. During February 2019 this decreased further.

There remains a consistent theme regarding the higher use of Health support workers (HSW's) particularly across high acuity areas during January and February (Becklin wards, Newsam wards 1 (PICU), Ward 2N (forensic male) Ward 4N, The Mount wards and 3 Woodland Square.

Newsam ward 6 used a higher number of RN's during the night and Riverfields and Westerdale at Clifton House used a higher number of RN's during the day.

The use of Allied health professionals for the areas currently able to record this data (Asket croft, Asket House and Newsam ward 6) has remained as compliant.

Under Compliant Shifts:

During January there were 199 shifts that had fewer than the planned number of RN and HSW staff on each shift (this differs from the unify report below which shows the total hours over the month rather than on a shift by shift basis). Where there are fewer than planned RN staff on shift it is usual for one or more extra HSWs to back fill the vacant duty and ensure safe staffing levels, where a RN is not available to fill the shift.

During January and February Ward 5 Mount (Perinatal), Ward 2 Mount and Mill Lodge were under compliance for Registered nurses; Ward 5B, PICU and Mount ward 1 were under compliance during January. 2 Woodland Square were under compliance with HSWs during January and February. All of these wards remained safely staffed through the use of bank, agency overtime and support from other wards.

Non-Compliant Shifts:

This metric represents the number of shifts where no Registered Nurses were on duty. Within the NQB definition if a RN is on duty then this is not a breech .There has been no breeches throughout January or February.

There are still challenges for ward 4 at the Mount ,Due to maternity leave (which is usually impossible to backfill) a vacancy and a band 6 sickness absence until the end of March; Ward 4 Mount has x5 RN's available to take charge of the shifts and x2 Preceptees that cannot take charge (until approx. April when they will have completed x6 months preceptorship). This means that the team does not have a large core of staff and the starting point of the roster translates into x15 shifts down each week.

As Ward 4 has had previous breeches in December as an improvement action, the CTM of this ward has moved substantive registered staff to the later part of the week to ensure better weekend cover and reducing the likelihood of last minute cancellations for weekend duties which appeared as an increasing theme with bank and agency staff.

Updates:

The Safer Staffing tool The latest dependency scoring and training examples were received directly from Keith Hurst in February and a number of information sessions have been held to allow colleagues from wards to test out scenarios with each other in order to familiarise themselves with the dependency scoring and to ensure that this is recorded consistently. The Reporting team have created a template to capture the data on a daily basis and this is being used 7 days a week from the starting date of the 11th February and will be running for the 4-6 months. The longer term ambition is to integrate the new patient system (Care Director) with the workforce E-Rostering system which will enable the Trust to triangulate the fluctuating acuity of patients, the care hours required and the corresponding deployment of resources to meet the requirement. The acuity scores will be processed against a set of algorithms via a platform that bridges the gap between Care Director and e-Roster. Keith Hurst is supportive of adopting this approach and we should hear by the end of March whether this has been agreed. There are alternative platforms we can use if this is not successful.

To date all wards are reporting no issues or problems using the tool on a daily basis, they feel it captures the right information and is easy to collate the information into the excel spread sheet. The acute and learning disability wards are capturing data once a day whilst the Forensic wards have chosen to collect the data on a shift by shift basis (x3 times daily). This is purely an individual ward decision as there is no evidence that the information should vary too significantly due to the continued requirement of professional judgment on a shift by shift basis.

Observation and engagement acuity is a key contributory factor to the use of higher numbers of staff (particularly HSW's) across our wards. A proportion of our patients with challenging behaviours, require general medical interventions and though nursed on a different hospital site continue to require this specialist intervention. Occasionally this requires 2:1 or 3:1 staffing support. There are a number of challenges in providing additional staffing for this reason and this has not previously been costed. Work is being progressed within clinical services to identify this.

Bank and agency staffing During January 32.8 WTE RN's and 184.9 WTE HSW's were used in addition to substantive staff. Figures for February will be available in the next reporting period. **Recruitment** of Registered nurses is improving as we have had 71 acceptances from current students; however we have acknowledged that we will not directly benefit from this improvement until this group register in September 2019. To ensure a smooth transition, work has been progressed to identify the number of Preceptees recruiting services can safely accommodate in addition to other learners in the care environments.

In the interim staff teams are increasingly trying to provide cross cover to avoid breeches using **deployment of registered staff** but availability is difficult. Matrons are working as part of a 3 month task and finish group to further explore options and manage oversight of deployment across the care system as opposed to individual services.

Summary

This paper highlights the impact of the continuing local and national shortfall of registered nurses and some of the actions being taken in LYPFT to address the shortfall in a way that is safe for our patients and staff teams. The testing of the safer staffing tool across all services will help us to build a clearer picture in the longer term that provides us support to make evidence based decisions about our staffing numbers alongside professional judgment.

A large proportion of additional duties have been provided by our Bank staff to cover vacancies and observation and engagement. In addition to creating an environment that opens opportunities more easily for our learners to seek employment with us as demonstrated in the Preceptee welcome days, we are also seeking other creative ways to recruit and retain staff. This has included successfully offering a number of our bank staff substantive posts.

APPENDIX A

Safer Staffing: Inpatient Services – January 2019

Fill rate indicator return
Staffing: Nursing, Care Staff and AHPs

	Day				Night				Allied Health Professionals				Care Hours Per Patient Day (CHPPD)						Day		Night		Allied Health Professionals	
Ward name	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Registered allied healtH professionals		Non-registered allied health professionals		Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Registered allied health professionals	Non-registered allied health professionals	Overall	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered allied health professionals (AHP) (%)	Average fill rate - non-registered allied health professionals (AHP) (%)
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours												
2 WOODLAND SQUARE	665	625.5	688	337	325.5	325.5	325.5	325.5					75	12.7	8.8	0.0	0.0	21.5	94.1%	49.0%	100.0%	100.0%		
3 WOODLAND SQUARE	370	396.5	663	938	325.5	326.75	294	388.5					100	7.2	13.3	0.0	0.0	20.5	107.2%	141.5%	100.4%	132.1%		
ASKET CROFT	620	657.1	966.5	866.65	341	341	682	689.65	371.08	371.08			605	1.6	2.6	0.6	0.0	4.8	106.0%	89.7%	100.0%	101.1%	100.0%	
ASKET HOUSE	450	455	457	579.5	341	342.5	319	362	314.25	314.25			489	1.6	1.9	0.6	0.0	4.2	101.1%	126.8%	100.4%	113.5%	100.0%	
BECKLIN WARD 1	1131	978.75	544.5	1502.5	660	653	671	916					682	2.4	3.5	0.0	0.0	5.9	86.5%	275.9%	98.9%	136.5%		
BECKLIN WARD 2 CR	708.75	605.5	1054.5	1198.5	713	646	1069.5	1131					164	7.6	14.2	0.0	0.0	21.8	85.4%	113.7%	90.6%	105.8%		
BECKLIN WARD 3	1030.5	880	785	1326	682	660	649	902					677	2.3	3.3	0.0	0.0	5.6	85.4%	168.9%	96.8%	139.0%		
BECKLIN WARD 4	1133	1080	810	1081.5	627	682	638	715					672	2.6	2.7	0.0	0.0	5.3	95.3%	133.5%	108.8%	112.1%		
BECKLIN WARD 5	1247.75	1050.58333	1030.5	1477.8	671	648.25	682	933					688	2.5	3.5	0.0	0.0	6.0	84.2%	143.4%	96.6%	136.8%		
MOTHER AND BABY THE MOUNT	757.5	701.5	821.5	918	649	440	682	913					222	5.1	8.2	0.0	0.0	13.4	92.6%	111.7%	67.8%	133.9%		
NEWSAM WARD 1 PICU	1263	1015.5	1450.5	2669	682.5	651.166667	649	1821.66667					338	4.9	13.3	0.0	0.0	18.2	80.4%	184.0%	95.4%	280.7%		
NEWSAM WARD 2 FORENSIC	846	728.75	808.5	1476.75	333.25	323.5	645	1039.83333					371	2.8	6.8	0.0	0.0	9.6	86.1%	182.7%	97.1%	161.2%		
WSAM WARD 2 WOMENS SERVI	880.5	833.25	858	1102	333.25	322.5	645	829.75					310	3.7	6.2	0.0	0.0	10.0	94.6%	128.4%	96.8%	128.6%		
NEWSAM WARD 3	787.5	783.75	798.48	930.25	322.5	333.25	666.5	720.25					434	2.6	3.8	0.0	0.0	6.4	99.5%	116.5%	103.3%	108.1%		
NEWSAM WARD 4	1095	1062.75	691.5	1708.5	682	683	649	1329.75					652	2.7	4.7	0.0	0.0	7.3	97.1%	247.1%	100.1%	204.9%		
NEWSAM WARD 5	870	940.75	1299	1240.5	671	682	682	682					552	2.9	3.5	0.0	0.0	6.4	108.1%	95.5%	101.6%	100.0%		
NEWSAM WARD 6 EDU	790.5	894.5	747.5	774.5	325.5	472.5	640.5	503.25	517.5	517.5	150	150	322	4.2	4.0	1.6	0.5	10.3	113.2%	103.6%	145.2%	78.6%	100.0%	100.0%
NICPM LGI	915	968.916667	352.5	345.5	651	651	325.5	325.5					124	13.1	5.4	0.0	0.0	18.5	105.9%	98.0%	100.0%	100.0%		
PARKSIDE LODGE	765	792	1991.7	2097.66667	325.5	367.5	1291.5	1351.75					139	8.3	24.8	0.0	0.0	33.2	103.5%	105.3%	112.9%	104.7%		
HE MOUNT WARD 1 NEW (MALE	878	853.733333	1588.5	2432	655.75	419.25	978.25	2174.5					502	2.5	9.2	0.0	0.0	11.7	97.2%	153.1%	63.9%	222.3%		
HE MOUNT WARD 2 NEW (FEMAL	818	913.25	1218	2298.25	623.5	408.5	666.5	1838.25					447	3.0	9.3	0.0	0.0	12.2	111.6%	188.7%	65.5%	275.8%		
THE MOUNT WARD 3A	855.25	823.083333	1261.5	1514.5	341	343	682	924					609	1.9	4.0	0.0	0.0	5.9	96.2%	120.1%	100.6%	135.5%		
THE MOUNT WARD 4A	831.25	808.25	1337.5	1526.83333	330	329.666667	682	895					635	1.8	3.8	0.0	0.0	5.6	97.2%	114.2%	99.9%	131.2%		
YORK - BLUEBELL	723	979	731.5	940.5	332.32	332.216667	664.33	718.3					257	5.1	6.5	0.0	0.0	11.6	135.4%	128.6%	100.0%	108.1%		
YORK - MILL LODGE	1374	940.583333	1257	1384.58333	682	584	682	847					315	4.8	7.1	0.0	0.0	11.9	68.5%	110.1%	85.6%	124.2%		
YORK - RIVERFIELDS	391	569.333333	660	899.5	332.32	337.216667	332.32	356.65					131	6.9	9.6	0.0	0.0	16.5	145.6%	136.3%	101.5%	107.3%		
YORK - WESTERDALE	691.5	1049	1138.3	1083.8	332.32	342.933333	975.21	1306.21667					271	5.1	8.8	0.0	0.0	14.0	151.7%	95.2%	103.2%	133.9%		

Appendix B

Safer Staffing: Inpatient Services – February 2019

Fill rate indicator return
Staffing: Nursing, Care Staff and AHPs

	Day				Night				Allied Health Professionals				Care Hours Per Patient Day (CHPPD)						Day		Night		Allied Health Professionals	
Ward name	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Registered allied healtH professionals		Non-registered allied health professionals		Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Registered allied health professionals	Non-registered allied health professionals	Overall	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered allied health professionals (AHP) (%)	Average fill rate - non-registered allied health professionals (AHP)
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours												
2 WOODLAND SQUARE	591.5	589.5	620	241.5	294	294	294	294					58	15.2	9.2	0.0	0.0	24.5	99.7%	39.0%	100.0%	100.0%		
3 WOODLAND SQUARE	322.5	359.5	632.5	852.66666667	294	262.5	294	399					69	9.0	18.1	0.0	0.0	27.2	111.5%	134.8%	89.3%	135.7%		
ASKET CROFT	558	576.46666667	805	976.08333333	308	311	616	802	381.41	381.41			552	1.6	3.2	0.7	0.0	5.5	103.3%	121.3%	101.0%	130.2%	100.0%	
ASKET HOUSE	401	402.25	405	562	308	308	308	309	234.25	234.25			390	1.8	2.2	0.6	0.0	4.7	100.3%	138.8%	100.0%	100.3%	100.0%	
BECKLIN WARD 1	1,080.5	825.5	471	1,375.25	616	596	616	738.5					629	2.3	3.4	0.0	0.0	5.6	76.4%	292.0%	96.8%	119.9%		
BECKLIN WARD 2 CR	634.75	561.75	920	1,011	644	590.5	943	1,011					157	7.3	12.9	0.0	0.0	20.2	88.5%	109.9%	91.7%	107.2%		
BECKLIN WARD 3	975.5	867.5	681	1,183.5	616	616	605	836.5					618	2.4	3.3	0.0	0.0	5.7	88.9%	173.8%	100.0%	138.3%		
BECKLIN WARD 4	1,123.5	922.41666667	672.5	1,045.3	605	616	583	692.2					633	2.4	2.7	0.0	0.0	5.2	82.1%	155.4%	101.8%	118.7%		
BECKLIN WARD 5	1,122	893.5	876	1,800.66666667	605	585	605	1,266					617	2.4	5.0	0.0	0.0	7.4	79.6%	205.6%	96.7%	209.3%		
MOTHER AND BABY THE MOUNT	671.5	611.16666667	684	765.5	572	341.5	605	847					177	5.4	9.1	0.0	0.0	14.5	91.0%	111.9%	59.7%	140.0%		
NEWSAM WARD 1 PICU	1,128	876.25	1,287	2,295.5	616	527.5	616	1,619					309	4.5	12.7	0.0	0.0	17.2	77.7%	178.4%	85.6%	262.8%		
NEWSAM WARD 2 FORENSIC	723.5	671.25	716.5	1,387	301	302.08333333	602	1,052.75					336	2.9	7.3	0.0	0.0	10.2	92.8%	193.6%	100.4%	174.9%		
NEWSAM WARD 2 WOMENS SERVICES	790.5	748.5	771	909.5	301	301	602	602					276	3.8	5.5	0.0	0.0	9.3	94.7%	118.0%	100.0%	100.0%		
NEWSAM WARD 3	713	721.25	694.33	860.75	301	301	580.5	676.75					392	2.6	3.9	0.0	0.0	6.5	101.2%	124.0%	100.0%	116.6%		
NEWSAM WARD 4	934.5	935	600.2	1,602.2	616	618	605.58	1,261.5					598	2.6	4.8	0.0	0.0	7.4	100.1%	266.9%	100.3%	208.3%		
NEWSAM WARD 5	727.5	755	1,117.5	1,139.5	616	616	615.5	652					504	2.7	3.6	0.0	0.0	6.3	103.8%	102.0%	100.0%	105.9%		
NEWSAM WARD 6 EDU	688.5	728.5	610.5	1,179.5	294	347	575.75	961	375	375	127.5	127.5	326	3.3	6.6	1.2	0.4	11.4	105.8%	193.2%	118.0%	166.9%	100.0%	100.0%
NICPM LGI	873	878.5	309.5	306.5	588	578.75	294	294					112	13.0	5.4	0.0	0.0	18.4	100.6%	99.0%	98.4%	100.0%		
PARKSIDE LODGE	732.5	648	1,749.5	1,769.66666667	294	315	1,144.5	1,145.08333333					112	8.6	26.0	0.0	0.0	34.6	88.5%	101.2%	107.1%	100.1%		
THE MOUNT WARD 1 NEW (MALE)	772.5	796.5	1,558.5	2,178.16666667	602	569.75	892.25	1,688.25					476	2.9	8.1	0.0	0.0	11.0	103.1%	139.8%	94.6%	189.2%		
THE MOUNT WARD 2 NEW (FEMALE)	785	815.5	1,067	2,056.08333334	569.75	387	591.25	1,621.5					412	2.9	8.9	0.0	0.0	11.8	103.9%	192.7%	67.9%	274.2%		
THE MOUNT WARD 3A	798.5	715.16666667	1,153	1,360.5	308	311.25	616	913					537	1.9	4.2	0.0	0.0	6.1	89.6%	118.0%	101.1%	148.2%		
THE MOUNT WARD 4A	750	746.41666668	1,207.5	1,352.33333333	308	310.5	605	827.66666666					667	1.6	3.3	0.0	0.0	4.9	99.5%	112.0%	100.8%	136.8%		
YORK - BLUEBELL	675	707.5	630	915	300.16	289.35000009	600.04	600.13333324					206	4.8	7.4	0.0	0.0	12.2	104.8%	145.2%	96.4%	100.0%		
YORK - MILL LODGE	1,238.67	895.58333331	1,134	1,330.83333332	616	565.33333333	616	914					276	5.3	8.1	0.0	0.0	13.4	72.3%	117.4%	91.8%	148.4%		
YORK - RIVERFIELDS	357	428.16666666	625	710.66666666	300.16	304.06666676	300.16	300.06666676					84	8.7	12.0	0.0	0.0	20.7	119.9%	113.7%	101.3%	100.0%		
YORK - WESTERDALE	608.25	1,002.5	1,024.5	962	300.16	310.78333342	900.2	932.35000001					229	5.7	8.3	0.0	0.0	14.0	164.8%	93.9%	103.5%	103.6%		

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

18

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Workforce Performance Report
DATE OF MEETING:	28 March 2019
PRESENTED BY: (name and title)	Claire Holmes, Director of OD and Workforce
PREPARED BY: (name and title)	Claire Holmes, Director of OD and Workforce Lindsay Jensen, Deputy Director of Workforce Angela Earnshaw, Head of Learning & OD

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

EXECUTIVE SUMMARY

The 2018 staff survey results have been released and overall the results are very positive with the Trust exceeding the sector average in 70% of survey themes. This report focuses on the ten high level themes, setting out key trends, improvements and challenges.

Following the appraisal audit late 2018, seven key deliverables set out in the improvement plan are summarised within the report. The full action plan supporting these deliverables has been included as Schedule 1 of the report.

Assurance is provided in relation to the Trust's position on Settlement Agreements following the Cornwall Review which recommends that Settlement Agreements must not be used to avoid dealing with Whistleblowing issues.

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 content of the action plan and Schedule 1.

MEETING OF THE BOARD OF DIRECTORS

28 March 2018

Workforce Performance Report

1 Executive Summary

The Workforce Performance Report provides an overview of the 2018 staff survey results. Overall the results are very positive with the Trust exceeding the sector average in 70% of survey themes and this report focuses on the ten high level themes, setting out key trends, improvements and challenges.

Following the appraisal audit in late 2018, seven key deliverables set out in the improvement plan are summarised within the report. As previously requested, the full action plan supporting these deliverables has been included as Schedule 1 of the report.

2 Staff Survey Results 2018

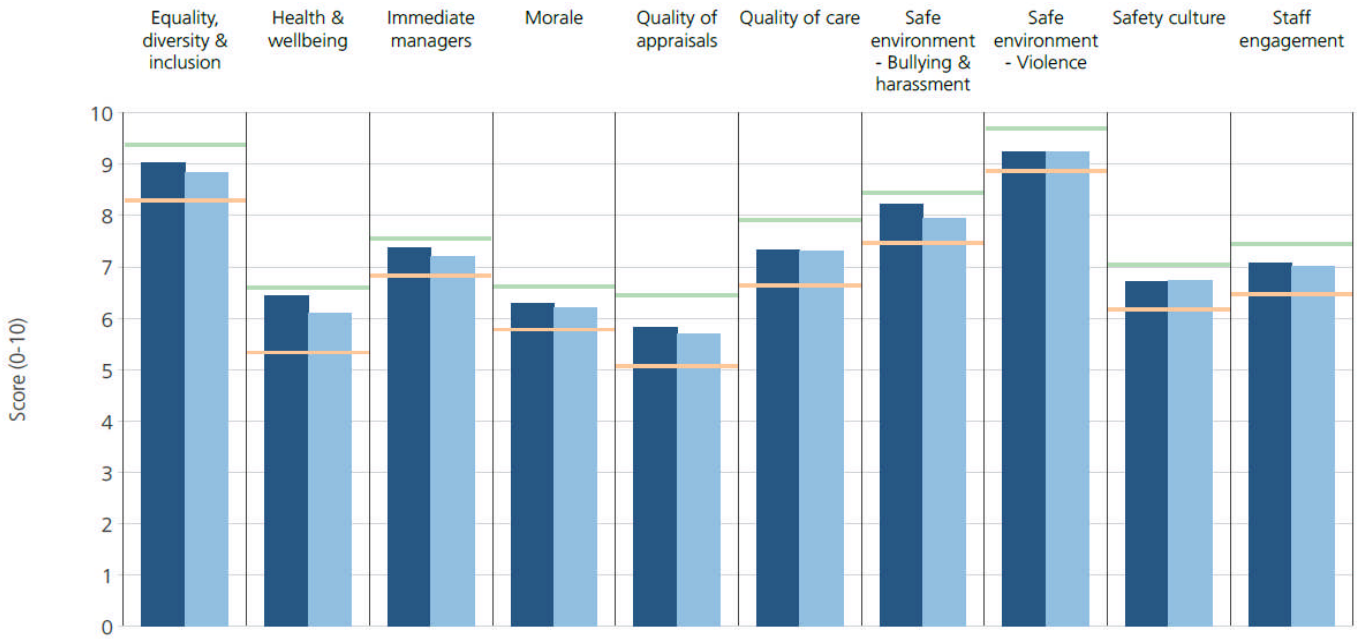
1420 staff responded to the Trust survey this year, resulting in a 58% response rate, an increase of 2% on last year. Overall the Trust results were positive, exceeding the sector average in 70% of the survey themes.

Comparably to other Mental Health Trusts, two of the top areas of performance are;

- Health and Wellbeing, where our results sit above average and only 0.2 off of the best reported Trust; and
- Support from Immediate Managers, where again our result is again above average and 0.1 below the best reported score within our Mental Health comparators.

Although positive, caution must be exercised with the comparator scores as although indicated we are performing well on that theme within the context of the wider Mental Health Arena, Health and Wellbeing remains one of the lower scoring themes for the Trust and an area of key focus for 2019.

The chart below provides a visible summary of the Trust's performance against comparator Trusts on all 10 themes:



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.4	6.6	7.5	6.6	6.4	7.9	8.4	9.7	7.0	7.4
Your org	9.0	6.4	7.4	6.3	5.8	7.3	8.2	9.2	6.7	7.1
Average	8.8	6.1	7.2	6.2	5.7	7.3	7.9	9.3	6.7	7.0
Worst	8.3	5.3	6.8	5.8	5.1	6.6	7.5	8.9	6.2	6.5

We have improved our scores in the 2018 survey compared to our 2017 results in the following areas:

- **Quality of appraisals:** Our score has increased from 5.4 in 2017 to 5.8 in 2018 and this now takes us above the national average score of 5.7. This is encouraging as whilst compliance rates remain a challenge, much effort has been invested to provide further training for managers undertaking appraisal and it is positive to see that staff report that the quality of appraisals has improved. Staff also report that this has enabled them to improve on how they do their job and that they have clear objectives.
- **Safety Culture:** Our score has increased from 6.5 in 2017 to 6.7 in 2018 and sees us now achieving the national average score of 6.7. Safety culture covers a number of areas around staff feeling treated fairly when incidents, errors or near misses have been reported, given feedback on any changes made in response to incidents, errors or near misses, whether they feel secure in raising concerns about unsafe clinical practice and feel confident that any concerns raised will be addressed.

- **Staff engagement:** Our score has increased from 6.9 in 2017 to 7.1 in 2018 and this now takes us above the national average score of 7.0. Staff engagement covers a number of questions in the survey and our most above average scores are that staff look forward to going to work, staff feel there are frequent opportunities to show initiative and suggest improvements, and are able to make improvements happen.

Equality and Diversity is the only theme in which we have seen a lower score in 2018 than in 2017, declining from 9.1 to 9.0. There was a decrease of 2% (87% in 2017, 85% in 2018) as to whether staff feel the organisation 'acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?' We have also seen an increase in staff experiencing discrimination at work from service users, but a decrease in discrimination from their manager/other colleagues. It is important to note whilst we have seen a decrease in score for this theme, we are still above the sector average of 8.8.

Safe Environment – Violence represents only theme where our score is lower than the sector average, where we achieved a score of 9.2 comparted to a sector average of 9.3. Our score does however show an improvement on our 2017 score of 9.1. The questions in this theme cover whether staff have experienced violence at work from service users (their relatives or other members of the public), managers, or other colleagues.

Top 5 improvements since 2017: Looking at individual questions we can see some significant changes with our most improved scores compared to 2017:

- The extent to which staff feel the organisation values their work (+10%)
- Recommending the Trust to others as a place to work (+8%)
- Receiving recognition for good work (+7%)
- The care of service users being the organisations top priority (+7%)
- The organisation treating staff that are involved in an error, near miss or incident fairly (+7%)

Where we have scored less well in comparison 2017? There is however some key questions where our scores have dropped in comparison to 2017:

- Receiving an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review in the last 12 months (-3%)

- Reporting harassment, bullying or abuse at work (-3%)
- Receiving training, learning or development in the last 12 months? (-2%)
- Experiencing musculoskeletal problems (MSK) as a result of work activities (+2%)
- Feeling unwell as a result of work related stress (+2%)

Recurring themes 2016-18

When we look at our results over the last three years we see 6 areas where we are continuing to improve and three areas where we are still facing challenges.

Improvements	**2016**	**2017**	**2018**
Staff working additional unpaid hours for the Trust	58%	55%	54%
The Trust's values are being discussed during the appraisal process	30%	34%	55%
Staff feeling supported by their immediate manager	73%	77%	78%
Senior managers are involving staff in important decisions	33%	36%	40%
Staff feeling satisfied with the opportunities for flexible working patterns	59%	61%	66%
Staff feeling that the organisation values their work	39%	40%	50%

Challenges	**2016**	**2017**	**2018**
Staff feeling unwell as a result of work related stress over the last 12 months *(a lower score is better here)*	35%	38%	40%
Staff putting themselves under pressure to come to work *(a lower score is better here)*	91%	92%	94%
Staff saying they (or a colleague) reported harassment, bullying or abuse at work last time they experienced it	64%	65%	61%

Next Steps:

At Trust level the staff survey results provide invaluable information and insight which helps to inform our strategic planning and priorities. It is the Trust's practice to look to our individual service areas to undertake specific action planning arising from the staff survey responses. This helps to invoke a greater sense of accountability and reinforces the importance of maintaining continuous improvement at the front line delivery of services. Staff feedback has been very positive in respect of this approach and it is our intention to employ the same principled to the 2018 survey results.

3 Appraisal Improvement Plan

Work to improve the Trust appraisal processes has been ongoing since September 2018, when a report, outlining the issues and agreed actions was presented to the Trust Senior Leadership Team. As part of this improvement work an audit has been undertaken on the Trust Appraisal Process which reported in December 2018. Following this audit, a number of further improvements have been identified to the Trust Appraisal Policy, Procedure, supporting systems and processes. These have been summarised into 7 key deliverables:

1. Launch a new Appraisal Policy, focused on building a culture of positive management and continuing professional development
2. Improve the Quality of the Appraisal Reporting Mechanisms to ensure high levels of credibility and confidence
3. Review current governance structures and processes with regards to compliance, including a defined escalation procedure
4. Review appraisal hierarchies and devise local strategies where ratios are inappropriate
5. Embed iLearn as the sole appraisal completion mechanism, utilising the technological solution to improve our ability to undertake a central training needs analysis
6. Ensure managers have the skills and capabilities to conduct quality appraisals
7. Establish a robust appraisal quality assurance audit

These improvements must be delivered whilst ensuring the Trust Appraisal Policy and Procedures deliver the requirements of the 2018 national pay award. A Pay Award Task and Finish Group have been established for this purpose.

It should be noted that the Trust has already committed to reviewing the long-term viability of the Ilearn learning management system as the system of choice for recording of appraisal activity and reporting. Improvements to the appraisal module on Ilearn have been delivered very recently by the system provider and the new functionality is currently being reviewed by system users in the Trust. The feedback from users in the Trust will form part of the overall review and decision making about the long-term viability of Ilearn. The overall review will be completed by the 30th September 2019 and the outcome of this review may lead to a review of this improvement plan. A full copy of the action plan is attached as Schedule 1.

4 Freedom to Speak Up Recommendations

Following a review of practice at Cornwall Trust, a recommendation has been issued that Settlement Agreements must not be used where the offer of such an agreement is a purposeful means of avoiding a Whistleblowing issue. Leeds and York NHS Partnership Trust has not entered into any settlement agreement which had, or could have had, the intended or unintended consequence that a Whistleblowing concern was unaddressed. The Trust is wholly committed to continuing with this good practice.

5 Update on Workforce Governance Review

A review has been continuing of current workforce governance arrangements and a new draft structure will be presented to the current Executive led Workforce and Organisational Development Group for comment on 18th April 2019 following which this will be presented to Board.

6 Recommendation

The Board is asked to note the report.

Schedule 1: Appraisal Processes Improvement Action Plan

March 2019

Leeds and York Partnership NHS Foundation Trust

Actions	Lead	Target Date	Progress to date (March 2019)
1. Launch a new Appraisal Policy, focused on building a culture of positive management and continuing professional development			
• Consult with a range of stakeholders to inform the new policy. • First draft of Policy ready by 31 March 2019 • Policy approved and ratified by 30 June 2019 • To refresh supporting appraisal documentation and processes to ensure managers and staff are supported to deliver quality appraisals.	Angela Earnshaw Head of Learning and OD	30.06.19	Task and finish group established and on target to develop first draft by 31 March 2019.
2. Improve the Quality of the Appraisal Reporting Mechanisms to ensure high levels of credibility and confidence			
• Validate appraisal data to ensure full integrity and accuracy as quickly as possible • Maintain proactive dynamic working relationship with system provider to maximise current system and future system developments. • Provide support to teams on using the system effectively	Andrew McNichol Workforce Information Manager	31.3.19	Worked in partnership with the system provider to correct and resolve outstanding system software errors to improve quality and accuracy of reports. Targeted and proactive support has been provided to teams and services which has also included data validation and correction, as required

3. Review current governance structures and processes with regards to compliance, including a defined escalation procedure			
• Accurate weekly appraisal compliance reports provided to all managers at a team level and senior managers • Creation of a Workforce Metrics Group to oversee the appraisal compliance audit plan and put in place local action plans for improvement as required • Defined escalation process to be included in the revised appraisal policy	Andrew McNichol Workforce Information Manager	30.9.19	Improved weekly compliance reports developed Targeted and proactive support has been provided to teams and services which has also included data validation and correction, as required
4. Review appraisal hierarchies and devise local strategies where ratios are inappropriate			
• New appraisal policy to define appraisal hierarchies and ratios. • HR Business Partners to work with services to support and implement local plans to achieve defined hierarchies and manageable ratios. •	HR Business Partners & Andrew McNichol, Workforce Information Manager	30.9.19	Task and finish group established and on target to develop first draft by 31 March 2019
5. Embed Ilearn as the sole appraisal completion mechanism, utilising the technological solution to improve our ability to undertake a central training needs analysis			
• Paper based appraisal system to cease and embed Ilearn as sole appraisal mechanism • New and improved training for Managers on full utilisation of the system • Adopt new Ilearn appraisal module to deliver improved functionality. • Collect central TNA by March 2020	Angela Earnshaw Head of Learning and OD Andrew McNichol, Head of Workforce Information	30.9 19	Task and finish group established and on target to develop first draft by 31 March 2019 A 2 click system introduced for easy notification of appraisal completion Streamlining of the Ilearn e-form has been completed Testing of the new module will take place with Trust users in March/April 2019 with a view to adopting the new module as soon as is feasible.

6. Ensure managers have the skills and capabilities to conduct quality appraisals			
• Providing Managers with the skills and confidence to conduct quality appraisals • Regular updated information provided as the system develops to support the quality conversation. • Develop video based training and guidance materials which will be available to managers and staff on staff net.	Angela Earnshaw Head of Learning and OD	30.6.19	New appraisal training programme been developed for roll out to new Managers Essential Programme Face to face training on request for all Since September 2018 regular consistent and comprehensive information and guidance provided to all staff via the intranet and trust wide communications.
7. Establish a robust appraisal quality assurance audit			
• Rollout an appraisal quality assurance scheme including questionnaires to staff and a sample grandparent audit of completed appraisals. • Evaluation of the pilot scheme used in Specialist and LD.	Angela Earnshaw, Head of Learning and OD HR Business Partners	30.12.19	Task and finish group established and on target to develop first draft by 31 March 2019 Data being collected on the pilot in Specialist and LD

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:	Chief Financial Officer Report Month 11
DATE OF MEETING:	28 March 2019
PRESENTED BY: (name and title)	Dawn Hanwell, Chief Financial Officer and Deputy Chief Executive
PREPARED BY: (name and title)	Dawn Hanwell, Chief Financial Officer and Deputy Chief Executive

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

EXECUTIVE SUMMARY

This report provides an overview of the financial position at month 11 (February 19), and an update on clinical contracts for 19/20.

The position at month 11 shows financial performance is significantly ahead of plan. The income and expenditure position has improved mainly due to additional revenue support from Leeds CCG, which fully covers the in-year financial risks for Out of Area Placements. The finance score is '1' due to a high surplus ratio. The forecast outturn will exceed plan. Notwithstanding this performance pressures continue and we maintain the momentum to reduce these, moving into the next financial year.

We are making good progress to finalise our main clinical contracts for 19/20.

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:

- month 11 position with overall surplus above plan and the Finance Score is '1'.
- high confidence levels in exceeding year end Control Total
- progress in finalising clinical contracts for 19/20

BOARD OF DIRECTORS

28 MARCH 2019

CHIEF FINANCIAL OFFICER REPORT MONTH 11

1 Introduction

This report provides an overview of the financial position at month 11 (February 2019), and an update on clinical contracts for 19/20.

2 Clinical Contracts

The timetable for 19/20 operational planning set by NHSI required commissioners and providers to sign contracts by 21 March. Whilst we have not achieved this in terms of agreeing full contract documentation we have agreed outline financial values to inform next year's financial plan. The Leeds CCG contract offer includes some investment funding, and an agreement to support a revised Out of Area Placement trajectory. We currently have a roll forward position with NHS England but are still working through some detail on CAMHS and Forensic services contracts, which may impact on the overall final value.

We have not been able at this stage to secure any investment in Gender Identity Services, as this is prohibited whilst a decision on the national procurement approach is announced. We have been assured that this announcement is now imminent (early April), and at this point we can review the business case we submitted as part of our initial negotiations.

We do not envisage any risks in agreeing contracts and have confirmed we will not be escalating any issues for mediation/arbitration.

3 Financial Performance - Key Indicators Month 11

A summary of overall performance against key metrics is shown in the table 1 below. The key point to note is the Trusts overall Finance Score remained a '1' due to the size of surplus which is driven by the Provider Sustainability Fund (PSF) phasing.

Table 1

Key Metrics:	Year to date		
	Plan	Actual	Trend
Single Oversight Framework Finance Score	1	1	⟷
Income & Expenditure Position (£000s)	25,834	28,745	↑
Recurrent CIP (£000s)	2,626	2,617	⟷
Cash (£000s)	65,714	68,065	↑
Capital (£000s)	5,300	4,080	⟷

4 Statement of Comprehensive Income

Table 2 below summarises the income and expenditure position showing an overall net surplus of £12,470k pre PSF and £28,745k inclusive of PSF. This position significantly exceeds the year to date plan (£2,911k overachievement) which is attributable to:

- Leeds CCG additional financial support for Out of area placement pressures.
- Income improvements including Commercial Procurement activities.
- Review of provisions.

Due to the improvements noted above, the overall position exceeds the full year planned position of £28m surplus. We are therefore confident that the outturn position will exceed the control total and the Trust will therefore receive further PSF.

Table 2

Income & Expenditure Position	Month 11		
	Plan £000's	Actual £000's	Variance £000's
Clinical Income	123,884	128,245	4,361
Other Operating Income	21,450	20,909	(541)
Total Operating Income	**145,334**	**149,154**	**3,820**
Employee Expenses Substantive	(99,339)	(99,209)	130
Employee Expenses Agency	(4,499)	(4,738)	(239)
Employee Expenses Total	**(103,838)**	**(103,947)**	**(109)**
Non Pay	(36,923)	(37,527)	(604)
Total Operating Expenses	**(140,761)**	**(141,474)**	**(713)**
Non-Operating income	9,098	8,906	(192)
Non-Operating expenses	(4,112)	(4,116)	(4)
Surplus (Deficit)	**9,559**	**12,470**	**2,911**
PSF	**16,275**	**16,275**	
Total Surplus (Deficit) inc. PSF	**25,834**	**28,745**	**2,911**

The material variances to date are:

- Operating income shows a £3.8m positive variance but this is due to Agenda for Change pay award central funding and additional CCG income linked to OAPs pressures, offset by internal re-phasing of other developments including commercial procurement activities (not an income under-recovery issue).
- Pay expenditure position is a £0.11m over spent against plan, comprising a £0.13m under-spend on substantive/bank staff and £0.24m overspend on locum & agency staff expense. This position is offsetting the income re-phasing as noted above.
- Non-pay spending is over plan by £0.6m at month 11 primarily as a consequence of higher than planned locked rehabilitation and adult acute out of area placements offset by slippage on developments.
- Non-operating income is showing a £0.19m adverse variance at month 11 due to PFI refinance shortfall offset by additional profit on disposal and investment income.
- No significant non-operating expenses variance at month 11.

This translates into a variance analysis at Directorate level as detailed in table 2a below:

Table 2a

Directorate	Variance £000's
Leeds Care Group	(2,325)
Specialist Care Group	(1,072)
CPC	729
Corporate & Reserves	5,579
Surplus (Deficit)	**2,911**

5 Cost Improvement Plans

The identified recurrent CIPs are £10k behind plan as detailed in table 3 below. This is not a material concern at this stage, and is anticipated will be achieved in year. The level of recurrent unidentified savings (£0.31m) has been identified recurrently and in year.

Table 3

CIP Summary	2018-19 Plan £'000	Month 11			
		Plan £'000	Actual £'000	Variance £'000	Variance %
Leeds Mental Health Care Group	364	319	321	2	1%
Specialist & Learning Disability Care Group	615	563	550	(13)	-2%
Chief Financial Officer	1,491	1,362	1,363	1	0%
Medical	61	56	56	0	0%
Chief Nurse	45	41	41	0	0%
Sub Total allocated/ identified	**2,576**	**2,341**	**2,332**	**(10)**	**0%**
Recurrent to be allocated/identified	310	285	285	0	0%
Total Recurrent Position	**2,886**	**2,626**	**2,617**	**(10)**	**0%**

6 Capital Position

Capital expenditure is reported as £4,080k at month 11, which is £778k under plan (reforecast) due to strategic estates scheme delays.

Our latest 2018/19 forecast capital expenditure is £4.6m, LYPFT original capital plan included enabling works for CAMHS tier 4 St Marys Hospital scheme which will not now be carried out before March 2019.

Progress on the implementation of the new electronic patient record is on track to the amended timescale and key milestones have been met.

Appendix 1 provides full details of capital spend by scheme compared to plan at month 11 and outlines the reforecast capital position for 2018-19.

7 Cash Flow

The cash position of £68.1m is £2.4m above plan at the end of month 11 and liquidity remained strong at 174 days operating expenses.

8 Finance Score

The NHSI key metrics by which financial performance is monitored and assessed are shown below in table 4. The Trust achieved the plan at month 11 with an overall Finance Score of 1.

The key sensitivity/ concerns regarding agency spending continues in month 11 and the metric remained a score of '2'. An improvement in the capital service cover metric as a result of addition non-recurrent in year Provider Sustainability Funding is offsetting the deterioration in the agency score metric.

Table 4

February 2019	Score	Actual	Plan
Capital Service Capacity	6.06	1	1
Liquidity	174	1	1
I&E Margin	17.4%	1	1
Variance in I&E Margin	1.39%	1	1
Agency Cap	4.2%	2	1
Overall Finance Score		**1**	**1**

NHS I Metric Score Criteria:	1	2	3	4
Capital servicing capacity	2.5	1.75	1.25	<1.25
Liquidity ratio (days)	0	-7	-14	<-14
I&E Margin	1%	0%	-1%	<=-1
Variance in I & E Margin	0%	-1%	-2%	<=-2%
Agency Cap	0%	25%	50%	>=50%

Capital Service Cover: Measures the ability to repay debt, based on the amount of surplus generated. The Trust scores relatively poorly on this metric due to the higher level of PFI debt repayment. However, additional in year non-recurrent PSF agreed in the updated plan results in a rating of 1.

Liquidity: Measures the ability to cover operational expenses after covering all current assets/liabilities. The healthy cash position of the Trust pushes this rating up significantly. At month 11 the Trust reported a liquidity metric of 174 days (167 days in month 10) achieving a rating of 1.

Income and Expenditure (I&E) Margin and Variance in I&E Margin: Measures the surplus or deficit achieved expressed as a percentage of turnover and provides a comparison to the planned percentage. The Trust has reported a 17.4% (rating of 1) I&E margin which is a 1.39% (rating of 1) positive variance to the revised plan.

Agency Ceiling: The Trust reported agency spending 4.2% (3.3% in month 10) above the capped level (rating of 2) in month 11. Given the increasing reliance on agency medical cover there is a risk that the agency ceiling will be breached for year.

Previously an increased reliance on agency staffing linked to Commercial Procurement activities caused the cap to be exceeded, an action plan was put in place and reliance on agency staff has subsequently reduced.

9 Conclusion

The position at month 11 remains ahead of plan and a reported finance score of '1' due to a high surplus ratio as a consequence of the PSF and non- recurrent revenue benefits including PFI refinance. The most significant ongoing risks continue to be OAPs expenditure and inpatient staffing.

The current forecast surplus for 2018/19 indicates that the Trust will exceed the Control Total. We continue the momentum on internal actions to reduce pressures.

10 Recommendation

The Board of Directors is asked to note the:

- month 11 position with overall surplus above plan and the Finance Score is '1'.
- high confidence levels in exceeding year end Control Total.
- progress in finalising clinical contracts for 19/20.

Appendix 1

CAPITAL PROGRAMME - at 28 FEBRUARY 2019	Original Plan 2018-19 Plan £'000	YTD YTD Plan £'000	Actual Spend £'000	YTD Variance £'000	2018-19 Forecast £'000
Estates Operational					
Health & Safety /Fire	100	80	16	(64)	16
Planned Annual Commitments	150	110	20	(90)	20
Estate refurbishment	350	290	109	(181)	109
Sub-Total	**600**	**480**	**145**	**(335)**	**145**
IT/Telecomms Operational					
PC Replacement Programme	200	180	432	252	452
IT Network Infrastructure	630	430	79	(351)	100
Additional Server/Storage	40	40	13	(27)	13
Cyber security software	30	30		(30)	0
Sub-Total	**900**	**680**	**524**	**(156)**	**565**
Estates Strategic Developments					
PFI Estate upgrade	850	650	188	(462)	188
St Marys Hospital - enabling work / CAMHS Tier 4	1,000	750	45	(705)	45
St Marys Hospital Reprovision	350	350	9	(341)	59
Community Model redesign	2,000	1,500	1,460	(40)	1,571
Estates Technology	1,000	750		(750)	0
YCPM Re-Location	0	0	8	8	8
Sub-Total	**5,200**	**4,000**	**1,710**	**(2,290)**	**1,871**
IT Strategic Developments					
Integration System	50	50	12	(38)	25
Replacement EPR	1,550	1,350	1,040	(310)	1,300
Remote Access	200	150	99	(51)	99
Smartphones	15	13		(13)	0
Current EPR System Developments	40	40		(40)	0
Sub-Total	**1,855**	**1,603**	**1,151**	**(452)**	**1,424**
Contingency Schemes					
Contingency	500	450		(450)	595
Clifton Key Alarm System			30	30	
Clifton Bluebell Seclusion Room			7	7	
Clifton Westerdale Seclusion Room			6	6	
Mill Lodge Door Access System			6	6	
Eating Disorders IT			17	17	
Public WiFi Deployment			2	2	
Westerdale Forensic Inpatients			108	108	
Platform - Cospace North			243	243	
CPC IT			46	46	
Hinged Rebate Lathes - PFI			27	27	
Smoking Lockers - PFI			5	5	
Anti-Lig Bath Taps - PFI			24	24	
Newsam Woodwork Room			23	23	
Liaison Psychiatry Dishwasher			5	5	
Sub-Total	**500**	**450**	**550**	**100**	**595**
TOTAL CAPITAL PROGRAMME	**9,055**	**7,213**	**4,080**	**(3,133)**	**4,600**

Capital Programme Summary	Annual Plan £'000	YTD Plan £'000	Actual Spend £'000	YTD Variance £'000	2018/19 Forecast £'000
Estates Operational	600	480	145	(335)	145
IT/Telecomms Operational	900	680	524	(156)	565
Estates Strategic Developments	5,200	4,000	1,710	(2,290)	1,871
IT Strategic Developments	1,855	1,603	1,151	(452)	1,424
Contingency Schemes	500	450	550	100	595
Total	**9,055**	**7,213**	**4,080**	**(3,133)**	**4,600**

Reforecast Plan Position	**5,300**	**4,858**	**4,080**	**(778)**

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
20

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Approval of the Data Security and Protection Toolkit
DATE OF MEETING:	28 March 2019
PRESENTED BY: (name and title)	Dawn Hanwell, Chief Financial Officer / SIRO
PREPARED BY: (name and title)	Carl Starbuck, Head of Information Governance / Data Protection 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.	

EXECUTIVE SUMMARY

Presenting the final scoring of this year's annual NHS Digital Data Security & Protection Toolkit return.

This is the first return against the DSP Toolkit, which was drafted and issued based largely on the National Data Guardian's 10 recommended data security standards that were first presented in the "Caldicott 3" report. The DSP Toolkit replaces the former Information Governance Toolkit, which was superseded following submission in March 2018.

Pending Audit opinion, for which we are still awaiting the final report at the time of writing, the Trust believes it has evidenced an overall "Standards Met" position, based on all compulsory assertions having been met for the 2018-2019 reporting year.

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

RECOMMENDATION

To consider the assurance provided and ratify the Data Security & Protection Toolkit final scoring for publication via the NHS Digital DSP Toolkit website.

MEETING OF THE BOARD OF DIRECTORS

28 March 2019

Approval of the Data Security & Protection Toolkit

1 Executive Summary

Presenting the final scoring of this year's annual NHS Digital Data Security & Protection Toolkit.

This is the first return against the new DSP Toolkit, which was drafted and issued based on the National Data Guardian's 10 recommended data security standards that were first presented in the "Caldicott 3" report. The DSP Toolkit replaces the former Information Governance Toolkit, which was superseded following submission in March 2018.

Pending Audit opinion, for which we are still awaiting the final report at the time of writing, the Trust believes it has evidenced an overall "Standards Met" position, based on all mandatory Assertions having been met for the 2018-2019 reporting year.

2 Data Security & Protection Toolkit v1 – 2018-2019

Based on the recommendations of Dame Fiona Caldicott in her role as the National Data Guardian, the 15-year-old NHS Digital Information Governance Toolkit was replaced with a new self-assurance tool for 2018-2019, known as the Data Security & Protection Toolkit. The online self-assessment tool states that:-

Data Security and Protection Standards for health and care (opens in a new tab) sets out the National Data Guardian's (NDG) data security standards. Completing this Toolkit self-assessment, by providing evidence and judging whether you meet the assertions, will demonstrate that your organisation is working towards or meeting the NDG standards.

The DSP Toolkit consists of 32 mandatory "Assertions" & 8 non-mandatory Assertions, broken down into the following 10 domains:-

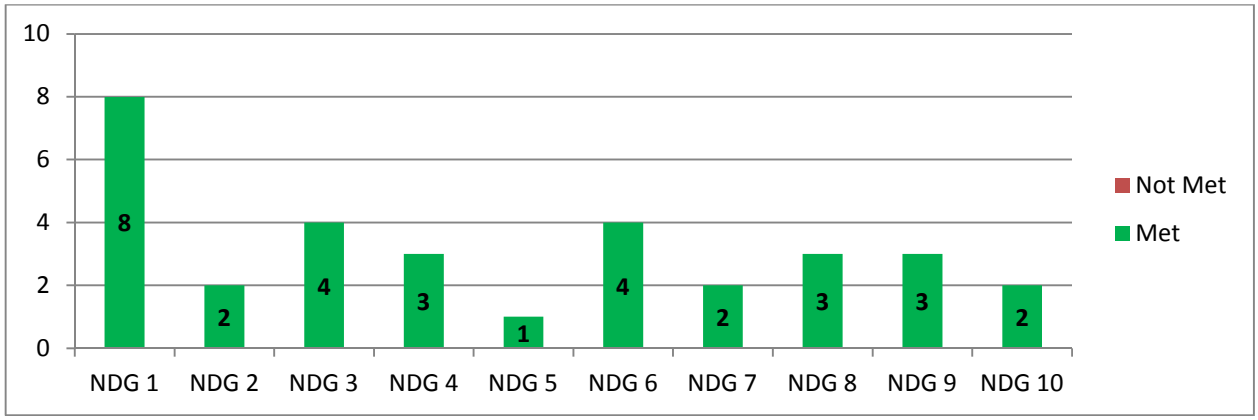
1 Personal Confidential Data
2 Staff Responsibilities
3 Training
4 Managing Data Access
5 Process Reviews
6 Responding to Incidents

7 Continuity Planning
8 Unsupported Systems
9 IT Protection
10 Accountable Suppliers

The 32 mandatory Assertions further break down into 100 mandatory evidence items.

As with the IG Toolkit, the approach taken is to pass each of the Assertions to an appropriate subject matter expert (mainly in Information Governance & ICT, but also with some Procurement & HR input), to have them assemble an evidence base against the Assertion and then document our compliance on the DSP Toolkit website. Each Assertion has evidential sub-sections and all mandatory sub-sections must be complete to mark the Assertion as "Met".

At the time of writing, the Trust is stating that all assertions have been met, with the reporting graphically represented as follows:-



Reference	NDG Standard*
NDG 1	Personal Confidential Data (8)
NDG 2	Staff Responsibilities (2)
NDG 3	Training (4)
NDG 4	Managing Data Access (3)
NDG 5	Process Reviews (1)
NDG 6	Responding to Incidents (4)
NDG 7	Continuity Planning (2)
NDG 8	Unsupported Systems (3)
NDG 9	IT Protection (3)
NDG 10	Accountable Suppliers (2)

**figures in brackets denote the number of Assertions per standard.*

As this is a "Year One" exercise based on the outright replacement of the outgoing Information Governance Toolkit, The IG team agreed, via the IG Group, that only the mandatory Assertions would be targeted in this iteration. This parallels the approach previously taken with the IG Toolkit, where the maximum performance level (level 3) was

not targeted for some requirements due to the resource / work required not yielding a tangible benefit.

As was the case with the IG Toolkit, our internal audit service are conducting an audit of our evidence base and at the time of writing we are still awaiting their final report, which may vary the overall outcome.

Acknowledging this was the first iteration of a new assurance tool, NHS Digital issued the following statement (08/03/2019) regarding the approach to take in the event that mandatory assertions had not been met:-

Organisations are expected to achieve 'Standards Met' on the DSP Toolkit. With this being the first year of the DSP Toolkit Standard, NHS Trusts, Local Authorities, CCGs, and CSUs will be allowed to publish a DSP Toolkit if they are approaching a level of 'Standards Met' in all but a few areas. They will be required to provide an Improvement plan of how they going to bridge the gap between their current position and meeting the DSP Toolkit 'Standards Met'. The functionality to allow the publication of a DSP Toolkit with an Improvement plan will be enabled 25th March 2019 to allow the maximum chance for organisations to achieve 'Standards Met'.

Should audit opinion indicate that any standards have not been met we will take the above recommended approach.

This report and the underlying Assertions were reviewed and approved by the Information Governance Group (27/03/2019).

3 Conclusion

This concludes the summary of assurance provided against the NHS Digital Data Security & Protection Toolkit for 2018-2019.

4 Recommendation

To consider the assurance provided and ratify the Data Security & Protection Toolkit final scoring for publication via the NHS Digital DSP Toolkit website.

Carl Starbuck
Head of Information Governance / Data Protection Officer
18 March 2019

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
21

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Freedom to Speak Up Action Plan and Strategic Policy
DATE OF MEETING:	28 March 2019
LEAD DIRECTOR: (name and title)	Cath Hill – Associate Director for Corporate Governance
PAPER AUTHOR: (name and title)	Cath Hill – Associate Director for Corporate Governance

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

EXECUTIVE SUMMARY

The Board is reminded that at the September 2018 meeting the National Guardian's Office and NHS Improvement's Board self-assessment tool and action was signed off.

The action plan was then submitted to NHS Improvement with a request that updates on progress against the action plan is submitted to NHSI in December 2018 and again in March 2019. The Board also agreed that prior to submission the action plan would be presented to the Quality Committee for assurance on progress.

This action plan is attached and it shows those actions that actions have been completed within the agreed timescales and those that have been started are on track for completion by the agreed deadline or have not yet been started as they refer to dates later in 2019. At its meeting on 12 March 2019 the Quality Committee received assurance on the progress against the action plan and also received and supported the strategic policy.

The Board is asked to note that there are a number of actions relating to the strategic policy which are currently marked as 'amber', these will be completed once the Board signs off the strategic policy which is attached.

The Board is also asked to note that at its meeting on 12 March the Quality Committee was advised that the action relating to the development of the FTSU / Whistleblowing procedure was on track for completion by the end of March 2019. Having reviewed the next steps for this procedure it was felt important to consult again with staff on this, and two other interlinked procedures (those regarding bullying and harassment and the grievance process) before they are finalised. This has resulted in the action now being shown as 'red'. In light of this the Board is asked to agree an amended completion date of end July 2019.

The Board is also asked to receive and note the Freedom to Speak Up Strategic Policy which has been through a process of development including being reviewed by the NED with lead for speaking up. The Board is asked to agree the strategic policy in accordance with the requirements of the National Guardian's Office and NHS Improvement.

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 progress with the actions and to be assured of the progress against the actions
- Agree a revised date of end July 2019 for the completion of the Freedom to Speak Up / whistleblowing Procedure
- Agree the Freedom to Speak up Strategic Policy.

Freedom to Speak Up action plan

March 2019

Not due
Completed
On track to be completed in the timescale
Concern about the agreed timescale

Freedom to speak up Action Plan – March 2019

Self-review indicator (number refers to the section in the self-assessment tool)	**Action**	**Lead**	**Timescale**	**Expected Outcome**	**Status of action**
4) Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.	FTSU Strategy to be developed and launched	Associate Director for Corporate Governance	March 2019	Freedom to Speak Up Strategy in place	**ONGOING** – The strategy has been drafted and is presented to the Board in March – senior leaders in the organisation have been involved in the drafting of the strategy – there will be further work during the launch to raise awareness.
5) There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.	FTSU Strategy to be developed and launched	Associate Director for Corporate Governance	March 2019	Freedom to Speak Up Strategy in place	**ONGOING** – The strategy has been drafted and is presented to the Board in March

Self-review indicator (number refers to the section in the self-assessment tool)	**Action**	**Lead**	**Timescale**	**Expected Outcome**	**Status of action**
7) The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian.	FTSU Strategy to be developed and launched	Associate Director for Corporate Governance	March 2019	Freedom to Speak Up Strategy in place	**ONGOING** – The strategy has been drafted and is presented to the Board in March. This has been consulted on with a range of stakeholders and aligns with existing guidance
8) Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.	FTSU Strategy to be developed and launched	Associate Director for Corporate Governance	March 2019	Freedom to Speak Up Strategy in place	**ONGOING** – The strategy has been drafted and is presented to the Board in March. Progress against the details outlined in the strategy will be reported on through the FTSUG report to the Board.
18) Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.	FTSUG to attend Trustwide Clinical Governance Group (Immediate: FTSUG and Medical	FTSUG and Medical Director and Director of Nursing and Professions	Immediate	FTSUG attends governance meetings as agreed and is able to triangulate speaking up themes and concerns	**COMPLETED** –It has been agreed that the FTSUG should be in attendance at the Trustwide Clinical Governance Group – the FTSUG will also report into the Workforce and OD group twice a year to present information on concerns

Self-review indicator (number refers to the section in the self-assessment tool)	Action	Lead	Timescale	Expected Outcome	Status of action
	Director) Identify any other governance meetings where speaking up and learning is discussed that the FTSUG should attend in order to support triangulation (November 2018: FTSUG, Director of Nursing and Professions, Director of OD and Workforce)	Director of OD and Workforce	November 2018		**COMPLETED** – This has been considered and it has been agreed that the FTSUG attends: • Equality Impact Group • Bank staffing forum • Staffside meeting • Trust welcome day • Leadership forum • Interface with GoSWH, Caldicott Guardian, Drs in training etc. • Leeds and York universities (Practice Learning and Development Team / Student interface) • Safeguarding meetings

Self-review indicator (number refers to the section in the self-assessment tool)	**Action**	**Lead**	**Timescale**	**Expected Outcome**	**Status of action**
20) Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.	Review programme of work to promote the vision, FTSUG role, contact arrangements, and the policy	FTSUG and Associate Director for Corporate Governance	December 2018	Refreshed programme of work which looks at any potential gaps in team / service coverage	**COMPLETED** – The programme of work has been reviewed by the FTSUG and the Associate Director for Corporate Governance to ensure this captures all services
24) Lessons learnt are shared widely both within relevant service areas and across the trust	Review how lessons from speaking up are promoted more widely in the organisation	Associate Director for Corporate Governance and FTSUG	December 2018	Strengthened system of reporting lessons from speaking up across the Trust	**COMPLETED** – It has been agreed that lessons learnt will be shared within the organisation through Clinical Improvement forums, Trustwide Clinical Governance Group, FTSUG blog, Board reports and by posting the Board report on Staffnet.

Self-review indicator (number refers to the section in the self-assessment tool)	**Action**	**Lead**	**Timescale**	**Expected Outcome**	**Status of action**
26) FTSU policies and procedures are reviewed and improved using feedback from workers	Further work required to ensure this is consulted on with workers directly	HR lead and FTSUG	March 2019	Evidence that workers have been included in the refresh of the FTSU policy	**ONGOING** – The Bullying and Harassment procedure, grievance procedure and the FTSU/Whistleblowing procedures are all being aligned to ensure they complement one another in terms of their style and content so staff are clear where one set of guidance starts and ends and know how to access the help and support they require.
29) Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.	The next bi-annual report will be added to the commissioners information pack	FTSUG and Contracting Lead	December 2018	Commissioners advised of FTSU data and information	**COMPLETED** – this has now been included in the pack of information sent to the commissioners

Self-review indicator (number refers to the section in the self-assessment tool)	**Action**	**Lead**	**Timescale**	**Expected Outcome**	**Status of action**
38) Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.	Include the NED lead in these reviews	Associate Director and FTSUG	Immediate	NED lead included in the process for review of guidance and national case reviews	**COMPLETED** – the NED lead will be informed and involved in any considerations of national case reviews – the FTSUG has added this requirement to his internal procedure
	Advise the executive directors of the outcome of these reviews for assurance and any areas of learning that need to applied	FTSUG	Immediate	All EDs advised of any implications from national case reviews	**COMPLETED** – the Executive Directors will be informed and involved in any considerations of national case reviews – the FTSUG has added this requirement to his internal procedure

Self-review indicator (number refers to the section in the self-assessment tool)	**Action**	**Lead**	**Timescale**	**Expected Outcome**	**Status of action**
40) The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.	FTSU Strategy to be developed and launched Review of the effectiveness of the strategy	Associate Director for Corporate Governance	March 2019	Freedom to Speak Up Strategy in place	**ONGOING** – The strategy has been drafted and is presented to the Board in March
		Associate Director for Corporate Governance and FTSUG	March 2020	Review of effectiveness of strategy and report to Board	**NOT YET STARTED**
41) The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.	Extend the review to include workers	FTSUG and HR	March 2019	Evidence that workers have been included in the refresh of the FTSU policy	**ONGOING** – The FTSUG and the AD for Corporate Governance are working with HR in the refresh of the procedure

Self-review indicator (number refers to the section in the self-assessment tool)	**Action**	**Lead**	**Timescale**	**Expected Outcome**	**Status of action**
42) A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored	There needs to be assurance that these areas of assurance listed are picked up in the annual internal audit of the FTSU function to provide the Board with independent assurance on the process	FTSUG and Internal Audit	November 2018	Confirmation that the standards are included in the internal audit Future internal audits will assess compliance	**COMPLETED** – Internal audit have been informed of the requirements so these can be incorporated into the next audit

Self-review indicator (number refers to the section in the self-assessment tool)	**Action**	**Lead**	**Timescale**	**Expected Outcome**	**Status of action**
43) Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.	Look at how lessons from speaking up are promoted more widely in the organisation	Associate Director for Corporate Governance and FTSUG	December 2018	Strengthened system of reporting lessons from speaking up across the Trust	**COMPLETED** – It has been agreed that lessons learnt will be shared within the organisation through Clinical Improvement forums, Trustwide Clinical Governance Group, FTSUG blog, Board reports and by posting the Board report on Staffnet.

Self-review indicator (number refers to the section in the self-assessment tool)	**Action**	**Lead**	**Timescale**	**Expected Outcome**	**Status of action**
50) Executive lead overseeing the creation of the FTSU vision and strategy.	FTSU Strategy to be developed and launched Review of the effectiveness of the strategy	Associate Director for Corporate Governance	March 2019	Freedom to Speak Up Strategy in place	**COMPLETED** – the Chief Executive has oversight of the development of the strategy
53) Ensuring that a sample of speaking up cases have been quality assured.	Ned to ensure that NHSI recommended areas of review are included in that audit	Internal Audit and FTSUG	November 2018	Future internal audits will assess compliance	**COMPLETED** – Internal audit have been informed of the requirements so these can be incorporated into the next audit
54) Conducting an annual review of the strategy, policy and process	FTSU Strategy to be developed and launched	Associate Director for Corporate Governance	March 2020	Freedom to Speak Up Strategy in place	**NOT YET STARTED**

Self-review indicator (number refers to the section in the self-assessment tool)	**Action**	**Lead**	**Timescale**	**Expected Outcome**	**Status of action**
55) Operationalising the learning derived from speaking up issues.	Look at how lessons from speaking up are promoted more widely in the organisation	Associate Director for Corporate Governance and FTSUG	December 2018	Strengthened system of reporting lessons from speaking up across the Trust	**COMPLETED** – It has been agreed that lessons learnt will be shared within the organisation through Clinical Improvement forums, Trustwide Clinical Governance Group, FTSUG blog, Board reports and by posting the Board report on Staffnet.
57) Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process	Future reports will include assurance on the FTSU strategy once this has been devised, launched and its effectiveness reviewed	FTSUG	July 2019	Board reporting against strategy measures	**NOT YET STARTED** (Due July 2019)

Self-review indicator (number refers to the section in the self-assessment tool)	Action	Lead	Timescale	Expected Outcome	Status of action
58) Ensuring NED lead is aware of latest guidance from National Guardian's Office.	Ensure there is a consistent email forwarding system when NGO guidance is received	FTSUG and NED Lead	Immediate	NED Lead aware of latest guidance from NGO	**COMPLETED** – the FTSUG has added the NED lead to his procedure for managing the forwarding of emails for NGO guidance
59) NED lead Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.	FTSU Strategy to be developed and launched	Associate Director for Corporate Governance	July 2019	Holding to account for strategy measures	**ONGOING** – The strategy has been drafted and provided to the lead NED for speaking up – further work will be undertaken to ensure the strategy is communicated widely through the organisation
60) Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement	The FTSU strategy will provide objectives on which challenge can be brought	NED lead and other members of the Board	March 2019 onwards	Effective challenge at Board	**ONGOING** – The strategy has been drafted and is presented to the Board in March – reports on its implementation will be made through the FTSUG bi-annual report

Self-review indicator (number refers to the section in the self-assessment tool)	Action	Lead	Timescale	Expected Outcome	Status of action
65) Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.	Look at how lessons from speaking up are promoted more widely in the organisation	HR and FTSUG	December 2018	Strengthened system of reporting lessons from speaking up across the Trust	**COMPLETED** – It has been agreed that lessons learnt will be shared within the organisation through Clinical Improvement forums, Trustwide Clinical Governance Group, FTSUG blog, Board reports and by posting the Board report on Staffnet.
66) Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.	Review programme of work to promote the vision, FTSUG role, contact arrangements, and the policy Review ways in which the FTSUG can	FTSUG and Associate Director for Corporate Governance	December 2018	Workers report that they know how to raise concerns and managers are able to support workers in doing this	**COMPLETED** – the FTSUG has agreed a programme of work to raise awareness of how to raise concerns and to ensure that he connects with managers

Self-review indicator (number refers to the section in the self-assessment tool)	Action	Lead	Timescale	Expected Outcome	Status of action
	identify any training needs for managers and look at options for how this can be delivered	FTSUG and HR team	March 2019		**ONGOING** – The refreshed procedure will include links to national training videos which are specific to both staff and also to managers.

Freedom to Speak Up Vision and Strategic Policy

1 SUMMARY

This strategic policy seeks to ensure we create a psychologically safe environment where people feel comfortable and have the opportunity to ask questions, ask for feedback, be respectfully critical and suggest ideas. People need to know they can make a difference when raising concerns about how Leeds and York Partnership NHS Foundation Trust provides care and delivers its services. We want to encourage people to Speak Up, ensure leaders listen and for all parts of the organisation to act on the lessons learnt from concerns raised. We want to create a psychologically safe environment where people feel able to raise concerns within their normal management arrangements and also have a number of other safe ways in which they can do this which suit their needs.

2 PURPOSE

The concept of Freedom to Speak Up was derived from a review undertaken by Sir Robert Francis which concluded in February 2015. The aim of the review was to assess the processes, mechanisms and culture in place regarding speaking up across the NHS. As a result of variations in the experience of individuals, the review recommended the implementation of 'Freedom to Speak Up Guardians' across the NHS. The aim of Freedom to Speak Up is to ensure a consistent approach across the NHS and ensure that staff are encouraged, supported and feel safe to raise concerns; free of any detriment.

We know that services with a high degree of psychological safety are also of higher physical and quality and have the ability to improve by the recognition of many different views and the welcoming of feedback.

This document outlines our vision and strategic policy in relation to Speaking Up and should be read in conjunction with the *Freedom to speak up: Raising Concerns (Whistleblowing) Procedure* (HR-0009).

3 OUR TRUST STRATEGY AND VALUES

Our Freedom to Speak Up strategic policy supports the delivery of the Trust's overarching strategy and the supporting strategic plans. The Trust's strategy aims to:

Provide outstanding mental health and learning
disability services as an employer of choice

We recognise that we cannot provide outstanding services without the active involvement of our staff (service users, carers, governors and key stakeholders) and we want to encourage

them to speak up and for us to listen to any concerns they have about the quality of our services so that we can continue to improve them.

Our values are directly linked to the ethos of Freedom to Speak Up. We have **integrity** – we are committed to continuously improving what we do because we want the best for our service users. We are **caring** – we make sure people feel we have time for them when they need it, we listen and act upon what people have to say. We keep it **simple** – we make processes as simple as possible.

Our learning culture places equal emphasis on accountability and learning. We recognise that in order to improve our services we need to learn from when care has gone well or not gone as expected. Where it has not gone well we need to understand why this was and not necessarily who was responsible. We need all staff to engage in these learning activities, including speaking up when they believe we are not addressing anything they have concerns about.

4 OUR VISION FOR SPEAKING UP

Our vision is to create a psychologically safe space to ensure that raising concerns becomes business as usual within the Trust, with staff feeling able to raise concerns routinely with their line managers and being confident that concerns will be addressed appropriately.

The Board is committed to ensuring that all staff feel safe to Speak Up. To support this, our Board and senior management team will:

- Model the behaviours to promote a positive culture in the Trust. This includes acknowledging mistakes and making improvements
- Provide the resources required to deliver an effective Freedom to Speak Up function, including working in partnership with the freedom to Speak Up Guardian
- Have oversight of the Speaking Up strategic policy and procedure to ensure they are being effectively implemented
- Be proactive in developing ideas and initiative to support Speaking Up.

Our Freedom to Speak Up Guardian has a key role in:

- Helping to raise the profile of raising concerns in our organisation and fostering a positive culture of Speaking Up
- Acting as a key point of contact for staff raising concerns
- Being the vital link between staff raising concerns and the officers who investigate any matters of concern
- Promoting learning and improvement resulting from staff speaking up.

5 OUR STRATEGIC POLICY

In order to deliver our vision for Speaking Up we will:

- Ensure we have in place a *Freedom to speak up: Raising Concerns (Whistleblowing) Procedure* which is regularly reviewed and which supports the Freedom to Speak Up vision and strategic policy
- Provide effective communication for staff so they know how to raise concerns
- Ensure managers are clear about their roles and responsibilities when handling concerns and are trained and supported to do so effectively
- Raise the profile of the Freedom to Speak Up Guardian throughout the Trust
- Communicate key findings to staff and the Board about the level and type of concerns raised and any resultant action taken, being mindful not to breach the confidentiality of staff who have raised concerns
- Share good practice and learning from concerns raised with the Board and staff
- Actively seek the opinion of staff to assess whether they are aware of and confident in using local processes and use this feedback to ensure our arrangements are improved based on staff experience and learning.

Responsibility for the delivery of the actions to achieve the vision and strategic policy will rest with the Chief Executive supported by the Associate Director for Corporate Governance.

6 MONITORING

To provide assurance of the effectiveness and delivery of our Speaking Up vision and strategic policy a Freedom to Speak Up Annual Report (and supplementary bi-annual update reports) will be presented to the Board of Directors by the Freedom to Speak Up Guardian.

This will include:

- An assessment of the effectiveness of the arrangements in place to support Speaking Up
- An overview of the cases reported and the themes identified
- Benchmarking against national indicators
- Details of any improvements that need to be made in the coming 12 months.

28 March 2019

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
22

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Annual Declarations of Interest, Non-executive Directors' Independence, and Fit and Proper Person
DATE OF MEETING:	26 March 2019
PRESENTED BY: (name and title)	Cath Hill, Associate Director for Corporate Governance
PREPARED BY: (name and title)	Cath Hill, associate Director for Corporate Governance

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

EXECUTIVE SUMMARY

At least annually all members of the Board of Directors are required to complete Declaration of Interest forms, fit and proper person annual declarations, and for NEDs only, a declarations for their independence.

A paper setting out the current position in relation to Board members' declarations of interest and fit and proper person status is presented at each meeting. The matrix presented to the April meeting is set out at agenda item 3 and shows the declared interests for directors and that all have been judged to be fit and proper, not only as a result of their annual declaration, but through a comprehensive and ongoing process of checks.

For the declarations made by the NEDs in relation to their independence (as required by NHS Improvement's Code of Governance for Foundation Trusts) a matrix of these is attached at Appendix A. All have declared their independence. On 18 March 2019 a meeting took place between the Chair of the Trust and the Trust Board Secretary to consider the declarations and having taken account of the positive declarations made by two NEDs (detaled on the attached matrix) all have been deemed to be independent in accordance with the Code of Governance's definition.

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 declarations of interest as set out at agenda item 3
- That all directors have been judged and declared themselves to be fit and proper
- That all NED have declared they are independent.

Should any Board member know of any reason why any NED may not be independent they are asked to advise of this matter for further consideration.

Annual Declaration of Non-executive Director Independence

(Declared as at March 2019)

Name	Has been an employee of the Trust within the last 5 years.	Has, or has had within the last three years, a material business relationship with the Trust directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the Trust.	Has received or receives additional remuneration from the Trust apart from a director's fee, participates in the Trust performance-related pay scheme, or is a member of the Trust's pension scheme.	Has close family ties with any of the Trust's advisers, directors or senior employees.	Holds cross-directorships or has significant links with other directors through involvement in other companies or bodies.	Has served on the Board for more than nine years from the date of their first appointment.	Any other reason you wish to declare. This should include any 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)
Sue Proctor Non-executive Chair	None	None	None	None	None	None	None
John Baker Non-executive Director	None	None		None	None	None	None
Helen Grantham Non-executive Director	None	None	None	None	None	None	None
Andrew Marran Non-executive Director	None	None	Mental Health Act Manager for the Trust and for Leeds Community Healthcare The role as MHAM for the Trust now falls within the remit of the role of a NED and as such is not considered to affect his independence. Being a MHAM for another organisation does not compromise independence in relation to the role Andrew will need to carry out for this Trust.	None	None	None	Director for Morelite (UK) Ltd and obesity treatment company and subsidiary of Leeds Beckett University. This has been judged to be a declaration of interest which does not compromise Andrew's independence.

Name	Has been an employee of the Trust within the last 5 years.	Has, or has had within the last three years, a material business relationship with the Trust directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the Trust.	Has received or receives additional remuneration from the Trust apart from a director's fee, participates in the Trust performance-related pay scheme, or is a member of the Trust's pension scheme.	Has close family ties with any of the Trust's advisers, directors or senior employees.	Holds cross-directorships or has significant links with other directors through involvement in other companies or bodies.	Has served on the Board for more than nine years from the date of their first appointment.	Any other reason you wish to declare. This should include any 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)
Margaret Sentamu Non-executive Director	Yes The status of this "employment" is as a mental health act manager, which is an appointment and does not require a contract of employment. This has been deemed not to affect her independence.	None	None	None	None	None	None
Sue White Non-executive Director	None	None	None	None	None	None	None
Martin Wright Non-executive Director	None	None	None	None	None	None	None

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
23

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Leeds Providers' Integrated Committees in Common (LPICC) Programme Directors' Report
DATE OF MEETING:	28 March 2019
PRESENTED BY: (name and title)	Sue Proctor - Chair of the Trust
PREPARED BY: (name and title)	Katherine Sheerin - Programme Support

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

EXECUTIVE SUMMARY

The Board of Directors is asked to receive the attached paper and to note the key issues discussed from the meeting of the Leeds Providers' Integrated Care Collaborative Committees in Common (LPICC) held on 12 March 2019. It is also asked to receive the approved minutes for the LPICC meeting that was held on 22 January 2019.

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 Programme Directors' report for the LPICC meeting held 12 March 2019 and to receive the minutes of the meeting held 22 January 2019.

MEETING OF THE BOARD OF DIRECTORS

28 March 2019

Leeds Providers' Integrated Care Collaborative

Programme Director's Report

1. Summary

The purpose of this paper is to present an overview of the key items discussed at the meeting of Leeds Providers' Integrated Care Collaborative (Committees in Common) held on 22 January 2019. Appendix 1 includes the final minutes of the meeting held on 22 November 2018.

2. Background

Leeds Providers' Integrated Care Collaborative has been established to bring together the four main NHS providers of care in the city to better integrated health services, in order to improve care and outcomes for people and make best use of resources.

In order to reflect that people's health care needs are met through more providers than the NHS, the Local Authority Adults and Health Directorate (as a provider) and third sector representative also attend the CIC, to take part in discussions and to inform direction.

A meeting was held on 12 March 2019. The key issues discussed were as follows:–

- Developing a blue print for the city
- Implementing Local Care Partnerships
- Transforming Services for People Living with Frailty
- Enabling further integration – taking a city wide approach to Service Redesign / Quality Improvement resources across providers
- Review of LPICC (Committees in Common)

3. Key Issues Discussed

3.1 Developing a blue print for the city

A proposal for how demand and capacity could be modelled to support the development of a blue print for service provision in Leeds over the next 3-5 years was discussed. It was agreed that this needed to be high level initially in order to understand the gaps in service provision which, if met, would improve health outcomes and support sustainable service provision. Frank Wood, Chief Analyst, Leeds Health and Care Hub will be leading this work, drawing on expertise across the system. It was confirmed that Frank Wood is well engaged in the Population Health Management Programme, Joint Strategic Assessment and other strategic analyses, and as such will ensure these are drawn together for the blue print.

3.2 Local Care Partnerships – Programme Initiation Document

A presentation was given on progress in relation to the implementation of LCPs and a proposal put forward for how the governance should work. A team is being appointed and is starting to take forward the programme.

There was a discussion about Primary Care Networks which are a fundamental part of the new GP Contract, and how this approach could impact on the development of LCPs which are far wider in scope. It was agreed that this needs to be subject to a further discussion which takes a view of wider strategic issues (see below). It was also stressed that there needs to be some simplification of how we are describing and supporting very local place based care.

3.3 Transforming services for people living with frailty – Programme Initiation Document

A proposal to establish a formal programme arrangement to oversee this work, including how transformation moneys are used to support service change was discussed and agreed. It was acknowledged that there is considerable overlap with the LCP programme and as such, the work needs to be streamlined wherever appropriate.

It was highlighted that work is on-going to establish the Virtual Ward for Frailty which forms part of this programme, with the aim to have the service in place for July 2019.

3.4 Enabling Greater Integration

A paper was considered which proposed a city wide approach is taken to service redesign and quality improvement in order to support system integration. The CIC noted the paper and agreed that actions should be taken to co-ordinate existing QI work plans, with an understanding developed of how the current resource (including in the Health Partnerships Team) could be utilised to support city-wide working.

3.5 Review of LPICC

The CIC considered a high level review of progress in the first six months. It was acknowledged that it is still early days, however, progress has been good in terms of strengthening relationships and creating a stronger shared view of provision for the city. There was some concern that the original purpose of the CIC had been lost, and a need to ensure that strategic focus is not lost. There was also some discussion about creating an independent chair for the CIC, and for meetings to move to quarterly from bi-monthly.

It was agreed that the next meeting should have a more strategic focus in order that providers can collectively consider key issues and develop a shared response.

4 Key Actions

- It was noted that the MOU has now been confirmed by each full member organisation. As such, a final copy will be circulated for signing.
- Programme Boards for Frailty and LCPs to be established to report into LPICC.
- Next meeting of LPICC – Richard Barker, Rob Webster and Tim Ryley to be invited in order for members to consider national / local strategic issues and to develop a shared response.
- CEOs to meet to plan the strategic session.
- Independent Chair – role outline, approach to appointment process etc to be developed.

5 Equality Analysis

Equality analyses will have to be undertaken for each element of the work programme. However, it should be stressed that the work of LPICC will all be within the overarching ambition of ‘improving the health of the poorest the fastest’.

6 Publication Under Freedom of Information Act

This paper is currently exempt from publication under Section 22 of the Freedom of Information Act 2000 as this does not reflect the organisation’s agreed position and will be made available to the public once all parties have formally agreed to the MOU.

7 Recommendation

The Board is asked to note the key issues discussed at Leeds Providers' Integrated Care Collaborative (shadow) Committees in Common meeting.

8 Supporting Information

Minutes from meeting held 22 January 2019.

Katherine Sheerin
19 March 2019

Leeds Providers Integrated Care Collaborative
Final Minutes of the Committees in Common
Tuesday 22nd January 2019

Members:
Neil Franklin (NF), Chair, Leeds Community Healthcare Trust (chair)
Sue Proctor (SP), Chair, Leeds and York Partnership FT
Chris Schofield (CS), Non-executive Director, Leeds Teaching Hospitals Trust (representing Linda Pollard)
Chris Mills (CM), Chair, Leeds GP Confederation
Thea Stein (TS), Chief Executive, Leeds Community Healthcare Trust
Jim Barwick (JB), Chief Executive, Leeds GP Confederation
Yvette Oade, Acting Chief Executive, Leeds Teaching Hospitals Trust
Sara Munro (SM), Chief Executive, Leeds and York Partnership FT

In attendance:
Shona McFarlane (SMcF), Leeds Local Authority (Adults and Health) (representing Cath Roff)
Katherine Sheerin (KS), LPICC
Diane Allison (DA), Leeds Community Healthcare Trust
Tim Ryley (TR), NHS Leeds CCG, (to present item 27, present from beginning of the meeting until the end of item 30a)
Becky Barwick (BB), NHS Leeds CCG (to present item 30a, present from beginning of meeting until this item)
Andrea North (AN), Leeds Community Healthcare Trust, (to present item 30c)

Item no.	Item	Action
2018-19 (24)	Introduction and welcome	
	Apologies Apologies were noted from Linda Pollard and Cath Roff (with Chris Schofield and Shona McFarlane representing respectively) and Karen Pearse. Declarations of interest The register of interest for full members was shared. YO confirmed her interests which will be added to the register.	K Sheerin
2018-19 (25)	Minutes from meeting held 22nd November 2018	
	These were confirmed as a true record. Matters arising were all covered as part of the agenda. TS asked the Committees to note that the collaborative bid for Tier 3 Weight Management service had been successful, although this was in the 'stand still' period and as such not in the public domain at this point.	

2018-19 (26)	Action Log	
	All actions not completed (ie amber) were on the agenda and so would be discussed in due course, with the following exception:- MOU – Work Programme to be shared with GP Confederation in order for MOU to be considered and agreed. JB confirmed that this discussion is scheduled for later in January.	Jim Barwick
2018-19 (27)	Integrated Population Health Management Transformation Fund	
	Tim Ryley, Director of Strategy, Performance and Planning, NHS Leeds CCG attended to present this paper. He explained that the proposed approach is based on the direction set out in the NHS Long Term Plan and builds on work already underway in Leeds. He set out that the NHS Long Term Plan is a mix of 'ends' (eg population health outcomes) and 'means' (eg greater collaboration of providers) and that CCG wants to facilitate a strategic test of how we implement those 'means', making changes to services living with frailty in a strategic and deliberative way. As such, the paper is proposing that the resources for this population are identified as a shared 'pot', and that additional funds are available to transform services, creating headroom to test new models and system capacity (clinical leadership, change management, programme delivery) to enable this to happen. Indicative conversations suggest the transformational resource would be in the region of £3 – 5m per year over 3 years; this is subject to confirmation. The proposal is that LPICC manage this resource, and take responsibility for ensuring a plan is in place and delivered for how services are changed over the next 3 years. These changes need to take account of physical, mental and social needs, and have a real emphasis on prevention and proactive care, with solutions driven by the results of population health analysis. This is not seen as a quick fix, but would support long term improvement in health outcomes. It would also facilitate understanding of the role of the 'payer' in the system, with more operational commissioning being undertaken by providers supported by skills currently in the CCG. The proposal was unanimously welcomed by members of the Committees. YO commented that this will need clear work streams to ensure delivery. She highlighted that there are lots of intiatives already in place; these may need to be scaled up. She also added that there are lots of things that LTHT is doing which may be more appropriately delivered outside of hospital.	

	TS stressed that this is a once in a decade opportunity and it is vital to take time to plan for this properly. We need to spend time understanding where we are now and set off in a thoughtful way. JB reflected that we need to ensure the right connections are in place with work in the Leeds Plan (eg self management and proactive care) and suggested we need to confirm our approach to Quality Improvement. SM echoed TS' view regarding taking time for planning. She expressed nervousness in terms of the maturity of the Committees and its ability to oversee this, as much of the expertise sits in the CCG, for example, analysis and modelling. She explained that there could be lessons to learn from the work undertaken in Mental Health on new models of care and offered to connect to NHSE commissioners. She also highlighted the risks in assuming that this would be cost neutral, given the increasing numbers of people with frailty. CM was very enthusiastic about how this can take forward the clinical model developed by the clinicians, and enable closure of medically fit for discharge beds. He recognised that it will need effective governance to ensure improvements are delivered. TR confirmed that the CCG would wish to see thoughtful and robust planning, and that some of the transformational resource should support this. He was also keen that existing CCG expertise is used to support the work, and that we test the commissioning capabilities needed by providers in the future. He recognised that it is unlikely that bed capacity would be reduced, but we need to focus on reducing expenditure per head of person with frailty, rather than overall costs. TS stressed that we would need really good financial modelling and support. SP highlighted the risk that pilots could create inequalities and the need for robust exit strategies. She raised the experience of other agencies in transforming services, for example Fire and Rescue. YO highlighted the need for balance between planning/ governance and delivery, and that we need to understand are there some schemes already in place which should be quickly scaled up for the city. SMcF raised that need for metrics to support decision making, with a targeted approach to how investment is used. CS suggested that we aim to have a clear plan with well developed work streams by 30/6. KS fed back views from KP regarding the need to focus on 'dignity and respect' and keenness that the 3rd sector is involved from an early stage.	

	The CIC welcomed the paper and agreed that a group is identified to take this forward. A paper setting out how this will be managed will be presented to the next meeting of LPICC and a clearly defined plan will be developed.	Chris Mills / Becky Barwick
2018-19 (28)	CQC System Report	
	YO introduced the paper. It was highlighted how connected the previous agenda item is to delivering the improvements identified in the System Review, and that this gives us more impetus to move at pace. SM highlighted that the overarching plan was being discussed at Health and Wellbeing Board the following day. TS commented that much of this would rest with SRAB. However, we need to ensure we are monitoring the holistic experience of people who use the system, not just the individual parts. SM explained that she was involving in discussions about how a quality network is developed for Leeds. NF cautioned that there are a number of groups overseeing the same or similar territory, and as such there is a danger that no one really accepts responsibility. CM offered that whilst SRAB had a role in this work, there is much which is focused on prevention which would not sit there. YO raised the question regarding the role of LPICC in this and whether it should be the group that ensures things are happening. SMcF highlighted that the CQC Action Plan is not an entity in itself, but should be embedded into other work. The Committee noted the report and agreed that priorities arising from this for LPICC should be reviewed in light of the agreed action plan.	Yvette Oade
2018-19 (29)	Work Plan Overview	
	KS presented the Work Plan. She explained that it has been re-shaped in light of previous discussions. The plan now contains 7 projects, each of which has a clear description, named leads, milestones and ‘rag’ rating against progress. Key issues highlighted were as follows – Project 1 – Prepare an outline of service capacity required in community and hospital settings by 2024:	

	KS explained that she has spent time clarifying how this fits with the work to refresh the Leeds Plan, the need for a response to the Long Term Plan and work on population health management. She has also identified an analytical lead, and together are working on a methodology to share at the next LPICC meeting. A gap is mental health data; SM agreed to confirm who best to link with in LYPFT for this.	Sara Munro
	KS also raised her role on the working group to refresh the Leeds Plan. She has been asked to attend to represent LPICC, however, stressed that the role of the working group is to determine how to develop the content of the refreshed plan, not to re-write the plan. LPICC members supported this.	K Sheerin
	Project 2 – Implementing LCPs TS confirmed that Liz Hindmarsh had been appointed to lead this work and would bring an update report to a future meeting.	Thea Stein / Liz Hindmarsh
	Project 3 – to be covered later on the agenda	
	Project 4 – to be covered later on the agenda	
	Project 5 – to be covered later on the agenda	
	Project 6 – Ensuring effective collaboration where appropriate for future tendering opportunities KS explained that she had confirmed with CCG leads that it is unlikely that there will be further major procurements in the next year. However, it is not clear how providers are working together to respond to the current Urgent Treatment Centre procurement, or the approach being taken by the commissioner. CM stressed that there needed to be swift discussions by providers to shape the service and ensure it is consolidate across all 5 sites. SM highlighted that it would be a missed opportunity not to include mental health in the offer. She also connected this back to the earlier paper on frailty, and how this could be one of the areas tested. SMcF stated that we need to ensure the underlying issues are addressed. about how providers needed to shape the service through an integrated offer, which included mental health. TR supported the direction being discussed of the providers working together to present an offer for how best to deliver UTC.	
	CM and JB agreed to take this forward and to bring together an operational group. CM highlighted that we should be looking to develop a single management team to deliver this.	Chris Mills Jim Barwick
	Project 7 – Future organisational arrangements KS highlighted two issues. Firstly that a review of the committee would be undertaken and presented at the next meeting. As part of this, she	

	would meet with all the chairs (having met with all CEOs prior to Christmas). She would also review the existing processes used by each organisation to adapt and adopt for LPICC. Secondly, with regard to structural arrangements, it was suggested that this is pushed back until later in 2019/20 in order that there is more clarity regarding any changes arising from the NHS Long Term Plan The Committee noted the work plan, the progress in each project and the actions required.	KS / Chairs
2018-19 (30)	Work Plan Deep Dives	
2018-19 (30a)	a)Project 3: Delivering the outcomes framework for people living with frailty and at the end of life – implementation plan BB presented the paper. It was explained that there have been several significant developments since the last LPICC meeting, including the introduction of the transformation fund, the start of the PHM acceleration programme, the publication of the NHS Long Term Plan and a decision to separate 'end of life' from the work on frailty. Because of these issues, it was felt that the implementation plan requested by the Committees should be paused, in particular, in order to discuss the proposed transformation fund. This fitted with the earlier agreement to aim to have an implementation plan for June 2019. CM raised the virtual ward, and explained that Optum have been asked to ensure the data to understand the need for this is captured as part of the PHM programme. He also suggested that this needed to be merged with the virtual respiratory ward, and that this could be an area for transformation funding. The Committee noted the update and supported the direction of travel.	Chris Mills Becky Barwick
2018-19 (30b)	b) Project 4: Update on the work to transform outpatient services	
	KS presented this paper which had been prepared by Helen Lewis (NHS Leeds CCG) with input from Robert Hakin (LTHT). It was explained that whilst this is a project in the LPICC work plan, it formally reports into the Optimising Secondary Care element of the Leeds Plan. The paper described the challenge of managing the growth in outpatient services, the ambition to avoid 30m appointments nationally, the work undertaken to date in Leeds and suggested priorities for 19/20. SM raised the work being led by West Yorkshire and Harrogate to adopt interventions which reduce the need for referrals, to ensure that this is connected in. JB highlighted that the implications of making changes to pathways will	

	be much wider than the impact in secondary care, and as such, needed broader oversight. YO highlighted that 10% of outpatient activity is for Ophthalmology and asked how discussions regarding the role of Optometrists in this was being picked up CM suggested that the key work of the Committees should be on Frailty, LPCs, UTCs. The Committee noted the paper and supported the direction of travel. The Committee asked for further reports to keep progress under review.	Helen Lewis Julian Hartley/ H Lewis
2018-19 (30c)	c) Project 5: Update on integration projects in adult specialist services and next steps	
	AN presented this paper. It gave an overview of the key projects already underway which involve teams across organisations, primarily LCH and LTHT. AN highlighted some of the challenges to the work, and explained that sometimes it felt that things were changing in spite of the system, rather than being supported by organisations. Key examples included joint working agreements, MOUs, HR issues, data access, with the same problem having to be solved multiple times. There were also some really positive examples including the work on stroke services which has moved with real pace. AN raised a question about whether having an overarching framework was possible (rather than individual agreements for each service) and highlighted the need for recognised joint clinical and managerial leadership teams for integrated services. SM reflected that whilst working through MOUs and service agreements feels difficult, the process is often important in order to build relationships across teams. However, the process can be better supported. SM agreed to raise the HR issues with the HR Directors in a meeting scheduled for February. CM emphasised the importance of including General Practice in the work. TS stressed that the Committee needs to stay really close to this and the actions highlighted in the paper, as it will offer a barometer to check whether the rhetoric is becoming reality. YO commented how pleasing it was to hear about the progress in stroke services. 12.30 – YO left the meeting.	Sara Munro

	The Committee noted the paper and the positive work which is underway. The Committee supported the priorities and actions proposed, and requested regular updates to understand whether changes are being enacted.	Andrea North Helen Lewis
2018-19 (31)	Matters for Boards	
	There were no decisions to refer to Boards.	
2018-19 (32)	Messages from the meeting	
	It was confirmed that KS would prepare a Programme Director's report to share with all Boards.	KS
2018-19 (33)	Any other business	
	None	
2018-19 (34)	Date and time of next meeting	
	Now confirmed as 2pm, 12th March 2019. Executive Directors' Office, Trust HQ, St James' Hospital, LTHT	All

AGENDA ITEM

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Glossary of Terms

In the table below are some of the acronyms used in the course of a Board meeting

Acronym / Term	Full title	Meaning
AHP	Allied Health Professionals	Allied Health is a term used to describe the broad range of health professionals who are not doctors, dentists or nurses.
ASC	Adult Social Care	Providing Social Care and support for adults.
BAF	Board Assurance Framework	A document which is to assure the Board that the risks to achieving our strategic objectives are being effectively controlled and that any gaps in either controls or assurances are being addressed.
CAMHS	Child and Adolescent Mental Health Services	The services we provide to our service users who are under the age of 18.
CGAS	Child Global Assessment Scale	A numeric scale used by mental health clinicians to rate the general functioning of youths under the age of 18
CCG	Clinical Commissioning Group	An NHS statutory body which purchases services for a specific geographical area. (CCGs purchase services from providers and this Trust is a provider of mental health and learning disability services)
CIP	Cost Improvement Programme	Cost reduction schemes designed to increase efficiency/ or reduce expenditure thereby achieving value for money and the best quality for patients

Acronym / Term	Full title	Meaning
CMHT	Community Mental Health Team	Teams of our staff who care for our service users in the community and in their own homes.
Control Total		Set by NHS Improvement with individual trusts. These represent the minimum level of financial performance required for the year, against which the boards, governing bodies and chief executives of organisations will be held directly accountable.
CPA	Care Programme Approach	The Care Programme Approach (CPA) is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. You might be offered CPA support if you: are diagnosed as having a severe mental disorder.
CQC	Care Quality Commission	The Trust's regulator in relation to the quality of services.
CAS	Crisis Assessment Unit	The Leeds Crisis Assessment Service (CAS) is a city-wide acute mental health service. It offers assessment to people 18 years and over who are experiencing acute mental health problems that may pose a risk to themselves and/or others, who require an assessment that day or within the next 72 hours.
CTM	Clinical Team Manager	The Clinical Team Manager is responsible for the daily administrative and overall operations of the assigned clinical teams.
DBS	Disclosure and Baring Service	A service which will check if anyone has any convictions and provide a report on this
DToCs	Delayed Transfers of Care	Service users who are delayed in being discharged from our service because there isn't an appropriate place for them to go to.

Acronym / Term	Full title	Meaning
EMI	Elderly Mentally Ill	Those patients over working age who are mentally unwell
EPR	Electronic Patient Records	Clinical information system which brings together clinical and administrative data in one place.
First Care		An electronic system for reporting and monitoring sickness. The system is used by both staff and managers
GIRFT	Get it right first time	This is a programme designed to improve clinical quality and efficiency within the NHS by reducing unwarranted variations.
ICS	Integrated Care System	NHS organisations working together to meet the needs of their local population, bringing together NHS providers, commissioners and local authorities to work in partnership in improving health and care for the local population.
I&E	Income and Expenditure	A record showing the amounts of money coming into and going out of an organization, during a particular period of time
iLearn		An electronic system where staff and managers monitor and record training and supervision.
KLoEs	Key Lines of Enquiry	The individual standards that the Care Quality Commission will measure the Trust against during an inspection.
LADS	Leeds Autism Diagnosis Service	The Leeds Autism Diagnostic Service (LADS) provides assessment and diagnosis of people of all intellectual ability who may have autism who live in Leeds.
LCG	Leeds Care Group	The care services directorate within the Trust which manages the mental health services in Leeds

Acronym / Term	Full title	Meaning
LTHT	Leeds Teaching Hospitals NHS Trust	An NHS organisation providing acute care for people in Leeds
LCH	Leeds Community Healthcare NHS Trust	An NHS organisation providing community-based healthcare services to people in Leeds (this does not include community mental health care which Leeds and York Partnership NHS Foundation Trust provides)
MDT	Multi-disciplinary Team	A multidisciplinary team is a group of health care workers who are members of different disciplines (professions e.g. Psychiatrists, Social Workers, etc.), each providing specific services to the patient
MSK	Musculoskeletal	Conditions relating to muscles, ligaments and tendons, and bones
Never event	Never Events	Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
NHSI	NHS Improvement	The Trust's regulator in relation to finances and governance.
OD	Organisational Development	A systematic approach to improving organisational effectiveness
OPEL	Operational Pressures Escalation Level	National framework set by NHS England that includes a single national system to improve management of system-wide escalation, encourage wider cooperation, and make regional and national oversight more effective.
OAPs	Out of Area Placements	Our service users who have to be placed in care beds which are in another geographical area and not in one of our units.

Acronym / Term	Full title	Meaning
PFI	Private Finance Initiatives	A method of providing funds for major capital investments where private firms are contracted to complete and manage public projects
PICU	Psychiatric Intensive Care Unit	
Prevent	The Prevent Programme	Prevent is part of the UK's Counter Terrorism Strategy known as CONTEST. It aims to reduce the number of people becoming or supporting violent extremists.
Q1, Q2, Q3, Q4	Quarter 1, Quarter 2, Quarter 3 Quarter 4	Divisions of a financial year normally Quarter 1 – 1 April to 30 June Quarter 2 – 1 July to 30 September Quarter 3 – 1 October to 31 December Quarter 4 – 1 January to 31 March
S136	Section 136	Section 136 is an emergency power which allows you to be taken to a place of safety from a public place, if a police officer considers that you are suffering from mental illness and in need of immediate care.
SI	Serious Incident	Serious Incident Requiring Investigation.
SOF	Single Oversight Framework	The targets that NHS Improvement says we have to report against to show how well we are meeting them.
SS&LD	Specialist Services and Learning Disability	The care services directorate within the Trust which manages the specialist mental health and learning disability services
STF	Sustainability and Transformation Fund	Money which is given to the Trust is it achieves its control total.

Acronym / Term	Full title	Meaning
Tier 4 CAMHS	Tier 4 Child Adolescent Mental Health Service	Child and Adolescent Mental Health Tier 4 Children's Services deliver specialist in-patient and day-patient care to children who are suffering from severe and/or complex mental health conditions who cannot be adequately treated by community CAMH Services.
TRAC		The electronic system for managing the process for recruiting staff. A tool to be used by applicants, managers and HR
Triangle of care	-	The 'Triangle of Care' is a working collaboration, or 'therapeutic alliance' between the service user, professional and carer that promotes safety, supports recovery and sustains well-being.
WRAP	Workshop to Raise Awareness of Prevent	This is an introductory workshop to Prevent and is about supporting and protecting those people that might be susceptible to radicalisation, ensuring that individuals and communities have the resilience to resist violent extremism.
WRES	Workforce Race Equality Standards	Ensuring employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

Below is a link to the NHS Confederation Acronym Buster which might also provide help

http://www.nhsconfed.org/acronym-buster?l=A