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 29 October 2020
this meeting will be held virtually through Zoom – the joining details are in the diary invite

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A G E N D A

		LEAD
1	**Sharing stories an audio story from Farzana, a service user from the perinatal service** (verbal)	
2	**Apologies for absence** (verbal)	**SP**
3	**Declarations of interests and any conflicts of interest in any agenda item** (enclosure)	**SP**
4	**Minutes of the meeting held on 24 September 2020** (enclosure)	**SP**
5	**Matters arising** (verbal)	
6	**Actions outstanding from the public meetings of the Board of Directors** (enclosure)	**SP**
7	**Chief Executive's report** (verbal)	**SM**
8	**Report from the Chair of the Quality Committee for the meeting held on 13 October 2020** (enclosure)	**JB**
9	**Report from the Chair of the Workforce Committee for the meeting held 15 October 2020** (enclosure)	**HG**
10	**Report from the Chair of the Audit Committee for the meeting held 20 October 2020** (enclosure)	**MW**
11	**Report from the Chair of the Finance and Performance Committee 27 October 2020** (to follow)	**SW**
12	**Combined Quality, Performance and Workforce Report** (enclosure)	**JFA**
13	**Report from the Chief Financial Officer** (enclosure)	**DH**
14	**Quality Report** (enclosure)	**CW**
15	**Report from the Safe-working Guardian (enclosure)**	**Ben Alderson**
16	**Workforce Race Equality Standard and Workforce Disability Equality Standard report** (enclosure)	**CHolmes**
17	**Update report on preparations for winter** (enclosure)	**JFA**
18	**Board Assurance Framework** (enclosure)	**SM**
19	**Appointment of the Senior Independent Directors** (enclosure)	**SP**
20	**Approval of proposed changes to the Constitution** (enclosure)	**SM**

21 **Use of Trust Seal** (verbal) **SP**

22 **Any other business**

The next meeting of the Board will held on Thursday 26 November 2020 at 9.30 am
This meeting will be held virtually – joining details will be advised separately

AGENDA ITEM

3

Declaration of Interests for members of the Board of Directors

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

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

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NON-EXECUTIVE DIRECTORS								
Susan Proctor Non-executive Director	**Owner / director** SR Proctor Consulting Ltd Independent company offering consultancy on specific projects relating to complex and strategic matters working with Boards and senior teams in health and faith sectors. Investigations into current and historical safeguarding matters.	None.	None.	None.	**Associate** Capsticks Law firm. **Independent Chair** Safeguarding Adults Board North Yorkshire Count Council	None.	**Member** Lord Chancellor's Advisory Committee for North and West Yorkshire **Chair** Safeguarding Group, Diocese of York **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 **Director** Otley Golf Club Limited	**Sole owner,** Entwyne Ltd	None	None	None	None	None	None
Cleveland Henry Non-executive Director	**Director** **63 Argyle Road Ltd** Management Company	None	None	**Trustee** **Community Foundation For Leeds**	None	None	**Group Delivery & Deployment Director** **EMIS Group** Digital Health sector	Partner Lead Cancer Nurse Leeds Teaching Hospitals NHS Trust
Andrew Marran Non-executive Director	**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	None.	None.	None.	None. .	None. .	None.	None.

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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**	**CHos**	**JFA**	**CHol**	**SP**	**CHe**	**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 24 September 2020 at 9:30 am. This meeting was held virtually via teleconference facilities

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	
Mr C Henry	Non-executive Director	
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 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
Ms K McMann	Deputy Trust Board Secretary
Ms N Sanderson	Deputy Director of Nursing (deputising for Mrs Woffendin)
Five members of the public (four of whom were governors)	

		Action
	Prof Proctor opened the public meeting at 9.30 am and welcomed everyone.	
20/102	**Sharing stories** (agenda item 1) Prof Proctor welcomed Lucy Blake and Claire Jopson who shared their experiences of the Trust's Eating Disorders Service. They talked about the importance of: ensuring that the service is located in the right environment; having a therapeutic area that inpatients have access to; and good kitchen facilities where service users can prepare their own food. One issue they both felt to be important to service users was the continuation of support people receive in the community once they leave the inpatient setting. Mrs Hanwell spoke about the inpatient environment area and the plans to ensure the Eating Disorders Service was co-located with other mainstream mental health services. She noted that whilst it was a complex process to move services within the estate, it was a priority to site this service in the right location.	

	Mrs Forster Adams noted the comments that had been made about the difficulties of transitioning from 24 hour support into the community and agreed to liaise with senior managers to look at how the service offer might be strengthened and to bring a progress report back to the Board in March 2021.	**JFA**
	Dr Munro reported that she was Chair of the Programme Board which oversees the CONNECT service and that the issues that had been raised in this session would be shared to help to inform the ongoing development of the service.	
	Prof Proctor thanked Ms Blake and Ms Jopson for their honesty and candour, noting that the comments made had given valuable insight and would inform the discussions at Board meetings.	
20/103	**Apologies for absence** (agenda item 2)	
	Apologies were received from Mrs Woffendin, Director of Nursing, Professions and Quality.	
20/104	**Questions from governors**	
	It was noted that Mark Clayton had submitted a number of questions for the Board and it was agreed that these would be addressed outside of the meeting.	
20/105	**Declaration of interests for directors and any declared conflicts of interest in respect of agenda items** (agenda item 3)	
	The Board noted that there was a change to the declaration of interest for Mrs Hanwell, whose son was an apprentice for Interserve Construction Ltd. Mr Henry also asked for it to be noted that he was not a Board-level director with the EMIS Group but a senior leader within the organisation and as such this should be moved to the "other declarations" column. He also noted that his appointment with UKCloud should now be removed from the list. Mrs Hill agreed to make these changes.	**CHill**
	It was noted that no other director had a change in their declarations of interest and that no director at the meeting had advised of any conflict of interest in relation to any agenda item.	
20/106	**Minutes of the previous meeting held on 30 July 2020** (agenda item 4.1)	
	The minutes of the meeting held on 30 July 2020 were **received** and **agreed** as an accurate record.	
20/107	**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.

20/108 **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 **received** a log of the actions. It **noted** the details, the timescales and progress.

20/109 **Chief Executive's report** (agenda item 7)

Dr Munro provided a verbal update to the Board. She reported that nationally the level of risk for the COVID-19 pandemic had been raised to Level 4, but that the NHS still remained at Level 3 under the incident management framework with the focus being on reset and recovery. She noted that this position was not without challenges as the NHS looks to manage winter pressures and the additional demands this presents particularly in the context of local restrictions which may be placed on the area.

Dr Munro reported that both within the Trust and across the city, incident management meetings were taking place on a regular basis in order to continue to manage the ongoing impact of the pandemic and that discussions were taking place with regard to the potential impact local restrictions may have on services users. Dr Munro also reported that the Nightingale Hospitals remain on standby for any increase in critical care capacity, adding that the Trust was participating in the operational meetings in order to provide input from a mental health and liaison psychiatry perspective.

With regard to EU Exit transition arrangements, Dr Munro reported that there had been a formal notification that the internal governance for managing any potential impact were to be stood back up and that this would be managed through the incident response structures alongside the management of the COVID-19 pandemic.

Dr Munro then assured the Board that there continues to be a significant amount of planning and contingency whilst maintaining a steady state to ensure there is sufficient capacity as the Trust enters the winter period.

Mr Henry asked about the level of infection amongst staff. Dr Munro reported that the levels were relatively low in comparison to other organisations, but that there were a number of staff not in work due to a family member having to isolate or awaiting the outcome of a test.

Mrs White asked about the availability of testing for front-line staff. Dr Munro reported that there were some delays in accessing testing but that the Trust was working with Leeds Teaching Hospitals NHS Trust to put in place local swabbing capacity in the short-term. Ms Sanderson also reported that 'drive-through' clinics were being established which could be accessed by healthcare staff and that these would be monitored for accessibility.

Prof Baker sought assurance on the availability of medicines, particularly lithium, with the approach the end of the EU Exit transition period. Dr Munro assured the Board that arrangements were in place for the management of medicines through the national supply chain. With regard to the potential for the withdrawal of some lithium medication by manufacturers, Dr Munro added that representation was being made to the government to ask them to intervene in this matter and to explain the impact of this decision.

Prof Proctor asked for there to be a further update on EU Exit alongside COVID-19 in the private session of the October Board meeting, with an update to the November Council of Governors' meeting. **SM / Exec Directors**

The Board discussed the use of the Test and Trace App. It was noted that guidance had been developed and issued to staff to help them manage the use of the app and any impact for them or a family member that was contacted through the test and trace system. With regard to supporting service users and providing clear messages to them it noted that there was to be a shared approach through the West Yorkshire Directors of Public Health in order to ensuring there was shared communications strategy, which the Trust was linked into.

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

20/110 **Report from the Chair of the Workforce Committee for the meeting held 4 August 2020** (agenda item 8)

Miss Grantham provided a verbal report in relation to the meeting held on 4 August 2020. She reported that meetings had been held informally in the recent months, but that from October these would be held on a formal footing and that the focus of the committee would be the NHS People Plan; the review of the strategic risks around workforce; and the performance data required to monitor workforce metrics.

She noted that at the August meeting the committee had received assurance and updates on the plan to safely return staff to the workplace and the well-being assessments which have been carried out, in particular for bank staff.

With regard to the completion of well-being assessments for bank staff, Mrs Holmes reported that significant progress had been made. She then explained how the process for completing the assessments had been changed to facilitate this increase in uptake.

	The Board **received** the report from the Chair of the Workforce Committee.	
20/111	**Report from the Chair of the Mental Health Legislation Committee for the meeting held on 4 August 2020** (agenda item 9) Mrs White as Deputy Chair of the committee presented the update report. In particular she drew attention to the difficulties receiving data for advocacy services in York. It was noted that one of the Trust's governors was a Cllr for York City Council and it was suggested that her contact details be provided to Oliver Wyatt who may find this to be useful in progressing this issue. Mrs Hill agreed to provide these details.	**CHill**
	The Board **received** the update report from the Deputy Chair of the Mental Health Legislation Committee.	
20/112	**Ratification of the Terms of Reference for the Mental Health Legislation Committee** (agenda item 9.1) The Board considered the Terms of Reference and highlighted a number of changes that needed to be made. Mrs Hill agreed to provide the details of these to Ms Layton. It was also requested that responsibility for reviewing and assuring the Audit Committee on the sufficiency of the Internal Audit Programme was added to these and all Board sub-committees' terms of reference. Mrs Hill agreed to action this.	**CHill** **CHill**
	The Board **received** and **reviewed** the Terms of Reference for the Mental Health Legislation Committee and **ratified** these subject to the changes agreed in the meeting.	
20/113	**Report from the Chair of the Quality Committee for the meeting held 8 September 2020** (agenda item 10) Prof Baker presented the Chair's report from the Quality Committee that took place on 8 September 2020 and gave a brief outline of the issues highlighted in the report noting that the committee had been assured on the way in which the outbreaks of COVID-19 had been handled within the Trust. Prof Baker noted that no pressure ulcers had been recorded since October 2019 and the committee had been assured that this was not a recording error, adding that a significant amount of work had been carried out over the last two years around the management of pressure ulcers. He reported that the committee had reviewed the final Suicide Prevention Plan and reported that the committee had supported the Plan, adding that it was assured that it would be reviewed in light of any national or regional	

changes to suicide prevention.

Finally, Prof Baker reported that the committee had reviewed a proposal to invest in additional resources to support the Chair of the Ethical Advisory Group and that it agreed the Group should be embedded within the organisation and become part of the Trust's governance structure. Prof Proctor asked if she and Mrs Hill could discuss how issues identified by the Ethical Advisory Group would be reported through to Board. **SP / CHill**

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

20/114 **Report from the Chair of the Finance and Performance Committee 22 September 2020** (agenda item 10)

Mrs White presented a report of the matters that had been discussed by members of the Finance and performance Committee on 22 September 2020. In particular:

- A review of the Out of Area Placements / patient flow position and received assurance on a system-wide project that the Trust was to lead on.
- The Informatics Plan update and the positive impact and challenges of going live with CareDirector during the COVID-19 pandemic.
- The Data Security and Protection Toolkit ahead of it being presented to the Board of Directors, noting that the Toolkit performance had received significant assurance from Internal Audit.
- The Emergency Preparedness Resilience and Response statutory return which would be reviewed at the October committee meeting noting that the committee would also be looking at the plans for the Trust's EU Exit arrangements.

With regard to cyber security, Mrs White reported that the Information Team was developing a dashboard of data which would be reported to the committee in the coming months. Prof Proctor asked for the Board to be sighted on the dashboard which it was anticipated would be available for quarter 4. **DH**

Miss Grantham suggested that it might be helpful to have a summary of the impact of COVID-19 on the Trust's performance against targets and standards and asked whether there was an opportunity to reshape the national targets to take account of the changes in how services are now provided. It was suggested that this could be picked up in the discussion relating to the performance report later in the meeting.

The Board **received** the report on behalf of the Chair of the Finance and Performance Committee and **noted** the matters reported on.

20/115 **Combined Quality, Performance and Workforce Report** (agenda item 12.1)

Mrs Forster Adams presented the report noting that this had been presented and discussed in detail at the Finance and Performance Committee and also at the Quality Committee that the main points had been highlighted earlier in the Board agenda.

Mrs Forster Adams reported that the majority of services had continued to operate over the last few months but with a reduced number of referrals. However, she noted that the referral and activity rates had now increased to near normal levels. She also outlined the different ways in which service users were being supported through the use of new technology, however she noted that these new ways of working were not always reflected in how some of the targets and standards were set. She reported that there was a working group looking at this and at how the performance report could be made more meaningful taking account of these changes. Miss Grantham indicated that this had addressed the point she had made in the previous agenda item.

Prof Baker suggested that the joint Quality / Finance and Performance / Workforce Committee meeting in November looks at some of the ethical decisions that had been taken. Mrs Hill agreed to add this to the agenda for the meeting. **CHill**

With regard to the discussions that were taking place with commissioners related to potential changes in standards and targets, Mrs Forster Adams reported that the Head of Performance was looking at this in partnership with commissioners. Dr Munro added that the issue of how performance had been impacted by COVID-19 was also being discussed within the ICS and outlined the detail of some of these discussions.

The Board discussed the work that was ongoing to look at the breaches that had occurred in the Acute Liaison Psychiatry service, which Mrs Forster Adams indicated was also looking at what the contributing factors might be to understand the breadth of reasons why these occur. It was suggested that information relation to the outcome of this work be included in the report in the next quarter. **JFA**

Prof Proctor asked about the work that was ongoing across the city to project demand due to impact (direct and indirect) of the COVID-19 pandemic. Mrs Forster Adams reported that discussions were taking place within the incident response meetings in Leeds to help predict future demand and potential gaps. However, she added that there also needed to be discussions relating to the funding for this extra demand or consideration of how services will be changed to meet this. Mrs Forster Adams also confirmed that these discussions were taking account of matters not only related to health and social care but to all services which impact on the wellbeing or the residents of Leeds, including housing.

Prof Baker asked about the provision of care for people experiencing the psychological impact of COVID-19. Dr Munro reported that support for people with Long-COVID was being picked up through Leeds Community

Healthcare NHS Trust and that there was further consideration required to establish what the input was required from the Trust into this service. However, Dr Munro noted that there was still concern about the funding and staffing resource to support these additional services and that this was being discussed across the city.

The Board **received** and **noted** the content of the Combined Quality, Performance and Workforce Report performance report.

20/116 **Report from the Chief Financial Officer** (agenda item 12.2)

Mrs Hanwell presented the Chief Financial Officer's report. Firstly, she outlined the position for months 1 to 6 noting that this was fairly static with the requirement to report a break-even position on income and expenditure, after accounting for nationally calculated block income allocations and expenditure including reasonable additional COVID-19 expenditure.

With regard to months 7 to 12, Mrs Hanwell explained that the position was very different and that there had been a number of significant changes to the interim financial framework which would be effective during this next period. She also noted that the changes were in the context of the expectation that all organisations within the Integrated Care System (ICS) operate within a single defined financial envelope. Mrs Hanwell reported that work was being carried out to understand the impact of the new guidance in the context of changing demand and requirements.

Dr Munro advised that the submission to the ICS is expected to report that there would be a funding gap and that this would be supported by a narrative setting out the assumptions, risks and caveats.

Prof Proctor asked about the governance arrangements and the implications for Trusts, and where responsibility lies in relation to the submission to the ICS. Mrs Hanwell noted that this was still being worked through and that many aspects of ICS governance were still unclear, but that it remained unchanged that the Trust Board had overall accountability for the use of the its resources. Prof Proctor also identified the lack of non-executive director involvement and challenge and clarity around accountability. It was suggested that this explored further in the private session including how this would be raised within the ICS.

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

20/117 **Data Security and Protection Toolkit** (agenda item 15)

Mrs Hanwell presented the submission for ratification. It was noted that this had been looked at in some detail by the Finance and Performance Committee and it had supported the submission.

The Board considered and approved the Data Security and Protection Toolkit final scoring and noted that this would be published via the NHS Digital DSP Toolkit website.

Miss Grantham noted that the NHS People Plan would inform the Trust's People Plan and that this would be scrutinised in the Workforce Committee. Miss Grantham left the meeting.

20/118 **NHS People Plan** (agenda item 13)

Mrs Holmes presented the paper and outlined the main points in the report which the Board considered in detail. She noted that the paper provided an overview of the four key commitments set out in the plan: Looking after our People; Belonging in the NHS; New ways of working; and Growing for our future. She added that it also looked at how these align to our own internally developed priorities.

Prof Baker noted that the NHS People Plan did not adequately address the issue of recruiting and retaining Learning Disability Nurses and that international recruitment for this part of the workforce probably would not achieve the outcome required. Mrs Holmes supported this comment. She noted that that because this was a challenge there was a proposal that dedicated resource was identified to focus on this and that a number of options were being explored.

The Board acknowledged that the NHS People Plan as an overarching plan would not address all the challenges being experienced locally but the principles and objectives would help to inform the local plans to deliver the workforce required by the Trust.

In regard to the governance arrangements to oversee the application of the NHS People Plan within the Trust, Mrs Holmes asked the Board to approve assurance arrangements being taken through the Workforce Committee with a quarterly Equality and Inclusion report coming directly to the Board. This was agreed.

The Board also considered the request for there to be a non-executive director champion for well-being. Prof Proctor agreed to pick this up outside of the meeting. **SP**

Board members who wish to take part in the Reciprocal Mentoring programme were asked to submit their application forms to the Director of OD and Workforce by the end of the month. **All**

With regard to the Freedom to Speak up Ambassadors, Mrs Holmes assured the Board that the relationship between the Ambassadors and the Freedom to Speak up Guardian had been formalised and incorporated into the role description for the Guardian. It was noted that the Ambassadors will be invited to observe Board meetings as part of their development in due course.

	The Board **noted** the progress and **supported** the plan.
20/119	**Report from the West Yorkshire Mental Health Learning Disability and Autism Collaborative Committees in Common** (agenda item 14)
	The Board **received** and **noted** the content of the report.
20/120	**Approval of the West Yorkshire Mental Health Learning Disability and Autism Collaborative Committees in Common Terms of Reference** (agenda item 14.1)
	The Board **approved** the Terms of Reference
20/121	**Use of the seal** (agenda item 16)
	The Board noted that the seal had not been applied since the last meeting.
20/122	**Any other business** (agenda item 17) There were no items of any other business.
20/123	**Resolution to move to a private meeting of the Board of Directors** At the conclusion of business the Chair closed the public meeting of the Board of Directors at 12:30 and thanked members of the Board and members of the public for attending. The Chair then resolved that members of the public be excluded from the meeting having regard to the confidential nature of the business transacted, publicity on which would be prejudicial to the public interest.

Signed (Chair of the Trust) …….

Date …….

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

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
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 / Cathy Woffendin**	October Board of Directors' meeting	**COMPLETED** An update on progress has been provided as part of the Chief Financial Officers' report to the October Board meeting.
Sharing Stories (minute 20/102 - agenda item 1 – September 2020) **NEW -** Mrs Hill to write to thank Claire and Lucy for attending the meeting and sharing their stories with members of the Board	**Cath Hill**	Management action	**COMPLETED**

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Questions from governors (minute 20/104 - September 2020) **NEW -** The response to the questions asked by Mark Clayton to be included in the minutes of the September Board meeting as an addendum.	**Exec Directors**	Management action	**COMPLETED**
Chief Executive's Report (minute 20/109 - agenda item 7 – September 2020) **NEW -** Update to the October private Board meeting on our incident response arrangements regarding EU Exit / COVID / winter with an update to the Council of Governors in November.	**Sara Munro / executive directors**	Board of Directors' meeting October 2020 Council of Governors' meeting November 2020	**ONGOING** This will be reported on through the Chief Executive's Report to the private Board meeting in October
Terms of Reference for the Mental Health Legislation Committee (minute 20/112 - agenda item 7.1 – September 2020) **NEW -** Mrs Hill to provide details to Sarah Layton of the updates required to the Committee's Terms of Reference as discussed by the Board.	**Cath Hill**	Management action	**COMPLETED**

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Terms of Reference for the Mental Health Legislation Committee (minute 20/112 - agenda item 7.1 – September 2020) **NEW -** The Board agreed that the Terms of Reference for all Board sub-committees should include a duty to consider and advise on the Internal Audit Annual Plan. Mrs Hill agreed to insert this into the narrative for the committees Terms of Reference.	**Cath Hill**	Management action	**COMPLETED**
Report from the Chair of the Mental Health Legislation Committee (minute 20/111 - agenda item 7 – September 2020) **NEW -** Oliver Wyatt to link with the Appointed Governor for York City Council, Anna Perrett, in relation to the data for advocacy services in York. Mrs Hill agreed to provide contact details to Mr Wyatt.	**Cath Hill**	Management action	**COMPLETED**
Report from the Chair of the Quality Committee (minute 20/113 - agenda item 10 – September 2020) **NEW -** Prof Proctor and Mrs Hill to discuss how the Board can best receive assurance from the Ethical Committee.	**Prof Proctor / Cath Hill**	Management action	**COMPLETED**
Combined Quality, Performance and Workforce Report (minute 20/115 - agenda item 12.1 – September 2020) **NEW -** Mrs Hill agreed to add to the agenda of the joint Quality / Finance and Performance / Workforce Committee meeting in November the matter of ethical decisions.	**Cath Hill**	Joint committee meeting November	**COMPLETED**

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
NHS People Plan (minute 20/118 - agenda item 13 – September 2020) **NEW -** A non-executive well-being champion to be identified by the Chair.	**Prof Proctor**	Management action	**COMPLETED** The role will be incorporated and overseen by the Workforce Committee
NHS People Plan (minute 20/118 - agenda item 13 – September 2020) **NEW -** Board members who wish to take part in the Reciprocal Mentoring programme to submit their application forms to the Director of OD and Workforce by the end of the month.	**All Board members**	Management action	**COMPLETED**
Combined Quality, Performance and Workforce Report (minute 20/115 - agenda item 12.1 – September 2020) **NEW -** Narrative to be added to the next quarter CQPR in relation to the breaches in Liaison Psychiatry, the findings and the actions taken.	**Joanna Forster Adams**	Board of Directors' meeting October 2020	**COMPLETED** Additional analysis has been added to the CQPR
Sharing stories (minute 20/102 - agenda item 1 – September 2020) **NEW -** Mrs Forster Adams to liaise with senior managers in the Eating Disorder Service to look at how the transition arrangements and strengthen the support that Is put in place. A progress report will be brought back to the March 2021 Board meeting.	**Joanna Forster Adams**	Board of Directors' meeting March 2021	

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Report from the Chair of the Finance and Performance Committee (minute 20/114 - agenda item 11 – September 2020) **NEW -** The Board is to be sighted on the dashboard of data relating to cyber security.	**Dawn Hanwell**	Board of Directors meeting March 2021	

CLOSED ACTIONS

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Sharing stories (minute 20/085 - agenda item 1 – July 2020) It was agreed that Ms Wardle's contact details would be shared with Mrs White.	**Kerry McMann**	Management Action	**COMPLETED**
Sharing stories (minute 20/085 - agenda item 1 – July 2020) Mrs Hill agreed to write to Ms Wardle thanking her for sharing her story.	**Cath Hill**	Management Action	**COMPLETED**
Questions from Governors (minute 20/089 – July 2020) Mrs Forster Adams agreed to speak to the Leadership Team and to Mrs Rawcliffe-Foo to ensure they were aware of the rationale for the decision taken about Rose Ward at Clifton House.	**Joanna Foster Adams**	Management Action	**COMPLETED**
Minutes of the previous meeting held on 25 June 2020 (minute 20/90 - agenda item 4.1 – July 2020) Mrs Hill agreed to amend the minutes of the meeting.	**Cath Hill**	Management Action	**COMPLETED**

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Chief Executive's report (minute 20/093 - agenda item 7 – July 2020) Mr Marran asked if details of the work relating to the dietetics team could be circulated to the Board. Mrs Woffendin agreed to do this.	**Cathy Woffendin**	Management Action	**COMPLETED**
Chief Executive's report (minute 20/093 - agenda item 7 – July 2020) Prof Baker asked if the Trust was providing information to staff about how they can claim tax relief for working from home. Mrs Hanwell indicated that the position on this was complex and agreed to look again at what might be possible in terms of support to staff with this matter.	**Dawn Hanwell**	Management Action	**COMPLETED**
Report from the Chair of the Quality Committee for the meeting held 14 July 2020 (minute 20/094 - agenda item 8 – July 2020) In terms of time commitment for members of the Ethics Committee it was agreed that Dr Hosker would speak to Dr Munro on this matter.	**Chris Hosker**	Management action	**COMPLETED** A summary paper and proposal has been submitted to the Quality Committee and will be considered on the 8.9.2020 in that forum
Operational performance report (minute 20/097 - agenda item 11.1 – July 2020) Mrs Forster Adams agreed to pick up the matter of ethnicity reporting with the Head of Performance.	**Joanna Forster Adams**	Management action	**COMPLETED** The Care Director team have confirmed that ethnicity is due to start to report again in October and this will be included in the performance report as soon as possible after that

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Report from the Chair of the Audit Committee for the meeting held 21 July 2020 (minute 20/095 - agenda item 9 – July 2020) Prof Proctor asked for the meeting of the Boards of the Trust and Leeds Community Healthcare NHS Trust is progressed and a date sought.	**Cath Hill**	Management Action	**COMPLETED**

AGENDA ITEM
8

Chair's Report

Name of the meeting being reported on:	Quality Committee
Date your meeting took place:	13 October 2020
Name of meeting reporting to:	Board of Directors – 29 October 2020

Key discussion points and matters to be escalated:

At the Quality Committee meeting that took place on the 13 October 2020:

- The Committee received the Research and Development Annual Report for 2019/20. It discussed the research projects that the Trust was currently involved in relating to Covid-19 and explored alternative funding opportunities for research projects.
- The Committee received a report on the Trust's consideration of the recommendations from the 'First Do No Harm' report regarding the use of valproate in women of child bearing age. It discussed the work being carried out to develop a register for all women in Leeds prescribed valproate for a mental health indication, to ensure every women of childbearing age on valproate is continuously monitored, advised of the risks and aware of the pregnancy prevention programme. The Committees recognised that more could be done in this area and the need for this to be a nationally led campaign.
- The Committee reviewed the final draft of the Quality Report and Account 2019/20. It acknowledged the developments that had been made to the report and the amount of work that had gone into preparing the Report. The Production Plan for the Quality Report and Account 2020/21 will be presented at the next meeting in November 2020.
- The Committee received the Combined Quality and Workforce Performance Report. It expressed concern that the 2020/21 data for certain metrics was not yet available due to CareDirector related technical reporting developments. The Committee has requested an update on when this data will be available
- The Committee was informed that work had been carried out around the Trust's winter planning arrangements and asked for this to be shared with the Board of Directors at its October meeting.
- The Committee discussed safeguarding. It was informed of the merging together of the Children's Trust Board and the Safeguarding Children's Board and a piece of work being carried out around resourcing the Front Door service.

• The Committee identified a strategic risk and ethical issue around deprioritising services and expressed concern around the plans for the waiting list for the Trust's Gender Identity Service being closed to new referrals.	
Report completed by:	Professor John Baker 16 October 2020

AGENDA ITEM
9

Chair's Report

Name of the meeting being reported on:	Workforce Committee
Date your meeting took place:	15 October 2020
Name of meeting reporting to:	Board of Directors – 29 October 2020

Key discussion points and matters to be escalated:

The Workforce Committee meeting that took place on the 15 October 2020 was the first formal meeting since the start of the Covid-19 pandemic. At this meeting:

- The Committee spent time discussing governance matters including minutes, action logs and hibernation plans, as well as considering the work programme for 2021 and a schedule of strategic discussions that would take place at each meeting.

- The Committee noted that Lindsey Jensen, Deputy Director of Workforce, would be leaving the Trust at the end of November to take up a position as Deputy Director of Workforce at South West Yorkshire Partnership NHS Foundation Trust. The Committee thanked Lindsey for her commitment and work with the Trust and wished her well in the future.

- The Committee reviewed its Terms of Reference in light of the Board agreeing that it will have oversight of the equality and inclusion agenda with the Chair of the Trust as Lead Non-executive. It recognised that a significant element of the Trust's work to ensure equality and inclusion was with regard to the workforce and, as such, it was agreed that the Committee would continue to have oversight of relevant workforce data and specific initiatives as requested by the Board. The Committees Terms of Reference have been updated to reflect this and it was suggested that all sub-committees consider whether they have a specific role regarding equality and inclusion and whether this should be reflected in their Terms of Reference.

- The Committee considered the requirement of the NHS People Plan for a Non-executive Wellbeing Champion to be nominated. It noted that the detail of the role was yet to be clarified and therefore it was recommended that the role of Wellbeing Champion would be taken by the Workforce Committee as a whole and that this would be reflected in the Terms of Reference of the Committee.

- On behalf of the Board, the Committee received assurance that the nationally mandated Wellbeing Assessments were progressing at all levels of the organisation. It was agreed that as a Trust we were going above and beyond NHS requirements in line with the Trust's values which had led to good engagement. Examples of the impact of the assessments were provided and assurance was given on the approach with Bank Staff. At the time of the meeting, the completion rate for wellbeing assessments was 88.5% (92.2% for substantive staff and 58.6% for bank staff)

- The Committee received a presentation on the development of the Trust's People Plan following discussions with the Council of Governors and Board of Directors. It noted that work was ongoing to develop a final plan for communication and sign off and that work was progressing on all aspects of the priority areas.

- The Committee received assurance on the work being carried out to improve compliance around appraisals. It acknowledged that appraisals had been paused due to the pandemic but that they were now restarting and would include a career conversation. It noted that, on average, 120 appraisals were being completed per month however it was informed that 230 appraisals would need to be carried out per month if the 85% target was to be reached. The Committee noted this was a risk with other pressures and agreed that it would be kept under review. The Director of Nursing, Quality and Professions agreed to seek clarity from the Care Quality Commission as to the expectations regarding compliance.

- The Committee agreed that clinical supervision remained a concern although it was improving. It agreed that this would be a priority with continued focus.

Report completed by:	Helen Grantham 21 October 2020

AGENDA ITEM

10

Chair's Report

Name of the meeting being reported on:	Audit Committee
Date your meeting took place:	20 October 2020
Name of meeting reporting to:	Board of Directors – 29 October 2020

Key discussion points and matters to be escalated:

The Audit Committee met on 20 October 2020 and agreed the items below were to be reported to the Board for information and assurance.

- **Quality Report** – the committee received assurance on the Quality Accounts and noted the content. It was advised that for the report relating to 2019/20, the external auditors had not been required to provide a limited assurance report on the content. The committee also noted the huge amount of work that had gone into the production of the report and asked for thanks to be extended to the staff involved in its production.

- **Internal Audit progress report** – the committee received assurance from the Internal Auditors that two reports which had previously been given limited assurance (Management of Contracts and Service Users' Money and Property) had been re-audited and each had now been given significant assurance. However, it was noted that there was further work to be carried out by Internal Audit to ensure that new procedures were being applied appropriately. The committee also noted that the work to continue the development of CareDirector vis-à-vis the rebuild of data reporting capacity was continuing. The committee noted that Mrs Hanwell would provide an update to the Finance and Performance Committee on progress with this.

- **Health and Safety Annual Report –** the committee noted the progress that had been made with the production of this report, although it noted that there was still further work to be carried out to refine it and that a separate meeting would be arranged to discuss the report and consider the management of Health and Safety within the Trust more generally.

- **Board Assurance Framework –** the committee received the latest version of the BAF which had been updated to reflect the current position and noted that the target dates for the gaps and actions had now been updated. It also noted that it would recommence going to the Board and also to the various Board sub-committees in accordance with their cycles of business following a period of hibernation due to COVID-19.

- **Registers –** the committee received and was satisfied with the information presented in the Losses and Special Payments Register; the Management Consultants Register; the Hospitality Register; and the Gifts and Sponsorship Registers.

- **Terms of Reference –** the committee received the Terms of Reference in accordance with it cycle of business and agreed that there were no changes to be made other than one item of duplication which it agreed to remove. It noted that this was not a substantive change to the Terms of Reference and as such they did not need to go to the Board.

- **Annual committee effectiveness questionnaire** – the committee received and considered the comments from members and attendees of the committee. It discussed the consolidated scores and the comments and concluded that there were no changes that it needed to make to the way in which the committee operated.

- **Outstanding Internal Audit actions** – the committee received a summary report on the outstanding internal audit actions. It noted that substantial progress had been made by action owners to complete actions and update the system. It noted that this had been achieved during a time of huge pressure for the organisation and NHS as a whole and asked for the amount of work this had taken to be acknowledged.

- **Future Audit Committee meeting dates** – it was noted that the meeting dates for 2021 had been set and that the dates in May 2021 for scheduling the Audit Committee and the Board would be predicated on the close-down timetable for the Annual Accounts. It acknowledged that there was only a very small window in which these two dates could be set and that we would work with the External Auditors to finalise the date of the Audit Committee meeting in May.

Report completed by:	Martin Wright – 21 October 2020

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
12

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Combined Quality, Performance and Workforce Report
DATE OF MEETING:	29 October 2020
PRESENTED BY: (name and title)	Joanna Forster Adams - Chief Operating Officer
PREPARED BY: (name and title)	Nikki Cooper – Head of Performance Management and Informatics Cathy Woffendin – Director of Nursing and Professions Claire Holmes – Director of Workforce Chris Charlton – Information Manager Performance & BI

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.

Since April, when we implemented Care Director as our Electronic Patient Record system, our performance reporting capability has been being rebuilt. This means that the CQPR has been more limited than our routine Board level report. However, in broad terms the report aims to set out our performance against:

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

As discussed over the course of the last few months we have continued within our services to use live data and the availability of dashboards and reports has been increasing.

This month we indicate where we are working to establish standards which reflect the new way many of our services are delivered and in particular where practice has changed. Please note that these changes over the course of the Covid pandemic has resulted in challenges in terms of our traditional and established performance target achievement as set out in the attached 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 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 AND PERFORMANCE REPORT

Lead Director: Joanna Forster Adams, Chief Operating Officer

Date: Oct 2020 (reporting Sep 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 September 2020**

Consistency and improvement:

During September, a number of services achieved access standard / contractual targets; these included the percentage of inpatients followed up within 3 days of discharge from CCG commissioned services; the percentage of service users who stayed on CRISS caseload for less than 6 weeks; and the percentage of referrals seen within 4 weeks of receipt of referral within our Community Learning Disability services. Data quality improvement remains key, as a range of metrics were subject to redesigned recording and reporting processes as part of Care Director implementation.

Data reported in 2020-21 should continue to be treated with some caution following implementation of CareDirector and the ongoing data quality work taking place. The finance section remains under review and is dependent on clarity around Covid-19 funding arrangements.

Workforce:

As a Trust we continue to work hard to keep each other, our service users and families safe and well protected from infection. As we see more updates to national guidance, and the introduction of the three tier local lockdown system, our workforce are playing a vital role in keeping us safe and controlling the virus and we remain grateful and appreciative of their ongoing support in all of our services.

We continue our approach to managing the next phase of the pandemic, by continuing to adapt to changeable circumstances, without compromising on the specialist help and care we deliver to our service users. We recognise that to keep supporting people with mental health and learning disability needs, we can only do this by keeping safe ourselves, by continuing to practice social distancing, washing our hands and wearing the correct PPE. There is a constant reminder to staff via our weekly communications and the IPC team have created posters, video blogs to support staff. This will allow us to keep adapting to the changing situation we find ourselves in, and maintain our focus on what matters to us most – the people we serve.

Work in Progress:

Data completeness measures on NHS number, ethnicity and sexual orientation have been redeveloped and included in the report for the first time in 2020-21. Some routine KPIs remain unavailable for reporting and we continue to develop our data warehouse and reporting to accommodate data from CareDirector. Measures will continue to be re- introduced into the report as they become available. Additional service activity trend data continues to be included in the report to assist with understanding activity in the absence of some routine KPIs.

Last month we discussed the changes in how we deliver services and how our standards and measures can be amended to reflect our new ways of working. This is being reviewed at a service level so that we can make clinically informed decisions about where it is appropriate to change the measure. We remain committed to delivering care in the most appropriate, individualised and clinically effective way within the constraints we now are faced with. To this end we also recognise that a number of the waiting time measures don't fit with the current service offers due to Covid-19 and we are looking to develop some alternative measures that better reflect this.

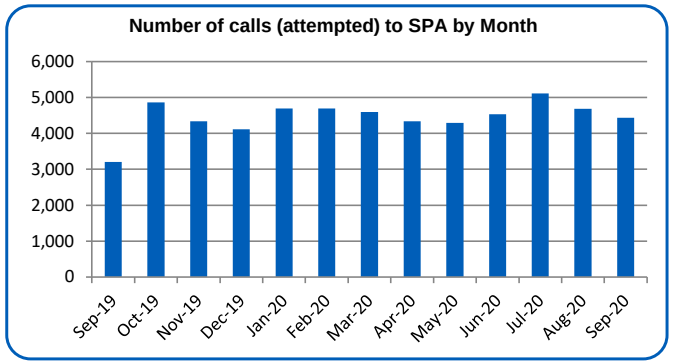
Service Performance – Chief Operating Officer

Services: Access & Responsiveness: Our response in a crisis	Target	Jul-20	Aug-20	Sep-20
Percentage of crisis calls (via the single point of access) answered within 1 minute	-	63.4%	63.2%	58.9%
Percentage of ALPS referrals responded to within 1 hour	90%	15.9%	33.9%	47.7%
Percentage of S136 referrals assessed within 3 hours of arrival	-	7.8%	12.3%	12.3%
Percentage of appropriate crisis referrals offered a face to face assessment within 4 hours of referral	Sep 80%	8.7%	18.1%	18.3%
Percentage of service users who stayed on CRISS caseload for less than 6 weeks	70%	95.3%	84.4%	89.7%
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support	50%	23.7%	22.7%	33.1%
Percentage of CRISS caseload where source of referral was acute inpatients	tba in Q2	*reporting in development*		
Services: Access & Responsiveness to our Regional and Specialist Services	**Target**	**Jul-20**	**Aug-20**	**Sep-20**
Gender Identity Service: Median wait for those currently on the waiting list (weeks)	-	*reporting in development*		
Gender Identity Service: Number on waiting list	-	*reporting in development*		
Leeds Autism Diagnostic Service (LADS): Percentage starting assessment within 13 weeks (quarterly)	95%	-	-	64.7%
CAMHS inpatients: Proportion of people assessed within 7 days of admission (HoNOSCA / GBO) quarterly	-	*reporting in development*		
Deaf CAMHS: average wait from referral to first face to face contact in days (monthly)	-	215	-	-
Forensics: HCR20: Percentage completed within 3 months of admission (quarterly)	95%	*reporting in development*		
Forensics: HCR20 & HoNOS Secure: Percentage completed (LOS greater than 9 months) (quarterly)	95%	*reporting in development*		
Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency) (quarterly)	-	-		0.0%
Perinatal Community: Percentage waiting less than 2 weeks for first contact (routine) (quarterly)	85%	-		34.4%
Perinatal Outreach: Average wait from referral to first contact (all urgencies) (quarterly)	-	*reporting in development*		
Perinatal Community: Total number of distinct women seen in rolling 12 months (quarterly)	Q2 530	-	-	371
Perinatal: Face to Face DNA Rate (quarterly)	-	-		3.7%
Community LD: Percentage of referrals seen within 4 weeks of receipt of referral	90%	84.6%	73.9%	91.3%
Community LD: Percentage of Care Plans reviewed within the previous 12 months	90%	*reporting in development*		
Services: Our acute patient journey	**Target**	**Jul-20**	**Aug-20**	**Sep-20**
Number of admissions to adult facilities of patients who are under 16 years old	-	0	0	0
Crisis Assessment Unit (CAU) bed occupancy	-	52.7%	82.8%	88.3%
Crisis Assessment Unit (CAU) length of stay at discharge	-	4.9	7.3	7.7
Liaison In-Reach: attempted assessment within 24 hours	90%	72.0%	70.3%	70.0%
Bed Occupancy rates for (adult acute excluding PICU) inpatient services:	94-98%	98.0%	99.0%	98.3%
• Becklin – ward 1 (female)	-	95.7%	95.5%	97.9%
• Becklin – ward 3 (male)	-	99.7%	99.0%	98.5%
• Becklin – ward 4 (male)	-	101.0%	100.9%	98.5%
• Becklin – ward 5 (female)	-	94.9%	101.3%	99.1%
• Newsam – ward 4 (male)	-	98.9%	98.2%	97.6%
• Older adult (total)	-	75.5%	85.3%	91.9%
• The Mount – ward 1 (male dementia)	-	58.6%	70.0%	91.6%
• The Mount – ward 2 (female dementia)	-	70.5%	78.5%	83.6%
• The Mount – ward 3 (male)	-	77.0%	90.7%	94.3%
• The Mount – ward 4 (female)	-	89.0%	94.6%	94.7%

Service Performance – Chief Operating Officer

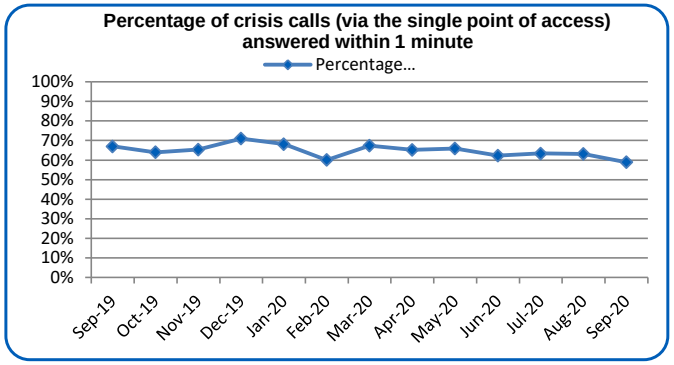
Services: Our acute patient journey	Target	Jul-20	Aug-20	Sep-20
Percentage of delayed transfers of care	<7.5%	*reporting in development*		
Total: Number of out of area placements beginning in month	-	22	11	12
Total: Total number of bed days out of area (new and existing placements from previous months)	Sep 234	731	622	376
Acute: Number of out of area placements beginning in month	-	18	5	8
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	537	387	292
PICU: Number of out of area placements beginning in month	-	4	6	4
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	194	235	84
Older people: Number of out of area placements beginning in month	-	0	0	0
Older people: Total number of bed days out of area (new & existing placements from previous months)	-	0	0	0
Cardiometabolic (physical health) assessments completed: Inpatients (quarterly)	90%	-	-	42.6%
Services: Our community care	**Target**	**Jul-20**	**Aug-20**	**Sep-20**
Percentage of inpatients followed up within 3 days of discharge (Trust Level monthly local tracking)	-	78.2%	76.7%	84.9%
Percentage of inpatients followed up within 3 days of discharge (CCG commissioned services only)	80%	78.5%	80.0%	87.2%
Number of service users in community mental health team care (caseload)	-	4,594	4,667	4,701
Percentage of referrals seen within 15 days by a community mental health team	80%	82.2%	68.1%	68.6%
Percentage of referrals to memory services seen (face to face) within 8 weeks (quarter to date)	90%	81.8%	76.9%	60.0%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50%	0.0%	25.0%	22.6%
Early intervention in psychosis (EIP) or at risk mental state (ARMS): Percentage starting treatment within 2 weeks	60%	53.3%	40.0%	56.7%
Early intervention in psychosis (EIP) : Percentage of people with at least 2 outcome measures recorded at least twice	Q1 15%	*reporting in development*		
Early intervention in psychosis (EIP) : Percentage of people discharged to primary care (quarterly)	tbc	-	-	50.0%
Cardiometabolic (physical health) assessments completed: Community Mental Health (patients on CPA)		*placeholder >>> DQIP*		
Cardiometabolic (physical health) assessments completed: Early Intervention in Psychosis Service (quarterly)	90%	-		41.1%
Services: Clinical Record Keeping	**Target**	**Jul-20**	**Aug-20**	**Sep-20**
Data Quality Maturity Index for the Mental Health Services Dataset (MHSDS)	95%	APR	MAY	JUN
		85.0%	82.2%	81.9%
Percentage of service users with NHS Number recorded	-	-	-	99.3%
Percentage of service users with ethnicity recorded	-	-	-	80.1%
Percentage of service users with sexual orientation recorded	-	-	-	22.2%
Percentage of in scope patients assigned to a mental health cluster	-	*reporting in development*		
Percentage of Care Programme Approach Formal Reviews within 12 months	95%	*reporting in development*		
Timely Communication with GPs: Percentage notified in 7 days (CPA Care Plans only) (quarter to date)	80%	*reporting in development*		
Timely Communication with GPs: Percentage notified in 24 hours (inpatient discharges only) (quarter to date)	tba	*reporting in development*		
Percentage of perinatal referrals with reason recorded to enable identfication of preconception/perinatal (DQIP)	tba	*placeholder >>> DQIP*		

Services: Access & Responsiveness: Our response in a crisis



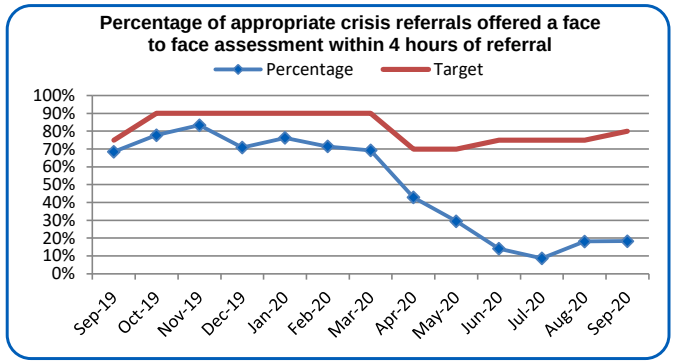
Sept calls: 4,438

Sept 19 data only 12th - 30th Sep due to system migration



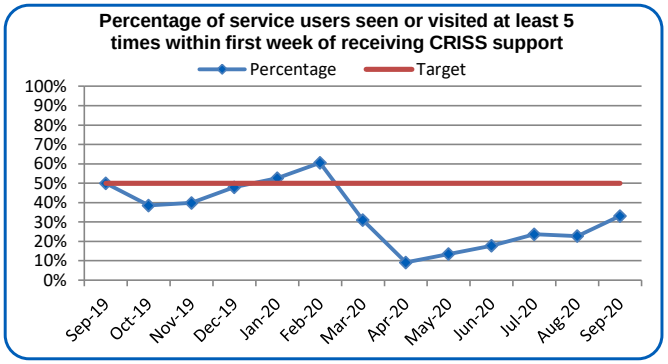
Local target: within 1 minute: Sept 58.9%

Sept 19 data limited due to system migration

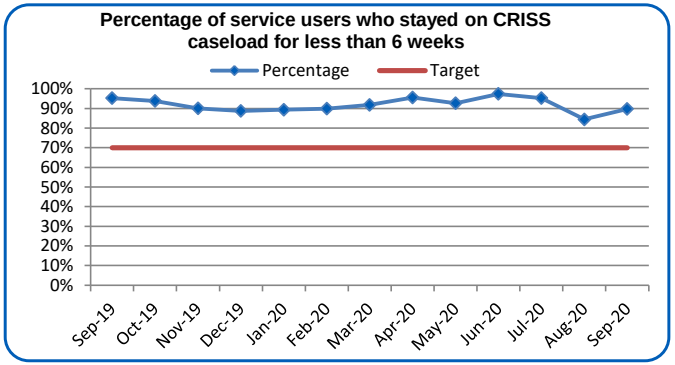


Contractual target 80% (Sept) to 90% (EOY) Sept 18.3%

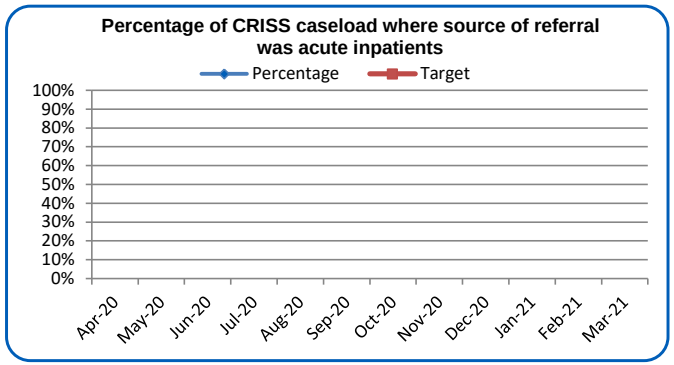
20-21 data quality validation ongoing



Contractual target 50%: Sept 33.1%

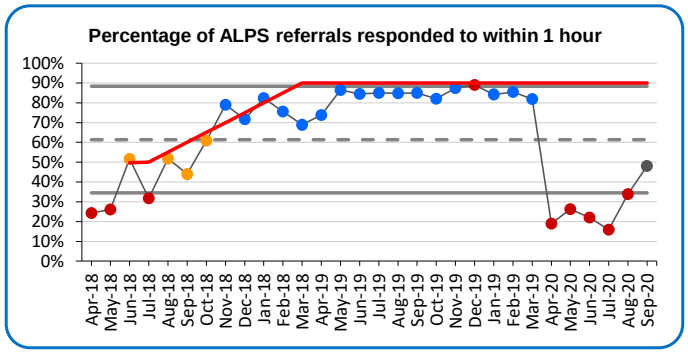


Contractual target 70%: Sept 89.7%

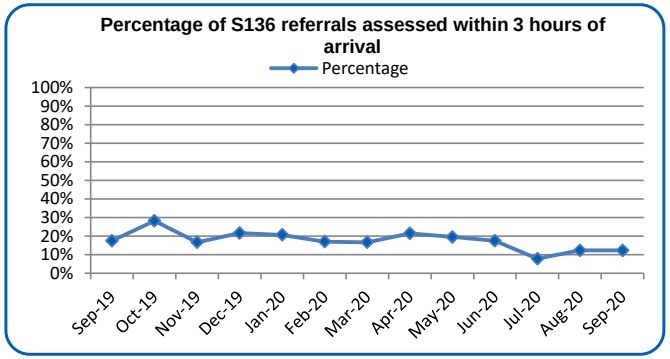


Contractual target - Baseline in Q1, target tba from Q2 *20-21 data development ongoing*

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



Contractual target 90%: Sept 48%



Contractual measure: Sept 12.3%

SPC Chart Key

- Average
- Lower process limit
- Target
- Upper process limit
- Actual

Services: Access & Responsiveness: Our response in a crisis

Within the Crisis Resolution and Intensive Support Service (CRISS) the team continue to be committed to achieving the Core Fidelity standards and the improvements we made as part of the community redesign. The percentage of appropriate crisis referrals offered a face to face assessment within 4 hours of referral supports Core Fidelity Standard 1 and timely access to services and has continued to be provided throughout the Covid19 pandemic based on individual risk assessment. The 2020-21 trajectory agreed with commissioners aims for performance above 80% during September, moving towards 90% by March 2021. Of course the changes made during Covid has seen some change to the way we deliver care but we continue to see and respond to service users on a face to face basis but this has not been reflected in our performance reports since changing to CareDirector. Data quality issues previously identified on CareDirector (and particularly impacting on this measure) continue to be worked through, with further meetings planned to address recording of key information, particularly focused to understand what changes we need to make with our use of the system so that activity is more accurately reflected.

In September 18.3% of appropriate crisis referrals were recorded as being offered a face to face assessment within 4 hours of referral. The Service Manager reports that this is not reflective of the way the team have continued to operate and is actively working to resolve the recording issues alongside our Information team. Most referrals to the service are appropriate to be seen within 24 hours; if it is felt based on the referral that someone needs to be seen within 4 hours, the service can ensure that resources are organised to deliver this.

Core Fidelity standard 38 states we should aim to provide face to face contact 5 times in the first week of referral, for at least 50% of referrals. As previously stated, prior to Covid-19 and the change in EPR system the CRISS service were achieving this. In September 33.1% of people were recorded as being seen face to face 5 times in the first week of referral, continuing the month on month improvement seen so far in 20-21. Further work is required on this indicator to ensure our reporting is accurate.

The proportion of face to face appointments has been fairly consistent in Q2 - on average 32% of total weekly health appointments - and whilst the service are not currently expecting to be doing the same level of face to face contacts as previously the soft intelligence from within the service indicates that this level of face to face activity is inconsistent with their experience. Whilst these contractual measures were defined prior to 2020, and explicitly reference the need for contacts to be face to face, there have been some early discussions around considering the inclusion of telemedicine contacts against this target. Telemedicine / video conferencing type contacts are not currently included, and given the current situation consideration is being given to exploring alternative and complementary metrics. How we provide the service to each individual – and in particular whether face to face work is clinically indicated – continues to be discussed in daily MDT meetings, supported by an individual assessment of risks and priority.

During September 89.7% of people remained on the CRISS caseload for less than 6 weeks, a measure which we are consistently over performing against the 70% target.

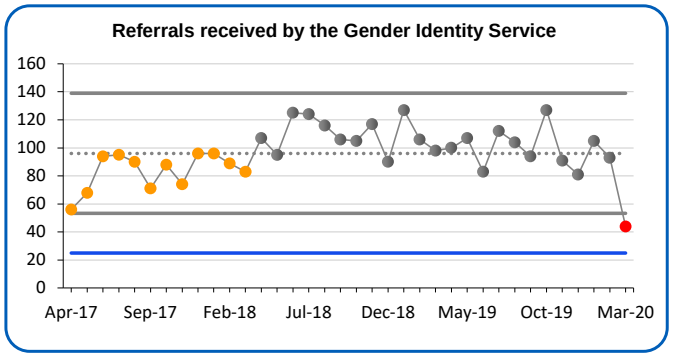
Actions taken/to be taken: The Service Manager is actively working with the Information team to establish what changes should be made to enable accurate recording and reporting of activity.

We are reporting performance below the 90% threshold against the 1 hour response target for the Acute Liaison Psychiatry Service (ALPS), with 48% referrals (73 of 153) responded to within 1 hour in September. This is an improvement on recent months. 98 people (64%) were responded to within 2 hours, 111 (73%) within 3 hours, the remaining 42 people (27%) over 3 hours.

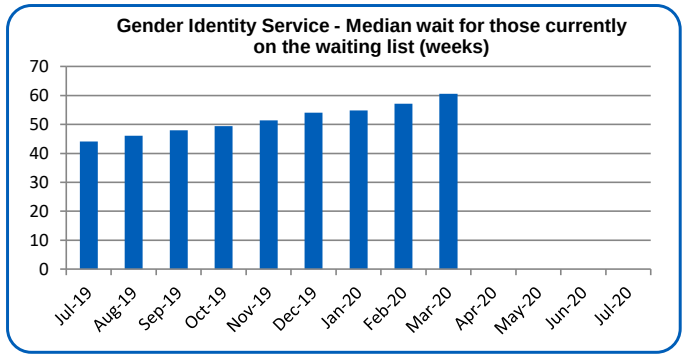
The 1 hour standard remains significantly challenging due to the ALPS team being relocated from St James Hospital Emergency Department to the Becklin Centre, which sometimes affects the response times. We continue to work in partnership with LTHT colleagues to agree how best to manage and resolve this heading into winter. Data quality concerns also exist in relation to this service, along with reporting processes. These have been reviewed in September, with additional monitoring by the service now in place in order to better understand our reported performance against this target.

Actions taken/to be taken: The ALPS leadership team continue to review all breaches of 1 hour in detail, and to investigate any emerging recording issues which are negatively impacting on the data e.g. referral/case reasons. Data quality remains a focus for the team and our reported information will be reviewed in detail each month to identify any errors or gaps, supported by the informatics team and in partnership with LTHT where we are aiming to share our clinical pathway information to understand delays and identify potential improvements. The team continue to work with Leeds Teaching Hospitals to support the re-location of staff within ED to enable the 1hr target to be met.

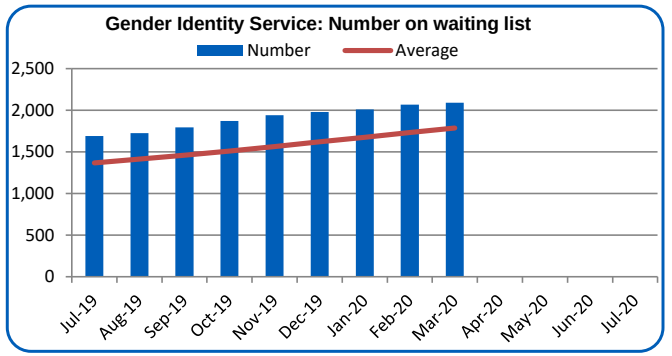
Services: Our Specialist Services



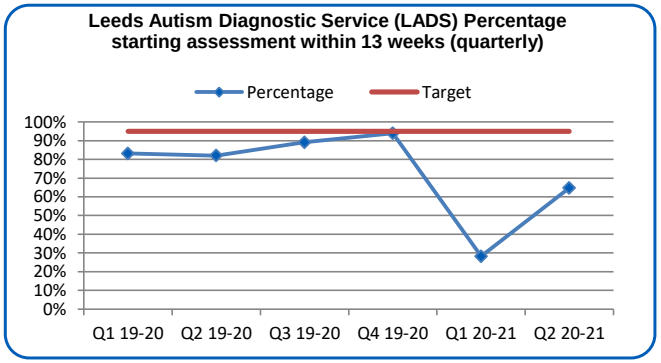
Total referrals: *20-21 data development ongoing*



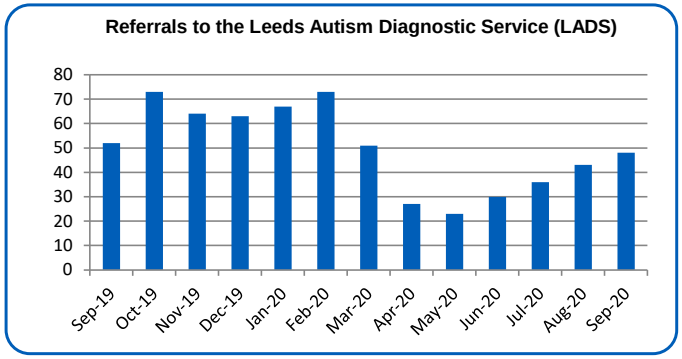
Median wait: *20-21 data development ongoing*



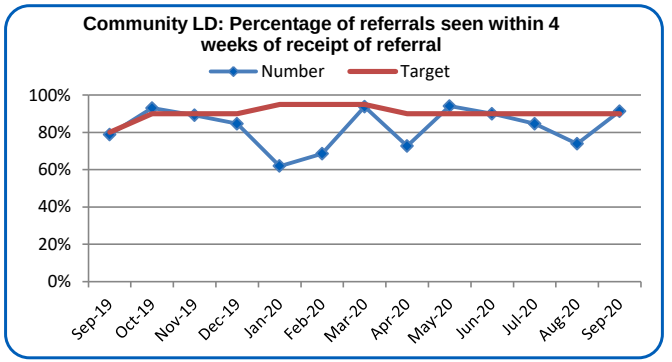
Number on waiting list: *20-21 data development ongoing*



Contractual target 95% Q2: 64.7%



Local measure: Sept 48

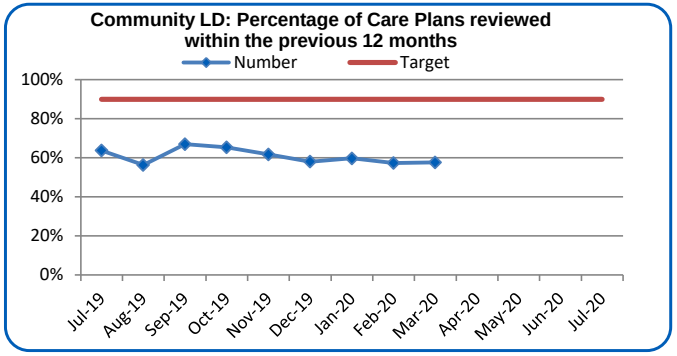


Contractual target 90% Sept 91.3%

SPC Chart Key

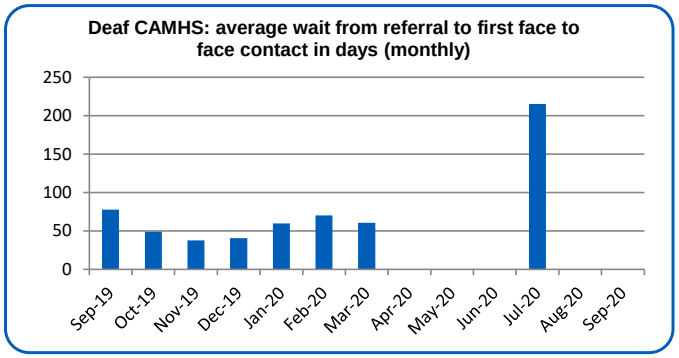
Average
Lower process limit
Target
Upper process limit
Actual

Services: Our Specialist Services (continued)

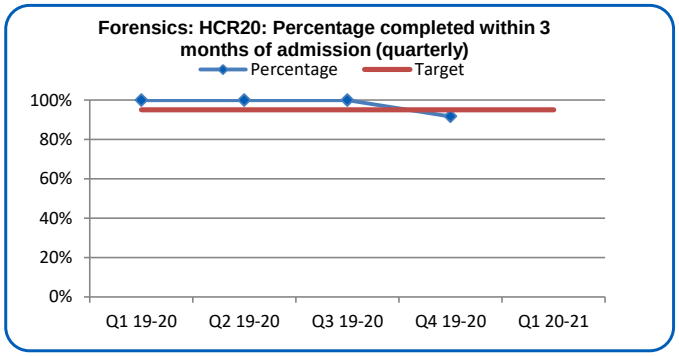


Contractual target 90%: *20-21 data development ongoing*

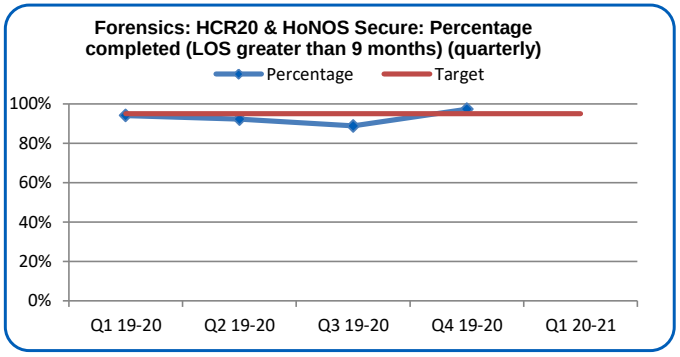
Placeholder : CAMHS inpatients: Proportion of people assessed within 7 days of admission (HoNOSCA / GBO) quarterly



Local measure: Sept - no data

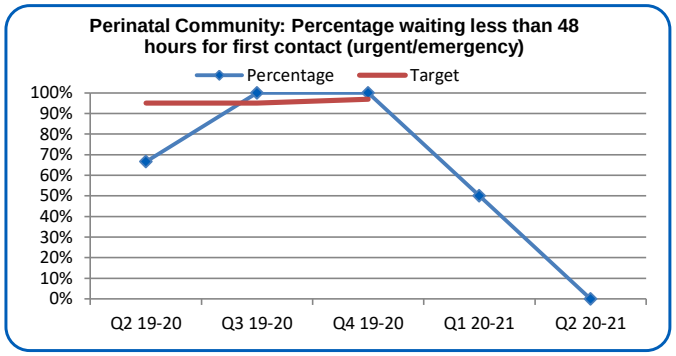


Contractual target 95%: *20-21 data development ongoing*

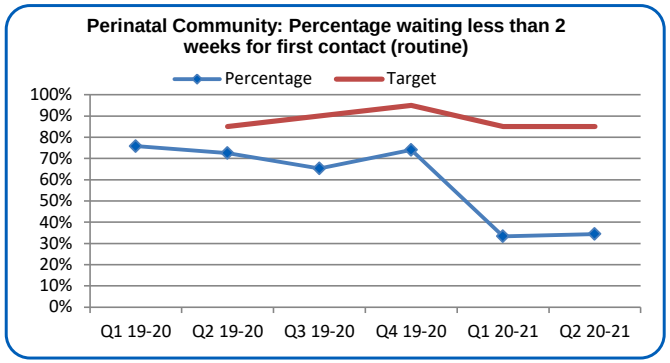


Contractual target 95%: *20-21 data development ongoing*

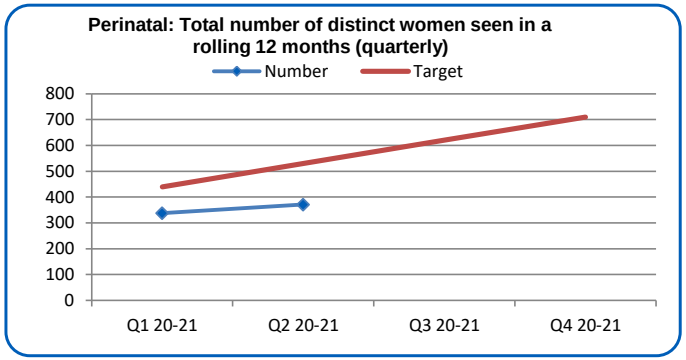
Services: Our Specialist Services (continued)



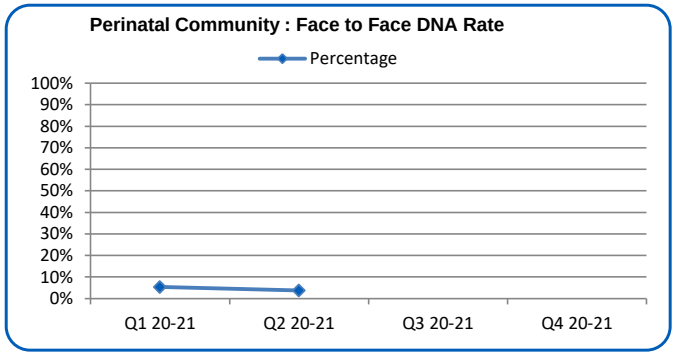
Contractual Target: tba Q2 0%



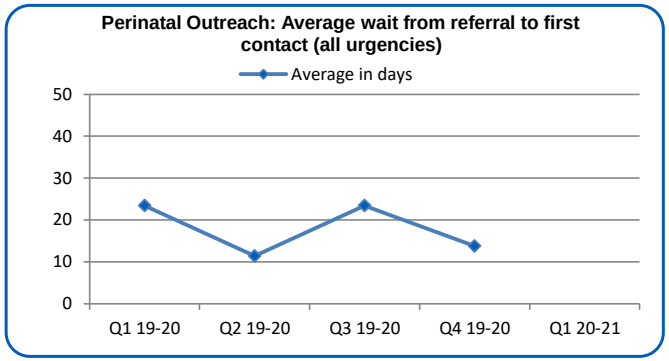
Contractual Target 85%, Q2: 34%



Local measure: Q2 Target 530, Q2 371



Contractual measure: Q2 3.7%



Local measure: *20-21 data development ongoing*

Services: Our Regional and Specialist Services

In Q2 64.7% of people referred to LADS started their assessment within 13 weeks, up from 28.3% during Q1. 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.

Clinical capacity in LADS has been affected by the redeployment of two autism nurses. One nurse returned mid-July and the second returned at the beginning of Sept. There was also some long term sickness absence of one team member (2 months) although this was partially offset by a returning former member of staff on a part-time basis Uncertainty of staff availability altered the team procedure of booking clinical appointments at shorter notice than usual (around 1 week notice compared with the usual 3-4 weeks).

There has been an increase in DNA rates compared to pre-lockdown – either people not answering telephone calls, not joining zoom meetings, or not having sufficient technical knowledge to operate zoom. We have attempted to mitigate this by the admin staff explaining the process, and including a covering email explaining how the zoom consultation works. Finally a significant number of service users who were given the option of telephone or video call appointments opted for neither.

Actions taken / to be taken: The service will continue to review and implement their reset plans, and will closely monitor changes to activity as a result of this, making adjustments to practice where necessary and aiming for minimal disruption from here on in.

The Perinatal Service continue to review data quality on CareDirector to improve the accuracy of activity recording, such as referral priority and health appointment outcomes. We also continue to discuss the scope of ‘counted activity’ for the service, which at this point – based on a steer from NHS E/I – does not include telephone activity.

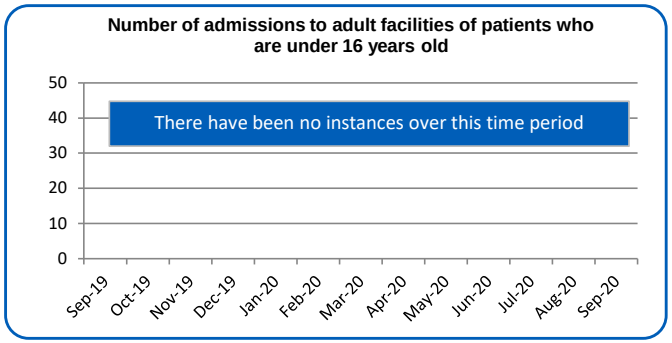
The recording of contact waiting time for the service is currently being reviewed in detail. In Q2 there was only 1 urgent referral to the service, the other reported here was in error and will be retrospectively amended on our system. The service continue to working towards increasing the use of telemedicine and F2F contact, with the majority of previously redeployed staff now back within the community team. In partnership with commissioners we have finalised a revised trajectory for the number of new women to be seen by the service, and this has been submitted as part of our plan refresh to NHSE/I.

Actions taken / to be taken: Continue to identify and address data quality and accurate recording in Clinical Team Manager and Clinical lead meetings. A regular review meeting and data set has been agreed with commissioners, to monitor our activity against the new trajectory.

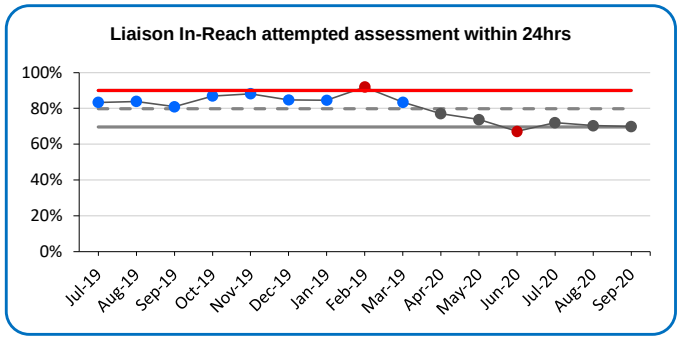
The Community Learning Disability Team (CLDT) continue to work through the process of returning services to normal with activity delivered differently. The contractual target of 90% of referrals to be seen within 4 weeks of referral was met in September, with 91.3% (21 out of 23 people) recorded as seen within the agreed standard.

A number of key performance indicators which support our Regional and Specialist Services remain in re-development following the significant impact of our implementation of CareDirector on reporting. We aim to resume reporting of these during Q3; this includes Gender Service referrals and waiting times. The Covid-19 pandemic has significantly affected the delivery of clinical care and waiting times for those people who access Leeds Gender Service; as well as ongoing referrals to other providers. Subsequently the service has been operating at a reduced level of service, in response to managing change, new initiatives and new ways of working have been developed. Local data indicates that waiting lists to access the service are now at approximately 36 months.

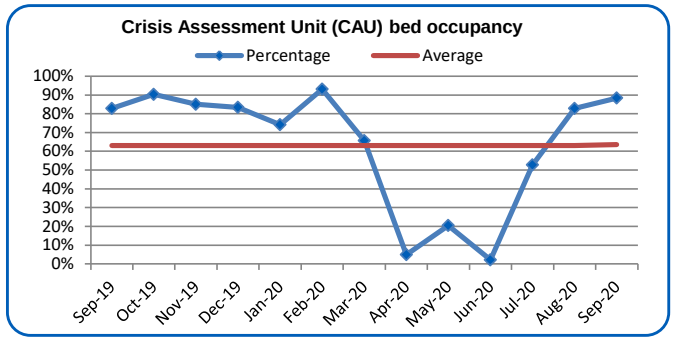
Services: Our acute patient journey



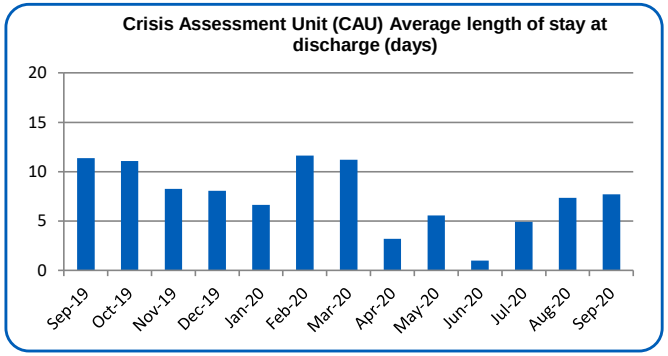
National (NOF): No target: Sept 0



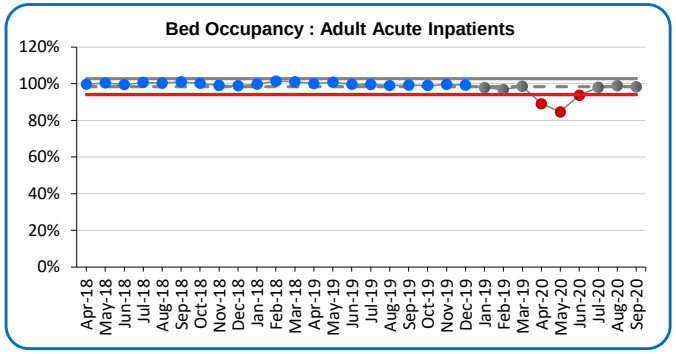
Contractual target: 90%: Sept 70%



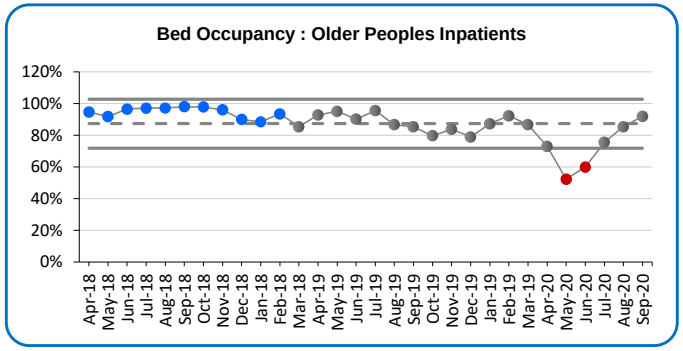
Local measure: Sept 88.3%



Local measure: Sept 7.7



Contractual target 94-98% : Sept 98.3%

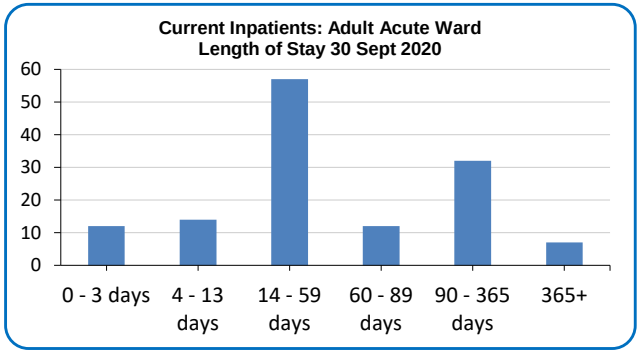


Local measure and target 85% : Sept 91.8%

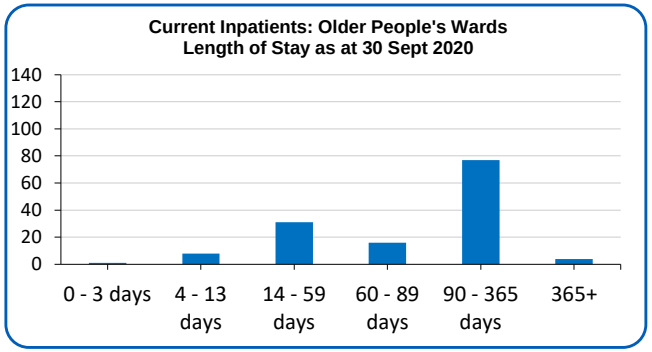
SPC Chart Key

- Average
- Lower process limit
- Target
- Upper process limit
- Actual

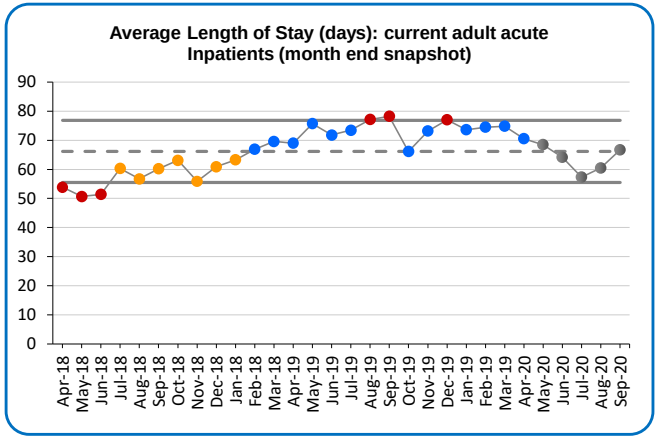
Services: Our acute patient journey (continued)



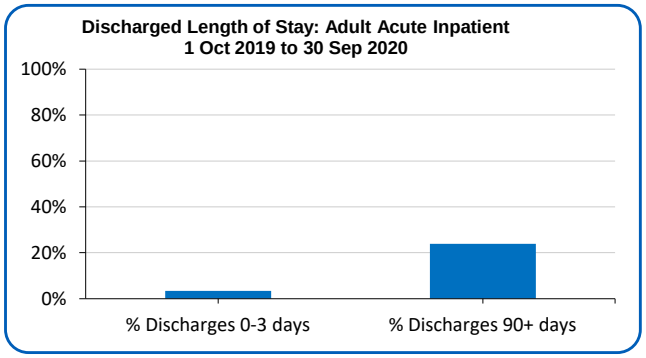
Local activity : 39 people with LOS 90+ days



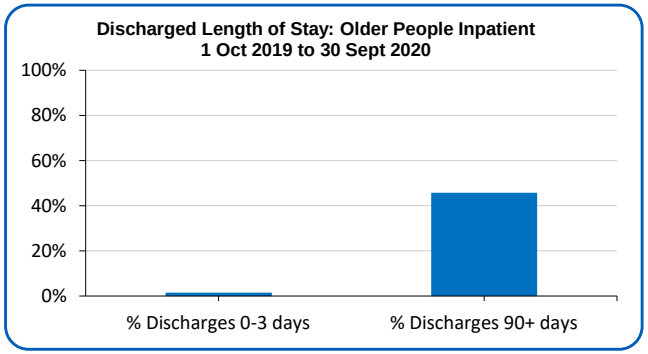
Local activity : 27 people with LOS 90+ days



Local tracking measure: Sept 67 days



Local activity : % discharged LOS 90+ days = 23.8%

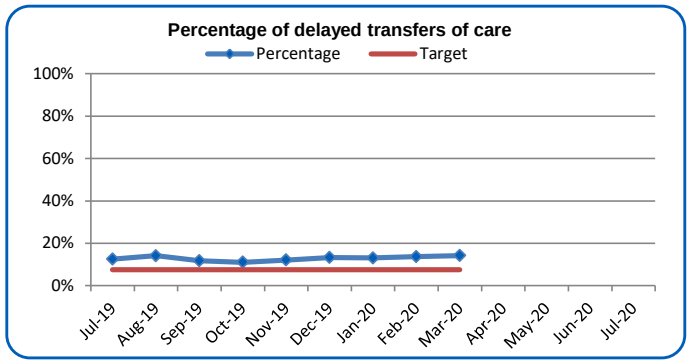


Local activity: % discharged LOS 90+ days = 45.7%

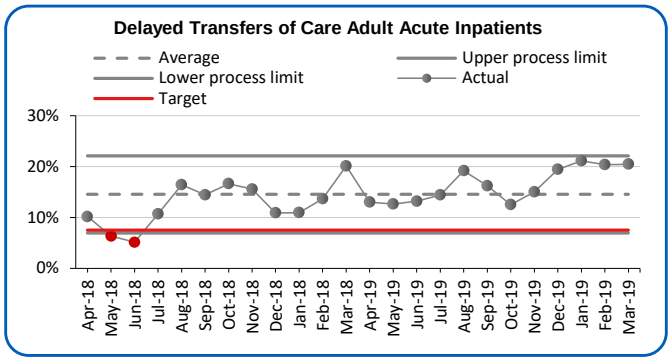
SPC Chart Key

Average
Lower process limit
Target
Upper process limit
Actual

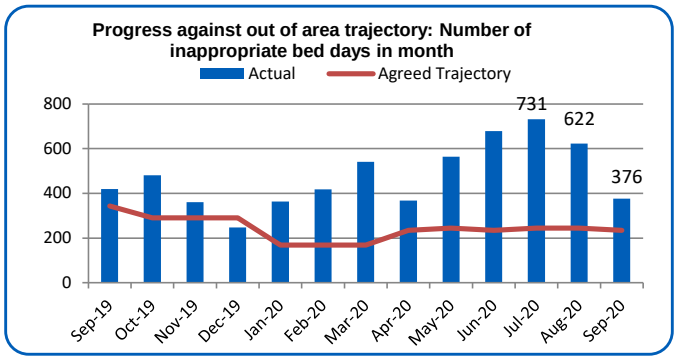
Services: Our acute patient journey (continued)



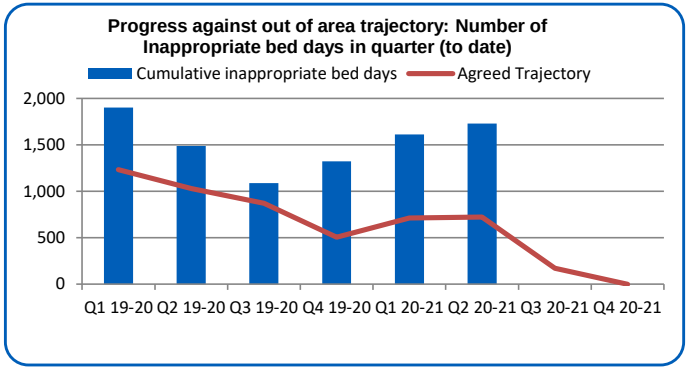
Local target: <7.5%: *20-21 data development ongoing*



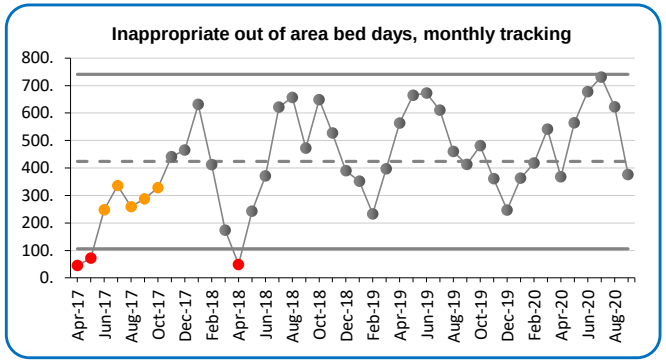
Local target <7.5%: *20-21 data development ongoing*



Nationally agreed trajectory (Sept 234) Sept 376



Nationally agreed trajectory (Q2: 724 days):
Q2 to date: 1,729 days

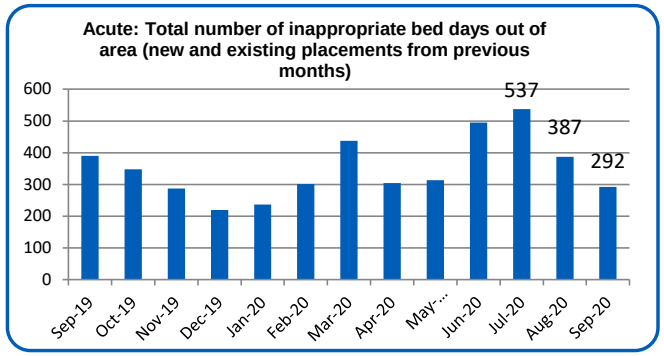


Local tracking measure: Sep: 376 bed days

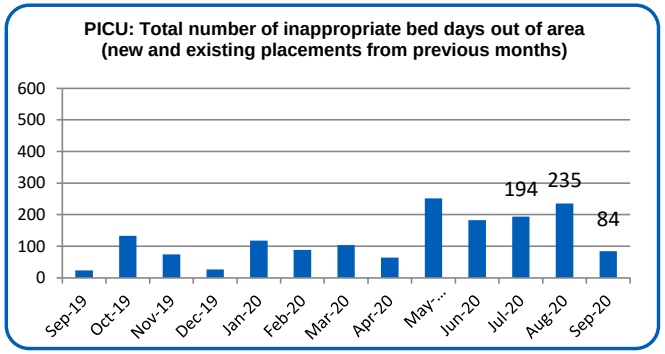
SPC Chart Key

Average
Upper process limit
Lower process limit
Actual
Target

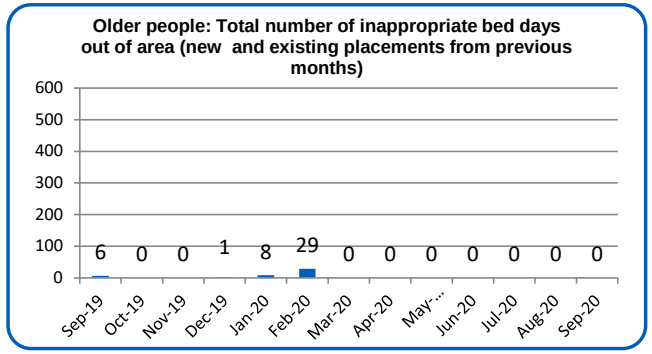
Services: Our acute patient journey (continued)



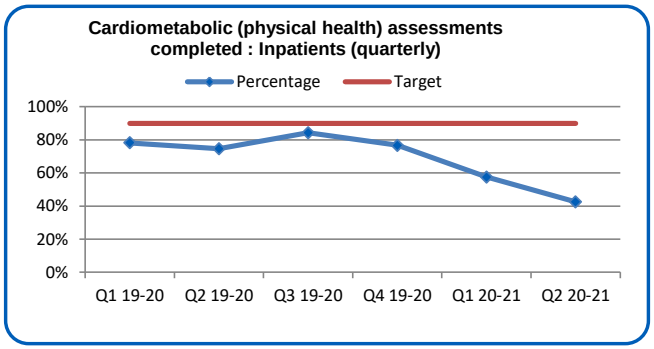
Local measure: Sept 292 days



Local measure: Sept 84 days



Local measure: Sept 0 days



Contractual target: 90%: Q2 42.6%

Services: Our acute patient journey

Adult acute services continue to experience bed pressures with high levels of occupancy and enhanced observations across the wards. Extra staff above profiled levels have been consistently required to support increased engagement and observation, often driven by the need to support service users during periods necessitating isolation. In September bed occupancy for adult acute services was at 98.3% overall. There is continued demand for female beds in particular and this has also been consistent across other providers nationally.

As at the end of September the average length of stay for people on the acute wards was 67 days, remaining within our process limits but significantly beyond the national average of 32 days described in the Long Term Plan. At the end of September, 39 people had been in an adult acute ward setting for 90 days or more.

The physical health measure for inpatients Q2 performance was reported at 42.6% against a 90% contractual target. At the end of Q2 106 people from 249 inpatients had a cardiometabolic assessment recorded on admission.

Actions taken / to be taken: The acute care excellence programme has now restarted, including defining and designing collaborative focus and structure. This is being linked to the national GIRFT (Get It Right First Time) programme. Some additional capacity has been identified to support the Physical Health Team with routine performance reporting. We are also reviewing the frequency and attendance of our current DToC partnership meetings with adult social care, in order to further improve pathways for discharge. The Chief Operating Office will lead a system level Acute Care Oversight group which will drive the delivery of elements of the the pathways recently commissioned in order to improve service user alternatives to admission and discharge options.

During September, total bed occupancy in Older People's Services increased to 91.9%, where the service aims for the local standard of 85%. Demand for beds in our functional wards at The Mount shows a rise with bed occupancy at 94.3% (W3) and 94.7% (W4) in September. Clinically, the teams are reporting that people have higher levels of need both in terms of their physical and mental health needs and the service continue to experience a requirement for significantly increased levels of observations. The DTOC position is increasing but this is being mitigated through an increase in frequency of the operational discharge group, which is a partnership arrangement with Leeds City Council and the CCG. Reporting in this area remains under development, however real time operational dashboards are available on CareDirector to support our services managing patient flow.

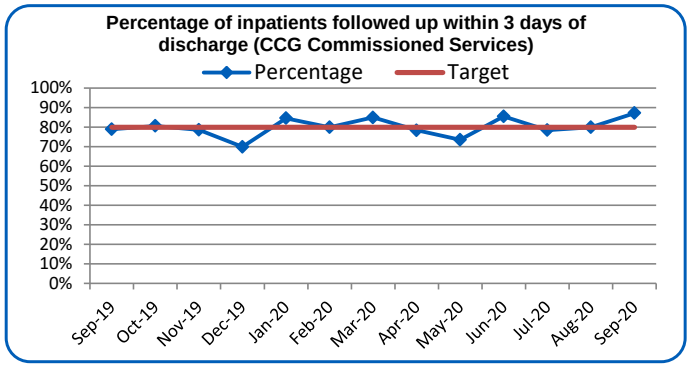
Approximately 70% of assessments were attempted within 24 hours by the Liaison In-Reach team in September, which is below the 90% target. The underlying data contributing to this measure has been subject to review and has since been refreshed back to April where performance has been consistently around the 70% mark each month. Further work will be undertaken within the team to further improve against this target.

The COVID 19 pandemic continues to impact on our ability to manage the reduction of inappropriate out of area placements in line with our agreed trajectory, although in September there were a total of 376 inappropriate out of area bed days which represents an improvement against previous months, especially in relation to PICU bed use. Cumulatively in Q2 we had 1,729 bed days against a Q2 trajectory of 724. The number of OOA Acute bed days has dropped from a high of 537 in July to 292 in September, and use of out of area PICU beds dropped to 84 inappropriate bed days.

Our trajectory for inappropriate out of area placements for 2020/21 was recently reviewed and revised jointly with the CCG as part of an NHS E/I stocktake, and will be included here once it has been formally agreed as part of our final plan resubmission.

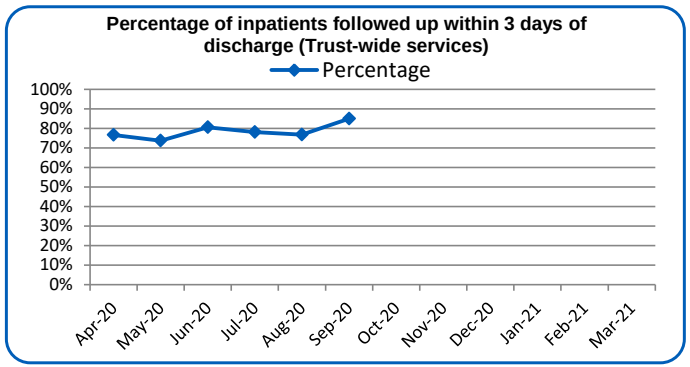
Actions taken / to be taken: We are actively reviewing and revising our monitoring arrangements and will adapt these as required in response to our reported position. A joint review of our 'road map' plans which set out actions to mitigate and reduce Out of Area bed use is planned with the CCG. We have identified additional resource to support the Older Peoples IHTT team, which aims to impact on admission at the Mount.

Services: Our community care

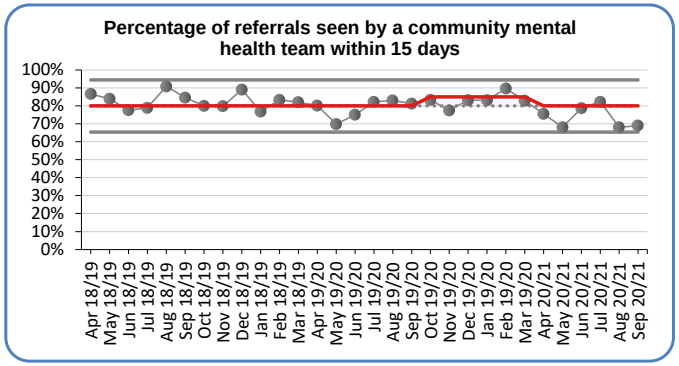


Contractual Target 80% Sept 87.2%

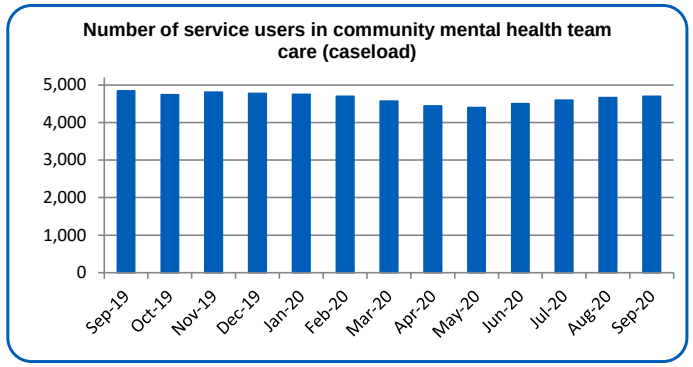
NB: Data prior to April 20 is from CQUIN for comparison, this is now part of the NHS Standard Contract. 20-21 reporting subject to ongoing validation



Local Tracking Measure: Sept 84.9%



Contractual target: 80%: Sept: 68.6%



Local measure: Sept 4,701

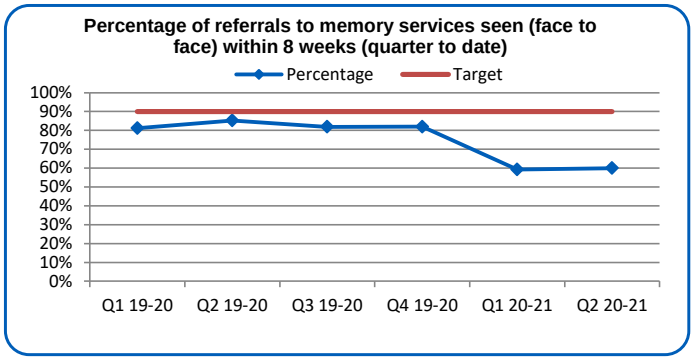
Placeholder - Early intervention in psychosis (EIP) : Percentage of people with at least 2 outcome measures recorded at least twice

Contractual target: Q1 15%: *20-21 data development ongoing*

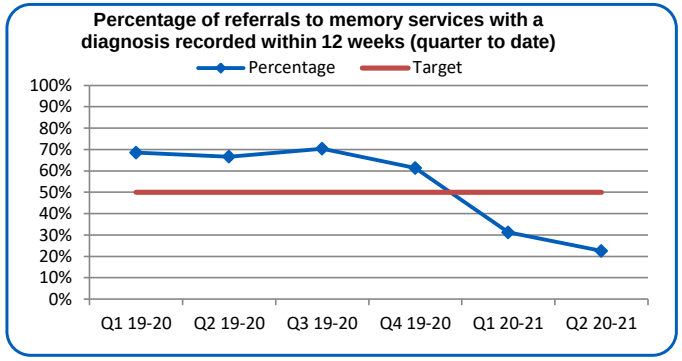
SPC Chart Key

- Average
- Lower process limit
- Target
- Upper process limit
- Actual

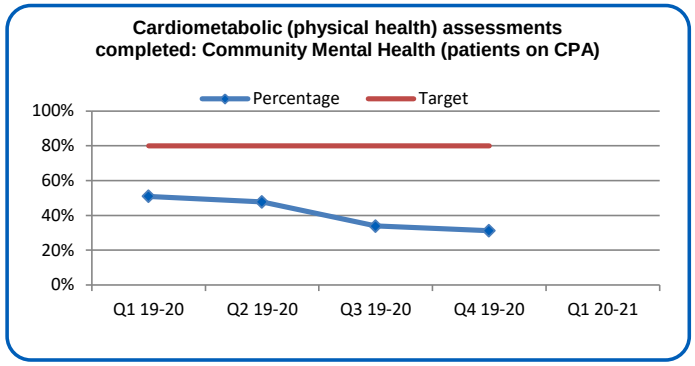
Services: Our community care (continued)



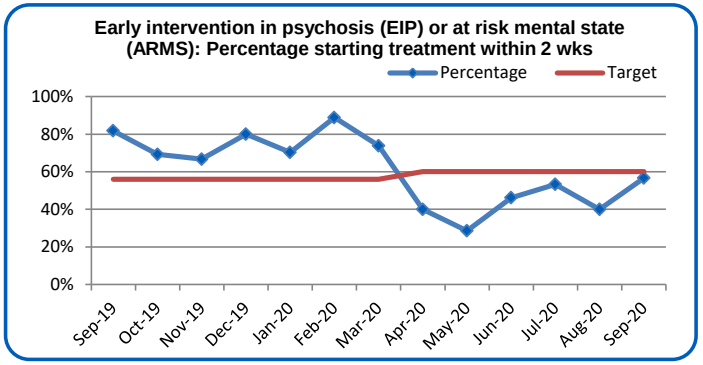
Contractual target: 90% Q2 60%



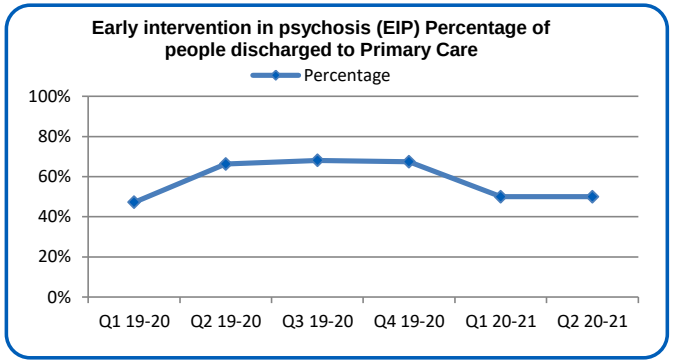
Contractual target: 50% Q2 22.6%



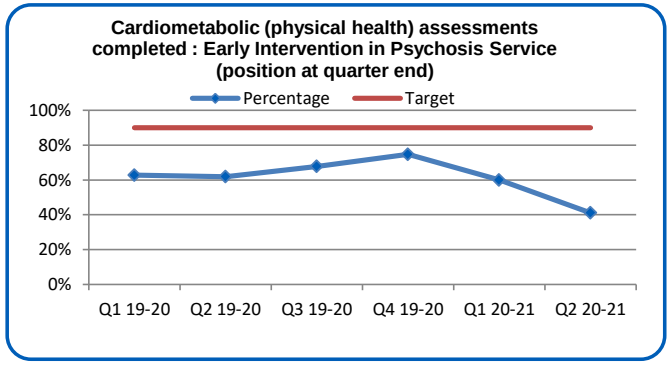
DQUP: *reporting process to be redeveloped*



Contractual target: 60%: Sept 56.7%



Contractual target: tbc: Q2 50%



Contractual target: 90%: Q2: 41.1%

Services: Our community care

87.2% of inpatients were followed up within 3 days of discharge from CCG commissioned services in September, meeting our contractual target of 80%.

Of the 12 reported breaches; 4 people were subject to an attempted but unsuccessful 3 day follow up, 2 of which have since been followed up, 1 refused service involvement and 1 was not followed up directly with the person. 4 people were followed up within the previous '7 day standard', 1 person was followed up on the actual day of discharge (which doesn't meet required standards), and the remaining 3 are subject to assurance / data quality checks with Services.

Trust-wide our performance was also positive with 84.9% of all inpatients followed up within 3 days of discharge from all LYPFT services.

The quality of recording on CareDirector has improved as teams are becoming more familiar with the new system and processes. Latest benchmarking data shows the England average to be 78.2% in July.

Actions taken/to be taken: Where data quality concerns have highlighted recording errors, the correct process is reiterated to the staff involved.

The Memory Assessment Service reopened on 1st October with a waiting list for new referrals. We did not report data for the 8 week KPI in Q1 due to the closure of this service during the Covid-19 pandemic. Whilst there has been an increase in activity during recent months the focus has been on managing a backlog of post diagnostic support as part of system wide service reset work. This has impacted on the data informing performance measures.

The percentage of people who started treatment within 2 weeks of referral for early intervention in psychosis (EIP) or at risk mental state (ARMS) has improved following some focused data quality and process work. In September reported performance was just below the 60% standard at 56.7%. The service are making concerted efforts to ensure CareDirector recording processes are followed with specific focus on health appointment outcomes.

In Q2 the physical health measure performance for EIP services is reported at 41.1% (192 / 467) against a target of 90%. Covid-19 and stopping routine / non-urgent physical interventions continues to impact on this measure. Physical Health practitioners at aspire are developing a recovery plan to increase the volume of physical health assessments for clients on the aspire caseload. Additionally existing social recovery team staff have been trained to complete physical health assessments alongside their existing role, which alongside existing physical health practitioners will enable the completion of more assessments to meet the needs of our clients. We anticipate an improvement to our performance from Q3 with aspirations to meet the 90% target by the end of 2020-21.

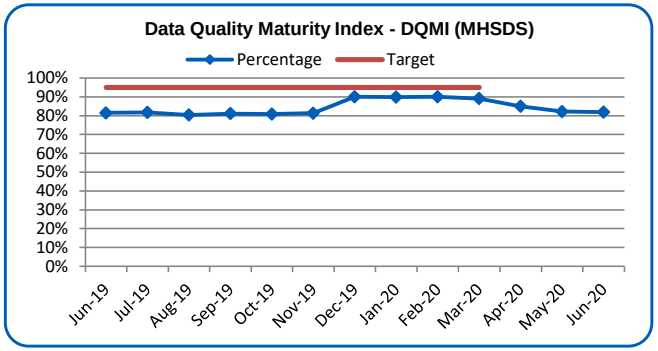
The percentage of referrals seen by community mental health teams within 15 days remains within levels of expected normal variation, with some local variation both above and below the contractual target. Performance in September was 68.6% against an 80% target and referral rates to the service are consistent with pre-Covid-19 levels. There is further work to be done to provide the CMHTs with more detailed supporting data to help them better manage performance in this area. A new quality, delivery and performance report should help identify variance across the service.

Actions taken/to be taken: The community services leadership team will work with the teams to utilise local data to focus on this area and develop plans for improvement. This will include the sharing of 'best practice' across teams where appropriate.

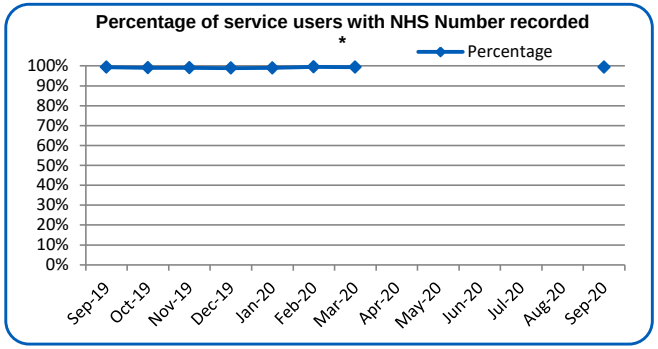
Pressures relating to capacity /staffing remain with a combination of vacancies and sickness absence, North East Leeds area a particular pressure point with capacity challenges and demand for services.

Actions taken/to be taken: Monitor the implementation of our plans to address vacancy gaps and capacity challenges, including piloting new roles through 3rd sector partners. Some additional capacity identified to support the CMHTs through covid/winter schemes, and these have been reviewed to reflect a different skill mix that is more likely to be achieved.

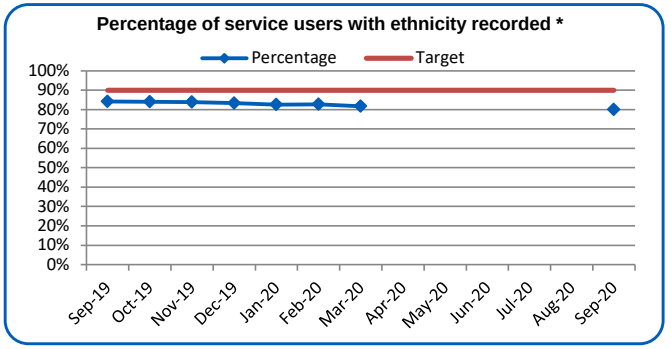
Services: Clinical Record Keeping



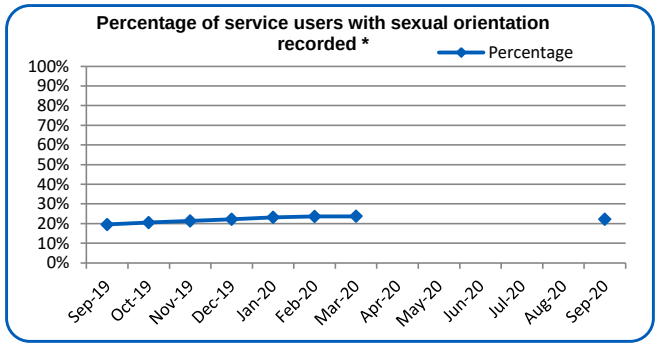
19/20 CQUIN June: 81.9%



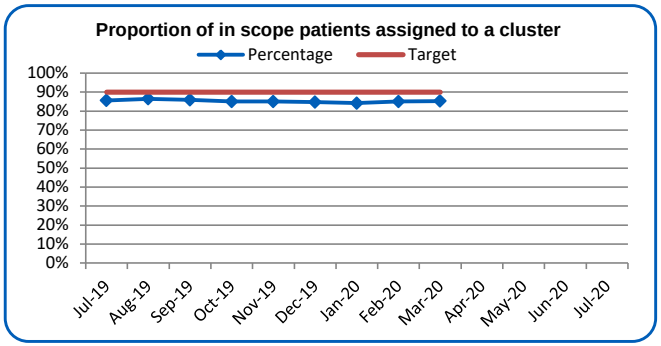
Local measure: Sept: 99.3%



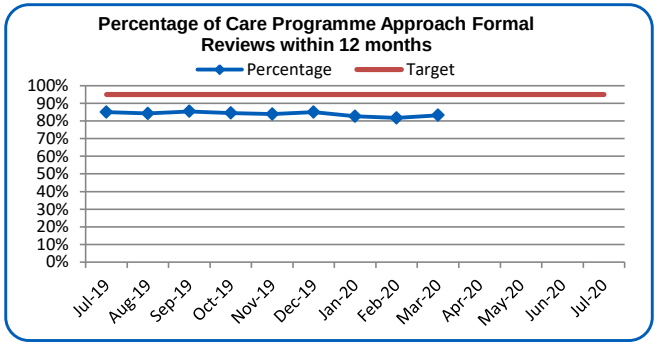
Local target: 90%: Sept 80%



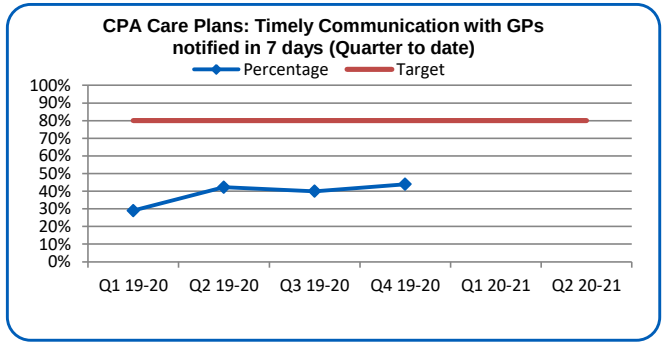
Local measure: Sept: 22.2%



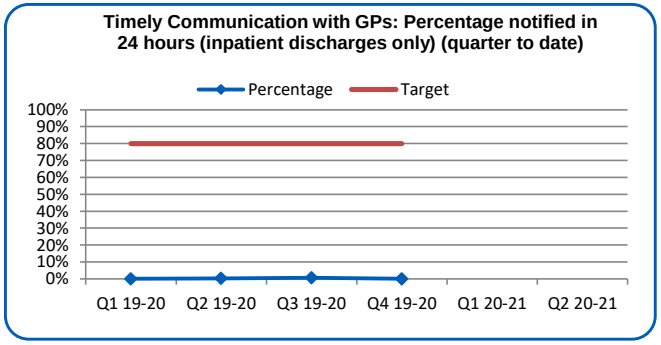
Local target (tbc) : *20-21 data development ongoing*



Local target: 95%: *20-21 data development ongoing*



Contractual target: 80%: *20-21 data development ongoing*



Contractual target: tbc : *20-21 data development ongoing*

Placeholder - Percentage of perinatal referrals with reason recorded to enable identfication of preconception/perinatal (DQIP)

* Data Completeness KPIs - now redeveloped from CareDirector, however unable to report pre-Sept data due to reporting logic i.e. snapshot

Services: Clinical Record Keeping

Our latest DQMI (Data Quality Maturity Index) position, published by NHS Digital via the Mental Health Services Data Set is 81.9% (June 2020). This represents a further drop in data quality which was anticipated for May/June following CareDirector implementation. Work is ongoing with our teams following the implementation of CareDirector to support staff in regaining expected standards of data quality. Feedback received via our online collaboration platform Your Voice Counts over the summer showed that staff continue to require support and training on the new system. There are also areas of the system that could be improved that would make data collection easier for staff leading to an improvement in data quality (options around this are currently being explored).

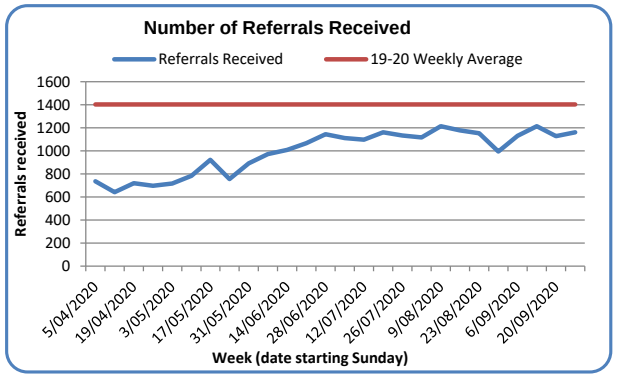
Reporting has now been redeveloped on the underlying and contributory data completeness measures for NHS Number, ethnicity, sexual orientation. Due to the reporting logic being a 'snapshot' retrospective reporting is not possible. As at September 99.3% of care records had an NHS number recorded, 80% ethnicity and 22% sexual orientation.

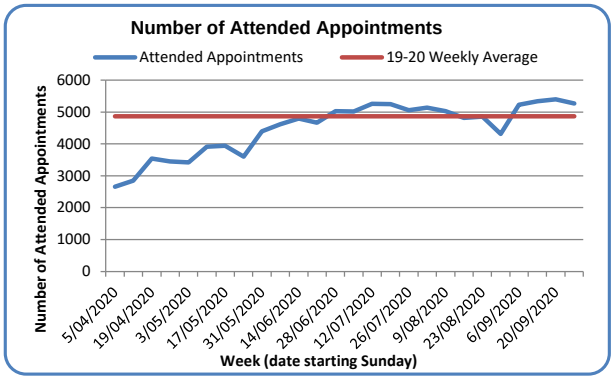
Actions taken / to be taken: Continue to promote data completeness throughout 2020/21 with a focus on supporting staff in using CareDirector well.

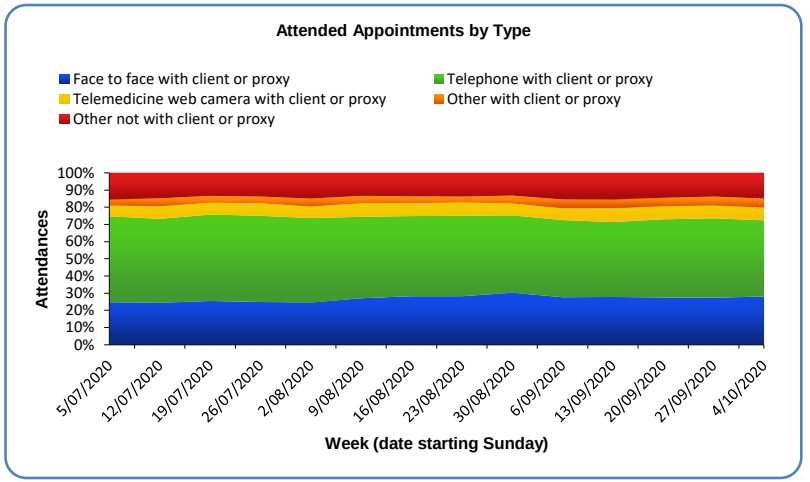
Improving the timely transfer of care plans and discharge summaries to GPs is a Trust priority. For inpatient discharge summaries (to be transferred within 24 hours), consideration is being given to changing the process and using an automated system pulling the data from EPMA (our electronic prescribing system) and CareDirector during the second half of 2020/21.

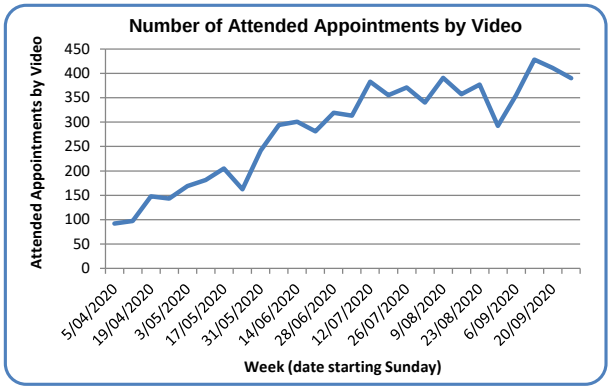
Actions taken / to be taken: Options for the future based on the integration of our electronic prescribing system (EPMA) and our new electronic patient record (CareDirector) will be explored for inpatient discharge summaries but this is unlikely to bring improvement in the short / medium term.

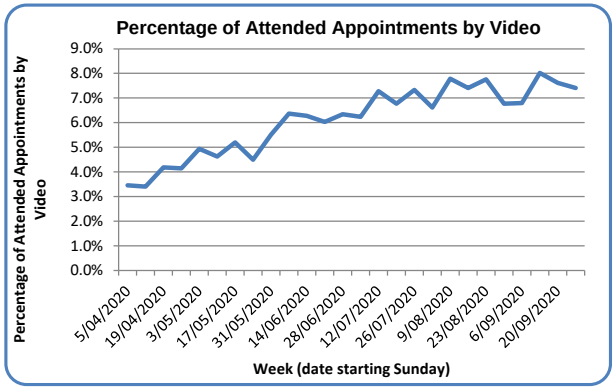
Trust Level (Weekly Trend)



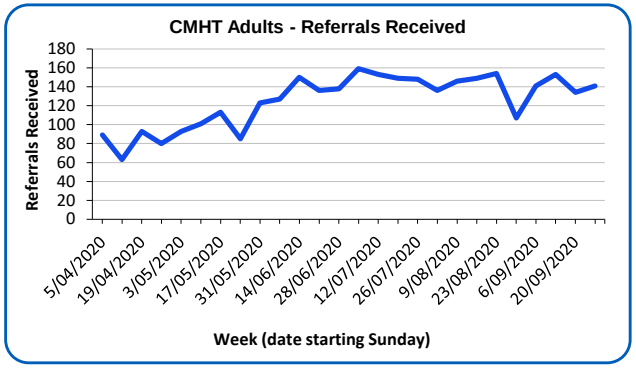


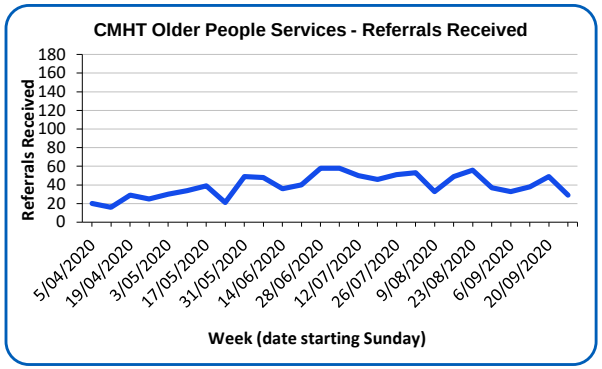


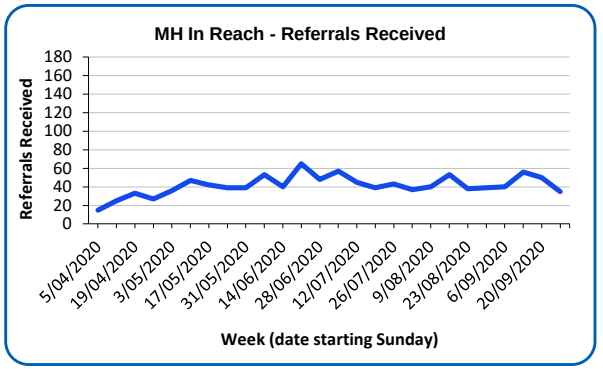


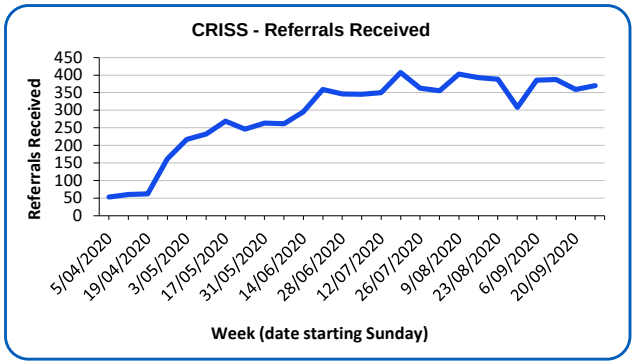


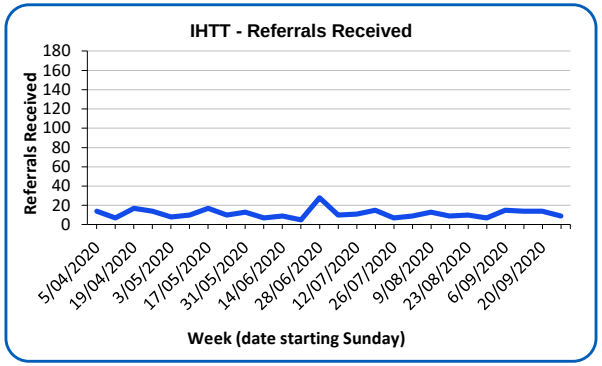
Service Specific Highlights (Crisis Response and Community)

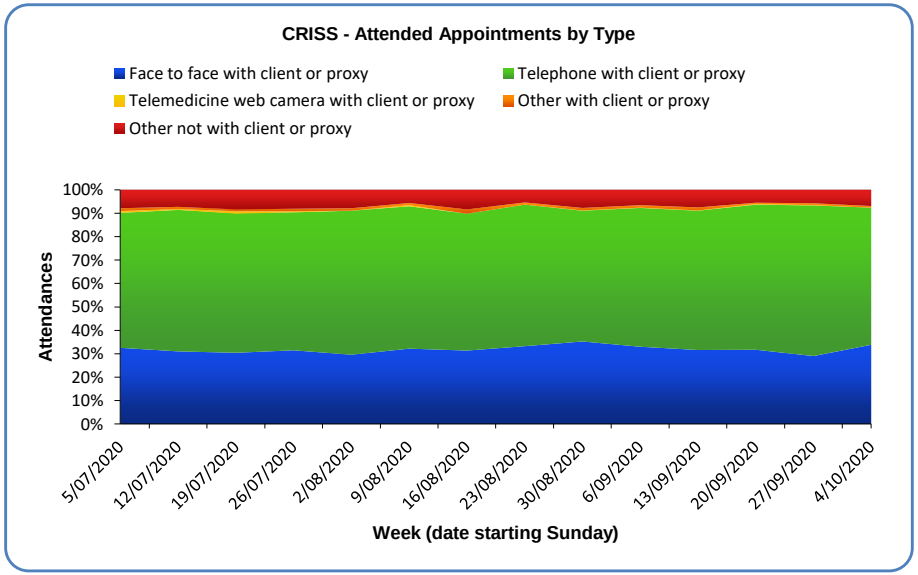


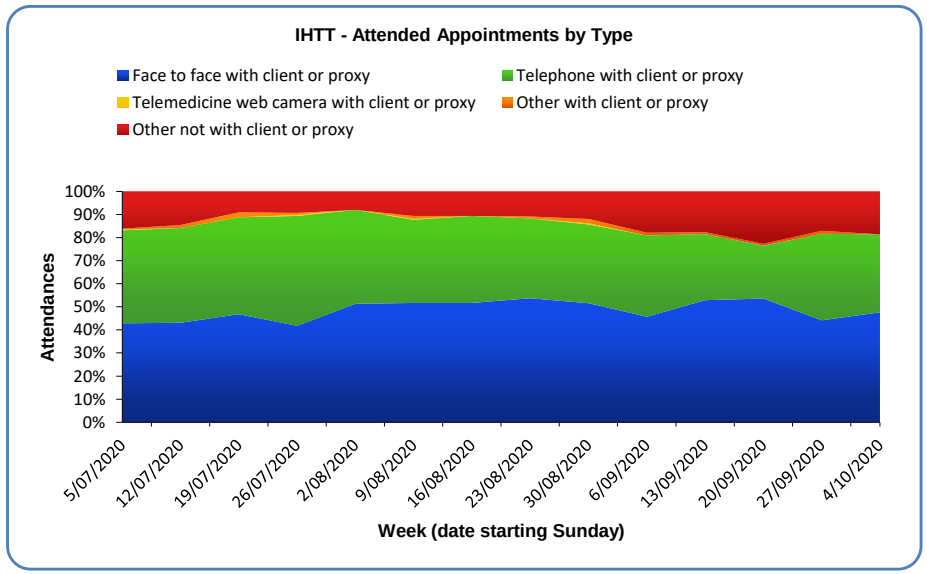




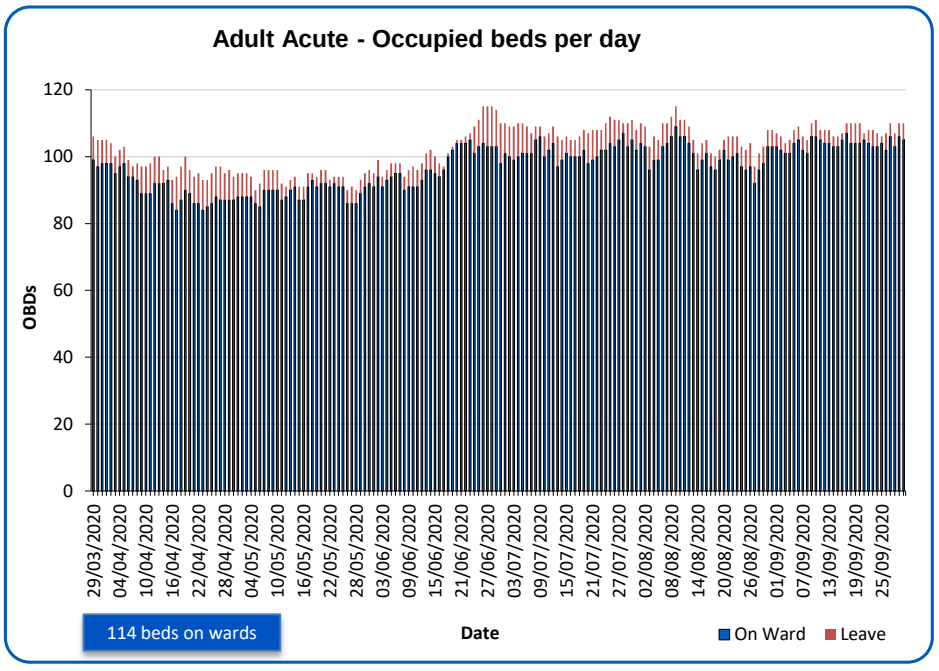


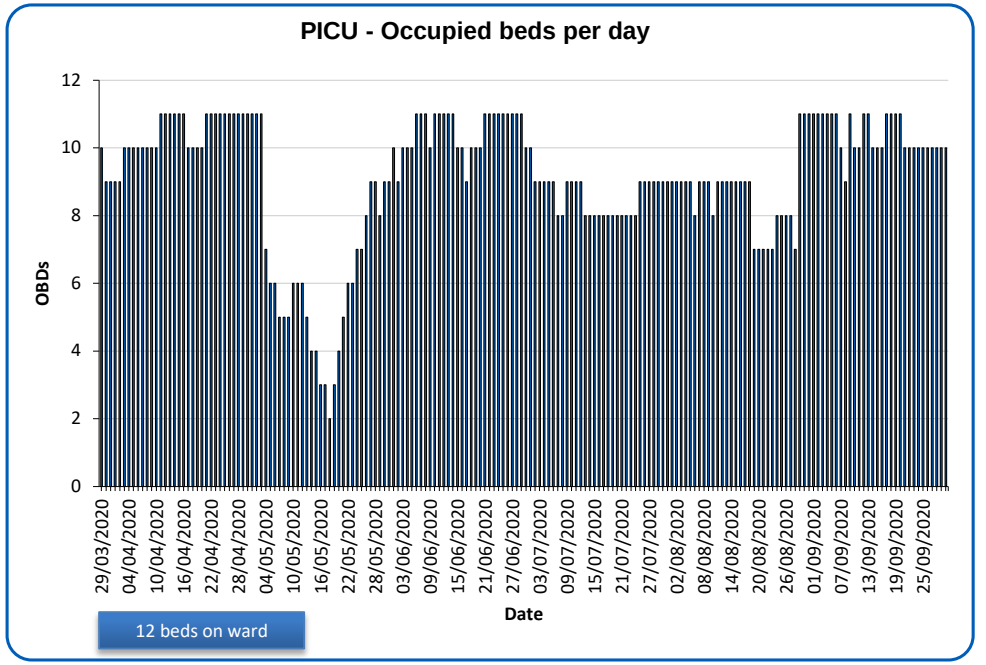


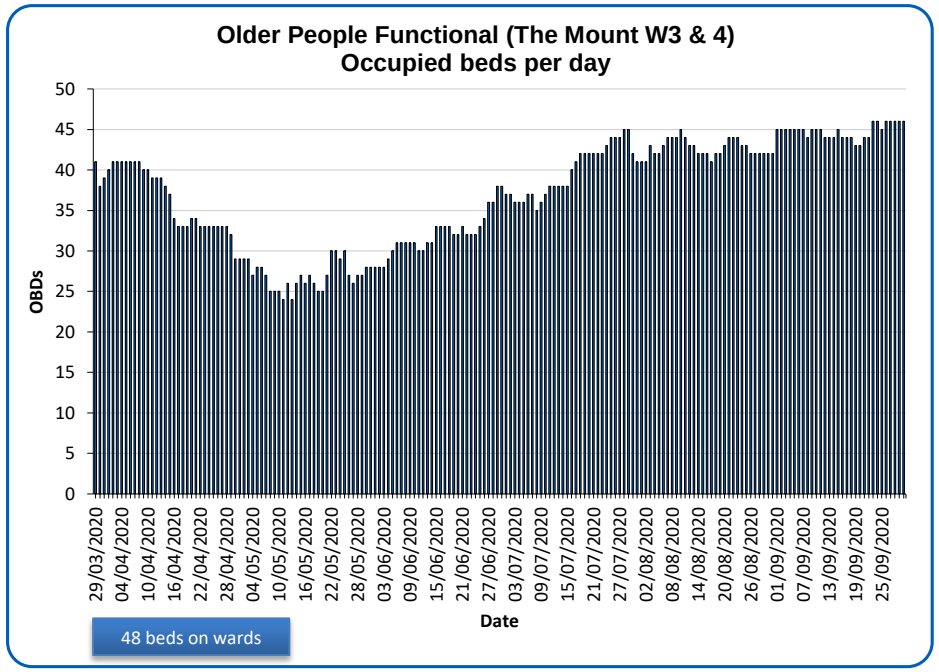


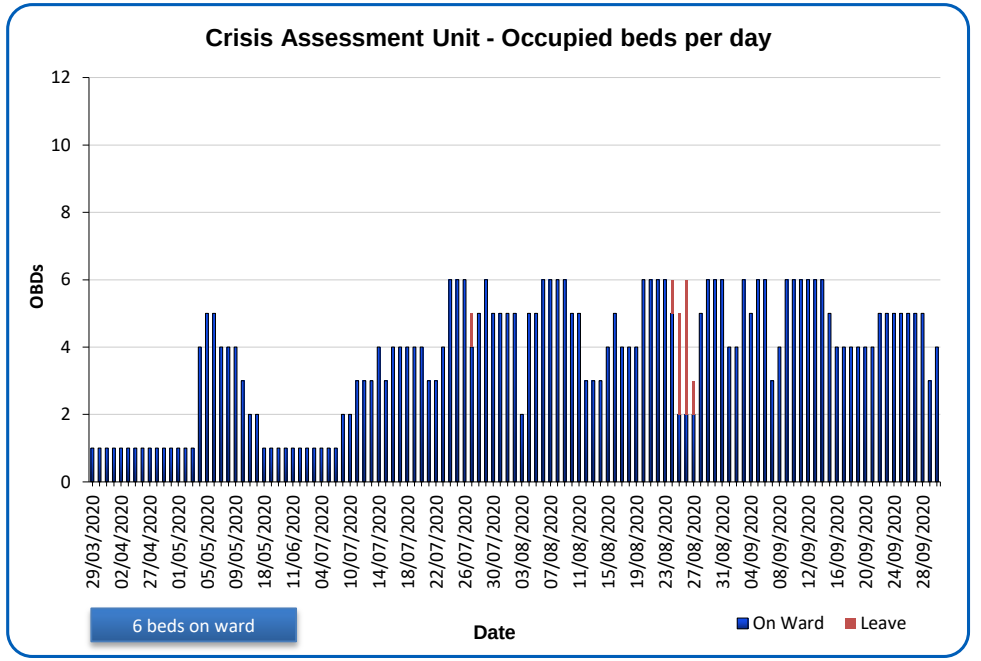


Service Specific Highlights (Inpatient)









Care Services Activity

Services: Trust Level Weekly (week commencing)	13-Sep	20-Sep	27-Sep
Number of Referrals	1,213	1,127	1,160
Number of Attended Appointments	5,333	5,401	5,269
Number of Attended Appointments undertaken by video	428	411	390
Percentage of Attended Appointments undertaken by video	8.0%	7.6%	7.4%
Services: Crisis and Community - Weekly (week commencing)	**13-Sep**	**20-Sep**	**27-Sep**
Number of Referrals to:			
CMHT Adult	153	134	141
CMHT Older People Services	38	49	29
MH In-Reach	56	50	35
CRISS	387	359	370
IHTT	14	14	9
Services: Inpatient - Snapshot at end of month (see charts for daily breakdown)	**Jul-20**	**Aug-20**	**Sep-20**
Occupied Beds per Day (inc On Ward, On Leave):			
Adult Acute Total - 114 beds	110	108	105
PICU (12 beds)	9	11	10
Older People Functional (The Mount W3/4 - 48 beds)	41	43	46
Crisis Assessment Unit (6 beds)	5	6	4
	Aug-20	**Sep-20**	**Oct-20**
Delayed Transfers of Care *	24	24	41

* Indicative mid-month position of patients from CareDirector (18th Oct), reporting subject to ongoing development

Service Activity Trends - Supporting Narrative

Trust Level - Summary

In September the average number of referrals per week was approximately 1,125, compared to the weekly average in 2019 -20 of around 1,400.

The weekly average number of attended health appointments in September was 5,110, above the 2019 -20 weekly average number of clinical contacts of 4,860. Data quality work continues to focus on the recording of key fields such as appointment outcomes (e.g. attended or did not attend) on CareDirec tor to ensure activity is fully reflected in the reported data.

The number and percentage of attended appointments by video has increased, from an average of 120 per week during April, to 3 75 in September, reflecting the work that has been done on stabilising and resetting our services. 7.3% of attended appointments are currently being carried out via video conferencing, compared to 3.8% during April. A higher proportion of appointments are also being carried out face to face, approx 28% in September compared to 20% between April and June.

Service Activity Trends - Referrals and Attended Appointments

The volume of initial contact activity i.e. referrals and health appointments in CRISS continues to be fairly consistent week on week. In September the weekly average number of referrals was 362 and the weekly average number of attended health appointments was 825. Approximately 32% of attended health appointments were conducted face to face and the proportion of appointments carried out over the telephone has dropped from 63% in June to 60% in September. Many of t hese calls relate to SPA triage work (referrals which require a clinical triage to determine how to proceed), which has increased significantly over recent months.

In September the average number of weekly referrals to the Older Peoples IHTT service was around 12 and on average 239 attend ed health appointments per week.

Referral rates to the Mental Health Inreach teams at LTHT are consistent with a weekly average of 44 in September. The average number of attended health appointments per week was 89 in September.

Referral rates to Community Mental Health Teams (CMHTs) are consistent with pre -Covid levels with a weekly average in September of around 135 referrals to Adults, consistent with the 19/20 rate of 130-135 per week. A greater proportion of Adult appointments continue to be carried out face to face (24%) or by video conferencing (6.3%) than earlier in the year (in June the proportion carried out face to face was 19% and by video 2.7%). There were on average 37 referrals per week to the Older Peoples CMHT in September. The number of OPS CMHT attended health appointments has increased slightly with a weekly average of 391 in September. The per centage of appointments carried out face to face continues to increase with a weekly average of approximately 36% carried out by this method in September.

We continue to work with ALPS on data quality concerns, aiming to improve their data collection on CareDirector.

Quality and Workforce metrics: Tabular overview

Quality: Our effectiveness	Target	Jun-20	Jul-20	Aug-20
Number of healthcare associated infections: C difficile	<8	0	0	0
Number of healthcare associated infections: MRSA	0	0	0	0
Number of inpatients diagnosed positive with Covid19	-	0	0	3
Percentage of service users in Employment	-	n/a*	n/a*	n/a*
Percentage of service users in Settled Accommodation	-	n/a*	n/a*	n/a*
Quality: Caring / Patient Experience	**Target**	**Jun-20**	**Jul-20**	**Aug-20**
Friends & Family Test: Percentage recommending services (total responses received)	-	n/a**	100% (2)	50% (2)
Mortality:				
· Number of deaths reviewed (incidents recorded on Datix)***	Quarterly	103	-	-
· Number of deaths reported as serious incidents	Quarterly	7	-	-
· Number of deaths reported to LeDeR	Quarterly	1	-	-
Number of complaints received	-	4	13	13
Percentage of complaints acknowledged within 3 working days	-	100%	100%	100%
Percentage of complaints allocated an investigator within 3 working days	-	n/a **	100%	100%
Percentage of complaints completed within timescale agreed with complainant	-	n/a **	100%	100%
Number of enquiries to the Patient Advice and Liaison Service (PALs)	-	200	173	126

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

* Metric subject to data warehouse redevelopment and report re-writing following Care Director implementation

** Some Quality data for Q1 was unavailable due to Covid-19. Quality Health did not provide patient FFT submissions/reporting in May/June. NHS

*** 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

Quality and Workforce metrics: Tabular overview

Quality: Safety	Target	Jun-20	Jul-20	Aug-20
Number of incidents recorded	-	837	944	951
Percentage of incidents reported within 48 hours of identification as serious	100%	100% (2)	100% (1)	100% (0)
Number of Self Harm Incidents	-	104	112	100
Number of Violent or Aggressive Incidents	-	70	98	101
Number of never events	-	0	0	0
Number of restraints	-	198	191	249
No. of patients detained under the MHA (includes CTOs/conditional discharges)*	-	445*	443*	485*
Adult acute including PICU: % detained on admission	-	n/a*	n/a*	n/a*
Adult acute including PICU: % of occupied bed days detained	-	n/a*	n/a*	n/a*
Number of medication errors	Quarterly	128	-	-
Percentage of medication errors resulting in no harm	Quarterly	92.2%	-	-
Safeguarding Adults: Number of advice calls received by the team	Quarterly	209	-	-
Safeguarding Adults: Percentage of advice calls to safeguarding that resulted in a referral to social care	Quarterly	12% (26)	-	-
Safeguarding Children: Number of advice calls received by the team	Quarterly	92	-	-
Safeguarding Children: Percentage of advice calls to safeguarding that resulted in a referral to social care	Quarterly	29% (27)	-	-
Number of falls	-	70	90	96
Number of Pressure Ulcers	-	0	0	0

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

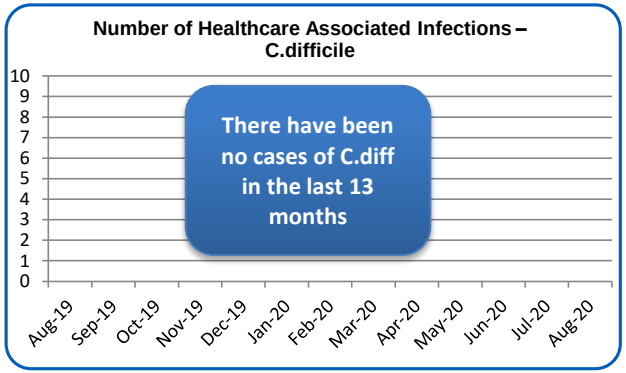
* Metric subject to data warehouse redevelopment and report re-writing following Care Director implementation

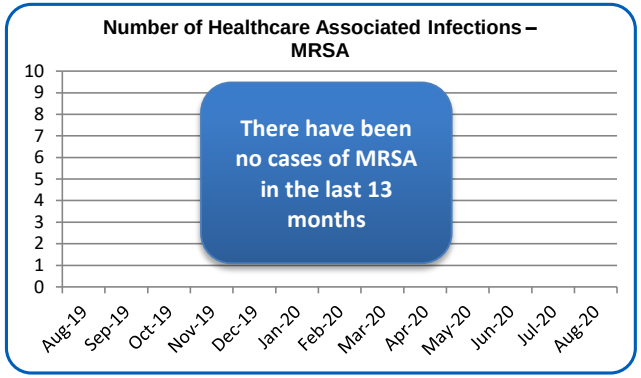
Quality and Workforce metrics: Tabular overview

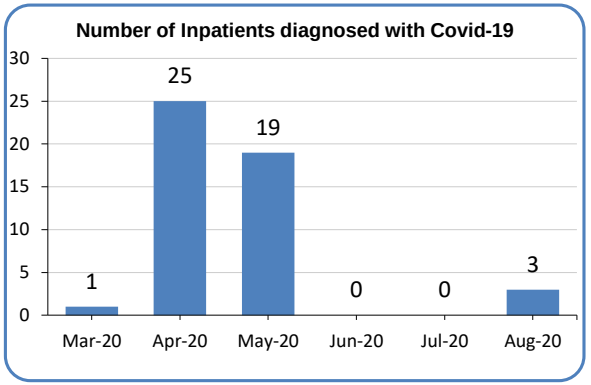
Our Workforce	Target	Jun-20	Jul-20	Aug-20
Percentage of staff with an appraisal in the last 12 months	85%	56.8%	54.9%	55.4%
Percentage of mandatory training completed	85%	88.8%	87.8%	87.2%
Safeguarding: Prevent Level 3 training compliance (quarter end snapshot)	85%	95.5%	-	-
Percentage of staff receiving clinical supervision	85%	68.2%	73.4%	67.6%
Staff Turnover (Rolling 12 months)	8-10%	8.6%	8.7%	8.6%
Sickness absence rate in month	-	4.8%	5.0%	5.4%
Sickness absence rate (Rolling 12 months)	4.9%	5.1%	5.1%	5.2%
Percentage of sickness due to musculoskeletal issues (MSK; rolling 12 months)	-	14.9%	14.5%	14.0%
Percentage of sickness due to Mental Health & Stress (rolling 12 months)	-	39.7%	40.6%	41.3%
Number of Covid19 related absences of staff, either through sickness or self-isolation (staff days)	-	3,676	2,725	791
Medical Consultant Vacancies as a percentage of funded Medical Consultant Posts (percentage)	-	12.2%	12.1%	15.2%
Medical Consultant Vacancies (number)	-	9.5	9.4	11.9
Medical Career Grade Vacancies as a percentage of funded Medical Career Grade Posts (percentage)	-	16.8%	16.9%	16.9%
Medical Career Grade Vacancies (number)	-	6.6	6.7	6.7
Medical Trainee Grade Vacancies as a percentage of funded Medical Trainee Grade Posts (percentage)	-	9.4%	13.3%	4.4%
Medical Trainee Grade Vacancies (number)	-	9.5	13.5	4.4
Band 5 inpatient nursing vacancies as a percentage of funded B5 inpatient nursing posts (percentage)	-	24.0%	26.0%	29.0%
Band 5 inpatient nursing vacancies (number)	-	55.1	59.3	64.8
Band 6 inpatient nursing vacancies as a percentage of funded B6 inpatient nursing posts (percentage)	-	10.0%	10.0%	10.0%
Band 6 inpatient nursing vacancies (number)	-	9.6	9.4	9.4
Band 5 other nursing vacancies as a percentage of funded B5 non-inpatient nursing posts (percentage)	-	23.5%	21.3%	22.8%
Band 5 other nursing vacancies (number)	-	24.2	22.0	23.3
Band 6 other nursing vacancies as a percentage of funded B6 non-inpatient nursing posts (percentage)	-	3.1%	1.5%	0.0%
Band 6 other nursing vacancies (number)	-	8.8	4.4	0.0
Percentage of vacant posts (Trustwide; all posts)	-	10.6%	10.0%	10.0%

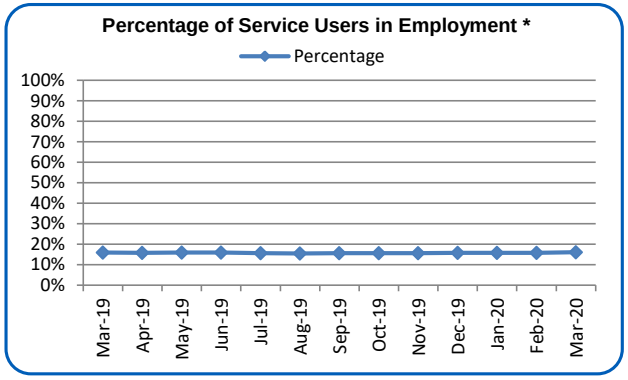
Nursing vacancies excludes nursing posts working in corporate/development roles

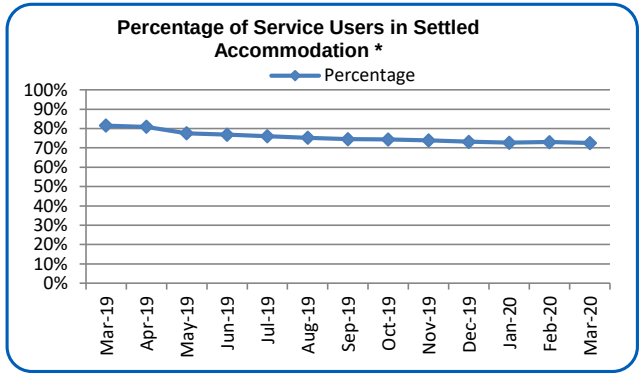
13 month trend: Quality: Effectiveness





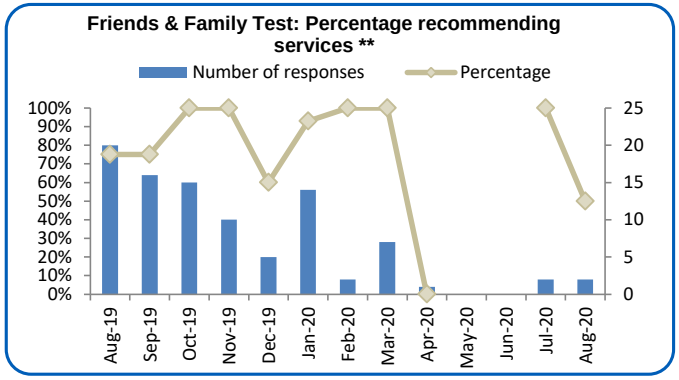


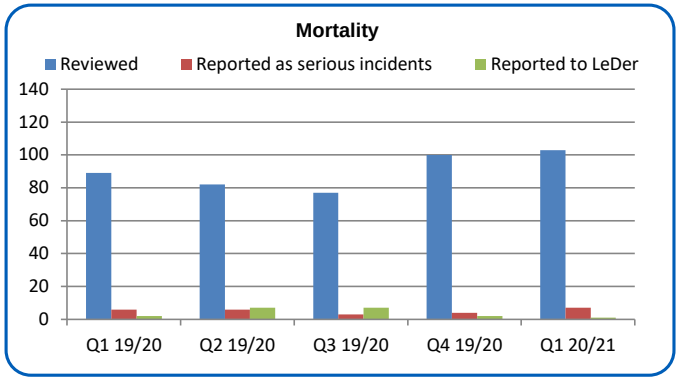


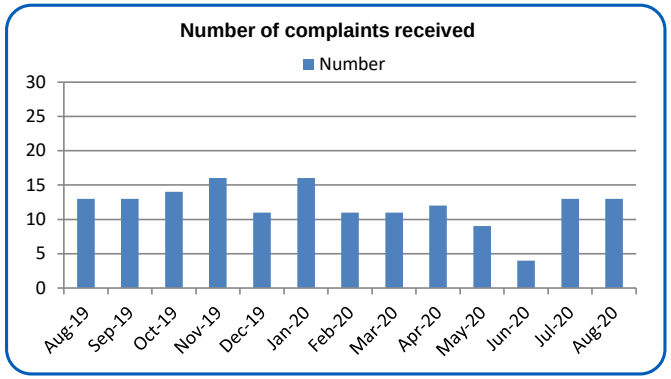


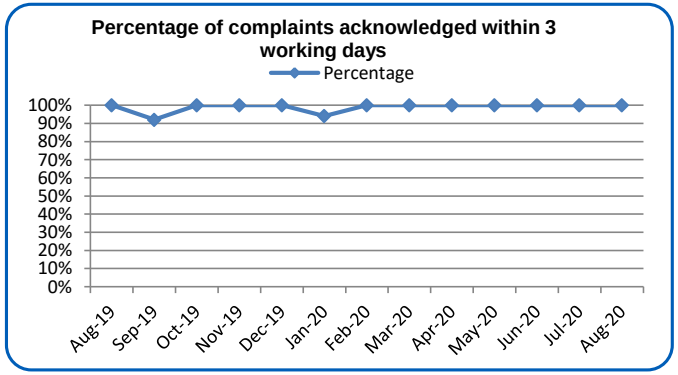
Please note that new metrics are only reported from the month of introduction onwards.
*** 20/21 data not yet available, subject to Care Director related technical reporting developments**

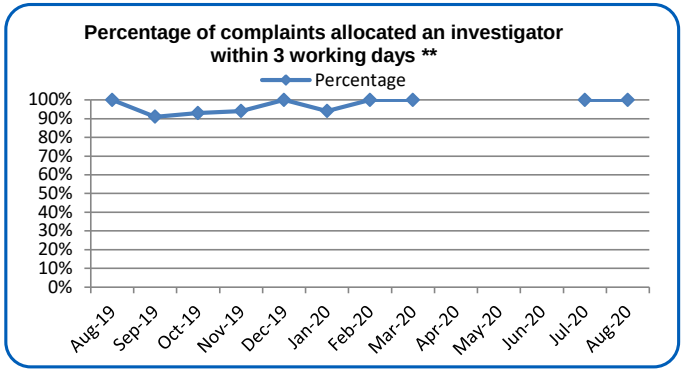
13 month trend: Quality: Caring/Patient Experience

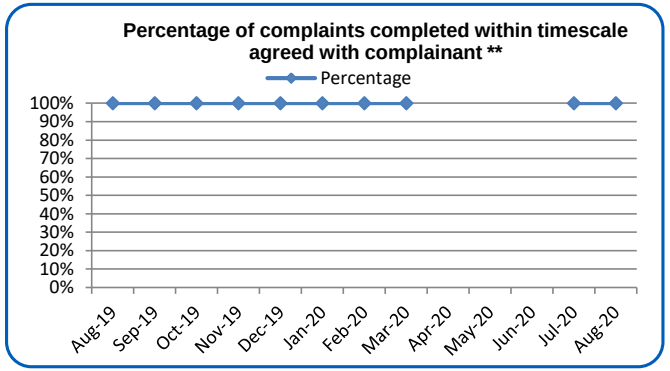


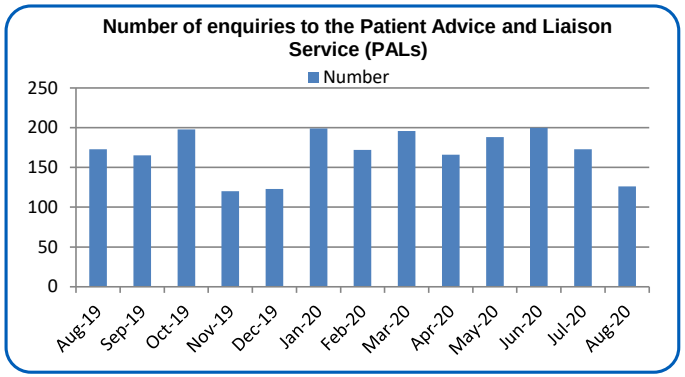






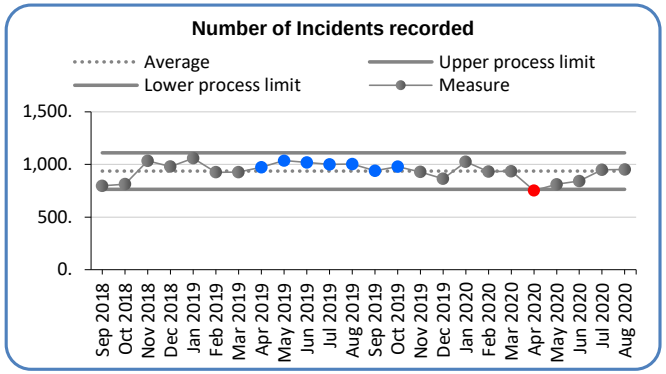


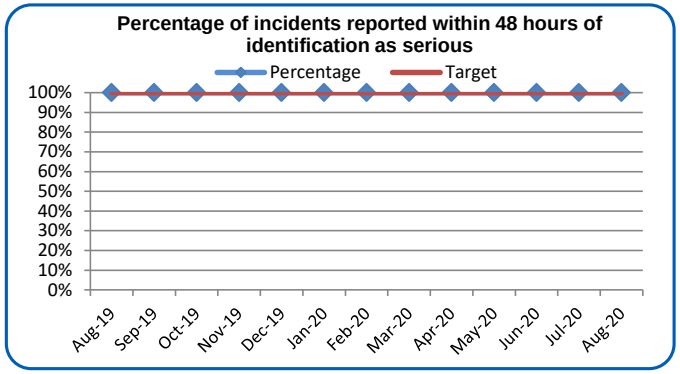


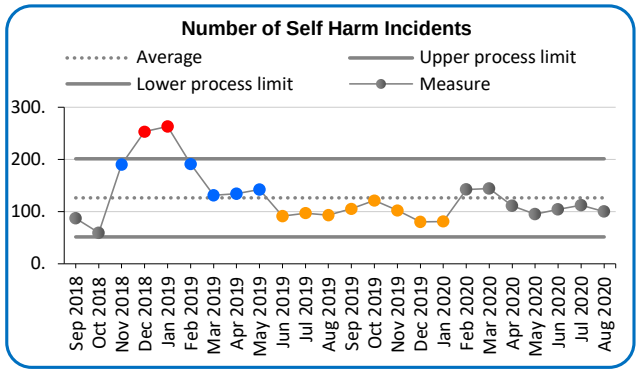


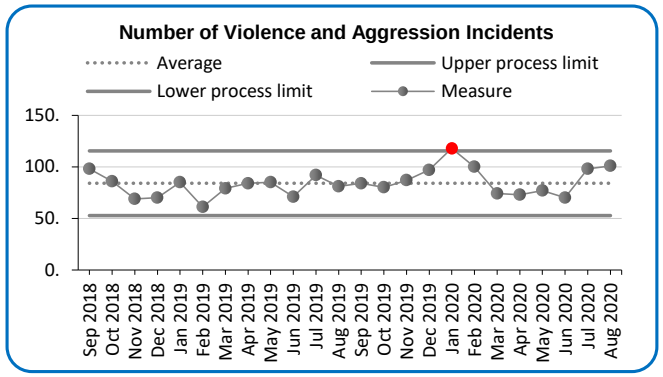
Please note that new metrics are only reported from the month of introduction onwards.
**** 2020-21 Q1 reporting impacted by Covid19 related reporting unavailability / suspension**

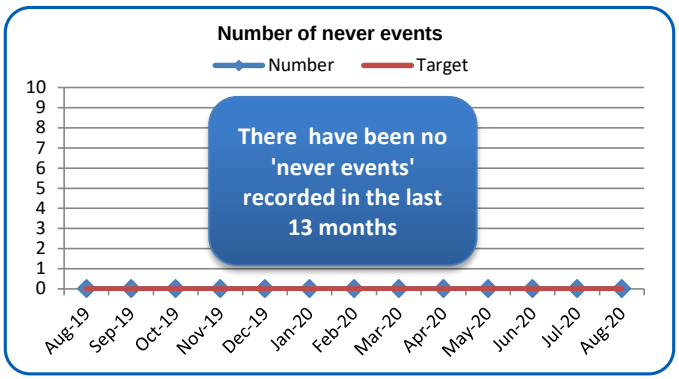
13 month trend: Quality: Safety

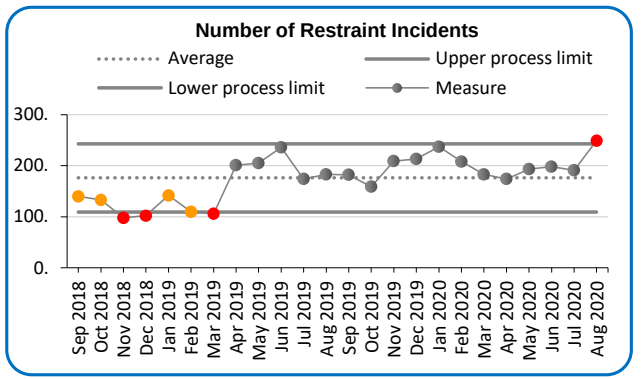


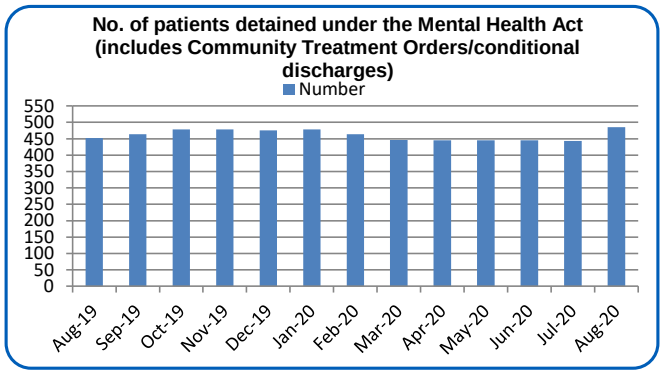


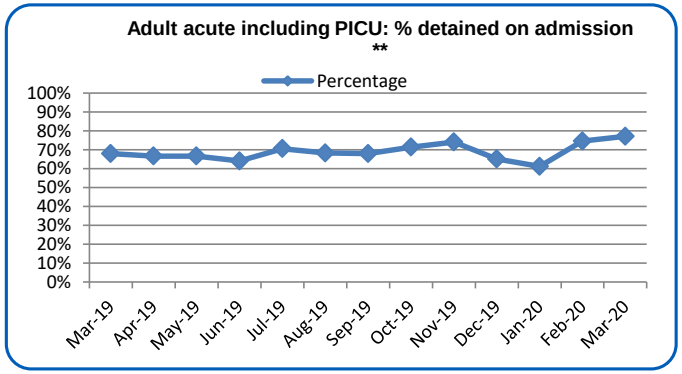


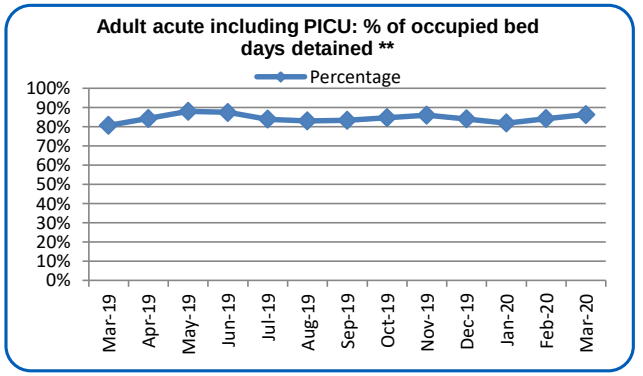




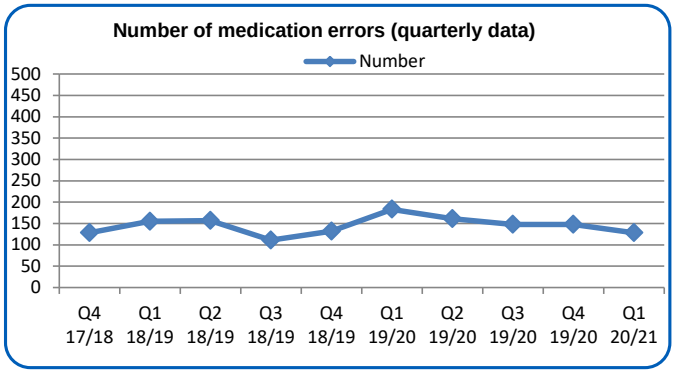


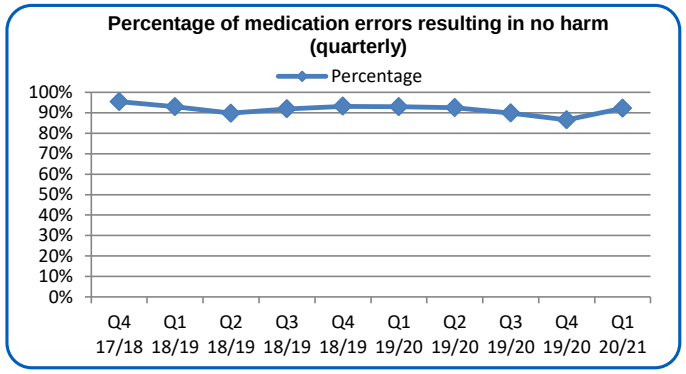


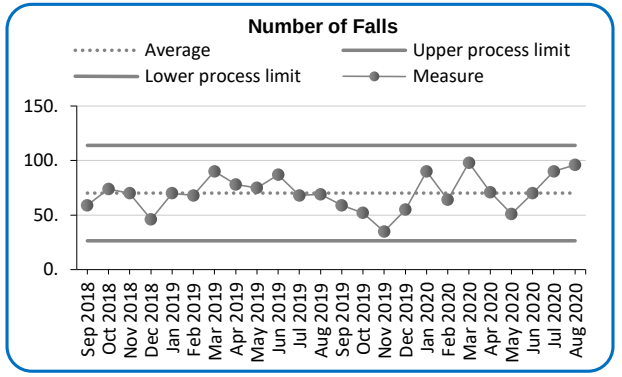


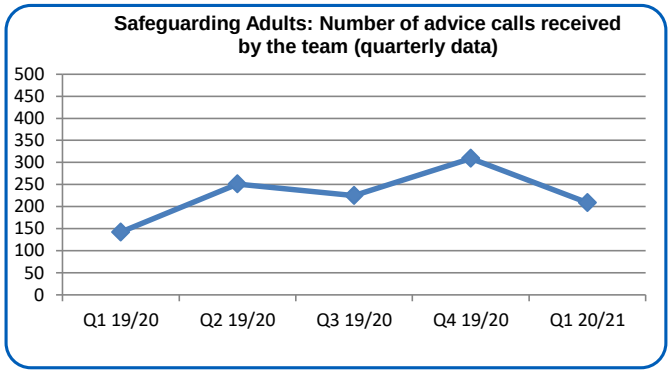


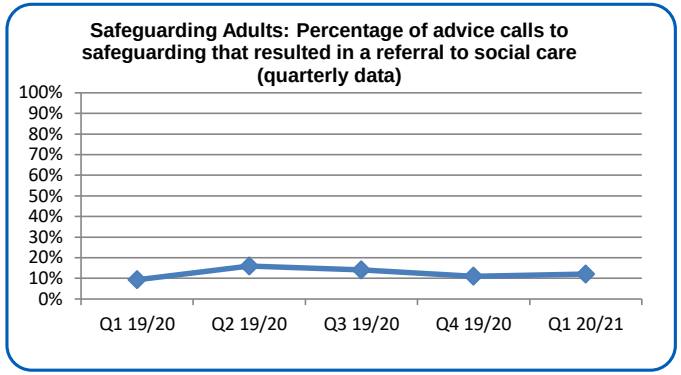
13 month trend: Quality: Safety - continued

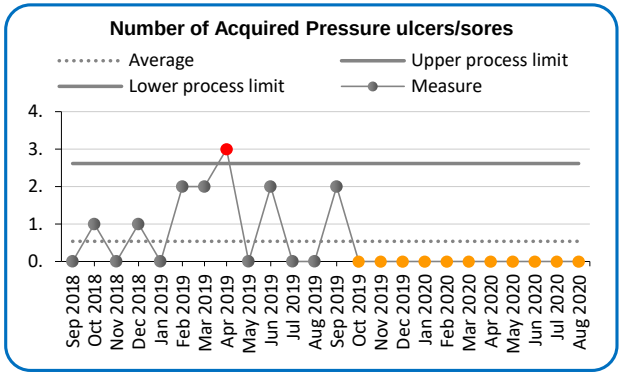


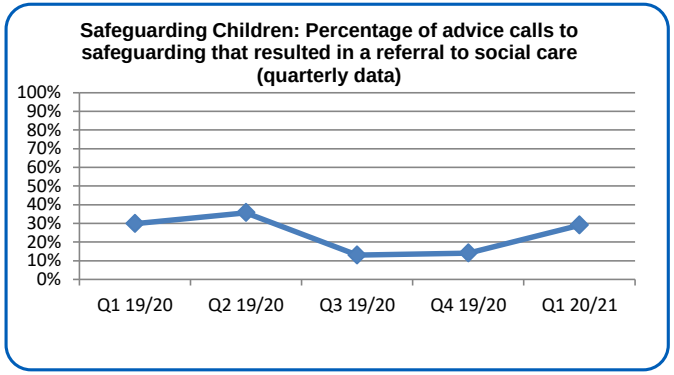


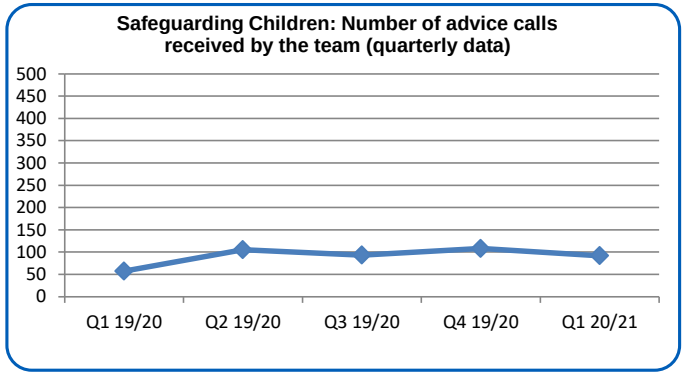




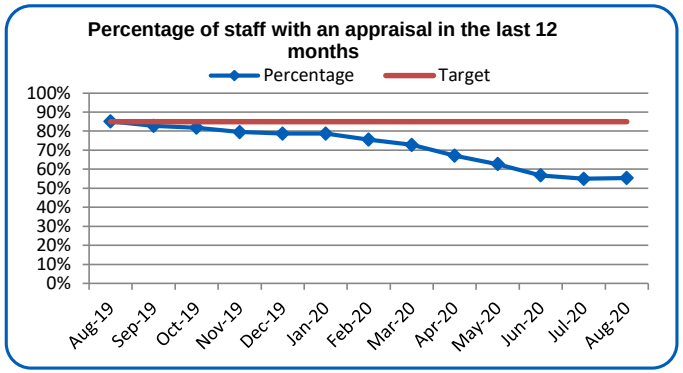


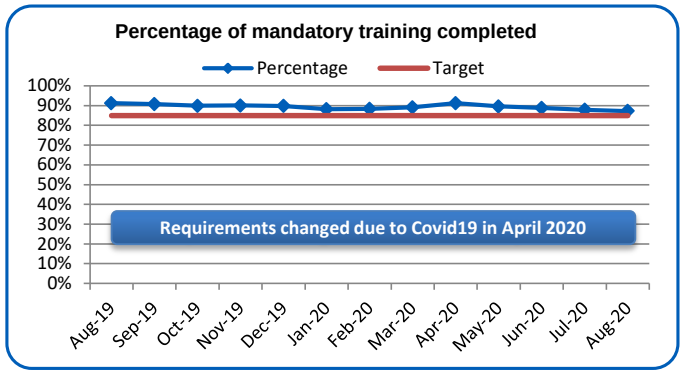


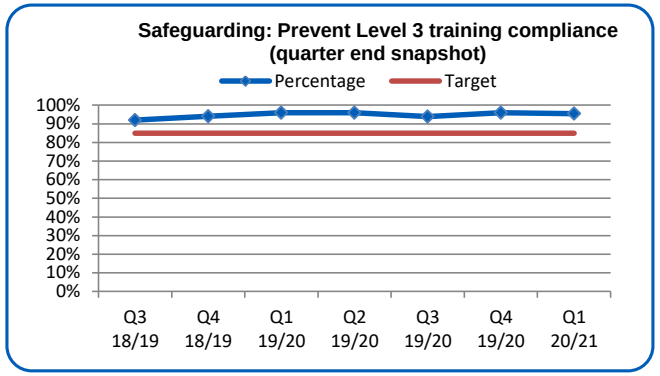


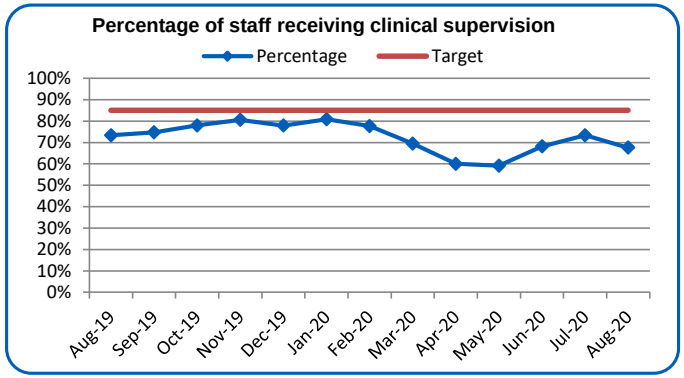


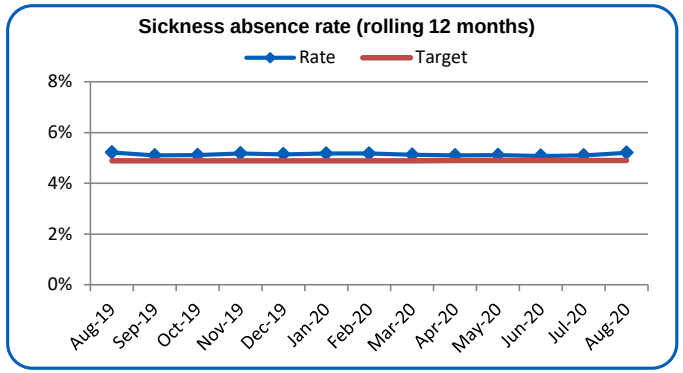
13 month trend: Our Workforce

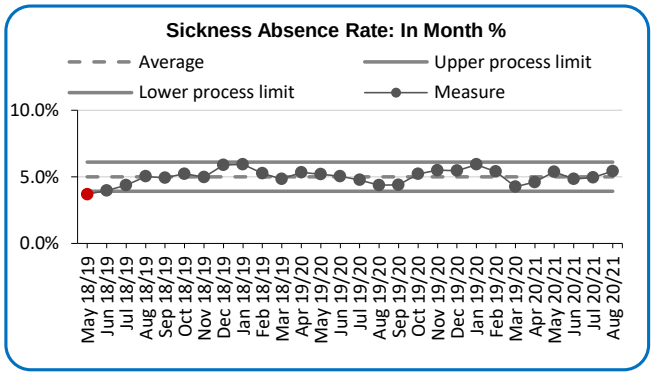


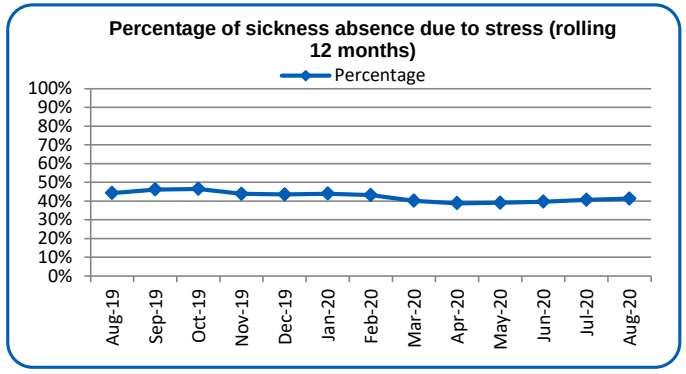


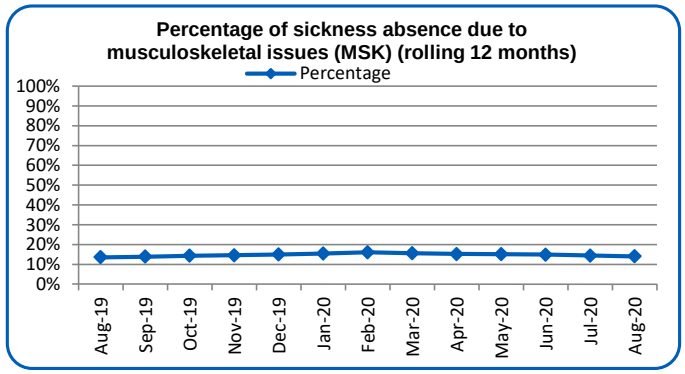


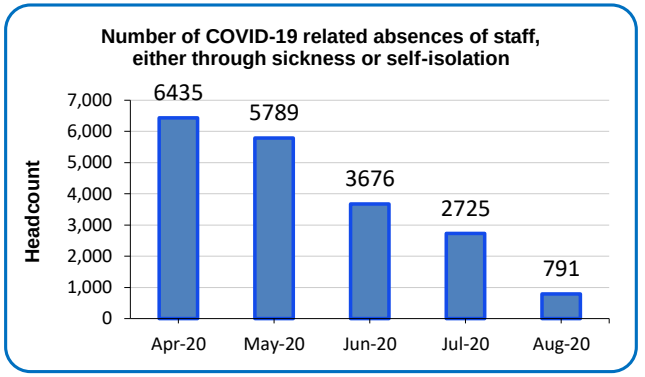




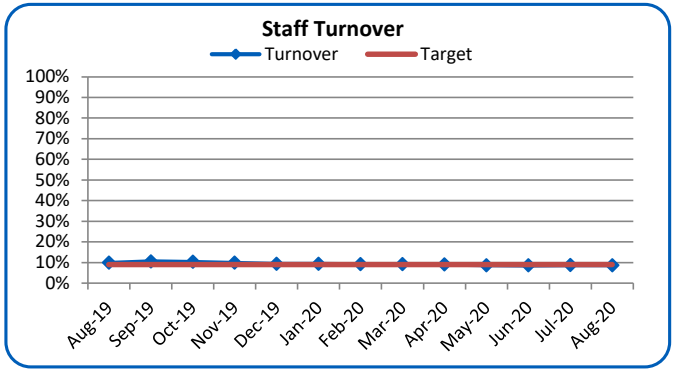


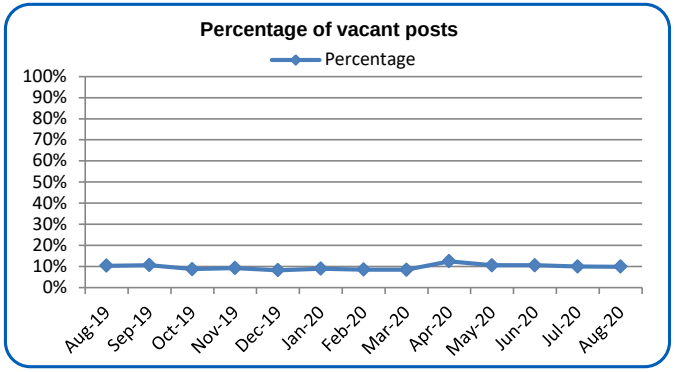


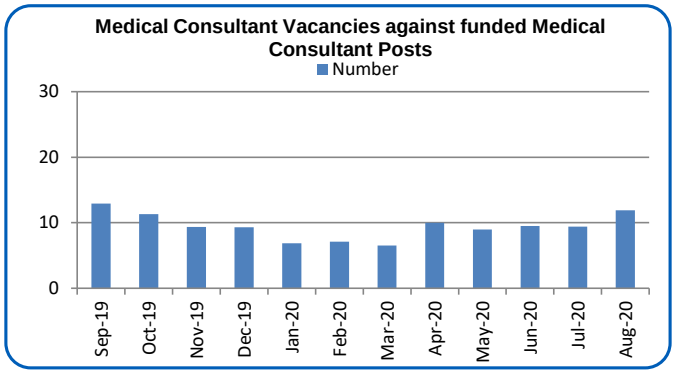


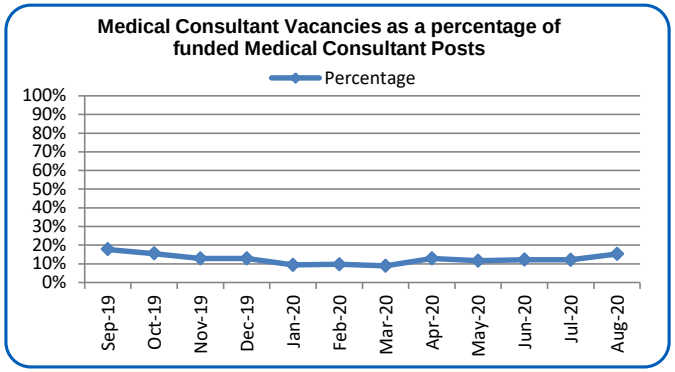


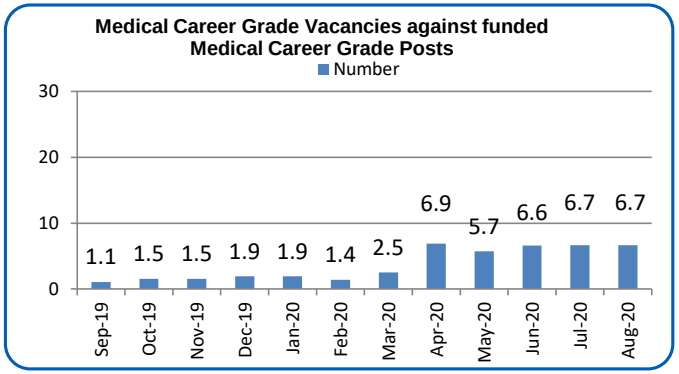
13 month trend: Our Workforce - continued

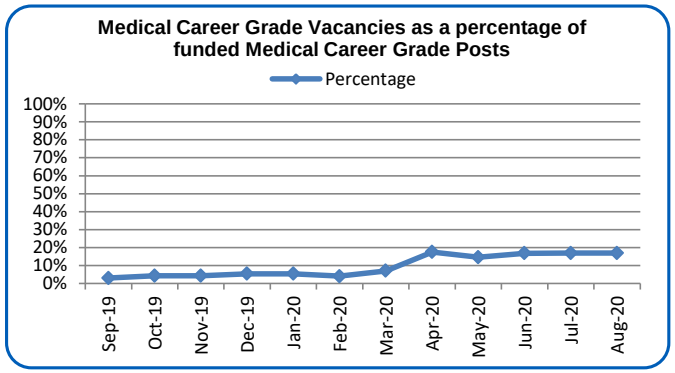


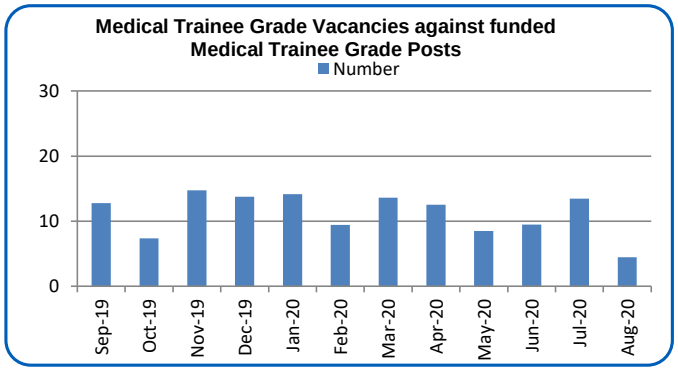


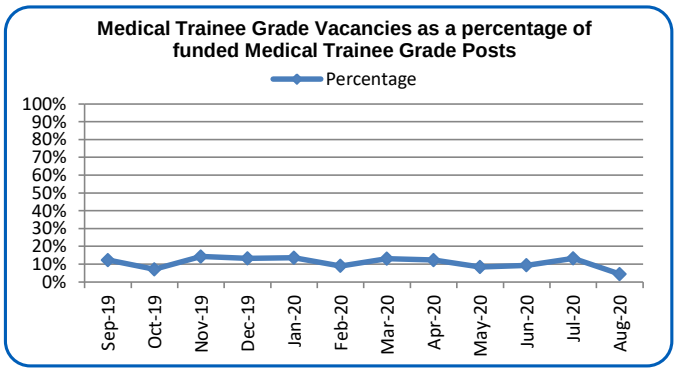




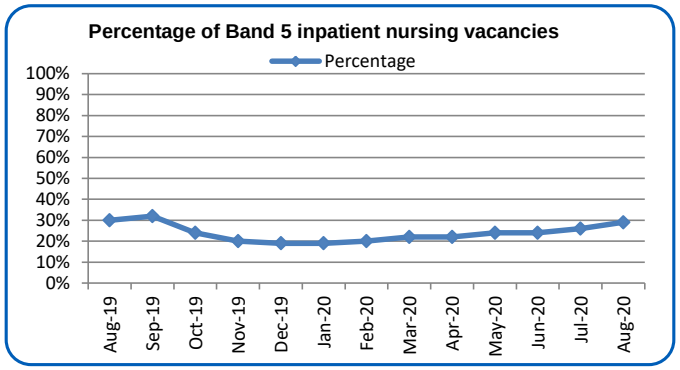


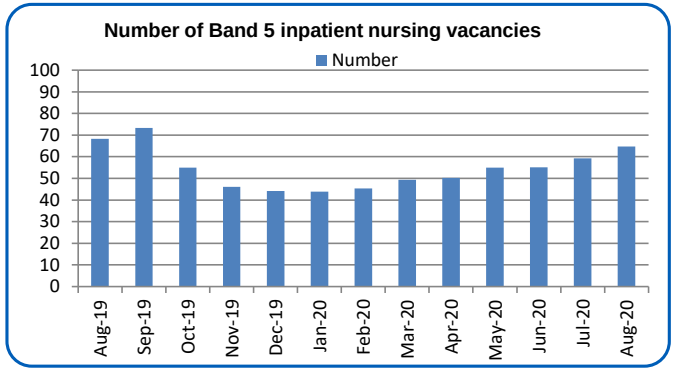


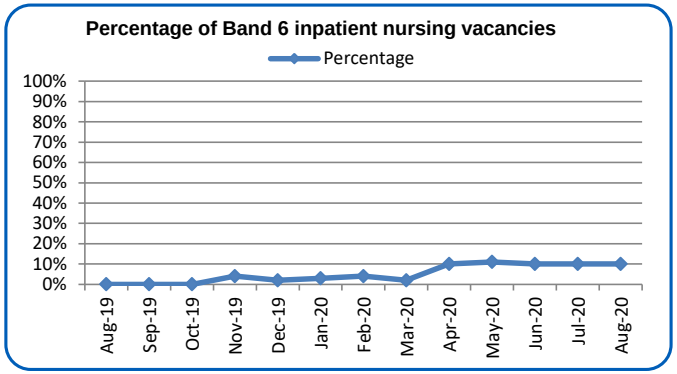


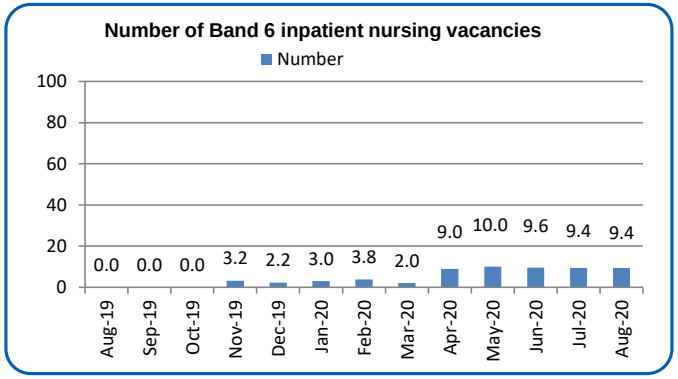


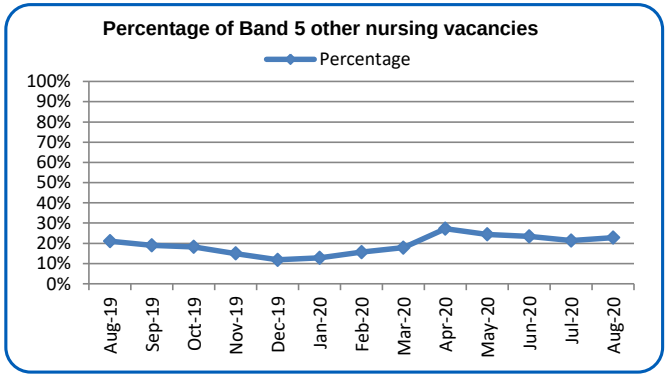
13 month trend: Our Workforce - continued

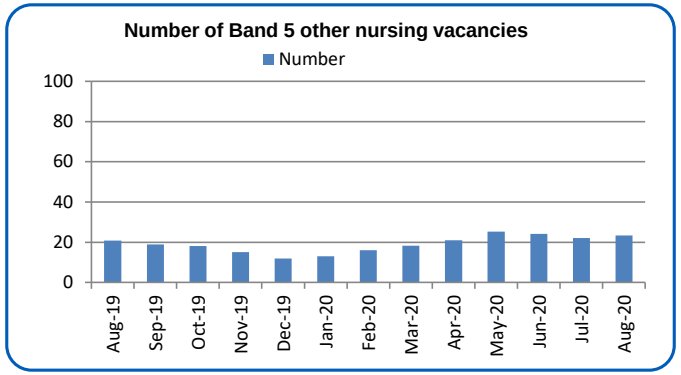


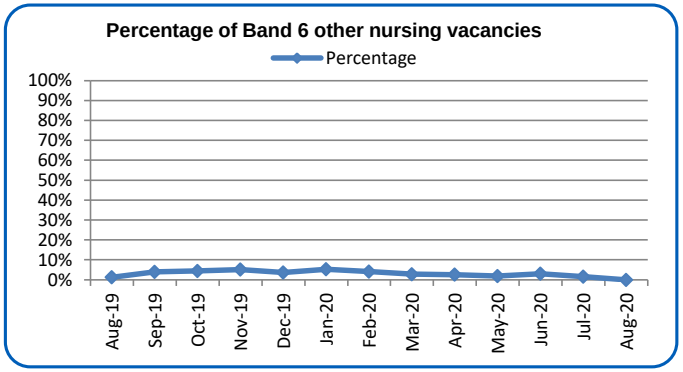


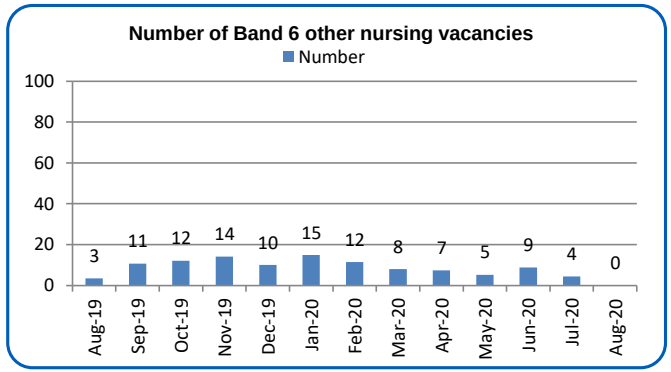












Local intelligence

PREVIOUS MONTH: JULY

Clinical Record Keeping

Data Quality Maturity Index: Latest data published by NHS Digital shows our May position at 82.2%, a further drop in data quality which was anticipated following CareDirector inplementation. We are continuing to develop our new EPR system to meet the needs of the organisation. Feedback from staff has been vital in shaping the application and we are working closely with services and teams to map processes, resolve queries and suggest developments. A wider conversation is taking place, via our Your Voice Counts online collaboration platform for staff to anonymously share experiences since the launch, and offer ideas on how we can further optimise the system.

Patient Experience

S136: There were 3 breaches in July, all working age adults. 2 of the breaches had medical recommendations completed but breaches occurred due to no available beds. The remaining breach was due to a combination of poor communication/handover and the subsequent unavailability of a Section 12 doctor, the incident has since been discussed in team meetings and action taken to prevent re-occurrence.

Complaints: There were 13 complaints received in July, slightly higher than in recent months but in line with the monthly average over the last 12 months, which is 12. All 13 complaints were acknowledged within the 3 days standard, allocated an investigator within 3 days, and completed within agreed timescales. The 3 month pause on the complaints process, endorsed by NHS England and NHS Improvement, ended on 30 June 2020. The PALS team have been operating as normal during this time with 173 enquiries received in July.

Friends and Family Test: Due to the situation with Covid-19 Quality Health did not provide patient FFT submissions/reporting in May and June. They have however recently provided data for April and July. All 3 responses were from Inpatient services, a 0% 'unlikely to recommend' from one patient discharged from The Mount in April and a 100% positive recommendation from 2 responses at discharge from Inpatients, one from The Mount and one unspecified.

Safety

Incidents: The number of incidents, including those for violence/aggression, self harm and restraint all remain within expected levels of normal variation. In July 443 people were detained under the Mental Health Act, including community treatment orders and conditional discharges. The monthly average over the last 12 months has been 462.

Medication: In Q1 there were 128 medication related incidents, 92.2% of which resulted in no harm. The Medicine Safety Committee scrutinises all medication-related incidents reported across the organisation bi-monthly and lessons learned are shared. In April, the way in which medication incidents are recorded changed on the Datix reporting system. Previously there was 29 options for different types of error which caused confusion for staff and led to challenges in interpreting data, this was rationalised to 8 options. 49% of reported medication incidents in Q1 were related to the administration of medication, 1 of the 8 options.

The increase in reports of administration incidents compared to previous quarters is thought to be a result of the change to the Datix reporting system in April, as opposed to an increase in administration incidents. This will be closely monitored by the committee. The task and finish group, set up by the Lead nurse to look at medication training for nurses, is going to incorporate learning from incidents from Q2.

Safeguarding: Q1 is the first period where Safeguarding data has been generated from the new Datix reporting processes. Whilst a positive development, there have been some early data quality issues and reporting is subject to further development. Furthermore some changes in recording methodology mean time series analysis will become more robust as time progresses. In Q1 92 (31%) advice calls handled by the Safeguarding Team were child related and 209 (69%) related to adults. Q1 figures were slightly below average for adult advice, believed due to the impact of Covid-19 on services and reporting.

Activity increased in June (with further increase expected in July) with more advice being sought, corresponding to easing of lockdown, access to service-users and service adjustment. Referral process and outcomes with Adult Social Care are currently routinely reviewed by the Safeguarding and Risk Manager for Mental Health and the Trust Deputy Head of Safeguarding. Outcome rates remain stable overall, despite Covid-19 and reduction in face to face contacts, with extra information communicated to staff highlighting risks to vulnerable adults and families during this time, enabling the response to remain constant. At 12% outcome referrals to Adult Social Care remains comparable to average figures. Patterns of abuse roughly reflect national and previous LYPFT data with physical, psychological and financial abuse being significant for our service users.

There has been a noticeable proportionate increase in domestic abuse and violence calls for advice, and this is reflected in the local and national picture. Of the 92 advice calls relating to children 29% were referred on to Adult Social Care. On the training front the Safeguarding team are providing on-line face to face bespoke sessions and are implementing the flexible learning document for both child and adult safeguarding, with pop up stalls at trust sites, presentations at governance forums and regular trust-wide communications being provided for staff. At Q1 95.5% of staff are trained in Basic Prevent (Target 85%).

Local intelligence

PREVIOUS MONTH: JULY (continued)

Workforce

Appraisals: With appraisals on hold during Covid-19 (unless there are exceptional circumstances agreed between the appraiser and appraisee) compliance has fallen from 72.8% in March to 54.9% in July. An interim appraisal process has been agreed to run between now and the end of March and we expect to see improvement from October onwards.

Mandatory Training: Classroom sessions, including updates for Resuscitation, PMVA and Moving and Handling are now available for booking. Due to restrictions on class sizes, places are more limited than usual. Appropriately risk assessed PPE and social distancing measures are in place and enforced for all these classes. Against an 85% target compliance in July was at 87.8%.

Clinical Supervision: This measure had fallen significantly under the 85% target to a low of 59.2% in May. All staff were advised of procedures to ensure that supervision continued whilst many staff were redeployed in other areas. An expected improvement over the last few months has seen performance increase to 73% in July.

Sickness Absence: At 5% the in month sickness rate remains within levels of normal variation.

Vacancies: The picture remains fairly consistent with the percentage of vacant posts, at 10%, in line with the 12 month rolling average. Our social media recruitment campaign called “Let’s Talk” has now gone live across our social media channels. We are encouraging staff, colleagues, friends and family who are active on these channels to please like and share. This will help increase our reach to new audiences who might be interested in talking to us about job opportunities.

When the Covid-19 pandemic hit, the Recruitment Team adapted their process at speed so that the service could continue to operate and be Covid-19 secure. The changes and innovations the team made also meant that during the pandemic we've seen over 90 students employed by the Trust under various contract types, we've actively recruited more newly qualified nurses than before, and we've employed 19 additional staff across the AHP profession. Our Recruitment Team are also currently working with colleagues in care services to plan some virtual open days.

Coronavirus: We are pleased to report low rates of infection amongst staff and service users in our own wards, however we recognise that our staff continue to support service users with Covid-19 in other settings, including hospitals, care homes and in the community. Each week we’ve seen the numbers of patients and staff with Covid symptoms fall and this is testament to the hard work of staff in observing infection control procedures, wearing PPE, washing hands and staying alert to control the virus and save lives.

Over the past few months there has unsurprisingly been a huge increase in remote working and many services and teams and found creative ways to share information and help each other learn. While these have been challenging times with many of us having to work differently, we continue to encourage new ways of working and keep these innovations going forward to see real constructive change in the Trust. The Trust is currently working in partnership with a number of NHS organisations to prepare the delivery of Covid-19 vaccine trials. At present, a number of locations throughout Leeds and North Yorkshire are being considered as centres to deliver the vaccine trials and make sure that everyone in Leeds, Harrogate and York can take part. It is likely that these trials will be taking place towards the end of the year and we are encouraging as many people as possible to consider registering their interest in taking part.

Local intelligence

CURRENT MONTH: AUGUST

Clinical Record Keeping

Data Quality Maturity Index: Work is ongoing with teams following the implementation of CareDirector to support staff in regaining expected standards of data quality. Feedback received via our online collaboration platform Your Voice Counts over the summer showed that staff continue to require support and training on the new system. There are also areas of the system that could be improved that would make data collection easier for staff leading to an improvement in data quality (options around this are currently being explored).

Patient Experience

S136: In August there were 3 breaches, all working age adults and due to delays attributable to non-availability of beds.

Complaints: There were 13 complaints received in August, all acknowledged within the 3 days standard, allocated an investigator within 3 days, and completed within agreed timescales. The PALS team received 126 enquiries in August.

Friends and Family Test: Quality Health have resumed the monthly patient FFT submissions/reporting following a pause in Q1. In August there were 2 responses, both from postcards given at point of discharge from our inpatient services. The first was a positive recommendation from one patient discharged from The Mount, noting helpful and positive attitude of staff. The other response was from our Regional and Specialist Services at the Newsam Centre who responded that they were neither likely or unlikely to recommend.

Safety

Incidents: The number of incidents, including those for violence/aggression and self harm remain within expected levels of normal variation, however in August the number of restraint incidents moved outside expected levels. There were higher numbers of restraint incidents in Adult Acute and in Eating Disorders. Within Eating Disorders restraint is used to facilitate naso-gastric tube feeding.

Work continues in maintaining patient safety with zero numbers of pressure ulcers reported in the last 12 months, a notable achievement evidencing excellent standards of inpatient care and following significant awareness work across the Trust in the last 2 years.

Workforce

Appraisals: A Covid-19 related interim appraisal process is being implemented. This has been slightly delayed to allow the integration of career conversation into the process in accordance with the National People Plan. In August the percentage of staff with an appraisal in the last 12 months is 55.4% and we anticipate an improvement from November.

Mandatory Training: In response to the Covid pandemic and to reduce pressure on clinical services, refresher periods for all compulsory training elements were extended in April by up to 6 months. We are working to return to the mandated periods and ensuring all staff have completed the compulsory training required for their roles. Over the next 12 months, we will be returning extended refresher periods to the original durations on a monthly basis starting with subjects available as e-Learning through our iLearn system. This phased approach is designed to be as supportive as possible, recognising the significant challenges we are continuing to face on a daily basis. Against an 85% target compliance in August was at 87.2%.

Clinical Supervision: Improvements in recording supervision were expected as staff returned from redeployment in other areas of the Trust during August. The percentage varies considerably within service lines, for example within Older People's Services: inpatients 73% and community 51%.

Sickness Absence: The in month sickness rate in August was 5.4% and within levels of normal variation.The rolling 12 month average is 5.2%. The end of the formal shielding programme has impacted upon the number of Covid19 related absences of staff, either through sickness or self-isolation.

Vacancies: At 10% the percentage of vacant posts remains consistent, and in line with the 12 month rolling average. The number of Medical Trainee Grade vacancies fell from 13.5 in July to 4.4 in August, likely due to the annual rotation of junior doctors. The number of band 5 inpatient nursing vacancies continues to increase with 65 in August, 25% of funded band 5 inpatient nursing posts. We will see over the next few weeks the 36 Aspirant Nurses recently recruited as 3rd Year students receiving their NMC PIN and therefore moving automatically from a band 4 Aspirant Nurse contract into a band 5 role, supported by a comprehensive preceptorship programme. We are continuing to advertise and attract applicants to our band 5 posts and currently have 12 posts going through pre-employment checks. Most of the staff that were redeployed to prioritised services have now returned to their substantive posts as we start to reset and restore all our services.

Coronavirus: Due to the high infection rate in Leeds, the government has introduced additional local restrictions for the city, some of which are enforceable. We have since circulated an FAQ, produced by Leeds CCG, to all staff to explain the detail behind these new restrictions, and how they impact. We continue our approach to managing the next phase of the pandemic, by continuing to adapt to changeable circumstances, without compromising on the specialist help and care we deliver to our service users. We recognise that to keep supporting people with mental health and learning disability needs, we can only do this by keeping safe ourselves, by continuing to practice social distancing, washing our hands and wearing the correct PPE. This is a constant reminder to staff via our weekly communications and the IPC team have created posters, video blogs to support staff. This will allow us to keep adapting to the changing situation we find ourselves in, and maintain our focus on what matters to us most – the people we serve.

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

Acronym	Full Title	Definition
		calling our Trust's switchboard
ARMS	At Risk Mental State	ARMS is used to describe young people aged 14-35 years who are experiencing low levels signs of psychosis.
C difficile	Clostridium difficile	Spore-forming anaerobic Gram-positive bacillus (rod) that causes diarrhoeal illness, which can progress to more severe conditions including perforation of the bowel and intra-abdominal sepsis.
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.
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 quality and performance throughout a given month.
CQUIN	Commissioning for Quality and Innovation	The Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care.
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

Acronym	Full Title	Definition
		day, 7 days a week, 365 days a year.
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.
CTO	Community Treatment Order	Allows a person who has been detained in hospital for treatment to leave hospital (discharged from detention) and get treatment in the community.
Deaf CAMHS	Deaf Child and Adolescent Mental Health Service	Service that works with children and young people aged 0-18 who have a severe to profound hearing loss, have deaf parents or have BSL (British Sign Language) as a first language and who also experience emotional and/or behavioural issues consistent with a Children's Global Assessment Scale [CGAS] rating of 50 or less.
DNA	Did not attend	
DQIP	Data Quality Improvement Plans	Allow the commissioner and the provider to agree a local plan to improve the capture, quality and flow of data to meet the requirements of the NHS Standard Contract Schedule 6A and to support both the commissioning and contract management processes.
DQMI	Data Quality Maturity Index	A monthly publication about data quality in the NHS
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.
EHCP	Education, Health and Care Plan	It outlines any special educational needs a child has, and the provision a local authority must put in place to help them
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.
EPMA	Electronic Prescribing and Medicines Administration	EPMA is the electronic system the Trust uses to prescribe medication for service users. It is provided by an external company and managed by the Pharmacy Team.
EPR	Electronic Patient Records	The system used to store patient records electronically.
FFT	Friends and Family test	An important feedback tool that supports the fundamental principle that people who use NHS

Acronym	Full Title	Definition
		services should have the opportunity to provide feedback on their experience.
GBO	Goal Based Outcomes	The goal-based outcomes (GBO) tool is a simple and effective method to measure progress and outcomes of an intervention. It grew out of work with children, young people and their families in mental health and emotional well-being settings but can be used in any setting, that is change-focused and goal-oriented – including adult and physical health contexts. The tool tracks what is arguably the most important thing to measure in any intervention: “Is this helping you make progress towards the things that you really want help with?”
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.
LCCG	Leeds Clinical Commissioning Group	CCGs are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. NHS Leeds CCG is made up of 97 GP practices and covers a population of around 870,000 people. Leeds CCG work with a range of partners, including LYPFT, to help meet their objectives as well as supporting the work on the Joint Health and Wellbeing Strategy for Leeds.
LCG	Leeds Care Group	One of the Care Groups (groupings of services) within the Leeds & York Partnership Foundation Trust.
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

Acronym	Full Title	Definition
		those deaths, and take forward the learning into service improvement initiatives.
LGI	Leeds General Infirmary	Leeds General Infirmary, also known as the LGI, is a large teaching hospital based in the centre of Leeds, West Yorkshire, England, and is part of the Leeds Teaching Hospitals NHS Trust.
LOS	Length of Stay	Length of stay is a whole number which is calculated as the difference between the admission and discharge dates for the provider spell.
LTHT	Leeds Teaching Hospital Trust	Leeds Teaching Hospitals NHS Trust is an NHS trust in Leeds, West Yorkshire, England.
LYPFT	Leeds & York Partnership Foundation Trust	Leeds and York Partnership NHS Foundation Trust provides mental health and learning disability services across Leeds and York.
MDT	Multi-Disciplinary Team	A multidisciplinary team is a group of health care workers who are members of different disciplines (professions e.g. Psychiatrists, Social Workers, nurses, physio or occupational therapists), each providing specific services to the patient .
MH	Mental Health	A person's condition with regard to their psychological and emotional well-being.
MHA	Mental Health Act	The Mental Health Act 1983 is an Act of the Parliament of the United Kingdom which applies to people in England and Wales. It covers the reception, care and treatment of mentally disordered persons, the management of their property and other related matters.
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.
MRSA	Methicillin-resistant Staphylococcus aureus	MRSA is a type of bacteria that's resistant to several widely used antibiotics. This means infections with MRSA can be harder to treat than other bacterial infections.
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.

Acronym	Full Title	Definition
OAP	Out of Area Placements	Out of area placements refers to a person admitted to a unit outside their usual local services.
PALS	Patient Advice and Liaison Service	Provides a confidential and free service to guide service users/visitors/carers/relatives on the different services available at the Trust
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.
SNOMED CT	Systematized Nomenclature of Medicine -- Clinical Terms	An international clinical terminology for use in electronic patient records.
SOF	Single Oversight Framework	A framework from NHS Improvement to oversees NHS trusts and NHS foundation trusts
SPA	Single Point of Access	Single Point of Access offers mental health triage for routine, urgent and emergency referrals, information and advice 24 hours a day, 7 days a week, and 365 days per year.
SS&LD	Specialist Services and Learning Disabilities Care Group	One of the Care Groups (groupings of services) within the Leeds & York Partnership Foundation Trust.
Tier 4 CAMHS	Tier 4 Child Adolescent Mental Health Service-	Child and Adolescent Mental Health (CAMH) Tier 4 Children's Services deliver specialist in-patient and day-patient care to children who are suffering from severe and/or complex mental health conditions that cannot be adequately treated by community CAMH Services.
TOC	Triangle of care	The 'Triangle of Care' is a working collaboration, or "therapeutic alliance" between the service user, professional and carer that promotes safety, supports recovery and sustains well-being principles.

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
13

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Financial Officer Report - Month 6
DATE OF MEETING:	29 October 2020
PRESENTED BY:	Dawn Hanwell, Chief Financial Officer and Deputy Chief Executive
PREPARED BY:	David Brewin, Assistant Director of Finance

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

EXECUTIVE SUMMARY

This report provides an overview of the financial performance of the Trust at month 06. The Trust continues to operate in the month 1-6 interim financial framework.

There are no material issues of concern.

Separate work to develop a financial plan for month 7 to 12 has been underway and is considered in a separate report.

Further work is underway to begin financial planning for 21/22 recognising the complexity of the on-going pandemic and the uncertainty of the financial framework which will be in place.

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

RECOMMENDATION

The Board of Directors is asked to:

- Note the cumulative financial position at month 6, which is balanced in accordance with the interim financial regime. (the report has been reviewed in full by the Finance and Performance Committee)

BOARD OF DIRECTORS
29 OCTOBER 2020
CHIEF FINANCIAL OFFICER REPORT - MONTH 6

1 Introduction

This report provides an update on the financial position at month 6, operating within the interim financial framework. From month 7 a new framework will be in place and a full financial plan for months 7 to 12 is required. This will considered in a separate report in part 2.

2 Month 6 2020/21 Income & Expenditure Performance

In line with the interim framework the reported income and expenditure position at month 6 is balanced. Table 1 below shows that cumulatively £5.99m retrospective total top up income has been required to achieve this position. At this point NHSEI have paid the top up payments for month 1 to month 4. We have now received notification that a previously withheld top up payment will be paid in October. This related to a significant error in national calculation of public dividend capital payment, not any queries regarding the reasonableness of Covid-19 costs which have all been accepted.

Table 1

Income & Expenditure Position	In month						Cumulative
	Month 1 £000's	Month 2 £000's	Month 3 £000's	Month 4 £000's	Month 5 £000's	Month 6 £000's	£000's
COVID-19 Costs	(747)	(1,002)	(906)	(1,004)	(809)	(933)	(5,401)
Hosted services actual deficit	(307)	(88)	(63)	(19)	(65)	168	(374)
Core surplus	312	(82)	63	(90)	(44)	(372)	(213)
Sub total deficit pre top up	**(742)**	**(1,173)**	**(906)**	**(1,113)**	**(919)**	**(1,137)**	**(5,989)**
Top up	742	1,173	906	1,113	919	1,137	5,989
Reported Balanced I&E Position	**0**	**(0)**	**0**	**0**	**0**	**0**	**(0)**

The key points to note are:

- The overall total top-up in month 6 was slightly higher than month 5, mainly reflecting the back dated medical pay award. The additional/incremental costs associated with the Trust's response to COVID-19 are shown in appendix 1.
- Due to the various cohorting and isolation requirements in inpatient settings there has been a significant impact on out of area placements (OAPs). The use of OAPs continues to be higher than our agreed pre Covid-19 trajectory.
- The Trust operates commercial income generating activities which have made cumulative losses of £347k in the first 6 months. The most significant impact has been a reduction in

salary sacrifice income related to lease car agreements (North of England Commercial Procurement Collaborative). However in month 6, a marked improvement was reported.

3 Capital Expenditure

Year to date capital expenditure is reported as £5.9m (inclusive of £0.7m COVID-19 related capital spend). This position is £2.0m below plan at month 6 largely due to timing of staged payments in relation to the CAMHS new build construction and the delayed implementation of Care Director (our electronic patient record). An analysis of spend against schemes is attached at appendix 2

As our wider strategic estates planning has been interrupted by COVID-19, we have undertaken a reforecast of deliverable capital schemes in year. There will be a strategic session planned with the Board to consider the reset of our estates planning based on impact, consequences and learning from COVID-19. Our revised forecast reflects our priorities in the year, which means we are likely to underspend our plans by c£2m.

4 Conclusion

The Trust continued to operate within the current interim financial framework and report a balanced income and expenditure position at month 6. Our run rate is broadly in line with our previous assumptions. This framework delivers financial balance at organisational level assuming reasonable COVID-19 costs are incurred. Excluding specific COVID-19 related cost the Trust would have been in a net deficit position, however this is not representative of our underlying position as the pandemic has clearly impacted all aspects of the Trust operations.

This regime is changing for month 7-12 which requires full prospective planning for the remainder of the year. The plan for months 7-12 is considered in a separate report. Over and above this we are also now beginning to assess what financial planning work is needed to develop our plans into 21/22 financial year, which will continue to be complex and impact by ongoing events. There is no clear indication at this stage what the financial regime will be but it is likely to be some form of variation on the current year and the role of the Integrate Care System (ICS) within this remains a key consideration.

5 Recommendation

The Board of Directors is asked to:

- Note the cumulative financial position which has been considered at the Finance and Performance Committee

Dawn Hanwell
Chief Financial Officer and Deputy Chief Executive
22 October 2020

Appendix 1

Underlying Financial Position:	**Month 6**
	£000's
Reported deficit (pre top up)	**(5,989)**
Less: COVID-19	
Additional clinical shifts	(519)
Staffing - additional hours & overtime	(1,278)
Sub total COVID Pay	**(1,797)**
Additional out of area capacity	(1,885)
Taxis	(235)
Additional meals for staff	(262)
Medical Equipment	(149)
Uniforms	(136)
Care Homes 1:1s	(222)
PPE	(57)
Mobile phone costs & remote working	(28)
Additional store at Roseville Road	(127)
Clinical waste bins etc	(73)
Additional cleaning hours	(121)
Other general supplies	(292)
Other equipment	(18)
Sub total COVID Non Pay	**(3,604)**
Sub total COVID Pay and Non Pay	**(5,401)**
Surplus / (Deficit) excluding COVID	**(588)**

Comprising:	
Hosted Services actual deficit	(374)
Core Deficit	(213)
Surplus / (Deficit) excluding COVID	**(588)**

Appendix 2

CAPITAL PROGRAMME - at 30 September 2020	Year to Date		
	YTD Plan £'000	Actual Spend £'000	YTD Variance £'000
Estates Operational			
Health & Safety / Fire/Sustainability / Backlog	175		(175)
Estate vehicles/other fleet	25		(25)
Newsam Unit Door locks	60		(60)
Sub-Total	**260**	**0**	**(260)**
IT/Telecomms Operational			
PC Replacement Programme	90	70	(20)
IT Network Infrastructure	180	20	(160)
Additional Server/Storage	15		(15)
Sub-Total	**285**	**91**	**(194)**
Estates Strategic Developments			
CAMHs Unit Construction	4,784	4,072	(712)
CAMHs Unit Construction and Enabling works	115	117	2
St Marys Hospital upgrades	520	238	(282)
York Estate development	60	18	(42)
Estates Technology	25		(25)
Locked rehab development	200		(200)
Sub-Total	**5,704**	**4,444**	**(1,260)**
IT Strategic Developments			
Integration System	50	32	(18)
Replacement EPR	735	515	(220)
EPR developments	20		(20)
Smartphones	20	42	22
Remote access & agile working	8		(8)
Sub-Total	**833**	**588**	**(245)**
Contingency Schemes			
Contingency	95		(95)
Electronic document management		63	63
Medicines Optimisation Team		7	7
Woodland Square 5		13	13
Woodland Square 3		10	10
South Wing Treatment Room		1	1
2019/20 Completed Schemes		(36)	(36)
Sub-Total	**95**	**59**	**(36)**
Total (excluding COVID-19)	**7,177**	**5,181**	**(1,996)**

Capital Programme Summary	YTD Plan £'000	Actual Spend £'000	YTD Variance £'000
Estates Operational	260	0	(260)
IT/Telecomms Operational	285	91	(194)
Estates Strategic Developments	5,704	4,444	(1,260)
IT Strategic Developments	833	588	(245)
Contingency Schemes	95	59	(36)
Sub Total (excluding COVID-19)	**7,177**	**5,181**	**(1,996)**
COVID-19	**659**	**675**	**16**
Total including COVID-19	**7,836**	**5,856**	**(1,980)**

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:	Quality Report and Account 2019 - 2020
DATE OF MEETING:	29 October 2020
PRESENTED BY: (name and title)	Cathy Woffendin, Director of Nursing, Professions and Quality
PREPARED BY: (name and title)	Sam Marshall, Legal Services and Complaints Lead

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

EXECUTIVE SUMMARY

The Board of Directors are requested to approve the final version of the Quality Report and Account 2019/20.

The document has been produced in consultation with services, staff, patients and carers, Trust governors and stakeholders. It has been updated to in response to feedback from:

- Trustwide Clinical Governance and Quality Committee meetings
- final review by all contributors and executive leads
- a 30 day consultation with stakeholders

The timescale for the completion of the 2019/20 Quality Report & Accounts was amended as a result of the COVID-19 pandemic, with the deadline for online publication and submission to the Secretary of State extended beyond the 30 June 2020. NHS England and Improvement recommended that Trusts should aim to provide draft accounts to stakeholders by the 15 October 2020 and finalise these for publication by 15 December 2020. We have progressed the report in order to ensure publication by this date. The report has been approved by the Quality Committee and Audit Committee.

Assurance work on quality accounts and quality reports also ceased as a result of COVID-19, with no limited assurance opinions expected to be issued in 2019/20. We have maintained contact with our auditors on this matter and will provide them with a copy of the final report for their information.

It should be noted that these amendments only concern Quality Accounts relating to the reporting period ending on 31 March 2020 and they are not expected to apply indefinitely.

This final document will be used to produce an accessible version available through our website. The communications team are supporting this production and will aid with the social media promotion including an animation. A "bite size" version will also be developed to ensure that the report reaches all possible audiences.

Following Board of Director approval, the document will be submitted to NHS Improvement and NHS Choices in accordance with due process.

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 requested to:

- receive assurance on the production of the Quality Report and Account for 2019/20
- approve the content of the final draft document

NHS
Leeds and York Partnership
NHS Foundation Trust

Quality Report and Account

2019 - 2020




integrity | simplicity | caring

Quality Report & Account Contents

Introduction – who we are

We are Leeds and York Partnership Foundation NHS Trust – we provide specialist mental health and learning disability services to the people of Leeds and York as well as regionally and nationally.

Our vision is to provide outstanding mental health and learning disability services as an employer of choice. This means supporting our service users and carers, our staff and the communities we serve to live healthy and fulfilling lives where we can all achieve our personal and professional goals, and live free from stigma and discrimination.

We are an NHS foundation trust. This means:

- **we have some freedoms to decide locally how to meet our requirements**
- **we are accountable to the people within our communities, who can become members and governors**
- **we are authorised and monitored by NHS Improvement, who support us and hold us to account**

We offer services to people who need support and treatment for a wide range of mental health conditions, from depression, anxiety and obsessive compulsive disorder, to dementia, bipolar disorder, schizophrenia and personality disorders.

We support people living with issues such as addictions, eating disorders, or physical problems with psychological causes, and those needing the support of our gender identity service.

We offer community, supported living and inpatient care to people with a learning disability, who can present to us with challenging behaviour or complex physical health needs. We offer services across the region, and in a variety of locations, including inpatient children's services in York, deaf children's services across northern England, and secure services for Leeds and York.

The majority of our care is provided in, or close to, people's own homes, with the need for people to stay in hospital kept to a minimum.

Here's a summary of our services, you can visit our website for more details about these at https://www.leedsandyorkpft.nhs.uk/:

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Forensic inpatient/secure wards
- Child and adolescent mental health wards
- Wards for older people with mental health problems.
- Wards for people with learning disability or autism
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for older people
- Specialist Deaf Community-based mental health services for children and young people
- Community mental health services for people with learning disability or autism

- Specialist Core Service - National Centre for Psychological Medicine

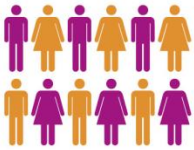
The Trust also provides one adult social care service which is the Supported Living Service.

Living our values to improve health and lives

Our values are integrity, simplicity, caring. They are integral to how we go about our business. The way we behave and interact with one another is central to living our values and we have to continue to challenge ourselves to demonstrate these in all that we do.

Our Trust in numbers

our people



2,841
staff

457
bank staff

73
consultant psychiatrists

630
health support workers

768
qualified nursing and midwifery staff

80
psychologists

166
allied health professionals

719
admin or non-clinical staff

140
volunteers donating
25,480
hours of their time

137
members of our Workforce Race Equality Network (WREN)

30
members of our Disability and Wellbeing Network (DaWN)

300+
staff attended diversity and inclusion development days in 2019

our services

53

the number of sites we operate from

3

clinics opened to support people affected by gambling addiction

Good

our overall CQC rating

2%

increase in the number of compliments we received in 2019/20 in comparison to the year before

81%

of staff feel satisfied with the quality of care they deliver

85%

of staff feel their role makes a difference to service users

400

people enrolled to attend courses at our Recovery College in its first two terms

Our Trust online

16,780

the average number of visitors to our website each month

2,757

people liked our Facebook page by the end of March 2020

760

the number of new followers we gained on Twitter between April 2019 and March 2020

SECTION 1 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

As I write my introduction for this year's Quality Report and Account 2019/2020, I do so at a time like no other. NHS organisations like ours have never before faced a challenge like the current Coronavirus pandemic and I'd like to take this opportunity to pay tribute to the work undertaken by our staff and the values they've shown during this unprecedented time. But first of all, it's important to reflect on some of our progress and achievements from over the past year before our lives, personally and professionally, changed before our eyes.

This document shares with you a range of data, information and stories to assure you about the quality of our services. This report also provides statements of assurance on the quality of services and describes some of the quality improvements and developments we have made during 2019/20. It reviews the Quality Improvement Priorities (QIPs) we made a commitment to in 2019/20; and reports on the positive progress against those to date. We have also set out the quality priorities we have identified for the forthcoming year (2020/21), how these have been developed and how we will measure and report on them going forward.

This year's report has been co-produced using service user and carer feedback and engagement; in consultation with our staff and Clinical Care Services; and using lots of intelligence available to us through our electronic systems, reports and governance meetings. Many of the stories regarding the development and quality improvement of our services have been written by service leads; and those who work hard to ensure we provide the best possible service to our service users and those that care for them.

Making improvements

There's been a range of service developments over the past year, both within the Trust and with our partners. In September, we opened our first Northern Gambling Clinic in Leeds, followed shortly by more in Manchester and Sunderland. This is such a crucial service and I'm pleased we're able to support the growing number of people struggling with gambling addiction across the North.

Much has also been achieved to help people across the city access immediate support for their mental health. For example, the Leeds Recovery College, which opened in September, offers courses to people living and working in Leeds to help them live mentally and physically well. The Leeds Mental Wellbeing Service is a partnership involving our Trust that offers psychological therapies, both face to face and online. It's another way we're supporting local people to overcome common mental health problems.

We received an early Christmas present when planning was approved for the new regional CAMHS unit on our St Mary's Hospital site. The West Yorkshire and Harrogate collaborative have been working closely together to develop a better way of providing care for young people with complex mental health issues across the region, and planning approval marks an important milestone in our efforts. I'm pleased to say that as I write this, work has already begun onsite.

In March, we switched to a new patient record system, CareDirector, an event that was two years in the making. It was a challenging time for staff to move to something so new and different but their resilience and determination shone through and I'm happy to say it was a safe and secure launch. CareDirector has been an important tool in our fight against Coronavirus, and its flexibility means it can be developed to suit our needs now and in the future.

Listening and responding

I'm so pleased we were able to include our bank staff in this year's Staff Survey– this reflects the crucial role they play in our teams. Our Trustwide results have improved or stayed the same in most areas, with significant improvements in how we rate our line managers and staff morale.

We've made extra efforts to listen to our staff this year, in the form of 'culture conversations'. There are some fantastic examples of positive culture across the organisation, and there's also ways we can improve how we work together, which in turn shapes our quality of care and performance. Both online and face to face conversations have taken place to understand how our staff feel about coming to work for us every day, and we're now analysing those conversations to give us a focus for improvement. I'm really invested in this piece of work, and I'm excited to see it come to fruition over the next year.

Listening and having conversations is just as important outside our organisation, with our members, service users, carers and the public – after all, these are the people we serve. I'm pleased that we have recently launched our co-produced Patient and Carer Experience Strategy, which sets out how we will better involve people in the development of our services and improve their experience with us. We also carried out surveys and focus groups to evaluate our redesigned Community Mental Health Services, to ensure our service users and carers remain at the heart of our decision making.

Celebrating our achievements

In November came our annual Trust Awards, a glittering event and one of my favourite nights of the year, where I help to present awards and celebrate with our staff and volunteers. Beyond our internal celebrations, some of our teams and individuals have gone on to be nominated for and even win national awards. There are too many amazing people to mention here, but what I will say is how proud I am of all their achievements and I'm so pleased that they are recognised by their peers externally too. On the night I was also very pleased to see the launch of our Trust choir who provided us with an uplifting start to the event. They continue to come together and provide inspiration to us all.

The Trust as a whole received its own accolade in December, when we received a rating of "Good" by the Care Quality Commission. All of us remember the feeling of waiting for exam results, hoping your efforts have paid off. For me, those feelings returned while we're awaiting our CQC report, and I am delighted that the hard work undertaken by everyone at the Trust has been recognised. The CQC's report says we really are fulfilling our purpose of improving the health and lives of people with mental health problems, learning disabilities and autism. And after all, that's why we all come to work every day.

Unprecedented times

The Coronavirus pandemic has proved to be the biggest healthcare crisis in a generation. As events began to unfold, the future felt daunting for many of us. But in such challenging times I found strength in our staff, and their courage and determination to continuing caring for our service users.

The crisis has affected all of us, personally and professionally. We've had to change how we support our service users, how we work together and how we balance our work and lives.

Throughout all this change and uncertainty, I'm incredibly proud of our staff and I can't thank them enough for what they do. They've lived our values in the most difficult of situations – we have integrity, we keep it simple, we are caring – and they've shown many more too, like determination, bravery, flexibility, resilience, and compassion. They've supported each other through overwhelming circumstances and remained committed to our service users despite having their own families and loves ones to care for. I consider myself lucky to lead an organisation that is full of such heroic individuals.

As we look to the year ahead, I hope for peace and stability for our staff and service users. It's likely that current events will further highlight the importance of mental health services, and as a Trust we're committed to continuing to develop and improve our mental health and learning disability services for the people who need us.

I am happy to state that, to the best of my knowledge, the information included in our Quality Report is accurate. We very much hope you enjoy reading about the progress we have made over the last year; and our plans for 2020/21.

Dr Sara Munro
Chief Executive

What is a Quality Account?

Once a year, every NHS Trust is required to produce and publish a Quality Account Report. The report is a look back over the year to show how we have improved the quality of our services, a look forward at what our plans are for the coming year and an explanation of who we are.

This Quality Account is for service users, carers and members of the public. The aim is to make sure that everyone who would like to know about our services can access this information.

What's included?

The core elements of a Quality Account are:

- How we performed last year (2019-20), both through our prioritised activities and through other quality improvement work.
- The information we are required by law to provide – this is reported in a very strict way so that we can be compared to other NHS Trusts.
- What we plan to do next year (2020-21), why we have chosen these priorities, and how we will go about doing that.
- Stakeholder and external assurance statements including statements from Healthwatch, Scrutiny Board and our commissioners.

Understanding the Quality Account Report

We know that this may be the first time you have looked at a Quality Account and we want to make this an interesting and easy to understand experience, as we know not everybody has experience of healthcare services.

To aid this process we have used coloured boxes throughout this document, to provide explanations and examples for key terms you may not be familiar with. We have also included a list of acronyms (abbreviations) at the end of the report.

This is a "What is it?" box
These explain a term or abbreviation

This is a "Quotes from staff, service users, carers' and others box
These support and illustrate the information in the report

This is a "Comments" box
These include quotes from regulators and other governing bodies

Statement of Directors' responsibilities in respect of the Quality Report and Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health issues guidance on the format and content of Quality Accounts, which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010, as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011.

NHS Improvement (NHSI) has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report and Account, directors are required to take steps to satisfy themselves that:

- The content of the report meets the requirements set out in the NHS foundation Trust annual reporting manual 2018/19 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2019 to May 2020
  - Papers relating to quality reported to the board over the period April 2019 to date
  - Feedback from commissioners received in September 2020
  - Feedback from governors received through consultation
  - Feedback from the local Healthwatch received September 2020

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report and Account.

By order of the Board

.....**Date** .....**.Chair**

SECTION 2

Trust Strategies in relation to Quality

Within our Quality Report and Account 2018/19 we introduced a number of new strategies and this year we would like to update you on the progress we have made in respect of these.

We have a set of strategies that define how we want to develop our services and workforce over the next 5 years. In 2016 our staff, service users, members and partners were invited to re-imagine our future and refresh our five year strategy as part of the Your Voice Counts campaign. Our strategy on a page sets this out in a simple way:

Our five year strategy for 2018 to 2023

Our purpose	Our vision	Our ambition
Improving health, improving lives	To provide outstanding mental health and learning disability services as an employer of choice.	We support our service users and carers, our staff and the communities we serve to live healthy and fulfilling lives. We want to achieve our personal and professional goals; to live our lives free from stigma and discrimination; and to improve the lives of people with a learning disability and mental ill health.

Our values		
We have integrity We treat everyone with respect and dignity, honour our commitments and do our best for our service users and colleagues.	**We keep it simple** We make it easy for the communities we serve and the people who work here to achieve their goals.	**We are caring** We always show empathy and support those in need.

Our strategic objectives and priorities		
1. We deliver great care that is high quality and improves lives.	2. We provide a rewarding and supportive place to work.	3. We use our resources to deliver effective and sustainable services.

Update on our Quality Strategic Plan 2018 - 2021

The Trust wide Quality Strategic Plan was approved by the Board in February 2018 and draws on the White Paper from the Institute for Healthcare Improvement (IHI) called *'A Framework for Safe, Reliable and Effective Care'* January 2017.

There has been a lot of activity over the last 12 months, specifically this update focuses on the partnership work with the Institute for Healthcare Improvement (IHI) and associated activities.

Our approach

Our approach to quality improvement continues to develop as our understanding deepens and the challenges and tensions across the organisation are identified. It needs to help people take ownership of quality, yet bring it together for the entire organisation. It must take the best international evidence, yet build on local experience of our service users, carers and staff. It must acknowledge the many ways we can see and improve quality, yet provide a systematic and integrated whole. It must see quality as what happens in the care of those who use our services, yet acknowledge the contribution of all our staff. It is experienced at the frontline, yet led from every level, including the top.

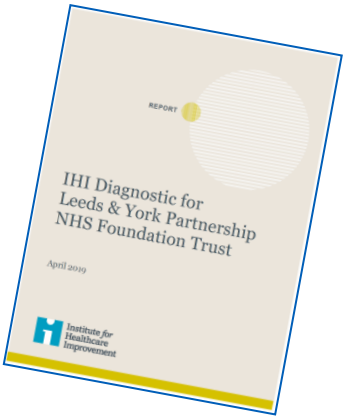
To help us to further align quality with the needs of the organisation, we embarked on a partnership with the IHI in 2019.

Partnership with the IHI

Working in collaboration with the IHI, we commissioned them to facilitate a diagnostic site visit using the IHI Framework for Safe, Reliable and Effective Care. IHI utilises the framework as a lens to understand the Trust's current system-wide priorities, strategies and initiatives, its quality, safety and clinical excellence capabilities, and leadership's current role.

The overall objective of the diagnostic was to understand the gap between where we are and where we want to be, bringing focus to the strategic direction of the organisation including leadership, joy in work (burnout prevention) for staff, current assets and any existing barriers to improvement and learning.

Following the Site Visit, the IHI produced a written executive summary report of the visit that provided a review of the team's findings and recommendations on how to close the gap between where the Trust is with respect to quality improvement and where it wants to be in both the short and long term. This report has been shared will all staff



The report used the IHI Framework for Safe, Reliable and Effective Care to give structure to the document, with each component having its own section that covered what the Diagnostic Team observed during their visit and some foundational recommendations.

We are now part of a Global Learning Network with partners that include Children's Hospital of Philadelphia, Institute of Healthcare Improvement, Ochsner Medical Centre - Louisiana and St George's Hospital – London. This is to help further understand and develop the framework, in an action focused way

The forthcoming year will see us continue to build on the work already undertaken in response to these recommendations and to start to embed the elements of the framework for Safe, Reliable and Effective Care within the culture of the organisation.

* Adapted by Leeds and York Partnership NHS Foundation Trust, from the Institute for Healthcare Improvement White Paper 'A Framework for Safe, Reliable and Effective Care' January 2017

Update on our Medical Strategy

The Trust has developed a plan for a medical strategy and an event was undertaken to ensure there is a collaborative production of the strategy in line with our model of collective leadership. This work was been halted by the COVID-19 pandemic but will be resumed and reported on in greater detail in the Quality Report 2020/21.

Update on our Nursing Strategy 2018-2021

The nursing workforce has continued to demonstrate a commitment to improving the experience of nursing within our organisation as **an Employer of Choice**, as well as supporting patients to have quality outcomes.

We have actively recruited second year nursing students who have studied with us and following two events where we engaged with a cohort of 74 students, over 86% of students favoured employment with us.

We promised to embed systems to support nursing development throughout the career pathway and have successfully supported non registered staff onto Nursing Associate (NA) training. We have 12 NA's in training and for the first time two of our staff have already successfully completed the course and registered with the Nursing and Midwifery council (NMC). Additionally, one of the successful registrants is now undertaking Registered Nurse training.

In the summer of 2019, Health Education England announced increased support for Learning Disability nurse training. Two staff members are being supported through a two year training route in Learning Disability nursing and there is potential for a further four to engage in a two year Trainee Nursing Associate (TNA) programme, followed by a two year LD nursing course.

To support our nurses mid-career we have introduced career conversations and a transfer process. Both of these processes are designed to support nurses in gaining a range of experiences within the organisation to enable fulfilling and rewarding careers.

For senior clinical roles we are seeing an increase in applications to become non-medical prescribers and we are working to ensure there is a clear strategy in place that supports this important role to deliver better outcomes for our patients. We are proud to welcome our first non-medical Responsible Clinician in the Women's Service and aspire to develop and further embed these new roles across all clinical areas. We will introduce a structure within our Senior Nurse forums to monitor and deliver on this work.

The health and safety of our patients is important to us. We strive to provide care that is positive and safe and as such are working hard towards an improved culture of collaboration in all our services. This promotes reflection and learning in order to reduce the need to use restrictive practice to manage challenging situations.

Our Physical Health Team delivers training across our services to refresh and develop nurses' core physical health monitoring skills. This has been an area of focus as we know our patient population requires support with their physical health too. Examples include: prescribing of nicotine replacement therapy, the management of diabetes and the delivery of brief advice for healthy lifestyle changes.

We are engaging people to offer feedback of their experience of our services as a priority area and are working with teams to develop patient reported experience measures, appropriate for the service users and care setting to enable results to be easily used in service developments.

Update on our Allied Health Professional Strategy

Our Allied Health Professional (AHP) Strategy for 2018-2021 was developed by engaging with our AHPs and connecting with the national AHP strategy *'AHPs into Action'.* Clear priorities emerged from this work and we were successful in achieving our year 1 action plan during 2019 and highlights of this included:

- Successfully starting an Occupational Therapy rotation across health and social services in Leeds.
- Ensuring cover arrangements are established so that nursing teams can know how to access an AHP.
- Promoting a food first approach, with supporting videos being accessible to all staff via the eLearning training platform.
- Safety huddles established in key areas reducing the impact of falls.

Another priority was to ensure that the potential of AHP's is better understood. This was achieved through a number of events both within the organisation and by joining up with partners in the city. There were several events where AHP's came together to share best practice and develop ideas to innovate and minimise duplication. We plan to build upon those achievements and events further in the next 12 months by working across providers in Leeds and West Yorkshire. So far plans include providing a joint Physiotherapy rotation with Leeds Teaching Hospital Trust and being the Lead Provider testing an AHP faculty, this will improve AHP workforce supply.

We will also continue to build upon AHP's skills by developing competency frameworks for staff, support co-production initiatives and provide leadership development.

Pictured from left to right:
Lead Clinician (Learning Disabilities), Lyndsey Charles
Strategic AHP Lead, Marie-Clare Trevett
AHP Lead Specialist and Learning Disabilities Services, Jennifer McIntosh
AHP Lead Leeds Care group and Healthy Living Service Manager, Claire Paul
Not Pictured: Sarah Hickey AHP Lead

Update on our Psychological Professions Strategy

Our Psychological Professions Strategy is now in draft and is in the process of consultation with a variety of stakeholders. Our contribution to the ambition of providing outstanding specialist mental health and learning disability services can only be met if we embrace both our ability to deliver therapies in accordance with NICE guidance and also provide clinical and systems leadership to support a culture of evaluation and learning.

The high level objectives of the Psychological Professions Strategy are:

- All service user and carer contact across the organisation is psychologically informed.
- All psychological practice is safe, caring and compassionate, effective, cost-effective and well led.
- To focus on workforce development to ensure the sustainability of our skilled and knowledgeable staff.
- To identify and pursue strategic growth, research and innovation opportunities.

Some key priorities include:

- Development of the Multi-professional Psychological Care and Interventions Group, and a framework to support the co-ordination of training and governance of psychological therapies.
- Development of a more comprehensive offer of psychologically informed groups.
- Development of an action plan to improve access and reduce' drop out' rates of Minority ethnic group service users.
- Development of a consistent process for the co-ordination of training of Psychotherapists.
- Development of career pathways across clinical and nonclinical domains at all levels of the organisation, including Clinical Associates in Psychology (CAPs) and Multidisciplinary Approved Clinicians.
- To maintain high levels of engagement with the R&D department.

'Psychological care is everyone's business'

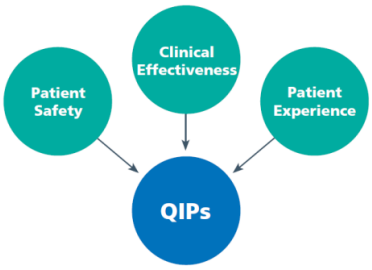
Sharon Prince,
Strategic Lead for Psychology & Psychotherapy
(pictured right)

Review of our Quality Improvement Priorities (QIPs) 2019/20

For 2019/20 we committed to a set of QIPs developed in consultation with our services and leadership, which we committed to reviewing as part of our requirements for this report. Progress against these have been monitored over the year and reported on a quarterly basis to the Trust Wide Clinical Governance Group (TWCG) and at 6 monthly stages to our Quality Committee. This section details the progress made against each of the QIPs.

We have made significant improvements over the last 12 months to bring together knowledge and data we have in the Trust to use it to inform better care.

We have been pulling together data across our teams, identifying themes that help us concentrate on the right areas of concern.



We will not be 'retiring' any of the 2019/20 priorities where they are still in progress. We will continue to monitor those priorities through the forums described within this section, to ensure they remain on track against the proposed completion dates.

The following 2019/20 QIPS remain a priority for us and will continue in a new way within the QIPs for 2020/21:

- Suicide Prevention Plan; development of a Trust approach
- Safety Planning across the Care Services
- Positive & Safe Group actions and impact
- Always Events
- Triangle of Care

You can read more about how these have been refreshed within Section 4.

In the rest of this section you will see the QIPs we developed for 2019/20, the progress made against them and a summary on how we achieved the required outcome.

Name of Priority: Process improvement of Complaints and Claims including triangulation of themes

Projected QIP 2019/20	Time frame	Progress achieved
High quality, timely response to concerns and complaints, handled as agreed with the complainant Triangulation of themes and learning from feedback, Complaints, concerns, PALS, SIs and Incidents, Inquests and Claims; and sharing of learning	**April 2020**	**Achieved**

A review of the complaints process was completed and quality improvements were made including streamlining the triage of complaints with the PALS team now undertaking this function.

Complaints training has been developed and is included as part of the "investigation" training.

Data and assurance reports have been combined to include Incidents, PALS, complaints, concerns, compliments, inquests and claims and the team are continuing to improve how data is communicated and analysed.

The impact of this priority has ensured that our complainants are provided with various options to resolve their concerns in line with their wishes, receive timely updates in relation to the investigation of their concerns and that an effective relationship is established between the complainant and the complaints team. Improvements made to reporting have provided a more rounded lens of looking at complaints data and triangulating this with incident data.

Name of Priority: Patient Experience; Patient and Carer Feedback and Involvement

Projected QIP 2019/20	Time frame	Progress achieved
Implement actions arising from the outcome of the review of the Patient Experience Service, as appropriate	**April 2020**	**Achieved**

In 2018 we asked Professor Mark Gamsu to review the way we went about Patient Experience. In 2019 we started putting the findings into action.

The Patient Experience and Involvement team are making progress in ensuring that we have the systems and structures in place that allow a fully inclusive approach to patient, carer and public engagement and involvement. These improvements were identified as part of our Patient Experience Service review, led by Professor Mark Gamsu, a professor at Leeds Beckett University focussing on outward facing work supporting local health systems strengthen their relationship with the public and the voluntary sector.

The team are moving away from the centrally based service which was routinely identified as being responsible and accountable for patient experience and involvement. The inclusive approach promoted by the team is driving the ethos that patient experience and involvement is everybody's business.

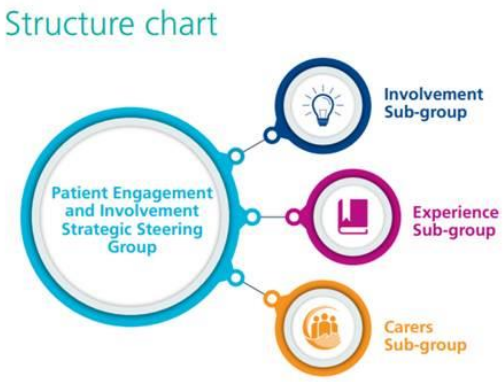
Led by the Patient Experience and Involvement Strategic Steering Group, which is chaired by our Director of Nursing, Quality and Professions, priority areas of focus have been agreed for each of the strategic subgroups providing leadership and direction for experience, involvement and carers.

The priority areas are articulated through a newly developed coproduced Experience and Involvement Strategy which is supported by a fair and transparent Policy for the Payment and Reimbursement of Service Users, Patients, Carers and Members of the Public. In addition, to support people to choose the activities they wish to take part in, work is in progress to deliver a bespoke package of 'involvement ready training' alongside our partners such as the recovery college; to support people to be able to make a meaningful contribution in the way that they choose to be involved.

The team has also progressed work to make it easier for people to provide us with feedback. Each service will be supported by the PET coordinators to develop patient reported experience measures using consultation, collaboration or co-production approaches; appropriate for the service users and setting. The results will actively be used in service developments.

We are building better relationships with services and our partner providers across the city in recognition that there are already many effective groups running in the community. We have promised to work more closely with these groups to gather feedback and will ensure that we promote flexible working and no longer rely on people coming to us.

Patient Experience Sub Groups - Overarching Priorities



Involvement

- Develop an Involvement Ready Training package for service users, carers and volunteers
- Map out Involvement Opportunities for service users, carers and volunteers
- Develop a policy for the Payment and Reimbursement of Service users, Carers and Members of the Public

Carers

- Achieve Triangle of Care accreditation by September 2020 (Quality account priority)
- Producing a Carer Reported Experience Measure to be used by all services May 2020
- Increasing overall engagement of Carers

Experience

- Develop guiding principles that allow us to gather meaningful feedback in order to demonstrate improvements
- Develop a "You said, We are doing" style of reporting to share what we are doing as a result of collecting feedback
- Improving communication between services on all aspects of care to reduce repetition and ultimately inform better care.

Co-producing the Patient and Carer Experience and Involvement Strategy with our service users, carers, members of the public and partnership agencies, demonstrated LYPFT's commitment to listening and responding to the people who are cared for and supported by our services, in order to further improve and enhance their experiences. The Patient Experience Team will continue to support services to collect meaningful and up to date feedback which can be used to implement positive changes. We will share the learning from the feedback and publicise the changes we have implemented with your help.

The introduction of the Policy for the Payment and Reimbursement of Service Users, Patients, Carers and Members of the Public demonstrates a fair and equitable approach to reimbursement to those people who are involved in supporting activities aimed at improving the provision of services and service user and carer experience. It will ensure that those who are willing to become involved will understand what level of involvement payment or reimbursement fee they will receive before they decide to become involved; in addition to recognising the importance LYPFT places on those who give up their valuable time to improve the lives of others.

Patient and Carer experience is everyone's business.

Name of Priority: Triangle of Care Stage 2

Projected QIP 2019/20	Time frame	Progress achieved
Achievement of Triangle of Care: Stage 2 Submission	**September 2020**	**Achieved**

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.

All teams/services have submitted the Triangle of Care self-assessment forms (November 2019). These have been quality checked by a team of clinicians and carers.

Following quality checking, updated supportive action plans were returned to the teams in order to assist them in being able to satisfy the 6 standards of the Triangle of Care (Jan 2020): By March 2020 50% of teams had made improvements and changes to their services in order to work to achieve the 6 standards.

The six standards of the Triangle of Care are:

1. Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
2. Staff are 'carer aware' and trained in carer engagement strategies.
3. Policy and practice protocols regarding confidentiality and sharing information are in place.
4. Defined post(s) responsible for carers are in place.
5. A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.
6. A range of carer support services is available.

An audit of the self assessment forms was planned to be carried out by a group of carers in March 2020 to ensure that teams "were doing what they said they were doing". Unfortunately this plan did not go ahead in March due to the Covid-19 pandemic and the requirement for a number of staff to be redeployed to priority areas. However the PET team have continued to work with services where possible to maintain the progress already achieved and keep on track to reach 2nd stage accreditation of the Triangle of Care by September 2020.

LYPFT is committed to ensuring that our teams and services are working towards achieving the 6 standards of care in order to recognise and provide support for our carers, who provide valuable support to their loved ones. This work is being overseen by The Patient Experience Team who seek to promote positive attitudes, reduce barriers and ensure that our carer's voices are heard. Our carers have told us that they want to be kept involved and be kept updated with regards to assessments, care planning and transfers of care of their loved ones to other services. Therefore we have identified Carer Champions in all of our services who actively encourage partnership working in their teams, between the service user, carer and health professional.

A specific Learning Disability Carers Champion Group has been set up, which will ensure that the Triangle of Care standards are kept "live" within the learning disability services. In the future we would like to set up other specialised groups to provide distinct support to our carers who care for loved ones with specific needs.

Name of Priority: Improved Community Mental Health Services across Leeds

Projected QIP 2019/20	Time frame	Progress achieved
Community Service Redesign Evaluation plan: people's experiences of our redesigned community services they receive are positive	**April 2020**	**Achieved**

In 2018 we consulted with service users, staff and carers to redesign our community services to better meet the needs of the Leeds community

During October 2019 service users using the LYPFT Community Services were contacted & asked to participate by providing feedback. They could take part in a postal survey, online survey or focus group. There were responses from 390 service-users in total. Overall 78% of participants said they were either very/ mostly satisfied with the service. Six themes resulted from the feedback data. An overwhelming theme was that service-users welcomed the shift in working practices and being seen by clinicians at home or in their local area. Areas of improvement following thematic analysis included 'customer service'; timely and easy access to services (CMHT); care planning involving service-users and carers; consistency of staff (CRISS); and mental health interventions. This service user engagement exercise was received positively by the community services and the three services Older Peoples Services (OPS), Working Age Adult (WAA) & Crisis Resolution and Intensive Support Service (CRISS) intend to organise local service specific engagement events with service-users and carers in April 2020.

The following is an overview of the new services launched on the 25 March 2019:

Community Mental Health Service for Working Age Adults (WAA)

This service is designed to work with adults (usually aged 18-65) in two groups: those that require shorter time-limited services, and those with more complex needs that require longer term care. The service operates Monday to Friday, 9am to 5pm, with support from other services (described below) outside these hours. It offers home-based treatment for the majority of people where this is appropriate but there are also opportunities to receive services in other community locations.

Crisis Resolution and Intensive Support Service (CRISS)

This service operates 24 hours a day, 7 days a week, 365 days a year. It supports adults (usually aged 18-65) experiencing a mental health crisis with intensive home-based treatment as a genuine alternative to hospital admission. It will also support older people in crisis outside of normal working hours.

Community Mental Health Teams for Older People

This is a new dedicated service for people aged over 65. This service is run by three teams operating across Leeds offering home-based care to people who are experiencing mental health difficulties. They also work with people experiencing problems related to dementia if it has

already been diagnosed. Previously this work would have been done by our Memory Service so this is a change to previous arrangements.

Intensive Home Treatment Team (IHTT) for Older People

This new service assesses and cares for older people with more acute and complex problems related to their mental health or dementia. It provides intense support to help avoid hospital admission if that is what the person prefers. This means they will normally offer support where a person lives. The team will also help to support people when they are discharged from hospital.

Memory Assessment Service

The Memory Assessment Service continues to provide assessment, diagnosis and short-term treatment for older people experiencing early dementia. This service will focus on diagnosing memory problems. The majority of people will be seen in a clinic and some in their own home if required. Their aim is to see people within eight weeks from referral and make their diagnosis within 12 weeks of referral. The team will identify a person's needs and work with them and their family on what longer term treatment or support may be required, involving a person's GP and other health care providers.

Care Homes Service

Our new Care Homes Service supports people with mental health problems who live in care homes across Leeds. It will now be split into two teams.

Firstly, there will be a team working with people with longer term mental health needs, including people with dementia. This is to ensure these people receive the same level of service they could expect if they were living at home – where they would be under the care of a Community Mental Health Team for example.

Secondly, there will be an intensive care homes team who will work with people in the shorter term. Their focus will be helping people in care homes avoid hospital admission, and to support faster discharge from hospital back to care homes.

The Younger People with Dementia Team

This team has not changed and will continue to provide assessment, diagnosis and treatment for working age adults with dementia and their families.

Name of Priority: Patient Safety

Projected QIP 2019/20	Time frame	Progress achieved
Serious Incidents: Process improvement and Learning from Trust wide SI investigations	**April 2020**	**Achieved**

The membership of the Trust Incident Review Group has been reviewed and the Terms of Reference updated. An action template was developed and agreed with Clinical Governance collaboration and is now in use. A maturity matrix depicting Learning from deaths and working with bereaved families and carers has been developed with strong progress made across the actions.

Fact Find training has been rolled out across the Trust, with the Fact Find going live on DATIX in October 2019.

A Patient Safety Incident Learning event was held on 24th October. A number of workshops were provided on the day, demonstrating the work streams and learning as a result of patient safety incidents, more details are included within section 2.

The Clinical Effectiveness Team are monitoring the Trustwide Serious Incident Action plan which has ensured that an improved reporting of exceptions is now embedded. The Clinical Effectiveness Team produce a monthly report which is reviewed within the Care Group Governance Forums.

Changes to fluid balance/MEWS as a result of learning from Serious Incidents is one aspect of improvement for patient safety.

Name of Priority: Care Group Safety Planning

Projected QIP 2019/20	Time frame	Progress achieved
Safety Planning across the Care Services	**April 2020**	**Achieved**

Following completion of the pilot, safety planning went live within our Intensive Support Service (ISS) teams from October 2019 after a period of staff training. Staff have engaged in the use of the tool, embedding it well with evident areas of good practice. A staff focus group was held in January 2020 to gain feedback on the process so far.

A bespoke safety plan section that is easily visible and accessible has been created within CareDirector our forthcoming patient record system. New functionality with the system, including digital dictation, will support staff to record care plans more easily and in a timely manner.

The next set of services to implement the safety plan will be our Older Peoples Services, our Intensive Home Treatment Team and the female acute wards at the Becklin Centre and Aspire. These teams were all either involved in the pilot or are currently using some form of safety planning. The training package is currently being reviewed to include some of the learning points from use of the tool to date. This includes developing the initial training package for teams and identifying ways of developing best practice in partnership with the ISS teams already using the tool.

Name of Priority: Suicide Prevention Plan

Projected QIP 2019/20	Time frame	Progress achieved
Suicide Prevention Plan; development of a Trust approach	**2022**	**On track to be achieved**

The suicide prevention plan aims *'to implement within LYPFT a coordinated approach to suicide prevention that is co-produced with service users, carers, staff and partners from the current fragmented approach to an embedded and sustained culture by 2022'.*

This plan has been created in support of the organisation's vision to keep people safe so that they can save their own lives'.

The plan has been considered alongside the

- West Yorkshire and Harrogate Integrated Care System Suicide Prevention Strategy (2017-2022),
- Leeds Suicide Prevention Action Plan (2018-2021)
- Patient Safety Strategy (2019-2022).

Partnership working with local and ICS colleagues continues.

We're currently exploring how to involve service users and carers in the project with the Patient Experience Team and the Recovery College managers.

Safe and Effective Care and Treatment – this is progressing well and all services have agreed to use the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) self-assessment toolkit for safer services.

Learning and Development - The clinical risk training baseline assessment has been completed and presented at the Clinical Cabinet. The group are currently putting together an options appraisal.

Name of Priority: Always Events®

An Always Event is something that improves patient experience that should always happen. E.g. NHS staff introducing themselves to service users

Always Events® are *"those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the health care delivery system"* (NHS England).

Always Events is a quality improvement methodology which seeks to understand what really matters to patients, people who use services, their families and carers so that changes can be identified to improve experience of care. Genuine partnerships between patients, service users, care providers, and clinicians are the foundation for co-designing and implementing reliable solutions that transform care experiences with the goal being an "Always Experience."

Projected QIP 2019/20	Time frame (revised)	Progress achieved
Development of Always events with all services. Pilot Always Events within services and roll-out across all services to embed within the organisation and culture.	**2021 and ongoing**	**Not achieved; QIP revised and in progress**

Always Events National Programme

This year we joined the NHSI Always Events Programme and in addition to a one day workshop for some of our staff we also benefit from monthly phone calls with our cohort of other Trusts and from having a "buddy" from another Trust who have established Always Events, to help us through the process.

Always Events did not progress as well as anticipated in 2019/20 due to absence and vacancies within the new Patient Experience team. This lead to delays in the project in developing and implementing Always Events in partnership with our services. Interventions to support progress have been undertaken and we now have two new Patient Experience Co-ordinators within the team.

Always Events continue as a QIP for 2020/21 and details of the revised QIP can be found in Section 4. Furthermore a new oversight group has been set up to support progress of the QIP and ensure it remains on track.

Name of Priority: Mental Health Legislation

Projected QIP 2019/20	Time frame	Progress achieved
a) Reduction in document management issues identified by the monthly 10% audit of legislation officers caseloads b) Sample re-audit of assessments of capacity in relation to medication for mental disorder. c) Redesign of the MHA face to face training to ensure it meets the needs of clinical staff; and implement/evaluate	Begin after Jan 2020	**Achieved**
The Mental Health Legislation Team have successfully reduced document management issues, evidence of this is available through monthly audits. During a recent unannounced CQC Mental Health Act (MHA) Reviewer visit, it was acknowledged that there has been a dramatic reduction in issues with capacity assessments. New MHA training has been developed and agreed. There are two levels – initial and refresher. This training will fulfil the needs of clinical staff; following roll out of the training an evaluation of the effectiveness of the training will be completed.		

Name of Priority: Continuous learning and improvement including Patient experience impact measures

Projected QIP 2019/20	Time frame	Progress achieved
Develop and include 'patient experience and impact' assessment as part of the CQI process when working with services to improve patient care and pathways	**April 2020**	**Achieved**
Patient Experience is included in the training offered to staff taking part in quality improvement projects. All continuous improvement projects and activities evidence that consideration has been given towards direct service user/customer involvement.		

Name of Priority: Community Physical Health Monitoring and Improvement Service

Projected QIP 2019/20	Time frame	Progress achieved
Service users in the care of Community Mental Health Teams (CMHT) who require physical health monitoring will receive this and any intervention needed from the city-wide Physical Health Monitoring and Improvement Team (PHMIT). The service will be implemented using a quality improvement approach.	**April 2020**	**Achieved**

A citywide service developed to provide physical health monitoring to people on certain medications, and help them to improve their ongoing health and wellbeing by linking with services such as One You Leeds.

This service began in 2019 as part of the newly designed community mental health service and is now running across all 3 localities. Over the last year the team has been working with the Community Mental Health services to improve the pathway for referral and increase the number of people receiving monitoring. The team has also been working to make sure that it is available to all those who need it, at a location which is convenient to them; this has included developing a new clinic facility at St Mary's House.

In 2019/20, a total of 989 service users have received monitoring by the service (367 of these receiving clozapine monitoring and 622 physical health monitoring for other medications). It is anticipated that the referral rate will increase as pathways between the Community Mental Health Teams and the PHMIT continue to improve.

A link is now established between the Healthy Living Service and PHMIT to improve awareness of the availability of community support for lifestyle and healthy behaviour changes.

Name of Priority: Physical Health Care, Relaunch of Smoke Free status in the Trust including review of the Nicotine Management and Smoke free Procedure

Projected QIP 2019/20	Time frame	Progress achieved
Reducing harm to service users, staff and visitors by review of the Trust's approach to Nicotine management	**April 2020**	**Achieved**

Last year we reported our plans to review our Nicotine Management and Smoke free Procedure to ensure this was in line with the latest national recommendations on supporting people to stop smoking. In September 2019 we launched a pilot of our revised policy on the Newsam Centre site. This introduced e-cigarettes as an aid to help people to quit or abstain from smoking whilst an inpatient. The pilot is being evaluated and we hope to use learning from this to improve our stop smoking support across the Trust.

The draft Nicotine Management and Smoke Free policy supported the pilot at the Newsam Centre.

An increase in Nicotine Replacement Treatment (NRT) is being reviewed as an indicator of successful stop smoking support; work is being done to evaluate how NRT should be used following evaluation of e-cigarettes as an alternative method to support abstinence or harm reduction.

Data has been collected for smoking related incidents; however analysis is not yet complete to be able to share this.

Name of Priority: Positive and Safe Group actions and impact

Projected QIP 2019/20	Time frame	Progress achieved
Develop service user involvement in training. Review and have a renewed approach to training. Roll out the new training programme to include syllabus and lesson plans for Prevention and Management of Violence and Aggression (PMVA) training. Commence application for PMVA training accreditation scheme.	**April 2020**	**Achieved**

Positive and Safe - Recognising behaviour that challenges and working in a proactive and collaborative way to prevent and manage these behaviours

The PMVA team reviewed the mandatory training syllabus to ensure it reflected the new PMVA training standards, the current Training Needs Analysis and feedback from the compulsory training group. This work was completed and presented to the compulsory training group in January 2020.

The De-escalation Task and Finish Group will be engaging with the patient experience team to address the issue of service user and carer involvement. They have also reached out to Advonet to be involved in their Restraint, Seclusion and Segregation (RSS) Project for people who have experienced RSS and their carers. Project feedback sessions were held on the 12 December 2019. This project aims to explore how service user and carers voices and experiences can be included in the work.

Improving the quality of our services

In addition to the QIPs we have described so far, we have been working hard over the year in many other ways to improve the quality of services. Some of these initiatives were brand new in 2019/20 whilst others are continued improvements that you might have read about previously. We would like to share some examples of the great work that has been and is happening as follows.

Learning from Patient Safety Incidents, a Trustwide Event

In October 2019 our first Trust wide learning event took place at The Bridge Community Church in Leeds and over 100 staff attended. The focus of the day was quality improvement in respect of patient safety.

Dr Claire Kenwood, Medical Director (pictured left), was our key note speaker who set the scene for the day, speaking about how quality improvement methodology can be utilised in practice to improve safety and quality of care.

A number of clinical staff presented workshops, detailed below, to demonstrate changes within their clinical areas which have resulted in quality improvement in practice. The Deputy Director of Public Health Leeds presented the Leeds Suicide Prevent Plan and described our involvement with this.

A second event is planned, with a focus on Suicide Prevention and our strategy for this.

Victoria Eaton, Deputy Director of Public Health Leeds

Workshop - Safewards

Safewards is a containment model that is intended to reduce flash points and consequent incidents on mental health wards and to instil a consistent approach that helps to make wards safer,

This workshop was devised and delivered to look beyond the interventions and gain an understanding of some of the basic theory behind it. The workshop encouraged staff to relate this theory to their own personal experience of working in mental health and to evoke the understanding required to truly implement Safewards.

Safewards could appear to be just 10 simple interventions but these interventions were drawn from a great deal of research and discussion with service users and clinicians. Implementing Safewards on the wards has been a challenging process as it requires willingness to change and a shift in culture in many areas. A better understanding of the ethos of Safewards gives credibility to the function of the interventions providing motivation to use them and creating a greater overall impact. The ten interventions are as follows:

Clear Mutual Expectations – Clear mutual expectations for service users and staff underpinning an individual's care on the ward, providing clear, mutual guidance on how staff and service users should behave with one another.

Soft Words – An intervention that supports staff in navigating the restrictive elements of inpatient mental health care in the most respectful and honest manner possible.

Talk Down – The nature of mental health wards and mental health problems means that sometimes service users can become agitated, upset or angry. This intervention provides guidance on the best way for staff to approach these situations to help service users through difficult emotions.

Positive Words – A process to support staff in understanding why service users might behave in certain ways, particularly behaviour that challenges. A good understanding of certain behaviours and also regularly handing over positive behaviour helps staff to remain empathetic and compassionate and is a constant reminder that there is a human being at the heart of it all.

Bad News Mitigation – A guide used to identify and plan how best to support service users that receive bad news as these situations can lead to people becoming upset or angry.

Know Each Other – A very simple way in knowing each other and building rapport.

Mutual Help Meeting – A meeting that harnesses the power of community on our wards.

Calm Down Methods – A collection of items available for use that can help service users remain happy and calm on inpatient wards.

Reassurance – This intervention is intended to support service users when they have seen difficult situations on the wards and to help prevent further consequent incidents by others.

Discharge Messages – Messages of hope written by service users on discharge. These are displayed on the wards in a bid to offer hope to others and to hopefully reduce the shock of being admitted to an inpatient ward.

Workshop - Green Light, Learning Disability mortality and the national work

The Learning Disability Mortality Review Programme (LeDeR) was established to drive improvement in the quality of health and social care service delivery for people with learning disabilities (LD) by looking at why people with learning disabilities typically die much earlier than average.

A Trust wide Steering Group has been formed to improve the care for people with a learning disability and/or autism within mental health services. The group's work is based upon the outcome from all teams completing the Green Light Audit, the recommendations from LeDeR and the recently published NHSi Learning Disability Improvement Standards.

The workshop was used to introduce the purpose of the steering group to staff and to gain feedback from them on what challenges they experience in providing high quality care to this service user group.

Staff informed the workshop facilitators that they would like face to face training, improved partnership working and clarity about how to access support from specialist learning disability services.

Photo shows an example of a breakout session

Workshop - Structured Judgement Review (SJR) and Mortality Review

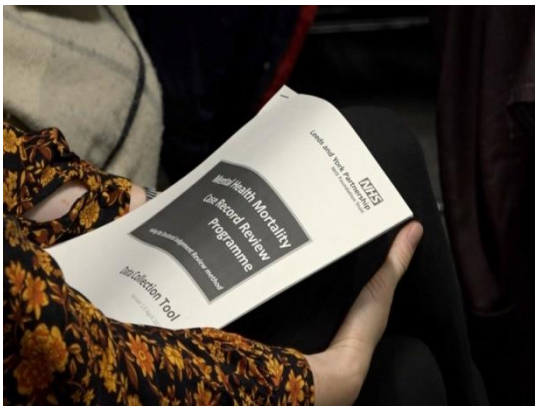
SJR is a validated tool to review mortality and was adapted for use in mental health services. We use the Royal College of Psychiatrists tool.

The Trust has a bi-monthly Learning from Incidents and Mortality Meeting (LIMM), where all deaths of patients in receipt of our services are reviewed.

A number of review types are undertaken in line with our local and national Learning from Healthcare deaths Policy. One such review is the Structured Judgement Review process.

Over 40 SJR's have been completed in the last year and presented at our LIMM as well as being shared with the clinical teams. The SJR process involves reviewing the patient's record and speaking to people. An overall score is applied to the review stating if the care was excellent, good, adequate, poor or very poor based on the findings. This is also broken down into sections so that different parts of a patient's care can also be scored. An example is the standard of the risk assessment.

Our SJR's have highlighted a number of themes such as physical health care as part of clinical observations. This has led to a Trust wide change on how observations are recorded and earlier recognition of deterioration of a patient's physical health. The SJR's have also highlighted good practice, in particular with discharge planning and communication.



More than 30 clinical staff, including medical staff have been trained in how to do an SJR. This year the process will be used to complete thematic reviews on patients who are prescribed, and monitored for, a medication called Clozapine.

The Trust supported the NHS Improvement Team with a video presentation on the effectiveness of the SJR process to inform quality improvement. This was used as part of a patient safety award when the NHSI was nominated for the work on SJR's for mortality review.

Workshop - Risky items in community settings

A risky item identified as being considered by the patient to inflict harm could be a washing line, dressing gown cord, dog lead, bladed instrument and medications.

This workshop was driven by the local knowledge that it is not unusual for practitioners in community based services to make the decision to remove items from a service user that are identified as being considered to inflict self-harm

The removal of a person's personal property raises the issue of when this needs to be returned. Workshop facilitators highlighted that this aspect is not consistently considered by staff. Currently there is no specific Trust guidance on this for community based staff. The workshop was used to generate discussion and consider what they would like to include in a local Practice Guidance Document. This Practice Guidance is now in development informed by the workshop.

Workshop - Staff Burnout

Following a service evaluation looking at violence and aggression in Acute Inpatient Services in 2016, it was felt that an understanding of the current levels of staff burnout (fatigue) and job satisfaction was needed. The evaluation included our inpatient and crisis services within Leeds Care Group.156 staff responded from a range of disciplines, the majority being nursing staff and support workers.

The workshop encouraged discussion on this topic and afforded the facilitator opportunity to update staff on the action plan developed in response to the findings. Positive actions that have taken place following the learning event include the delivery of staff resilience sessions and reflective practice groups.

Workshop - Safety Huddles

A safety huddle is a daily forum for staff to discuss safety concerns, the key principles of safety huddles are that they are clinically led, multi professional and brief.

Safety Huddles focus on identified harms and safety concerns and how working together as a team can reduce these.

The process for implementing huddles starts with culture surveys. These enable teams to feel engaged and motivated in the process as they have a say and a voice from the outset. An importance is placed on discussing and reflecting on the impact of team culture on patient safety to identify areas that could impact on patient safety; and how this can be improved.

Ward 5 at our Becklin centre introduced safety huddles on 1 April 2019. Following the introduction of safety huddles there has been a 50% reduction of incidents of violence and aggression. The team were keen to focus on harm caused by violence and aggression following a number of serious incidents and learning reviews where not being proactive in treating a patient or working as a team had led to harm. On average the team where experiencing 3 to 5 incidents per week, which has now reduced to 2. The length of days between incidents is also gradually increasing with the longest time between incidents being 15 days.

Ward 1 at the Mount introduced safety huddles to address falls in May 2017. The aim of the huddles was to reduce harm, increase clinical knowledge in fall preventions and address team issues such as the lack of regular staff meaning higher use of bank and the impact this had. Initially there was an increase in falls however the harm from the falls reduced and as the understanding and knowledge of falls prevention improved there has since been a decline in the number of falls.

On review of both wards there has been significant improvement in the culture with teams feeling valued and seeing the positive impact of using safety huddles.

Acute Care Excellence (ACE)

The acute inpatient service has embarked on a journey of improvement in order to ensure the provision of an effective, safe, purposeful and high quality service.

We believe that the service we offer at the moment is good however we have a desire to work purposefully to deliver high quality care, excellent service. We recognise that we can do this through changes in how we organise, manage and deliver care and how we engage our service users, staff and carers to ensure that each of these groups are at the heart of what we do and why we do it.

The ACE programme is being designed as a journey of continuous improvement which will offer the opportunity for engagement with everyone who uses and works within our services and across the whole health system in Leeds.

Initially a small working group met to develop a work plan exploring and testing the scope of the ACE journey. It was recognised that there was no formal model of quality improvement used within the service and a half day workshop for clinicians and managers was facilitated by the Institute of Health Improvement as an introduction to quality improvement. Views were taken from the board of governors, executive and non-executive directors on what they would like to see from the programme for staff, carers and service users and this was shared within the service.

A poster campaign was developed to encourage participation from service users, staff and carers and a survey was sent out to staff. Ward staff facilitated sessions with service users to hear as much as possible about current experiences of care, the environment and services offered.

An away day was attended by over 60 members of staff working within or aligned to the acute service. The aim of the day was to ensure a shared understanding of ACE and develop a vision for the future by working together to share and understand the difference we would like to see within the service, to begin to explore the work needed to influence a good inpatient journey; and identify who should be involved.

We began by looking at some of the areas that we were proud of within the service, particular projects such as the implementation of safe wards, safety huddles, learning meetings and care planning work were included. Teams believed that the culture we hold was a reason for pride.

The away day concluded with an agreement on the larger pieces of work that we want to improve within the service and split this into three areas: Pre-admission, inpatient admission and Transfer of Care. These three areas will form the initial work streams of the acute care excellence programme and progress will be shared in the next Quality Account.

At the away day staff reported to be proud of …….

Safe staffing update

Safe staffing means having enough staff with the right skills and knowledge, in the right place, at the right time.

Since the 1st August 2019, alongside recording registered and non-registered nurse staffing levels; there is now a requirement to record the staffing level of Registered Nursing Associates and Allied Health Professionals (AHPs).

High numbers of vacancies across the wards and national vacancies at over 40,000 registered nurses (one in nine posts) tells us that we will not be able to recruit a sufficient number of registered nurses in the near future. Whilst the care we provide is safe, there is a requirement for additional resources to ensure that we can provide the additional care time that some service users require due to the complexity of their presentation. This will enable more robust deployment of a multi-professional workforce rostered as part of the team delivering patient care.

We know that there are a number of skills sets that can complement care delivery and we have been working hard to ensure that an appropriately skilled workforce is available to deliver safe and effective care on our inpatient wards as part of our Professional strategies.

The use of the Keith Hurst Optimal Staffing Tool is now routine daily practice across all of our inpatient services and from 1 February 2019 to 30 September 2019 ward leads used the tool to record patient acuity. The data we collected from this is the first step in assisting us in our discussions with our commissioners regarding current budgets compared to the required costs based on what using the staffing tool tells us. This can help us reduce unwarranted variation in staffing levels.

In the first instance, the areas of focus and analysis have been prioritised within our acute inpatient and older people's services. Use of the tool has enabled our teams to highlight the investment needed to improve how we care for our service users in these areas. Further analysis will take place in relation to our forensic services and be reported on in June 2020.

Following on from the results of the tool, services are now considering more creative ways to fill staffing gaps to ensure service user need is met; and further assess the bespoke skills required to deliver person centred care and treatment. This will include considering aspirational roles such as Nurse Consultants, Pharmacist Consultants, Medical Associates and General Practitioners.

Our Estate update

We have made a number of changes to the way we run and use our estate linked with the delivery of the priorities we set ourselves as part of the Strategic Estates Plan.

What is PFI Estate?

Private Finance Initiative (PFI) estate is property that we lease over a long period of time that has been built and is managed by a private company.

In developing our Strategic Estates Plan back in 2018 it enabled a full assessment of the quality and efficiency of all our estate. We have divested of the buildings that were inefficient and not cost effective to operate or maintain and have embarked of a adopting an agile estate. We have already begun to make changes to our community hubs across the city, creating work environments that are more adaptive, flexible and enable our clinical teams to have access to office space when required, hot desking space or meeting rooms. We are also working with our partners across the city in how we will all work to the principle of 'one public estate'.

In adopting this new flexible approach we need to ensure that our workforce are equipped with the right technology. We are increasing the use of laptop computers as opposed to desktops, installing Gov.Roam and implementing the virtual desktop. We are also linked with the introduction of greater meeting room spaces, rolling out an electronic room booking system with mobile App so bookings can be made when on the move.

Key priorities for 2020/21 include completing the ward lifecycle work required across our Private Finance Initiative (PFI) buildings, completing the work to improve the agility of our community estate and expanding the reach of our estate to include the new regional services we now provide.

Electronic Patient Record (EPR)

An Electronic Patient Record (EPR) is a software application which brings together essential clinical and administrative data into one place.

In the last year we have been preparing to replace our existing Electronic Patient Record (EPR) *Paris* that we have been using for the last 10 years. The Trust is deploying a next generation product, CareDirector which went live on the 30th March.

Why is the new system better?
The new system is designed to be easier to navigate and bring data to the clinician or admin user rather than them having to search for data across numerous parts of the system. Users are able to view a timeline of a service user's care and navigate to the events on the timeline with a single click. Dashboards display information on a single screen that show information on an individual Service User, a clinician's own workload or a team's activity.

Benefits include:

- Less time spent searching for data and assessing workload priority and more time for face to face contact with service users
- A built in mobile application that can be used on phones or tablets to view information on a service user, manage appointments, record notes and complete assessments
- Helps staff navigate to the appointment, address or telephone the service user within a single click on the app screen
- We can work offline without losing recorded information
- Improved recording using voice and text notes
- Reduced paperwork
- Reduced travel time; the system negates the need to travel to the office between appointments
- Integrated systems: national standards mandate that clinical systems are able to 'talk' to one another and CareDirector can be integrated with a wide variety of other systems, such as:
  - the Leeds Care Record both (data from Acute and Primary Care providers)
  - a dictation system to produce clinical letters
  - our electronic prescribing system

It is an exciting time for the Trust and this is just the start of our journey with CareDirector. There will be many opportunities to use the capabilities of the EPR to improve the way our services work as we learn more about how our staff interact with CareDirector and how we can do this better.

We will be working with the supplier to develop further functionality such as patient portals to give service user increased access and interaction with their record and to link to further systems used by our healthcare partners in the region.

Patient and Carer Stories at our Trust Board meetings

Patient and carer stories are presented at our Trust Board meetings. This ensures that our Board members hear first-hand accounts of people's personal experiences of what it is like being cared for and supported by our organisation. It is important that we ensure that we also share…"*and so what has happened as a result of these experiences".*

Examples of stories that have been presented to the Trust Board over the past year and what happened as a result of the experiences:

Mark Clayton told his story of being both a patient and a carer to one of his adult children. Mark was a Middle Manager in BP, however found himself homeless at one point. He has spent time in hospital and following this he was able to describe his journey to recovery which detailed aspects of both good and poor care. Mark felt very strongly that he was not supported well when he became a carer for his adult daughter. As a result of his experiences, Mark is actively involved in working closely with the Trust to ensure that patients and carers are supported in an effective and empathetic manner and more importantly that their voices are heard. He is currently Co-chair of the Carers Sub Group and of the Patient Experience and Involvement Strategic Steering Group, an active member of the Patient Experience and Involvement Sub groups and sometimes chairs the Service User Network Meetings in the Chairs' absence. He is also very active in working with our third sector partnership organisations. This enables Mark to have a very powerful voice in helping to improve our services.

In January 2020 Board Members enjoyed listening to Lisa Cormack's story of how her involvement with our Learning Disability Team has led to paid employment with our Trust. Lisa has been a tenant in our Specialised Supported Living Service where she has lived since 2010. Lisa is a very passionate and enthusiastic volunteer and has held numerous volunteering posts, including working at St Gemma's Hospice Charity Shop and being involved with People in Action. She has been actively involved with the Trusts Learning Disability Service, by helping to recruit staff and by being a service user representative at the LD Governance Group. Her experience led her to apply for one of 3 part time posts as an Involvement Coordinator Co-worker, at a Band 5 level. In one of these newly formed posts, Lisa will build on the values of co-production to help place equal value between a persons lived experience of a learning disability and the professional experience other members of the team bring to their roles. Lisa's work will ensure that people who are supported by LD services, have a say and are involved in improving their own services.

> I am so proud of myself and I continue to push for more. I have just sent my CV to "Workfit". My next challenge is another paid job at Leeds University.
>
> Lisa Cormack

Tribute should be paid to Amy Hirst and John Burley from the Learning Disability Involvement Team who were able to ensure that these posts were specifically designed to value the important contribution that people living with a learning disability can make to improve our services. Amy and John worked in partnership with the supported employment provider "People Matters" to help develop the posts. An easy read job advert, application form and job summary document were designed to go alongside the existing Involvement Co-ordinator job description and person specification. Interviews for the post involved designing practical tasks aligned to the job specification so applicants were able to demonstrate their skills and show how they would co work and

feedback ideas to a group of service users and staff members. Finally Amy worked closely with the Trust's Recruitment Department to make reasonable adjustments to the employment checks. These included a face to face DBS (Disclosing and Barring Service) appointment and paper based occupational health questionnaire rather than applicants having to fill in online forms.

We will look forward to seeing how Lisa's new role expands over the forthcoming year.

Service User Network (SUN)

Our Service User Network (SUN) gives a voice to service users and their carers who access our Trust services.

Our Service User Network (SUN) Group is held on the first Wednesday of every month and is currently held at the Cardigan Centre in Burley. The SUN is co-chaired by service users and is a very influential group in helping to design and shape our future services. Everybody's voice counts and is listened to with respect.

The group's objectives are:

- To provide a social network that includes peer support.
- To share lived experiences in order to shape the planning, development and evaluation of Trust services.
- To provide a forum where service users can work together to promote recovery focused, inclusive and accessible services.
- To ensure that members who are involved with other partnership organisations share information with the group, with regards to initiatives and opportunities happening across the city.

SUN SERVICE USER NETWORK

Examples of events and projects where SUN members have recently been involved in co-producing and influencing decision making are:

- Helping to co-produce the new Patient and Carer Experience and Involvement Strategy (2020 – 2023) by providing their views, advising on the process and giving a service user and carer view with regards to the layout of the strategy.
- Giving their feedback and views on the new Policy for the Payment and Reimbursement of Service Users, Patients, Carers and Members of the Public.
- Working with the Crisis Resolution and Intensive Support Service to identify questions to be asked as part of their Patient Recorded Experience Measure in order to collect meaningful feedback about their service
- Reviewing the Complaints Satisfaction Survey form
- Reviewing the way in which the Trust involves Service Users and Carers in the current staff recruitment process and suggesting more effective ways that this could be done

If you would like at attend the Service User Network, please contact the Patient Experience Team via email patientexperience.lypft@nhs.net or by telephone 0113 855 6840 and we would be happy to support you to attend the meeting. Members are provided with refreshments and travel costs can be reimbursed.

Patient Reported Experience Measures (PREMs)

PREMs are questionnaires measuring the patients' perceptions of their experience whilst receiving care.

Several of our teams are already using PREM's effectively in order to gain patient feedback about their services:

- The Personality Disorder Clinical Network
- Perinatal Mother and Baby Unit
- Child and Adolescent Mental Health Service (CAMHS)
- Rehabilitation and Recovery Service

Importantly these services have been able to demonstrate changes they have made since introducing these measures. For example, the Rehabilitation and Recovery Service have co-produced a 12 question easy read survey with their patients/service users. Data from the measure is fed back into the clinical governance structure and is also displayed on a "Your Views" notice board for patients/service users and carers to see. As a direct result of receiving patient feedback, patient experience has been improved by introducing changes to care plans and by improving the layout of the Family Room, where patients/service users can spend time with their families and friends.

Inviting patients/service users to attend Multi-Disciplinary Team (MDT) meetings and enabling them to have access to laptops have been some of the changes implemented by the CAMHS team based at Mill Lodge in York, as a direct result of using a PREM to gain feedback.

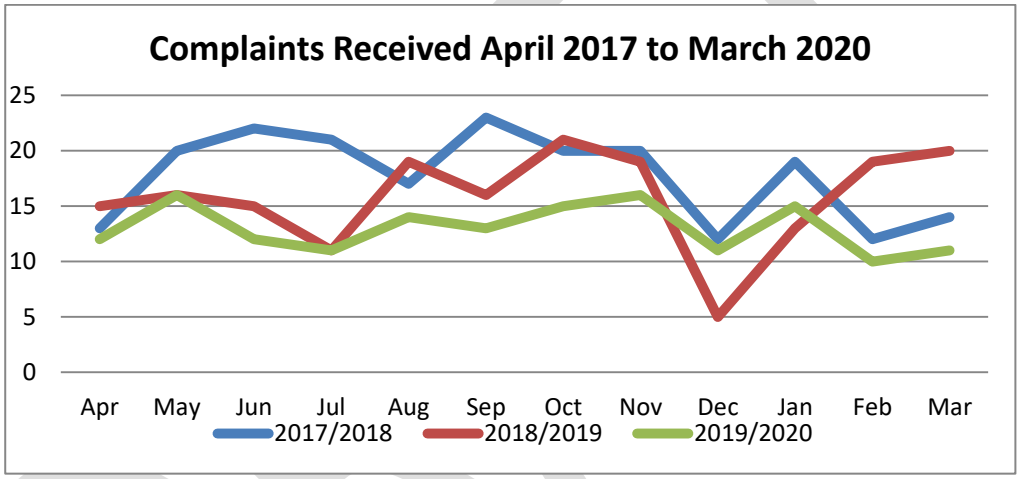
Over the next 12 months the Patient Experience Team will work closely with other teams and services across the Trust to ensure that they all have a PREM which is specifically tailored to meet the needs of their service, to enable positive changes to be made as a direct result of receiving patient feedback.

PALS (Patient Advice and Liaison Service), Concerns and Complaints

We are committed to providing opportunity for any user of the organisation to seek advice, raise concerns or make a complaint about the services it provides. The Complaints and PALS Team provide a gateway to hear concerns and complaints; and ensure they are managed in accordance with regulatory requirements. The team strives to ensure that they deliver an accessible, robust complaints service driven by the rights of patients set out within the NHS Constitution.

We recognise that the formal complaints process is not always the best pathway for patients and families to receive a speedy resolution to a problem. We continue to promote a welcoming and positive culture for everyone making contact with the PALS and Complaints Team. Our PALS team are based at our Becklin Centre and are accessible for all users of our services via our dedicated Freephone number.

During 2019/20, the Team dealt with 1904 PALS enquiries/concerns and 156 complaints. The chart below shows the comparison of complaints received over the last three financial years:



We receive a relatively small number of complaints, however they remain a valuable source of feedback and learning from complaints and the value of sharing this learning across the organisation is one of the most important aspects of our complaints process. Complaints present an opportunity for us to review care, our services; and the way in which we interact and provide information to our service users, from another perspective.

A CLIP (Complaints, Litigation, Incidents & PALS) report is produced on a monthly basis and discussed within the relevant forums. Actions from complaints and their progress are also discussed within relevant service meetings.

The top three themes for **complaints** during 2019/20 were:

- Poor General Care (19) 28%
- Conduct of staff/attitude (6) 9%
- Waiting Times (5) 7%

Themes of **concerns** tend to vary from formal complaints. Concerns are often problems that require immediate action such as meal options and environmental issues.

Key Achievements in 2019/20

- The PALS team receive and triage all concerns and complaints received in the Trust. The PALS team use their skills to resolve issues by the most efficient means ensuring the best outcome is achieved in a timely way, as agreed with the complainant.
- The PALS & Complaints team also process our Care Opinion postings; these concerns are included in reporting and triangulated with PALS activity and formal complaints.

Aims for 2020/21

- To explore other ways to obtain feedback from complainants and to use this effectively to improve the experience of using our services.
- To improve how we capture equality monitoring data across complaints.

Many thanks for all your very efficient help through all this. I've really noticed and appreciated how thorough and quick you've been, and how well you've been able to deliver on your promises. It's really unpleasant to have to go through a complaints process, but I've found contact with you has made it that bit easier, so thank you. Please do take that as an official compliment!

Complainant

Compliments

Our teams and staff often receive compliments. Compliments are received for treatment, care and support, in respect of our environment, atmosphere, and cleanliness. Staff can record all compliments received (either written or verbal) as well as being able to attach any cards/letters to our DATIX system.

During 2019/20, the Trust received 414 compliments, this is a 2% increase compared to 2018/19 (406 recorded compliments). Compliments are a key measure of patient experience and we are keen to develop recording of compliments alongside our other methods of feedback in order to create a fuller picture of where we are doing well and where we might be able to further improve.

Development of our Leadership and workforce

Developing an inclusive culture based on Trust values and behaviours

We are committed to delivering high quality care that supports and meets the needs of people from our diverse communities. In order to do this, we recognise that it is essential that our workforce is as diverse as the communities we support and that we continue to build knowledge, skills and behaviours to address inequalities to deliver truly inclusive services.

In 2019 over 300 staff attended Diversity and Inclusion development days, which support staff to understand why certain communities experience inequality of access to services or treatment to inform their clinical and personal practice.

Ensuring that we understand and learn from the experiences of people from diverse communities is central to our approach. During 2019 we commenced a co-created project with the Synergi Collaborative working with our service users and communities with focus on crisis support to improve mental health access and experience for Black, Asian and Minority Ethnic (BAME) service users.

In March 2020 we established Clinical Engagement, Access and Inclusion Coordinators in our crisis and perinatal teams. They are working with the services and wider communities to understand and address potential barriers to access for people from BAME communities.

We have also further developed our Rainbow Alliance Network through co-creation, which aims to ensure that our services and processes are inclusive for people who are Lesbian Gay Bisexual or Transgender (LGBT+).

We have established our Disability and Wellbeing Network (DaWN) and expanded involvement in our Workforce Race Equality Network (WREN). Through co-development with our staff networks members, areas we are working on include;

- Reviewing our Reasonable Adjustments processes for our Disabled staff.
- Increasing awareness of key support and personal development structures for our BAME staff.
- Sharing of personal stories and journeys to increase cultural understanding and inclusive leadership approaches.

Trust Leadership Forum

In 2019 the Trust leadership forum continued to meet and provide senior leaders with a valued networking and learning space. The forum sessions focused on sharing good practice, the power of personal story telling, developing personal resilience and using a coaching approach to develop collective leadership impact.

Developing Teams

The Affina Team Journey is an online team assessment and development tool for team leaders to use with their teams. It improves performance by giving teams a structured, evidence-based experience they will value and enjoy.

A clear, ten-stage layout enables teams to work through the practical and interactive materials at their own pace, usually in four to six months.

This year there have been 13 team development programmes and 10 Affina Team Journeys completed or progressing, out of a total of 46 requests to the Learning and OD team.

The Learning and Organisational Development team have started to work more closely with the Continuous Improvement team to align approaches, develop a shared and deeper understanding of the challenges faced by teams and to improve the development support to teams. Eleven Affina Team coaches across the Trust have been trained to date. During 2019 these coaches supported teams following the Trust's re-design of its community services.

The Forensic Leadership team recommend the Affina Team Journey and reported that it feels like a different team, a different service. There's an energised buzz around their meetings. They changed the name of the management team to the Leadership Community to reflect a more open, transparent and positive outlook.

Learning and Organisational Development

We value our staff and want to ensure we give them the support and care that is needed for them to thrive and provide good patient care. As a reflection of this we have newly appointed a Health and Wellbeing Manager who will be a dedicated resource to drive our strategy forward.

Support currently offered to staff includes:

- Employee Assistance Programme - this provides one to one counselling services and legal advice.
- A comprehensive Occupational Health service including self - referrals to a physiotherapist, and will be developing further links with other organisations in terms of mental health support.
- Financial wellbeing support - we offer financial advice and loans through a partner company, and this year we will focus more on encouraging staff to save money.
- Mental Health First Aiders - we have several staff trained and will be looking at ways to best utilise this resource.
- Workplace Wellbeing Advisors offer support and signposting and work across the Trust.

Trust Appraisals

Throughout 2019 we have worked to deliver improvements to the Trust Appraisal processes. A simplified appraisal policy has been introduced and in January 2020 we will be introducing a process to measure the quality of appraisals. The information will be used to inform future improvements and direct support to areas in need.

Mary Seacole Programme

The Mary Seacole programme is a six month leadership development programme which was designed by the NHS Leadership Academy in partnership with global experts, Korn Ferry Hay Group, to develop knowledge and skills in leadership and management.

We continue to successfully deliver a local version of the NHS Leadership Academy's Mary Seacole Programme in partnership with the West Yorkshire Mental Health Collaborative, aimed at those new to leadership or those wishing to further develop their leadership behaviours and impact and in June 2020 we will hold our third annual celebration event.

Testimonial from Lorna Dunsire, one of our Mary Seacole graduates:

I feel that I learnt a lot, about myself as well as the most effective strategies for facilitating positive changes, whilst completing the Mary Seacole programme. During the programme, I was successful in securing a Clinical lead position and now I lead a team of Occupational Therapists within the Inpatient mental health wards. Without the support of the Mary Seacole programme, I don't think I would have the confidence to apply for the job, never mind to identify the skills and opportunities which I could bring to the formal leadership position. I would highly recommend the Mary Seacole programme to anyone who is keen to put the work in to develop their leadership skills.

A number of leadership development programmes (in partnership with other mental health and learning disability Trusts across the West Yorkshire Mental Health Collaborative) have been delivered. These include the Shadow Board programme, a powerful experiential learning programme for aspiring directors.

Effectiveness of enabling MDT (Multidisciplinary Team) engagement to improve patient care

An MDT meeting is a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual service users

The Quality, Delivery and Performance (QDaP) process originated in the specialist and learning disability services care group from a desire to improve patient care by collaboratively engaging staff in dialogue around activity, performance and quality employing a facilitative leadership approach and a participative style to collectively examine compliance and quality areas of service delivery.

As a part of a dissertation for the MSc component of the Elizabeth Garrett Anderson programme the researcher began a case study/service evaluation of the QDaP process in order to understand the benefits and limitations of this kind of engagement. The case study explored the engagement of staff in the QDaP process by understanding and analysing the experiences of clinical team members and leaders who participate in a quality and

performance forum with senior leadership in the specialist and learning disability services care group.

The aims of this study were to:

1) gain a broader understanding of how leaders can drive engagement of multidisciplinary teams (MDT);
2) explore whether clinical teams feel engaged in a quality assurance process and if they feel it positively impacts on care; and
3) Identify staff perceptions of the leadership of the quality assurance process.

A qualitative approach using mixed methods was predominantly used with a total population survey of 55 people (with a 90% response rate) and semi structured interviews with eight participants who volunteered as part of the survey process. The findings suggest that participants typically feel that the quality assurance process studied successfully engaged staff in what they saw as a useful and constructive process. The opportunity to engage with senior operational and clinical leadership was seen as the most important factor.

Engaging teams of clinical and operational staff by bringing them together with senior clinical and operational leadership team members and relevant corporate staff to explore matters of quality, service delivery and performance is an effective use of time and resources. It is clear that the leadership of such a pursuit must demonstrate a values-led, collective leadership approach in order to make the engagement meaningful and successful.

Apprenticeships

Apprenticeships support employment routes into the Trust for health care support workers and provide career development pathways for our existing support staff. These include Level 3 qualifications in health and social care and higher level support worker qualifications for nursing associates and associate practitioner roles. Our first nursing degree apprenticeships are commencing in learning disabilities with options for mental health nursing being explored.

More apprenticeships are being approved for delivery; this includes professional qualifications in procurement, pharmacy, information technology, human resources, finance and leadership and management qualifications.

There are evidence based benefits to using apprenticeships to develop the workforce, these include:

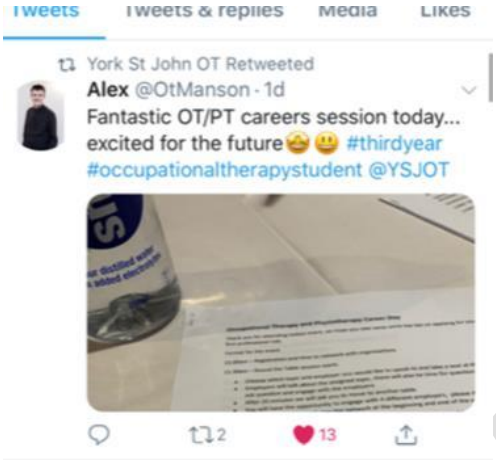
- Increased staff morale and retention
- Upskilling existing staff and supporting career development
- Improved productivity and quality of care delivered

Update on our Preceptorship Programme

Promotion of the LYPFT Preceptorship programme to third year AHP University students

The Practice Learning and Developing team (PLDT) have provided information at Careers Fairs to discuss tips for interview skills and job applications. These were a great opportunity to network with our future workforce and advertise our preceptorship programme for potential job applicants. Feedback from the university was extremely positive and students reported that it was great to meet the person behind the shortlisting of applications.

Positive Feedback – January 2020 – York St John University Careers Fair



A Change to the preceptorship programme – Focus on staff well-being to improve mental well-being of the newly qualified nurses and AHP

In September 2019 we developed and introduced a new session called 'Embracing **your** preceptorship journey with self-care and compassion'. This is a rolling theme for each in house training day. The session was developed using evidence from the HEE (Health Education England Mental Well-being Commission Report and Framework (2018).

The long term aim is to ensure that NHS preceptees feel supported and fulfilled in their role and also feel it safe to 'not be ok'. Through raising awareness of self-compassion and encouraging staff to take care of them we can improve staff well-being and create safer quality care.

Feedback following the September session:

'Fantastic session, it's the first time I have been given the time as a clinician to stop and reflect on how I am feeling'.

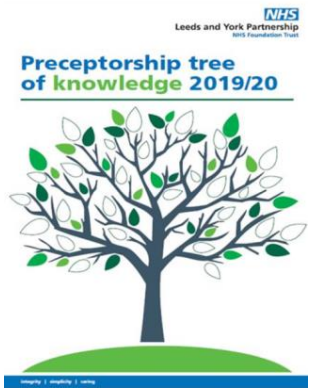
I didn't realise that I was almost running on empty, trying too hard to keep all plates spinning, a vital session on permission to self-care'

'I didn't realise how critical my inner voice was until I reflected on this in the workshop'

Coaching Style Culture 'Hot Seat'

We have introduced the 'Hot Seat' coaching style session for preceptees to reflect on clinical issues which may be affecting their area or practice by using their network of preceptees. This was based on the Mental Health Taskforce's Five year Forward 2016 report to improve self-management and develop life skills through a coaching approach. The 'Hot Seat' method is used to develop a coaching style to aid their personal development and improve relationships with their multi-disciplinary colleagues from the start of their careers.

Introduction of the Preceptorship Tree – November 2019



The tree is to be used at all preceptorship sessions to encourage networking between all the multidisciplinary professionals who take part in the preceptorship programme. Preceptees write on leaves which are blank to share tips for the preceptorship journey to encourage and support people who are new to the programme.

Trust Awards

Each year we host a “Trust Awards” night. Staff nominate other members of staff for 11 different award categories. The night provides the perfect opportunity to take time out to acknowledge all that has been achieved over the past year. This year we received nearly 160 nominations, which is a testament to the fantastic people we have in the Trust.

As guests started to arrive at the venue, they were serenaded by our fantastic staff choir 'Trust Your Voice' who created a buoyant mood for the award announcements.

Dr Sara Munro, Chief Executive, tweeted about the evening: "What an amazing night with colleagues celebrating the amazing work of so many people" along with Professor Sue Proctor, Chair, "Wonderful night celebrating our terrific staff and volunteers. Thanks so much to everyone for making it so memorable #proudtobeNHS"

Non-Clinical Employees of the Year (Joint) - Vanessa Williamson and Tracey Williams, Domestic Assistants, Mill Lodge
Clinical Employee of the Year - Jayne Langdale, Occupational Therapist / Mental Health Practitioner, Deaf CAMHS
Health and Wellbeing Award - Amanda Bailey, Physical Health and Smokefree Lead
Bank Employee of the Year - Henrietta Forichi, Nursing Assistant
Non-Clinical Team of the Year - Recruitment Team
Clinical Team of the Year Award - Veterans' Mental Health Complex Treatment Service
Partnership Award - Jamie Scott, Operational Manager, Personality Disorder Service
Volunteer of the Year - Melanie Hardwick, Rainbow Alliance
Equality and Inclusion Award - Sajimon Madathil, Clinical Lead, Bank Staffing Department
Inspiring Leader Award - Dr Elaine McMullan, Senior Clinical Psychologist, The Becklin Centre
Chair and CEO Award - Danielle Booth, Staff Nurse, The Newsam Centre and Dr Sharon Nightingale, Consultant Psychiatrist and Director of Medical Education

Star Awards

The Star Award scheme recognises staff, teams and volunteers who display positive behaviours in keeping with the Trust's values. They provide the Trust with an opportunity to celebrate the valuable contributions made by its employees and teams.

Any employee, team or volunteer can be nominated for an award. Award winners receive £100 of High Street Gift Vouchers and a framed certificate at a surprise presentation.

"I was gobsmacked as no-one in my office gave the game away! All I do is the job I'm paid to do and treat people how I'd like them to treat me – I don't do anything special! I don't know what I'll spend the vouchers on, but I know I'll buy something special so in 10 years' time I can look back and remember my Star Award."

Ron Kennington, Cashier, Newsam Centre

From left to right:
Linda Rose, Head of Nursing
Emma Oldham-Fox, Professional Practice Lead, award winner
Dawn Hanwell, Director of Finance

National Awards

In 2019/2020 we were recognised externally in a number of national awards.
These are shown in the table below:

Awarding Body	Award Status	Name/Category of Award	Team/Individual
Positive Practice in Mental Health Awards	Winners	Eating Disorders' category	CONNECT Eating Disorders Service
Positive Practice in Mental Health Awards 2019	Highly commended	Specialist Community Services for adults with complex mental health needs, including personality disorder' category	Personality Disorders Service
Nursing Times Awards 2019	Shortlisted	Nursing in Mental Health	Veterans' Mental Health Complex Treatment Service
Royal College of Psychiatrists	Shortlisted	Psychiatric Team of the Year 2019: Children and Adolescents' category	Deaf Child and Adolescent Mental Health Service
Learning Disabilities and Autism Awards	Shortlisted	'The Team Award'	'Easy on the I' Service
Yorkshire Evening Post Health Awards	Winner	Mental Health and Wellbeing Award	Paul Butler
Yorkshire Evening Post Health Awards	Shortlisted	Mental Health and Wellbeing Award	Stephanie Smith

Nomination for Stephanie Smith, Shortlisted, Mental Health and Wellbeing Award
"She listened without judgment. She identified my mental and social care needs often going above and beyond to help me and my family. I owe Steph everything."

Nomination for Paul Butler, Winner, Mental Health and Wellbeing Award
"I am truly grateful for Paul's care, kindness and genuine concern. He has been unassuming, but impactful in the way he has worked. I will never forget this gift among men."

Continuous Improvement Team Update

The CI Team is based at The Mount site within the Trust. A team of six staff work with clinical and corporate teams to transform good ideas into sustainable workable solutions designed to improve and deliver quality for everyone using our services.

Staff are empowered by senior leaders to generate solutions to issues and encouraged to implement good ideas in practice following a safe, reliable and effective improvement methodology. The CI team supports staff to continuously improve the quality of services they provide by offering a blend of improvement training, mentoring and coaching. This collaborative approach supports our aim of building improvement capability and contributes towards our growing continuous improvement culture.

To help accelerate and grow improvement capability in the Trust the Continuous Improvement Team are developing a number of improvement training courses for staff, scheduled to be released in 2020/21.

During 2019/20 the Continuous Improvement Team received 17 new Improvement Coaching Requests. The size and type of support requests received vary considerably from small scale issues and problems (e.g. poor appointment utilisation) to service wide performance related concerns such as not achieving Key Performance Indicator targets.

A major success of last year's coaching support was the work undertaken with the Leeds Autism Diagnostic Service (LADS). The service requested support to reduce the length of time service users were waiting for an autism diagnosis assessment, standing at an average of 204 days. Following an 18 month improvement project where the service focused on removing non-value added activity from their pathway & improving their operational management processes, diagnosis waiting times reduced to an average of 150 days. This benefit was achieved despite the service experiencing an 11% increase in referrals. Alongside an excellent reduction in waiting times the service also created 252 hour clinical resource efficiency by remodelling their diagnostic pathway. This was a fantastic achievement for the service and an excellent example of how an empowered and supported workforce can significantly improve the quality of service provided.

Freedom to Speak Up Guardian

A Freedom to Speak Up Guardian is a senior independent role, to enable and promote an open and transparent culture

The appointment of a Freedom to Speak up Guardian, in all NHS Trusts and Foundation Trusts, was recommended by Sir Robert Francis following his review into failings at the Mid Staffordshire NHS Foundation Trust.

We have had a Guardian in place since October 2017.

Our Guardian, John Verity, works across our organisation creating spaces for staff to share concerns about patient care and safety. The role is independent and reports directly to the Chief Executive and the Trust Board with the aim of ensuring that staff concerns can be heard within a supportive environment that encourages people to speak out.

John has worked hard this year to promote how he can assist staff and has used a number of methods to raise awareness of his role. These include a regular blog which details the sites John will be visiting and desk top notifications which are seen when staff switch on their computers.

John provides a report to the Trust Board on a bi-annual basis which includes data on the number of new cases received, the number closed, the broad category of the concern, and any feedback. It also contains anonymised case studies / examples and any lessons learnt. During 2019/20, the Freedom to Speak Up Guardian received 46 cases.

Individuals who raise concerns are kept informed of progress and concerns are only closed when the process has been completed. Once the concern has been completed a feedback questionnaire is sent to the individual for completion.

Our vision for 2020 includes strengthening the processes and procedures we have in place and to ensure that we continue to learn not just from the concerns raised within the Trust but also those raised regionally and nationally. The Guardian is linked into both regional and national events and also receives one-to-one peer support from local guardians from other Trusts. These activities provide the Guardian with a strong peer network and they also ensure that the Trust is working to current and best practice.

An audit of the service during this period by the internal audit team provided significant assurance.

Leeds Recovery College

The Recovery College takes an educational approach to improving mental health and offer information based workshops and training courses that focus on living mentally and physically well.

The Leeds Recovery College launched its first prospectus in September 2019, providing over 40 information based workshops and longer training courses that focus on mental health and recovery.

In its first year of development people who have personal experience of mental health and recovery have been recruited, alongside health professionals, education and community organisations to give their time and expertise to co-design and co-deliver the colleges curriculum.

During the first academic term (Sept/Dec 2019), over 30 individual courses were provided to over 250 students. Sessions are based at centres across Leeds including community hubs, Lovell Park, Stocks Hill and Vale Circles with people able to book onto a course without referral or diagnosis.

The recovery college has welcomed carers, family, friends and other health and care staff to equally participate in courses, including; *Wellness Recovery Action Planning, Vision boarding: my focus for the future, Dealing with feelings: talking about recovery, Developing self-compassion, Exploring resilience, Let's talk about self-harm, Let's talk about gender identity and health.*

The college continues to develop course design and content in co-production with the support of its steering group, which is made up of multi-agency partners and facilitator base (now over 40 people, strong) who have directly contributed to curriculum. There 11 trained mental health first aiders and a developed in- house train the trainer course to support new facilitators and students looking to get more involved in course development.

'Thank you for being there, in understanding, recognising my struggles, for taking the time to listen. You never let me forget that I am more than my bad days. I've learnt it is okay to do things in my own time. I'll get where I want to go. I've learnt to do what works for me.'
Leeds Recovery College Student and WRAP graduate, 2019

'Recovery and Mental Health is a lifelong journey, in which you can be an active participant throughout. It has provided a tool kit which can be customised to my life, personality and support network. It has helped me identify several sources of help and support which I did not think were available.'

Leeds Recovery College Student

Paul Fraser's Patient Story

My moto is "If I can do it, you can do it"

I have been a service user for over 30 years and I have accessed lots of different services within LYPFT. I wanted to share how being involved has made a great difference to my own recovery and wellbeing and the work I have done with the Recovery College.

I am also involved in the following:

- Chairing SUN with others who have accessed services
- Chairing SUNRAY's at Stocks Hill Day Centre
- Co-facilitating the Patient Experience Teams training
- I am a member of LIP (Leeds Involving People) and chair at their meetings called "Together We Can"
- I get involved in interviewing for staff at the Trust
- Time to Change
- Leeds Equality &Diversity group
- Better Lives Leeds
- Research with Leeds and Bradford Universities looking at long term side effects of medication

I have been working with the Leeds Recovery College and I have been involved in setting up and teaching IT courses for service users at Lovell Park HUB, The Vale and Stocks Hill. The course helps people to get basic IT skills. We have had challenges with numbers attending the course dwindling but I am not giving up and Simon Burton and me are working hard to promote the course and get more people doing it. On all the meeting I attend, I have a slot and Simon Burton gives me an update so I can feedback about the Recovery College to different audiences.
I have been offered lots of support from Christine Heath, Voluntary Manager to help do the mentoring skills course; they even helped to get me a suit!

Getting involved with all the above keeps me busy, and I enjoy this as it gives me structure to my days which is important. It makes me feel empowered and socially included. I help others by encouraging them to have a voice. I am seen as a positive role model to others. I feel I am giving back to society and this has helped me in my own recovery journey. I've become an official volunteer for the Trust. I just want to say I am passionate about mental health involvement and recovery.

I have been through entire system over the years and have taken every opportunity given to me, I have been to college, set up a social enterprise and am at Swarthmore doing a refresher course. I feel valued and listened to and because of my experiences I am able to buddy others that have had a similar journey to me.

New Northern Gambling Service

The NHS Northern Gambling Service (also known as the Northern Gambling Clinic) provides specialist addiction therapy and recovery to people affected by gambling addiction, as well as those with mental health problems such as depression, anxiety, trauma, and suicidal feelings

In Great Britain between a third and half a million people are estimated to have a gambling problem with another two million at risk of developing one. However, fewer than three per cent of those affected currently receive treatment or support.

This new NHS service, run by Leeds and York Partnership NHS Foundation Trust (LYPFT), is the first NHS gambling service of its kind to launch outside London. Its first base in Leeds has now opened, and further bases are set to open in Manchester by February 2020 with Sunderland launching in January 2020. The service is being funded jointly by NHS England and GambleAware in an agreement worth around £1million a year.

The service also provides intervention to people close to those with gambling addiction, such as family, partners, and carers. It covers the whole of the North of England and is a clinical team made up of psychologists, therapists, psychiatrists, and mental health nurses. There is also access to experts by experience, who have recovered from gambling addiction.

Former gym instructor and Leeds lad Nathan Barnes started gambling when he was 18 years old. Seven years later, he had three bad debt credit cards, a high interest overdraft, a standard overdraft, four payday loans and £4,500 of tuition loans . . . and found himself sleeping on his brother's floor.

He suddenly realised he needed to make a change when someone at work told him they'd been diagnosed with terminal cancer. He said: "I was wasting my life trying to win money from companies designed to take my money from me. After that I vowed never to gamble again and confessed everything to my family and friends. I also vowed to my new partner that I would never gamble again and that has been absolutely crucial in my recovery.

"What I would say to myself if I was dealing with my undiagnosed self would be to conjure up the courage to accept you've got a problem and you need help."

NHS Veterans Service

The NHS Veterans' Mental Health Complex Treatment Service (VMH CTS) is a specialist community mental health service for armed forces veterans.

The service is for those experiencing complex mental illness related to their time in the military, and is here to help veterans regardless of when they left the armed forces. Our service is for former forces personnel in the north of England – from communities from South Yorkshire and Cheshire up to the Scottish Borders– and is run in partnership with the UK's leading charity for veterans' mental health, Combat Stress.

It provides therapies for veterans experiencing psychological trauma (such as post-traumatic stress disorder), alongside a range of other treatments and advice. We appreciate that the culture of the armed forces is unique and that's why this service is provided by a team in tune with military needs. Military experience is central to what we do and the service has been shaped by feedback from veterans and their families.

More armed forces veterans in the north of England, who are facing complex mental health issues, will receive support as our service has had its contract extended for a further two years. This means that the Veterans' Mental Health Complex Treatment Service will be able to see more than 260 extra men and women, who are experiencing challenges as a direct result of their military service, by 31 March 2022.

This news comes as the service marks its first year, and since its launch in April 2018, it's already helped 150 people.

"The Veterans' Mental Health Complex Treatment Service is for former forces personnel diagnosed with complex mental illness. Many will have been affected by trauma, so we offer trauma-focused therapies and other support to veterans, including help with substance misuse, physical health, employment, accommodation, relationships and finances.

It's been a busy year, and when I look back, I feel proud - not only of the team for everything they've achieved in that time but also of those who've come to our service. Asking for help can be really difficult and it's been incredible to see so many of our veterans on their road to recovery. We're now looking to the future to make sure that we continue to provide the high quality service that they deserve."

Vicki Ray, Clinical Team Manager for the service

Leeds and York Partnership NHS Foundation Trust is one of only five NHS Trusts in the country to be providing this service, and we're working with Combat Stress, the UK's leading veterans' mental health charity, to deliver this service in the north of England.
The service started with a base in Leeds, to cover the Yorkshire and Humber region and has recently expanded to include a base at the Beacon of Light in Sunderland, to cover the North East, and at Salford Quays, to cover the North West.

With the service only just entering its second year, there's been plenty of opportunity to shape what's on offer and this has been an exciting time for all involved. For example, in the first year, the Yorkshire and Humber Team developed a group with veterans to focus on wellbeing. It follows feedback from those using the service that they 'missed getting out and about with the lads' – something which was integral to their military lives. An arrangement is now in place with Cannon Hall near Barnsley, where the group are often invited to volunteer in the 70 acres of historic parkland. So far the feedback has been positive and we're looking forward to seeing what comes next.

Garden of Governance

We've coined the phrase "Garden of Governance" to help service users understand what a good service looks like

The Specialist Supported Living Service Governance Group thought about ways of making it easier for service users to understand what governance is. The short answer from our service users was that it was about checking that the service is good. The group acknowledged that when you start to try and do this there are lots of things that need to be checked and that it was also important to understand why all these things need to be checked and what is the best way to check them.

The group agreed that this can be hard to understand and often jargon gets used to talk about things that make it difficult. The group agreed on an idea called "The Garden of Governance". On 17th July 2019, the Specialised Supported Living Service hosted a Have Your Say Day! and used the idea of "The Garden of Governance" to try and help people understand what governance was and why it is important to them.

The idea is easy to get. The people who use the service are the flowers. All of the things that are needed to help flowers grow are the things that must happen in the garden. If they don't happen the garden won't grow as well as it can.
The service used a picture to explain how this might to try and make it easy to understand, using all the ideas from the service users.

The staff also asked people who attended the day to help them make their own real garden of governance.
They began with each person making their own flower. The flower was to tell us what they wanted, using themselves as the flower head and writing things about themselves on the petals and leaves.

Outside, staff used some space to put the real garden together. They filled pots with soil to plant real flowers alongside the flowers people had made. They hung up watering cans and hung the water drops people had made over them. They also used chalks to decorate the walls and write up important messages.

An outcome of the day was that a governance group meeting would be held at a Service Café so that people can drop in. Staff and service user agreed to work together to continue to tend the garden, ensuring all the flowers are well tended and get what they need!

Events of Celebration

Celebrating 100 years of learning disability nursing

This year learning disability nursing will have been a recognised specialty for 100 years. Nurses support people with learning disabilities, usually as part of a multi-disciplinary team, working on inpatient wards, in the community and in specialist supported living services. Together the nursing team, with the help of their colleagues, help service users to lead their lives as fully and independently as possible.

A celebration event took place on Thursday 31st October at Bridge Community Church in Leeds, marking the 100 year milestone, it brought together nurses from different learning disability services in Leeds along with service users, carers and health and social care professionals.

The day provided attendees a unique opportunity to learn more about learning disability nursing, how it has advanced, what nurses do now and how the needs of people with learning disabilities are met in different settings. Those attending were invited to think about the past, present and the future at over 20 interactive information stands and also to share the special '100 years' cake!

There was lots to learn about the history of care in the city and how it continues to evolve to meet the needs of service users, for example with measures to stop over-medication (the STOMP project) and the 'Green Light' toolkit which shares best practice to ensure continuous improvement of care standards.

The Transitions Team from Leeds City Council talked about what care is put in place for young people transitioning into an adult settings to ensure people are cared for properly at every stage of life and whatever the complexity of their needs. It was an opportunity to show guests how health care and social work partners in Leeds work together for the benefit of some of the most vulnerable people in our community.

A highlight of the day was the wire '100' sculpture where guests could share a pledge about what they can do to keep moving forward to meet the needs of people with learning disabilities

.

Here are just a few pledges from the wire sculpture…
"More events like this!"
"More easy read information – we need it!"
"More joined up working."

"It's been a great day! Lots of information shared and it feels like a real celebration of our profession. Thank you to all our fantastic learning disability nurses who have contributed to the 100 years celebration. I am bursting with pride! We are a great service!"
Stacey Atkinson, the Lead Nurse for Learning Disability Services

The following nurses, have provided an insight in to what their job involves and what they enjoy most about being a learning disability nurse.

Christina Edwards, Advanced Nurse Practitioner for Community Learning Disability Services, St Mary's Hospital

Christina qualified as a Nurse for People with Learning Disabilities in 2006. "I have always found my job rewarding, being able to help someone achieve their goals. I am proud to have been involved in inpatient services, watching a service user's journey from admission, through treatment and discharge back to a community setting. I am also proud to have been in the team of nurses who discharged the last 'long term' service users from our inpatient services into community based care."

So, what improvements in care has Christina seen over the years? "I have seen a lot of changes over my 12 year post qualification both in inpatient and community based care. There have been changes in the law, and changes in attitudes towards individuals with learning disabilities. Care provided is now much more focussed on the person and about the individual's goals rather than service goals."

What about the future? "I would like to see more understanding of learning disabilities in the wider population and how nurses for people with learning disabilities support people – as our role is much different to nurses in other areas."

Julie Royle-Evatt, Clinical Team Manager, Health Facilitation Team, St Mary's Hospital

The Health Facilitation Team advises health service providers on how to make reasonable adjustments when meeting the needs of people with learning disabilities in mainstream settings.

Julie explains "For example, a surgeon may be treating someone with a physical problem and may need support to engage with the service user in a different way so that the treatment can be undertaken successfully. Our team would provide advice and training to help support them, ensuring that the service user has a smooth and relatively stress-free pathway through Leeds healthcare services.

"It's very satisfying to know that we are passing on lifelong skills, supporting the development of professionals and carers."

"The Team started in 2017 and we have trained over 1000 people in that time – from GPs and hospital staff through to carers in Leeds community services. Since we relaunched our website in August we have received 10,000 hits – it's really important that carers are able to access resources 24/7."

The Trust employs 54 registered learning disability nurses working in an array of services – Inpatient, the Community and also the Specialist Supported Living Service.

International Year of the Nurse and Midwife 2020

2020 is Florence Nightingale's bicentennial year, designated by World Health Organisation as the first ever global Year of the Nurse and Midwife. Nurses and midwives make up the largest numbers of the NHS workforce. They are highly skilled, multi-faceted professionals from a host of backgrounds that represent our diverse communities. 2020 is our time to reflect on these skills, the commitment and expert clinical care they bring, and the impact they make on the lives of so many. This year is also an opportunity to say thank you to the professions; to showcase their diverse talents and expertise; and to promote nursing and midwifery as careers with a great deal to offer.

To mark this occasion videos were displayed throughout the day in Leeds' Millennium Square. The national "We are the NHS" video was shown alongside "In the Footsteps of Florence Nightingale" a celebration of the life of Florence and how she changed the face of nursing forever. We also posted these videos on our Staff Facebook group in a watch party where members of staff got together and had a chat with each other as the films were shown. To try and make this available for as many staff to take part as possible we screened the films at 8am, 3pm and 7.30pm before the National lighting of lamps at 8.30pm. The Trust will continue to celebrate and recognize this event throughout the year for our nurses, as appropriate within the limitations of the COVID pandemic.

SECTION 3

STATEMENTS OF ASSURANCE FROM THE BOARD

This section has a pre-determined content and statements that provide assurance about the quality of our services in Leeds and York Partnership NHS Foundation Trust (LYPFT). The information provided is a combined content required by regulation (The National Health Service [Quality Account] Regulations 2010 and as amended); and taken from the NHS Improvement's (NHSI's) requirements for Quality Reports.

This information is provided in common across all Quality Reports/Accounts nationally, allowing for comparison of our services with other organisations. The statements evidence that we are measuring our clinical services, process and performance and that we are involved in work and initiatives that aims to improve quality.

Review of services

During 2019/20 LYPFT provided and/or sub-contracted 29 NHS services.

LYPFT has reviewed all the data available to them on the quality of care in all of these relevant health services.

LYPFT have taken the following actions to further improve data quality during 2019/20:

- Moved to a new clinical records system that will support more real-time monitoring of data quality to make it easier for staff to know when information is missing or required. This will have the added benefit of assuring that any metrics or outcomes measuring the quality of our services and care can be trusted for completeness and accuracy.
- Worked with services to cleanse our legacy EPR system (PARIS) in advance of data migration to CareDirector. This involved the discharging of historical records, the restructuring of teams on the system and updating of system user (staff) records.
- Analysed test data migrations of PARIS data into CareDirector. Results of each test migration were collated and feedback given to advise on changes to improve the quality of the data migration.
- Continued to raise awareness throughout the organisation of key clinical record keeping processes that impact on data quality and performance.
- Completed a number of local data quality audits as part of a kite-marking process, publicising the findings internally and following up any recommendations to ensure that they were completed. These audits assist with understanding any discrepancies in the data, identifying whether any high standards of performance & quality or dips in performance, are real or as a result of data quality. This then enables the right decisions and actions to be taken to support the highest levels of care for our service users.
- Continued the delivery of automated data quality reports to assist teams in identifying and resolving data quality issues.
- Continued to monitor and publish performance against national and contractual data quality metrics.
- Continued to dedicate time each month to data quality improvement via the Performance, Information and Data Quality Group.

LYPFT will be taking the following actions to improve data quality during 2020/21:

- Close monitoring of data completeness and quality following the launch of our new clinical records system (CareDirector) in March 2020.
- Provide support to staff in using the new clinical records system until the processes become familiar.
- Update our data quality policy to reflect the requirements of the new clinical records system.
- Re-establish and continue to deliver a programme of local data quality audits and kite-marking of data quality based on the new clinical records system.
- Continue to raise awareness throughout the organisation of key clinical record keeping processes that impact on data quality and performance.
- Update processes following the implementation of CareDirector to continue to monitor and publish performance against national and contractual data quality metrics

We recognise that if we are to move towards more outcome-based reporting to evidence performance and quality, then complete, timely and accurate clinical record keeping in an agreed structured format that meets both clinical and analytical needs will be critical. However this is not an easy task and in order for accurate performance and outcomes data to be analysed, the information needs to be entered in a structured way onto the Trust's clinical systems. Trust standards require input of information to be completed ideally within 24 hours of occurrence but no later than 72 hours after the event. This serves the dual purpose of minimising clinical risk and ensuring high standards of data quality. The Trust has just implemented a new electronic patient record system that is intended to support complete, timely and accurate clinical record keeping. We expect data quality to dip in the short term through quarter 1 of 2020/21 as staff get used to using the new system and any system issues are resolved.

The income generated by the relevant health services reviewed in 2019/20 represents 100% of the total income generated from the provision of relevant health services by LYPFT for 2019/20

Mental Health Services Data Set - Data Quality Maturity Index

LYPFT submitted records during 2019/20 to NHS Digital via the MHSDS which are included in the latest DQMI published data (March refresh). The percentage of records in the published data:

- that included the patients valid NHS Number was 99.3%
- that included the patient's valid General Medical Practice Code was 100%
- that included the person stated gender code was 100%

Our overall DQMI score as at March 2020 is 89.1%

Clinical Audit

"Clinical audit can be described as a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and. taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes." HQIP (2012), Clinical Audit

All clinical audits that are planned to be undertaken within LYPFT are registered on the clinical audit and effectiveness registration database. The monitoring of each audit includes results, summary report and action plans.

National clinical audits

During 2019/20 six national clinical audits and two national confidential inquiries covered the NHS services that LYPFT provides. During that period LYPFT participated in all national clinical audits and national confidential enquiries that LYPFT was eligible to participate in during 2019/20:

Eligible National Clinical Audits participated in
National audit of Inpatient Falls (NAIF)
POMH-UK: Topic 19a: Prescribing for depression in adult mental health
POMH-UK: Topic 17b: Use of depot/LA antipsychotic injections for relapse prevention
POMH-UK: topic 9d: Antipsychotic prescribing in people with learning disabilities
Eligible National Confidential Enquiries participated in
Mental Health Clinical Outcome Review Programme - National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
Learning Disabilities Mortality Review (LeDeR)

The national clinical audits and national confidential enquiries that LYPFT participated in, and for which data collection was completed during 2019/20 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audit	Number of cases submitted	Percentage
National audit of Inpatient Falls (NAIF)	Not set of number required - ongoing	NA
POMH-UK: Topic 19a: Prescribing for depression in adult mental health	Not set of number required - 31 cases	100%
POMH-UK: Topic 17b: Use of depot/LA antipsychotic injections for relapse prevention	Not set of number required – 71 cases	100%
POMH-UK: topic 9d: Antipsychotic prescribing in people with learning disabilities	Not set of number required – 19 cases	100%

National Confidential Enquiries	Number of cases submitted	Percentage
Mental Health Clinical Outcome Review Programme - National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	Not set of number required	NA
Learning Disabilities Mortality Review (LeDeR)	Not set of number required	NA

The findings of 3 national clinical audits registered in the previous financial year(s) were reviewed by the provider in 2019/20 and LYPFT intends to take the following actions to improve the quality of healthcare provided:

National Audit	LYPFT action 2019/20
National Clinical Audit of Anxiety and Depression (NCAAD) - Core Audit	• To continue consideration of psychological factors contributing to people diagnosed with anxiety and depression and discuss accessing psychological therapy with service users for people with anxiety and depression post discharge from ward as part of treatment plan; • To reinforce importance of electronic documentation.
NCEPOD Young People's Mental Health (study)	Due to the small number of cases submitted (n=9) it was suggested to the involved services to review, discuss and disseminate the results and national recommendations at their own clinical governance meeting for actions.
POMH-UK: The use of Clozapine	During the project, a Clozapine Group was put together by the Trust in order to develop an action plan to improve clinical practice. The findings of the audit will inform the group of areas of low compliance and help them to prioritise any future actions.

Trust and Local Clinical Audit

This section is divided into two parts: Trustwide (part of the priority programme) and service/team clinical audits (local).

Number of clinical audits	Trustwide	Service / Team
Registered during 2019/20	3	49
Completed during 2019/20	2	44

Trust Clinical Audit

Trustwide clinical audits are part of the priority programme. They fulfil the criteria of high risk or high profile projects identified by Trust management or Trustwide Clinical Governance. The 2 completed Trustwide clinical audits are listed below alongside the actions to improve care:

Title	LYPFT actions
National Mental Health CQUIN - Cardiometabolic screening	In the last 24 months clinicians were involved in the design of the new patient record's system. A Physical Health Dashboard has been included in the system; this will help to highlight any gaps and send a prompt to alert staff when one of the physical health's indicators won't be recorded. The Physical Health Lead will be responsible to review and assess effectiveness of the new system after it will be launched in March 2020.
Compliance with the Modified Early Warning Score (MEWS) within LYPFT Inpatient units	• The Physical Health Team has offered bespoke; ward based training for staff to support understanding of assessing and recording MEWS. • Ward teams should continue to carry out MEWS self-audits with the support of the Practice Development Nurses and the Physical Health Team.

The following 3 Trust-wide clinical audits are in progress:

- ✓ Mental Capacity Act – Best Interests audit;
- ✓ Antimicrobial prescribing;
- ✓ Documenting decisions, discussions and following up women of child bearing age who are prescribed valproate.

Local Clinical Audit

The reports of 44 local clinical audits were reviewed by the provider in 2019/20 and the Trust intends to take the following actions to improve the quality of healthcare provided (the below table highlights key themes and summarised quality improvement actions):

Audit Themes	Key quality improvement actions
Medication	• To include a new assessment page on the electronic record system where to record the prescribed medications and the date they were commenced: this will make easier to review medication history, changes and review specific notes from the day they were prescribed. • The impact of medications on pregnancy should be discussed routinely with women of childbearing age. • To create a proforma as a prompt for prescribers. To improve the use of non-pharmacological measures to manage insomnia and anxiety on ward 6 by creating a list as a prompt to the multidisciplinary team (MDT) to use at the time of admission. • Clozapine monitoring template to continue to be used when patient attend for regular clozapine monitoring appointment For liaison with physical health team to discuss possibility of adding date of annual health check, 6 monthly reviews of weight, lipids and blood pressure.

Audit Themes	Key quality improvement actions
	• A shared care approach for patient on long term Benzodiazepines prescription should be developed: template to be developed for inclusion in clinic letters to advise prescribing GPs of indication and timescale for review. • To design a template that can be used by medics in their clinics when a new psychotropic is being prescribed. This includes a tick box sheet which includes the medication prescribing standards.
NICE	• To trial the standardised measures (CGI and GASS) at Parkside Lodge across Learning Disabilities Services. • Smoking cessation practitioners available on the ward to provide regular updates, guidance and reminders about smoking cessation advice and nicotine replacement therapies (NRT) options available in the trust to all healthcare professionals on the ward. • Discuss the parameters that need collecting data on as per NICE guidelines and to ask from the team if a check list to prompt documentation would be helpful. • To include copy of the NICE guidance in the induction pack for trainee doctors.
Physical Health	• Incorporate the physical health proforma into the electronic patient notes, as part of the admission process. • Physical health monitoring equipment needs to be available in all rooms. • To include a physical health heading in the MDT notes, to ensure physical health monitoring is considered for all patients. • Create a physical health proforma, including all the monitoring requirements from Amber Guidelines. To include brief information about physical health measurements, and on-going requirements as per Amber Guidelines, on the GP discharge letter. • Teaching sessions for trainees and ward staff in the trust regarding NRT options from the smoking cessation practitioners. • A Physical Health Dashboard has been included in the system; this will help to highlight any gaps and send a prompt to alert staff when one of the physical health's indicators won't be recorded. • To develop a standardised page on the Electronic Care Record System (PARIS) in order to document the relevant physical health parameters.
Mental Health Legislation	• Education regarding completing a capacity assessment and general advice that the Capacity assessment proforma is available on PARIS would generally be recommended to ensure that satisfactory documentation is completed. • Education regarding recording remaining in the suite as necessary and proportionate and valid justification. This will be provided through the guidance and via the higher trainee's committee.
Care planning	• To add safety netting to accessibility of blood tests to ensure receipt in time for appointments: member of admin staff to check that results have been received / need to be chased up with GP when prepping clinics. • The Carer Involvement and Support Plan (CISP) tool to be reviewed in weekly MDT meetings. Documentation of reason in patient's medical notes if unable to complete CISP within the recommended time frame. • To design a template that can be used by medics in their clinics when a new psychotropic is being prescribed. This includes a tick box sheet which includes the medication prescribing standards.
Safeguarding	Service to discuss on standards of clinical letters on discussions on risks and subsequent plans as the content and letter construct differs widely across professional groups. This also needs to be in line with good practice guidelines of sharing information without losing the focus on accessibility of information for Deaf children and their families. This will be discussed within established clinical governance structures.

Audit Themes	Key quality improvement actions
Documenting key clinical decisions	• To discuss with the administration staff to identify the reason why address details or other demographic information might not be pulled through to the letter template. • When patient information is not accessible via Leeds Care Record (LCR), for the doctor to flag this up with LCR helpdesk so that it can be rectified. • A check list to be designed in order to record what to use when meeting families and this information will then be transferred to PARIS.
Data sharing	• A proposed standard letter template to be recommended for all letters from the South Community Mental Health Team (CMHT) to GPs which should ensure increased adherence to national guidelines. • To improve availability of blood test results by developing a single point of access: unique email address to be developed for results to be sent to by GPs.
Record keeping	• To work closely with administration staff in order to identify reason(s) why addresses details or other demographic information might not be pulled through to the letter template. • When patient information is not accessible via LCR, for the doctor to flag this up with LCR helpdesk so that it can be rectified. • Develop record keeping guidelines which are clear and accessible to both probation and NHS staff, including protocol for when there are barriers to adhering to guidelines.
Service user / carer involvement	• Staff member to encourage patients and their carers to complete the Carer Involvement and Support Plan (CISP) tool on admission. Results to be viewed at the weekly MDT meeting. • To ensure feedback to patients is given on their strengths and how to utilise them in their everyday life. Feedbacks to be discussed in MDT and clinical governance.

Service Evaluation

Evaluation is an integral part of quality improvement in healthcare. All service evaluations that are undertaken with the Trust should be registered with the Clinical Effectiveness Team. Service Evaluations help:

- place evidence at the heart of what the Trust does
- guide clinical decision-making
- identify and disseminate good practice
- build knowledge
- assess service quality and outcomes
- demonstrate impact on areas of focus and patient groups

Since April 2019, 70 projects have been registered with the team. All the projects are then supported throughout planning, data collection, data analysis and report write-up to ensure:

- the proposed design and data collection method(s) is appropriate for the project aim
- the project meets Health Research Authority's ethical review standards for the safety and well-being of participants (staff, stakeholders, service users and carers)

Figure 1: Status of All Projects as of February 2020. Total is higher as some projects were registered prior to April 2019

The below table provides an overview of some of the projects the team has been involved in over the past year.

Table 1: Examples of projects with the past year

Project Title	Project Overview	Support Provided to Date
Improving Culture Improving Lives	The Culture Collaborative has been created to make some positive changes and improve staff experience. This work will take place over multiple stages where staff views are collated and analysed to make changes.	Planning, Data Analysis and Report Writing
E-Cigarette Pilot at Newsam		Planning, Data Collection, Data Analysis and Report Writing
Medication Errors within Learning Disability Services	Datix reports indicated a number of medication errors with LD services. The project analysed the reports and conducted a focus group with staff to identify areas for improvement.	Planning, Data Collection, Data Analysis and Report Writing
Evaluation of the Videography Process	The videography team wanted to evaluate their service by collecting feedback from other teams across the Trust to identify how to improve the service.	Planning, Data Analysis and Report Writing
Effectiveness of Smoking Cessation Clinics running concurrently with Clozapine Clinics	Patients on Clozapine need to be closely monitored if their smoking status changes. The project will run a smoking clinic alongside a Clozapine clinic to assess its effectiveness.	Planning, Data Collection, Data Analysis and Report Writing

In addition to supporting Service Evaluations, the team also provides training to staff in:

- Questionnaire Design
- Thematic Analysis (Qualitative Data Analysis)
- Data Interpretation
- Statistical Process Control Charts

Further training is being developed for Quantitative Data Analysis, currently data analysis support is provided on an ad hoc basis, and Grounded Theory, which is another form of Qualitative Analysis. Feedback received from previous training includes:

"Good background and easy to understand as it can be easy to take the subject far too complicated."

"Focussed and left with skills to move forward"

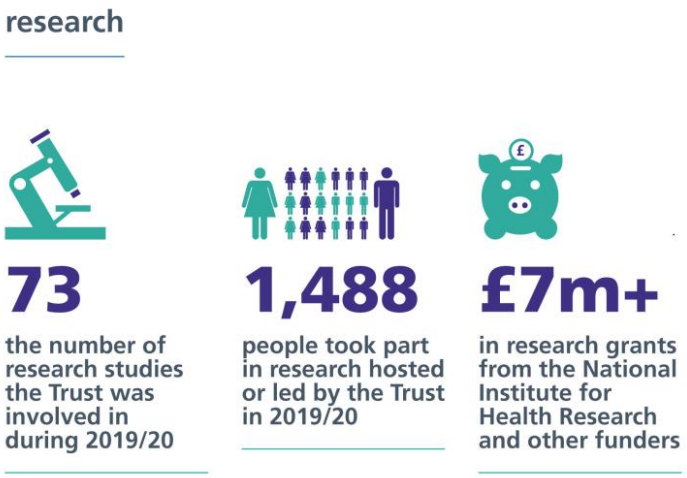
"It was easy and logical to follow"

"Practical application of the 6 stages."

"Good split between listening and participation"

Good quality analysis and the ability to use information effectively is an essential element in any learning health care system. Analysis can help shape care for individual patients as well as informing decisions for services or across organisations and health systems.

Clinical Research



The number of patients receiving NHS services provided or sub contracted by LYPFT in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 1488. This figure is formed from a combination of service users, staff, carers and school-aged children and young people.

Involvement of service users and carers

A large proportion of the Trust's 1488 research participants this year were service users or carers. A video of four people's experience of being involved in research has been made in collaboration between the participants, a member of the R&D team and the Yorkshire & Humber Clinical Research Network Service users' experience of research.

The "Help from Experts by Experience for Researchers" (HEER) group, facilitated by the R&D team continued to meet regularly to discuss research ideas, study detail, promotion and dissemination with a wide range of researchers who found their input invaluable.

Patient Research: Experience Survey

The National Institute for Health Research asked all NHS Trusts to collect information from patients about their experience of taking part in NHS research. The national information is at Research Participant Experience Survey. In LYPFT, the feedback from research participants has been overwhelmingly positive.

Of the 33 responses received, 87% recorded having had a positive experience of taking part in the study in which they were involved, only one participant recorded a negative experience and this appears to have been due to personal challenges with their memory such as recalling names and addresses. 6% remained neutral about their experience and 3% did not answer. 53% of participants who fed back recorded that they know where to find information about taking part in further research studies.

The written comments by participants confirmed the positive responses received, which are as follows:

"I would like to be involved more if possible, although retired; I worked as a civil servant for 42 years. I will consider all options you put to me."

"<Anonymous> enjoyed taking part in this research and it made him feel he was making a contribution."

"I am always interested in collaborating in research projects."

"I would like to help you in any way I can- for my own benefit and for research in general."

"The questionnaire part of the survey is very interesting and makes you think about the problem of dementia and its effects on the carer as well."

The responses shared by participants show enthusiasm and satisfaction in contributing to research and more than half of their responses indicated they took part in research to help others.

Commissioning for Quality and Innovation (CQUIN)

CQUIN is a payment framework which enables commissioners to reward excellence by linking a proportion of the healthcare provider's income to achievements

A proportion of LYPFT income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between LYPFT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework

Further details of the agreed goals for 2019/20 are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/

The operation of CQUIN (both CCG and specialised) for Trusts will be suspended for the period from April to December 2020; providers need therefore not take action to implement CQUIN requirements, nor carry out CQUIN audits or submit CQUIN performance data. (Commissioners and Trusts should also take a pragmatic approach to agreement of the final payment amounts for the 2019/20 CQUIN scheme, and this should be on the basis of all currently available data. We will not be seeking the submission of 2019/20 quarter 4 data from providers via the national CQUIN data collection.)
Information above inline with document: Revised arrangements for NHS contracting and payment during the COVID-19 pandemic – NHSI and England

Commissioner	CQUIN	Description	Q3 Position
Leeds CCG	2	Achieving an 80% uptake of flu vaccinations by frontline clinical staff.	Expect full achievement
Leeds CCG	3a	Achieving 80% of inpatients admitted to an inpatient ward for at least one night who are screened for both smoking and alcohol use.	Expect full achievement
Leeds CCG	3b	Achieving 90% of identified smokers given brief advice.	Expect full achievement
Leeds CCG	3c	Achieving 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.	Expect partial achievement
Leeds CCG	4	Achieving a score of 95% in the MHSDS Data Quality Maturity Index (DQMI).	Expect partial achievement *(4)
Leeds CCG	5a	Achieving a score of 95% in the MHSDS Data Quality Maturity Index (DQMI).	Expect partial achievement *(5)
Leeds CCG	5b	Achieving 70% of referrals where the second attended contact takes place between Q3-4 with at least one intervention* (SNOMED CT procedure code) recorded using between the referral start date and the end of the reporting period.	Expect full achievement

4* - The requirement this year has been changed from 7 day to 3 day follow-up. The Trust is endeavoring to change the focus from 7 day to 3 day follow ups with this being reiterated in local governance meetings, and guidance on the requirements of follow up has been recirculated to staff; particularly for new staff or those who moved into a role that undertakes 7/3 day follow up for the first time as part of the community services redesign. Published CQUIN figures report a

2019-20 monthly average of 78.3% and for Q4 the monthly average at 83.2% was above the operational standard of 80%. Now part of the NHS Standard Contract we will continue to develop our reporting on this measure to reflect the agreed indicator construct and definition. Despite best efforts being made, it is not always possible to contact service users if they do not want to engage with services.

5* - New elements have been included in the data set this year, but the requirement for data entry is backdated to 2016. The resources required to comply with this significantly outweigh the benefits, so the Trust has taken the decision to focus on improving data quality on new referrals from this year. Local commissioners have supported this approach and a revised target is being discussed which we expect to fully achieve.

CQUIN Planned income and penalty incurred:

Planned Income	2019/20 £000	2018/19 £000	2017/18 £000	2016/17 £000
Leeds CCGs	1,220	2,349	2,281	2,258
NHS England	307	605	600	577
Penalty Incurred				
Leeds CCGs	0	410	120	350
NHS England	0	0	0	0

The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period

We currently have a **target of 95%** for patients on CPA to receive a follow up review within 7 days of discharge. Performance against this target was a little below target in each quarter of the year with quarter 4 the highest at 92.86%.

Target of 95%	Q1	Q2	Q3	Q4
2018/19	93.81%	95.61%	96.06%	95.36%
2019/20	92.71%	91.38%	91.17%	92.86%

The LYPFT considers that this percentage is as described for the following reasons:

The Trust have been monitoring performance and data quality for this metric 3 times per week to ensure that teams are able to fulfil the follow up target.
This metric gets audited annually by our external auditors and often our internal auditors.

The LYPFT intends to take/has taken the following actions to improve the percentage, and so the quality of its services:

- The Trust has updated its frequently asked questions document to ensure staff understand the requirements, particularly in relation to the 72 hour target that has replaced the 7 day target in 2020/21.
- The Trust will continue to monitor performance for follow up within 72 hours rather than 7 days to ensure that people are followed up as quickly as possible post discharge.
- The Trust will continue the high level of scrutiny of performance and recording for this metric to ensure that service users are followed up appropriately

The percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period.

Crisis Gatekeeping	2019/20				
	Q1	Q2	Q3	Q4	Total
Gatekept Admissions	188	208	226	217	839
Admissions	188	210	230	218	845
Compliance	100.00%	99.05%	98.26%	99.54%	99.29%

The Leeds and York Partnership NHS Foundation Trust considers that this percentage is as described for the following reasons:

The data is produced according to the agreed specification and subject to monthly validation.

The Leeds and York Partnership NHS Foundation Trust intends to take/has taken the following actions to improve the percentage, and so the quality of its services by:

Our newly redesigned community services were launched in March 2019. One of the ambitions of the redesign was to improve the robustness of gatekeeping, routing service users to alternatives to admission where appropriate. The new Crisis and Intensive Support Service (CRISS) has led on face to face gatekeeping and is continuing to develop 24-hour intensive support to people seven days a week, 365 days a year. The service aims to prevent avoidable admissions and readmissions to hospital care. The assessment function of the service is working closely with colleagues across other services in order to gatekeep all acute admissions to hospital and provide intensive support at home.

The percentage of patients aged: (i) 0 to 15 and (ii) 16 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period

	Q1			Q2			Q3			Q4			2019-20		
	Discharges	Readmissions in 28 Days	Readmission Rate	Discharges	Readmissions in 28 Days	Readmission Rate	Discharges	Readmissions in 28 days	Readmission Rate	Discharges	Readmissions in 28 Days	Readmission rate	Discharges	Readmissions in 28 Days	Readmission Rate
0-15	7	0	0.0%	5	0	0.0%	2	0	0.0%	9	0	0.0%	23	0	0.0%
16+	402	14	3.5%	435	21	4.8%	425	19	4.5%	269	16	5.9%	1,531	70	4.6%
Summary	**409**	**14**	**3.4%**	**440**	**21**	**4.8%**	**427**	**19**	**4.4%**	**278**	**16**	**5.8%**	**1,554**	**70**	**4.5%**

The Leeds and York Partnership NHS Foundation Trust considers that this percentage is as described for the following reasons:

The data is produced routinely following the agreed specification. Please note that the data reported for Qtr4 only includes discharges up to the end of February as this will then cover up to the 28 day period to when we changed our EPR system in the Trust at the end of March. Including the March discharges would have skewed the data as we don't yet have the ability to report readmissions 20-21 from our new care records system.

The Leeds and York Partnership NHS Foundation Trust intends to take/has taken the following actions to improve the percentage, and so the quality of its services:
Following the redesign of our community services in 2019-20, the Trust has tracked readmissions as part of the evaluation of the impact of this redesign.
Readmissions are part of this suite of measures and any increase in the percentage are flagged with the teams to review. This is likely to continue during the next year.

The percentage of patients under 16 years old admitted to adult facilities:
There were none during the reporting year.

The Trust's "Patient experience of Community Mental Health Services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period

Community mental health service survey 2019 – our results

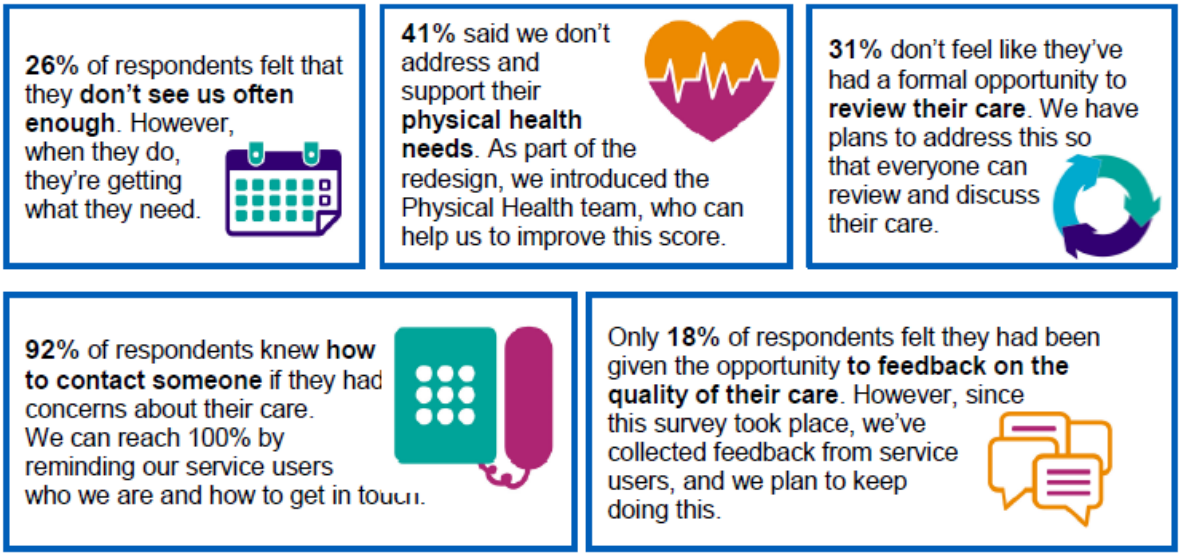
During 2019, 253 service users completed the Care Quality Commission's survey about our community mental health services.

On the whole, we scored on par with other Trusts on the vast majority of questions. However, we saw a slight dip in our overall performance when compared to our results from 2018.

Many service users report that they do not feel they have seen services enough for their needs – this has worsened since last year. Many did not feel as involved as they wanted to be in deciding which therapies to use, and the percentage of service users who know who to contact out of office hours if they have a crisis has decreased since 2018.

On a positive note, our score for how well service users' care is organised has improved and, this year, service users feel more involved in making decisions about their care in review meetings.

Key findings



What we're already doing to improve our community services

In spring 2019, we carried out the community service redesign. There are some core principles that underpin this work:

- We build meaningful relationships with service users to create a partnership
- We invest time in the initial assessment to make sure we understand our service users' needs fully
- We use this understanding and work in partnership with service users to develop a care plan that is authentic and achievable
- We support service users by working as multi-disciplinary teams, including integrated psychological support

We've evaluated the impact of the redesign on transfers of care; you can read our evaluation report on how service users felt about this here. We've also carried out surveys and focus groups with service users to help us continue to improve care and results will be published soon.

More information regarding these developments is available upon request by emailing: e.devine@nhs.net

Friends and Family Test (FFT)

The Friends and Family Test enables NHS Providers to understand whether the patients and service users they support are happy with the care provided and if not, to understand where changes need to be made. We received 121 individual pieces of feedback through FFT and are working towards improving this by re-launching the FFT with improved questions in 2020/2021. Of the overall feedback received in 2019/2020, 83% were extremely satisfied/satisfied with the care provided, 11% extremely unsatisfied/unsatisfied and 6% provided a neutral response. The questions are answered anonymously and are usually asked at the point of discharge from a service. Here are examples of some of the feedback we have received this year from the FFT responses.

In October 2019, positive feedback was received for the Chronic Fatigue Service who are based at the Newsam Centre. Comments included:-

> Staff were responsive to my needs. Consultants helped me to move towards better understanding and control of my condition

> Resources given have helped me to gain a better insight to my condition

> Advice and support was always tailored to my needs

> Staff listened to me and offered solutions to my problems

In November and December 2019 service users gave positive feedback with regards to the staff at The Resource Centre, St Mary's Hospital (who included the care coordinator and psychiatrist)

> Staff were caring and amenable and all of whom were very understanding

> Staff gave me practical advice which helped to give me a balance in my life. This enables me to have a normal a life as is possible.

From the 1st April 2020 changes will be made to the question which must be asked on the Friends and Family Test surveys. The new question will be "Overall, how was your experience of our service" and can be asked at any time during which a person is being provided with care. NHS providers must also ask other questions which enable a patient or service user to leave qualitative information by providing a free text box.

The changes to the FFT questions will be welcomed by services within our Trust as the questions asked of people will hopefully capture more meaningful responses. These responses can be used by services to make effective improvements and there will be accountability over the forthcoming year for teams to demonstrate what changes they have made as a direct result of receiving FFT patient feedback.

Care Quality Committee (CQC) registration, Ratings and Improvement Plans

CQC is part of the Department of Health and Social Care of the United Kingdom. CQC regulates and inspects health and social care services in England

LYPFT is required to register with the Care Quality Commission (CQC) and its current registration status is full registration without condition. The current overall rating LYPFT achieved in December 2019 following inspection in July and August 2019 is GOOD

As a Trust, we are registered with the CQC to carry out the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Diagnostic and screening procedures
- Nursing care & personal care

LYPFT has not participated in any special reviews by the CQC during the reporting period.

The CQC inspect NHS Trusts using the 5 Key Lines of Enquiry (KLOEs), these are: Safe, Effective, Caring, Responsive, and Well led.

During 2019-20 we received notification of a CQC inspection to take place in July and August 2019.

This time the CQC visited these services:

- Forensics inpatient service,
- Older People's inpatient wards,
- New community services for Older People.
- New community services for working age adults
- Rehabilitation and Recovery wards
- Learning Disabilities inpatient ward and respite centres

The CQC also interview the leadership team as part of the "Well-led" category.

The Trust achieved an overall rating of *"Good"* which demonstrates an improvement in the quality of our services compared to the previous inspection in 2018 when we were rated as *'Requires Improvement'*.

- We rated “good” in the well led key question at the Trust level.
- We rated “good” in effective, caring, responsive and well-led.
- The rating for the acute mental health wards for adults of working age and psychiatric intensive care units and the forensic or secure wards is good overall and in all key questions.
- The wards for people with a learning disability or autism is rated as good for caring as patients’ communication needs are now assessed and CQC saw good examples of adaptive communication strategies used to enable patients to participate fully in their treatment and care.
- Systems are effective to ensure that documentation is in place and readily available demonstrating that directors meet the fit and proper person requirement, regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014.
- There is good practice in relation to the application of the Mental Health Act and the Mental Capacity Act. Audits are completed to monitor the compliance with these Acts.
- Governance systems have been established to assess, monitor, and improve the quality and safety of the service, and manage risk, and operate effectively across the Trust and are embedded in locally in most services.
- The CQC observed that staff know and understand the values of the Trust. Staff were able to give descriptions of how the values were used to underpin both individual and team good practice. There is an open and transparent culture where staff knew who the freedom to speak up guardian was and felt able to raise concerns without fear of retribution. Staff felt respected, supported and valued and were supported with opportunities for career progression.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good ↑ Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Good ↑ Dec 2019
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement ↓ Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Requires improvement ↓ Dec 2019	Requires improvement ↓ Dec 2019
Forensic inpatient or secure wards	Good ↑ Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Good ↑ Dec 2019
Child and adolescent mental health wards	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018
Wards for older people with mental health problems	Requires improvement ↓ Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Good →← Dec 2018	Good →← Dec 2019
Wards for people with a learning disability or autism	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019
Community-based mental health services for adults of working age	Requires improvement ↓ Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Good →← Dec 2019
Mental health crisis services and health-based places of safety	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018
Specialist community mental health services for children and young people	Good Nov 2016	Good Nov 2016	Outstanding Nov 2016	Outstanding Nov 2016	Outstanding Nov 2016	Outstanding Nov 2016
Community-based mental health services for older people	Requires improvement ↓ Dec 2019	Requires improvement ↓ Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Requires improvement ↓ Dec 2019
Community mental health services for people with a learning disability or autism	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
National Inpatient Centre for Psychological Medicine	Good Apr 2018	Outstanding Apr 2018	Outstanding Apr 2018	Requires improvement Apr 2018	Good Apr 2018	Good Apr 2018
Overall	Requires improvement →← Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Good ↑ Dec 2019

Outstanding Practice, as reported in our latest CQC report

Acute wards for adults of working age and Psychiatric Intensive Care Units
Delayed discharges – managers had implemented innovative ways to identify and overcome barriers to discharge. Soon after admission, dedicated staff were available to identify with the patient factors which could be a barrier. Where possible, the team could put measures in place to overcome any potential barriers, such as, where changes needed to be made to the patient's home environment before they could be discharged. Managers held daily meetings with the discharge team to discuss capacity and patient flow.

All staff had been trained in identifying early warning signs of increased risk of developing pressure ulcers in their patient group. This was in line with an initiative called 'React to Red Skin' - a pressure ulcer prevention campaign that was committed to educating as many people as possible about the dangers of pressure ulcers and the simple steps that people can take to avoid them.

Long stay/ rehabilitation wards for adults of working age
The rehabilitation and recovery team on site at the Asket Centre provided all patients with intensive support and rehabilitation and were integral in providing a successful rehabilitation pathway for the patients. They provided care coordination during their stay and after discharge to ensure they had the right support when transitioning back into the community.

Wards for older people with mental health problems
Staff provided patients with access to education. For example, staff arranged for one patient with an interest in singing to attend vocal coaching lessons and be part of a singing group at a local college.
Staff also provided patients with rubber soled socks to reduce the risks of slips and falls on the wards.

Forensic inpatient or secure wards
At Clifton House a new service 'Forensic Outreach Liaison Service' had been introduced. This service worked with patients planning discharge and acted as the care co-ordinator for the community health teams. This ensured discharge planning and after discharge care was the responsibility of the same person. The CQC felt this was an outstanding example.

During the inspection the CQC met a patient living in the community who had been collected by a nurse from the team to come into Clifton House for treatment. The nurse had stayed with the patient monitoring them for possible side effects and was visiting their old ward to speak with friends before returning them back to their home address. Nurses not only provided medical support but also social support to ensure patients did not relapse.
The team also took referrals about potential patients for Clifton House working with the relevant community health team to prevent the need for admission.

The CQC has not taken enforcement action against LYPFT during 2019/20

For areas where we still require improvement we have created action plans, progress against which will be monitored via our CQC Project Group. These action plans have been approved by the Board of Directors.

Due to COVID-19 priorities we did not hold CQC project meetings with our clinicians and operations managers from April 2020. Clinicians and frontline staff do not have the capacity to address action plans and CQC agreed with Trusts that other emergency activities took priority during these months; we have however reinstated these from July 2020.

Improving quality of care in our Forensic Services

Leeds and York Forensic Services are delighted to have received a 'good' rating in the recent Care Quality Commission (CQC) inspection demonstrating the improvements in quality they have implemented over the past few years.

The development of a new clinical model is a fundamental part of a quality improvement journey that the service has taken.

Trauma Informed Care recognises that experiencing trauma in the past can affect the ways a person perceives and responds to their environment in the present.

Trauma informed care creates conditions that reduce harm and promote healing, especially in individuals who have already experienced trauma.

Aspects of a situation that may seem benign to someone with no history of trauma can trigger overwhelming feelings of distress in a trauma survivor, leading the individual to behave in ways that might be labelled as, for example, 'oppositional', 'non-compliant', 'delinquent' or 'hostile'.

Working within a trauma informed care model helps to understand more about the service users' individual care needs; 'what has happened to them', 'what have been their personal experiences,' and thus helps foster a therapeutic relationship that is focussed on empowerment and a culture of safety.

Evaluation is key to ensuring that the service assesses and responds to the impact of implementation. To this end they are in the second cycle of administering a co-created patient experience questionnaire and undertaking activity to evaluate staff wellbeing. With the support of the Clinical Effectiveness Team the service has submitted a research proposal to the Trust organised "Dragon's Den" with the hope of gaining academic support for this process.

Colleagues in the service have recently had a paper published in The International Institute of Organisational Psychological Medicine (IIOPM) Journal describing the work that has been undertaken to create, embed and sustain a trauma informed clinical model.

Dr Kerry Hinsby, Lead Consultant Clinical and Forensic Psychologist, said:
"The aim of writing up the methodology was to share the experience of working in an exciting and innovative way. Since publication, it has already generated quite a lot of interest."

Information Governance

The NHS Digital IG Toolkit was superseded in 2018 by the Data Security & Protection Toolkit, based largely on the National Data Guardian's Data Security Standards. The Trust was ready to make* a self-assessment against the 2nd iteration of the NHS Digital Data Security & Protection Toolkit of 'Standards Met' at 31 March 2020, meeting the required evidential standard for all Mandatory Assertions and maintaining the standard achieved last year despite an increase in the number of Mandatory Assertions. This was supported by an internal audit appraisal of a sample of 29 of the 40 Mandatory Assertions, with an outcome of "Significant Assurance". Requirements were included from across all ten of the National Data Guardian's core data security standards.

Throughout the year the Trust has worked on several key Information Governance work streams, including:

- Continuing the embedding of General Data Protection Regulation (GDPR) and its UK enactment as the Data Protection Act (2018)
- Servicing DPA subject access requests against the statutory 1 calendar month timescale, with compliance at >97% reviewed on a rolling 12-month basis
- Maintaining our 100% record for statutory compliance with our Freedom of Information Act request processing
- Continuing to work to the revised NHS Digital Information Governance breach reporting standards, aligned to GDPR, resulting in no reportable incidents since implementation
- Maintaining the highest levels of clinical coding accuracy for Finished Consultant Episodes, with an external accuracy audit confirming outstanding accuracy standards of 100% in 3 of 4 KPIs (including Primary Diagnosis), and 95% in Secondary Diagnosis.
- Maintaining the highest standards of medical records availability, with no DATIX reports of records not located in the 12 months to date
- Implementing numerous data quality / data completeness work streams, aiming to improve data quality and completeness standards throughout the Trust

**Due to COVID19 working restrictions, NHS Digital announced the postponement of the usual DSP Toolkit completion from March 31st to September 30th 2020. Paralleling this, the Trust Board also postponed receiving the end-of-year DSP Toolkit report, so has yet to authorise the publication of our final position as stated above.*

Payment by Results

LYPFT was not subject to the Payments by Results clinical coding audit during 2019/20 by the audit commission.

Learning from Deaths

The Trust continues to review all patient deaths that have been in receipt of care by LYPFT in the 6 months prior to death. The Learning from Healthcare Deaths Policy is under review and will be completed in May 2020.

The Northern Alliance of mental health Trusts is a well-established group and has agreed a consistent approach to learning from deaths in mental health and learning disability services, including how mortality data will be presented to Boards and key themes of learning. The alliance is made up of us and: Sheffield Health & Social Care NHS Foundation Trust, Tees, Esk and Wear Valleys Foundation NHS Trust, North Cumbria Integrated Care NHS Foundation Trust, Northumberland, Tyne and Wear NHS Foundation Trust, Bradford District Care NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust, Humber NHS Foundation Trust, Rotherham Doncaster and South Humber NHS Foundation Trust

The Trust continues to play an active role in the Northern Alliance Mortality Group, which has been useful to share findings and themes across the region.

Two reviews completed by the Trust were escalated to a more comprehensive review after concerns were raised from families about the care provided.

The Trust reports all Learning Disability patient deaths to the Learning Disability Mortality Review Programme. In addition we also participate in the reviews across the city.

Links are also being made with Leeds Teaching Hospital to further progress joint reviews and with an aim to develop a city wide mortality review process. This will ensure learning from mortality is reviewed from a wider perspective that just one individual organisation.

Where a family member or carer raises a concern about any element of care prior to the death of a service user a full comprehensive investigation is completed. We provide healthcare for patients across a wide breadth of partnership services and often we are not classified as the main provider of the deceased person's care. For example we provide psychiatric input for people with cognitive impairment via our memory services and their GP is responsible for the person's ongoing physical healthcare needs.

The total number of deaths (Severity 5) by Quarter are provided in the below table.

Learning From Deaths	Q1	Q2	Q3	Q4
Total number of deaths reported and reviewed 1 April 2019 – 31 March 2020	**98**	**88**	**76**	**102**

We continue to develop the mortality review process. As a result of the work with the Northern Alliance Mortality Group and revision of our own policy we are clearer about whether a patient death should be reviewed or not, this has resulted in us not reviewing deaths outside the scope of our policy.

LYPFT considers that this number and/or rate are as described for the following reasons:

- The Trust actively encourages incident reporting and has developed a supportive and responsive culture of patient safety
- The Trust takes a collaborative approach to reviewing incidents of severity 4 and 5
- The incidents reported as severity 4 and 5 (386 incidents) are low in comparison with those reported as severity 1 and 2 (10880 incidents).

The Leeds and York Partnership NHS Foundation Trust intends to take/has taken the following actions to improve the percentage, and so the quality of its services by continuing to develop the below approach:

- The Trust policy stipulates that all known deaths are reported via DATIX, the Trusts incident reporting system.
- Incidents are discussed at monthly care group governance forums.
- A summary report (CLIP) is provided monthly to aid discussion and highlight concerns.
- All patient safety incidents reported as severity 4 and 5 are reviewed at the twice monthly Learning from Incidents and Mortality Meeting.
- The Trust has refined the use of the Mazar's mortality review codes to avoid confusion and now uses the following:
  - EN1 Expected Natural Death
  - UN2 Unexpected Death from a natural cause
  - UU Unexpected and unnatural death.
  - NOD Not our death, not provider of care.
- Where a patient death is recorded as unexpected/unexplained a further review is undertaken to identify if any care or service delivery problems have contributed to the patient's death.
- All learning disability patient deaths are subject to a review whether unexpected or otherwise, this process is via the Learning Disabilities Mortality Review. The Trust is a panel member of the NHS Leeds LeDer review meetings and has a reviewer allocated to support this process. Any learning is fed back to the Trust from the panel. Additionally, if there are any concerns following initial review of a Learning Disability patient mortality review, a Structured Judgement Review will be completed alongside the LeDer review to ensure learning is identified in the Trust.

Inquests

Between the 1 April 2019 and 31 March 2020 we were registered by the Coroner to be involved in **49** inquests, all of which have been concluded. From these inquests, LYPFT received one Prevention of Future Death (PFD) report served by the Coroner under the Coroner's (investigations) Regulation 28.

Patient Safety Incidents

The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death

The Trust is committed to continually improving the quality and safety of all services. Incident reporting is a fundamental tool of risk management, the aim of which is to collect information about adverse incidents, including near misses, ill health and hazards, which will help to facilitate wider organisational learning.

Staff report patient safety incidents and categorise the degree of harm or potential degree of harm, for example: medication error where a patient has not received the prescribed dose which has the potential to affect their wellbeing is reported as a PSI and categorised accordingly. In addition a patient is provided with an explanation and apology in line with our Duty of Candour policy. The categories are described as follows:

- Severity 1 – No Harm
- Severity 2 – Minor Harm, e.g. required minor treatment
- Severity 3 – Moderate Harm, e.g. required further treatment
- Severity 4 – Major/Severe Harm, e.g. permanent harm/disability, medium psychological harm
- Severity 5 – Death/Catastrophic

The open reporting of incidents (including near misses and 'errors') is positively encouraged by the Trust, as an opportunity to learn and to improve safety, systems and services.

The information below shows the number and percentage of patient safety incidents (PSIs) reported within the LYPFT during the reporting period and previous years, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Period	Number of patient safety incidents uploaded to NRLS	Severe (No)	Severe (%)	Death (No)	*Death (%)
19-20 Q1	1146	2	0.17	1	0.08
19-20 Q2	1308	9	0.68	1	0.07
19-20 Q3	1074	0	0.00	4	0.37
19-20 Q4	1589	0	0.00	1	0.06
Totals:	**5117**	**11**	**0.85**	**7**	**0.58**

* This percentage is the number of deaths reported as serious incidents in accordance with the framework where either a RC of CF were reported as significant factors in the patients care

Between 1 April 2019 and 31 March 2020 a total of 7901 patient safety incidents were reported on the Trust's incident reporting system DATIX. Of these incidents 383 (5%) were categorised as severe harm, indicating long term significant harm (severity 4) or death (severity 5).All patient deaths are categorised as a severity 5, which includes those confirmed as natural, expected deaths. This facilitates a review of all reported deaths to ensure that there is a clear view of mortality and to identify any learning.

We review all patient deaths bi-monthly. The death of any person who has died within the last 6 months of care, who has been in receipt of inpatient mental health services, Care Coordination in Community Services or has accessed the Crisis service is subject to a more in-depth review. This can vary from establishing additional information (fact finding) to a full comprehensive investigation.

According to the NHS National Reporting & Learning System (NRLS) *(2015)* organisations that report more incidents generally have a better, more effective safety culture. Below is our data, including national comparison, as is currently available:

NB: our 'How to understand and improve your patient safety incident reporting to the National Reporting and Learning System (NRLS)' benchmark report is for data set: April 2018 to September 2018.

Period	No Harm	Low	Moderate	Severe	Death	Number of patient safety incidents uploaded
19-20 Q1	808	270	57	2	9	1146
19-20 Q2	910	317	51	9	21	1308
19-20 Q3	716	284	52	2	20	1074
19-20 Q4	1062	419	63	4	41	1589
Totals:	3496	1290	223	17	91	5117

The NHS Patient Safety Strategy: Safer Culture, safer systems, safer patients

This strategy describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems.

The NHS England and NHS Improvement Patient Safety Strategy was published in July 2019. The strategy has a number of recommendations for implementation over the next 2 years. It aims to develop a Patient Safety System across the NHS which is responsive to patient need.

Headlines from the document include:

- Replacing the National Reporting and Learning System (NRLS) and Strategic Executive Information System (STEIS). The Trust reports all patient safety incidents (within an Agreed framework) to the NRLS and all Serious Incidents in accordance with the Serious Incident Framework to the STEIS. The revised system will create a single method of reporting for staff to use.

- The national Serious Incident Framework is being reviewed as part of the strategy. The Patient Safety Strategy plans to develop a broader scope for serious incident reviews rather than a focus on an individual review thus creating thematic reviews to identify wider learning. This will create a systems wide patient safety culture.

- The strategy includes a Medical Examiner role which will enable us to provide a better service for the bereaved; and an opportunity for them to raise any concerns with a doctor not involved directly with the patient's care.

  If you would like to read more about this strategy you can find it here: https://improvement.nhs.uk/resources/patient-safety-strategy/

Falls Group and Pressure Ulcer management

Every 3 months we produce quality reports which provide an overview of pressure ulcers and falls. These provide assurance that all incidents relating to pressure ulcers and falls within LYPFT services are reported, reviewed and investigated; and that we have systems in place to share lessons and improve patient safety.

Our falls are reviewed by severity as follows:

Severity 1 Falls: no injuries sustained

	Q1 (2019/20)	Q2 (2019/20)	Q3 (2019/20)	Q4 (2019/20)
SS/LD Services	36	23	15	42
Leeds Care Services	145	116	92	157

Severity 2 Fall: first aid given, minor interventions

	Q1 (2019/20)	Q2 (2019/20)	Q3 (2019/20)	Q4 (2019/20)
SS/LD Services	08	14	12	13
Leeds Care Services	39	38	20	39

Severity 3 Falls: medical treatment, surgery

	Q1 (2019/20)	Q2 (2019/20)	Q3 (2019/20)	Q4 (2019/20)
SS/LD Services	02	00	01	00
Leeds Care Services	02	01	02	01

Examples of improvements arising from cases of falls include:

- Falls Safety Huddles continue to be held across inpatient services at The Mount with learning from implementing the Falls Huddles being shared within care group governance meetings and regionally at improvement networks. This photograph illustrates a Falls Huddle being held on one of the dementia inpatient services based at The Mount.
- Falls audit in relation to the use of the falls multi-factorial risk assessment at The Mount inpatient services
- Development of a Falls Assessment Tool to raise awareness of risk of falls for service users who are admitted to the acute inpatient mental health service

Pressure Ulcers

The table below details the pressure ulcers reported within our services in 2019/20 and identifies which of those reported were attributable to LYPFT:

	Q1 (2019/20)	Q2 (2019/20)	Q3 (2019/20)	Q4 (2019/20)
Attributable to LYPFT	4	5	2	0
Non-attributable to LYPFT	1	1	1	3

National pressure ulcer reporting guidance from NHS Improvement has recently been incorporated within the LYPFT DATIX reporting system to promote more accurate reporting of pressure ulcers, moisture lesions and device related pressure damage. The reporting categories will also contain whether the pressure ulcer/moisture lesion/device related pressure damage was present on admission to LYPFT clinical services or acquired during care since admission.

Infection Prevention Control Team (IPCT)

We have worked hard in 2019/2020 to improve the standards of care delivered and the environment we all share including ensuring we maintain cleanliness standards, manage outbreaks and implement the flu campaign. The IPCT team progressed with an annual programme of work and the achievements for 2019/20 include:

No reportable cases of Clostridium difficile (C. diff), MRSA or gram negative blood stream infections. The IPCT provides monthly reports ensuring the board are aware of any risk to service users and is appropriately managed.

Key performance data is available and reviewed via a series of reports from the IPCT information system to observe trends. Outbreaks remain consistently low peaking over the winter months with the common causes remaining as influenza and norovirus.

Following the influenza outbreaks in February 2019, a change to the seasonal influenza procedure was implemented including a shortened response time and ensuring prophylactic treatment commenced at the earliest opportunity.

The below table shows the number of recorded outbreaks (any type):

YEAR	QUARTER 1	QUARTER 2	QUARTER 3	QUARTER 4
2019/20	0	3	1	1
2018/19	0	1	1	3
2017/18	0	2	1	4

Environmental audits

Environmental audits are carried out on a yearly basis; the scores provide an indication of compliance and benchmarking across the Trust. Overall achievement scores range between 86% and 98%. This represents acceptable compliance and minimal risk to service users.
A walk-round is conducted monthly to ensure standards are maintained. Furthermore, the Trust undertakes patient led assessment of the care environment (PLACE) audits. This is led by estates who provide support and training for governors or patient representatives to carry out the audit from their perspective. The patient representative carries out the scoring of these visits.

The Annual Flu campaign

The NHS England strategic objectives for the flu plan and the associated Clinical Commissioning Group CQUINs' aim is to actively offer the influenza vaccine to 100% of eligible staff with sliding scale set at 60% to 80%.

Planning for the influenza immunisation programme is a year round process to enable our IPCT and trained colleagues to administer the first vaccinations in October.

Behind the scenes the ground work had already been carried out with the objective being to help staff to understand the importance of consenting to having the vaccination creating a safe

environment for service users. Through regular communication we emphasise how we can help others to stay safe this winter, bust myths and encourage staff to achieve a common goal.

The theme of helping others this year extended to the get a jab give a jab scheme in support of the UNICEF child vaccination programme.

The campaign is close to completion and we have smashed last year's uptake of 79.4 % beating the 80% CQUIN at 84.3%. Service users are encouraged to also have a flu vaccination also.

Safeguarding

Safeguarding is a term to denote measures to protect the health, well-being and human rights of individuals, which allow people — especially children, young people and vulnerable adults — to live free from abuse, harm and neglect.

Over the last year the safeguarding team have implemented a duty system to increase efficiency in response to staff seeking support and advice on safeguarding concerns. The duty system operates over office hours and comprises an allocated safeguarding practitioner working in conjunction with the safeguarding administrator to take and respond to phone and e-mail advice as and when it comes in. Over this year the duty system has given advice to approximately 1200 queries.

Staff are made aware of how to contact the team through a variety of methods including training, Trust intranet, bulletins, policy, posters in clinical areas and Trust wide communications.

The level 3 safeguarding training has been revised in line with the new child and adult intercollegiate documents and a new flexible learning package created. Approximately 1100 staff in the organisation require this level of training. This package has been piloted with staff and outlines the specific learning requirements that each staff member is required to achieve and what specific learning events and resources can be used as evidence. The package is enhanced by the roll out of the regular Trust-wide safeguarding bulletin with updates as to relevant forthcoming learning and teaching events and resources.

Think Family means securing better outcomes for children, young people and families with additional needs by co-ordinating the support they receive from children's, young people's, adults' and family service

An internal audit last year gave significant assurance around safeguarding practice. We continue to champion and promote Think Family and staff are encouraged to gain the child's perspective and listen to the child in the safeguarding context.

Child safeguarding supervision is based on the Morrison 4x4x4 model. This is an evidence based way of providing support, supervision, and reflection to individuals or groups of clinical staff to enhance understanding and better practice.

Other sessions include a thematic adolescent to parent violence session as an action from an Individual Management Review (IMR) related to on-going Serious Case Review (SCR). This is further embedded through the establishment of a network between safeguarding links in the Community Mental Health Team (CMHT)'s and the early help hubs within children's services. Early Help hubs are a combination of different professional workers who wrap around families with children where there is additional need. The establishment of this network further embeds whole family thinking within the Trust and increases timely access to and information sharing with these services for our service-users and their families.

We have undertaken a number of safeguarding investigations which include two thematic analyses around self-neglect and homelessness. Two workshops were provided for the Self Neglect conference hosted by the Safeguarding Adult Board. The learning and recommendations from these investigations and events are actioned through the Trust's governance arrangements.

CareDirector will enable better data collection and progression and recording of safeguarding advice. The figures currently collected are under the four categories of abuse for safeguarding children but can now be widened to capture more specific data such as Child Sexual Exploitation (CSE), Child Criminal Exploitation (CCE) and modern slavery.

Our psychiatric intensive care and perinatal services now employ a social worker with a safeguarding remit who works closely with the safeguarding team around adult and child safeguarding with a particular focus on service users who are parents.
The new Veterans service has been supported with a number of disclosures of War Crimes resulting in the creation of an internal procedure.

We have established our governance in relation to MAPPA (Multi Agency Public Protection arrangements) and the Deputy Head of Safeguarding holds a lead role in this area. This is a new role in the Trust and is key to developing the Trust MAPPA policy, staff learning and procedures to ensure that our service-users, their families and the public are as safe as possible.

The team are supporting the secondment of one of our clinical staff from the forensic service to the front door safeguarding hub to contribute mental health expertise to the daily Multi Agency Risk Assessment Conference (MARAC) meetings, duty and advice calls and strategy meetings.

Mental Health Legislation: Quality improvement

Mental Health Legislation includes a wide variety of legal topics relating to people with a diagnosis or possible diagnosis of a mental health condition, and to those involved in managing or treating these people

The Mental Health Legislation Team is here to offer advice and support to staff, patients and carers in all matters relating to the Mental Health Act (MHA), Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). We understand that an admission to hospital can be a very difficult time and our role is to ensure that the Trusts responsibilities under the relevant legislation are met and patients' rights are protected. We ensure that staff receive the appropriate training and support and meet regularly with patients and carers to make sure they understand their rights under the Acts.

Training

We provide face to face training for inpatient and community staff across the Trust which includes the MHA and MCA/DoLS. We have redesigned the training and now provide both initial and refresher training. All relevant staff complete the initial training once followed by the refresher training every two years. The refresher training focuses on assessments of capacity, clinical scenarios, themes from CQC visits and changes to legislation and case law. We continue to offer bespoke training on request for clinical teams and partner organisations.

Liberty Protection Safeguards

We are actively planning for the implementation of Liberty Protection Safeguards (LPS), which will replace the current DoLS system. While we await the guidance and Code of Practice we are working with local NHS providers and Leeds City Council to ensure that we have a system that meets our statutory responsibilities provides protection for service users and is financially responsible.

Mental Health Act Managers (MHAMs)

Mental Health Act Managers (MHAMs) have a delegated responsibility to hear appeals and hold reviews of patients' detentions. They are not employed by the Trust and are independent in their decision making. We are committed to ensuring that those carrying out this role reflect the diverse cultures of our patient groups and will continue to actively recruit to achieve this. We provide regular training for MHAMs to ensure that they are equipped for their role and hold a quarterly managers forum which is well attended

Out of Area Placements

An 'out of area placement' (OAP) occurs when a person with acute mental health needs who requires inpatient care is admitted to a unit which does not form part of the usual local network of services

We recognise that being placed in hospital away from their community provides a poor experience for both service users and their carers. We have a clear aim to ensure that people are treated either as close to their community as possible.

A citywide review of patient flow in Leeds has shown that we have broadly the correct number of beds for our adult and older people's population. We recognise that we sometimes have problems moving people on from hospital care and these delayed transfers of care result in beds not being available to meet the demand for them. We therefore have to send people to out of area beds.

We review all our delays with the wards and with colleagues and partners in the wider mental health pathway. When people are placed out of area a nurse will visit them once per week and work with the ward team and the patient to agree a plan of care. When people have to be placed further from home we maintain contact with the care team by telephone. We will always ensure that people are allocated a care coordinator to work with them towards planning for transfer from inpatient care.

We aim to transfer people back to their community as soon as possible; this decision will always be based on the clinical needs of the patient.

A trajectory for reducing adult acute and PICU (psychiatric intensive care unit) out of area placements to zero by March 2021 in line with the Mental Health Five Year Forward View is in place. This has been agreed between the Trust and Leeds CCG. A range of initiatives to improve the system's ability to prevent unnecessary admission and shorten inpatient stays has been agreed. We have implemented a new community model to improve access to crisis assessment, gatekeeping and intensive home treatment that will enable early step down from inpatient wards and are monitoring the effect of this on inpatient flow. We are looking in partnership with the CCG at the possibility of providing a community unit as an alternative to hospital admission.

Each week the capacity and flow team have a teleconference with colleagues from Bradford and South West Yorkshire to discuss any shared themes across West Yorkshire affecting capacity and flow / bed management. Recently issues relating to the demand for beds for social care placements for people with learning disabilities and mental health needs have been discussed with Trusts seeing an increase in demand. Delays for people needing a move to low secure forensic services have also been highlighted and the affect this has on PICU capacity. The Trust is leading a piece of work on PICU capacity across the ICS area looking at standardising clinical practice and reviewing capacity and demand across all Trusts.

Progress against out of area trajectory: Number of inappropriate bed days in month*

	Q1 19/20	*Q2 19/20*	*Q3 19/20*	*Q4 19/20*
Trajectory	1,231	1,029	872	504
Actual bed days	1,901	1,489	1,089	1,356

Staff Satisfaction survey

The table below shows the percentage of staff employed by the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends*, as reported on the NHS National Staff Survey**. This includes comparison with the previous three years.

*current definition: "if a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"
**definition has changed since Quality Account guidance was issued

Year	Number of staff employed	% of those staff employed who recommend the trust to family or friends	National Average (Mental Health and LD Trusts)	Highest/Lowest
2019	2616	64%	62%	76% - 38%
2018	2459	64%	61%	81% - 38%
2017	2419	59%	61%	87% - 42%
2016	2412	58%	60%	82% - 44%
2015	2670	57%	58%	84% - 36%

LYPFT considers that this percentage is as described for the following reasons:

March 2019 saw the official launch of an organisational re-design of our community services, affecting approximately 400 staff directly. This changed the way many of our teams within community services work and encouraged flexibility, adaptability and resilience amongst those colleagues.

We see 64% as a positive outcome as:

- From 2015-2018 we saw a year on year increase for this score. The high score achieved in 2018 has been sustained for 2019
- 2018 was the first time our Trust score was higher than the average score for Mental Health and LD Trusts and we have maintained this for 2019

77% of our staff consider that the 'care of patients/service users is my organisation's top priority' which mirrors the 2018 score for this question.

Having a more highly engaged workforce has a positive impact on patient care and we are therefore working on:

- The continuation of our 'Culture Collaborative' work which started in 2019 to understand how staff feel about coming to work, and what needs to change to improve our culture
- Launching an online conversation in June 2020 for staff to discuss our culture throughout the Covid-19 pandemic, how it has felt and what we can learn and take forward as part of recovery
- Looking to pilot a 'happy app' to support organisation-wide improvement led by teams and their direct managers
- Forming an Apprenticeship Steering group tasked with increasing the number of enrolments and increasing number of apprenticeship opportunities available to staff
- Continuing our focus on the health and wellbeing of our staff through a variety of supportive interventions
- Addressing how we can move our development offers online to be accessible in light of the Covid-19 pandemic. We can then continue with our Resilience and 'Effective Manager' programmes

For the last 3 years we were asked to include the most recent LYPFT NHS Staff Survey results for indicators:

'KF19' reported in the LYPFT 2018 results as Key Question 13c (Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months)

In 2019 the percentage for this question was 14%, a favourable decrease of 1% from the 2017 score. We are therefore two favourable percentage points below the sector average of 16%.

And;

'KF27' reported in the LYPFT 2018 results as Key Question 14 (Percentage of staff believing that the organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?) for the Workforce Race Equality Standard

In 2019 the LYPFT percentage for this question was 85% which mirrors that of 2018. The sector average for this question was also 85%.

SECTION 4

OUR QUALITY IMPROVEMENT PRIORITIES FOR THE FORTHCOMING YEAR

Development of our Quality Improvement Priorities (QIPs) for 2020/21

Development of our QIPs for 2020/21 has been through a consultative process, which has included:

- Triangulation with our organisation's vision and values; and Quality Strategy
- A retrospective review of service user, carer and public feedback to identify themes and areas for improvement
- Consideration of the stakeholder feedback we received regarding our 2018/19 Quality Report and Account
- Engagement and meetings with key staff, service leads and our leadership team
- Sessions at our Care Services' Clinical Governance Councils to gain input and insight from Professional Leads to ensure the QIPs are meaningful and relevant to services
- Intelligence, data and information presented and discussed, regarding our current areas of concern and focus within our leadership and governance meetings
- Approval of the proposed QIPs through our Quality Committee
- Consultation with our Council of Governors (February 2020)

A refreshed set of QIPs has been developed for 2020/21 through a consultative process as in 2019/20. In developing these QIPs we have continued to consider:

We have ensured that at least two 2020/21 QIPs relate to each of ***Patient Safety, Effectiveness and Patient Experience****, as recommended in the Quality Account Toolkit.*

The QIPs for 2020/21 have been aligned to the CQC domains: **Safe, Effective, Caring, Responsive and Well Led.** Whilst each QIP has been assigned to a predominant domain, all QIPs cut across more than one domain and a Well Led approach is required in all areas to succeed in their quality improvement aims.

The Coronavirus pandemic has proved to be the biggest healthcare crisis in a generation and we continue to experience extremely high levels of operational pressure as a result. In order to ensure our clinical staff are able to prioritise the delivery of care we have not progressed all QIPs as planned but will be doing so as work streams commence.

Safe

SAFE - people are protected from avoidable harm and abuse. When mistakes occur, lessons will be learned.
Our 2020/21 QIPs for improving safety are:

Quality priority	**Projected quality improvement outcomes 2019/20**	**Progress monitoring and reporting measures**
S1 ***Patient Safety***	Suicide Prevention Plan, development of a Trust approach	We will review the Suicide Prevention Plan and develop an improvement plan on how to support staff affected by suicide. We will report on the NCISH baseline assessment toolkit and produce a report on how to ensure the plan is sustainable. A final report on the implementation of the Trust suicide prevention plan will be completed.
S2 ***Patient Safety***	Safety Planning across the Services	We will deliver training to the following services: IHTT, female acute inpatients and aspire. We will agree the go live date for these teams via the Safety Planning Implementation Group. Top up training and support will be provided to the ISS teams around best practice. We will complete evaluation of roll out and implementation so far, including quality audit of completed safety plans. We will use data gathered to inform the timetable for further service roll out. On-going training and service roll out will be completed as agreed via the Implementation Group. On-going audit and evaluation of services that are newly using the tool. Development of service user training via the Recovery College. Focus groups for service users and carers to get feedback around their experiences of safety planning.

Effective

EFFECTIVE: we will achieve good outcomes with people based on best available evidence. Our 2020/21 QIPs for improving effectiveness are:

Quality priority	Projected quality improvement outcomes 2019/20	Progress monitoring and reporting measures
E1 Mental Health Legislation	Audit of seclusion records	We will have robust processes in place to enable audit of legislative compliance and will establish baseline understanding of areas for improvement and develop action plan. The action plan will be reviewed and we establish next steps. Any identified steps will be progressed appropriately.
E2 Physical Health	Improving the quality of physical healthcare monitoring and the associated interventions: Improve the processes within the physical health monitoring clinics for: – antipsychotic side effect monitoring – Lifestyle review and support to access community services	We will complete a review of side effect monitoring processes practice against best practice guidance. A review of Trust audit results will be completed to understand current practice and variations across the Trust. We will identify opportunities for increasing positive changes and pathways for intervention. Any required changes, in line with the evidence, into the processes of the physical health clinics will be made and we will evaluate for impact on staff and service users.

Caring

CARING: we will involve and treat people with compassion, dignity and respect.

Our 2020/21 QIPs for caring are:

Quality priority	Projected quality improvement outcomes 2019/20	Progress monitoring and reporting measures
C1 Always Events	Develop Always events Using patient experience data and co-production chose the most impactful Always Event and pilot in one service. Roll-out Always Events to other areas as appropriate.	We will establish oversight roles & responsibilities – (terms of reference, following Always Event protocol). We will analyse sources of data for themes and trends and suggest up to 12 themes. We plan to host a Patient Experience workshop to choose the 3 most important topics defined by service users from these themes. We will agree with services which areas will be pilot sites for Always Events. We will establish the aim statement and benchmark one area and implement Always Events. We will test the change idea and monitor the progress of Never Events through the Patient Experience Sub-group on a quarterly basis. We will evaluate progress and plan for 2021/22.
C2 Physical Health	Reducing harm via Nicotine management and e-Cigarette use. Priorities for the year 2020/21 are: 1. Develop a protocol to ensure nicotine replacement therapy provided by the Trust is delivered in an evidence based and cost effective way; this will support more effective use and identify those where alternative harm reduction methods would be suitable 2. Increase stop smoking support for community patients in the Trust	**Outcome 1** We will review evidence for NRT use in the context of the wider stop smoking support offer within the Trust. We will identify the cohort of inpatients receiving NRT who a) have been using for longer than the recommended 12 weeks, b) continue to smoke cigarettes and/or c) use an additional nicotine containing product. We will develop guidance for staff to follow for prescription and review of NRT in form of a protocol. We will review and evaluate use of the protocol to include service user feedback, cost analysis, and staff compliance. **Outcome 2** We will review the effectiveness of the process for identifying and documenting service users who smoke in the

		community setting. We will identify the training need for community staff to enable widespread delivery of very brief advice and nicotine prescribing across all community teams. We will deliver training and collaborate with OneYouLeeds stop smoking service to increase on-site availability of support for service users. We will evaluate the availability of community stop smoking support to identify areas for priority.

Responsive

RESPONSIVE: we will respond to people's needs in a timely way.

Our 2020/21 QIPs for responsive are:

Quality priority	Projected quality improvement outcomes 2019/20	Progress monitoring and reporting measures
R1 Patient Experience & Feedback	Triangle of Care	The Patient Experience Team (PET) will lead the assurance audit of each service/team against their self-assessments. This will be supported by clinical and operational colleagues and carers. Services will provide monthly updates to the Triangle of care steering group in order to share good practice and identify any learning needs. The PET team will have central oversight of self-assessments (via a RAG rated tracker). This will be monitored on a monthly basis through the Triangle of Care steering group and Professional leads will provide updates to Clinical Governance Councils. Triangle of care steering group will review stage 2 submission preparedness and assess the progress with standards and report to Carer strategic sub group. We will start the accreditation document. The PET will coordinate and hold oversight of service contributions. Submission to be agreed by Triangle of Care Steering group and signed off by the Carer strategic sub group. A summary report will be presented to the Patient Experience, Involvement and Carer Strategic group We will submit application for accreditation and communicate successful submission internally and externally.
R2 Continuous Improvement	Increased access to quality improvement training that builds capability and capacity at pace, which also complements the current skills and knowledge building that is delivered during the life cycle of an improvement activity that is supported by the Continuous Improvement Team	We will plan for building capability and capacity at pace across the Trust. Developing and piloting different depths and levels of training resources for use across the Trust. We will roll out and commence the delivery of the range of training resources. We will complete an evaluation and create a 2021/2022 QI training plan.

Well Led

WELL LED: we will work in partnership and learn from our mistakes.

Our 2020/21 QIPs for well led are:

Quality priority	Projected quality improvement outcomes 2019/20	Progress monitoring and reporting measures
W1 Continuous Quality Improvement	Positive & Safe Group actions and impact for 2019/20 - Implementation of Strapline - Involving Service users and carers in reducing conflict and containment	We will develop a strategy for service user and carer involvement to ensure training is co-produced. We will finalise a new training curriculum and advertise Trust wide. We will begin delivering the new training curriculum and the PMVA team will begin RRN certification process. We will complete a training needs analysis (TNA) for community workforce. We will present TNA to clinical governance groups for consultation.
W2 Safeguarding	Safeguarding supervision	More staff will be trained in 4x4 supervision skills increasing capacity across the organisation. An audit of supervision will be set up with audit team with a supervision timetable for the year to be created. A peer model of supervision will be rolled out. A review of the supervision policy will be completed. Audit completion will be shared with the committee. Recommendations from the audit action plan will be completed and an evaluation of peer supervision model.
W3 Patient Experience & Patient Safety	Autism Awareness Training	We will establish funding stream(s), and recruit staff to project team, consult with stakeholders and measure baseline metrics. We will develop a training package and pilot in services. Following pilot period we will commence the training and evaluate any feedback, making requirements where necessary.
W4 Quality Improvement	Supporting the development of clinical leadership for quality, using evidence based methodologies and a partnership working approach – 2 year plan.	The first year is taking the opportunity of the refreshed clinical leadership within the trust to explore systematised improvement with an evidence base in order to develop clinical leadership and improve an important element of clinical care simultaneously.

		We will complete the service clinical leadership redesign including the identification of a clinical leader for this work. We will define the scope of the work, identify representatives, confirm the focus on clinical outcomes and work with partners to develop the plan. We will pilot the 90 day rapid innovation process to set the foundations for the Break Through Series. We will set milestones for the Break Through Series in collaboration with partners.

How our quality and quality priorities will be monitored throughout the year:

The QIPs described in sections 2 and 4 of this report will be monitored as identified with each indicator. At service level a progress review of the indicators will take place via the Care Group Clinical Governance Groups. This will enable service leads and services to know and share how they are doing in relation to their quality improvement goals and provide opportunity for them to identify actions early with regards to any delays in progress against the overall QIP.

Progress against the 2020/21 QIPs will also be monitored by our Trustwide Clinical Governance Group on a quarterly basis, also at our Quality Committee bi-annually, before being presented to our Trust Board at the end of the year as part of the Quality Report and Account process.

Reporting and monitoring in this way ensures that senior managers and the Trust Board are aware of how we are performing against our quality improvement priorities. It is also an opportunity for them to scrutinise and seek further assurance on any actions underway to make those improvements, in order to better ensure they are achieved.

Looking further forward into 2020/2021

In addition to the Quality Improvement Priorities detailed within this section, the following highlights other initiatives within the Trust:

Hepatitis C screening in Forensic Services

We plan to begin screening inpatients for Hepatitis C in forensic services early in 2020. Hepatitis C is a blood borne virus which causes liver damage and can cause cancer, but often goes unidentified until the damage is severe. Because of this, many individuals with infection do not get diagnosed and treated.
Many people in our services fall into the high risk groups identified by Public Health England so we are working with the Hepatitis Specialist Nursing Team at Leeds Teaching Hospital to provide testing and treatment to those at highest risk.

New Eating Disorders Model of Care in West Yorkshire

Our Trust and our mental health collaborative partners have been given a huge vote of confidence by NHS England as we've been given commissioning and budget responsibilities for the new eating disorders model of care in West Yorkshire.
This is part of NHS England's programme for 'provider collaborations' to take on specialised commissioning powers in an expansion of its mental health new care models programme.
This four year contract will come into effect from 1 April 2020.

Physical Health Monitoring and Improvement Team (PHMIT)

In 2020-2021 the team will be working on the following priorities:

- improving the processes for monitoring the side effects of antipsychotic medication
- improving referrals to services which can help people to achieve healthier lifestyles
- improving the quality of information shared with GPs about physical health measurements and blood test results

Physical Health –
Our priorities for the year ahead are:

- Revise our protocol for nicotine replacement therapy to ensure this supports more effective use and identify people where alternative treatments would be suitable
- Increase stop smoking support for community patients in the Trust

Leeds Mental Wellbeing Service (LMWS)

The Trust is part of an exciting collaborative delivering new primary care mental health services from November2019, following a contract announcement by Leeds CCG.

The new Leeds Mental Wellbeing Service (LMWS), which will be led by Leeds Community Healthcare NHS Trust (LCH), brings together Improving Access to Psychological Therapies (or IAPT), a citywide primary care liaison service and perinatal mental health. There are 11 partners involved including us, the Leeds GPs and third sector organisations.

The service will grow over the coming years with new roles being based in general practice, making it more accessible. There are exciting opportunities for us to work together with partners, improve patient retention and help target underrepresented groups. There is also a plan to increase digital therapy which will increase capacity in the service and reduce waiting times.

LMWS will be clinically-led by the Leeds GP Confederation, and LCH will be the lead contract holder.

The Leeds Mental Wellbeing Service Partners are:
- Leeds Community Healthcare NHS Trust,
- Leeds and York Partnership NHS Foundation Trust,
- Leeds GP Confederation, •Northpoint Wellbeing,
- Community Links,
- Touchstone,
- Women's Counselling and Therapy Service
- Homestart Leeds,
- Ieso Digital Health,
- SilverCloud Health,
- SignHealth

Staff Wellbeing

In 2020/21, we will review relevant policies and procedures to ensure they are more 'person centric' and supportive, as well as looking at new initiatives to bring in. The five key areas of Health and Wellbeing we will look at will be: Financial, Mental, Physical, Family friendly and Environmental.

We will be re-examining the support we provide to staff following critical incidents as a priority, ensuring we have a structured procedure which ensures all staff receive the same high level of care and support.

Leading for Inclusion

In 2020 we are planning to develop and launch a “leading for inclusion” programme of development for our senior leadership community. This will include developing and testing a Trust behavioural competency framework and a connected senior leadership development programme. The programme has the following high level aims:

- Increase in levels of psychological safety for all staff
- Increased embedding of Trust values and behaviours
- Consistent behavioural accountability from Trust leaders
- Support leaders to effectively manage themselves
- Improvements in the experience at work of all our staff with a particular focus on the experience of diverse groups. Including BAME disabled and LGBT+ staff.
- Improvements in staff wellbeing

Collaborative Leadership Development

In 2020 the Trust is planning to work in partnership to offer the Moving Forward programme, a specifically designed leadership development for our BAME leaders and staff.

Culture Collaborative

Since July 2019 we have been running an engagement campaign with our staff on the culture of our Trust. We want to understand what our current culture feels like for staff, what good culture would look like and to identify ways in which we can work together to improve our culture.

Continuing to improve our culture is essential to the delivery of high quality services for our service users, as clear links and evidence exists that if staff experience is good this positively impacts on service user experience.
As part of this work we have been able to identify six key themes for improvement through 2020, which are:

- Diverse, consistent leadership
- Safe working environments
- Autonomy and empowerment in effecting changes
- Career development
- Feeling valued and rewarded
- Healthy work/life balance

SECTION 5

STATEMENTS FROM OTHERS ON THE QUALITY REPORT AND ACCOUNT

We welcome the number of positive things, through a patient experience lens, to read in this Quality Account - an intent on collecting better feedback, working with existing community groups and incorporating specific measures based on responses by carers. The real test on the effectiveness of patients' influence will possibly be the Quality Account this time next year: it's an impressive level of ambition, and one in which we will hopefully hear more about over the coming year.

At Healthwatch, our priority focus has been mental health and specifically we have looked at people's experience of having a mental health crisis in Leeds. LYPFT are key partners around this and we are looking forward to seeing how their services develop following the recommendations we have made.

With the Covid 19 Pandemic, and the significant affect it is having on people's mental health, timely access to support and services is essential and LYPFT are key in ensuring people's needs are met.

Representatives from the Trust have been involved in citywide work we are leading on around Peoples Voice, Inclusion for All (with a focus on implementing the Accessible Information Standard), Complaints and Digital Inclusion. We look forward to continuing to work in partnership with LYPFT to help improve the experiences of people accessing their services.

On a general point of presentation, this Quality Account seems very structure and governance-heavy. Whilst acknowledging there are a few case studies included it would have been good to have seen a case study or two on how some of the changes described within the Account will be - or maybe already are - evident from the perspective of a patient; a "how does it feel for me?"-angle.

NHS
Leeds
Clinical Commissioning Group

Ms Cathy Woffendin
Executive Director of Nursing, Quality and Professions
Leeds & York Partnership NHS Foundation Trust
Trust Headquarters
Thorpe Park
Leeds
LS15 8ZB

18th September 2020

Dear Cathy

Thank you for providing the opportunity to feedback on the Quality Account for Leeds & York Partnership NHS Foundation Trust 2019-2020.

This report has been shared with key individuals within Leeds Clinical Commissioning Group (CCG) and this response is on behalf of the organisation. We acknowledge the report provided is in draft form and additional information will be added and amendments made before final publication. Please accept our observations of your report on this basis.

The CCG recognises that the challenges the Covid19 Pandemic brought, has impacted on Trust performance towards the end of 2019-2020, and would like to commend and thank all staff for their responsiveness and dedication during this difficult time.
Overall we feel the document is in a well-presented, easy to read format. The coloured boxes interspersed throughout the document help bring the story to life, engaging the reader in the process. The thorough glossary is useful. The Trust's values of integrity, caring and keeping it simple are reflected throughout. We can confirm that the information provided in the account is in line with statutory requirements as laid out in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010, and amended by the National Health Service (Quality Accounts) Amendment Regulations 2011.

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Other comments are as follows;

It is great to see the range and depth of quality improvement initiatives being taken forward by the Trust, alongside an emphasis on a continuous improvement ethos which underpins all service developments, and that service users are engaged throughout the whole process. It is also good to see the service user perspective used as a basis for the strategy. The voice of the service user can be heard throughout the document, which is commendable. We welcome the inclusion of some well selected patient stories, which are a good reminder to the reader that the patient should be at the heart of all decision making. In relation to patient feedback we noted there was not any reference made to the nationally collected FFT data, which it is felt may have helped provide a more rounded picture of the overall feedback, However we recognise the challenges in using the current FFT tool which is not tailored to meet the complexities of people with mental health conditions or learning disabilities and acknowledge your efforts to address this with NHS England. The introduction of the new FFT tool this year should support the capture of more meaningful qualitative data in these service user groups going forward and we will be interested to see how this is incorporated in to future accounts.

We have however noted that rather than providing the scores for the Friends and Family Test, you have selected some quotes, showing positive feedback and note that whilst these positive views are good to see, without the overall FFT scores this does not necessarily provide a rounded picture of the overall feedback received in 2019/20.

The partnership with the IHI demonstrates a proactive approach to gap analysis and the intent to build on the work already undertaken in respect of the recommendations from the IHI report, is good to see. There is a welcome emphasis on developing leadership capability, which is clearly reflected in the staff survey results, whereby more staff are reporting the Trust as a good place to work (and which is above the national average) and has increased over the last 4 years. This also responds to the CQC assessment and helped improve the Trust's overall rating from Requires Improvement, to Good.

The QIPs for 2019/20 were ambitious and plentiful (13 QIPs and more additional work streams identified) however the Trust have met the majority of QIPs for 2019/20 and where those have not been fully met, the CCG is encouraged to see that they will be carried on into 2020/21. The new QIPs for 2020/21 include implementation of the new Northern Gambling Service and mechanisms for inclusion of service users in understanding governance, which demonstrates the Trust is responding to current challenges faced by our society and viewing service users as partners in care.

The CCG welcomes the introduction of the Physical Health Team, recognising that your patient population requires support with their physical health, and using this team to further develop nurses physical health monitoring skills through training in addition to supporting patients directly, is a great use of that team.

The development of the Recovery College is a really valuable addition for service users. It is good to see that 250 students have accessed the 30 courses and we look forward to seeing this grow further in the next year.

In relation to new priorities, the CCG supports the QIPs for 2020/21 and looks forward to working with the Trust in response to the challenges it continues to face around maintaining the quality and integrity of services as we move through the phase of 'living with Covid'. In preparation for the 2020/2021 Quality Account we offer our support in the creation of that account.

Once again we thank you for the opportunity to review the latest Quality Account, which throughout demonstrates a culture of respect for the service users. We hope that our feedback is accepted as a fair reflection and look forward to seeing the progress made over the coming year.

Yours sincerely

Jo Harding
Executive Director of Nursing and Quality
NHS Leeds Clinical Commissioning Group

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Leeds and York Partnership NHS Foundation Trust's responses to stakeholder comments

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Gipton Approach
Gipton
Leeds LS9 6NL

8 October 2020

Dear Stuart

Re: Quality Report and Account 2019/20

Thank you for Healthwatch Leeds' feedback on our draft Quality Report and Account, as invited via the stakeholder consultation. I acknowledge the comments received and welcome the positive feedback regarding some of the document's content, as seen through the patient lens.

I note that you found the general presentation of the report to be structure and governance heavy, and lacking in demonstrating the patient perspective. As you will know, we are required to produce the report in accordance with the national requirements for Trusts. Our report combines those requirements for both the Quality Report (NHSE/I) and the Quality Account which should be set out as prescribed within the associated toolkit.

We pledged last year to increase the inclusion of service user experience in this year's report and having achieved this aim we have received positive feedback in this respect, including that from our colleagues at NHS Leeds Clinical Commissioning Group. Work has already begun to further build on this for the 2020/21 document with the involvement of our Patient Experience Team.

Within the document we have aimed to link all of the included case studies to a piece of service development and/or improvement work. Examples include:

- The Recovery College P59 followed by Paul Fraser's patient story.
- Northern Gambling Service P61 followed by Nathan Barnes patient story.
- Patient & Carer Stories at our Trust Board meetings followed by the stories of Mark Clayton and Lisa Cromack.

We have also incorporated coloured blue boxes throughout the report to include quotes from staff, service users and carers. These support and illustrate the information in the body of the report.

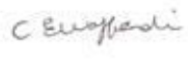
Our Patient Experience and Involvement Strategy web page also provides videos of some of the work we have undertaken as part of co-production with our service users and carers in the last 12 months: https://www.leedsandyorkpft.nhs.uk/get-involved/get-involved/patient-carer-strategy/.

The Healthwatch priority work regarding people's experience of having a mental health crisis in Leeds has been positively received within the Trust and our services have developed actions in response to the recommendations made. We will look to include a review of the quality impact assessment of those in this year's Quality Report and Account.

We have very much welcomed being involved in the work of the People's Voices Group and we report on this involvement internally and externally with our commissioners to ensure a continued awareness and focus on inclusion, particularly in this time where many of our services are being provided and accessed via alternative ways. We look forward to contributing to this work further, to help continuously improve the experience of people accessing healthcare across Leeds during this challenging time.

We will of course ensure that your feedback is shared with the all of the staff and service users involved in the co-production of this year's document.

Yours sincerely



Cathy Woffendin
Executive Director of Nursing, Quality and Professions

Leeds and York Partnership NHS
NHS Foundation Trust

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8 October 2020

Ms Jo Harding
Executive Director of Nursing and Quality
NHS Leeds Clinical Commissioning Group
Suites 2-4, WIRA House
West Park Ring Road
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LS16 6EB

Dear Jo

Re: Quality Report and Account 2019/20

Many thanks for NHS Leeds Clinical Commissioning Group's feedback on our draft Quality Report and Account, as invited via the stakeholder consultation. I acknowledge the well balanced and helpful comments received.

I appreciate the feedback regarding the format and presentation of the document and your acknowledgement of the Trust's values being reflected throughout it, along with the voice of the service user. It was really pleasing to note that our aim to increase the inclusion of service user experience in this year's report has been recognised. Work has already begun to further build on this for the 2020/21 document with the involvement of our Patient Experience Team.

We acknowledge that there is further work to do with regards to The Friends and Family Test (FFT). Unfortunately, as you note, this is more suited to gaining feedback in the acute Trust setting rather than in Mental Health and/or Learning Disability services; and we have raised this with NHS England and Improvement. We are working towards improving the number of FFT responses we receive by re-launching the survey with improved questions in 2020/2021. This will be used alongside a variety of other methods and tools to gain feedback as appropriate to our range of services. We have added reference to this to the report for completeness.

We are proud of our achievements in gaining the CQC rating of 'Good' during the reported year and our service leads are working hard to address those areas where we can still improve through dedicated action plans and regular monitoring of these. Our ongoing work with the Institute for Healthcare Improvement, though our Continuous Improvement Team; and our focussed approaches to leadership development will be significant to facilitate this, taking us forward to achieve our ambition of being an 'Outstanding' organisation in this respect.

Thank you for commending the work of our staff throughout this challenging time. Their dedication to continuing to progress the improvements identified through the Quality Improvement Priorities is notable. I am happy to see the positive comments in this respect and welcome your support of the priorities for the forthcoming year, and in creating the 2020/21 Quality Report and Account.

We will of course ensure that your positive feedback is shared with all of the staff and service users involved in the co-production of this year's document.

Yours sincerely

C Woffendin

Cathy Woffendin
Executive Director of Nursing, Quality and Professions

Acknowledgements

We would like to sincerely thank everyone who made a contribution to the content and publication of our 2019/20 Quality Report and Account. This includes, but is not limited to, patients, carers and representative groups, many of our staff, service and professional leads, the Senior Management Team and the Board of Directors.

This document provides an insight into how we are working to realise our values, our strategies and plans for these; and our aim to continually improve, which is at the heart of everything we do. We hope you find the document to demonstrate this and have enjoyed reading about the quality of our services.

Contact Us

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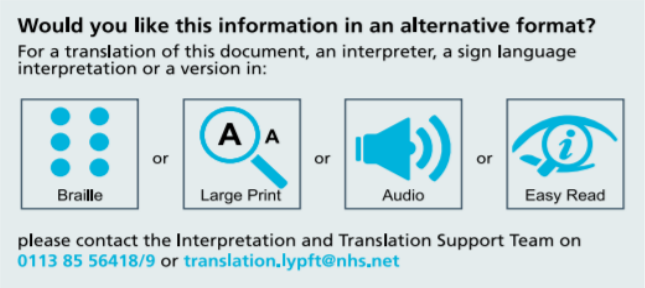

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Let's get social
Facebook: Leeds and York Partnership NHS Foundation Trust
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Youtube: Leeds and York PFT
Linked in: Leeds and York Partnership NHS Foundation Trust

Communications
For all media enquiries or if you would like copies of this report or more information about the Trust you can contact us on:
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Glossary

Adult Intercollegiate document: a guidance document that helps ensure that the health workforce, now and in the future, is equipped with the knowledge and skills they need to work in partnership with patients to safeguard them.

Allied Health Professional (AHP): comprises of distinct occupations including: art therapists, dietitians, music therapists, occupational therapists, physiotherapists, and speech and language therapists.

Anorexia Nervosa: an eating disorder and **psychological** condition marked by extreme self-starvation due to a distorted body image.

Appraisal: a method of reviewing the performance of an employee against nationally agreed standards within the NHS.

Audit: a review or examination and verification of accounts and records (including clinical records)

Board of Directors: the team of executives and non-executives who are responsible for the day to day running of an organisation.

Care Opinion postings: Care Opinion is a website that members of the public can post their comments about our service and we respond accordingly

Care Quality Commission (CQC): the independent Health and Social Care regulator for England.

Clinical cabinet: A group that meets to provide assurance those effective systems of governance are in operation across the organisation

Clinical coding: an electronic coded format that describes the condition and treatment given to a patient.

Clinical supervision: a reflection process that allows clinical staff to develop their skills and solve problems or professional issues. This can take place on an individual basis or in a group.

Clostridium difficile (C diff): an infection caused by bacteria that affects the digestive system. It most commonly affects people who have been treated with antibiotics.

Commissioners: organisations that agree how money should be spent on health within a community. This could be for example Clinical Commissioning Groups (CCGs – Groups of GPs) or NHS England (the central government organisation).

Community Mental Health Team (CMHT): support people living in the community who have complex or serious mental health problems

Continuous Improvement (CI): a management approach that organisations use to reduce waste, increase efficiency, and increase internal (employee) and external (customer/patient) satisfaction. It is an ongoing process that evaluates how an organisation works and ways to improve its processes.

CQUIN (Commissioning for Quality and Innovation): a financial incentive encouraging Trusts to improve the quality of care provided.

Datix: an electronic risk management system (database) used to record incidents, complaints and risks for example.

DOLS (Deprivation of Liberty): DoLS protect people who lack capacity to consent to being deprived of their liberty. This means that because an illness, an injury or a disability has affected the way their mind works they are not able to agree that they will not be allowed to do certain things.

Duty of Candour (DoC): a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to harm.

Elizabeth Garrett Anderson programme: a unique fully accredited healthcare leadership programme, leading to an NHS Leadership Academy Award in Senior Healthcare Leadership and a Masters in Healthcare Leadership.

E-Rostering: an electronic staff management tool used to plan staff requirements and reported on staff hours worked, annual leave, sickness etc.

Friends and Family Test (FFT): a measure of satisfaction usually via a survey or text message, which asks if staff/ patients would recommend the service they received to their friends or family.

IHI: The Institute for Healthcare Improvement takes a unique approach to working with health systems, countries, and other organizations on improving quality, safety, and value in health care

Information governance: the rules and guidance that organisations follow to ensure accurate record keeping and secure information storage.

Inquest: a judicial inquiry to ascertain the facts relating to an incident.

Keith Hurst Optimal Staffing Tool: a tool to help calculate the required number of staff required on a ward depending on the type of ward, the number of service users and the acuity of the service users

Key Performance Indicator (KPI): help us define and measure progress towards our organisational goals.

LD: Learning Disability: a reduced intellectual ability and difficulty with everyday activities – for example household tasks, socialising or managing money – which affects someone for their whole life.

LIMM: Learning from Incidents and Mortality Meeting

Legislation: a law or set of laws suggested by a government and made official by a parliament.

MAPPA: Multi Agency Public Protection arrangements

MARAC: Multi Agency Risk Assessment Conference

Medicines management: processes and guidelines which ensure that medicines are managed and used appropriately and safely

Mental Health Act (1983): the main piece of **legislation** that covers the assessment, treatment and rights of people with a **mental health disorder**. People detained under the Mental Health Act need urgent treatment for a **mental health disorder** and are at risk of harm to themselves or others.

Meticillin resistant Staphylococcus aureus (MRSA): blood stream infection caused by bacteria that is resistant to some treatments.

Methodology: a system of methods used in a particular area of study or activity

NHS England (NHSE): the central organisation that leads the NHS in England and sets the priorities and direction of the NHS

NHS Improvement (NHSI): an NHS organisation that supports us to provide consistently safe, high quality, compassionate care

National Institute for Health and Care Excellence (NICE): an organisation that provides national guidance and advice to improve health and social care with the aim of improving outcomes for people using the NHS and other public health and social care services

National NHS staff survey: a survey that gathers the views of staff working in the NHS to give an overall indication of their experience of working for the NHS

National Reporting and Learning System (NRLS): a central database of patient safety incident reports

Non-medical prescribers: Since May 2006, some nurses, pharmacists and other healthcare professionals have undertaken further training and are qualified to prescribe medicines that were previously only allowed to be prescribed by doctors. Non-medical prescribing has been introduced to improve patients' access to treatment –making it easier for you to get the medicines you need

Non-medical Responsible Clinician: Traditionally, only psychiatrists could be an Approved Clinician, (sole responsibility for the overall care and treatment of someone detained under the Mental Health Act). In 2007 amendments were made enabling non-medics, such as nurses, social workers, psychologists and occupational therapists, to become Approved Clinicians.

Outcome Measures: a measure (using various tools) of the impact of the intervention from a clinician's perspective or a measure of progress related to a specific condition or issue

Patient acuity: a measure of the severity of illness of the patient and the intensity of nursing care that patient requires.

Patient Advice and Liaison Service (PALS): a service that provides a listening, enquiry and signposting service to ensure that patients, carers and public have their questions and concerns resolved as quickly as possible

Patient experience: feedback from patients on 'what happened and how they felt' in the course of receiving their care or treatment

Patient satisfaction: a measurement of how satisfied a person felt about their care or treatment

Payment by results: the system applied to some services whereby NHS providers are paid in accordance with the work they complete

Preceptee: a person undergoing preceptorship (see below)

Preceptor: an experienced member of staff who provides role support and learning experiences to the preceptee to assist them acquire new competencies

Preceptorship: a structured period of transition for a newly qualified member of clinical or therapy staff when then begin their employment in the NHS

Pressure ulcer: damage caused to the skin and the tissue below when it is placed under enough pressure to stop the blood flowing

Psychological: a mental or emotional rather than a physical cause.

Public Health England: an organisation that works to protect and improve national health and wellbeing, and reduce health inequalities

Quality improvement methodology: a systematic approach using specific methods to improve quality; achieving successful and sustained improvement. Through changing provider behaviour and organisation through using a systematic change method and strategies.

RAG rating: a popular project management method for rating status reports based on traffic lights using red, amber (yellow), and green to signify different scale ratings. We use a RAG rating to indicate if a project is on track or at risk.

Risk Assessment: a process to identify risks and analyse what could happen as a result of them

Root Cause Analysis (RCA): a method of investigating and analysing a problem that has occurred to establish the root cause

Scrutiny Board (Health and Well-being and Adult Social Care): a function of the local authority with responsibility to hold decision makers to account for the services they provide

Serious Incident (SI): when a patient, member of staff (including those working in the community), or a member of public suffers injury or unexpected death, or the risk of death or injury in hospital, or health service premises or other premises where healthcare is provided or where actions of health service staff are likely to cause significant public concern.

Strategy: the overall plan an organisation has to achieve its goals over a period of time

Structured Judgement Review (SJR): used to effectively review the care received by patients who have died. This will in turn allow learning and support the development of quality improvement initiatives when problems in care are identified

Subject Access Requests (SAR): requests made for personal information under the Data Protection Act 1998.

Standard Operating Procedure (SOP): a set of step-by-step instructions compiled by an organisation to help workers carry out routine task.

Sustainability and Transformation Plans (STPs): a group of local NHS organisations and councils that have drawn up proposals to improve health and care in the areas they serve. Some are now called Integrated Care Systems (ICS).


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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 report
DATE OF MEETING:	29 October 2020
PRESENTED BY: (name and title)	Dr Chris Hosker, Medical Director
PREPARED BY: (name and title)	Ben Alderson, Guardian of Safe Working

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).

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

RECOMMENDATION

The Board is requested to:

- Consider the information provided within this report.
- Receive this information for assurance of the work ongoing within the Trust.

Leeds and York Partnership NHS
NHS Foundation Trust

GUARDIAN OF SAFE WORKING ANNUAL REPORT

April 2019 to March 2020

This report has been delayed due to COVID. It is to be presented at the Trust Board Meeting 29 October 2020.

1. Executive Summary

On 1st February 2017 Leeds and York Partnership Foundation Trust transitioned all the junior doctors onto the 2016 Junior Doctor Contract.

There are a number of vacancies within both the CT1-3 and ST4-7 and these produce a number of vacant out of hours shifts. The majority of these have been filled using internal locums.

There have been a total of 50 exception reports since the contract was implemented in February 2017. 17 of these are within the reference period of this report.

There have been four reports raising concerns regarding patient safety. Investigation into these reports showed that two reports related to staffing the out of hours rota. The doctors indicated that had there been any further additional work load then the trainees would have been unable to cover this however there was no harm to patients as the workload was manageable. Two reports relate to a lack of clinic room raised by the same doctor on consecutive weeks. The Doctor felt that there had been the potential for safety issues however no safety issues had arisen as the doctor arranged for a different room to be used on each occasion.

There is a Trust strategic workforce plan in place to address recruitment and retention of staff. We continue to work with our junior doctors and their clinical supervisors to ensure patient safety and effective training. The room booking challenge was addressed with the administrative team at the site in question.

Dr Alderson was appointed to role of Guardian on December 1 2019, taking over from Dr Cashman who had been in post since the introduction of the 2016 contract.

2. Introduction

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

The report is for the period from 1st April 2019 and 31st March 2020. It covers:

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

3. Background

Health Education England for Yorkshire and the Humber (HEEYH) fund 65 whole time equivalent posts via the medical tariff. Less than full time trainees (LTFT) can be allocated to Trusts on a supernumerary basis i.e. additional to the agreed training scheme posts. LYPFT has 5 LTFT doctors in training within the Trust at present.

LYPFT is lead employer for the Leeds and Wakefield Psychiatry core training scheme. The two hosting Trusts within this scheme are South West Yorkshire Partnerships Foundation Trust (SWYPFT) and Leeds Community Health Trust (LCH). SWYPFT run their own on call whereas LCH participate in the LYPFT on call rotas. There are 38 Core Trainees (CT) posts allocated to LYPFT. Four of these are allocated on to LCH on the rotas for out of hours working. Rotas for LYPFT and LCH are coordinated through LYPFT. The Psychiatry Resident On Call (PROC) rota is staffed by the CT's.

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

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

Leeds Teaching Hospitals Trust (LTHT) is the lead employer for the Foundation Training Scheme. LYPFT hosts 16 Foundation Trainees including six that participate in the LYPFT PROC rota.

The current head count of doctors in training working in the Trust is 89. A summary table is included in appendix A.

The LYPFT Guardian of Safe Working (GSW) was appointed in November 2016 and is responsible for the directly employed trainees. This requires the GSW to liaise with the hosting organisations with reciprocal liaison with the other Trusts' trainees hosted in LYPFT and not directly employed as exceptions occurring as part of work within other Trusts is reviewed and addressed within that Trust. For example if a CT employed by LYPFT working in SWYPFT reports an exception this is received by LYPFT but addressed by SWYFT.

When there are vacant training places the Trust recruits junior grade doctors on temporary contracts. With the implementation of the 2016 contract these posts are called Trust doctors. These doctors are also employed under the junior doctors 2016 contract as agreed with the Local Negotiating Committee. There are currently 3 Trust doctors employed within the Trust under this mechanism, 2 at 1.0 whole time equivalent and one at 0.75 (this reduced rate post was to back-fill maternity leave).

4. Vacancies and Rota Gaps

4.1 Current Vacancies

Individual services are responsible for addressing gaps in day time cover if there is no trainee using a risk assessment approach. The options available to meet service needs are establishing specialty doctors posts or booking of an agency locum if the need is short term or recruitment to specialty doctor post is unsuccessful.

The CT vacancy for this period is 1 whole time equivalent as the 4 total vacant posts were filled by 3 Trust doctors. The vacancies shown in the appendix were filled with trust doctors funded through service budget as agency doctors due to the mechanism of funding from HEE.

4.2 Rota Gaps

There have been a total of 505 rota gaps, 329 on the CT rota and 176 on the HT rota. The monthly breakdown of rota gaps has been provided in each of the quarterly reports. These are provided in Appendix B.

287 shifts (87% of rota gaps) of the CT rota gaps were covered by internal locums, with 14 shifts (4% of the rota gaps) covered by agency locums. A total of 20 (6%) were left uncovered.

182 shifts (98.9% of rota gaps) of the HT rota rota gaps were covered by internal locums, with 2 shifts (1.1% of the rota gaps) covered by agency locums. 2 shifts were left uncovered.

4.3 Cover for Rota Gaps

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

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

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

If the shift remains uncovered, then the rota may be authorized to run on reduced staffing by the Associate Medical Director for doctors in training (AMD for DiT). In this scenario the medical education team communicates this to the doctors of all grades on the rota, on-call senior manager and switchboard for the date affected to make them aware of the reduced cover.

5. Exception Reports

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

The ER's in this reporting period year have been related to the reduced number of doctors on the rota (and therefore support available whilst on call) or the number of hours worked. No safety concerns were raised related to these issues other than those described above in this report which, when reviewed, had no impact on patient safety. There were 2 ER's raised related to room bookings as highlighted earlier in the report that were incorrectly labelled as patient safety concerns.

6. Work Schedules

There was a return rate of 50% (22/40 for CT's and 11/25 for HT's) for completed personalised work schedules (WS). Last year's return rate was 72%. MEC followed up the schedules not returned. The process prior to COVID was that MEC send out 3 reminder emails, after this an email is sent by the guardian to the trainee and their CS to complete and return the WS. The process involved several reminder emails and was work intensive. For the most recent cohort of WS we have sent 1 reminder

from MEC and 1 email from the Guardian to the trainee and their CS. The reduced WS return rate is most likely explained by the service pressures which came into force at the end of this reporting period as a result of COVID.

7. Fines

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

8. Junior Doctors Forum

The JDF has met on four occasions. JDF was chaired twice by Dr Cashman and twice by Dr Alderson in this period.

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

- Use of Facilities and Fatigue charter funding (£30,000) from the BMA
- Concerns raised by CTs regarding potential increased workload following Trust redesign and enquiries OOH from CRISS and IHTT. This concern did not result in an measurable increased workload
- Concerns raised from CTs re handover process and number of calls received in handover time period. AMD for DiT to raised the issue with ward staff and this was overcome.
- Proposed change to the use of 999 by medical professionals was a potential area for concern. This was raised with the medical director and challenges to the OOH emergency physical health issues were resolved
- HTs flagged up the possibility of under payment on the new contract. Medical Directorate Manager and Medical Education Manager investigated and arrageed back-payment where this as due.
- Concern from the junior doctor body that the rota changes which must be implemented by August 2020 would negatively impact training opportunities and reduce salaries. Exceptional meeting conducted with 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 rota: change to rota be actioned In August 2020
- 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
- use of Zoom for regular teaching sessions appreciated by trainees
- regular contact from DME and AMD for DiT through COVID has been valued by trainees

9. Issues Arising

9.1 Engaging Junior Doctors

I have attended the junior doctor committee and held a GSW introduction after I was appointed. Within these sessions I have been able to discuss the trainees' experience of exception reporting since its inception in 2016. This is something that I will continue to do regularly. I also plan to hold a drop-in session once a quarter for trainees to feedback any concerns that are not brought the junior doctor forum – this plan has delayed due to COVID but I intend to use Zoom to arrange this. I will continue to encourage attendance at the JDF by junior doctors. I also share my email address with trainees who can contact me directly for support or to raise concerns. Through this method I have learnt of some issues that were not exception reported as they did not meet the threshold, but we were able to liaise with the AMD for DiT and address the issues that were arising.

It is important that as a Trust we must continue to support a culture of reporting variance from the work schedule. Relative to our partners in Leeds and across the HEEYH Guardian network LYPFT has a relatively small number of exception reports. It is apparently consistent with that of other local mental health trusts based on verbal reports. I will continue to encourage junior doctors to use ER as it is an important mechanism within their contract to ensure they are working safely for patients.

9.3 BMA Funding for workspace improvement

The £30,000 figure quoted above was allocated from the BMA as part of the Facilities and Fatigue charter. There has been a plan created for how to spend the non-recurrent money however due to CVOID the estates team have not been able to prioritise this work. Works will have been completed in the financial year 20/21 otherwise the funding will be lost.

9.5 Recruitment

National recruitment in Core Psychiatry Training reached over 90% fill rate for the first time in many years in 2019. 381 doctors accepted posts to start in August 2019 nationally. This success was reflected locally with all but 4 CT posts being filled.

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

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

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

10. Summary

There have been very few ER's during this reporting period. Although 4 were identified as patient safety issues on exploration of the reports there were no occasions when patients came to harm.

There is scope to further encourage ER with the junior doctors. I will lead on this over the next 12 months through increased engagement using remote tools and virtual meetings to support this strategy.

Rota gaps continue to be a challenging issue. There are many reasons for rota gaps. These include the national challenge of encouraging more doctors to train in psychiatry as well as individual factors such as unplanned leave for sickness. MEC have worked extremely hard to minimise impact of rota gaps and have covered the vast majority of rota gaps from the internal locum pool of doctors.

Given that there have been no patient safety concerns from ER it is clear that the rota patterns enable the junior doctors to deliver safe patient care. With the forthcoming rota change in August 2020 this will be kept under close review through by the GSW.

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

Dr J B Alderson
GMC 6166755
Guardian of Safe Working Hours

Appendix A

Grade of Dr	LYPFT lead employer	LTHT lead employer	LCH allocation	York placement
CT Psychiatry	38	0	4	0
HT Psychiatry	30	0	0	1
GP Trainee	4			
FY Dr	0	16	0	0

Appendix B

Quarter 1 2019.2020

Rota Gaps		April		May		June	
		CT	HT	CT	HT	CT	HT
	Gaps	10	12	7	15	9	21
	Internal Cover	8	12	7	15	8	20
	Agency cover	1	0	0	0	0	0
	Unfilled	1	0	0	0	1	1
Fill Rate		99.4%	100%	100%	100%	99.4%	96.7%

Quarter 2 2019/2020

Rota Gaps		July		August		September	
		CT	HT	CT	HT	CT	HT
	Gaps	27	22	28	17	36	4
	Internal Cover	23	22	24	15	32	4
	Agency cover	0	0	4	2	1	0
	Unfilled	4	0	0	0	3	0
Fill Rate		98%	100%	100%	100%	98%	100%

Quarter 3 2019/2020

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%

Quarter 4 2019/2020

Rota Gaps		January		February		March	
		CT	HT	CT	HT	CT	HT
	Gaps	28	13	14	14	40	20
	Internal Cover	24	13	14	14	38	20
	Agency cover	0	0	0	0	0	0
	Unfilled	4	0	0	0	2	0
Fill Rate		86%	100%	100%	100%	95%	100%

Appendix C

Exception Reports (ER)	
Reference period of report	01/04/19 - 31/03/20
Total number of exception reports received	17
Number relating to immediate patient safety issues	4
Number relating to hours of working	3
Number relating to pattern of work	3
Number relating to educational opportunities	2
Number relating to service support available to the doctor	9

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	3
Total number of overtime payments	0
Total number of work schedule reviews	0
Total number of reports resulting in no action	11
Total number of organisation changes	0
Compensation	0
Unresolved	2
Total number of resolutions	**14**
Total resolved exceptions	**14**

Reasons for ER over last quarter by specialty & grade

ER relating to:	Specialty	Grade	No. ERs carried over from last report	No. ERs raised	No. ERs closed	No. ERs outstanding
Immediate patient safety	Psychiatry	CT3		2	1	1
	Psychiatry	ST4		2	2	0
Total				**4**	**3**	**1**
No. relating to hours/pattern	Psychiatry	CT1		1	1	0
	Psychiatry	CT1 (2016)		3	3	0
	Psychiatry	CT3		1	0	1
	Psychiatry	Specialty registrar in core training 1		1	1	0
Total				**6**	**5**	**1**
No. relating to educational	Psychiatry	CT1		1	1	0
	Psychiatry	CT2		1	1	0
Total				**2**	**2**	**0**
No. relating to service support available	Psychiatry	CT1		3	1	1
	Psychiatry	CT2		2	2	0
	Psychiatry	CT3		1	1	0
	Psychiatry	ST4		3	3	0
Total				**9**	**7**	**1**

MEETING OF THE BOARD OF DIRECTORS

DATE

Guardian of Safe Working Hours Report

Quarter 1 April – June 2020

1 Executive Summary

The purpose of this quarterly report is to give assurance to the board that doctors in training are safely rostered and that their working hours are compliant with the Junior doctors contract 2016 and in accordance with Junior doctors terms and conditions of service (TCS). The report includes the data from 01.04.2020 to 30.6.2020.

2 Quarter 2 Overview

Vacancies		There are 3 vacancies in the Core Trainee establishment.					
		There are 9 vacancies in the Higher Trainee establishment.					
Rota Gaps		April		May		June	
		CT	HT	CT	HT	CT	HT
	Gaps	37	31	35	23	27	24
	Internal Cover	31	31	28	23	26	23
	Agency cover	4	0	7	0	1	1
	Unfilled	2	0	0	0	0	0
Fill Rate		95%	100%	100%	100%	100%	100%
Exception reports (ER)		2	0	0	0	0	0
		The 2 ER's raised were related to an uncovered rota gap. The doctor reported working 45 minutes over there allocated shift. This was resolved with TOIL. The second issue related to service pressure – there was no patient safety issue however the doctor reported being at the limit of safe working. Please note that due to an error on allocate the PROC rota record by the Doctor had to be made on the HT rota. Also, due to the supervisor being incorrectly allocated this was closed by the GSW following discussion with the junior doctor, who had spoken with their supervisor to resolve both issues.					

Fines	None
Patient Safety Issues	None
Junior Doctor Forum	Meeting held in July 2020. Items of note were: • The HT pay issue is now resolved. • Trainees were happy with the use of Zoom for remote teaching • It was discussed that the junior doctors had worked with phenomenal effort to support the oncall rotas and the running of clinical services to maintain patient safety during the pandemic

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 this new system

Dr John Benjamin Alderson
GMC 6166755
Guardian of Safe Working Hours

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:	Workforce Race Equality and Workforce Disability Equality Statutory Report
DATE OF MEETING:	29 October 2020
PRESENTED BY: (name and title)	Claire Holmes, Director of Workforce and Organisational Development
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

This report provides an update on the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) indicators. As part of the NHS Standard Contract requirements, the Trust submitted this data to NHS England & Improvement in August. The Trust is now required to publish this data, and the associated action plans arising from this, on the LYPFT website by the end of October 2020.

This report details the equality data required under the regulatory framework and highlights key areas of focus and provides details of the WRES and WDES action plans which are due to be published by 31st October 2020.

The data shows that although there are several areas of improvement and several areas where the Trust outperforms our national Mental Health peers, there remains a differential in experience between our BAME and disabled colleagues when compared to white or non-disabled colleagues.

Our current position remains unacceptable and significant improvement is required to provide a fair and inclusive experience for all of our staff.

Priority actions to address the inequality and improve the experience of our colleagues have been presented and supported by the Executive Management Team in September 2020. In addition staff engagement work through our WREN (race) and DaWN (disability) equality staff networks has been undertaken to co-produce actions which are also integral to the Trust's strategic equality and inclusion plan. The WRES and WDES action plans are detailed within Appendix 1 and Appendix 2 of the attached report.

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

RECOMMENDATION

The Board of Directors is asked to;

- To note the 2020 WRES and WDES data and progress against 2019.
- To confirm a level of assurance on the priorities and actions set to address the inequality reported in the WRES and WDES
- To agree to receive quarterly progress updates

MEETING OF THE BOARD OF DIRECTORS

October 2020

Workforce Race Equality Standard and Workforce Disability Equality Standard Regulatory Report

1. Executive Summary

This report provides an update on the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) indicators. As part of the NHS Standard Contract requirements, the Trust submitted this data to NHS England & Improvement in August. The Trust is now required to publish this data, and the associated action plans arising from this, on the LYPFT website by the end of October 2020.

This data was shared and discussed with the Executive Management Team in September 2020, alongside the approach to developing priority actions for the next twelve months.

This report will share the equality data we are required under the regulatory framework, drawing comparisons with the previous year and highlight the key areas of focus and action plans for the forthcoming year.

2. Analysis of the issue - Workforce Race Equality Standard (WRES) Data

WRES reports data over nine metric and has been part of the NHS Standard Contract since 2015. Metrics 1 to 4 examine workforce data. For the workforce metric 2, 3 & 4, the aspirational target is to achieve a score of 1. This would evidence parity; a score outside this indicates an adverse impact on a subgroup. Metric 5 to 8 examine the experience of work via the NHS National Staff Survey results. Metric 9 considers representation of the Trust Board in comparison to the overall workforce.

WRES Metric 1 – Workforce Profile within Agenda for Change Pay scales

Note: Metric 1 Data is based on a 2 year collection period from April 1st 2018 – March 31st 2020

As at 31st March 2020 the number of colleagues identifying as from Black, Asian & Minority Ethnic (BAME) backgrounds increased from 371 to 409 across the agenda for change pay scales. Full representation including Medics (consultant, non-consultant and trainee grades) is 484 or 17.4% of the workforce. BAME under WRES is defined as non-white.

In relation to more senior roles there has been no notable change in BAME representation at Band 7 or 9. There has however been an increase of BAME staff within Band 8 of approximately 1.5%. Although not published within the WRES data set, the greatest increase has been at Band 8b where the percentage of BAME staff in this band has increased from 4% in 2019 to 11% in 2020.

Band	Ethnicity Group	2019	2020
Band 7	BAME	8.58%	8.65%
	Not Stated	2.58%	3.38%
	White	88.84%	87.97%
Band 8	BAME	7.39%	8.88%
	Not Stated	3.48%	3.09%
	White	89.13%	88.03%
Band 9	White	100.00%	100.00%

WRES Metric 2 – Recruitment

Note: Data is based on a 1 year collection period from April 1st 2019 to March 31st 2020

The relative likelihood of BAME applicants being appointed to posts in comparison to people from white backgrounds has disappointingly decreased. For 2020 this metric shows white applicants as being 2.65 more likely to be appointed than people from BAME backgrounds compared to 2.22 times more likely in 2019. More recently this figure is supported by the engagement discussions with BAME network members who have shared their experiences of not being successful during the shortlisting/selection process of recruitment.

A number of actions have been taken to improve this metric including a review of recruitment manager training, two workshops were designed with Workplace Race Equality Scheme members input to address their experiences and identified gaps in completing applications, interviews techniques and confidence building and additionally peer support and mentoring were encouraged amongst members to support interview techniques. This has not yet seen the desired improvement and this has been identified through the Equality and Inclusion taskforce as a priority are for 2020 with additional programmes of work planned to support improvement.

WRES Metric 3- Disciplinary Process

Note: Data is based on a 2 year collection period from April 1st 2018 – March 31st 2020

This has been a focus of the equality improvement work during 2019. There has been some success with the relative likelihood of colleagues from BAME backgrounds entering formal disciplinary processes falling from 2.53 times more likely to 2.12 times more likely in 2020. As part of the work on ‘Fair Experience for All’ a number of workshops have been held to understand and share the experience of our staff (in

particular our BAME staff) who have undergone the disciplinary process, as well as the experience of managers and colleagues who are involved throughout the process, to understand the key areas of improvement. As a result of this feedback, work commenced to review the disciplinary policy and introduce a decision tree, however this work was hibernated during the height of Covid.

Significant improvement is required and this continues to be a priority area for 2021. Work has now recommenced to review the disciplinary process and several additional actions have been agreed to move this metric to within the acceptable range of 0.80 – 1.25.

WRES Metric 4 – Access to Non Mandatory Training

Note: Data is based on a 1 year collection period from April 1st 2019 – March 31st 2020

Non-mandatory training – refers to any learning, education, training or staff development activity undertaken by an employee, the completion of which is neither a statutory requirement (e.g. fire safety training) or mandated by the organisation (e.g. clinical records system training).

The relative likelihood of colleagues from BAME background accessing non mandatory training has remained static at 0.8. This data set is taken from I-Learn for LYPFT delivered training.

The rating is determined by an algorithm based on how likely each group are to access non-mandatory training. The table below outlines the percentage of staff accessing training by ethnicity and the likelihood calculation shows that in our Trust white staff are less likely to access non-mandatory training (0.807), meaning BAME staff are 1.2 times more likely to access non-mandatory training than white counterparts.

Ethnicity	Staff Accessing Training	Staff in Post	Relative Likelihood of staff accessing training
White	943	2210	43%
BME	256	484	53%
Not Stated	35	81	43%
Total	1234	2775	44%
		Likelihood rate	1.240

WRES Metric 5 to 8 – Staff Survey Results

Metrics 5 through to 8 are taken from the National NHS Staff Survey results for 2019 which show an increase overall in the LYPFT scores in the Equality, Diversity & Inclusion theme:

Theme	2018	2019	National Average	Best Performing
Equality, Diversity and Inclusion	9.0	9.1	9.0	9.3

Whilst the Staff Survey results show improvements in the Equality, Diversity and Inclusion theme, our BAME colleagues continue to report a different experience to that of their white colleagues.

For the WRES metric the results for 3 of the metrics in the staff survey have increased whilst 1 has decreased.

WRES Indicator	WRES Description		2018 %	2019 %	National MH Ave for BAME. %
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White	29.5	27.6	39.7
		BAME	36.9	35.0	
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White	19.5	17.5	25.5
		BAME	21.6	17.5	
7	Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion.	White	87.8	87.3	74.3
		BAME	71.9	75.5	
8	Percentage of staff reporting experiencing discrimination at work from a manager/team leader or other colleagues in the last 12 months.	White	4.7	4.9	14.0
		BAME	9.3	11.6	

Reducing bullying and harassment has been a significant focus for the Trust over the past 2 years and the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public has decreased therefore improving this metric. The Trust scores better than the National Average for BAME colleagues however there is still a 7.5% differential between the experiences of our BAME staff to that of White colleagues. The percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months has decreased at a faster rate for BAME colleagues than white colleagues, resulting in a consistent experience that for BAME colleagues reflect a 8.5% improvement on the national average BAME colleague experience.

Perception of career progression has increased and is better than the national average. The Workplace Race Equality Network is a forum at which opportunities and promotions get discussed to help increase confidence in applying for roles. Further work is planned targeting both our senior roles, and our Band 6 clinical roles to continue to improve in this area with the roll out of career conversations and targeted recruitment support.

The percentage of BAME colleagues who reported experiencing discrimination from management and colleagues during the preceding 12 months has sadly increased by 2%. Although this remains below the national average, the experience of our White colleagues comparatively decreased very slightly, again highlighting a differential of experience for our BAME colleagues to our White Colleagues.

WRES Metric 9 – Board Representation

BAME representation on the Trust Board of Directors was 7.7% as at 31 March 2020. In comparison the overall representation of colleagues from BAME backgrounds in the Trust, including Medical & Dental colleagues was 17.4%. The difference (7.7 – 17.4) is

reported as minus 9.8% in the WRES 2020, indicating the Board is less representative (by – 9.8%) when considering ethnicity in comparison to our overall workforce. There has been no change in the Executive management team in representation of BAME staff since the implementation of WRES standard. Nationally, there has been an increase of 35 BAME staff at board level with an additional 18 executive and 19 non-executive members.

3. Analysis of the issue - Workforce Disability Equality Standard (WDES) Data

WDES reports data over ten metric and commenced in 2019. Metrics 1 to 3 examine workforce data with consideration of the Disabled staff representation across the pay bands, recruitment and application of the HR formal capability process. For the workforce metric 2 and 3 the aspirational target is to achieve a score of 1, as this would evidence parity. Metric 4 to 9 examine the experience of work via the NHS National Staff Survey results. Metric 10 considers representation of the Trust Board in comparison to the workforce.

WDES Metric 1 – Workforce Profile within Agenda for Change Pay scales

Note: Data is as at March 31st 2020 with previous figures included for comparison.

In 2020 the proportion of colleagues identifying as being Disabled remained at 5.3%, with 85.7% non-disabled and 9% with a status unknown. To avoid identifying Disabled colleagues the WDES reports the workforce profile in clusters of pay bands.

Pay Cluster	Disabled	Non- disabled	Not Stated
Band 1, 2, 3 & 4	5.4%	86.2%	8.4%
Band 5, 6 & 7	5.6%	91.1%	3.3%
Band 8a & 8b	3.0%	92.4%	4.5%
Band 8c, 8d, 9 & Very Senior Managers	2.8%	83.3%	13.9%
Medical & Dental – Consultants	2.6%	89.3%	8.0%
Medical & Dental – SAS Grades	0.0%	94.3%	5.7%
Medical & Dental – Trainees	2.6%	68.4%	28.9%
WDES 2020 Workforce Profile	**5.3%**	**85.7%**	**9%**
WDES 2019 Workforce Profile	**4.83%**	**86.96%**	**8.21%**

The representation of Disabled colleagues, although fairly static in the first two pay clusters, decreases by half as we move into the highest two pay clusters.

It is important to recognise that in total 23.2% colleagues who completed the staff survey in 2019 indicated living with a physical or mental health condition, disability or illness which was expected to last for 12 months or more. This is significantly higher than the 5.3% of colleagues who have declared a Disability on ESR. The staff survey is anonymous and therefore the following data relating to the Workplace Disability Equality Scheme can only report on the 5.3% who have declared a disability. The

Disability and Wellbeing Network are working with members to understand what actions we need to take to create a psychologically safe environment in which all staff feel confident to disclose a disability.

WDES Metric 2 – Recruitment

Note: Data is as at March 31st 2020 with previous figures included for comparison.

The relative likelihood of Disabled people being appointed to posts in comparison to non-disabled people has improved in 2020 to 1.30. This is an improvement from 2019 when it was reported non-disabled people were 1.65 times more likely to be appointed to posts. The national average for Mental Health trusts is 1.01 and more work is required to continue to improve in this area.

WDES Metric 3 – Formal Capability Processes.

Note: Data is based on a 2 year collection period from April 1st 2018 – March 31st 2020

The relative likelihood of Disabled colleagues entering a formal capability process for unsatisfactory work performance, in comparison to non-disabled colleagues, has increased, with 2020 data showing disabled colleagues were 5.35 times more likely to enter a formal capability process than White colleagues. In 2019 no Disabled colleagues entered the formal capability process. It should be noted that the overall number of capability cases over the two year reporting period was four of which one was categorised as disabled.

WDES Metric 4 to 9 – Staff Survey Results

Metric 4 through 9 are taken from the National NHS Staff Survey results for 2019. As noted in the WRES analysis above, the Trust performs well in the overall staff survey theme of Equality, Diversity & Inclusion with a theme score of 9.1 out of 10, however again there are differing experiences for the 23% of colleagues who disclosed a disability during the survey in comparison to non-disabled colleagues.

We have seen over a 5% decrease in the number of disabled staff experiencing harassment, bullying or abuse from service user, relatives or members of the public and a 3.5% decrease from colleagues. Comparatively the improvement has been greater for disabled staff than non-disabled staff but a differential in experience remains with disabled staff reporting 3% more likely to experience such treatment from service users or the public and 8% more likely to experience such treatment from colleagues than non-disabled staff. The percentage of disabled staff reporting harassment, bullying or abuse from managers however has increased by 1.6% whilst non-disabled colleagues report a minor decrease in this experience, this widening the differential. In all three areas the Trust outperforms the national average for Mental Health Trusts.

The percentage of staff who said they, or a colleague, reported witnessing bullying, harassment or abuse from a colleague decreased for both disabled and non-disabled colleagues. The decrease was significantly more pronounced for disabled colleagues which has created an 8% gap in experience and taken us below the national average.

This reinforces the need to develop the work of the Disability and Wellbeing network in creating a psychologically safe environment for our staff, in particular, our disabled staff.

There has been a slight improvement in the percentage of disabled staff believing the Trust provide equal opportunities for career progression or promotion, despite a slight drop in this response from non-disabled colleagues. The Trust performs at the national average but there remains a gap between the experience of our disabled and non-disabled colleagues which need to be addressed.

Our disabled staff are reporting feeling greater pressure to come into work despite not feeling well enough to perform their duties than in the previous year. Although slightly below the national average, our disabled staff are twice as likely to report feeling this pressure than our non-disabled staff.

The extent to which our disabled staff feel satisfied with the extent to which the organisation values their work has improved by almost 7% on last year. Again, this is an improved position comparatively to the national average for mental health trusts but a significant differential of 8% remains compared to the extent to which non-disabled staff are satisfied the organisation values their work.

The percentage of staff reporting that adequate reasonable adjustments have been made to enable them to carry out their work remains relatively static and in line with the national peer average.
Finally, the staff engagement score for disabled staff has improved slightly and is now slightly ahead of the national average but engagement remains lower than non-disabled colleagues.

In summary, when reflecting on the 9 outcomes which make up metrics 4 through to 9, the Trust is below average on only 1 and exceed on 6. Whereas this presents a positive position comparative to other Trusts, there remains a negative differential of experience for our disabled colleagues comparatively to non-disabled colleagues on all of the metrics.

The table below summarises all of the relevant metrics:

Metric	WDES Descriptor	Disabled/ Non-disabled staff	2018 (%)	2019 (%)	National MH Ave. Disabled (%)
4a i	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from - Patients / Service Users, their relatives or other members of the public	Disabled staff	36.6	31.1	37.1
		Non-disabled staff	28.8	27.7	
4a ii	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from – Managers	Disabled staff	11.7	13.3	16.6
		Non-disabled staff	6.5	5.9	
4a iii	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from – Colleagues	Disabled staff	23.8	20.3	23.1
		Non-disabled staff	13	12.4	
4b	Percentage of Disabled staff compared to non-	Disabled staff	61.5	52.4	58.2

	disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	Non-disabled staff	63.6	60.5	
5	Percentage of Disabled staff compared to non – disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	Disabled staff	77.8	79.3	79.3
		Non-disabled staff	87.7	87.5	
6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Disabled staff	17.4	21.6	22.3
		Non-disabled staff	14.2	10.6	
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	Disabled staff	38.5	45.3	41.7
		Non-disabled staff	53.1	53.5	
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	Disabled staff	77.3	77.1	77.1
9	The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.	Disabled staff	6.7	6.8	6.7
		Non-disabled staff	7.2	7.3	

WDES Metric 10 – Board Representation

Recorded/declared representation on the Trust's Board of Directors of Disabled colleagues was 0% as of 31 March 2020. In comparison the overall representation of Disabled colleagues in the Trust was 5.3%. The difference (0% - 5.3%) is reported as minus 5%, indicating the Board is less representative (by – 5%) when considering disability in comparison to our overall workforce.

4. WRES and WDES Priority Actions 2020

The following actions have been critical in starting to change the narrative and will require ongoing assurance and commitment for these to continue with the support of the Board of Directors and the Executive management team to drive change and to cultivate a culture of inclusion for our workforce and for our service users and carers;

WRES

- The Workforce Race Equality Network (WREN) being sponsored by the CEO and supported by the Director of Organisational Development and Workforce (leadership from the top)
- Inclusion of BAME staff at interview panels, initially for roles at Band 8b and above (commenced from August 2020)
- WREN network led communications and staff engagement work aimed at enabling people to work comfortably with race equality to drive culture change; including developmental sessions, information sharing and giving, and celebrating achievement.
- Implementation of the Developing Cultural Intelligent (CQ) & Inclusive Leaders Post Covid-19 programme for senior leaders from October 2020.
- Board reciprocal mentoring programme commencing in November 2020.
- Wellbeing Assessment conversation process to provide a holistic and person centred approach to managing Covid related risk for all staff but with particular

focus on those at higher risk, including BAME staff and staff with underlying health conditions.

- Full review of the disciplinary and grievance process to strengthen and provide assurance on decision making process (recommenced September 2020, on hold due to pandemic response work).
- Introduction of career conversations within appraisal process in October 2020, prioritising conversations with BAME staff by April 2021.
- Revised recruitment training for appointing managers from September 2020 to incorporate cultural intelligence and unconscious bias modules.
- Establishment of five Freedom to Speak Up Ambassadors in September 2020, working alongside the Freedom to Speak up Guardian, to increase routes for staff to speak out.

WDES

- The workforce Disability and Wellbeing Network (DaWN) being sponsored by the Director of Organisational Development and Workforce (leadership from the top).
- Reviewed, revised and promoted Support Package Agreement with DAWN network. Further guidance developed on reasonable adjustments, Disability Leave and role of HR representative within process to support consistent decision making processes.
- Inclusive leadership programme implementation.
- Wellbeing assessment conversation process.
- Revise recruitment training for appointing managers from September 2020, to incorporate social model of disability and unconscious bias modules.
- Establishment of five Freedom to Speak Up Ambassadors in September 2020, working alongside the Freedom to Speak up Guardian, to increase routes for staff to speak out.

5. Priority Action and Assurance Process

It is evident that aspects of the Trusts WRES and WDES data remain unacceptable. It is clear actions which make a significant impact are needed to improve the WRES and WDES figures, especially those reported via the staff survey and the recruitment metrics.

Priority actions to address the inequality and improve the experience of our colleagues have been presented and supported by the Executive management team in September 2020. In addition staff engagement work through our WREN (race) and DaWN (disability) equality staff networks has been undertaken to co-produce actions which are also integral to the Trust's strategic equality and inclusion plan. The WRES and WDES action plans are detailed within Appendix 1 and 2 within this report.

Quarterly progress assurance will be presented to the Equality Assurance Group and reported to the Trust Board.

Key priorities for the coming year include;

- Strengthen communication and engagement of WRES and WDES actions, plans and progress reporting throughout the Trust.
- Continue implementation, development and evaluation of the WRES actions detailed above including- reciprocal mentoring; disciplinary and grievance process review; BAME staff at interview panels and career conversations.
- Scope and implement BAME and disabled staff positive action career development activity with focus on bands 5 and 6.
- Fully establish and launch Freedom to Speak Up Ambassadors to increase routes for staff to speak out.
- Deliver Leeds place based workforce race equality event in collaboration with NHS partners (postponed due to pandemic response work).
- To further promote and launch revised Support Package Agreement, disability leave guidance and reasonable adjustments good practice information.
- Encourage increase of self-declaration rates on disabilities with the introduction of the revised Support Package Agreement and provide reasonable adjustments.
- Review of the capability process to strengthen and provide assurance on decision making processes.
- Deliver internal disability equality event to formally launch the DaWN staff network.
- Review the investment in Equality and Inclusion activity to ensure the right resources are in place to deliver positive change.

6. Summary

Nurturing a positive culture which promotes equality and inclusion is of strategic importance to the Trust. As both the Leeds and West Yorkshire and Harrogate Integrated Care Systems have developed, we have been working collaboratively and in partnership to develop innovative solutions to a systematic problem of inequality.

Our WRES data shows that the pace of change has been slow and that aspects of the Trusts WRES and WDES data remain unacceptable. Actions which make a significant impact are needed to improve the WRES and WDES figures.

The People Plan provides the opportunity to develop and deliver on approaches to workforce race and disability equality at increased pace, with focus on how we develop a culture of inclusion and belonging, with a particular focus on the systemic discrimination that our BAME and disabled colleagues face.

Our staff networks play a key role in influencing and driving our race and disability equality strategic direction and plans. The membership and involvement of our Workforce Race Equality Network (WREN) has increased substantially, particularly over the pandemic period to over 148 members. Frequency of meetings also increased to weekly over the height of the pandemic in response to the emerging risk factors for people from BAME backgrounds. Members have been active in sharing their knowledge and experience to inform and influence process and culture change through a variety of methods including participating in workshops, delivering presentations; creating videos and blogs and through social media.

Conversely the active membership of our Disability and Wellbeing Network (DaWN) has substantially reduced since last year and particularly over the pandemic period. Further focused work is required to develop the network further and to increase links at internal strategic level to support the development and delivery of our disability equality and WDES plans.

Planning work is taking place to clearly articulate our equality and inclusion ambitions and further focus and action is required to strengthen communication of WRES and WDES related actions and progress.

7. Recommendation

The Board of Directors are asked to:

- To note the 2020 WRES and WDES data and progress against 2019.
- To confirm a level of assurance on the priorities and actions set to address the inequality reported in the WRES and WDES
- To agree to receive quarterly progress updates

Caroline Bamford
Head of Diversity and Inclusion
20th October 2020

Leeds and York Partnership
NHS Foundation Trust

Appendix 1

WRES LYPFT Action Plan October 2020/September 2021

Item	WDES Priority Area / Output	Objective	Action	Lead	Timescale
1	**WRES Metric 2 - Recruitment**	Inclusion of BAME staff at interview panels commencing with focus on areas of greatest under-representation and where disparities identified. Initial focus on senior roles (Band 8b and above) followed by clinical roles (e.g. Band 6 nursing) : to drive cultural change and equity of opportunity	Minimum of 10 BAME staff volunteers to support Trust Appointing Officers on recruitment panels. Staff will be provided with support and guidance through refresher recruitment training, peer coaching and be fully briefed/supported by Appointing Officers.	Caroline Bamford, Head of Diversity	Implement Jan 2021
2		To review and revise recruitment training for Appointing Managers to incorporate cultural intelligence and unconscious bias modules .	Lead Recruitment Team member to work alongside Diversity & Inclusion Team and WREN network/Chair to incorporate experiential narrative from staff on recruitment/promotion challenges and barriers. To include content which identifies inclusive practice in the recruitment stages.	Ian Hoyles, Recruitment Team Manager	Implement October 2020
3		To introduce career conversations within the appraisal process, prioritising conversations with BAME staff by April 2021	Career conversation process to be developed and implemented aligned to wider career development and talent management support model development.	Julie Thornton, Head of learning and Development	Commence October 2020

4		Representative workforce- increasing representation within leadership roles	Develop and implement a 12 month reciprocal mentoring programme, to increase inclusive leadership learning and development opportunities.	Ruby Bansel, Diversity and Inclusion Project Manager	Commence November 2020
5		Scope and implement BAME staff positive action career development activity with focus on bands 5 and 6.	To deliver a BAME positive action career development programme- Moving Forward in collaboration aimed at staff at Bands 5 to 7 with NHS partner organisations. To evaluate the impact of the programme with the aim to incorporate this within our learning and development offer.	Cath Jackson, Learning and OD Lead	Commence by August 2021
6	**WRES Metric 3 - Disciplinary**	Reduce the ethnicity gap when entering into a formal disciplinary process from 2.12 to between 0.8-1.25 times more likely	Review and revise disciplinary process, using feedback and recommendations from internal workshops held 2019/20 including decision tree checklist; post action audit on decisions and pre-formal action check and revised training for managers; ▪ Develop mobilisation plan ▪ Implement communications and engagement plan ▪ Revise process ▪ Revise training for managers	Lindsay Jensen, Associate Director of Workforce and Mubina Ahmed, HR Operational Manager	By December 2020
7		Strengthen routes for speaking up with focus on diversity and inclusion	Launch and roll out FTSU Ambassador programme- initially 5 ambassadors	John Verity, FTSuG	Implement from October 2020
8	**Developing Collective and Inclusive Leadership**	Increase the overall visibility and involvement in race equality improvements at Trust Board, with senior leaders and with all staff across the organisation.	Cultural Intelligence Programme to commence from October 2020 which aims develop skills and confidence for managers to lead culturally inclusive teams. To be delivered in 4 cohorts until March 2021.	Angela Earnshaw, Head of Learning and OD	Oct 2020-March 2021
9	**Deliver wellbeing,**	Review governance arrangements to ensure that staff networks are	WREN network led communications and staff engagement work aimed at	Caroline Bamford, Head of Diversity and	Ongoing- evaluate impact by August

	learning and cultural change	able to contribute to and inform decision-making processes.	enabling people to work comfortably with race equality. Strengthen communication and engagement of WRES actions, plans and progress reporting throughout the Trust. - Increasing awareness to senior leaders and staff around equality issues, using staff stories and experiential narratives	Inclusion and Wendy Tangen. WREN Staff network Chair	2021
10		To deliver a Leeds city-based workforce race equality event in collaboration with NHS partners to raise to celebrate workforce race equality and diversity, share experiential narrative of BAME NHS staff and promote good practice.	Work in partnership with Leeds NHS and CCG organisations to co-ordinate the development and delivery of a cross-organisational event, endorsed and supported by organisational Executive Leads.	Caroline Bamford, Ruby Bansel, Wendy Tangent	August 2021
11		Discuss equality, diversity and inclusion as part of the health and wellbeing conversations	EDI discussion and actions embedded within wellbeing assessment conversations • Data assurance that Wellbeing Assessment discussions including EDI discussion as part of 1;1's and appraisal take place • Evaluate Wellbeing Assessment process and impact	Andrew McNichol, Head of Workforce information Richard Wylde, Head of Improvement and Knowledge	Ongoing December 2020

Appendix 2

WDES LYPFT Action Plan October 2020/September 2021

Item	WDES Priority Area / Output	Objective	Action	Lead	Timescale
1	**WDES Metric 1 – Workforce Profile**	Encourage increase of self-declaration rates on disabilities with the introduction of the revised Support Package Agreement and provide reasonable adjustments	Develop and implement revised Support Package Agreement and reasonable adjustments guidance: Design and send out communication to staff in collaboration with our Disability and Wellbeing Network (DaWN): • Disability equality background information • What the information is used for. • How the data is used and shared. How to enter the ESR portal and update their demographic information on the self-service portal Introduction and promotion of revised Wellbeing and Managing Attendance procedure and communicate commitment to disability equality	Caroline Bamford, Head of Diversity and Inclusion	January 2021
2	**WDES Metric 2 – Recruitment**	Revise recruitment training for appointing managers to incorporate social model of disability and unconscious bias modules	Lead Recruitment Team member to work alongside Diversity & Inclusion Team and DaWN network/Chair to incorporate experiential narrative from staff on recruitment/promotion challenges and barriers. To include content which identifies inclusive practice in the recruitment stages.	Ian Hoyles, Recruitment Team Manager	Implement October 2020
3		To undertake career conversations with our staff with disabilities or long term health conditions to improve recruitment and promotion	Career conversation process to be developed and implemented aligned to wider career development and talent management support model development.	Julie Thornton, Head of Learning and Development	To commence October 2020

		opportunities and practices			
4	**WDES Metric 3 – Formal Capability Processes**	Review of the capability process to strengthen and provide assurance on decision making processes	Complete a review of the capability process and procedure to strengthen decision making processes	Lindsay Jensen// HR Lead (TBC)	January 2021
5	**WDES Metric 4 to 9 – Staff Survey Questions- Experiences, engagement and organisational culture**	Strengthen workforce communications and engagement with DaWN and the disability equality agenda	To further develop and promote the work of the DaWN staff network via Trust Welcome Days; senior leadership team meeting and management group meetings. WDES data and disability equality communications to be co-produced with DaWN (blogs, experiential case studies), social media campaigns, website promotion and teams aiming to engage staff.	Ruby Bansel, Diversity and Inclusion project Manager	To commence October 2020
6		To increase membership (including allies) and staff engagement with the Trust's Disability and Wellbeing Network (DaWN)	Deliver internal disability equality event to formally launch the DaWN staff network	Ruby Bansel, Diversity and Inclusion Project Manager	By August 2021
7		Further promote existing channels to support staff with disabilities and long term health conditions to access relevant and appropriate support and to encourage staff to speak up (Health and Wellbeing offers, Freedom to Speak Up Guardian and Ambassadors)	Launch and roll out FTSU Ambassador programme- initially 5 ambassadors to strengthen routes for speaking up with focus on diversity and inclusion	John Verity, FTSuG	From October 2020
8	**Driving Cultural and systemic change**	To further promote and launch revised Support Package Agreement, disability leave guidance and reasonable adjustments good practice information	Review and promote Support Package Agreement information to include further guidance on reasonable adjustments and Disability Leave. Promote role of HR representative within process to support consistent decision making processes.	Curtis Abbott, HR Manager and Ruby Bansel, Diversity and Inclusion Project Manager	January 2021

9		To review and revise the Wellbeing and Managing Attendance processes and procedure using feedback and recommendations from DaWN network	To develop separate Wellbeing procedure using feedback and recommendations from DaWN staff network.	Curtis Abbott, HR Manager and Ruby Bansel, Diversity and Inclusion Project Manager	January 2021
10		Discuss equality, diversity and inclusion as part of the health and wellbeing conversations	EDI discussion and actions embedded within wellbeing assessment conversations • Data assurance that Wellbeing Assessment discussions including EDI discussion as part of 1;1's and appraisal take place • Evaluate Wellbeing Assessment process and impact	Andrew McNichol, Head of Workforce information Richard Wylde, Head of Improvement and Knowledge	Ongoing December 2020
11		Strengthen communications and engagement and review governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes.	DaWN network led communications and staff engagement work aimed at enabling people to work comfortably with race equality. Strengthen communication and engagement of DaWN actions, plans and progress reporting throughout the Trust. Increasing awareness to senior leaders and staff around disability equality issues, using staff stories and experiential narratives	Caroline Bamford, Head of Diversity and Inclusion	Ongoing
12		Increase visible commitment to disability equality and strengthen assurance processes	Review and revise Wellbeing and Managing Attendance processes and procedure using feedback and recommendations from DaWN network including reasonable adjustments assurance process; disability leave guidance and reasonable adjustments good practice guidance; ▪ Develop mobilisation plan ▪ Implement communications and	Lindsay Jensen, Associate Director of workforce and Curtis Abbott, HR Manager	By January 2021

			engagement plan ▪ Revise process ▪ Revise training for managers		

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM

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MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Winter Resilience and Operating Plan
DATE OF MEETING:	29 October 2020
PRESENTED BY: (name and title)	Joanna Forster Adams, Chief Operating Officer
PREPARED BY: (name and title)	Joanna Forster Adams, Chief Operating Officer, Andy Weir, Deputy Chief Operating Officer EPRR Incident management Team

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

EXECUTIVE SUMMARY

In previous years we have provided a Winter Plan containing the technical and governance arrangements for winter and separately reported on Service delivery arrangements. In the context of the continued impact of the Covid19 pandemic our winter planning document provides a combination of technical, governance and operating arrangements. It is a dynamic document and will continue to be refreshed throughout the winter following the principles of our decision making process, set out in the plan, and in response to the impact of the on-going incident over the course of winter 2020/2021.

The plan has been shared with members of the Finance and Performance committee.

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

RECOMMENDATION

Board members are requested to endorse and support the operating objectives established to prepare for the winter 2020/21 (recognising the dynamic response and adaptations that may be necessary). In addition to discuss any areas of concern identifying any further strengthened actions required.

Leeds and York Partnership NHS
NHS Foundation Trust

Winter Resilience and Operating Plan

2020/2021

Contents

The LYPFT Winter and Operational Plan will be subject to review and be updated in line with changes made through our Incident Response and Coordination arrangements and governance structure.

Version control of this document will be maintained by the Incident EPRR team and retained within our Incident repository for review and references throughout the Winter 2020/21.

1. Introduction

The purpose of the Winter Resilience and Operating Plan is to set out the approach that Leeds and York Partnership NHS Foundation Trust (the Trust) will take to maintaining service provision and minimising disruption during the winter of 2020/21.

The plan details the arrangements the Trust has in place to manage clinical and operational delivery of services, and the actions that will be taken to mitigate anticipated risks during this period. This includes:

- Reference to underpinning legislative and other key frameworks in place
- The identification of critical services
- Identification of risks to service provision
- Identification of current and planned mitigations, including processes and systems in place
- Links to EPRR structure and incident response.

As we head into winter 2020/21 this has already been an unprecedented year as a result of the impact of the Covid-19 pandemic. This has required us to adapt the majority of what we do across LYPFT in order to minimise the impact on our service users. In this context, we have needed to review and revise and adapt our EPRR plans, contingency plans and service delivery arrangements over the last 6 months. Our winter planning arrangements are built on our learning from 2019/20 plus our learning and experience developed throughout the period of the pandemic. As a result the Winter Plan has been developed and set out in the context of the Covid pandemic.

We have aimed to align and streamline our incident response and coordination arrangements simplifying how we manage and support all of our services throughout the coming months. Now, more than ever we know that effective resilience will only be achieved during the winter period through effective system and partnership working with our NHS, Social care, Third Sector CVS partners, with the general public, with the people that use our services and with our staff. Covid-19 has exposed some of the most significant health and wider inequalities. Our planning and response must incorporate actions that support the objectives of protecting the most vulnerable, mitigate and address the inequality risks identified, and restore services inclusively. LYPFT have a key role to play in this, recognising the immediate and longer term impacts that the health, social and economic consequences of the Covid pandemic may have upon mental health generally and in particular on those with a mental illness, and ensuring that our services are planning to respond to these. This focus on inequalities has therefore been a key aspect of our Covid-19 response to date, and will be a key focus in our delivery of our Winter Resilience plan over the coming months. This can only be achieved in partnership – with other health & social care system partners, and with wider communities.

The Winter Resilience Plan includes information relating to:

- the current context and legislative framework under which the Trust provides services
- our Clinical Services and approaches to prioritising, delivering & maintaining these

- Our strategies, principles and processes for operational delivery which underpin this
- Additional schemes we are establishing to build further resilience through the Winter period
- Assessment of readiness for our corporate services
- Incident, Business Continuity and Partnership arrangements
- An assessment of key risks and mitigations / preventative measures.

2. Operating Objectives – Winter 2020/21

Our operating objectives for the winter period are summarised as:

- We aim to maintain all elements of service delivery in line with the current operating models we have established. This means that service delivery will be at the levels we have outlined and in the way we have described, where at all possible.
- That we value and recognise that all service interventions, support and delivery are equally important and to this end we are aiming to minimise disruption to staff, service users and people supporting service users.
- To maintain effective business continuity and respond to triggers and pressures that may disrupt access, care and support to those in need.
- To support our staff to prepare for and respond to the pressures and challenges we face through winter.
- Ensure that our contingency plans and emergency measures are evaluated to understand the impact they will have and mitigate risks wherever possible.
- To be an effective and responsive partner maximising the ability for health and care partners to respond to demand and provide effective care throughout winter.
- To have internal systems and arrangements in place to prepare for, mitigate and respond to the specific challenges we face which affect our ability to maintain a minimum disruption to service delivery throughout winter. This includes having the correct management and oversight arrangements in place that allow us to continue to adapt and respond as things change.

3. Legislative and Contractual Framework

The Trust operates under the obligations and requirements of the NHS Contract 2019-21.
However, as a result of the Covid-19 pandemic significant changes have been made (and continue to be made) to the contractual, planning and financial processes across the NHS.

Therefore the development of the LYPFT Winter Resilience Plan 2021 has included reference to a number of additional national guidance documents, including:

- Managing capacity & demand within inpatient and community mental health, learning disabilities and autism services for all ages (NHS England & NHS Improvement)
- Third Phase of the NHS Response to Covid 19 (NHS Chief Executive & COO)
- Implementing phase 3 of the NHS response to the Covid-19 pandemic (NHS England & NHS Improvement)
- The NHS People Plan
- NHS Mental Health Implementation Plan 19/20-23/24
- Mental Health Transformation Programme; Covid-19 Priorities & Next Steps (March 2020)
- Advancing Mental Health Equalities Strategy.

In response to the Covid-19 pandemic, the NHS stepped down the declared Level Four national incident (declared on 30 January 2020) to a Level Three regional incident in August 2020. This means that the response is managed at a regional level but with national NHS E oversight and also national NHS England objective and guidance setting.
The plan for delivery of our services across the winter period has been influenced by the Phase 3 National Planning process and associated financial regimes. This is underpinned by a national ambition to continue to implement the core components of the Mental Health Implementation Plan and accelerate development of services, recognising that the Covid-19 pandemic is likely to significantly adversely impact on our usual winter pressures - and in particular likely to result in an increase in mental health needs.

The planning framework developed by NHSE & I (August 2020) acknowledges that Covid-related restrictions will have a direct impact on the delivery of mental health and learning disability services. As a result our plans and trajectories need to be a realistic reflection of the context we operate within, whilst maintaining the momentum to deliver local developments, improvements and the Long Term Plan wherever possible.

4. Clinical Service Delivery

4.1 Guidance and Planning Context to Service Delivery

In line with phase 3 of the NHS response to Covid 19, Trusts were tasked to develop plans to restore services where possible to near-normal levels of activity prior to the pandemic, working collectively with local systems and partners to address local priorities within this. The national planning framework establishes that over the coming months / winter period, mental health needs are likely to increase significantly, and there is a need to maintain focus across all aspects of the pathway in particular in access services, crisis services and alternatives to admission, as well as strengthening community services to help people stay well and avoid escalation where possible.

It is however recognised within the planning framework that Covid-related practical constraints (such as staff absence, social distancing or disruption to referral pathways) may restrict what can be delivered, and that alternative methods of delivery (such as the use of technology) will need to continue throughout the winter period and beyond.

There is a required specific emphasis on physical health monitoring and support (and in particular those with a learning disability) and people with serious mental illness (SMI). Additionally, ensuring a key focus on access, experience and outcomes within mental health and learning disability services, with specific reference to groups facing inequalities. This is reflected in much of the work that has been undertaken over the last 6 months and will continue throughout the winter period, as well as in the additional winter schemes that we have developed (as set out later in this document).

A number of service developments and transformation programmes have recommenced or started over recent months that will contribute specifically towards the aims and objectives of the national Mental Health Transformation Programme (Long Term Plan). These include work programmes (either locally within LYPFT or at an ICS level) relating to crisis pathways, acute care, CMHT transformation, perinatal services, rehabilitation services, suicide reduction, older peoples services, and some specialised services such as for gambling addiction. Wherever possible we will seek to maintain and deliver these programmes during the winter period, recognising that – despite some significant challenges in relation to capacity – these programmes will deliver outcomes that will further develop services, quality & outcomes, as well as system resilience.

4.2 LYPFT Approach to Reset and Stabilisation

Following the initial phase of the Covid-19 pandemic, all services underwent a process of 'resetting' their service plans and delivery models. The service specific work was underpinned by the experience we had gained and by an evaluation of the impact on service users, families and staff. We additionally took into consideration the limitations and challenges that continue as a result of the ongoing pandemic, and recognised that for many services this result in a new service offer / configuration – described as the recovery position (and also sometimes described as "the new normal").

Our service reset work was underpinned by a number of key principles which include:

- Maintaining flexibility and adaptability to manage any future increase in demand together with changes related to the effects of the Covid 19 infection.
- Ensuring we are informed & guided in our decision making by understanding of clinical needs and risks.
- Understanding the impact and experience of service users and staff.
- Evaluating the impacts that reducing or standing down services to date.
- The opportunity to build on and lock in innovation including different ways of working, including those that had been developed in the initial stages where these had delivered positive outcomes.
- Focusing on engaging consistently and effectively with staff, service users & carers, commissioners and other key stakeholders in our planning.
- Developing plans together with partner agencies and commissioners across the city, our ICS partners and more widely where our services and networks stretch across regional and national boundaries.

A reset & recovery / stabilisation process was therefore developed, where all services undertook an assessment of across domains to reflect our key principles. Intelligence and experience led, this resulted in Service leads developing and presenting proposals for their new/reset delivery models. This was described as the "Decision Making Framework for Reset and Stabilisation" and resulted in refreshed Service descriptions (Operating Models) which have been widely communicated and operationalised over the course of the last 3 months.

4.3 Where we are now? Current Service Provision and Plans

As a result of the reset work, all Care Services have operating models for delivery over the winter period. Service leaders have supported these with detailed updated working instructions so that staff have clarity in order to support their work. We have also associated activity trajectories (some still in development) so that we can trigger additional support or provide a response where demand or activity exceeds our anticipated "normal" levels or has unusual trends or variation outside normal limits. Later in this document we set out how we will ensure and respond to the need for effective and safe staffing levels. Our workforce availability, wellbeing and resilience is key in maintaining our ambition for minimal disruption to service delivery throughout the winter so this is where much of our effort and support will be focused. We are establishing contingency arrangements and measures to maintain staffing availability but in contrast to the arrangements we established at the outset of the pandemic, we are not planning, at this stage, widespread proactive service closure to enable staff redeployment (this would only be a step taken in an extreme business continuity situation and managed through our incident response arrangements).

Across all of our services, we continue to operate a consistently used clinical tool to determine the need and identified risks for the service user, which assists to determine the level and type of intervention required.

A highlight summary below sets out our current operating arrangements for services.

Service Line	Service	Current delivery
Acute & CRISS	Crisis Resolution & Intensive Support	Service fully operational; mixture of face to face and virtual / telephone contacts. Aim to increase level of face to face work.
	Single Point of Access (SPA)	Remains fully operational; significant increase in referrals and levels of demand for clinical triage. Telephone helpline in place
	Acute admission & PICU wards	Operating as usual with some restrictions on visiting and off-ward activities. Some bed reduction anticipated to facilitate cohorting.
Community & Wellbeing	CMHTs (Working age adult)	Operating with blended model of remote working / digital technology and face to face (both at team base and in the community)

Service Line	Service	Current delivery
Acute & CRISS	Crisis Resolution & Intensive Support	Service fully operational; mixture of face to face and virtual / telephone contacts. Aim to increase level of face to face work.
	Single Point of Access (SPA)	Remains fully operational; significant increase in referrals and levels of demand for clinical triage. Telephone helpline in place
	Acute admission & PICU wards	Operating as usual with some restrictions on visiting and off-ward activities. Some bed reduction anticipated to facilitate cohorting.
		when clinically indicated. Enhanced partnership working with the Third Sector CVS partners is maintained. Work being undertaken on models of delivery of psychological therapies.
	Physical Health Care service	Reduced service due to need to redesign model (less clinics and increased community contacts).Has maintained focus on clozapine / amber drug monitoring based on risks. Plan to increase capacity and step up other monitoring & physical health interventions.
Older Peoples Services	IHTT and CMHTs	Services operating fully offering a mix of face to face and telephone activity, with increased levels of direct contact. Work being undertaken on models of delivery of psychological therapies. Plan to increase capacity to support Home Treatment.
	Care Homes & Intensive Care Homes teams	Services brought together to maintain a care homes offer and manage reduced capacity.
	Memory Assessment Service	Service recommenced in October with a significant waiting list. New assessment activity will start in January with reduced capacity due to need to increase home visits (rather than clinics)
Service Line	Service	Current delivery
	The Mount inpatient unit	Operating as usual with some restrictions on visiting. Additional cohorting ward available on site.
Children & Young People	National Deaf CAMHS service	Face to face activity effectively ceased (as a result of need for masks) – some direct work has now been reintroduced and plan to increase across the 3 sites. Virtual & telephone contact is ongoing, as is work with local CAMHS services and schools.

	Mill Lodge Tier 4 Inpatient Unit	Operating as usual with some restrictions on activities / leave and visiting
Forensic Services	Low secure services Newsam & Clifton House	Operating as usual with some restrictions on activities / leave and visiting. Cohorting space available for low secure patients at Newsam.
	Community forensic services	Operating through mix of face to face and virtual / telephone contact. Clinics due to resume.
Learning Disability Services	Inpatient & Respite services	ATU unit currently temporarily closed. Challenging Behaviour Respite service (3 Woodlands Square) and Complex Multiple Impairment Respite (2 Woodlands Square) both operating fully.
	Community LD Services	Operating through a mix of remote / telephone contact and some face to face work. Aim to increase face to face work (including clinics) from October.
	Specialised Supported Living	Operating as usual; some restrictions on community based activities
Liaison & Perinatal	Liaison Psychiatry – ALPS & Inreach	Continue to provide a 24/7 service across LTHT, both in EDs and across all wards. Additional ALPS ED-avoidance assessment service established at the Becklin Centre.
	Liaison Psychiatry – Outpatients, CFS and Psychosexual service	Adapted service now in place which incorporated virtual clinics (using 'attend anywhere') and telephone appointments. Return to face to face clinics being explored.
	Perinatal services	Inpatient service (mother & baby unit) operating as usual with some restrictions on leave. Community services operating a blended model of telephone / virtual contacts and face to face community based work.
	NICPM inpatient unit	Operating as usual for planned admissions although occupancy has reduced
Service Line	Service	Current delivery
Gender, Rehab & Eating Disorders	Gender service	Service has now recommenced majority of the pathway including screening, 1-1 diagnostic appointments and hormone clinic. Majority of contact is virtual, with some face to face clinic work now commencing.

	Rehabilitation services	Inpatient rehab service (Asket) operating as usual although reduced capacity due to cohorting space and some planned estates works. Complex rehab ward (Ward 5) operating as usual, with some reduced capacity due to shared cohorting with forensic service. Community team (recovery centre) operating with mix of face to face and virtual / telephone contacts. Recovery College operating virtually with significant focus on support and resilience activities. Assertive Outreach team operating as usual with a mix of face to face and virtual / telephone contacts.
	Eating Disorders services	Inpatient Unit (Ward 6) – operating as usual with some limitations to activities and visiting Community Service (CONNECT) – pathway now returned to pre-covid model, with a mix of virtual and face to face contacts. Virtual group activity in place. Plan to retain an increased level of virtual work in the core model moving forward.
Regional & Specialist services	Neurodevelopmental (Autism & ADHD)	Both services have reopened from being stepped down / reduced, with referrals and waiting lists increasing. Work is mostly remote with some face to face on site work commenced in October.
	Addictions service	Service continues to operate within the Forward Leeds hubs. Mix of face to face and remote / telephone working in place.
	Personality Disorder Service	All core aspects of the PD network are being delivered (DBT, virtual groups, and care coordination). Most work is remote (telephone and virtual groups with some face to face activity where indicated. Offender PD service operational and all interventions available – some reduced access to Probation sites.
	Gambling service	Service is being delivered remotely currently, including virtual group work and individual therapy. Potential to recommence face to face work from designated sites from October onwards.
Service Line	Service	Current delivery
	Veterans service	Service operational – some face to face work being delivered and regular virtual / telephone work. Plan to increase face to face contacts over coming weeks.

NSCAP	Child & Adolescent Psychotherapy Clinical Service	Some direct clinical service being resumed from October onwards.

4.4 Maintaining Flow and Meeting Demand

A key aspect of maintaining Operational Delivery during the winter period will be processes that are in place to maintain and monitor flow, and meet demand.

We have established a number of systems for monitoring and maintaining flow through our inpatient services, with specific emphasis on our Acute, PICU and Older Peoples services.
The current systems that are in place to deliver and support this include:

- Daily monitoring and reporting of occupancy, demand and delayed transfers of care (via Opel)
- Daily calls / huddles within services to review
- Weekly activity reporting across services
- Completion of a weekly 'heat map' for each service line to identify pressures and risks
- Discussion at the Clinical & Operational sit-rep calls (3 weekly but can escalate to daily), Service Line meetings and at the Operational Delivery Group meeting as required.

Throughout the winter period we will retain our dedicated Bed Management and Capacity roles, which include a dedicated Out of Area placement nurse who works with our local systems and any out of area providers to ensure transfer back to home services as soon as possible.

In addition, we will retain - and for acute adult services, will strengthen – the weekly 'system' meeting that that we hold with social care, commissioners and other partners, which has shown to be particularly effective in supporting accelerated discharge (where clinically indicated) and addressing delayed transfers of care (DToC). We have also agreed a plan with commissioners to retain some additional temporary supported accommodation capacity during the winter period.

The national ambition to eliminate inappropriate Out of Area placements by March 2021 has not changed, although the national plans do recognise that service capacity may be changed as a result of the pandemic and therefore this may have a direct impact on out of area placements. This was certainly true for LYPFT; at the peak of the first wave of Covid, we had 21 acute / PICU beds closed as a result of cohorting or infection prevention & control plans. As a result of delays in the implementation of some of the initiatives planned to reduce our inappropriate Out of Area placements, we have developed a revised trajectory for Out of Area placements for the winter period (until April 2021) in partnership with our commissioners.

4.5 Service Prioritisation: Critical Services

We have established service prioritisation as part of our EPRR business continuity refresh. This identifies which services are an essential priority and required to be

maintained and at full capacity at all times. This will influence our decisions around the use / deployment of resources throughout the winter period. Three levels of priority have been agreed as below:

Priority 1 services	These key services are essential priority and are required to be maintained at full capacity. Normal staffing numbers and skill mix will be maintained. This includes 24/7 inpatient services, supported living houses and urgent access / crisis services.
Priority 2 services	There services need to be maintained, but may safely be delivered at a reduced capacity or alternate skill mix. . This will be informed by an assessment of service user need, risk and vulnerability using our agreed clinical RAG rating process. Services may therefore be reduced or consolidated, and some staff redeployed into priority 1 services
Priority 3 services	These services could be reduced to a minimum level of delivery or could be stepped down entirely. The majority of staff are therefore likely to be redeployed into priority 1 services (or into priority 2 services as part of a revised skill mix to release other staff to priority 1 services)

Priority 1 services have been identified as our inpatient wards (excluding respite services) and services that people use to access mental health services in a crisis (CRISS & Section 136, ALPS, Hospital In-reach, Liaison service, Learning Disability Intensive Support Team, and Older Peoples IHTT (crisis and home treatment) service.

A full list of services and their priority can be found at *Appendix A.* The service priority framework is reviewed and agreed each week in the Operational and Clinical SitRep Group, and overseen by the Executive led Operational Delivery Group. It has been referred to members of our Ethics group and on-going review and refresh will be established throughout the winter period.

4.6 Cohorting plans

As part of the Covid-19 response, provider Trusts were asked to develop and implement plans to reconfigure inpatient services to create ‘cohorted’ wards, in order to reduce the risk of contagion and support infection control. This also required us to consider how we would manage cohorted service users with complex needs or high levels of acuity.

The cohorting plans for LYPFT have been revised and updated on a number of occasions, and in response to changing national guidance. The current plans reflect a mix of dedicated cohorting space (within the Mount for Older people, Becklin Centre for acute adults and the Newsam Centre for patients requiring a level of physical security) and local cohorting plans for specific or specialised services (such as the Mother & Baby Unit, CAMHS service and rehabilitation services).

The most recent version of our cohorting plans is at *Appendix B.*

4.7 Activity and Performance Management

As a key part of our stabilisation and reset work, all services completed a review of their activity levels and demand during the initial 6 months of the financial year (and therefore during the initial phase of the pandemic). Each service has been able to develop a projected trajectory for activity during the winter period (until April 2021), including forecasts based upon a number of variable factors (such as a potential increase or reduction in staffing or changes in restrictions which would affect practice). Trajectories (together with the baseline month 1-6 information and information on levels of demand) will be used to monitor activity and demand fluctuations throughout the coming months. Importantly this will enable us to support Service leaders to adapt our provision and deploy resources responsively where at all possible.
This information will also be used to assist in demonstrating the effectiveness of designated winter schemes (and is shown in detail in Section 7 below).

Notwithstanding some implementation and utility challenges relating to the transfer to Care Director earlier this year, services continue to receive and review activity data relating to our key services on a live basis with increasing access to performance dashboards. We have re-established more regular formalised governance relative to performance and activity via our Operational Delivery Group (ODG). We have also established a 'heat map' approach for all service lines which is reviewed regularly and highlights area of particular concern or challenge to maintaining service delivery and business continuity.

We are in the process of negotiating some changes to our KPIs and other activity trajectories with our commissioners, and these continue to be monitored through a monthly submission to CCG Commissioners, completion of mandated NHS England returns for specialised commissioned services, and the Combined Quality & Performance Report (CQPR) which is reported to the Board.

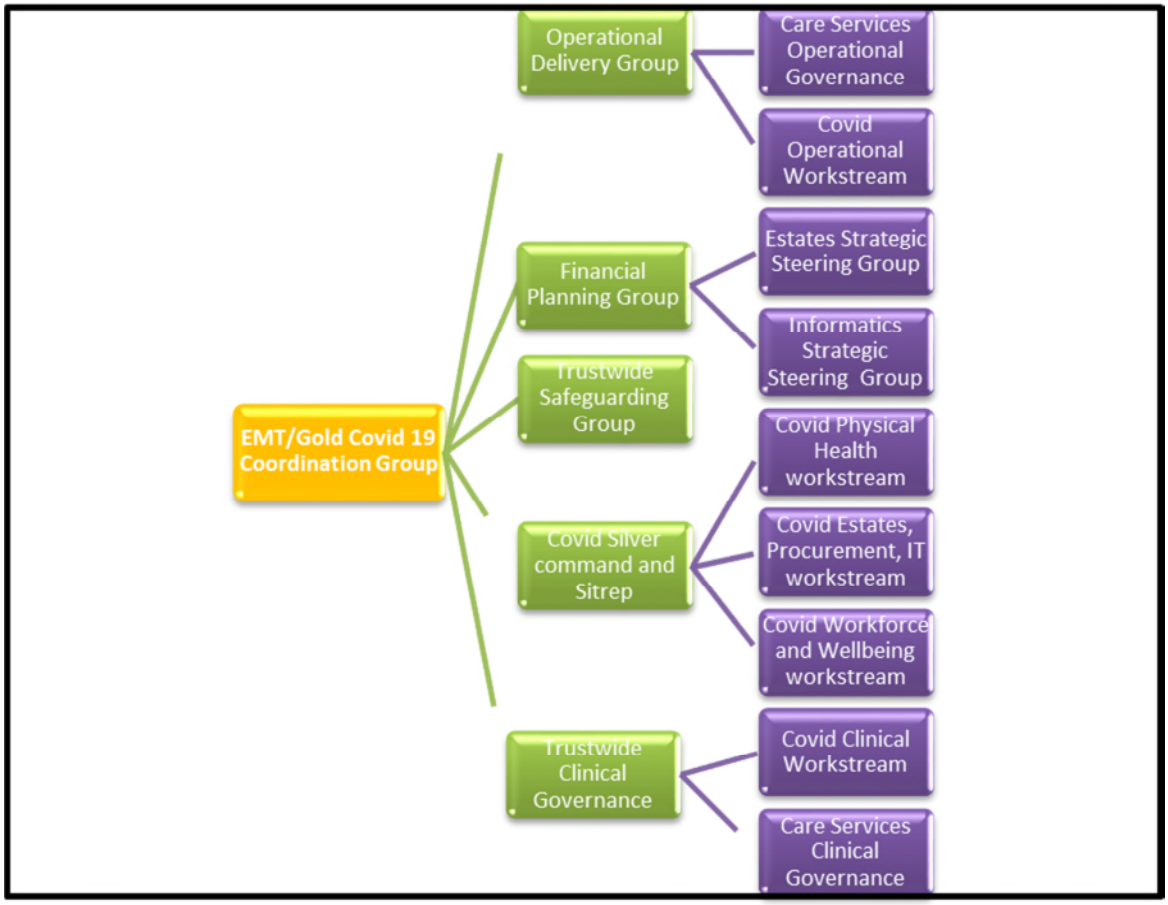
5 Supporting Governance and Workstreams

5.1 Incident Response and Coordination Arrangements

The Trust has established a clear Incident Management and Leadership structure in response to the Covid-19 pandemic being declared a national incident which is overseen by the Chief Operating Officer as the designated EPRR Accountable Executive Officer.
A number of refreshed, new and different plans, protocols, procedures and processes have been required and developed over recent months to ensure that we prioritise, manage and maintain delivery through the challenges of the Covid-19 pandemic. We have maintained coordination through our EPRR incident response arrangements – reviewing and adapting these in line with requirements and the needs of our Organisation. These arrangements are described in this section of the document but may be subject to change as we review the appropriateness and effectiveness of our indent coordination on an on-going basis.
Our incident response and coordination arrangements will be the structure we use to manage service delivery throughout winter 2020/21.

These arrangements are described in Appendix C.

The structure meets the requirements of the prescribed model of Incident Coordination. We operate internally at Gold (Strategic) level, Silver (Tactical) and a number of work streams are in place in line with our EPRR arrangements. In addition we have restarted a number of Exec led Governance arrangements but specifically those related to the ongoing management of the pandemic and winter include the Operational Delivery Group, Financial Planning, Trust wide Clinical Governance and Trust wide Safeguarding.
The IRT working arrangements are shown diagrammatically below.



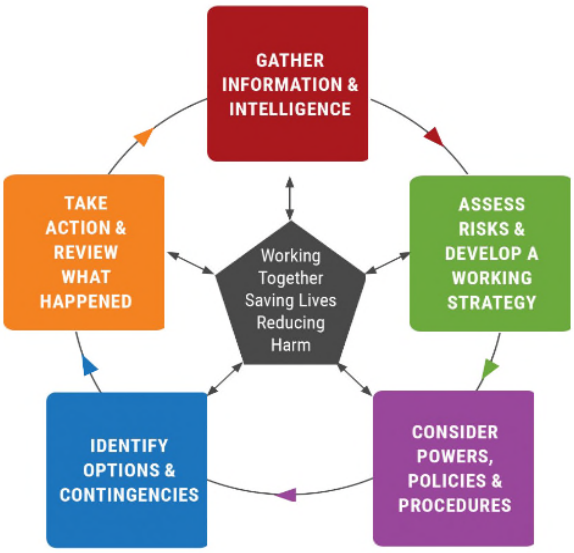
Undoubtedly we have been operating throughout in very challenging circumstances and our staff and the people we serve have responded and adapted amazingly. However, there have at times been some very difficult decisions to make and the introduction of an Ethics advisory committee at an early stage in the pandemic, has helped us evaluate these decisions in order to balance clinical need (both mental & physical), patient safety and risk.

In particular, members of the Ethics committee been involved in the prioritisation of services; monitoring, deployment and redeployment of staff; and ensuring we have robust leadership and management structures available across a 24/7 period to support those staff delivering services. This arrangement will continue so that issues we are faced requiring changes and decisions to be made can be as informed as possible.

5.1.1 Our Approach to Decision Making (JESIP Principles)

We have specifically and purposefully utilised the decision making framework set out in the Joint Emergency Services Interoperability Principles (JESIP) programme to provide evidence based consistency.. The decision model aims to bring together all available information, reconcile objectives and make effective joint decisions. The model focuses on gathering the available information and intelligence to assess impacts & risks and develop agreed plans and strategies, including an assessment of options and contingencies. The framework works in a cyclic process, whereby actions are then reviewed and outcomes assessed, which forms the basis of information to support further decision making. Decision making is supported by reference to core values.

The model is represented diagrammatically below:



The JESIP principles underpin all elements of our incident response and were used as the basis for our decision making framework described early in Service reset and stabilisation. The use of the principles and decision making framework has supported us to approach decision making in a dynamic way, which has been essential in the frequently changing context of recent months.

5.2 Business Continuity Refresh

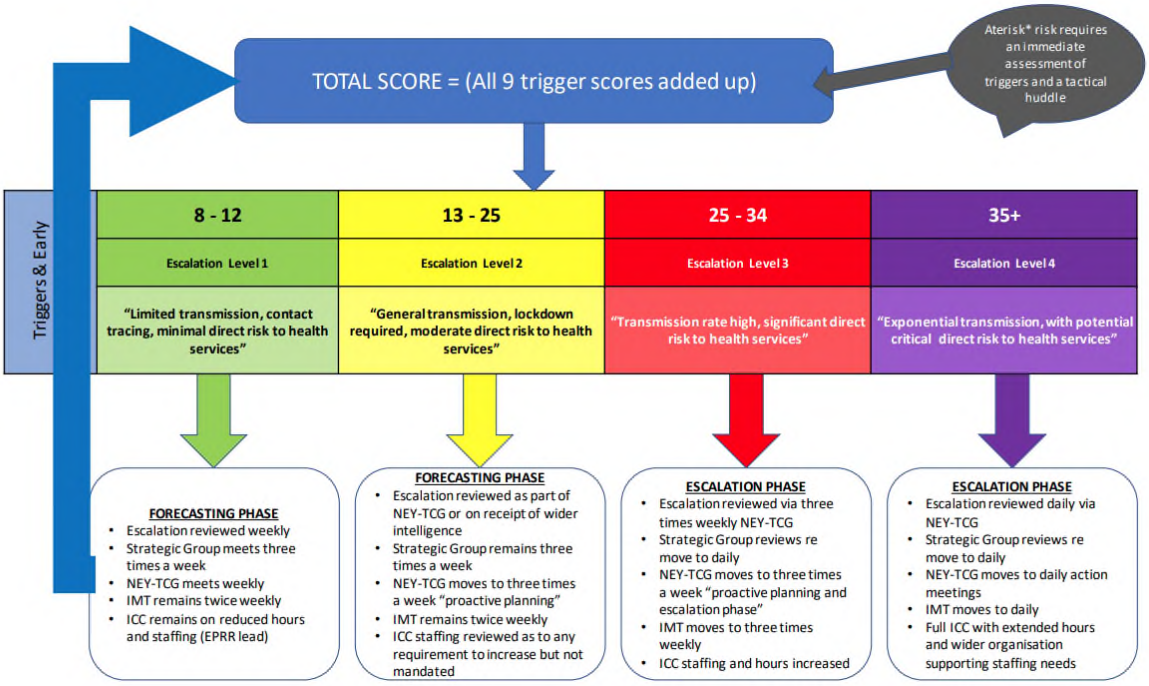
As part of our Incident Response arrangements, we have undertaken a robust and comprehensive refresh of our Business Continuity arrangements led by our EPRR Organisation Lead. These have been tested through a process of scenario exercises and have influenced our resultant Winter resilience and Operational Plan.

5.3 Status of Incident and Resultant EPRR Structure.

On 31st July 2020 the status of the incident was reduced to a Level 3 regional incident, this means as a Trust we remain within incident response requirements led by the regional EPRR team within NHSE. We maintain close contact with the regional team through weekly calls and our operating and incident response arrangements are in line with their requirements.

The regional EPRR team have worked with us to develop a mechanism to monitor when the incident may trigger an alternative response. This model is shared below but again is subject to change and amendment. It supports us to understand regional pressures within the health economy and enables the regional team to coordinate mutual aid and responsive actions where necessary.

Triggers & Early Warning Signs	Post Pandemic Phase Indicators	Escalation Thresholds								Score for each Trigger/EWS
Regional Intelligence (R)	0	R between 0.40 and 0.75	1	R between 0.75 and 1.0	2	R between 1.0 and 2.0	4	R between 2.0 and 3.0*	5	
Rate per 100,00 (7 days prior)	N/A	Less than 3 UTLA's shown as red	1	Less than 6 UTLA's shown as red	2	6-12 UTLA's shown as red	3	More than 12 UTLA's shown as red	4	
Presentation	Planned Covid activity only (vaccination)	Covid 111 activity/GP appts. remain within 8 week average	1	111 call volumes and GP appts. for Covid rise by up to 10% of 8 week average*	2	Unexplained surge in calls to 111 and to GP's against forecast*	3	111 and GP activity mirrors initial spike of March 2020	4	
Outbreaks	No Covid related outbreaks reported	Less than 10 Covid related outbreaks reported across the region	1	Between 10 and 20 Covid related outbreaks reported across the region	3	Covid related outbreaks result in loss of capacity (e.g. Care home or ward/bed closures)	3	Fatalities directly attributable to a Covid outbreak within an inpatient or care setting	5	
Staffing	Staff absences remain unrelated to Covid-19	Staffing absence related to Covid activity remains within 8 week average	1	Increase in staff absences due to self-isolation requirements (self, carers leave etc)*	3	Increase in staff absences due to sickness/ Covid related symptoms (10% above average)*	4	ICS/ICP reports service impacts due to staffing despite mutual aid being enacted locally	5	
Restoration Plan	N/A	Restoration Plan remains on schedule	1	Restoration plan impacted upon by rate limiting factors only (e.g. PPE)	3	Restoration plan impacted upon by regional risks and Covid resurgence*	4	Restoration Plan directly affected by Covid resurgence - critical prioritisation required	5	
Admissions	Admissions remain unrelated to Covid-19	Covid activity remains within designated "Covid Units"	1	Covid activity increases by up to 5%	2	Covid positive areas extended into non-Covid areas, or beds lost due to outbreak (any)*	4	Surge areas in use/services reduced due to Covid demand, or wards lost due to outbreak (any)	5	
Critical Care	No Covid inpatients within Regions Critical care	Covid activity remains within designated "Covid units" or within commissioned bed base	1	Level 2 & Level 3 (confirmed/suspected Covid) demand begins to increase*	2	Level 2 & Level 3 (confirmed/suspected Covid) requirements equalises with non-Covid bed use	4	Surge areas in use to meet increase in demand for Covid critical care capacity or seasonal variation	5	
UEC & Other risks/threats	Work in Progress (TBC)									
Soft Intelligence*	• Reports of the number of contacts asked to isolate as a result of Test & Trace increases by 10% (add 2 points) or by 20% (add 4 points) • Geographical Rising Tide in Covid activity evident suggesting likely impacts on region (add 2 points) • Outbreak of an unrelated type within an ICS/ICP footprint indicative of a reduction in social distancing compliance or reduced compliance/availability of PPE (3 points) • Cluster of positive cases linked to a staff group (e.g. ambulance station, fire crew, care home etc) • Threat & Risk assessment to be included here – e.g. other incident or event (flooding, concurrent incident or BCP activation)									



As a Trust we will continue to be flexible in our response to the regional working arrangements whilst reflecting the local need and responding accordingly.

5.4 Operational Arrangements to Support and Manage Service Delivery (including Out of Hours Contingency Arrangements)

As described above, Operational and Clinical work streams have been established which meet at an agreed frequency each week. A joint Operational & Clinical SitRep is held at a minimum of 3 times per week, and can be convened at any time.

We have revised and implemented strengthened Out of Hours Contingency arrangements to support the safe and effectively delivery of services 'out of hours'. These now include:

- A Duty Manager (Clinical Team Manager level) on every shift across 24 hours each day, who is supernumerary and able to coordinate and provide advice / support to all services
- An On-Call Senior Manager (Operational Manager or above)
- A duty Head of Operations during core hours (9am-5pm) every day 7 days per week, to provide senior operational management oversight and support to the duty and on-call managers
- An identified senior Consultant Psychiatrist on call to provide clinical advice and support to the Head of Operations / Senior Managers as required, and where necessary coordinate the work of the on-call Consultants
- An On-Call Director, who also serves at the formal IRT Director if required.

These arrangements are reviewed regularly via the Clinical & Operational SitRep group and the Operational Delivery Group (ODG) and are supported by the wider Trust Incident response arrangements set out above.

6 Focus on Workforce

The NHS People Plan for 2020/21 clearly sets out the national aims and objectives in relation to our workforce moving forward, with a key focus on 4 areas:

- **Looking after our people** – with quality health and wellbeing support for everyone
- **Belonging in the NHS** – with a particular focus on tackling inequalities and the discrimination that some staff face
- **New ways of working and delivering care** – making effective use of the full range of our people's skills and experience
- **Growing for the future** – how we recruit and keep our people, and welcome back colleagues who want to return

These areas have influenced and been reflected in our plans over recent months. In relation to the Winter Resilience plan, there is a specific focus on 2 key areas – staff health & wellbeing, and different ways of working to most effectively deploy staff to meet service user need and our objective to maintain the continuity of our priority services.

6.1 Maintaining Safe Staffing: Deployment Process

Having sufficient experienced staff on duty throughout the winter period is a major asset in mitigating disruption. As a result of the initial wave of Covid-19, the Trust was required to develop a revised, formalised approach to deployment & redeployment of staff in order to maintain minimum safe staffing levels (particularly within the agreed priority services of the Trust) as a result of significant and sustained reduced staff availability. At the peak of the first wave of Covid19, 171 staff were redeployed across the Trust to maintain safe staffing and ensure priority needs were met. Some services were temporarily stepped down or significantly reduced to support this.

Throughout this period, the redeployment process, and its impact, was actively reviewed. This included a dedicated redeployment forum, some facilitated discussions with ward / team managers, and the wider Trust evaluation and staff feedback processes).

Fundamentally, our approach to maintaining safe staffing through the coming months has resulted in redeployment still being one of a number of options we have in response to specific business continuity issues.

We have had to carefully consider how we can mobilise redeployment as a response to these specific pressures, learning from the experience our staff have had during phase 1 together with continuing to recognise that this is likely to be a vital element of maintaining service delivery in our critical services. The feedback and learning has been incorporated into a revised approach and process, which was developed through discussions with operational, clinical and professional leads. The revised process

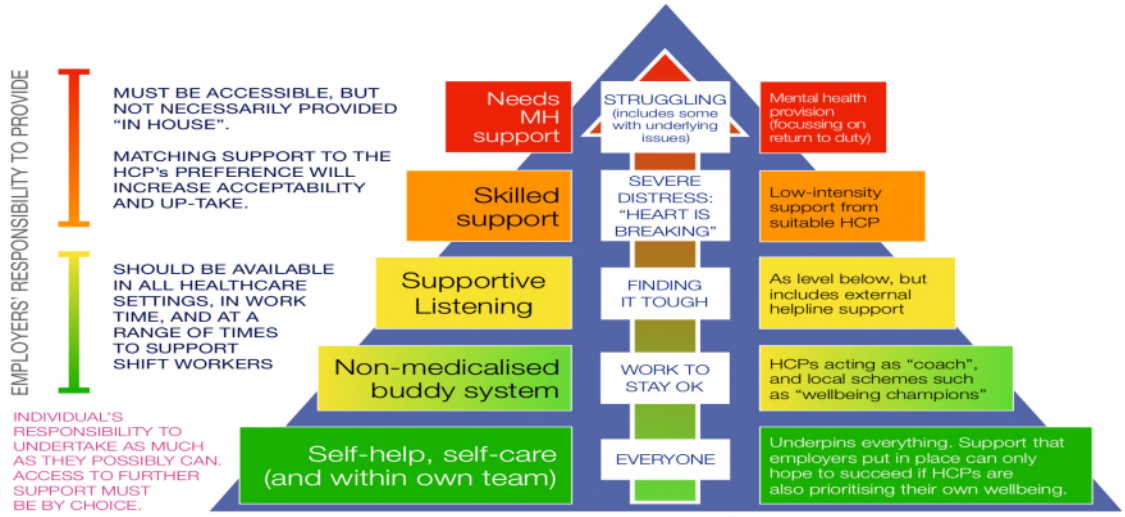
aims to meet the need for redeployment whilst maintaining some level of service delivery for as many of our services as possible, through the use of an identified (contingency) redeployment pool. Services can then explicitly plan for this, and also project (and plan to mitigate against) any adverse effects of reduced staffing.

For small numbers of ad-hoc / single instance requirements for additional staff in order to maintain safe staffing levels, the standard approach of seeking additional staff, cancelling non-essential activities, and moving staff on a shift by shift basis based upon need will be applied (as set out in the Trust Staffing Escalation Protocol).

However, when the need for additional staff to maintain minimum staffing is more sustained (or when actual or predicted levels of absence exist across a large number of services), an alternative approach is required using the agreed Deployment and Redeployment process. Deployment & Redeployment is overseen by a dedicated group, which includes operational, clinical / professional and work force representatives.
The revised Deployment & Redeployment process can be found at ***Appendix D.***

6.2 Staff Wellbeing

The health, welfare and wellbeing of our staff is a key Trust priority. We have established a staff health and wellbeing group which oversees and coordinates our approach to staff wellbeing, and have drawn on the framework developed by Dr Alys Cole King (shown below) to offer graded levels of support to staff and optimise preparedness, wellbeing and functioning. We recognise that the pandemic has already had a significant physical, mental and psychological impact on our staff, and that this will continue through the winter period.



Dr Alys Cole-King & Dr Linda Dykes with input of BCUHB Staff Welfare and @HCW_Welfare Collaboratives

In line with national guidance, we have undertaken individual Wellbeing Assessments for all staff across the Trust (in the initial stages with specific emphasis on BAME staff), and use these to support decisions around deployment of staff and staff wellbeing initiatives. A staff Health and Wellbeing Hub has been established on the internet with tools & resources to support self-help and supporting others, supported

by other initiatives such as home working guidance, on line physiotherapy support, a staff Facebook group and the availability of individual support for staff through our employee assistance programme and occupational health routes.

A data set in relation to staff absence levels, trends and reasons for this is maintained and reviewed at the Silver SitRep on a regular basis, and strengthened arrangements have been put in place to support staff who are absent from work and support their return to work. These arrangements will be maintained and further developed during the Winter period.

6.3 Flu vaccination

A key component of our health and well-being approach during the Winter months is to promote, deliver and improve uptake of the flu vaccination, especially in underrepresented at risk groups, recognising that during this winter we may be faced with co-circulation of Covid-19 and flu.

Flu vaccination clinics for staff commenced in October, supported by a high number of Peer to Peer vaccinators within inpatient and community teams. This year we are utilising a pre booked appointment system to ensure staff safety and social distancing. Our weekly target aim is to vaccinate 170 staff each week, with a stretching ambition of vaccinating 100% of the target group that are able to have the vaccine by the end of December.

6.4 PPE Availability and Use

We have established an effective process of monitoring and maintaining PPE availability, which is led by the Estates, Procurement and IT work stream and reported regularly at the Silver SitRep call. Our PPE stock is pushed to the Trust via the standard managed inventory process. We have been in a relatively stable position concerning our stock levels for some time now, with the ability if the need arises to obtain additional stock via escalation to the National Supply Distribution Response process or mutual aid with partners. Internally we manage our stock levels both at our Warehouse and across the stockrooms at a site level. Stocktakes both at a site level and at our warehouse are undertaken twice weekly and fed into our purpose built system developed by our colleagues at the Commercial Procurement Collaborative. These stocktakes are important in ensuring the correct volume of PPE reaches the sites. We are also able to effectively monitor usage. An overall stock dashboard is presented to silver at each meeting for full transparency of our position.

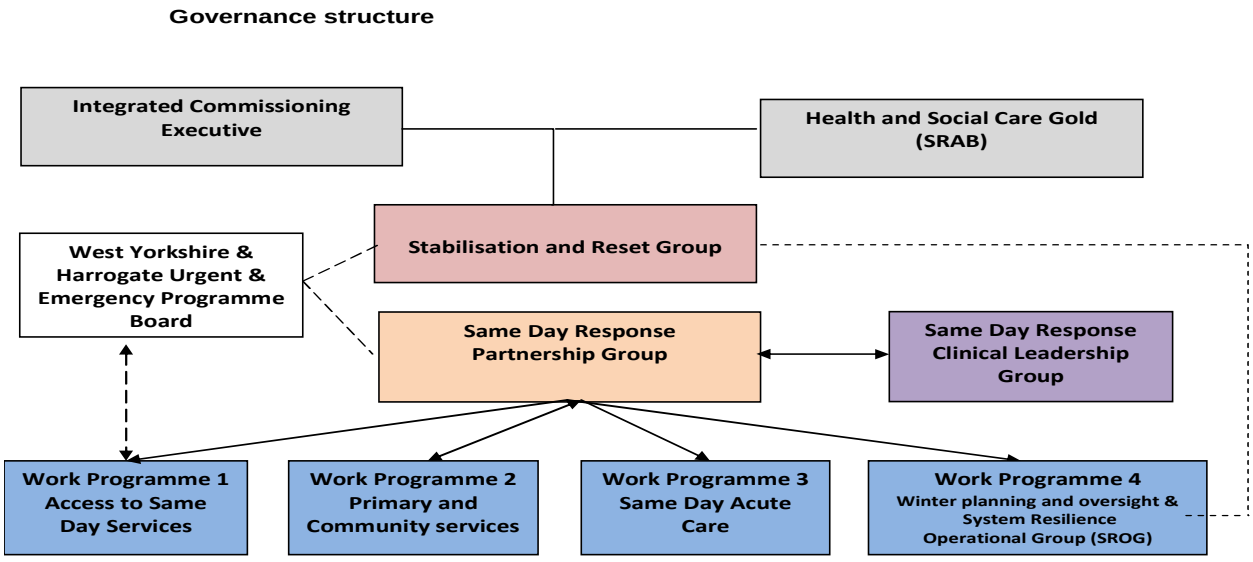
7. Working as a System

7.1 System level winter arrangements (Leeds)

As a result of the Covid-19 pandemic, health, social care and third sector VCS partners across the Leeds system revised our partnership working arrangements, recognising the need to ensure effective inter-agency system planning and working. A formal system structure of Gold & Silver command meetings is in place, and this will continue into the winter months. We continue as previously to contribute to a daily OPEL (Operating Pressures Escalation Level framework) report for the Leeds system, which allows system partners to monitor demand, flow and pressures and respond to these, and thus maintain quality and safety.

In addition to this, the Leeds system has developed a specific winter action plan for 2020/21. This work has been supported by system Winter Review 2019/20 workshops, which tested and explored our management, governance and communication processes across the system, and identified the key challenges that were predicted for the Leeds system for Winter 20/21, the challenges and opportunities presented by Covid-19, and Winter priorities and work plans.

The system Governance structure for winter has been reviewed in light of the Covid response structures in place, with specific focus on the City Silver Stabilisation and Reset Group. The revised structure includes a work programme specifically focusing on winter planning and oversight, and is shown below.



The Trust delivers mental health and learning disability services across Leeds through a number of key partnerships within the system. These include (but are not limited to) the delivery of A&E liaison and in reach liaison psychiatry services within and across Leeds Teaching Hospitals Trust; joint delivery of a range of adult mental health services with third sector partners (such as Community links and Touchstone); integrated delivery of addiction services with partner agencies within the Forward Leeds model; delivery of out of hours CAMHS assessments and CAMHS Section 136

services with Leeds Community Healthcare; and a range of joint partnership arrangements with our adult social care partners.

We have established and will maintain effective partnership structures across our services, and where appropriate have worked together with partners in both our reset & stabilisation and winter planning work. The delivery of our winter plans will be overseen by existing governance and partnership structures (including formal partnership meetings with adult social care and LTHT), and we will continue to work together at an operational level to monitor, mitigate and manage pressures and delivery challenges (for example, through the integrated DToC escalation meetings in both working age adult and older peoples mental health services, or through our joint approach to managing ED pressures with our LTHT partners.)

7.2 Areas of Focus to Support Service Delivery and System wide Patient Pathways Through Winter - Additional Winter / Covid Schemes Established

As both part of our planning for winter and our response to the on-going Covid-19 pandemic, we have identified 5 schemes for investment to strengthen and enhance our current delivery arrangements. Specifically they aim to strengthen our approach to response in a MH crisis, admission avoidance including the provision of home treatment, and maintaining physical healthcare for those with an on-going mental health need. The schemes are as follows:

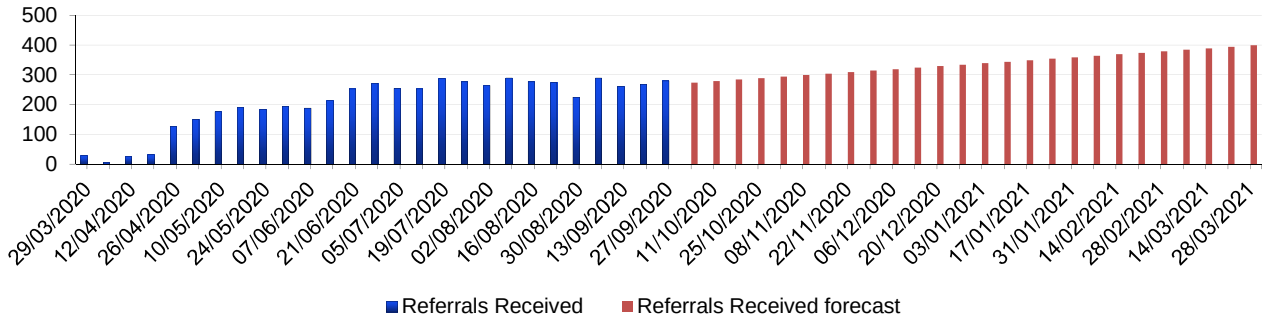
Service	Objective	Additional capacity
CRISS / ALPS	Increase capacity to respond flexibly to increased referrals / activity surges across the crisis / assessment / ED pathways, and support delivery of increased home treatment for working age adults. Includes potential to further expand an ED avoidance assessment area in the Becklin Centre (subject to further confirmation)	6 Registered Nurses / Occupational Therapists 0.7 Consultant Psychiatrist 1.9 Reception support staff
Community Mental Health Teams (working age)	Increase capacity to meet increasing referrals / demand and required signposting for increased presenting social difficulties	4 Registered Nurses 2 Healthcare Support Workers
Physical Health Team	Service has been required to significantly adapt delivery (previously clinics). Increase capacity to reflect increase in community / mobile working, increase support available, and to meet identified (covid related)	3.5 Healthcare Support workers 1 x administrator

	backlog of physical health checks	
Older Peoples Mental Health	Reconfiguration and enhancement of the Older Peoples Mental Health community services, to increase capacity in crisis / assessment & home treatment function and admission avoidance. Additional capacity to address waiting list for Memory Assessments that has developed during the initial Covid period.	1 Consultant Psychiatrist 1 Clinical Team Leader 0.8 Pharmacist 8 Registered Nurses / OTs 2 Healthcare Support Workers 2 Administrators
Perinatal service (mother & baby unit)	Service relocated to stand-alone unit to accommodate cohorting space and reduce transmission risks. Increased staffing to ensure safe, high quality care	4 Registered Nurses and 3 Healthcare Support Workers

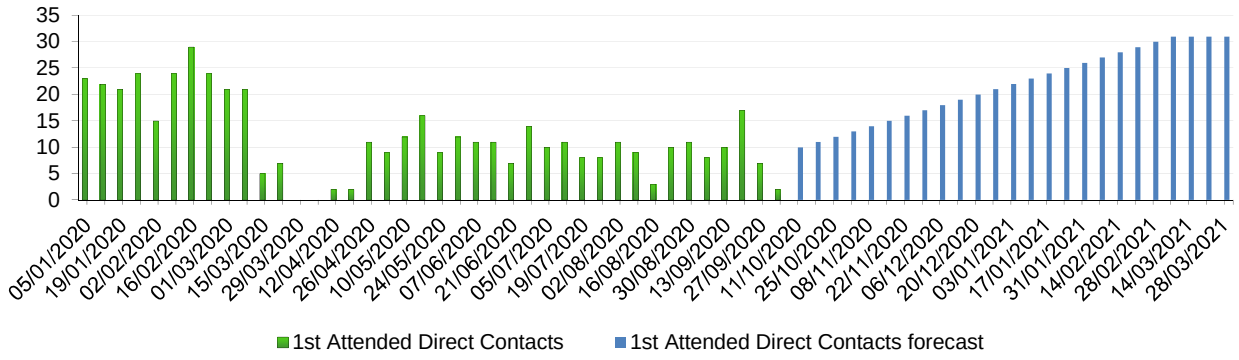
7.2.1 Crisis, Assessment and Home Treatment

The additional resource will work flexibly across the CRISS and ALPS services to particularly build capacity in the referral / assessment and triage components of the service. The additional capacity will work across the pathway and will be able to respond flexibly to meet increasing demand in both the CRISS and ALPS services. This will also support improvement against the 4 hour response target for crisis assessment and the 1 hour ED response target for ALPs.

The number of referrals resulting in face to face crisis assessments significantly reduced in Quarter 1, and whilst these have not yet consistently returned to pre-covid levels, they are increasing. The number of referrals to SPA (frequently requiring clinical triage) have significantly increased and continue to do so (with a forecast as shown below, by week).



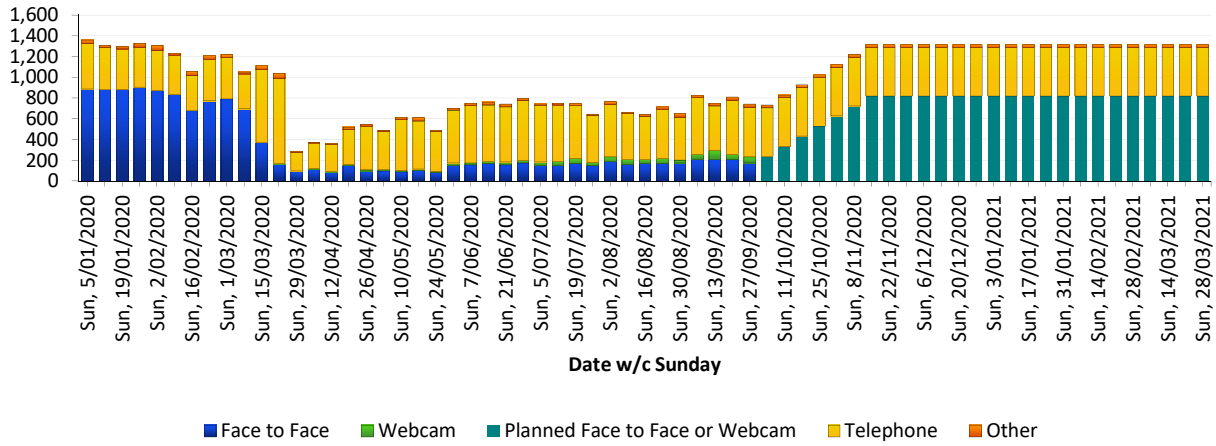
It is anticipated – based on the increasing levels of referrals for assessment, increased need for face to face crisis contact, and forecast increase in demand – that, with the availability of the additional capacity, the forecast new face to face crisis assessments per week will increase as below.



7.2.2 Community Mental Health Service (Working Age)

During the initial covid period, both referrals and CMHT contacts significantly reduced, but steadily increased over the following weeks, particularly in relation to telephone and other virtual contact. The plan – supported by additional capacity - is to increase and consistently maintain the current level of contacts but increase the proportion of contacts with service users delivered face to face, particularly now that clinic based activity is being reinstated. This trajectory incorporates assumptions for annual leave and some increased sickness absence, along with the inclusion of the additional staff to meet increasing demand.

CMHT contacts trajectory

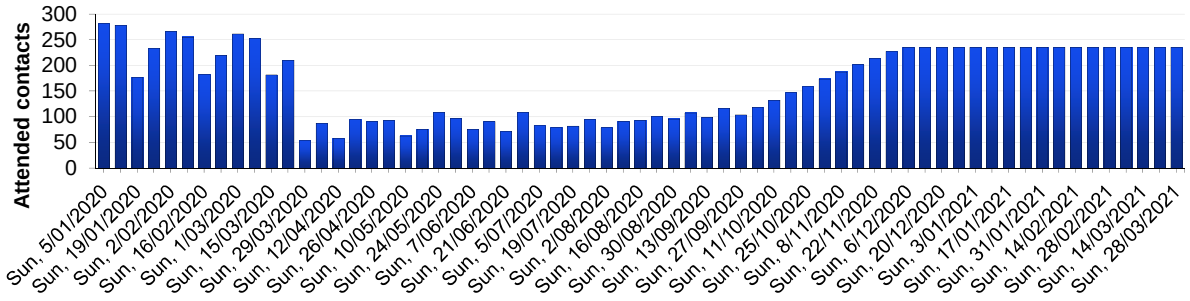


7.2.3 Physical Health Team

The physical health team have been required to significantly change their delivery model, from a required delivery model change from a less resource intensive clinic based " one-stop shop" to a domiciliary model requiring multiple home contacts and additional staff to be re-deployed into the service. They have prioritised the delivery of clozapine monitoring due to physical and MH health vulnerabilities of that cohort of

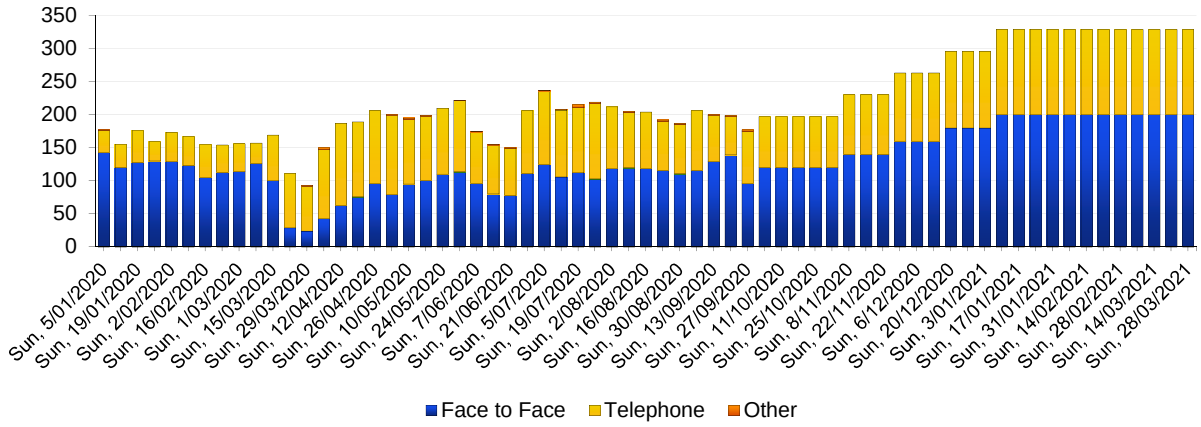
service users, through pausing routine cardio metabolic monitoring for service users newly commenced on antipsychotic medication activity.

The service has stepped up a proportion of appropriate clinic based activity following completion of the work to develop the standard operating procedures for safe use of estates for clinical delivery. Assumption is made that mixed delivery of clinic and home contact approach can be maintained with the recruitment to the additional resources for the physical health team The revised process for more robustly identifying service users commenced on antipsychotic medication, and the work progressing the review of the shared care pathway with primary care will enable sustainably recommencing the routine baseline cardio metabolic monitoring for service users newly commenced on antipsychotics from end of November in addition to maintaining the clozapine monitoring- assumption made of approximately 30 service users per month newly prescribed antipsychotics across the CMHTs. Activity trajectory from Nov onwards reflects this:



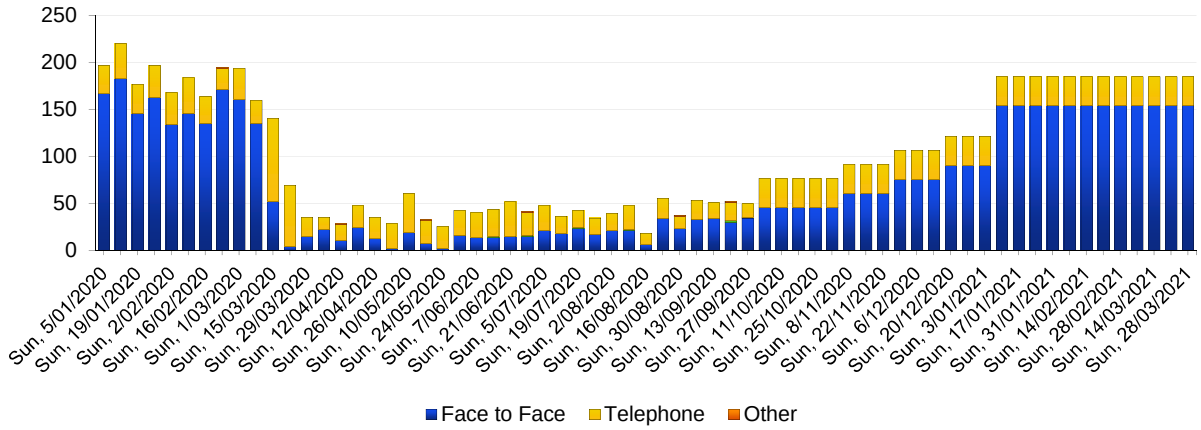
7.2.4 Older Peoples Mental Health

The additional capacity for older peoples services will be used flexibly across the assessment / crisis and home treatment pathway (delivered through the IHTT) and to address the significant waiting list of memory assessments that developed through the Covid period. Due to recruitment processes, we have assumed the additional resource will become operationalised in a phased way during Quarter 3. Assuming that the resource is essentially split on a 50-50 basis across these 2 functions, and assuming an associated increase in both the number of contacts and the amount of face to face work, the activity trajectory for IHTT has been modelled (by week) as follows:



Memory Assessments were essentially 'stood down' during the initial phase of the Covid pandemic, not least due to the requirement to undertake these in a face to face setting, and the need to redeploy a number of staff to support the inpatient services.

Assuming half of the additional capacity to the service is able to be released to focus on this work, the forecast trajectory for memory assessment activity can be shown below (by week):



8. Support Services Readiness for Winter

To support the delivery of our Winter objectives, our corporate / support services have been asked to complete an assessment of readiness for the winter period (in relation to staffing, wellbeing, resources and partnerships / mutual aid. This includes our Estates & Facilities, ICT, Mental Health Act and Procurement services.

This tool will support us to identify any gaps or concerns in our capacity and plans that need to be mitigated, and supports services to consider any further planning requirements. As a result of our Incident Response arrangements, we are confident that our support services have considered and are monitoring these issues on a regular basis, and that any emerging issues will be identified and escalated as required.

9. Key Risks, Mitigations & Preventative Measures

Identified Risk	Mitigation	Monitoring
High levels of staff unavailability as a result of illness / absence	• Daily monitoring and forecasting of staffing situation & absence • Robust e-rostering and use of temporary staff • Deployment and redeployment process & plans in place • Group established to oversee deployment and staffing • Workforce group in place	• Updated from daily reports and Clinical & Operational Groups to Silver Sitrep • Weekly service heat maps reviewed at ODG • Redeployment Group & Workforce Group reports to Gold
Changes to national response to Covid pandemic requiring further rapid change to service delivery	• Incident Management & strengthened operational structures in place and well established • Evidence of service ability to respond quickly and flexibly	• Service changes overseen and monitored via ODG • Decision logs maintained to record rational and objective of change
Significant increase in pressure on the acute sector (ED attendances, occupancy & bed pressures)	• Increased capacity in ALPS / Liaison service through winter schemes & redeployment • Daily deployment process • Partnership approach with LTHT (winter group) • ED avoidance assessment area in operation	• Daily operational & clinical SitRep and reports to Liaison management team • Performance reporting framework / CQPR • Partnership Group with LTHT
Severe weather resulting in disruption to services (staffing, access, estates risks such as power outages)	• Business Continuity & Deployment & Redeployment plans in place supported by strengthened operational management structures • Estates work stream & IRT structures in place to support rapid response • Estates business continuity plans & on-call arrangements • Mutual aid	• Daily operational & clinical Sit Rep escalating to Silver as required • Estates, IT & procurement workstream SitReps

Identified Risk	Mitigation	Monitoring
Reduced engagement of staff as a result of ongoing pressures and repeated changes	• Health & Wellbeing and staff support interventions, leadership packs and oversight group • Enhanced and regular comms and engagement forums (including CEO open sessions) • Local team/ service line communication structures, briefings and virtual staff meetings • Individualised Wellbeing risk assessments and managerial relationships	• Health & Wellbeing steering group and Workforce committee • Daily sit-reps • HR metrics • Evaluation reports • Staff survey
Reduced third sector provision resulting in reduced support and increased isolation for service users during winter	• Individual service user RAG rating and care planning • Increased capacity in CMHTs and third sector partnerships • Service adaptations to increase social support • Regular discussion & system meetings with commissioners & social care partners	• Monitoring of CMHT RAG ratings • Local governance & partnership structures • Mental Health system meetings
Increased pressure on access services and reduced community capacity resulting in increased admission and Out of Area	• Increased capacity in clinical triage and CRISS • CAU remodelled to provide short term assessment with CRISS • Daily capacity reviews and regular partnership meetings • Assertive monitoring of Out of Area placements (case manager)	• Daily monitoring and reporting (OPEL) • Weekly capacity system meeting with partners • Weekly ICS system call • Routine performance monitoring framework

Joanna Forster Adams: Chief Operating Officer

Andy Weir: Deputy Chief Operating Officer

October 2020

GLOSSARY

Term	Explanation
Business Continuity	The capability of the organisation to continue delivery of products or services at acceptable predefined levels following a disruptive incident.
Business continuity incident	A business continuity incident is an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. (This could be a surge in demand requiring resources to be temporarily redeployed).
Command and control (and communication)	Often referred to as $C^{3.}$ The exercise of vested authority through means of communications and the management of available assets and capabilities, in order to achieve defined objectives.
Critical incident	A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions.
EPRR	This refers to Emergency Preparedness, Resilience and Response - this term covers all aspects of responding to emergency incidents and disruptive events in the NHS.
Mitigation	Measures taken to reduce an undesired consequence
Mutual aid agreement	Pre-arranged understanding between two or more entities to render assistance to each other
OPEL	Operating Pressures Escalatory Limits - this is the NHS England Framework governing how health providers reflect their position regarding capacity, demand and flow and the necessary actions to take to try to alleviate these pressures.
SiTRep	Situation Report - a teleconference or report detailing the current situation affecting a service, department or site. This is used as a basis to formulate action to manage the incident or problem.

Appendix A: Service Priority Categorisation

PRIORITY SERVICES	
CRISS Older Peoples IHTT LD Intensive Support Team MH Primary Care ALPS & LTHT Liaison Inreach Section 136 suite Veterans High Intensity Service	All crisis / urgent access services
Acute Wards & PICU CAU Mount wards Asket Wards Mill Lodge Mother & Baby Unit YCED (Ward 6) Complex Rehab (Ward 5) Forensic Wards Parkside Lodge / 3 Woodlands Square Supported Living	Inpatient services and Supported Living Houses – maintain 24/7 Some reduction in full MDT availability in some teams, which will be managed by cross cover or redeployment (depending on requirements) Minimum staffing requirements being reviewed & confirmed in partnership with nursing directorate
NICPM	Maintain as a priority ward unless LTHT require ward space.
Maintain but can reduce / redeploy some staff	
CMHTs CLDTs Assertive Outreach Community R&R CONNECT community team Community Forensic Team Community Perinatal Deaf CAMHS Physical Health Team Care Homes Team Recovery College (telephone & online support) Forward Leeds (Addictions) PD Network LADS & ADHD Gender service Gambling service Chronic Fatigue & Liaison Outpatients Psychosexual medicine Offender PD services Veterans service	These services can all operate currently on a reduced number of staff, but have a requirement to maintain some access and an active caseload, including direct contact (including some face to face contact) with some service users. All service users have been RAG rated and this informs the required capacity and skill mix for the team Some staff are therefore available for redeployment from these teams.
Could step down	
LD Involvement Team PD Pathway Development Service 2 Woodland Square	These services can be closed to new referrals and stepped down, with only emergency contact cover in place

APPENDIX B – Cohorting Plan

SUMMARY INTERIM GUIDANCE FOR MANAGEMENT OF SUSPECTED COVID POSITIVE PATIENT LYPFT

Patient presents with symptoms of COVID-19

Continuous Cough Or

High temperature Or

Loss of smell

Immediate Action

- **Ensure the appropriate use of personal protective equipment according to local guidance**
- **Isolate patient and organise urgent clinical assessment of physical/mental Health and capacity risks.**
- **Organise swab through infection control.**
- **Whilst awaiting result of swab. Patients to be isolated on ward.**
- **If patient is positive organise urgent meeting involving local clinicians, ops manager and IPC team.**

Once identified as not needing acute hospital care, the aim would be to move the patient to identified cohort area to avoid an outbreak scenario and minimise risks.
This will trigger the process around identification of staffing.
However this decision needs consider the questions outlining underlying principles:

1. **Is a cohorting bed available within identified area?**
2. **Are there enough staff to manage the patient in the identified cohorting area?**
3. **Will it be clinically safe to move the patient from a MH perspective?**
   a. **Consider need for potential seclusion**
   b. **Impact of relational security.**
4. **Would the service user agree to be managed in their bedroom if moving is an issue?**
5. **Are en-suite facilities available or is there a dedicated bathroom which could be used?**
6. **Is there appropriate separate space for a donning/doffing area for staff.**

Site	Patients who are well enough to go home.	Move to dedicated cohorting area	For symptomatic service users or for service users who refuse to move to cohorting area	Impacts – capacity, staffing and other
The Becklin Centre – Clinical services comprise of 4 Acute in Patient Wards, Section 136 Suite and Crisis Assessment Unit.	Can the patient be safely discharged / stay at home? • If yes - Ensure appropriate support arrangements are in place with CRISS and IHTT • If No ⟶	**Allocated beds in the Crisis Assessment Unit** will be the cohorting area and any positive cases will move to this area to be safely managed away from the main ward area by default.	Wards to identify space within the home ward where positive service users could be isolated within their room with access to dedicated bathroom and with dedicated staff team	Reduced capacity for acute care: Reduction of beds in CAU Potential additional staffing needed.
The Newsam Centre				

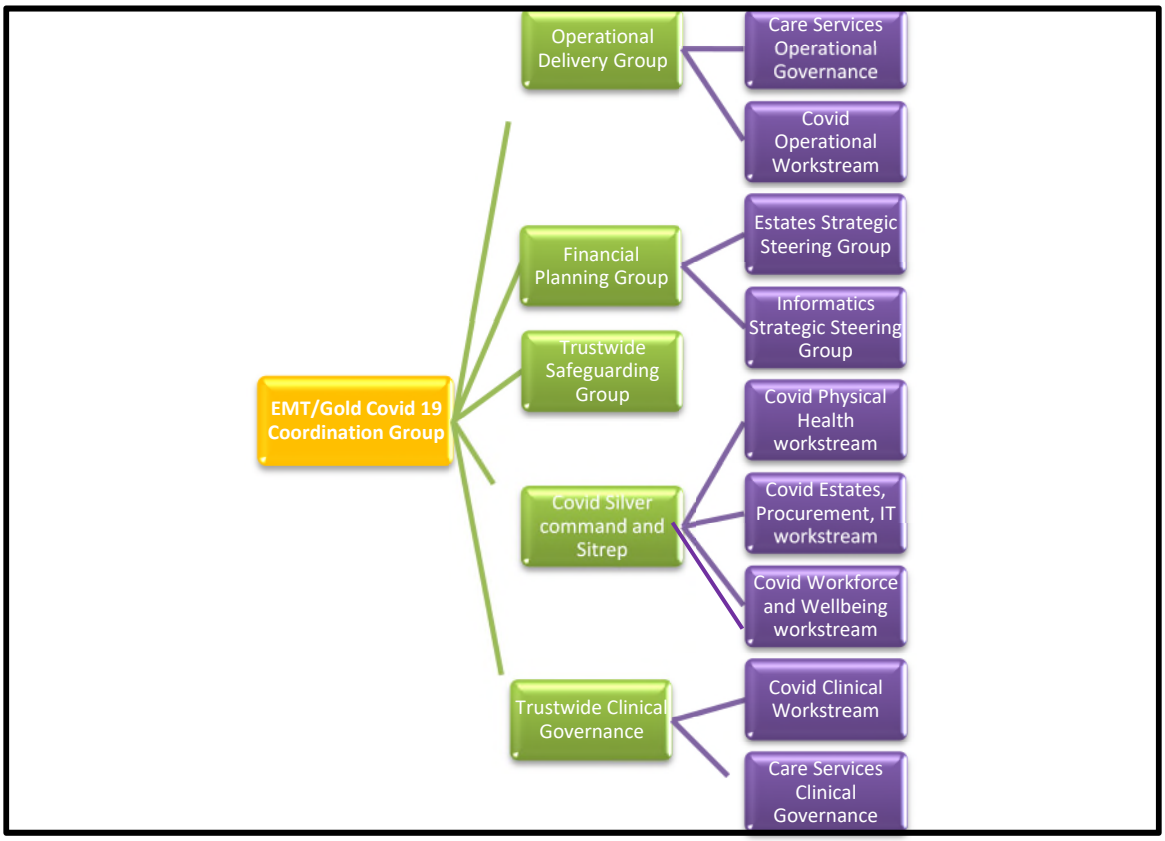
Ward 1 – PICU and Ward 5 Rehab.	If well enough to step down, consider transfer to acute ward.	Transfer to cohorting area on ward 3 Newsam Centre.	Use of isolated area of the ward – old 136 suite (PICU) or area of ward 5.	Potential need for increased staffing.
Wards 2&3 – Low secure forensic	N/A	Use of 4 bedded area on ward 3.	Service users will be managed within their rooms in areas of each ward.	Potential need for increased staffing.
Ward 4 – acute	Can the patient be safely discharged/ stay at home? • If yes - Ensure appropriate support arrangements are in place with CRISS and IHTT • If No ⟶	Transfer to CAU cohorting space.	Ward to identify space within the home ward where positive service users could be isolated within their room with access to dedicated bathroom and with dedicated staff team?	Potential need for increased staffing.
Ward 6 – eating disorder service	Can the patient be safely discharged/stay at home? • If yes - Ensure appropriate support arrangements are in place with CRISS and community CONNECT • If No ⟶	Isolate in situ in dedicated area of ward.	Isolate in situ	High need for PPE – in place Need to monitor supply Potential need for increased staffing.
Mill Lodge (York) – Stand-alone CAMHS in Patient Unit.	Can the patient be safely discharged/stay at home? • If yes - Ensure appropriate support arrangements are in place with local crisis teams. • If No ⟶	. Use of short corridor of beds with planned use the High dependency area to manage patients if required.	Bed occupancy has been reduced and designated bed areas have been agreed as suitable for safely isolating, containing and managing the risk of infection.	Admissions being managed to ensure balance of acuity and staffing. Potential need for increased staffing.
Clifton House (York) - Stand – alone Forensic Low Secure Service; Bluebell Ward, Westerdale Ward and Riverfields.	N/A	Transfer to cohort area at ward 3 Becklin	Service users will be managed within their rooms with additional staff support. .	Familiar staff from Clifton to accompany service user. Issues and risks around seclusion. Potential need for increased staffing.
Asket Croft – Rehabilitation and Recovery Service	Can the patient be safely discharged/stay at home? • If yes - Ensure appropriate community support arrangements	Patient to be managed in cohorting area of Asket Croft.	Manage within room with increased staffing support.	High need for PPE Staffing needed correspondingly Potential need for increased staffing.

The Mount –	Can the patient be safely discharged/stay at home? • If yes - Ensure appropriate support arrangements are in place with IHTT • If No ⟶	Move service user to AECU	Isolate on ward in room with daily reviews of situation.	Process for standing up staffing for AECU being worked up. This is likely to need redeployed staff.
Mother & Baby unit	Can the patient be safely discharged./stay at home? • If yes - Ensure appropriate support arrangements are in place with CRISS and community perinatal team • If No ⟶	Area of the MBU identified to cohort in.	Isolate in room with daily review.	Increased staffing likely given location at PSL and to support isolation. Potential possibility of baby being cared for elsewhere and mum transfer to CAU cohorting area if patient cannot isolate. Potential need for increased staffing.
Specialist Supported Living	Own homes.	Isolate within room	May become an issue with some of the residents with challenging behaviour. Being reviewed on a place by place basis.	Staffing issues and support.

- This Guidance to be used alongside more detailed COVID Standard Operating Procedures available on staff net.
- This Guidance to be used alongside appropriate liaison with MHA office and guidance.
- This Guidance to be used with the support of usual clinical/operational structures and the Ethics Committee.

Appendix C

Arrangements for Covid 19 Incident Management and Leadership Incident Governance Structure



1. Regional and National EPRR Picture

The NHS stepped down its declared level four national incident (declared on 30 January 2020) on 1 August to a level three regional incident. This means that the response is managed at a regional level but with national NHS E oversight and also national NHS E objective and guidance setting.

The key objectives of an NHS funded organisations Incident Coordination Centre (ICC) either physical or virtual is:

- the maintenance of a SPOC (Single Point of Contact) via phone and your ICC email) in order to respond to urgent requests or actions within 1 hour,
- the ability to maintain delivery of SITReps and respond to information requests,
- the ability to manage and report Outbreaks (as previously communicated) and
- the ability to step up your ICC in response to a COVID-19 related issue requiring immediate action

In terms of satisfying these requirements, the Trust's position is:

- The Resilience Lead's telephone number is the SPOC contact number and the lmh-tr.covid-19@nhs.net e-mail box is the ICC e-mail.
- SiTRep responsibility has been defined as:
    - National daily SiTRep:
        - Daily routine 11:00 return - EPRR
        - Exception report - EPRR with IRT director sign-off.
    - Shielding patients - Clinical composition of the return and EPRR upload
    - Patient and Staff deaths from Covid - Nursing Directorate
    - Outbreak SITReps:
        - Local HPA and NHS England notifications - Infection Control/ Physical health workstream
        - IIMARCH return - EPRR working with Physical health for additional details. IRT director and DIPC sign-off.

          In the absence of the DIPC, the Deputy Director of Nursing will sign off and in the event of both staff being unavailable; the Physical Health Care Lead will sign off.

- Outbreak management will be based on the existing Trust outbreak procedure and will be led by the Outbreak management Team.
- ICC is virtual structure (given the risks posed by a physical meeting in one place) and can be established rapidly in hours as the situation warrants. Out of hours the ICC devolves to an enhanced out of hours management structure. The establishment of an emergency ICC falls to the on call director drawing assistance from Operational managers on duty and on call.

In addition there is the requirement to mirror NHS England Northern and Yorkshire's ICC hours of operation and management meetings (Annex one - .Third Phase of NHS Response to Covid-19 letter 31 July 2020)

- As of 1 September 2020 these are: Mon-Fri 08:00-17:00 and Sat-Sun 09:00-16:00. Communication from region outside of these hours is therefore unlikely unless an emergency.
- National and Regional incident management team meetings are Monday, Wednesday and Friday and hence the Trust parallels these with its Monday and Friday Silver and Wednesday Gold meetings.

2. Internal Gold Command – Covid 19 Coordination Group (Strategic)/ Executive Management Team

Membership:

- Chair – CEO – Sara Munro
- Deputy Chair – Dawn Hanwell
- EPRR AEO – Joanna Forster Adams

- Executive Directors
    - Chris Hosker
    - Cathy Woffendin (DIPC)
    - Claire Holmes
- EPRR Lead – Andrew Jackson
- Incident Coordinator – Alison Kenyon
- Corporate Governance – Cath Hill
- Loggist – IRT Administrator – Corporate Governance Team

Note in the absence of the chair and deputy chair, Gold will be chaired by the IRT director for that week.

Meets:

Weekly meeting as part 1 of the EMT meeting where the Incident Coordinator and EPRR lead will join the meeting

Key Functions:

- Oversees strategic objective for managing the response to Covid 19
- Assesses and reaches a decision on complex service resetting and recovery proposals that involve:
    - Significant new capital or revenue expenditure as defined in SFIs and FPs
    - Potentially contentious issues with regard to external stakeholders including partner organisations, commissioner, regulators and local/ national government
    - Evaluating the consequences of recovery/ resetting where several services are involved with potentially conflicting needs from resource allocation to effect recovery
- Evaluate on-going impact, progress and success of response and management of the impact of Covid19
- Establish the governance arrangements appropriate to the status and phase of the incident
- Set the parameters for delegated decision making at tactical level
- Ensure coordination of activities, plans and projects in line with strategic objective
- Resource allocation and oversight of the financial framework
- Oversight of maintenance of key service objectives
- External issues and interface including media
- External interface at place, ICS, Region and National including expert networks and MH and LD Networks.

3. Internal Silver Command – Incident Response Team Arrangements rostered (Tactical)

Operates:

The silver command structure will operate between 08:00 to 17:00 each weekday (bank holidays excluded - see below)

Membership

- Lead : IRT Director –weekday rota
- Communications Lead – 7 day rota
- Rostered work stream leads only
    - Operations lead- 7 days rota
    - Physical health / IPC - 7 day rota
- Members not providing 7 day cover (unless rostered on)
    - EPRR AEO
    - Incident coordinator
    - EPRR Lead
    - Executive Officer
    - Workstream Leads
    - Procurement and Supplies

SiTRep populated by work stream lead. Coordinated and shared by IRT Administrator in readiness for SiTRep

Call and Zoom

- Details circulated in diary invite.
- Details reiterated to daily leads by IRT Administrator.
- setup and logged by the IRT Administrator.

Meets: Monday and Friday at 12pm.

Chaired by an executive director - the same director will chair both the Monday and Friday call.

Each Friday an agreement will be reached regarding weekend arrangements (IRT Administrator to setup invites for weekend calls where appropriate and circulate contact details).

Out of hours

From 17:00 of weekdays and all day bank holiday and weekends out of hours on call arrangements will be responsible for overseeing and coordinating any necessary response to Covid 19. The on call director will assume the role of IRT should this be required in any out of hours response to Covid 19 issues.

Key functions:

- Implement the strategic objectives
- Establish the situational position in services and agree the appropriate response
- Establish status of themes of work being undertaken in enabling work streams
- Coordinate the various elements of the operational response
- Allocate resources for immediate operational response
- Prioritise activities
- Determine measures required in response to the immediate situation
- Measure the effectiveness of the response and modify working strategies accordingly.
- Agree key messages and communications for staff and stakeholders.

4. Work streams

Appropriate leadership arrangements in place

Established meeting routine to respond to status of incident

Work programme and priorities established and to be regularly refreshed by work stream lead in agreement with responsible Executive Director.

Covid Work stream	**Lead Executive**	**Lead officer/s - SitRep**
Operational work stream	Joanna Forster Adams	Rotational Head of Operations
Physical Health Work stream	Cathy Woffendin	Nichola Sanderson
Clinical	Chris Hosker	Sophie Roberts, Tom Mullen
Workforce and wellbeing	Claire Holmes	Lindsay Jensen
Estates, Procurement and IT	Dawn Hanwell	Amanda Burgess Emma Polhill

Key functions

- Carry out identified objectives
- identify risks and threats to the implementation of key objectives
- Escalate operational difficulties where tactical assistance is needed
- Provide expert input to problem solving
- Allocate tasking of specific actions to staff
- Collate reports and information from service and team level to enable tactical to form a coherent picture of the impact of the indent on the Trust

Workstream Arrangements

The appendices to this document contain details of how the workstream and directorates are organised to support the management of the response to Covid.

5. External SITReps

5.1. **Daily NHS E SiTRep** - done by the EPRR team by 11:00 - rota in place to complete on weekends and bank holidays. Weekend SITReps can now be done on the following Monday by 11:00.

5.1.1. Ad-hoc SiTRep triggered if any operational difficulties are identified - this will be compiled by the EPRR team and sent to duty IRT director/ on call director (if weekend) for sign off.

5.2. **Ad-hoc shielding SiTRep** - compiled by Medical staff and sent to EPRR staff for uploading.

6. Test and Trace arrangements update

NHS Test and Trace will contact the Trust via a dedicated mailbox: mailto:covid19testandtrace.lypft@nhs.net. This mailbox is required to be monitored during the hours of 08:00 to 22:00.

6.1. Arrangements from 1 September 2020

Normal working hours (Monday to Friday 09:00-17:00)

Workforce staff will monitor the test and trace mailbox from 08:00 to 17:00 and liaise with infection control staff accordingly if cases are notified.

17:00 to 20:00

The mailbox is monitored by Infection Control staff.

Weekend and bank holidays

Monitoring of the mailbox will be provided by on duty Newsam admin staff: The rota for September 2020 is below. Newsam admin staff will notify Infection Control who will engage the on call Workforce as needed

An on call workforce manager will be available to support the process if required. The on call manager for weekends and bank holidays will be communicated in the weekend IRT bulletin each week and will be on call from 08:00 to 17:00 each day.

If an outbreak situation is occurring then workforce on call managers will move to being on duty to support

Newsam admin staff test and trace mailbox monitoring rota.

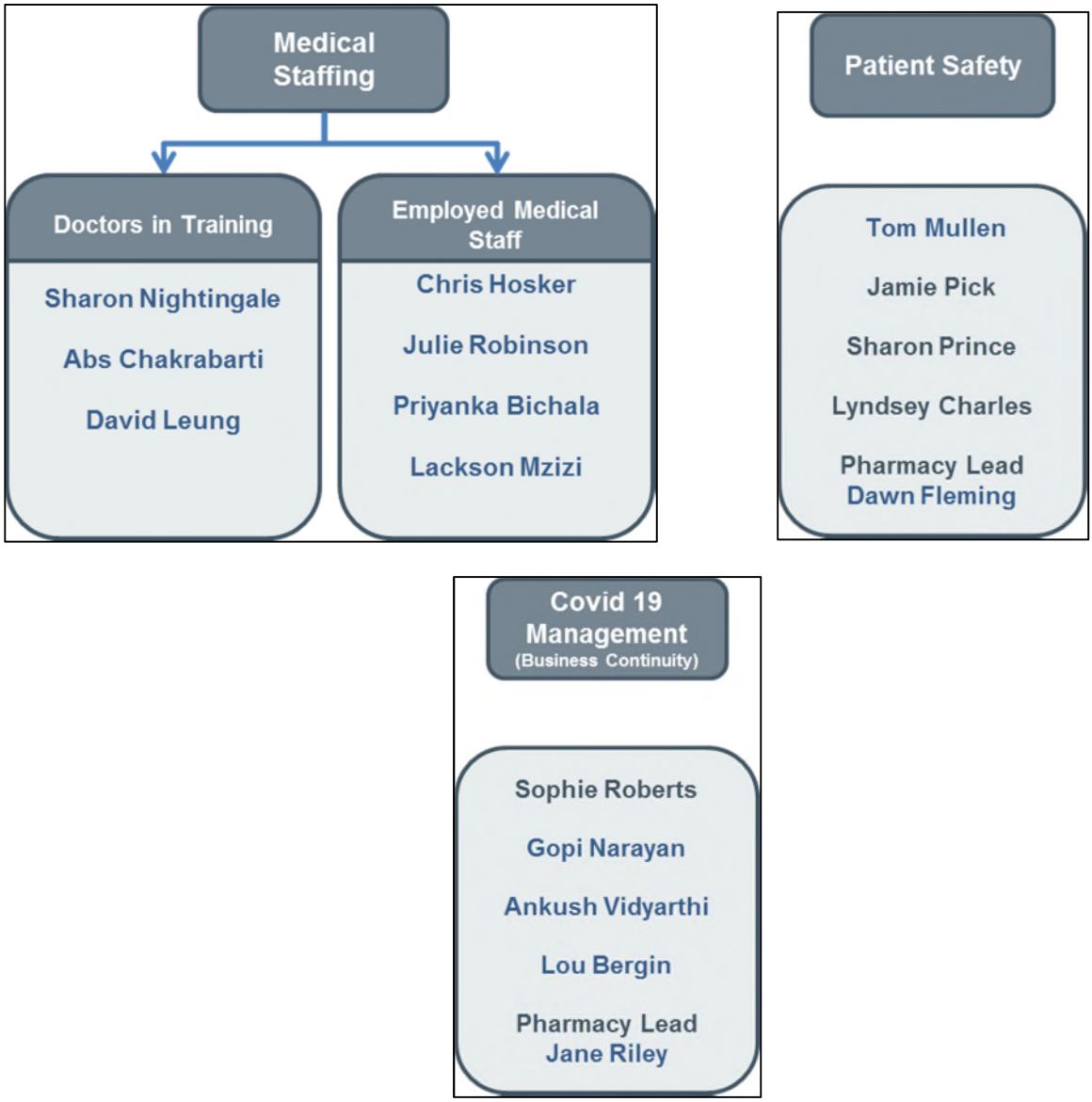
7. National Supply Disruption Response (NSDR) – PPE Support

Note that the NSDR has reduced its operational hours to 7 am on Monday to 10 pm on Friday. Any PPE stock issues (low stock levels) over the weekend will need resolution via mutual aid at organisational level or via the PPE portal.

Calls can be made to the NSDR helpline at any time: **0800 915 9964** but these will only be actioned when the NSDR is operational again.

Appendices - workstream and directorate structures

1. Medical Directorate



Pharmacy:

In hours workstream response arrangements – for those who have specified Covid related workstream responsibilities – Workforce, physical health, estates and logistics, clinical and Operations i.e. meetings, frequency, where do you escalate , staff involved	During COVID the following members of the team have the following specific work stream responsibilities; - Lead for workforce- Anita Solanki - Lead for physical health- Michael Dixon - Lead for estates and logistics-Not had a identified individual for this. Anita Solanki and Helen Black, Chief pharmacy technician have been predominantly leading as issues have been discussed at workforce meeting and Helen is responsible for the dispensary. During COVID the senior pharmacy team have been meeting weekly to discuss all issues relating to COVID and share feedback from the COVID operational meeting (Chief pharmacist/deputy

	chief pharmacist have been attending as clinical lead), workforce meeting and physical health meeting. Issues are escalated to the medical directorate meeting, Trust Wide Clinical governance or operational/workforce /physical health meetings as applicable.
Describe out of hours arrangements - staff on duty, staff on call relating specifically or largely to Covid. Period covered out of hours.	Pharmacy have an on call rota, an on call pharmacist can be contacted outside normal working hours, Mon- Fri 9 am-5 pm. The on call pharmacist has a buddy. The on call pharmacist/ buddy pharmacist skill mix is so that at least one pharmacist is an advanced clinical pharmacist or lead pharmacist. During COVID this has been further supplemented by a senior lead pharmacist being third on call if necessary. The need for a lead senior pharmacist is due for review 25/08/2020. In addition to a pharmacist on Saturday and Sunday mornings, 2 members of the technical staff are in work to support urgent supply of medication.
Describe how you would mobilise staff should an out of hours response be needed to Covid - this is over and above a typical outbreak response where there is a need for significant numbers of manager level staff to develop a response to manage business continuity threats to staffing, building viability, patient capacity, risks of infection, standing up resources	The lead senior pharmacist would work with the on call manager to identify resource needed. The on call pharmacist and buddy pharmacist would be first to respond and extra resource contacted if needed. The on call pharmacist has contact details for all pharmacy staff.

2. Estates, Procurement and Finance

In hours workstream response arrangements – for those who have specified Covid related workstream responsibilities – Workforce, physical health, estates and logistics, clinical and Operations i.e. meetings, frequency, where do you escalate , staff involved	We have just adjusted meeting frequency to once a week – 8.30 Wednesday Chaired by myself CFO (notes/minutes by PMO – Jenny Trainor or Donna Batley) Attendees David Brewin David Furness Myles Callaway Keith Rowley Darren Wilson Bill Fawcett Amanda Burgess
Describe out of hours arrangements - staff on duty, staff on call relating specifically or largely to Covid. Period covered out of hours.	Reverted to normal out of hours on call arrangements for :- IT Estates Procurement still operating both on call and also physical presence (working) on Sundays as this is when we have scheduled push stock delivery

Describe how you would mobilise staff should an out of hours response be needed to Covid - this is over and above a typical outbreak response where there is a need for significant numbers of manager level staff to develop a response to manage business continuity threats to staffing, building viability, patient capacity, risks of infection, standing up resources	We would use our standard out of hours arrangements to respond to an emergency situation

Appendix D

Maintaining Safer Staffing to priority services: Revised Deployment Approach

This paper aims to set out the agreed approach to deployment & redeployment of staff in order to maintain minimum safe staffing levels within the agreed priority services of the Trust, as a result of significant and sustained reduced staff availability as a result of the on-going Covid pandemic or other pressures.

In the initial stages of the Covid pandemic, an approved process for proactive Redeployment of staff was developed and implemented (Clinical & Operational Staffing Redeployment, April 2020 – attached as Appendix 1).

Both during and following implementation, the redeployment process has been reviewed through a number of processes (such as ongoing redeployment forums, some facilitated discussions with ward / team managers, and through the wider Trust evaluation and staff feedback processes). The feedback and learning has been considered and incorporated into this revision, which has also been developed through discussions with operational, clinical and professional leads.

This revision also sets out a revised approach to the prioritisation of services, based on significant discussion across Care Services and beyond, including through the Operational Delivery Group.

For a small number of ad-hoc / single instance requirements for additional staff in order to maintain safe staffing levels, the standard approaches of seeking additional staff, negotiating changes with local staff (such as cancelling training or ad-hoc leave) and moving staff on a shift by shift basis based upon need will be applied (as set out in the Staffing Escalation Protocol, which can be found at Appendix 3 of the Clinical & Operational Staffing Redeployment process).

However, when the need for additional staff to maintain minimum staffing is more sustained (or when actual or predicted levels of absence exist across a large number of services), an alternative approach is required.

Deployment & Redeployment is overseen by a dedicated group, which includes operational, clinical / professional and work force representatives. The Terms of Reference are attached as Appendix 2.

1. Identification of need

In order to identify a sustained need, a number of potential factors will be considered:

- Use of a workforce information dashboard
- Daily staffing reporting from all priority services through the operational route
- Escalation from Heads of Operations

a) Workforce information dashboard

Utilising existing workforce information systems and data capture processes, a collection of KPI's will be compiled into a dashboard with an embedded RAG rating system to identify potential sustained staffing shortages. The dashboard will act as an early warning system enabling us to make informed, evidence based decisions about potential / actual need for additional staff to maintain safe staffing.

The dashboard will be produced and distributed at 2 separate intervals (weekly and 4 weekly forecasting) to effectively capture and manage both short-term spikes and trend trajectories at ward level across the organisation.

The planned schedule is as follows:

Weekly Report: Capturing a 7 day forecast for the coming week which will aggregate data to capture areas consistently struggling and trends in staffing availability.

4 Week Reporting: Aligned to the Ward rosters, this report is an extension of the 7 day forecast report but allows for a greater projection to determine whether planned absence/leavers/starters will contribute to the ability to staff the ward safely.

The Scorecard will include

- ***Covid Related Absence -*** All Covid related absence is recorded under the "Other Absence" code in the Healthroster system in real time by ward managers and has been utilised throughout the Covid period to provide the National SitRep data to NHS Digital

- ***Total Unavailability-*** a combination of all types of unavailability affecting the units' ability to Safely Staff this includes Sickness, Annual Leave, Maternity, Study & Other absence (Jury Duty, Compassionate leave etc). Wards are profiled to accommodate an unavailability of 24%.

- ***Unfilled Roster -*** The number of hours that remain unfilled after all shifts have been rostered, sent to Bank/Agency for cover this would incorporate vacancies and shifts not covered due to the above unavailability reasons.

- ***Redeployed People Hours -*** where action has already been taken to support the unit and staff from outside the service have been utilised

- ***Vacancy rate –*** indicator of the level of vacancy in the service, which will impact on consistency of staffing and capacity of the ward to manage an increased unavailability

Example Dashboard:

Redeployment Dashboard Test					
Unit	**Covid Absence %**	**Total Unavailability %**	**Unfilled Roster %**	**Redeployed People Hrs**	**Current Vacancies**
Newsam Ward 5	10.1 %	25.4 %	3.8 %	201.00	6%
Becklin Ward 1	6.9 %	12.4 %	8.8 %	0.00	4%
Becklin Ward 3	14.8 %	38.9 %	12.1 %	0.00	11%

In addition to the above, real time information can be drawn from the system as required on a daily basis to better understand and predict safer staffing issues as they arise and are escalated from the daily reports and through clinical / operational routes below.

b) Daily staffing reports

As a result of increased absence, all priority services report their staffing position each morning for the next 24 hours (and on Friday for the weekend period). This supports the local operational & clinical managers, on-call managers and duty Head of Operations to predict and address staffing shortages, and to prioritise staff deployment as required.

Clearly this is a snapshot in time; experience has shown that the reported position at 9am is frequently very different to the position at midday (often due to shifts being filled during the course of the morning).

When the daily report indicators that there are significant forthcoming shortages across a number of the services, the duty Head of Operations will consider convening further reviews of the changing staffing position as required throughout the day, and will seek to ensure that mitigating actions are taken to maintain (minimum) safe staffing numbers across all priority services. As indicated above, information can be drawn from the HR / workforce information systems to support this if required.

c) Escalation from Head of Operations

There are some additional clinical & operational factors that will have an impact on both staffing requirements and safety within services – these include, for example, high levels of acuity, enhanced observations, incidents of significance and bed occupancy. Where these factors exist and this results in a requirement to increase staffing for a sustained period, this will be escalated by the Head of Operations (or in their absence via the ward matron or designated deputy).

The staffing position for each service is also routinely reviewed at the Clinical & Operational meeting, which currently meets 3x per week, but can increase to a daily meeting if required.

2. Revised prioritisation of services

In line with the previous process, we have maintained an approach of prioritising services using the following criteria:

Priority 1 services	These key services are essential priority and are required to be maintained at full capacity. Normal staffing numbers and skill mix will be maintained. This includes 24/7 inpatient services, supported living houses and urgent access / crisis services.
Priority 2 services	There services need to be maintained, but may safely be delivered at a reduced capacity or alternate skill mix. . This will be informed by an assessment of service user need, risk and vulnerability using our agreed clinical RAG rating process. Services may therefore be reduced or consolidated, and some staff redeployed into priority 1 services
Priority 3 services	These services could be reduced to a minimum level of delivery or could be stepped down entirely. The majority of staff are therefore likely to be redeployed into priority 1 services (or into priority 2 services as part of a revised skill mix to release other staff to priority 1 services)

The key change is that, whereas a number of service were previously stepped back to minimum staffing providing only emergency or signposting cover, the vast majority of services have moved into the 'priority 2' grouping. This reflect a specific wish to maintain a level of direct service provision across all services, reflecting both national & local drivers to carry on providing as many services as possible, and recognising the impact of some services (in terms of escalation of clinical presentation and significant increased waiting lists) of the previous redeployment approach. The revised service priority groups are therefore shown at Appendix 3.

This has been debated at some length, with a number of different views considered. The impact of this approach is that, rather than identify services to step down immediately, services within the priority 2 group will have identified a number of staff that are available to be redeployed, and this will be agreed with the staff in advance. The service will be able to proactively plan – and clearly articulate – the potential impacts of those staff being redeployed, and will be able to plan to mitigate & manage these accordingly. This approach was strongly advocated and favoured by both the clinical and operational leaders.

It is however essential to recognise that, as part of this approach, if safer staffing cannot be maintained through the redeployment of the identified staff, then it will be necessary to consider releasing additional staff from these services (and therefore further reducing their capacity & operational delivery) or stepping down some services entirely in order to release additional capacity. This approach is described below.

3. Identifying staff for redeployment

In the first instance, for low level and short term additional staffing requirements to maintain agreed minimum staffing levels, the usual local actions will be taken to seek to meet these (as set out in the Staffing Escalation policy) . These include (but are not limited to)

- Review of current staffing requirements on the ward (including enhanced observations and any escorted patient leave)
- Seeking additional bank staff or overtime
- Cancelling training & rostered management days
- Cancelling 'ad hoc' annual leave in negotiation with the member of staff
- Moving of staff from other clinical areas whilst maintaining agreed minimum safe staffing numbers

However, once a priority 1 service has been identified as having a sustained requirement for additional staffing, the 'redeployment group' will utilise available information to determine the number of staff required and an appropriate skill mix, supported by additional members from the clinical & operational leadership teams as required.

Appropriate staff will then be identified using a hierarchy as below, working from the top until the identified need is met

1. *Volunteers* - cohort of staff who have self-identified as willing to be redeployed and have completed the redeployment proforma identifying skills & areas of preference. This includes volunteers from non-clinical / corporate services (based on positive experience previously)

2. *Cohort of 'early redeployees'* - identified specific groups of staff who would be redeployed in initial wave (generally clinical staff not undertaking direct clinical roles; this may include partial redeployment, as previously)

3. *Identified proposed redeployees from Amber priority services* (services that will be reducing staff & operating differently but maintained)

*4. Additional redeployment from Amber priority services (*with assessment of associated risks / impacts and how these could be managed; this may result in a service being stepped down to minimum cover)

5. *Stepping down of non- priority 1 services* - services that will be stepped down or reduced to minimum cover to release further staff. This would require IRT approval.

A pre-determined duration for all redeployments will be agreed to ensure we can meet the needs of the sustained requirement for additional resource as well as manage the expectations of the 'home' service, redeployed service and individual staff members.

4. Deployment of staff to identified cohorting areas

Recognising the particular challenges of staffing identified cohorting / Covid-positive areas (based upon the earlier experiences), the following approach will be taken in addition in these areas:

- Acute adult and Older Peoples services will have identified a cohort of staff who express a willingness to work in these areas, and this will also be asked of Bank staff. This will be known to the redeployment group and these staff will be prioritised for deployment into these areas.

- For all staff, their wellbeing assessment and individual circumstances will influence the decision in relation to working within the cohorting area.
- Once deployed into the Cohorting area, staff will remain there for the period that the unit remains open. Other than in emergency circumstances staff will only work each day in the cohorting area, and will not move between wards.

5. Learning from previous redeployment feedback

Significant efforts have been made to ascertain and then collate feedback regarding the initial redeployment process, with responses obtained from:

- Manager forums
- Your Voice Counts
- Redeployment staff forums
- Evaluation by the Clinical Effectiveness team.

As a result, a number of process changes have been developed in order to:

- Improve **communication** between the redeployment team, managers, clinical and professional leads
- Raise **awareness**, via multiple methods, for all staff regarding rationale for redeployment and the process for implementation
- Improve **consistency of implementation** of the deployment and redeployment processes across teams and service areas
- Provide clearer **information** for redeployed staff regarding their new teams / roles and for managers regarding their skills, competencies and potential concerns
- **Plan** for redeployment actions in advance wherever possible with individual services to mitigate impact and provide opportunities for staff engagement
- Improve **effectiveness** of redeployment by seeking to redeploy staff who volunteer and/or have developed relevant skills, training and experience having been redeployed previously to the priority 1 service areas
- Improved focus on **supporting staff wellbeing** through incorporating staff wellbeing assessments into the redeployment process and being clear as to the expected duration of their redeployment commitment
- Wherever possible, provide **clear anticipated time scales** for the duration of the redeployment period on an individual basis.

These priority changes have been incorporated into this revised process, and will continue to be reviewed and evaluated both through the Redeployment Group and through other Trust structures.

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:	Board Assurance Framework
DATE OF MEETING:	29 October 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 updating 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
- Reviewed by the lead executive director who has ensured the details overall are up to date.

Attached to this paper is the latest version of the BAF. This is presented so the Board can receive assurance on the way in which the risks to achieving the strategic objectives are being mitigated and that effectiveness of the controls that are in place, or that where there are gaps in controls or assurance these are being sufficiently addressed.

After a period of hibernation due to the CVOID pandemic, this version of the BAF has been updated by executive directors to take account of the current position. It has also been presented to the Audit Committee at its meeting on the 20 October and it considered the content.

As we start to step back up our governance reporting arrangements the BAF will be considered by each of the Board sub-committees in accordance with their cycle of business.

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 Board Assurance Framework and consider its content and to be assured that further detailed consideration of the content will take place in the relevant Board sub-committees.

BOARD ASSURANCE FRAMEWORK OVERVIEW											QUARTER 2 - 2020/21
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.**	Partial (assurance reduced)	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)			There is evidence that there is continuous learning, improvement and innovation in the Trust but this is in the process of being embedded .	Chris Hosker (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)			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)			There are a number of significant workforce challenges which the Trust is working to address.	Claire Holmes (Director of OD and Workforce)	Workforce Committee	20	→

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)			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 Financial 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)			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 Financial 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)			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 2020)	Q2 (end of September 2020	Q3 (end of December 2020)	Q4 (end of March 2021)
	Partial	Partial		

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Risk Lead / responsible director	Overseeing group	Q1 (end of June 2020)	Q2 (end of September 2020	Q3 (end of December 2020)	Q4 (end of March 2021)
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 / Chris Hosker	Mental Health Operational Group	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	Following a recent operational restructure and consultation process resulting in moving to 9 service lines from 2 care groups the clinical governance arrangement s have been strengthened with additional resource of two Heads of clinical governance and additional resource at clinical director level. These posts will work together over the next three months to review the new arrangements and provide a proposal which will be signed off by the executive management team. The previous governance current arrangements are still in place to mitigate any risks. 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 2019/20. Self certifications were signed off by the Board for 2019/20which also highlighted if there were any risks to compliance for 2020/21 and how these would be addressed.	Jun-20
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	An update was provided to the council of governors and board members at the board to board in August I can't remember the date Cath can you please advise by the Executive director of nursing , quality and professions providing assurance that all actions were progressing and the oversight of this had been re-established from July following hibernation as agreed with our CQC relationship managers	Sep-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	Chris Hosker (Medical Director)

Assurance rating (quarterly) (limited, partial, significant)	Q1 (end of June 2020)	Q2 (end of September 2020)	Q3 (end of December 2020)	Q4 (end of March 2021)
	Partial	Partial		

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end of June 2020)	Q2 (end of September 2020)	Q3 (end of December 2020)	Q4 (end of March 2021)
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		
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		
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		

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	Research Annual Report	This was presented to the Trustwide Clinical Governance Group for assurance on their work	Oct-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-21
829	Serious incident reporting and investigation (gap in control)	We are developing metrics to assess the strength of the recommendations	Jun-21
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.	Mar-21

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**	**20**	**Executive lead**	Claire Holmes (Director of OD and Workforce)

Assurance rating (quarterly) (limited, partial, significant)	Q1 (end of June 2020)	Q2 (end of September 2020)	Q3 (end of December 2020)	Q4 (end of March 2021)
	Partial	Partial		

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	**Description**	**Lead / responsible director**	**Overseeing group**	**Q1 (end of June 2020)**	**Q2 (end of September 2020)**	**Q3 (end of December 2020)**	**Q4 (end of March 2021)**
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		
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		
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		
705	Maintaining continuity of medical input is unstable due to the use of temporary contracts and agency staff.	Jamie Pick	Future Workforce Group	12	12		
732	Lack of medical staffing at Clifton House and the reliance on a mutual aid SLA with TEWV	Steven Dilkes	Future Workforce Group	8	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	25	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 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	Regular 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 taking place for nursing posts. Work in partnership with care services to identify identifying priority areas and new services areas. Proactive recruitment for aspirant nurses through national programmes and bring back service. Supporting current staff to apply for nurisng associate posts. Exploring international recruitment across the ICS.	Sep-20
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. Workforce planning work paused but support offered to care services in redeploying and deployment of staff to support clinical priority areas.	Oct-20
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. RO AR provided to July 2020 Board	Jul-20
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 and ensuring full representation of all areas in panel selection.	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 to be implemented from November 20 but could be delayed if a surge in Covid 19 over winter	Nov-20
830	Most of the planned workforce activity and devlopments have been paused or hibernated to support Buiness contiuity and Covid response.	Recovery and reset plans being worked through with some areas of workforce activity stepping up from October and the devlopment of the Trust's People Plan	Mar-21
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.	Jun-21
830	New and changing guidance as to key workforce support measures taking place which can cause confusion	Regular webinars in place with Chief People Officer . Communication and Workforce group in place meeting weekly with cross representation with the Operations group and bronze workforce group meeting twice weekly	Mar-21
830	Increase in NHS Test and Trace increasong numbers of staff self-isolating due to tracing in community and social settings	Redeployment Group set up to manage and prioritise resources to deliver priority services and using bank and agency staff to fill gaps	Mar-21

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 Financial Officer)
Assurance rating (quarterly) (limited, partial, significant)	Q1 (end of June 2020)	Q2 (end of September 2020)	Q3 (end of December 2020)		Q4 (end of March 2021)	
	Partial	Partial				

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end of June 2020)	Q2 (end of September 2020)	Q3 (end of December 2020)	Q4 (end of March 2021)
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		
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		
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		
834	The Trust is vulnerable to fraud by inadequate systems and processes or those in a position to bypass controls. The risk is both internal and external and involves intent to evade detection	Gerard Enright / Dawn Hanwell	Audit Committee	5	5		
731	Increasing agency spend could cause a deterioration in the Trusts Finance Score.	David Brewin / Dawn Hanwell	Financial Planning Group	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. Follow-up audit carried out and significant assurance provided.	Oct-20
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-19

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	Apr-20
619	Budgetary and accounting control framework	The internal audit of the budgetary and accounting control framework has provided significant assurance	Apr-20
619	Achieved the control total and the 2018/19 financial plan	Accounts were audited at the end of 2019/20 to verify the financial outturn	Jun-20
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-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*
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	Dec-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	Mar-21

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 Financial Officer)
Assurance rating (quarterly) (limited, partial, significant)	Q1 (end of June 2020)	Q2 (end of September 2020)	Q3 (end of December 2020)		Q4 (end of March 2021)	
	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	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	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		

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	May-19
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	Mar-21
615	Utilising one public estate	Reproviding services in suitable premises in accordance with the clinical plan	Jun-21
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-21
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	Dec-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 2020)	Q2 (end of September 2020)	Q3 (end of December 2020)	Q4 (end of March 2021)
	Partial	Partial		

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end of June 2020)	Q2 (end of September 2020)	Q3 (end of December 2020)	Q4 (end of March 2021)
8	Failure to derive maximum clinical and business benefits from digital technologies	Bill Fawcett / Dawn Hanwell	Information Steering Group	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		
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.	Jane Riley / Chris Hosker	Medicines Optimisation Group	6	6		
813	Concerns that EPMA is not recording some administered doses of medication which could lead to double dosing	Jane Riley / Chris Hosker	Medicines Optimisation Group	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	9	9		
874	EPMA/CareDirector Interface - the interace is not working reliably between the two systems	Bill Fawcett / Dawn Hanwell	Information Steering Group	N/A	9		
882	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	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*
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	Electronic drug charts - a small number of staff are able to admit and transfer service users on EPMA manually. Reference codes are being manually assigned to minimise the risk of this occurring	Checks that drug charts are not missing a reference code	May-21
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**	**12**	**Executive lead**	Sara Munro (Chief Executive)
Assurance rating (quarterly) (limited, partial, significant)	**Q1 (end of June 2020)**	**Q2 (end of September 2020)**	**Q3 (end of December 2020)**		**Q4 (end of March 2021)**	
	Partial	Partial				

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	**Description**	**Lead / responsible director**	**Overseeing group**	**Q1 (end of June 2020)**	**Q2 (end of September 2020)**	**Q3 (end of December 2020)**	**Q4 (end of March 2021)**
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	Sara Munro	Gold Command / Executive Management Team	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*
877	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-20
877	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
877	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
877	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
877	NED / Governor engagement events set up for WY MHLDA Collaborative	This provides governors and NEDs with an oppotinity to understand and feed into the future plans for the collaborative	Oct-19
877	Board awareness training on partnership governance structures and models	Training provided by external legal adviser	Jan-20
877	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
877	The Strategy for the WY&H ICS Collaborative has been published	All partners in the ICS have signed up to the Strategy	Jan-20
877	Established lead provider models	Eating Disorders Lead Provider Collaborative agreed	Sep-20
877	The Board receives regular updates on changes in governance models and opporuntities to be involved	Each private Board meeting	Sep-20
877	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*
877	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.	Mar-21

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
19

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Approval of the appointment of the Senior Independent Director
DATE OF MEETING:	29 October 2020
PRESENTED BY: (name and title)	Sue Proctor – Chair of the Trust
PREPARED BY: (name and title)	Cath Hill – Associate Director for Corporate Governance

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

EXECUTIVE SUMMARY

The Board will be aware that it is required to appoint a Senior Independent Director (SID) as per the Code of Governance and also the Constitution

Since February 2019 Martin Wright has carried out the role of the SID; however he comes to the end of this two year appointment in February 2021. The Chair of the Trust has spoken with Mr Wright and he has agreed to continue in this role for a further two years at which point a successor will be identified and put forward to the Board for appointment

This is a Board appointment but one which has the support of the Council of Governors. At the Council meeting on the 5 November the Council will be advised of this Board appointment and it support sought. The timing of the paper to the Council will be in time for second term of appointment to commence in February 2021.

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 approve the appointment of Martin Wright as the Independent Senior Director with effect from 17 February 2021 for a further period of 2 years.

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:	Proposed changes to the Constitution and it Annexes
DATE OF MEETING:	29 October 2020
PRESENTED BY: (name and title)	Dr 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

It is good governance to review the Trust's Constitution from time to time to ensure it is consistent with legislation and still reflects the needs of the organisation.

The Constitution is made up of different sections; the Constitution which is based on the Model Core Constitution and is prescribed by NHS Improvement / England (Monitor); annexes which can be locally determined by the Trust.

This Trust has 10 Annexes and these have been reviewed by the Associate Director for Corporate Governance to ensure they meet the needs of the organisation, reflect current governance arrangements and practice.

Attached is a list of the proposed changes.

The Board is reminded that under the Health and Social Care Act 2012 the responsibility for approving changes to the Constitution and its Annexes lies with the Board of Directors AND the Council of Governors. This Board is being asked to consider and approve the proposed changes before these are presented to the Council of Governors on 5 November for similar consideration and approval.

One change which has not been made is in respect of the Appointed Governors that sit on the Council of Governors. Currently there is a seat named for Equitix (PFI partner). This seat has not been filled for some time and Equitix was clear at the end of the last appointed governors' term of office that they would not be making another appointment to this seat.

On authorisation as an FT it was felt appropriate to invite Equitix to take a seat on the Council. However the Board is asked to consider and suggest who might be invited to be on the Council of Governors to reflect current partnership working so further work can be undertaken to effect this change. The views of the Board will be provided to the Council for its consideration.

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 Board is being asked to:

- Consider and approve the proposed changes before these are presented to the Council of Governors on 5 November for similar consideration and approval.
- Suggest which partner organisation could be invited to have a seat on the Council of Governors to reflect current partnership working and the priorities of the Trust.

List of proposed changes for the Constitution and its Annexes

Section	Para	Original text	Proposed text	Rationale
The Constitution (Definitions)	45	Monitor is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act	Monitor is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act. (the functions of this body corporate are enacted and carried out by NHS Improvement / England).	Clarification has been added to reflect that the statutory functions of Monitor (as defined in law) are now enacted and carried out by NHS Improvement / England.
Annex 4 (List of Appointed Governors)	1	Partner organisations: • Volition • Tenfold	Partner organisations: • Volition Leeds (mental health representative) • Volition Leeds (learning disability representative)	This reflects the change in name for these organisations
Annex 6 (Criteria for ineligibility to be a governor)	2.2	He/she is the chair, a non-executive director, executive director or a governor of another NHS foundation trust, any other NHS body or health service provider (unless he/she is appointed as a governor by an appointing organisation which is a health service body or provider).	He/she is the chair, a non-executive director, executive director or a governor of another NHS foundation trust, any other NHS body or health service provider (unless he/she is appointed as a governor by an appointing organisation which is a health service body or provider). For clarity, this organisation will be listed in Annex 4 of this Constitution in the Appointed Governor section).	The final sentence provides clarity in order to identify which appointing organisation this paragraph refers to.
Annex 6 (Criteria for ineligibility to be a governor)	2.6	He/she is a member of a Local Involvement Network (LINk) or equivalent statutory organisation.	He/she is a member of Healthwatch or equivalent statutory organisation.	This has been amended due to Local Involvement Networks now being replaced by Healthwatch

Section	Para	Original text	Proposed text	Rationale
Annex 6 (Criteria for ineligibility to be a governor)	2.12	He/she is a person whose tenure of office as the chair, non-executive, executive director or governor of a health service body has been terminated for non-attendance at meetings, for non-disclosure of a pecuniary interest or on the grounds that his/her appointment is not in the interests of the health service.	He/she is a person whose tenure of office as the chair, non-executive, executive director or governor of a health service body has been terminated for non-attendance at meetings, for non-disclosure of a pecuniary interest on the grounds that his/her appointment is not in the interests of the health service or for any other reason deemed sufficiently serious as to warrant the termination of office by that body.	Added clarity
Annex 6 (Code of Conduct for Governors)	7.3	None	Governors are required to sign a copy of the Code of Conduct as confirmation of acceptance of the Code at the time of appointment / election or at any other point in a governor's period of office as may be determined by the Trust Board Secretary.	Added this section clarity for
Annex 6 (Code of Conduct for Governors)	7.4	None	A governor not signing the Code of Conduct may be a reason for termination of office as set out in paragraph 3.6 of this Annex.	Added this section clarity for and it makes the link back to the earlier section 3.6.

Section	Para	Original text	Proposed text	Rationale
Annex 6 (Council of Governors' Performance)	9.1	The Chair of the Trust, being responsible for the leadership of the Council of Governors shall, at least annually lead a compulsory assessment process for the performance of each individual governor and the Council of Governors as a whole; to enable a review of skills, roles, structure, composition and procedures, taking into account emerging best practice.	The Chair of the Trust, being responsible for the leadership of the Council of Governors shall, at least annually hold one to one meetings with each individual governor. These one to one meetings will facilitate conversations and identify any emerging themes for future work-plans of the Council of Governors or areas for development.	Section updated to reflect current practice
Annex 6 (Partner organisation governors)	12.3.2 and 12.3.3	Partner organisations: • Volition • Tenfold	Partner organisations: • Volition Leeds (mental health representative) • Volition Leeds (learning disability representative)	This reflects the change in name for these organisations
Annex 7 (Composition of the Council of Governors)	3.5	The Trust Secretary shall be present at all Council of Governors' meetings.	The Trust Secretary or their deputy shall be present at all Council of Governors' meetings	Allows the deputy Trust Secretary to be present at Council Meetings in the absence of the Trust Secretary
Annex 7 (Meetings of the Council of Governors)	4	None	Meetings of the Council of Governors may be held by virtual conferencing or teleconference facilities or be held face-to-face. By whatever method the meeting is held these standing orders shall apply.	To bring this paragraph up to date and clarify that different methods of meeting can be used.

Section	Para	Original text	Proposed text	Rationale
Annex 7 (Minutes of the Council of Governors)	4.11.1	The minutes of the proceedings of each meeting of the Council of Governors shall be drawn up and entered into a book kept for that purpose and submitted for agreement at the next ensuing meeting, and thereafter will be signed by the Chair.	The minutes of the proceedings of each meeting of the Council of Governors shall be drawn up and submitted for agreement at the next ensuing meeting,. The acceptance or amendments of the minutes will be recorded in the minutes of the next ensuing meeting. Minutes many be held either electronically or in paper format but always in a way which is accessible and preserves the continuous record of the meeting.	To bring this paragraph up to date and in line with digital options and remote working
Annex 7 (List of Council of Governors' sub-committees)	5.2.1	Without prejudicing the formation of any other committee as the Council of Governors see fit and agree, the major committees of the Council of Governors shall be the: • Appointments and Remuneration Committee; • Membership and Development Committee; and • Strategy Committee.	Without prejudicing the formation of any other committee as the Council of Governors see fit and agree, the major committees of the Council of Governors shall be the: • Appointments and Remuneration Committee;	Removed the two committees which have been disbanded
Annex 8 (Composition of the Board of Directors)	2.9	The Trust Secretary shall be present at all Board of Directors' meetings.	The Trust Secretary or their deputy shall be present at all Board of Directors' meetings	Allows the deputy Trust Secretary to be present at Board Meetings in the absence of the Trust Secretary

Section	Para	Original text	Proposed text	Rationale
Annex 8 (Meetings of the Board of Directors)	3	None	Meetings of the Board of Directors may be held by virtual conferencing or teleconference facilities or be held face-to-face. By whatever method the meeting is held these standing orders shall apply.	To bring this paragraph up to date and clarify that different methods of meeting can be used.
Annex 8 (Minutes of the Board of Directors)	3.9.1	The Minutes of the proceedings of a meeting shall be drawn up and entered in a book kept for that purpose and submitted for agreement at the next ensuing meeting, and thereafter will be signed by the Chair.	The minutes of the proceedings of each meeting of the Board of Directors shall be drawn up and entered into a book kept for that purpose and submitted for agreement at the next ensuing meeting, and thereafter will be signed by the Chair. The acceptance or amendments of the minutes will be recorded in the minutes of the next ensuing meeting. Minutes many be held either electronically or in paper format but always in a way which is accessible and preserves the continuous record of the meeting.	To bring this paragraph up to date and in line with digital options and remote working

Section	Para	Original text	Proposed text	Rationale
Annex 8 (List of the sub-committees of the Board of Directors)	5.1.8	Without prejudicing the formation of any other committees or sub-committees as the Board of Directors see fit, the major committees of the Board of Directors shall be: • Audit Committee • Remuneration Committee • Nominations Committee • Quality Committee • Finance and Business Committee • Mental Health Legislation Committee	Without prejudicing the formation of any other committees or sub-committees as the Board of Directors see fit, the major committees of the Board of Directors shall be: • Audit Committee • Remuneration Committee • Nominations Committee • Quality Committee • Finance and Performance Committee • Mental Health Legislation Committee • Workforce Committee	Updated to reflect current Board sub-committees

Section	Para	Original text	Proposed text	Rationale
Annex 10	1.7	The Council of Governors may decide where an Annual Members' Meeting is to be held and may for the benefit of members arrange for the Annual Members' Meeting to be held in different venues each year.	The Council of Governors may decide where an Annual Members' Meeting is to be held and may for the benefit of members arrange for the Annual Members' Meeting to be held in different venues each year. As appropriate, the Council of Governors may agree that the event will be held virtually or face-to-face.	To bring this paragraph up to date and clarify that different methods of meeting can be used.