LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

PUBLIC MEETING OF THE BOARD OF DIRECTORS
will be held at 13.00 on Thursday 28 July 2016
in Meeting Room 1&2, Trust Headquarters, 2150 Century Way, Thorpe Park, Leeds LS15 8ZB

A G E N D A

Members of the public will be given the opportunity to ask questions at both the beginning and the end of the meeting.

It is preferable if questions could be written down and handed to either the Chair or the Head of Corporate Governance at the meeting, before these points in the meeting are reached or if they could be submitted in advance of the meeting (contact details provided below *). However, the absence of a written comment/question will not preclude members of the public from being allowed to put these to the Board.

		LEAD
1	**Apologies for absence** (verbal)	**FG**
2	**Declaration of a change in directors' interests and any conflicts of interest in respect of agenda items** (verbal)	**FG**
3	**Opportunity to receive comments/questions from members of the public in order to inform the discussion on any agenda item ***	**FG**
4	**Minutes of the previous meeting**	
4.1	**Minutes of the public meeting held on 23 June 2016** (enclosure)	**FG**
5	**Matters arising** (verbal)	
5.1	**Update on the clinical claim case (minute 16/098)** (verbal)	**AD**
6	**Actions outstanding from the public meetings of the Board of Directors** (enclosure)	**CH**
PART A – QUALITY		
7	**Integrated Quality and Performance Report and quarter 1 monitoring returns / self-certification** (enclosure)	**AD**
8	**Serious untoward incidents update and lessons learnt following the Trust Incident Review Group (TIRG) meeting held on 8 June 2016** (enclosure)	**JI**
9	**Safer Staffing Report** (enclosure)	**AD**
10	**Complaints Summary Report** (enclosure)	**AD**
11	**Responsible Officer and revalidation annual report April 2015 – March 2016** (enclosure)	**JI**
PART B – STRATEGIC		
12	**Operational plan implementation report quarter 1** (enclosure)	**LP**
13	**Trust Strategy Refresh** (enclosure)	**JC**
PART C – GOVERNANCE		
14	**Verbal report from the chair of the Audit Committee for the meeting held on 21 July 2016** (verbal)	**JT**
15	**Verbal report from the chair of the Quality Committee for the meeting held on 19 July 2016** (verbal)	**CT**
16	**Verbal report from the chair of the Finance and Business Committee for the meeting held on 21 July 2016** (verbal)	**GT**

17	**Verbal report from the chair of the Mental Health Legislation Committee for the meeting held on 22 July 2016** (verbal)	**SWH**
18	**Outcome and action plan for the Well-led Governance Review and next steps** (enclosure)	**AD**
19	**Ratify the Terms of Reference for the Remuneration Committee** (enclosure)	**FG**

PART D – FOR INFORMATION

20	**Chair's report** (verbal)	**FG**
21	**Chief Executive's report** (enclosure)	**JC**
22	**Draft minutes of the Infection Prevention and Control and Medical Devices Committee** (enclosure)	**AD**
23	**Northern School of Child and Adolescent Psychiatry (NSCAP) Annual Report 2015/16** (enclosure)	**JI**
24	**Use of the Trust's seal** (verbal)	**FG**
25	**Any other business / any other matter to escalate to the Board** (verbal)	
26	**Opportunity for any further comments/questions from members of the public** (verbal)	

The next PUBLIC meeting of the Board of Directors' meeting will be held on Thursday 15 September 2016 in Meeting Room 1&2, 2150 Century Way, Thorpe Park, Leeds LS15 8ZB

* Questions for the Board can be submitted to Cath Hill (Head of Corporate Governance / Trust Board Secretary) using the following contact details:

Email: chill29@nhs.net
Telephone: 0113 8555930
Address: 2150 Century Way
Thorpe Park
Leeds, LS15 8ZB

AGENDA ITEM 4.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Minutes of the Public Meeting of the Board of Directors held on held on Thursday 23 June 2016 in Studio 7, Northern Ballet, Quarry Hill, Leeds, LS2 7PA

Board Members		Apologies	Voting Members
Ms J Copeland	Interim Chief Executive		✓
Mr A Deery	Director of Nursing		✓
Mr F Griffiths	Chair of the Trust		✓
Mrs D Hanwell	Chief Financial Officer	✓	✓
Dr J Isherwood	Medical Director		✓
Mrs L Parkinson	Interim Chief Operating Officer	✓	✓
Mrs M Sentamu	Non-executive Director (Deputy Chair of the Trust)		✓
Mrs J Tankard	Non-executive Director		✓
Dr G Taylor	Non-executive Director (Senior Independent Director)	✓	✓
Prof C Thompson	Non-executive Director	✓	✓
Mrs S Tyler	Director of Workforce Development		✓
Mr K Woodhouse	Non-executive Director		✓
Mr S Wrigley-Howe	Non-executive Director		✓

In attendance

Ms F Limbert	Governance Assistant (secretariat)
Ms R Cooper	Administration Assistant
Mr D Brewin,	Deputy Director of Finance attending for agenda item 7 (minute 16/0095)
Ms K Gorse-Brightwater	CQC Inspector (observing the Board meeting)

		Action
	The Chair opened the meeting at 13.30 and welcomed members of the Board of Directors and members of the public. Mr Griffiths noted that the meeting was being observed by Olayemi Karim from Ernst and Young as part of the Well-led Review.	
16/088	**Apologies for absence** (agenda item 1) Apologies were received from Mrs D Hanwell, Chief Financial Officer; Mrs L Parkinson, Interim Chief Operating Officer; Dr G Taylor, Non-executive Director; and Prof Thompson, Non-executive Director. Mr Griffiths noted the large number of apologies was due to having to change the date of the meeting at short notice.	
16/089	**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 there were no changes advised by any director in respect of their declarations of interest and that no director present at the meeting had any conflict of interest in respect of any agenda item to be discussed.	

16/090 **Opportunity to receive comments / questions from members of the public** (agenda item 3)

There were no questions from the public.

16/091 **Minutes of the meeting held on 28 April 2016** (agenda item 4.1)

The minutes of the meeting held on 28 April 2016 were **received** and **agreed** as a true record of the meeting.

16/092 **Minutes of the extraordinary meeting held on 23 May 2016** (agenda item 4.2)

The minutes of the meeting held on 23 May 2016 were **received** and **agreed** as a true record of the meeting.

16/093 **Matters arising** (agenda item 5)

There were no matters arising.

16/094 **Actions outstanding from the public meetings of the Board of Directors** (agenda item 6)

Ms Limbert 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. Ms Limbert noted that on this occasion there were no actions outstanding.

The Board **received** the log and noted there were no actions outstanding.

16/095 **Integrated Quality and Performance Report – exception report** (agenda item 7)

Mr Deery presented the IQP Exception Report, noting that this reports on exceptions pertaining to the month of May where performance is below expected targets. Mr Deery reported that the introduction of this report was agreed in relation to feedback from the recent Well-led Review, noting that a full quarterly report will still be brought to the Board in line with the dates for the NHS Improvement Board self-assessment returns.

With regard to the information provided in the report Mr Deery assured the Board that none of these exceptions affect the Trust's performance of compliance with KPIs as required by NHS Improvement.

Mr Deery drew attention to those areas of under-performance including: the appraisals target noting that this was still below 90%; the Trigger to Board event relating to a defective Mental Health Act detention; data completeness around

ethnicity; adult liaison services seeing services users within three hours; and the mental health payment system clustering. Mr Deery noted that there are action plans in place for each of these areas of underperformance and that for the report at the end of Quarter 1 it is expected there will be a shift in performance closer to the target.

With regard to the Trigger to Board event Mr Griffiths asked Mr Deery to explain the medical scrutiny as described in the report. Mr Deery and Dr Isherwood explained how this is different from the administrative scrutiny and what the requirements of the act are in regard to this.

Mr Woodhouse supported this new report. He noted that progress had been made over the last 6 months which was good to see. However, he noted that during his visits to services staff are noting the pressure they are under due to the number of vacancies and that they are having to decide how to prioritise their time, with the result that service users are taking priority over carrying out for example, appraisals. With this in mind he asked where the recruitment initiatives are up to. Mrs Tyler acknowledged the fact that staff are having to prioritise their time. She also noted that nationally there is a shortage of nursing staff and that recruitment is a challenge for this and other Trusts. Mrs Tyler advised the Board of the initiatives that have been undertaken to attract staff to the Trust and outlined the successes and outcomes of these, whilst acknowledging the ongoing challenge particularly in the Band 5 nursing posts in some areas. She also outlined the future plans for recruitment drives and also the changes to internal processes to help support these drives.

Mrs Tankard asked for assurance that clinical staff time is focussed on care rather than on 'housekeeping' or administrative tasks. Mr Deery and Ms Copeland assured the Board of the work to ensure staff time is appropriately used.

Mr Wrigley-Howe asked about the CPA target noting that some service users appear not to have a Care Co-ordinator. Mr Deery explained the work that is being undertaken to look at this matter on a case-by-case basis. Mr Griffiths asked Mr Deery to bring a report back on this matter to a future Board meeting. **AD**

With regard to financial performance Mr Brewin outlined to the Board the control total and original plan assumptions noting that the original plan to make a £1 million surplus had then been superseded by a control total of £3.051 million, which he noted had been mandated on the Trust by NHS Improvement and agreed by members of the Board outside of the meeting.

Mr Brewin set out the caveats to achieving this revised control total noting that this now requires the Trust to identify additional CIPs and increase its planned to surplus to £2.1 million. Mr Brewin advised the Board that if this increased surplus is achieved the CCG will give the Trust a cash sum of £900k, thereby resulting in an overall surplus at the end of the year of £3 million.

Mr Brewin then set out the current financial position and forecast position in relation to these assumptions noting that at the end of May 2016 the Trust had achieved a surplus of £80k noting that this is behind even the original plan for the Trust to achieve a £1 million surplus. Mr Brewin then advised the Board that the surplus of £80k had been achieved through non-recurrent items and if these are

taken out the Trust's underlying position is a deficit of £404k as at month 2, noting that this is mainly due to spending on Out of Area Treatments whereby the Trust is spending more on these than it is funded for; CIPs which haven't yet been achieved; and the offset of the vacancies the Trust is carrying.

With regard to the forecast Mr Brewin explained how this had been calculated and the assumptions made including the OATs spending remaining at the current level month-on-month and advised the Board that the best-case position is £0.5 million deficit by the end of March 2017, with a Financial Risk Rating of 2, noting that this would not be acceptable to our regulator and would incur detailed scrutiny of the organisation not least because the Trust had failed to meet the imposed surplus.

The Board noted that the Trust was a significant way from the financial plan as required by the regulator and discussed what measures could be put in place.

Mrs Tankard asked about OATs for locked rehabilitation and what the options are for caring for these service users other than out of area. Mr Deery noted that the bed modelling exercise carried out earlier in the year indicated that there were the correct number of beds in the Trust, but noted that there is clearly now a demand issue in relation to beds. Mr Deery then explained what the Trust is doing within the care pathways and the criteria for treating people in various types of facilities to ensure service users are treated in the most appropriate way and ensure the capacity to treat people within Trust services, either as inpatients or in the community. Ms Copeland also noted that the CCG has recognised this as a system issue and are looking at how the Trust can be supported in relation to the increased demand. However, Ms Copeland noted that there is the option for the Trust to hand back the budget to the commissioners and transfer the risk to them.

Mrs Sentamu asked about CIPs and how the achievement of these can be accelerated. Mr Brewin outlined some of the key areas where there are opportunities for CIPs being achieved including the possibility of PFI refinancing and procurement. He also noted that all CIPs require a Quality Impact Assessment to be carried out prior to commencing, and will be monitored as they progress with the option of halting them if they are having an adverse impact on quality.

Mr Woodhouse asked about the control total and whether there has been any legal contest to what the regulator is imposing on Foundation Trusts, and whether the Trust has made it clear to NHS Improvement what the likely outcome is for the services in the organisation resulting from the imposed surplus. Ms Copeland noted that she was not aware of any challenge. She also noted that it would appear that it would appear that mental health trusts who traditionally have larger surpluses are being asked to support the acute sector to a greater degree. She also noted the huge challenge to the Trust in achieving the control total.

With regard to the matter of PFI refinancing Mr Griffiths asked for a fuller report to be brought back to the Board. **DH**

The Board **noted** the exceptions and was **assured** that there were action plans in place to address the underperformance.

16/096 **Serious untoward incidents update and lessons learnt following the Trust Incident Review Group (TIRG) meeting held on the 11 May 2016** (agenda item 8)

Dr Isherwood presented the paper and advised the Board that there were only a small number of cases discussed at the meeting, but assured the Board that the backlog was being addressed and that systems were in place to ensure continued progress was made.

Dr Isherwood outlined some of the lessons learnt from the various incidents investigated. He also noted that the Mortality Review Group was now in place and that this reports to TIRG.

Mr Woodhouse asked about the £4 million funding which the Board had approved for improvements in the estate and how the use of this was progressing. Mr Deery outlined the four areas identified: replacement of radiator covers, bathroom and toilet facility upgrades, the replacement of furniture, and anti-barricade doors, noting that work was centring on the priority areas first and that an action plan was in place to complete work in the other areas. He then outlined the work that had already been undertaken and that which is still waiting to be completed.

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

16/097 **Safer Staffing Report** (agenda item 9)

Mr Deery presented the safer staffing report for the month of April and highlighted four areas not meeting the standards expected. He explained the causes for these exceptions and assured the Board that mitigations were in place in all other areas to ensure safe and adequate staffing.

Mr Wrigley-Howe asked for a trend analysis to be included in the report to help identify any hot-spots.

The Board **received** the safer staffing report and **noted** the exceptions and the reasons for these occurring.

16/098 **Complaints Summary Report** (agenda item 10)

Mr Deery presented the complaints summary report noting that the system continues to perform effectively. He noted that complaints training had been rolled out to staff across the Trust, he also noted that the complaints team is managing to achieve the 30-day response time except for the cases where an alternative timeline had been agreed with the complainant.

Mr Deery then drew attention to the outcome of complaints closed within the month and outlined some of the issues reported back to the clinical teams so these could be addressed. In particular he noted that the reliance on bank and

agency staff is something service users complain about and indicated that this issue is being addressed through safer staffing.

Mrs Sentamu noted that some of the delays in response to complainants. Mr Deery explained the steps being taken to address this.

Mr Woodhouse asked about clinical claims in particular a case with a value of £12 million. Mr Deery agreed to report back in relation to the detail around this case. **AD**

The Board **received** the complaints summary report and **noted** the progress being made and also some of the issues which are reported by complainants and what is being done to address these within the services.

16/099 **Trust Strategy and Sustainability and Transformation Plan Update** (agenda item 11)

Ms Copeland presented a paper updating the Board on progress with refreshing the Trust's Five Year Strategy and the development of the Leeds and West Yorkshire Sustainability and Transformation Plans (STPs).

She noted that the Trust's strategy was responding to national and local developments including the STP for Leeds and West Yorkshire. She also noted there was a comprehensive process of engagement including with staff, governors, members, service users and carers. She also noted that 20% of staff had engaged with the Clever Together process, which was a very good response.

Ms Copeland noted that the strategy will be brought to the Board and the Council of Governors as it is developed. She also noted that it was intended to bring a draft of the strategy to the Annual Members' Day in order to start the consultation on the content with stakeholders and to ensure there is time to allow it to reflect the outcome of the STP.

In relation to governors Ms Copeland indicated there is a group which has been formed to allow governors to input meaningfully to the development of the strategy noting that Mr Wrigley-Howe had been invited to join that group.

With regard to the STPs Ms Copeland noted that these are high-level documents with the West Yorkshire STP becoming the most prominent due to it being the preferred unit of planning within the system. Ms Copeland drew attention in particular to the opportunity to bid for Tier 4 CAMHS services noting that this was being done in collaboration with Leeds Community Healthcare.

With regard to service provision in Leeds Ms Copeland noted that there had been a meeting with commissioners on how the Trust and Leeds Community Healthcare could work more collaboratively noting that the commissioners in Leeds have indicated that there should be a single contracting mechanism for out of hospital / community based care with there being a lead provider model. Ms Copeland outlined the discussions that had taken place in relation to progressing this to better understand the implications of it and the models through which this will be delivered with a view to there being something in place by April 2017.

	The Board **received** the update report and **discussed** the content, its implications and was **assured** with the progress made.	
16/100	**Verbal report from the chair of the Quality Committee for the extraordinary meeting held 24 May 2016** (agenda item 12) Mr Wrigley-Howe provided a verbal report of the extraordinary Quality Committee which was held on 24 May 2016. He reported on the following matters: • Assurance as to the progress made with preparations for the CQC inspection.	
	The Board **received** the verbal report and **noted** the matters discussed at that meeting.	
16/101	**Draft minutes of the meeting of the Quality Committee held 12 April 2016** (agenda item 12.1)	
	The draft minutes of the meeting of the Quality Committee meeting held on 12 April 2016 were **received** by the Board.	
16/102	**Draft minutes of the meeting of the Extraordinary Quality Committee held 24 May 2016** (agenda item 12.2)	
	The draft minutes of the extraordinary meeting of the Quality Committee meeting held on 24 May 2016 were **received** by the Board.	
16/103	**Re-appointment of Mental Health Act Managers** (agenda item 13) Mr Deery presented to the Board a proposal about the re-appointment of a number of Mental Health Act Managers following the expiry of their current term of appointment which will come to an end on 30 September 2016. Mr Deery noted that a recruitment process would be undertaken to ensure the pool of Mental Health Act Managers is refreshed. Mrs Sentamu asked the reason why there were nine managers undertaking hearings in excess of the required 12-18 hearings a year. Mr Deery agreed to look into why this was.	**AD**

	Having considered the matter the Board **confirmed** that Brian Kemp, Enid Atkinson, Lindsay Councell, Heather Limbach, Bernard Marsden, David Walkden, Maggie Archer, Brian Councell, Roger Helm, Anne Rice, and Jill Hetherton, would be appointed for a further six months to conclude on 31 March 2017.	
16/104	**Ratification of the revised Terms of Reference for the Mental Health Legislation Committee** (agenda item 14) Mr Wrigley-Howe presented the Terms of Reference for the Mental Health Legislation Committee noting that these had been refreshed and agreed at the last committee meeting. He noted that the members of the committee had been reviewed although he raised a question as to whether the committees of the Board should be made up of only non-executive directors or should have a mixture of executive and non-executives. Mrs Hill was asked to clarify this point. He also drew attention to some of the changes made including the involvement of the Mental Health Act Managers who would attend committee meetings and the input that service users can make to understanding the patient's experience of the application of the Mental Health Act. Mr Wrigley-Howe also referred to the recent judicial review in regard to decisions taken at a Mental Health Act hearing. Mr Griffiths asked for the email outlining the case to be circulated to all Board members.	**CH** **AD**
	The Board **considered** and **ratified** the revised Terms of Reference for the Mental Health Act Committee.	
16/105	**Approval of the changes to the Trust's Constitution** (agenda item 15) Ms Copeland presented the proposed changes to the Trust's constitution, noting that the changes were in regard to the make-up of the Council of Governors. Ms Copeland reported that these changes had been presented to the Council of Governors at their meeting on the 12 May and had been approved there and as such asked the Board to now approve these.	
	Having considered the proposed changes to the Constitution to Board **approved** these changes with immediate effect.	
16/106	**Chair's report** (agenda item 16) Mr Griffiths noted there were no matters to report to the Board at this point.	

16/107	**Confirmation of the independence of the Non-Executive Directors** (agenda item 16.1) Mr Griffiths noted that at the Board meeting held on the 23 May 2016 the independence of NEDs had been discussed and the Board had confirmed that each of the NEDs were independent in character and judgement. Mr Griffiths noted that this was now a mater to be reported in public and asked the Board to again note this matter.
	The Board **noted** the independence of NEDs.
16/108	**Chief Executive's report** (agenda item 17) Ms Copland presented the Chief Executives report noting that this is for information which was noted by the Board.
	The Board **received** and **noted** the Chief' Executive's report.
16/109	**Draft minutes of the public meeting of the Council of Governors' held 12 May 2016** (agenda item 18)
	The Board **received** and **noted** the report minutes from the Council of Governors' meeting held on 12 May 2016.
16/110	**Draft minutes of the meeting of the Audit Committee held 21 April 2016** (agenda item 19)
	The Board **received** and **noted** the report minutes from the Audit Committee meeting held on 21 April 2016.
16/111	**Draft minutes of the meeting of the Audit Committee held 18 May 2016** (agenda item 20)
	The Board **received** and **noted** the report minutes from the Audit Committee meeting held on 18 May 2016.
16/112	**Draft minutes of the meeting of the Finance and Business Committee held 21 April 2016** (agenda item 21)
	The Board **received** and **noted** the report minutes from the Finance and Business Committee meeting held on 21 April 2016.

16/113	**Draft minutes of the meeting of the Mental Health Legislation Committee held 19 April 2016** (agenda item 22)
	The Board **received** and **noted** the report minutes from the Mental Health Legislation Committee meeting held on 19 April 2016.
16/114	**NHSE Annual Organisational Audit Questionnaire 2015/16** (agenda item 23)
	The Board **received** and **noted** the content of the NHSE Annual Organisational Audit Questionnaire 2015/16.
16/115	**Use of the Trust's seal** (agenda item 24) Mr Griffiths noted that the Trust seal had been used on one occasion since the last meeting: • Log number 93 signed on the 9 June 2016; licence for alterations for 34-36 Springwell Road, Leeds.
	The Board **noted** that the seal had been used once since the last meeting.
16/116	**Any other business** (agenda item 25) There were no items of other business.
16/117	**Further Questions or Comments from the Public** (agenda item 26) There were no further questions 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 15:20 and thanked members of the Board and members of the public for attending.

BOARD OF DIRECTORS' ACTION SUMMARY
(PUBLIC MEETING)
Meeting held Thursday 23 June 2016

FOR INFORMATION ONLY
SEE CUMULATIVE ACTION LOG FOR DETAILED INFORMATION

MINUTE	ACTION SUMMARY (PUBLIC MEETING – PART A)	LEAD DIRECTOR
16/095	**Integrated Quality and Performance Report – exception report** (agenda item 7) With regard to the matter of PFI refinancing Mr Griffiths asked for a fuller report to be brought back to the Board. Mr Wrigley-Howe asked about the CPA target noting that some service users appear not to have a Care Co-ordinator. Mr Deery explained the work that is being undertaken to look at this matter on a case-by-case basis. Mr Griffiths asked Mr Deery to bring a report back on this matter to a future Board meeting.	**DH** **AD**
16/098	**Complaints Summary Report** (agenda item 10) Mr Woodhouse asked about clinical claims in particular a case with a value of £12 million. Mr Deery agreed to report back in relation to the detail around this case.	**AD**
16/103	**Re-appointment of Mental Health Act Managers** (agenda item 13) Mrs Sentamu asked the reason why there were only nine of the managers undertaking hearings in excess of the required 12-18 hearings a year. Mr Deery agreed to look into why this was.	**AD**
16/104	**Ratification of the revised Terms of Reference for the Mental Health Legislation Committee** (agenda item 14) Mr Wrigley-Howe noted that the members of the committee had been reviewed although he raised a question as to whether the committees of the Board should be made up of only non-executive directors or should have a mixture of executive and non-executives. Mrs Hill was asked to clarify this point. Mr Wrigley-Howe also referred to the recent judicial review in regard to decisions taken at a Mental Health Act hearing. Mr Griffiths asked for the email outlining the case would be circulated to all Board members.	**CH** **AD**

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:	Actions outstanding from public meetings of the Board of Directors
DATE OF MEETING:	28 July 2016
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)					
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)		

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	To advise the Board on those actions agreed at the public Board meetings which are still outstanding and those that have been closed since the last meeting.
What are the key points and key issues the Board needs to focus on	It is considered good practice to formally monitor progress against actions agreed by the Board of Directors, so that 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 Board action list is detailed and 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 challenge or comment on any area where it is not assured or where further updates can be provided.
What is the impact on the quality of care	The Board is ultimately responsible for all aspects of the quality of care and completing Board actions as requested supports high quality and responsive care.
What are the benefits and risks for the Trust	The benefit of reporting on agreed actions is 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

Key to status =

Still outstanding/awaiting completion

Completed

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
199	**16/095 (June 2016)**	**Integrated Quality and Performance Report – exception report** (agenda item 7) With regard to the matter of our PFI options Mr Griffiths asked for a fuller report to be brought back to the Board.	**Dawn Hanwell**	July 2016	THE BOARD IS ASKED TO CONSIDER IF THIS ACTION IS COMPLETE A report is to be made to the July Board meeting	
200	**16/095 (June 2016)**	**Integrated Quality and Performance Report – exception report** (agenda item 7) Mr Wrigley-Howe asked about the CPA target noting that some service users appear not to have a Care Co-ordinator. Mr Deery explained the work that is being undertaken to look at this matter on a case-by-case basis. Mr Griffiths asked Mr Deery to bring a report back on this matter to a future Board meeting.	**Anthony Deery**	Date for a paper to come back to Board to be advised		

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
201	**16/098 (June 2016)**	**Complaints Summary Report** (agenda item 10) Mr Woodhouse asked about clinical claims in particular a case with a value of £12 million. Mr Deery agreed to report back in relation to the detail around this case.	**Anthony Deery**	Management Action	COMPLETED Information regarding this claim has been circulated to members of the Board – confirmation from NHSLA that this is an erroneous figure. Verbal report made to the Board in July	
202	**16/103 (June 2016)**	**Re-appointment of Mental Health Act Managers** (agenda item 13) Mrs Sentamu asked the reason why there were only nine of the managers undertaking hearings in excess of the required 12-18 hearings a year. Mr Deery agreed to look into why this was.	**Anthony Deery**	Management Action	THE BOARD IS ASKED TO CONSIDER IF THIS ACTION IS COMPLETE Information on this matter has been circulated to non-executive directors	
203	**16/104 (June 2016)**	**Ratification of the revised Terms of Reference for the Mental Health Legislation Committee** (agenda item 14) Mr Wrigley-Howe also referred to the recent judicial review in regard to decisions taken at a Mental Health Act hearing. Mr Griffiths asked for the email outlining the case would be circulated to all Board members.	**Anthony Deery**	Management Action		

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
204	**16/104 (June 2016)**	**Ratification of the revised Terms of Reference for the Mental Health Legislation Committee** (agenda item 14) Mr Wrigley-Howe noted that the members of the committee had been reviewed although he raised a question as to whether the committees of the Board should be made up of only non-executive directors or should have a mixture of executive and non-executives. Mrs Hill was asked to clarify this point.	**Cath Hill**	Management Action	COMPLETED	

AGENDA ITEM
7

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Integrated Quality and Performance report
DATE OF MEETING:	28 July 2016
LEAD DIRECTOR: (name and title)	Anthony Deery, Director of Nursing, Professions and Quality
PAPER AUTHOR: (name and title)	Mark Gallacher, Head of Performance

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

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	This is the Quarter 1 IQP for 2016/17. The exception report at the beginning of the IQP gives further information regarding the targets that have not been met for April to June 2016 and the actions being carried out to address them.
What are the key points and key issues the Board needs to focus on	The Trust has met all its NHSI targets for Q1. Some local targets agreed with commissioners have not been met. Remedial action plans are produced for the commissioners to identify how these targets will be met going forward. The Board is asked to note the introduction of two new performance indicators into the IQP, namely the Friends and Family Test and the Mental Health Safety Thermometer. Further details about these are given in the exception report. From August 2016 a new format for the IQP is to be introduced. The Performance and Quality and Informatics team feel that this is a better format for the following reasons: • It is an improvement in style and is much easier to analyse. • More information can be fitted on one page making the report more concise. • The current format takes far longer to produce, several hours, whereas the new format can be run in several minutes. This would allow refreshed reports to be produced more frequently if required. • Further lines can be added to the report as requested without causing a delay in producing the report. In Quarter 1 the Trust's financial position is showing a Continuity of Service Risk Rating of '3'.
What is the Board being asked to consider	The Board is asked to note the Trust's performance against Q1 targets, the success in meeting all NHSI targets, and the actions being put into place to address where performance against local targets has not been achieved. In addition the Board is asked to note the measures introduced and the new format of report to be used going forward. The Board is asked to consider the position against both non-financial and financial targets and to comment on the degree to which it feels assured regarding both current performance and future trajectories.

What is the impact on the quality of care	It is not anticipated that there will be an immediate effect on the Quality of care. However, remedial Action Plans are developed to address the issues causing the shortfall in performance in order that appropriate action is taken before there is any effect on the quality managers also monitor –performance in real time through COGNOS reports to identify where there may be issues.
What are the benefits and risks for the Trust	The benefits for the Trust are that it continues to demonstrate transparency with regard to its performance and quality.
What are the resource implications	None.
Next steps following this paper being presented to the Board	The final IQP will be shared with our commissioners, NHSI and published on our website.
What are the reputational implications and how will these be addressed	The reputational implication would arise if we didn't report and publish our performance.
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 trust generated activity and performance and so service users are not part of its production.
Previous meetings where this report has been considered (including date)	This report has been to the Executive.

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:

- Consider the position against both non-financial and financial targets and to comment on the degree to which it feels assured regarding both current performance and future trajectories.
- Confirm that the board anticipates maintaining a continuity of service risk rating of at least 3 over the next 12 months, as required by Monitor, and sign the attached declaration.
- Confirm that the board is satisfied that plans in place are sufficient to ensure on-going compliance with all existing targets (after the application of thresholds) as set out in Appendix B of the Compliance Framework and, a commitment to comply with all known targets going forwards and sign the attached declaration.
- Confirm that there are no matters arising in the quarter requiring an exception report to Monitor (per Compliance Framework) which have not already been reported and sign the attached declaration.

*** 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 – July 2016 (Quarter 1/June 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
Financial Summary

Appendix 1 Financial Sustainability Risk Rating
Appendix 2 Statement of Comprehensive Income
Appendix 3 Cost Improvement Plans & Revenue Generations Scheme 2015/16
Appendix 4 Statement of Financial Position
Appendix 5 Cash Flow Analysis
Appendix 6 Capital Programme

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.

compliant

partially compliant

non-compliant

Exception Reporting

- **Memory service- Time from referral to diagnosis -55% within 8 weeks by quarter 3.**
  Current attainment for Q1 is 8.8%. This is disappointing but the Trust is confident this figure will improve from Q2 onwards. At present there is no mechanism on PARIS to exclude referrals which arrive for their first appointment without all their tests having being arranged in primary care prior to their referral. This means that many referrals do not meet the target due to issues outside the Trust's control. Once these cases can be excluded from Q2 there will be a much more accurate figure. In addition the whole pathway for the memory service is under review to identify areas that can be improved to support meeting the target. The Trust will also work with the CCG to support GPs in ensuring they complete all the relevant diagnostic tests prior to referral.

- **Data completeness**
  This is a newly established target for 90% of all service users to have their ethnicity recorded. This currently stands at 77.1% against a target of 90%. There are certain services, however, where there is a waiting list which lowers the figures as these service users have not yet been asked for this information by the Trust. These services are non- inpatient services and include Gender Identity, LADS and ADHD. Commissioners are aware of this issue and so have asked for a breakdown of results. Therefore two reports are presented here, one for inpatients and one for the Trust as a whole.

  An Action plan has been developed to address the Trust figure and includes the following actions for quarter 2: To ensure that teams understand the target and its importance, to support teams to know how to record ethnicity on Paris correctly, provide regular reports to teams on compliance, monitor compliance and performance manage teams through existing management and governance structures and provide reports to teams on ethnicity monitoring of caseloads

- **Proportion of in scope patients assigned to a cluster -**Target 95%
  Currently 87.47% attainment.
- **Proportion of in scope patients assigned to a cluster and reviewed within recommended Timescales** - Target 75%
  Currently 69.48% attainment.
  There is one action plan for both of the cluster KPI's. Below are actions for Quarter 2:

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

- Provision of active caseload reports and cluster caseload analysis

- **Referral and receipt of diagnosis in LADS service**- Target 50%
  Currently 34.5% attainment.
  During March some key clinical staff had to take unplanned leave which has impacted on the services ability to complete diagnosis for service users moving forward. Whilst this has not affected Q4 reporting there is likely to be an impact on the team's ability to reach diagnostic decisions without this key staff member being available. Whilst other members of the team are attempting to cover this absence it will affect future performance.
  An action plan has been developed which includes the following improvements for quarter 2:

  - Put more robust cover arrangements in place to mitigate wait times as much as possible
  - Automate reports to allow accurate forecasting of times to diagnosis

- **Dual Diagnosis Training** – Target 80%
  Currently 74.5% attainment. At the end of quarter 4 2015/16, performance was above the 80% target however since then a number of staff have left the Trust and new staff have been appointed who require this training. An action plan has been developed and the actions for quarter 2 include: Training courses are booked in Q2 with sufficient capacity to move services to compliance (30 spaces per course and 7 members of staff need to attend to achieve the target), receive attendance and booking sheets to ensure compliance with target and give information back to locality managers on numbers required to be trained to be compliant

- **Triggers to Board** - 2

  1. Fundamentally Defective Community Treatment Order - The Mental Health Legislation Clinical Department Manager scrutinised the Community Treatment Order (CTO). The CTO documentation, part 1 had not been signed by the relevant doctor, when making the CTO application. This was considered to be fundamentally defective. Immediate Action included the Internal incident report was completed (DATIX) and a home visit to the service user and subsequent telephone contact by the relevant staff. Information was shared with the service user and was they were informed of the Trust's complaints process. Agreed that the CTO was invalid from the date the error was noted therefore the CTO discharged. Service manager, care co-ordinator and consultant informed of the error.
     Duty of Candour. Verbal and written apology sent to the service user. Written apology sent on the 7 June 2016. No documented next of kin.

2. Fundamentally Defective Detention - Service user detained under mental health act section 2. Both medical recommendations supporting the application for detention deemed by the medical scrutineer not to provide sufficient reasons to warrant detention. As a result the section was considered fundamentally defective. Immediate Action: Service user too unwell to be informed at the time of the incident. The mental health legislation informed the ward that the section was fundamentally defective on the 8 June 2016. The service user was discharged from section 2 at 12 noon on the 8 June 2016 and placed on section 5(2) as requires assessment for re detention.
   Duty of Candour - Family to be contacted. Unable to inform service user as too unwell. However, the service user will be informed as soon as appropriate.

- **Compulsory Training** - Target 90%
  Currently 84.7% attainment.
  An action plan has been developed for both compulsory training and appraisals and include the following actions for Quarter 2: P&C Manager to meet with Matrons and locality managers to agree trajectory to achieve 90%, All services to sign off trajectory and P&C manager will report back operational and systematic issues affecting target compliance to appropriate managers.

- **Appraisals** - Target 90%
  Currently 77.5% attainment.
  The Trust is two months into a new process to monitor the uptake and recording of appraisals and so a further period of time is required to allow this to fully bed in. Every two weeks managers receive a list directly from HR informing them who is compliant in their team and who is due for an appraisal in the next four weeks. The feedback from managers has been positive and allowed them to confirm accurate staff lists and confirm people who are not in scope, e.g. on secondment. In addition the recording process has been streamlined in order to make it more user friendly and less bureaucratic for staff. The work will continue to be monitored on a weekly basis in the Fundamental Standards Group. Going forward the aim is for the Appraisal system to go on to ILearn, the Trust's web based system which will allow staff to access their appraisal from different locations. Please also see Action plan for compulsory training and this action plan cover requirements for both compulsory training and Appraisals.

- **Waiting times for Community Mental Health Teams for face to face contact within 14 days** – Target 80%
  Currently 76.6%% attainment.
  Demand for assessment has increased from quarter 4 15/16 to Q1 16/17 and overall in year demand for CMHT assessment has increased by 12%. This follows a pattern of increasing numbers of referrals to the Trust via the single point of access. To cope with this increasing demand teams had added additional weekend and evening clinics in order to keep pace with this however the ability to continue to provide this extra capacity is limited by staff availability to undertake additional work. In order to help manage and reduce demand to SPA and CMHTs the Trust has submitted and received approval for a business case for additional staff to work

directly with primary care. These staff will focus on working with colleagues in primary care to improve decision making related to referrals and to build resilience and skills to help primary care manage care without referral to secondary care. They will also work with CMHTs and primary care to support transfer of care from secondary care. The work of the team will be monitored over the year and measured against these key indicators. Recruitment to these posts has commenced and the team will be fully established and operational by October 2016.

An action plan has been developed and includes the following actions for Quarter 2: Recruitment is an ongoing process and the Trust has implemented innovative approaches to recruiting staff including holding Trust wide recruitment events. Review of the triage process will include a tiered approach to assessment based on need identified in the referral. This is being piloted in WNW community team and with measures in place to demonstrate the outcomes.

- **Timely access to a mental health assessment by the ALPs team in the LTHT Emergency –**Target 90% within 3 hours
  Currently 85% attainment - The reason for this non-attainment is due to demand on the service. The trust will continue to look at ways in which it can improve processes to meet the target on a regular basis.

- **Staff Turnover** – Target 15%,
  Currently 32.5%. This is at 32.5% as it is a rolling yearly average and still includes staff that transferred to TEWV in October 2015. Without the transferred staff the figure is more likely to be 10-11%.

- **Sickness Absence** – Target 3.7%
  Our current sickness level is 5% as at June 2016, which is a slight improvement on Q4 2015-16. .The trust has a very ambitious target of 3.7% for sickness absence. It is currently strengthening its approach to supporting staff to remain at work through engagement in the national CQUIN schemes, introducing Health and Well Being initiatives for staff. This is in addition to the initiatives previously reported such as the First Care absence reporting system and quicker referrals to occupational health. We have compared ourselves to other trusts in the region and we are not an outlier in our levels of sickness. The work will continue to support staff to stay at work and improve sickness levels.

NEW to IQP

1. The Mental Health Safety Thermometer – Harm Free Care. Currently there is no target set for this indicator.
   This is being reported for the first time in the IQP. The roll out of this to relevant services will be completed by the end of August 2016 when CMHTs and ICS commence using it, and so this is not truly reflective of the Trust position. The survey is carried out one day per month and asks:
   The proportion of people that have self harmed in the last 24 hours?
   The proportion of people that feel safe at the point of survey?

Proportion of people that have been the victim of violence aggression in the last 72 hours?
Proportion of people that have had a medicine omission in the last 24 hours?
Proportion of people that have been restrained in the last 72 hours (inpatient only)?

2. Friends and Family Test. The Trust has been participating in the FFT since 2014 as per the requirements of the CQUIN. The question asks service users “How likely they are to recommend our service to friends or family if they needed similar care or treatment.” There are a range of responses from “Extremely likely”, “Likely” to “Extremely Unlikely”. There were 71 responses in June of which 19 were unlikely or very unlikely which gave the overall score of 73.2%. The Head of Patient Experience has recently redesigned the FFT questionnaire to improve the response rate by separating out the PREM into an in-house customer satisfaction survey, managed whenever the clinical team feel is best to invite a person to complete. This was introduced in March this year and already the FFT return has shown an increase. The response rate will be continued to be monitored to assure ourselves of the increased uptake.

At a glance performance summary

		Actual	Target
Strategic Goal 1 - People achieve their agreed goal for improving health and improving lives	Delayed Transfers of Care (Monitor)	1.0%	< 7.5%
	Admissions to inpatient services had access to crisis resolution / home treatment teams (Monitor)	100.0%	>= 95.0%
	Care Programme Approach Formal Reviews within 12 months (Monitor)	97.3%	>= 95.0%
	Data Completeness - Identifiers (Monitor)	99.8%	>= 97.0%
	Data Completeness - Ethnicity (NHS Standard Contract)	77.1%	>= 90.0%
	Data Completeness - Inpatient Ethnicity	96.8%	>= 90.0%
	Bed occupancy rates for inpatient services (Leeds Contract)	99.4%	94.0% to 98.0%
	Inpatient Length of Stay – Adult Mental Health Inpatient Units Adult Wards (Leeds Contract)	38.1	N/A
	Inpatient Length of Stay – Adult Mental Health Inpatient Units Older People's Wards (Leeds Contract)	105.6	N/A
	Inpatient Length of Stay – Adult Mental Health Inpatient Units - <3 days or >90 (Leeds Contract)	16	N/A
	Emergency Readmissions within 28 Days - Adult Acute Mental Health Wards (Local)	6.0%	N/A
	Readmissions to Adult and Older peoples Mental Health In Patient Units - Cumulative (Leeds Contract)	514	N/A
	Readmissions to Adult and Older peoples Mental Health In Patient Units - Median days (Leeds Contract)	226	N/A
	Proportion of in scope patients assigned to a cluster (Leeds Contract)	87.2%	>= 95.0%
	Proportion of in scope patients assigned to a cluster and reviewed within recommended timescales (Leeds Contract)	70.3%	>= 75.0%
	Referral and Receipt of a Diagnosis within LADs Service (Leeds Contract)	34.5%	>= 60.0%
	Percentage of people in settled accommodation (Leeds Contract)	68.6%	N/A

At a glance performance summary

		Actual	Target
Strategic Goal 2 - People experience safe care	7 Day Follow Up (Monitor)	98.9%	>= 95.0%
	Dual Diagnosis Training (Leeds Contract)	73.6%	>= 80.0%
	Increasing awareness of Autism in registered mental health nurses (Leeds Contract)	83.6%	>= 80.0%
	Healthcare Associated Infections – C.difficile	0	= 0
	Healthcare Associated Infections – MRSA	0	= 0
	Percentage of people with a Crisis Assessment Summary and formulation plan in place within 24 hours (Leeds Contract)	100.0%	>= 95.0%
	Memory Services - Time from Referral to Diagnosis (Leeds Contract)	8.8%	>= 55.0%
	Never Events (National)	0	= 0
	Trigger to Board Events (Local)	2	= 0
	NHS Safety Thermometer Harm Free Care	100.0%	>= 95.0%
	NHS MH Safety Thermometer Harm Free Care	86.3%	N/A
	Compulsory Training (Local)	84.7%	>= 90.0%
	Appraisals (Local)	77.5%	>= 90.0%
Strategic Goal 3 - People have a positive experience of their care and support	Data Completeness Indicator for Mental Health Outcomes for CPA Patients (Monitor)	75.5%	>= 50.0%
	Access to Healthcare for People with a Learning Disability (Monitor)		N/A
	Friends and Family Test Likely or Extremely Likely to Recommend	73.2%	N/A
	Waiting times for Community Mental Health Teams for face to face contact within 14 days (Leeds Contract)	76.6%	>= 80.0%
	Out of Area placements (Leeds Contract)	10	N/A

At a glance performance summary

		Actual	Target
Strategic Goal 3 - People have a positive experience of their care and support	Out of Area placements by bed days (Leeds Contract)	196	N/A
	Waiting Times Access to Memory Services (Leeds Contract)	91.1%	>= 65.0%
	Timely Communication with GPs Notified in 10 days (Leeds Contract)	81.4%	>= 80.0%
	Timely access to MH assessment under S136 (Leeds Contract)	29.1%	N/A
	Timely access to a mental health assessment by the ALPs team in the LTHT Emergency Department (Leeds Contract)	85.0%	>= 90.0%
	Better Access to Mental Health Services by 2020: Access to Early Intervention in Psychosis Services (Leeds Contract)	100.0%	>= 50.0%
	Staff Turnover	32.5%	< 15.0%
	Sickness Absence	5.0%	< 3.7%

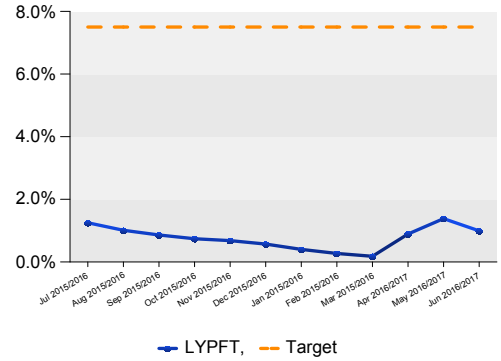
Strategic Goal 1 - People achieve their agreed goal for improving health and improving lives

Delayed Transfers of Care (Monitor)

Target <7.5%

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	1.2%	1.0%	0.9%	0.7%	0.7%	0.6%	0.4%	0.3%	0.2%	0.9%	1.4%	1.0%

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	0.9%	0.6%	0.2%	1.2%

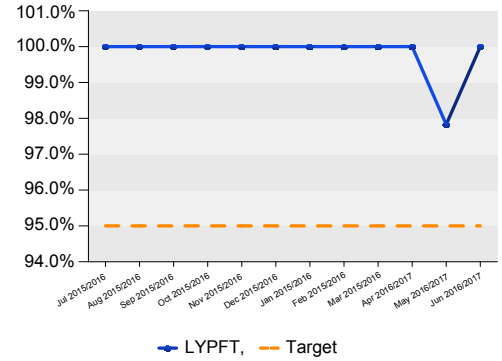


Admissions to inpatient services had access to crisis resolution / home treatment teams (Monitor)

Target >=95.0%

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.8%	100.0%

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	100.0%	100.0%	100.0%	100.0%



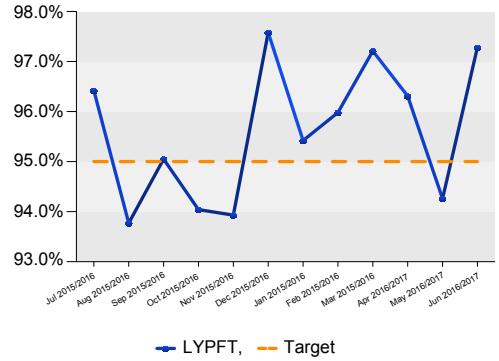
Strategic Goal 1 - People achieve their agreed goal for improving health and improving lives

Care Programme Approach Formal Reviews within 12 months (Monitor)

Target >=95.0%

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	96.4%	93.8%	95.0%	94.0%	93.9%	97.6%	95.4%	96.0%	97.2%	96.3%	94.3%	97.3%

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	95.0%	97.6%	97.2%	97.3%

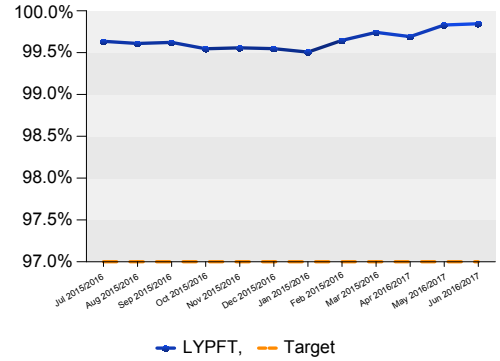


Data Completeness - Identifiers (Monitor)

Target >=97.0%

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	99.6%	99.6%	99.6%	99.5%	99.6%	99.5%	99.5%	99.6%	99.7%	99.7%	99.8%	99.8%

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	99.6%	99.5%	99.7%	99.8%



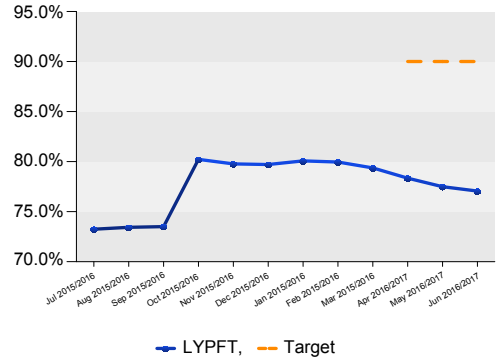
Strategic Goal 1 - People achieve their agreed goal for improving health and improving lives

Data Completeness - Ethnicity (NHS Standard Contract)

Target >=90.0%

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	73.2%	73.4%	73.5%	80.2%	79.8%	79.7%	80.1%	80.0%	79.4%	78.3%	77.5%	77.1%

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	73.5%	79.7%	79.4%	77.1%

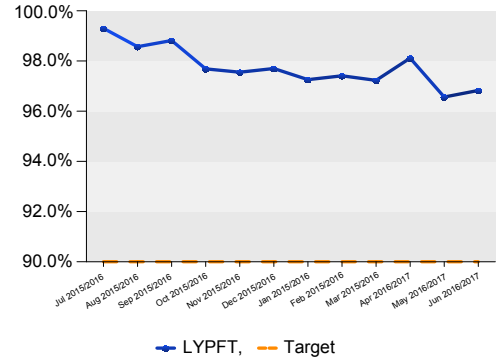


Data Completeness - Inpatient Ethnicity

Target >=90.0%

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	99.3%	98.6%	98.8%	97.7%	97.6%	97.7%	97.3%	97.4%	97.2%	98.1%	96.6%	96.8%

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	98.9%	97.6%	97.3%	97.3%



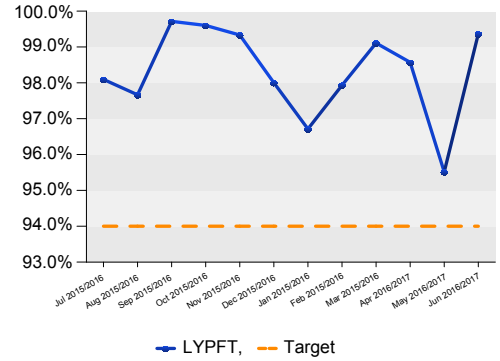
Strategic Goal 1 - People achieve their agreed goal for improving health and improving lives

Bed occupancy rates for inpatient services (Leeds Contract)

Target 94.0% to 98.0%

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	98.1%	97.7%	99.7%	99.6%	99.3%	98.0%	96.7%	97.9%	99.1%	98.6%	95.5%	99.4%

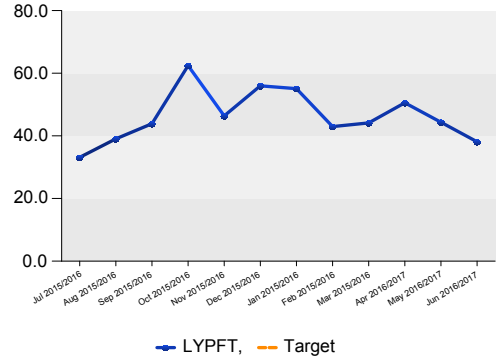
	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	98.5%	99.0%	97.9%	97.6%



Inpatient Length of Stay – Adult Mental Health Inpatient Units Adult Wards (Leeds Contract)

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	33.125	39.03636	43.87037	62.41095	46.36842	55.95833	55.06153	42.95161	44.1194	50.54545	44.33333	38.09836

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	37.91534	55.5337	47.41237	44.48704

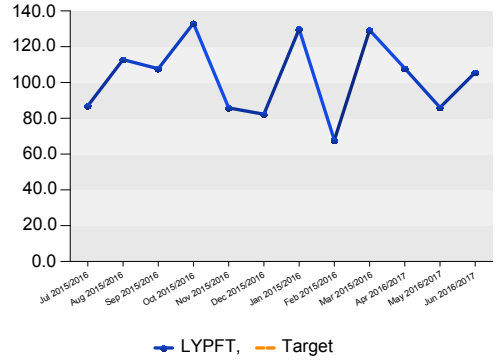


Strategic Goal 1 - People achieve their agreed goal for improving health and improving lives

Inpatient Length of Stay – Adult Mental Health Inpatient Units Older People's Wards (Leeds Contract)

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	86.92592	112.7647	107.66666	133.06896	85.7826	82.25	129.84	67.72413	129.26923	107.88	86	105.60869

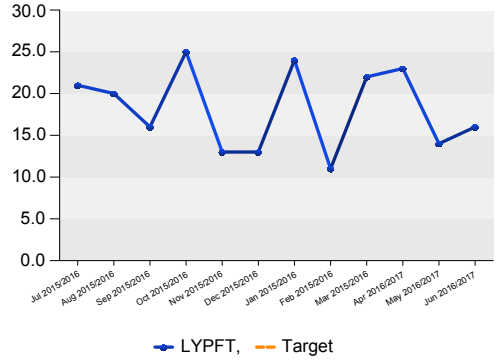
	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	100.70588	103.84722	107.1375	101.12121



Inpatient Length of Stay – Adult Mental Health Inpatient Units - <3 days or >90 (Leeds Contract)

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	21	20	16	25	13	13	24	11	22	23	14	16

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	57	51	57	53

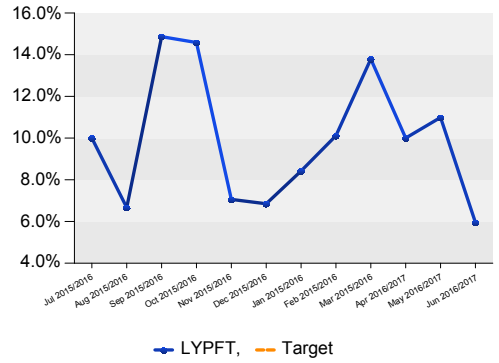


Strategic Goal 1 - People achieve their agreed goal for improving health and improving lives

Emergency Readmissions within 28 Days - Adult Acute Mental Health Wards (Local)

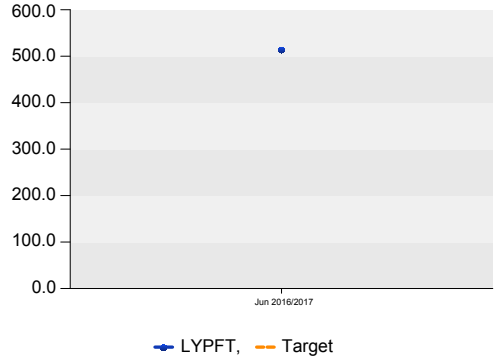
	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	10.0%	6.7%	14.9%	14.6%	7.1%	6.8%	8.4%	10.1%	13.8%	10.0%	11.0%	6.0%

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	10.5%	9.8%	10.7%	9.0%



Readmissions to Adult and Older peoples Mental Health In Patient Units - Cumulative (Leeds Contract)

	2016/2017 Q1
LYPFT	514



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

Readmissions to Adult and Older peoples Mental Health In Patient Units - Median days (Leeds Contract)

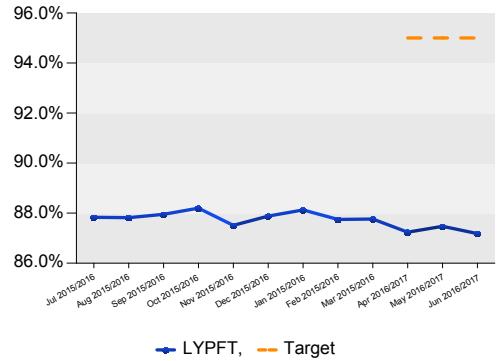
	2016/2017 Q1
LYPFT	226

Proportion of in scope patients assigned to a cluster (Leeds Contract)

Target >=95.0%

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	87.8%	87.8%	88.0%	88.2%	87.5%	87.9%	88.1%	87.7%	87.8%	87.2%	87.5%	87.2%

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	87.9%	87.9%	87.9%	87.2%



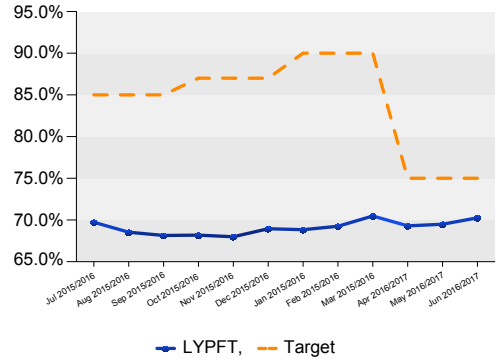
Strategic Goal 1 - People achieve their agreed goal for improving health and improving lives

Proportion of in scope patients assigned to a cluster and reviewed within recommended timescales (Leeds Contract)

Target >=75.0%

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	69.7%	68.5%	68.1%	68.2%	68.0%	68.9%	68.8%	69.2%	70.5%	69.3%	69.5%	70.3%

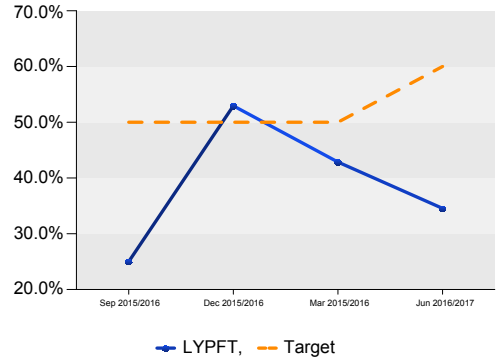
	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	68.8%	68.4%	69.5%	70.3%



Referral and Receipt of a Diagnosis within LADs Service (Leeds Contract)

Target >=60.0%

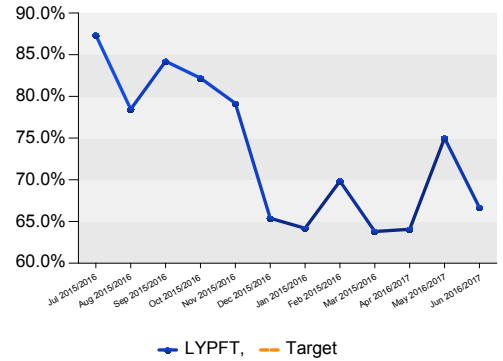
	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	25.0%	52.9%	42.9%	34.5%



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

Percentage of people in settled accommodation (Leeds Contract)

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	83.6%	76.3%	66.0%	68.6%



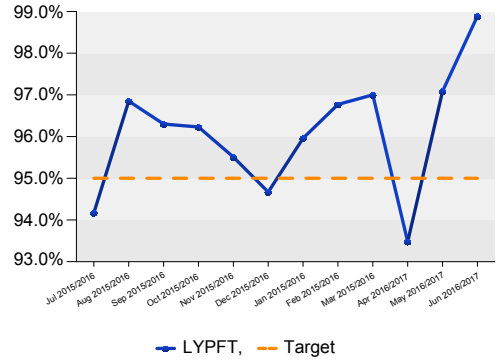
Strategic Goal 2 - People experience safe care

7 Day Follow Up (Monitor)

Target >=95.0%

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	94.2%	96.8%	96.3%	96.2%	95.5%	94.7%	96.0%	96.8%	97.0%	93.5%	97.1%	98.9%

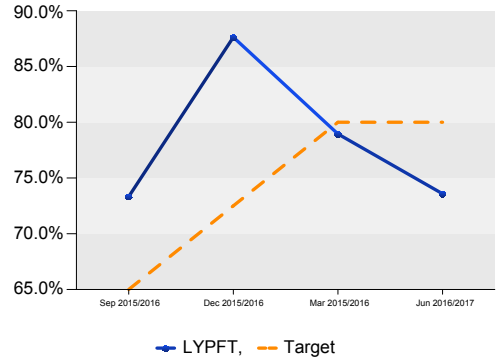
	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	95.8%	95.6%	96.6%	96.2%



Dual Diagnosis Training (Leeds Contract)

Target >=80.0%

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	73.3%	87.6%	78.9%	73.6%

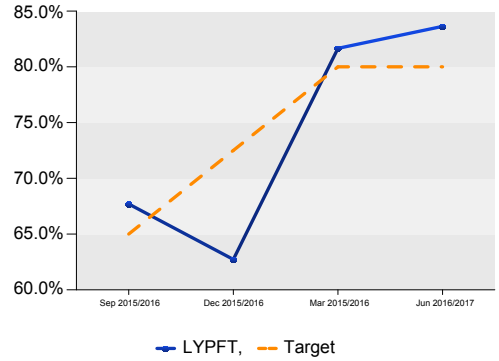


Strategic Goal 2 - People experience safe care

Increasing awareness of Autism in registered mental health nurses (Leeds Contract)

Target >=80.0%

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	67.7%	62.7%	81.7%	83.6%

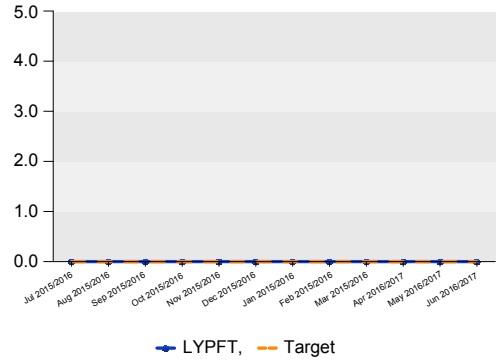


Healthcare Associated Infections – C.difficile

Target =0

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	0	0	0	0	0	0	0	0	0	0	0	0

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	0	0	0	0



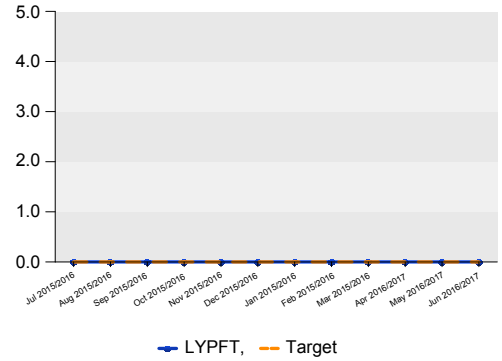
Strategic Goal 2 - People experience safe care

Healthcare Associated Infections – MRSA

Target =0

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	0	0	0	0	0	0	0	0	0	0	0	0

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	0	0	0	0

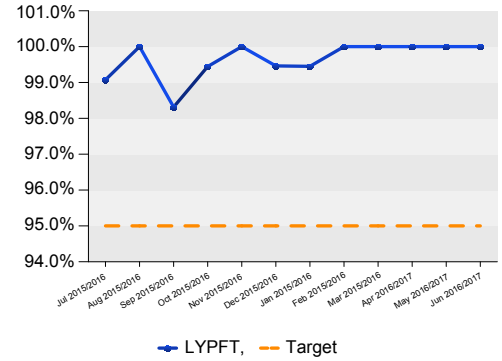


Percentage of people with a Crisis Assessment Summary and formulation plan in place within 24 hours (Leeds Contract)

Target >=95.0%

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	99.1%	100.0%	98.3%	99.4%	100.0%	99.5%	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	99.2%	99.7%	99.8%	100.0%

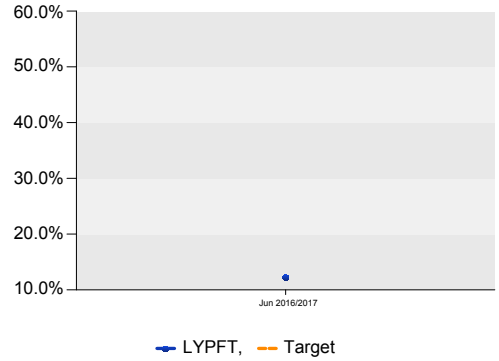


Strategic Goal 2 - People experience safe care

Memory Services - Time from Referral to Diagnosis (Leeds Contract)

Target >=55.0%

	2016/2017 Q1
LYPFT	8.8%

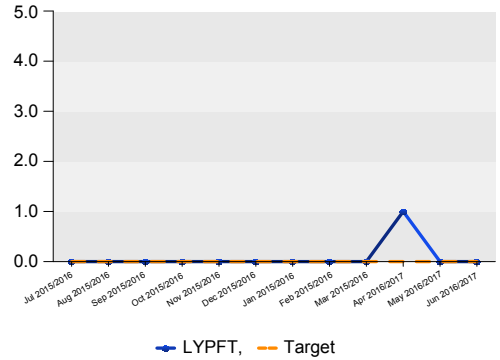


Never Events (National)

Target =0

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	0	0	0	0	0	0	0	0	0	1	0	0

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	0	0	0	1



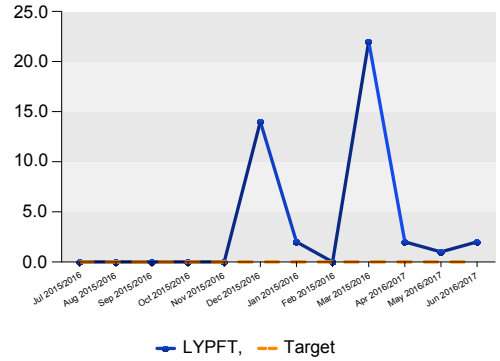
Strategic Goal 2 - People experience safe care

Trigger to Board Events (Local)

Target =0

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	0	0	0	0	0	14	2	0	22	2	1	2

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	0	14	24	5

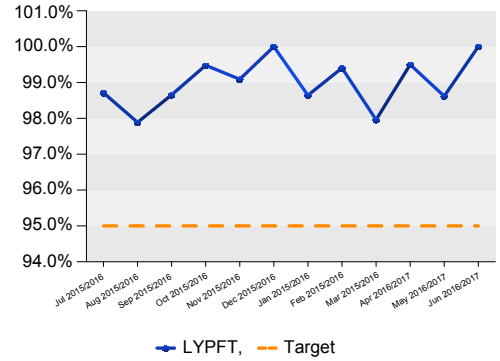


NHS Safety Thermometer Harm Free Care

Target >=95.0%

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	98.7%	97.9%	98.7%	99.5%	99.1%	100.0%	98.6%	99.4%	98.0%	99.5%	98.6%	100.0%

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	98.4%	99.5%	98.6%	99.2%

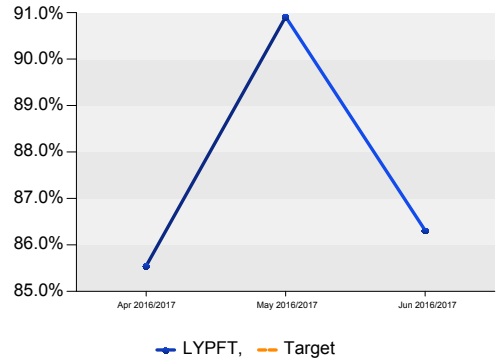


Strategic Goal 2 - People experience safe care

NHS MH Safety Thermometer Harm Free Care

	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	85.5%	90.9%	86.3%

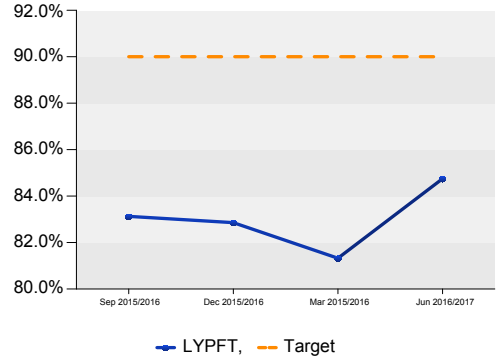
	2016/2017 Q1
LYPFT	87.4%



Compulsory Training (Local)

Target >=90.0%

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	83.1%	82.9%	81.3%	84.7%



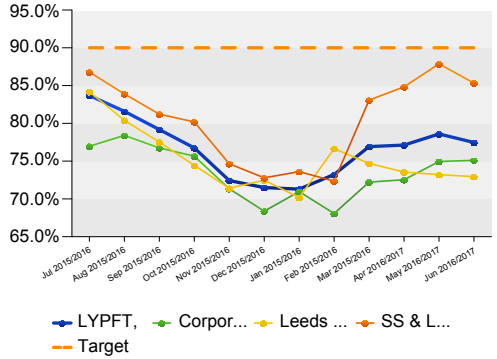
Strategic Goal 2 - People experience safe care

Appraisals (Local)

Target >=90.0%

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	83.7%	81.6%	79.2%	76.7%	72.4%	71.5%	71.3%	73.2%	76.9%	77.1%	78.6%	77.5%
Corporate Services	77.0%	78.4%	76.7%	75.7%	71.3%	68.4%	71.0%	68.1%	72.2%	72.5%	74.9%	75.1%
Leeds MH Care Group	84.2%	80.4%	77.5%	74.4%	71.4%	72.5%	70.2%	76.6%	74.7%	73.5%	73.2%	72.9%
SS & LD Care Group	86.8%	83.9%	81.2%	80.2%	74.6%	72.8%	73.6%	72.3%	83.1%	84.8%	87.9%	85.3%

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	79.2%	71.5%	76.9%	77.5%
Corporate Services	76.7%	68.4%	72.2%	75.1%
Leeds MH Care Group	77.5%	72.5%	74.7%	72.9%
SS & LD Care Group	81.2%	72.8%	83.1%	85.3%



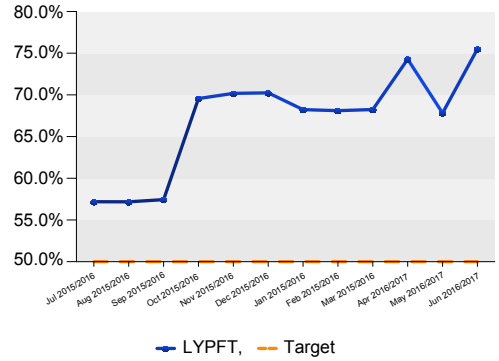
Strategic Goal 3 - People have a positive experience of their care and support

Data Completeness Indicator for Mental Health Outcomes for CPA Patients (Monitor)

Target >=50.0%

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	57.2%	57.2%	57.4%	69.6%	70.2%	70.2%	68.2%	68.1%	68.2%	74.3%	67.8%	75.5%

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	57.3%	70.0%	68.2%	74.8%



Access to Healthcare for People with a Learning Disability (Monitor)

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT												

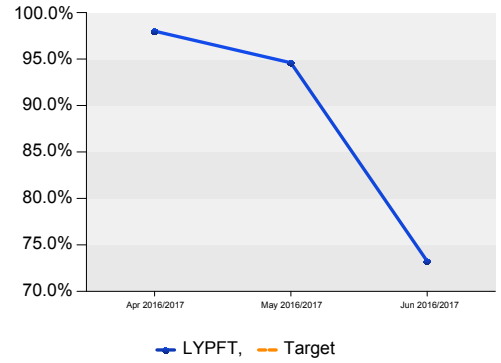
	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT				

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

Friends and Family Test Likely or Extremely Likely to Recommend

	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	98.0%	94.6%	73.2%

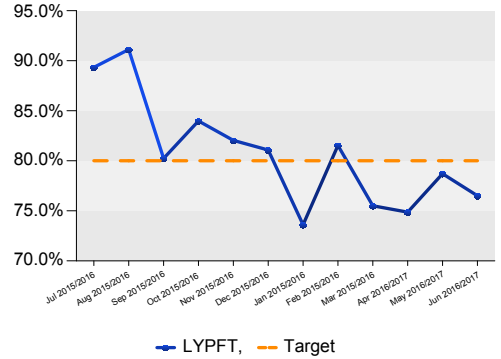
	2016/2017 Q1
LYPFT	86.1%



Waiting times for Community Mental Health Teams for face to face contact within 14 days (Leeds Contract)

Target >=80.0%

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	83.5%	80.7%	75.6%	76.6%

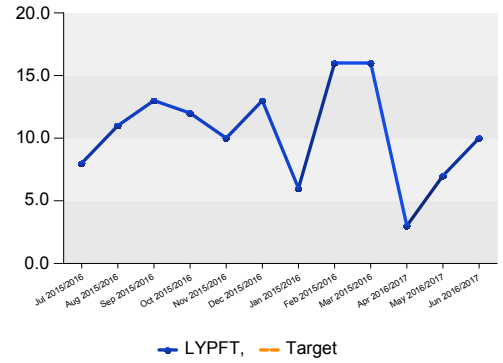


Strategic Goal 3 - People have a positive experience of their care and support

Out of Area placements (Leeds Contract)

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	8	11	13	12	10	13	6	16	16	3	7	10

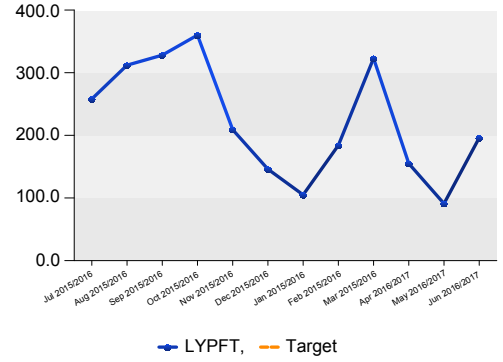
	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	32	35	38	20



Out of Area placements by bed days (Leeds Contract)

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	258	312	328	360	209	146	105	184	323	155	91	196

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	898	715	612	442

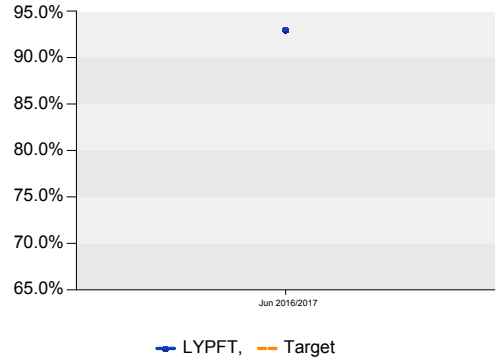


Strategic Goal 3 - People have a positive experience of their care and support

Waiting Times Access to Memory Services (Leeds Contract)

Target >=65.0%

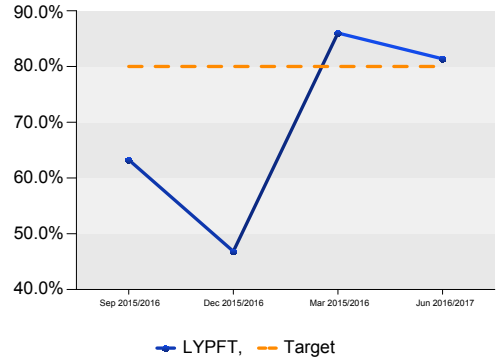
	2016/2017 Q1
LYPFT	91.1%



Timely Communication with GPs Notified in 10 days (Leeds Contract)

Target >=80.0%

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	63.3%	46.8%	86.0%	81.4%

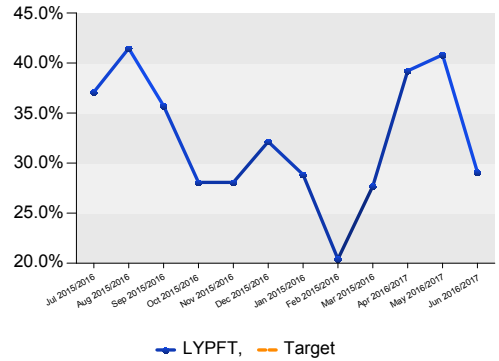


Strategic Goal 3 - People have a positive experience of their care and support

Timely access to MH assessment under S136 (Leeds Contract)

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	37.1%	41.5%	35.7%	28.1%	28.1%	32.1%	28.8%	20.4%	27.7%	39.2%	40.8%	29.1%

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	37.9%	29.4%	25.9%	32.6%

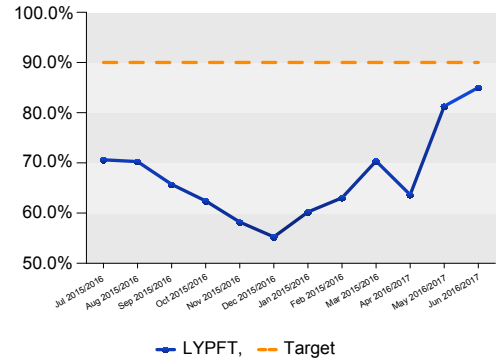


Timely access to a mental health assessment by the ALPs team in the LTHT Emergency Department (Leeds Contract)

Target >=90.0%

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	70.6%	70.2%	65.7%	62.4%	58.2%	55.2%	60.2%	63.0%	70.4%	63.6%	81.3%	85.0%

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	68.9%	58.5%	64.4%	62.6%



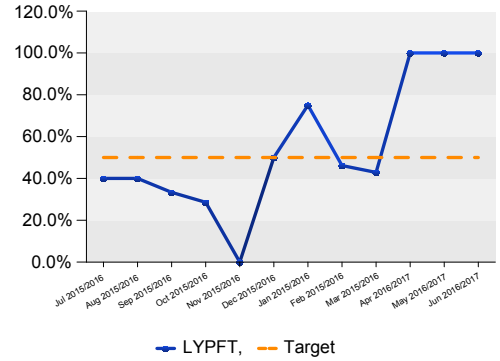
Strategic Goal 3 - People have a positive experience of their care and support

Better Access to Mental Health Services by 2020: Access to Early Intervention in Psychosis Services (Leeds Contract)

Target >=50.0%

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016	Apr 2016/2017	May 2016/2017	Jun 2016/2017
LYPFT	40.0%	40.0%	33.3%	28.6%	0.0%	50.0%	75.0%	46.2%	42.9%	100.0%	100.0%	100.0%

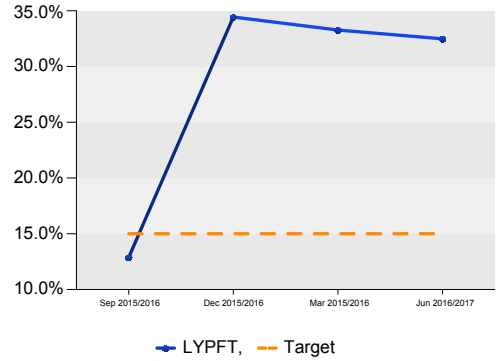
	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	37.5%	31.6%	50.0%	100.0%



Staff Turnover

Target <15.0%

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	12.9%	34.4%	33.3%	32.5%

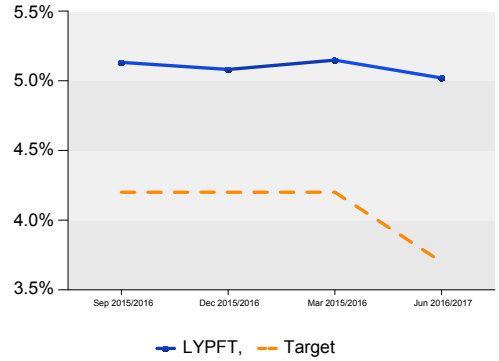


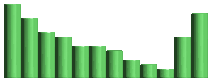
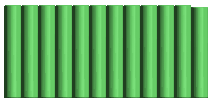
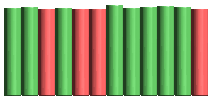
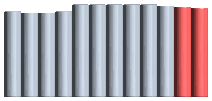
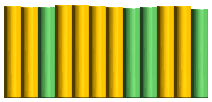
Strategic Goal 3 - People have a positive experience of their care and support

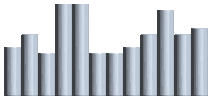
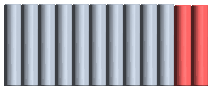
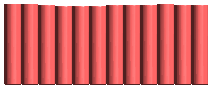
Sickness Absence

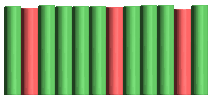
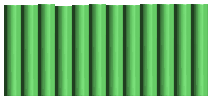
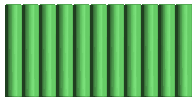
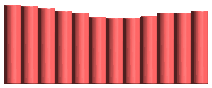
Target <3.7%

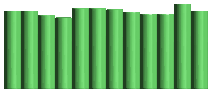
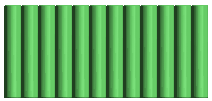
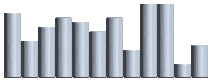
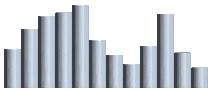
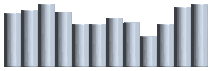
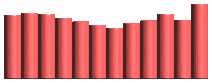
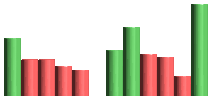
	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4	2016/2017 Q1
LYPFT	5.1%	5.1%	5.1%	5.0%



Strategic Goal 1 - People achieve their agreed goal for improving health and improving lives			
	May 2016/2017	Target	Trend
Delayed Transfers of Care (Monitor)	1.4%	7.5%	
Admissions to inpatient services had access to crisis resolution / home treatment teams (Monitor)	97.83%	95.00%	
Care Programme Approach Formal Reviews within 12 months (Monitor)	94.26%	95.00%	
Data Completeness - Identifiers (Monitor)	99.83%	97.00%	
Data Completeness - Ethnicity (NHS Standard Contract)	77.49%	90.00%	
Bed occupancy rates for inpatient services (Leeds Contract)	95.51%	94.00% to 98.00%	
Inpatient Length of Stay – Adult Mental Health Inpatient Units Adult Wards (Leeds Contract)	44.33		
Inpatient Length of Stay – Adult Mental Health Inpatient Units Older People's Wards (Leeds Contract)	86.00		
Inpatient Length of Stay – Adult Mental Health Inpatient Units - <3 days or >90 (Leeds Contract)	14.00		

	May 2016/2017	Target	Trend
Emergency Readmissions within 28 Days - Adult Acute Mental Health Wards (Local)	10.99%		
Proportion of in scope patients assigned to a cluster (Leeds Contract)	87.47%	95.00%	
Proportion of in scope patients assigned to a cluster and reviewed within recommended timescales (Leeds Contract)	69.48%	75.00%	

Strategic Goal 2 - People experience safe care	May 2016/2017	Target	Trend
7 Day Follow Up (Monitor)	97.09%	95.00%	
Healthcare Associated Infections – C.difficile	0	0	
Healthcare Associated Infections – MRSA	0	0	
Percentage of people with a Crisis Assessment Summary and formulation plan in place within 24 hours (Leeds Contract)	100.00%	95.00%	
Improving the implementation of action goals following a serious untoward incident which relates to a suspected suicide (Contract)	100.00%	100.00%	
Never Events (National)	0	0	
Trigger to Board Events (Local)	0	0	
NHS Safety Thermometer Harm Free Care	98.62%	95.00%	
Appraisals (Local)	78.59%	90.00%	

Strategic Goal 3 - People have a positive experience of their care and support			
	May 2016/2017	Target	Trend
Data Completeness Indicator for Mental Health Outcomes for CPA Patients (Monitor)	67.82%	50.00%	
Access to Healthcare for People with a Learning Disability (Monitor)			
Out of Area placements (Leeds Contract)	7.00		
Out of Area placements by bed days (Leeds Contract)	91.00		
Timely access to MH assessment under S136 (Leeds Contract)	40.82%		
Timely access to a mental health assessment by the ALPs team in the LTHT Emergency Department (Leeds Contract)	81.28%	90.00%	
Better Access to Mental Health Services by 2020: Access to Early Intervention in Psychosis Services (Leeds Contract)	100.00%	50.00%	

Information Governance Incident Reports & Information Governance Incidents Requiring Investigation Q1

	2014/15	2015/16	Quarter 1 2016/17
Near Miss	75	77	21
Level 0	12	*	*
Level 1	8	27	4
Level 2 (SIRI)	1	9	3

The 3 x Level 2 (ICO / DoH reportable) incidents in Q1 2016-2017 are as follows:-

- Member of staff inappropriately accessing a service user record on LTHT systems. ICO considering criminal prosecution under DPA Section 55, pending the outcome of LYPFT disciplinary action.
- Letter sent to one service user contained highly sensitive information relating to another service user, picked up in error when assembling outgoing correspondence.
- Service user letter sent to wrong address – 66 instead of 56 – a repeat incident within this team / for this employee.

* Revisions to the HSCIC grading and reporting guidelines have resulted in incidents currently being rated as either Near Miss, Level 1 (non-SIRI, non-reportable) or Level 2 (SIRI, ICO / DoH Reportable) only. For comparison, incidents rated Level 0 in 2014-2015 would now be graded as Level 1.

Board of Directors Performance Report - Medical Revalidation

On 3 December 2012, Medical revalidation was formally launched by the General Medical Council (GMC). It is the process by which all doctors with a licence to practise in the UK will need to satisfy the GMC, at regular intervals that they are fit to practise and should retain their licence. The first cycle of revalidation will take until 2017 to complete.

Year zero	January 2013 to March 2013	1 recommendation made	Recommendation approved
Year one	April 2013 to March 2014	24 recommendations made	24 recommendations approved (22 for revalidation, 2 deferments)
Year two	April 2014 to March 2015	38 recommendations made	38 recommendations approved (37 for revalidation, 1 deferment)
Year three	April 2015 to March 2016	42 recommendations made	42 recommendations approved (39 for revalidation, 3 to defer)
Year four	April 2016 to March 2017	Q1 April to June	6 recommendations approved (5 for revalidation, 1 to defer)

In this quarter, the Trust's Responsible Officer has made six revalidation recommendations and all were approved. One of the recommendations was to defer because there was insufficient evidence for a recommendation to revalidate due the doctor being a new starter and no recent appraisal history.

The doctors that LYPFT has responsibility in terms of making recommendations about revalidation to the GMC is determined by National policy. These doctors must have a prescribed connection to the Trust. Each month, the Medical Directorate Manager updates GMC Connect (secure partner portal to maintain doctors' prescribed connections) regarding these doctors (including leavers and starters and changes from training contracts).

Due to doctors starting, leaving or changing their roles within the Trust the numbers scheduled for revalidation may alter from quarter to quarter. The information provided in this report was current as at 30.6.16.

Controlled Drugs – Quarter 1 April 1st to June 30th 2016

The key activities relating to the management of Controlled Drugs performed in Quarter 1 (April to June 2016) were:-

- Quarterly audit of Controlled Drugs held on wards and departments Trust-wide
- Prescription pads security information
- Errors, incidences or occurrences reported through the IR1 system
- Prescribed Controlled Drugs information (analysis of prescribing; quantities and trends)

The findings reported by exception are:-

The following discrepancies were noted at the Becklin Pharmacy:

- 100 cocodamol tablets and Diazepam 5mg 23 tablets unaccounted for , losses remain unresolved. Weekly checks carried out since detection, no further losses.
- 6 wards required to update their nurses/Dr signature lists
- 3 wards found where weekly CD checks not being carried out (or not documented)

Prescription pad security information

- 2 FP10 prescriptions missing from Dr Johnson's OP clinic unknown if mislaid or stolen

CD Incidents /Errors

- YCPM 2 incidents of CDs for destruction in the 'doop bin' but not made inaccessible
- YCPM Oramorphine administered but not signed for
- YCPM Oxycodone dose exceeded max in 24 hours
- ADHD, Methylphenidate tablets 18mg x 6, 27mg x14 and 36mg x8 found in office drawer, presumed returned from patient. Sent to pharmacy for destruction.

Elaine Weston, Chief Pharmacist 5.7.2016

2016/17 Quarter 1 Monitoring Return (April - June 2016)

CHANGES TO THE BOARD OF DIRECTORS

Executive Team

Whilst there have been no changes to the voting members on the Board of Directors during Quarter 1 of 2016/17, the interviews for the substantive appointment of Chief Executive took place and Dr Sara Munro was appointed. She will be starting with the Trust on the 5 September 2016.

Non-executive Team

A process of NED appointments commenced during the first quarter to fill two posts; Post 1 quality skills in the area of quality improvement with a clinical / medical background; and Post 2 skills and experience in devolved models of care and working across different health and social care sectors. There has been a good response to the advert with 21 applicants across the two posts. Members of the Council of Governors' Appointments and Remuneration Committee and the Chair of the Trust met to carry out the shortlisting on the 5 July. Three candidates were shortlisted for Post 1 and four candidates were shortlisted for Post 2. Interviews will take place on the 25 July 2016 and the outcome of the interviews will be reported in Quarter 2.

CHANGES TO THE COUNCIL OF GOVERNORS

Elections during Quarter 1 2016/17

On the 28 June 2016 an election process commenced for the following seats:

Name of the Constituency	Number of seats included in the election
Public: Leeds	6 seats
Public: Rest of England and Wales	1 seat
Carer: Leeds	2 seats
Service user: Leeds	3 seats
Service user: York and North Yorkshire	1 seat
Service user and carer: Rest of UK	1 seat
Staff: Clinical York and North Yorkshire	3 seats

A report on the outcome of this process will be provided in the Quarter 2 report.

Elected Governors

During Quarter 1 of 2016/17 one elected governors stepped down:

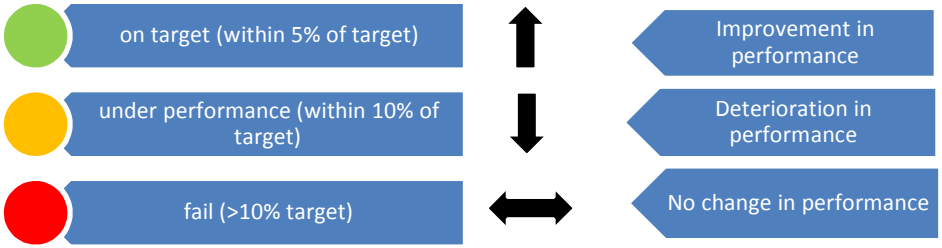
- Libby Rowland (Service user: Leeds) – stepped down on 15 June 2016

Appointed Governors

During Quarter 1 there was one change to the appointed governors:

- Ant Hanlon (Appointed Governor for Volition) – stepped down on 18 May 2016.

Cath Hill
Head of Corporate Governance



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 Financial Sustainability Risk Rating (FSRR) is 3. Variances from plan at month 3 relate to the revised plan. NHS Improvement requested that the annual plan be resubmitted on 30 June 2016 to reflect the revised control total.	**1**
Statement of Comprehensive Income (I&E)			The overall position at month 3 is a £0.16m surplus predominantly resulting from a number of non recurrent factors offset by out of area cost pressures. Overall this is a £0.02m favourable variance compared to the revised plan position. The key variances against plan are summarised below.	**2**
Income			Total Operating income is £0.27m above plan at month 3. The main variances comprise:- **Clinical Income:** Clinical Income is consistent with the revised plan. **Non-Clinical income:** Non-Clinical income is £0.27m above plan due to invoicing Leeds CCGs for additional out of area costs. **Non-Operating Income** Non-operating income is consistent with plan.	**2**
Pay			Pay expenditure is showing an adverse variance of £0.19m, comprising a £0.116m over-spend on planned permanent employee pay and a £0.07m over-spend on locum and agency staff expense. This variance is linked to unidentified cost improvement plans and agency cost pressures. At the end of June 2016, the number of permanent vacancies is in excess of 200 whole time equivalents (excluding development slippage).	**2**
Non Pay			Non pay spend is £0.07m over spent at month 3, comprising higher than planned spending on out of area placements.	**2**

Efficiency: Cost Improvement			The Cost Improvement Plan (CIP) for month 3 is 17% below plan with £0.4m achieved compared to a £0.48m plan. The main under achievement against the plan relates to unidentified CIPs.	**3**
Statement of Financial Position (Balance Sheet)			The main statement of financial position variances (excluding cash and capital) are: **Non NHS Trade Receivables –** £0.51m variance. This is mainly due to Commercial Procurement Collaborative (CPC) membership fees being received earlier than planned (£0.48m) and £0.57m of over 90 days debt with the National Probation Service cleared in June 2016. **Prepayments -** £0.20m variance. This relates to prepayments for the Care Quality Commission (CQC) annual registration fee (£0.10m) and in relation to IT contracts (£0.06m). **Deferred Income** - £0.26m variance. This is mainly due to the phasing of mHabitat income (£0.08m) and a reduction in deferred income from the Department of Health (£0.09m). **Trade Payables -** £0.39m variance**.** This is due to a £0.43m reduction in approved invoices, which is reflected in an increase in accruals below. **Capital Payables -** £0.25m variance**.** This is due to an increase in PFI accruals for anti-ligature work and dementia care. **Accruals** - £0.27m variance. This is mainly due to the reduction in approved invoices (as above).	**4**
Cash			The cash position of £48.4m is £0.45m above revised plan at the end of month 3. Liquidity decreased to 88 days operating expenses at the end of June 2016 (89 days at 31 May 2016).	**5**
Capital			Capital expenditure was £0.6m, which is £0.01m (2%) above plan at the end of month 3. The variance against plan is due to overspending against Estates strategic (£0.06m) and operational (£0.03m) offset by underspending on IT strategic (£0.05m) and operational schemes (£0.03m).	**6**

Financial Sustainability Risk Rating
June 2016 YTD

Capital Service Cover

Revenue available for Debt Service			
Surplus		161	
Impairments		0	
Restructuring Costs		0	
PDC Dividend		83	
Depreciation		988	
Interest expense		994	
Other Finance Costs		23	
Gain/(Loss) on disposal		0	
Capital grants/donations		0	
	A		2,247
Capital Servicing Costs			
PDC Dividend		83	
Bank interest		0	
Loan interest		0	
PFI/Finance Lease interest		525	
Contingent Rent		469	
Other Finance Costs		23	
PDC repayment		0	
Loan repayment		0	
PFI/Fin lease capital		359	
	B		1,458
Capital Service Cover	**A/B**		1.54
Category			2

Liquidity

Cash for Liquidity Purposes			
Working capital facility		0	
Total current assets		54,938	
Total current liabilities		-20,711	
Inventories		-36	
Derivatives		0	
Financial AHfS		0	
PFI prepayments		0	
Non-current AHfS		0	
Current AHfS by charity		0	
Current LHfS by charity		0	
	A		34,191
Operating Expenses			
within EBITDA		34,955	
	B		34,955
Liquidity	**A*90/B**		88
Category			4

I&E Margin

I&E Surplus	**A**	161
Total Operating Income	**B**	37,203
I&E Margin	**A/B**	0.4%
Category		3

Variance in I&E Margin

Actual I&E Margin	**A**	0.4%
Plan I&E Surplus	**B**	137
Plan Operating Income	**C**	36,928
Plan I&E Margin	**B/C**	0.4%
Variance in I&E Margin	**A - B/C**	0.1%
Category		4

Financial Sustainability Risk Rating

	Weighting	Score	Weighted Score
Capital Service Cover	25	2	0.50
Liquidity	25	4	1.00
I&E Margin	25	3	0.75
Variance in I&E Margin	25	4	1.00
Calculated Rating		**3**	**3.25**
Any metric 1		N	
FSRR		**3**	

Statement of Comprehensive Income at June 2016

	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	975	1,048	73
Block Contract Total	28,642	28,659	18
Clinical Partnerships providing mandatory services (including S31 agreements)	1,939	1,937	-2
Other clinical income from mandatory services	181	99	-81
NHS Mental Health activity Income, Total	**31,737**	**31,744**	**7**
Other Operating income			
Research and Development income	196	196	0
Education and Training income	997	1,001	4
Grants received in cash & to fund Operating Expenses	1	0	-1
Parking revenue	0	0	0
Catering revenue	11	9	-2
Revenue from non-patient services to other bodies	324	324	0
Misc. Other Operating Income	3,612	3,879	267
Other Operating income, Total	**5,141**	**5,409**	**268**
Operating Income, Total	**36,877**	**37,152**	**275**
Operating Expenses			
Raw Materials and Consumables Used			
Drugs	-476	-418	58
Clinical supplies	-275	-264	11
Non-clinical supplies	-331	-338	-7
Raw Materials and Consumables Used, Total	**-1,082**	**-1,020**	**62**
Purchase of healthcare services from other NHS bodies	-6	27	33
Purchase of healthcare services from non-NHS bodies	-1,346	-1,475	-129
Purchase of healthcare services / secondary commissioning, total	**-1,352**	**-1,448**	**-96**
Employee expenses, Substantive, bank and overtime staff	-25,586	-25,702	-116
Employee expenses, Locum and agency staff	-1,117	-1,189	-71
Employee Benefits Expenses, Total	**-26,703**	**-26,891**	**-187**
Research and Development expense	-255	-241	14
Education and training expense	-213	-244	-31
Consultancy Expense	-23	-6	17
Premises	-1,465	-1,541	-75
Clinical Negligence	-54	-54	0
Misc. Other Operating expense	-1,867	-1,863	3
PFI operating expenses	-1,648	-1,648	0
Depreciation and Amortisation			
Depreciation and Amortisation - owned assets	-615	-583	33
Depreciation and Amortisation - PFI assets	-408	-405	3
Depreciation and Amortisation, Total	**-1,023**	**-988**	**36**
Impairment (Losses) / Reversals net	0	0	0
Operating Expenses, Total	**-35,686**	**-35,943**	**-258**
Profit (Loss) from Operations	**1,192**	**1,209**	**17**
Non Operating			
Non-Operating income			
Interest Income	50	50	0
Profit/Loss on Asset Disposal	0	0	0
Non-Operating income, Total	**50**	**50**	**0**
Non-Operating expenses			
Finance Costs [for non-financial activities]			
Interest Expense			
Interest Expense on PFI leases & liabilities	-521	-525	-4
Interest Expense, Total	**-521**	**-525**	**-4**
PDC dividend expense	-83	-83	0
Other Finance Expenses	-23	-23	0
Finance Costs [for non-financial activities], Total	**-627**	**-630**	**-4**
Non-Operating PFI Costs (e.g. Contingent Rent)	-478	-469	10
Non-Operating expenses, Total	**-1,105**	**-1,099**	**6**
Surplus (Deficit) before Tax	**137**	**161**	**23**
Income Tax (expense)/ income	0	0	0
Surplus (Deficit) After Tax	**137**	**161**	**23**

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

Month 3

CIP SUMMARY	2016-17 Plan £'000	Plan 2016/17 year to date			
		Plan £'000	Actual £'000	Variance £'000	Variance %
Leeds Mental Health Care Group	681	167	155	(13)	-8%
Specialist & Learning Disability Care Group	653	134	113	(21)	-16%
Workforce and Development	62	14	13	(1)	-7%
Fit-for-purpose, cost effective buildings	311	63	62	(1)	-1%
Delivering cost effective corporate services	386	59	56	(3)	-6%
Unidentified CIPs	411	41	0	(41)	-100%
TOTAL	**2,505**	**478**	**398**	**(80)**	**-17%**

Pay	1,563	266	193	(73)	-28%
Non Pay	942	212	205	(7)	-3%
Total CIP	**2,505**	**478**	**398**	**(80)**	**-17%**

Statement of Financial Position at June 2016

	Revised Plan June £'000	2016/17 Actual June £'000	Variance June £'000
Assets			
Assets, Non-Current			
Intangible Assets, Net	425	475	50
Property, Plant and Equipment, Net	30,124	30,121	-4
PFI: Property, Plant and Equipment, Net	18,576	18,579	3
Prepayments, Non-Current	3,732	3,733	1
Assets, Non-Current, Total	**52,857**	**52,907**	**50**
Assets, Current			
Inventories	36	36	0
Trade and Other Receivables, Net, Current			
NHS Trade Receivables, Current, Gross	1,000	802	-198
NHS Capital Receivables, Current, Gross	0	0	0
Non NHS Trade Receivables, Current, Gross	3,000	2,488	-512
Other Receivables, Current, Gross	650	595	-55
Impairment of Receivables, Current (for bad & doubtful debts)	-402	-402	0
Trade and Other Receivables, Net, Current, Total	**4,248**	**3,482**	**-766**
Accrued Income	1,500	1,593	93
Prepayments, Current	1,200	1,403	203
Cash	47,971	48,423	452
Non-Current Assets held for sale	0	0	0
Assets, Current, Total	**54,955**	**54,938**	**-18**
Total Assets	**107,812**	**107,844**	**32**
Liabilities			
Liabilities, Current			
Deferred Income, Current	-4,173	-3,914	259
Provisions, Current	-962	-911	51
Trade and Other Payables, Current			
Trade Payables, Current	-4,766	-4,375	390
Other Payables, Current	-3,600	-3,744	-144
Capital Payables, Current	-450	-695	-245
Trade and Other Payables, Current, Total	**-8,816**	**-8,814**	**1**
Other Financial Liabilities, Current			
Accruals, Current	-5,200	-5,469	-269
PFI leases, Current	-1,479	-1,479	0
PDC dividend payable, Current	-123	-123	0
Other Financial Liabilities, Current, Total	**-6,801**	**-7,071**	**-269**
Liabilities, Current, Total	**-20,752**	**-20,711**	**42**
NET CURRENT ASSETS (LIABILITIES)	**34,203**	**34,227**	**24**
Liabilities, Non-Current			
Provisions, Non-Current	-1,821	-1,871	-50
Other Financial Liabilities, Non-Current			
PFI leases, Non-Current	-24,395	-24,395	-1
Other Financial Liabilities, Non-Current, Total	**-24,395**	**-24,395**	**-1**
Liabilities, Non-Current, Total	**-26,216**	**-26,266**	**-51**
TOTAL ASSETS EMPLOYED	**60,844**	**60,867**	**23**
Taxpayers' and Others' Equity			
Public dividend capital	19,569	19,569	0
Retained Earnings (Accumulated Losses)	32,684	32,707	23
Revaluation Reserve	9,242	9,242	0
Miscellaneous Other Reserves	-651	-651	0
TAXPAYERS EQUITY, TOTAL	**60,844**	**60,867**	**23**
TOTAL ASSETS EMPLOYED	**60,844**	**60,867**	**23**

Leeds and York Partnership NHS Foundation Trust

Cashflow Analysis as at June 2016

	Revised Plan YTD £'000	Actual YTD £'000	Variance YTD £'000
Surplus/(deficit) after tax	**137**	**161**	**23**
non-cash flows in operating surplus/(deficit)			
Finance income/charges	949	943	-6
Other operating non-cash movements	26	26	0
Depreciation and amortisation, total	1,023	988	-36
Impairment losses/(reversals)	0	0	0
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	83	83	0
Other increases/(decreases) to reconcile to profit/(loss) from operations	0	0	0
Non-cash flows in operating surplus/(deficit), Total	**2,081**	**2,039**	**-41**
Operating Cash flows before movements in working capital	**2,218**	**2,200**	**-18**
Increase/(Decrease) in working capital			
(Increase)/decrease in inventories	0	0	0
(Increase)/decrease in NHS Trade Receivables	533	731	198
(Increase)/decrease in Non NHS Trade Receivables	-41	471	512
(Increase)/decrease in other receivables	831	887	55
(Increase)/decrease in accrued income	-991	-1,084	-93
(Increase)/decrease in prepayments	-181	-384	-203
(Increase)/decrease in other assets	0	0	0
Increase/(decrease) in Deferred Income	2,913	2,654	-259
Increase/(decrease) in provisions	-74	-75	-1
Increase/(decrease) in post-employment benefit obligations	0	0	0
Increase/(decrease) in Trade Payables	-894	-1,285	-390
Increase/(decrease) in Other Payables	246	390	144
Increase/(decrease) in accruals	-1,033	-763	269
Increase/(Decrease) in workling capital, Total	**1,308**	**1,542**	**234**
Net cash inflow/(outflow) from operating activities	**3,526**	**3,742**	**215**
Net cash inflow/(outflow) from investing activities			
Property, plant and equipment expenditure	-474	-243	231
Proceeds on disposal of property, plant and equipment	376	376	0
Net cash inflow/(outflow) from investing activities, Total	**-98**	**133**	**231**
Net cash inflow/(outflow) before financing	**3,428**	**3,875**	**447**
Net cash inflow/(outflow) from financing activities			
Public Dividend Capital received	0	0	0
Public Dividend Capital repaid	0	0	0
PDC Dividends paid	0	0	0
Interest element of finance lease rental payments -*On-balance sheet PFI*	-999	-994	6
Capital element of finance lease rental payments -*On-balance sheet PFI*	-359	-359	1
Interest received on cash and cash equivalents	50	50	0
Movement in Other grants/Capital received	0	0	0
(Increase)/decrease in non-current receivables	-116	-117	-1
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	**-1,425**	**-1,419**	**6**
Net increase/(decrease) in cash and cash equivalents	**2,004**	**2,456**	**452**
Opening cash and cash equivalents	45,968	45,968	0
Effect of exchange rates	0	0	0
Closing cash and cash equivalents	**47,971**	**48,423**	**452**

CAPITAL PROGRAMME - at 30 JUNE 2016	Revised Plan £'000	Actual Spend £'000	YTD Variance £'000
Estates Operational			
Health & Safety /Fire	42		-42
Planned Annual Commitments	10		-10
Estate refurbishment	200	316	116
Sub-Total	**252**	**316**	**64**
IT/Telecomms Operational			
PC Replacement Programme	85	91	6
IT Network Infrastructure	32	4	-29
VOIP Roll Out	10	10	0
Additional Server/Storage	11	1	-10
Sub-Total	**139**	**105**	**-33**
Estates Strategic Developments			
Dementia Care At The Mount	55	84	29
Sub-Total	**55**	**84**	**29**
IT Strategic Developments			
E-Pharmacy	50	56	6
Integration System	20		-20
Public WiFi Deployment	8		-8
Standard Smartphones for all staff - phase 1	20		-20
Cisco Unified Comms/Presence	9		-9
Tablets Wards - Leeds	2	2	0
EPR System Developments	50	50	0
Sub-Total	**159**	**108**	**-51**
Contingency Schemes			
2015/16 Completed Schemes	0	4	4
Sub-Total	**0**	**4**	**4**
TOTAL CAPITAL PROGRAMME	**605**	**618**	**13**

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:	Serious untoward incidents update and lessons learnt following the Trust Incident Review Group (TIRG) meetings held on the 08 June 2016
DATE OF MEETING:	28 July 2016
LEAD DIRECTOR: (name and title)	Dr Jim Isherwood - Medical Director
PAPER AUTHOR: (name and title)	Samantha Marshall - Serious Incident Administrator/Legal Support 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	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	The attached paper is a briefing for the Board of Directors following the Trust Incident Review Group meetings held 08/06/2016.
What are the key points and key issues the Board needs to focus on	The purpose of this paper is to provide the Board of Directors with information relating to new incidents that are subsequently categorised as Serious Untoward Incidents (SUI) and highlight any learning from the monthly Trust Incident Review Group meetings.

What is the Board being asked to consider	The attention of the Board of Directors is drawn to the following highlights within the report:
	• Progress with reporting and investigating serious incidents
	• From 4 reports reviewed, 3 root causes and 7 contributory factors were determined.
	• Learning from investigations:
	  ○ Staff Skills.
	  ○ Demands on staff time in relation to training.
	  ○ Communication with other parties.
	• Goddard Inquiry – action for the Trust.
	• Positive experience as external reviewer for LTHT incident.

What is the impact on the quality of care	Serious incidents are a key source of learning within the Trust to ensure we improve the quality of care provided to our service users.
What are the benefits and risks for the Trust	Promotes the Trust's duty of candour and commitment to learning from experience.
What are the resource implications	None.
Next steps following this paper being presented to the Board	None.
What are the reputational implications and how will these be addressed	Promotes the Trust's duty of candour and commitment to learning from experience.

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	TIRG is attended by a representative from staff side and the Chair of the Trust
Previous meetings where this report has been considered (including date)	This paper will also be submitted to the public Council of Governors' 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 content of the report.
- Be assured that the actions in respect of the lessons learnt are being progressed appropriately through the committee (or organisation).

*** 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
Following the Trust Incident Review Group Meeting Held: 08/06/2016

Part A: Serious Untoward Incidents Update

1 Purpose

The purpose of this paper is to provide the Board with information relating to new incidents that are subsequently categorised as Serious Untoward Incidents (SUI).

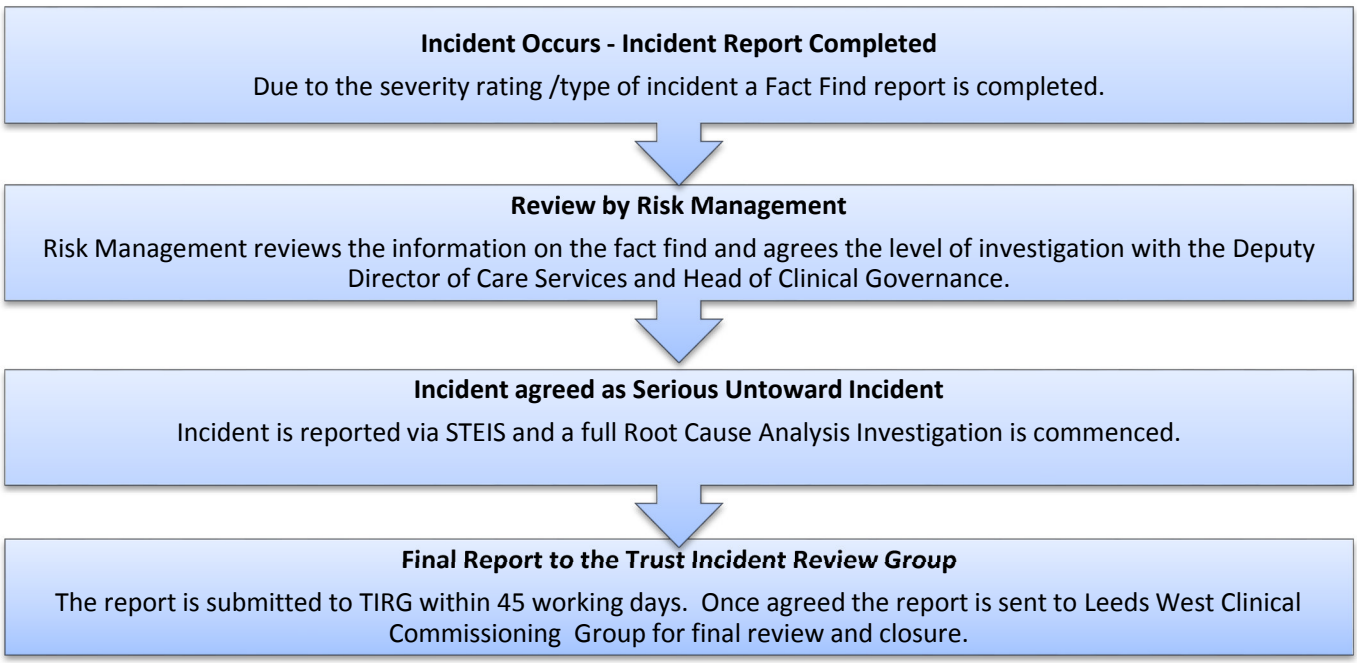
2 Executive Summary

The paper details the following information:

- TABLE 1 – Breakdown of Serious Untoward Incidents – May 16
- TABLE 2 – Overview of Serious Untoward Incidents by Directorate May 16
- TABLE 3 – Number of Final reports of STEIS (Strategic Executive Information System) incidents submitted to TIRG within 12 week
- TABLE 4 – Schedule of cases to be presented to Trust Incident Review Group

3 Background

The following table shows a brief flow of action: from incident occurring to presentation at the Trust Incident Review Group (TIRG).



All incidents that are agreed as Serious Untoward Incidents and STEIS reported are presented at TIRG.

Following review of the fact find information, a Root Cause Analysis Investigation can be required even though the incident is not STEIS reported. In these cases the report is presented to TIRG at the discretion of the Care Group and TIRG Chair.

TABLE 1 – Breakdown of Serious Untoward Incidents (SUI)

	Leeds Care Group	Specialist and LD Care Group	TOTAL
NUMBER OF INCIDENTS REPORTED VIA STEIS MAY 2016	6	1	7*

* Of the 7 incidents reported – 3 incidents within the Leeds Care Group and 1 incident within the Specialist and LD Care Group required concise investigation.

TABLE 2 – Overview of SUI's by Care Group

Care Group	Incident Date	Incident Type	Incident Number	Severity Rating	Service
Specialist	18/05/16	IG Breach*	WEBINC15054	3	Psycho Sexual Clinic
Leeds	09/05/16	**Death - Overdose**	WEBINC-15224	5	South CMHT
Leeds	10/05/16	Fall - Fracture NoF*	WEBINC-15060	3	W5 Becklin
Leeds	10/05/16	**Self-Harm**	WEBINC-15000	3	ENE CMHT/ Community Links
Leeds	13/05/16	**Death**	WEBINC-15102	5	Crisis Assessment Service
Leeds	16/05/16	IG Breach*	WEBINC-15161	3	ENE CMHT
Leeds	28/05/16	Fall - Fracture NoF*	WEBINC-15495	3	W2 The Mount

Please Note:

- Serious Incidents requiring comprehensive RCA investigation and presentation to TIRG – 3 incidents (as bold text).
- Serious Incident requiring a concise RCA investigation – 4 incidents as marked with *

TABLE 3 – Number of Final reports of STEIS incidents submitted to TIRG within 12 week

Period: May 15 – May 16	Leeds Care Group	Specialist and LD Care Group	York North Yorkshire Care Group	TOTAL
NUMBER OF REPORTS DUE FOR THIS PERIOD May 15 – May 16	27	1	10	38
NUMBER OF REPORTS SUBMITTED ON DUE DATE (Aim 100%)	3 (11%)	0 (0%)	0 (0 %)	3 (8 %)
OVERDUE 1 MONTH	2	0	0	2
OVERDUE 2 MONTH	6	0	1	7
OVERDUE 3 MONTH	3	0	4	7
OVERDUE 4 MONTH	3	0	1	4
OVERDUE 5 MONTHS +	3	0	4	7
NUMBER OF REPORTS STILL OUTSTANDING FOR THIS PERIOD May 15 – May 16	7	1	0	8
TOTAL NUMBER OF REPORTS FOR THE CARE GROUP IN PROGRESS INCLUDING THOSE OUTSTANDING	23	1	1	25

TABLE 4 – Schedule of cases to be presented to Trust Incident Review Group

Incident Date	Care Group	Incident	STEIS	Ref	Investigator	*60 Working Days	TIRG
23/10/2014	Leeds	Assault SU to SU	36402	17-14.15	Robert Mann – reallocated Claire Paul 07/01/16	**14/01/2015**	Police investigation has now concluded. Internal investigation has commenced
02/10/2015	Leeds	Unexpected Death	31823	23-15.16	Maureen Cushley	**30/12/2015**	Presented 09/03/16 – representation required TIRG 08/06/16
09/11/2015	Leeds	Suspected Suicide	LTHT	N/A	Linda Rose	**N/A**	TIRG 08/06/16
16/01/2016	Leeds	Death - Hanging	1456	35-15.16	Anthony Atkins	**13/04/2016**	
16/01/2016	Leeds	Homicide	1947	36-15.16	External – TBC	**18/04/2016**	
17/01/2016	Specialist	Death – Self Harm	LCH	N/A	Jan McAdam LYPFT Lead	**13/04/2016**	Presented 09/03/16 – representation required. Reviewer needs to interview member of staff who is on sick leave in order to fulfil requirements of TIRG
28/01/2016	Specialist	Death - Overdose	5794	44-15.16	Marie-Claire Trevett	**27/05/2016**	
02/02/2016	Leeds	Unexpected Death - Overdose	3384	37-15.16	Janet Johnson	**03/05/2016**	TIRG 08/06/16
22/02/2016	Leeds	Death - Fire setting	5771	43-15.16	Peter Johnstone	**27/05/2016**	
23/01/2016	Leeds	Injury to self and others	2743	38-15.16	John Needham	**26/04/2016**	TIRG 08/06/16
06/01/2016	Leeds	Death - Hanging	6002	46-15.16	Tim Richardson	**31/05/2016**	
09/03/2016	Leeds	Death - Hanging	6782	47-15.16	Pam Mareya	**08/06/2016**	
09/03/2016	Leeds	Death - Ligature	6769	48-15.16	Sharon Prince/Tom Mullen	**08/06/2016**	
13/03/2016	Leeds	Death - Hanging	7982	49-15.16	Simon Chambers	20/06/2016	
22/03/2016	Leeds	Death - Jump from height	8105	50-15.16	Beverley Hunter	21/06/2016	
18/03/2016	Leeds	Ligature/Attempted Hanging	9211	01-16.17	Alison Gordon/Christine Woodward	30/06/2016	

09/04/2016	Leeds	Death - Carbon Monoxide	9752	02-16.17	Gail Longley	06/07/2016	
08/04/2016	Leeds	Jump/Fall from 30ft Balcony	9920	03-16.17	Requested to delog as an SI	07/07/2016	
18/04/2016	Leeds	Death - Hanging	10651	04-16.17	TBC	15/07/2016	
10/05/2016	Leeds	Self-Harm	13008	08-16.17	Community Links	08/08/2016	
13/05/2016	Leeds	Death	13825	09-16.17	Eve Townsley	15/08/2016	
09/05/2016	Leeds	Death - Overdose	13888	11-16.17	Nicky Needham	15/08/2016	

Following the Trust Incident Review Group Meeting Held: 08/06/16

Part B:
Serious Untoward Incidents Lessons Learnt

1 Purpose

- Summary of lessons learnt from Serious Untoward Incidents.
- Sharing of good practice highlighted from reports.
- Conclusions of any thematic reviews undertaken.
- Results of any trend analyses.
- Summary of major actions that have been implemented.

2 Executive Summary

Learning from experience is critical to the delivery of safe and effective services in the NHS. To avoid repeating mistakes organisations need to recognise and learn from them, to ensure that the lessons are communicated and shared and that plans for improving safety are formulated and acted upon. The findings and learning from any adverse event within the Trust may have relevance and valuable learning for the local team and also other teams and services. This paper outlines the identified lessons learnt following the Trust Incident Review Group meeting 08/06/16.

3 Background

The purpose of the Trust Incident Review Group is to review the investigation reports to ensure that all serious untoward incidents have been investigated thoroughly, to agree recommendations and action plans that are relevant and achievable, to oversee the implementation of those action plans and to identify trends and patterns of untoward incidents that may require further investigation.

This activity supports LYPFT to be an organisation with a memory, to assist learning from incidents and to continue the drive towards safer therapeutic care for all service users.

Findings from the meetings held: 08/06/2016

4 Serious Incident Review reports were reviewed by the group with the following findings agreed:

Root Causes	3
Contributory Factors	7
Incidental Findings	0
Family Questions	0

4 Outline of Lessons Learnt from Serious Untoward Incidents

Staff Skills

It was identified from a review that the care coordinator did not have the skills or experience to take on such a complex case.

It was agreed that the Community Services Manager will look at reviewing the skills and experience of all care coordinators to ensure they have the necessary requirements to carry out their role effectively.

The Community Services Manager will also develop an assessment approach to recruitment and look at a bespoke set of competencies against which to recruit. The Medical Director also agreed to speak to the HR Director about this matter.

Demands on staff time in relation to training

TIRG agreed that there are competing demands on staff's time when deciding what training is important, with the compulsory training taking precedence over training that could be more beneficial to the delivery of services.

The Medical Director noted that he would raise the matter of the balance of compulsory training in relation to other training at the Quality Committee and also at the Board of Directors.

Referrals to the Crisis Assessment Service (CAS)

A review highlighted that there was no system within the CAS for ensuring that referrals are picked up and dealt with appropriately.
The referral made to CAS had not been picked up for nearly 48 hours and the group sought to understand why this was. The group discussed the impact the vacancies in the team had on this; with the reviewer advising the group that the team has a long-term issue of vacancies which are addressed through arrangements such as overtime. It also noted that there had not been a process in place to flag up referrals. The group noted that the process for referrals had been reviewed and changed following this incident.

Communication with other parties

A review noted there had been a lack of clear instruction to the team caring for a service user LTHT of what was meant in regard to the level of observation that was required and recommended.

The review recommended the following action in relation to this issue:
The senior management team for liaison psychiatry need to develop a common language to describe observations which is then communicated to other parties.

Goddard Inquiry

The Head of Safeguarding updated TIRG in relation to the Goddard Inquiry, advising that the only action for the Trust is not to destroy any records. The group suggested that there should be communication of this through a lessons learnt briefing so all staff are clear.

5 Areas of Good Practice

External Investigator - LTHT

The investigator found good examples of caring and compassionate clinical staff who behaved in a cooperative, open and honest manner during the investigation.

As an external investigator to LTHT, the reviewer also commented that it was helpful to be supported by the LTHT Head of Nursing - Acute Medicine and the LTHT Serious Incident Investigations & Learning Manager.

Recommendations

The Board is requested to:

- Note the content of the report
- Be assured that the actions taken in respect of the lessons learnt are being progressed appropriately through the organisation.

GLOSSARY OF DEFINITIONS

The following definitions are of relevance to this document:

Definition	Meaning
Case Conference	Meeting to discuss complex cases that are very serious or have a multi-agency aspect and that may include criminal offences and possible organisational failures.
CAS	Crisis Assessment Service
CPA	Care Pathway Approach
CPN	Community Psychiatric Nurse
CCG	Clinical Commissioning Group (replaced PCT's)
DHR	Domestic Homicide Review
Duty of Candour	As a direct response to the Francis Inquiry report, a statutory duty to be open, transparent and candid has been introduced for health and care providers. This is called the Duty of Candour and is set out in CQC's Regulation 20.
Goddard Inquiry	Independent Inquiry into Child Sexual Abuse which will investigate whether public bodies and other non-state institutions have taken seriously their duty of care to protect children from sexual abuse in England and Wales
ICS	Intensive Community Services
Incident	For the purpose of the Trust's incident reporting system, an incident is defined as: - *'Any event, untoward or unusual, which is a deviation from the normal pattern of activity or therapeutic well-being or smooth running of the workplace (e.g. ward/ department, client's home, etc.), which involves service users and/or staff and/or visitors, and which may adversely affect their health and/or safety and/or welfare and/or confidentiality then or later'.*
LYPFT	Leeds and York Partnerships Foundation Trust
MDT	Multi-Disciplinary Team - A group composed of members with varied but complimentary experience, qualifications, and skills that contribute to the achievement of the specific objectives.
NCISH	The National Confidential Inquiry into Suicide and Homicide by people with mental illness
OBSERVATION	Observation and engagement is a key clinical activity requiring a commitment from all health care staff, through a shared approach, involving assessment, care planning, risk management, clinical review and evaluation. Types of observations: General, Intermittent, Within Eyesight and Within Arm's
PARIS	Electronic patient information record system.
RCA	Root Cause Analysis.
Risk	A risk is characterised by both the likelihood/probability of harm or

	information security breach actually occurring (e.g. low, medium or high) and the impact/severity of the harm (e.g. slight injury, major injury, death). The level of risk to health increases with the impact/severity of the hazard and the duration and frequency of exposure to the hazard.
SAMP	Safety Assessment and Management Plan
SAR	Safeguarding Adults Return
SCR	Serious Case Review
Section 17 Leave	Section 17 of the Mental Health Act 1983 makes provision for patients who are liable to be detained under various other sections of the Act to be granted leave of absence. Section 17 applies to patients who are detained under ss.2, 3, 37, or 47 of the Act.
Serious Untoward Incident (SUI)	A serious untoward incident is defined as *'any accident or incident where a service user, member of staff (including those in the community), or member of the public suffers serious injury, major permanent harm or unexpected death, (or the risk of death or injury), on hospital, other health service premises or other premises where health care is provided, or where actions of health services staff are likely to cause significant concern'.*
STEIS	Strategic Executive Information System This is the Trust's mechanism for reporting serious untoward incidents to the Clinical Commissioning Group.
TIRG	Trust Incident Review Group
MEWS	Modified Early Warning System
CAMHS	Child and Adolescent Mental Health Services
CQUINN	Commissioning for Quality and Innovation

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:	Safer staffing
DATE OF MEETING:	28 July 2016
LEAD DIRECTOR: (name and title)	Anthony Deery, Director of Professions, Nursing and Quality.
PAPER AUTHOR: (name and title)	Linda Rose, Assistant Director of Nursing.

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	There is a national requirement for all NHS Trusts to publish information about the number of Registered nurses (RN) and Health support workers (HSW) on duty per shift. The data included is for the 1st May 2016 to the 31st May 2016.
What are the key points and key issues the Board needs to focus on	Those wards where actual staffing numbers do not meet planned levels and the actions being taken to mitigate this.
What is the Board being asked to consider	The content of the exception reports for each individual area.
What is the impact on the quality of care	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	Safer staffing task and finish group continuing to progress effective use of data and testing workforce tool. Share this report with care group risk forums to ensure local understanding, ownership of staffing issues and any follow up required.
What are the reputational implications and how will these be addressed	Risk of sub-standard care delivery due to poor staffing levels addressed by monitoring provision monthly.
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 20th July 2016.

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**	

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
23rd June 2016
Safer Staffing
May 2016

1. Background

All hospitals are required to publish information about the number of Registered Nurses (RN) and Health Support Workers (HSW) on duty per shift on their inpatient wards.

This initiative is part of the NHS response to the Francis Report which called for greater openness and transparency in the health service.

Full details of staffing levels are reported to public meetings of our Board of Directors and made accessible to the public (via the Unify Report) at NHS Choices website. Safer staffing information is also accessible to the public via the Trust's own website.

In addition to this the Trust is required openly display information for patients and visitors in all of our wards that shows the planned and actual staffing available at the start of every shift.

2. Purpose of this report

LYPFT reports on 27 inpatient areas and this paper helps to provide public and organisational oversight of any signs that there might be a problem with staffing levels using an exception reporting system.

Six inpatient wards are participating LYPFT's safer staffing task and finish group who testing a dashboard system and metrics as part of the work to help develop a workforce staffing tool. (**See appendices A (Key to metrics and dashboard) and B (Unify report)**.

This report is retrospective and covers the period of the 1st May 2016 to the 31st May 2016.

3. Updates

3.1 The six-monthly safer staffing review by the Director of nursing is due to be submitted at the end of July 2016. This report and patient safety and experience data will be triangulated to inform the review.

3.2 Ward and Community managers were presented with a guided tour of the weekly dashboard developed to triangulate patient safety data at the most recent forum in June.

3.3 In response to a huge demand for older people's beds, LYPFT have taken the action of converting the triage area on Ward 3 (male ward) at the Mount into a female area. This action was required to prevent any older people being transferred out of area. The situation is being reviewed on a regular basis and we are assured that there are no issues relating to mixed sex environment requirements.

3.4 The Safe Staffing Task and Finish Group discussed the inclusion of the Incident data as an additional reporting level at a recent meeting. It was felt that the number of incidents and the type of incident may provide further insight/assurance around the correlation between staffing levels and incidents on inpatient units. This information has been added to the report for the benefit of the pilot managers but the Board members may wish to use their discretion as to whether it should be included at Board level.

4. Exception reports against Planned and Actual staffing

Any incidence of planned staffing levels reported at less than 80% or exceeding a 120% fill rate is considered an 'exception'. Where this is the case an explanatory note is provided.

4.1 Leeds Mental Health Care Group

4.1.1 Ward 1 Becklin Centre (Adult acute mental health female service)

There was an underfill of Registered nurses (RN) during the day and an overfill of Health support workers (HSW) during the day and night.

Contributory factors and mitigation

As in the previous report, this ward continues to have 4 band 5 vacancies outstanding as they are awaiting start dates of newly registered staff in September/October. Skill mix has been adjusted to compensate the vacant RN hours. Acuity in terms of observation and engagement levels was a key feature for this ward during May and included the use of within eyesight observations to cover the care and treatment of a CAMHS service user; 2:1 observation on a service user awaiting a transfer to PICU and a service user requiring escort for treatment at LTHT over a period of x4 days.

Q - Was the ward safely staffed throughout this period?
A – Yes with the exception described below.

The 2nd registered nurse on night duties has been filled with bank or agency. On one occasion during the month of May there was one duty where they were unable to fill with 2nd RN and an additional HSW was used to backfill instead.

4.1.2 Ward 3 Becklin Centre (Adult acute mental health male)

There was an overfill of HSW hours during the day.

Contributory factors and mitigation
The overfill of HSW hours is in response to managing acuity and replacing vacant RN hours. All shifts were covered with x2 RN's on duty.

Q - Was the ward safely staffed throughout this period?
A – Yes

4.1.3 Ward 4 Becklin Centre (Adult acute mental health male)

There was an underfill of RN hours during the day and an overfill of HSW hours during the day.

Contributory factors and mitigation

There are x2 band 5 posts which have been recruited to but have start dates in September in addition to a band 6 vacancy. A Band 5 RN is on a secondment to the women's service and sickness absence is a contributory factor to staffing numbers.

Q - Was the ward safely staffed throughout this period?
A – Yes

4.1.4 Ward 5 Becklin Centre (Adult acute mental health female service)

(This ward is a member of the safer staffing task and finish group, for which dashboard data is available at Appendix A).

There was an overfill of HSW hours during the day and night.

Contributory factors and mitigation

As reported last month, this ward has 4 band 5 vacant posts that have been recruited to but are awaiting September / October start dates. As a result of the RN vacancies skill mix has been adjusted to compensate and to support acuity in terms of observations. Further impact of awaiting recruitment is that nearly a third of duties are being filled by bank and agency staff and nearly a quarter of RN's in post are Preceptees. However, our data tells us that only a small percentage of bank and agency are not regular workers and the ward has been able to maintain 2 RN's on each shift. Ward 5 is part of the women's service in addition to being a ward within

the Becklin Centre. Staffing as a unit is frequently reviewed by the Ward managers and the units Matron.

Q - Was the ward safely staffed throughout this period?
A – Yes

4.1.5 Ward 1 Newsam Centre (Psychiatric intensive care unit)

There was an overfill of HSW hours during the day and night.

Contributory factors and mitigation

This ward continues with an average of 2 service users requiring within eyesight 1-1 or 2-1 nursing observations which requires working above funded numbers. There has also been a Registered nurse vacancy over a number of months which has now been recruited into and is awaiting a start date. Staff sickness absence has also been a contributory factor.

Q - Was the ward safely staffed throughout this period?
A – Yes

4.1.6 Ward 4 Newsam Centre (Adult acute mental health male)

There was an underfill of RN hours during the day and an overfill of HSW hours during the day.

Contributory factors and mitigation

Extra duties have been created to fill the vacant RN shifts due to sickness and vacancies. 3 RN's have been appointed but do not have start dates until October 2016.

Q - Was the ward safely staffed throughout this period?
A – Yes.

4.1.7 Ward 5 Newsam Centre (Locked rehabilitation and recovery)

There was an overfill of HSW hours during the day and night.

Contributory factors and mitigation

The overfill is in response to having 2 service users on within eyesight observations and engagement.

Q - Was the ward safely staffed throughout this period?
A – Yes.

4.1.8 Ward 1 The Mount (OPS dementia female)

There was an overfill of HSW hours during the day and night.

Contributory factors and mitigation

This ward continues to have 2 band 5 vacancies and 1.4 band 3 vacancies. Other staff unavailability factors were long term and short term sickness absence, and supernumery phased return. In addition 2 service users were prescribed within arm's length observations for the entire month.

This ward planned to close in April but refurbishment was temporarily delayed. It closed officially for refurbishment on the 6th June.

Q - Was the ward safely staffed throughout this period?
A – Yes

4.1.9 Ward 2 The Mount (OPS dementia male)

There was an overfill of HSW hours during the day and night.

Contributory factors and mitigation

Additional HSW duties have been used to cover a number of vacant shifts. Sickness absence and maternity leave is also a contributory factor.

Whilst the RN fill rate remained within range a number of vacant duty twilight shifts were reallocated to HSW's. Acuity on the ward remained high in terms of observation and engagement levels. This ward also has 6.5 substantive HSW posts vacant.

Q - Was the ward safely staffed throughout this period?
A – Yes.

4.1.10 Ward 3 The Mount (OPS mental health male)

(This ward is a member of the safer staffing task and finish group, for which dashboard data is available at Appendix A)

There was an overfill of HSW hours during the night.

Contributory factors and mitigation

The increase is due to within eyesight observations and acuity of the service user group. A number of service users currently require up to 2-3 staff to manage

personal care, mobility issues and supervision pre ECT. Whilst the dashboard places skill mix in the red, this ward is nearly fully staffed, has a manageable proportion of newly registered staff balanced with a lower use of bank and agency staff.

Q - Was the ward safely staffed throughout this period?
A – Yes

4.1.11 Ward 4 The Mount (OPS mental health female)

This ward was within the accepted range and had no exceptions to report.

Q - Was the ward safely staffed throughout this period?
A – Yes

4.1.12 Asket House Inpatient Unit (Rehabilitation and recovery)

There was an overfill of HSW hours during the day and night.

Contributory factors and mitigation

The overfill was in response to placing an additional HSW on each shift to provide within eyesight observations.

4.1.13 Crisis assessment service

There was a slight overfill of HSW hours during the day and night.

Contributory factors and mitigation

The overfill of hours is linked to sickness with further contributory factors of annual leave and vacancies.

Q - Was the ward safely staffed throughout this period?
A – Yes

4.2 Specialist and Learning Disabilities Care Group

4.2.1 Bluebell Ward (Forensic female mental health)

There was an underfill of RN hours during the day and an overfill of HSW hours during the day.

Contributory factors and mitigation

This ward has 1 vacant RN post but additional unavailable RN hours due to long-term sickness absence, acting up duties, maternity leave and part time research. The impact of this is that the ward is currently functioning on 1 RN per shift rather than 2 unless they have pre-planned work that requires 2 SNs. The ward reports no untoward incidents that have required further additional staff.

4.2.2 Riverfields (Forensic low secure male mental health treatment, continuing care and rehabilitation).

There was an underfill of RN's during the day and an overfill of HSW hours during the day and an underfill of HSW hours during the night.

Contributory factors and mitigation

The RN underfill is due to long-term sickness absence and HSW's were used to backfill these duties. The underfill for HSW's on nights is due to Riverfields and Westerdale alternating in the provision of an extra HCA on nights.

Q - Was the ward safely staffed throughout this period?
A – Yes

4.2.3 Rose Ward (Forensic low secure female assessment, treatment and rehabilitation)

This ward was within the accepted range and had no exceptions to report.

4.2.4 Westerdale (Forensic low secure male mental health admissions, assessment and rehabilitation)

(This ward is a member of the safer staffing task and finish group, for which dashboard data is available at Appendix A)

There was a substantive overfill of HSW hours during the day and night.

Contributory factors and mitigation

Observation and engagement levels are consistently high with individuals requiring 2:1 staffing. Skill mix and newly registered nursing has moved further into the red from last month's report though the used of bank and agency has decreased by 11%.

Q - Was the ward safely staffed throughout this period?
A- Yes, however, the levels were not at an optimum level.

Improvement action

As reported last month this team has had a recent away day to support effective team working and identify structures that will allow consistency in the way care is delivered.

The staff team are being supported to develop an improved understanding of relational, procedural and physical security which will help to manage the difficult and complex presentations.

4.2.5 YCPM (WARD 40 LGI Liaison psychiatry)

(This ward is a member of the safer staffing task and finish group, for which dashboard data is available at Appendix A)

This ward was within the accepted range and had no exceptions to report.

The dashboard shows a good mix of newly registered staff and skill mix with low bank and agency usage. It also shows that the staffing fill rate was consistently not meeting demand; however this is in response to lower bed occupancy.

Q - Was the ward safely staffed throughout this period?
A- Yes.

4.2.6 Ward 2 Newsam Centre (Forensic assessment and treatment male)

There was an overfill of HSW hours during the day.

Contributory factors and mitigation

As reported last month, this ward has 2 RN vacancies recruited to with a start date of September 2016 and 2 HSW's posts have also been recruited to. The overfill of HSW's is due to covering escorts for court and admission.

Q - Was the ward safely staffed throughout this period?

A – Yes

4.2.7 Ward 2 Newsam Centre (Forensic female)

There was an overfill of HSW hours during the day.

Contributory factors and mitigation

This was to accommodate escorting patients to court and physical health appointments. Escorts required a minimum of 2 staff. Skill mix was also adjusted to compensate for RN unavailability and 1 service user required increased levels of observation for a period of 72 hours.

Q - Was the ward safely staffed throughout this period?
A –Yes

4.2.8 Ward 3 Newsam Centre (Treatment and recovery)

There is a slight overfill of HSW hours during day.

Contributory factors and mitigation

The overfill of HSW hours was in response to backfilling the RN vacancies held.

Q - Was the ward safely staffed throughout this period?
A – Yes

4.2.9 Ward 6 Newsam Centre (Eating disorders)

There is an overfill of RN hours during the night and an overfill of HSW hours during the day and night.

Contributory factors and mitigation

Ward 6 continues to have 5.5 RN vacancies, with 1 RN on maternity leave, and 2 HSW vacancies.
In addition there are now 4 substantive members of staff who due to due to physical health reasons are not able to provide care where PMVA techniques may need to be used.

2 RN's have now completed their preceptorship. HSW's have backfilled vacant RN duties and responded to observation acuity. Staffing is documented on the local risk register.

Q - Was the ward safely staffed throughout this period?
A – Whilst patients were kept safe, staffing was not at an optimum level. Patient acuity in terms of observation levels (2.1 within arm's reach) continues to be met by a higher use of HSW's during the day and night. Rostering tries to ensure that substantive RN's are placed on day shifts - therefore using more bank and agency RN cover at night.

Improvement action
The concerns have been escalated to the senior management team. Recruitment is ongoing and staffing has been placed as a risk on the local risk register.

4.2.10 Ward 5 Mount (Perinatal)
(This ward is a member of the safer staffing task and finish group, for which dashboard data is available at Appendix A)

There is an overfill of HSW hours during the day and night.

Contributory factors and mitigation

HSW's have been used to backfill the vacant RN shifts and some sickness absence and maternity leave. Backfill has been proactively managed in terms of using substantive HSW's who are familiar with the unit and service users. Recruitment is in progress. A substantive RN has now commenced and a band 6 post has been recruited to. In addition 3 new members of staff with be starting over the next 3 months.

Q - Was the ward safely staffed throughout this period?

A – Yes. Whilst the dashboard shows that this wards use of bank and agency increased by 7% and that there were a number of shifts where supply did not meet demand, it does routinely use consistent staff that are familiar with the service and its users.

4.2.11 Parkside Lodge (LD acute assessment and treatment)-see appendix
(This ward is a member of the safer staffing task and finish group, for which dashboard data is available at Appendix A)

There was an overfill of RN hours during the night and an overfill of HSW hours during the day and night.

Contributory factors and mitigation

Acuity remains high in terms of observation and engagement levels.

Q - Was the ward safely staffed throughout this period?

A – Whilst patients were kept safe, staffing was not at an optimum level. The dashboard shows a high vacancy factor, poor skill mix and increased bank and agency usage from the previous month. In mitigation bank and agency usage has been tested and it should be noted that over a 3 month period whilst bank and agency usage appeared high, actual non regular bank / agency usage stood at 3.32% of this workforce.

Improvement action

In response to Parkside being a standalone unit and improved safety measures, RN staffing at night has been increased. The service is in the process of recruiting new HSW's but they are currently supernumerary status during the induction period. The staffing budget will reflect this change in future reports.

4.2.12 No 2 Woodland Square (LD respite for complex physical health)

This ward was within the accepted range.

Q - Was the ward safely staffed throughout this period?
A – Yes

4.2.13 No 3 Woodland Square (LD continuing care and rehabilitation / health respite)

There was a slight underfill of HSW hours during the day and slight overfill during the night.

This is reflective of annual leave hours taken and some weeks where there were not many service users utilising respite care.

Q - Was the ward safely staffed throughout this period?
A – Yes

4.2.14 Mill Lodge (CAMHS)

There was an overfill of HSW hours during the night.

Contributory factors and mitigation

There are a number of RN vacancies which are being backfilled with HSW hours.

Although the percentage of registered nurses is within range during the day it is worth noting that this has been achievable with substantive staff working extra hours on a regular basis.

Q - Was the ward safely staffed throughout this period?
A – Yes

5. Conclusion

The underfill of available registered nurses continues to be supplemented by the use of non-registered health support workers. However we do understand from our data that a substantive number of our additional hours are supplied by staff who work for us regularly and are familiar with our service areas and patients. (See Appendix C).

This report highlights high usage of staffing in terms of observation and engagement. A service improvement initiative is being developed with Westerdale, Parkside Lodge, Ward 1 Becklin, Ward 4 Mount and Mill Lodge (as testing sites) in terms of improving the quality and requirement for within eyesight observations specifically. This will support a review of procedural guidance and improved clinical practice.

6. Next steps

Work with matrons and operational manager to inform the six-monthly safer staffing review.

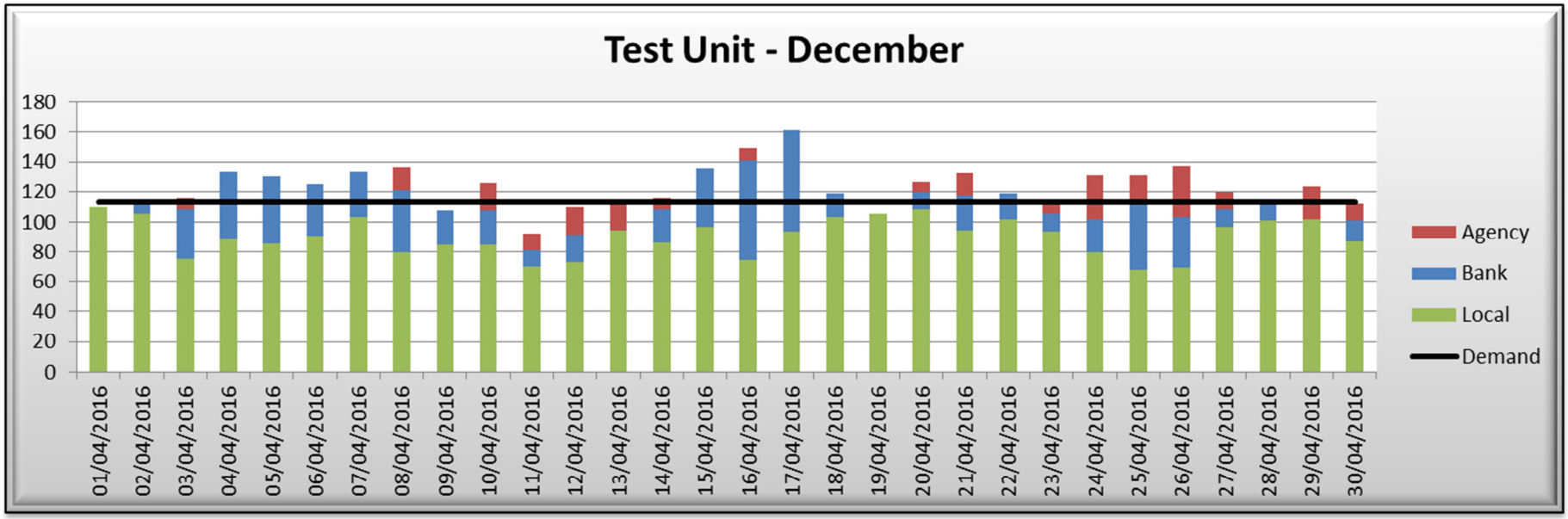
Continue the improvement work of the safer staffing task and finish group.

7. Recommendations

- Receive the report and note the contents.
- Discuss any issues raised by the content
- Confirm that the Board is satisfied with the analysis and measures taken by the Trust to ensure the wards were safely staffed during this period with the notable exceptions highlighted above.

Key to metrics and dashboard reports:

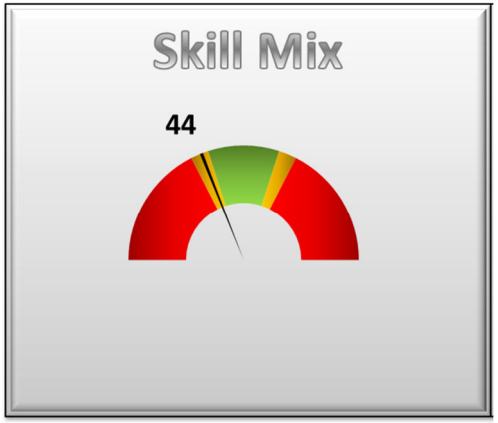
As part of the Safe Staffing Task and Finish Group a number of metrics were discussed with clinical colleagues to define what safe staffing should look like in Mental Health Trusts. These metrics are described below.



The chart demonstrates:

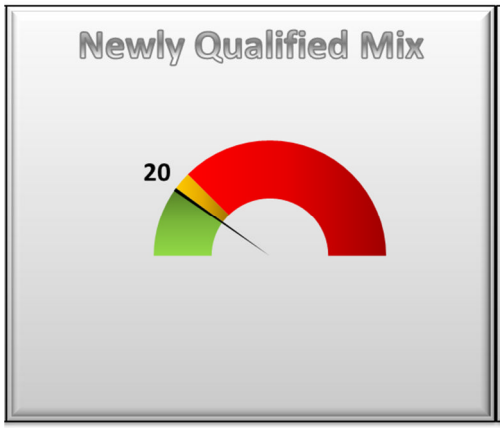
The combined RN and HCA hours per day broken down by fulfilment type (Local/Bank/Agency) – The bar chart shows the actual RN and HCA hours against the total RN and HCA hours identified as required per day (shown as a black line)

The metric is designed to demonstrate whether the unit is staffing the agreed/budgeted daily demand on the unit.



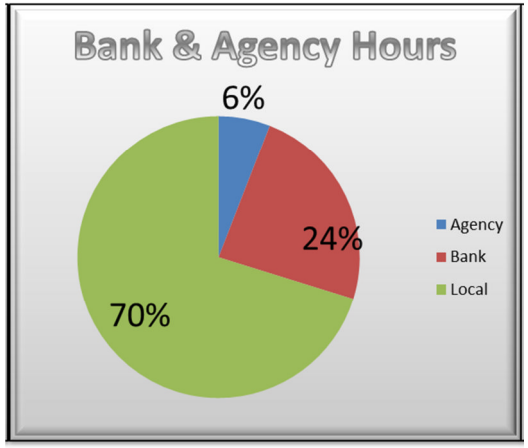
Skill Mix:

The percentage of RN/HCA in post on the unit over that roster period.
Poor skill mix on the unit can mean that the unit has too few Registered Nurses available or too few HCAs available to support services users. Each unit should have a balanced overview for the acuity type on that unit.



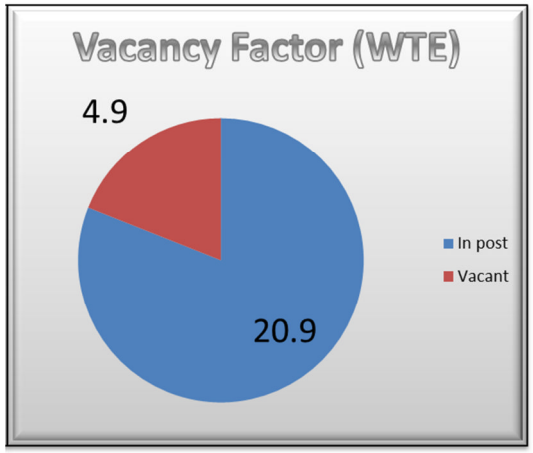
Newly Qualified Mix:

The percentage of Newly Qualified RNs in post on the unit over the roster period.
Too many Newly Qualified staff may present a risk to service users due to a lack of experience on the unit and no availability to complete preceptorships effectively.



Bank and Agency hours:

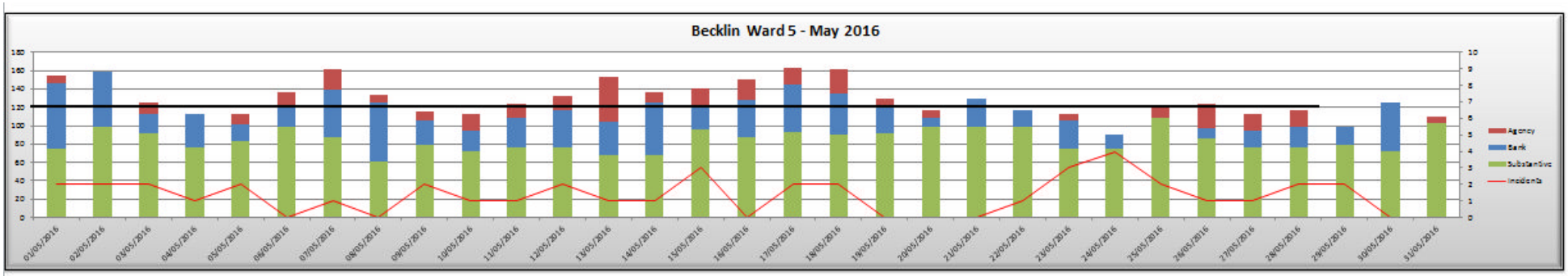
The percentage of hours fulfilled by Substantive, Bank or Agency staff.
Ideally units should be staffed with a high percentage of substantive staff for the purposes of continuity of care and familiarity with the unit/local procedures. Whilst high levels of temporary staffing usage does not directly indicate that the unit is unsafe it should be included in our safety metrics.

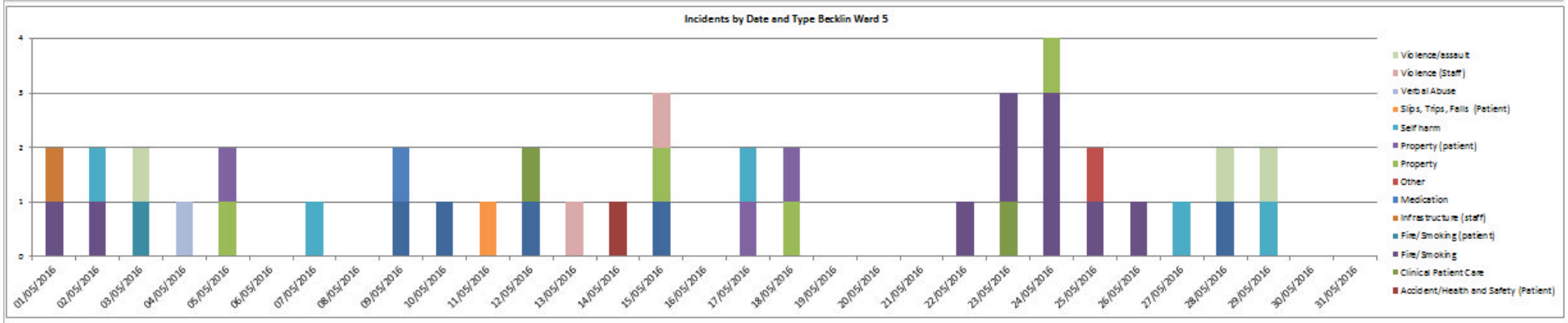


Vacancy Factor:

Indicates the number of vacancies the unit is carrying in the RN and HCA grade types.
High vacancy factors on the unit may lead to the inability to staff the unit adequately and a reliance on temporary staffing.

Trust Dashboards:

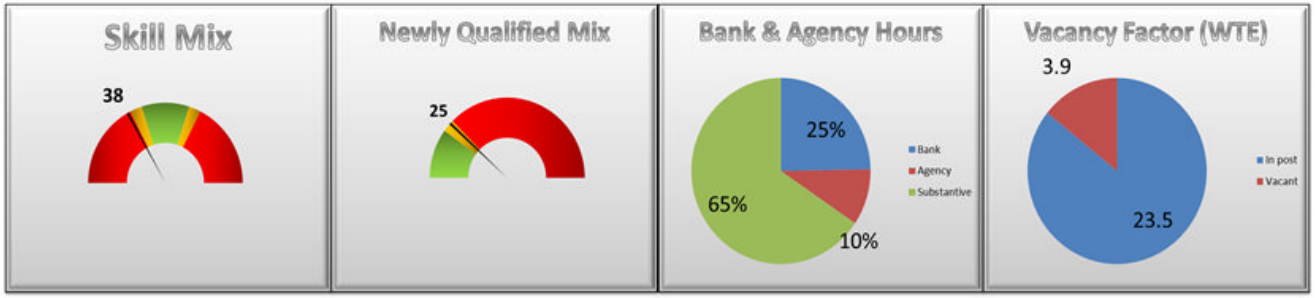


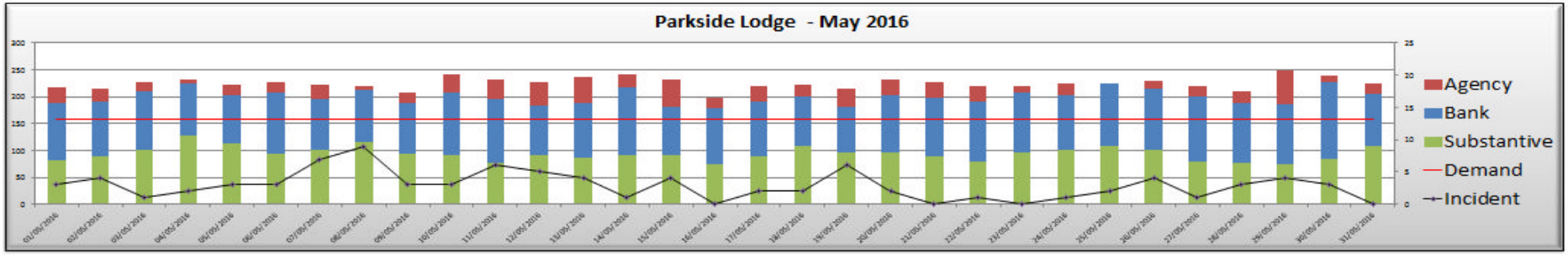


Bank & Agency Hours	
Bank	386.5
Agency	390.5
Substantive	2615.5
Grand Total	**3392.5**

States	Vacancy Factor (WTE)
In post	23.5
Vacant	3.9
Required	27.4

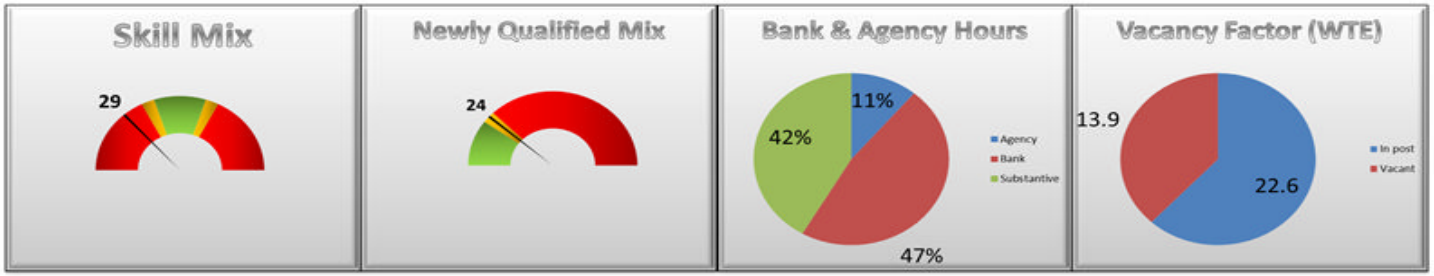
Row Labels	Sum of Work Time
Adjusted Skill Mix	287.5
Escort	153
Observation	278
Unknown	27
Using up staff hol	22.5
Vacancy	169.5
Grand Total	**937.5**

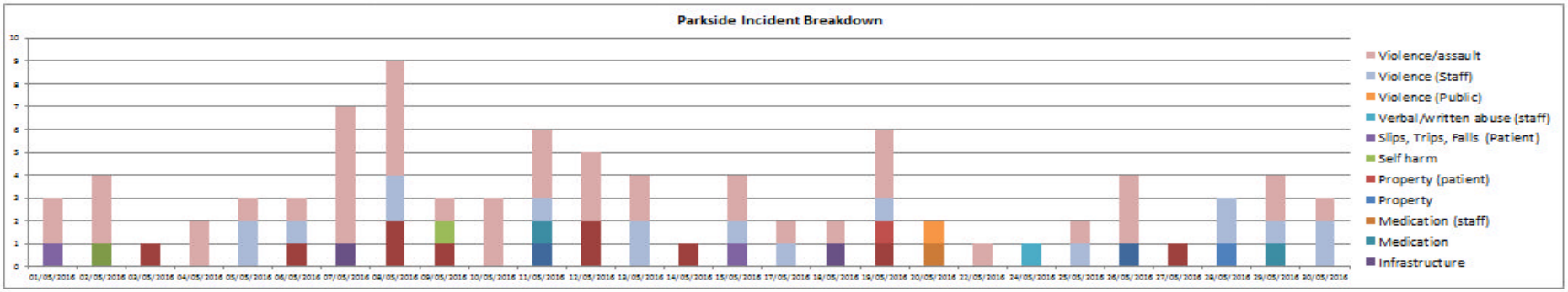


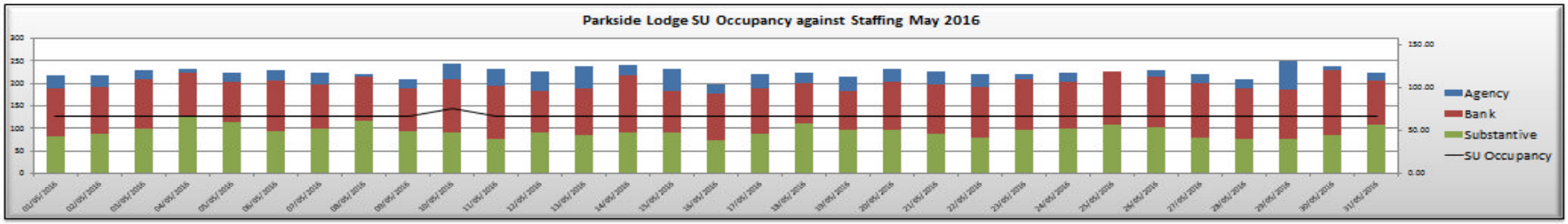


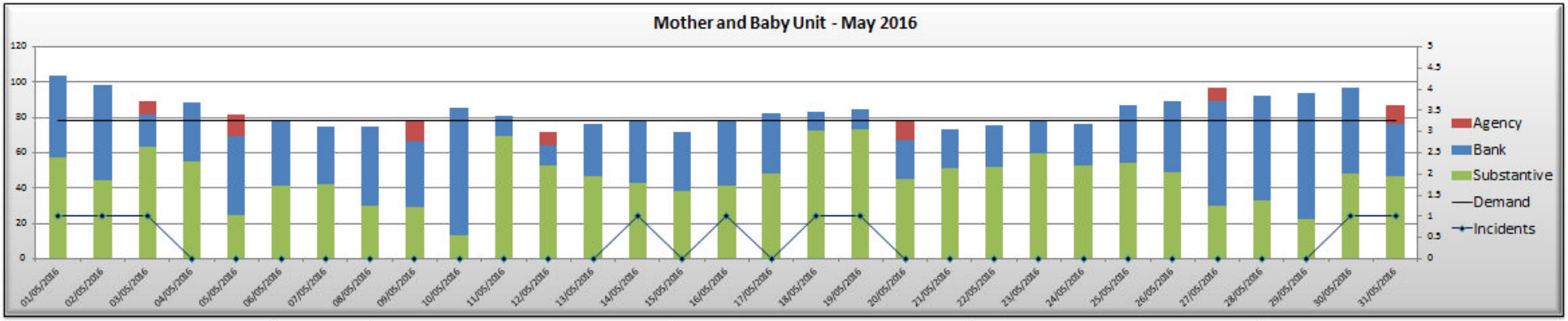
Bank & Agency Hours	
Agency	775.25
Bank	3294.25
Substantive	2904.5
Grand Total	6974

Status	Vacancy Factor (WTE)
In post	22.6
Vacant	13.9
Required	36.5





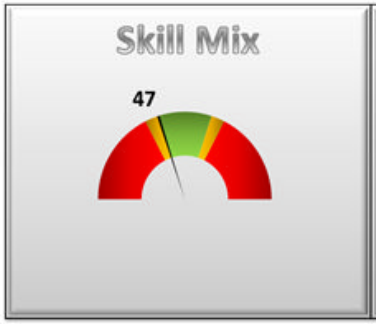


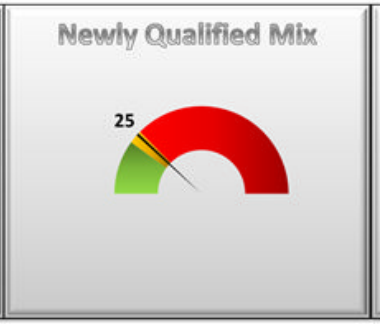


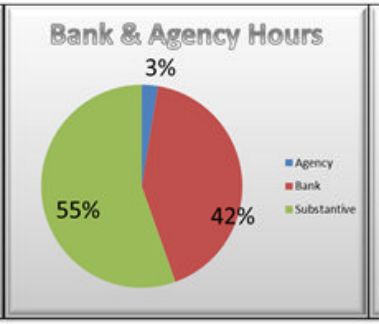
Bank & Agency Hours	
Agency	66.5
Bank	1083.5
Substantive	1431.42
Grand Total	**2581.42**

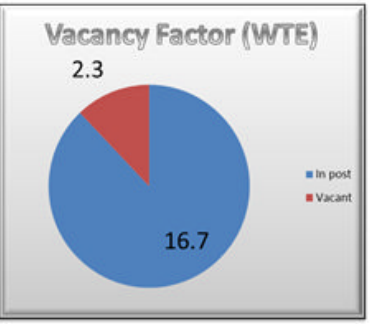
Status	Vacancy Factor (WTE)
In post	16.7
Vacant	2.3
Required	19

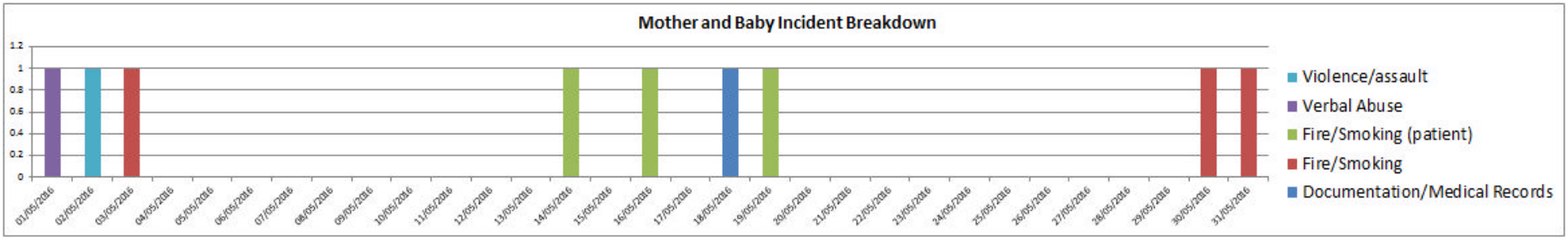
Row Label	Sum of Work Time
Adjusted Skill M	588
Observation	114.5
Unknown	15
Using up staff h	27
Vacancy	22.5
Grand Total	**767**

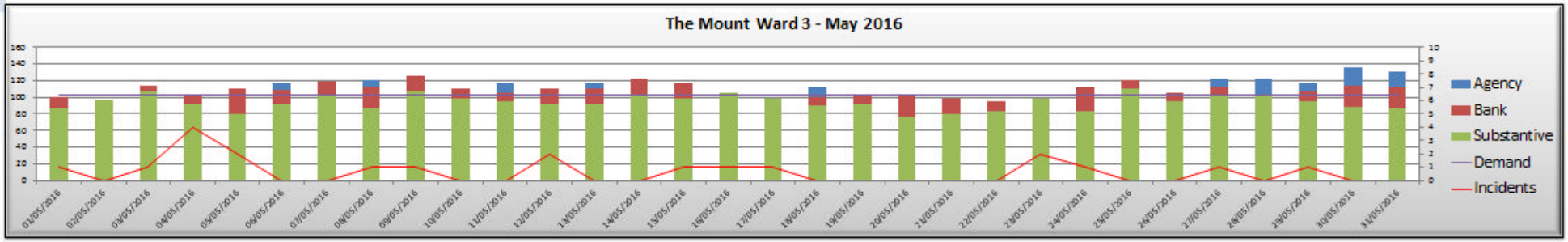


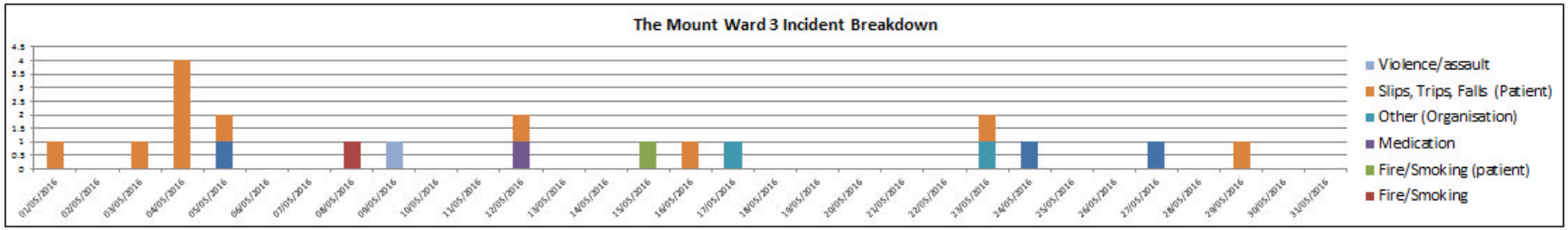








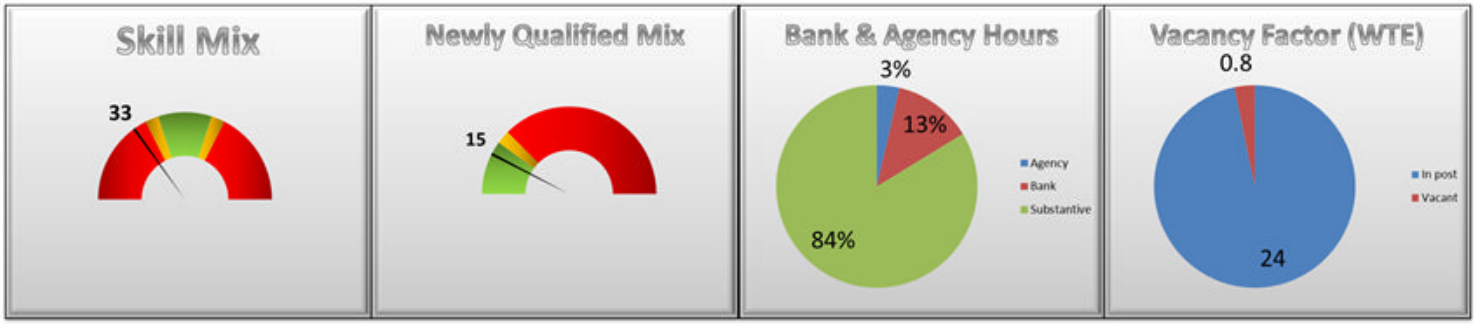


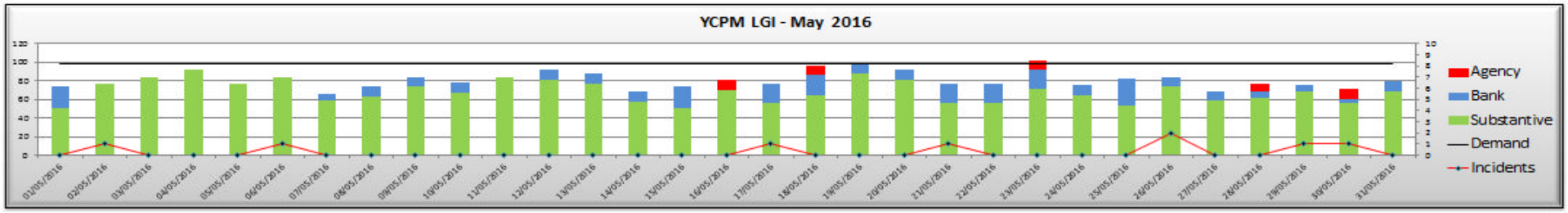


Bank & Agency Hours	
Agency	125.50
Bank	443.00
Substantive	2915.42
Grand Total	**3483.92**

Status	Vacancy Factor (WTE)
In post	24
Vacant	0.8
Required	24.8

Row Labels	Sum of Work Time
Adjusted Skill Mix	61.25
Escort	22.5
Observation	284.5
Using up staff hour	7.5
Vacancy	7.5
Grand Total	**383.25**

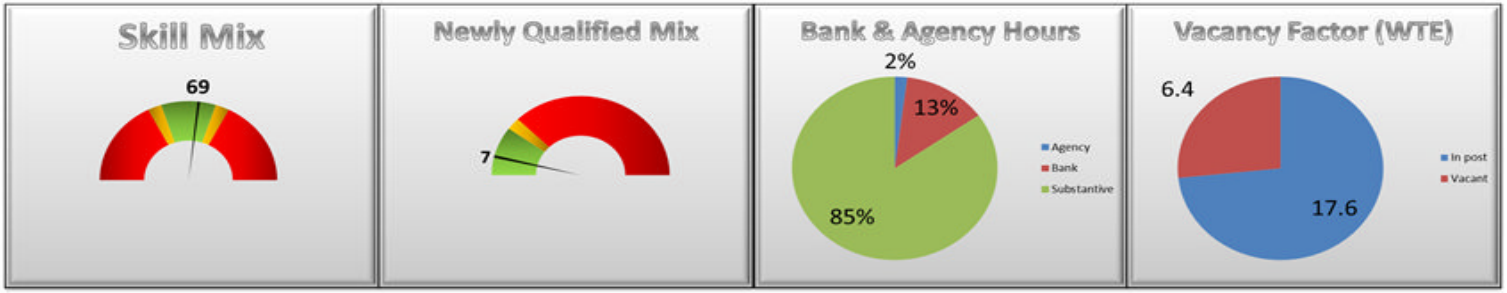


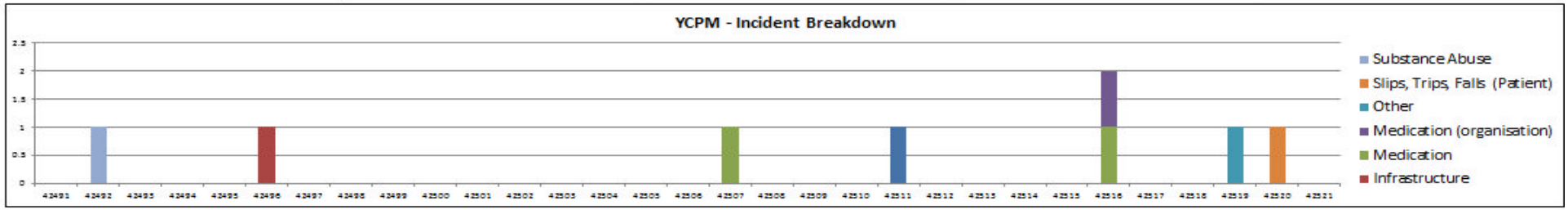


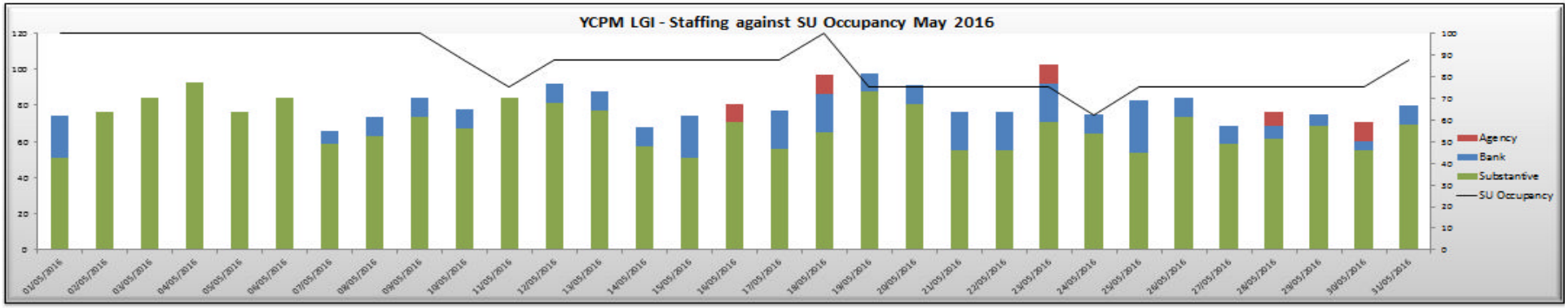
Bank & Agency Hours	
Agency	43.50
Bank	331.50
Substantive	2127.17
Grand Total	**2508.17**

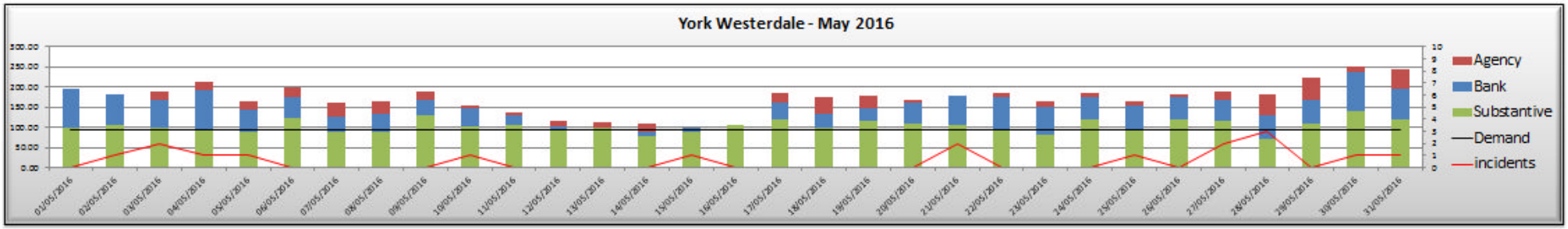
Status	Vacancy Factor (WTE)
In post	17.6
Vacant	6.4
Required	24

Row Labels	Sum of Work Time
Using up staff ho	54.5
Vacancy	10.5
Grand Total	**65**





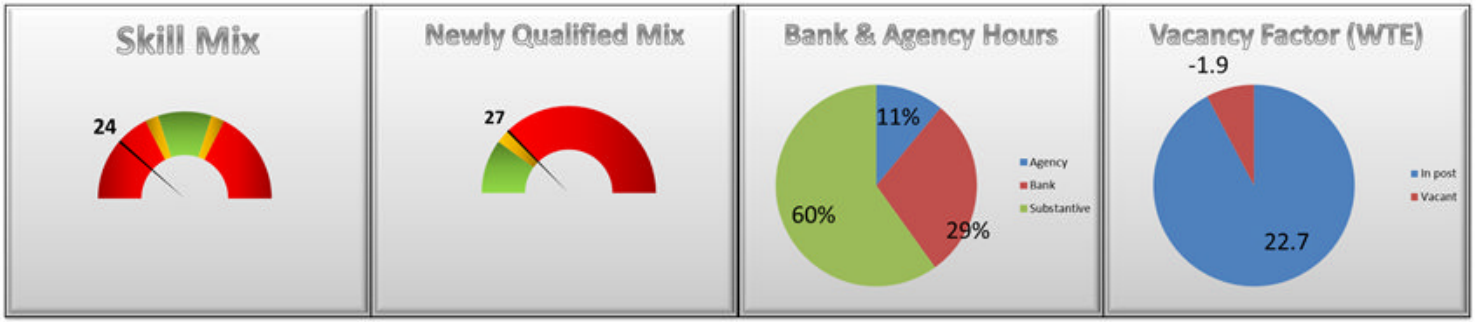


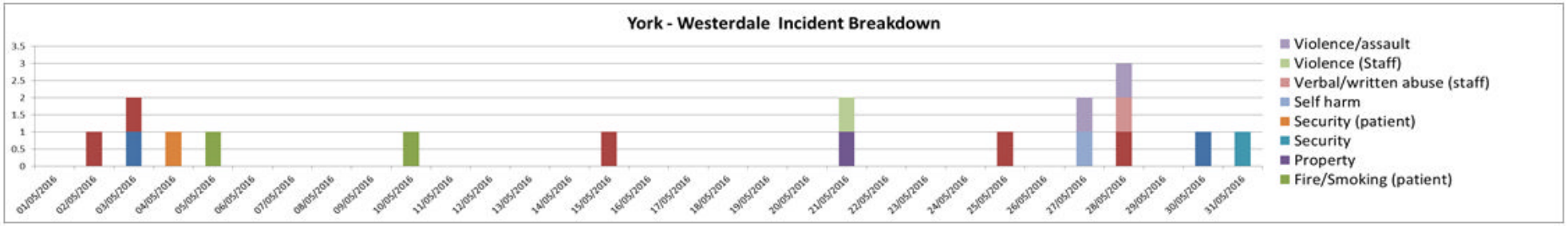


Bank & Agency Hours	
Agency	530.47
Bank	1553.42
Substantive	3207.80
Grand Total	**5351.68**

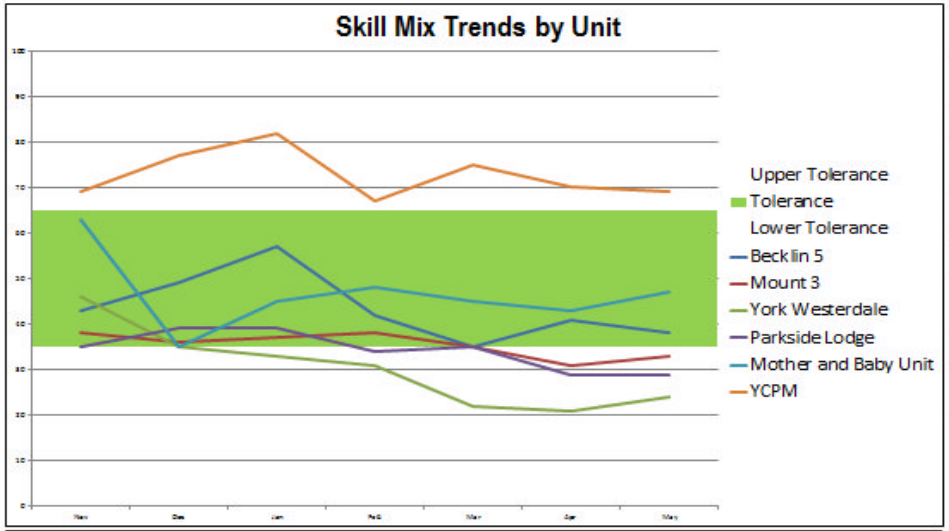
Status	Vacancy Factor (WTE)
In post	22.7
Vacant	-1.9
Required	20.8

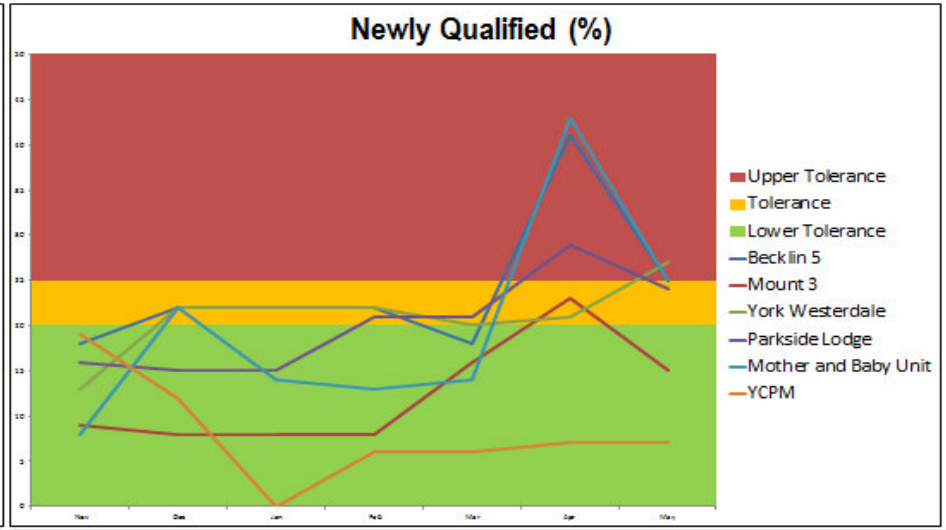
Row Labels	Sum of Work Time
Adjusted Skill Mix	80.15
Observation	2712.35
Using up staff hours	15
Vacancy	59.15
Grand Total	**2867.25**

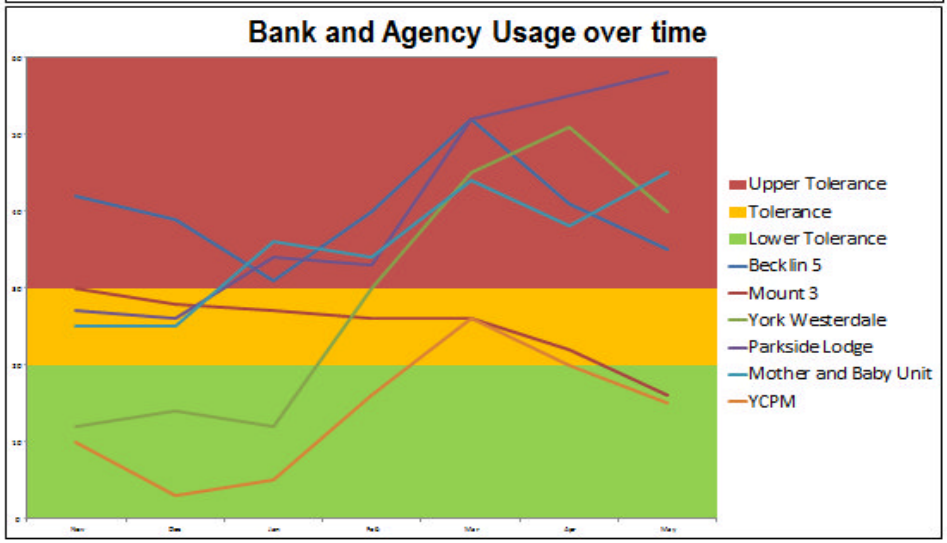


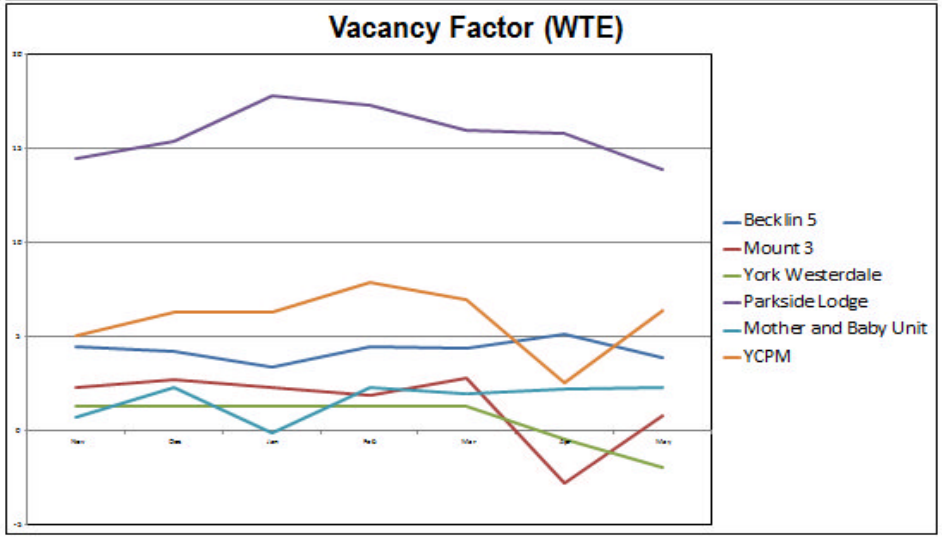


Appendix A - Metric trend analysis: (option1)









Appendix A - Metric trend analysis: (option 2)

Skill Mix	Nov	Dec	Jan	Feb	Mar	Apr	May
Becklin 5	43	49	57	42	35	41	38
Mount 3	38	36	37	38	35	31	33
York Westerdale	46	35	33	31	22	21	24
Parkside Lodge	35	39	39	34	35	29	29
Mother and Baby Unit	63	35	45	48	45	43	47
YCPM	69	77	82	67	75	70	69

Bank and Agency	Nov	Dec	Jan	Feb	Mar	Apr	May
Becklin 5	42	39	31	40	52	41	35
Mount 3	30	28	27	26	26	22	16
York Westerdale	12	14	12	30	45	51	40
Parkside Lodge	27	26	34	33	52	55	58
Mother and Baby Unit	25	25	36	34	44	38	45
YCPM	10	3	5	16	26	20	15

Newly Qual mix	Nov	Dec	Jan	Feb	Mar	Apr	May
Becklin 5	18	22	22	22	18	41	25
Mount 3	9	8	8	8	16	23	15
York Westerdale	13	22	22	22	20	21	27
Parkside Lodge	16	15	15	21	21	29	24
Mother and Baby Unit	8	22	14	13	14	43	25
YCPM	19	12	0	6	6	7	7

Vacancy Factor	Nov	Dec	Jan	Feb	Mar	Apr	May
Becklin 5	4.5	4.2	3.4	4.5	4.4	5.14	3.9
Mount 3	2.3	2.7	2.3	1.9	2.8	-2.74	0.8
York Westerdale	1.3	1.3	1.3	1.3	1.3	-0.43	-1.9
Parkside Lodge	14.5	15.4	17.8	17.3	16	15.8	13.9
Mother and Baby Unit	0.7	2.3	-0.1	2.3	2	2.2	2.3
YCPM	5.1	6.3	6.3	7.9	7	2.56	6.4

Appendix B Unify report:

HospitalName	HospitalSiteCode	WardName	Type	PlannedRegHoursDay	ActualRegHoursDay	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
ASKET HOUSE	RGDAP	Asket Inpatient Unit	HCW	1,338	1,929.5	144.21%	1,023	1,430	139.78%
			Nursing	1,054.5	1,093.08	103.66%	682	685	100.44%
BECKLIN CENTRE	RGDBL	Becklin Ward 1	HCW	613.5	1,323	215.65%	682	882	129.33%
			Nursing	1,254	872.5	69.58%	682	671	98.39%
		Becklin Ward 2 CR	HCW	713	926.5	129.94%	713	857	120.20%
			Nursing	701.5	632.75	90.20%	713	632.5	88.71%
		Becklin Ward 3	HCW	665	1,336.5	200.98%	682	748	109.68%
			Nursing	994.5	911	91.60%	682	682	100.00%
		Becklin Ward 4	HCW	784.5	1,282.5	163.48%	682	814	119.35%
			Nursing	1,288.5	847.5	65.77%	682	671	98.39%
		Becklin Ward 5	HCW	754	1,401	185.81%	682	947	138.86%
			Nursing	1,216.5	984.5	80.93%	671	660	98.36%
Clifton House	RGDT5	York - Bluebell	HCW	639	1,157	181.06%	664.33	676.06	101.77%
			Nursing	837	589	70.37%	332.32	332.32	100.00%
		York - Riverfields	HCW	687	1,033	150.36%	664.33	514.4	77.43%
			Nursing	805.5	633.5	78.65%	332.32	332.32	100.00%
		York - Rose	HCW	762	679.5	89.17%	664.33	675.05	101.61%
			Nursing	795	648.5	81.57%	321.6	321.6	100.00%
		York - Westerdale	HCW	484.5	2,190.86	452.19%	664.33	1,883.68	283.55%
			Nursing	787.5	923.5	117.27%	332.32	353.74	106.45%
LEEDS GENERAL INFIRMARY	RGD03	YCPM LGI	HCW	510	466.5	91.47%	325.5	336	103.23%
			Nursing	1,066.5	1,086.17	101.84%	630	619.5	98.33%
NEWSAM CENTRE	RGDAB	New sam Ward 1 PICU	HCW	1,458	2,139.5	146.74%	671	1,595	237.70%
			Nursing	1,216.5	1,240	101.93%	649	630.75	97.19%
		New sam Ward 2 Forensic	HCW	889.5	1,217.5	136.87%	666.5	762.75	114.44%
			Nursing	849	827.25	97.44%	333.25	333.25	100.00%
		New sam Ward 2 Womens Services	HCW	858	1,269.42	147.95%	666.5	703.25	105.51%
			Nursing	889.83	731	82.15%	333.25	344	103.23%
		New sam Ward 3	HCW	831	1,010.5	121.60%	666.5	672.33	100.87%
			Nursing	873	736.5	84.36%	333.25	322.5	96.77%
		New sam Ward 4	HCW	768	1,269	165.23%	682	759	111.29%
			Nursing	1,191	878	73.72%	682	682	100.00%
		New sam Ward 5	HCW	1,164	1,736.5	149.18%	682	1,187	174.05%
			Nursing	783	867.34	110.77%	638	639	100.16%
		New sam Ward 6 EDU	HCW	817	1,685.5	206.30%	640.5	1,031.5	161.05%
			Nursing	831	946.26	113.87%	325.5	619.5	190.32%
PARKSIDE LODGE	RGDPL	Parkside Lodge	HCW	1,505.75	3,008	199.77%	1,291.5	1,995	154.47%
			Nursing	1,255.5	1,320	105.14%	315	651	206.67%
ST MARY'S HOSPITAL	RGD17	2 Woodland Square	HCW	674.5	575.5	85.32%	325.5	325.5	100.00%
			Nursing	677	630	93.06%	325.5	325.5	100.00%
		3 Woodland Square	HCW	892.5	638.5	71.54%	325.5	399	122.58%
			Nursing	625.5	561	89.69%	325.5	325.5	100.00%
THE MOUNT	RGD05	Mother and Baby The Mount	HCW	394.5	681.25	172.69%	275	704	256.00%
			Nursing	710.5	749.17	105.44%	429	439	102.33%
		The Mount Ward 1	HCW	1,033.5	1,751	169.42%	999.75	1,386.75	138.71%
			Nursing	1,065	866.5	81.36%	333.25	333.25	100.00%
		The Mount Ward 2a	HCW	1,473.5	2,402.25	163.03%	999.75	1,729.75	173.02%
			Nursing	1,074.5	876.5	81.57%	333.25	333.25	100.00%
		The Mount Ward 3a	HCW	1,227	1,370.92	111.73%	682	907	132.99%
			Nursing	843.5	746.5	88.50%	341	344.5	101.03%
		The Mount Ward 4a	HCW	1,254.5	1,390.75	110.86%	671	746.92	111.31%
			Nursing	814.5	698.84	85.80%	341	339.33	99.51%
York - Mill Lodge	RGDVE	York - Mill Lodge	HCW	1,374	1,432	104.22%	682	889	130.35%
			Nursing	1,433.17	1,165.01	81.29%	682	674	98.83%

Appendix C CQC Data Pack:

NOTES

Bank and Agency Total - Total % of hours between Jan and March complete by Bank and Agency staff	**Regular Workers -** The total percentage of hours worked by Regular Bank and Agency workers classed as those that work 15 hours or more on average per week in the Trust (15 Hours * 13 Weeks = 195 Hours) Also includes those staff who have a substantive post in the Trust.	**Irregular B&A -** The total percentage of hours worked by Bank and Agency staff who work less than an average of 15 hours per week in the Trust.

Unit	Agency	Bank Only	Regular Agency	Regular Bank	Substantive	Substantive Bank	Grand Total	Bank & Agency Total	Regular Workers	Irregular B&A
15-17 Sledmere Lane	0.71%	0.14%	0.00%	12.95%	75.60%	10.61%	100.00%	24.40%	23.55%	0.85%
156 Austhorpe Road	0.00%	0.44%	0.00%	14.73%	65.69%	19.14%	100.00%	34.31%	33.87%	0.44%
2 Reinwood Avenue	0.00%	0.00%	0.00%	18.98%	66.50%	14.52%	100.00%	33.50%	33.50%	0.00%
2 Woodland Square	0.00%	0.20%	0.00%	0.00%	93.36%	6.45%	100.00%	6.64%	6.45%	0.20%
26 Harley Rise	0.00%	0.00%	0.00%	0.00%	95.59%	4.41%	100.00%	4.41%	4.41%	0.00%
3 Woodland Square	0.46%	6.18%	0.81%	3.69%	85.34%	3.53%	100.00%	14.66%	8.02%	6.64%
34 Stainbeck Road	0.00%	0.00%	0.00%	13.70%	83.58%	2.72%	100.00%	16.42%	16.42%	0.00%
45 Maryfield Ave.	0.00%	0.00%	0.00%	10.79%	74.61%	14.60%	100.00%	25.39%	25.39%	0.00%
49 Gledhow Park (F)	0.00%	0.44%	0.74%	8.26%	82.35%	8.22%	100.00%	17.65%	17.21%	0.44%
8/10 The Oval	0.00%	2.02%	0.00%	3.19%	76.14%	18.65%	100.00%	23.86%	21.83%	2.02%
A&C AMH Services - JW	0.00%	0.00%	17.96%	35.50%	46.54%	0.00%	100.00%	53.46%	53.46%	0.00%
A&C Mental Health Legislation Admin	0.00%	2.32%	15.59%	0.00%	82.09%	0.00%	100.00%	17.91%	15.59%	2.32%
Asket Inpatient Unit	0.73%	2.18%	0.50%	12.64%	77.25%	6.70%	100.00%	22.75%	19.84%	2.91%
Becklin Ward 1	1.60%	4.30%	2.27%	19.80%	66.45%	5.57%	100.00%	33.55%	27.64%	5.90%
Becklin Ward 2 CR	0.50%	0.14%	0.19%	0.96%	98.12%	0.09%	100.00%	1.88%	1.24%	0.64%
Becklin Ward 3	2.65%	3.24%	2.82%	8.15%	75.05%	8.09%	100.00%	24.95%	19.06%	5.89%
Becklin Ward 4	3.45%	1.99%	3.59%	13.61%	66.81%	10.55%	100.00%	33.19%	27.75%	5.44%
Becklin Ward 5	3.77%	4.44%	4.55%	20.55%	61.24%	5.45%	100.00%	38.76%	30.55%	8.21%
Calverley Bungalow (F)	0.45%	0.56%	0.79%	2.12%	82.16%	13.91%	100.00%	17.84%	16.82%	1.01%

Cedar House	0.32%	0.00%	0.00%	5.71%	79.68%	14.29%	100.00%	20.32%	19.99%	0.32%
Chapel Fold	0.79%	0.98%	0.89%	16.05%	74.81%	6.48%	100.00%	25.19%	23.42%	1.77%
Coppice Head	0.00%	0.00%	0.00%	9.32%	82.17%	8.51%	100.00%	17.83%	17.83%	0.00%
E/NE Locality CMHT Team	0.00%	2.35%	0.00%	1.73%	95.70%	0.23%	100.00%	4.30%	1.96%	2.35%
East Locality ICS	1.31%	0.43%	0.49%	0.93%	95.93%	0.92%	100.00%	4.07%	2.34%	1.73%
ECT Team Becklin	0.00%	19.36%	0.00%	4.16%	73.36%	3.12%	100.00%	26.64%	7.29%	19.36%
Laburnum Cottage	1.02%	0.00%	0.00%	1.82%	87.19%	9.96%	100.00%	12.81%	11.78%	1.02%
Liaison Psychiatry AMH	0.00%	0.96%	0.00%	3.07%	95.98%	0.00%	100.00%	4.02%	3.07%	0.96%
Little Woodhouse Hall	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	100.00%	100.00%	100.00%	0.00%
Methley Lodge	0.00%	0.17%	0.00%	25.83%	67.82%	6.18%	100.00%	32.18%	32.02%	0.17%
Mother and Baby The Mount	0.41%	2.74%	0.69%	18.05%	72.38%	5.73%	100.00%	27.62%	24.47%	3.15%
NE Locality ICS	0.00%	0.30%	0.00%	0.00%	99.13%	0.57%	100.00%	0.87%	0.57%	0.30%
Newsam Band 6 Nights	0.00%	0.00%	0.00%	0.00%	96.01%	3.99%	100.00%	3.99%	3.99%	0.00%
Newsam Ward 1 PICU	4.96%	3.06%	5.54%	18.20%	57.02%	11.21%	100.00%	42.98%	34.95%	8.03%
Newsam Ward 2 Forensic	4.40%	2.64%	6.81%	39.42%	42.37%	4.37%	100.00%	57.63%	50.60%	7.04%
Newsam Ward 2 Womens Services	3.33%	2.32%	4.51%	17.64%	65.31%	6.89%	100.00%	34.69%	29.05%	5.65%
Newsam Ward 3	1.96%	5.68%	1.29%	22.61%	65.06%	3.41%	100.00%	34.94%	27.31%	7.63%
Newsam Ward 4	3.01%	3.11%	1.86%	21.28%	68.15%	2.60%	100.00%	31.85%	25.73%	6.12%
Newsam Ward 5	1.74%	1.37%	1.93%	9.69%	74.33%	10.94%	100.00%	25.67%	22.56%	3.11%
Newsam Ward 6 EDU	3.32%	2.45%	5.94%	9.70%	72.62%	5.96%	100.00%	27.38%	21.61%	5.77%
Parkside Lodge	1.26%	2.05%	1.21%	23.32%	63.18%	8.97%	100.00%	36.82%	33.51%	3.32%
Parkwood View	1.19%	3.32%	0.99%	22.22%	62.26%	10.01%	100.00%	37.74%	33.23%	4.51%
PTS Family Therapy	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	100.00%	100.00%	100.00%	0.00%
Pudsey Bungalow	0.32%	4.58%	0.00%	9.14%	79.15%	6.81%	100.00%	20.85%	15.96%	4.90%
South Locality CMHT Team	0.89%	0.27%	0.00%	0.00%	98.84%	0.00%	100.00%	1.16%	0.00%	1.16%
South Locality ICS	0.00%	5.20%	0.00%	0.00%	91.21%	3.59%	100.00%	8.79%	3.59%	5.20%
The Mount Ward 1	2.14%	1.74%	3.81%	9.18%	74.63%	8.50%	100.00%	25.37%	21.49%	3.88%
The Mount Ward 2a	1.87%	1.80%	5.67%	19.62%	67.40%	3.65%	100.00%	32.60%	28.93%	3.67%
The Mount Ward 3a	2.65%	2.35%	6.88%	5.63%	75.63%	6.86%	100.00%	24.37%	19.36%	5.00%
The Mount Ward 4a	2.24%	2.32%	2.58%	4.65%	76.40%	11.82%	100.00%	23.60%	19.05%	4.56%
W/NW Locality CMHT Team	0.00%	1.14%	0.00%	1.21%	97.38%	0.27%	100.00%	2.62%	1.48%	1.14%
W/NW Locality ICS	0.00%	0.00%	0.00%	0.11%	99.89%	0.00%	100.00%	0.11%	0.11%	0.00%
YCPM LGI	0.36%	2.55%	0.99%	4.92%	87.84%	3.34%	100.00%	12.16%	9.24%	2.92%
York - Bluebell	2.67%	4.04%	1.83%	15.32%	75.88%	0.26%	100.00%	24.12%	17.41%	6.71%
York - Mill Lodge	3.80%	1.58%	3.40%	6.10%	83.16%	1.96%	100.00%	16.84%	11.46%	5.38%
York - Riverfields	0.86%	0.77%	1.96%	2.36%	94.04%	0.00%	100.00%	5.96%	4.32%	1.64%
York - Rose	5.94%	3.49%	13.60%	16.61%	60.16%	0.20%	100.00%	39.84%	30.40%	9.43%

AGENDA ITEM 10

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Complaints Summary Report
DATE OF MEETING:	28 July 2016
LEAD DIRECTOR: (name and title)	Anthony Deery - Director of Nursing, Professions & Quality
PAPER AUTHOR: (name and title)	Clare Blackburn- PALS, Complaints & Claims 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	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)	

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	The report provides activity and performance information about complaints, PALS, compliments and claims received during June 2016.
What are the key points and key issues the Board needs to focus on	Complaints Management training has now been in place since May 2015, with a total of 12 sessions having been delivered to date. A further five training sessions have been scheduled for 2016. Uptake of training continues to rise and a total number of 113 staff have now been trained (with a further 20 staff booked on future training). Training is evaluated after each session with positive comments being received. Feedback from the Complaints Management training highlighted the need for additional customer service training for front-line support staff (bands 2 to 5). As a result, a Customer Services training package has been developed. A total of eight training sessions have been scheduled for 2016 with the first training session held on 1 July 2016. Training is evaluated after each session with positive comments being received. Claims scorecards are provided by the NHSLA and are split into coloured zones based on the volume and value of the claims. We have queried the claim with a stated value of £12,016,000 and NHSLA have confirmed this is an error and should read £12,016.
What is the Board being asked to consider	To be assured of sustained improvements in relation to Complaints, PALS, compliments and claims.
What is the impact on the quality of care	Complaints are a key source of feedback and we use information from complaints to improve the quality of our services.
What are the benefits and risks for the Trust	Good complaints management helps us to demonstrate that we are responsive and care about providing high quality services.
What are the resource implications	None
Next steps following this paper being presented to the Board	None
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	Complaints Management is a key means by which we measure service user experience. Service users now participate in panels to quality assess a random selection of final response letters (anonymised).
Previous meetings where this report has been considered (including date)	The Board of Directors and the Council of Governors receives a report on complaints at each 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:

- Receive and note the improvement initiatives highlighted within the report.

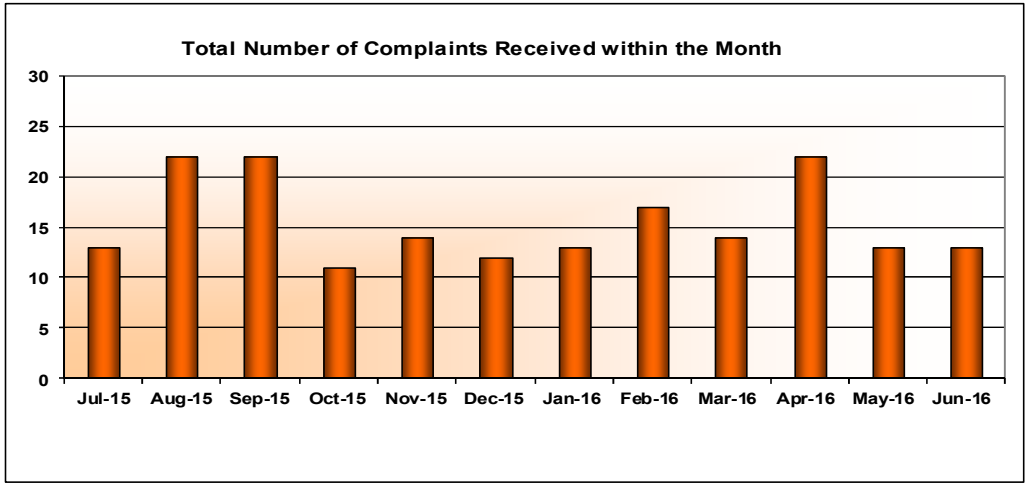
*** EQUALITY ACT 2010**

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).

PALS and Complaints Summary Report: July 2016 (based on June 2016 data)

This report provides data on activity and performance information about complaints, PALS, compliments and claims for June 2016.

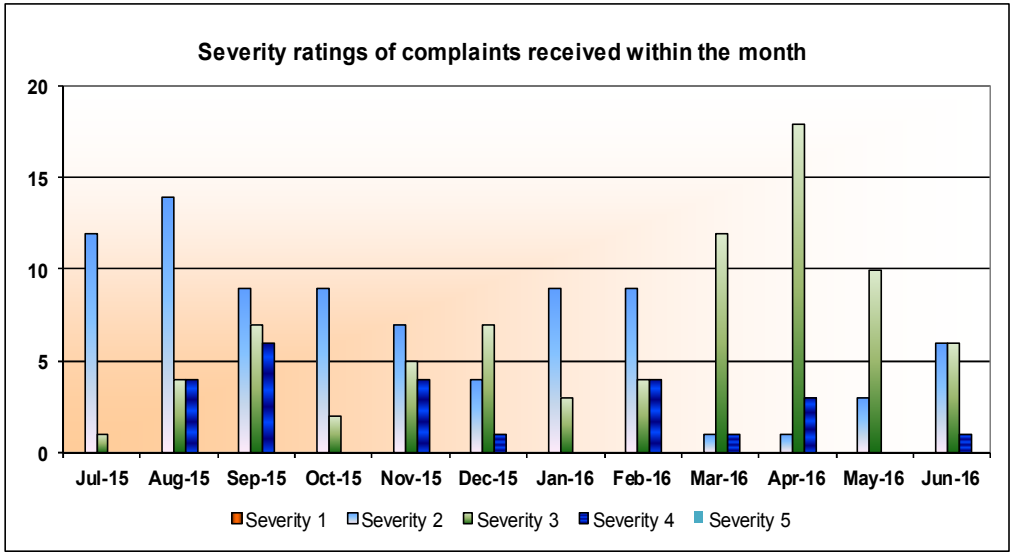
1. Total number of complaints received within the month



In June 2016, the Trust received 13 formal complaints.

A weekly complaints tracker is sent to Care Groups, providing a summary of open complaints with timeframes for completion. The complaints team pro-actively monitors progress to ensure complaints are on track to achieve timeframes. Extension of timescales can only be granted once the complainant and the PALS, Complaints & Claims Manager have agreed the reasons for an extension; and an appropriate extension period.

2. Severity Ratings of complaints received within the month



There was one complaint received, rated as a Severity 4, in June 2016.

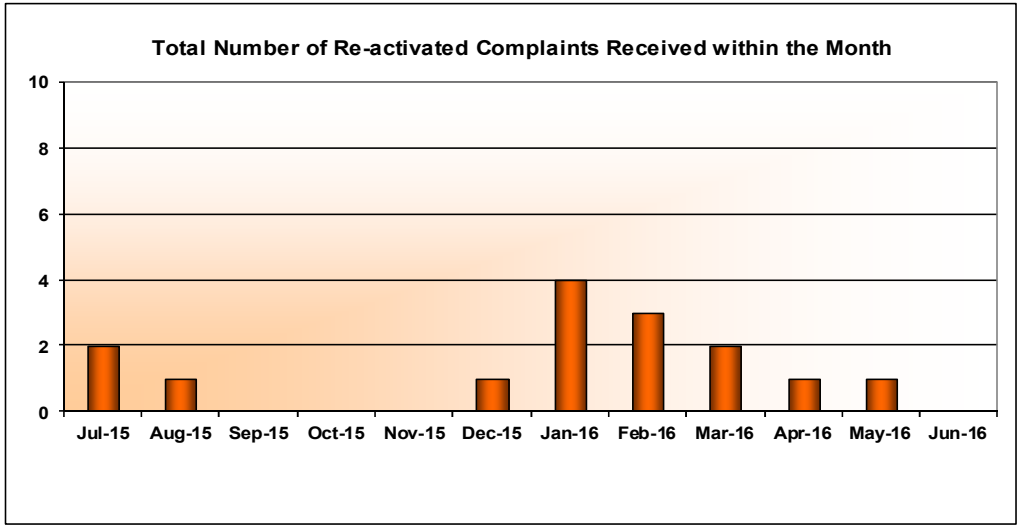
The complainant had made a serious sexual allegation against a member of staff. The Trust's Safeguarding team are aware of this complaint and are also conducting their own investigation.

Updates

The investigation into the outstanding Severity 4 rated complaint received in April 2016 has been concluded, with the outcome as 'partly upheld'. Details are as follows;

- It was acknowledged that there had been a lack of explanation of referral processes within the Trust. As a result of the complainant not fully understanding these processes, IAPT input was ended. This left the complainant feeling vulnerable and unsupported. The service has discussed the complaint within their team meeting to ensure learning, and all staff have been reminded that they must ensure that service users are fully aware of referral processes.

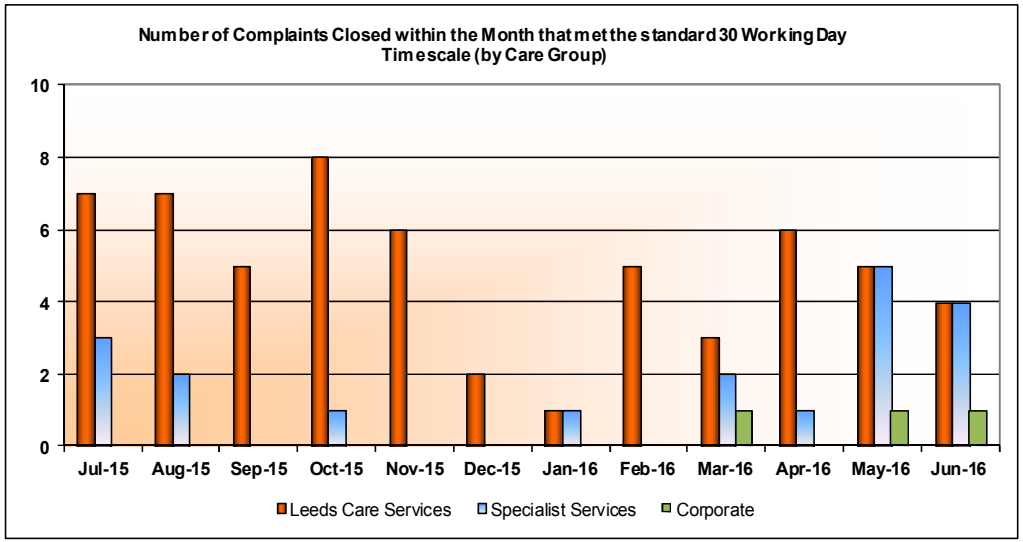
3. Total number of re-activated complaints received within the month



There have been no re-activated complaints received during June 2016.

In line with the Complaints Management Procedure, should a complainant remain dissatisfied following a reinvestigation of their complaint, we provide details of how they can access further independent help, including the Parliamentary and Health Services Ombudsman.

4. Number of complaints closed within the month that met the standard 30 working day timescale (by Care Group)



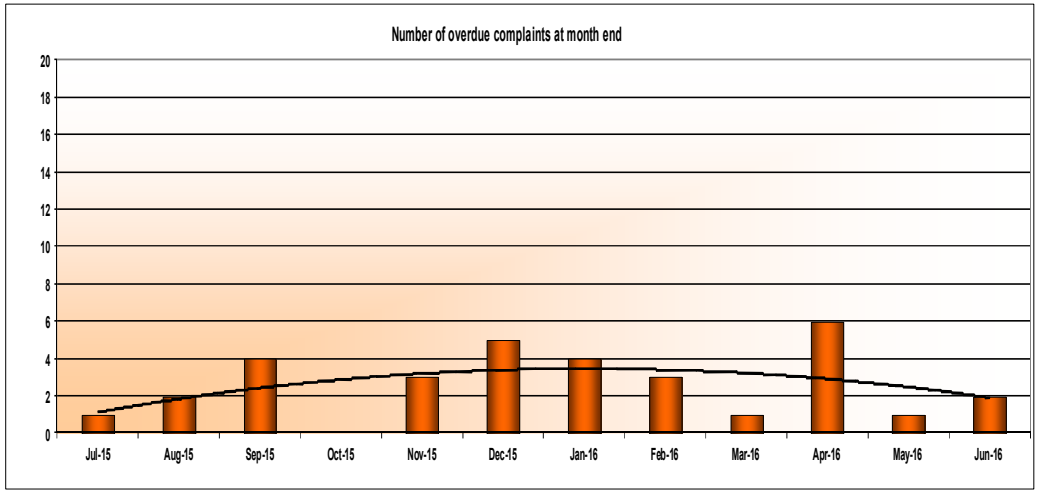
Of the 18 complaints closed in June 2016, nine were responded to within the standard 30 working day timescale. Five complaints had a revised timescale with the full agreement of the complainant.

The remaining four complaint responses were overdue by between 32 and 46 working days. The delays were attributed to:-

- One complaint response was delayed due to the investigator going on annual leave and not submitting the draft response.
- One complaint response was delayed due to the investigator going on sick leave.
- Two complaint responses were delayed waiting for the Associate Directors to approve the draft response.

The weekly complaints tracker which is sent to each Associate Director provides a summary of open complaints for their Care Group, with timeframes for completion. In addition the PALS, Complaints & Claims Manager e-mails investigators of open complaints each week, routinely drawing their attention to any deadlines approaching in the next two weeks.

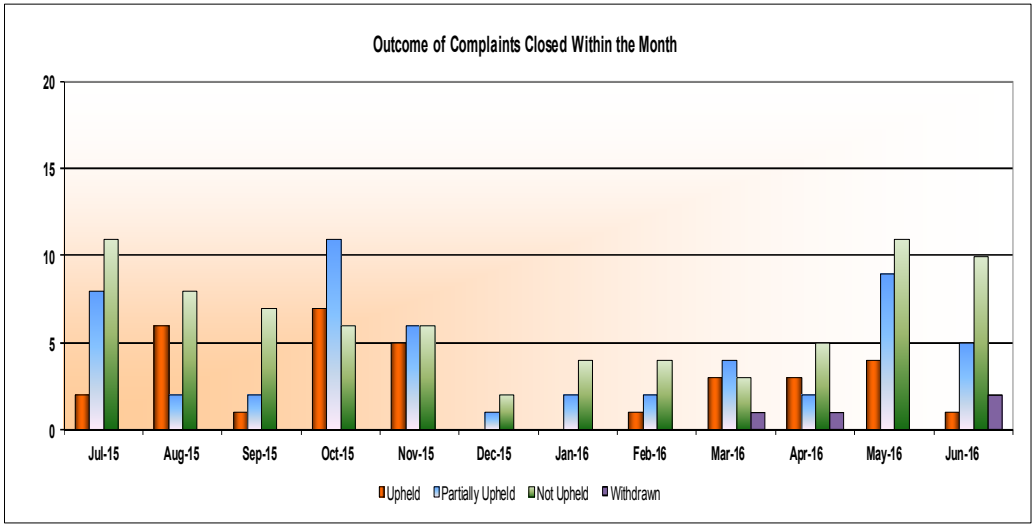
5. Number of complaints overdue at month end



As of the 4 July 2016, there are two overdue complaints (Specialist Services). These complaints are currently with the investigators.

The Complaints team regularly prompt investigators and Associate Directors for progress updates on all complaints; but there are still occasions when capacity issues within care services result in delays. The interim Chief Operating Officer has confirmed that she is made aware of any delays through the weekly tracker and intervenes as necessary to prevent delays.

6. Outcome of complaints closed within the month



Of the 18 complaints closed during June 2016, 10 were not upheld, five were partly upheld, one was upheld and two were withdrawn.

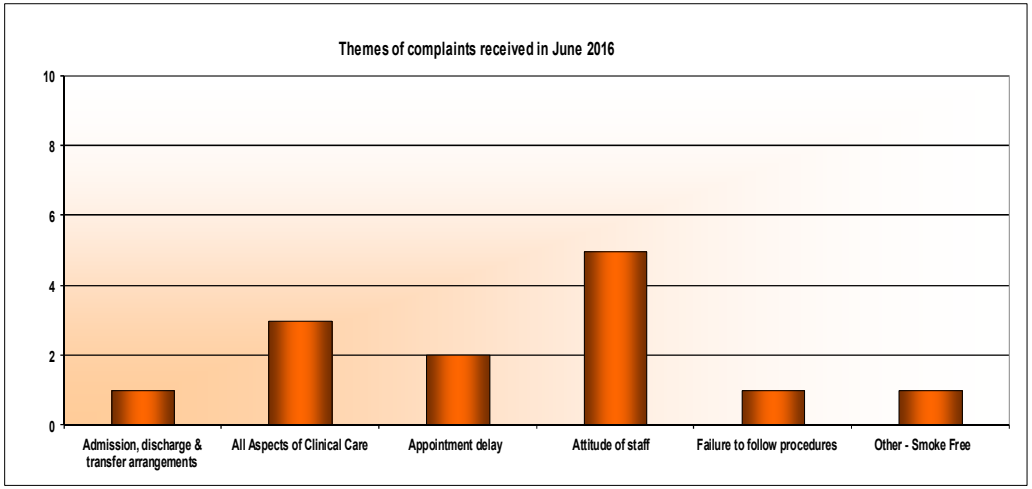
The upheld and partly upheld complaints related to the following issues:

- The service failed to respond to the needs of patients and their carers compassionately; and to respect patient choice.
- During a voice coaching session, it was acknowledged that there was not enough time to ask questions or practice exercises in between sessions.
- The service did not explain referral processes clearly enough which led to IAPT input ending.
- A staff member accepted responsibility over an unprofessional comment they had made. They offered a sincere apology to the complainant.
- A written response sent to a service user following an assessment was not of the standard expected.
- It was acknowledged that a service user had not been offered more time to get used to the change in formulation before being discharged from the Community Mental Health Team.

A robust process is in place to ensure all issues identified in complaints are identified and responded to; and that actions identified are robust and proportionate. Complaint actions are discussed within Care Group Risk Forums. The PALS, Complaints & Claims Manager attends these meetings to provide updates and to answer any queries in relation to complaints.

Care Group Risk Forums are the owners of their action plans, with the Complaints Team monitoring actions to completion.

7. Themes of complaints received within the month



Categories used to capture complaints themes are devised by NHS England for reporting purposes; they are very broad and do not support learning.

Through the 'Learning to Improve' process we are now categorising *actions* arising from complaints; claims; serious incidents (SIs); CQC MHA visits; and safeguarding; to identify more meaningful cross-cutting trends and themes.
The rationale for considering themes from agreed actions is that these will always relate to areas where we have identified learning and improvement actions required.

Main actions identified from complaints closed in June:

- Staff member to reflect on feedback provided by the complainant and in particular, consider for future learning.
- Mental Health Act documentation to be completed correctly, in particular Section 17 leave.
- Team to reflect on their communication, especially when light hearted banter may not be appropriate, and how this can be received by service users.
- Further negotiation at service manager level to improve transport provision for transporting patients between other NHS organisations.
- To ensure that all referral forms are reviewed, prior to invitations being sent for courses, to ensure any adaptations can be made for individuals attending.
- A Trust-wide "Lessons Learnt" email will be sent out reminding staff of the importance of assessing and recording risk for patients following Tribunal hearings. They will be asked to consider history, current presentation and the outcome of the hearing.

Themes from complaints are reported to each Care Group, via the CLIP (Complaints, Litigation, Incidents and PALS) report, for their actions. Themes from actions will also be included in future CLIP reports.

8. Training

Complaints Management Training

Complaints Management training has now been in place since May 2015, with a total of 12 sessions having been delivered to date. A further five training sessions have been scheduled for 2016. Uptake of training continues to rise and a total number of 113 staff have now been trained (with a further 20 staff booked on future training). Training is evaluated after each session with positive comments being received (reproduced as written):

- *"Thankful that there is now some training for complaints. My experience is a matter of "you're a manager now so now it's an expectation that you do it!", without any training. Grateful for this. "Very informative and enjoyable, thank you."*
- *"Clear and enjoyed the training. Pat on the back for both of you! Very helpful!"*
- *"The training has been most helpful. However, I expect I am going to learn lots more during the "process" of investigation. I can't say I'm not apprehensive but I am reassured to know you are available for support throughout. Thanks"*

- 96% of attendees felt that the topics covered in the training course helped them to understand the complaints process better.
- 99% of attendees felt that the content of the training course was organised and easy to follow.
- 88% of attendees felt more confident in investigating a complaint.

Names of those who have completed the training are forwarded to Associate Directors to assist with capacity planning for investigations.

Customer Services Training

Feedback from the Complaints Management training highlighted the need for additional customer service training for front-line support staff (bands 2 to 5). As a result, a Customer Services training package has been developed. A total of eight training sessions have been scheduled for 2016 with the first training session held on 1 July 2016. Training is evaluated after each session with positive comments being received (reproduced as written):

- *"The training was well prepared and relevant to my role. Made it fun and re-enforced expectations."*
- *"Best presentation and interaction during this training than I have experienced for a long time, well done."*
- *"Thank you for the consideration you have given to frontline staff – it's a welcome change and I hope it continues".*
- *"Really enjoyed the training. Would recommend as mandatory for all support staff."*

9. Learning from complaints

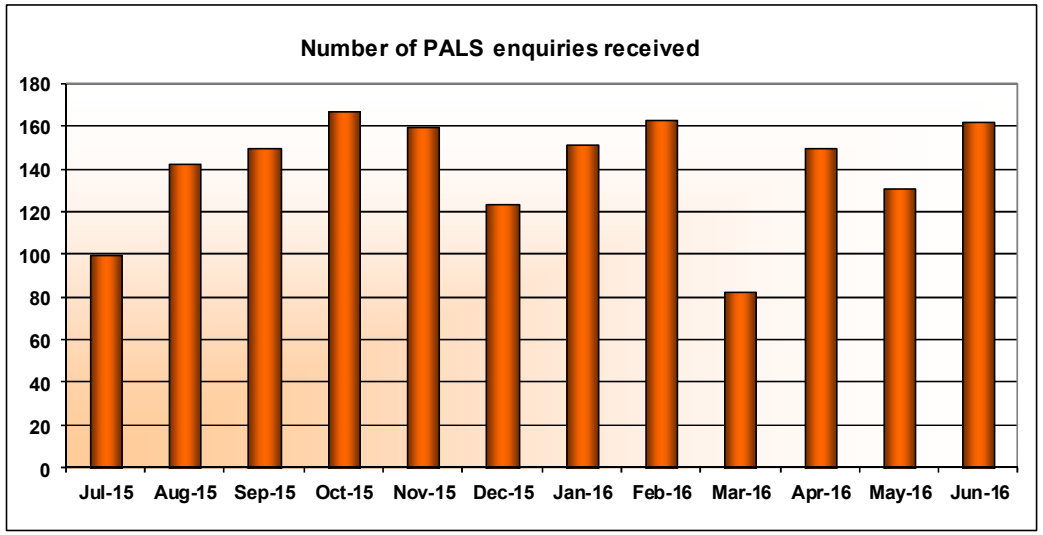
On 8 July 2016 we will hold our second complaints review panel, made up of people with lived experience of mental health services.

The purpose of these meetings is to quality assess a random selection of final response letters (anonymised). Panel members will review the complaints and our final responses, and comment on their view of the impact of the response (have we demonstrated compassion, warmth, responsiveness, openness to learning?). This is a significant new development, aiming to improve the quality of complaints responses. In our first meeting we heard positive comments about the structure of the letters, but concern that one of the letters lacked empathy. We will feed learning from these sessions into complaints training, and where appropriate capture learning in the CLIP report.

Learning from complaints is disseminated through the CLIP report, via Clinical Governance Councils. Learning can also be shared through Lessons Learned bulletins, or through Ward Managers and Community Managers Forums and the Consultants Committee, where appropriate.

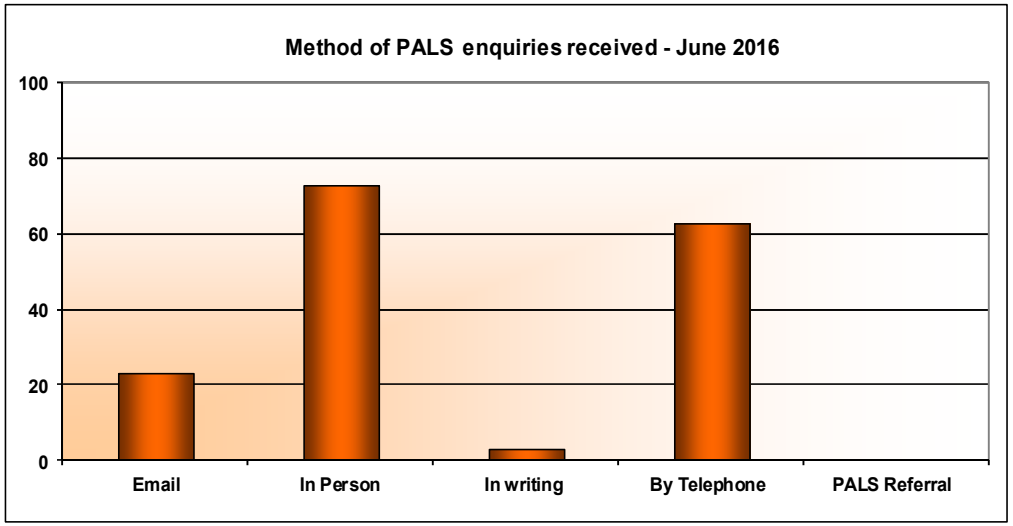
Feedback from complainants is actively pursued and each response letter is accompanied by a feedback form, with a self-addressed envelope. The format of the complaints feedback questionnaire has been revised in line with national best practice. Since April 2015, 27 responses have been received. Feedback broadly indicates that complaint responses are easy to understand; however 66% of responses to date indicated a lack of confidence that the Trust will learn from the complaint. Improving feedback remains a key priority for the PALS & Complaints Manager and we continue to explore ways of improving feedback rates.

10. Number of PALS enquiries received



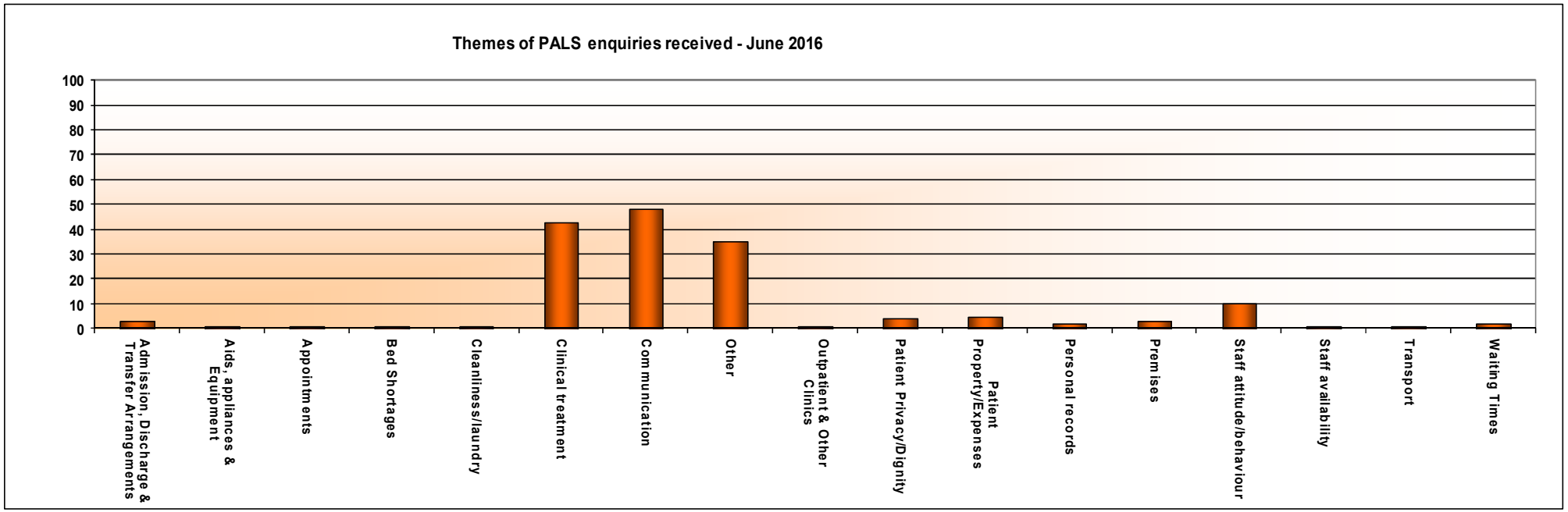
During June 2016, records indicate that there were 162 PALS enquiries. One person accounted for 7% of PALS activity during June 2016.

11. Method of PALS enquiries received



During June 2016 there has been a slight increase in PALS enquiries received in person. This is attributable to the PALS team continuing to visit clinical areas across the Trust.

12. Themes of PALS enquiries received



Of 162 PALS enquiries recorded in June 2016, 30% were categorised as 'communication'. Enquiries that make up the "communication" category include: written information for third party agencies; information on advance statements; and communication issues with clinical staff.

Enquiries that make up the "other" category include: callers wanting telephone numbers for third party agencies; information on the referral process; arranging meetings with ward staff; and general chats regarding their health.

The PALS team liaise directly with services as soon as issues are raised, to secure speedy resolution. As part of our review of data collection and reporting we plan to develop a methodology for routinely capturing whether PALS contacts are meeting service user requirements.

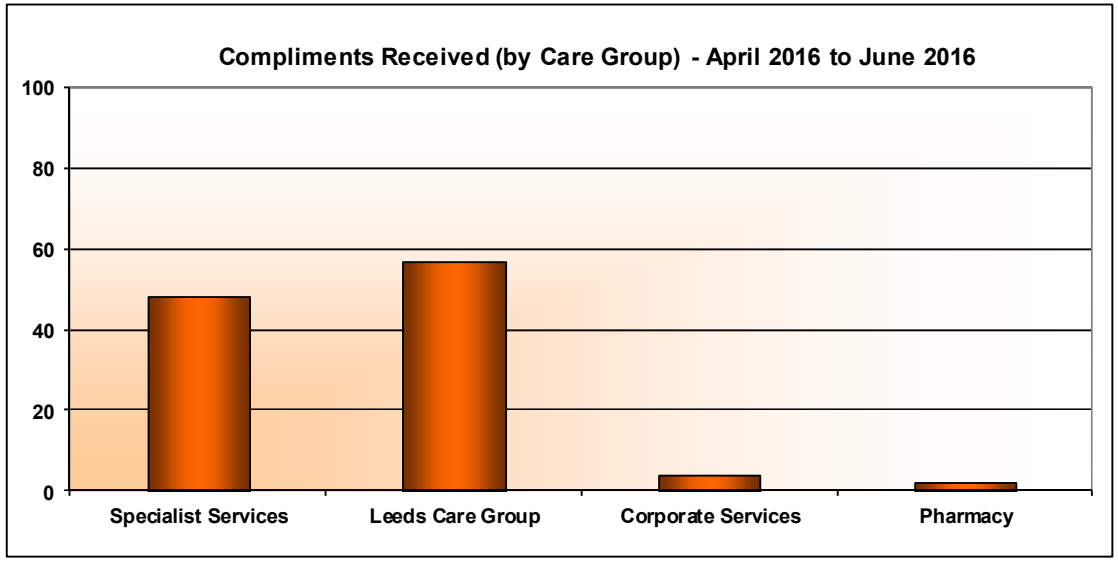
Four of the 162 enquiries resulted in a formal complaint.

13. Compliments Received

Staff often receive compliments by letter or card, verbally or via a gift. They are thanked for treatment, care and support, or complimented on the environment, atmosphere, and cleanliness of the ward. We now have the functionality within DATIXWeb to formally record all of our compliments. There is a link on the Staffnet site (under QuickLinks) where staff are able to report all compliments received (either written or verbally) as well as being able to attach any cards/letters.

Compliments are a key measure of patient experience and we would therefore like to be in a position to consider compliments alongside complaints, aiming to create a stronger patient focus and further develop a culture that learns from feedback.

Since April 2016, 111 compliments were formally recorded in DATIXWeb.



The Complaints team will continually remind all staff to formally record all compliments. This will be done via Trust-wide email communication and through Clinical Governance meetings etc.

Examples of compliments received during the month are:

- *A patient who had been discharged from section returned to the ward some days later to say how pleased he had been with his care and to thank the staff personally. He also made positive comments in a card he provided.*

- *Letter recieved form a patient today prior to her leaving treatment as a planned discharge, from the inpatient service back to Yorkshire Centre for Eating Disorders Community Treatment Service. The letter thanks the Clinical Team Manager, inpatient team and the Operations manager for all their support and advice. She acknowledges how hard staff work and the commitment they have to their patients and the service. She also makes reference to the valuable advice given by the Operations manager in her previous treatment to the ward and how useful this has been in moving forward in her ongoing treatment and her recovery.*

- *Sensible, clear advice provided well to help understand the condition and how best to manage it. Support offered until point it was needed, extending planned sessions to accommodate a change in circumstances.*

- *Compliment received from a Mental Health Social Worker: I wanted to take the time to make you aware of the actions of two of my colleagues and my appreciation of their efforts to rectify a situation that occurred yesterday with one of my clients. One of my Service User's depot was missed for some time as another Trust were supposed to pick it up and they never did, this came to light in a review meeting. Following a discussion (more like a rant) with a member of your team she immediately took charge of the situation, contacted the relevant individuals and got the depot card signed and ordered it. Another member of your staff then offered to give her the depot on the way home from work, which I believe is not in the same direction. I just wanted to thank them both for their efforts and their "can approach" to the situation, I'm not sure if this is recorded anywhere. I know all too often we don't get thanked for the little things that we do, and in this instance it prevented any further delay in my SU receiving her treatment and a possible hospital admission.*

14. Claims Received

A summary of all open claims is shared via the care group CLIP reports to Clinical Governance Councils. Clinical Directors and Associate Directors are informed of any new claims.

Claims scorecards are provided by the NHSLA and are split into coloured zones based on the volume and value of the claims. It is important to note that for this latest scorecard the reporting period is **between 1 April 2010 and 31 March 2015**.

We have queried the £12,016,000 claim on the non-clinical scorecard and NHSLA have confirmed this is an error; and should read £12,016. The error will be investigated by their Informatics team and a revised Claims Scorecard will be sent to the Trust once this error has been rectified.

Clinical Claims Scorecard (data correct at 30 August 2015)

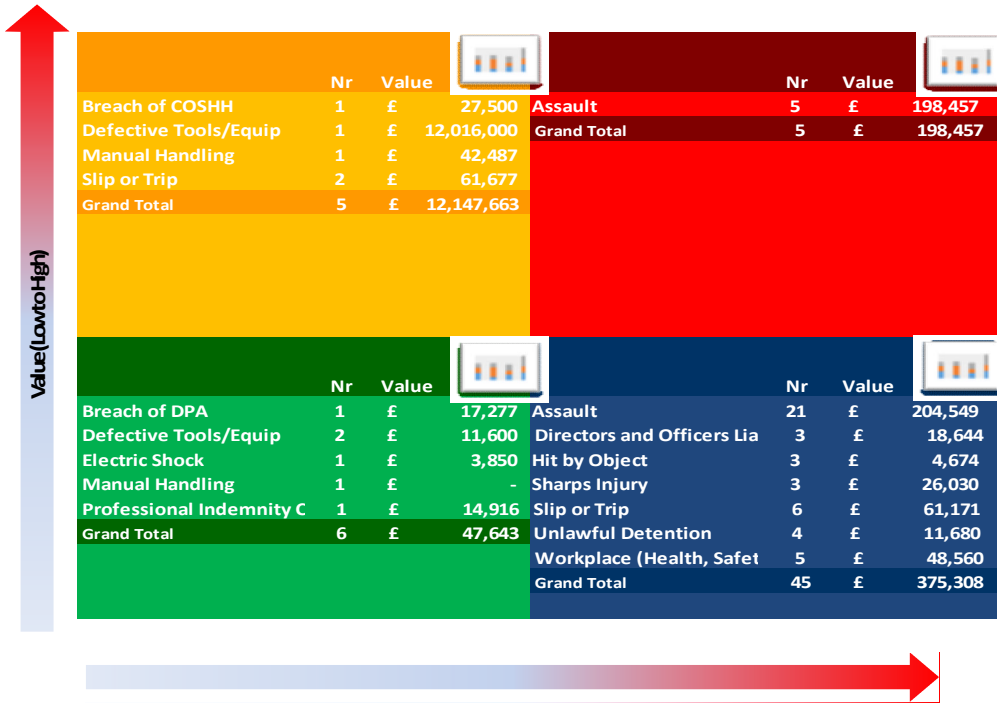
The scorecard shows the number of clinical negligence claims relating to the period 1 April 2010 and 31 March 2015. Nine clinical claims were received in this reporting period, all of which fell into the high volume, low value category. High value is considered at over £1m and high volume over three claims in a specialty.

In total the number of claims for the Trust is nine, with a total value of £423,549.55.

Non-Clinical Claims Scorecard (data correct at 30 August 2015)

The scorecard shows the number of non-clinical claims relating to the period 1 April 2010 to 31 March 2015. The majority of non-clinical claims (by value) were high volume, low value. High value for non-clinical claims is considered at over £25k. High volume is three claims or over of this value.

In total there have been 61 claims. Subject to confirmation of the transcription error from NHSLA we estimate the actual total value to be approximately £765k.



AGENDA ITEM
11

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Responsible Officer and Revalidation Annual report April 2015 - March 2016
DATE OF MEETING:	28 July 2016
LEAD DIRECTOR: (name and title)	Jim Isherwood, Medical Director
PAPER AUTHOR: (name and title)	Gina White, Medical Directorate 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	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)	

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	To provide assurance that there is effective governance to support medical revalidation within the Trust and allow the Responsible Officer (RO) to fulfil their statutory duty.

What are the key points and key issues the Board needs to focus on	The key points to note are:
	
	• At 31 March 2016 there were 99 doctors with a prescribed connection with the Trust.
	• There were nine approved incomplete or missed appraisals reported in the Annual Organisational Audit submitted to NHS England and reported to Board as information on 23 June. The reasons were:
	  ○ Absence health x 2
	  ○ Incomplete – appraisal taken place but forms not returned, doctor now absent x 2
	  ○ Maternity leave
	  ○ New starter x 2
	  ○ No appraisal – new starter who returned to training
	  ○ Returned from career break
	• At 31 March 2016 there were 16 trained appraisers.
	• The appraisal inputs and outputs audit confirmed that the use of the audit template supports quality checks on an ongoing basis that allows timely resolution of queries and feedback as needed to either the doctor or the appraiser.
	• The year-end evaluation of feedback from appraised doctors showed that in the vast majority of instances, our doctors value medical appraisal and the efforts of our medical appraisers.
	• All 42 revalidation recommendations were made on time and there were no non engagement notifications. 39 were positive recommendations, three recommendations were made to defer for the following reasons;
	  ○ new starter having insufficient supporting information
	  ○ doctor returning from a career break
	  ○ doctor on career break
	• An audit of recruitment and engagement background checks highlighted the need to;
	  ○ improve processes for collecting end of placement feedback for agency doctors
	  ○ review the pre-employment to support a consistent approach such as recording the previous RO
	• The audit of concerns about doctors identified 20 doctors with concerns. 8 had a prescribed connection with the Trust, the remainder were trainees. The primary concerns were;

	○ 4 capability (3 doctors in training and 1 Specialty doctor) ○ 4 conduct (3 doctors in training and 1 Consultant) ○ 13 health (6 doctors in training, 4 Specialty doctors and 2 Consultants) • The risk assessment was reviewed at the November MR&A group meeting and accepted. • The 15/16 work plan was completed and ongoing items brought forward to the 16/17 work plan.
What is the Board being asked to consider	The Board of Directors are asked i. to agree that this report provides assurance that there is effective governance to support medical revalidation within the Trust ii. to support the Board Chairman to sign off the statement of compliance (Appendix C) on behalf of the Board for submission to NHS England
What is the impact on the quality of care	The medical revalidation process gives the Trust confidence that its doctors meet their professional standards. In time the requirements of revalidation will develop to drive improvements in quality of care.
What are the benefits and risks for the Trust	The benefit of completing the audits within the Framework of Quality Assurance for Responsible Officers and Revalidation (FAQA) (NHSE Medical Revalidation Programme, April 2014) is the opportunity to improve the system and processes for medical revalidation. In response to the limited functionality of the RO dashboard a procurement exercise is in progress to purchase and implement an e-appraisal system before 1 April 2017 to mitigate the inability to view supporting information for the whole of a revalidation cycle.
What are the resource implications	The cost for 110 doctors is circa £5,500. Improved administration and reporting functionality is expected to create capacity to provide administrative & management support to new Guardian of Safe Working Practices role.
Next steps following this paper being presented to the Board	The statement of compliance will be submitted to NHS England. The medical directorate will implement its 16/17 work plan to further improve the professional management of doctors in the Trust.

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?	The collection of data on missed/incomplete appraisals and recorded concerns allows analysis to take place to identify if there are trends emerging or not.
What public / service user / staff / governor involvement has there been	There has been no public, service user or governor involvement in the completion of this audit. The Trust requires doctors to complete Multi Source feedback including patient feedback every three years whereas the General Medical Council require this to be completed once in a revalidation cycle that usually covers 5 years.
Previous meetings where this report has been considered (including date)	The draft report was presented and agreed at the Medical Revalidation and Appraisal Group on 15 June 2016 and signed off by the Medical Director as Chair of the group prior to submission to the Board.

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. to read and agree this report provides assurance that there is effective governance to support medical revalidation within the Trust
2. to agree the Board Chairman can sign off the statement of compliance (Appendix C) on behalf of the Board for submission to NHS England

*** 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

RESPONSIBLE OFFICER AND REVALIDATION
ANNUAL REPORT APRIL 2015 - MARCH 2016

improving health, improving lives

1. Executive Summary

This Board report has been produced using A Framework of Quality Assurance for Responsible Officers and Revalidation (FAQA) (NHSE Medical Revalidation Programme, April 2014) to inform the content.

At the 31 March 2016 there were 99 doctors with a prescribed connection with the Trust. These doctors are consultant or non-consultant career grades and with the exception of locums approved for service (LAS) training grades does not include doctors in training grades.

Doctors in training grades, with the exception of LAS doctors, have their prescribed connection with Health Education Yorkshire and The Humber (HEY&H). The Trust's Medical Education Manager provides 6 monthly exception reports on trainees working within the Trust and the relevant Associate Medical Director liaises with the HEY&H Responsible Officer where concerns with a trainee doctor are identified until resolved.

In the appraisal year that runs from 1 April 2015 to 31 March 2016, there were 90 appraisals reported as complete in the Annual Organisational Audit (AOA) submitted to NHS England. Section 5 of this report provides the detail of the appraisals not reported as complete.

Issues identified from the AOA and the completion of the templates within the FAQA guidance has been documented into the annual work plan in Section 11.

2. Purpose of the Report

Medical revalidation is a legal requirement which applies to all licensed doctors listed on the General Medical Council (GMC) register in both the public and independent sectors. Its purpose is to improve patient care by bringing all licensed doctors into a governed system that prioritises professional development and strengthens personal accountability.

As a 'designated body' under the Medical Profession (Responsible Officer) Regulations 2010 and 2013 (referred to as the Responsible Officer Regulations) there is a duty to appoint or nominate a responsible officer. These senior doctors must ensure that every doctor connected to the designated body, as set out in the legislation:

i. Receives an annual medical appraisal meeting nationally agreed standards

ii. Undergoes the appropriate pre-engagement/employment background checks to ensure that they have qualifications and experience appropriate to the work performed

iii. Works within a managed system in which their conduct and performance are monitored, with any emerging concerns being acted upon appropriately and to nationally agreed standards

iv. Has a recommendation made to the GMC regarding their fitness to practise every 5 years, on which their continuing licence to practise is based

This report summarises the work taking place within the Trust to provide assurance that the appropriate systems and processes are in place to ensure that each doctor working within the Trust is safe to practise.

3. Background

On 3 December 2012, Medical revalidation was formally launched by the General Medical Council (GMC). It is the process by which all doctors with a licence to practise in the UK will need to satisfy the GMC, at regular intervals that they are fit to practise and should retain their licence. The first cycle of revalidation will take until 2017 to complete.

The Trust has participated fully in the national audits and questionnaires to support readiness for medical revalidation since 2010. An annual report on medical appraisals has been produced for the last five years and they are available on Staffnet.

4. Governance Arrangements

4.1 Management Arrangements

The Trust's Responsible Officer (RO) is Dr Jim Isherwood. In September 2012, Dr Douglas Fraser took up the role of Associate Medical Director for Medical Appraisal and Continuous Professional Development.

Gina White, Medical Directorate Manager continues to provide the day to day management for medical appraisals supported by Josh Bickerstaff, Medical Directorate Administrator since November 2015 when Laura Turner took up the post of Personal Assistant to the Medical Director and Chief Nurse.

Vickie Lovett, Medical Education Manager provides 6 monthly exception reports on trainees working within the Trust to HEY&H and oversees the completion of the annual review of competency progression (ARCP) for doctors in training in conjunction with the relevant Training Programme Directors. The relevant Associate Medical Director for Doctors in training liaises with the HEY&H Responsible Officer where concerns with a trainee doctor are identified until resolved. The doctors in training working in the York services at Specialist trainee year 1-3 are employed by Tees Esk and Wear Valley Foundation Trust (TEWV) on a Lead Employer basis contracted within a service level agreement with TEWV. Specialist trainees year 4-6 are employed directly in keeping with arrangements across the region for this grade of doctor in training. Their input to the York on call is managed as part of the service level agreement. There are regular meetings, with the doctors in training representatives and managers from TEWV involved in medical education. Initially these were monthly to ensure safe transfer and have now reduced to bimonthly.

4.2 Appraisals

The list of doctors with a prescribed connection with the Trust for the purposes of revalidation and requiring an annual appraisal are recorded and managed using the Revalidation Support Team RO dashboard.

Completed appraisals are notified to workforce who plan update Electronic Staff Record (ESR).

4.3 Revalidation Recommendations

The doctors that LYPFT have responsibility for in terms of making revalidation recommendations to the GMC are determined by National policy. These doctors must have a prescribed connection to the Trust. Each month, the Medical Directorate Manager updates GMC Connect (secure partner portal to maintain doctors' prescribed connections) regarding these doctors (including leavers, starters and changes from and to training contracts).

Each month, the MR&A meeting consider the doctors listed by the GMC as under notice for revalidation before the RO makes the recommendation. Doctors due to be revalidated in the forthcoming year are reviewed for any potential issues that would prevent a recommendation to revalidate.

From March 2013, quarterly reports on recommendations made and the outcome have been included in the Board of Directors Performance Report.

4.4 Medical Revalidation and Appraisal Group

There is a Medical Revalidation and Appraisal (MR&A) Group that meets monthly chaired by the RO and attended by Associate Medical Director for Medical Appraisal and Continuous Professional Development, Medical Education Manager, Medical Directorate Manager, Medical Directorate Administrator and Senior Human Resources Manager.

Agendas, minutes of the meeting and terms of reference are available on Staffnet. This group reviews data to support the RO in making his recommendation for a doctor's revalidation. This data may include investigations, health issues and other matters that for reasons of confidentiality require the minutes to be restricted to the group members.

Standing agenda items include revalidation recommendations, recorded concerns and the current year's appraisals.

A summary of the meeting is provided to the Quality Committee.

5. Medical Appraisal

5.1 Appraisal data

The organisation's appraisal year runs from 1st April 2015 until 31st March 2016. The activity reported is from the data supplied in the NHSE Annual Organisational Audit End of Year Questionnaire 2015-16. The submitted questionnaire was provided to the Board of Directors meeting held on 23 June 2016 for information.

At 31 March there were 99 doctors with a prescribed connection with the Trust listed on GMC Connect. This list was used in conjunction with the guidance notes in the Annual Organisational Audit (AOA) End of year questionnaire 2015-16 to provide the data on completed appraisals to populate section 2.1 of the questionnaire.

The categories were

Measure 1a Completed medical appraisal is one where the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*, the outputs have been agreed and signed off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April 2015 and 31 March 2016.

Measure 1b Completed medical appraisal is one where the appraisal meeting has taken place between 1 April 2015 and 31 March 2016, the outputs have been agreed and signed off by the appraiser and the doctor but one or more of the following apply:

- The appraisal did not take place in the window of three months preceding the due date
- The outputs have been agreed and signed off by the appraiser and doctor between 1 April 2015 and 28 April 2016
- The outputs have been agreed and signed off by the appraiser and the doctor more than 28 days after the appraisal meeting

However, in the judgement of the responsible officer the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.

Measure 2 Approved incomplete or missed appraisal is one where the appraisal has not been completed according to the criteria for Measure 1a or 1b but the Responsible Officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or

cancellation in order for it to be counted as an approved incomplete or missed annual medical appraisal.

Measure 3 an unapproved incomplete or missed annual medical appraisal is one where the appraisal has not been completed according to the parameters of either Measure 1a or 1b and the Responsible Officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an unapproved incomplete or missed annual medical appraisal.

The results of the audit by individual doctor were provided to the MR&A meeting held on 18 May. Key points from the audit were:

- The audit found one doctor who no longer had a prescribed connection with the Trust because they had returned to training in February; this doctor has been included in the audit and has now been removed from the GMC Connect list. A summary of the results is provided in the table below.

Grade	No of Prescribed Connections	Measure 1a	Measure 1b	Measure 2	Measure 3
Consultant	63	32	26	5	0
Specialty doctors & Associate Specialists	31	12	17	2	0
Temp or Short term contract holders	5	3	0	2	0
Totals	99	47	43	9	0

- Measure 1b was given for the following reasons:

    - < 1 week after the appraisal due date
    - One week after the appraisal due date
    - < 1 month after the appraisal due date
    - > 1 month after the appraisal due date

    With the following supplementary reasons:

    - Appraiser had to be changed
    - ARCP so no previous due date

- Form not returned with 28 days
- New starter

- Measure 2 was given for the following reasons:

  - Absence health x 2
  - Incomplete – appraisal taken place and forms not returned, doctor now absent x 2
  - Maternity leave
  - New starter x 2
  - No appraisal – new starter and then returned to training
  - Returned from career break

There were six doctors, who are not doctors in training, working within the Trust whose appraisal is the responsibility of another organisation.

5.2 Appraisers

As at 31 March 2016 there were 16 trained appraisers.

Due to retirements and leavers from the organisation, one round of recruitment was planned in June 2015. With the announcement of the York services tender transferring to TEWV the number of appraisers remaining with the Trust was sufficient and there was no need to recruit new appraisers. The application from a doctor transferring to TEWV was passed to the TEWV appraisal lead to progress.

The quarterly appraiser development forums have continued offering ongoing support and development to appraisers. Topics have included ‘How good am I? Self assessment using Excellence Quality Assurance Form’ and ‘Support to challenge’.

Briefing notes from each of the forums are available on Staffnet. The link to the latest briefing note is circulated to all appraisers after each meeting.

5.3 Quality Assurance

5.3.1 Appraisal Portfolio

The completed appraisal documentation is receipted by the Medical Directorate Administrator and the appraisal inputs and outputs audit template from FAQA document is used as a quality check. Completing the audit as the appraisal forms are received was introduced to even out the year-end audit work needing completing. It has meant more documentation is sampled and allows for timely follow up with either the doctor or the appraiser if needed.

When queries arise from audit of appraisal inputs and outputs, the medical directorate manager uses the ‘Excellence’ quality assurance tool to complete a

review of the appraisal. This informs the feedback provided to the appraiser for areas of appraisal practice needing improvement by the AMD for MA & CPD.

New doctors to the Trust or doctors returning from an extended absence appraisal forms are reviewed by the AMD for MA & CPD with a letter summarising findings and advising where necessary improvements or actions that need to be completed by the doctor before the next appraisal. The appraiser receives a copy of this letter.

The audit was presented to the MR&A meeting held on 15 June 2016 and agreed with the conclusion that the use of the audit template supports quality checks on an ongoing basis that allows timely resolution of queries and feedback as needed to either the doctor or the appraiser. The group commended the introduction of the commentary for the gaps in compliance that evidence how the learning from the audit has improved practice and process. An example is provided below.

Audit Question: Scope of work: Has a full scope of practice been described?
Two doctors in the sample had not included the fact that they were appraisers. Appraisers are identified in the appraisal schedule so that they are provided with supporting information related to their appraisal activity in the month before their appraisal.

5.3.2 Individual Appraisers

There is a CPD reflective record available for all doctors to use to document an individual's reflection. Copies are available on Staffnet.

Feedback from doctors who have been appraised is collected via the completion of an e-questionnaire. Doctors are asked to rate their experience based on three areas: the organisation of appraisals, the appraiser and the appraisal discussion. The feedback is provided to the individual appraiser.

The year-end evaluation report of the responses was presented to the MR&A meeting held on 15 June 2016 and the following comments were noted.

- Of the doctors that responded it was an exception when a doctor had rated lower than satisfactory.

- The comments provide valuable insight on the importance of reminding appraisers of the basics of good appraisal as part of the appraiser development forum e.g. an appraiser planning their time for appraisal so that they are well prepared and punctual for the actual meeting, making PDPs meaningful rather than tick box.

- The feedback for the appraisers was extremely positive, with only a couple of specific negative comments which have been addressed directly with the appraisers involved.

- It was good to have supporting evidence to confirm that our doctors value appraisal and believe that the appraisal process enhances their professional development. Where issues have been identified they have been investigated further and appropriate issues addressed.

The group agreed that the report of the full appraisal year provided assurance that, in the vast majority of instances, our doctors value medical appraisal and that the efforts of our medical appraisers are valued by the doctors they have appraised.

As a minimum each appraiser has one appraisal form reviewed using the 'Excellence' quality assurance tool. This informs the recommendations provided in the appraiser's annual review which is provided for inclusion as supporting information for the appraiser's appraisal. The AMD for MA & CPD meets appraisers with consistently low scores on an individual basis to discuss the improvements needed.

5.3.3 Organisation

Learning from the audits and feedback informs improvements to the Trust's medical appraisal system and processes. A monthly appraiser allocation meeting allows prospective and retrospective review of the process to identify and resolve issues as they arise. An example is provided below.

Audit Question: Review of complaints: Have all complaints been included?
One doctor named in complaint but no narrative to confirm whether or not the complaint was reflected upon. Appraiser made aware of need to note in appraisal summary

The e-questionnaire has a specific organisation section which seeks feedback on the management of the appraisal process and access to the necessary supporting information. This confirmed that for the majority of doctors this works well, two doctors raised the quality of the data in their comments. In keeping with such queries made directly to either the medical directorate administrator or manager the doctors are advised to raise the query directly with the relevant department.

Both the audit of inputs and outputs in conjunction with the year-end evaluation report provided assurance to the MR&A group that the Trust's systems and processes are working.

5.4 Access, Security and confidentiality

Section 2.2.3 of the medical appraisal procedure covers issues relating to confidentiality, who has access to the appraisal documentation and the reason.

One doctor continues to request that their appraisal documentation is not reviewed by the Associate Medical Director for MA & CPD because they are colleagues based in the same service team. This request has been

accommodated by the Medical Directorate Manager reviewing the appraisal documentation with the approval of the RO.

There have been no occasions of patient identifiable information being found in appraisal portfolios.

5.5 Clinical Governance

Corporate data provided for appraisal includes the following:

- Compulsory training record
- Clinical activity data
- Clinical Audit
- Significant events and incidents
- Research
- Complaints

The compulsory training record which was provided directly to the doctor each month by the Health Education Support Service the doctor is now able to access directly via the 'iLearn' system. The 'iLearn' system has the additional benefits as it also provides detail on forthcoming expiries and the doctor can click to access e-modules or request a place on classroom based topics.

The Medical Directorate Administrator continues to request and provide the remaining corporate data to the doctor in advance of the doctor's appraisal. This has included supporting information for the doctors that transferred to TEWV.

The Medical Directorate Administrator continues to check that the doctor has not triggered any of the health indicators in the Employee Wellbeing and Managing Attendance procedure and provides the date of the last Multi Source Feedback report that includes patient feedback and when the next cycle needs to be completed.

In addition this year, where a doctor has been named in a defective detention this data has been provided with a specific requirement to reflect as to changes needed to prevent reoccurrence. All doctors have been asked to reflect on the audit completed.

6. Revalidation Recommendations

Revalidation recommendations made in cycle 1 are detailed below.

Year zero	January 2013 to March 2013	1 recommendation made	Recommendation approved
Year one	April 2013 to March 2014	24 recommendations made	24 recommendations approved (22 for revalidation, 2 deferments)

Year two	April 2014 to March 2015	38 recommendations made	38 recommendations approved (37 for revalidation, 1 deferment)
Year three	April 2015 to March 2016	Q1 April to June	22 recommendations approved (22 for revalidation)
		Q2 July to September	11 recommendations approved (8 to revalidate, 3 to defer)
		Q3 October to December	4 recommendations approved (all 4 for revalidation)
		Q4 January to March	5 recommendations approved (all for revalidation)

All 42 recommendations were made on time.

39 were positive recommendations.

Three recommendations were made to defer were for the following reasons

- new starter having insufficient supporting information
- doctor returning from a career break and needing to participate in appraisal
- doctor on career break so not currently able to participate in appraisal

There were no non-engagement notifications.

An audit of revalidation recommendations has not been carried out as revalidation recommendations are considered each month at the Medical Revalidation and Appraisal meeting. The revalidation recommendations are reported on a quarterly basis in the performance report provided to the Board of Directors.

7. Recruitment and Engagement background checks

An audit of recruitment and engagement background checks has been completed using the template in national guidance and presented to the MR&A meeting held on 15 June 2016. The audit highlighted the following:

- For Consultant and Specialty doctors there is a need to improve the process for collecting end of placement including asking the agencies to provide forms for completion in word format as pdfs do not allow basic data of the booking to be added before sending out to the supervising doctor.

- For doctors in training, the administrator responsible was thanked for her diligence in collecting the data given this grade of doctor are often needed at short notice for gaps in the on call rotas.
- Directly employed doctors audit due to turnover in the recruitment team staff was a sample of appointments made. The audit proved its usefulness in identifying parts of the pre-employment process that need to be reviewed to support a consistent approach such as recording the Responsible Officer at the time of recruitment.

GMC have made improvements to the information available on the list of medical practitioners so that it now includes revalidation information which will assist knowing a doctor's Responsible Officer. GMC Connect has also been improved as it now includes a doctor's revalidation history.

8. Monitoring Performance

The performance of all doctors is monitored through the following

- Health

  Absences are reported to line managers via FirstCare. Individuals triggering the health indicators are reported in the workforce reports for support from their line manager. This would include frequent short term absences or an absence in excess of three weeks.

  Absences in excess of two weeks usually necessitate the booking of an agency locum and allow health concerns to be tracked in the MR&A Group.

- Performance (Capability)

  An integrated performance report provided to the Quality Committee by the Risk Management team. The report highlights if there were clusters of incidents and the causes for these would be investigated. Serious incidents trigger a fact find and if the individual member of staff is a doctor the RO would be asked to advise in relation to the application of Maintaining High Professional Standards formal or informal processes.

- Conduct

  Issues relating to behaviour would be managed by the line manager with advice from the Workforce Directorate to ensure appropriate application of Maintaining High Professional Standards. The RO would be informed of issues requiring Workforce Directorate involvement.

9. Responding to Concerns and Remediation

Each month a briefing paper is prepared for the MR&A meeting in conjunction with Workforce managers to report new concerns and progress on concerns being managed.

The audit of concerns template was used to review concerns managed within the appraisal year. The MR&A meeting held on 15 June 2016 considered the results. They were:

- 20 doctors with concerns. 8 had a prescribed connection with the Trust, the remainder were trainees. The primary concern was:
    - 4 capability (3 doctors in training and 1 Specialty doctor)
    - 4 conduct (3 doctors in training and 1 Consultant)
    - 13 health (6 doctors in training, 4 Specialty doctors and 2 Consultants)
- There were no formal remediation cases
- 2 doctors (trainees) were referred to the General Medical Council
- There were no doctors that underwent fitness to practice procedures and had conditions placed on their practice.
- Advice was sought from NCAS with respect to 2 doctors and an NCAS assessment of one doctor was completed

There were no investigations completed by NCAS. There are 13 (16.06.16) Trust based NCAS trained Case Investigators. One case investigation was completed by an internal case investigator.

The RO meets regularly with the GMC Employment Liaison Advisor. This provides an opportunity to discuss issues hypothetically at an early stage or provide updates on the management of cases.

10. Risk and Issues

The risk assessment was reviewed at the November MR&A Group meeting and accepted.

In 15/16, due to the limited functionality of the RO dashboard, a procurement exercise has been progressed to select an e-appraisal system for medical appraisal. The redesign of the national Model Appraisal Form (MAF) in 15/16 has removed the ability to carry forward supporting information for a revalidation cycle. Therefore, the last year this can be used is the 16/17 appraisal year. Purchase and implementation of an e-appraisal system before 1 April 2017 will mitigate the inability to view supporting information for the whole of a revalidation cycle.

11. Corrective Actions, Improvement Plan and Next Steps

The 15/16 development plan was reviewed regularly at the MR&A meeting to ensure progress was made. The work completed has been reported on within this report. A copy is attached as Appendix A.

Work still in progress from the 15/16 plan has been transferred to 16/17 work plan. The plan incorporates work identified from the audits completed to prepare this report. A copy is attached as Appendix B.

12. Conclusion

In the 15/16 appraisal year work was completed to address areas identified to improve the assurance of the quality of medical appraisal. The systems and procedures in place enable appraisals to take place or know when they are not, revalidation recommendations to be made at the appropriate time and concerns to be managed. There is a clear plan for the forthcoming year to sustain this and continue to make improvements.

13. Recommendations

The Board of Directors are asked:

i. to read and agree this report provides assurance that there is effective governance to support medical revalidation within the Trust
ii. to agree the Board Chairman can sign off the statement of compliance attached as Appendix C on behalf of the Board

Gina White
Medical Directorate Manager
30.6.16

Appendix A 15/16 Annual Work Plan

Governance Arrangements					
Guidance Ref	**Issue**	**Action**	**Lead**	**Date for Completion**	**Comments**
	Responsible Officer	Ensure Responsible Officer remains up to date	JI	Mar-16	Complete
		Attend RO Network meetings	JI	Mar-16	Complete
		Attend MH RO & Appraisal Lead N/w meetings	JI	Mar-16	Next meeting 14.3.16 rearranged from January 2016
NHS QA framework	RO Annual Report	Prepare and agree 14/15 annual report to Board	GW	Jul-15	Signed declaration sent to NHSE. Completed
		Prepare and agree 15/16 annual report to Board	GW	Jul-16	
	Numbers of revalidation recommendation	Prepare and agree Performance Report to the Board	GW	Apr-15	Qtr 4 2014/15 information by 17.4.15 Completed
				Jul-15	17.7.15(Qtr 1 2015/16 information)
				Oct-15	5.10.15 (Qtr 2 2015/16 information)
				Jan-16	13.1.16 (Qtr 3 15/16 information)
				Apr-16	6.4.16 (Qtr 4 15/16 information)
		Briefing paper on revalidation recommendations to be provided	GW	Monthly	see meetings folder
		Update GMC Connect	GW	Monthly	on receipt of leaver and starter forms or e-mail notifications
		Validate GMC Connect list to RO Dashboard	JB	Monthly	see meetings folder
	NHSE Reporting	provide quarterly report	GW	May-15	27.5.15 Full year information. Completed
				Jul-15	date tba (Qtr 1 2015/16 information)Accepted NHSE inviatation to only report annually
				Oct-15	date tba (Qtr 2 2015/16 information)Accepted NHSE inviatation to only report annually
				Jan-16	(Qtr 3 15/16 information) Accepted NHSE invitation to only report annually

Appendix A 15/16 Annual Work Plan

				May-16	See May MR&A meeting folder
	Deanery Reporting	provide 6 monthly reports	VL	Apr-15	Completed
				Oct-15	Completed
	Medical Revalidation and Appraisal (MR&A) Group	Complete monitoring	LT	Sep-15	Completed
		Review terms of reference and update as needed	GW	Sep-15	Completed
		Schedule 16/17 meetings	JB	Nov-15	Completed

Medical Appraisal

Guidance Ref	Issue	Action	Lead	Date for Completion	Comments
	Medical Appraisal procedure	Review and Update	GW	Jun-15	
		Consult		Jul-15	JLNC 16.7.15
		Approval		Sep-15	WSG
		Ratification		Oct-15	Quality Committee
		Disseminate		Dec-15	on staffnet
	Exception Audit	Complete NHSE 15/16 annual return	GW	May-16	See May MR&A meeting folder
		Analysis of 15/16 exceptions	GW	May-16	see 16/17 work plan
	Appraisers			Jun-15	Sufficient post transfer of York services
		Recruitment of Appraisers	GW	Jun-16	Agreed in Feb to complete round of recruitment
		Deliver new appraiser training	DF	Jun-16	see above
		Review and update appraiser training needs	DF	Oct-15	Reviewed at ADF - agreed to continue current format
		Review number of appraisers available	GW	Dec-15	Agreed need to recruit Feb 2016
		Appraiser Development Forum (ADF)		19.6.15	Rearranged date due to NCAS training. 1 attended
				15.9.15	5 attended
				13.11.15	1 attended
			DF	9.2.16	3 attended
		Schedule 16/17 ADFs	JB	Oct-15	Complete

Appendix A 15/16 Annual Work Plan

		Provide supporting information on appraiser performance	JB	Monthly	ongoing
	New Starters	Send out appraisal information and request past appraisal documentation	JB	as needed	ongoing
		Book appointments for appraisal orientation	JB	as needed	ongoing
	Existing doctors	Review support needed	DF	Aug-15	No issues identified from MA procedure review
		Obtain and provide supporting information including locums	JB	Monthly	Ongoing
	Staffnet site	Review and update	GW	Nov-15	Current site up to date. Trust approach under review
	Appraisal Evaluation	Issue Questionnaires	JB	On receipt of appraisal documentation	ongoing
		collate evaluation data	JB	Monthly	ongoing
		Report evaluation data		Jun-15	Qtr 4 2014/15 and full year information. Completed
				Sep-15	(Qtr 1 2015/16 information)
				Nov-15	(Qtr 2 2015/16 information)
				Feb-16	Tba (Qtr 3 15/16 information)
			GW	May-16	See 16/17 Work Plan
	Quality Checks	Review appraisal forms on receipt	JB	Monthly	Use NHSE QA Audit tool
		Provide feedback on appraisal	DF	Monthly	Detailed letter to new starters, returners from extended absence, at request of doctor
		Review using recommended QA tool	GW	Monthly	where detailed letter not provided
		Address themes from QC outputs	DF	Monthly	covered at allocation meeting
		Briefing paper to MR&A group	G	Monthly	see meetings folder

Concerns

Guidance Ref	Issue	Action	Lead	Date for Completion	Comments
MHPS	Management of Concerns	Briefing paper to MR&A group	GW	Monthly	see meetings folder
		Complete annual audit	GW	Jun-15	Use NHSE QA Audit tool
		Complete analysis of doctors of concern	GW	Aug-15	Numbers small - not completed

Appendix A 15/16 Annual Work Plan

	Review national guidance available	Arrange for updates to relevant procedures as needed	GW	Aug-15	See 16/17 Work Plan
	Review resources available to support doctors in difficulty	Update staff net and workforce managers	GW	Aug-15	Complete
Employment					
Guidance Ref	**Issue**	**Action**	**Lead**	**Date for Completion**	**Comments**
	Preemployment Checks	Complete audits for			Use NHSE QA Audit tool
		a. Agency Consultants and Specialty doctors	JB	Monthly	ongoing
		b. Agency doctors in training grades	VL	Monthly	delegated to Jayne Wilson, MEC Administrator
		c. Directly employed doctors	AE	Monthly	delegated to Georgina Hill, Head of Recruitment
		Report 14/15 audit data	GW	Jun-15	Complete
		Report 15/16 audit data	GW	Jun-16	See 16/17 Work Plan
	Provision of information on new doctors	Leaver and starter reports provided	AE	Monthly	Delegated to Kay Houlding, Workforce Planning
	Changes in roles	Check on doctors leaving and starting training already within the Trust	GW	Aug-15	Complete
				Feb-16	Complete
	Exit reports	Provision of supporting information to doctors leaving the organisation	JB	Monthly	on request
	End of placement forms	Completed and returned to agency	JB	Monthly	on going
	Local Working Instruction - Agency locums	Review and update as needed	GW	Feb-16	Complete
Medical CPD					
Guidance Ref	**Issue**	**Action**	**Lea**	**Date for Completion**	**Comments**

Appendix A 15/16 Annual Work Plan

	Support for medical practitioners to keep up to date	Complete training need analysis	DF	Oct-15	delegated to Monique Schelhase for Specialty Doctors. Presented to May 16 meeting
		Agree annual programme of CPD	DF	Dec-15	presented to May meeting
	Ensure access to CPD resources	Review reports on CPD taken and spend	DF	Quarterly	Ongoing
		Follow up as necessary	DF		
	Assurance on use of funding received	Provde reports to HEE Y&H		Nov	Complete
			GW	18.4.16	Complete

Other

Guidance Ref	Issue	Action	Lead	Date for Completion	Comments
	E-management system	Develop business case	GW	Sep-15	Agreed in principle by MR&A
		Complete procurement		Sep-16	Demos to be arranged for 22.4.16
					See 16/17 Work Plan

End of Appendix A

Appendix B 1617 Work Plan

Governance Arrangements					
Guidance Ref	**Issue**	**Action**	**Lead**	**Date for Completion**	**Comments**
	Responsible Officer	Ensure Responsible Officer remains up to date	JI	Mar-17	
		Attend RO Network meetings	JI	Mar-17	
		Attend MH RO & Appraisal Lead N/w meetings	JI	Mar-17	
		Nominate or appoint new RO and plan training to meet RO roles as appropriate	JI	Sep-16	New action required due to current RO returning to full-time clinical role.
NHS QA framework	RO Annual Report	Prepare and agree 15/16 annual report to Board	GW	Jul-16	
		Prepare and agree 16/17 annual report to Board	GW	Jul-17	17/18 Work plan
	Numbers of revalidation recommendations	Prepare and agree Performance Report to the Board	GW	Apr-16	6.4.16 (Qtr. 4 15/16 information)
				Jul-16	
				Oct-16	
				Jan-17	
				Apr-17	
		Briefing paper on revalidation recommendations to be provided	GW	Monthly	
		Update GMC Connect	GW	Monthly	
		Validate GMC Connect list to RO Dashboard	JB	Monthly	
	NHSE Reporting	provide quarterly report	GW	May-16	End of year
				Jul-16	Q1
				0ct 16	Q2
				Jan-17	Q3
				May-17	Year end
	Deanery Reporting	provide 6 monthly reports	VL	Apr-16	
				Oct-16	
	Medical Revalidation and	Complete monitoring	JB	Sep-16	
	Appraisal (MR&A) Group	Review terms of reference and update as needed	GW	Oct-16	
		Review risk assessment	GW	Nov-16	
		Schedule 17/18 meetings	JB	Nov-16	

Appendix B 1617 Work Plan

Medical Appraisal

Guidance Ref	Issue	Action	Lead	Date for Completion	Comments
	Medical Appraisal procedure	Review and Update	GW		b/f to 18/19 work plan unless review earlier indicated (cross ref to E-Appraisal system)
		Consult			
		Approval			
		Ratification			
		Disseminate			
	Exception Audit	Complete NHSE 15/16 annual return	GW	May-16	See May MR&A meeting folder
		Analysis of 15/16 exceptions	GW	Jun-16	
	Appraisers	Recruitment of Appraisers	GW	Jun-16	
		Deliver new appraiser training	DF	Jul-16	
		Review and update appraiser training needs	DF	Oct-16	
		Review number of appraisers available	GW	Dec-16	
		Appraiser Development Forum (ADF)	DF	13.5.16	
				6.9.16	
				25.11.16	
				tba	
		Schedule 17/18 ADFs	JB	Oct-16	
		Provide supporting information on appraiser performance	JB	Monthly	
	New Starters	Send out appraisal information and request past appraisal documentation	JB	as needed	
		Book appointments for appraisal orientation	JB	as needed	
	Existing doctors	Review support needed	DF	tba	Link to implementation of E-appraisal system
		Obtain and provide supporting information including locums	JB	Monthly	
	Staffnet site	Review and update	GW	tba	Current site up to date. Trust approach under review. Link to implementation of e-appraisal system

Appendix B 1617 Work Plan

	Appraisal Evaluation	Issue Questionnaires	JB	On receipt of appraisal documentation	ongoing
		collate evaluation data	JB	Monthly	ongoing
		Report evaluation data		Jun-16	Q4 & 15/16 full year
				Sep-16	(Qtr. 1 2016/17 information)
				Nov-16	(Qtr. 2 2016/17 information)
				Feb-16	(Qtr. 3 2016/17 information)
			GW	Jun-16	(Qtr. 4 2016/17 information) & full year
	Quality Checks	Review appraisal forms on receipt	JB	Monthly	Use NHSE QA Audit tool
		Provide feedback on appraisal	DF	Monthly	Detailed letter to new starters, returners from extended absence, at request of doctor
		Review using recommended QA tool	GW	Monthly	where detailed letter not provided
		Address themes from QC outputs	DF	Monthly	covered at allocation meeting
		Include issues on briefing paper to MR&A group	GW	Monthly	see meetings folder

Concerns

Guidance Ref	Issue	Action	Lead	Date for Completion	Comments
MHPS	Management of Concerns	Briefing paper to MR&A group	GW	Monthly	see meetings folder
		Complete annual audit	GW	Jun-16	Use NHSE QA Audit tool
		Complete analysis of doctors of concern	GW	Jul-16	
	Review national guidance available	Arrange for updates to relevant procedures as needed	GW	May-16	
	Review resources available to support doctors in difficulty	Update Staffnet and workforce managers	GW	Aug-16	

Employment

Guidance Ref	Issue	Action	Lead	Date for Completion	Comments
	Preemployment Checks	Complete audits for			Use NHSE QA Audit tool
		a.Agency Consultants and Specialty doctors	JB	Monthly	ongoing
		b. Agency doctors in training grades	VL	Monthly	delegated to Jayne Wilson, MEC Administrator

Appendix B 1617 Work Plan

		c.Directly employed doctors	AE	Monthly	Iain Hoyles, head of Recruitment briefed & audit form sent
		Report 15/16 audit data	GW	Jun-16	
		Report 16/17 audit data	GW	Jun-17	17/18 work plan
	Provision of information on new doctors	Leaver and starter reports provided	AE	Monthly	Delegated to Kay Houlding, Workforce Planning
	Changes in roles	Check on doctors leaving and starting training already within the Trust		Aug-16	
				Oct-16	
			GW	Feb-17	
	Exit reports	Provision of supporting information to doctors leaving the organisation	JB	Monthly	
	End of placement forms	Completed and returned to agency	JB	Monthly	
	Local Working Instruction - Agency	Review and update as needed	GW	Nov-16	links with review of Temporary staff procedure

Medical CPD

Guidance Ref	Issue	Action	Lead	Date for Completion	Comments
	Support for medical practitioners to keep up to date	Complete training need analysis	DF	May-16	Consultants 16/17 TNA
		Complete training need analysis for 17/18	DF	Dec-16	
		Agree annual programme of CPD	DF	Jan-17	
	Ensure access to CPD resources	Review reports on CPD taken and spend	DF	Quarterly	
		Follow up as necessary	DF		
	Assurance on use of funding received	Provide reports to HEE Y&H		Jun-16	Meeting with HEE Y&H Specialty Dr Lead
				Nov-16	
			GW	Apr-17	

Other

Guidance Ref	Issue	Action	Lead	Date for Completion	Comments
	E- appraisal system	Complete procurement	**GW**	Sep-16	Demos held 22.4.16
		Implementation		Mar-17	

End of Appendix B

Appendix C RO&RAR Statement of compliance

Leeds and York Partnership NHS
NHS Foundation Trust

Designated Body Statement of Compliance

The Board of Directors of Leeds and York Partnership NHS Foundation Trust can confirm that the Medical Revalidation and Appraisal group have carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

Comments:
James Isherwood was appointed as Medical Director/Responsible Officer in September 2012 and has completed RO training and ongoing CPD for this role.

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

Comments:
Responsible Officer and Revalidation Annual Report section 4 Governance Arrangements provides supporting narrative.

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

Comments:
Responsible Officer and Revalidation Annual Report section 5.2 Appraisers provides supporting narrative.

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

Comments:
Responsible Officer and Revalidation Annual Report section 5.3 Quality Assurance provides supporting narrative.

5. All licensed medical practitioners either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

Comments:
Responsible Officer and Revalidation Annual Report section 5.2 Appraisers provides supporting narrative.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

Comments:
Responsible Officer and Revalidation Annual Report sections 5.3 Quality Assurance and 5.5 Clinical Governance provide supporting narrative.

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Comments:
Responsible Officer and Revalidation Annual Report section 8 Monitoring Performance and Section 9 Responding to Concerns and Remediation provides supporting narrative.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments:
There is a standard template letter that is used to request supporting information when a doctor with a prescribed connection works with other organisations. The RO to RO information transfer form was reviewed and agreed for use at the medical revalidation and appraisal group meeting on 18 February 2014.

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners have qualifications and experience appropriate to the work performed; and

Comments:
Responsible Officer and Revalidation Annual Report section 7 Recruitment and background checks provides supporting narrative.

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments:
Responsible Officer and Revalidation Annual Report section 11 Corrective Actions, Improvement Plans and next steps provides supporting narrative along with copies of completed 15/16 work plan and 16/17 work plan.

Appendix C RO&RAR Statement of compliance

Signed on behalf of the designated body

Name: Frank Griffiths Signed: _ _ _ _ _ _ _ _ _ _

[Trust Chairman]

Date: _ _ _ _ _ _ _ _ _ _

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:	Operational Plan Implementation Quarter 1 Report
DATE OF MEETING:	28 July 2016
LEAD DIRECTOR: (name and title)	Lynn Parkinson, Interim Chief Operating Officer
PAPER AUTHOR: (name and title)	Richard Wall, Associate Director of Strategy & Partnerships

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)					
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	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 first report of 2016/17. The summary includes an overview of our Operational Plan, and highlights any objectives that have not been achieved in the first quarter. Where applicable a brief description of the challenge and actions that will be taken is highlighted. 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 one 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.
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 the 19th July 2016

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 progress made against our Operational Plan priorities at the end of quarter one 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 1 REPORT

1. Purpose

This report provides a summary of the Trust's progress against our objectives within our 2016/17 Operational Plan, and the strategically significant projects monitored via the Programme Management Office.

This is our first 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.

2. 2016/17 Operational Plan status summary

We have now assessed ourselves against our first quarter targets as set out within our 2016-17 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 a scheme has not achieved its milestones at the end of quarter one these have been rated as red (including unmet first quarter performance target trajectories).

For the schemes where we are behind on delivering against key milestones at the end of quarter one but a clear plan is in place to be back on track by the end of the second quarter, these schemes are rated as amber. A green rating has been applied to one year schemes which have been delivered and/or are on track for delivery by the end of March 2017.

At the end of quarter one all of our schemes set out in the 2016/17 Operational Plan are underway. We have also fully delivered one of our one-year schemes:

- **Pharmacy service:** At the end of the first quarter we have successfully implemented an in-house extended pharmacy service. This includes seven day working and an in-house 24/7 on call service.

At the end of the first quarter we have assessed all schemes in order to report on those we know are amber or red. There are four schemes that are reporting as red at the end of quarter one. Details of these schemes are:

- **CQC fundamental standards (appraisal and compulsory training):** The appraisal and compulsory training target of 90% has not been achieved and was at 85% at the end of quarter one. The Learning and Organisational Development team are working with service leads to devise departmental plans to achieve compliance and we expect to achieve the target in quarter 4.

- **Staff engagement:** The work underway to fully Implement and embed the new Intranet was originally scheduled to be completed at the end of September. Unfortunately, some delays

to the design have put this back towards the end of October. This in the main is due to the active directory capabilities which provide the source in which accurate staff information is made available. This is an important aspect of the intranet, specifically relating to the accuracy of data and the management of permissions. Solutions for how this is resolved are underway, however it is envisaged that the implementation will now take place in October (quarter three).

- **Mental health payments:** We have not achieved our mental health payment system trajectory target of 95% at the end of quarter one (June 86.5%) for the percentage of people receiving care and treatment who are allocated a 'care cluster'. This project has now been deemed to be business as usual and will be performance managed by the Care Services Performance, Information & Capacity Group. A Project Closure Report has been prepared and will be submitted to the Executive Team for ratification during quarter two.

- **Finance and contracting:** The Trust has adopted a very robust approach to developing 2016/17 cost improvement plans, taking into account 2% (£2.7m) national efficiency assumptions. As at quarter one 2016/17 the CIP position is £0.08m behind plan, this equates to a 17% shortfall.

At the end of quarter one there are seven schemes that are reporting as amber. Details of these schemes are:

- **New Clinical service developments:** Commencing and scoping of the CFS/ME (chronic fatigue) review and rebranding has been delayed until quarter two. Plans are in place to undertake this work to ensure a new rebranded service including improved access is in place before the end of March 2017.

- **Regional/ specialist strategic developments and partnerships:** 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. The development of the Memorandum of Understanding has begun but not yet been finalised, however it is envisaged that this will be completed during quarter two.

- **Workforce planning:** Work to source a new workforce planning tool has been delayed due to the decision to explore other alternatives in addition to the Calderdale Framework. An options appraisal outlining the solutions available will be discussed by the Executive Team in early quarter two.

- **New clinical service developments:** The contract with Turning Point to provide input into Garrow House tier 4 personality disorder service is in place until April 2017. Recruitment to all posts is complete with the exception of a Consultant Psychiatrist post which is currently out to advert. It is envisaged that this post will be filled during quarter two.

- **Outcomes:** The Patient Reported Outcome Measure (PROM) is not being offered routinely and consistently across the Trust, with the PROM implementation plan still continuing to be rolled out including outcomes user guide, leaflets and posters to service areas. In addition, we have not achieved the Clinical Reported Outcome Measure (CROM) target 90%, (87.2% achieved), for people in and out of scope of mental health payments. Further CROM options have been agreed by clinical improvement forums and professions groups with an improvement plan being developed.

  Moreover, discussions and proposals are to be finalised regarding the future plans to deliver the Recovery Programme across LYPFT and the resources to support this. The care pathways element of the project is now completed and the Project Closure Report has been developed and will be ratified during quarter two.

- **Promoting the Trust:** During quarter one we have selected and appointed a media monitoring agency to undertake routine reporting. Regrettably, the six month trial with the agency has not yet begun, however this will be commencing during quarter two.

- **Information technology/mHabitat:** At the end of 2015/16 the four mHabitat digital developments had been delivered. During quarter one funding host discussions have been taking place with a view to developing a proposal for mHabitat to become a subsidiary company. With these developments taking place we have agreed to close the project down with the Project Closure Report being ratified during quarter two.

  During quarter one the evaluation of the WIFI trial at The Mount has been successfully completed. The evaluation of the WIFI trial for cross-city council premises is yet to take place and it is envisaged that this would be undertaken during quarter two. Furthermore, work is underway to compile a new Health Informatics Strategy and further stakeholder consultation is scheduled to take place in September.

3. Delivery of our 2016/17 Cost Improvement Plans

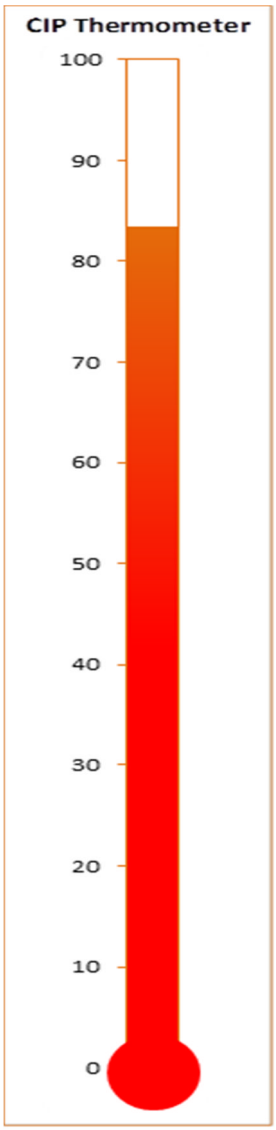
Major cost improvement plans (CIPs) identified as part of our Operational Plan are managed as formal programmes or projects and adhere to MSP/PRINCE2 methodology. All our CIPs for 2016/17 have been quality and delivery impact assessed, with the CIP proforma being completed for each individual scheme.

In 2016/17 as part of our ongoing rolling programme to identify transformational service change as well as incremental opportunities for efficiency we identified £2.094m of achievable cost savings and £0.25m revenue generation opportunities. In order to achieve the national efficiency target of 2% a further planned cost saving of £0.411m is to be identified in year.

As at quarter one 2016/17 the CIP position is £0.08m behind plan, this equates to a 17% shortfall.

Whilst a number of potential initiatives have been identified they are not yet delivering efficiencies in quarter one, resulting in a £41k year to date shortfall. Further recurrent efficiencies need to be identified in year to avoid impacting on the underlying financial position of the Trust.

Delayed implementation of skill mix savings in the Leeds Care Group (£11k) and specialist Care Group (£20k) is contributing £31k to the CIP shortfall position as at quarter one.



4. 2016/17 Operational Plan risks and Strategic Risks

At the end of quarter one we have one risk recorded on the electronic risk register. This relates to the compulsory training project which aim is to achieve the 90% compliance target by the end of 2016/17 and is currently scored as 'high'. All risks are monitored routinely via the individual project group meetings, Executive Team on a monthly basis and are recorded on the operational/local risk register. No project risks are recorded as extreme.

The Trust's strategic risk register is provided at appendix 2 and includes a number of high risk items with one current extreme risk related to delayed transfers of care.

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 one 2016/17; and confirm that they are assured of progress being made to address areas for improvement.

APPENDIX 1 – OPERATIONAL PLAN PROGRESS DASHBOARD AT Q1 2016/17

Operational Plan scheme dashboard		*	PMO reported project	
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**			
1.4.1	Mental health payments *			
1.4.2	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)**			
2.2.1	Implement MH Urgent Care Vanguard plans with other West Yorkshire providers			

Operational Plan scheme dashboard		*	PMO reported project
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 Q1 2016/17

Strategic risks as of 14/07/16

ID	Care Group	Title	Description	Controls in place	Risk level (initial)	Risk level (CURRENT)	Risk level (Residual)
2	Professions and Quality - Corporate	Care Quality Commission compliance actions	Failure to meet deadlines for implementation of agreed procedures/systems and improvements for all compliance actions notified to CQC	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 Jackson using an audit action tracker.	High Risk	High Risk	Moderate Risk
3	Finance - Corporate	Deterioration in financial standing of Trust	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 absorb 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.	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 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	Extreme Risk	High Risk	Moderate Risk

ID	Care Group	Title	Description	Controls in place	Risk level (initial)	Risk level (CURRENT)	Risk level (Residual)
				budget holder training in place Financial modelling and forward forecasting in place to identify risks early			
5	Workforce Development	Workforce not equipped or sufficiently engaged to deliver new models of care.	Requirement for new skills in the workforce to support new models and also lack of staff engagement and involvement in the new models.	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 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	High Risk	High Risk	Moderate Risk

ID	Care Group	Title	Description	Controls in place	Risk level (initial)	Risk level (CURRENT)	Risk level (Residual)
9	Facilities (Finance)	Providing services from premises that are not in direct ownership of Trust	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)	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	Extreme Risk	Moderate Risk
58	Clinical Services (for Risk Management Dept use Only)	Increasing number of vacancies in Care Services	High number of vacancies in Care Services (Clinical staff)	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	Extreme Risk	High Risk

ID	Care Group	Title	Description	Controls in place	Risk level (initial)	Risk level (CURRENT)	Risk level (Residual)
96	Leeds Mental Health Care Group	High percentage of beds occupied by patients clinically fit for discharge	Service users cannot be discharged in a timely way due to reduction in local authority budgets and availability of suitable placements leading to lack of appropriate social care support and placements	Bed Capacity and OAT plan in place in Leeds care group to address and improved acute inpatient flow. Complex later life (older peoples) project in place to address dementia and older peoples bed capacity LYPFT attendance at citywide system flow and system resilience meetings to raise capacity issues and impact of local authority reduced funding. Citywide escalation of bed pressures through REAP reporting. S75 agreement with Leeds City Council to progress integration of services and achieve optimal use of resources to support mental health and LD service users. Review of S75 underway with Leeds City Council. The purposeful inpatient admission process has been implemented on all inpt acute ward and is being rolled out to older peoples wards	Extreme Risk	Extreme Risk	High Risk
105	Health Informatics Services (Finance)	Cyber Attack	The danger of a cyber-attack to the Trust's ICT infrastructure through malicious hacking or system virus infection.	The ICT infrastructure has firewalls, virus protection software and e-mail protection systems that are continually updated to prevent attack. A working programme to improve our awareness and response to threats is in progress.	High Risk	High Risk	Moderate Risk

ID	Care Group	Title	Description	Controls in place	Risk level (initial)	Risk level (CURRENT)	Risk level (Residual)
115	Professions and Quality - Corporate	Fundamentally Defective Detentions	Failings in systems and processes have arisen and the Trust is currently not assured of the legality of detentions/ restrictions under the Mental Health Act.	A detailed responsive action plan has now been fully implemented, with further assurance of progress being provided by a re-audit of files and a peer review of systems and processes. The Mental Health Legislation Operational Steering Group has monitored progress and has confirmed in July 2016 that it is assured that significant improvements have been made in Mental Health Legislation systems and processes; that these improvements are still bedding in and will result in enduring and systemic quality improvements.	Extreme Risk	High Risk	Moderate Risk
128	Finance - Corporate	Inability to agree long term estate strategy and optimum use of estate	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.	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	High Risk	Moderate Risk

ID	Care Group	Title	Description	Controls in place	Risk level (initial)	Risk level (CURRENT)	Risk level (Residual)
156	Workforce Development	Failure to achieve 90% compliance KPI with Compulsory Training	The Trust has a ratified Compulsory Training Procedure and a Trust Board KPI of achieving 90% compliance against all compulsory training specified in this procedure. The Trust is not achieving this target with compliance currently standing at 85%. This risk was recorded on the previous risk register for the Trust and has been since 2010.	- 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	Extreme Risk	High Risk	Moderate Risk

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:	**Trust Strategy Refresh**
DATE OF MEETING:	28 July 2016
LEAD DIRECTOR: (name and title)	Jill Copeland Interim Chief Executive
PAPER AUTHOR: (name and title)	Richard Wall Associate director of strategy and partnerships

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)	

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	This paper provides an overview of the process and journey to date of our strategy refresh project and what we have learnt from our two rounds of online crowdsourcing from April to June. The focus of the paper is how we have co-created our vision, and framework of behaviours and values and the next steps we need to consider.
What are the key points and key issues the Board needs to focus on	The Board is asked to consider the process and the results achieved to date. Importantly, members of the Board are asked to reflect upon what has been co-created by staff and stakeholders; make any changes that they feel are required; and then offer staff the opportunity to validate the final vision, values and behaviours.
What is the Board being asked to consider	The Board is specifically being asked to consider the proposed Vision, Values and Behavioural Framework. The Board also needs to consider the emerging strategic objectives and how these may align with the implications of the Sustainability and Transformation Plans (STPs).
What is the impact on the quality of care	Our strategy, and the Your Voice Counts engagement process to co-create the vision, values and behaviour, is a fundamental part of ensuring we continue to deliver high quality care.
What are the benefits and risks for the Trust	Having a well engaged and concise strategy ensures that the Trust has an engaged workforce; that there is clarity over the Trust's future vision; and that service users, carers, and external stakeholders are clear about our direction and what we are aiming to deliver.
What are the resource implications	The creation of the strategy and process to develop it has been agreed and resourced. Workforce, estates, and other considerations will be developed as the strategy is finalised.
Next steps following this paper being presented to the Board	The Board is being asked to consider and agree the vision, values and behaviours. The Board is also being asked to consider leadership of the next steps, and how developments will align with the STPs.
What are the reputational implications and how will these be addressed	Not applicable
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	No
What public / service user / staff / governor involvement has there been	Substantial stakeholder engagement through the crowdsourcing process and Governor leadership of the process has been a significant part of the development to date.

Leeds and York Partnership NHS
NHS Foundation Trust

Previous meetings where this report has been considered (including date)	The Council of Governors on 26 July 2016.

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. Note the work to date developed by the Strategy Development Group and facilitated by Clever Together.
2. Note the Strategy Refresh Journey appendix and the steps to developing the Vision and Values.
3. Consider and agree next steps in approving the proposed Vision and Values, taking into account the views of the Council of Governors.
4. Note the emerging strategic objectives and how these need to be consistent and considered against the STP implications.
5. Consider and recommend next steps and senior leadership.

*** 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).

Trust Strategy Refresh

1. Introduction

We can see that national and local policy relating to both the NHS and the future of mental health and learning disability services is changing. We also know that traditional approaches to how care and support are delivered, and the way the system operates, also need to change. It is clear that staff in organisations providing physical, mental health and social care services (in the statutory and third sectors) need to work much more closely together to ensure that people's needs are met more effectively.

The recent Sustainability and Transformation Plans for both West Yorkshire and Leeds highlight the above points in some detail. The West Yorkshire STP focuses on work that is best done at a macro level and across wider geographic footprints, whilst the Leeds plan highlights the intent to integrate services around the needs of people at a primary/community population level. The challenge for the Trust is to understand these changes and to be in a position to respond effectively, share our expertise, and collaborate across a changing health and social care system.

Our strategy development is about our collective place within this new system and how we will lead a vision for improvement that is co-created with service users, carers, staff and stakeholders. To do this we have set out to:

- first, imagine the impact we could have together if everything we did was outstanding;
- second, agree the expectations we should have for ourselves and each other; and
- third, develop a shared plan for how we can make our vision a reality.

2. The Strategy Refresh Project

The attached appendix is a summarised version of the strategy development to date which has been facilitated by our partners Clever Together, who have led a two-stage online crowdsourcing process running from April to June 2016. There has been a significant amount of interest and engagement in the process with over 600 stakeholders sharing 6,419 contributions. This has consisted of 403 ideas, 1,750 comments, and 5,245 votes. The discussions have been lively and have led to the co-creation of a vision and values, and a supporting behavioural framework.

3. Our Vision and Values

We are now at a point of seeking approval for the new Vision and Values.

Our proposed vision is:

Our vision
We want everyone to live in communities that are healthy and happy, with no stigma attached to mental ill health or learning disabilities. We want our Trust to be staffed by healthy and happy people, working as one team with the communities we serve, to support those with mental ill health or learning disabilities to achieve their personal goals.

Our proposed values and their underpinning behaviours are:

Our values	Behaviours you can expect from staff
We have integrity We treat everyone with respect and dignity, honour our commitments and do our best for our service users and colleagues.	• I consider the feelings, wishes and rights of others and am committed to continuously improving what we do. • I give positive feedback as a norm and constructively challenge unacceptable behaviour. • I work in partnership with service users and colleagues and I am open and transparent in the actions I take and the decisions I make**.**
We are caring We always show empathy and support those in need.”	• I make sure people feel I have time for them when they need it. • I listen and act upon what people have to say. • I talk to people in a kind tone of voice.
We keep it simple “We make it easy for the communities we serve and the people who work here to achieve their goals.”	• I make processes as simple as possible. • I avoid jargon and make sure I am understood. • I am clear what my goals are and help others to achieve their goals.

3. Our emerging Strategic Objectives

Following the creation of the vision and values, a further 1,722 ideas, comments and votes were shared in the online workshops by staff and stakeholders in response to the question “What should we stop, start or do differently to improve our Trust and achieve our vision?” and “Do you have other ideas to improve our Trust?”

The analysis of these contributions has highlighted six emergent strategic objectives and potential work-streams to support their delivery. These include:

Our People	To be recognised as providing a dynamic, rewarding and supportive workplace
Our Partnerships	To be recognised as a Trust where our people work as one team with each other and the communities
Our Services	To be recognised as a provider of excellent, caring, truly person-centred care.
Our Premises and Facilities	To be recognised as a Trust with effective premises and facilities.
Our Quality and Governance	To be recognised as a transparent and accountable Trust that is steered by its service users and staff and that meets or exceeds all relevant guidelines and measures.
Our IT, Systems and Finance	To be recognised as financially sustainable Trust with great systems.

4. Issues and Considerations

The Your Voice Counts programme has been a resounding success as a tool for engaging staff and stakeholders. The number of contributions and comments has been overwhelming and there has been a clear surge in how staff and stakeholders have engaged when compared to previous engagement processes. Beginning slowly at first, we saw how the Interim Chief Executive Jill Copeland's listening events and blogs created interest and a sense of staff feeling listened to and engaged. Having this visible leadership has led to the co-creation of our vision and values framework and we need to ensure this momentum is continued and develops as we look to finalise our strategic objectives.

Our emergent strategic objectives must be aligned and will need to be intrinsically linked to those of the West Yorkshire and Leeds STP. The implications of the STP will present options for the Trust which our staff, service users and partners will need to be aware of, and contribute to.

5. Next Steps

We are communicating to staff through the July payroll a summary of what we have achieved to date which will highlight our proposed vision, values and behaviours. Members of the Council of Governors have helped lead the development of the strategy and have had an opportunity to review this paper on 26 July 2016, just prior to Board. The next steps for the Board of Directors are to: consider feedback from the Council of Governors; reflect upon what has been co-created by staff and stakeholders; make any changes that they feel are required; and then offer staff the opportunity to validate the final vision, values and behaviours.

The Vision and Values provides a foundation in which the rest of the Trust strategy will be developed. Our next steps will be to seek approval to launch the final version of our vision and values, whilst agreeing and setting out a process in which our emerging objectives can be developed within the context of our future direction.

6. Recommendations

The Board of Directors is asked to:

1. Note the work to date developed by the Strategy Development Group and facilitated by Clever Together.

2. Note the Strategy Refresh Journey appendix and the steps to developing the Vision and Values.

3. Consider and agree next steps in approving the proposed Vision and Values, taking into account the views of the Council of Governors.

4. Note the emerging strategic objectives and how these need to be consistent and considered against the STP implications.

5. Consider and recommend any views and suggestions relating to next steps and senior leadership.

Strategy Refresh Project

Your Voice Counts online conversation journey and report

28th of June, 2016

Clever Together
change@clevertogether.com

Leeds and York Partnership NHS
NHS Foundation Trust

your VOICE counts

clevertogether

Our journey to date

Our strategy refresh project involved two rounds of crowdsourcing throughout April, May and June.

APRIL	MAY	JUNE	JULY

1st online workshop

20 /04 – 11/05
Co-create vision and framework of behaviours and values.

23/05 – 30/05
Enhance and validate new vision and framework of behaviours and values.

2nd online workshop

07/06 – 22/06
Co-create 5 Year Plan
What should we stop, start, do differently to achieve our vision and improve our Trust?

Write-up and submit

07/06 – 08/07
Write-up:

- Report
- Strategy on a page
- Submit outline strategy to Board.

Leeds and York Partnership NHS
NHS Foundation Trust

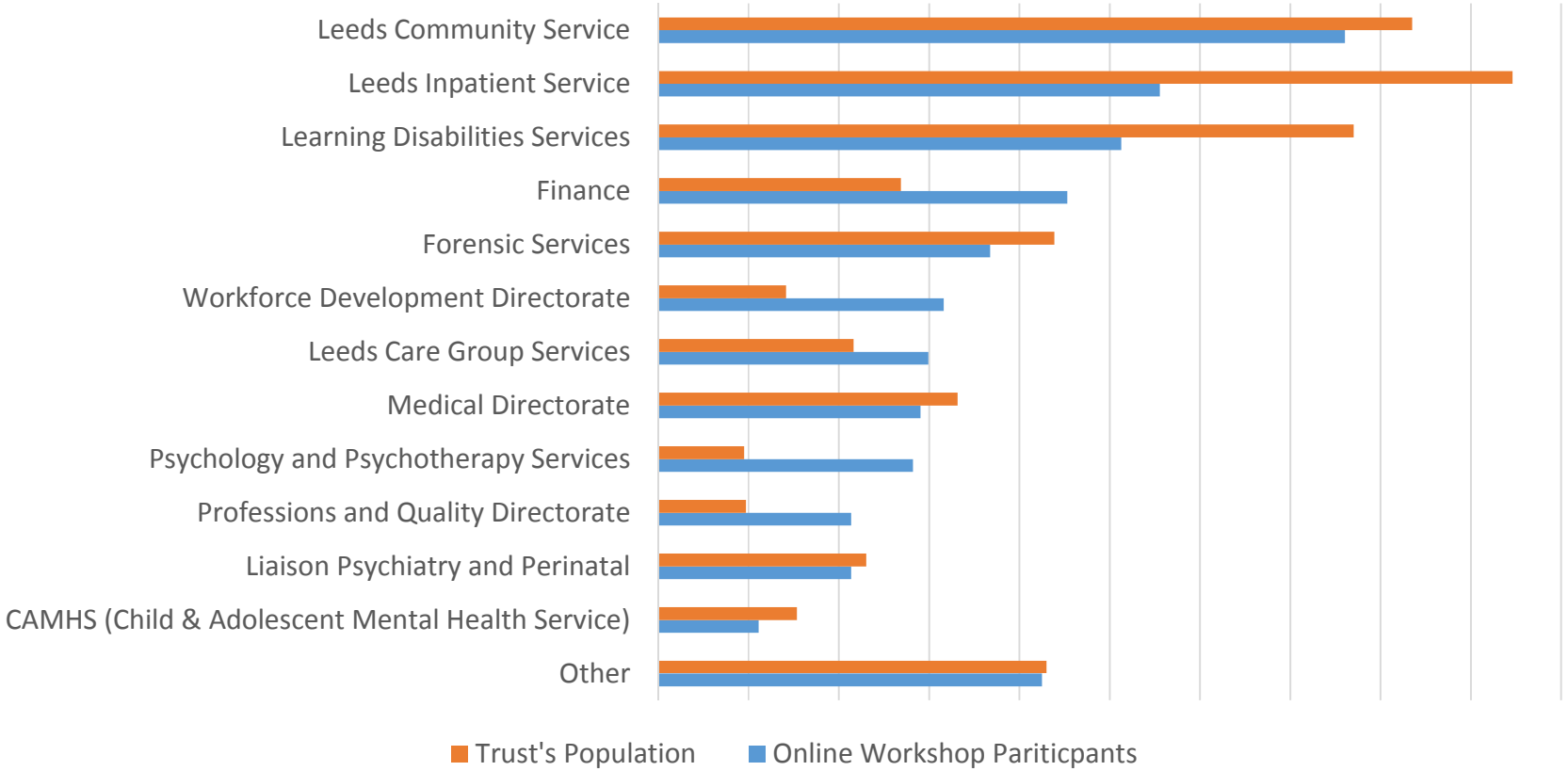
your VOICE counts

clevertogether

Who took part

Staff from every corner of the Trust have joined the online workshops – every service and band have made their voice count

For example, here's the participation breakdown by Service



What we asked

Over two months, we have facilitated the online workshops through four key questions

What is our vision for 2021?	What difference do we want to make to the lives of the people and communities we serve? Please answer this question in one very short inspiring paragraph - a vision statement.
How do we want our people to behave?	Staff have repeatedly said we need to be better at holding each other to account. This means we must be clear about the ideal behaviours we want from our people. Can you help us define these behaviours - what is expected and what is unacceptable?
What should we stop, start or do differently	What should we stop, start or do differently to improve our Trust and achieve our vision
An opportunity to share other ideas to improve our Trust	If you have any other ideas about how to improve our Trust, please share them here.

Building a new vision

We themed the ideas and comments regarding our vision

Analysis of the 1,712 contributions shared by staff and stakeholders regarding our vision revealed a shared focus on four themes:

- our communities;
- our people;
- our partnerships; and
- stigma.

Ideas were clustered into the four themes in their primary coding, many of the secondary codes revolved around stigma.

Community	People	Partnerships	Stigma
58%	13%	18%	6%

NB: The percentages don't add up to 100% because some contributions offered feedback, rather responding to the challenge set.

Building a new vision

We have a new co-created vision for Governor and Board approval

237 further contributions from staff and stakeholders helped us improve our first draft vision to the following:

"We want everyone to live in communities that are healthy and happy, with no stigma attached to mental ill health or learning disabilities. We want our Trust to be staffed by healthy and happy people, working as one team with the communities we serve, to support those with mental ill health or learning disabilities to achieve their personal goals."

NB: There seems to be some confusion in the Trust about the purpose of a vision, e.g. some think it should be a strapline.

Behaviours and values

We themed the 1,626 ideas, comments and votes regarding staff behaviour to reveal nine expected behaviours that underpin three core values

Our values	We have integrity "We treat everyone with respect and dignity, honour our commitments and do our best for our service users and colleagues."	We are caring "We always show empathy and support those in need."	We keep it simple "We make it easy for the communities we serve and the people who work here to achieve their goals."
Behaviours you can expect from staff	• I consider the feelings, wishes and rights of others and am committed to continuously improving what we do. • I give positive feedback as a norm and constructively challenge unacceptable behaviour. • I work in partnership with service users and colleagues and I am open and transparent in the actions I take and the decisions I make.	• I make sure people feel I have time for them when they need it. • I listen and act upon what people have to say. • I talk to people in a kind tone of voice.	• I make processes as simple as possible. • I avoid jargon and make sure I am understood. • I am clear what my goals are and help others to achieve their goals.

Achieving our vision – towards a five year plan

Staff input reveal six emergent strategic objectives, each with potential workstreams and projects

1,722 ideas, comments and votes were shared in the online workshops by staff and stakeholders in response to “what should we stop, start or do differently to improve our Trust and achieve our vision?” and “do you have other ideas to improve our Trust?”. Our cluster analysis of these contributions reveals:

- six emergent strategic objectives,
- each objective can be achieved with a number of potential streams work,
- each stream of work can be delivered with a focus upon specific actions and projects.

Achieving our vision – towards a five year plan

The six themes of staff input represent six emergent strategic objectives

Focus	Emergent objective
Our People	To be recognised as providing a dynamic, rewarding and supportive workplace
Our Partnerships	To be recognised as a Trust where our people work as one team with each other and the communities we serve.
Our Services	To the recognised as a provider of excellent, caring, truly person-centred care.
Our Premises and Facilities	To be recognised as a Trust with effective premises and facilities.
Our Quality and Governance	To be recognised as a transparent and accountable Trust that is steered by its service users and staff and that meets or exceeds all relevant guidelines and measures.
Our IT, Systems and Finance	To be recognised as financially sustainable Trust with great systems.

Our strategy - the emerging "big picture"

How we expect staff to behave

We have integrity
"We treat everyone with respect and dignity, honour our commitments and do our best for our service users and colleagues."

We are caring
"We always show empathy and support those in need."

We keep it simple
"We make it easy for the communities we serve and the people who work here to achieve their goals."

Streams of work will likely align around six strategic objectives

- our **PEOPLE**
- our **PARTNERS**
- our **SERVICES**
- our **PREMISES** and **FACILITIES**
- our **QUALITY** and **GOVERNANCE**
- our **IT, SYSTEMS** and **FINANCE.**

Our Vision

If we live our values and deliver our objectives we will achieve our new vision:

"We want everyone to live in communities that are healthy and happy, with no stigma attached to mental ill health or learning disabilities. We want our Trust to be staffed by healthy and happy people, working as one team with the communities we serve, to support those with mental ill health or learning disabilities to achieve their personal goals."

We note that there were almost zero ideas or comments regarding the operating model of the Trust to achieve this vision. We counsel that options are drawn up, based upon an analysis of policy drivers and LYPFT's external context, then shared with staff for debate and discussion, as they will impact the focus of likely workstreams and staff morale.

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:	Outcome of the Well-led Governance Review and next steps
DATE OF MEETING:	28 July 2016
LEAD DIRECTOR: (name and title)	Anthony Deery, Director of Nursing, Professions and Quality
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)		

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	This paper is to advise the Board of the outcome of the Well-led Governance Review conducted by Ernst and Young (EY) and to advise of the next steps.
What are the key points and key issues the Board needs to focus on	The Trust commissioned EY to carry out a well-led review in accordance with NHS Improvement's *Well-led Framework for Governance Reviews*. This review looked at four governance domains and 10 key questions which sought to test the high-level governance arrangements within the Trust; review performance against the Board's self-assessment; and make recommendations as to how the Trust's governance arrangements could be strengthened. EY carried out their review during April and May 2016 and issued their final report in June 2016. An extract from this report is now presented to the Board in Appendix A. Full copies will be circulated to members of the Board separately. As part of the final report EY looked at the RAG rated self-declaration made by the Board in July 2015 and provided their view of how the Trust had performed based on their findings (full details of this are in Appendix A). In summary EY assessed there to be: • No areas rated 'green' • Seven areas rated 'amber/green' • Three areas rated 'amber/red' • No areas rated 'red'. EY then made recommendations against each of the domains and questions. These have been considered by the Executive Team and key senior managers. Observations and responses have been provided against each recommendation and these will be formulated into a full action plan though the CQC Fundamental Standards Group which reports into the Quality Committee. The final stage in the review is for the Chair of the Trust to write a letter to NHS Improvement with confirmation of the outcome of the review. With regard to this letter the Trust the Board is asked to support the view that the governance review has been completed and there are no 'material governance concerns' on the basis that no 'red' ratings have been received. NHSI will be kept informed of progress against the Trust's action plan

	through the quarterly governance submission and self-certification and will be further assured of progress through the quarterly telephone conference call with our chief Executive and relationship manager.
What is the Board being asked to consider	The Board needs to: • Be sighted on The RAG rating concluded by EY against the self-declaration made by the Board in July 2015 • Note the high-level findings and recommendations made by EY • Note and support the next steps in taking forward the action plan to address the recommendations • Support the assurance that will be provided to NHS Improvement that there are no major governance concerns.
What is the impact on the quality of care	It is important that the Trust is well-led in order to be able to deliver high quality care. The Board needs to have confidence in the processes, procedures and structures it has put in place in order to be assured about quality and to have sufficient information to be able to challenge any areas of poor quality.
What are the benefits and risks for the Trust	The benefit for the Trust is that it is able to review the recommendations and improve on any areas as per the recommendation; the risk is that NHS Improvement will not be convinced of the progress being made against the action plan.
What are the resource implications	None have been identified at this point.

Next steps following this paper being presented to the Board	The next steps are: • The Chairman will need to write to NHS Improvement within 60 days of the submission of the review to the Board to confirm the outcome of the review • Detailed action plans will be formulated and monitored through the our CQC Fundamental Standards Group in order to link this into the Trust's governance structure • Assurance reports will be made to the Quality Committee, and therefore the Board in regard to progress with the implementation of action plans • Update NHS Improvement of progress through the quarterly governance return and telephone conference call with our relationship manager.
What are the reputational implications and how will these be addressed	If the Trust is deemed not to be well-led there will be reputational consequences within the wider health care sector and potentially have an effect on the recruitment and retention of staff.
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	Staff within the Trust are responsible for taking forward the action. Service users, governors and stakeholders were consulted by EY as part of the review.
Previous meetings where this report has been considered (including date)	The report has been considered by ET in relation to responding to the recommendations.

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:

- Be sighted on The RAG rating concluded by EY against the self-declaration made by the Board in July 2015
- Note the high-level findings and recommendations made by EY
- Note and support the next steps in taking forward the recommendations and resulting action plans
- Support the assurance that will be provided to NHS Improvement that there are no major governance concerns.

*** 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).

2. Executive summary

2.1 Overview

During our review, interviews with Board members demonstrated a passion to deliver high standards of care and we observed examples of good governance during our review. These include the summary papers that accompany Board papers, Committee reporting to the Board and relationships with Governors.

Interviewees consistently commented on the strong leadership and direction provided by the Interim Chief Executive since January 2016. We also note that the Trust has recently undertaken a number of initiatives in response to quality issues it has identified.

These include the Interim Chief Executive holding listening events with staff to increase engagement as well as launching the Your Voice Counts online Crowdsourcing platform to engage with large numbers of staff. This process will help address some of the issues raised during the 2015 Staff Survey, in which some scores reduced from the prior year and other scores were below national averages for Mental Health providers.

They also include a third party review commissioned by the Trust to obtain views on its Board from external stakeholders in Leeds. We understand that York Commissioners declined to take part in the review. This review has not yet been shared and discussed by the Board collectively and it is important that once it is, views and perceptions of stakeholders are understood by the Board, even if they are not agreed with. The Board then needs to develop actions to address themes raised.

The table below provides our RAG assessment against each question. The criteria for ratings is defined by NHSI and provided in appendix A. Despite making progress against the issues identified above, the guidance states that Amber/Red should apply when action plans to address perceived gaps are in early stage of development.

As well as the status of the issues raised above, we have also considered issues regarding the development of the Trust's strategy, the timeliness of reporting of KPIs to the Board and the appropriateness, at times, of challenge and debate at Board meetings. We also note that there will be considerable change within the Board over the next 10 months, which, although the Trust has started preparing for, will require careful management and an effective induction process. These points are summarised in section 2.3 to 2.6.

2.2 Scoring summary

Table 1 below shows the Trust self-assessment scores. We have applied the technical rules around scoring, and provided our RAG rating based on the independent assessment. We recommend that the Trust Board give particular consideration to the areas where the RAG ratings are different to the Board self-assessment and consider implementation of the suggested actions.

Table 1 – Assessment summary

Key domains	Question	Characteristics	Board self-assessment RAG [as at July 2015]	Independent assessment RAG	Explanation for variance
A. Strategy and planning	1. Does the Board have a credible strategy to provide high-quality, sustainable services to patients and is there a robust plan to deliver?	1) There is a clear statement of vision and values, driven by quality and safety. It has been translated into a credible strategy and well-defined objectives that are regularly reviewed to ensure that they remain achievable and relevant.	Amber / Green	Amber / Red	The Trust is in the process of developing its Strategy and there are action plans to engage with internal and external stakeholders. As, the engagement plans are currently being implemented (and Board walkarounds had yet to commence at the end of our fieldwork) and as the Strategy is not yet completed, there is no track record of delivery. Once the strategy has been finalised, the Board will need to consider how to communicate it with internal and external stakeholders.
		2) The vision, values and strategy have been developed through a structured planning process with regular engagement from internal and external stakeholders, including people who use the service, staff, commissioners and others.	Green		
		3) The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place.	Amber / Green		
		4) Strategic objectives are supported by quantifiable and measurable outcomes which are cascaded through the organisation.	Green		
	2. Is the Board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?	5) Staff in all areas know and understand the vision, values and strategic goals.	Amber / Green	Amber / Green	
		6) There is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks.	Amber / Green		
		7) Service developments and efficiency changes are developed and assessed with input from clinicians to understand their impact on the quality of care. Their impact on quality and financial sustainability is monitored effectively. Financial pressures are managed so that	Green		

		they do not compromise the quality of care.			
B. Capability and culture	3. Does the Board have the skills and capability to lead the organisation?	8) The Board has the experience, capacity and capability to ensure that the strategy can be delivered.	Amber / Red	Amber / Red	The Board development programme has recently been relaunched. At the date of our fieldwork, the programme had yet to cover how the Board can work most effectively as a team.
		9) The appropriate experience and skills to lead are maintained through effective selection, development and succession processes.	Green		
		10) The leadership is knowledgeable about quality issues and priorities; understand what the challenges are and takes action to address them.	Green		
	4. Does the Board shape an open, transparent and quality-focused culture?	11) Leaders at every level prioritise safe, high quality, compassionate care and promote equality and diversity	Green	Amber / Green	
		12) Candour, openness, honesty and transparency and challenges to poor practice are the norm. Behaviour and performance inconsistent with the values is identified and dealt with swiftly and effectively, regardless of seniority.	Amber / Red		
		13) The leadership actively shapes the culture through effective engagement with staff, people who use the services, their representatives and stakeholders. Leaders model and encourage co-operative, supportive relationships among staff so that they feel respected, valued and supported.	Amber / Green		
		14) Mechanisms are in pace to support staff and promote their positive wellbeing.	Green		
		15) There is a culture of collective responsibility between teams and services.	Amber / Green		
		16) The leadership actively promotes staff empowerment to drive improvement and culture where the benefit of raising concerns is valued.	Green		
	5. Does the Board support continuous learning and development across the organisation?	17) Information and analysis are used proactively to identify opportunities to drive improvement in care.	Green	Amber / Green	
		18) There is a strong focus on continuous learning and improvement at all level of the organisation. Safe innovation is supported and staff have objectives focused on improvement and learning.	Amber / Green		
		19) Staff are encouraged to use information and regularly take time out to review performance and make improvement.	Amber / Green		
C. Processes and structures	6. Are there clear roles and	20) The Board and other levels of governance within the organisation function effectively and interact with each	Green	Amber / Red	The Trust reporting cycles to the Board are currently not

	accountabilities in relation to Board governance (including quality governance?)	other appropriately.			consistent with other providers we have worked with, where KPIs linked to quality and the Trust objectives are reported to the Board monthly.
		21) Structures processes and systems of accountability, including the governance and management of partnerships, joint working and shared services, are clearly set out, understood and effective	Amber / Green		
		22) Quality receives sufficient coverage in Board meetings and in other relevant meeting below Board level.	Green		
	7. Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	23) The organisation has the processes and information to manage current and future performance.	Amber / Green	Amber / Green	
		24) Performance issues are escalated to the relevant committees and the Board through clear structures and processes.	Amber / Green		
		25) Clinical and internal audit processes function well and have a positive impact in relation to quality governance, with clear evidence of action to resolve concerns.	Green		
	8. Does the Board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?	26) A full and diverse range of people's views and concerns are encouraged, heard and acted on. Information on people's experience is reported and reviewed alongside other performance data.	Amber / Green	Amber / Green	
		27) The service proactively engages and involves all staff and assures that the voices of all staff are heard and acted on.	Green		
		28) Staff actively raise concerns and those who do (including external whistle-blowers) are supported. Concerns are investigated in a sensitive and confidential manner, and lesson are shared and acted on.	Amber / Green		
		29) The service is transparent, collaborative and open with all relevant stakeholders about performance.	Amber / Green		
D. Measurement	9. Is appropriate information on organisational and operational performance being analysed and challenged?	30) Integrated reporting supports effective decision making.	Green	Amber / Green	
		31) Performance information is used to hold management and staff to account.	Amber / Green		
	10. Is the Board assured of the robustness of information?	32) The information used in reporting, performance management and delivering quality care is accurate, valid, reliable, timely and relevant.	Amber / Green	Amber / Green	

2.3 Strategy and planning

Although the Board has agreed three key priorities for 2016/17, the Board recognises that the strategy needs updating. The strategy refresh has been timed to coincide with the outcome of the STP processes. However, the Board has progressed discussions with Leeds Community Services regarding a potential merger or acquisition. Some Board members have questioned whether this is the best means to achieve the Trust's strategy and we recommend that the Trust first defines its strategic objectives and then validates this approach to their achievement. The Trust should also be mindful of the guidance previously issued by NHS Improvement on how to approach strategy setting.

In developing the strategy, the Trust needs to obtain input from its clinicians, management and staff within the Care Groups.

Once the strategy has been agreed, the Trust needs to communicate it effectively to internal and external stakeholders.

The 2016 Operational Plan notes the Trust's commitment to delivering high quality services with a focus on patient safety, clinical effectiveness and patient experience. Personal objectives of the Directors in the Trust have been linked to the delivery of the quality priorities identified in the Operational Plan.

The Strategic Risk Register was well developed and incorporates the risks from the respective Care Groups and corporate functions. We have recommended that the contents of the risk registers needs to be consistent across the Trust with a clear alignment to the Trust's strategic objectives.

Discussions with Board members show an awareness of the high level risks facing the Trust and these risks were aligned to the Strategic Risk Register.

2.4 Capability and culture

The Board currently has a mix of skills with experience across public, private and third sectors. The term of the Chair was recently extended by a year to allow for the recruitment exercise for a Chief Executive to be concluded and some period of continuity prior to a new Chair being appointed. In addition to the Chair, the terms of three other NEDs expire within the next year and the Board has started to identify profiles of the requirements of incoming NEDs.

In the Board and Committee meetings we observed, we noted that Board members were engaged and provided robust challenge. We observed a tendency however, for some Executives to contribute within their functional areas only. While many Board members noted that the ability of members to challenge was a strength, other felt that this challenge, at times, becomes unconstructive. The Board commenced discussions on the Board Development programme in December 2015 and we recommend a future session considers how the Board works together effectively as a team and how it ensures that the viewpoints of all members are consistently encouraged.

The Board is focussed on quality in its meetings and receives a number of reports commenting on the Trust's progress towards meeting quality targets. However, patient stories are not minuted. In addition, the quality section is not as prominent on the Board agenda as at other FTs. A CQC inspection in 2014 noted an overall rating of "Requires Improvement". A follow up inspection has been scheduled for July 2016. The Trust is in the process of implementing actions developed in response to the CQC review.

The staff survey in 2015 identified a number of areas where improvement is required in staff engagement. The Trust has developed action plans to address these and the Interim Chief Executive conducted a number of “Listening events” to enhance staff engagement as well as launching the Your Voice Counts online Crowdsourcing platform with large numbers of staff.

2.5 Processes and structures

The Finance and Business Committee meets quarterly. Our observation of the meetings was that it was well run and the NEDs in the Committee were engaged and provided effective challenge during the meeting. We had similar comments regarding the Quality Committee and Audit Committee, which we also observed, although not all attendees appeared fully engaged through the meetings.

We also note that the Executive Team performance meeting we observed, had a rigorous focus on the performance metrics of the Trust (as contained within the Integrated Quality and Performance report).

We were concerned that the Board, however, meets every six weeks and only receives the Integrated Quality and Performance (IQP) report quarterly. Most Foundation Trusts we work with receive a report containing KPIs monthly to enable regular monitoring of performance against strategic and quality priorities. The Interim Chief Executive explained how she would raise any performance concerns by exception in her Chief Executive’s report to the Board and also in the weekly updates she sends to all Board members. However, not all Board members were able to articulate this process. The Trust needs to be clear as to how the Board would be made aware of emerging issues on a timely basis and we recommend that the Board has sight of the full IQP on a monthly basis.

The content and structure of the IQP is consistent with that which we have observed at other FTs, and there is clear explanation of areas of non-performance.

The Trust will need to revisit the metrics in the IQP both for the quality priorities agreed for 2016/17 and for the strategic objectives once they have been updated.

From the interviews we held, it was commented that, with the exception of two members, the Board was not visible and engaged with the organisation. Whilst we recognise that it is not the only means to engage with staff and patients, the Trust does not have Board to Ward walkarounds and visits, as is common at many Trusts we work with. We recommend that the Board introduces such a programme for greater engagement, that findings are captured and acted upon, and that these visits are communicated to the Trust.

2.6 Measurement

As commented, the Board receives the Integrated Quality and Performance report on a quarterly basis. This contains a number of measures as determined by NHSI, nationally, and locally at the Trust. The report highlights a high number of areas where the Trust is underperforming. Considerations should be given to phasing of targets for KPIs the Trust has historically struggled to meet, particularly its HR related targets.

An Internal Audit review of the migration of data to the new Patient Administration System provided a Limited Assurance opinion. The Trust has since developed action plans to address findings by Internal Audit. In addition, in compliance with the Information Governance toolkit requirements, the Trust has achieved a score of 76.5% (Satisfactory).

3. Recommendations

3.1 Summary of recommendations requiring implementation

Domains	Recommendations
Strategy and planning	▸ The Trust's Five Year Strategic Plan was last prepared in 2013. The Trust recognises that they need to update the strategy and indicate that the refreshed strategy will include consideration for the consideration of the Five Year Forward View (FYFV), published by the NHS England in October 2014 and the work performed by the local health economy in developing Sustainability and Transformation Plans (STP). The Trust should ensure that it also familiarise itself with the strategy planning tool previously released by Monitor and ensure that the approach to setting strategy is consistent with this ▸ We are aware of the discussions the Trust has had regarding a potential merger or acquisition with Leeds Community Services. We recommend that the Trust updates and defines its strategy and then reconsiders whether this change in organisational form is the best means of delivering the identified strategy. ▸ The Trust needs to consider how to effectively engage external stakeholders in the Strategy setting process (considering outputs of recent stakeholder review that has just been completed and the STP process). Whilst we recognise the recent efforts of the Executive Team, led by the Interim Chief Executive, to engage with staff, the Trust needs to effectively involve clinicians and Care Groups in the development of the strategy at key milestones in the process. ▸ Once agreed, the Trust then needs to consider how it will communicate the strategy internally and externally. ▸ The Trust should ensure that there is an alignment of its Strategic Objectives with the immediate priorities for 2016/17. ▸ Risks in the Strategic Risk Register should be linked to the Strategic goals identified in the Operational Plan (in the interim) and in the Five Year Strategy when developed. ▸ The Board needs to have greater visibility and engagement with the organisation. A plan for Board members to conduct site visits should be developed, with a formal feedback process reporting on the outcome of these visits. These site visits, and outcomes, should be communicated to the organisation ▸ The Risk Registers in each Care Group or corporate function should be redesigned and made consistent across each function. These should have considerations for the following: o Risks should be aligned to the Trust's strategic objectives o Mitigating actions / controls should have target completion dates o Risks in the Board Assurance Framework should be referenced to the source Risk Register.
Capability and culture	▸ The Trust has recently re-launched its Board Development agenda and we recommend that a key element of this is focussed on how the Board works

	together effectively as a team and how the Board works to make sure that all members feel that they can contribute to discussions and that constructive challenge is within the Directors' Code of Conduct which Board members have signed up to. ▸ Agenda items relating to quality should be given greater prominence. We also understand that the Board does receive Patient Stories although these are not recorded in minutes. We recommend that Patient Stories are part of the formal agenda and documented as such. ▸ As there is due to be turnover within the NEDs and should a need for change in EDs arise, the Trust should review the induction and appraisal processes for Board members to identify the development needs of its members. ▸ In addition to review of succession plan for Board members, the Trust should consider implementing a formal process whereby a review of staff is done to identify potential future leaders. ▸ The split of performance in each Care Group is done centrally and Care Group managers have indicated that they do not always have sight of Board papers written about their Care Group. The Executive Team should engage the Care Group leaders more in preparation of information shared with the Board in respect of their respective Care Groups. We understand that the Board IQP is now being discussed with Senior Managers of the Care Groups in the extended Executive Team meetings. ▸ The Trust should ensure that corporate actions or campaigns introduced, address the results of the staff survey and issues identified during the listening events. ▸ The Trust should ensure that compliance with the requirements of Duty of Candour is considered in future Quality Committee meetings. ▸ As part of its engagement with Governors, the Trust should consider organising training and development sessions for Governors to equip them to be more effective in their role. ▸ The Trust should consider developing a phased trajectory for when they expect to be consistent with KPIs relating to appraisals and training.
Process and structures	▸ The Trust should explore including more discussions on strategic issues in the public Board meetings. ▸ Key performance reporting is only provided quarterly and the Board only meets six weekly with Committees meeting quarterly. The Trust needs to be clear as to how the Board would be made aware of emerging issues on a timely basis. We note the use of weekly updates are a positive introduction. ▸ The Terms of Reference of the Remuneration Committee has not been renewed within the last year. The Trust should review the document and update it accordingly. ▸ The Trust should ensure that the Communications Strategy being developed includes considerations on how to effectively engage external and internal stakeholders, and is appropriately disseminated.

	▸ While a Whistle Blowing policy exists, cases reported in the HR systems are not clearly reported to the Committees or the Board. Management acknowledges that reporting arrangements to the Quality Committee will be reviewed when a Freedom to Speak up Guardian is employed. ▸ Trust should ensure that the Freedom to Speak up Guardian role is advertised and recruited to as planned.
Measurement	▸ Considerations should be given to phasing of targets for KPIs the Trust has historically struggled to meet, such as those related to training and appraisals. ▸ The Trust should consider estimating the performance of key targets (including NHSI targets), to identify risks to future performance and identify actions to address these.

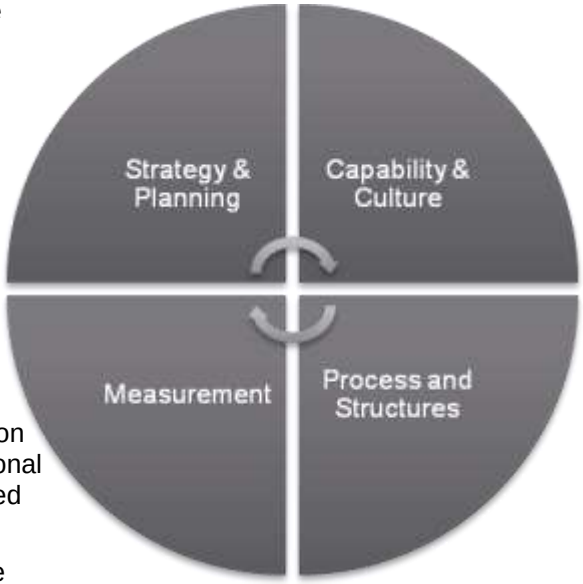
4. NHSI's well-led framework

4.1 The well-led framework

Under the 'Risk assessment framework' and in line with their Code of Governance, NHSI expects NHS foundation trusts to carry out an external review of their governance every three years.

In the current version of the well-led Framework[1], NHSI has aligned the four domains and ten high level questions asked of NHS provider organisations with the CQC's characteristics of 'good' under their well-led domain. Figure 1 below illustrates the elements of the framework.

1. Does the Board have a credible strategy to provide high quality, sustainable services to patients and is there a robust plan to deliver?
2. Is the Board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?



3. Does the Board have the skills and capability to lead the organisation?
4. Does the Board shape an open, transparent and quality-focused culture?
5. Does the Board support continuous learning and development across the organisation?
6. Are there clear roles and accountabilities in relation to Board governance (including quality governance)?
7. Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance?
8. Does the Board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?
9. Is appropriate information on organisational and operational performance being analysed and challenged?
10. Is the Board assured of the robustness of information?

Figure 1 – Well-led governance framework

Its purpose is to support NHS Foundation Trusts in gaining assurance that they are well led and, therefore, to help them to continue to meet patients' needs and expectations in challenging circumstances.

[1] Well-led framework for governance reviews: guidance for NHS Foundation Trusts, Monitor April 2015

5. Approach

5.1 Introduction

This section provides an overview of our approach and key steps we adopted for this review

5.1.1 Review of the self-assessment completed by the Board

The Trust Board had given individual scores to the ten questions of the well-led governance framework as well as provided qualitative comments. Issues raised were explored during interviews.

5.1.2 Review of the Board, Board committee papers and documents provided by the Trust to support the well-led framework review

This was a desk top review of the Trust's documents including Board minutes, papers, and agendas; board assurance framework; audit reports; strategic documents, for example, the Trust's strategy, business plan, objectives supporting the strategy; and internal/ external audit reports, annual governance and corporate governance statements

The aim during this review was to establish:

- How ongoing issues and risks within the Trust were communicated and managed
- The quality of information being produced to support decision-making and
- How the board prioritises issues at the Trust and divides its attention.

5.1.3 Understanding stakeholder views

We conducted interviews with Board members to assess their understanding of the Strategic Plan and major risks. To obtain a balanced view of the Board we gathered the views of external and internal stakeholders through individual meetings and phone calls.

These sessions were shaped by the key themes arising from the review of the Well-led Framework and evidence.

5.1.4 Observation of Board and relevant Committee meetings

We attended the Board, Quality Committee, Finance & Business Committee, Audit Committee and the Executive Team meetings as an observer to watch how the Executive and Non-Executive Directors work together and interact. In addition, the Board was observed to assess the effectiveness of how NEDs hold the Executive to account, whether Board challenge is appropriately balanced with support and the level of strategic discussion. We also held a focus group session with a Governor to understand their view of the Trust Board.

5.2 Report phase

Following the four discovery stages described above we then developed our report and recommendations based around the four domains, looking for evidence of good practice that demonstrated conformance with the examples given in the guidance. We derived our overall view of the Trust in line with NHSI's rating scheme through a process of team consideration and challenge to ensure that our diagnostic review was based on a triangulation of observations.

Appendix A NHSI RAG rating guidance

Scoring against Well-led governance framework:

Risk rating	Definition	Evidence
Green	Meets or exceeds expectations	Many elements of good practice + no major omissions
Amber/Green	Partially meets expectations, but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, + some minor omissions and + robust action plans to address perceived gaps with proven track record of delivery
Amber/Red	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable timeframe	Some elements of good practice + no major omissions. + action plans to address perceived gaps are in early stage of development with limited evidence of track record of delivery
Red	Does not meet expectations	Major omission in governance identified. + significant volume of action plans required with concerns regarding management's capacity to deliver

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:	Ratification of the Terms of Reference for the Remuneration Committee
DATE OF MEETING:	28 July 2016
LEAD DIRECTOR: (name and title)	Frank Griffiths - Chair of the Trust and Chair of the Remuneration Committee
PAPER AUTHOR: (name and title)	Cath Hill - Head of Corporate Governance and Secretariat of the Remuneration Committee

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)					
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 is to present to the Board the Terms of Reference for the Remuneration Committee for review and ratification.
What are the key points and key issues the Board needs to focus on	The Terms of Reference for the committee requires these to be reviewed annually to ensure they remain fit for purpose. These were reviewed by the committee on 23 June and found to correctly reflect the work of the committee.
What is the Board being asked to consider	The Board is being asked to ensure that the Terms of Reference still meet it requirements of its Remuneration Committee.

What is the impact on the quality of care	By reviewing the Terms of Reference it will help to ensure that there is clarity as to the duties of the committee regarding the recruitment and retention of appropriately qualified and experienced members of the executive team by agreeing appropriate reward packages.
What are the benefits and risks for the Trust	The benefit of reviewing the Terms of Reference is so the committee is assured it is carrying out the right work in the right way and is able to provide the right level of assurance and challenge.
What are the resource implications	None.
Next steps following this paper being presented to the Board	None.
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	Not applicable.
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 consider, review and ratify the Terms of Reference for the Remuneration Committee							

*** 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

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Remuneration Committee

Terms of Reference
(To be ratified by the Board of Directors 28 July 2016)

.

1 NAME OF GROUP

The name of this committee is the Remuneration Committee.

2 COMPOSITION OF THE GROUP

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

Members

Title	Role in the committee
Chair of the Trust	Committee chair and responsible for evaluating the assurance given and identifying if further consideration action is needed.
All non-executive directors	Responsible for evaluating the assurance given and identifying if further consideration / action is needed. The Deputy Chair would normally chair the committee in the absence of the Chair of the Trust or another non-executive member may chair if the Deputy Chair is absent.

Only members of the committee have the right to attend committee meetings. However, other individuals, including external advisors, may also be invited to attend the meeting, at the discretion of the chair of the meeting.

In attendance

Title	Role in the committee	Attendance guide
Chief Executive	Advice specific to the executive team including but not limited to executive director performance and the structure of the team	Every meeting except for items referring to their pay or performance or where there is a conflict of interest

Title	Role in the committee	Attendance guide
Director of Workforce Development	Advice specific to the executive team including but not limited to workforce procedure and employment legislation	Every meeting except for items referring to their pay or performance or where there is a conflict of interest
Head of Corporate Governance (acting as Trust Board Secretary)	Committee support and advice	Every meeting

A schedule of deputies for those in attendance is set out at appendix 1.

3 QUORACY

Number: The minimum number of members for a meeting to be quorate shall be three non-executive directors. Attendees do not count towards this number. If the Chair of the Trust is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by the Deputy Chair. In the absence of the Deputy Chair another non-executive member may chair the meeting.

Deputies: Attendees may nominate a deputy to attend in their absence. A schedule of deputies is attached at appendix 1.

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

4 MEETINGS OF THE GROUP

Frequency: The Remuneration Committee will normally meet as required but will in any case meet no fewer than twice a year.

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

Minutes: The Head of Corporate Governance will take minutes of the meeting.

Draft minutes will be circulated to the chair of the committee no later than two weeks after the meeting. Actions from the meeting will be circulated to relevant members within 10 working days from the day of the committee taking place.

Minutes will be distributed to the Board for assurance purposes.

5 AUTHORITY

Establishment: In accordance with the NHS Act 2006 and the Code of Governance (and other statutory guidance) the Board of Directors is required to establish a Remuneration Committee as one of its sub-committees.

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

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

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

6 ROLE OF THE COMMITTEE

6.1 Purpose of the Committee

The purpose of the Remuneration Committee is to provide the Board of Directors with assurance that executive directors are rewarded appropriately for their contribution; that appropriate contractual arrangements are in place; and to be assured of the performance of individual executive directors against their agreed objectives, and that plans are in place to address any areas of development.

The committee shall execute its role by providing active and independent challenge and thereby adding to the assurance around the Trust's goals:

- People achieve their agreed goals for improving health and improving lives
- People experience safe care
- People have a positive experience of their care and support.

The remit of the Remuneration Committee enables it to seek assurance in the areas of the following strategic objectives:

Objective	Committee roles
Quality and outcomes	The Remuneration Committee has a key role regarding the recruitment and retention of appropriately qualified and experienced members of the executive team by agreeing appropriate reward packages.
Efficiency and sustainability	The Remuneration Committee exercises scrutiny of the remuneration of executive directors in determining terms of both salary and other areas of reward (as may be applicable).
Governance and compliance	The Remuneration Committee has a core responsibility to ensure compliance with all legal obligations, regulations, codes and recommendations of the Department of Health and NHS in terms of the employment and remuneration of executive directors.

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

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

- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Working together
- Everyone counts.

6.3 Duties of the Remuneration Committee

The following shall be those items which will form the duties of the committee (it should be noted that where these duties impact on any appointment to a new or vacant executive director or Chief Executive post the Remuneration Committee will advise the Nominations Committee (through the Trust Board Secretary) as that is the committee with responsibility for expediting the recruitment to such posts:

Contracts and Remuneration

- To set the individual remuneration (including annual pay uplift), allowances and other terms and conditions of office (including termination arrangements) for the Trust's executive directors and Chief Executive, including taking a lead on determining such packages for any new / vacant executive director / chief executive posts

- Consult the Chief Executive on the proposals relating to remuneration of other executive directors

- In determining an appropriate remuneration package for executive directors and the Chief Executive consult benchmarking data and industry standards to ensure the right calibre of individuals can be recruited and retained.

- Approve any changes to the standard contract of employment for executive directors and the Chief Executive, including termination arrangements taking into account any guidance from NHS Improvement's Code of Governance (E.1.4), or any other relevant guidance as may be applicable

- Consider the removal of an executive director prior to approval by the Board of Directors

- Consider any other employment issues that may arise from time-to-time for executive directors and the Chief Executive.

Performance

- To monitor and evaluate the performance of the Trust's Chief Executive and executive directors against objectives for the previous year and note forward objectives

- Make a report on the outcome of the annual appraisals of executive directors to the Board of Directors.

Reporting

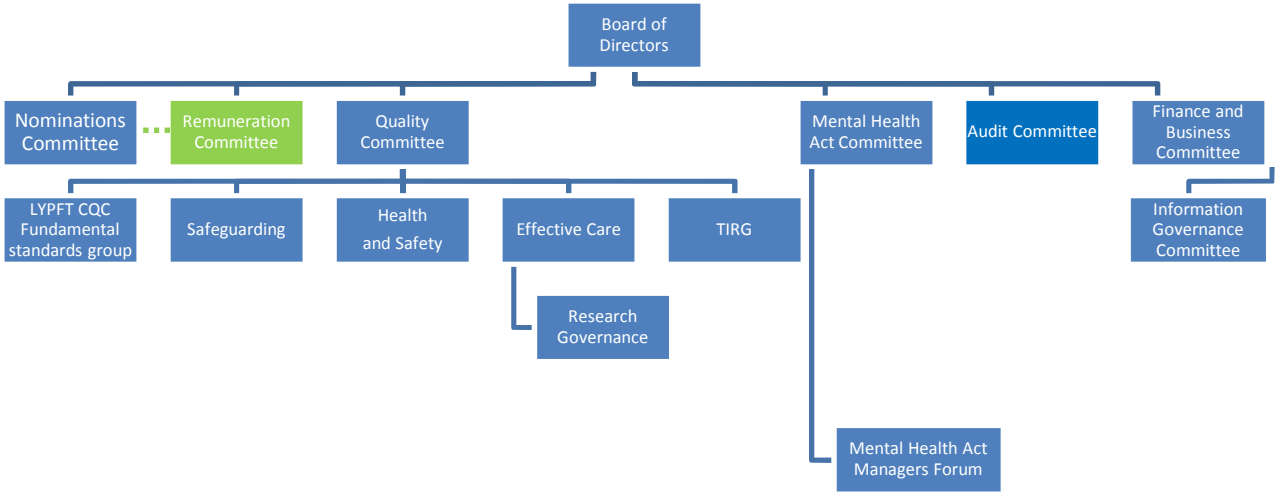
- Agree the statement in the Annual Report in respect of directors' remuneration, (namely the Remuneration Report) and be assured that this is in accordance with the requirements of Monitor's Code of Governance and the Annual Reporting Manual.

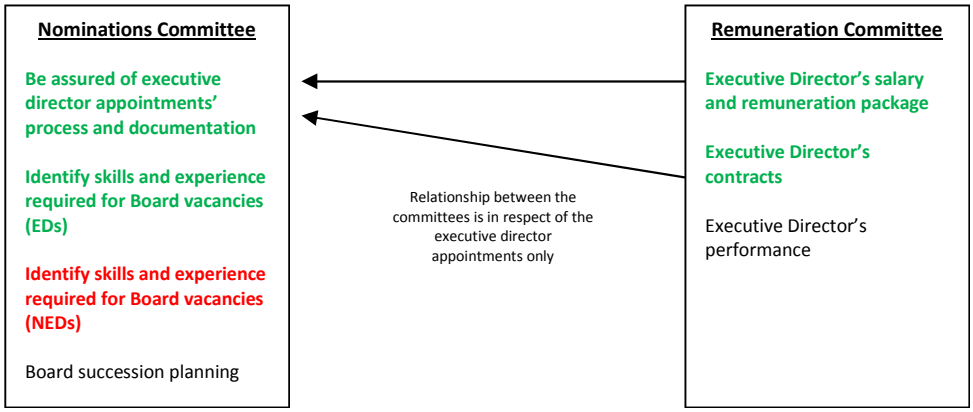
Other

- To undertake any other duties as directed by the Board.

7 RELATIONSHIP WITH OTHER GROUPS AND COMMITTEES

The Remuneration Committee shall have a direct relationship with other Board sub-committees as shown below:





8 DUTIES OF THE CHAIRPERSON

The chair of the group shall be responsible for:

- Agreeing the agenda with the Head of Corporate Governance
- Directing the conduct of the meeting ensuring it operates in accordance with the Trust's values
- Giving direction to the minute taker
- Ensuring all attendees have an opportunity to contribute to the discussion
- Ensuring the agenda is balanced and discussions are productive, and when they are not productive they are efficiently brought to a conclusion
- Deciding when information or matters presented to the Remuneration Committee need escalation to the Board of Directors
- Checking the minutes
- Ensuring sufficient information is presented to the Board of Directors in respect of the work of the committee.

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

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

9 REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

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

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

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 below.

Topic	Monitoring Audit	Lead Manager	Data Source	Sample	Data Collection Method	Frequency Of Activity	Review Body
Reporting arrangements to the Board of Directors including frequency of meetings	Monitoring	Head of Corporate Governance	Minutes of Remuneration Committee	All minutes of Remuneration Committee	Minutes of meeting	Following all Remuneration meetings	Board of Directors
Membership, including frequency of attendance/ quorum	Monitoring	Head of Corporate Governance	Minutes of Remuneration Committee	All minutes of Remuneration Committee	Minutes of meeting	Attendance will be monitored throughout the year and included in the annual report (annually)	Board of Directors
Reporting arrangements into Remuneration Committee	Monitoring	Head of Corporate Governance	Minutes and reports received by Remuneration Committee	All minutes of Remuneration Committee	Agenda of meeting	Record of minutes and reports received by the Remuneration Committee will be included in the annual report	Board of Directors
Duties of the committee will be monitored by adherence to all of the above.							

Appendix 1

Schedule of Deputies

Committee member or attendee	Deputising officer
Chief Executive	Deputy Chief Executive
Director of Workforce Development	Deputy Director of Workforce Development
Head of Corporate Governance	Governance Support Assistant

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

21

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Executive's Report
DATE OF MEETING:	28 July 2016
LEAD DIRECTOR: (name and title)	Jill Copeland, Interim Chief Executive
PAPER AUTHOR: (name and title)	Jill Copeland, Interim Chief Executive

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)					
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	This paper provides a short report on developments and issues at Trust, local and national levels.
What are the key points and key issues the Board needs to focus on	• Care Quality Commission inspection • Updated section of the Scheme of Delegation • Next Steps Graduate Programme • Leeds Health and Wellbeing Strategy and Sustainability and Transformation Plan • General Medical Council medical trainees survey • West Yorkshire Sustainability and Transformation Plan • 'Implementing the Five Year Forward View for Mental Health' • CQC review into how NHS trusts investigate and learn from deaths
What is the Board being asked to consider	Agenda item for information only
What is the impact on the quality of care	• CQC inspection likely to result in recommendations for improvements to quality of care • Leeds and West Yorkshire STPs intended to address gaps in health and quality of care • Five Year View for Mental Health promises investment in mental health services which should improve quality and access times
What are the benefits and risks for the Trust	• Opportunities to improve health and quality of care through delivery of STPs and CQC recommendations • Improving diversity of workforce through Next Steps Graduate Programme • Potential investment in mental health through delivery of Five Year View • Risks not clear at this stage
What are the resource implications	Not known at this stage
Next steps following this paper being presented to the Board	Further work to determine impact on Trust of STPs and 'Implementing the Five Year Forward View for Mental Health'
What are the reputational implications and how will these be addressed	Potential reputation risk if CQC ratings are not improved. We are confident that significant progress has been made since last inspection.
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)	

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 this report for information.							

*** 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's Report

1 Introduction

This paper provides a short report on developments and issues at Trust, local and national levels.

2 Trust developments and issues

2.1 Care Quality Commission inspection

The CQC carried out a full inspection of our services beginning 11 July 2016. This provided the Trust with the opportunity to demonstrate the significant improvements we have made since the last at the end of 2014. The CQC's inspection report is likely to be published in October.

2.2 Updated section of the Scheme of Delegation

In July 2016 the Mental Health Legislation Team updated Section 9 of the Board of Directors' Scheme of Delegation ('Schedule of Decisions / Duties delegated by the powers of the Mental Health Act 1983 or any of its subsequent amendments'). This was to reflect changes in the section numbers in the Code of Practice and titles of individual officers and teams within the Trust.

On the 18 July the Board approved these changes electronically and the document was finalised and submitted to the CQC inspectors and also uploaded to Staffnet and the Trust's website.

Should any member of the public or Board wish to receive a copy these are available from the Head of Corporate Governance and is on the website www.leedsandyork.nhs.uk.

2.3 Next Steps Graduate Programme

There is undisputable evidence that inequalities continue to exist for people from Black and Minority Ethnic (BME) communities, such as in accessing employment within the NHS and differential experiences of their employment. Roger Kline's 2013 Discrimination by Appointment research across 30 Trusts identified that BME candidates were three times less likely to be appointed than white applicants.

In the Trust, we aim to develop both a diversity of talent and a culture of inclusion in which diversity can thrive. I am therefore delighted to welcome our cohort of eight graduates on the Next Steps programme, who started their 12 month training within

the Trust in June. This pilot programme is being delivered in partnership with Health Education England Yorkshire and Humber and PATH Yorkshire.

The aim of the programme is to support the graduates to gain the necessary experience and leadership skills to gain employment within the NHS. The trainees will be supporting the review and redesign of a number of service improvement projects, whilst developing core skills in areas of leadership and management.

2.4 Leeds Health and Wellbeing Strategy and Sustainability and Transformation Plan

A new joint Health and Wellbeing Strategy for Leeds has been published. It centres on reducing health inequalities and building stronger connections across communities to help people live happier lives. It will underpin activity not just across the health sector, but across city plans more generally and it focuses on five areas:

- People will live longer and have healthier lives
- People will live full, active and independent lives
- People's quality of life will be improved by access to quality services
- People will be actively involved in their health and their care
- People will live in healthy, safe and sustainable communities

Overall, it is about how we all put in place the best conditions in Leeds for people to live fulfilling lives – a healthy city with high quality services.

The Leeds STP is still being developed, and the headlines have been submitted to NHS England as part of the West Yorkshire STP (see below). The Leeds STP has developed specific themes that look at what action the health and care system needs to take to help fulfil the priorities identified within the Leeds Health and Wellbeing Strategy. These themes include:

- Social contract with citizens: this supports the ethos of the refreshed Leeds Health and Wellbeing Strategy and sees citizens and communities as the co-producers of health and wellbeing rather than the passive recipients of services. Individuals' health and wellbeing is supported through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources with people more involved in decision making.
- Prevention, proactive care and rapid response in time of crisis: this focuses on what action the system needs to take to improve prevention and rapid response to people in crisis. Multi-agency, integrated multidisciplinary teams will work proactively to reduce unplanned care and avoidable hospital admissions. These teams will be rooted in neighbourhoods and communities, with co-ordination between primary, community, mental health and social care.
- Efficient and effective secondary care: this is about ensuring that we only admit those people who need to be admitted. As described above this needs population–based, integrated models of care, sensitive to the needs of local communities. This must be supported by better integration between physical and mental health and care provided in and out of hospital.

- Innovation, education and research: the focus here is on making better use of technological innovations in patient care, particularly for long term conditions management. This will support people to more effectively manage their own conditions in ways which suit them.

Mental health is considered alongside physical health in all aspects of the Leeds STP, whereas in the West Yorkshire STP there is a separate workstream on mental health.

2.4 General Medical Council medical trainees' survey

The Trust has been ranked 4th in the country in the recent GMC Trainees' Survey, demonstrating the excellence of our training for doctors.

3 Regional developments

3.1 West Yorkshire Sustainability and Transformation Plan

Health and care organisations across the NHS and Local Government in West Yorkshire have developed a five-year West Yorkshire STP (WYSTP). The WYSTP is formed from the six local STPs (of which Leeds is one) and a set of six supporting West Yorkshire programmes (prevention at scale, cancer, mental health, urgent and emergency care, specialised commissioned services, and stroke). The WYSTP is a five-year plan, and the focus is on providers and commissioners collectively returning a currently unsustainable health and care system to long-term sustainability by 2020/21.

A draft WYSTP was submitted to national bodies (including NHS England, NHS Improvement and the Local Government Association) on 30 June 2016. Further work will be completed on the WYSTP during July and August, and approval will be sought from Health & Wellbeing Boards, Clinical Commissioning Group Governing Bodies and provider Trust Boards in September 2016. The final submission of the WYSTP to NHS England will be in September.

4 National developments

4.1 'Implementing the Five Year Forward View for Mental Health'

NHS England has published 'Implementing the Five Year Forward View for Mental Health', which outlines the changes people will see on the ground over the coming years in response to the Mental Health Taskforce's recommendations to improve care.

Intended as a blueprint for the changes that NHS staff, organisations and other parts of the system can make to improve mental health, the plan also gives a clear indication to the public and people who use services what they can expect from the NHS, and when.

The report details how new funding, pledged in response to the Five Year Forward View for Mental Health, rising to £1bn a year by 2020/21 in addition to the cumulative £1.4bn already committed for children, young people and perinatal care, will be made available for CCGs year on year. It also shows how the workforce requirements will be delivered in each priority area and outlines how data, payment and other system levers will support transparency.

Four areas which will see immediate action as a result of this plan include:

- Investment of £72 million over two years to better integrate physical and mental health services. Expanding psychological therapies in up to a third of all CCGs through building 'Integrated Improving Access to Psychological Therapies (IAPT)' services – co-located in and integrated with physical health services – to improve health for people with mental health and long-term physical health problems or persistent unexplained medical symptoms. £17.8 million of funding in 2016/17 and up to £54 million in 2017/18 will go directly to training new staff and delivering new 'early implementer' integrated services.
- A new pilot with investment of £1.8m initially directed at six pilot sites testing new approaches to delivering mental health care. Putting budgets in the hands of local providers and commissioners to drive the design of new approaches to delivering secure mental health services and children and young people's mental health services, with a focus on reducing admissions and lengths of stay, and bringing those people placed out of area closer to home.
- Clear plans for how £365m allocated for specialist perinatal mental health services over the next five years will help 30,000 more women per year. This includes a proposal to set up a perinatal community development fund during 2016/17 to invite bids from local areas (including STP footprints) to begin to develop specialist teams and to improve quality, with a particular focus on areas of under-capacity. Bids will be invited in the autumn for investment over up to three years as the size of the fund grows. From 2019/20, this will be mainstreamed into CCG allocations.
- A £12m roll-out over next two years of Liaison and Diversion services, for people who may have mental health needs and find themselves in the court system or police services. Services will be available across the whole country by 2020. Building on the 16 existing teams around the country specifically designed to serve around 50,000 people a year who need a mental health assessment following arrest – around 70% of who go on to require support – the new money will ensure this service can be rolled out to all people who need it by 2020.

Further information will be provided to the Board of Directors once the implications for the Trust of these developments are known.

4.2 CQC review into how NHS trusts investigate and learn from deaths

In response to the Mazars report into deaths at Southern Health NHS Foundation Trust, the CQC is undertaking a review into how NHS trusts investigate and learn from deaths. All NHS acute, mental health and community trusts have been asked to provide data to help to inform this review by 25 July 2016. We have worked with colleagues in mental health trusts in Yorkshire and Humber and the North East to ensure consistency of approach.

5 Recommendation

Members of the Board of Directors are asked to note this report for information.

Jill Copeland
Interim Chief Executive
20 July 2016

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

22

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Infection Prevention Control and Medical Devices Committee
DATE OF MEETING:	28 July 2016
LEAD DIRECTOR: (name and title)	Anthony Deery, Director of Nursing, Professions and Quality
PAPER AUTHOR: (name and title)	Stan Cutcliffe, Senior Infection Control Nurse

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)		

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	For information- To provide an overview of the ongoing work within the trust in relation to infection control and medical devices.
What are the key points and key issues the Board needs to focus on	1. Only 2 outbreak over the last year 2. Flu campaign 40.7% (2014) 48% (2015).Target for December 2016 65%-75% 3. Drop in training compliance triggered action plan 4. Annual report 5. Antimicrobial prescribing
What is the Board being asked to consider	For information
What is the impact on the quality of care	1. Reduced staff and service user sickness. 2. Potential value £225,000 dependent on resources being made available and staff co-operation. 3. May figure 75%-Minimal action plan in effect intermediate training data up 6% 15/06/2016 4. Attached for information 5. Audit of overall compliance with guidance 65% identified areas for improvement
What are the benefits and risks for the Trust	1. Potential reduction in costs. 2. We were one of the few Trusts that improved last year nationally. However this was from a low start point common in mental health. To achieve 65% or above would have both financial and reputational value 3. No risk- To be made available to the public. 4. Educated workforce 5. It should improve the quality of prescribing
What are the resource implications	1. Reduced sickness 2. Flu vaccinators require protected time/training/room allocation/communications. 3. Training time made available. 4. None 5. None.
Next steps following this paper being presented to the Board	IPCMC will follow up the actions to completion
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	PHE, Microbiology, Facilities, LCC, Pharmacy, Matrons from car Leeds, York and specialist services, Infection control team, Director of Infection Prevention and Control.
Previous meetings where this report has been considered (including date)	Quality Committee 19.07.16

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: for information only							

*** 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

Infection Prevention and Control and Medical Devices Committee
25th May 2016, Meeting room 1 & 2, Trust HQ

Minutes of Meeting

Present:	Stan Cutcliffe	Senior Nurse – Infection Control (chair)
	Helen Guerin	Clinical Risk Advisor & Medical Devices Safety Officer
	Linda Rose	Assistant Director of Nursing
	Mark Robertson	Ward Manager – R&R
	Richard Mellor	Lead Pharmacist
	Helen Whitelam	Head of Occupational Health
	Kavita Sethi	Consultant Microbiologist - Leeds
	Simon Chambers	Matron - LD
	Paul Exley	Matron – OPS The Mount
	Judith Barnes	Operational Manager - CAS
	Ian Patterson	Fire Safety Advisor (attending on behalf of Estates & Facilities)
	Dawn Eshelby	Acting Matron – Forensic services
In attendance:	Helen Evans (minutes)	Senior Administrator

	Agenda Item	Action
1.	**Welcome & Introduction and Apologies** Mike Gent (PHE), Gail Evans (LCC), Rachel Walker, Gail Galvin, Anthony Deery	
2.	**Minutes & actions from last meeting** Minutes accepted as accurate. See action sheet.	
3.	**Declaration of Interests** None	
4.	**Managed Risks:** IC risk register shown to the group. 1 Risk to note – Alcohol hand sanitizers and the storage of. SC will send the 'risk' to Matrons & Operational Managers for comment. Risk register will be a standing agenda item at future meetings.	SC
5. Standard Business Items		
5.1	**Outbreaks/Monitoring/Incident:** Only 2 outbreaks in the last year, no incidents requiring follow up this qtr. IC training compliance, drop in compliance from clinical staff, IC team to focus on this over the next month. More training sessions added, compliance reports studied and areas contacted to push on with the training.	
5.2	**(i) Environmental audit:** Last quarter audits, common themes: General wear & tear of buildings including walls; blinds require cleaning; bins with no lids (not of LYPFT standard); out of date spillage kits and dip in cleaning standards. Change of use for a room – the furniture may not be appropriate and may need changing. Check the cleaning standards for the use of the room. Keep this in mind when changing the use of the room. If an audit is completed and results in an amber or red action, this will be followed	

	up by the IPC Team after 3 months. **(ii) Matrons audit:** Common themes: some issues around cleanliness; manufacturer's instructions; cleaning of medical devices; green tags and fridge temperatures. HG asked if there was a follow up action plan to Matron audits. Matrons thought medical devices actions would be completed via DATIX. Inventory training – HG will provide this training. SC/Infection control team will continue to feed back to matrons.	
5.3	**IPC Annual Report** Presented for info/comment. Comments required by 8th June.	ALL
6. Pharmacy		
6.1	**Pharmacy** Antimicrobial audit took place in March-April 2016; audits looked at drug charts and patient notes for compliance to documentation standards and administration of correct dosages etc. Results taken from all services across the trust. Results are embedded below.  6.1(i) Trustwide Report Draft V2.pdf Antimicrobial policy to update Organise education lessons for medics Circulate info including flowcharts.	 RM RM RM
7. Specific Agenda Items		
7.1	**Exception Reporting from Matrons:** No IPCC exception reports noted.	
8.	**Policies & Procedures**	
	None	
9. Updates from Committee/Groups:		
9.1	**Leeds Citywide IPCC Minutes:** This group may be disbanded due to the new formation of HCAI Improvement Group. Points of note: LCH – C.Diff. cases down minimum of about 11 a month. CCG's – exceed CDI targets. Allocations for 2016/17 have been released and are exactly the same as this 2015/16. Pandemic flu plans have been signed off by HP Board. TB – a couple of areas in the city (South Leeds) where there is a high instance of TB, extra funding has been released. Head lice – chronic levels and rising, prevalent in eastern European children. HCAI Group – will be looking into IC training figures and targets and also will review any RCA's sent to them. CPE – would like a common approach to these cases. We as a trust are low risk.	
9.2	**NYY IPCC Minutes:** No meeting	
9.3	**Joint Cleaning Standards:** Discussed in actions arising.	
10. Medical Devices		
10.1	**Medical Devices report & Update:** Medical Device walk around, 54 clinical areas – 48 visited, picked up: Acceptance checks – looks like some equipment is going to areas without going	

	through procurement. HD working with the procurement team on this issue. MD Inventory – updated most area's inventory, some tidying up still required. Manufacturer's instructions – picked up by the Matrons' audit & liaison with clinical staff, procurement team also involved with this. Manager's briefing pack - updated and will be redistributed. Training on the use of MD's – most managers doesn't have a recording system, taking forward. Service history (maintenance of equipment) – HG will email a reminder. Medical physics will carry out some planned preventative maintenance. Neil Andrews will write to all managers individually to arrange visits. Profiling beds – service plan being carried out. Models & manufacturers – unknown models will be risk assessed. Central Alerting System – Patient Safety incident reporting, responding to patient safety alerts. This alert gone to all risk forums. Patient safety alerts - Nothing reported to MHRA, some lessons learnt & medical devices. MD advice in the next 'Risky Business'. E-learning – will now be reported every quarter, very little uptake. MD trials will be part of the procedure update. HG will be offering 1:1 training on the use of Datix in the future. **Training Needs Analysis – Options appraisal** following meeting on 22/04 committee asked to support in taking this forward. Comments on Pros & Cons to HG by 8th June, this will then be taken forward by HG. HG to send out a proforma regarding equipment & instructions for use.	ALL HG
11	**Items for escalation:**	
	(i) To the Health & Safety Committee: None (ii) To the Quality Committee: None	
12	**Any other business:**	
12.1	Flu Campaign 2016 – Health & Wellbeing CQUIN 2016/17 advises that extra funding will be released to trusts if it reaches 65% or more (Flu Vaccine uptake) by 31st December 2016. If the uptake reaches 75%, this is worth around £225,000 to the trust. This year we need to identify more flu fighters and hold more training dates. First Flu meeting will be 4th July, future meeting dates TBC.	

Future meetings:

~~Wednesday 9th March 2016 @ 2pm – 4pm, Trust HQ~~
~~Wednesday 25th May 2016 @ 2pm – 4pm, Trust HQ~~
Thursday 25th August 2016 @ 2pm – 4pm, Trust HQ
Thursday 24th November 2016 @ 2pm – 4pm, Trust HQ

Leeds and York Partnership NHS
NHS Foundation Trust

INFECTION PREVENTION AND CONTROL
ANNUAL REPORT APRIL 2015 - MARCH 2016

improving health, improving lives

Contents

INTRODUCTION

1.1 This annual report details infection prevention and control activity between 1st April 2015 and 31st March 2016.

1.2 It provides an overview for the Board of Directors on the progress and achievements in infection prevention and control in relation to the annual Infection Control Programme (ICP); registration with the Care Quality Commission; compliance with the Health and Social Care Act 2008; Essential Standards Outcome 8 and Implementation of the Hygiene Code of Practice.

1.3 The Health and Social Care Act 2008 (amended 2015 Code of Practice for the prevention and control of healthcare associated infections and related guidance superseded the Health Act (2006), ensures that systems to prevent healthcare associated infections and compliance with policies are embedded in practice and a corporate responsibility.

1.4 The Trust's ICP for 2015/16 is based on the updated criteria and cross references all DoH guidance publications and CQC Health Care Associated Infection (HCAI) registration guidance.

2. REGISTRATION WITH THE CARE QUALITY COMMISSION

2.1 The Health and Social Care Act 2008 (amended 2015) established the Care Quality Commission (CQC) in 2008 and set out the regulation framework for health and social care activities. From April 2009, providers of health and social care had to be registered with the CQC. All Trusts are required to provide evidence of compliance with the Health and Social Care Act in order to register with the CQC. In 2015, Leeds and York Partnership NHS Foundation Trust (LYPFT) was again awarded unconditional registration with the CQC based on the compliance and work carried out under the annual infection prevention and control plan.

3. EXCUTIVE SUMMARY

3.1 Organisation

The Director of Nursing Professions and Quality is also the designated Director of Infection Prevention and Control (DIPC) for the Trust and reports directly to the Chief Executive and the Trust Board.

3.2 The DIPC is supported via a service level agreement with the Microbiology Department from Leeds Teaching Hospitals Trust (LTHT) providing a Consultant Medical Microbiologist.

The Senior Nurse Infection Prevention and Control is the nominated Trust Infection Control Lead, and is responsible for the development and implementation of the annual programme in compliance with the Health and Social Care Act 2008 (amended 2015). The Senior Nurse is also responsible for the development of infection control policies and their review.

The Infection Control Committee meets four times a year and is chaired by the DIPC. The Assistant Director of Nursing is the deputy chair. The Committee reports to the Board of Directors. It is made up of representatives from clinical teams, support services within the organisation and expert advisors. The overall purpose of this group is to provide both strategic and operational leadership in relation to IPC standards and performance. The group members are responsible for cascading information to their relevant teams and for bringing to the group, information aimed at improving standards.

4. PROGRESS OF THE INFECTION CONTROL WORK PROGRAMME 2015-2016

4.1 The Infection Prevention and Control Team (IPCT) has made considerable progress with the annual work programme 2015-2016.

Key achievements:

- There were no reportable cases of Clostridium difficile (C. diff) or MRSA. The Trust remains well within targets. (Target CDI 8, MRSA 0).
- Compulsory training. 80% of all staff attended various Infection prevention and control training sessions, an overall improvement of 2% on last year's figures.
- The seasonal flu vaccination programme was well received by staff with an increase from 40.9% ~~to 48.6~~to 48.6% of staff receiving the vaccine.
- The Environmental audit compliance was 86-96%, Compliance levels remain on par with the previous year.

5. Surveillance

Monthly data continues to be collected on the incidences of alert organisms. Reporting to the Board of Directors has been strengthened with monthly reports on alert organisms, outbreaks, incidents and mandatory training.

This Report provides an overview of infection prevention and control activity and provides comparison against previous years.

Key performance data is available via a series of reports from the IPCT information system to observe trends. The IPCT benchmark their service performance against national standards. A root cause analysis is undertaken for all alert organisms to identify contributing factors and learn from these events.

CDI contributory factors include:-

- Omeprazole (PPI) prescribed as a prophylactic.
- Irritable bowel syndrome.

.

Alert Organisms

YEAR	MRSA	GRE	E COLI	CDI	MSSA
2015/16	0	0	0	0	0
2014/15	0	0	0	4	0
2013/14	0	0	0	1	0
2012/13	0	0	0	0	0

Outbreaks year by year analysis

YEAR	QTR 1	QTR 2	QTR 3	QTR 4
2015/16	1	0	1	0
2014/15	1	0	1	1
2013/14	8	0	1	6
2012/13	2	3	3	5

5.1 Key issues raised and actions taken as a result of outbreaks

Outbreaks	
Key Issues	Action taken
When service users self-report episodes of diarrhoea, collecting samples has proven difficult.	Following outbreak feedback, we identified the need to provide disposable bed pans.
Where the requirement for service user isolation is required in inpatient services, this has remained a challenge.	Isolation policy advises staff to contact the IPC team, where additional guidance is available providing a consistent approach

Identifying and reporting of outbreaks and individual cases has improved.

6. MRSA Screening

6.1

The Trust participates in the Mandatory Enhanced Surveillance Scheme (MESS) and has accumulated robust information on the local pattern of MRSA HCAI. The Trust has seen 0 cases of MRSA bacteraemia. The trajectory for the year was set at no avoidable cases. In order to achieve this all new admissions meeting the screening criteria are followed up by the IPCT to ensure screening is carried out if required and completion of treatment where indicated.

7. Audit

7.1 In accordance with the Health and social Care Act 2008 (Amended 2015) infection prevention and control audits of the environment and compliance with infection prevention and control policies and procedures are carried out on all wards and departments by the IPCT. An audit tool specifically for the Mental Health/Learning Disability environment has been developed by a national team from the Infection Prevention Society (IPS), headed by the Senior Nurse Infection Prevention and Control. The results from audit provide evidence regarding standards of healthcare practice and compliance with policies and procedures including decontamination, hand hygiene, standard precautions and the safe disposal of sharps, in line with requirements for continued registration and compliance with the Hygiene Code.

IPCT environmental audits are scored to provide an indication of compliance and benchmarking in Leeds and York.

Overall achievement scores range between 86% and 98%.

- Below 75% represents minimal compliance and high risk.
- 76-84% represents partial compliance and a moderate risk.
- 85% and above represents compliance with minimal risk.

Issues identified are addressed at the Infection Prevention and Control and Medical Devices Committee meeting and The Joint Cleaning Standards Group.

Audits are completed with a pre-arranged member of the clinical team, the results are sent to the Clinical Team Manager (CTM) and Infection Control Lead. The action plan identifies standards that have not been met. The CTM will ensure completion of actions within the time scale

identified thereby completing the audit cycle. One key component of the year's audit programme had been to utilise a shortened version of the audit tool that could be carried out on a monthly basis by CTMs or Matrons allowing the IPCT to spot local issues more rapidly whilst having an added benefit of increasing communication with lead nurses.

7.2 The IPCT audit and investigate all sharps injuries on a quarterly basis. In 2014-15 8 needle stick injuries were reported and in 2015-16 following the introduction of the EU Directive on safety sharps, there were 7 needle stick injuries reported. The reports related to incorrect activation of the sharps safety device, of which 50% involved students. This is fed back to Leeds Beckett University and Leeds University programme leads and lead mentors via the Practice Learning Facilitator in order to learn from these incidents. The remaining incidents predominantly featured insulin pen needles. The Trust has moved to using BD auto shields to address the problem and incorporated this into training. Incidents reported to the IPCT via the Datix electronic reporting system 2015 to 2016, included bites, eye contamination and reported near misses. Recommendations are made and where indicated, practice changed as a result of investigations to prevent further incidents. To further support staff training the IPCT has developed a Think Sharps Safety video which can be found on the staff- net Infection control page.

7.3 The key to effective practice is an audit and education training programme; this has helped to improve knowledge and raise the profile of infection control in practice areas. The awareness of the potential risks of infection has been developed. The table below indicates the number of staff that have attended infection control training in the period April 2015 to March 2016 in comparison to the previous year.

Course	Staff Numbers 2014-15	Staff Numbers 2015-16
Infection Control Mandatory training update	2581	e-learning = 258 train the trainer = 64 classroom = 2185
Link Champions	65 active link champions	60 active link champions
TOTAL	2581 (78%)	2507 (80%)

Link Champion numbers do fluctuate as people move around, miss training or leave. We have 60 Link Champions listed compared to 65 the previous year. Following the loss of some services in York the two years cannot be directly compared as the total number of staff trained decreased. However the percentage of the remaining staff trained increased

7.4 The induction programme runs monthly and captures all new staff; the session focuses on hand hygiene as well as The Health Act, responsibilities of the Trust, its employees and standard precautions.

7.5 Infection control Link Champions have taken on the role of delivering training in support of the IPCT. The champions are provided with training materials and given access to equipment. Records are kept and are available for inspection by the Care Quality Commission. In

order to take on this role the Link Champions have received training in support of their role.

7.6 All clinical staff are required to attend an annual update and non-clinical staff attend every 3 years. During 2015/2016 the IPCT increased training capacity and introduced the on-line training for non- clinical staff to provide greater opportunity for staff to attend training.

8. Policy Development

8.1 Policy/Procedures under Development/Review

All relevant policies and procedures have been reviewed and updated over the last 12 months. A consultation process was carried out on all of the policies to ensure compatibility and policies were amended accordingly.

9. The Infection Prevention and Control Committee (IPCC)

9.1 The Committee, chaired by the DIPC, is made up of representatives from clinical services and support services within the organisation and expert advisors. The meetings are held on a quarterly basis. The overall purpose of this group is to provide both strategic and operational leadership in relation to IPC standards. The group members are responsible for cascading information to their relevant teams and for bringing to the group, information aimed at improving standards.

10. Reporting Arrangements

10.1 The day to day operational management of the IPC is led by the Senior Nurse who reports directly to the Assistant Director of Nursing and the

Director of Infection Prevention and Control or . The team meet on a regular basis to provide updates, and discuss future plans and progress against targets.

10.2 The DIPC is directly accountable and reports to the Chief Executive and the Board of Directors (BoD).

10.3 The DIPC leads the Quality Committee ensuring robust communication across the organisation.

10.4 The IPCT work closely with Public Health England and local services to ensure communication and a whole system approach is maintained.

11. Hand Hygiene Observational Audit

11.1 In 2015/16 the IPCT continues to facilitate the implementation of the DoH document Essential Steps to Safe, Clean Care (2007) and coordinated LYPFT wide hand hygiene audit. The audits were carried out by Infection Control Champions. The audits provided a means of monitoring compliance with hand hygiene policy across a wide range of staff.

11.2 The results are continually evaluated and fed back to staff and incorporated into the mandatory training programme.

The IPCT will seek to use the findings to improve compliance and target training over the next 12 months.
Ongoing Work is planned with the Link Champions to improve observational skills and consistency in audit results.

12. Aseptic clinical procedure

12.1 The IPCT has developed a procedure around aseptic techniques. We will work with services to develop and deliver training in relation to invasive devices and wound care in conjunction with tissue viability.

13. Decontamination of Re-usable Equipment

13.1 Accountability and organisational lead responsibility sits with The Head of Risk Management for the decontamination of medical devices. Compliance with (MDD) 93/42 EEC and standard C4c are continually monitored by annual infection control audit. All single use syringe systems and licensed single patient use equipment are now used in accordance with all national decontamination directives meeting the requirements of 93/42/EEC.

14. Cleaning Services

14.1 The Infection Prevention and Control Committee continues to monitor cleaning standards. The Senior Infection Control Nurse attends the Cleaning Standards Group which feeds back to the committee. The IPCT now provides training for all cleaning service staff.

14.2 LYPFT has policies and procedures in place for management of the environment which include waste management, cleaning services and food hygiene. The Facilities department and The Infection Prevention and Control Team are always actively seeking to get involved in programmes to improve services.

14.3 The Trust undertakes annual Patient Led Assessment of the Care Environment (PLACE) audits. The 2015 team consisted of the following people:-

- Infection Prevention and Control Team.
- Hotel Services Manager.
- PFI Contracts Manager.
- Head of Estates.
- Unit Managers
- Governor
- Patient Representative

The PLACE audit results cover areas remaining with the trust from 1st October 2015. Cleaning services identified the Becklin centre and Clifton House as areas that needed to improve. Great efforts have been made to improve the environment on the Yorkshire Centre Psychological Medicine, floor coverings, furnishings and fittings have been replaced. Following on from the report last year periodic deep cleaning continues across the trust on an annual basis. Weekly/Monthly walk rounds by Matrons and the IPCT are in place to ensure standards remain constant over the year. Provisional data from audit indicates further improvement. Action plans are already being implemented to further improve standards.

Results of the PLACE audit 2015

2015					
Site Name	LYPFT Cleanliness	LYPFT Food	LYPFT Privacy, Dignity and Wellbeing	LYPFT Condition, Appearance and Maintenance	LYPFT Condition, Appearance and Maintenance (dementia)
Asket Croft	97.10%	84.50%	91.07%	94.25%	
Becklin Centre	91.56%	85.82%	93.40%	91.72%	
Asket House	96.69%		94.85%	93.38%	
Newsam Centre	99.10%	97.55%	95.23%	95.92%	
Parkside Lodge	98.02%	85.88%	84.35%	93.33%	85.70%
The Mount	100.00%	87.65%	94.47%	99.72%	93.11%
2-3 Woodland Square	99.22%	91.95%	97.17%	92.42%	78.54%
YCPM	99.33%	96.17%	86.81%	87.80%	
Clifton House	95.94%	73.78%	88.62%	91.67%	
Mill Lodge Unit	99.31%	88.34%	78.13%	80.99%	
NATIONAL AVERAGE	97.57%	88.49%	86.03%	90.11%	74.51%
REGIONAL AVERAGE	98.20%	89.70%	87.80%	91.20%	73.50%
MENTAL HEALTH AVERAGE	97.60%	89.00%	90.70%	91.10%	84.80%
ORGANISATIONAL AVERAGE	97.63%	79.16%	90.41%	92.12%	85.78

15. Waste management

15.1 The Waste Policy is compliant with EU Directive and implemented through staff briefings. Complete audit of LYPFT compliance with the policy is carried out yearly by an external auditor.

16. Antibiotic prescribing

16.1 The pharmacy department's role is to guide the infection control agenda in areas of antibiotic prescribing. The Trust antimicrobial pharmacist is leading a group on antimicrobial stewardship. Antimicrobial guidelines are available on the intranet to promote with best practice and an annual audit is carried out to assess compliance with this. The guidance recommends empirical treatments with the aim of controlling resistance and reducing the incidence of and healthcare associated infections like Clostridium caused by broad spectrum antibiotics. Education for prescribers is being developed to support appropriate antimicrobial use. Overall antibiotic use remains low in comparison to acute trusts.

17. Key actions for success 2016/2017

The **Action plan/programme** is based on the code of practice for the prevention and control of health care associated infections (the Health and Social care Act 2008 see Appendix 1 for the full programme). Below are a few of the key points:

- IPCT environmental audits & Matron ~~audits~~Audits will continue to provide an accurate measurement of compliance and benchmarking to ensure best practice is followed. Provision of a minimum of one audit per year for Both Leeds and York is included in the work programme.
- Compliance with (MDD) 93/42 EEC and standard C4c medical devices will be monitored via the matrons audit tool, in particular documentation and tagging will be monitored;

- Develop and strengthen the role of the Infection Control Champion. Provision has been made for a minimum of one training session per month.
- Continue working with estates and facilities to ensure infection prevention and control procedures are followed, and incorporated into future building plans including upgrade to hand hygiene facilities and alcohol gel/foam dispensers across the Trust.
- To ensure that HCAIs are controlled and avoidable infections are prevented by providing monitoring systems and processes to achieve our targets.
- The Trust is committed to a Seasonal Flu vaccination programme. Local vaccine clinics will be held within clinical bases. This will enable staff to attend for their vaccine with the minimum of disruption. The Infection Prevention and Control Team took over leadership of the 2015-16 vaccination programmes, and will lead the vaccination programme with support from Occupational Health and local staff volunteers. This year we are looking to achieve a target in excess of 47%. The Department of Health target of 75% would be an ambitious target bearing in mind the mean average uptake for mental health trusts is recognised nationally to have a low uptake.

17.1 Multi agency relationships

Our public partners, Clinical Commissioning Groups, Public Health England, Leeds Community Healthcare, Leeds Teaching Hospitals Trust, Leeds Environmental Health, Infection Prevention Society, Leeds Metropolitan University, Tees, Esk and Wear Valleys NHS Foundation Trust, York Teaching Hospital NHS Foundation Trust and Environmental Health Selby, are afforded the opportunity to comment on new and revised policy patient information. Our partners will be consulted on initiatives including hand hygiene campaigns, pandemic

flu plans and new projects. One of our key actions for success is for the IPCT to regularly network ensuring our practice is based on the highest standards of evidence based practice.

18. Conclusion

18.1 Over the last 12 months the Infection Prevention and Control Team have made a considerable difference to services by increasing staff and public awareness. The service has developed awareness across the Trust and this is reflected in the steadily improving training figures and performance data.

18.2 The report recognises and acknowledges the achievements of the last 12 months.

ANNUAL INFECTION CONTROL WORK PROGRAMME 2016/17 Appendix 1

Objective	Action	Lead	Outcome	Evidence	Date to be achieved
1. To meet mandatory surveillance requirements, monitor trends in infection and identify potential outbreaks promptly CQC **Criterion 1,8**	• Continue common alert organism and condition surveillance i.e. Norovirus, MRSA, scabies, influenza • Ensure access to laboratory results from York, access to Leeds now available • To be alerted of all D&V viral samples taken • To visit the ward within 3hours of notification of 2 cases • Continue mandatory surveillance of MRSA,MSSA,E Coli and Clostridium difficile • Provide advice and support in the event of outbreaks or infection control incidents • Provide performance reports for the Board of	Stan Cutcliffe (SC) Gugu Ncube (GN) M Winspear (MW) MW,SC SC, GN,MW SC, GN,MW SC, GN,MW SC	Meet mandatory requirements. Report trends and outbreaks to Infection Prevention and Control Committee. Introduce new PHE tool for monitoring Norovirus.	Surveillance reports to IPCC. Root Cause Analysis (RCA) reports Summary of outbreak reports Minutes from the BoD meetings	Continuous Continuous Continuous Continuous Monthly

	Directors • A member of the IPCT will visit the ward receiving a new admission within 48hrs to ensure they have been screened on admission if required.	MW			
2. To provide specialist infection control input into the PLACE assessment process and national standards of cleanliness audits. **Criterion 2,7**	• To agree requirements and date of inspections with Hotel Services lead. • Follow up any infection control risks identified during these inspections • Agree any actions required with Hotel Services Lead and discuss at the Cleaning Standards Group. • Work with facilities to improve isolation facilities.	SC SC, GN,MW GN SC	That the PLACE teams are formally constituted and that expert advice is available. Issues regarding poor standards of environmental cleanliness are auctioned. Refurbishment of hygiene facilities.	PLACE Reports National PLACE returns National Standards Audits CSG Minutes	Complete March 2016 Continuous Continuous
3. To implement 'Essential Steps for Cleaner, Safer Care'.	• Implement the hand hygiene part of 'preventing the spread of infection' care bundle	MW	Risk associated with clinical practice will be minimised	Compliance audits	Bi yearly

Criterion 6	with CTMs/Infection Control Leads • Monitor the use of the inter healthcare patient risk assessments form • Review progress regularly at each Infection Control Lead update. • Review progress at Infection Prevention and control Committee meetings.	MW MW GN SC	Risk of cross infection is minimised Risk associated with clinical practice will be minimised As above	Audit results Infection Prevention and Control Committee Minutes	Monthly Quarterly Continuous
4. To ensure that infection control knowledge is appropriate to job role and purpose. To aid staff in compliance with up to date infection control policies and procedures. **Criterion 6, 10**	• Ad hoc sessions to meet training needs will be planned in response to requests, identified training need or audit findings. • Mandatory training will continue. Staff will be trained to monitor hand hygiene compliance. • Mandatory training will include outbreaks, standard precautions,	SC, GN,MW SC, GN,MW SC, GN,MW	To provide bespoke training to individual groups To provide enough training sessions to cover 100% of staff	Record of training sessions Lesson plans Record of training session dates provided	Continuous Continuous

	sharps and waste management • The Infection Control Champion programme will continue. The IPCT will provide ongoing support and guidance and as well as initial training and monthly meetings.	GN,MW	To provide bespoke training for Infection Control Champions two sessions per month	As above	Continuous
5. To improve hand hygiene awareness and compliance Safe hands for service users **Criterion3, 10**	• Continue with mandatory training programme and NPSA cleanyourhands campaign using the campaign materials to raise awareness among staff, patients and visitors. • Compliance will be monitored using cleanyourhands champions and infection control leads. • Provide suitable information and training for service users • Provide service user feedback forms	GN,MW MW GN,MW Link champions	Compliance with LPFT Hand hygiene procedure To identify areas of poor practice provide support and training to rectify any issues. To empower service users	Training records Service user feedback	Continuous Continuous

6. To undertake infection control audits of named inpatient, day case and addiction services using the adapted IPS/DH MH/LD audit tool. This will include hand hygiene, decontamination, use of PPE, safe sharps practice, environmental and other practice areas if relevant **Criterion 4**	• Undertake audits and complete reports. Follow up outstanding actions. • Support units to develop action plans for remedial action. • Advise Risk Manager and DIPC of any specific hazards/risks. • Report analysis of audit in Annual Report. • Undertake a monthly audit of the inter health transfer form. • Support and monitor monthly infection control audits /walk rounds carried out by matrons/Lead nurses/DIPC	SC, GN,MW SC, GN,MW SC, GN,MW SC MW GN	There is heightened awareness of infection control issues and practice standards are improved. Audit 50 locations Provide action plans for units audited by IPCT Provide current information to the IPCT	Audit Reports Action Plans Annual report LOG/ Audit Reports	Ongoing cycle: Monthly
7. To ensure that all staff receive infection control training at induction and as part of essential training.	• Infection Control input will be provided on the corporate induction programme, co-ordinated by the Staff Development Team. • Induction and essential training of medical staff	SC SC	Awareness of service, contact details and policies fundamental to safe practice Mandatory HHT Target 90% of staff	Training records Induction Packs Training records	Continuous Target completion

Criterion10	will be reviewed and evaluated and further developed as required. This will be monitored by the medical appraisal process.			Appraisal records	date March 2017
8. To ensure the provision of relevant, evidence based, up to date infection control policies that have been approved and ratified by appropriate bodies. **Criterion 10,9**	• Review and revise existing policies according to review date. • Ensure core policies /procedures are those required by the Hygiene Code. • Ensure policies, procedures and guidelines are available via Staffnet to ensure that all staff are working to the same standards. • Maintain links to other Trust wide policies, such as Occupational Health and HR policies on Blood borne viruses. • To review policies /procedures to ensure compatibility compliance with Both	SC SC SC SC SC	Trust wide policies, procedures and guidelines are available to all staff. Infection Control policies, procedures and guidelines reflect current infection control guidance.	Audit reports Infection Prevention and Control Manual. . IPCC Minutes. Quality Committee Minutes. Infection control staffnet page	Continuous Continuous Continuous Continuous or 2 yearly review

	Leeds and York • Move to one set of policy at the earliest opportunity	SC			
9. To ensure that service users and their carers are updated on risks of HCAI and given specific information on infections **Criterion 3, 10**	• Review currently available information and ensure it reflects current guidance and needs. Ensure information available on: • general risk of infection • diarrhoea and vomiting • MRSA • Clostridium *difficile*	SC	Infection Control Risks to patients, staff and visitors will be minimised.	Information leaflets on wards	Continuous
10. To ensure that specialist infection control advice is provided to work partners where infection control input will minimise risks to patients, staff and visitors. **Criterion 5**	An infection prevention and control member will attend meetings of relevant committees/groups i.e. • H&S • Waste/environmental management • Medical Devices • Clinical Procurement • New build/refurbishment steering groups • Quality • PHE	SC	Infection Control Risks to patients, staff and visitors will be minimised.	Meeting minutes	Continuous

	• Effective Care				
11. To ensure that new national guidance is reviewed and acted upon	• Ongoing review of national directives from the DH, NPSA, HCC/CQC	Stan Cutcliffe/Anthony Deery	Trust policies and infection control practice will comply with national guidance	Infection Prevention and Control Committee Minutes	Continuous
12. To ensure that the Trust meets requirements for registration with the CQC, reflecting core standards of the Hygiene Code (2006) as amended (2008)	• Review 9 criterions for registration with the CQC and assess level of compliance. • Produce action plans to address any areas where deficits identified • Provide evidence of frequent review. • Submit registration within agreed application period • Continually monitor quality of evidence for annual health check.	SC/Anthony Deery (AD) SC SC SC/AD SC	Registration with CQC Provide evidence sheet for ward use All wards to produce an evidence folder No breaches of the Code	Evidence form compliance criteria. Environmental audit IPCC minutes	Ongoing Ongoing Quarterly
13. To deliver written reports to the Board of Directors and make them available to the	• Ensure IPCC meetings are held at appropriate times in the calendar to ensure availability of papers to the BoD. • Ensure papers are	SC SC	All deadlines are met Submission deadlines	Meeting timetable Minutes Minutes	Ongoing Quarterly

Public.	submitted to the BoD at agreed times. • Ensure Infection Control Annual Report appears on the public website for information.	SC	of two weeks prior to meetings are met. Annual Report appears on LYPFT web site within 14 days of the BoD meetings.	Available on public web site	Expected completion date August 2016
14. To ensure that the Infection Control Team attends courses to obtain specialist information/qualifications. All staff to have the opportunity for development opportunities that will contribute to overall skill level and performance	• Identify training and development needs through personal development review process • Infection Control course	SC MW	Appropriately trained infection control team	Copy of qualification retained for records	Continuous Expected date of completion July 2017
15. To monitor the use of anti-microbials and promote prudent use.	• Audit supply of antimicrobial medicines to all units. • Appropriate antimicrobial prescribing to be part of Medicines management training for medical	Elaine Weston Dr. J Isherwood	Demonstrate the appropriate use of antibiotics through audit. Greater understanding of and adherence to prescribing guidelines with regard to antimicrobial	6/12 Audit report	Bi yearly

	staff.		medication used for treating and preventing infections.		
16. To increase the uptake of influenza vaccine by staff.	• Provide vaccination sessions in support of Occupational health • Provide vaccination sessions at trust Induction days	Helen Whitelam SC	Achieve 65% target.		March 31st 2017

AGENDA ITEM
23

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Northern School of Child and Adolescent Psychotherapy (NSCAP): Annual Report 2015-2016
DATE OF MEETING:	28 July 2016
LEAD DIRECTOR: (name and title)	Dr Jim Isherwood, Medical Director
PAPER AUTHOR: (name and title)	Lynda Ellis, NSCAP Clinical Director and Nick Waggett, NSCAP Operational 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	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)	

SUMMARY DETAILS OF THE PAPER

Purpose of paper	To provide up to date information to the Board about the work of NSCAP which is the North of England NHS Centre for Psychoanalytic Psychotherapy and which has been hosted within the Trust since 2008.
What are the key points and key issues the Board needs to focus on	NSCAP is a unique organisation and its aims, ambitions and successes are demonstrated in this Annual Report. The NSCAP model is to integrate clinical practice, research and training across the developmental lifespan: • NSCAP's largest contract is with Health Education England (HEE) to provide the North of England clinical training scheme for Child and Adolescent Psychotherapists, plus a wide range of post-graduate and briefer programmes for professionals working in both the child and adult sectors. The report demonstrates the continuing high quality and success of these programmes. • The launch of NSCAP Clinical Services (NCS) to provide specialist psychoanalytic assessment, treatment and consultation was celebrated in September 2015. This coincided with the commencement of a major contract with the School Partnership Trust Academies (SPTA) to provide a new service model for their Alternative Provision Development. • We were awarded, with the University of Leeds, a prestigious National Institute of Health Research (NIHR) 'Research for Patient Benefit' (RfPB) grant for a feasibility study for a trial on improving inter-generational attachment for children undergoing behavioural difficulties (TIGA-CUB).
What is the Board being asked to consider	The Board is asked to note the continuing success and development of NSCAP. The Board is asked to endorse the continuation of LYPFT's existing relationship and to support the development of NSCAP's integrative model and prospects for further income generation.
What is the impact on the quality of care	NSCAP is a highly regarded organisation which has consistently demonstrated the quality of its learning and teaching in validation and re-accreditation processes with universities and professional bodies.

What are the benefits and risks for the Trust	The Trust benefits from having a centre of expertise, with regional and national partnerships, on which it can draw to support Trust Strategic Objectives. NSCAP is also a net contributor to the Trust's financial position. A significant risk relates to uncertainty about the future of HEE as a commissioning body, and specifically the funding of NHS training for Child and Adolescent Psychotherapists, following changes to healthcare education funding introduced in the Comprehensive Spending Review.
What are the resource implications	NSCAP is a complex organisation which requires input and support from all of the Trust's corporate services, and for which HEE provide funding. A significant issue is that the lease for NSCAP's dedicated premises in Holbeck expires in August 2018 and support from Estates will be needed to either renew the lease or locate alternative accommodation.
Next steps following this paper being presented to the Board	NSCAP is currently finalising a new strategy document and would welcome the opportunity to present this to the Board at an appropriate time and to gain support for ongoing developments.
What are the reputational implications and how will these be addressed	NSCAP has an established reputation as an innovative and high quality organisation within and external to 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?	NSCAP has commenced a process to increase the representation of male students and black and minority ethnic (BME) students. An independent report was commissioned to help NSCAP investigate and address the facilitators and obstacles within their training and education programmes. The next step is to undertake a formal Equality Impact Assessment which is likely to inform national developments in this area.
What public / service user / staff / governor involvement has there been	Previously, the primary service users of NSCAP were the professionals undertaking training and there is a robust evaluation process for courses and opportunities for student feedback. Ways to extend this approach to clinical service provision are under consideration.
Previous meetings where this report has been considered (including date)	The Annual Report 2015-2016 was presented at the contract review meeting in June between the Trust and HEE.

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 NSCAP Annual Report 2015-2016 and to note NSCAP's continuing success and development.

*** 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).

NSCAP

Learning

ANNUAL REPORT

NSCAP is a major NHS centre of mental health practice, research and training.

Practice

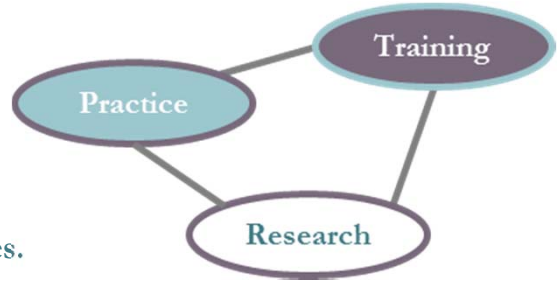
2015 - 2016

Research

NHS
Northern School
of Child and Adolescent Psychotherapy

CONTENTS:

Welcome to the NSCAP Annual Report 2015-2016

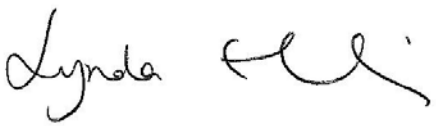


NSCAP is a unique organisation and our aims, ambitions and successes are again demonstrated in this Annual Report. The NSCAP offer, both in terms of range and type of activity, has been extended significantly over the past five years as we continue to adapt to and address current and future challenges.

The NSCAP model is to integrate clinical practice, research and training across the developmental lifespan, maintaining the quality of our uniquely psychoanalytic observational approach whilst at the same time engaging with developments from other clinical perspectives and modalities. The three components of the integrated model continue to develop in concert but are at different stages. The largest area of activity remains the contract with Health Education England (HEE) to provide the North of England clinical training scheme for Child and Adolescent Psychotherapists, and a wide range of post-graduate programmes and continuing professional development for professionals working in both the child and adult sectors. Ultimately all of this work aims to improve access to, and the quality of, services for children, young people, families and adults, especially where their needs are complex, severe or enduring. This year's report highlights the training in infant mental health and early intervention with under threes and their parents.

In the last two years the NSCAP 'tripod' has become increasingly more stable and sustainable as there have been significant and welcome developments in the other two 'legs' of clinical practice and research. The official launch of NSCAP Clinical Services (NCS) to provide specialist psychoanalytic assessment, treatment and consultation was celebrated in September 2015. This coincided with the commencement of a major contract with the School Partnership Trust Academies (SPTA) to provide a new service model for their Alternative Provision Development. Requests for clinical input continue to increase, demonstrating both a demand for specialist provision and NCS's status as a high quality provider. In the area of research the major news was that we were awarded, with the University of Leeds, a prestigious National Institute of Health Research (NIHR) 'Research for Patient Benefit' (RfPB) grant for a feasibility study for a trial on improving inter-generational attachment for children undergoing behavioural difficulties (TIGA-CUB). This report also highlights ongoing work to evaluate the effectiveness of our training and education programmes.

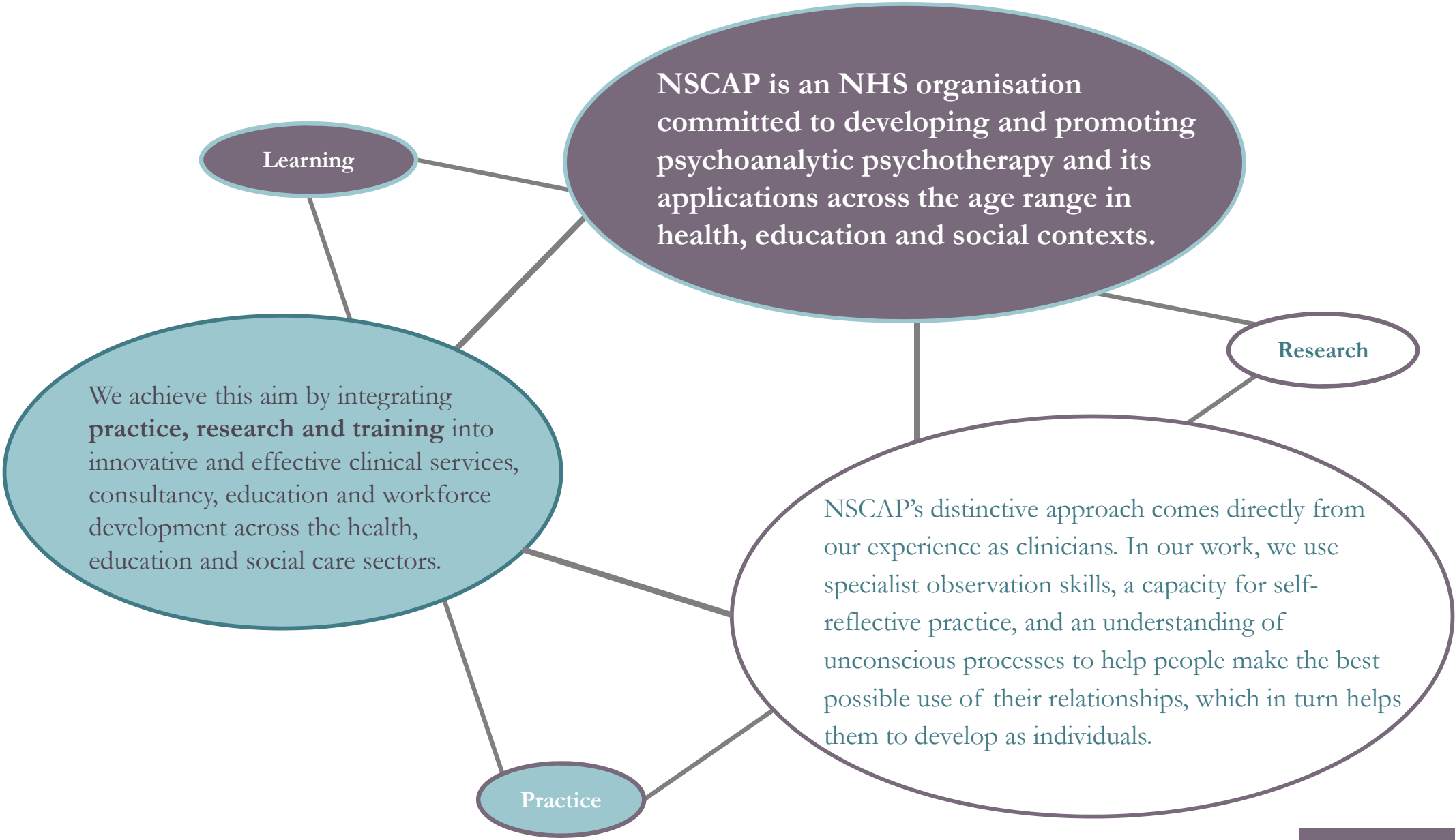
We know that significant challenges lie ahead, not least in proposed changes to the role and funding of HEE and further impacts from austerity measures. By working in partnership with key regional and national organisations and in further developing our integrated model we aim to position NSCAP as an invaluable centre for mental health practice, research and training that will be able to respond and innovate as new opportunities emerge.



Lynda Ellis, Clinical Director

Nick Waggett, Operational Director

NSCAP integrated practice, research and training:



NSCAP demonstrated the quality of its learning and teaching :

In addition to the successful university re-validations noted in last year's Annual Report NSCAP was visited in July 2015 by it's professional regulating body, the Association of Child Psychotherapists:

- The Association of Child Psychotherapists four-yearly re-accreditation of the clinical training in child and adolescent psychotherapy took place over three days and included visits to NHS Trusts hosting training placements and meetings with staff and students.
- The re-accreditation panel was led by Barbara Lund from Health Education England in the South West and was overseen by the Independent Scrutiny and Advisory Committee.
- The final report of the panel concluded that all ACP standards were met; unusually there we no conditions and there were a small number of recommendations to which we are responding.

"The visiting team is confident that NSCAP is being well managed and has rigorous and robust systems and processes in place. Course outcomes and learning outcomes are clearly defined, the system for recruitment and selection is well organised and thorough, as is the system for monitoring and tracking trainee progress."

We did well:

The panel commended NSCAP on the following:

• Excellent premises and facilities;
• An excellent handbook;
• The professionalism with which NSCAP manages the Professional Doctorate in Child Psychoanalytic Psychotherapy and its other courses;
• The School's capacity to think about the training and support for students in innovative and flexible ways;
• The way in which the School manages to support service supervisors and trainees over a wide geographical area;
• The way in which the School successfully manages placements in what are sometimes very challenging contexts;
• The recognition of the importance of the Service Supervisor role, evidenced through the organisation of service supervisor meetings, structured training and the funding of the post of Lead for Service Supervision.
• Excellent and committed teaching and administrative staff;

Standardised Course Evaluation

We continued to use our standardised quantitative and qualitative evaluation process across all NSCAP courses.

This process is now in its fourth year and is demonstrating statistically significant improvements in student's self-evaluation ratings after completing courses.

NSCAP commenced a process to increase the representation of male students and black and minority ethnic (BME) students

We commissioned an independent report to help NSCAP investigate and address the facilitators and obstacles to the representation of male students and black and minority ethnic (BME) students within our training and education programmes.

The independent report was produced by Rob Fitzpatrick and Dr Manawar Jan-Khan from Confluence Partnerships following a consultation process with internal and external stakeholders.

It is clear from the recommendations that NSCAP has a number of actions that can be taken forward straight away, beginning with a formal equality impact assessment, establishing systems for leadership, steering and student consultation, and conducting outreach work within BME communities.

There are also aspects of this work that can only be achieved through collaboration with partner organisations including Leeds and York Partnership NHS Foundation Trust, Tavistock and Portman NHS Foundation Trust, University partners, Health Education England, the Association of Child Psychotherapists and community organisations such as Touchstone. Through this process of engagement it is hoped that NSCAP will contribute to the development of a national agenda for race equality within child and adolescent psychotherapy training..

We are determined to continue the work started in this report to develop good practice in the recruitment, training and career progression of BME and male students.

The following external stakeholders contributed to the listening exercise.

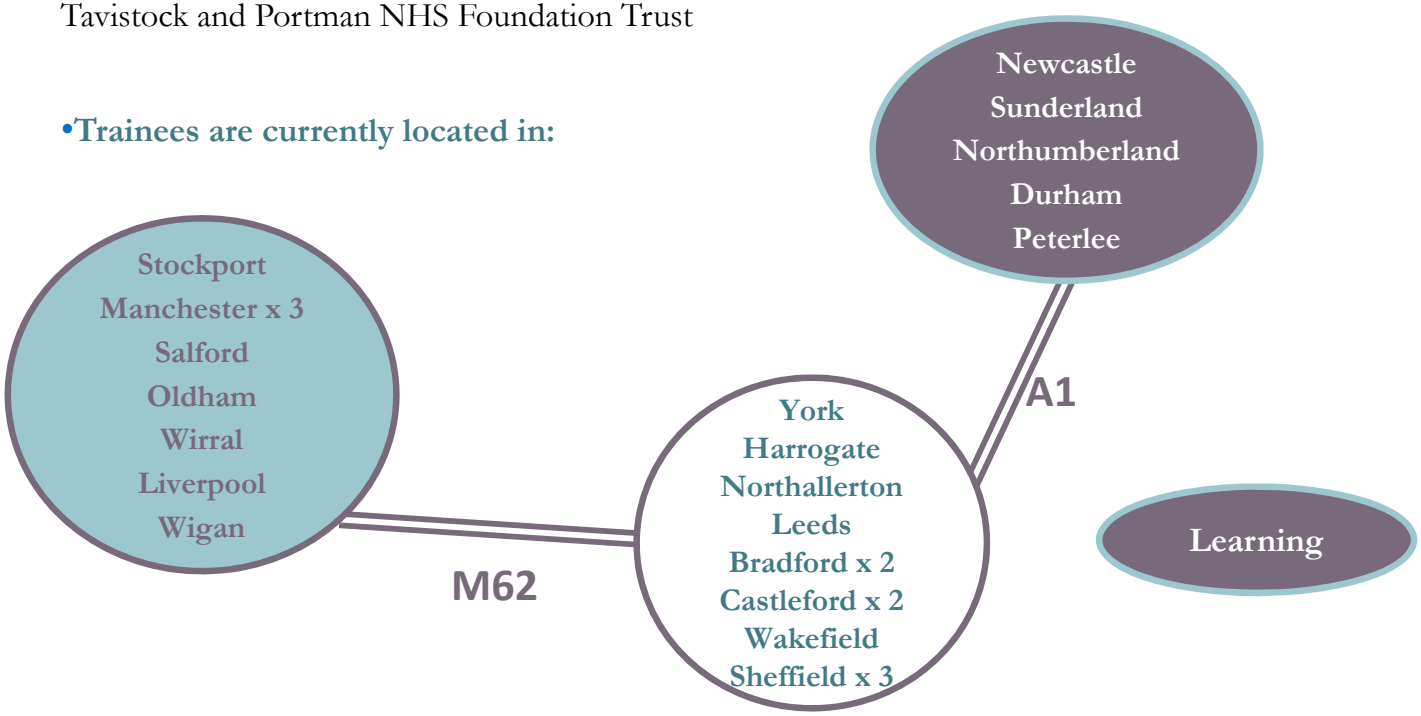
Name	Organisation	Role
Caroline Bamford	Leeds and York Partnership NHS Foundation Trust	Equalities Lead
Rachel Brown	University of Essex	Partnerships Manager, Academic Services
Andrea Overton	Health Education England	OD and Leadership Consultant Y&H
Sally Poysner and Vanysha Sahota	Touchstone	IAPT Manager and Community Development Worker
Karen Tanner	Tavistock and Portman NHS Foundation Trust	Associate Dean, Learning and Teaching
Heather Stewart	Association of Child Psychotherapists	Chair

NSCAP delivered clinical training to increase the specialist CAMHS workforce and access to services for children and young people:

The Health Education England funded NHS Clinical Training in Child and Adolescent Psychotherapy for the North of England:

- Eight trainees qualified in 2015 and secured employment in the NHS or related public services
- By the end of the 2015/16 academic year 45 people will have qualified as CAPts with NSCAP adding significantly to the CAMHS workforce.
- The total CAPt workforce in the North of England increased to 67 qualified and 21 trainees from a baseline of 13 qualified in 2003.
- The clinical training was accredited by the University of Essex as a Professional Doctorate in Psychoanalytic Child and Adolescent Psychotherapy and is delivered by NSCAP in partnership with the Tavistock and Portman NHS Foundation Trust

- **Trainees are currently located in:**



Completed Doctorates

In 2015/16 three students on the M80N programme were awarded their Professional Doctorates by the University of East London. They are:

Dr Janine Cherry-Swaine
Dr Christine Chester
Dr Julie Klingert Hall

NSCAP congratulates them on this significant achievement.

Trainees at 09/2015

Year	Number
First Year	7
Second Year	6
Third Year	4
Fourth Year	4
Extensions	0
Total	**21**
Completing Doctorate (Post-qualification)	**7**

NSCAP delivered post-graduate education to help professionals learn from experience and develop real improvements in practice:

Post-graduate programmes for professionals working with children, young people and families:

Psychoanalytic Observational Studies (Leeds)

	Students
First Year	12
Second Year	9
Third Year	7
Dissertation	8
Total	36

In partnership with the University of Leeds

Working with Adolescents: A Psychoanalytic Observational Approach (M33Leeds)

	Students
First Year	5
Second Year	6
Dissertation	2
Total	13

In partnership with the Tavistock and Portman NHS Foundation Trust and the University of Essex.

Working with Children, Young People and Families: A Psychoanalytic Observational Approach (M7Liverpool)

	Students
First Year	11
Second Year	4
Third Year	3
Dissertation	4
Total	22

The Psychoanalytic Observational Studies programme in Newcastle is delivered by *Northumbria University* and has an annual intake of six students.

Post-graduate programmes for professionals working with adults:

Foundation Course in Psychodynamic Psychotherapy (D58Leeds)

	Students
First Year	7
Second Year	6
Third Year	1
Total	14

Inter-cultural Psychodynamic Psychotherapy (D59Leeds)

	Students
First Year	6
Second Year*	0
Third Year	7
Total	13

*intake in alternate years

Learning

NSCAP trained people from a wide range of professions, enhancing their capabilities in working with resilience in complex and demanding services:

Occupations of new students starting programmes in 2015-16:

Psychoanalytic Observational Studies

- Teacher
- Creative Writer
- Primary School Teacher
- Secondary School Teacher
- Child Minder
- Foster Carer
- Self Employed Hypno-Psychotherapist
- Sessional Worker - Specialist Fostering
- Social Worker
- Educational Psychologist x 2

Working with Children, Young People and Families

- Paediatric Staff Nurse
- Therapist NEC
- Social Worker
- Foster Carer
- Unemployed
- Teaching Assistant
- SEN Support Worker
- Learning Coach
- Bookings Co-Ordinator
- ABA Tutor
- Paediatric Occupational Therapist

Working with Adolescents

- Youth Engagement Worker
- Family Support Worker
- Consultant Clinical Psychologist x 2
- Assistant Headteacher

Application process 2014-15 and 2015-16:

Course	Year	Applied	Withdrew	Deferred last year	Return from intermission	Intermitting	Re-apply next year	Late applications	Not offered place	Not accepted place	DNA interview	Confirmed students
M7L	2014/15	11	5	1								5
M7L	2015/16	20	3	5			1					11
MPO	2014/15	26			2	3		3	2	4	3	12
MPO	2015/16	33	4	7				6			4	12
M33N	2014/15	12	3									9
M33N	2015/16	5										5
M80N	2014/15	13					1		6			6
M80N	2015/16	13	1						5			7

NSCAP provided continuing professional development to improve the skills and capacities of people working across a wide range of services:

For Psychotherapists:

Neuroscience Research Reading & Clinical Discussion Group (Leeds)	23
Neuroscience Research Reading & Clinical Discussion Group (Cambridge)	20
Neuroscience Research Reading & Clinical Discussion Group (Edinburgh)	15
CPD Working with Complex Patients	**14**
CPD Working with Groups: Theory and Practice of Group Analysis	**13**
CPD Seminars - Hull Psychotherapy Service	**17**
New Donald Meltzer Study Group: "The Kleinian Development".	7
North West CPD Group for Child & Adolescent Psychotherapists	10
CPD for Service Supervisors of Trainee Child Psychotherapists	**10**

"Stimulating, thought provoking and challenging."

"The best style of teaching and learning that I have ever experienced."

One Day Events:

Donald Meltzer CPD Workshop	**23**
CAPt CPD events - Anne Alvarez Study Day	47
CPD One Day Event for Service Supervisors	**10**
Short-Term Psychoanalytic Psychotherapy (IMPACT) Study Day	20
(Not) Working Together - CPD for Yorkshire Psychologists	**50**
NLAAC Forum: 'The Challenge of Leadership in Residential Child Care'	60
NLAAC Forum: 'Reflective Social Work: The Way Forward'	64
NLAAC Forum: Using models to develop services for LAAC'	49

For the Wider Children's and Mental Health Workforce:

Personality Development - A Psychoanalytic Approach (Leeds)	**32**
Personality Development - A Psychoanalytic Approach (Manchester)	**18**
Organisational Development: A : Exploring personal & team effectiveness at work (Leeds)	9
Organisational Development: B: Exploring authority & leadership at work (Leeds)	7
Organisational Development: A: Exploring personal & team effectiveness at work (Manchester)	7
The Emotional Roots of Learning for Pen Green Children's Centre	**6**
Infant Mental Health and Early Intervention with Under Threes and their Parents (Oldham)	10
Infant Mental Health and Early Intervention with Under Threes and their Parents (Leeds)	10
Infant Mental Health and Early Intervention with Under Threes and their Parents (Oldham)	10
Leadership & Management in Residential Child Care	**9**
Workplace Leeds Work Discussion Seminars	**5**
The Institute of Psychoanalysis "Annual Introductory Lectures"	12

"I have really enjoyed being part of a small seminar group – really felt able to speak about my thoughts & feelings."

NSCAP provided intensive training for professionals in the early years workforce to help address difficulties in the parent-infant relationship:

Infant Mental Health and Early Intervention with Under Threes and their Parents 10-week series

The 10 week course in Infant Mental Health helps professionals address difficulties in the parent-infant relationship.
This highly regarded course considers infant development from the perspectives of psychoanalysis, attachment theory, infant developmental research, social policy and risk assessment.
The programme was developed by Child Psychotherapist Peter Toolan and has been delivered in Edinburgh and Newcastle, Leeds and Greater Manchester.

Feedback

“

Well pitched, good facilitation of interesting and relevant discussions; supportive learning environment.

Thoughtful approach to teaching, very knowledgeable tutors.

Really supportive and inclusive learning environment, pitched to involve all professionals from health visitors to service managers.

Excellent, thought provoking, participatory. The best course I have ever done. Very helpful for applying to my job and making me a better practitioner.

”

Outcomes of Course Evaluation

Full evaluations with pre- and post-course questionnaires have been completed and analysed for two series, one in Leeds and one is Stockport. The feedback and statistical analysis of responses is very positive.

A Wilcoxon Signed Ranks test was applied to the participants' pre- and post-course competency ratings. **The findings for both series show a statistically significant improvement in student's generic and specific competency self-evaluation ratings after completing the course.**

Generic competencies/areas of development, common to all NSCAP courses

a) my psychoanalytic understanding of emotional development/mental health/organisational psychodynamics, as relevant to the course
b) my capacity to tolerate complex/disturbing situations in relevant contexts
c) my capacity to reflect on myself and/or others in relevant contexts
d) my understanding of complex issues in relevant networks

Specific competencies/areas of development, linked to the course aims and intended learning outcomes

a) my understanding of parent-infant relationships
b) my knowledge of new ideas about early preventative intervention
c) my observational skills in relation to infant mental health and development
d) my understanding of behaviour as communication of an emotional state

NSCAP Clinical Services (NCS) continued to grow:

NSCAP Clinical Services NHS
Specialist Psychoanalytic Assessment, Treatment & Consultation

Following the NCS launch in September 2015, this year we have consolidated and enhanced the systems that govern and support our highly specialist psychoanalytically-informed clinical service.

This important work includes the successful migration to an electronic data system and a clinical management and governance structure that has afforded the progression from steering a vision to implementing it.

Implementing the vision:

- High quality facilities for on-site clinical services continue to be available but are operating at near full capacity. An extension of, or alternative to, existing arrangements will be required if we are to be in a position to respond to future clinical commissioning opportunities.
- The NCS-SPTA partnership, established to develop a service model for Alternative Provision for those children and young people unable to access mainstream education, has had a testing first year of operation. An annual activity and performance report is in preparation and will inform the service specification going forward.
- NCS was successful in being appointed to the Approved Provider List (APL) for the Provision of Therapeutic Services (Adoption/Post-Adoption) by North Yorkshire County Council led consortium of commissioners

Practice

- We continue to provide clinical consultations, assessment and treatment of children and young people with complex presentations and to parents/carers
- Our contract with Dove Adolescent Services has been augmented to provide not only specialist assessment and treatment for young people in residential care but also clinical opinion and advice in relation to referrals and admission to care
- Clinical consultation and work discussion remains a core component of provision to Leeds Mother and Baby (perinatal) Unit and has been enhanced by the provision of a training placement for a senior clinical child and adolescent psychotherapy trainee
- A steady flow of requests for individual and group supervision for a range of clinicians in different settings continues and incudes clinical supervision for those undertaking clinical training programmes hosted by NSCAP

NSCAP's research activity grew strongly:

We celebrated when:

- NSCAP's Research and Development Lead, Dr. Elizabeth Edginton, and a team from the University of Leeds were awarded a prestigious National Institute of Health Research (NIHR) 'Research for Patient Benefit' (RfPB) grant for a pragmatic, parallel-group, multi-centre individually randomised controlled feasibility study for a trial on improving inter-generational attachment for children undergoing behavioural difficulties (TIGA-CUB). The manual for this second line, Child Psychotherapy intervention for children aged 5-11 with conduct disorders and their primary carers has been developed by Lynda Ellis, Elizabeth Edginton, and Child Psychotherapy colleagues at NSCAP.
- We were awarded a White Rose Social Science Doctoral Training Centre ESRC Collaborative Award Studentship jointly with the University of York under the title: Relational dynamics and interaction in adolescent psychotherapy.

Research

NSCAP also:

- Welcomed senior CAPt colleagues from across the UK to the IMPACT Short-Term Psychoanalytic Psychotherapy National Implementation Group Meeting which was chaired by Dr Rajni Sharma who is leading the regional roll-out of the IMPACT STPP model for NSCAP.
- Delivered the 'Introduction to Researching Child Psychotherapy in the NHS' course for qualified Child and Adolescent Psychotherapists.
- Responded on behalf of the ACP to the consultation on NICE Guidelines for Depression in Children and Young People and psychodynamic psychotherapy is now included in the first tier of treatment for moderate to severe depression.
- Taught research and audit skills seminars for clinical trainees.
- Contributed significantly to the re-validated Doctorate in Child Psychoanalytic Psychotherapy with the University of Essex.
- Entered our third year of using a standardised quantitative and qualitative evaluation process across all NSCAP courses.

NSCAP continued to develop its role as a Hub for activity in the North:

We hosted and supported the delivery of several specialist training and development programmes in order to provide access to them in the North of England:

The Institute of Psychoanalysis "Annual Introductory Lectures" in Leeds.

The first Northern Cohort of the training in psychoanalysis at the Institute of Psychoanalysis.

MSc and BSc Programmes in Personality Disorder: Knowledge and Understanding Framework (KUF) run by the Institute of Mental Health in Nottingham.

Colleagues from the Family Nurse Partnership based in the region.

Adult IAPT Training

NSCAP is commissioned by HEE to deliver, for the Yorkshire and the Humber and North West regions, training in three IAPT-approved high intensity therapies:

Trainees in 2015/16	Y&H	NW
Couple Therapy for Depression	13	10
Couples Therapy Foundation Training	1	18
Dynamic Interpersonal Therapy (DIT)	1	6
Interpersonal Psychotherapy (IPT)	6	11
IPT Refresher Training for Supervisors	16	

We joined with the School of Education, University of Sheffield to organize:

The 3rd Psychoanalysis and Education Conference 2015

Keynote speakers:
Professor Stephen Frosh, Birkbeck, University of London
Professor Peter Taubman, Brooklyn College, New York
Professor Michael Rustin, University of East London

NSCAP was proud to present a talk by Kath Hinchliff on: 'Life after the NHS: a health care worker in Cambodia'

Kath Hinchliff worked for the Strategic Health Authority in Yorkshire and played a major role in commissioning the Northern School of Child and Adolescent Psychotherapy (NSCAP) in 2002. Following her retirement, she worked as a VSO health volunteer in Cambodia.

In this talk on she described how the country is still trying to rebuild its health system following the Genocide of the 1970s. She described how she supported the development of a health professional regulation system for maternity and other services and let us know what it was like working and living in an entirely different culture and context.

NSCAP collaborates with key organizations regionally and nationally:

NSCAP is funded and supported by:

NHS Health Education England

NSCAP's HEE contract is hosted by:

Leeds and York Partnership NHS Foundation Trust

NSCAP works in partnership with:

The Tavistock and Portman NHS Foundation Trust

NSCAP's clinical training is regulated by:

professional standards authority

ACP Association of Child Psychotherapists

NSCAP's is an Affiliate Member of:

British Psychoanalytic Council

NSCAP's academic partners are:

UNIVERSITY OF LEEDS

University of Essex

UEL University of East London

northumbria UNIVERSITY

NSCAP's clinical training placements are provided by:

- Central Manchester University Hospitals NHS Foundation Trust
- Bradford District Care NHS Foundation Trust
- South West Yorkshire Partnership NHS Foundation Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Foundation Trust
- Leeds Community Healthcare NHS Trust
- Sheffield Children's NHS Foundation Trust
- Alder Hey Children's NHS Foundation Trust
- 5 Boroughs Partnership NHS Foundation Trust
- Pennine Care NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust

NSCAP provides clinical services and training in partnership with:

School Partnership Trust Academies

THE INSTITUTE OF PSYCHOANALYSIS

pengreen Research, Development & Training Base & Leadership Centre

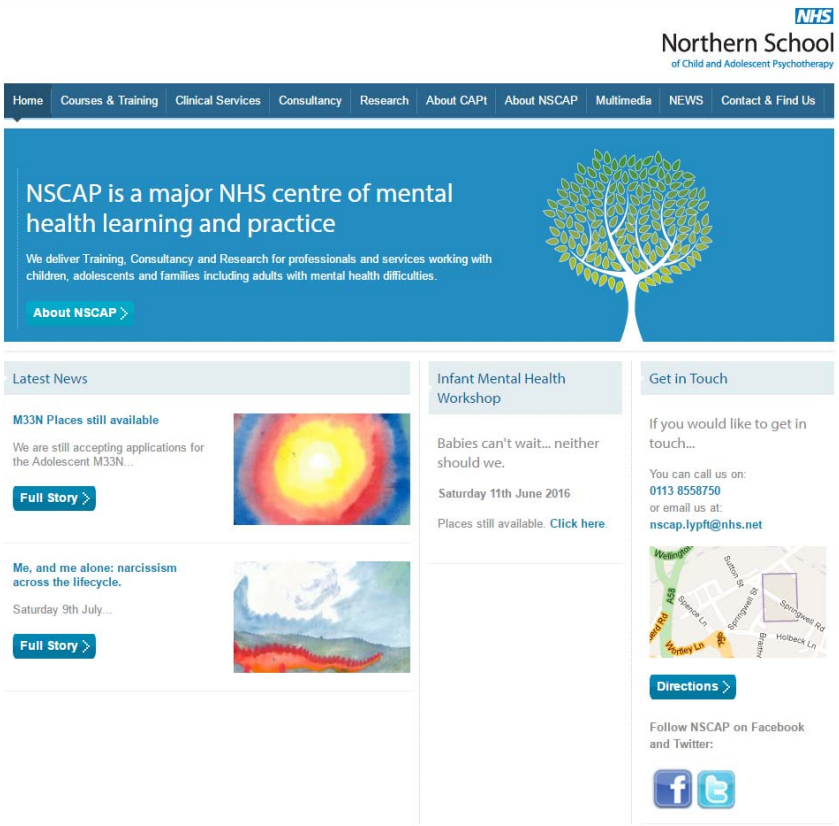
DOVE ADOLESCENT SERVICES

NSCAP delivers IAPT-approved training:

iapt Improving Access to Psychological Therapies NHS

Please visit the NSCAP website:

www.nscap.org.uk



We are also on Facebook, Twitter, LinkedIn and YouTube

Upcoming Events in 2016

Conference organised with the Harry Guntrip Psychotherapy Trust

Infant Mental Health Workshop: Babies can't wait... neither should we.

11th June 2016

Conference organised with Manchester Mental Health and Social Care Trust

Me, and me alone: narcissism across the lifecycle.

9th July 2016

Three-day Group Relations Conference with Conference Director Maxine Dennis

Looking Inwards & Outwards: Complexities of Leadership and Followership in Organisational Life.

7th – 9th September 2016

Northern School of Child & Adolescent Psychotherapy
Bevan House
34-36 Springwell Road
Leeds
LS12 1AW
Tel: 0113 8558750
Email: nscap.lypft@nhs.net