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 25 March 2021
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	**Apologies for absence** (verbal)	**SP**
2	**Declarations of interests and any conflicts of interest in any agenda item** (enclosure)	**SP**
3	**Minutes of the meeting held on 28 January 2020** (enclosure)	**SP**
4	**Matters arising** (verbal)	
5	**Actions outstanding from the public meetings of the Board of Directors** (enclosure)	**SP**
6	**Chief Executive's report** (verbal)	**SM**
7	**Report from the Chair of the Mental Health Legislation Committee for the meeting held on 2 February 2021** (verbal)	**AM**
8	**Report from the Chair of the Quality Committee for the meetings held on 9 February 2021 and 9 March 2021** (enclosure)	**JB**
9	**Report from the Chair of the Workforce Committee for the meeting held on 18 February 2021** (enclosure)	**HG**
10	**Report from the Chair of the Finance and Performance Committee for the meeting held on 23 March 2021** (to follow)	**SW**
11	**Combined Quality, Performance and Workforce Report** (enclosure)	**JFA**
12	**Safe staffing report** (enclosure)	**CW**
13	**Medical Director's Report (enclosure)**	**CHos**
14	**Guardian of safe working quarterly report (Q3)** (enclosure)	**CHos**
15	**Staff survey results** (enclosure)	**CHol**
16	**Chief Financial Officer Report** (enclosure)	**DH**
17	**Board Assurance Framework** (enclosure)	**SM**
18	**West Yorkshire and Harrogate Climate Change asks of partner organisations** (enclosure)	**SM**
19	**The organisation's commitment to joining together to form an Integrated Care Partnership** (enclosure)	**SM**
20	**West Yorkshire Mental Health Learning Disability and Autism (WYMHLDA) Committees in Common** (enclosure)	

20.1	**Review of Memorandum of Understanding (MoU) and associated actions** (enclosure)	**SM**
20.2	**Report from the WYMHLDA Committees in Common meeting held 21 January 2021** (enclosure)	**SM**
21	**Use of Trust Seal** (verbal)	**SP**
22	**Any other business**	

The next meeting of the Board will held on Thursday 20 May 2021 at 9.30 am
This meeting will be held virtually – joining details will be advised separately

AGENDA ITEM

2

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 Chief Executive	None.	None.	None.	None.	None.	None.	None.	Partner: **Director** Whinmoor Marketing Ltd. *Marketing and advertising company to help with the growth of local, national and overseas markets.* Son: **Apprentice** Interserve Construction Ltd *British multinational group of construction companies based in the UK.*

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Claire Holmes Director of Organisational Development and Workforce	None.	None.	None.	None.	None.	None.	None.	Partner: **Acting Area Director of South Coast Channel Islands** British Red Cross *United Kingdom body of the worldwide neutral and impartial humanitarian network the International Red Cross and Red Crescent Movement.*
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.
Joanna Forster Adams Chief Operating Office	None.	None.	None.	None.	None.	None.	None.	Partner: **Director of Public Health for Middlesbrough and Redcar** Middlesbrough Council and Redcar and Cleveland Borough Council Partner: **Chair** The Junction Charity *Works to empower children, young people and their families to embrace life with confidence, facing life's challenges in a positive way.*

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NON-EXECUTIVE DIRECTORS								
Susan Proctor Non-executive Director	**Director** SR Proctor Business 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.	**Chair** Day One Charity *Holistic support for patients and families affected by major trauma.*	None.	None.	**Chair** Adult Safeguarding Board, North Yorkshire	None.
John Baker Non-executive Director	None.	None.	None.	None.	None.	**Professor** University of Leeds	None.	None
Helen Grantham Non-executive Director	**Director,** Entwyne Ltd *Provides HR and OD consultancy and services which include projects, advice, recruitment support* **Director** Otley Golf Club Ltd.	**Sole owner,** Entwyne Ltd *Provides HR and OD consultancy and services which include projects, advice, recruitment support*	None	None	None	None	None	None

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Cleveland Henry Non-executive Director	**Director** 63 Argyle Road Ltd. *Property Management Company.*	None	None	**Trustee** Community Foundations For Leeds *Supports thousands of charities and voluntary groups across the city, addressing inequalities and working together to help create opportunities for those that need help the most.*	None	None	**Group Delivery & Deployment Director** EMIS Group (Digital Health sector) *Provider of healthcare software, information technology and related services in the UK.*	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*	None.	None.	None.	None. .	None. .	None.	None.
Susan White Non-executive Director	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
Martin Wright Non-executive Director	None.	None.	None.	**Trustee** 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 28 January 2021 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 Hosker	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
Mr John Verity	Freedom to Speak up Guardian (for minute 21/007)
Three members of the public (one of whom was a governor)	

		Action
	Prof Proctor opened the public meeting at 9.30 am and welcomed everyone.	
21/001	**Apologies for absence** (agenda item 2) There were no apologies received.	
21/002	**Declaration of interests for directors and any declared conflicts of interest in respect of agenda items** (agenda item 3) Prof Proctor reported that since the last meeting she had been appointed to the role of Chair of the charity 'Day One Trauma Support', noting that this had been added to the declaration of interests table. Mrs Holmes also noted that her partner's role had been updated in the table, but that this should show that he was an 'Acting' Area Director. This was noted by the Board and Mrs Hill agreed to make this amendment. It was noted that no other director had any change in their declarations of interest and no director advised of any conflict of interest in any agenda item scheduled for the meeting.	**CHill**

21/003	**Minutes of the previous meeting held on 26 November 2020** (agenda item 4) Mr Wright and Mrs Woffendin highlighted a number of minor typographical errors which were noted by the Board. Mrs Hill agreed to make these changes.	**CHill**
	The minutes of the meeting held on 26 November 2020 were **received** and **agreed** as an accurate record subject to the amendment of the minor typographical errors.	
21/004	**Sharing stories** (agenda item 1) Rachel Pilling from the Patient Experience Team and Aya Khalid joined the meeting to talk about Ms Khalid's experience of the Child and Adolescent Mental Health Service (CAMHS) including her experience of transitioning from the CAMHS service provided by another Trust into adult mental health services. She noted that the transition had not been well managed and that there hadn't been a plan in place for her move between these services which had created a gap in treatment and had caused her some problems. Ms Khalid then talked about her experience of the different adult mental health services she had used within this Trust and the way in which staff had supported her. She also talked about the way in which she had been involved in contributing to the development of these services and her involvement in the Trust's service user network, noting that it was important for service users to have their voice heard and to feel valued. The Board was concerned to hear about the gap in treatment due to her transitioning between services and noting that this had been due to a lack of communication. Mrs Woffendin was interested to learn more about how service users can be supported when transitioning between CAMHS and adult mental health services and suggested that she contacts Ms Khalid to talk to her about this further. The Board was pleased that Ms Khalid would like to become a volunteer in the Trust noting that this would allow her to share her experiences with other service users. Dr Munro also encouraged her to use volunteering as a pathway into paid employment	
	The Board **thanked** Ms Khalid for sharing her experiences with the Board noting that it used these to inform how services could be developed in the future.	
21/005	**Matters arising** (agenda item 5)	

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

21/006 **Actions outstanding from the public meetings of the Board of Directors** (agenda item 6)

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

With regard to an update on the new arrangements for the completion and submission of Mental Health Act paperwork, Dr Hosker reminded the Board that this had been brought about by a recent change in mental health legislation. He added that the new system had presented a number of issues relating to the use of the new electronic forms, but that a policy had been agreed with partners across the city which was making its way through a process of authorisation and would be communicated to staff very shortly.

Dr Hosker also updated the Board on the guidance issued by NHS England for remote assessments relating to the Mental Health Act, noting that a recent ruling had deemed these to be illegal. In light of this, Dr Hosker advised that the Mental Health Legislation Team would be revisiting all detentions made since March to ascertain if there was a problem with any of these. The Board asked for an update on progress with this review to be brought back to Board in March as part of the Mental Health Legislation Committee's Chair's report. **AM**

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

21/007 **Freedom to Speak up Guardian Report** (agenda item 14)

Mr Verity presented the Freedom to Speak up Guardian's report and outlined the main details in the document. He noted that Freedom to Speak up Ambassadors had now been appointed and were being inducted into the role, adding that as part of this induction Alix Bennett and Robin Ellis were observing the Board meeting, and that other Ambassadors would be observe future Board meetings.

Miss Grantham sought assurance that the Freedom to Speak up Guardian was linked into Staffside. Mr Verity noted that there were formal meetings that he attended and there was also an open-door policy to facilitate a good working relationship between him and Staffside.

Mr Wright noted that he meets with the Guardian on a monthly basis and that relevant information is shared, particularly that relating to any areas of benchmarking and good practice which had been highlighted through reports from the National Guardian's Office.

Mr Henry asked if remote working was having a detrimental impact on people accessing the Guardian as a result of him not having a regular physical presence on wards and in departments. Mr Verity advised that in the past people mostly made contact through email or telephone so there hadn't been a huge impact on staff's access. Mrs Holmes also noted that the success of the Guardian's role was Mr Verity's ability to work flexibly to ensure staff had the right level of access at the times they need this. She added that Mr Verity would be sufficiently flexible with his working arrangements to ensure he was able to attend key meetings and remained available for staff when they need him.

Mr Verity noted that he had some questions around the process of Whistleblowing. It was agreed that he would speak to Mrs Holmes about these. He also agreed to bring an update to the Board in his next report. **JV / CHol**

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

21/008 **Chief Executive's report** (agenda item 7)

Dr Munro provided a verbal Chief Executive's Report. She firstly advised there would be no planning guidance issued for the financial year 2021/22; that contracts would be rolled forward and funding made on that basis. She added that Mrs Hanwell would provide a more detailed update in her report later in the meeting.

With regard to the national funding of £500m for mental health services, Dr Munro noted that further details on this were still awaited. However, she noted that across West Yorkshire a combination of 'Place-based' plans had been submitted to access the transformation money; that these were in relation to community mental health teams; and that this would result in several million pounds of additional investment.

With regard to the GP contract for the coming year, Dr Munro reported that there would be a requirement for every GP practice to have a mental health professional in their premises. She noted that Leeds had made significant progress in relation to these arrangements and that as part of the wellbeing agenda practitioners were already in place in GP practices. Dr Munro commented that despite the challenges around managing the pandemic, there had been a significant amount of work undertaken to strengthen mental health services across the city.

Dr Munro then drew attention to the consultation on the future ICS governance framework noting that this had now closed and that the outcome was awaited. She also outlined the work to influence the discussions and the framework for provider collaboratives in particular the discussions to ensure the role of governors was taken account of in relation to public accountability.

With regard to COVID-19, Dr Munro reported on the rate of infection in West Yorkshire including the data relating to its spread and the number of hospital admissions. Dr Munro then updated the Board in relation to the West

Yorkshire vaccination programme. She noted that whilst a large proportion of the local population in the first four priority groups had been vaccinated there was still a large amount of work to do to reach those people who had not yet taken up the offer of a vaccine. She also noted that there had been discussions at a West Yorkshire level to look at family units and households being vaccinated rather than vaccinating only those who were vulnerable in the household. She added that by doing this it would help to alleviate any concerns around potential infection.

The Board recognised the huge amount of work that had been undertaken by the Trust's Vaccination Team and also noted that 70% of staff in both Leeds and York services had now received their vaccination. It also recognised that there would be a greater proportion of effort needed to reach the smaller percentage of staff not yet vaccinated and noted the work being undertaken to understand and track which groups were still to come forward and to look at what targeted action might be required.

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

21/009 **Report from the Chair of the Quality Committee for the meetings held on 8 December 2020 and 12 January 2021** (agenda item 8)

Prof Baker presented the Chair's report from the Quality Committee for the meetings that had taken place on 8 December 2020 and 12 January 2021. In particular he drew attention to:

- The discussion which highlighted the actions taken in the first wave of the pandemic around the redeployment of staff and the increase of therapeutic activities on inpatient wards. He noted that this had been seen to have a positive impact on the ward environment and that it was learning that shouldn't be lost.
- The continuing focus on clinical supervision, noting the important role this had on staff safety.
- The receipt and consideration of the Ockenden review of maternity services, noting that from a mental health perspective the Trust was doing all it could in relation to the recommendations where they related to any of the Trust's services. However, Prof Baker noted that the committee had considered the recommendation for there to be a non-executive director (NED) champion for Perinatal Services and that it had been agreed that this would not be remitted to one NED, but that the Quality Committee would take on this role.

The Board considered and agreed the proposal that the Quality Committee would subsume the role of NED champion for Perinatal Services and that it would seek assurances on aspects of the service on behalf of the Board.

Mrs Forster Adams spoke about the impact of the second wave on therapeutic activities on wards, and noted that circumstances had led to these being more constrained than in the first wave. However, she noted that the position had now been recovered and that meaningful activities were taking place on the inpatient wards. She added that this had been

	achieved through the re-deployment of staff, the use of volunteers and also support from third sector organisations. Mrs Woffendin then drew attention to the Patient Experience Report that had been presented to the committee, noting that this had outlined the significant amount of work undertaken with service users and carers during previous months. She agreed to circulate this report to Board members.	**CW**
	The Board **received** the report from the Chair of the Quality Committee.	
21/010	**Ratification of the Terms of Reference for the Quality Committee** (agenda item 8.1) The Board considered and approved the changes that had been made to the Terms of Reference for the Quality Committee. It also noted that in addition to these changes reference should be made to the committee having assurance oversight of the Perinatal Service as agreed in the previous agenda item. It was also suggested that the Terms of Reference for other committees which take on oversight roles should be amended to reflect this. In addition Mrs Holmes asked for the wording in relation to equality and inclusion to be made wider and agreed to provide amended wording to Miss McMann.	**KM / CHill** **CHol / KM**
	The Board **received** and **ratified** the Terms of Reference for the Quality Committee subject to the amendments agreed by the Board.	
21/011	**Report from the Chair of the Audit Committee for the meeting held on 19 January 2021** (agenda item 9) Mr Wright presented the report from the Audit Committee for the meeting that had taken place on 19 January 2021. In particular he drew attention to: • A change in the date for the completion and submission of the Annual Report and Accounts, noting that this would likely result in a change in the dates for both the Board and the Audit Committee meetings. • The Head of Internal Audit Opinion, noting that at the meeting there had been assurance provided that despite the number of audits that had been deferred the Internal Auditors were expecting to have completed sufficient work to be able to issue an opinion at the end of the year. • The suggestion that Internal Audit could use spare audit days created by deferred audits to look at benchmarking information in relation to various aspects of Trust governance. • The advisory audit report on the 'Escalation of Estates Issues', noting all the good work that takes place within the Estates Directorate and outlining the discussions relating to the report's recommendations	

and a wider review of structures within the department.
- The appointment of a Health and Safety Manager, noting that the committee would be meeting with them later in the year.

The Board **received** the update report from the Chair of the Audit Committee and **noted** the matters reported on.

21/012 **Report from the Chair of the Workforce Committee for the meeting held on 1 December 2020** (agenda item 11)

Miss Grantham presented the report from the Workforce Committee for the meeting that had taken place on 1 December 2020. In particular she drew attention to:

- The assurances relating to the findings of the Pattinson Inquiry and the monitoring and managing any issues relating to the Trust's clinicians.
- The discussions that had taken place about the arrangements relating to the health and wellbeing of the workforce.

Miss Grantham also advised the Board that due to the deferral of the audit of the work of the Trust's Workforce Committee, Internal Audit had been asked to look at benchmarking data around the role of comparable Workforce Committees in other organisations in order to inform the continuing development of the role of the Trust's committee.

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

21/013 **Ratification of the Terms of Reference for the Workforce Committee** (agenda item 11.1)

The Board **considered** and **ratified** the updated Terms of Reference for the Workforce Committee, subject to the inclusion of its oversight role for Wellbeing. **CHill / KM**

21/014 **Report from the Chair of the Finance and Performance Committee for the meeting held on 26 January 2021** (agenda item 10)

Mrs White presented the report from the Finance and Performance Committee for the meeting that had taken place on 26 January 2021. In particular she drew attention to:

- The cyber security dashboard, noting that the Board would be receiving a report on this at a future meeting. She also noted that due to the new remote ways in which staff were working, new issues and risks had been encountered which the IT department was

working to address.

- The pressures on the IT team brought about by these different ways of remote working and delivering services, noting that IT staff were providing help and support on a number of different technical issues which would not have arisen had staff been working at Trust sites.
- Reporting of key data through CareDirector, noting that there had been a delay in implementing these fully due to a change in focus for the Data Information team brought about in part by reporting on COVID-19 and the vaccination programme.

With regard to the increasing demand on the IM&T team, Prof Proctor asked if this had been adequately reflected in the Trust's COVID-19 planning. Mrs Hanwell assured the Board that there was a focus on restructuring and recruitment to the teams to take account of the additional workloads bought about not only by COVID-19, but also by a change in the geographical area from which services were now being provided and also by the new ways of delivering services to service users. Mr Henry noted that there was a need to look at the estate which would be required for the emerging digital landscape. Mrs Hanwell added that this was an important strategic issue for organisations across the city and that early discussions had started in relation to how this might be addressed.

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

21/015 **Combined Quality, Performance and Workforce Report** (agenda item 12)

Mrs Forster Adams reminded the Board that all aspects of this report had been looked at in the various Board sub-committees and that some of the issues reported on were contained in the Chairs' reports which had already been received by the Board.

Mrs Forster Adams drew attention to one particular issue relating to there being a potential to restrict the admission of female service users into inpatient services, noting that where people had to be placed out of area this would wherever possible be done locally and that work was ongoing on a mutual aid basis with mental health partners in West Yorkshire.

Prof Proctor asked about Out of Area Placements and what the arrangements were for the repatriation of people back into Leeds. Mrs Forster Adams outlined the arrangements to support these service users on an individual basis and explained how staff manage the transition of care back in the Trust's services from out of area. Mrs Forster Adams also noted that commissioning Psychiatric Intensive Care services across West Yorkshire also helped to support the care of people with complex needs at a more local level.

Mr Marran asked about the level of demand for Psychiatric Intensive Care services and where the extra capacity would come from. Mrs Forster Adams noted that a decision had been taken to commission additional capacity from the independent sector.

The Board **received** and **noted** the Combined Quality and Performance Report.

21/016 **Safe staffing report** (agenda item 13)

Mrs Woffendin presented the Safe Staffing Report. She outlined the main points, in particular noting that this was a more detailed six-monthly update and that it drew on the requirements of the National Quality Board's (NQB) Safe Staffing requirements. She added that it contained a high-level overview of data and analysis providing the Board with information on the position of ward staffing against safe staffing levels for the six month period 1 May 2020 to 31 October 2020.

Prof Baker noted that the Quality Committee had received the report and had discussed the Forensic Service in some detail and that it had understood and supported the reasons for the uplift in headroom.

Mr Wright asked if there was any benchmarking data for length of stay in Forensic Wards and how the Trust compares with other organisations. Mrs Woffendin acknowledged that this was not included in the report. However, it was also noted that this was an area that the Joint Quality, Finance and Performance, and Workforce Committee had undertaken to look at. Mrs Hanwell then explained that going forward differences in length of stay within Forensic Services was one of the issues that would be picked up and addressed through the Provider Collaborative arrangements.

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

21/017 **Guardian of Safe-working Quarterly Report** (agenda item 15)

Dr Hosker presented the Guardian of Safe-working Quarterly Report and gave a brief overview of the content. He assured the Board that during the period there had been one exception report, but that it had not led to any patient safety issue.

Miss Grantham asked about the position relating to medical trainees who in the recent months had been diverted to work in other medical specialties due to the impact of the pandemic. Dr Hosker noted that this was not now happening and that core trainees were now working within their normal training programmes.

The Board **received** the assurance report and **noted** the content.

21/018 **Report from the Chief Financial Officer** (agenda item 16)

Mrs Hanwell drew attention to a number of points in her report. She noted that the Trust was in a favourable position against its financial plan and

outlined the factors that had contributed to this. However, she explained that the Trust's financial position would play into the ICS system's plan with Place-based organisations working in partnership to deliver a minimum balanced position overall. Mrs Hanwell indicated that this may result in some redistribution of system resources to ensure all organisations would be in balance or surplus at the end of the year. She added that it was likely that the Trust would remain in surplus and that there was little risk of a deficit position being reported.

Mrs Hanwell then the advised that the planning process had been paused to enable organisations to continue to focus on the response to the pandemic. She explained that for financial planning purposes this had resulted in a decision to roll forward the current financial arrangements and that organisational financial planning for the first quarter of 2021/22 would be based on adjusted 2020/21 information. She added that it was expected that information on the planning process would be available from the second quarter of 2021/22 when it was anticipated that arrangements would return to a more normal position.

Prof Baker asked about the redistribution of resources. He noted that the Mental Health Investment Standard had been put in place due to an identified gap in funding for mental health services and expressed some concern that resources would now be diverted into acute trusts. Mrs Hanwell assured the Board that the overall level of funding for mental health had not been reduced but that some of the planned expenditure had not taken place due to the pandemic. She assured the Board that the Trust was sighted on the Mental Health Investment Standard and the base-line allocation would grow against that. She also noted that there was a sum of £500m for transformation that was being ring-fenced for mental health services.

Prof Proctor asked about the redistribution of funds and whether this would be used to benefit other non-NHS organisations that provide health and social care. Mrs Hanwell clarified the position noting that there was a large proportion of redistribution relating to the COVID funding where organisations might have needed less than anticipated. However, she advised that discussions were taking place with other partners in the city, including non-NHS partners, to look at how the provision of mental health can be supported more widely.

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

21/019 **Proposal to change the Constitution: Partner Governor seat** (agenda item 17)

Mrs Hill reminded the Board that at the November meeting it had approved a number of changes to the Constitution and that it had also been asked for suggestions as to which organisation might be invited to take up the partner governor seat left vacant by Equitix.

She added that a proposal had been made to offer this to the West

Yorkshire and Harrogate ICS (WY&H ICS), in particular the Director for Children and Families Programme. Prof Proctor explained that by making this addition to the Council of Governors it would further enhance the partnership working arrangements between the Trust and the WY&H ICS and it would also bring to the Council knowledge and expertise in the area of children at a point where the Trust was about to take on the Tier 4 inpatient CAMHS services in Leeds and establish a new CAMHS unit on the St Mary's Hospital site.

Mr Marran asked whether this was an opportunity to review other partner governor seats to ensure the Trust had the right stakeholders on the Council of Governors. Prof Proctor suggested there might be an opportunity to look at this again once the ICS statutory framework had been confirmed and was in place.

The Board **approved** a change to the Constitution in relation to partner governors and the appointment of the Director for Children and Families Programme within the West Yorkshire and Harrogate ICS as a partner governor. The Board also **noted** that this change to Constitution would be proposed to the Council of Governors at its meeting on 4 February and if approved this change would come into being.

21/020 **Board Assurance Framework** (agenda item 18)

Dr Munro presented the latest version of the Board Assurance Framework, noting that this had been seen at all relevant Board sub-committees. She noted that the impact of COVID had been reflected in the risk scores for each of the strategic risks. She also noted that there was work to do to look at the wording for the workforce risk and that this was being considered by the Workforce Committee.

The Board **received** the Board Assurance Framework and **noted** the content.

21/021 **The use of the seal** (agenda item 19)

It was **noted** that the seal had not been used since the last Board meeting.

21/022 **Any other business** (agenda item 20)

Prof Proctor noted that this was the last meeting for Mrs White as Deputy Chair. She thanked her for all her valuable help and support over her period of appointment. She also noted that Miss Grantham would be taking over as Deputy Chair with effect from 1 February 2021.

21/023	**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 11:55 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.

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
Declaration of interests for directors and any declared conflicts of interest in respect of agenda items (minute 21/002 - agenda item 3 – January 2021) **NEW -** Mrs Holmes also noted that her partner's role had been updated in the table, but that this should show that he was an 'Acting' Area Director. This was noted by the Board and Mrs Hill agreed to make this amendment.	**Cath Hill**	Management Action	**COMPLETED**
Minutes of the previous meeting held on 26 November 2020 (minute 21/003 - agenda item 4 – January 2021) **NEW -** Mr Wright and Mrs Woffendin highlighted a number of minor typographical errors which were noted by the Board. Mrs Hill agreed to make these changes.	**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
Freedom to Speak up Guardian Report (minute 21/007 - agenda item 14 – January 2021) **NEW -** Mr Verity noted that he had some questions around the process of Whistleblowing. It was agreed that he would speak to Mrs Holmes about these.	**John verity / Claire Holmes**	Management Action	**CLOSED AS A BOARD ACTION** The discussion has taken place. The outcome of which was agreement to separate Whistleblowing from the Freedom to Speak Procedure pending the release of any national policy which may supersede this. The Whistleblowing Procedure has been drafted in partnership with Mr Verity and is now subject to relevant engagement before approval.
Report from the Chair of the Quality Committee for the meetings held on 8 December 2020 and 12 January 2021 (minute 21/009 - agenda item 8 – January 2021) **NEW -** Mrs Woffendin then drew attention to the Patient Experience Report that had been presented to the committee, noting that this had outlined the significant amount of work undertaken with service users and carers. She agreed to circulate this report to Board members.	**Cathy Woffendin**	Management Action	**COMPLETED**
Ratification of the Terms of Reference for the Quality Committee (minute 21/010 - agenda item 8.1 – January 2021) **NEW -** It noted that reference should be made to the committee having assurance oversight of the Perinatal Service.	**Kerry McMann**	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
Ratification of the Terms of Reference for the Quality Committee (minute 21/010 - agenda item 8.1 – January 2021) **NEW -** In addition to this Mrs Holmes asked for the wording in relation to equality and inclusion for the Quality Committee Terms of Reference should be made wider and agreed to provide amended wording to Miss McMann.	**Claire Holmes / Kerry McMann**	Management Action	**COMPLETED**
Ratification of the Terms of Reference for the Workforce Committee (minute 21/013 - agenda item 11.1 – January 2021) **NEW -** It was suggested that the Terms of Reference for other committees that take on oversight roles should be added to their Terms of Reference, in particular the Workforce Committee for its role in relation to Wellbeing.	**Kerry McMann**	Management Action	**COMPLETED**
Report from the Chief Financial Officer (minute 20/137 - agenda item 13 – October 2020) Consideration by the executive team as to when a strategic discussion on the Estates Strategic Plan can be programmed into the Board forward plan.	**Dawn Hanwell**	Management action	**ONGOING** As part of Board development sessions the schedule of when we review the key operational strategies will be agreed

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Actions outstanding from the public meetings of the Board of Directors (minute 21/006 - agenda item 6 – January 2021) **NEW -** The Board asked for an update on progress with the review of detentions made since March to be brought back to Board in March as part of the Mental Health Legislation Committee's Chair's report.	**Andrew Marran**	March Board of Directors' meeting	**COMPLETED** An update was also provided at the February Board development day
Report from the Chair of the Finance and Performance Committee (minute 20/114 - agenda item 11 – September 2020) The Board is to be sighted on the dashboard of data relating to cyber security.	**Dawn Hanwell**	Board of Directors meeting ~~March~~ May 2021	**ONGOING** This paper will also discuss the need to refresh Board understanding of Cyber issues and how this can be achieved This paper has been deferred to the May meeting

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Chief Executive's Report (minute 20/153 - agenda item 7 – November 2020) The report into LD deaths due to COVID will be brought back to the Board once this has been presented to the West Yorkshire Executive Group	**Chris Hosker / Cathy Woffendin**	Provisionally May Quality Committee with a report to the May Board of Directors' meeting	**ONGOING** • The report was presented at the Senior Leadership Executive Group (SLEG) in February and a number of additional actions were suggested. These are being incorporated into an updated report which will go back to SLEG in March • Once the amended report is received in the Trust this will go to the LD Leadership Team and also be discussed in the LD Governance meeting. A proposal / response to the paper and actions will be documented and escalated for discussion at the Care Service Governance meeting. • The finalised response and action plan will be presented to the Trust Wide Clinical Governance meeting. • Following which it is expected the report will be shared with Quality Committee in May.
Workforce Race Equality Standard and Workforce Disability Equality Standard report (minute 20/139 - agenda item 16 – October 2020) The learning, themes and issues from the Reciprocal Mentoring Programme to be discussed at an April / May Board workshop. In addition to this Mr Henry to lead part of that session on the learning from the Seacole Programme.	**Claire Holmes / Cleveland Henry**	April / May Board strategic discussion / workshop	

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
Chief Executive's Report (minute 20/153 - agenda item 7 – November 2020) Mrs Woffendin to consider what COVID testing arrangements will be available for student nurses working within the Trust.	**Cathy Woffendin**	Management action	**COMPLETED** All students working in our ward environments are offered lateral flow testing kits which allows them to test themselves twice weekly before they are due on duty, a positive test result would ensure they receive a PCR test and a period of self-isolation would be followed in line with PHE guidance if this result was positive
Chief Executive's Report (minute 20/153 - agenda item 7 – November 2020) The ICS Consultation document will be considered at the Board development session on 10 December and the document will be included in the pack to pre-reading which will be circulated to Board members.	**Cath Hill**	Management action	**COMPLETED**
Report from the Chair of the Mental Health Legislation Committee for the meeting held on 3 November 2020 minute 20/154 - (agenda item 8 – November 2020) The Board agreed to receive an update in regard to the arrangements for changes to the Mental Health Act paperwork in light of the introduction of an electronic system for completion and submission.	**Chris Hosker**	January Board of Directors' meeting	**COMPLETED** An update was provided to the January Board meeting

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Flu Assurance Framework (minute 20/160 - agenda item 14 – November 2020) Mrs Woffendin to raise with NHS England the issue of whether carers are being included in the NHS flu vaccination programme.	**Cathy Woffendin**	Management action	**COMPLETED** Carers are included in the NHS England flu campaign but this is through the primary care route via their GP practice and based on those who are known to be carers on the GP record

AGENDA ITEM
8

Chair's Report

Name of the meeting being reported on:	Quality Committee
Date your meeting took place:	9 February 2021
Name of meeting reporting to:	Board of Directors – 25 March 2021

Key discussion points and matters to be escalated:

Issues to which the Board needs to be alerted

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

Issues for advice from the Board

- No issues for advice.

Things on which the Board is to be assured

- The Committee received a report which summarised the key findings from the NHSE&I Learning Disability Mortality Review (LeDeR) Programme: Action from Learning. It noted that the report had been written to support health practitioners across the Trust when providing care and interventions to people with a learning disability. It discussed the key findings of the report.

- The Committee discussed the Trust's involvement in the CQC consultation on changes for more flexible and responsive regulation. It was assured that that the Trust had been involved in the consultation process, that the relevant individuals met regularly with Trust's CQC Relationship Manager and that the CQC received regular progress updates on the Trust's must do and should do actions.

- The Committee received an update on the Covid-19 outbreaks across the Trust and was assured by Trust's management of the outbreaks. It discussed the staffing issues faced on Ward 5 and received an update on the work that had been carried out to reopen the ward to admissions. The Committee was pleased to hear that the Trust had vaccinated 80.8% of its staff.

- The Committee received updates on the work of the Trust's Incident Command Groups, the TWCGG, the Ethical Advisory Group and the Physical Health Workstream. It acknowledged the amount of work that was being carried out alongside responding to the pandemic.

- The Committee received the Combined Complaints, Concerns, PALS, Compliments and Patient Safety Report which contained the data for quarter three. It was informed that the Parliamentary and Health Service Ombudsman (PHSO) had developed a Complaints Standard Framework that would be published in March 2021. It noted that this would include a model complaints procedure to lead a more consistent approach to complaint handling across NHS organisations.

- The Committee reviewed the Infection Prevention and Control BAF and agreed that it was assured around the oversight of the Trust's infection prevention procedures and plans. It was agreed that this would be presented to the Committee on a six monthly basis.

- The Committee received the Combined Quality and Workforce Performance Report. It discussed clinical supervision and mandatory training. The Committee received an update on data quality from Mrs Nikki Cooper, Head of Performance and Informatics. It noted that reporting was stable and the quality of data was improving.

Report completed by:	Prof John Baker February 2021

AGENDA ITEM
8

Chair's Report

Name of the meeting being reported on:	Quality Committee
Date your meeting took place:	9 March 2021
Name of meeting reporting to:	Board of Directors – 25 March 2021

Key discussion points and matters to be escalated:

Issues to which the Board needs to be alerted

- The Committee discussed the staffing challenges that had been faced on inpatient wards over the last few months due to the pandemic. It was informed that therapeutic activities had been reduced for a brief period of time in order to focus on maintaining staffing levels. The Committee expressed concern about the impact of this on quality.

Issues for advice from the Board

- No issues for advice.

Things on which the Board is to be assured

- The Committee was assured by the business continuity plans that had been activated to manage recent staffing challenges and the work that was being carried out to mitigate staffing challenges over the Easter period.

- The Committee received a report which outlined the developing approach within the Trust to improve safe and effective care to prevent suicide. It discussed the trust's approach to suicide prevention and the governance arrangements in place. It noted the agreed priorities for the Safe and Effective Care Group and the three sub groups and agreed that a further, more detailed update would be provided in six months.

- The Committee received the Learning from Deaths Report and reviewed the data from quarter three. It was informed that a total of 58 deaths were subject to review over this period, with seven serious incidents declared in accordance with the NHS England Serious Incident Framework, all of which were in progress. It was assured of the work ongoing within the Trust to improve mortality review and the learning across the organisation.

- The Committee received an update from the Trustwide Safeguarding Group and was pleased to hear that an e-learning module that had been written by members of the Trust's Safeguarding Team to support medical staff and improve practice in relation to 'think family' had been approved by the Royal College of Psychiatrists and would be available to members of the College from March 2021.

- The Committee received a progress report on the production of the Quality Report and Account 2020/21, the progress made with the 2020/21 Quality Improvement Priorities (QIPS) and the chosen 2021/22 QIPS following consultation. The Committee was informed that a creative approach had been taken for the 2020/21 Quality Report to ensure that the development of the report would not have an impact on clinical time. The Committee welcomed this approach. It noted that that there would be seven QIPS for 2021/22 rather than 12 and agreed that this was a sensible approach considering the current pressures.

Report completed by:	Prof John Baker March 2021

AGENDA ITEM
9

Chair's Report

Name of the meeting being reported on:	Workforce Committee
Date your meeting took place:	18 February 2021
Name of meeting reporting to:	Board of Directors – 25 March 2021

Key discussion points and matters to be escalated:

Issues to which the Board needs to be alerted

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

Issues for advice from the Board

- The Committee discussed the Trust's professional workforce strategies that were due to be reviewed and presented to the Committee at its June 2021 meeting. It discussed the possibility of extending the review dates of the current strategies by one year due to the pressures caused by Covid-19 and agreed that this should be considered by the Board of Directors.

Things on which the Board is to be assured

- The Committee received a report which provided an integrated and evidence based review of clinical leadership in order to support its development within the Trust. It discussed the report in detail. The Committee agreed on the importance of the Clinical Lead role having a consistent job description and banding. It agreed that it was assured on the work being carried out to develop clinical leadership within the Trust.

- Mrs Holmes delivered a presentation which provided an update on key workforce issues across the Trust. Updates included the current staffing position, the work carried out to manage annual leave, changes to the workforce governance structure, unavailability projections for the coming months and the inclusion work that was being carried out across the Trust. The Committee was informed of six regional objectives relating to Equality, Diversion and Inclusion and Nursing.

- The Committee discussed vaccinations. It was pleased to hear that as of the 18 February 2021 83.9% of staff had received their first vaccination. It was informed that the Trust had been asked to lead a roving vaccination function to reach those service users in the community. The Committee recognised the achievements made with regard to the vaccination roll out.

- The Committee received an update on redeployment. It noted that 52 staff members were redeployed and was informed the work that was being carried out to prevent further redeployment. The Committee discussed the impacts of redeployment on other areas of the Trust. It received assurance on the support mechanisms in place for those staff members who had been redeployed. The Committee questioned whether there were any links between redeployment and the rise in occupational health referrals. It was assured that although referrals to Occupational Health had increased since the start of the Covid-19 pandemic, only six of those referrals had involved staff members that had been redeployed.

- The Committee discussed the resourcing work that had been carried out to increase staffing including the Assistant Health Care Support Worker role, internships, career conversations, recruitment overflow, and the Lets Talk Campaign. It acknowledged the work that was being carried out alongside responding to the pandemic.

Report completed by:	Helen Grantham February 2021

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
11

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	**Combined Quality, Performance and Workforce Report**
DATE OF MEETING:	**Thursday 25 March 2021**
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.

We continue to work 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

NHS
Leeds and York Partnership
NHS Foundation Trust

Lead Director: Joanna Forster Adams, Chief Operating Officer

Date: Mar 2021 (reporting Feb 2021 data, unless otherwise specified)

integrity | simplicity | caring

Introduction

Key themes to consider this month: **Unless otherwise specified, all data is for February 2021**

Consistency and improvement:

A number of services achieved access standard / contractual targets during February. These included the percentage starting treatment within 2 weeks of referral to Early intervention in psychosis (EIP) or at risk mental state (ARMS), the percentage of referrals seen by community mental health teams within 15 days, the percentage of inpatients followed up within 3 days of discharge from CCG commissioned services; and the percentage of service users who stayed on CRISS caseload for less than 6 weeks.

Workforce:

Our inpatient wards have been experiencing extreme pressure due to COVID-19 outbreaks resulting in additional demand for staff combined with high levels of staff absence. As a result, some of our services moved into business continuity mode. There is a lot of work going on internally and externally to maintain safe staffing within our identified higher risk services to address COVID-19 related pressures. Following a call for mutual aid from partner organisations we received an offer of social care agency support workers to come into our older people's wards, and we have also secured six third year students from York University to work in band 4 nurse associate roles.

We continue to operate with redeployed staff into our inpatient services. This is overseen at Executive level due to the employee and service impacts. We are currently ensuring that staff have the ongoing support they need and that we can commit to a timescale for their temporary positions.

Work in Progress:

Support continues to be provided to services on the various operational supporting dashboards in CareDirector and the Quality, Delivery and Performance report is being rolled out with increased engagement and reference in Service quality and performance meetings.

Service Performance – Chief Operating Officer

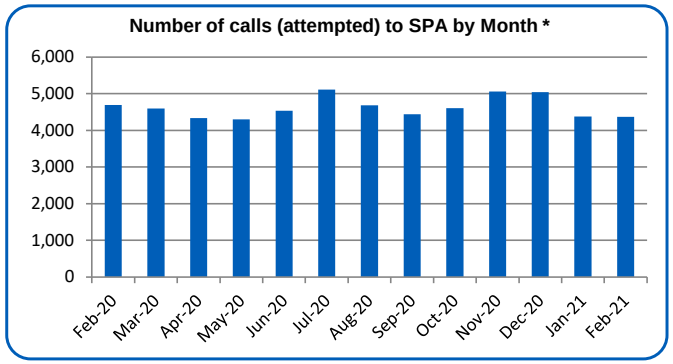
Services: Access & Responsiveness: Our response in a crisis	Target	Dec-20	Jan-21	Feb-21
Percentage of crisis calls (via the single point of access) answered within 1 minute *	-	37.3%	41.5%	44.1%
Percentage of ALPS referrals responded to within 1 hour	90%	55.5%	61.7%	67.4%
Percentage of S136 referrals assessed within 3 hours of arrival	-	14.0%	10.9%	2.2%
Percentage of appropriate crisis referrals offered a face to face assessment within 4 hours of referral	Feb 85%	50.0%	87.5%	53.6%
Percentage of service users who stayed on CRISS caseload for less than 6 weeks	70%	96.0%	93.4%	88.4%
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support	50%	27.6%	18.7%	30.8%
Percentage of CRISS caseload where source of referral was acute inpatients	tba	29.5%	24.6%	25.6%
Services: Access & Responsiveness to Learning Disabilities, Regional and Specialist Services	**Target**	**Dec-20**	**Jan-21**	**Feb-21**
Gender Identity Service: Number on waiting list	-	2,742	2,793	2,839
Leeds Autism Diagnostic Service (LADS): Percentage starting assessment within 13 weeks (quarterly)	95%	63.6%	-	-
CAMHS inpatients: Proportion of people assessed within 7 days of admission (HoNOSCA / GBO) (quarterly)	-	85.7%	-	-
Deaf CAMHS: average wait from referral to first face to face (inc. telemedicine) contact in days	-	36	69	89
Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency) (quarterly)	-	100.0%	-	-
Perinatal Community: Percentage waiting less than 2 weeks for first contact (routine) (quarterly)	85%	30.3%	-	-
Perinatal Community: Total number of distinct women seen in rolling 12 months (quarterly)	Q3 512	409	-	-
Perinatal Community: Face to Face DNA Rate (quarterly)	-	3.4%	-	-
Community LD: Percentage of referrals seen within 4 weeks of receipt of referral	90%	84.0%	75.0%	76.0%
Community LD: Percentage of Care Plans reviewed within the previous 12 months	90%	*reporting in development*		
Services: Our acute patient journey	**Target**	**Dec-20**	**Jan-21**	**Feb-21**
Number of admissions to adult facilities of patients who are under 16 years old	-	0	0	0
Crisis Assessment Unit (CAU) bed occupancy	-	1.1%	29.0%	95.8%
Crisis Assessment Unit (CAU) length of stay at discharge	-	2.0	6.4	7.8
Liaison In-Reach: attempted assessment within 24 hours	90%	68.7%	76.4%	78.4%
Bed Occupancy rates for (adult acute excluding PICU) inpatient services:	94-98%	93.5%	94.5%	79.3%
• Becklin – ward 1 (female)	-	101.2%	93.0%	44.2%
• Becklin – ward 3 (male)	-	93.8%	94.4%	95.9%
• Becklin – ward 4 (male)	-	92.8%	94.6%	85.2%
• Becklin – ward 5 (female)	-	100.1%	100.3%	83.4%
• Newsam – ward 4 (male)	-	79.1%	90.2%	88.1%
• Older adult (total)	-	78.7%	79.1%	80.5%
• The Mount – ward 1 (male dementia)	-	68.1%	86.1%	98.9%
• The Mount – ward 2 (female dementia)	-	62.8%	70.5%	53.1%
• The Mount – ward 3 (male)	-	87.8%	72.4%	77.7%
• The Mount – ward 4 (female)	-	86.8%	85.8%	87.0%

* A new SPA 0800 freephone number was introduced in Nov 20, overall call volumes have been refreshed to include the new number AND the old 0300 number, which is running concurrently until Feb 21. As a result there are some current issues with call response data, attributable to the automatic announcement of the number change which is affecting the local 1 min response target.

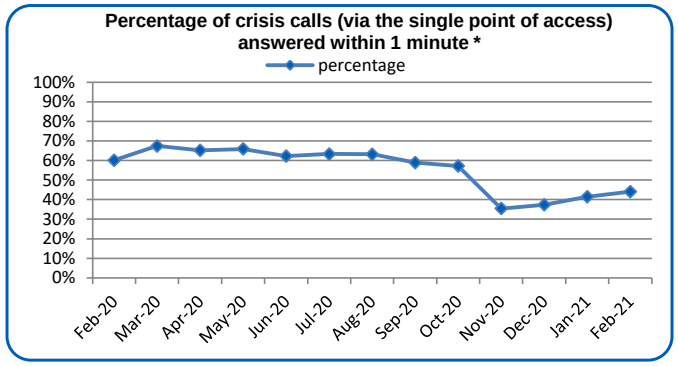
Service Performance – Chief Operating Officer

Services: Our acute patient journey	Target	Dec-20	Jan-21	Feb-21
Percentage of delayed transfers of care	-	9.5%	9.6%	7.8%
Total: Number of out of area placements beginning in month	-	6	10	20
Total: Total number of bed days out of area (new and existing placements from previous months)	Feb 0	169	183	349
Acute: Number of out of area placements beginning in month	-	5	5	16
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	109	92	200
PICU: Number of out of area placements beginning in month	-	1	5	3
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	60	91	140
Older people: Number of out of area placements beginning in month	-	0	0	1
Older people: Total number of bed days out of area (new & existing placements from previous months)	-	0	0	9
Cardiometabolic (physical health) assessments completed: Inpatients (quarterly)	90%	32.7%	-	-
Services: Our community care	**Target**	**Dec-20**	**Jan-21**	**Feb-21**
Percentage of inpatients followed up within 3 days of discharge (Trust Level monthly local tracking)	-	82.9%	86.7%	87.0%
Percentage of inpatients followed up within 3 days of discharge (CCG commissioned services only)	80%	87.8%	88.7%	85.9%
Number of service users in community mental health team care (caseload)	-	4,551	4,498	4,459
Percentage of referrals seen within 15 days by a community mental health team	80%	84.6%	66.5%	80.3%
Percentage of referrals to memory services seen within 8 weeks (quarter to date)	90%	60.7%	42.7%	40.1%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50%	49.2%	55.3%	51.6%
Early intervention in psychosis (EIP) or at risk mental state (ARMS): Percentage starting treatment within 2 weeks	60%	61.1%	87.5%	76.5%
Early intervention in psychosis (EIP) : Percentage of people with at least 2 outcome measures recorded at least twice		*reporting in development*		
Early intervention in psychosis (EIP) : Percentage of people discharged to primary care (quarterly)	tbc	50.0%	-	-
Cardiometabolic (physical health) assessments completed: Early Intervention in Psychosis Service (quarterly)	90%	41.1%	-	-
Services: Clinical Record Keeping	**Target**	**Dec-20**	**Jan-21**	**Feb-21**
Data Quality Maturity Index for the Mental Health Services Dataset (MHSDS)	95%	SEP	OCT	NOV
		87.6%	86.9%	86.8%
Percentage of service users with NHS Number recorded	-	99.3%	99.3%	99.3%
Percentage of service users with ethnicity recorded	-	77.4%	76.9%	76.5%
Percentage of service users with sexual orientation recorded	-	21.7%	21.5%	21.6%
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*		

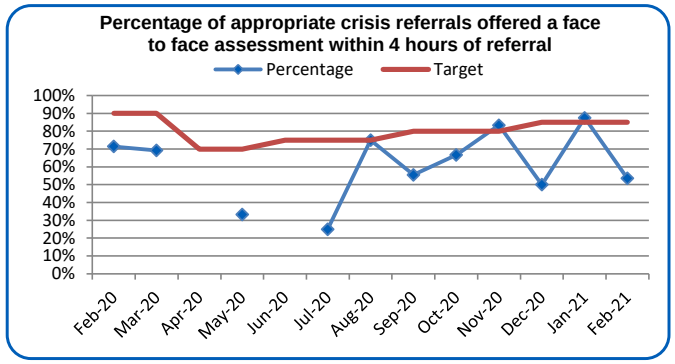
Services: Access & Responsiveness: Our response in a crisis



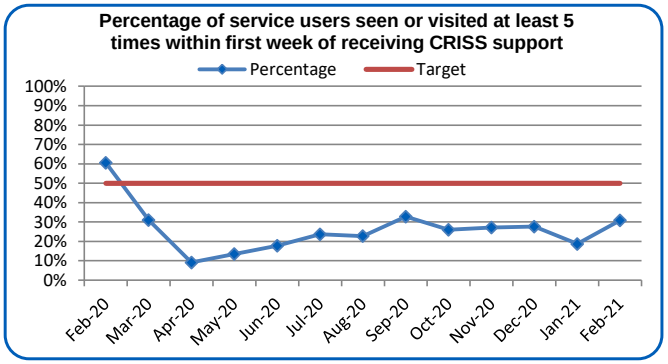
Feb calls: 4,369



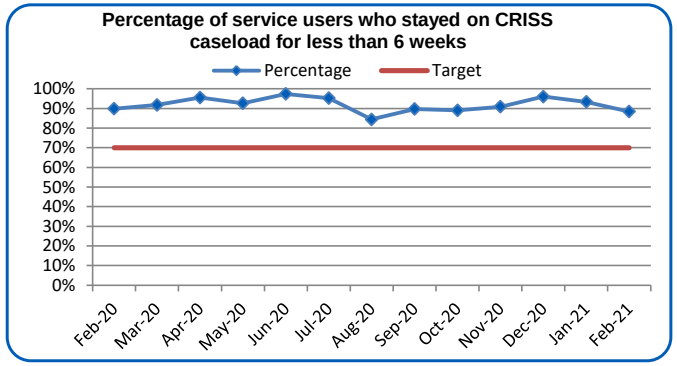
Local target: within 1 minute: Feb 44.1%



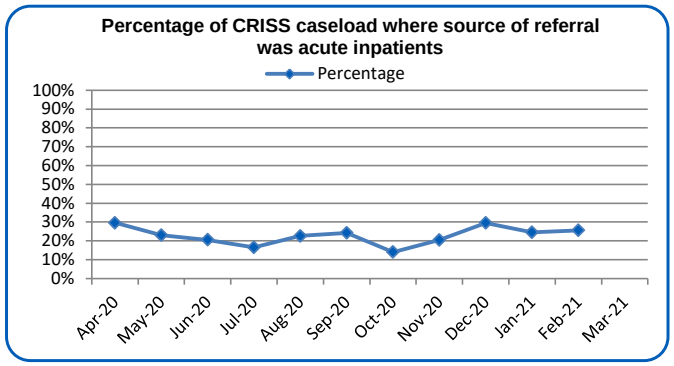
Contractual target 85% (Feb) to 90% (EOY) Feb 53.6%



Contractual target 50%: Feb 30.8%



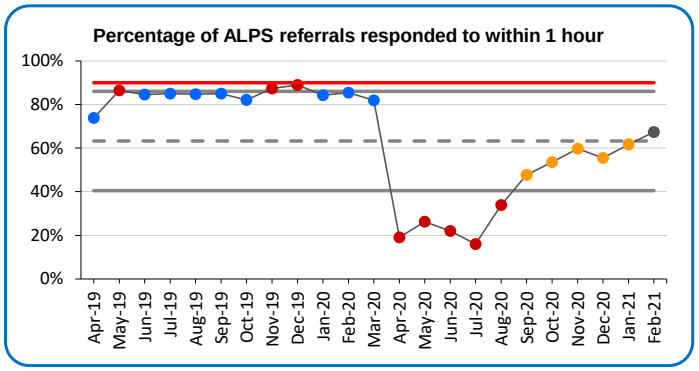
Contractual target 70%: Feb 88.4%



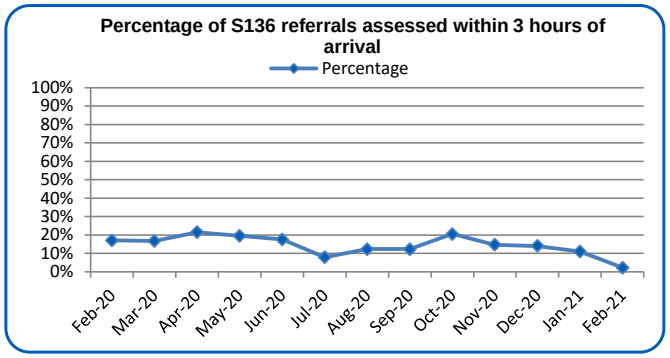
Contractual target tba : Feb 25.6%

** A new SPA 0800 freephone number was introduced in Nov 20, overall call volumes have been refreshed to include the new number AN D the old 0300 number, which are running concurrently until Feb 21. Additionally this has impacted on call response data with the automatic recorded announcement of the number change adversely affecting the local 1 min response target.*

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



Contractual target 90%: Feb 67.4%



Contractual measure: Feb 2.2%

SPC Chart Key

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

Services: Access & Responsiveness: Our response in a crisis

The recently established Freephone telephone number for the Single Point of Access (SPA) continues to impact on the crisis call response data reliability. The automatic recorded announcement of the number change adversely affecting performance against the local 1 minute response target. We are reviewing the impact of this change as at the end of February when the once the concurrent running of the old 0300 number ends.

The Crisis Resolution and Intensive Support Service (CRISS) continue to be committed to achieving the Core Fidelity standards and the improvements we made as part of the community redesign, including offering a face to face assessment within 4 hours where indicated (based on clinical assessment of urgency). The 2020-21 trajectory agreed with commissioners aims for performance above 85% during February, moving towards 90% by March 2021.

We did not meet the standard in February with 54% of appropriate crisis referrals recorded as being offered a face to face assessment within 4 hours of referral. However some improvement in our processes in SPA / Crisis Resolution have been implemented this month, aiming to provide a quicker and more responsive triage.

Core Fidelity standard 38 states we should aim to provide face to face contact 5 times in the first week of contact, for at least 50% of referrals. In February 31% of people were recorded as being seen face to face 5 times in the first week of referral. A detailed review of activity against the frequency of contact standard has been undertaken by the service, to try and better understand quality and performance in this area and to provide assurance that our reporting process is accurate. A variety of themes emerged from the case review including showing a proportion of contacts made were telephone, an ongoing adjustment to Covid-19, some service users moving from red to amber within the first 7 days and so not requiring face to face contact, short term wrap around care with CMHTs with some people discharged within the week, and shared care with wards / joint working with other community teams meaning not all contacts are from the intensive support service. We are now working to improve our working arrangements and information reporting so that we can demonstrate effective clinical practice and responsiveness in line with the standard.

88% of people remained on the CRISS caseload for less than 6 weeks, a measure which we are consistently over performing against the 70% target.

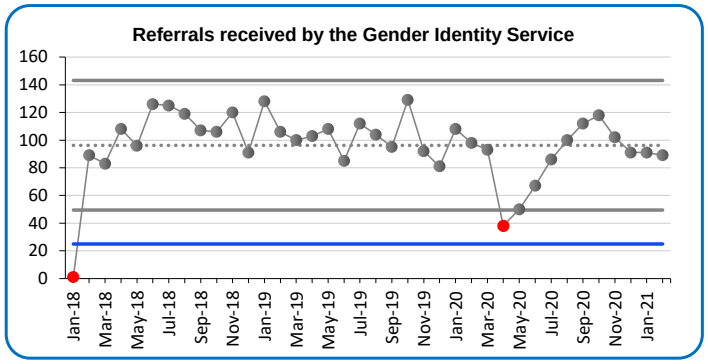
In February 2% of S136 referrals (1 out of 45) were assessed within 3 hours of arrival. Internal discussions and steps to improve this are taking place to ensure we are aligned to national standards in this area. The Code of Practice states that it is good practice for the doctor and the AMHP to attend within 3 hours in accordance with best practice recommendations of the Royal College of Psychiatrists in their “Standards on the use of s.136 of the Mental Health Act 1983 (England and Wales)”

Actions taken/to be taken: Data meeting held in February to analyse the data. The service continue to actively work with the Information team to enable accurate recording and reporting of activity. In addition we are implementing improvements to ensure that we are responding effectively in line with individual needs and risks of service users.

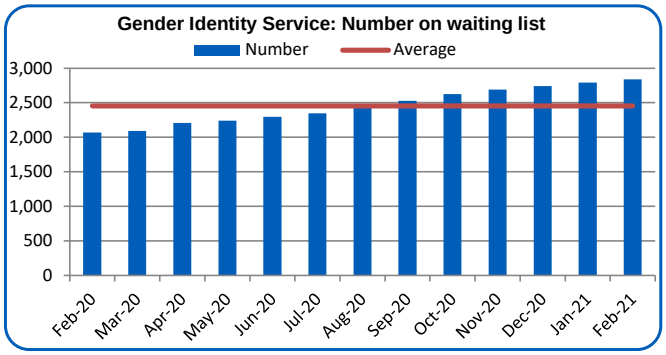
In the Acute Liaison Psychiatry Service (ALPS) performance continues on an upward trajectory towards the 90% threshold against the 1 hour response target. In February 67.4% referrals were responded to within 1 hour. 82% of referrals were responded to within 3 hours, the remaining 18% over 3 hours. Operational challenges remain both with the team being located in the Becklin Centre (rather than the Emergency Department as previously) and limited assessment space being available due to the reconfiguration of St James Hospital Emergency Department. In February there was an increase in the number of contacts for patients awaiting mental health beds. Each month the ALPS leadership team review all breaches of the 1 hour target, to improve the response by attending ED handovers to proactively identify referrals.

Actions taken/to be taken: The team continue to work jointly with Leeds Teaching Hospitals to support the re-location of staff within ED to enable the 1hr target to be met and support improved access to clinical space, and continue to monitor all breaches monthly.

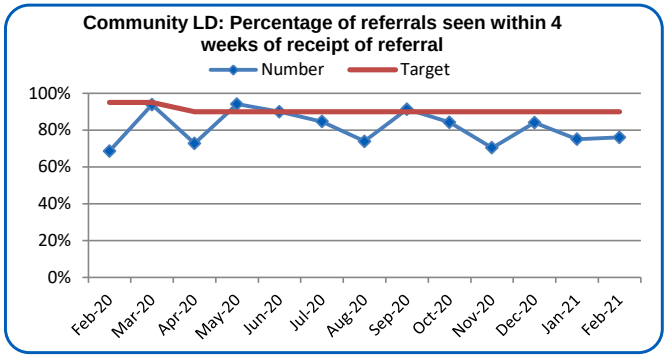
Services: Access & Responsiveness to Learning Disabilities, Regional and Specialist Services



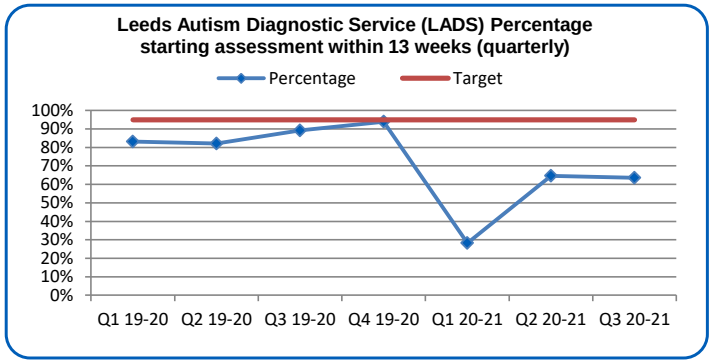
Total referrals: Feb 89



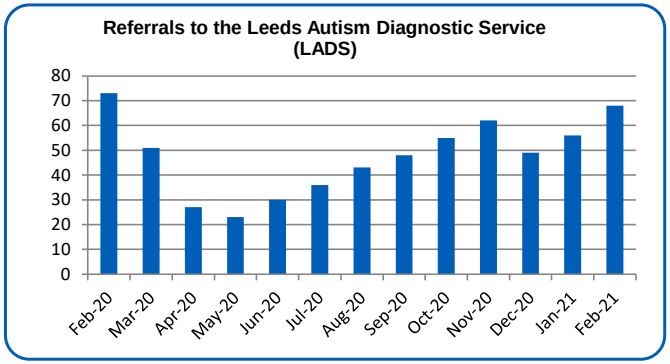
Number on waiting list: Feb 2,839



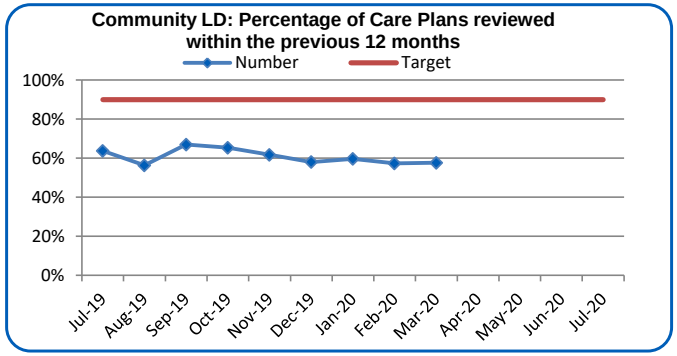
Contractual target 90% Feb 76%



Contractual target 95% Q3: 63.6%



Local measure: Feb 68

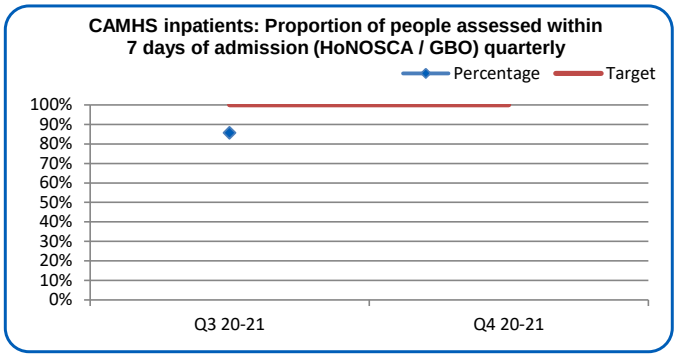


Contractual target 90%: *20-21 data development ongoing*

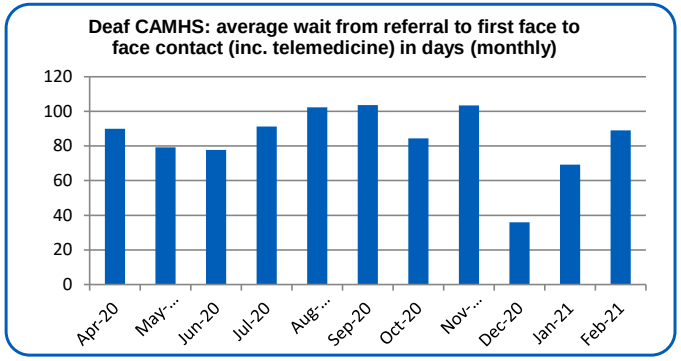
SPC Chart Key

Average
Lower process limit
Target
Upper process limit
Actual

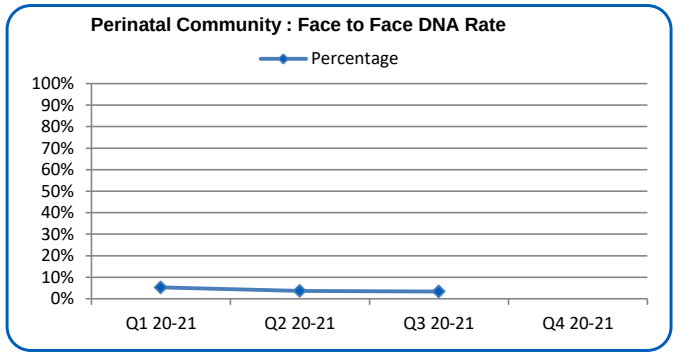
Services: Access & Responsiveness to Learning Disabilities, Regional and Specialist Services (continued)



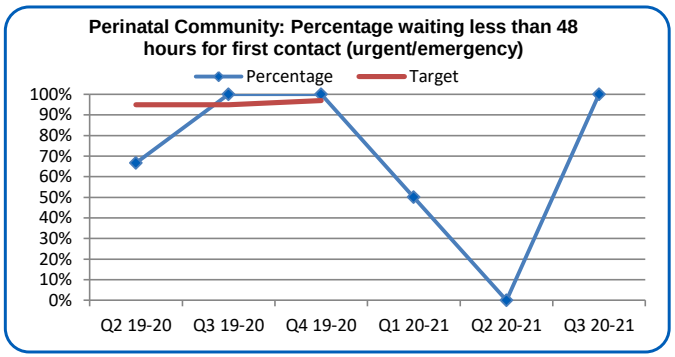
Contractual target 100% Q3 85.7%



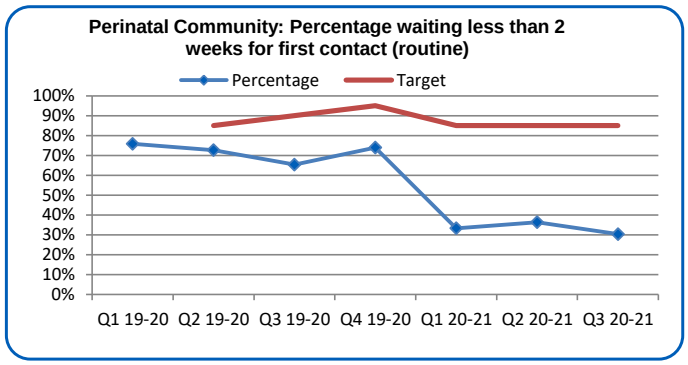
Local measure: Feb 89 days



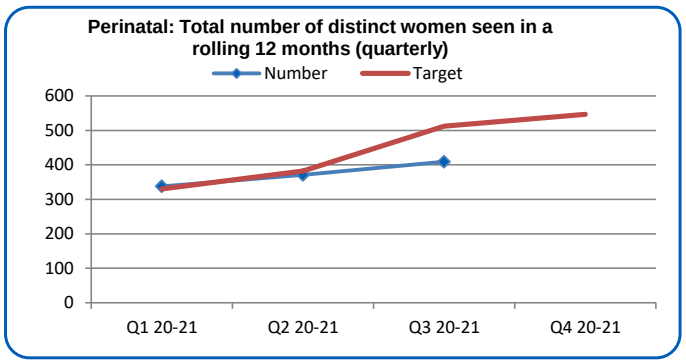
Contractual measure: Q3 3.4%



Contractual Target: tba Q3 100%



Contractual Target 85% Q3: 30.3%



Local measure: Q3 Target 512, Q3 409

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

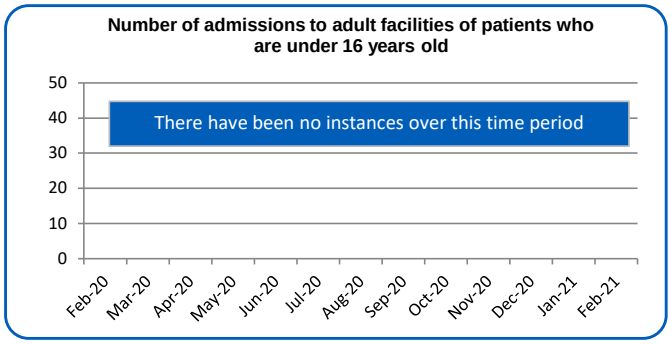
In Learning Disability Services 76% of people were recorded as being seen within the 90% contractual target for referrals seen within 4 weeks. A small number of cases can impact on performance on this measure as the Community Learning Disability Team (CLDT) continues to work through the process of returning services to normal with activity delivered differently. There are a cohort of people who will remain with the Assessment and Referral Team (ART) whilst it is established if they have a Learning Disability or a health need requiring a Learning Disability specialist service. This is proving difficult as we cannot undertake IQ assessments in face masks and are having to gather information from a variety of sources, which in some cases is proving time consuming. We are hoping the clear face masks, currently being evaluated, will be approved enabling us to offer LD assessments (IQ) for those we are unsure of eligibility.

In Gender services all appointment types, including new appointments, have recommenced. Gender Outreach support continues to be available by virtual technology or telephone, with a small number of face to face clinics taking place. The waiting time for those people who access Leeds Gender Service continues to increase and in February currently stands at 2,839 people, the Covid-19 pandemic significantly affecting delivery of clinical care. Changes to NHSE contractual reporting requirements allows us an opportunity to review how we best measures our waiting times in this area, previously the 'median' wait in weeks. Conversations have been taking place with the service to explore options ahead of the new financial year.

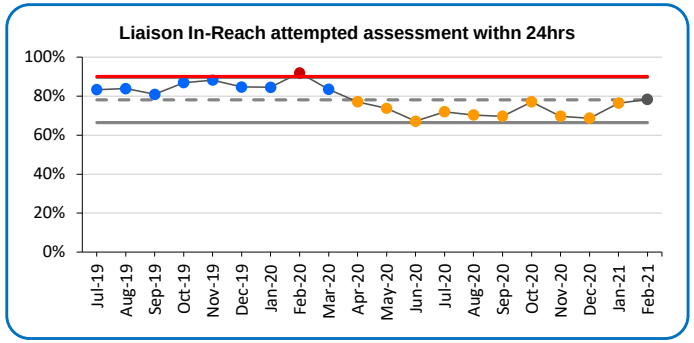
In Deaf CAMHS the recently re-developed average waiting time (from referral to first contact) measure aims to more accurately reflect service activity and includes health appointments delivered via telemedicine. In February the average wait from referral to first direct contact was reported at 89 days. Face to face contacts in the service are reviewed on a case by case basis, but with some potentially reverting to telemedicine contacts or be postponed during the latest lockdown.

Actions taken/to be taken: CareDirector dashboard demonstrations to be set up and familiarisation required to improve accuracy of the waiting time measures.

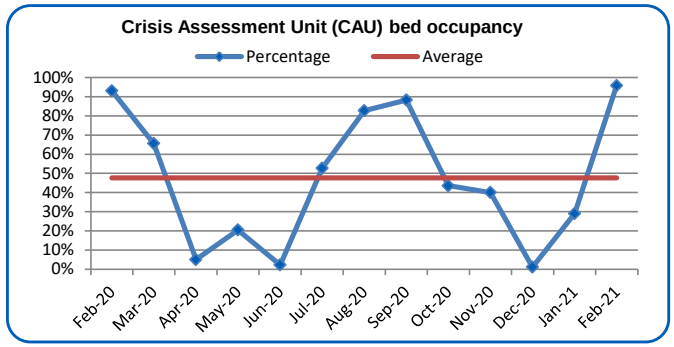
Services: Our acute patient journey



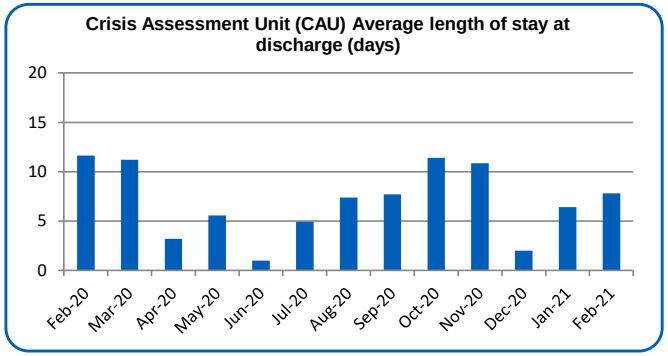
National (NOF): No target: Feb 0



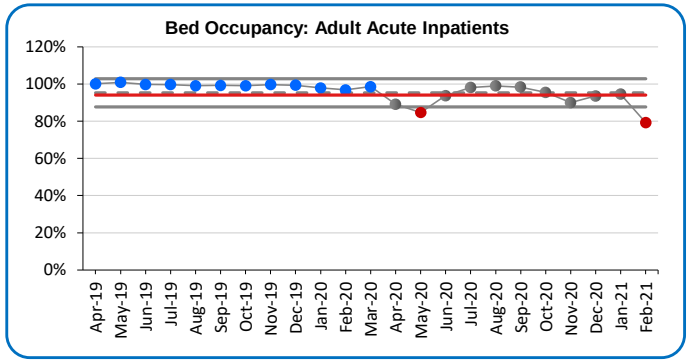
Contractual target: 90%: Feb 78.4%



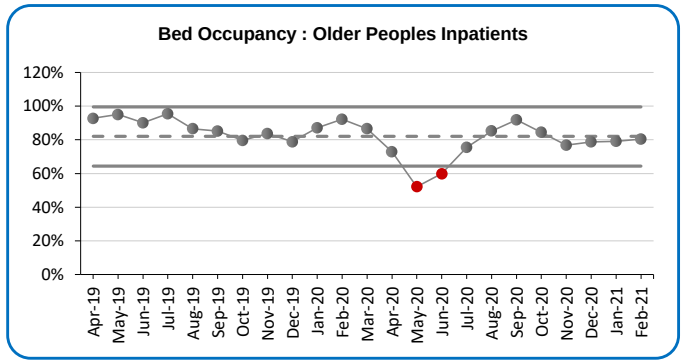
Local measure: Feb 95.8%



Local measure: Feb 7.8 days



Contractual target 94-98% : Feb 79.3%

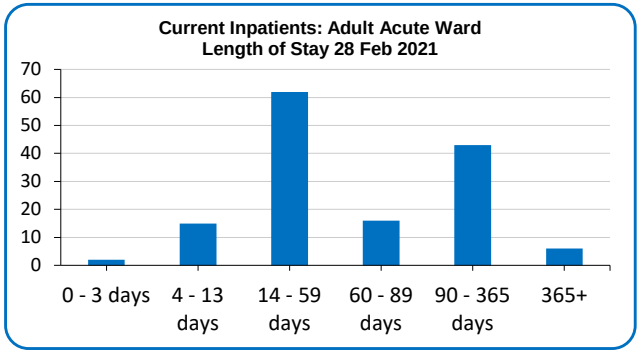


Local measure and target 85% : Feb 80.5%

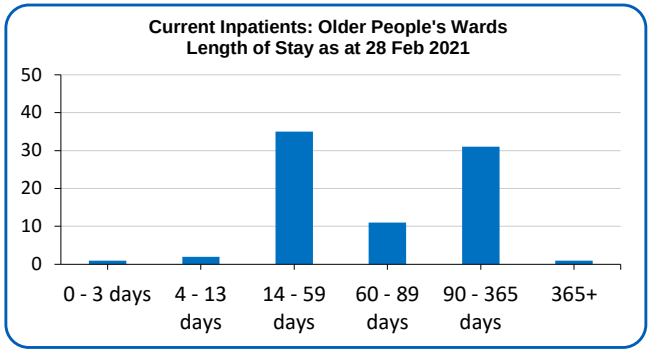
SPC Chart Key

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

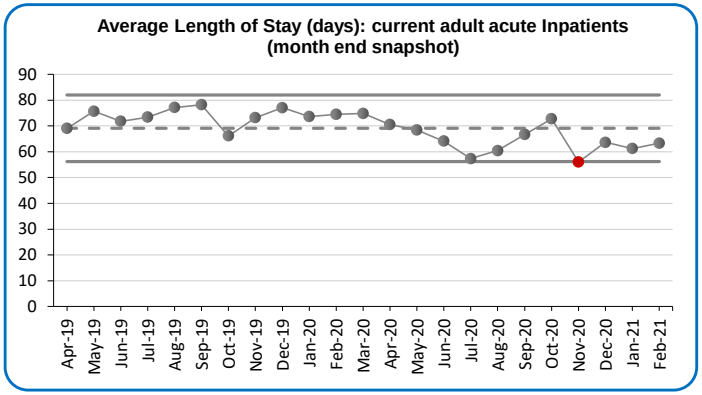
Services: Our acute patient journey (continued)



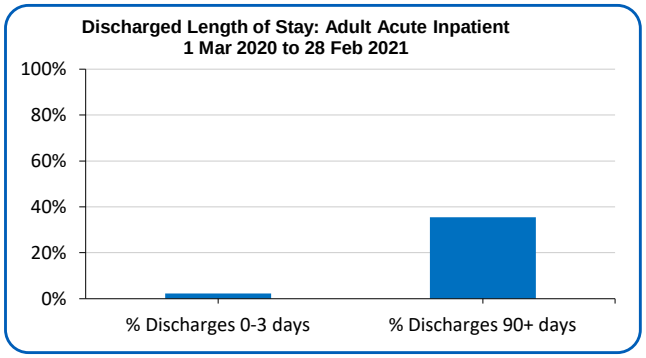
Local activity : 49 people with LOS 90+ days



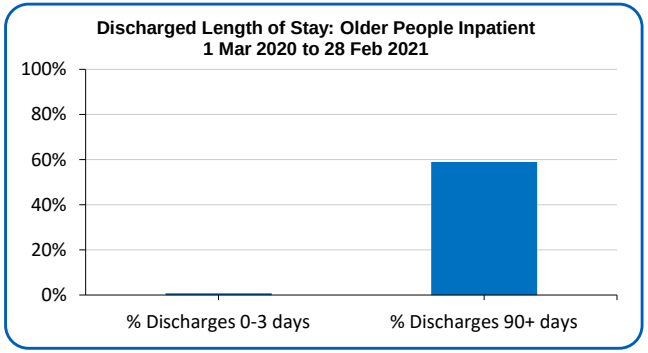
Local activity : 32 people with LOS 90+ days



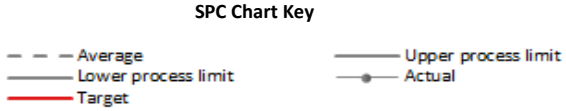
Local tracking measure: Feb 63.3 days



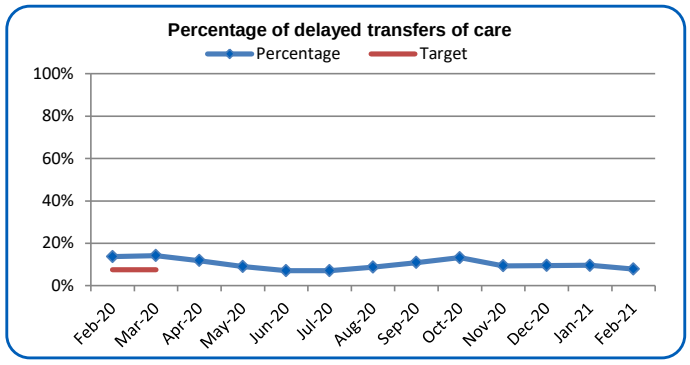
Local activity : % discharged LOS 90+ days = 35.5%



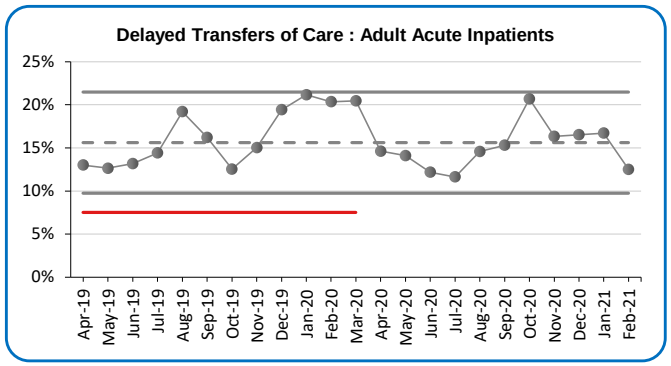
Local activity: % discharged LOS 90+ days = 58.9%



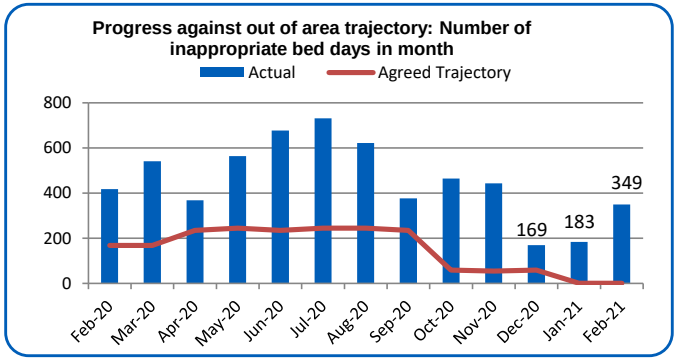
Services: Our acute patient journey (continued)



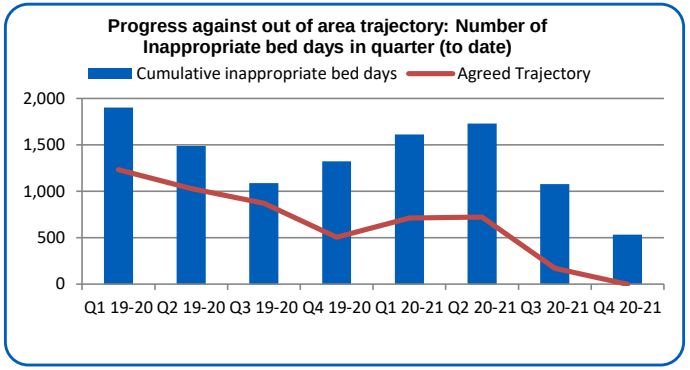
Local tracking measure: Feb 7.8%



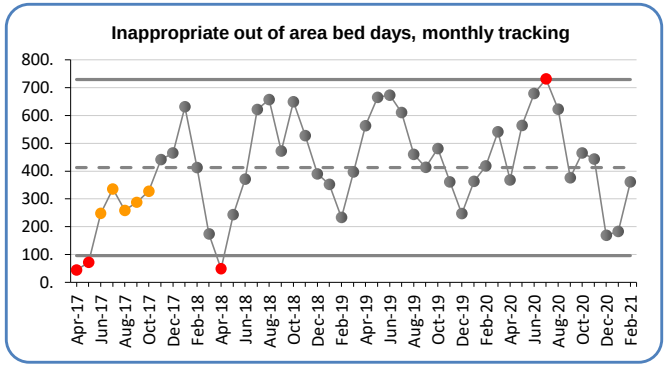
Local tracking measure: Feb 12.5%



Nationally agreed trajectory (Feb 0) Feb 349 days



Nationally agreed trajectory (Q4: 0 days):
Q4 to date: 532 days

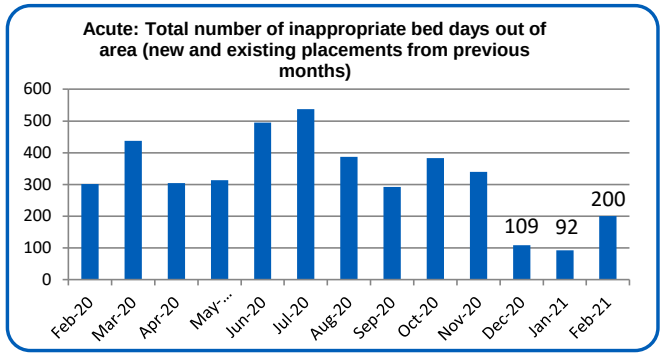


Local tracking measure: Feb: 349 bed days

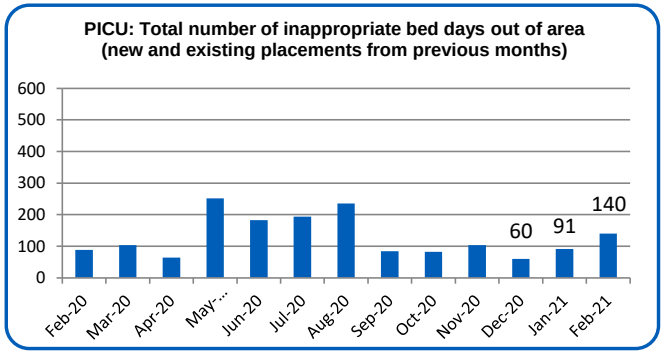
SPC Chart Key

Average
Lower process limit
Target
Upper process limit
Actual

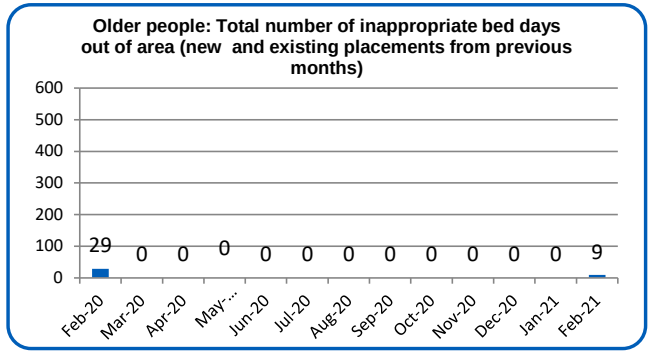
Services: Our acute patient journey (continued)



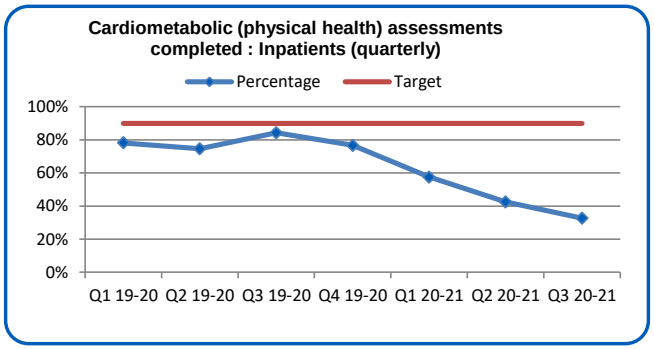
Local measure: Feb 200 days



Local measure: Feb 140 days



Local measure: Feb 9 days



Contractual target: 90%: Q3 32.7%

Services: Our acute patient journey

In February bed occupancy for Adult acute services was impacted on by a Covid outbreak and dropped to 79.3% overall. For the majority of February Becklin Wards 1 and 5 were closed to admission with Ward 5 used as a cohorting area. Subsequently there have been capacity challenges as a result of the requirement to staff the cohort area and increased engagement and observation required. All wards are now open with a graduated return to admissions in place and a stabilisation plan developed. At the end of the month, 49 people had been in an adult acute ward setting for 90 days or more, the average length of stay for people on our acute wards was 63 days, remaining within our process limits but significantly beyond the national average of 32 days described in the Long Term Plan. In Older People's Services Wards 2, 3 and 4 at the Mount were also closed due to Covid outbreaks with staggered planned opening dates into early March. Overall bed occupancy in February was 80.5%.

Delayed Transfers of Care was reported 7.8% overall in month, 12.5% for Adult acute services and within levels of normal variation. Performance continues to be mitigated through the operational discharge group, which is a partnership arrangement with Leeds City Council and the CCG. The group continues to meet twice a week to maintain an overview of, and manage discharges effectively. The group is proving successful in improving our DTOC position, however some of the practical aspects of discharge (for example testing requirements from different providers) can still cause some issues in discharging effectively.

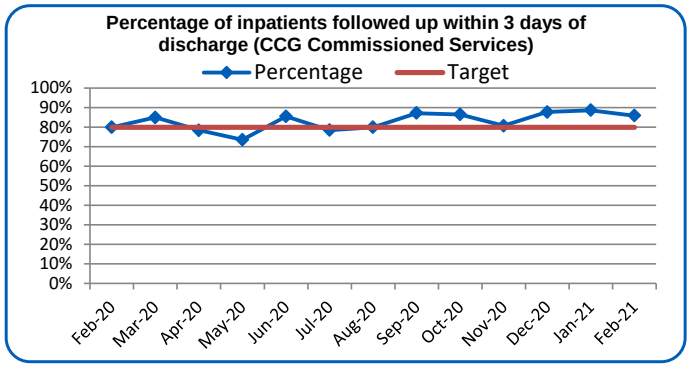
Actions taken / to be taken: The acute care excellence programme is underway and provides a focus on occupancy rates and length of stay, and work is ongoing with our social care partners and commissioners in relation to DToC. Work is also progressing on the implementation of the Crisis House in Leeds, and some ICS work in relation to women with complex presentations (primarily with a diagnosis of personality disorder) – once operational, we expect this to have a positive impact on reducing admissions and/or length of stay.

78.4% of assessments were attempted within 24 hours by the Liaison In-Reach team, below the 90% target but within normal levels of variation. The team experienced operational pressures in February primarily related to increased level of support required for patients in LTHT who were awaiting a mental health bed. Overall, response times within 24 hours have remained very consistent throughout the pandemic despite the multiple challenges within LTHT including compliance with rigorous IPC guidance.

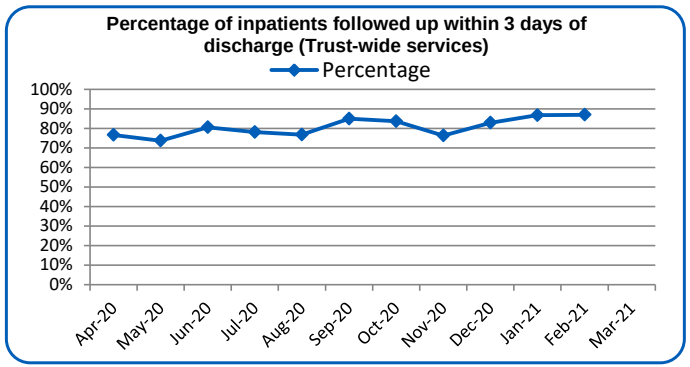
There were a total of 349 inappropriate out of area bed days in February where the trajectory for Q4 is zero. 200 of the bed days were attributable to Adult Acute whilst the use of out of area PICU beds accounted for 140 inappropriate bed days, plus there were 9 days attributable to Older Adults. 20 out of area placements started in the month, 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.

Actions taken / to be taken: A further joint review of our Out of Area 'road map' plans (which set out actions to reduce Out of Area bed use) is planned with the CCG. Again, work on the Crisis House is a key component of this plan.

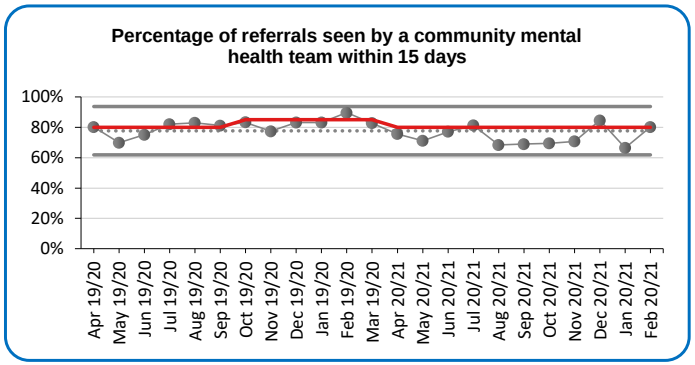
Services: Our community care



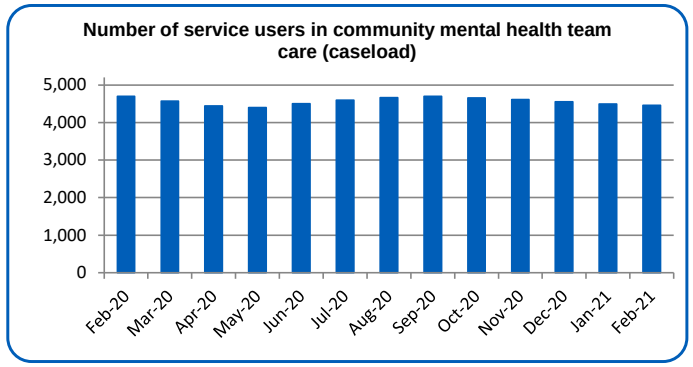
Contractual Target 80% Feb 85.9%



Local Tracking Measure: Feb 87%



Contractual target: 80%: Feb 80.3%



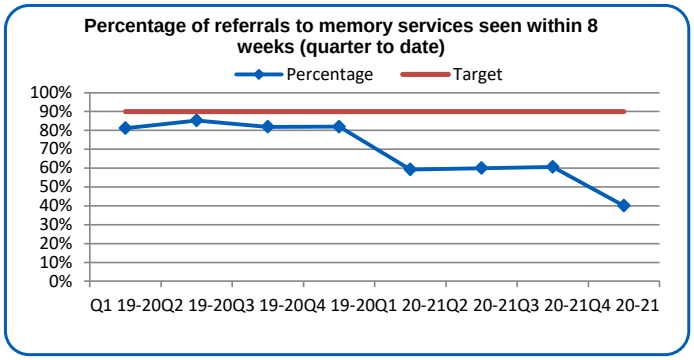
Local measure: Feb 4,459

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

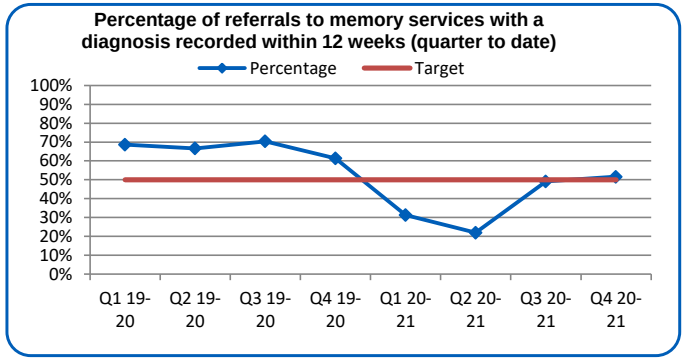
Contractual target: *20-21 data development ongoing*

SPC Chart Key

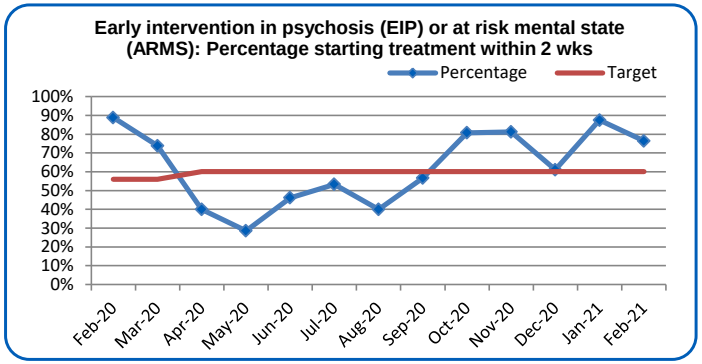
Services: Our community care (continued)



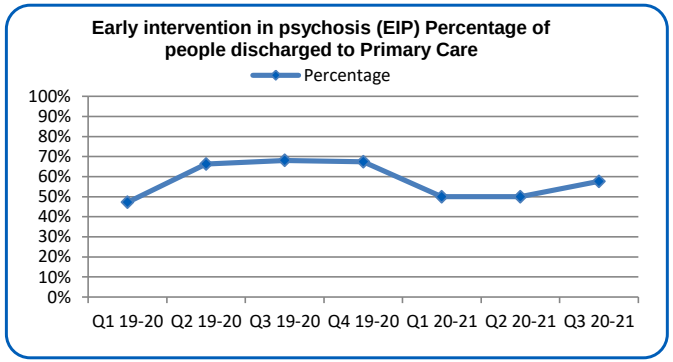
Contractual target: 90% Q4 to date 40.1%



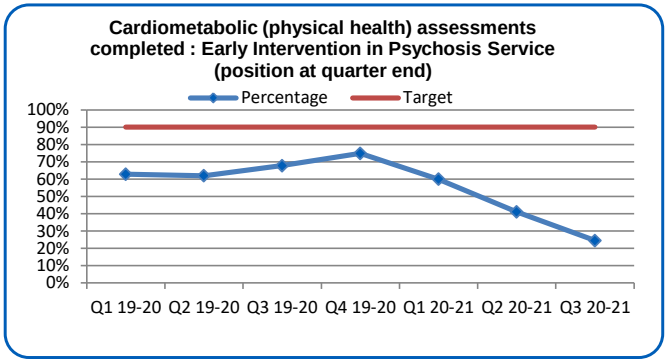
Contractual target: 50% Q4 to date 51.6%



Contractual target: 60%: Feb 76.5%



Contractual target: tbc: Q3 57.6%



Contractual target: 90%: Q3: 24.5%

Services: Our community care

In February 85.9% of inpatients were followed up within 3 days of discharge from CCG commissioned services, exceeding our contractual target of 80%. For all LYPFT Services trust-wide our performance also met standards with 87% of all inpatients followed up within 3 days of discharge. We continue to routinely follow up all breaches of the standard during the month, any concerns around data quality or recording processes are followed up with teams and additional support provided if required. Latest benchmarking data published for Nov 2020 shows the England average to be 76%.

The Trust also met expected standards for the percentage of referrals seen by community mental health teams within 15 days in February. Performance was reported at 80.3% against the 80% contractual target. Once again there was some local variation across, and within services, with Community and Wellbeing Adult CMHT performance 83% and in Older People Services CMHT performance 72%. In Community and Wellbeing Services 74% of contact activity with service users is being delivered remotely either via telephone or video conference, supported by recent evaluation of service user feedback undertaken. Face to face contact guidance to support clinical decision making based on individual risk assessment is now in use within teams to encourage consistency in maintaining and safely increasing necessary face to face contact. Referral demand remains above pre-Covid average rates, which with discharge rates declining across the service is resulting in a sustained trend of incremental increasing caseloads and pressure on resources. In Older Peoples CMHTs there have been multiple contributing factors including an increase in referral rates, vacancies cross the service, together with the impact of redeployment to other areas of the Trust. Actions are being taken to monitor this target within management supervisions and team meetings, where the information available is informing discussions to enable teams to achieve the performance target going forward.

40.1% of referrals to memory services were seen within 8 weeks (Q4 to date, target is 90%). Since the service re-opened in October 2020 the focus has been on new referrals, however with current limited staffing capacity across the service, it is expected that it will be around 4-5 months until we see a significant improvement in performance against the 90% target. We anticipate our implementation of carrying out appointments (where possible and clinically appropriate) using videoconferencing will contribute positively.

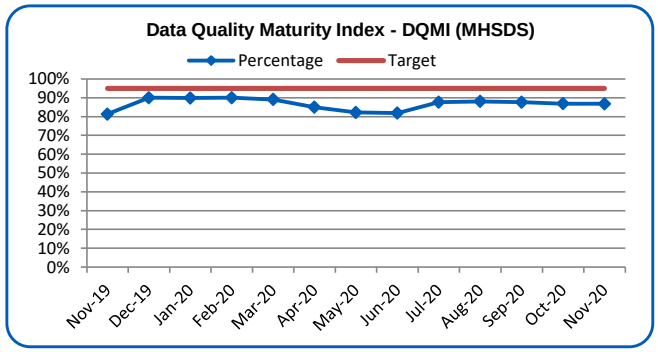
At the end of the February 51.6% of referrals (64 from 124) to memory services in Q4 to data had a diagnosis recorded within 12 weeks, meeting the 50% contractual target. The delays within the MAS Pathway have impacted on assessments, diagnostic and Post Diagnostic Support (PDS). Within MAS the initial focus on the backlog work was for those waiting post diagnostic support. Across the city the numbers of those waiting for PDS were extremely high in comparison to other areas, however good progress has been made to date and the outstanding numbers for those waiting on PDS alone currently stands at 155 across the whole of the city.

Actions taken/to be taken: Services continue to develop and monitor plans for improvement, including pro-active sharing of 'best practice' across teams where appropriate.

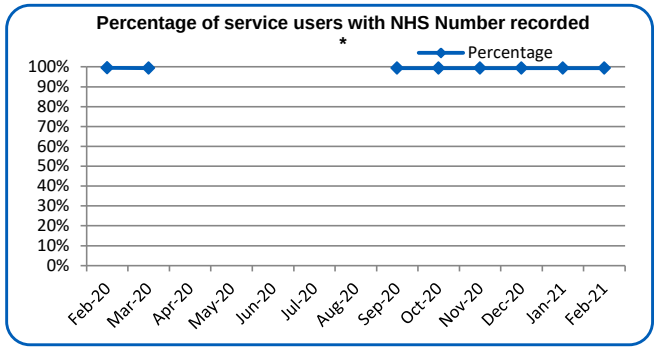
In February 76.5% of people referred to the Early Intervention Psychosis Service started treatment within 2 weeks, against a 60% standard. Collaboration between the Trust and Aspire is ongoing to promote better understanding of the information contributing to quality and performance and the supporting tools available in CareDirector. Now that reported performance is viewed as an accurate reflection of operational quality the contractual target is now consistently being achieved month on month.

Actions taken/to be taken: EIP Service to continue to monitor caseload activity levels, quality and performance.

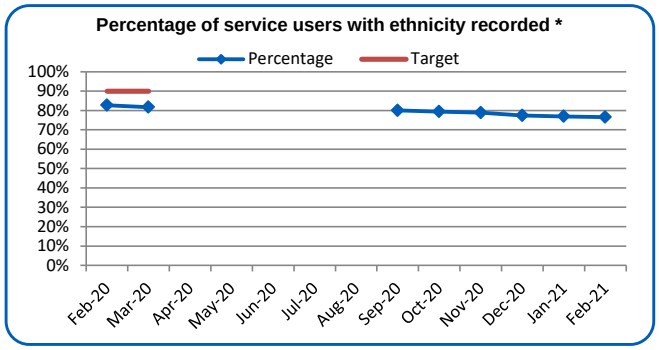
Services: Clinical Record Keeping



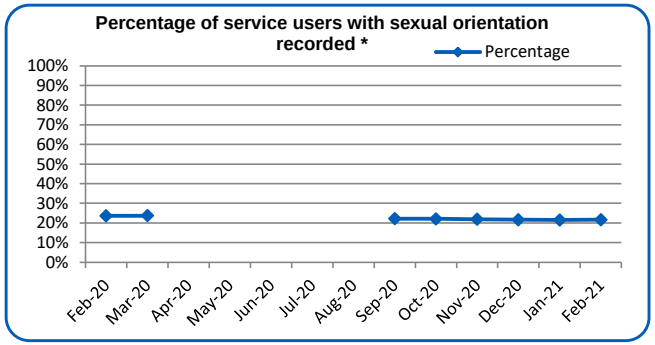
19/20 CQUIN / NHSOF Target - Nov: 86.8%



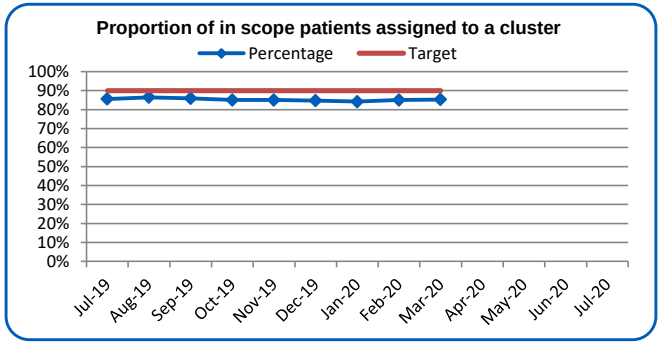
Local measure: Feb 99.3%



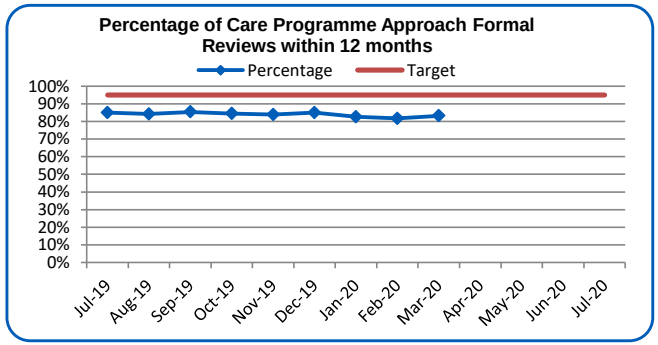
Local measure: Feb 76.5%



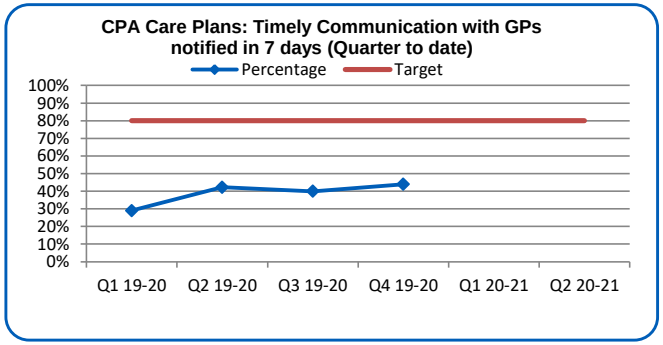
Local measure: Feb 21.6%



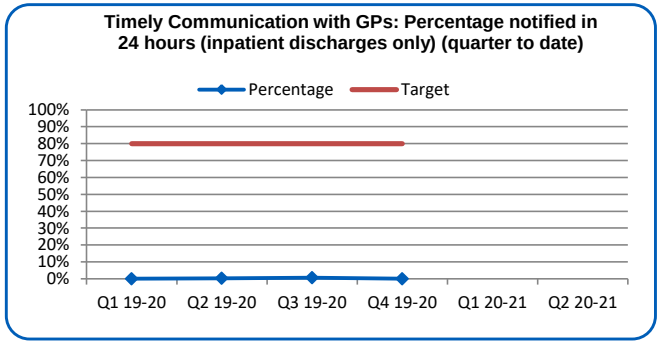
Local target (tbc) : *20-21 data development ongoing*



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



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



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

* 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 teams continue to support staff in regaining expected standards of data quality and further support and training on our CareDirector EPR system. As at February 99.3% of care records had an NHS number recorded, 76.5% ethnicity and 21.6% sexual orientation. We continue to promote data completeness throughout 2020/21 with a rolling programme of focused data quality discussions aimed at supporting staff in using CareDirector well. Our latest DQMI (Data Quality Maturity Index) score for Mental Health Services data, published by NHS Digital, is 86.8% (as at Nov 2020).

Areas of focus this month have included identification, via the annual Community Mental Health Survey, that work is required to improve recording of the 'Allow correspondence' flag on CareDirector. In support of the Covid19 vaccination programme approximately 1,000 staff details have been checked against National Immunisation and Vaccination System (NIVS) and where errors have been identified work has been completed to resolve. The dashboards to support the process of recording appointment outcomes have been demonstrated to the Veteran High Intensity Service and an improvement in Jan 21 compared to Dec 20 is evidenced. Correspondence has been sent to team coordinators / administrators requesting for those service users with multiple cases open that a single case should be used, and therefore to close those cases without future appointments and staff involvements.

A programme of KPI audits and associated clinical records is being planned from Q1 21/22. The proposal is for six KPI audits to be completed during 21/22 with two further audits of the data quality of CareDirector clinical records carried out focusing on the use of a particular part of the system. The scope of these audits will be all records (within the audit timeframe) rather than only records contributing to an identified KPI construct.

Actions taken / to be taken: Await IG Group approval of data quality audits. 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), requirements are being developed for providing an automated electronic discharge advice note containing the required information from EPMA (Prescribing system) and CareDirector and the automation of CPA care plans & outpatient letters for delivery during Q1 2021-22.

Actions taken / to be taken: Services piloting our interim solution which no longer requires letters to be posted. Reporting to resume again in Q2 2021-22.

Quality and Workforce metrics: Tabular overview

Quality: Our effectiveness	Target	Nov-20	Dec-20	Jan-21
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	-	8	2	4
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**	**Nov-20**	**Dec-20**	**Jan-21**
Friends & Family Test: Percentage recommending services (total responses received)	-	100% (1)	0% (0)	0% (0)
Mortality:				
· Number of deaths reviewed (incidents recorded on Datix)**	Quarterly	-	63	-
· Number of deaths reported as serious incidents	Quarterly	-	3	-
· Number of deaths reported to LeDeR	Quarterly	-	1	-
Number of complaints received	-	14	7	10
Percentage of complaints acknowledged within 3 working days	-	100%	100%	100%
Percentage of complaints allocated an investigator within 3 working days	-	97%	86%	100%
Percentage of complaints completed within timescale agreed with complainant	-	100%	100%	100%
Number of enquiries to the Patient Advice and Liaison Service (PALs)	-	114	74	81

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

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

Quality and Workforce metrics: Tabular overview

Quality: Safety	Target	Nov-20	Dec-20	Jan-21
Number of incidents recorded	-	814	914	1,018
Percentage of incidents reported within 48 hours of identification as serious	100%	100% (2)	100% (3)	100% (1)
Number of Self Harm Incidents	-	106	125	101
Number of Violent or Aggressive Incidents	-	74	102	137
Number of never events	-	0	0	0
Number of physical restraints *	-	241	261	266
No. of patients detained under the MHA (includes CTOs/conditional discharges)	-	483	483	470
Adult acute including PICU: % detained on admission	-	58.8%	55.7%	54.0%
Adult acute including PICU: % of occupied bed days detained	-	85.3%	79.3%	78.0%
Number of medication errors	Quarterly	-	150	-
Percentage of medication errors resulting in no harm	Quarterly	-	94.0%	-
Safeguarding Adults: Number of advice calls received by the team	Quarterly	-	221	-
Safeguarding Adults: Percentage of advice calls to safeguarding that resulted in a referral to social care	Quarterly	-	23% (50)	-
Safeguarding Children: Number of advice calls received by the team	Quarterly	-	60	-
Safeguarding Children: Percentage of advice calls to safeguarding that resulted in a referral to social care	Quarterly	-	13% (8)	-
Number of falls	-	68	63	67
Number of Pressure Ulcers	-	0	0	0

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

* This measure has been reconfigured to show physical restraints only, and to account for Datix records flagged as not being the record of restrictive practice (i.e. another Datix record having been recorded for this information)

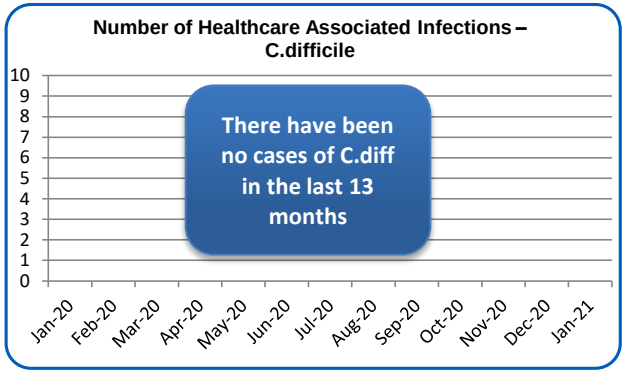
Quality and Workforce metrics: Tabular overview

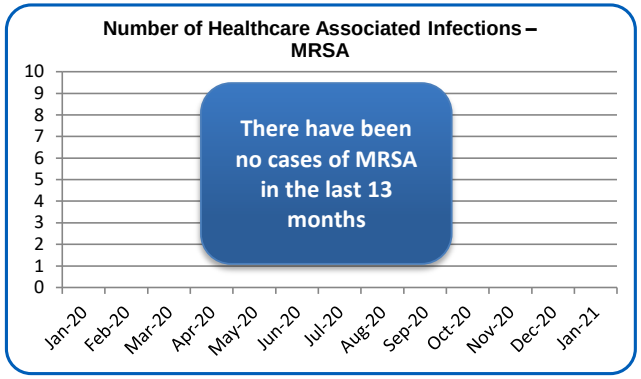
Our Workforce	Target	Nov-20	Dec-20	Jan-21
Percentage of staff with an appraisal in the last 12 months	85%	57.8%	53.8%	58.5%
Percentage of staff with a wellbeing assessment completed	-	-	82.0%	82.0%
Percentage of mandatory training completed	85%	85.1%	84.9%	84.9%
Safeguarding: Prevent Level 3 training compliance (quarter end snapshot)	85%	-	95.7%	-
Percentage of staff receiving clinical supervision	85%	69.7%	58.8%	65.8%
Staff Turnover (Rolling 12 months)	8-10%	8.6%	9.0%	8.9%
Sickness absence rate in month	-	5.5%	4.9%	5.3%
Sickness absence rate (Rolling 12 months)	4.9%	5.2%	5.1%	5.1%
Percentage of sickness due to musculoskeletal issues (MSK; rolling 12 months)	-	12.0%	13.9%	10.9%
Percentage of sickness due to Mental Health & Stress (rolling 12 months)	-	42.3%	48.0%	42.9%
Number of Covid19 related absences of staff, either through sickness or self-isolation (staff days)	-	2,529	917	2,446
Medical Consultant Vacancies as a percentage of funded Medical Consultant Posts (percentage)	-	13.3%	15.0%	16.6%
Medical Consultant Vacancies (number)	-	10.4	11.7	13.0
Medical Career Grade Vacancies as a percentage of funded Medical Career Grade Posts (percentage)	-	10.8%	11.0%	13.8%
Medical Career Grade Vacancies (number)	-	4.3	4.3	5.4
Medical Trainee Grade Vacancies as a percentage of funded Medical Trainee Grade Posts (percentage)	-	18.8%	18.8%	17.9%
Medical Trainee Grade Vacancies (number)	-	19.0	19.0	18.0
Band 5 inpatient nursing vacancies as a percentage of funded B5 inpatient nursing posts (percentage)	-	23.0%	25.0%	26.0%
Band 5 inpatient nursing vacancies (number)	-	50.4	55.4	58.2
Band 6 inpatient nursing vacancies as a percentage of funded B6 inpatient nursing posts (percentage)	-	10.0%	5.0%	5.0%
Band 6 inpatient nursing vacancies (number)	-	10.0	5.2	4.4
Band 5 other nursing vacancies as a percentage of funded B5 non-inpatient nursing posts (percentage)	-	16.4%	16.5%	14.4%
Band 5 other nursing vacancies (number)	-	16.5	16.5	14.5
Band 6 other nursing vacancies as a percentage of funded B6 non-inpatient nursing posts (percentage)	-	0.0%	0.0%	0.0%
Band 6 other nursing vacancies (number)	-	0.0	0.0	0.0
Percentage of vacant posts (Trustwide; all posts)	-	10.8%	7.0%	9.6%
			JAN	FEB
Number of staff vaccinated for Covid19 (first dose)*			2,672	2,969
Percentage of staff vaccinated for Covid19 (first dose)*			78%	85%

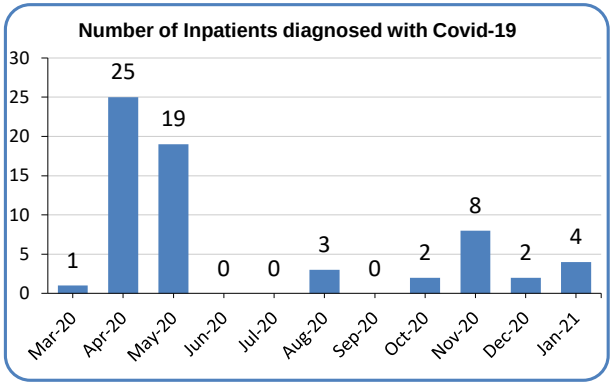
Nursing vacancy measures exclude nursing posts working in corporate/development roles

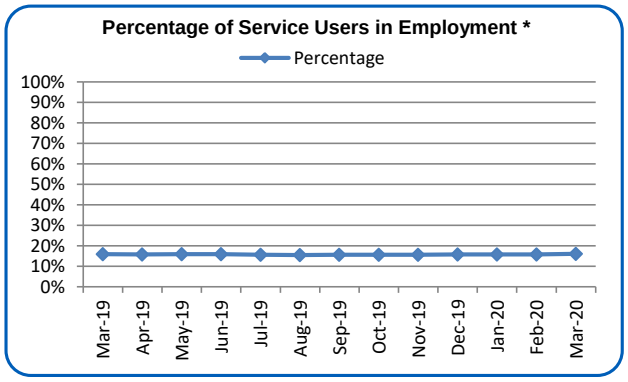
** Jan data as at 29th Jan | Feb data as at 25th Feb*

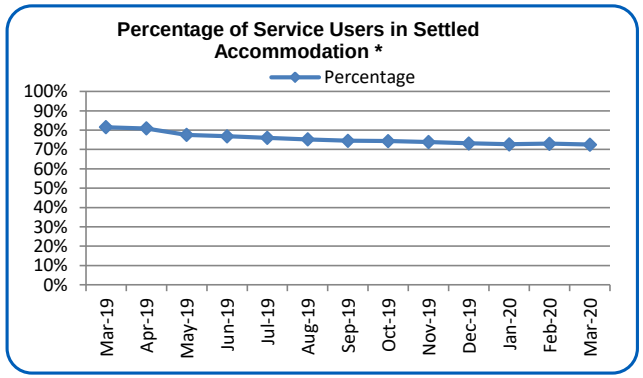
13 month trend: Quality: Effectiveness





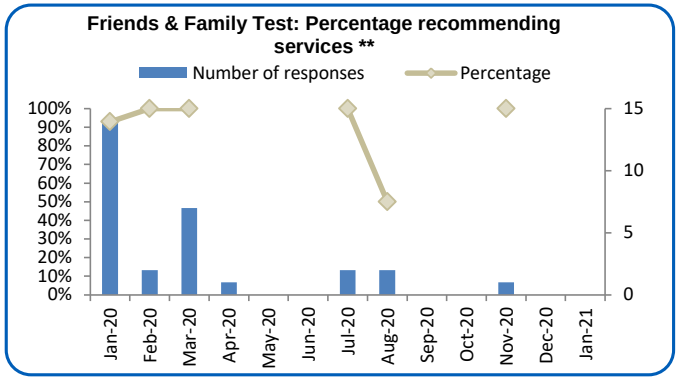


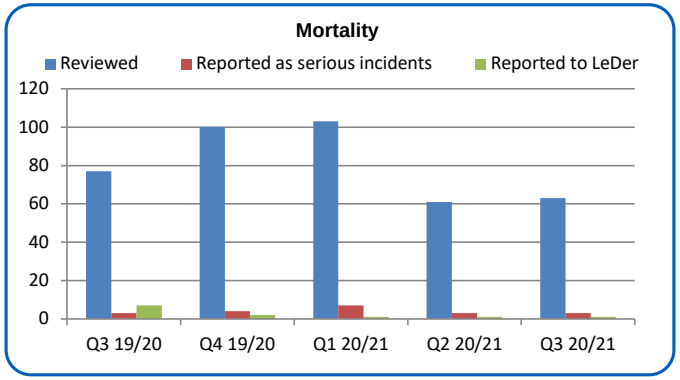


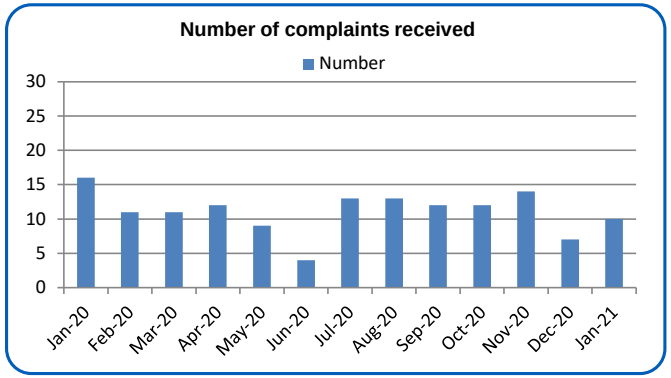


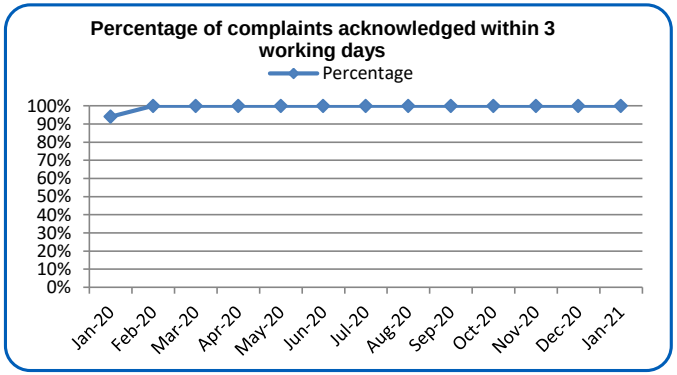
* 20/21 data not yet available, subject to technical reporting developments

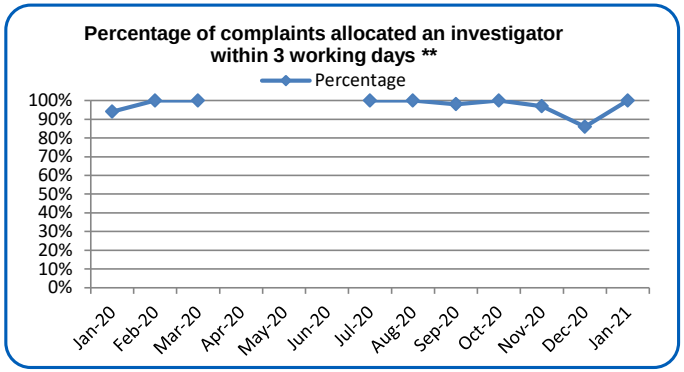
13 month trend: Quality: Caring/Patient Experience

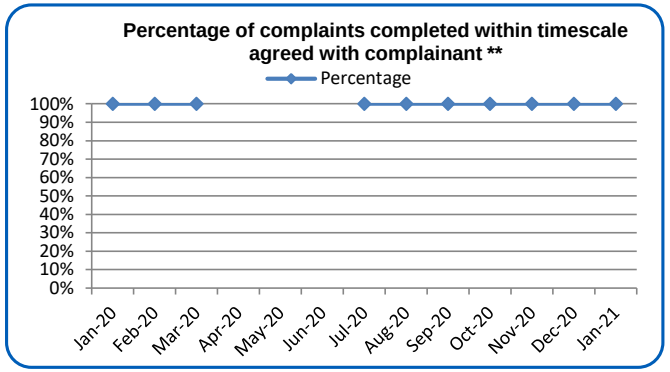


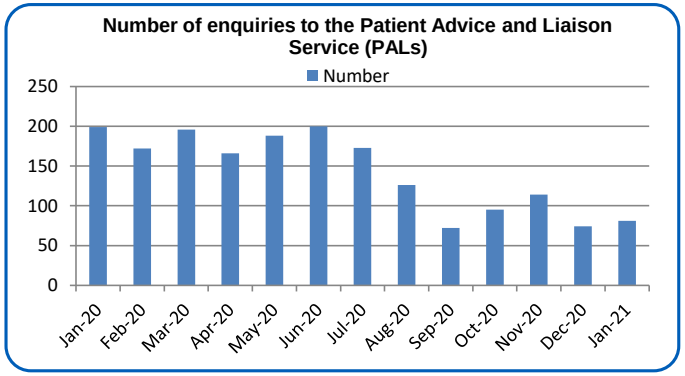






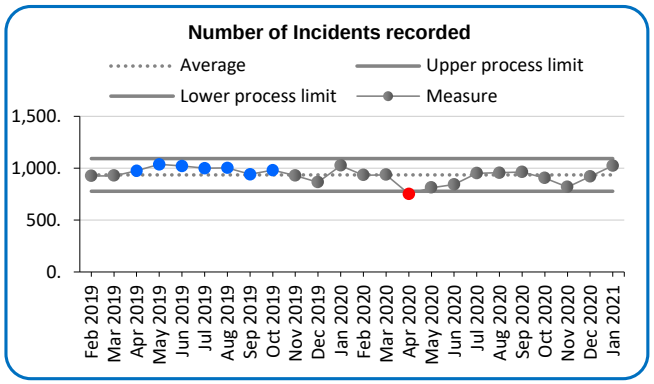


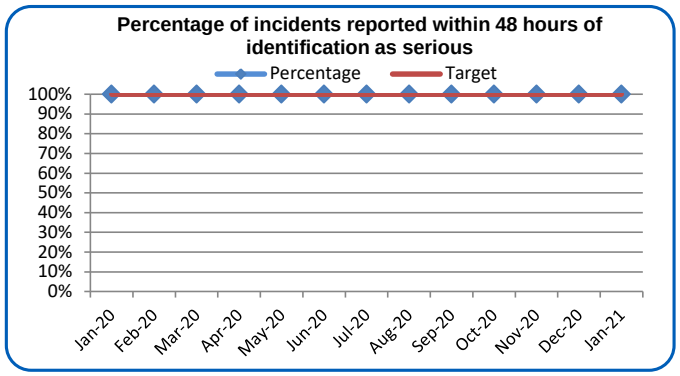


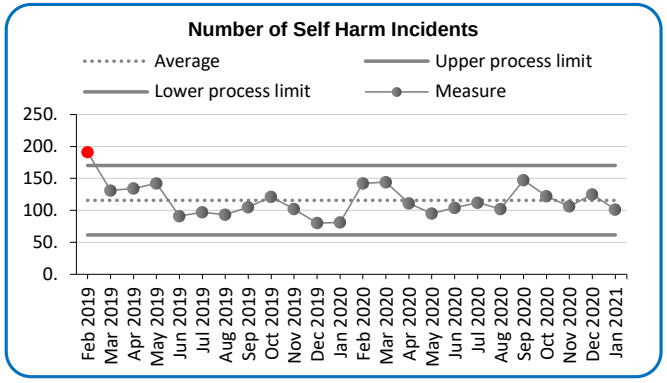


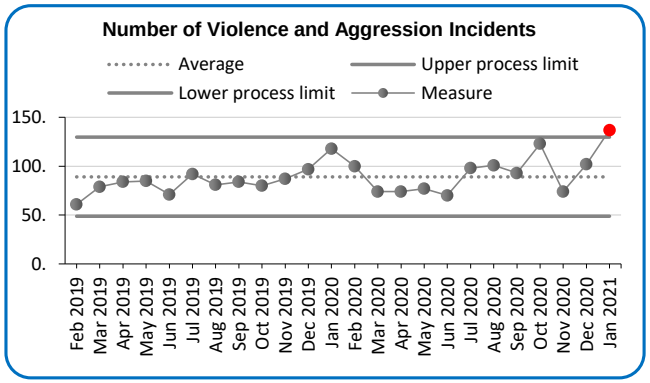
** 2020-21 Q1 reporting impacted by Covid19 related reporting unavailability / suspension

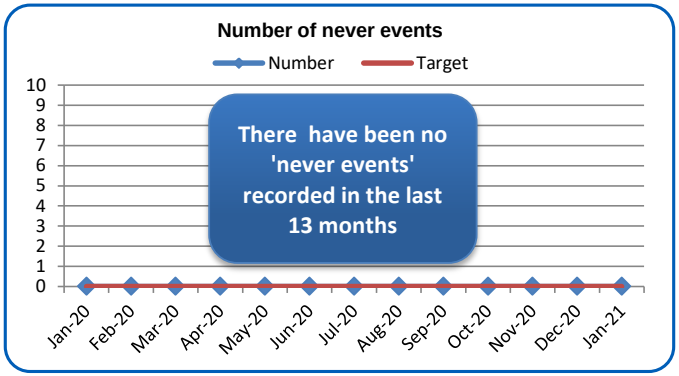
13 month trend: Quality: Safety

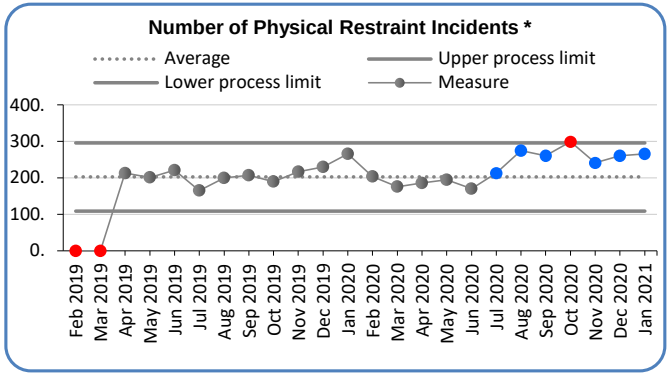


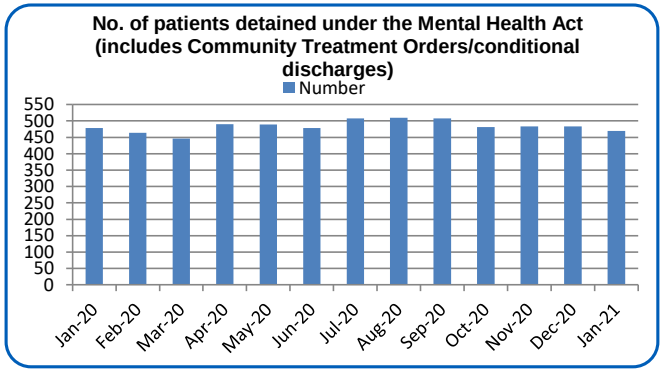


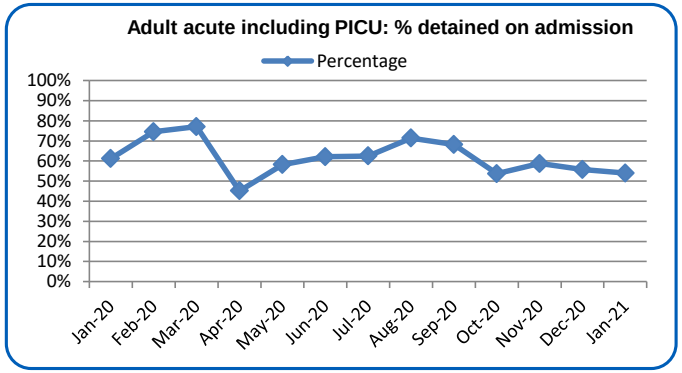


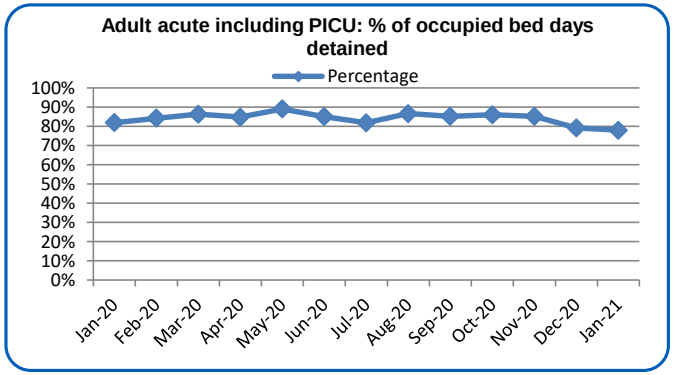






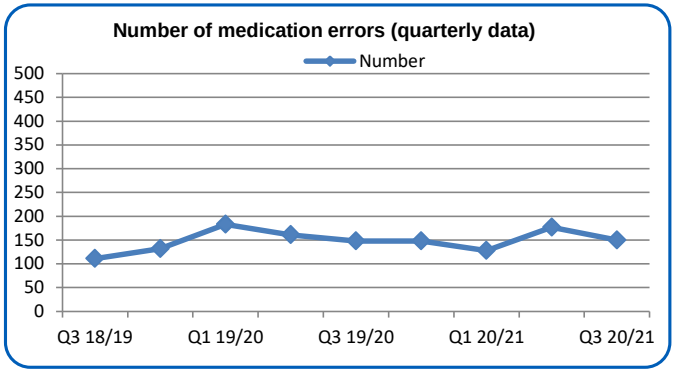


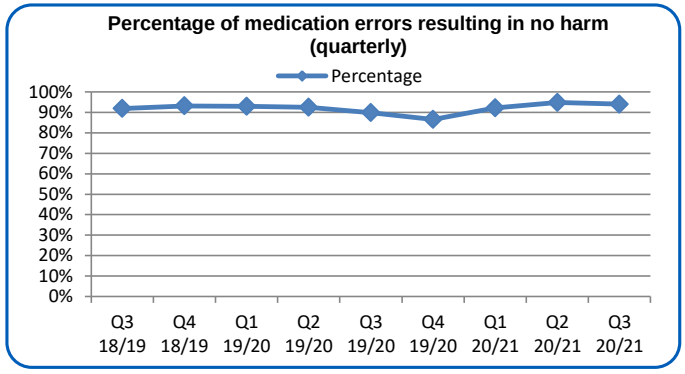


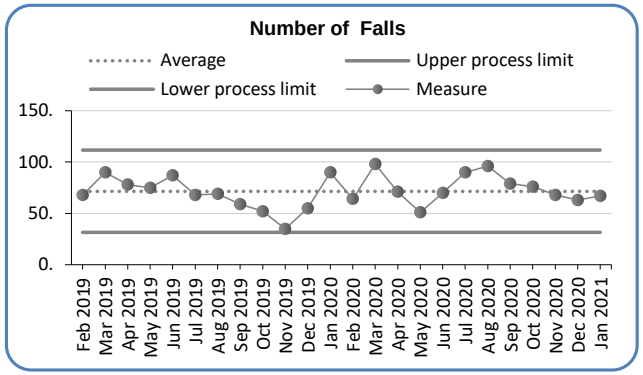


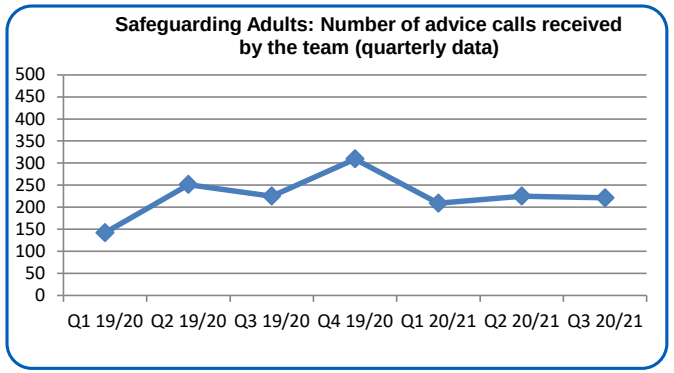
* Re-developed measure to reflect the number of physical restraints only.
Restraint reporting logic not applicable pre Apr 19

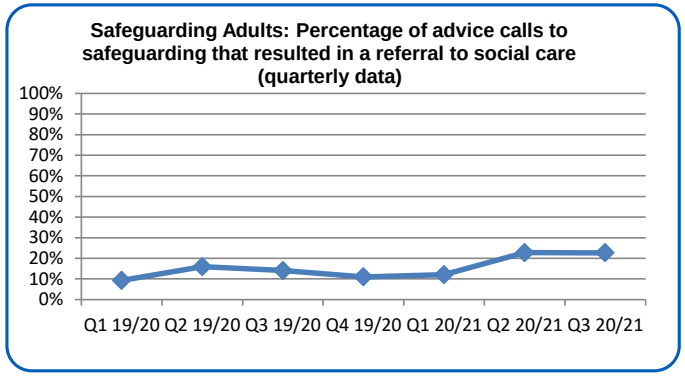
13 month trend: Quality: Safety - continued

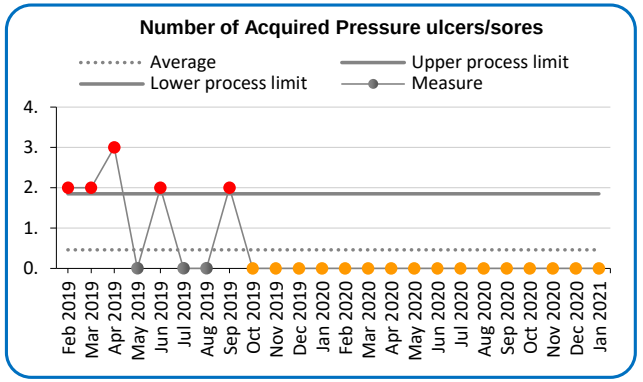


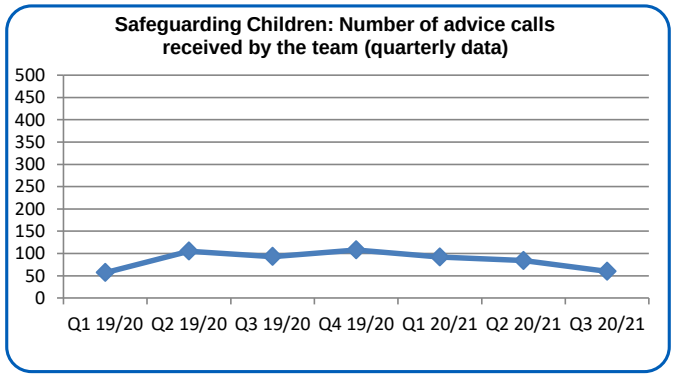


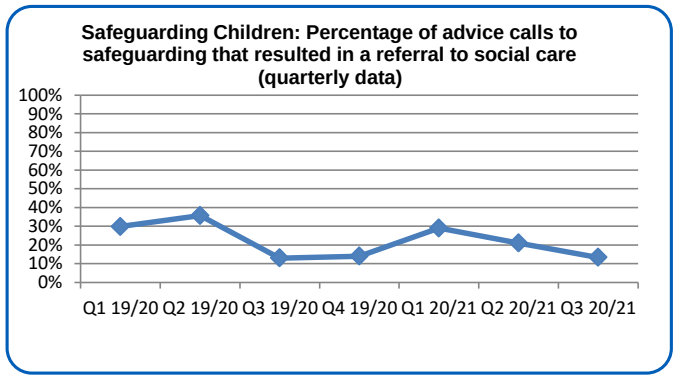




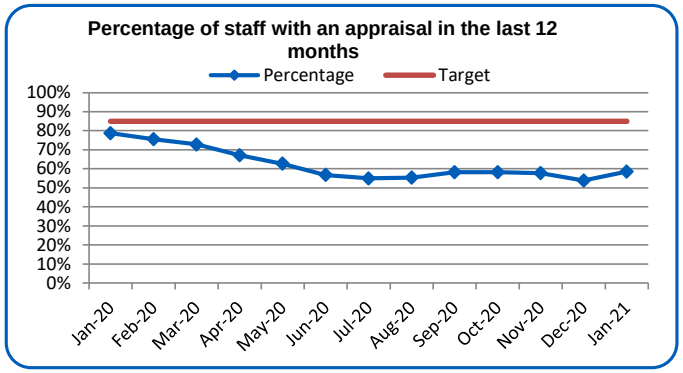


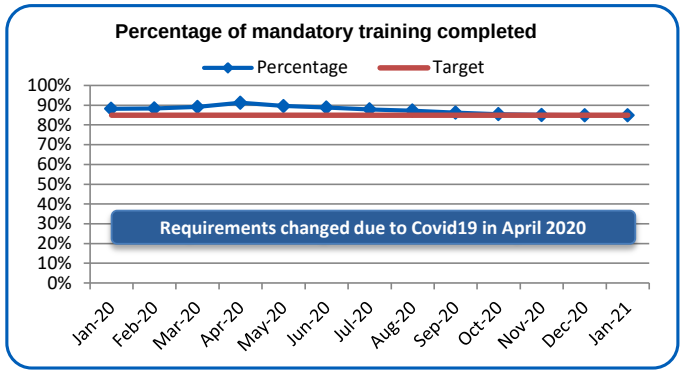


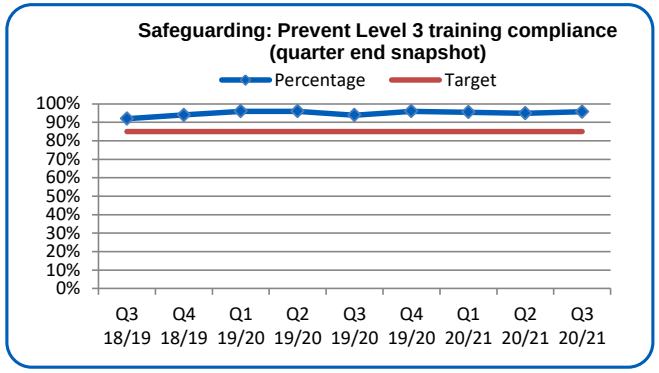


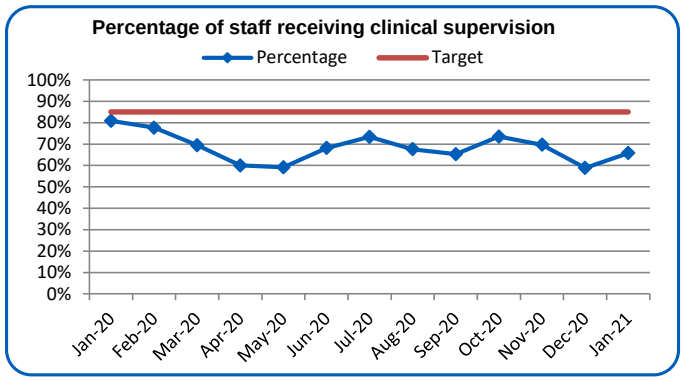


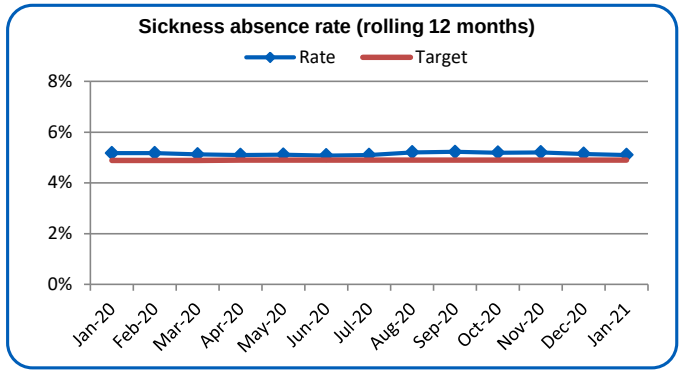
13 month trend: Our Workforce

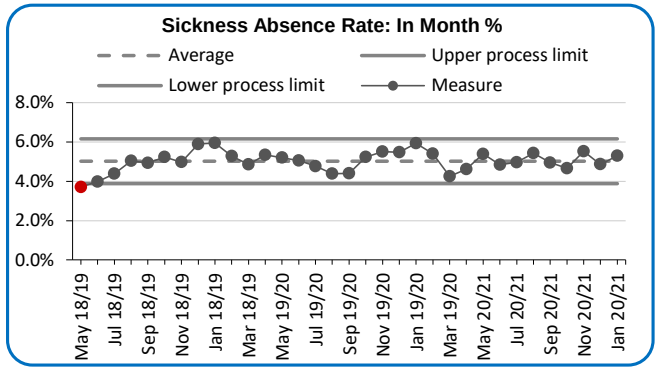


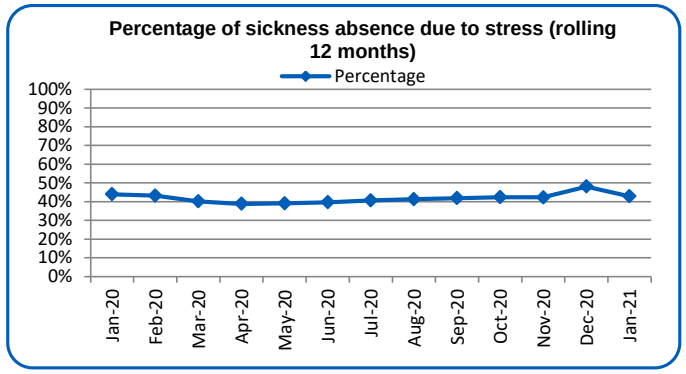


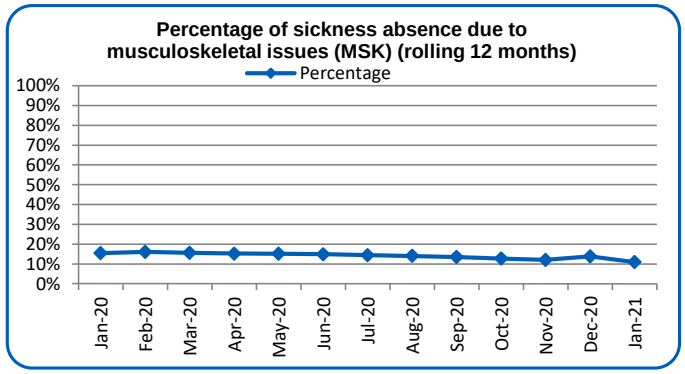


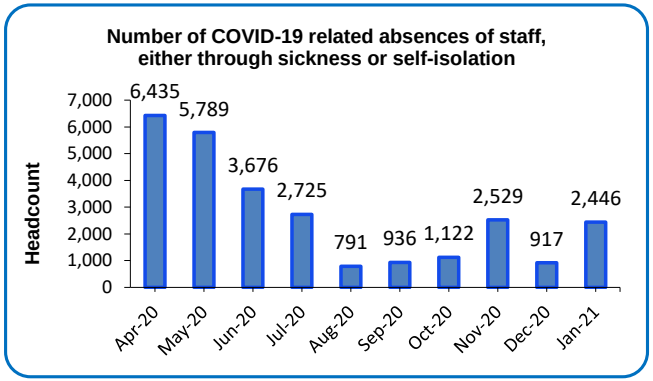




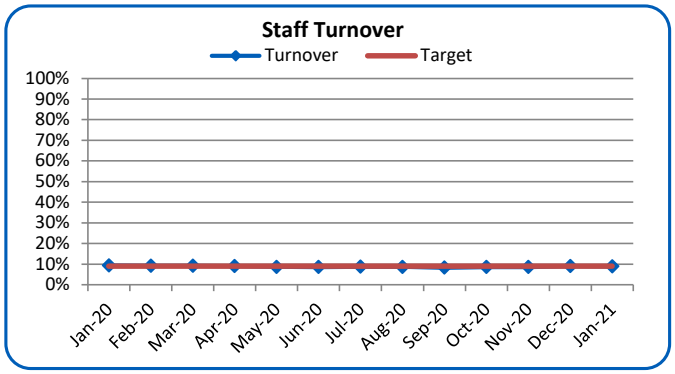


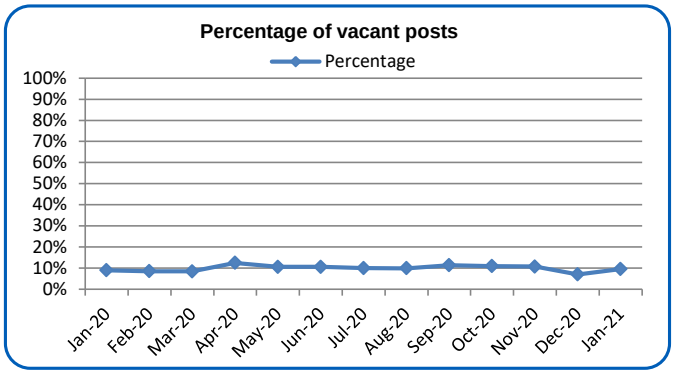


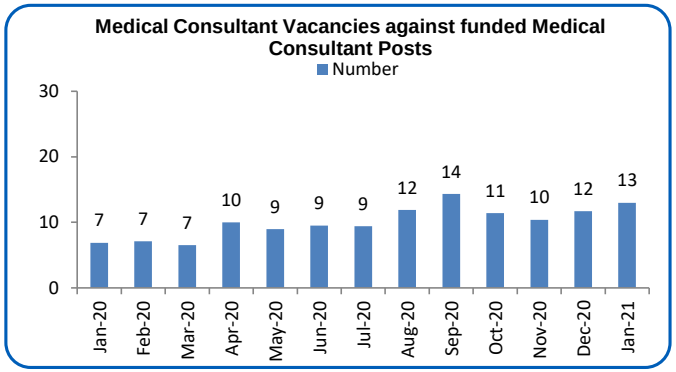


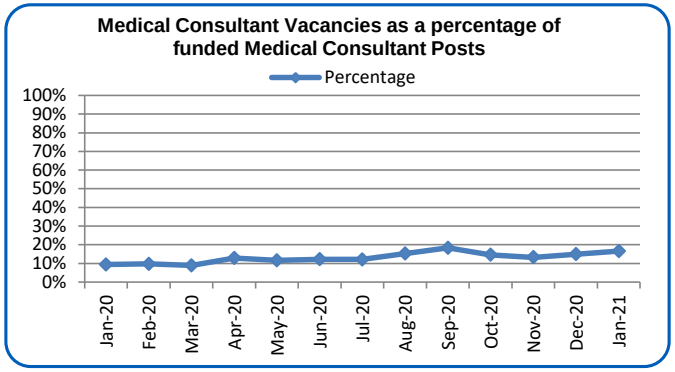


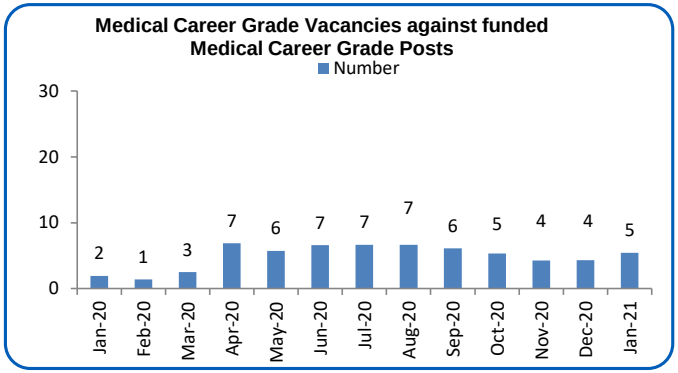
13 month trend: Our Workforce - continued

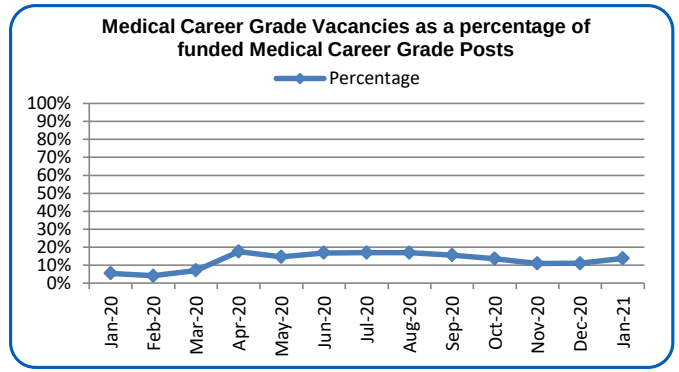


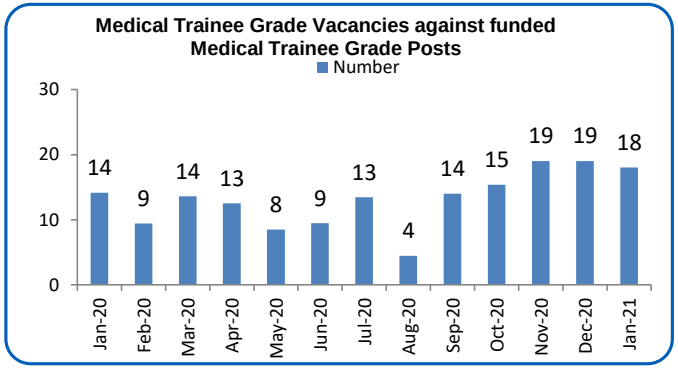


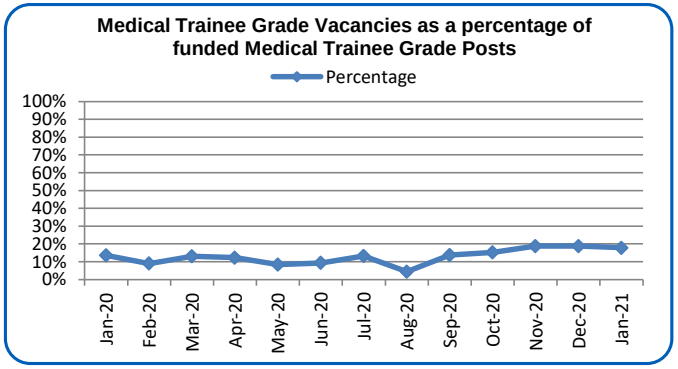




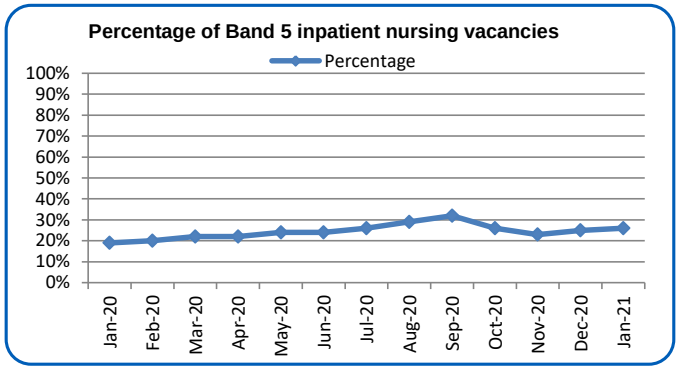


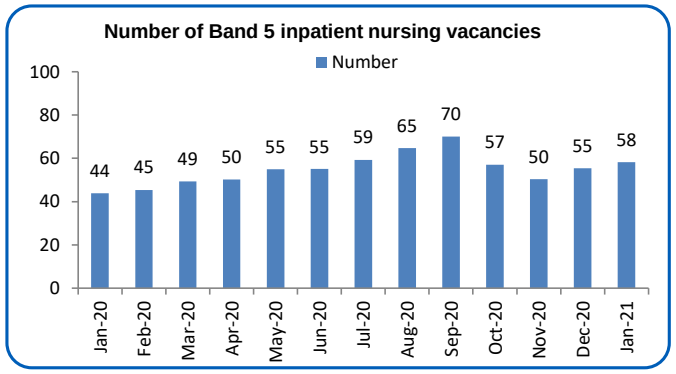


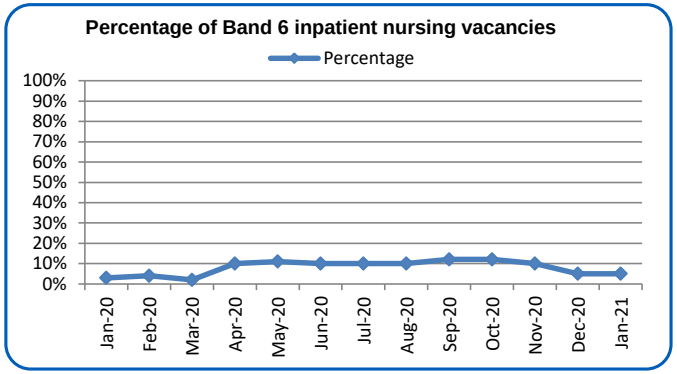


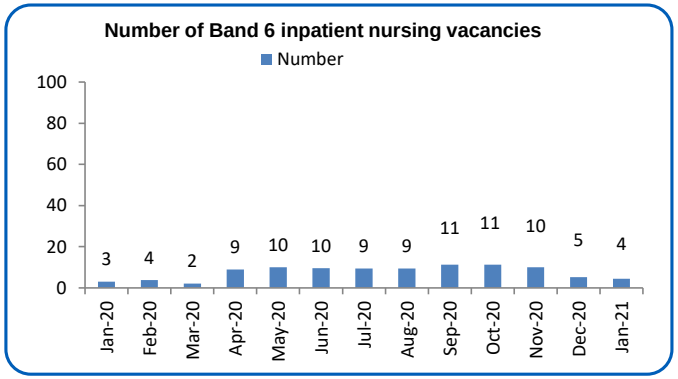


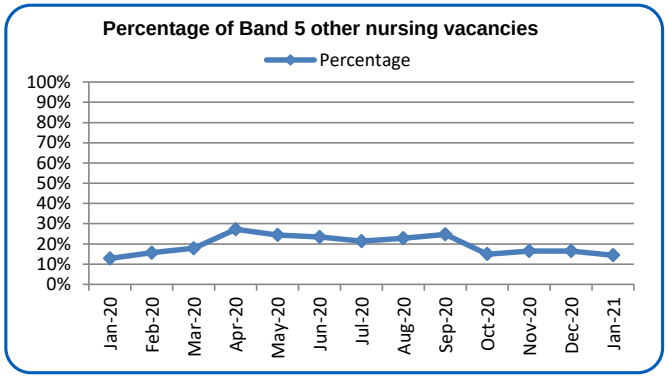
13 month trend: Our Workforce - continued

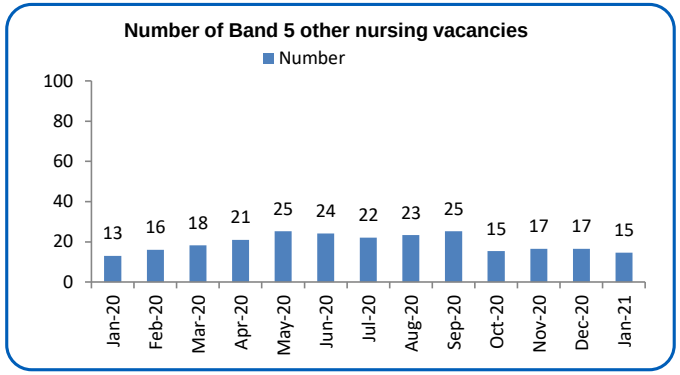


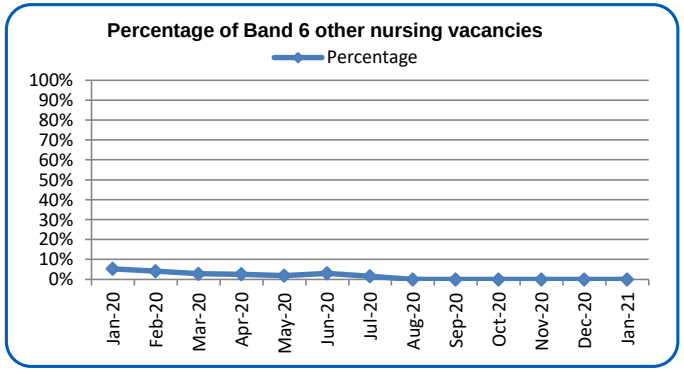


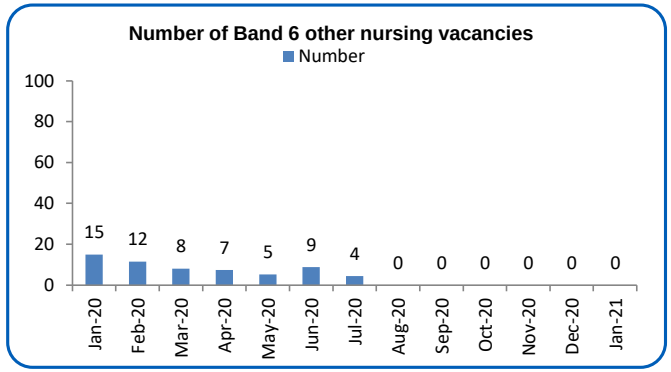












Local intelligence

PREVIOUS MONTH: DECEMBER

Clinical Record Keeping

Data Quality Maturity Index: Our teams continue to support staff in regaining expected standards of data quality and further support and training on our CareDirector EPR system. As at December 99.3% of care records had an NHS number recorded, 77.4% ethnicity and 21.7% sexual orientation. We continue to promote data completeness throughout 2020/21 with a rolling programme of focused data quality discussions aimed at supporting staff in using CareDirector well. Our latest DQMI (Data Quality Maturity Index) score for Mental Health Services data, published by NHS Digital, is 86.9% (as at Oct 2020).

Patient Experience

S136: There were 6 Section 136 breaches in December, 5 working age adults and 1 CAMHS and all down to lack of bed availability.
Complaints: In December there were 7 complaints received, 100% acknowledged within the 3 days standard, 86% allocated an investigator within 3 days (6 out of 7), and 100% completed within agreed timescales. There were 74 enquiries received by the PALS team in December.
Friends and Family Test: No friends and family surveys were submitted to Quality Health for December. We have started to roll out the new 'Have Your Say' Trustwide feedback measure. This is being introduced to make sure our service users and carers can have their voices heard and includes the mandatory Friends and Family Test (FFT) question, which asks service users to rate their overall experience of their care. It will also ask what has been good about a person's care and whether there are any areas for improvement. Feedback can be given in a number of ways – by completing a pre-paid postcard, via online survey, by scanning a QR code with a mobile phone, or by feeding back over the telephone or via email.

Safety

Incidents: In December the number of incidents, including those for violence/aggression, self harm and use of restraint remain within expected levels of normal variation.
Medication: In Q3 there were 150 medication related incidents, 94% 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. 41% of reported medication incidents in Q3 were related to administration of medication. A theme identified in Q3 is medication incidents as a result of poor communication of medication and medication administration across interfaces within our organisation, with primary care and LTHT. The committee are reassured to hear that work has begun within the organisation to develop an improved electronic discharge advice note. Whilst this is being developed, the committee are looking to develop and implement guidelines on completing current discharge advice notes. These guidelines will pull together learning from incidents and recent audits in this area. In addition to this work, the committee have asked for medication to be included in a wider piece of work currently being undertaken with LTHT to look at sharing of information. This will cover when service users are transferred between the two hospitals. The committee will continue to monitor, contribute and receive updates on ongoing work to address these and other challenges that arise across the interface.
Safeguarding: In Q3 60 advice calls handled by the Safeguarding Team were child related, of which 8 (13%) resulted in a referral to social care. 221 advice calls related to adults, of which 50 (23%) resulted in a referral to social care. At Q3 95,7% of staff are trained in Prevent Level 3 (Target 85%). The number of calls for adult advice have remained at a quarterly average for Q2 and Q3. Patterns of abuse roughly reflect national and previous LYPFT data with physical, psychological and financial abuse being significant for our service users. Calls for advice on domestic abuse and violence remain relatively high. The acute care pathway remains the highest source of concerns. Referral to adult social care for safeguarding remains at between 10 – 20%. This quarter the numbers of calls for child advice have fallen to quarter average (50) after being sustained at a relatively high number for the previous few quarters. Referral to children's social care has fallen slightly and is between 10 – 20%. Reports of neglect have reduced slightly from Q2 and emotional and physical abuse remained consistent. As with the adult data, the amount of advice in relation to Domestic Abuse and Violence has remained proportionally high.

Local intelligence

PREVIOUS MONTH: DECEMBER (continued)

Workforce

Staff Wellbeing Assurance / Appraisals: In December 53.8% of staff had received an appraisal in the last 12 months. At the end of the month 82% of staff had received a wellbeing assessment through our Staff Wellbeing Framework which has been developed in response to the emerging risk factors identified for Covid-19. Knowing what support our staff need now and beyond the pandemic is critical. Wellbeing conversations should take place every 6 months as a minimum and be reviewed on an ongoing basis via supervision, 1-1's to capture any change in circumstances, considering staff members' feelings regarding safety, skills development and mental health and wellbeing.

Mandatory Training: Against an 85% target compliance in December was 84.9% as we continue to work towards a return to the mandated periods and ensuring all staff have completed the compulsory training required for their roles. The Trust is offering a development programme for BAME staff who are ready to take the next step in their leadership management journey within the next 12 – 18 months. The programme is delivered as part of the Trust leadership development offer and is designed to develop understanding of key leadership and management principles and practice.

Clinical Supervision: There has been a further fall in the percentage of staff receiving clinical supervision, down to 58.8% in December (target 85%). With the high levels of acuity and service user distress due to the impact of the pandemic it is vital that staff who provide clinical care also take time to look after themselves and their service users by using their clinical supervision sessions. In December 2020 Dr Joubert, Consultant Clinical Psychologist has taken the lead on reviewing how Clinical Supervision is conducted and reported in the organisation and is liaising with Workforce Information leads to support the Trust achieving its targets. As part of the review recent comms have re-iterated the importance and the different ways of completing clinical supervision e.g. via more agile methods such as Zoom and MS Teams to connect with supervisors and at the time of writing the Trust is currently reporting 66% compliance with Clinical Supervision.

Sickness Absence: The rolling 12 months sickness absence figure is 5.1% and the in-month sickness absence rate in December was 4.9% and remains within levels of normal variation. In December 917 staff days were lost to Covid-19 related absences through sickness or isolation, down from 2,529 in November.

Vacancies: Trustwide the percentage of vacant posts has fallen, however this can be explained by a catch up on some historical data and will return to a higher number next month. Via a National HSW programme, NHSE/I have provided funding to accelerate our Healthcare Support Worker (HSW) recruitment to help address the ongoing challenges of COVID-19 and winter pressures. The funding aims to support Trusts to get to zero vacancies, or as close as possible, by March 2021 and support increased HSW workforce demand. LYPFT have worked with services to support the adjustment to our establishment to now include 12 x Apprenticeship HCSW roles which didn't previously exist (adjusted from B3 establishment), this is a positive step change in our recruiting externally to these posts, allowing us to attract an untapped workforce of those with no prior healthcare experience but with transferable skills. As part of this programme we have partnered with Indeed to promote a career webinar, sharing and promoting our Apprentice HSW and HSW vacancies. The webinar yielded over 400 RSVP's and saw 93 prospective candidates in attendance on the day. We are currently managing the applications and will look to run recruitment days to offer interviews to these candidates, hoping to make job offers with a start date in March 2021.

Coronavirus: Since the rollout of the vaccination programme we have vaccinated over 2,670 members of our staff through our Hub at The Mount or at the Thackray Centre. In line with guidance set out by the UK government, we are aiming to vaccinate as many of our staff as we can before the end of January. We are prioritising and targeting staff who are patient or public facing or by the nature of their work need to be on site, but we want to everyone to come forward because we do not want to waste any vaccine or the time of the vaccination team.
Latest staff vaccination figures (as at 3:30pm on 31st January) report that 77.8% of LYPFT staff (2,672) had been vaccinated including bank, Interserve and some of our front line third sector partners. 78% (49 of 63) 'clinically extremely vulnerable' staff had received their first dose and 29% (18) their second dose. 64% of staff (1,594) in patient facing roles had received their first dose of the vaccine, compared to 62% (578) of non patient facing staff. We are actively encouraging staff in services with lower numbers to get themselves booked in. Our focus is on identifying what active steps we can take to improve access to our BAME staff, encourage the continued reporting from staff who have been vaccinated in PCN's or by GP's, and planning capacity and demand to inform our vaccination programme group. We have 1,600 service users who are over 80 on our caseload and reassurance will be sought on whether these people have been vaccinated through PCN's. We all have a really important role to play to be supportive colleagues by promoting vaccine confidence, addressing myths and debunking fake news.

Local intelligence

CURRENT MONTH: JANUARY

Clinical Record Keeping

Data Quality Maturity Index: Our teams continue to support staff in regaining expected standards of data quality and further support and training on our CareDirector EPR system. As at January 76.9% of care records had ethnicity recorded and 21.5% sexual orientation. We continue to promote data completeness throughout 2020/21 with a rolling programme of focused data quality discussions aimed at supporting staff in using CareDirector well. Our latest DQMI (Data Quality Maturity Index) score for Mental Health Services data, published by NHS Digital, is 86.8% (as at Nov 2020). Engagement with services around CareDirector dashboards continues via a number of meetings focused on improving recording of key information such as appointment outcomes. A new dashboard has been published focusing on inpatient admissions and the recording of physical health monitoring measurements (blood pressure, blood glucose, cholesterol, smoking status, alcohol consumption, substance use and nutrition). The dashboard shows details of people who have been admitted without these details correctly recorded and therefore will assist reported KPI performance and improve the accuracy of the clinical record.

Patient Experience

Complaints: 10 complaints were received in January, all acknowledged within the 3 working days standard. 100% of complaints were allocated an investigator within 3 working days, and 100% completed within the timescales agreed with complainants. The PALS team received 81 enquiries in January.
Friends and Family Test: There were no friends and family surveys submitted to Quality Health in January. The new 'Have Your Say' Trustwide feedback measure, being introduced to make sure our service users and carers can have their voices heard, includes the mandatory Friends and Family Test (FFT) question which asks service users to rate their overall experience of their care. Recent Covid outbreaks have meant some restrictions with the Patient Experience unable to physically visit the involved teams to deliver the feedback materials. The pilot teams involved (PICU, Becklin Ward 3, R&R Services and Learning Disabilities), as well as a second phase of teams, are equipped to collect feedback from March onwards.
S136: In January there were 8 Section 136 24 hour breaches, all working age adults with 5 due to lack of bed availability, 2 availability of an AMHP and 1 because of the availability of a doctor.

Safety

Incidents: In January the total number of incidents, including falls, self-harm and restrictive interventions, remained within levels of normal variation. In total there were 1,018 incidents recorded, of which 254 were restrictive interventions, 101 self-harm, and 67 were falls. The number of violent or aggressive incidents in January was 137, one point out of the statistical process upper limit. Following discussions with our Professional Practice Lead we have re-developed the restraints data reported to reflect the number of physical restraints only, to be consistent with contractual returns. The measure also now excludes Datix records flagged as not being the record of restrictive practice (i.e. another Datix record having been recorded for this information). Quality indicators reporting the percentage of people detained on admission to Adult Acute/PICU, and the percentage of occupied bed days detained, have been redeveloped and data refreshed retrospectively to allow reporting of the 13 month trends.

Workforce

Appraisals: Appraisal rates continue to hold steady at 58.5% in January. Since the launch of the wellbeing assessment in the summer of 2020 2,634 initial conversations have taken place, demonstrating our commitment to making the wellbeing of our staff a priority in these very challenging times. Continuing to review the wellbeing of our staff is important and we are recommending that this review takes place in regular 1-1/supervision meetings and a review of the wellbeing assessment form takes place 6 monthly. At the end of January 82% of staff had received a recent wellbeing assessment through our Staff Wellbeing Framework.
Mandatory Training: Compliance in January was 84.9%. The Trust continues to make positive decisions to prioritise the redeployed staff who will support our service users and to have the necessary skills to do so.
Clinical Supervision: Clinical supervision rates continue to fluctuate and are the subject of partnership discussions, led by our new Clinical Directors, to review how Clinical Supervision is conducted and reported in the organisation. In January 65.8% of eligible staff received a clinical supervision.
Sickness Absence: The In-month sickness absence rate remains within levels of normal variation at 5.3%. The rolling 12 month average as at January is 5.1%. 2,446 staff days were lost to Covid-19 related absences through sickness or isolation, more than double the 917 reported during the previous month.
Vacancies: Trustwide the percentage of vacant posts is 9.6%.
Coronavirus: Our inpatient wards are currently experiencing extreme pressure due to COVID-19 outbreaks and being short-staffed. As a result, some of our services have moved into business continuity mode. There is a lot of work going on internally and externally to maintain safe staffing within our identified higher risk services to address COVID-19 related pressures. Following a call for mutual aid from partner organisations we've received an offer of social care agency support workers to come into our older people's wards, and we have also secured six third year students from York University to work in band 4 nurse associate roles.
The Prime Minister has set out a four-step roadmap to cautiously ease lockdown restrictions with schools and colleges reopening from the 8th March, and further subsequent lifting of the rules if certain conditions are met. Public Health England have also confirmed that everyone on the GP learning disability register will be invited for vaccination as part of priority group six, regardless of how severe their disability is. While these developments give us cause for optimism we continue with our efforts to protect our staff, our patients and the public at a time when Covid pressures continue. Latest staff vaccination figures (as at 25th Feb) report that 84.5% of LYPFT staff (2,969) had been vaccinated (first dose). 81% of 'clinically extremely vulnerable' staff had received their first dose and 30% their second dose. 75% of staff in patient facing roles had received their first dose of the vaccine, compared to 73% of non-patient facing staff.

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
12

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Safer staffing
DATE OF MEETING:	25 March 2021
PRESENTED BY: (name and title)	Cathy Woffendin, Director of Nursing, Professions and Quality and Director of Infection Prevention
PREPARED BY: (name and title)	Linda Rose, Head of Nursing and Patient Experience Adele Sowden, E-Rostering Team Manager

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

EXECUTIVE SUMMARY

Leeds and York Partnership NHS Foundation Trust (LYPFT) provides inpatient care across 26 wards.

This report is the second Board of Directors bi monthly update since it was stepped down in March 2020 as a consequence of the covid-19 pandemic. The reporting requirements were reinstated late last year and are a requirement of the National Quality Board (NQB). This paper is in addition to the more detailed 6 monthly staffing report which was presented to board members in January 2021.

We continue to work in changing times, responding to the challenges of covid-19 in addition to the emerging picture that our some of our service users are experiencing acute breakdowns of their mental health due to the long term impact of covid from a health and social care perspective. This report highlights the planning and coordination arrangements in place to ensure that we maintain safe service delivery and resilience as far as possible into our future plans.

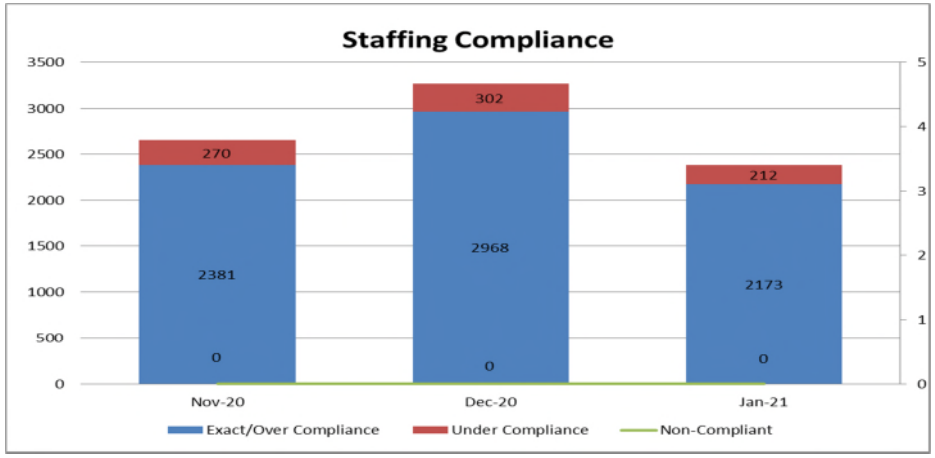
This report covers the period of the 1st December 2020 to the 31st January 2021.

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

Safer Staffing: Inpatient Services – December 2020 and January 2021



	Number of Shifts		
	November	December	January
Exact/Over Compliance	2381	2968	2173
Under Compliance	270	302	212
Non-Compliant	0	0	0

Risks:

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

Mitigating Factors:

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

Narrative on Data Extracts Regarding LYPFT Staffing Levels on 26 wards during December 2020 and January 2021:

Exact or Over Compliant shifts:

During December 2020 there was an increase in the number of shifts meeting the exact / over compliance planned staffing numbers for Registered nurses (RN's) and Health Support Workers (HSW's). During January 2021 this figure decreased.

Under Compliant Shifts:

During December there were 302 shifts that had fewer than the planned number of RN and HSW staff on each shift (this differs from the unify reports in Appendix A and B which show the total hours over the month rather than on a shift by shift basis). During January this number decreased to 212 shifts.

Non-Compliant Shifts:

This metric represents the number of shifts where no Registered Nurses were on duty. This metric was not breached in December 2020 or January 2021.

As with the national picture the challenge continues in relation to filling current RN vacancies and this is further impacted upon by long term sickness, covid related absence, including isolating and shielding staff. The inpatient services report high care activity, with some patients requiring 2:1 nursing observations to maintain safe levels of effective patient centred care. In some instances this was because a low stimulus environment (PICU) was needed but availability of PICU beds was minimal. This also accounts for the use of higher numbers of staff than originally planned for.

During this period the number of shifts required for safe staffing has decreased by 27% from the previous month where an exceptional number of shifts were required. The change may be a reflection of the closure of a number of wards to admissions due to a number of covid-19 outbreaks across the organisation.

Exception reports

- **The Acute inpatient services** continue to report the impact of vacancies as one of the contributory reasons for staff unavailability. This includes x 12.0 wte Band 5 RN's and 2.0wte Ward managers across the service. The service has a rolling recruitment programme to recruit to Band 5's and a review of the workforce is proposed as part of the Acute Stabilisation Programme. The Ward Manager has been advertised and interviews will be held by the end of March.
- **The CAU** had been operating as a covid positive cohort area.
- **The Mount** reported increased activity related to providing support to isolating patients on Wards 1 & 2 in addition to a number of staff members being off due to either returning to shielding or due to Covid-19. The vacancies for RNs across all 4 Wards have been supported by redeployed staff and this enabled substantive staff members to staff the cohort area on AECU at this time.

•CAMHS – RN unavailability in this unit is due to a combination of maternity leave and vacant posts. The service has successfully recruited an RN whom will start in January and further posts will go out to re-advert. The service has also had a number of young people requiring nasogastric feeding in excess of the numbers the service would usually manage. In addition, due to a national shortage of CAMHs PICU beds (for 5 days), Mill Lodge staff provided care for a young person within the seclusion area of Clifton house, in line with agreed practice.

Updates:

- Four Nursing associates qualified on ward 1 Mount, ward 5 Becklin, ward 6 Newsam and community LD with x12 due to start training in February 2021 across key priority inpatient areas including CRISS and York services. The NAs are in the process of waiting for the invitation to apply for their pins from the NMC having successfully completed the course before being able to work as registered staff.

- 48 third year students have now chosen their preferences for the service areas where they wish to work upon qualifying. Career conversations are now in progress to keep the students engaged.

Conclusion:

The data in the Unify submissions identify x11 wards (42%) as areas requiring further enquiry and this has been explored in the exception reports above and through discussion in the Safer staffing steering group, where a combination of reasons affecting the capacity of services to sufficiently staff the areas with Registered nurses has been described.

January was a particularly challenging time as there were a number of outbreaks across the organisation including The Mount, The Becklin Centre, Ward 3 Newsam, CRISS, 5 Newsam and NICPM. This later evolved into an extraordinary and exceptional measure being taken as a very last resort in February to create female capacity in the system by opening temporary female beds on Ward 4 Newsam Centre. This was robustly risk assessed as the safest option available to the service with increased staffing put in place to support any safety issues, alongside the use of a separate corridor with no access/egress from and the main ward using Digi locks to ensure patient safety. This was managed for a very short period and the CQC were advised.

As the pandemic progresses, for the first time in a number of months there are currently no covid positive patients on the inpatient wards and redeployed staff are being pulled back to their substantive posts.

Whilst the assurance measures remain in place to monitor and mitigate nurse and health support worker staffing shortfalls across the Trust on a daily basis for the 24-hour period ahead; Matrons have described the significant challenges experienced in managing deployment and redeployment to ensure that patient safety and staff wellbeing has been maintained.

A recovery plan for stabilising services is now being progressed and work will focus within services to look at flow and service mapping. This is being done with help from the clinical effectiveness and continuous improvement teams to identify what the services and teams need. The aim is to get the wards back to operating closer to their core establishments and this work will include looking for any linkages with incidents, observations and lack of activity for service users.

APPENDIX A

Safer Staffing: Inpatient Services – December 2020

Fill rate indicator return

Staffing: Nursing, Care Staff and AHPs

		Care Hours Per Patient Day (CHPPD)							Day				Night				Allied Health Professionals	
Ward name	Cumulative count over the month of patients at 23:59 each day	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Registered Nursing Associates	Non-registered Nursing Associates	Registered allied health professionals	Non-registered allied health professionals	Overall	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - registered allied health professionals (AHP) (%)	Average fill rate - non-registered allied health professionals (AHP) (%)
2 Woodland Square	53	12.4	11.1	0.0	0.0	0.0	0.0	23.5	116%	57%	-	-	100%	58%	-	-	-	-
3 Woodland Square	67	12.4	20.2	0.0	2.9	0.0	0.0	35.5	99%	126%	-	100%	100%	174%	-	-	-	-
Asket Croft	405	2.6	3.1	0.0	0.0	0.9	0.0	6.6	115%	58%	-	-	100%	105%	-	-	100%	-
Asket House	463	1.7	2.3	0.0	0.0	0.4	0.0	4.4	97%	81%	-	-	100%	127%	-	-	100%	-
Becklin CAU	2	687.3	1481.3	40.3	0.0	275.5	0.0	2484.4	65%	141%	100%	-	72%	154%	100%	-	100%	-
Becklin Ward 1	690	2.3	5.3	0.0	0.0	0.2	0.2	8.1	69%	186%	-	-	95%	247%	-	-	100%	100%
Becklin Ward 3	640	2.7	3.1	0.2	0.0	0.2	0.2	6.5	77%	117%	100%	-	100%	164%	100%	-	100%	100%
Becklin Ward 4	633	2.6	4.0	0.0	0.0	0.3	0.3	7.1	73%	149%	-	-	100%	171%	-	-	100%	100%
Becklin Ward 5	683	2.4	4.4	0.0	0.0	0.3	0.2	7.4	78%	170%	-	-	98%	179%	-	-	100%	100%
Mother and Baby at Parkside Lodge	200	7.6	10.8	0.5	0.0	0.3	0.0	19.2	88%	111%	100%	-	65%	137%	100%	-	100%	-
Newsam Ward 1 PICU	297	5.5	15.0	0.0	0.0	0.3	0.4	21.2	75%	127%	-	-	95%	187%	-	-	100%	100%
Newsam Ward 2 Forensic	352	3.4	8.5	0.0	0.0	0.1	0.3	12.3	99%	173%	-	-	104%	210%	-	-	100%	100%
Newsam Ward 2 Womens Services	253	4.7	12.3	0.0	0.0	0.7	0.0	17.7	91%	183%	-	-	107%	222%	-	-	100%	-
Newsam Ward 3	293	4.2	4.7	0.0	0.0	0.6	0.4	9.9	92%	82%	-	-	117%	95%	-	-	100%	100%
Newsam Ward 4	515	3.3	6.0	0.0	0.0	0.4	0.2	9.9	80%	191%	-	-	98%	223%	-	-	100%	100%
Newsam Ward 5	549	2.9	3.5	0.0	0.0	0.4	0.2	6.9	104%	88%	-	-	100%	100%	-	-	100%	100%
Newsam Ward 6 EDU	291	4.8	10.1	0.0	0.0	1.0	0.0	15.9	103%	190%	-	-	133%	178%	-	-	100%	-
NICPM LGI	170	8.0	2.9	0.0	0.0	1.3	0.0	12.2	82%	81%	-	-	98%	100%	-	-	100%	-
The Mount Ward 1 New (Male)	359	4.6	10.0	0.0	0.0	0.4	0.3	15.4	131%	121%	-	-	98%	161%	-	-	100%	100%
The Mount Ward 2 New (Female)	10	118.8	614.1	17.5	0.0	25.5	0.0	775.9	93%	192%	100%	-	106%	297%	100%	-	100%	-
The Mount Ward 3a	292	3.8	9.3	0.4	0.0	0.3	0.3	14.2	85%	120%	100%	-	100%	189%	100%	-	100%	100%
The Mount Ward 4a	653	2.1	4.5	0.0	0.0	0.3	0.1	7.1	110%	119%	-	-	100%	194%	-	-	100%	100%
York - Bluebell	673	1.8	3.0	0.2	0.0	0.2	0.2	5.4	96%	105%	100%	-	115%	148%	-	-	100%	100%
York - Mill Lodge	310	5.8	7.5	0.0	0.0	2.6	0.7	16.5	80%	105%	-	-	92%	124%	-	-	100%	100%
York - Riverfields	264	3.7	4.9	0.0	0.0	0.3	0.2	9.2	137%	97%	-	-	106%	142%	-	-	100%	100%
York - Westerdale	310	4.3	7.5	0.0	0.0	0.3	0.5	12.6	63%	111%	-	-	103%	113%	-	-	100%	100%

APPENDIX B

Safer Staffing: Inpatient Services – January 2021

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

Ward name	Cumulative count over the month of patients at 23:59 each day	Care Hours Per Patient Day (CHPPD)							Day				Night				Allied Health Professionals	
		Registered Nurses/Midwives	Non-registered Nurses/Midwives	Registered Nursing Associates	Non-registered Nursing Associates	Registered allied health professionals	Non-registered allied health professionals	Overall	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - registered allied health professionals (AHP) (%)	Average fill rate - non-registered allied health professionals (AHP) (%)
2 Woodland Square	47	13.9	12.7	0.0	0.0	0.0	0.0	26.6	111%	85%	-	-	112%	106%	-	-	-	-
3 Woodland Square	64	11.3	24.8	0.0	3.0	0.0	0.0	39.1	62%	133%	-	100%	100%	220%	-	-	-	-
Asket Croft	383	2.6	3.3	0.0	0.0	0.7	0.0	6.6	111%	68%	-	-	100%	100%	-	-	100%	-
Asket House	429	2.0	1.9	0.0	0.0	0.7	0.0	4.7	115%	65%	-	-	107%	111%	-	-	100%	-
Becklin CAU	72	17.3	43.0	2.2	0.0	6.3	0.0	68.7	94%	141%	100%	-	84%	189%	100%	-	100%	-
Becklin Ward 1	663	2.4	6.4	0.0	0.0	0.3	0.2	9.3	71%	200%	-	-	95%	337%	-	-	100%	100%
Becklin Ward 3	638	2.6	3.6	0.2	0.0	0.2	0.2	6.8	78%	133%	100%	-	98%	210%	100%	-	100%	100%
Becklin Ward 4	613	2.5	5.5	0.0	0.0	0.4	0.2	8.7	75%	188%	-	-	97%	265%	-	-	100%	100%
Becklin Ward 5	625	2.6	5.0	0.0	0.0	0.5	0.2	8.3	84%	156%	-	-	99%	225%	-	-	100%	100%
Mother and Baby at Parkside Lodge	209	7.5	8.6	0.6	0.0	0.5	0.0	17.2	88%	111%	100%	-	79%	120%	100%	-	100%	-
Newsam Ward 1 PICU	336	4.5	10.8	0.0	0.0	0.4	0.3	16.0	72%	113%	-	-	91%	144%	-	-	100%	100%
Newsam Ward 2 Forensic	354	3.2	7.7	0.0	0.0	0.0	0.3	11.2	92%	165%	-	-	100%	209%	-	-	-	100%
Newsam Ward 2 Womens Services	202	5.4	9.3	0.0	0.0	1.0	0.0	15.7	88%	99%	-	-	104%	155%	-	-	100%	-
Newsam Ward 3	270	4.0	5.4	0.0	0.0	0.6	0.4	10.5	82%	97%	-	-	113%	106%	-	-	100%	100%
Newsam Ward 4	403	4.0	6.1	0.0	0.0	0.4	0.0	10.6	78%	155%	-	-	97%	186%	-	-	100%	100%
Newsam Ward 5	523	2.8	3.5	0.0	0.0	0.5	0.2	7.1	101%	87%	-	-	100%	105%	-	-	100%	100%
Newsam Ward 6 EDU	179	7.8	18.2	0.0	0.0	1.9	0.0	27.9	117%	197%	-	-	113%	237%	-	-	100%	-
NICPM LGI	178	7.2	2.6	0.0	0.0	1.2	0.0	11.0	86%	84%	-	-	100%	100%	-	-	100%	-
The Mount Ward 1 New (Male)	295	4.3	11.6	0.0	0.0	0.0	0.0	15.9	111%	121%	-	-	80%	176%	-	-	-	-
The Mount Ward 2 New (Female)	302	4.4	20.0	0.4	0.0	0.0	0.0	24.8	113%	191%	100%	-	94%	299%	-	-	-	-
The Mount Ward 3a	584	2.0	4.3	0.1	0.1	0.0	0.0	6.5	92%	107%	100%	100%	107%	193%	100%	-	-	-
The Mount Ward 4a	687	1.5	4.4	0.0	0.0	0.0	0.0	6.0	82%	147%	-	-	99%	183%	-	-	-	-
York - Bluebell	284	3.9	7.7	0.0	0.0	0.6	0.4	12.6	89%	140%	-	-	103%	147%	-	-	100%	100%
York - Mill Lodge	204	8.5	10.8	0.0	0.0	3.9	0.9	24.0	87%	109%	-	-	90%	112%	-	-	100%	100%
York - Riverfields	300	3.0	3.5	0.0	0.0	0.5	0.1	7.0	127%	93%	-	-	102%	100%	-	-	100%	100%
York - Westerdale	266	4.4	9.5	0.0	0.0	0.5	0.5	14.8	60%	127%	-	-	100%	128%	-	-	100%	100%

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
13

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Medical Director's Report
DATE OF MEETING:	25 March 2021
PRESENTED BY: (name and title)	Chris Hosker, Medical Director
PREPARED BY: (name and title)	Jane Riley, Chief Pharmacist

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

EXECUTIVE SUMMARY

This paper gives an overview of the work taking place or being led by the Medical Directorate in relation to pharmacy and medicines management. It covers

- Service Delivery
- Workforce
- Other key areas of work

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

RECOMMENDATION

The Board are asked to consider the information provided and discuss the content further if needed to gain assurance of the work taking place to support patients and staff.

MEETING OF THE BOARD OF DIRECTORS

25 March 2021

MEDICAL DIRECTORS REPORT

1. Executive Summary

This paper gives an overview of the work taking place or being led by the Medical Directorate in relation to pharmacy and medicines management.

2. Overview

2.1 Service Delivery

i. A rapid and intensive review of medicines management procedures was completed to be able to provide medicines information and advice to support the safe and effective use of medicines during the pandemic. Challenges posed by the pandemic were minimising the pressure on the medicines supply chain, reducing the risk of infection spread, maintaining supply of medication to service users during lockdown.

ii. Medicines management guidance for caring for covid patients in a mental health setting was made available covering general symptomatic treatment, specific guidance for lithium, clozapine, depot antipsychotics, administration of medicines via Nebulisers, oxygen prescribing and palliative care.

iii. The interim premises improvement work planned to ensure existing pharmacy work bases were fit for purpose has not been able to take place due to the covid pandemic. The pandemic and the need for social distancing when at work have created new work patterns that will inform revision of improvement work needed. A single dispensary remains the service's longer term plan.

iv. Pharmacy staff had started to work in a more agile way to support efficiency and staff well-being as well as demand for working space within the existing pharmacy premises. The pandemic has accelerated how the service can be maintained with minimal staff on site. Pharmacy staff now all have smart phones and laptops. Software purchased to support financial analysis of drug spends and transfer of information to community pharmacists.

v. A new Chief Pharmacy Technician has been appointed and oversees the medicines supply services day to day operational support for medicines management to Care Services. This post along with the appointment of a team administrator is creating the capacity for the registered pharmacy workforce to be more accessible to patients/ carers.

vi. In order to meet the business continuity demands of the pandemic the development work planned has not progressed. However in adapting to the pandemic there has been learning which will inform future service delivery. This learning has been captured in the Covid evaluation.

2.2 Workforce

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

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

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

iv. Nationally and locally there are work streams to address the above and an increase in the number of cross-sector training and working opportunities. A business case has been submitted for a consultant MH pharmacist to work across the city. The funding that was available means it may be a part-time role. Health Education England is funding a work stream to improve the management of mental health medicines in the acute setting as part of a West Yorkshire ICS initiative.

v. A Senior Pharmacist was accepted onto the BAME Fellowship Programme and is completing the Senior Placement development programme aimed at experienced leaders who are looking to bridge practical experience gaps coupled with strategic board level, system leadership development that has been a barrier to career progression. It involves a substantial time out of the service, in the first six months of the 12-month programme; two days a week are spent on a system project and then the remaining six months in a senior placement gaining practical senior experience.

vi. Recruitment and retention is challenging given the new opportunities available to pharmacists creating vacancies or long term cover needs in addition to known maternity leave and increased service demands to support vaccination clinics, various service developments such as IHTT, ASPIRE, CREST team. A flexible approach is being taken to recruitment so that appointments made to posts that may need staffing establishment to be flexed between bandings.

2.2 Other Key Areas of Work

i. Pharmacists have been integral to mobilising the vaccination programme within the Trust and in the city. They have produced standard operating procedures in relation to safe storage and use of the vaccine as well as being available to provided expert advice queries arising from information on consent forms.

ii. Re-establishing a multidisciplinary team and governance structure for the Electronic Prescribing and Medicines Administration (EPMA) system has meant that the long standing risk relating to online back up for the printer functionality has progressed. The options appraisal and recommendation was agreed by the group and signed off by the Information Management Steering group. A software upgrade to EPMA in December and monitoring presented to the group has confirmed the duplication issues are resolved.

3. Conclusion

The pharmacy staff have supported services to maintain day to day care for our service users as well as meeting the challenges for professional advice and resources to meet the new care needs created by the covid pandemic. The acknowledgement of their contribution by being awarded Team of the Month in December was very much appreciated by the pharmacy staff.

4. Recommendation

The Board are asked to consider the information provided and discuss the content further if needed to gain assurance of the work taking place to support patients and staff.

Dr Chris Hosker
Medical Director
15 March 2021

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
14

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Guardian of Safe Working Quarterly Report Quarter 1 October 2020 to 31 December 2020
DATE OF MEETING:	25 March 2021
PRESENTED BY: (name and title)	Dr Chris Hosker, Medical Director
PREPARED BY: (name and title)	Dr Ben Alderson, Guardian of Safe Working Hours

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

EXECUTIVE SUMMARY

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

- There have been 31 exception reports
- There have been 3 patient safety issues recorded, but on exploration these were incorrectly labelled on the Allocate software
- Junior doctors forum met in January 2021 and there were no urgent concerns raised

In summary, exception reporting (ER) is now established in the Trust. We continue to work with the junior doctors and clinical supervisors to ensure that we are developing a culture where ERs are positively received and used as a mechanism to effect change.

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

RECOMMENDATION

The Board of Directors are asked:

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

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

MEETING OF THE BOARD OF DIRECTORS

DATE

Guardian of Safe Working Hours Report

Quarter 3 October – December 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 01.09.2020 to 31.12.2020.

2 Quarter 2 Overview

Vacancies		There are 3 vacancies in the Core Trainee establishment which are covered by trust doctors (1 employed, 2 agency).					
		There are 7 vacancies in the Higher Trainee establishment.					
Rota Gaps		October		November		December	
		CT	HT	CT	HT	CT	HT
	Gaps	28	21	36	36	22	27
	Internal Cover	22	20	31	31	21	26
	Agency cover	2	0	2	2	0	1
	Unfilled	4	1	3	3	1	0
Fill Rate		86%	95%	92%	92%	95%	100%
Exception reports (ER)		3	0	6	0	22	0
		There were 31 ERs raised during this reporting period. 3 were identified as mediate patient safety concern. On review, 1 of these related to core working hours ward staffing and on exploration did not meet the threshold for a patient safety incident. The other 2 ERs related to the same on-call shift where there was 1 less CT on the rota from 9am-4pm. There were no patient safety incidents as the medical on-call tier was made aware of this deficit through pro-active discussion by the CT doctors on the shift. There were 22 recorded ERs in December. This is a					

	significant outlier in the reporting process. I have spoken to the Dr who made 16 of these ERs. They related to work pressures on the base ward during core working hours. The ERs were all recorded on the Allocate system during a short time frame but reflected a difficulty which had been present over months. The Dr had been supported to record the overtime that was being worked through ER in order to better identify the pressures and provide solutions. The result has been a new non-training grade Doctor appointment to that ward to improve working conditions and ensure there are no concerns with regards patient safety due to training grade Doctors working outside their contracted hours. The Doctor in question was satisfied with TOIL as a solution to the overtime worked and was pleased to learn of the alteration to medical staffing levels that has resulted.
Fines	None
Patient Safety Issues	None
Junior Doctor Forum (JDF)	Meeting held in January 2021. Items of note were: • There had been a recent national lockdown announcement and it was anticipated this would affect the LYPFT workforce. Trainees were encouraged to use ER as a method of raising concerns if workload pressures were increasing due to rising rates of COVID. • The Child and Adolescent Mental Health Service (CAMHS) unit at St Mary' Hospital will be a standing agenda item for the JDF, The training grade doctors are currently undertaking review of CAMHS workloads on the PROC rota. • It was further recognised that the junior doctors had worked with great 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 since 2016 with the first ER being made in 2017. We continue to work with the junior doctors and clinical supervisors to ensure that we are developing a culture where ERs are positively received and used as a mechanism to effect change.

4 Recommendations

The Board of Directors are asked:

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

Dr John Benjamin Alderson
GMC 6166755
Guardian of Safe Working Hours

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:	2020 NHS Staff Survey and Bank Staff Survey
DATE OF MEETING:	25 March 2021
PRESENTED BY: (name and title)	Claire Holmes Director of Workforce and Organisational Development
PREPARED BY: (name and title)	Lucy Heffron Engagement & OD Practitioner

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

EXECUTIVE SUMMARY

This paper provides the Board of Directors with a summary of the results and outcomes of the 2020 Staff Survey. The paper looks at how the Trusts results compare to the 2019 results and highlights any emerging themes on where we have made improvements or seen deterioration. The results are broken down into 10 Key Themes.

For the second year in a row we also opted to survey our Bank Staff. The report contains the results of this Bank Staff survey and makes comparisons between the 2019 Bank Staff Survey results, as well as the results of the survey to our substantive staff.

The results for 2020 are broken down into 10 Key Themes. Our scores improved for four of the Key Themes compared to the 2019 scores. The scores for five Key Themes remained static and one Key Theme (Team Working) has declined from 2019. At question level, the results show that we have improved or remained static in 79% of the questions with comparable data from 2019.

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

RECOMMENDATION

The Board of Directors is asked to receive and note the outcome of the 2020 National Staff Survey results.

MEETING OF THE PUBLIC BOARD OF DIRECTORS

25 March 2021

2020 NHS Staff Survey and Bank Staff Survey Results

1 Executive Summary

This paper provides the Board of Directors with a summary of the results and outcomes of the 2020 Staff Survey. The paper looks at how the Trusts results compare to the 2019 results and highlights any emerging themes on where we have made improvements or seen deterioration. The results are broken down into 10 Key Themes.

For the second year in a row we also opted to survey our Bank Staff. The report contains the results of this Bank Staff survey and makes comparisons between the 2019 Bank Staff Survey results, as well as the results of the survey to our substantive staff.

The results for 2020 are broken down into 10 Key Themes. Our scores improved for four of the Key Themes compared to the 2019 scores. The scores for five Key Themes remained static and one Key Theme (Team Working) has declined from 2019. At question level, the results show that we have improved or remained static in 79% of the questions with comparable data from 2019.

2 Introduction

The purpose of this report is to provide a summary of the key outcomes of the 2020 survey results provided by Quality Health (QH) for the Leeds and York Partnership NHS Foundation Trust (LYPFT).

We will be reporting on the 2020 NHS Staff Survey Results for substantive staff as well as the results from our 2020 Bespoke Bank Staff Survey, conducted for the second year. The majority of questions are the same in both surveys to allow us to make comparisons across staff groups.

For the NHS Co-ordination Centre to make reasonable comparisons between organisations and to account for Trust size when calculating national results, the NHS Staff Survey data is weighted and the results in this report are from that 'weighted data'. However our bespoke Bank Staff Survey is not submitted into the NHS Co-ordination Centre, so the data we report on for these results will be "unweighted" or "raw" data.

For 2020 the NHS Co-ordination Centre largely used pre-existing Staff Survey questions to match the previous Key Themes. Utilising pre-existing questions allows us to access historical data and compare our progress. However, the Key Theme on 'Quality of Appraisals' is not included this year as all appraisal related questions were removed after appraisals were stood down for the majority of 2020.

The official NHS Staff Survey result reports were made public on 11 March 2021 when NHS England published the reports for all Trusts in England. All result data was under embargo until 9:30am on this date.

Following the national publication date, our NHS Staff Survey full results are available on Cognos for any of our staff to access. This was implemented in 2018 and we are continuing to provide full transparency of our results at Trust, service and team level data. This year the availability of breakdown options has increased to allow staff to also look at the Staff Survey data by Staff Group and by Ethnicity. A further breakdown of the Trust results in respect of Ethnicity and Staff Group will be presented by Quality Health.

The Bank Staff Survey Results are with the Bank Workforce Managers for onward discussion and action planning with our Bank Workforce via the Banking Forum. Data from both surveys were presented to the Board of Directors 25 February 2021.

3 Background

The 2020 LYPFT NHS Staff Survey ran from 1 October-27 November 2020. The Trust's official sample size was 2,802 which is a full census of all substantive staff in post on 1 September 2020. This is consistent with the approach we have taken in previous years. For the second year we also conducted a survey of our Bank Staff.

Once again we deployed a Task & Finish Group to support the delivery of the Staff Survey. In recognition of the pressures Trusts have been facing, we received assurance from the NHS Staff Survey Co-ordination Centre that it was we were not expected to undertake the same level of activity to increase our response rate this year. In previous years we have run a full communications campaign however this was pared back considerably for 2020. We emailed all line managers on a weekly basis with their team level response rates to enable local encouragement where this was appropriate.

Our response rate for 2020 saw a 7.5% decline on last year, reaching 47%. We knew that both the Covid-19 pandemic and the reduction in communications would impact our final response rate so this decline did not come as a surprise. The final national response rate for the 120 Trusts and specialist organisations partnered with Quality Health was 45%, and at 2% ahead we still consider 47% a positive achievement.

In addition to the standard NHS Staff Survey we ran a Bespoke Bank Staff Survey for the second year in a row. The questionnaire was sent directly to 496 Bank Staff home addresses to encourage participation. The survey ran from 1 October-27 November with a response rate of 25%. Of the 120 Trusts partnering with Quality Health, we were the only one to opt to survey our Bank Staff.

4 2020 NHS Staff Survey Results for Substantive Staff

The data from all 86 Key Questions (KQs) indicates that we have:

- **43 KQs have shown an improvement** in comparison to 2019
- **16 KQs have shown a decline** in comparison to 2019
- **17 KQs have remained static** in comparison to 2019

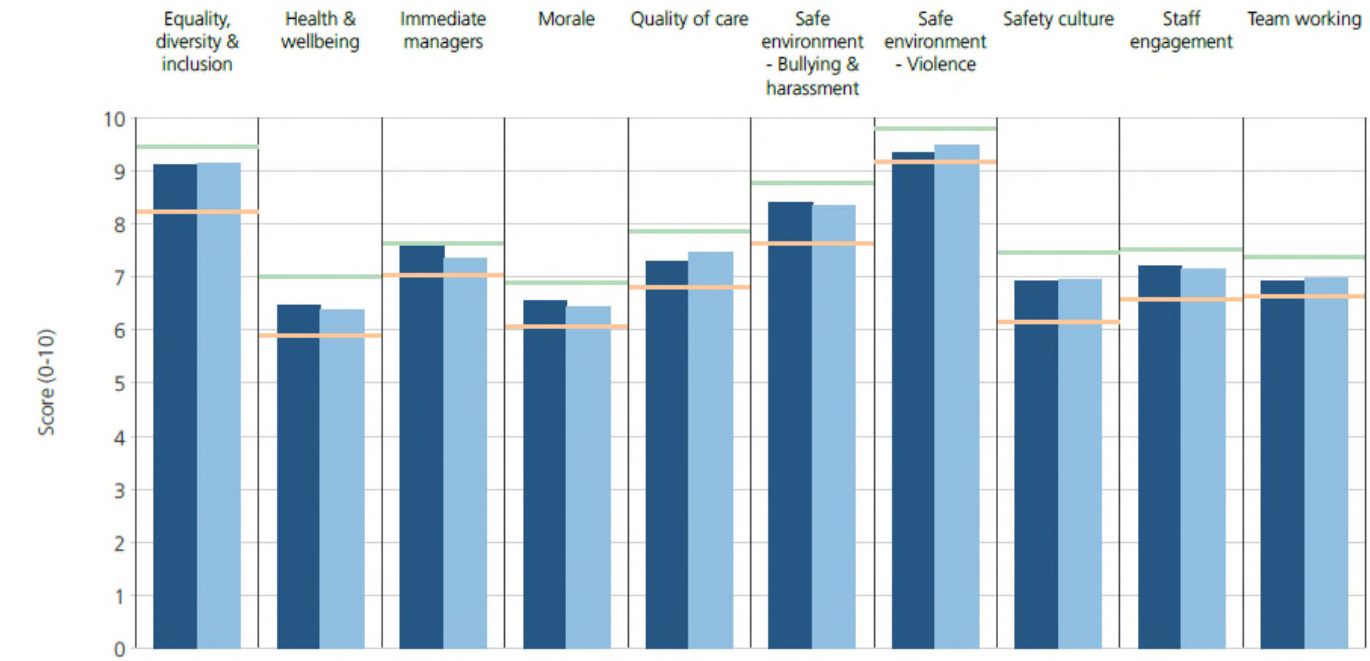
We have improved or remained static in 79% of the questions with comparable data from 2019. The results for 2020 are broken down into 10 Key Themes. Our results show that we are showing a significant improvement in the Key Theme on 'Safety Culture, increasing from a score of 6.8 in 2019 to 6.9 in 2020.

When comparing our results across our benchmark group of other Mental Health and Learning Disability Trusts in England, four of our Key Theme scores are above that of the sector average. Three key themes are in line with average scores and three themes are below the sector average.

Our score for the Key Theme on 'Immediate Managers' is statistically significantly higher than that of our benchmark group and we are a top performing Trust for this theme, matching the top score of 7.6 with our own of 7.6 too. However, we are statistically significantly below our benchmark group for the Key Theme 'Safe Environment – Violence':

Chart one details our all of our Key Theme scores against that of our benchmark group.

Chart one: LYPFT Key Theme scores compared to that of our benchmark group



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	7.0	7.6	6.9	7.9	8.8	9.8	7.5	7.5	7.4
Your org	9.1	6.5	7.6	6.5	7.3	8.4	9.3	6.9	7.2	6.9
Average	9.1	6.4	7.3	6.4	7.5	8.3	9.5	6.9	7.2	7.0
Worst	8.2	5.9	7.0	6.1	6.8	7.6	9.1	6.1	6.6	6.6
Responses	1,302	1,306	1,303	1,299	983	1,290	1,293	1,306	1,307	1,290

5 2020 overall results based on Key Themes

Using this data we are able to identify the following themes:

a) The **Safety Culture** at our Trust is **improving**:

- **All questions** in this theme improved for 2020
- The **biggest increase** in the theme was around **staff receiving feedback** about changes made in response to reported errors, near misses and incidents (q16d)
- Improvements were also seen in staff feeling those involved in an incident or near miss are **treated fairly** (q16a) and when errors do happen, the organisation takes steps to make sure they don't occur again (q16b)
- Questions around **raising concerns** also saw improvements

- Staff feel more secure raising concerns about **unsafe clinical practice**, more **confident the organisation would address their concern**, and increasingly that the organisation acts on concerns **raised by service users**

b) **Relationships with managers are consistently strong:**

- We are a **top performing Trust** for this theme, scoring significantly higher than our benchmark group
- All but one question in this theme remained static or improved
- Improvements were seen in staff feeling their immediate manager **values their work** and takes a **positive interest in their health and wellbeing**
- Scores around staff feeling satisfied with the **support from their immediate manager** and **receiving clear feedback** have remained static (q5b and q8c)
- The one question showing a decline was staff feeling that their manager **asks their opinion** before making decisions that affect their work (q8d)

c) Levels of **morale** across the Trust are **showing improvements,** with seven of the nine questions within this theme increasing or remaining static:

- The biggest improvement was staff feeling they have a **choice in how to do their work** (q6b)
- We saw favourable declines in staff saying they **often think about leaving** (q21a) and that they would **look for a new job** elsewhere in the next 12 months (q21b)
- We also saw an increase in **staff feeling encouraged by their immediate manager** (q8a)
- The **two declining scores** were around staff feeling **involved in changes** that affect their work area/team (q4c) and staff experiencing **unrealistic time pressures** (q6a)

d) Our staff's perceptions of the Trust's **health and wellbeing** offer are varied, however some questions saw **vast improvement:**

- The score for staff feeling **satisfied with our flexible working** offer has seen one of the biggest improvements across our entire survey this year, increasing by 7% (q5h)
- We have also seen improvement in staff feeling that the organisation takes **positive action on health and wellbeing** (q11a)
- There has been a **favourable decline** for staff saying they have come to work in the last 3 months despite not feeling well enough (q11d)
- However, more staff have **experienced MSK problems** as a result of work related activities (q11b). This question has seen an unfavourable increase across our entire benchmark group
- An increased number of staff have also **felt unwell as a result of work related stress** in the last 12 months (q11c)

e) **Safe Environment - violence** was our only Key Theme for 2020 to score **below that of the sector average**. However, we have remained static in two of the three questions making up this theme, with the other showing a favourable decline. This means while our scores have stayed the same or improved, they are still below the benchmark group score:

- The number of staff experiencing physical violence at work from service users has shown a **favourable decline** (q12a)
- Staff experiencing **physical violence at work from managers or from colleagues** has remained static (q12b and q12c)

- While not directly included in the Key Theme score, **staff reporting physical violence** at work when they experience it remains high at 91%

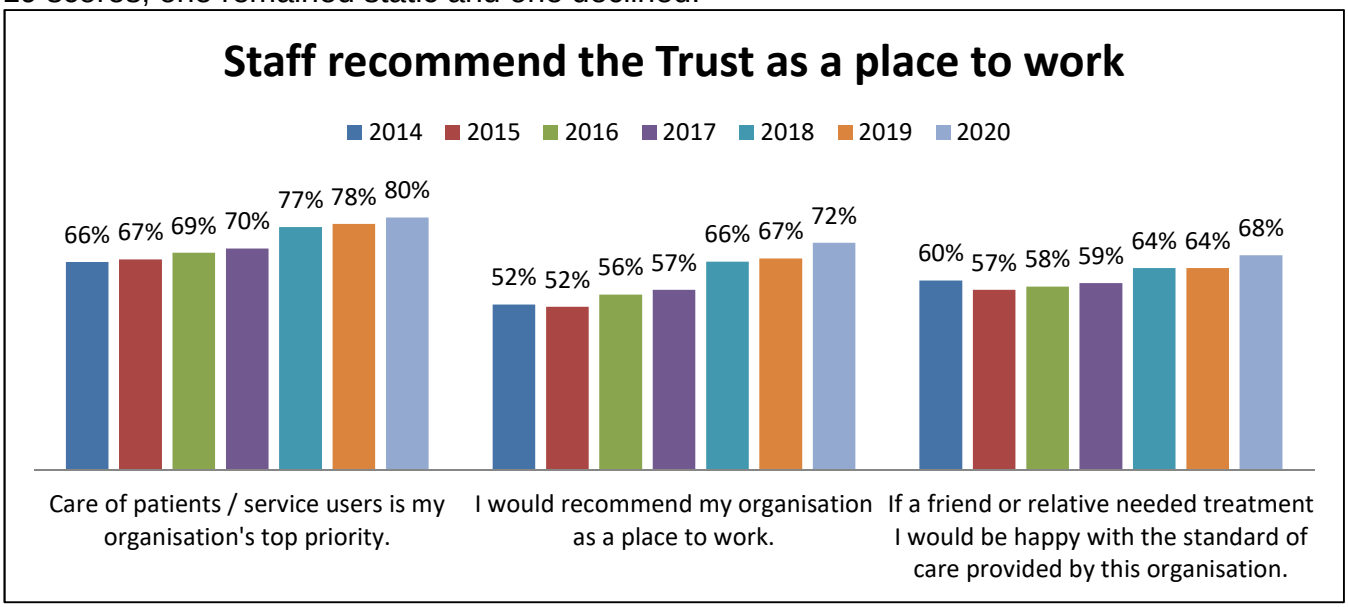
f) While it is not a Key Theme according to the NHS Staff Survey Coordination Centre, there are some patterns emerging in the 2020 results around whether staff **feel their opinion is taken into account**, or that they have **influence over decision making**:

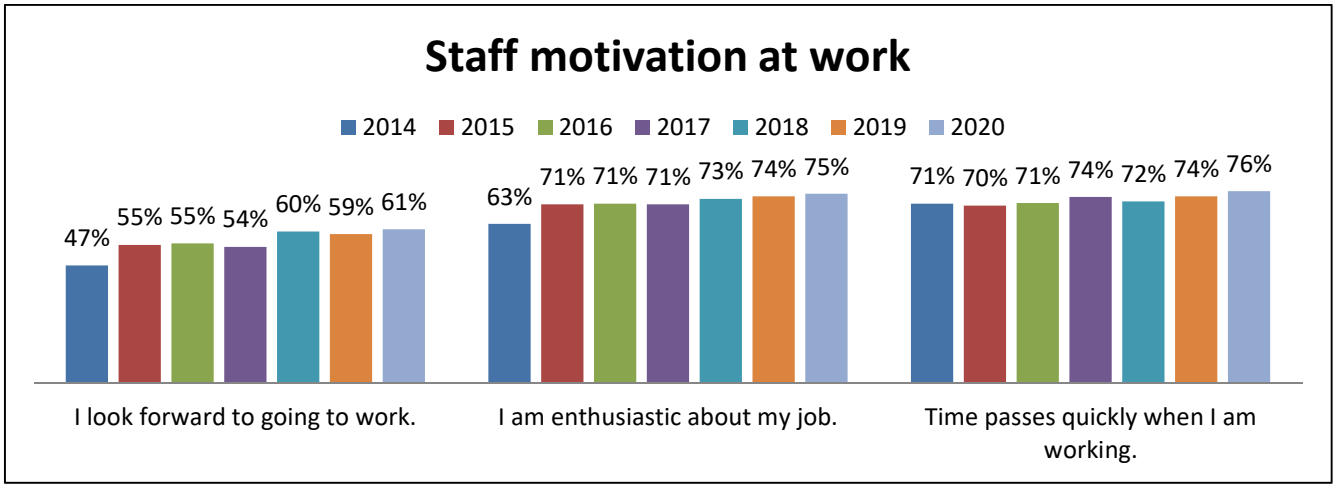
- We saw a decline in staff feeling their **immediate manager asks for their opinion** before making decisions that affect their work (q8d)
- The number of staff feeling they are **involved in deciding on changes** introduced that affect their work area/team/department has gone down (q4c)
- Staff feeling that they have **frequent opportunity to show initiative** has declined (q4a)
- In almost direct contrast however, more staff feel they are **able to make improvements** in their area of work (q4d)

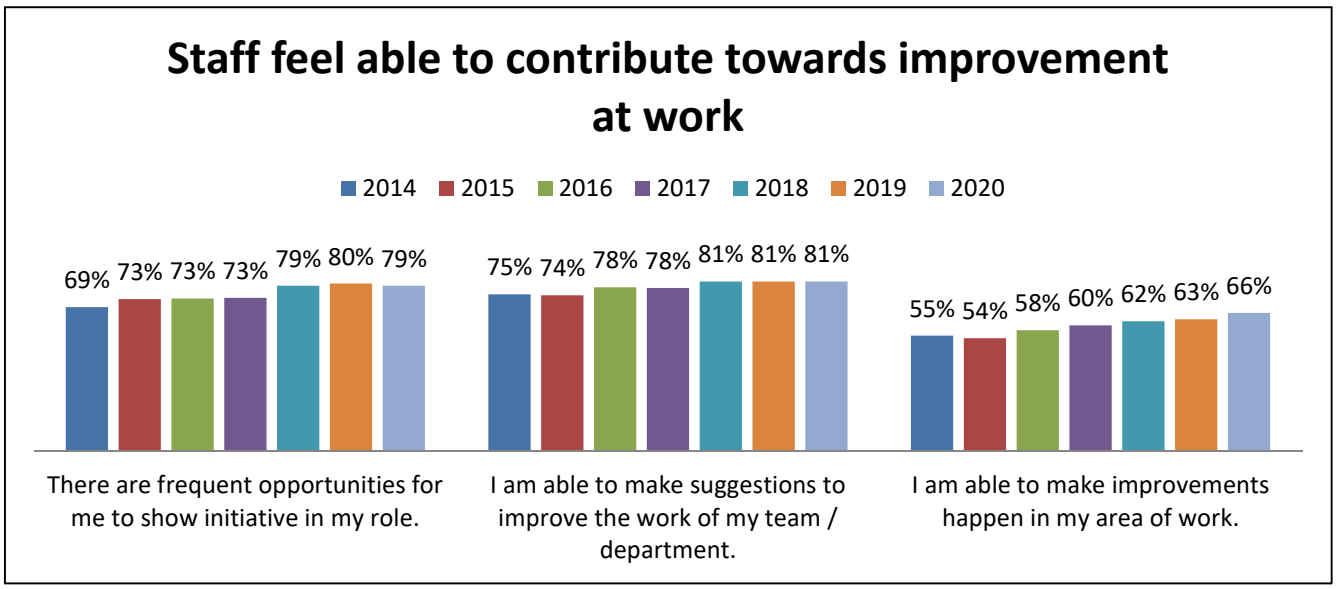
6 Staff engagement score

In 2020 the Trust's engagement score was 7.2 (out of 10) which is an increase on our 7.1 score from 2019.

The Staff engagement score is made up of nine questions, seven of which increased from the 2019 scores, one remained static and one declined:







7 Recurring themes 2014-20

The 2020 results highlight a couple of recurring themes and areas where the Trust continues to **struggle to make improvements** including:

- Staff **feeling unwell as a result of work related stress** dropped favourably in 2019 after increasingly unfavourably for three years, however this score has **risen unfavourably again** in 2020 to 45%
- Staff feeling able to **deliver the care they aspire** to has fluctuated from 61% in 2015, 67% in 2016, 62% in 2017, 66% in 2018 and 68% in 2019. This score has **declined for 2020 to 65%**

However on a positive note we have **continued to improve** in the following areas:

- Staff are feeling **increasingly satisfied** with the opportunities for **flexible working patterns**. This has grown considerably from 55% in 2015 to 73% in 2020
- There has been continuous improvement in the number of staff feeling the **Trust takes positive action on health and wellbeing**. In 2015, 26% answered 'yes definitely' and this has grown to 42% for 2020
- Staff feeling their **immediate manager takes positive interest in their health and wellbeing** continues to increase (70% in 2015, 75% in 2016, 77% in 2017 and 2018, 80% in 2019 and 81% in 2020)
- There has been a steady increase in staff feeling **communication with senior managers is effective**. This has risen from 31% in 2015 to 48% in 2020.
- Other questions relating to **senior managers have also seen continuous improvement**. 45% of staff feel senior managers involve staff in important decisions (27% in 2015) and 43% feel senior managers act on staff feedback (26% in 2015).
- Staff feeling that the **organisation acts on concerns raised by service users** has reached an all-time high for 2020 of 75%. This had previously peaked at 74% in 2018% after starting at 69% in 2015

8 2020 Bespoke Bank Staff Survey Results

As this is the second year we have conducted a Bespoke Bank Staff Survey, we now have two years' worth of data to make some year on year comparisons. We will also continue to assess the Bank Staff Survey data against the substantive staff results to compare the experiences of the two staff groups. Some key differences year on year and across staff groups are:

a) Equality, Diversity and Inclusion

- The number of Bank Staff feeling that the **Trust acts fairly with regard to career progression/promotion**, regardless of ethnic background, gender, religion, sexual orientation, disability or age has declined by 10% for 2020, to 76%. This is below the substantive staff score of 87%
- Compared to 2019, an additional 10% of our Bank Staff (67%) feel that the **Trust has made adequate adjustment(s)** to enable you to carry out your work. This is lower than for our substantive score of 81%.

b) Health and Wellbeing

- Bank Staff (83%) are feeling more **satisfied with the opportunities for flexible working** than substantive staff (73%). This score has risen for Bank Staff from 80% in 2019
- 52% of Bank Staff feel that the organisation takes **positive action on health and wellbeing**, compared to 42% of substantive staff
- The score for staff **experiencing MSK problems** as a result of work related activities has risen unfavourably since 2019 for both bank and substantive staff
- 20% of Bank Staff said they have felt unwell as a result of **work related stress** in the last year. this is an unfavourable increase from 12% in 2019 but a favourably lower score than the 45% of our substantive staff

c) Quality of Care

- This theme shows some of the greatest differences between our substantive and Bank Staff scores
- 91% of Bank Staff feel **satisfied with the quality of care** they give, which is a 4% increase on last year. This is considerably higher than the score of 78% for our substantive staff
- Bank Staff feeling that their role **makes a difference to service users** had a slight dip for 2020 of 2% to 94%, but remains higher than the substantive staff score of 86%
- The biggest difference is for the question on staff feeling **able to deliver the care they aspire to**. The score for Bank Staff was 92% (an 11% increase from 2019) but 65% for substantive staff

d) Safe Environment Themes

- Since 2019, an additional 4% of Bank Staff have **experienced physical violence** at work from service users, their families, or other members of the public. At 41% the Bank Staff score is much higher than the substantive staff score of 18%
- While 0% of substantive staff experienced **physical violence from their manager**, this score went up for Bank Staff from 0% in 2019 to 2% in 2020. This equates to

approximately 9 people. The number of Bank Staff experiencing **physical violence form colleagues** also rose for 2020 to 4%

- The score for Bank Staff experiencing **bullying or harassment** at work from service users has remained static at 39% but this is unfavourably higher than the substantive staff score of 26%
- Bank Staff experiencing **bullying or harassment from managers** has increased by 2% to 6%
- However, there has been a favourable decline of 2% for Bank Staff **experiencing bullying or harassment from colleagues**. At 16%, this is still unfavourably higher than the substantive staff score of 14%

e) Staff Engagement

- We have seen some variation on the 2019 scores with some questions improving and others declining
- 91% of Bank Staff feel **enthusiastic about their job** which is a 6% increase on 2019. This score is also higher than the substantive staff score at 75%
- Bank Staff feeling able to **make suggestions to improve the work** of their department fell by 3% to 66%
- The score for Bank Staff feeling that the **care of service user's is the Trust's top priority** declined by 4% to 89%. This remains higher than the substantive staff score of 80%

9 Bank Staff Only Questions

Following the same format as in 2019 we asked three additional questions, specifically about the experiences of our Bank Staff only. All three questions **showed a decline** for 2020:

Bank Specific Questions	**2019**	**2020**	**% diff**
As a member of the Bank Workforce, I feel like an integrated and valued member of any team that I work in.	75%	65%	-10%
As a member of the Bank Workforce, I am treated with dignity and respect by the services that I work in.	79%	75%	-4%
The Trust has improved its engagement with the Bank Workforce over the last 12 months.	67%	64%	-3%

The full results across all surveys are attached as Appendix 1. Please note that questions in italics represent those where a lower score is more favourable.

10 Conclusion

Continuing to measure staff experience in this way through the NHS Staff Survey ensures we have a consistent data set to measure progress over time. In light of a difficult year, the Trust's results as a whole show some really positive improvement on how our staff feel about coming to work. The results also highlight some really important areas in which more work is needed to improve staff experience too.

As with previous years, managers will be encouraged to complete an action plan based on their team level results. It is suggested that they work with their team to choose up to three specific

actions they want to work on over the next 12 months to improve the experiences of staff in that team.

The results of our bespoke Bank Staff Survey are with the Bank Workforce Managers to discuss with Bank Staff via the Bank Forum to co-create a Bank-specific action plan.

12 Recommendation

The Board of Directors is asked to receive and note the outcome of the 2020 National Staff Survey results.

Lucy Heffron
Organisational Development Lead - Communications and Engagement
18th March 2021

APPENDIX 1

Scores are RAG (Red, Amber, Green) rated by percentage change year on year.
*An unfavourable or favourable difference of 5% or more is highlighted **red**/**green**.*
*Unfavourable differences between 3%-5% are highlighted **amber***

2017	2018	2019	2020	Diff +/-	2019	2020	Diff +/-
1347	1420	1410	1311	-99	129	125	-4

National Staff Survey 2020
Leeds and York Partnership NHS Foundation Trust
Heat Mapped against previous year results
Question Scores & Bank Scores are Raw Data
Theme Scores are Weighted Data
Questions in italics represent where a lower score and percentage decrease are more favourable

		Substantive Staff - 2017 Data	Substantive Staff - 2018 Data	Substantive Staff - 2019 Data	Substantive Staff - 2020 Data	YoY % Change 19-20 Substantive Staff	Bank Staff - 2019 Data	Bank Staff - 2020 Data	YoY % Change 2019-20 Bank Staff
THEME 1: Equality, Diversity & Inclusion		**2017**	**2018**	**2019**	**2020**	**% diff**	**2019**	**2020**	**% diff**
Q14	Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	87%	86%	85%	87%	2%	86%	76%	-10%
Q15a	*In the last 12 months have you personally experienced discrimination at work from any of the following? Patients / service users, their relatives or other members of the public*	*9%*	*10%*	*8%*	*9%*	1%	*28%*	*27%*	-1%
Q15b	*In the last 12 months have you personally experienced discrimination at work from any of the following? Manager / team leader or other colleagues*	*7%*	*5%*	*6%*	*6%*	0%	*13%*	*13%*	0%
Q28b	Has your employer made adequate adjustment(s) to enable you to carry out your work?	79%	77%	77%	81%	4%	57%	67%	10%
THEME 1: SCORE		**9.1**	**9.0**	**9.1**	**9.1**	**0.0**	**8.0**	**7.8**	**-0.2**
THEME 2: Health and Wellbeing		**2017**	**2018**	**2019**	**2020**	**% diff**	**2019**	**2020**	**% diff**
Q5h	How satisifed with .....The opportunities for flexible working patterns.	61%	66%	66%	73%	7%	80%	83%	3%
Q11a	Does your organisation take positive action on health and well-being?	34%	36%	36%	42%	6%	48%	52%	4%
Q11b	*In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?*	*19%*	*21%*	*21%*	*29%*	8%	*13%*	*19%*	*6%*
Q11c	*During the last 12 months have you felt unwell as a result of work related stress?*	*38%*	*40%*	*37%*	*45%*	8%	*12%*	*20%*	*8%*
Q11d	*In the last three months have you ever come to work despite not feeling well enough to perform your duties?*	*53%*	*51%*	*52%*	*43%*	-9%	*22%*	*11%*	*-11%*
THEME 2: SCORE		**6.4**	**6.4**	**6.4**	**6.5**	**0.1**	**8.1**	**8.0**	**-0.1**
THEME 3: Immediate Managers		**2017**	**2018**	**2019**	**2020**	**% diff**	**2019**	**2020**	**% diff**
Q5b	How satisfied with .....The support I get from my immediate manager.	77%	78%	80%	80%	0%	70%	75%	5%

Q8c	My immediate manager gives me clear feedback on my work.	70%	70%	74%	74%	0%	54%	53%	-1%
Q8d	My immediate manager asks for my opinion before making decisions that affect my work.	63%	65%	70%	69%	-1%	39%	45%	6%
Q8f	My immediate manager takes a positive interest in my health and well-being.	77%	77%	80%	81%	1%	62%	69%	7%
Q8g	My immediate manager values my work.	77%	80%	82%	82%	0%	71%	81%	10%
THEME 3: SCORE		**7.3**	**7.4**	**7.6**	**7.6**	**0.0**	**N/A**	**N/A**	**N/A**

THEME 4: Morale		**2017**	**2018**	**2019**	**2020**	**% diff**	**2019**	**2020**	**% diff**
Q4c	I am involved in deciding on changes introduced that affect my work area / team / department.	56%	59%	62%	60%	-2%	30%	34%	4%
Q4j	I receive the respect I deserve from my colleagues at work.		76%	76%	76%	0%	75%	74%	-1%
Q6a	*I have unrealistic time pressures.*		*26%*	*24%*	*26%*	*2%*	*8%*	*15%*	*7%*
Q6b	I have a choice in deciding how to do my work.		61%	62%	64%	2%	46%	41%	-5%
Q6c	*Relationships at work are strained.*		10%	11%	*10%*	*-1%*	*9%*	*13%*	*4%*
Q8a	My immediate manager encourages me at work.		79%	80%	81%	1%	63%	64%	1%
Q21a	*I often think about leaving this organisation.*		*29%*	*26%*	*25%*	*-1%*	*16%*	*10%*	*-6%*
Q21b	*I will probably look for a job at a new organisation in the next 12 months.*		22%	21%	*19%*	*-2%*	11%	9%	-2%
Q21c	*As soon as I can find another job, I will leave this organisation.*		*14%*	*12%*	*12%*	0%	*6%*	*10%*	4%
THEME 4: SCORE			**6.3**	**6.5**	**6.5**	**0.0**	**6.6**	**6.7**	**0.1**

THEME 6: Quality of Care		**2017**	**2018**	**2019**	**2020**	**% diff**	**2019**	**2020**	**% diff**
Q7a	I am satisfied with the quality of care I give to patients / service users.	78%	81%	81%	78%	-3%	87%	91%	4%
Q7b	I feel that my role makes a difference to patients / service users	87%	87%	85%	86%	1%	96%	94%	-2%
Q7c	I am able to deliver the care I aspire to	62%	66%	68%	65%	-3%	81%	92%	11%
THEME 6: SCORE		**7.2**	**7.3**	**7.3**	**7.3**	**0.0**	**8.1**	**8.3**	**0.2**

THEME 7: Safe Environment - Bullying and Harassment		**2017**	**2018**	**2019**	**2020**	**% diff**	**2019**	**2020**	**% diff**
Q13a	*In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Patients / service users, their relatives or other members of the public*	*30%*	*31%*	*29%*	*26%*	*-3%*	*39%*	*39%*	*0%*
Q13b	*In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Managers*	*9%*	*8%*	*8%*	*7%*	*-1%*	*3%*	*6%*	*3%*
Q13c	*In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Other colleagues*	*15%*	*16%*	*14%*	*14%*	*0%*	*18%*	*16%*	*-2%*
THEME 7: SCORE		**8.2**	**8.2**	**8.3**	**8.4**	**0.1**	**8.0**	**8.0**	**0.0**

THEME 8: Safe Environment - Violence		2017	2018	2019	2020	% diff	2019	2020	% diff
Q12a	*In the last 12 months how many times have you personally experienced physical violence at work from...? Patients / service users, their relatives or other members of the public*	*22%*	*23%*	*22%*	*18%*	*-4%*	*37%*	*41%*	*4%*
Q12b	*In the last 12 months how many times have you personally experienced physical violence at work from...? Managers*	*1%*	*0%*	*0%*	*0%*	*0%*	*0%*	*2%*	*2%*
Q12c	*In the last 12 months how many times have you personally experienced physical violence at work from...? Other colleagues*	*2%*	*1%*	*1%*	*1%*	*0%*	*3%*	*4%*	*1%*
THEME 8: SCORE		**9.1**	**9.2**	**9.3**	**9.3**	**0.0**	**8.7**	**8.5**	**-0.2**

THEME 9: Safety Culture		2017	2018	2019	2020	% diff	2019	2020	% diff
Q16a	My organisation treats staff who are involved in an error, near miss or incident fairly.	51%	58%	61%	63%	2%	53%	56%	3%
Q16c	When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	65%	70%	72%	74%	2%	69%	74%	5%
Q16d	We are given feedback about changes made in response to reported errors, near misses and incidents.	57%	59%	60%	63%	3%	61%	60%	-1%
Q17b	I would feel secure raising concerns about unsafe clinical practice.	71%	73%	73%	74%	1%	73%	70%	-3%
Q17c	I am confident that my organisation would address my concern.	56%	59%	60%	62%	2%	67%	63%	-4%
Q20b	My organisation acts on concerns raised by patients / service users.	69%	74%	73%	75%	2%	84%	83%	-1%
THEME 9: SCORE		**6.5**	**6.7**	**6.8**	**6.9**	**0.1**	**7.2**	**6.8**	**-0.4**

THEME 10: Staff Engagement		2017	2018	2019	2020	% diff	2019	2020	% diff
Q2a	I look forward to going to work.	54%	60%	59%	61%	2%	80%	78%	-2%
Q2b	I am enthusiastic about my job.	71%	73%	74%	75%	1%	85%	91%	6%
Q2c	Time passes quickly when I am working.	74%	72%	74%	76%	2%	67%	68%	1%
Q4a	There are frequent opportunities for me to show initiative in my role.	73%	79%	80%	79%	-1%	75%	78%	3%
Q4b	I am able to make suggestions to improve the work of my team / department.	78%	81%	81%	81%	0%	69%	66%	-3%
Q4d	I am able to make improvements happen in my area of work.	60%	62%	63%	66%	3%	46%	48%	2%
Q20a	Care of patients / service users is my organisation's top priority.	70%	77%	78%	80%	2%	93%	89%	-4%
Q20c	I would recommend my organisation as a place to work.	57%	66%	67%	72%	5%	83%	82%	-1%
Q20d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	59%	64%	64%	68%	4%	77%	78%	1%
THEME 10: SCORE		**6.9**	**7.1**	**7.1**	**7.2**	**0.1**	**7.5**	**7.6**	**0.1**

THEME 11: Team Working	2017	2018	2019	2020	% diff	2019	2020	% diff

Q4h	The team I work in has a set of shared objectives.	71%	73%	76%	75%	-1%	70%	68%	-2%
Q4i	The team I work in often meets to discuss the team's effectiveness.	64%	67%	69%	69%	0%	58%	55%	-3%
THEME 11: SCORE		**6.7**	**6.8**	**7.0**	**6.9**	**-0.1**	**N/A**	**N/A**	**N/A**

Questions not linked to Key Themes		**2017**	**2018**	**2019**	**2020**	**% diff**	**2019**	**2020**	**% diff**
Q3a	I always know what my work responsibilities are.	83%	83%	82%	83%	1%	94%	89%	-5%
Q3b	I am trusted to do my job.	90%	91%	90%	91%	1%	94%	93%	-1%
Q3c	I am able to do my job to a standard I am personally pleased with.	77%	79%	80%	78%	-2%	92%	90%	-2%
Q4e	I am able to meet all the conflicting demands on my time at work.	45%	49%	48%	48%	0%	59%	69%	10%
Q4f	I have adequate materials, supplies and equipment to do my work.	63%	65%	65%	69%	4%	73%	78%	5%
Q4g	There are enough staff at this organisation for me to do my job properly.	33%	37%	39%	43%	4%	41%	57%	16%
Q5a	How satisfied with …..The recognition I get for good work.	56%	64%	67%	67%	0%	61%	66%	5%
Q5c	How satisfied with …..The support I get from my work colleagues.	82%	84%	84%	83%	-1%	80%	80%	0%
Q5d	How satisfied with …..The amount of responsibility I am given.	73%	78%	77%	80%	3%	75%	78%	3%
Q5e	How satisfied with …..The opportunities I have to use my skills.	69%	74%	74%	75%	1%	75%	70%	-5%
Q5f	How satisfied with …..The extent to which my organisation values my work.	40%	50%	52%	52%	0%	60%	58%	-2%
Q5g	How satisfied with …..My level of pay?	34%	39%	42%	43%	1%	34%	39%	5%
Q8b	My manager…. can be counted on to help me with a difficult task at work.	78%	78%	80%	82%	2%	70%	72%	2%
Q8e	My immediate manager (who may be referred to as your 'line manager') is supportive in a personal crisis.	80%	82%	83%	83%	0%	62%	64%	2%
Q9a	I know who the senior managers are here.	82%	83%	84%	87%	3%	65%	66%	1%
Q9b	Communication between senior management and staff is effective.	36%	41%	44%	48%	4%	48%	51%	3%
Q9c	Senior managers here try to involve staff in important decisions.	36%	40%	43%	45%	2%	45%	40%	-5%
Q9d	Senior managers act on staff feedback.	32%	34%	41%	43%	2%	43%	42%	-1%
Q11e	*Have you felt pressure from your manager to come to work?*	*18%*	*15%*	*14%*	*16%*	2%	*4%*	*23%*	*19%*
Q11f	*Have you felt pressure from colleagues to come to work?*	*18%*	*17%*	*17%*	*17%*	0%	*11%*	*8%*	*-3%*
Q11g	*Have you put yourself under pressure to come to work?*	*92%*	*94%*	*93%*	*95%*	2%	*85%*	*100%*	*15%*
Q12d	The last time you experienced physical violence at work, did you or a colleague report it?	90%	92%	90%	92%	2%	85%	84%	-1%
Q13d	The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	64%	64%	59%	65%	6%	74%	65%	-9%
Q16b	My organisation encourages us to report errors, near misses or incidents.	85%	88%	89%	89%	0%	92%	90%	-2%
Q17a	If you were concerned about unsafe clinical practice, would you know how to report it?	95%	97%	96%	95%	-1%	95%	98%	3%

New for 2020		2017	2018	2019	2020	BenchM Group	2019	2020
Q20e	I feel safe in my work				81%	81%		82%
Q20f	I feel safe to speak up about anything that concerns me in this organisation				72%	70%		74%

Your experience during the Covid-19 pandemic		2017	2018	2019	2020	BenchM Group	2019	2020
Q22a	Have you worked on a Covid-19 specific ward or area at any time?				20%	19%		31%
Q22b	Have you been redeployed due to the Covid-19 pandemic at any time?				16%	12%		11%
Q22c	Have you been required to work remotely/from home due to the Covid-19 pandemic?				64%	63%		10%
Q22d	Have you been shielding? (for myself or for a member of my household)				11%	12%		26%

Bank Staff only questions			2019	2020	% diff
Q18a	As a member of the Bank Workforce, I feel like an integrated and valued member of any team that I work in.	N/A	75%	65%	-10%
Q18b	As a member of the Bank Workforce, I am treated with dignity and respect by the services that I work in.		79%	75%	-4%
19a	The Trust has improved its engagement with the Bank Workforce over the last 12 months.		67%	64%	-3%

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

16.

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Financial Officer Report - Month 11
DATE OF MEETING:	25 March 2021
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 11 and a forecast outturn position. In addition the report also includes a planning update for 2021/22.

The Trust reported an income and expenditure surplus of £2.45m as at month 11. The level of expenditure is significantly lower than planned at this stage but in line with our run rate trend. There are still a number of issues which could impact on the forecast outturn position and some technical accounting issues to work through. We have continued to work with partners across the Leeds place to manage financial risk issues and ensure a minimum overall balanced plan. Capital expenditure remains in line with our assumptions.

A significant amount of work is ongoing across the organisation to understand capital and revenue requirements for 2021/22 in the context of the financial framework in which we are working. This does not reflect the normal full planning process. We anticipate the submission date for planning returns is mid-April. There will be a non-mandatory option to adjust plans in early May, which would give an opportunity for further review at April Board.

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 income and expenditure position at month 11, which is favourable variance from plan of £3.57m
- Note the work ongoing to determine financial plans for 21/22.
- Note the Trust remains in an overall good financial position.

MEETING OF THE BOARD OF DIRECTORS

25 MARCH 2021

CHIEF FINANCIAL OFFICER REPORT - MONTH 11

1 Introduction

This report provides an overview of the financial performance of the Trust at month 11 and a forecast outturn position. The revenue position reflects the 5 months (October 20 to February 21) of operating within the revised interim financial framework implemented for months 7- 12. The capital position represents the full year to date (April 20 to February 21) position. In addition the report also includes a planning update for 21/22.

2 Month 11 2020/21 Income & Expenditure Performance

At month 11 (month 5 of the planning period) the Trust reported an income and expenditure surplus of £2.45m against a planned deficit of £1.12m. This is a cumulative positive variance of £3.57m.

Table 1 below shows a high level summary of the position and variance.

Table 1

Income & Expenditure Position	Plan £000s	Actual £000s	Variance £000s
Pay	(59,688)	(57,506)	2,182
Non Pay	(23,588)	(21,931)	1,657
Total Expenditure	**(83,276)**	**(79,437)**	**3,839**
Income: System allocations			
COVID	3,777	3,777	0
Top up - Prospective	1,586	1,586	0
Block contracts	67,981	65,581	(2,400)
Growth	598	598	0
Sub Total System Allocations	**73,942**	**71,542**	**(2,400)**
Other Income	**8,211**	**10,346**	**2,135**
Total Income	**82,153**	**81,888**	**(265)**
Total Surplus/ (Deficit)	**(1,123)**	**2,451**	**3,574**

The positive variance reflects a consistent trend of our run rate being under our planned estimates and also includes an adjustment to our block contract income with Leeds CCG.

3 Forecast Income and Expenditure Position

The forecast outturn position is within the ICS envelope, and will be an overall surplus. Our range forecast position is between £1.1m surplus and £2.4m surplus, the extent of this is affected by some national technical adjustments which are yet to be confirmed by NHSEI. The overall ICS position has also improved.

4 Capital Expenditure

Cumulative year to date capital expenditure (months 1-11) is reported as £12.94m including substantial spend on the CAMHS unit. This is in line with our anticipated forecast which has been impacted by COVID as previously reported.

5 Planning 2021/22

Planning guidance and revenue allocations are still not issued. As previously reported there will be a continuation of month 7 to 12 20/21 financial framework principles for Q1 of 21/22 and possibly Q2 of 21/22.

We understand that 21/22 planning requirements will initially take the form of two planning submissions, a financial and workforce plan for Q1 and a mental health specific planning submission covering 21/22 financial year.

The capital planning guidance and set full year 21/22 allocations have been issued. The guidance builds on arrangements introduced in 20/21 whereby envelopes are issued at system level. Whilst individual organisational allocations have been identified, there is an expectation that ICS prioritisation will be undertaken to agree the overall distribution. In this context LYPFT will be required to review its current capital plan estimates and prioritise capital expenditure requirements as we are significantly above our indicative funding envelope. Our indicative capital allocation is c£7m of which £5.1m is already pre-committed in 2021-22.

6 Conclusion

The Trust reported an income and expenditure surplus of £2.45m as at month 11. The level of expenditure is significantly lower than planned at this stage but in line with our run rate trend. There are still a number of issues which could impact on the forecast outturn position and some technical accounting issues to work through. We have continued to work with partners across the Leeds place to manage financial risk issues and ensure a minimum overall balanced plan. Capital expenditure remains in line with our assumptions.

The Trust is in a good financial position in year. Whilst we are not being monitored against the usual external metrics for cash and liquidity, our cash position remains strong with a cash balance of £122.3m (inclusive of c£13m income in advance for block income), and liquidity is strong with cover for 155 days operating expenses.

A significant amount of work is ongoing across the organisation to understand capital and revenue requirements for 2021/22 in the context of the financial framework in which we are working. This does not reflect the normal full planning process. We anticipate the submission date for planning returns is mid-April. There will be a non-mandatory option to adjust plans in early May, which would give an opportunity for further review at April Board.

7 Recommendation

The Board of Directors are asked to:

- Note the income and expenditure position at month 11, which is favourable variance from plan of £3.57m
- Note the work ongoing to determine financial plans for 21/22.
- Note the Trust remains in an overall good financial position.

Dawn Hanwell
Chief Financial Officer and Deputy Chief Executive
19 March 2021

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
17

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Board Assurance Framework
DATE OF MEETING:	25 March 2021
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.

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 (remains same)	Partial (remains same)	Partial (remains same)		We have put in place a number of controls to ensure that we comply with our regulatory standards and we are not in breach of any of our regulatory requirements.	Cathy Woffendin (Director of Nursing, Professions and Quality)	Quality Committee	20	→
		SR2. (Risk 829) There is a risk that we fail to make the improvements outlined in the quality strategic plan and that this has an adverse impact on the care of those who use our services.	Partial (remains same)	Partial (remains same)	Partial (remains same)		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)	Partial (remains same)		Whilst some of the infrastructure is in place to govern the work of the ICS and MHLDA Collaborative there is still more work to do to understand the impact of the emerging governance arrangements.	Sara Munro (Chief Executive)	Board	15	→
2. We provide a rewarding and supporting place to work		**SR3. (Risk 830) Due to an inability to recruit and retain sufficient numbers of staff with the appropriate skills experience and behaviours, there is a risk that we are unable to deliver high quality, evidence based, person centred care to meet new models of care now and in the future.**	Partial (remains same)	Partial (remains same)	Partial (remains same)		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)	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	**15**	⬇
		SR5. (Risk 615) Due to inadequate, inflexible or poorly managed estates we compromise the safe environment which places staff, service users and visitors at risk.	Partial (remains same)	Partial (remains same)	Partial (remains same)		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	**12**	⬇
		SR6. (Risk 635) As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.	Partial (remains same)	Partial (remains same)	Partial (remains same)		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	**8**	⬇

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	SR	Q4 (end of March 2021)
	Partial	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	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. In addition the CQC Well led inspection report DEC2019 gave an overarching rating of good which included our governance system and processes	Dec-19
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 September 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-21

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	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	9	
645	Risk that there is no systematic approach to identifying and helping those teams who need support from the Service Improvement Team	Richard Wylde / Claire Kenwood	Trustwide Clinical Governance Group	6	6	6	
900	Higher Trainee on call rota gaps due to COVID realated adjustments	Abhijit Chakrabarti	TBC	N/A	N/A	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*
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	Research annual report was approved by TWCG in Oct 2020 and presented to Quality Committee for assurance also in Oct 2020	Oct-20
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.	Apr-21
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	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)**
56	The Care Group currently has a high number of vacancies impacting on quality and safety.	Andy Weir / Joanna Forster Adams	Operational Delivery Group (ODG)	9	9	9	
109	Inability to recruit permanent staff across the Trust resulting in the need to rely on bank and agency staff within services	Claire Holmes	Workforce and Communications Group	12	12	12	
TBC	Absence relating to Covid-19 illness, self isolation and school closures significantly reducing capacity to deliver clinical care	Claire Holmes	Workforce and Communications Group	25	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	Workforce and Communications Group meeting weekly, with cross representation from the operations group and regular feeding to and from the daily sitreps.	Jan-21
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 Increased HCSW pipeline being utilised via national funding based on current Trust vacancies. Linking with national bring back staff scheme and voluntary sector to increase staff availability.	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 activities to support workforce supply and current vacancies, including nursing vacancies	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 nursing associate posts. Successfully secured funding for international recruitment across the ICS. Developing career pathway to support future supply of nursing through apprenticeship training. Kickstart Scheme, working in partnership with the DWP to support and develop unemployed communities in to work through a new entry pathway, including pastoral and career support to aid their development to become a substantive employee. Running incentivised recruitment offers for key recurrent vacancies. Let's Talk quarterly recruitment campaigns with key focus (latest one targeted bring back staff)	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 establishment of this group has been paused, the work has continued, overseen by the Workforce and Communications group. 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 and Talent Management work is 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	Dec-20
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	Fully flexible bank workforce established and deployed during the pandemic to support increased workforce supply to services as needed. During the pandemic both redeployment and responsive workforce team have been utilised to support effective deployment.	Nov-19
830	Education and Learning Steering Group	Education and Learning Steering Group continues to support alignment of learning needs and available funding.	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	Wellbeing Assessments and Career Conversations	Formal appraisal has continued for staff, where capacity in teams has allowed, if this is not possible the wellbeing assessment conversations are being used to support staff. Career conversations are also being used and a Trust wide process has been established for managers and staff to access.	Jan-21
830	Apprenticeship Delivery Plan	We are increasing numbers of clinical apprenticeships including establishing new roles such as nurse associates and associate practitioners and clinical associate psychologists. Utilising apprenticeships to deliver the national health care support worker programme, which will directly impact on our current healthcare support worker vacancies.	Nov-19
830	Medical staff Recruitment (AAC panels) programme	We are increasing numbers of clinical apprenticeships including establishing new roles such as nurse associates and associate practitioners and clinical associate psychologists. Utilising apprenticeships to deliver the national health care support worker programme, which will directly impact on our current healthcare support worker vacancies.	Nov-19
830	Staff engagement and reward and recognition programme	Staff engagement has continued throughout the pandemic and has shaped the Trust response to key issues, including staff wellbeing. Bank staff included in 2020 staff survey and 47% of staff completed the survey. Revised staff recognition and award scheme implemented, including team of the month and revised STAR award. Culture development conversation taken place during summer of 2020 and open access leadership development session delivered virtually as a key response to this. CEO all staff call introduced to improve staff engagement and communications during the pandemic.	Nov-19
830	Appraisal process audit	This process was audited and significant assurance provided	Jan-20
830	Equality Steering Group	Equality Steering Group established as part of pandemic response. This group has supported a number of key actions including, BAME representation on senior recruitment panels and also planning launch of leadership development programme for BAME leaders and reciprocal mentoring for Board members and BAME colleagues WREN network has continued to develop during the pandemic. Wellbeing assessments are being used to support the health and wellbeing all staff including BAME colleagues.	Jan-21

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, Work on this has been paused due to continued pandemic response work. Plan to re-start in April 2021 but could be subject to further delay if pandemic continues.	Sep-21

830	Most of the planned workforce activity and developments have been paused or hibernated to support Business continuity and Covid response.	Recovery and reset plans being worked through with some areas of workforce activity stepping up from October 2020 and the development of the Trust's People Plan. Re-set and recovery work including development of the People Plan paused as a result of covid response from November 2020.	Jun-21
830	Embedding the use of apprenticeships in Trust workforce planning to address strategic resourcing challenges	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. Continued to deliver apprenticeship programmes throughout the pandemic to ensure future development and growth into workforce supply.	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 . Workforce and Communication group in place meeting weekly with cross representation with the Operations group and close links to Deployment and staffing group.	Mar-21
830	Increase in NHS Test and Trace increasing numbers of staff self-isolating due to tracing in community and social settings	Deployment and Staffing 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	15	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	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, with a risk of a fine from the ICO.	Bill Fawcett / Dawn Hanwell	Information Governance Group	9	9	9	
649	Evolution of New Care Models (NCM) impact on clinical income and sustainability. TEWV led CAMHS NCM involves the development of local CAMHS community services aimed at reducing out of area placements, this could reduce Tier 4 CAMHS (Mill Lodge) income and activity. Eating Disorders NCM results in LYPFT taking the full financial risk for out of area placements.	David Brewin / Dawn Hanwell	Finance & Performance Committee	9	9	9	
651	Failure to achieve ongoing CIP requirements and demonstrate efficient and effective care will lead to a deterioration in the financial position.	David Brewin / Dawn Hanwell	Finance & Performance Committee	9	9	9	
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	5	
731	Increasing agency spend could cause a deterioration in the Trusts Finance Score.	David Brewin / Dawn Hanwell	Financial Planning Group	9	9	9	
907	Change in ICS regulation and the impact this will likely have on the financial regime	David Brewin / Dawn Hanwell	Financial Planning Group	N/A	N/A	9	
908	Reliance on non-core income	David Brewin / Dawn Hanwell	Financial Planning Group	N/A	N/A	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.	Whilst COVID-19 interim contracting arrangements did not require signed contracts for 20/21, minutes of discussions with commissioners demonstrate good working relationships and good progress on key priority investments including agreeing the safer staffing business case and full access to mental health investment standard growth in 20/21, based on a list of jointly agreed priority investments in efficient and effective models of care. Further positive joint working with NHS E resulted in agreeing a funding baseline for the Adult Eating Disorders Provider Collaborative and NHSE approval to operate as Lead Provider on 1st October 2020. Throughout 2020/21 we have continued to engage in regular and positive dialogue with Leeds commissioners to promote efficient and effective models of care. Evidence of growing business from existing commissioners and winning tenders provides further assurance.	Jan-21
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 Financial Planning Group and further assurance provided to Finance & Performance Committee in relation to new and existing business. Service reviews with commissioners demonstrate there is a process of providing assurance to the executive directors in relation to commissioning activity. Minutes of meeting demonstrating and evidencing assurance. During COVID response period the frequency of meeting has been reduced but have scheduled meetings when priority decisions needed consideration.	Jan-21

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.	Assurance papers are provided to the Finance and Performance Committee which is scrutinised by the non-executive directors on behalf of the Board.	Jan-21
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.	Jan-21
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 PEG and citywide Director of Finance Group show a level of assurance on the partnership working arrangements across the city. Minutes of West Yorkshire Mental Health CFOs group (includes lead ICS CFO for mental health) and other key strategic partnership roles (Programme Director for WYICS MHLD&A and CCG	Jan-21
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. As a consequence of our COVID response (in line with the national direction) we have paused our efficiency programme.	Oct-20
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. The internal audit of the budgetary and accounting control framework has provided significant assurance.	Apr-20
619	Consistent achieved of organisational plans in the context of system control targets.	Accounts audited at the end of 2019/20 to verify the financial outturn. Monthly reporting in 20/21 provides assurance that the Trust is on track to achieve the LYPFT element of the system control target.	Jan-21
619	Financial modelling and forward forecasting in place to identify risks early.	NHS Improvement Financial Plan submitted in September 2020 which included a detailed assessment of cost pressures and commissioning intentions based on wide ranging engagement within the Trust. Subsequently, monthly and quarterly forecasting provided to NHSEI, Leeds Plan forecast and ICS reporting and forecasting update each month.	Jan-21

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.	Mar-21
619	Excess expenditure not covered by exceptional income	Mitigated by current underlying run rate, and interim changes to finance business rules nationally.	Mar-21
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	12	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	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	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	6	
TBC	lack of strategic planning for the estate	Myles Callaway / Dawn Hanwell	Estates Steering Group	N/A	N/A	9	
700	The Trust does not have a dedicated decant facility capable of receiving service users evacuated from a ward or unit due to an emergency - fire, flood, loss of power or other environmental/ security threat.	Andrew Jackson	Emergency Preparedness Resilience and Response Group	12	12	12	

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.	May-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	Dec-20
615	SLA in place for the Estate in York	SLA 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	Dec-20
615	Lack of ability to plan longer term estates requirements in context of wider service collaboration	Active engagement with city wide Strategic Estates Group and ICS level Capital and Estates Group to develop clearer joined up planning	Dec-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.	Dec-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	Inpatient estate remains sub optimal	Strategic Asset Plan to develop PFI options, and PFI management in line with DHSC guideline to 2028. Revised assessment of NICPM options	Mar-22
615	NICPM business case not progressed	Revised assessment of options for NICPM in context of uncertain commissioning landscape is being progressed	Mar-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	Feb-21
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	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	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	8	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	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	6	
105	The danger of a cyber-attack to the Trust's ICT infrastructure through malicious hacking or system virus infection.	Bill Fawcett / Dawn Hanwell	Information Steering Group	12	12	12	
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	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	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	9	
888	EPMA does not back up all records for off line charting in the event of a system failure. The risk is that if the system goes off line and the back-up drug charts are required then there is a chance the wrong chart will be used on the patient.	Bill Fawcett / Dawn Hanwell	Information Steering Group	N/A	N/A	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
635	Procurement review all web site expenditure with IT prior to giving approval to purchase.	Procurement and IT meet monthly to assess all technology procurements over £10K for the Trust.	Dec-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*
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.	Conduct Cyber Security Audit in progress through Dec and Jan. This will be followed by toolkit audit in Feb-March 21 to identify any discrepancy.	Apr-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.	Internal audit of Cyber controls for the Trust currently in progress and scheduled to complete in March 21 followed by IG Tool Kit assessment in Feb 21.	Mar-21
635	Requirement to improve knowledge of staff of the dangers of a cyber attack on the Trust	Conduct a Phishing exercise across the Trust to expose the dangers of opening suspicious e-mails with follow up programme.	Jun-21
635	Requirement to test the Trusts defences against a cyber attack	Conduct a Penetration test exercise across the Trust to expose weaknesses in the Trusts cyber defences with follow up action programme to address areas of concern.	Jun-21

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	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	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 opportunity to understand and feed into the future plans for the collaborative	Nov-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 opportunities to be involved	Each private Board meeting	Jan-21
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. The Board considered and submitted its views and comments on the NHS England Consultation document on the proposed ICS regulatory framework	Mar-21

635	Data security and protection toolkit audit	Internal audit of data security and protection toolkit pr assurance
615	Estates strategy agreed by the Board	The internal audit of the Estates Strategy has provided assurance

ɔvided significant	Mar-19
significant	May-19

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:	West Yorkshire and Harrogate Health and Care Partnership Climate Change asks of organisations
DATE OF MEETING:	25 March 2021
PRESENTED BY: (name and title)	Dr Sara Munro – Chief Executive
PREPARED BY: (name and title)	Dr Sara Munro – Chief Executive

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

EXECUTIVE SUMMARY

The people of West Yorkshire and Harrogate (WY&H) are living through a climate emergency. Our communities and staff see the impacts, particularly of poor air quality and flooding, so regularly that it is no longer noteworthy.

The attached paper was produced following a presentation to the WY&H System Leadership Executive Group on 3 November 2020 which recommended that the 'asks' in this paper be considered by every partner organisation's Board and this paper highlights and supports those 'asks' of each organisation in the WY&H Health and Care Partnership.

The Board is also asked to note that a response has also been made to a baseline survey to indicate that we have an identified executive lead for sustainability (Dawn Hanwell) and a NED champion (Sue White) we have also confirmed that the Trust has an assessment and plan which is integrated with the Leeds system plan and brought together under the Health and Wellbeing Board for Leeds.

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

RECOMMENDATION
The Board is asked to consider and support the ‘asks’ relating to creating a greener NHS and to also note the responses already made to the baseline survey.

West Yorkshire and Harrogate Health and Care Partnership Climate Change asks of organisations

January 2021

Drafted by Yannish Naik and Frank Swinton, Climate Change Leads at WY&H Health and Care Partnership – please contact frank.swinton@nhs.net if you have any queries.

Executive Summary

The people of West Yorkshire and Harrogate (WY&H) are living through a climate emergency. Our communities and staff see the impacts, particularly of poor air quality and flooding, so regularly that it is no longer noteworthy. This is not normal.

This paper was produced following a presentation to the WY&H System Leadership Executive Group on 3 November 2020 who recommended that the asks in this paper be considered by every partner organisation's Board. This paper highlights and supports those asks of each organisation in the WY&H Health and Care Partnership.

Every organisation in the WY&H Health and Care Partnership is hereby asked to:

- Ensure every organisation has a named board and operational lead by April 2021 and inform the climate change leads of who this is. Local authorities are likely to choose Councillors rather than a board lead.
- Have a board (or Councillor) development session on climate change by the end of 2021.
- Have a board approved Green Plan (formerly Sustainable Development Management Plan (SDMP)), or similar, by the end of 2021.
- Help implement this work in every organisation across all domains of organisational activity - please incorporate a "sustainability consideration" within all management and board papers and declare a climate emergency for your organisation (please see appendix 1 for an example of an impact assessment which incorporates sustainability).
- Embed assurance and accountability around large capital spending schemes to ensure they achieve the highest possible environmental standards (Passivhaus, LEED Platinum or BREEAM Excellent).
- Enable colleagues that don't have a direct sustainability remit to act as regional champions on climate change by providing protected, paid time.
- Make one personal and one organisational pledge now after reading this paper. For instance; I'm going to volunteer to be the board lead; or I'm going to ask someone what we're doing about our response to climate change; or I'm going to cycle to work one day more each week; or I'm going to learn what I can do to promote biodiversity on site.

Please do let us know what support you may need in your organisation's delivery of these asks

Expected benefits

Delivering the asks in this paper helps achieve the WY&H Health and Care Partnership ambition of being a global leader in responding to the climate emergency[i], one of its ten big ambitions in its five year plan.

This will include a reduction in carbon emissions, increases in biodiversity, and increased resilience to climate-related risks such as flooding and heatwaves. It will also include better patient outcomes as being truly sustainable involves preventing disease and reducing the need for healthcare. What is more, many of the infrastructure changes required to decarbonise heat and the switch to LED lighting will pay for themselves many times over in the course of their lifetimes in terms of reduction in energy bills. This will offset the short term need for some capital spends.

The rest of the paper that follows is to provide insight and assistance to all organisations. In the WY&H Health and Care Partnership which is a diverse group of organisations that all contribute positively to population health and wellbeing, acknowledging that not all are healthcare providers. We also recognise that different organisations will be at different stages in the development of their response to the climate crisis. The content that follows is to provide a common baseline or starting point for those less clear on the asks, and it is not intended to be prescriptive.

Contents

Definitions

- Climate change – human-driven change in earth's climate due to release of greenhouse gases leading to average temperature increase across the globe with increased risk of flooding, extreme heat, etc. Accompanied by loss of biodiversity and wildlife.
- Sustainability – this paper refers primarily to environmental sustainability rather than financial viability, recognising that environmental sustainability can be accompanied by cost-savings or cost-increases depending on the topic. Where trade-offs occur careful processes will need to be used to address these issues.
- Climate-related risks includes a range of risks made worse by climate change such as floods, heatwaves and the risk of food security.

Background

Climate change and health

The climate change emergency is a human health problem. Health and care contributes significantly to climate change (the NHS alone is responsible for 5.4% of UK total CO2 emissions[ii]) and the climate change emergency already places a large burden on the NHS and this will increase significantly in the future (40,000 premature deaths in the UK this year due to air pollution alone[iii]). Climate change will deepen health inequalities[iv] and its impacts are already being felt locally; addressing climate change can provide substantial gains in population health, reductions in health inequalities and reduce demand for health and social care services.

Our regional ambition

The WY&H Health and Care Partnership have an ambition to be a global leader in responding to climate change, through increased investment, mitigation and culture change throughout our system[i].

Climate related-risks

Climate change poses a number of risks to health and care. Flooding, for example, can cause significant mental health issues and significant disruption to travel routes or even health and care infrastructure. Heat can cause excess mortality and increased incidence of a number of conditions. So far there has been a lack of system-level understanding of and response to these risks. Climate change also poses a range of other, more global risks such as potential supply chain issues and issues around food security.

Climate change is everyone's business

Because of the complex nature of both care and climate change, there is no one solution which will move us to a sustainable future. In order to move towards sustainability, every person in every industry needs to incorporate a process of thinking about climate change in every aspect of their personal, professional, social and private lives along the same way in which we think about keeping the law in everything we do. In the same way that law and order is maintained despite a few people disregarding them, humans can move to sustainability not by the huge efforts of some but by the actions of the vast majority in every dimension of their lives.

Policy context

There is high public and staff support for action on sustainability within the NHS[v].
The UK has a legal obligation under the 2008 Climate Change Act to be net carbon zero by 2050[vi] and West Yorkshire Combined Authority has pledged to be net carbon neutral by 2038 with significant progress towards this by 2030.

The NHS has increasingly strong guidance and legislation around climate change. We include highlights here both as an aide memoir for NHS organisations but also as a framework for those who are not in the NHS.

The NHS published a Net Zero report on 1 October 2020 with a net zero target for the NHS of 2040[vii]. This document also expects NHS organisations to:

- Identify a Board level lead for sustainability.
- Have a board approved Green Plan with clear sustainability and carbon targets (April 2021).
- Set Net Zero carbon reduction targets to eliminate carbon by 2045 at the latest.
- Sign up to the NHS Plastics Pledge and eliminate single use plastic where possible.
- All new builds and retrofits building projects to be Net Zero.
- Conduct a Green and Grey fleet review with the Energy Saving Trust (available for free here: https://www.energysavingtrust.org.uk/sites/default/files/23580-EST%2BDFT-Fleet%20support%20A5-WEB_Green%20fleet%20review.pdf).

The NHS Operational Planning Guidance[viii] has several key targets on climate change by 2021:

- All organisations should implement the Estates and Facilities Management Stretch programme by NHS England and NHS Improvement in 2020.
- All lighting replaced with LED alternatives during routine maintenance activities.
- Reduce air pollution from vehicles purchased/leased after 1 April 2020 to support the transition to low and ultra-low emission vehicles.
- Ensure car leasing schemes restrict the availability of high-emission vehicles.
- End business travel reimbursement for domestic flights within England, Wales and Scotland.

And by 2030:

- Reduce the carbon impact of Metered Dose Inhalers in line with long term plan commitments.
- Identify route to eliminating harmful anaesthetic gas phase out.

The NHS Standard Contract 2019/2020[ix] also demands:

- 90% of fleet to be zero emission (including 25% ultra-low emissions) by 2028.
- Reduce business mileage by 20% by 2023/24.

What are the key drivers of climate change from a health and care perspective?

The key drivers of climate change will vary on the nature of the organisation considered. For example, in primary care pharmaceutical prescribing will be the largest factor influencing carbon emissions, whereas in hospital energy use and equipment are likely to play a larger part. Travel is a key cause of carbon emissions – whether patients, visitors, staff or business.

Two specific medicines account for a large proportion of the health and care footprint – inhalers (3%) and anaesthetic gases (2%) – though these will clearly only be relevant for specific organisations. While it is not possible here to provide a thorough analysis of the carbon footprint of every type of organisation, we provide a list of resources in Appendix 1 which organisations can use to better understand their own drivers of climate change.

Based on existing analyses and policy documents (such as the NHS Net zero report) and discussions with the regional network, the WY&H climate change leads have identified several priorities for short term action which are underway and developed a framework for action in the longer term which are outlined in Appendix 2.

What does it mean to be a global leader?

The UK has high baseline carbon intensity in its health sector[x] so there is a long way to go.

There are many aspects of becoming a global leader that we can aspire to, and defining our ambitions in more detail will be vital to developing a clear action plan for years to come.

Becoming a global leader in responding to the climate emergency means doing very well across a wide range of activity – the Nordics have a concept of being top 5% in everything[xi]

We need to be global leaders in preventing ill health in order to reduce demand for health and social care and then ensuring that residual care is as sustainable as possible by capitalising on our assets such as our health technology sector and addressing gaps in the field such as the use of commissioning levers and sustainable social care. Further engagement work will be required to explore how we will become global leaders. We will embed a health inequalities lens on our climate change wherever possible.

The role for the Health and Care Partnership

Conversations suggest the WY&H Health and Care Partnership adds value on climate change through:

- Systems leadership – generating shared narrative and commitment, identifying and supporting cost-saving interventions and innovative funding, activating and enabling local assets and capacity and conducting engagement work.
- Joint activity – on key topics such as inhalers, anaesthetics, travel.
- Connecting and supporting – information sharing, best practice and collaborations including seeking external sources of funding.
- Influencing regional and national agendas such as transport, housing, innovation funds and procurement.
- Supporting places and drawing learning for the wider system.
- Analysis – providing insights and business case on key topics, monitoring progress.

This approach has already begun to add value – including our work on inhalers, the briefing we arranged for staff to access information about the Public Sector Decarbonisation Funding, and our climate change summit.

Our offer:

- There is already a board level sustainability lead in the region who is keen to bring together a board level sustainability group to share good practice and ideas to progress in meeting the WY&H Health and Care Partnerhip's ambition.
- We support a network of over 30 organisational leads and we are keen to further develop this network.
- We have developed a framework for action on which we are working at a regional level (see appendix 2) – we welcome engagement and collaboration on these topics.
- 100 free training spaces are available to staff from across health and care in the region (see website for more information).
- We are keen to support in other ways depending on specific support needs from our partner organisations.

Our regional approach aims to:

- Empower and educate staff and mobilise at scale
- Encourage experiment, don't try to control but learn from and steer
- Sustainability at the heart of everything we do
- Celebrate success

The role of different organisations & their current impacts

Different organisations will clearly have a different impact and remit around climate change; we would highlight several key facts here:

- Acute trusts are the largest carbon emitters.
- Commissioners can use this function as a lever to shape the system to be more sustainable.
- In primary care pharmaceutical prescribing is a large factor.
- Resilience & preparedness eg to heat/cold/flooding requires a response from all organisations.
- Social care commissioners should work across the social care sector.

What can health and care organisations do?

Local authorities across the country have declared climate emergencies. Through approaches such as citizen assemblies, commissions and inquiries, they are taking a wide range of approaches to addressing the issue. We know that many of our local authorities are already working on this. Useful resources to further support this work include:

- So you've declared a climate emergency – what next?
- Social Care Institute of Excellence past work programme on sustainability
- On 1st October 2020 Greener NHS issued its strategy document, "Delivering a Net Zero National Health Service" which included the expectations that every NHS organisation:
    - Has a board-level net zero lead
    - Works with its suppliers to ensure that all of them meet or exceed our commitment on net zero emissions before the end of the decade
    - Works towards a shift to zero emission ambulances by 2022 and the rest of the fleet by 2032
    - Ensures any new build is net zero as part of the government's Health Infrastructure Plan with a new Net Zero Carbon Hospital Standard
    - Works to decarbonise heat requirements and transitions to LED lighting
    - Builds climate resilience and adaptation into all its strategic thinking

Suggested outline of a board lead role

Depending on the organisation, the role of the board lead may differ slightly but should include:

- Strategic responsibility for driving forward the climate change work in their own organisation.
- Responsibility for sharing learning and resources across the Partnership.
- Ensuring appropriate plans are in place to address their own organisation's climate change context.
- Responsible both for;
    - mitigation (reducing the impact of their organisation on climate change)
    - adaptation (strengthening their organisation's awareness and resilience to climate-related risks)

For example, an NHS board lead could have the following remit:

- Take responsibility for the Green Plan (formerly SDMP (Sustainable Development Management Plan)) for your organisation. The Green Plan should include the whole scope of your organisation including, but not limited to:
    - Air pollution
    - Energy, waste and water efficiency
    - Plastic reduction
    - Carbon emissions
    - Adaptation
    - Staff engagement in social and environmental activity
    - Travel
    - Procurement
    - Upstream supply chains
- Report to the board at least quarterly on implementation of the Green Plan.
- Work to further embed sustainability considerations and practices in every aspect of your organisation's business.
- Developing organisational risk maturity around climate-related risk.

Board-Level Net Zero Lead Opportunities:

- Training is available with the Centre for Sustainable Healthcare via WY&H.
- Link in with other Board-Level Net Zero Leads in the region via WY&H.
- Potentially publish case studies to be used as national exemplars.

Questions for the Board Level Lead to ask of the organisation:

- How do we currently measure carbon emissions?
- What is our baseline assessment of risk related to climate change?
- What are our key priorities for action?
- What is our progress to date?
- What are our existing plans & governance status?
- What are the opportunities to accelerate?

Appendix 1: Useful Resources

- For a greener NHS website (currently still being populated)
- Legacy NHS Sustainable Development Unit website
- Centre for Sustainable Healthcare website (NB their Networks are probably the best place to crowdsource ideas)
- WY&H Combined Impact Assessment Tool (Soon to have the sustainability tabs revised):

WYH Combined Impact Assessment -

- How to produce a Green Plan
- SCIE page about social care and sustainability
- Free fleet review by the Energy Saving Trust
- Article about what to do after declaring a climate emergency
- WY&H Climate Change website
- Contact the WY&H climate change team: frank.swinton@nhs.net

Appendix 2: A framework for action at a regional level

Specific organisations may find inspiration here and wish to support this work, plans at an organisational level may differ

Objective 1: Reduce demand for healthcare via a healthy, equitable and environmentally sustainable society
A. The transport system and air quality
B. The natural and built environment – housing, greenspace and green social prescribing
C. Inclusive and green economy
D. Health inequalities – including climate related risk
E. Food
Objective 2. Ensure residual healthcare is high quality, equitable and environmentally sustainable
A. Insight and analysis
B. Estates – buildings, energy, waste
C. Travel – including patients, staff, business and visitors
D. Technology and innovation
E. Clinical care – eg inhalers, anaesthetic gases
F. Engaging the whole workforce in delivering change
G. Social care
Programme Activities
A. Mobilisation of different sectors and citizens
B. Governance including our steering group
C. Climate change in other WY&H programmes
H. Levers - commissioning and procurements

References

[i] https://www.wyhpartnership.co.uk/publications/our-five-year-plan

[ii] https://www.arup.com/perspectives/publications/research/section/healthcares-climate-footprint

[iii] https://www.rcplondon.ac.uk/projects/outputs/every-breath-we-take-lifelong-impact-air-pollution

[iv] https://pubmed.ncbi.nlm.nih.gov/29219089/

[v] NHS SDU. Staff survey – action and attitudes to sustainability; NHS SDU, 2016. Sustainability and the NHS, Public Health and Social Care system – Ipsos Mori survey

[vi] https://www.legislation.gov.uk/ukpga/2008/27/contents

[vii] https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf

[viii] https://www.england.nhs.uk/publication/nhs-operational-planning-and-contracting-guidance-2020-21

[ix] https://www.england.nhs.uk/wp-content/uploads/2019/03/3-FL-SCs-1920-sepsis.pdf

[x] http://norden.diva-portal.org/smash/get/diva2:1293369/FULLTEXT01.pdf

[xi] http://norden.diva-portal.org/smash/get/diva2:1346242/FULLTEXT01.pdf

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:	Developing an Integrated Care Partnership (ICP) in Leeds
DATE OF MEETING:	25 March 2021
PRESENTED BY: (name and title)	Dr Sara Munro – Chief Executive
PREPARED BY: (name and title)	Leeds Partnership Executive Group

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.	**X**
SO2	We provide a rewarding and supportive place to work.	**X**
SO3	We use our resources to deliver effective and sustainable services.	☒

EXECUTIVE SUMMARY

Our Trust is a strong and active partner within Leeds, West Yorkshire and the wider region with membership and leadership roles in a number of boards, committees in common and provider collaboratives. As a Trust Board we have been considering in recent development sessions the implications of wider policy and proposed legislative changes that will make Integrated Care Systems (ICS) a legal body in 2022.

Our primary ICS is West Yorkshire and within that the aim is for each 'place' to operate as an Integrated Care Partnership bringing together NHS and local authorities organisations with primary care, voluntary and community sector to deliver care that is seamless, efficient and effective. This is important because we know from events such as the Big Leeds chat and our own quality reports the lack of effective integration across pathways and organisations compromises quality, safety and the experiences of health and care services. Provider collaboratives based on specialities will also continue to grow and lead on the development and delivery of services across ICPs/places and across ICS and regional footprints. We continue to be a member of the Humber Coast and Vale ICS and whilst our service provision is significantly smaller there the work to ensure integrated care pathways is just as important for our service users.

The purpose of this paper is to update all boards within the Leeds health and care system (place) of the progress to date and intended next steps to formally operate as an Integrated Care Partnership for Leeds.

This is not a new step for Leeds or indeed the ICS. The partners in Leeds have all been working closely together for several years with established governance arrangements in

place including Boards to Boards which involve elected members of the council, Trust Chairs and NEDs, the Partnership Executive Group (PEG) and the growing shared functions through the Leeds One Workforce, estates and digital strategies that are key enablers to support our workforce. In the past 12 months we have also seen great progress at the frontline as our teams have worked together to deal with the covid pandemic and the nature of the current transfer of the Tier 4 CAMHS service from Leeds Community Trust to ourselves all indicate the strength of our place based relationships.

In light of this and the white paper we believe now is the time to seek formal sign up from our respective boards for the Leeds ICP and this to form the 'place' based arrangements for integration as the ICS takes on a statutory footing. As a Trust we will also continue to be part of the West Yorkshire collaborative for Mental Health Learning Disability and Autism Committee in Common and these two key formal partnerships should be seen as complimentary and in line with the future landscape set out in the white paper.

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

RECOMMENDATION

The Board is asked to consider and support the recommended next steps set out in the enclosed document as a core member of the Leeds Integrated Care Partnership.

Developing an Integrated Care Partnership in Leeds – Progress, proposals and next steps

Report of:	Leeds Health and Care Partnership Executive Group (PEG)
Date:	Version 9.1, 15/03/21

1 Purpose

This paper has been written by the Leeds Health and Care Partnership Executive Group (PEG) whose members include: the CEOs from the NHS in Leeds; Leeds City Council (LCC); Healthwatch; Directors of Adults and Health, Childrens and Families; Public Health; and advocates from the 3rd sector, General Practice and Clinical Senate.

This paper will be used to support discussions with Boards and executive teams to:

1. Affirm commitment to the shared purpose and degree of ambition set out in the Leeds Health and Wellbeing Strategy and measured through a shared set of outcomes and measures.
2. Gain a mandate to scope the establishment of a Leeds Integrated Care Partnership (ICP) and underpinning governance arrangements, including a formal partnership agreement and/or joint committee.
3. Confirm Board support for the establishment of a set of shared integration functions and capabilities for the city as a key component of a proposed ICP.

2 Recommendations

It is recommended that Boards:

Recommendation 1 – **Reaffirm support** for our shared ambition as measured by the strategic indicators described within the city's Left Shift Blueprint.

Recommendation 2 – **Commit their organisations** to a further degree of integration by tasking their leaders to scope, define and propose arrangements for a Leeds ICP.

Recommendation 3 – **Provide support in principle** to the creation of a partnership agreement and/or joint committee that has delegated powers to underpin and enable the Leeds ICP.

Recommendation 4 – **Provide sign-up** to securing a co-ordinating/integrating set of capabilities in the city through a dedicated ICP function and commitment to doing things once where it makes sense to do so.

Recommendation 5 – **Sign-up** to a specific relationship with the ICP, as a constituent part of the ICS, that takes responsibility for the discharge of duties in Leeds (as opposed to duties being discharged separately to the ICP).

3 Achieving our ambition

3.1 Our shared ambition

Our Leeds Health and Wellbeing Strategy has set the focus of our partnership that together we will make Leeds the best city in the UK for health and wellbeing, a healthy caring city for all ages, where the poorest improve their health the fastest. The best city for all ages, both now and for future generations.

Despite some fantastic work to date, good health and prosperity in our city is still not felt by all and there is evidence that some inequalities are widening and will worsen as a result of the Covid pandemic. Making Leeds a more equal city with more people benefiting from the life chances currently enjoyed by the few is at the heart of our vision. This is why we emphasise the importance of good health, the need to boost resilience, and focusing on prevention as a means of enabling higher quality, person-centred service provision.

A social model of health is fundamental to prevention of poor physical and mental health, which take into account influences on health and wellbeing, including social, cultural, economic, and environmental factors. We believe that people are the catalysts for change in their local communities and within the front-line and should be actively involved in identifying, planning, designing and implementing solutions to health issues and unjust health inequalities. Strategic alliances of individuals, communities, services, professionals and local councillors, will be used and developed further to support this shift.

Improving health services needs to happen alongside achieving financial sustainability, making the best use of the collective resources, and working more purposefully in an integrated way to ensure we improve the health and wellbeing of the people of Leeds.

3.2 Delivering our ambition

Having a shared ambition is only part of the picture. We need a clearly defined and shared work programme to collectively own and deliver. This work programme also needs people centred outcomes and indicators that are jointly owned and which can be used to measure our success not just in the here and now but also improving the health and wellbeing of the Leeds population over a longer time period.

In November 2019, NHS Leeds CCG committed on behalf of the partners to lead the development of the ‘Left-shift Blueprint’ as one of the contributions towards delivering our collective partnership ambition. Over the last 12 months, as a partnership, we have developed the ‘Left-shift Blueprint’ which sets out how health and care services will be delivered in Leeds over the next five years.

Whilst this work is essential to ensuring a coherent approach to improving health and wellbeing outcomes across the city, it is even more critical that it is undertaken now given the planned initiatives to rebuild hospital estates and to understand and address the impact of the pandemic on health outcomes and health inequalities. It is essential that through the ‘Left-shift Blueprint’ we develop an agreed model of care for the city which drives health improvement, meets future demand and can also be delivered within our future estates footprint. The ‘Left-shift Blueprint’ sets out our system wide ambitions through three types of strategic indicators.

- Health outcome ambitions – these are longer term indicators looking at over a 10 year period

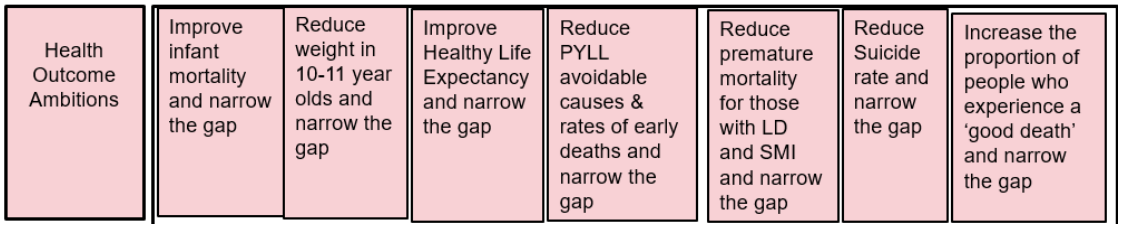
- System activity metrics – these indicators will provide a more immediate view of impact and will be measured through the Leeds Data Model
- Quality experience measures – these will use a balanced scorecard approach using a mixture of user voice: Healthwatch and other user-led feedback mechanisms, compliments and complaints information, multi-agency and multi-disciplinary case file audits, and metrics. It is important that these reflect experience from a population rather than just a service perspective.

It is proposed that for each of these strategic indicators, our ambition is to:-

- Be as good as, if not better than the England average
- Where measurement allows – we will commit to reducing the gap between Leeds and deprived Leeds by 10%

These specific targets and metrics have been developed and selected due to their impact and span across our populations in terms of our ability to influence and deliver across health and care pathways. The various programme boards have played a significant role in helping shape these. Wherever possible effort has been to ensure clear links to other existing and emerging delivery models across the health system (such as Building the Leeds Way and the development of the Primary Care Networks (PCN) and Local Care Partnerships (LCP)) in order to retain cohesion across sectors in our delivery aims. An overview of the strategic indicators as developed to date are provided in Appendix 1.

The particular health outcome ambitions are set out below.



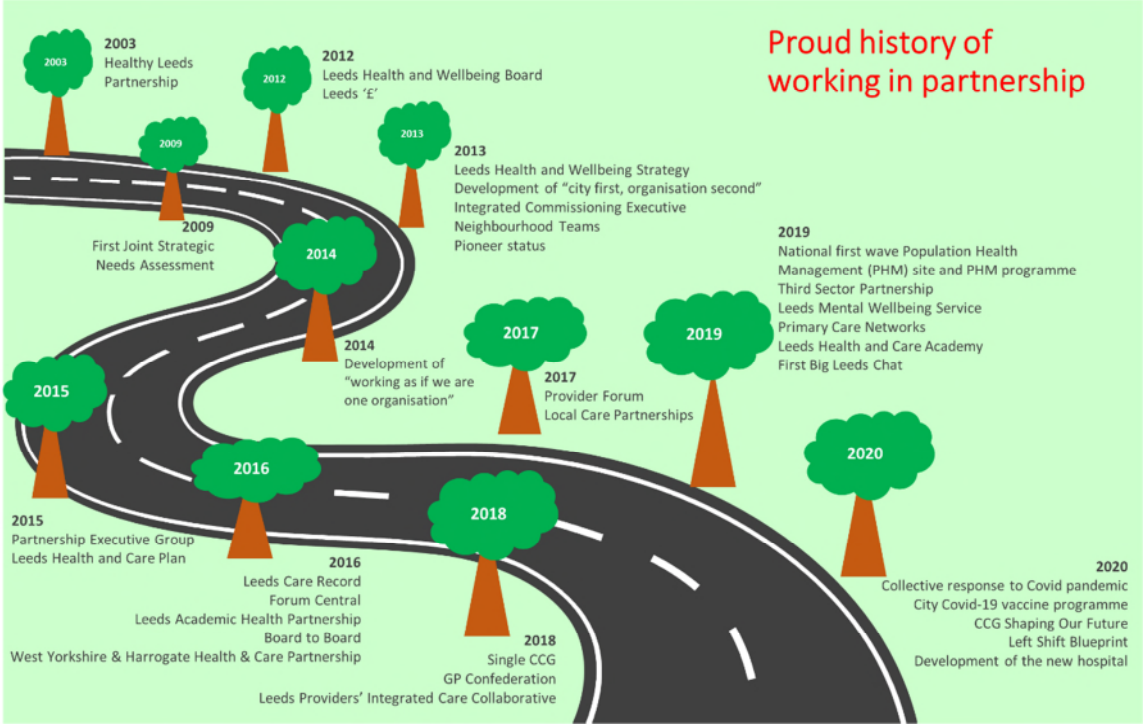
Measurable improvement across these strategic indicators will be driven by clinicians, professionals, 3rd sector and people of Leeds using Population Health Management (PHM) approaches and local insight (at LCP and city level) to identify, design and implement interventions and service change that will have the biggest impact. In-line with our Health and Wellbeing Strategy ethos of starting with people and communities, we will ensure that coproduction runs through all aspects of change. Clinical and professional leadership at place level (through the Clinical Senate), at programme level (through named clinical and professional leads at programme and Programme Board level) and at LCP level (through multi-professional LCP teams) will be critical to successful delivery of our ambition.

Recommendation 1 – Boards are asked to reaffirm support for our shared ambition as measured by the strategic indicators described within the city's Left Shift Blueprint.

4. Proposal to create a formal Integrated Care Partnership for Leeds

4.1 Our partnership and journey towards integrated care

Leeds has a long history of successful partnership working with people at the heart and with a breadth of assets[1] to enable genuine whole system change. There are many examples of how, by working together as a partnership, we have achieved successes and improvements to lives of people who live and work in Leeds. Some examples are provided in the diagram below.



Most recently, the response to the Coronavirus pandemic across the city has once again demonstrated what can be achieved when heath and care staff from different organisations and different roles work together, alongside communities, to achieve shared goals. There is a strong consensus that our response to the pandemic offered an opportunity around integrated clinical working and clinician engagement that coincides with an ambition to develop an ICP and progress health and care integration.

Building on this success, we want to proactively create the conditions that enable and support our health and care staff from all professions to continue to work together, and with people and communities, to deliver measurable progress towards our ambition to improve outcomes and reduce inequalities for our population.

[1] Home to: NHS England/Improvement; NHS Digital; several of the world's leading health technology and information companies; one of Europe's largest teaching hospitals; many good or outstanding services and providers; being one of the first integrated care Pioneers; Council recognised as a Department for Education Partner in Practice; one of four 'first wave' national Population Health Management (PHM) sites; several leading universities; a diverse and thriving third sector; and a GP Confederation - a membership organisation that comprises of all 19 Primary Care Networks, with the governance that allows for integration and collaborative working with other providers

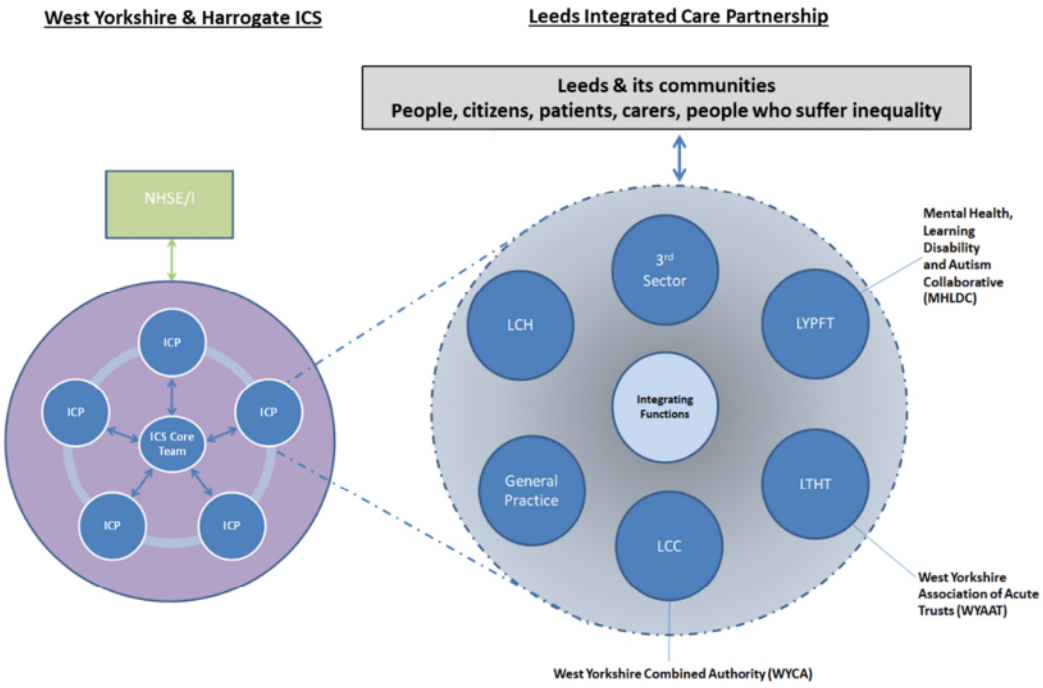
4.2 Proposals for an Integrated Care Partnership for Leeds

There is opportunity to develop and enable closer working relationships and practice by establishing more formal integrated care partnership arrangements in Leeds.

The proposed legislative changes outlined in the February 2021 Health and Social Care White Paper[2] and the associated development of the West Yorkshire & Harrogate ICS (WYHICS) Operating Model strengthen the case for formalising integrated care partnership arrangements in Leeds.

From April 2022, ICSs will become statutory organisations absorbing commissioning functions currently undertaken by CCGs and NHS England. Strong place based arrangements (Integrated Care Partnerships) are the cornerstone of the emerging WYHICS Operating Model (depicted in Figure 1 below).

Figure 1 – Proposed Operating Model for WYHICS and what a Leeds ICP could be



Central to the proposed WYHICS Operating Model is that 'Place' is the primary unit of planning and collaboration, with place-level partnerships working closely with local Health and Wellbeing Boards. Joint committees between the members of Integrated Care Partnerships and Provider Collaboratives will enable more integrated working and mean that ICPs and Provider Collaboratives will be able to discharge the duties of an ICS at place level. Continuing to have a strong place based approach is essential to delivering high quality person centred care, working with people at a neighbourhood (LCP) level.

Within the context of our shared ambition, our track record of collaboration and integration and the opportunities afforded through national reform; a Leeds ICP could be described as:

[2] Integration and Innovation: working together to improve health and social care for all (publishing.service.gov.uk)

"An alliance of health and care partners that work together to improve the health outcomes and reduce inequalities of the population by using our resources collectively to deliver population-health driven integrated care".

The formalising of existing partnership arrangement into a Leeds ICP would help us achieve measurable delivery of our shared ambition (as set out in the 'Left Shift Blueprint') by enabling us to jointly plan and agree how we use our collective resources to enable clinically-led design and implementation of initiatives and services that improve quality, clinical effectiveness and people's experience.

Establishing a place level ICP for Leeds also creates an opportunity to connect Population Health Management (PHM) approaches at place and Local Care Partnership level, to enable resources to be directed to populations (geographical and needs-based) where the greatest opportunities for improvement exist. There are opportunities to create a citywide improvement capability with shared methods and data to improve value and quality across care pathways. Just as engagement with people is key, for meaningful change, clinical leadership and engagement is also essential; citywide ambitions and improvement activity need to be applicable to all health and care staff so that those who are doing the work can improve the work. It is also important to work with the research and academic sector to apply skills and expertise the sector can bring to innovation. As depicted in Figure 1, the WYHICS Operating Model is constructed around place-level ICPs supported by an ICS core team. Within this model, a Leeds ICP would operate with sufficient autonomy to remain focussed on the delivery of our ambition for Leeds whilst retaining its membership as part of the wider WYHICS.

Work is required to scope, define and propose arrangements for a Leeds ICP clearly articulating how these arrangements will better enable us achieve our ambition within our collective available resources.

4.3 Engagement and coproduction

Creating a culture of collaboration around a shared vision through engagement with our teams, and the people of Leeds, will be key to making meaningful change. Leeds's successful partnership has been in part due to the way all partners are engaged with the aim to coproduce and have people's voices at the heart. It is recommended Leeds embarks on an ambitious 'Team Leeds' engagement programme to coproduce the future 'integrated care partnership', the principles and the culture with both staff (including clinicians and the 3rd sector) and the public. It is proposed that the staff element is led by the Strategic Workforce Programme and the public element is led by Healthwatch with both elements supported by the Health Partnerships Team.

Recommendation 2 – Boards are asked to commit their organisations to a further degree of integration by tasking their leaders to scope, define and propose arrangements for a Leeds Integrated Care Partnership

4.4 Creating of a Partnership Agreement / Joint Committee

Legislation proposed in the recent White Paper specifies that to enable Integrated Care Partnerships to discharge duties on behalf of the ICS, there must be a 'weight bearing' partnership agreement and/or joint committee at the (Leeds) place level to underpin the ICP.

The arrangements set out within a partnership agreement will be designed to further strengthen relationships between partners within the Leeds ICP, all of whom are strategic planners (commissioners) and/or providers of health and care services in Leeds, for the benefit of the population of Leeds. The arrangements will also enable the ICP to operate with a level of autonomy required to act and make decisions to enable the ICP to fulfil its purpose and deliver its ambition. Specifically this would include the ability to manage the delegated budget for the city to enable delivery of agreed priorities.

The ambition will be that the ICS provides sufficient support through former CCG colleagues to ensure that the ICP can move quickly to ensure it is able to discharge the ICS duties at place. Our CCG colleagues who are already embedded in the city and our ICP development work will continue to be so regardless of changes in the statutory organisation that employs them. The ICP will identify those areas where it believes the ICS will add additional value by undertaking them once across West Yorkshire.

A key area to be agreed is the membership model for the Leeds Integrated Care Partnership. Membership will need to include both statutory health and care organisations and non-statutory partners (covering the 3rd sector, independent sector and statutory sector) recognising the whole partnership approach we have in Leeds. Initial thinking based on learning from other areas is to have two categories of membership – “full member” and “associate member”. The membership type will likely be determined by how organisations are constituted and their statutory authority. All members will be able to input to any discussions requiring a decision, but decisions concerning statutory NHS requirements are only taken by full members. However, both full and associate members will be equally committed to delivering the objectives of the ICP.

It is proposed that members of the Leeds ICP will work together under a governance framework (set out in a partnership agreement) to develop place-based arrangements to enable the collective planning and delivery of person centred integrated care. These arrangements may ultimately include requirements in relation to outcomes, risk/gain share, financial and contract management and regulatory requirements. The agreement will also include a financial framework to allow pooling of resources and ensuring there is system visibility of budgets where there is no direct alignment or pooling to ensure that decisions take account wider system implications.

The emerging Operating Model for the WYHICS proposes that appropriate governance arrangements should be in place, in shadow form, from September 2021. As changes to the national legislation will take many months to be developed and enacted, there may be a need to iterate any local governance arrangements once changes to legislation are made. Appendix 2 provides a high level overview of potential content of a partnership agreement.

4.5 Relationship with existing organisational governance in Leeds

As part of the development of the ICP and underpinned by a formal agreement, it is important to note that:

- Existing individual Boards will retain accountability and responsibility for individual organisations but will have chosen to work together in specific ways on specific programmes and delivering a set of shared capabilities.
- Boards are doing this because they believe that by working more formally together we will deliver the shared purpose and ambition.

- The Leeds Health and Wellbeing Board will continue to lead partnerships in Leeds and fulfil its statutory functions to produce a Health and Wellbeing Strategy, Joint Strategic Needs Assessment and promote integration.
- The WYICS Operating Model is founded on the principle that the ICPs are the place-based units of the ICS. Individual organisations and the integrated care partnership will contribute to and thus have regard to plans set by the ICS.
- The future relationship between the ICP and the Leeds Health and Care Partnership Executive group needs to be defined.
- The review of ICP governance arrangements creates a useful opportunity to review the wider partnership governance and to streamline where appropriate.

Work is required to understand, scope and recommend options regarding the membership and form of partnership agreement and/or joint committee to underpin the Leeds ICP. This will require collaborative working with governance leads from organisations across the Leeds health and care system as well as input from legal experts.

Recommendation 3 – Boards are asked to provide support in principle to the creation of a partnership agreement and/or joint committee that has delegated powers to underpin and enable the Leeds Integrated Care Partnership

5. Securing a co-ordinating/integrating set of capabilities in the city

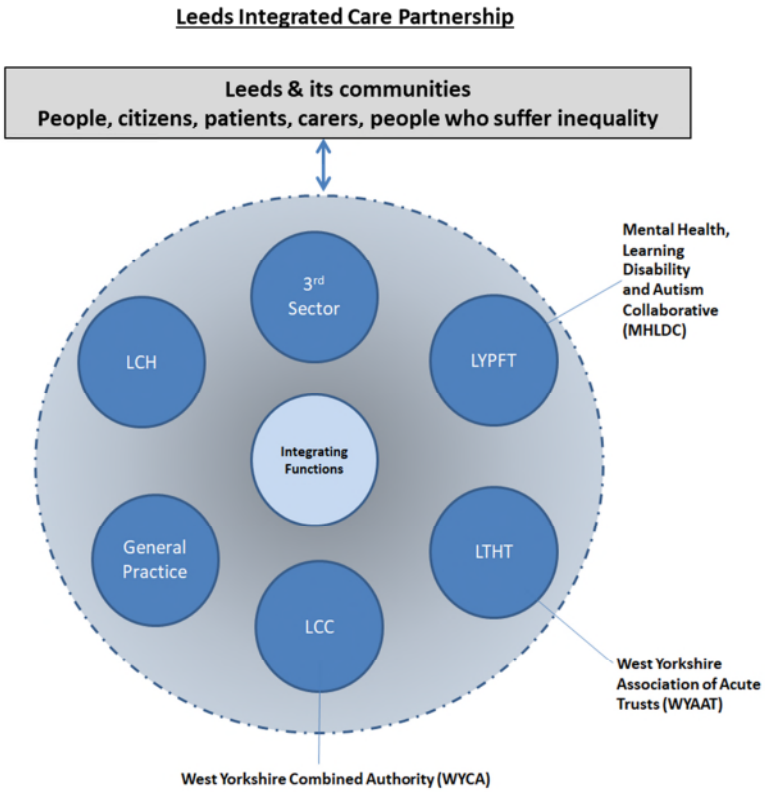
5.1 Shared capabilities

Successful integrated health and care systems from across the world have in common, a set of coordinating or integrating capabilities. The existence of these capabilities allows each partner to both retain a level of organisational autonomy whilst coming together where it makes to do so to jointly deliver the shared ambition in a consistent efficient way.

As part of the aforementioned legislation, from April 2022, functions undertaken by CCGs will be undertaken by ICSs and CCGs will no longer exist. Through its Shaping Our Future programme (SOF) NHS Leeds CCG has redesigned the way it will operate from a traditional commissioning organisation to an organisation able to use Population Health Management approaches to deliver Strategic Planning and System Integration capabilities in its future capacity.

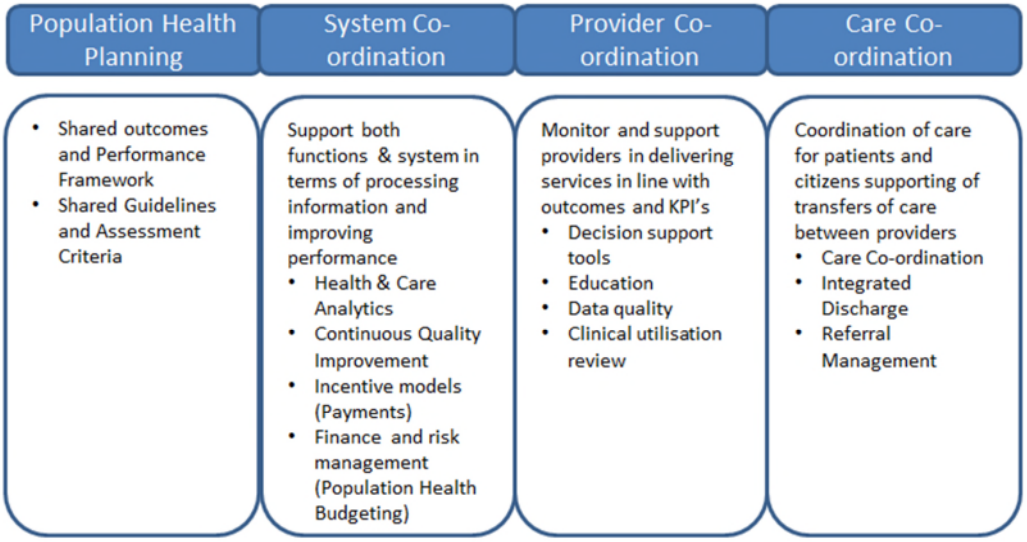
As part of the emerging WYICS Operating Model, CCG staff will continue to work and be embedded in Leeds to deliver a set of value-adding integrating capabilities to the ICP, as well as ensuring the ICP is capable immediately of discharging in place the duties of an ICS.

Figure 2 – Integrating functions as part of the Leeds Integrated Care Partnership



Though the former CCG staff play a key role in the integrating functions, it is important that all partners play a role in the different integrating functions and that there is strong alignment with all partners. A high level summary of the integrating / coordinating capabilities which could be established are described in Figure 3. The CCG through its Shaping Our Future programme is already in process of developing many of these capabilities ahead of any changes in legislation. A fuller description can be found in Appendix 3.

Figure 3 – Joint integrating / coordinating capabilities



It is important to note that establishing this full range of capabilities for the ICP will require time and in some cases technical development. Time limited external expertise may be required to understand the priorities for capability development and also to provide targeted technical support in the development of some of these capabilities.

Recommendation 4 – Boards are asked to provide sign-up to securing a co-ordinating/integrating set of capabilities in the city through a dedicated ICP function and commitment to doing things once where it makes sense to do so.

5.2 Relationship with West Yorkshire and Harrogate Integrated Care System

Leeds is a strong supporter of the devolved place based leadership approach we have adopted across the region and the principle of subsidiarity with work taking place at the appropriate level and as near to local as possible. We know from engaging with the public and staff, there is a much stronger connection to place and local community rather than an ICS body which can feel much more distant to the front-line.

By implementing the proposals set-out in this paper, Leeds will be in a strong position to support the ICS to discharge its duties through a place based model.

Leeds is and will continue to be an active member of the West Yorkshire and Harrogate Integrated Care System (ICS) to improve health and healthcare across the wider region. Leeds has taken leadership roles across the ICS for example, Chairing the West Yorkshire Association of Acute Trusts (WYAAT), Chairing the Mental Health, Learning Disabilities and Autism Provider Collaborative (MHLDC), as well as taking on sector rep roles for local authority which will strengthen this approach and alongside this our contribution to West Yorkshire wide programmes.

Recommendation 5 – Boards are asked to sign-up to a specific relationship with the ICP, as a constituent part of the ICS, that takes responsibility for the discharge of duties in Leeds (as opposed to duties being discharged separately to the ICP)

6. Next steps

A significant amount of work is required to explore, scope and propose options around the constitution, governance and membership of a Leeds ICP. This work will require a significant contribution from all partners at place level and will also need to develop within the context of the evolving ICS Operating Model and national legislation.

It is proposed that existing partnership structures will need to be adapted to establish an Integrated Care Partnership Development Programme Board with CEO / Accountable Officer level membership from the NHS, LCC, 3rd sector, Healthwatch and clinical representation to drive forward the development of a Leeds ICP. The Programme Board will need to engage with Governing Boards at each stage of the development of the proposals to ensure that they progress with the support of the partnership.

The following is the outline of the next steps.

Citywide 'hearts and minds' engagement and co-production process	**March – July 2021**
Agree a range of priority programmes for the first twelve months that reflect our health ambitions and the development of ICP	**April 2021**
Sign-off of a formal collaboration agreement	**May 2021**
Joint Committee in place in shadow form	**June 2021**
Describe the approach to delivering the integrating / coordination functions in Leeds	**June 2021**
Joint Committee formally established	**September 2021**

Appendix 1

Proposed system level outcomes and indicators

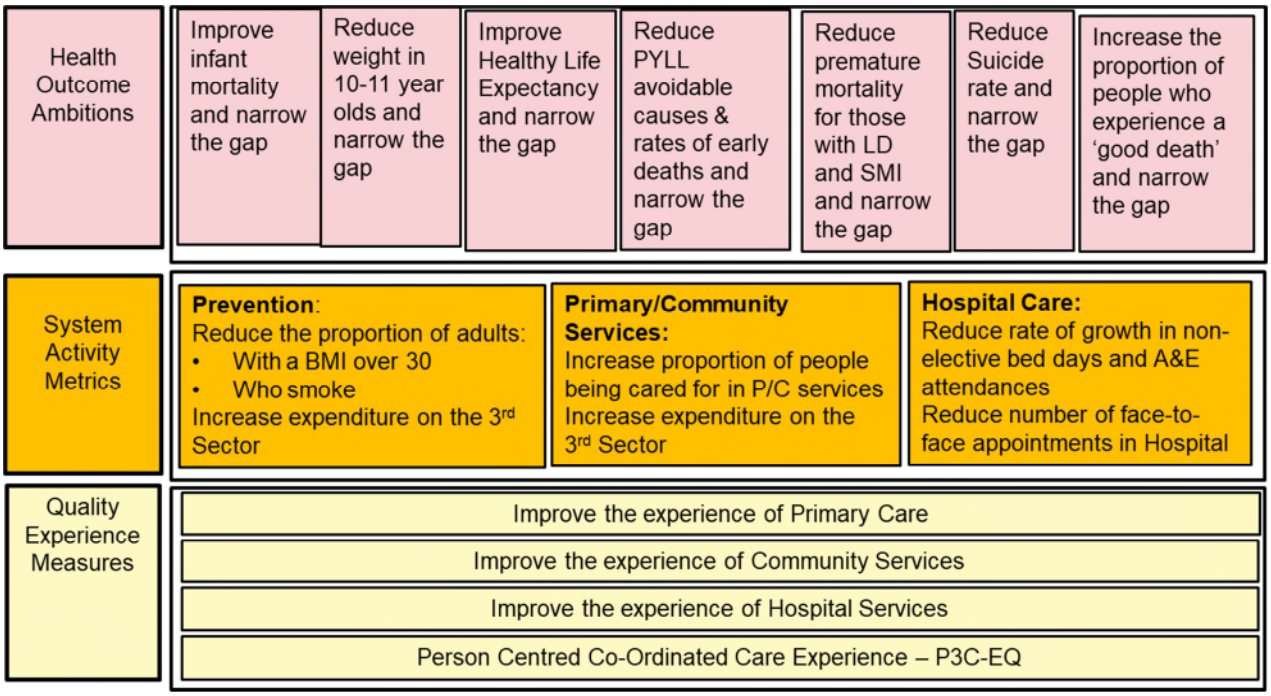
The 'Left Shift Blueprint' proposes the following system wide ambitions through three types of strategic indicators.

- Health outcome ambitions – these are longer term indicators looking at over a 10 year period
- System activity metrics – these indicators will provide a more immediate view of impact and will be measured through the Leeds Data Model
- Quality experience measures – This will use a balanced scorecard approach using a mixture of user voice: Healthwatch and other user-led feedback mechanisms, compliments and complaints information, multi-agency and multi-disciplinary case file audits, and metrics. It is important that these reflect experience from a population rather than just a service perspective.

It is proposed that for each of these strategic indicators, our ambition is to:-

- Be as good as if not better than the England average
- Where measurement allows – we will commit to reducing the gap between Leeds and deprived Leeds by 10%.

An overview of the strategic indicators as developed to date are described in the diagram below. These will be refined through further engagement with partners.



Appendix 2

Outline partnership agreement

If Boards support the recommendations outlined in this paper, then it is likely that a partnership agreement will need to cover the following:

- Those the agreement is made between, includes full and associate.
- The background, any context and reasons for the agreement
- Definitions and interpretations
- Status and purpose of the agreement
    - Sets out the main reasons for the agreement and what parties have signed up to do.
- When the agreement commences and duration
- Vision
    - That of the Leeds Health & Wellbeing Strategy
- Objectives
    - A combination of the Leeds Health & Wellbeing Strategy and Left Shift Blueprint
- Principles of collaboration
    - The way the collaboration will work together, decisions it will make and behaviours
- Problems, resolution and escalation
- Reserved Matters
    - Where there are statutory duties a members has to comply with outside of the agreement
- Transparency
- Obligations
    - Includes the obligations of full and associate members
- Governance agreements
    - The architecture, decision making responsibility. What different groups, committee, boards are responsible for
- Conflicts of interest
- Financial planning
- Exclusion and termination
- New members
- Liabilities
- Variations
- Confidentiality
- Intellectual property
- Schedules
    - Definitions
    - Priority areas
    - Principles
    - Implementation
    - Governance TORs
    - Rights and obligations of full and associate members
    - Dispute resolution

Appendix 3

Changes the CCG is making to support the development of co-ordinating/integrating capabilities

Population Health Planning	• **Outcomes:** The Director of Population Health Planning (recently appointed by the CCG) has a value adding offer that is linked to shared outcomes and performance. • **Data Architecture:** The joint Chief Digital Officer between LCC and the CCG is starting the development of proposals to create an office of data analytics and ensure that common data architecture is in place.
System Co-ordination	• **Quality Improvement:** Establishment of citywide quality improvement capability, combining existing experience from use of the Institute for Healthcare Improvement, LTHT Leeds Improvement Method and the CCG Quality Improvement Team. This capability can help create high quality care and value across pathways and help establish citywide methods and capability for improvement. • **Incentive Models:** A capability to manage the commercial relationships between partners within the partnership including development of incentives and importantly to ensure general practice management is retained in Leeds • **Finance and Risk Management:** Teams to support the ICP to manage overall financial position independently and value adding capabilities around understanding population health and financial risk – population health budgeting The CCG has also identified: • support for governance requirements which will sit alongside organisational governance • support for development and implementation of ICP policies in smaller members of the partnership that don't have the capacity at a broader level • support to develop and maintain a roadmap on the journey towards integration
Provider Co-ordination and care Co-ordination	Pathway integration functions are designed to pick-up many of these capabilities and able to flex in the future whilst recognising that the NHS will still like named leads for key areas such as Cancer or Mental Health. Capacity around training and development has not been included as the city already has the Leeds Health & Care Academy. However, what is more radical in international examples is that care co-ordination is a key function not placed in any individual provider as we currently operate it. This is not set out in detail in the CCG design as will need further discussion across the partnership.

West Yorkshire and Harrogate
Health and Care Partnership
Mental Health, Learning Disabilities & Autism

Paper title:	Review of Memorandum of Understanding (MoU) (and associated actions)	**Agenda item** **20.1**
Presented by:	WYMHLD&AC Chairs	
Prepared by:	Paul Hogg, Director of Corporate Affairs (on behalf of the t the Company Secretaries)	

Purpose of the report

To present the refreshed MoU to the four Trust Boards for approval, following discussions at the Committees-in-Common (CinC) meeting of Chairs and Chief Executives held on 21 January 2021.	For approval	✓
	For discussion	
	For information	

Executive summary

The Chairs of the four members of the WYMHLD&AC tasked the Company Secretaries to consider a number of governance issues relating to the work of the CinC meetings and advise on some housekeeping changes to the MoU, which was due for review. At the meeting of the CinC held on 21 January 2021 a number of minor changes to the MoU were supported (attached at Appendix 1, tracked changes and clean copy) for submission to Trust Boards.

The CinC also endorsed the adoption of a 'Triple A' assurance report (attached at Appendix 2) that would be produced for inclusion on the public agenda of Trust Board meetings (and where applicable the public agenda of Council of Governors' meetings). Public and private minutes of CinC meetings would continue to be presented at Board meetings. Finally, the CinC supported the suggestion that Non-Executive Directors would be offered the option of observing a CinC meeting as part of their orientation and induction, with attendance arranged through the WYMHLD&AC Secretariat.

These changes further strengthen the governance arrangements for the CinC meetings. It was agreed that any substantial revisions to the MoU should be undertaken once there was clarity on the future direction for ICSs and how the CinC can maintain its strategic decision-making roles set against future legislation.

Recommendations

That Trust Board:

- Approve the refreshed MoU at Appendix 1;
- Note the use of the 'Triple A' assurance report that will be used to summarise CinC meetings to Trust Boards; and
- Note that a more substantial review of the MoU will be commissioned by the CinC when appropriate.

WEST YORKSHIRE MENTAL HEALTH, LEARNING DISABILITIES & AUTISM COLLABORATIVE

DATE

30 April 2018

1. **BRADFORD DISTRICT CARE NHS FOUNDATION TRUST**
2. **LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST**
3. **LEEDS COMMUNITY HEALTHCARE NHS TRUST**
4. **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST**

MEMORANDUM OF UNDERSTANDING
FOR WEST YORKSHIRE MENTAL HEALTH, LEARNING DISABILITIES AND AUTISM COLLABORATIVE (WYMHLD&AC)

No	Date	Version Number	Author
1	15/11/17	01 -	Trust Company Secretaries / Governance leads
2	29/11/17	0.2	Trust Company Secretaries / Governance leads
3	4/12/17	0.3	Trust Company Secretaries / Governance leads
4	15/01/18	0.4	Trust Company Secretaries / Governance leads
5	7/03/18	0.5	Trust Company Secretaries/Governance lead
6	15/03/18	0.6 Incorporating comments from audit committee chairs	Trust Company Secretaries/Governance lead
7	25/04/18	0.7 Incorporating comments from Boards	Trust Company Secretaries/Governance lead
8	11/02/21	0.8 incorporating approvals from Committee-in-Common meeting	Trust Company Secretaries/Governance lead

CONTENTS

Date: TBC

This Memorandum of Understanding (**MoU**) is made between:

(1) **BRADFORD DISTRICT CARE NHS FOUNDATION TRUST** of New Mill, Victoria Road, Saltaire, Bradford, West Yorkshire, BD18 3LD;

(2) **LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST** of 2150 Century Way, Thorpe Park, Leeds, West Yorkshire, LS15 8ZB

(3) **LEEDS COMMUNITY HEALTHCARE NHS TRUST** of First Floor, Stockdale House, Headingley Office Park, Victoria Road, Leeds, West Yorkshire, LS6 1PF

(4) **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST** of Fieldhead Hospital, Ouchthorpe Lane, Wakefield, West Yorkshire, WF1 3SP

(each a "**Party**" and together the "**Parties**").

RECITALS

(A) In entering into and performing their obligations under this MoU, the parties are working towards a collaborative programme including ownership and commitment to collaboration as set out in the West Yorkshire and Harrogate Health and Care Partnership (STP) ("**WYHHCP**").

(B) The Parties together form the West Yorkshire Mental Health, Learning Disabilities and Autism Collaborative ("**WYMHLD&AC**") and have agreed to collaborate in delivering region-wide efficient and sustainable acute and specialist mental health services for patients. The Parties have formed Committees in Common ("**WYMHLD&AC C-In-C**") which have the specific remit of overseeing a comprehensive system wide collaborative programme to deliver the objective of a more collaborative model of care for acute and specialist mental health services in West Yorkshire (WY). The intention being to deliver a system model, operating as a network, that is coherent, integrated, consistent (reducing unwanted variation) and focused on quality and value for the population and patients (the "**WYMHLD&A Collaborative Programme**").

(C) This MoU is focused on the Parties' agreement to develop the detail in relation to the function and scope of the WYMHLD&AC C-In-C; developing the principles that will underpin collaborative working and the timetable for implementation in order to tackle a number of significant operational, clinical and financial challenges for services in the WYMHLD&AC service area.

(D) The Parties recognise the different levels of provision of acute and specialist mental health services in portfolios of services and this will be reflected in any agreements the collaborative

makes and managed through the Gateway Decision Making Process.

OPERATIVE PROVISIONS

1. DEFINITIONS AND INTERPRETATION

1.1. In this MoU, capitalised words and expressions shall have the meanings given to them in this MoU.

1.2. In this MoU, unless the context requires otherwise, the following rules of construction shall apply.

1.3. a reference to a "**Party**" is a reference to the organisations party to this MoU and includes its personal representatives, successors or permitted assigns and a reference to "**Parties**" is a reference to all parties to this MoU;

2. PURPOSE AND EFFECT OF MOU

2.1. The Parties have agreed to work together on behalf of patients and the population to deliver the best possible care, experience and outcomes within the available resources for acute and specialist mental health services in WY. The aim is for the Parties to organise themselves around the needs of the population rather than planning at an individual organisational level so as to deliver more integrated, high quality cost effective care for patients as detailed in Schedule 1. The Parties wish to record the basis on which they will collaborate with each other through the WYMHLD&AC in this MoU.

2.2. This MoU sets out:

2.2.1. the key objectives for the development of the WYMHLD&AC;
2.2.2. the principles of collaboration;
2.2.3. the governance structures the Parties will put in place; and
2.2.4. the respective roles and responsibilities the Parties will have during the development and delivery of the collaboration model.

2.3. In addition to the MoU, the Parties will seek to agree additional documents to manage the relationships for confidentiality, conflicts of interest and sharing of information between themselves in more detail.

3. KEY PRINCIPLES

3.1. The Parties shall undertake the development and delivery of the WYMHLD&A Collaborative Programme in line with the Key Principles as set out in Schedule 1 (the "**Key Principles**").

3.2. The Parties acknowledge the current position with regard to the WYMHLD&AC and the contributions, financial and otherwise, already made by the Parties.

4. PRINCIPLES OF COLLABORATION

4.1. The Parties agree to adopt the following principles including shared values and behaviours when carrying out the development and delivery of the WYMHLD&A Collaborative Programme (the "**Principles of Collaboration**"):

4.1.1. address the vision - in developing WYMHLD&AC the Parties seek to establish a model of collaborative care, to provide high quality, sustainable acute and specialist mental health services for the population, enabled by integrated solutions and delivering best value for the taxpayer and operating a financially sustainable system;

4.1.2. collaborate and co-operate - establish and adhere to the governance structure set out in this MoU to ensure that activities are delivered and actions taken as required to deliver change collectively and in partnership with each other and the wider NHS;

4.1.3. hold each other mutually accountable for delivery and challenge constructively - take on, manage and account to each other, the wider WYHHCP and the WYMHLD&AC service area population for performance of the respective roles and responsibilities set out in this MoU;

4.1.4. be open and transparent and act with honesty and integrity - communicate openly with each other about major concerns, issues or opportunities relating to WYMHLD&AC and comply with the seven Principles of Public Life established by the Nolan Committee (the Nolan Principles) and where appropriate the NHS Foundation Trust Code of Governance (as issued by Monitor and updated in July 2014) including implementing a transparent and explicit approach to the declaration and handling of relevant and material conflicts of interests arising;

4.1.5. adhere to statutory requirements and best practice - comply with applicable laws and standards including procurement rules, competition law, data protection and freedom of information legislation;

4.1.6. act in a timely manner - recognise the time-critical nature of the WYMHLD&A Collaborative Programme development and delivery and respond accordingly to requests for support;

4.1.7. manage stakeholders effectively - ensure communication and engagement both internally and externally is clear, coherent, consistent and credible and in line with the Parties' statutory duties, values and objectives.

4.1.8. deploy appropriate resources - ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this MoU; and

4.1.9. act in good faith - to support achievement of the Key Principles and in compliance with these Principles of Collaboration.

5. GOVERNANCE

5.1. The governance structure (summarised below in Schedule 2) of this MoU provides a structure for the development and delivery of the WYMHLD&A Collaborative

Programme.

5.2. The governance arrangements will be:

5.2.1. based on the principle that decisions will be taken by the relevant organisations at the most appropriate level in accordance with each organisation's internal governance arrangements, particularly in respect of delegated authority;

5.2.2. shaped by the Parties in accordance with existing accountability arrangements, whilst recognising that different ways of working will be required to deliver the transformational ambitions of the WYMHLD&A Collaborative Programme. The Parties intend that there should be as far as permissible a single governance structure to help oversee and deliver the WYMHLD&A Collaborative Programme in accordance with the Key Principles; and

5.2.3. underpinned by the following principles:

(a) the Parties will remain subject to the NHS Constitution, their provider licence and their own constitutional documents and retain their statutory functions and their existing accountabilities for current services, resources and funding flows; and

(b) clear agreements will be in place between the providers to underpin the governance arrangements.

6. ACCOUNTABILITY AND REPORTING LINES

Accountability and reporting should be undertaken at the following levels within WYMHLD&AC:

WYMHLD&AC Committees in Common ("WYMHLD&AC C-In-C")

6.1. The WYMHLD&AC C-In-C will receive reports at each meeting from the Programme Executive highlighting but not limited to:

6.1.1. progress throughout the period;

6.1.2. decisions required by the WYMHLD&AC C-In-C;

6.1.3. issues and risk being managed;

6.1.4. issues requiring escalation to the WYMHLD&AC C-In-C; and

6.1.5. progress planned for the next period.

Under a standing agenda item, WYMHLD&AC C-In-C will agree the key communications arising from its meetings that should be relayed to the Parties' respective organisations. The minutes from the Programme Director will be circulated promptly to all WYMHLD&AC C-In-C Members as soon as reasonably practical for inclusion on the public and private agendas of each Parties' Board meeting. A summary assurance report from the Programme Director will also be provided for inclusion on the public agenda of each Parties' Board meeting (and where applicable the public agenda of the Council of Governors' meeting).

WYMHLD&AC Programme Executive

6.2. The WYMHLD&AC C-In-C will hold each of the Parties' Chief Executives to account for the delivery of their sponsored workstreams within the WYMHLD&A Collaborative Programme via the WYMHLD&AC Programme Executive.

7. ROLES AND RESPONSIBILITIES

The Parties shall undertake the roles and responsibilities set out in this MoU to help develop the WYMHLD&A Collaborative Programme in line with the Key Principles:

WYMHLD&AC Committees in Common

7.1. The WYMHLD&AC C-In-C comprises senior members of the Parties and provides overall strategic oversight and direction to the development of the WYMHLD&A Collaborative Programme. It is chaired by existing Chairs of the Parties, on a rotational basis, as underpinned by principles of continuity and equity collectively agreed by members, for a minimum duration of 12 months.

7.2. The WYMHLD&AC C-In-C shall be managed in accordance with the governance arrangements in section 5 and the Terms of Reference in Schedule 5.

WYMHLD&AC Executive Group

7.3. The WYMHLD&AC Executive Group will provide assurance to the WYMHLD&AC C-In-C that the key deliverables are being met and that the development of the WYMHLD&A Collaborative Programme is within the boundaries set by the WYMHLD&AC C-In-C. It will provide management at programme and workstream level.

8. DECISION MAKING

8.1. The Parties intend that WYMHLD&AC C-In-C individual Members will each operate under a model scheme of delegation whereby each WYMHLD&AC C-In-C individual Members shall have delegated authority to make decisions on behalf of their organisation relating to:

- matters falling under the scope of the WYMHLD&AC C-In-C and agreed collaborative programme underpinned by a 'case for change' set out in Schedule 2;
- the devolving of the Key Principles set out in Schedule 1; and,
- in accordance with the WYMHLD&AC Gateway Decision Making Framework set out in Schedule 4 on behalf of their respective organisations.

Each party will reflect in its individual Scheme of Delegation the authority delegated to its representatives on the WYMHLD&AC C-In-C.

8.2. The Parties intend that WYMHLD&AC C-In-C Members shall report to and consult with their own respective organisations at Board level, providing governance assurance that is compliant with their regulatory and audit requirements, for organisational decisions relating to, and in support of the WYMHLD&AC Key Principles and facilitating these functions in a timely manner.

9. ESCALATION

9.1. If any Party has any issues, concerns or complaints regarding the WYMHLD&A Collaborative Programme, or any matter in this MoU, such Party shall notify the other Parties and the Parties acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

9.2. Subject as otherwise specifically provided for in this MoU, any dispute arising between the Parties out of or in connection with this MoU will be resolved in accordance with Schedule 3 (Dispute Resolution Procedure).

9.3. If any Party receives any formal or media enquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000) in relation to the development of the WYMHLD&AC, the matter shall be promptly referred to the WYMHLD&AC Programme Director in the interests of consistency, however recognising the request remains the responsibility of the receiving organisation.

10. CONFLICTS OF INTEREST

10.1. The Parties agree that they will:

10.1.1. disclose to each other the full particulars of any relevant or material conflict of interest which arises or may arise in connection with this MoU, the development of the collaboration model or the performance of activities under the WYMHLD&A Collaborative Programme, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Parties or any person employed or retained by the Parties for or in connection with the development and delivery of the WYMHLD&A Collaborative Programme; and

10.1.2. not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this MoU (without the prior consent of the other Parties) before participating in any action in respect of that matter.

10.1.3. Comply with the terms of any agreed conflict of interest protocol as set out in paragraph 2.3 above.

11. FUTURE INVOLVEMENT AND ADDITION OF PARTIES

The Parties are the initial participating organisations in the development of the WYMHLD&A Collaborative Programme but it is intended that other providers to the WYMHLD&AC service area population may also come to be partners (including for example independent sector and third sector providers). Partner organisations may where appropriate be invited to meetings of the WYMHLD&AC C-In-C as observers or for a specific agenda item/workstream or through an additional stakeholders forum. If appropriate to achieve the key deliverables, the Parties may also agree to include additional party or parties to this MoU. If they agree on such a course the Parties will cooperate to enter into the necessary documentation, including reference to the relevant organisation's Scheme of Delegation and Standing Order procedures of joining Parties.

12. COMPETITION AND PROCUREMENT COMPLIANCE

The Parties recognise that it is currently the duty of the commissioners, rather than the Parties as providers, to decide what services to procure and how best to secure them in the interests of patients. In addition, the Parties are aware of their competition compliance obligations, both under competition law and, in particular under the NHS Improvement/Monitor Provider Licence for providers, and shall take all necessary steps to ensure that they do not breach any of their current or future obligations in this regard. Further, the Parties understand that in certain circumstances collaboration or joint working could trigger the merger rules and as such be notifiable to the Competition and Markets Authority and NHS Improvement/Monitor and will keep this position under review accordingly.

The parties agree not to disclose or use any confidential information which is to be disclosed under the arrangements in a way which would constitute a breach of competition law.

13. REVIEW

13.1. A formal review meeting of the WYMHLD&AC C-In-C shall take place 12 months after the date of implementation of this MoU (1st April 2018) or sooner if deemed as required by the Parties.

13.2. The WYMHLD&AC C-In-C shall discuss and agree as a minimum:

13.2.1. the principles of collaboration;
13.2.2. the governance arrangements as set out in Section 5;
13.2.3. the scope of the WYMHLD&A Collaborative Programme and individual workstreams;
13.2.4. the progress against the key deliverables; and
13.2.5. key decisions required in support of Schedule 4.

14. TERM AND TERMINATION

14.1. This MoU shall commence on 1st April 2018 (having been executed by all the Parties)

14.2. This MoU may be terminated in whole by:

14.2.1. mutual agreement in writing by all of the parties
14.2.2. in accordance with paragraph 15.2; or
14.2.3. in accordance with paragraph 1.5 of Schedule 3.

14.3. Any Party may withdraw from this MoU giving at least six calendar months' notice in writing to the other Parties, or the length of the remainder of any existing contract, whichever is longer. The MoU will remain in force between the remaining parties (unless otherwise agreed in writing between all the remaining parties) and the remaining Parties will agree such amendments required to the MoU in accordance with section 16.

14.4. In the event a Party is put into administration, special measures and/or is otherwise not able to perform its role under the WYMHLD&A Collaborative Programme and this MoU, the remaining Parties shall be entitled to consider and enforce, on a case by case basis, a resolution of the WYMHLD&AC C-In-C for the removal of the relevant Party from the MoU on a majority basis provided that:

14.4.1. reasonable notice shall have been given of the proposed resolution; and
14.4.2. the affected Party is first given the opportunity to address the WYMHLD&AC C-In-C meeting at which the resolution is proposed if it wishes to do so.

14.5. This MoU shall be terminated in accordance with the provision at paragraph 14.2.

15. CHANGE OF LAW

15.1. The Parties shall take all steps necessary to ensure that their obligations under this MoU are delivered in accordance with applicable law. If, as a result of change in applicable law, the Parties are prevented from performing their obligations under this MoU but would be able to proceed if a variation were made to the MoU, then the Parties shall consider this in accordance with the variation provision at section 16.

15.2. In the event that that the Parties are prevented from performing their obligations under this MoU as a result of a change in applicable law and this cannot be remedied by a variation or a variation is not agreed by all Parties, then the Parties shall agree to terminate this MoU on immediate effect of the change in applicable law.

16. VARIATION

This MoU may only be varied by written agreement of the Parties signed by, or on behalf of, each of the Parties.

17. CHARGES AND LIABILITIES

17.1. Except as otherwise provided, the Parties shall each bear their own costs and expenses incurred in complying with their obligations under this MoU, including in respect of any losses or liabilities incurred due to their own or their employee's actions.

17.2. No Party intends that any other Party shall be liable for any loss it suffers as a result of this MoU.

18. NO PARTNERSHIP

Nothing in this MoU is intended to, or shall be deemed to, establish any formal or legal partnership or joint venture between the Parties, constitute any Party as the agent of another Party, nor authorise any of the Parties to make or enter into any commitments for or on behalf of the other Parties.

19. COUNTERPARTS

19.1. This MoU may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this MoU, but all the counterparts shall together constitute the same agreement.

19.2. The expression "**counterpart**" shall include any executed copy of this MoU transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e mail attachment.

19.3. No counterpart shall be effective until each Party has executed at least one counterpart.

We have signed this Memorandum of Understanding on the date written at the head of this memorandum.

SIGNED by	)	……..
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	))	DATE: 30 April 2018

SIGNED by	)	……..
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST	))	DATE: 30 April 2018

SIGNED by	)	……..
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
LEEDS COMMUNITY HEALTHCARE NHS TRUST	))	DATE: 30 April 2018

SIGNED by	)	……..
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	))	DATE: 30 April 2018

SCHEDULE 1

THE KEY PRINCIPLES

1. The continued challenge of ensuring the quality and financial sustainability of mental health services requires a more collaborative approach between providers ensuring that the best possible care can be delivered to people in WY making best use of the collective resources.

2. Through the WYMHLD&A Collaborative Programme, the Parties Key Principles are to achieve sustainable, safe, high quality and cost effective acute and specialist mental health services across WY, based on clear integrated and standardised operating models, networks and alternative service delivery models where risk and benefits will be collectively managed. This will be achieved through addressing the following:

   2.1. Achieving the clinical and financial stability across the WYMHLD&AC service areas.

   2.2. Enhancing partnership working through collaboration between providers, leading to interdependency, care delivered by stream or pathway rather than by individual organisations and by collective provider responsibility.

   2.3. The approach to collaboration:

   - The Parties will work on the greatest challenges together to ensure high quality, sustainable mental health services now and in the future.
   - Reduce variation in quality by building on best practice and developing standard operating procedures and pathways to achieve better outcomes for people in WY.
   - Take a collaborative approach to the delivery of acute/specialist mental health services via clinical pathways and networked services (rather than individual place/provider led developments).
   - Developing ‘centres of excellence’ for the more specialist mental health services e.g. forensic services, Child and Adolescent Mental Health Services (CAMHs) Tier 4, adult eating disorders.
   - Delivering economies of scale in mental health service support functions.
   - Build constructive relationships with communities, groups, organisations and the third sector to ensure there are lines of communication and ways of engaging on issues which have an impact on people’s health and wellbeing.
   - Ensure there is appropriate public engagement on those matters which need to be communicated more widely.

SCHEDULE 2

WYMHLD&A COLLABORATIVE PROGRAMME APPROACH AND KEY STAGES

1. Purpose of the Collaborative Programme

The purpose of the collaborative programme is to reduce variation and deliver sustainable acute and specialist mental health services to a standardised model which is efficient and of high quality. In developing this programme the Parties will be designing services over a wider NHS footprint (the WYMHLD&AC service area), thinking of different models of care and making collective efficiencies where the potential exists.

2. The WYMHLD&A Collaborative Programme Approach

The Key Principles and five key steps to developing the WYMHS Collaborative Programme approach are set out in Schedule 1.

3. WYMHLD&A Collaborative Programme Priorities

The WYMHLD&A Collaborative Programme priorities are expected to be generated as a result of the following internal and external drivers;

- WYMHLD&AC clinical and operational sustainability priorities.
- WYMHLD&AC analysis of variation.
- West Yorkshire & Harrogate Health and Care Partnership.
- Regulatory requirements and expectations within NHSE/I Planning Guidance.

The structure of the programme will reflect these priorities as shown in the workstreams below (as at 1st January 2020). Those in yellow are priorities for the CinC, those in blue are priorities for the wider partnership MHLDA programme which the CinC does not focus on, but receives updates on because the work is linked.

Origin	Workstreams	Strands
Delivering pre-COVID priority workstreams	Specalised services	Adult Eating Disorders
		Tier 4 CAMHS
		Forensics
		'Next Wave' (ie Perinatal MH)
	Secondary Care Pathways	Psychiatric Intensive Care
		Community Transformation
	Complex Rehabilitation	Community teams
		Inpatient provision
	Learning Disability	Assessment & Treatment Units
		Transforming Care Programme
		Reasonable

		Adjustments
	Autism	Diagnosis
		Understanding barriers
		Pre/post diagnostic support
	Children & Young People	Whole Pathway Commissioning
	Improving Determinants of Health	Suicide Prevention
		Perinatal Mental Health
		BAME access & treatment
		Healthy Hospitals and physical health
Delivering ongoing support and response during COVID	Mutual aid	Crisis Pathways
		Cohorting/inpatient capacity
		Sharing of practice, learning and fortnightly communication
	Population support schemes	Keeping connected
		Grief and Loss helpline
Delivering new priorities as a result of COVID	Improving collaboration	Prevention & Management of Violence & Aggression
		Collaborative staff bank
	Staff health and wellbeing	West Yorkshire Mental Wellbeing Hub

4. Key Workstream Stages

4.1 Long term workstream priorities will be developed based on a robust case for change (risk and benefit evaluation of workstream potential based on current service models) or through agreement by collaborative partners of a need to respond more quickly to emerging concerns.

4.2 The table below illustrates the sequence of stages of the workstream development process, this will be a scalable process and proportionate to the workstream:

Stage	Outputs	Key Requirements
1. Case for change (Proposal)	Detailed description of current services Gap/challenges relating to safety, resilience, quality, sustainability (Data analysis) Scope for improvement Evaluation framework Risk sharing approach	Clinical leadership and involvement External Experts and Clinical Senate involvement
2. Design the Future	Standardise operating procedures	

Stage	Outputs	Key Requirements
Operating Model	Workforce models Capacity modelling Best Practice benchmarks for future performance Scale of improvement which can be achieved	
3. Develop Options	New Models of Care Organisational change Operational networks Alternative provider arrangements and service delivery models Commissioner requirements and consultation	
4. Evaluation & selection of the preferred option	Clinical (Quality) Financial/Legal/Regulatory Workforce Performance Quality impact assessments Equality impact assessments	
5. Implementation planning	Timescales Resources Evaluation and review delivery of benefits Management of risks and issues	

4.3 The WYMHLD&AC Executive will be responsible for the execution and delivery of the programme governance and ensuring that a common approach is applied to all applicable workstreams (some workstreams may not require this approach) and that the workstream pipeline is managed within defined timescales.

4.4 Each workstream will have a WYMHLD&AC Director (identified by the WYMHLD&A Collaborative Executive) and Senior Lead Clinical sponsor. The inputs at each stage will include:

- Clear articulated case for change i.e. use of data, standards etc.
- Identification and use of organisational change/service improvement models
- Targeted clinical/staff engagement and empowerment in order to lead the design and change e.g. facilitated workshops
- Transparent options appraisal process
- Quality impact assessments
- Equality impact assessments

- Use of external scrutiny
- Appropriate commissioner engagement
- Appropriate public/patient engagement
- Governor engagement

4.5 The WYMHLD&AC Executive and WYMHLD&AC C-In-C will make decisions on the prioritisation and progressing of workstreams to the next stage as shown in the Decision Making Schedule and gateways (as set out in Schedule 4).

5. Risk and Gain Sharing Principles

5.1. Some WYMHLD&AC projects developed under the workstreams will have the potential to disproportionately benefit participating WYMHLD&AC organisations at the expense of others. The potential impact of the implementation of a project through a workstream will be established and set out within the 'Case for Change' stage (Gateway 1) and the 'risk gain share' model between the respective WYMHLD&AC members affected by the project developed in preparation for selection of the preferred option at Gateway 3. The model will be tailored to each project and will be designed on the following principles reflecting that organisations are working for the delivery of better care and a more sustainable system for patients in the WYMHLD&AC service area:

5.1.1. The costs of delivering the project will be met by all Parties in the proportions agreed and submitted within the submission for Gateway 3 so that the WYMHLD&AC C-In-C can be clear when selecting the preferred option where the costs will be met from and how any losses may be reimbursed;

5.1.2. The allocation of net benefits from a project will be agreed based on one or a combination of these methods, the detail of which will be developed and agreed at Gateway 3 of decision making process :

- equal gain share;
- proportional gain share; and/or
- successful contribution to the initiative.

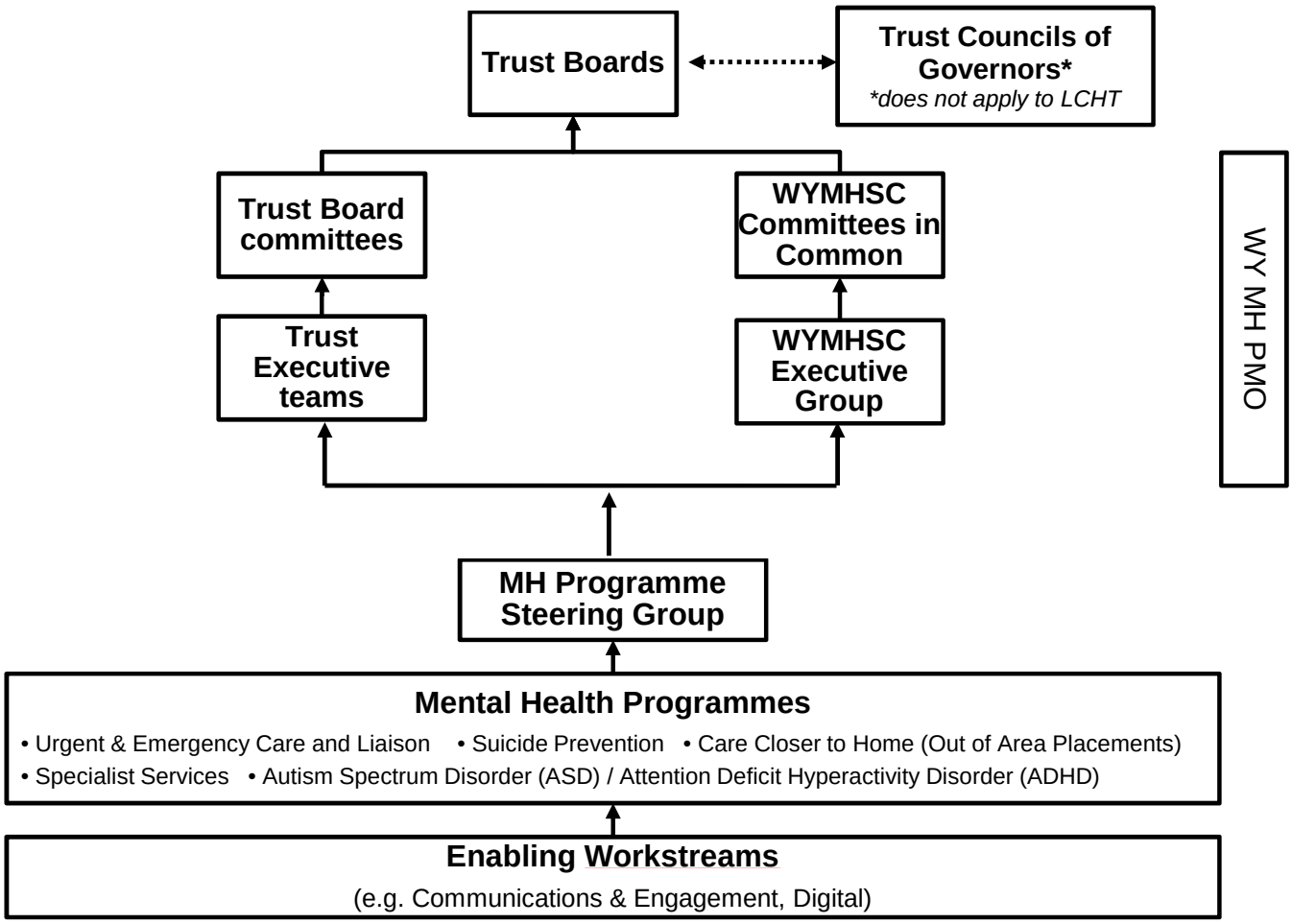
5.1.3. The allocation of net benefits will be agreed between the relevant Parties based on the benefit and risk profile using these methods; and

5.1.4. The same principles will apply to the sharing of risks and costs in the event that a project does not deliver the anticipated net benefit.

6. High Level Programme Structure

The high level programme structure, linked to the West Yorkshire and Harrogate Health and

Care Partnership (previously STP), is shown below:



SCHEDULE 3

DISPUTE RESOLUTION PROCEDURE

1. Avoiding and Solving Disputes

1.1 The Parties commit to working co-operatively to identify and resolve issues to their mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this MoU.

1.2 The Parties believe that:

1.2.1 by focusing on the agreed Key Principles underpinned by the five step approach as set out in the MoU and in Schedule 1;

1.2.2 being collectively responsible for all risks; and

1.2.3 fairly sharing risk and rewards in relation to the services in scope in the WYMHLD&A Collaborative Programme.

they reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with this MoU.

1.3 A Party shall promptly notify the other Parties of any dispute or claim or any potential dispute or claim in relation to this MoU or its operation (each a "**Dispute**') when it arises.

1.4 In the first instance the WYMHLD&AC Programme Executive shall seek to resolve any Dispute to the mutual satisfaction of each of the Parties. If the Dispute cannot be resolved by the WYMHLD&AC Programme Executive within 10 Business Days (a **Business Day** being a day other than a Saturday, Sunday or public holiday in England when banks in London are open for business) of the Dispute being referred to it, the Dispute shall be referred to the WYMHLD&AC C-In-C for resolution.

1.5 The WYMHLD&AC C-In-C shall deal proactively with any Dispute on a "Best for Meeting the Key Principles" basis in accordance with this MoU so as to seek to reach a majority decision. If the WYMHLD&AC C-In-C reaches a decision that resolves, or otherwise concludes a Dispute, it will advise the Parties of its decision by written notice. The Parties recognise that any dispute or operation of this procedure will be without prejudice to and will not affect the statutory duties of each Party. This MoU is not intended to be legally binding and, given the status of this MoU (as set out in Section 2), if a Party disagrees with a decision of the WYMHLD&AC C-In-C or the independent facilitator, they may withdraw from the MoU at any point in accordance with section 14 of the MoU.

1.6 If a Party does not agree with the decision of the WYMHLD&AC C-In-C reached in accordance with the above, it shall inform the WYMHLD&AC C-In-C within 10 Business Days and request that the WYMHLD&AC C-In-C refer the Dispute to an independent facilitator in agreement with all Parties and in accordance with paragraph 1.7 of this Schedule.

1.7 The Parties agree that the WYMHLD&AC C-In-C, on a “Best for Meeting the Key Principles” basis, may determine whatever action it believes is necessary including the following:

1.7.1 If the WYMHLD&AC C-In-C cannot resolve a Dispute, it may request that an independent facilitator assist with resolving the Dispute; and

1.7.2 If the independent facilitator cannot facilitate the resolution of the Dispute, the Dispute must be considered afresh in accordance with this Schedule and in the event that after such further consideration again fails to resolve the Dispute, the WYMHLD&AC C-In-C may decide to:

(i) terminate the MoU; or

(ii) agree that the Dispute need not be resolved.

SCHEDULE 4

WYMHLD&AC CIC DECISION MAKING

1. The Memorandum of Understanding (MoU) and Terms of Reference (TOR) for the WYMHLD&AC Committee in Common (WYMHLD&AC C-In-C) takes into consideration existing accountability arrangements of participating Trusts and decisions (where these apply to the services in scope in the collaborative) being made under a scheme of delegation.

2. Whilst it is recognised that some decisions taken at the WYMHLD&AC C-In-C may not be of obvious benefit to all Parties, it is anticipated that the WYMHLD&AC C-In-C will look to act on the basis of the best interests of the wider population investing in a sustainable system of healthcare across the WYMHLD&AC service area in accordance with the Key Principles when making decisions at WYMHLD&AC C-In-C meetings.

3. There are expected to be two categories of decision making:

   - **All parties will need to participate in the initiative** for reasons of interdependency, safety or financial viability. These decisions will be made on the basis of all the affected organisations reaching an agreed decision in common.

   - **Organisations will need to confirm their own commitment and involvement at key stages (Gateways)** in order to ensure the Business Case assumptions (benefits) and risks are robust, only trusts directly affected by the Case for Change (eligible constituency under paragraph 5 of this Schedule) will be able to make decisions (the Gateways) and once an organisation has committed to participate at a specific Gateway they cannot withdraw.

4. The WYMHLD&AC 'Gateway' decision making mechanism should be used (where appropriate) to achieve agreements that will be binding across relevant members. The mechanism will follow a staged approach and unless new material comes to light, once progression has been made through the respective stages, progress will remain at the relevant stage that has been reached and will not 'fall back'. On agreement of progression through stages, members will commit to the next steps in developing the proposal.

5. All proposals brought before the WYMHLD&AC C-In-C will require a detailed case for change. At this stage the WYMHLD&AC C-In-C will determine if the proposal warrants further development and consideration and is appropriate to pass to the next stage of development. This stage will also consider which Parties would be directly or indirectly affected and eligible/required to vote (to be known as the eligible constituency).

6. The table below illustrates the 'Gateway Decision Making' Process:

Stage	Gateway	Outcome
Case for change (Proposal)	Gateway 1 Requires support of a simple majority	No fall back unless material new information All organisations participate in design phase
Develop Options	Gateway 2 Seek unanimous support by all parties eligible to make decisions	Options and Evaluation Framework agreed
Evaluation and selection of the preferred option	Gateway 3 Seek unanimous support by all parties eligible to make decisions	Application of agreed framework Identification of agreed option
Recommendation to Committee in Common	Gateway 4 Seek unanimous support by all parties eligible to make decisions	Proceed with formal agreements/contracts as required and implement plan

7. If a Party does not support a proposal then it will not be bound to act in accordance with that proposal as the Parties remain independent statutory bodies under the WYMHLD&A Collaborative Programme.

8. Bilateral and Tripartite Agreements between Individual Trusts

8.1. The WYMHLD&AC Gateway Decision Making Framework does not preclude any Party from developing bilateral or tripartite agreements with other trusts in WYMHLD&A services outside the Collaborative Programme. It is expected that there will be transparency in developing such agreements and the option for other WYMHLD&A trusts to join an initiative and that the associated benefits and risks are appropriately considered in terms of the impact on other providers and the WYMHS Collaborative Programme.

8.2. Recognising that being part of the WYMHLD&AC C-In-C does not preclude Parties alliances or existing relationships with other organisations.

8.3. Parties may wish to invite other organisations to be party to initiatives agreed by the WYMHLD&AC C-In-C.

9. Forum for engaging with the wider system

9.1. The WYMHLD&AC C-In-C could also be used as a forum to provide responses to queries and recommendations from the commissioners or the wider system (for example following a request from the WYHHCP) on specific issues.

SCHEDULE 5

WYMHLD&AC Committees in Common -TERMS OF REFERENCE

THESE TERMS OF REFERENCE FORM PART OF THE WYMHLD&AC MEMORANDUM OF UNDERSTANDING DEFINITIONS AND TERMINOLOGY ALIGN TO THE MEMORANDUM OF UNDERSTANDING

1. Scope

    a. The West Yorkshire Mental Health, Learning Disability & Autism Collaborative ('the Collaborative') is the collective governance vehicle for joint decision making, with delegated authority for the four NHS mental health, learning disability and autism provider Trusts in West Yorkshire.

    b. The Collaborative is one part of the wider West Yorkshire and Harrogate Health and Care Partnership, which is committed to putting combined efforts into tackling the long-term trends of ill-health. This includes specific ambitions to:

        i. Achieve a 10% reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism and the rest of the population by 2024 (including a focus on early support for children and young people)

        ii. Reduce suicide by 10% by 2020/21 and achieve a 75% reduction in targeted areas by 2022

    c. The overall responsibility for delivery of these two ambitions rests with the whole Partnership. This responsibility is discharged and governed by the system-wide Mental Health, Learning Disability and Autism Programme Board which is comprised of providers and commissioners, covering the NHS, local authority, VCS and other partners.

    d. **The Committees in Common for the Collaborative reports into the Board of each individual provider within the Partnership (BDCFT, LCH, LYPFT, SWYPFT). It is overall responsible for supporting service transformation, integration and innovation and specifically, responsible for leading development of identified workstreams, improving service delivery to support the overall ambitions of the Partnership.**

    e. This Terms of Reference is approved through each individual provider Board.

    f. Appendix 1 to the Terms of Reference describes this relationship in a diagram

2. Standing

    a. Members shall only exercise functions and powers of a Party to the extent that they are permitted to ordinarily exercise such functions and powers under that Party's internal governance.

3. General Responsibilities of the Collaborative Committees in Common

a. Ensuring alignment of all parties to the WY&H Mental Health, Learning Disability and Autism strategy, confirming the role of the Collaborative in delivery;

b. Providing overall strategic oversight and direction to the improvement of services within the Collaborative for people with a Mental Health condition, learning disability and/or autism;

c. To emphasise the primacy of individual organisations' decision making ability and relationship with their local place, but also to set the expectation through individual boards and within operational teams that:

    i. Where agreed through the CinC there will be service delivery, development work and clinical/operational relationships that require a 'WY&H first' viewpoint, rather than an individual organisational viewpoint.

    ii. All partners within the collaborative take informed decisions in consultation with other collaborative partners and relevant stakeholders where there might be an impact on others' services.

    iii. The CinC will consider and agree adoption of joint policies and procedures across all organisations that will benefit the work of the collaborative.

d. Formally recommending the roles and responsibilities within identified workstreams, reviewing the key deliverables and ensuring adherence with required timescales;

e. Receiving assurance that identified workstreams have been subject to robust engagement and impact assessments;

f. Reviewing and identifying the risks associated with the performance of any of the Parties in terms of the impact to the Collaborative or to the ambitions of the Partnership, recommending remedial and mitigating actions;

g. Receiving assurance that the risks associated with the Collaborative work programme are being identified, managed and mitigated;

h. Formulating, agreeing and implementing strategies for delivery of the Collaborative workplan;

i. Seeking to determine or resolve any matter referred to it by the Programme Team or any individual Party and any dispute in accordance with the MoU:

j. Considering the shape of the Programme Team, agreeing and reviewing the extent of the Collaborative's financial support for the team, against wider Partnership funding;

k. Reviewing the Terms of Reference for the Committees in Common;

l. Reviewing and agreeing the deployment of any joint Collaborative budget, with reference to the deployment of Partnership Transformation Funding and CCG baselines; this includes collective approval of substantial capital funding decisions in accordance with the Risk and Gain Sharing Principles.

4. Members of the Collaborative Committees in Common

    a. Each Party will appoint their Chair and Chief Executive as Committees in Common Members and the parties will always maintain a Member on the Committees in Common.

    b. Deputies will be permitted to attend on the behalf of a Member. The deputy must be a voting board member of the respective Party and will be entitled to attend and be counted in the quorum at which the Member is not personally present.

    c. Each Party will be considered as one entity within the Collaborative.

    d. The Parties will ensure that, except for urgent or unavoidable reasons, their respective Committees in Common Member (or Deputy) attend and fully participate in the meetings of the Committees in Common.

5. Proceedings of the Collaborative Committees in Common

    a. The Committees in Common will meet quarterly, or more frequently as required. In addition an annual strategic meeting will be held to review overall progress and set the direction and objectives for the year ahead.

    b. The Chair may call additional meetings as required. Other members may request the Chair to call additional meetings by making individual representation, although the Chair will make the final decision on whether to proceed.

    c. The Committees in Common shall meet in private where appropriate in order to facilitate discussion and decision making on matters deemed commercially sensitive and by virtue of the confidential nature of the business to be transacted across the Members. It is agreed by the Parties that the necessary checks and balances on openness, transparency and candour continue to exist and apply by virtue of the Parties each acting within existing accountability arrangements of the Parties' respective organisations and the reporting arrangements of the Committees in Common into the Parties' Trust public Boards.

    d. The Parties will select one of the Parties' Chairs to act as the Chair of the Committees in Common on a rotational basis for a period of twelve months. The Chair will ensure they are able to attend every meeting over that period. If in cases of urgent, unavoidable absence the Chair cannot attend, one of the other Parties' Chairs will be asked to step in.

    e. The Committees in Common may regulate its proceedings as they see fit as set out in these Terms of Reference.

    f. No decision will be taken at any meeting unless a quorum is present. A quorum will not be present unless every Party has at least one Member present (four members in total).

    g. Members of all Parties will be required to declare any interests at the beginning of each meeting.

    h. A meeting of the Committees in Common may consist of a conference between the Members who are not all in one place, but each of whom is able directly or by telephonic or video communication to speak to each of the others, and to be heard by each of the others simultaneously.

i. Each Member will have an equal say in discussions and will look to agree recommendations in line with the Principles of the Collaborative.

j. Any issues to be raised within individual Party board committees will be noted and listed for action, with a dedicated agenda item reserved for this purpose.

k. The Committees in Common will review the meeting effectiveness at the end of each meeting with a dedicated agenda item reserved for this purpose.

6. Decision making within the Collaborative

a. Each Member will comply with the existing accountability arrangements of their respective appointing organisation and will make decisions which are permitted under their organisation's Scheme of Delegation.

b. Recognising that some decisions may not be of obvious benefit to or impact directly upon all Parties, Members shall seek to pay due regard to the best interests of the wider population in investing in a sustainable system of healthcare across the service area in accordance with the Key Principles and ambitions of the Partnership when making decisions at Committees in Common meetings.

c. In respect of matters which require decisions where all Parties are affected the Parties will seek to make such decisions on the basis of all Members reaching an agreed consensus decision in common in accordance with the Key Principles.

d. In respect of the matters which require decisions where only some of the Parties are affected, then the Parties shall reference the Collaborative Gateway Decision Mechanism at Schedule 4 of the Memorandum of Understanding.

7. Attendance of third parties at the Committees in Common

a. The Committees in Common shall be entitled to invite any person to attend, such as advisors, experts by experience or Partnership leaders but not take part in making decisions at meetings of the Committees in Common. The Chair will agree final attendance lists for each meeting.

8. Administration for the Committees in Common

a. Meeting administration for the Committees in Common will be provided by the WYMHLD&A Programme Team, maintaining the register of interests and the minutes of the meetings of the Committees in Common. Members are required to openly and proactively declare and manage any conflicts of interests.

b. The Chair will be responsible for finalising agendas and minutes, based on the agreed workplan and in collaboration with the WYMHLD&A Programme Team.

c. Where required by the agenda, governance leads from the Collaborative will be asked to attend and provide advice to the Committees in Common on decision making and due diligence.

d. Papers for each meeting will be sent by the WYMHLD&A Programme Team to Members no later than five working days prior to each meeting. By exception; and only with the agreement of the Chair, amendments to papers may be tabled

before the meeting.

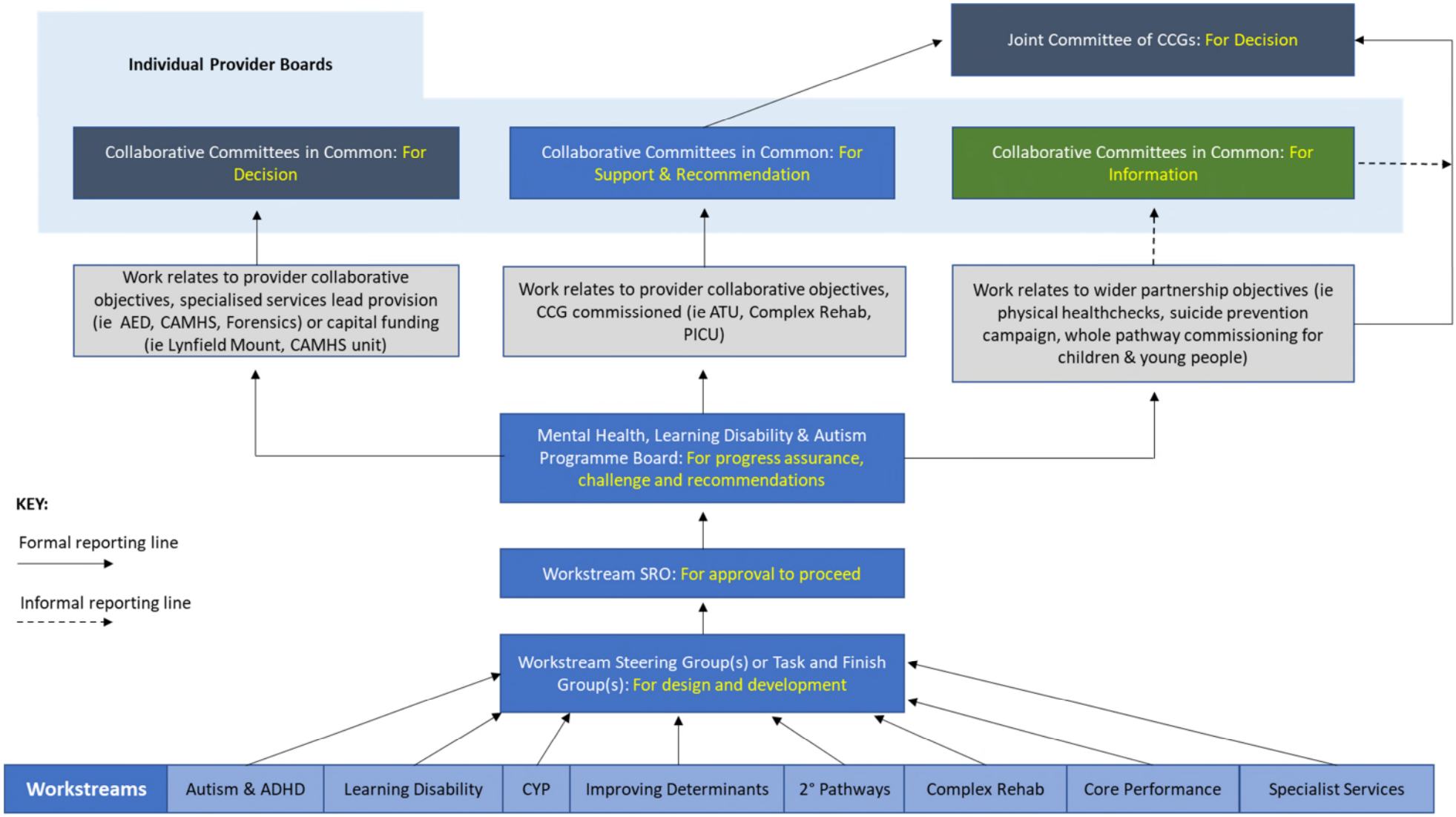
e. The minutes, and a summary report from the Programme Director will be circulated promptly to all Members and Trust governance leads as soon as reasonably practical for inclusion on the public agenda of each Parties' Board meeting. Any items not for public consumption will be marked as private in the minutes and be noted at Trust private boards but not circulated with the public papers.

f. Following the annual Partnership 'check and confirm' session for the WYMHLD&A programme a report will be made available by the Programme Director for the Committees in Common to review. Each Party should reflect the work detailed in this report within their annual Quality Accounts.

9. Review

a. The Committees in Common will review these Terms of Reference at least annually.

Appendix 1 – Decision making relationship between the Committees in Common and the wider Partnership



WEST YORKSHIRE MENTAL HEALTH, LEARNING DISABILITIES & AUTISM COLLABORATIVE

DATE

30 April 2018

1. **BRADFORD DISTRICT CARE NHS FOUNDATION TRUST**
2. **LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST**
3. **LEEDS COMMUNITY HEALTHCARE NHS TRUST**
4. **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST**

MEMORANDUM OF UNDERSTANDING
FOR WEST YORKSHIRE MENTAL HEALTH, LEARNING DISABILITIES AND AUTISM COLLABORATIVE (WYMHLD&AC)

No	Date	Version Number	Author
1	15/11/17	01 -	Trust Company Secretaries / Governance leads
2	29/11/17	0.2	Trust Company Secretaries / Governance leads
3	4/12/17	0.3	Trust Company Secretaries / Governance leads
4	15/01/18	0.4	Trust Company Secretaries / Governance leads
5	7/03/18	0.5	Trust Company Secretaries/Governance lead
6	15/03/18	0.6 Incorporating comments from audit committee chairs	Trust Company Secretaries/Governance lead
7	25/04/18	0.7 Incorporating comments from Boards	Trust Company Secretaries/Governance lead
8	11/02/21	0.8 incorporating approvals from Committee-in-Common meeting	Trust Company Secretaries/Governance lead

CONTENTS

Date: TBC

This Memorandum of Understanding (**MoU**) is made between:

(1) **BRADFORD DISTRICT CARE NHS FOUNDATION TRUST** of New Mill, Victoria Road, Saltaire, Bradford, West Yorkshire, BD18 3LD;

(2) **LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST** of 2150 Century Way, Thorpe Park, Leeds, West Yorkshire, LS15 8ZB

(3) **LEEDS COMMUNITY HEALTHCARE NHS TRUST** of First Floor, Stockdale House, Headingley Office Park, Victoria Road, Leeds, West Yorkshire, LS6 1PF

(4) **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST** of Fieldhead Hospital, Ouchthorpe Lane, Wakefield, West Yorkshire, WF1 3SP

(each a "**Party**" and together the "**Parties**").

RECITALS

(A) In entering into and performing their obligations under this MoU, the parties are working towards a collaborative programme including ownership and commitment to collaboration as set out in the West Yorkshire and Harrogate Health and Care Partnership (STP) ("**WYHHCP**").

(B) The Parties together form the West Yorkshire Mental Health, Learning Disabilities and Autism Collaborative ("**WYMHLD&AC**") and have agreed to collaborate in delivering region-wide efficient and sustainable acute and specialist mental health services for patients. The Parties have formed Committees in Common ("**WYMHLD&AC C-In-C**") which have the specific remit of overseeing a comprehensive system wide collaborative programme to deliver the objective of a more collaborative model of care for acute and specialist mental health services in West Yorkshire (WY). The intention being to deliver a system model, operating as a network, that is coherent, integrated, consistent (reducing unwanted variation) and focused on quality and value for the population and patients (the "**WYMHLD&A Collaborative Programme**").

(C) This MoU is focused on the Parties' agreement to develop the detail in relation to the function and scope of the WYMHLD&AC C-In-C; developing the principles that will underpin collaborative working and the timetable for implementation in order to tackle a number of significant operational, clinical and financial challenges for services in the WYMHLD&AC service area.

(D) The Parties recognise the different levels of provision of acute and specialist mental health services in portfolios of services and this will be reflected in any agreements the collaborative

makes and managed through the Gateway Decision Making Process.

OPERATIVE PROVISIONS

1. DEFINITIONS AND INTERPRETATION

1.1. In this MoU, capitalised words and expressions shall have the meanings given to them in this MoU.

1.2. In this MoU, unless the context requires otherwise, the following rules of construction shall apply.

1.3. a reference to a "**Party**" is a reference to the organisations party to this MoU and includes its personal representatives, successors or permitted assigns and a reference to "**Parties**" is a reference to all parties to this MoU;

2. PURPOSE AND EFFECT OF MOU

2.1. The Parties have agreed to work together on behalf of patients and the population to deliver the best possible care, experience and outcomes within the available resources for acute and specialist mental health services in WY. The aim is for the Parties to organise themselves around the needs of the population rather than planning at an individual organisational level so as to deliver more integrated, high quality cost effective care for patients as detailed in Schedule 1. The Parties wish to record the basis on which they will collaborate with each other through the WYMHLD&AC in this MoU.

2.2. This MoU sets out:

2.2.1. the key objectives for the development of the WYMHLD&AC;
2.2.2. the principles of collaboration;
2.2.3. the governance structures the Parties will put in place; and
2.2.4. the respective roles and responsibilities the Parties will have during the development and delivery of the collaboration model.

2.3. In addition to the MoU, the Parties will seek to agree additional documents to manage the relationships for confidentiality, conflicts of interest and sharing of information between themselves in more detail.

3. KEY PRINCIPLES

3.1. The Parties shall undertake the development and delivery of the WYMHLD&A Collaborative Programme in line with the Key Principles as set out in Schedule 1 (the "**Key Principles**").

3.2. The Parties acknowledge the current position with regard to the WYMHLD&AC and the contributions, financial and otherwise, already made by the Parties.

4. PRINCIPLES OF COLLABORATION

4.1. The Parties agree to adopt the following principles including shared values and behaviours when carrying out the development and delivery of the WYMHLD&A Collaborative Programme (the "**Principles of Collaboration**"):

4.1.1. address the vision - in developing WYMHLD&AC the Parties seek to establish a model of collaborative care, to provide high quality, sustainable acute and specialist mental health services for the population, enabled by integrated solutions and delivering best value for the taxpayer and operating a financially sustainable system;

4.1.2. collaborate and co-operate - establish and adhere to the governance structure set out in this MoU to ensure that activities are delivered and actions taken as required to deliver change collectively and in partnership with each other and the wider NHS;

4.1.3. hold each other mutually accountable for delivery and challenge constructively - take on, manage and account to each other, the wider WYHHCP and the WYMHLD&AC service area population for performance of the respective roles and responsibilities set out in this MoU;

4.1.4. be open and transparent and act with honesty and integrity - communicate openly with each other about major concerns, issues or opportunities relating to WYMHLD&AC and comply with the seven Principles of Public Life established by the Nolan Committee (the Nolan Principles) and where appropriate the NHS Foundation Trust Code of Governance (as issued by Monitor and updated in July 2014) including implementing a transparent and explicit approach to the declaration and handling of relevant and material conflicts of interests arising;

4.1.5. adhere to statutory requirements and best practice - comply with applicable laws and standards including procurement rules, competition law, data protection and freedom of information legislation;

4.1.6. act in a timely manner - recognise the time-critical nature of the WYMHLD&A Collaborative Programme development and delivery and respond accordingly to requests for support;

4.1.7. manage stakeholders effectively - ensure communication and engagement both internally and externally is clear, coherent, consistent and credible and in line with the Parties' statutory duties, values and objectives.

4.1.8. deploy appropriate resources - ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this MoU; and

4.1.9. act in good faith - to support achievement of the Key Principles and in compliance with these Principles of Collaboration.

5. GOVERNANCE

5.1. The governance structure (summarised below in Schedule 2) of this MoU provides a structure for the development and delivery of the WYMHLD&A Collaborative

Programme.

5.2. The governance arrangements will be:

5.2.1. based on the principle that decisions will be taken by the relevant organisations at the most appropriate level in accordance with each organisation's internal governance arrangements, particularly in respect of delegated authority;

5.2.2. shaped by the Parties in accordance with existing accountability arrangements, whilst recognising that different ways of working will be required to deliver the transformational ambitions of the WYMHLD&A Collaborative Programme. The Parties intend that there should be as far as permissible a single governance structure to help oversee and deliver the WYMHLD&A Collaborative Programme in accordance with the Key Principles; and

5.2.3. underpinned by the following principles:

(a) the Parties will remain subject to the NHS Constitution, their provider licence and their own constitutional documents and retain their statutory functions and their existing accountabilities for current services, resources and funding flows; and

(b) clear agreements will be in place between the providers to underpin the governance arrangements.

6. ACCOUNTABILITY AND REPORTING LINES

Accountability and reporting should be undertaken at the following levels within WYMHLD&AC:

WYMHLD&AC Committees in Common ("WYMHLD&AC C-In-C")

6.1. The WYMHLD&AC C-In-C will receive reports at each meeting from the Programme Executive highlighting but not limited to:

6.1.1. progress throughout the period;

6.1.2. decisions required by the WYMHLD&AC C-In-C;

6.1.3. issues and risk being managed;

6.1.4. issues requiring escalation to the WYMHLD&AC C-In-C; and

6.1.5. progress planned for the next period.

Under a standing agenda item, WYMHLD&AC C-In-C will agree the key communications arising from its meetings that should be relayed to the Parties' respective organisations. The minutes from the Programme Director will be circulated promptly to all WYMHLD&AC C-In-C Members as soon as reasonably practical for inclusion on the public and private agendas of each Parties' Board meeting. A summary assurance report from the Programme Director will also be provided for inclusion on the public agenda of each Parties' Board meeting (and where applicable the public agenda of the Council of Governors' meeting).

WYMHLD&AC Programme Executive

6.2. The WYMHLD&AC C-In-C will hold each of the Parties' Chief Executives to account for the delivery of their sponsored workstreams within the WYMHLD&A Collaborative Programme via the WYMHLD&AC Programme Executive.

7. ROLES AND RESPONSIBILITIES

The Parties shall undertake the roles and responsibilities set out in this MoU to help develop the WYMHLD&A Collaborative Programme in line with the Key Principles:

WYMHLD&AC Committees in Common

7.1. The WYMHLD&AC C-In-C comprises senior members of the Parties and provides overall strategic oversight and direction to the development of the WYMHLD&A Collaborative Programme. It is chaired by existing Chairs of the Parties, on a rotational basis, as underpinned by principles of continuity and equity collectively agreed by members, for a minimum duration of 12 months.

7.2. The WYMHLD&AC C-In-C shall be managed in accordance with the governance arrangements in section 5 and the Terms of Reference in Schedule 5.

WYMHLD&AC Executive Group

7.3. The WYMHLD&AC Executive Group will provide assurance to the WYMHLD&AC C-In-C that the key deliverables are being met and that the development of the WYMHLD&A Collaborative Programme is within the boundaries set by the WYMHLD&AC C-In-C. It will provide management at programme and workstream level.

8. DECISION MAKING

8.1. The Parties intend that WYMHLD&AC C-In-C individual Members will each operate under a model scheme of delegation whereby each WYMHLD&AC C-In-C individual Members shall have delegated authority to make decisions on behalf of their organisation relating to:

- matters falling under the scope of the WYMHLD&AC C-In-C and agreed collaborative programme underpinned by a 'case for change' set out in Schedule 2;
- the devolving of the Key Principles set out in Schedule 1; and,
- in accordance with the WYMHLD&AC Gateway Decision Making Framework set out in Schedule 4 on behalf of their respective organisations.

Each party will reflect in its individual Scheme of Delegation the authority delegated to its representatives on the WYMHLD&AC C-In-C.

8.2. The Parties intend that WYMHLD&AC C-In-C Members shall report to and consult with their own respective organisations at Board level, providing governance assurance that is compliant with their regulatory and audit requirements, for organisational decisions relating to, and in support of the WYMHLD&AC Key Principles and facilitating these functions in a timely manner.

9. ESCALATION

9.1. If any Party has any issues, concerns or complaints regarding the WYMHLD&A Collaborative Programme, or any matter in this MoU, such Party shall notify the other Parties and the Parties acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

9.2. Subject as otherwise specifically provided for in this MoU, any dispute arising between the Parties out of or in connection with this MoU will be resolved in accordance with Schedule 3 (Dispute Resolution Procedure).

9.3. If any Party receives any formal or media enquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000) in relation to the development of the WYMHLD&AC, the matter shall be promptly referred to the WYMHLD&AC Programme Director in the interests of consistency, however recognising the request remains the responsibility of the receiving organisation.

10. CONFLICTS OF INTEREST

10.1. The Parties agree that they will:

10.1.1. disclose to each other the full particulars of any relevant or material conflict of interest which arises or may arise in connection with this MoU, the development of the collaboration model or the performance of activities under the WYMHLD&A Collaborative Programme, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Parties or any person employed or retained by the Parties for or in connection with the development and delivery of the WYMHLD&A Collaborative Programme; and

10.1.2. not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this MoU (without the prior consent of the other Parties) before participating in any action in respect of that matter.

10.1.3. Comply with the terms of any agreed conflict of interest protocol as set out in paragraph 2.3 above.

11. FUTURE INVOLVEMENT AND ADDITION OF PARTIES

The Parties are the initial participating organisations in the development of the WYMHLD&A Collaborative Programme but it is intended that other providers to the WYMHLD&AC service area population may also come to be partners (including for example independent sector and third sector providers). Partner organisations may where appropriate be invited to meetings of the WYMHLD&AC C-In-C as observers or for a specific agenda item/workstream or through an additional stakeholders forum. If appropriate to achieve the key deliverables, the Parties may also agree to include additional party or parties to this MoU. If they agree on such a course the Parties will cooperate to enter into the necessary documentation, including reference to the relevant organisation's Scheme of Delegation and Standing Order procedures of joining Parties.

12. COMPETITION AND PROCUREMENT COMPLIANCE

The Parties recognise that it is currently the duty of the commissioners, rather than the Parties as providers, to decide what services to procure and how best to secure them in the interests of patients. In addition, the Parties are aware of their competition compliance obligations, both under competition law and, in particular under the NHS Improvement/Monitor Provider Licence for providers, and shall take all necessary steps to ensure that they do not breach any of their current or future obligations in this regard. Further, the Parties understand that in certain circumstances collaboration or joint working could trigger the merger rules and as such be notifiable to the Competition and Markets Authority and NHS Improvement/Monitor and will keep this position under review accordingly.

The parties agree not to disclose or use any confidential information which is to be disclosed under the arrangements in a way which would constitute a breach of competition law.

13. REVIEW

13.1. A formal review meeting of the WYMHLD&AC C-In-C shall take place 12 months after the date of implementation of this MoU (1st April 2018) or sooner if deemed as required by the Parties.

13.2. The WYMHLD&AC C-In-C shall discuss and agree as a minimum:

13.2.1. the principles of collaboration;
13.2.2. the governance arrangements as set out in Section 5;
13.2.3. the scope of the WYMHLD&A Collaborative Programme and individual workstreams;
13.2.4. the progress against the key deliverables; and
13.2.5. key decisions required in support of Schedule 4.

14. TERM AND TERMINATION

14.1. This MoU shall commence on 1st April 2018 (having been executed by all the Parties)

14.2. This MoU may be terminated in whole by:

14.2.1. mutual agreement in writing by all of the parties
14.2.2. in accordance with paragraph 15.2; or
14.2.3. in accordance with paragraph 1.5 of Schedule 3.

14.3. Any Party may withdraw from this MoU giving at least six calendar months' notice in writing to the other Parties, or the length of the remainder of any existing contract, whichever is longer. The MoU will remain in force between the remaining parties (unless otherwise agreed in writing between all the remaining parties) and the remaining Parties will agree such amendments required to the MoU in accordance with section 16.

14.4. In the event a Party is put into administration, special measures and/or is otherwise not able to perform its role under the WYMHLD&A Collaborative Programme and this MoU, the remaining Parties shall be entitled to consider and enforce, on a case by case basis, a resolution of the WYMHLD&AC C-In-C for the removal of the relevant Party from the MoU on a majority basis provided that:

14.4.1. reasonable notice shall have been given of the proposed resolution; and
14.4.2. the affected Party is first given the opportunity to address the WYMHLD&AC C-In-C meeting at which the resolution is proposed if it wishes to do so.

14.5. This MoU shall be terminated in accordance with the provision at paragraph 14.2.

15. CHANGE OF LAW

15.1. The Parties shall take all steps necessary to ensure that their obligations under this MoU are delivered in accordance with applicable law. If, as a result of change in applicable law, the Parties are prevented from performing their obligations under this MoU but would be able to proceed if a variation were made to the MoU, then the Parties shall consider this in accordance with the variation provision at section 16.

15.2. In the event that that the Parties are prevented from performing their obligations under this MoU as a result of a change in applicable law and this cannot be remedied by a variation or a variation is not agreed by all Parties, then the Parties shall agree to terminate this MoU on immediate effect of the change in applicable law.

16. VARIATION

This MoU may only be varied by written agreement of the Parties signed by, or on behalf of, each of the Parties.

17. CHARGES AND LIABILITIES

17.1. Except as otherwise provided, the Parties shall each bear their own costs and expenses incurred in complying with their obligations under this MoU, including in respect of any losses or liabilities incurred due to their own or their employee's actions.

17.2. No Party intends that any other Party shall be liable for any loss it suffers as a result of this MoU.

18. NO PARTNERSHIP

Nothing in this MoU is intended to, or shall be deemed to, establish any formal or legal partnership or joint venture between the Parties, constitute any Party as the agent of another Party, nor authorise any of the Parties to make or enter into any commitments for or on behalf of the other Parties.

19. COUNTERPARTS

19.1. This MoU may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this MoU, but all the counterparts shall together constitute the same agreement.

19.2. The expression "**counterpart**" shall include any executed copy of this MoU transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e mail attachment.

19.3. No counterpart shall be effective until each Party has executed at least one counterpart.

We have signed this Memorandum of Understanding on the date written at the head of this memorandum.

SIGNED by	)	……..
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	))	DATE: 30 April 2018

SIGNED by	)	……..
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST	))	DATE: 30 April 2018

SIGNED by	)	……..
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
LEEDS COMMUNITY HEALTHCARE NHS TRUST	))	DATE: 30 April 2018

SIGNED by	)	……..
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	))	DATE: 30 April 2018

SCHEDULE 1

THE KEY PRINCIPLES

1. The continued challenge of ensuring the quality and financial sustainability of mental health services requires a more collaborative approach between providers ensuring that the best possible care can be delivered to people in WY making best use of the collective resources.

2. Through the WYMHLD&A Collaborative Programme, the Parties Key Principles are to achieve sustainable, safe, high quality and cost effective acute and specialist mental health services across WY, based on clear integrated and standardised operating models, networks and alternative service delivery models where risk and benefits will be collectively managed. This will be achieved through addressing the following:

   2.1. Achieving the clinical and financial stability across the WYMHLD&AC service areas.

   2.2. Enhancing partnership working through collaboration between providers, leading to interdependency, care delivered by stream or pathway rather than by individual organisations and by collective provider responsibility.

   2.3. The approach to collaboration:

   - The Parties will work on the greatest challenges together to ensure high quality, sustainable mental health services now and in the future.
   - Reduce variation in quality by building on best practice and developing standard operating procedures and pathways to achieve better outcomes for people in WY.
   - Take a collaborative approach to the delivery of acute/specialist mental health services via clinical pathways and networked services (rather than individual place/provider led developments).
   - Developing ‘centres of excellence’ for the more specialist mental health services e.g. forensic services, Child and Adolescent Mental Health Services (CAMHs) Tier 4, adult eating disorders.
   - Delivering economies of scale in mental health service support functions.
   - Build constructive relationships with communities, groups, organisations and the third sector to ensure there are lines of communication and ways of engaging on issues which have an impact on people’s health and wellbeing.
   - Ensure there is appropriate public engagement on those matters which need to be communicated more widely.

SCHEDULE 2

WYMHLD&A COLLABORATIVE PROGRAMME APPROACH AND KEY STAGES

1. Purpose of the Collaborative Programme

The purpose of the collaborative programme is to reduce variation and deliver sustainable acute and specialist mental health services to a standardised model which is efficient and of high quality. In developing this programme the Parties will be designing services over a wider NHS footprint (the WYMHLD&AC service area), thinking of different models of care and making collective efficiencies where the potential exists.

2. The WYMHLD&A Collaborative Programme Approach

The Key Principles and five key steps to developing the WYMHS Collaborative Programme approach are set out in Schedule 1.

3. WYMHLD&A Collaborative Programme Priorities

The WYMHLD&A Collaborative Programme priorities are expected to be generated as a result of the following internal and external drivers;

- WYMHLD&AC clinical and operational sustainability priorities.
- WYMHLD&AC analysis of variation.
- West Yorkshire & Harrogate Health and Care Partnership.
- Regulatory requirements and expectations within NHSE/I Planning Guidance.

The structure of the programme will reflect these priorities as shown in the workstreams below (as at 1st January 2020). Those in yellow are priorities for the CinC, those in blue are priorities for the wider partnership MHLDA programme which the CinC does not focus on, but receives updates on because the work is linked.

Origin	Workstreams	Strands
Delivering pre-COVID priority workstreams	Specalised services	Adult Eating Disorders
		Tier 4 CAMHS
		Forensics
		'Next Wave' (ie Perinatal MH)
	Secondary Care Pathways	Psychiatric Intensive Care
		Community Transformation
	Complex Rehabilitation	Community teams
		Inpatient provision
	Learning Disability	Assessment & Treatment Units
		Transforming Care Programme
		Reasonable

		Adjustments
	Autism	Diagnosis
		Understanding barriers
		Pre/post diagnostic support
	Children & Young People	Whole Pathway Commissioning
	Improving Determinants of Health	Suicide Prevention
		Perinatal Mental Health
		BAME access & treatment
		Healthy Hospitals and physical health
Delivering ongoing support and response during COVID	Mutual aid	Crisis Pathways
		Cohorting/inpatient capacity
		Sharing of practice, learning and fortnightly communication
	Population support schemes	Keeping connected
		Grief and Loss helpline
Delivering new priorities as a result of COVID	Improving collaboration	Prevention & Management of Violence & Aggression
		Collaborative staff bank
	Staff health and wellbeing	West Yorkshire Mental Wellbeing Hub

4. Key Workstream Stages

4.1 Long term workstream priorities will be developed based on a robust case for change (risk and benefit evaluation of workstream potential based on current service models) or through agreement by collaborative partners of a need to respond more quickly to emerging concerns.

4.2 The table below illustrates the sequence of stages of the workstream development process, this will be a scalable process and proportionate to the workstream:

Stage	Outputs	Key Requirements
1. Case for change (Proposal)	Detailed description of current services Gap/challenges relating to safety, resilience, quality, sustainability (Data analysis) Scope for improvement Evaluation framework Risk sharing approach	Clinical leadership and involvement External Experts and Clinical Senate involvement
2. Design the Future	Standardise operating procedures	

Stage	Outputs	Key Requirements
Operating Model	Workforce models Capacity modelling Best Practice benchmarks for future performance Scale of improvement which can be achieved	
3. Develop Options	New Models of Care Organisational change Operational networks Alternative provider arrangements and service delivery models Commissioner requirements and consultation	
4. Evaluation & selection of the preferred option	Clinical (Quality) Financial/Legal/Regulatory Workforce Performance Quality impact assessments Equality impact assessments	
5. Implementation planning	Timescales Resources Evaluation and review delivery of benefits Management of risks and issues	

4.3 The WYMHLD&AC Executive will be responsible for the execution and delivery of the programme governance and ensuring that a common approach is applied to all applicable workstreams (some workstreams may not require this approach) and that the workstream pipeline is managed within defined timescales.

4.4 Each workstream will have a WYMHLD&AC Director (identified by the WYMHLD&A Collaborative Executive) and Senior Lead Clinical sponsor. The inputs at each stage will include:

- Clear articulated case for change i.e. use of data, standards etc.
- Identification and use of organisational change/service improvement models
- Targeted clinical/staff engagement and empowerment in order to lead the design and change e.g. facilitated workshops
- Transparent options appraisal process
- Quality impact assessments
- Equality impact assessments

- Use of external scrutiny
- Appropriate commissioner engagement
- Appropriate public/patient engagement
- Governor engagement

4.5 The WYMHLD&AC Executive and WYMHLD&AC C-In-C will make decisions on the prioritisation and progressing of workstreams to the next stage as shown in the Decision Making Schedule and gateways (as set out in Schedule 4).

5. Risk and Gain Sharing Principles

5.1. Some WYMHLD&AC projects developed under the workstreams will have the potential to disproportionately benefit participating WYMHLD&AC organisations at the expense of others. The potential impact of the implementation of a project through a workstream will be established and set out within the 'Case for Change' stage (Gateway 1) and the 'risk gain share' model between the respective WYMHLD&AC members affected by the project developed in preparation for selection of the preferred option at Gateway 3. The model will be tailored to each project and will be designed on the following principles reflecting that organisations are working for the delivery of better care and a more sustainable system for patients in the WYMHLD&AC service area:

5.1.1. The costs of delivering the project will be met by all Parties in the proportions agreed and submitted within the submission for Gateway 3 so that the WYMHLD&AC C-In-C can be clear when selecting the preferred option where the costs will be met from and how any losses may be reimbursed;

5.1.2. The allocation of net benefits from a project will be agreed based on one or a combination of these methods, the detail of which will be developed and agreed at Gateway 3 of decision making process :

- equal gain share;
- proportional gain share; and/or
- successful contribution to the initiative.

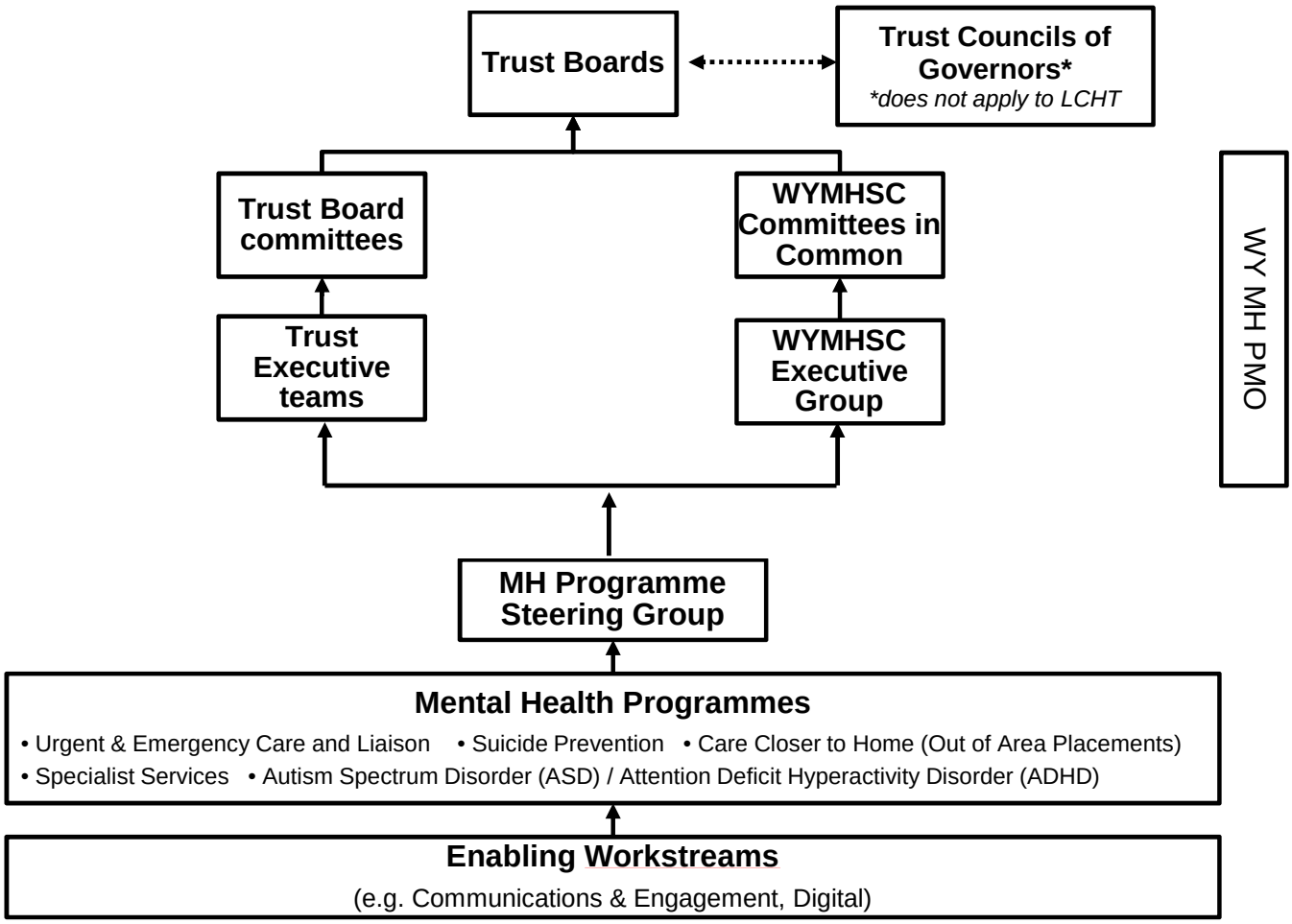
5.1.3. The allocation of net benefits will be agreed between the relevant Parties based on the benefit and risk profile using these methods; and

5.1.4. The same principles will apply to the sharing of risks and costs in the event that a project does not deliver the anticipated net benefit.

6. High Level Programme Structure

The high level programme structure, linked to the West Yorkshire and Harrogate Health and

Care Partnership (previously STP), is shown below:



SCHEDULE 3

DISPUTE RESOLUTION PROCEDURE

1. Avoiding and Solving Disputes

1.1 The Parties commit to working co-operatively to identify and resolve issues to their mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this MoU.

1.2 The Parties believe that:

1.2.1 by focusing on the agreed Key Principles underpinned by the five step approach as set out in the MoU and in Schedule 1;

1.2.2 being collectively responsible for all risks; and

1.2.3 fairly sharing risk and rewards in relation to the services in scope in the WYMHLD&A Collaborative Programme.

they reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with this MoU.

1.3 A Party shall promptly notify the other Parties of any dispute or claim or any potential dispute or claim in relation to this MoU or its operation (each a "**Dispute**') when it arises.

1.4 In the first instance the WYMHLD&AC Programme Executive shall seek to resolve any Dispute to the mutual satisfaction of each of the Parties. If the Dispute cannot be resolved by the WYMHLD&AC Programme Executive within 10 Business Days (a **Business Day** being a day other than a Saturday, Sunday or public holiday in England when banks in London are open for business) of the Dispute being referred to it, the Dispute shall be referred to the WYMHLD&AC C-In-C for resolution.

1.5 The WYMHLD&AC C-In-C shall deal proactively with any Dispute on a "Best for Meeting the Key Principles" basis in accordance with this MoU so as to seek to reach a majority decision. If the WYMHLD&AC C-In-C reaches a decision that resolves, or otherwise concludes a Dispute, it will advise the Parties of its decision by written notice. The Parties recognise that any dispute or operation of this procedure will be without prejudice to and will not affect the statutory duties of each Party. This MoU is not intended to be legally binding and, given the status of this MoU (as set out in Section 2), if a Party disagrees with a decision of the WYMHLD&AC C-In-C or the independent facilitator, they may withdraw from the MoU at any point in accordance with section 14 of the MoU.

1.6 If a Party does not agree with the decision of the WYMHLD&AC C-In-C reached in accordance with the above, it shall inform the WYMHLD&AC C-In-C within 10 Business Days and request that the WYMHLD&AC C-In-C refer the Dispute to an independent facilitator in agreement with all Parties and in accordance with paragraph 1.7 of this Schedule.

1.7 The Parties agree that the WYMHLD&AC C-In-C, on a “Best for Meeting the Key Principles” basis, may determine whatever action it believes is necessary including the following:

1.7.1 If the WYMHLD&AC C-In-C cannot resolve a Dispute, it may request that an independent facilitator assist with resolving the Dispute; and

1.7.2 If the independent facilitator cannot facilitate the resolution of the Dispute, the Dispute must be considered afresh in accordance with this Schedule and in the event that after such further consideration again fails to resolve the Dispute, the WYMHLD&AC C-In-C may decide to:

(i) terminate the MoU; or

(ii) agree that the Dispute need not be resolved.

SCHEDULE 4

WYMHLD&AC CIC DECISION MAKING

1. The Memorandum of Understanding (MoU) and Terms of Reference (TOR) for the WYMHLD&AC Committee in Common (WYMHLD&AC C-In-C) takes into consideration existing accountability arrangements of participating Trusts and decisions (where these apply to the services in scope in the collaborative) being made under a scheme of delegation.

2. Whilst it is recognised that some decisions taken at the WYMHLD&AC C-In-C may not be of obvious benefit to all Parties, it is anticipated that the WYMHLD&AC C-In-C will look to act on the basis of the best interests of the wider population investing in a sustainable system of healthcare across the WYMHLD&AC service area in accordance with the Key Principles when making decisions at WYMHLD&AC C-In-C meetings.

3. There are expected to be two categories of decision making:

   - **All parties will need to participate in the initiative** for reasons of interdependency, safety or financial viability. These decisions will be made on the basis of all the affected organisations reaching an agreed decision in common.

   - **Organisations will need to confirm their own commitment and involvement at key stages (Gateways)** in order to ensure the Business Case assumptions (benefits) and risks are robust, only trusts directly affected by the Case for Change (eligible constituency under paragraph 5 of this Schedule) will be able to make decisions (the Gateways) and once an organisation has committed to participate at a specific Gateway they cannot withdraw.

4. The WYMHLD&AC 'Gateway' decision making mechanism should be used (where appropriate) to achieve agreements that will be binding across relevant members. The mechanism will follow a staged approach and unless new material comes to light, once progression has been made through the respective stages, progress will remain at the relevant stage that has been reached and will not 'fall back'. On agreement of progression through stages, members will commit to the next steps in developing the proposal.

5. All proposals brought before the WYMHLD&AC C-In-C will require a detailed case for change. At this stage the WYMHLD&AC C-In-C will determine if the proposal warrants further development and consideration and is appropriate to pass to the next stage of development. This stage will also consider which Parties would be directly or indirectly affected and eligible/required to vote (to be known as the eligible constituency).

6. The table below illustrates the 'Gateway Decision Making' Process:

Stage	Gateway	Outcome
Case for change (Proposal)	Gateway 1 Requires support of a simple majority	No fall back unless material new information All organisations participate in design phase
Develop Options	Gateway 2 Seek unanimous support by all parties eligible to make decisions	Options and Evaluation Framework agreed
Evaluation and selection of the preferred option	Gateway 3 Seek unanimous support by all parties eligible to make decisions	Application of agreed framework Identification of agreed option
Recommendation to Committee in Common	Gateway 4 Seek unanimous support by all parties eligible to make decisions	Proceed with formal agreements/contracts as required and implement plan

7. If a Party does not support a proposal then it will not be bound to act in accordance with that proposal as the Parties remain independent statutory bodies under the WYMHLD&A Collaborative Programme.

8. Bilateral and Tripartite Agreements between Individual Trusts

8.1. The WYMHLD&AC Gateway Decision Making Framework does not preclude any Party from developing bilateral or tripartite agreements with other trusts in WYMHLD&A services outside the Collaborative Programme. It is expected that there will be transparency in developing such agreements and the option for other WYMHLD&A trusts to join an initiative and that the associated benefits and risks are appropriately considered in terms of the impact on other providers and the WYMHS Collaborative Programme.

8.2. Recognising that being part of the WYMHLD&AC C-In-C does not preclude Parties alliances or existing relationships with other organisations.

8.3. Parties may wish to invite other organisations to be party to initiatives agreed by the WYMHLD&AC C-In-C.

9. Forum for engaging with the wider system

9.1. The WYMHLD&AC C-In-C could also be used as a forum to provide responses to queries and recommendations from the commissioners or the wider system (for example following a request from the WYHHCP) on specific issues.

SCHEDULE 5

WYMHLD&AC Committees in Common -TERMS OF REFERENCE

THESE TERMS OF REFERENCE FORM PART OF THE WYMHLD&AC MEMORANDUM OF UNDERSTANDING DEFINITIONS AND TERMINOLOGY ALIGN TO THE MEMORANDUM OF UNDERSTANDING

1. Scope

    a. The West Yorkshire Mental Health, Learning Disability & Autism Collaborative ('the Collaborative') is the collective governance vehicle for joint decision making, with delegated authority for the four NHS mental health, learning disability and autism provider Trusts in West Yorkshire.

    b. The Collaborative is one part of the wider West Yorkshire and Harrogate Health and Care Partnership, which is committed to putting combined efforts into tackling the long-term trends of ill-health. This includes specific ambitions to:

        i. Achieve a 10% reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism and the rest of the population by 2024 (including a focus on early support for children and young people)

        ii. Reduce suicide by 10% by 2020/21 and achieve a 75% reduction in targeted areas by 2022

    c. The overall responsibility for delivery of these two ambitions rests with the whole Partnership. This responsibility is discharged and governed by the system-wide Mental Health, Learning Disability and Autism Programme Board which is comprised of providers and commissioners, covering the NHS, local authority, VCS and other partners.

    d. **The Committees in Common for the Collaborative reports into the Board of each individual provider within the Partnership (BDCFT, LCH, LYPFT, SWYPFT). It is overall responsible for supporting service transformation, integration and innovation and specifically, responsible for leading development of identified workstreams, improving service delivery to support the overall ambitions of the Partnership.**

    e. This Terms of Reference is approved through each individual provider Board.

    f. Appendix 1 to the Terms of Reference describes this relationship in a diagram

2. Standing

    a. Members shall only exercise functions and powers of a Party to the extent that they are permitted to ordinarily exercise such functions and powers under that Party's internal governance.

3. General Responsibilities of the Collaborative Committees in Common

a. Ensuring alignment of all parties to the WY&H Mental Health, Learning Disability and Autism strategy, confirming the role of the Collaborative in delivery;

b. Providing overall strategic oversight and direction to the improvement of services within the Collaborative for people with a Mental Health condition, learning disability and/or autism;

c. To emphasise the primacy of individual organisations' decision making ability and relationship with their local place, but also to set the expectation through individual boards and within operational teams that:

    i. Where agreed through the CinC there will be service delivery, development work and clinical/operational relationships that require a 'WY&H first' viewpoint, rather than an individual organisational viewpoint.

    ii. All partners within the collaborative take informed decisions in consultation with other collaborative partners and relevant stakeholders where there might be an impact on others' services.

    iii. The CinC will consider and agree adoption of joint policies and procedures across all organisations that will benefit the work of the collaborative.

d. Formally recommending the roles and responsibilities within identified workstreams, reviewing the key deliverables and ensuring adherence with required timescales;

e. Receiving assurance that identified workstreams have been subject to robust engagement and impact assessments;

f. Reviewing and identifying the risks associated with the performance of any of the Parties in terms of the impact to the Collaborative or to the ambitions of the Partnership, recommending remedial and mitigating actions;

g. Receiving assurance that the risks associated with the Collaborative work programme are being identified, managed and mitigated;

h. Formulating, agreeing and implementing strategies for delivery of the Collaborative workplan;

i. Seeking to determine or resolve any matter referred to it by the Programme Team or any individual Party and any dispute in accordance with the MoU:

j. Considering the shape of the Programme Team, agreeing and reviewing the extent of the Collaborative's financial support for the team, against wider Partnership funding;

k. Reviewing the Terms of Reference for the Committees in Common;

l. Reviewing and agreeing the deployment of any joint Collaborative budget, with reference to the deployment of Partnership Transformation Funding and CCG baselines; this includes collective approval of substantial capital funding decisions in accordance with the Risk and Gain Sharing Principles.

4. Members of the Collaborative Committees in Common

    a. Each Party will appoint their Chair and Chief Executive as Committees in Common Members and the parties will always maintain a Member on the Committees in Common.

    b. Deputies will be permitted to attend on the behalf of a Member. The deputy must be a voting board member of the respective Party and will be entitled to attend and be counted in the quorum at which the Member is not personally present.

    c. Each Party will be considered as one entity within the Collaborative.

    d. The Parties will ensure that, except for urgent or unavoidable reasons, their respective Committees in Common Member (or Deputy) attend and fully participate in the meetings of the Committees in Common.

5. Proceedings of the Collaborative Committees in Common

    a. The Committees in Common will meet quarterly, or more frequently as required. In addition an annual strategic meeting will be held to review overall progress and set the direction and objectives for the year ahead.

    b. The Chair may call additional meetings as required. Other members may request the Chair to call additional meetings by making individual representation, although the Chair will make the final decision on whether to proceed.

    c. The Committees in Common shall meet in private where appropriate in order to facilitate discussion and decision making on matters deemed commercially sensitive and by virtue of the confidential nature of the business to be transacted across the Members. It is agreed by the Parties that the necessary checks and balances on openness, transparency and candour continue to exist and apply by virtue of the Parties each acting within existing accountability arrangements of the Parties' respective organisations and the reporting arrangements of the Committees in Common into the Parties' Trust public Boards.

    d. The Parties will select one of the Parties' Chairs to act as the Chair of the Committees in Common on a rotational basis for a period of twelve months. The Chair will ensure they are able to attend every meeting over that period. If in cases of urgent, unavoidable absence the Chair cannot attend, one of the other Parties' Chairs will be asked to step in.

    e. The Committees in Common may regulate its proceedings as they see fit as set out in these Terms of Reference.

    f. No decision will be taken at any meeting unless a quorum is present. A quorum will not be present unless every Party has at least one Member present (four members in total).

    g. Members of all Parties will be required to declare any interests at the beginning of each meeting.

    h. A meeting of the Committees in Common may consist of a conference between the Members who are not all in one place, but each of whom is able directly or by telephonic or video communication to speak to each of the others, and to be heard by each of the others simultaneously.

i. Each Member will have an equal say in discussions and will look to agree recommendations in line with the Principles of the Collaborative.

j. Any issues to be raised within individual Party board committees will be noted and listed for action, with a dedicated agenda item reserved for this purpose.

k. The Committees in Common will review the meeting effectiveness at the end of each meeting with a dedicated agenda item reserved for this purpose.

6. Decision making within the Collaborative

a. Each Member will comply with the existing accountability arrangements of their respective appointing organisation and will make decisions which are permitted under their organisation's Scheme of Delegation.

b. Recognising that some decisions may not be of obvious benefit to or impact directly upon all Parties, Members shall seek to pay due regard to the best interests of the wider population in investing in a sustainable system of healthcare across the service area in accordance with the Key Principles and ambitions of the Partnership when making decisions at Committees in Common meetings.

c. In respect of matters which require decisions where all Parties are affected the Parties will seek to make such decisions on the basis of all Members reaching an agreed consensus decision in common in accordance with the Key Principles.

d. In respect of the matters which require decisions where only some of the Parties are affected, then the Parties shall reference the Collaborative Gateway Decision Mechanism at Schedule 4 of the Memorandum of Understanding.

7. Attendance of third parties at the Committees in Common

a. The Committees in Common shall be entitled to invite any person to attend, such as advisors, experts by experience or Partnership leaders but not take part in making decisions at meetings of the Committees in Common. The Chair will agree final attendance lists for each meeting.

8. Administration for the Committees in Common

a. Meeting administration for the Committees in Common will be provided by the WYMHLD&A Programme Team, maintaining the register of interests and the minutes of the meetings of the Committees in Common. Members are required to openly and proactively declare and manage any conflicts of interests.

b. The Chair will be responsible for finalising agendas and minutes, based on the agreed workplan and in collaboration with the WYMHLD&A Programme Team.

c. Where required by the agenda, governance leads from the Collaborative will be asked to attend and provide advice to the Committees in Common on decision making and due diligence.

d. Papers for each meeting will be sent by the WYMHLD&A Programme Team to Members no later than five working days prior to each meeting. By exception; and only with the agreement of the Chair, amendments to papers may be tabled

before the meeting.

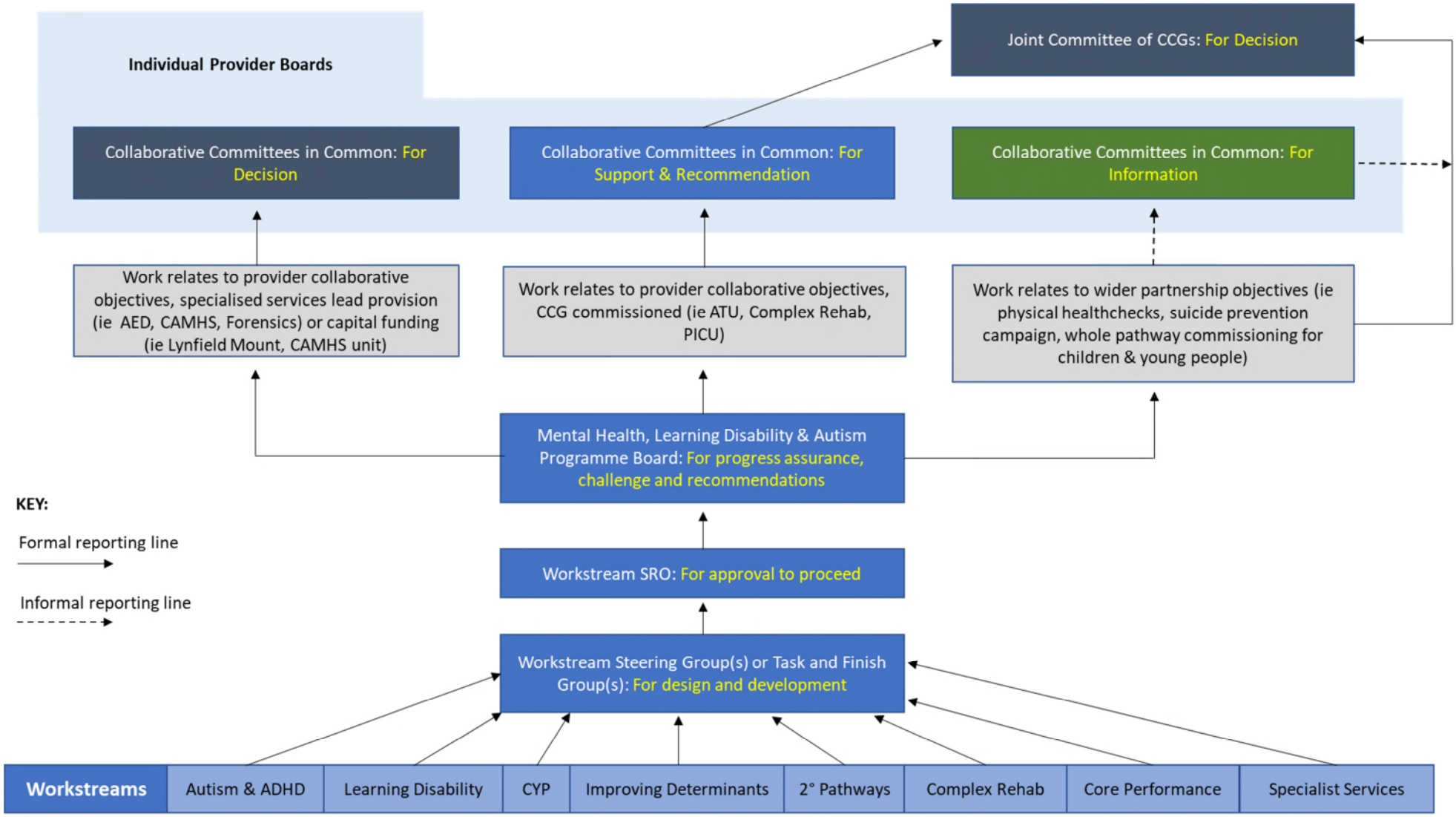
e. The minutes, and a summary report from the Programme Director will be circulated promptly to all Members and Trust governance leads as soon as reasonably practical for inclusion on the public agenda of each Parties' Board meeting. Any items not for public consumption will be marked as private in the minutes and be noted at Trust private boards but not circulated with the public papers.

f. Following the annual Partnership 'check and confirm' session for the WYMHLD&A programme a report will be made available by the Programme Director for the Committees in Common to review. Each Party should reflect the work detailed in this report within their annual Quality Accounts.

9. Review

a. The Committees in Common will review these Terms of Reference at least annually.

Appendix 1 – Decision making relationship between the Committees in Common and the wider Partnership



Appendix 2

Escalation and Assurance Report Template

Report from: WYMHSC Committees-in-Common
Date the meeting:

Key discussion points and matters to be escalated from the discussion at the meeting:
Alert/Action:
• to escalate an issue that requires further discussion or action by individual Boards • • •
Advise:
• to highlight an issue that may require further monitoring (by the Committee-in-Common) over a period of time • • •
Assure:
• to provide positive news on performance, best practice, improvements or learning • • •
Risks discussed: • High level overview
New risks identified: • High level overview

Report completed by: WHMHLD&AC Programme Director
Date:

West Yorkshire and Harrogate
Health and Care Partnership
Mental Health, Learning Disabilities & Autism

Escalation and Assurance Report

Report from: WYMHSC Committee-in-Common
Date of the meeting: 21/01/2021

Key discussion points and matters to be escalated from the discussion at the meeting:

Alert/Action:

To escalate an issue that requires further discussion or action by individual Boards

- Committees in Common discussed the response to the PHE/LeDeR report into learning disability deaths during COVID. A discussion was held at System Leadership Executive (SLE) on 2 January to agree responsibilities across all partners, not just MHLDA providers, to take practical action to address gaps in reasonable adjustments for people with a learning disability (LD).
- Committees in Common agreed revisions to the existing collaborative Memorandum of Understanding for ratification by individual boards.
- Each organisation has been updated as to the position with the Adult Secure business case and will receive the business case for approval at February 2021 board meetings

Advise:

To highlight an issue that may require further monitoring (by the Committee-in-Common) over a period of time

- The Committees in Common agreed to monitor at future meetings:
  - Capital Planning and requirements into 2021/22
  - Recommendations and deliver against the WY&H BAME and LD reviews.
  - Final recommendations from the Prevention and Management of Violence & Aggression task and finish group exploring a collaborative approach to training.
  - The impact of COVID 19 on demand for MHLDA services now and in the future.
  - Transformation plans and delivery for Assessment Treatment Units in the ICS.

Assure:

To provide positive news on performance, best practice, improvements or learning

- The successful West Yorkshire and Harrogate Health and Care Partnership (WY&HHCP) Mental Health, Learning Disabilities and Autism (MHLDA) Non-Executive Director (NED) and Governor virtual event in November 2020 was well received and attended with good engagement. The next event has been held in diaries for the 11th June 2021.
- Significant transformation funding bids being submitted and funding continuing to be received from NHSE to support Community Mental Health Transformation, alternatives to Crisis provision, discharge arrangements and perinatal mental health
- A WY&H Mental Wellbeing Hub is now operational to support wellbeing, curation of good practice, training for managers and signposting/triage of complex cases from places.

Report completed by: WY&H MHLDA Programme Director **Date:** 27/01/21