Leeds and York Partnership NHS
NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

PUBLIC MEETING OF THE BOARD OF DIRECTORS
will be held at 9.00 am on Thursday 27 April 2017
in Meeting Room 3, Clifton House, Bluebeck Drive, Shipton Road, York YO30 5RA

A G E N D A

Members of the public are welcome to attend the Board meeting, which is a meeting in public not a public meeting. If there are any questions from members of the public please could they advise the Chair or the Head of Corporate Governance in advance of the meeting*.

		LEAD
1	**Apologies for absence** (verbal)	**SP**
2	**Annual declaration of interests for directors** (enclosure)	**SP**
	2.1 Declared conflicts of interest in respect of agenda items (verbal)	**SP**
3	**Minutes of the previous meeting held on 30 March 2017** (enclosure)	**SP**
4	**Matters arising**	
5	**Actions outstanding from the public meetings of the Board of Directors** (enclosure)	**SP**
6	**Chief Executive's report** (enclosure)	**SM**

PART A – QUALITY

7	**Integrated quality and performance (including full financial information) for March 2017** (enclosure)	**LP**
8	**Safe staffing report** (enclosure)	**AD**
9	**CQC action plan** (enclosure)	**AD**
10	**Operational plan implementation report quarter 4** (enclosure)	**LP**
11	**Medical Director's report** (enclosure)	**CK**
12	**Guardian of Safe Working Guardian annual report April 2016 to March 2017** (enclosure)	**CK**
13	**Freedom to Speak up Guardian annual report** (enclosure). Helen Wiseman will be in attendance for this item	**HW**

PART B – STRATEGY

No items

PART C – GOVERNANCE

14	**Verbal report from the Chair of the Audit Committee for the meeting held 24 April 2017** (verbal)	**JT**
15	**Verbal report from the Chair of the Finance and Business Committee for the meeting held 24 April 2017** (verbal)	**SWH**
16	**Verbal report from the Chair of the Quality Committee for the meeting held 25 April 2017** (verbal)	**JB**
17	**CQC Learning, candour and accountability and NQB Guidance on Learning from deaths report – a framework** (enclosure)	**AD**
18	**Serious incidents and lessons learnt** (enclosure)	**AD**
19	**Division of duties between the Chair and Chief Executive** (enclosure)	**CH**

20	**Any other business** (verbal)	**SP**
21	**Board evaluation** (verbal)	**SP**
22	***Chair to resolve that members of the public be excluded from the meeting having regard to the confidential nature of the business transacted, publicity on which would be prejudicial to the public interest***	**SP**

* Questions for the Board can be submitted to:

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

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

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

2

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Annual declaration of interest from Board members
DATE OF MEETING:	27 April 2017
LEAD DIRECTOR: (name and title)	Prof Sue Proctor – Chair of the Trust
PAPER AUTHOR: (name and title)	Cath Hill – Head of Corporate Governance

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)

Quality		Strategic		Governance	✓	Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	We work with service users and carers to support their achievement of outcomes and wellbeing	
G2	We are an employer of choice with a compassionate and highly trained workforce committed and supported to provide excellent innovative care and support	✓
G3	We work with others to improve health and improve lives through effective, innovative and sustainable partnerships	
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	
SO2	We provide a dynamic, rewarding and supportive place to work	
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	
SO4	We are transparent and accountable to the people and partners we work with	✓
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	

STATUS OF PAPER (please tick relevant box/s)	✓
To be taken in the public session (Part A)	✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:	
Legal advice relating to legal proceedings (actual or possible)	
Negotiations in respect of employee relations where they are of a confidential nature	
Procurement processes and contract negotiations	
Information relating to identifiable individuals or groups of individuals	
Other – not yet a public document	
Matters exempt under the Freedom of Information Act (quote section number)	

Leeds and York Partnership NHS
NHS Foundation Trust

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	This paper advises the Board of the declarations made by each director in accordance with the Constitution.
What are the key points and key issues the Board needs to focus on	All members of the Board of Directors are required to complete a Declaration of Interest form annually, or when a change arises in their circumstances throughout the year which would require a new form. Declarations have been made as at April 2017. They are a matter of public record and are available for inspection should such a request be made. However, the Head of Corporate Governance is awaiting an annual declaration from Prof John Baker and Margaret Sentamu. For the purpose of advising the Board of any declared interests on the attached paper the latest information provided by Prof Baker and Mrs Sentamu have been included in the report.
What is the Board being asked to consider	The Board is being asked to receive this for information and assurance on the declarations being made and they are received at a public meeting so the declarations are open and transparent.
What is the impact on the quality of care	By having directors who are open and transparent about their interests this ensures that they are able to be judged as carrying out their duties in the interests of the organisation and our service users rather than for personal gain.
What are the benefits and risks for the Trust	A summary of declared interests is attached. It should be noted that because a declaration has been made this does not mean that it constitutes a conflict of interest.
What are the resource implications	None.
Next steps following this paper being presented to the Board	The declaration forms will be held as a public record by the Head of Corporate Governance.
What are the reputational implications and how will these be addressed	Any director who does not correctly declare an interest or a resulting conflict of interest could call the integrity of the Board into question and as such damage the reputation of the Trust.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No.
What public / service user / staff / governor involvement has there been	The Board of Directors have made their own declarations. The Non-executive director declarations of; interest, fit and proper person, and independence will be seen by the Trust's Council of Governors for information.
Previous meetings where this report has been considered (including date)	None.

RECOMMENDATION (This report is being provided to the Board for) (please tick relevant box/s): ✓							
Assurance	✓	**Discussion**		**Decision**		**Information only**	✓

Provide details of what you want the Board to do:

The Board is asked to:

- Receive and note the record of those interests declared by members of the Board of Directors as at April 2017
- Note that two declarations are still awaited from Prof Baker and Mrs Sentamu

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Appendix A

Annual Declaration of Interests for members of the Board of Directors

(Declared as at April 2017)

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.
Anthony Deery Director of Nursing, Professions and Quality	None.	None.	None.	None.	None.	None.	None.	None.
Dawn Hanwell Chief Financial Officer and Deputy Interim Chief Executive	None.	None.	None.	None.	None.	None.	None.	**Partner** Director / owner of Whinmoor Marketing Ltd.
Clare Kenwood Medical Director	None.	None.	None.	None.	None.	None.	None.	None.
Lynn Parkinson Interim Chief Operating Office	None.	None.	None.	None.	None.	None.	None.	**Partner** Civil Servant at HMRC.
Susan Tyler Director of Workforce Development	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
NON-EXECUTIVE DIRECTORS								
Susan Proctor Non-executive Director	**Director** SR Proctor Consulting Ltd Independent company offering consultancy on specific projects relating to complex and strategic matters working with Boards and senior teams in health and faith sectors. Investigations into current and historical safeguarding matters.	None.	None.	None.	**Associate** Capsticks Law firm.	None.	**Member** Lord Chancellor's Advisory Committee for North and West Yorkshire **Chair** Safeguarding Group, Diocese of York **Member** Veterinary Nurse Council (RCUS)	**Partner** **Employee** Capita Finance company.
John Baker Non-executive Director **Declarations made 12 September 2016**	None.	None.	None.	None.	None.	**Professor** University of Leeds	None.	**Partner** **CBT Therapist** Pennine Care NHS Trust
Margaret Sentamu Non-executive Director **Declarations made 29 February 2016**	**Non-executive Director** **Traidcraft PLC** Fights poverty through trade, practising and promoting approaches to trade that help poor people in developing countries transform their lives.	None.	None.	**President** **Mildmay International** Pioneering HIV charity delivering quality care and treatment, prevention work, rehabilitation, training and education, and health strengthening in the UK and East Africa.	None.	None.	None.	None.
Jacki Simpson Non-executive Director	**Director** Hale Prep School	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
Julie Tankard Non-executive Director	None.	None.	None.	None.	**Director, Group Contract Management BT PLC** BT is a major IT network company.	None.	None.	None.
Susan White Non-executive Director	None.	None.	None.	None.	None.	None.	None.	None.
Steven Wrigley-Howe Non-executive Director	**Non-executive director- The Rehab Group** An independent international group of charities and commercial companies which provides training, employment, health and social care, and commercial services for over 80,000 people each year in Ireland, England, Wales, Scotland and Poland.	None.	None.	**Non-executive director- The Rehab Group** An independent international group of charities and commercial companies which provides training, employment, health and social care, and commercial services for over 80,000 people each year in Ireland, England, Wales, Scotland and Poland.	**Non-executive director- The Rehab Group** An independent international group of charities and commercial companies which provides training, employment, health and social care, and commercial services for over 80,000 people each year in Ireland, England, Wales, Scotland and Poland.	None. .	None.	**Partner Dentist Humanby Dental Practice.**

AGENDA ITEM 3

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Minutes of the Public Meeting of the Board of Directors held on held on Thursday 30 March 2017 at 13.00 in Training Room 3, Becklin Centre, Alma Street, Leeds LS9 7BE

Board Members		Apologies	Voting Members
Prof J Baker	Non-executive Director		✓
Mr A Deery	Director of Nursing, Professions and Quality		✓
Mr F Griffiths	Chair of the Trust		✓
Mrs D Hanwell	Chief Financial Officer and Deputy Chief Executive		✓
Dr C Kenwood	Medical Director		✓
Dr S Munro	Chief Executive		✓
Mrs L Parkinson	Interim Chief Operating Officer		✓
Mrs M Sentamu	Non-executive Director		✓
Mrs J Simpson	Non-executive Director	✓	✓
Mrs J Tankard	Non-executive Director (Deputy Chair of the Trust)	✓	✓
Mrs S Tyler	Director of Workforce Development		✓
Mrs S White	Non-executive Director		✓
Mr S Wrigley-Howe	Non-executive Director (Senior Independent Director)		✓

In attendance

Prof S Proctor	Vice Chair of Harrogate and District NHS FT (attending as incoming Chair of the Trust)
Mrs C Hill	Head of Corporate Governance (secretariat)
Ms R Cooper	Governance Assistant (minutes)
1 member of the public	

Action

The Chair opened the public meeting at 13.00 and welcomed members of the Board of Directors, noting that Prof Sue Proctor, the incoming Chair of the Trust, had been invited to attend the meeting. Mr Griffiths noted that whilst constitutionally Prof Proctor did not have the right of vote at the meeting she had been asked to play a full part in all other respects.

17/033 **Apologies for absence** (agenda item 1)

Apologies were received from Mrs Julie Tankard, Non-executive Director and Mrs Jacki Simpson, Non-executive Director.

17/034 **Declaration of change in directors' interests and any conflict of interests in respect of agenda items** (agenda item 2)

It was noted by the Board that no changes in declared interests had been advised by any director and that no director present at the meeting had declared any conflict of interest in respect of any agenda item to be discussed.

17/035 **Opportunity to receive comments / questions from members of the public** (agenda item 3)

There were no questions or comments from the public.

17/036 **Minutes of the meeting held on 26 January 2017** (agenda item 4.1)

Prof Proctor noted that there were two minor typos. Firstly, in minute 17/013 where there had been a reference made to service user "stores" which should have been "stories" and that in minute 17/020 Mr Wrigley-Howe had been referred to as "Mrs". The Board noted and agreed these amendments.

Mr Wrigley-Howe also noted that in minute 17/008 there was an action which hadn't been captured in the log in relation to measuring 'the number of adults and children who are in crisis / who have Section 136 applied'. Mrs Hill agreed to add this action to the log.

The minutes of the meeting held on 26 January 2017 were **received** and **agreed** as a true record of the meeting, subject to the amendments agreed above.

17/037 **Matters arising** (agenda item 5)

There were no matters arising.

17/038 **Actions outstanding from the public meetings of the Board of Directors** (agenda item 6)

Mrs Hill presented the action log which showed those actions previously agreed by the Board at its public meetings, those that had been recently completed and those that were still outstanding. Mrs Hill asked the Board to be assured on progress.

The Board **received** the actions agreed at previous public meetings and was **assured** on progress against these.

17/039 **Chief Executive's report** (agenda item 7)

Dr Munro presented the Chief Executive's report. She welcomed Dr Claire Kenwood, the new Medical Director, to the Board and announced that Joanna Forster-Adams had been appointed as the new Chief Operating Officer, noting that a start date was currently being agreed. She discussed the recent changes to the Leeds commissioning landscape and the renewed focus on Sustainability and Transformation Plans nationally, noting which groups within the West Yorkshire and Harrogate footprint are attended by executives and senior members of staff.

Mrs White expressed concern that changes to the commissioning

	arrangements amongst the three Clinical Commissioning Groups (CCGs) may impact on the Trust's contractual agreements with third sector partners and asked for assurance that the Trust would continue to work with those organisations in partnership. Dr Munro assured the Board that the proposed lead-provider model would help to unlock opportunities for working in partnership across the city. Regarding the new Leeds Plan, Prof Proctor asked for further detail on the possible implications for the Trust. Dr Munro explained that having met with Ms Corrigan (Chief Executive across the three Leeds CCGs) the proposed direction of travel is a move towards an outcomes-based commissioning relationship which will be informed by the population health management framework being developed by Mr Gray (Chief Officer for System Integration). She assured the Board that regular communication would be maintained. Prof Proctor requested an update on the Board-to-Board workshop that took place on the 27 March 2017 with particular regard to lessons learnt from last winter. Dr Munro explained that there had been insufficient assurance that there is currently a plan in place which will be effective in preventing a repeat of the pressures next winter and that it had been agreed that work will continue via the System Resilience and Assurance Board and that the strategy will be reviewed by the Partnership Executive Group. She noted that if this does not provide adequate assurance to Boards then the group would reconvene in July, ahead of September, when plans are scheduled to be implemented and an update to the Board will be provided in July.	**SM**
	The Board **received** the Chief Executive's report and **noted** its contents and was assured of progress particularly in relation to the STP and partnership working in the city.	
17/040	**Integrated Quality and Performance (IQP) exception report** (agenda item 8) Mr Deery presented the IQP exception report noting that this also includes full financial information up to February 2017. He discussed the six exceptions that were highlighted in the report and briefly outlined the actions in place to address these. In relation to Mr Wrigley-Howe's question earlier Mr Deery explained that the data for 'timely access to mental health assessment under section 136' would be recorded routinely in the IQP for 2017/18 once the baseline data around waiting times had been established. Mr Deery noted that this would be included in the next report to the Board.	**LP**
	Mr Wrigley-Howe observed the reduction in the number of out of area placements, and was pleased to see an improved picture overall in respect of bed occupancy and delayed discharges. He suggested that the management team overseeing this work be congratulated for achieving this improved position. Mrs Sentamu asked how the ethnicity recording data is being used within	

the Trust. Mr Deery explained that Caroline Bamford, Head of Diversity and Inclusion, was managing this piece of work through the Mental Health Legislation Operational Steering Group and that this group reports to the Mental Health Legislation Committee. He noted that the data will help to identify high instances of BAME referrals and that this will assist the CCG for the delivery of services to better meet the needs of the communities served.

Dr Munro then suggested that those involved in the discussions with commissioners around ethnicity data collection should ask for the way this is collected to be revisited. It was suggested that commissioners replace the current monthly reporting pattern with point prevalence reporting at an agreed time in the year, as this would better inform longer term changes in service delivery. **AD**

Mrs White expressed concern that the figures for the proportion of in-scope patients assigned to a cluster was below target and asked for assurance that channelling resources into this area was adding value to the work on clinical outcomes. Mr Deery indicated that clinical involvement had been reduced in order to make gathering essential information predominantly an administrative task. He remarked there is less focus on clustering as a meaningful measure for clinicians.

Mrs White also noted that the waiting list for the Gender Identity Service had increased since last the last report to the Board. Mrs Parkinson acknowledged this and explained that there had been a rise in demand for the service nationally. She noted that additional investment from commissioners had been secured. That the service had successfully recruited to psychology and speech and language therapy posts and it was in the process of recruiting an additional nurse and consultant psychiatrist, which it was expected would be filled early in 2017/18. Mrs Parkinson added that some redesign work in the service should release an increase in capacity but that this may be slightly offset by a rising number of referrals. She assured the Board that the impact of these changes would be closely monitored to ensure they are effective in addressing the waiting list.

Dr Munro expressed concern at the comment in the report that indicated that some service users had not had a review within a 12-month period. Further that this included service users awaiting the allocation of a care-co-ordinator. She asked did this indicate that because some service users were waiting 12 months for a care co-ordinator, they therefore had not had a CPA review during that time. Mrs Parkinson assured the Board that since the report had been issued, work had continued to investigate this and that it was predominantly a system data issue. She did note that during the course of looking at this, there were some service users who were eligible for a CPA care plan who had not had one and that these cases were being highlighted to care co-ordinators as a matter of priority.

Mrs Hanwell then provided the Board with an update on the finance section of the report and highlighted the Trust's financial position, the NHS Improvement bonus and incentive scheme, and provided an update on progress with the Trust's capital programme.

Mrs Hanwell explained the bonus and incentive scheme and the positive impact this may have on the plan for this and next year. She noted that this would be discussed in greater detail by the Finance and Business Committee. Dr Munro noted that it was important to ensure the reasons for the improved year-end position were communicated carefully and clearly.

The Board **received** the IQP for the month of February 2017 and was **assured** of progress against the targets.

17/041 **CQUIN for Healthy Food for staff, visitors and service users** (agenda item 8.1)

Mr Deery introduced the paper, noting that this had been presented to the Board in accordance with the national requirements set by NHS England to review the arrangements for meeting the CQUIN prior to 31 March 2017. Mr Deery explained that this CQUIN works towards promoting the health and wellbeing of NHS staff, visitors and service users and that it seeks to improve the support available for them to eat well.

The Board discussed the paper and recognised the importance of this CQUIN; however, Mr Wrigley-Howe noted the report lacked a clear definition as to what constitutes healthy food.

The Board **considered** the information provided and was **assured** of the actions being taken to meet the delivery of the CQUIN standard.

17/042 **Serious incidents update and lessons learnt report** (agenda item 9)

Mr Deery referred to the report noting that it aims to assure the Board on investigations undertaken, that the standards set out in the NHS Improvement Serious Incident Reporting Framework are being met, and that the lessons learnt are being shared through the organisation. Mr Deery also indicated that the report shows that national developments are also being taken account of and that processes are being amended accordingly. In particular Mr Deery drew attention to the CQC report in relation to learning from deaths noting that this had been reviewed and outlined some of the work being undertaken by the Risk Management Team.

Mrs White was pleased to see the Trust had commissioned Root Cause Analysis training for those staff involved in the investigation of serious incidents. The Board also discussed the governance route for this report and Mr Griffiths noted that the relationship between the Trust Incident Review Group and the Quality Committee was under review.

Prof Proctor asked if the information in the report could be more clearly set out so that the information in the various tables around findings, lessons learnt, contributory factors etc. was articulated in a way which better showed the links and gaps. Mr Deery noted that more work needs to be done to **AD**

	refine the report. Prof Proctor also requested a précis to come back to the Board in relation to the two reports referred to in the paper: *CQC Learning, candour and accountability report* and the National Quality Board's *Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care*. Prof Proctor asked for the paper to address the duties of the Board and it was agreed that this would be brought back to the April meeting.	**AD**
	The Board **received** and **discussed** the content of the report.	
17/043	**Safe Staffing Report** (agenda item 10) Mr Deery introduced the report noting that it provided data for December 2016 and January 2017 in relation to safe staffing levels. Mrs White asked for assurance that levels in the Trust's community services were being closely monitored, although she noted that this was not required to be formally reported on. Mr Deery agreed that this information would be included in future reports.	**AD**
	Prof Baker queried the high staffing levels on Ward 1 at the Newsam Centre Psychiatric Intensive Care Unit (PICU) in December and January and questioned whether service users were being treated on the most appropriate ward. Mr Deery explained that the staffing pressures on the ward were as a result of the high acuity of the service users. He added that those service users had been assessed as having low-secure care requirements. Mrs Parkinson assured the Board that the situation was being monitored and Mr Deery indicated that further conversations would need to take place with commissioners. Dr Munro felt that the Board needed further assurance that the Trust is utilising its own expertise across PICU and low secure care to properly manage risk and it was agreed this would be reported on again at the next Board meeting.	**AD**
	The Board **received** the safer staffing report, **noted** the exceptions and reasons for these.	
17/044	**Complaints Summary Report** (agenda item 11) Mr Deery presented the report and noted that it provided activity and performance information about complaints, PALS contacts, compliments and claims received during February 2017. He commented that the compliments received by the Head of Complaints and PALS were routinely fed back to those involved. Mr Deery recognised that there had been an increase in the number of delayed responses to complaints and that the contractual 30-day timeframe had not always been met. He indicated that this had triggered a review of the sign-off process for complaints in order to look at the reasons for this [when will we be able to bring an update back to the Board].	

Prof Proctor asked whether the delay in Associate Directors approving the draft responses was a result of insufficient capacity and whether additional training could be provided to support the process. Mrs Parkinson acknowledged that there were capacity issues but added that the quality-checking process prior to Associate Director sign-off needed to be revised to minimise the need to redraft responses later on. She explained that additional training had been provided to those staff writing the responses and that this had generated some improvement but she indicated that there is still further work to be done. Mrs Parkinson noted the delays were also partly a performance management issue and that this is due to be discussed at the next Senior Management Group meeting and an update will be provided at the April Board meeting. **AD**

Finally, Prof Proctor suggested renaming the report so it better reflects the information being reported on. This was agreed. **AD**

The Board **received** the complaints summary report. It **noted** the issues highlighted in regard to meeting the target for completing complaints.

17/045 **Staff Survey Results** (agenda item 12)

Mrs Tyler introduced the report which set out the key themes and issues from the 2016 NHS Staff Survey, noting that this had been discussed in detail at the recent Board workshop. She noted that the results had been made public on 7 March when NHS England published the feedback reports for all trusts in England. She highlighted the positive findings from the organisation Listening in Action (LiA) and the comparison exercise they carried out which saw the Trust move up seven places from 2015 when compared against all other mental health and learning disability trusts in England.

Mrs Tyler indicated that there were still areas of further development and also noted that a staff engagement plan had been agreed at the Senior Management Group meeting which highlighted three areas of focused work in the coming year: improving communication between staff and senior management; team effectiveness; and tackling violence, abuse and harassment.

With regard to the response rate in the completion of the surveys Mrs Tyler noted the good response in comparison to previous years and to other Trusts. However, she indicated that to try to increase uptake for future surveys, both on-line and paper-based forms will be available for staff and that members of the Trust's management and Staffside would continue to be involved to encourage participation. Prof Proctor discussed how the context of NHS services provided over numerous locations can be a challenge to achieving a high record of participation and that the Trust had performed well.

	The Board **received** information on the outcome of the 2016 Staff Survey results and was assured as to the next steps.
17/046	**Approval of the Trust's Strategy** (agenda item 13) Dr Munro introduced the paper and outlined the steps involved in finalising the Trust's strategy. She explained that this had been discussed and supported by the Council of Governors and that it was now presented to the Board for final ratification. Dr Munro set out the next steps following the ratification, explaining that a paper detailing the Trust's priorities for the next 12 months will be presented to the Senior Management Group. She outlined the priorities identified including monitoring delivery against the current CQC action plan and improving communication and engagement with staff at team and service level. She noted that once these priorities have been agreed they will feed into the objectives and appraisals of the executive directors and the senior leadership team.
	The Board **considered** and **ratified** the Trust's refreshed strategy.
17/047	**Verbal report from the Chair of the Mental Health Legislation Committee for the meeting held 27 January 2017 (agenda item 14)** Mr Wrigley-Howe gave a verbal report of the main issues discussed at the meeting held on 27 January 2017. In particular he noted that there had been a presentation made to the committee entitled, 'Making Sense of Community Treatment Orders: The Service User Experience'. He noted that this had been well received and that it might be of interest to the Board would be interested in receiving at some point in the future.
	The Board **noted** the verbal update from the Chair of the Mental Health legislation Committee.
17/048	**Minutes of Mental Health Legislation Committee meeting held 27 January 2017** (agenda item 14.1)
	The Board **received** the minutes of the Mental Health Legislation Committee meeting held 27 January 2017.

17/049	**Report from the non-executive director / governor service visits** (agenda item 15) Mrs Hill presented the summary report from the service visits that had just been concluded and noted that this was being presented to the Board by way of update and information and to provide assurance that any actions or issues identified had considered by the executive directors. The Board received the paper which set out the observations from the non-executive / governor service visits and was **assured** that any issues highlighted were being addressed by the relevant executive director.	
17/050	**Approval of the Declaration Against the NHS Digital Information Governance Toolkit** (agenda item 16) Mrs Hanwell noted that it was a requirement for this paper to be presented to a meeting of the Board of Directors before 31 March 2017 and for it to be assured of the declaration prior to it being submitted to NHS Digital. Mrs Hanwell advised the Board that the trust had declared an overall score of "satisfactory" against the tool kit and that the Trust has met the statutory and regulatory requirements. Further, that it continues to perform in accordance with its contractual requirements. Mrs Hanwell also noted that once approved, the return would be submitted and published on the NHS Digital website. The Board **approved** the return to NHS Digital and was **assured** of the performance against the required standards.	
17/051	**Board Assurance Framework** (agenda item 17) Dr Munro presented the Board Assurance Framework and indicated that in light of the new Trust strategy a review of the Board Assurance Framework and the Strategic Risk Register would need to take place. Mr Wrigley-Howe added that he felt that the assurance around ligature risks referred to under Strategic Objective 2.1 should see a report coming to the Board rather than just to the Finance and Business Committee. The Board **received** the Board Assurance Framework.	**SM/CH**
17/052	**Appointment of Mental Health Act Managers** (agenda 18)	

The Board **approved** the appointment of the named individuals to the role of Mental Health Act Manager (MHAM).

17/053 **Extension of Mental Health Act Managers' Contracts** (agenda item 18.1)

Mr Deery explained that a recommendation was being made to extend the contract of some Mental Health Act Managers in order to maintain the required level of service to hear reviews and appeals by service users in an effective and timely manner. Further that the Trust has sufficient capacity to fulfil its legal responsibilities in regard to the review of detention and Community Treatment Orders.

Mr Griffiths cautioned against repeatedly reappointing managers in favour of refreshing the team regularly with new recruits. Mr Wrigley-Howe indicated that the proposal to extend the contracts may be a recruitment issue and suggested opportunities such as Annual Members' Day could be used to advertise this role to the public. Mrs Sentamu suggested that there should be a phased approach to new appointments in the interest of continuity.

The Board agreed that the workload needed to be spread out across managers. Mrs White assured the Board that the procedure for allocating MHAMs to hearings is being reviewed for this reason.

The Board **agreed** to further extend the final term contracts of the MHAMs (seven in total) for a further 12 months to support the recruitment, training and mentorship of the newly recruited MHAMs.

17/054 **Chair's Report** (agenda item 19)

The Chair discussed the value of the recent NHS Providers' meeting on 23 March 2017 and thanked Board members for their contribution to the event.

The Board **received** the Chair's report.

17/055 **Minutes of the Council of Governors' meetings held 16 November 2016 and 14 February 2017** (agenda item 20)

The Board received the minutes of the public meeting of the Council of Governor for information. Mrs Hill also noted that it should be minuted that at the private meeting of the Council of Governors on 14 February it had approved the appointment of Prof Sue Proctor as Chair of the Trust and Mrs Jacki Simpson as a Non-executive Director.

	The Board **received** the minutes of the Council of Governors' meetings held 16 November 2016 and 14 February 2017.
17/056	**Draft minutes of the Audit Committee for the meeting held 12 January 2017** (agenda item 21)
	The Board **received** the draft minutes of the Audit Committee meeting held 12 January 2017.
17/057	**Draft minutes of the Finance and Business Committee meeting held 23 January 2017** (agenda item 22)
	The Board **received** the draft minutes of the Finance and Business Committee meeting held 23 January 2017.
17/058	**Draft minutes of the Quality Committee meeting held 24 January 2017** (agenda item 23)
	The Board **received** the draft minutes of the Quality Committee meeting held 24 January 2017.
17/059	**Use of the Trust's seal** (agenda item 24)
	The Board **noted** that the seal had not been used since the last meeting.
17/060	**Any other business** (agenda item 25) Dr Munro reminded the Board that this was the last meeting for Mr Griffiths as Chair of the Trust and took the opportunity to thank him for his dedication to the Trust, to mental health and learning disability services across Leeds and York and for his contribution to national forums. In particular, she emphasised the importance of open and transparent engagement with the public. The Board joined Dr Munro in thanking Mr Griffiths for his time as Chair over the last seven years.
17/061	**Further questions or comments from the public** (agenda item 26) There were no further questions or comments from members of the public.

At the conclusion of business the Chair closed the public meeting of the Board of Directors of Leeds and York Partnership NHS Foundation Trust at 14:40 and thanked members of the Board and members of the public for attending.

Signed (Chair of the Trust) ……

Date ……..

BOARD OF DIRECTORS' ACTION SUMMARY
(PUBLIC MEETING)
Meeting held Thursday 30 March 2017

FOR INFORMATION ONLY
SEE CUMULATIVE ACTION LOG FOR DETAILED INFORMATION

MINUTE	ACTION SUMMARY (PUBLIC MEETING – PART A)	LEAD DIRECTOR
17/039	**Chief Executive's report** (agenda item 7) Assurance on 2017 winter pressures planning to come to the Board in July.	**SM**
17/040	**Integrated Quality and Performance (IQP) exception report** (agenda item 8) The data for 'timely access to mental health assessment under section 136' would be recorded routinely in the IQP for 2017/18 once the baseline data around waiting times had been established and this will be included the April data to the May Board. In relation to ethnicity data collection, it should be suggested that the way this is collected be revisited in order to replace the current system of monthly reporting with point prevalence reporting at an agreed time in the year. There is to be a meeting on the 19 April to discuss)	**LP** **AD/LP**
17/042	**Serious untoward incidents update and lessons learnt report**(agenda item 9) The information in the report should be more clearly set out so that the information in the various tables around findings, lessons learnt, contributory factors etc. was articulated in a way which better showed the links and gaps. A proposal will come to the April Board. A report to come back to the April Board in relation to the *CQC Learning, candour and accountability report* and the National Quality Board's *Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care* and for the focus of the paper to be around the duties of the Board.	**AD** **AD**
17/043	**Safe Staffing Report** (agenda item 10) Information is to be included in future reports in respect of assurance that staffing levels in the Trust's community services with an update to come to the July Board. At the April meeting the Board is to receive further assurance that the Trust is utilising its own expertise across PICU and low secure to properly manage risk.	**AD** **AD**

MINUTE	ACTION SUMMARY (PUBLIC MEETING – PART A)	LEAD DIRECTOR
17/044	**Complaints Summary Report** (agenda item 11) April Board to receive further assurance on the actions being taken to ensure that the delays in responding to complaints are being addressed. The report to the April Board be renamed to better reflect its content which includes not only complaints, but compliments and information about PALS.	**AD** **AD**
17/051	**Board Assurance Framework** (agenda item 17) A review of the risks on the Strategic Risk Register and the Board Assurance Framework in light of the new Trust strategy. With an update to come back to the July Board.	**SM/CH**

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM
5

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Actions outstanding from public meetings of the Board of Directors
DATE OF MEETING:	27 April 2017
LEAD DIRECTOR: (name and title)	Cath Hill – Head of Corporate Governance
PAPER AUTHOR: (name and title)	Cath Hill – Head of Corporate Governance

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)							
Quality		Strategic		Governance	✓	Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	People achieve their agreed goals for improving health and improving lives	✓
G2	People experience safe care	✓
G3	People have a positive experience of their care and support	✓
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We provide excellent quality, evidence-based, safe care that involves people and promotes recovery and wellbeing	
SO2	We work with partners and local communities to improve health and lives	
SO3	We value and develop our workforce and those supporting us	
SO4	We provide efficient and sustainable services	
SO5	We govern our Trust effectively and meet our regulatory requirements	✓

STATUS OF PAPER (please tick relevant box/s)	✓
To be taken in the public session (Part A)	✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:	
Legal advice relating to legal proceedings (actual or possible)	
Negotiations in respect of employee relations where they are of a confidential nature	
Procurement processes and contract negotiations	
Information relating to identifiable individuals or groups of individuals	
Other – not yet a public document	
Matters exempt under the Freedom of Information Act (quote section number)	

Leeds and York Partnership NHS
NHS Foundation Trust

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	To advise the Board on those actions agreed at public Board meetings. This report shows those actions still outstanding and those that have been closed since the last meeting. The Board is also asked to note that historic closed actions are included in the report for information.
What are the key points and key issues the Board needs to focus on	It is considered good practice to formally monitor progress against any actions agreed by the Board of Directors. This is so undue delay or failure to complete actions is formally challenged and so items are returned to the Board in a timely manner. Accordingly. The cumulative action list is presented to the Board for assurance on progress.
What is the Board being asked to consider	The Board is being asked to note the progress and to seek further information on any area where it is not assured.
What is the impact on the quality of care	The Board is ultimately responsible for all aspects of the quality of care. Completing actions as requested by the Board supports safe and high quality care.
What are the benefits and risks for the Trust	The benefit of reporting on agreed actions is that the Board is aware of progress and can challenge where it is not assured.
What are the resource implications	None.
Next steps following this paper being presented to the Board	The action log is not only received by the Board of Directors at each of its meetings but is also reported to the executive directors so they can review their actions ahead of the Board meeting, with the Chief Executive maintaining an overview of the completion and progress of actions.
What are the reputational implications and how will these be addressed	There are none linked directly to this report.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No.
What public / service user / staff / governor involvement has there been	Not applicable to this report.

Leeds and York Partnership NHS
NHS Foundation Trust

Previous meetings where this report has been considered (including date)	Executive Team meeting.

RECOMMENDATION **(This report is being provided to the Board for)** (please tick relevant box/s): ✓							
Assurance	✓	**Discussion**	✓	**Decision**		**Information only**	✓
Provide details of what you want the Board to do:							
The Board is asked to note the actions from previous public Board meetings and to be assured of progress seeking further clarification as necessary.							

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Leeds and York Partnership NHS
NHS Foundation Trust

Cumulative Action Report for the Public Board of Directors' Meeting

OPEN ACTIONS

Key to status =
Still outstanding/awaiting completion
Completed since the last Board meeting

LOG NUMBER	MINUTE NUMBER AND ORIGINATING MEETING DATE	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	STATUS
208	**16/125 (July 2016)**	**Serious incidents update and lessons learnt following the Trust Incident Review Group (TIRG) meeting held on the 8 June 2016** (agenda item 8) Progress made against the recurring themes in the report and asked that these and their corresponding actions be displayed in the future.	**Anthony Deery**	Management action	THE BOARD IS ASKED TO CONSIDER THIS ACTION CLOSED A paper is presented to the April Board meeting which seeks assurance on the governance arrangements for reporting on serious incidents. The Board is asked to be assured by the proposals in the paper and is asked to close this action in the light of those proposals.	
222	**17/008 (January 2017)**	**Integrated Quality and Performance (IQP) Report and quarter 3 monitoring return** (agenda item 8) The Trust is to provide narrative assurance regarding its intent as to how it intends to use cash at hand to enhance the quality of its services.	**Dawn Hanwell**	July 2017		

LOG NUMBER	MINUTE NUMBER AND ORIGINATING MEETING DATE	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	STATUS
223	**17/039 (March 2017)**	**Chief Executive's report** (agenda item 7) Assurance on 2017 winter pressures planning. Update report to come to the Board in July 2017.	**Sara Munro**	July 2017	ONGOING Once the plan has been developed and signed off at the System Resilience and Assurance Board (chaired by CCG), which is expected to be by July, Lynn Parkinson will report this on to the Board setting out what the implications are for this Trust.	
224	**17/040 (March 2017)**	**Integrated Quality and Performance (IQP) exception report** (agenda item 8) The data for 'timely access to mental health assessment under section 136' would be recorded routinely in the IQP for 2017/18 once the baseline data around waiting times had been established and this will be included the April data to the May Board.	**Lynn Parkinson**	May 2017		
225	**17/040 (March 2017)**	**Integrated Quality and Performance (IQP) exception report** (agenda item 8) In relation to ethnicity data collection, it should be suggested that the way this is collected be revisited in order to replace the current system of monthly reporting with point prevalence reporting at an agreed time in the year.	**Anthony Deery / Lynn Parkinson**	Management Action	COMPLETED At the meeting with commissioners on 19 April it was agreed that ethnicity data would be collected as suggested	

LOG NUMBER	MINUTE NUMBER AND ORIGINATING MEETING DATE	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	STATUS
226	**17/042 (March 2017)**	**Serious untoward incidents update and lessons learnt report**(agenda item 9) The information in the report should be more clearly set out so that the information in the various tables around findings, lessons learnt, contributory factors etc. was articulated in a way which better showed the links and gaps.	**Anthony Deery**	-	THE BOARD IS ASKED TO CONSIDER THIS ACTION CLOSED A paper is presented to the April Board meeting which seeks assurance on the governance arrangements for reporting on serious incidents. The Board is asked to be assured by the proposals in the paper and is asked to close this action in the light of those proposals.	
227	**17/042 (March 2017)**	**Serious untoward incidents update and lessons learnt report**(agenda item 9) A report to come back to the April Board in relation to the *CQC Learning, candour and accountability report* and the National Quality Board's *Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care* and for the focus of the paper to be around the duties of the Board.	**Anthony Deery**	April 2017	COMPLETED This item has been included on the April Board agenda	

LOG NUMBER	MINUTE NUMBER AND ORIGINATING MEETING DATE	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	STATUS
228	**17/043 (March 2017)**	**Safe Staffing Report** (agenda item 10) Information is to be included in future reports in respect of assurance that staffing levels in the Trust's community services.	**Anthony Deery**	July 2017	ONGOING Guidance is still awaited in regard to safe staffing in community services. Once received we will be able to scope out what an appropriate report looks like as part of the Workforce Report. The anticipated timeframe for this is an update by July 2017.	
229	**17/043 (March 2017)**	**Safe Staffing Report** (agenda item 10) At the April meeting the Board is to receive further assurance that the Trust is utilising its own expertise across PICU and low secure to properly manage risk.	**Anthony Deery**	April 2017	COMPLETED Information has been included in the report to the April Board	

LOG NUMBER	MINUTE NUMBER AND ORIGINATING MEETING DATE	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	STATUS
230	**17/044 (March 2017)**	**Complaints Summary Report** (agenda item 11) April Board to receive further assurance on the actions being taken to ensure that the delays in responding to complaints are being addressed and the report needs to have a title that reflects its content.	**Anthony Deery**	April 2017	THE BOARD IS ASKED TO AGREE TO CLOSE THIS ACTION At the Senior Management Group on the 4 April a new process for monitoring and managing timeliness of complaints responses was agreed. This will now be monitored via SMG on a monthly basis. It is proposed that we provide quarterly data on complaints and response times as part of the IQP report to the board.	
231	**17/051 (March 2017)**	**Board Assurance Framework** (agenda item 17) A review of the risks on the Strategic Risk Register and the Board Assurance Framework in light of the new Trust strategy. With an update to come back to the July Board.	**Sara Munro / Cath Hill**	July 2017		

HISTORIC CLOSED ACTIONS

LOG NUMBER	MINUTE NUMBER AND ORIGINATING MEETING DATE	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
221	**17/008 (January 2017)**	**Integrated Quality and Performance (IQP) Report and quarter 3 monitoring return** (agenda item 8) A report on the investigations carried out by the Chief Pharmacist and the Local Security Management Specialist into discrepancies with drugs on Rose Ward to go to Quality Committee.	**Anthony Deery**	To go onto the Quality Committee agenda	THE BOARD IS ASKED TO CLOSE THIS ACTION AS A BOARD ACTION This item has been included on the April Quality Committee agenda

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

6

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Executive's Report
DATE OF MEETING:	27 April 2017
LEAD DIRECTOR: (name and title)	Dr Sara Munro, Chief Executive
PAPER AUTHOR: (name and title)	Dr Sara Munro, Chief Executive

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)							
Quality		Strategic		Governance		Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	We work with service users and carers to support their achievement of outcomes and wellbeing	✓
G2	We are an employer of choice with a compassionate and highly trained workforce committed and supported to provide excellent innovative care and support	✓
G3	We work with others to improve health and improve lives through effective, innovative and sustainable partnerships	✓
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	✓
SO2	We provide a dynamic, rewarding and supportive place to work	✓
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	✓
SO4	We are transparent and accountable to the people and partners we work with	✓
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	✓

STATUS OF PAPER (please tick relevant box/s)	✓
To be taken in the public session (Part A)	✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:	
Legal advice relating to legal proceedings (actual or possible)	
Negotiations in respect of employee relations where they are of a confidential nature	
Procurement processes and contract negotiations	
Information relating to identifiable individuals or groups of individuals	
Other – not yet a public document	
Matters exempt under the Freedom of Information Act (quote section number)	

Leeds and York Partnership NHS
NHS Foundation Trust

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	This paper provides a report on the activities of the Chief Executive.
What are the key points and key issues the Board needs to focus on	• Organisational priorities 2017/18 • Governance Matters • Reasons to be proud
What is the Board being asked to consider	Agenda item for information only.
What is the impact on the quality of care	Celebrating the good work of staff improves morale, staff wellbeing and subsequently patient experience.
What are the benefits and risks for the Trust	Not applicable.
What are the resource implications	Not applicable.
Next steps following this paper being presented to the Board	Further consideration of the implications of the governance review when the full report is received.
What are the reputational implications and how will these be addressed	No specific reputational issues identified.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No.
What public / service user / staff / governor involvement has there been	Not applicable.
Previous meetings where this report has been considered (including date)	None.

Leeds and York Partnership NHS
NHS Foundation Trust

RECOMMENDATION (This report is being provided to the Board for) (please tick relevant box/s): ✓							
Assurance		**Discussion**		**Decision**		**Information only**	

Provide details of what you want the Board to do:

The Board is asked to receive this report for information and to be assured of the work being carried out by the Chief Executive.

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Chief Executive Report to the Board - April 2017

1. Introduction

The purpose of this paper is to update the board on the activities of the chief executive and bring to the boards attention key matters of interest.

2. Organisational priorities 2017/18

At the last board meeting the trust board approved the new strategy and ambition for our organisation be an outstanding provider of mental health and learning disability services and the employer of choice. In response to this I set out for the senior management group the key objectives for the next 12 months to enable the achievement of our ambition.

These objectives will form part of the annual appraisal and objective setting for all executive directors, associate directors and heads of service which will be completed during the first quarter of the year. They should then be cascaded and tailored for relevant service managers/clinical leads/team leads/staff members. They are set against a backdrop of us not always being clear on what the core set of priorities are whilst facing an ever increasing set of demands and expectations.

It is recognised that the core priorities do not reflect all of the work departments and senior managers would wish to undertake. Therefore they are not intended to be an exhaustive list. However in exercising judgement and discretion as to whether to undertake pieces of work in addition to these priorities senior leaders must ensure that in doing so it does not compromise capacity and capability to deliver on the objects for 2017/2018. Where such additional actions/pieces of work have wider impact beyond your specific service or team etc. then these should be discussed with line managers and where appropriate through the Senior Management Group to ensure good communication and decision making. The objectives are set out below however it is important to note that these are interdependent with one another.

Progress against the core objectives will be reported on quarterly to the SMG meeting with a report from all corporate departments and care groups. The first report will be due at SMG in July 2017.

Trust Core priorities and Objectives

a) **CQC standards** - achievement of all recommendations arising from the last comprehensive inspection during the first 6 months of the year with further actions identified that move towards outstanding service provision.

b) **This includes a specific priority to ensure we improve our approach and evidence of learning from incidents and patient harm so we can demonstrate improved safety for our patients.**
c) **Operational Plan** - Delivery of the first year of the operational plan as submitted to NHSI which includes achievement of our financial plan and cost improvement programme.
d) **Strategic plan** – each area/directors portfolio will have a prime strategic plan which they will be involved in the delivery of e.g. care services – clinical services strategic plan, quality plan, workforce and OD plan, estates plan, IM&T plan.
e) **Staff Engagement** – the findings from the staff survey results will be used to develop plans at teams and service level to improve staff engagement and staff experience. This should be underpinned by the Trust values and include methods for improving communication at all levels.
f) **Collective leadership** and development of internal relationships – building on our trust values and behaviours we need to support one another to maximise our individual knowledge, expertise and commitment for a greater collective impact. This is not easy to capture in a single sentence but can be described as having trusting supportive relationships that are mutually respectful. We seek to share knowledge, problem solve, encourage constructive challenge and debate in order to bring out the best in each and every one of us with the primary aim of delivering outstanding services for our service users, carers and local communities.
g) **External facing** – all members of the senior leadership team are involved in programmes of work/projects etc. that are external facing and require partnership working with other agencies. These should be explicit, managed in line with our trust values and trust strategy and therefore afforded time and resource as appropriate.

3. Governance Matters

For the past 3 months Deloittes have been undertaking a piece of work to review our governance, accountability and escalation arrangements across the organisation. I commissioned this based on feedback from our staff, senior leadership team and the issues raised in the CQC review. Our current arrangements are not sufficiently clear for all staff and there was a consensus that we needed to change them to give a clearer line of site to the front line and greater focus on delivery and impact.

This work has now concluded and the outcomes will be reviewed by the executive team on the 28th April 2017 at which point we will agree the actions to take forward to strengthen our existing governance arrangements. However the board is asked to note that we have commenced some actions during the review period such as strengthening the senior management group meeting which is now chaired by the

CEO, establishing a new trust clinical governance committee and developing a new approach to performance management with care services both of which will commence from May 2017. I will update the board on the final outcomes and actions in my next report.

I will also be informing the board that I have asked for learning from incidents to go on the trust risk register and for the quality committee to be provided with on-going updates and assurance on the action and mitigation being taken.

4. Reasons to be proud

In this month's report I have chosen to focus on one individual and the remarkable and inspirational efforts they have taken to challenge stigma towards mental health.

Josef Faulkner is a mental health nurse and locality manager in our community mental health services. He is seen as a role model, leader, rising star and highly valued member of staff by all who know him and work with him. The staff he manages consistently describes the support, leadership and direction he provides to support them to improve the quality of services the community teams provide. Josef has also shared openly his own personal family experiences of mental health and how this has been an influential factor in his career and the challenge he has taken on.

On the 14th April 2017 after months of training Joe set off to run from Leeds to London, arriving in time to run the London Marathon as part of the Rethink team. This meant running roughly the equivalent of a marathon each day to get there and sharing his journey through social media along the way. The reason for doing this is to raise money for rethink and awareness and support to tackle stigma towards mental health.

I am personally struck by Joe's modesty and personal drive to complete this challenge and it is a real honour for us that he works for our organisation. Therefore I want to ensure the board are aware of his contribution both as a member of staff but as someone who is going above and beyond to make a difference in mental health. It is our privilege that he works in our organisation.

Thank you Joe and Well Done.

Joe's journey has been shared through his twitter account which includes links to his daily blogs @JOEFL2L

Dr Sara Munro
Chief Executive
April 2017

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

7

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Integrated quality and performance report (including full financial information) for March 2017
DATE OF MEETING:	27 April 2017
LEAD DIRECTOR: (name and title)	Lynn Parkinson, Interim Chief Operating Officer
PAPER AUTHOR: (name and title)	Jim Woolhouse, Performance and Capacity Manager

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)							
Quality	✓	Strategic		Governance		Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	We work with service users and carers to support their achievement of outcomes and wellbeing	✓
G2	We are an employer of choice with a compassionate and highly trained workforce committed and supported to provide excellent innovative care and support	✓
G3	We work with others to improve health and improve lives through effective, innovative and sustainable partnerships	✓
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	✓
SO2	We provide a dynamic, rewarding and supportive place to work	
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	
SO4	We are transparent and accountable to the people and partners we work with	
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	✓

STATUS OF PAPER (please tick relevant box/s)	✓
To be taken in the public session (Part A)	✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:	
Legal advice relating to legal proceedings (actual or possible)	
Negotiations in respect of employee relations where they are of a confidential nature	
Procurement processes and contract negotiations	
Information relating to identifiable individuals or groups of individuals	
Other – not yet a public document	
Matters exempt under the Freedom of Information Act (quote section number)	

improving health, improving lives

Leeds and York Partnership NHS
NHS Foundation Trust

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	This paper presents the Trust's performance against agreed performance and quality indicators for March 2017 and for Quarter 4 of 2016/17 together with the financial position for March 2017.
What are the key points and key issues the Board needs to focus on	The exception report at the beginning of the IQP gives further information regarding the targets that have not been met for March 2017 and for Q4 of 2016/17 and the actions being carried out to address these.
What is the Board being asked to consider	The Board is asked to note the Performance of the Trust and the actions being taken to address the indicators where there is non-achievement of targets.
What is the impact on the quality of care	Through this reporting the quality of services can be continually monitored and any risks to the quality of care can be identified and mitigated for.
What are the benefits and risks for the Trust	The benefit for the Trust is demonstrating transparency and an understanding of its performance against reporting requirements.
What are the resource implications	None
Next steps following this paper being presented to the Board	The report will be shared with our commissioners and published on the Trust website. NHSI will also review data on NHS Digital that is presented here.
What are the reputational implications and how will these be addressed	It could affect our regulatory standing and public confidence, however, the action plans are designed to provide assurance that the Trust is managing the improvement required.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No
What public / service user / staff / governor involvement has there been	Not applicable
Previous meetings where this report has been considered (including date)	The IQP report (not exemption report) is a standing agenda item on the Performance, Information and Data Quality Group monthly meetings. This data was reviewed at the meeting on 11-4-17.

Leeds and York Partnership NHS
NHS Foundation Trust

RECOMMENDATION (This report is being provided to the Board for) (please tick relevant box/s): ✓							
Assurance	✓	**Discussion**		**Decision**		**Information only**	

Provide details of what you want the Board to do:

The Board is asked to:

- Note the contents of the paper, in particular the actions to recover the performance issues
- Confirm they are assured by the actions being taken to mitigate against the risks.

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Leeds and York Partnership NHS
NHS Foundation Trust

INTEGRATED QUALITY & PERFORMANCE REPORT – April 2017 (March 2017 data)

Exception Reporting
Strategic Goal 1 – People achieve their agreed goals for improving health and improving lives
Strategic Goal 2 – People experience safe care
Strategic Goal 3 – People have a positive experience of their care and support

This report shows the Trust's current compliance with national and local performance requirements which are aligned to the Trust's three Strategic Goals. Each performance requirement has been RAG rated to demonstrate compliance.

Exception Reporting

- **Data Completion Ethnicity – 79.93% (March 2017), 77.96% (Q4)**

  This indicator includes service users which have had an active referral to the Trust with the period but who may not have been seen by Trust staff. The national requirement for the collection of ethnicity is that the service user is asked to give their ethnicity and therefore this can only be collected for service users who have had a direct contact. This is a particular issue within the Gender specialist service, where we have a significant number of service users at any time who are in the referral stage of the process but have not yet been seen

  Whilst the Specialist and LD care group will soon have dedicated support around performance issues - and improvement against this measure is seen as a priority – it is unlikely the gender service will ever achieve a 90% compliance in this area. Work will however continue with each service in the care group to improve recording of ethnicity and to put in place processes to maximise compliance.

  Services within the Leeds care group are currently meeting the 90% requirement for service users who have been allocated to a worker.

- **Proportion of in scope patients assigned to a cluster – 86.72%**
- **Proportion of in scope patients assigned to a cluster and reviewed within recommended timescales – 67.39% (this measure is not a requirement of the Leeds contract from 2017/18)**

  There is currently a remedial action plan in place to address this under-performance which involves:

  • Clinical support provided for management of expired and un-clustered patients.

  • Provision of regular and timely information to clinical staff and managers to allow appropriate actions to be taken to manage compliance issues. Work with the Performance Team to manage data quality issues such as on-hold referrals, duplication and incomplete MH Clustering Tools. There is regular provision of active caseload reports and cluster caseload analysis.

  • Working with the ADs & Clinical Service Managers (CSMs) for Community and CMHT Clinical Leads to ensure effective caseload management is taking place

  • New streamlined process for allocating service users to a cluster who are on ‘medical only’ caseloads in order to improve completeness. This initiative has recently been agreed and is now being implemented. In 6 weeks 375 service users have been clustered using this new process.

  • A Rapid Improvement Event (RIE) in October 2016 agreed ‘effective clustering’ test with Millfield House CMHT. Millfield House non-medical cluster caseload is currently at 100% of those who can be clustered. Cluster guidance was developed as part of this work and circulated to in scope clinicians to help improve practice. The RIE also agreed a work stream to develop a caseload management tool and patient tracking.

• A Clinical Global Impression outcome measure and Cluster tool for medical staff is now live. This tool is more user-friendly than the previous clustering tool.

• Work is ongoing with the CCG to examine how clustering can provide greater utility in the system.

A proposal to address the future monitoring of clustering and moving the trust toward an outcomes based contract has been developed and will be presented to the Quality Committee and the Commissioners later this month, this proposes changes to the monitoring arrangements for clustering. A date for compliance will be agreed with commissioners and a trajectory for achievement will be developed and monitored.

- **7 day follow up – 95.4% (March 2017), 94.85% (Q4)**

The 95% target for March was met by the care groups. Overall the target for quarter was missed due to the reduced level of performance in February. In both January and March the target was met. The reasons for the breaches in February were reported through the IQPR last month.

The care groups have reviewed all breaches and actions have been taken to address this including local reviews and through individual clinical supervision where this was appropriate In addition, the Inpatient Services manager and the Community Services manager are reviewing the process for discharge planning, to ensure the 7 day follow up requirements are included in the plans. All teams are sent information three times per week regarding discharges in order that all staff involved can ensure they are carrying out their responsibilities in relation to meeting the milestones for discharge.

- **Appraisals – 81.3% (LYPFT), 86.88% (Leeds Care Group), 75.98% (SSLD care Group), 81.38% (Corporate services)**

There are currently a number of actions in progress related to improving compliance with appraisal rates, including those detailed on the CQC action plan.

- **Memory service – time from referral to diagnosis (48.78%)**

In March issues related to information and data provided to the memory services have been resolved through the development of new and agreed reports which have been produced by the health informatics team. The reports are being automatically e-mailed to key clinical staff and managers and provide an up to date position with regards to compliance against the target.

The service has recruited an administrator to assist with the recording of diagnosis onto Paris on a short term contract. Once the process of recording diagnosis is up to date this will be continued by existing staff within the service.

A simpler way of recording whether the required tests have been completed in primary care is being introduced onto the memory service referral forms in Paris. This will ensure that the team has the most accurate information on service users who are referred without CT scans

and blood tests being ordered to allow target work with individual practices and more informed discussions with commissioners.

- **Referral and receipt of a diagnosis within LADs service (74.46%)**

  In Q3 the LADs service has seen 47 service users of which 12 received a diagnosis in greater than 26 weeks. The service is aware of the need to give a diagnosis in the least possible time, but also the requirement to collect collaborative information and interview family and others in order to get a picture of the service user's development and give an accurate diagnosis.

  The service currently accepts referrals for 17 year olds but cannot begin assessment until their 18th Birthday, which causes a reported delay. An additional band 5 nurse is due to start work with the service in April, and the service manager is currently working with members of the team to agree an improvement trajectory (target numbers of expected clinical decisions to be undertaken per month).

- **Timely access to a mental health assessment by the ALPS team in the LTHT emergency department – 88.99%**

  The pattern of demand within the LTHT Emergency Departments is highly variable, and the ALPS team have undertaken much work in recent months to understand this demand and to staff the service accordingly taking into account the periodic highs and lows. During January and February the service achieved a 92% compliance with the 3 hour target and this reduced to 88.9% in March. The need for additional capacity to be funded within the ALPS service (in order to consistently achieve this target) is well known and accepted by commissioners.

  Analysis of the breaches in March shows that on 13 occasions the access time was breached due to a high number of service users arriving and requiring assessment within a short period of time (sometimes over multiple sites). In March there were also an unusually high number of joint assessments required (due to service user complexity) which further reduced available capacity during some periods.

- **Waiting times access to memory services, referral to first face to face contact within 8 weeks (77.43%)**

  A new set of reports have been developed for the memory service to tie together the assessment and diagnosis information for service users into one combined set of information. This has been introduced in March following discussion with the team.

  In line with the agreed memory pathway the team have been working hard on transferring service users back to the care of their GP practice for ongoing monitoring of need. This has meant that there have been capacity issues to both achieve transfer to primary care whilst maintaining access to assessment. The service is developing specialist assessment skills within the nursing workforce which will be expected to address these capacity issues. This training has been commissioned with Bradford University and will commence in May 2017.

- **Gender identity service average waiting time to first offered appointment**

  A significant amount of work has been undertaken in collaboration with our NHS England Commissioners over the last year, mapping demand

and undertaking capacity planning. Whilst this has resulted in increased staffing within the service (and additional investment of approximately £0.5m), the rate of demand continues to grow significantly beyond that which was expected / planned. We have successfully implemented a number of initiatives to better support people who are waiting for their first appointment, whilst also taking a number of steps to increase capacity for first appointments.

In the last 6 weeks the waiting list for the Gender identity service has reduced from 813 people to 774 people. The current average wait time is 381 days, which has reduced from the position in March 2016 of 423. Recruitment to the remaining vacant posts is near to completion, and the service has been working to review all open cases in order to increase capacity further. The service is also involved in the national review of Gender service models, and is currently reviewing our previous capacity planning work with commissioners to better reflect the current rate of referrals. We anticipate a further reduction in waiting times from Quarter 1 2017/18 both as a result of the effects of the work already undertaken and of further increase in staffing capacity.

- **Financial position Month 12.**

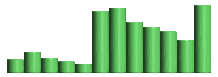
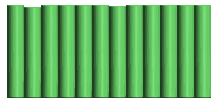
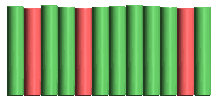
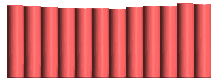
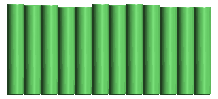
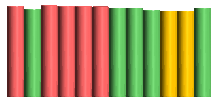
  The Trust has delivering its overall financial plan for the year. The reported surplus excluding sustainability and transformation funding (STF) is £2.88m and £4.3m inclusive of STF. This is £1.25m above plan.

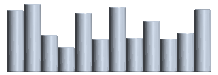
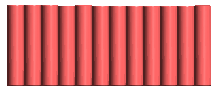
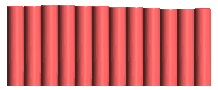
  The Trust has agreed a current year financial risk share contribution for out of area treatments with Leeds CCGs, which underpinned achievement of the plan. The Trust marginally exceeded its overall control total target which has resulted in matched funding from NHSI (£0.5m).

  The financial position is wholly under-pinned by non-recurrent factors, detailed analysis of which has been reported to Finance and Business Committee.

  The capital programme delays (linked to extended tendering process for PFI refurbishment works) impacted significantly on forecast outturn capital expenditure. This capital expenditure for 2016/17 was £3.48m (£1.9m below original plan, a further £0.8m reduction from the previous revised plan) which was consistent with the latest forecast provided to NHSI.

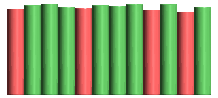
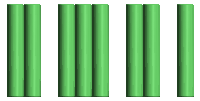
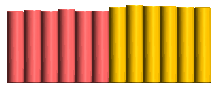
Strategic Goal 1 - People achieve their agreed goal for improving health and improving lives

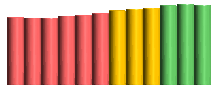
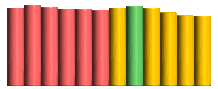
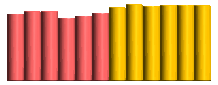
	Mar 2016/2017	2016/2017 Q4	Target	Trend
Delayed Transfers of Care (Previously reported to Monitor, not requested as part of the SOF)	4.4%	4.3%	7.5%	
Admissions to inpatient services had access to crisis resolution / home treatment teams (Single Oversight Framework)	100.00%	100.00%	95.00%	
Care Programme Approach Formal Reviews within 12 months (Previously reported to Monitor, not requested as part of the SOF)	95.39%	95.39%	95.00%	
Data Completeness - Identifiers (Single Oversight Framework)	99.14%	99.28%	97.00%	
Data Completeness - Ethnicity (NHS Standard Contract)	79.93%	77.96%	90.00%	
Data Completeness - Inpatient Ethnicity	94.68%	95.36%	90.00%	
Bed occupancy rates for inpatient services (Leeds Contract)	96.87%	94.76%	94.00% to 98.00%	
Inpatient Length of Stay – Adult Mental Health Inpatient Units Adult Wards (Leeds Contract)	51.09	44.07		
Inpatient Length of Stay – Adult Mental Health Inpatient Units Older People's Wards (Leeds Contract)	63.53	70.74		

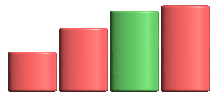
	Mar 2016/2017	2016/2017 Q4	Target	Trend
Inpatient Length of Stay – Adult Mental Health Inpatient Units - <3 days or >90 (Leeds Contract)	17.00	47.00		
Emergency Readmissions within 28 Days - Adult Acute Mental Health Wards (Local)	10.14%	7.25%		
Proportion of in scope patients assigned to a cluster (Leeds Contract)	86.72%	86.72%	95.00%	
Proportion of in scope patients assigned to a cluster and reviewed within recommended timescales (Leeds Contract)	67.39%	67.39%	90.00%	

	2016/2017 Q4	Target	Trend
Readmissions to Adult and Older peoples Mental Health In Patient Units - Median days (Leeds Contract)	283.00		
Readmissions to Adult and Older peoples Mental Health In Patient Units - Cumulative (Leeds Contract)	493		
Percentage of people in settled accommodation (Leeds Contract)	64.50%		
CAMHS use on Admission of HoNOSca and CGAS as effective tools for improving outcomes (NHS England)	100.00%	95.00%	
CAMHS use on Discharge of HoNOSca and CGAS as effective tools for improving outcomes (NHS England)	100.00%	95.00%	

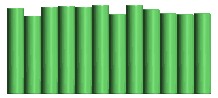
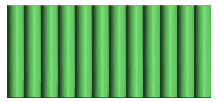
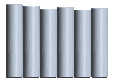
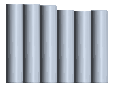
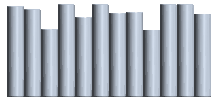
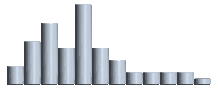
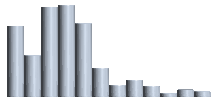
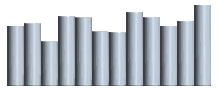
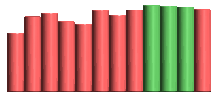
Strategic Goal 2 - People experience safe care

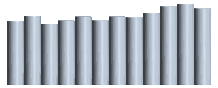
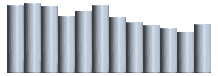
	Mar 2016/2017	2016/2017 Q4	Target	Trend
7 Day Follow Up (Single Oversight Framework)	95.40%	94.85%	95.00%	
Healthcare Associated Infections – C.difficile	0	0	0	
Healthcare Associated Infections – MRSA	0	0	0	
Percentage of people with a Crisis Assessment Summary and formulation plan in place within 24 hours (Leeds Contract)	99.27%	99.70%	95.00%	
Incidents reported within 48 hrs from incident identified as serious (Contract)		100.00%	100.00%	
Admissions to adult facilities of patients who are under 16 years old (Single Oversight Framework)	0	0		
Never Events (National)	0	0	0	
NHS Safety Thermometer Harm Free Care	97.32%	98.30%	95.00%	
Appraisals LYPFT	81.30%	81.30%	85.00%	

	Mar 2016/2017	2016/2017 Q4	Target	Trend
Appraisals Leeds Care Group	86.88%	86.88%	85.00%	
Appraisals Specialist and LD Care Group	75.98%	75.98%	85.00%	
Appraisals Corporate Services	81.38%	81.38%	85.00%	

	2016/2017 Q4	Target	Trend
Dual Diagnosis Training (Leeds Contract)	98.15%	80.00%	
Increasing awareness of Autism in registered mental health nurses (Leeds Contract)	88.64%	80.00%	
Memory Services – time from Referral to Diagnosis (Leeds Contract)	48.78%	80.00%	
Referral and Receipt of a Diagnosis within LADs Service (Leeds Contract)	74.47%	75.00%	
Compulsory Training (Local)	89.15%	85.00%	

Strategic Goal 3 - People have a positive experience of their care and support

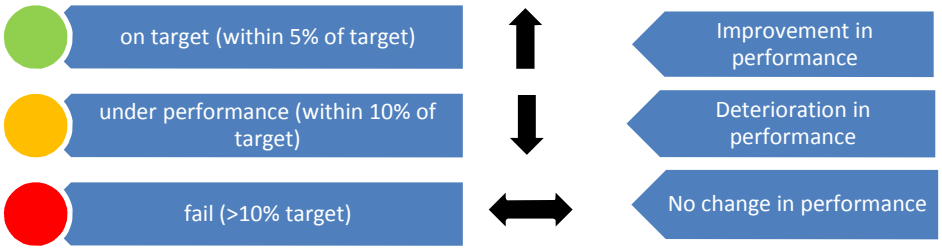
	Mar 2016/2017	2016/2017 Q4	Target	Trend
Data Completeness Indicator for Mental Health Outcomes for CPA Patients (Previously reported to Monitor, not requested as part of the SOF)	69.70%	69.45%	50.00%	
Access to Healthcare for People with a Learning Disability (Previously reported to Monitor, not requested as part of the SOF)				
In Employment (Single Oversight Framework)	11.22%	11.34%		
In Settled Accommodation (Single Oversight Framework)	62.90%	63.03%		
Friends and Family Test Likely or Extremely Likely to Recommend	90.00%	97.67%		
Out of Area placements (Leeds Contract)	1.00	5.00		
Out of Area placements by bed days (Leeds Contract)	13.00	39.00		
Timely access to MH assessment under S136 (Leeds Contract)	52.73%	43.12%		
Timely access to a mental health assessment by the ALPs team in the LTHT Emergency Department (Leeds Contract)	88.99%	92.27%	90.00%	

	Mar 2016/2017	2016/2017 Q4	Target	Trend
Gender Identity Service Waiting List (NHS England)	833	833		
Gender Identity Service Average Waiting Time To First Offered Appointment (NHS England)	422.92	379.70		

	2016/2017 Q4	Target	Trend
Waiting times for Community Mental Health Teams for face to face contact within 14 days (Leeds Contract)	80.72%	80.00%	
Waiting Times Access to Memory Services; Referral to first face to face contact within 8 weeks (Leeds Contract)	77.43%	95.00%	
Timely Communication with GPs Notified in 10 days (Leeds Contract)	86.25%	80.00%	

Appendix

	2016/2017 Q4	Target	Trend
Staff Turnover	12.32%	15.00%	



Leeds and York Partnership NHS
NHS Foundation Trust

Financial Performance Summary

KEY ISSUES	RAG	Trend	Financial Performance Against Monitor Plan	Appendix
Financial Reporting Indices			The Finance and Use of Resources score is 1 (highest rating).	**1**
Statement of Comprehensive Income (I&E)			The reported position at month 12 is a £2.88m surplus, £4.3m including £1.41m core and incentive Sustainability & Transformation Funding (STF). The position predominantly results from a number of non-recurrent factors including additional STF funding. Overall this is a £1.2m favourable variance compared to the plan. The final position will increase as the Trust is eligible for further "bonus" STF funding, not yet notified. The key variances against plan are summarised below.	**2**
Income			Total Operating income is £3m above plan at month 12. The main variances comprise:- **Clinical Income:** Clinical Income is £1.16m above revised plan, predominantly due to the additional STF (£0.5m), and additional income from CCGs for new developments and an extra contribution to the OATs pressures. **Non-Clinical income:** Non-Clinical income is £1.86m above plan. This is largely a presentational variance attributable to invoice arrangements for out of area recharges to Leeds CCGs and reclassification of drugs recharge income. North of England CPC (hosted service) income also exceeded plan. Research and Development income exceeded plan, this increase was matched with additional spend. **Non-Operating Income** Non-operating income is £75k below plan due to reduced interest rates.	**2**
Pay			Pay expenditure is £0.08m positive variance against plan, comprising a £0.35m under-spend on permanent employee pay offset by a £0.27m over-spend on locum and agency staff expense. At the end of March 2017, the number of permanent vacancies is in excess of 200 whole time equivalents (excluding development slippage), which mitigates the overall pressure on unidentified cost improvement plans and agency cost pressures.	**2**
Non Pay			Non pay spend is a negative variance of £1.78m at month 12. This is largely driven by: • Opposite entries linked to technical accounting non-clinical income variance (as above) and increased provisions. Offset: by: • Lower than planned spending on out of area placements and reduced depreciation.	**2**

Efficiency: Cost Improvement			The Cost Improvement Plan (CIP) for month 12 is 17% below plan, with £2.08m achieved compared to a £2.51m plan. The main under achievement against plan relates to previously unidentified CIPs, of which £0.2m remains unidentified on a recurrent basis.	**3**
Statement of Financial Position (Balance Sheet)			The main statement of financial position variances (excluding cash and capital) are: **NHS trade receivables** - £0.59m variance. This is due to a reduction in the number of outstanding invoices at year end (£0.25m) and an increase in provisions (£0.36m). **Non-NHS trade receivables –** £0.28m variance. This is due to an increase in outstanding invoices with the Joint Commissioning Service. **Other receivables –** £0.34m variance. This is due to a delay in receiving the February VAT reclaim (received on 4 April 2017). **Provisions** - £2.39m variance. This is mainly due to increased redundancy (£1.7m) and dilapidation provisions (£0.16m) and the timing of unwinding current provisions in relation to the working time directive and dilapidations (£0.52m). **Trade payables -** £0.57m variance. This is due to anticipated repayments to NHS England not realised (£0.4m). **Other payables -** £1.57m variance. This is due to the March statutory payovers to NHS pensions being earlier than planned (£1.4m). **Capital Payables -** £0.84m variance**.** This is due to accruals in relation to the PFI anti-ligature work and increased IT capital expenditure in month (£0.47m).	**4**
Cash			The cash position of £47.7m is £3.7m above plan at the end of month 12. This is mainly due to the cash impact of the increased surplus including STP funding (£1.25m) and capital cash slippage (£2.7m). Liquidity increased to 95 days operating expenses at the end of March 2017.	**5**
Capital			Capital expenditure is £3.48m, £0.87m (20%) below revised plan at the end of month 12. The variance is due to slippage against the Estates replacement schemes for PFI units and single site pharmacy due to extended tender exercises.	**6**

Leeds and York Partnership NHS Foundation Trust **Appendix 1**

Use Of Resource Metric
YTD as at 31 March 2017

Capital Service Capacity

Revenue available for Debt Service		
Surplus	4,296	
Impairments	-352	
Restructuring Costs	0	
PDC Dividend	423	
Depreciation	4,081	
Interest expense	3,930	
Other Finance Costs	23	
Gain/(Loss) on disposal	0	
Capital grants/donations	0	
	A	12,401
Capital Servicing Costs		
PDC Dividend	423	
Bank interest	0	
Loan interest	0	
PFI/Finance Lease interest	2,056	
Contingent Rent	1,874	
Other Finance Costs	23	
PDC repayment	0	
Loan repayment	0	
PFI/Fin lease capital	1,479	
	B	5,855
Capital Service Capacity	**A/B**	2.12
Category		2

Liquidity

Cash for Liquidity Purposes		
Working capital facility	0	
Total current assets	54,521	
Total current liabilities	-17,556	
Inventories	-46	
Derivatives	0	
Financial AHfS	0	
PFI prepayments	0	
Non-current AHfS	0	
Current AHfS by charity	0	
Current LHfS by charity	0	
	A	36,919
Operating Expenses		
within EBITDA	140,167	
	B	140,167
Liquidity	**A*360/B**	95
Category		1

I&E Margin

I&E Surplus	**A**	3,944
Total Operating Income	**B**	152,438
I&E Margin	**A/B**	2.6%
Category		1

Distance from Financial Plan

Actual I&E Margin	**A**	2.6%
Plan I&E Surplus	**B**	3,051
Plan Operating Income	**C**	149,417
Plan I&E Margin	**B/C**	2.0%
Variance in I&E Margin	**A - B/C**	0.5%
Category		1

Agency Spend

Actual spend	**A**	4,791
Agency Ceiling	**B**	6,249
Variance	**A-B**	-1,458
Distance	**(A - B)/B**	-23.3%
Category		1

Overall

	Weighting	Score	Weighted Score
Capital Service Capacity	20	2	0.40
Liquidity	20	1	0.20
I&E Margin	20	1	0.20
Distance from Financial Plan	20	1	0.20
Agency Spend	20	1	0.20
Calculated Rating		**1**	**1.20**
Any metric 4		N	
Rating		**1**	

Leeds and York Partnership NHS Foundation Trust **Appendix 2**

Statement of Comprehensive Income at March 2017

	2016/17		
	Revised Plan YTD £'000	Actual YTD £'000	Variance Monitor YTD £'000
Operating			
NHS Mental Health activity Income			
Other - Cost and Volume Contract Income	3,309	3,396	87
Block Contract Total	116,972	118,143	1,171
Clinical Partnerships providing mandatory services (including S31 agreements)	7,752	7,897	146
Other clinical income from mandatory services	875	632	-243
NHS Mental Health activity Income, Total	**128,908**	**130,068**	**1,160**
Other Operating income			
Research and Development income	843	1,061	218
Education and Training income	3,908	4,078	170
Grants received in cash & to fund Operating Expenses	47	6	-40
Parking revenue	0	0	0
Catering revenue	53	41	-12
Revenue from non-patient services to other bodies	1,297	1,297	0
Misc. Other Operating Income	14,363	15,887	1,524
Other Operating income, Total	**20,510**	**22,370**	**1,860**
Operating Income, Total	**149,417**	**152,438**	**3,020**
Operating Expenses			
Raw Materials and Consumables Used			
Drugs	-2,178	-2,294	-116
Clinical supplies	-1,038	-954	84
Non-clinical supplies	-1,273	-1,574	-301
Raw Materials and Consumables Used, Total	**-4,489**	**-4,822**	**-333**
Purchase of healthcare services from other NHS bodies	-10	188	198
Purchase of healthcare services from non-NHS bodies	-5,476	-4,648	828
Purchase of healthcare services / secondary commissioning, total	**-5,487**	**-4,461**	**1,026**
Employee expenses, Substantive, bank and overtime staff	-102,119	-101,768	350
Employee expenses, Locum and agency staff	-4,518	-4,791	-272
Employee Benefits Expenses, Total	**-106,637**	**-106,559**	**78**
Research and Development expense	-1,033	-1,261	-228
Education and training expense	-714	-944	-230
Consultancy Expense	-212	-186	26
Premises	-5,629	-5,216	413
Clinical Negligence	-217	-217	0
Misc. Other Operating expense	-6,751	-9,762	-3,011
PFI operating expenses	-6,715	-6,740	-25
Depreciation and Amortisation			
Depreciation and Amortisation - owned assets	-2,657	-2,456	202
Depreciation and Amortisation - PFI assets	-1,650	-1,625	25
Depreciation and Amortisation, Total	**-4,308**	**-4,081**	**227**
Impairment (Losses) / Reversals net	0	352	352
Operating Expenses, Total	**-142,192**	**-143,895**	**-1,703**
Profit (Loss) from Operations	**7,225**	**8,542**	**1,317**
Non Operating			
Non-Operating income			
Interest Income	205	130	-75
Profit/Loss on Asset Disposal	0	0	0
Non-Operating income, Total	**205**	**130**	**-75**
Non-Operating expenses			
Finance Costs [for non-financial activities]			
Interest Expense			
Interest Expense on PFI leases & liabilities	-2,056	-2,056	0
Interest Expense, Total	**-2,056**	**-2,056**	**0**
PDC dividend expense	-330	-423	-93
Other Finance Expenses	-23	-23	0
Finance Costs [for non-financial activities], Total	**-2,409**	**-2,502**	**-93**
Non-Operating PFI Costs (e.g. Contingent Rent)	-1,970	-1,874	96
Non-Operating expenses, Total	**-4,379**	**-4,376**	**2**
Surplus (Deficit) before Tax	**3,051**	**4,296**	**1,245**
Income Tax (expense)/ income	0	0	0
Surplus (Deficit) After Tax	**3,051**	**4,296**	**1,245**

Leeds and York Partnership NHS Foundation Trust **Appendix 3**

Month 12

CIP SUMMARY	Plan 2016/17			
	Plan £'000	**Actual £'000**	**Variance £'000**	**Variance %**
Leeds Mental Health Care Group	681	561	(120)	-18%
Specialist & Learning Disability Care Group	653	474	(179)	-27%
Workforce and Development	62	54	(8)	-13%
Fit-for-purpose, cost effective buildings	311	311	0	0%
Delivering cost effective corporate services	386	438	52	13%
Unidentified CIPs	411	239	(172)	-42%
TOTAL	**2,505**	**2,077**	**(427)**	**-17%**

Pay	1,563	1,100	(463)	-30%
Non Pay	942	977	36	4%
Total CIP	**2,505**	**2,077**	**(427)**	**-17%**

Leeds and York Partnership NHS Foundation Trust **Appendix 4**

Statement of Financial Position at March 2017

	Revised Plan March £'000	2016/17 Actual March £'000	Variance March £'000
Assets			
Assets, Non-Current			
Intangible Assets, Net	365	629	264
Property, Plant and Equipment, Net	32,908	32,192	-716
PFI: Property, Plant and Equipment, Net	17,334	18,066	733
Prepayments, Non-Current	3,930	3,937	7
Assets, Non-Current, Total	**54,537**	**54,825**	**288**
Assets, Current			
Inventories	36	46	10
Trade and Other Receivables, Net, Current			
NHS Trade Receivables, Current, Gross	1,250	656	-594
NHS Capital Receivables, Current, Gross	0	0	0
Non NHS Trade Receivables, Current, Gross	2,300	2,585	285
Other Receivables, Current, Gross	650	991	341
Impairment of Receivables, Current (for bad & doubtful debts)	-402	-410	-8
Trade and Other Receivables, Net, Current, Total	**3,798**	**3,822**	**24**
Accrued Income	1,650	1,606	-44
Prepayments, Current	1,200	1,310	110
Cash	44,006	47,737	3,731
Non-Current Assets held for sale	0	0	0
Assets, Current, Total	**50,690**	**54,521**	**3,831**
Total Assets	**105,227**	**109,346**	**4,119**
Liabilities			
Liabilities, Current			
Deferred Income, Current	-1,633	-969	665
Provisions, Current	-343	-2,732	-2,389
Trade and Other Payables, Current			
Trade Payables, Current	-3,766	-3,195	571
Other Payables, Current	-3,600	-2,030	1,570
Capital Payables, Current	-400	-1,242	-842
Trade and Other Payables, Current, Total	**-7,766**	**-6,467**	**1,298**
Other Financial Liabilities, Current			
Accruals, Current	-5,200	-5,763	-563
PFI leases, Current	-1,602	-1,602	0
PDC dividend payable, Current	0	-23	-23
Other Financial Liabilities, Current, Total	**-6,802**	**-7,388**	**-586**
Liabilities, Current, Total	**-16,544**	**-17,556**	**-1,012**
NET CURRENT ASSETS (LIABILITIES)	**34,146**	**36,965**	**2,819**
Liabilities, Non-Current			
Provisions, Non-Current	-1,753	-2,041	-288
Other Financial Liabilities, Non-Current			
PFI leases, Non-Current	-23,152	-23,152	0
Other Financial Liabilities, Non-Current, Total	**-23,152**	**-23,152**	**0**
Liabilities, Non-Current, Total	**-24,905**	**-25,193**	**-288**
TOTAL ASSETS EMPLOYED	**63,778**	**66,597**	**2,819**
Taxpayers' and Others' Equity			
Public dividend capital	19,569	19,569	0
Retained Earnings (Accumulated Losses)	35,598	37,232	1,634
Revaluation Reserve	9,262	10,447	1,184
Miscellaneous Other Reserves	-651	-651	0
TAXPAYERS EQUITY, TOTAL	**63,778**	**66,597**	**2,819**
TOTAL ASSETS EMPLOYED	**63,778**	**66,597**	**2,819**

Leeds and York Partnership NHS Foundation Trust

Cashflow Analysis as at March 2017

	Revised Plan YTD £'000	Actual YTD £'000	Variance YTD £'000
Surplus/(deficit) after tax	**3,051**	**4,296**	**1,245**
non-cash flows in operating surplus/(deficit)			
Finance income/charges	3,821	3,800	-20
Other operating non-cash movements	26	34	8
Depreciation and amortisation, total	4,308	4,081	-227
Impairment losses/(reversals)	0	-352	-352
Gain/(loss) on disposal of property plant and equipment	0	0	0
Gain/(loss) on disposal of intangible assets	0	0	0
PDC dividend expense	330	423	93
Other increases/(decreases) to reconcile to profit/(loss) from operations	0	0	0
Non-cash flows in operating surplus/(deficit), Total	**8,484**	**7,985**	**-499**
Operating Cash flows before movements in working capital	**11,536**	**12,282**	**746**
Increase/(Decrease) in working capital			
(Increase)/decrease in inventories	0	-10	-10
(Increase)/decrease in NHS Trade Receivables	283	877	594
(Increase)/decrease in Non NHS Trade Receivables	659	374	-285
(Increase)/decrease in other receivables	831	490	-341
(Increase)/decrease in accrued income	-1,141	-1,097	44
(Increase)/decrease in prepayments	-181	-291	-110
(Increase)/decrease in other assets	0	0	0
Increase/(decrease) in Deferred Income	373	-292	-665
Increase/(decrease) in provisions	-761	1,916	2,678
Increase/(decrease) in post-employment benefit obligations	0	0	0
Increase/(decrease) in Trade Payables	-1,894	-2,465	-571
Increase/(decrease) in Other Payables	246	-1,323	-1,570
Increase/(decrease) in accruals	-1,033	-470	563
Increase/(Decrease) in workling capital, Total	**-2,619**	**-2,291**	**328**
Net cash inflow/(outflow) from operating activities	**8,916**	**9,990**	**1,074**
Net cash inflow/(outflow) from investing activities			
Property, plant and equipment expenditure	-5,270	-2,556	2,714
Proceeds on disposal of property, plant and equipment	376	376	0
Net cash inflow/(outflow) from investing activities, Total	**-4,894**	**-2,181**	**2,714**
Net cash inflow/(outflow) before financing	**4,022**	**7,810**	**3,788**
Net cash inflow/(outflow) from financing activities			
Public Dividend Capital received	0	0	0
Public Dividend Capital repaid	0	0	0
PDC Dividends paid	-370	-440	-70
Interest element of finance lease rental payments - *On-balance sheet PFI*	-4,026	-3,930	95
Capital element of finance lease rental payments - *On-balance sheet PFI*	-1,479	-1,479	0
Interest received on cash and cash equivalents	205	130	-75
Movement in Other grants/Capital received	0	0	0
(Increase)/decrease in non-current receivables	-314	-321	-7
Increase/(decrease) in non-current payables	0	0	0
Other cash flows from financing activities	0	0	0
Net cash inflow/(outflow) from financing activities, Total	**-5,984**	**-6,040**	**-56**
Net increase/(decrease) in cash and cash equivalents	**-1,962**	**1,770**	**3,731**
Opening cash and cash equivalents	45,968	45,968	0
Effect of exchange rates	0	0	0
Closing cash and cash equivalents	**44,006**	**47,737**	**3,731**

CAPITAL PROGRAMME - at 31 MARCH 2017	Revised Plan £'000	Actual Spend £'000	YTD Variance £'000
Estates Operational			
Health & Safety /Fire	75	22	-53
Planned Annual Commitments	75		-75
Estate refurbishment	2,161	1,613	-548
Sub-Total	**2,311**	**1,635**	**-676**
IT/Telecomms Operational			
PC Replacement Programme	150	236	86
Softcat Asset Management Software	57	57	0
IT Network Infrastructure	150	135	-15
VOIP Roll Out	19	19	0
IT-Voice Telecoms Network E Directory	39		-39
Additional Server/Storage	3	3	0
Sub-Total	**418**	**450**	**31**
Other Equipment			
	0		0
Sub-Total	**0**	**0**	**0**
Estates Strategic Developments			
Pharmacy - single site	75		-75
St Marys Hospital	10	10	0
Perinatal In-patient Expansion	131	152	21
The Mount Annexe	21		-21
North Yorks Catering Equipment	43	12	-32
Seclusion Room - Newsam Centre	9	9	0
Dementia Care At The Mount	201	199	-2
ENE Hub	0	21	21
LD In-Patient Reprovision	2	2	0
Sub-Total	**492**	**405**	**-87**
IT Strategic Developments			
E-Prescribing	250	188	-62
Big Hand Voice Recognition	25		-25
Replacement PAS	110	109	-1
Remote Access	338	250	-88
Virtual Desktop Build	0	12	12
Public WiFi Deployment	15		-15
MDM - Additional HW/SW	38		-38
Standard Smartphones for all staff - phase 1	240	276	36
Webfiltering	48	48	1
Remote support system	11		-11
Tablets Wards - Leeds	2	2	0
Digital Pens	19	19	0
EPR System Developments	96	96	0
Sub-Total	**1,192**	**1,000**	**-191**
Contingency Schemes			
Contingency	-54		54
2015/16 Completed Schemes	-13	-11	2
Sub-Total	**-67**	**-11**	**56**
TOTAL CAPITAL PROGRAMME - JANUARY 2017 PLAN	**4,346**	**3,479**	**-867**

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

8

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Safe staffing report
DATE OF MEETING:	27 April 2017
LEAD DIRECTOR: (name and title)	Anthony Deery, Director of Nursing, Professions and Quality
PAPER AUTHOR: (name and title)	Linda Rose, Assistant Director of Nursing and Acting Head of Clinical Governance

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)							
Quality	✓	Strategic		Governance	✓	Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	We work with service users and carers to support their achievement of outcomes and wellbeing	
G2	We are an employer of choice with a compassionate and highly trained workforce committed and supported to provide excellent innovative care and support	✓
G3	We work with others to improve health and improve lives through effective, innovative and sustainable partnerships	
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	✓
SO2	We provide a dynamic, rewarding and supportive place to work	
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	
SO4	We are transparent and accountable to the people and partners we work with	✓
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	✓

STATUS OF PAPER (please tick relevant box/s)	✓
To be taken in the public session (Part A)	✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:	
Legal advice relating to legal proceedings (actual or possible)	
Negotiations in respect of employee relations where they are of a confidential nature	
Procurement processes and contract negotiations	
Information relating to identifiable individuals or groups of individuals	
Other – not yet a public document	
Matters exempt under the Freedom of Information Act (quote section number)	

Leeds and York Partnership NHS
NHS Foundation Trust

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	There is a national requirement for all NHS Trusts to publish staffing data on NHS Choices website on a monthly basis and to report to the Board exceptions to planned staffing levels where fill rates are either exceed 120% or falls below 80%. The information relates specifically to Registered Nurses (RNs) and Health Support Workers (HSWs). The data attached at Appendix A, submitted to NHS Choices relates to February 2017.
What are the key points and key issues the Board needs to focus on	Recruitment remains a significant local and national issue. 30% of the 26 Wards covered by this report experienced significant pressures and actions were taken to mitigate this. Acuity in terms of violence and aggression are of concern and work is in progress to improve the safety and experience of staff and service users. To note the action taken following the concerns raised by the Board in regard to the Psychiatric intensive Care Unit (PICU) at the March Board meeting.
What is the Board being asked to consider	Those actions taken to maintain safety the safety of staff and service users have been sufficient across care services.
What is the impact on the quality of care	Slightly more Agency RNs were used to fill shifts in February than the previous month. Low numbers of available regular staff and a high dependency on bank/agency staff is costly and can have a significant impact on patients in terms of the relational element of their care.
What are the benefits and risks for the Trust	This report enables the Trust to clearly identify where our staffing challenges are and put plans in place to make improvements.
What are the resource implications	Resource is required to collate, manage and interrogate appropriate data.
Next steps following this paper being presented to the Board	This report will continue to be shared with care group risk forums and governance councils to ensure local understanding, ownership of staffing issues and any follow up required.

What are the reputational implications and how will these be addressed	There is a risk that where staffing does not meet planned levels the Trust is unable to provide the high quality care it aspires to and this may result in poor patient and carer experience. Through the agreed escalation procedure, ongoing staff recruitment and retention strategies and quality improvement plans, the Trust continues to proactively mitigate these pressures.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No
What public / service user / staff / governor involvement has there been	This paper is made routinely accessible to the pubic via the NHS Choices website.
Previous meetings where this report has been considered (including date)	Executive team on the 19 April 2017

RECOMMENDATION **(This report is being provided to the Board for)** (please tick relevant box/s): ✓							
Assurance	✓	**Discussion**	✓	**Decision**		**Information only**	
Provide details of what you want the Board to do:							
The Board is asked to receive the report and discuss any issues raised by the content.							

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Report to the Board of Directors
April 2017
Safer Staffing

1. Purpose

The purpose of this paper is to provide a monthly exception report to the Board of safer staffing.

The information in this paper relates specifically to Registered Nurses (RNs) and Health Support Workers (HSWs) on our inpatient wards and is in line with the national requirement to report this information

The data attached at Appendix A, submitted to NHS Choices, relates to the 1st February 2017 to the 28th February 2017.

2. Safer staffing exception report

2.1 Leeds Mental Health Care Group

The Becklin Wards theme is of high use of Health support workers across the unit and low Registered Nurse (RN) cover during the night on Wards 3 and 4. Skill mix was adjusted to cover RN vacancies.

Clinical need was reported as high during this period, e.g some service users required 'within eyesight observation' and in some cases two members of staff due to the level of risk presented.

The service reported an increase in the level of violence and aggression as a particular challenge and the care group have since met to examine this and agree remedial actions.

At the Newsam Centre, RN availability on PICU has been affected by long term sickness, maternity leave and one whole time equivalent (wte) RN vacancy. The post has been recruited to, however, the applicant is not available to start until October 2017. The level of referrals to PICU has increased in response to the several serious incidents across the adult acute inpatient services. An additional challenge for PICU staff is managing service users who require specialised/ PD/ Forensic/ Brain injury care, but are currently unable to access options better suited to their individual need as the availability of suitable service provision elsewhere is not currently available.

In addition to this a meeting was held on the 12 April attended by the Associate Director, Leeds Care Group, Service Manager, Matron, Medical Director and Director of Nursing to discuss the current pressures on PICU. The following actions were agreed.

1. Analysis of incidents/factors the acute wards cannot manage – Dr Vikram Luthra, Consultant Psychiatrist, Becklin Centre
2. Analysis of reasons for admission to PICU – Maureen Cushley, Service Manager.

3. PICU Budget – Anthony Deery/Dawn Hanwell
4. Chase up NHS England commissioners regarding forensic placements – AD/Lynn Parkinson
5. Need to act up B6 to B7 role – Gail Galvin, Matron.
6. Communication of support to the staff – AD/Alison Kenyon, Associate Director

The demands and acuity levels are having an impact on staff morale and the senior managers in care group are providing additional support.

The care group have also considered a number of improvement options including, a recent joint day of day of action with West Yorkshire Police to help reduce the use of illicit drugs by people who use the Becklin Centre, embedding the memorandum of understanding with the Police; supporting staff and improving out of hour's escalation to manage incidents.

2.2 Specialist and Learning Disabilities Care Group

Riverfields at Clifton House and Ward 5 Newsam Centre reported lower availability of RNs during February due to vacancies.

Clifton House has not been able to recruit sufficient numbers of RNs to reopen Westerdale Ward in April as originally planned and longer term options are being considered.

An independent review of both Leeds and York-based forensic services was commissioned to help understand the challenges and to provide assurance that action is being taken in the right areas to enable a more sustainable workforce.

The review team presented their findings to staff on Tuesday 28 March and made 24 recommendations which were accepted by the leadership team. A workshop event is planned for 26 April 2017, at which the recommendations will be discussed and actions agreed.

3. Update

On the 15 March the National Quality Board's (NQB) published a draft improvement resource: *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time - safe, sustainable and productive staffing*, (mental health). They developed this resource to help commissioners and providers of NHS-commissioned services create, review and sustain, safe and effective specialist mental health services and have asked for comments on it. A small group of senior nurses and HR colleagues met in April to consider the draft and will submit comments to the NQB. A detailed paper will be presented to the Board following the final publication by the NQB.

In addition to this, we are developing an exception report for community mental health teams and will present this to the Board once this has been completed.

4. Conclusion

Recruitment and retention remain a challenge; whilst 30% of the 26 Wards covered by this report experienced significant pressures, appropriate action was taken to mitigate this; however, the levels of acuity, particularly in regard to violence and aggression is one of the key challenges. The care groups keeping this under close review, supporting the staff and work with colleagues in the Trust's Risk Management Team, Workforce Development and West Yorkshire Police to gain a clearer understanding of the factors and possible actions to take.

4. Recommendations

The Board is asked to:

- Receive the report and note the contents.
- Discuss any issues raised by the content

HospitalName	HospitalSiteCode	WardName	Type	PlannedRegHoursDay	ActualRegHoursDay	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
ASKET HOUSE	RGDAP	Asket Inpatient Unit	HCW	1,247	1,219.5	97.79%	924	924	100.00%
			Nursing	952	1,027.16666666	107.90%	616	616	100.00%
BECKLIN CENTRE	RGDBL	Becklin Ward 1	HCW	555	782.25	140.95%	616	660	107.14%
			Nursing	1,104.5	980	88.73%	616	616	100.00%
		Becklin Ward 2 CR	HCW	644	719.5	111.72%	621	681	109.66%
			Nursing	644	559.5	86.88%	632.5	632.5	100.00%
		Becklin Ward 3	HCW	728.5	1,127.75	154.80%	616	649	105.36%
			Nursing	1,105.5	856	77.43%	594	618.5	104.12%
		Becklin Ward 4	HCW	687	1,206.5	175.62%	605	848	140.17%
			Nursing	1,174	926.25	78.90%	616	595	96.59%
		Becklin Ward 5	HCW	682.5	1,226	179.63%	605	889.5	147.02%
			Nursing	1,069.5	983.66666667	91.97%	605	607	100.33%
Clifton House	RGDT5	York - Bluebell	HCW	636	970	152.52%	600.04	600.13333324	100.02%
			Nursing	724.5	703.25	97.07%	278.72	314.06666676	112.68%
		York - Riverfields	HCW	555.5	1,186	213.50%	600.04	632.28333325	105.37%
			Nursing	729.5	574.5	78.75%	300.16	289.35000009	96.40%
		York - Rose	HCW	621	906	145.89%	600.04	800.2833333	133.37%
			Nursing	699	809	115.74%	300.16	300.06666676	99.97%
		York - Westerdale	HCW	840	0	0.00%	600.04	0	0.00%
			Nursing	465	0	0.00%	300.16	0	0.00%
LEEDS GENERAL INFIRMARY	RGD03	YCPM LGI	HCW	413	383	92.74%	273	294	107.69%
			Nursing	829.5	831.5	100.24%	577.5	588	101.82%
NEWSAM CENTRE	RGDAB	Newsam Ward 1 PICU	HCW	1,186.5	2,643.5	222.80%	583	2,310	396.23%
			Nursing	1,155	992.5	85.93%	605	459	75.87%
		Newsam Ward 2 Forensic	HCW	810	1,045.5	129.07%	602	612.33333333	101.72%
			Nursing	778.5	769.5	98.84%	290.25	301	103.70%
		Newsam Ward 2 Womens Services	HCW	783	1,082	138.19%	602	588	97.67%
			Nursing	798	645	80.83%	301	345.5	114.78%
		Newsam Ward 3	HCW	674.5	1,017.2	150.81%	602	690	114.62%
			Nursing	745.5	661	88.67%	290.25	333.25	114.81%
		Newsam Ward 4	HCW	639	965	151.02%	605	726	120.00%
			Nursing	1,074	1,032.5	96.14%	583	616	105.66%
		Newsam Ward 5	HCW	1,075	1,592.91666666	148.18%	616	997.25	161.89%
			Nursing	742.5	682.5	91.92%	605	468	77.36%
		Newsam Ward 6 EDU	HCW	739.5	829.75	112.20%	588	556.5	94.64%
			Nursing	776	852.75	109.89%	294	325.5	110.71%
PARKSIDE LODGE	RGDPL	Parkside Lodge	HCW	1,263	2,937.5	232.58%	840	2,118	252.14%
			Nursing	1,040	928.5	89.28%	556.5	567	101.89%
ST MARY'S HOSPITAL	RGD17	2 Woodland Square	HCW	596	383.5	64.35%	294	283.5	96.43%
			Nursing	606	552.5	91.17%	294	304.5	103.57%
		3 Woodland Square	HCW	774	877.5	113.37%	294	388.5	132.14%
			Nursing	573	393.5	68.67%	294	294	100.00%
THE MOUNT	RGD05	Mother and Baby The Mount	HCW	774	1,420.75	183.56%	572	814	142.31%
			Nursing	675	698.25	103.44%	528	553	104.73%
		The Mount Ward 1 New (Male)	HCW	1,559.5	1,813.5	116.29%	903	1,279.25	141.67%
			Nursing	761.5	779.15	102.32%	602	322.5	53.57%
		The Mount Ward 2 New (Female)	HCW	1,140	1,540.66666667	135.15%	602	1,107.25	183.93%

THE MOUNT	RGD05	The Mount Ward 2 New (Female)	Nursing	790.5	773.41666667	97.84%	591.25	397.75	67.27%
		The Mount Ward 3a	HCW	1,091.5	1,169.03333333	107.10%	616	638.16666667	103.60%
			Nursing	745.75	690.83333333	92.64%	308	308.08333333	100.03%
		The Mount Ward 4a	HCW	1,098.5	1,211.16666666	110.26%	616	638	103.57%
			Nursing	756	819.58333333	108.41%	297	308.5	103.87%
York - Mill Lodge	RGDVE	York - Mill Lodge	HCW	1,173	1,138.08333332	97.02%	616	1,025	166.40%
			Nursing	1,236	1,118.73333334	90.51%	616	632	102.60%

Missing Wards

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

9

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	CQC Action Plan
DATE OF MEETING:	27 April 2017
LEAD DIRECTOR: (name and title)	Anthony Deery, Director of Nursing, Professions and Quality
PAPER AUTHOR: (name and title)	Anthony Deery, Director of Nursing, Professions and Quality

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)							
Quality	✓	Strategic		Governance	✓	Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	We work with service users and carers to support their achievement of outcomes and wellbeing	✓
G2	We are an employer of choice with a compassionate and highly trained workforce committed and supported to provide excellent innovative care and support	✓
G3	We work with others to improve health and improve lives through effective, innovative and sustainable partnerships	✓
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	✓
SO2	We provide a dynamic, rewarding and supportive place to work	✓
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	✓
SO4	We are transparent and accountable to the people and partners we work with	✓
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	✓

STATUS OF PAPER (please tick relevant box/s)	✓
To be taken in the public session (Part A)	✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:	
Legal advice relating to legal proceedings (actual or possible)	
Negotiations in respect of employee relations where they are of a confidential nature	
Procurement processes and contract negotiations	
Information relating to identifiable individuals or groups of individuals	
Other – not yet a public document	
Matters exempt under the Freedom of Information Act (quote section number)	

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	This purpose of this paper is to provide assurance to the Board about the CQC Action Plan. The paper sets out the actions taken by the Trust following the CQC Comprehensive Inspection 2016. It includes a progress update in respect of the CQC Action Plan and provides details of the Trust's governance arrangements to support the Action Plan and identified risks.
What are the key points and key issues the Board needs to focus on	The key areas requiring improvement and the progress made against each of these. • Fit and Proper Person Test – Not all the documentation requested by CQC at the time of the inspection was readily available. They did however acknowledge that checks had been completed and there were not concerns about the fitness of the Directors. • Compulsory Training/Appraisals/Supervision – Trust not meeting its own threshold and not achieving the expected 75% CQC threshold. • Incident Reporting – Specialist Supported Living Service and National Reporting and learning System • Eliminating Mixed Sex Accommodation - Yorkshire Centre for Psychological Medicine based at the Brotherton Wing at LGI. • Mental Health Act and Mental Capacity Act – training and practice issues, e.g. improvement required around s.136 recording and s.62 Urgent Treatment reviews. • Physical Health checks and monitoring of anti-psychotic medication.
What is the Board being asked to consider	Does the plan and progress to date provide sufficient assurance that the Trust is adequately addressing the CQC requirements.
What is the impact on the quality of care	Delivery of the Action Plan should ensure that the Trust is meeting the Fundamental Standards and thereby delivering good quality care.

Leeds and York Partnership NHS
NHS Foundation Trust

What are the benefits and risks for the Trust	**Benefits** Assures the people who use our service that we are providing good quality care. Provides the Trust with a good public standing Positive message for our staff. **Risks** Failure to assure the CQC may result in further regulatory action. Weakens the Trust's reputation
What are the resource implications	Not quantified.
Next steps following this paper being presented to the Board	Feedback to the CQC Fundamental Standards Group Share the report with Commissioners Provide an update to CQC at the next engagement meeting on 2 May 2017.
What are the reputational implications and how will these be addressed	Delivery of the Action Plan and assurance to the CQC that the requirements have been achieved will enhance the reputation of the organisation.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	None
What public / service user / staff / governor involvement has there been	None
Previous meetings where this report has been considered (including date)	Executive team on the 19 April 2017

RECOMMENDATION (This report is being provided to the Board for) (please tick relevant box/s): ✓							
Assurance	✓	**Discussion**	✓	**Decision**		**Information only**	
Provide details of what you want the Board to do: The Board is asked to receive the report, discuss any issues and confirm it is assured by the reported progress.							

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Leeds and York Partnership NHS Foundation Trust
CQC Action Plan
Update Report to the Board
27 April 2017

1. Purpose of this paper

This is the first paper to the Board following submission of the Trust's CQC Action Plan in December 2016. It is designed to provide assurance about the action taken and progress made to address the CQC findings following their Comprehensive Inspection in July 2016, and published reports November 2016. The Trust received 13 Core Service reports and 1 Provider level report.

2. Background

The CQC completed a comprehensive inspection of the Trust in July 2016. They found there had been significant improvements since their inspection in 2014, with 78% or services rated as either 'Good' or 'Outstanding', e.g Deaf CAMHS they rated as outstanding. They also found that the Older Peoples' service had moved to 'Good' rating from 'Inadequate', they acknowledged the positive and proactive approach to service user involvement, praised the work around recruitment and use of bank/agency, noted the significant improvements to the management of complaints and the ongoing improvements to the clinical environments in particular the ligature risk assessment work.

Despite these improvements, the overall Trust rating remained at 'Requires Improvement'. Table 1 highlights the key areas for improvement.

Table 1

Key Areas Requiring Improvement
• Fit and Proper Person Test – Not all the documentation requested by CQC at the time of the inspection was readily available. They did however acknowledge that checks had been completed and there were not concerns about the fitness of the Directors. • Compulsory Training/Appraisals/Supervision – Trust not meeting its own threshold and not achieving the expected 75% CQC threshold. • Incident Reporting – Specialist Supported Living Service and National Reporting and learning System • Eliminating Mixed Sex Accommodation - Yorkshire Centre for Psychological Medicine based at the Brotherton Wing at LGI. • Mental Health Act and Mental Capacity Act – training and practice issues, e.g. improvement required around s.136 recording and s.62 Urgent Treatment reviews. • Physical Health checks and monitoring of anti-psychotic medication.

- Medicines Management – audits not completed in some areas and fridge temperatures not acted upon when outside of normal range.
- Audit of Emergency Grab bags and equipment.
- Completion of clinical care records

3. Action Plan

CQC provided the Trust with verbal feedback immediately following the inspection, the points were confirmed in writing to the Trust (Appendix 1) and a responsive action plan (Appendix 2) was submitted by the Trust to address these points.

Following publication of the CQC report in November 2016, a Quality Summit was held, in Leeds, on the 8 December 2016. This led by CQC and NHS Improvement and attended by members of the Trust Board, including the Chair, the Executive team together with a range of external stakeholder including commissioners, Scrutiny Committee members and senior local authority colleagues.

Following the Quality Summit the Trust was required to submit its Action Plan to CQC by 16 December.

In developing the Action Plan the priority areas were the Regulatory Compliance Actions, also referred to as 'Must Do' actions followed by the areas which CQC believed some improvements were required, referred to as 'Should Do' actions in the reports.

The Trust was found to be in breach of 6 Regulations, four of which were highlighted at Provider Level. Regulation 18, Staffing in regard to compulsory training had the highest number of breaches across the core services. The other regulations against which compliance actions were issued included;

Regulation 9 - Person-centred care – One breach at Core Service level – Mental health crisis and Health based place of Safety
Regulation 10 - Dignity and respect – Two breaches. Core Service Level – Yorkshire Centre for Psychological Medicine (YCPM) carried through to Provider Level as a compliance action for YCPM.
Regulation 12 - Safe care and treatment - Three breaches. Core Service level – Wards for people with a Learning Disability and Specialised Supportive Living Services. Also at Provider level in regard to care planning.
Regulation 13 - Safeguarding service users from abuse and improper treatment (safeguarding training) – Four breaches at Core Service level only – Wards for people with a Learning disability/Acute In-patient wards & PICU/CAMHS inpatient/Forensic services.
Regulation 17 - Good governance – Four breaches at Core Service and Provider Level. Cores services – MH Crisis & HBPoS, Wards for Older People and

Specialised Supportive Living Service. At Provider level Fit and Proper Persons Test, Incident reporting, medication error checks, MHA/MCA training and policies, ability to return CQC data in a timely way.

The Action Plan were developed and agreed through the Trust's CQC Fundamental Standards Group. Prior to submission the Action Plan was discussed at the December meeting of the Quality Committee.

The CQC Fundamental Standards Group remains as the main assurance group for the CQC Action Plan. This has involved working with the IT department and directorates to establish an Action Plan Tracker which has been designed to enable monitoring and reporting of progress of the action plans at provider and care group level. The development of the Tracker is now at an advanced stage and it is expected by the end of April it will become the central mechanism for monitoring and reporting progress. In the interim, the Care Groups and Corporate Services have used the standard action plan spreadsheets.

Governance Process for managing the actions;

1. Agreed Action Plan
2. Identified Action owner – designated individual(s) responsible for the action
3. Action overseer – senior manager to oversee progress.
4. Agreed Governance Group for the particular action – confirms action completed with submitted evidence.
5. Responsible Director – signs off completion and provides assurance to the CQC Fundamental Standards Group.
6. CQC FSG provides assurance to the Quality Committee and Board.

Progress against the Provider Must and Should Dos are attached

Table 2 attached at Appendix 3 provides an update on the Provider Must Do actions
Table 3 attached at Appendix 4 the Should Dos.

Specific actions relating to the Core Services are managed through the Care Groups and reported via the tracker. Assurance on these actions is also provided through reports to the Senior Management Group and the CQC FSG.

4. Key Risks

1. The CQC Action Tracker has taken longer to establish than anticipated which has limited the update reports. It is now operational and staff are trained in its use and can therefore update their actions and submit evidence via this system.
2. YCPM – Eliminating Mixed Sex Accommodation – this matter has not yet been resolved and is subject to ongoing discussions with NHS England and CQC.
3. Physical Health care monitoring – to date the Trust has not met the national CQUIN requirements. Recent internal clinical audit results indicate further

improvements are required. A revised action plan via the Physical Health CQUIN delivery group is now in place.

4. Incident Reporting at the Specialist Supported Living Service – this remains a manual system until the electronic options have been tested and implemented.
5. Policy and procedures – a number of policies and procedures have been revised following the CQC inspection. It is vital that staff are aware and fully understand the revisions in regard to their practice. We are looking at the most effective way of achieving this set alongside the other mandatory requirements for staff and the ongoing capacity issues.
6. Compulsory training – ensuring all areas are complaint with compulsory training requirements, especially Immediate Life Support. Trainer capacity has been assessed, and we need to ensure that the low uptake areas are prioritised.
7. Medication Audits/Monitoring of fridge temperatures – ensure the actions that have been put in place are sustained. These will form part of the Care Group's and the Medicine Optimisation Group's routine reports.

Completion of the CQC action plan is on the Trust's Strategic Risk Register.
Internal Audit are undertaking an audit of the CQC Action Plan process which will provide additional assurance and recommendations.

5. Conclusion

Following the CQC inspection and report published in November 2016, the Trust has taken the necessary steps to respond to the findings and put in place plans to address the regulatory compliance actions.

These plans are supported by an agreed governance structure and the Trust has established an electronic tracker to support the process.
Action owners, Overseers and Responsible Directors are clearly identified and clear about their responsibilities.

There has been significant progress around most of the actions and key risk issues identified.

Anthony Deery
Director of Nursing, Professions and Quality

Appendix 1

Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

Sent via email

Ms Jill Copeland
Chief Executive
Leeds and York Partnership NHS Foundation Trust
2150 Century Way
Thorpe Park
Leeds
LS15 8ZB

19 July 2016

CQC Reference Number: SPL1-2480084032

Dear Jill

Re: CQC inspection of Leeds and York Partnership NHS Foundation Trust

Following your feedback meeting with Nicholas Smith, Phil Confue, Kate Gorse-Brightmore and Chris Watson on 15 July 2016. I thought it would be helpful to give you written feedback of our preliminary findings as highlighted at the inspection and given to you and your colleagues Anthony Deary and Lyn Parkinson at the feedback meeting.

This letter does not replace the draft report we will send to you, but simply confirms what we fed-back on 15 July 2016 and provides you with a basis to start considering what action is needed rather than waiting for the draft inspection report.

An overview of our preliminary findings

The preliminary findings that we fed back to you were:

We observed the following areas that need to be brought to the attention of the trust

- Issues around the use of the Mental Health Act as follows:
    - Concerns around the use of Urgent treatment (section 62) there appeared in some areas to use section 62 as routine rather than as an urgent treatment plan. The ward staff in the areas where this was

happening did not know how long treatments were being used for, as there was no audit completed. You informed us at feedback that this is not the case and central audits are in fact completed.

- The use of seclusion in the Child and adolescent mental health services based in York were not being applied in line with the trust policy, which identified that seclusion was not practiced at this location. There was also some confusion from the staff interviewed as to when seclusion should be recorded.

- There was an infection control issue identified on 2 Woodland Square where we found mattresses being stored on the floor in the shower room. The unit was dirty in places and the skylight was leaking leading to water coming into the unit when it rained.

- We were concerned about the language used to describe patients on the wards at Clifton house where CQC staff heard patients described as prisoners.

- We identified concerns that the doors in the Crisis assessment unit were not closed to separate male and female sides of the unit. You explained that this was not how the doors are expected to be used.

- The staff on ward 3 at the Becklin Centre told us they did not feel safe, as they were not confident to challenge patients. When we were at the Becklin Centre we saw cigarettes and people smoking on the way to the outside area and one patient was smoking what staff on the ward identified as cannabis.

- We found that the cold chain for medicines might not be being maintained. There were fridges in wards and pharmacies, which showed they might not be operating within expected ranges. There was no evidence of the action taken to address this.

- Policies for the application of the Mental Capacity Act were in place. The information was there strategically but on the ground, there were gaps in practice and implementation between services. The staff in the MHA office could identify people that were restricted of their liberty and that the clinical lead did not agree.

We found also the following:

- In the community services for people using mental health services, there was good service user involvement and comprehensive support for people in their discharge. There were stablished links with key stakeholders to assist with this. The trust visions and values were well embedded in these teams and formed everyday practice.

- In the rehabilitation services, the use of technology to assist people to remain supported as the progressed to discharge and allowed continued support and people in the service spoke highly of contact once discharged. The use of community facilities and the proactive approach to improving physical health

care were examples of practice that supports the individuals on their discharge.

- In the acute wards for people of working age, the use of organised activities in the evenings and at weekends was identified by the patients as assisting them to stay active. Patients and Staff identified that the daily meetings

- In child and adolescent services the engagement and involvement of the young people in all aspects of their care was embedded in the care delivered. There were also good link with external stakeholder and agencies to ensure that the needs of the young people were supported during their time in the service.

- In the crisis services, a good working relationship had been developed with stakeholders and there were good examples of interagency working identified.

- During the inspection, we met some motivated staff in particular the person leading on restraint who had some good ideas to continue to reduce the number of episode of restraint and reducing further the number of restraints that are in the prone position.

Following the feedback session, you have also confirmed the position of the trust in relation to the fit and proper person checks that were in place, and the program of continued monitoring assurance of this regulation.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any further queries at this stage, please do not hesitate to contact me.

Yours sincerely

Nicholas Smith

Head of Hospitals Inspection

c.c. Chair of Trust

Leeds and York Responsive Action Plan to issues raised in the letter from CQC Lead Inspector ref: SPL1-2480084032 on 19 July 2016

N^{o}	Issue	Action and/or evidence of action
1	Concerns around the use of Urgent treatment (section 62) there appeared in some areas to use section 62 as routine rather than as an urgent treatment plan. The ward staff in the areas where this was happening did not know how long treatments were being used for, as there was no audit completed. You informed us at feedback that this is not the case and central audits are in fact complete)	Section 62.docx
2	Use of seclusion at Mill Lodge contrary to Trust not being applied in line with the trust policy, which identified that seclusion was not practiced at this location. There was also some confusion from the staff interviewed as to when seclusion should be recorded.	Seclusion at Mill Lodge CAHMS service
3	There was an infection control issue identified on 2 Woodland Square where we found mattresses being stored on the floor in the shower room. The unit was dirty in places and the skylight was leaking leading to water coming into the unit when it rained	Infection Control Issue - mattress 2 wo Mattress Managment Procedure.docx
4	We were concerned about the language used to describe patients on wards at Clifton House where CQC staff heard patients described as prisoners.	CQC issues response 18 July 2016.docx
5	We identified concerns that the doors in the Crisis	Following the issue with the door being escalated me on the 15th July the following action has been taken:

N^{o}	Issue	Action and/or evidence of action
	assessment unit were not closed to separate male and female sides of the unit. You explained that this was not how the doors are expected to be used	• Existing maglock system on the corridor doors set to lock to prevent free access between male and female areas • Corridor doors partially obscured to enhance privacy and dignity • LWI updated (see attached) and submitted to the CQC local office team. • All staff briefed on the new LWI's on the day and in team meetings • Door bell system incorporated by corridor doors in order for staff to rapidly respond to service users needing to enter another part of the unit under escort. The updated LWI went to the Leeds Care Group Clinical Governance Forum for approval on 2nd August and is on the agenda for our CAS Clinical Improvement Forum for 1st September. This is the forum where they will continue to be monitored to ensure compliance.  Crisis Assessment Unit Local Working In:
6	The staff on ward 3 at the Becklin Centre told us they did not feel safe, as they were not confident to challenge patients. When we were at the Becklin Centre we saw cigarettes and people smoking on the way to the outside area and one patient was smoking what staff on the ward identified as cannabis.	 2016 07 22 Response to issues ra
7	We found that the cold chain for medicines might not be	• All wards and pharmacy have the attached new fridge recording sheet

N^{o}	Issue	Action and/or evidence of action
	being maintained. There were fridges in wards and pharmacies, which showed they might not be operating within expected ranges. There was no evidence of the action taken to address this.	• All nursing staff have been made aware that it is their role to monitor the fridge temp daily and follow instructions on the sheet if out of range • All wards have been directed to purchase thermometers to record ambient room temp which is also recorded on the sheet • Pharmacy staff are checking weekly that the monitoring is being carried out • An audit of the ward fridges has been carried out , as attached • Some fridges have been found to be defective (Clifton) and have been replaced • The pharmacy Fridge SOP is being revised and an appendix to the LYPFT Medicines Code produced re fridge and room temp monitoring. • Pharmacy staff have trained nursing staff re the operation of the fridges and resetting temps after reading • Pharmacy have carried out the audits ,but daily monitoring is the nurses responsibility and reporting incursions is the nurses responsibility • Fridges provided through the PFI contract (recorded on the asset register) are the responsibility of Interserve Facility's Management to maintain/ repair / replace as required. Monitoring of temperatures is responsibility of the nursing staff.

N^{o}	Issue	Action and/or evidence of action
		Fridge monitoring sheet.1.doc
8	Policies for the application of the Mental Capacity Act were in place. The information was there strategically but on the ground, there were gaps in practice and implementation between services. The staff in the MHA office could identify people that were restricted of their liberty and that the clinical lead did not agree.	Application of MCA.docx

Appendix 3 Provider Must Dos - Leeds and York Partnership NHS Foundation Trust RGD

Table 2

Provider	Action	How action will address the issue raised- evidence provided	Governance forum initially responsible for monitoring.	Lead/Timeframe	Status
Must Do					
The provider must ensure that the governance systems are established to assess, monitor, and improve the quality and safety of the service, and manage risk, operate effectively and are embedded in the service.	Formal review of Serious Incident Review Process in line with review of Trust Incident Policy , acknowledging NHS Serious Incident Framework (March 2015) and subsequent Care Quality Commission – Deaths Review.	Creating a timely, responsive and well governed review process, fully supported by clinical groups will ensure timely reporting, , notification, investigation, review and improvement to clinical and non-clinical services in line with national timescales overseen and scrutinised by Clinical Commissioning Groups and part of Care Quality Commission inspection processes. Evidence of assurance from Clinical Commissioning Groups. Evidence of improvements through monitoring of compliance through Trust Incident Review Group.	TIRG/Effective Care	April 2017 Anthony Deery- Director of Nursing Quality and Professions	A review of the Serious Incident process was carried out in March 2017. The outputs from this review will be considered as part of the work the Trust is now taking forward in response to the CQC learning, Candour and Accountability Report Dec2016 and the National Quality Board Framework for reviewing deaths Mar 2017
	Formal review of Trust's Risk Management Framework and review of risk escalation processes.	Review of Risk Management Policy and process, to ensure timely escalation of risks through organisation, and ensure all risks are clinically or operationally owned and governance structures are used to escalate as appropriate.		February 2017	A revised system for controlled (formerly managed) risks agreed and implemented with directorates. In view of the on-going governance review this process will be subject to further review.
	Review of Risk Management System.	Formal review of the risk management system and everything it currently delivers / supports the organisation with, along with a direct comparison of		February 2017	

		other similar or nationally available risk management systems. Supported by the IT strategy to create links with clinical dashboards, so that information is automatically available to clinical / operational services and specialists to look at trend analysis and individual patient risk.		Revised to July 2017	
	Review of governance around Policies and Procedures processes with administrative support.	Concern was identified around a number of policies and procedures being out of date. A full review of the processes relating to the authoring, consultation, collating, storing, archiving, ratification and dissemination of policies to be carried out to ensure there is a robust management process in place, and all documents are available on both the intranet and the internet, to aid access for internal and external requirements. Random audit of all policies to ensure in date and plans in place for review.		February 2017	Policy and Procedure Group in place. All Policies and Procedures have been checked. Work in progress prioritising those due for revision and those where there is an identified policy author gap. Revised timeframe to address additional work May 2017
The provider must ensure that the systems and processes in place with regard to the documentation that confirms that the directors meet the fit and proper person requirement, regulation 5 of the Health and Social Care Act (Regulated	Review and if necessary update the procedure to ensure it reflects the requirements of the CQC regulation, and that it adequately describes the systems and processes in place. This will ensure the systems and processes relating to how the Trust makes and evidences the F&PP checks are clearly described. The procedure will be updated and ratified in accordance with the Trust's internal processes for approving procedures. •Review all directors' individual files to ensure they contain all	Checklists for the information required will be devised and completed for each file to ensure they contains all the necessary information. There will be an annual audit	Audit Committee. Assurance reports will be provided to the monthly CQC FSG and quarterly to the Quality Committee with exception reporting to the Trust Board	Cath Hill Head of Corporate Governance	Completed

Activities) Regulations 2014, provides assurance to themselves and the Care Quality Commission.	the documentation necessary to evidence that F&PP checks have been carried out in accordance with the CQC regulation. These files will provide assurance that the F&PP checks have been carried out in accordance with the regulation, that all directors are fit and proper and that the checks have been adequately evidenced.				
The provider must ensure all its services comply with the Department of Health Guidance on Eliminating Mixed Sex accommodation and the Mental Health Act code of practice.	Admissions monitored on a monthly basis and assurance reports provided to commissioner. Audit all inpatient wards environments for compliance against the Department of Health Guidance on Eliminating Mixed Sex Accommodation	The Trust is compliant across it's estate with the exception of the issue raised by CQC in regard to YCPM and the Crisis Assessment Unit (CAU) The particular actions in respect of YCPM and CAU are referred to in the respective core service reports. The collective actions will ensure that inpatients will have their safety, privacy and dignity safeguarded whilst in the ward environments	Estates Strategy Group Assurance reports will be provided to the monthly CQC FSG and quarterly to the Quality Committee with exception reporting to the Trust Board	Anthony Deery/Dawn Hanwell April 2017	CQC are satisfied that the action taken at the CAU to address this issue meets the requirements. However, CQC remain of the view that the YCPM does not. This matter has been escalated to local commissioners and NHS England. Both have visited the unit and do not believe it breaches the guidance. NHS England are due to meet with CQC on 20.4.17 to discuss this matter with them. In the meantime the Trust has explored alternative locations for this service and possible work in situ but neither have resulted in a viable option.

					The Operational Policy and Local working instruction ensures that patient's safety and dignity is maintained at all times.
The provider must ensure that incidents are identified and reported in teams and services across the trust and that the systems are in place to enable them to do so	DATIX system to be available for all teams to report incidents, including Specialist Supported Living Service.	Full compliance with evidence in central DATIX system that all services are reporting through the electronic portal in a timely manner and that all incidents are being authorised as per Trust Policy.	This action will be monitored through the agreed local Care Group Clinical Governance Council Assurance reports will be provided to the monthly CQC FSG and quarterly to the Quality Committee with exception reporting to the Trust Board	Tony Gray December 2016 Bill Fawcett May 2017	Due to IT and private landlord issues at the Specialist Supported Living Service it has not been possible to implement an electronic DATIX system. An interim manual system has been established while work progresses with an electronic system. Bill Fawcett, Chief Information Officer (2017-03-17) Wireless solution has been specified. Delivery of system planned for the 31st of March. Testing of system completed by 21st of April Equipment has been ordered and delivered. POC (proof of concept) has been arranged with third party supplier on 11th April. If successful then a rollout plan will be arranged to order additional hardware, commission and test to all other sites. This will run into April/May
The provider must	At time of inspection the Trust	Work has progressed since the inspection and PSI	CQC	Tony Gray /	Completed

ensure that they respond to requests for information from the Care Quality Commission and report all incidents to the national reporting and monitoring systems, in a timely way.	was running with a lag of 71 days for reporting Patient Safety Incidents (PSI) to NRLS against a national average of 26 days.	are now reported in a more timely way. Last data period independently confirmed an average timescale of 17 days against the national average of 26 days, which shows significant improvement.	Fundamental Standards Group. Assurance reports will be provided to the Quality Committee with exception reporting to the Trust Board	Anthony Deery Action completed and actions need to be maintained December 2016	
The provider must ensure that records are accurate and contemporaneous, including all decisions about patient's care and treatment within their care record.	Education programme for staff on all aspects of record keeping. Clinical supervision will be included in the Trust iLearn system and will be used as a mechanism to reinforce good record keeping.	A records and compliance audit will be undertaken to ensure the required improvements have been made.	This action will be monitored through the agreed local Care Group Clinical Governance Council. Assurance reports will be provided to the monthly CQC FSG and quarterly to the Quality Committee with exception reporting to the Trust Board	Lynn Parkinson/ Anthony Deery	Ward managers and Community Managers Forum 10 February 2017 Internal Audit March/April 2017. Report due May 2017. Included in the Internal Audit Plan for 2017-18 Ongoing work with the care groups led by Linda Rose. Care groups have previously contributed to a piece of work to help staff add depth and context to documentation where they have had 1 to 1 discussions with service users. It resulted in the formulation of an aide memoir called the 4C's of good record keeping. This is being reviewed and will

					be used as a framework. Random sampling will be carried out between May and August 2017 to test the effectiveness of this..
The provider must ensure that the emergency equipment and medication checks are sufficiently robust to ensure that equipment for providing care and treatment is safe for use and are in sufficient quantities to ensure the safety of service users and meet their needs.	Audit all grab bags to ensure medicines and equipment is in date, commenced 12.12.16, expected completion date 23.12.16 to compile responses. Trustwide reminders already sent out via communications team, with checklist for nursing staff to check grab bags. In addition senior nurses need to cascade the reminder to nursing staff for implementation.	Assurance that equipment in grab bags are in date via review timetable. All out of date equipment / medication found to be reported on datix. Audit completed and showed 100% compliance.	Medicine Optimisation Group/ Effective care	Elaine Weston Chief Pharmacist December 2016	Completed Monitored via Care Group Clinical Governance Forums.
The provider must ensure that they monitor fridge and ambient room temperatures and ensure that medicines are stored at the correct temperatures to	SOP describing in detail the process for monitoring temperatures in clinic rooms and medication fridges has been produced and ratified at the Policy and Procedures Group, distributed to all ward managers and matrons for implementation and uploaded onto staffnet. New recording charts have been employed on every ward /dept with medication. Pharmacy staff	Reduction in datix reports around missed monitoring of fridge/ clinic room temperatures or/and aberrant temperature reporting	Medication Safety Committee (sub Group of Medicines Optimisation Group) This action will be monitored through the Clinical	Elaine Weston, Chief Pharmacist December 2016	Completed Monitored via Care Group Clinical Governance Forums.

remain effective.	to check weekly that monitoring is taking place by nursing staff, breeches to be datixed.		Environment Operational Group. Assurance reports will be provided to the monthly CQC FSG and quarterly to the Quality Committee with exception reporting to the Trust Board		
The provider must ensure that physical health monitoring of antipsychotic medication is completed in line with the National Institute of Health and Care Excellence guidelines and clarify responsibilities.	A continuous improvement will be held to identify the relevant staff who will be clear on their responsibilities regarding physical health monitoring, what is to be monitored, who will carry out that monitoring and how that information will be shared with colleagues in Primary care. Establish a physical health steering group to set out the monitoring 'must dos', by whom, how and when and to address the ongoing training requirements to support staff to deliver the appropriate interventions.	Monthly reporting to Trust wide, Care Group and local Clinical Improvement/Governance forums CQUIN results	Establishment of physical health steering group. Effective Care Committee/Trust Clinical Governance Group. Assurance reports will be provided to the monthly CQC FSG and quarterly to the Quality Committee with exception reporting to the Trust	Anthony Deery April 2017	In progress Limited Assurance based on recent clinical audit information. This stream of work forms part of the Trust's response to national physical health CQUINS and is being overseen by Alison Kenyon AD for the Leeds Care Group and progress is reported to the Physical Health Steering group. An action plan has been developed with milestones accountable to a CQUIN Delivery group chaired by Alison Kenyon. Membership is made up of the named leads in the action plan.

			Board		A Trustwide Lead for Physical Healthcare has been approved and we are currently out to advert.
The provider must ensure that all staff have sufficient training, supervision and appraisal to enable them to carry out their role	We will consolidate our recording and reporting of clinical supervision, appraisal and compulsory training into a single electronic system (iLearn) by end of March 2017 •Managers will then receive a single integrated report (on a weekly basis) showing compliance against clinical supervision, appraisal and compulsory training targets •Supervision – we will initially pilot and then fully implement a new standard process for the recording of clinical supervision •Compulsory training – we will implement a system of 'block' compulsory training events which maximise the opportunity for attendance by clinical staff to build on the current overall compliance rate we currently have of 88% •We will also establish a Compulsory training Task & Finish group to review the delivery and compliance of each aspect of our compulsory	At Board level, compliance will continue to be reported in the monthly Integrated Quality Report, and monitored via reports to the Quality Committee. Across Care Services, Integrated compliance reports will be monitored each month via the Care Group Management Team and through individual supervision with team / ward managers and professional leads. This action will be monitored through the agreed local governance ie Care Group Clinical Governance Council or CEOG, however, as a golden thread all actions will be monitored via the CQC FSG and assurance reports submitted to the Quality Committee on a quarterly basis with the exception reported to the Trust Board	This action will be monitored through the Care Group Clinical Governance Councils. Assurance reports will be provided to the monthly CQC FSG and quarterly to the Quality Committee with exception reporting to the Trust Board	Susan Tyler (Director of Workforce Development) Lynn Parkinson (Interim Chief Operating Officer June 2017	**19.4.17** **Compulsory Training** Trust wide currently 89% overall compliance so green performance against 85% KPI - currently only 4 of the 33 areas of training are below the 75% threshold - ILS (74%), MHA Community Level 2 (64%), Safeguarding Children Level 2 (73%) and Moving & Handling Advanced OPS (65%) – these areas have sufficient capacity to achieve 85% by end June '17 Leeds Care Group currently 88% overall compliance so green performance against 85% KPI - currently only 2 of the 33 areas of training are below the 75% threshold - ILS (72%) and Safeguarding Children Level 3 (74%) and sufficient provision is in place to achieve 85% by end June '17 - we are also working with the Care

	training programme that is achieving below 85%. This group will agree and implement specific plans to increase compliance against each specific training that is underperforming, and will agree trajectories for each service area to maintain or achieve an 85% compliance by the end of June 2017. •Appraisal – all team managers will develop local plans to achieve or maintain compliance with an 85% target •Care Services (supported by the HR business partners) will ensure – within both Care Groups – that a clear process is in place for the monthly monitoring of performance in relation to appraisal, supervision and compulsory training, via the Care Group management and governance meetings.				Group to address individual services where compliance is below 85% Specialist and LD Care Group currently 90% overall compliance so green performance against 85% KPI - currently only 3 of the 33 areas of training are below the 75% threshold - MHA Community Level 2 (50% but this is only 5 staff), Moving & Handling Advanced OPS (31% but this is only 25 staff with a new training requirement), Safeguarding Children Level 2 (72%) and sufficient provision is in place to achieve 85% by end June ’17 - we are also working with the Care Group to address individual services where compliance is below 85% **Clinical Supervision** Recording and reporting of this went live in ILearn at the start of April ’17 Early reports show staff are engaging with it – compliance reports will start to be produced in May ’17 once sufficient data is recorded in the system

					The reporting schedule for this and appraisal are being agreed with Care Groups Communications, management meeting demonstrations and drop in sessions planned as of wc 24.4.17 to support **Appraisals** Trust wide currently 81% overall compliance so amber performance against 85% KPI Leeds Care Group currently 87% overall compliance so green performance against 85% KPI – Care Group has worked on their own trajectories to maintain KPI by end June '17 Specialist and LD Care Group 76% overall compliance so amber performance against 85% KPI – Care Group has worked on their own trajectories to achieve KPI by end June '17 Appraisal function in ILearn has just gone live this week – plan for 6 week transition period from ESR onto ILearn to ensure consistency of KPI data and support users

					making the transition from an old paper based approach to new online approach – communications, management meeting demonstrations and drop in sessions planned as of wc 24.4.17 to support this.
The provider must ensure internal medication audit systems are sufficiently robust.	The implementation of Electronic prescribing Trustwide eradicates the issue of non-recorded unintentional 'missed doses' as the system demands a reason for a dose not being given. The Medication Safety Committee will determine the frequency of audit of medication charts via EPMA re 'missed doses' and other medication issues and formulate an action plan on the results. All Datix regarding medication are reviewed by the Medicines Safety Committee to identify trends and implement necessary training or action to avoid repetition. 6 monthly medication error report is produced that goes to the Medicines Optimisation Group and Effective care. The Nurse leads need to encourage reporting of errors involving medication onto Datix	The EPMA reports of numbers of missed doses should decline. An increase in overall datix reporting re medication errors /incidents should occur. Datix reports regarding medication are reviewed regularly by Meds Safety Committee, identifying trends and implementing necessary training or action to avoid repetition. The 6 monthly report provides recommendations to the Trust for improvement. The Medicines Safety Committee to be the guardians of the drug chart audit reporting of the EPMA system.	Medication Safety Committee (sub group of Medicines Optimisation Group) This action will be monitored through the Care Group Clinical Governance Councils. Assurance reports will be provided to the monthly CQC FSG and quarterly to the Quality Committee with exception reporting to the Trust Board	Elaine Weston January 2017	Completed

The provider must ensure that staff have a good understanding of the Mental Capacity Act and their responsibilities under the Act and those patients are detained using the appropriate legal authority such as by Deprivation of Liberty Safeguards.	MCA/DOLS level 2 training is mandatory for professionally qualified staff (AC's and section 12 approved Dr's are exempt). In December we achieved 82% compliance for this training. Regular dates for training were planned for the next six months . Jan/Feb 2017 priority training with CAMHS around competency and authorising a deprivation of liberty in under 18 year olds. To increase knowledge and support around the use of the MCA and DOLS we are training 'MCA Champions'. These will be identified individuals in clinical areas who will receive more in-depth training, delivered in partnership with adult social care, and will offer advice and support to their clinical area. The MH Legislation team also producing a practical guide to the use of the MCA and DOLS in clinical areas. This will assist	The action plan will be monitored by the Mental Health Legislation Operational Steering Group and the Mental Health Legislation Committee to ensure actions and timescales are met. Monthly audits of detention documentation and processes are in place. Yearly audit cycle of documentation relating to the detention of patients within the trust 20.3.17 Mental Capacity Act and DoLs - Level 2 90% Mental Health Act - Community - Level 2 77% Mental Health Act - Inpatient - Level 2 77% Mental Health Legislation Awareness - Level 1 92%	Mental Health Legislation Committee. Assurance reports will be provided to the monthly CQC FSG and quarterly to the Quality Committee with exception reporting to the Trust Board	Anthony Deery March 2017 Achieve 85% compliance with training by June 2017.	Training capacity now in place. 20.3.17 Overall compliance 84%

	staff in identifying when someone may be deprived of their liberty and how to authorise this, assessments of capacity, consultation and best interest decisions. The legislation department will continue to provide support and advice around all matters relating to MCA/DOLS, including attending best interest meetings and supporting assessment of capacity.				
The provider must ensure that the systems and guidance to support the application of the Mental Health Act and to ensure that the code of practice is sufficiently embedded across all the services and detailed in the trust policies.	Ensuring systems are in place to support and monitor the application of the MHA. Ensuring that all relevant staff are familiar with the changes in the Code of Practice (2015). Ensuring all policies and procedures are compliant with the CoP.	We have developed a system to enable the monitoring of rights read under section 132. A report will be run by the legislation department on a weekly basis and sent to Clinical Team Managers. This will indicate the time between detention and the first reading of rights and the date of the last reading of rights. This will ensure that we are compliant with 4.28-4.29 MHA CoP. Develop a system to monitor the use of section 62 urgent treatment. The section 62 form will be on our electronic system which will enable us to monitor the use of urgent treatment and fulfil our responsibilities under 25.42 MHA CoP. The clinical audit team is carrying out an audit of the use of section 62. All policies and procedures are compliant with the updated Code of Practice. We have a schedule of review for all procedures relating to the MHA to ensure they are fit for purpose and support the application of the act. Changes to the Code of Practice have been incorporated in the MHA mandatory training.	Mental Health Legislation Operational Steering Group. Mental Health Legislation Committee. Assurance reports will be provided to the monthly CQC FSG and quarterly to the Quality Committee with exception reporting to the Trust Board	Anthony Deery November 2016 Feb 2017 Feb 2017 Feb 2017	Completed Completed Completed Completed

		Changes will be reiterated in a bulletin to be sent to all clinical staff and a document will be available on MH legislation staff net page which clearly highlights the changes to the code.			

Appendix 4 Provider Should Dos - Leeds and York Partnership NHS Foundation Trust RGD

Table 3

Provider	Action	How action will address the issue raised- evidence provided	Governance forum initially responsible for monitoring.	Lead/Timeframe	Status
Should Do					
The provider should ensure that the outstanding actions on the trust's reducing restrictive interventions action plan are addressed and that the use of seclusion, restraint and rapid tranquilisation are in line with the trust policy.	Emma Oldham Fox is leading on the challenging behaviour procedure which will provide reference to restraint and rapid tranquilisation. Tom Mullen is leading work on seclusion.	They will complete the outstanding actions	Reducing Restrictive Interventions Steering Group/Effective Care Committee	Anthony Deery Jan 2017	Partially complete The Procedure for the Therapeutic clinical management of challenging, violent and aggressive behaviour is currently in draft form and will include use of restraint and rapid tranquilisation. The Seclusion Policy has now been fully revised and needs to be implemented.
The provider should ensure that they continue to build on the existing work completed to continue to reduce bed occupancies and out of area	The Trust will reduce the number of patients placed in out of area beds by - Continuing the implementation of the PIPA model - Continuing the implementation of the actions identified from the Rapid Improvement Event facilitated by NHSi including the	Actions have been identified through the implementation of the Purposeful Inpatient Admission (PIPA) process and a Rapid Improvement Event (RIE) that will reduce the number of patients in out of area beds. Occupied bed days for patients in out of area placements will be monitored and presented as evidence	Leeds Care Group Assurance reports will be provided to the monthly CQC FSG and quarterly to the Quality Committee with exception reporting to the Trust Board	Alison Kenyon April 2017	Work in-progress. RIE event completed and now implementing the action. The next Inpatient Pathway meeting is on the 26th April 2017 when the monitoring systems will be agreed at this time. Significant reduction in out of

placements	following o The development of an escalation policy o Reduction of clinical variation between wards o Development of a new risk management tool - Undertaking an improvement event to improve the flow of patients through the PICU Monitor the number of bed days occupied by patients in an out of area placements				area placements have been achieved since the RIE
The provider should ensure that patients have a choice of meals that meet their dietary requirements and take into account cultural and individual preferences.	Finding mainly related to CAMHs service. Trust dietician to produce recommendations regarding meus, which will include advice on choices, mealtimes and requirement to annually review and rotate menus. Aim to have this completed by end of December. Implement with Interserve and the other providers. There does also need to be a food and drink strategy developed as an overarching approach to provision.	Ensure that healthy, nutritional and culturally appropriate meals are available	Specialist Services Clinical Governance Forum	Dawn Hanwell/Anthony Deery Assigned to Tim Richardson and Jennifer McIntosh.	Specialist Services CQC progress update 4.4.17 Introduction of new menu in Mill Lodge (CAMHS) completed.
The provider should ensure that patients	The two advocacy providers for services in Leeds and York did not have CAMHS specialist advocacy	Meeting to be arranged with both Advonet and Cloverleaf advocacy services to explore CAMHS specialist	Mental Health Legislation Operational Steering	Oliver Wyatt March 2017	In progress Timothy Richardson (2017-03-

have access to advocacy that is relevant to their specific requirements.	services	provision. The advocacy service is commissioned by CCG's and not LYPFT so relevant CCG's will be involved in these discussions. Advocacy is an agenda item in the Mental Health Legislation Steering Group and provision was discussed at the last meeting in November CAMHS Service Manager to review current provision of advocacy, and ensure provision is specific to young people Specific advocacy services for young people are available	Group. Mental Health Legislation Committee Specialist & LD Care Group Management Team Assurance reports will be provided to the monthly CQC FSG and quarterly to the Quality Committee with exception reporting to the Trust Board	Tim Richardson Service Manager July 2017	21 15:35:14) PALS provide advocacy, which is adequate though we are exploring alternatives. Deaf CAMHS service users are signposted to local PALS
The provider should ensure that the community services have systems in place to manage risk effectively with regard to supporting patients whilst they are on the waiting list, managing the premises, and employing sufficient lone	A review of the referral and assessment process for psychology services will be undertaken and revised systems will be implemented. Patients will be provided with information to escalate any concerns whilst waiting for access to services that will reduce risk Lone working practices will be reviewed and use of technology to support this will be considered.	Evidence of the actions from the review of the referral system will be provided. Copies of the information supplied to patients will be provided Revised lone working procedures will be produced Evidence of the technology to be utilised	Leeds Care Group Management Meeting Assurance reports will be provided to the monthly CQC FSG and quarterly to the Quality Committee with exception reporting to the Trust Board	Alison Kenyon February 2017 Anthony Deery, Director of Nursing, Professions and Quality	In progress LSMS work complete around identifying technological solution. Business case presented to ET. Clarification

working systems to protect staff and patients.		will be supplied		January 2017	sought about other possible options via the new smart phones. Feasibility of this currently with the CIO and CCIO. Outcome to be discussed at May SMG and decision to be made about the best technological option.
• The provider should ensure all patients receive psychological therapies in a timely manner and within national guidelines.	Undertake a capacity and demand analysis of the community services Redesign of the management of referrals and scheduling of patients Recruit temporary posts to support a waiting list initiative	Provide information to identify required resources to meet demand. New pathway developed Additional temporary staff in post This action will provide information to target the training strategy (completed survey) Multidisciplinary staff will be trained to undertake lower level psychological interventions within a stepped care framework. (training strategy to be produced) When considering referrals for psychological intervention the 5P framework will be used to encourage a stepped approach to intervention. (Formulation documented in Paris notes) The psychology staff will oversee/supervise smaller groups of mdt staff to ensure closer and better quality governance of team based	Care Group Clinical Governance Council and Clinical Improvement Forums	Alison Kenyon March 2017	Alison Kenyon (2017-04-12 17:23:58) Modelling has commenced based on the revised service delivery model Edward Devine (2017-04-10 12:10:37) Pilot underway of integrated approach to referral and allocation processes in SSE locality team, including referrals stepped up from IAPT. meeting planned for 21/04/17 to agree electronic process on clinical system (PARIS) Edward Devine (2017-04-10 12:10:46) Pilot underway of integrated approach to referral and allocation processes in SSE locality team, including referrals stepped up from IAPT. meeting planned for 21/04/17 to agree electronic process on clinical system (PARIS)

	Conduct a training needs analysis to appraise team based psychological skills Undertake training to develop appropriate team based psychological skills Utilise a formulation based approach that emphasises team based psychological skills. Restructure psychological governance of CMHT based psychological activity	psychological activity (Structure to be discussed in the Clinical Improvement Forum)			Edward Devine (2017-04-10 12:06:45) 0.4 wte increase in temporary increase in hours from existing staff. Recruitment to 3 wte band 7 substantive posts in progress Alison Kenyon (2017-04-12 17:21:37) Length of time taken to recruit has prevented this timescale being met Edward Devine (2017-04-10 11:56:07) New psychological therapies professional/clinical leadership structure being implemented which identifies a clear leadership role in community to support training needs analysis and development of training. initial workshop planned for 26/03/2017 to progress TNA. Alison Kenyon (2017-04-12 17:15:37) There has been a delay in the implementation of the new psychological therapies model causing a delay in the delivery of this action Alison Kenyon (2017-04-12 17:26:56) Family Therapists training to provide training family interventions model into the wider CMHTs training to

					commence later in the Spring Alison Kenyon (2017-04-12 17:28:13) Psychological therapists are now fully integrated into the community teams and formulation process Edward Devine (2017-04-10 12:12:51) Revised psychological therapies professional/clinical leadership structure currently being implemented with an identified community role with accountability to drive improved governance of psychological activity within the teams.
The provider should ensure that all inpatient wards are clean and that ligature cutters are easily accessible in an emergency.	Re-examine Terms of Reference for Joint Cleanliness Group. Redefine and respecify cleanliness standards.	Revised Schedules and specification will be implemented. In reference to Procedure for the safe use of ligature cutters C-0065 could staff ensure all Hook Rescue Knives should be stored securely but also easily accessible in case of emergency and clearly labelled using Appendix D of this procedure.	This action will be monitored through the local Care Group Clinical Governance Councils and CEOG. Assurance reports will be provided to the monthly CQC FSG and quarterly to the Quality Committee with exception reporting to the Trust Board	Dawn Hanwell Chief Finanace Officer March 2017 Anthony Deery March 2017	David Furness (2017-03-27 14:02:34) 1. Within the performance framework – cleaning issues/standards have been raised predominantly at Newsam and Becklin. The specific issues raised have been dealt with. At the beginning of January Interserve Facilities Management (IFM) instructed to reduce the current specification and frequencies of cleaning to offices and divert this time to clinical areas. This has placed extra resource into areas causing concern.

	Safety alert distributed via trust wide email. This is an expansion of an alert sent out in January of this year.				Formal monitoring process in place on this and the initial results have been shared with the Cleaning Review Group. There are significant improvements across the estate , but still room for more at the two main sites Supervisors – IFM have been conducting an exercise to assess what their supervisors are spending the time on (a work study). This has been running since Nov and they are now assessing the results. They have indicated changes to what they require supervisors to do, but the full review outcome is not yet complete. Safety Alert recirculated. All ward managers and matrons have been reminded and asked to confirm they are easily accessible and that all staff, including bank and agency, are aware of their location.
The trust should consider privacy and dignity with regards to gender of patient	Assess the feasibility of further environmental adaptations to the current layout		This action will be monitored through the local Care Group Clinical Governance Councils and CEOG.	Anthony Deery, Director of Nursing, Professions and Quality January 2017	Judith Barnes (2017-04-06 11:58:50) CAU and 136 procedures have been updated and environmental work in CAU has now been completed including

in all its services including the section 136 suite and crisis assessment unit, and the respite services.	Review the current Local Working Instruction applicable to the unit to ensure service users privacy and dignity is being managed and safeguarded	Develop a local operating procedure to manage mixed sex usage of the CMI respite service	Assurance reports will be provided to the monthly CQC FSG and quarterly to the Quality Committee with exception reporting to the Trust Board	Andy Weir January 2017	installation of beverage area in female lounge. Further environmental needs of CAU is being considered in the Estates Strategy In draft – to be signed off in April.

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

10

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Operational Plan Implementation Quarter 4 Report
DATE OF MEETING:	27 April 2017
LEAD DIRECTOR: (name and title)	Lynn Parkinson, Interim chief operating officer
PAPER AUTHOR: (name and title)	Amanda Burgess, programme management office manager

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)							
Quality	✓	Strategic		Governance		Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	We work with service users and carers to support their achievement of outcomes and wellbeing	✓
G2	We are an employer of choice with a compassionate and highly trained workforce committed and supported to provide excellent innovative care and support	✓
G3	We work with others to improve health and improve lives through effective, innovative and sustainable partnerships	✓
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	
SO2	We provide a dynamic, rewarding and supportive place to work	
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	
SO4	We are transparent and accountable to the people and partners we work with	
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	✓

STATUS OF PAPER (please tick relevant box/s)		✓
To be taken in the public session (Part A)		✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:		
Legal advice relating to legal proceedings (actual or possible)		
Negotiations in respect of employee relations where they are of a confidential nature		
Procurement processes and contract negotiations		
Information relating to identifiable individuals or groups of individuals		
Other – not yet a public document		
Matters exempt under the Freedom of Information Act (quote section number)		

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	This is our quarterly Operational Plan Implementation report. It is provided in summary format to highlight to the Board challenges, areas of achievements, strategic risks and overall progress against our agreed annual priorities.
What are the key points and key issues the Board needs to focus on	The Board is asked to note that this is our fourth and final report of 2016/17. The summary includes an overview of our Operational Plan, highlights the one year schemes we have delivered/not delivered. It also detailed the two-year schemes where we are behind on delivering against key milestones at the end of quarter four. As this is the final report for the year we have included a brief description of our successes, challenges and actions to be taken forward into the new financial year. This paper also includes the Trust's strategic risk register.
What is the Board being asked to consider	The Board are asked to note the progress made against our Operational Plan priorities at the end of quarter four 2016/17.
What is the impact on the quality of care	Monitoring progress against our Operational Plan and strategy is a key part of assessing the impact on the quality of care we provide. In some instances the Operational Plan sets out intent to develop improvements to the care we provide.
What are the benefits and risks for the Trust	The Operational Plan summary highlights our ongoing commitment to improving the services we provide and highlights areas for improvement.
What are the resource implications	The summary provides a high level overview of our annual CIP plans and progress towards delivery.
Next steps following this paper being presented to the Board	We are currently in the process of redefining our strategy, taking into account such initiatives as the 5 Year Forward View and the local Sustainability and Transformation Plan.
What are the reputational implications and how will these be addressed	The Operational plan should be achievable without any reputational impact.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No, the recommendations are focused on the summary review of the Trust Operational Plan.

Leeds and York Partnership NHS
NHS Foundation Trust

What public / service user / staff / governor involvement has there been	The Operational Plan priorities are often drawn from processes related to staff, stakeholder and service user and carer involvement.
Previous meetings where this report has been considered (including date)	Executive Team meeting scheduled for 19th April 2017.

RECOMMENDATION (This report is being provided to the Board for) (please tick relevant box/s): ✓							
Assurance	✓	**Discussion**		**Decision**		**Information only**	

Provide details of what you want the Board to do:

The Board is asked to note the progress made against our Operational Plan priorities at the end of quarter four 2016/17; and confirm that it is assured of progress made and that areas where we will be seeking to improve and review are identified.

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Leeds and York Partnership NHS
NHS Foundation Trust

OPERATIONAL PLAN IMPLEMENTATION QUARTER 4 REPORT

1. Purpose

This report provides a summary of the Trust's progress against our objectives within our 2016/17 Operational Plan. This is our fourth and final report of 2016/17 and is set out to provide an overall summary of our progress against each of the schemes in the 2016/17 Operational Plan. This report also includes how we are progressing against our cost improvement programme.

2. 2016/17 Operational Plan status summary

We have now assessed ourselves against our quarter four milestones as set out within our 2016-2017 Operational Plan. The programme of work is being closely supported, monitored and reported upon via our Programme Management Office to track the progress we have made. Our 2016/17 Operational Plan includes schemes for delivery over a one year or longer timeframe. Where a longer timeframe has been agreed, the Operational Plan tracks progress for this year only against the planned one year milestone. A summary of our overall performance is provided at appendix 1, with further detailed information available upon request.

Our 2016/17 Operational Plan schemes have clearly defined milestones for achievement each quarter. Where our one year schemes have not been delivered at the end of quarter four these have been rated as red (including unmet fourth quarter performance target trajectories).

Two year schemes where we are behind on delivering against key milestones at the end of quarter four are rated as amber. A green rating has been applied to one year schemes which have been delivered.

At the end of quarter four all 77 schemes set out in the 2016/17 Operational Plan are underway. We have fully delivered 40 one-year schemes. The completed one-year schemes are:

- **CQC fundamental standards:** We were fully prepared for our fully comprehensive Care Quality Commission inspection which commenced on 11 July 2016 and have extensive processes in place to address all our compliance actions, including a programme of quality reviews that support our journey to become an outstanding Trust.

- **CQUIN and performance targets:** We have developed a memorandum of understanding with the third sector in Leeds and integrated mental health pathways for clusters 4 – 17. We have also implemented smoke-free services from 4 April 2016, with a report setting out our progress against the anticipated benefits being compiled for consideration in June 2017.

- **Mental health legislation:** We have completed a review of our mental health legislation systems and processes, with a further internal audit completed in quarter three. The outcome of the audit was a rating of 'significant assurance' that all the recommendations had now been implemented.

- **Strategic clinical developments:** We have continued our development journey of recovery-focused services, including: the implementation of Triangle of Care; EQUIP training rolled out across the Trust to increase service user input into care planning; finalised the cluster specifications to include third sector options; implemented a prototype Recovery College with

Converge, Leeds Mind and Leeds universities; and finally work is underway to develop a recovery focused framework which increases choice for our service users.

- **New clinical developments:** We have successfully implemented a number of service developments including: increased capacity within our gender identity services to aid the national reductions in waiting times; rebranded our chronic fatigue services with improved access; completed a review of our community learning disability services and are on track to fully implement the new model during 2017/18; and our in-house pharmacy service has now been in place since 1 April 2016 and operates over 7 days with an on call 24/7 service in place. We have also reduced acute inpatient out of area placements as a consequence of the rapid improvement work undertaken.

- **Performance reporting/management and performance framework:** We have completed the rollout of comprehensive performance dashboards across the Trust which incorporates valuable clinical and HR data. Trial performance reviews have been conducted with the first formal review being planned for May 2017.

- **Research and evaluation:** We have successfully secured research capacity funding to support the delivery of a physical health clinic in one of our community teams, with a further opportunity to advertise joint posts by June 2017. During 2016/17 we have continued our engagement in the Yorkshire and Humber CLAHRC research capacity initiative and have implemented an evaluation framework for all service developments.

- **Local strategic developments and partnerships:** Considerable work has been completed during 2016/17 on three prototypes across each of the Leeds CCGs. These models are currently operational and will be analysed by the CCG's to assess their responsiveness and future feasibility. The impact of these will affect our future configuration of SPA and how we better work with IAPT. We are further developing partnerships with local education and training providers to support the registered and non-registered workforce. We have successfully launched the partnership procurement framework with new developments being supported and identified through the new Clinical Plan.

- **Regional specialist strategic developments and partnerships:** We have continued to be involved in the crisis and urgent care networks and West Yorkshire Urgent Emergency Care Vanguard. We are also in discussions with our neighbouring partners concerning a shared back office model. In addition, working in collaboration with other West Yorkshire providers we are implementing the mental health urgent care vanguard plans, with shared outcomes/multi-agency care planning specified as the basis of the new model.

- **Staff engagement:** We have continued to build our new programme of significant staff engagement including: join the conversation events with the Chief Executive/executive team; rolling programme of ET and NED visits to services to improve visibility; regular Chief Executive blog; monthly Trust Brief; quarterly leadership forums to engage with senior clinical and managerial leaders; and launched our new Trust intranet site. In addition, we also completed a refresh of our Trust strategy which includes the co-creation of a new vision, values, behaviours and five-year strategic goals and objectives.

- **Recruitment and retention:** We have developed and implemented a number of initiatives to support the retention of our workforce including: established an internal assessment centre process linked to our development and appraisal process; launched the manager essentials and Mary Seacole Training programmes; developed the nurse preceptee programme to track and support newly qualified nurses; and are delivering identified improvement measures associated with the equality and diversity framework. We have also completed a review of administrative support to clinical teams.

- **Promoting the Trust:** We have developed improved communication channels including: the launch of our internal Intranet site and our external website; established mechanisms for ensuring maximum media coverage via social media and e-marketing; and launched our new Trust member engagement campaign.

- **Information technology and estates:** We have initiated a number of developments which drive forward our IT delivery plans, including the completion of business cases to support the procurement of a new clinical information system and document management solution. We have also operationalised new processes for achieving timely response to general estate and facilities improvement works and have agreed revised arrangements with NHS Property Services for York premises and our PFI provider for Leeds premises.

- **Finance, Trust strategic direction, well-led review and Board of Directors:** On 30 March 2017 the Board of Directors ratified our new Trust strategy framework, we are now in the process of finalising our new Trust strategy document ready for ratification by the Board in June 2017. At the end of March 2017 we have achieved our control total surplus target of £3.05m and have successfully reviewed our risk management processes.

At the end of the fourth quarter we have assessed all schemes in order to report on those we know are amber or red. The details of the one-year schemes that are reporting as red at the end of quarter four are:

- **CQUINs and performance targets:**
  - **Maintain delivery targets:** At the end of quarter four we have not achieved some of our delivery targets. These include: access to memory services within 8 weeks and diagnosis within 12 weeks; seven day follow up; ethnicity recording; autism diagnosis within 26 weeks; number of people placed out of area; and flu vaccination of 75% of all staff. Remedial action plans are in place to address performance across these areas.
  - **Reduce reliance on out of area placements for long term rehab:** At the end of quarter four we have 9 people currently placed out of area from our locked rehab service. Work is nearing completion to scope out and identify a new pathway for how our locked rehab service is accessed and how discharge procedures are better aligned, with a number of agreed actions to aid the reduction of independent sector spend.

- **Key performance indicators:** The mental health clustering target has not been achieved. At the end of quarter four we are at 86.7% against a target of 95% for people in scope of mental health payments. On 1st April 2016 we committed to achieving a 10% increase on our 2015/16 performance, at the end of the fourth quarter we are -0.8% on the same position last year.

- **Trust strategy and functional strategy/plan development (schemes 1.6, 3.4, 4.1, 4.2.1, 4.5.3, 4.5.4):** A number of schemes have objectives for completion at the end of quarter four related to the approval and ratification of both the new Trust strategy and it's underpinning functional plans. Our new Trust strategy framework: vision, ambition, values, strategic goals and objectives have now been ratified, with the new Trust strategy document to be ratified by the Board of Directors at the June meeting. Consequently, the timescales for producing the underpinning functional strategies: Clinical Services Plan; Quality Plan; Workforce and OD Plan; Health Informatics Plan and Estates Plan will now be finalised by the end of quarter two 2017/18.

- **Strategic clinical service developments:**
  - **New model for older peoples services in Leeds**: Work is now underway at pace to implement a new community model for older peoples in Leeds. Project arrangements have been established, with the team working towards developing the detailed service specification, out of which will form the basis of our implementation plan. Our outline critical

path sees the new model being fully implemented by the third quarter of 2017/18 and is a key deliverable for our Clinical Plan.

- **New clinical service developments:**
  - **Tier 4 inpatient CAMHS & forensic services tenders:** Tender notifications have not yet been released for tier 4 inpatient CAMHS and forensic services. We are awaiting further details from NHS England and no timescales are known at this point.
  - **Future Trust input into Garrow House:** Modelling work is nearing completion to develop a new strategy including costing for the future of the tier 4 personality disorder service, ahead of any new commissioning intentions being released. To date we have received no further update on commissioner intentions for this service.

- **Information technology:**
  - **Digi pen rollout:** We have now extended the trial of twenty digi pens across some of our specialist areas for use and evaluation over the next 12 months. The outcome of this trial will be known in quarter four 2017/18.
  - **New mobile phone rollout:** There have been delays with the delivery of the new mobile phones from our suppliers. We have now taken delivery of 450 new phones, with the target to deploy all the phones by the end of April 2017.
  - **Public WIFI rollout:** There has been a delay to the rollout of public WIFI access across all appropriate sites. This is due to hardware availability issues which will be resolved fully for full deployment by the end of quarter two 2017/18.
  - **mHabitat:** Exploratory work concerning mHabitat becoming a subsidiary company has been undertaken. A revised business model is currently in progress with a separate delivery model new being considered. An update will be provided to the Finance and Business Committee in April 2017.

- **Finance and contracting:** Review of PFI funding arrangements: Exploratory work to review our PFI funding arrangements is underway. A full options appraisal will shortly be concluded and will be presented to the Executive Team in April. The outcome and proposed approach going forward will be agreed by the Board of Directors in June 2017.

- **Promoting the Trust and Board development:** Given the appointment of a new chair, this scheme has been put on hold pending a review of the board appraisal processes and including the board development plan.

- **Well-led review:** We have enlisted the support of Deloitte to complete a review of our governance processes which incorporates the well-led framework. Following conclusion of the review a full action plan will be created in-line with our CQC governance and delivery timescales.

At the end of quarter three the details of the two-year schemes that are reporting amber are:

- **CQC fundamental standards (appraisal and compulsory training):** We have agreed to reduce both the appraisal and compulsory training target threshold from 90% to 85% for overall achievement by the end of quarter one 2017/18. At the end of quarter four we are at 89% for compulsory training and 81% for appraisals. In addition, we have agreed that the 85% target must be achieved for each service area across the Trust.

- **Outcomes and mental health payments:** The Clinical Reported Outcome Measure (CROM) target has not been achieved. At the end of quarter four we are 65% against a target of 90% for people in and out of scope of mental health payments. Our REQOL (measure of health-related quality of life and recovery for people with mental health conditions) Patient Reported Outcome Measure pilot has been underway for 6 months. Initial feedback from staff and

service users has been positive and that the tool is easy to complete and helpful in informing care planning. In terms of the DEMQOL (measure of health-related quality of life for people with dementia) pilot, we have received mixed feedback from staff and service users and although further analysis is needed we are giving consideration to whether an experience measure would be more suitable for this client group.

- **Commissioner clinical service developments:**
  - **New primary care mental health initiative:** At the end of quarter four we have fully recruited six primary care liaison workers (two per CCG locality), with a positive impact shown. A comprehensive evaluation is underway with an initial longer term proposal set out, however it is not anticipated that the findings will be presented until the end of quarter three 2017/18, linked to the future longevity and funding for the service.
  - **Develop and implement a single point of access**: We have completed a feasibility study to implement a single point of access facility which includes IAPT, with the findings presented to our commissioners. To date our commissioners have agreed not to progress the integration proposal at this point, however have agreed that in partnership with Leeds Community Healthcare we should devise a new pathway for step 3 and 4 of the IAPT model with the proposal being presented to the commissioners in June 2017.
  - **New community service model:** We have now formalised a joint working relationship between ourselves and Adult Social Care (ASC) to look to generate a more efficient use of resources across the two organisations. Our aim is to develop a joint service model that defines our collective eligibility criteria, referral management, care planning and review, approach to crisis management and how we will support effective discharge back to primary care and/or third sector support. A memorandum of understanding between the two organisations alongside a proposed model document will be developed by the end of quarter one 2017/18.
  - **Liaison psychiatry model:** There have been delays to the implementation of a new all-age liaison psychiatry model, as we are still in discussions with commissioners concerning funding allocation on a recurrent/non-recurrent basis. Discussions are ongoing to resolve the issue and we remain positive that a satisfactory outcome can be reached.

- **Local strategic developments and partnerships (place-based plans):**
  - **Place-based plan for Leeds and WYSTP:** Although changing structures within the city are starting to take shape, clarity around the transformational structure to implement both the Leeds based Plan and West Yorkshire STP and future service configurations are still in an infancy stage affecting our ability to assess our input and role within that.

- **Regional/specialist strategic developments and partnerships:**
  - **New approach to partnership working:** We set a target to have a memorandum of understanding in place across providers to support partnership working related to forensic services and our child and adolescent mental health service. Development of the memorandum of understanding has begun but not yet finalised. We are working collaboratively with Leeds Community Healthcare related to CAMHS work in the run up to commissioner clarity regarding specification and procurement. In terms of forensic services, work around this is currently being delivered via the STP partnership group.

- **Recruitment and retention:**
  - **Significantly reduce vacancies:** Extensive work has been undertaken to implement different approaches to recruitment and selection that go some way to reducing the number of vacancies in some areas, however due to continued staff turnover this does not reflect an overall reduction in vacancies across the Trust. At the end of quarter four we have now established monthly selection and assessment centres for nurses and health support worker roles, with drop in events taking place during April to galvanise staff feedback on the current process. In addition, we are also finalising our plans to hold a selection assessment centre for allied health professional roles.

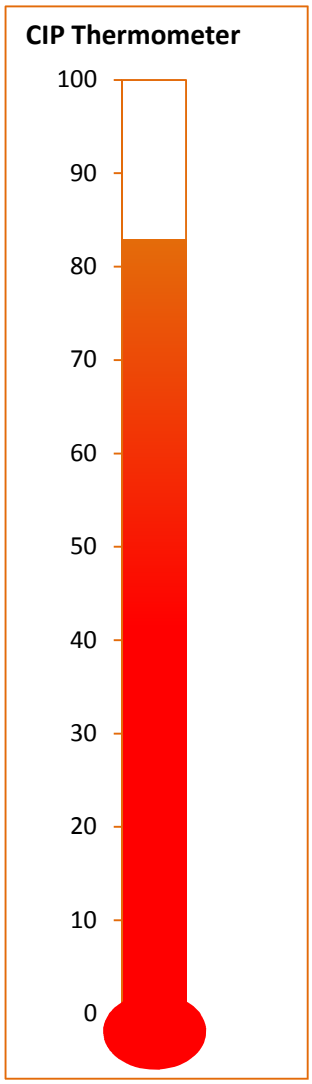
- **Workforce planning:** There have been delays in staff accessing the Calderdale Framework training for facilitators and therefore identifying project areas for completion. Training has now been completed and key projects are underway led by the trained staff.

3. Delivery of our 2016/17 Cost Improvement Plans

Major cost improvement plans (CIPs) identified as part of our Operational Plan are managed as formal programmes or projects and adhere to MSP/PRINCE2 methodology. All our CIPs for 2016/17 have been quality and delivery impact assessed, with the CIP proforma being completed for each individual scheme.

The Trust has adopted a robust approach to developing 2016/17 cost improvement plans, taking into account 2% (£2.7m) national efficiency assumptions. As at quarter four, we have achieved £2.1m in 2016/17. The full year recurrent impact of the achieved cost improvement programme is £2.3m, £0.2m below the quarter four target.

Whilst we have achieved the vast majority of our programme there have been delays with the implementation of the learning disability and liaison psychiatry skill mixes and the review of our locked rehab pathway which have impacted on the overall position. The skill mix schemes have transferred across to the 2017/18 plan, with definitive delivery timescales to be agreed.



4. 2016/17 Operational Plan risks and Strategic Risks

At the end of quarter four there are three new risks recorded on the electronic Strategic Risk Register. These relate to the problems of staff recruitment at Clifton House (scored as 'extreme'), the impact of Brexit on regulations which will have a negative impact on the Trust (score as 'high'), and the failure to meet the deadlines notified to the CQC on the implementation of agreed procedures/systems (scored as 'high'). All risks are monitored routinely via the individual project group meetings and the Executive Team on a monthly basis.

The Trust's Strategic Risk Register is provided at **appendix 2** and includes a number of high risk items with three current extreme risks related to delayed transfers of care, high level of vacancies

in Care Services and estate not under the direct ownership/control of the Trust. It also includes the new risk related to staff recruitment as detailed above.

5. Recommendation

Members of the Board of Directors are asked to note the progress made against our Operational Plan priorities at the end of quarter four 2016/17; and confirm that they are assured of progress being made to address areas for improvement.

APPENDIX 1 – OPERATIONAL PLAN PROGRESS DASHBOARD AT Q4 2016/17

Operational Plan scheme dashboard		✓	Objective completed
			Objective suspended
1.1	**CQC fundamental standards**		
1.1.1	Prepare for a full comprehensive CQC Inspection		
1.1.2	Ensure deliver of CQC action plan, including appraisal and compulsory training targets*		
1.1.3	Support staff to demonstrate compliance with CQC fundamental standards and compliance through Quality Reviews		
1.2	**CQUINs and performance targets**		
1.2.1	Maintain delivery of targets; achieve new CQUINs		
1.2.2	CQUIN: Development of an MOU and integrated mental health pathways for clusters 4 - 17	✓	
1.2.3	Significantly reduce reliance on out of area placements for long term rehabilitation		
1.2.4	Implement smoke-free services from 4 April, 2016 *		
1.3	**Key performance indicators**		
1.4	**Outcomes and mental health payments**		
1.4	Recovery, Care Pathways and Outcomes *		
1.5	**Mental Health legislation**		
1.6	**Strategic clinical service developments**		
1.6.1	Develop clear clinical services strategy to inform estates strategy		
1.6.2	Continue development of recovery-focused services		
1.6.3	Implement a prototype Recovery College with partners		
1.6.4	Complete review of learning disability services and implement changes agreed with commissioners		
1.6.5	Agree and finalise implementation plan for an integrated, system-wide model for older people's services		
1.6.6	Implemented governance and programme management arrangements for service development programme		
1.7	**New clinical service developments (CFS)**		
1.7.1	Increase capacity in gender identity services to reduce RTT waits in line with agreed trajectory		
1.7.2	Rebrand CFS/ME service to improve access		
1.7.3	Tender for Tier 4 inpatient CAMHs		
1.7.4	Tender for forensic services		
1.7.5	Agree future of Trust input to Garrow House, personality disorder service and develop strategy for PD model		
1.7.6	Implement in-house extended pharmacy service for 7 days, in house on call 24/7 service	✓	
1.8	**Commissioner clinical service developments**		
1.8.1	Implement and evaluate a new primary care mental health initiative		
1.8.2	Develop and implement single point of access and assessment, to include IAPT		
1.8.3	Develop plans and processes to develop new community service model, SPA and assessment, longer term rehab out of area placements		
1.8.4	Reduce acute inpatient oats		
1.8.5	Implement the new urgent/emergency/crisis care model with commissioner plans and MH Urgent care Vanguard		
1.8.6	Implement new all-age liaison psychiatry model following service review		
1.9	**Performance reporting and management**		
1.10	**Research and evaluation**		
1.10.1	Agree and implement evaluation framework for service developments		
1.10.2	Develop nurse and AHP research training opportunities and joint clinical/research posts		
1.10.3	Continue engagement in Yorkshire & Humber CLAHRC research capacity building initiative		
2.1	**Local strategic developments and partnerships (place-based plans)**		
2.1.1	Fully participate in the development of place-based plan for Leeds and West Yorkshire sustainability and Transformation Plan		
2.1.2	Develop and implement new models of care prototypes with Leeds West, South & East and North CCG		
2.1.3	Develop and refocus the PMO to provide more strategic support to internal and external initiatives		
2.1.4	Explore delivery of shared back office functions with Leeds Community Healthcare and other partners		
2.1.5	Work with partners to agree best community based services provider model to deliver new models of care		
2.1.6	To further develop partnerships with local education and training providers		
2.2	**Regional specialist strategic developments and partnerships (MoU)**		

Operational Plan scheme dashboard		✓	Objective completed
			Objective suspended
2.2.1	Implement MH Urgent Care Vanguard plans with other West Yorkshire providers		
2.2.2	Agree approach to partnership working with other providers		
2.3	**Partnership initiatives**		
3.1	**Staff engagement**		
3.1.1	Continue new programme of staff engagement		
3.1.2	Launch Strategy refresh using crowdsourcing for engagement		
3.1.3	Launch new staff intranet *		
3.2	**Recruitment and retention**		
3.2.1	Significantly reduce vacancies through different approaches to recruitment*		
3.2.2	Implement recommendations from review of administration support to clinical teams to retain staff		
3.2.3	Develop and implement plans for improved retention, career development framework		
3.2.4	Implement plans to ensure we have a workforce that reflects the diversity of the population we serve		
3.3	**Workforce planning (planning models)**		
3.4	**Organisational development**		
4.1	**Clinical services strategy**		
4.2	**Promoting the Trust (market test)**		
4.2.1	Building on the outcome of the stakeholder survey, develop different approaches to communicate with key stakeholders		
4.2.2	Agree plans in response to 360 degree survey of key stakeholders to benchmark reputation and perceptions		
4.2.3	Develop improved communications channels, including staff intranet and public website as well as social media and e-marketing channels		
4.2.4	Ensure maximum media coverage of Trust member engagement campaign, positive news stories and awards		
4.2.5	Pilot external media monitoring and evaluation service and assess impact		
4.2.6	Launch new Trust member engagement campaign	✓	
4.3	**Business development**		
4.4	**Information technology (WIFI)**		
4.4.1	Procure new clinical information system		
4.4.2	Ensure public WIFI access across all appropriate sites across the City		
4.4.3	Pilot and rollout new technology solutions to reduce burden on clinical staff		
4.4.4	Develop digital strategy to improve outcomes for service users*		
4.4.5	Procure a document management system		
4.4.6	Procure a new contract and deploy smart phones for staff Trustwide		
4.4.7	Develop delivery vehicle for mHabitat		
4.5	**Estates**		
4.5.1	Implement new process for achieving timely response to requirements for estates and facilities improvement works and monitor delivery		
4.5.2	Agree revised arrangements with NHS Property Services for York premises and PFT provider for Leeds premises		
4.5.3	Agree estates strategy by end of Q3 that better reflects use of space, mobile working and involves staff in discussions		
4.5.4	Implement estates strategy including development and agreement of business cases		
4.6	**Finance and contracting**		
4.6.1	Deliver agreed control total for 2016/17.		
4.6.2	Deliver CIPs for 2016/17, including procurement savings		
4.6.3	Review PFI funding arrangements		
5.1	**Trust strategic direction**		
5.2	**Well-led Review and Board of Directors**		
5.2.1	Complete well-led review by April 2016 and implement recommendations		
5.2.2	Agree and implement Board Development Plan		
5.2.3	Review risk management processes and implement required improvements		
5.3	**Reporting and performance framework**		

APPENDIX 2 – STRATEGIC RISK REGISTER PROGRESS AT Q4 2016/17

Strategic risk register 31/03/17

ID	Care Group	Handler	Latest Review date	Description	Risk level (initial)	Controls in place	Risk level (Current)	Action	Action due date	Action completed date	Risk level (Target)
3	Finance - Corporate	Brewin, David	15/02/2017	Potential inability to maintain a strong financial position in context of - increasing demand (and a largely fixed block contract, with out of area responsibility being soley with the Trust) - uncertainty of potential tender processes(mainly specialist services) - commissioner and local authority funding positions and wider system pressures, requiring Trust to potentially absord unfunded service developments. - capability to deliver further on going efficiencies. All of the above could impact on the on-going financial performance of the Trust.	Extreme Risk	Good working relationships established with commissioners Commissioning activity around new and existing business is monitored through the Clinical Income Management Group (CIMG): attended by Chief Financial Officer, Chief Operating Officer and Director of Nursing, Professions and Quality. Oversight by Finance and Business Committee: in relation to financial and clinical impact of tenders, in the context of the overall sustainability of the organisation. Tender opportunities will be reviewed by CIMG 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) Partnership working arrangements in Leeds, 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) Cost Improvement plans developed to be robust and subject to clinical impact assessment. Contingency reserve held centrally to mitigate against financial	High Risk	Work stream to design and agree with commissioners a reporting framework to demonstrate quality and outcomes, incorporating mental health cluster profile reporting, linked to changing funding mechanism in 17/18	31/03/2017		Moderate Risk
								Longer term savings plans to be developed and agreed (as part of wider system planning through Sustainability and Transformation plan).	31/03/2017		
								Work-stream to address variation in bed occupancy and length of stay to mitigate out of area risks	31/03/2017		
								Developing risk share arrangements with commissioners to manage demand. Risk share managed via contractual mid-year review condition.	30/04/2016	24/06/2016	
								Develop service line management and detailed benchmarking analysis to understand cost profile of services to inform financial strategy	31/03/2017		

ID	Care Group	Handler	Latest Review date	Description	Risk level (initial)	Controls in place	Risk level (Current)	Action	Action due date	Action completed date	Risk level (Target)
						pressures, and robust approvals process to access funding Senior management involvement in the development of realistic and achievable CQUINs and KPIs. Growth Strategy developed to provide a basis for assessing growth opportunities. Robust budgetary control framework and budget holder training in place Financial modelling and forward forecasting in place to identify risks early					
5	Workforce Development	Jensen, Lindsay	15/02/2017	Requirement for new skills in the workforce to support new models and also lack of staff engagement and involvement in the new models.	High Risk	Staff are involved and consulted about potential service redesign schemes. Organisational Development staff support strategic improvement and employee engagement in the development of changes to services. Training needs analysis is undertaken for all new service developments and there is investment in training where required. Assistant Director of Nursing posts focus sing	High Risk	Funding is being sought to improve specialist clinical skills in Community teams	16/10/2016		Moderate Risk
								Vocational skills programme for bands 1-4 including care certificate for unqualified health support workers. The new Apprenticeship Plan will contribute to the development of support workers	06/10/2016	08/03/2016	

ID	Care Group	Handler	Latest Review date	Description	Risk level (initial)	Controls in place	Risk level (Current)	Action	Action due date	Action completed date	Risk level (Target)
						on nursing development. Development and implementation of new skills and new roles in partnership with Skills for Health for bands 1-4. Close partnership with the Universities to support research and new models of care. Well established coaching scheme to support individuals. Dedicated Continuous Improvement (CI) team in care services. Using staff data to improve engagement, e.g. Staff Survey, Family and Friends test. Training Needs identified through personal development plans. Review of OD cohort to support innovation and change. Delivery of appropriate Leadership and Management interventions/development programmes aligned to specific change requirements. Continued dialogue with HEE about new roles and skills requirements Working in collaboration with partners across Leeds on City Wide transformation Project		Workforce Directorate supporting CI Leads to identify impact of change on workforce and to design appropriate interventions to manage consequence. Skill gap analysis to be included as reviews and changes occur. This has not occurred due to development of Clinical Strategy and waiting for Calderdale Framework Training and Redesign projects to commence.	31/12/2016	14/12/2016	
								Review of job descriptions to ensure skill requirements are fully reflected and updated following any redesign of service	31/12/2016		
								Funding received to train staff to deliver the Calderdale Framework a workforce planning tool from May 2016 to develop workforce planning and re-design skills to support new models of care. Training for 10 Facilitators was delayed and took place in January 2017.	30/11/2016		
								Use of crowd sourcing technology to improve staff engagement and communication to support changes programmes	31/12/2016	14/12/2016	

ID	Care Group	Handler	Latest Review date	Description	Risk level (initial)	Controls in place	Risk level (Current)	Action	Action due date	Action completed date	Risk level (Target)
								New models of care will rely more on the use of technology and mobile technology to ensure smarter and agile working to increase patient contacts and outcomes. Staff need to be trained and supported to use these technologies taking account of learning styles and organisational demographics.	31/03/2017		
9	Facilities (Finance)	Furness, David	10/03/2017	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)	Extreme Risk	Appropriately trained staff managing risks clinically. Health and safety inspections. Ligature anchor point audits supported by risk assessments Operational estate group overseeing risk assessments to determine works required. Responsive maintenance process managed by monthly meetings with third party suppliers Site management escalation to third party supplier suitability for admission. Formal partnership working with PFI partners Working arrangements with NHS Property Services Ltd, improving but under review due to further organisational restructure.	Extreme Risk	SLA with NHSPS to be finalised	28/02/2017		Moderate Risk
								Lease with NHS PS (including their third party maintenance supplier MITIE) to be signed by 31/03/2017 subject to legal challenge.	31/03/2017		
								Group to review ALL processes linked to reactive and planned maintenance including ligature assessment process, and change request process to determine best practice document lean approach and embed - all to be delivered by 30th June 2016	30/06/2016	15/02/2017	
								New robust lease arrangements to be negotiated with NHSPS and their third party maintenance supplier MITIE.	30/04/2016	15/02/2017	
								Negotiate change/improvements to contract with Equitix , including market testing of elements of service Action amended Senior Management Group 15/02/17:- Financial modelling for options to be reported back.	28/02/2017		

ID	Care Group	Handler	Latest Review date	Description	Risk level (initial)	Controls in place	Risk level (Current)	Action	Action due date	Action completed date	Risk level (Target)
58	Clinical Services (for Risk Management Dept use Only)	Parkinson, Lynn	20/03/2017	High number of vacancies in Care Services (Clinical staff)	Extreme Risk	The ability to use bank and agency staff. Detailed recruitment plan supported by Executive Team (ET). ET have approved extra resources - achieving recruitment plan Care Groups also have this risk identified on their register. Care Services Strategic Management Group (CSSMG)will receive regular updates on actions. Recruitment events have taken place and staff have been recruited, risk still remains within Community, Forensic and CAMHS services.	Extreme Risk	Recruitment group to review current process of recruitment and consider also holding bespoke recruitment for particular areas.	30/06/2017		High Risk
								Hot spots identified in relation to recruitment and bespoke recruitment plans to be developed for the individual areas. This will be monitored by the Recruitment Steering Group.	31/03/2017		
								Review of current retention of staff and development of plan to increase retention of staff. this will be monitored by the Recruitment Steering Group	31/03/2017		
								Leeds care group to ensure this is included on their risk register	16/09/2015	03/03/2016	
								York care group to ensure this is included on their risk register	16/09/2015	03/03/2016	
								Specialist and Learning Disability services to ensure this is included on their risk register	16/09/2015	13/07/2016	
105	Health Informatics Services (Finance)	Fawcett, Bill	17/03/2017	The danger of a cyber-attack to the Trust's ICT infrastructure through malicious hacking or system virus infection.	High Risk	The ICT infrastructure has firewalls, virus protection software and e-mail protection systems that are continually updated to prevent attack. A working	High Risk	Security Policy to be created and approved at the Finance and Business Committee and published on the Intranet.	04/08/2016	04/08/2016	Moderate Risk

ID	Care Group	Handler	Latest Review date	Description	Risk level (initial)	Controls in place	Risk level (Current)	Action	Action due date	Action completed date	Risk level (Target)
						programme to improve our awareness and response to threats is in progress.		Bases on the work conducted by BT in 2016 create and deploy a programme to address the primary areas of weakness in the Trust's technology defenses with and penetration test of our systems to be conducted at the end of the financial year 2016-17 A full security audit was completed in February 2017 and significant assurance was given to the Trust. A new set of actions has now been agreed that have a completion date of 29th December 17	29/12/2017		
								CIO leading a review of current systems and processes with Head of Networks, Head of Service Delivery and Head of IG using a template provided by BT. Output will be a targeted action plan focused on areas of highest risk to a Cyber-attack.	03/06/2016	05/08/2016	
128	Finance - Corporate	Hanwell, Dawn	09/03/2017	The use of estate is constrained by lack of clear clinical strategy for some services, potential tender changes/risks and lack of commissioner strategy/intent. (main services affected are Leaning Disability, Forensic CAMHS, Perinatal, Personality Disorder, Yorkshire Centre for Psychological Medicine).This is impacting the development of long term estate strategy and business cases for key changes required.	High Risk	A number of business cases are already in development Commissioner discussions progressing specifically with regard to LD Partnership arrangements being developed re CAHMS with LCH	High Risk	Work on going in care services to define and agree clinical priorities aligned to commissioner intent, workshop to agree with Board of Directors	30/09/2016		Moderate Risk
								Work on going working with care services to refresh estate strategy linked to emerging clinical priorities	31/10/2016		

ID	Care Group	Handler	Latest Review date	Description	Risk level (initial)	Controls in place	Risk level (Current)	Action	Action due date	Action completed date	Risk level (Target)
156	Workforce Development	Third, Joanne	19/03/2017	The Trust has a ratified Compulsory Training Procedure and a Trust Board KPI of achieving 85% compliance against all compulsory training specified in this procedure. This Trust was not achieving this KPI in 2010 and significant effort went in to improving organisational performance in the subsequent years as this was rated as an extreme risk. The Trust is now achieving this KPI and has been since October 2016.	Extreme Risk	- A ratified Compulsory Training Procedure is in place that articulates the required training for every role in the Trust - A compulsory training programme is in place with sufficient training for all staff to be trained and remain in date and compliant - Compulsory training is recorded centrally and is performance reported at a Trust, Care Group, Service Area and Individual levels through ILearn	Moderate Risk	Current coverage at Service Area level is not 100% across all services - to be reviewed and 100% coverage to be achieved using automated 2 weekly iLearn reports	31/05/2016	14/07/2016	Moderate Risk
								Reporting at Departmental level is not in place - coverage to be achieved using automated 2 weekly iLearn reports to assist in local departments managing compliance	01/06/2016	14/07/2016	
								Reporting at Manager level is through iLearn Manager Self Service - the data needs to be pushed out to managers in 2 weekly iLearn reports	30/06/2016	08/08/2016	
								Bank staff compliance to be driven up to the same standard as substantive through introduction of payment, and restriction to shifts using E-Roster as the gateway for staff not trained	01/09/2017		
								Ensuring all staff can access iLearn has been reviewed several times - currently circa 2300 of 3000 staff have used iLearn in the first 6 months - review and prompt users yet to log in and assist in ensuring all staff have a registered email	30/06/2016	08/08/2016	
								A number of Block Compulsory Training Events were delivered in 2015/16 Q4 - the efficiency was poor with low uptake of places as a percentage - modifications to be made an further to be scheduled for inpatient services staff	01/09/2017		

ID	Care Group	Handler	Latest Review date	Description	Risk level (initial)	Controls in place	Risk level (Current)	Action	Action due date	Action completed date	Risk level (Target)
								Care Groups to identify and address areas below 85% compliance with Learning and OD support where specific interventions needed so all areas are 85% or above	30/06/2017		
								Care Groups to identify and address areas below 85% compliance with Learning and OD support where specific interventions needed so all areas are 85% or above	30/06/2017		
								Identify areas of training below 85% at an organisational level and ensure sufficient and appropriate provision to achieve 85%	30/06/2017		
488	Specialist Services	Dilks, Steven	14/03/2017	There have been problems with recruiting and retaining staff at the unit. Staff working within Clifton House may suffer from further stress/ pressure due to lack of staff available to assist. Activities/ therapies within the unit maybe limited due to reduced staffing.	Extreme Risk	Reviewed regularly with the service and Care Group, steering group set up to manage the recruitment of staff, oversee the reconfiguration of the unit as needed. Discussed and reviewed by the Chief Operating Officer Reviewed and discussed by the Executive Team Independent review commissioned	Extreme Risk	High profile recruitment campaign. Skill mix Review. Review of terms and conditions to look at possible incentives	30/04/2017		Low Risk
								The OD team are providing team coaching sessions into the wards to support improved cultures and team working. A focus on how to develop a positive environment for new starters but how to manage feelings and stressors in a difficult work climate	01/05/2017		

ID	Care Group	Handler	Latest Review date	Description	Risk level (initial)	Controls in place	Risk level (Current)	Action	Action due date	Action completed date	Risk level (Target)
								The service has already commenced a recruitment drive. We have a number of planned interviews in the coming weeks and have advertised a generic MH practitioner role to work in to the wards to ensure qualified MH registered staff are working alongside nursing.	31/05/2017		
491	Chief Executives office - Corporate	Munro, Sara	22/02/2017	Changes in regulation brought about by Brexit will have a negative impact on the Trust.	High Risk	There is currently a watching brief by Executive Directors on the progression of changes in legislation.	High Risk	There is a watching brief on the outcome of any changes to legislation as the Brexit negotiations progress. This will be carried out by the Chief Executive, Executive Directors and Head of Corporate Governance. The Chief Executive will assess the point at which a working group is formed to look at specific changes and their impact as they unfold and will also ensure there is sufficient ED scrutiny of the likely impact and any related actions that need to be taken.	22/08/2017		Low Risk

ID	Care Group	Handler	Latest Review date	Description	Risk level (initial)	Controls in place	Risk level (Current)	Action	Action due date	Action completed date	Risk level (Target)
540	Professions and Quality - Corporate	Deery, Anthony	20/03/2017	Failure to meet deadlines for implementation of agreed procedures/systems and improvements for all regulatory requirements and must do's and should do's notified to CQC	High Risk	Action Plan has been developed and is being actively followed up. CQC fundamental standards group comprising of Executive Directors who monitor actions. Actions are monitored by a bespoke action tracker overseen by CQC fundamental standards group. This tracker requires action owners to update evidence to confirm they have completed the actions. Director of Nursing has monthly engagement meetings with the CQC to update regarding progress against the action tracker.	High Risk	Action Plan has been developed and is being actively followed up. CQC fundamental standards group comprising of Executive Directors who monitor actions. Actions are monitored by a bespoke action tracker overseen by CQC fundamental standards group. This tracker requires action owners to update evidence to confirm they have completed the actions.	01/09/2017		Moderate Risk

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

11

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Medical Director's report
DATE OF MEETING:	27 April 2017
LEAD DIRECTOR: (name and title)	Claire Kenwood, Medical Director
PAPER AUTHOR: (name and title)	Claire Kenwood, Medical Director

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)

Quality	✓	Strategic		Governance		Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	We work with service users and carers to support their achievement of outcomes and wellbeing	✓
G2	We are an employer of choice with a compassionate and highly trained workforce committed and supported to provide excellent innovative care and support	✓
G3	We work with others to improve health and improve lives through effective, innovative and sustainable partnerships	✓
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	✓
SO2	We provide a dynamic, rewarding and supportive place to work	✓
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	✓
SO4	We are transparent and accountable to the people and partners we work with	✓
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	✓

STATUS OF PAPER (please tick relevant box/s)		✓
To be taken in the public session (Part A)		✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:		
Legal advice relating to legal proceedings (actual or possible)		
Negotiations in respect of employee relations where they are of a confidential nature		
Procurement processes and contract negotiations		
Information relating to identifiable individuals or groups of individuals		
Other – not yet a public document		
Matters exempt under the Freedom of Information Act (quote section number)		

Leeds and York Partnership NHS
NHS Foundation Trust

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	This report provides an account of the activities and initial plans of the Medical Director.
What are the key points and key issues the Board needs to focus on	• Induction visits and activities • Clinical Governance structures • Medical Directorate stock-take and planning meetings • Mortality review across the system
What is the Board being asked to consider	This paper is being presented for information
What is the impact on the quality of care	• Early priorities will set direction and signal a clear focus on quality
What are the benefits and risks for the Trust	
What are the resource implications	
Next steps following this paper being presented to the Board	
What are the reputational implications and how will these be addressed	None
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No
What public / service user / staff / governor involvement has there been	None
Previous meetings where this report has been considered (including date)	None

RECOMMENDATION (This report is being provided to the Board for) (please tick relevant box/s): ✓

Leeds and York Partnership NHS
NHS Foundation Trust

Assurance		Discussion		Decision		Information only	✓

Provide details of what you want the Board to do:

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

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Medical Director's report April 2017

The purpose of this report is to brief the board on my activities and initial priorities in my first six weeks in post as Medical Director. During this period I have:

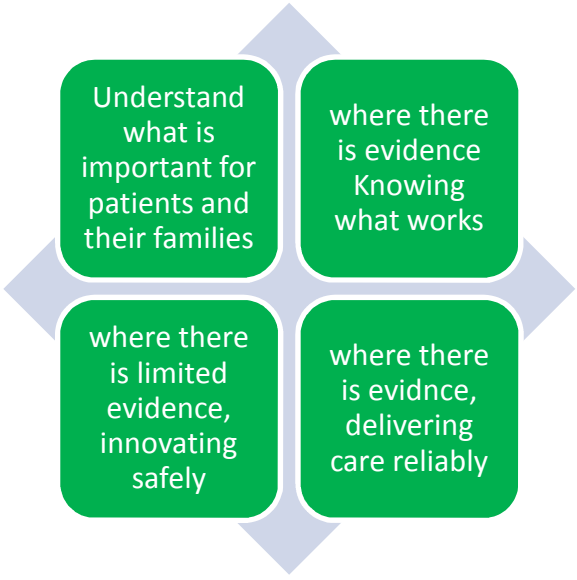
- Visited a number of key sites. These include the Becklin Centre, the Mount, St Mary's House, St Mary's hospital, Aire Court and Millfield House.
- Met with a number of staff from varied clinical services. These have included CMHT, ICS, Inpatient services and Crisis Assessment, Older People service, Rehabilitation and Recovery, Liaison and Learning Disabilities).
- Met with staff in essential support services (Safeguarding, Professional leads, Information Governance, Corporate Governance, R&D, Audit, Pharmacy, Medical Education, Medical Appraisal and Revalidation, Library Services).
- Made external links with colleagues in a range of organisations including fellow Medical Directors in mental health (SWYFT, BDCT, upcoming NTW, TEWV, CPFT Medical Directors peer group) and acute care colleagues (LTHT) and also public health, commissioners and the STP leadership group.
- I have taken up both the role of Responsible Office and Caldicott Guardian. This has included appropriate local induction and the required national mandated training has been arranged to support these roles

More broadly I have met with all executive and non-executive colleagues, and have experienced ¾ of a cycle of corporate meetings.

This report highlights a number of areas which I intend to prioritise. These include:

Effective care meeting and the clinical governance structures

Following a Senior Management Group decision a collaborative redesign of the effective care and associated meetings will be undertaken. This will be an iterative process commencing at the meeting on the 4th May. We will adopt a Harvard model of *care at the frontline* which prioritises a frontline focus.



A key agenda item at the first meeting will be to discuss the existing meetings and clinical governance structures to ensure that they are clearly defined and that these are further developed to support frontline quality. I have also circulated the January 2017 IHI paper on safe, reliable and effective care. This is intended to inform the leadership and to support effective cultures for quality and learning.

The link to the IHI paper is here:

http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Safe-Reliable-Effective-Care.aspx

Medical Directorate stock-taking and planning meetings

I am in the process of exploring and understanding the medical directorate's structure, functions and processes. One key objective is to allow me to develop my understanding as rapidly as possible. There is also a sense in my current discussions with staff that a visible process of stock-taking and direction setting would be welcome. My work in this area to date has included informally assessing:

- The work of the Andrew Sims Centre.
- The R&D strategy, resourcing and connections with academic institutions.
- The place and contribution of Clinical Audit within an integrated improvement support function.
- Medical staffing processes; we have started with a focus on recruitment and the support of new recruits.
- Clinical leadership and engagement

Mortality reviews

Alongside the Director of Quality and Nursing, I am supporting the process of mortality reviews. To achieve this we are working with local mental health trusts and also within the 'Northern Alliance' group (Yorkshire and Humber and the North East and Cumbria). We are working to ensure that we have shared understanding of the scope of deaths to be included and also the reliability and value of the methods currently available to review them. We are both aware and reflective of the danger that one of the central items of learning from the Southern Health Review, the importance of support for and listening to families, is not lost in the more technical aspects of required action.

Other areas of note

- My first impressions of the Trust include an overwhelming sense of the national profile and the committed and professional clinicians of all backgrounds and I will continue to work to understand how we can strengthen the clinical elements of the collective leadership within the Trust.
- Significant work has clearly been done to ensure that two of the high risk areas nationally – controlling locum costs and ensuring safe working hours for junior doctors – are well understood and developed.
- I have had early meetings to develop my links with Quality Improvement forums locally and will maintain a connection with the Q initiative

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

12

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Guardian of Safe Working Annual Report: April 2016 to March 2017
DATE OF MEETING:	27 April 2017
LEAD DIRECTOR: (name and title)	Dr Claire Kenwood, Medical Director
PAPER AUTHOR: (name and title)	Dr Elizabeth Cashman, Guardian of Safe Working Hours

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)							
Quality	✓	Strategic		Governance	✓	Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	We work with service users and carers to support their achievement of outcomes and wellbeing	
G2	We are an employer of choice with a compassionate and highly trained workforce committed and supported to provide excellent innovative care and support	✓
G3	We work with others to improve health and improve lives through effective, innovative and sustainable partnerships	
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	
SO2	We provide a dynamic, rewarding and supportive place to work	✓
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	
SO4	We are transparent and accountable to the people and partners we work with	✓
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	

STATUS OF PAPER (please tick relevant box/s)	✓
To be taken in the public session (Part A)	✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:	
Legal advice relating to legal proceedings (actual or possible)	
Negotiations in respect of employee relations where they are of a confidential nature	
Procurement processes and contract negotiations	
Information relating to identifiable individuals or groups of individuals	
Other – not yet a public document	
Matters exempt under the Freedom of Information Act (quote section number)	

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	To provide the first annual report since the introduction of the Guardian of Safe Working as part of the Terms and Conditions for 2016 (TCS) Junior Doctors Contract and implementation. To provide an overview and assurance of the Trust's compliance with safe working hours for doctors across the Trust and to highlight and detail any areas of concern.
What are the key points and key issues the Board needs to focus on	The key points to note are: • The 2016 Junior Doctor contract was been implemented within the Trust on the 1st February. There are 79 junior doctors currently working under the contract. • The Trust has taken a number of steps to ensure compliance with the requirement of the terms and conditions of the contract. • There are 12 CT and 5HT vacancies and 5 Trust doctors have been recruited to provide temporary CT cover. • Nationally psychiatric recruitment has been a long term shortage specialty. Recruitment to the Core Training scheme is on the Trust's risk register as full recruitment is not expected to be achieved for August 2017. • From 1 February to 31 March there were 38 gaps on the CT rota and 25 gaps on the HT rota. • Rota gaps have been filled with internal locums with the exception of 5 shifts that external locum cover was booked and 5 shifts that ran with a reduced number of doctors. • To date there have been no exception reports raised. • The lack of exception reports may be in relation to awareness of the need to complete these as historically junior doctors and clinical supervisors have agreed recompense for additional hours worked without the use of a formal structure. • Future work will be aimed at engaging junior doctors and clinical supervisors with the exception report process.
What is the Board being asked to consider	The Board of Directors are asked to consider: 1. That this report provides an assurance level for the systems in place to support the working arrangements of the 2016 TCS for the junior doctors working in the Trust and that they are meeting their objective of maintaining safe services

	2. Providing constructive challenge where improvement could be identified within this new system
What is the impact on the quality of care	Junior doctors are working safe hours to provide safe patient care.
What are the benefits and risks for the Trust	The benefit of compliance with the 2016 TCS is that the junior doctors are working within the TCS of the new contract to provide safe patient care. The risk of not doing so is junior doctors work excessive hours leading to unsafe working, costs increase through additional payments and fines in an unplanned way and quality of care to patients deteriorates.
What are the resource implications	Financial penalties will be applied if junior doctors breach the working hours outlined in the TCS.
Next steps following this paper being presented to the Board	Feedback from the Board will be used to inform future work planned.
What are the reputational implications and how will these be addressed	There are no reputational implications to be addressed.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No. The TCS has the potential to impact due to annual pay progression being by competency achievement rather than previous annual increment. This could affect females more than males as it may affect doctors who have extended absences or work part-time e.g. maternity leave. The Director of Medical Education has agreed to be champion of less than full-time working to mitigate this.
What public / service user / staff / governor involvement has there been	There has been no public, service user or governor involvement in the completion if this report. Junior doctor representatives and managers with responsibilities for junior doctors and medical education have been involved in the implementation and monitoring of the TCS.
Previous meetings where this report has been considered (including date)	The report content was discussed at the Junior Doctor Forum on the 7 April 2017.

Leeds and York Partnership NHS
NHS Foundation Trust

RECOMMENDATION (This report is being provided to the Board for) (please tick relevant box/s): ✓							
Assurance	✓	**Discussion**		**Decision**		**Information only**	

Provide details of what you want the Board to do:

The Board is asked to:

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

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Leeds and York Partnership NHS
NHS Foundation Trust

GUARDIAN OF SAFE WORKING ANNUAL REPORT
April 2016 to March 2017

1. Executive summary

On 1st February 2017 Leeds and York Partnership Foundation Trust (LYPFT) transitioned all the junior doctors from CT1 to ST7 onto the 2016 junior doctor contract. In line with the terms and conditions a number of steps to ensure that the rotas are compliant and that the junior doctors are working in a way that is safe and fair have been taken.

This report provides a summary of the work completed to implement the 2016 junior doctors contract.

There are a number of vacancies within both the CT1-3 and ST4-7 and these produce a number of vacant out of hours shifts. The majority of these have been filled using internal locums. There is a plan in place to address recruitment and retention of junior doctors.

So far there have been no exception reports. We expect that this is related to the redesign of the rotas to meet the junior doctors contract. In addition junior doctors and clinical supervisors have been ensuring that additional hours worked and unmet training needs were addressed in a timely manner prior to the initiation of the exception reporting system.

The next steps are to ensure that all junior doctors and clinical supervisors are familiar with the processes in place and are using them effectively. A quality improvement approach is planned to incorporate learning from the actual working of the contract.

2. Introduction

The purpose of this first 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 will include the data from 1.2.17 to 31.3.17 on:

- exception reports

- work schedule reviews
- staff vacancies and locum usage

In addition it will provide data on the previous monitoring system in place prior to the implementation of 2016 TCS reporting data available from 1.8.16 to 31.1.17

3. Background

Health Education England funds 86 whole time equivalent doctors in training posts via the medical tariff. Less than full time trainees can be allocated to Trusts on a supernumerary basis i.e. additional to the agreed training scheme posts. LYPFT has 6 less than full time (LTFT) supernumerary doctors in training to work within the Trust at present. The current head count of doctors in training working in the Trust on 2016 TCS is 79.

The number of junior doctors reported on within this report will be less than the funded and filled posts because each Trust is required to report to their respective Trust Board.

LYPFT is lead employer for the Leeds and Wakefield Psychiatry core training scheme. The two hosting Trusts within this scheme are South West Yorkshire Partnerships Foundation Trust (SWYPFT) and Leeds Community Health Trust (LCH). SWYPFT run their own on call whereas LCH participate in the LYPFT on call rotas. There are 34 Core Trainees (CT) posts allocated to LYPFT and a further 4 from LCH on the rotas for out of hours working.

LYPFT is the employer of psychiatry Higher Trainees (HT) allocated to placements within the Trust. There are 28 trainees allocated to Leeds based placements and 3 York based placements.

Leeds Teaching Hospitals Trust (LTHT) is the lead employer for the Foundation Training Scheme. LYPFT hosts 18 Foundation Trainees including 6 that participate in the LYPFT CT on call rota.

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

LYPFT guardian was appointed from November 2016 and is responsible for the directly employed trainees. This requires the guardian to liaise with the hosting organisations with reciprocal liaison with the other Trusts' trainees hosted in LYPFT and not directly employed as exceptions occurring as part of work within other Trusts is reviewed and addressed within that trust for example if a CT employed by LYPFT working in SWYPFT reports an exception this is received by LYPFT but addressed by SWYPT.

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

The 2016 Junior Doctors contract highlights the importance that junior doctors are fully trained in a way that is safe and fair. The TCS of this contract have introduced a number of safeguards to ensure the risk of staff fatigue is mitigated. The role of the Guardian of Safe Working Hours (GSWH) in summary is to:

- ensure the confidence of doctors that their concerns will be addressed
- require improvements in working hours and rotas for doctors in training
- provide boards with assurance that junior medical staff are safe and able to work, identifying risk and advising boards on the required response
- ensure fair distribution of financial penalty income, to the benefit of doctors in training.

The GSWH job description and person specification is provided in Appendix A

4. Implementation of the 2016 Contract within LYPFT

LYPFT transferred all of its junior doctors onto the 2016 junior doctor contract on the 1st February 2017. Prior to implementation, in line with the TCS preparatory work completed was:

- CT rota needed to be redesigned as no longer sustainable as insufficient trainees to maintain the two rotas. These were therefore amalgamated to one rota to maintain patient safety by minimizing need for use of agency locums to fill rota gaps.
- HT rota adjusted to meet the new TCS i.e. 24 hour partial shift no longer existed so needed to move onto an on call rota.
- An individual generic work schedule was provided prior to each trainee before starting their placement and includes the training opportunities within that post. The trainee then agreed within the first weeks of starting in post a personalized timetable with their clinical supervisor that will link to their required learning objectives to meet the MRCPsych curriculum and the Annual Review of Competency Progression requirements.
- Set up a junior doctor forum.
- Implemented the information system Allocate to support rota management by production of rotas, highlighting non compliance with TCS and populates pay to reflect on call availability allowances as well as offering exception report functionality.

5. Vacancies and Rota Gaps

5.1 Current Vacancies

There should be 38 CTs. There are 12 vacancies. Five Trust doctors have been employed on temporary contracts to cover doctors in training vacancies. There are also three LTFT CTs that are supernumerary.

There should be 29 HTs. There are five vacancies. There is also one supernumerary LTFT HT.

Individual services are responsible for addressing gaps in day time cover if there is no trainee using a risk assessment approach. The options available to meet service needs are establishing specialty doctor posts or booking of an agency locum if the need is short term or recruitment to specialty doctor post is unsuccessful.

The production of this report had identified that there is a need to keep a record of vacancies on a month by month basis to identify trends and inform medical recruitment plans.

The overall annual vacancy rate calculated on the number of vacancies as percentage of funded posts is 25% reducing to 18% with the appointment of Trust doctors.

5.2 Rota Gaps

Retrospective collection of data in relation to how rota gaps have been covered prior to 1 February has been considered and it was felt that the managerial and administrative resource should be focused on planning and managing cover for the rota gaps including data collection to inform future reports.

Since 1 February 2017, for core trainees there were 10 shifts that were not covered by internal cover, five shifts were covered by agency locums and 5 shifts remained uncovered. The information on the rota gaps on the current rotas from February 2017 for the CTs and from October 2016 for the HT has been provided in the tables below.

Psychiatry Core Trainees						
	Total Rota Gaps	**Number of shifts uncovered (over the month)**	**Average number of shifts uncovered (per week)**	**Number of shifts covered internally**	**Number of shifts covered by agency locums**	**Reason for rotas gaps**
Feb	15	2	0.5	9	4	Sickness – 4 Vacancies – 7 Paternity

						leave – 4
Mar	23	3	0.75	19	1	Sickness – 5 Vacancies – 11 Carers leave – 1 Unpaid leave – 4 Reduced duties - 2

Psychiatry Higher Trainees						
	Total Rota Gaps	**Number of shifts uncovered (over the month)**	**Average number of shifts uncovered (per week)**	**Number of shifts covered internally**	**Number of shifts covered by agency locums**	**Reason for rotas gaps**
Oct	17	0	0	17	0	Vacant – 11 Mat leave – 3 Off rota – 2 Special leave – 1
Nov	14	0	0	14	0	Vacant – 8 Mat leave – 4 Off rota – 1 Sickness – 1
Dec	14	0	0	14	0	Vacant – 7 Mat leave – 4 Off rota – 1 Sickness – 2
Jan	15	0	0	15	0	Vacant – 9 Mat leave – 3 Off rota – 2 Sickness – 1
Feb	13	0	0	13	0	Vacant - 5 Off rota – 2 Acting up – 4 Mat leave – 1 Sickness - 1
Mar	12	0	0	12	0	Off rota – 5 Vacant – 3 Acting up – 2 Mat leave – 1 Sickness - 1

In addition to the 7 CT vacancies, there are further rota gaps as follows:

- 1 long term sickness absence
- 1 adjusted working arrangements (reduced night duties)

In addition to the 5 HT vacancies, there are further rota gaps as follows:

- 1 agreed acting up to consultant training experience
- 1 adjusted working arrangements (weekend daytime shifts only)
- 1 maternity leave

5.3 Cover for Rota Gaps

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

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

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

If the shift remains uncovered, then the rota may be authorized to run on reduced staffing by the Associate Medical Director for doctors in training (AMD for DiT). In this scenario the medical education team communicates this to the doctors of all grades on the rotas for the date affected to make them aware of the reduced cover.

The majority of the rota gaps have been covered by internal locum shifts. From 1 February there have been five shifts booked with agency locums and five shifts run with reduced cover i.e. 3 CTs rather than the planned 4 on the CT 5pm to 10pm shift. The number of agency bookings made for the full year is attached as Appendix B.

There have been no bookings above the capped rates. These are reported separately as exceptions to NHS Improvement (NHSI). Changes to the NHSI exception reporting mean that from the 1 April 2017 the cost of the bookings will be reported on a weekly basis.

The Allocate rota software assists the medical education team to manage the locum work carried out by individual doctors as it highlights when a doctor will exceed working time regulations. If a doctor is wanting to work shifts that take their total hours worked above beyond 48 hours per week then they need to complete an Opt Out form. The medical education team does not allow trainees to complete any requests for locum shifts that would take weekly working hours above 56.
Currently there are 13 CTs and 8 HTs that have opted out of the EWTD.

6. Exception Reports

Exception reporting is the mechanism by which junior doctors inform the employer when their day-to-day work varies significantly and/or regularly from the agreed work schedules. Primarily these variations will be in relation to differences in the total number of hours worked, patterns of hours work, as well as differences in the education opportunities and support available to the doctor. Exception reports allow the employer the opportunity to address issues as they arise, and to make timely adjustments to work schedules.

Within LYPFT the clinical supervisor is responsible for reviewing and addressing exception reports. There can be a number of possible outcomes depending on the circumstances of the report. In the event that additional hours have been worked the trainee can either be paid at their hourly rate for the hours worked or be given time off in lieu as recompense. Repeated exception reports identifying additional hours worked or missed training experiences may trigger a work schedule review.

The GSWH is responsible for reviewing the outcome of all exception reports related to working hours and the Director of Medical Education (DME) for those reports related to training.

Since implementation on 1st February 2017 there have been no exception reports raised.

Feedback at the April Junior Doctors Forum has informed actions to be taken as follows:

- When junior doctors are aware in advance of workload that will need them to work additional hours they had agreed with their clinical supervisor the need to complete the work and when they could take the time back prior to this occurring. No exception reports have been submitted as it had been mutually agreed and time owing recompensed. Exception reporting is the formal way of recording these occurrences and allows the Trust to identify patterns in breaches of working hours or intensity of workload. Trainee representatives were asked to feedback to the junior doctors that exception reports are needed to identify patterns to support quality improvement. As GSWH I agreed to communicate with the consultants to raise their awareness to encourage the trainees to report exceptions to working arrangements agreed.
- Reduced cover on the night shift had resulted in the completion of a DATIX report. AMD for DiT had communicated to the higher trainees and consultants the reduced cover for the shift. The DATIX had been raised because of a delayed response to see a patient. There was no harm to the patient and no safety issues during the shift as the CT had prioritised the workload appropriately. However this has highlighted the need to complete exception reports to raise awareness of work intensity issues should these occur, irrespective of the number of trainees on shift.

Up to the 1st February the working hours of junior doctors working within LYPFT were monitored on a 6 monthly basis as per the 2002 junior doctor contract. Below is the information regarding working hours for the 6 month period prior to February 2017.

Hours monitoring exercises (for doctors on 2002 TCS only)					
Rota	Grade	Rostered hours	Monitored hours	Banding	WTR compliant (Y/N)
1A/B	CT1-3	48	46.54	1B	Y*
2A/B	CT1-3	48	47.23	1B	Y
East	ST4+	64	49.08	1B	Y
West	ST4+	64	50.09	1B	Y

* 1 X less than 11 hours rest between shifts, 4 X inadequate breaks

7. Work Schedules

Work schedules allow employers to plan and deliver clinical services while delivering appropriate training. They are designed to take into account the expected service commitment and the relevant training curriculum that can be achieved within the post. The work schedule will normally apply for the duration of the trainee in post and outline the number and distribution of hours for which the doctor is contracted.

Each trainee receives a generic work schedule prior to commencing their placement. These are then adjusted by the trainee and their clinical supervisor to reflect the needs of the individual trainee.

Each individual trainee was provided with a generic work schedule reflective of their grade and placement designed using the RCPsych curriculum and Gold Guide. These generic work schedules have been personalised by the trainee and their supervisor reflecting any individual training needs of the junior doctor.

As yet there have not been any work schedule reviews requested either as the result of exception reporting or at the request of individual trainees, supervisors, the GSWH or Director of Medical Education (DME).

Return rate of 55% for completed personalized work schedules is in line with normal return rates for the induction documentation. Medical education team are following up the schedules not returned.

8. Fines

As per the TCS there are a number of breaches that will incur a financial penalty upon the Trust. These are:

a) a breach of the 48 hour average working week
b) a breach of the maximum 72 hour limit in any seven days
c) the minimum 11 hour rest requirement between shifts has been reduced to fewer than 8 hours.
d) breaks have been missed on at least 25% of occasions across a 4 week reference period.

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

9. Junior Doctors Forum

The TCS requires the GSWH and DME within each Trust to establish a Junior Doctor Forum (JDF) to advise them regarding issues related to the TCS. This committee must comprise of junior doctors, appropriate representatives of the LNC, human resource representatives as well as relevant medical education representatives. This committee will participate in the scrutiny and distribution of any fines accrued.

It was agreed in December 2016 that the junior doctors monitoring group would become the JDF. The forum has now been set up and the terms of reference agreed and will be sent to the Quality Committee for authorisation. The terms of reference are provided in Appendix C and the meetings for the year are scheduled.

Feedback from the April JDF included:

- Frequencies of shortages on the on call rota resulting in occasions with less than full cover. It was accepted that work intensity increases when there is less cover although dependent on the workload junior doctors may still be able to complete their work and take the required rest breaks. The learning from this was that the AMD for DiT will continue to e-mail the individual trainees working on a shift with reduced cover, but will now request that they ensure that they submit an exception report if the workload has an issue i.e. if missing break, staying over shift or unsafe delays to assessing patients.
- Locum rates of pay were raised. This is an issue that the medical education team are aware of, and are currently working with LTHT and other local MH Trusts to develop an agreement with regards to pay. The current locum pay rate is in accordance with TCS; however we are aware that other local Trusts are paying in excess of this. One suggested reason for this was that not all Trusts had fully implemented the 2016 TCS yet and have therefore not applied the TCS rates; it is also possible that they are unable to fill the shifts

applying the TCS rate. An option to address this which is being considered is to establish a bank across the Trusts.

- Time off after locum shift was queried. As per TCS there is an onus on trainee when accepting additional shifts to be able to work safely in their normal working hours and planned rota shifts especially if swopping shifts. Medical education team usually are selective about the doctors they ask to cover night shifts due to the need to be able to rest afterwards.
- The forum raised the issue of trainees who have not opted out but are still being contacted regarding locum work. It was agreed that trainees not wanting to ever be contacted should contact the medical education to be removed from the distribution list. It will be reiterated to the trainees that there is no requirement for them to undertake additional locum work, and there is no detriment to those who do not opt out.
- HTs advised that at the current time there have been no issues with regards to additional work, this is likely due to the fact that there are less vacancies on the HT rota. The post on call after locum shift is not an issue as work pattern is such they are able to take their breaks/rest periods.

10. Issues Arising

The 2016 junior doctor contract was implemented by LYPFT for all its junior doctors on the 1st February 2017. Prior to its implementation significant work was completed to ensure the TCS were met.

Following the implementation of the contract no exception reports have been raised. There are several reasons that this may have occurred. It was expected that there may be no exception reports raised as at present the trainees are working in line with their personalised work schedules. However due to the recent nature of the implementation and feedback from the junior doctors representatives, we are aware that doctors of all grades are still adjusting to the new way of monitoring their working hours.

As a Trust we have a very good relationship with our junior doctors. Whilst the exception reporting process is new, the process designed for clinical supervisors to address these have been common practice. That is to say that if a junior doctor finds that it is necessary for patient safety to work additional hours, this will have been discussed with their clinical supervisor and appropriate time off in lieu arranged. From the junior doctors representative feedback there was a lack of awareness that prospective mutually agreed changes should be exception reported.

It is important to build a culture to report exceptions or concerns. The junior doctors should be encouraged to complete exception reports as a matter of course. Exception reporting is designed to be used as a tool to improve patient safety and training and should not be seen as an inconvenience or method of identifying doctors in difficulty. As GSWH I will be attending the Junior Doctors Committee meeting and HT committee to clarify with the trainees the importance and purpose of exception reporting in ensuring that their working hours are in line with TCS and they are receiving all their training appropriately.

The residual and recurrent issues of concern are:

- Nationally
    - Ongoing impact from the national negotiations of the 2016 TCS and subsequent industrial action for future recruitment.
    - National recruitment:
        - It is too early to know if the recruitment premia will assist national recruitment to the Psychiatry schemes.
        - Although there is an increase in medical undergraduate places from 18/19 without a national approach to addressing the attrition rates from medical school to Foundation training, Foundation training to Specialist training it will not resolve recruitment/supply issues.
    - Impact of 'Brexit' for future recruitment and continuation or further changes to visa restrictions
    - Exception reporting has negative connotations. The term "exception" is used on the documentation completed by each junior doctor prior to their Annual Review of Competency Progression to identify issues when junior doctor is in difficulty. As a Trust we have informed the trainee representatives at both the February and April JDF meetings that exception reporting is not part of their annual review.
    - Impact of NHSI initiatives such as IR35 requirement when booked to public sector to have tax and national insurance deducted on agency locum supply
- Locally
    - Recruitment to Foundation Training Scheme and Core Training Programmes.
    - Ability to deliver collaborative working to establish a shared bank of doctors available for locum shifts and equity of pay rates in relation to work intensity.
- LYPFT
    - Known risks in relation to recruitment and maintaining rotas recorded on the directorate risk register and include actions agreed.

11. Summary

Overall the implementation of the 2016 Junior Doctor contract appears to have been successful. Information and feedback received so far indicates that the rotas remain compliant with the TCS and that all junior doctors are working within their personalised work schedules.

As Exception Reporting is a new process it is important that we continue to work with both the junior doctors and clinical supervisors to ensure that these are being completed appropriately. A key aspect to achieving this is developing a positive reporting culture with a shared understanding of how it informs continuous quality improvement.

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

There have been no exception reports related to either working hours or training, and as such the current staffing levels and working arrangements for the junior doctors are safe. However maintaining this continues to be a challenge to all involved with operational and educational delivery.

12. Recommendations

The Board of Directors are asked:

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

Dr Elizabeth Cashman
GMC 6128434
Guardian of Safe Working Hours

Appendices

A	Guardian of Safe Working Hours Job description and person specification
B	Number of agency bookings for 16/17
C	Junior doctors forum terms of reference

Leeds and York Partnership NHS
NHS Foundation Trust

JOB DESCRIPTION

JOB TITLE:	Guardian of Safe Working
GRADE:	NHS Consultant or equivalent seniority
ACCOUNTABLE TO:	Chief Executive
REPORTING TO:	Medical Director
KEY RELATIONSHIPs:	Director of Medical Education (DME) Associate Medical Director for Doctors in Training (AMD for DiT) Medical Education Manager Junior doctors fora Local Negotiating Committee Deputy Director of Workforce LETB Director of Quality Medical Directorate Manager Service leads and managers
TIME COMMITMENT	1 PA
TENURE	3 years, subject to annual review
NOTICE PERIOD	3 months

Job Purpose

The safety of patients is a paramount concern for the NHS. Significant staff fatigue is a hazard both to patients and to the staff themselves. The safeguards around working hours of Doctors in Training are outlined in the terms and conditions of service and are designed to ensure that this risk is effectively mitigated and that this mitigation is assured.

The guardian is a senior person, independent of the management structure within the Trust for whom the doctor in training is working and/or the organisation by whom the doctor in training is employed. The guardian is responsible for protecting the safeguards outlined in the 2016 terms and conditions of service (TCS) for Doctors and Dentists in Training. The guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and /or employer, as appropriate; and will provide assurance to the Trust Board that doctors' working hours are safe.

The Trust employs the following Doctors in Training: GP Trainees, Core and Specialist

Trainees in Psychiatry. Trainees will send exception reports electronically to their educational supervisor except in the case of GP trainees where they will send reports to a designated College Tutor. Upon receipt of an exception report, the educational supervisor will discuss with the doctor what action is necessary to address the reported variation or concern. The educational supervisor will set out the agreed outcome of the exception report, including any agreed actions, in an electronic response to the doctor, copying the response to the Guardian, AMD for DiT and DME. The Guardian of Safe Working Hours reviews the outcomes of all exception reports to identify whether further improvements to the doctor's working hours are required to ensure that the limits on working hours are being met.

Exception reporting is the mechanism used by doctors in training to inform the employer when their day-to-day work varies significantly and/or regularly from the agreed work schedule. (Personalised work schedules for doctors in training are provided by employers to plan and deliver clinical services while delivering appropriate training). Exception reports allow the employer the opportunity to address issues as they arise, and to make timely adjustments to work schedules.

Key Results Areas

The guardian will:

1. Act as the 'champion' of safe working hours for doctors in approved training programmes and ensure that action is taken to ensure that the working hours within the Trust are safe.
2. Provide assurance to the Trust Board that doctors are safely rostered and are working hours that are safe and in compliance with the TCS.
3. Record and monitor compliance with the restrictions on working hours stipulated in the terms and conditions, through receipt and review of all exception reports in respect of safe working hours and copy the outcome to the Associate Medical Director for Doctors in Training (AMD for DiT) and Director of Medical Education (DME)
4. Review the outcomes of all exception reports to identify whether further improvements to the doctor's working hours are required to ensure that the limits on working hours are being met.
5. Ensure that exception reports regarding training requirements outside core placement service provision, as set out in the work schedule, are sent to the DME for action.
6. Work in collaboration with the DME, AMD for DiT and LNC to ensure that the identified issues within exception reports concerning both working hours and training hours are properly addressed by the employer and/or host organisation.
7. Escalate issues in relation to working hours raised in exception reports to the relevant governance group for decisions where these have not been addressed at a local level.
8. Require a work schedule review to be undertaken where there are regular or persistent breaches in safe working hours which have not been addressed.
9. Directly receive exception reports where there are immediate or serious risks to safety and ensure that the organisation at a local level has addressed the concerns that led to the exception report. Where this is not addressed within the timescales identified in Schedule 5, and the guardian deems it appropriate, the guardian will raise this with the Executive Director of the employing and/or host organisation.
10. Review the reports received when a manager does not authorise payment for hours worked beyond those described in the work schedule in order to secure patient

safety and recommend action where appropriate

11. Have the authority to intervene in any instance where the guardian feels the safety of patients and/or doctors is compromised, or that issues are not being resolved satisfactorily.
12. Distribute monies received as a consequence of financial penalties to improve the training and working experience of all doctors. Examples may include and should not be limited to:
    i. Improving IT systems beyond what is fundamentally required
    ii. Facilitating study leave
    iii. Improving rest facilities
    iv. Improving handover systems
    v. Improving expertise in rota design
    vi. Service improvement projects
    vii. Examination/course/professional support
    viii. Role redesign pilots
    ix. Improving staff engagement
    x. Improving library facilities
    xi. Corporate journal subscriptions.
13. Prepare, not less than quarterly, a report for the Trust Board, copied to the LNC, which summarises all exception reports and work schedule reviews and provides assurance on compliance with safe working hours by both the employer and doctors in approved training programmes.
14. Prepare no less than annually a plan of improvement on rota gaps and submit the plan in a statement in the Trust's Quality Account, which will also need to be signed off by the Trust's Chief Executive.
15. Submit details of the disbursement of financial penalties for inclusion in the organisation's annual report, including clear detail of where fines have been spent.
16. Chair the Trust's Junior Doctors Working Hours Group, review and update terms of reference to reflect TCS to ensure an overall quality assurance system in relation to safe hours of work and linkage to appropriate governance and assurance groups within the Trust.
17. Oversee all diversity and equality issues associated with ensuring safe working practices. This will include liaison with the DME to ensure that a member of the educational faculty in the Trust is designated a champion of flexible training.

Assignment and Review of Work

18. Accountable to the Chief Executive and line managed by the Executive Medical Director
19. The work of the post holder is generated through exception reporting and work schedule reviews made by Doctors in Training.
20. The post holder is also expected to initiate work in response to areas of concern.
21. The post holder will agree objectives with the line manager, who will contribute to their appraisal process. The system of performance management will include the opportunity for representatives of the doctors in training to contribute to the assessment, for example, through a system of 360° appraisal.

Communications and Working Relationships

22. The role of the guardian must be independent from the line management arrangements in the host and/or employing organisation to ensure that the post holder has the confidence of doctors in training.

23. The post holder must be of sufficient seniority to ensure that the role has an effective voice within the organisation.
24. The post holder will have regular contact with doctors and dentists in training, the DME and any associate DMEs, educational and clinical supervisors, the Postgraduate Dean, other senior staff within the Deanery, and both Executive and non-Executive Board members.
25. The post holder will also have links with other Guardians in the Trust and other organisations.

Appointment to the role

26. The provisions for appointing the guardian will be in line with those set out in local appointment policies and with the provisions of Schedule 6 of the TCS.

Notes

27. The guardian of safe working hours is a separate role from, and should not be confused with, other guardian roles within the organisation (e.g. Caldicott Guardian, Freedom to Speak Up Guardian)
28. Monies received as a consequence of financial penalties must not be used to supplement the facilities, study leave, IT provision and other resources that are defined by Health Education England as fundamental requirements for doctors in training and which should be provided by the employer/host organisation as standard.

Leeds and York Partnership NHS
NHS Foundation Trust

Guardian of Safe Working

PERSON SPECIFICATION

SKILLS/ABILITIES/KNOWLEDGE	**Essential (E)/ Desirable (D)**	**Evidence Sought From**		
		Application Form	Interview	Presentation
Knowledge & understanding of terms and conditions of doctors in training.	E	✓	✓	✓
Knowledge of recent development in medical education & of key issues.	D	✓	✓	✓
Knowledge and understanding of Working Time Regulations and safe working patterns and rotas for doctors in training.	E	✓	✓	✓
Facilitation, interpersonal, mediation and negotiation skills in order to promote medical and dental education and challenge practice within the LEP.	E	✓	✓	✓
Ability to manage budget.	E	✓	✓	✓
Proven ability in leadership to achieve goals, manage change and deal with constraints.	E	✓	✓	✓
Ability to act as an effective champion for safe working.	E	✓	✓	✓

EXPERIENCE	**Essential (E)/ Desirable (D)**	Application Form	Interview	Test
Previous experience of postgraduate education & training.	D	✓	✓	✓
Consultant /GP level or equivalent senior medical or management level	E	✓	✓	✓
Previous management experience and training	D	✓	✓	✓
Relevant experience and or employment with a local NHS organisation.	E	✓	✓	✓
QUALIFICATIONS	**Essential (E)/ Desirable (D)**	Application Form	Interview	Test
Medical or Dental practitioner with postgraduate qualifications or appropriate HR or management qualification	E	✓	✓	✓
PERSONAL QUALITIES				
Enthusiasm for preserving safeguards for the benefit of patients and doctors in training	E	✓	✓	✓
Excellent communication skills in all forms	E	✓	✓	✓
Clear understanding of equal opportunities	E		✓	

Appendix B: Agency locum bookings 1 April 2016 to 31 March 2017

Key	Rota shift	Service cover	Doctor not to be booked again

Grade	Specialty	Location	Start Date	End Date	Reason
CT	GA	Becklin Centre	5.4.16	6.5.16	vacant post
CT	ED	Newsam Centre	18.4;16	27.5.16	vacant post
CT	GA	Becklin Centre	7.5.16		Sickness
CT	GA	Becklin Centre	21.5.16	22.5.16	vacant post
CT	GA	Becklin Centre	7.5.16	7.5.16	vacant post
CT	GA	Becklin Centre	29.5.16	29.5.16	vacant post
CT	GA	Becklin Centre	25.5.16	25.5.16	Sickness
CT	GA	Becklin Centre	5.6.16	5.6.16	vacant post
CT	GA	Becklin Centre	4.5.16	4.5.15	Sickness
CT	GA	Becklin Centre	30.7.16	30.7.16	vacant post
CT	GA	Becklin Centre	7.8.16	7.8.16	vacant post
CT	GA	Becklin Centre	26.8.16		vacant post
CT	LD	Parkside Lodge	5.9.16	30.9.16	vacant post
CT	GA	Becklin Centre	14.9.16	15.9.16	vacant post
CT	LD	Parkside Lodge	3.10.16	31.10.16	Sckness
CT	LD	Parkside Lodge	1.11.16	14.11.16	Sickness
CT	GA	Becklin Centre	20.11.16	20.11.16	Sickness
CT	GA	Becklin Centre	21.12.16	21.12.16	Sickenss
CT	GA	Becklin Centre	18.12.16	18.12.16	Sickness
CT	GA	Becklin Centre	27.1.17	28.1.17	Sickness
CT	GA	Becklin Centre	3.2.17	3.2.17	Sickness
CT	GA	Becklin Centre	10.2.17	11.2.17	Sickness
CT	GA	Newsam Centre	27.2.17	31.3.17	vacancy
CT	GA	Becklin Centre	17 & 19.2.17	18&20.3.17	sickness
CT	GA	Becklin Centre	23.3.17	24.3.17	sickness

Appendix C: Junior Doctors Forum Terms of Reference

Leeds and York Partnership NHS
NHS Foundation Trust

Junior Doctors Forum

Terms of Reference

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1. NAME OF GROUP

Junior Doctors Forum (JDF)

2. COMPOSITION OF THE GROUP

- Associate Medical Director – Doctors in Training
- British Medical Association Representative
- Chair of Junior Doctors Committee or Core Trainee Representative
- Director of Medical Education
- Guardian of Safe Working (GSW)
- Higher trainee representative
- HR Manager
- Junior doctor BMA/LNC representative
- Leeds Community Health (LCH) representative
- Leeds Community Health (LCH) junior doctor representative
- Local Negotiating Committee Chair
- Medical Directorate Manager
- Medical Education Manager

In the absence of a substantive member of the group, a deputy may be nominated in order that the business of the group can be progressed. Deputies attending will be listed as members of the group on the date attending. Deputies are listed in Appendix A.

The meeting will be chaired by the GSW.

The Chair may invite other individuals to attend in support of items on the agenda as and when necessary. These individuals will be listed as in attendance.

3. QUORACY

The group will be quorate if at least three members are present provided there is junior doctor representation.

In the event the meeting is not quorate the meeting will be cancelled. Chair's action will be taken on any agenda item that cannot be deferred until the next scheduled meeting.

4. MEETINGS OF THE GROUP

The group will meet quarterly.

Action notes will be produced and circulated from each meeting. The Medical Directorate administrator will ensure these are sent out within 5 working days of the meeting to the chair prior to circulating to the group.

Action notes and related documents will be filed in the Junior Doctors Forum site on staff net.

Requests for an extra meeting should be made to the GSW as Chair of the group.

5. AUTHORITY

The Quality Committee has authorised the establishment of this group with formal delegated authority to make decisions in respect of its duties as listed in section 6.3 regarding the Junior Doctors 2016 Contract implementation.

For governance purposes the Quality Committee will be the ratifying body for specific authority to progress the work needed for the contract implementation. The authority to wind up the group is with the Quality Committee

For operational purposes this group will report via the Medical Director to the Executive team for the operational issues relating to the contract.

6. ROLE OF THE GROUP

6.1 Purpose of the Group

The purpose of the group is to fulfil the requirements of the junior doctors contract (2016).

6.2 Guiding Principles for members (and attendees) when carrying out the duties of the group

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

Purpose: Improving health, improving lives	
Our new Trust values	**Behaviours you can expect from staff**
We have integrity We treat everyone with respect	• We are committed to continuously improving what we do because we want the best for our service users. We consider the feelings, needs and rights of

and dignity, honour our commitments and do our best for our service users and colleagues.	others • We give positive feedback as a norm and constructively challenge unacceptable behaviour • We're open about the actions we take and the decisions we make, working transparently and as one team with service users, colleagues and relevant partner organisations.
We are caring We always show empathy and support those in need.	• We make sure people feel we have time for them when they need it • We listen and act upon what people have to say • We communicate with compassion and kindness.
We keep it simple "We make it easy for the communities we serve and the people who work here to achieve their goals."	• We make processes as simple as possible • We avoid jargon and make sure we are understood • We are clear what our goals are and help others to achieve their goals.

6.3 Duties of the Group

. The Junior Doctors Forum will support and scrutinise the work of the Guardian of Safe Working to ensure that the junior doctors' working hours and conditions are effectively monitored and their contractual rights upheld. More specifically, the JDF;

i. Will take part in the scrutiny of the distribution of income drawn from fines.
ii. Will collaborate with the GSW to devise the allocation of funds. These funds must not be used to supplement the facilities, IT provision and other resources that are already defined by HEE as fundamental requirements for doctors in training and which should be provided by the employer as standard.

The JDF also supports the Guardian's role within LYPFT by;

iii. Providing a forum for ideas and suggestions to be discussed and put forwards for consideration by the appropriate committee
iv. Provide a forum for the Trust to engage with and harness the energy and vision of junior doctors in developing and improving its services, working conditions, education and training.

In addition, the JDF will also contribute to locally negotiated and determined arrangements as set out in the 2016 Terms and Conditions of Service proposed in the following areas:

v. Exception reporting and work schedule reviews as set out in Paragraph 2, Schedule 5, including the effectiveness of the operation of the process of exception reporting as set out in paragraphs 4, 5 and 6 and whether any improvements are needed
vi. Paragraph 27, Schedule 3 agreements regarding scheduling of consecutive on-call rotas for a minimum of 7 days where it is safe and acceptable to do so
vii. Arrangements for locum processes as set out in Paragraph 44, Schedule 3
viii. Work scheduling and educational reviews as set out in Paragraph 18, Schedule 4
ix. Arrangements for the disbursement of fines as set out in Paragraph 18, Schedule 5
x. Quarterly reporting on the safe working as set out in Paragraph 35, Schedule 5
xi. Review rota shifts and on call rotas as set out in Paragraph 11a, Schedule 6
xii. Scrutiny of the distribution of income as set out in Paragraph 13, Schedule 6
xiii. Leave arrangements as set out in Paragraph 10, Schedule 7, including swapping of leave and leave taken at the end of placements
xiv. The JDF will function within its remit but may refer to the LNC Chair for guidance.

7. RELATIONSHIP WITH OTHER GROUPS AND COMMITTEES

This group reports to the Quality Committee. This group reviews data to support the Guardian in meeting the responsibilities and duties of the guardian's role.

The notes of the meeting will be provided to the Quality Committee.

This group will keep the doctors informed about the work of the group via the Senior Medical Council, Joint Local Negotiating Committee, Trust Medical Education Committee and Junior Doctor fora.

Work from the group will be disseminated to the Senior Medical Council, Joint Local Negotiating Committee, Trust Medical Education Committee and Junior Doctor fora.

8. DUTIES OF THE CHAIRPERSON

The Chair person is the GSW. If the GSW is unavailable, they will nominate a group member to chair the meeting.

The chair of the group shall be responsible for:

- Directing the conduct of the meeting ensuring it operates in accordance with the Trust's values.
- Giving direction to the note taker.
- Ensuring all attendees have a reasonable chance to contribute to the discussion.
- Ensuring the agenda is balanced and discussions are productive, and when they are not productive they are efficiently brought to a conclusion.
- Deciding when it is beneficial to vote on a motion or decision.
- Ensuring sufficient information is presented to the 'parent group' in respect of the work of the group.

The Medical Directorate Administrator will support the GSW in the preparation of the agenda and ensure actions agreed are progressed.

9. REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

The Terms of Reference shall be agreed by the group and then presented to the Quality Committee for ratification.

In addition to this the group must also carry out an annual assessment of how effectively it is carrying out its duties for inclusion in the GSW's annual report to Board including any recommendations for improvement.

10. MONITORING

To comply with the Risk Management Standards the Trust has to include certain details in all of its terms of reference documents. These details are included in the sections above. The Trust also has to collect evidence of compliance with these areas.

Compliance with RMST Standard 1 Criteria 3 will be monitored as per the table in Appendix B.

Date Adopted: insert date

Date to be reviewed: One year from date of adoption unless the group agree an earlier review is needed

Gina White,
Medical Directorate Manager
24.2.17

Appendix C: Junior Doctors Forum Terms of Reference

Appendix A Schedule of Deputies

Group member	Name	Deputy	Name
Guardian of Safe Working	Liz Cashman	**Nominated as needed**	
Associate Medical Director – Doctors in Training	Abs Chakrabarti	**Nominated as needed**	
British Medical Association Representative	Marie Butterfield		To be advised
Chair of Junior Doctors Committee	James Whelan	Core Trainee Representative	Alex Collins
Director of Medical Education	Sharon Nightingale	**Nominated as needed**	
Higher trainee representative	Rebecca Asquith	Higher trainee representative	Ben Alderson
HR Manager	Alison Evans	Nominated as needed	
Junior doctor BMA/LNC representative	To be advised		To be advised
LCH junior doctor representative	To be advised		To be advised
LCH representative	Roger Lakin		Graham Dunn
LNC Chair	Lawrence Atkins	Nominated as needed	
Medical Directorate Manager	Gina White	Nominated as needed	
Medical Education Manager	Vickie Lovett	Nominated as needed	

Appendix C: Junior Doctors Forum Terms of Reference

Appendix B

Topic	Monitoring/ Audit	Lead Manager	Data Source	Sample	Data Collection Method	Frequency of Activity	Review Body
Reporting Arrangements to Quality Committee	Audit	Medical Directorate Manager	QC Agenda	All QC Agendas	Medical Directorate Administrator to review the previous year's QC Agendas to ensure each the meeting has been reported	Annual	The audit will be presented to the group and inform the annual review of the terms of reference. The results, recommendations and action plan submitted to QC for approval and monitoring of progress.
Membership (including nominated deputy) including frequency, attendance and quorum	Audit	Medical Directorate Manager	JDF minutes	JDF Minutes	Medical Directorate Administrator to review the previous year's notes for the frequency of meetings, attendance by members and quoracy.	Annual	
Reporting Arrangements into the Group	Not Applicable						
Duties of the group	Audit	Medical Directorate Manager	Action log	JDF minutes	Medical Directorate Administrator to review the previous year's agendas and minutes for completion of issues	Annual	

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

13

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Freedom to Speak Up Guardian Report
DATE OF MEETING:	27 April 2017
LEAD: (name and title)	Helen Wiseman, Freedom to Speak Up Guardian
PAPER AUTHOR: (name and title)	Helen Wiseman, Freedom to Speak Up Guardian

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)							
Quality		Strategic		Governance		Information	✓

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	We work with service users and carers to support their achievement of outcomes and wellbeing	
G2	We are an employer of choice with a compassionate and highly trained workforce committed and supported to provide excellent innovative care and support	✓
G3	We work with others to improve health and improve lives through effective, innovative and sustainable partnerships	
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	
SO2	We provide a dynamic, rewarding and supportive place to work	✓
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	
SO4	We are transparent and accountable to the people and partners we work with	✓
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	

STATUS OF PAPER (please tick relevant box/s)		✓
To be taken in the public session (Part A)		✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:		
Legal advice relating to legal proceedings (actual or possible)		
Negotiations in respect of employee relations where they are of a confidential nature		
Procurement processes and contract negotiations		
Information relating to identifiable individuals or groups of individuals		
Other – not yet a public document		
Matters exempt under the Freedom of Information Act (quote section number)		

Leeds and York Partnership NHS
NHS Foundation Trust

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	This is the first paper to the Board following the Trust's appointment of a Freedom to Speak Up Guardian (FTSUG) in October 2016.
What are the key points and key issues the Board needs to focus on	The number and nature of individual 'speak ups' reported to the FTSUG and themes noted from conversations with clinical teams across the organisation.
What is the Board being asked to consider	How the information included in this report will support and inform the ongoing work around organisational culture and meeting Trust values.
What is the impact on the quality of care	Informs the work across the Trust on achieving organisational priorities and meeting Trust values.
What are the benefits and risks for the Trust	The Trust is required to support a culture of openness, transparency and candour and encourage all staff to treat patients with compassion, respect and dignity. If this does not occur there are risks to the quality of care, our ability to learn from mistakes and reputational damage.
What are the resource implications	None, a FTSUG has been appointed.
Next steps following this paper being presented to the Board	Develop awareness of the role across the organisation and support and encourage a culture of openness and transparency.
What are the reputational implications and how will these be addressed	If the Trust does not encourage and support openness and transparency then there is a risk of poor quality care and reputational damage.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No
What public / service user / staff / governor involvement has there been	Regular contact with staff at all levels of the organisation.
Previous meetings where this report has been considered (including date)	This is the first report.

Leeds and York Partnership NHS
NHS Foundation Trust

RECOMMENDATION (This report is being provided to the Board for) (please tick relevant box/s): ✓							
Assurance	✓	**Discussion**		**Decision**		**Information only**	

Provide details of what you want the Board to do:

The Board is asked to receive the report and to be assured of the work of the FTSUG in the first months of its implementation in the Trust.

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Freedom to Speak up Guardian Annual Report up to 31 March 2017

1) Introduction and Background

The appointment of a National Guardian and local Freedom to Speak Up Guardian in all NHS Trusts was recommended by Sir Robert Francis following his review and subsequent report into failings at the Mid Staffordshire NHS Foundation Trust in February 2013 and the further review in February 2015.

In July 2015, the Secretary of State confirmed the steps needed to be taken to develop a culture of safety, and supported Sir Robert Francis' recommendations. The NHS contract 2016/17 specifies that NHS Trusts should have nominated a Freedom to Speak Up Guardian (FTSUG) by October 2016.

The priorities of the National Guardian Dr Henrietta Hughes, appointed October 2016, include: establishing and supporting strong regional networks of FTSUGs; highlighting NHS organisations who are successful in creating the right environment for staff to speak up safely and share best practice across the NHS; independently review cases where NHS organisations may have failed to follow good practices; and working with statutory bodies to take action where needed.

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

This is the first FTSUG report to the board and will outline the progress made in implementing the role since mid-October 2016, the impact the role is working within the organisation and will include some recommendations.

2) Freedom to Speak Up

Implementing the role

Helen Wiseman was appointed to the role which became live on 17 October 2016. The Trust has allocated 3 days per week to the role which allows sufficient time to carrying out the duties of a FTSUG.

The role has been well received and well supported within the organisation at the most senior levels. Engagement with all staff has its challenges, especially for an organisation employing over 3000 staff providing services across Leeds, in York and elsewhere. Being available and responsive to staff is key to the success of the role, meaning the role is flexible and agile as opposed to being office based. Staff are always given a choice about where to meet and when they wish to

meet. It is important to maintain both the independence and confidentiality that goes with the role.

Currently the guardian is recording details locally of concerns and the action taken, but will explore establishing a new module on the Datix system which would allow the FTSUG to record the details and run reports as required.

It is important to carry out a follow up with staff who have raised concerns, so a 3 month ‘wellbeing’ check is being designed and we are looking to build this into the Datix system to ensure this happens where appropriate. This would include a brief questionnaire about their experience of raising a concern.

To raise awareness of the role and raising concerns a communication strategy was launched in November 2016. The role was introduced via the Trust’s Intranet, and through the publications of flyers and posters which have been distributed throughout the organisation and included in the corporate induction day. The FTSUG attends Staffside meetings, HR meetings, Care Group Governance and Business meetings, local Clinical team meetings, professional meetings as well as walkabouts across the Trust sites.

Updating the Freedom to Speak Up: Raising Concerns (whistleblowing) Procedure

NHS England has set minimum standards for whistle blowing/raising concerns and the expectations of the National Guardian in that these are incorporated into the Trusts own local policies/procedures. As a result, an updated procedure was ratified in June 2016. It is now time to refresh that procedure and this process has begun. It will include references to third party responsibilities and the government’s extended protection for NHS whistle blowers that prohibits discrimination against them if they seek reemployment in the NHS.

Networking:

There is a requirement and expectation of the FTSUG to attend national and regional events and training to promote standardised approaches to the role and to share and learn from peers including setting up a ‘buddying’ system. The FTSUG has attended the national training programme, a national meeting with the National Guardian Dr Henrietta Hughes, attended share and learn events, been part of establishing a regional network for Yorkshire and the Humber FTSUGs and has ‘buddied’ with local guardians.

The national office will be requiring performance data from each FTSUG to be published nationally. At this stage the request is high level including the number of concerns raised (anonymously or not), the nature of the issue/broad themes eg patient safety and outcomes. The NHS staff survey results specifically around raising concerns will be used as a benchmark for improvement.

Raising Concerns: the story so far Nov 2016- March 2017

Early intelligence gleaned from the regional network suggests that an average number of ‘speak up’ contacts per month is between 2-4 depending on the size of the Trust. It is difficult to make comparisons as the number of staff differ in each Trust, the length of time each FTSUG has been in post and the amount of time each FTSUG has been allocated to undertake the role (ranging from 1 session to a maximum of 3 days.)

Since commencing in October 2016 there have been a total of 9 individual concerns (speak ups) raised to the FTSUG up to and including the 31 March 2017. Some staff have made contact out of a frustration with current procedures or a lack of progress/communication with an existing problem and others have raised concerns that have not yet been raised elsewhere and therefore not had the opportunity to be discussed or addressed. These situations are not unexpected as the role is new and FTSUGs across the country are having similar experiences.

Of note, none of the individuals who have contacted the FTSUG have done so anonymously, this is encouraging as it helps to establish the independence and confidentiality of the role, as well as providing the FTSUG an opportunity to feedback to individuals and ensure no detriment is suffered as a result of raising a concern.

Summary of Concerns Raised

Month	No of Contacts	Open	Closed	Anonymous
October	1		1	
November				
December	2		2	
January	4		4	
February	1	1		
March	1		1	
Total	9	1	8	0

Staff Groups- Raising Concerns

AHP/Psychology – 4

Nursing – 3

HSW – 1

Admin – 1

Areas of Concern

Area of Concern	Number of cases	High level description of type eg see below
Patient safety	1	Sleeping on duty
Attitudes and Behaviours	7	Bullying behaviours from manager(s)
Suspected Financial Mismanagement	1	Mismanagement of local budget and Service User resources*

*Escalated to AD and counter fraud

The FTSUG has regular meetings with the Chief Executive and can have direct access to the Chair, Senior Independent Director or any other senior executive or Board member if and when required. The FTSUG can also go to the National FTSUG if that independence was ever necessary.

Themes from Presentation and Discussions with teams across the Trust

- Poor communication – it feels like ideas/solutions are ignored as there is no feedback to front line staff, there is a disconnect with Executive Team and Board of Directors
- Bank staff – lack of access to clinical supervision
- Disproportionate numbers of disciplinaries involving bank staff/BME staff
- Investigations – timelines are often very protracted and staff don't feel prepared or sufficiently supported during the process
- The organisation feels transactional, reactive/firefighting, no headroom for transformational, proactive work.

Outcomes:

Concerns that remain 'open' are those which are currently being investigated or reviewed or the individual is deciding on their next steps. The individual who raised a concern is kept informed of progress, concerns are closed when the process/procedures have been completed and/or the individual concludes the process. There is one open case as of the end of March 2017.

Outcomes of the concerns that have been closed have included a review of current management structures, changes to procedures/local working instructions and a safety audit.

Next steps

- Some joint working is being explored with the Trust's Head of Diversity and Inclusion and with the Trust's Head of Learning and Organisational Development
- It is anticipated that the FTSUG will attend the revised corporate induction days to introduce the role to all new employees
- Explore establishing a new module on the Datix system to record FTSUG data.

Conclusion

Living the Trusts values makes a huge contribution to the culture of raising concerns. Ensuring all staff are aware of how to raise and handle concerns is everybody' responsibility.

Awareness around the role is an ongoing task, whilst progress has been made there is more work to do which needs to be supported by leadership at all levels.

Staff have felt able to raise concerns and these have all been dealt with appropriately and no cases remain open as 31 March 2017.

Recommendation

The Board is asked to receive the report and to be assured at the work of the FTSUG in the first months of its implementation in the Trust.

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

17

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD

PAPER TITLE:	CQC Learning, Candour and Accountability; and NQB Guidance on Learning from deaths reports – a Framework
DATE OF MEETING:	27 April 2017
LEAD DIRECTOR: (name and title)	Anthony Deery
PAPER AUTHOR: (name and title)	Anthony Deery

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)							
Quality	✓	Strategic	✓	Governance	✓	Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	People achieve their agreed goals for improving health and improving lives	✓
G2	People experience safe care	✓
G3	People have a positive experience of their care and support	✓
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We provide excellent quality, evidence-based, safe care that involves people and promotes recovery and wellbeing	✓
SO2	We work with partners and local communities to improve health and lives	✓
SO3	We value and develop our workforce and those supporting us	✓
SO4	We provide efficient and sustainable services	
SO5	We govern our Trust effectively and meet our regulatory requirements	✓

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	This paper has been prepared to inform and assure the Board that the Trust has reviewed and responded to recommendations and requirements set out in both the CQC Learning, candour and accountability report, Dec 2016; and the National Quality Board's, National Guidance on Learning from Deaths; A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care, March 2017.
What are the key points and key issues the Board needs to focus on	1. The actions taken by the Trust to date have been sufficiently responsive. 2. The Action Plan addresses the key recommendation and requirements 3. To note the approach already in place for working with

	families and the recognition of the need for further development. 4. The Trust's participation in a collaborative approach within the Norther Alliance
What is the Board being asked to consider	1. That sufficient assurance has been provided in regard to the Trust actions. 2. To approve the proposed governance set out at number 5 in the action plan.
What is the impact on the quality of care	Learning from deaths is one of the most fundamental actions a provider can undertake to ensure that it a) provides the right level of support to families and b) identifies any systems, process and practice issues that can be improved to prevent similar future occurrences
What are the benefits and risks for the Trust	The Trust can demonstrate it is an open, transparent and learning organisation with a continuous focus on providing safe and effective care for patients and the best level of support for families and carers.
What are the resource implications	Not determined at this stage
Next steps following this paper being presented to the Board	Director of Nursing and Medical Director to convene a small steering group to oversee this work. The new Trust Clinical Governance Committee will receive monitor the action plan and receive assurance reports. An update on progress will be provided to the Quality Committee in July 2017 The Trust will continue to be involved in the regional Northern Alliance work.
What are the reputational implications and how will these be addressed	The reputational implications are significant as demonstrated in the Mazars Review of Southern Health NHS Foundation Trust. The Trust will address this by delivery of its action plan, development of a communication plan for key stakeholders, continuing to be a member of the Alliance

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No
What public / service user / staff / governor involvement has there been	None
Previous meetings where this report has been considered (including date)	None

RECOMMENDATION **(This report is being provided to the Quality Committee for)** (please tick relevant box/s): ✓							
Assurance	✓	**Discussion**	✓	**Decision**	✓	**Information only**	

Provide details of what you want the Quality Committee to do:

The Board is asked to:

1. Comment on the content of the paper and the action plan.
2. Confirm that sufficient assurance has been provided in regard to the Trust actions.

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Leeds and York Partnership NHS
NHS Foundation Trust

CQC Learning, candour and accountability, Dec 2016; and National Quality Board, Guidance on Learning from Deaths; A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care, Mar 2017.

1. Purpose

The purpose of this paper is to provide the Board with information about the requirements set out in the CQC Learning, Candour and Accountability Report, Dec 2016, the National Quality Board (NQB) Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care, March 2017 and to provide assurance on the actions being taken by the Trust to meet the requirements.

2. Background

The Mazars report, December 2015, highlighted the limited number of deaths that had been investigated at Southern Health NHS Trust. This led to the Secretary of State asking the Care Quality Commission to carry out a national review in 2016.

3. CQC learning, candour and accountability report

This report found there was no single framework for NHS trusts in England that sets out what they need to do to maximise the learning from deaths that may be the result of problems in care. It found that there are a range of systems and processes in place, and that practice varies widely across providers. Consequently if found that learning from deaths is not being given enough consideration in the NHS and opportunities to improve care for future patients are being missed. It also found that families and carers often have a poor experience of investigations and are not always treated with kindness, respect and honesty.

The report made seven recommendations one of which (recommendation 7) applied to provider Trusts.

Provider boards should ensure:

- Patients who have died under their care are properly identified.
- Case records of all patients who have died are screened to identify concerns and possible areas for improvement and the outcome documented.
- Staff and families/carers are proactively supported to express concerns about the care given to patients who have died.
- Appropriately trained staff are employed to conduct investigations.
- Where serious concerns about a death are expressed, a low threshold should be set for commissioning an external investigation.
- Investigations are conducted in a timely fashion, recognising that complex cases may require longer than 60 days.
- Families and carers are involved in investigations to the extent that they wish.
- Learning from reviews and investigations is effectively disseminated across their organisation, and with other organisations where appropriate.
- Information on deaths, investigations and learning is regularly reviewed at board level, acted upon and reported in annual Quality Accounts.

- That particular attention is paid to patients with a learning disability or mental health condition.

It also included the following recommendation; that Leaders of national oversight bodies (NHS Improvement, NHS England and CQC) and Royal Colleges, work together with families to develop a new single framework on learning from deaths.

This resulted in the National Quality Board Framework, March 2017, which sets out a number of requirements for provider organisations

4. National Quality Board Framework – Appendix 1

From April 2017, Trusts are required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public Board meeting in each quarter to set out the Trust's policy and approach (by the end of Q2) and publication of the data and learning points (from Q3 onwards). This data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care. The dashboard provided with the guidance shows what data needs to be collected and a suggested format for publishing the information. See Appendix 1.

In addition, each Trust should publish an updated policy by September 2017 on how it responds to, and learns from, deaths of patients who die under its management and care, including:

- How its processes and responds to the death of an individual with a learning disability (Annex D) or mental health needs (Annex E), an infant or child death (Annex F) and a stillbirth or maternal death (Annex G).
- The Trust's approach to undertaking case record reviews. The guidance highlights the Structured Judgement Review (SJR) method. Methods like SJR were not developed for mental health and community Trusts but can be used as a starting point and adapted by these providers to reflect their individual service user and clinical circumstances.
- Case record reviews of deaths of people with learning disabilities by acute, mental health and community Trusts should adopt the methodology developed by the Learning Disabilities Mortality Review (LeDeR) programme in those regions where the programme is available.
- Categories and selection of deaths in scope for case record review: As a minimum and from the outset, Trusts should focus reviews on in-patient deaths in line with the criteria specified at paragraph 14(ii). In particular contexts, and as these processes become more established, Trusts should include cases of people who had been an in-patient but had died within 30 days of leaving hospital.
- Mental Health Trusts and Community Trusts will want to carefully consider which categories of outpatient and/or community patient are within scope for review taking a proportionate approach. The rationale for the scope selected by Trusts will need to be published and open to scrutiny.

- A further development in 2017 /18 will be: the development of guidance for bereaved families and carers. This will support standards already set for local services within the Duty of Candour and the Serious Incident Framework and cover how families should be engaged in investigations.

  Under our existing policy the Trust ensures families/carers are made fully aware of the serious investigation process and are provided with an opportunity to raise any questions regarding the investigation and to specifically ask for particular matters to be investigated. The lead investigator remains the point of contact for the family throughout the investigation and beyond, e.g through to a Coroner's Hearing, and ensures they receive and are met with to discuss the findings of the investigation.

Specifically, the NQB set out the following requirements some of which endorse the CQC recommendations.
The Board should ensure that their organisation:

- has an existing board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda and an existing non-executive director to take oversight of progress;
- pays particular attention to the care of patients with a learning disability or mental health needs;
- has a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review;
- adopts a robust and effective methodology for case record reviews of all selected deaths (including engagement with the LeDeR programme) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented;
- ensures case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur;
- ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board in order that the executives remain aware and non-executives can provide appropriate challenge. The reporting should be discussed at the public section of the board level with data suitably anonymised;
- ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and reported in annual Quality Accounts;
- shares relevant learning across the organisation and with other services where the insight gained could be useful;
- ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths;
- offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death;

- acknowledges that an independent investigation (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in some circumstances be warranted, for example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved; and,
- works with commissioners to review and improve their respective local approaches following the death of people receiving care from their services. Commissioners should use information from providers from across all deaths, including serious incidents, mortality reviews and other monitoring, to inform their commissioning of services. This should include looking at approaches by providers to involving bereaved families and carers and using information from the actions identified following reviews and investigations to inform quality improvement and contracts etc.

5. Current position in response to the CQC and NQB requirements

	Action	Current Position	Future Position	Timescale	Responsibility
1	All Trusts publish a policy on learning from deaths by September 2017.		An agreed policy across the Northern Alliance Trusts	Sept 2017	Dr Claire Kenwood/Anthony Deery
2	Has an existing board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda and an existing non-executive director to take oversight of progress;	The Trust's Medical Director is the lead for patient safety. Due to a recent change in personnel the Director of Nursing has been the interim Director Lead. At present there is not a designated non-executive director lead.	Identified Director and Non-Executive Director leads To be agreed	April 2017	Chair/CEO
3	From April 2017, Trusts are required to collect and publish on a quarterly basis specified information on deaths.	Data is currently reported via DATIX, for review at the Mortality Review Group.	Develop a quarterly report for the Board in line with the requirements set out in the NQB Framework	June 2017	Christine Woodward, Head of Risk Management
4	Adopt a robust and effective methodology for case record reviews of all selected deaths (including engagement with the LeDeR programme) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for	Existing methodology covered by the Serious Incident Framework and Mortality Review Group. We are currently exploring the use of the Structured Judgement Review as recommended in the NQB Framework.	Working with the Northern Alliance Collaborative to develop a consistent methodology across all organisations. In the meantime we are continuing to use our agreed care record review methodology	June 2017	Christine Woodward

	improvement, with the outcome documented;				
5	Patients who have died under their care are properly identified.	Following the Mazars Report, in May 2016 the Trust established a Mortality Review Group. Its purpose is to review all deaths, natural and unnatural causes, and to ensure they were being investigated appropriately. This is a multi-professional group chaired by the Head of Risk Management. We now need to evaluate the effectiveness of the existing Mortality Review process and governance to ensure there are no attritions and the reviews address the Framework requirement	To create a mortality dashboard which triangulates information from the local and national systems to assess and analyse to give a 0 attrition rate, based on patients that are current to services at death or have been recently discharged from services in the last 6 months. Revised Terms of Reference and governance for the Mortality Review Group, with reporting to the proposed Trust Clinical Governance Group and the Quality Committee.	June 2017	Anthony Deery/ Dr Claire Kenwood/ Christine Woodward
6	Case records of all patients who have died are screened to identify concerns and possible areas for improvement and the outcome documented.	Expected natural cause deaths undergo a care plan review. All deaths meeting the threshold of a Serious Incident are subject to full root cause analysis investigation..	The Trust Serious Incident procedure is currently under review. We need to establish a mortality review process, supported by the Alliance Health Service Network and North East Quality Observatory, that will address all of the requirements set out in the Framework	June 2017	Dr Claire Kenwood/Christine Woodward
7	Staff and families/carers are proactively supported to express concerns about the care given to patients who have died.	This already occurs around our established Duty of Candour policy and is evidenced in our SI investigation reports.	These processes will be extended to all deaths following an assessment of any concerns identified for any non-SI related death, which may include natural and expected deaths. Further national guidance is expected in 17-18	June 2017	Dr Claire Kenwood/Christine Woodward
8	Appropriately trained	The Trust has in	A review of the levels	June 2017	Anthony

	staff are employed to conduct investigations.	place a central dedicated serious incident investigator, and is out to recruitment for another 1.0 wte. In addition to this there are a number of staff trained to undertake Root Cause Analysis investigations and the Trust has recently commissioned additional training. Investigators are supported by a lead clinician from the services. The Trust is currently exploring use of the SJR methodology.	and nature of investigations for non-SI deaths will be agreed and capacity and demand including any increased costs will be reported through to the Trust's Senior management Group, as an outcome of the new mortality review process.		Deery/Christine Woodward
9	Where serious concerns about a death are expressed, a low threshold should be set for commissioning an external investigation.	Within existing serious incident processes, where information comes to light or there is concern relating to the true independence of investigation this is escalated to the Executive Director, to seek for authorisation of allocation to an external investigator, supported by a lead clinician in the Trust.	Capacity and demand fluctuates for this and likely this will be impacted by a small group of external professionals being available, and facing more requests from a number of Trusts in future. Demand and compliance will be reported through the quarterly report	June 2017	Christine Woodward
10	Investigations are conducted in a timely fashion, recognising that complex cases may require longer than 60 days.	The Trust reports on its compliance against current 60 working day timescales through the monthly All Incident's report which is shared with Clinical Commissioning Groups. Extensions are agreed in advance and by exception.	Monitoring of these timescales will continue to be shared with CCG's and included in the Quarterly Board.	July 2017	Dr Claire Kenwood/Christine Woodward
11	Families and carers are involved in investigations to the extent that they wish.	Families and carers are involved at the outset in any investigation, where they are contactable following a death.	This approach will need sensitive consideration and included into the mortality review process for Non-SI	June 2017	Dr Claire Kenwood/Christine Woodward

		Extensions are agreed to delay the investigation at their request due to impact of bereavement. Reports are shared that answer the specific questions they have and agreements in place with all coroners where deaths are subject to inquest to direct concerns or questions to the Trust to be included.	deaths.		
12	Learning from reviews and investigations is effectively disseminated across their organisation and with other organisations where appropriate.	The Trust, at present, has a system that is limited to SI investigations.	This approach will need to be reviewed with a much clearer governance framework for learning from all reviews/investigations, disseminating the learning and receiving evidential assurance that this has been applied in practice. This will be considered as part of the SI process review.	June 2017	Dr Claire Kenwood/Anthony Deery/Clinical Directors
13	Information on deaths, investigations and learning is regularly reviewed at board level, acted upon and reported in annual Quality Accounts.	The Trust has had a transparent and open approach to reporting and learning from deaths that were subject to a SI investigation at the open part of the Board of Directors	This will be expanded to include a report on all deaths and incorporated into future Quality Accounts	July 2017	Dr Claire Kenwood/Anthony Deery
14	That particular attention is paid to patients with a learning disability or mental health condition.	This recommendation is applied across all service providers, and by default would naturally apply to a Mental Health / Learning Disability Trust	Work needs to be completed to improve the quality of diagnosis of all patients who die, to understand their diagnosis. We need to develop this through the Norther Alliance work to ensure there is a consistent approach.	June 2017	Dr Claire Kenwood/Anthony Deery
15	**Trust identified requirement** To develop a communication plan	Involvement of the Trust's communication team in the review of the existing governance and action planning.	Communication brief for internal and external stakeholders	June 2017	Dr Claire Kenwood/Anthony Deery and Oliver Tipper.

6. Conclusion

Following the initial Mazars report the Trust acted swiftly to modify the DATIX reporting system and established a Mortality Review Group in order to ensure it was recording and reviewing all deaths. The Group was observed by CQC during their comprehensive inspection in July 2016 and complimented for the work it was doing. The Trust is also been a member of the Northern Alliance, which comprises of 8 mental health and learning disability Trust across the Yorkshire and Humber and the North of England. The Chief Executive Officers have approved resource to support a Mortality Review Group, facilitated by Mazars and whose purpose is to facilitate a collaborative response to the CQC and NQB reports in order to ensure there is a consistent and comparable approach across the footprint of the Alliance.

The Trust already has already taken action to address many of the recommendations and continues to work collaboratively with key stakeholders to ensure these are fully addressed.

7. The Board is being asked to consider

1. The Board is assured the Trust has reviewed and responded to the recommendations and requirements set out in the national guidance.
2. The action plan provides assurance that we are adequately addressing the requirements.

National Guidance on Learning from Deaths

A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care

National Quality Board

First edition March 2017

National Guidance on Learning from Deaths

Contents

Foreword

Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards "from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals".

This was reinforced by the recent findings of the Care Quality Commission (CQC) report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*. It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning.

Understanding and tackling this issue will not be easy, but it is the right thing to do. There will be legitimate debates about deciding which deaths to review, how the reviews are conducted, the time and team resource required to do it properly, the degree of avoidability and how executive teams and boards should use the findings.

This first edition of *National Guidance on Learning from Deaths* aims to kickstart a national endeavour on this front. Its purpose is to help initiate a standardised approach, which will evolve as we learn. Following the Learning from Deaths conference on 21st March 2017 we will update this guidance to reflect the collective views of individuals and organisations to whom this guidance will apply to ensure that it is helpful.

Professor Sir Bruce Keogh
National Medical Director
NHS England

Professor Sir Mike Richards
Chief Inspector of Hospitals
Care Quality Commission

Dr Kathy McLean
Executive Medical Director
NHS Improvement

On behalf of the National Quality Board.

Executive Summary

Introduction

1. For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system-wide failures. NHS staff work tirelessly under increasing pressures to deliver safe, high-quality healthcare. When mistakes happen, providers working with their partners need to do more to understand the causes. The purpose of reviews and investigations of deaths which problems in care might have contributed to is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

2. The following definitions apply for the purposes of this guidance:

(i) Case record review: The application of a case record/note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened, for example Structured Judgement Review delivered by the Royal College of Physicians.

(ii) Investigation: The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.

(iii) Death due to a problem in care: A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.

Governance and Capability

3. Learning from a review of the care provided to patients who die should be integral to a provider's clinical governance and quality improvement work. To fulfil the standards and new reporting set out in this guidance for **acute, mental health and community NHS Trusts and Foundation Trusts**, Trusts should ensure their **governance arrangements**

and processes include, facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care. Trusts should also ensure that they share and act upon any learning derived from these processes. The standards expected of Trust boards are set out at Annex A including having an existing **executive director** take responsibility for the learning from deaths agenda and an existing **non-executive director** take responsibility for oversight of progress. Guidance for non-executive directors is at Annex B.

4. Providers should review and, if necessary, enhance **skills and training** to support this agenda. Providers need to ensure that staff reporting deaths have appropriate skills through specialist training and protected time under their contracted hours to review and investigate deaths to a high standard.

5. Providers should have a **clear policy for engagement with bereaved families and carers**, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. Providers should make it a priority to work more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.

Improved Data Collection and Reporting

6. The following minimum requirements are being introduced to complement providers' current approaches in relation to reporting and reviewing deaths:

A. POLICY ON RESPONDING TO DEATHS

- Each Trust should publish an **updated policy** by September 2017 on how it responds to, and learns from, deaths of patients who die under its management and care, including:

  i. How its processes respond to the death of an individual with a **learning disability** (Annex D) or **mental health needs** (Annex E), **an infant or child death** (Annex F) and a **stillbirth or maternal death** (Annex G).
  ii. **The Trust's approach to undertaking case record reviews**. Acute Trusts should use an evidence-based methodology for reviewing the quality of care provided to those patients who die. The Structured Judgement Review (SJR)

case note methodology is one such approach and a programme to provide training in this methodology for acute Trusts will be delivered by the Royal College of Physicians over the coming year (the current version of the SJR approach is available at https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrr-programme-resources Other approaches also exist, such as those based on the PRISM methodology. Methods like SJR were not developed for mental health and community Trusts but can be used as a starting point and adapted by these providers to reflect their individual service user and clinical circumstances. Annex J provides a case study of how SJR is being adapted for mental health Trusts. Case record reviews of deaths of people with learning disabilities by acute, mental health and community Trusts should adopt the methodology developed by the Learning Disabilities Mortality Review (LeDeR) programme in those regions where the programme is available (details of the programme are available from Annex D).

iii. **Categories and selection of deaths in scope for case record review:** As a minimum and from the outset, Trusts should focus reviews on in-patient deaths in line with the criteria specified at paragraph 14(ii). In particular contexts, and as these processes become more established, Trusts should include cases of people who had been an in-patient but had died within 30 days of leaving hospital. Mental Health Trusts and Community Trusts will want to carefully consider which categories of outpatient and/or community patient are within scope for review taking a proportionate approach. The rationale for the scope selected by Trusts will need to be published and open to scrutiny.

B. DATA COLLECTION AND REPORTING

- **From April 2017, Trusts will be required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public Board meeting in each quarter to set out the Trust's policy and approach (by the end of Q2) and publication of the data and learning points (from Q3 onwards).** This data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care. The dashboard provided with this guidance shows what data needs to be collected and a suggested format for publishing the information,

accompanied by relevant qualitative information and interpretation.

- **Changes to the Quality Accounts regulations will require that the data providers publish be summarised in Quality Accounts from June 2018** (Annex L), including evidence of learning and action as a result of this information and an assessment of the impact of actions that a provider has taken.

Further Developments

7. In 2017-18, further developments will include:

- **The Care Quality Commission will strengthen its assessment of providers learning from deaths** including the management and processes to review and investigate deaths and engage families and carers in relation to these processes.
- **NHS England, led by the Chief Nursing Officer, will develop guidance for bereaved families and carers.** This will support standards already set for local services within the Duty of Candour[1] and the *Serious Incident Framework*[2] and cover how families should be engaged in investigations. Health Education England will review training of doctors and nurses on engaging with bereaved families and carers.
- **Acute Trusts will receive training to use the Royal College of Physicians' Structured Judgement Review case note methodology.** Health Education England and the Healthcare Safety Investigation Branch (Annex L) will engage with system partners, families and carers and staff to understand broader training needs and to develop approaches so that NHS staff can undertake good quality investigations of deaths.
- **NHS Digital is assessing how to facilitate the development of provider systems and processes** so that providers know when a patient dies and information from reviews and investigations can be collected in standardised way.
- **The Department of Health is exploring proposals to improve the way complaints involving serious incidents are handled** particularly how providers and the wider care system may better capture necessary learning from these incidents[3].

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[1] Further information is available from: http://www.cqc.org.uk/sites/default/files/20141120_doc_fppf_final_nhs_provider_guidance_v1-0.pdf

[2] https://improvement.nhs.uk/resources/serious-incident-framework/

[3] This follows the Parliamentary and Health Service Ombudsman's report *Learning from Mistakes* (July 2016) and the Public Administration and Constitutional Affairs Committee hearings on this report.

Chapter 1 - Mortality Governance

Context

8. In December 2016, the Care Quality Commission (CQC) published its review *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England.* The CQC found that none of the Trusts they contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented.

9. The Secretary of State for Health accepted the report's recommendations and in a Parliamentary statement[4] made a range of commitments to improve how Trusts learn from reviewing the care provided to patients who die. This includes regular publication of specified information on deaths, including those that are assessed as more likely than not to have been due to problems in care, and evidence of learning and action that is happening as a consequence of that information in Quality Accounts from June 2018.

Accountability

10. Mortality governance should be a key priority for Trust boards. Executives and non-executive directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge.

11. This *National Guidance on Learning from Deaths* should be read alongside the *Serious Incident Framework*. Trust boards are accountable for ensuring compliance with both these frameworks. They should work towards achieving the highest standards in mortality governance. However, different organisations will have different starting points in relation to this agenda and it will take time for all Trusts to meet such standards. Over time this guidance is likely to be updated to include wider providers of NHS care and whole healthcare systems.

Responding to Deaths

12. Each Trust should have a policy in place that sets out how it responds to the deaths of patients who die under its management and care. The standards expected of Trusts are set out at Annex C.

13. Boards should take a systematic approach to the issue of potentially avoidable mortality and have robust mortality governance processes. This will allow them to identify any areas of

[4] https://www.gov.uk/government/speeches/cqc-review-of-deaths-of-nhs-patients]

failure of clinical care and ensure the delivery of safe care. This should include a mortality surveillance group with multi-disciplinary and multi-professional membership, regular mortality reporting to the Board at the public section of the meeting with data suitably anonymised, and outputs of the mortality governance process including investigations of deaths being communicated to frontline clinical staff.

Death Certification, Case Record Review and Investigation

14. There are three levels of scrutiny that a provider can apply to the care provided to someone who dies; (i) death certification; (ii) case record review; and (iii) investigation. They do not need to be initiated sequentially and an investigation may be initiated at any point, whether or not a case record review has been undertaken (though a case record review will inform the information gathering phase of an investigation together with interviews, observations and evidence from other sources). For example, the apparent suicide of an in-patient would lead to a Serious Incident investigation being immediately instigated in advance of death certification or any case record review. The three processes are summarised below:

(i) Death Certification: In the existing system of death certification in England, deaths by natural causes are certified by the attending doctor. Doctors are encouraged to report any death to the coroner that they cannot readily certify as being due to natural causes. Reforms to death certification, when implemented in England (and Wales), will result in all deaths being either scrutinised by a Medical Examiner or investigated by the Coroner in prescribed circumstances. Additionally, Medical examiners will be mandated to give bereaved relatives a chance to express any concerns and to refer to the coroner any deaths appearing to involve serious lapses in clinical governance or patient safety.

(ii) Case Record Review: Some deaths should be subject to further review by the provider, looking at the care provided to the deceased as recorded in their case records in order to identify any learning. At a minimum, providers should require reviews of:

i. all deaths where **bereaved families and carers, or staff, have raised a significant concern about the quality of care provision**;
ii. all in-patient, out-patient and community patient deaths of those with **learning disabilities** (the LeDeR review process outlined at Annex D should be adopted in those regions where the programme is available otherwise Structured Judgement Review or another robust and evidence-based methodology should be used) and

with **severe mental illness**;

iii. all deaths in a **service specialty, particular diagnosis or treatment group where an 'alarm' has been raised** with the provider through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator);

iv. all deaths in areas where people are **not expected to die**, for example in relevant elective procedures;

v. deaths where **learning will inform the provider's existing or planned improvement work**, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically;

vi. **a further sample of other deaths** that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall. This does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each weekday.

The above minimum requirements are additional to existing requirements for providers to undertake specific routes of reporting, review or investigations for specific groups of patient deaths, such as deaths of patients detained under the Mental Health Act 1983 (Annex E).

Providers should review a case record review following any linked inquest and issue of a "Regulation 28 Report on Action to Prevent Future Deaths" in order to examine the effectiveness of their own review process.

Providers should apply rigorous judgement to the need for deaths to be subject to a Serious Incident reporting and investigation. For example, there may be instances where deaths clearly meet Serious Incident criteria and should be reported as such (whether or not a case record review has already been undertaken). Equally, problems identified in case record review may lead to the need for investigation whether this is an investigation under the Serious Incident Framework or other framework/procedure (see section iii)

(iii) Investigation: Providers may decide that some deaths warrant an investigation and should be guided by the circumstances for investigation in the Serious Incident Framework.

Some deaths will be investigated by other agents, notably the coroner. Indeed, the coroner has a duty to investigate any death where there are grounds to suspect that the death may have been avoidable. While care should be taken not to compromise such investigations, equally waiting until other investigations are completed may cause unacceptable delay. A good working relationship and close communication are needed to avoid problems.

Providers should review an investigation they undertake following any linked inquest and issue of a "Regulation 28 Report to Prevent Future Deaths" in order to examine the effectiveness of their own investigation process. If an inquest identifies problems in healthcare, providers may need to undertake additional investigation and improvement action, regardless of the coroner's verdict.

Consistency and Judgement in Case Record Review

15. All Trusts currently undertake some form of mortality review. However there is considerable variation in terms of methodology, scope, data capture and analysis, and contribution to learning and improvement. To generate learning for improvement in healthcare, clinicians and staff should engage in robust processes of retrospective case record review to help identify if a death was more likely than not to have been contributed to by problems of care.

16. The Structured Judgement Review (SJR) case note methodology is an approach being rolled out by the Royal College of Physicians. Other methodologies exist and Trusts may already be using them. Trusts need to be assured that the methodology they are using is robust and evidence-based, that it will generate the information they are now being required to publish and that their staff are trained and given sufficient time and resources to undertake case record reviews and act on what they learn.

17. Case record review assessment is finely balanced and subject to significant inter-reviewer variation. It does not support comparison between organisations and should not be used to make external judgements about the quality of care provided.

18. The judgement of whether a problem may have contributed to a death requires careful review of the care that was provided against the care that would have been expected at the time of death. Research has shown that when case record review identifies a death that may have been caused by problems in care, that death tends to be due to a series of problems none of which would be likely to have caused the death in isolation but which in

combination can contribute to the death of a patient[5][6]. Some of these elements of care are likely to have occurred prior to the admission and providers should support other organisations, for example in primary care, to understand and act on areas where care could be improved.

19. Trusts should acknowledge and cooperate with separate arrangements for the review (and where appropriate investigation) of certain categories of deaths, for example suicides, homicides, and child and maternal deaths.

Objectivity in Case Record Review

20. To ensure objectivity, case record reviews should wherever possible be conducted by clinicians other than those directly involved in the care of the deceased. If the specific clinical expertise required only resides with those who were involved in the care of the deceased, the review process should still involve clinicians who were not involved in order to provide peer challenge. Objectivity of reviews should be a component of clinical governance processes. Providers may wish to consider if their review processes should additionally be the responsibility of a designated non-executive director who could do this by chairing the relevant clinical governance committee.

Investigations

21. This *National Guidance on Learning from Deaths* and the *Serious Incident Framework* are complementary. This guidance sets out what deaths should be subject to case record review (paragraph 14(ii)), which is inevitably a wider definition than deaths that constitute Serious Incidents. Equally, when a death meets Serious Incident criteria there is no need to delay the onset of investigation until case record review has been undertaken. A review of records will inevitably be undertaken as part of an investigation process. However, immediate action to secure additional information and evidence to support full investigation should not be lost due an inappropriate requirement for all deaths (regardless of nature) to first undergo a case record review.

[5] Hogan et al. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study. *BMJ Qual Saf2012*: 21: 737-45.

[6] Hogan et al. Avoidability of hospital deaths and association with hospital-wide mortality ratios: a retrospective case record *BMJ* 2015; 351:h3239.

22. Inquiries by the coroner[7] and investigations by providers are conducted to understand the cause of death and contributing factors. However provider investigations are not conducted to hold any individual or organisation to account. Other processes exist for that purpose including criminal or civil proceedings, disciplinary procedures, employment law and systems of service and professional regulation, including the General Medical Council and the Care Quality Commission. In circumstances where the actions of other agencies are required then those agencies must be appropriately informed and relevant protocols must be followed.

Medical Examiners

23. The introduction of the Medical Examiner role will provide further clarity about which deaths should be reviewed. Medical Examiners will be able to refer the death of any patient for review by the most appropriate provider organisation(s) and this new mechanism should ensure a systematic approach to selecting deaths for review, regardless of the setting or type of care provided in the period before a patient's death. NHS Improvement and the Department of Health are commissioning research to explore whether Medical Examiners are best placed to select which deaths need further review and ensure they do not inadvertently miss or over-refer certain types of cases. Prior to the implementation of the Medical Examiner system, Trusts are advised to allow for any doctors undertaking the certification of death to refer cases for case record review to the most relevant organisation.

Learning

24. Providers should have systems for deriving learning from reviews and investigations and acting on this learning. The learning should be shared with other services across the wider health economy where they believe this would benefit future patients, including independent healthcare services and social care services. Recommendations within any "Regulation 28 Report on Action to Prevent Future Deaths" from the coroner should also be integral to a provider's systems to support learning within and across their organisation and local system partners.

25. Regardless of whether the care provided to a patient who dies is examined using case record review or an investigation, the findings should be part of, and feed into, robust clinical governance processes and structures. The findings should be considered alongside

[7] Coroner investigations, A short guide (February 2014) is available from: https://www.gov.uk/government/publications/guide-to-coroner-services-and-coroner-investigations-a-short-guide

other information and data including complaints, clinical audit information, mortality data, patient safety incident reports and data and outcomes measures etc. to inform the Trust's wider strategic plans and safety priorities.

26. Where case record review identifies a problem in care that meets the definition of a patient safety incident (any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care) then this should be reported via local risk management systems to the National Reporting and Learning System (NRLS).

27. All patient safety incidents reported as resulting in death or severe harm to a patient are clinically reviewed by the National Patient Safety Team at NHS Improvement to determine if there are implications for national learning and if a response is appropriate. Any deaths that are identified via case record review as due to problems in healthcare would meet the criteria for NRLS reporting. More information on the national process is available at https://improvement.nhs.uk/resources/patient-safety-alerts. All serious incidents that relate to patients should be reported to the NRLS for the same reason.

Cross-system Reviews and Investigations

28. In many circumstances more than one organisation is involved in the care of any patient who dies. Guidance in relation to cross-system reviews and investigations is at Annex H.

Roles and Responsibilities of National Bodies and Commissioners

29. Guidance is provided at Annex I. The lead roles with overall responsibility for the learning from deaths programme at each of the relevant national organisation are provided at Annex K.

Chapter 2 - Bereaved Families and Carers

Key Principles

30. Providers should engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death and operate according to the following key principles below.

BEREAVED FAMILIES AND CARERS - KEY PRINCIPLES:

- bereaved families and carers should be treated as **equal partners** following a bereavement;
- bereaved families and carers must always **receive a clear, honest, compassionate and sensitive response** in a sympathetic environment;
- bereaved families and carers should receive a **high standard of bereavement care** which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support;
- bereaved families and carers should be informed of their **right to raise concerns about the quality of care** provided to their loved one;
- bereaved families' and carers' views should **help to inform decisions about whether a review or investigation is needed**;
- bereaved families and carers should receive **timely, responsive contact and support in all aspects of an investigation process**, with a single point of contact and liaison;
- bereaved families and carers should be **partners in an investigation** to the extent, and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations;
- bereaved families and carers who have experienced the investigation process should be supported to work in partnership with Trusts in **delivering training for staff in supporting family and carer involvement** where they want to.

Context

31. Dealing respectfully, sensitively and compassionately with families and carers of dying or deceased patients within the NHS is crucially important. The principles of openness, honesty, and transparency as set out in the Duty of Candour should also be applied by

providers in all their dealings with bereaved families and carers. Yet the Care Quality Commission's report *Learning, candour and accountability* identified that NHS providers are continuing to fail too many bereaved families and carers of those who die whilst in their care.

32. When a patient dies under the management and care of a Trust, bereaved families and carers should be informed immediately after the death. People who are bereaved need others to recognise and acknowledge their loss. Recognition by professionals, appropriately expressed, may be particularly valued. Communication at the time of a death, and afterwards, should be clear, sensitive and honest. Bereaved families and carers should be given as much information as possible in line with the Duty of Candour for providers. Every effort should be made to hold these discussions in a private, sympathetic environment, without interruptions. Providers should ensure that their staff, including family liaison officers where available, have the necessary skills, expertise and knowledge to engage with bereaved families and carers. This includes recognising and dealing with common issues such as family members feeling guilty about their loss.

33. All too often the terms of the conversation people have with the NHS about a concern or complaint are set by the organisation. Organisations can often be too quick to dismiss or explain away concerns, compounding the grief of bereaved families and carers with obfuscation and a lack of openness. Paying close attention to what bereaved families and carers say can offer an invaluable source of insight to improve clinical practice. Listening to them goes hand in hand with the Duty of Candour. In particular, bereaved families and carers should be asked if they had concerns about the quality of care received by the deceased to inform decisions about the need to undertake a case record review or investigation.

34. When reviewing or investigating possible problems with care, involvement of bereaved families and carers begins with a genuine apology. Saying sorry is not an admission of liability and is the right thing to do. The appropriate staff member should be identified for each case, including to explain what went wrong promptly, fully and compassionately. This may include clinicians involved in the case but this may not always be appropriate and should be considered on a case by case basis.

35. Depending on the nature of the death, it may be necessary for several organisations to make contact with those affected. This should be discussed with the bereaved families and carers and a co-ordinated approach should be agreed with them and the

organisations involved. If other patients and service users are involved or affected by the death they should be offered the appropriate level of support and involvement.

36. The provider should ensure that the deceased person's General Practitioner is informed of the death and provided with details of the death as stated in the medical certificate at the same time as the family or carers. The GP should be informed of the outcome of any investigation.

Bereavement Support

37. Bereavement can influence every aspect of well-being. Providers should offer a bereavement service for families and carers of people who die under their management and care (including offering or directing people to suicide bereavement support) that offers a caring and empathetic service at a time of great distress and sadness. This includes offering support, information and guidance. This should include bereavement advisors to help families and carers through the practical aspects following the death of a loved one such as:

- arranging completion of all documentation, including medical certificates;
- the collection of personal belongings;
- post mortem advice and counselling;
- deaths referred to the coroner;
- emotional support, including counselling;
- collection of the doctor's Medical Certificate of Cause of Death and information about registering a death at the Registrar's Office;
- details of the doctor's Medical Certificate of Case of Death (this is needed to register a death at the Registrar's Office).

38. The following should also be considered:

- timely access to an advocate (independent of the Trust) with necessary skills for working with bereaved and traumatised individuals;
- support with transport, disability, and language needs;
- support during and following an investigation. This may include counselling or signposting to suitable organisations that can provide bereavement or post-traumatic stress counselling, with attention paid to the needs of young family members, especially siblings;

- further meetings with the organisations involved or support in liaising with other agencies such as the police.

Review

39. If the care of a patient who has died is selected for case record review providers should:

- have formed that decision based on the views of the family and carers. Providers should require reviews in cases where family and carers have raised a significant concern about the quality of care provision (paragraph 14 (ii)(i));
- communicate to the family and carers the findings of the review if any problems with care are identified and any lessons the review has contributed for the future.

Investigations

40. If a provider feels that an investigation into a death is needed, early contact should have been made with bereaved families and carers so that their views helped to inform the decision.

41. Bereaved families and carers will expect to know: what happened; how; to the extent possible at the time, why it happened; and what can be done to stop it happening again to someone else. If a provider proceeds with an investigation, skilled and trained investigators need to be able to explain to bereaved families and carers the purpose of the investigation which is to understand what happened. If problems are identified, the investigation should be clear why and how these happened so that action can be taken to prevent the same mistakes from occurring again.

42. Provided the family or carer is willing to be engaged with regarding the investigation, an early meeting should be held to explain the process, how they can be informed of progress, what support processes have been put in place and what they can expect from the investigation. This should set out realistic timescales and outcomes. There should be a named person as a consistent link for the families and carers throughout the investigation, for example a family liaison officer.

43. Bereaved families and carers should:

- be made aware, in person and in writing, as soon as possible of the purpose, rationale and process of the investigation to be held;

- be asked for their preferences as to how and when they contribute to the process of the investigation and be kept fully and regularly informed, in a way that they have agreed, of the process of the investigation;
- have the opportunity to express any further concerns and questions and be offered a response where possible, with information about when further responses will be provided;
- have a single point of contact to provide timely updates, including any delays, the findings of the investigation and factual interim findings. This may disclose confidential personal information for which consent has been obtained, or where patient confidentiality is overridden in the public interest. This should be considered by the organisation's Caldicott Guardian and confirmed by legal advice in relation to each case;
- have an opportunity to be involved in setting any terms of reference for the investigation which describe what will be included in the process and be given expectations about the timescales for the investigation including the likely completion date;
- be provided with any terms of reference to ensure their questions can be reflected and be given a clear explanation if they feel this is not the case;
- have an opportunity to respond on the findings and recommendations outlined in any final report; and,
- be informed not only of the outcome of the investigation but what processes have changed and what other lessons the investigation has contributed for the future.

Guidance

44. NHS England will develop guidance for bereaved families and carers, identifying good practice for local services on the information that families say they would find helpful. It will cover what families can expect by way of local support in relation to investigations and what to expect when services have identified the death as complex or needing an independent investigation so potentially involving longer timeframes and multiple agency involvement.

45. Public Health England has published guidance which provides advice to local authorities and the NHS on developing and providing suicide bereavement support[8].

8 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/590838/support_after_a_suicide.pdf

Annexes

Annex A - Board Leadership

BOARD LEADERSHIP - KEY POINTS

The board should ensure that their organisation:

- has an existing board-level leader acting as **patient safety director** to take responsibility for the learning from deaths agenda and an existing **non-executive director** to take oversight of progress;
- pays particular attention to the care of patients with a **learning disability or mental health needs**;
- has a systematic approach to **identifying those deaths requiring review** and selecting other patients whose care they will review;
- adopts a robust and **effective methodology for case record reviews** of all selected deaths (including engagement with the LeDeR programme) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented;
- ensures **case record reviews and investigations are carried out to a high quality**, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur;
- ensures that **mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board** in order that the executives remain aware and non-executives can provide appropriate challenge. The reporting should be discussed at the public section of the board level with data suitably anonymised;
- ensures that learning from reviews and investigations is **acted on** to sustainably change clinical and organisational practice and improve care, and **reported in annual Quality Accounts**;
- **shares relevant learning** across the organisation and with other services where the insight gained could be useful;
- ensures sufficient numbers of **nominated staff have appropriate skills** through specialist training and protected time as part of their contracted hours to review and investigate deaths;
- **offers timely, compassionate and meaningful engagement with bereaved families and carers** in relation to all stages of responding to a death;
- acknowledges that an **independent investigation** (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in

some circumstances be warranted, for example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved; and,

- **works with commissioners to review and improve their respective local approaches** following the death of people receiving care from their services. Commissioners should use information from providers from across all deaths, including serious incidents, mortality reviews and other monitoring, to inform their commissioning of services. This should include looking at approaches by providers to involving bereaved families and carers and using information from the actions identified following reviews and investigations to inform quality improvement and contracts etc.

Annex B - Non-Executive Directors

Context

1. The board of directors of an NHS Trust or Foundation Trust is collectively responsible for ensuring the quality and safety of healthcare services delivered by the Trust, and in the case of a Foundation Trust taking into consideration the views of the board of governors.

2. Boards must ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. Providers should ensure such activities are adequately resourced. Commissioners are accountable for quality assuring the robustness of providers' systems so that providers develop and implement effective actions to reduce the risk of avoidable deaths, including improvements when problems in the delivery of care within and between providers are identified.

3. All Trust directors, executive and non-executive, have a responsibility to constructively challenge the decisions of the board and help develop proposals on strategy. Non-executive directors, in particular, have a duty to ensure that such challenge is made. They play a crucial role in bringing an independent perspective to the boardroom and should scrutinise the performance of the provider's management in meeting agreed goals and objectives and monitor the reporting of performance. Non-executive directors should satisfy themselves as to the integrity of financial, clinical and other information, and that clinical quality controls and systems of risk management, for example, are robust and defensible.

Learning from Deaths

4. Executive and non-executive directors have a key role in ensuring their provider is learning from problems in healthcare identified through reviewing or investigating deaths by ensuring that:

    - the processes their organisation have in place are robust, focus on learning and can withstand external scrutiny, by providing challenge and support;
    - quality improvement becomes and remains the purpose of the exercise, by championing and supporting learning, leading to meaningful and effective actions that improve patient safety and experience, and supporting cultural change; and

- the information the provider publishes is a fair and accurate reflection of its achievements and challenges.

5. From April 2017, providers will start to collect and publish new data to monitor trends in deaths. Alongside this, they will need to establish an ongoing learning process. Board oversight of this process is as important as board oversight of the data itself. As a critical friend, non-executive directors should hold their organisation to account for its approach and attitude to patient safety and experience, and learning from all deaths, particularly those assessed as having been avoidable. The roles and responsibilities of non-executive directors include:

   i. **Understand the process: ensure the processes in place are robust and can withstand external scrutiny, by providing challenge and support. For example:**
      - be curious about the accuracy of data and understand how it is generated; who is generating it, how are they doing this, is the approach consistent across the Trust, are they sufficiently senior/experienced/trained?
      - seek similar data and trend information from peer providers, to help challenge potential for improvements in your own organisation's processes, but understand limitations of any direct comparisons;
      - ensure timely reviews/investigations (what is the interval between death and review or investigation?), calibre of reviewer/investigator and quality of the review or investigation;
      - is the Care Record Review process objective, conducted by clinicians not directly involved in the care of the deceased?
      - how was the case-record review selection done? For example, does selection reflect the evidence base which suggests older patients who die or those where death may be expected are no less likely to have experienced problems in healthcare that are associated with potentially preventable death? Does it ensure all vulnerable patient groups (not just those with learning disabilities or mental health needs) are not disadvantaged?
      - are deaths of people with learning disabilities reviewed according to the LeDeR methodology?
      - for coordination of responses to reviews/investigations through the provider's clinical governance processes, who is responsible for preparing the report, do problems in care identified as being likely to have contributed to a death feed into the organisation's Serious Incident processes?

ii. **Champion and support learning and quality improvement such as:**

- ensuring the organisation has a long-term vision and strategy for learning and improvement and is actively working towards this;
- understanding the learning being generated, including from where deaths may be expected but the quality of care could have been better;
- understanding how the learning from things going wrong is translated into sustainable effective action that measurably reduces the risks to patients - ensuring that learning and improvements are reported to the board and relevant providers;
- supporting any changes in clinical practice that are needed to improve care resulting from this learning;
- ensuring families and carers are involved reviews and investigations, and that nominated staff have adequate training and protected time to undertake these processes;
- paying attention to the provision of best practice and how the learning from this can be more broadly implemented.

iii. **Assure published information; ensure that information published is a fair and accurate reflection of the provider's achievements and challenges, such as:**

- ensuring that information presented in board papers is fit for publication i.e. it is meaningful, accurate, timely, proportionate and supports improvement;
- checking that relevant team are working towards a timely quarterly publication, in line with the Quality Accounts regulations and guidance;
- checking that arrangements are in place to invite, gather and act on stakeholder feedback on a quarter by quarter basis;
- ensuring the organisation can demonstrate to stakeholders that "this is what we said we would do, and this is what we did" (learning and action), and explain the impact of the quality improvement actions.

Annex C - Responding to Deaths

Trusts should have a policy in place that sets out how they respond to the deaths of patients who die under their management and care.

POLICY FOR RESPONDING TO DEATHS - KEY POINTS

The policy should include how providers:

- **determine which patients are considered to be under their care and included for case record review if they die** (it should also state which patients are specifically excluded);
- **report the death within the organisation and to other organisations who may have an interest** (including the deceased person's GP), including how they determine which other organisations should be informed;
- **respond to the death of an individual with a learning disability** (Annex D) or **mental health needs** (Annex E), **an infant or child death** (Annex F) **and a stillbirth or maternal death** (Annex G) and the provider's processes to support such deaths;
- **review the care provided to patients who they do not consider to have been under their care at the time of death but where another organisation suggests that the Trust should review the care provided to the patient in the past**;
- **review the care provided to patients whose death may have been expected**, for example those receiving end of life care;
- **record the outcome of their decision whether or not to review or investigate the death**, which should have been informed by the views of bereaved families and carers;
- **engage meaningfully and compassionately with bereaved families and carers** - this should include informing the family/carers if the provider intends to review or investigate the care provided to the patient. In the case of an investigation, this should include details of how families/carers will be involved to the extent that they wish to be involved. Initial contact with families/carers are often managed by the clinicians responsible for the care of the patient. Given that providers must offer families/carers the opportunity to express concerns about the care given to patients who have died, then the involvement of clinicians who cared for the patient may be considered a barrier to raising concerns. Providers should therefore offer other routes for doing this;
- **offer guidance, where appropriate, on obtaining legal advice for families,**

carers or staff. This should include clear expectations that the reasons, purpose and involvement of any lawyers by providers will be communicated clearly from the outset, preferably by the clinical team, so families and carers understand the reasons and are also offered an opportunity to have their own advocates.

Annex D - Learning Disabilities

Context

1. Since the 1990s, there have been a number of reports and case studies which have consistently highlighted, that in England, people with learning disabilities die younger than people without learning disabilities. The Confidential Inquiry of 2010-2013 into premature deaths of people with learning disabilities (CIPOLD) reported that for every one person in the general population who died from a cause of death amenable to good quality care, three people with learning disabilities would do so[9]. Overall, people with learning disabilities currently have a life expectancy at least 15 to 20 years shorter than other people[10].

2. A concerning finding from CIPOLD was that assumptions were sometimes made that the death of a person with learning disabilities was 'expected' or even inevitable, because that person had learning disabilities. As with the CQC report of 2016[11], CIPOLD also identified deaths that should have been, but were not, reported to mandatory review processes, including safeguarding reviews and to the coroner.

3. The lives of people with learning disabilities often involve a complex array of service provision with multiple care and support staff. If we are to improve service provision for people with learning disabilities and their families, and reduce premature deaths, we need to look wider than NHS-related circumstances leading to a person's death, in order to identify the wider range of potentially avoidable contributory factors to their death. A cross-sector approach to reviewing deaths of people with learning disabilities is imperative; one that includes families, primary and secondary healthcare, and social and third sector care providers. Such a balanced approach across acute and other settings is needed from the outset of a review process, in order to accurately determine if there are any concerns about the death, or to identify examples of best practice that could lead to service improvement.

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[9] Heslop P, Blair P, Fleming P, Hoghton M, Marriott A, Needleman D, Russ L. (2013) Confidential Inquiry into premature deaths of people with learning disabilities. Bristol: University of Bristol.

[10] Glover G,et al, 2017. Williams R. Heslop P, Oyinlola J, Grey J. (2016) Mortality in people with intellectual disabilities in England. *Journal of Intellectual Disabilities Research, 61, 1, 62-74; Health and Care of People with Learning Disabilities, 2014-15*, NHS Digital, 9 December 2016.

[11] *Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England*, Care Quality Commission December 2016.

4. There is unequivocal evidence that demands additional scrutiny be placed on the deaths of people with learning disabilities across all settings. This work has already been started by the Learning Disabilities Mortality Review (LeDeR) programme, commissioned by Healthcare Quality Improvement Partnership (HQUIP) for NHS England. Once fully rolled out, the programme will receive notification of all deaths of people with learning disabilities, and support local areas to conduct standardised, independent reviews following the deaths of people with learning disabilities aged 4 to 74 years of age. These will be conducted by trained reviewers.

5. The purpose of the local reviews of death is to identify any potentially avoidable factors that may have contributed to the person's death and to develop plans of action that individually or in combination, will guide necessary changes in health and social care services in order to reduce premature deaths of people with learning disabilities.

Scope

6. A conceptual definition of learning disabilities is used in the Learning Disabilities White Paper 'Valuing People'[12] (2001).

7. At present, NHS England is working with NHS Digital to explore the options and potential of 'flagging' the records of people with learning disabilities on the NHS Spine[13]. Over time, this could provide an access point for identifying that a person who has died had learning disabilities.

8. The LeDeR programme currently supports local reviews of deaths of people with learning disabilities aged 4 years and over. The lower age limit is set at 4 years of age because before that age, it can be difficult to be sure that a child has learning disabilities as defined above.

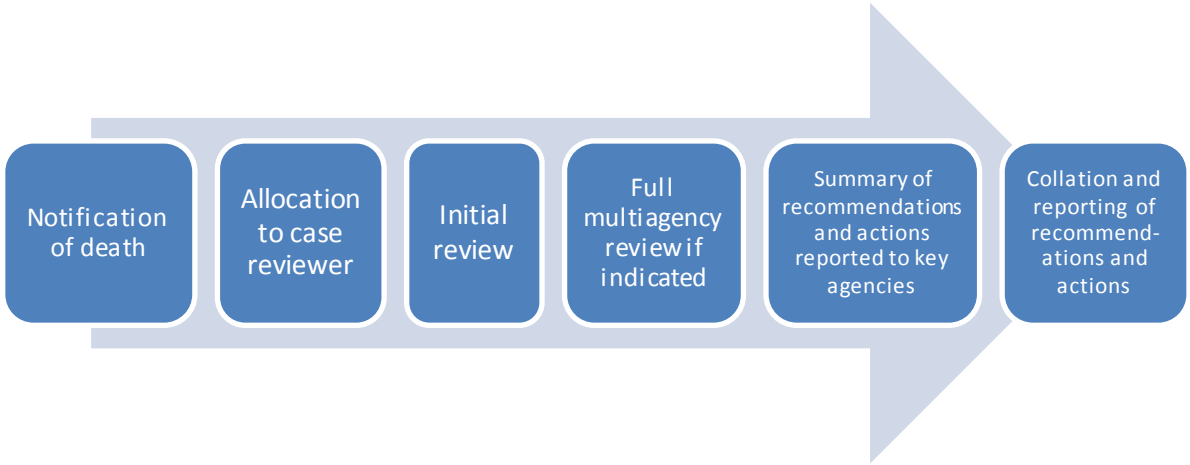
Operationalising Mortality Reviews of People with Learning Disabilities

9. The LeDeR programme has an established and well-tested methodology for reviewing the deaths of people with learning disabilities.

[12] Valuing People: A New Strategy for Learning Disability for the 21st Century, Department of Health, 2001. LeDeR briefing paper.

[13] Spine supports the IT infrastructure for health and social care in England, joining together over 23,000 healthcare IT systems in 20,500 organisations.

Current process



10. All deaths of people with learning disabilities are notified to the programme. Those meeting the inclusion criteria for mortality review receive an initial review of their death by an independent, trained reviewer.

11. The standardised review process involves discussing the circumstances leading up to the person's death with someone who knew them well (including family members wherever possible), and scrutinising at least one set of relevant case notes. Taking a cross-agency approach, the reviewer develops a pen portrait of the individual and a comprehensive timeline of the circumstances leading to their death, identifies any best practice or potential areas of concern, and makes a decision, in conjunction with others if necessary, about whether a multi-agency review is indicated.

12. A full multi-agency review is required if the criteria for the current themed priority review are met (death of a person from a Black and Minority Ethnic background or aged 18-24), or where an assessment of the care received by the person indicates deficiencies in one or more significant areas. A full multi-agency review is recommended if there have been any concerns raised about the death, if any 'red flag alerts'[14] have been identified in the initial review, or if the reviewer thinks that a full multi-agency review would be appropriate. The purpose of the multi-agency review is to gain further learning which will contribute to improving practice and service provision for people with learning disabilities, so the review process concludes with an agreed action plan and recommendations that are fed back to the regional governance structures for the programme.

[14] 'Red flag' alerts are those identified in the initial review that may suggest potential problems with the provision of care e.g. no evidence that an assessment of mental capacity has been considered when this would have been appropriate; delays in the person's care or treatment that adversely affected their health.

13. The LeDeR programme currently operates independently of, but communicates and cooperates with, other review and investigatory processes. This enables an integrated approach to initial reviews of deaths of people with learning disabilities to be taken whenever possible, so as to avoid unnecessary duplication but ensure that the specific focus of the different review or investigation processes is maintained.

14. Alignment of LeDeR with SJR for example will enable a balanced approach to be taken to reviewing deaths of people with learning disabilities that draws on contributions from across acute and other settings. Deaths of people with learning disabilities that occur in hospital settings should be subject to the LeDeR review process in order that insights from families, primary and secondary healthcare, and social and third sector care providers are all included in the mortality review.

15. The LeDeR programme provide annual reports on its findings, collating learning and recommendations at the regional and national level on how best to take forward the learnings across the NHS.

16. Because of the different methodology adopted by the LeDeR programme, it would not be appropriate to use the same definition of 'avoidable death' as used by the SJR, nor to compare rates of avoidable deaths across and between the two review processes. The LeDeR programme will continue to use the Child Death Review Process terminology of 'potentially avoidable contributory causes of death' and the Office for National Statistics definition of avoidable deaths using ICD-10 coding of the underlying cause of death[15].

Integration of the LeDeR Process into National Level Mortality Review Structures

17. When a death of a person with learning disabilities occurs, mandatory review processes need to take precedence, working with the LeDeR programme reviewers to ensure that a coordinated approach is taken to the review of the death in order to minimise duplication and bring in the learning disabilities expertise of the LeDeR reviewers, whilst recognising that some investigatory processes will be more focused than that of LeDeR which is cross-agency in nature and may require the provision of additional information.

[15] Office for National Statistics (2016) Revised Definition of Avoidable Mortality and New Definition for Children and Young People.
https://www.ons.gov.uk/aboutus/whatwedo/statistics/consultationsandsurveys/allconsultationsandsurveys/reviewofavoidablemortalitydefinition

18. Learning and recommendations from LeDeR reviews will identify opportunities for improvement at the local, regional and national level. Governance structures that can support the cross-agency implementation of recommendations from mortality reviews are required at all levels, but in particular for the reviews of deaths of people with learning disabilities. Such structures exist in the form of regional steering groups for the LeDeR programme, and these are usually best placed within the safeguarding framework. Not all deaths of people with learning disabilities are safeguarding issues; however the existing multi-agency framework and statutory responsibility mean that this is a natural 'home' for governance of mortality reviews.

Guidance for Providers

19. Key points to note are:

- All deaths of people with learning disabilities aged four years and older are subject to review using LeDeR methodology;
- The LeDeR programme is currently being rolled out across England. Full coverage is anticipated in all Regions by the end of 2017. If there is a death of a person with learning disabilities in an acute setting in an area that is not yet covered by the LeDeR programme, Trusts are recommended to use the SJR process or a methodology of equivalent quality that meets the requirements for the data that must be collected as an interim measure;
- If a Trust wishes to complete its own internal mortality review, it is recommended that it uses the LeDeR initial review process and documentation available at: http://www.bristol.ac.uk/media-library/sites/sps/leder/Initial%20Review%20Template%20version%201.2.pdf The provider can then submit that as an attachment to the LeDeR notification web-based platform once their internal review is completed;
- Once the LeDeR review has been completed, a copy will be sent to the relevant governance body at the Trust where the death occurred;
- Trusts are encouraged to identify appropriate personnel to undertake LeDeR training and review processes. Reviewers would be expected to conduct reviews independent of the Trust in which they work.

Annex E - Mental Health

1. Physical and mental health are closely linked. People with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people[16]. In addition, people with long term physical illnesses suffer more complications if they also develop mental health problems.

2. Reporting and reviewing of any death of a patient with mental health problems should consider these factors i.e. premature death of those with a mental disorder and the increased risk of complications for those with physical and mental health difficulties.

Inpatients detained under Mental Health Act

3. Regulations[17] require mental health providers to ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the Care Quality Commission without delay. In 2015, the Care Quality Commission reported concern that providers were failing to make this notification in 45% of cases. The Commission has since updated its notifications protocols to ensure that providers ensure they report in a timely way.

4. Under the Coroners and Justice Act 2009, coroners must conduct an inquest into a death that has taken place in state detention, and this includes deaths of people subject to the Mental Health Act. Providers are also required to ensure that there is an appropriate investigation into the death of a patient in state detention under the Mental Health Act (1983).

5. In circumstances where there is reason to believe the death may have been due, or in part due to, to problems in care - including suspected self-inflicted death - then the death must be reported to the provider's commissioner(s) as a serious incident and investigated appropriately. Consideration should also be given to commissioning an independent investigation as detailed in the *Serious Incident Framework*.

People with Mental Health Disorders in Prisons

6. Evidence shows that there is a high incidence of mental health problems in prisons: 72% of adult male and 71% of female prisoners may have 2 or more mental disorders (e.g.

[16] *The Five Year Forward View For Mental Health* (NHS England, 2016) is available at: https://www.england.nhs.uk/wp-content/.../Mental-Health-Taskforce-FYFV-final.pdf

[17] Regulation 17, Care Quality Commission (Registration) Regulations 2009

personality disorder, psychosis, anxiety and depression, substance misuse); 20% have 4 or more mental disorders.

7. There have been large increases in the number of natural and non-natural deaths in prisons over the most recent five-year reporting period. The increase in recent years in non-natural deaths in prisons are due to a number of factors. Prisons contain a high proportion of vulnerable individuals, many of whom have experienced negative life events that increase the likelihood of suicide or self-harm. Issues that increase risk include drug/alcohol abuse, family background, social disadvantage or isolation, previous sexual or physical abuse, and mental health problems. The increase in part reflects an ageing prison population. Prisons are also very challenging environments particularly so for those prisoners who have a learning disability. Average estimates of prevalence of learning disabilities amongst adult offenders in the UK is thought to be between 2-10%. This figure is much higher for children who offend[18]. Prisoners with learning disabilities are also more likely than other prisoners to suffer mental ill health. As such, the mental wellbeing of prisoners with learning disabilities should be a key consideration for healthcare staff of NHS providers along with all other prison staff.

8. The *Serious Incident Framework* states that in prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Police Complaints Commission (IPCC) who are responsible for carrying out the relevant investigations. Healthcare providers must fully support these investigations where required to do so. The PPO has clear expectations in relation to health involvement in PPO investigations into death in custody. Guidance published by the PPO[19] must be followed by those involved in the delivery and commissioning of NHS funded care within settings covered by the PPO.

[18] *Equal Access Equal Care*, Guidance for Prison Healthcare Staff treating Patients with Learning Disabilities (2015) *available at* https://www.england.nhs.uk/.../equal-access-equal-care-guidance-patients-ld.pdf

[19] Guidance is available online: http://www.ppo.gov.uk/updated-guidance-for-clinical-reviews/

Annex F - Children and Young People

Infant and Child Mortality

1. Over the last 20 years, the UK has gone from having one of the lowest mortality rates for 0 to 14 year olds in Europe to one of the highest[1]. In 2014, 4, 419 children and young people aged 0 to 18 years old died in England and Wales. 24% of deaths in children and young people are thought to be preventable[2]. In the year ending March 2016, 68% of all deaths occurred in hospital, 22% in the home, 4% in a public place, and 4% in a hospice. In the year ending March 2016, 32% of all deaths occurred following a perinatal or neonatal event, 26% in children with chromosomal, genetic and congenital anomalies, 8% in children with 'sudden unexpected and unexplained' death, 7% in children with malignancy, 6% in children with acute medical or surgical illnesses, 6% in children with infection, 5% in children suffering trauma, 3% in young people taking their life, and 2% following deliberately inflicted injury, abuse or neglect[2].

2. In child mortality review, professionals have moved away from defining 'avoidability' to instead using the language of 'a preventable death' where the latter is defined as a death in which 'modifiable factors may have contributed to the death and which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths'[3]. In the year ending March 2016, 54% of deaths in hospital and 31% of death in the home were identified as having modifiable factors. Most modifiable factors are found in children dying from perinatal/neonatal events, followed by trauma, followed by those with chromosomal, genetic and congenital anomalies[2].

National Data on Causes of Death and International Comparisons[4]

3. The UK ranks 15 out of 19 Western European countries on infant (under one year of age) mortality and has one of the highest rates for children and young people in Western Europe[5]. There is a strong association between deprivation and mortality; for example infant mortality is more than twice as high in the lowest compared with the highest socio-economic groups[6].

Infants (under 1 year)

4. Around 60% of deaths during childhood occur in infancy. Infant mortality can be split into neonatal mortality (deaths 0–27 days) and post-neonatal mortality (28–365 days). Births without signs of life (stillbirths if after 24 weeks of pregnancy) do not contribute to infant mortality but are also an important indicator of maternal and child health. The Infant

Mortality Rate (IMR) is an indicator of both population health and the quality of healthcare service. It is also a key international indicator in the United Nation's Sustainable Development Goals and in UNICEF international comparisons.

5. Neonatal mortality accounts for between 70% and 80% of infant deaths. The great majority of neonatal deaths are due to perinatal causes, particularly preterm birth, and are strongly related to maternal health, as well as congenital malformations. The remainder of infant deaths are post-neonatal and are due to a broad range of causes including sudden infant death syndrome (SIDS). Stillbirths (defined in the UK as a baby born without signs of life after 24 completed weeks of pregnancy) account for half of all deaths during the perinatal period. In 2014, the IMR across the UK was 3.9 deaths per 1,000 live births. Although there has been an overall decline in the IMR across the UK over the past 45 years, in recent years the reduction in infant mortality in the UK has not equalled the gains observed in comparable countries. An international study of mortality in the UK compared with similar wealthy countries in Europe and elsewhere showed the UK to have IMR in 1970 similar to the average of the group, but that the UK had become among the worst performing 10% by 2008[7].

6. Social inequalities play a role in almost all the leading causes of infant death. The mechanisms underlying this social gradient are related to increased risk of preterm delivery in more deprived groups, as well as to maternal health during pregnancy (for example, smoking, poor nutrition, substance abuse) and uptake of recommended practices such as breastfeeding and safe infant sleeping positions[8]. Maternal age is also associated with infant mortality[6]. Many of the causes of infant mortality are preventable and necessitate actions at both a population and individual level[9]:

    - maximising the health and wellbeing of women before conception and during pregnancy (smoking cessation programmes, promotion of breastfeeding and promoting healthy weight in women of childbearing age)
    - protecting and supporting health promotion and early intervention services (universal midwifery and health visiting services for new mothers)
    - promoting evidence-based research into maternal and infant health, and translating findings into improved practice, standards of care, and ultimately policy
    - identifying best practice and reducing variations in outcomes across health care services

Children (1-9 years)

7. The main factors that contribute to death during childhood are different to those that contribute to death during infancy or adolescence. The common causes of death amongst 1 to 9 year-olds are cancer, injuries and poisonings, congenital conditions and neurological and developmental disorders. Injuries and poisonings from external causes are the leading cause of death in boys aged one to four years, whilst cancer is the leading cause of death in girls of the same age[5]. For both girls and boys five to nine years of age, cancer is the leading cause of death. Very early life also still has an impact on mortality in later childhood; children who were born preterm remain more likely to die before age 10 years compared to children born at term.

8. In the period 2012-2014, the mortality rate in children aged 1-9 years in the U.K. was 12.1 per 100,000 population. Although the mortality rate has declined across the UK since the 1970s, the UK's recent progress has been significantly lower than in other wealthy European countries, and concerningly the incidence of death due to diseases such as asthma and diabetes is higher than equivalent high-income countries. The scale of difference between the UK child mortality rate and the average suggests there are around 130 excess deaths of 1- to 9-year-olds each year in the UK[10].

9. Many childhood deaths are preventable. As with infants there is a strong association between deprivation, social inequality, and mortality. Causes amenable to interventions include environmental and social factors as well as health service factors and key actions include the following[9]:

    - creating safe environments, including access to information and safety equipment schemes to promote safety in the home;
    - reduce road speed limits in built-up areas to 20mph;
    - ensuring that clinical teams looking after children with long-term conditions such as asthma, epilepsy and diabetes deliver care to the highest standards, incorporating good communication, open access for patients and families, use of established tools such as the epilepsy passport and asthma plan, adherence to the components prevalent in the best practice tariff for diabetes, and address early the optimal conditions for safe transition to adult services. Implicit in this is teaching self-management and ownership of the condition;
    - increasing the provision of high-quality end-of-life care and access to appropriate palliative care;

- delivering integrated health systems across primary and secondary care; whilst providing the optimal configuration of specialist services for children with complex conditions needing tertiary care, such as cardiac, renal conditions and children's cancer.

Young People (10-19 years)

10. After the first year of life, adolescence is the life stage when children are most likely to die. The factors leading to death in adolescence are different to those in earlier childhood, and differ between males and females. The most common causes of death in this age group are injuries, violence and suicide, followed by cancer, substance misuse disorders and nervous system and developmental disorders.

11. Although the mortality rate in young people has decreased across the UK since the 1970s, progress recently has been slower than that seen in other wealthy countries[10]. The UK's 'average' adolescent overall mortality today is a mixed picture. Whilst our injury mortality rate is amongst the lowest, we have a higher rate of deaths due to 'non communicable diseases' such as asthma than other equivalent wealthy countries. Social inequalities are important since injury and illness are associated with poor environmental conditions and hazards such as smoking, alcohol, and drug use[8].

12. Many deaths are preventable and key actions include[9]:

- reducing deaths from traffic injuries through the introduction of graduated licensing schemes;
- improving adolescent mental health services;
- improving services for children with long term conditions, and especially those transitioning to adult care;
- increasing the involvement of young people and their families with rare and common long-term conditions in developing guidelines, measuring outcomes, service design and research trials.

13. Underpinning all efforts to reduce child mortality in England lies an urgent need to collect high-quality data to better understand the reasons why children die, to allow accurate international comparisons, and to inform health policy. This requires a national system for the analysis of child mortality data, as well as improved child death review processes.

Historical Background to the Process of Child Mortality Review

14. Since 1st April 2008, Local Safeguarding Children's Boards in England have had a statutory responsibility for Child Death Review (CDR) processes. The relevant legislation underpinning such responsibility is enshrined in the Children's Act 2004 and applies to all children under 18 years of age. The processes to be followed when a child dies are described in Chapter 5 of the statutory guidance document, *Working Together to Safeguard Children*[11]. The overarching purpose of child death review is to understand how and why children die, to put in place interventions to protect other children, and to prevent future deaths. *Working Together* describes two interrelated processes:

    i. a "Rapid Response" multi-professional investigation of an individual unexpected death; and,
    ii. a Child Death Overview Panel (CDOP) review of all deaths in a defined geographical area. The purpose of the CDOP is to establish the exact cause of death, identify patterns of death in community and remedial factors, and to contribute to improved forensic intelligence in suspicious deaths. The family should be kept central to the process.

Drivers for Change including new Legislation

15. The review of child deaths has been, to date, far more comprehensive than that for adults. However the following drivers for change exist:

    i. *Variation in process.* There is significant variation across the system in how child deaths are reviewed, which deaths are reviewed, and the quality of the review. Specifically:

        - 'unexpected' deaths in the community are generally reviewed as per the Sudden Unexpected Deaths in Infancy (SUDI) process. However there is variation in when a death is considered "unexpected" and in the timing of triggering investigations.
        - hospital deaths are usually reviewed at a Mortality and Morbidity (M&M) meeting. However there is wide variation, across the NHS, in how these meetings are convened, no standardisation on terminology, and a confused array of investigations (root cause analysis, serious incident inquiry, mortality review) that follow certain types of deaths.

- there is wide variation in CDOP processes (size, structure and functioning) and many CDOP panels are dislocated from governance processes within their local children's hospital.

ii. *The Wood Review*[12]. In 2016, Alan Wood recommended that national responsibility for child death reviews should move from the Department for Education to the Department of Health, that DH should re-consider how CDOPs should best be supported within the new arrangements of the NHS, and that DH should determine how CDOPs might be better configured on a regional basis with sub-regional structures to promote learning. He also recommended that child deaths be reviewed over a population size that allowed a sufficient number of deaths to be analysed for patterns and themes. He went further to recommend that the NHS consider the role CDOPs should play in the process for achieving a common national standard for high quality serious incident investigations. Finally, he supported the intention to introduce a national child mortality database, and urged DH to expedite its introduction.

iii. *The National Adult Case Review programme*[13]. This programme uses a very different structured judgment review (SJR) methodology to that used in child mortality review. It focuses on problems in heath care processes within an organization rather than trying to understand the cause of death. Cases in which care is judged to be poor are scored according to an 'Avoidability of Death' scale. It is important to recognise that many 16 and 17 year olds die in adult ITU's and therefore it is important to understand what processes should take precedence in the review of such patients.

iv. *Medical Examiner process*. The Medical Examiner will be introduced across England. This appointee will link with bereaved families as well as the Coroner and their involvement will affect all mortality review processes.

v. *CQC report: Learning, Candour, and Accountability*[14]. This report identified inconsistencies in: the involvement of families and carers; the process of identifying and reporting the death; how decisions to review or investigate a death was made; variation in the quality of reviews and investigations; and variation in the governance around processes and questionable demonstration of learning and actions.

vi. *Legislative change (Children and Social Work Bill 2017)*. The Wood Review recommendation that national responsibility for child death reviews should move from the Department for Education to the Department of Health is being enacted through

the Children and Social Work Bill 2017. Under the new legislation, local authorities and clinical commissioning groups are named as 'child death review partners' and must make arrangements for the review of each death of a child normally resident in the local authority area. They may also, if they consider it appropriate, make arrangements for the review of a death in their area of a child not normally resident there. The proposed legislation also states that the 'child death review partners' must make arrangements for the analysis of information about deaths reviewed and identify any matters relating to the death or deaths in that area a) relevant to the welfare of children in the area or to public health and safety and b) to consider whether it would be appropriate for anyone to take action in relation to any matters identified.

National Child Mortality Programme

16. NHS England is undertaking a national review of child mortality review processes both in the hospital and community. A key aim is to make the process easier for families to navigate at a very difficult time in their life. Central to the programme is the creation of a National Child Mortality Database, which is currently being commissioned. The effective functioning of the national database requires high-quality, standardised data arising from simplified and standardised local mortality and CDOP review processes. NHS England have therefore established 3 work streams:

- the simplification and standardisation of mortality review processes in the community and hospital;
- a review of the governance arrangements and standardisation of CDOP processes;
- the creation of the national child mortality database.

17. The goals of the NHS England's child mortality review programme are to:

- establish, as far as possible, the cause or causes of each child's death;
- identify any potential contributory or modifiable factors;
- provide on-going support to the family;
- ensure that all statutory obligations are met;
- learn lessons in order to reduce the risk of future child deaths;
- establish a robust evidence base to inform national policy across government to reduce avoidable child mortality across the UK nations.

18. NHS England, the Department of Health and the Department for Education are working together to produce new statutory guidance for child death review. This guidance will cover the processes which should take place following the death of a child, and in particular how the death should be reviewed at local mortality meeting and child death overview panel. This new guidance will be published in late 2017.

Reporting

19. The definitions used within the adult Case Review programme for record review and to identify problems in care are not recognised within *Working Together*. NHS England's work programme intends to identify best practice and standardise processes across deaths in hospital and the community, to improve the experience of families and professionals. The deaths of children who are treated in acute, mental health and community NHS Trusts should be included by Trusts in quarterly reporting from April 2017. The information should come from child death review processes, and should include reporting problems related to service delivery.

Board Leadership

20. Hospital Trust, Local Authority, Community Trust, Mental Health Trusts, and CCG boards should ensure that learning is derived from the care provided to children who die, by the appropriate application of the child mortality review process, and that learning is shared and acted on.

21. Many of the points around board leadership relating to adult deaths (set out in the main body of this guidance) also apply for child deaths. For example, providers must ensure that they have a board-level leader designated as patient safety director to take responsibility for the learning from deaths agenda (Annex A) and he or she should also have specific responsibility for the learning from child mortality processes. The director should ensure that the reviews are delivered to a high quality, with sufficient numbers of trained staff to lead the child mortality review process.

22. Particular attention should be paid to the deaths of children and young people with learning disabilities or mental health conditions, as these present with frequent co-morbidities and are often a more vulnerable group.

23. Providers should acknowledge that an independent investigation (one commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may be required where the integrity of the investigation is likely to be challenged.

Best Practice in responding to Death of a Child who dies under a Trust's Care

24. All Trusts should have a policy in place that sets out how they respond to the deaths of children who die under their care. In doing this they should be mindful of current expectations described within *Working Together to Safeguard Children* (2015) and of NHS England's current review of child mortality review processes. New statutory guidance on child death review will be published in late 2017.

25. That policy should also set out how Trusts:

- communicate with bereaved parents and carers. This should include providing an honest and compassionate account of the reasons for death and knowledge of any potential problems in care that may need further review, ensuring initial contacts are managed by clinicians responsible for the care of the patient, and offering support to express concerns about the care given to patients who have died;
- achieve independence (where relevant) and objectivity in the child mortality review process, as well as lay membership within wider clinical governance systems.

Cross-system Reviews and Investigations

26. When the death of a child involves treatment across the health care pathway (primary: secondary: tertiary care) it is expected that child mortality review processes will not be duplicated and that a single overarching meeting will be convened. Child mortality review processes should interface with existing organisational governance systems. The NHS England child death review programme is mindful of expectations arising from the Serious Incident Framework, which sets out the circumstances in which further investigation is warranted in certain situations. It is therefore anticipated that when a review identifies a problem in care that meets the definition of a patient safety incident (any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care) then this is reported via local risk management systems to the National Reporting and Learning System (NRLS). Regardless of the type of review, its findings must form an integral part of and feed into the organisation's clinical governance processes and structures. Review findings should be considered alongside other information and data including complaints, clinical audit information, patient safety incident reports and other outcomes measures to inform the Trust's wider strategic plans and safety priorities.

Bereaved Families and Carers

27. *Working Together* places the family at the heart of its processes. However it is recognised that the multitude of investigations that may unfold following a child's death can cause great confusion and distress to parents. The national bereavement group and bereavement charities are closely involved with developing NHS England's child death review programme – both in the co-design of systems and public guidance that explains processes.

28. The national Child Death Review programme recognises the following principles:

- bereaved families and carers should be treated as equal partners both in the delivery of care and following a bereavement;
- bereaved families and carers should receive a high standard of bereavement care, including being offered appropriate support;
- bereaved families and carers must always receive an honest, caring and sensitive response;
- bereaved families and carers should receive timely, responsive contact and support in all aspects of any review process, with a single point of contact and liaison.

Learning Disabilities and Mental Illness

29. NHS England's National Child Mortality Review programme fully recognises the unique challenge in reviewing the deaths of children with learning disabilities and mental health disorders. The Programme is working closely with the Learning and Disabilities Mortality Review (LeDeR) programme, and also aims to align itself with the Children and Young People's (CYP) Mental Health Programme and Specialised Commissioning particularly with regard to deaths in Tier 4 inpatient CAMHS Units. It will also work closely with the National Programme on Suicide in Young People. Going forward, the programme will ensure that there are appropriate mechanisms in place to allow data flows to occur unencumbered between all these systems and the national Child Mortality Database.

Conclusion

30. This section highlights the very different circumstances that pertain to the death of a child in acute, mental health and community organisations. Although infant and child mortality has declined in the UK, these improvements have not been sustained in comparison to other European countries. While poverty and inequality have a major impact on child mortality, we can nonetheless do much in front line service delivery to improve outcomes

for children, and experiences for both bereaved parents and the professionals who deliver care. Sadly, deaths in childhood are often an inevitable consequence of congenital malformations, birth events, and long-term conditions or chronic illness. Many, however, have preventable factors, and there is therefore an absolute imperative to scrutinise all deaths both locally and nationally to ensure that learning always occurs.

31. NHS England is seeking to address this by establishing a National Child Mortality Database to allow analysis and interpretation of child mortality data. The programme will also seek to improve, standardise and simplify the processes that follow the death of a child. This is predominantly to improve the experience of bereaved parents at such an overwhelming time, but also to enable uniformly robust data collection, to ultimately lead to a reduction in infant and child mortality in this country.

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Annex G - Maternity

1. In England, maternity care is generally safe and for the majority of women and their babies there is a good outcome. However, when things go wrong, the impact is devastating and has a profound effect on the parents, partners, siblings and extended family members.

2. Dr Bill Kirkup was tasked by the Secretary of State for Health to investigate and report on maternity services at Morecambe Bay NHS trust. The Report of the Morecambe Bay Investigation in 2015[20] highlighted a number of failures over a number of years at the Trust which resulted in poor care and the tragic deaths of mothers and babies. The report makes recommendations for mandatory reporting and investigation of serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. It recommends a requirement that investigation of these incidents be subject to a standardised process, which includes input from and feedback to families, and independent, multidisciplinary peer review. In *Learning not Blaming*[21] the Government accepted this recommendation.

3. In October 2016, *Safer maternity care: next steps towards the national maternity ambition* was published setting out an action plan for the Government's vision for making NHS maternity services some of the safest in the world, by achieving the national ambition to halve the rates of stillbirths, neonatal deaths, brain injuries that occur during or soon after birth and maternal deaths, by 2030 with an interim measure of 20% by 2020. The plan details the actions needed at national and local level that build on the progress already made to improve the safety of maternity services.

4. Currently MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK)[22], appointed by Health Quality Improvement Partnership and funded by NHS England, run the national Maternal, Newborn and Infant

[20] The report of the Morecambe Bay Investigation (March 2015): https://www.gov.uk/government/news/morecambe-bay-investigation-report-published

[21] The government response to the Freedom to Speak Up consultation, the Public Administration Select Committee report 'Investigating Clinical Incidents in the NHS', and the Morecambe Bay Investigation (July 2015).

[22] 'MBRRACE-UK' is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to continue the national programme of work investigating maternal deaths, stillbirths and infant deaths, including the Confidential Enquiry into Maternal Deaths (CEMD). The aim of the MBRRACE-UK programme is to provide robust information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services.

Clinical Outcomes Review to conduct surveillance of all late fetal losses, stillbirths and neonatal deaths, biennial topic-specific confidential enquiries into aspects of stillbirth and neonatal death or serious neonatal morbidity and surveillance and confidential enquiries of all maternal deaths.

5. Surveillance reports on stillbirths and neonatal deaths are published annually. Reports on maternal deaths are published on a triennial basis, because the number of maternal deaths from individual causes is small, and thus three years' worth of data is required to identify consistent lessons learned for future care and to maintain anonymity and confidentiality.

6. A maternal death is defined internationally as a death of a woman during or up to six weeks (42 days) after the end of pregnancy (whether the pregnancy ended by termination, miscarriage or a birth, or was an ectopic pregnancy) through causes associated with, or exacerbated by, pregnancy. Deaths are subdivided on the basis of cause into: direct deaths, from pregnancy-specific causes such as preeclampsia; indirect deaths, from other medical conditions made worse by pregnancy such as cardiac disease; or coincidental deaths, where the cause is considered to be unrelated to pregnancy, such as road traffic accidents. Maternal deaths are very rare. The MBRRACE-UK report 'Saving Lives, Improving Mothers Care highlights that for 2012-14, the maternal death rate was 8.5 per 100,000 women. Overall, 241[23] women among 2,341,745 maternities in 2012–14 died during or within 42 days of the end of pregnancy in the UK.

7. Better Births (2016)[24], the report of the NHS England commissioned National Maternity Review, set out a five year forward view for improving outcomes of maternity services in England. The report highlighted the lack of a standard approach to investigating when things wrong during before, during or after labour: Reviews and investigation are currently undertaken using different protocols and processes by different organisations. The Report recommended there should be a national standardised investigation process for when things go wrong, to get to the bottom of what went wrong and why and how future services can be improved as a consequence. Work has now begun on the development of a Standardised Perinatal Mortality Review Tool that will enable maternity

[23] Of these 41 deaths were classified as coincidental

[24] https://www.england.nhs.uk/wp-content/.../02/national-maternity-review-report.pdf

and neonatal services to systematically review and learn from every stillbirth and neonatal death in a standardised way.

8. Maternal deaths, neonatal deaths and stillbirths occurring in acute, mental health and community Trusts should be included by Trusts in quarterly reporting from April 2017.

9. It should be borne in mind that in addition to hospital obstetric units, maternal deaths can occur in a local midwifery facility (for example, a local midwifery unit or birth centre) or during home births. The definition also covers up to 42 days after the end of pregnancy.

Annex H - Cross-system Reviews & Investigations

1. In many circumstances more than one organisation is involved in the care of any patient who dies, with the most common combinations being primary care and acute care, ambulances services and acute care, or mental health services combined with any of these. Case record reviews typically have to rely on the records held by a single organisation, but even these records can provide indications of possible problems in earlier stages of the patient pathway.

2. Where possible problems are identified relating to other organisations, it is important the relevant organisation is informed, so they can undertake any necessary investigation or improvement. Most trusts already have effective systems to notify other organisations when concerns are raised via incident reports, and are likely to be able to adapt these to address potential problems identified in case record review.

3. Trusts should consider whether they can routinely arrange joint case record reviews or investigations for groups of patients where more than one organisation is routinely providing care at the time of death - for example, for older people with dementia and frailty receiving frequent input from their GP and from community mental health nurses. Commissioners have a role in encouraging appropriate routine collaboration on case record review.

4. Where the provision of care by multiple providers, and particularly the coordination of that care, is thought to have potentially contributed to the death of a patient, investing the significant resources required to coordinate major and complex investigations must be considered. For example, the Serious Incident Framework outlines the principles which underpin a serious incident investigation process and the relevant content is set out in paragraphs 5 to 10 below.

5. The organisation that declares the serious incident is responsible for recognising the need to alert other providers, commissioners and partner organisations as required in order to initiate discussions about subsequent action.

6. All organisations and agencies involved should work together to undertake one single investigation wherever this is possible and appropriate. Commissioners should help to facilitate discussions relating to who is the most appropriate organisation to take responsibility for co-ordinating the investigation process. Commissioners themselves should provide support in complex circumstances. For example, where no one provider organisation is best placed to assume responsibility for co-ordinating an investigation, the commissioner may lead this process. If commissioners do not have the capability or capacity to manage this type of activity this should be escalated to ensure appropriate resources are identified. This may be something to consider escalating through the relevant Quality Surveillance Group or through specific review panels and clinical networks. This should ensure the cumulative impact of problems with care can be resolved.

7. In some circumstances the local authority or another external body may be responsible for managing and co-ordinating an investigation process. Where this is the case, providers and commissioners must contribute appropriately and assure themselves that problems identified will be addressed.

8. Often in complex circumstances, separate investigations are completed by the different provider organisations. Where this is the case, organisations (providers and commissioners and external partners as required) must agree to consider cross boundary issues, such as gaps in the services that may lead to problems in care. The contributing factors and root causes of any problems identified must be fully explored in order to develop effective solutions to prevent recurrence. Those responsible for coordinating the investigation must ensure this takes place. This activity should culminate in the development of a single investigation report.

9. To determine oversight of an investigation, the RASCI (Responsible, Accountable, Supporting, Consulted, Informed) model supports the identification of a single 'lead commissioner' with responsibility for managing oversight of serious incidents within a particular provider. This means that a provider reports and engages with one single commissioning organisation who can then liaise with other commissioners as required. This approach is particularly useful where the 'accountable commissioner' is geographically remote from the provider (and therefore removed from other local systems and intelligence networks) and/or where multiple commissioners' commission services from the same provider. It facilitates continuity in the management of serious incidents, removes ambiguity and therefore the risk of serious incidents being

overlooked and reduces the likelihood of duplication where there is confusion regarding accountability and/or responsibility and general management of the serious incident process.

Healthcare Safety Investigation Branch

10. The Healthcare Safety Investigation Branch (HSIB) will provide capability at national level to offer support and guidance to NHS organisations on investigations, and to carry out up to 30 investigations itself per year where there is a deeper learning opportunity for the NHS. Through a combination of setting exemplary practice and structured support to others, the HSIB is expected to make a decisive difference to the NHS, promoting a culture of learning and a more supportive relationship with patients, families and staff.

11. Providers will benefit from the HSIB, and their expert advice on safety improvement. It should mean timely investigations, with a genuine commitment to openness, transparency and engagement with staff and patients and their families and carers that adopt an ethic of learning and continuous improvement. The HSIB will contribute strongly to the culture change that is needed in the NHS.

Annex I - Roles and Responsibilities of National Bodies and Commissioners

1. Each national organisation will have a single lead at executive level who has accountability, internally and externally for that organisation's support of delivering against the national programme on learning from deaths. This will include ensuring progress is reported to the National Quality Board and ensuring that learning from deaths remains a priority area in future developments. A list of the lead roles for each national organisation is at Annex K and will be made available on each organisation's website.

2. As the independent regulator of health and social care, the **Care Quality Commission** will use this national guidance on learning from deaths to guide its monitoring, inspections and regulation of services. Inspectors will use new key lines of enquiry in relation to safety and governance, set out in the Care Quality Commission's assessment framework, to assess learning from deaths, collect evidence and identify good practice. Where specific concerns are identified, the Care Quality Commission can use its powers to take action with individual providers and will report its findings of good and poor progress in individual inspection reports or national publications to help encourage improvement.

3. **NHS Improvement** will continue to provide national guidance for managing serious incidents. Local processes setting out what deaths should be subject to case record review will inevitably use a wider definition than deaths that constitute Serious Incidents. Equally, when a death clearly meets Serious Incident criteria there is no need for an initial stage of case record review to be completed before work to initiate and support a full investigation is undertaken. Serious Incident guidance provides the framework upon which the Care Quality Commission and commissioners (including CCGs and NHS England) will assess the quality of investigations undertaken across the NHS. NHS Improvement will, alongside the Healthcare Safety Investigation Branch and others, support implementation of best practice in investigations by Trusts.

4. As the revised inspection regime of the Care Quality Commission will assess providers' ability to learn from deaths as a key component of high quality care, work to address this will be factored into NHS Improvement's work to support providers in achieving good or outstanding Care Quality Commission care ratings. Regional teams will work with

providers, their commissioners and NHS England to identify areas where improvements can be made and the strategies which can help deliver the change required.

5. Nationally, NHS Improvement commissions (via the Healthcare Quality Improvement Partnership) the work of the Royal College of Physicians to develop and roll-out the Structured Judgement Review methodology, which will be providing a national training programme for acute Trusts to support them to carry out the methodology for adult inpatient deaths.

6. **NHS England** has a direct commissioning role as well as a role in leading and enabling the commissioning system. This national guidance on learning from deaths will guide its practice in both of these areas.

7. The **National Institute for Health and Care Excellence (NICE)** has produced best practice guidelines on the care of the dying, covering adults and children. These guidelines are supported by measurable quality standards that help Trusts demonstrate high quality care, and by information for the public describing the care that should be expected in the last days of life.

Annex J - Structured Judgement Review in Mental Health Trusts

Background

1. Some mental health providers have seen a missed opportunity in not learning more widely from deaths by reviewing the safety and quality of care of a wider group of people. This is despite research showing that people with mental health problems have greater health care needs than the general population and may suffer unnecessarily with untreated or poorly managed long-term conditions.

Where Next - Making a Decision on the Review Method

2. Since 2014 hospitals in Yorkshire and the Humber have been working together with the AHSN Improvement Academy to refine a mortality review method called Structured Mortality Review (SJR), a method proposed for all acute hospitals in England. The acute sector methodology reviews phases of care appropriate to their settings, such as initial assessment and first 24 hours, care during a procedure, discharge/end of life care and assessment of care overall. Written explicit judgements of care and phase of care scores form the basis of the reviews. This now forms the basis of the national acute hospitals mortality review programme.

3. This methodology and review format was seen as potentially valuable by three regional Mental Health trusts and they have individually worked to create phase of care headings more appropriate to mental health care, with the support of the Improvement Academy and Professor Allen Hutchinson. These three trusts are at different stages of implementation. In the early adopter trust the tool was also adapted to include a pen picture to enable the reviewer to understand both the life and death of the person, considering this fundamental to understanding areas for learning that may include review of physical health and lifestyle choices. In the same trust this approach was used within Learning Disability services prior to the introduction of the Learning Disability Review of Deaths (LeDeR) programme. In another trust both the mental health care and community care facilities have been using the methods.

Introducing the Review Process

4. Just as with the acute services, future reviewers require initial training in how to make explicit judgements of the quality and safety of care and how to assess care scores for

each phase of care. Assessments are made of both poor and good care and it is common to find that good care is far more frequent than poor care.

5. One of the findings from introducing the methods into mental health care is that many of the reviewers naturally have a focus on the mental health care component of the services. But review teams have found that using this review method they also identify common long-term conditions such as diabetes and heart disease that do not appear to have been well managed. For example, in one hospital it became evident that many people had a number of co-existing comorbid/long term conditions, yet it was unclear from the records whether or not the person was receiving support and or review from primary care and or secondary care services for their physical health. There is value, therefore, in also training up review staff who have an understanding of what good care looks like in long-term conditions within the context of mental health facilities.

6. Scoring of the phases of care is a new approach for many clinical staff in mental health care (just as has been the case in acute care) and scoring was initially felt to be very daunting by some reviewers. Nevertheless, as staff become more confident with its use, scoring can often be seen as a natural outcome of their judgements on the level of care provided. Some of the hospital teams have set up a mortality-reviewers support group to provide peer review and guidance. Feedback of the good care may be shared with both the individual staff and the wider teams - this is often well received. Of course, concerns also have to be discussed with services to identify areas for improvement.

Where Next

7. The use of the structured judgement method often receives very positive feedback from staff trained in this methodology and so in one centre SJR is being rolled out for wider use to review the quality of care being received whilst people are currently receiving services. Looking forward, it has been recognised that whilst services can learn from each case, more can be learnt from the aggregation of cases, where patterns of poor care and good care emerge. In one case study that has sought for such patterns it is of note that where patterns exist of poorer care, these have been in the main linked to the management of physical ill health within mental health and learning disability services.

8. For further details please contact Allyson Kent allyson.kent@nhs.net , or Professor Allen Hutchinson allen.hutchinson@sheffield.ac.uk Yorkshire and The Humber AHSN Improvement Academy.

Annex K - National Leads

The list below provides the lead role with overall responsibility for the learning from deaths programme at relevant national organisations:

- NHS Improvement - Executive Medical Director
- Care Quality Commission - Chief Inspector of Hospitals
- Department of Health - Director of Acute Care and Workforce
- NHS England - National Medical Director

Annex L - Background and Links

Learning Disabilities Mortality Review (LeDeR) programme

Background is available at http://www.bristol.ac.uk/sps/leder

Quality Accounts

Background is available at:
http://www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Pages/about-quality-accounts.aspx

Healthcare Safety Investigation Branch

The new Healthcare Investigation Branch (HSIB) will offer support and guidance to NHS organisations on investigations, and carry out certain investigations itself. It is envisaged that the HSIB will be established to:

i. generate investigation findings and recommendations which drive action on the reduction or prevention of incident recurrence;
ii. conduct investigations and produce reports that patients, families, carers and staff value, trust and respect; and,
iii. champion good quality investigation across the NHS, and lead on approaches to enhance local capability in investigation.

The HSIB will be hosted by NHS Improvement and will undertake a small number of investigations annually. It will focus on incident types that signal systemic or apparently intractable risks in local healthcare systems. The HSIB and the role of Chief Investigator will play a crucial part in developing the culture of safety, learning and improvement in the NHS that will be one of the key elements of national policy and cross-system action in the years ahead.

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

18

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Serious Incidents and Lessons Learnt
DATE OF MEETING:	27 April 2017
LEAD DIRECTOR: (name and title)	Anthony Deery, Director of Nursing, Professions and Quality
PAPER AUTHOR: (name and title)	Anthony Deery, Director of Nursing, Professions and Quality

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)							
Quality	✓	Strategic		Governance	✓	Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	We work with service users and carers to support their achievement of outcomes and wellbeing	✓
G2	We are an employer of choice with a compassionate and highly trained workforce committed and supported to provide excellent innovative care and support	✓
G3	We work with others to improve health and improve lives through effective, innovative and sustainable partnerships	✓
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	✓
SO2	We provide a dynamic, rewarding and supportive place to work	
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	
SO4	We are transparent and accountable to the people and partners we work with	✓
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	✓

STATUS OF PAPER (please tick relevant box/s)	✓
To be taken in the public session (Part A)	✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:	
Legal advice relating to legal proceedings (actual or possible)	
Negotiations in respect of employee relations where they are of a confidential nature	
Procurement processes and contract negotiations	
Information relating to identifiable individuals or groups of individuals	
Other – not yet a public document	
Matters exempt under the Freedom of Information Act (quote section number)	

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	The purpose of this paper is to provide the Board with an update on issues that need to be addressed to improve the risk management reporting, learning and safety systems within the Trust.
What are the key points and key issues the Board needs to focus on	There are a number of factors that need to be taken into account and addressed; • CQC Inspection findings • National reports • Existing system and processes
What is the Board being asked to consider	To agree that the key factors have been identified and the proposal for triangulated information and a system that provides high quality information and evidenced based improvements is in line with the Board's requirements.
What is the impact on the quality of care	The current system does not provide sufficient assurance that we are applying lessons learnt in an efficient and effective way, which may adversely affect the quality of care.
What are the benefits and risks for the Trust	Benefit • A rigorous and transparent process that provides assurance to our patients, the public and regulators • Improved support to families • Improved safety culture Risk • Failure fulfil our duties to patients/carers and families • Failure to learn lessons • Regulatory actions
What are the resource implications	Not quantified at this stage
Next steps following this paper being presented to the Board	Trustwide Clinical Governance Group
What are the reputational implications and how will these be addressed	This will improve the Trust's reputational standing

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No
What public / service user / staff / governor involvement has there been	None
Previous meetings where this report has been considered (including date)	None

RECOMMENDATION (This report is being provided to the Board for) (please tick relevant box/s): ✓							
Assurance	✓	**Discussion**	✓	**Decision**		**Information only**	
Provide details of what you want the Board to do:							
The Board is asked to receive the report, discuss any issues raised and approve next steps.							

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Leeds and York Partnership NHS
NHS Foundation Trust

Serious Incidents and Learning Lessons

1. Purpose

The purpose of this paper is to provide the Board with an update on issues that need to be addressed to improve the risk management reporting, learning and safety systems within the Trust.

2. Background

It is a fact that a number of safety issues arise within the Trust, from low level incidents, serious incidents, complaints and comments, audit reports and external inspections. Each of these provides an opportunity to learn and improve thereby creating a stronger safety culture. Key to this is the efficiency of our reporting and learning system and the quality of the information reported.

The Trust currently has a system in place for sharing and learning from the Trust Incident Review Group, with each individual serious incident report being shared with the clinical groups, who, as part of their clinical governance arrangements, review the report and action plan for individual or team learning. This system is limited in that there is no auditable process for identifying how incidental findings are addressed or how wider learning is shared across the organisation.

The CQC inspection 2016 identified weaknesses in the serious incident reporting and investigation process and made recommendations for improvement.

3. Action already taken

In response to the CQC findings a number of improvements have been made including a review of the serious incident email notification system to improve the quality of the information provided, this was completed in November 2016.

A review of structures to support safety improvements, including serious incident investigations, lone working and policy and procedure management are in progress.

Reporting to the National Reporting and Learning System (NRLS) has significantly improved and the provisional data is now monitored monthly. The Trust's average reporting time is now at 17 days against a national average of 26 days.

A Review of the Policy and Procedure Process has been completed and actions to improve this are being taken forward as part of the CQC action plan.

A Trust wide Security Group was established in November 2016 to review all security systems in place such as Lone Working arrangements, CCTV, site security etc.

A workshop to review the serious incident process took place on the 23 March 2017 to improve the 60 working day compliance and the mechanisms for embedding the learning from these incidents. The timescale for investigation on

average has been 85 working days, with a number of incidents over 100 working days, this is unacceptable and work is progressing to improve this. This review should lead to serious incidents being recorded within a robust risk management system that will allow the Trust to evaluate improvements over time, providing analysis by themes and trends, across services and locations and to review whether changes that have been implemented have reduced the risk or re-occurrence.

A Complaints, Litigation, Incidents and Patient Experience (CLIP) report has been developed and is shared with the care groups. The purpose of this report is to provide triangulated information to the Care Groups identifying themes and trends and key learning points. It is a relatively new process and its effectiveness has not yet been evaluated.

4. Recent national reports

In December 2016 CQC published their Learning, candour and accountability report in regard to learning from deaths.
The major findings were:-

- Families and carers were inconsistently involved in the investigation process and felt un-listened to.
- There was variation and inconsistency in how Trusts reported, identified and investigated deaths.
- There was a lack of any consistent framework for informing Boards, or learning from incidents.
- CQC found no single Trust which it considered to have a gold standard system but was able to identify areas of good practice.

The report makes seven recommendations, one of which directly relates to provider services. All Trusts will need to report on learning from mortality in their Quality Accounts. The first report is due in June 2018 covering activity over the 2017/18 financial year. The new Healthcare Safety Investigation Branch was launched on 1st April 2017 and is charged with carrying out independent investigations where there have been safety failings.

Following publication of the CQC report the Trust established a Mortality Review Group (MRG) to review all reported deaths. In light of the recently published National Quality Board Framework, Guidance on reporting from deaths, March 2017, the terms of reference and governance of the MRG needs to be reviewed. One of the kay requirements of the NQB Framework is that Trusts collect and publish specified data on a quarterly basis commencing in Q2 of 2017/18. The detail of this has been reported separately to the Board.

5. Risk registers

Risk registers exist at a team, service, directorate, care group, corporate and strategic level. There is a process is place for the escalation of risks and the risk

registers are monitored via the Trust's Audit Committee. Key corporate and strategic risks are reported to the Board through the Board Assurance Framework. The Senior Management Group meeting on 4 April 2017 identified the need for further work to ensure there is a coherent approach to how we manage and report risks across the Trust. It is anticipated that this will be reviewed as part of the Governance Review currently being undertaken by Deloitte.

6. Existing reports to the Board

The Board receives a report from the Trust Incident Review Group. This includes information about the Serious Incidents that have been investigated during the reporting period, completion timescales and lessons learnt from these investigations. It does not include; any detail on how the lessons learnt have been followed through or evidence of improvements made; other incidents that may not meet the serious incident criteria but have important quality and safety implications; themes and trends information following a triangulated analysis of complaints, litigation, incidents and patient experience data.

7. Conclusion

It is acknowledged, we have seen some improvements to individual elements of the risk management system, however, the current governance for reporting and learning from incidents across the organisation requires further improvement.

Dr Claire Kenwood, recently appointed Medical Director and Anthony Deery, Director of Nursing, Professions and Quality are currently reviewing the factors referred to above and plan to improve the current risk management systems and develop a report for the Board that meets the national requirements on learning from deaths and importantly provides assurance to the Board that there is a coherent, triangulated approach to learning lessons supported by evidence from the services. A proposal will be brought to the June 2017 Board.

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

19

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Division of duties between the Chair and Chief Executive
DATE OF MEETING:	27 April 2017
LEAD DIRECTOR: (name and title)	Cath Hill – Head of Corporate Governance and Trust Board Secretary
PAPER AUTHOR: (name and title)	Cath Hill – Head of Corporate Governance and Trust Board Secretary

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)							
Quality		Strategic		Governance	✓	Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	We work with service users and carers to support their achievement of outcomes and wellbeing	
G2	We are an employer of choice with a compassionate and highly trained workforce committed and supported to provide excellent innovative care and support	✓
G3	We work with others to improve health and improve lives through effective, innovative and sustainable partnerships	
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	
SO2	We provide a dynamic, rewarding and supportive place to work	
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	
SO4	We are transparent and accountable to the people and partners we work with	✓
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	

STATUS OF PAPER (please tick relevant box/s)	✓
To be taken in the public session (Part A)	✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:	
Legal advice relating to legal proceedings (actual or possible)	
Negotiations in respect of employee relations where they are of a confidential nature	
Procurement processes and contract negotiations	
Information relating to identifiable individuals or groups of individuals	
Other – not yet a public document	
Matters exempt under the Freedom of Information Act (quote section number)	

Leeds and York Partnership NHS
NHS Foundation Trust

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	This paper is to advise the Board that a Memorandum of Understanding, setting out the individual duties of the Chair and Chef Executive, has been signed by Prof Sue Proctor (Chair of the Trust) and Dr Sara Munro (Chief Executive). A copy of the document is held on file by the Head of Corporate Governance.
What are the key points and key issues the Board needs to focus on	The Code of Governance requires there to be a document that sets out the division of duties between the Chair of the Trust and the Chief Executive, which is agreed by the Board (Main Principle A.2 and Code Provision A.2.1). This is not a role description but it complements these documents. It contains the duties drawn from supporting governance documents such as NHS Improvement's Code of Governance for Foundation Trusts, and the Accounting Officers' Memorandum, but it is tailored to reflect our organisation. With the appointment of Prof Sue Proctor as Chair of the Trust (with effect from 1 April 2017) there is a requirement to have in place a newly signed Memorandum of Understanding (MoU) which sets out the division of duties between the Chair and the Chief Executive.
What is the Board being asked to consider	The Board is being asked to be assured that a new document has been signed in accordance with statutory requirements.
What is the impact on the quality of care	It will ensure that each is aware of their area of duty in ensuring the Trust provides safe and effective care.
What are the benefits and risks for the Trust	The benefit is that each is aware of their area of duty and the Trust is meeting its statutory obligations by having the document in place.
What are the resource implications	None
Next steps following this paper being presented to the Board	The original document is filed and held by the Head of Corporate Governance/Trust Board Secretary.
What are the reputational implications and how will these be addressed	None

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No
What public / service user / staff / governor involvement has there been	None
Previous meetings where this report has been considered (including date)	Not applicable

RECOMMENDATION (This report is being provided to the Board for) (please tick relevant box/s): ✓							
Assurance	✓	**Discussion**		**Decision**		**Information only**	

Provide details of what you want the Board to do:

The Board is being asked to be assured that a new document has been signed by Prof Sue Proctor and Dr Sara Munro in accordance with statutory requirements.

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).