Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

PUBLIC MEETING OF THE BOARD OF DIRECTORS
will be held at 9.30 am on Thursday 26 March 2020
in Meeting Room 1&2, Trust Headquarters, 2150 Century Way, Thorpe Park, Leeds LS15 8ZB

Dial in facilities are available for this meeting:

The number to dial = 0800 917 1950
Participant passcode: 24646839#

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 then 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	**Apologies for absence** (verbal)	**SP**
2	**Declaration of interests for directors and any declared conflicts of interest in respect of agenda items** (enclosure)	**SP**
3	**Minutes of the previous meeting held on 30 January 2020** (enclosure)	**SP**
4	**Matters arising**	
5	**Actions outstanding from the public meetings of the Board of Directors** (enclosure)	**SP**
6	**Chief Executive's report** (verbal)	**SM**
	PATIENT CENTRED CARE	
7	**Report from the Chair of the Quality Committee for the meetings held 11 February and 10 March 2020** (enclosure)	**JB**

8	**Report from the Chair of the Finance and Performance Committee for the meetings held on 24 March 2020** (verbal)	**SW**
9	**Report from the Chair of the Mental Health Legislation Committee for the meeting held on 4 February 2020** (verbal)	**MS**
10	**Report from the Chair of the Workforce Committee for the meeting held on 20 February 2020** (enclosure)	**HG**
11	**Combined Quality and Performance Report** (enclosure)	**JFA**
12	**Report from the Director of Nursing** (enclosure)	**NS**
13	**Safe Staffing Report** (enclosure)	**NS**
14	**Report from the Medical Director** (enclosure)	**CK**
15	**Guardian of Safe-working Quarterly Report** (enclosure)	**CK**
WORKFORCE		
16	**Reciprocal mentoring programme** (enclosure)	**CH**
17	**Health Education England – Provider Placement Self-Assessment Return**(enclosure)	**CH**
USE OF RESOURCE		
18	**Report from the Chief Financial Officer** (enclosure)	**DH**
PARTNERSHIPS		
19	**West Yorkshire Mental Health, Learning Disability and Autism report from the Committees in Common (for information only)** (enclosure)	**SM**
GOVERNANCE		
20	**Board Assurance Framework** (enclosure)	**SM**
21	**Use of seal** (verbal)	**SP**
22	**Any other business**	
23	**Glossary** (enclosure)	**SP**
24	***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 21 May 2020 at 9.30 am
Conservatory Room, 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

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Declaration of Interests for members of the Board of Directors

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

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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

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John Baker Non-executive Director	None.	None.	None.	None.	None.	**Professor** University of Leeds	None.	None
Helen Grantham Non-executive Director	**Director and Owner,** Entwyne Ltd	**Sole owner,** Entwyne Ltd	None	None	**Manchester City Council** Interim Director of HR and OD	None	None	None
Andrew Marran Non-executive Director	**Chairman** **Leeds Students Residences Ltd** Delivering housing and accommodation services across Leeds **Non-executive Director** **MoreLife (UK) Ltd** Delivers tailor-made, health improvement programmes to individuals, families, local communities; within workplaces and schools **Non-executive Director** **My Peak Potential Ltd** An organisational development company that specialises in leadership and management development using the outdoors as a vehicle for learning **Non-executive Director** **Rhodes Beckett Ltd**	None.	None.	None.	None. .	None. .	None.	None.

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	A University associated company which developed a Wellbeing app and website to provide access to staff.							
Margaret Sentamu Non-executive Director	None.	None.	None.	None.	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

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Minutes of the Public Meeting of the Board of Directors held on held on Thursday 30 January 2020 at 9:30 am in Inspire@ Room, Horizon Leeds (3rd Floor), 2 Brewery Wharf, Kendell Street, Leeds, LS10 1JR

Board Members

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

All members of the Board have full voting rights

In attendance

Mrs C Hill	Associate Director for Corporate Governance / Trust Board Secretary
Mrs L Jenson	Deputy Director of Workforce (deputising for Claire Holmes)
Seven members of the public (one of whom was a member of the Council of Governors)	

		Action
	Prof Proctor opened the public meeting at 9.30 am and welcomed everyone.	
20/001	**Sharing Stories** (agenda item 1) Prof Proctor welcomed Lisa Cromack who attended the Board to share her story of gaining employment as an Involvement Co-ordinator with the Learning Disability Involvement Team and explained the difference this employment had made to her. Ms Cromack also talked about the process had provided a springboard for her to apply for another part-time job at the University of Leeds. She advised that achieving her goal had also meant that she was in a position to share her experiences with others and how this had helped to inspire other service users in working towards achieving their goals. Gill Galea (Social Care Manager) explained how the Learning Disabilities Team had developed an appropriate and accessible interview process. She added that this had been co-produced with service users and had resulted in Ms Cromack and a number of other people with Learning Disabilities being	

	employed as involvement workers within the team. It was noted that Ms Cromack would be attending the next Council of Governors' meeting to share her story. Prof Proctor reminded the Board that the governors were interested in how the Trust supported service users, particularly with learning disabilities, in gaining employment and that Ms Cromack's presentation would be of great interest to them. The Board thanked Ms Cromack for sharing her inspirational story and it was suggested that her presentation be uploaded to the Trust's website. Mrs Hill agreed to send this to Mr Tipper.	**CHill**
	On behalf of the Board, Prof Proctor **thanked** Ms Cromack for attending the Board to share her story.	
20/002	**Apologies for absence** (agenda item 2) Apologies were received from Mrs Holmes, Director for OD and Workforce; and Mr Marran, Non-executive Director. It was noted that Lindsay Jensen, Deputy Director of Workforce, was deputising for Mrs Holmes at the meeting.	
20/003	**Declaration of interests for directors and any declared conflicts of interest in respect of agenda items** (agenda item 3) Miss Grantham noted that there had been a change in her declaration of interests; that she was now sole owner, not co-owner, of Entwyn Ltd and agreed to send an updated form to Mrs Hill. Mrs Sentamu also noted that she had stepped down as the President of Mildmay International. The Board noted there were no other changes to directors' declarations of interests. It was also noted that no director at the meeting had advised of any conflict of interest in relation to any agenda item.	**HG**
20/004	**Minutes of the previous meeting held on 28 November 2019** (agenda item 4) Mr Wright noted that within minute 19/163 there was a typographical error and that this should have indicated that the report was from the Chief Operating Officer. In addition to this he added that minute 19/169 had not sufficiently captured the need to thank staff for the huge amount of work undertaken to develop the governance arrangements for the new Provider Collaborative. Mrs Woffendin noted that she was at the November meeting and that the minutes should not have shown that Nichola Sanderson was in attendance. Mrs Hill agreed to amend the minutes prior to them being signed by the Chair.	**CHill**

The minutes of the meeting held on 28 November 2019 were **received** and **agreed** as an accurate record subject to the amendments detailed above.

20/005 **Matters arising** (agenda item 5)

The Board **noted** there were no matters arising that were not either on the agenda or on the action log.

20/006 **Actions outstanding from the public meetings of the Board of Directors** (agenda item 6)

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

With regard to the action for Mrs Hanwell to make a report to the Clinical Environments Group about the issues observed on the Section 136 Suite during a recent visit by Prof Baker, she confirmed that the issues had been raised at the meeting and that remedial work had been carried out. However, she added that there was a fundamental issue with the layout of the unit which could not be resolved in the short-term and that this would need further consideration by the Care Services Directorate as to how this might be addressed. It was suggested that this could form part of the Board's session on the Estates Strategic Plan in February.

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

20/007 **Chief Executive's report** (agenda item 7)

Dr Munro presented the Chief Executive's Report and drew attention to the main points outlined in the report. In particular, Dr Munro noted that there had been an unannounced visit by the West Yorkshire Fire and Rescue Service to the Becklin Centre and that they had been impressed with the action that had been taken to address their initial findings and that the Fire Service had confirm that it would not be taking any further action against the Trust.

Mrs Sentamu asked about the bank staff survey noting that there had been a 26% response from these staff. She noted that there was currently a Bank Staff Forum in place and asked whether there were sufficient senior staff present at these meetings. Dr Munro noted that whilst there was still more that could be done there had been huge amount of work undertaken to ensure that bank staff feel supported, listened to and valued and that this had resulted in the increase in some of the positive responses received in the survey. Mrs Jensen added that the 26% response rate was good for the

first survey and that the workforce team was already looking at what it could do to increase the response rate for future surveys. She also noted that a number of other trusts had expressed an interest in understanding the work the Trust was doing with its bank staff and that this had resulted in a number of visits from partners.

Mrs Sentamu also noted that at a recent Bank Staff Forum there had been a number of questions raised as to the reasons for them having to undertake training on CareDirector. Mrs Woffendin explained the importance of ensuring that all staff, including bank staff, were able to use and input to the new system and that for this reason a programme of training had been put in place.

Prof Proctor noted that the Secretary of State for Health and Social Care was to be invited to the Gambling Addiction Service in Manchester and asked if Claire Murdoch (NHS England's National Mental Health Director) could also be invited to the event. It was agreed that Mr Tipper would look at taking this forward. **OT**

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

20/008 **Report from the Chair of the Audit Committee for the meeting held on 23 January 2020** (agenda item 8)

Mr Wright presented the report as Chair of the Audit Committee relating to the meeting held on 23 January 2020. In particular he drew attention to:

- **Estimated Discharge Dates:** Mr Wright noted that this was something that the committee had looked at previously and that it had asked for assurance on the consistent application of estimating discharge dates within care plans. He noted that assurance had been received by the committee that compliance rates had increased as a result of the work carried out, but that there was more still to do. He also noted that there would be a further internal audit carried out in the coming year to look at the progress made and the impact of the actions taken.

- **IT security and housekeeping controls:** Mr Wright advised that the committee had been pleased to note that the recent audit on IT security and housekeeping controls had provided significant assurance on the Trust's arrangements for securing information technology and data, adding that this was an important area for the Trust.

- **Contract management internal audit report:** Mr Wright noted that this audit had resulted in a rating of 'limited assurance'. He added that there had been a number of recommendations made which had been accepted by management and that assurance had been received on the steps being taken to address the findings. Mr Wright noted that one of the actions would likely incur additional management costs, and that whilst it was an Executive Team

decision as to whether to appoint any additional management capacity, the committee had been assured as to the need for this and the benefit it would bring to strengthening the procurement management arrangements.

- **Service user's money and property internal audit:** Mr Wright noted that this audit had resulted in a rating of 'limited assurance'. He added that whilst the committee had been concerned at some of the findings it was assured that management and the staff who will implement the procedures had accepted all of the recommendations; had completed some of the work; that there was support for staff going forward; that the learning from this audit would be factored into training; and that improvements were being seen in operational areas.

- **Health and safety action plan:** Mr Wright reported that the committee had considered the Health and Safety Executive action plan and had been assured that good progress had been made against the actions.

Prof Proctor asked about the deferral of audits and whether this would impact on the capacity to complete these before the end of the financial year. Mr Wright reported that the committee had been assured on the programme of audits and that the committee had not been concerned at the proposals for the revised programme.

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

20/009 **Report from the Chair of the Quality Committee for the meetings held on 10 December 2019 and 14 January 2020** (agenda item 9)

Prof Baker presented the Chair's reports from the meetings held on 10 December 2019 and 14 January 2020. In particular he noted that there had been presentations from the Older People's Service and also the Veteran's Service and that the committee had explored some of the challenges for these services particularly in relation to workforce. He also noted that there had been a discussion on the outcome of the Mental Health Optimal Staffing Tool (MHOST) and that there had been the opportunity to look at the staffing levels and resulting costs the tool had identified.

Prof Baker also noted that the committee had received a report on the effectiveness and sustainability of serious incident reviews and that it had looked at the actions this had generated. He added that this was an important and interesting paper and asked for this to be circulated to those Board members who do not attend the committee which Mrs Hill agreed to dos. Dr Kenwood spoke about the importance of this work and how it needed to link to the cultural work being carried out across the Trust. Dr Munro noted that this piece of reflective work facilitated the creation of an environment, space and time where people feel safe and able to learn from serious incidents.

Chill

	The Board then noted that the Infection Control Team had achieved a vaccination rate of 83.3%. Prof Proctor asked that thanks be conveyed to the team in relation to this achievement.	**CW**
	The Board **received** a report from the Chair of the Quality Committee and **noted** the content.	
20/010	**Report from the Chair of the Finance and Performance Committee for the meeting held on 28 January 2020** (agenda item 10) Mrs White provided a verbal report from the meeting of the Finance and Performance Committee held on 28 January 2020. She advised of the discussions that had taken place in respect of: • **Discharge summaries communicated to GPs**, noting that there had been concerns raised about the delay in the summaries being sent to GP surgeries and that there had been a detailed discussion on the potential impact of these delays and the actions being taken. Mrs White also noted that the committee would receive a further update on this matter at the next meeting. • **Capacity and demand aspects of the CQPR,** in particular the Acute Care Excellence work streams and the importance of clinical leadership to progress this work. • **The latest benchmarking data,** noting that in some areas the Trust was an outlier in comparison to other organisations. Mrs White noted that the committee had been advised that this data had been triangulated with the Model Hospital data and that there had been discussions about how performance could be improved and ways in which further efficiency opportunities could be identified. • **IT security dashboard,** noting that the committee had identified some key indicators that would be used to develop a dashboard and that ultimately these would be incorporated into the CQPR. Mrs Forster Adams provided an update on the discharge summaries communicated to GP surgeries. She advised that whilst summaries were being provided to GPs this was not always being done within the required timescale. She also advised the Board on the actions being taken to address this and outlined some of the challenges in implementing the potential solutions.	
	The Board **received** a report from the Chair of the Finance and Performance Committee and **noted** the matters reported on.	

20/011 **Combined Quality and Performance Report (CQPR)** (agenda item 11)

Mrs Forster Adams introduced the CQPR and outlined the main points of focus as detailed in the report. She also noted that the content of the report had been discussed in detail at recent meeting of the Finance and Performance Committee, the Quality Committee and the Workforce Committee.

She drew attention in particular to the Acute Liaison Psychiatry Service noting that the team was working hard to achieve their target of seeing service users within 1 hour. She added that to assist with improvement in performance the team was looking to recruit additional staff. She also noted that despite the challenge of staffing levels the team was receiving consistently good feedback from the acute Trust in respect of their work within the Accident and Emergency Department.

Mrs Forster Adams noted that the new patient record system CareDirector was due to go live shortly but that during the cut-over period there could be a short-term issue with the provision of data. This was noted by the Board.

Mrs Sentamu asked about appraisals and the survey that was due to be launched for Trust staff. Mrs Jensen advised that the survey had come about as a result of a recent Internal Audit report, and that and this would assist in looking at the quality of individual staff's appraisals. She added that by asking staff about their experience it would be possible to gauge how effective appraisals were and whether there was any action that may need to be taken in relation to the process.

Prof Proctor asked about the increase in number of restraint incidents. Mrs Woffendin noted that these were discussed in detail at the Positive and Safe Practice Group. She added that during the period reported on the increase in the number of incidents had been in relation to two service users with complex needs and that the increase was not indicative of a wider trend.

The Board **received** the CQPR. It **noted** the progress made and the areas currently under review.

20/012 **Safe Staffing Report** (agenda item 12)

Mrs Woffendin presented the safe staffing report which the Board received and noted. She added that there had been no breaches highlighted in the report.

The Board **received** the safe staffing report and **noted** the content.

20/013 **Update on the implementation of the smoke-free policy** (agenda item 13)

Mrs Woffendin presented a paper which gave an overview of the pilot and

progress with the implementation of the smoke-free policy. She outlined the work that had taken place and asked the Board to support the pilot being extended by six months to allow sufficient evaluation of its impact prior to this being implemented more widely.

Dr Munro commended the work that had been undertaken and noted the challenges there had been in implementing a smoke-free policy. The Board discussed the steps taken to implement the policy and achieve a safe and therapeutic environment for service users and staff. It also noted the ongoing discussions with PFI partners around the use of e-cigarettes within PFI units.

The Board discussed the impact of the use of e-cigarettes on staff's working environment and asked for staff's views on this to be captured and factored into the evaluation of the pilot. **CW**

The Board received and considered the report on the pilot and asked that a further update would be brought back to the July Board meeting. **CW**

The Board **received** the paper and **noted** the contents. It also **supported** the pilot being extended by a further six months.

20/014 **Report from the Chief Financial Officer** (agenda item 14)

Mrs Hanwell presented the Chief Financial Officer's report noting that this had been looked at in detail at the Finance and Performance Committee. She advised that as at month 9 the Trust was ahead of plan and was rated at a financial score of '1'. She added that the income and expenditure position continued to be underpinned by significant variances between planned budgets and actual expenditure, with a high degree of reliance on underspending budgets to offset other pressure areas.

With regard to capital Mrs Hanwell indicated that following national scrutiny on capital expenditure by regulators, organisations had been asked to review their capital plans. Mrs Hanwell advised that as a result of this there had been a further re-forecast for the full-year position with a reduction of £1m. She added that this was mainly achieved as a consequence of VAT savings and timing adjustments and was not due to any further deferral of schemes.

Mrs Hanwell then advised that the Planning Guidance for 2020/21 was still awaited and that ahead of this, work was ongoing to prepare operational plans ready for approval and submission to NHS Improvement / England.

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

20/015	**First annual review of the Partnership Memorandum of Understanding (MoU) for the WY&H Health and Care Partnership** (agenda item 15) Dr Munro presented the paper. She noted that the MoU had been consulted on with the various partner organisations and that it was now presented to the Board so it could confirm its continued support of the work of the ICS. Dr Munro noted that whilst the MoU had no legal standing it represented an ongoing commitment for partners to work together to ensure the effective provision of care to service users. Mrs Hanwell noted that whilst the MoU had no legal standing there was soon to be a System Collaboration and Financial Management Schedule that would form part of the NHS Model Contract and that this would tie Trust's into some of the detail currently in the MoU. Mrs Hanwell noted that there was further work to do to look at the implications of this new schedule. Mrs White asked if there had been any discussion about there being a lay chair of the ICS. She also noted that the Partnership Board had a number of decision making rights and asked how the Board would be sighted on such issues ahead of any decisions being taken. Dr Munro noted that the discussion around the chair of the ICS had concluded that having a chair from the Local Authority would embed councils into the work and the decisions being taken. Dr Munro then outlined the governance arrangements in respect of the decisions that would be taken and how this was tied into the structures in the Trust. Mr Wright noted that the governance arrangements for the ICS was on the agenda for the Audit Committee and that alongside this there was an external event for Audit Chairs in March which would look at this. He agreed to provide an update at the March Board meeting. The Board discussed the way in which the financial and performance regime might work within the ICS and what was likely to be expected of trusts to support partners who may be in financial 'distress'. It also discussed the emerging maturity of the ICS in tackling some of the issues which might arise in the future. The Board **considered** and **approved** the updated Memorandum of Understanding for the WY&H Health and Care Partnership	**MW**
20/016	**West Yorkshire Mental Health, Learning Disability and Autism Collaborative Committees in Common meeting minutes and report** (agenda item 16) Dr Munro presented the minutes and report from the meeting of the Committees in Common and the Board noted the content.	

	The Board **received** the West Yorkshire Mental Health, Learning Disability and Autism Collaborative Committees in Common meeting minutes and report and **noted** the content
20/017	**Use of seal** (agenda item 17) Prof Proctor noted that the seal had been used on one occasion since the last Board meeting: • Log number 120 – Licence to occupy the Beacon of Light.
	The Board **noted** the occasion on which the Seal had been applied.
20/018	**Any other business – flu vaccination assurance statement** (agenda item 18) Mrs Woffendin presented the assurance statement on flu vaccination. She noted that the campaign had been extremely successful and that the Trust had received all the CQUIN money due as a result of achieving the target. With regard to the assurance statement Mrs Woffendin noted that this would be uploaded to the Trust's website.
	The Board **received** and **noted** the content of the flu vaccination assurance statement.
20/019	**Glossary** (agenda item 19) The Board received the glossary.
19/183	**Resolution to move to a private meeting of the Board of Directors** (agenda item 22) At the conclusion of business, the Chair closed the public meeting of the Board of Directors 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.

The Chair of the Trust closed the meeting at 12:00 and thanked everyone for attending.

Signed (Chair of the Trust) ……………………………………………………

Date ……………………………………………………………………………

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

5

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
NEW - **Sharing Stories** (minute 20/001 – January 2020 - agenda item 1) It was suggested that Lisa Cromack's presentation would be uploaded to the Trust's website. Mrs Hill agreed to send this to Mr Tipper.	**Cath Hill**	Management action	**COMPLETED** The presentation was forwarded to Oliver Tipper and has been used as part of the Chair's Blog and shared thorough the Trust's social media channels
NEW - **Declaration of interests for directors and any declared conflicts of interest in respect of agenda items** (minute 20/003 – January 2020 - agenda item 3) Both Miss Grantham and Mrs Sentamu noted that had been a change to their declarations of interests. Mrs Hill agreed to ensure that the matrix was amended.	**Cath Hill**	Management action	**COMPLETED** The decelerations of interest have been updated

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
NEW - **Chief Executive's report** (minute 20/007 – January 2020 - agenda item 7) It was suggested whether alongside the Secretary of State for Health and Social Care being invited to visit the Gambling Addition Service in Manchester, Claire Murdoch (NHS England's National Mental Health Director) could also be invited to the event. It was agreed that Mr Tipper would look at whether this was possible.	**Oliver Tipper**	Management action	**REQUEST TO CLOSE THIS AS AN ACTION** Matt Hancock was due to visit the service on 5 March but this was cancelled due to coronavirus. An invitation was made to both to participate in a stakeholder launch event on 24 March but this has also been cancelled.
NEW - **Report from the Chair of the Quality Committee for the meetings held on 10 December 2019 and 14 January 2020** (minute 20/009 – January 2020 - agenda item 9) It was suggested that the paper that had been presented to the Quality Committee on the effectiveness and sustainability of serious incident reviews be circulated to all Board members. Mrs Hill agreed to do this.	**Cath Hill**	Management action	**COMPLETED** This paper that was presented to the Quality Committee in January 2020 has been circulated to those Board members who do not attend the meeting
NEW - **Report from the Chair of the Quality Committee for the meetings held on 10 December 2019 and 14 January 2020** (minute 20/009 – January 2020 - agenda item 9) The Board noted that the Infection Control Team had achieved a vaccination rate of 83.3%. Prof Proctor asked that a letter of thanks be sent to the team congratulating them on this achievement.	**Cath Hill**	Management action	**COMPLETED** A letter of thanks was sent to the Head of Infection Control

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
NEW - **Update on the implementation of the smoke-free policy** (agenda item 13) The Board discussed the impact of the use of e-cigarettes on staff's working environment and asked for staff's views to be captured and factored into the evaluation of the pilot.	**Cathy Woffendin**	Management Action	**COMPLETED** Staffs views will be incorporated into the evaluation and an update provided in July's paper
NEW - **First annual review of the Partnership Memorandum of Understanding for the WY&H Health and Care Partnership** (agenda item 15) Mr Wright noted that he was attending an external event run by NHS Audit Yorkshire for Audit Chairs in March which will look at the governance arrangements for the ICS. He agreed to provide an update at the March Board meeting.	**Martin Wright**	Board of Directors March 2020	
Workforce Race and Disability Equality Progress Report (minute 19/147 – September 2019 - agenda item 15) A reciprocal mentoring programme would be developed and brought back to the Board for consideration and approval.	**Claire Holmes**	March 2020 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
Safe Staffing Report (minute 19/144 – September 2019 - agenda item 12) Mrs Hanwell stated that there would need to be work done to look at the resources required and the resulting budgets and that this work would be taking place over the next six months. Prof Proctor asked for the Board to kept informed of the outcome of this work and for a report to come back to the May 2020 Board meeting.	**Dawn Hanwell**	May 2020 Board of Directors' meeting	
NEW - Update on the implementation of the smoke-free policy (agenda item 13) The Board received and considered the update on the smoke-free pilot and asked that a further update would be brought back to the July Board meeting.	**Cathy Woffendin**	Board of Directors July 2020	

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 Session (19/155 – agenda item 1 – 28 November 2019) Look at what more can be done to support the work of the Leeds City College and the role of the Recovery College in supporting service users more widely.	**Joanna Forster Adams**	Management action	**THE BOARD IS ASKED TO CLOSE THIS AS AN ACTION** This will be incorporated into the on-going development of the recovery college – specifically picking up the feedback and intelligence provided by Mr Frazer. Overseen by members of our service development group, an update in more detail will be provided to them at the end of April 2020.
Chief Executive's Report (19/161 – agenda item 7 – 28 November 2019) A letter of thanks to be sent on behalf of the Board to Adam Maher, Linda Rose and Dr Sharon Nightingale.	**Cath Hill / Sue Proctor**	Management action	**COMPLETED**
Guardian of Safe Working Hours (19/177 – agenda item 20 – 28 November 2019) A letter of thanks to be sent on behalf of the Board to Dr Liz Cashman	**Cath Hill / Sue Proctor**	Management action	**COMPETED**

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
Glossary (minute 19/182 – November 2019 - agenda item 26) Mrs Hill agreed to add SRAB (Systems Resilience Assurance Board) and CQPR (Combined Quality and Performance Report) to the glossary.	**Cath Hill**	Management Action	**COMPLETED**
Chief Executive's report (minute 19/139 – September 2019 - agenda item 7) Dr Munro also noted that there was a further draft of the Five-year Strategy, advising that she would circulate a copy of this to Board members for information.	**Sara Munro**	Management action	**COMPLETED** The updated slides were circulated to the Board 6 January 2020
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**	January 2020 Board of Directors' meeting	**COMPLETED** Verbal update to be provided to board members around vacancies, WTE benchmarking data detailed in January safer staffing report
Nicotine replacement management at LYPFT; summary of options for adoption of e-cigarette use (minute 19/123 – July 2019 - agenda item 14) Mrs Woffendin agreed to bring an update on the pilot to the January Board meeting.	**Cathy Woffendin**	January 2020 Board of Directors' meeting	**COMPLETED** This has been included on the January Board of Directors' 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 Mental Health Legislation Committee for the meeting held on 5 November 2019 (agenda item 13) Mrs Hanwell agreed to raise the issues with the environment through the Clinical Environments Group that had been observed during a NED visit with the S136 suite accommodation on some sites.	**Dawn Hanwell**	Management Action	**COMPLETED**

AGENDA ITEM
7

Chair's Report

Name of the meeting being reported on:	Quality Committee
Date your meeting took place:	11 February 2020 10 March 2020
Name of meeting reporting to:	Board of Directors – 26 March 2020

Key discussion points and matters to be escalated:

At the Quality Committee meeting that took place on the 11 February 2020, the Committee:

- Received a report which outlined the progress that had been made against the recommendations that came out of the Patient Experience Review in January 2019. It was satisfied with the progress made and reviewed the draft Patient and Carer Experience and Involvement Strategy. It received an update on the Triangle of Care Framework and noted that the submission date to achieve stage two accreditation had been delayed until September 2020. The Committee was assured that this would be possible as all 53 of the Trust's services had now completed the Triangle of Care Self-Assessment Tool.

- Received a quarterly report on Complaints, Concerns, PALS, Compliments and Patient Safety. It welcomed the Trust's approach to dealing with historic complaints, the improvement seen within the complaints data in the Combined Quality and Workforce Performance Report and the positive impact that had been made as a result of the changes to the complaints process now that the PALS team had begun to triage complaints.

- Reviewed the results from a Learning Organisation Survey that had been carried out to assess whether the meeting was a supportive learning environment. It noted that it had benchmarked above average and agreed to complete this survey on an annual basis. It suggested that the Trusts other Board Sub-committees also use this tool.

At the Quality Committee meeting that took place on the 10 March 2020, the Committee:

- Received an annual quality and safety report from the Crisis Resolution Intensive Support Service (CRISS). It was pleased to hear about the approaches that had been taken to improve staff health and wellbeing and to manage staff behaviours since four teams had merged to create the CRISS. The Committee discussed how the changes made to the Service as part of the Community Redesign had made a positive impact the quality of care provided by the CRISS.

- Reviewed the first draft of the Quality Report and Account. It acknowledged the improvements that had been made to the report and welcomed the engagement and consultation that had taken place on this area of work. It noted that the final draft would be presented to the Committee in May 2020.

- Reviewed both the draft Strategic Internal Audit Plan and the Clinical Audit Priorities Plan for 2020/21. It was assured on the proposed audit topics from a quality and safety perspective and suggested additional audit topics.

- Received a report which outlined the progress made against the Trust's Suicide Prevention Plan, and an overview of self-harm across the Trust and how this was currently being managed. It agreed that it was assured on the progress made against the Trust's Suicide Prevention Plan.

  It expressed concern that there was not a consistent Trustwide approach to the management of self-harm, but was informed that work had begun to create overarching Trustwide principles that could be interpreted based on service requirements. The Committee acknowledged that the changes to Trust estates could be disruptive for service users and could have an impact on the number of self-harm incidents that take place. The Committee agreed that where changes were made to services including changes to estates or staffing, the impact on quality and safety from a service user perspective should be considered. Mrs Forster Adams agreed to feedback to the Committee on how the Trust would approach this.

Report completed by:	Professor John Baker 19 March 2020

AGENDA ITEM
10

Chair's Report

Name of the meeting being reported on:	Workforce Committee
Date your meeting took place:	20 February 2020
Name of meeting reporting to:	Board of Directors – 26 March 2020

Key discussion points and matters to be escalated:

At the Workforce Committee meeting that took place on the 20 February 2020, the Committee:

- Discussed the Workforce Performance Report and was informed about the work of the Bank Department to reduce agency spend, in line with the NHSI/E recommendations for agency use, through collaborative cluster contracting, targeting transitioning of agency staff and challenging off-framework engagements.

- Received an update from the Health and Wellbeing Manager on her activity since joining the Trust in December 2019. The Committee discussed the influence of the workplace environment on the health and wellbeing of staff and agreed that a prompt should be added to the feedback form that is completed by Non-executive Directors and Governors during service visits. It agreed the importance of considering workforce when designing, procuring or commissioning services.

- Received an update about the development of the Trust's Strategic People Plan and the timescales for its comprehensive consultation process. It noted that it would return to the Workforce Committee in April 2020 and June 2020, and that it would be presented to the Board of Directors for ratification at its meeting on the 30 July 2020.

- Welcomed an update on the development of a Trustwide reciprocal mentoring programme and noted that the proposed implementation date for this was July 2020.

- Had a strategic discussion around equality, diversity and inclusion and helped to influence the key priority areas for the Trust's future organisational approach to equality, diversity and inclusion.

Report completed by:	Helen Grantham 27 February 2020

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
11

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Combined Quality and Performance Report
DATE OF MEETING:	26 March 2020
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 OD & Workforce Dawn Hanwell – Chief Finance Officer and Deputy Chief Executive Nikki Cooper – Head of Performance Management and Informatics

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 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: March 2020 (reporting February 2020 data, unless otherwise specified)

NHS
Leeds and York Partnership
NHS Foundation Trust

Introduction

Key themes to consider this month: ***Unless otherwise specified, all data is for February 2020***

Consistency and improvement:

During February, a number of services achieved their access standard / target including the percentage of people seen or visited at least 5 times within the first week of receiving CRISS support, Liaison In-Reach attemped assessment within 24 hours, the 2 week referral to treatment standard for early intervention in psychosis/at risk mental state and the percentage of referrals seen (face to face) within 15 days by a community mental health team. Consistency remains key as a range of metrics fluctuate just above and below their targets.

The need to use placements out of area continues with long lengths of stay and delayed transfers of care impacting on the flow within our inpatient setting.

Workforce:

Staff are working hard together to be as prepared as possible for what is likely to be a significant impact from Coronavirus over the coming weeks and months. The Trust is working its way through national measures and guidance, our priority being to keep all staff, service users and those who need our support as safe and well as can be. Planning and coordination arrangements are in place to ensure that the Trust maintains safe service delivery and resilience as far as possible into the future. Local infection prevention experts continue to support other staff in the organisation, and are working alongside colleagues in other organisations. The Trust continues to collaborate and work closely with other providers of care and support across Leeds, West Yorkshire and beyond.

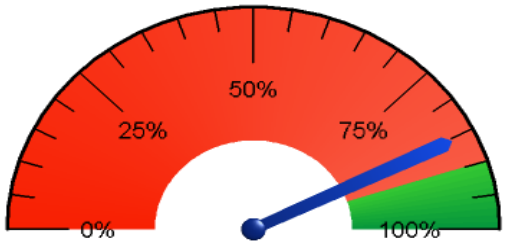
The Trust recognises that it supports some of the most vulnerable people in society and our care for them and for each other will continue to be vital. Taking time to plan and respond is crucial too, so the Trust will be aiming to work in a way that recognises the significant impact of responding to the coronavirus challenge.

Work in Progress:

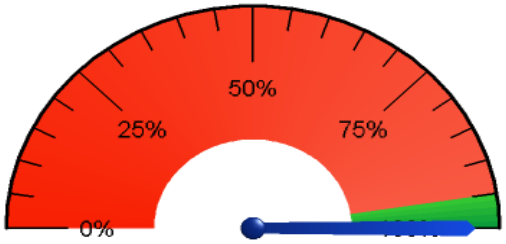
At the end of March, the Trust is scheduled to go-live with it's new electronic patient record system, CareDirector. Staff have welcomed the CareDirector 'familiarisation period' that began at the beginning of March, making the most of the opportunity to get to grips with the system and test out the functions available. Additionally, a series of 'How to Guides' and 'Step-by-Step' videos have been made available to help staff, with further drop in sessions planned in the run up to go-live. This is a significant change for all staff with some tangible benefits such as mobile working. However, as with any new system, it will require a period of "bedding in" that could impact on the quality of data collected in the initial weeks as staff familiarise themselves.

Our Service Performance

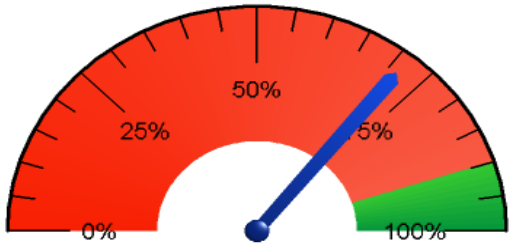
Access & Responsiveness: Our response in a Crisis



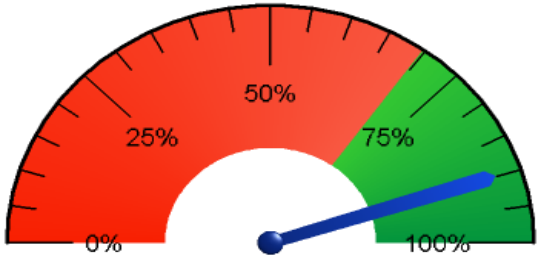
Percentage with timely access to a MH assessment by the ALPs team in the LTHT Emergency Department (1 hour)



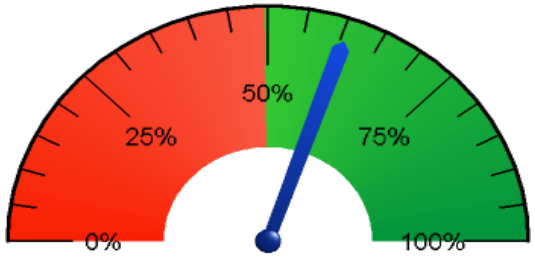
Percentage of admissions to inpatient services that had access to crisis resolution / home treatment teams



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



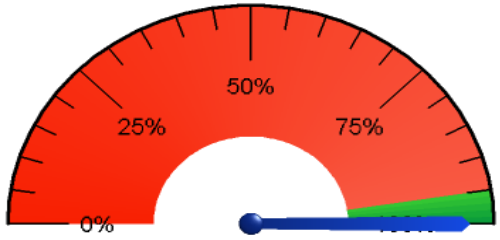
Percentage of service users who have stayed on CRISS caseload for less than 6 weeks



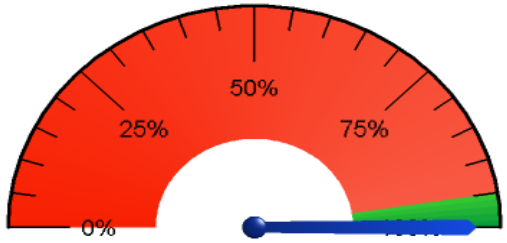
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support

Our Service Performance

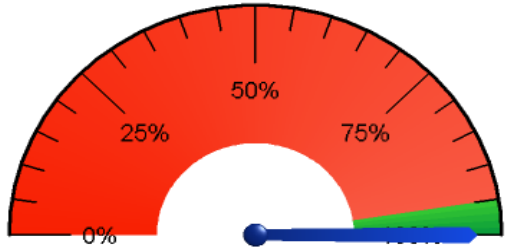
Our Specialist Services



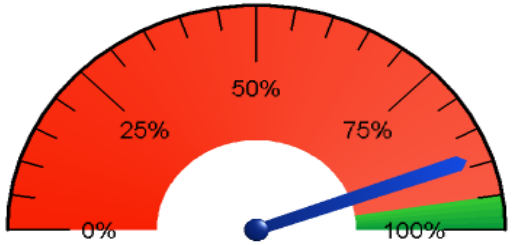
CAMHS inpatients: Honosca & CGAS: % completed at admission (quarterly) Q3



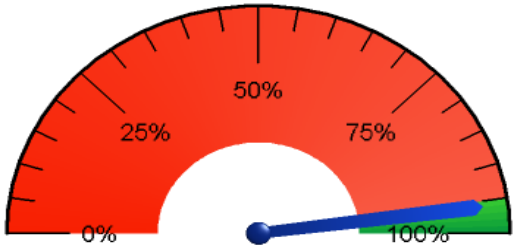
CAMHS inpatients: Honosca & CGAS: % completed at discharge (quarterly) Q3



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



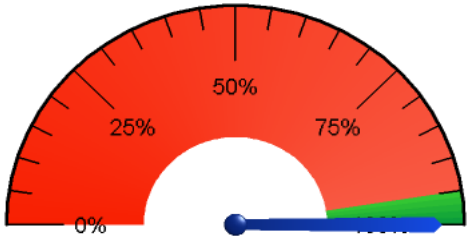
Forensics: HCR20 & HoNOS Secure: Percentage completed (LOS greater than 9 months) (quarterly) Q3



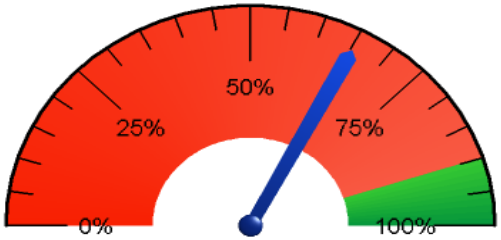
Leeds Autism Diagnostic Service (LADS): Percentage starting their assessment within 13 weeks of referral

Our Service Performance

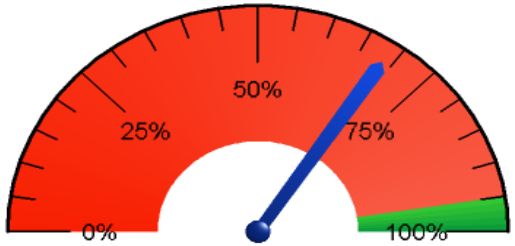
Our Specialist Services Continued



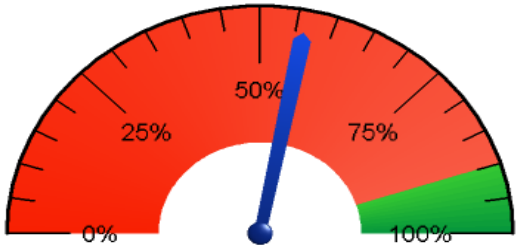
Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency) Q3



Perinatal Community: Percentage waiting less than 2 weeks for first contact (routine) Q3



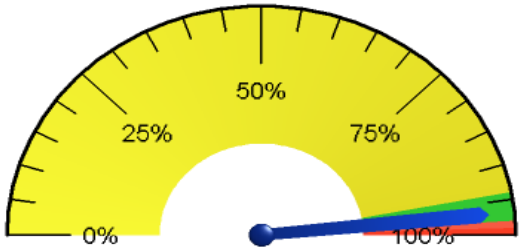
Community LD: Percentage of referrals seen within 4 weeks



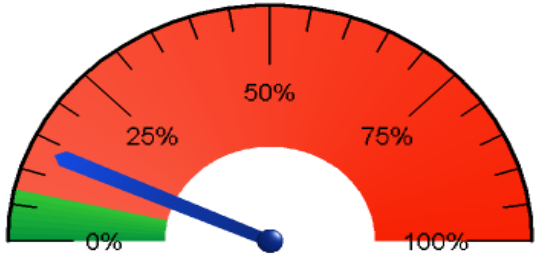
Community LD: Care plans reviewed within the previous 12 months

Our Service Performance

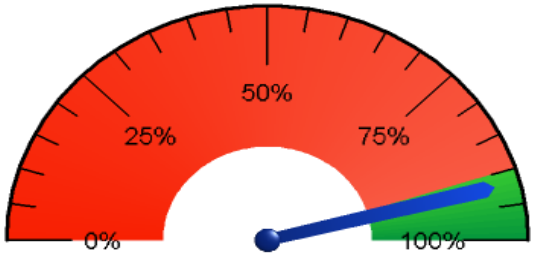
Our Acute Patient Journey



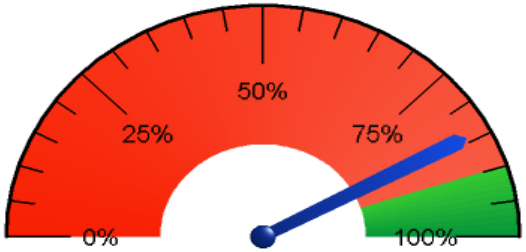
Bed Occupancy rates for (adult acute) inpatient services



Percentage of Delayed Transfers of Care



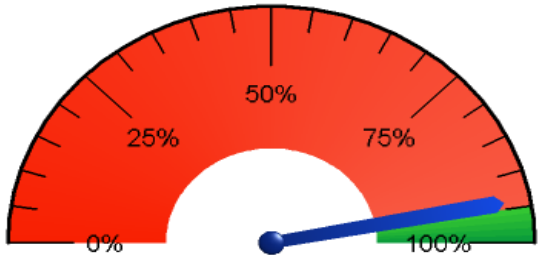
Liaison In-Reach: attempted assessment within 24 hours



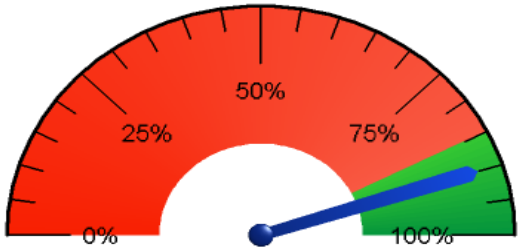
Cardio Metabolic (Physical health) Assessment completed (Current SMI inpatients) Q3

Our Service Performance

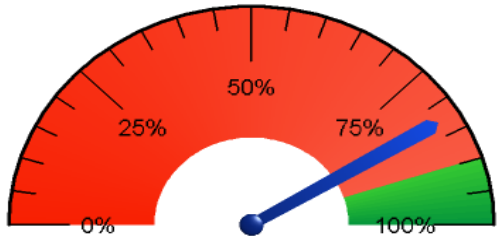
Our Community Care



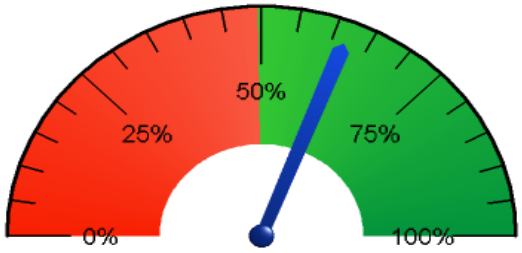
Percentage of inpatients followed up within 7 days of discharge



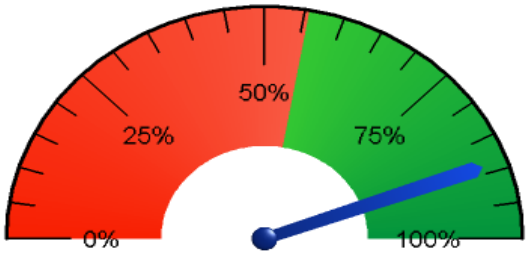
Percentage of referrals seen (face to face) within 15 days of receipt of referral to a community mental health team



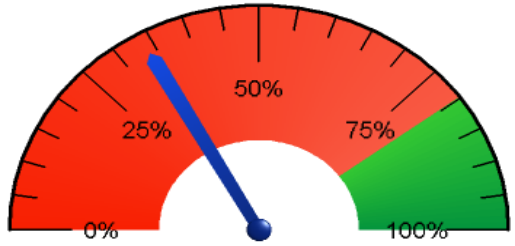
Waiting Times Access to Memory Services; Referral to first Face to Face Contact within 8 weeks Q4 to date



Memory Services – Time from Referral to Diagnosis within 12 weeks Q4 to date



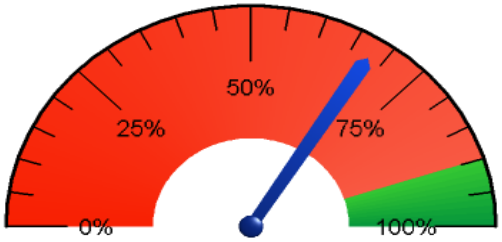
EIP 2 week wait to start NICE-recommended package of care



Cardio Metabolic (Physical health) Assessment completed (SMI community caseload) Q3

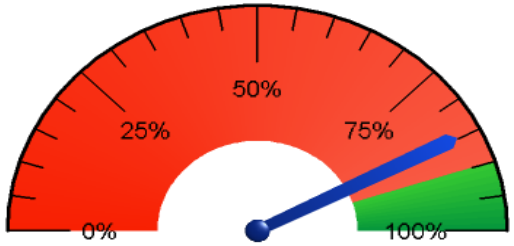
Our Service Performance

Our Community Care Continued

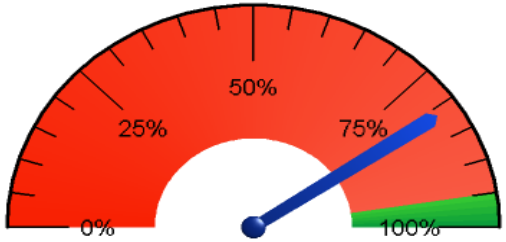


Cardio Metabolic (Physical health) Assessment completed (Early Intervention in Psychosis) Q3

Clinical Record Keeping: Mandated requirements

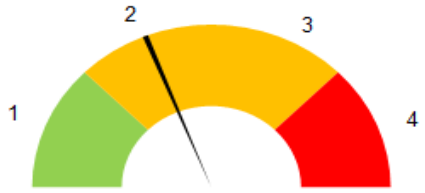


Proportion of in scope patients assigned to a cluster



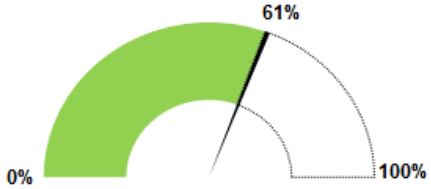
Percentage of Care Programme Approach Formal Reviews within 12 months

Finance - February data

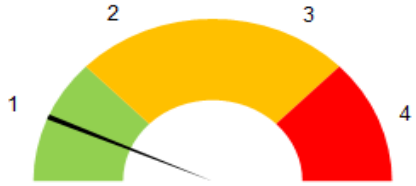


Single Oversight Framework – Finance Score

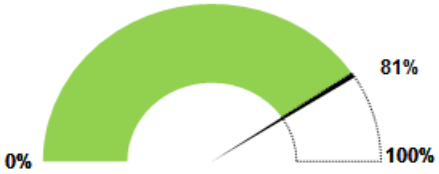
Income and Expenditure Position (£000s)



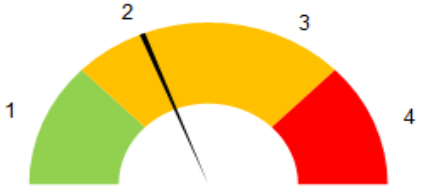
Cost Improvement Programme (£000s)



Cash (£000s)



Capital (£000s)



Agency spend (£000s)

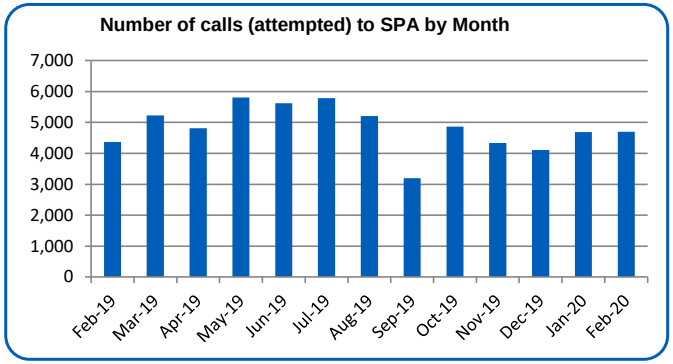
Service Performance – Chief Operating Officer

Services: Access & Responsiveness: Our response in a crisis	Target	Dec-19	Jan-20	Feb-20
Percentage of crisis calls (via the single point of access) answered within 1 minute	-	71.0%	68.2%	60.1%
Percentage of admissions gatekept by the crisis teams	95%	98.8%	98.9%	100.0%
Percentage of ALPS referrals responded to within 1 hour	90%	89.0%	84.2%	85.4%
Percentage of S136 referrals assessed within 3 hours of arrival	-	21.6%	20.7%	17.0%
Percentage of appropriate crisis referrals offered a face to face assessment within 4 hours of referral	Q3/4 90%	70.8%	76.3%	71.4%
Percentage of service users who stayed on CRISS caseload for less than 6 weeks	70%	88.7%	89.4%	89.9%
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support	50%	47.9%	52.7%	60.5%
Services: Our Specialist Services	**Target**	**Dec-19**	**Jan-20**	**Feb-20**
Gender Identity Service: Median wait for those currently on the waiting list (weeks)	-	54.1	54.8	57.1
Gender Identity Service: Number on waiting list	-	1,979	2,011	2,068
Leeds Autism Diagnostic Service (LADS): Percentage starting assessment within 13 weeks	95%	100%	92%	95.8%
CAMHS inpatients: Honosca & CGAS: % completed at admission (quarterly)	95%	100%	-	-
CAMHS inpatients: Honosca & CGAS: % completed at discharge (quarterly)	95%	100%	-	-
Deaf CAMHS: average wait from referral to first face to face contact in days (monthly)	-	40.4	59.6	70.0
Forensics: HCR20: Percentage completed within 3 months of admission (quarterly)	95%	100%	-	-
Forensics: HCR20 & HoNOS Secure: Percentage completed (LOS greater than 9 months) (quarterly)	95%	88.9%	-	-
Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency) (quarterly)	Q3 95% Q4 97%	100%	-	-
Perinatal Community: Percentage waiting less than 2 weeks for first contact (routine) (quarterly)	Q3 90% Q4 95%	65.3%	-	-
Perinatal Outreach: Average wait from referral to first contact (all urgencies) (quarterly)	-	23.4	-	-
Perinatal: Number of new women supported versus trajectory (quarterly; LCCG only)	129	74	-	-
Perinatal: Total number of women supported (quarterly; LCCG only)	-	182	-	-
Community LD: Percentage of referrals seen within 4 weeks of receipt of referral	Q3 90% Q4 95%	84.6%	61.9%	68.6%
Community LD: Percentage of Care Plans reviewed within the previous 12 months	90%	58.0%	59.7%	57.3%
Services: Our acute patient journey	**Target**	**Dec-19**	**Jan-20**	**Feb-20**
Number of admissions to adult facilities of patients who are under 16 years old	-	0	0	0
Crisis Assessment Unit (CAU) bed occupancy	-	83.3%	74.2%	93.1%
Crisis Assessment Unit (CAU) length of stay at discharge	-	8.1	6.6	11.6
Liaison In-Reach: attempted assessment within 24 hours	90%	84.7%	84.6%	91.9%
Bed Occupancy rates for (adult acute excluding PICU) inpatient services:	94-98%	99.3%	97.9%	96.8%
• Becklin – ward 1 (female)	-	100.7%	96.9%	101.9%
• Becklin – ward 3 (male)	-	99.0%	99.6%	95.5%
• Becklin – ward 4 (male)	-	98.4%	98.4%	95.5%
• Becklin – ward 5 (female)	-	99.3%	99.7%	99.1%
• Newsam – ward 4 (male)	-	99.2%	94.8%	92.0%
• Older adult (total)	-	78.9%	87.1%	92.2%
• The Mount – ward 1 (male dementia)	-	86.3%	89.8%	89.2%
• The Mount – ward 2 (female dementia)	-	71.0%	91.2%	95.6%
• The Mount – ward 3 (male)	-	53.6%	66.5%	81.6%
• The Mount – ward 4 (female)	-	103.8%	103.4%	102.6%

Service Performance – Chief Operating Officer

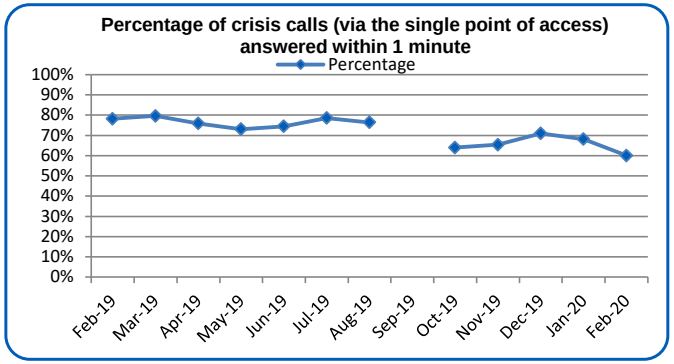
Services: Our acute patient journey	Target	Dec-19	Jan-20	Feb-20
Percentage of delayed transfers of care	<7.5%	13.3%	13.1%	13.7%
Number of out of area placement bed days versus trajectory (in days: cumulative per quarter)	-	217	-141	280
Acute: Number of out of area placements beginning in month	-	12	11	12
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	220	237	301
PICU: Number of out of area placements beginning in month	-	5	11	8
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	26	118	91
Older people: Number of out of area placements beginning in month	-	1	1	1
Older people: Total number of bed days out of area (new & existing placements from previous months)	-	1	8	29
Cardiometabolic (physical health) assessments completed: Inpatients (quarterly)	90%	84.3%	-	-
Services: Our community care	**Target**	**Dec-19**	**Jan-20**	**Feb-20**
Percentage of inpatients followed up within 7 days of discharge	-	91.2%	92.8%	94.0%
Percentage of inpatients followed up within 7 days of discharge (quarterly data)	95%	91.2%	-	-
Percentage of inpatients followed up within 3 days of discharge	-	70.8%	81.1%	77.1%
Number of service users in community mental health team care (caseload)	-	4,773	4,754	4,701
Percentage of referrals seen (face to face) w/in 15 days by a community mental health team	85%	83.2%	83.2%	89.6%
Percentage of referrals to memory services seen (face to face) within 8 weeks (quarter to date)	90%	81.9%	79.5%	82.1%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50%	70.4%	58.0%	59.2%
Early intervention in psychosis (EIP) or at risk mental state (ARMS): Percentage starting treatment within 2 weeks	56%	80.0%	70.4%	88.9%
Cardiometabolic (physical health) assessments completed: Community Mental Health (patients on CPA) (quarterly)	80%	33.9%	-	-
Cardiometabolic (physical health) assessments completed: Early Intervention in Psychosis Service (quarterly)	90%	67.8%	-	-
Services: Clinical Record Keeping	**Target**	**Dec-19**	**Jan-20**	**Feb-20**
Data Quality Maturity Index for the Mental Health Services Dataset (MHSDS) - revised specification from April onwards	95%	SEP 81.1%	OCT 80.9%	NOV 81.3%
Percentage of service users with ethnicity recorded	-	83.3%	82.5%	82.7%
Percentage of service users with sexual orientation recorded	-	22.1%	23.1%	23.6%
Percentage of in scope patients assigned to a mental health cluster	90%	84.8%	84.2%	85.0%
Percentage of Care Programme Approach Formal Reviews within 12 months	95%	85.0%	82.7%	81.7%
Timely Communication with GPs: Percentage notified in 7 days (CPA Care Plans only) (quarter to date)	80%	40.0%	39.8%	43.0%
Timely Communication with GPs: Percentage notified in 24 hours (inpatient discharges only) (quarter to date)	80%	0.6%	0.0%	0.0%

Services: Access & Responsiveness: Our response in a crisis



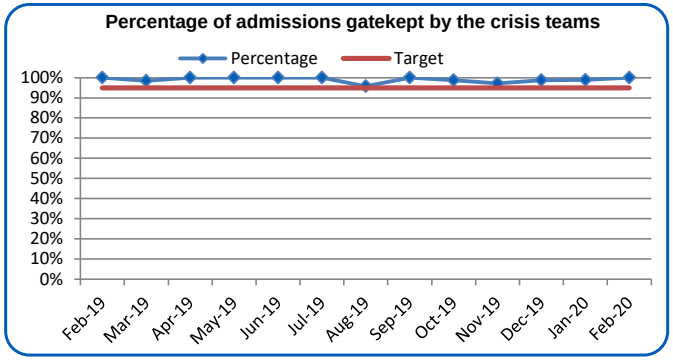
Feb calls: 4,694

Data from only 12th - 30th Sep due to system migration

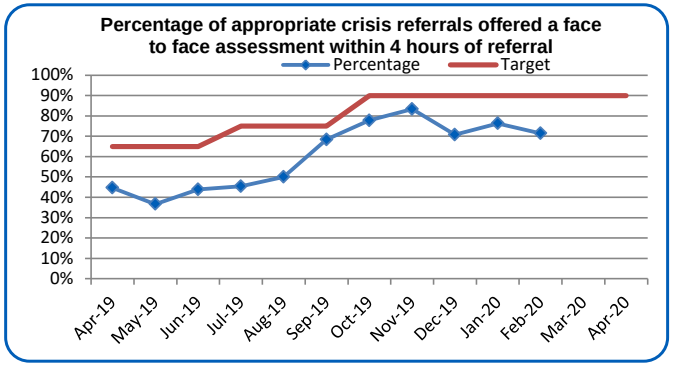


Local target: within 1 minute: Feb: 60%

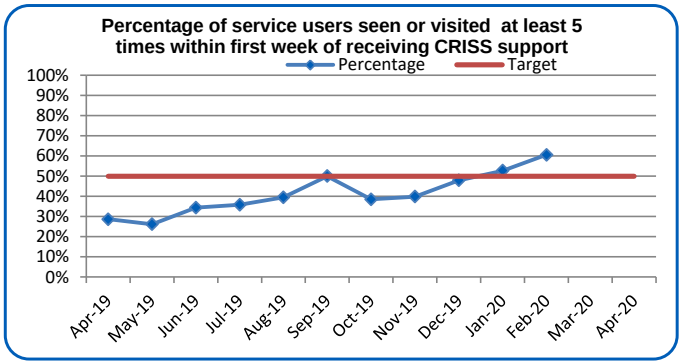
Data for Sept n/a due to system migration



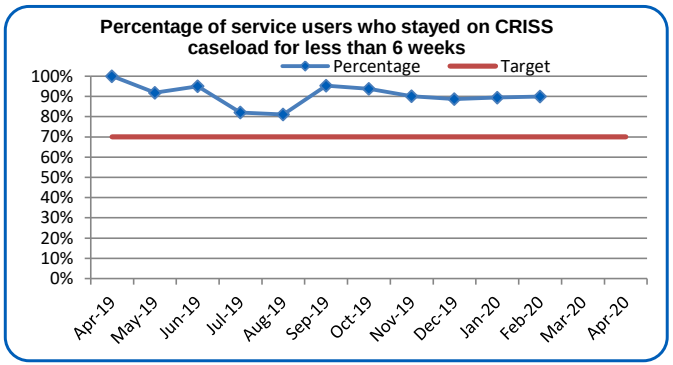
Local target: 95%: Feb: 100%



Contractual target Q4: 90% Feb: 71.4%

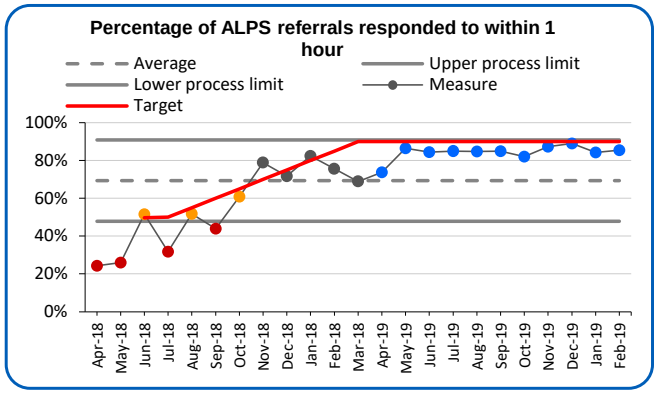


Contractual target: 50%: Feb: 60.5%

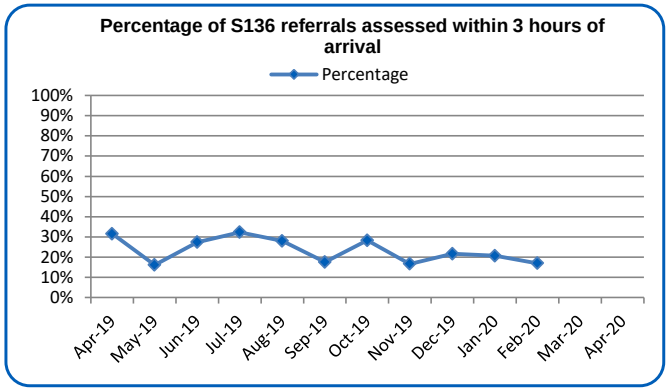


Contractual target: 70%: Feb: 89.9%

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



Contractual target: 90%: Feb: 85.4%



Contractual measure: Feb: 17%

Services: Access & Responsiveness: Our response in a crisis

Performance against the 1 hour response target for the Acute Liaison Psychiatry service (ALPs) remains consistent (above 80%) but just below the 90% threshold. In February, performance was 85% with over 230 people seen in month, in line with the monthly average year to date of 229. The 90% target was met at the St James's site but not the Leeds General Infirmary (LGI) where fewer staff are based and demand is generally lower; (only 26% of referrals responded to were at the LGI).

Actions taken/to be taken: During February, the team reviewed all breaches of 1 hour for January and found a number of recording issues negatively impacting on the data; data quality will remain a focus for the team.

Within the Crisis Resolution and Intensive Support Service (CRISS), the team continue to be committed to achieving the Core Fidelity standards. Significant improvement has been seen since the redesign of the service where the team were 7% compliant. Indications are the team have moved to 60% compliant with a further audit planned for April/May. A positive for this month is that the CRISS service aims to provide face to face contact 5 times in the first week of referral in line with Core Fidelity standard 38 for at least 50% of referrals, in February this was 60.5%, our highest performance year to date and representing an upward trend for the 4th consecutive month.

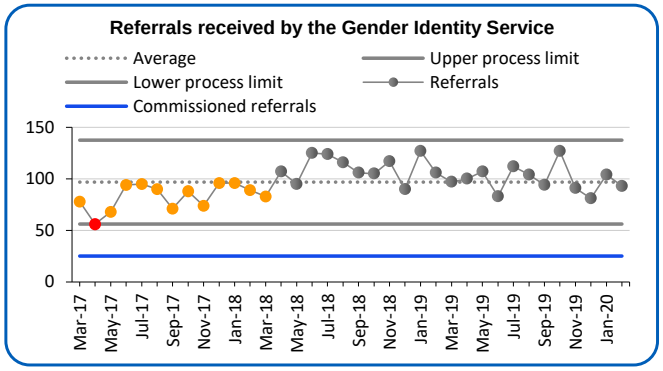
Actions taken/ to be taken: Undertake the audit against Core Fidelity Standards in April / May. Continue to ensure that anyone with a RED rating is seen face to face each day.

Core Fidelity Standard 1 relates to timely access to the CRISS service (within 4 hours for emergency referrals). Data quality issues with reporting the referral priority (emergency/urgent/routine) have hampered understanding performance previously but this has improved with all issues being followed up with individual clinicians. Through January and into February, staff sickness was a concern and the service is actively recruiting over establishment to compensate for this. The Trust, as part of contract negotiations, is in the process of agreeing a trajectory for next year that would see performance remaining above 70% and moving towards 90% by March 2020.

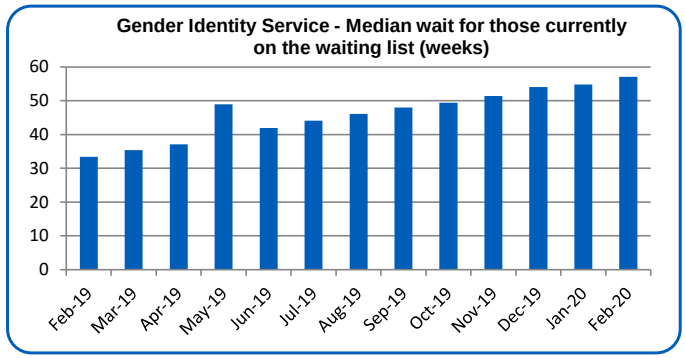
Actions taken/ to be taken: Complete recruitment and confirm an agreed performance trajectory for 2020/21 with Leeds CCG.

Within the CRISS service, improvement work and evaluation of the service as part of the community redesign is ongoing. For example, the service are in the early stages working with CMHTs and the acute inpatient team in the avoidance of admission and early discharge of service users. This coming year will see a joined up approach to this work within the acute care excellence (ACE) forum. The CRISS operational manager and the clinical director are leading on the ACE pre-admission work stream.

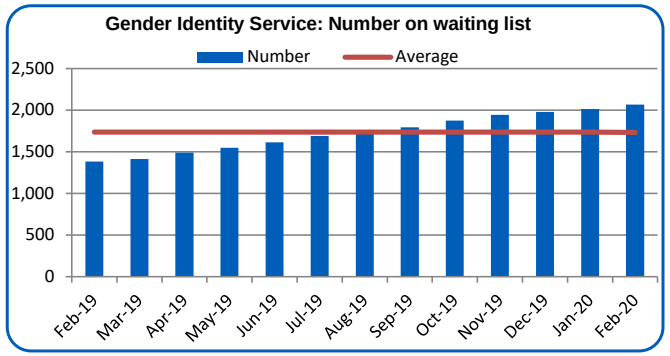
Services: Our Specialist Services



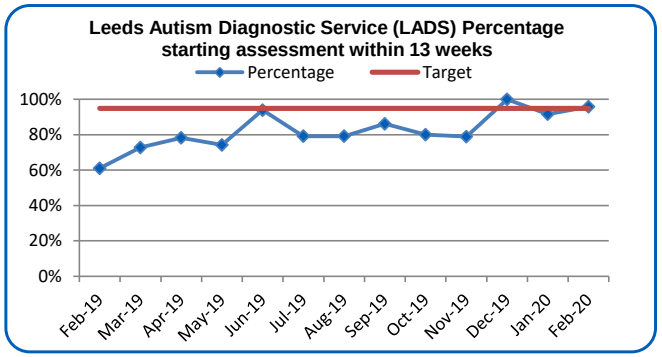
Total referrals: Feb: 93



Median wait: Feb: 57 weeks

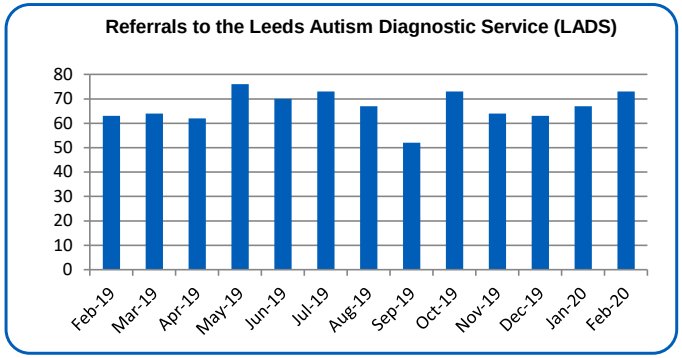


Number on waiting list: Feb: 2,068

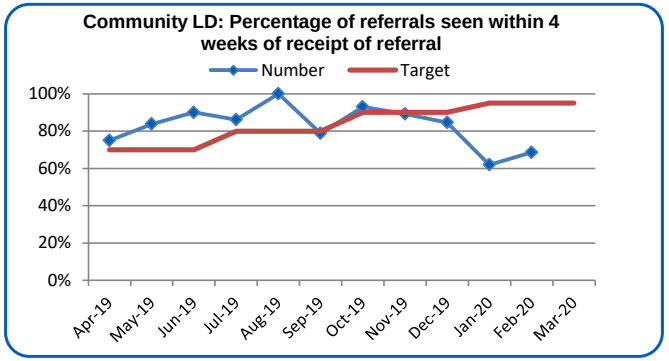


Contractual target: 95%*: Feb: 95.8%

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

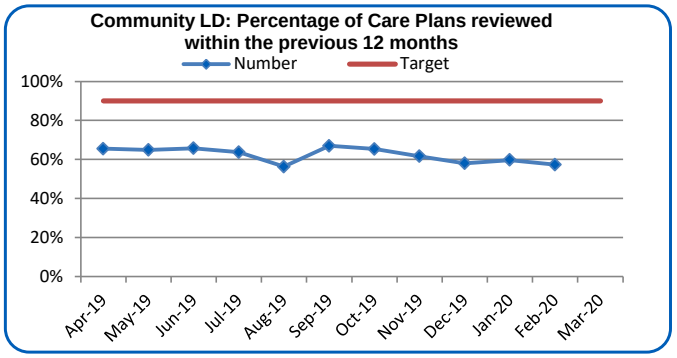


Local measure: Feb: 73

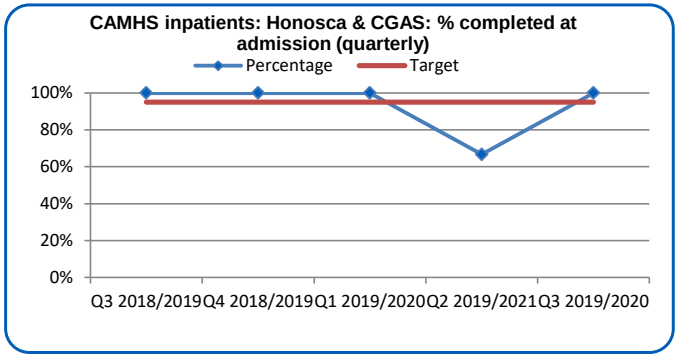


Contractual target: Q4 95%: Feb: 68.6%

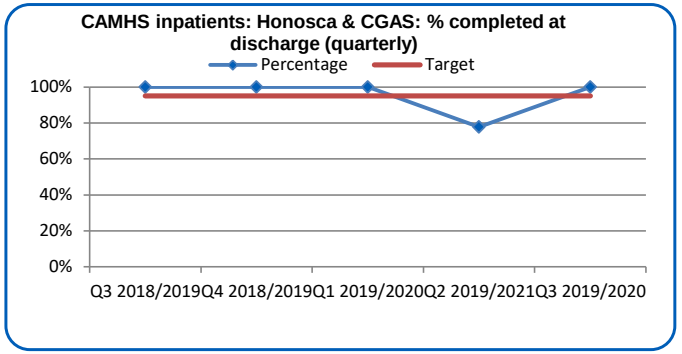
Services: Our Specialist Services continued



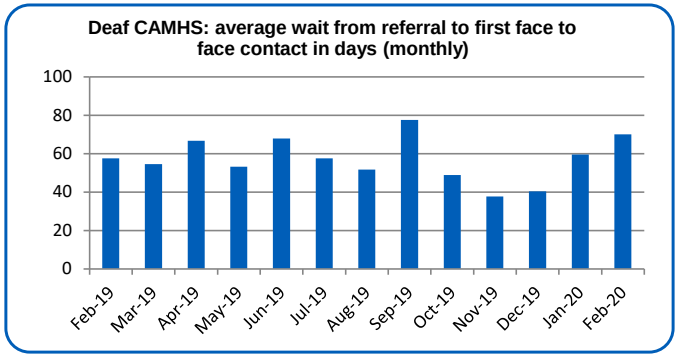
Contractual target: 90%: Feb: 57.3%



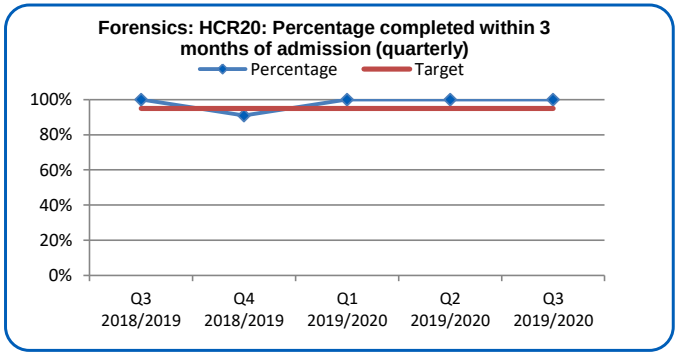
Contractual target: 95%: 2019/2020 Q3: 100%
(not met for 2 service users in Q2)



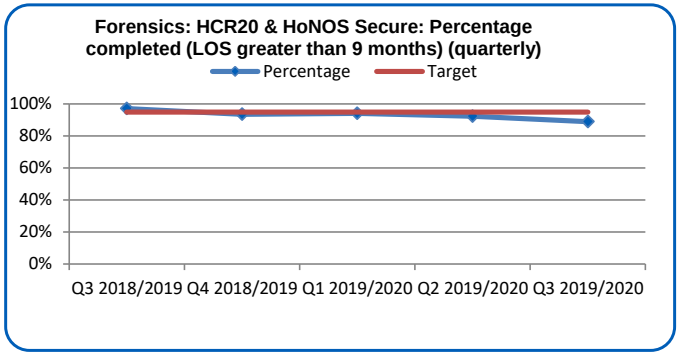
Contractual target: 95%: 2019/2020 Q3: 100%
(not met for 2 service users in Q2)



Local measure: Feb: 70 days

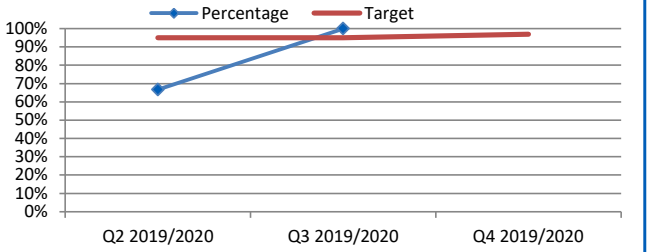


Contractual target: 95%: 2019/2020 Q3: 100%

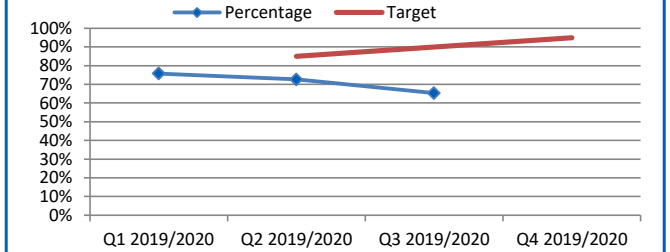


Contractual target: 95%: 2019/2020 Q3: 88.9%
(not met for 2 service users in Q1, 3 in Q2 and 4 in Q3)

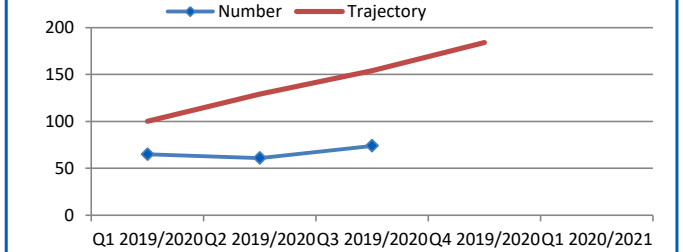
Services: Our Specialist Services continued



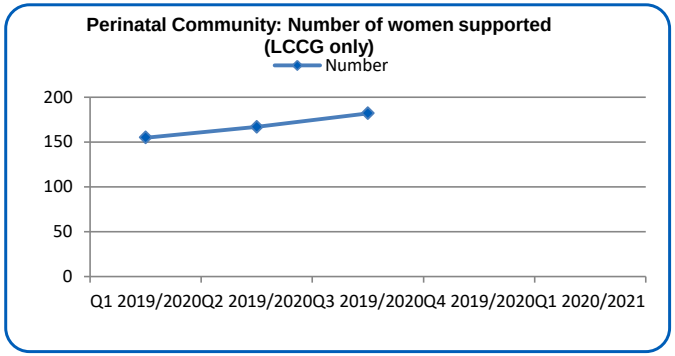
Contractual Target: 95% in Q3 > 97% in Q4, Q3:100%
(Not met for 1 service user in Q2)



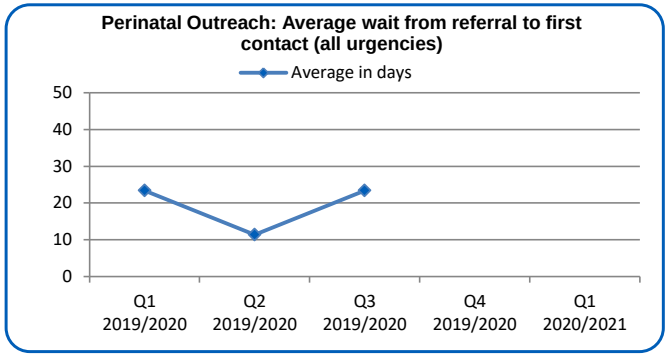
Contractual Target: 90% in Q3 > 95% in Q4, Q3: 65.3%



Contractual target: Q3 Trajectory: : Q3: 74



Local measure: Q3: 182



Local measure: Q3: 23.4 days

Services: Our Specialist Services

In order to achieve the Leeds Autism Diagnostic Service target of 95% starting assessment within 13 weeks, referral numbers usually allow for only 1 breach of the target. Performance has been strong for the last 3 months with no breaches in December, 3 in January and 1 in February but remaining consistently above 95% continues to be challenging.

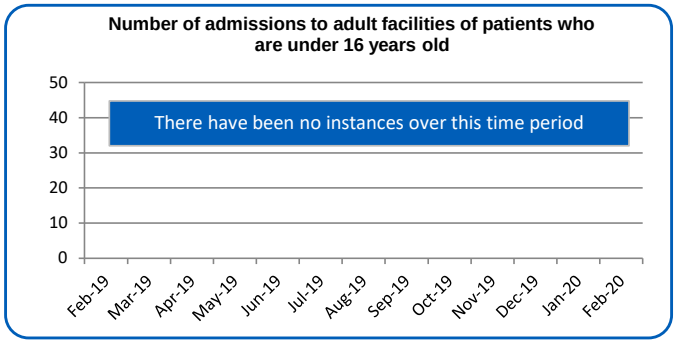
The Community Learning Disability Team (CLDT) has a contractual target of 90% of referrals to be seen within 4 weeks of referral. Analysis of the breaches of 4 weeks has previously shown a mixture of visits being recorded in case notes (that then don't register as appointments on the system) or service user/carer choice.

Actions taken / to be taken: Recording continues to be addressed in Clinical Team Manager and Clinical lead meetings but should also see improvement as part of the move to the new electronic patient record system, CareDirector, where all contacts should be recorded in the health diary.

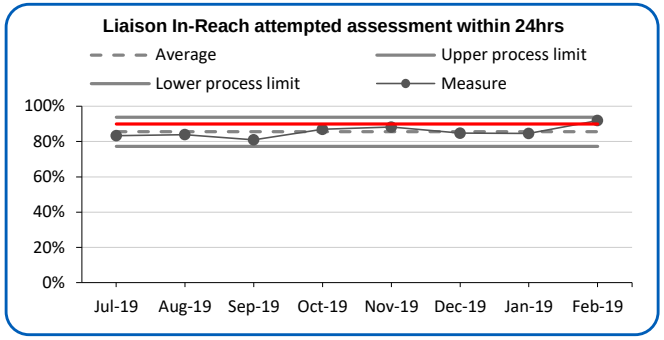
The CLDT is also monitored contractually for ensuring that all care plans are reviewed within each 12 month period. The team manager has been reviewing breaches to understand the reasons behind them. In some cases, the service user has had an open referral with another team (sometimes including other LD teams) within the organisation for over 12 months so whilst the service user has not been with the CLDT for over 12 months, a care plan review should have taken place.

Actions taken / to be taken: Improve understanding of the measure and its requirements within the CLDT team.

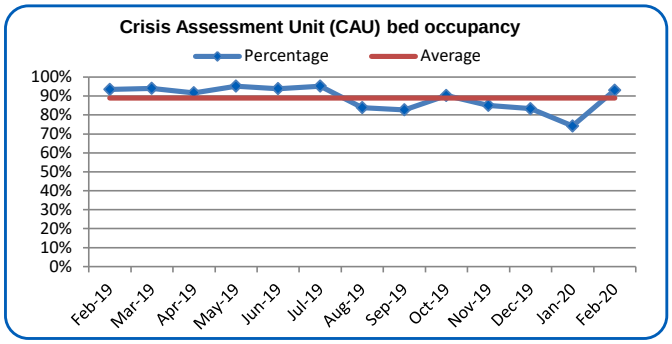
Services: Our acute patient journey



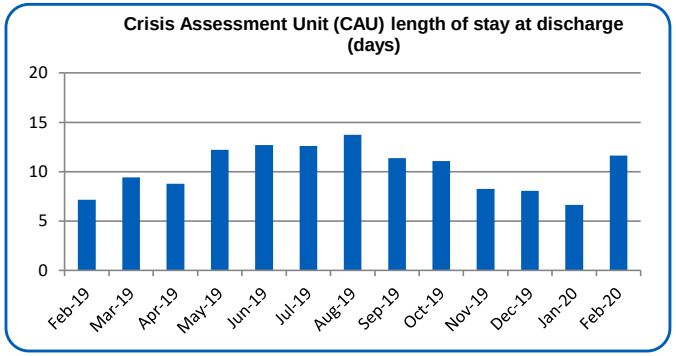
National (SOF): no target: Feb: 0



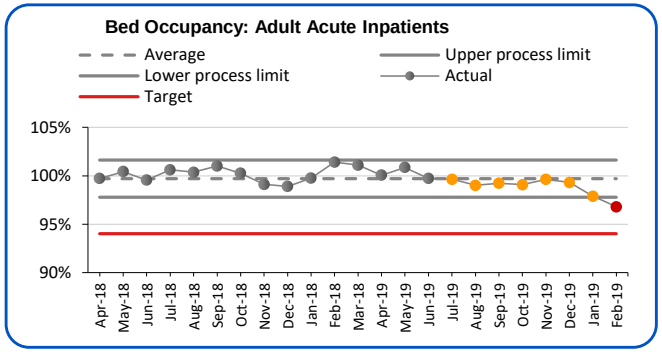
Contractual target: 90%: Feb: 91.9%



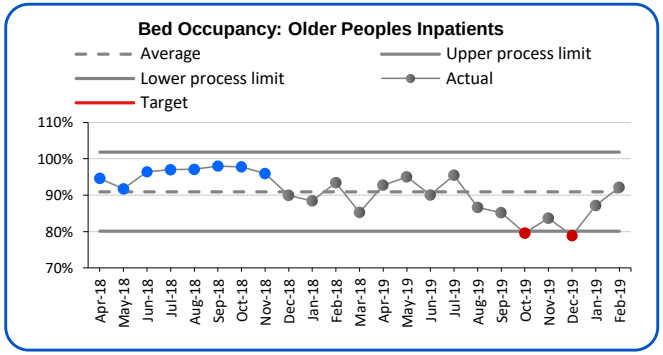
Local measure: Feb: 93.1%



Local measure: Feb: 11.6 days

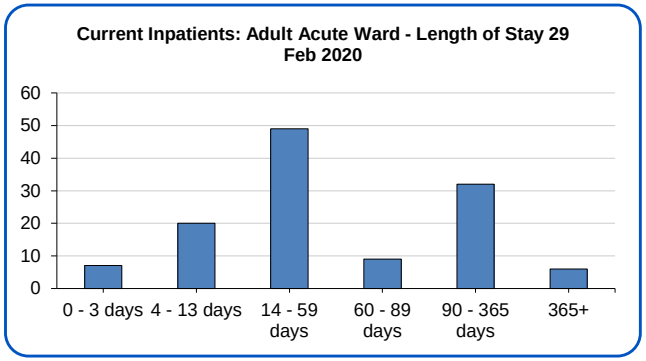


Contractual target: 94-98%: Feb: 96.8%

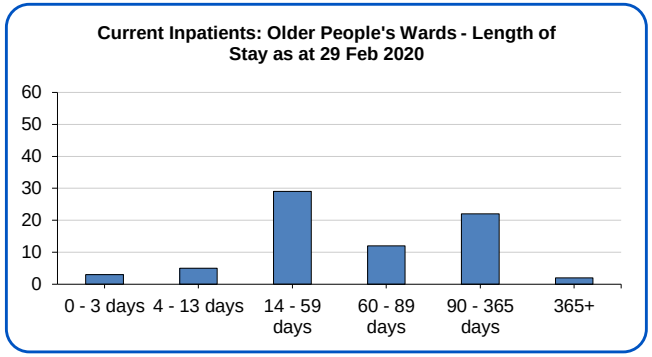


Local measure and target of 85%: Feb: 92.2%

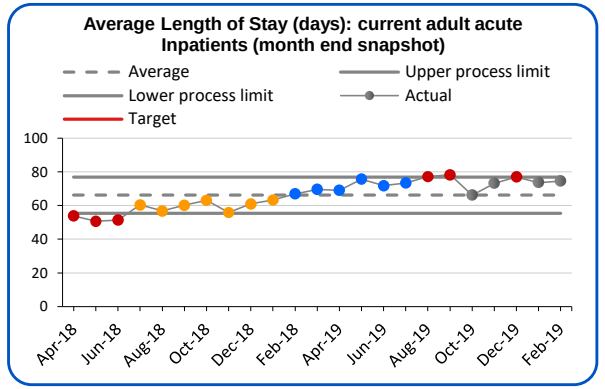
Services: Our acute patient journey continued



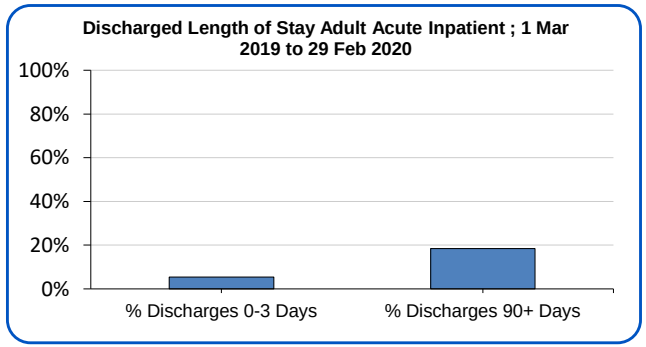
Local activity Feb: 38 people with LOS 90+ days



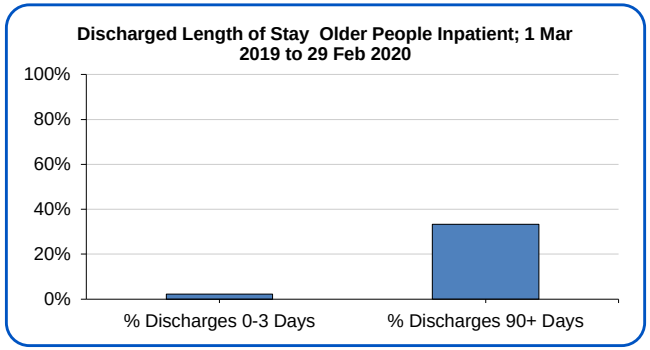
Local activity Feb: 24 people with LOS 90+ days



Local tracking measure: Feb: Average LOS = 74.5 days

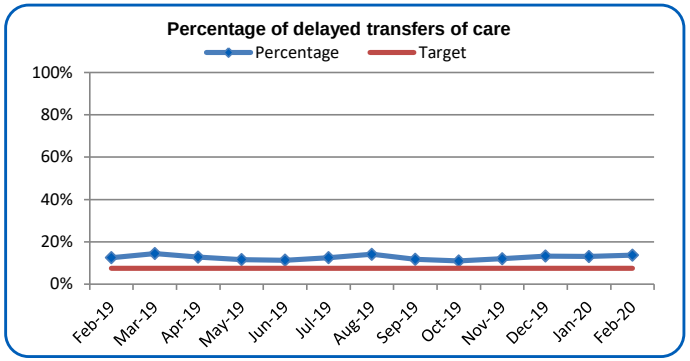


Local activity Feb: % discharged LOS 90+ days = 18%

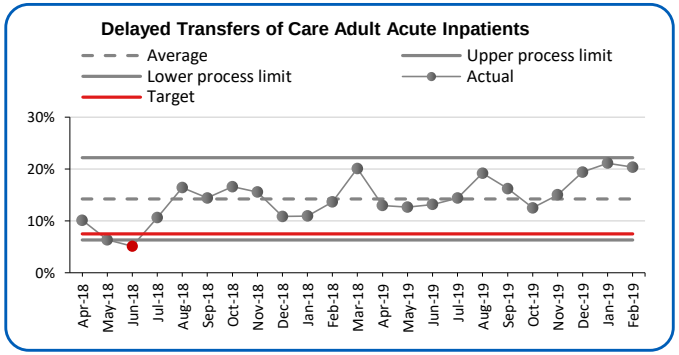


Local activity: Feb: % discharged LOS 90+ days = 33%

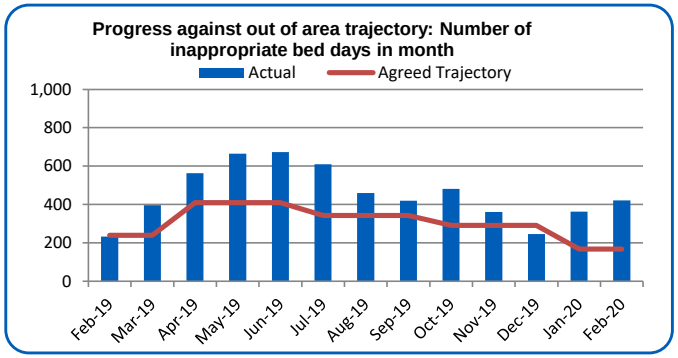
Services: Our acute patient journey continued



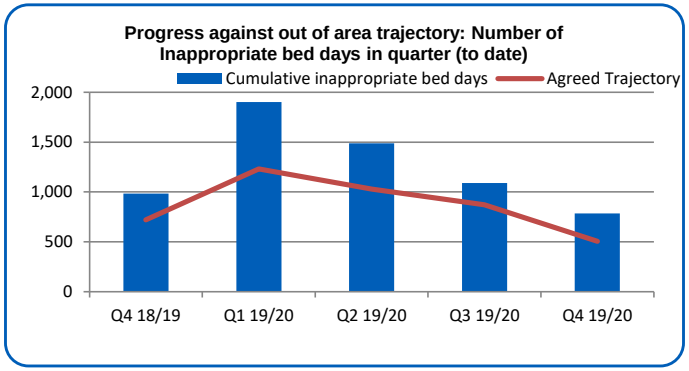
Local target: <7.5%: Feb: 13.7%



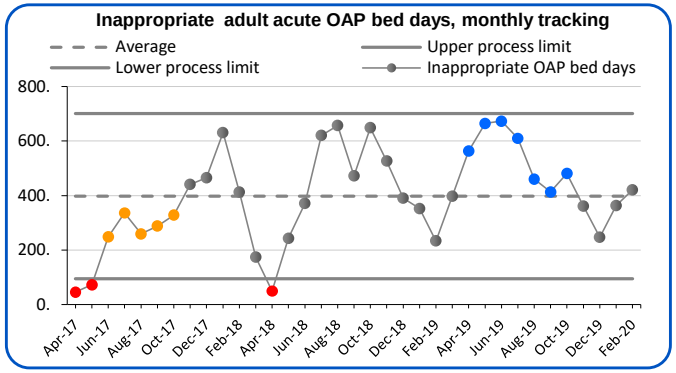
Local target <7.5%: Feb: 20.4%



Nationally agreed trajectory: Feb: 168

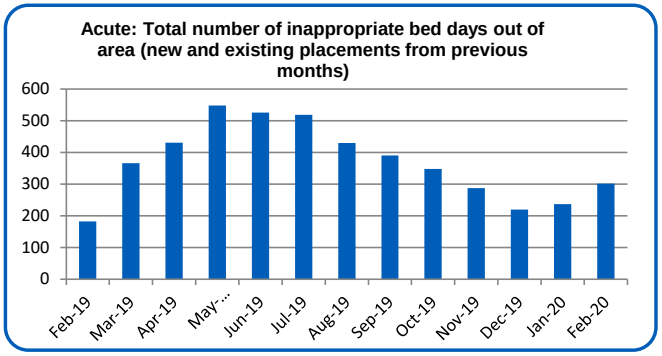


Nationally agreed trajectory (Q4: 504 days): Q4: 784 days

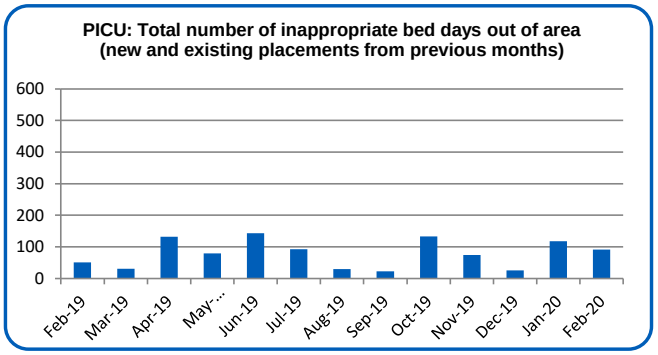


Local tracking measure : Feb: 421 bed days

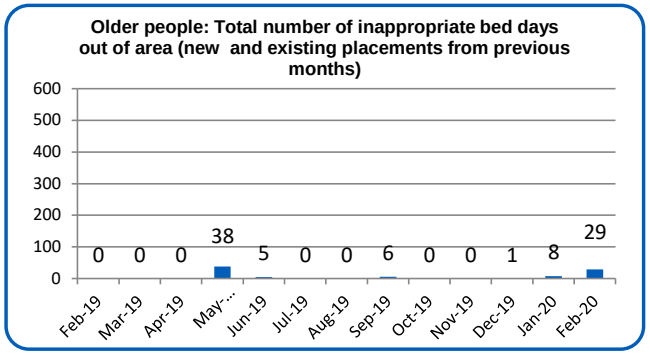
Services: Our acute patient journey continued



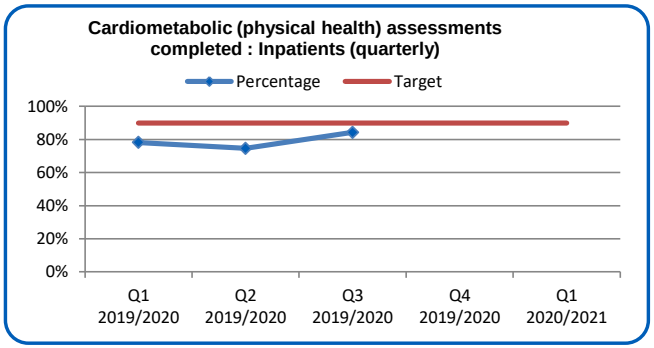
Local measure: Feb: 301 days



Local measure: Feb: 91 days



Local measure: Feb: 29 days



Contractual target: 90%: Q3: 84.3%

Services: Our acute patient journey

The Liaison In-reach team has performed above 80% during the year to date and, in February, in spite of above average referral numbers, achieved the 90% target (at 92%) for the first time since April. However, consistently achieving the target will remain challenging. For example, delays in moving patients to the Mount Hospital (Older People's services) results in an increase in daily reviews for sectioned patients which then has a knock on effect on the team's capacity to see new patients.

Actions taken / to be taken: Continue to monitor performance and available resources.

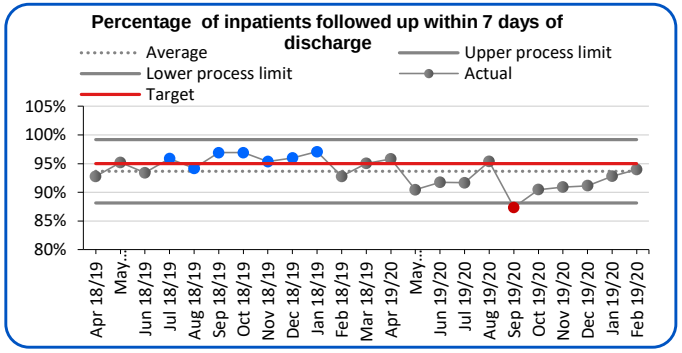
In spite of adult acute bed occupancy dropping into the target range of 94-98% over the last couple of months, pressure remains high in the adult acute service. The average length of stay for those currently on the acute wards at 74.5 days, sits just below our upper process limit but well outside the national average of 32 days described in the Long Term Plan. Nearly 40% of those in an adult acute bed at the end of February had been there for 60 or more days with 6 over 365 days. This is closely linked with a picture of increased delayed transfers of care (DToC). Whilst within expected levels of normal variation for the Trust, delayed discharges for acute adults are high with delays in February the second highest in-month year to date. Housing remains a major contributor to these delayed discharges.

Within Older People's services, the wards aim for the local standard of 85% occupancy. During January and February, occupancy was back within expected levels of normal variation at 92% but higher than optimum levels. Due to the continuing high demand for female beds, ward 3 (male functional) was moved to mixed sex (from mid October), in order to manage demand and avoid out of area placements, and shows a rise in bed occupancy from 54% occupancy in December increased to 82% in February.

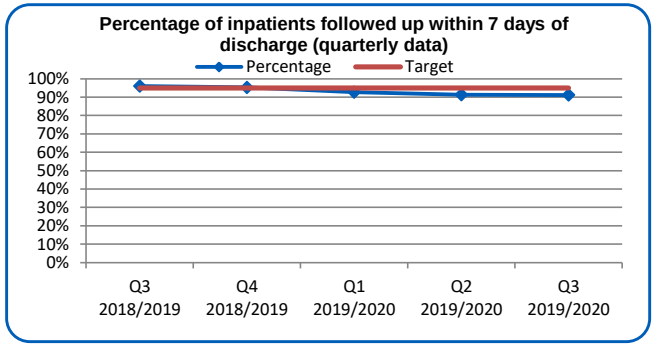
At the end of February, 18 service users remained out of area ranging from 2 to 39 days and the number of inappropriate adult acute out of area bed days rose to just above average for the first time in 4 months. The need to use PICU out of area beds decreased slightly in February with 8 placements starting in month compared with 11 in January and 7 people remaining out of area in a PICU bed at the end of February. There was one new older people's inappropriate out of area placement during February but this was resolved before the end of the month.

Actions taken / to be taken: As part of annual planning, the Trust is currently reviewing assumptions around the inappropriate out of area trajectory for 2020/21 and revising the trajectory in light of the availability of the Crisis House from October 2020 and an increase in supported accommodation places (also from October).

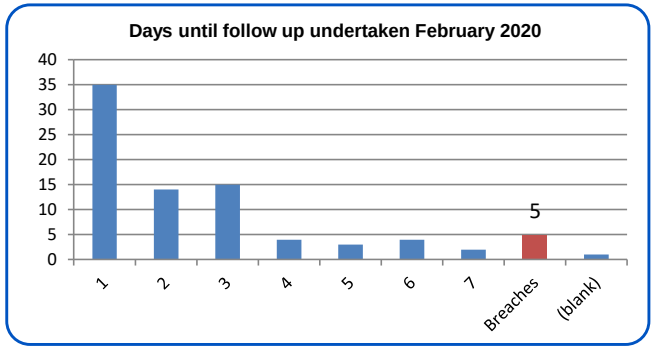
Services: Our community care

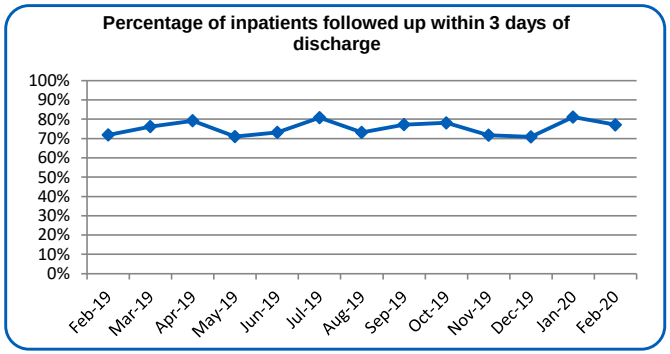


Local monthly target: 95%: Feb: 94%

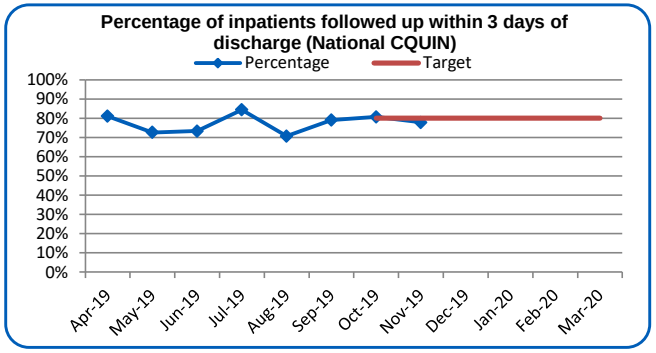


National (SOF) target: 95%: 2019/2020 Q3: 91.2%

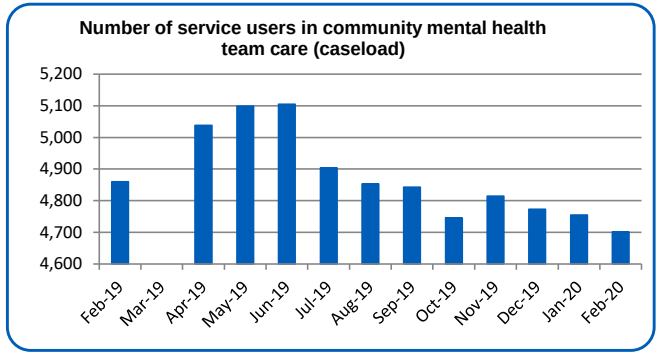




CQUIN target: 80% for Q3&Q4: Feb: 77.1%
NB: This is a proxy local measure

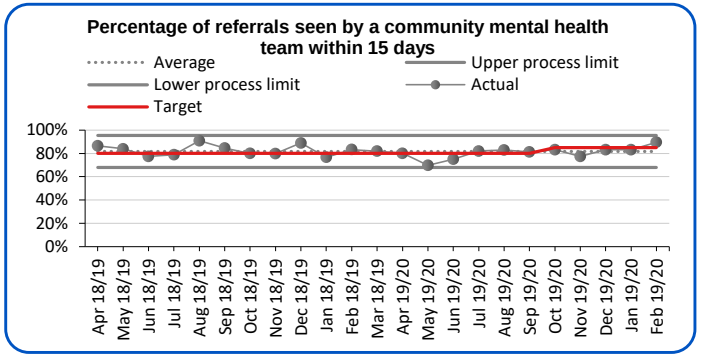


CQUIN target: 80% for Q3&Q4: Nov: 77.8%
NB: This is nationally published data

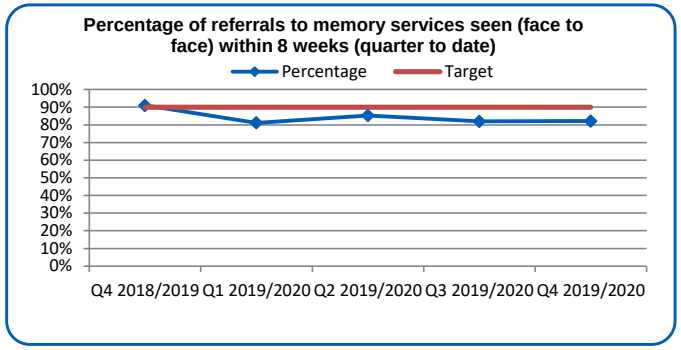


Local measure: Feb: 4,701
Mar: Unavailable due to caseload transfer for new community services

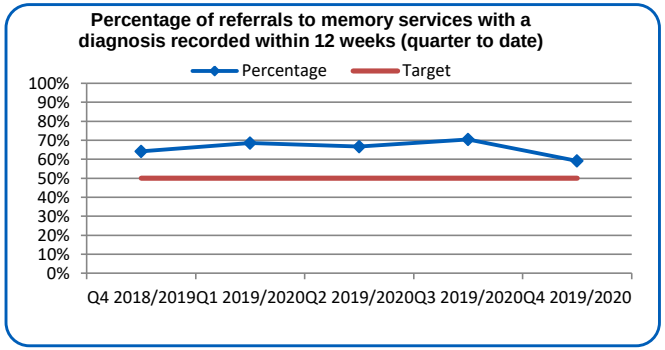
Services: Our community care continued



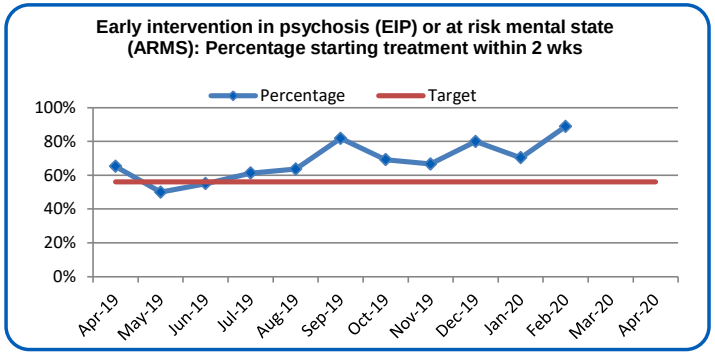
Contractual target: Qtr4 85%: Feb: 89.6%



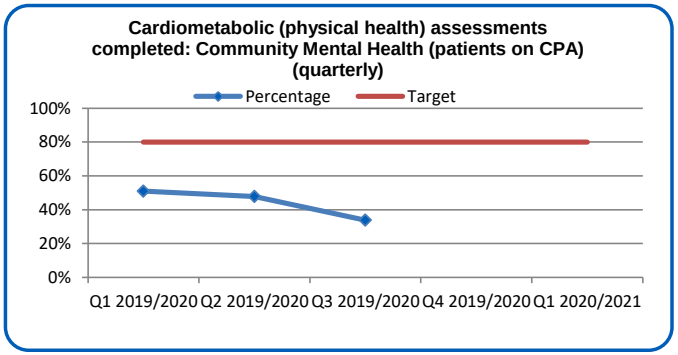
Contractual target: 90%: Q4 to date: 82.1%



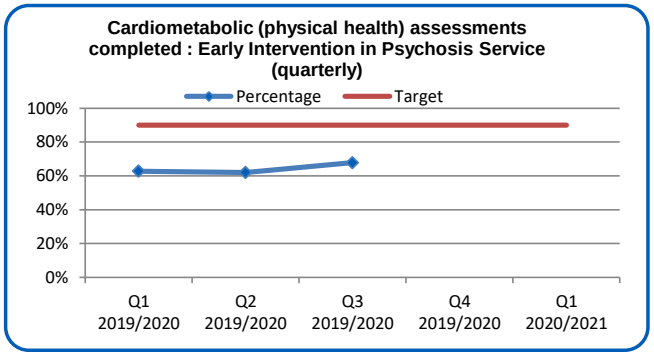
Contractual target: 50%: Q4 to date: 59.2%



Contractual target: 56%: Feb: 88.9%



Contractual target: 80%: Q3: 33.9%



Contractual target: 90%: Q3: 67.8%

Services: Our community care

February saw continued strong performance against the Early Intervention in Psychosis 2 week referral to treatment standard which has now been met for 8 consecutive months. February shows the highest performance year to date at 88.9%.

The CMHT 15 day target of 85% was also exceeded in February at 89.6%, representing the highest performance year to date and 8% above the monthly average. Given the known staffing pressures within these teams, this is of particular note but expected levels of normal variation suggest that fluctuation above and below the target is likely.

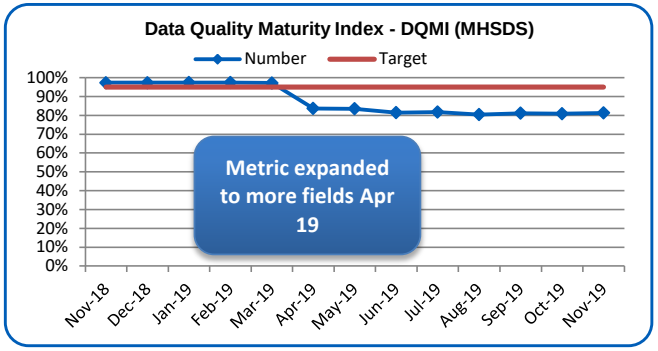
Whilst the Trust has seen some improvement over the last 5 months, it remains below the national 7 day follow up standard post an inpatient discharge. Performance in February was 94% with 5 breaches. Reasons for breaches were: 3 where attempts to arrange the appointment were made and all 3 were seen within 10 days, 1 with someone with an extensive history of non-engagement with services, and 1 lapse in internal process but where person has since been followed up. The Trust is also working on achieving the national CQUIN (payment is scaled based on achieving 50-80% (full payment for 80% and over) of follow up within 3 days. Latest published data (November data) for England shows 75% compared with the Trust's 78%. From April 2020 onwards, the 7 day national standard will be removed and the 3 day standard formalised.

Actions taken/to be taken: Where process errors have occurred, the correct process is reiterated to the staff involved.

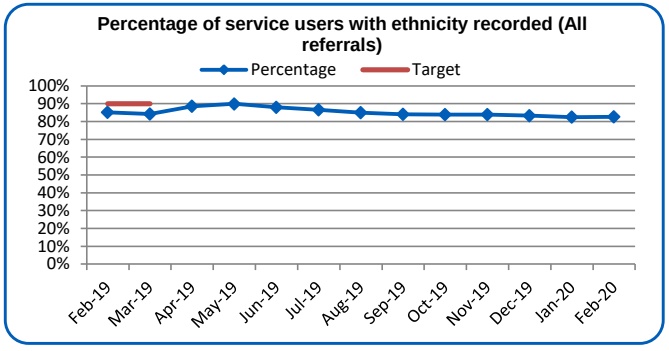
During Q4 to date, the Trust remains above the 50% standard from referral to diagnosis within 12 weeks for Memory Services but below the 90% required for the 8 weeks from referral to assessment standard. Progress by the Memory Assessment Service (MAS) task and finish group has been slower than anticipated with the issues impacting on performance continuing to be related to inconsistency in administative support and practice in managing MAS referrals across all localities and activity recording not always being timely or complete.

Actions taken/to be taken: Following a remedial action plan being developed, the Head of Operations for Older People's services anticipates a return to compliance from April onwards. This will include ensuring junior doctors are clear on recording activity as part of their induction, entering the backlog of unrecorded activity and working through any breaches as well as consistency in administration.

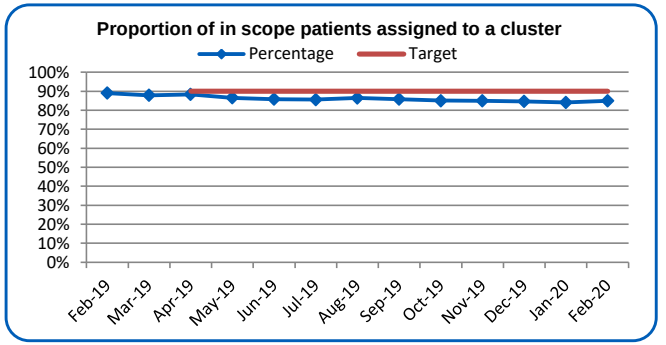
Services: Clinical Record Keeping



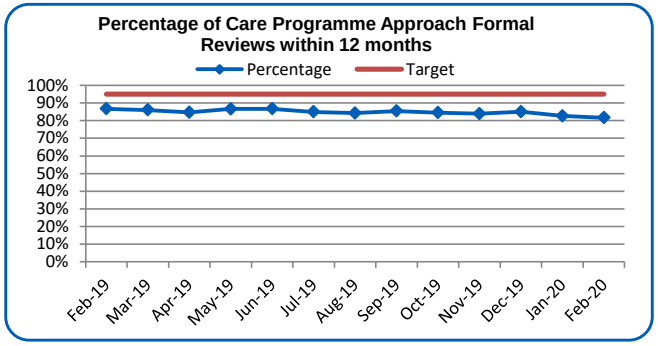
CQUIN 19/20: 95% Q2 onwards: Nov: 81.3%



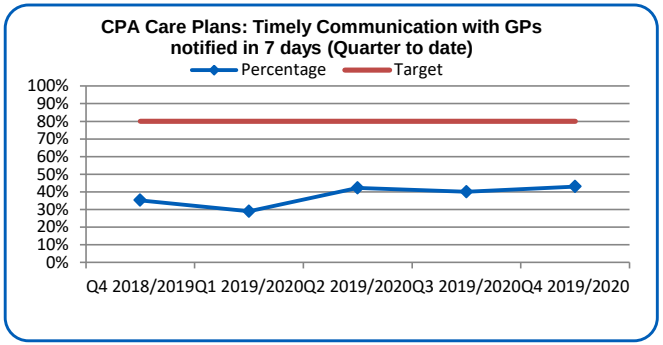
Local target from Apr 19: 90%: Feb: 82.7%



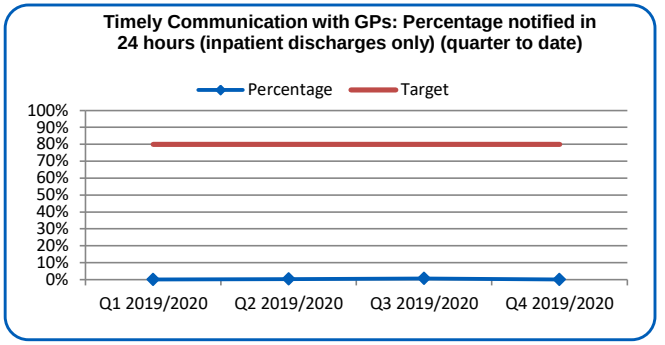
Contractual target from Apr 19: 90%: Feb: 85%



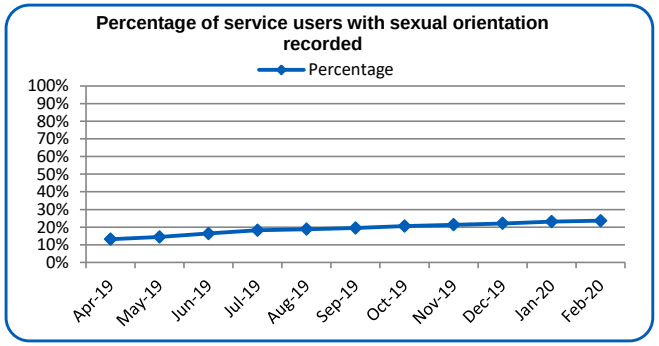
Local target: 95%: Feb: 81.7%



Contractual target: 80%: Q4 to date: 43%



Contractual target: 80%: Q4 to date: 0.0%



Local measure: Feb: 23.6%

Services: Clinical Record Keeping

The Data Quality Maturity Index (DQMI) CQUIN for 2019/20 covers up to 36 items from the national dataset (Mental Health Services Dataset submitted monthly). Nationally, achievement of the CQUIN payment is based on achieving 90-95% from Q2 onwards. The Trust is not expecting to achieve the 90% threshold due to the CQUIN looking at data back to 2016 and including items that have only recently been added to our clinical system and has agreed a local target with the Leeds CCG of 83% that will support performance assessment at the end of Q3 to allow the Trust to focus on the CareDirector patient record system implementation in Q4. National data is only available through to November currently, this shows the Trust at 81.3%. There remains some risk that the 83% may not be achieved but considerable work was undertaken ahead of our December refresh data submission to achieve the target. This measure will not be a CQUIN for next year but Trusts have been asked to commit to a planned trajectory for the year as part of annual planning. The Trust has chosen to submit a trajectory below expected performance levels due to the anticipated impact on data quality in the early part of the year as CareDirector goes live.

Actions taken / to be taken: Continue to promote data completeness through into 2020/21 with a focus on supporting staff in using CareDirector well.

The second part of the CQUIN concerns the submission of intervention codes in the format of SNOMED CT (a clinical terminology). Payment is based on achieving 15-70% from quarter 3 onwards. A mapping exercise to take the intervention codes from our clinical system and map them to SNOMED CT was completed and submitted in the September data to NHS Digital. Nationally, the latest published data for England shows 57.2% compared with the Trust's 96.4%. The Trust expects to achieve full payment for this CQUIN.

Improving the timely transfer of care plans and discharge summaries to GPs is a Trust priority. With regards to care plans within 7 days, performance has improved slightly, Q4 to date is 43% and up 3% on the previous quarter. Performance is variable across teams. For inpatient discharge summaries (to be transferred within 24 hours), consideration is being given to changing the process and using an automated system pulling the data from EPMA (our electronic prescribing system) and CareDirector during the second half of 2020/21.

Actions taken / to be taken: Options for the future based on the integration of our electronic prescribing system (EPMA) and our new electronic patient record (CareDirector) will be explored for inpatient discharge summaries but this is unlikely to bring improvement in the short / medium term. The process will remain the same post the initial go-live of CareDirector.

Quality and Workforce metrics: Tabular overview

Quality: Our effectiveness	Target	Nov-19	Dec-19	Jan-20
Number of healthcare associated infections: C difficile	<8	0	0	0
Number of healthcare associated infections: MRSA	0	0	0	0
Percentage of service users in Employment	-	15.5%	15.7%	15.8%
Percentage of service users in Settled Accommodation	-	73.9%	73.2%	72.7%
Quality: Caring / Patient Experience	**Target**	**Nov-19**	**Dec-19**	**Jan-20**
Friends & Family Test: Percentage recommending services (total responses received)	-	100% (10)	60% (5)	93% (14)
Mortality:				
· Number of deaths reviewed (incidents recorded on Datix)**	Quarterly	-	77	-
· Number of deaths reported as serious incidents	Quarterly	-	3	-
· Number of deaths reported to LeDeR	Quarterly	-	7	-
Number of complaints received	-	16	11	17
Percentage of complaints acknowledged within 3 working days	-	100%	100%	94.1%
Percentage of complaints allocated an investigator within 3 working days	-	94%	100%	94.1%
Percentage of complaints completed within timescale agreed with complainant	-	100%	100%	100%
Number of enquiries to the Patient Advice and Liaison Service (PALs)	-	120	123	199

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

**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

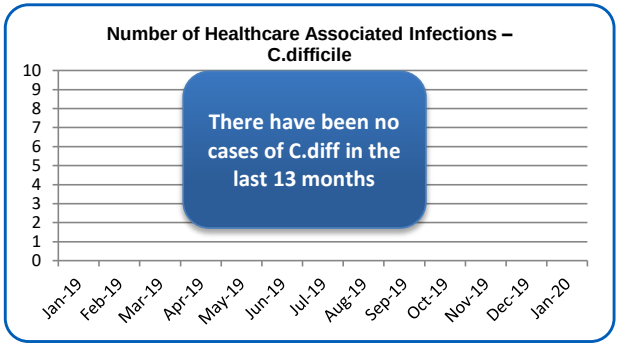
Quality: Safety	Target	Nov-19	Dec-19	Jan-20
Number of incidents recorded	-	917	859	1,014
Percentage of incidents reported within 48 hours of identification as serious	100%	100% (1)	100% (0)	100% (1)
Number of Self Harm Incidents	-	102	80	69
Number of Violent or Aggressive Incidents	-	87	97	109
Number of never events	-	0	0	0
Number of restraints	-	209	213	237
No. of patients detained under the Mental Health Act (includes Community Treatment Orders/conditional discharges)	-	478	475	478
Adult acute including PICU: % detained on admission	-	74.1%	65.2%	61.2%
Adult acute including PICU: % of occupied bed days detained	-	86.1%	84.1%	82.0%
Number of medication errors	Quarterly	-	148	-
Percentage of medication errors resulting in no harm	Quarterly	-	89.9%	-
Safeguarding Adults: Number of advice calls received by the team	Quarterly	-	225	-
Safeguarding Adults: Percentage of advice calls to safeguarding that resulted in a referral to social care	Quarterly	-	14% (32)	-
Safeguarding Children: Number of advice calls received by the team	Quarterly	-	93	-
Safeguarding Children: Percentage of advice calls to safeguarding that resulted in a referral to social care	Quarterly	-	13% (12)	-
Number of falls	-	35	55	91
Number of Pressure Ulcers	-	0	0	0

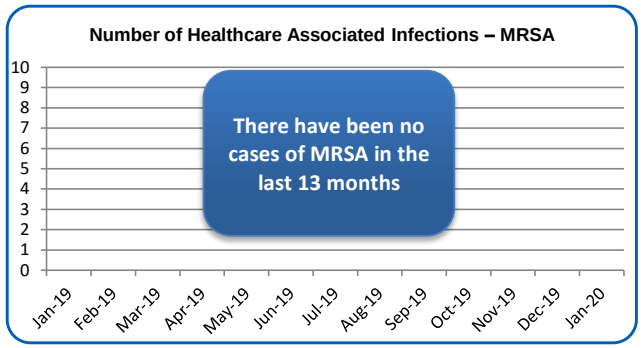
Quality and Workforce metrics: Tabular overview

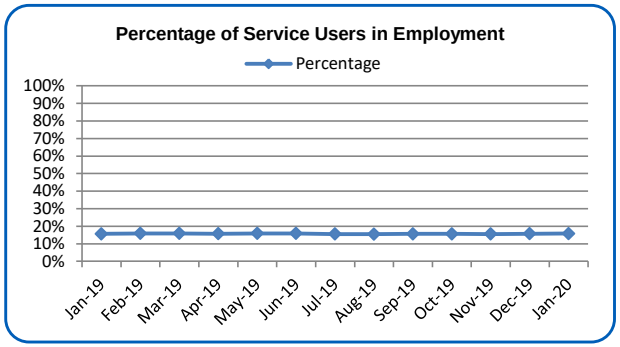
Our Workforce	Target	Nov-19	Dec-19	Jan-20
Percentage of staff with an appraisal in the last 12 months	85%	79.5%	78.7%	78.7%
Percentage of mandatory training completed	85%	90.0%	89.8%	88.2%
Safeguarding: Prevent Level 3 training compliance (quarter end snapshot)	85%	-	93.9%	-
Percentage of staff receiving clinical supervision	85%	80.5%	77.9%	80.9%
Staff Turnover (Rolling 12 months)	8-10%	9.9%	9.4%	9.4%
Sickness absence rate in month	-	5.5%	5.5%	5.9%
Sickness absence rate (Rolling 12 months)	4.88%	5.2%	5.1%	5.2%
Percentage of sickness due to musculoskeletal issues (MSK; rolling 12 months)	-	14.6%	14.9%	15.4%
Percentage of sickness due to Mental Health & Stress (rolling 12 months)	-	43.8%	43.5%	43.9%
Medical Consultant Vacancies as a percentage of funded Medical Consultant Posts (percentage)	-	12.8%	12.8%	9.4%
Medical Consultant Vacancies (number)	-	9.3	9.3	6.9
Medical Career Grade Vacancies as a percentage of funded Medical Career Grade Posts (percentage)	-	4.2%	5.4%	5.4%
Medical Career Grade Vacancies (number)	-	1.5	1.9	1.9
Medical Trainee Grade Vacancies as a percentage of funded Medical Trainee Grade Posts (percentage)	-	14.2%	13.3%	13.7%
Medical Trainee Grade Vacancies (number)	-	14.7	13.7	14.1
Band 5 inpatient nursing vacancies as a percentage of funded B5 inpatient nursing posts (percentage)	-	20.0%	19.0%	19.0%
Band 5 inpatient nursing vacancies (number)	-	46.0	44.2	43.8
Band 6 inpatient nursing vacancies as a percentage of funded B6 inpatient nursing posts (percentage)	-	4.0%	2.0%	3.0%
Band 6 inpatient nursing vacancies (number)	-	3.2	2.2	3.0
Band 5 other nursing vacancies as a percentage of funded B5 non-inpatient nursing posts (percentage)	-	14.9%	11.8%	12.9%
Band 5 other nursing vacancies (number)	-	15.0	11.9	13.1
Band 6 other nursing vacancies as a percentage of funded B6 non-inpatient nursing posts (percentage)	-	5.1%	3.6%	5.3%
Band 6 other nursing vacancies (number)	-	14.1	10.0	15.0
Percentage of vacant posts (Trustwide; all posts)	-	9.3%	8.3%	9.0%

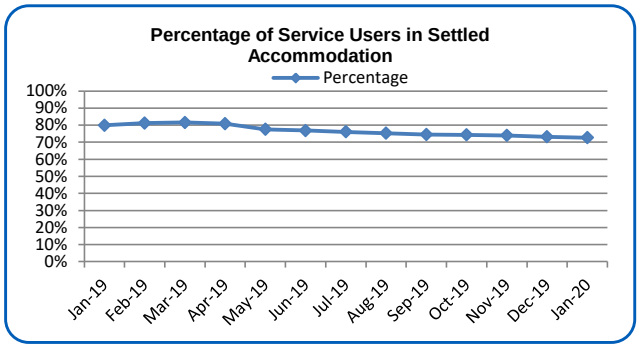
Nursing vacancies excludes nursing posts working in corporate/development roles

13 month trend: Quality: Effectiveness

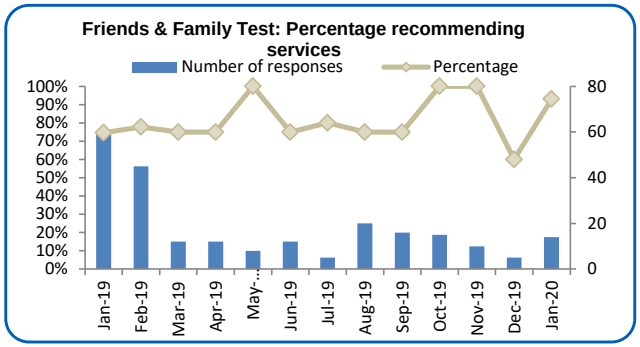


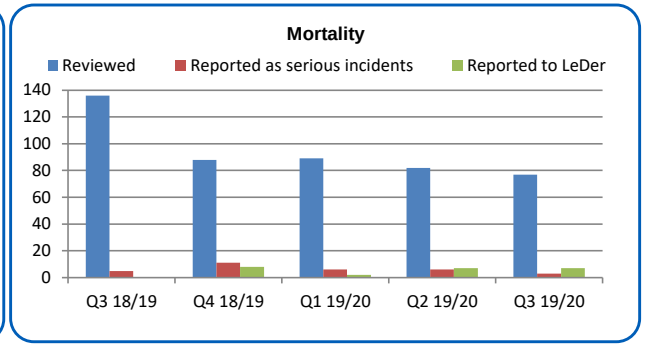


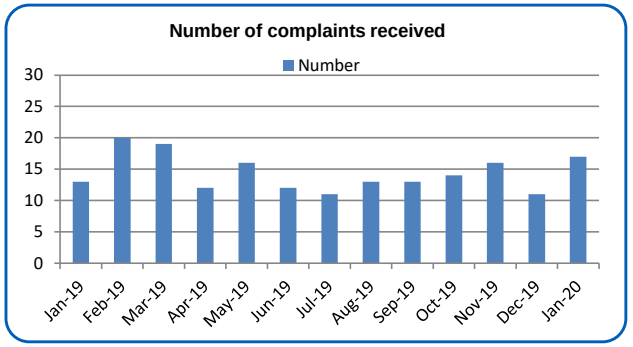


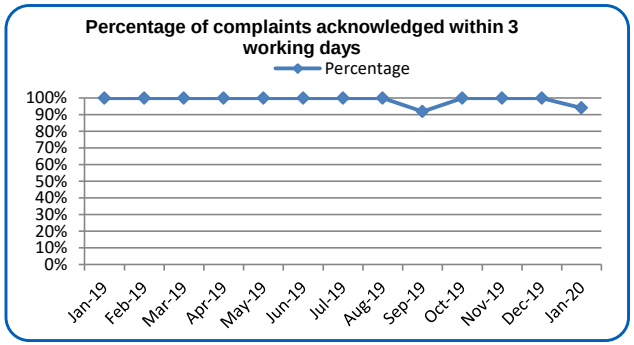


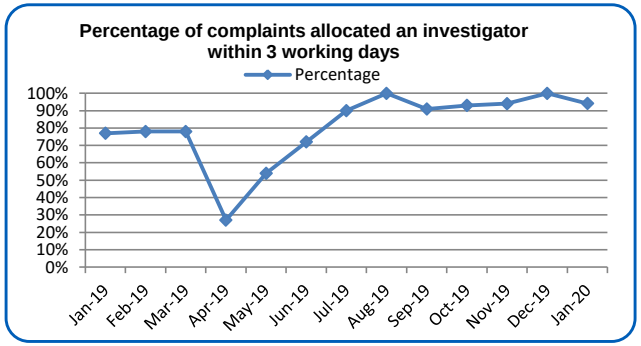
13 month trend: Quality: Caring/Patient Experience

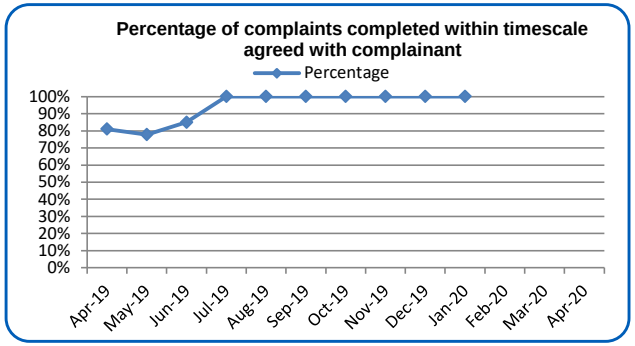


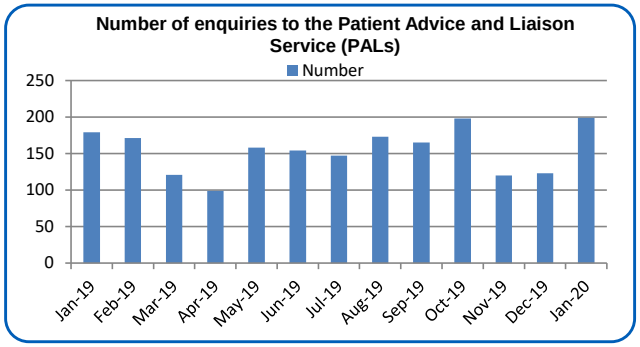




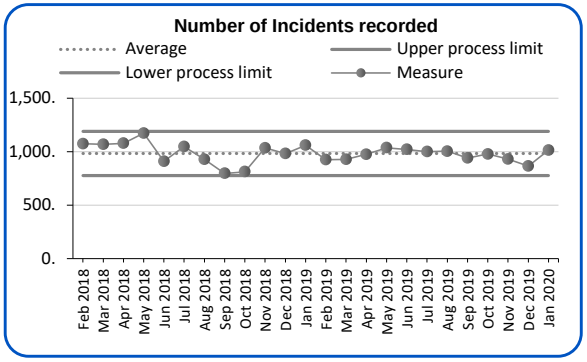


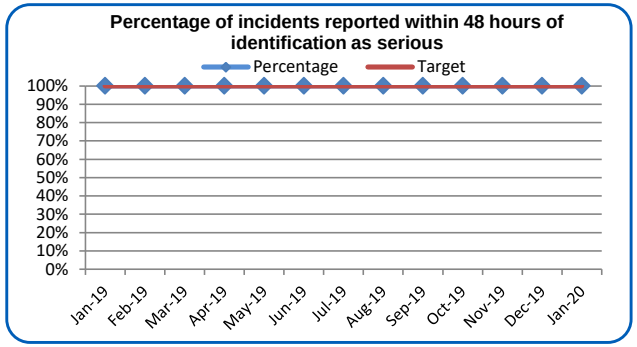


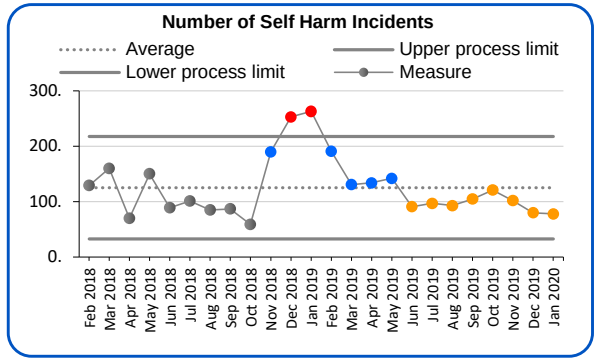


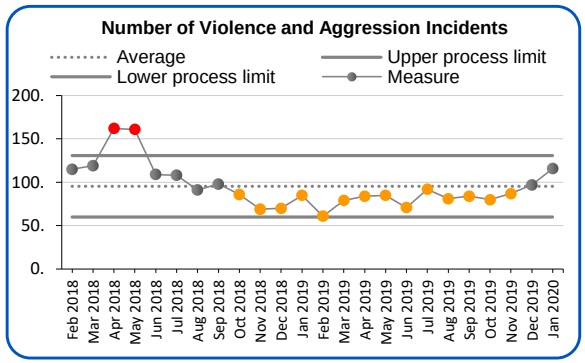


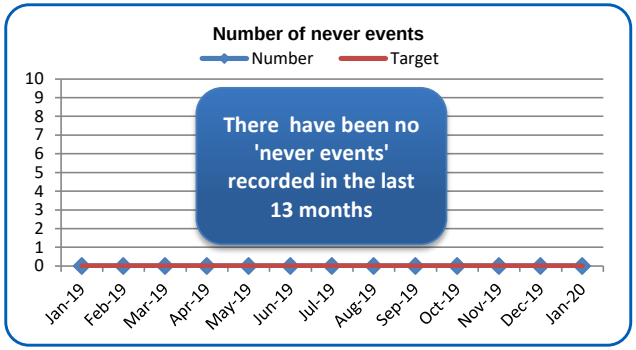
13 month trend: Quality: Safety

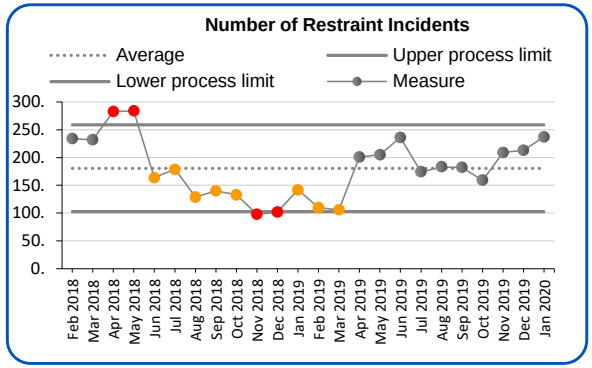


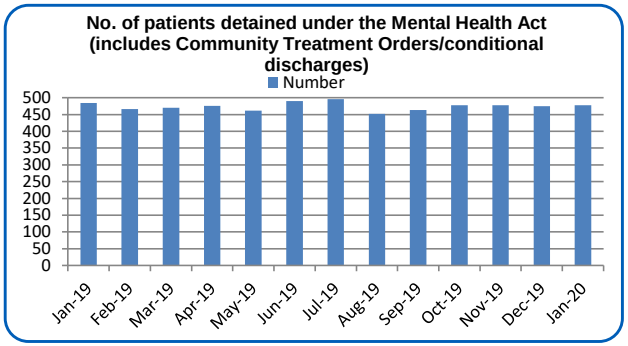


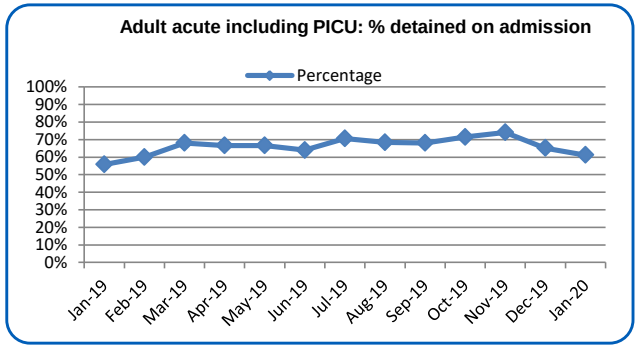


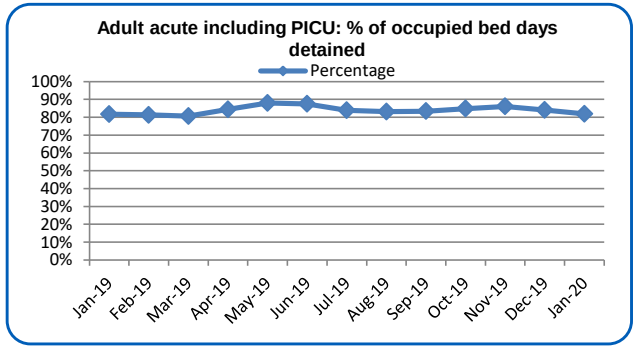




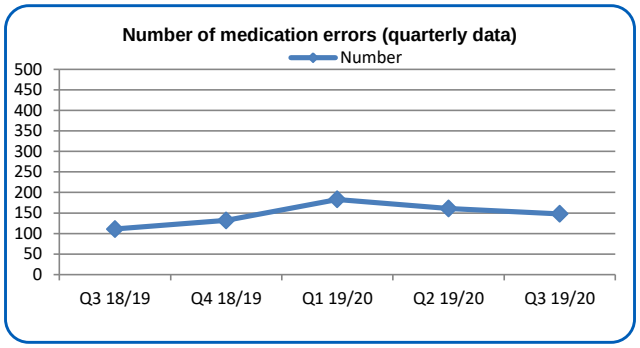


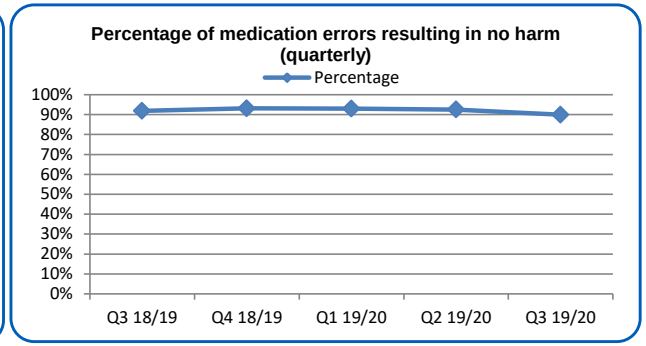


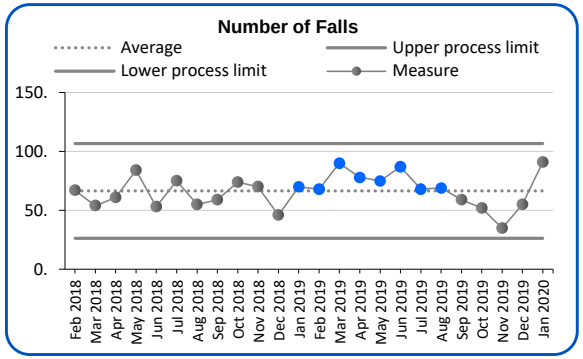


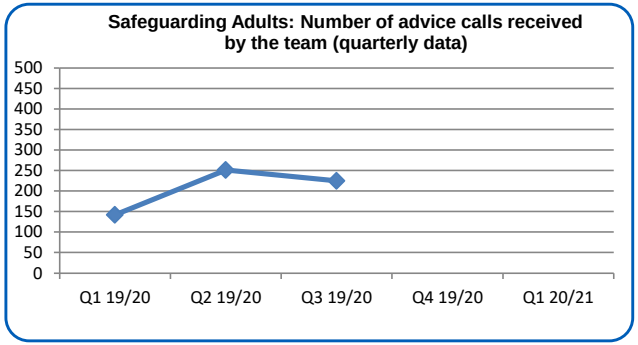


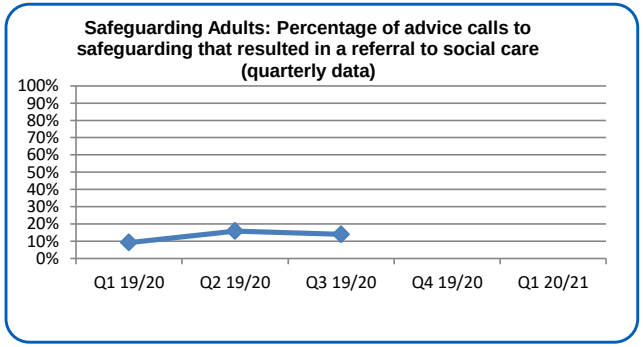
13 month trend: Quality: Safety - continued

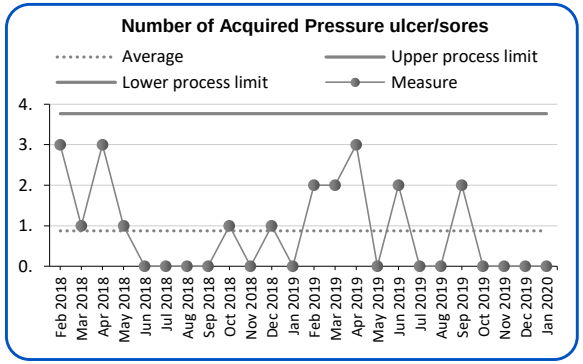


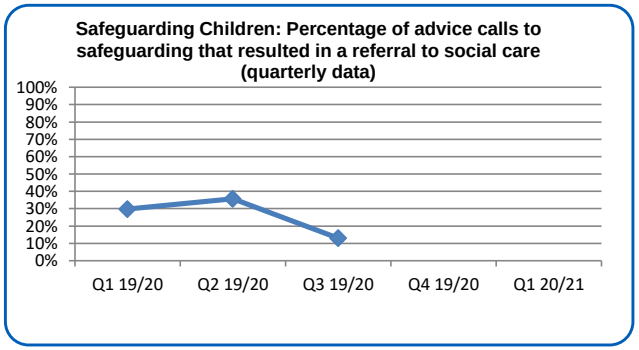


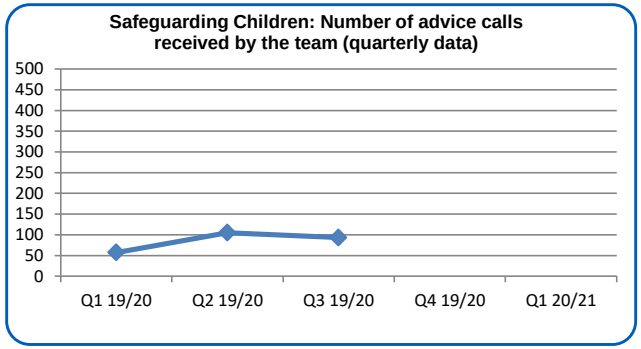




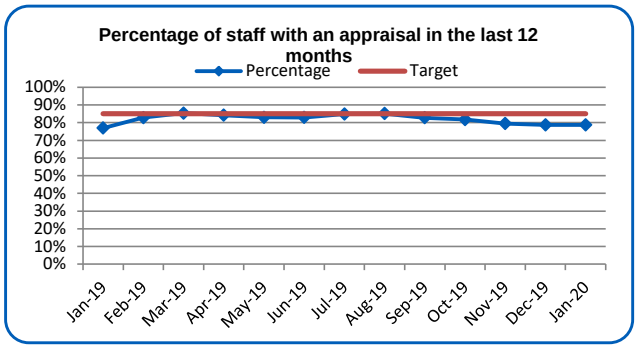


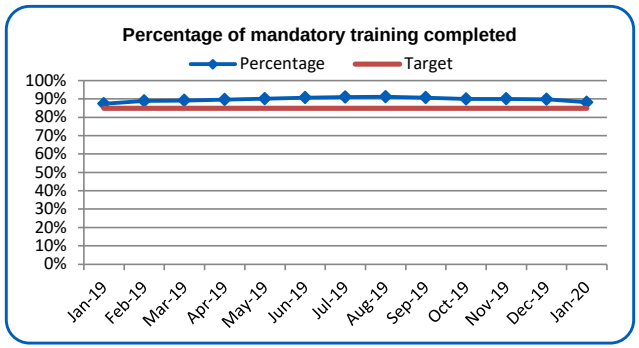


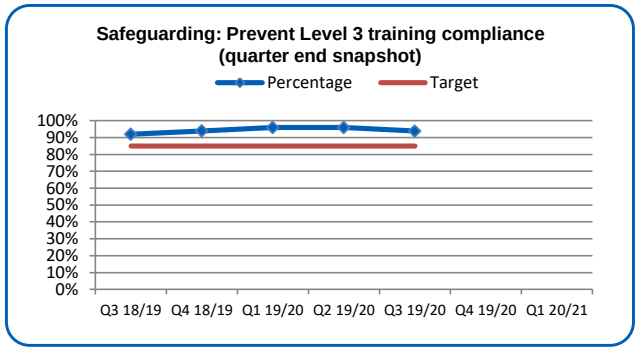


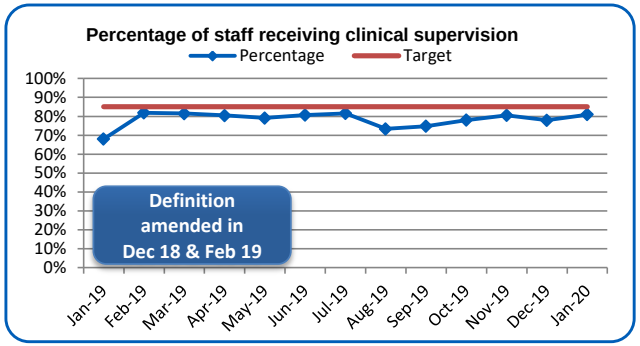


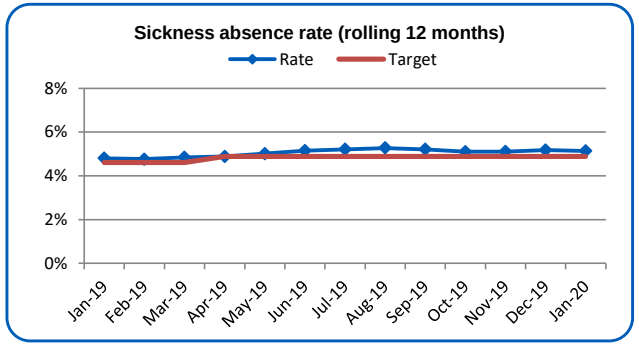
13 month trend: Our Workforce

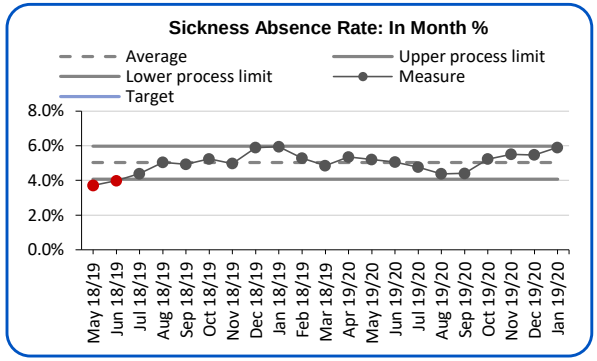


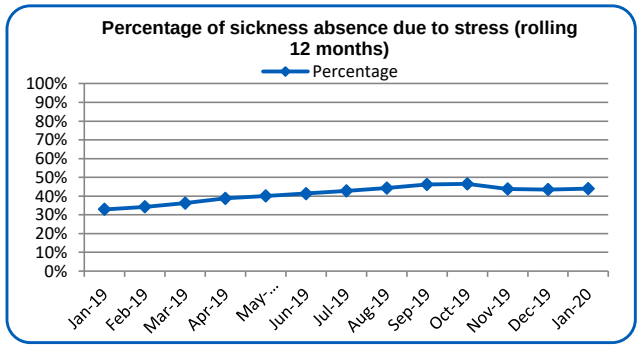


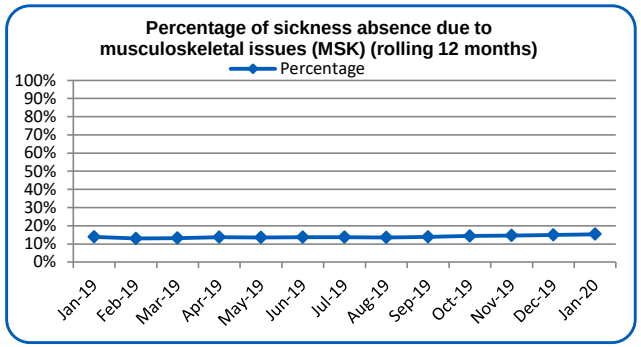




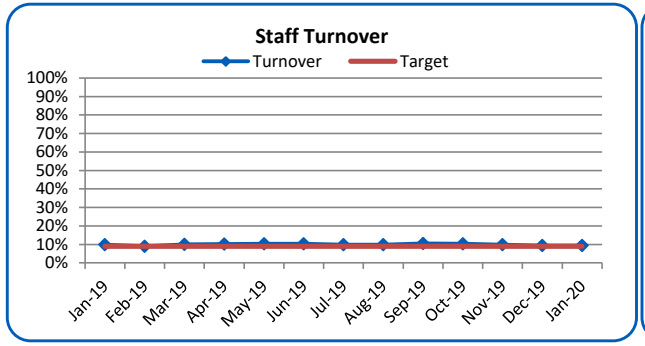


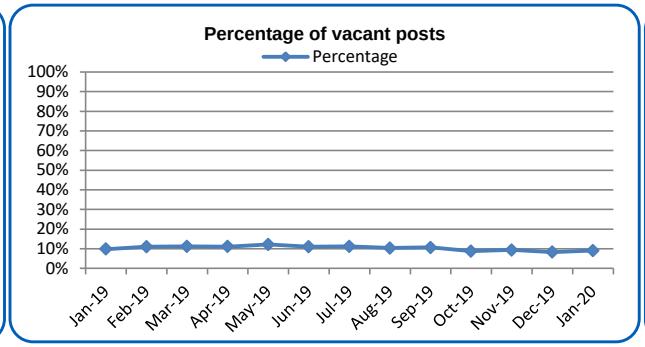


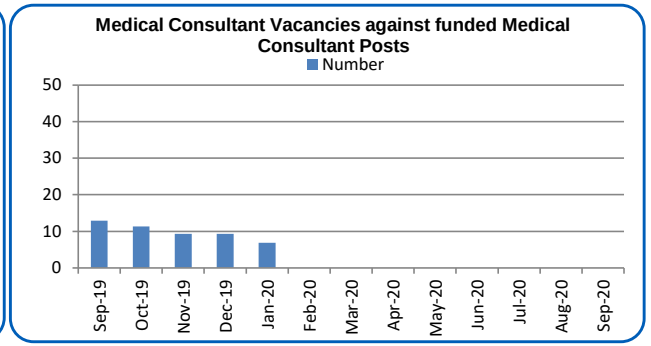


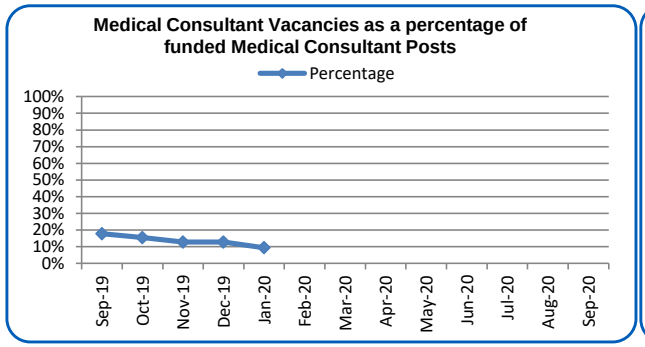


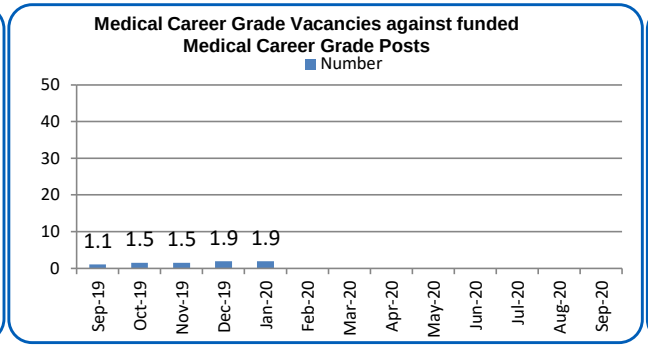
13 month trend: Our Workforce - continued

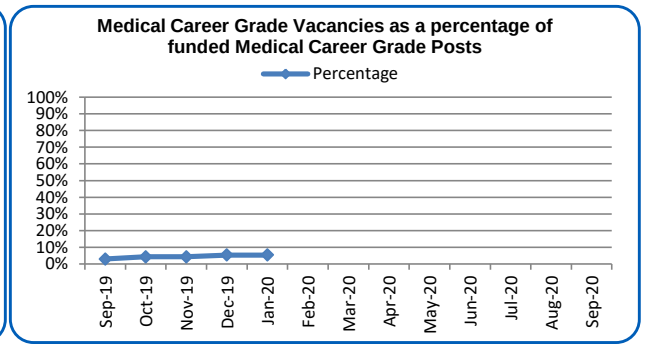


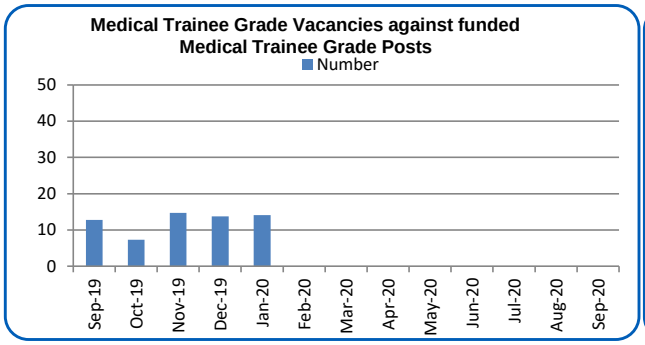


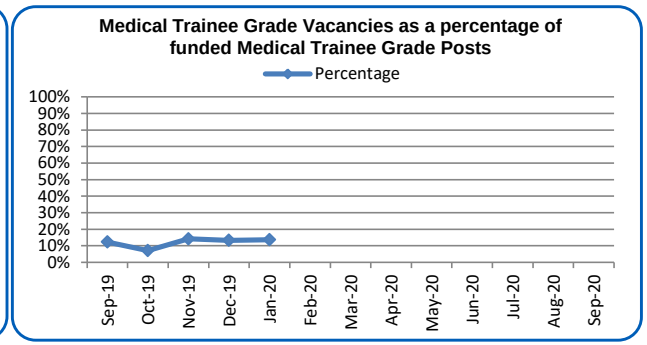




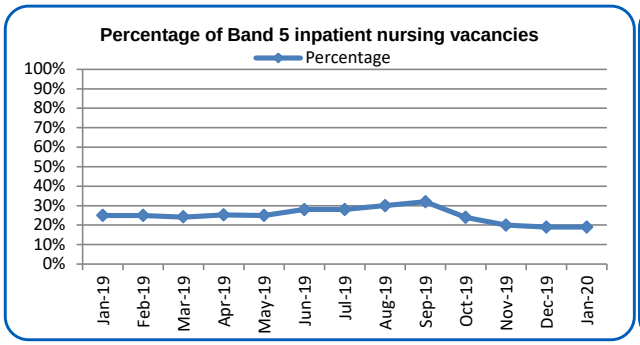


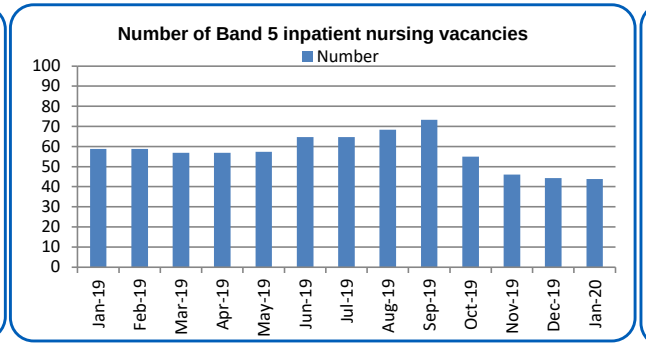


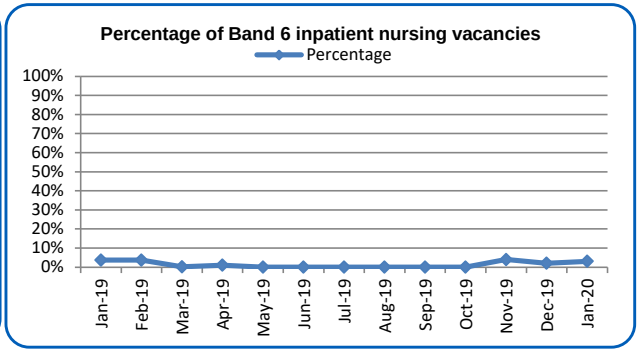


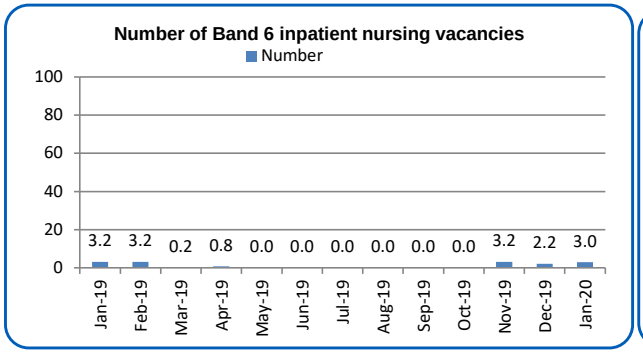


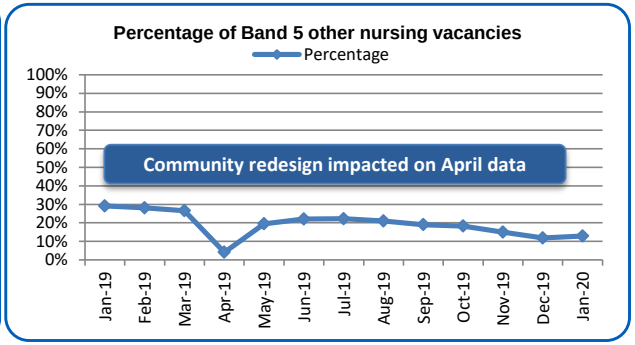
13 month trend: Our Workforce - continued

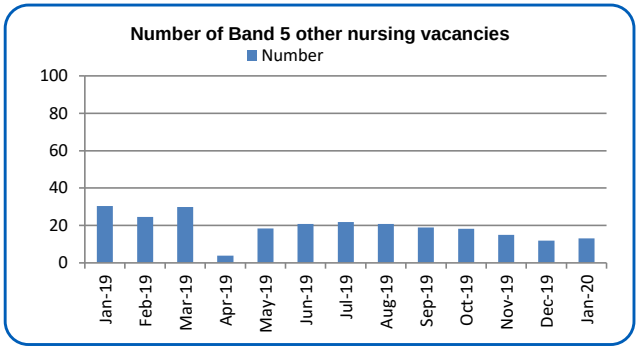


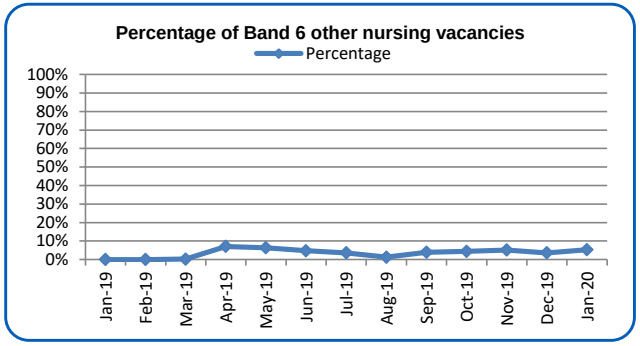


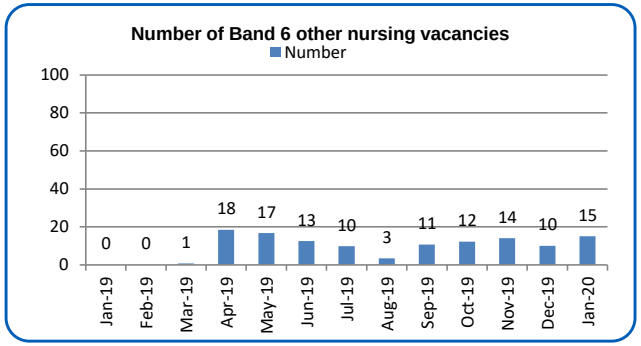












Local intelligence continued

CURRENT MONTH: JANUARY

Clinical Record Keeping:
Data Quality Maturity Index: At 80.9% the Trust is below the 90-95% CQUIN payment threshold, as at October. Further improvements are expected following a focus on a couple of key fields during December and January. Agreement has been reached with the Leeds CCG to assess performance based on Decem ber data to allow for the introduction of our new electronic patient record system, CareDirector during quarter 4.

GP Communications: As we move into quarter 4, there remains no real change in performance for CPA care plans transferred to G Ps within 7 days. For inpatient discharge summaries (to be transferred within 24 hours), the process should involve the letters being dictated/typed into the BigHand s oftware before being signed off for electronic transfer. A quality improvement project has begun to understand the barriers to timely completion of discharge summaries, and options f or changing the electronic process once CareDirector is in place are being reviewed.

Patient Experience:
S136: There were 8 service users who remained in the 136 suite for longer than 24 hours in the month; 5 were due to a lack of bed availability, the remaining three were due to the lack of availability of an AMHP, doctor and interpreter.

Complaints: One complaint was acknowledged outside of the 3 working day timescale due to the complaints team not receiving th e complaint from the service in a timely manner. The 3 working day acknowledgement period is calculated from the Trust receiving the complaint and not when the complaint s team receive it. The relevant service were notified of this immediately and the process was reiterated to them. A Trustwide reminder has been circulated to remind all staf f to forward complaints to the complaints team immediately.

Safety:
Incidents: The number of incidents, including those for violence/aggression, self harm and restraint all remain within expect ed levels of normal variation with self harm incidents continuing a below average trend. Although the number of falls looks to have increased, the number remains within expected le vels of normal variation.

Workforce:
The mixed picture remains for training, supervision and appraisal. Mandatory training requirements continue to be met. Apprai sal compliance has dropped slightly month on month since August 2019 and remains under target at 78.7%. However, clinical supervision, although under the 85% target, is a t its highest point since July 2019. In month sickness remains within levels of normal variation.

Local intelligence continued

PREVIOUS MONTH: DECEMBER

Clinical Record Keeping:
Data Quality Maturity Index: The Trust is below the 90-95% CQUIN payment threshold as at September at 81% but has reached an agreement with the Leeds CCG for a revised payment schedule that takes into account the introduction of our new electronic paper record system, CareDirector during quarter 4. The agreed target of 83% is still challenging with a reliance on fields such as "estimated date of discharge" being fully completed.

Patient Experience:
S136: There were 5 service users who remained in the 136 suite for longer than 24 hours in the month; all were due to a lack of bed availability.
Complaints: For the first time since August, all 3 complaints metrics in December show 100% achieved.
Friends and Family Test: Numbers of responses remain low. The Trust has developed a draft Patient Experience and Involvement Strategy, "Together" involving staff and service users. A steering group will oversee the implementation of the strategy which includes an "Experience sub group" that will lead on the collection of meaningful feedback from service users to improve the patient experience.

Safety:
Incidents: The number of incidents, including those for violence/aggression, self harm and restraint all remain within expected levels of normal variation.
Medication: The Medicine Safety Committee scrutinises all medication-related incidents reported across the organisation bi-monthly and lessons learned are shared across the organisation. In Q3, just under a quarter of incidents related to omission of a drug, or incorrect administration of a drug. Upon further investigation a common theme emerged with regards to confirming a service users identity. There were practical challenges associated with the current service user identification policy and the uploading of service users photographs onto the EPMA system which meant staff were struggling to adhere to the policy; this is being addressed by the Lead nurses. Another trend is the increasing number of incident reports regarding medication across the interface with primary care. This can be attributed to more LYPFT staff working in primary care liaison roles and formally reporting what are thought to be pre-existing problems. These incidents are providing valuable information to shape their service and improve medication systems across the city.
Safeguarding - Advice from clinicians for both child and adult safeguarding matters has remained high with only a small decrease from the preceding quarter. Increased reflection on cases and learning through the roll out of child safeguarding supervision may explain the continued high volume of cases. The adult trend is mirrored across social care data and other health organisations in the region. Conversion rates to a social care referral in child cases have increased during the quarter and if this continues into the next quarter it will need to be monitored; the conversion rate for advice to adult social services referrals has remained roughly the same. Prevent Level 3 training compliance remains high at 94%.

Workforce:
Whilst mandatory training remains above target, further consistency is required to maintain the appraisal standard and achieve the clinical supervision target of 85%. During January, there is a focus on the effectiveness of appraisals including speaking to staff who have had an appraisal in the last few months to ask them about their experience and to conduct a review of appraisal documentation for a sample of recent appraisals. Although in-month sickness absence remains within expected levels of normal variation and the percentage of sickness absence due to stress or mental health related absence (rolling 12 months data) is showing signs of reducing, managing sickness absence remains a key priority for the new Wellbeing Manager.

Finance – Chief Financial Officer and Deputy Chief Executive

Unless otherwise specified, all data is for February 2020

This section highlights performance against key financial metrics and details known financial risks as at February 2020. The financial position as reported at month 11 is within plan tolerances.

Finance	Target	Dec-19	Jan-20	Feb-20
Single Oversight Framework: Overall Finance Score	1	1	1	2
Single Oversight Framework: Income and Expenditure Rating	1	1	1	2
Income and Expenditure: Surplus		£2.25m	£2.41m	£2.44m
Cost Improvement Programme versus plan (% achieved)	100%	60.63%	60.63%	60.80%
Cost Improvement Programme: achieved		£1.35m	£1.50m	£1.65m
Single Oversight Framework: Cash Position Liquidity Rating	1	1	1	1
Cash Position	-	£93.72m	£96.18m	£95.24m
Capital Expenditure (Percentage of plan used) (YTD)	100%	85.31%	93.04%	81.63%
Single Oversight Framework: Agency Spend Rating	1	2	2	2
Agency spend: Actual	-	£4.21m	£4.68m	£5.13m
Agency spend (Percentage of capped level used)	-	112.00%	112.00%	112.00%

Finance

Single Oversight Framework – Finance Score The Trust achieved the planned Finance Score at month 11 with an overall Finance Score of 2.	**Income and Expenditure Position (£000s)** The income and expenditure position at month 11 is £1.51m surplus, £0.43m ahead of plan before accounting for £0.94m additional PSF relating to 18/19.
Cost Improvement Programme (£000s) CIP performance at month 11 is under the plan of £2.72m, CIP achieved £1.65m (61% of plan).	**Cash (£000s)** The cash position of £95.24m is £14.29m above plan at month 11, reflecting unplanned 18/19 PSF and capital underspending. The Trust achieved a liquidity rating of 1 (highest rating).
Capital (£000s) Capital expenditure (£5.92m) is behind plan at month 11 (82% of plan).	**Agency spend (£000s)** Compares actual agency spend (£5.13m at month 11) to the capped target set by the regulator (£4.60m at month 11). The Trust reported agency spending 12% above the capped level and achieved a rating of 2.
Areas of Financial Risk as at February 2020 • OAPs run rate deterioration. • CIP performance. • Wards overspending. • Agency spending run rate.	

Glossary

Statistical Process Control (SPC) Charts: A number of these charts are used within the report to help identify changes in performance that are outside the expected levels and worth further investigation. The charts follow performance/activity over time and show the upper and lower process limits; these are used to identify where you can expect your performance to fall 99% of the time under normal circumstances. Data points are coloured as per the table below with a run defined as at least 7 points in a row.

Symbol	Used to:
	Identify a point within the process limits.
	Identify a point outside the process limits. This is unlikely to have occurred by chance and can warrant further investigation.
	Identify a run of increasing points or a run of points above the average line. Unlikely to have occurred by chance and signifies a change that may require further understanding.
	Identify a run of decreasing points or a run of points below the average line. Unlikely to have occurred by chance and signifies a change that may require further understanding.

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

Acronym	Full Title	Definition
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 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.

Acronym	Full Title	Definition
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.
EIP	Early Intervention in Psychosis	First episode psychosis (FEP) is the term used to describe the first time a person experiences a combination of symptoms known as psychosis; the service that supports people with this is called EIP.
EPR	Electronic Patient Records	The system used to store patient records electronically.
GP	General Practitioner	General practitioners (GPs) treat all common medical conditions and refer patients to hospitals and other medical services for urgent and specialist treatment. They focus on the health of the whole person combining physical, psychological and social aspects of care.
HCR20	Historical, Clinical, Risk Management - 20	The Historical, Clinical, Risk Management-20 (HCR-20) is an assessment tool that helps mental health professionals estimate a person's probability of violence
HoNOS	Health of the Nation Outcome Scales	The Health of the Nation Outcome Scale (Working Age Adults) is a means of measuring the health and social functioning of people of working age with severe mental illness
Honosca	Health of the Nation Outcome Scales Child and Adolescent Mental Health	The Health of the Nation Outcome Scale (Children and Adolescents) is a means of measuring the health and social functioning of children and adolescents with severe mental illness
KPI	Key Performance 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

Acronym	Full Title	Definition
		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 Unit	Leeds Psychiatric Care Intensive Service (PICU) provides intensive and specialist care and treatment for adult service users with mental health needs, whose risks and behaviours cannot be managed on an open acute ward.
S136	Section 136	Section 136 is an emergency power which allows service users to be taken to a place of safety from a 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
SNOMED CT	Systematized	An international clinical terminology for use in electronic patient records.

Acronym	Full Title	Definition
	Nomenclature of Medicine -- Clinical Terms	
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
12

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Director of Nursing report
DATE OF MEETING:	26 March 2020
PRESENTED BY: (name and title)	Nichola Sanderson, Deputy Director of Nursing
PREPARED BY: (name and title)	Cathy Woffendin, Director of Nursing, Professions and Quality

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

EXECUTIVE SUMMARY

The purpose of this report is to provide a quarterly update to Trust board members in relation to progress across the Director of Nursing, professions and Quality portfolio and areas of responsibility .

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 note the contents of this report and to continue to support the staff and services with their ongoing initiatives.

Meeting of the Trust Board

March 2020

Director of Nursing and Professions Quarterly Report

1. Safeguarding

Leeds Safeguarding Adults Board has presented its draft strategic plan, April 2020 to March 2023 which is currently being circulated to all partners for comments. Our Head of Safeguarding is collating comments on behalf of LYPFT and these will be considered at our Safeguarding Committee prior to been shared with external partners .

The Boards strategic plan sets out how the Safeguarding Adults Board will work towards achieving its vision ensuring "Leeds is a Safe Place to live for everyone".

The plan is underpinned by 4 key ambitions:

1) Talk to me, hear my voice.
2) Improve awareness of safeguarding across all communities.
3) Develop effective responses for people experiencing self-neglect.
4) Learn from experience to improve how we work.

Each of these ambitions has key actions, objectives and expected outcomes which will be monitored by the Board, with the expectation that all key partners will contribute to these. LYPFT Safeguarding Committee will have oversight against our individual progress and contribution to each ambition and once the final strategic plan has been approved this will be added to our cycle of business.

2. MAPPA

During the last 6 months a significant amount of work has been undertaken to strengthen both our internal and external systems and processes in relation to our Multi agency Public Protection Arrangements [MAPPA], for managing sexual and violent offenders. Traditionally in

most mental health organisations the focus of MAPPA is on service users within a forensic setting. MAPPA is not a body but a framework to enable participating agencies to better discharge their statutory responsibilities to protect the public in a coordinated manner. Section 325 of the Criminal Justice Act 2003 imposes a statutory duty on the MAPPA Responsible Authority who comprises of the Police, The National Probation Service and HM Prison Service to establish arrangements to assess and manage the risks posed by:

- Relevant sexual and violent offenders
- Other persons who, by reason of offences they have committed are considered by the Responsible Authority to be persons who may cause serious harm to the public.

Section 325[3] of the Act also imposes a duty on other specified agencies to cooperate which includes all NHS Trusts who may be required to exchange information. As part of our Duty to cooperate an information sharing agreement and memorandum of understanding have been sent out to all relevant agencies for approval and executive signature, both documents have been reviewed and signed by the Director of Nursing , Quality and Professions. To strengthen our partnership arrangements around this agenda our named adult safeguarding lead now attends the multiagency strategic meetings and in conjunction with other key experts has developed a draft LYPFT MAPPA policy which is currently out for consultation and will be presented to the Safeguarding Committee for approval with final ratification at our Policies and procedures group by April.

3. Patient Experience and Involvement

In response to the Professor Gamsu report Listening, Involving, Acting (2018), LYFPT has been developing an Experience & Involvement Strategy to outline the vision for including service users, carers and the public in the development of services across the Organisation. In addition to developing the strategy, the policy for the reimbursement of people who are involved in involvement activities across the Organisation has been reviewed and both pieces of work are being monitored as part of the work streams of the Trust Wide Patient Experience and Involvement Strategic Steering Group which was established in April 2019.

The Experience & Involvement strategy is linked to the Organisational vision and values via the Quality Strategy. It has been developed using a collaborative approach, working together

with service users, carers and staff to produce a simple, easy to read document which identifies achievable priorities to develop service user involvement across the Organisation.

The views of service users and carers were sought through consultation at SUN and SUNRAY and via an on line survey. These, together with feedback from the Patient Experience Workshop 22nd March 2019 and feedback from the Annual Members Meeting/Big Conversation 2019 were used to draw together themes which have informed the strategy.

The Experience & Involvement Strategy is a 3 year plan developed together with patients, service users, carers & staff. The overarching aims of the strategy include:

- Working together to make sure patients, service users & carers are involved in all aspects of their care.
- Developing ways to understand and act on patient, service user & carer feedback.
- Developing support services for carers, family and friends of our patients.

The policy for payment and reimbursement of service user, patients, carers and members of the public has been reviewed and approved at the February Patient Experience and Involvement Strategic Steering Group. The revised policy introduces a new process for identifying, recording and monitoring all involvement activity across the Organisation. The aim is that the Organisation will have a central record of all involvement activities taking place including outcomes and benefits from involvement, together with clear guidance ensuring people feel valued and ar**e** reimbursed in a timely manner.

The benefits

- LYFPT is working in line with and benchmarked against national and local practice.
- People giving time for involvement activities are reimbursed fairly and equitably across all services.
- Staff have clear guidance to ensure involvement activity is fair and transparent.
- The strategy will provide a clear vision for involvement providing a framework to monitor progress against the priorities.
- Processes will be implemented to provide feedback to people on how involvement has made a difference.

Risks

Costs for involvement may increase as more people undertake involvement activities and the real cost of involvement is calculated across the Organisation.

Impact on the quality / safety of care

- The involvement of service users, patients and carers in co design and production will have direct benefits to the quality of services and care provided by the Organisation.
- Staff will be able to encourage involvement without considering whether there is a budgetary consideration for those services with limited resource

Where this has been considered previously and what the outcome was:

The Experience & Involvement strategy & policy has been discussed at:

- The Trust Wide Patient Experience and Involvement Strategic Steering Group, and the related sub groups:

    - The Carers strategic sub group
    - The Experience strategic sub group
    - The Involvement strategic sub group
    - The Leeds care group and the SS/LD care group clinical governance meetings
    - SUN network
    - Trust Service user groups, PD network, LD network
    - Shared with Deputy Director of HR for comment
    - Shared with Deputy Director of Finance for comment
    - Shared with the Head of Diversity & Inclusion

- In addition a detailed 6 monthly report was provided to Quality Committee in February 2020 which also included the priorities and progress of the work of the three strategic sub groups covering experience, involvement and carers which report to the Patient experience and involvement strategic steering group.

Each of the strategic sub groups have played a key role in supporting the development of the Experience and Involvement Strategy and the Policy for the Payment and Reimbursement of Service User's, Patients, Carers and Members of the Public reimbursement policy.

A shared vision via the new Experience & Involvement strategy and the Trust Wide Patient Experience and Involvement Strategic Steering Group is key to developing and valuing involvement and patient experience within LYPFT. The new policy will be a positive step in standardising reimbursement of service users, patients, carers and members of the public. It will provide a coordinated and fair approach to reimbursement of people in line with national policy. Both documents will support staff and ensure the Trust has an evidence based approach to involvement activities supported by robust financial and HR principles.

This proposed change to the monitoring of the Involvement budget will effectively ensure that all involvement throughout the Organisation is centrally recorded and monitored for quality purposes. It will also ensure, for each involvement activity, a detailed account of the costs and outcomes of involvement from our valued service users, patient and carers can be provided.

The establishment of the Patient Experience and involvement Strategic Steering Group has been pivotal to moving this agenda forward and for ensuring clear oversight of the development of the Patient Experience and Involvement Strategy and the key priorities and action plans which sit within each sub group. Although there is still significant work to do across these work streams, the work of the last 12 months since the establishment of these strategic meeting structures has started to demonstrate some tangible outputs and have resulted in a cultural shift in some areas across the organisation. In recognition of this progress a Service user, carer and involvement event was originally planned for the 9th April at the Bridge Community Centre to officially launch our 3 year Patient Experience and Involvement Strategy, in light of the COVID 19 national guidance this event has been postponed and will be reconsidered in due course.

4. Safer Staffing

Following the detailed piece of work and pilot of the MHOST Tool across our inpatient service areas which demonstrated an increase in the current baseline budget, a business case was pulled together and presented to our CCG colleagues on the 24th February. The CCG were receptive to the findings of the paper and the need to increase funding to facilitate an increase in staffing ratios based on the complexity of need identified during the pilot. The final agreed funding is still awaited for this year and a phased approach will be considered for a year on year increase to meet the overall funding gap outlined in the business case and will be considered as part of contract negotiations and the CCG funding plans.

5. Recruitment and Retention

Turnover rate has increased slightly over the last quarter, but remains 0.9% lower than at the start of the retention work. Retirement remains the most common reason for leaving, but at a lower rate than other mental health organisations. Giving relocation as a reason to leave continues to grow and is significantly higher than in other organisations. We have also seen a shift in the point at which people leave, this is now earlier and more likely to be in first 3 years, rather than after 3-5 years' service. Therefore this year's action plan includes establishing exit interviews to understand relocation reasons in more detail, promoting the retire and return opportunities and further developing career pathways including a rotation for nurses and development posts in hard to recruit posts.

We have 36 RMN graduates who are due to qualify in summer and have expressed an interest in a post. Only 2 graduates have not accepted the offer. They are currently being offered a career conversation in their preferred area; this will be followed by a slotting in process which will take place at the end of March to find the best match of people to posts.

There are 2 Associate Practitioners and 9 Nursing Associates due to qualify this year they have been asked to preference a post from the current list of identified vacancies. As there are more posts than people we hope that they can be slotted in without the need to have any additional selection process. In the event that there be an oversubscribed position there will be an interview process applied.

6. Chief Nursing Officer Conference

Our Deputy Director of Nursing attended the two day CNO conference held on the 11th and 12th March in Birmingham. The key messages and priority areas from our Chief Nursing Officer Ruth May were:

1. Our people
2. Maternity
3. CovID-19

1st Priority Our People

To build a workforce that increases the number of nursing staff we have, with an aim to train / return to work and employ a further 50, 0000 nurses.

To achieve this there will be a 3 pronged approach:

1. To work closely with university's to build the supply of nurses, internal recruitment and to encourage former colleagues to return to work through the return to work scheme.
2. For nurses to remain in employment through appropriate training education and support, with a number of new courses to be developed to uplift our nurses. Ensuring there is pride and development opportunities in our workforce, with a strong focus on leadership.
3. Funding has been agreed to recruit nurses from overseas and ensure this is a speedy process with minimum bureaucracy.

2nd Priority Maternity

Great progress has been made to reduce the risk of still births over the years. The aim is to be the safest place to birth. This can be achieved through learning from recent cases. A re-structure in midwifery leadership to include direct reporting to a board member director. I.e. midwives to sit on board.

To develop leadership that empowers midwives to deliver the safest care. All women to have outstanding maternity care by March 2021. .

3rd priority COVID-19

The CNO like other key government officials stated this was the biggest leadership challenge of our lives. She stressed the importance of working with colleagues to ensure mechanisms are in place so colleagues can come back into nursing. Consideration about how we enable 3rd year students to become part of our registered workforce. At the same time we must be the advocate for patients and staff in conjunction with evidence based research facilitating patient safety. Our success will shape the future of nurses, she was clear that this journey is about senior leaders in creating the NHS of the future.

7. Body Worn Camera research

Following on from an interesting discussion on this topic earlier this year within the mental health forums, I thought board members would like to know that the Maudsley Charity has funded an independent research project led by Prof Alan Simpson.

"Body worn cameras allow NHS staff and patients on inpatient wards to request a situation to be filmed. The use of body worn cameras is being trialled in a number of mental health trusts in the UK. This project, led by researchers at the Institute of Psychiatry, Psychology & Neuroscience, King's College London and clinicians at South London and Maudsley NHS Foundation Trust will undertake the largest study to date of NHS staff and patient attitudes to the potential use of body worn cameras and explore the ethical and therapeutic considerations of their use in NHS healthcare settings."

https://maudsleycharity.org/case-studies/body-worn-camera-study/

8. Recommendations

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

Cathy Woffendin,
Director of Nursing, Professions & Quality
March 2020

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:	Safe Staffing
DATE OF MEETING:	26 March 2020
PRESENTED BY: (name and title)	Nichola Sanderson, Deputy Director of Nursing
PREPARED BY: (name and title)	Linda Rose, Head of Nursing and Patient Experience Adele Sowden, E rostering team manager

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

EXECUTIVE SUMMARY

Leeds and York Partnership NHS Foundation Trust (LYPFT) staff provides inpatient care across 27 wards. This paper includes routinely reported Safer staffing information from the 1st January 2020 to the 31st January 2020 and the 1st February 2020 to the 29th February 2020.

There were no staffing breeches to report during this period and an update has been provided regarding the suitability of the Adult Inpatient Wards Safer Nursing Care Tool (SNCT) as an alternative to the use of the MHOST tool across the Older People's wards.

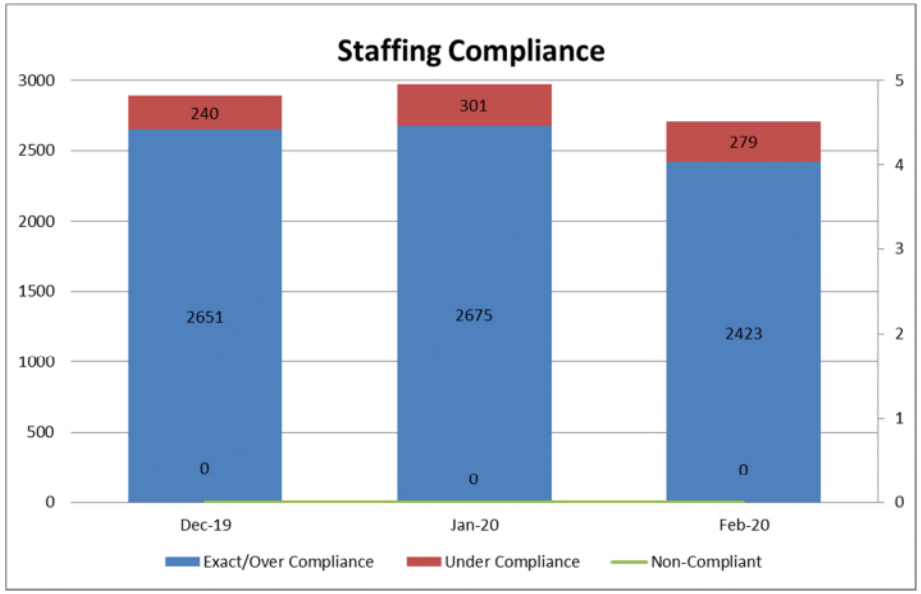
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes please set out what action has been taken to address this in your paper
	No	

RECOMMENDATION

The Board is asked to:

- Review and discuss the staffing rates and updates provided in this report.
- Note the next steps for the development of the MHOST Dementia toolkit.

Safer Staffing: Inpatient Services – January and February 2020



	Number of Shifts		
	December	**January**	**February**
Exact/Over Compliance	2651	2675	2423
Under Compliance	301	279	329
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 across x27 Wards during January and February 2020

Exact or Over Compliant shifts:

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

Under Compliant Shifts:

During January there were 279 shifts that had fewer than the planned number of RN and HSW staff on each shift and during February there were 329 shifts that had fewer than the planned number of RN and HSW staff on each shift (this differs from the unify report below which shows the total hours over the month rather than on a shift by shift basis). Where there are fewer than planned RN staff on shift it is usual for one or more extra HSWs to back fill the vacant duty and ensure safe staffing levels, where a RN is not available to fill the shift.

Non-Compliant Shifts:

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

Exception reports

The Unify reports in Appendix A show that during January and February 2020, Westerdale, Mill Lodge and Ward 4 the Newsam Centre all showed an underfill of Registered nurses during the day. The Mother and baby unit (Ward 5 Mount) also showed an underfill of Registered nurses during the night in February 2020. However there were no breeches regarding Registered nurses during this period.

The primary reason is the high number of vacancies across the services and this is unlikely to ease in the near future.

Matrons have also identified the challenges they are facing regarding obtaining bank staff to fill duties for a combination of reasons. For the acute inpatient services, this has included the impact of Care director training reducing availability to cover the back fill; an increase in 2:1 observations across many wards, and an increase in seclusion at PICU.

The Older people's services at the Mount, have also described daily challenges. During January, Ward 4 the Mount was closed to admissions for 5 days due to a D and V outbreak and there was some concern that a small number of Bank and agency staff had dropped shifts because of this at the last minute. The Bank staffing department are to pick this up with individual members of staff to prevent a repetition of this type of circumstance and to ensure that any learning from this is picked up.

Bank staffing has also successfully supported a number of Bank staff into substantive positions and this has consequently chipped away at the volume of bank staff available. A business case has been submitted to build more capacity within the team to enable them to recruit more frequently to meet bank staffing demands.

The meeting of the January 2020 Safer staffing group agreed that it would be helpful to have a joined up conversation in clinical and operations to identify pinch points / hotspots over the next 8 weeks as we approach the end of the financial and annual leave year as this impacts on the availability of staffing.

Services are reviewing their rosters and where low staffing is identified Matrons will get in contact with the Bank staffing lead to do some focused work to support managing the shortages and redeployment. Q3 redeployment figures have also been examined to monitor the movement of staff across the services and it is clear that this is being under reported on the system. Staff will be reminded of the importance of doing this routinely at the March Safer staffing meeting.

Other Updates:

- The Mental Health Optimal Staffing Tool (MHOST)

The Six Month Mental Health Optimal Staffing Tool data analysis was presented to the Quality committee in December 2019.and private trust board in January 2020. In the absence of a current integrated solution we have worked well collaboratively to deliver the pilot and the analysis through the development of an in-house solution utilising the MHOST licence. As an outcome of the Quality Committee discussion, it was agreed to review whether the Adult Inpatient Wards Safer Nursing Care Tool (SNCT) should be applied as an alternative option across the Older People's wards as the MHOST did not easily pick up on activity; particularly on the dementia wards where physical healthcare interventions such as washing and dressing and medication administration require additional staff capacity.

This option has been progressed by the Workforce Information Manager through discussions with colleagues at Mid-Yorkshire hospitals and following review with the Shelford Group. It is evident that the Safer Nursing Care Tool (SNCT) is not an appropriate toolkit to use for the purposes of measuring acuity/physical activity in our dementia units.

The care descriptors e.g. 'Monitoring and supportive therapy for compromised/collapse of two or more organ/ systems', are incompatible with the care we provide so attempting to use the data we have already gathered under the MHOST care descriptors against the SNCT care descriptors would give a completely compromised outcome.

We are now working with the Shelford Group to enquire into the development of the Dementia wards in Older Peoples services MHOST toolkit that was not available to us at the start of the pilot.

- The 2019/2020 Internal Audit Operational Plan

This includes an audit of safe staffing. As part of the audit a small selection of wards will be visited by the auditors to check that the correct safer staffing processes are in place and understood. The report will go to the Audit Committee in April 2020.

- Allied Health Professionals

We are now able to include Allied Health Professionals in the safe staffing numbers as their shifts are now in place on the rosters.

- Recruitment of Graduates

There has been a positive result from the 37 new graduate Registered Nurses as our services have been preferenced by x35 of them. This is for Sept/Oct 2020 recruitment cohort and we are increasing our link work with York University to ensure consistency with opportunities for employment.
APPENDIX A

- Covid-19

We are working to manage the significant impact of responding to the coronavirus challenge. Planning and coordination arrangements are in place to ensure that we maintain safe service delivery and resilience as far as possible into the future. Managers and clinical leads are working together to establish how we can deliver care and support people in different ways to minimise the spread of the virus. In addition, we have stepped down all non-essential meetings and events which also allows us to maximise redeployment as required.

Safer Staffing: Inpatient Services – January 2020

Fill rate indicator return

Staffing: Nursing, Care Staff and AHPs

Ward name	Cumulative count over the month of patients at 23:59 each day	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Registered Nursing Associates	Non-registered Nursing Associates	Registered allied health professionals	Non-registered allied health professionals	Overall	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - registered allied health professionals (AHP) (%)	Average fill rate - non-registered allied health professionals (AHP)
BECKLIN WARD 1	661	2.7	4.2	0.0	0.0	0.0	0.0	6.9	91.2%	161.8%			101.8%	188.3%				
BECKLIN WARD 3	679	2.7	3.5	0.0	0.0	0.0	0.0	6.1	89.7%	166.0%			100.0%	171.0%				
BECKLIN WARD 4	671	2.7	3.0	0.0	0.0	0.0	0.0	5.6	92.7%	138.0%			100.0%	147.5%				
BECKLIN WARD 5	680	2.5	2.7	0.0	0.2	0.0	0.0	5.4	84.5%	117.8%		100.0%	99.4%	115.9%		100.0%		
BECKLIN WARD 2 CR	138	10.3	15.9	0.0	0.1	0.0	0.0	26.3	103.8%	102.2%			100.4%	106.6%		100.0%		
YORK - BLUEBELL	195	6.7	9.4	0.0	0.0	0.0	0.0	16.1	133.3%	193.2%			103.3%	116.1%				
YORK - RIVERFIELDS	310	3.5	3.9	0.0	0.0	0.0	0.0	7.5	219.7%	135.1%			100.9%	100.0%				
YORK - WESTERDALE	337	4.1	6.6	0.0	0.0	0.0	0.0	10.7	73.7%	106.8%			100.0%	113.3%				
3 WOODLAND SQUARE	92	9.0	14.3	0.0	1.1	0.0	0.0	24.3	85.8%	118.9%		100.0%	106.9%	148.1%		100.0%		
PARKSIDE LODGE	93	14.1	35.3	0.0	1.0	0.0	0.0	50.4	117.5%	92.3%		100.0%	132.3%	119.2%				
2 WOODLAND SQUARE	88	10.1	7.8	0.0	0.0	0.0	0.0	17.9	104.2%	71.7%			100.0%	100.0%				
YORK - MILL LODGE	309	5.3	5.8	0.4	0.0	0.0	0.0	11.5	70.8%	100.7%	100.0%		97.0%	100.1%	100.0%			
THE MOUNT WARD 1 NEW (MALE)	473	3.6	10.6	0.3	0.0	0.0	0.0	14.5	131.8%	169.4%	100.0%		91.8%	255.0%	100.0%			
THE MOUNT WARD 2 NEW (FEMALE)	424	3.5	11.6	0.0	0.0	0.0	0.0	15.0	121.3%	238.3%			115.0%	330.6%				
THE MOUNT WARD 3A	495	2.1	4.4	0.0	0.1	0.0	0.0	6.7	83.0%	105.1%		100.0%	107.0%	127.6%		100.0%		
THE MOUNT WARD 4A	769	1.5	3.7	0.0	0.0	0.0	0.0	5.2	97.0%	131.1%			100.3%	166.3%				
MOTHER AND BABY THE MOUNT	255	5.8	5.7	0.0	0.4	0.0	0.0	12.0	117.7%	82.5%		100.0%	85.4%	122.0%		100.0%		
NEWSAM WARD 1 PICU	333	5.1	14.2	0.0	0.0	0.0	0.0	19.3	90.8%	146.4%			95.2%	212.1%				
NEWSAM WARD 2 WOMENS SERVICES	310	3.8	5.1	0.0	0.0	0.0	0.0	8.9	96.3%	104.4%			100.0%	100.0%				
NEWSAM WARD 2 FORENSIC	367	2.9	5.7	0.0	0.0	0.0	0.0	8.7	99.9%	153.0%			100.0%	159.9%				
NEWSAM WARD 3	425	2.9	3.8	0.0	0.0	0.0	0.0	6.7	111.4%	117.3%			106.5%	115.1%				
NEWSAM WARD 4	617	2.7	6.2	0.0	0.0	0.0	0.0	8.9	79.6%	354.6%		100.0%	100.0%	280.2%				
NEWSAM WARD 5	520	3.1	3.7	0.0	0.0	0.0	0.0	6.8	135.4%	94.2%			99.8%	116.1%				
NEWSAM WARD 6 EDU	356	4.1	4.4	0.0	0.0	1.8	0.2	10.5	134.6%	135.5%			135.5%	93.5%			100.0%	100.0%
ASKET CROFT	610	1.6	2.9	0.0	0.0	0.9	0.0	5.3	100.1%	101.2%			103.3%	128.2%			100.0%	
ASKET HOUSE	477	1.7	1.9	0.0	0.0	0.6	0.0	4.2	106.2%	109.7%			100.1%	125.8%			100.0%	
NICPM LGI	127	13.0	6.2	0.0	0.0	0.0	0.0	19.2	102.4%	115.4%			99.7%	110.5%				

Safer Staffing: Inpatient Services – February 2020

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

Only complete sites your organisation is accountable for	Care Hours Per Patient Day (CHPPD)								Day				Night				Allied Health Professionals	
Ward name	Cumulative	Registered	Non-registe	Registered	Non-registe	Registered	Non-registe	Overall	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill	Average fill
BECKLIN WARD 1	650	2.4	3.9	0.0	0.0	0.0	0.0	6.2	83.5%	165.1%			96.7%	179.4%				
BECKLIN WARD 3	609	2.7	3.7	0.0	0.0	0.0	0.0	6.3	95.9%	166.4%			96.6%	172.3%				
BECKLIN WARD 4	609	2.8	2.9	0.0	0.0	0.0	0.0	5.7	95.5%	124.9%			102.0%	138.6%				
BECKLIN WARD 5	632	2.6	3.6	0.0	0.1	0.0	0.0	6.3	89.4%	135.9%		100.0%	97.0%	178.3%		100.0%		
BECKLIN WARD 2 CR	162	7.2	14.0	0.0	0.0	0.0	0.0	21.2	97.8%	110.1%			86.9%	117.0%				
YORK - BLUEBELL	229	4.7	8.2	0.0	0.0	0.0	0.0	13.0	106.6%	253.4%			103.6%	126.8%				
YORK - RIVERFIELDS	290	3.4	4.1	0.0	0.0	0.0	0.0	7.5	199.6%	139.4%			102.2%	100.6%				
YORK - WESTERDALE	335	3.4	5.9	0.0	0.0	0.0	0.0	9.3	59.0%	111.7%			103.6%	102.4%				
3 WOODLAND SQUARE	87	9.2	12.3	0.0	2.1	0.0	0.0	23.6	92.5%	120.3%		100.0%	107.1%	128.5%		100.0%		
PARKSIDE LODGE	97	11.7	31.1	0.0	1.9	0.0	0.0	44.7	111.0%	88.2%		100.0%	107.3%	130.1%		100.0%		
2 WOODLAND SQUARE	91	10.6	7.2	0.0	0.0	0.0	0.0	17.8	110.9%	56.4%			100.0%	100.0%				
YORK - MILL LODGE	289	5.1	6.3	0.3	0.0	0.0	0.0	11.7	64.5%	104.5%	100.0%		98.9%	101.7%				
THE MOUNT WARD 1 NEW (MALE)	440	2.9	9.6	0.2	0.0	0.0	0.0	12.7	88.9%	163.5%	100.0%		92.9%	233.7%				
THE MOUNT WARD 2 NEW (FEMALE)	416	3.6	11.5	0.0	0.0	0.0	0.0	15.1	131.6%	231.1%			116.2%	372.0%				
THE MOUNT WARD 3A	568	1.8	3.7	0.0	0.0	0.0	0.0	5.6	91.3%	98.0%			100.0%	147.0%				
THE MOUNT WARD 4A	714	1.5	3.6	0.0	0.0	0.0	0.0	5.1	95.9%	132.0%			99.8%	153.3%				
MOTHER AND BABY THE MOUNT	221	6.0	6.9	0.0	0.1	0.0	0.0	13.1	107.0%	105.7%		100.0%	70.3%	137.1%				
NEWSAM WARD 1 PICU	339	4.4	10.8	0.0	0.0	0.0	0.0	15.2	80.7%	130.0%			91.8%	160.8%				
NEWSAM WARD 2 WOMENS SERVICES	309	3.7	6.1	0.0	0.0	0.0	0.0	9.8	98.3%	133.9%			110.4%	136.7%				
NEWSAM WARD 2 FORENSIC	348	3.0	5.6	0.0	0.0	0.0	0.0	8.6	96.6%	161.2%			107.1%	141.9%				
NEWSAM WARD 3	404	2.7	4.3	0.0	0.0	0.0	0.0	7.1	99.4%	161.3%			113.9%	120.9%				
NEWSAM WARD 4	560	2.6	4.2	0.0	0.2	0.0	0.0	6.9	69.5%	223.0%		100.0%	100.0%	183.2%		100.0%		
NEWSAM WARD 5	522	3.0	3.6	0.0	0.0	0.0	0.0	6.6	138.1%	100.0%			100.0%	121.0%				
NEWSAM WARD 6 EDU	194	6.5	7.0	0.0	0.0	2.1	0.0	15.6	115.8%	127.0%			145.0%	81.6%			100.0%	
ASKET CROFT	580	1.5	2.6	0.0	0.0	0.6	0.0	4.7	94.7%	105.6%			100.0%	101.7%			100.0%	
ASKET HOUSE	464	1.6	1.6	0.0	0.0	0.6	0.0	3.8	106.8%	97.8%			100.0%	103.4%			100.0%	
NICPM LGI	210	7.2	3.6	0.0	0.0	0.0	0.0	10.8	102.4%	103.6%			98.3%	123.6%				

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:	Medical Directors Report- Pharmacy Services
DATE OF MEETING:	26 March 2020
PRESENTED BY: (name and title)	Claire Kenwood- Medical Director
PREPARED BY: (name and title)	Jane Riley- Chief Pharmacist

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 Medical Directors report focuses on pharmacy services.

This paper provides a brief update on the pharmacy service since the current chief pharmacist came into post in May 2018.

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

This is provided for information, the Board are asked to note the content.

MEDICAL DIRECTOR REPORT- PHARMACY SERVICES UPDATE

The following provides a brief update on the pharmacy service since the current chief pharmacist came into post in May 2018.

Service Delivery

- On the 31st of August 2018 The Retreat dispensary and pharmacy staff based there transferred to TEWV.

- Despite ongoing work with colleagues in estates it has not proved possible to move to a single pharmacy dispensary within the existing estate. There has been some work with the Continuous Improvement team to optimise the workflow within the current pharmacy dispensaries (at The Mount and Becklin Centre) and some interim premises improvement work is planned this year to ensure the existing spaces are fit for purpose.

- There is also ongoing work to support pharmacy staff to work in a more agile way which along with other benefits, such as efficiency and staff well-being, also reduces the demand for working space within the existing pharmacy premises.

- A single dispensary remains within the services longer term plans, as it would be more efficient, free up pharmacy staff time for more patient facing roles and could potentially allow wider hours of service and pharmacy staff to work more flexibly.

- The pharmacy service continues to deliver services within budget and contributing to the annual CIPs. Commissioners have recently agreed to fund the provision of specialist MH and LD pharmacy services to GP practices, expanding a small pilot to a total of six pharmacists and six pharmacy technicians working across the city.

- Pharmacy Services are being planned in accordance with Carter recommendations (which are to increase the numbers of specialist pharmacy professionals working in multidisciplinary teams to lead and co-ordinate medicines across the care system, increase the number of pharmacist prescribers, innovative use of pharmacy staff/ systems/ technologies, ensure value for money of all infrastructure activities and to streamline processes for the ordering, approval and delivery of medicines).

- In order to make the registered pharmacy workforce more accessible to patients/ carers there is ongoing work reviewing the teams skill mix (increased use of band 2/3 support/ admin staff) and to increase the use of enabling technology (wider roll-out of smart phones and laptops, upgrading desktop devices, purchase of software to support financial analysis of drug spend and transfer of information to community pharmacists).
- We were really pleased to see the following in our recent CQC report '*We rated it as good because:…pharmacy staff met directly with patients and their families to help them understand prescribed treatment'.*

- A Medicines Management Internal Audit in 2019 concluded there was 'Significant assurance'.

- Work continues to provide the same level of service to patients under the care of LYPFT beyond the inpatient setting with more pharmacist/ technician involvement in the community based services. And as mentioned above an expanding team working into GP practices (the Medicines Optimisation Liaison Service, MOLS).

Workforce

- Nationally there have been some quite significant changes within pharmacy. Community pharmacy contracts are becoming increasingly focused on the provision of clinical (rather than medicines supply) services. Whilst few disagree with the overall direction of travel the transition is challenging and has resulted in the closure of community pharmacies.

- The NHS Plan a significant increase in the number of pharmacists working in general practice and supporting care homes. Professionally this is great news however it remains unclear where this additional workforce (an estimated 6,000 pharmacists working in PCNs by 2024) will come from as to date there has not been the corresponding increase in pre-registration pharmacist placements.

- Whilst there is nationally funded training aimed at supporting community pharmacists transition into these new PCN roles, pharmacists with hospital experience are a more natural fit. This combined with the preferential terms and conditions (such as no weekends/ on-call) offered in primary care is creating a pharmacy workforce pull from secondary care.

- Nationally and locally there are work streams to address the above and an increase in the number of cross-sector training and working opportunities. At a recent citywide meeting there was widespread support for a Consultant MH pharmacist to work across the city and this is being progressed.

- To date the pharmacy service has no long term vacancies and has not used agency staff since The Retreat transferred to TEWV 18months ago.

- Detailed analysis has not yet been completed on the most recent NHS Staff Survey but there was a 74% pharmacy staff response rate in 2018 with >80% positive responses regarding the quality of line management and appraisals, staff engagement and safety culture. An action plan was completed in response to areas with less positive responses such as opportunities for flexible working, MSK/ stress-related sickness and the fair treatment of staff involved in an error.

- Pharmacy staff feedback on our in-house E&T program was very positive and we'll be pursing the use of technology to record these sessions to make them more widely available to our staff (and possibly other teams too).

- The departure of the previous deputy chief pharmacist enabled a rethink of senior pharmacists' roles within the team. The Trusts Medicines Safety Officer (MSO) role

now sits with Deputy Chief Pharmacist, reflecting the importance of medicines safety across the Trust (and nationally) and a pharmacy/ medicines optimisation patient experience lead has been established. Senior Lead Pharmacists areas of responsibility have been re-visited to align with Care Services and external partners.

Other Key Areas of Work

- Embedding a '*Just Culture*' approach (psychologically safe and accountable) to the management of medicines-related incidents and near misses.

- Trustwide Quality Improvement work regarding the safe and effective use of clozapine, the use of valproate in women of child-bearing potential and protective our patients from VTE. Also on other high risk areas of drug use such as the use of high dose antipsychotics, rapid tranquilisation acd the use of unlicensed medicines.

- Optimal use of Non-Medical Prescribers (NMPs) of all disciplines across the Trust. Also, supporting the training, development and competency assurance of all staff involved in the use of medicines.

- Due to recent concerns regarding the Electronic Prescribing and Medicines Administration (EPMA) system the deputy Chief Pharmacist has stepped in to address current concerns regarding the system and re-establish a multidisciplinary team and governance structure for the system (which will also ultimately ensure optimal use of the system through its full roll-out across the organisation and effective integration with Care Director).

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:	Guardian of Safe Working Quarterly Report Quarter 3 October 2019 to December 2019
DATE OF MEETING:	26 March 2020
PRESENTED BY: (name and title)	Dr Claire Kenwood- Medical Director
PREPARED BY: (name and title)	Dr Ben Alderson- 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

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

- There have been seven exception reports
- There were no patient safety issues
- Junior doctors forum met in February 2020
- Pay queries in relation to potential underpayment to Higher Trainees has still to be finalised
- Forthcoming changes to CT rota to comply with updated TCS

In summary, exception reporting (ER) has now been in place within the Trust for over 3 years. We continue to work with the junior doctors and clinical supervisors to ensure that we are developing a culture where ERs are positively received and used as a mechanism to effect change.

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

RECOMMENDATION

The Board of Directors are asked:

I. To agree that this reports provides an assurance level for the systems in place to support the working arrangements of the 2016 Contract and TCS for the junior doctors working in the Trust and that they are meeting their objective of maintaining safe services
II. To provide constructive challenge where improvement could be identified within this system.

MEETING OF THE BOARD OF DIRECTORS

26 March 2020

Guardian of Safe Working Hours Report

Quarter 3 October – December 2019

1 Executive Summary

The purpose of this quarterly report is to give assurance to the board that doctors in training are safely rostered and that their working hours are compliant with the Junior doctors contract 2016 and in accordance with Junior doctors terms and conditions of service (TCS). The report includes the data from 01.10.19 to 31.12.19.

2 Quarter 2 Overview

Vacancies		There are 2 vacancies in the Core Trainee establishment.					
		There are 6 vacancies in the Higher Trainee establishment.					
Rota Gaps		October		November		December	
		CT	HT	CT	HT	CT	HT
	Gaps	41	16	40	14	41	18
	Internal Cover	37	15	36	14	36	18
	Agency cover	3	0	3	0	2	0
	Unfilled	1	1	1	0	3	0
Fill Rate		96%	94%	98%	100%	93%	100%
Exception reports (ER)		2	0	0	3	2	0
		4 ER's in this period relate to CT rota gaps where educational opportunities to attend ALPS were missed due to there being 3 doctors on shift rather than 4. None of these incidents resulted in patient safety issues or working beyond contracted hours. 3 ER's relate to the same incident occurring on consecutive weeks. This was erroneously recorded as an immediate safety concern. The HT had their room booking at South Wing over-written resulting in them struggling to find space					

	to see the booked appointments
Fines	None
Patient Safety Issues	None
Junior Doctor Forum	Meeting held on 7 February 2020. Items of note were: • There is ongoing concern regarding the delay in back-payment for HT's. This has been escalated by the medical education manager to payroll. • Concern from the junior doctor body that there are CT rota changes which must be implemented by August 2020. Trainees were concerned that reducing from 8 consecutive working days to 7 consecutive working days would result in a pay reduction and may limit training opportunities. An exceptional meeting was held with the junior doctor body on 24.2.20 with attendance by Guardian of Safe working hours, AMD for DiT, BMA representative and Medical Directorate Manager to address concerns and explain process of change to the rota. • Junior doctors will continue to use ER as method to record administrative issues which result in room booking errors where there are missed educational opportunities or patient safety issues
Guardian of Safe Working Recruitment	Dr Ben Alderson was appointed to the position from 1 December 2019.

3 Conclusion

Exception Reporting has now been in place within the Trust for over 3 years. We continue to work with the junior doctors and clinical supervisors to ensure that we are developing a culture where ERs are positively received and used as a mechanism to effect change.

4 Recommendations

The Board of Directors are asked:

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

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

Dr John Benjamin Alderson
GMC 6166755
Guardian of Safe Working Hours
13 March 2020

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:	Reciprocal Mentoring
DATE OF MEETING:	26 March 2020
PRESENTED BY: (name and title)	Claire Holmes, Director of OD & Workforce
PREPARED BY: (name and title)	Caroline Bamford, Head of Diversity and Inclusion

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 development and delivery of a reciprocal mentoring programme in the Trust was approved at the February 2020 Workforce Committee meeting. The attached paper provides background, overview and timescales for the programme development.

Our ambition is to have a representative workforce, with focus on increasing diversity at senior levels across our organisation, particularly Black, Asian and Minority Ethnic (BAME) leadership representation. The NHS Workforce Race Equality Standard strategy [1] sets out the targeted ambition of leadership which is representative of the overall BAME workforce by 2028.

The purpose of the programme will be to promote learning, insight and understanding of lived experience of colleagues from different groups, to support career development and contribute towards creating a diverse and inclusive culture.

The development of reciprocal mentoring will provide the opportunity to enhance our cultural change work through providing a structured, but informal process for mutual knowledge and experience exchange to enhance and develop skills and to develop inclusive leadership practice.

A cohort of seven mentors and seven mentees is proposed for this first programme, with it commencing in July 2020. The participation of Board members as mentors would support

[1] A Model Employer; increasing black and minority ethnic representation at senior levels across the NHS; NHS England and NHS Improvement, January 2019

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

RECOMMENDATION
The Board of Directors are asked to support the development of reciprocal mentoring. Members are asked to consider being involved as mentors in this first programme and to agree timescales and process for expressions of interest.

MEETING OF THE BOARD OF DIRECTORS

26 March 2020

Reciprocal Mentoring Programme

1 Executive Summary

The development and delivery of a reciprocal mentoring programme in the Trust was approved at the February 2020 Workforce Committee meeting. This paper provides background, overview and timescales for the programme development.

Our ambition is to have a representative workforce, with focus on increasing diversity at senior levels across our organisation, particularly Black, Asian and Minority Ethnic (BAME) leadership representation. The NHS Workforce Race Equality Standard strategy [1] sets out the targeted ambition of leadership which is representative of the overall BAME workforce by 2028.

The purpose of the programme will be to promote learning, insight and understanding of lived experience of colleagues from different groups, to support career development and contribute towards creating a diverse and inclusive culture.

Evidence from other NHS organisations implementing similar programme have identified positive outcomes for both mentors and mentees. These indicate positive career development outcomes and a shift in their underlying culture, to one where strong alliances have been built and the power of difference is valued and where biases are challenged.

Reciprocal mentoring aims to support genuine learning exchange through a two way relationship between individuals that come from diverse organisational, professional and/or cultural backgrounds. Within the mentoring, both parties take on the role of mentor and mentee

[1] A Model Employer; increasing black and minority ethnic representation at senior levels across the NHS; NHS England and NHS Improvement, January 2019

and the relationship is not based on seniority or status but driven by mutual knowledge exchange by the individuals involved.

The benefits of mentoring include increased peer recognition, broadening networks and to enhance and develop skills.

The development of a reciprocal mentoring programme was proposed by Sara Munro, Chief Executive and supported by Board members and senior leaders at an internal diversity and inclusion workshop held in September 2019.

2 Model and Next Steps

An action learning approach will be used and this first programme will be collaboratively developed by the Diversity and Inclusion and Organisational Teams in partnership with our staff BAME network, the Workforce Race Equality Network (WREN).

A working group is currently being established to develop a model and evaluation process which meets the needs of our organisation, incorporating best practice and learning from the Leadership Academy and other NHS organisations. Based on experience and evaluation from other similar programmes, it is recognised that development activity for both mentors and mentees will be an essential part of the programme to support the development of mentoring skills and to build trust in the process. This will aim to positively impact both uptake and outcomes from the programme.

A maximum one day, mentoring development session for both mentors and mentees will be developed to be delivered by an external expert facilitator in this area. This will be developed in line with the European Mentoring and Coaching Council Codes of Practice.

It is proposed that Board members are encouraged to participate in the programme as mentors, with any additional opportunities being made available to senior leaders. Mentees would be recruited to the programme via our WREN staff network members. There will be a maximum of seven mentoring pairs (fourteen participants) within the first cohort.

Mentors and mentees will be recruited to the programme through a brief expression of interest process. Guidance and promotional information will be developed, setting out clear details of

the aims and purpose of the programme and expectations from both mentors and mentees framed under the following four areas;

- Working together
- Taking responsibility
- Being authentic
- Embracing change

The initial matching process will be facilitated by the Diversity and Inclusion and Organisational Development Teams using the same professional and ethical boundaries used within our established coaching model.

To enable sufficient and robust development time through the proposed working group, a July start date is proposed.

The number and location of mentoring meetings will be mutually agreed by participants, with meetings taking place a minimum of once every two months.

Ongoing peer and co-ordination support will be provided to both mentors and mentees throughout the programme. This will be led by Ruby Bansel, the Diversity and Inclusion Project Manager. Ruby has experience of successfully delivering a previous mentoring programme for BAME graduates within our Trust and is a key member of our staff WREN staff network.

Feedback and evaluation from other trusts indicates that ideal timescales for the mentoring relationship are twelve months or longer, to maximise learning for both mentors and mentees. This will be explored further and agreed through the working group.

Full evaluation will be undertaken following the first programme to inform future development and opportunities for extending the programme out and further developing the model to meet the needs of different groups, for example Disabled staff.

3 Conclusion

The development of reciprocal mentoring will provide the opportunity to enhance our cultural change work through providing a structured, but informal process for mutual knowledge and experience exchange to enhance and develop skills and to develop inclusive leadership practice.

Initial feedback from our WREN staff network members has indicated that they would value the opportunity to participate in a reciprocal mentoring programme.

The participation of Board members as mentors would support the success of the programme.

4 Recommendation

The Board of Directors are asked to support the development of reciprocal mentoring. Members are asked to consider being involved as mentors in this first programme and to contact Caroline Bamford to express interest or for further information by Friday 10th April.

Caroline Bamford
Head of Diversity and Inclusion
19th March 2020

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:	Health Education England (HEE) Education & Training Self-Assessment Report (SAR), Reporting Period: 2019/20
DATE OF MEETING:	26 March 2020
PRESENTED BY: (name and title)	Claire Holmes, Director of OD and Workforce
PREPARED BY: (name and title)	Angela Earnshaw, Head of Learning and 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

All HEE placement providers need to complete an annual Self-Assessment Return (SAR). The SAR covers the following:

- Section 1: Organisation overview linked to the HEE Quality Framework
- Section 2: Reporting against HEE 2019/20 Priorities
- Section 3: Assurance and exception reporting
- Section 4: List of supporting information
- Section 5: Financial accountability
- Section 6: Additional sections
  - 6.1: Simulation, patient safety and human factors
  - 6.2: Equality and diversity
  - 6.3: Libraries and knowledge services (LQAF)
  - 6.4: Staff, associate specialist and specialist doctors
  - 6.5: Supporting learners at coroners' court and following serious incidents

The HEE Quality Framework six domains are:

1. Learning Environment and Culture
2. Educational Governance and Leadership
3. Supporting and Empowering Learners
4. Supporting and Empowering Educators
5. Developing and Implementing Curricula and Assessments
6. Developing a Sustainable Workforce

HEE expect the Trust's Board to have seen the SAR and have approved its submission. The deadline for submission is 10th April 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

The Board of Directors are asked to

1. Read and note the contents of the SAR
2. Approve the SAR for submission to HEE

NHS
Health Education England

2020 Education & Training

Self-Assessment Report (SAR)

Reporting Period: 2019/2020

Deadline for submission to HEE: 10th April 2020

Trust's name:	**Leeds and York Partnership NHS Foundation Trust**
Value of contract / funding with HEE:	1. Total initial 19/20 LDA value *(including undergraduate and NSCAP)*: £9,268,000 2. Total for salaries for doctors in training in 19/20: £ 1,707.000 3. Total estimated Medical placement tariff in 19/20: £ 932,000 4. Total estimated Non-medical placement tariff in 19/20: £ 428,000
Trust Chief Executive's name:	**Sara Munro**
Director of Medical Education (DME) **Head of nursing and patient experience**	**Sharon Nightingale** **Linda Rose**
Name of Board Level Exec/Non-exec Director responsible for Education and Training strategy within your organisation:	**Claire Holmes, Director of Organisational Development and Workforce**
Report compiled by (responsible for completion of):	**Head of Learning and OD, working with Education Professional Leads**
Report signed off by:	
Date signed off:	
Board Approval: **1. Approved by / on behalf of the Trust Board: (date / details)** **2. Date seen at or scheduled for Board meeting**	

Contents

Section 1: Organisation overview linked to the HEE Quality Framework

1.1. Statement of how the HEE Quality Domains are being met organisationally

This SAR is aligned to the HEE Quality Framework: https://hee.nhs.uk/our-work/quality
For medical education the SAR is also aligned to the GMC Standards:
http://www.gmc-uk.org/education/index.asp

The Trust's values are to provide a caring workforce with integrity, and make it easy for the communities we serve and the people who work here to achieve their goals. Behaviours to uphold these values means investing time and resources in the continual professional development of our colleagues/students. The following evidences how the Trust enables educational governance and leadership, nurtures and maintains our enthusiastic and innovative educators to deliver high quality training, assessments, clinical placements for learners; and produces a sustainable future workforce.

The Trust is very fortunate to have a Board with a strong academic and educational background with education being at the heart of patient safety.

Supporting learners and educators, we have strong established links with Higher Education Institutions (HEI), Health Education England (HEE), Yorkshire School of Psychiatry and the Royal College of Psychiatrists (RCPsych).

Specialising in mental health and learning disabilities, we recognise the importance of developing a sustainable workforce. In recent years and with predicted future shortfall in workforce, having a robust recruitment and retention strategy for our learners and educators is key. Multi-professionally, we are proud of our ongoing work, some examples this reporting year are:

- Employment of first registered Nursing Associates (NA) and increasing numbers of trainee nursing associates and Associate Practitioners (AP)
- First registered NA commencing the 2 year learning disability nursing top up programme
- International medical graduate tutor post and RCPsych and HEE award winning induction programme
- Director of Medical Education (DME) received Chair and CEO staff award for inspiring leadership and developing others
- Trust funded Academic Clinical Fellow (ACF) Core Trainee (CT) post was winner of RCPsych Mohsen Naguib Prize for the best short scientific paper
- ST6 was awarded Yorkshire School of Psychiatry Higher Trainee of the Year
- Strategic Lead for Psychology and Psychotherapy a member of the trail blazer group for the development of clinical associates in Psychology
- NA apprenticeship for internal health support workers
- Established an internal recruitment process for Associates in training offering equal opportunities to all for post-qualifying AP and NA roles
- Scoping out opportunities for qualified Associates internally to complete an apprenticeship to become registered nurses or AHPs
- Working with local universities to improve BAME recruitment, widening the recruitment pool in Leeds and wider.
- Involvement in the recruitment of applicants to the undergraduate courses in Leeds.
- Supporting secondary school students in their decision to choose a healthcare-related career.

There are emerging AHP faculties nationally looking at increasing supply routes into AHP careers. LYPFT were successful in applying to run a faculty test bed pilot project to address wider challenges experienced nationally for our AHP workforce. The national project is funded by HEE and out of 27 bids we were one of the 24 projects selected.

The faculty aims to highlight and investigate low diversity within the AHP workforce, the impact on the service provided and engagement of service users as the AHP population does not reflect society and service user population. The faculty have set up workstreams to focus on increasing BAME applications to undergraduates in education, improve work experience for our minority groups and support continuing education and training

1.2. Top three successes

This section should be used to document a high-level summary of the successes your organisation is most proud of achieving during the reporting period.

Description of success	Domain(s)	Standard(s)
Multi-professional positive practice visit from Health Education England	Themes 1-6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Commissioning of Service Evaluation Projects by clinical psychologists in the Trust. Clinical Psychology trainees complete service related research and evaluation projects as a core component of their research training. High quality commissioned projects receive ethical approval and contribute to high levels of evaluation within the Trust, with clear opportunities to impact positively on services and on service user experience (Sharon Prince)	Themes 1-6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Inpatient units are building links with community services to facilitate an experience of the care pathway for students, integrating good peer support and experience with different educators e.g. Older peoples service (OPS) Pathway – and Community Pathway	Themes 1-6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust

1.3. Top three challenges or prominent issues that HEE should be aware of

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section.

Description of challenges	Domain(s)	Standard(s)
Implementation of the new EPR in March 2020	Themes 1-6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Maintaining commitments to clinical psychology working age adults (WAA) due to challenges accessing clinical space, perceived capacity of supervisors and increased complexity in the service user population.	Themes 1-6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Sufficient Practice Placement Educators / Practice Assessors / Practice Supervisors to meet the student population needs	Themes 1-6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust

Section 2: Reporting against HEE 2019/20 Priorities

HEE Domain 1 Learning Environment and Culture
For additional guidance refer to HEE Quality Framework, page 9 & 10
HEE priority for 2019/20 reporting in this domain is: • *In your organisation, in which clinical service areas does clinical workload regularly impact adversely on your ability to deliver clinical training?* • *What strategies do you employ to maintain both clinical service and training on a daily basis?*

In which clinical service areas does clinical workload regularly impact adversely on your ability to deliver clinical training?

Nursing, AHP's

There are on-going challenges throughout the Trust around capacity of educators and assessors for both nursing and AHP. Placement capacity is the real challenge for practice education. The current challenging environment in healthcare provision is the recent and on-going service reorganisation, and the desire to increase student numbers necessitates the need for close collaboration between practice and academic partners. Strong working partnerships across HEI partners and membership of regional governance meetings and initiatives help to ameliorate some of the issues and maximise the utilisation of available capacity.

The multi-disciplinary nature of the majority of the practice placements across the Trust further necessitates the consideration of students' needs across all professions, including learners from new routes into nursing such as Nursing Associates and nursing apprenticeships. LYPFT are currently involved in a city-wide project looking at capacity across the city and this is enabling new learning environments to become available to all learners.

This is due to vacancy rates and nurses having the level of training appropriate to become sign off mentors. The changes to learning envisaged as part of the SSSA introduction will mean key alterations to the Supporting Learners in Practice (SLiP) programmes - the PLDT is at the centre of these cultural and programme changes and is anticipating these challenges. The Trust will continue to promote the acquisition of the additional essential skills required to operate as a skilled assessor in clinical practice.

The development of the Nursing and Midwifery Council (NMC) (2018) Standards for Student Supervision and Assessment (SSSA) has led to close partnership working with HEI partners in providing a joined up process that will facilitate the smooth adoption of the standards. This will be a key part of the future culture of the support for undergraduate nursing students. It necessitates an increase in the inter-professional assessment of nursing students.

Medical

NHS Consultant Psychiatry recruitment and retention continues to struggle nationally. In Leeds, the general adult psychiatry inpatient wards have not attracted full substantive Consultant recruitment. All CT and specialist trainees (ST) in psychiatry have a mandated length of training needed in inpatient units and this can only be delivered by General Medical Council (GMC) approved substantive consultant psychiatrists. This has put pressure on those trainers in post

and remains an on-going risk for future placements. The DME remains in close contact with the Training Programme Directors (TPD) for Foundation, Core and Speciality Psychiatry Training to ensure good quality and consistent clinical supervision available. The senior medical leadership team is working with services and human resources to look at innovative ways to improve recruitment and retain consultants including retire and return, flexible working and hybrid clinical, leadership, teaching and research posts. Learning from consultant vacancies in the general adult wards led to successful short term over recruitment of GMC approved clinical supervisors for planned retirements in the old age psychiatry wards to prevent predicted gap for education and patient care. A process has been agreed with Yorkshire School of Psychiatry/Mental Health Trusts that LYPFT DME has oversight of Specialist Trainees (ST) CCT due dates and matches them (with trainee permission) to East and West locality Mental Health Trusts medical directors to enable filling of regional consultant posts.

Foundation doctors (FP) and CTs continue to be expected to undertake phlebotomy and ECGs on inpatient wards at the expense of developing psychiatry competencies. Non- medical staff being up skilled in programme for improving physical health in our service users. CTs are part of a joint LYPFT and Acute Trust research project on mobile hand held ECG administration.

Innovations in delivery of medical undergraduate psychiatry placements continue and face to face patient contact remains challenging due to reduced bed base and more community based services. This year our feedback for patient involvement again improved but still has room to develop. DME and undergraduate lead are working with University of Leeds (UoL)to increase clinical teaching in psychiatry throughout curriculum and DME incorporated 'Top tips for trainers for medical students in psychiatry' into the HEE approved teaching delivered to postgraduate clinical and educational supervisors in psychiatry Yorkshire and Humber wide.

There is reduced attendance at the internal medical teaching programme for consultants and SAS due to accessibility of teaching space and parking facilities. In the Trust, to allow ready access to return to wards, only one training room at the Becklin centre has capacity to accommodate half of the trainees at a time (hence same programme runs twice a month to allow access for all) and no parking on site. This training is mandated for junior doctors with good attendance but they are requesting more regular senior medical attendance as they feedback it improves quality significantly and allows vicarious modelling of teaching skills and production of work placed based assessments. The Trust Medical Education Committee is reviewing options for 'off site' teaching options to improve attendance but allow readily accessible return to Becklin, Mount and Newsam ward

Psychology

Clinical Psychology has a 15% vacancy rate nationally. The key HEI partner is the University of Leeds which hosts a long established Clinical Psychology Training Programme. This is the main training provider within West Yorkshire. Each year of the Doctorate Programme has 16 Trainees who are placed in clinical settings within West Yorkshire. LYPFT is a key provider of placements across a range of services for Adults.

The Trust is very well represented in the provision of placements in all 'specialist' settings (i.e. people with learning disabilities, older people's services, rehab and recovery, inpatient services, personality disorder, forensic, eating disorder, gender identity, and neuropsychology).
There have been challenges in the provision of working age adult mental health placements, where transformation/redesign, workload and complexity, and limited clinic space have impacted on provision. The WAA Psychology Service Lead has met with senior clinical tutor staff from the University to discuss these challenges and a plan for a sustained increase in placement provision has been agreed in this service area.

What strategies do you employ to maintain both clinical service and training on a daily basis?

Nursing, AHP's

There is a high priority placed on the naming of an Education Lead (EL) for both nursing and AHPs within each placement area. These individuals take on the responsibility for promoting the quality of the learning environment and linking with the Practice Learning and Development Team.

The quality of placements is constantly assessed through the use of student feedback both through the new PARE platform and through informal peer networks, creating the structure for awareness and a positive culture within clinical environments.

Student feedback issues are raised and managed with HEI partners and within the Trust. This positively drives the culture and expectation within all clinical areas.

The use of the Trust's incident reporting platform (DATIX) allows for the sharing of crucial information when learners are involved in incidents. As a result students can be offered early support and there is an active process to ensure that all parties have relevant knowledge.

The Practice Learning and Development Team regularly attend Trust clinical governance meetings and influence the agenda for learners across the Trust.

There is an annual development day targeted at Education Leads and senior mentors which considers the wider cultural changes in education and allows for innovative practices to be showcased and discussed.

The recent development of the Clinical Academic Liaison Nurse role has raised the expectation that the best undergraduate dissertations undertaken by final year students will be given a real platform within the Trust and contribute to the improving governance of practice.

Medical

Undergraduate Medical Students (UoL)
All medical student placements are co-ordinated via the undergraduate lead and medical education centre and the clinical supervisor notified well in advance of their student arriving. All have a trust wide and local induction highlighting joint expectations of clinical and educational systems. The quality of induction is ranked highly by learners. All clinical supervisors are job planned for a medical student. This year to improve training in the clinical placement, each medical student has a named SAS/Consultant 'firm lead' for teaching and pastoral support and is readily available if clinical supervisor off or concerns in placement. The firm leads report to and have supervision from the undergraduate lead and DME.
All medical students are allocated a specified session with the crisis team, self-harm team and on call CT to enable emergency psychiatry training safely without impacting on clinical care so the team staff aware of the exact number of students per shift.
Quarterly, there is a DME and UoL interface meeting to review placements and service changes.

Postgraduate
All junior doctors have a mandated interactive clinical and educational induction package in the Trust with excellent feedback.
All CT/ST have protected time in their personalised work schedule for:

- Attendance at internal teaching programme
- Teaching experience

- Psychotherapy competencies
- Portfolio management (including reflective practice)
- Service improvement, leadership, management and research activities,
- Special Interest day for STs and
- UoL Core Psychiatry Training Course attendance for CTs
- Electroconvulsive treatment (ECT) training
- Emergency psychiatry experience

All FP/CT/GP trainees/ST have 1 hour weekly protected educational supervision with a named GMC clinical supervisor and access to senior clinical supervision 24/7 as required. All junior doctors have a named educational supervisor who meets with them regularly and feeds back any concerns to the TPDs and DME.
All clinical and educational supervisors have appropriate job planned time for their junior doctor grade.
The following ensure patient safety and education at heart of service delivery and not competing/conflicting with it:

- Psychiatry specific GMC medical educators appraisal and revalidation guide for all consultants and SAS
- HEE Clinical and Education Supervisors training course in house and/or at HEE delivered by DME quarterly
- DME member of Trust Wide Clinical Governance Committee
- DME member of HEE Psychiatry CT and ST allocation committee to enable Trust/HEE interface re service changes and individual trainee educational needs
- CT and ST coproduced rota templates ensuring trainees 'supported and valued' whilst 24/7 medical cover maintained
- DME quality assures all medical education from trust wide medical undergraduate education through to SAS and Consultant CPD

<u>Psychology</u>

Trainees are allocated to placements within timescales agreed with the University. Newly qualified staff have Introductory Supervisor Training (recognised by the professional body) prioritised within their appraisals and personal development plans. Those training to be supervisors have supervision of their supervision, including written feedback. Clinical services review the work available with regard to suitability of that work for trainees (with adjustment for their year of training). Trainees hold a defined caseload with clinical responsibility being held by the qualified supervisor. Supervisors have access to trainees work through direct observation and recordings of work to ensure the standard of work and provide feedback. Clinical services/teams provide desk and clinical space in order that those in training can contribute to service delivery. Trainees are provided with inductions to teams and clinical areas, and supervision is in keeping (and typically exceeds) the minimum standards set by the professional body. All factors listed above are monitored by the Placements Subcommittee at the University of Leeds, of which Trust staff are members

The following ensure patient safety and education at heart of service delivery and not competing/conflicting with it:

- Introductory Supervisor Training is mandatory for all placement supervisors, with learning objectives that prioritise the wellbeing of service users as an outcome
- Advanced Supervisor Training is mandatory for all experienced supervisors in line with the expectations of the professional body
- Supervisors have direct and indirect access to the work of trainees to ensure quality of

service and provide feedback

- Trainees regularly use service user feedback/sessional measures alongside outcome measures which are reviewed in supervision to monitor and reflect on service delivery and anonymised for placement monitoring purposes with the university.

Leeds and York Partnership NHS Foundation Trust is committed to continuously supporting our staff to deliver safe, effective and compassionate care. The Trust has embedded values and behaviours that were co-created with our staff and stakeholders in 2016/17 and these values inform our approach to leadership, staff development and culture change. We are also committed to giving our staff a voice in local and organisation-wide decision making and we use a number of engagement approaches to deliver this, including our Your Voice Counts crowdsourcing platform.

Our most recent staff engagement activity has involved all staff being invited to take part in a number of conversations about changing our culture, from these conversations we now have a number of key themes which we will all work on the coming months/years.
Learning needs are reviewed and identified as part of the staff appraisal process and the Trust has recently (2019) reviewed and updated the non-medical appraisal policy and process to ensure staff are fully supported to receive the development they need in current roles and also to support future career development.

HEE Domain 2 Educational Governance and Leadership
For additional guidance see HEE Quality Framework, page 11 & 12
HEE priority for 2019/20 reporting in this domain is: • *Many clinical services are undergoing review and change as part of the NHS Long Term Plan & People Plan, what governance steps have you put in place to ensure the required notification of any change in service is given to both HEE and the HEIs to ensure continued clinical placements within your organisation?* • *How does your organisation ensure the governance of education?*
The following factors relate to the Leeds and York Partnership NHS Foundation Trust (LYPFT) structure regarding educational governance and leadership, which is designed to actively support and promote practice learning across the Trust. The structure is illustrative of the utilisation of financial resources provided by HEE to support learning. There is evidence of a link from the learning environment to the organisation's Senior Management Team. The structure also considers the requirements of the 2014 Learning Development Agreement (LDA) linking financial resources to the quality of learning. The following factors also illustrate a desire to promote and utilise placement capacity intelligently whilst recognising capacity as being a challenge in practice. <u>Nursing, AHP's</u> The Practice Learning and Development Team (PLDT) was established to provide support for students across non-medical professions (nursing and Allied Health Professionals (AHPs)) and is funded by the Non-Medical Education Tariff (NMET). The manager of the Practice Learning and Development Team is a permanent member of the newly formed Trust-wide Education Committee. The Freedom to Speak Up Guardian has links with the PLDT and also attends the students' orientation days. Student surveys are shared by the Executive Team and a report on the quality of learning environments is submitted to the Internal Quality Committee on an annual basis. Each placement has a named Education Lead (EL) for both nursing and AHPs. They are responsible for promoting the quality of the learning environment and linking with the Practice Learning and Development Team. All Educational Leads are members of an established network which includes Educational Lead Forums which take place six times every year. These provide the opportunity to share best practice, peer to peer support and promoting innovation. An annual Educational Lead Away Day has recently been established which is funded by the NMET, with guest speakers from local Higher Education Institutions (HEIs). The Practice Learning and Development Team have close and established working partnerships with HEI colleagues, contributing to student recruitment and selection events, course curriculum content and the promotion of student wellbeing and mentorship support. Serious untoward incidents (SUIs) which impact on students are monitored via the Trust's Datix incident reporting system. The Practice Learning and Development Team receives an automated alert to such incidents and in partnership with HEI colleagues manage any pastoral support required for the student.

Students provide feedback about practice placements using the new platform, Practice Assessment Record and Evaluation (PARE). This is reviewed on a regular basis by the Practice Learning and Development Team and areas of concern are discussed within the team meeting on a monthly basis.

Feedback over the last year has been overwhelmingly positive with less than 4% of the total student feedback being negative (436 across all nursing, AHP students and Trainee Nursing Associates). Student feedback issues are raised with clinical team managers with the support of local HEI partners, where action plans are devised and implemented as appropriate.

The close working partnership between the Practice Learning and Development Team and HEI partners enables the provision of Supporting Learners in Practice (SLiP) programmes; attendance is supported across LYPFT by team managers. AHP Practice Educators are supported by the Practice Learning and Development Lead for AHPs, working closely with HEI partners to provide bespoke SLiP programmes, such as APPLE.

The close working partnerships also enable the provision of nurse mentor and AHP Practice Educator updates, promoting strong and supportive links with academic colleagues.

Nurse mentor numbers remain stable, currently numbering 272 in total, and LYPFT have supported 80 of its existing mentors to complete their transition training to become Practice Assessors/Practice Supervisor so far in 2020.

SLiP programmes for AHPs are integrated into the preceptorship programme and the Practice Supervisor training is integrated into the preceptorship programme for nurses.

At any point in time a number of nurse mentors will be inactive because of maternity leave, career breaks etc, and this is reviewed regularly at the Recruitment and Retention meeting chaired by the Director of Nursing, Professions and Quality.

Nurse mentors adhere to current NMC SLiP standards (2010) supported by the Practice Learning and Development Team. Nurses acting as primary mentors for students are 100% compliant with current NMC SLiP standards (2010) evidenced in the student's Practice Assessment Document (PAD) and verified by the student's personal academic tutor: this is a requirement for a nursing student to successfully pass any practice placement.

The Practice Learning and Development Team are currently implementing the new NMC standards for Supporting Learners in Practice (2018) regionally, with the intention of promoting smooth transition and quality assurance for practice learning.

The Director of Nursing, Chief Operating Officer and Director of Medical Education attend the monthly Trust Wide Clinical Governance Committee allowing the integration and sharing of educational and clinical systems and governance. This allows accountability, early identification and transparency of risks to patient safety and quality of education.

The Trust Education Learning and Steering Group (EL&SG) provides the over-arching governance in the Trust to the Education and Learning agenda. Membership of this group includes Education Professional Leads, chairs of the professional education committees, operational service representatives and members whose role supports professional education. Members are required to provide a link from the EL&SG to other Trust profession forums/groups, education providers, external quality assurance standards and commissioning bodies, for example Health Education England (HEE).

The E&LSG has its parent group, the People Development Group, one of the workforce strategic decision groups. The Trust Medical Education Committee and Non-Medical Education Committee (to be established) feed into the EL&SG.

The group works to deliver the following key objectives:-

- The Trust Education and Learning Steering Group will ensure that the Trust meets its education, learning and development needs, in compliance with professional bodies and other national regulation, standards and guidance, within the Trusts governance framework.

- The Trust Education and Learning Steering Group will support a co-ordinated approach to delivering the Trust Education, Learning and Development priorities by supporting the delivery of a Trust wide learning needs analysis and the effective and efficient use of allocated funding and resources.

- The Trust Education and Learning Steering Group will support the effective use of funding and partnership working with professional bodies and HEE, and promote opportunities for funding, in the context of workforce plans and Trust strategy.

<u>Medical</u>

- There is a quarterly Trust Medical Education Committee (TMEC) chaired by the DME that has overseen medical education governance for over a decade. This now quality assures from work experience, undergraduate through to SAS and Consultant CPD. TMEC has a diverse membership and ensures sharing of educational and clinical governance, sharing of outcomes of education and training programmes, reviewing collected data needed for GMC approval requirements and ensuring appropriate learners progression in their clinical and non-clinical intended learning outcomes. Learners attendance at TMEC allows them to raise any concerns about education and training in the Trust.

- All junior doctors are line managed by the Associate Medical Director (AMD) for Doctors in Training (DiT) who works closely with the DME. The AMD for DiT identifies junior doctors via the learner themselves, their supervisor, DATIX or complaints when there are concerns about a learner's professionalism, progress, performance, health or conduct that may affect a learner's wellbeing and/or patient safety. The AMD for DiT will ensure the DME is fully informed to provide pastoral support for the learners and update HEE responsible officer via the exception reporting system.

- All junior doctors at induction are introduced to DME, Champion of Flexible Working, the Guardian for Freedom to Speak Out and The Guardian of Safe Working Hours and made aware of the various ways to report concerns for their own working patterns, loss of educational opportunities, bullying and harassment and patient safety concerns.

- As part of our on-going drive to improve quality, please see the email of medical education driver diagrams used at our annual Medical Leadership Day to drive discussions, look to where we are, we want to be and how to get there. The DME attends HEE CT allocation committee where service changes are a standing agenda item and also is asked to attend or verbally feedback at the ST allocation committee about services changes. This ensures constant and timely notification to HEE of any planned service changes that may affect clinical placements.

- Quarterly, there is a DME and UoL interface meeting to review placements and service

changes.

Psychology

- The Professional Lead for Psychology and Psychotherapy for the Trust sits on the Regional Training Advisory Group which discusses issues of workforce, service change and governance

- Trust staff are well represented within the planning frameworks for academic teaching and have membership of the Academic Subcommittee of the Clinical Psychology training Programme. Trust staff are responsible for the co-ordination of each core population module in the second year of training (People with Learning Disabilities, Older People, Forensic and Psychosis).

- Trust clinicians teach in each of the three years of training and in so doing update learners regarding the relevant context for placements and for practice when qualified

HEE Domain 3 Supporting and Empowering Learners

For additional guidance refer to HEE Quality Framework, page 13-14

HEE priority for 2019/20 reporting in this domain is:

- *Medical trainee support*

Support to medical trainees who submit Exception Reports or Code of Practice concerns?

The Trust uses Allocate software system for Exception Reporting (ER). The trainees all have access to this as soon as commence in post. The Guardian of Safe Working (GoSWH) hours is frequently present to them and chosen by them and assists them in any queries. The GoSWH also assists the supervisors in completing the ER as they remain a rare event in our Trust. The junior doctor rotas are coproduced with the trainees and rank highly on satisfaction for emergency experience, training and work life balance. It is a rarity to have an unfilled rota gap. Anytime a trainee is absent from a rota whether work load excessive or not an ER is requested to be completed.

How do you encourage trainees to identify Educational Exception Reports (e.g. loss of specific training session to cover clinical service gap) from ERs relating to working beyond regular hours?

Both the DME and GoSWH encourage trainees to submit ERs for loss of educational opportunity. So far none have been submitted and on discussion in the Junior doctor forum this is because all junior doctor teaching time, ECT, psychotherapy, study leave is mandatory and protected in their personalised work schedule so they have not struggled to be released. None of our junior doctors do on call cover during core placement hours as this is covered by SAS and consultant grade.

How have you used the 'Rest Monies' allocated to you from central funding to support doctors in training?

The trainees have agreed how ‘rest monies’ are to be used and awaiting work to be undertaken. The Director of Finance who oversees estates is liaising with estates to complete this work as soon as possible.

How does your organisation provide support to learners to ensure they can access rest facilities, IT resources and pastoral support during their placement.

The Trust operates within the RCPsych ‘Trainees supported and valued’ recommendations. This is a standing agenda item at TMEC and the Junior Doctor Forum. Rest facilities and IT resources are thus reviewed at the minimum quarterly and an action log with named person accountable reviewed each meeting. All junior doctors have access to a separate clinical and educational supervisor for pastoral support and career advice. Any trainee involved in a significant event or complaint, failing to progress is also seen by the DME for on-going pastoral support and assistance with reflective practice and portfolio maintenance.

The Champion of flexible working is readily available to meet with trainees considering flexible working for advice and liaises with HEE and the SuppoRTT programme.

How do you support academic learners?

The Trust has financed 1 x CT, 1 x ACF this year to develop an academic psychiatry pathway. From August 2020, there will be 3 CT ACF in psychiatry (2 trust funded and 1 NIHR). The Trust

has created 1 x Trust funded consultant ½ clinical, ½ research and 1x part Trust, Part University of Leeds Funded to provide supervision for the academic trainees. The ACF placements are fully supported by both the clinical supervisors and TPD to ensure protected research time. The ACFs are encouraged to ER if clinical work prevented research time. The current ACF was this year's winner of RCPsych Mohsen Naguib Prize for the best short scientific paper.

HEE Domain 4 Supporting and Empowering Educators
For additional guidance refer to HEE Quality Framework, page 15
HEE priority for 2019/20 reporting in this domain is: • *MEDICAL TRAINING: Please provide details of the specific SPA time you allocate to individual trainers undertaking the roles of named Educational and Clinical Supervisor. Job planned 'one hour per week per trainee under named supervision' is the accepted standard and this is covered by the placement tariff sent with the LDA. Does your organisation meet this standard; if not, what tariff do you apply?* • *MULTIPROFESSIONAL TRAINING: Please provide details of the protected annual time for continued development you allocate to those providing educational roles over and above the time required annually for their continuing clinical development. What in house courses/support do you provide; what external courses do you regularly use?*

Medical

We have 52 consultant trainers and all have job planned a minimum of one hour per week per trainee and medical student under named supervision

All our consultant trainers:

- are GMC approved clinical supervisors and/or educational supervisors
- Are in Good Standing for Continual Professional Development (CPD) with the Royal College of Psychiatrists. This includes the expected hours of medical educator CPD per revalidation cycle.
- have access to study leave budget and clinical cover for CPD as a medical educator
- have 1 hour protected educational supervision per allocated trainee in the job plan
- Have protected job planned time to attend the Senior Medical Council (Monthly) where updates on education and training are covered. This reporting year that included a teaching session on appraisal and revalidation as an educator, recruitment strategy, improving undergraduate experience.
- Have job planned SPA time to teach on the CPTC at Leeds University, attend internal teaching programme and be a facilitator for the Safer Care in Psychiatry Course.

LYPFT fund additional programme activities for 5 College Tutors (1 PA/per week) who oversee the core trainees educational supervision and have special areas of responsibility in the following:

- Induction
- Service Improvement/Audit
- Trainees experiencing difficulty
- Internal Teaching Programme
- Foundation Programme Lead

LYPFT job plan SPA time for 7 consultants to act as Specialty Trainee Tutors (including educational supervisor function) to support STs this reporting year. This can range from 4-10 depending on uptake from other Trusts with STs in Psychiatry in East and West Locality of HEE Yorkshire and the Humber

LYPFT created a new role of International Medical Graduate (IMG) Tutor, job planned at 0.5 SPA

per week, who has introduced a tailored IMG induction for all IMG's in Psychiatry in the West Locality. This induction programme has won prizes at both the RCPsych IMG conference and the Yorkshire School of Psychiatry Conference.

Psychology

The Trust operates within the requirements of the Guidelines for Clinical Placements issued by the Committee for Training in Clinical Psychology (Division of Clinical Psychology, British Psychological Society). These are monitored by the Placement Subcommittee of the Clinical Psychology Training Programme on which supervisors from the Trust are represented. These Guidelines require a minimum of one hour supervision per trainee per week and a minimum of three hours overall contact, to include observation, shadowing and other joint working

All supervisors have:

- provision for supervision within job description and associated job plans
- completed introductory supervisory training that is accredited by the British Psychological Society (typically the 4 day programme organised by the 3 Yorkshire and Humber Clinical Psychology Training Programmes)
- are a minimum of 2 years post qualification before they take full responsibility for placements
- have attended advanced supervisor workshops at least every 5 years following introductory training
- are Health and Care Professions Council (HCPC) registered as a requirement of their posts

Nursing, AHP's

Annual EL away day recently established-funded by the NMET. Study leave is considered by line managers for any educator or mentor who has wanted to attend the annual SLiP conference run by the HEIs.

Only a small proportion of tariff is available to the Practice Learning and Development Team to use to support student placements, this is termed the 'innovation fund' which service areas can apply to access.

Established Practice Learning Development Team (PLDT) provides support for students across non-medical professions (nursing and Allied Health Professionals) which is funded by the Non-Medical Education Tariff (NMET). This supports posts within the Practice Learning and Development Team, including 2 full time nurse posts, one full time AHP posts and one full time administration post. The team also has a temporary funded post to support clinical apprenticeship courses for Nursing Associates and Associate Practitioners. This is full time and is funded by Health Education England funding linked to the apprenticeships.

The PLDT also host in-house Educational Lead Forums and Associate Network Forums to support Educational Leads, Practice Assessors and Practice Supervisors working with pre-registration learners and clinical apprentices.

HEE Domain 5 Delivering Curricula and Assessments
For additional guidance refer to HEE Quality Framework, page 16
HEE priority for 2019/20 reporting in this domain is: • *With the introduction of new workforce roles (e.g. Physicians Associates) and increased numbers of Advanced Practitioners in training, together with an increased reliance on Locally Employed Doctors on service rotas, how do you ensure that doctors in training receive their required curricular opportunities and where necessary how are these needs prioritised?* • *The NHS People Plan identifies the need for increased placement numbers to accommodate the planned growth in student numbers to meet future workforce demand. What plans do you have in place to accommodate increased student placements? What impact do you envisage this will have on your ability to maintain the learning experience provided to current students and to clinical service provision?*

Medical

Due to the integrated clinical and educational governance already described, junior doctors core placements and non- clinical intended learning outcomes have remained protected and valued by the Trust to develop a fit for purpose future workforce. Joint working and being part of a multidisciplinary team is the 'norm' in mental health and doctors and advanced practitioners working together and understanding others developmental needs is common place, as is job planned supervision time for supervisors. Junior doctors are actively supported by the DME to submit an exception report should there be a risk to any lost training opportunity. CTs on core placement are seen to service as 'added value' rather than expected and ST's are supernummary to requirements as placements chosen by the ST so the service must be able to function without. We do not currently employ physician's associates.

UoL will have an increased quota of 20 medical students into 4th Year from 20/21 when they undertake clinical placement in psychiatry. The four mental health trusts that accept the placements, including LYPFT, have proactively undertaken a student planning exercise considering various options to ensure the increased numbers can be accommodated and the good standard of learning maintained in their clinical placement.

This exercise allowed a more transparent system of allocating the additional 20 students and bringing some stability to the allocation system. LYPFT historically had absorbed the majority of the variability in the student numbers – both reduced and increased numbers each year. To prevent this variability students are now allocated on a basis proportionate to current agreed numbers. 10 more students are to be allocated LYPFT for 20/21 which the planning showed was possible in our current clinical services. On-going student number for each year will be discussed in the UoL Psychiatry Course Management Team as part of the placement allocations for the following year to agree between the four Trusts how any variation can be managed.

Nursing, AHP's

There is a dynamic and well-established Practice Learning Development Team (PLDT) that actively supports and promotes practice education across the Trust. It is closely involved in the development of curricula and standards to supports students. The development of the Nursing and Midwifery Council (NMC) (2018) Standards for Student Supervision and Assessment (SSSA) has led to close partnership working with HEI partners in providing a joined up process that will facilitate the smooth adoption of the new curriculum and standards. This will be a key part of the

future culture of the support for undergraduate nursing students.

There is a close and productive partnership with HEI colleagues and this has been improved in the last 12 months by the appointment of a Clinical Academic Liaison Nurse. The appointment is entirely collaborative and is aimed at the improvement of both academic support for learners and the practical placement support.

Each practice placement has a named Education Lead for both nursing and AHP, responsible for the promotion and facilitation of a quality learning environment. They carry the main responsibility for ensuring the quality assurance audit and assessment of their clinical areas.

The Education Leads within each clinical area co-ordinate the availability of mentors locally and ensures that learners have an allocated assessor/mentor. In addition, each area has a second named contact for continuity and quality assurance. For Allied Health Professionals - placement capacity is overseen by the AHP lead within PLDT. They are currently reviewing the existing capacity within the AHP educator workforce and looking at how to support teams to increase capacity for taking AHP students. They are also liaising with the HEIs about the possibility of more role emerging placements.

Nurse mentors adhere to the current NMC SLiP guidance (2010) facilitated by the PLDT and the Education Lead for nursing. The NMC SSSA developments are being incorporated into the annual updates so that Trust will be well prepared for the changes ahead.

PLDT and Trust clinicians contribute to the delivered course content across professions with HEI partners. There are both in house and HEI-based lectures from Trust staff that showcase the innovative practices occurring within the organisation. This collaboration across the different partners allows for shared understand and the development of closer working arrangements.

Psychology

The number of training places commissioned from local courses, including the University of Leeds has remained the same for more than 10 years. The intake for 2020 remains at 16. However, recent discussions within the Regional Training Advisory Group have confirmed that if funding for more places were provided the Trust and other regional providers would support the profession through increasing placement offers.

HEE Domain 6 Developing a Sustainable Workforce
For additional guidance refer to HEE Quality Framework, page 17
HEE priority for 2019/20 reporting in this domain is: • *The People Plan identifies as a priority the need to tackle both 'The Nursing Challenge' (Chapter 3) and to create the workforce needed to deliver '21st Century Care' (Chapter 4). What plans for 2019-21 does your organisation have to meet these challenges from an educational and training perspective?*

Nursing, AHP's

- Career talks to be offered to Nurses or AHP starting throughout 2020.
- Professional change days to be planned.
- Streamlined process for graduate recruitment.
- Recruitment process now identified to address retention of clinical apprentices and ensure qualified Associate roles are identified prior to the end of training programmes.
- Established multi-professional preceptorship programme for all new registrants and quarterly preceptor workshops to support the role of the preceptor. This programme now includes qualified Nursing Associates and Associate Practitioners.
- Completing a strategic workforce plan for the Trust, to define skill sets and competencies that apply to professional groups and services, informing training needs. Continue to utilise opportunities for clinical apprenticeships and develop a workforce strategy that sets out how many staff can be recruited to cohorts in 2020/2021
- Trust wide learning needs analysis linked to workforce plan at Trust, Service and Individual level to create a delivery plan for education and training which will inform funding streams and allocations.
- LD and MH Nursing Recruitment Campaign (WY&H).
- Introducing apprenticeships level 2 Maths and English as standard requirements for HCSW to encourage progression.

Creation of medical workforce needed

LYPFT have continued to be innovative in ways to improve recruitment to psychiatry. This has shown dividends in the core psychiatry training scheme, having trainees highest fill rate and lowest Trainees experiencing difficulties in over a decade. The Trust continues to offer the following recruitment initiatives:

- Work experience and clinical attachments,
- Undergraduate
    - Summer School
    - Mentors
    - Teaching for UoL Psyched society
    - Electives
    - Extended research projects for medical students
    - Balint groups
- FP
    - Specific teaching programme
    - Tutor
    - Shadowing
    - Teaching on bridging the gap days

- Taster programme
- Balint group
- FP3/trust doctor posts with allocated educational supervisor to develop CV for CT application

- CT/ST
  - IMG tutor
  - IMG induction
  - ACF
  - Formal teaching opportunities
  - Mary Seacole Programme
  - Trainee Enhancement Forum
  - Trainee led annual conference
  - Coproduction of rotas
  - Multiple active roles in Trust committees
  - Active involvement with clinical effectiveness team
  - Active involvement with research team

LYPFT has implemented a CESR training programme commencing 1st April 2020. Up to two SAS doctors will be supported through this programme each two years. They receive a supervisor and protected SPA time to develop the required competencies. The Programme is overseen by the DME.

The DME chairs the quarterly West Yorkshire Senior Medical Leaders Committee where the West locality mental health medical directors and DME's quality assure, share good practice and enable equity in mental health training, recruitment and retention of learners and medical educators throughout the West STP.

Psychology

Applications to clinical psychology training programmes remain at a very high level and entry to the profession is highly competitive (only 15% of applicants are successful in being offered a training placement). The University of Leeds Clinical Psychology Training Programme typically has a ratio of more than 35 applications for each place on the course.

The nature of the work involved in clinical settings is frequently sensitive and confidential and therefore access to first hand good quality information about the work is difficult. There are frequent misconceptions about the work of psychologists. In order to address this Trust staff are engaged in the following

- The Trust provides a number of placements to undergraduate psychology students at the University of Leeds through the 'Year in Industry' placement scheme. These have been provided alongside placements for the postgraduate/pre-registration Clinical Psychology Training Programme. They have been provided in the following areas: Learning Disabilities, Personality Disorder, Forensic Services, Addictions, Clinical Neuropsychology and Gender Identity Services
- Careers sessions are provided to undergraduate and masters students at the University of Leeds and at Leeds Beckett University. These involve Trust clinicians and trainees on placement within the Trust
- Careers talks to local schools from Trust clinicians and plans for a more formal partnership

with career advisor services for young people, to increase the visibility of the profession.

There is a longstanding issue regarding access to the profession from particular communities within the wider population. Of particular note is the pattern of underrepresentation of people from BAME communities within training grades and therefore in post qualification positions. This pattern can be seen across the UK Clinical Psychology Training Programmes and a number of initiatives have taken place locally within this reporting period (and are on-going).

- Open days hosted by the Yorkshire and Humber Clinical Psychology Training Programmes for applicants from BAME communities. These were held at the University of Leeds (2018) where the Professional Lead for Psychology and Psychotherapies in the Trust was the Keynote Speaker, and at the University of Sheffield (2019) which was supported by staff from the Trust. A further event is planned for summer 2020.
- The establishment of a Mentorship Scheme for BAME applicants in West and South Yorkshire, with the Trust providing mentors for this initiative
- Increased involvement from qualified psychologists from BAME communities in selection/admissions to the University of Leeds Clinical Psychology Training Programme (shortlisting and interviewing). Trust staff have contributed to improvements in this area.
- Trust staff are also involved in consultations with the University of Leeds to consider opportunities for a contextual admissions process for clinical psychology training. This would address issues of access for people who have experienced socioeconomic disadvantage (people from BAME communities are overrepresented in this group).

Section 3: Assurance and Exception Reporting

All domains met for multi-professional and medical. HEE do not require action plans to be attached.

Domain 1 Learning Environment and Culture,

*please see **HEE Quality Framework** page 9 & 10.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.	☑	☐	☐
1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.	☑	☐	☐
1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence-based practice (EBP) and research and innovation (R&I).	☑	☐	☐
1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.	☑	☐	☐
1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.	☑	☐	☐
1.6 The learning environment promotes inter-professional learning opportunities.	☑	☐	☐

Domain 2 Educational governance and leadership,

please see HEE Quality Framework page 11 & 12.

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.	☑	☐	☐
2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.	☑	☐	☐
2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.	☑	☐	☐
2.4 Education and training opportunities are based on principles of equality and diversity.	☑	☐	☐
2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.	☑	☐	☐

Domain 3 Supporting and empowering learners

please see HEE Quality Framework page 13 & 14.

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	☑	☐	☐
3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.	☑	☐	☐
3.3 Learners feel they are valued members of the healthcare team within which they are placed.	☑	☐	☐
3.4 Learners receive an appropriate and timely induction	☑	☐	☐

into the learning environment.			
3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.	☑	☐	☐

Domain 4 Supporting and empowering educators,

*please see **HEE Quality Framework** page 15.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.	☑	☐	☐
4.2 Educators are familiar with the curricula of the learners they are educating.	☑	☐	☐
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.	☑	☐	☐
4.4 Formally recognised educators are appropriately supported to undertake their roles.	☑	☐	☐

Domain 5 Delivering curricula and assessments,

*please see **HEE Quality Framework** page 16.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.	☑	☐	☐
5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.	☑	☐	☐
5.3 Providers proactively engage patients, service users and learners in the development and delivery of	☑	☐	☐

education and training to embed the ethos of patient partnership within the learning environment.			

Domain 6 Developing a sustainable workforce,

*please see **HEE Quality Framework** page 17.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	☑	☐	☐
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	☑	☐	☐
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	☑	☐	☐
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	☑	☐	☐

Section 4: List of Supporting Information

Organisational policies and processes in support of delivery of the HEE Quality Framework.

Any additional information to be sent separately to the SAR to NQAT@hee.nhs.uk

Description of supporting information	HEE Domain(s)	HEE/GMC Standard(s)
Medical Education Committee Terms of Reference (TOR)	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Education and Learning Steering Group (TOR)	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Clinical Cabinet TOR	1 to 6	Knowledge, skills and performance
Undergraduate Education Driver Diagram	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Psychiatry Trainees Education Driver Diagram	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Foundation Doctors Education Driver Diagram	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Specialist Psychiatry Trainees Education Driver Diagram	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining

		trust
SAS Medical Workforce Strategy Driver Diagram	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust

Section 5: Financial accountability

Details of LDA Funding

Has the funding listed in the LDA has been utilised for its intended purpose? YES

Have you received any further funding not included in the LDA? YES

Amount received	Description
£19.950	AHP Faculty Test Bed
£46,271	0.50 band 8c Clinical Psychologist Recharge

LDA Trust finance information

Schedule E Funding Summary

Quarter 1 2019/20

Levy	Contract heading	19/20 Q1 Funding
Non Med	Pharmacy	121,505
Non Med	Trainer Grant	44,372
Non Med	Contract	480,000
Non Med	Nursing Associates	12,350
Non Med	Non-medical Tariff	433,359
Non Med	IAPT EIP	10,838
Non Med	Return to Practice	500
Non Med Total		1,102,924
Postgraduate	Education Contract Posts	2,602,044
Postgraduate	Foundation Activity Related	800
Postgraduate	Excess Travel	6,689
Postgraduate	Less Than Full Time	19,463
Postgraduate	Curriculum Delivery	130
Postgraduate	Tariff Transition	- 22,990
Postgraduate Total		2,606,136
Other	Fatigue and Facilities	30,000
Other	Adjustment for Apr, May & June payment on account	- 1,071,223
Other Total		- 1,041,223
Workforce Development	Non Tariff SAS LEAD	3,000
Workforce Development Total		3,000
Undergraduate Medical	Placement activity funding	770,862
Undergraduate Medical Total		770,862
Education Support	TPD	40,400
Education Support Total		40,400
Grand Total		3,482,099

Section 6: Additional sections

6.1 Patient Safety, Simulation and Human Factors

6.1.1. Patient Safety

Please consider the following questions below.

Questions	Trust's response
1. Who is the Lead for Patient Safety in your organisation? What support do they receive in delivering this role? E.g. job-planned time, resources etc.	Nichola Sanderson, Deputy Director of Nursing is the Patient Safety Lead, supported by Pamela Hayward-Sampson, Safety and Risk Lead. Both job descriptions have a focus on this aspect of their roles and responsibilities and are resourced appropriately.
2. Please advise up to three areas relating to patient safety agenda that you have worked on in the last two years and you are most proud of? Could these be applied regionally and be shared with HEE?	Physical health monitoring – training and education has been rolled out across all inpatient units with regards to the early detection of the deteriorating patient, alongside effective physical health monitoring. This includes a revision of the National Early Warning score documentation to meet national guidance. This has resulted in a significant improvement in patient safety. Fluid balance and oral intake monitoring – As a result of serious incident reviews and themes highlighted, there has been a revised fluid balance created, which includes urine output and ensuring an accurate balance is documented. In addition the nutritional intake records have also been adapted to ensure more accurate recording and monitoring. Safety planning. As a result of themes from serious incidents the mental health community teams have commenced work to improve patient safety plans in joint collaboration with patients and carers/family. This work is on-going but can on completion be shared more widely.
3. In which areas would you like support from HEE? E.g. educational events, funding, specific areas of training for example quality improvement?	Funding support for mental health risk training – currently this is provided by staff but not in a clearly defined way, with costing factored in. The trust is keen to roll out risk training to all clinical staff, using the most up to date evidence base, collaborating with other NHS mental health trusts with the STP. This would ensure that a joint approach is provided for training and would enable larger numbers to be trained. Identification of risk has been highlighted in mortality reviews and can be a challenge for staff, in an ever changing demographic. This has been highlighted also as a key patient safety risk within the organisation. There are a number of standardised mental health risk training programmes, which provide a good standard of evidence based training. Funding would enable the trust to identify trainers to complete this as either a dedicated role or a significant part of individual's job description.

6.1.2 Simulation

Prompt: We advise you to consult with your Simulation Manager or Lead when compiling your response.

Questions	Trust's response
1. Who is the Simulation lead in your organisation? Please advise on name, job title and email address. What support do they receive in delivering this role? E.g. job-planned time, resources etc. Are they linked in with the HEE Simulation Network in their locality?	As yet, LYPFT does not have a lead for this The DME has a special interest in simulation training. She leads the simulation training on the CPTC for all core trainees in psychiatry in HEE Yorkshire and the Humber with the support of the University of Leeds and Sheffield Health and Social Care Trust. The simulation training is on advanced clinical interview skills covering process, psychopathology and safe care planning. The CPTC feedback on this is excellent. One of the key learning outcomes for the medical undergraduates is to develop their history taking, consultation and communication skills. However students still feedback that they do not receive enough input re this whilst on placement and in particular that they would like more opportunities for observation and feedback in this area. This is a particular problem in community placements where patients sometimes do not turn up for clinic or refuse for the student to see them. We therefore created the FOCAS (Formative Observation of Clinical Assessment Skills) by adapting the FACS for this reporting year. Using paid Simulated Patients, each medical student is provided with detailed written feedback on their consultation skills. The scenarios were low mood (depression history) and psychosis (mental state in acute schizophrenia). The feedback is outstanding as seen in the Medical School Evaluation data. The Trust designed and implemented a multidisciplinary 'Safer Care In Psychiatry Course' (SCiP) which is now priority training. The Head of HEE Yorkshire School of Psychiatry attended this as a guest this reporting year and rated it outstanding. The steering group has members from Resus Department, DME, AHP representative and acute ward nursing leads. It is a 1 day multi-professional course The morning session is 3 x HEE RAMPPS (Recognising and assessing medical problems in a psychiatric setting) scenarios The afternoon session; through QI cycles has been developed; and now encompasses • management of bleeding and burns (using

	ABCDE approach and examining Trust grab bags), • clinical skill training (BP assessment, pulse, oximetry and oxygen use, CBG, pulse assessment) • prescribing for agitated or distressed patient (including non-pharmaceutical management of aggression/violence, prescribing considerations and monitoring requirements s in rapid tranquilisation as per policy) Faculty is from internal workforce; trained using HEE materials (2 faculty day; working faculty with attendees identified and invited to join based on competence and enthusiasm) <u>Outcomes</u> 1. In all assessed domains of self-reported confidence the trend is towards improvement in confidence after the days course for all professional groups 2. Thematic analysis of comments: • Multi-professional learning reflects reality of life on acute wards • Learning as a team enhances the experience • Scenario-based learning with actors is excellent • Debrief is crucial to consolidate learning • Space to reflect on experiences of the day is highly valued • The interactive nature of the course engages staff and encourages participation (despite initial nerves) • The course meets the needs of the attendees 3. Attendees from • Medical workforce (CT's, GPVTS, FY Drs) • Nurses (band 5, 6 and student nurses) • HCA/HCSW • Associate practitioners • Occupational therapy and OTA • Social work

	<u>The future</u> • Continued development of afternoon sessions through review of feedback and needs of organisation • Review of scenarios in line with above and Datix reporting of incidents (examined by faculty lead attendance at the Trust's Learning form Incidents and Mortality Meeting) • Consideration of use of materials and project for community staff • Further faculty training dates
2. Who is responsible for keeping an inventory of the simulation equipment within the Trust including all task trainers and low fidelity mannequins?	The Trust's resuscitation department based at St Mary's Hospital.
3. How many simulation specific trained faculty does the trust have?	Due to the success of SCiP, the Trust now has 11 RMN, 2 RGN, 13 doctors (9 consultants, 4 SAS), 1 OT, 2 associate practitioners and form the SCiP faculty.
4. Which directorates or inter-professional groups are actively engaged with simulation based education within your organisation? How do you encourage equitable access to simulation for all staff?	Safer Care in Psychiatry course is fully multi-professional. The board consists of the DME, resuscitation lead, nursing development leads and SAS doctor. Practice development nurses are responsible for identifying staff to attend SCiP training therefore ensuring the correct skill mix of the groups and meeting the development needs of individuals and ward teams.
5. Is there strategic engagement and representation in simulation activity in the organisation i.e. board level, clinical governance, patient safety, incident reviews?	Yes, the Medical Director and Director of Nursing are keen to extend the SCiP further to embrace patient safety e.g. Section 136, community settings and all scenarios are based on learning from significant events in mental health The Trusts PMVA training is currently under review; simulation training is going to be incorporated in to the training for staff in de-escalations skills in managing the escalation of behaviours of concern.

6.1.3 Human Factors

Questions	Trust's response
1. Who is the Lead for Human Factors in your organisation? What support do they receive in delivering this role? E.g. job-planned time, resources etc.	This is currently an unmet need in the Trust

2. Please describe the extent to which your HF training covers the following domains: • People – the individual & teamwork • Environment – the physical aspects of a workspace • Equipment and technology • Tasks and processes • Organisation • Ergonomics and research methods	Human factors training in SCiP faculty training and during the course covers people, environment, equipment and technology, tasks and processes and organisation. There is not a focus on ergonomics or research methods The Prevention and management of violence and aggression training (PMVA) covers how staff behaviour plays a role in the escalation of incidents of conflict behaviour and explores how this can be both positive and negative in relation to incident outcome. They also cover the emotional impact of behaviours of concern have on individuals and teams it promotes a model of post incident staff support.
3. For the training delivered in the reporting period please also consider and describe the following: • The audience to which HF training is being delivered, including details of multi-professional staff. • Frequency of training, or whether ad hoc events. • Who are the faculty that deliver the training? Please describe their "HF expertise", professional background, specialty, whether they have job-planned time to deliver HF training. • What is the wider Trust context within which HF training is delivered. Is there a link between patient safety incidents, SI investigations, root cause analysis? • To what extent is HF training seen as part of a wider patient quality and safety agenda or integrated into clinical governance structure/process?	The audience to which the training is delivered consists of consultants, SAS, junior doctors, nurses and allied health professionals. SCiP runs for 1 day every 8 weeks. It consists of three HEE RAMPPS scenarios in the morning followed by working lunch with clinical skills and then the afternoon dedicated to clinical skills, burns and bleeding and psychotrophics. The faculty is multi-professional and consists of consultants, SAS, nurses, occupational therapists and health support workers. All trained in HF's by HEE e learning then full faculty training day ran by HEE RAMPPS steering group experts All scenarios used in HF training are based on SI investigations nationally in mental health. PMVA training is delivered to all inpatient nursing and OT staff on an annual basis

6.2 Equality and Diversity

Question	Trust Response
Name of Trust Equality, Diversity and Inclusion Lead:	Caroline Bamford
1. How do you ensure that learners with different protected characteristics are welcomed and supported into the trust, demonstrating that you value diversity as an organisation?	In October and November 2019, the Practice Learning and Development Team (PLDT) hosted 2 welcome events for 1st year students who had joined the nursing programme. This day included a presentation on diversity and inclusion in the workforce and also gave an overview of health inequality. A discussion on race inequality was had and the WREN and Rainbow Alliance networks were promoted. The role of Freedom to Speak Up Guardian was spoke of in the context of concerns around equality. Reasonable adjustments were discussed and discussion around physical health and mental health of staff. Competency frameworks for newly registered professionals are also being adapted to include gender inclusive pronouns of 'they/them'
2. How do you liaise with your trust Equality, Diversity and Inclusion Lead to: • Ensure trust reporting mechanisms and data collection take learners into account? • Implement reasonable adjustments for disabled learners? • Ensure your policies and procedures do not negatively impact learners who may share protected characteristics? • Analyse outcome data (such as exam results, assessments, ARCP outcomes) by protected characteristic?	Support needs including reasonable adjustments are a fundamental part of the support package for learners and information is requested prior to commencing with the Trust and through prior engagement with learners and their education provider where appropriate. Guidance and information is sourced on a case by case basis from both HR and EDI. The Universities and the learner will liaise with educational leads in teams in advance of a student coming on placement; this process should include any reasonable adjustments which need taking into account. EDI and Human Rights principles apply equally to all learners within the Trust. Supervision and induction processes provide the support structures for individual learners and information on support and reporting processes shared. This includes the role of Freedom to Speak Up Guardian and HR. Currently the Trust does not analyse outcome data for junior doctors based on exam results, ARCP outcomes by protected characteristics.
3. How do you support learners with protected characteristics to ensure that known barriers to progression can be managed effectively?	This is achieved via the training and support networks including through the Practice Learning Development Team. Staff awareness is raised through the bi-monthly educational lead forum. ELs then disseminate this information back to

	their teams ensuring that educators and mentors are aware of these barriers. Educators and mentors are also encouraged to attend annual Supporting Learning in Practice conference which is hosted by the University. Support is also given to educators and mentors of students via the academic tutor they have at University.
4. How do you educate learners on equality and diversity issues that may relate to themselves, their colleagues, or the local population of the trust?	The University deliver a module on programme in relation to equality and diversity. Learners are also given access to staff training for both LGB and Trans awareness.
5. How do you support your educators to develop their understanding of, and support for, learners with protected characteristics?	This achieved via having a periodic emphasis on diversity and inclusion as part of the educational lead forum. ELs are also encouraged to engage in the Trust staff networks in order to be able to effectively support educators within their teams and services. An annual EL away day is held at the beginning of each year and features an exercise or presentation around supporting those with protected characteristics
6. Is there monitoring or strategies in place to look at those accessing progression opportunities, and those progressing into more senior roles? What is the Trust view on data on progression in the trust? Are there any responses or resulting objectives to data held by the Trust?	Progression monitoring is undertaken but currently this process is being strengthened as part of succession planning and talent management strategic planning. Specific equalities monitoring is undertaken and BAME and Disabled staff progression rates are an area of focus as detailed below. From our Workforce Race Equality Standard (WRES) data it is recognised that experience and satisfaction data is lower for BAME staff. This is particularly in relation to access to progression opportunities and this is therefore an area of focus, particularly within senior roles (Bands 8A and above). This is therefore a priority improvement objective within our WRES action plan and will be a priority within our strategic People Plan which is currently under development. Actions include the development of a BAME reciprocal mentoring programme and a BAME career development programme, Moving Forward. Experience and satisfaction data is also lower for Disabled staff, particularly in relation to perceived bullying and harassment from staff and Disabled staff feeling valued by the trust. These are therefore priority improvement areas within our Workforce Disability Equality Standard (WDES) action plan and a key focus of our current cultural change programme a priority within our strategic People Plan. Actions include a reasonable

	adjustments journey review in collaboration with Disabled staff to further develop support processes.
7. Does the Trust invest in additional Equality and Diversity training for some or all staff (i.e. more than statutory training)?	Twice yearly Diversity and Inclusion CPD days are delivered to up to 150 staff, volunteers and learners at each event. The aim of these events is to improve the knowledge and experience of our clinical workforce in working effectively with the diverse communities we serve. These full day events are comprised of workshops delivered by our internal knowledge experts and through external partners.
8. Are there any training or initiatives (in place or being considered) to learn from cases that have an E&D theme?	A full scale review of disciplinary employee relations cases is being undertaken, using the national Fair Experience for All guidance. This is to further understand and learn from the disproportionate number of BAME staff entering the Trust's formal disciplinary process through learning from the experiences of our BAME staff.

6.3 Libraries and Knowledge Services (LQAF)

We recommend that you consult with your Library and Knowledge Services Manager or Lead to complete this section. Please provide narrative and evidence (for 1, 3 and 4) on the following 4 areas for your Library and Knowledge Service. Please also highlight any issues or concerns, including any areas which are not being met. If your Library and Knowledge Service is provided via a service level agreement, please consult with the providing Library and Knowledge Services Manager. Additional prompts have been added under each heading.

1. Describe how your Trust is implementing the ***HEE Library and Knowledge Services Policy*** (https://hee.nhs.uk/sites/default/files/documents/NHS%20Library%20and%20Knowledge%20Services%20in%20England%20Policy.pdf) namely:

   "To ensure the use in the health service of evidence obtained from research, Health Education England is committed to:

   - Enabling all NHS workforce members to freely access library and knowledge services so that they can use the right knowledge and evidence to achieve excellent healthcare and health improvement.
   - Developing NHS librarians and knowledge specialists to use their expertise to mobilise evidence obtained from research and organisational knowledge to underpin decision-making in the National Health Service in England."

   Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. You could provide evidence from your Library and Knowledge Services' strategy or annual action/implementation/business/service improvement plan.

Trust's response:

LYPFT Library and Knowledge Services (LKS) implement the HEE Library and Knowledge Services Policy in a number of ways.

LKS contributes to the creation of patient information by monitoring when LYPFT produced patient leaflets are due for update and alerting the Communications Team; providing a literature search service to aid leaflet updates; and is citied in the LYPFT Patient Information Policy (MC-0001)

The Library and Knowledge Services remains under the Medical Directorate and is now managed by the Clinical Effectiveness Team. The LKS achieved a compliance score of 99% in 2018.

The LKS was again selected to be a book giver for World Book Night 2020 (April).

In December 2019, the LKS participated in a "Give the Gift of Feedback" competition with other health library services in Leeds (Leeds Community Healthcare NHS Trust, Leeds Teaching Hospitals Trust, and the Public Health Resource Centre). The report for this promotion is still in draft form.

LKS offers a literature searching service and produces evidence summaries on request.

LKS facilitates access to journals, books, e-books, databases, and other resources, through information skills training, organisation subscriptions, NHS Open Athens administration, and

medicated searches. User activity for each of these services and resources are given for the last 3 years in the LKS Annual Report.

LKS supports the dissemination of NICE Guidance in the Trust and manages the NICE Guidance Intranet page.

LKS created the Quality and Improvement Bookcase on the Intranet to facilitate access to organisational knowledge including service evaluations, lessons learned Trust publications, on-going research projects, NICE Guidance, and clinical audits. This was presented at the Health Libraries Group Conference 2018 in Keele by the Library and Knowledge Lead.

The LKS has continued to promote the use of its space for non-study use to encourage LYPFT staff that may not usually visit the library to use the space. The regular knitting group has been trialled at different times of the day with an "after work" group having a much improved attendance. The regular book club has proved successful with a number of staff attending the sessions, enabling staff who don't usually read to discover the benefits of reading for pleasure. As a low cost promotional activity with high potential for attracting library "non-users" we will continue to plan these throughout 2019-2020.

This reporting year sees an increase in literature searches, which could be due to the decision to offer searches to staff who are studying (with the exception for dissertations and theses). In combination with this, the LKS has had representation at Trustwide Clinical Governance meetings and Learning from Incidents and Mortality meetings so it has been completing more searches for corporate projects as well as those for patient care and service development. With the increase in professionally qualified librarians the LKS has also been able to reach more teams and promote the library which could also have increased the literature searching share.

2. HEE's ***Library and Knowledge Services Policy is*** delivered primarily through local NHS Library and Knowledge Services.
   - Please identify the budget allocated to your Library and Knowledge Service in the current financial year.
   - If possible please identify the sources of this funding, differentiating for example between educational tariff funding and any contribution from your organisation.

   Prompt: Your Finance department and/or your Library and Knowledge Service Manager should be able to supply this information.

Trust's response

LKS has an annual budget of £138,215 (pay and non-pay combined)

It is estimated that the educational tariff funding contributes to 55% of this budget figure, with 45% of the budget funded by the Trust.

3. Please tell us about any areas of Library and Knowledge Services good practice that you would like to highlight.
   Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. You could provide evidence of impact on clinical practice, impact on management decision-making (including cost savings) and any innovation submissions originating from your Library and Knowledge Service.

Trust's response

Literature searching – a core service, supporting, clinical practice, patient care, management decision making, CPD, and revalidation. The literature search service consistently evaluates well.

This year's literature search impact feedback showed all users felt LKS satisfied their expectations and majority felt it exceeded their expectations. Several impact stories have been published to promote the LKS and disseminate good practice (see section 3 for Literature Search Impact Survey 2017 and impact stories 1-6).

4. The **Learning and Development Agreement** that Health Education England has with your organisation states that the LKS should achieve a minimum of 90% compliance with the national standards laid out in the current Library Quality Assurance Framework (LQAF).

   If your LKS has a score below 90% please describe the improvements you are planning to attain this minimum requirement in 2018-19.

   Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. The details should be available from the LQAF Action Plan developed following the 2017-18 LQAF.

Trust's response
Not applicable.

LYPFT Library and Knowledge Services achieved 99% on the LQAF in 2018; there was no LQAF assessment in 2019 due to the new framework being launched in 2020.

6.4 Staff, Associate Specialist and Specialist Doctors

Use of funding to Support Staff, Associate Specialist and Specialty Doctors (SAS) and Locally Employed Doctors (LEDs) Faculty development

Please provide answers to the following questions. You may wish to include funding details, as required. For further information in relation to LEDs please review the following NACT document LEDs across the UK http://www.nact.org.uk/documents/national-documents/.

Number of SAS doctors and LEDs in the trust

Number of Specialty Drs:	34 + 2 vacant
Number of Associate Specialists:	3
Number of Staff Grades:	0
TOTAL number of SAS doctors:	39
Number of LEDs (e.g. Trust Grade, Clinical Fellow):	3

Study leave budgets

	Amount
Trust study leave funding allocation per SAS doctor (£):	600
Trust study leave funding allocation per LED (£):	600

How do these allocations compare to the study leave funding allocation for consultants?

Answer: Parity

Please outline any examples of good practice or challenges regarding study leave budget allocations:

SAS doctors are encouraged to identify PDP through the appraisal process and in line with identified peer groups. There is a clear pathway for applying for study leave and for personal budgets. Training needs analysis of the group is carried out annually to identify group needs, and relevant courses are organized though the SAS tutor in conjunction with the Andrew Simms Centre. Not all SAS Doctors make the most of their study budgets, engagement in the SAS days is about 50% (Approx)

HEE SAS Development Funding received during the financial year 2018/19

	Amount (£)	Details if required
SAS Development Fund – Individual courses (£):	21124	
SAS Development Fund – Trust-hosted courses (£):	10440.80	Medical Psychotherapy day, Intercommunications, SUMO Guy, Autonomy

Funding for SAS tutor/ lead role (£):	9264	1 PA, tutor has now changed
Funding for SAS administrator role (£):	This support is Trust funded	The SAS tutor is supported by the Andrew Sims Centre to deliver the events agreed from the annual SAS training needs analysis. Event management costs are included in the event
Any other funding received from SAS Development Fund (please give details):	No other spending from SASG funding.	Internal venues provided for the SAS committee meetings. SAS doctors supported to be medical appraisers
TOTAL funding received from HEE (£):	40828.80	

Identification of SAS doctor development needs

	Development Needs
Please describe the process by which the development needs of SAS doctors within your organisation were individually and collectively identified:	The development needs are identified via an annual SAS Training Needs Analysis (TNA). The results are collated and the main four to five training needs are identified. Priorities are identified via a group TNA which is completed annually. All SAS doctors are encouraged to be active peer group members to support identification of learning and development needs for their personal development plans (PDP). Appraisal can sometimes identify addition learning and development needs and an agreed PDP is a key output of appraisal.
How were priorities decided in regard to applications to the HEE SAS development fund?	Priorities are identified via a group TNA which is completed annually.

CESR

Number of doctors currently being supported by the trust to work towards CESR application:	None at present. CESR program to commence soon
Number of doctors who completed a successful CESR application during the year April 2018 to March 2019:	None

SAS doctors as Clinical and Educational Supervisors

Number of SAS doctors who are GMC-approved Clinical Supervisors:	None
Number of SAS doctors who are GMC-approved Educational Supervisors:	None

Who decides which trainees have a SAS doctor as their named Clinical or Educational Supervisor?

Not applicable

What governance arrangements are in place for SAS doctors who are Clinical and Educational Supervisors?

Not applicable

SAS doctors in leadership roles

Number of SAS doctors who are in leadership roles:	5
Please give details of the roles being undertaken:	1. Clinical lead Eating disorder 2. Clinical lead Veterans service 3. Clinical lead ECT department 4. QI leads for the trust x2 5. SAS Tutor

Has the SAS Charter been implemented in the trust? YES

Please give details of any examples of good practice or challenges in implementing the SAS Charter:

Good Practice	Challenge
Task and finish group was set up to triangulate what the trust was doing well and what the deficits were	This has only met once to date. The need is for this to be consistent.
SAS doctors are able to take leads in various aspects of fulfilling the charter, e.g. autonomous practice document and developing a CESR program	The length of time it takes for these proposals to be scrutinised and to pass though the relevant committees has been long.

Please give details of any programmes or initiatives in place to support the development of LEDs:

- SAS training days organised by the SAS tutor as a result of the training needs analysis.
- CESR programme starting April 2020 in the trust to assist SAS doctors gain CESR.

- Document on Autonomous practice being developed with SAS doctors at present.
- Trust have adopted SAS charter in all its components, a task and finish group has identified any needs from this and these are worked on from within the SAS group in conjunction with medical management.
- It has been agreed with medical management that SAS Doctors will be considered for any additional responsibility roles where appropriate.
- SAS doctors are encouraged to become appraisers within the trust. Currently there are 4 appraisers from within this group.
- SAS doctors sit on various committees within the trust at various levels.

Please outline any examples of good practice in developing SAS doctors or LEDs which you would like to highlight:

Good Practice - Please outline any examples of good practice in developing SAS doctors or LEDs which you would like to highlight:	**Challenges - Please outline any particular challenges in developing SAS doctors or LEDs:**
SAS doctors are leaders in the trust. Clinical leads & QI leads.	Engagement from within the SAS group can be low at times. Approx. 50% engagement at SAS specific training days
Identified SAS tutor from within the SAS group	GMC survey identified low morale nationwide; this is reflected in the trust feedback, though to a lesser extent.
CESR training program to commence April 2020	Pathway for approval of documents pertinent to the SAS group can be slow in progress through trust committees
Trust has adopted the SAS charter and actively seeks to implement and improve on this through the tutor and the task and finish group.	

6.5 Supporting Learners at Coroners' Court and following Serious Incidents

Serious Incidents and Never Events

Questions	Trust's Response
Please provide an account of how your organisation identifies learner involvement in Serious Incidents. How is that degree of involvement defined?	Multi-professionally, the line manager is notified and follows the system identified in the next question below. The Medical Education Manager identifies any doctors involved in a DATIX of any level and notifies the AMD for DiT for junior doctors and the Clinical lead for SAS/consultants. The Director of Medical Education is notified of all Serious Incidents reported in the Trust via an email which contains the STEIS report. The AMD for DiT investigates all DATIX involving a junior doctor and all outcomes are notified to the junior doctor, clinical and educational supervisor and DME. DME offers pastoral support and completes an exception report for the Responsible Officer at HEE and copies to the junior doctor for their annual Form R for ARCP
What support systems exist to support learners? How are these systems monitored?	The line manager will ensure that as soon as is possible following the incident the staff on duty/involved are given an easy opportunity to talk about the incident which may involve: • How the members of staff feel • How they might feel in the next few days • Any trigger points As part of the SI process the investigator will hold a learning review, this is in addition to any local debrief sessions, to discuss the incident. The investigator also uses this opportunity to ensure that staff are receiving the support required; line managers are invited to these sessions. ST's in Psychiatry undertake a personal development day opportunity working alongside an investigator and the feedback for this experience is excellent.
What feedback do you receive from learners about their experience of being involved in Serious Incidents?	No formal feedback has been requested
What formal organisational links exist between the Governance team coordinating investigations and the Postgraduate team supervising the trainees? the HEIs supporting learners?	The Medical Education Manager identifies any doctors involved in a DATIX of any level and notifies the AMD for DiT for junior doctors and the Clinical lead for SAS/consultants. The Director of Medical Education is notified of all Serious

	Incidents reported in the Trust via an email which contains the STEIS report. The AMD for DiT investigates all DATIX involving a junior doctor and all outcomes are notified to the junior doctor, clinical and educational supervisor and DME. DME offers pastoral support and completes an exception report for the Responsible Officer at HEE and copies to the junior doctor for their annual Form R for ARCP
How many patient safety incidents have you reported to NHSI.	The Trust submits all patient safety incident data to the National Reporting and Learning System (NRLS). The latest report covers the period October 2018 to March 2019. The Trust continues to remain within the middle 50% in relation to the reporting rate for incidents per 1,000 bed days. In this period the Trust reported 2964 incidents.
How many serious incidents impacting on trainees revalidation have you made to your HEE local office within the reporting period? What proportion of these have been resolved/closed after completion of investigations?	*None impacting on a trainees revalidation.*
How does your organisation disseminate learning from Root Cause Analysis reports? How does your organisation promote a patient safety culture?	<u>Staff involved in the incident</u> The investigator will, in consultation with the senior manager, agree who will share the outcome of the review with the relevant staff/ team. There may be times when immediate learning is shared in advance of the final report as changes to practice may need to occur without delay. If it is regarding a junior doctor, the AMD for DiT meets them personally. <u>Trust wide learning</u> All action plans will be considered and implemented by the Care Group where the incident occurred. Action plans are monitored in the care group risk meetings. The SI Team produce a yearly thematic report based on the recommendations and actions from SI's to ensure that the themes have been acted upon. SI's data and learning have been used to inform service change. All action plans and learning are stored for information on the medical education website and common themes and the link to the website covered during junior doctor induction.

Coroners Hearings

Questions	Trust's Response
What support is available for learners who are required to provide statements and/or attend Coroners hearings?	Requests for reports and attendance at inquest are sent to the member of staff and the line manager if known in order to offer support. If the line manage is not known an addition to the request is sent stating "please share this email with your line manager to ensure they are aware of this request and can provide you with the necessary support". Support is provided by the SI team and is guided by the member of staff: this can include meeting face to face to assist with the statement and attending at Coroners Court for support. This support is in addition to that provided by Line Management. Junior doctors all receive pastoral support from DME even if move Trusts during their training.
How is your organisation involving learners in responding to Duty of Candour responsibilities?	The initial duty of candour is completed locally by the care team involved. This is usually by telephone with a follow up letter. The SI team also make early contact with the service user or family via a letter from the Deputy Director of Nursing to ensure that they are included within the SI investigation as early as possible.

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:	26 March 2020
PRESENTED BY: (name and title)	Dawn Hanwell, Chief Financial Officer, and Deputy Chief Executive
PREPARED BY: (name and title)	Dawn Hanwell, Chief Financial Officer and Deputy Chief Executive

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

EXECUTIVE SUMMARY

This report provides an overview of the financial position at month 11, including an indication of the year end forecast. It also includes an overview of the response and changes to financial governance that the NHS finance community is being asked to implement due to COVID-19.

The overall financial position at month 11 is better than plan and the Trust reported a finance score of '2'. This income and expenditure position continues to be underpinned by significant variances between planned budgets and actual expenditure, with a high degree of reliance on underspending budgets to offset pressure areas. There is also significant non recurrent benefit from slippage on development reserves, and some prior year fortuitous benefit.

LYPFT has confirmed it is able to improve its position as part of wider organisational/system offsetting negotiations. We have committed to a £400k improvement in our trajectory, therefore we are forecasting a c£360k surplus. However the underlying financial position remains a concern due to the level of "offsetting" variances.

With regard to operational planning the finance function is adapting and responding to the revised financial governance processes and Business Continuity resilience has been tested. At this stage we are confident that we can deliver on the requirements.

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

RECOMMENDATION

The Board of Directors is asked to:

- Note the month 11 reported financial position is better than plan with an overall surplus (excluding unplanned PSF funding relating to 18/19) and Finance Score is '2'.
- Note the cost pressures in relation to OAPs and inpatient services, rising medical agency costs and unidentified CIPs and the risk associated with reliance on "offsetting" variances.
- Note the revised capital forecast position.
- Note the financial /operational planning requirements for 2020/21.

BOARD OF DIRECTORS
26 MARCH 2020

CHIEF FINANCIAL OFFICER REPORT - MONTH 11

1 Introduction

This report provides an overview of the financial position at month 11, including an indication of the year end forecast. It also includes an overview of the response and changes to financial governance that the NHS finance community is being asked to implement due to COVID-19.

2 2019/20 Month 11 Financial Performance - Key Indicators

A summary of overall performance against key metrics is shown in table 1 below. The key point to note is the Trust achieved an overall Finance Score of '2', and is ahead of the planned income and expenditure position. The position continues to reflect a number of cost pressures areas being offset by underspending and slippage on new development funding.

Table 1

Key Metrics:	2019/20		
	Plan	Actual	Trend
Single Oversight Framework Finance Score	2	2	⟷
Income & Expenditure Position (£000s)	1,078	2,444	↑
Recurrent CIP (£000s)	2,722	1,655	⟷
Cash (£000s)	80,946	95,239	↑
Capital (£000s)	7,256	5,970	↑

The income and expenditure position at month 11 is £1,508k surplus, £430k ahead of plan before accounting for £936k additional one off Provider Sustainability Funding (PSF) relating to 18/19. (This income has been received and reported in 19/20 but does not form part of the assessment of performance for control total purposes).

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 work is ongoing to identify recurrent solutions.

3 Capital Position

Year to date capital expenditure is reported as £6m. Work continues on all key schemes as previously notified , including EPR and the CAMHS development, neither of which have been affected (at this stage) by the COVID-19 crisis. The revised full year forecast is £6.6m, with month 12 spend being mainly around the two schemes noted above.

4 Forecast year end outturn

A detailed forecast was undertaken to assess the likely range of outturn positions and there is a high level of confidence and expectation that the Trust will significantly exceed its planned £43k deficit. In discussion on the overall ICS control total LYPFT has confirmed it is able to improve its position as part of wider organisational/system offsetting negotiations. We have committed to a £400k improvement in our trajectory, therefore we are forecasting a c£360k surplus.

5 Financial/Operational Planning 20/21.

On the 17 March 2020 Sir Simon Stevens wrote to Chief Executives of all NHS trusts and foundation trusts outlining the next steps on NHS response to COVID-19. The letter outlined a number of important actions for the NHS, including removal of routine burdens and suspension of the operational planning process for 2020/21, to free up time to devote maximum operational effort to COVID readiness and response.

The key planning implications for the Trust are:

- Normal financial arrangements have been suspended for an interim period (1 April 2020 to 31 July 2020) although this period is likely to be extended.
- During the interim period contracts are not expected to be agreed and a central calculation for contract payments will be mandated. These arrangements are likely to delay implementation of the Adult Eating Disorder Provider Collaborative.
- Uncertainty on transformation funding allocations and schemes may not proceed as planned.
- No expectation that Trusts will be planning efficiencies during the interim period.
- Capital expenditure will be focused on emergency and urgent response to COVID-19. Commitment to existing fully approved STP capital schemes remains but schemes not yet fully approved (this impacts on the Complex Rehabilitation bid) are not expected to proceed as planned.

- Potential extension to annual accounts timetable is not expected to be significant. Quality Accounts will be required although not subject to audit assurance, this requirement is embedded in legislation but may change.
- Exceptional costs for Covid to be funded but clear justification will be required.
- No new revenue business investments should be entered into unless related to Covid-19 or unless approved by NHSE/I as consistent with a previously agreed plan.

The maintenance of financial control and stewardship of public funds will remain critical during the NHS response to COVID-19. Chief Executives, Accountable Officers and Boards must continue to comply with their legal responsibilities and have regard to their duties as set out in Managing Public Money and other related guidance

Internally we are still working to complete our budgetary process informed by our current contract negotiations and national planning assumptions. At some later point there will be a requirement to reconcile and revise our internal plans, and complete a final operational plan for 2020/21.

6 Conclusion

The overall financial position at month 11 is better than plan and the Trust reported a finance score of '2'. This income and expenditure position continues to be underpinned by significant variances between planned budgets and actual expenditure, with a high degree of reliance on underspending budgets to offset pressure areas. There is also significant non recurrent benefit from slippage on development reserves, and some prior year fortuitous benefit.

LYPFT has confirmed it is able to improve its position as part of wider organisational/system offsetting negotiations. We have committed to a £400k improvement in our trajectory, therefore we are forecasting a c£360k surplus.

However the underlying financial position remains a concern due to the level of "offsetting" variances.

The finance function is adapting and responding to the revised financial governance processes and Business Continuity resilience has been tested. At this stage we are confident that we can deliver on the requirements.

7 Recommendation

The Board of Directors is asked to:

- Note the month 11 reported financial position is better than plan with an overall surplus (excluding unplanned PSF funding relating to 18/19) and Finance Score is '2'.
- Note the cost pressures in relation to OAPs and inpatient services, rising medical agency costs and unidentified CIPs and the risk associated with reliance on "offsetting" variances.
- Note the revised capital forecast position.
- Note the revised financial /operational planning requirements for 2020/21.

Dawn Hanwell
Chief Financial Officer and Deputy Chief Executive
20 March 2020

Minutes of the

West Yorkshire Mental Health Services Collaborative Committees in Common (WYMHSC C-In-C)

held Tuesday 21 January, 10.00 – 12.00pm in

Small Conference Room, Wellbeing and Learning Centre, SWYPFT, Fieldhead Hospital, Ouchthorpe Lane, Wakefield, WF1 3SP

Present:

Angela Monaghan (Chair) (AM) – Chair, South West Yorkshire Partnership NHS Foundation Trust
Brent Kilmurray (BK) – Chief Executive Officer, Bradford District Care NHS Foundation Trust
Cathy Elliott (CE) – Chair, Bradford District Care NHS Foundation Trust
Rob Webster (RW) – Chief Executive Officer, South West Yorkshire Partnership NHS Foundation Trust
Sara Munro (SM) – Chief Executive Officer, Leeds & York Partnership NHS Foundation Trust
Thea Stein (TS) – Chief Executive Officer, Leeds Community Healthcare NHS Trust

In attendance:

Keir Shillaker (KS) – Programme Director, Mental Health, Learning Disability & Autism
Helen Grantham (HG) – Non-Executive Director, Leeds & York Partnership NHS Foundation Trust
Jonathan Booker (JB) – Senior Analyst, WY&H Health and Care Partnership
Helen Eade (notes) (HE) – Programme Support Officer, Mental Health, Learning Disability & Autism

Apologies:

Neil Franklin – Chair, Leeds Community Healthcare NHS Trust, Sue Proctor – Chair, Leeds & York Partnership NHS Foundation Trust

Glossary of acronyms in this document can be found on page 5.

Item	Discussion / Actions	By whom
1	**Introductions:** A Monaghan (AM) welcomed the group and noted apologies as above.	
2	**Declaration of Interests Matrix / Conflict of Interest:** The declaration of interests was reviewed and agreed to be correct. No conflicts were identified.	
3a	**Review of Previous Minutes:** **ACTION 1/01**: Private and public minutes to be circulated to the group for future meetings. With the above noted, the notes from the previous meeting held 3 October were accepted as an accurate record.	**HE**
3b	**Actions log and matters arising:** The actions log had been updated to reflect progress with members discussing the actions below: 10/6 – completed. 11/6 – completed. 12/6 – to mark as closed. 8/10 – LD resilience tabletop exercise undertaken in December, working through MOU as part of emergency planning. Action 8/10 from the action log has been specifically noted to be included in this update. **ACTION 3/01**	**BK**
4	**Context Setting: Expectations of the Planning Guidance:** RW described how the Planning Guidance had not yet been released, so was unable to set out expectations. However, there is the expectation that the role of ICS will be strengthened including a 'system-first' ethos for planning, with two main roles being transformation and holding the system to account.	

Item	Discussion / Actions	By whom
5	**Programme update:** The group noted the items for information and considered three main items: 1. Risk and the escalation of risks 2. Committee membership and what this looks like 3. Workplan 1. The risk reporting process is still a work in progress to ensure consistency however the group were asked to consider what should be appropriately escalated to the C in C. It was agreed that the three main types of risk that C in C should discuss are: Any risk that is red rated or has been escalated by NHSE/I. Related to core delivery, or New or underlined historic issues, and any risk escalated during the meeting by a member of the CinC. Discussion also concluded that the focus should be on programme/transformation risks rather than provider operational risks, as they will be well served within each individual organisation. It was agreed to review the risk escalation process after 9 months **ACTION 4/01** – to put on work programme. 2. It was agreed that AM will chair the next meeting, then CE will take over. KS, AM and CE will review the existing terms of reference and bring back for approval in April. **ACTION 5/01**. Members were asked to feedback to KS in respect of terms of reference within next 3 weeks (by 11th February). **ACTION 6/01.** The group also discussed current membership, concluding that the focus should remain on the provider collaborative until WY&H is clearer on the outputs of the Commissioning Futures work being led by the CCG Accountable Officers. 3. The aim is to develop a clearer workplan so we know what is coming up at future meetings. This included reaffirming the need to spend time on decision making regarding the big ticket provider focused items such as ATUs, PICU and Complex Rehabilitation. The discussion also covered: • The need to reflect on the planning guidance when issued and implications regarding digital capital and workforce. **ACTION 7/01.** • The need for slightly longer C in C meetings (extending to 2.5 hrs) due to the volume and complexity of discussion items. • The need to undertake deep-dives on certain risks. • The development of strategic sessions once per year to review the full programme of work. **ACTION 8/01.** The group also reflected on the draft communications and engagement plan, and how there is more detailed planning undertaken for each specific workstream (e.g.. ATU). A communications manager has been recruited with dedicated time for this programme. Feedback on the draft plan was that it was strong on communication but needed to be more explicit regarding inclusion, understanding of	**KS** **KS/AM/ CE** **ALL** **KS** **KS**

Item	Discussion / Actions	By whom
	cultural sensitivity and staff side/union engagement. **ACTION 9/01.**	**KS**
	The Committee **NOTED** the report and supported the recommendations. It was **AGREED** that KS, AM and CE would review the terms of reference and bring any recommendations back the the Aril meeting.	
6	**Programme Metrics & Dashboard:** There are three categories of metrics being developed: • Big programme ambitions • Individual workstream measures – including proxy measure for transformation • Core performance measures The CinC was asked to consider the regularity of metrics being presented and what types of information would be useful. Discussion covered the proposed metrics which the programme board will review on a regular basis through highlight reports/deep dives, and some of the practical issues with obtaining timely and valuable data. It was agreed that the main purpose of bringing metrics to the CinC is to help with decision making, or manage risk. Not all data is needed in this forum, the focus will be on core performance. And when particular items are brought for decision they will need to be accompanied by up to date metrics that relate to the required decision. However, the annual strategic session can take a broader view and look at the full suite of information.	
7	**Steady State Commissioning:** The group noted the items for information and discussed two main topics: 1. The development of a commissioning team 2. Agreement of a reporting process 1. It was noted that the specialised services programme board had not yet had chance to receive and agree a formal proposition regarding the commissioning team. Following this meeting on Friday 24th January a proposition will be reviewed by the Collaborative Executive on 4th February before recommending to individuals boards/the Committees in Common for approval outside of the formal meeting. It was also agreed that the proposal should also be tested with governance leads in the provider collaborative before being finalised. HG reflected on a development session from Hill Dickinson about different governance arrangements and will send details of this to all members of C in C. It could be a useful session at a future NED/Governor event. **ACTION 10/01.** The Programme Board will deal with specialised services as a key workstream, so highlight reports on CAMHS, forensics and AED will be presented at Programme Board along with any other services that join the specialised services list. It was agreed that this highlight report will also be provided to the Committees in Common to provide direct assurance on the steady state commissioning work. **ACTION 11/01.**	**HG** **KS**

Item	Discussion / Actions	By whom
8	**CAMHS Update:** LCH indicated that October 2020 is too soon to go live and recommended pushing this back until April 2021. Both the financial modelling and potential commissioning implications are too risky at this stage. We need more clarity regarding integrated commissioning costs and from NHSE regarding staff transfer. It was acknowledged that there is a collective set of financial and clinical risks to deal with. We need to understand the degree of risk and what is needed, then discuss the implications of this with NHSE. The group **AGREED** to postpone the CAMHS go live date to April 2021 in principle, but for further information to be provided to individual provider boards to support a final decision. **ACTION 12/01.** Once confirmed the collaborative will send a formal letter in respect of CAMHS to NHSE. TS to consider when letter should be sent. **ACTION 13/01.**	**TS** **TS**
9	**Any other business** LYPFT will submit a bid to provide High Intensity Mental Health Services for Veterans for the North of England. Isolation units in schools for CAMHS services were raised, and although this is mainly an issue for individual places within the partnership it is something the collaborative can remain aware of.	
	Date and Time of Next Meeting: Thursday 23rd April 2020, Meeting Room 1, Block 7, SWYPFT, Fieldhead Hospital, Ouchthorpe Lane, Wakefield, WF1 3SP.	

Item	Discussion / Actions	By whom

Glossary

ATU	Assessment and Treatment Unit
BDCFT	Bradford District Care Foundation Trust
CQC	Care Quality Commission
CAMHS	Child and Adolescent Mental Health Services
C-In-C	Committees in Common
CCG	Clinical Commissioning Group
DTOC	Delayed Transfers of Care
ICS	Integrated Care System
LD	Learning Disabilities
LCH	Leeds Community Healthcare NHS Trust
LYPFT	Leeds and York Partnership NHS Foundation Trust
MHLDA	Mental Health, Learning Disabilities and Autism
MoU	Memorandum of Understanding
NCM	New Care Model
NED	Non-Executive Director
NHSE/I	National Health Service England / Improvement
SWYPFT	South West Yorkshire Partnership NHS Foundation Trust
TCP	Transforming Care Programme
VCH	Voluntary and Community Sector
WY&H	West Yorkshire & Harrogate
WY&H HCP	West Yorkshire & Harrogate Health and Care Partnership
WY&H ICS	West Yorkshire & Harrogate Integrated Care System (internal reference to WY&H HCP)
WYMHSC C-In-C	West Yorkshire Mental Health Services Collaborative Committees in Common

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:	Board Assurance Framework as at 20 March 2020
DATE OF MEETING:	26 March 2020
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

Overall responsibility for the BAF sits with the Chief Executive; it is administered by the Associate Director for Corporate Governance who has a co-ordinating role in respect of the information and for ensuring the document moves through its governance pathway effectively and provides check and challenge to the content.

The BAF is populated with the seven strategic risks from the Strategic Risk Register. Each risk is assigned to a lead executive director. Each individual risk has been:

- Refreshed on behalf of the lead director using the information on DATIX and reference to senior management leads to ensure that: the content is up to date; it adequately describes the controls and assurances in place; the gaps are adequately described; and any high level actions are articulated
- Provided to the lead executive director who has ensured the details overall are up to date.

For this version of the BAF the impact of COVID-19 has been reflected within the document. This has resulted in the risk score of all the strategic risks increasing. As relevant, the controls, gaps and contributory risks for the strategic risks now reflect the impact COVID-19. However, the Board is reminded that the Trust has in place robust Business Continuity plans, specific governance / command and control arrangements in place (both internally and externally determined) to manage the day to day risks posed by the pandemic and lessen the overall impact on our service users, staff, carers and visitors.

The BAF as a whole has been:

- Presented to those Board sub-committee named as an assurance receiver in order for them to be assured of the completeness of the detail and that it has received

sufficient and appropriate assurance in relation to the risks and that any gaps are being sufficiently managed. Where the committee feels that it hasn't received sufficient assurance it may require a further detailed 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 BAF and to be assured of its completeness and that it has been scrutinised by its sub-committees.

BOARD ASSURANCE FRAMEWORK OVERVIEW											QUARTER 1 - 2018/19
Strategic Objective	Risk appetite	Strategic Risk	Quarterly Assurance Rating				Reason for Current Assurance Rating	Executive Lead	Assuring Committee	Current Risk Score	Change
			Q1	Q2	Q3	Q4					
1. We deliver great care that is high quality and improves lives	ntial options and solutions. It is classed as 'high' in relation to that openness but the board would not take risks that compromise compliance with the core regulatory and legislative frameworks within which it has a licence to operate.	**SR1. (Risk 636) If there is a breakdown of quality and safety assurance processes we risk not being able to maintain compliance with regulatory requirements.**	Significant (remains same)	Significant (remains same)	Significant (remains same)	Partial (assurance reduced)	We have put in place a number of controls to ensure that we comply with our regulatory standards and we are not in breach of any of our regulatory requirements.	Cathy Woffendin (Director of Nursing, Professions and Quality)	Quality Committee	20	↑
		SR2. (Risk 829) There is a risk that we fail to make the improvements outlined in the quality strategic plan and that this has an adverse impact on the care of those who use our services.	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	There is evidence that there is continuous learning, improvement and innovation in the Trust but this is in the process of being embedded .	Clare Kenwood (Medical Director)	Quality Committee	15	↑
		SR7. Changes in the roles of commissioners and providers and the move to system-level working will require changes in the role and function NHS Trust boards and new governance arrangements There is a risk we do not have appropriate governance arrangements in place nor the capacity and capability to fulfil all our statutory functions.	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	Whilst some of the infrastructure is in place to govern the work of the ICS and MHLDA Collaborative there is still more work to do to understand the impact of the emerging governance arrangements.	Sara Munro (Chief Executive)	Board	15	↑
2. We provide a rewarding and supporting place to work		**SR3. (Risk 830) 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.**	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	There are a number of significant workforce challenges which the Trust is working to address.	Claire Holmes (Director of OD and Workforce)	Workforce Committee	25	↑

3. We use our resources to deliver effective and sustainable services	**3 - Open - ('high') We have a risk appetite which is 'open' to considering all pote either compromise our compliance with its duty of care to staff and patients or**	**SR4. (Risk 619) A lack of financial sustainability results in a destabilisation of the organisation and an inability to deliver services.**	Partial(remains same)	Partial(remains same)	Partial (remains same)	Partial(remains same)	Whilst we have maintained good working relationships with commissioners and have a track record of meeting our financial regulatory requirement, and our previous financial performance has generated a strong risk rating and high liquidity levels which acts as a buffer and mitigates against deterioration in our financial position there is still uncertainty in relation to a number of factor which could adversely impact on the Trust's financial performance	Dawn Hanwell (Chief Finance Officer)	Finance and Performance Committee	**20**	↑
		SR5. (Risk 615) Due to inadequate, inflexible or poorly managed estates we compromise the safe environment which places staff, service users and visitors at risk.	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	Overall the estate is managed to an adequate standard but development and improvement is constrained by the ownership and control model in operation. Long term this can only be addressed by significant change to the PFI contractual arrangements and will require investment. This is an ongoing process.	Dawn Hanwell (Chief Finance Officer)	Finance and Performance Committee	**20**	↑
		SR6. (Risk 635) As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	There are a number of significant controls in place and assurances that these controls are robust however, the Trust is constantly in a position of threat from external sources and must maintain a position of vigilance at all times.	Dawn Hanwell (Chief Finance Officer)	Finance and Performance Committee	**20**	↑

Strategic Objective	1. We deliver great care that is high quality and improves lives			Risk appetite	3 - Open ('High')
Strategic Risk		**Initial Risk Score**	**4**	**Committee**	Quality Committee
SR1. (Risk 636) If there is a breakdown of quality and safety assurance processes we risk not being able to maintain compliance with regulatory requirements.		**Current Risk Score**	**20**	**Executive lead**	Cathy Woffendin (Director of Nursing, Professions and Quality)

Assurance rating (quarterly) (limited, partial, significant)	Q1 (end of June 2019)	Q2 (end of September 2019)	Q3 (end of December 2019)	Q4 (end of March 2020)
	Significant	Significant	Significant	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Risk Lead / responsible director	Overseeing group	Q1 (end of June 2019)	Q2 (end of September 2019)	Q3 (end of December 2019)	Q4 (end of March 2020)
803	Our current information system does not enable us to carry out live monitoring of the use of urgent treatment on inpatient wards. The Code of Practice states that hospital managers should monitor the use of these exceptions to the certificate requirement to ensure that they are not used inappropriately or excessively.	Oliver Wyatt / Cathy Woffendin	Mental Health Operational Group	6	6	6	6

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
636	Governance Structure in place which sets out where performance and compliance is discussed and assurance is received and provided	The governance structure has been signed off by the Executive Management Team . There is executive director oversight of the reporting arrangements through the executive-led groups with assurance reports to the Board sub-committees which will identify any risks to compliance with regulatory requirements. The Governance Assurance Accountability and Performance Framework (GAAP) was audited and given significant assurance	Sep-18
636	Annual process for reporting on the controls in place in relation to risk including risks to compliance (Annual Governance Statement - Compliance with the provider licence)	The Annual Governance Statement was signed off by the Audit Committee, the Auditors and the Chief Executive for 2018/19. Self certifications were signed off by the Board for 2018/19 which also highlighted if there were any risks to compliance for 2019/20 and how these would be addressed.	May-19
636	Process in place for reporting serious incidents to Board and Quality Committee	NHSE investigation reports were presented to the May 2019 Board and Quality Committee and assurance was provided and received as to the process of reporting and the content of the cases provided	May-19
636	Serious incident reporting and investigation process in place	The action plan from the audit carried out in April 2017 have all been completed and evidence provided back to the internal auditors. A new process for reporting on serious incidents was signed off and presented to the Board for assurance in September 2017. Regular reports are sent to commissioners on each SI and they are assured of the processes in place. There has also been an audit on Learning from deaths in April 2019 which gave significant assurance	May-19
636	CQC Project Team in place to oversee compliance with CQC Standards. CQC Project Team Meeting chaired by the Director of Nursing	The CQC Project Team Meeting has received assurance and supporting evidence from leads responsible for CQC actions and compliance of robust processes and procedures in place. Regular updates are provided to Trust Board and Quality Committee through DoN quarterly reporting and CQC update reports.	Jan-20
636	Quarterly meetings with the CQC leads	Regular meetings take place with the Regional Team. No concerns have been raised by the team in relation to the Trust being able to implement the agreed actions.	Jan-20
636	Nursing Strategy and AHP Strategy in place	The Nursing and AHP strategies have been developed, agreed and launched into the organisation	Oct-18

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
636	Due to the current COVID 19 pandemic we are experiencing challenges to our current working arrangements and are working to the model of a LEVEL 4 NHS Incident with National command and control structures in place	Utilising business continuity plans across all areas; Emerging risks and clinical governance issues requiring assurance are discussed at daily SITrep calls and through an established incident coordination infrastructure	Sep-20

Strategic Objective	1. We deliver great care that is high quality and improves lives			Risk appetite	3 - Open ('High')
Strategic Risk		**Initial Risk Score**	**9**	**Committee**	Quality Committee
SR2. (Risk 829) There is a risk that we fail to make the improvements outlined in the quality strategic plan and that this has an adverse impact on the care of those who use our services.		**Current Risk Score**	**15**	**Executive lead**	Clare Kenwood (Medical Director)

Assurance rating (quarterly) (limited, partial, significant)	Q1 (end of June 2019)	Q2 (end of September 2019)	Q3 (end of December 2019)	Q4 (end of March 2020)
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	**Description**	**Lead / responsible director**	**Overseeing group**	**Q1 (end of June 2019)**	**Q2 (end of September 2019)**	**Q3 (end of December 2019)**	**Q4 (end of March 2020)**
643	Quality improvement, organisational development and clinical governance offering is not integrated and operates in silo, as a result our Quality Improvement approach is siloed, and not widely available/visible	Richard Wylde / Claire Kenwood	Trustwide Clinical Governance Group	9	9	9	15
638	There is a risk we adversely impact the experience of our service users, carers and staff by failing to embrace a culture of innovation and improvement.	Richard Wylde / Claire Kenwood	Trustwide Clinical Governance Group	12	12	12	15
645	Risk that there is no systematic approach to identifying and helping those teams who need support from the Service Improvement Team	Richard Wylde / Claire Kenwood	Trustwide Clinical Governance Group	6	6	6	15
TBC	There is a risk in continuity of knowledge due to a change in Medical Director	Sara Munro	Board	N/A	N/A	N/A	0

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
829	Quality Plan	The quality plan has been developed and agreed which defines the metrics and methods of evidencing continuous learning, improvement and innovation	Feb-18
829	The IHI 'Safe Effective Reliable Care Framework' has been adopted and adapted for the organisation	This was set out in the Strategic Quality Plan which was reviewed by the Trustwide Clinical Governance Group, the Quality Committee and the Board	Sep-18
829	Improvement methodology adopted and adapted for the organisation	IHI methodology has been adopted and is being rolled out and embedded across the Trust	Mar-19
829	Serious incident reporting and investigation process in place	A process for reporting on serious incidents was signed off and presented to the Board for assurance in September 2017. Regular reports are sent to commissioners on each SI and they are assured of the processes.	Mar-18
829	Reporting and investigation of deaths process in place	The internal audit into the reporting and investigation of deaths provided significant assurance	Mar-19
829	Complaints, Litigation, PALs (CLIP) report	This is sent monthly to the services to outline any learning	Mar-19
829	Governance structure and map in place and agreed	There is a ward to Board governance structure which was recommended by Deloittes; approved by the Board, EMT and care services. This has been reviewed on a number of occasions to ensure it reflects the needs of the organisation. Its last iteration was reviewed in July 2019	Jul-19
829	Sets of Quality performance information available published and used across the organisation (HR, Finance, Quality and Operational)	Cognos information is available and accessed routinely across services. HR data set circulated across the organisation on a weekly basis. The Information Team validation process established across key metrics. Finance system accessible and used routinely by managers (supported by Management accountants). Contracts manager collates and validates activity information. Performance report shared on a cascade basis through Board to direct reports and their teams.	Jan-19
829	Performance data is consolidated and relevance checked and shared at every level of the organisation.	Work has been undertaken to ensure that suites of information are produced and used at every level of the organisation in relation to quality and performance (ward to Board)Performance Management Reporting was audited and given significant assurance	Jul-19
829	Governance, accountability, assurance and performance framework in place including performance framework and review cycle providing ward to Board reporting	A consistent use of highlight reports are in place and ensure transparent escalation and linkage across the organisation. The Governance Assurance Accountability and Performance Framework set out ward to Board reporting and was audited and given significant assurance	Sep-18
829	Freedom to Speak up Guardian appointed and available to all staff	There is a report provided to the Board detailing the themes of the issues staff have raised. The themes identified by the guardian are reported into our governance structure and used to inform learning including a report to the Board of Directors.	May-19
829	Established a partnership with the IHI to support embedding a culture of quality improvement	Contract with IHI signed and they carried out a diagnostic report which highlighted areas of good practice and where systems and structures need strengthening	May-19

829	The IHI 'Five Core Components 'and the model for improvement have been chosen as the methodology for the organisation	IHI shared the five core components model which was subsequently selected as the chosen methodology. This has been seen in Trustwide Clinical Governance Group and Quality Committee and assurance provided that this is an appropriate methodology.	Nov-19

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
829	The establishment of a multi-disciplinary group to support change (from local teams to organisational wide priorities)	To continue to develop the relationship between specific support services for example Continuous Improvement Team and Organisational Development Team.	Dec-20
829	The culture of innovation and improvement needs to be developed	This will be picked up and developed through the Culture Collaborative	May-20
829	Serious incident reporting and investigation (gap in control)	We are developing metrics to assess the strength of the recommendations	Jun-20
829	There is a gap in the processes in place to quantify and audit learning (gap in control)	The processes that need to be put in place are: an audit of the effectiveness of learning; methods of quantifying learning; and methods of quantifying there is a learning culture	Dec-20
829	There is limited use of both the Safe, Effective, Reliable Care Framework and the Five Core Components model across the organisation	To continue to raise awareness and apply to all new improvement activity	Ongoing
829	As a result of the COVID-19 pandemic continuous improvement work will not take place at the pace expected whilst staff focus on maintaining day to day delivery of operational services	The continuous improvement team will provide any support necessary to teams who identify any urgent improvement work that needs to take place and hibernation plans have been issued by the Health Foundation to support the management of projects which need to be paused during this time.	Dec-20

Strategic Objective	2. We provide a rewarding and supporting place to work			Risk appetite	3 - Open ('High')	
Strategic Risk			**Initial Risk Score**	**15**	**Committee**	Workforce Committee
SR3. (Risk 830) 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.			**Current Risk Score**	**25**	**Executive lead**	Claire Holmes (Director of OD and Workforce)

Assurance rating (quarterly) (limited, partial, significant)	Q1 (end of June 2019)	Q2 (end of September 2019)	Q3 (end of December 2019)	Q4 (end of March 2020)
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	**Description**	**Lead / responsible director**	**Overseeing group**	**Q1 (end of June 2019)**	**Q2 (end of September 2019)**	**Q3 (end of December 2019)**	**Q4 (end of March 2020)**
5	Requirement for new skills in the workforce to support new models and also lack of staff engagement and involvement in the new models.	Lindsay Jenson	Future Workforce Group	9	9	9	9
56	The Care Group currently has a high number of vacancies impacting on quality and safety.	Andy Weir / Joanna Forster Adams	Care Group Management Meeting	9	9	9	9
109	Inability to recruit permanent staff across the Trust resulting in the need to rely on bank and agency staff within services	Lindsay Jensen / Claire Holmes	Future Workforce Group	12	12	12	12
705	Maintaining continuity of medical input is unstable due to the use of temporary contracts and agency staff.	Jamie Pick	Future Workforce Group	16	16	16	12
732	Lack of medical staffing at Clifton House and the reliance on a mutual aid SLA with TEWV	Steven Dilkes	Future Workforce Group	12	12	12	8
TBC	Absence relating to Covid-19 illness, self isolation and school closures significantly reducing capacity to deliver clinical care	Claire Holmes	Communications and staff welfare Group	N/A	N/A	N/A	25

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
830	Communications and staff welfare group in place as part of emergency response	Communications and staff welfare group meeting twice weekly, with cross representation from the operations group and regular feeding to and from the daily sitreps.	Mar-20
830	National co-ordination of response providing additional support to maximise staff availability	Weekly webinars in place with Chief People Officer enabling two way flow of information and feedback	Mar-20
830	HRD networks in place across place and MH Collaborative to maximise ability to respond	MH Collaborative Project Manager has been redeployed to wholly support the three mental health trusts within the ICS with implementing a co-ordinated workforce support where it is efficient and effective to do so to	Mar-20
830	Regular planned recruitment events for nursing posts	Ongoing recruitment event held for nursing posts with. Work in partnership with care services to identify identifying hot spots. Proactive recruitment for student nurses with guaranteed job offers based on referencing. Annual recruitment for student nurses. Supporting current staff to retrain. Utilising available funding (and Trust funding) to support training for improving Learning Disability nursing provision	Nov-19
830	Future Workforce Planning Group	The establishment of the Future Workforce Planning Group, exec chaired and supported by the newly appointed Strategic Resourcing Manager will bring together the work undertaken by differing professional groups under on Trust resourcing umbrella. The Strategic Resourcing Manager provides dedicated resource to the creation of clear career pathways and to maximise opportunities for both our staff to progress improving skills and retention and to create a more attractive offer to potential candidates. Work is underway to deliver workforce planning and talent management framework. External partnership with branding company to increase Trust profile to support recruitment and retention of staff.	Nov-19
830	West Yorkshire & Harrogate Mental Health Workforce Collaborative Group	Work scoped for a shared workforce plan, supported by HEE. The ICS MH Workforce Project Manager has been appointed to support this work.	Nov-19

830	Trust wide Learning Needs Analysis	Work underway to deliver a Trustwide learning needs analysis, enabling the Trust to maximise the return on value of investment in training and development, targeting resources towards the key skill requirements and working in collaboration with other partners to gain greater value for money.	Jun-20
830	Workforce and OD strategic plan agreed by the Board	The Workforce & OD Strategic Plan sets out how the Trust will address shortages of staff and the training and development of staff to meet the needs of the organisation.	Apr-20
830	Workforce Committee (a sub-committee of the Board of Directors) established	This increases Board level scrutiny of workforce issues and assurance to the Board	Oct-19
830	Nursing and AHP strategies have been agreed and launched	Participated in NHSI Recruitment and Retention Programme and continuing to embed good practice, ie career conversations for all staff	Sep-19
830	Regular monitoring of compulsory training compliance	Monthly reports showing a consistent achievement of Trust target of 85% compliance.	Nov-19
830	Medical Revalidation process	There are systems and processes in place to ensure that medical revalidation requirements are met. Assurance is provided through the Annual Responsible Officer Report. Revalidation was audited and given significant assurance	Aug-19
830	Well established internal nursing and HSW bank to provide a flexible workforce	Bank employee experience improvement work completed, including launch of bank handbook and established bank forums.	Nov-19
830	Education and Learning Steering Group	Establishing a Trust wide learning needs analysis and aligning development funding streams to improve skills and retention.	Jul-19
830	New Appraisal and Performance Review Policy	New Policy launched in August 2019. Quality Assurance process for appraisal being developed.	Aug-19
830	Apprenticeship Delivery Plan	Apprenticeships being utilised to support development of career pathways and develop skills in the workforce.	Nov-19
830	Medical staff Recruitment (AAC panels) programme	Planned recruitment for consultant posts. Improved AAC process. Partnership working between Workforce and Medical Directorate to develop future workforce plans	Nov-19
830	Staff engagement programme	Improved Local staff survey reporting and action planning. Bank staff included in staff survey for 2019. Culture collaborative launched in October 2019 and led by the Trust CEO	Nov-19
830	Appraisal process audit	This process was audited and significant assurance provided	Jan-20
830	Equality and Inclusion Plan monitored through the Equality and Inclusion Group	Launched staff networks and improvement plans	Nov-19

Significant gaps in control / assurance		**Actions**	**Deadline**
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
830	Trust Workforce Planning and |Governance Framework still in development	Resource is now in place facilitate the development of the framework and establish robust assurance measures	Jun-20
830	Establishing a programme for apprentices (gap in control)	To use new apprentice roles and opportunities to support recruitment into vacancies whilst also focusing on occupations with shortages. Working with the Mental Health Collaborative to maximise opportunities to benefit from apprenticeship programmes.	Mar-21
830	National guidance as to key workforce support measures still awaited	Weekly webinars in place with Chief People Officer . Communication and staff welfare group in place meeting twice a week with cross representation with the Operations group	Apr-20

Strategic Objective	3. We use our resources to deliver effective and sustainable services			Risk appetite	3 - Open ('High')		
Strategic Risk			Initial Risk Score	8	Committee	Finance and Performance Committee	
SR4. (Risk 619) A lack of financial sustainability results in a destabilisation of the organisation and an inability to deliver services.			Current Risk Score	20	Executive lead	Dawn Hanwell (Chief Finance Officer)	
Assurance rating (quarterly) (limited, partial, significant)	Q1 (end of June 2019)	Q2 (end of September 2019)	Q3 (end of December 2019)		Q4 (end of March 2020)		
	Partial	Partial	Partial		Partial		

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end of June 2019)	Q2 (end of September 2019)	Q3 (end of December 2019)	Q4 (end of March 2020)
570	Errors in outgoing correspondence (letter to wrong address, letter for one patient in correspondence to another etc) & other reportable IG breach incidents persist in care services. There has been an increase in reportable incidents year-on-year since the current reporting mechanism was established in 2012 with a risk of a fine from ICO.	Bill Fawcett / Dawn Hanwell	Information Governance Group	9	9	9	9
649	Evolution of New Care Models (NCM) impact on clinical income and sustainability. TEWV led CAMHS NCM involves the development of local CAMHS community services aimed at reducing out of area placements, this could reduce Tier 4 CAMHS (Mill Lodge) income and activity. Eating Disorders NCM results in LYPFT taking the full financial risk for out of area placements.	David Brewin / Dawn Hanwell	Finance & Performance Committee	9	9	9	9
651	Failure to achieve ongoing CIP requirements and demonstrate efficient and effective care will lead to a deterioration in the financial position.	David Brewin / Dawn Hanwell	Finance & Performance Committee	9	9	9	9
731	Increasing agency spend could cause a deterioration in the Trusts Finance Score.	David Brewin / Dawn Hanwell	Financial Planning Group	N/A	9	9	9

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
619	Good working relationships established with commissioners. Actively engaging commissioners and putting forward proposals that promote efficient and effective models of care.	Short term sustainability controls are in place following signing contract variations with Leeds CCG and NHS E for 2019/20 following a number of positive contractual discussions. Further joint working with NHS E resulted in the development of a new forensic model in HC&V. Throughout 2019/20 we have continued to engage in regular and positive dialogue with Leeds commissioners to promote efficient and effective models of care.	May-19
619	Commissioning activity around new and existing business is monitored through the Financial Planning Group: attended by Chief Financial Officer, Chief Operating Officer and Director of Nursing, Professions and Quality.	Agendas and minutes from Activity & Finance meeting / service reviews with commissioners demonstrate there is a process of providing assurance to the executive directors in relation to commissioning activity.	Dec-19
619	Oversight by Finance and Performance Committee: in relation to financial and clinical impact of tenders, in the context of the overall sustainability of the organisation.	An assurance paper is provided to the Finance and Performance Committee which is scrutinised by the non-executive directors on behalf of the Board.	Jan-20
619	Tender opportunities are reviewed by Financial Planning Group on a case by case basis along with considerations of whether to bid or not bid on any given tender. (led and including executive directors)	Operational metrics are presented to the Financial Planning Group for assurance in respect of tender opportunities	Dec-19
619	Partnership working arrangements in Leeds and ICS level, to ensure strategic influence is maintained on how resources are distributed and management of system wide risks (including city wide Director of Finance forum, Partnership Executive Group).	Minute of the PEF and citywide Director of Finance Group show a level of assurance on the what in which organisations are working in partnership across the city	Nov-19
619	Cost Improvement plans developed to be robust and subject to clinical impact assessment. Develop approach to identifying longer term cost improvement plans, engaging Care Groups to target areas for consideration. The approach is to carry out a full diagnostic and full sharing of information relating to cost pressures, agency spend, discretionary spending, viability of services, performance against activity targets.	The Director of Nursing and the Medical Director sign off the CIP programme and assess the quality impact. The Board and its sub-committees receive assurance on the CIPs though reports. Minutes of the committees / Financial Planning Group / Star Chambers show a level of assurance and check and challenge on the programme. This process was audited and significant assurance provided	Jun-18
619	Robust budgetary control framework and budget holder training in place	There is online training on Staffnet for all budget holders. Financial training for managers is also an integral part of the management essential training programme that is being developed. This process was audited and significant assurance provided	Dec-18
619	Budgetary and accounting control framework	The internal audit of the budgetary and accounting control framework has provided significant assurance	Jul-19

619	Achieved the control total and the 2018/19 financial plan	Accounts were audited at the end of 2018/19 to verify the financial outturn	May-19
619	Financial modelling and forward forecasting in place to identify risks early.	NHS Improvement Financial Plan and monthly and quarterly forecast. Leeds Plan forecast	Mar-19

Significant gaps in control / assurance		**Actions**	**Deadline**
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
619	Weakening of financial governance and controls as consequence of focus on clinical operational work and reduced capacity to attend to efficiency plans	Mitigated by current underlying run rate, and interim changes to finance business rules nationally	Oct-20
619	Excess expenditure not covered by exceptional income	Mitigated by pledge of NHSI/E to cover excess expenditure during the NHS response to COVID-19	Dec-20
619	Establish a process for identifying longer-term CIPs (gap in control)	Develop an approach to identifying longer term cost improvement plans, engaging Care Groups to target areas for consideration. The approach is to carry out a full diagnostic and full sharing of information relating to cost pressures, agency spend, discretionary spending, viability of services, performance against activity targets	Dec-20

Strategic Objective	3. We use our resources to deliver effective and sustainable services			Risk appetite	3 - Open ('High')
Strategic Risk			Initial Risk Score	8	Committee	Finance and Performance Committee
SR5. (Risk 615) Due to inadequate, inflexible or poorly managed estates we compromise the safe environment which places staff, service users and visitors at risk.			Current Risk Score	20	Executive lead	Dawn Hanwell (Chief Finance Officer)
Assurance rating (quarterly) (limited, partial, significant)	Q1 (end of June 2019)	Q2 (end of September 2019)	Q3 (end of December 2019)		Q4 (end of March 2020)	
	Partial	Partial	Partial		Partial	

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end of June 2019)	Q2 (end of September 2019)	Q3 (end of December 2019)	Q4 (end of March 2020)
9	The majority of operational estate is not under the direct ownership/control of the Trust and is managed through contract/lease arrangements with third parties.(NHS Property services and Equitix). There is risk of unacceptable delays in executing identified environmental changes and also responsiveness to maintenance requests if these contracts are not robustly managed and process are not clearly understood by all parties involved (3 way relationships exist with sub contracting arrangements between property owners, maintenance providers and Trust staff)	Myles Callaway / Dawn Hanwell	Estates Steering Group	6	9	9	6
125	The estate is not being used in an agile manner due to it being inflexible	Myles Callaway / Dawn Hanwell	Estates Steering Group	6	9	9	6
700	The Trust does not have a dedicated decant facility capable of receiving service users evacuated from a ward or unit due to an emergency - fire, flood, loss of power or other environmental/ security threat.	Andrew Jackson	Emergency Preparedness Resilience and Response Group	12	12	12	12

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
615	Ligature anchor points audit supported by risk assessments	Significant reduction in Ligature Anchor Points through prioritised programme of works. Action plan has been developed reporting to the Clinical Environments Group and CQC weekly meetings.	Feb-20
615	Clinical Environments Group overseeing risk assessment to determine work required	Clinical Environments Group meets on a monthly basis, risks are brought to the group via the Clinical leads for the service and discussed actions agreed and entered onto the action log. Where there is a specific Estates / Facilities requirement the work is specified and costed with inclusion of Clinical services and brought back to the group for a discussion. if the work is agreed a business case is produced with Estates and Clinical for consideration / approval at ESG	Feb-20
615	SLA in place for the Estate in York	SLA to be approved and signed with NHS Property Services	Sep-18
615	Estates strategy agreed by the Board	The internal audit of the Estates Strategy has provided significant assurance	Jun-18
615	Scheduled programme of maintenance on all leased and owned properties	This is monitored regularly through the Estates Steering Group	Jan-20

615	Contractual performance requirements on PFI estate to ensure that the estate is maintained to a good standard. Change control processes are in place to enable variations to the estate (limited by configuration). PFI negotiations strengthened resulting in relationship and contractual improvements	Meetings on performance of PFI and NHS PS contracts . Monitored by Quarterly assurance group.	Jul-20

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
615	The Trust still has sub-optimal estate	PFI options appraisal underway and the disposal of long-term nature of this currently being considered	May-20
615	Utilising one public estate	Reproviding services in suitable premises in accordance with the clinical plan	Jun-20
615	Development of PFI assets as per a programme of work as agreed with care services	Provide improved environments for service users with an in-patient focus. Work will be delivered in tandem with lifecycle and will be delivered using a decant solution	Jun-20
615	Added demand on facilities service (in particular domestic, cleaning, catering) impacting environments for service users and staff	Business Continuity Plans in place which have been enacted due to COVID-19 - eg changing to cleaning regimes, food supply options	Sep-20
615	Disruption of the planned programme of maintenance due to COVID-19 as a result of a reduced workforce capacity and restricted access to some clinical areas	Focus only on essential work to continue to maintain the estate where possible	Dec-20

Strategic Objective	3. We use our resources to deliver effective and sustainable services		Risk appetite	3 - Open ('High')	
Strategic Risk		Initial Risk Score	12	Committee	Finance and Performance Committee
SR6. (Risk 635) As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.		Current Risk Score	20	Executive lead	Dawn Hanwell (Chief Finance Officer)

Assurance rating (quarterly) (limited, partial, significant)	Q1 (end of June 2019)	Q2 (end of September 2019)	Q3 (end of December 2019)	Q4 (end of March 2020)
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end of June 2019)	Q2 (end of September 2019)	Q3 (end of December 2019)	Q4 (end of March 2020)
8	Failure to derive maximum clinical and business benefits from digital technologies	Bill Fawcett / Dawn Hanwell	Information Steering Group	6	6	6	6
105	The danger of a cyber-attack to the Trust's ICT infrastructure through malicious hacking or system virus infection.	Bill Fawcett / Dawn Hanwell	Information Steering Group	12	12	12	12
580	Should a failure occur of the Medchart system due to LYPFT server failure, back up charts can be printed off on each ward so that administration of medication can continue. The back up chart process relies on the dedicated PCs on the wards not being turned off at any time as this prevents the electronic backing up of the drug charts.	Caroline Dada / Claire Kenwood	Medicines Optimisation Group	6	6	6	6
618	There are duplicate entries on the EPMA system which could lead to service users receiving too much or too little medication	Jane Riley / Claire Kenwood	Medicines Optimisation Group	6	12	12	6
767	The PARIS system has a number of inadequacies which is leading to an inability to interface with other systems, difficulty for staff navigating the system, data being difficult to retrieve, difficulties with reporting	Bill Fawcett / Dawn Hanwell	PARIS design group	6	6	6	6
813	Concerns that EPMA is not recording some administered doses of medication which could lead to double dosing	Jane Riley / Claire Kenwood	Medicines Optimisation Group	12	8	4	4
848	Staff creating new public websites without proper consultation from Health Informatics or Procurement Department. The risk is: personal identifiable information is stored on the website and not secured appropriately, therefore potentially compromising the data; relevant security of the websites is not met to current standards and therefore risk of being compromised	Hergy Galsinh / Dawn Hanwell	Information Steering Group	N/A	N/A	9	9
TBC	Risk of staff not having access to appropriate IT hardware and remote working programmes due to increased demand as a result of the need to mobilise more staff to work in an agile way	Bill Fawcett / Dawn Hanwell	Information Steering Group	N/A	N/A	N/A	15

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
635	CareCert alerts are received from NHS Digital on a weekly basis to key stakeholders within Informatics. These alerts are reviewed and actioned regularly within the teams.	The monitoring of these alerts are overseen by the Information Governance Group (IGG) on a monthly basis and the CIO oversees the process. A new Cyber monitoring system is being installed to provide detailed reporting on vulnerabilities .	Jan-20
635	The ICT infrastructure has firewalls, intrusion prevention, virus protection software and e-mail protection systems that are continually updated to prevent attack. A working programme to improve our awareness and response to threats is in place. Alerts received from NHS Digital are closely monitored, actioned on a regular basis.	Penetration testing has been conducted by an independent accredited organisation (SEC-1 LTD) earlier this year. This included internal and external testing of the infrastructure to highlight any serious issues or vulnerabilities . SEC-1 found no serious threats or findings. Internal audit also provided significant assurance on the IT security and housekeeping arrangements	Oct-19
635	Data security and protection toolkit audit	Internal audit of data security and protection toolkit provided significant assurance	Mar-19
635	Cyber Security audit	Internal audit of cyber security provided significant assurance	Jul-18
635	IG Toolkit in particular Information security which includes patching, updating of systems, malware, cyber security etc.	IG Toolkit outcome has one of two results, satisfactory or non-satisfactory. This year we submitted satisfactory and it is anticipated for next year the outcome will also be satisfactory	Mar-19

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
635	Gaps may exist in the process of monitoring CareCert alerts from NHS Digital and if relevant actions are being dealt with accurately and effectively within given timescales. There is possible room for improvement.	To continuously monitor the alerts received from NHS Digital and to review the process that these are being actioned effectively within the IT and Network teams within reasonable timescales. Also to review the reporting process into Information Governance Group (IGG) and an escalation process is in place.	Mar-20

Strategic Objective	1. We deliver great care that is high quality and improves lives			Risk appetite	
				3 - Open ('High')	
Strategic Risk			Initial Risk Score	12	Committee	Board of Directors
SR7. Changes in the roles of commissioners and providers and the move to system-level working will require changes in the role and function NHS Trust boards and new governance arrangements There is a risk we do not have appropriate governance arrangements in place nor the capacity and capability to fulfil all our statutory functions.			Current Risk Score	15	Executive lead	Sara Munro (Chief Executive)

Assurance rating (quarterly) (limited, partial, significant)	Q1 (end of June 2019)	Q2 (end of September 2019)	Q3 (end of December 2019)	Q4 (end of March 2020)
		Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end of June 2019)	Q2 (end of September 2019)	Q3 (end of December 2019)	Q4 (end of March 2020)
TBC	Humber Coast and Vale ICS governance arrangements are not fully developed	Andy Weir / Joanna Forster Adams	Humber Coast and Vale ICS Programme Board	N/A	N/A	N/A	8
TBC	Uncertainty around the future direction for services at Clifton House and Mill Lodge	Andy Weir / Joanna Forster Adams	Humber Coast and Vale ICS Programme Board	N/A	N/A	N/A	8

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
TBC	Our Executive Team are linked into the governance arrangements for the WY&H ICS and the West Yorkshire Mental Health, Learning Disability and Autism Collaborative (MHLDA Collaborative)	Regular reports are made into the executive meetings and also to the Board through the CEO reports	Sep-19
TBC	Memorandum of Understanding for the WY&H ICS which has been agreed by all the partner Boards which sets out how the ICS will link into the Board	The MoU has been agreed by the Board and regular reports on the work of the ICS and any decisions that need to be taken are made through the CEO reports	Sep-19
TBC	Memorandum of Understanding for the MHLDA Collaborative which has been agreed by all the partner Boards which sets out how the ICS will link into the Board	The MoU has been agreed by the Board and regular reports on the work of the MHLDA Collaborative and any decisions that need to be taken are made through the CEO reports	Sep-19
TBC	A Committees in Common has been established for the MHLDA Collaborative which has as its members our Chair and CEO	The Committees in Common meets on a regular basis and reports back to our Board through the CEO reports	Sep-19
TBC	Board awareness training on partnership governance structures and models	Training provided by external legal adviser	Jan-20
TBC	Good representation in relation to Leeds Population Health Management to ensure it connects to the Trust and supports MH and LD services	City-wide meetings	Jan-20
TBC	The Strategy for the WY&H ICS Collaborative has been published	All partners in the ICS have signed up to the Strategy	Jan-20
TBC	The Trust's CEO is the SRO for the ICS	IG Toolkit outcome has one of two results, satisfactory or non-satisfactory. This year we submitted satisfactory and it is anticipated for next year the outcome will also be satisfactory	Mar-19

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
TBC	The COVID 19 pandemic removes the ability to work effectively in partnership at Trusts focus on the day to day delivery of services within their own Trust	Dialogue continues with partner organisations to look at ways of working in partnership and pooling resources and the ability to manage the effects of the pandemic	*Dec-20*
TBC	Lack of clarity as to the impact of the governance arrangements for the ICS and the lead provider model going forward.	The Trust will continue to influence the governance arrangements as we go forward and to understand how this impacts on our Trust; making amendments to our internal arrangements as needed.	Sep-20

AGENDA ITEM 23

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.
CQPR	Combined Quality and Performance Report	The report which advises the Board on performance against internal, contractual and regulatory performance measures.
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

Acronym / Term	Full title	Meaning
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.
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.

Acronym / Term	Full title	Meaning
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
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

Acronym / Term	Full title	Meaning
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.
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.

Acronym / Term	Full title	Meaning
SRAB	System Resilience and Assurance Board	A Board that brings together key stakeholders across the city to look at developing the system's commitment to the recovery, management, sustainability and the transformation of the unplanned health and care system in Leeds.
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.
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.

Acronym / Term	Full title	Meaning
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