Leeds and York Partnership NHS
NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

PUBLIC MEETING OF THE BOARD OF DIRECTORS
will be held at 9.30 am on Thursday 23 May 2019
in Jimi's Community Room, The Old Fire Station, Gipton Approach, Gipton, Leeds, LS9 6NL

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 – Dr. Alison Stansfield, Clinical Lead from the Leeds Autism Diagnostic 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 25 April 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 7 May 2019** (enclosure)	**JB**
8.1	**Annual report from the Quality Committee for 2018/19 (for noting)** (enclosure)	**JB**
9	**Report from the Chair of the Mental Health Legislation Committee for the meeting held on 15 May 2019** (verbal)	**MS**
9.1	**Annual report from the Mental Health Legislation Committee for 2018/19 (for noting)** (enclosure)	**MS**
9.2	**Revised Terms of Reference from the Mental Health Legislation Committee** (enclosure)	**MS**
10	**Report from the Chair of the Audit Committee for the meeting held on 20 May 2019** (verbal)	**MW**
10.1	**Annual report for the Audit Committee for 2018/19 (for noting)** (enclosure)	**MW**
11	**Report from the Chair of the Finance and Performance Committee for the meeting held on 21 May 2019** (verbal)	**SW**
11.1	**Annual report from the Finance and Performance Committee for 2018/19 (for noting)** (enclosure)	**SW**
12	**Combined Quality and Performance Report** (enclosure)	**JFA**
13	**Freedom to Speak up Guardian Annual Report** (enclosure)	**JV**
14	**Safe-working Guardian Annual Report (including quarter 4 information)** (enclosure)	**LC**

15		**Mortality Review: Learning from deaths** (enclosure)	**CK**
16		**Safer staffing report** (enclosure)	**CW**
WORKFORCE			
17		**Workforce and organisational development report** (enclosure)	**CH**
	17.1	**Workforce governance arrangements** (enclosure)	**CH**
USE OF RESOURCES			
18		**Report from the Chief Financial Officer** (enclosure)	**DH**
GOVERNANCE (INCLUDING YEAR-END ITEMS) **The papers for the agenda items marked * are unable to be published or made available publically until they have been submitted to our regulators and laid before parliament**			
19		**Strategic Priorities End of Year Progress Report** (enclosure)	**DH**
20		**Approval of the refreshed strategic risks for the Board Assurance Framework** (enclosure)	**SM**
21	*	**Adoption of Trust's Annual Accounts 2018/19** (enclosure)	**DH**
22	*	**Approval of the Annual Report 2018/19** (enclosure)	**SM**
23		**Approval of the Annual Governance Statement** (enclosure)	**SM**
24		**Compliance with NHS Improvement's NHS Foundation Trust Code of Governance** (enclosure)	**CHill**
25	*	**Approval of the Quality Report 2018/19** (enclosure)	**CW**
26		**Declarations required by the NHS Provider Licence including the Corporate Governance Statement** (enclosure)	**CHill**
27	*	**Letters of Representation (enclosure)**	**DH**
28		**Glossary** (enclosure)	
29		***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 July 2019 at 9.30 am
The Conservatory, St. George's Centre, Great George Street, Leeds, LS1 3DL

Questions for the Board 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

3

Declaration of Interests for members of the Board of Directors

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

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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
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	Interim Director - HR and OD at Manchester City Council	None
Andrew Marran Non-executive Director	**Chairman** **Leeds Students Residences Ltd** Delivering housing and accommodation services across Leeds **Non-executive Director**	None.	None.	None.	None. .	None. .	None.	None.

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	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 company which developed a Wellbeing app and website to provide access to staff.							

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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

Minutes of the Public Meeting of the Board of Directors held on held on Thursday 25 April 2019 at 9:30 am in Headingley 3, Weetwood Hall, Otley Rd, Leeds LS16 5PS

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 or 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

Ms F Limbert	Corporate Governance Team Leader / Deputy Trust Board Secretary
Three members of the public (two of whom were members of the Council of Governors)	

		Action
	Mrs White opened the public meeting at 9.30 am. She noted that she was chairing the meeting as part of her on-going development and that Prof Proctor would be participating as a member of the Board.	
19/062	**Sharing Stories** (agenda item 1) Mrs White welcomed Lyla Asif noting that she was attending the Board to share her story as a carer for her mother. Ms Asif told the Board about a past experience of her mother visiting the Accident and Emergency Department (A&E) at St James's Hospital in relation to her experiencing a period of acute mental illness. Ms Asif noted that it had been her experience that there had been a lack of understanding of the needs of person with severe mental ill-health and suggested that it might be helpful for the staff in A&E to have training in how to care for people who are mentally unwell. Ms Asif then explained the experience of her mother being transferred from A&E to the Becklin Centre and the delays there had been. The Board thanked Ms Asif for her story and noted that there was a meeting with the Board of Leeds Teaching Hospitals NHS Trust (LTHT) later in the day and that there may be an opportunity to raise some of the issues highlighted by Ms Asif. Mrs Forster Adams then explained the service	

provided by the Liaison Psychiatry Team which has responsibility to work with the staff in A&E to provide care for people presenting experiencing mental illness.

Ms Asif also noted that there were a number of organisations in the city that provided support to carers, but noted that for those carers who work it was not always possible to attend these sessions. She then suggested that something on-line that was responsive to the needs of carers would be helpful. Mrs Woffendin reminded the Board that the first meeting of the Patient Experience and Involvement Steering Group would be held on 30 April and that a sub-group of this would be looking at what support is needed for carers. Mrs Woffendin invited Ms Asif to participate in that work.

Dr Kenwood then outlined the work that was taking place in relation to service improvement and the need to ensure that not only processes and training was addressed, but also that there was a cultural and behavioural change in the way services are provided.

The Board then discussed further the opportunities there were for the service user groups in both the Trust and LTHT to meet and share their experiences and noted that this might be something for the Patient Experience and Involvement Steering Group to look at.

The Board **thanked** Ms Asif for attending the Board and sharing her story. Directors **acknowledged** that services need to be looked at holistically, particularly where care is provided across organisations. The Board also noted that the sharing stories session were important in informing the design and improvement of the Trust's services and that they helped to inform the discussion at the Board meeting.

19/063 **Apologies for absence** (agenda item 2)

Apologies were received from Prof Baker, Non-executive Director.

19/064 **Declaration of interests for directors and any declared conflicts of interest in respect of agenda items** (agenda item 3)

The Board noted that there were no changes to directors' declarations of interests as set out in the Board papers. It was also noted that no director at the meeting advised of any conflict of interest in relation to any agenda item.

19/065 **Minutes of the previous meeting held on 28 March 2019** (agenda item 4)

The minutes of the meeting held on 28 March 2019 were **received** and **agreed** as an accurate record and were signed by the Chair.

19/066 **Matters arising** (agenda item 5)

The Board noted that there were no matters arising.

19/067 **Actions outstanding from the public meetings of the Board of Directors** (agenda item 6)

Mrs White 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.

The Board discussed the action log. With regard to the development of the five-year strategy for the West Yorkshire and Harrogate ICS, Dr Munro advised that there had been a meeting of the Programme Board of the West Yorkshire and Harrogate Mental Health and Autism Collaborative where it had been agreed that a case for investment would be developed resulting in a bid for ICS transformation money. She noted that an update would be brought to the June Board meeting. **SM**

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

19/068 **Chief Executive's report** (agenda item 7)

Dr Munro presented her Chief Executive's report and drew attention to some of the main highlights. The Board discussed the main items in the report. Miss Grantham noted that nationally there was an increase in demand for mental health services and noted that the profile of mental health was being raised within the media and that this had likely contributed to the increase in demand for services. Dr Munro noted that this was a complex area and spoke about the demand and capacity work which was looking to understand the peaks and flows and how these can be addressed.

Prof Proctor asked about the understanding in the Leeds system of the demand for mental health services. Dr Munro spoke about the work in the city to look at this and noted that this issue was recognised by the System Resilience and Assurance Board and was covered in the meetings in order for discussions to be undertaken with partners.

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

19/069 **Report from the Chair of the Quality Committee for the meeting held on 9 April 2019** (agenda item 8)

On behalf of the chair of the chair of the Quality Committee, Miss Grantham presented a report on the work of the committee for the meeting held on 9 April 2019. She drew attention to:

- The annual quality and safety report for the Personality Disorder

Service noting that the areas highlighted had been: the challenges faced by the service in relation to the diversity of service users, and ensuring that it has a diverse workforce; and examples of how the service's niche expertise is called upon at a national level to share learning.

The Board noted the items discussed by the committee.

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

19/070 **Report from the Chair of the Audit Committee for the meeting held on 16 April 2019** (agenda item 9)

Mr Wright presented the chair's report from the meeting of the Audit Committee held on 16 April 2019. He drew attention to the following items:

- The assurance provided by the external auditors that they were happy with the calculation of the gain generated by the Trust from the PFI refinancing, noting that they would be auditing the disclosure of the gain within the accounts as part of their year-end work.

- The draft Head of Internal Audit Opinion, noting that at present there were no issues that had been identified which would give rise to a negative opinion, and that subject to the completion of the remaining internal audit work for 2018/19, it was expected that the positive assurance outlined in the draft opinion would be retained in the final version.

- The internal audit progress report, noting the positive nature of the assurances given, with most reports attracting "significant assurance". Mr Wright added that in the single instance where there was a limited assurance report, appropriate assurances had been provided by the executive director that there was a robust action plan in place to address the recommendations and that assurance had been provided in relation to progress against those actions.

Mr Wright then drew attention to the action that had been delegated to the committee by the Board which was for it to consider what assurance there was in relation to the effectiveness of the Standard Operating Procedure between LYPFT and LTHT and whether a further piece of assurance work should be commissioned. Mr Wright noted that this action was related to a specific incident involving a service user who had been cared for in the acute services, but asked the Board to consider whether this piece of work should also incorporate perceptions of those who receive the service given the comments from the Sharing Stories session earlier in the meeting.

Dr Munro suggested that the committee retains the original remit for this piece of work. With regard to the experience of service users in relation to how organisations work together Dr Munro noted that Healthwatch had just undertaken a review of Patient Experience relating to crisis care and that

	once the outcome of that work was know there would be a discussion between Mrs Woffendin and the Director of Nursing at Leeds Teaching Hospitals NHS Trust as to any additional ways of exploring the experience of those whose pathway of care was covered both Trusts. Dr Munro also noted that this might be something which was picked up by the Patient Experience and Involvement Steering Group. Miss Grantham also drew attention to the assurances the committee had received in relation to the work around health and safety noting the sufficiency of those assurances.	**CW**
	The Board **received** the report from the chair of the Audit Committee and **noted** the matters raised.	
19/071	**Report from the Chair of the Finance and Performance Committee for the meetings held 23 April 2019** (agenda item 10) Mrs White presented a report on the work of the Finance and Performance Committee for the meeting held on 23 April 2019. In particular, she drew attention to: • The financial out-turn, noting that this was expected to show £33m surplus due mainly to one-off items of income, although she noted that the underlying position is one of deficit which was supported by non-core services generating surpluses. Mrs White noted that the committee had suggested there be further work to look at the risks and opportunities presented by these non-core services, with a report being brought back to the committee • Risks to core services noting that these were in respect of out of area placements, agency costs for medical locums, and overspending departments • The Strategic Estates Plan and the timescales for the capital project on the St James's Hospital site • Update on the health informatics project including the risks around the implementation of CareDirector • The review of the CAMHS service development on the St Mary's Hospital site.	
	The Board **received** the update report from the Chair of the Finance Performance Committee for the meeting that took place on 23 April 2019.	
19/072	**Glossary** (agenda item 11) The Board received the glossary.	
19/073	**Resolution to move to a private meeting of the Board of Directors** (agenda item 12) At the conclusion of business the Chair closed the public meeting of the	

Board of Directors at 10.45 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
Report from the Chair of the Audit Committee for the meeting held on 16 April 2019 (agenda item 9) **NEW -**With regard to the experience of service users in relation to how organisations work together, once the outcome of the work carried out by Healthwatch is known there will be a discussion between Mrs Woffendin and the Director of Nursing at Leeds Teaching Hospitals NHS Trust as to any additional ways of exploring the experience of those whose pathway of care was covered both Trusts.	**Cathy Woffendin**	Management Action	**ONGOING** The Director of Nursing, Professions and Quality will advise the Audit Committee once the Healthwatch report is produced and its findings considered
Sharing Stories (minute 19/034 - agenda item 1 – March 2019) Prof Baker noted the comments made by Dr Baskind in relation to the cost effectiveness of the interventions they provide and asked if there was any learning from other services who make a case for being cost effective and the relative impact on outcomes. Prof Baker agreed to meet with Dr Baskind to explore this further.	**John Baker**	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
Report from the Chair of the Finance and Performance Committee and Quality Committee joint meeting held 26 March 2019 (minute 19/046 - agenda item 11 – March 2019) The Board noted the value of the two committees coming together to discuss cross-cutting issues and agreed that there would be further consideration as to when the committees might meet together again and for this to be picked up after the May IHI Workshop.	**John Baker / Sue White**	Management Action (to be completed after the May IHI Workshop)	
Report from the Director of Nursing, Professions and Quality (minute 19/051 - agenda item 16 – March 2019) Prof Proctor noted that there was more work to do on achieving a smoke-free environment. However, she asked that Mrs Woffendin seeks the Nursing and Midwifery Council's position in relation to nurses offering service users e-cigarettes. Mrs Woffendin agreed to contact the NMC for their view.	**Cathy Woffendin**	Management Action	**COMPLETED** Response from CQC received on the 13 May to advise that following the guidance from the Professional Standards Guidance in July 2012 they have stopped giving professional views. The NMC feel the need to remain impartial and sign post professionals to working within the NMC code and to follow the law and employment policies.

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 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 will be added to the forward plan – Cath Hill is following this up with Paul Bolland
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.	**Claire Kenwood**	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.

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 19/047 - agenda item 12 – March 2019) The Board acknowledged the huge amount of work that had gone into the redesign and thanked all the staff who had been involved in this. The Board asked for a commentary on the impact of the Community Redesign in the report to the May meeting.	**Joanna Forster Adams**	May Board of Directors' meeting	**ONGOING** Work has started to develop the narrative around the crisis service which is a core component of the community redesign. We are continuing development and gathering data to analyse impact and report consistent with the evaluation milestones
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**	May Board of Directors' meeting	**ONGOING** The metrics to be included are in the process of being identified and will be incorporated into the report which will be presented to the May meeting
Matters arising (minute 19/027 - agenda item 5 – February 2019) 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) 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	**COMPLETED** This is on the agenda for the May public 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 in summer 2019. 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	**COMPLETED** This has been included on the May Board agenda

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 19/067 - agenda item 6 – April 2019) **NEW -** With regard to the development of the five-year strategy for the West Yorkshire and Harrogate ICS, Dr Munro advised that there had been a meeting of the Programme Board of the West Yorkshire and Harrogate Mental Health and Autism Collaborative where it had been agreed that a case for investment would be developed resulting in a bid for ICS transformation money. Update will be brought to the June Board meeting.	**Sara Munro**	July Board of Directors' meeting	
Changes to the remuneration of the Mental Health Act Managers (minute 19/044 - agenda item 9.1 – March 2019) It was noted that the Terms of Reference for the committee would be amended and submitted to the Board for ratification.	**Sara Layton / Margaret Sentamu**	July Board of Directors' meeting	
Chief Executive's report (agenda item 19/041 - agenda item 7 – March 2019) Mrs White asked if the third sector was part of the Partnership Board. Dr Munro assured the Board that they were and agreed to bring the Terms of Reference for the board once they had been approved, which was expected to be around July 2019.	**Sara Munro**	July 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
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.
Report from the Medical Director (minute 19/049 - agenda item 14 – March 2019) It was agreed that there would be an update on CareDirector to the September Board to Board meeting.	**Dawn Hanwell / Claire Kenwood**	September Board to Board meeting with the CoG	
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	

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
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.	**Cathy 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 19/023 - agenda item 1 – February 2019) 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) Mr Tipper agreed to contact Mrs Webster to look at how her story could be used and promoted.	**Oliver Tipper**	Management Action	**COMPLETED**
Actions outstanding from the public meetings of the Board of Directors (minute 19/028 - agenda item 6 – February 2019) 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

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) 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

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 19/034 - agenda item 1 – March 2019) Dr Munro then spoke about the development of the five-year strategy for the West Yorkshire and Harrogate ICS and asked Mrs Forster Adams and Dr Kenwood to ensure both the ADHD and Autism services are fed into the priorities for the strategy and the need to ensure that access to these services is not cut off at the age of 18.	**Joanna Forster Adams / Claire Kenwood**	Management Action	**CLOSED** that there had been a meeting of the Programme Board of the West Yorkshire and Harrogate Mental Health and Autism Collaborative where it had been agreed that a case for investment would be developed resulting in a bid for ICS transformation money. She noted that an update would be brought to the June Board meeting
Sharing Stories (minute 19/034 - agenda item 1 – March 2019) Prof Proctor also agreed to raise awareness of Ms Wolstencroft's YouTube channel into her blog.	**Sue Proctor**	Management Action	**COMPLETED**
Workforce and organisational development report (minute 19/053 - agenda item 18 – March 2019) Dr Munro also noted that the national benchmarking data was now available and agreed to share the report with the Board.	**Sara Munro**	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
Workforce and organisational development report (minute 19/053 - agenda item 18 – March 2019) Prof Proctor noted the important issue of equality and diversity and suggested that the Rainbow Alliance is invited to the Council of Governors to talk about their work. Mrs Hill agreed to add this to the forward plan for the Council.	**Cath Hill**	Management Action	**CLOSED AS A BOARD ACTION** This has been added to the forward plan for the Council of Governors
Report from the Chief Financial Officer (minute 19/054 - agenda item 19 – March 2019) The Board discussed the financial report. It noted that an announcement was due about the Gender Identity Service investment and asked for a verbal update to be provided to the public Board in April.	**Dawn Hanwell**	April Board of Directors' meeting	**COMPLETED** This will be picked up as part of the CEO Report to the April private Board
Changes to the remuneration of the Mental Health Act Managers (minute 19/044 - agenda item 9.1 – March 2019) To provide assurance on the uptake of training and also on the efficacy of making a payment to the managers, it was agreed that there would be a report on compliance for compulsory training for MHAM to be made to the Quality Committee in 6 months' time.	**Sara Layton / Margaret Sentamu**	Quality Committee October 2019	**CLOSED AS A BOARD ACTION** This has been added to the forward plan of the committee

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:	23 May 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 23rd May

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 April/May 2019.

1. **Staff Engagement and Service Visits**

Following two separate serious incidents earlier this month I have visited community staff at St Marys House and inpatient staff on Ward 5 Newsam. The incidents will be discussed in more detail in the private session of the board and members can be assured that all appropriate steps have been taken to manage these incidents and support staff. The primary reason for visiting personally was to provide support and reassurance on behalf of the board and to seek feedback as to whether there is any more we can do. We already know that the job our staff do has an impact on them personally and so by focusing on providing the right support when it is needed we aim to reduce the stress and distress staff experience, as well as reinforce a culture based on learning.

Co Space North Launch Event – mHabitat which is hosted by the Trust held the official opening of their new digital networking space which is adjacent to the train station in Leeds City Centre. This space is based on collaboration between mHabitat, Leeds city council, NHS digital to name just a few and the launch event was very well attended. I was asked to say some words on behalf of the Trust given our support to mHabitat. We are also planning on holding our board development session on digital at Co Space North with input from the team alongside our CIO and CCIO.

2. Leeds Health and Care Academy Showcase

The Leeds Health and Care Academy is a Leeds Academic Health Partnership (LAHP) project. As one of only two UK members of the Association of Academic Health Centers International, the LAHP was invited to present the Academy – its ambition, vision and progress - at its Global Issues Forum in Washington DC on 6 May. Myself as SRO for workforce in the city and the academy along with Jenny Lewis (Executive Lead and Director of Human Resources and Organisational Development, Leeds Teaching Hospitals NHS Trust) gave a presentation on behalf of Leeds and all LAHP partners to an international audience comprising clinical and operational directors, academics and system leaders. The Academy is thought to be unprecedented in scope, ambition and scale and therefore a great story for positioning Leeds and its health and care sector in the vanguard.

Since going live in April, the Academy is focusing on laying foundations across the city's workforce. For example:

- it is training extra mental health first aiders from within its partner organisations to increase and enhance support for all staff
- it has recruited the first 22 Academy ambassadors from among health and care practitioners, who are visiting local schools, colleges and its most deprived communities, to promote careers in health and care
- it is rolling out across the city a training programme to help those in leadership roles begin to focus more on the city as a whole and to think and plan for the whole 'system' rather than just their own organisational needs
- and – for the 3,000 or so people who join the Leeds health and care sector every year – the Academy has launched a citywide induction, with more than 1,000 having watched the introductory film. Whichever role or organisation someone is joining, they will understand from the start that they are part of a 'one workforce' culture and approach.

The film that was produced for the presentation and for wider communication of the academy work can be viewed through the following link:-

https://www.youtube.com/watch?v=HOy2crGXQIE

The presentation was very well received and some of the questions and comments reinforced the uniqueness of this work. For example including offer to volunteers, social care being an integral partner, growing our own through community engagement were some of the areas of interest. There were wider benefits to us of attending the conference, many of the discussions explored the importance of addressing the social determinants of ill-health from a wider system perspective and the opportunities with health and academia to contribute to this was a very strong theme. Cultural diversity and migrant health also featured heavily along with supporting innovation and outward facing research initiatives that generate learning back for organisations.

3. Update on the Refresh of the Leeds Plan

Following a refresh of the JSNA for Leeds and the requirement to develop the 5 year strategy for the ICS PEG agreed to undertake a review of the Leeds Plan. Work has been ongoing through a range of engagement exercises and targeted consultation with various stakeholders to inform this review. Building on the success of the Children's Strategy in Leeds we have agreed to adopt an approach which focuses the system on key obsessions. At the May PEG meeting we reviewed the proposed obsessions and these are outlined below. Further work is being carried out with all partners to refine these obsessions and determine key indicators and metrics as well as ensuring we have the right infrastructure in place to support delivery. The board is asked to note this work and be assured that we are actively engaged in its development which is evident with the increased focus on mental health in the obsessions. Paul Bollom, Head of Leeds Plan and Health Partnership Team has agreed to attend a future board session to discuss the plan in more detail.

Area One	**Reducing inequalities through better prevention** **Proposed obsession:** Prevention of ill health and reducing inequalities Scope: Health and Care role in doing more around prevention. Key "risky" behaviours: smoking, alcohol, poor diet, inactivity and stressful living.

	Priority groups to be identified: 10% most deprived, pregnant women, people with mental health problems.
Area Two	**Place of care being someone's home / community / Promoting independence** **Proposed obsession:** That people live well in their own homes and communities. (This would include beds in acute mental health and inpatient learning disabilities services)
Area Three	**Good mental health** **Proposed obsession: '**Improved mental health outcomes (for people living in) communities with the poorest mental health' **or** 'Leeds will be a mentally healthy city for all ages'

4. Update on Mental Health Strategy for Leeds

The Mental Health Partnership Board for Leeds was tasked with developing a new strategy by the Health and Well Being Board as one of the HWB Board's priorities is to promote mental and physical health equally.

The strategy will cover the full breadth of mental health and illness from prevention and the range of community based services through to in-patient treatment. It is intended to complement existing strategies. The development of this new strategy is underway and the Trust is actively involved in this. The board should note the direct links to the obsessions proposed for the Leeds Health and Care Plan which we see as very positive to ensure alignment and focus on mental health in the city. The strategy is much broader than the work of our organisation but we are a key partner and through our involvement the issues faced by people with complex mental health needs that we support are included in the priorities for action. An update on progress was shared at the HWBB at the end of April to obtain support to carry out further consultation using a range of networks and forums during

May. This will be followed by targeted engagement work with specific groups not previously approached or involved.

Vision

The vision is for Leeds to be a mental health city for all and four passions have been proposed;

1. Close the inequalities gap and reduce the number of people with the poorest health
2. Reduce the numbers of suicides and people who self-harm
3. Reduce the numbers of people from BAME backgrounds who are detained under the Mental Health Act
4. Increase the numbers of people with mental health needs in education, training and employment

Priorities

- Preventing mental health problems and promoting good mental health
- Making available the right information at the right time
- Supporting every child to achieve the best possible start in life through improved perinatal mental health provision
- Supporting self-care, with more people managing their own mental health
- Reducing health inequalities by focussing on key groups that we know are at risk and therefore need targeted support
- Talking a whole person, Think Family approach, recognising the impact that adult mental health needs can have on children's health and wellbeing
- Improving the social, emotional, mental health and wellbeing of children and young people
- Meeting both mental and physical health needs
- Improving accommodation support for people with moderate to severe mental health problems
- Changing services to better meet the needs of older people
- Developing more community based crisis support services

Intended Outcomes for the people of Leeds

- People of all ages and communities will be comfortable talking about their mental health and wellbeing
- People will live in and create mentally healthy, safe and supportive families and communities
- People living with the impact of complex trauma will be able to access appropriate mental health services and will lead healthy and fulfilling lives
- Peoples quality of life will be improved by swift access to appropriate mental health services and information
- People will be actively involved in their mental health and their care
- People with long term mental health conditions will live longer and lead fulfilling, healthy lives

5. Tackling Inequalities in Care provided to BAME communities in Leeds

The board received a presentation in February from Dr Dissanyaka on experiences of BAME in the context of the services we provide, wider evidence base and the review of the Mental Health Act that has recently been carried out. The Executive Management team were tasked with considering what additional actions we could take to make longer term changes which mean BAME citizens feel and experience much more appropriate care and treatment from the Trust. The EMT revisited the notes from the board session at our away time in April and reviewed the work that is being proposed within the wider system of which we are an active partner. The board should be assured therefore that since the session in February we are taking forward these actions with the full support of the wider system which is outlined below.

The board should note that one of the areas of focus in the wider Leeds Mental Health Strategy and which is also one of the proposed obsessions for the Leeds plan relates to the experiences of BAME citizens in accessing and receiving mental health care and treatment. This also includes addressing the differences in crisis support and rates of detention under the Mental Health Act which was a significant focus of our previous discussions. A partnership has now been created between ourselves, public health, Forum Central (third sector collaborative) and the Synergi Collaborative.

The Synergi collaborative centre

The Lankelly Chase Foundation has commissioned Queen Mary University of London, the University of Manchester and Words of Colour Productions to establish an independent centre of excellence on ethnic inequalities, severe mental illness and multiple disadvantages.

Synergi aims to better understand and tackle ethnic inequalities in the *risk* and *consequences* of severe mental illnesses among ethnic minority people. A key focus of the work is to crystallise the evidence and transform this into co-created/-produced actions which are more likely to be successful.

Synergi will be working with Leeds, Birmingham and Manchester (and other potential municipalities) to support systems change. This will include action across the following domains:

- Collate, collect, analyse, interpret and communicate data and knowledge on ethnic inequalities in
  mental health and related systems, and how this relates to severe and multiple disadvantage.
- Bring together the full range of stakeholders through models of co-production, and co-curation of knowledge, to develop and implement solutions.
- Place lived experience narratives centre stage.
- Use creative, digital and evidence-based platforms to share these narratives to a variety of stakeholders with the view to strategically inform policy development.
- Become a focal point for action, leading to systems change tackling ethnic inequalities and multiple disadvantages in mental health services.
- Identify additional opportunities to reduce and prevent ethnic inequalities to improve the health of individuals and populations.

At a stakeholder meeting with strategic leaders (February 2019), it was agreed that partners in Leeds would collaborate with Synergi in order to address health inequalities, specifically related to mental health detentions.

The proposal is as follows:

- Leeds City Council, Forum Central and Leeds & York Partnership Foundation Trust, to work in partnership with Synergi in order to develop new approaches to understanding the drivers of inequalities experienced by people from Black, Asian and other ethnic minority backgrounds, including people of Mixed Ethnicity; and to reduce these.
- The specific area of interest is compulsory detention and ethnicity, and how various pathways track into this outcome. The partnership will consider how interventions at the various stages of the pathways towards this outcome can become the focus of preventive actions to reduce inequalities.
- Synergi will support Leeds to develop a shared/common understanding about 'what's happening' and why. The first action to enable this will be a facilitated Creative Spaces event with a range of stakeholders in September 2019.

6. Reasons to be Proud

Publishing Success for the Leeds Autism Diagnostic Team

ABC of Autism (https://www.wiley.com/en-gb/ABC+of+Autism-p-9781119317258) provides clinicians and medical students with a succinct, evidence-based overview of the symptoms, evaluation, treatment, and management of autism in both daily practice and for ongoing patient support plans. This accessible and informative guide allows primary healthcare professionals to quickly reference the essential information required for appropriate patient care. The book contains 16 chapters – half of which have been authored by members of our LADS team.

Accreditation of specialist skills in Mental Health Pharmacy

Michael Dixon who is one of our Trusts pharmacists was recently re-credentialed as a member of the College of Mental Health Pharmacy following an assessment of his clinical practice. The College of Mental Health Pharmacy promotes the role of pharmacists as experts in medication use within the field of psychiatry. This is in part achieved by credentialing individual pharmacist's clinical competence. The assessors fed back that Michael demonstrated a very high standard of competence within psychiatric therapeutics

and was therefore granted continued membership of the College and so it is clearly our privilege to have Michael working in our organisation.

Queens Garden Party

This year we encouraged a number of staff to apply to attend the Queens garden party in recognition of the outstanding commitment and work they do in the Trust. Two of the staff have been successful which is fantastic; Mary Dresser who works at the Becklin Centre and Julie Foster a community mental health nurse.

Easy on the I shortlisted in Awards

The National Learning Disabilities & Autism Awards celebrate excellence in the support for people with learning disabilities and aim to pay tribute to those individuals or organisations that excel in providing quality care. Easy on the I who have also recently featured in a national news programme produce a wide range of communication aids that support individuals who have a learning disability to better access and understand health and social care. The materials are co-produced with service users and widely available through their dedicated website.

Dr Sara Munro
CEO Leeds and York Partnership NHS Trust
16th May 2019

AGENDA ITEM
8

Chair's Report

Name of the meeting being reported on:	Quality Committee
Date your meeting took place:	14 May 2019
Name of meeting reporting to:	Board of Directors – 23 May 2019

Key discussion points and matters to be escalated:

At the Quality Committee meeting that took place on the 14 May 2019 the following items were discussed:

- The Committee received the annual quality and safety report for the Perinatal Services. From discussing the areas highlighted within the report and the challenges and opportunities faced by this service, it was agreed that the Committee would escalate three matters to the Board of Directors. These were around:

  - What the Leeds System is doing in terms of support to families in terms of early years and the 'early help offer' given that this is a priority in the Leeds Plan
  - Making the Board aware of an action for the Clinical Director, at the next meeting of the St James' New Build Board, to raise the issue of the provision of accommodation for carers and families within the new build on the St James's Hospital site
  - In relation to equality and diversity amongst service users it was noted that the majority of service users within the Perinatal Services were British. The Committee noted the assurances the Board had received in the past around ensuring a diverse workforce, but questioned whether sufficient work was being done to ensure equitable access to all services from within diverse communities.

- The Committee was informed that an external audit had been carried out around Safeguarding which had received significant assurance. The Committee commended the improvements in this area.

Report completed by:	Name of Chair and date: Prof John Baker 15 May 2019

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

8.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Annual Report from the Quality Committee
DATE OF MEETING:	23 May 2019
PRESENTED BY: (name and title)	Prof John Baker – Non-executive Director
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

The Terms of Reference for the Quality Committee requires it to make an annual report to the Board setting out how it has carried out its duties during the financial year.

At its meeting on the 9 April 2019 the committee received and agreed the attached annual report. The report provides the Board with an outline of the governance processes the committee has in place; the work it has undertaken during 2018/19; and any key issues it has found necessary to highlight to the Board. Its detail has been drawn from the Terms of Reference, the committee's work schedule and the minutes of all meetings in the timeframe.

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 and to be assured that the committee has worked within its Terms of Reference and has escalated appropriately any key issues to the Board through the verbal reports made by the chair of the committee.

Leeds and York Partnership
NHS Foundation Trust

The Quality Committee

Annual Report

Financial Year 1 April 2018 to 31 March 2019

CONTENTS

1 PERIOD COVERED BY THIS REPORT

This report covers the work of the Quality Committee for the financial year 1 April 2018 to 31 March 2019.

2 INTRODUCTION

2.1 Development

2018/19 has seen the continued development of the Quality Committee. This development started as a result of the externally commissioned review of the Trust's governance framework. The external review was undertaken during the 2017/18 financial year by Deloittes, and resulted in a series of recommendations being presented to the Board of Directors at one of their workshops (September 2017). During the same period, the Trust formed the Trustwide Clinical Governance Group (TWCG) meeting. The TWCG was introduced to provide a clinical governance forum which oversees and triangulates escalation and assurance from across each aspect of clinical governance activity. The Quality Committee is joined to the TWCG as an assurance and escalation receiver. The Committee provides the check and challenge to the TWCG and provides a mechanism of connectivity between care services governance and a trust-wide accountability framework. Developments to the Trust's governance framework have seen the Committee further strengthen its escalation and assurance reporting. With a standing item at each Committee meeting now being 'Assurance and Escalation Reporting'. This provides an opportunity for those executive directors present to provide an update to non-executive director colleagues on any areas that they wish to bring to their attention.

Dr Claire Kenwood, Medical Director, worked closed with Fran Limbert, Corporate Governance Team Leader to support the delivery of the Quality Committee refresh. Part of this work resulted in a review of the work-strands that had been presented to the Committee in the previous two years'. The start of 2018/19 saw the Committee collectively agree what work-strands would form part of the Committees Annual Cycle of Business. Work then took place to revise the Terms of Reference to align them to what had been agreed by the members of the Committee.

Another key development for the Committee was the introduction of a private meeting which is solely for members of the Committee. These meetings, referred to as Part B, are scheduled accordingly, and provide the members with a forum to discuss confidential or sensitive data. Part B meetings have their own supporting governance framework, with escalation reporting being to the private meeting of the Board of Directors.

The Committee supported the proposal for annual quality and safety reports to be produced by Trust services. The reports enhance understanding, connection, and oversight of services and provide a comprehensive picture of clinical governance. The reports are drafted by the service leads, both clinical and non-clinical, and have their own governance pathway which culminates at the Quality Committee. The development of these reports further strengthens the Trust's assurance and escalation reporting and the flow of information from frontline clinical services to the Board of Directors. The creation of these reports provides Trust services with a platform to self-reflect and analyse. Presenting them to the Trustwide Clinical Group and the Quality Committee also supports shared learning.

2.2 Objective of the Committee

The Quality Committee has been formally established by the Board of Directors as one of its sub-committees. It is authorised to investigate and seek assurance on the effectiveness of the Trust's quality systems and processes and the quality of the services provided. This includes seeking assurance on the management of quality related risks at operational and strategic level. The Committee will monitor and report to the Board of Directors on the effectiveness of these systems and processes. With its key objectives being to seek assurance that:

- systems and processes are effective
- the quality of services provided is good and continuously improving
- the experience of people using Trust services is good and continuously improving.

The Committee will receive assurance on:

- systems and processes to ensure monitoring and assessment of the quality and improvements in services
- mechanisms to involve service users, carers, the public and partner organisations in improving services
- systems for identifying, reporting, mitigating and managing quality and safety related risks including the monitoring of incidents, investigations and deaths; and complaints, claims, and compliments
- risks within the Board Assurance Framework where the Committee is the named assurance receiver
- performance monitoring and CQUIN delivery relating to key quality and safety indicators
- quality impact assessments for key strategic programs of work
- reports on activity within operational services that contributes to the understanding and improvement of quality and safety within the Trust.

This report covers the work the Committee has undertaken at the meetings held during 2018/19. It seeks to assure the Board on the work it has carried out and the assurances received, and to demonstrate that it has operated within its Terms of Reference.

Secretariat support is provided by the Corporate Governance Team in relation to agenda planning; minutes; managing cumulative action logs; and general meeting support.

3 ASSURANCE

The Committee receives assurance from the executive director members of the Committee and from the subject matter experts who attend the meetings as required dependant on the agenda items being discussed.

Assurance is provided through written reports, both regular and bespoke, through challenge by members of the Committee and by members seeking to validate the information provided through wider knowledge of the organisation; specialist areas of expertise; attending Board of Directors', and Council of Governors' meetings; visiting services, talking to staff, and attending the Trustwide Incident Review Group meeting and the Learning from Incidents and Mortality meeting as an observer.

The Committee is assured that it has the right membership to provide the right level and calibre of information and challenge and that the right reporting methods, structures and work plans are in place to provide oversight on behalf of the Board in respect of performance in the areas covered by its Terms of Reference.

Part of its assurance role is to receive the Board Assurance Framework (BAF); a primary assurance document for the Board which details those key controls in place to ensure that the risks to achieving the strategic objectives are being well managed. The BAF lists those committees that are responsible for receiving assurance in respect of the effectiveness of those controls, and the Quality Committee will be asked to note, in particular, those where it is listed as an assurance receiver to ensure that it had received sufficient assurance through the reports that come to the Committee or to commission further information where there was a lack of assurance (actual or perceived). These are:

- SR2. We are unable to maintain compliance with regulatory requirements relating to the quality and safety of our services due to a failure to provide care in line with national standards and best practice
- SR3. Due to inadequate systems to support continuous learning, improvement and innovation, there is a risk that our services deliver poor outcomes for service users
- SR7. As a result of a culture of blame which does not foster a psychologically safe environment for our staff we are unable to reduce patient harm or provide a positive experience for our service users.

The Committee reviews the BAF on a quarterly basis prior to it being presented to the Board of Directors.

4 TERMS OF REFERENCE FOR THE QUALITY COMMITTEE

In May 2018 the Terms of Reference for the Quality Committee were approved by the members. Following this, they were ratified by the Board of Directors that same month.

5 MEETINGS OF THE COMMITTEE

In 2018/19 the Committee met on 11 occasions. The dates on which the Committee has met during the year are as follows:

- 10 April 2018
- 8 May 2018
- 12 June 2018
- 10 July 2018
- 11 September 2018
- 9 October 2018
- 13 November 2018
- 11 December 2018
- 15 January 2019
- 12 February 2019
- 12 March 2019

The draft agenda for each meeting is presented to the Chair of the Committee, the Director of Nursing, Professions and Quality, and the Medical Director by the Committee Secretariat. It is also shared with the Head of Quality and Clinical Governance who supports the delivery of the TWCG meeting.

In line with its Terms of Reference, paperwork for this meeting is circulated to members seven calendar days prior to the meeting taking place. All actions pertaining to the meetings of the Committee are tracked on a cumulative action log and presented to each meeting by the Committee Secretariat for assurance with progress made.

6 MEMBERSHIP OF THE COMMITTEE AND ATTENDANCE AT MEETINGS

Membership of the Quality Committee is made up of three non-executive directors; the Director of Nursing and Professions, the Chief Operating Officer, Medical Director, and the Director Workforce Development. During the 2018/19 financial year the Director of Workforce Development left the Trust the end of May 2018. From that point in time, until the end of September 2018, an Interim Director of Workforce Development was in place, following this, the position of Director of Organisational Development and Workforce was substantively recruited and commenced their employment with the Trust October 2018. The Chief Financial Officer is also a member of the Committee and attends meetings as appropriate dependant on the agenda items being discussed. The Committee is chaired by a non-executive director (NED), Professor John Baker. Steven Wrigley-Howe (up until 16 February 2019 when he came to the end of his second term of office as a non-executive director), Andrew Marran (from the 17 February 2019 who was appointed as a new non-executive director), and Helen Grantham are the other regular NED members of this Committee. Should the NED chair be unable to chair the meeting this role will fall to another NED.

Subject area experts are also invited to attend the meetings as appropriate, to provide expertise and knowledge on the areas that they are responsible for. On this occasion, they are attendees and do not count towards to membership of the meetings as outlined in the Terms of Reference.

The Trust also invites governors to observe Board sub-committee meetings. This opportunity allows governors to observe the work of the Committee, rather than to be part of its work as they are not part of the formal membership of the Committee. Governors observes Board sub-committee meetings in order to get a better understanding of the work of the Trust and to observe non-executive directors appropriately challenging the executive directors for the operational performance of the Trust.

The table below show attendance for substantive members of the committee for the meetings that took place during 2018/19.

Attendance at Quality Committee meetings by substantive members

Key:

✓ shows attendance
- shows when apologies had been given by a member for a particular meeting.
stipulates when the individual was not eligible to attend the meeting
Part B shows when a private part of the meeting for members only also took place
* stipulates the Chair of the meeting
** shows when the individual was observing the meeting

Name	10 April 2018	8 May 2018 - Part B	12 June 2018	10 July 2018 - Part B	11 September 2018	9 October 2018 - Part B	13 November 2018	11 December 2018 - Part B	15 January 2019	12 February 2019 - Part B	12 March 2019
Professor John Baker (Non-Executive Director)	✓*	✓*	-	✓*	✓*	✓*	-	✓*	✓*	✓*	✓*
Joanna Forster-Adams (Chief Operating Officer)	✓	✓	-	✓	✓	✓	✓	✓	✓	-	✓
Helen Grantham (Non-Executive Director)	✓	✓	-	✓	✓	✓	-	✓	✓	-	✓
Dawn Hanwell (Chief Finance Officer/Deputy Chief Executive)	-	-	-	✓	-	-	-	-	-	-	-
Claire Holmes (Director of Organisational Development and Workforce)						-	-	✓	✓	-	✓
Lindsay Jensen (Interim Director of Workforce Development)			-	✓	✓						
Dr Claire Kenwood (Medical Director)	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	✓
Andrew Marran (Non-Executive Director)										**	✓
Susan Tyler (Director of Workforce Development)	✓	✓									
Cathy Woffendin (Director of Nursing, Professions and Quality)	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓
Steven Wrigley-Howe (Non-Executive Director)	✓	-	✓*	✓	✓	✓	✓*	✓	✓	-	

Attendance at Quality Committee meetings by formal attendees

Key:

✓ shows attendance
- shows when apologies had been given for a particular meeting
stipulates when the individual was not eligible to attend the meeting
** shows when the individual was observing the meeting

Name	10 April 2018	8 May 2018	12 June 2018	10 July 2018	11 September 2018	9 October 2018	13 November 2018	11 December 2018	15 January 2019	12 February 2019	12 March 2019
Associate Director for Corporate Governance	✓	✓	✓	✓	-	✓	-	✓	✓		✓
Chair of the Trust					✓						
Chief Pharmacist					✓		✓	✓		✓	
Clinical Director Leeds Care Group									✓	✓	
Clinical Lead for Learning Disability Service					✓					✓	
Clinical Lead for Eating Disorder Service							✓				
Clinical Lead Acute Service									✓		
Corporate Governance Team Leader (Committee Secretariat)	✓	-	✓	✓	-	✓	✓		-	✓	✓
Corporate Governance Assistant				**	✓						
Corporate Governance Officer									✓		
Care Programme Approach Development Manager						✓					
Deputy Director of Nursing					✓						
Deputy Director of Workforce Development						✓				✓	
Deputy Medical Director						✓					
Eating Disorder Service Manager							✓				
Forensic Services Manager		✓					✓				
Head of Continuous Improvement					✓						
Head of Nursing and Patient Experience				✓		✓					
Head of Operational Quality and Governance Development		✓			✓						

Head of Performance and Informatics	✓	✓	✓		✓	✓	✓	✓	-	✓	-
Head of Quality and Governance							✓	✓	-	✓	✓
Head of Research and Development						✓					
Interim Associate Director Leeds Care Group						✓		✓	✓		
Interim Clinical Director Specialist and Learning Disability Care Group						✓	✓			✓	
Interim Service Manager						✓					
Professional Practice Lead						✓					
Psychologist – Rehab and Recovery Service						✓					
Senior Nurse Infection Control								✓			
Serious Incidents Complaints Claims and Inquest Manager		✓						✓			✓
Strategic Development Manager				✓		✓					

The Quality Committee also extends an invitation to governors to observe its business. During 2018/19 the following governors attended main business meetings in the capacity of observer.

Key:

stipulates when the individual did not attend the meeting
** shows when the individual was observing the meeting

Name	10 April 2018	8 May 2018	12 June 2018	10 July 2018	11 September 2018	9 October 2018	13 November 2018	11 December 2018	15 January 2019	12 February 2019	12 March 2019
Staff: Clinical							**				
Staff: Clinical							**				
Service Users: Leeds										**	

7 REPORTS MADE TO THE BOARD OF DIRECTORS

The Chair of the Quality Committee makes an assurance and escalation report regarding the most recent meeting of the Committee to the next available Board of Directors' meeting. This verbal report seeks to assure the Board on the main items discussed by the

Committee and should it be necessary to escalate to the Board any matters of concern or urgent business which the Committee is unable to conclude. The Board may then decide to give direction to the Committee as to how the matter should be taken forward or it may agree that the Board deals with the matter itself.

Where the Board wants greater assurance on any matters that are within the remit of the Terms of Reference of the Committee the Board may ask for these to be looked at in greater detail by the Committee.

The below table outlines the date that the assurance and escalation report was presented by the Chair of the Quality Committee to the Board of Directors meeting.

Date of meeting	Assurance and escalation report to Board by Chair
10 April 2018	26 April 2018
8 May 2018	24 May 2018
12 June 2018	28 June 2018
10 July 2018	26 July 2018
11 September 2018	27 September 2018
9 October 2018	25 October 2018
13 November 2018	29 November 2018
11 December 2018	31 January 2019
15 January 2019	31 January 2019
12 February 2019	28 February 2019
12 March 2019	28 March 2019

8 THE WORK OF THE COMMITTEE DURING 2018/19

During 2018/19 the Chair of the Quality Committee confirmed that the Committee has carried out its role in accordance with its Terms of Reference. Further details of all of these areas of work can be found in the minutes and papers of the Committee.

A high-level presentation of areas of work on which the Committee has received assurance and during 2018/19 are as follows:

Assurance on:

- Claims; incidents; NHS England independent investigations; and NMC cases (in the Part B private meeting)
- Developments of the Forensic Service in York
- Discussions taken place at Trustwide Clinical Governance Group and the Safeguarding Committee
- The Trust's approach to reducing restrictive practice
- Board Assurance Framework

- The Trust's response to the LeDeR recommendations
- Progress made against the Quality Strategic Plan
- Community redesign project
- Trust findings from the Gosport Report
- CQUIN Delivery and Performance
- Trust learning from deaths
- Progress made against the Trust's Operational Plan
- Trust working towards compliance for the Falsified Medicines Directive
- Freedom to Speak Up Action Plan
- Out of area placements for people with a learning disability
- Development of clinical supervision
- Developments made to further strengthen the complaints management process.

Reports on:

- Complaints, Claims, Complements
- Incidents, Investigations, and Deaths
- Quality and Workforce data performance
- Quality Impact Assessments for the Cost Improvement Programmes
- Care Quality Commission Updates
- Recovering Quality of Life pilot within the Trust
- Externally commissioned patient experience review.

Presentation of:

- Draft Quality Account
- Quality Improvement Priorities
- Infection Prevention and Control and Medical Devices Annual Report
- Clinical Audit and NICE Annual Report
- Continuous Improvement Annual Report
- Research and Development Strategic Plan; and Annual Report
- Medicine Management Annual Report
- Safeguarding Annual Report
- Freedom to Speak Up Strategic Policy
- Non-executive Director visits to Trust services.

Quality and Safety Reports from the following services:

- Deaf Child and Adolescent Mental Health
- Mill Lodge
- CONNECT Eating Disorders
- Adult Acute Inpatient
- Learning Disabilities.

8 CONCLUSION

The Chair of the Quality Committee would like to assure the Board of Directors that the Committee has fulfilled its Terms of Reference during 2018/19. The Board is asked to recognise the significant transformational work that has taken place in the development of the Quality Committee. Members of the Committee and the Corporate Governance Team worked collectively together to agree the vision and remit of the Committee. This work is underpinned by the refresh of its Terms of Reference, and it's Annual Cycle of Business.

It has added value by maintaining an open and professional relationship with officers of the Trust and has carried out its work diligently; discussed issues openly and robustly; and kept the Board of Directors apprised of any possible issues or risks.

Members of the Quality Committee would like to thank all those who have responded to its requests during the year and who have supported it in carrying out its duties.

Professor John Baker
Non-executive Director and
Chair of the Quality Committee
March 2019

Fran Limbert
Corporate Governance Team Leader and
Secretariat for the Quality Committee
March 2019

Quality Committee

Terms of Reference
(Approved and ratified May 2018)

1 NAME OF GROUP

The name of this committee is the Quality Committee.

2 COMPOSITION OF THE COMMITTEE

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

Members

Title	Role in the committee
Non-executive Director (NED)	Committee Chair
Non-executive Director	Deputy Chair
Non-executive Director	
Director of Nursing, Professions and Quality	Joint executive Lead for quality and Chair of the Patient Experience Group. Assurance and escalation provider to the Quality Committee.
Chief Operating Officer	Executive Director with day to day responsibility for operational delivery of services. Assurance and escalation provider to the Quality Committee.
Medical Director	Joint executive Lead for quality. Medical input and Chair of the Trustwide Clinical Governance Group. Executive Lead for quality improvement. Assurance and escalation provider to the Quality Committee.
Director of Workforce Development	Staff training and development issues related to quality. Assurance and escalation provider to the Quality Committee.
Chief Financial Officer	Executive lead for financial resources including Cost Improvement Programmes and Chair of the Health and Safety Committee.

	Assurance and escalation provider to the Quality Committee. Attendance at meetings will be dependent on the agenda items being discussed.

Attendees

The Quality Committee may also invite other members of Trust staff and its non-executive directors to attend to provide advice and support for specific items when these are discussed in the Committee's meetings.

These could include, but are not exhaustive to, the following individuals:
Clinical Directors
Deputy Director of Nursing
Head of Nursing and Patient Experience
Head of Corporate Governance.

2.1 Governor Observers

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

At the meeting the governor observer will be required to declare any interest they may have in respect of any of the items to be discussed (even-though they are not formally part for the discussion). Papers for governors will be available at the meeting Governor observers will be invited to the meeting by the Corporate Governance Team.

3 QUORACY

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

Non-quorate meeting: Non-quorate meetings may go forward unless the chair decides otherwise. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

4 MEETINGS OF THE GROUP

Frequency: The Quality Committee will meet monthly to transact its normal business.

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

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

Papers: Papers for the meeting will be distributed electronically by the Corporate Governance Team seven working days prior to the meeting. Papers received after this date will only be included if decided upon by the chair.

5 AUTHORITY

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

Powers: The Quality Committee is constituted as a standing committee of the Trust Board of Directors. The Committee is authorised by the Board to investigate and seek assurance on any activity within its terms of reference.

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

6 ROLE OF THE GROUP

6.1 Purpose of the Group

The Quality Committee has responsibility for providing assurance to the Board of Directors on the effectiveness of the:

- Trust's quality and safety systems and processes
- quality and safety of the services provided by the Trust
- control and management of quality and safety related risk within the Trust.

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

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

- we have integrity
- we are caring

- we keep it simple.

6.3 Duties of the Quality Committee

The Quality Committee is seeking assurance that:

- systems and processes are effective
- quality of services that the Trust provides is good and continuously improving
- quality of the experience of people using our service is good and continuously improving.

It carries out its duties to provide assurance to the Board of Directors. In addition to this, it is authorised to seek information that will allow it carry out its purpose. It will receive assurance on:

- systems and processes to ensure monitoring and assessment of the quality and improvements in services
- mechanisms to involve service users, carers, the public and partner organisations in improving services
- systems for identifying, reporting, mitigating and managing quality and safety related risks including the monitoring of incidents, investigations and deaths; and complaints, claims, and compliments;
- to review the Board Assurance Framework to ensure that the Board of Directors receives assurances that effective controls are in place to manage strategic risks related to any area of the Quality Committees' responsibilities relating to key quality and safety indicators
- quality impact assessments for key strategic programs of work
- work carried out, and reported to the Trustwide Clinical Governance Group, including: Quality Plan; Quality Report; Infection Prevention and Control; Health and Safety; Safeguarding; Research and Development; Clinical Audit and NICE; Continuous Improvements; and Measuring outcomes across Trust services
- reports on activity within operational services that contributes to the understanding and improvement of quality and safety within the Trust.

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

7 Links with Other Committees

The Quality Committee does not have any sub-committees. It is linked to the Health and Safety Committee; and Trustwide Clinical Governance Group as an assurance receiver. The Quality Committee provides a route of escalation for these two groups to the Board of Directors. Although this does not preclude any other group being asked to provide assurance.

8 DUTIES OF THE CHAIR

The Chair of the Committee shall be responsible for:

- agreeing the agenda with the Director of Nursing and Professions
- directing the conduct of the meeting ensuring it operates in accordance with the Trust's values
- giving direction to the Committee secretariat
- ensuring all members have an opportunity to contribute to the discussion
- ensuring the agenda is balanced and discussions are productive, and when they are not productive they are efficiently brought to a conclusion
- deciding when a matter requires escalation to the Board of Directors
- checking the minutes
- ensuring key information is presented to the Board of Directors in respect of the work of the Committee.

9 REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

The terms of reference shall be reviewed by the Committee at least annually, and then presented to the Board of Directors for ratification. This was also occur throughout the year if a change has been made to them.

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

Schedule of Deputies

Committee Member	Deputy
NED Chair	Second NED
NED member	Third NED
NED member	None
Director of Nursing and Professions	Deputy Director of Nursing
Chief Operating Officer	Deputy Chief Operating Officer
Director of Workforce Development	Deputy Director of Workforce Development
Medical Director	No deputy available to attend
Chief Financial Officer	Assistant Director of Finance

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

9.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE TRUST BOARD

PAPER TITLE:	Mental Health Legislation Committee Annual Report for the year 2018/19
DATE OF MEETING:	23 May 2019
PRESENTED BY: (name and title)	Margaret Sentamu, Non-Executive Director
PREPARED BY: (name and title)	Sarah Layton, Mental Health Legislation Team Leader

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

In accordance with the Trust's own internal governance processes, the committee is required to prepare an Annual Report for submission to Board of Directors, in order to show that it has met its Terms of Reference.

The attached document sets out the main areas of work and assurances. It has been prepared on the Trust's annual report template which is used by all governance groups and committees in the Trust, where they are required to provide an annual report.

It is presented to the Board of Directors' to support the final Annual Governance Statement, following approval by the MHL Committee on 15 May 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 report is presented to the Board of Directors' to support the final Annual Governance Statement, and provide assurance that the Committee is fulfilling its duties in line with its Terms of Reference. The annual report was approved by the MHL Committee on 15 May 2019.

Mental Health Legislation Committee

Annual Report

1 April 2018 – 31 March 2019

CONTENTS

1 PERIOD COVERED BY THIS REPORT

This report covers the work of the Mental Health Legislation Committee for the financial year 1 April 2018 to 31 March 2019.

2 INTRODUCTION

The Mental Health Legislation Committee is a sub-committee of the Board of Directors and provides assurance to the Board of Directors on compliance with all aspects of mental health legislation. It receives assurance through reports, both regular and bespoke, to ensure compliance is regularly monitored. These include reports from the Mental Health Legislation Operational Steering Group and the Mental Health Managers Forum. Assurance is also brought to the committee through the chair's contact with Mental Health Act Managers (MHAMs), who ensures any concerns relating to service users and their rights are raised. The committee may also invite other individuals to attend to provide advice on specific items for consideration.

Membership of the Mental Health Legislation Committee is currently made up of two non-executive directors (including the Chair of the Committee) and the Director of Nursing. Whilst only two non-executive directors are substantive members of the committee, the other non-executive directors are invited to attend on an ad-hoc basis as and when they feel it appropriate, or to ensure quoracy. The deputy Chair of the MHAMs Forum attends the Committee. Further information about the membership of the committee can be found in section 5 below.

3 TERMS OF REFERENCE

The Terms of Reference were presented at the March 2018 meeting. They were ratified by the Board of Directors and are attached for information at Appendix 2.

4 MEETINGS OF THE GROUP / COMMITTEE

In respect of the period covered by this report the committee met on three occasions:

- 16 May 2018
- 30 October 2018
- 13 February 2019

5 MEMBERSHIP OF THE COMMITTEE AND ATTENDANCE AT MEETINGS

Margaret Sentamu became Chair of the Mental Health Legislation Committee following the May 2018 meeting. The previous Chair, Sue White continues to attend the committee as a Non-Executive Director and deputy Chair. Jeffrey Tee, the lead Mental Health Act Manager has continued his role of Deputy Chair of the Mental Health Act Managers Forum during the reporting period.

The Director of Nursing, Cathy Woffendin holds portfolio responsibility for the administration of the application of mental health legislation and is a substantive member of the Committee. If the Director of Nursing is not available to attend the meeting, another executive director (ideally with knowledge and experience of mental health legislation) can be called upon to provide representation and to ensure

quoracy. The meetings on 16 May 2018, 30 October 2018 and 21 March 2019 were quorate and attended by the Director of Nursing. The Deputy Director of Nursing attended meetings on 16 May 2018 and 21 March 2019.

The table below shows attendance for members of the committee for the period 1 April 2018 to 31 March 2019.

Name	16 May 2018	30 October 2018	21 March 2019
Sue White (Chair)	✓		
Margaret Sentamu (Chair)		✓	✓
Cathy Woffendin (Director of Nursing)	✓	✓	✓
Margaret Sentamu (Non-Executive Director)	✓		
Sue White (Non-Executive Director)		✓	✓
Nichola Sanderson (Deputy Director of Nursing)	✓		✓

The Mental Health Legislation Committee may also invite other members of the Trust's staff or its non-executive directors to attend at the discretion of the chair and may request individuals to attend to provide advice and support for specific items from its work plan when these are discussed in the committee meetings. Mental Health Act Managers may be invited to attend for specific agenda items, and governors are invited to observe the meetings, but have no power to comment at the meeting unless invited by the chair of the committee to do so. A representative from Leeds City Council with responsibility for Deprivation of Liberty Safeguards is also invited to attend.

6 REPORTS MADE TO THE BOARD OF DIRECTORS

The Chair of the Mental Health Legislation Committee provides a written Chairs report at the Board of Directors' meetings to assure the Board of the main items discussed by the committee. Should it be necessary to make the Board aware of any matters of concern, this will be done by the Chair of the Committee in that report, and an outline given of how the Committee will take this forward. Where the matter is of significant concern the Chair of the Committee will ask for direction from the Board, or it may be that the Board takes a decision to receive reports directly.

Following the Mental Health Legislation Committee on 21 March 2019 – the Board of Directors were asked to approve changes to the remuneration rates to the Mental Health Act Managers and to update the Committees Terms of Reference. The proposed changes to remuneration rates were to provide remuneration to Mental Health Act Managers on completion of compulsory training. A request was made to the Trust Board to delegate powers to the Mental Health Legislation committee in respect of future remuneration to Mental Health Act Managers. The recommendations were approved by the Trust Board during March 2019 and the Committees Terms of Reference have been updated and submitted to the May 2019 Committee for final approval prior to Board ratification.

In addition to the Chairs report, the Board of Directors receives the Annual Report.

.

7 THE WORK OF THE COMMITTEE DURING 1 April 2018 – 31 March 2019

During 2018/2019 the Chair of the Mental Health Legislation Committee confirmed that the committee has fulfilled its role, in accordance with its Terms of Reference, (attached at Appendix 2 for information). The Committee's work plan is under review. Further details of all of these areas of work can be found in the minutes of the committee.

The Committee is committed to ensuring that service user experience informs its work. This is achieved indirectly via case studies brought to the Mental Health Act Managers Forum.

Other areas of work on which the Committee has received assurance during 2018/19 are set out below:

Mental Health Legislation

During the reporting period the Committee has been cited on a number of complex Mental Health Act Managers hearings requiring investigation. During the investigation process a joint training need was identified to support both Mental Health Act Managers and clinical staff to understand their roles and responsibilities with regards to the hearings. A joint training session was held during September 2018. The Committee received positive feedback from those in attendance who were supportive this session being provided on an annual basis.

The Committee was informed of the Trusts 'requires improvement' rating following inspection by the Care Quality Committee (CQC) in January 2018. Mental Health Act Administration was rated as good overall, demonstrating a significant improvement from previous inspections. Assurance was provided to the Trust Board regarding the effectiveness of mental health legislation processes and procedures. The Committee receives feedback from the Mental Health Legislation Operational steering Group at each meeting via the Chairs report and this includes oversight of provider action statements monitoring following CQC Mental Health Act inspections.

The Committee continues to receive reports from the mental health legislation team following monthly documentation audits. The Committee is pleased to note that no fundamentally defective or challengeable detentions have been identified during the audits for the reporting period. The audits provide robust assurance to the Committee that statutory and internal processes and procedures are managed effectively to meet legislative requirements.

During the reporting period the Trusts Advocacy provider in Leeds (Advonet) which is commissioned by the Local Authority underwent a change in management. The Committee has expressed concerns that this has led to an absence of activity data. The Committees local authority representative agreed to raise this with the Advocacy provider as part of commissioning discussions. The committee will continue to monitor to ensure appropriate data is received.

Throughout the reporting period the Committee has continued to express concern regarding compliance with compulsory mental health legislation training. The

committee is pleased to note that training compliance has improved to meet Trust targets.
The Committee welcomes proposed changes to the training provision following review which includes service specific initial and refresher training which will focus on CQC issues and take a case study approach.

The Committee previously expressed concern about the continuing challenge of disproportionately high rates of crisis access by people from a BAME background and has throughout the year monitored actions being taken by the operational group to address this challenge.

The Committee received assurance on operational matters from the Mental Health Legislation Operational Steering Group. This is presented to the Committee via the Chairs report. The Mental Health Operational Steering Group meetings monthly.

The Committee has received information following the Mental Health Act Review and welcomes the recommendations made; the Committee will continue to monitor the legislative changes to ensure compliance.

The Committee has expressed concern regarding the number of Deprivation of Liberty Safeguard (DoLS) applications outstanding but has been assured that the Trust's responsibilities as managing authority have been complied with. The Committee noted that legislative changes to the DoLS system expected to take effect during 2020 may have an impact on service demand and resource and have been assured that these will be considered when the Trust completes its impact review following confirmation of the legislative changes.

8 CONCLUSION

As a governance Committee of the Board of Directors, the Mental Health Legislation Committee has provided assurance to the Board regarding compliance with all aspects of the Mental Health Act 1983 and subsequent amendments; and that it has complied with all aspects of mental health legislation including the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. It carried out its work diligently; discussed issues openly and robustly; and kept the Board of Directors apprised of any possible issues or risks.

The Mental Health Legislation has fulfilled its role as a Board of Directors' governance committee in accordance with its Terms of Reference. This enables the Board of Directors to comment on the adequacy and effective operation of the organisation's internal control systems and compliance with the law and regulations.

The members of the Mental Health Legislation Committee would like to thank all those who have responded to its requests during the year and who have supported it in carrying out its duties, and particularly recognises the valuable contribution made by staff in the MHL Team.

1 May 2019
Margaret Sentamu
Chair of the Mental Health Legislation Committee

Appendix 1

MENTAL HEALTH ACT MANAGERS ANNUAL REPORT
1 April 2018- 31 March 2019

The Role and remit of the Mental Health Act Managers

Mental Health Act Managers (MHAMs) are members of the public, appointed by the Board of Directors, together with a number of non-executive directors who act in this role. Their key responsibilities are to:

- Review the detention of service users who are either detained under the Mental Health Act or who have been placed on Community Treatment Orders (CTO)

- Discharge those service users who no longer meet the criteria to be detained or are subject to a Community Treatment Order.

The Board of Directors' has established a Mental Health Legislation Committee as a sub-committee of the Board. During 2018/19 this committee was chaired by a non-executive director. Margaret Sentamu took over Chair responsibilities from Sue White in August 2018. Sue White continues to attend as a non-executive director (Margaret Sentamu). The Forum met four times during 2018/19. The Managers Forum reports directly to the Mental Health Legislation Committee to provide a forum for communication between the Trust Board, the Mental Health Act Managers and the Officers of the Trust and provides a mechanism for assurance on, the robustness of arrangements in place for the Trust to meet its duties in respect of the Mental Health Act 1983. The forum is also chaired by a non-executive director to ensure a direct link to the Board of Directors in accordance with the Mental Health Act Code of Practice.

In 2018/19 the Forum met 4 times;

- 9 May 2018
- 16 August 2018
- 12 November 2018
- 20 February 2019

The recruitment of further MHAMs continued during 2018/19 and eleven new MHAMs were appointed. The regular recruitment drives ensure diversity is addressed within the group and that the organisation retains sufficient panel members to review detention and CTOs, in accordance with the Trust's own standard. Eight Managers reached the end of their fixed term appointment on 31 March 2018 which reinforces the need to constantly refresh our group of MHAMs. The Trust is extremely grateful to the retiring MHAMs for their hard work and commitment over many years.

Training of Mental Health Act Managers

We are committed to ensuring that our MHAMs are appropriately trained for their role and that all new managers attend a one-day induction, followed by a period of observation with support from experienced MHAMs. On-going training is provided at forum meetings. This year, training information and discussion sessions were held;

- 9 May 2018
- 16 August 2018

- 12 November 2018
- 20 February 2019

MHAMs were invited to join the Trust's training event on equality, inclusion and diversity. MHAMs considered case studies, enabling shared learning and exchange of best practice.
Information sessions provided during the reporting period have included representatives from Advonet to discuss the role of the Independent Mental Health Advocate (IMHA), particularly in relation to attendance at hearings. A session covering unconscious bias, and discussions around the needs of MHAMs in relation to cultural awareness have been delivered , as a result of which further training is planned during the next reporting period.
Training sessions taking place during the reporting period have included, a mental health legislation refresher session, including the recording of decisions and joint MHAMs and clinician training.

During April 2018 the forum completed a review of its effectiveness. The overall feedback was generally positive, with some suggestions for further training needs and smaller group work. The Forum also completed a critical review of the data provided, following the review, data has been streamlined to identify any themes of areas for action.

Remuneration, Monitoring, Effectiveness and Appraisals

Remuneration payments for MHAMs were reviewed by the Trust Board and it was agreed to retain current levels as they compared favourably with other Trusts.

During the reporting period all MHAMs have completed a development review – the overall process which was mainly done via telephone conference has been well received, with a number of actions and items for group discussion being highlighted. The development review process will continue on an annual basis.

At the March 2019 meeting of the Mental Health Legislation Committee, the re-appointment of nine MHAMs were confirmed; these MHAMs have completed their second term. The Committee reviewed the current level of MHAMs and confirmed sufficient numbers at this time, with no immediate plans to recruit. Consideration is being given regarding how to improve diversity of recruitment to the MHAMs panel in the future.

In 2018/2019, there were 76 appeal hearings (an increase of 16 from the previous year), of which 70 were heard within our standard of 10 days. The MHAMs reviewed 305 renewals / extensions of detention and CTOs (an increase of 57 from the previous year). A total of 11 (a reduction of 6 from the previous year) nearest relative barring orders were heard. The MHL Committee monitors hearing data at its quarterly meetings and seeks assurance as to how processes can be made more effective.

Following the Mental Health Legislation Committee on 21 March 2019 – the Board of Directors was asked to approve changes to the remuneration rates to the Mental Health Act Managers and to update the Committees Terms of Reference. The proposed changes to remuneration rates were to provide remuneration to Mental Health Act Managers on completion of compulsory training. A request was made to the Trust Board to delegate powers to the Mental Health Legislation committee in respect of future remuneration to Mental Health Act Managers. The recommendations were approved by the Trust Board during March 2019 and the Committees Terms of Reference have been updated and submitted to the May 2019 for final approval prior to Board ratification.

We currently have 45 Mental Health Act Managers and the table below shows those people who have acted in this capacity during 2018/2019.

Table 1 – Mental Health Act Managers during 2018/2019

Mental Health Act Managers during the period 1 April 2018 to 31 March 2019					
John	Devine	Andrea	Robinson	Graham	Martin
Michael	Hartlebury	Sarah	Smith	David	Mayes
Trevor	Jones	Susan	Smith	Ismail	Patel
Andrea	Kirkbride	Elisabeth	Sunley	Shamaila	Qureshi
Alex (William)	Sangster	Janice	Wilson	Mohammed	Hussain
Jennifer	Taylor	Paul	Yeomans	Harold	Kolawole
Viv	Uttley	Ian	Hughes	Susan	Mosley
Bernadette	Addyman	Andrew	Marran	Gillian	Nelson
Marilyn	Bryan	Michael	Yates	Lynsey	Nicholson
Deborah	Byatt	Nasar Ali	Ahmed	John	OHara
Aqila	Choudhry	Judith	Devine	Harold	Oluwaseun
Debra	Pearlman	Lorna	James		
Janis	Bottomley*				
Jeffrey	Tee	Peter	Jones		
Claire	Turvill	Claire	Morris		
Rebecca	Casson	Niccola	Swan		
Nicolle	Levine	Thomas	White		

* retried during 2018/19

Non-executive directors also acting as Mental Health Act Managers during 2018/19
Sue White Margaret Sentamu Andrew Marran

We are appreciative of the time and commitment that Mental Health Act Managers and non-executive directors acting as Mental Health Act Managers have given this year. Once again we wish to thank them for their dedication and the skill they apply when undertaking this vital role.

1 May 2019
Margaret Sentamu
Chair of the Mental Health Legislation Committee

Appendix 2

Mental Health Legislation Committee

Terms of Reference

Approved by the Board of Directors – May 18

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1 NAME OF GROUP / COMMITTEE

The name of this committee is the Mental Health Legislation Committee.

2 COMPOSITION OF THE GROUP / COMMITTEE

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

Members: full rights

Title	Role in the group / committee
Non-executive Director	Committee Chair
Non-executive Director	Deputy Chair
Director of Nursing	Executive Director with MHL Knowledge
Deputy Chief Operating Officer	Linkage to Care Services, Chair of the MHL Operational Steering Group
Associate Director for Leeds Care Group	Linkage to care services
Associate Director for Specialist Services	Linkage to specialist services

Attendees:

Title	Role in the group / committee	Attendance guide
Associate Medical Director for Mental Health Legislation	Advisory and technical expertise	Every meeting
Adult Social Care representatives (for Leeds,)	Linkage to social workers	Every meeting
Head of Corporate Governance	Linkage to Board and other sub-committees	As required
Mental Health Clinical Development Manager	Advisory and technical expertise	Every meeting
MHA managers' nominated individual	MHAM's perspective, experience and concerns	Every meeting
Governor	Observer with opportunity to contribute to discussions	Every Meeting

In addition to anyone listed above as a member, at the discretion of the chair of the committee the committee may also request individuals to attend on an ad-hoc basis to provide advice and support for specific items from its work plan when these are discussed in the meetings.

3 QUORACY

Number: The minimum number of members for a meeting to be quorate is 4. This must include the Chair / Deputy Chair of the meeting, the director of nursing and two nominated individuals (or their deputies), one to represent each care group. Attendees do not count towards quoracy. If the chair is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by the Deputy Chair.

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

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

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

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

Alternate chair: The unique character of Board sub-committees is that they are non-executive director chaired. The Mental Health Legislation Committee has two non-executive director members hence the role of the chair will automatically fall to the other non-executive director if the chair is unable to attend.

4 MEETINGS OF THE COMMITTEE

Frequency: The Mental Health Legislation Committee will normally meet every three months or as agreed by the Committee.

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

Minutes: Draft minutes will be sent to the Chair for review and approval within seven working dates of the meeting by the MHL Team Leader.

5 AUTHORITY

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

Powers: The MHL Committees powers are detailed in the Trust's Scheme of Delegation. The Mental Health Legislation Committee has delegated authority to oversee the management and administration of the Mental Health Act 1983, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. The Committee is authorised by the Board to investigate and seek assurance on any activity within its terms of reference. The Committee is authorised by the Board to approve the appointment and re-appointment of the Trusts Mental Health Act Managers, final ratification will be provided by the Trust Board.

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

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

This committee is implemented as a part of the 2013 governance review

ROLE OF THE COMMITTEE

6.1 Purpose of the Committee

Objective	How the group / committee will meet this objective
Governance and compliance	The MHL Committee provides assurance to the Board regarding compliance with all aspects of the Mental Health Act 1983 and subsequent amendments and on compliance with all aspects of mental health legislation including, but not limited to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

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

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

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

6.3 Duties of the group / committee

The MHL Committee has the following duties:

- Mental health legislation

- The Committee will monitor and review the adequacy of the Trust's processes for administering the Mental Health Act 1983 and subsequent amendments and on compliance with all aspects of mental health legislation including the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.
- Formally submit an annual report on its activities and findings to the Board of Directors.
- Consider and make recommendations on other issues and concerns in order to ensure compliance with the relevant mental health legislation and to promote best practice by adherence to the codes of practice.
- Review the findings of other relevant reports functions, both internal and external to the organisation, and consider the implications for the governance of the organisation

- Mental Health Act Managers' Forum

  - The Mental Health Legislation Committee will ensure that the Mental Health Act Managers' Forum is supported to share experience, promote shared learning and raise concerns, where appropriate both amongst themselves and, with the Trust Board and management
  - The Mental Health Legislation Committee will act as arbiter of any disputes in the work of Mental Health Act Managers arising either through the Mental Health Act Managers Forum or from individuals

- Performance and regulatory compliance

  - Will receive assurance from the MHL Operational Steering Group regarding the flow of Mental Health Act inspection reports and related Provider Action Statements.
  - Wil receive assurance from the MHAMs Forum regarding training, learning and development.
  - To provide relevant assurance to the Board as to evidence of compliance with the Care Quality Commission registration and commissioning requirements related to Mental Health Act.

- Training, clinical development and guidance

  - To monitor and recommend action to ensure there are adequate staff members/skill mix trained in the application of mental health legislation and there is sufficient training provided to maintain the required competency levels within clinical teams.
  - To oversee the development and implementation of good clinical practice guidelines and effective administrative procedures in regard to the Mental Health Act and Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and advise on any other matters pertinent to MCA within the Trust

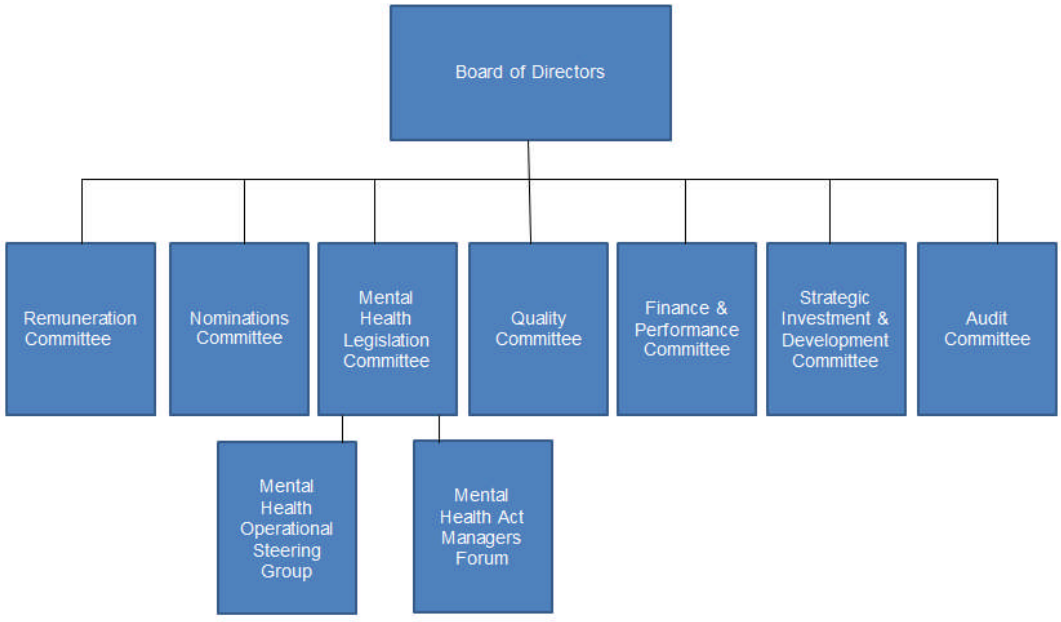
- Assurance

- To ensure adequate quality control arrangements are in place to enable:
  - Annual Mental Health Act report
  - Continuous monitoring arrangements
  - Agreed board reporting process
- To ensure there is an agreed programme of clinical audit and mechanisms for following up actions arising
- Receive the Board Assurance Framework and ensure that sufficient assurance is being received by the committee in respect of those strategic risks where it is listed as an assurance receiver
- Receive the quarterly documentation audit to be assured of the findings, how these will be addressed and progress with actions.

- User and carer involvement

  - To ensure there is a mechanism for service users, carers and other groups with an interest to contribute to discussions and agreement on proper use of the relevant legislation, with particular regard to the experience of compulsory detention and its therapeutic impact
  - Consider any feedback received from service user surveys.

7 RELATIONSHIP WITH OTHER GROUPS AND COMMITTEES



DUTIES OF THE CHAIRPERSON

The chair of the group / committee shall be responsible for:

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

- Ensuring everyone at the meeting has a reasonable chance to contribute to the discussion
- Ensuring discussions are productive, and when they are not productive they are efficiently brought to a conclusion
- Deciding when it is beneficial to vote on a motion or decision
- Checking the minutes
- Ensuring sufficient information is presented to the Trust Board of Directors in respect of the work of the group / committee.

It will be the responsibility of the chair of the committee to ensure that it (or any group that reports to it) carries out an assessment of effectiveness annually, and ensure the outcome is reported to the Trust Board along with any remedial action to address weaknesses. The chair will also be responsible for ensuring that the actions to address any areas of weakness are completed.

In the event of there being a dispute between any committees in the meeting structure it will be for the chairs of those committees to ensure there is an agreed process for resolution; that the dispute is reported to the committees concerned and brought to the attention of the Board of Directors; and that when a resolution is proposed that the outcome is reported back to all the committees concerned for agreement.

9 REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

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

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

Schedule of deputies

It may not be necessary or appropriate for all members (or attendees) to have a deputy attend in their absence. If this is the case please state below "no deputy required".

Full member (by job title)	**Deputy (by job title)**
Non-executive Director (Chair)	Non-executive Director second member
Non-executive Director	None
Director of Nursing	Executive Director (ideally with knowledge and experience of MHL)
Deputy Chief Operating Officer	Associate Director
Associate Director for Leeds Care Group	Another Associate Director / Deputy
Associate Director for Specialist Services	Another Associate Director / Deputy

Attendee (by job title)	**Deputy (by job title)**
Associate Medical Director for Mental Health Legislation	No deputy available to attend this Committee
ASC representative (for Leeds,)	
Head of Corporate Governance	Governance Officer
Mental Health Clinical Development Manager	Mental Health Legislation Team Leader / Law Advisor
MHA managers' nominated individual	Another MHA Manager
Governor	

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
9.2

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE Trust Board

PAPER TITLE:	Review of Mental Health Legislation (MHL) Committee Terms of Reference
DATE OF MEETING:	23 May 2019
PRESENTED BY: (name and title)	Margaret Sentamu, Non-Executive Director
PREPARED BY: (name and title)	Sarah Layton, Mental Health Legislation Team Leader

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 Trust Board is presented with an update to the Committees Terms of Reference.

The Terms of Reference have been updated to include delegated powers from the Trust Board in relation to remunerations to Mental Health Act Mangers and include updates to job titles since last review.

The Terms of Reference were reviewed and approved that the meeting of the MHL Committee on 15 May 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
	~~**Yes**~~ **/ No**	

RECOMMENDATION

The Trust Board is asked to note the updates to the Terms of Reference and ratify the Terms of Reference of the MHL Committee.

Leeds and York Partnership
NHS Foundation Trust

Mental Health Legislation Committee

Terms of Reference

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1 NAME OF GROUP / COMMITTEE

The name of this committee is the Mental Health Legislation Committee.

2 COMPOSITION OF THE GROUP / COMMITTEE

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

Members: full rights

Title	Role in the group / committee
Non-executive Director	Committee Chair
Non-executive Director	Deputy Chair
Director of Nursing	Executive Director with MHL Knowledge
Deputy Chief Operating Officer	Linkage to Care Services, Chair of the MHL Operational Steering Group

Attendees:

Title	Role in the group / committee	Attendance guide
Associate Medical Director for Mental Health Legislation	Advisory and technical expertise	Every meeting
~~Adult Social Care representatives (for Leeds,)~~Head of Service (Adult Social Care, Leeds)	Linkage to ~~social workers~~Local Authority	Every meeting
Associate Director for Corporate Governance	Linkage to Board and other sub-committees	As required
~~Mental Health Clinical Development Manager~~Head of Mental Health Legislation	Advisory and technical expertise	Every meeting
~~MHA managers' nominated~~	MHAM's perspective, experience and concerns	Every meeting

Title	Role in the group / committee	Attendance guide
~~individual~~Deputy Chair of Mental Health Act Managers Forum		
Associate Director for Leeds Care Group	Linkage to care services	Every meeting
Associate Director for Specialist Services	Linkage to specialist services	Every meeting
Governor	Observer with opportunity to contribute to discussions	Every Meeting

In addition to anyone listed above as a member, at the discretion of the chair of the committee the committee may also request individuals to attend on an ad-hoc basis to provide advice and support for specific items from its work plan when these are discussed in the meetings.

3 QUORACY

Number: The minimum number of members for a meeting to be quorate is 4. This must include the Chair / Deputy Chair of the meeting, the director of nursing and two nominated individuals (or their deputies), one to represent each care group. Attendees do not count towards quoracy. If the chair is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by the Deputy Chair.

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

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4 MEETINGS OF THE COMMITTEE

Frequency: The Mental Health Legislation Committee will normally meet every three months or as agreed by the Committee.

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

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

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

This committee is implemented as a part of the 2013 governance review

ROLE OF THE COMMITTEE

6.1 Purpose of the Committee

Objective	How the group / committee will meet this objective
Governance	The MHL Committee provides assurance to the Board

and compliance	regarding compliance with all aspects of the Mental Health Act 1983 and subsequent amendments and on compliance with all aspects of ~~mental health~~mental health legislation including, but not limited to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

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The MHL Committee has the following duties:

- Mental health legislation
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    - Formally submit an annual report on its activities and findings to the Board of Directors.
    - Consider and make recommendations on other issues and concerns in order to ensure compliance with the relevant mental health legislation and to promote best practice by adherence to the codes of practice.
    - Review the findings of other relevant reports functions, both internal and external to the organisation, and consider the implications for the governance of the organisation

- Mental Health Act Managers' Forum
    - The Mental Health Legislation Committee will ensure that the Mental Health Act Managers' Forum is supported to share experience, promote shared learning and raise concerns, where appropriate both amongst themselves and, with the Trust Board and management
    - The Mental Health Legislation Committee will act as arbiter of any disputes in the work of Mental Health Act Managers arising either through the Mental Health Act Managers Forum or from individuals

- Performance and regulatory compliance

  - Will receive assurance from the MHL Operational Steering Group regarding the flow of Mental Health Act inspection reports and related Provider Action Statements.
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  - To oversee the development and implementation of good clinical practice guidelines and effective administrative procedures in regard to the Mental Health Act and Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and advise on any other matters pertinent to MCA within the Trust

- Assurance

  - To ensure adequate quality control arrangements are in place to enable:
    - Annual Mental Health Act report
    - Continuous monitoring arrangements
    - Agreed board reporting process
  - To ensure there is an agreed programme of clinical audit and mechanisms for following up actions arising
  - Receive the Board Assurance Framework and ensure that sufficient assurance is being received by the committee in respect of those strategic risks where it is listed as an assurance receiver
  - Receive the quarterly documentation audit to be assured of the findings, how these will be addressed and progress with actions.

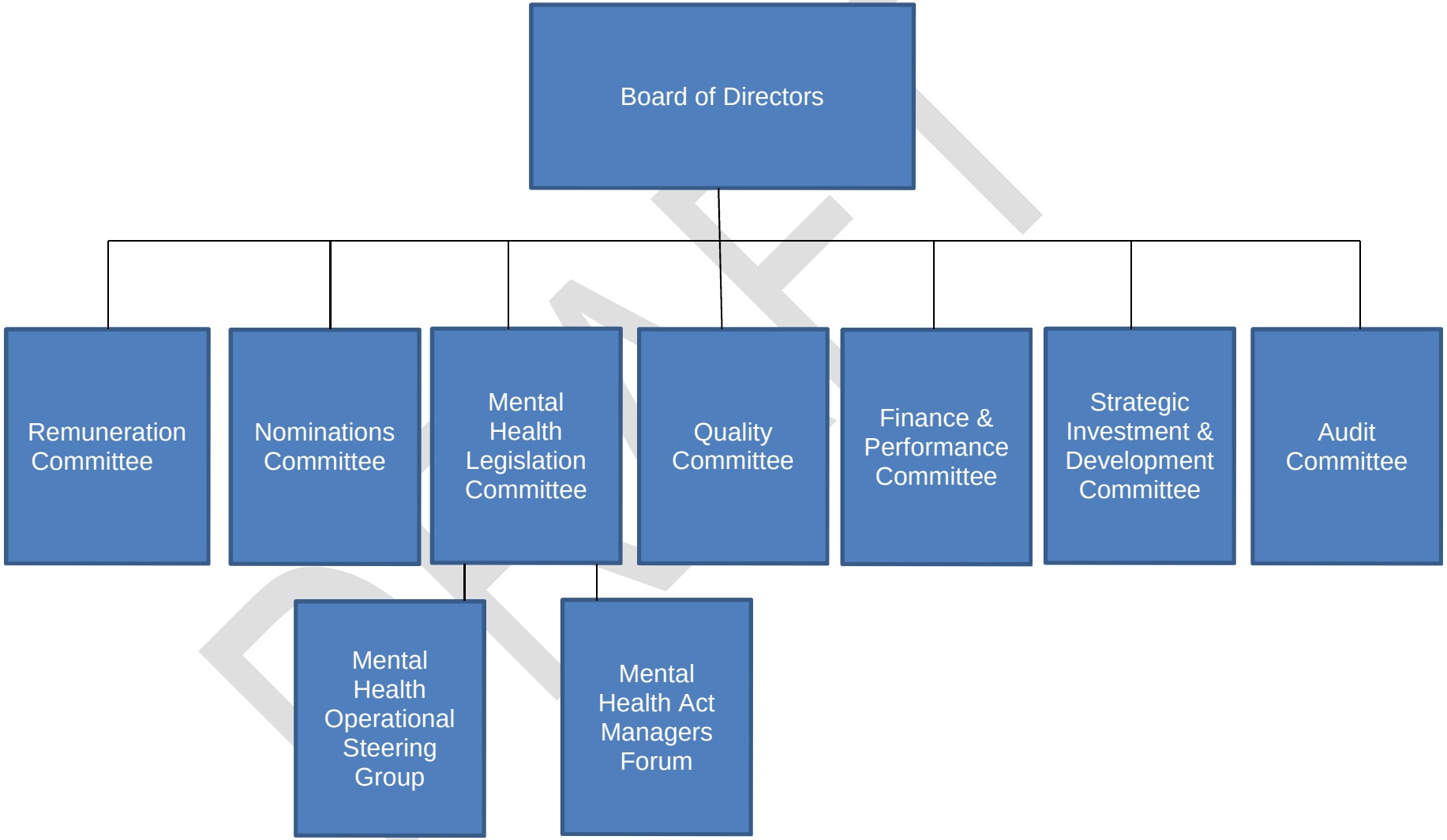
- User and carer involvement

  - To ensure there is a mechanism for service users, carers and other groups with an interest to contribute to discussions and agreement on proper use of the relevant legislation, with

particular regard to the experience of compulsory detention and its therapeutic impact

- Consider any feedback received from service user surveys.

7 RELATIONSHIP WITH OTHER GROUPS AND COMMITTEES



8 DUTIES OF THE CHAIRPERSON

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- Giving direction to the minute taker
- Ensuring everyone at the meeting has a reasonable chance to contribute to the discussion
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9 REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

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

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

Appendix 1

Schedule of deputies

It may not be necessary or appropriate for all members (or attendees) to have a deputy attend in their absence. If this is the case please state below "no deputy required".

Full member (by job title)	**Deputy (by job title)**
Non-executive Director (Chair)	Non-executive Director second member
Non-executive Director	None
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Attendee (by job title)	**Deputy (by job title)**
Associate Medical Director for Mental Health Legislation	No deputy available to attend this Committee
~~ASC representative (for Leeds,)~~Head of Service (Adult Social Care, Leeds)	Service Delivery Manager
Head of Corporate Governance	Governance Officer
~~Mental Health Clinical Development Manager~~Head of Mental Health Legislation	Mental Health Legislation Team Leader / Law Advisor
MHA managers' nominated individual	Another MHA Manager
Governor	

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
10.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Annual Report from the Audit Committee
DATE OF MEETING:	23 May 2019
PRESENTED BY: (name and title)	Martin Wright, Non-executive Director
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

The Terms of Reference for the Audit Committee requires it to make an annual report to the Board setting out how it has carried out its duties during the financial year.

At its meeting on the 16 April 2019 the committee received and agreed the attached annual report. The report provides the Board with an outline of the governance processes the committee has in place; the work it has undertaken during 2018/19; and any key issues it has found necessary to highlight to the Board. Its detail has been drawn from the Terms of Reference, the committee's work schedule and the minutes of all meetings in the timeframe.

The annual report also forms part of the process of governance for the Annual Governance Statement and provides assurance on the level of scrutiny of the key systems of control in place.

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 and to be assured that the committee has worked within its Terms of Reference and has escalated appropriately any key issues to the Board through the verbal reports made by the chair of the committee.

The Audit Committee

Annual Report

Financial Year 1 April 2018 to 31 March 2019

CONTENTS

1 PERIOD COVERED BY THIS REPORT

This report covers the work of the Audit Committee (the Board of Directors' primary governance committee) for the financial year 1 April 2018 to 31 March 2019.

2 INTRODUCTION

The Audit Committee provides an independent and objective review of our internal controls. It seeks high-level assurance on the effectiveness of: the Trust's governance (corporate and clinical); risk management; and systems of internal control. It reports to the Board of Directors on its level of assurance.

The committee receives assurance from the executive team and other areas of the organisation through reports, both regular and bespoke. It validates the information it receives through the work of internal audit, external audit, counter-fraud, and where appropriate, clinical audit. Assurance is also brought to the committee through the knowledge that non-executive directors gain from other areas of their work, not least their own specialist areas of expertise; attending Board and Council of Governors' meetings; visiting services; and talking to staff.

Further information about the work of the committee can be found in Section 7 below.

Should our external auditors (KPMG) carry out any non-audit work, the Audit Committee has responsibility for ensuring that their independence is maintained. The committee will do this by reviewing and approving the scope of the work and the fees charged prior to the work being undertaken.

The substantive membership of the Audit Committee is made up three non-executive directors. The Chair of the Trust may not be a substantive member of the committee, but is invited to attend one meeting during the financial year. The other non-executive directors may be invited to attend on an ad-hoc basis, either when it is deemed appropriate for other non-executive directors to attend for a particular agenda item, or to ensure quoracy.

Further information about the membership of the committee can be found in Section 5 below.

3 TERMS OF REFERENCE FOR THE AUDIT COMMITTEE

In July 2018 the committee reviewed its Terms of Reference (ToR) and found that only minor changes needed to be made. The revised Terms of reference were ratified by the Board of Directors in July 2018. The ToR relate to the work of the committee during 2018/19 and are attached to this report.

The committee also carried out a review of its effectiveness in July 2018 and concluded that there was a high level of effectiveness of the committee and that there were no areas of concern which it needed to bring to the attention of the Board.

4 MEETINGS OF THE COMMITTEE

In respect of the period covered by this report the committee met on five occasions:

- 17 April 2018
- 21 May 2018 (extraordinary meeting for the year-end accounts, annual report, quality report and compliance statements)
- 17 July 2018
- 20 November 2018
- 22 January 2019

5 MEMBERSHIP OF THE COMMITTEE AND ATTENDANCE AT MEETINGS

Membership of the Audit Committee is made up three non-executive directors.

The Chair of the Trust may not be a substantive member of the committee, but is invited to attend one meeting during the financial year. In 2018/19 the Chair attended the meeting in 20 November 2018.

The table below shows attendance for members of the committee for the period 1 April 2018 to 31 March 2019.

Attendance at Audit Committee meetings 2018/19

Name	17 April 2018	21 May 2018	17 July 2018	20 November 2018	22 January 2019
Substantive non-executive director members					
Martin Wright (chair of the committee)	✓	✓	✓	✓	✓
Margaret Sentamu	✓	✓	✓	X	✓
Helen Grantham	✓	✓	✓	✓	✓

During 2018/19 meetings of the Audit Committee were attended on a regular basis by the Chief Financial Officer; and the Associate Director for Corporate Governance.

Internal audit and counter fraud representation was provided by the NHS Audit Yorkshire. External audit representation was provided by the audit team from KMPG.

In addition to the officers that regularly attend the committee, invitations were extended to members of the executive team and senior managers who attended meetings to present papers and make assurances as required.

To ensure that committee members have the skills required to carry out their role on

the committee they have the opportunity to attend training courses. Some of these are provided by NHS Audit Yorkshire and they cover topics which are relevant specifically to members of the audit committees and also those which are relevant to the issues facing NHS organisations.

6 REPORTS MADE TO THE BOARD OF DIRECTORS

The chair of the Audit Committee makes a report regarding the most recent meeting of the committee at the next scheduled Board of Directors' meeting. This report assures the Board of the main items discussed by the committee. Should it be necessary to make the Board aware of any matters of concern this will be done by the chair of the committee in that report, and an outline given of how the committee will take this forward. Where the matter is of significant concern the committee will ask for direction from the Board, or it may be that the Board takes a decision to receive reports directly.

During 2018/19 the chair of the committee made reports to the April, May, July, November and January Board meetings. These assured the Board on matters that the committee had considered. Whilst these matters where identified for onward reporting to the Board there were no matters of significant concern that the committee felt necessary to escalate to the Board.

Conversely where the Board wants greater assurance on a matter this can be referred to the Audit Committee.

In July 2018 the Board asked the committee to receive assurances on the action plan to come from the audit of the Commercial Procurement Collaborative (CPC) procurement process in relation to the Bowel Cancer Screening Programme. The committee received a report from the CPC in relation to progress against the agreed actions and was able to provide assurance to the November 2018 Board meeting on those actions that had been completed and those that were still progressing. The Audit Committee received final assurance on the outstanding actions at the January 2019 committee meeting and concluded its assurance on this plan.

In addition to the reports made by the chair of the committee this annual report also goes to the Board of Directors. Once received by the Board it will go to the Council of Governors as one method of providing assurance as to how the non-executive directors have held the executive directors to account for the performance of the Board. It also provides the Council with an outline of the work carried out by the external auditors (whom they appoint). The committee's Annual Report for 2017/18 was presented to the 3 July 2018 Council of Governors' meeting by Martin Wright.

7 THE WORK OF THE COMMITTEE DURING 2018/19

For 2018/19 the chair and members of the Audit Committee confirm that the committee has fulfilled its role as the primary governance and assurance committee in accordance with its Terms of Reference, which are attached at Appendix 1 for information.

In 2018/19 the committee approved the work plans for both the internal and external auditors and the counter-fraud service. It received and reviewed both regular progress reports and concluding annual reports for the work of internal and external audit and the counter-fraud team. This allowed the committee to determine its level of assurance in respect of progress with various pieces of work and the findings. These reports have also provided assurance on the Trust's internal controls. The committee assessed the effectiveness of these functions by reviewing the periodic reports from the auditors and monitoring the pre-agreed key performance indicators.

Areas of work on which the committee received assurance during 2017/18 are set out below. Details of the work of the committee can be found in the minutes of its meetings which are available from the Associate Director for Corporate Governance (chill29@nhs.net).

Quality Report:

- At its May 2018 reviewed the Quality Report for 2017/18 before being presented to the Board of Directors for approval. It also received the audit report on the Quality Report for 2017/18 and was advised that there were no significant matters to report.

Risk Management:

- The Director of Nursing, Professions and Quality attended the committee to make assurances on the risk management system and the system for recording risks, noting that significant progress had been made in relation to these systems.

Health and Safety:

- The committee received assurances on the actions being taken to address the findings from a Health and Safety Executive Inspection that had taken place in 2018. A final report will be presented to the April 2019 meeting.
- It also asked to be assured on the management arrangements in respect of Health and Safety noting that an external consultant had been appointed to look in detail at these arrangements and make recommendations. The committee will continue to receive assurances on the sufficiency of the arrangements and the actions needed to strengthen these through 2019/20.

Board Assurance Framework:

- Received the Board Assurance Framework for assurance on both the content and the process.

Annual Report and Accounts for 2017/18:

- The Annual Report and Accounts for 2017/18 were reviewed prior to being presented to the Board of Directors for adoption in May 2018
- The ISA 260 (which is the report to those charged with governance on the annual accounts) was also received and the findings from the audit of the annual accounts discussed. It was noted that there were no matters of any significance to bring to the committee's attention by the auditors
- The Head of Internal Audit Opinion and the Annual Governance Statement were reviewed and found to be consistent
- Assurance was received on the process for the declarations required by

General Condition G6 and Condition FT4 (for foundation trust governance) of the NHS Provider Licence
- Reviewed the Corporate Governance Statement and the statement on training for governors and was assured of the process by which the declarations were made and the completeness of the evidence provided to support the statements
- Reviewed compliance with NHS Improvement's Code of Governance.

Internal Audit, Counter-fraud:
- Approved the Audit Annual Plan and the Counter Fraud Annual Plan for 2018/19
- Received assurances about the processes in place to tackle fraud and bribery
- Received internal audit progress reports on a regular basis to update the committee on the major findings, with assurance being provided on the actions taken to address any weaknesses in the systems of control
- The Internal Audit Annual Report was received which brought together all the findings from across the year
- Local Counter-fraud progress reports were received on a regular basis in respect of those cases that can be reported to the committee in order to update the committee on the major findings and any lessons learnt from individual cases
- The Counter-fraud Annual Report was also received which brought together to work from across the year.

In addition to the update reports received from Internal Audit the committee also received specific assurances from the lead executive directors in respect of "limited assurance" reports. For 2018/19 these were in respect of the audit on Delayed Transfers of Care (DToC) and Out of Area Placements and the audit of the Appraisal Process. The lead executive directors assured the committee on the actions being taken to address the recommendations and also on the progress against those actions.

External audit:
- Reviewed and approved the work plan for 2018/19 and the associated fee
- Received regular update reports about the work of the auditors and also information about changes within the health sector which will impact on the Trust
- Received details of relevant sector updates along with assurances on how the executive directors had implemented or taken account of the guidance contained in the update report.
- Reviewed the wording for the year-end Letter of Representation.

Action Tracking:
- Received regular reports in respect of progress with the implementation by managers of agreed audit recommendations and sought assurance on progress in particular with a number of old and outstanding actions. The committee also received specific assurance on the process for dealing with and monitoring outstanding actions, with particular reference to the role of the Executive Risk Management Group which has oversight of the actions.

Registers:

- The committee carried out a review of the Hospitality Register, the Sponsorship Register, register for the use of Management Consultants and the Losses and Special Payments Register, to ensure the appropriateness and completeness of the content.

Tender and Quotation Exception reports:

- Assurance received on the reasons for the Tender and Quotation procedures being waived during 2018/19.

Other governance items:

- Reviewed and approved changes to the Scheme of Delegation.

Supported the Trust becoming a formal member of the NHS Audit Yorkshire Consortium

- The committee received a report from the Chief Financial Officer (CFO) which set out the intention for the Trust to be a formal member of the NHS Audit Yorkshire consortium rather than a client. The committee noted the reasons for this, not least the financial benefits, and supported the decision of the CFO.

8 Conclusion

As the primary governance committee of the Board of Directors the Audit Committee preserved its independence from operational management by not having executive membership (although executive directors support the committee by providing information and context only).

It added value by maintaining an open and professional relationship with internal and external audit, counter-fraud and clinical audit. It carried out its work diligently, discussed issues openly and robustly, and kept the Board of Directors apprised of any possible issues or risks. The Audit Committee fulfilled its work programme for 2018/19 and provided assurances to the Board for any issues referred to it.

The chair of the Audit Committee considers that the committee has fulfilled its role as the Board of Directors' senior governance committee and provided assurance to the Board on the adequacy and effective operation of the organisation's internal control systems.

Members of the Audit Committee would like to thank all those who have responded to its requests during the year and who have supported it in carrying out its duties.

April 2019

Martin Wright
Chair of the Audit Committee

APPENDIX 1

AUDIT COMMITTEE

Terms of Reference

(Ratified by the Board of Directors - 28 July 2018)

1 NAME OF COMMITTEE

The name of this committee is the Audit Committee.

2 COMPOSITION OF THE GROUP / COMMITTEE

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

Members

Title	Role in the committee
Non-executive director	Committee chair and responsible for evaluating the assurance given and identifying if further consideration / action is needed.
2 non-executive directors	Responsible for evaluating the assurance given and identifying if further consideration / action is needed. Either of the routine non-executive members may chair if the chair of the committee is absent.

While specified non-executive directors will be regular members of the Audit Committee any other non-executive can attend the meeting on an ad-hoc basis if they wish and will be recognised as a member for that particular meeting and if necessary will count towards the quoracy.

In attendance

Title	Role in the committee	Attendance guide
Chief Financial Officer	Key responsibilities regarding audit and reporting	Every meeting
Internal Audit representation	Independent assurance providers	Every meeting
External Audit representation	Independent assurance providers	Every meeting
Local Counter Fraud representation	Independent assurance providers	Dependant on the agenda

Title	Role in the committee	Attendance guide
Associate Director for Corporate Governance	Committee support and advice	Every meeting

The chair of the Audit Committee shall be seen as independent and therefore must not chair any other governance committee either of the Board of Directors or wider within the Trust.

Executive directors and other members of staff may attend by invitation in order to present or support the presentation of agenda items / papers to the committee. In particular, executive directors will be invited to attend a meeting where a limited assurance report has been issued by Internal Audit and is on the agenda to be discussed.

The Chair of the Trust and the Chief Executive will be invited to attend the Audit Committee once per year.

3 QUORACY

Number: The minimum number of members for a meeting to be quorate is 2. Attendees do not count towards this number. If the chair of the committee is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by another non-executive director.

Deputies: Non-executive directors do not have deputies. Non-core non-executive directors may be asked to attend if there is a risk to the meeting not being quorate.

Attendees should nominate a deputy to attend in their absence. A schedule of deputies, attached at appendix 1, this should be reviewed at least annually to ensure adequate cover exists.

Non-quorate meeting: Non-quorate meetings may go forward unless the chair decides otherwise. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

Alternate chair: If the Chair of the Audit Committee is not available the meeting shall be chaired by one of the other non-executive directors.

4 MEETINGS OF THE COMMITTEE

Frequency: The Audit Committee will normally meet as required but will in any case meet no fewer than four times per year.

Urgent meeting: Any of the committee members may, in writing to the chair, request an urgent meeting. The chair will normally agree to call an urgent meeting to discuss the specific matter unless the opportunity exists to discuss the matter in a more expedient manner (for example at a Board meeting).

Minutes: The Associate Director for Corporate Governance will ensure there are minutes of the meeting and that appropriate support for the meeting is provided. The minutes will be provided to the Chair of the committee for checking.

The chair will give a verbal update to the Board of Directors which may be in advance of the Audit Committee formally approving the minutes of the prior meeting. This is to ensure any urgent information is reported promptly to the Board of Directors.

Private Sessions of the Committee

At least once a year the committee will meet privately with representatives from internal audit and external audit.

At the discretion of the chair of the committee, it may also choose to meet privately with the Director of Finance and any other key senior officer in the Trust as may be required.

Members of the committee will also meet together in private at a frequency determined by the Chair.

5 AUTHORITY

Establishment: In accordance with the NHS Act 2006 and the Code of Governance the Board of Directors is required to establish an Audit Committee as one of its sub-committees.

Powers: The committee is a non-executive committee of the Board of Directors and has no executive powers. The committee is authorised by the Board of Directors to seek assurance on any activity. It is authorised to seek any information or reports it requires from any employee, function, group or committee; and all employees are directed to co-operate with any request made by the committee.

The committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of persons outside the Trust with relevant experience and expertise if it considers this necessary.

Cessation: The Audit Committee is a standing committee in that its responsibilities and purpose are not time limited. While the functions of the Audit Committee are required by statute the exact format may be changed as a result of its annual review of its effectiveness.

In addition, the Trust should periodically review its governance structure for continuing effectiveness and as a result of such a review the Board may seek to alter the format or the number of non-executive director core members of the Audit Committee.

6 ROLE OF THE COMMITTEE

6.1 Purpose of the Committee

The purpose of the Audit Committee is to provide the Board of Directors with assurance that:

- Clinical, financial reporting, compliance, risk management, and internal control principles and standards are being appropriately applied and are effective, reliable and robust
- An effective governance framework is in place for monitoring and continually improving the quality of health care provided to service users to enable the Trust's strategic objectives to be achieved.

Objective	How the group / committee will meet this objective
We deliver great care that is high quality and improves lives	The Audit Committee has a core responsibility to scrutinise the Trust's governance arrangements to determine that these are operating effectively and that the Trust is able to provide high quality care through these arrangements.
We use our resources to deliver effective sustainable care	The Audit Committee exercises scrutiny of the annual financial reporting of the organisation; on-going financial health; and controls designed to deliver efficiency, effectiveness and economy for all Trust functions

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

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

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

6.3 Duties of the group / committee

Notwithstanding any area of business on which the committee wishes to receive assurance the following shall be those items on which the committee shall receive assurance:

Board Assurance Framework

- Be assured that the organisation has in place an effective Board Assurance Framework

- Be presented with the Board Assurance Framework and receive assurance that this presents the up to date position in respect of controls, assurances and that gaps are being addressed, and be assured as to the completeness of the information included in the Framework
- Use the Board Assurance Framework to inform the committee's forward work plan, in particular focussing on those gaps that pose a major risk to the organisation.

Quality Report

- Be assured in respect of the process for delivering the Quality Report
- Be presented with the final version of the Quality Report before being presented to the Board
- Be presented with the audit opinion on the Quality Report and be advised as to the findings and be assured that the recommendations are being addressed by management and be assured that there are no (or otherwise) significant findings.

Risk Management

- Receive assurance as to the Risk Management Process (including structures processes and responsibilities for managing key risks), including the process for capturing and reviewing high and extreme risks.

Health and Safety

- Receive an annual report on health and safety management within the Trust.

Compliance and Disclosure Statements

- Be assured of the action taken by officers who have operated outside of the tender and quotation procedures
- Be presented with notification of any waivers of the Standing Financial Instructions and Standing Orders (for the Board of Directors and Board of Governors) and be assured of their appropriateness.

Annual Accounts and Annual Report

- Be presented with and review the main items / contentious items in the Annual Accounts, taking advice from the Chief Accounting Officer and the External Auditors as to accuracy, prior to advising the Board if the Accounts can be adopted
- Be presented with the ISA260 Report on the Annual Accounts and be assured as to the findings and the management actions agreed, also be assured that either there were no (or otherwise) significant findings
- Be presented with a periodic report setting out the progress against the recommendations made in the ISA 260 reports (pertaining to the last set of

annual accounts), and be assured as to progress against recommendations / action plans.

Annual Governance Statement and Head of Internal Audit Opinion

- Be presented with the draft Annual Governance Statement and have an opportunity to input to the content
- Be presented with the final version of the Annual Governance Statement and be assured that it provides an accurate picture of the processes of internal control within the organisation
- Be presented with the Head of Internal Audit Opinion and be assured that this is an accurate assessment of the Trust and also be assured that the opinion is in accordance with the Annual Governance Statement.

Registers

- Be presented with the Losses and Special Payments Report to be assured as to the appropriateness of payments made and that control weaknesses have been addressed
- Be presented with the Sponsorship Register to be assured that it is complete and that sponsorship received by the organisation / individuals is appropriate and has been applied for according to the procedure
- Be presented with the Hospitality Register to be assured that it is complete and that hospitality received by individuals is appropriate, proportionate, and unable to be considered an inducement and has been recorded according to the procedure
- Be presented with the register of Management Consultants to be assured that it is complete and that consultants have been appointed appropriately, and according to the procedure.

Internal Audit

- The committee shall ensure there is an effective Internal Audit function established by management that meets mandatory NHS Internal Audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

    - Consideration of the provision of the Internal Audit service, the cost of the audit function and (where the service is provided in-house) any questions of resignation and dismissal
    - Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation
    - Consideration of the major findings of Internal Audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources

- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing with the organisation.

External Audit

- The committee shall review the work and findings of the External Auditor. In addition to this the committee will:

    - Make recommendations to the Council of Governors as to the appointment, reappointment, termination of appointment and fees of the External Auditor, and if the Council of Governors rejects the Audit Committee's recommendations, it will prepare an appropriate statement for the Board of Directors to be included in the Trust's Annual Report
    - Review the audit program of work and fees and discuss with the External Auditor, before audit work commences, the nature and scope thereof
    - Review External Audit reports together with the management response, and the annual governance report (or equivalent)
    - Consider whether it is appropriate and beneficial to the Trust for the External Auditor to undertake investigative and advisory work for the Trust.

Counter Fraud

- The committee's responsibilities regarding counter fraud are governed by Section 47 of the Base Model Contract between Foundation Trusts and PCTs and Schedule 13 of this contract and the duties of the Audit Committee are set out in this contract specifically that:

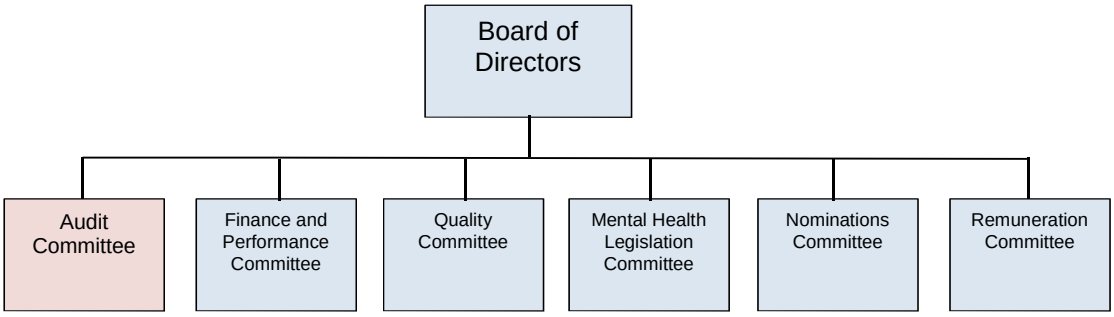
    - The committee shall allow the Local Counter Fraud Specialist service (LCFSs) to attend Audit Committee meetings
    - The committee shall receive a summary report of all fraud cases from the LCFSs
    - The committee shall receive reports from the LCFSs regarding weaknesses in fraud related systems
    - The committee shall receive and review the LCFSs' Annual Report of Counter Fraud Work
    - The committee shall receive the LCFSs' annual work plan for comment.

7 RELATIONSHIP WITH OTHER GROUPS AND COMMITTEES

The Audit Committee is the primary governance committee providing an overarching governance role, having a direct relationship with other Board sub-committees.

The Board sub-committees will provide one of the main sources of assurance to the Audit Committee. However, this assurance will be validated by the work of, and reports from other sources of assurance including, but not exclusively, Internal Audit, External Audit, Counter Fraud Services,.

The following is a diagram setting out the governance structure in respect of assurance:



8 DUTIES OF THE CHAIRPERSON

The chair of the group / committee shall be responsible for:

- Agreeing the agenda
- Directing the meeting ensuring it operates in accordance with the Trust's values
- Giving direction to the minute taker
- Ensuring everyone at the meeting has a reasonable chance to contribute to the discussion
- Ensuring discussions are productive, and when they are not productive they are efficiently brought to a conclusion
- Deciding when it is beneficial to vote on a motion or decision
- Checking the minutes
- Ensuring sufficient information is presented to the Board in respect of the work of the group / committee
- Ensuring the Chair's report is submitted to the Board as soon as possible.

It will be the responsibility of the chair of the Audit Committee to ensure that the committee carries out an assessment of the committee's effectiveness annually, and ensure the outcome is reported to the Board of Directors along with any remedial action to address weaknesses. The chair will also be responsible for ensuring that the actions to address any areas of weakness are completed.

In the event of there being a dispute between any groups in the hierarchy it will be for the chairs of those groups to ensure there is an agreed process for resolution; that the dispute is reported to the groups concerned and brought to the attention of the "parent group"; and that when a resolution is proposed that the outcome is reported back to the all groups concerned for agreement.

9 REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

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

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

Schedule of deputies

It may not be necessary or appropriate for all members (or attendees) to have a deputy attend in their absence. If this is the case please state below "no deputy required".

Full member (by job title)	**Deputy (by job title)**
Not applicable as non-executive directors do not have deputies	

Attendee (by job title)	**Deputy (by job title)**
Chief Financial Officer	Deputy Director of Finance
Chief Operating Officer	Deputy Chief Operating Officer
Associate Director for Corporate Governance	Governance Officer

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
11.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Annual Report from the Finance and Performance Committee
DATE OF MEETING:	23 May 2019
PRESENTED BY: (name and title)	Sue White, Non-executive Director
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

The Terms of Reference for the Finance and Performance Committee requires it to make an annual report to the Board setting out how it has carried out its duties during the financial year.

At its meeting on the 23 April 2019 the committee received and agreed the attached annual report. The report provides the Board with an outline of the governance processes the committee has in place; the work it has undertaken during 2018/19; and any key issues it has found necessary to highlight to the Board. Its detail has been drawn from the Terms of Reference, the committee's work schedule and the minutes of all meetings in the timeframe.

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 and to be assured that the committee has worked within its Terms of Reference and has escalated appropriately any key issues to the Board through the verbal reports made by the chair of the committee.

The Finance and Performance Committee

Annual Report

Financial Year 1 April 2018 to 31 March 2019

CONTENTS

1 PERIOD COVERED BY THIS REPORT

This report covers the work of the Finance and Performance Committee for the financial year 1 April 2018 to 31 March 2019.

2 INTRODUCTION

The Finance and Performance Committee has powers delegated to it by the Board to seek high-level assurance on the controls and management in respect of financial governance, and business and growth opportunities focusing on areas including: the financial data for submission to the Board; the financial plan; the procurement strategy; income contracts; the information technology and information governance strategies; the capital programme; estates strategy; business planning and growth opportunities; and emergency planning and resilience.

This report covers the work the committee has undertaken at the meetings held during 2018/19. It seeks to assure the Board on the work it has carried out and the assurances received, and to demonstrate that it has operated within its Terms of Reference. The Committee is currently undertaking an effectiveness review and results of this will be presented to the Committee meeting on the April 2019.

Membership of the Finance and Performance Committee is made up of three non-executive directors; the Chief Financial Officer, the Chief Operating Officer, and the Director Organisational Development and Workforce. The Committee is chaired by a non-executive director (NED), Sue White (from the period of 22 May 2018). The first meeting of this financial year was chaired by Steven Wrigley-Howe in April 2018; he since then stepped down but remained a member until his term of office ended on the 16 February 2019. The Committee also has as one of its non-executive director members the Chair of the Audit Committee (Martin Wright). This NED provides independent financial expertise to the Committee. The other NED member is Andrew Marran who joined the Committee in March 2019.

Should the NED chair be unable to chair the meeting this role will fall to one of the other NEDs, but not the Chair of the Audit Committee. This allows the Chair of the Audit Committee to maintain a high degree of independence within the governance structure as required by the Audit Committee handbook.

Further information about the membership of the committee can be found in Section 6 below.

Secretariat support is provided by the Corporate Governance Team in relation to agenda planning, minutes and general meeting support.

3 ASSURANCE

The Committee receives assurance from the executive director members of the Committee and from the subject matter experts (key senior members of staff) who attend each meeting on a regular basis. This includes the Assistant Director of Finance; the Chief Information Officer; and others who may be required to attend as necessary.

Assurance is provided through written reports, both regular and bespoke, through

challenge by members of the Committee and by members seeking to validate the information provided through a wider knowledge of the organisation; specialist areas of expertise; attending Board of Directors', and Council of Governors' meetings; visiting services and talking to staff.

The Committee is assured that it has the right membership to provide the right level and calibre of information and challenge and that the right reporting methods, structures and work plan are in place to provide oversight on behalf of the Board in respect of performance in the areas covered by its Terms of Reference.

Part of its assurance role is to receive the Board Assurance Framework (BAF); a primary assurance document for the Board. The BAF details the key controls in place to ensure that the risks to achieving the strategic objectives are well managed. The BAF lists the committees that are responsible for receiving assurance in respect of the effectiveness of the controls. The Finance and Performance Committee is asked to note those where it is listed as an assurance receiver to confirm that it has received sufficient assurance through the reports presented to the Committee, or to commission further information where there is a lack of assurance (actual or perceived).

The Committee reviews the BAF on a quarterly basis prior to it being presented to the Board of Directors. During 2018/19 this was discussed at the Committee meetings and each time it confirmed that it had received sufficient assurance in regard to those risks where it was named as an assurance receiver. At the Committee meeting on the 26 March 2019 it was noted that the strategic risks would be reviewed to ensure they continue to reflect the needs of the organisation. These will be reflected in the 2019/20 BAF.

4 TERMS OF REFERENCE FOR THE FINANCE AND PERFORMANCE COMMITTEE

In April 2019 the Terms of Reference for the Finance and Performance Committee were reviewed. These were amended to include the Director of Workforce Development as a member of the Committee. It was agreed that their attendance at meetings would be dependent on the agenda items being discussed.

5 MEETINGS OF THE COMMITTEE

In 2018/19 the Committee met on eight occasions:

- 24 April 2018
- 22 May 2018
- 24 July 2018
- 25 September 2018
- 23 October 2018
- 18 December 2018
- 29 January 2019
- 26 March 2019

The Chair of the Committee agreed the agendas for each of the meetings and a full set of papers was circulated to members of the Committee within the agreed timescales. All actions pertaining to the meetings of the Committee were tracked on a cumulative action log and presented to each meeting by the Corporate Governance Team for assurance with progress made.

6 MEMBERSHIP OF THE COMMITTEE AND ATTENDANCE AT MEETINGS

The substantive membership of the Committee is made up of three non-executive directors; the Chief Financial Officer, the Chief Operating Officer and Director Organisational Development and Workforce. The Committee is attended by a number of subject matter experts (as listed in the Terms of Reference). The table below shows the attendance of substantive members for the meetings that took place during 2018/19.

Attendance at the Committee meetings by substantive members

- stipulates when apologies had been given by a member for a particular meeting

Name	24 April 2018	22 May 2018	24 July 2018	25 Sept 2018	23 October 2018	18 December 2018	29 January 2019	26 March 2019
Andrew Marran (from 17 February 2019) (Non-Executive Director)								✓
Sue White (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓
Steven Wrigley-Howe (up until 16 February 2019) (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	
Martin Wright (Non-Executive Director)	✓	✓	-	✓	✓	✓	✓	✓
Joanna Forster Adams (Chief Operating Officer)	✓	✓	-	✓	✓	✓	✓	✓
Dawn Hanwell (Chief Financial Officer & Deputy Chief Executive)	✓	✓	✓	✓	✓	✓	✓	✓
Claire Holmes (Director of Organisational Development and Workforce from 1 October 2018)					-	-	-	-
Lindsay Jensen (Interim Director of Workforce Development from 1 June 2018)			✓	✓				
Susan Tyler (Director of Workforce Development until 31 May 2018)	✓	-						

The Committee is also attended by senior managers (subject matter experts); some attend on a regular basis (marked *) and other attend only when they have a specific paper to present or reason to attend (marked **). Attendance is shown in the following table.

Attendance at Finance and Business Committee meetings by formal attendees

Name	24 April 2018	22 May 2018	24 July 2018	25 Sept 2018	23 October 2018	18 December 2018	29 January 2019	26 March 2019
David Brewin, Deputy Director of Finance *	✓	-	-	✓	✓	✓	✓	✓
Bill Fawcett, Chief Information Officer *	✓	-	✓	-	-	✓	✓	✓
Cath Hill, Associate Director for Corporate Governance *		✓	✓	✓	✓	✓	-	✓
Victoria Betton, Mental Health Programme Director **		✓				✓		
Keith Rowley, Managing Director of North of England Commercial Procurement Collaborative **	✓		✓		✓			

7 REPORTS MADE TO THE BOARD OF DIRECTORS

The Chair of the Finance and Performance Committee makes a verbal report regarding the most recent meeting of the Committee to the next available Board of Directors' meeting. This verbal report seeks to assure the Board on the main items discussed by the Committee and allows an opportunity to escalate to the Board any matters of concern or urgent business which the Committee is unable to conclude. The Board may then decide to give direction to the Committee as to how the matter should be taken forward or it may agree that the Board deals with the matter itself.

Having received the verbal reports from the Chair of the Committee there were no matters on which the Board asked for further update or clarification and it was assured that the Finance and Performance Committee was progressing matters appropriately.

Where the Board wants greater assurance on any matters that are within the remit of the Terms of Reference of the Committee the Board may ask for these to be looked at in greater detail by the Committee. In 2018/19 the Board did not delegate any matters to the Committee over and above its Terms of Reference.

Date of meeting	Verbal report to Board by chair
24 April 2018	27 April 2018
22 May 2018	24 May 2018
24 July 2018	26 July 2018
25 September 2018	27 September 2018
23 October 2018	25 October 2018
18 December 2018 & 29 January 2019	31 January 2019
26 March 2019	28 March 2019

8 THE WORK OF THE COMMITTEE DURING 2018/19

During 2018/19 the Chair of the Finance and Performance Committee confirmed that the Committee has carried out its role in accordance with its Terms of Reference, which are attached at Appendix 1 for information. Further details of all of these areas of work can be found in the minutes and papers of the Committee (some of which will not be publically available due to them being 'commercial in confidence' in nature and content).

Areas of work on which the Committee has received assurance on during 2018/19 are set out below.

Financial performance and forecast out-turn:

- received and reviewed in detail the Financial Plan for 2018/19 looking at the key financial risks associated with the plan, noting that whilst the Trust would slightly exceed the control total this was due to one off fortuitous items received in year and that the underlying position was one of the Trust being in deficit
- received assurance in regard to the development of the financial plan
- reviewed in detail the financial performance reports at each meeting, noting the underlying deficit and seeking to understand the fortuitous non-recurrent benefits that the Trust had received during the year and the impact on the longer-term financial outlook
- received the year-end financial out-turn prior to this being reported to the Board
- reviewed progress against the Trust's Cost Improvement Programme
- received confirmation of the outcome of the reference costs, noting that this had provided significant assurance
- received assurance on the Trust's financial risk rating; noting that during the year this had initially reduced from a score 1 to 2, mainly due to the breach of the agency cap, but had returned to a rating of 1 in October 2018
- received assurance on the Trust's agency spend, including the need to bring in specialist expertise to support the work being carried out by the North of England Commercial Procurement Collaborative, and locums to support the medical workforce.
- reviewed the Trust's capital programme
- sought assurance as to the systems and processes in place for developing an action plan that will monitor the delivery of the Lord Carter recommendations.

Procurement:

- received update reports on how the Trust's Procurement Workplan was being progressed and how it was delivering savings in the Trust
- received an update on the development of the Trust's Procurement Dashboard, which demonstrated the level of compliance with required standards when purchasing goods and services
- noted that the future focus for procurement work streams was the delivery of sustainable efficiencies.

Estates:

- received assurances on the progress with the PFI refinancing and reshaping to improve the commercial performance of the contract
- considered the business case for the PFI refinancing arrangements and recommended the refinance of the PFI to the Board
- received updates against the Strategic Estates Plan (SEP) 2018-21, which now included two major strategic schemes; a proposed significant development on St James' site, and the construction of the CAMHS Tier 4 on the St Mary's Hospital site
- undertook a detailed review of the business case for the National Centre for Psychological Medicine in advance of it being presented to the Board at its Extraordinary meeting in December 2018
- assessed the situation in relation to the Interserve contract and the assurances that any risks were being managed appropriately
- received the draft Sustainable Development Management Plan, approved the Trust's vision for sustainability and agreed to receive six monthly updates of progress against the agreed action plan targets.

Clinical Contracts:

- received regular reports in relation to progress against clinical contracts, noting any risks
- received assurance on the developments supporting the procurement and funding options for Tier 4 CAMHS
- received regular updates on the Gender Identity Service and the publication of a tender for the service in 2019.

Informatics

- reviewed the Strategic Health Informatics Plan and were assured that the plan was in line with the Trust's overall Strategy
- noted that CareWorks were awarded the contract for the Trust's new Electronic Patient Recording system and received subsequent progress updates on the new Electronic Patient Record System (CareDirector)
- sought assurance on the Trust's approach to potential digital and cyber risks
- received assurance on the actions taken following the recommendations from last PEN test whilst working towards meeting the criteria for Cyber Essentials Plus
- received regular assurance reports and the Annual Report from the Information Governance Group

Performance:

- reviewed the financial and service sections of the Combined Quality and Performance Report at each meeting and reviewed assurance on the actions taken

to improve performance related issues
- sought assurance on demand and capacity issues relating to Out of Area Placements and bed occupancy rates, and in particular the impact winter would have on these areas
- received assurance in regard to there being a costed action plan to meet the 2019/20 trajectory for Out of Area Placements and were made aware of the risks to achieving the plan
- received assurances regarding actions taken in response to the Becklin fire
- endorsed the four priorities within the patient flow and capacity diagnostic summary
- received a Report on Partnerships which described and assessed the current partnership arrangements in place across the Trust and considered how new partnership arrangements could be developed
- supported a recommendation to the Board for the Trust to sub-contract Early Intervention in Psychosis services to Community Links
- received assurance on the short and longer-term solutions that were being sought as a result of the system review undertaken by Niche and Newton Europe in relation to capacity and the demand and flow issues.

North of England Commercial Procurement Collaborative (NoE CPC):
- received regular update reports on the North of England Commercial Procurement Collaborative and were assured of the financial progress being made
- received regular progress updates in relation the forming of the Limited Liability Partnership: NHS CPP LLP
- sought assurance on the issue of trade union recognition for staff who had 'TUPED' into the Limited Liability Partnership from the NHS

mHabitat:
- reviewed and supported the investment case for the Trust to consider hosting Co>Space North as a founding sponsor
- received the 2019/20 business plan for Co>Space North to provide income generating consultancy services provided to the public, third and commercial sectors
- reviewed mHabitat's proposed strategic direction with the associated risks and opportunities and agreed that a review of options would come back to this Committee for consideration in 2019.

Business Continuity:
- received assurance on Trust's systems in relation to business continuity should the Trust's IT systems fail
- received the Emergency Preparedness Resilience and Response (EPRR) Annual Report and Assurance.

8 Conclusion

The Chair of the Finance and Performance Committee would like to assure the Board of Directors that the Finance and Performance Committee has fulfilled its Terms of Reference during 2018/19 and has provided assurance to it in respect of financial governance focusing on areas including: the financial data; the financial strategy; the procurement strategy; income contracts; the information technology and information governance

strategies; the capital programme; estates strategy; business planning and growth opportunities; emergency planning and resilience, and the initiation of performance reporting structures and the governance supporting these.

It has added value by maintaining an open and professional relationship with officers of the Trust and has carried out its work diligently; discussed issues openly and robustly; and kept the Board of Directors apprised of any possible issues or risks.

Members of the Finance and Performance Committee would like to thank all those who have responded to its requests during the year and who have supported it in carrying out its duties.

April 2019

Sue White
Chair of the Finance and Performance Committee

Finance and Performance Committee

Terms of Reference

1 NAME OF GROUP

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

2 COMPOSITION OF THE GROUP

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

Members:

Title	Role in the committee
Non-executive Director	Committee Chair
Non-executive Director	Additional non-executive member (see section 3) – Chair of the Audit Committee
Non-executive Director	Additional non-executive member (see section 3) – Deputy Chair, they must not also be the Chair of the Audit Committee
Chief Financial Officer	Executive lead for financial resources within the Trust. Assurance and escalation provider to the Finance and Performance Committee.
Chief Operating Officer	Executive Director with day to day responsibility for operational delivery of services and performance. Assurance and escalation provider to the Finance and Performance Committee.
Director of Organisational Development & Workforce	Executive lead for workforce development. Assurance and escalation provider to the Finance and Performance Committee. Attendance at meetings will be dependent on the agenda items being discussed.

Attendees
The Finance and Performance Committee may also invite other members of Trust staff, its non-executive directors, and partners to attend to provide

advice and support for specific items from its work plan when these are discussed in the Committee's meetings.
These could include, but are not exhaustive to, the following individuals:

- Managing Director North of England Commercial Procurement Collaborative
- Director of mHabitat
- Chief Information Officer
- Assistant Director of Finance
- Head of Facilities
- Head of Corporate Governance.

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

2.1 Governor Observers

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

At the meeting the governor observer(s) will be required to declare any interest they may have in respect of any of the items to be discussed (even though they are not formally part for the discussion). The Chair of the Committee has the right to request any present governor be excused from the room if it is deemed appropriate. Governor observers will be invited to the meeting by the Corporate Governance Team and will be provided with the papers on the day of the meeting.

3 QUORACY

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

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

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

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

4 MEETINGS OF THE GROUP

Frequency: The Finance and Performance Committee will meet up to eight times a year or as agreed by the Committee. The Committee will meet following the NHS Improvement quarter close downs. There will be up to another four meetings scheduled each financial year which will be deemed as strategic meetings as opposed to operational reporting.

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

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

Papers: Papers for the meeting will be distributed electronically by the Corporate Governance Team seven working days prior to the meeting. Papers received after this date will only be included if decided upon by the Chair.

5 AUTHORITY

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

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

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

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

6 ROLE OF THE GROUP

6.1 Purpose of the Group

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

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

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

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

6.3 Duties of the Finance and Performance Committee

The Finance and Performance Committee has the following duties.

i. General governance duties

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

ii. Financial governance

Receiving assurance that:

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

iii. Procurement

Receiving assurance that:

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

iv. Financial strategy

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

Receiving assurance:

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

v. IT and information governance

Receiving assurance:

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

vi. Capital and estates

Receiving assurance that:

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

vii. Performance

Receiving assurance on the Trust's performance against:

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

7 Links with Other Committees

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

Reporting:

The Finance and Performance Committee will receive an assurance report from the Information Governance Committee.

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

Links with operational processes

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

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

- Information Steering Group
- Estates Steering Group
- Procurement Strategy Steering Group
- Financial Planning Group
- Emergency, Preparedness, Resilience and Response Group.

8 DUTIES OF THE CHAIRPERSON

The Chair of the Committee shall be responsible for:

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

9 REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

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

Note 1

Schedule of Deputies

Committee Member	Deputy
NED Chair	Another NED who is not the chair of the Audit Committee (as chair)
NED member	Another NED
NED member	Another NED
Chief Financial Officer	Assistant Director of Finance
Chief Operating Officer	Associate Director

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

12

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Combined Quality Performance Report
DATE OF MEETING:	23 May 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 NHS England 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.

COMBINED QUALITY & PERFORMANCE REPORT

Lead Director: Joanna Forster Adams, Chief Operating Officer

Date: May 2019 (reporting April 2019 data, unless otherwise specified)

NHS
Leeds and York Partnership
NHS Foundation Trust

Introduction

Unless otherwise specified, all data is for April 2019

Key themes to consider this month:

Access and responsiveness:
During April, the Trust met its access standards for assessments by the in-reach liaison team within 24 hours, the community learning disability team referrals seen within 4 weeks and referrals seen within 15 days by the community mental health team. Of particular note is the achievement of 90% of assessments attempted within 24 hours by the in-reach liaison team for the first time. Following collaborative work between the Trust's continuous improvement team and the Leeds Autism Diagnostic Service, significant improvement continues to be seen in the 13 week wait from referral to start of an autism assessment rising by almost 40% between January and April. Although the 90% 1 hour standard for response to referrals from A&E by the Acute Liaison Psychiatry Service was not met in April, 2 new members of staff are now undergoing their induction process and performance in May is already showing improvement.
A number of new access and quality measures have been introduced this month as part of the go-live of the Crisis Resolution and Intensive Support Service (CRISS). It is very much early days for the service and time is being spent on understanding and using the data now available.

Quality:
The Trust again achieved the 95% standard for following up service users post discharge from hospital within 7 days; almost 80% of these were completed within 3 days. Achieving 80% for 3 day follow up has become a commissioning for quality and innovation (CQUIN) standard for 2019/20 (from quarter 3 onwards) but will only be applicable for services commissioned by Leeds clinical commissioning group rather than across our full range of services. Monitoring in this report currently includes all services.
Included for the first time this month is the community learning disability team's performance against its standard for ensuring care plans are up to date and reviewed within each 12 month period. This is under the standard of 90% and the service are reviewing their data to understand where any gaps may be.

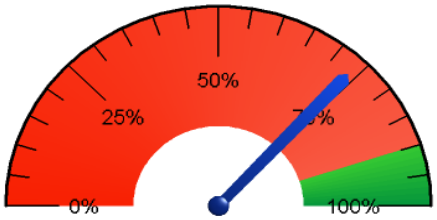
Capacity:
Issues with flow and capacity came to the fore in March with delayed discharges reaching 20% for our acute inpatient wards and bed occupancy on these wards remaining over 100% leading to an increase in inappropriate out of area bed days. Whilst delayed transfers of care for these wards did reduce in April, bed occupancy remained over 100% and the number of inappropriate out of area bed days increased with 21 acute adult and psychiatric intensive care service users remaining out of area at the end of April. It will take time for a number of the schemes the Trust is introducing during 19/20 (e.g. the crisis house) and for the impact of the redesign of our crisis services to take effect. However, an AMPH qualified social worker has now started in post to assist with delayed discharges and recruitment is underway for a housing officer.

Workforce:
At year end, the Trust successfully met the appraisal target of 85% completion for the first time. The 85% targets for compulsory training and Safeguarding Level 3 PREVENT training continued to be exceeded at year end. The Trust also retained an improved outcome of in excess of 80% in relation to Clinical Supervision but still remains below the 85% target and improvement work continues in this area.

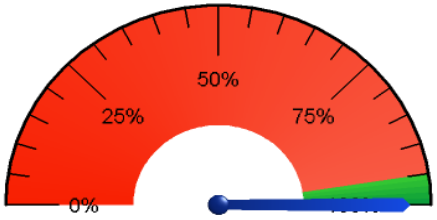
Work in Progress:
Internally, there is continued focus on tracking the progress of the implementation of the new model in community services with analysis of available data being used to understand how processes are embedding and where further work is required to improve record keeping to enable demonstration of the benefits of the change. Improving the timeliness of communication to GPs both for copies of Care Programme Approach care plans and inpatient discharge summaries is being highlighted across our services.

Our Service Performance

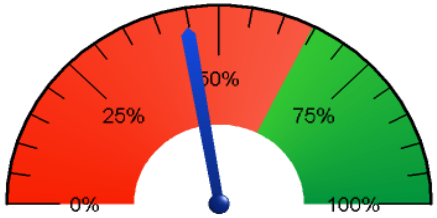
Access & Responsiveness: Our response in a Crisis



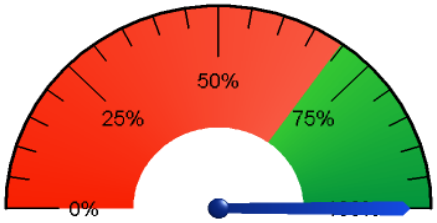
Percentage with timely access to a MH assessment by the ALPs team in the LTHT Emergency Department (1 hour)



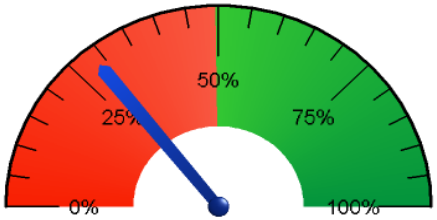
Percentage of admissions to inpatient services that had access to crisis resolution / home treatment teams



Percentage of appropriate crisis referrals offered a face to face assessment within 4 hours of

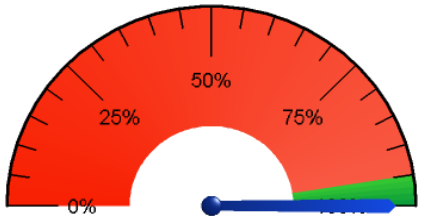


Percentage of service users who have stayed on CRISS caseload for less than 6 weeks

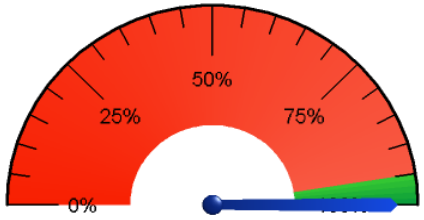


Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support

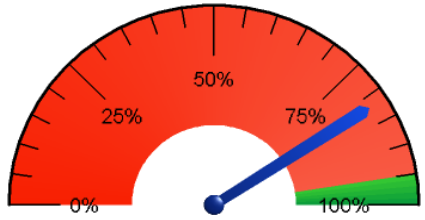
Our Specialist Services



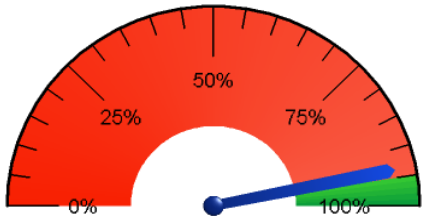
CAMHS inpatients: Honosca & CGAS: % completed at discharge (quarterly) Q4



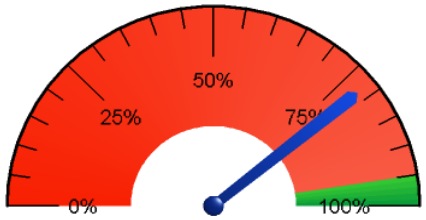
CAMHS inpatients: Honosca & CGAS: % completed at admission (quarterly) Q4



Forensics: HCR20: Percentage completed within 3 months of admission (quarterly) Q4

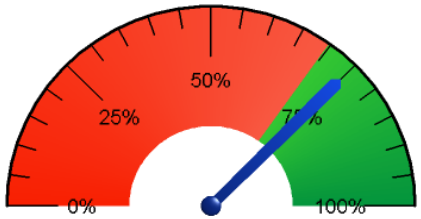


Forensics: HCR20 & HoNOS Secure: Percentage completed (LOS greater than 9 months) (quarterly) Q4

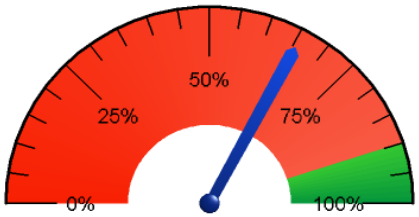


Leeds Autism Diagnostic Service (LADS): Percentage starting their assessment within 13 weeks of referral

Our Specialist Services Continued

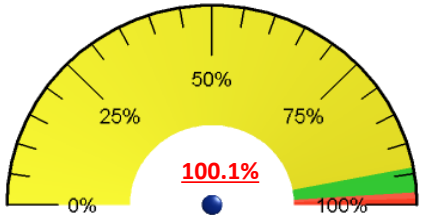


Community LD: Percentage of referrals seen within 4

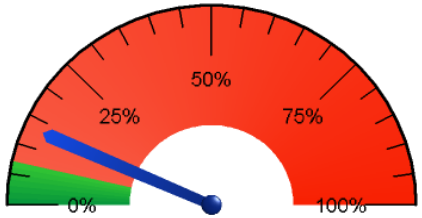


Community LD: Care plans reviewed within the previous 12 months

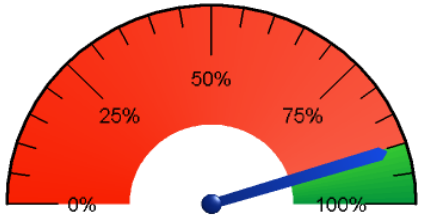
Our Acute Patient Journey



Bed Occupancy rates for (adult acute) inpatient services

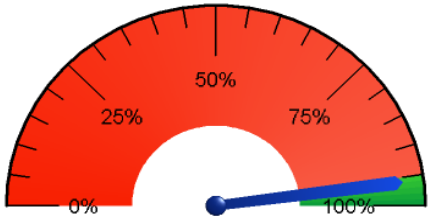


Percentage of Delayed Transfers of Care

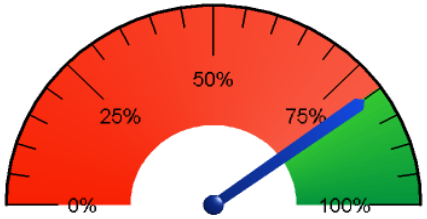


Liaison In-Reach: attempted assessment within 24 hours

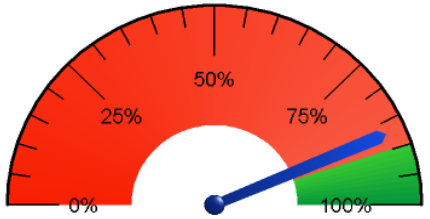
Our Community Care



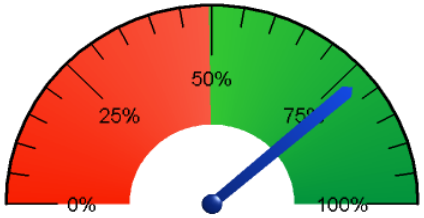
Percentage of inpatients followed up within 7 days of discharge



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

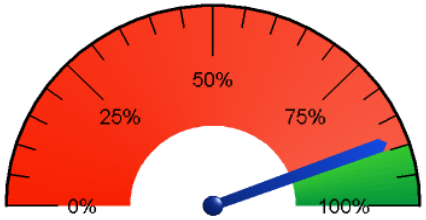


Waiting Times Access to Memory Services; Referral to first Face to Face Contact within 8 weeks (quarter to date)

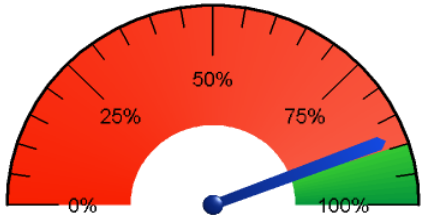


Memory Services – Time from Referral to Diagnosis within 12 weeks

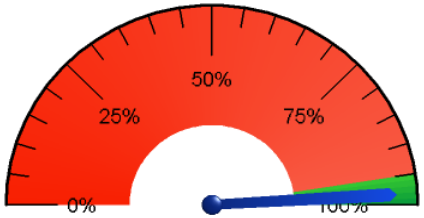
Clinical Record Keeping: Mandated requirements



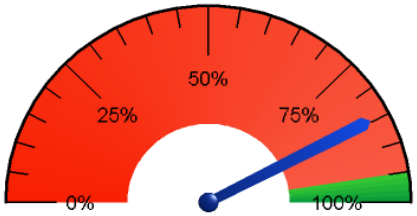
Percentage of service users with ethnicity recorded



Proportion of in scope patients assigned to a cluster

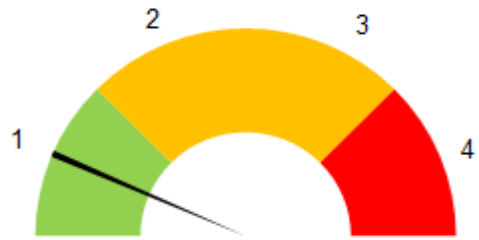


NHS Classic Safety Thermometer Percentage of Harm Free Care

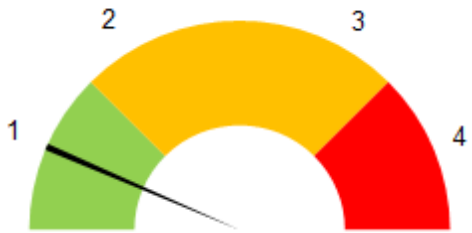


Percentage of Care Programme Approach Formal Reviews within 12 months

Finance - Year end position (March)

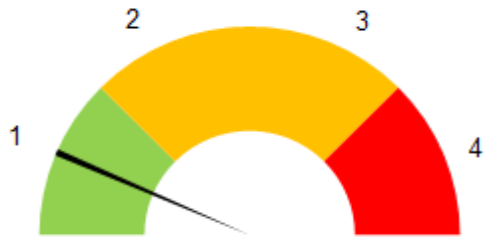


Single Oversight Framework – Finance Score



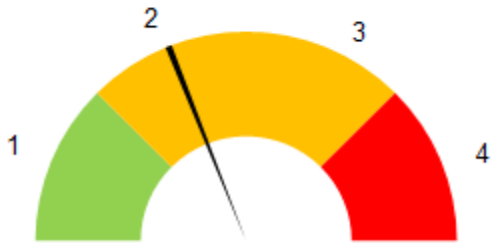
Income and Expenditure Position (£000s)

Cost Improvement Programme (£000s)



Cash (£000s)

Capital (£000s)



Agency spend (£000s)

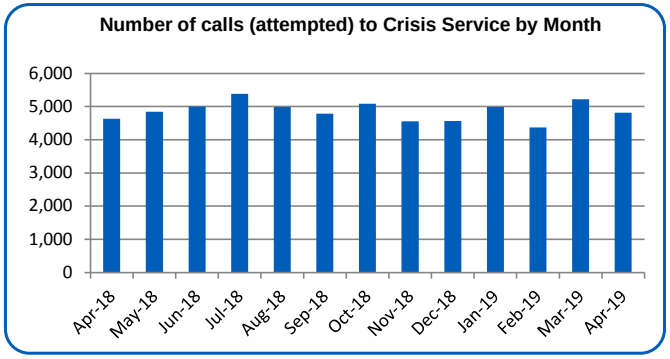
Service Performance – Chief Operating Officer

Services: Access & Responsiveness: Our response in a crisis	Target	Feb-19	Mar-19	Apr-19
Percentage of crisis calls (via the single point of access) answered within 1 minute	-	78.2%	79.6%	75.9%
Percentage of admissions gatekept by the crisis teams	95%	100.0%	98.5%	100.0%
Percentage of ALPS referrals responded to within 1 hour	90%	75.7%	68.2%	73.7%
Percentage of S136 referrals assessed within 3 hours of arrival	-	-	-	31.6%
Percentage of appropriate crisis referrals offered a face to face assessment within 4 hours of referral	65%	-	-	44.7%
Percentage of service users who stayed on CRISS caseload for less than 6 weeks	70%	-	-	100.0%
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support	50%	-	-	28.7%
Services: Our Specialist Services	**Target**	**Feb-19**	**Mar-19**	**Apr-19**
Gender Identity Service: Median wait for those currently on the waiting list (weeks)	-	33.4	35.4	37.1
Gender Identity Service: Number on waiting list	-	1,381	1,413	1,489
Leeds Autism Diagnostic Service (LADS): Percentage starting assessment within 13 weeks	95%	60.9%	72.7%	78.3%
CAMHS inpatients: Honosca & CGAS: % completed at admission (quarterly)	95%	-	100.0%	-
CAMHS inpatients: Honosca & CGAS: % completed at discharge (quarterly)	95%	-	100.0%	-
Deaf CAMHS: wait from referral to first face to face contact in days (monthly)	-	57.6	54.6	66.7
Forensics: HCR20: Percentage completed within 3 months of admission (quarterly)	95%	-	90.9%	-
Forensics: HCR20 & HoNOS Secure: Percentage completed (LOS greater than 9 months) (quarterly)	95%	-	93.6%	-
Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency) (quarterly)	-	-	-	-
Perinatal Community: Percentage waiting less than 2 weeks for first contact (routine) (quarterly)	-	100.00%	77.8%	-
Perinatal Outreach: Average wait from referral to first contact (all urgencies) (quarterly)	-	-	-	-
Community LD: Percentage of referrals are seen within 4 weeks of receipt of referral (quarter to date)	70%	-	-	75%
Community LD: Percentage of Care Plans reviewed within the previous 12 months (quarter to date)	90%	-	-	65.5%
Services: Our acute patient journey	**Target**	**Feb-19**	**Mar-19**	**Apr-19**
Number of admissions to adult facilities of patients who are under 16 years old	-	0	0	0
Crisis Assessment Unit (CAU) bed occupancy	-	93.5%	94.1%	91.7%
Crisis Assessment Unit (CAU) length of stay at discharge	-	7.16	9.4	8.8
Liaison In-Reach: attempted assessment within 24 hours	90%	83.4%	88.3%	90.6%
Bed Occupancy rates for (adult acute excluding PICU) inpatient services:	94-98%	101.4%	101.1%	100.1%
• Becklin – ward 1	-	101.7%	102.2%	102.6%
• Becklin – ward 3	-	102.1%	99.9%	98.0%
• Becklin – ward 4	-	100.3%	99.3%	99.5%
• Becklin – ward 5	-	102.8%	100.3%	102.0%
• Newsam – ward 4	-	101.4%	104.0%	98.1%
• Older adult (total)	-	93.4%	85.3%	92.8%
• The Mount – ward 1	-	100.0%	95.8%	98.8%
• The Mount – ward 2	-	98.1%	94.6%	97.1%
• The Mount – ward 3	-	79.9%	70.7%	87.5%
• The Mount – ward 4	-	99.3%	86.6%	91.0%

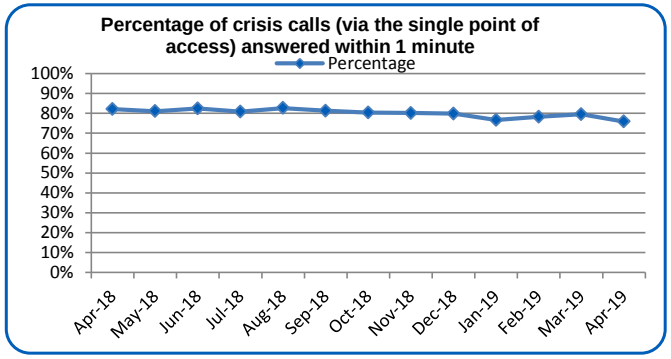
Service Performance – Chief Operating Officer

Services: Our acute patient journey	Target	Feb-19	Mar-19	Apr-19
Percentage of delayed transfers of care	<7.5%	12.5%	14.5%	12.8%
Number of out of area placement bed days versus trajectory (in days: cumulative per quarter)	-	+101	+262	-622
Acute: Number of out of area placements beginning in month	-	16	15	17
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	182	366	461
PICU: Number of out of area placements beginning in month	-	5	6	4
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	51	31	148
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**	**Feb-19**	**Mar-19**	**Apr-19**
Percentage of inpatients followed up within 7 days of discharge	-	93.8%	95.1%	95.8%
Percentage of inpatients followed up within 7 days of discharge (quarterly data)	95%	-	95.4%	-
Percentage of inpatients followed up within 3 days of discharge	-	71.9%	76.2%	79.2%
Number of service users in community mental health team care (caseload)	-	4,860	-	5,038
Percentage of referrals seen (face to face) w/in 15 days by a community mental health team	80%	83.3%	82.0%	80.1%
Percentage of referrals to memory services seen (face to face) within 8 weeks (quarter to date)	90%	88.7%	91.0%	87.2%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50%	59.9%	64.2%	77.1%
Services: Clinical Record Keeping	**Target**	**Feb-19**	**Mar-19**	**Apr-19**
Data Quality Maturity Index for the Mental Health Services Dataset (MHSDS) - revised specification from April onwards	95%	97.4%	97.2%	-
Percentage of service users with ethnicity recorded	90%	85.2%	84.3%	88.6%
Percentage of in scope patients assigned to a mental health cluster	-	89.1%	87.9%	88.3%
Percentage of Care Programme Approach Formal Reviews within 12 months	95%	86.7%	86.0%	84.6%
Timely Communication with GPs: Percentage notified in 7 days (CPA Care Plans only) (quarter to date)	80%	38.3%	35.3%	24.8%
Timely Communication with GPs: Percentage notified in 24 hours (Discharges only) (quarter to date)	80%	-	-	-

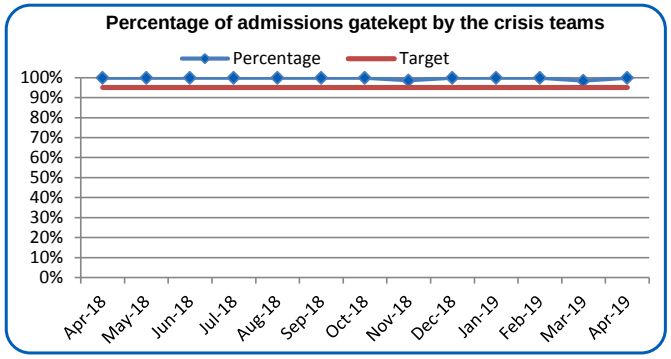
Services: Access & Responsiveness: Our response in a crisis



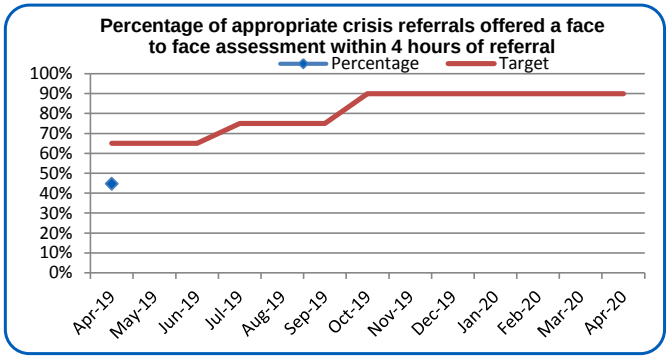
Apr calls: 4,817



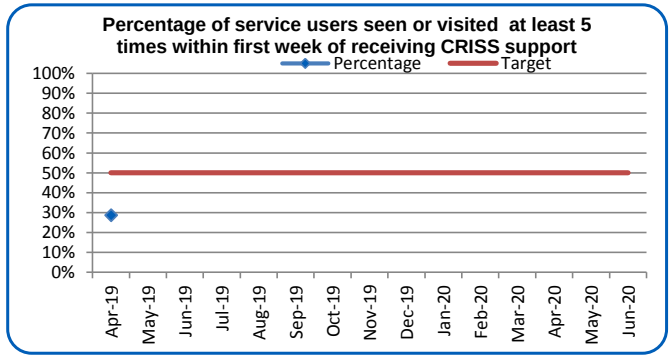
Local target: within 1 minute: Apr: 75.9%



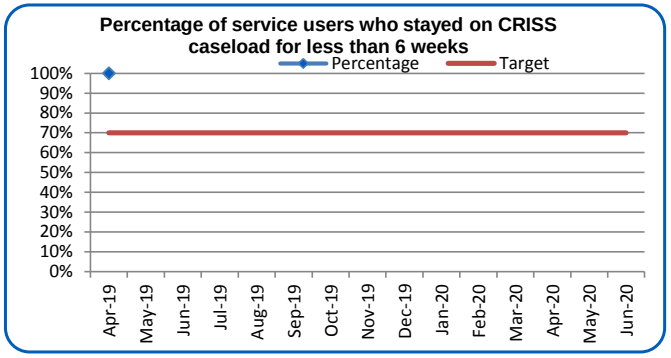
Local target: 95%: Apr: 100%



Contractual target Q1: 65% Apr: 44.7%

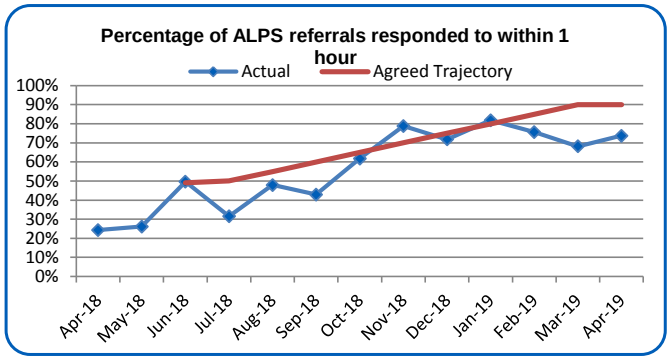


Contractual target: 50%: Apr: 28.7%

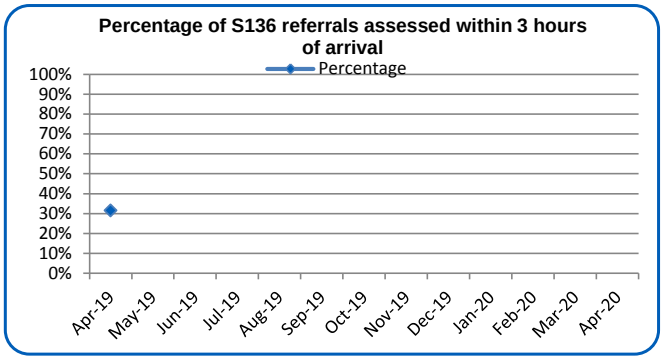


Contractual target: 70%: Apr: 100%

Services: Access & Responsiveness: Our response in a crisis continued



Contractual target: 90%: Apr: 73.7%



Contractual target: Apr: 31.6%

Services: Access & Responsiveness: Our response in a crisis

At the end of March, the newly redesigned services within our crisis and community services "went live". For the crisis and intensive support teams, the new model is about providing a flexible resource, with a focus on face to face assessment and an intensive support service providing home based treatment. There are a number of new metrics included in this month's report that will be used to track progress. As indicated by the data, it will take a little time for the new ways of working to embed and show the desired impact on access, responsiveness and quality.

The new Crisis Resolution and Intensive Support Service (CRISS) has been set up to deliver the nationally recognised Crisis Team Optimisation and Relapse Prevention (CORE) study's fidelity standards. For example, within the CORE fidelity standards, it recommends that 90% of appropriate crisis referrals should be offered a face to face assessment within 4 hours of referral. Since the service went live, it has been recognised that further work is needed to enable the Single Point of Access (SPA) to screen and identify those that fit the need for a crisis resolution assessment within 4 hours. Therefore, the Trust has a quarterly trajectory through the year to reach the 90% standard beginning with 65% in Quarter 1.

Initial analysis of the new metric for service users seen or visited at least 5 times within first week of receiving CRISS support has shown under-reporting of performance. This is due to inconsistent recording of activity on our electronic patient record (PARIS). Reviews of individual records has highlighted variation in practice with a reliance on free text casenotes rather than standardised recording of activity. In order to rectify this, some simple guidance for staff within CRISS is being drawn up, additional support/training will be given then daily monitoring of recording by staff members put in place to ensure that the benefits of the new ways of working can be evidenced. Whilst some improvement may be seen in May data; the impact of this standardisation is expected from June data onwards.

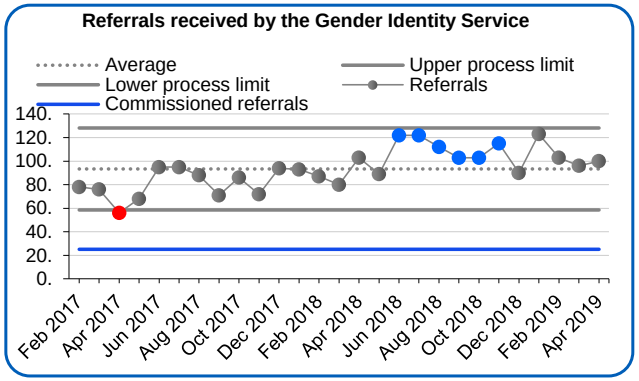
With the aim of the CRISS service being short term crisis resolution and intensive home treatment, the Trust is also monitoring the caseload for the service with a target of 70% of service users to remain with CRISS for less than 6 weeks. This is based on discharges from CRISS and as the service had only been running for 5 weeks at the end of April, the data shows 100%; May data will show a true reflection of length of time with the service.

From April, the extended mental health support line (provided by the third sector) took over from SPA in providing out of hours support. Guidance has also been developed for the administrative staff within SPA in directing people on to the appropriate team (including the telephone support line) with clinical support of 1 whole time equivalent remaining in SPA for clinical triage (backed up by CRISS staff outside these hours) in the short term to ease the transition. However, the support line is not a 24 hour citywide helpline and during the day, all calls continue to go into SPA before being passed on to the support line where appropriate; as demonstrated by the SPA telephone data, there is no significant reduction in calls to SPA and performance against the aim of answering calls within 1 minute remains largely unchanged.

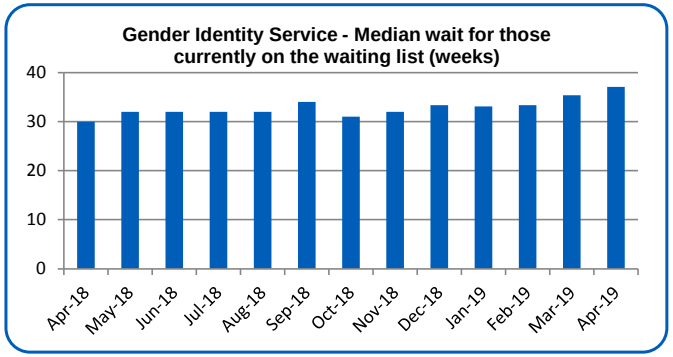
The Trust is also monitoring the percentage of 136 suite referrals assessed within 3 hours. There is no target set for this currently and local data has shown that the ability to make an assessment within 3 hours is often hampered by the level of intoxication of the service user (drugs or alcohol) that usually affects at least a quarter of cases.

After having received its highest ever number of referrals in March (over 400 including A&E referrals and medically admitted self harm referrals) , the Trust's Acute Liaison Psychiatry service (ALPs), received fewer referrals in April and showed improved performance at 73.7% but still below the 90% target. Analysis has shown that a high proportion of breaches of the 1 hour standard were overnight. Whilst this has been recognised previously, there has been an increase in overnight referrals in recent months. The team are reviewing how shifts are weighted across the 24 hours. This includes working to sustain at least 3 staff on a night shift and staggering start ties to day shifts to provide stronger cover between 7pm and midnight. As recognised last month, the team had experienced delays in the start date for 2 replacement staff (induction for these staff began in May) alongside some long term sickness. However, data as at mid-May does show a signifcant improvement in response times.

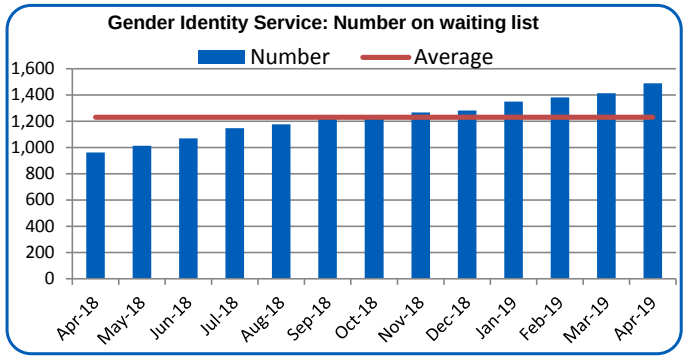
Services: Our Specialist Services



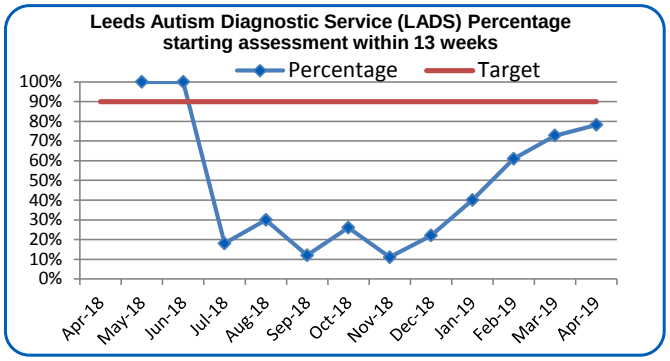
Total referrals: Apr: 100



Median wait: Apr: 37.1 weeks

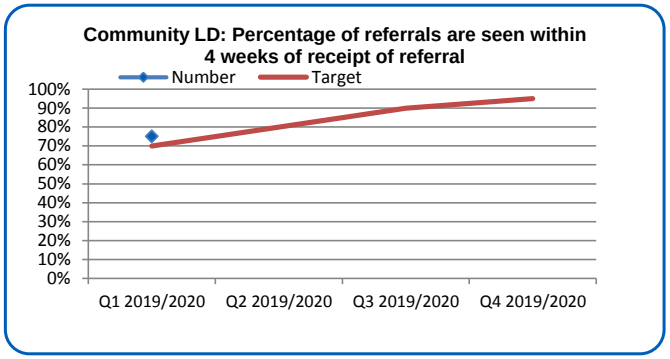


Number on waiting list: Apr: 1,489

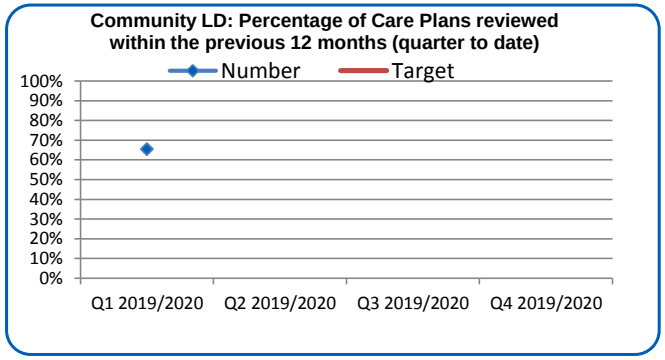


Contractual target: 95%*: Apr: 78.3%

**Trajectory to be agreed with the CCG to achieve 95% during 19/20.*

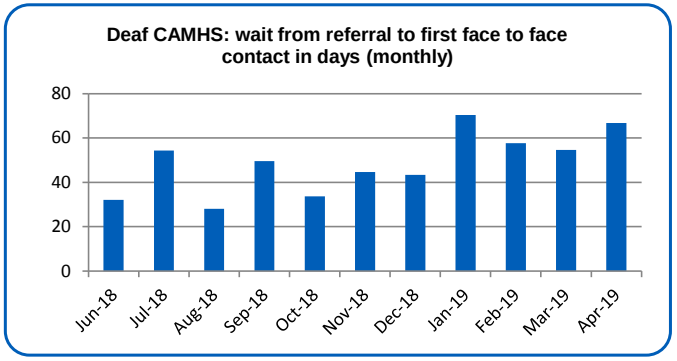


Contractual target: Q1 70%: Apr: 75%

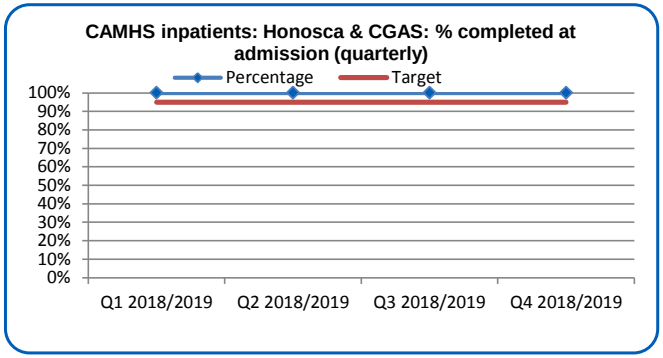


Contractual target: 90%: Apr: 65.5%

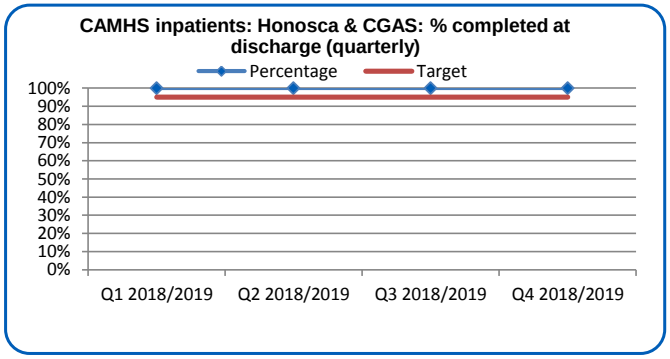
Services: Our Specialist Services continued



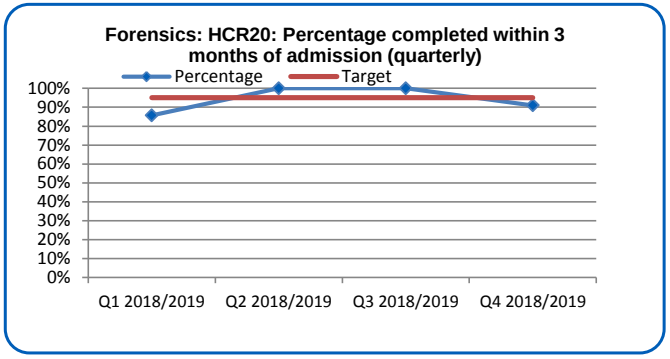
Local measure: Apr: 66.7 days



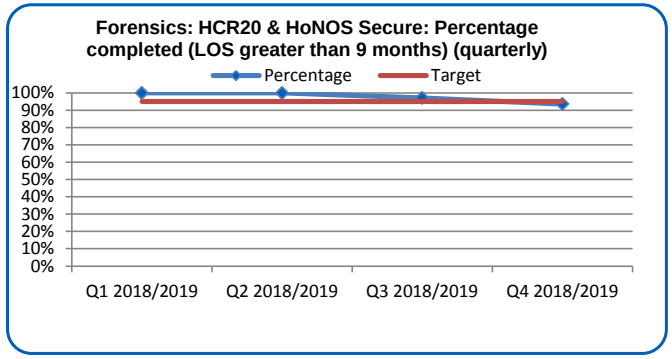
Contractual target: 95%: Q4: 100%



Contractual target: 95%: Q4: 100%



Contractual target: 95%: Q4: 90.9%
(not met for one service user in Q4)



Contractual target: 95%: Q4: 93.6%
(not met for two service users in Q4)

Services: Our Specialist Services

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

After recognising the increasing length of time from referral to start of an autism assessment back in September, the Leeds Autism Diagnostic Service (LADS) h as worked with the Trust's continuous improvement team to identify ways to improve the pathway and reduce the wait; the teams have been meet ing weekly to agree on actions then monitor their impact. There has been a marked improvement over time with performance in the last 3 months rising from 40% in January to 78% in April. April data will be used as a baseline to set a trajectory with commissioners to achieve 95% starting assessment within 13 weeks during 2019/20.

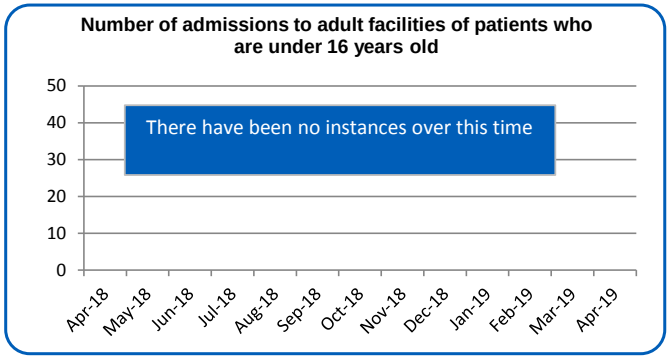
There are two new metrics introduced this month for our community learning disability team: 95% of referrals to be seen within 4 weeks of receipt of referral and 90% of service users within the Community Learning Disability Team to have an up to date care plan (reviewed in last 12 months). The Trust has an agreed trajectory with its commissioners to achieve 70% in quarter 1, rising to 95% by quarter 4 for referrals to be seen within 4 weeks. April performance is above target at 75%. National benchmarking data for Q3 18/19 has the median wait from referral to 1st contact as 83 days for the Trust compared with the national position of 120 da ys with the Trust in quartile 2 (quartile 1 being the shortest median wait). With regards to care plans reviewed within the last 12 months, the Trust is under target. The servic e is now receiving a monthly report for any care plans requiring a review to help with ensuring the standard is met.

On the 8th April, the Gender Identity National Procurement process commenced, incorporating a number of 'lots' for different aspects of the new national Gender service delivery model. Currently, we are collectively developing our approach to the procurement, including an assessment of the ben efits and risks of the different component parts. As the referrals received chart shows, the Trust continues to receive referrals significantly in excess of the commissioned level of activity. Any new refer ral into the service can now expect to wait up to 100 weeks for their first assessment based on capacity and the current waiting list of nearly 1,500 people. The service continues to work on finding ways to alleviate the pressure where possible (including recent employment of an additional doctor), and we have made a propo sal to NHS England commissioners for the allocation of non-recurrent additional resources to increase capacity within the team.

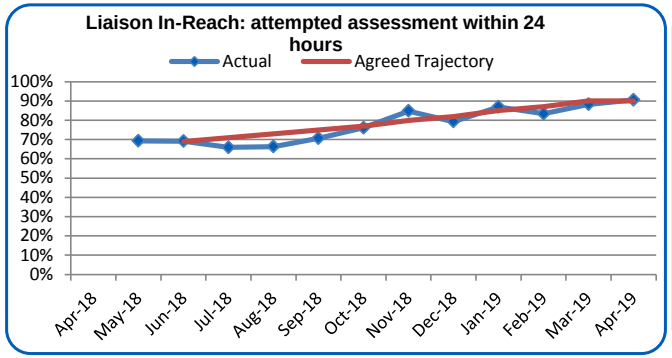
Quarter 4 data shows 100% achieved for both the CAMHS inpatient measures for the completion of the health of the nation outcome score f or children and adolescents and the children's global assessment scale at admission and discharge (Honosca and CGAS). Within Forensics, the completion of the vi olence risk assessment HCR-20 is expected within 3 months of admission; this was not met for one service user who was discharged back to prison in the first 6 -7 weeks of admission. 2 service users did not have a Honos (health of the nation outcome scale) review completed within the quarter (applicable to those with a length of stay gre ater than 9 months). These were completed but outside the expected timeframe. All HCR-20 reviews were completed.

Due to small numbers involved, reporting of the 3 new perinatal measures has been moved to quarterly (trend charts will be in cluded from end of quarter 1).

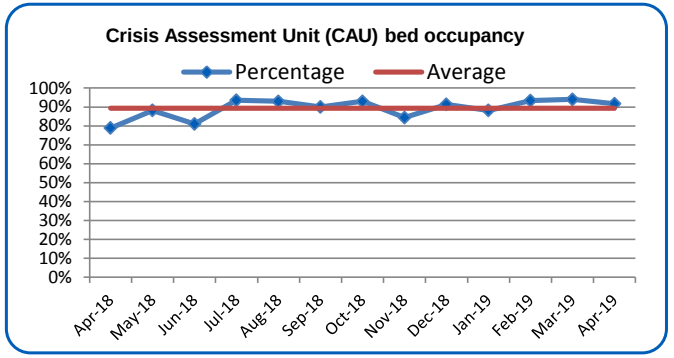
Services: Our acute patient journey



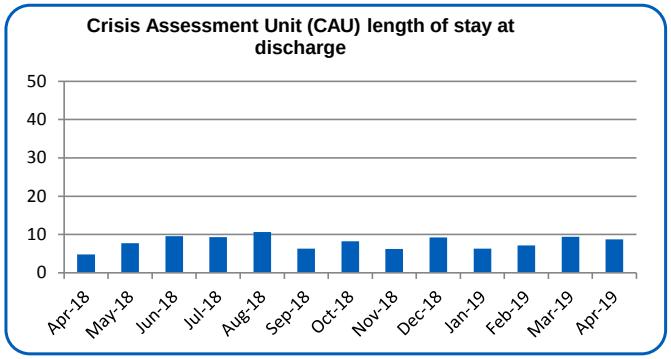
National (SOF): no target: Apr: 0



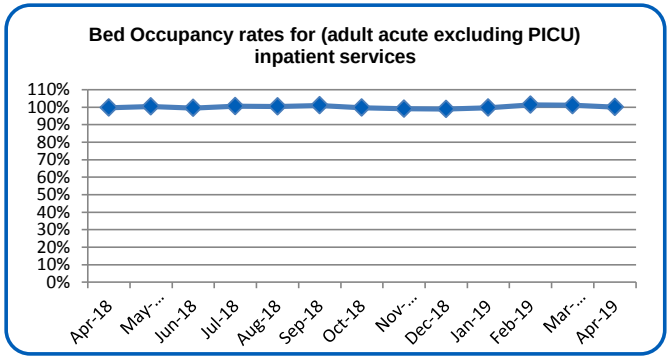
Local contractual target: 90%: Apr: 90.6%



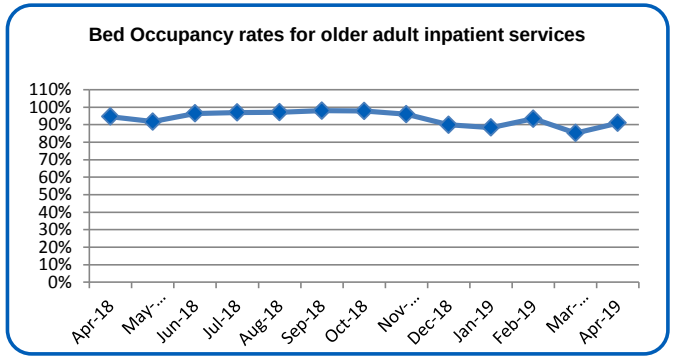
Local measure: Apr: 91.7%



Local measure: Apr: 8.8 days

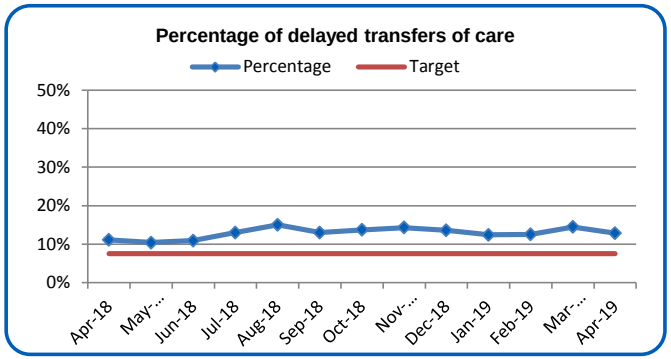


Local contractual target: 94-98%: Apr: 100.1%

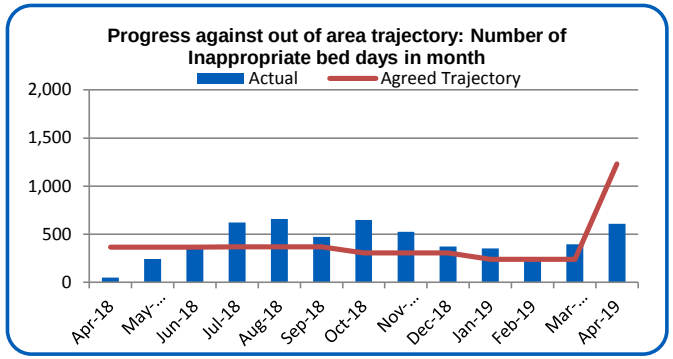


Local measure: Apr: 92.8%

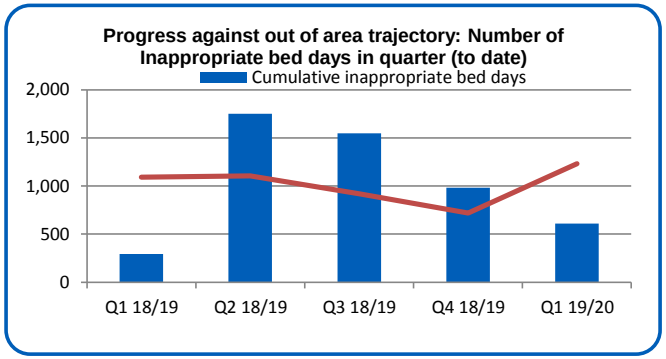
Services: Our acute patient journey continued



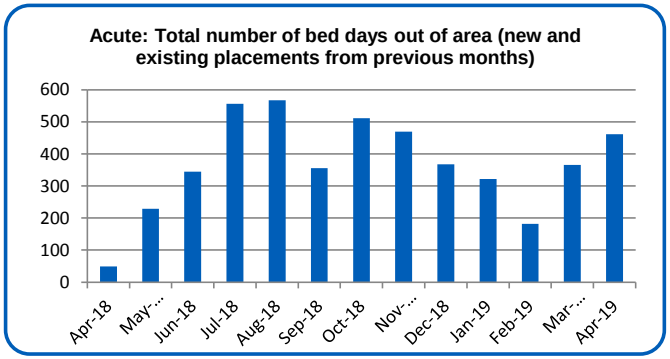
Local target: <7.5%: Apr: 12.8%



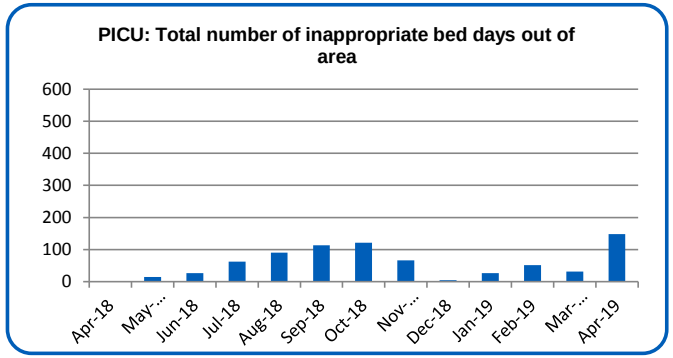
Nationally agreed trajectory: Apr: 609



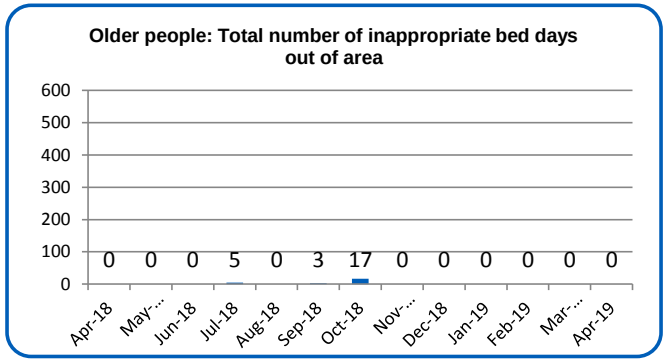
Nationally agreed trajectory (Q1: 1,231 days): Q1 to date: 609 days



Local measure: Apr: 461 days



Local measure: Apr: 148 days

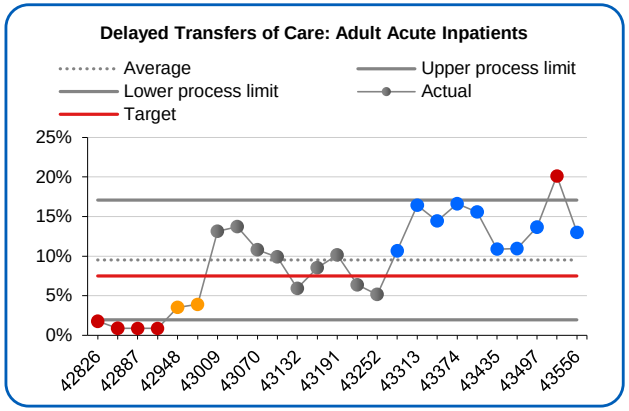


Local measure: Apr: 0 days

Services: Our acute patient journey

The liaison in-reach service achieved its highest percentage and the 90% standard for the first time for referrals responded to within 24 hours during April.

The acute pathway remains under considerable pressure with bed occupancy in our acute inpatient wards remaining at over 100% and, whilst delayed transfers of care (DTOC) for the acute inpatient wards have reduced from 20% last month to 13%, they remain high.



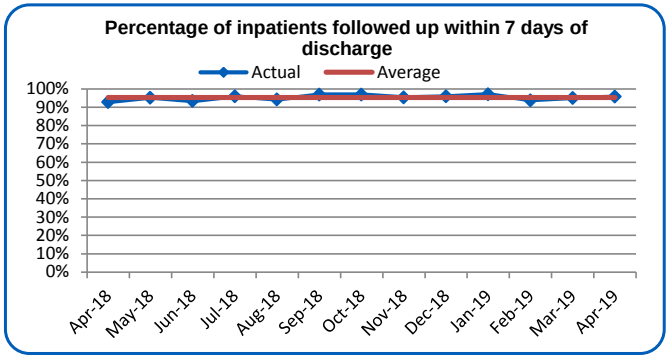
Daily capacity and flow calls continue to take place as we work to minimise delays in moving service users along their pathway. The lack of consistent senior medical cover on some wards has remained a considerable challenge and impacts directly on the discharge rate (increasing DTOCs), particularly where there is a reliance on short term locums. An AMPH qualified social worker has been appointed and has now taken up post; part of the focus of this role will be to support teams in managing delayed transfers of care in order to ensure a more timely discharge. The leadership teams have been working hard to ease pressure where possible by looking to create capacity within the Intensive Support Service (part of the new CRISS) to support early discharge but we recognise it will take some time for the new community model to embed and take full effect and for the benefits to be materialised. The acute care excellence improvement project will also support reducing variation in length of stay across our wards to improve access to beds.

High levels of DTOC are also a contributing factor to inappropriate out of area placements; at the end of April, the Trust had used 49% of the bed days within its quarter 1 trajectory of a maximum of 1,231 inappropriate out of area bed days. At the end of April, 21 people remained in an out of area bed.

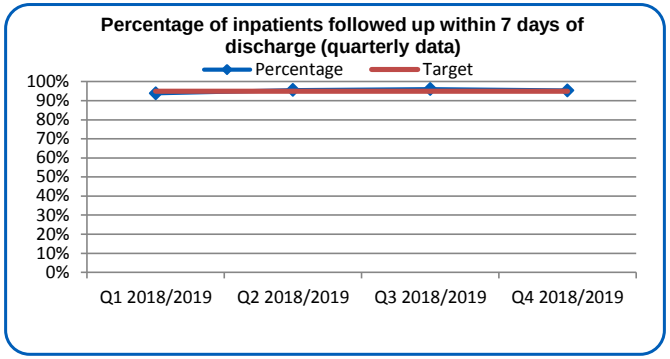
As at 30th April 2019, Inappropriate out of area placements:

	30th April
Number remaining out of area	17 (Adult)
	0 (Older Adult)
	4 (PICU)
Of these:	
Longest number of days to month end	68 (Adult)
Shortest number of days to month end	1 (Adult)

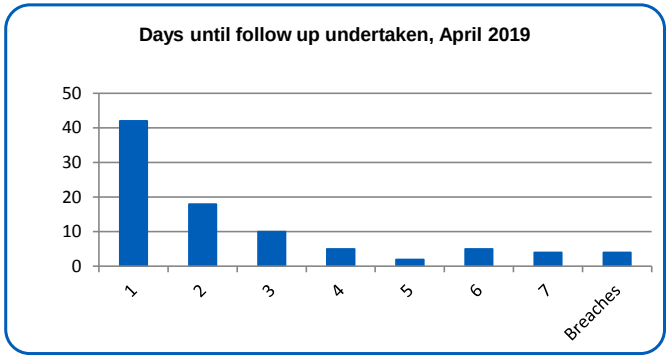
Services: Our community care

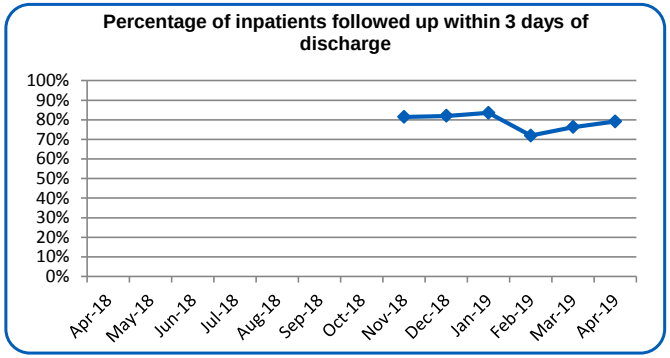


Local monthly target: 95%: Apr: 95.8%



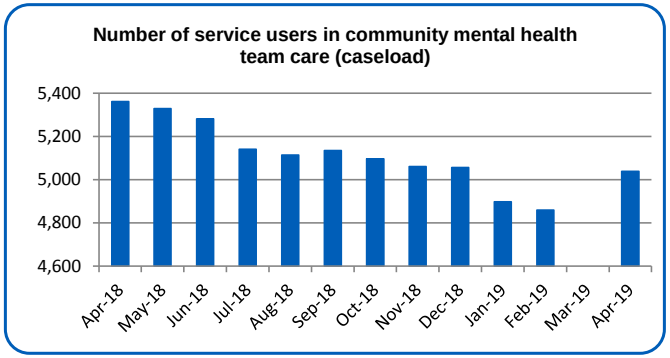
National (SOF) target: 95%: Q4: 95.4%





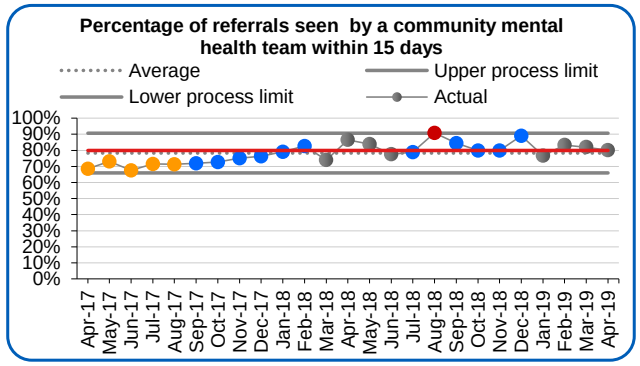
Contractual target: 80% for Q3&Q4: Apr: 79.2%

NB: This is a proxy local measure - see narrative



Local measure: Apr: 5,038

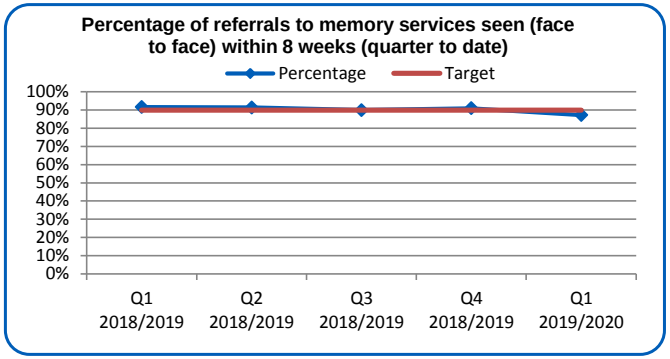
Mar: Unavailable due to caseload transfer for new community services



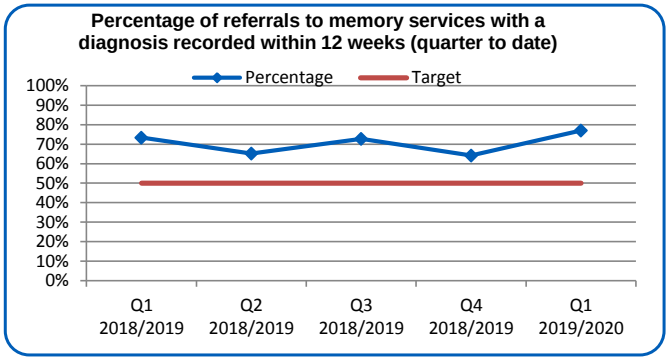
Local contractual target: 80%: Apr: 80.1%

NB: Target was 14 days until April 2018

Services: Our community care continued



Local contractual target: 90%: Q1 to date: 87.2%



Local contractual target: 50%: Q1 to date: 77.1%

Services: Our community care

April saw the first full month of operation for the new model of service under the Community Services Redesign project. The p roject aims to maximise clinical outcomes and provide a high quality experience for our service users. The ageless community mental health teams (CMHTs) have now been spl it into separate working age adult and older people's teams in each locality. Where service users are moving into the new older people's CMHTs, the Care Programme Approac h (CPA) transfer process is being used to ensure a smooth transition. Within the working age adult CMHTs, the focus has been on embedding the daily huddles and multid isciplinary team meetings with the leadership team using the "Affina team tool" to support staff with the new ways of working and ensure consistency across localities. Ea rly feedback is that the huddles are proving effective for staff in providing clarity and clinical support and that the 6 week assessment process that has been introduced is also working well. Similarly, within the older people's CMHTs, the focus is on embedding new systems and processes consistently.

The CMHT 15 day access target was achieved again this month. National benchmarking data for quarter 3 of 2018/19 suggests t hat the Trust is in the top quartile for both the median wait from referral to first contact and from first to second contact.

During April, the Trust achieved the 7 day follow up target post discharge from an inpatient stay (monitored quarterly by NHS Improvement) with 4 breaches of the target. The breaches included a service user going abroad post discharge, the service user being transferred to another specialised unit and another where there is evidence of numerous attempts to complete the follow up.

From this month onwards, a variation of the 3 day follow up metric the Trust has already been monitoring will become a CQUIN with a target of 80%; this will only include services commissioned by Leeds CCG and payment will be based on Q3 and Q4 performance. At a national level, the constructio n of the metric is still being refined so it should be noted that the measure included in this report is a proxy measure and includes all our services. This will be repl aced by nationally published data once it becomes available.

Although it is only measured quarterly, the Trust tracks performance against the two standards for memory services (8 weeks t o assessment and 12 weeks to diagnosis). There was small dip in performance for the assessment standard as staff transitioned to new teams, with a gap in administrati ve cover at go-live particularly in one locality. This has been now been resolved and cover provided by moving staff and using temporary staff.

Services: Clinical Record Keeping

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)
An expanded version of the DQMI covering up to 36 data items from the national dataset (Mental Health Services Dataset submitted monthly) by the end of 2019/20 (previously only 6 items) will be a CQUIN for 19/20. Achievement of the CQUIN payment will be based on achieving 90-95% from Q2 onwards. 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 making achievement of this CQUIN difficult.

Trust performance: 80% as at January 2019 (DQMI website)
CQUIN Target 95%

Ethnicity
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 forms part of the Data Quality Maturity Index (see above) and is no longer part of the National Contract.
April data for the Leeds Care Group was 93% and 85% for the Specialist and Learning Disabilities Care Group. Performance is lower in the Specialist and Learning Disabilities Care Group (SS&LD) where waiting times are longer but improvement continues to be seen (having risen from 79% in April 2018 to 85%). Weekly reports are being sent out to individual services where this data is missing.

Trust Performance 88.6%
Local Target 90% (but forms part of DQMI - see above)

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 forms part of the measures in the Leeds CCG contract for 19/20 against a target of 90%.

Following the redesign of our Community Services , 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. This has been adjusted to reflect this but it should be noted that any national publication will continue to use the 2nd face to face contact. Data for Aspire (sub-contracted to provide early intervention in psychosis on behalf of the Trust) is also included from April data onwards.

Trust Performance 88.3%
Contractual target – 90%

Services: Clinical Record Keeping continued

Percentage of Care Programme Approach Formal Reviews within 12 months
Reviewing care plans for those on CPA is an important part of our provision to our service users and their GP.
There are known issues with care plans being recorded in casenotes rather than on assessment forms that can be identified for reporting purposes, referrals not being discharged off the system (appearing to require a review but actually discharged) and care plans not given an end date as complete. Issues have been raised and highlighted to teams for resolution and a monthly report is issued identifying any service user requiring a review.

Trust Performance: **84.6%**
Local Target: 95%

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 reports against the electronic transfer of CPA care plans to Leeds GP practices. 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 the technical mechanism to support the electronic transfer to all GP practices is available nationally but cannot be measured. An audit of care plans that have been transferred electronically is underway to try to understand the issues in more detail.

Trust Performance: 24.8% (Q1 to date)
Monthly performance: 24.8% (April)
Contractual target: 80%

Timely Communication with GPs notified in 24 hours (inpatient discharges only)
This currently is also an NHS contract service condition. The requires discharge summaries to be sent to GPs within 24 hours of discharge. The electronic transfer of both inpatient discharge letters and outpatient letters went live in mid-February. The old process of posting discharge summaries is continuing in parallel until we are confident that the technical mechanism to support electronic transfer to all GP practices is available nationally but cannot be measured. Work is ongoing to build reporting against the electronic transfer. The Trust is aware that performance is poor against this standard as there is a known backlog in dictation and sign off of discharge summaries by senior medical staff on the wards, particularly where there are medical staffing issues. The medical leadership team are looking at ways to clear this backlog.

Trust Performance: Not yet available
Monthly performance: Not yet available
Contractual target: 80%

Quality and Workforce metrics: Tabular overview

Services: Clinical Record Keeping	Target	Jan-19	Feb-19	Mar-19
Data Quality Maturity Index for the Mental Health Services Dataset (MHSDS)	95%	97.3%	97.4%	97.2%
Percentage of service users with ethnicity recorded (service users seen in month)	90%	94.4%	94.4%	93.7%
Percentage of service users with ethnicity recorded (NHS Standard Contract)	90%	85.0%	85.2%	84.3%
Percentage of NHS number recorded	99%	99.4%	99.5%	99.3%
Percentage of in scope patients assigned to a mental health cluster	-	89.5%	89.1%	87.9%
Timely Communication with GPs: Percentage notified in 7 days (CPA Care Plans only) (quarter to date)*	-	43.9%	38.3%	35.3%
Quality: Our effectiveness	**Target**	**Jan-19**	**Feb-19**	**Mar-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)	-	89.9%	88.9%	87.3%
Classic Safety Thermometer: Percentage of harm free care (point prevalence survey)	95%	99.5%	100.0%	98.2%
Percentage of service users in Employment	-	15.7%	15.9%	15.9%
Percentage of service users in Settled Accommodation (definition amended in Aug 18)	-	79.9%	81.3%	81.6%
Quality: Caring / Patient Experience	**Target**	**Jan-19**	**Feb-19**	**Mar-19**
Friends & Family Test: Percentage recommending services (total responses received)	-	74.6% (59)	39% (13)	75% (12)
Mortality:		-	-	-
· Number of deaths reviewed (incidents recorded on Datix)**	Quarterly	-	-	88
· Number of deaths reported as serious incidents	Quarterly	-	-	11
· Number of deaths reported to LeDeR	Quarterly	-	-	8
Number of complaints received	-	13	20	19
Percentage of complaints acknowledged within 3 working days	-	100.0%	100.0%	100.0%
Percentage of complaints allocated an investigator within 3 working days	-	77.0%	78.0%	78.0%
Percentage of complaint responses sent to the complainant within 30 working days	-	77.0%	60.0%	64.0%
Number of enquiries to the Patient Advice and Liaison Service (PALs)	-	179	171	121

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

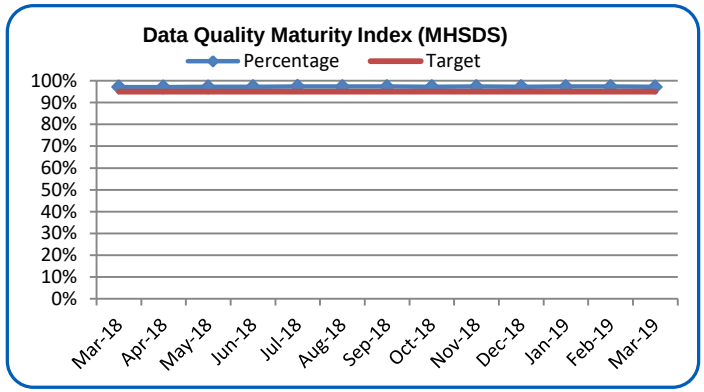
**All deaths reported via staff on the Trust's incident system, Datix, are reviewed; in addition to this any death for someone who has been a service user with us previously identified via the NHS SPINE is given a tabletop review and followed up in more detail if required.

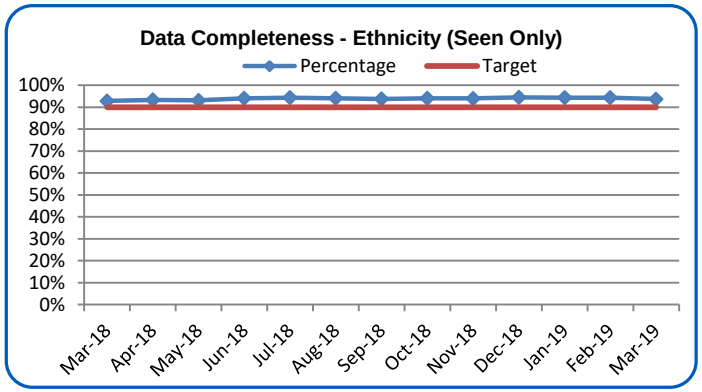
Quality and Workforce metrics: Tabular overview

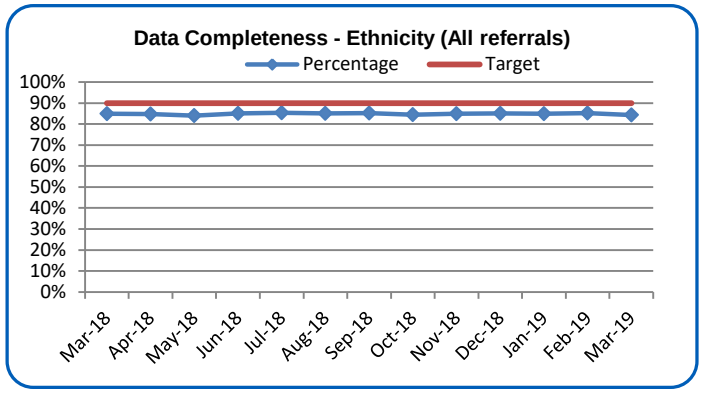
Quality: Safety	Target	Jan-19	Feb-19	Mar-19
Number of incidents recorded	-	1,047	908	916
Percentage of incidents reported within 48 hours of identification as serious	100%	100% (3)	100% (2)	100% (6)
Number of never events	0	0	0	0
Number of restraints	-	147	110	104
No. of patients detained under the Mental Health Act (includes Community Treatment Orders/conditional discharges)	-	485	467	470
Adult acute including PICU: % detained on admission		55.8%	60.0%	68.0%
Adult acute including PICU: % of occupied bed days detained		81.8%	81.3%	80.7%
Number of medication errors	Quarterly	-	-	132
Percentage of medication errors resulting in no harm	Quarterly	-	-	93.2%
Safeguarding Adults: Number of advice calls received by the team	-	47	71	83
Safeguarding Adults: Percentage of advice calls to safeguarding that resulted in a referral to social care		6.4% (3)	4% (3)	3.6% (3)
Safeguarding Children: Number of advice calls received by the team	-	26	21	29
Safeguarding Children: Percentage of advice calls to safeguarding that resulted in a referral to social care		38.5% (10)	19% (4)	24.1% (7)
Number of falls	-	70	66	90
Our Workforce	**Target**	**Jan-19**	**Feb-19**	**Mar-19**
Percentage of staff with an appraisal in the last 12 months	85%	76.9%	82.8%	85.3%
Percentage of mandatory training completed	85%	87.4%	88.9%	89.2%
Safeguarding: Prevent Level 3 training compliance (month end snapshot)	85%	93.0%	93.0%	94.0%
Percentage of staff receiving clinical supervision	85%	68.0%	81.9%	81.5%
Staff Turnover (Rolling 12 months)	8-10%	9.9%	8.9%	10.0%
Sickness absence rate (Rolling 12 months)	4.6%	4.8%	4.8%	4.9%
Percentage of sickness due to musculoskeletal issues (MSK; rolling 12 months)	14.7%	13.9%	13.0%	13.3%
Percentage of sickness due to Mental Health & Stress (rolling 12 months)	15.0%	32.9%	34.3%	36.2%
Band 5 inpatient nursing vacancies as a percentage of funded B5 inpatient nursing posts (percentage)	-	25.0%	25.0%	24.2%
Band 5 inpatient nursing vacancies (number)	-	58.7	58.7	54.6
Band 6 inpatient nursing vacancies as a percentage of funded B6 inpatient nursing posts (percentage)	-	3.7%	3.7%	0.2%
Band 6 inpatient nursing vacancies (number)	-	3.2	3.2	0.2
Band 5 other nursing vacancies as a percentage of funded B5 non-inpatient nursing posts (percentage)	-	29.1%	26.5%	26.5%
Band 5 other nursing vacancies (number)	-	30.4	29.8	29.8
Band 6 other nursing vacancies as a percentage of funded B6 non-inpatient nursing posts (percentage)	-	0.0%	0.0%	0.3%
Band 6 other nursing vacancies (number)	-	0.0	0.0	0.6
Percentage of vacant posts (Trustwide; all posts)	-	9.8%	11.0%	11.2%

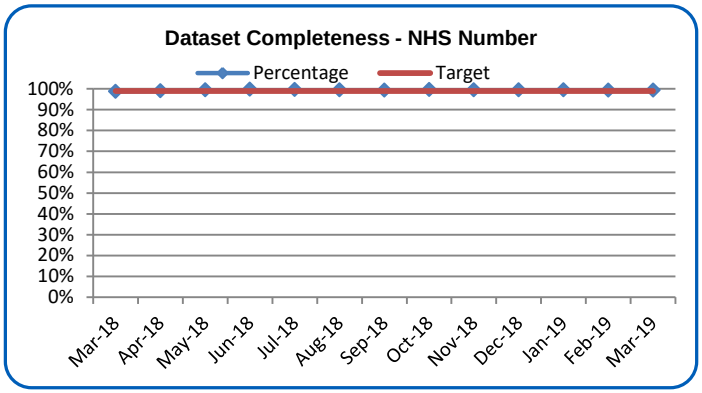
Nursing vacancies excludes nursing posts working in corporate/development roles

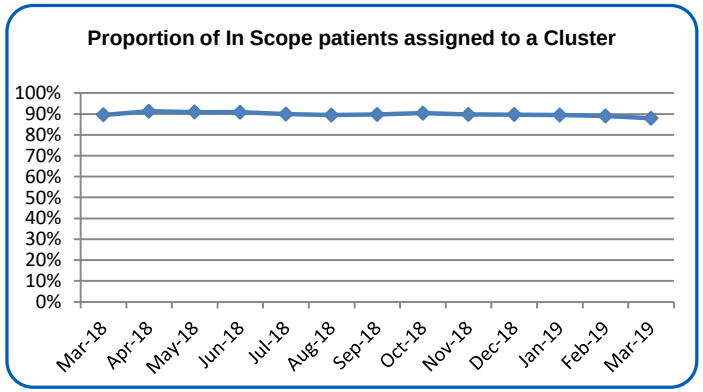
13 month trend: Clinical Record Keeping

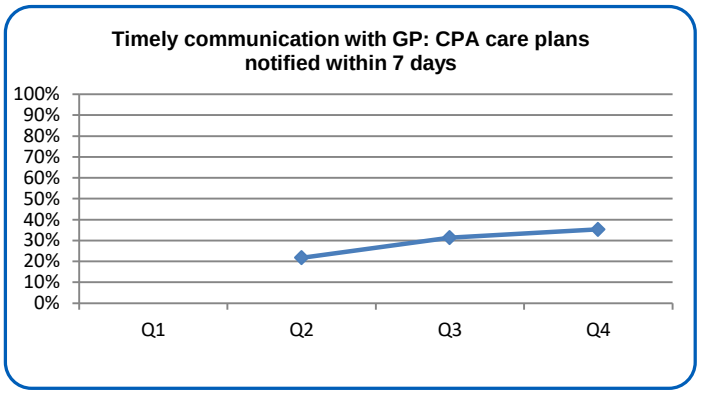






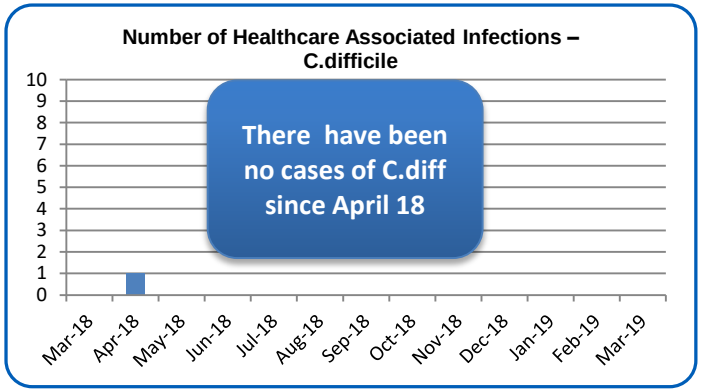


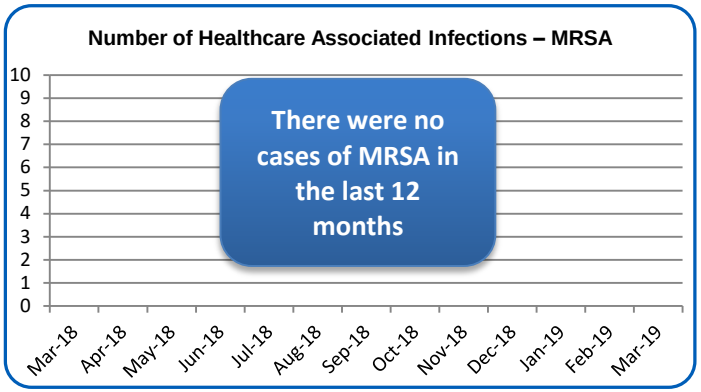


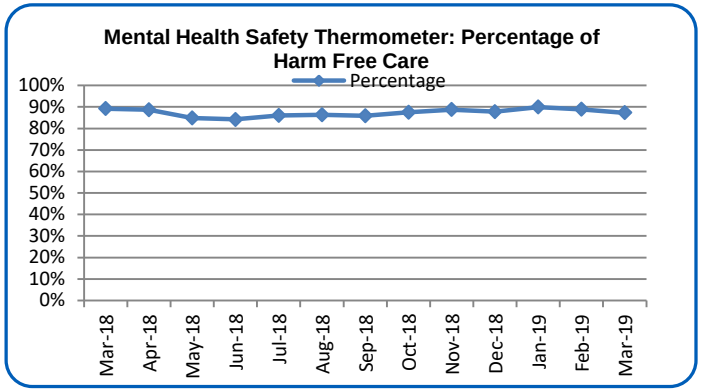


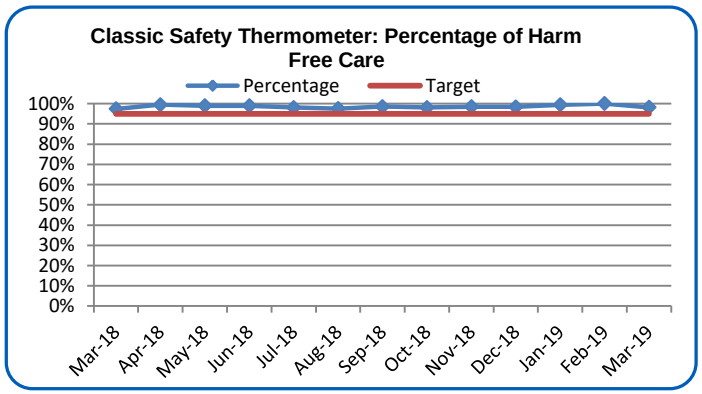
Please note that new metrics are only reported from the month of introduction onwards.

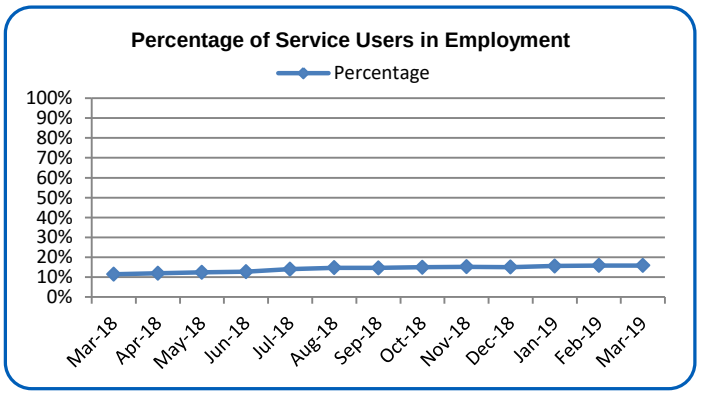
13 month trend: Quality: Effectiveness

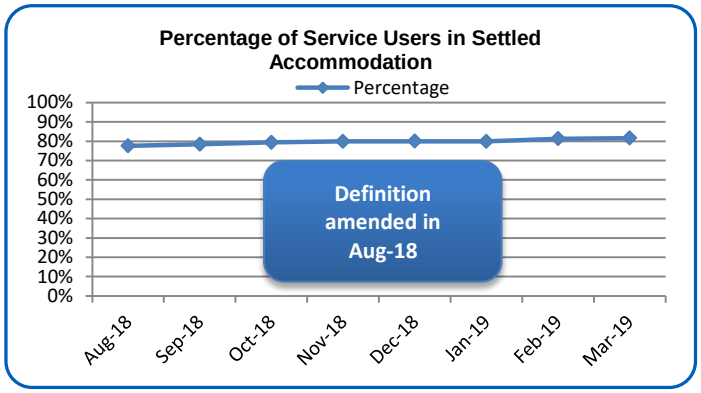




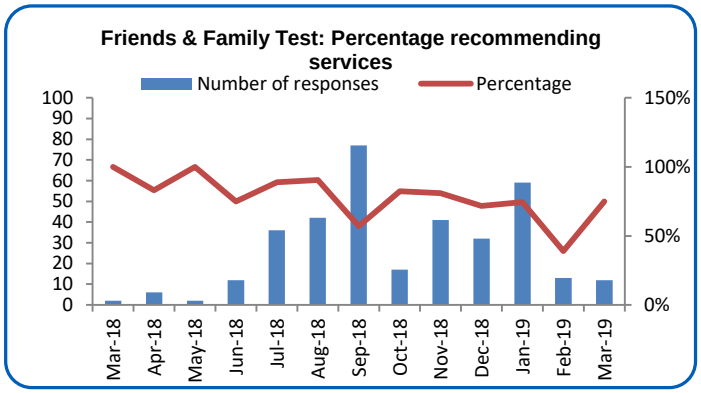


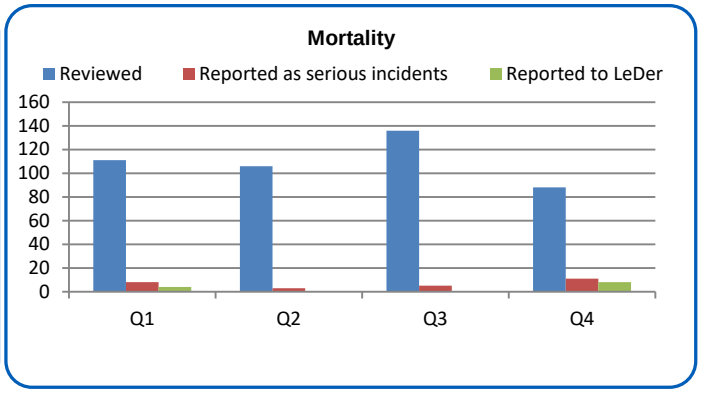


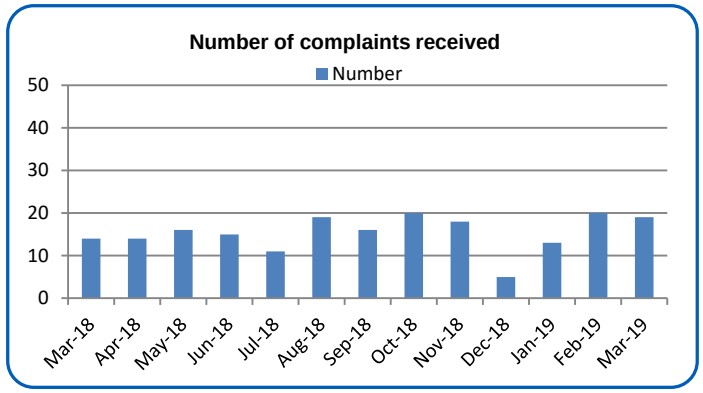


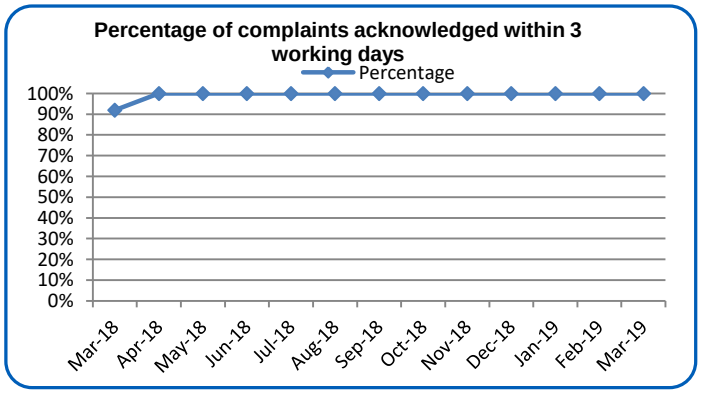


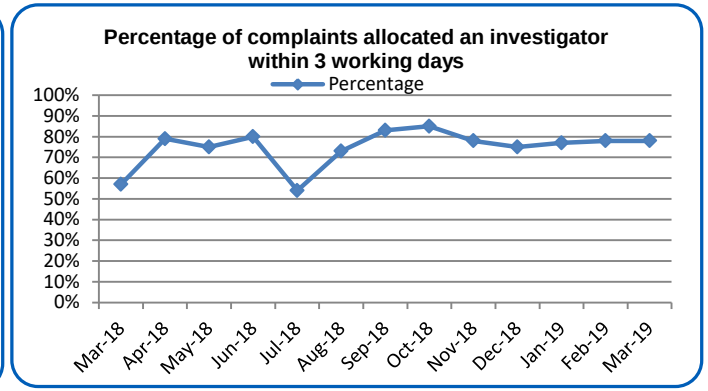
13 month trend: Quality: Caring/Patient Experience

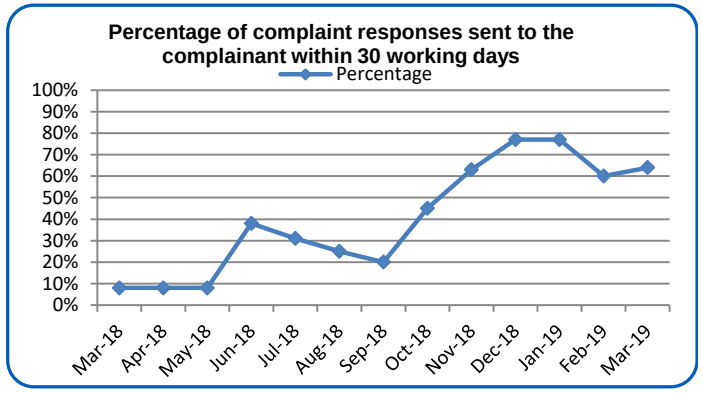


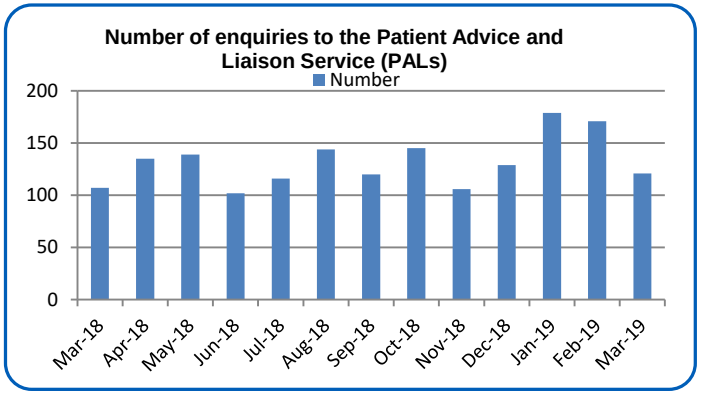




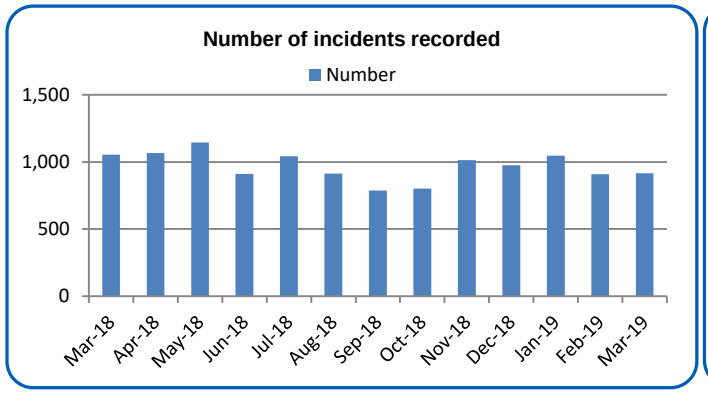


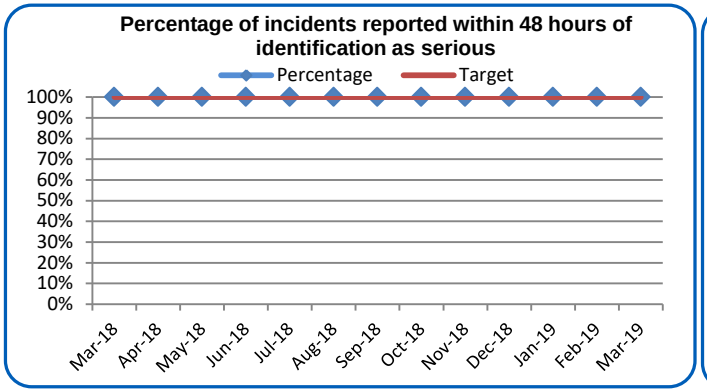


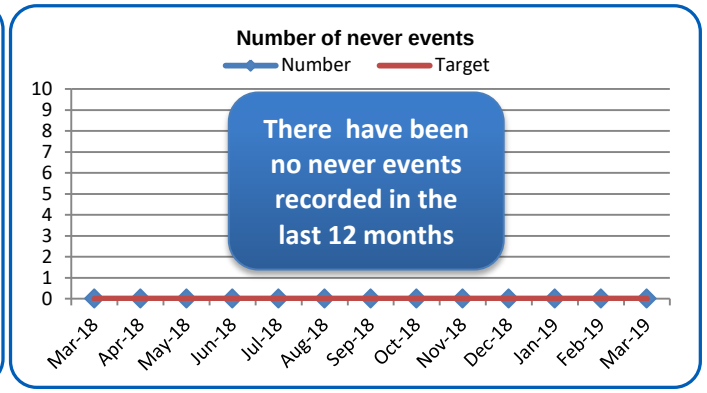


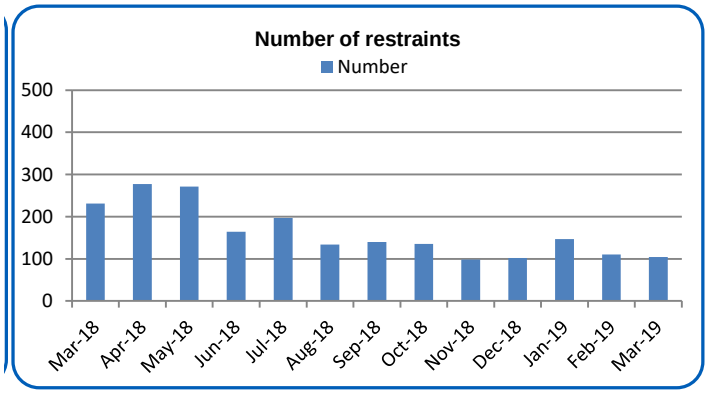


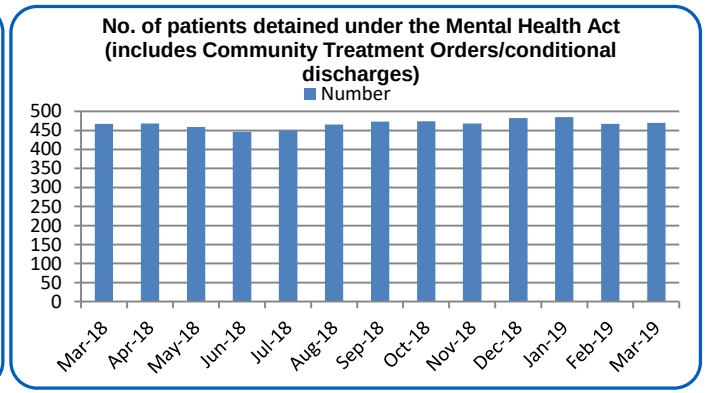
13 month trend: Quality: Safety

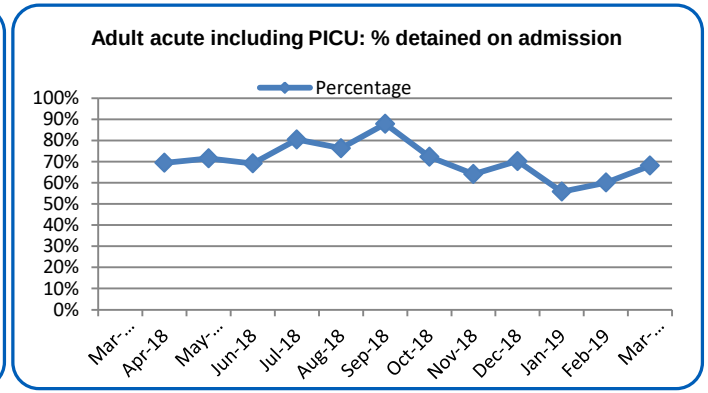


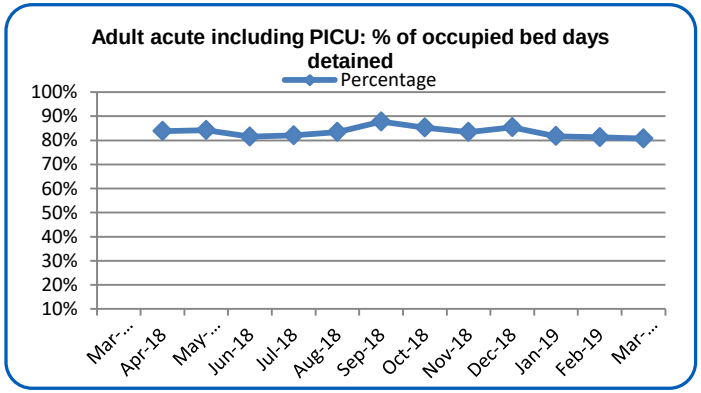




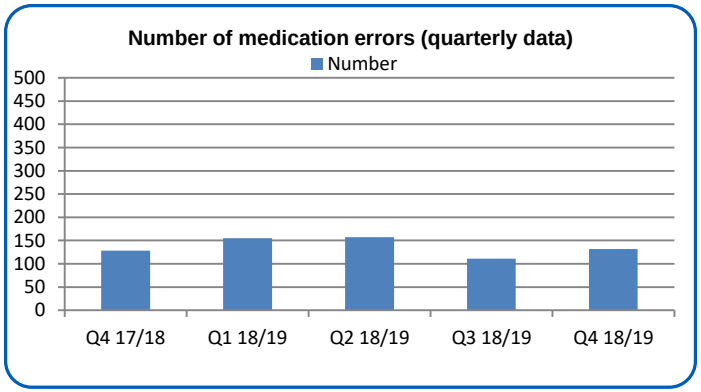


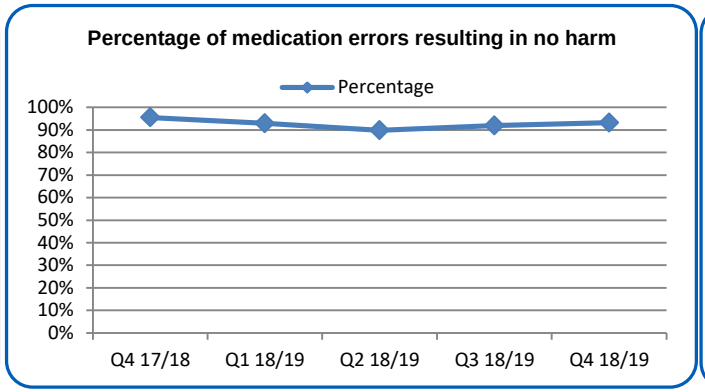


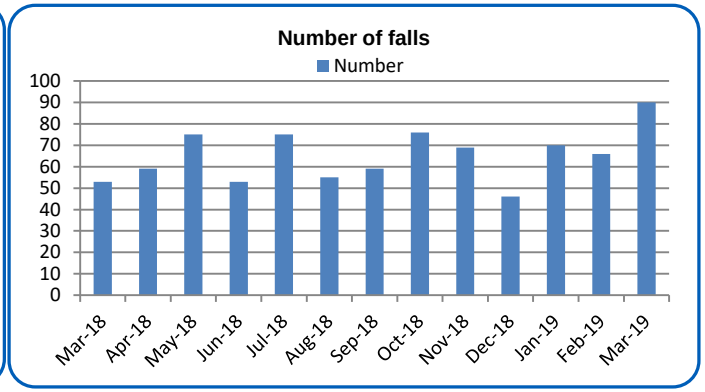


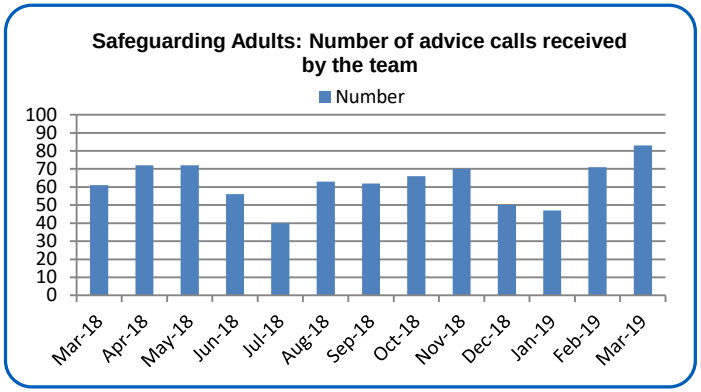


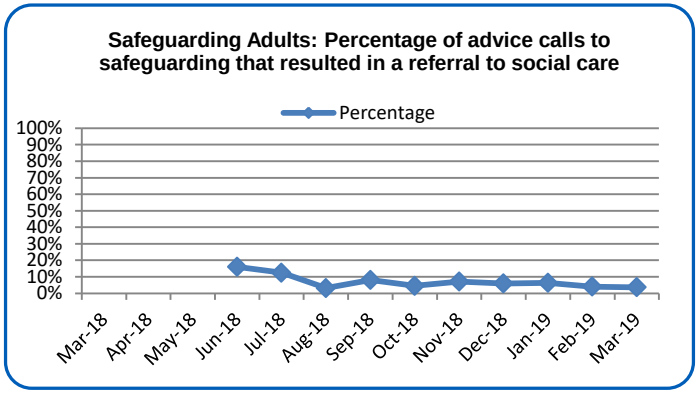
13 month trend: Quality: Safety - continued

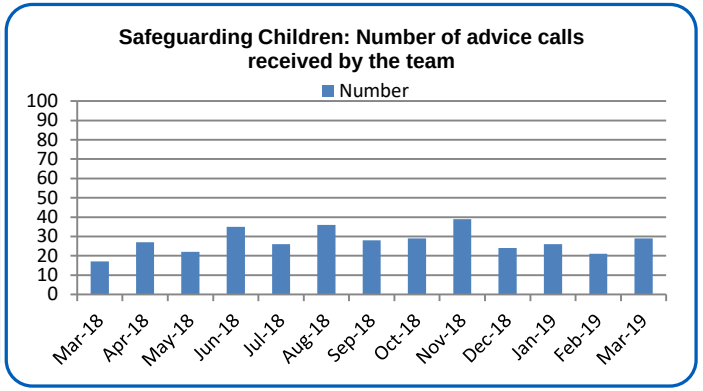


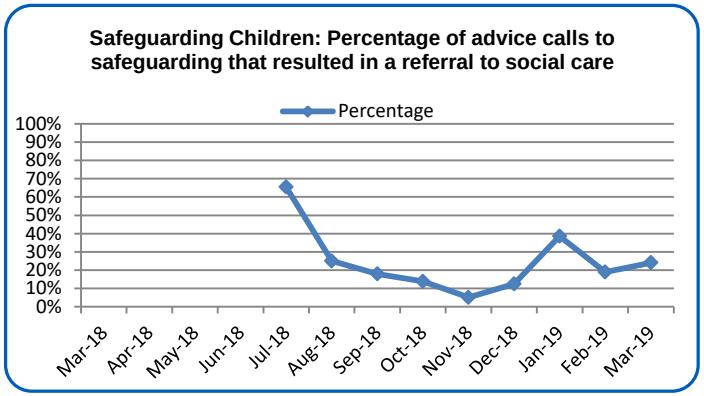




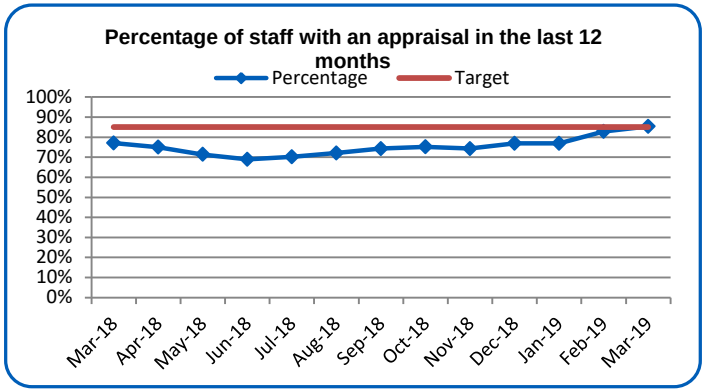


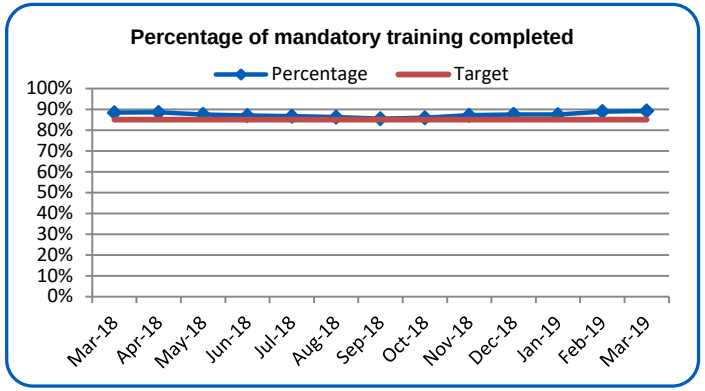


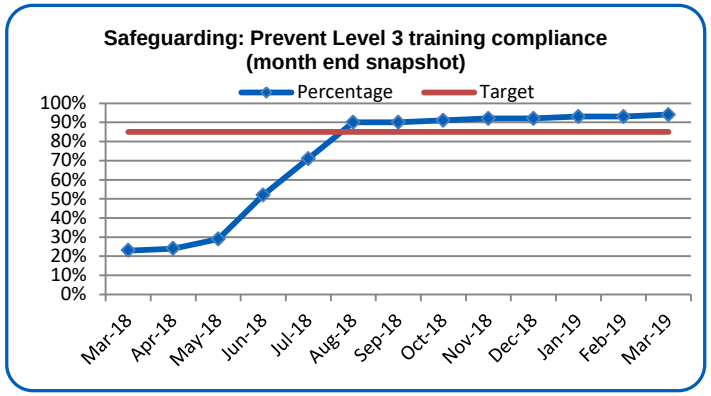


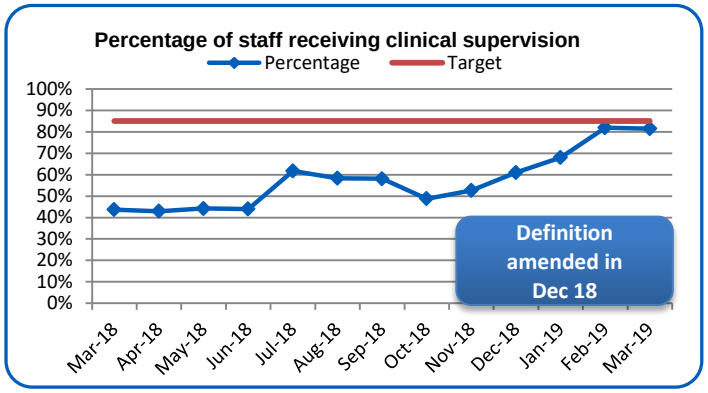


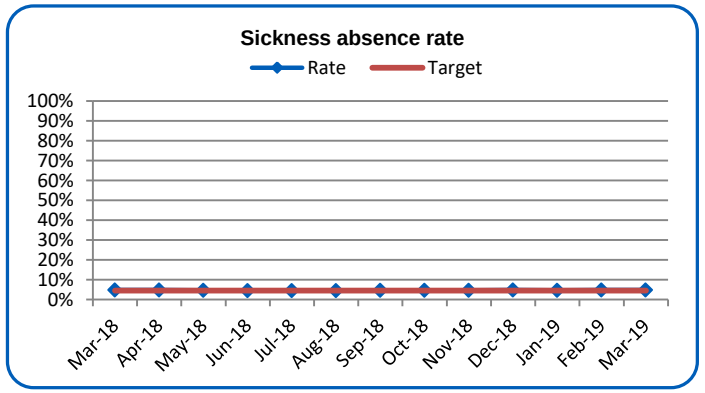
13 month trend: Our Workforce

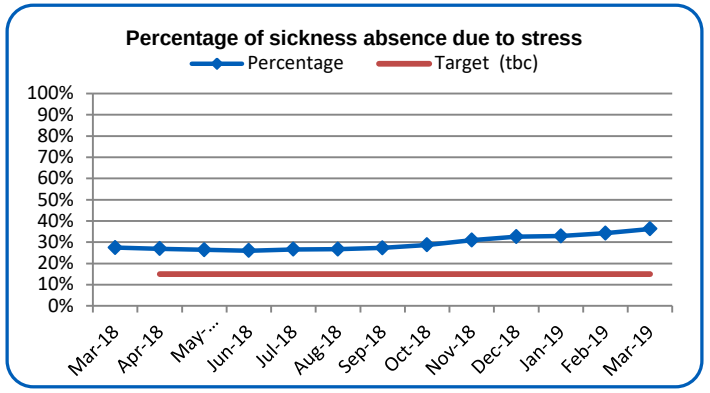


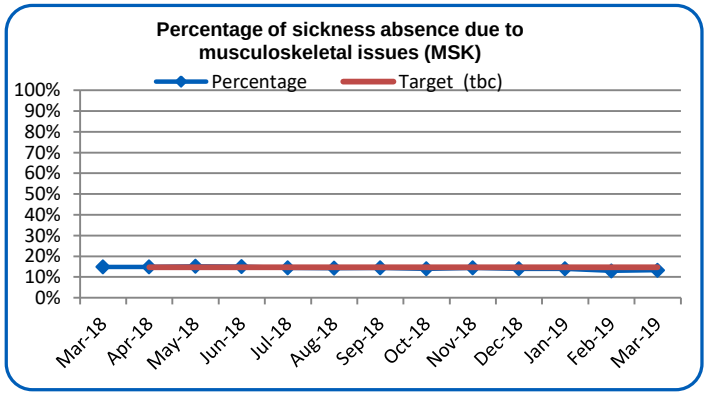




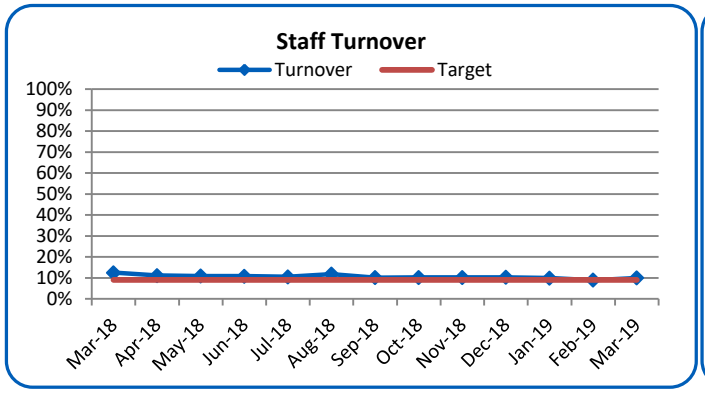


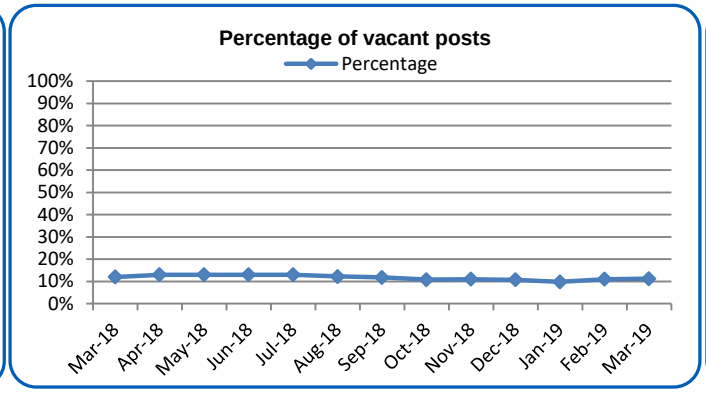


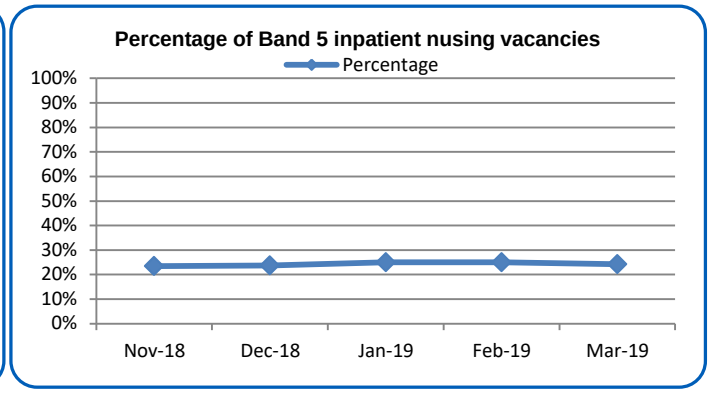


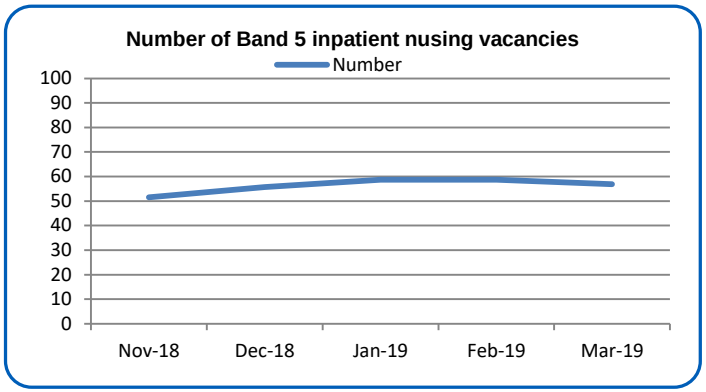


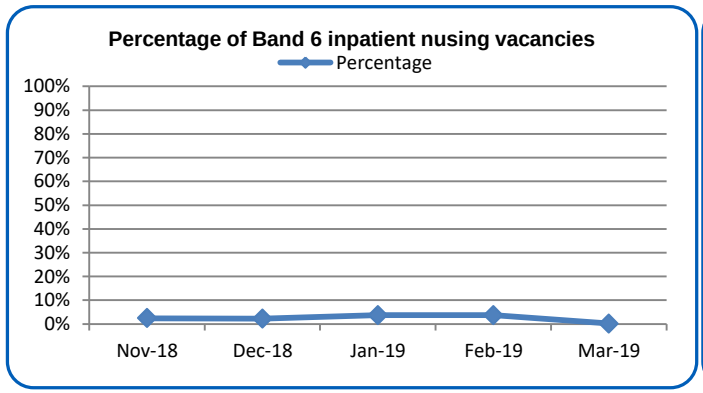
13 month trend: Our Workforce - continued

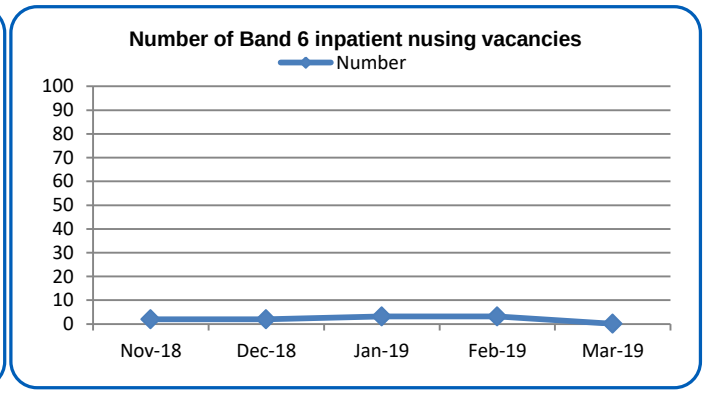




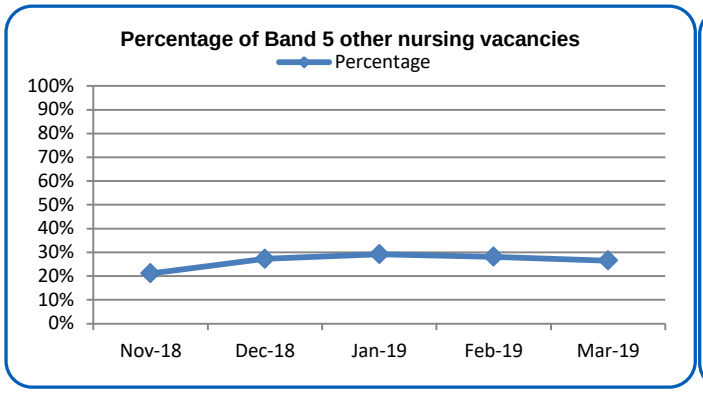


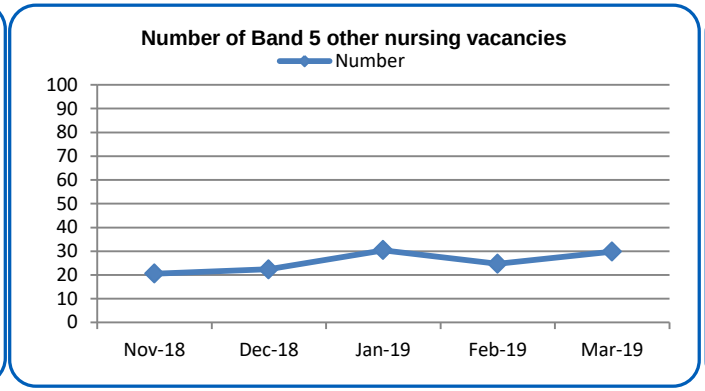


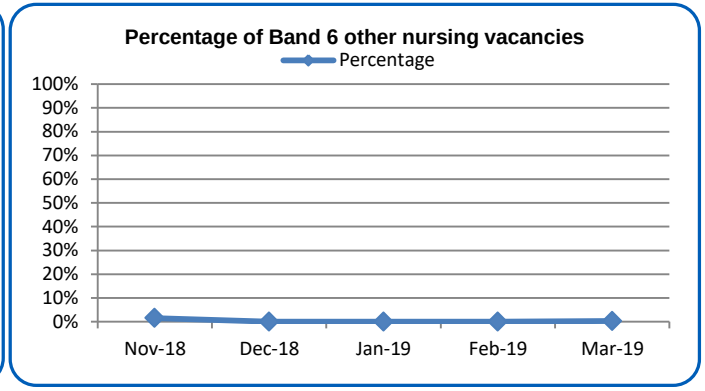


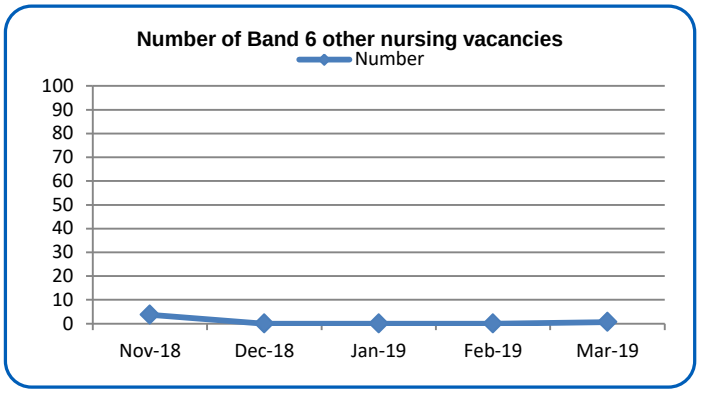


13 month trend: Our Workforce - continued









Local intelligence

Points to note:

FEBRUARY:

Safety: There was one service user who remained in the 136 suite for longer than 24 hours in February, bringing the year to date total to 14. This was due to the individual's mental state. This means that the individual was not willing or able to engage in the assessment and it was deemed necessary by the assessment team to have a period of 'downtime' which may include actively medicating the individual prior to the assessment being able to take place.
February was the last month for the measurement of staff having the flu vaccination. The Trust achieved the threshold required with more than 75% of clinical staff being vaccinated.

Patient Experience: Whilst the Trust endeavours to send a response to complainants within 30 working days, each complaint is reviewed individually and timescales agreed with the complainant. This is particularly important if a complaint is complex to set expectations. During February, there were a number of complex complaints being handled that did require extended timescales to be agreed with the complainant. Responses to the Friends and Family Test continue to fluctuate alongside a temporary reduction in resource to support it.

Workforce: There have been a number of improvements in workforce metrics in February. In particular, since January, an initiative has been in place targeting real time recording of appraisal and clinical supervision rates with positive outcomes in both areas. It should be noted in relation to clinical supervision that from February onwards, the Trust implemented the revised policy requiring a minimum of 6 sessions in each 12 month period, measured on the basis of supervision taking place in the previous 60 days for rolling reporting purposes. This revision in itself would have increased the compliance rate by 5%, the remaining increase of 9% is attributable to the improvement work. The Trust has seen an increase in absence due to Mental Health and Stress in February and investment has been agreed to implement a Health and Wellbeing Manager to undertake a deep dive into this figure and work proactively to ensure a comprehensive and cohesive staff support structure is in place.

MARCH:

Safety: There were two service users who remained in the 136 suite for longer than 24 hours in March, bringing the year to date total to 16. Both were due to no beds being available locally and, at the time, no beds being available out of area. Following the delay, one of the service users was able to be successfully supported by home treatment and did not require admission and the other was transferred to a bed in one of our wards the following day.
Over the quarter, adult safeguarding advice has followed the usual trend of the highest concerns being about emotional, financial and physical abuse. The referrals on to adult social care, however, have been concerning allegations of neglect and sexual abuse. Queries around emotional and physical abuse remain the main reasons for clinicians contacting the safeguarding team for child safeguarding advice. This trend is reflected in those cases that are then recommended for social service referral.

Workforce: At year end, the Trust successfully met the appraisal target of 85% completion for the first time. The 85% targets for compulsory training and Safeguarding Level 3 PREVENT training continued to be exceeded at year end. The Trust has retained an improved outcome of in excess of 80% in relation to Clinical Supervision but still remains below the 85% target and improvement work continues in this area. Over the next couple of months, the change in hierarchies within the Ilearn system to reflect Trust wide changes may create additional reporting complexities until all structures are resolved. Sickness absence remains above target and has increased by a further 0.1%. The Trust has continued to see a rise in the proportion of absence related to Mental Health and Stress and the process to appoint a Trust Wellbeing Manager is in progress.

Finance – Chief Financial Officer and Deputy Chief Executive

Unless otherwise specified, all data is for March 2019

This section highlights performance against key financial metrics and details known financial risks as at March 2019. The financial position as reported at month 12 is within plan tolerances.

Finance	Target	Jan-19	Feb-19	Mar-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		£25.16m	£28.75m	£30.03m
Cost Improvement Programme versus plan (% achieved)	100%	99.72%	99.63%	100.00%
Cost Improvement Programme: achieved		£2.36m	£2.62m	£2.89m
Single Oversight Framework: Cash Position Liquidity Rating	1	1	1	1
Cash Position	-	£65.27m	£68.06m	£69.42m
Capital Expenditure (Percentage of plan used) (YTD)	100%	77.10%	83.99%	96.43%
Single Oversight Framework: Agency Spend Rating	1	2	2	2
Agency spend: Actual	-	£4.30m	£4.70m	£5.14m
Agency spend (Percentage of capped level used)	-	103.00%	104.00%	104.00%

Finance

Single Oversight Framework – Finance Score The Trust achieved the plan at month 12 with an overall Finance Score of 1.	**Income and Expenditure Position (£000s)** £30.03m surplus income and expenditure position at month 12. Overall net surplus £1.99m 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 12 is fully achieved against plan, £2.89m CIP achieved (100%)	**Cash (£000s)** The cash position of £69.42m is £0.39m below plan at the end of month 12 and achieved a liquidity rating of 1 (highest rating).
Capital (£000s) Capital expenditure (£4.44m) is behind plan at month 12 (96.43% of plan).	**Agency spend (£000s)** Compares actual agency spend (£5.14m at month 12) to the capped target set by the regulator (£4.96m at month 12). The Trust reported agency spending 4% above the capped level and achieved a rating of 2.
Areas of Financial Risk as at March 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
ARMS	At Risk Mental State	ARMS is used to describe young people aged 14-35 years who are experiencing low levels signs of psychosis.
CRISS	Crisis Resolution and Intensive Support Service	The CRISS supports adults (usually aged 18-65) experiencing a mental health crisis with intensive home-based treatment as a genuine alternative to hospital admission. It also supports older people in crisis outside of normal working hours. CRISS operates 24 hours a day, 7 days a week, 365 days a year. This includes working closely with health and social care partners and third sector agencies to ensure people's needs are planned for in a coordinated way.
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

Acronym	Full Title	Definition
		one of ten categories that range from ‘extremely impaired’ (1-10) to ‘doing very well’ (91-100).
CMHT	Community Mental Health Team	There are six CMHTs (3 working age adult and 3 older people’s) two cover each area of Leeds – West North West, South South East and East North East.
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 and 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

Acronym	Full Title	Definition
KPI	Key Performance Indicator	A quantifiable measure used to evaluate success
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.
LCG	Leeds Care Group	One of the Care Groups (groupings of services) within the Leeds & York Partnership Foundation Trust.
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.
NICE	National Institute for Health and Care Excellence	NICE provide guidelines on identification and pathways to care for common mental health problems aims to improve how mental health conditions are identified and assessed.
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	Leeds Psychiatric Care Intensive Service (PICU) provides intensive and specialist care and treatment

Acronym	Full Title	Definition
	Unit	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 public place, if a police officer considers that you are suffering from **mental** illness and in need of immediate care.
SOF	Single Oversight Framework	A framework from NHS Improvement to oversees NHS trusts and NHS foundation trusts
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 Services and Learning Disabilities Care Group	One of the Care Groups (groupings of services) 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

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Report from the Freedom To Speak Up Guardian
DATE OF MEETING:	23 May 2019
PRESENTED BY: (name and title)	John Verity, Freedom To Speak Up Guardian
PREPARED BY: (name and title)	John Verity, Freedom To Speak Up Guardian

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

EXECUTIVE SUMMARY

Attached is the annual report from the Freedom to Speak Up Guardian. This report sets out the work of the Guardian over the period, details the number and type of concerns raised and the lessons learnt.

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

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

RECOMMENDATION

The Board is asked to:

- Receive the report from the Freedom To Speak Up Guardian,
- Note the content,
- Support the work being undertaken
- Be assured that staff are aware of how to and are raising concerns in the appropriate way.

MEETING OF THE BOARD OF DIRECTORS

23 May 2019

Freedom to Speak up Guardian Annual Report 2018/19

1. Introduction and background

The appointment of a Freedom to Speak up Guardian (FTSUG) in all NHS Trusts and Foundation Trusts was recommended by Sir Robert Francis following his review and second report in February 2015 into failings at the Mid Staffordshire NHS Foundation Trust. This Trust has had a Guardian in place since October 2016.

FTSUGs have a key role in helping to raise the profile of raising concerns in their organisation and providing confidential advice and support to staff in relation to concerns they have about patient safety and / or the way their concern has been handled. Guardians do not get involved in investigations or complaints, but help facilitate the raising concerns procedure; ensuring organisational policies are followed correctly.

2. Raising awareness of the Freedom to Speak up Guardian

Our current Guardian is John Verity and since his appointment in October 2017 he has carried out extensive work to raise the profile and awareness of the role and the ways in which he can support staff who wish to raise a concern. Below is a summary of the ways in which he has done this.

Since his appointment John has completed over 200 face-to-face contacts. To ensure he maximises the number of staff he sees he has attended staff handover meetings, team meetings and away days, the monthly bank staffing forum and the Trust's Welcome day for new staff. He has also carried out walkabouts across Trust sites on both a planned and non-planned basis to ensure he achieves a far reaching spread. He has also established 'hot desk' arrangements in many areas to increase the profile of the role, and be available to staff too.

The Guardian has carried out visits to all the main sites and more recently has visited the more remote areas including our Deaf CAMHS at both Manchester and Newcastle. In conjunction with these services the Guardian has developed posters specifically aimed at our deaf staff with an emphasis on 'SPEAK UP SIGN UP' incorporating a QR code which can be accessed by smart phones/ technology.

The Guardian has established relationships with Forward Leeds and our smaller remote areas including our Specialised Supported Living Service. He recently met with the Veterans' Mental Health Complex Treatment Service Clinical Team Manager; and with staff from the Northern Gambling Clinic.

In addition to the informal ways of raising his profile the FTSUG has also attended a number of formal meetings. These include: Staffside meetings; HR meetings; Equality Impact Group meetings(EIG); Equality and Diversity workshops; Care Group Governance and Business meetings; the Trust Wide Clinical Governance Group; local clinical team meetings; Clinical improvement forums and professional meetings.

To report on his work and raise awareness he has a regular blog in which he describes recent activity and learning. He uses this blog to advise staff of his up-coming visits at locations across the Trust.

In addition to meeting staff our Guardian has distributed updated posters, which now have an image of the Guardian so people can recognise him when he is in our units. He has business cards with an invite to contact him not only if a member of staff wants to raise a concern but if groups of staff want to invite him on a planned visit. He is also working closely with managers to ensure there is maximum access to the Guardian.

The Guardian has ensured that the language and message of communications are consistent with national guidance and will continue to monitor that this is provided in a manner consistent to this guidance.

To ensure the Guardian is more accessible to all groups and there is an inclusive approach to raising concerns and the Guardian is working closely with the Head of Diversity and Inclusion.

This work identifies ways of ensuring appropriate communication and accessible approaches to raising awareness. The Guardian meets regularly with the Bank Staffing lead and is a core member of the Bank Staffing Forum, which helps reach staff who are sometimes difficult to access due to their different work/shift patterns. The Bank Staffing Forum is always well attended and a good place to hear concerns of staff and again help with signposting.

To make sure the Guardian reaches out to our students/apprentices he has met with student /apprentice lead(s) and provided them with updated posters and flyers. He has also met with students at staff meetings and walk-arounds. The student/ apprentice leads have now incorporated visual representation and information as a part of their induction event(s).

The role has been well received and well supported within the organisation at all levels. Engagement with all staff has its challenges due to the geography of the Trust, but being available and responsive to staff is key to the success of the Guardian so the role works on a flexible and agile basis as opposed to being office based. Staff are always given a choice as to where and when they would like to meet. Often staff request to meet off-site to allow them to maintain confidentiality.

The Guardian has regular access to the Chair, Chief Executive and the Senior Independent Director. He also has access to Guardian of Safe-working Hours, the consultant for Junior Doctors in training and our Caldicott Guardian.

In summary the Guardian has used a number of methods of raising awareness of the role. These include:

- Face-to-face contact at team meetings
- Face-to- face meetings and poster/flyer and business card drops
- Developing Stand up – Sign up posters for our Deaf CAMHS colleagues
- Informal contact / meetings with staff and managers
- Desk top notifications which will be seen when staff switch on their computer
- Trustwide emails
- Individual email communication targeting managers of clinical services
- Regular blog to include drop in and all main sites on a regular rotation
- Staffnet page providing details of the role and how to contact the Guardian

- Inclusion in the event for the Trust induction with a slot on the induction programme to ensure that all staff at the event receive consistent messages and information about raising concerns
- Peer reviews are conducted too
- Training aids are now added to the Raising Concerns Staffnet page.

3. CQC Inspection

In January 2018 the CQC undertook a 'well-led' review which included looking at our arrangements for raising concerns. The CQC was complementary about these arrangements and indicated that the handling of concerns raised by staff always met with best practice. As part of the forthcoming inspection the Guardian will meet the CQC team.

In preparation for a CQC inspection and to ensure we maintain compliance with standards and good governance, peer reviews are conducted within the services. As a part of this review staff are asked whether they have an awareness of the Guardian. Any areas where it is felt beneficial for a Guardian visit is fed back to the Guardian following this process.

4. Internal audit report

Earlier in 2018 NHS Audit Yorkshire (our internal auditors) carried out an audit of the systems, processes and procedures relating to the FTSUG role. This resulted in a rating of 'significant assurance' overall. Whilst the systems and processes were found to be strong there were a number of minor administrative processes recommendations which are now complete. In addition to this there were recommendations relating to the Raising Concerns (Whistleblowing) Procedure which is presently under review. The FTSUG and HR are expecting to have the refreshed procedure signed off by the Workforce and Organisational Development Committee and re-launched into the Trust.

5. Regional and national networking:

There is a requirement and expectation for the Guardian to attend regional and national events including training to promote standardised approaches to the role and to share and learn from peers. The Guardian is linked into both our regional events, the national events and also

receives one-to-one peer support from some of the local guardians from other trusts. These activities ensure that the Guardian has a strong peer network and they also ensure the Trust is working to current and best practice and to build networks.

At the regional meetings Guardians share their experiences and good practice. They have the opportunity to discuss reviews and recommendations supplied by the National Guardians Office. A member of the National Guardians Office (NGO) is generally present. The Regional meeting is a safe place to have group supervision and to discuss and thoughts and concerns or experiences other Guardians may wish to share.

The Regional Guardians also discuss current national benchmarking information as below.

2017/18 data headlines (latest full year of data available)

- 3,206 (45%) cases included an element of bullying / harassment
- 2,266 (32%) cases included an element of patient safety / quality
- 1,254 (18%) cases were raised anonymously
- 361 (5%) cases indicated that detriment as a result of speaking up may have been involved
- 6 NHS trusts either did not make a return or reported that they received no cases through their Freedom to Speak up Guardian in all four quarters.

Q4 data headlines (as at March 31st 2019)

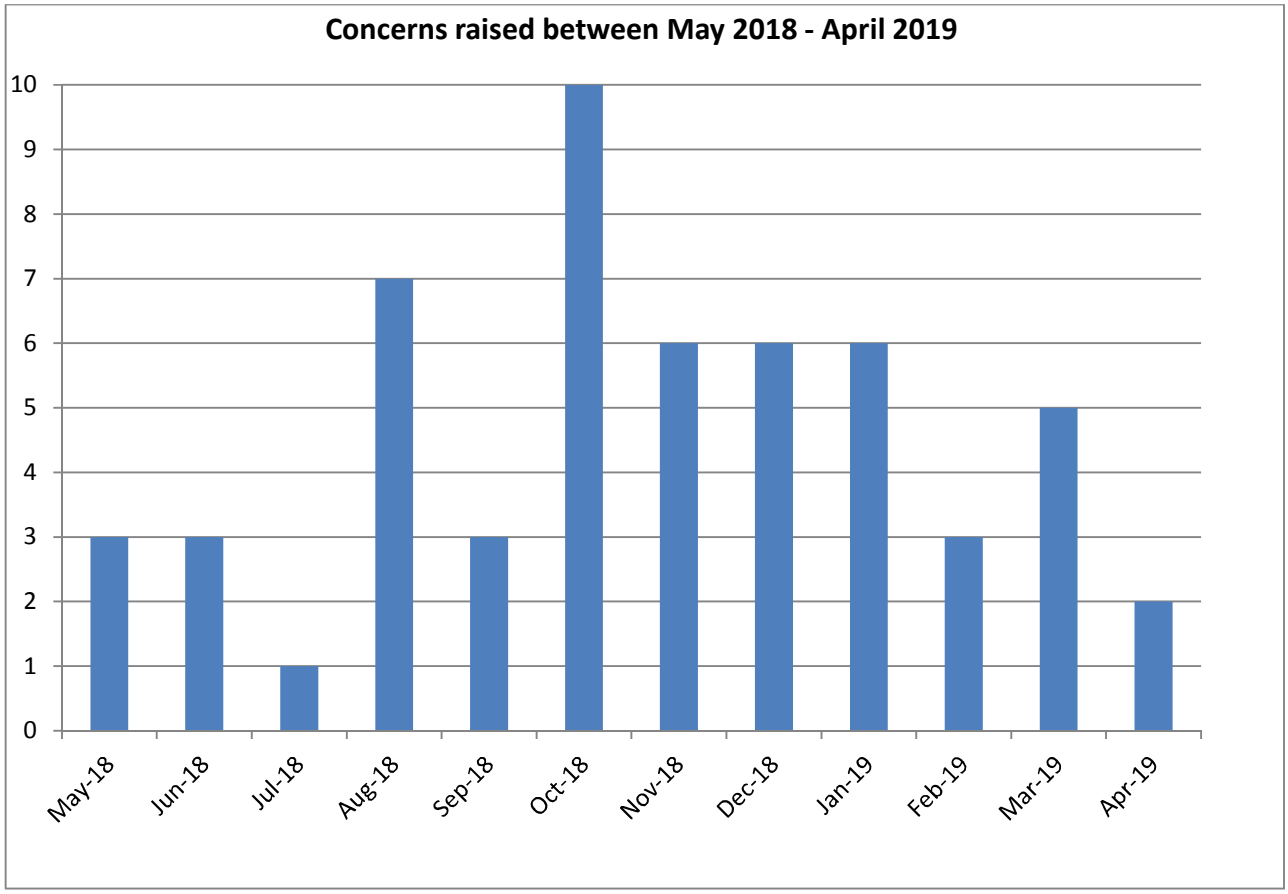
- 3,406 cases were raised to Freedom to Speak up Guardians / ambassadors / champions
- 928 of these cases included an element of patient safety / quality of care
- 1,312 included elements of bullying and harassment
- 122 related to incidents where the person speaking up may have suffered some form of detriment
- 506 anonymous cases were received
- 5 trusts did not receive any cases through their Freedom to Speak Up Guardian
- 220 out of 227 NHS trusts sent returns.

6. Summary of Concerns Raised up to April 2018

6.1 Number of concerns raised

Details of any concerns raised are recorded locally via a 'concerns tracker' which is a local database held by the Guardian. This records the action taken and the classification of the concerns that have been raised. The Guardian also has access to the Datix incident reporting system to allow triangulation with other events which may have taken place in a particular area or ward. This allows the potential to identify trends and patterns**.**

Since the last report was made to the Board in November 2018, 28 concerns have been raised between December 2018 and April 2019 making a total of 55.



The Board is asked to note that whilst there are peaks and troughs throughout the period shown above the Trust's overall average for raising concerns is 4.6 (56/12) concerns raised

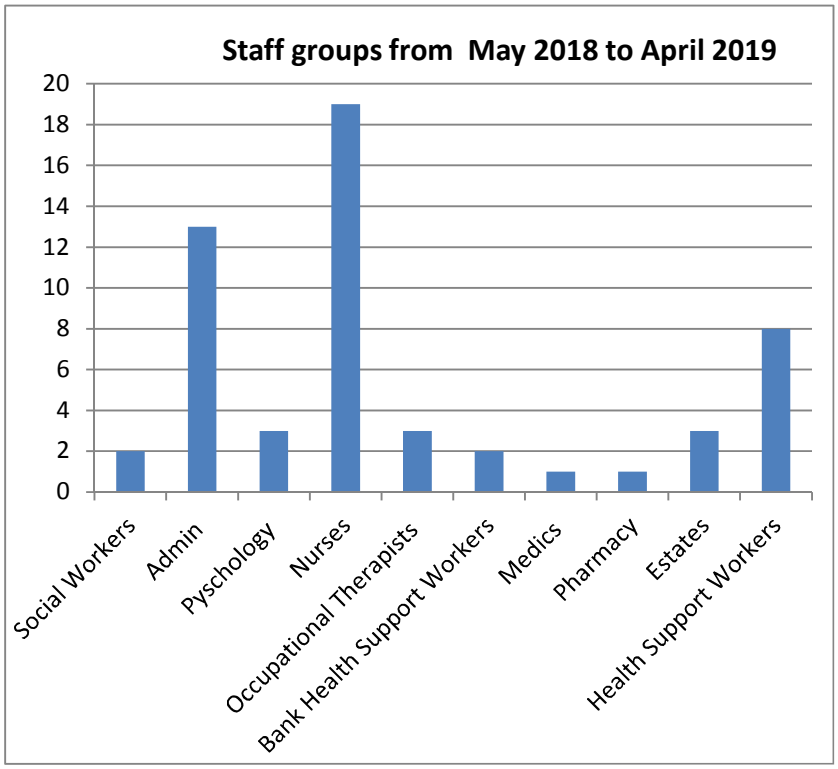
per month which is comparable to the national average for small trusts (i.e. those having less than 5000 staff).

However, at the November 2018 Board Meeting, it was noted that there was a spike in October 2018 with the number of concerns rising to 10 in that month. This increase has been analysed and the Guardian is confident that the increase was due to the relaunch of the poster and the drive to ensure that staff are aware of how to contact the Guardian. There is no indication that the increase is due to an increase in patient safety concerns and the themes remain consistent with previous months.

With regard to national data trends, the National Guardian's Office (NGO) requires performance data from each Guardian so it can be added to that national database. These national figures are then published by the NGO. Quarter 4 data was submitted by the deadline and the 2018/19 annual results are published on the NGO website which can be accessed here:
https://www.cqc.org.uk/national-guardians-office/content/speaking-data

6.2 Professions - Raising Concerns

The following table shows the groups of staff that have raised a concern between May 2018 and April 2019



The graph above shows that the majority of concerns are from nurses. Nurses make up the majority of the workforce in number, our spike mirrors that of the national trend nationally in that between 1 April 2017 and 31 March 2018 more cases (2,223, 31% of the total) were raised by nurses than other professional groups.

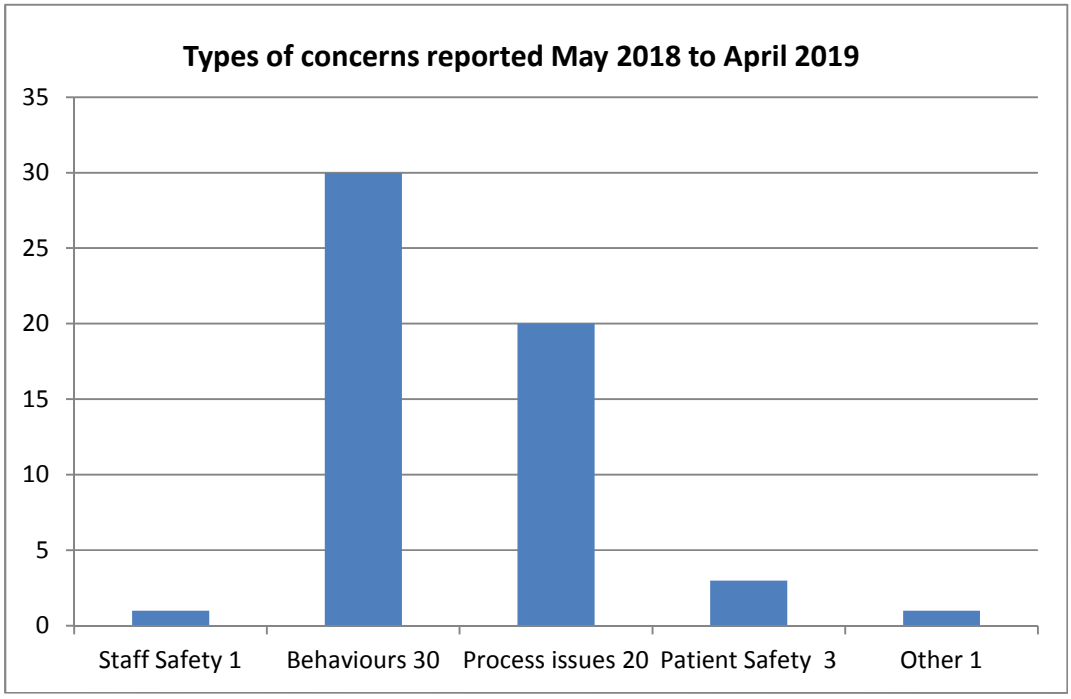
Our second highest staff group raising concerns are our admin staff and the Guardian has observed that for this Trust this has been linked to the service redesign. Again nationally admin staff are ranked the 2nd highest reporters which mirrors the data for the Trust.

6.3 Whistleblowing cases

There have been no cases of whistleblowing reported since the last report.

7. Themes for the concerns raised and lessons learnt

In relation to the 55 concerns raised since from May 2018 to April 2019 the following themes have been identified.



The table below provides some further detail of the themes that have been raised:

Area of Concern	No.	Themes and Lessons Learnt
Staff Safety	1	One concern raised was around youths regularly climbing onto a trust building and the risk this posed not only to them but also to staff's safety. There was a thorough investigation and some remedial action taken. This issue has also been added to the directorate risk register.
Behaviours	30	This is where the greatest numbers of concerns are raised and are often where working relationships have become strained or have broken down and where low-key facilitation is required / signposting to appropriate services or policies and procedures. The FTSUG has helped to facilitate discussions taking place and has helped support staff with the signposting they need to ensure there is a resolution. In many occasions mediation is offered. The key themes and lessons learnt are: • Some working relationships became strained and broken down • Staff are requesting structured supervision and a yearly appraisal • Staff find the policies and procedures around Bullying and harassment and Grievance are not as simple to use as they maybe However, a drive to increase the percentage and uptake/recording of appraisals and supervision has shown promising results. The appraisal uptake increased from 75% (April 2018) to the Trust target of 85% (March 2019) The Clinical Supervision uptake increased from 43.69% (March 2018) to 82.00% (March 2019). As the Bullying and Harassment, Grievance and Raising Concerns policies and procedures are presently under review it is hoped that a simplified procedure may well see a decrease in the number of concerns regarding behaviours, with the appropriate policy/procedure utilised before signposting to the correct HR procedure from the Guardian. The three policies mentioned above are to be presented to staff workshops before going out for further consultation. LYPFT now has a Workplace Wellbeing Scheme, which is a confidential service where staff can talk to advisers about anything that is affecting a staff members wellbeing, this initiative has full support of our Chief executive, Director of OD and Workforce and Staffside.

Area of Concern	No.	Themes and Lessons Learnt
Process issues	20	These are cases where staff were unsure of to how to proceed and needed help with signposting / support to the appropriate services or policies and procedures. As the Bullying and Harassment, Grievance and Raising Concerns policies and procedures are presently under review it is hoped that a simplified procedure may well see a decrease in the number of concerns re behaviours, with the appropriate policy/procedure utilised before signposting to the correct HR procedure from the Guardian
Patient Safety / quality	3	Two of these concerns are linked to medical cover within a specific area, and the 3rd was around use of ECT within the older peoples' service. The latter was signposted to the person's clinical supervisor with the Guardian receiving no further information or concerns, and the former is being overseen by the appropriate heads of service working closely with our Director of OD and Workforce and the Medical Director. Where any case raised indicates there may be an element of patient safety this is discussed with the Chief Executive and the apporporate execuitve director. The Guardian will also speak with the Chair and or Senior Independent Director as needed.
Other	1	This is presently in process as received on 30 April 2019

8. Outcomes

Most concerns are able to be closed soon after being raised. Concerns that remain 'open' are those that are currently being signposted or where the individual is deciding on their next steps. Individuals who raise concerns are kept informed of progress and concerns are only closed when the process has been completed to the individual's satisfactions, where the individual concludes the process, or where it is agreed that the FTSUG cannot help with the matter any further. There are currently 12 concerns still open and the guardian is working with these staff to bring about a satisfactory conclusion.

Once the process has been completed a feedback questionnaire will be sent to the individual. A further three month follow up is conducted to maintain contact and to check the appropriate outcome was achieved.

Feedback has previously been received by Survey Monkey and now the Guardian is using a more simplified system paper based questionnaire which may account for a dip in responses during the transition period from one system to another.

This uses demographic and ethnicity reporting to be consistent with the Workplace Wellbeing Sheme initiative. The anonymised information on protected charecteristics to include age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity will be included in future.

Question No.	Question	Results
1	How did you find out about the Freedom to Speak Up Guardian role?	• Posters/Leaflets 42.86 % • Other 57.14 Comments 1. I dont remember how I found out about John 2. The Freedom to Speak Up Gardian is well known within the Trust 3. John came to our MDT and trust induction 4. John came to talk to the team
2	How easy was it to make initial contact?	• Very easy 85.71 % • Reasonably easy 14.29%
3	How did you find the response from the Guardian?	• Very helpful 85.71 % • Reasonably helpful 14.29%
4	Did you feel that your concerns were taken seriously?	• Yes 100%
5	Did you receive regular feedback or updates from the Guardian?	• Yes 100%
6	Has your concern been addressed?	• Yes 85.71% • Partly14.29%
7	Did you feel that your concern was treated confidentially?	• Yes 100%
8	Have you suffered any negative consequences as a result of raising your concern?	• No 100%

Question No.	Question	Results
9	Is there anything else you would have liked the Guardian to have done for you?	Comments • No • No • Reflecting on the process with him was really useful • No • He was very professional, kept in contact but didn't interfere • Some advice on how to prepare for the meeting may of been beneficial, suggested to make notes of specific instances of concern and not just general complaints. • No • No • No
10	Based on your experience of raising a concern, would you do it again?	• Yes 100%

9. Learning from external reports

In order to ensure that we promote a learning culture and have in place best practice we have benchmarked ourselves against the key findings and recommendations for any case reviews carried out by the National Guardian's Office (NGO). The latest reports benchmarked are:

- Royal Cornwall Hospitals NHS Trust, A review by the National Guardian of speaking up in an NHS trust
- Nottinghamshire Healthcare NHS Foundation Trust, A review by the National Guardian of speaking up in an NHS trust.

The Guardian has shared these recommendations with our Senior Independent Director at a meeting on 15 April 2019. In addition to this our Director of OD and Workforce assisted with a response regarding the settlement agreements mentioned in the Cornwall recommendations and assurance was made to the Board in March in relation to the Trust's position on settlement agreements.

From these reviews it has been concluded that we benchmark very favourably and there are no actions that we needed to take to strengthen our governance processes around speaking up. However, we are constantly looking for ways in which we can do things better and will continue to look at any future reports which are published.

On behalf of the Board, the Associate Director for Corporate Governance completed the NHS Improvement (NHSI) and the National Guardian's Office (NGO) self-review tool against the standards expected which enables boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identified areas for action. The action plan was signed off by the Board in September 2018 and a further report was made in March 2019. Assurance was provided to the Board on progress against the actions with the main area of work outstanding being the refresh of the speak up procedure.

10. Conclusion

The role of the Freedom to Speak up Guardian is an important one in the Trust. The Guardian continues to work to ensure that staff at all levels know how to raise and concern and feel they are able to do so. The Guardian also provides valuable support to staff who feel unable to raise concerns by themselves. The feedback received is positive, from staff who have raised concerns, the CQC and internal audit. However, we are always looking for ways in which we can strengthen the systems processes and procedures we have in place to ensure we continue to learn not just from the concerns raised, but also from the raising concerns process regionally and nationally.

John Verity
Freedom to Speak Up Guardian
May 2019

Direct report / Line management /appraisal /management supervision

- Cath Hill – Associate Director for Corporate Governance

Submission of reports

- LYPFT public board meeting: twice yearly report, presented in May and November
- Trustwide Clinical Governance, Monthly Meeting presenting a quarterly report to update on Lessons learnt
- Staffside Meeting: bi-monthly where an update report is required on any pertinent/relevant issues are discussed
- Workforce and OD Committee: as and when required to provide an update on any staff related learning
- National Guardians Office: quarterly submission to update qualitative and quantative statistical information

FTSUG Direct access

- Chair
- Chief Executive
- Chief Financial Officer and Deputy Chief Executive
- Medical Director
- Director of Nursing, Professions and Quality
- Director for OD and Workforce (Executive director for Whistle Blowing)
- Chief Operating Officer
- Deputy Chief Operating Officer
- Non- executive director (Senior Independent Director lead for Speaking up and Chair of the Audit Committee)
- Inpatient service manager(s)
- Matrons
- Clinical Team Managers
- Associate Director for Corporate Governance

Please note this is not an exhaustive list

Where lessons learnt are discussed /shared

- Direct access to colleagues and managers involved in a concern
- Public board meeting
- Trustwide Clinical Governance Meeting
- Staffside Meeting
- Workforce and OD Committee
- Clinical Improvement Forums(CIFs)
- Bank Staffing Forum
- Staff/Ward meetings
- Raising Concerns page on Staff Net
- FTSUG Blog
- Staffnet page, Lesson learnt
- Human Resources team
- National Guardians Office, Quarterly submission to update qualitative and quantative statistical information

Raising the Guardian profile(as in Section 2)

The Guardian has used a number of methods in raising awareness of the role. These include:

- Planned and diarised drop ins at main trust sites
- Planned visit to remote areas
- Face to face contact at team meetings
- Clinical Improvement Forums(CIFs)
- Staffside Meeting

- Bank Staffing Forum
- Leadership forum
- Equality and diversity CPD days
- Equality Impact Group
- Human Resources team
- Trust Induction Monthly
- Informal contact / meetings with staff and managers
- Desk top notifications which will be seen when staff switch on their computer
- Trustwide emails
- Individual email communication targeting managers of clinical services
- Text messages and phone calls
- Regular blog
- Staffnet page providing details of the role and how to contact the Guardian
- Video of FTSUG message with FTSUG with signed communication for our Deaf CAMHS colleagues
- Posters/flyers which have been delivered to service areas, with signed information
- Pop up banner - general awareness raising via portable asset for our Deaf CAMHS colleagues
- Business / post cards
- Inclusion in the market place event for the Trust induction
- Feedback from people who have raised a concern and a 3 month follow up

The Guardian has ensured that the language and message of communications are consistent with national guidance and will continue to monitor that this is provided in a manner consistent to this guidance.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
14

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Guardian of Safe Working Annual Report April 2018 to March 2019 (integrating Q4)
DATE OF MEETING:	23 May 2019
PRESENTED BY: (name and title)	Dr Claire Kenwood Medical Director
PREPARED BY: (name and title)	Dr Elizabeth 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 and assurance of the Trust's compliance with safe working hours for doctors across the Trust and to highlight and detail any areas of concern.

The key points to note are:

- The 2016 Junior Doctor contract was implemented within the Trust on the 1st February. There are 80 junior doctors currently working under the contract.
- There are 3 CT and 6HT vacancies.
- There were 500 rota gaps between the HT and CT rotas
- Rota gaps have been filled with internal locums with the exception of 48 shifts which required external locum cover and 33 shifts that ran with a reduced number of doctors. This equates to a 99% fill rate overall.
- There were 17 exception reports, 11 related to hours works, 5 to differences in support available and 1 related to the pattern of working. 8 were resolved with time off in lieu, 2 resolved by payment for additional hours worked and 5 required no further action.
- 2 exception reports indicated that there were patient safety concerns but investigation into these showed that the trainees wanted to highlight that had there been additional work load then this could not have been met. On both occasions this had been escalated to the HT at the time.

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: 1. 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 working in the Trust and that they are meeting their objective of maintaining safe services 2. To provide constructive challenge where improvement could be identified within this new system.

MEETING OF THE BOARD OF DIRECTORS

23 May 2019

GUARDIAN OF SAFE WORKING ANNUAL REPORT

April 2018 to March 2019

1 Executive Summary

On 1st February 2017 Leeds and York Partnership Foundation Trust transitioned all the junior doctors from CT1 to ST7 onto the 2016 Junior Doctor Contract.
There are a number of vacancies within both the CT1-3 and ST4-7 and these produce a number of vacant out of hours shifts. The majority of these have been filled using internal locums. There is a Trust strategic workforce plan in place to address recruitment and retention of staff.

There have been a total of 33 exception reports since the contract was implemented in February 2017, 17 of these within the reference period of this report.

There have been two reports raising concerns regarding patient safety, investigation into these reports showed that they were related to doctors indicating that were there any further additional work load then the trainees would have been unable to cover this, however there was no actual harm to patients.

We continue to work with our junior doctors and their clinical supervisors to ensure patient safety and effective training.

2 Introduction

The purpose of this report is to give assurance to the board that doctors in training are safely rostered and that their working hours are compliant with the Junior doctors contract 2016 and in accordance with Junior doctors terms and conditions of service (TCS)
The report is for the period from 1st April 2018 and 31st March 2019. It covers:

- staff vacancies and locum usage
- exception reports
- work schedule reviews

3 Background

Health Education England for Yorkshire and the Humber (HEEYH) fund 68 whole time equivalent posts via the medical tariff. Less than full time trainees (LTFT) can be allocated to Trusts on a supernumerary basis i.e. additional to the agreed training scheme posts. LYPFT has three LTFT doctors in training within the Trust at present.

LYPFT is lead employer for the Leeds and Wakefield Psychiatry core training scheme. The two hosting Trusts within this scheme are South West Yorkshire Partnerships Foundation Trust (SWYPFT) and Leeds Community Health Trust (LCH). SWYPFT run their own on call whereas LCH participate in the LYPFT on call rotas. There are 34 Core Trainees (CT) posts allocated to LYPFT and a further four from LCH on the rotas for out of hours working.

LYPFT is the employer of psychiatry Higher Trainees (HT) allocated to placements within the Trust. There are 30 training posts allocated to Leeds based placements and 1 York based placement.

York services are a hybrid arrangement with LYPFT being the employer of CAMHS HT (ST4-7) and Tees Esk and Wear Valley NHS Foundation Trust (TEWV) the lead employer for the CTs allocated to CAMHS and Forensic services. All York based trainees participate in the York locality rotas.

Leeds Teaching Hospitals Trust (LTHT) is the lead employer for the Foundation Training Scheme. LYPFT hosts 18 Foundation Trainees including six that participate in the LYPFT CT on call rota.

The current head count of doctors in training working in the Trust is 80. (A break down is detailed within the appendix A).

The LYPFT guardian of safe working (GSW) was appointed in November 2016 and is responsible for the directly employed trainees. This requires the guardian to liaise with the hosting

organisations with reciprocal liaison with the other Trusts' trainees hosted in LYPFT and not directly employed as exceptions occurring as part of work within other Trusts is reviewed and addressed within that Trust. For example if a CT employed by LYPFT working in SWYPFT reports an exception this is received by LYPFT but addressed by SWYFT.

When there are vacant training places the Trust recruits junior grade doctors on temporary contracts. With the implementation of the 2016 contract these posts are called Trust doctors (previously referred to as Locum Approved for Service). These doctors are also employed under the junior doctors 2016 contract as agreed with the Local Negotiating Committee. There are currently four Trust doctors employed within the Trust

4 Vacancies and Rota Gaps

4.1 Current Vacancies

There should be 38 CTs (34 CT1 and 4 GP trainees) in post, there are seven vacancies. Four trust doctors have been employed on temporary contracts to cover doctors in training vacancies. There are also three LTFT CTs that are supernumerary.

There should be 31 HTs, there are six vacancies. Four of the funded posts are filled by LTFT trainees.

Individual services are responsible for addressing gaps in day time cover if there is no trainee using a risk assessment approach. The options available to meet service needs are establishing specialty doctors posts or booking of an agency locum if the need is short term or recruitment to specialty doctor post is unsuccessful.
The overall annual vacancy rate calculated on the number of vacancies as percentage of funded posts is 15.5%% reducing to 11% with the appointment of Trust doctors.

4.2 Rota Gaps

There have been a total of 500 rota gaps, 373 on the CT rota and 127 on the HT rota. This equates to 17.0% of all shifts on the CT rota and 17.4% on HT rota. The monthly breakdown of rota gaps has been provided in each of the quarterly reports. These are provided in Appendix B.

286 shifts (76.6% of the rota gaps) of the CT rota gaps were covered by internal locums, with 48 shifts (12.9% of the rota gaps) covered by agency locums. A total of 33 shifts (0.9% of all shifts) were left uncovered. In 31 cases this meant that the evening shift had 3 trainees on rather than 4 and on 2 occasions the night shift had 1 trainee on shift rather than 2.

All of the HT rota gaps were covered using internal locums.

4.3 Cover for Rota Gaps

The medical education team's approach to providing cover for rota gaps for patient safety reasons is in the first instance to agree internal cover by doctors already working on the rota. This is known as an internal locum shift.

If the gap is still not covered, there are a number of doctors who have worked on the LYPFT rotas or are working in a medical post within the Trust that does not include an on call commitment. These would also be known as internal locum shifts.

In the event that the shift has still not been covered, then medical locum agencies would be contacted to fill the shift. The medical education team work with four preferred suppliers in the first instance with a view to working with the same doctors as much as possible. If the preferred suppliers are not able to fill the shift the request would go to all the agency contacts that are on the Procurement Framework Agreement. All agency bookings are recorded to facilitate knowing the doctors who have worked on the rota before. The majority of these shifts are booked at capped rates.

If the shift remains uncovered, then the rota may be authorized to run on reduced staffing by the Associate Medical Director for doctors in training (AMD for DiT). In this scenario the medical education team communicates this to the doctors of all grades on the rota, on-call senior manager and switchboard for the date affected to make them aware of the reduced cover.
There has been two agency core trainee grade doctors booked for core hours by medical education team due to service pressures. These bookings were only achieved by agreeing hourly rates above the capped rates. These are reported separately as exceptions to NHS Improvement (NHSI). From 1 April 2017, the cost of the bookings has been reported on a weekly basis.

5 Exception Reports

There have been 17 Exception Reports (ERs) over the past year. These are detailed in the quarterly reports provided in Appendix C.

These have all been in relation to either the number of hours worked or the support available. Those related to support available have been, in all but one case, related to a reduced number of CTs on shift. There were a total number of 33 shifts with a reduced number of trainees, only 6 of these resulted in ERs being completed (13.8%). Two of these reduced staffed shifts were night shifts; ERs were completed for both of these.

One of the reduced staffed shifts was as a result of an agency locum not attending for the shift. When the locum was contacted by MEC they reported that they had cancelled the shift with the agency. The agency did not inform medical education of this. This shift was further reduced from 3 CTs to 2 CTs at 3pm when one of the CTs had to go home sick. Neither trainee had to stay past the end of their shifts to complete outstanding work. Two further reduced staffed shifts were a result of a CT calling in sick immediately prior to the start of the shift. Switchboard were unable to find any cover at such late notice on either occasion. MEC were informed late in the afternoon about an on call CT being sick, they were unable to identify any cover.
Two of the reduced staff shifts resulted in CTs having to work additional hours; they were compensated with time off in lieu. No patient safety concerns were raised in relation to reduced staffing on out of hours shifts.

Four ERs have been raised relating to additional hours worked within core placements. Three of these were related to emergencies occurring that could not be handed over, one in relation to reduced staffing levels within the inpatient unit requiring the CT to work over hours to complete tasks that could not be handed over. These exceptions have been resolved using time off in lieu, with the exception of one which received compensatory payment.

There have been patient safety concerns raised related to two of the ERs; one in relation to reduced staffing levels on an inpatient unit resulting in one trainee covering the entire unit. Whilst there was no specific incident the trainee wished to flag the occurrence as a potential risk as had there been further workload they may not have been able to respond to emergencies. The other raised on a fully staffed OOH shift, again no harm came to any patient but the trainees wished to raised that it was an extremely busy shift and that had additional workload occurred that the

trainees would have not been able to respond to this. In both cases the concerns were escalated to the HTs at the time.

6 Work Schedules

Return rate of 72% for completed personalised work schedules (WS), this in an increase on the previous year's return rate of 55%. MEC are following up the schedules not returned. The current process is that they send out 3 reminder emails, after this an email is sent by the guardian to the trainee and their CS to complete and return the WS. The current process involves several reminder emails and is work intensive, this will therefore be reviewed prior to August.

7 Fines

There have been no breaches in junior doctors working hours resulting in a financial penalty for the Trust.

8 Junior Doctors Forum

The JDF has met on four occasions.

In addition to discussing rota gaps and exception reports junior doctors have used the forum to highlight areas of concern. These included:

- CTs reports limited experience of acute mental health assessments whilst on call. This has been addressed by one of the CTs being placed with ALPS during the evening and weekend shifts.
- Concerns regarding availability of work space for junior doctors in two trust sites (Aire Court and Newsam Centre). Additional work space has been allocated at Aire Court and additional computers have been placed within the doctors room at The Newsam Centre. It is also planned to provide all junior doctors with a Trust laptop, reducing the need for available desktop computers.
- Concerns were raised by the CTs regarding possible lone working when reduced staffing on night shifts. CTs to inform switchboard of their whereabouts and expected return time.
- The potential discontinuation of paging systems across the NHS following DoH directive was discussed. Only one pager is used within the Trust for the CT on call 1A. Issues with removing this were identified such as the lack of mobile phone reception in A&E at LTHT. This is to be discussed with LTHT to understand their plans to address this.

- The Trust's use of internet and in particular secure apps to discuss patient related information was discussed following RCPsych's publication on guidance. Guidance was provided by the Head of Information Governance that WhatsApp is secure, as long as used on a phone that has NHSmail enabled.
- Concerns raised re staffing levels at The Mount, particularly at periods of staff change due to almost all staff requiring several days of induction and therefore ward cover left to one CT. The Mount now covered by 5 FY1/2 doctors and 1 CT, therefore in August, December and April all FYs off ward for induction. Previously has not raised issues due to having 2 additional staff grade doctors, however one of these is currently off work, resulting in increased workload for the remaining CT.

9 Issues Arising

9.1 Engaging Junior Doctors

I have attended both the junior doctor committee and held a guardian teaching/meet the guardian session within each of the mandatory post induction teaching sessions. Within these sessions I have been able to discuss the trainees experience and opinions of exception reporting. This is something that I will continue to do regularly. The junior doctors have also been encouraged to attend the JDF. Informal feedback from these meetings is that when trainees do have to complete work outside of their work schedules they feel that there are already processes in place to ensure that they are given the time back.

A BMA survey was conducted within the Trust to gain an understanding of the junior doctor's perception of the 2016 contract. The feedback from this survey relating to the role of the guardian indicated that overall the trainees are comfortable with the exception reporting process.

It is important that as a Trust we must continue to support a culture of reporting variance from the work schedule.

Whilst we have only had a relatively few number of exception reports completed, the number appears consistent with that of other local mental health trusts.

9.2 Raising Concerns

Once again it has been highlighted by the Freedom to Speak up Guardian that few, if any, concerns are raised by the junior doctors. It is likely that due to the number of alternative avenues available to the junior doctors to raise concerns that they do not feel that approaching the Freedom Speak up Guardian is required. This is supported by the feedback junior doctors have provided in both the National Training Survey and also the Staff Survey.

9.3 Clinical Supervisors (CS)Leaving Trust

Two ERs were outstanding as the CS had left the Trust without completing the ER. The junior doctors completing the ER report that the meetings were held within a timely manner of them reporting these, however the documentation was left unfinished. Allocate does not allow for anyone else to complete this.

This issue has been discussed at the JDF. Incomplete ERs by the CS will be escalated to the medical director if the CS does not complete the paperwork following prompting from the guardian.

In the event that the CS leaves the Trust, the trainee submitting the report will be asked to re submit the ER to an alternative CS or the guardian to complete the review.

9.4 BMA Fatigue Charter

This charter has been produced by the BMA to provide a framework to employers designed to address issues contributing to sleep deprivation and fatigue. It identifies a number of strategies to both provide support to employees and ensure appropriate measures are in place to reduce the risks related to staff fatigue. As a Trust we already complete the majority of the strategies outlined in the charter and have agreed with the BMA to undertake a review to address any outstanding issues.

9.5 Recruitment

There are ongoing issues with psychiatric recruitment nationally, and the number of rota gaps this year is in part due to vacant posts. From August 2017 to 2018 the national fill rate for CT1 has increased from 69% to 82%, within Yorkshire and the Humber (Y&H) CT1 fill rate has increased from 44% to 76%, with LYPFTs fill rate being 78%. Projected recruitment for August 2019 is 100% based on recent national recruitment.

LYPFT have a number of strategies in place aimed at increasing recruitment targeted at both medical students and Foundation Trainees. These include a Summer School offering workshops, lectures and taster sessions to medical students and Foundation Trainees from across the country who are considering a career in psychiatry.

The CTs are encouraged to participate in the medical student teaching programme by having protected time to deliver this to students from years 2 – 4. This provides a valuable experience for both the trainee and the students.

The Trust have a named Foundation Year tutor to enhance trainees experience within the speciality, as well as a designated teaching programme for the FYs placed within the Trust.

We have are also developing our profile as a desired place to train both by theTrust performance in the GMC training survey but also in relation to our success rate with the MRCPsych examinations being significantly higher than the national average.

10 Summary

Whilst there have been a low number of exception reports where these have been completed they have been addressed in a timely manner and in agreement with the trainee.
It is important that we continue to work with supervisors and junior doctors to build a culture where exception reporting is accepted and considered a routine part of training.
There have been rota gaps due to the ongoing national recruitment issues, these gaps were filled by either Trust doctors or OOH locum shifts. On the occasions when shifts are unfilled no patient safety concerns have been raised and junior doctors are able to work within their scheduled hours. As such it indicates that current staffing levels and working patterns are safe, however maintaining these continues to be a challenge to all those involved in operational and educational delivery.

11 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 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

Appendix A

Funding of Junior Doctors

	LYPFT based	SWYFT based	LCH based	York based	Total Number	Comments
FY1	**9**	n/a	n/a	n/a	**9**	Employed by LTHT and carry out on-call duties at LTHT
FY1 ACF	**2**	n/a	n/a	n/a	**2**	Employed by LTHT and carry out on-call duties at LTHT
	11					
FY2	**6**	n/a	n/a	n/a	**6**	Employed by LTHT carry out on-call duties at LYPFT
FY2 ACF	**1**	n/a	n/a	n/a	**1**	Employed by LTHT and carry out on-call duties at LTHT
					18	
CT	**34**	**7**	**4**	n/a	**45**	LYPFT is lead employer
GP	**4**	**4**	n/a	n/a	**8**	LYPFT is lead employer for 4 x LYPFT posts Mid Yorks is lead employer for 4 x SWYFT posts
ST	**30**	n/a	n/a	**1**	**31**	

Higher Trainees

	General Adult	Old Age	Psychotherapy	Learning Disability	Forensic	CAMHS
Funded	16	8	2	3	1	1
Vacant	1	2	0	2	0	1

Head Count

	FY1	FY2	CT	GP	HT	LTFT	Trust Doctors	Total
Funded	11	7	34	4	31	3	0	90
In post	11	6	27	4	25	3	4	80

Appendix B

Rota Gaps

Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total gaps	Number of shifts uncovered (over the year)	Average no. of shifts uncovered (per week)
CT	92	98	107	76	373	33	0.6
HT	44	20	30	33	127	0	0
Total	**136**	**118**	**137**	**109**	**500**	**33**	**0.6**

Core Trainees

Month	**Total Rota Gaps**	**Number of shifts uncovered (over the month)**	**Number of shifts covered internally**	**Number of shifts covered by agency locums**	**Reason for rota gaps**
Apr	31	4	25	2	Vacant - 10 Sickness - 8 Special Leave - 4 *Other – 16
May	28	3	21	4	Vacant- 2 Sickness - 7 Off rota – 8 Special Leave - 2 Other – 9
June	33	1	13	9	Vacant - 2 Off rota - 14 Sickness - 6 Other - 11
July	33	4	21	8	Vacant - 5 Sickness - 5 Off Rota – 18 Other - 5
Aug	42	5	32	5	Vacant - 3 Sickness - 2 Off Rota - 22 Other – 15
Sept	23	3	18	2	Sick - 4 Off Rota - 15 Other – 4
Oct	23	2	16	5	Off Rota- 14 Sickness – 3 Other- 6
Nov	46	1	43	2	Vacant-3 Off Rota- 26 Other – 17

Dec	38	4	29	5	Off rota – 24 Sickness – 1 Other – 13
Jan	45	1	38	6	Off rota – 23 Left Scheme- 8 Sickness - 1 Other – 13
Feb	19	1	18	0	Off rota – 9 Left Scheme – 1 Sickness – 4 Other – 5
Mar	12	0	12	0	Vacant – 3 Off rota – 2 Left Scheme – 4 Left Trust – 3

Higher Trainees

Month	Total Rota Gaps	Number of shifts uncovered (over the month)	Number of shifts covered internally	Number of shifts covered by agency locums	Reason for rota gaps
Apr	16	0	16	0	Vacant - 4 Off rota - 4 Sickness - 1 Acting up - 3 Leaver- 4
May	12	0	12	0	Vacant – 5 Off rota – 1 Sickness – 1 Acting up – 2 Leaver- 2
June	16	0	16	0	Vacant – 3 Off rota – 1 Sickness – 1 Acting up – 4 Leaver- 7
July	8	0	8	0	Vacant- 2 Off Rota - 5 Sickness - 1
Aug	10	0	10	0	Vacant -4 Acting Up- 2 Leaver- 4
Sept	2	0	2	0	Vacant– 1 Off Rota – 1
Oct	7	0	7	0	Vacant- 2 Sickness – 2 Acting up- 2

					Other – 1
Nov	10	0	10	0	Vacant- 1 Off Rota- 2 Sickness – 4 Acting up- 2 Other – 1
Dec	13	0	12	0	Sickness – 2 Off Rota – 3 Left Scheme – 3
Jan	11	0	11	0	Vacant – 2 Off Rota – 2 Left Scheme - 5 Sickness – 1 Other – 1
Feb	10	0	10	0	Vacant – 3 Off Rota – 3 Left Scheme – 2 Left Trust - 2 Other – 0
Mar	12	0	12	0	Off Rota - 2 Vacant – 3 Left Scheme – 4 Left Trust - 3 Paternity leave – Adverse weather – Cover CT rota gaps -

Appendix C

Exception Reports by Grade

Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	**Total**
FY1					
FY2					
CT1	4	7		3	**14**
CT2		1	1		**2**
CT3			1		**1**
ST4					
ST5					
ST6					
ST7					
Total	**4**	**8**	**2**	**3**	**17**

Exception Reports by Type

Type	Quarter 1	Quarter 2	Quarter 3	Quarter 4	**Total**
Hours	4	4		3	**11**
Pattern			1		**1**
Support		4	1		**5**
Training					
Education					
Total	**4**	**8**	**2**	**3**	**17**

Exception Reports by Outcome

Type	Quarter 1	Quarter 2	Quarter 3	Quarter 4	**Total**
TOIL	1	4		3	**8**
NFA	1	4	2		**7**
WSR					
Payment	2				**2**
Total	**4**	**8**	**2**	**3**	**17**

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

15

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Mortality Review – Learning from Deaths Quarter 4 (January-March 2019)
DATE OF MEETING:	23 May 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 4. A total of 88 deaths reported via Datix were reviewed, in addition a further 225 deaths were also reviewed via the NHS Spine. No complaints or concerns from staff were raised in relation to any patient death during Quarter 4.

The Trust has received significant assurance with regards to its mortality review process following an internal audit. Work continues with the Northern Alliance and progress is being made to establish further joint mortality reviews across the Leeds city NHS providers.

Learning identified is shared with the Care Groups via the Incident Review Group and LIMM. These are linked to quality improvement work streams.

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

RECOMMENDATION

The Board 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 data collection.

BOARD OF DIRECTORS

23 MAY 2019

LEARNING FROM MORTALITY QUARTER 4 (JANUARY- MARCH 2019) REPORT

Introduction

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

The mortality data is collated weekly and reviewed twice a month at the Learning from Incidents and Mortality Meeting (LIMM). The information is obtained from the Trust Incident reporting system (DATIX) and from the NHS PAS system, to ensure all deaths are reviewed. We continue to use the Mazars coding for deaths as agreed with the regional trusts as below:

1. **Level 0** - Reviewed and not LYPFT death, close, no code required.
2. **Level 1** - No concerns, no further action, close and code death.
3. **Level 2** - Further information required, i.e. updated datix or if a fact find has been completed, await updated fact find and discuss at the next week's meeting. Code death
4. **Level 3** - Carer/staff member has raised a concern about the care – complete investigation and feedback findings and learning to LIMM. Code death
5. **Level 4** - Potential gaps in care identified- Concise report required and feedback findings and learning to LIMM. Code death
6. **Level 5** - Unexpected, unnatural death or more serious concerns noted about gaps in care – Comprehensive Root Cause Analysis investigation to be completed and learning shared through the Care Groups and the Trust Incident Review Group. Code death.

In addition to this we also comply with reporting all Learning Disability Deaths to Bristol University, via the LeDer system. In addition a Structured Judgement Review is completed for every LD death, to ensure any learning is shared within the Trust, due to concerns that LeDer reviews are allocated to external reviewers by the CCG and the learning is not always shared with LYPFT.

The Trust is actively involved in the Northern Alliance Mortality Review Group, where sharing of findings and reviews is undertaken. The Safety and Risk Lead has also participated in a presentation with NHS Improvement Academy as part of their shortlist for a Patient Safety Award. The award relates to the role out of Structured Judgement Reviews and our trust was an early

adopter within mental health. We have been praised for adapting this methodology and evidencing the benefits and value associated with this review process.

Links have also been made to enhance joint working with mortality reviews across Leeds NHS services, including LTHT. The first meeting took place in May to develop a collaborative approach.

An internal audit report of the Learning from Deaths process was competed April 2019 and provided significant assurance. The areas for improvement were predominantly related to additions to the Learning from Deaths Policy. The policy is due to be amended accordingly.

Context

This paper provides information to the board for Quarter 4 mortality. This relates to all deaths identified via the incident reporting system and the NHS Spine data.

Q4 Mortality data

Quarter 4 Learning From Deaths and Incidents recorded on Datix	**Total**
Total number of deaths reported 1 January 2019-31 March 2019	**88**
Awaiting Cause of Death confirmation	**11**
LYPFT not the primary provider of care	**54**
ENE 1 (Expected Natural Death -Expected to occur within a timeframe)	**5**
ENE 2 (Expected Natural Death - Expected death but not expected in the timeframe)	**1**
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)	**2**
UU (Unexpected Unnatural Death)	**13**

- Of the above total number of deaths, 8 deaths were reported to LeDer as the deceased service user had a learning Disability. No concerns regarding care were identified at the initial table top review, but these are all subject to a Structured Judgement review. The reviews are currently ongoing.
- Two deaths were coded UN2. Both are subject to further review, one comprehensive review of a patient who became unwell at The Mount, resulting in admission to Leeds Teaching Hospital and one Structured Judgement Review, including one patient with a learning disability, whose death was unexpected.

- Of the above total number of deaths, 13 deaths were recorded as Unexpected, Unexplained, pending confirmation of cause of death. Of these 11 were STEIS reported in accordance with the NHSE Serious Incident Framework. These reviews are ongoing at the time of this report. One mortality review is subject to a joint review with TEWV and Community Links. TEWV are leading on this.
- There were no complaints raised by carers of staff with regards to a patients care prior to death, therefore no investigations have commenced as a result of this.
- An additional 225 deaths were reported in Q4 via NHS Spine. These are all subject to a review. This data will be included in subsequent reports. However, none were escalated as a concern or red flags as the patients not in our care within the last 6 months or received minimal contact some months ago, ie memory services or in reach liaison, where the death would be coded by LTHT as the patient was only seen for advice and not in receipt of mental health care prior to admission to LTHT. This avoids duplication of mortality coding.

Key Learning from deaths identified for Quarter 3

As the reviews for the patient deaths in Q4 have not all yet been completed, the learning identified in this paper relates to the reviews completed during Q1, 2, and 3. The percentage of deaths reviewed in Q3 identifying service and delivery problems was 1.5%. This percentage is lower than the previous quarter.

The key learning identified from the 1.5% included the following:

- No family involvement in care planning
- Information provided from a third party not shared at MDT
- No specific plan handed over to receiving team to assist the team to understand their role with the patient.
-

The Leeds Care Group have a number of improvement plans in place to address the learning from the mortality reviews, including Triangle of Care , which links with family involvement and NICE guidance.

Good practice learning included:

- High standard of assessment by Acute Liaison Psychiatry Service
- Good family engagement throughout
- Excellent support for One to One provision on the ward
- Well planned discharge from inpatient to the community team

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.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
16

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Safer staffing report
DATE OF MEETING:	23 May 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 March 2019 to the 31st March 2019 and the 1st April 2019 to the 30th April 2019.

This paper highlights the impact of a continuing local and national shortfall of registered nurses and the release of the Mental Health Optimal Staffing Tool (MHOST).

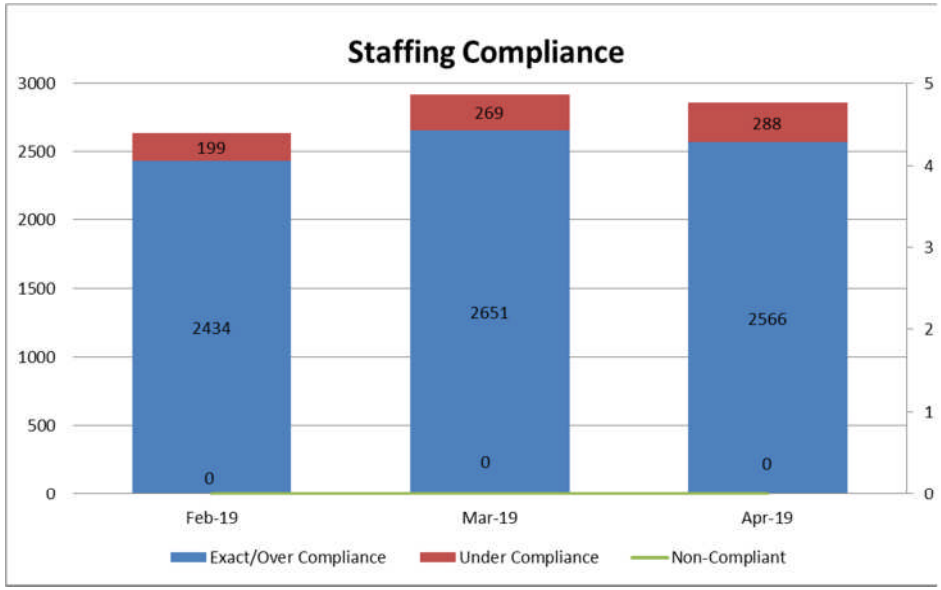
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes please set out what action has been taken to address this in your paper
	No	

RECOMMENDATION

The Board is asked to:

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

Safer Staffing: Inpatient Services – March & April 2019



	Number of Shifts		
	February	**March**	**April**
Exact/Over Compliance	2434	2651	2566
Under Compliance	199	269	288
Non-Compliant	0	0	0

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

Mitigating Factors:

Reduced 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 March and April 2019

Exact or Over Compliant shifts:

During March the compliance data showed an increase in the number of shifts which were staffed exactly as planned or staffed above the planned number of Registered Nurse (RN) and Health support worker (HSW) staff.

During April there was a slight decrease in the shifts staffed exactly or above planned numbers of Registered Nurse (RN) and Health support worker (HSW) staff.

Under Compliant Shifts:

In March 269 shifts had fewer than the planned number of RN and HSW staff on each shift and in April this figure was 288 (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.

Non-Compliant Shifts:

This metric represents the number of shifts where no Registered Nurses were on duty. This metric was not breached in March or April.

Exception reports

There was a similar picture across the acute services during March and April in terms of a lower actual RN fill and high vacancy rates for band 5 nurses. The services affected were Mill Lodge, Becklin Wards 1, 3 and 5, Newsam wards 1 (PICU), 2 Newsam (female), Parkside Lodge, Mount Wards 2 and 5, and the CAU. A number of vacancies have been recruited to across all services but do not have start dates until September / October

Of note, Ward 3 Becklin Centre highlighted that they have x3 RN vacancies and x2 RN's on long term sick leave. Ward 1 Becklin centre's overfill of HSW's during the day and night was due to an increase in

observations on the ward with patients requiring the support of 2 members of staff due to the increased risk of violence towards others and also patients requiring observation support at LTHT.

Parkside lodge is struggling with recruitment and have again gone back out to advert, however, over the past couple of months, patient numbers have remained below 4 and so a ratio of 4 patients to one nurse has not compromised patient safety. Ward 1 Newsam (PICU) have high levels of acuity requiring additional staffing to manage the associated risks which has increased within eyesight observations and episodes of seclusion across the month.

Updates:

Safe staffing Steering Group

The inpatient services continue to use the Keith Hurst optimal staffing acuity tool as a means of analysing the needs of service users present on the ward every day. Although no concerns have been raised by the teams regarding the use of the tool, the data collection period is not yet sufficient to make evidence based determinations on staffing. The safe staffing group is working with the information department in the interim to establish if any patterns are starting to emerge and the services have agreed to extend the initial 8 week trial for a total of 6 months. In terms of the licence, we have been informed again that the final touches to the IP and copyright arrangements are being made and that formal release of the tool is imminent.

In addition to the Keith Hurst optimal staffing acuity tool, The Mental Health Optimal Staffing Tool (MHOST) has just been announced as available to mental health organisations. The development of the MHOST was commissioned and funded by Health Education England (HEE). It is part of the suite of safer staffing care tools being developed and managed by the Shelford Group Chief Nurses, in partnership with the Imperial College London and the NHS Chief Nursing Officer for England. The MHOST is being marketed as a multidisciplinary and evidence based tool that enables ward based clinicians in mental health settings to assess patient acuity and dependency. It converts acuity and dependency data into a workload index and required Full time equivalents (FTEs) using built-in staffing multipliers to ensure that ward establishments reflect patient needs. The tool is free of charge to all NHS trusts in England and the safer staffing steering group will consider its application and internal use at the next safer staffing meeting.

The Steering group has also considered the ‘take charge’ (nurse in charge) element of preceptorship in relation to whether this period which can last for up to 6 months could be shortened. It was agreed that sign off to be nurse in charge should remain part of asserting confidence through preceptorship development. However it was also noted that our local universities are requesting input from provider services as they are planning to review their training modules. There is an opportunity to proactively do some further work to improve our students final placements in terms of leadership and resilience. The Practice learning and development team will work with the higher education institutions to help support coaching the final year nursing students so that confidence in the taking charge element is improved upon in the last placement prior to becoming registered professionals.

- ## Redeployment task and finish group

The redeployment task and finish group is a sub group of the Safe staffing steering group. The group has considered the role of the on call manager when staffing issues are escalated. One of the issues raised is the lack of familiarity with every service. The group established that all areas had already put together a brief of their service for their business continuity plans; and that this information could be reviewed to ensure it remained current and fit for purpose. It was agreed to add other information including staffing establishment; minimum staffing numbers (e.g. early x2RN and x2 HSW’s and x1 AHP); locality of ward / unit; and descriptors of different workforce roles. The updated information will be saved in the on call folder to aid on call decision making regarding safe staffing. The Business continuity manager has been asked to make easier link access to the business continuity plans.

In addition to the on call information, inpatient services are also to provide a brief summary for staff working in their area for the first time. The front page of this document will use the ‘proud to nurse’ logo.

Bank staff have raised an issue of being asked to escort service users they are not familiar with to the acute trusts when they require treatment. It was acknowledged that this was not specifically a temporary staff related issue and that this was a wider piece of qualitative work that will be considered as part of the longer term review of the observation and engagement procedure.

- **Preceptee nursing recruitment overview April 2019**

In January 2019 two events were held in which we spoke to x74 3rd year nursing students who had expressed an initial interest in working in the organisation.

Following an allocation process of job preference and preceptee capacity, we have been able to allocate x56 jobs to 3rd year nursing students which matched either their 1st 2nd or 3rd preference. 10 students did not preference us and sought employment elsewhere; and we are continuing to work with x8 3rd year nursing students who we were unfortunately unable to provide employment in any of their preferred areas and are working with them to find alternatives.

We have committed to keeping in contact with the 3rd year students and have asked the recruitment team to share 3rd year nursing students contact details with relevant managers to assist with maintaining an employment relationship prior to their autumn start dates. The practice learning and development team have arranged an engagement event on the 11th July, with a theme of team building that supports team identity and a smoother transition from student to newly qualified nurse.

- **Summary**

This paper highlights the impact of the continuing local and national shortfall of registered nurses and the actions being taken in LYPFT to try to address this alongside our healthcare partners. The official count of vacant nurse jobs nationally has risen this year and whilst our Health support worker , Nursing associate and Associate practitioner workforce have a key role in ensuring safe care, they do not act as substitutes for registered nurses. Recruitment planning meetings for registered nurses regularly take place each month and a focus remains on the key hot spot areas namely, the Becklin Centre, The Newsam Centre and The Mount, all of whom have bespoke campaigns and recurrent advertising agreed with potential for recruitment incentives currently under discussion.

APPENDIX A

Safer Staffing: Inpatient Services – March 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	649.5	701	669.5	438.5	325.5	325.5	325.5	325.5					101	10.2	7.6	0.0	0.0	17.7	107.9%	65.5%	100.0%	100.0%		
3 WOODLAND SQUARE	377.5	403.5	751.5	921	315	325.5	325.5	367.5					97	7.5	13.3	0.0	0.0	20.8	106.9%	122.6%	103.3%	112.9%		
ASKET CROFT	610.5	628.1	1015	1042.75	341	353	671	846.5	292.13	292.13			595	1.6	3.2	0.5	0.0	5.3	102.9%	102.7%	103.5%	126.2%	100.0%	
ASKET HOUSE	449	450.5833	441	656.5	341	341	341	584.5	272.5	272.5			484	1.6	2.6	0.6	0.0	4.8	100.4%	148.9%	100.0%	171.4%	100.0%	
BECKLIN WARD 1	1209	964.5	519	1454.5	660	638	649	848.75					697	2.3	3.3	0.0	0.0	5.6	79.8%	280.3%	96.7%	130.8%		
BECKLIN WARD 2 CR	695.5	572.25	1013.3	1119.75	713	605	1045.8	1161.417					175	6.7	13.0	0.0	0.0	19.8	82.3%	110.5%	84.9%	111.1%		
BECKLIN WARD 3	990	907.25	787.5	1291.25	671	660.5	682	814.5					681	2.3	3.1	0.0	0.0	5.4	91.6%	164.0%	98.4%	119.4%		
BECKLIN WARD 4	1191.5	993.4167	767	1155.5	682	660	660	726.5					677	2.4	2.8	0.0	0.0	5.2	83.4%	150.7%	96.8%	110.1%		
BECKLIN WARD 5	1218	934.5	1020	1450.25	671	650	682	803					684	2.3	3.3	0.0	0.0	5.6	76.7%	142.2%	96.9%	117.7%		
MOTHER AND BABY THE MOUNT	722.5	579.5	880	1036.5	671	462	671	880					245	4.3	7.8	0.0	0.0	12.1	80.2%	117.8%	68.9%	131.1%		
NEWSAM WARD 1 PICU	1187.5	995	1392	2460	682	492	682	1969.75					342	4.3	13.0	0.0	0.0	17.3	83.8%	176.7%	72.1%	288.8%		
NEWSAM WARD 2 FORENSIC	791.5	689.9167	694.5	1643.5	333.25	345.75	666.5	1290.667					383	2.7	7.7	0.0	0.0	10.4	87.2%	236.6%	103.8%	193.6%		
NEWSAM WARD 2 WOMENS SERVICES	897	713.3	858	1067.75	333.25	322.75	666.5	720.25					279	3.7	6.4	0.0	0.0	10.1	79.5%	124.4%	96.8%	108.1%		
NEWSAM WARD 3	832	680.5	781.5	1098.483	322.5	397.75	655.75	603					434	2.5	3.9	0.0	0.0	6.4	81.8%	140.6%	123.3%	92.0%		
NEWSAM WARD 4	1078	955.0833	736	1628	682	685	671	1199					677	2.4	4.2	0.0	0.0	6.6	88.6%	221.2%	100.4%	178.7%		
NEWSAM WARD 5	805.5	775	1213	1277.25	671	671	682	682					528	2.7	3.7	0.0	0.0	6.4	96.2%	105.3%	100.0%	100.0%		
NEWSAM WARD 6 EDU	785	808.9167	721	1159	325.5	388.5	651	796	285	285	112.5	112.5	386	3.1	5.1	0.7	0.3	9.2	103.0%	160.7%	119.4%	122.3%	100.0%	100.0%
NICPM LGI	952.5	933.0833	291.5	334	651	651.25	325.5	325.5					107	14.8	6.2	0.0	0.0	21.0	98.0%	114.6%	100.0%	100.0%		
PARKSIDE LODGE	795	676.5	1993	1798.733	325.5	378	1302	1036.75					98	10.8	28.9	0.0	0.0	39.7	85.1%	90.3%	116.1%	79.6%		
THE MOUNT WARD 1 NEW (MALE)	817.5	954.9167	1609.5	2775.5	666.5	549.5833	999.75	2430.5					505	3.0	10.3	0.0	0.0	13.3	116.8%	172.4%	82.5%	243.1%		
THE MOUNT WARD 2 NEW (FEMALE)	835.5	994.5	1194.5	2364	666.5	440.75	655.75	2021.417					440	3.3	10.0	0.0	0.0	13.2	119.0%	197.9%	66.1%	308.3%		
THE MOUNT WARD 3A	867.75	810.0833	1277.25	1687.917	341	325	682	1421.5					526	2.2	5.9	0.0	0.0	8.1	93.4%	132.2%	95.3%	208.4%		
THE MOUNT WARD 4A	856.5	891.75	1308.25	1536.083	330	353.0833	682	1060.667					644	1.9	4.0	0.0	0.0	6.0	104.1%	117.4%	107.0%	155.5%		
YORK - BLUEBELL	696	888	756	839.5	321.6	300.0667	664.33	664.4333					217	5.5	6.9	0.0	0.0	12.4	127.6%	111.0%	93.3%	100.0%		
YORK - MILL LODGE	1375	1059.917	1233	1577.667	682	609	682	1273					265	6.3	10.8	0.0	0.0	17.1	77.1%	128.0%	89.3%	186.7%		
YORK - RIVERFIELDS	381	545.5833	633	747.75	332.32	344.2167	289.44	407.2333					93	9.6	12.4	0.0	0.0	22.0	143.2%	118.1%	103.6%	140.7%		
YORK - WESTERDALE	636.5	1220.5	1206	762	332.32	349.65	975.21	933.7833					285	5.5	6.0	0.0	0.0	11.5	191.8%	63.2%	105.2%	95.8%		

APPENDIX B

Safer Staffing: Inpatient Services – April 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	
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	658.5	593	658.5	479.5	315	315	315	315					78	11.6	10.2	0.0	0.0	21.8	90.1%	72.8%	100.0%	100.0%		
3 WOODLAND SQUARE	347.5	462.25	846	857.5	315	315	315	451.5					73	10.6	17.9	0.0	0.0	28.6	133.0%	101.4%	100.0%	143.3%		
ASKET CROFT	600	732.1333	1003.5	923.25	330	330	649	693	214	214			563	1.9	2.9	0.4	0.0	5.1	122.0%	92.0%	100.0%	106.8%	100.0%	
ASKET HOUSE	435.5	442.75	411	696.5	319	331	330	672	288.66	288.66			460	1.7	3.0	0.6	0.0	5.3	101.7%	169.5%	103.8%	203.6%	100.0%	
BECKLIN WARD 1	1177.5	926	469.5	1721	660	627	660	1221					677	2.3	4.3	0.0	0.0	6.6	78.6%	366.6%	95.0%	185.0%		
BECKLIN WARD 2 CR	661.5	524.5	1020.5	1229	678.5	557	1012	1296.25					165	6.6	15.3	0.0	0.0	21.9	79.3%	120.4%	82.1%	128.1%		
BECKLIN WARD 3	1122	878	769.5	1219	649	639	660	796					647	2.3	3.1	0.0	0.0	5.5	78.3%	158.4%	98.5%	120.6%		
BECKLIN WARD 4	1149.5	973.0833	771.5	1207.5	649	617.5	649	726					657	2.4	2.9	0.0	0.0	5.4	84.7%	156.5%	95.1%	111.9%		
BECKLIN WARD 5	1195.5	943.75	906	1473.5	660	639	660	891					673	2.4	3.5	0.0	0.0	5.9	78.9%	162.6%	96.8%	135.0%		
MOTHER AND BABY THE MOUNT	749.5	726	927	904.5	627	552.5	594	660					229	5.6	6.8	0.0	0.0	12.4	96.9%	97.6%	88.1%	111.1%		
NEWSAM WARD 1 PICU	1159	860.5	1302	2927.5	660	596	660	2206					351	4.1	14.6	0.0	0.0	18.8	74.2%	224.8%	90.3%	334.2%		
NEWSAM WARD 2 FORENSIC	776	659.5	772.5	1246.917	322.5	312.8333	634.25	841.5					369	2.6	5.7	0.0	0.0	8.3	85.0%	161.4%	97.0%	132.7%		
NEWSAM WARD 2 WOMENS SERVICES	866.5	800.75	843	928.5	322.5	365.5	645	602					249	4.7	6.1	0.0	0.0	10.8	92.4%	110.1%	113.3%	93.3%		
NEWSAM WARD 3	766	704.5	820.5	1109.5	311.75	327.25	645	675.25					420	2.5	4.2	0.0	0.0	6.7	92.0%	135.2%	105.0%	104.7%		
NEWSAM WARD 4	1113	963.5	727.5	1297.5	660	664	660	889.5					618	2.6	3.5	0.0	0.0	6.2	86.6%	178.4%	100.6%	134.8%		
NEWSAM WARD 5	781.5	857.5	1225.5	1171.5	660	629	660	697					502	3.0	3.7	0.0	0.0	6.7	109.7%	95.6%	95.3%	105.6%		
NEWSAM WARD 6 EDU	720.5	826.5167	717	987.5	315	493.5	630	441	420	420	120	120	378	3.5	3.8	1.1	0.3	8.7	114.7%	137.7%	156.7%	70.0%	100.0%	100.0%
NICPM LGI	1034	1053.5	337.5	346	619.5	630	315	315					98	17.2	6.7	0.0	0.0	23.9	101.9%	102.5%	101.7%	100.0%		
PARKSIDE LODGE	765	569.1667	1918.5	1686.433	315	315	1218	1144.167					96	9.2	29.5	0.0	0.0	38.7	74.4%	87.9%	100.0%	93.9%		
THE MOUNT WARD 1 NEW (MALE)	837	961.75	1530	3168.5	634.25	626.5	946	2732.333					504	3.2	11.7	0.0	0.0	14.9	114.9%	207.1%	98.8%	288.8%		
THE MOUNT WARD 2 NEW (FEMALE)	832.5	886.75	1080	2680	612.75	408.5	645	2171.5					437	3.0	11.1	0.0	0.0	14.1	106.5%	248.1%	66.7%	336.7%		
THE MOUNT WARD 3A	850.5	765.25	1220.5	1541.917	330	333	660	1184.75					630	1.7	4.3	0.0	0.0	6.1	90.0%	126.3%	100.9%	179.5%		
THE MOUNT WARD 4A	838.5	844.6667	1282.5	1576.25	319	351.9167	638	980					655	1.8	3.9	0.0	0.0	5.7	100.7%	122.9%	110.3%	153.6%		
YORK - BLUEBELL	584	598.5	659.75	1019.667	321.9	321.8333	643.6	654.3833					210	4.4	8.0	0.0	0.0	12.4	102.5%	154.6%	100.0%	101.7%		
YORK - MILL LODGE	1293	912	1227	1233.833	649	531.25	660	858					239	6.0	8.8	0.0	0.0	14.8	70.5%	100.6%	81.9%	130.0%		
YORK - RIVERFIELDS	360	485.4167	596	631.5	321.6	325.5	321.6	323.5					90	9.0	10.6	0.0	0.0	19.6	134.8%	106.0%	101.2%	100.6%		
YORK - WESTERDALE	607.5	1248.75	1087.5	1040	321.6	333.25	943.06	1174.833					328	4.8	6.8	0.0	0.0	11.6	205.6%	95.6%	103.6%	124.6%		

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
17

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Workforce Performance Report
DATE OF MEETING:	23 May 2019
PRESENTED BY: (name and title)	Claire Holmes, Director of OD & Workforce
PREPARED BY: (name and title)	Lindsay Jensen, Deputy Director Workforce Development 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

This report provides an overview of the key workforce performance measures as at March 2019. In comparison to March 2018, we have either retained, and in most instances achieved improvements in, performance across all areas with the exception of sickness absence rates which have seen a 0.2% in that period. Supervision rates, although significantly improved, remain below target and further work continues in this area.

The remaining sections of the report update on a number of workforce initiatives including; a reflection on the 2018 Shadow Board Programme; our intention to implement a bank staff experience survey from this year; and an update on our involvement in current workforce system initiatives.

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

RECOMMENDATION

The Board is asked to support the proposal for Shadow Board Members to be given the opportunity to deputise for their Executive Director either in whole or part at a Board Meeting within 12 months of the completion of their programme.

MEETING OF THE BOARD OF DIRECTORS

23 MAY 2019

WORKFORCE PERFORMANCE REPORT

1. Executive Summary

This report sets out the year end position on our workforce performance indicators as agreed in our Workforce and OD strategic plan. These are showing positive improvements in the most of the targets with appraisal, compulsory training, turnover, time to hire, bank recruitment and bank fill rates all at or above target.

Also included is an update on a number of initiatives which support our workforce priorities including a reflection on the 2018 Shadow Board Programme, our intention to implement a bank staff experience survey from this year and an update on our involvement in current workforce related system initiatives.

2. Workforce Key Performance Metrics

The table below shows the end of year compliance against our KPIs.

	Target	March 2018	March 2019
Appraisal	85%	77%	85%
Supervision	85%	43%	82%
Compulsory Training	85%	89%	89%
Turnover	8-10%	12%	10%
Bank recruitment (increase in Headcount)	44	NA	94
Bank Fill Rates – Nursing	80%	NA	86%
Bank Fill Rates – HCA	80%		83.4%
Recruitment Time to Hire (days)	62	NA	61.3
Sickness Absence	4.6%	4.6%	4.8%

We have achieved our performance target of 85% for appraisals for the first time in the last 5 years and there has been a significant improvement against the clinical supervision target with reported compliance rates almost doubling. Our compliance for compulsory training has remained above target all year.

The Trust has a target to grow the Bank by 10% year on year, in 2018/2019, the target was significantly exceeded with a growth rate of 20% achieved. In the same period we achieved a higher than target fill rate for Registered Nursing and Health care Assistants.

We are on target in relation to turnover rates and recruitment time to hire but are exceeding the target in relation to Sickness Absence. The reduction in turnover rates has been supported through our participation in the NHSI retention programme. As previously reported to the Board, absence relating to mental health and stress continues to rise and this is reported via the Quality Committee. We are in the process of recruiting a Health and Wellbeing Manager for the Trust to provide dedicated capacity to ensure our support mechanisms are both preventative and effective and engaged with piloting the NHSI Supportive Leadership Programme.

The NHSI Supportive Leadership Programme is aimed at mid to senior leaders and will focus on developing supportive leadership behaviours with a focus upon resilience and wellbeing. On the 23 May 2019 the Trust is hosting a train the trainer programme, following which the Leadership programme will be piloted and evaluated before a final decision is made as to whether to add this to our portfolio of leadership development interventions. The Trust is also taking the lead on working with our wider system partners in Leeds and in the West Yorkshire Mental Health Collaborative to create an opportunity to use this programme to support the delivery of wider system strategic workforce priorities.

3. 2018 Shadow Board Programme Review and Feedback

In 2018 the Trust delivered its first shadow board programme in collaboration with our mental health Trust partners, South West Yorkshire Partnership NHS Foundation Trust, Bradford District Care NHS Foundation Trust and our external provider the Integrated Leadership Network (ILN). The shadow board programme is a short, modular and practical programme with the objectives of:

- Enabling participants to deepen their understanding and insight into board-level working and good corporate/clinical governance.
- Support each Trusts' talent management, clinical leadership and senior succession plans, building strategic leadership capability.

- Support participants individual development and help prepare for future leadership roles, including aspiring directors
- To network and learn with colleagues across the mental health collaborative
- Champion equality, diversity & inclusion.

The LYPFT shadow board was chaired by Sue Proctor, Chair of the Trust and Sue White, Trust Deputy Chair and observed by an external observer with feedback delivered to participants following each shadow board meeting. Cath Hill, Associate Director of Corporate Governance provided board secretariat support. Participants were also invited to observe board meetings and board sub-committee meetings. There were 7 participants from LYPFT from a variety of professions.

Feedback from participants has been collected at several points during and after programme delivery. A formal evaluation day was held in November 2018 and all participants from all 3 Trust were invited to attend. Good levels of individual learning and impact as measured against the programme aims were shared during the evaluation session. Opportunities from the collaborative approach to delivery were also highlighted by participants, including increased opportunity to build relationships across the three Trusts, share learning and opportunities to build partnerships. A number of positive suggestions have been made as to how to further increase the benefit and maximise the learning opportunities from the programme, including a review of the duration of the programme to allow sufficient time for feedback, reflection and development.
The programme supports the Trust's strategic ambition to become an employer of choice as described in the Workforce and OD strategic plan and addresses in particular 2 key areas, recruiting and retaining an inclusive workforce and developing talent and collective leadership. The next programme is being planned for spring 2020 and there is strong commitment to develop and deliver a future programme with our mental health Trust partners.

2018 participants will have the opportunity to further their development through the following mechanism:

- Providing the opportunity for participants to deputise for their director and/or present a paper at Trust Board (within a year of graduating from programme)
- Utilise shadow board graduates to mentor future participants

- Provide opportunities to utilise the shadow board talent pool, both internally and across the mental health collaborative, eg secondments, project work, system wide opportunities.

Two system-wide shadow board programmes have also been delivered in 2018/19, both with LYPFT participants. Lindsay Jensen, Deputy Director of Workforce Development has participated in the Shadow Partnership Executive Group shadow board programme and Andy Weir; Deputy Chief Operating Officer has participated in the Integrated Care System shadow board programme.

4. Inclusive Agenda – Engagement with Bank Staff

Every year we receive feedback from our substantive staff through the NHS National Staff Survey. Our Bank staff are an important part of our workforce and although we have other engagement mechanisms in place, no widespread mechanism exists for gaining valuable feedback on the experiences of this workforce within the Trust. As part of our inclusive strategy we are really pleased that we have secured funding to implement an adapted survey to our bank staff alongside the national 2019 survey.

5. System Involvement – Workforce

5.1 Our Future Health and Care Workforce – Leeds Health and Care Academy Recruitment and Careers Event

LYPFT is participating in two initiatives coordinated by the Leeds Health and Care Academy, to inspire and recruit our future health and care workforce.

Over 300 Health and Care jobs were promoted at a recruitment and careers event held at the Civic Hall on 15 May 2019. Over 30 employers were in attendance to promote employment and development opportunities across the Leeds health and care workforce. For the first time on this scale, the Trust promoted a range of roles and visitors will also be able to speak to ambassadors and staff from the trust about their roles and experiences.

In April 2019 LYPFT launched its Ambassador programme. Following training, 6 staff from a variety of professions have committed to spend two or three days a year motivating and inspiring the future health and care workforce in Leeds and York by visiting communities, schools and job centres.

5.2 NHS People Plan event at LTHT

On 25 April, we attended an event hosted by LTHT where 50 staff were invited to hear from Julian Hartley (CEO LTHT), Baroness Dido Harding (Chair of NHSI, Prerana Issar, (new Chief People Officer) and Sir David Behan (Chair of HEE) about the current state of the draft NHS People Plan to support the NHS 10 year plan. This was also an engagement event where attendees were asked for their contributions to the emerging themes and priorities with a focus on the NHS being the best place to work, leadership and development, recruitment, new and emerging workforce roles and how technology can support the workforce. It is intended that there will be a series of events over the summer with the final plan due out in the autumn.

5.3 Leeds Anchors Network – Healthy & Inclusive Workforce

We are part of the Leeds Anchor Network and attended a workshop in April on how we can work together to deliver, develop and promote healthy inclusive workplaces to improve city organisational and workforce outcomes. This will include signing up to a City Wide Workplace Wellbeing Pledge which is currently in development.

To help move this work forward a working group is to be established which we will be a member of to agree priorities and actions going forward. To assist with this a priorities questionnaire to be completed by Anchor organisations to determine future work programmers and themes. We will be strongly advocating for support for mental and physical wellbeing.

6. Recommendation

The Board is asked to note the report and support the proposal for Shadow Board Members to be given the opportunity to deputise for their Executive Director either in whole or part at a Board Meeting within 12 months of the completion of their programme.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
17.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Future Workforce Governance Proposal
DATE OF MEETING:	23 May 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

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 reviews two options in relation to Future Workforce Governance. The first is to retain but strengthen the current Workforce and OD Group as an assurance committee, the second is to remove the Workforce and OD Parent Group and implement a Workforce Board Sub Committee. The benefits and challenges of each approach are set our within the paper.

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

It is recommended that the Board consider adopting Option 2, creating a Formal Workforce Committee to provide both additional time for representatives of the Board to focus upon key strategic Workforce issues and to provide additional assurance as to the implementation of the agreed Workforce Strategy.

MEETING OF THE BOARD OF DIRECTORS

23 MAY 2019

FUTURE WORKFORCE GOVERNANCE PROPOSAL

1 Background

In October 2018, the Board raised concerns in relation to the current Workforce Governance Structures and whether they currently provide the assurance the Board requires in relation to the development and implementation of the Workforce Strategy. The reporting structure for Workforce is unclear with elements going to Quality, elements to Finance and Performance, and the remaining direct to Board as required. Specifically, the question of whether the Board would like to implement a formal Workforce Subcommittee has been raised. As the Director of OD and Workforce was new to post, it was agreed to take some time to review the current arrangements in place and assess the feasibility, benefits and disadvantages of implementing a formal Workforce Subcommittee. This paper presents the Director OD & Workforce's assessment of the current options.

2 Current Arrangements

The current OD and Workforce Group meets bi-monthly and is the parent group to which 11 sub-groups report.

- Equality & Inclusion Group
- Health and Wellbeing Group
- Employment Procedures Group
- Recruitment and Retention Group
- Joint Local Negotiating Committee
- Joint Negotiating Consultation Committee
- Bank and Agency Meeting
- Compulsory & Priority Training Review
- Education & Development Steering Group
- Staff Survey Task & Finish Group
- Medical Revalidation & Appraisal Group*

*The Medical Revalidation & Appraisal Group also forms part of the Governance Group Reporting Structure.

Within the original terms of reference, the Group was intended to be an assurance committee however has developed over time to be an amalgamation of both a decision making and assurance committee. This has led to multiple instances of duplication of reporting and delays in time sensitive decisions being undertaken and it is the view of the Director of OD and Workforce that the Terms of Reference for the Group, and the subgroups, require review.

3 Future Options

3.1 Option 1: Retain Workforce and OD Group as an assurance committee.

Currently the Workforce and OD Group spends significant time within meetings debating agenda items without reaching a consensus. The group is simply too large and the time is too limited to enable items to be meaningfully debated and decisions reached within the bi-monthly meetings. Under this proposal, the sub groups would be strengthened as decision making committees where the engagement and robust challenge can take place by appropriate nominated representatives. The core purpose of the Workforce and OD Group would return to seeking assurance on the decision making process and not to replay the decision itself.

Although it will require review, this Group is already in existence and this option could be achieved with minimum disruption. Under this option, the Board would continue to have oversight of strategic issues via a Workforce and OD Board report.

3.2 Option 2: Implement a formal Workforce Sub Committee of the Board in place of the Workforce & OD Group.

The purpose of the subcommittee would be, as in option 1, to seek assurance that the sub groups identified are making, robust, effective and engaged decisions that align to the vision and strategic objectives of the Trust. The sub groups would still be strengthened as decision making committees chaired by a member of the Trust Executive or Senior Leadership Team and attended by appropriate nominated representatives.

Decisions falling outside of the delegated authority of these Groups, for example if significant financial investment was required to undertake a recommended

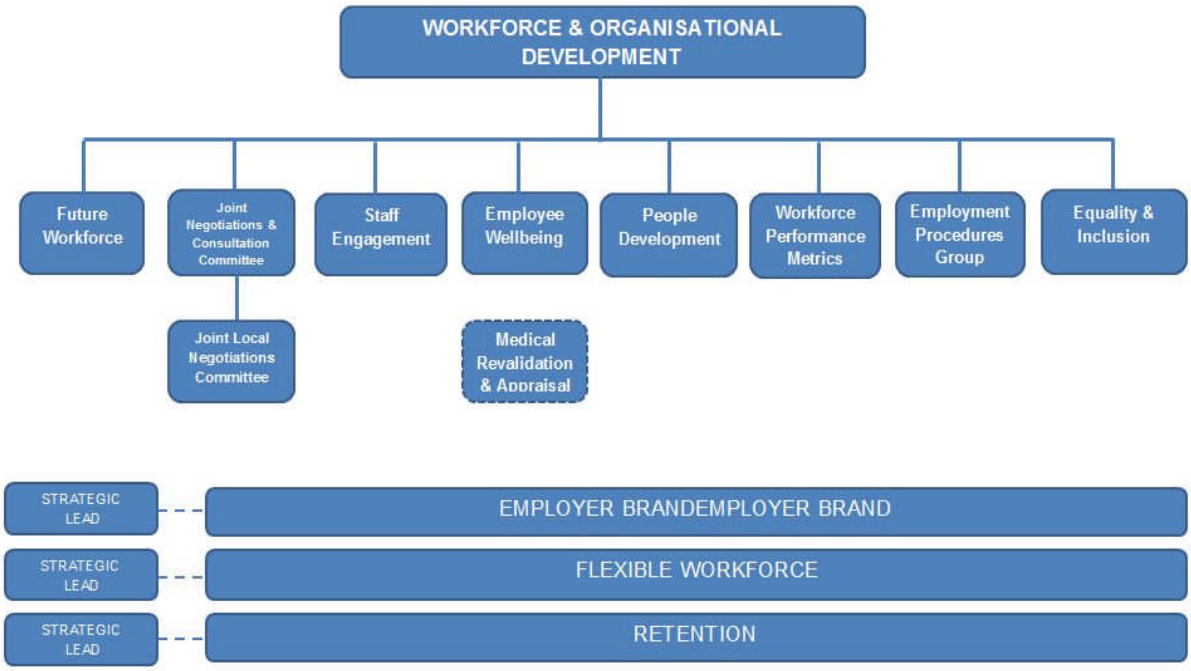
programme of work, would escalate to the Executive Management Team via the Director of OD and Workforce.

The opportunity for the Board to provide robust challenge on the development and implementation of the Workforce Strategy is limited during the Public Board and this approach would provide a direct line of sight to the Board on the implementation of the Workforce strategy and remove any potential duplication or confusion within current Board Committees as to the responsibility for Workforce.

There are potential disadvantages in relation to the additional draw on non-executive time and the potential additional work in relation to preparation of documents to provide to the Group. The former should be considered by the Board when reviewing this option and the latter could be managed through ensuring that the reports being produced by, and for, the sub groups can be escalated to the Workforce Committee as opposed to developing a separate suite of reporting.

4 Sub Groups

In order to enable either option set out above to be effective, the current sub groups would need to be strengthened as decision making committees, ensuring they have the right representation to make engaged and robust decisions. The following structure is proposed:



The more significant changes to note are:

- The addition of a Future Workforce Group looking at workforce requirements, the development of new roles across the Trust, undertaking workforce planning. A Strategic Resourcing Manager role has been created to support this vital activity
- The creation of a Workforce Performance Metrics Group to provide a mechanism of 'check and challenge' at Trust level in relation to Workforce Performance. This Group would own the work to be undertaken in relation to defining workforce information requirements.

Sitting alongside the sub groups are three overarching strategic themes which would form a core part of all of the Groups Terms of Reference. A strategic lead would be appointed to hold collective accountability for each strategic theme. The three themes are:

- Employer Brand – taking a cohesive approach to our Employer offering, communicating this as a package which supports our ambition to be a great employer.
- Flexible Workforce – Bank and Agency staff are a core and important part of our workforce and should be considered within the day to day decisions that are being taken. This is also about ensuring that our workforce policies and decisions support a flexible and agile culture.
- Retention – Ensuring that all parts of our workforce offering support the retention of staff and continue to develop the good work undertaken through the NHSi retention programme. Specific areas of the Trust where issues of retention are identified will be reviewed within the Subgroups under the direction of the strategic lead.

5 Recommendation

Option1, although providing for minimum disruption, does not provide the Board with the opportunity for additional input or oversight of the Workforce Strategy. It is therefore recommended that the Board adopt Option 2, which would provide the Board dedicated time for appointed representatives of the Board to seek that assurance and remove the current risks of duplication of workforce issues between the current Sub Committees.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
18

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Financial Officer Report
DATE OF MEETING:	23 May 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 reported financial position at month 01, which is stable and broadly in line with plan.

It provides a briefing on national capital planning issues and the context for the Trust in 19/20. A reduced capital expenditure plan has been submitted based on a reassessment of value and timing of schemes.

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

RECOMMENDATION

The Board of Directors is asked to:

- Consider the month 1 financial position
- Note the national capital planning issues and the potential future strategic impact.

BOARD OF DIRECTORS

23 May 2019

CHIEF FINANCIAL OFFICER REPORT – MONTH 1

1 Introduction

This report provides an overview of the financial position at month 1, and an update on national capital planning issues.

2 Financial Performance - Key Indicators Month 01

A summary of overall performance against key metrics is shown in the table 1 below:

Table 1

Key Metrics:	2019/20		
	Plan	Actual	Trend
Single Oversight Framework Finance Score	3	3	⬇
Income & Expenditure Position (£000s)	-284	-293	⬇
Recurrent CIP (£000s)	471	373	⬇
Cash (£000s)	71,515	70,438	⬆
Capital (£000s)	120	146	⬆

The position overall is broadly on plan. The key messages are:-

Income and Expenditure “run rate” patterns continue broadly as per the prior year, with significant offsetting between cost pressure areas and underspending budgets.

The main cost pressures continue to be inpatient staffing, OAPs and medical agency.

£1.1m CIP is unidentified at this point, with some plans in progress to mitigate, whilst ongoing work to identify recurrent solutions.

The plan is underpinned by signed contracts with all commissioners and the previously signalled financial risks with NHS England specialised commissioners largely mitigated (risk of lower occupancy in CAMHS and Forensic services contained within reasonable parameters).

3 National Capital Planning Issues

A national issue has emerged with a significant aggregate over commitment against the NHS capital departmental expenditure limit (CDEL) for 19/20. In response to this Provider organisations have been requested to review their individual capital plans and resubmit a reduced plan if able to do so. This request is in advance of a potential mandatory process of review, which if required is likely to be driven through a process of prioritisation at Integrated Care System level.

The Trust has undertaken a full review and has submitted a revised plan of £10m (original plan £13.4m). The detail of this has been reviewed by the Finance and Performance Committee. The Board can be assured there is no impact on delivering the Trusts operational plan priorities for 19/20. The reduction is based on an assessment of value and timings of key projects, as at the time of submitting the original plan, a significant amount of the expenditure was based on very high level estimates and assumptions, as well as an unplanned contingency.

The strategically significant point of this planning issue is the potential impact to future years and the direction signalled in the consultation on potential legislative changes. It is clear that the current disparity between foundation trusts being able to set individual capital spending limits unlike non-foundation trusts, is deemed problematic to national planning. In the context of “constrained” capital availability at a national level, there is an aim to encourage more joined up prioritisation of capital expenditure at system level. The imposition of some form of capital spending limit is likely. It is therefore important to recognise that the Trust has purposefully signalled intent to spend a significant amount on capital expenditure from its own cash reserves over the strategic planning period. It will be important that we continue to articulate how this investment aligns to our priorities, clinical strategy and demonstrate value for money. The thresholds for requiring external approval of investment (including where resourced from internally generated resources) is also likely to reduce.

4 Conclusion

The month 1 financial position shows that the Trust reported a finance score of ‘3’ as planned. This position is underpinned by significant variances between planned budgets and actual expenditure, with a high degree of reliance on underspending budgets to offset pressure areas. The most significant risks in month 1 continue to be OAPs expenditure, inpatient staffing, rising agency medical costs and unidentified CIPs.

5 Recommendation

The Board of Directors is asked to:

- Consider the month 1 financial position.
- Note the national capital planning issues and the potential future strategic impact.

Dawn Hanwell
Chief Financial Officer and Deputy Chief Executive
23 May 2019

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

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LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Strategic Priorities End of Year Progress Report
DATE OF MEETING:	23 May 2019
PRESENTED BY: (name and title)	Dawn Hanwell, Chief Financial Officer and Deputy Chief Executive
PREPARED BY: (name and title)	Amanda Burgess, Strategic Development Manager

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

EXECUTIVE SUMMARY

This is our fourth and final report of 2018/19 and is set out to provide an overall summary of our position against each of the key deliverables described in the 2018 - 2019 Operational Plan.

Our top priorities for delivery over 2018/19 have been derived from each our strategic plans (clinical, health informatics, estates, workforce & OD and quality). At the end of quarter 4 we have achieved all of our one-year milestones. Our two/three year actions that are currently behind schedule are as follows:

- Implement a new forensic community outreach model
- Explore the feasibility and viability of a female only PICU service
- Achievement of our out of area placement trajectory for acute and PICU
- Complete a series of safe staffing reviews
- Develop our gender identity services and actively participate in the national procurement process
- Reduce LD assessment and treatment beds

No actions are currently identified as red.

In addition, this paper informs the Board of the collective priorities that have been agreed and will be led by the Executive Management Team during 2019 – 2020.

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
Members of the Board of Directors are asked to: ▪ Note the progress made against our strategic priorities at this end of year point and refreshed priorities for delivery during 2019/20. ▪ Confirm that they are assured of progress being made to address areas for improvement.

MEETING OF THE BOARD OF DIRECTORS

THURSDAY 23 MAY 2019

STRATEGIC PRIORITIES END OF YEAR PROGRESS REPORT

1. Purpose

This report sets out the progress we are making against the strategic priorities described within our 2018 – 2019 Operational Plan. This is our final report of 2018/19 and is set out to provide an overall summary of our progress against each of the priorities.

All key deliverables set for delivery during 2018/19 feature as part of each of our three-year strategic plans (clinical, quality, health informatics, estates and workforce and organisational development).

This paper also sets out the collective priorities that have been agreed and will be led by the Executive Team during 2019/20. All these priorities were detailed as part of our 2019/20 Operational Plan approved by the Board of Directors in March 2019.

2. 2018/19 strategic priorities status summary

We produced our one-year Operational Plan in April and submitted it to NHS Improvement on 30 April 2018. Our Operational Plan describes in total, 21 organisational strategic priorities for commencement and/or delivery during 2018/19 which have been financially modelled. All of our priorities link with our strategic plans. Our strategic plans also contain further key deliverables from those detailed within our Operational Plan.

We submitted our 2019/20 Operational Plan to NHS Improvement/England on 4 April 2019. Included as part of our plan is a refreshed version of our priorities for delivery, taking into account the one-year priorities which are fully completed, priorities to be completed over 2019 – 2021 (three-year strategic plan) and any new priorities we have identified.

Progress we have made at the end of quarter four (end of year)
We have now assessed ourselves against our fourth quarter milestones as set out within our 2018 – 2019 Operational Plan.

All our strategic priorities have clearly defined milestones for achievement. Our one year schemes that we are behind schedule on achieving and doubtful will be achieved by the agreed timescale have been rated as red.

Two or three year schemes where we are behind on delivering against key milestones at this end of year point are rated as amber. A green rating has been applied to schemes which have either been delivered or on schedule.

Overall at the end of the fourth quarter of the 21 schemes, 8 are fully delivered. 7 schemes are currently rated as green and 6 rated as amber. We have no schemes rated as red. A summary of the schemes and the progress we are making can be found below.

Objective	Actions	Timescales	Progress	Rating	CIP
Key deliverables within our Community and crisis services					
Implementation of a new community and crisis model for older and working age adults.	▪ 06.04.18: paper to Adult & Health Scrutiny Working Group around the proposed model ▪ April – June: 8 week engagement process with staff, stakeholders, service users and carers ▪ July: end of engagement analysis and communication of engagement exercise ▪ Sept – Dec: staff consultation process ▪ Jan – Mar: transition to new working arrangements – caseload transfer, system changes ▪ Feb - Mar: EPR team structure and reporting alterations delivered ▪ 25 March: go-live	Pathway implementation March 2019 **(Scheme completed)**	▪ New service model went fully live on 25 March 2019. ▪ Quality Committee considered an assurance report about the community redesign at the December and January meetings detailing the quality and delivery impacts the changes will make. ▪ Board of Directors considered an assurance report at the January meeting. ▪ Implementation lead started in February 2019. This is a two-year post to support and monitor the mobilisation of the new service model including the evaluation. ▪ Evaluation plan in place and agreed through a process involving service users, carers and our commissioners. ▪ Clinical skills training and OD programme underway to support staff transitioning to the new working arrangements. ▪ Transferring of caseloads across the new locality boundaries continues with support mechanisms in place for both staff and service users being transferred.		£64k (LC9)
Integrate the specialist liaison outpatient model with Leeds Teaching Hospitals NHS Trust (acute provider) specialisms and identify growth opportunities in non-acute outpatient care.	▪ Exploring opportunities to expand our specialist liaison outreach model. ▪ Receive funding to provide bariatric liaison outpatient service with LTHT.	April 2020 **(Scheme included in our 2019/20 Operational Plan)**	▪ The combined weight management bid between LCH, LTHT and LYPFT was successful. ▪ Internal mobilisation within LYPFT is underway, with the successful recruitment of a Consultant and Cognitive Behavioural Therapist – both scheduled to start in post by the end of May 2019.		N/A

Objective	Actions	Timescales	Progress	Rating	CIP
Key deliverables within our Community and crisis services					
We will respond to people who visit the emergency department in crisis within 1 hour by increasing our specialist triage provision provided by the Assessment and Liaison Psychiatry Service (ALPS).	▪ Awaiting clarification from Leeds CCG as to whether funding will be available from 2018/19 – completed ▪ Recruitment process completed - awaiting commencement of new staff	Quarter 4 2018/19 **(Scheme completed)**	▪ The trajectories are virtually on track, dipping at the beginning of the year due to a 30% increase in referrals. The trajectory is improving in April with new staff commencing in post. Given the measures now in place we are hopeful that this will continue to improve during the first quarter of 2019/20 progress.		N/A
As part of the winter pressures planning across Leeds, we will implement an enhanced Care Homes Service that will offer intensive assessment and support to newly placed care home residents.	▪ Increased responsiveness to care home sector/ greater understanding of the delayed transfers of care position. ▪ Improved understanding of system issues, relationship building and service improvements. ▪ Enhanced care homes team staff will be trained and fit for purpose, increasing the quality of clinical interventions. Required tweaks to processes will be made. ▪ To provide evidence based feedback to measure and inform service success / intelligence for future business planning intentions. ▪ Service level need for managing delayed transfers of care linked to the care home sector is considered within service redesign conversations /on-going agenda.	March 2020 **(Scheme included in our 2019/20 Operational Plan)**	▪ Consistent seven day service maintained. ▪ We have received agreement with our commissioners to recurrently fund this function as part of the broader Care Homes Service.		£84k (LC1)
Implement a new forensic community outreach model	▪ STP located forensic service in partnership with other providers ▪ Lead community provider to be	December 2019 **(Scheme**	▪ In Humber Coast & Vale STP, an expanded community team has been recruited to and is operational from Clifton House.		£98k (Sp2)

Objective	Actions	Timescales	Progress	Rating	CIP
Key deliverables within our Community and crisis services					
(including in-reach) that provides specialist community support and intervention for service users with on-going significant / complex mental health needs leaving secure care, and/or who present a significant potential risk to others or exhibit serious offending behaviour.	agreed by Humber, Coast & Vale STP for forensic model ▪ Humber, Coast & Vale STP redesign inpatient services at Clifton House in line with commissioning plans ▪ West Yorkshire STP lead provider for community forensic model for the STP footprint to be agreed in April ▪ Both STP's actively engaged in community LD model development	**included in our 2019/20 Operational Plan)**	▪ Links with other providers are being developed and further work is underway to develop a new STP model of community forensic care as part of a formal STP programme. This will be submitted to NHS England for consideration during the first half of 2019/20. ▪ West Yorkshire ICS developments have not yet resulted in any change to community provision. A working group has been established to develop a New Care Model proposal for forensic services (incorporating a community model) which, as with Humber Coast & Vale, will be submitted for consideration by Specialist Commissioners at NHS England.		
We will mobilise our plans for a veterans' mental health intensive service.	▪ Implement a veterans mental health intensive service in-line with the service specification/our tender ▪ Implement governance processes for the service ▪ Monitor, evaluate the new service effectiveness	April 2018 **(Scheme completed)**	▪ Veterans' service mobilised. ▪ Negotiations underway with Combat Stress in regard to Peer Support provision.		
Key deliverables within our inpatient services					
We will redesign our low secure model at Clifton House, York, including: o Implement two assessment and treatment wards (12 bedded male ward and a 10 bedded female ward) o Implement a 10	▪ Agree model with STP partners and NHSE ▪ Develop service model and ward descriptors ▪ Develop recruitment campaign ▪ Recruit to key posts ▪ Complete estates work on wards ▪ Induct new starters and develop teams to work within new pathway	December 2018 **(Scheme completed)**	▪ The local restructure is now completed and the wards are reconfigured. ▪ Occupancy is not high at present due to the limited number of referrals and people needing to step down from the new male assessment and treatment ward to the rehab ward. Monitoring of this occupancy is important. ▪ All staff are settled into their new roles.		N/A

Objective	Actions	Timescales	Progress	Rating	CIP
Key deliverables within our Community and crisis services					
bedded male low secure rehabilitation and transitional ward, for men who are preparing to leave secure care and require less intensive procedural and relational security.					
Explore the feasibility and viability of a female only PICU.	▪ Development of a business case for a female only PICU, linked with the existing staffing situation and thresholds needed. Also need to reflect WYSTP proposals. ▪ Linked with the business case determine our preferred option for on a West Yorkshire or Leeds footprint.	March 2020 **(Scheme included in our 2019/20 Operational Plan)**	▪ Delays with the procurement of an external organisation to support the capacity review for West Yorkshire have occurred as it was proposed the scope be expanded to include acute inpatient capacity. ▪ The procurement of this project has commenced and the objective has been carried forward into the Operational Plan for 2019/20.		N/A
We will ensure achievement of our out of area placement trajectory for acute and PICU	▪ Initiatives to ensure a reduction in length of stay ▪ The Admissions and Discharge Group will undertake work to reduce clinical variation ▪ The Care Navigator post within the older peoples services will be implemented ▪ Complete the STP work on PICU and locked rehab	April 2021 **(Scheme included in our 2019/20 Operational Plan)**	▪ We had an out of area placement target of 720 days. At the end of the fourth quarter we had service users placed out of area for 982 days. ▪ Revised trajectory agreed with Leeds CCG, linked with funding intentions. ▪ We have successfully recruited a Social Worker who joins the team during May 2019. ▪ Criteria led discharge was implemented during quarter three. Regrettably uptake was poor, our intent is to relaunch during quarter one with a process of weekly ward manager's performance calls in place.		£45k (Sp9)
We will engage an organisation to review our bed numbers with the priority focus upon	▪ NICHE (previously known as Mental Health Strategies) have been retained to complete a review of our bed numbers.	Sept 2019 **(Scheme included in our**	▪ Keith Hurst acuity tool fully adopted during quarter four with the intention to extend its use for a further six months. ▪ Agreement made for NICHE to review our bed		N/A

Objective	Actions	Timescales	Progress	Rating	CIP
Key deliverables within our Community and crisis services					
our acute beds and Crisis Assessment Unit. Alongside this work we will complete a series of safe staffing reviews, with our priority area being PICU, learning disabilities and dementia wards.	▪ The outputs from the report and recommendations for action will be provided to the Board on 12th July.	**2019/20 Operational Plan)**	numbers. ▪ Agreement to increase PICU staffing during quarter one 2019/20.		
Key deliverables within our specialist and learning disability services					
Implementation new models of care for adult eating disorders	▪ Finalise financial arrangements with NHSE to implement new model (both inpatients and community) ▪ Evaluate and monitor new model via the STP Programme Board	April 2018 **(Scheme completed)**	▪ The project goes live on the 01.04.18 with a graded implementation due to not having the service fully recruited to. We have worked in partnership with BDCT, SWYPFT & TEWV to implement the service across the STP. ▪ Finances have been agreed with NHSE. ▪ The service will be evaluated and monitored over the next 18 months as per the requirements of the pilot.		£30k (Sp3)
We will explore the opportunity to further increase our perinatal bed base	▪ Rebase bed expansion for 2018/19 ▪ Discussions with NHSE to agree future bed provision and develop as required	March 2018 **(Scheme completed)**	▪ Fully functioning with an increase of two beds (now 8 bedded ward serving Yorkshire & Humber).		N/A
Develop our gender identity services and actively participate in the national procurement process.	▪ Implementation of an outreach model across the north west ▪ Redesign service if required upon publication of national specification ▪ Completion of a procurement exercise once national specification known	August 2019 **(Scheme included in our 2019/20 Operational Plan)**	▪ The service has embarked on stage 1 of the Gender Clinic full procurement. This is in line with national timescales and published procurement process. The service is in discussion with other providers regarding possible joint applications and matrix working.		N/A
We will reduce LD assessment and	▪ Develop joint plan with Bradford District Care Trust for future	September 2019	▪ Consideration is now being given to Assessment and Treatment being provided		N/A

Objective	Actions	Timescales	Progress	Rating	CIP
Key deliverables within our Community and crisis services					
treatment beds in line with Transforming Care Plan and explore options for co-location.	provision of inpatient beds ▪ Develop locked rehab provision in line with Transforming Care Plan ▪ Remodel staffing finances for inpatients once model known	**(Scheme included in our 2019/20 Operational Plan)**	across the STP footprint rather than just Leeds and Bradford. ▪ Workshop held to support the development of a full proposal and business case. Business case will be in May 2019 for implementation. ▪ Locked Rehab discussions have not been taking place with Commissioners. CCG has requested some other work to focus on community provision with the scoping of extending LYPFT Supported Living Service to support Transforming Care cohort. A costed proposal has been submitted. ▪ Further request by Leeds CCG for the creation of an Intensive Support Team has been made with funding agreed.		
Key deliverables within our support services					
Commence implementation of a new replacement electronic patient record system across the Trust.	▪ Contract agreed with supplier in June 2018 ▪ Mobilisation of plans ▪ Infrastructure and environment available ▪ Testing of CareDirector to take place in September 2019 ▪ End user training and Trust-wide rollout scheduled for May 2020	June 2020 **(Scheme included in our 2019/20 Operational Plan)**	▪ EPR programme is running according to plan and on budget. ▪ Workshops and staff engagement programmes are being run with high staff attendance and positive feedback in order to ensure that the system is clinically led. ▪ Linkages to clinical redesign have been established. ▪ Programme governance arrangements have received a high level of assurance following a recent Internal Audit. ▪ The new EPR system has been built in the Microsoft Cloud and version six of the system is now being configured.		N/A
Confirm the feasibility of a PFI restructure/refinance.	▪ Timeline of the restructure and refinance to be define in July, with the aim to deliver in October 2018.	October 2018 **(Scheme completed)**	▪ PFI refinance arrangement fully concluded in January 2019.		£470k (CFO06)
Achievement of the	▪ Conclude the sale of four Trust	October 2018	▪ All contracts exchanged for all four properties.		£1.9m

Objective	Actions	Timescales	Progress	Rating	CIP
Key deliverables within our Community and crisis services					
disposal of four Trust properties: Springfield Mount, Malham House, Southfield House and The Cottage.	properties: Malham House, Springfield Mount, Southfield House and The Cottage.	**(Scheme completed)**	Scheduled to vacate premises at the end of November 2018. All sales are fully completed. ▪ Both Southfield House and Malham House staff transferred to St Mary's House on 21 and 22 November 2018.		(profit on disposal)
Commence implementation of our workforce and organisational development plans, including staff engagement, OD expertise, well-being and stress, retention and management of change capacity.	▪ Maximise engagement and staff wellbeing through a variety of tools i.e. staffnet, Your Voice Counts. ▪ Design a comprehensive Trust leadership development offer that supports talent management processes and collective/individual PDPs. ▪ Provide high level integrated performance data to indicate team performance and support delivery of care. The data to inform prioritisation of resource for team and leadership development. ▪ Maximise opportunities around recruitment, retention and developing talent in the workforce. ▪ Developing and learning innovative approaches to change i.e. agile working. ▪ Developing the right policies, rewards and systems. ▪ Developing behaviours to ensure Trust values live.	March 2021 **(Scheme included in our 2019/20 Operational Plan)**	▪ **Staff engagement: 2018 Staff Survey** concluded on 1 December with our highest ever response rate at 58.1%. Early results show positive increases across many of the questions. A new reporting deck, via COGNOS is being developed, sharing local level results to teams in February 2019 ahead of the start of local action planning. Additionally we plan to focus our next **Your Voice Counts** conversation in early April 2019 on health and wellbeing following the 2018 Staff Survey Results. We continue to actively support the **Community Redesign** programme with staff engagement events held during Jan/Feb 2019. ▪ **Leadership Development: Mary Seacole (MS):** Cohorts 11 and 12 of the MS programme have now commenced. Meetings took place in early January to discuss plans for the local licence renewal post April 2019. ▪ **Management Essentials:** Workshops have now restarted for this programme and the appetite for attending this training is increasing, particularly in the Supporting Resilience Workshops. Revisions are ongoing to all workshops in liaison with the experts from HR. ▪ **Team Development: Affina OD training.** A group of 12 Team Coaches have commenced their training in this team development journey. OD are currently working with the Community		N/A

Objective	Actions	Timescales	Progress	Rating	CIP
Key deliverables within our Community and crisis services					
			Redesign Leadership Team to develop a rollout of this team development tool. ▪ **Talent Management:** 57 apprenticeship enrolments have been achieved to date with the present focus being on the development of our existing workforce. Work continues to develop further our future plans to fully meet our future workforce needs and maximise use of the levy. ▪ **Supporting Change/OD Expertise:** The Learning and OD team are actively supporting key change projects. A Learning and OD Plan to support the changes involved in implementing the new community services model is currently being developed. In addition, a change agent to support the EPR programme has successfully been recruited.		
Complete a review of patient experience and delivery of improvements identified.	▪ A formal independent review of patient experience has been commissioned by the Director of Nursing and Professions.	October 2018 **(Scheme included in our 2019/20 Operational Plan)**	▪ Independent review report presented to the Board of Directors in January 2019, with improvements identified and a recommendation to introduce strategic oversight and governance of this portfolio. ▪ The first meeting of the Patient Experience and Involvement Strategic Steering Group took place on the 30th April 2019 chaired by the Director of Nursing, Professions and Quality. ▪ The Patient Experience and Involvement Strategic Steering Group has tasked the sub groups (experience, involvement and carer) to identify x3 key priorities to take forward over the next 12months. The chairs for the sub groups have been identified. Key priorities to be agreed and signed off at the steering group for rollout during 2019/20.		N/A

Objective	Actions	Timescales	Progress	Rating	CIP
Key deliverables within our Community and crisis services					
Commence implementation of the defined model for quality improvement and ensure delivery of the supporting workstreams already underway.	▪ First Quality Strategic Plan Workshop scheduled to take place on 23rd July ▪ 6 monthly progress report to the Quality Committee scheduled for 11th September ▪ Quality Exchange Forum is scheduled to take place on 4th October	March 2021 **(Scheme included in our 2019/20 Operational Plan)**	▪ Work continues to build an organisation-wide improvement framework and model based on the Institute for Healthcare Improvements five core components which links to the Model for Improvement. ▪ Leadership for Improvement workshops have been co-developed and will be co-delivered with the Institute for Healthcare Improvements. ▪ More in depth improvement training is currently being scoped and developed to align with the new model.		N/A
Completion of any actions identified as a result of the CQC inspection completed in January 2018.	▪ Should do action plans completed for most actions ▪ Continuing to embed the new ways of working with evidence of compliance and improvement ▪ Measuring and reporting of quality improvements ▪ Peer Reviews continue through the services ▪ Readiness for next CQC inspection (expected from 12 months after the January 2018 inspection if requesting a reassessment of rating)	March 2020 **(Scheme included in our 2019/20 Operational Plan)**	▪ Received notification from the CQC of the imminent inspection with completion of the Pre-Inspection Report. ▪ Across Trust CQC meetings continue monthly. Continued improvement following completion of actions remains a focus alongside a look forward to CQC inspection readiness and beyond. ▪ All CQC 'must do' actions complete. ▪ All CQC 'should do' actions are on track, on-going or complete. ▪ Peer Reviews initially concentrated on services that received a "Requires Improvement" CQC rating and have rolled out to other services ▪ Clinical Record Task & Finish group have delivered a Trust-wide clinical record audit tool and procedures for operation.		N/A

3. Organisational priorities 2019/20

Our 2019/20 Operational Plan describes our priorities for delivery. The identification of these priorities has been based on our responsiveness to known or expected commissioning intentions that aligns to our core activity. All priorities are fully aligned with our overall financial plan.

These priorities reflect the most significant and cross cutting work programmes which have executive leadership and ensure delivery of service improvements in line with our overall direction of travel. There are likely to be additional programmes of work the Executive Management Team agree to prioritise in response to wider changes across the WYICS, Leeds Plan, and commissioner intentions. Therefore we need to maintain a degree of flexibility and pragmatism. All the priorities identified in this paper are core to the work of care groups and corporate teams going forward.

The table at **appendix one** outlines our intentions around how we will report on the progress we are making against our priorities for 2019/20. We will continue to provide a high-level assurance report to the Board of Directors on a bi-annual basis, this will have been presented to the various Board sub-committees for assurance and more detailed scrutiny.

4. Recommendation

Members of the Board of Directors are asked to:

- Note the progress made against our strategic priorities at this end of year point and refreshed priorities for delivery during 2019/20.
- Confirm that they are assured of progress being made to address areas for improvement.

Dawn Hanwell
Chief Financial Officer/Deputy Chief Executive
Tuesday 14 May 2019

APPENDIX ONE: 2019/20 Organisational Priorities

Key deliverables for 2019 – 2020		Executive lead	Operational governance	Period	Report	Assurance governance
Key deliverables within our Community and crisis services	Mobilisation of a new community and crisis model for older and working age adults optimising provision within existing resources and developing plans for investment.	Chief Operating officer	PMO reporting into the Service Development Group	Each meeting	Details of progress made against the plans in place.	Quality Committee bi-annually prior to reporting to the Board of Directors (providing assurance on progress with implementation).
	Integrate the specialist liaison outpatient model with Leeds Teaching Hospitals NHS Trust (acute provider) specialisms and identify growth opportunities in non-acute outpatient care.	Chief Operating officer	PMO reporting into the Service Development Group	Each meeting	Details of progress made against the plans in place.	Quality Committee bi-annually prior to reporting to the Board of Directors (providing assurance on progress with implementation).
	We will ensure the delivery of an enhanced Care Homes Service that offers intensive assessment and support to newly placed care home residents and reduces admission to inpatient services.	Chief Operating officer	PMO reporting into the Service Development Group	Each meeting	Details of progress made against the plans in place.	Quality Committee bi-annually prior to reporting to the Board of Directors (providing assurance on progress with implementation).
	In partnership we will develop a new service model for primary care mental health service (incorporating IAPT and primary care mental health) linked with the tender process. Specifically our part in the partnership relates to the development and rollout of primary care mental health services in communities.	Chief Operating officer	PMO reporting into the Service Development Group	Each meeting	Details of progress made against the plans in place.	Quality Committee bi-annually prior to reporting to the Board of Directors (providing assurance on progress with implementation).
Key deliverables within our inpatients services	Complex Care (locked rehabilitation) collaborative work in STP with MH providers: explore feasibility of a female locked rehab provision in Leeds and/or elsewhere within the WYSTP footprint.	Chief Operating officer	PMO reporting into the Service Development Group	Each meeting	Details of progress made against the plans in place.	Quality Committee bi-annually prior to reporting to the Board of Directors (providing assurance on progress with implementation).
	Develop new models of inpatient rehabilitation provision involving third sector partners in Leeds.	Chief Operating officer	PMO reporting into the Service Development Group	Each meeting	Details of progress made against the plans in place.	Quality Committee bi-annually prior to reporting to the Board of Directors (providing assurance on progress with implementation).
	As part of the West Yorkshire Mental Health Programme we will complete a review of the acute/PICU pathway to fully understand capacity and demand impacts upon each organisation and how this can influence the future configuration of the bed base across West Yorkshire.	Chief Operating officer	PMO reporting into the Service Development Group	Each meeting	Details of progress made against the plans in place.	Quality Committee bi-annually prior to reporting to the Board of Directors (providing assurance on progress with implementation).
	We will ensure achievement of an agreed out of area placement trajectory for acute and PICU with the underpinning assumption of core mental health	Chief Operating officer	PMO reporting into the Service	Each meeting	Details of progress made	Quality Committee bi-annually prior to reporting

Key deliverables for 2019 – 2020		Executive lead	Operational governance	Period	Report	Assurance governance
	investment to provide out of hospital alternatives to admission.		Development Group		against the plans in place.	to the Board of Directors (providing assurance on progress with implementation).
	Using a nationally recognised acuity tool we will complete a review of the level of staffing across our inpatient services.	Chief Operating officer Director of Nursing & Professions	Service Development Group/ Operational Delivery Group	Each meeting	Details of progress made against the plans in place.	Quality Committee bi-annually prior to reporting to the Board of Directors (providing assurance on progress with implementation).
	Implement the Acute Care Excellence programme of work to address clinical variation and in particular length of stay across our acute wards.	Chief Operating officer	PMO reporting into the Service Development Group	Each meeting	Details of progress made against the plans in place.	Quality Committee bi-annually prior to reporting to the Board of Directors (providing assurance on progress with implementation).
Key deliverables within our specialist and learning disability services	Evaluate the new models of care for adult eating disorders via the STP.	Chief Operating officer	PMO reporting into the Service Development Group	Each meeting	Details of progress made against the plans in place.	Quality Committee bi-annually prior to reporting to the Board of Directors (providing assurance on progress with implementation).
	We will ensure the delivery of a Perinatal Community Service that will see clear referral pathway for psychological therapies for Leeds service users and work with colleagues across the region to ensure an agreed perinatal pathway across the spectrum of perinatal mental illness.	Chief Operating officer	PMO reporting into the Service Development Group	Each meeting	Details of progress made against the plans in place.	Quality Committee bi-annually prior to reporting to the Board of Directors (providing assurance on progress with implementation).
	Develop our gender identity services and actively participate in the national procurement process.	Chief Operating officer	Service Development Group/ Financial Planning Group	Each meeting	Details of progress made against the plans in place.	Finance & Performance Committee for assurance against the financial plan.
	Implement a new forensic community outreach model (including in-reach) that provides specialist community support and intervention for service users with on-going significant / complex mental health needs leaving secure care, and/or who present a significant potential risk to others or exhibit serious offending behaviour.	Chief Operating officer	PMO reporting into the Service Development Group	Each meeting	Details of progress made against the plans in place.	Quality Committee bi-annually prior to reporting to the Board of Directors (providing assurance on progress with implementation).
	Mobilise the new northern NHS Gambling service (in collaboration with GamCare).	Chief Operating officer	PMO reporting into the Service Development Group	Each meeting	Details of progress made against the plans in place.	Quality Committee bi-annually prior to reporting to the Board of Directors (providing assurance on progress with implementation).
	As part of the new care model for York CAMHS we are working with our commissioners to redefine our clinical model, including recalibrating the bed base across the wider STP patch.	Chief Operating officer	PMO reporting into the Service Development	Each meeting	Details of progress made against the plans	Quality Committee bi-annually prior to reporting to the Board of Directors

Key deliverables for 2019 – 2020		Executive lead	Operational governance	Period	Report	Assurance governance
			Group		in place.	(providing assurance on progress with implementation).
	Working in collaboration with the other providers across West Yorkshire develop a standard future model for Learning Disability assessment and treatment inpatient care, as a networked service working to the same standards. Linked with the Leeds Transforming Care Partnership Programme for people with learning disabilities, we will be developing an intensive community service that provides intensive and transitional support enabling people with learning disabilities to step down from hospital much sooner. We are also developing a business case to provide a step down/supported living service for 6-7 individuals with learning disabilities in partnership with a housing provider.	Chief Operating officer	PMO reporting into the Service Development Group	Each meeting	Details of progress made against the plans in place.	Quality Committee bi-annually prior to reporting to the Board of Directors (providing assurance on progress with implementation).
Key deliverables within our support services	Implementation of a new replacement electronic patient record system across the Trust.	Medical Director Chief Financial Officer	EPR Project Team reporting into the Information Steering Group at each meeting detailing progress made against the plans in place.	Each meeting	Details of progress made against the plans in place.	Finance & Performance Committee bi-annually prior to reporting to the Board of Directors (providing assurance on progress with implementation).
	Seek agreement through a full business case process a new build development that will see the relocation of the National Inpatient Centre for Psychological Medicine (NICPM).	Chief Financial Officer	Programme Board reporting into the Estates Steering Group at each meeting detailing progress against the plans in place.	Each meeting	Details of progress made against the plans in place.	Finance & Performance Committee bi-annually prior to reporting to the Board of Directors (providing assurance on progress with implementation).
	In partnership with Leeds Community Healthcare, build a new inpatient facility for children and young people across West Yorkshire.	Chief Financial Officer	Project Board reporting into the Estates Steering Group at each meeting detailing progress against the plans in place.	Each meeting	Details of progress made against the plans in place.	Finance & Performance Committee bi-annually prior to reporting to the Board of Directors (providing assurance on progress with implementation).
	Commence our ward refurbishment programme that will see the transfer of our acute ward based at the Newsam Centre relocated to the Becklin Centre.	Chief Financial Officer	Project Board reporting into the Estates Steering Group at each meeting detailing progress against the plans in place.	Each meeting	Details of progress made against the plans in place.	Finance & Performance Committee bi-annually prior to reporting to the Board of Directors (providing assurance on progress with implementation).

Key deliverables for 2019 – 2020		Executive lead	Operational governance	Period	Report	Assurance governance
	Implementation of our workforce and organisational development plans, including staff engagement, OD expertise, well-being, retention and management of change capacity.	Director of Organisational Development & Workforce	Workforce and Organisational Development Group	Quarterly	Report on performance against the Workforce & OD Strategic Plan	Board bi-annually to report against progress on plans.
	Implementation of the actions pertaining from our review of patient experience and delivery of improvements identified.	Director of Nursing & Professions	Patient Experience and Involvement Strategic Steering Group	Each meeting	Details of progress made against the plans in place.	Quality Committee bi-annually prior to reporting to the Board of Directors (providing assurance on progress with implementation).
	Commence implementation of the defined model for quality improvement and ensure delivery of the supporting workstreams already underway. This will include the outcome from the review undertaken by the Institute for Healthcare Improvement.	Medical Director	Trust-wide Clinical Governance Group to receive updates on the progress against the priorities detailed within the Quality Strategic Plan.	Quarterly or as required	Details of progress made against the plans in place.	Quality Committee to receive assurance reports on the progress we are making against the priorities within our Quality Strategic Plan.
	Organisational readiness for our 2019 CQC inspection process.	Director of Nursing & Professions	Trust-wide Clinical Governance Group to receive updates	Monthly	Details of progress made against the plans in place.	Quality Committee to be assured on progress and implications quarterly.
	Delivery of Emergency Preparedness, Resilience and Response standards and business continuity arrangements associated with a no-deal EU exit (Brexit).	Chief Operating Officer	Operational Delivery Group to receive updates.	Monthly	Details of progress made against the plans in place.	Finance & Performance Committee bi-annually prior to reporting to the Board of Directors (providing assurance on progress with implementation).

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
20

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Approval of the refreshed strategic risks for the Board Assurance Framework
DATE OF MEETING:	23 May 2019
PRESENTED BY: (name and title)	Sara Munro, Chief Executive
PREPARED BY: (name and title)	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 Board is reminded that it was agreed at its November 2018 meeting that the strategic risks that feed into the Board Assurance Framework would be refreshed after the end of the financial year.

The Executive Team met in April to look at the risks and to consider how the risks. Executive directors took account of those 'big ticket' issues that the Trust is dealing with and also took into consideration the key strategic priorities.

Attached are seven proposed new risks. These are set alongside those currently in the BAF so the Board can see the progression between the old and proposed new risks.

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 consider and agreed the proposed new strategic risks for inclusion on the risk register and the Board Assurance Framework.

MEETING OF THE BOARD OF DIRECTORS

23 May 2019

Approval of the refreshed strategic risks for the Board Assurance Framework

1 Executive Summary

The Board is reminded that it was agreed at its November 2018 meeting that the strategic risks that feed into the Board Assurance Framework would be refreshed after the end of the financial year.

The sections below detail the current ten strategic risks and the seven proposed new risks.

2 Current Strategic Risks

Below is the list of strategic risks which were agreed by the Board in 2017:

SR1. Due to an inability to align our workforce capacity to planned models of care, there is a risk that we are unable to deliver high quality, evidence based, person centred care.

SR2. We are unable to maintain compliance with regulatory requirements relating to the quality and safety of our services due to a failure to provide care in line with national standards and best practice.

SR3. Due to inadequate systems to support continuous learning, improvement and innovation, there is a risk that our services deliver poor outcomes for service users.

SR4. We are unable to maintain effective, productive relationships with key external stakeholders, with the result that we are unable to work successfully with partners to support innovative care and exceptional outcomes for service users.

SR5. If we cannot produce and effectively use information about our services to support the operation of our governance structures, there is a risk that there will be a lack of confidence in our management information and that we will be unable to ensure the safety of our services.

SR6. We are unable to deliver an effective and attractive programme of training and development opportunities for our staff due to a lack of clarity of

the training needs of our workforce and inadequate capability and capacity, corporately and within care services.

SR7. As a result of a culture of blame which does not foster a psychologically safe environment for our staff we are unable to reduce patient harms or provide a positive experience for our service users.

SR8. A lack of financial sustainability results in us having insufficient funds to sustain and develop our services and invest in high quality outcomes for our service users.

SR9. Due to inadequate, inflexible or poorly maintained estates and facilities we are unable to provide a safe and positive environment for service users and staff.

SR10. As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.

3 Proposed new risks

The Executive Team met in April to look at the risks and to consider how the risks. Executive directors took account of those 'big ticket' issues that the Trust is dealing with and also took into consideration the key strategic priorities.

SR1 - Due to an inability to recruit and retain sufficient numbers of staff with the appropriate skills, experience and behaviours, there is a risk that we are unable to deliver high quality, evidence based, person centred care to meet new models of care now and in the future

SR2 – If there is a breakdown of controls and lack of evidence around assurance processes we risk being able to maintain compliance with regulatory requirements

SR3 – There is a risk that we limit a positive service user and staff experience by failing to embrace a culture of innovation and improvement.

SR4 – There is risk that we fail to make the improvements outlined in the quality strategic plan and that this has an adverse impact on the care to those who use our services

SR5 - A lack of financial sustainability results in a destabilisation of the organisation and an inability to deliver services

SR6 - Due to inadequate, inflexible or poorly managed estate , we compromise the safe environment which places staff, service users and visitors at risk

SR7 - As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.

4 Recommendation

The Board is asked to consider and agree the strategic risks which will be used in the Board Assurance Framework.

Cath Hill on behalf of Sara Munro
17 May 2019

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
23

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Approval of the Annual Governance Statement
DATE OF MEETING:	23 May 2019
PRESENTED BY: (name and title)	Sara Munro – Chief Executive
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

The Chief Executive is required to produce an Annual Governance Statement (AGS), setting out the governance arrangements within the Trust. It shows how the responsibilities of the Accounting Officer have been discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives. Please note that the narrative marked in red is mandatory and cannot be changed.

Each section of the AGS has been reviewed by the relevant executive director and the Chief Executive to ensure it is consistent with the controls in place at the end of the financial year. The draft AGS has been reviewed by Internal Audit in order to inform the Head of Internal Audit Opinion and by the Audit Committee on 20 May to ensure it is consistent with the Head of Internal Audit Opinion. The Chair of the Audit Committee will provide confirmation of the committee's decision at the Board meeting.

Once the Board has confirmed the content of the AGS it will be signed by the Chief Executive before being submitted to the Auditors and NHS Improvement and then incorporated into the Annual Report.

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 being asked to be assured that the Annual Governance Statement is complete and presents a true and fair view of the governance systems in place prior to being signed by the Chief Executive.

SECTION 2.9 – ANNUAL GOVERNANCE STATEMENT

This statement seeks to make assurances about the framework of internal controls put in place to identify and manage risk for the period 1 April 2018 to 31 March 2019.

2.9.1 SCOPE OF RESPONSIBILITY

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

2.9.2 THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Leeds and York Partnership NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Leeds and York Partnership NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the Annual Report and Accounts.

2.9.3 CAPACITY TO HANDLE RISK

The Board of Directors has overall responsibility for the governance of the Trust. It provides high-level leadership for risk management. The directors (both executive and non-executive) have appropriate skills and experience to carry out this function effectively and each member of the Board of Directors has corporate and joint responsibility for the management of risk across the organisation.

The Board is responsible for reviewing the effectiveness of the system of internal control, including systems and resources for managing all types of risk. The cycle of Board meetings continues to ensure that it devotes sufficient time to setting and monitoring strategy and the key risks to achieving the strategic objectives. The Board also monitors performance against key targets and measures and considers any risks to achieving these.

A Board sub-committee structure includes the: Quality Committee, Finance and Performance Committee, Mental Health Legislation Committee, and an Audit Committee. Each has delegated responsibility for monitoring risk within their areas of responsibility, including receiving the Board Assurance Framework in accordance with their terms of reference.

The Director of Nursing, Professions and Quality has overall lead responsibility for the development and implementation of organisational risk management. However, all executive directors have a duty to effectively manage risk within their own area of responsibility. The Chief Financial Officer (CFO) has delegated responsibility for managing the development and implementation of financial risk (including oversight for counter-fraud). Within their portfolio, the CFO also has the role of Senior Information Risk Officer (SIRO); and the Medical Director is the Caldicott Guardian and Responsible Officer. The responsibility for risk management is communicated to all staff through their job descriptions and the compulsory training module.

2.9.3.1 Staff training

The organisation provides compulsory training for all staff to complete in order to comply with internal, legislative and regulatory standards. The composition of compulsory training programmes for different groups of staff have been risk assessed to ensure these are targeted, and that appropriate packages of training are in place. We have a process for monitoring the uptake of compulsory training through a system called iLearn. The Workforce and Organisational Development Group oversees performance, and assurance reports are made to the Quality Committee and to the Board of Directors on performance against our target measures.

Risk management training and awareness is included in the compulsory health and safety training and is supported by local induction. The Trust's risk management team delivers specific risk management training at all levels across the Trust. The role of individual staff in managing risk is supported by a framework of policies and procedures that promotes learning from experiences and sharing good practice.

The Board also receives training on risk through bespoke training sessions which address their legal responsibilities as a Board member.

2.9.3.2 Incident reporting and capacity to learn

The Trust actively encourages an open and honest culture of reporting incidents, risks and hazards. It uses all such reports as an opportunity to learn and improve.

Incidents of severity 3 and above are now being reviewed on a weekly basis, with support offered to the relevant teams and any learning established including good practice.

The Learning from Incidents and Mortality Meeting (LIMM) reviews all deaths and codes them in accordance with the Mazar tool. The group decides the required level of investigation and monitors its progress through the relevant forums in the Trust's governance structure.

The work of LIMM identifies themes and trends and where appropriate will provide more depth to the mortality review process and reduce variation in reviews. LIMM is a sub-committee to the Trust Incident Review Group (TIRG) and reports to it accordingly.

The Trust Incident Review Group (TIRG) has responsibility for reviewing in detail all incidents reported as serious, for agreeing that the recommendations and actions are appropriate.

The Trust also seeks to learn from good practice (both internal and external to the Trust) through a range of mechanisms including: benchmarking; clinical supervision and reflective practice; individual and peer reviews; continuing professional development programmes; clinical audit; the application of evidence-based practice; and the application of robust Health and Safety processes. Points of learning from any of these sources and potential changes in clinical practice are reviewed as necessary by the Trustwide Clinical Governance Group with assurances being made to the Board through the Quality Committee.

2.9.3.3 NHS Litigation Authority risk management standards

The Trust is committed to the effective and timely investigation of any claims and subsequent response to any claim. The Trust is a member of NHS Resolution (previously NHS Litigation Authority) claims management scheme. As a member, it respects the requirements and notes the recommendations of the Department of Health and Social Care and of NHS Resolution and its claim handling schemes.

- Clinical negligence claims are covered by the NHS Resolution Clinical Negligence Scheme for Trusts (CNST). The CNST handles all clinical negligence claims against the Trust. The Trust is the legal defendant, however, the NHSR takes over full responsibility for handling the claim and meeting the associated costs
- Employer liability claims are covered by the NHS Resolution Risk Pooling Scheme for Trusts (RPST) and Liability to Third Parties Scheme (LTPS). LTPS covers employers' liability claims,

from straightforward slips and trips in the workplace to serious manual handling, bullying and stress claims. In addition LTPS covers public and products liability claims, from personal injury sustained by visitors to NHS premises to claims arising from breaches of the Human Rights Act, the Data Protection Act and the Defective Premises Act
- Public liability claims are handled as above
- Claims in respect of loss or damage to Trust property are covered by the NHS Resolution RPST Property Expenses Scheme (PES).

2.9.3.4 Work performed to assess Well-led

In 2017 the Board asked Deloitte LLP to carry out an independent review of our governance arrangements against the well-led framework. The Board decided to do this so it had assurance that the Trust met the standards of good practice. This looked at both Board and sub-Board level structures and processes i.e. ward to Board structures and processes.

This review made a number of recommendations as to how the governance structures and arrangements could be strengthened. These were accepted by the Board and then implemented. To ensure the organisation is 'well-led' the following key arrangements are in place:

- An experienced leadership team with the skills, abilities, and commitment to provide high-quality services. We recognise the training needs of managers at all levels, including those of the leadership team, and provide development opportunities for the future of the organisation
- The Board has set a clear vision and values that are at the heart of all the work within the organisation and we ensure staff at all levels understand them in relation to their daily roles
- The Trust strategy is directly linked to the vision and values of the Trust and we have involved stakeholders in the development of the strategy. We also have five strategic plans which have been aligned to each other and to the delivery of the strategy.
- Senior leaders visit all parts of the Trust and feed back to the Board to inform the discussion in relation to the challenges staff and the services face
- The Board has a sharing stories session at the beginning of each public meeting which allows service users to come and share their experience of our services
- We are actively engaged in collaborative work with external partners including NHS partners, primary care, local authorities, the voluntary sector, and the local transformation plans
- The Board has sight of the most significant risks and mitigating actions through the Board Assurance Framework
- Appropriate governance arrangements are in place in relation to Mental Health Act administration and compliance
- We have a structured and systematic approach to staff engagement
- The Board reviews performance reports that include data about the services. We also have an Executive Performance Overview Group which allows executive directors and service managers and staff to be sighted on their key performance indicators and any issues to delivery
- We are committed to improving services by learning from when things go well and when they go wrong; we also promote research and innovation
- We monitor the quality of our services at all levels of our organisation with our governance structure providing clear lines of accountability and ward to Board reporting.

2.9.4 THE RISK AND CONTROL FRAMEWORK

The Trust has in place a comprehensive Risk Management Policy which is available to all staff on Staffnet. The purpose of this policy is to ensure that the Trust manages risks in all areas using a systematic and consistent approach. It provides the framework for a robust risk management process throughout the Trust. The document describes the Trust's overall risk management process and the Trust's risk identification, evaluation and control system.

All risks are assessed using an electronic system for recording and managing risk assessments, which can be accessed through Staffnet. This system is used by staff to assess and record risk assessments, scoring risks using a 5 x 5 assessment of likelihood and impact. Risks are then captured on the appropriate risk register which could be local, directorate, corporate or strategic. We have in place an Executive Risk Management Group which is chaired by the Chief Executive. This monitors risk, in particular those scoring 15+.

Clinical risk management is based on a structured clinical assessment model under-pinned by CPA and supported by decision-making aids.

Business, financial and service delivery risks are derived from organisational objectives through the business planning process. Clinical and non-clinical risks are identified through a well-defined process of assessment and reporting.

2.9.4.1 The Board Assurance Framework

The Board Assurance Framework (BAF) is one of the key risk assurance tools for the Board. It contains the principal risks to the achievement of the organisation's strategic objectives, which are taken from the strategic risk register. It also sets out the Board's risk appetite in relation to those risks. The BAF enables the Board, primarily through its Board sub-committee structure, to monitor the effectiveness of the controls required to minimise the principal risks to the achievement of the Trust's objectives and therefore provides evidence to support this Annual Governance Statement.

The BAF is formally reviewed by the Board on a quarterly basis and the Audit Committee at least twice a year. The relevant sections of the BAF are also reviewed by the Board sub-committees on a quarterly basis for those risks where they are named as assurance receivers. The BAF has been audited in-year and found to be fit-for-purpose with 'significant assurance' being given to its governance process.

2.9.4.2 Quality governance arrangements

The Trust has established a Governance, Accountability, Assurance and Performance Framework which sets out the organisation's overarching principles and approach to delivering a quality service in a high performing organisation. The framework aims to ensure the Trust successfully delivers national standards for governance and performance through clear lines of accountability.

The framework describes how the Trust will use improved information management, alongside clear governance and accountability in order to deliver better performance. This will be achieved through the introduction of a tiered performance management process which demonstrates rigour, support, challenge, timely escalation and a consistent approach to clinical governance and performance management at all levels of the organisation. It uses the approach set out in the Single Oversight Framework from NHS Improvement (November 2017).

The underpinning principles of the framework are also aligned with the Trust's strategy, values and behaviours and the Care Quality Commission's Key Lines of Enquiry (KLoE).

The Trust is registered with the CQC and is fully compliant with the registration requirements. Compliance with the Care Quality Commission (CQC) essential standards of quality and safety are one of the elements of the organisation's risk management process.

To manage any risk of non-compliance with the CQC registration the Trust has established a CQC Project Group which meets monthly to monitor progress against the CQC action plan and to identify any risks which require immediate action. All actions and supporting evidence would have previously been agreed and signed off in the relevant Clinical Governance Forum. The Trust has a Quality Review process to support all areas to attain a rating of 'good' or 'outstanding'. There are also monthly discussions between the Nursing Leadership Team and the CQC link officers and a quarterly meeting between the Director of Nursing, Professions and Quality and the CQC officers linked with the Trust.

We will take a Trustwide view of the themes from our CQC inspections and take a holistic approach to resolving these issues and reducing risks of non-conformity across the Trust. We ensure that the programme of activities and projects are working together and that benefits and improvements are brought to all core services.

The Trust has a bespoke electronic activity tracker which is a tool to monitor deadlines, record evidence of actions and evidences in which governance meeting the action was signed off. This provides an audit trail and assurance for the CQC Group who then make assurance reports to the Quality Committee and in turn the Board.

The Trust has a programme of Peer Reviews throughout the year to improve, share and embed best practice around the Trust. The Peer Reviews are based around the CQC Key Lines of Enquiry (KLoE). Membership of the Peer Review teams changes and is shared between core services to ensure transparency and to spread the learning amongst staff. During these reviews we identify risks to service delivery and use the evidence to make processes and procedures easier to comply with.

2.9.4.3 Fraud, corruption and bribery

The Trust has procedures in place that reduce the likelihood of fraud, corruption and bribery occurring. These include an Anti-fraud and Bribery Procedure, Standing Orders, Standing Financial Instructions, documented procedures, a system of internal control (including internal and external audit) and a system of risk assessment. In addition, the Trust seeks to ensure that a comprehensive anti-fraud, corruption and bribery culture exists throughout the Trust via the appointment of a dedicated Local Counter-fraud Specialist (LCFS) in accordance with the standards set out in the provider contracts.

Our LCFS has conducted work across all generic areas of counter-fraud activity, placing emphasis on the continued anti-fraud culture within our Trust and the prevention of fraud. Presentations at staff induction sessions and to selected groups of staff have been undertaken. The LCFS has continued to be proactive in their work and our staff have continued to be alerted to potential and real fraud risks.

2.9.4.4 Principal risks to compliance with licence Condition 4.2 of FT4 (FT Governance)

The Trust has put in place measures to ensure that the Board is able to confirm compliance with Licence Condition 4.2 of FT4 (FT Governance) i.e. that we apply systems and standards of good corporate governance expected of a supplier of health services. Our arrangements include a governance structure with four locally-determined Board sub-committees, over and above those required in statute (the Quality Committee, the Finance and Performance Committee, the Mental Health Legislation Committee and the Strategic Investment and Development Committee). This ensures that members of the Board (particularly non-executive directors) are more closely involved in the governance of the organisation and assurance on the quality of services (clinical and non-clinical). There is also a structure beneath the Executive Management Team to support executive directors in delivering their individual portfolios to support the Chief Executive in carrying out their duties as Accounting Officer.

The Board of Directors and its sub-committees have agreed terms of reference setting out accountabilities and the delegated authority they have been given by the Board to carry out work on its behalf. The Trust has in place all the necessary statutory documentation including a constitution, a scheme of delegation and matters reserved to the Board. The Trust also has a Corporate Governance Strategy which describes the framework for corporate governance and which references all the documents that sit within that framework. All members of the Board have role descriptions, clearly setting out their duties and areas of accountability and there is a signed memorandum of understanding between the Chair and Chief Executive, setting out their respective responsibilities, all Board members have been deemed to be Fit and Proper in accordance with the CQC standard.

On a monthly basis the Board receives a Combined Quality and Performance Report that details compliance with, and achievement of, all regulatory, contractual and local targets and also provides financial information. The Board and its sub-committees receive timely and accurate information to the meetings, and in accordance with their scheduled cycles of business. Performance data relating to their areas of responsibility will be scrutinised. Performance is also reported to the Council of

Governors and governors are provided with an opportunity of holding the non-executive directors to account for the performance of the Board.

2.9.4.5 Corporate Governance Statement

The Corporate Governance Statement (CGS) has been prepared in accordance with the guidance issued by NHS Improvement; its completion in 2018/19 was co-ordinated by the Associate Director for Corporate Governance. Evidence of compliance or risks to compliance with each of the standards in the CGS was provided by a lead senior manager (identified for each condition). This was then approved by an identified director before the entire document was submitted to the executive directors for consideration and to the Audit Committee for assurance about the process.

2.9.4.6 Stakeholders and partners

The Trust involves stakeholders and partners in identifying and managing risks to its strategic objectives in a number of ways. These include:

- Working in partnership to develop system-wide plans with stakeholders across Leeds and West Yorkshire through the Integrated Care System (ICS) process.
- Participating within the citywide strategic partnership group for mental health (West Yorkshire Mental Health Services Collaborative and the Committees in Common)
- Working with partners in health and social services in developing and considering business and service change. The Trust has a framework for managing change to services agreed as part of its contracts with its main commissioners. The Trust also has good relationships with Overview and Scrutiny Committees
- Active relationships with Healthwatch and service user and carer groups, working with these groups on the management of service risks and change
- Active engagement with governors on strategic, service, and quality risks and changes including active engagement in the preparation of the Quality Report and the setting of strategic priorities.

2.9.4.7 NHS Pension Scheme control measures

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme's regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments to the scheme are in accordance with the scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

2.9.4.8 Equality, diversity and human rights control measures

Control measures are in place to ensure that the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Board has arrangements in place to ensure that the Foundation Trust complies with the Equality Act 2010. It has approved equality objectives for 2018 to 2020 and an annual equality progress assessment is undertaken using the Equality Delivery System framework.

We have in place systems for monitoring equality progress and compliance against our objectives through the Workforce and Organisational Development Group. This includes reporting to the Quality Committee and to the Board of Directors on performance against our target measures and the publication of an annual Equality and Diversity and Human Rights Report.

Evidence that issues specific to equality and diversity have been considered is required before policy decisions are made. Equality analysis screening is required for all papers presented to governance meetings and for all new and revised procedural documents as detailed in the Trust's Procedure for the Development and Management of Procedural Documents.

2.9.4.9 Carbon reduction delivery plans

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

2.9.4.10 Workforce

Our Workforce and OD Strategic Plan 2018-2021 sets out our longer term vision and ambitions as well as the annual priorities and deliverables. 2018/19 was the first year of implementation and our deliverables are aligned to the plan. We have undertaken an active role in the NHS Improvement Retention cohort with the objective of reducing our turnover, and improving our recruitment processes, career pathways and career development for nurses and Allied Health Professionals. Since commencing this work we have seen a reduction in our turnover from 11.26% to 9.53%. We have also revised a number of our practices to improve access to substantive opportunities including implementing a guaranteed job scheme for our student nurses, a more flexible Retire and Return policy, and implementation of a fast track bank to substantive recruitment process. Part of our Workforce and OD Strategic Plan is to increase the quality and grow our internal bank to reduce reliance on agency staff. In 2018/19 we have achieved a growth rate of 20%. Our workforce requirements and performance are effectively managed through the executive-led Workforce and OD Committee, supported by a range of focused operational groups including our safer staffing and workforce planning groups which identify short and long term workforce requirements, solutions to meet immediate, and undertake long term job planning in relation to the development of new roles. The performance of workforce is held to account directly by the Board of Directors and specific performance indicators monitored through the CQPR report and the Quality Committee.

We recognise that some of our wider workforce challenges are best met by working in partnership. We are already working collaboratively within both Leeds and in the West Yorkshire and Harrogate ICS on shared leadership and development programmes; workforce planning; coaching and mediation services; and promotional recruitment materials to promote working in the NHS and in shortage occupations. We are also active partners in the development and leadership of the new Health and Social care Academy in Leeds and are part of the West Yorkshire Mental Health Workforce Collaborative.

2.9.4.11 Registers of Interests

The Trust has published an up-to-date register of interests for the decision-making staff within the past twelve months, as required by the ‘Managing Conflicts of Interest in the NHS.

2.9.5 KEY RISKS FOR THE ORGANISATION

Key risks for the organisation are those that have been identified as strategic risks on the Strategic Risk Register. In summary these are:

- Due to an inability to align our workforce capacity to planned models of care, there is a risk that we are unable to deliver high quality, evidence based, person centred care
- We are unable to maintain compliance with regulatory requirements relating to the quality and safety of our services due to a failure to provide care in line with national standards and best practice.
- Due to inadequate systems to support continuous learning, improvement and innovation, there is a risk that our services deliver poor outcomes for service users
- We are unable to maintain effective, productive relationships with key external stakeholders, with the result that we are unable to work successfully with partners to support innovative care and exceptional outcomes for service users
- If we cannot produce and effectively use information about our services to support the operation of our governance structures, there is a risk that there will be a lack of confidence in our management information and that we will be unable to ensure the safety of our services

- We are unable to deliver an effective and attractive programme of training and development opportunities for our staff due to inadequate capability and capacity, corporately and within care services
- As a result of a culture of blame which does not foster a psychologically safe environment for our staff we are unable to reduce patient harms or provide a positive experience for our service users
- A lack of financial sustainability results in us having insufficient funds to sustain and develop our services and invest in high quality outcomes for our service users
- Due to inadequate, inflexible or poorly maintained estates and facilities we are unable to provide a safe and positive environment for service users and staff
- As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.

Each of these risks has an identified executive director and management lead. These risks will be managed through the risk management and risk register processes and reported to the Executive Risk Management Group, the Board and the relevant Board sub-committee through the Board Assurance Framework.

Behind each risk is a detailed risk assessment which sets out the controls and mitigations. The strategic risk register is reviewed by the Executive Risk Management Group via the Board Assurance Framework.

2.9.6 REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

We published our refreshed Trust Strategy for 2018 to 2023 in November 2017. This sets out our ambitions and plans for the next five years. In refreshing our strategy we wanted to make sure it is relevant and fully aligned with the key themes within national and local strategies that are relevant to people using our services, carers, our staff and our organisation as a whole. Of particular note is the NHS Five Year Forward View and the Mental Health Five Year Forward View. All these plans have been translated into local actions through the sustainability and transformation plans, the local Leeds plan and the Transforming Care programme for learning disability services.

Our Strategy describes what we want to achieve over the next five years (to 2023) and how we plan to get there. The strategy is designed around three key elements: delivering great care; rewarding and supportive workplace; and effective and sustainable services.

Refreshing our strategy has given us the opportunity to go back to people who use our services, carers, staff and partners to determine what our key strategic objectives should be for the next five years and to help us develop a list of priorities for action.

To enable the delivery of our strategy we have developed a set of strategic plans. These are our delivery plans which provide detailed information about how we will achieve our ambitions and include our plans for: clinical services; estates; health informatics; workforce and development; and quality. Each year we set out our annual actions for achievement as part of our Operational Plan (Trust business plan and financial strategy).

The financial strategy for the coming year is set out in the Trust's one-year Operational Plan. This shows on a projected basis what the expected financial performance for the coming year is to be. There is in place a comprehensive process for developing the plan with there being consultation with the Council of Governors and sign-off by the Board of Directors prior to submission to NHS Improvement. To be assured of progress against the plan (both financial and operational) the Board receives a quarterly update.

As part of the annual planning process we are required to identify our Cost Improvement Plans (CIPs). All our CIPs have been through the standard quality and delivery impact assessment process, with a CIP pro-forma being completed for each individual scheme. Each scheme has been scored and electronically signed off by both the Medical Director and the Director of Nursing, Professions and Quality and is monitored through the Programme Management Office.

The Financial Planning Group is set up to provide routine assurance and oversight related to the quality and financial impact of existing cost improvement schemes. This group meets on a bi-monthly basis and is chaired by the Chief Financial Officer. The ongoing process of assessing the actual impact on quality and delivery is routinely undertaken by each responsible directorate management team meetings and escalated through to the Financial Planning Group. All accepted plans are presented to a join meeting of the Quality Committee and the Finance and Performance Committee where assurance is provided on the rigour of the quality and delivery impact assessment process.

The Trust operates within a well-defined corporate governance framework, with financial governance being set out through a number of documents including the Corporate Governance Policy, Standing Financial Instructions, financial procedures, the Scheme of Delegation and Matters Reserved to the Board of Directors. This framework includes explicit arrangements for:

- Setting and monitoring financial budgets
- Delegation of authority for committing resources
- Performance management
- Achieving value for money.

The Trust receives its core accounting systems and processes from third parties. The main accounting functions are provided by NHS Shared Business Services Ltd. Assurance is provided to the Trust through the Statement of Auditing Standards (SAS) No. 70, prepared by NHS Shared Business Services independent auditors. This internationally-recognised auditing standard signifies that a service organisation has had its control objectives and control activities examined by an independent accounting and auditing firm.

The payroll service is provided by the Leeds Teaching Hospitals NHS Trust (LTHT). Assurance is received from LTHT and its internal auditors regarding both the performance and controls associated with the Electronic Staff Record (ESR) system, which concludes that the payroll function is operational within an environment of effective control.

The structures that have been applied in maintaining and reviewing economy, efficiency and effective use of resources include:

- **The Board of Directors** receives reports on any significant events or matters that affect the Trust. The Board also receives the Combined Quality and Performance Report monthly which reports on performance against the Trust's regulatory, contractual and internal targets and standards both non-financial and financial; the Board Assurance Framework; progress against the Operational Plan measures; and reports from the Chairs of its sub-committees including the Audit Committee

- **Internal Audit** (Audit Yorkshire) provides an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the Trust's objectives. The audit plan is derived from an assessment of risk areas within the Trust and includes all areas where Internal Audit is named in the Board Assurance Framework as a provider of assurance on the effectiveness of key controls.

  In 2018/19 the Internal Audit reports issued in the year have generated an overall opinion of 'Significant assurance' as detailed in the Head of Internal Audit Opinion.

  Whist an overall opinion of 'significant assurance' has been provided, attention is drawn to the fact that there have been two reports issued in 2018/19 with a 'limited assurance' opinion which are detailed below.

  - **LY06/2019 Appraisal System**

    The audit identified areas where further improvement was required to increase the number and quality of appraisals undertaken at the Trust. The Trust had identified many of the issues and was already in the process of taking actions to improve the process, including a detailed management deep dive review.

The key issue identified in the audit was the validity of the data used for monitoring the Trust's Key Performance Indicator for appraisals. The Trustwide Appraisals Report included significantly overdue appraisals which were unlikely to be correct. There were also members of staff whose appraisals were last conducted over three years ago but may have had appraisals which have not been recorded. An appraisals report obtained for October 2018 found that a number of employees had a PDR Expiry Date of 2020, with one having an expiry date of 2021. Since the issue of the audit report the Trust has been undertaking an exercise to cleanse the data.

Additional points identified related to the quality of appraisal completed., the robustness of the procedure, procedures to support escalation of non-compliance and a review of the appropriate number of appraisals to be allocated to reviewing managers so that the process is manageable. An action plan has been agreed with management to address these points. Further audit work is planned in 2019/20 to review the design of the new procedures with further work planned in 2020/21 to evaluate its implementation

- **LY12/2019 GDPR Implementation**

  The review found that the Trust had built upon its established data protection arrangements, amending its systems and processes where required to achieve compliance with GDPR. However, some weaknesses were identified in both design and implementation of those refinements.

  Whilst the Trust's GDPR action plan was based on guidance from the Information Commissioner, local interpretation of that guidance was inconsistent in parts and no gap analysis had been carried out against subsequent NHS-specific advice from the Information Governance Alliance.

  There was some indication of over-reliance on the Information and Knowledge Manager, particularly as the role combines the monitoring and advisory functions of Data Protection Officer. The review highlighted some weaknesses in oversight and scrutiny of the work programme, which led to the overall opinion of Limited Assurance. An action plan has been with management and will be monitored during 2019/20.

All the above areas will be audited again in 2019/20 to ensure the sufficiency of the actions taken to address areas of weakness identified by our internal auditors.

- **External Audit** (KPMG) provides audit scrutiny of the annual financial statements, and looks at the Trust's economy, efficiency and effectiveness in its use of resources. External audit also provides assurance through the review of systems and processes as part of the annual audit plan

  Our audit team will carry out the audit of the 2018/19 annual accounts and will provide a report on their findings (ISA 260 Report) to the Audit Committee which is the body 'charged with governance' in the Trust.

- **The Audit Committee** is a sub-committee of the Board of Directors, the membership of which is made up of non-executive directors. It reports directly to the Board. The committee has responsibility for being assured in respect of the Trust's internal controls, including risk management, and for overseeing the activities of internal audit, external audit and the local counter-fraud services.

  The committee executes this role by approving the annual plans for internal and external audit and counter-fraud; receiving reports and updates against those plans; reviewing risks through the Board Assurance Framework; carrying out deep-dives into any area where further assurance is required on an area of risk

- **Board sub-committee structure** is made up of three locally determined committees; the Quality Committee, the Mental Health Legislation Committee and the Finance and Performance Committee; each of which has responsibility for assurance in areas of clinical and financial performance and compliance. The Board also has two further statutory committees: the Nominations Committee and the Remuneration Committee. Each of the Board sub-committees is chaired by a non-executive director, with the Remuneration Committee being made up wholly of non-executive directors.

2.9.7 INFORMATION GOVERNANCE

2.9.7.1 Incidents relating to information governance

Below is an analysis of our information governance incident reporting records for 2018/19. This shows 3 incidents that have sensitivity factors that classify them as a Serious Incident Requiring Investigation (SIRI), which have been reported via the national online tool.

Aligned to General Data Protection Regulation (GDPR) / Data Protection Act (2018) a new approach to incident grading has been devised by NHS Digital. This method of grading takes a different approach to previous iterations, and uses a 5 x 5 likelihood vs impact approach, assessing both the likelihood and severity of harm caused. Serious incidents are still escalated to the Information Commissioners' Office (ICO), but only the most serious or large-scale are further escalated to the Department for Health and Social Care (DHSC). This new approach to incident grading came into effect on 25 May 2018.

Incidents are now graded as follows:-

- Non-Reportable
- ICO Reportable
- ICO Reportable and DHSC Notified

The 3 incidents reported below occurred under the older, pre 25 May reporting regime, and there have been no reportable incidents that have occurred under the new reporting thresholds.

Table 2.9A – Summary of incidents involving personal data as reported to the Information Commissioner's Office in 2018/19

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
March 18 (reported in current year)	Disclosed in error	Patient found in possession of data relating to fellow patient.	1	DH / ICO notification via NHS Digital website
April 18	Disclosed in error	E-mail sent to wrong & inappropriate non-care e-mail address.	1	DH / ICO notification via NHS Digital website
April 18	Disclosed in error	Appointment letter sent to wrong address.	1	DH / ICO notification via NHS Digital website
Further action taken	A local senior management fact-find has been undertaken in relation to each incident and process improvements and / or disciplinary actions have been actioned, where appropriate, to prevent recurrence. Although no regulatory action has been taken by the ICO in respect of the above incidents, we have enacted recommendations where appropriate including communications to Trust staff via e-mail broadcast. We will continue to monitor and assess information governance breaches. When weaknesses			

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
	in systems or processes are identified there will be interventions undertaken. Low-level and near-miss events will be monitored and when there are common themes we will undertake Trust-wide communications to address these themes. We will continue to support information governance training via the national e-learning tool. All staff to undertake annual refresher training as a reminder of their information governance obligations.			

The Trust has a robust Information Governance function and framework that utilises subject matter expertise from Information Governance (IG), Information, Communication and Technology (ICT), networks, informatics, health records and systems administration. The Trust's Senior Information Risk Owner (SIRO) (Chief Financial Officer) and Caldicott Guardian (Medical Director) are members of the Information Governance Committee. The committee makes assurance reports to the Finance and Performance Committee, thereby maintaining a reporting line to the Board of Directors as required by regulation. It maintains effective links with the Trust's clinical teams by the escalation of incidents to the Trustwide Clinical Governance Group on a quarterly basis.

The group monitors IG breach incidents, triggering appropriate responses to clusters or themes of low-level non-SIRI incidents and those incidents which would have been reportable under the old reporting regime.

2.9.7.2 Data security

The Trust recognises that our approach to information security requires both a technical and organisational approach as described in the 6th Data Protection Principle (DPA 2018).

The Trust has a highly developed and mature approach to information governance, which includes high compliance with staff IG training and a comprehensive suite of IG-related procedural documents, giving instruction and regulation to our staff. The Trust deploys the mandatory public sector safeguards recommended by the HM Government Cabinet Office "Data Handling Procedures in Government"; including the operation of secure network storage, port control and the provision of encrypted digital media, and the encryption of high-risk portable computing resources.

The Trust continues to use NHSmail, facilitating secure digital communications with other NHS partners and the wider public sector via the Government Secure Intranet (GSi), and to local partner organisations operating e-mail services with Transport Level Security.

Senior managers in ICT receive the NHS Digital "CareCERT" broadcasts, to maintain an awareness of current information security threats so that timely and appropriate action can be taken where necessary. We have embedded the use of a CareCERT action tracking solution, with all CareCERT-reported threats recorded, assessed for exposure and potential impact, with solutions tracked, implemented and reported monthly to the IG Group.

The Trust continues to use the national NHS IG Training offering, *Data Security Awareness Level 1*, which contains both refreshed content on IG in a healthcare context and entirely new content on the user aspects of information / cyber security. Course content was refreshed again in November 2018.

We have a robust approach to business continuity (BC) / disaster recovery (DR) within ICT, with senior management taking ownership of developing BC/DR plans for their services. Work is continuing to align ICT BC/DR with clinical service system criticality. Review cycles of current plans are undertaken in response to any actual or near-miss BC/DR events.

The Trust made a self-assessment against the NHS Digital Data Security and Protection Toolkit of 'Standards Met' at 31 March 2019, meeting the required evidential standard for all compulsory Assertions. This was supported by an internal audit appraisal of a sample of 14 of the 32 compulsory Assertions, with an outcome of "Significant Assurance". Requirements were included from across all ten of the National Data Guardian's core data security standards.

2.9.8 ANNUAL QUALITY REPORT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercising the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of Annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Director of Nursing, Professions and Quality is the executive director with the responsibility for the Quality Report. We have compiled our Quality Report in accordance with the guidance issued by NHS Improvement. The Quality Report is then published alongside our Annual Report and Accounts to ensure it contributes to a balanced view of the quality of the care provided by the Trust.

Our Council of Governors is made up of the public, service users, carers and staff and they have been involved in agreeing the indicators within the Quality Report. Public and easy read version of the Quality Report will be made available and the full report will be accessible on the Trust's website.

The following steps have been put in place to assure the Board that the Quality Report presents a balanced view and that there are appropriate arrangements in place to ensure the quality and accuracy of performance information.

- Performance reports to the Board of Directors, which set out performance against external requirements including NHS Improvement targets, the Single Oversight Framework and our contractual requirements with our main commissioners
- Assurance regarding maintaining CQC registration requirements is managed through the monthly CQC Project Group with assurances being made to the Quality Committee
- Performance reports to the Council of Governors
- The Executive Performance Overview Group seeks to supportively challenge performance within directorates.

There are systems and processes in place for the collection, recording, analysis and reporting of data which will ensure this is accurate, valid, reliable, timely, relevant and complete.

To manage the risk of there being incorrect data, the Trust has a Data Quality Policy which clearly identifies roles and responsibilities for the collection and input of service user information into patient records' systems. The Data Quality Team deals with erroneous entries and there are systems and processes in place to alert relevant managers of any issues in order to ensure that data presented in the Quality Report is both accurate and reliable. A data quality warehouse is used to ensure that data quality issues are dealt with proactively and quickly to maintain data integrity.

2.9.9 REVIEW OF EFFECTIVENESS

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit, and the executive managers and clinical leads within the Leeds and York Partnership NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Quality Committee, the Finance and Performance Committee, and the Mental Health Act Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I have drawn on the content of the performance information available to me. My review is also informed by comments made by the external auditors in their opinion; the Head of Internal Audit Opinion other audit reports. I have been advised on the effectiveness of the systems of internal

controls by: the Board of Directors; the Audit Committee; the Quality Committee; the Finance and Performance Committee; the Mental Health Legislation Committee; the Board Assurance Framework; and internal audit reports. I have also been advised by leadership from the executive directors with regard to risk reporting (clinical and non-clinical), implementing learning, and plans to address weaknesses and ensure continuous improvement of the systems in place.

2.9.10 CONCLUSION

In summary, the Trust has a sound system of internal control in place and no significant control issues have been identified. The systems of internal control are designed to ensure delivery of the Trust's goals and strategic objectives and to manage and minimise exposure to risks and that no significant internal control issues have been identified.

I am satisfied that the process for identifying and managing risks is robust and dynamic as evidenced above. I am also satisfied that the Trust is doing all it can to mitigate the risks that have been identified and has in place a sufficient system of internal control to manage the strategic and other organisational risks.

Dr Sara Munro
Chief Executive

Date:

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
24

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Compliance with NHS Improvement's NHS Foundation Trust Code of Governance
DATE OF MEETING:	23 May 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

The NHS Foundation Trust Code of Governance (the Code) is made up of a number of different elements including elements which are on a 'comply or explain' basis. Each year the Board is required to make a statement in the Annual Report that it has complied with the Code and explain any areas of non-compliance. The attached paper sets out the process to support making this declaration and the areas of non-compliance with will be explained in the Annual report.

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 process for assessing compliance and the evidence to support this will be reviewed by the Audit Committee at its meeting on the 20 May. The Chair of the Audit Committee will confirm to the Board its conclusion in relation to the process and declarations made and will make a recommendation as to whether the statement proposed in the attached paper should be included in the Annual Report.

MEETING OF THE BOARD OF DIRECTORS

23 May 2019

Compliance with NHS Improvement's NHS Foundation trust Code of Governance

1 Executive Summary

The NHS Foundation Trust Code of Governance (the Code) is in the main a 'comply or explain' document. It is made up of a number of main principles, supporting principles and code provisions.

Within the Code there are elements which are: statutory which must be complied with and are not within the comply or explain section; disclosures to be included in the annual report which are covered by the Annual Reporting Manual and their inclusion in the report is audited as part of the audit of the annual accounts to ensure compliance; information which must be on the website; and those that are on a 'comply or explain' basis.

This paper deals with the 'comply or explain' elements only.

2 Review of Compliance

'Comply or explain' means that the Trust is expected to comply with the code principles or provide an explanation in the Annual Report as to why it has not been able to comply.

The Board is asked to be assured that the process for assessing compliance and the evidence to support this will be reviewed by the Audit Committee at its meeting on the 20 May. The Chair of the Audit Committee will confirm to the Board its conclusion in relation to the process and declarations made.

3 Declaration made in the Annual Report

Each year the Board is required to make a declaration in the Annual Report and for 2018/19 it is asked to support the following declaration:

"A full review of compliance with the Code is submitted to the Audit Committee on an annual basis to support this statement. A copy of the full report to the Audit Committee is available on request from the Associate Director for Corporate Governance. The Trust carried out a detailed self-assessment against the requirements of the Code and submitted the assessment to the Audit Committee for approval and to support this statement that the Trust continues to comply with the principles of the Code with the exceptions as listed in the table below.

Areas of non-compliance or limited compliance with the provisions of the Code of Governance

Code provision	Requirement	Explanation
D.2.2	The Remuneration Committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management.	The Remuneration Committee sets the pay for executive directors both at the point of advertising for a vacancy and then periodically if required to do so. The Remuneration Committee has also agreed that the pension rights for executive directors are determined by the NHS pension scheme not by itself. PARTIAL COMPLIANCE

4 Recommendation

The Board is asked to be assured that the process for assessing compliance and the evidence to support this will be reviewed by the Audit Committee at its meeting on the 20 May. The Chair of the Audit Committee will confirm to the Board its conclusion in relation to the process and declarations made and will make a recommendation as to whether the proposed statement above should be included in the Annual Report.

Cath Hill
Associate Director for Corporate Governance

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
26

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Declarations required by the NHS Improvement Provider Licence Conditions
DATE OF MEETING:	23 May 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

The Provider Licence requires the Board to self-certify annually their compliance with the conditions set out in the provider licence, and if a Trust provides commissioner requested services (which this Trust does) that they have the required resources available for the next 12 months. Additionally section 151(5) of the Health and Social Care Act 2012 requires FTs to ensure that their governors are equipped with the skills and knowledge to undertake their role and to make a declaration in relation to this also.

The attached paper sets out these declarations in more detail and assures the Board of the evidence collecting and assurance process has been reviewed by the Audit Committee.

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

RECOMMENDATION

The Board is asked to agree the declarations made at Appendix 4 and delegate authority to the Chair and Chief Executive to sign the declaration forms provided by NHS Improvement.

COMPLIANCE WITH THE PROVIDER LICENCE AND S151(5) OF THE HEALTH AND SOCIAL CARE ACT 2012

DECLARATIONS REQUIRED UNDER THE PROVIDER LICENCE

The Provider Licence requires Boards of NHS providers to self-certify annually compliance with the conditions of the provider licence, including compliance with the governance requirements and (if providing commissioner requested services) that they have the resources available to continue to provide those services.

These declarations are made up of:

1. **A statement that we have the systems for compliance with licence conditions and related obligations (Condition G6(3))**

   Confirming that, following a review processes and systems, in the Financial Year most recently ended, the Licensee took all such precautions to ensure compliance with the licence conditions.

2. **Availability of required resources (Condition CoS7(3))**

   Confirm that we have a reasonable expectation that required resources will be available to deliver the designated services in the next 12 months.

3. **A corporate governance statement (Condition FT4(8))**

   Confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks.

DECLARATIONS REQUIRED IN RELATION TO S151(5) OF THE HEALTH AND SOCIAL CARE ACT 2012

In addition to the self-certifications required under the provider licence, S151(5) of the Health and Social Care Act 2012 requires Foundation Trusts to ensure governors are equipped with the skills and knowledge to undertake their role. The Board needs to provide a statement which shows the level of compliance with this section of the act and will ask the Board to consider the following statement:

In the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in S151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

THE PROCESS FOR COLLECTING EVIDENCE

To ensure the Board can confirm compliance (or not) with the requirements above the process of compiling evidence is overseen by the Associate Director for Corporate Governance and is as follows:

1. All licence conditions were assigned to a senior manager lead and an executive director
2. Evidence to demonstrate compliance was listed on internally generated templates
3. In addition, for FT4, risks to compliance in the coming year (if any) were identified and listed
4. Executive director leads were asked to review and confirm the validity of the information provided
5. Chief Executive asked to confirm in its entirety the information provided is sufficient and provides a true and fair representation of the systems and processes in place
6. Information is circulated to governors for their views
7. A paper outlining the process and evidence presented to the Audit committee for assurance
8. A paper outlining compliance (or not) with each condition is presented to the Board of Director along with the recommended compliance statement.

Detailed supporting evidence and documentation explaining how we are compliant with the above statements is attached for information.

- Appendix 1: Certification against (G6(3) and CoS7);
- Appendix 2: Corporate Governance Statement (FT4(8))
- Appendix 3: Statement on the training of governors

PROPOSED DECLARATIONS

Attached at Appendix 4 are the proposed declarations that the Board should make, based on the evidence provided in Appendix 1, 2 and 3.

RECOMMENDATION

The Board is asked to agree the declarations made at Appendix 4 and delegate authority to the Chair and Chief Executive to sign the declaration forms provided by NHS Improvement.

Cath Hill
Associate Director for Corporate Governance
May 2019

PROVIDER LICENCE (Compliance with condition G6) 2018/19

(Please note: licence condition FT4 is dealt within the Corporate Governance Statement which is a separate declaration)

Under the Provider Licence (Condition G6) the Board of Directors is required to certify that it is (or is not) satisfied that it took all reasonable precautions against the risk of failure to comply with the conditions of the provider licence. To allow this certification to be made, leads (as identified in the column below) are required to declare as to whether the Trust has been c*ompliant / non-compliant* with the following licence conditions during 2018/19 Supporting evidence of how we comply with each condition is set out below.

SUPPORTING EVIDENCE FOR EACH LICENCE CONDITION

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
G1 - Provision of information Reflecting the requirements of the Health and Social Care Act 2012, this Condition places an obligation on Licensees to provide the Regulator (NHS Improvement) with the accurate, complete and timely information they require in order to undertake their Licensing functions, This Condition also allows a requirement for the Regulator (NHS Improvement) to request Licensees to generate information	**Statement of compliance** The Trust has robust data collection and validation processes and has a good track record of producing and submitting accurate, complete and timely information to regulators and third parties to allow it to carry out its licenced functions. All NHS Improvement returns are in the required format and are delivered on time. There have been no adverse comments from NHS Improvement regarding late or incomplete returns. All returns are reviewed by at least one other person than the author.	**Evidence of compliance** • There are two established contacts for NHS Improvement: the Chief Executive; and the Chief Financial Officer • Minutes of meetings confirm that the Quality Report for 2017/18 was approved by the Board prior to being sent to NHS Improvement and the Quality Report for 2018/19 will follow the same process. Working papers and notes, including the audit opinion, are available to show that the information contained in the Quality Report is accurate and complete, monthly monitoring returns are held on file confirm that the report was sent to NHS Improvement. Minutes of Board meetings show that measures in the Single Oversight Framework were considered by the Board and that the financial plan is also considered by the Board and by the Finance and Performance Committee. The Annual Report and Accounts for 2017/18 were scrutinised by the Audit Committee and signed off by the Board prior to being submitted to NHS Improvement • The Trust has in place a performance team with responsibility for ensuring the data provided to our regulator is correct; a Programme Management Office with responsibility for submitting the Operational Plan; a Corporate Governance	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
that is not currently collected (i.e. to collect information against certain benchmarks).		Team with responsibility for submitting the Annual Report; and a finance team with responsibility for the Annual Accounts and monthly financial information and returns • There are data collection and validation processes in place to ensure that the data submitted in the reports and returns is accurate • The Board and its sub-committees regularly receive accurate and detailed information on quality and finance performance which supports the process for providing NHS Improvement with accurate and timely information.	
G2 - Publication of information This Condition requires Licensees to publish information in a manner that is made accessible to the public, as directed or may be required by the Regulator (NHS Improvement) (i.e. to publish performance information in order to promote patient rights to make choices.	**Statement of compliance** The Trust complies with this condition as requested and information is publicised as required in accordance with all NHS Improvement guidance including the Code of Governance and the Annual Reporting Manual. All NHS Improvement returns form part of the public Board of Directors and Council of Governors' meeting papers and are published on the Trust's website.	**Evidence of compliance** • A Combined Quality and Performance Report is available on the Trust's website • The public Board and Council agendas, minutes and papers are available to the public, including minutes of Board and Council sub-committees (this is done via the website and by hard copy papers at the meeting and is done ahead of the meetings) • Only those matters which are considered confidential (in accordance with a pre-determined set of criteria) are discussed in private. Papers pertaining to this are held confidentially, but may be subject to FOI • The website has details of all the necessary reports on it (which can be requested in an accessible format if necessary) (Quality Report, Annual Report and Accounts, Operational Plan, Strategy etc.) • Statement of evidence of how we comply with the Code of Governance is contained in the Annual Report • The Trust has measured itself against the requirements of the Code of Governance in its entirety • Freedom of Information Publication Scheme is published on the Trust's website	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro
G3 - Payment of fees to NHS Improvement	**Statement of compliance**	**Evidence of compliance**	Lead for evidence = Cath Hill – Associate Director

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
This condition gives NHS Improvement the ability to charge fees and obliges licence holders to pay fees to NHS Improvement if requested in respect of the Regulator exercising its functions.	The Trust will comply with this condition when required. No fees have been levied by NHS Improvement during 2017/18	• The Chief Financial Officer and the Associate Director for Corporate Governance will be notified of any fees required by NHS Improvement by reviewing all monthly and quarterly updates sent by NHS Improvement • However, there is currently no action required to be taken and the Trust is currently keeping a watching brief on the situation.	for Corporate Governance with lead director = Sara Munro
G4 - Fit and proper persons This licence condition prevents licensees from allowing unfit persons to become or continue as governors or directors, except with the approval in writing of NHS Improvement. An unfit person is deemed to be an individual who has been adjudged bankrupt; or who within the preceding five years has been convicted and a sentence of imprisonment (whether suspended or not) for a period of not less than three months was imposed on them; or who is subject to an unexpired	**Statement of compliance** All governors and directors have been deemed to be fit and proper persons as part of the 2017/18 year-end declaration process. The declaration process which is carried out at the end of 2018/19 is underway and the Trust is expecting its governors and directors to be compliant. (It should be noted that the CQC fit and proper person test places a further layer of check over and above those of NHS Improvement. These are not dealt with here).	**Evidence of compliance** • The Trust has in place a procedure for the ensuring that directors are, on appointment and thereafter, continue to be fit and proper to carry out their role, this includes the requirements of the provider licence • Directors are checked on appointment and every three years and also through a process of annual appraisals. A file of evidence is maintained for each director • The Constitution contains the relevant clauses for becoming or continuing as a director or governor • The application form for non-executive directors asks for a declaration that they are fit and proper persons as per the NHS Improvement licence requirements • The executive director contract and non-executive director appointment letter have been amended to ensure they comply with the fit and proper persons' test as per the NHS Improvement provider licence • There is a Code of Conduct for Directors and Governors which requires them to confirm they are fit and proper in accordance with the Trust's procedures. • Declarations are made by governors on election that they are eligible to hold office and there is no reason by they would be barred • The nomination form for governors is clear as to who may not be a governor (in terms of NHS Improvement's fit and proper	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
disqualification order made under the Company Directors' Disqualification Act 1986.		persons' test).	
G5 - NHS Improvement guidance General Condition 5 requires that the Licensee at all times has regard to guidance issued by NHS Improvement. Where the Licensee decides not follow NHS Improvement's guidance it shall inform NHS Improvement of the reasons for that decision.	**Statement of compliance** The Trust complies with all NHS Improvement guidance when issued. The requirements of the Foundation Trust Code of Governance have been complied with exceptions as detailed in the Annual Report "comply or explain" sections.	**Evidence of compliance** • The Trust has successfully submitted to the Regulator the Annual Report, Annual Accounts, Quality Report, Operational Plan, Board declarations and quarterly monitoring returns all of which evidences compliance with NHS Improvement's requirements • The Trust receives NHS Improvement guidance updates and publications via email, these are received by key people in the various corporate teams (Associate Director for Corporate Governance for corporate governance; Finance Manager for finance; Programme Management Officer for the Annual Plan and business plans) • The Board has consistently had regard to the requirements of the Code of Governance and complied or explained any non-compliance as needed.	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro
G6 - Systems for compliance with licence conditions and related obligations This condition requires the Licensee to take all reasonable precautions against the risk of failure to comply with the licence, NHS Constitution and NHS Acts.	**Statement of compliance** The Trust is compliant with all conditions of the licence and has made the necessary assurances to the Audit Committee and provided any evidence required to support this and to support the Board making the necessary self-declarations.	**Evidence of compliance** <u>Process of Risk Management</u> • There is a Risk Management Policy in place • There are several key documents and processes in relation to managing risks and compliance in place: o Risk Registers are in place and monitored and maintained on a regular basis (Strategic, Corporate and Directorate Risk Registers). • A bi-monthly meeting (Risk Management Review Group) takes place, chaired by the Chief Executive. A monthly dashboard is presented to this group, which includes high	Pamela Hayward Sampson – Risk Management Lead with lead director = Cathy Woffendin

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
The Licensee must ensure the establishment and implementation of processes and systems to identify risks and guard against their occurrence. The Licensee shall also regularly review those processes and systems to ensure they have been implemented and are effective. Not later than two months from the end of each financial year, the Licensee shall prepare and submit to NHS Improvement a certificate to the effect that following a review of these systems and processes its Directors are, or are not, satisfied that within the last full financial year, it took such precautions as were necessary to comply with this Condition. The Licensee shall publish the certificate within one month of its submission to NHS Improvement in such		level information relating to the risk registers across the Trust. This report highlights actions and risks beyond their review date and any risk movement over the reporting period. This provides assurance to the Board that risks are monitored and managed within timescales and the risk are appropriate, including mitigation and escalation of risks. In addition, throughout the year the group reviews the care groups' risk registers in detail. • Each month an update on the Care Groups risk registers are sent to the risk owners, which is RAG rated to provide a reminder to update the register accordingly. • The Board Assurance Framework contains details of the Strategic Risks • External assurance is provided by Internal / External audit in respect of risk processes. The internal follow-up audit of the revised risk management framework, completed March 2018, provided significant assurance • The Strategic Plan contains information regarding processes and systems in place to identify risks • The Annual Report contains information about the Risk Management process • The Audit Committee receives assurance as to the risk management processes in place • The report presented to the Audit Committee in December 2018 provided further evidence of the significant improvements in managing the risk registers. • The strategic risk register is submitted quarterly to the Trust Board as part of the Operational Plan Quarterly Report. <u>Process for managing risks to complying with the licence</u> • There is a performance team who monitor compliance with the NHS Improvement targets and provide a report to each Board meeting. This includes an exception report setting out risks of potential breach of any targets • There is a compliance statement for each element of the licence completed each year with gaps identified and actions	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
manner as is likely to bring it to the attention of parties reasonably expected to have an interest.		assigned • The Corporate Governance Statement is completed each year with risks to compliance with the conditions identified • The Annual Governance Statement is reviewed and agreed by the Audit Committee, internal audit, external audit and the Board prior to being signed off by the Chief Executive • The Head of Internal Audit Opinion comments on systems of internal control which help to manage and mitigate risks of not complying with the licence. <u>Process for complying with the NHS Constitution</u> • The NHS Constitution compliance is reported on an annual basis • There is a compliance statement for each element of the NHS Constitution • Each year we ask the lead responsible senior manager to complete the compliance statements that they are responsible for • The updated statements also have an evidence section which is also updated by the lead responsible senior manager • The completed statement and evidence documents are presented to the Trust Wide Clinical Governance Group for approval and assurance purposes.	
G7 - Registration with the Care Quality Commission This condition requires Licensees to be registered at all times with the CQC. The Licensee shall notify Monitor/NHSI promptly of any application to the CQC for the	**Statement of compliance** The Trust is fully registered with the CQC. All sites are registered and the Director of Nursing, Professions and Quality has responsibility for ensuring the Trust is and remains registered.	**Evidence of compliance** • There is a Director of Nursing, Professions and Quality in post with responsibility for ensuring continuing CQC registration • The Director of Nursing, Professions and Quality has responsibility for informing NHS Improvement of any change in registration • The Trust's current registration document confirms that the Trust is currently unconditionally licensed. The CQC registration has not been cancelled and there is no evidence to demonstrate the threat of revocation of the licence has been issued	Lead for evidence = Nichola Sanderson with lead director = Cathy Woffendin

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
cancellation of its registration, or the cancellation by the CQC of its registration. This condition allows the Regulator to withdraw a Licence from Providers whose CQC registration is withdrawn.		• No enforcement notices have been received • Where there are any matters for concern action plans are drawn up and closely monitored by the Director of Nursing, Professions and Quality, the CQC Project Group and the Executive Team, with assurances to the Board and its sub-committees (as appropriate) • The CQC registration status is contained within the Annual Governance Statement and also in the Quality Report	
G8 - Patient eligibility and selection criteria This Condition requires that Licensees set transparent eligibility and selection criteria, apply those criteria in a transparent way and publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them.	**Statement of compliance** Patient eligibility and selection criteria is made available to the general public, through publishing services on the Trust website which state what is offered and to whom it is offered. Where service users are not eligible for a service that service will give advice to referrers on other more suitable services available to meet the patient's needs. Service specifications are in place and publicly available which describe how services are provided to the person including types of interventions to be offered.	**Evidence of compliance** • Information on the Trust's website • Clinical Audit carries out audits that investigate and review these criteria as evidenced by the list of audits • Strengthened access to Community Mental Health Services through Community Redesign • Single point of access for CCG commissioned services to reduce variance and aid selection of service to meet service user's needs.	Lead of evidence = Andy Weir Interim Deputy Chief Operating Officer with lead director = Joanna Forster Adams
G9 - Application of Section 5 (Continuity of Services) The Conditions in Section 5 shall apply whenever the Licensee is subject to a	**Statement of compliance** The Trust is compliant with this condition and has agreed its commissioner requested services. There are no disputes in relation to what services are classified as commissioner requested. Leeds CCGs have not acted to formally agree CRS status for services; all	**Evidence of compliance** • The Board has confidence in the ability to provide a continuity of services as evidence of the financial standing of the Trust • There are systems and processes in place to ensure that it will continue to operate as a 'going concern' for at least the next 2 years.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
contractual or other legally enforceable obligation to provide a Commissioner Requested Service. A service is considered to be a Commissioner Requested Service if it is of a description which the Licensee is required to provide pursuant to an NHS contract, or any other service which the Licensee has contracted with a Commissioner to provide, as a Commissioner Requested Service.	LYPFT services (as per statement of purpose) "grandfathered" in when CCGs were set up. We have agreed CRS for 2017/18 FY and anticipate a similar agreement with the Leeds CCGs. However, it remains a commissioner responsibility to resolve this position.	• The Annual Report contains a statement of going concern which is agreed by the Board • The Trust has a strong working relationship with key strategic commissioning partners and is working closely with them to facilitate delivery of services to service users • There are a set of agreed growth principles in place against which any growth opportunities are assessed • A strong programme of efficiency and quality improvement (CIPs) is robustly monitored and reported to the Quality Committee and the Finance and Performance Committee • Letter and email exchange with NHS England regarding CRS. Further information is included the Continuity of Services (CoS) section	
P1 - Recording of information From the time of publication by NHS Improvement of Approved Reporting Currencies the Licensee shall maintain records of its costs and of other relevant information in accordance with those Currencies by allocating all costs expended by the Licensee in providing health care services for the	**Statement of compliance** The Trust is compliant with this condition and its implementation is in line with current financial procedures of the Trust including the following of HFMA guidance.	**Evidence of compliance** • Reference costing paper was produced and reported to Finance and Performance Committee in April 2018. This paper included the declaration relating to the self-assessment quality checklist and costing was in line with NHSI's Approved Costing Guidance • The Trust operates a costing timetable which details key dates for recording of information.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
purposes of the NHS within that Currency. Such cost allocation methodology and procedures should adhere to the information as set out in the Approved Guidance.			
P2 - Provision of information The Licensee shall provide NHS Improvement with such information and documents as NHS Improvement may require for the purpose of performing its pricing functions. The Licensee shall take all reasonable steps to ensure that the information is accurate and complete.	**Statement of compliance** The Trust would comply with this condition as the requirement arose.	**Evidence of compliance** • No requests have been made of the Trust by NHSI as yet.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell
P3 - Assurance report on submissions to NHS Improvement If required the Licensee shall submit to NHS Improvement an assurance report relating to its costing submission. Such a	**Statement of compliance** The Trust would comply with this condition as the requirement arose.	**Evidence of compliance** • No requests have been made of the Trust by NHSI as yet.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
report shall meet the requirements if it is prepared by an approved auditor, it expresses a view on whether the submission is based on cost records which complies with guidance and provides a true and fair assessment of the information it contains.			
P4 - Compliance with the National Tariff Except as approved in writing by NHS Improvement, the Licensee shall comply with the rules and apply the methods concerning charging for the provision of health care services for the purposes of the NHS contained in the national tariff published by NHS Improvement.	**Statement of compliance** The Trust has adopted local tariffs.	**Evidence of compliance** • Finance managers have access to the NHSI Approved Costing guidance and the Department of Health reference cost guidance through the shared network drive, and these provide guidance on the rules and methods that the Trust should adhere to when charging for the provision of healthcare.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell
P5 - Constructive engagement concerning local tariff modifications The Licensee shall engage constructively with Commissioners,	**Statement of compliance** The NHS Standard contract, which has been signed off by the Chief Financial Officer of the Trust and Chief Officers of CCGs, shows that each service provided has a price and cost attached to it there is also engagement with commissioners in relation to pricing.	**Evidence of compliance** • Standard contracts • Costing working papers • Minutes of commissioner clustering sub group	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
with a view to reaching agreement in any case in which it is of the view that the price payable for the provision of a service for the purposes of the NHS in certain circumstances or areas should be the price determined in accordance with the national tariff for that service subject to modifications.			
C1 - The right of patients to make choices Subsequent to a person becoming a patient of the Licensee and for as long as they remain such a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, they are notified of that choice and told where information about that choice can be found. Information and advice	**Statement of compliance** The Trust fully complies with the provision of clear and truthful information for service users and does not offer or give any benefits or inducements to refer service users of commission services. It has complied with the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulation 2013 removing mental health service exemptions from certain of the obligations that previously existed in relation to choice. The Trust publishes information about its services on the Trust's website and also publishes information about performance in relation to service targets and measures allowing service users to make a more informed choice about services.	**Evidence of compliance** • Service user surveys are undertaken by the Trust which document overall service user choice. This shows that service users have a choice of provider under the NHS Constitution • The Trust website details a list of services available to service users • Monthly performance reports available via the Trust's website • Standards of Business Conduct in place • Anti-fraud and Bribery Policy circulated to staff • Hospitality and gifts procedure in place • Declaration of interest procedure in place for directors, governors and staff • Information is available via choose and book where applicable, and NHS Choices.	Lead for evidence = Andy Weir – Interim Deputy Chief Operating Officer with lead director = Joanna Forster Adams

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
about patient choice made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that assists patients in making well informed choices. In the conduct of any NHS activities, the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.			
C2 - Competition oversight The Licensee shall not enter into any agreement or other arrangement or engage in activities which have the object or which have (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of NHS	**Statement of compliance** The Trust fully supports the principles of competition and works openly with partners to provide comprehensive and complementary services to benefit service users. The Trust is aware of the requirements of competition in the health sector and would seek legal and or specialist advice should the Board decide to enter into any structural changes such as mergers or Joint Ventures.	**Evidence of compliance** • The Financial Planning Group, has responsibility for contract management and contracts are monitored through this group and help ensure that no unlawful arrangements are entered into • A Whistleblowing Policy is in place • No whistleblowing occurrences had highlighted any agreements that distorted competition • The Trust has completed a Partnership Procurement Framework which enables us to simplify procurement from third sector providers.	Lead for evidence = Andy Weir – Interim Deputy Chief Operating Officer with lead director = Joanna Forster Adams

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
care.			
IC1 - Provision of integrated care The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling its provision of health care services for the purposes of the NHS to be integrated with the provision of such services by others.	**Statement of compliance** The Trust is fully supportive of the delivery of integrated care. There is extensive engagement with other providers to ensure services are joined up and that integrated care is provided where possible. The Trust is also involved in the development and implementation of New Models of Care.	**Evidence of compliance** • There is no private sector presence that would cause the Trust to be detrimental to the provision of healthcare for the purposes of the NHS provision • The Trust is an active participant in the local health and social care economy and is working in partnership with stakeholders to further integrate services and address issues that adversely affect efficient service operation across the health economy • The Trust has a track record of working on integrated care pathways with other providers i.e. adult social care, learning disability services, the third sector and children's services.	Lead for evidence = Andy Weir – Interim Deputy Chief Operating Officer with lead director = Joanna Forster Adams
CoS1 - Continuing provision of Commissioner Requested Services The Licensee shall not cease to provide, or materially alter the specification, any Commissioner Requested Service other than with the agreement in writing of all Commissioners to which the Licensee is required by a contractual or other legally enforceable	**Statement of compliance** The Trust is delivering a list of services that meet the requirements of the CQC and which are in accordance with a signed contract with our commissioners. Any disposals which may affect the provision of service, these would have to be approved by the Commissioners prior to disposal. If any services in the future fell outside this framework, or were due to be cancelled in the future, this would be discussed during a meeting with the commissioning services and advised to the Finance and Performance Committee and the Board of Directors.	**Evidence of compliance** • Signed contracts • Activity information provided to the Financial Planning Group and the Board of Directors • The Finance and Performance Committee has been assured of clinical services' contracts and any risks associated with them • The terms of reference for the Financial Planning Group include mechanisms to oversee contract management • CQC Inspection Report from the 2017 inspection showing that the appropriate services are being delivered.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
obligation to provide the service as a Commissioner Requested Service.			
CoS2 - Restriction on the disposal of assets The Licensee shall establish and maintain an asset register which lists every relevant asset used by the Licensee for the provision of Commissioner Requested Services. The Licensee shall not dispose of, or relinquish control over, any relevant asset except with the consent in writing of NHS Improvement.	**Statement of compliance** The Trust maintains an asset register and will comply with the terms of the condition regarding asset disposal as required. The asset register shows that there have been no ad-hoc disposals within the year which would have required prior consent from NHSI.	**Evidence of compliance** • The Finance Department holds and updates the asset register which lists owned and leased properties, and equipment over a value of £5,000 • NHSI receives the Operational Plan commentary and templates which contain a list of assets due to be disposed throughout the year. This is a full asset register including land and buildings which encompass all of the Commissioner Requested Services • The approval letter in relation to the Trust's Annual Strategic Plan, which contained the list of disposals for the coming year, confirming that this had been approved by NHSI.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell
CoS3 - Standards of corporate governance and financial management The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management which reasonably would	**Statement of compliance** The Trust has sound, well developed systems of corporate and financial governance. The Trust has a Use of Resources score of 1. The Trust commissioned a well-led review by Deloitte which was concluded in 2017/18.	**Evidence of compliance** <u>Corporate Governance</u> • Assurances of good corporate governance and financial management are demonstrated through the use of internal and external audit, which challenge and review key areas of the organisation • The Trust has a Constitution in place, and also complies with all other guidance and good practice in terms of documentation in place	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
be regarded as suitable for a provider of the Commissioner Requested Services provided by the Licensee, and providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern.		• There is a detailed risk management procedure in place including Strategic, Corporate and Directorate Risk Registers • There is a Board Assurance Framework in place which is reported to the Board, Audit Committee and Board sub-committees • Annual Governance Statement is reviewed by the Board and signed by the Chief Executive • The Trust has a Corporate Governance Policy in place which sets out the processes, structures and procedures in place to govern the Trust • Internal audit and external audit ensure a sound system of internal controls are in place and report these to the Audit Committee. The outcome of all reports are reported to the Audit Committee • Self-assessment under the Code of Governance with the necessary declarations being made in the Annual Report. <u>Financial Management</u> • Standing Financial Instructions and a Scheme of Delegation are in place which outline financial responsibilities and thresholds • Operational Plan with financial projections • Annual Report and Accounts which detail financial management procedures and the end of year out-turn • The Combined Quality and Performance Report includes financial information which is presented to the Board • Financial performance information is presented to the Finance and Performance Committee.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell
CoS4 - Undertaking from the ultimate controller The Licensee shall procure from each company or person the	**Statement of compliance** The Trust is a Public Benefit Corporation and neither operates nor is governed by an Ultimate Controller arrangement so this licence condition does not apply.	**Evidence of compliance** • Not applicable.	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking, in favour of the Licensee, that the ultimate controller will refrain from any action which would be likely to cause the Licensee to be in contravention of any of its obligations. Equally, the ultimate controller will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to NHS Improvement.			
CoS5 - Risk pool levy The Licensee shall pay to NHS Improvement any sums required to be paid in consequence of any requirement imposed on providers by the dates by which they are required to be paid. This condition future proofs the ability	**Statement of compliance** Not applicable.	**Evidence of compliance** This is currently not a requirement.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
of NHS Improvement to impose such an undertaking although there is no current requirement in this regard.			
CoS6 - Co-operation in the event of financial stress If NHS Improvement gives notice that it is concerned about the ability of the Licensee to carry on as a going concern, the Licensee shall provide such information as NHS Improvement may direct to Commissioners and others as NHS Improvement may direct, allow such persons as NHS Improvement may appoint to enter premises owned or controlled by the Licensee and co-operate with such persons as NHS Improvement may appoint to assist in the management of the Licensee's affairs, business and property.	**Statement of compliance** There is no evidence that the Trust is not a going concern and no requests have been made of the Trust by NHSI. In the event of this being applicable the Trust would comply with this condition as required.	**Evidence of compliance** • In year monthly financial reporting stating the Trust has a strong 'Use of Resources' score • Operational plan and financial monitoring signalling a strong use of resources score. • Financial reporting scrutinised by the Finance and Performance Committee and Board demonstrating strong financial management • Achievement of year-end control total	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
CoS7 - Availability of resources The Licensee shall act to secure that it has, or has access to, the Required Resources. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.	**Statement of compliance** The Trust is compliant with this condition, having made a declaration upon submission of the operational plan 2018/19 (and likewise the same declaration for 2019/20 plan). In addition to this the Trust is declaring a Use of Resources score of 1. Approval of the Trust's financial plan is discussed at Board and also at the Finance and Performance Committee.	**Evidence of compliance** • Combined Quality Performance Report with the financial information and projections included in this is presented to the Board • Finance and Performance Committee papers and minutes showing that the Committee is content that the Trust remains financially viable • Operational Plan submission and financial projections for the coming years, again demonstrating on-going financial viability • Quarterly review by NHSI and correspondence to show that NHSI have no concerns about the Trust's financial position • Signed and committed contracts which are predominantly block contracts • CIPs have been achieved for 2018/19 a robust process for monitoring is in place which is overseen by the Programme Management Office, the Finance and Performance Committee, the Quality Committee, the Board and Financial Planning Group • Capital programme is kept under constant review through the Finance and Performance Committee and the Board.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell
FT1 - Information to update the register of NHS FTs The Licensee shall ensure that NHS Improvement has available to it written and electronic copies of the following documents: • The current version of Licensee's constitution;	**Statement of compliance** The Trust has supplied and will continue to supply the required information in order for NHS Improvement to keep the register of Foundation Trust's up to date. This includes the submission of the Annual Report and Accounts and the Constitution when it was updated.	**Evidence of Compliance** • The Board and Audit Committee have cycles of business which include the scrutiny and approval of the Annual Report and Accounts • Copies of the Annual Report and Accounts and the current version of the Constitution are provided to NHS Improvement for inclusion its website • A copy of the auditor's report on the Accounts and Annual Report was included in the document which was submitted to NHS Improvement • The documentation relating to the latest version of the constitution was provided to NHS Improvement within 28 days of the adopted change.	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
• The Licensee's most recently published annual accounts and any report of the auditor on them; and • The Licensee's most recently published annual report.			
FT2 - Payment to NHS Improvement in respect of registration and related costs Should NHS Improvement determine that the Licensee must pay to NHS Improvement a fee in respect of NHS Improvement's exercise of its functions the Licensee shall pay that fee to NHS Improvement within 28 days of the fee being notified.	**Statement of compliance** No fees have been levied by NHS Improvement.	**Evidence of Compliance** • Not applicable.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell
FT3 - Provision of information to advisory panel The Licensee shall comply with any request for information or advice made of it.	**Statement of compliance** Prior to the advisory panel being disbanded there had been no request for the Trust to comply with any requests made by the panel.	**Evidence of Compliance** • Not applicable.	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro

Leeds and York Partnership NHS
NHS Foundation Trust

CORPORATE GOVERNANCE STATEMENT (CGS) 2018/19 and 2019/20

(How we comply with Condition FT4 of the Provider Licence)

Table A

SUPPORTING EVIDENCE FOR EACH GOVERNANCE CONDITION

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
The Board is satisfied that Leeds and York Partnership NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	The Board is satisfied that Leeds and York Partnership NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	• The Trust has in place a Board of Directors which is properly constituted and governed by Terms of Reference. It has beneath it a fully formed structure of sub-committees each chaired by a non-executive director, and appropriately monitored by the Board via reports from their chairs • The Trust has in place an appropriately constituted Council of Governors and an appropriate sub-committee structure to carry out its work • The executive and non-executive directors are appropriately qualified and experienced to lead the organisation; carry out their roles; and provide effective challenge within	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
		Board meetings, its sub-committee structure and within the wider organisation • The Board has been assured by the Head of Corporate Governance and the last CQC inspection that its members are Fit and Proper and that the Trust has in place a Fit and Proper Person Procedure which meets the CQC regulations • The Board has an agreed strategy incorporating goals and objectives, and five supporting strategies setting out the key priorities. It receives reports on progress against its priorities through its sub-committees • The Board has agreed, supports and promotes a set of values which it promotes throughout the Trust • The Board has agreed a schedule setting out those matters that are reserved to the Board and those it has delegated • The CEO has ensured the executive directors' portfolios are clearly defined and that appropriate management structures are in place to support the delivery of health care services and the delivery of their responsibilities as Accounting Officer.	

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
		• There is an appropriate risk management process in place and supporting procedures to ensure safe services are delivered and that lessons are learnt from incidents both internal and external to the Trust. • The Trust has in place appropriately qualified internal audit and external audit teams providing assurance on all aspects of the business of the Trust.	
The Board has regard to such guidance on good corporate governance as may be issued by NHSI from time to time.	• There is in place a governance structure which has the capacity and capability to interpret and implement the corporate governance guidance as issued by NHS Improvement • There are appropriate supporting structures and teams to implement such guidance. These teams are appropriately qualified, trained and resourced • In terms of the corporate governance documents the Board is able to demonstrate delivery of: o Annual Accounts o Annual Report o Annual Governance Statement o Corporate Governance Statement o Quality Report	• Annual Accounts • Annual Report • Annual Governance Statement • Corporate Governance Statement • Quality Report • Monthly monitoring returns • Board self-certification • The Trust's Strategy and supporting strategies • The Operational Plan • Comply or explain statement in respect the Code of Governance and the Provider Licence • Board Assurance Framework.	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	o Monthly monitoring returns o Board self-certification o Board Assurance Framework o The Trust's Strategy o The Operational Plan o Comply or explain statements.		
The Board is satisfied that Leeds and York Partnership NHS Foundation Trust implements: a) Effective board and committee structures;	• The Board of Directors has beneath it a comprehensive sub-committee structure consisting of an Audit Committee, Finance and Performance Committee, Quality Committee, Mental Health Legislation Committee, Remuneration Committee, and Nominations Committee • These committees have substantive members made up from members of the Board of Directors with others, such as senior staff, in attendance • The sub-committees are chaired by non-executive directors; have only Board members as substantive members (both executive and non-executive); are attended by appropriately qualified and experienced senior managers; and where appropriate are observed by governors • Each of its committees report back to the Board by way of a report from the chair	• Sub-committee Terms of Reference • Governance Structure • Minutes of the Board of Directors and minutes of each sub-committee • Effectiveness questionnaires.	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	of the committee highlighting the main areas of discussion and any matter to be escalated • The Terms of Reference for each Board sub-committee is clear that they are concerned with governance and assurance and those matters of day-to-day management are dealt within directorate structures reporting to the Executive Management Team • A review of effectiveness is required to be carried out at least annually and a report made to the 'parent group' in respect of the outcome and any areas of development.		
b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and	• The Board and each of its sub-committees have Terms of Reference agreed by that sub-committee and ratified by the Board • The role of each person (whether a substantive member or in attendance) is clearly set out in the Terms of Reference • There is an agreed memorandum of understanding between the Chair and Chief Executive setting out their division of responsibilities • There is a scheme of delegation • There is a comprehensive meetings	• Terms of Reference for the Board and its sub-committees • Job and role descriptions for executive directors and non-executive directors • Job descriptions for all staff reporting to and attending committees • Terms of Reference for Board sub-committees set out the reason for each senior manager attending • Document detailing the division of responsibility between the Chair and Chief Executive • Scheme of Delegation	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	manual and schedule of training on all aspects of running meetings.	• Meetings Administration Manual and schedule of training.	
c) Clear reporting lines and accountabilities throughout its organisation.	• The Board of Directors is accountable locally to members and members of the public through the Council of Governors and to its commissioners for the delivery of services through legally binding contracts • The Trust is also accountable to its regulators including NHS Improvement and the CQC • The Board of Directors and the Council of Governors have clear sub-committee structures with reports from each being made to it on the work they have carried out on its behalf. The Executive Team reports into the Board through the Chief Executive. The Executive Management Team meeting has a fully formed governance structure beneath it which supports the work of the executive directors in respect of the day-to-day management of the Trust • Agreed Terms of Reference for the Board, Council, EMT and their respective sub-committee structures are in place for all groups and committees • The Board has in place a number of high	• Terms of Reference for Board, Council, Executive Team and respective sub-committees that include an organogram for reporting • Terms of Reference for all groups and committees in the operational governance structure • Governance structure reporting organogram • Constitution • Matters reserved and scheme of delegation • Division of Duties between the Chair and Chief Executive • NHS Foundation Trust Accounting Officers' Memorandum • Meetings Administration Manual • Meetings Map • Governance, Accountability, Assurance and Performance Framework	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	level documents which set out accountabilities and responsibilities: the Constitution; Matters Reserved and Scheme of Delegation; division of duties between the Chair and the Chief Executive, the Chief Executive's Memorandum of Accounting • Each executive director has a clearly defined portfolio with clear accountability for their area of responsibility. Objectives are set each year for directors and are appraised by the Chief Executive • All job and role descriptions have a clear indication of the accountability lines of reporting and a process for objective setting and appraisal is in place • There is a Governance, Accountability, Assurance and Performance Framework in place which sets out accountability and reporting lines for performance • All groups and committees in the governance structure have Terms of Reference with parent groups shown in terms of reporting and escalation.		
The Board is satisfied that Leeds and York Partnership NHS Foundation Trust:	• Standing Financial Instructions (SFIs) and Financial Procedures (FPs) in place • External audit services procured and regularly market tested	• Standing Financial Instructions • Financial Procedures • Internal Audit Reports • External Audit Reports	David Brewin, Assistant Director of Finance

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
a) Effectively implements systems and/or processes to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively;	• Internal Audit service in place through a consortium arrangement • Regular reporting of detailed financial information to Board, Financial Planning Group, Finance and Performance Committee and Operational Delivery Group • Procurement work plan in place • Estates strategy developed to support the service strategy • In line with SFIs, all significant clinical and non-clinical developments are subject to Board approving a business case which details the economic case • Involvement in national and local benchmarking exercises • Chief Executive and Executive Director representation at Leeds 'place based' implementation groups to ensure Trust services operate efficiently, economically and effectively in the context of the wider Leeds health and social care economy • Partnership Procurement Framework in place to deliver efficient and effective engagement of voluntary sector organisations • Cost Improvement Programme Quality	• Papers and minutes of Board, Finance & Performance Committee, Financial Planning Group, and Operational Delivery Group • Procurement work plan quarterly progress report to Finance & Performance Committee • Estates Strategy quarterly progress report to Finance & Performance Committee • Board minutes • Output from local and national benchmarking exercise • Meetings notes and terms of reference • Framework documentation • Quality and Deliverability Impact Assessment forms and minutes and terms of reference for the Star Chamber.	(Dawn Hanwell)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	Impact Assessment Process.		
b) Effectively implements systems and/or processes for timely and effective scrutiny and oversight by the Board of the Licence holder's operations;	• The Board has in place a cycle of business which it has agreed for those items that it wants to receive on a cyclical basis throughout the year. It has also put in place a schedule setting out those duties that it has to delegate • The Associate Director for Corporate Governance has responsibility for ensuring that papers are presented to the Board in accordance with its business cycle and for ensuring other papers are delivered within agreed timeframes • The Associate Director for Corporate Governance also has responsibility for ensuring good flows of information between the Board, the Council of Governors, including through the sub-committee structure and that papers move through the governance structure in a timely manner. This is achieved through cycles of business, Terms of Reference of committees and action logs • The work of the Board's sub-committees is reported via reports and from the chair of the committee to the next available Board meeting • The Executive Team has established a	• Annual Cycle of Business for the Board of Directors • Scheme of Delegation and Matters Reserved • Terms of Reference (Board, Council and their sub-committees) • Attendance by the Head of Corporate Governance at all sub-committee meetings under the Board of Directors and Council of Governors • Minutes of meetings and Board • CEO Report to Board • Board sub-committees Terms of Reference and minutes • Minutes of the Board of Directors.	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	comprehensive structure of reporting beneath it with all groups and committees having agreed Terms of Reference. There are 9 executive-led groups reporting to the Executive Management Team, each being chaired by an executive director. The Chief Executive's Report will include those significant items that need to be brought to the attention of the Board. This supplements other substantive papers from executive directors to the Board.		
c) Effectively implements systems and/or processes to ensure compliance with health care standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	• Identified compliance actions following CQC inspections are monitored through the CQC Project Group, and assurances made to the Quality Committee (a Board sub-committee). Quarterly updates are provided to the Trust's Board by the Director of Nursing, Quality and Professions • Any risks to compliance are identified and managed through a live risk assessment and treatment plan • Risks to compliance are identified within the Combined Quality and Performance Report and any necessary actions in place to ensure compliance and improvements are documented.	• Terms of reference for the CQC Project Group • Action minutes of the CQC Project Group • Updated and reviewed CQC Action Plan • Combined Quality and Performance (CQPR) Report as presented to the Board, the Council of Governors, Quality Committee and the Finance and Performance Committee • Minutes of the Board of Directors, the Council of Governors and the Executive Team • Emails from the Clinical Quality Assurance Service to evidence sharing the CQPR with	Nichola Sanderson, Deputy Director of Nursing (Cathy Woffendin)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	• Peer review process in place to monitor actual practice against standards	commissioners.	
d) Effectively implements systems and/or processes for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern);	• Standing Financial Instructions (SFIs) and Financial Procedures (FPs) in place • Internal and external audit services • Regular reporting of detailed financial information, Single Oversight Framework Finance and use of Resources score to Board, Finance & Performance Committee and Financial Planning Group • Financial planning and modelling. Board approval of financial model as set out in the Operational Plan • Executive Directors involvement in the Financial Planning Group and Finance and Performance Committee which receive reports detailing all relevant clinical income risks and opportunities and strategies and action plans developed • Estates strategy developed to support service strategy and capital programme agreed • In line with SFIs, all significant clinical and non-clinical developments subject to Board approving a business case	• Standing Financial Instructions • Financial Procedures • Internal & External Audit Reports • Papers and minutes to Board, Finance and Performance Committee and Financial Planning Group • Financial Model approval minute from Trust Board • Terms of reference for Financial Planning Group and Finance and Performance Committee • Estates Strategy • Budgetary Control Framework and Virement Policy	David Brewin, Assistant Director of Finance (Dawn Hanwell)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	which details the economic case • Budgetary Control Framework and Virement Procedure in place to support effective management and control.		
e) Effectively implements systems and/or processes to obtain and disseminate accurate, comprehensive, timely and up-to-date information for Board and Committee decision-making;	• The Board and its sub-committees have in place an annual cycle of business, action logs, and bring forward system for agenda management to ensure that papers are received in an appropriate and timely manner • Minutes of meetings are formally presented to the next available "parent group" meeting both for information and so issues can be escalated as necessary • Reports to the Board and its sub-committee meetings are written by appropriately qualified and trained staff, and are approved by the lead director before being presented to meetings • Performance information in respect of clinical services, quality, workforce and finance is one of the main reporting tools informing Board and sub-committee decision making. To ensure there is accurate real-time performance information there is a Data Quality Policy clearly identifying roles and responsibilities for data input and	• Annual cycle of business for Board and its sub-committees • Chair's reports are presented to 'parent groups' with appropriate cover sheets • Data Quality Policy • Statement of Auditing Standards (SAS) No 70 for assurance on the SBS provision of ledger facility and core financial function.	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	collection and a performance team led by the Chief Financial Officer to interpret and present the information • Financial information is also presented to the Board and is interpreted by the CFO and in-house finance team. Shared Business Services manage the core ledger management function and provide real-time information to a pre-determined timetable.		
f) Effectively implements systems and/or processes to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	• The Board of Directors receives the Combined Quality and Performance Report which sets out the Trust's performance against internal and external requirements, measures and targets (local, regulatory and contractual) • The Council of Governors receives a performance report on a quarterly basis • Any risks to performance are identified within the combined Quality and Performance Report and any necessary actions in place to ensure compliance and improvements are documented • The CQPR is routinely shared with the Trust's main commissioner and published on the Trust's website • We have a systematic electronic approach to managing risks, which are	• Combined Quality and Performance Report as presented to the Board, Board sub-committees and the Council of Governors • Minutes of the Board of Directors, the Council of Governors and the Board sub-committees • Pages on the Trust website • Emails from the performance team to show we share the CQPR with commissioners.	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	managed progressively through the governance structure within the Trust • The Operational Plan includes an assessment of the risks associated with each of the Trust's priorities • Risks identified in the Operational Plan are managed by a lead manager and are monitored through the Programme Management Office • The Executive Risk Management Group has oversight of the strategic risks and any risks scored 15+ • The Executive Performance Overview Group oversees performance in the care groups and corporate directorates and provides support and challenge to staff in the services in relation to performance.		
g) Effectively implements systems and/or processes to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery;	• We have in place a strategic planning cycle which outlines the process by which we develop and monitor progress against the Operational Plan. • We have developed five three-year strategic plans agreed by the Board of Directors as follows: o Clinical Services o Estates o Workforce & Organisational	• Strategic planning cycle • Progress against our Operational Plan Quarterly Reports • Annual priorities	Amanda Burgess, Strategic Development Manager (Dawn Hanwell)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	Development o Health Informatics o Quality. • The strategic plans form the basis of our one year Operational Plan • Progress against the organisations top priorities as modelled within the Operational Plan is reported to the Board of Directors on a quarterly basis • The Programme Management Office is responsible for monitoring, supporting and reporting on the delivery of the organisation's top priorities as outlined in the five strategic plans and our one year Operational Plan • The CCG and NHS England commissioners routinely receive updates on our plans via the Contract Monitoring Board meetings.		
h) Effectively implements systems and/or processes to ensure compliance with all applicable legal requirements.	• Policies and procedures in place are referenced to the appropriate legislation including in the areas of: o Health and safety o Adult and child safeguarding o Medicines management o Mental Health Act	• Policies and procedures and reference to Section where relevant legislation is listed • Committee structure detailing those that are a legislative requirement • Directors' portfolios • Directorate and team structures.	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	o Fraud, bribery and corruption o Fire safety o Human resources o Public health o Estates and buildings o Information governance. • Statutory committees have been established within the committee structure to ensure compliance with relevant legislation (e.g. Health and Safety Committee) • Appropriately qualified executive directors with clear portfolios and responsibility for ensuring compliance with legislation within their functional areas • Directorate structures and teams established to ensure appropriately trained and qualified staff to oversee the implementation and adherence to relevant legislation • Regular Board training.		
The Board is satisfied: a) That there is sufficient capability at Board level to provide effective	• Appointments based on merit to non-executive director roles linked to required skill sets of the Board • Appointments based on merit to executive director posts, utilising an	• Executive director job and portfolio descriptions and recruitment process documentation • Non-executive director role descriptions and recruitment process	Cath Hill, Associate Director for Corporate Governance

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
organisational leadership on the quality of care provided;	assessment centre approach and based on agreed criteria derived from job descriptions and portfolios • Appraisals for non-executive directors and executive directors are carried out with actions agreed in areas of development • Reports on the outcome of the non-executive directors' appraisals being made to the Appointments and Remuneration Committee and Council of Governors • Full induction programmes completed for Board members • Ongoing Board workshops on topics relevant to Board development • NHS Providers programmes of NED training accessible to all non-executive directors. • Board members participate in a programme of Board development workshops. • Board members receive individual development, tailored to their roles and development objectives	documentation • Reports to the Appointments and Remuneration Committee and Council of Governors on the outcome of the appraisals of the non-executive directors. • Induction information • Board workshop schedules and topics discussed • Directors' pen portraits • Appraisal processes • Planned Board Development Plan. • Board Development Programme Schedule	(Sara Munro) AND Angela Earnshaw Head of Organisational Development (Claire Holmes)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	• Board members take part in appraisal and supervision to support their development		
b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	• The Board of Directors and the Executive Team receive a monthly Combined Quality and Performance (CQPR) Report which sets out Trust performance against external requirements, including NHS Improvement targets and other national / local standards. • Any risks to performance are identified within the report and any necessary actions in place to ensure compliance and improvements are documented. • The relevant sections of this report are also reviewed in more detail at the Trust Board's Quality and Finance & Performance Sub-Committees and further explanatory reports provided as requested. • The Council of Governors also receives a summarised version of the report on a quarterly basis. • This report is routinely shared with the Trust's main commissioner and published on the Trust's website.	• Quarterly Monitoring Returns signed off by the Board and evidence of submission to NHS Improvement • Combined Quality & Performance Report as presented to the Board of Directors & Executive Team • Combined Quality & Performance Report sections as presented to the relevant sub-committees and Council of Governors. • Minutes of the Board of Directors, Sub-Committees, the Council of Governors and the Executive Team • Pages on the Trust website • Emails from the Clinical Contracts Manager to show we share the CQPR with commissioners • Notes from quality / activity & finance meetings with commissioners which show the CQPR has been discussed.	Nikki Cooper, Head of Performance Management and Informatics (Joanna Forster Adams) AND

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	• Peer reviews are carried out to benchmark services against CQC standards to ensure ongoing compliance with registration	• Combined Quality Performance Report • Trust Board reporting template and sub group templates highlight areas of compliance • Peer reviews and self-assessments • Mental Health Act CQC reviews and returns • Trust Board sub group minutes and exec led group minutes	Nichola Sanderson, Deputy Director of Nursing (Cathy Woffendin) AND
	• A Quality Committee is in place, chaired by the non-executive director with responsibility for quality and has, as substantive members, the Director of Nursing, Professions and Quality, the Medical Director and the Chief Operating Officer • The Quality Committee receives assurance on compliance with those standards required for high quality and the safe delivery of care • The Quality Committee will seek assurance and opportunities to improve clinical quality, defined as issues looking at clinical effectiveness, patient	• Terms of Reference of the Quality Committee showing the membership and its duties • Minutes from the Quality Committee • Quality Committee papers include the quality performance report / learning lessons, integrated risk report and workforce performance report • Evidence of the Quality Committee's annual schedule of work relating to quality and safety issues. • Evidence of quality issues being discussed at the Board. For example, sharing patients' stories, learning from deaths, CQC action plans, complaints,	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	experience and patient safety • The Quality Committee has an annual schedule of work which incorporates both regular planned updates and deep dives on quality and safety related issues • The Trust Board receives regular updates on quality and safety as part of its annual work schedule and via the monthly chair's report from the chair of the Quality Committee and the CQPR. • Regular Executive Performance Overview Groups (EPOG) are in place for all Directorates and care groups where quality is discussed • The Medical Director chairs the Trust Wide Clinical Governance Group which is focused on quality and safety, clinical audit and effectiveness; and medicines management and Continuous improvement. This makes assurance reports to the Quality for onward reporting to the Board through the Chair's reporting mechanism.	claims and compliments and chair's reports from the Quality Committee • Annual schedule of dates and times for the Executive Performance Overview Group (EPOG) • Slides and action notes from EPOG, where patient centred care and quality is a specific topic area • Terms of Reference for Trust Wide Clinical Governance Group showing the membership and its duties • Minutes and chair's reports from Trust Wide Clinical Governance (TWCG) • Programme of Peer reviews • Chair's reports to the Board	
c) The collection of accurate, comprehensive, timely and up to date information on quality of care;	• The Performance, Information and Data Quality Group (PIDQG) meets monthly and provides a focus for the organisation in assuring the collection of high quality	• Combined Quality and Performance Report as presented to the Board, its sub-committees and the Council of Governors	Nikki Cooper, Head of Performance Management and

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	data; audits undertaken on behalf of the group are used to improve performance and quality. • Robust processes in place for collecting data from throughout the organisation relating to quality of care. • Data quality reports produced weekly and monthly to support improved record keeping. • Clinical effectiveness team provides support for clinical audit and service evaluation	• Minutes of the Board of Directors, its sub-committees and the Council of Governors • Quality Committee papers including service quality reports, learning from complaints and incidents. • Minutes and papers from the Performance, Information and Data Quality Group (PIDQG).	Informatics (Joanna Forster Adams)
d) That the Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care;	• The Board of Directors and the Executive Team receive a monthly Combined Quality and Performance (CQPR) Report which sets out Trust performance against external requirements, including NHS Improvement targets and other national / local standards. • Any risks to performance are identified within the report and any necessary actions in place to ensure compliance and improvements are documented. • The relevant sections of this report are also reviewed in more detail at the Trust Board's Quality and Finance & Performance Sub-Committees and further explanatory reports provided as	• Combined Quality and Performance Report as sent to the Board, its sub-committees and the Council of Governors • Minutes and papers from the Board's sub-committees	Nikki Cooper, Head of Performance Management and Informatics (Joanna Forster Adams)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	requested. • The Council of Governors also receives a summarised version of the CQPR on a quarterly basis.		AND
	• Detailed assessments of compliance through Peer Reviews with CQC registration are undertaken using the Key Lines of Enquiry (KLoE), and 'should / must do's' following the publication of inspection reports, with sign off from leads and lead executive directors. Assessments of compliance are reported on a quarterly basis to the Trustwide Clinical Governance Group and the CQC Project Group	• Completed and signed Peer reviews demonstrating compliance with CQC registration • Trust Board minutes and papers • Minutes of CQC Project Group • CQC must do / should do action plans	Nichola Sanderson, Deputy Director of Nursing (Cathy Woffendin)
			AND
	• There is a cycle of business which sets out when reports will be received. This is co-ordinated with data closedown dates • The Trust has a Governance, Accountability, Assurance and Performance (GAAP) framework in place which is used at all levels of the organisation • As set out in the GAAP, regular Executive Performance Overview Groups	• Minutes of the Board of Directors, and Council of Governors • Board of Director's cycle of business	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	(EPOG) are in place for all directorates and care groups where quality is discussed.		
e) That Leeds and York Partnership NHS Foundation Trust including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources;	• The Board of Directors receives stories from service users, carers and staff members through its monthly "Sharing Stories" sessions • Compliance will be further supported by an external Patient experience review which will include the views of all relevant stakeholders	• "Sharing Stories" programme • Patient experience review recommendations and outcome of patient experience review workshop (Valuing inclusion of people)	Linda Rose Head of Nursing and Patient Experience (Cathy Woffendin) AND
	• The Combined Performance and Quality Report contains details of complaints and compliments	• Combined Performance and Quality Report • External commissioned report on patient experience and engagement • Inclusion workshop held on 22 March, presentation and themes from the day • Community mental health survey • SUN and Sunray minutes	Nichola Sanderson, Deputy Director of Nursing (Cathy Woffendin) AND
	• The three quality priorities for quality improvements are set out in the Quality Account and are in line with the three	• Quality Account / Annual Report • Terms of Reference of the Quality Committee, agenda papers and	Rebecca Le-Hair Head of Quality and Clinical

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	goals as set out in the Strategy. These are underpinned by quality measures • The Quality Account is publically available in the Annual Report, on the Trust's website and NHS Choices • The Board of Directors receives in depth information and analysis of the NHS Staff Survey, highlighting where improvements have been achieved and further work is required. It also receives information in respect of the results from the Service User Surveys through its Quality Committee. • NED's undertake structured service visits including evening visits. • IHI Engaged to undertake Comprehensive Review of Quality Improvement Culture	minutes. • Staff Survey results as reported to Board and minutes of the meeting • NED Visit Feedback Form shared across Board • IHI Feedback Report and Workshop	Governance AND Angela Earnshaw Head of Organisational Development (Claire Holmes)
f) That there is clear accountability for quality of care throughout Leeds and York Partnership NHS Foundation Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including	• A Quality Committee is in place, chaired by the non-executive director with responsibility for quality and has substantive membership from the Director of Nursing, Professions and Quality, Medical Director and the Chief Operating Officer • The Quality Committee receives assurance on clinical governance in the	• Terms of Reference of the Quality Committee showing the membership and duties of the Committee • Minutes of the Quality Committee • Papers to the Quality Committee • Minutes of reports made to the Board of Directors outlining the work of the Committee and any issues that need to be escalated to Board	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
escalating them to the Board where appropriate.	Trust and monitors compliance with those standards required for high quality delivery of care • The Quality Committee has responsibility for seeking assurance and opportunities to improve clinical quality and safety, which is defined as issues looking at clinical effectiveness, patient experience and patient safety • Any matters which it feels should be escalated to Board will be done by the chair of the committee in their report to the next available Board meeting • We have in place a Governance Assurance Accountability and Performance Framework (GAAP) which clearly sets out the routes of escalation not least to Board where this is appropriate.	• Chair's reports from the Quality Committee to the Board • The GAAP framework set out the reporting and escalation arrangements from front line services to the Trust Board and from the Board to front line services.	
The Board of Leeds and York Partnership NHS Foundation Trust effectively implements systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licence holder's organisation who are sufficient in	• A full suite of recruitment and selection procedures in place ensuring appropriate selection, recruitment and retention of staff; with pre-employment checks carried out (DBS, qualifications and references) to ensure suitability for the post • Procedure and arrangements in place to	• Full suite of recruitment and selection procedures including Temporary Staffing Procedure • Procedure and arrangements in place to adhere to Fit and Proper Persons Test for Board Members and other key posts • Medical Revalidation Procedure	Lindsay Jensen Deputy Director of Workforce Development (Claire Holmes)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
number and appropriately qualified to ensure compliance with the Condition of this Licence.	adhere to Fit and Proper Persons Test for Board Members and other key posts • GMC, NMC and HPC interface with Electronic Staff Record (ESR) system to ensure professional registration compliance • A medical revalidation procedure and consultant appraisal procedure in place with Organisational Readiness Assessment System (ORSA) reports being made to the Board of Directors • Professional Registration Procedure incorporating nurse revalidation process • Programme of Continuing Professional Development (CPD) for all professional staff • Professional Clinical Leads in post across the Trust • A risk based compulsory training programme in place for all staff (including bank staff) with up-take reports being made to the Board in the monthly Combined Quality and Performance Report • Establishment of staffing ratios and skill mix reporting supported by an E-Rostering system • Safer Staffing reports for inpatient units	• Supervision Procedure for clinical staff • Educational Sponsorship and Study Leave Procedure • Compulsory Training Procedure and programme • Monthly compliance reports to managers for up-take of compulsory training and Combined Quality and Performance Report to Quality Committee and Board • Evidence of Consultant Appraisals and revalidation decisions • ORSA reports to Board and minutes of that Board meeting • Appraisal Procedure for Agenda for Change staff with Combined Quality and Performance Report to Quality Committee and Board on completion data for appraisals • Monthly reports to managers on Professional Registration renewals • Regular reports on bank fill rates. • Trust Strategy • Workforce and OD Strategic Plan 2018-21 • Organisational Structures • Apprenticeship Programme which includes support worker and wider	

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	reported to NHS England via Unify system • An internal temporary staffing resource (bank staff) with individuals being required to go through a recruitment and selection process ensuring they are appropriately trained and skilled, thereby ensuring a high level of quality of care from the temporary staffing resource • Agency workers procured through national frameworks to ensure compliance with employment and training requirements • Appraisals carried out for all Board members and all Agenda for Change staff with performance in respect of completion of staff appraisals being reported to the Board and monitored on an ongoing basis by the Quality Committee • Director of OD and Workforce is a substantive member of the Quality Committee.	workforce development • Monthly Safer Staffing reports to NHS England. • Board Development Programme • Quality Committee Terms of Reference showing membership and duties of the Committee.	

Table B

The Board of Directors is required to respond *compliant/non-compliant* with the following governance conditions, setting out any risks and mitigating actions planned for each. Compliance with each condition is at the date of this statement (31.03.19) and also a declaration of forward compliance with the coming financial year (1.04.19 to 31.3.20).

Governance condition	Compliance with the governance condition at the end of 31.03.19	Forward compliance with the governance condition for 01.04.19 – 31.03.20	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
The Board is satisfied that Leeds and York Partnership NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Compliant	Compliant	None	Not applicable	Cath Hill, Associate Director for Corporate Governance Confirmed by Sara Munro

Governance condition	Compliance with the governance condition at the end of 31.03.19	Forward compliance with the governance condition for 01.04.19 – 31.03.20	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
The Board has regard to such guidance on good corporate governance as may be issued by NHSI from time to time.	Compliant	Compliant	None	Not applicable	Cath Hill, Associate Director for Corporate Governance Confirmed by Sara Munro
The Board is satisfied that Leeds and York Partnership NHS Foundation Trust implements: a) Effective board and committee structures	Compliant	Compliant	None	Not applicable	Cath Hill, Associate Director for Corporate Governance Confirmed by Sara Munro

Governance condition	Compliance with the governance condition at the end of 31.03.19	Forward compliance with the governance condition for 01.04.19 – 31.03.20	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and	Compliant	Compliant	None	Not applicable	Cath Hill, Associate Director for Corporate Governance Confirmed by Sara Munro
c) Clear reporting lines and accountabilities throughout its organisation.	Compliant	Compliant	None	Not applicable	Cath Hill, Associate Director for Corporate Governance Confirmed by Sara Munro

Governance condition	Compliance with the governance condition at the end of 31.03.19	Forward compliance with the governance condition for 01.04.19 – 31.03.20	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
The Board is satisfied that Leeds and York Partnership NHS Foundation Trust: a) Effectively implements systems and/or processes to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively;	Compliant	Compliant	None	Not applicable	David Brewin Assistant Director of Finance Confirmed by Dawn Hanwell
b) Effectively implements systems and/or processes for timely and effective scrutiny and oversight by the Board of the Licence holder's operations;	Compliant	Compliant	None	Not applicable	Cath Hill, Associate Director for Corporate Governance Confirmed by Sara Munro

Governance condition	Compliance with the governance condition at the end of 31.03.19	Forward compliance with the governance condition for 01.04.19 – 31.03.20	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
c) Effectively implements systems and/or processes to ensure compliance with health care standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	Compliant	Compliant	None	Not applicable	Nichola Sanderson Deputy Director of Nursing Confirmed by Cathy Woffendin
d) Effectively implements systems and/or processes for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern);	Compliant	Compliant	None	Not applicable	David Brewin Assistant Director of Finance Confirmed by Dawn Hanwell

Governance condition	Compliance with the governance condition at the end of 31.03.19	Forward compliance with the governance condition for 01.04.19 – 31.03.20	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
e) Effectively implements systems and/or processes to obtain and disseminate accurate, comprehensive, timely and up-to-date information for Board and Committee decision-making;	Compliant	Compliant	None	Not applicable	Cath Hill, Associate Director for Corporate Governance Confirmed by Sara Munro
f) Effectively implements systems and/or processes to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	Compliant	Compliant	None	Not applicable	Cath Hill, Associate Director for Corporate Governance Confirmed by Sara Munro

Governance condition	Compliance with the governance condition at the end of 31.03.19	Forward compliance with the governance condition for 01.04.19 – 31.03.20	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
g) Effectively implements systems and/or processes to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery;	Compliant	Compliant	None	Not applicable	Amanda Burgess Strategic Development Manager Confirmed by Dawn Hanwell
h) Effectively implements systems and/or processes to ensure compliance with all applicable legal requirements.	Compliant	Compliant	None	Not applicable	Cath Hill, Associate Director for Corporate Governance Confirmed by Sara Munro
The Board is satisfied that: a) There are systems and processes to ensure That there is sufficient capability at	Compliant	Compliant	None	Not applicable	Angela Earnshaw Head of Organisational Development

Governance condition	Compliance with the governance condition at the end of 31.03.19	Forward compliance with the governance condition for 01.04.19 – 31.03.20	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
Board level to provide effective organisational leadership on the quality of care provided;	Compliant	Compliant	None	Not applicable	Confirmed by Claire Holmes AND Cath Hill, Associate Director for Corporate Governance Confirmed by Sara Munro
b) There are systems and processes to ensure that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	Compliant	Compliant	None	Not applicable	Nikki Cooper, Head of Performance Management and Informatics (Joanna Forster Adams)

Governance condition	Compliance with the governance condition at the end of 31.03.19	Forward compliance with the governance condition for 01.04.19 – 31.03.20	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
	Complaint	Compliant	None	Not applicable	AND Cath Hill, Associate Director for Corporate Governance (Sara Munro) AND Nichola Sanderson, Deputy Director of Nursing (Cathy Woffendin)
	Complaint	Compliant	None	Not applicable	

Governance condition	Compliance with the governance condition at the end of 31.03.19	Forward compliance with the governance condition for 01.04.19 – 31.03.20	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
c) There are systems and processes to ensure the collection of accurate, comprehensive, timely and up to date information on quality of care;	Compliant	Compliant	New Electronic Patient Record system implementation in November 2019 could result in a temporary glitch in data availability or capture	Programme Manager in place overseeing the implementation; Robust testing plans being developed; Project governance structure in place	Nikki Cooper, Head of Performance Management and Informatics (Joanna Forster Adams)
d) There are systems and processes to ensure that the Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care;	Compliant Compliant	Compliant Compliant	New Electronic Patient Record system implementation in November 2019 could result in a temporary glitch in data availability or capture None	Programme Manager in place overseeing the implementation; Robust testing plans being developed; Project governance structure in place Not applicable	Nikki Cooper, Head of Performance Management and Informatics (Joanna Forster Adams) AND Nichola Sanderson, Deputy Director

Governance condition	Compliance with the governance condition at the end of 31.03.19	Forward compliance with the governance condition for 01.04.19 – 31.03.20	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
	Compliant	Compliant	None	Not applicable	of Nursing (Cathy Woffendin) AND Cath Hill, Associate Director for Corporate Governance (Sara Munro)
e) There are systems and processes to ensure that Leeds and York Partnership NHS Foundation Trust including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as	Compliant	Compliant	A temporary reduction of available staff in the Patient experience team following the review will challenge the ability to centrally manage patient and carer feedback.	The service will agree key priority areas during the transition period with the executive lead and engage in the recruitment of appropriately skilled staff.	Linda Rose Head of Nursing and Patient Experience (Cathy Woffendin)

Governance condition	Compliance with the governance condition at the end of 31.03.19	Forward compliance with the governance condition for 01.04.19 – 31.03.20	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
appropriate views and information from these sources; and				Corporate oversight and management will be led through a Strategic level steering group chaired by the executive lead.	AND
	Compliant	Compliant	None	Not applicable	Nichola Sanderson, Deputy Director of Nursing (Cathy Woffendin)
					AND
	Compliant	Compliant	None	Not applicable	Angela Earnshaw Head of Organisational Development

Governance condition	Compliance with the governance condition at the end of 31.03.19	Forward compliance with the governance condition for 01.04.19 – 31.03.20	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
	Compliant	Compliant	None	Not applicable	(Claire Holmes) AND Alison Kenyon Interim Associate Director (Joanna Forster Adams)

Governance condition	Compliance with the governance condition at the end of 31.03.19	Forward compliance with the governance condition for 01.04.19 – 31.03.20	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
f) There are systems and processes to ensure that there is clear accountability for quality of care throughout Leeds and York Partnership NHS Foundation Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Compliant	Compliant	None	Not applicable	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Compliance with the governance condition at the end of 31.03.19	Forward compliance with the governance condition for 01.04.19 – 31.03.20	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
The Board of Leeds and York Partnership NHS Foundation Trust effectively implements systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licence holder's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Condition of this Licence.	Compliant	Compliant	National occupational shortages in nursing Increased use of bank and agency staff to support services Impact of Brexit. There are also challenges in the recruitment of doctors and again a programme of work to oversee this is in hand.	Part of the NHSI Retention Programme Additional resource to support workforce planning across the Trust Additional resource to deliver strategic resourcing to support, recruitment, talent management and career development Increase collaboration across the MH ICS for WY&H Improvements to the quality and skills of the internal bank workforce	Lindsay Jensen Deputy Director of Workforce Development Confirmed by Claire Holmes

Leeds and York Partnership NHS
NHS Foundation Trust

STATEMENT IN RESPECT OF TRAINING FOR GOVERNORS 2018/19

The Board of Directors are required to respond *compliant/non compliant* with the following statutory requirement, setting out any risks and mitigating actions planned for each. Compliance is at the date of this statement as at 31 March 2019.

Governance condition		Supporting evidence demonstrating compliance
The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Compliant	• Induction training provided for all new governors • Individual meetings between the Chair and governors to determine any specific needs • Action plan to incorporate the needs of governors into the forward plan for the Council of Governors • Workshop sessions on Council of Governors' days covering information about our services • Service visits with non-executive directors • Board to Board between the Council of Governors and the Board of Directors • Bespoke training provided by NHSI on accountability and also core skills – to be provided on a cyclical basis.

Proposed Declarations

	Statement	Declaration
G6(3)	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed compliant 2018/19
CoS(7)	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed for 2019/20
FT4(8)	The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed compliant 2018/19
FT4(8)	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed compliant 2018/19
FT4(8)	The Board is satisfied that the Trust implements: a) Effective board and committee structures b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees c) Clear reporting lines and accountabilities throughout its organisation	Confirmed compliant 2018/19

	Statement	Declaration
FT4(8)	The Board is satisfied that the Trust effectively implements systems and/or processes: a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern) e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery h) To ensure compliance with all applicable legal requirements.	Confirmed compliant 2018/19
FT4(8)	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c) The collection of accurate, comprehensive, timely and up to date information on quality of care d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed compliant 2018/19 Although it is recognised that with the implementation of the new patient records' system (CareDirector) there could be a temporary dip in the information available. This is being managed through robust testing and contingency plans are in place. With regard to engaging with service users and carers it is recognised that much work is going on in the Trust to strengthen these arrangements, including recruitment to the Patient Experience Team.

	Statement	Declaration
FT4(8)	The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed compliant 2018/19 The Board acknowledges that there are challenges around recruitment due to shortages across nursing and Junior Doctors in some specialities. These shortages are being actively monitored and managed.
Governor training	The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in S151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed compliant 2018/19 The Board acknowledges that there is work ongoing to develop the training programme.

AGENDA ITEM 28

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